CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Primary Care First

Frequently Asked Questions

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General Questions

1. *What is Primary Care First, and what is it looking to achieve?*

   Primary Care First is a voluntary, five-year alternative payment model to **reduce Medicare spending** by preventing avoidable inpatient hospital admissions, and **improve quality and access to care for all beneficiaries**, particularly those with complex chronic conditions and serious illness. The model specifically aims to reward value and quality by offering an innovative payment structure to support delivery of advanced primary care.

2. *What are the benefits of participating in Primary Care First?*

   As a participant in Primary Care First, your practice has the opportunity to benefit from the following:

   - **Opportunity to increase revenue** with performance-based payments that reward participants for reducing acute hospital utilization
   - **Access to actionable, timely data** to inform care transformation and assess your performance relative to peers
   - **Focus on a single outcome measure** that has significant impact for patients
   - **Enhanced payments for practices** that specialize in complex, chronic patients and high need, seriously ill populations
   - **Potential to become a Qualifying APM Participant** by participating in an Advanced Alternative Payment Model
   - **Less administrative burden and more flexibility** so providers can spend more time with patients and deliver care based on patient needs

3. *Where can I go for more information on Primary Care First?*

   For more information on Primary Care First, please visit our website at https://innovation.cms.gov/initiatives/primary-care-first-model-options/. The Primary Care First website contains information on upcoming model milestones. CMS will also post information on upcoming events as well as various model resources, including reference guides, FAQ documents, and webinar slides as these materials become available.

Application Process and Timeline

4. *What is the application process and timeline if we are interested in joining Primary Care First?*

   The Primary Care First Practice Application can be accessed at the following link: https://app1.innovation.cms.gov/PCF. The deadline to submit applications is January 22, 2020. CMS will notify eligible practices selected to participate in spring 2020. Please note that each practice site that is interested in participating in Primary Care First and is a part of a health system, provider group, Accountable Care Organization (ACO), or other grouping of practices must submit a separate application.

For payers interested in aligning payment, quality, and data sharing in support of Primary Care First practices, CMS will solicit Statements of Interest through December 6, 2019 and a solicitation for payer partnership beginning on December 9, 2019 through May 1, 2020.

Please visit the Primary Care First website (https://innovation.cms.gov/initiatives/primary-care-first-model-options/) for updates related to model timeline and model application.

5. *How many practices will be selected to participate in Primary Care First?*

If your practice is interested in Primary Care First and eligible to participate, then you are encouraged to submit an application. Please note that if more than 3,000 practices meet the eligibility requirements, CMS will institute a lottery system to select practice participants, with a small portion participating in a control group and being eligible to receive associated incentives to compensate for participation in evaluation activities.

6. *Will there be another application period in 2021 for the 2022 model launch?*

Yes. CMS plans to hold a second round of applications for practices that would begin Primary Care First participation in January 2022 exclusively for practices currently participating in Comprehensive Primary Care Plus (CPC+).

7. *Are practices participating in the Independence at Home (IAH) demonstration eligible to apply to Primary Care First?*

In the interest of ensuring continuity of care for beneficiaries, practices participating in the Independence at Home (IAH) demonstration would be eligible to apply to Primary Care First to participate in the first cohort, even if Primary Care First is not otherwise offered in the region or regions in which they participate as part of IAH. Permitting these practices to apply to participate in PCF recognizes that the IAH demonstration is authorized under Section 1866E of the Social Security Act through December 31, 2020. Should IAH demonstration authorization be extended by Congress, CMS may reconsider this approach and other potential interactions between IAH and Primary Care First.

Participant Eligibility and Related Requirements

8. *What are the eligibility criteria for participating in the PCF-General component?*

The eligibility criteria for practices interested in participating in the PCF-General component include the following (*note: practices participating in the Seriously Ill Population (SIP)-only component are not subject to the specific requirements marked with a '*****'*):

- Be **located in one of the Primary Care First regions**
- Include **primary care practitioners** (Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Physician Assistant (PA)), which is defined as being certified in one of the following specialties: internal medicine, general medicine, geriatric medicine, family medicine, or hospice and palliative medicine.
- Provide health services to a **minimum of 125** attributed Medicare beneficiaries*****

- Have primary care services account for **at least 70%** of the practices' collective billing based on revenue. In the case of a multi-specialty practice, 70% of the practice's eligible primary care practitioners' combined revenue must come from primary care services*****
- Demonstrate **experience with value-based payment arrangements**, such as shared savings, performance-based incentive payments, episode-based payments, and/or alternative to fee-for-service payments
- Use 2015 Edition **Certified Electronic Health Record Technology** (CEHRT), support **data exchange** with other providers and health systems via Application Programming Interface (API), and connect to their regional, national, or vendor-mediated **health information exchange** (HIE)*. Note that SIP-only practices that do not already meet the requirement to use 2015 Edition CEHRT will be granted a one-year delay of that requirement. It is important to note that these practices who utilize the one-year delay may not qualify as an APM under MIPS. All SIP-only practices will be required to use 2015 Edition CEHRT by performance year two.
- Attest via questions in the Practice Application to a limited set of **advanced primary care delivery** capabilities, including 24/7 access to a practitioner or nurse call line, and empanelment of patients to a primary care practitioner or care team

9. If my organization is not located in a current Comprehensive Primary Care Plus (CPC+) Track 1 or 2 region or in the states added for Primary Care First, is there any way we can still participate?

CMS selected the 26 regions for Primary Care First to ensure that the model test population would be representative of the entire Medicare population for the purposes of evaluation and to limit impact on the existing CPC+ evaluation strategy. The practices in regions that can participate in Primary Care First starting in 2021 include practices in the existing 18 CPC+ regions as well as eight additional regions (Alaska, California, Florida, New Hampshire, Virginia, Delaware, Maine, and Massachusetts). Practices currently participating in the Independence at Home Demonstration authorized under Section 1866E of the Social Security Act may also be eligible to apply for the model, even if Primary Care First is not otherwise offered in their region.

10. How does Primary Care First define a practice?)?

A practice is defined as the legal entity that employs the participating primary care practitioner(s) providing care at a single "brick and mortar" physical location. All primary care practitioners who provide care at that brick and mortar location and are identified on a submitted participant list are considered part of that practice. Note that you are still eligible to participate if your practice delivers home-based care and does not have a brick and mortar location.

11. How does Primary Care First define a primary care practitioner?

Primary care practitioners are defined as a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Physician Assistant (PA)) who is certified in one of the following specialties: internal medicine, general medicine, geriatric medicine, family medicine, and or hospice and palliative medicine.

12. *Can federally qualified health centers (FQHCs) or rural health centers (RHCs) participate in the model?*

    Neither FQHCs nor RHCs are eligible to participate in the model. Primary Care First is designed to test payment reform for traditional fee-for-service payment, and the billing processes for FQHCs and RHCs are distinct from other primary care practices. Because FQHCs and RHCs do not submit claims on a Medicare Physician/Supplier claim form (CMS 1500) and are not paid according to the Medicare Physician Fee Schedule for office visits, they are not eligible for participation.

    If you are an FQHC or RHC and have ideas for payment innovations in these settings, we encourage you to submit your ideas to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). More information on the PTAC can be found here: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee.

13. *Can hospital-owned physician groups or practices within hospital systems participate in the model?*

    Yes. Hospital-owned physician groups and practices embedded within hospital systems are both eligible to participate in Primary Care First, as long as they satisfy the other eligibility criteria outlined earlier in this section. Each brick-and-mortar location of a hospital system or group practice must apply to Primary Care First separately.

14. *Are multi-specialty practices eligible to participate in the model? Would all providers be eligible for participation or only primary care providers?*

    Yes, multi-specialty practices are eligible to participate in the model. With regard to the eligibility criterion that requires primary care services to account for at least 70% of your practice's collective billing based on revenue, all NPIs designated as primary care practitioners at a multi-specialty practice will need to demonstrate that at least 70% of their cumulative total revenue comes from primary care services. Please note that all primary care practitioners at a practice location are required to participate in the model.

15. *Can you please further explain the eligibility requirement related to supporting data exchange with other providers and health systems via Application Programming Interface (API)?*

    The requirement to support data exchange via API is intentionally broad to allow practices to use APIs in the manner that best meets their needs. Primary Care First practices will be expected to support data exchange with other providers and health systems via API to eliminate the use of faxes for health information exchange (HIE). Connecting to a regional, national, or vendor-mediated HIE using an API, would meet both the API data exchange and HIE requirements.

16. *Will practices in Primary Care First be required to meet any interoperability requirements?*

    Participating practices in Primary Care First will have to comply with certain interoperability requirements that will be included in the Participation Agreement.

17. Is my practice excluded from participation if there is not a regional health information exchange (HIE) in our practice area? What if an approved region does not have a regional HIE?

Practices are required to meet all model requirements by the start of the model, unless otherwise stated in the Request for Application and Participation Agreement. Practices participating in the PCF-General component and the SIP-only component (as well as hybrid practices who are participating in both payment model options) are required to connect to a regional, national, or vendor-mediated HIE to send and receive health information for all patients. Note that SIP-only practices will not be required to meet these health IT requirements in the first model performance year (2021). CMS will provide general information to practices to help SIP-only practices prepare to meet health IT requirements beginning in the second model performance year (e.g., information about EHR platforms designed for hospice and palliative care providers that meet the CEHRT requirement).

The Innovation Center will evaluate requests for exceptions if no HIE exists in a region as of January 1, 2021; however, practices should be ready to connect to a HIE once one becomes available.

18. How should my practice demonstrate our experience with value-based care?

Your practice can demonstrate its experience with value-based care by identifying experience with payment that is tied to cost, quality, and/or utilization performance. Examples of potential arrangements include shared savings payments (or other performance-based incentive payments), episode-based payments, or other alternatives to fee-for-service payments, such as partial or full capitation. These examples are applicable for arrangements made with both CMS and other payers.

Overlap with Other CMS Programs and Innovation Models

19. Can current Comprehensive Primary Care Plus (CPC+) Track 1 or 2 practices apply to participate in Primary Care First in 2020?

Current CPC+ Track 1 or 2 practices cannot apply in fall-winter 2019 to begin participation in Primary Care First in 2021; however, existing CPC+ Tracks 1 and 2 practices will have an opportunity to participate in Primary Care First beginning in January 2022. More information on this participation option will be released at a later date.

20. Some but not all clinics within my multi-clinic organization are participating in a model that does not allow simultaneous participation in Primary Care First [e.g., Comprehensive Primary Care Plus (CPC+)]. Can the practices that are not participating in one of these models begin participation in Primary Care First in 2021?

Practices that are not simultaneously participating in a CMMI model as a practice or as part of a larger entity participating under a common Tax Identification Number are eligible to participate in Primary Care First in 2021. Primary Care First does permit practices to participate in some models simultaneously, as described in the Program Overlaps and Synergies section of the RFA.

21. Can practices participating in the Medicare Shared Savings Program (MSSP) apply to participate in Primary Care First?

Yes, practices that are currently participating in MSSP are eligible to simultaneously participate in Primary Care First. This overlap aims to enhance patient care while avoiding duplicative payment for shared savings across those two models. As part of this overlap, patient-identifiable payments made under PCF will be included in the aggregate payments for the ACO when comparing to the benchmark in any shared savings or losses calculation. Please see the Request for Applications (RFA) and the Primary Care First Website for more guidance on this policy.

22. How will this model interact with bundled payment models [e.g., Bundled Payments for Care Improvement Advanced (BPCI-Advanced), Comprehensive Care for Joint Replacement (CJR), Oncology Care Model (OCM)]?

Potential for overlap exists between Primary Care First and the BPCI-Advanced Model, as well as with the CJR Model, both of which involve a single payment for multiple services included in certain medical episodes in order to encourage efficiency. Potential for overlap also exists with the Oncology Care Model, which provides participating practices the opportunity to receive a performance-based payment for qualifying episodes of care. Your practice can participate in the Primary Care First Model while simultaneously participating in any one of these models, where eligible. Any PCF payments made on behalf of a patient attributed to your practice will be included in the aggregate fee-for-service (FFS) spending amounts for episodes of care under these episode payment models, prorated to account for overlapping time periods.

Quality Payment Program

23. Is Primary Care First considered an Advanced Alternative Payment Model (APM) or Merit Based Incentive Payments System APM (MIPS APM)?

CMS anticipates that Primary Care First will qualify as an Advanced APM for all five years of the model test. CMS also anticipates that, SIP-only practices that utilize CEHRT will be considered participants in an Advanced APM. However, SIP-only practices that begin to comply with the CEHRT use requirements beginning with performance year two will not be considered to be participants in an Advanced APM for performance year one.

MIPS Eligible clinicians in Primary Care First practices who are either Partial Qualifying Advanced APM Participants (QPs) that elect to report to MIPS, or who are neither QPs nor Partial QPs will be scored for MIPS under the APM scoring standard. MIPS eligible clinicians in control group practices are not considered to be participating in an Advanced APM and will be scored as a MIPS APM under the APM scoring standard.

24. If another payer chooses to partner in Primary Care First, would that be counted toward Advanced Alternative Payment Model (APM) status under the all-payer combination option?

If another payer offers a payment arrangement that is aligned with Primary Care First, this arrangement may be able to qualify as an Other Payer Advanced APM, which would allow participation in that payment arrangement to count toward achieving QP status under the All-Payer Combination Option. CMS reviews other payer payment arrangements on request

and determines whether they meet the Other Payer Advanced APM criteria on a case-by-case basis. To meet these criteria, a payment arrangement must:

(1) Require use of Certified Electronic Health Record Technology (CEHRT),
(2) Base payments in part on quality measures comparable to Merit Based Incentive Payments System (MIPS) measures, and
(3) Require participants to bear more than a nominal amount of financial risk,
(4) Be subject to an active Memorandum of Understanding with CMS under the Primary Care First model.

Primary Care First payer partners who believe that their aligned payment arrangements meet the criteria to be Other Payer Advanced APMs will be strongly encouraged to submit them to CMS for determination.

25. Should Merit Based Incentive Payments System (MIPS)-eligible clinicians continue to report for MIPS if participating in Primary Care First?

Clinicians participating in Primary Care First will have multiple opportunities each performance year to be determined to meet Qualifying APM Participant (QP) status. Clinicians that do not qualify for QP status and are Partial QPs may elect to participate in MIPS. Participating practices that are MIPS eligible unless otherwise excluded and should continue reporting for MIPS going forward. Please note that Primary Care First is a MIPS Alternative Payment Model (MIPS APM), which means that participating MIPS eligible clinicians are evaluated under the APM Scoring Standard. The MIPS APM criteria include:

(1) APM Entities participate in the APM under an agreement with CMS or through a law or regulation;

(2) The APM is designed such that APM Entities participating in the APM include at least one MIPS eligible clinician on a Participation List;

(3) The APM bases payment on quality measures and cost/utilization; and

(4) The APM is neither an APM for which the first performance year begins after the first day of the MIPS Performance Period for the year and is not an APM in the final year of operation for which CMS determines, within 60 days after the beginning of the MIPS performance period for the year, that it is impracticable for APM Entity groups to report to MIPS using the APM scoring standard.

Beneficiary Attribution

26. What is the beneficiary attribution methodology for the PCF-General component? Is patient attribution prospective?

Primary Care First aligns beneficiaries and pays prospectively for the next quarter based on retrospective data from the last 24 months, with patient lists provided to practices quarterly. For the PCF-General component, a patient will be prospectively aligned with your practice if the patient selected one of your practice's practitioners on MyMedicare.gov (known as 'voluntary alignment').

In the absence of voluntary alignment, the beneficiary will be prospectively attributed to the Primary Care First practitioner that billed the most recent Annual Wellness or Welcome to Medicare visit during the most recent 24-month 'look-back' period. If a Primary Care First practitioner did not bill an Annual Wellness or Welcome to Medicare visit during the 'look-back' period, the beneficiary will be assigned to the Primary Care First practitioner with plurality of the beneficiary's primary care and eligible Chronic Care Management (CCM) services during the 24-month 'look-back' period. If a beneficiary has an equal number of qualifying visits and eligible CCM services billed by more than one practice (as measured by a discrete count of services), the beneficiary will be aligned to the practice with the most recent visit.

This methodology differs for those beneficiaries attributed to the Seriously Ill Population (SIP) payment model option of Primary Care First. More information on this can be found in the 'High Need Population and Seriously Ill Population (SIP) Model Option' section of this document.

CMS will provide each practice with a list of its attributed beneficiaries prior to the start of the performance period of the model and will provide an updated list each quarter thereafter. To align with the claims-based processes, CMS will also assess selections in MyMedicare.gov on a quarterly basis.

27. How is beneficiary attribution determined if a beneficiary sees multiple primary care providers (PCPs) within a given quarter?

If a beneficiary selects a practitioner via MyMedicare.gov, he or she is attributed to that practitioner. If not, they will be attributed to the practitioner that billed the most recent Annual Wellness or Welcome to Medicare Visit in the previous 24 months. If no practitioner has billed for such a visit, the beneficiary will be attributed to practitioner that billed the plurality of primary care visits and CCM services during the 24-month 'look-back' period.

28. Can dually eligible beneficiaries be attributed to my practice for Primary Care First?

Yes. Beneficiaries who are dually eligible for Medicare and Medicaid can be attributed to your practice for Primary Care First. Dually eligible Medicare-Medicaid beneficiaries are not eligible for attribution for Primary Care First if they are aligned with a demonstration under the Financial Alignment Initiative (FAI).

High Need Population and Seriously Ill Population (SIP) Model Option

29. What criteria is used to define seriously ill population (SIP) beneficiaries?

CMS will use claims data to identify beneficiaries who meet the two general SIP patient requirements: (1) experiencing serious illness and (2) exhibiting a pattern of care fragmentation. Patients must meet one of the claims-based criteria for each of these requirements to qualify as SIP patients:

Serious Illness – Patients must meet any one of the following criteria:

(1) Have significant chronic or other serious illness [defined as a Hierarchical Condition Category (HCC) risk score at 3.0 or greater] OR

(2) Have high hospital utilization in the context of chronic illness, demonstrated by both of the following:

(a) Have an HCC risk score greater than 2.0 and less than 3.0; AND

(b) Have two or more unplanned hospital admissions in the previous 12 months OR

(3) Show signs of frailty, as evidenced by a Durable Medical Equipment (DME) claim submitted to Medicare by a provider or supplier for a hospital bed or transfer equipment

AND

Care Fragmentation – A Medicare beneficiary will satisfy the care fragmentation requirement if, based on claims data, one of the following conditions is satisfied:

(1) No single practice (defined at the TIN level) provided more than half of their evaluation and management visits; OR

(2) The beneficiary had a high rate of hospital visits, including Emergency Department use, or such other claims-based criteria as may be set forth in the Participation Agreement.

30. What is the attribution methodology for seriously ill population (SIP) beneficiaries?

If applying to the SIP payment model option, your practice must specify the service area(s) by zip code where you are interested in participating. Your practice must also define the maximum number of attributed SIP beneficiaries that it has the capacity to manage at one time. Once CMS uses claims data to identify SIP beneficiaries, they are attributed via the following steps:

(1) CMS reaches out to the beneficiaries who meet the SIP claims-based criteria in order to provide general information about the model and help confirm initial interest.

(2) Once the beneficiaries indicate their initial interest in the model, CMS connects them with SIP practices as soon as possible (i.e., generally targeting within 24-48 hours). CMS also provides a monthly list of SIP-eligible beneficiaries to participating SIP practices.

(3) Practices reach out to beneficiaries as soon as possible, ideally within 24 hours, but no later than 60 days after CMS includes a SIP beneficiary on their monthly SIP-eligible beneficiary list to engage that beneficiary, as evidenced by a Medicare claim for the first face-to-face visit with that SIP patient.

(4) After the participating practice submits a claim for the first face-to-face visit with the SIP beneficiary, the SIP beneficiaries will be attributed to the practice and the monthly SIP payments (calculated on a PBPM basis but paid quarterly) will begin.

31. If there are multiple SIP providers in the same geography, how will CMS determine who receives that beneficiary referral?

In the case of an overlapping service area between two or more SIP practices, CMS will randomly assign beneficiaries so that a roughly equal number from the overlap area are eligible to be attributed to each practice and placed on their outreach lists (final attribution

will depend on beneficiary outreach and engagement, as well as practices' maximum capacity).

32. Does my practice need to have a minimum number of seriously ill population (SIP) beneficiaries to participate in the SIP-only component of Primary Care First?

SIP-only practices do not need to have a minimum number of beneficiaries to be eligible to participate in the model. However, in order to be eligible to earn back their quality withhold and quality bonus, SIP-only practices must have a minimum of 20 beneficiaries attributed at some point during the performance year. This minimum is necessary in order to calculate reliable and valid quality performance.

33. Is there a maximum limit to how many seriously ill population (SIP) beneficiaries CMS can align to my practice?

CMS will not set a limit on the number of SIP beneficiaries that can be aligned to your practice; however, CMS will ask your practice to specify the maximum number of SIP beneficiaries that you have capacity to accept and will take this number into account when assigning SIP beneficiaries.

34. Will my practice receive payments for seriously ill population (SIP) beneficiaries for 12 months only, or will I continue to receive payments following the first 12 months of the program?

By default, attribution (and payment) for a SIP beneficiary will last for 12 months, unless the beneficiary is de-attributed from the practice earlier due to transition out of SIP, hospice enrollment, death, a move out of the practice's service area, or a gap between face-to-face visits of more than 60 days. However, because SIP is a time-limited, intensive intervention and stabilization care model, CMS will encourage SIP practices to maintain an 8-month average length of attribution (i.e., the length of time from when a beneficiary is attributed to a SIP practice to when they are transitioned) for their SIP beneficiary population. This in combination with consideration of associated quality metrics is intended to facilitate an appropriate and timely transition of the beneficiary to a longer-term model of care provided by the same practice or to another health care provider in the community. Practices that exceed this 8-month average length of attribution for their SIP beneficiary population will not be eligible to earn back the $50 per beneficiary per month (PBPM) withhold from their monthly SIP payment or the additional $50 quality bonus for any of its SIP beneficiaries attributed during the measurement period.

Practices will have the opportunity to request an exception to the 12-month payment limit for individual beneficiaries. CMS expects that exceptions will be rare and short in duration. CMS is considering the factors it will apply in granting such exceptions and will identify these factors in the participation agreement.

35. Can you please explain the components of the SIP quality adjustment (i.e. the quality withhold and bonus)?

CMS will withhold $50 per beneficiary per month (PBPM) from practices' $275 monthly SIP payment. SIP practices will have the opportunity to earn back the $50 PBPM withhold, as well as an additional $50 PBPM base rate quality bonus, for a total PBPM payment of $325.

Together, the withhold and the quality bonus make up the SIP quality adjustment, which will be calculated and paid out the following performance year.

To encourage SIP practices to facilitate appropriate and timely beneficiary transitions out of SIP, whether a SIP practice is eligible to earn back the $50 PBPM withhold or the additional $50 PBPM quality bonus will depend on whether they do the following:

1. Meet the 8-month average length of attribution requirement, and
2. Successfully transition beneficiaries so that they avoid hospitalizations and Emergency Department visits in the three months post-transition.

If a practice does not meet these two requirements, it will not have its $50 PBPM withhold returned and will not be eligible for a $50 PBPM quality bonus. If a practice does meet these requirements, its quality adjustment will be calculated based on its performance on a small set of quality and utilization metrics, including an advance care plan registry measure and a total per capita cost measure.

- If a practice meets or exceeds the 70th percentile on all quality and utilization metrics, it will earn back its withhold and the quality bonus, for a final PBPM payment of $325.
- If a practice performs above the 50th percentile on all quality and utilization metrics, but not above the 70th percentile on all metrics, it will earn back its withhold, but will not earn a quality bonus, for a final PBPM payment of $275.
- If a practice performs below the 50th percentile on any metric--as a result of not performing above the 50th percentile on all quality and utilization metrics--then it will not earn back the withhold or quality bonus, for a final PBPM payment of $225.

More details, including specific quality and utilization measures, can be found in the Request for Applications (RFA).

36. How will CMS determine when a patient is ready to transition out of the SIP, and what does the patient transition to?

SIP practices are required to transition beneficiaries out of SIP once they have been clinically stabilized and a resulting step-down in care intensity is indicated. The manner in which a beneficiary is transitioned out of the SIP component is different for SIP-only practices vs. practices that are also participating in the PCF-General component ("hybrid practices").

For hybrid practices, the transition of a beneficiary out of the SIP component may simply be a step-down in care intensity that occurs without a transition to a different practitioner or health care provider. CMS expects that in most cases, hybrid practices will continue to care for a beneficiary post-transition, under their participation in the PCF-General component. The beneficiary may not notice a significant difference in the care team and care management after the transition, although the beneficiary's care needs are expected to be lower because the beneficiary has been clinically stabilized.

However, SIP-only practices, which are not participating in the PCF-General component, may help their SIP beneficiaries establish a relationship with another health care provider in the community who will be accountable for coordinating and managing their care post-

transition, if the SIP-only practice does not have the resources or capabilities to manage the beneficiary's care themselves in the longer term. Ideally, the health care provider that the beneficiary is transitioned to will participate in a risk or outcomes-based care and payment program or Innovation Center model and will take over comprehensive management of the beneficiary's needs over the longer term. For example, depending on the beneficiary and their needs and goals of care, this might be a transition to a practice participating in the PCF-General component of Primary Care First, the Direct Contracting (DC) model, the Medicare Shared Savings Program, or—in appropriate cases—to a hospice organization. SIP-only practices may continue to provide care to a beneficiary once they have been transitioned out of the SIP component. However, this care will be billed and reimbursed through Medicare Fee-For-Service (FFS).

37. How would a hospice or palliative care provider go about partnering with a primary care participant?

Clinicians enrolled in Medicare who typically provide hospice or palliative care services (e.g., those affiliated with a hospice, palliative care, or similar organization) will be able to provide care for SIP beneficiaries by collaborating with primary care practices or by directly participating in the SIP component of the model. Hospice and palliative care clinicians that collaborate with a Primary Care First practice must have a contract with the practice and be listed on the practitioner roster that the practice submits to CMS. The contractual relationship between the practice and the hospice or palliative care clinician must comply with all applicable laws and regulations. Hospice and palliative care clinicians can, alternatively, apply to participate in the model as a participating practice and execute a Participation Agreement with CMS if their practice meets all eligibility requirements and is selected for participation.

Primary Care First Quality Gateway

38. What are the various quality reporting requirements for participating in the model?

CMS has lessened practices' quality reporting burden by reducing the number of measures required for reporting under this model. Reporting is required annually, and the reporting benchmark will depend on the relevant measure [Merit-based Incentive Payment System (MIPS) benchmarks or reference populations either within the model, outside the model, or in the Control Group].

39. How is the improved patient experience going to be measured and incentivized?

CMS will use a patient experience of care modified Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey as part of the Quality Gateway.

40. Which Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey will be used for Primary Care First and SIP?

In order to meet the unique needs of the model, CMS has modified the original CAHPS survey to allow for increased response rate and ease of use among beneficiaries. More details on this can be found in the Request for Applications (RFA).

41. What is the advance care plan measure used in both Primary Care First and SIP?

The advance care plan measure is a Merit Based Incentive Payments System clinical quality measure (MIPS CQM) that may be reported by a qualified registry, a qualified clinical data registry, or reporting method as designated by the Quality Payment Program.

42. Will the Quality Gateway measures be reported through the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) or Primary Care First if a practice is participating in both models?

If participating in both models, practices are responsible for meeting the reporting requirements for both MSSP and Primary Care First. As a result, reporting through Primary Care First, will not meet the reporting requirements for MSSP, and vice versa. Practice will have to report to MSSP, in addition to reporting to Primary Care First to meet reporting requirements for this model and those of MSSP.

Data Sharing

43. How often will CMS share data with practices? Are they retrospective or prospective reports (i.e., claims-based vs. provided in real time)?

CMS will share retrospective, Medicare claims-based data with practices on a quarterly basis. CMS plans to pursue making data available through an actionable, timely, and interactive Data Feedback Tool and/or—for practices with experience receiving and processing claims data—through Claims and Claims Line Feeds (CCLF). CMS will also offer data on Primary Care First payment and attribution on a quarterly basis.

44. What kind of claims data will be made available to practices?

CMS will offer the following reports, which will summarize Medicare Fee-For-Service (FFS) expenditure, utilization, and care delivery data:

- Patient-identifiable and practice-level quarterly feedback reports
- Regionally aggregated reports

CMS will also offer expenditures, top diagnosis codes, and beneficiary-level data from the claims data submitted by other practitioners from which practices' attributed beneficiaries seek care in order to help practices select cost-effective specialty partners in their region.

Multi-Payer Arrangements

45. Can you provide more information on what CMS is looking for in payer partnerships and how the payer benefits from this partnership?

In Primary Care First, CMS will encourage other payers—including Medicare Advantage plans, commercial health insurers (including their self-insured business), Medicaid managed care plans (to the extent permitted and consistent with the Medicaid managed care plan's contract with the state), and State Medicaid agencies—to offer participating practices similar financial support and incentives. CMS believes that value-based payment is far more impactful when it applies across the majority of a practice's patient population, rather than its Medicare Fee-For-Service (FFS) population alone. As a result, payers working together to

offer aligned payment models may be more likely to realize quality improvements and cost reductions.

As in Comprehensive Primary Care Plus (CPC+) Tracks 1 and 2, CMS is seeking payer participants that will align with Primary Care First's payment methodology, quality measurement strategy, and data sharing policies. CMS will allow for flexibility in how payers can align, recognizing that many payers have already developed their own value-based primary care models and may have members with different attributes and care needs than the Medicare FFS population. At a high level, CMS will evaluate payers' proposals based on the extent of their alignment with the following activities:

Payment

- Commit to pursuing private arrangements with participating Primary Care First practices for the model's full duration
- Reimburse participating practices through at least a partial alternative to FFS payment, such as a population-based payment
- Offer an opportunity for a performance-based incentive payment that aligns with the Primary Care First financial model. The payment should be tied to practice performance on a combination of cost, quality, and/or utilization metrics

Data Sharing

- Share their attribution methodologies with CMS
- Make practice- and patient-level data available upon request and in accordance with applicable law, including data on cost, utilization, and quality for their attributed patients, either through reports or other methods of data sharing at regular intervals (e.g., quarterly)
- Participate in multi-payer collaboration around data sharing and the use of regional data infrastructure to the greatest extent possible

Quality Measures

- To the greatest extent possible, align practice quality and performance measures with CMS and other payer partners

46. Can you explain the payer solicitation and associated requirements for payer partnership?

Payers are invited to submit a non-binding Statement of Interest form indicating interest in partnering with CMS in Primary Care First. The Statement of Interest form will be available on the Primary Care First website for interested payers to complete through December 6, 2019. When the practice application period closes, CMS will notify payers that submitted Statement of Interest forms of how many practices applied, by region. Payers will be able to use this information to decide in which regions to respond to the formal payer solicitation, which will open once the practice application period closes.

The payer solicitation will be available to both existing Comprehensive Primary Care Plus (CPC+) Model payer partners and new, interested payers that have members in the eligible regions from December 9, 2019 to May 1, 2020. Payers do not have to submit a Statement of Interest form in order to respond to the payer solicitation. CMS will review

responses to the payer solicitation and select payer partners based on how well their proposed model aligns with Primary Care First in the domains of payment, data sharing, and quality measurement.

CMS will enter into a Memorandum of Understanding (MOU) with each selected payer partner, which will memorialize the payers' agreed upon payment approaches and state how they are expected to align with CMS on payment, quality measurement, and provision of data to practices. All payers should separately enter into agreements with the participating practices.

47. Will new payers be allowed to join following model application and launch?

CMS will allow new payers to join after the initial application period and model launch. CMS will provide additional detail about this process in the future.

Primary Care First Payments

General Payment Questions

48. Does the payment structure for Primary Care First replace all fee-for-service (FFS) billing, or are other FFS codes still billable?

The following table lists the services, with their relevant Healthcare Common Procedure Coding System (HCPCS) codes, that are included in the flat primary care visit fee and will be reimbursed according to the flat primary care visit fee rate if they are billed by your practice. If your practice bills for services that are not included in the flat primary care visit fee, you will receive the standard Medicare FFS payment for these services. The exception is billing of the chronic care management codes, which are not included in the flat primary care visit fee and should not be billed by participating practices for attributed beneficiaries because the professional population-based payment is designed to account for care management services.

Services Paid under the Flat Primary Care Visit Fee

HCPCS Codes	
Office/Outpatient Visit E/M	99201-99205, 99211-99215
Prolonged E/M	99354-99355
Transitional Care Management Services	99495-99496
Home Care E/M	99324-99328, 99334-99337, 99339-99345, 99347-99350
Advance Care Planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439

49. Will specialists continue to operate under Medicare Fee-for-Service (FFS)?

Primary Care First is a primary care model and only primary care practitioners (as defined in Question 11 above) are eligible to participate in Primary Care First. If a multi-specialty practice participates in Primary Care First, there will not be any change in specialists' payment or billing.

50. Will practices be permitted to offer beneficiary engagement incentives as part of this model?

CMS intends to allow practices to reduce or waive the applicable co-insurance for the flat primary care visit fee, with practices responsible for covering those costs (i.e., CMS will not compensate practices for the loss in cost sharing revenue). This approach would incorporate certain safeguards against abuse and allow practices flexibility to better support patient engagement, while allowing practices to focus on populations that might benefit most from co-insurance support, e.g., those with frequent or recent emergency department and hospital visits. Practices that wish to take advantage of this beneficiary engagement incentive must submit an implementation plan at a later date that identifies the categories of beneficiaries who will be eligible for cost sharing support, the types of services furnished by the practice that would be eligible for cost sharing support, and such other information as CMS may require. The implementation plan is subject to CMS approval. Primary Care First practices will be required to implement its cost sharing support policy in accordance with the implementation plan approved by CMS.

CMS may also permit practices to offer certain beneficiary enhancements, such as free or discounted local transportation services for any beneficiaries requiring face-to-face care with their Primary Care First practice or follow-up services outside of the primary care setting, such as transportation to a pharmacy or to a health care provider for specialty care. Primary Care First may also include additional patient engagement incentives, such as access to nutrition assistance programs (e.g., Weight Watchers) and remote patient monitoring technology. More details about patient enhancements will be available in the Primary Care First Participation Agreement.

51. How will Medicare beneficiary coinsurance be determined?

The professional population-based payment does not have associated coinsurance; however, there is an applicable patient co-insurance for the flat primary care visit fee. The standard 20% Part B coinsurance will be calculated based on the PFS allowed amount for the HCPCS code that a practice bills to receive the flat visit fee, rather than 20% of the flat visit fee rate. In other words, coinsurance will be equivalent to what a beneficiary would have paid under traditional FFS for the same primary care service and will not increase or decrease as a result of their attribution to a Primary Care First practice. As noted in the response to the preceding question, CMS intends to allow practices to reduce or waive the applicable co-insurance for the flat primary care visit fee, provided that certain conditions are satisfied. Practices will not be permitted to waive any applicable deductibles.

Total Primary Care Payment

52. What is the total primary care payment?

The total primary care payment is a hybrid payment that incentivizes advanced primary care while compensating your practice for higher-risk patients. It is composed of two types of payments:

1. Professional population-based payment: This is a per-beneficiary, per-month (PBPM) payment for services in or outside the office, adjusted for caring for higher risk populations. The payment amount depends on the average risk score of your practice's attributed patient population and is the same for all patients within your practice. This is paid prospectively on a quarterly basis.
2. Flat primary care visit fee: Payment for face-to-face primary care that reduces billing and revenue cycle burden, paid on a claim-by-claim basis.

53. Does the flat primary care visit fee apply to all services billed by a practice, such as flu shots, vaccines, labs, and other ancillary services?

No, the flat primary care visit fee does not apply to all services billed by a primary care practice. Primary Care First payments were designed to encompass primary care services delivered by the majority of primary care practices, as opposed to every code potentially billed. Please refer to the table below for the list of services covered by the flat primary care visit fee; all other services furnished by a Primary Care First practice will be reimbursed under traditional fee-for-service (FFS) Medicare.

HCPCS Codes	
Office/Outpatient Visit E/M	99201-99205, 99211-99215
Prolonged E/M	99354-99355
Transitional Care Management Services	99495-99496
Home Care E/M	99324-99328, 99334-99337, 99339-99345, 99347-99350
Advance Care Planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439

54. Will Chronic Care Management (CCM) Current Procedural Terminology (CPT) codes still be payable under Primary Care First?

No. CCM has already been accounted for and built into the professional population-based payment, given that CCM services are a critical component of primary care that contributes to better health and care for individuals. CCM primarily reimburses practitioners for activities that are furnished outside of a face-to-face visit, such as telephone communication, review of medical records and test results, and coordination and exchange of health information

with other practitioners and providers. However, if the practitioner believes a given beneficiary would benefit from additional face-to-face care related to chronic care management, they can deliver that care in the context of an E/M visit, and that E/M visit would be paid via the flat visit fee.

55. Does the flat primary care visit fee apply to telehealth visits?

Many Medicare telehealth services are billed using the same codes as in-person services, with a modifier to indicate that they were provided via telehealth. If the code billed for a telehealth service is included in the list of codes eligible for the flat primary care visit fee (e.g., an evaluation and management (E/M) visit), is billed by one of the Primary Care First practice's clinicians, and meets the Medicare telehealth coverage requirements (e.g. originating site requirements), the flat primary care visit fee applies. Further guidance regarding requirements and potential waivers will be issued at a later date.

56. Does the flat primary care visit fee apply to licensed and credentialed providers, such as nurse practitioners (NPs) and physician assistants (PAs)?

Yes. The flat primary care visit fee applies to eligible, face-to-face visits performed by primary care practitioners (MD, DO, CNS, NP, PA) in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine specialties.

57. Is risk group assigned based on the average Hierarchical Condition Category (HCC) risk score of the total patient population at my practice? Or, is risk group assigned to beneficiaries on an individual basis (e.g., my practice has 25 beneficiaries in risk group 2, 15 beneficiaries in risk group 3, etc.)?

The risk group is assigned based on the average HCC risk score of your practice's attributed patients; in other words, it is not assigned on an individual basis. The annual average HCC risk score will be used to classify your practice into one of four practice risk groups. Each practice risk group is associated with a professional, population-based, per-month payment amount.

For example, if your practice has 500 attributed beneficiaries and the average risk score among these beneficiaries is within the range of a group 3 risk practice, CMS would pay your practice the corresponding professional population-based payment ($100) per patient per month.

58. Will practices know which risk group they are aligned to prior to making a decision to participate?

It is CMS' goal to provide interested practices with as much information as possible to inform their decision about whether to participate in Primary Care First. To that end, we will make preliminary risk group information available to practices in advance of signing the Participation Agreement with CMS based on available data.

59. Can you elaborate on the "Leakage Adjustment"?

To ensure that practices continue to provide care to their attributed patients, the professional population-based payment will also be adjusted to account for "leakage rates," or the percent of primary care evaluation and management (E/M) and chronic care management (CCM) services furnished outside of the practice to the practice's attributed beneficiaries.

CMS will calculate a practice's leakage rate by dividing the number of primary care visits or qualifying CCM services from any provider that attributed beneficiaries received from practices other than the Primary Care First practice in the prior performance period, with adequate claims run-out, by the total number of primary care visits or qualifying CCM services from any provider that these beneficiaries received from any practice in the same time period.

Performance-Based Adjustment

60. When will the performance-based adjustment first be distributed, and how often does the performance-based adjustment occur?

The performance-based adjustment will first be distributed in quarter 3 of the first performance year. The performance-based adjustment is calculated and applied to payments on a quarterly basis and will apply to all performance years of the model.

61. How does the performance-based adjustment impact the total primary care payment?

The performance-based adjustment is an opportunity for your practice to increase revenue by up to 50% of your total primary care payment based on key performance measures. If a participating practice fails to exceed the Quality Gateway in performance year one, the maximum PBA it can earn in the second performance year is 0%. Whether it ultimately receives a neutral PBA (0%) or a negative PBA for each quarter of the second performance year will depend on its acute hospital utilization (AHU) performance relative to both the regional and historical benchmark. In performance year three and beyond, failing to exceed the Quality Gateway in the previous performance year will result in an automatic -10% PBA. The Quality Gateway penalty phases in to ensure practices continue to focus on quality outcomes as they become familiar with the model measures.

62. How is the regionally-based performance adjustment calculated?

To ensure that practices being rewarded are exceeding the performance of an average practice nationally, participating practices that exceed the Quality Gateway must also exceed the 50th percentile of a nationally constructed AHU benchmark to be eligible for a positive PBA. Practices that exceed these minimum thresholds will be eligible to earn a positive PBA based on how they perform relative to both a regional and individual historical benchmark.

Qualifying practices will have their PBA determined based on a regionally-specific benchmark. To calculate the regionally-based adjustment, CMS will establish a benchmark using data from a regional reference group of peer practices (including practices that do not participate in Primary Care First). There are seven possible levels of performance for the regionally-based adjustment, depending on practices' performance relative to the regional reference group, as summarized below:

Regionally Based Adjustment Potential Based on Performance Against Peer Practices Amongst Practices Performing in the Top 50 Percent of National Primary Care	
PBA Performance Level	**% of Total Primary Care Payment**
Group 1 – Top 10% of regional practices	34%
Group 2 – 11% - 20% of regional practices	27%
Group 3 – 21% - 30% of regional practices	20%
Group 4 – 31% - 40% of regional practices	13%
Group 5 – 41% - 50% of regional practices	6.5%
Group 6 – 51% - 75% of regional practices	0%
Group 7 – Practices performing in the bottom quartile of their region	-10%

Participating Primary Care First practices whose performance on the AHU measure places them in lowest 25% of the regional reference group will receive a -10% performance-based adjustment to a future quarter's total primary care payment. Participating practices whose AHU performance falls in the top 10% of the regional reference group will receive at least a 34% performance based-adjustment to a future quarter's total primary care payment (not including the historically-based adjustment).

63. How are continuous improvement targets determined?

The historically-based adjustment, also known as the continuous improvement (CI) bonus, rewards a practice's individual performance improvement on the Acute Hospital Utilization (AHU) measure. The practice's AHU performance will be compared to its own performance in the four-quarter period immediately preceding the performance period to calculate a practice's CI score. The CI score will then be used to determine the amount of the practice's CI bonus. A CI bonus will be paid to eligible participating practices each quarter, as long as they achieve their improvement target.

CI Bonus Potential based on Practice Improvement Performance		
AHU Regional Performance Level during the Historical Benchmark Period	**% Bonus on Total Primary Care Payment**	**Benchmark Group**
Group 1 – Top 10% of regional practices	16%	Practice's performance in the prior 4 quarters
Group 2 – 11% - 20% of regional practices	13%	Practice's performance in the prior 4 quarters
Group 3 – 21% - 30% of regional practices	10%	Practice's performance in the prior 4 quarters
Group 4 – 31% - 40% of regional practices	7%	Practice's performance in the prior 4 quarters
Group 5 – 41% - 50% of regional practices	3.5%	Practice's performance in the prior 4 quarters
Group 6 – 51% - 75% of regional practices	3.5%	Practice's performance in the prior 4 quarters
Group 7 – Practices performing in the bottom quartile of their region	3.5%	Practice's performance in the prior 4 quarters

How to Learn More

You can find more materials and information at the model website: https://innovation.cms.gov/initiatives/primary-care-first-model-options/.

If you have questions or feedback, please email PrimaryCareApply@telligen.com.