



Primary Care First Model

Frequently Asked Questions for Payers

1. *What does it mean for Primary Care First to be a multi-payer model, and does it differ from the Comprehensive Primary Care Plus (CPC+) Model?*

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. In Primary Care First, CMS will encourage other payer organizations to offer participating practices financial support and incentives that are similar to those in Primary Care First.

As in CPC+, CMS is seeking payer partners that will align their value-based primary care programs with Primary Care First's payment methodology, quality measurement strategy, and data sharing policies. Aligned models may differ on specific details, e.g. in the mechanics of their payment methodologies, but should align with Primary Care First's core model principles and objectives. The four core principles of Primary Care First are:

- (1) Moving away from a fee-for-service payment mechanism;
- (2) Rewarding value-based outcomes over process;
- (3) Using data to drive practice accountability and performance improvement; and
- (4) Leveraging multi-payer alignment as a critical tool for driving adoption of value-based care models.

CMS will enter into a Memorandum of Understanding (MOU) with each selected payer partner, which will memorialize the payers' agreed upon payment approach and include shared expectations for alignment around payment, quality measurement, and provision of data to practices. All payer partners will enter into their own separate agreements with the practices participating in Primary Care First to establish the terms of their own aligned models and how those models will impact practice reimbursement for services provided to their attributed members.

2. *How do payers benefit from partnering in Primary Care First?*

Increasing the value of healthcare spending is a common goal among payers, and most payers in the United States are now testing new ways to incentivize and support a transition towards value-based care. CMS believes that if payers work together to align these efforts, they can have a greater impact on practice performance than if they pursue independent initiatives. According to this theory of change, practices are more likely to change their behavior in response to value-based payment incentives when they face the same incentives across a majority of their patient population. One payer acting alone may struggle to affect how a practice delivers care, particularly when they only cover a small share of a practice's patient population. However, multiple payers working together can have a substantial impact if they align on incentivizing similar quality outcomes, using similar payment methodologies, and providing similar data reports to help practices understand and improve their performance. The potential result is a more successful payment reform model that delivers greater reductions in avoidable utilization and costs.

Payers that partner in Primary Care First also have the opportunity to model their value-based primary care models off of the Primary Care First model, which is evidence-based and was developed using lessons learned in past CMS primary care-focused models.

Additionally, in Primary Care First, the Innovation Center CMS will create a National Payer Community to support Primary Care First payer collaboration across and within regions. These conveners will create forums for Medicare and other payers to work together on topics including quality measure alignment, data aggregation, and practice coaching and learning. Payer convening provides an opportunity for payers to learn best practices from one another, identify areas for meaningful collaboration, and work together towards shared goals that can benefit all participants. Payers in the current CPC+ model have achieved significant accomplishments through convening—some regions have used their convener to develop one standard set of quality measures that all payers agree to use to measure practice performance; other regions have developed data aggregation platforms that integrate data from multiple payers so that practices can view a single source of data with information on their entire patient population. Both of these innovations have the potential to drive significant practice care improvements.

3. Who can be a payer partner in Primary Care First?

Commercial health insurers (such as plans offered via state or federally facilitated Health Insurance Marketplaces), states (through the Medicaid and CHIP programs, state employees programs, or other insurance purchasing), Medicaid/CHIP managed care organizations, Medicare Advantage plans, state or federal high risk pools, and self-insured businesses or administrators of a self-insured group (Third Party Administrator (TPA)/Administrative Service Only (ASO)) are all eligible to be payer partners in Primary Care First.

Both existing CPC+ Model payer partners and new, interested payers that have members in the 26 eligible Primary Care First regions will be eligible to submit proposals to partner with CMS for the first year of the model (2021).

4. What are CMS expectations for Primary Care First payer partners? How similar must a payer partner's aligned model be to the Medicare FFS approach in Primary Care First?

Payer partners do not have to implement a model that is identical to Medicare FFS. Rather, 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. CMS expects payer partners to commit to:

1. Reimbursing Primary Care First practices through an alternative to traditional fee-for-service (FFS), such as a population-based payment. Enhancements to FFS, e.g. paying 110% of current fee schedule rates, will not be considered an acceptable alternative to FFS payment methodology.
2. Implementing performance-based payments that meaningfully reward practices for high performance on quality and utilization outcome measures, rather than process-based measures, and create accountability for poor performance on such measures.

3. Sharing data with Primary Care First practices on cost, utilization, and quality at regular intervals to support continuous practice learning and improvement.
4. Participating in Primary Care First multi-payer collaborative activities, including setting shared annual goals for regional multi-payer collaboration and alignment and making progress towards those goals.

For more specific guidance on CMS's expectations for payers, and what CMS will be looking for when it evaluates payer proposals, please review the [Primary Care First Multi-Payer Alignment Principles](#).

5. How can payers submit proposals to partner with CMS for Primary Care First?

CMS is soliciting proposals from payers that wish to partner in Primary Care First. Interested payers located in one of the 26 Primary Care First regions can respond to this solicitation by completing an online form describing their proposed model. The online form can be accessed at <https://app1.innovation.cms.gov/PCF>. Payer proposals are due by May 1st, 2020.

6. Does a payer have to submit a Statement of Interest form in order to respond to the formal payer solicitation?

No; payers can respond to the formal payer solicitation even if they did not submit a Statement of Interest form. Statement of Interest forms are also non-binding, meaning that if a payer submits one, they are not then obligated to respond to the payer solicitation.

7. What is the benefit for payers that submitted a payer Statement of Interest form?

CMS will notify payers that submitted Statement of Interest forms of how many practices applied, by county, in the regions where they expressed interest once the practice application window closes at the end of January. Payers will be able to use this information to decide in which regions to respond to the formal payer solicitation, which is open until May 1, 2020. Please note CMS may provide limited information about practices that have submitted applications once their eligibility has been determined. Please note that CMS is not able to provide full identifying information about specific practices that have submitted applications such as TINs before they have been selected by CMS and sign participation agreements to become model participants.

8. Can payers complete the payer solicitation to begin in year two of the model (2022), rather than in year one (2021)?

Yes. There will be a separate solicitation period for payers who want to partner with CMS starting in year two of the model. This option will be available for both current CPC+ payer partners and new, interested payer organizations.

9. What happens if one of the 26 Primary Care First regions doesn't have any payer partners?

CMS will continue to offer Primary Care First to practices in a region even if no additional payer organizations choose to partner with CMS and offer an aligned model in that region.

10. Do I have to partner with all of the Primary Care First participating practices in my region?

No. Payer partners have the discretion to set their own eligibility criteria for their aligned model, e.g. minimum attributed member thresholds, which may exclude certain Primary Care First participating practices. However, payers are expected to set reasonable eligibility criteria that enable most Primary Care First practices to participate in their aligned model, or

to provide a data-based rationale for eligibility criteria that would exclude a significant share of the Primary Care First practices in their region. If a payer partner excludes most Primary Care First practices from its aligned model, it will dampen the positive impact of multi-payer partnership.

11. Do payer partners have to use a certain risk adjustment methodology?

No. Payer partners are expected to risk adjust their alternative to fee-for-service payments to account for factors including but not limited to health status and patient demographics. However, payers are not required to use a specific risk adjustment methodology.

12. Do payer partners have to align with the Seriously Ill Population (SIP) component of the Primary Care First model?

No. Payer partners may choose to align with the SIP component of Primary Care First, which aims to connect patients who are experiencing serious illness and uncoordinated care with a practice that will take accountability for managing and coordinating their care, but are not required to.

13. Does CMS anticipate that Primary Care First will qualify as an Advanced Alternative Payment Model (APM), and will payer partners' aligned models qualify as other payer advanced APMs?

CMS anticipates that Primary Care First will qualify as an Advanced APM for all six years of the model test.

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 upon 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, at the least:

- (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,
- (3) Require participants to bear more than a nominal amount of financial risk, and
- (4) Be subject to a written expression of alignment and cooperation with CMS, such as the Memorandum of Understanding under the CPC+ 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. More information about this process is available [here](#).