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**[Primary Care First](#)**

**Request for Applications**

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## Abstract

This Request for Applications (RFA) introduces Primary Care First, a new alternative payment model that offers an innovative payment structure to support the delivery of advanced primary care. Primary Care First is based on many of the same underlying principles as Comprehensive Primary Care Plus (CPC+), an existing Center for Medicare and Medicaid Innovation (CMMI) primary care model. CPC+ is designed to accommodate primary care practices at different stages of readiness to assume accountability for patient outcomes and currently has two tracks with different levels of payment redesign and care delivery requirements. By comparison, Primary Care First is geared towards advanced primary care practices that are ready to accept financial risk in exchange for greater flexibility, increased transparency, and performance-based payments that reward participants for outcomes. Additionally, in Primary Care First, CMS will provide payments that are higher than historical Medicare fee-for-service (FFS) payments, in the aggregate, for participating practices that care for complex, chronically ill patients, and will enable participating practices to proactively engage seriously ill patients who exhibit fragmented care patterns. Primary Care First will be tested over six performance years, with two staggered cohorts of participating practices, each participating for five performance years—one cohort will participate in the model from 2021 through 2025 and a second will participate from 2022 through 2026. Participating practices will generally include primary care practitioners, as well as other clinicians that are managing high need, seriously ill populations. Primary Care First tests several new concepts:

- **Shifting focus to outcomes.** Practices will be accountable for their attributed patient population through a simple two-tiered payment structure: (1) a total primary care payment, which consists of a population-based payment and flat primary care visit fee that allows care to be driven by clinicians rather than administrative requirements and revenue cycle management; and (2) a performance-based adjustment with greater upside than downside potential tied to a clear outcome measure—acute hospital utilization—that is highly correlated with total cost of care.
- **Increasing reimbursement for practices that care for patients with complex, chronic needs, relative to practices' historical aggregate Medicare FFS revenue.** Practices that serve complex, chronic patient populations will receive a larger population-based payment for the Medicare covered services provided to this population. In aggregate, combined with the flat primary care visit fee revenue, these practices' payments under the model will be larger than the Medicare FFS reimbursement they have historically received for delivering primary care services to complex chronic patients. The larger population-based payment is intended to account for the higher disease burden in these populations and the increased resources required to serve patients with multiple chronic illnesses.
- **Supporting high need, seriously ill populations.** In addition to providing higher payments for practices serving complex, chronic patient populations, Primary Care First also enables primary care practices, including clinicians who are enrolled in Medicare and typically provide hospice or palliative care services, to take responsibility for the care of high need, seriously ill beneficiaries who currently exhibit a fragmented pattern of care – a group referred to under the model as the Seriously Ill Population or “SIP.” CMS' goal is to identify seriously ill beneficiaries whose care does not appear to be well managed, and then provide additional financial resources for participating practices to proactively engage these beneficiaries, address their intensive care needs through comprehensive and person-centered care, help them achieve clinical stabilization, and then

facilitate a relationship between the beneficiary and a practitioner who will manage the beneficiary's longer term care after they transition out of the SIP component of the model.

### Primary Care First Overview

Under the authority of Section 1115A of the Social Security Act, CMS has designed Primary Care First, a primary care delivery and payment redesign initiative, to expand the scope of its primary care-focused Medicare innovation models. Relative to CPC+ (CMS's major existing primary care model), Primary Care First is designed for primary care practices that have already developed advanced primary care capabilities. CMS expects that practices interested in participating in the Primary Care First model will be prepared to take on greater financial risk in exchange for reduced care delivery requirements and the possibility of higher performance-based payments.

Primary Care First will not require participating practices to adhere to a lengthy set of care delivery requirements. Because Primary Care First practices are expected to already be delivering advanced primary care at the time they apply to participate in the Primary Care First model, they will be given flexibility under the model to use their own individualized approaches to care delivery as long as they satisfy a minimum threshold of care delivery requirements. Primary Care First will also have minimal care delivery reporting requirements, reducing administrative burden for participating practices.

Primary Care First is designed to test whether changing how Medicare pays for primary care can lead to reductions in acute hospital utilization and lower total cost of care while preserving or improving quality. Primary Care First introduces a simple payment model that represents a major step away from FFS and towards paying for value. Participating practices will receive a majority of their primary care professional revenue for treating attributed beneficiaries in the form of a prospective population-based payment (PBP), or professional PBP. Practices will be able to use these funds for innovative care delivery approaches, including those that are not dependent on office-based, face-to-face care, such as telehealth, care managers, and 24/7 primary care access. The amount of a practice's professional PBP will be determined for each quarter based in part on the average risk profile of its entire attributed patient population. Practices with high-risk, complex chronic patient populations will receive a higher professional PBP than practices primarily serving average or low-risk patients. To ensure that practices continue to provide care to their attributed patients, the professional PBP for each practice will be adjusted by a leakage penalty, which is based on the percentage of evaluation and management services or chronic care management (CCM) services that beneficiaries receive outside of the Primary Care First practice to which they have been attributed.

When practices participating in the model ("Primary Care First practices") deliver face-to-face primary care services to attributed beneficiaries, they are entitled to bill a flat primary care visit fee for each face-to-face encounter. The flat primary care visit fee will allow for a reduction in practices' documentation and coding burden, freeing up time and resources to focus on patient care. The traditional FFS system requires practitioners to bill using a variety of payment codes, and to extensively document their justification for using the codes that they bill. This billing and coding system can be time consuming and administratively burdensome. Under a flat visit fee methodology that treats face-to-face primary care services the same way, participating practitioners can spend less time on administrative tasks related to billing, and more time focused on comprehensive primary care delivery and care management activities that can improve patient outcomes and experience of care.

Under the model, a participating practice's professional PBP and flat primary care visit revenue will be referred to as its Total Primary Care Payment, or TPCP.

Primary Care First includes a performance-based payment adjustment (PBA) that is calculated and applied on a quarterly basis. This adjustment has the potential to increase a practice's TPCP by as much as 50%, or decrease it by up to 10%. The PBA rewards practices that:

**Exhibit a high standard of performance and quality.** To be eligible for a positive PBA, practices must exceed a national acute hospital utilization (AHU) performance benchmark. The national performance benchmark will be the 50th percentile of national performance on AHU. CMS will evaluate a practice's AHU performance based on the prior twelve months. During the first performance year, the PBA will be based solely on the practice's AHU performance. Beginning in the second performance year, practices must also exceed a Quality Gateway to be eligible for a positive PBA. The Quality Gateway is a performance threshold based on a set of clinical quality and patient experience measures.

**Excel compared to peer practices and improve over time.** Beginning in the second performance year, if a participating practice exceeds both the national AHU performance benchmark and the Quality Gateway, then the practice is eligible to receive a positive PBA during the next quarter after the practice's performance is assessed. The specific amount of the PBA that a practice receives will depend on its AHU performance relative to a reference group of practices in the same region, as well as its performance relative to its own historical experience. This approach is intended to reward high achieving practices that are optimizing outcomes, while acknowledging the importance of regional characteristics of care and continuous practice improvement.

**Improve or maintain high quality outcomes.** CMS will first evaluate participating practices' performance in terms of the Quality Gateway at the end of performance year one. If a participating practice does not meet the Quality Gateway in performance year one, the maximum PBA it can earn for all four quarters of 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 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.

Primary Care First also involves new, higher payments for Primary Care First practices that care for complex, chronically ill beneficiaries. In particular, it focuses on two high-risk beneficiary populations:

- 1) The **complex, chronically ill population**, who require intensive resources due to their high disease burden and multiple comorbid conditions. Participating practices that specialize in treating complex, chronically ill patients will receive a higher professional PBP than practices with average or low risk patient populations (as measured by the average HCC risk score of the practices' attributed beneficiaries). A higher PBP will enable these practices to use innovative care delivery strategies to better address their patients' complex care needs, reduce acute hospital utilization, and lower total cost of care.

- 2) The **seriously ill population (SIP)**, who may have a similar clinical profile to the complex, chronically ill population, but exhibit a fragmented pattern of care. The goal of the SIP component of the model is to proactively intervene with beneficiaries who appear unmanaged and on a downward clinical trajectory, stabilize them through high touch care coordination and case management, and transition them to a practitioner or other care setting (e.g. hospice) that can best meet their longer-term goals of care. Primary Care First will use a separate payment structure for practices that care for SIP beneficiaries, which will include a one-time per beneficiary payment for patient outreach and engagement, as well as monthly per beneficiary payments that include an upward or downward adjustment based on quality.

The SIP component of Primary Care First is optional; practices must indicate in their Primary Care First application whether they want to participate in the SIP component of the model in addition to, or in lieu of, the PCF-General component of the model.

Primary Care First is also a multi-payer model. Aligned multi-payer partnership increases the potential impact of Primary Care First in three ways. It increases the likelihood that:

- Participating practices have consistent financial incentives across their entire patient population, which strengthens the influence of those incentives;
- Participating practices work towards similar objectives for their entire patient panel. This enables them to develop one comprehensive care approach rather than having to apply different care delivery models depending on payer status, which is administratively burdensome and at odds with patient-centered care;
- Participating practices face lower administrative burden across all of their payers, resulting in a larger net reduction in burden and a greater increase in resources to devote to direct patient care.

CMS seeks payer partners that can align with the Primary Care First payment methodology, quality measurement strategy, and data sharing approach.

Overall, Primary Care First is responsive to stakeholder feedback from advanced practices that expressed interest in accepting increased financial risk in exchange for greater flexibility and fewer model requirements. Primary Care First also responds to stakeholders that have recommended a model to address the care of patients with multiple complex chronic conditions and serious illness. In particular, the design of the SIP component of the model draws heavily from Physician-Focused Payment Model Technical Advisory Committee (PTAC) palliative care proposals from the American Academy of Hospice and Palliative Medicine (AAHPM) and the Coalition to Transform Advanced Care (C-TAC).

### Scope

Primary Care First will be tested over six performance years, with two staggered cohorts of participating practices, each participating for five performance years—one cohort will participate in the model from 2021 through 2025 and a second will participate from 2022 through 2026. Practices located in the 26 eligible Primary Care First regions that are not currently participating in CPC+ are eligible to participate in the first cohort of Primary Care First; they will not be eligible to participate in the second cohort, which will include only current CPC+ practices.

CMS is accepting applications from practices located in the following 26 regions: Alaska (statewide), Arkansas (statewide), California (statewide), Colorado (statewide), Delaware (statewide), Florida (statewide), Greater Buffalo region (New York), Greater Kansas City region (Kansas and Missouri), Greater Philadelphia region (Pennsylvania), Hawaii (statewide), Louisiana (statewide), Maine (statewide), Massachusetts (statewide), Michigan (statewide), Montana (statewide), Nebraska (statewide), New Hampshire (statewide), New Jersey (statewide), North Dakota (statewide), North Hudson-Capital region (New York), Ohio and Northern Kentucky region (statewide in Ohio and partial state in Kentucky), Oklahoma (statewide), Oregon (statewide), Rhode Island (statewide), Tennessee (statewide), and Virginia (statewide). These regions were primarily selected 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 Comprehensive Primary Care Plus evaluation strategy.

Additionally, in the interest of ensuring continuity of care for beneficiaries, practices participating in the Independence at Home (IAH) demonstration would be eligible to participate in the first cohort of Primary Care First 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 currently scheduled to end on December 31, 2020. Should the IAH demonstration be extended, CMS may reconsider this approach and other potential interactions between IAH and PCF.

The application period for practices applying to begin participation in the model in January 2021 will open on October 24, 2019 and close on January 22, 2020.

During the first six weeks of this application period to December 6, 2019, payers will separately have the option to submit a non-binding Statement of Interest form signaling their interest in partnering in Primary Care First. At the end of the practice application period, payers that submitted a Statement of Interest form will receive information from CMS about how many practices submitted applications, by region and county. The solicitation period for payers will formally begin six weeks after the start of the practice application period, on December 9, 2019, and will close on March 13, 2020. This timeline will allow payers to clearly assess where there is likely to be high practice participation in Primary Care First, and make an informed decision about regions in which to develop their own aligned approaches as payer partners. CMS is interested in whether this approach can better align practices with payers who are willing to implement an approach that is aligned with the Primary Care First model.

Practice and payer selections will take place in Winter-Spring 2020. The model will begin in January 2021. CMS will focus on onboarding participating practices and payer partners to the model from July to December 2020.

The Primary Care First applications are not legally binding contracts; selected practices will be required to sign a Participation Agreement with CMS before beginning participation in the model. Selected payer partners must sign a Memorandum of Understanding with CMS. The Participation Agreement will contain greater detail regarding the model and some aspects of the model may be modified as we continue to consider stakeholder feedback and operational issues.



## Key Model Participants and Partners

### Practices

Primary Care First is designed for primary care practices with advanced primary care capabilities, including those that specialize in caring for complex, chronically ill patient populations, that are prepared to accept increased financial risk in exchange for greater flexibility and potential rewards based on practice performance. With the exception of practices that are participating in the Seriously Ill Population (SIP) component of Primary Care First only (discussed in the [Seriously Ill Population](#) section of the RFA), eligible applicants are primary care practices that provide primary care health services at a particular location to a minimum of 125 attributed Medicare beneficiaries, and can meet the Primary Care First eligibility requirements described in this RFA. If the practice offers medical services at multiple locations, the practice will need to submit separate applications for each practice location that it wishes to participate in Primary Care First. Eligible practitioners are those practicing in internal medicine, general medicine, geriatric medicine, family medicine, and/or hospice and palliative medicine. Each practice must submit a practitioner roster that identifies, by NPI, all Primary Care First eligible practitioners that practice at the relevant location and will bill under the TIN of the practice for the purposes of the model. Each practitioner should only be included on one Primary Care First practice's practitioner roster.

Primary Care First is also designed to include practices that specialize in caring for high need, serious illness populations. To support the special care needs of the seriously ill population, clinicians enrolled in Medicare who typically provide hospice or palliative care services will be eligible to participate in the SIP component. Hospice and palliative care clinicians will be able to provide care for SIP beneficiaries by partnering with primary care practices that are participating in the model or by participating in the model as a practice, should the practice have existing advanced primary care capabilities and otherwise meet the eligibility requirements for model participation. Practices that partner with hospice and palliative care clinicians must include these clinicians on the Primary Care First practitioner roster that they submit to CMS. 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.

SIP is one component of the broader Primary Care First model, and we anticipate that many Primary Care First participants will care for both SIP and non-SIP patients. However, practices will have the option to exclusively participate in the SIP component of Primary Care First, or exclusively participate in the non-SIP component. In other words, practices will have three participation options under Primary Care First:

- 1) Practices may choose to participate only in the PCF-General component of Primary Care First, and not in the SIP component, i.e. "PCF-General practices";
- 2) Practices may choose to participate only in the SIP component of Primary Care First, and not in the PCF-General component, i.e. "SIP-only practices";
- 3) Practices may choose to participate in both the SIP and PCF-General components of Primary Care First, i.e. "hybrid practices."

## Practice Application and Eligibility Criteria

Practice application questions, including deadlines and contact information, can be found in [Appendix A](#). Applicants must submit all application materials via an online portal available at <https://app1.innovation.cms.gov/PCF> by the deadline. It is the responsibility of the applicant to ensure that they include all required information in their application. With the exception of SIP-only practices, in order to be eligible to participate in Primary Care First, a practice must:

- Be located in one of the Primary Care First regions.
- Include primary care practitioners (MD, DO, CNS, NP, and PA) certified in internal medicine, general medicine, geriatric medicine, family medicine, or hospice and palliative medicine.
- Provide health services to a minimum of 125 attributed Medicare beneficiaries.<sup>1</sup>
- 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.
- Have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to FFS payments such as full or partial capitation.
- 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 health information exchange (HIE).
- Attest via questions in the Practice Application to a limited set of advanced primary care delivery capabilities, such as 24/7 access to a practitioner or nurse call line and empanelment of beneficiaries to a practitioner or care team. Practices with an average patient complexity in the top two practice risk score groups (*out of four; see [Payment Redesign](#) section for more detail about practice risk score groups*), will need to demonstrate certain clinical capabilities. These practices must illustrate competencies in successfully managing complex patients, including through interdisciplinary care teams, comprehensive person-centered care management, care coordination, family and caregiver engagement, 24/7 access to a member of the care team, and the ability to connect beneficiaries to resources in the community to help address social determinants of health and behavioral health issues.

Practices participating in the Medicare Shared Savings Program and the Track 1+ ACO model may participate in Primary Care First if they meet the above eligibility criteria. The following practice types are not eligible to participate in the model:

- Practices currently participating in the CPC+ model are not eligible to participate in the first performance year (calendar year 2021) of the Primary Care First model. Practices participating in CPC+ will be eligible to participate in the model in the second cohort, beginning in the second performance year of Primary Care First (calendar year 2022) for a five-year performance period

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<sup>1</sup> This requirement is not applicable for practices participating in the SIP-only track and not participating in other components of the Primary Care First Model.

(2022-2026). CMS will make available an updated Request for Applications in spring 2021. Practices currently participating in the CPC+ model would need to meet eligibility requirements described above in order to participate in Primary Care First beginning in January 2022.

- Concierge practices (any practice that currently charges patients a retainer fee, or intends to do so at any point during the 5-year performance period under the model Participation Agreement).
- Rural Health Clinics.
- Federally Qualified Health Centers (FQHCs).
- Critical Access Hospitals that have elected to bill under Method II

In general, the eligibility requirements for SIP-only practices are the same as the eligibility requirements for hybrid and PCF-General practices. However, they differ in the following ways:

- SIP-only practices have no minimum attributed Medicare beneficiary requirement.
- SIP-only practices will be required to attest that they will 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 health information exchange (HIE) by January 1 of the second model performance year (2022).

SIP-only practices will not be required to use CEHRT in the first model performance year (2021).<sup>2</sup> CMS will provide general information to practices to help them prepare to meet the CEHRT requirement in 2021, e.g. information about EHR platforms designed for hospice and palliative care providers that meet the CEHRT requirement.

Eligibility requirements for participation in the SIP component of Primary Care First are described in more detail the [Seriously Ill Population](#) section.

### Practice Selection

To be selected for participation in Primary Care First, practices must first meet the eligibility criteria, as described above.

Applicants that meet the Primary Care First practice eligibility requirements and successfully complete the practice application process will be selected to participate in Primary Care First, subject to the results of a program integrity screening. The legal entity whose TIN is used to bill Medicare for services rendered at the practice site address must sign a Participation Agreement with CMS as a condition of the practice's participation in Primary Care First. If the same legal entity operates at multiple practice site addresses, it must sign a separate Participation Agreement for each participating practice site address.

If 3,000 or more practices meet the Primary Care First eligibility requirements, then CMS will conduct a lottery, through which CMS will randomly select Primary Care First model participants and randomly

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<sup>2</sup> CMS recognizes that hospice and palliative care practitioners did not receive HITECH funding from the Office of the National Coordinator for Health IT (ONC) to adopt health IT and therefore may not be prepared to meet the CEHRT requirement at the start of the model. Hybrid practices are not eligible for this delay and they must meet the requirement in performance year one for their PCF-General component. Given that they will already be using CEHRT for their PCF-General attributed beneficiaries, CMS expects that they should be able to use CEHRT for their SIP beneficiaries as well.

assign a small share (i.e., <20%) of practices to a “control group” that will participate in the model in a different way. Practices randomly assigned to the control group will be considered participants in Primary Care First, and must enter into a separate Participation Agreement with CMS. Participation for this control group will be limited to activities to assist in evaluation of the model, including but not limited to responding to surveys and participating in interviews. However, they will continue to receive their usual payment under the Medicare Physician Fee Schedule for patient care. CMS will offer control group practices certain incentives to compensate for their participation in evaluation activities, including (1) an annual \$5,000 payment for time spent on evaluation activities, such as data collection and reporting and (2) access to Medicare beneficiary-level expenditure and utilization data upon request and in accordance with applicable law. Additionally, control group practices in Primary Care First will be scored for MIPS under the APM scoring standard.

If fewer than 3,000 practices meet the Primary Care First eligibility requirements, CMS will not create a randomly assigned control group for model evaluation purposes.

### **Practice Termination Policy**

As part of the Primary Care First model test, CMS aims to determine whether Primary Care First practices can succeed in improving quality and reducing costs over time. To that end, the Primary Care First model has a termination policy that is designed to encourage longer participation in the model. A participating Primary Care First practice may terminate its participation agreement upon advance written notice to CMS, which must specify the effective date of termination. However, a practice will not be permitted to specify an effective date of termination that occurs before the last day of a performance year unless it provides CMS advance written notice of termination no later than 60 days after the start of the first performance year (or February 28 of any subsequent performance year). If a practice provides a notice of termination before the end of a performance year pursuant to this exception, its payments under the model will cease as of the effective date of termination and the practice will revert to receiving Medicare FFS payments for primary care services furnished to attributed beneficiaries. In the case of other terminations by a model participant, the practice will continue to receive model payments for primary care services furnished to its attributed beneficiaries until the last day of the performance year. A practice may withdraw its notice of termination at any point before December 31<sup>st</sup> of the performance year and thereby continue its participation in the model during the next performance year.

Participating PCF practices that do not use the early termination exception described above but who terminate their participation agreements at the end of a performance year will not be able to participate in another Innovation Center model for a limited period of time that will be specified by CMS in the participation agreement. In addition, CMS may consider the amount of time that a practice participated in the Primary Care First model when reviewing a practice’s potential future application to participate in other Innovation Center models. Further, to prevent organizations that own multiple affiliated participating practices from selectively terminating the participation of lower performing practices in the model, CMS may terminate all of the affiliated participating practices if CMS finds that the participating practices are owned by an organization that owns multiple participating practices and appears to be selectively terminating the participation of its lower performing participants. The Primary Care First

participation agreements will specify a different termination policy for practices participating in the SIP component of the model.

## **Payers**

Through multi-payer engagement in Primary Care First, CMS aims to align incentives across a participating practice's entire patient population. 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 engage practices on similar outcomes with respect to their members.

Both existing CPC+ model payer partners and new payers that have members in the eligible regions will be eligible to participate in Primary Care First. 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.

## **Payer Solicitation Information**

CMS will evaluate payer proposals' based on the extent of their alignment with the following framework. Detailed information on the payer solicitation for prospective payer partners can be found in [Appendix B](#), including the specific criteria that CMS will use to evaluate payer proposal alignment.

### *Payment*

- Commit to pursuing private arrangements with participating Primary Care First practices for the entire performance period.
- Reimburse Primary Care First 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 financial model outlined in the [Payment Redesign](#) section. 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 to participating practices 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, as outlined in the [Data Sharing](#) section.

### *Quality Measures*

- To the greatest extent possible, align practice quality and performance measures with CMS and other payer partners, as outlined in the [Quality](#) section.

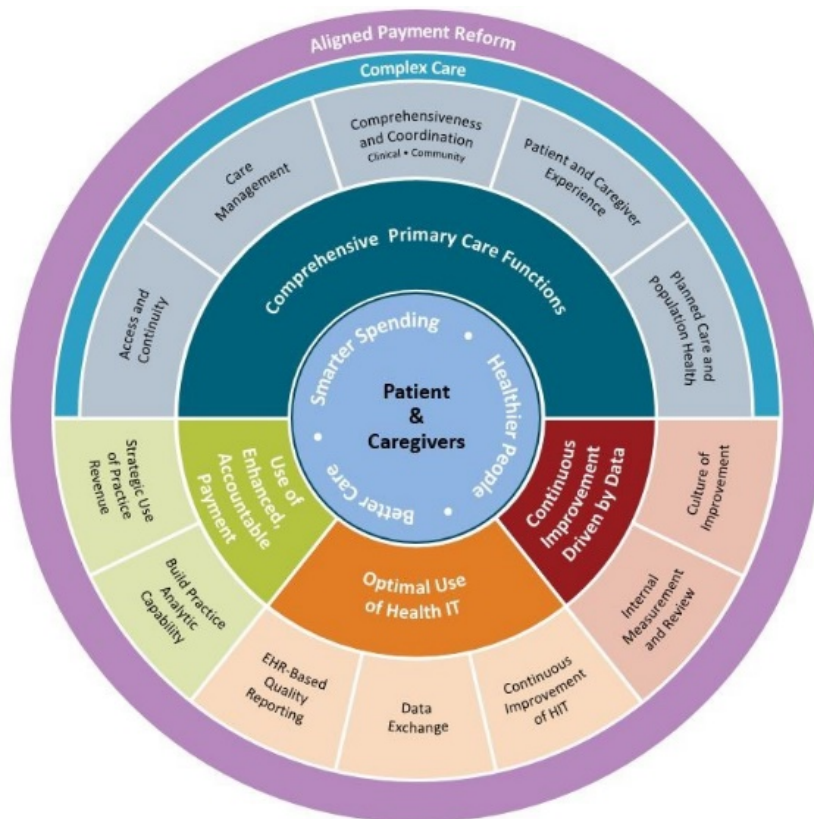
## Intervention

### Theory of Change and Driver Diagram

Primary Care First is a new model that shares some design elements with the current CPC+ model and also builds on the existing CPC+ model's theory of change.<sup>3</sup> The hypothesis is that practices in Primary Care First will provide comprehensive and continuous care, thereby improving patient care and reducing acute hospital utilization, which in turn should lead to higher quality and reduced Medicare expenditures overall.

The theory of change is supported by the key design elements of the model. Improved quality, a positive experience of care, and reduced total cost of care is achieved through five drivers in the model, as described in Figure 1 below.

Figure 1: Primary Care First and CPC+ Driver Diagram



The primary driver centers on the practitioner-patient relationship through the *Comprehensive Primary Care Functions* (the top half of the radial diagram, shown in light blue below). Three supportive drivers give practices the tools to deliver these primary care functions: *Use of Enhanced, Accountable Payment*

<sup>3</sup> CMS reserves the right to change design elements of Primary Care First to comply with any future laws or regulations, or to adjust program parameters based on program, policy, or operational needs.

(shown in green); *Optimal Use of Health IT* (shown in orange); and *Continuous Improvement Driven by Data* (shown in burgundy). We are also encouraging payer partners to provide practices the resources and incentives to spend more time with patients, while reducing costs and delivering high quality care through *Aligned Payment Reform* (outer concentric circle shown in purple).

Primary Care First shifts focus to paying practices for delivering outcome improvements (rather than paying them to fulfill process-oriented care delivery requirements) and reduces administrative burdens to empower practitioners to spend more time with patients. The Total Primary Care Payment, TPCP, is designed to allow Primary Care First practices to get off the “FFS Treadmill”<sup>4</sup> and achieve incentive neutrality (the incentive to bring a patient to the office is balanced with the incentive to provide necessary care outside of an office visit).<sup>5,6</sup>

Practices will be further incentivized through a performance-based adjustment (PBA) to their Total Primary Care Payment (TPCP), to improve quality of care by reducing unnecessary acute hospital utilization. The amount of a practice’s PBA will be calculated largely based on their acute hospital utilization performance, which will be measured as the risk-adjusted ratio of observed-to-expected inpatient admission and observation stay discharges during the measurement year.<sup>7</sup> The PBA is made quarterly in order to motivate more responsive behavioral change. Simultaneously, the model will promote transparency and competition through frequent data insights into practitioner performance relative to other model participants.

As described in Table 1, while the CPC+ model and the Primary Care First model share the same theory of change, the models focus and organize the work of the drivers differently.

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<sup>4</sup> Bitton, A., Schwartz, G.R., Stewart, E.E., Henderson, D.E., Keohane, C.A., Bates, D.W., & Schiff, G.D. (2012). Off the hamster wheel? Qualitative evaluation of a payment-linked patient-centered medical home (PCMH) pilot. *Milbank Q*, 90(3), 484-515.

<sup>5</sup> Ash, A.S., & Ellis, R.P. (2012). Risk-adjusted payment and performance assessment for primary care. *Med Care*, 50(8), 643-53.

<sup>6</sup> Vats, S., Ash, A.S., & Ellis, R.P. (2013). Bending the cost curve? Results from a comprehensive primary care payment pilot. *Med Care*, 51(11), 964-9.

<sup>7</sup> National Committee for Quality Assurance. (2018). Acute Hospital Utilization (AHU). Retrieved from <https://www.ncqa.org/hedis/measures/acute-hospital-utilization/>.



Table 1. Summary of Key Design Elements of CPC+ Model and Primary Care First Model:

Design Elements	CPC+ Track 1	CPC+ Track 2	Primary Care First
<b>Key Model Participants and Payer Partners</b>	Primary care practices that are in the early stages of developing advanced primary care capabilities and would benefit from upfront funds to invest in practice transformation; health care payer organizations, including Medicare Advantage plans, commercial plans, state Medicaid agencies, and Medicaid managed care plans that offer a program for CPC+ Track 1 practices that aligns with CMS’s approach	Primary care practices that have some experience with developing advanced primary care capabilities and are looking to deepen and expand their practice transformation efforts; health care payer organizations, including Medicare Advantage plans, commercial plans, state Medicaid agencies, and Medicaid managed care plans that offer a program for CPC+ Track 2 practices that aligns with CMS’s approach	Primary care practices that have developed advanced primary care capabilities and are willing to accept downside financial risk in exchange for greater flexibility, reduced administrative burden, and greater potential financial reward for positive outcomes; health care payer organizations, including Medicare Advantage plans, commercial plans, state Medicaid agencies, and Medicaid managed care plans that offer a program for Primary Care First practices that aligns with CMS’s approach
<b>Care Delivery</b>	Practices implement core capabilities of comprehensive primary care throughout model performance period.	Practices implement core and advanced capabilities of comprehensive primary care throughout model performance period.	Practices have capabilities to deliver advanced primary care at outset of model performance period.



Design Elements	CPC+ Track 1	CPC+ Track 2	Primary Care First
<b>Payment</b>	<p><i>Care Management Fee:</i> Practices augment staffing and training to implement core care delivery model.</p> <p><i>Performance-Based Incentive Payment:</i> Practices are motivated to reduce utilization and improve quality and experience of care.</p>	<p><i>Comprehensive Primary Care Payment:</i> Practices have flexibility to deliver care based in the modality that best meets patient need.</p> <p><i>Care Management Fee:</i> Practices augment staffing and training to implement advanced care delivery model. Practices receive increased support for patients with complex needs.</p> <p><i>Performance-Based Incentive Payment:</i> Practices are motivated to reduce utilization and improve quality and experience of care.</p>	<p><i>Total Primary Care Payment:</i> Practices are paid to deliver advanced primary care in and outside of the office. Practices focused on caring for patients with complex chronic needs and the seriously ill receive increased payments to support their care for these patient populations.</p> <p><i>Performance-Based Adjustment:</i> Practices are motivated to reduce AHU in an effort to reduce total cost of care, while meeting quality and experience of care performance thresholds.</p>
<b>Data Sharing</b>	<p>Medicare FFS expenditure and utilization data are delivered, if requested by participating practices, clearly and actionably on a quarterly basis. Data includes practice-level data and may include patient-level data for the practice's attributed patient population.</p>	<p>Medicare FFS expenditure and utilization data are delivered, if requested by participating practices, clearly and actionably on a quarterly basis. Data includes practice-level data and may include patient-level data for the practice's attributed patient population.</p>	<p>Medicare FFS expenditure and utilization data and Medicaid data, as available, are delivered, if requested by participating practices, clearly and actionably on a quarterly basis. Data includes practice and National Provider Identifier (NPI) level performance information for participating CPC+ practitioners. Practices can request claims line feeds for their attributed patient population, and incorporate any claims data received into their own analytic tools.</p>

**Care Delivery Design**

Primary care practitioners in CPC+, and now Primary Care First, are incentivized to achieve better care at lower costs. They accomplish this aim through delivery of five comprehensive primary care functions:

- 1) **Access and Continuity** builds on the patient-practitioner relationship to ensure patients receive the right care at the right time from the right care team member. All Primary Care First practices must provide 24/7 access to a care team practitioner with real-time access to the EHR. Practices serving complex, chronic beneficiaries (“Groups 3 & 4” practices) and those that have been attributed SIP beneficiaries must deepen this work by additionally providing timely callbacks to beneficiaries and their other health care providers who contact the practice.
- 2) **Care Management** supports the optimal management of complex care targeted to those most likely to benefit. All Primary Care First practices must provide risk-stratified care management. Practices in Groups 3 and 4 and those that have been attributed SIP beneficiaries must deepen this work by engaging high-risk beneficiaries in health care planning and ensuring that beneficiaries receive appropriate services from other health care providers (e.g., DME items and services).
- 3) **Comprehensiveness and Coordination** increases the breadth and depth of primary care, while facilitating care for beneficiaries as it occurs outside of the practice. Primary Care First practices must integrate behavioral health care, and assess beneficiaries’ psychosocial needs. Practices in Groups 3 and 4 and those that have been attributed SIP beneficiaries must deepen this work by creating an inventory of services and supports in the community to address their complex psychosocial needs.
- 4) **Patient and Caregiver Engagement** involves patients in their own care decisions and ensures that patients guide practice improvements. Primary Care First practices must implement a regular process for patients and caregivers to advise practice improvement. Practices in Groups 3 and 4 and those that have been attributed SIP beneficiaries must deepen this work by engaging families and caregivers in patient care for all beneficiaries, and with a particular focus on their high-risk beneficiaries.
- 5) **Planned care and Population Health** capabilities enable practices to meet the preventive and chronic care needs of the entire patient population. Primary Care First practices must set goals and continuously improve upon key outcome measures.

In Primary Care First, practices will have latitude to develop their own approaches to care delivery, rather than being required to meet many specific care delivery requirements under the model. Practices will be required to report some information about their care delivery capabilities to ensure program integrity and provide CMS insight into practice progress and opportunities to continuously improve the model.

### Payment Redesign

The payment design for Primary Care First represents a shift from making upfront investments in care delivery functions, as CMS does through care management fees in the CPC+ model, to paying practices primarily for outcomes. It is also a significant step away from FFS and towards population-based payment. The Primary Care First payment structure is designed to be simple, with a per-beneficiary per-month payment that frees practices from certain burdensome documentation and coding requirements, gives them the flexibility to use innovative care delivery tools and tactics, and sets clear, easy-to-understand performance standards.

The payment structure has two elements:

- 1) **Total Primary Care Payment (TPCP):** The TPCP will largely replace practices' traditional FFS billing for primary care services. It includes two elements, a lump-sum professional population-based payment (PBP) paid on a quarterly basis and a flat \$40.82 base rate per-visit primary care fee. Together, these payment mechanisms create an incentive to deliver advanced, patient-centered primary care while also compensating practitioners for face-to-face visits. As discussed in more detail below, the TPCP will include some adjustments to account for variations in cost of care, including a geographic adjustment, risk adjustment, and a leakage penalty to encourage practices to actively manage their attributed patients to limit their need to seek care from other primary care practices.
- 2) **Performance-Based Adjustment (PBA):** During performance year two and in subsequent performance years, a practice's TPCP will be adjusted based on its performance on five quality and patient experience of care measures, as well as a measure of acute hospital utilization (AHU). The quality metrics will be incorporated into a Quality Gateway, which is a minimum threshold that practices must meet in order to be eligible for a positive performance-based adjustment (PBA) beginning in performance year two. If a practice meets or exceeds the Quality Gateway, its performance on the AHU will then be used to determine whether it receives a positive, negative, or neutral PBA. The focus on AHU offers practices a clear outcomes-based metric that is highly correlated with total cost of care, while the Quality Gateway ensures that practices are not delivering lower quality care in an effort to reduce utilization.<sup>8</sup> Practices may receive a maximum possible positive PBA of 50% and a maximum possible negative PBA of -10%. Practices that fail to meet the Quality Gateway will receive no higher than a 0% PBA in performance year two.<sup>9</sup> Whether they ultimately receive a neutral PBA (0%) or a negative PBA for each quarter of the second performance year will be determined by their AHU performance. The penalty for failing to meet the Quality Gateway will increase to an automatic -10% PBA for model years thereafter, regardless of a practice's AHU performance.

Table 2 summarizes how the payment mechanism in Primary Care First compares to CPC+ Tracks 1 and 2. The remainder of this section discusses the components of the Primary Care First payment mechanism in greater detail.

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<sup>8</sup> McCarthy, D., Ryan, J., & Klein, S. (2015, October 29). Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis. Retrieved from <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/care-high-need-highcost-patients>

<sup>9</sup> Practices that fail to meet the quality gateway in year 2 may receive a -10% PBA if they are also in the bottom quartile of their regional AHU benchmark.

Table 2. Comparison of Payment Mechanisms between Primary Care First and CPC+ Tracks

Characteristic	Track 1	Track 2	Primary Care First
<b>Beneficiary Attribution</b>	Claims-based with voluntary alignment opportunity	Claims-based with voluntary alignment opportunity	Claims-based with voluntary alignment opportunity; proactive identification and assignment of sick and unmanaged beneficiaries
<b>Care Management Fee</b>	Yes (\$15 average)	Yes (\$28 average)	No
<b>Performance-Based Payment Potential (% of Revenue)</b>	~0-10%	~0-20%	~ -10-50%
<b>Underlying Payments to CPC+ Practice</b>	Standard FFS	Reduced FFS with prospective Comprehensive Primary Care Payment	Risk, geographic, and leakage adjusted professional PBP with a geographically adjusted flat primary care visit fee

### Attribution

#### Voluntary Alignment

The first step in the model’s attribution methodology is voluntary alignment. Under voluntary alignment, a beneficiary attests to his or her choice of a primary care practitioner in MyMedicare.gov. If he or she elects a Primary Care First practitioner, this attestation will supersede any future claims-based attribution of that beneficiary to another Innovation Center model, with the exception of beneficiaries aligned to the Comprehensive ESRD Care model and similar future kidney care models. This attestation will also supersede claims-based attribution in Primary Care First.

#### Claims-Based Attribution

The second step in the model’s attribution methodology is claims-based attribution. With the exception of beneficiaries who have already voluntarily aligned, beneficiaries will be prospectively attributed to a Primary Care First practice if, during the most recently available 24-month period prior to the start of the performance period of the model and each quarter thereafter, that practice either billed for the plurality of the beneficiary’s primary care visits and eligible CCM services, or billed the most recent claim (if that claim was for an Annual Wellness Visit or a Welcome to Medicare Visit). If a beneficiary has an equal number of qualifying visits and eligible CCM services billed by more than one participating practice, the beneficiary will be attributed to the participating practice with the most recent visit. This attribution methodology is outlined in more detail in [Appendix D](#). Note: these attribution rules do not apply to beneficiaries attributed to the SIP component of the model.

#### Total Primary Care Payment (TPCP)

In Primary Care First, the TPCP is designed to move away from traditional fee-for-service (FFS) payment incentives. Under FFS payment methodologies, there is a strong incentive to bring patients into the office in order to create a billable face-to-face service, even if phone calls or electronic communications would be a better means of meeting the patient’s needs or in accordance with patient preferences.

In order to balance these incentives, the TPCP includes two payment types: (1) a professional population-based payment (professional PBP) paid on a quarterly basis; and (2) a flat fee for each primary care visit, paid on a claim-by-claim basis. A list of the services included in the calculations of the professional PBP and for which the flat visit fee applies can be found in [Appendix E](#).

As summarized in Table 3 below, for the purposes of risk adjusting the professional PBP, practices will be divided into four groups based on the average hierarchical condition category (HCC) risk score of their attributed Medicare beneficiaries. The professional PBP rises as the practice’s risk group classification rises. To simplify billing and reduce coding and documentation burden, the flat primary care visit fee is the same across all five practice risk groups. However, beneficiaries in higher risk groups are expected to have more in-person visits due to their more complex care needs, resulting in a higher average per-beneficiary primary care visit fee revenue, as shown in Table 3. Please note that CMS reserves the right to modify these rates to ensure that TPCP payments are derivative of FFS.

*Table 3. Components of the Primary Care First Total Primary Care Payment<sup>10</sup>*

Practice Risk Group	HCC Overall Practice Average Risk Score Criteria	Professional PBP base rate <sup>11</sup> (PBPM)	Estimated PBPM Value of Flat Primary Care Visit Fee based on estimated number of visits per year <sup>12</sup>	Total Estimated Monthly Payment (PBPM)
<b>Group 1</b>	<1.2	\$28	\$21	\$49
<b>Group 2</b>	1.2-1.5	\$45	\$26	\$71
<b>Group 3</b>	1.5-2.0	\$100	\$29	\$129
<b>Group 4</b>	>2.0	\$175	\$37	\$212

### Professional Population-Based Payment

The professional PBP changes the payment mechanism for primary care from FFS to population-based payment, promotes flexibility in how participating practices deliver care, and allows them to increase the breadth and depth of primary care they deliver while focusing on continuous doctor-patient relationships. The professional PBP also enables services to be furnished in a way that best meets the needs of the patient, whether by email, phone, patient portal, or in alternative settings such as the patient’s home.

A practice’s per-beneficiary professional PBP is risk-adjusted based on the average HCC risk score of its attributed Medicare beneficiaries. Practices are assigned to one of four risk score groups according to the average HCC score of all attributed beneficiaries. Each risk score group is associated with a per-beneficiary per-month (PBPM) professional PBP base rate ranging from \$28 to \$175. Practices will receive the same professional PBP for all of their attributed beneficiaries, regardless of those

<sup>10</sup> CMS reserves the right to update these payment amounts in 2021 to ensure that they are derivative of revenue on average from FFS, including to make changes for updates to fee schedule payments.

<sup>11</sup> Base rates do not include geographic adjustment.

<sup>12</sup> PBPM flat primary care visit fee estimates based on estimated number of primary care visits per beneficiary per year. (e.g.,  $(\$40.82 + \$18 \text{ coinsurance}) * 4.4 / 12 \text{ months} = \text{approximately, } \$21 \text{ PBPM}$ ). Higher practice risk groups are expected to have more frequent in-person visits than lower practice risk groups. Calculations use the flat visit fee base rate and an estimate of beneficiary coinsurance, and do not include geographic adjustment.

beneficiaries' individual risk scores. The goal of this group-based risk adjustment methodology is to reduce practice focus on individual risk scores; because a practice's PBPM is determined by the average risk score across its entire attributed beneficiary population, a change in an individual beneficiary's risk score will likely not impact the overall amount of the professional PBP. Additional information on how risk scores are established in PCF will be provided separately. As noted, the risk adjustment approach for the model is aimed at addressing both concerns related to coding intensity but also prediction, particularly under-prediction for beneficiaries with significant health and related needs and for those that tend to align with a practice (such as through voluntary alignment) shortly following an acute health care event. Our aim is to ensure that practices focusing on these and similar patient populations are recognized and appropriately grouped in the model. This is intended to make the model attractive as a sustainable means of serving high need beneficiaries such as by practices focused on home-based primary care and care for complex chronic individuals.

Specifically, the base rate professional PBP for Group 1 will be \$28 PBPM, paid quarterly on a prospective basis. The base rate professional PBP for Groups 2-4 will range from \$45 to \$175 PBPM paid quarterly on a prospective basis to account for the resources needed to serve beneficiaries with increasingly complex care needs (Table 3). The professional PBP will be geographically adjusted in the same manner as Medicare Part B fee schedule rates to account for nationwide variations in cost. It will be provided to practices without beneficiary cost-sharing. These payments will also be adjusted periodically to reflect updates to relevant fee schedule rates for the services included in the professional PBP.

The professional PBP will also be adjusted to account for "leakage rates," or the percent of primary care services furnished outside of the practice to the Primary Care First practice's attributed beneficiaries. This adjustment incentivizes a sustained practitioner-patient relationship. Under this leakage rate construct, CMS presumes that beneficiaries will tend to increase the amount of primary care they seek elsewhere if they are not satisfied with the care they receive from the participating Primary Care First practice. Thus, an increase in primary care services received by attributed beneficiaries from practitioners outside of the practice will lead to a reduction in future professional PBPs. CMS will calculate a Primary Care First practice's leakage rate by counting the number of primary care services that the practice's attributed beneficiaries receive from *other* practices. This count of outside services will be divided by the total number of primary care services received by the practice's beneficiaries, including services provided both within and outside the Primary Care First practice. This calculation produces the percentage of beneficiaries' primary care services that are provided outside the practice, i.e. the leakage rate. The practice's professional PBP will then be reduced by this leakage rate. See Table 4 for an illustrative example.

Table 4. Illustrative Example of Professional PBP with Leakage Adjustment

Professional PBP for Group 2 Practice (PBPM)	Number of Primary Care Services that Attributed Beneficiaries Received Outside the Primary Care First Practice	Number of Primary Care Services that Attributed Beneficiaries Received from Any Practice, Including Primary Care First Practice	Leakage Rate	Future Quarter Professional PBP * (1- Leakage Rate) = Paid Professional PBP (PBPM)
\$28	40	100	40/100=0.4	\$28*(1-0.4) = \$16.80

#### Flat Primary Care Visit Fee

Primary Care First will include a flat primary care visit fee of \$40.82 (Medicare payment base rate) for face-to-face patient encounters. This flat primary care visit fee is intended to encourage practices to continue seeing beneficiaries face-to-face as appropriate, while also reducing their billing and revenue cycle burden. With a flat visit fee, practices can readily understand the payment they will receive for primary care furnished face-to-face to an attributed Medicare beneficiary.

Primary Care First practices will receive the flat visit fee when they bill a Healthcare Common Procedure Coding System (HCPCS) code for an eligible primary care service (listed in [Appendix E](#)) for an attributed beneficiary. The payment amount is roughly equivalent to the 2018 Medicare PFS payment for a Level 2 E/M service and is reflective of the care intensity of many primary care visits. The payment amount will be geographically adjusted in the same manner as Medicare Part B fee schedule rates to account for nationwide variations in cost. Similar to the Professional PBP, these payments will also be adjusted periodically to reflect updates to relevant fee schedule rates for the services included in the flat visit fee.

Coinsurance for the flat visit fee will be calculated as 20% of the PFS allowed amount for the HCPCS code that a practice bills to receive the flat visit fee, rather than 20% of the \$40.82 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. However, as a beneficiary engagement incentive and departing from CPC+ Tracks 1 and 2, CMS intends to allow practices to reduce or waive the applicable co-insurance (which will be based on the FFS rate for services provided), 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 recent ED and hospital visits. Not all beneficiaries aligned to a PCF practice would qualify for cost-sharing support. Practices that wish to take advantage of this beneficiary engagement incentive must submit an implementation plan 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 their cost sharing support policies in accordance with the implementation plan approved by CMS.

Subject to certain safeguards against abuse, CMS also intends to allow participating practices to provide free or discounted local transportation services for beneficiaries requiring face-to-face care with the Primary Care First practice and to connect beneficiaries with follow-up services outside of the primary care setting, such as transportation to specialty care and elective procedures and courier services for medication. CMS will not provide any payment for transportation services, so practices would need to bear the expense for offering them.

CMS will review flat primary care visit fee billing patterns on an ongoing basis and may audit outlier practices with very high visit rates to ensure that practices are not unnecessarily increasing the number of face-to-face visits for attributed beneficiaries in order to generate additional flat visit fee revenue.

### Performance-Based Adjustment

The performance-based adjustment (PBA) is designed to reward practices that meet key quality standards and work continuously to reduce unnecessary acute hospital utilization (AHU). Practices will have the opportunity to increase their TPCP by up to 50% through the PBA.

The PBA will be calculated on a quarterly basis, based on practices’ AHU performance over a rolling one-year look-back period that ends two quarters prior to the quarter in which the PBA is applied. This timeline is intended to make the PBA as responsive to changes in practice performance as possible. Table 5 illustrates the timeline for paying the PBA.

Table 5. Timeline for Applying PBA to Future Model Payments

	Year 1 Q1	Year 1 Q2	Year 1 Q3	Year 1 Q4	Year 2 Q1	Year 2 Q2
Q1						
Q2						
Q3						
Q4						
	= Last Quarter of One-Year Performance Period					
	= Performance Calculated based on One-Year Performance Period					
	= Performance-Based Adjustment Applied to Model Payments					

CMS will use a claims-based Acute Hospital Utilization (AHU) measure, included in the Healthcare Effectiveness Data and Information Set (HEDIS), to calculate the PBA. The measure is calculated based on the risk-adjusted ratio of observed-to-expected inpatient admission and observation stay discharges during the measurement year. CMS selected this measure because acute hospitalizations are the primary driver of patients’ total cost of care—inpatient utilization is shown to have a roughly 70% correlation with total cost of care, and inpatient admissions account for 42% of total cost of care on



average.<sup>13</sup> Additionally, AHU can be calculated at the practice level, and offers practices a clear, actionable outcomes metric.

The PBA has two components: a regional performance bonus and a continuous improvement bonus. Practices can receive up to 34% upside bonus or a -10% downside penalty through the regional performance adjustment. Practices can earn up to a 16% bonus through the continuous improvement bonus. The regional performance adjustment and the continuous improvement bonus are added together to determine a practice's quarterly PBA.

During the practice's first year of participation in the model, the PBA will be determined based on performance on the AHU measure only. The AHU measure will be calculated quarterly based on a rolling four-quarter look-back period and applied to starting in quarter three of year one. In the practice's second year of participation in the model (and subsequent performance periods) practices must exceed two separate standards to be eligible for a positive PBA:

1. **The Quality Gateway**, which is comprised of minimum thresholds on five quality metrics, as further explained in the [Quality Strategy](#) section below. The thresholds for performance will be made available to participating practices at the beginning of each performance year. This "Quality Gateway" serves as an indicator that participating practices are not decreasing their quality of care as they engage in strategies to reduce utilization. Practices that do not meet the minimum standards of the Quality Gateway for all of the measures will earn no higher than a 0% PBA<sup>14</sup> in each of the four quarters in performance year two. Whether a practice ultimately receives a neutral PBA (0%) or a negative PBA for each quarter of the second performance year will depend on its AHU performance. In performance year three and beyond, failing to exceed the Quality Gateway in the previous performance year will result in an automatic -10% PBA for all four quarters, regardless of AHU performance. The Quality Gateway penalty phases in to ensure practices continue to focus on quality outcomes as they become familiar with the model measures.
2. **Performance above the 50th percentile of a national AHU benchmark.** Participating practices that exceed the Quality Gateway must also exceed the 50th percentile of a nationally constructed AHU benchmark. This is to ensure that practices receiving a PBA are above average at managing avoidable utilization across similar Medicare practices regardless of their location. Practices that fail to exceed the national benchmark but perform above the 25<sup>th</sup> percentile relative to their regional reference group will receive a 0% regional PBA. Practices that fail to exceed the national benchmark and perform in the bottom quartile of their regional reference group will receive a -10% regional 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.

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<sup>13</sup> Estimates based on 2016 National Health Expenditure Data.

<sup>14</sup> Practices that fail the Quality Gateway in Year 2 can receive a -10% regional PBA if they are in the lowest quartile of their regional AHU benchmark, as described in this section.

To calculate the regional performance bonus, CMS will first establish a benchmark using data from a regional reference group of peer practices (including practices that do not participate in Primary Care First).<sup>15</sup> This approach incentivizes participants to provide better quality of care relative to all other practices within their region, while creating the potential for all Primary Care First practices to earn a positive regional performance bonus (because they are competing against both PCF and non-PCF practices). A regionally-based calculation also measures practice performance in a way that accounts for patient characteristics and care patterns that are specific to a particular geographic area but may not be captured by risk adjustment.

There are seven possible levels of performance for the regional performance bonus, depending on practices' performance relative to the regional reference group, as summarized in Table 6. Participating Primary Care First practices whose performance on the AHU measure places them in the lowest 25% of the regional reference group will receive a -10% regional performance adjustment. Participating practices whose AHU performance falls in the top 10% of the regional reference group will receive a 34% regional performance bonus. However, as described above, practices must have exceeded the Quality Gateway and the national performance benchmark in order to receive a positive PBA.

Table 6. PBA by Regional Practice Performance Level

Regional PBA Performance Level	Bonus as % of Total Primary Care Payment (TCP)	Benchmark Group
<b>Practices Performing in the Top 50 Percent of National Primary Care (Seven Relative Groupings Based on Performance)</b>		
<b>Group 1 – Top 10% of regional practices</b>	34%	Regional benchmark
<b>Group 2 - 11% - 20% of regional practices</b>	27%	Regional benchmark
<b>Group 3 – 21% – 30% of regional practices</b>	20%	Regional benchmark
<b>Group 4 – 31% – 40% of regional practices</b>	13%	Regional benchmark
<b>Group 5 – 41% - 50% regional practices</b>	6.5%	Regional benchmark
<b>Group 6 – 51% - 75% of regional practices</b>	0%	Regional benchmark
<b>Group 7 – Practices performing in the bottom quartile of their region</b>	-10%	Regional benchmark

The Continuous Improvement (CI) bonus rewards a practice's individual performance improvement on the AHU measure. The practice's AHU performance will be compared to its own performance in the 4-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. This policy creates the opportunity for participating practices that are lower performing, relative to other practices, to receive a PBA if they show improvement in AHU compared against themselves. As long as a participating practice surpasses the Quality Gateway, it is eligible to receive a CI bonus, even if it is in the

<sup>15</sup> This benchmark will be based on a regionally-specific reference group composed of Medicare clinicians. The benchmark will be made available to practices at the beginning of the model and updated annually.

lowest quartile of all practices regionally for AHU. To receive the CI bonus, the practice’s individual performance must have improved by a statistically reliable percentage threshold, determined prospectively, from the previous year. The target percentage reduction for a practice will vary based on their baseline AHU performance level; for example, improvement targets could range from 3-5% change, year-over-year.

In order to mitigate the concern that the change in the AHU measure over time could be random variation and not actual change, particularly for small practices, CMS will use statistical approaches (e.g., a reliability adjustment) to improve the reliability of the CI score. For example, CMS may adjust a practice’s CI score using the average CI score of “like practices,” based on how confident we are in a practice’s own CI score. The approach would allow CMS to assign CI scores to practices with low patient volume, among other limiting characteristics. Under this approach, part of the CI score is based on a practice’s own performance, while adjusting the score to account for the uncertainty of the estimate. A statistical approach like the reliability adjustment is intended to address concerns that random variation could impact the calculation of the CI bonus. CMS will release a Primary Care First Payment Methodology Paper in Spring 2020 that will provide the technical details of any potential reliability adjustment, in addition to the detailed Primary Care First methodologies for attribution, payment adjustments, and quality measures. The Primary Care First Payment Methodology Paper will contain similar information as included in the CPC+ Tracks 1 and 2 Payment Methodology Paper that is currently available on the CMS website.

Table 7. CI Bonus Potential based on Practice Improvement Performance

AHU Final Regional Performance Level	Benchmark for Continuous Improvement Bonus	Continuous Improvement Bonus as % of TPCP	Regional Performance Adjustment as % of TPCP (from Table 6)	Total PBA as % of TPCP (Continuous Performance Bonus + Regional Performance Adjustment)
<b>Group 1 – Top 10% of regional practices</b>	Practice’s own performance in the prior year	16%	34%	50%
<b>Group 2 - 11% - 20% of regional practices</b>	Practice’s own performance in the prior year	13%	27%	40%
<b>Group 3 – 21% – 30% of regional practices</b>	Practice’s own performance in the prior year	10%	20%	30%
<b>Group 4 – 31% – 40% of regional practices</b>	Practice’s own performance in the prior year	7%	13%	20%
<b>Group 5 – 41% - 50% regional practices</b>	Practice’s own performance in the prior year	3.5%	6.5%	10%

AHU Final Regional Performance Level	Benchmark for Continuous Improvement Bonus	Continuous Improvement Bonus as % of TPCP	Regional Performance Adjustment as % of TPCP (from Table 6)	Total PBA as % of TPCP (Continuous Performance Bonus + Regional Performance Adjustment)
<b>Group 6 – 51% - 75% of regional practices</b>	Practice’s own performance in the prior year	3.5%	0%	3.5%
<b>Group 7 – Practices performing in the bottom quartile of their region</b>	Practice’s own performance in the prior year	3.5%	-10%	-6.5%

Although CMS is only able to assess and pay the PBA at the practice-level, the Participation Agreement will require participating practices to agree to compensate individual practitioners in their practice in a way that reflects their individual performance on meaningful outcomes-based and process clinical quality measures, patient experience, and AHU. This stipulation provides Primary Care First participants with the flexibility to determine their own compensation arrangements with their practitioners, while also ensuring that the PBA motivates practitioners to take responsibility for their personal performance.

**Full Payment Calculation under the Primary Care First Model**

The quarterly payment for a practice in Primary Care First can be calculated as follows:

- Quarterly model payment = Total Primary Care Payment (TPCP) + Performance-Based Adjustment (PBA)
  - TPCP = (Professional PBP based on practice’s risk score group and leakage adjustment)\*(# of attributed beneficiaries) + (Flat Visit Fee \* geographic adjustment \* # of visits)
  - PBA = TPCP \* (-10% up to 50%, based on performance)

As stated above, high performing practices will have the opportunity to increase their TPCP by up to 50%. The below example (see Table 8) illustrates the potential PBPM compensation for a practice with no leakage, performing in the top decile of practices in their region, that meets their continuous improvement target. Note that although the TPCP is described as a quarterly payment calculation for illustrative purposes, and the professional PBP will be paid quarterly, face-to-face visits will be paid on a claim-by-claim basis, as a practice bills them.

*Table 8. Illustrative Example of Top Performing Group 2 Practice in Primary Care First (top 10% of primary care practices within the same region)*

Total Primary Care Payment (TPCP)

Professional PBP for Group 2 practice	* Leakage Rate of 0%	= Paid Professional PBP	+ Flat Visit Fee (estimated)	= Total Primary Care Payment PBPM*
<b>\$28</b>	* 1.0	= \$28	+ \$19	= \$47

*\*Total Primary Care Payment is calculated on a monthly basis but paid on a quarterly basis*

## PBA

Total Primary Care Payment (PBPM)	* Regional Performance-Based Adjustment for Top Group	= Regional Performance-Based Adjustment (PBPM)
\$47	*0.34	= \$15.98

Total Primary Care Payment (PBPM)	* Performance-Based Adjustment for Top Group Continuous Improvement	= CI Performance-Based Adjustment (PBPM)
\$47	*0.16	= \$7.52

Regional Performance-Based Adjustment for Practice Performance	+ Performance-Based Adjustment for Continuous Improvement	= Performance-Based Adjustment (PBPM)
\$15.98	+ \$7.52	= \$23.50

### Full Primary Care First Per Beneficiary Per Month (PBPM) Payment

Total Primary Care Payment (PBPM)	+ Performance-Based Adjustment (PBPM)	= Full Primary Care First Payment (PBPM)
\$47	+ \$23.50	= \$70.50

## **Quality Strategy**

In Primary Care First, CMS will use a focused set of clinical quality and patient experience measures to assess quality of care delivered at the practice. These measures were selected to be actionable, clinically meaningful, and aligned with CMS's broader quality measurement strategy. See Table 9 for the complete list of Primary Care First quality measures.

As discussed above, these measures will be incorporated into a "Quality Gateway," which is a threshold participating practices must meet or exceed starting in performance year one in order to be eligible for a positive PBA in year two that is tied to acute hospital utilization performance. The Quality Gateway serves as an indicator that practices are meeting or exceeding a threshold quality of care standard as they engage in strategies to reduce utilization.

For each of the five Quality Gateway measures, CMS will set a threshold based on national practice performance. In order to pass the Quality Gateway and be eligible for a positive PBA, practices must meet or exceed the threshold for all five measures. If practices fail to meet the threshold for one or more of the measures, they will not be eligible for a positive PBA based on their AHU performance for the following year.

CMS will begin collecting data for the five Quality Gateway measures in performance year one of the model. Unlike the acute hospitalization measure, which will be calculated quarterly based on a rolling four-quarter look-back period, the Quality Gateway measures will be calculated annually, based on the prior performance year. If a practice fails to meet the all of the Quality Gateway thresholds in the performance year, it will receive, at a maximum, a 0% PBA in performance year two (based on year one

performance) and an automatic -10% PBA in years thereafter. In contrast, if a practice meets or exceeds the Quality Gateway for the performance year, it will then be eligible for a positive PBA in the following year, and the PBA will be calculated quarterly based on the practice’s AHU performance. Because the prior performance year’s quality data for the Quality Gateway measures will not be available in year one, CMS will not evaluate practices based on the Quality Gateway in performance year one, and instead will calculate the practices’ PBAs quarterly, based exclusively on the AHU, beginning in quarter three of their first performance year participating in the model. The Quality Gateway will go into effect in year two based on the practice’s first performance year.

### Quality Measures for Practice Risk Score Groups 1-2

Table 9. Primary Care First Quality Measures

Measure Type	Measure Title	NQF /Quality ID		Benchmark
<b>Quality Gateway (starts in Year 2)</b>	Patient Experience of Care Survey (CAHPS® with supplemental items)	0005 and 0006 / 321	AHRQ®	PCF and/or non-PCF reference population
	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (eCQM)	0059 / 001	NCQA®	MIPS
	Controlling High Blood Pressure (eCQM)	0018/ 236	NCQA®	MIPS
	Advance Care Plan (MIPS CQM measure)	0326/47	NCQA®	MIPS
	Colorectal Cancer Screening (eCQM)	0034/113	NCQA®	MIPS
<b>Utilization Measure for PBA Calculation</b>	Acute Hospital Utilization (AHU) (HEDIS measure) <sup>16</sup>	N/A	NCQA®	Non-PCF and/or PCF reference population

16 The Acute Hospital Utilization and its specifications were developed by the National Committee for Quality Assurance (“NCQA”) under the Performance Measurements contract (HHSM-500-2006-00060C) with CMS and are included in HEDIS® with permission of NCQA. The HEDIS measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. HEDIS measures cannot be modified without the permission of NCQA. Any use of HEDIS measures for commercial purposes requires a license from NCQA. HEDIS is a registered trademark of NCQA. Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications. The American Medical Association holds a copyright to the CPT® codes contained in the measures specifications. The American Hospital Association holds a copyright to the Uniform Billing Codes (“UB”) contained in the measure specifications. The UB Codes in the HEDIS specifications are included with the permission of the AHA. The UB Codes contained in the HEDIS specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting HEDIS measure results or using HEDIS measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA.

## Quality Measures for Practice Risk Score Groups 3 or 4 (and SIP)

Practices in Risk Groups 3 or 4 will be evaluated on a slightly different set of quality measures to account for their patients’ specific clinical and supportive needs.

In performance year one, CMS will use two measures to calculate the PBA for these practices: 1) the advance care plan MIPS CQM measure (also used for practices in risk groups 1-2), which requires that a clinician discuss and/or document their beneficiaries’ advance directive to ensure their preferences are considered at the end of life; and 2) total per capita cost (TPCC), as used in MIPS. In performance year two, CMS will add a CAHPS® measure to the PBA calculation, bringing the number of quality measures for these practices to three.

CMS will also begin developing two quality measures for use in later years of the model: Days at home<sup>17</sup> and 24/7 clinician access.

- 1) Days at Home (claims-based): measures the number of days a Medicare beneficiary remains outside of an institutional care setting during a standardized time period
- 2) 24/7 Access to a Practitioner (survey-based): measures beneficiaries’ perception of round-the-clock access (data collected through a binary yes/no question that will be added to the CAHPS® survey currently in use for CPC+ and that will be used for Primary Care First)

CMS will begin collecting and tracking data on these measures in performance year one in order to support the measure development and data validation process. Additionally, in performance year one, CMS will administer the CAHPS® survey in order to develop benchmarks for performance years 2-5. CMS expects that these two new measures will be endorsed by National Quality Forum (NQF) and will be ready to be incorporated into the PBA calculation in performance year three. In performance year three, the PBA for practices in risk score groups 3 and 4 will therefore be based on five measures: 1) advance care plan MIPS CQM, 2) total per capita cost, 3) CAHPS®, 4) 24/7 access to a practitioner; and 5) days at home.

Table 10. Practice Risk Groups 3-4 Quality Measures

Measure	Collection Method	Model Years	Adjusts Payments	Monitoring Only	Benchmark	Rationale for delayed payment application
<b>1. Advance Care Plan</b>	MIPS Registry	PY1-5	Yes	No	MIPS National Benchmark	N/A

Anyone desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other commercial use, must obtain a commercial use license directly from the AHA.

<sup>17</sup> Groff A.C., Colla, C.H., Lee, T.H. (2016). Days Spent at Home - A Patient-Centered Goal and Outcome. *New England Journal of Medicine*, 375(17), 1610-1612.

Measure	Collection Method	Model Years	Adjusts Payments	Monitoring Only	Benchmark	Rationale for delayed payment application
<b>2.Total Per Capita Cost Measure</b>	Claims	PY1-5	Yes	No	Historical performance based on a non-SIP and/or SIP reference population	N/A
<b>3.CAHPS®</b>	Beneficiary Survey	PY1	No	Yes	N/A	<ul style="list-style-type: none"> <li>• CAHPS® assessment in PY1 will establish benchmarks for PY2</li> <li>• No further measure development expected beyond benchmarking</li> </ul>
	Beneficiary Survey	PY2-5	Yes	No	Prior performance year's reference population	N/A
<b>4. 24/7 Access to a Practitioner</b>	Beneficiary Survey	PY1-2	No	Yes	N/A	<ul style="list-style-type: none"> <li>• Question added to CAHPS® to ensure beneficiaries experience 24/7 access</li> <li>• Novel measure that needs to be validated and have benchmarks established</li> </ul>
	Beneficiary Survey	PY3-5	Yes	No	Historical reference population	N/A



Measure	Collection Method	Model Years	Adjusts Payments	Monitoring Only	Benchmark	Rationale for delayed payment application
5. Days at Home	Claims	PY1-2	No	Yes	N/A	<ul style="list-style-type: none"> <li>• Claims-based data collection through institutional dates of service</li> <li>• Novel measure that needs to be validated and have benchmarks established</li> </ul>
	Claims	PY3-5	Yes	No	Historical reference population	N/A

**Seriously Ill Population Component of Primary Care First**

People with serious illness often receive care that does not align with their preferences and goals under traditional FFS payment models, which can lead to fragmented, siloed care and poor care coordination, navigation difficulties, and at times, undesired or unnecessary treatments. Recognizing that FFS is poorly designed to incentivize comprehensive, coordinated care for seriously ill beneficiaries, CMS is introducing the Seriously Ill Population (SIP) component of Primary Care First (“SIP component”). The objective of the SIP component is to identify seriously ill beneficiaries who are experiencing fragmented, uncoordinated care under Medicare FFS, deliver an intensive, episodic intervention to stabilize their clinical condition, and establish a meaningful relationship between the beneficiary and a practitioner who is accountable for coordinating and managing their care in the longer term.

As previously described in the [Key Model Participants and Partners](#) section, practices can choose from three participation options under Primary Care First:

- 1) Practices choose to participate only in the PCF-General component of Primary Care First, and not in the SIP component, i.e. “PCF-General practices”;
- 2) Practices choose to participate only in the SIP component of Primary Care First, and not in the PCF-General component, i.e. “SIP-only practices”;
- 3) Practices choose to participate in both the SIP and PCF-General components of Primary Care First, i.e. “hybrid practices.”

This section provides additional detail on the eligibility, attribution, payment, and quality rules that will apply for the SIP component of the model. For ease of reference, “SIP practices” will be used throughout

the rest of this section to refer to all practices that participate in the SIP component, including both SIP-only and hybrid practices, unless otherwise noted.

### **SIP as an Intensive, Time-Limited Intervention**

The SIP component of Primary Care First is designed to support an intensive, time-limited intervention for a seriously ill beneficiary. SIP practices are expected to: 1) proactively engage beneficiaries who have been suffering from serious illness and a lack of effective care management under Medicare FFS; 2) facilitate goals of care conversations to understand what is most important to beneficiaries; 3) develop a care plan<sup>18</sup> to achieve those goals of care; 4) execute the care plan through a combination of face-to-face services and non-face-to-face care coordination; and 5) facilitate a relationship between the beneficiary and a practitioner who will be accountable for managing their longer term care once the beneficiary has been clinically stabilized.

To enable SIP-only and hybrid practices to meet these expectations, which will require substantial resources, the SIP component provides for a time-limited step-up in payments relative to both Medicare FFS and the PCF-General component of Primary Care First (see the [SIP quality and payment](#) section for more detail on the SIP payment methodology). This higher level of payment is appropriate when practices are delivering the high-intensity care necessary to stabilize and help a seriously ill beneficiary overcome a history of fragmented care, e.g. avoidable acute hospitalizations and emergency department visits. Once a beneficiary has achieved clinical stabilization, care intensity is expected to decline, and the higher level of payment provided under the SIP component of the model is no longer necessary. SIP-only and hybrid practices will therefore be required to transition beneficiaries out of the SIP component once they have been clinically stabilized and a resulting step-down in care intensity has occurred. SIP-only and hybrid practices will notify CMS when they have transitioned a SIP beneficiary out of the SIP component, which will end the higher SIP PBPM payments that the practice had been receiving for that beneficiary. CMS will provide more detail about the transition notification process, and what information must be included in the notification, in the Participation Agreement.

As part of the transition process, SIP-only and hybrid practices must develop a transition plan, communicate the transition plan to the SIP beneficiary and obtain their approval, transfer the beneficiary's detailed care plan to the receiving practitioner (if different than the SIP practitioner), and have a conversation with the receiving practitioner about the beneficiary (if different than the SIP practitioner). SIP-only and hybrid practices must work closely with beneficiaries to prepare them for transition out of the SIP component, including notifying beneficiaries of the transition prior to their final face-to-face visit under the SIP component, ensuring that they understand which practitioner is responsible for their longer term care after the transition, and in instances where that practitioner is different from the SIP practitioner, facilitating a warm transition to ensure that SIP beneficiaries do not

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<sup>18</sup> For example, a care plan might include: helping patients develop strategies to address basic care or living needs; engaging social support as needed; coaching patients on disease process and self-management according to their baseline level of understanding (including prevention, monitoring, recording and identifying appropriate interventions); working with other treating physicians to ensure patients have medications to stabilize active problems/symptoms and prevent future exacerbations; coordinating other levels of care, caregiver support or services to manage declining function and promote safety, in alignment with person-centered goals; providing medication reconciliation and addressing polypharmacy; and collaborating with all practitioners active in the care to ensure optimal care is coordinated and patient goals of care are communicated.

revert to fragmented care patterns e.g., by helping a beneficiary schedule a first appointment with the practitioner they are being transitioned to and helping the beneficiary arrange transportation to the appointment, if necessary. Additionally, if a SIP-only or hybrid practice is transitioning a beneficiary to a different health care provider, they must have a care agreement with that provider that governs the transition and expectations of support and care coordination after the transition. SIP practices should only transition a beneficiary to another health care provider if that provider can also demonstrate advanced competencies and relevant clinical capabilities for successfully managing complex patients such as interdisciplinary care teams, comprehensive, person-centered care management, family and caregiver engagement, 24/7 access to a member of the care team, and connections with community resources to address social determinants of health and behavioral health issues.

A beneficiary transition out of the SIP component will look different for SIP-only practices vs. hybrid practices. For hybrid practices, transitioning a beneficiary will likely look like a step-down in care intensity rather than a transition from one practitioner to another. CMS expects that in most cases, hybrid practices will continue to care for a beneficiary post-transition, under their PCF-General component. The beneficiary may not notice a significant difference in their 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. From the practice's perspective, the primary difference will be that the monthly payments it receives for the beneficiary will be lower than the amount it received for that beneficiary when they were attributed to the practice's SIP component; the amount of the monthly payment post-transition will be equal to the professional PBP that the practice receives for its non-SIP beneficiaries, which is based on the practice's risk score group (see [Payment Redesign](#) section for more information about the Primary Care First payment methodology for the PCF-General component). The practice will still be able to bill the flat visit fee for face-to-face services delivered to the beneficiary post-transition.

However, for SIP-only practices, which are not participating in the PCF-General component and thus may transition beneficiaries to other practices or providers, CMS expects that these practices will 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. 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 FFS; SIP-only practices will not continue to receive a PBPM payment or the \$40 flat visit fee once a beneficiary has been transitioned.

CMS will encourage SIP-only and hybrid practices to maintain an eight-month annual 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. Such an average will allow practices the flexibility to appropriately transition beneficiaries in a timely manner when the practice deems them not to require SIP-level services e.g., after a clinical assessment, but also to care for beneficiaries who need more intensive services for longer than eight months in order to be stabilized. The experience of

organizations with expertise managing similar populations suggests that eight months is an appropriate average length of attribution to ensure that SIP-level services are provided to the beneficiaries that are most likely to benefit, and in turn the model has a greater potential to generate savings for Medicare by accurately targeting higher SIP payments for these beneficiaries.

In addition to being assessed on the quality measures described in the [Quality Measures for Practice Risk Score Groups 3 or 4 \(and SIP\)](#) section above, SIP-only and hybrid practices will be assessed based on their ability to maintain an eight-month average length of attribution for SIP beneficiaries annually. Practices that exceed the eight-month average length of attribution for their SIP beneficiary population will receive a \$50 PBPM reduction to their monthly SIP payment through the quality adjustment, described in greater detail below. However, CMS notes that the appropriate length of time will vary by individual beneficiary, with some receiving SIP-level care for less than eight months and others receiving SIP-level care for longer than 8 months. In recognition of this variation in individual beneficiary needs, by default, CMS will allow attribution for an individual SIP beneficiary to last for up to 12 months, so long as the SIP-only or hybrid practice maintains an 8-month average length of attribution across its entire SIP beneficiary population. CMS will calculate the practice's average length of attribution annually, at the end of the performance year. A practice's average length of attribution will be calculated by averaging the time (in months) from attribution to transition for all beneficiaries who are transitioned out of the practice's SIP component in a given performance year. In exceptional cases, where necessary to support a beneficiary's care (e.g. where a SIP beneficiary still requires intensive care services and a transition of care would be harmful for the beneficiary's health), CMS may allow a practice to apply for an extension of this 12-month period in limited increments. To be eligible to seek an extension beyond 12 months, a SIP practice must still maintain an 8-month average length of attribution across its entire SIP beneficiary population.

### **Eligibility and Care Requirements for Practices Attributed SIP Beneficiaries**

SIP-only practices are not required to meet the minimum threshold of 125 attributed beneficiaries or the 70% minimum primary care revenue threshold that is required of other practices in order to be eligible to participate in the model.

Eligible practitioners are those practicing in internal medicine, general medicine, geriatric medicine, family medicine, and/or hospice and palliative medicine. Hospice and palliative care practitioners are eligible to care exclusively for SIP beneficiaries, either by participating in the model as a SIP-only practice or by joining a hybrid practice and being included on its practitioner roster.

SIP-only practices will be required to attest that they will 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 health information exchange (HIE) by January 1 of the second model performance year (2022). They 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 performance year two, e.g. information about EHR platforms designed for hospice and palliative care providers that meet CEHRT requirement.

Like practices in Practice Risk Groups 3 and 4 (i.e., practices with complex, chronic beneficiary populations), all practices that wish to participate as SIP-only or hybrid practices will need to meet

certain additional eligibility requirements. In their application, all practices that would like to participate in the SIP component of the model will need to demonstrate advanced competencies and relevant clinical capabilities for successfully managing complex patients. For example, these practices will need interdisciplinary care teams and the ability to fulfill requirements such as comprehensive, person-centered care management, family and caregiver engagement, and 24/7 access to a member of the care team, as well as be able to connect these beneficiaries to resources in the community to help address social determinants of health and behavioral health issues.

### **Attribution of SIP Beneficiaries**

Practices that apply to participate in the model as SIP-only or hybrid practices must describe in their application the service area(s) from which they are willing to accept attributed SIP beneficiaries using zip codes as descriptors. The practice must also note the maximum number of attributed SIP beneficiaries that the practice has the capacity to manage at one time. If the practice is accepted to participate in the model and signs a Participation Agreement with CMS, CMS will assign SIP beneficiaries in the SIP practice's approved service area to the practice, starting with SIP beneficiaries that live closest to the practice. 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 (final attribution will depend on beneficiary outreach and engagement as described below, as well as practices' maximum capacity).

CMS will use claims data to identify beneficiaries who meet the two general SIP beneficiary requirements: experiencing serious illness and exhibiting a pattern of care fragmentation. The claims-based criteria for each of these requirements are set forth below.

Serious Illness—Medicare beneficiaries that meet one of the following claims-based criteria will be deemed to satisfy the serious illness requirement:

- 1) Have significant chronic or other serious illness (defined as an HCC risk score at 3.0 or greater).
- 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.
- 3) Show signs of frailty, as evidenced by a DME claim submitted to Medicare by a provider or supplier for a hospital bed or transfer equipment.

Care Fragmentation—A Medicare beneficiary will satisfy the care fragmentation requirement if, based on claims data, one of the following conditions is satisfied: no single practice (defined at the TIN level) provided more than half of their evaluation and management visits; or, the beneficiary had two or more Emergency Department visits or observation stays in the previous 12 months, or such other claims-based criteria as may be set forth in the Participation Agreement.

Following identification, CMS will then reach out to beneficiaries who meet the SIP claims-based criteria in order to solicit their interest in the model. Once a beneficiary has indicated interest in the model, CMS will immediately (i.e. within 24-48 hours) provide their contact information to a SIP practice through a secure information transfer method, and, depending on beneficiary and practice preferences, may even help the beneficiary schedule their first appointment. In addition to this rapid connection,

CMS will also provide the identified practice with an updated list of SIP-eligible beneficiaries on a monthly basis for tracking purposes.

Practices are expected to reach out to beneficiaries as soon as possible, ideally within 24 hours after they receive a beneficiary's contact information from CMS, though they will have 60 days from when 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 beneficiary. After the participating practice has submitted a claim for the first face-to-face visit with the SIP beneficiary, the SIP beneficiary will be attributed to the practice and the monthly SIP payments (calculated on a PBPM basis but paid quarterly) will begin. CMS expects that SIP beneficiaries will require an intensive level of care; therefore, for a SIP beneficiary to remain attributed to the practice, the practice must have a face-to-face visit with the beneficiary at least once every 60 days, as defined by dates of service on claims billed under the practice's TIN. If this requirement is met, attribution (and SIP-level payment) will last for up to 12 months, or until one of the following circumstances occurs:

- 1) Beneficiary opts out of the SIP component after the first face-to-face visit (in this scenario, the practice should notify CMS);
- 2) The practice notifies CMS that the beneficiary has been transitioned out of the SIP component;
- 3) Beneficiary began receiving hospice care, as evidenced by hospice claims
- 4) Beneficiary moved out of the practice's service area for SIP beneficiaries; or
- 5) Beneficiary died prior to the care transition.

Practices will also have the opportunity to request an exception to the 12-month attribution limit for individual SIP beneficiaries. CMS expects that exceptions will be rare and will require practices to confirm that continuing to receive SIP-level payment for care is necessary for the beneficiary (e.g. the beneficiary still requires the same level of intensive care services).

CMS is aware that some SIP-eligible beneficiaries may not be identified by CMS's review of claims data, due to reasons such as new enrollment in Medicare and a resulting lack of historical data, or new and rapid onset of disease. Therefore, on a limited basis, CMS will allow SIP-only and hybrid practices to identify and refer beneficiaries for model participation under the SIP component even if they do not meet the claims-based criteria for SIP eligibility. This pathway for identifying SIP beneficiaries will be termed "direct referral."

CMS will identify non-claims-based clinical criteria that beneficiaries must meet to be eligible for direct referral. SIP practices seeking to directly refer a beneficiary to the SIP component will first seek the beneficiary's consent and then will attest to CMS that the beneficiary meets these clinical criteria. CMS will review these attestations and confirm that the beneficiary also meets general Primary Care First beneficiary eligibility criteria, e.g. enrollment in Medicare Parts A and B. If CMS confirms that the beneficiary meets eligibility criteria and the SIP practice has a subsequent face-to-face visit with the beneficiary, the beneficiary will be attributed to the SIP practice and SIP monthly payments will begin in the following month. If CMS determines that the beneficiary does not meet eligibility criteria, the beneficiary will not be eligible for attribution to the SIP practice. Any care that the practice furnishes to a beneficiary prior to attribution, e.g., in the course of evaluating the beneficiary's eligibility for SIP, will be reimbursed under FFS.

CMS expects that beneficiaries who are good candidates for the direct referral pathway will mostly be identified by other health care providers in the community, e.g. a hospital or ED, and then referred to the SIP practice for clinical assessment. The SIP practice will ultimately be responsible for determining whether the beneficiary meets the non-claims-based clinical criteria and submitting an attestation to CMS. SIP practices cannot directly refer a patient with whom they have an existing care relationship, as the goal of the SIP component is to identify patients who are experiencing fragmented care and do not currently have a primary practitioner that they regularly visit for their care. More information on the specific non-claims-based clinical criteria for direct referral will be available in the Participation Agreement.

In order to establish a comparison group of beneficiaries for evaluation of the SIP component, CMS may randomly assign a portion of SIP beneficiaries within the practice's service area who meet the SIP claims requirements, but have not yet been contacted about their interest in the model, to a “usual care” group, meaning they will not be assigned to a SIP practice and will continue to receive care under FFS. Random assignment improves the quality of the model evaluation, because it increases the likelihood that observed differences in outcomes between the intervention group and the control group are due to the model intervention, rather than underlying differences between the patient populations in the two groups.

See [Appendix D](#) for more detail on the SIP attribution methodology.

### **SIP Payment and Quality Methodology**

To compensate participating SIP-only and hybrid practices for the additional clinical work associated with the outreach and initial engagement of SIP beneficiaries, CMS will make a one-time payment of \$325 after a practice has the first face-to-face visit with the SIP beneficiary. For beneficiaries identified by CMS, this visit must occur within 60 days of the date the beneficiary was assigned to the practice on its monthly SIP beneficiary list. Once the first face-to-face visit occurs, and assuming the beneficiary does not opt out or ask to be removed from the program, the SIP beneficiary will be attributed to the participating practice. For beneficiaries identified via the direct referral process, practices will receive the one-time \$325 payment after CMS confirms that the beneficiary is eligible for SIP and the practice bills for a subsequent face-to-face visit with the beneficiary. Practices will not be permitted to bill the \$40.82 flat visit fee base rate for the first face-to-face visit with a SIP beneficiary, regardless of whether the beneficiary is identified through the claims-based attribution algorithm or through direct referral. After the first face-to-face visit, participating practices may bill the \$40.82 flat visit fee base rate for each face-to-face visit with SIP beneficiaries.

Beginning the month following the first face-to-face visit, the practice will receive a \$275 PBPM base rate minus \$50 PBPM, which will be withheld until verification after the end of the performance year that the practice meets a minimum quality standard, as described below. The monthly payment will be calculated on a PBPM basis but paid quarterly. The \$50 withhold will be calculated on a PBPM basis, but if the practice earns it back, it will be paid in one annual lump sum after the performance year. The \$275 PBPM and \$50 PBPM base rates will be geographically adjusted in a similar manner to Medicare Part B fee schedule rates to account for nationwide variations in cost. SIP practices will continue to receive this monthly payment for a beneficiary for either 12 months, or until the beneficiary is de-attributed from the practice 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 (see the attribution section above for more detail on circumstances under which a beneficiary would be de-attributed from a practice).

SIP practices will have the opportunity to earn back the \$50 PBPM base rate withhold from their SIP PBPM payment, as well as an additional \$50 PBPM base rate quality bonus. 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 their average SIP beneficiary attribution length and their rate of success in care transitions:

- **Average SIP beneficiary attribution length:** If a SIP practice's average length of SIP beneficiary attribution (calculated annually for all beneficiaries attributed and transitioned during the performance year) exceeds eight months, it will not be eligible to earn back the \$50 PBPM withhold or the additional \$50 quality bonus for any of its SIP beneficiaries attributed during the measurement period.
- **Rate of care transition success:** A practice's transition success rate will be defined as the share of its SIP beneficiaries with zero hospitalizations or emergency department (ED) visits in the three months following their transition out of the SIP component. A hospitalization or ED visit within three months of transitioning out of the SIP component may be a sign that the beneficiary either was not yet ready to be transitioned, or that the SIP practice did not adequately facilitate a relationship between the beneficiary and a practitioner within a longer term care arrangement who could be accountable for their care management post-transition. CMS recognizes that not all hospital and ED utilization may be related to a poor transition, and will not penalize practices for individual instances where a beneficiary was hospitalized or used the ED within three months post-transition. However, if a practice's transition success rate for all beneficiaries attributed and transitioned during the performance year is below a benchmark that will be specified before the start of each performance year, it will not be eligible to earn back the \$50 PBPM withhold or the additional \$50 quality bonus for any of its beneficiaries attributed during the measurement period. CMS will also be monitoring additional factors to ensure that SIP practices are transitioning beneficiaries out of the SIP component at the appropriate time for the beneficiary—see the [SIP monitoring](#) section for more detail.

If a practice meets the average attribution length and transition success rate criteria, its SIP quality adjustment will then be calculated based on its performance on a set of quality measures. SIP practices will be measured using the same quality measures as practices in Practice Risk Groups 3 and 4. See [Quality Measures for Practice Risk Groups 3 and 4 \(and SIP\)](#) for more detail on the specific measures that will be used to evaluate SIP practices. Practices that meet or exceed the 70<sup>th</sup> percentile as compared to the reference population<sup>19</sup> for all quality measures will be considered high quality for the purposes of the quality adjustment, and will earn back the full amount of the \$50 PBPM withhold plus a

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<sup>19</sup> SIP Reference populations are as follows: 1) MIPS for Advance Care Plan; and 2) SIP and/or non-SIP for Patient Experience of Care Survey, Total Per Capita Cost, 24/7 Access and Days at home.



quality bonus of \$50 PBPM (for a final PBPM of \$325). Practices that fall between the 50<sup>th</sup> and the 70<sup>th</sup> percentile as compared to the reference population for all quality measures will be considered satisfactory quality for the purposes of the quality adjustment, and will earn back their \$50 PBPM withhold but not the additional \$50 quality bonus (for a final PBPM of \$275). Practices that fall below the 50<sup>th</sup> percentile for all measures will be considered low quality for the purposes of the quality adjustment (for a final PBPM of \$225). Thus, even if a practice meets the average attribution length and transition success rate criteria, if the practice is considered low quality, it will forfeit its \$50 withhold.

The below table illustrates a few possible scenarios in relation to the SIP quality adjustment:

Indicators	Upfront PBPM base rate <sup>20</sup>	SIP Quality Adjustment (PBPM base rate)
<ul style="list-style-type: none"> <li>✓ High Quality (≥70th percentile relative to reference population)</li> <li>✓ ALOS ≤ 8 months</li> <li>✓ Successful Transition</li> </ul>	\$275 base rate – \$50 quality withhold = <b>\$225</b>	\$50 withhold paid back plus \$50 bonus = <b>\$50</b> PBPM; total PBPM is <b>\$325</b>
<ul style="list-style-type: none"> <li>✗ Satisfactory Quality (50<sup>th</sup> to 70<sup>th</sup> percentile relative to reference population)</li> <li>✓ ALOS ≤ 8 months</li> <li>✓ Successful Transition</li> </ul>	\$275 base rate – \$50 quality withhold = <b>\$225</b>	\$50 withhold paid back, no bonus paid out = <b>\$0</b> PBPM; total PBPM is <b>\$275</b>
<ul style="list-style-type: none"> <li>✗ Low Quality (&lt;50<sup>th</sup> percentile relative to reference population)</li> <li>✗ ALOS ≥ 8 months</li> <li>✗ Poor Transition</li> </ul>	\$275 base rate – \$50 quality withhold = <b>\$225</b>	\$50 withhold forfeited = <b>-\$50</b> PBPM; total PBPM is <b>\$225</b>

Beginning in performance year three, CMS may begin assigning more beneficiaries to SIP practices that score higher on a ratio of transition success rate to average length of attribution, if sufficient regional density of SIP beneficiaries exists to do so. This creates a performance-based approach where practices that demonstrate high quality and cost effectiveness with transitions could potentially benefit.

CMS may make changes to the SIP component of the model in future years as data accrues over the model test, including future amendments to the payment and care delivery requirements as described in the Participation Agreement.

### SIP Attribution, Payment, and Quality Example

For illustrative purposes, we present the following example of the attribution, payment calculation, and quality adjustment for a SIP beneficiary:

<sup>20</sup> The PBPM, including the quality withhold and quality adjustment, will be geographically adjusted to account for nationwide variations in cost.

- Practice A is a hybrid Primary Care First practice.
- In performance year two, a SIP-eligible beneficiary is identified through the claims-based algorithm. The SIP-eligible beneficiary has end-stage Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and Osteoarthritis, is seeing multiple different specialists in pursuit of quality care to address his symptoms and pain management, has visited the emergency department five times in the past year and has had two hospitalizations in the past six months.
- CMS reaches out to the SIP-eligible beneficiary and the beneficiary expresses interest in the model. CMS connects the beneficiary with Practice A and the SIP-eligible beneficiary is also added to Practice A's list of SIP beneficiaries in January.
- In January and February, Practice A conducts outreach activities to engage with the beneficiary and in mid-February, Practice A has its first face-to-face visit with the SIP beneficiary.
- In this first visit, Practice A provides a comprehensive assessment:
  - Practice A's interdisciplinary care team learns that the SIP beneficiary has been unable to get timely appointments with a primary care practitioner or pulmonologist, has confusion regarding what to do or which practitioner to call when symptoms arise, does not have a care plan (i.e. hasn't identified goals, care preferences, or a healthcare proxy), walks with a cane and uses stairs to get to his second floor bedroom, and has a cupboard at home filled with multiple pill bottles and inhalers, some of which are duplicative or expired.
  - Practice A identifies and prioritizes active symptoms, schedules a same-day follow-up with treating physicians, and begins coordinating additional medical and social services (e.g. home health and transportation services)
  - As a result of the first face-to-face visit, Practice A receives \$325 for the beneficiary and the beneficiary is now attributed to the practice. Beginning in March (i.e. the following month), monthly payments begin, equaling \$275 PBPM base rate minus a \$50 PBPM base rate withhold).
- Through the next eight months (March to October), Practice A continues to provide comprehensive, person-centered care coordination and case management of the beneficiary's total medical and social needs, advance care planning, and patient and family engagement for the SIP beneficiary. In addition to telephonic visits and outreach by members of the interdisciplinary care team, including a social worker and chaplain, a nurse practitioner (NP) or physician (who are also part of the SIP beneficiary's interdisciplinary care team) conducts home visits to assess the SIP beneficiary's medical needs, reconcile medications and review functional status as well as stabilize any exacerbations, as appropriate.
  - The SIP practice is closely coordinating the beneficiary's care in conjunction with specialists, and the beneficiary receives timely appointments that are coordinated with caregivers. The beneficiary hasn't experienced any Emergency Department visits in the past 3 months; the beneficiary had two COPD exacerbations that were managed in the outpatient setting. The beneficiary knows what to do and who to call if symptoms

worsen, with a clinician available 24/7. The beneficiary understands his illness, has identified a long-term plan specific to his goals, created an advance care plan including his end-of-life care preferences, and identified a healthcare proxy. The interdisciplinary care team performed a home safety evaluation and the beneficiary's bedroom was moved to the first floor. Through medication reconciliation services, the beneficiary had help discarding expired medications and now uses a pill organizer and carries his medication list with him.

- In October, Practice A determines that the SIP beneficiary is ready to be transitioned out of its SIP component and into its PCF-General component and begins transition care planning, including collaborating with other clinicians active in care to ensure care is coordinated and patient goals of care are communicated. In November, Practice A transitions the SIP beneficiary to its PCF-General component. Practice A notifies CMS that the SIP beneficiary was transitioned.
- Over the course of these nine months, Practice A has provided the beneficiary with a total of ten face-to-face visits made by an NP or physician (more intensive in initial months and transition months), and thus is paid in total an additional \$408.20 (or \$40.82 flat visit fee (base rate) for face-to-face visits (not including coinsurance or geographic adjustment) \*10).
- Practice A continues to care for the beneficiary, but under the PCF-General component of the model. The beneficiary may not notice a significant difference in his care team and care management after the transition, although his care needs are expected to be lower because he has been clinically stabilized. The payment that Practice A receives for this beneficiary will change from the SIP PBPM payment to the practice's professional PBP for a non-SIP beneficiary. For example, if Practice A is in practice risk group 4 for its PCF-General component, it will receive the practice risk group 4 professional PBP of \$175 for the beneficiary after he is transitioned out of SIP.
- In performance year two, the average length of time that all SIP beneficiaries were attributed to Practice A before being transitioned out of SIP was 7.8 months, and Practice A's transition success rate was 75%. Practice A also exceeded the 70<sup>th</sup> percentile on all quality measures and therefore was deemed a high quality performer.
- Because Practice A had an average attribution period of less than eight months at the end of performance year two, had a transition success rate above the minimum benchmark, and was a high quality performer, it is eligible to receive a quality bonus PBPM for its SIP beneficiaries, in addition to the \$50 PBPM withhold payment, which will be paid out in the beginning of performance year three.
- For the individual SIP beneficiary in this example, Practice A will receive a total of \$375.52 PBPM:

Outreach and First Face-to-Face Visit	Monthly Payments <sup>21</sup>	Retrospective Quality Adjustment <sup>22</sup>	Total Payments for Face-to-Face Visits (Flat Visit Fee*# of visits) <sup>23</sup>	Estimated PBPM <sup>24</sup> (Total payments / attributed months)
\$325	(\$275 base rate - \$50 withhold) * 9 = \$2025	<ul style="list-style-type: none"> <li>• Receives withhold back: \$50*9 = \$450</li> <li>• Receives bonus: \$50*9 = \$450</li> </ul>	\$40.82*10 = \$408.20	\$3658.20 / 10 = \$365.82

**SIP Practice Monitoring**

CMS will conduct claims-based monitoring of participating practices that have been attributed SIP beneficiaries. Monitoring will be designed to ensure that practices are engaging these beneficiaries on an ongoing basis through a mixture of face-to-face and telephonic encounters that are proactively deployed based on beneficiaries’ current and anticipated needs. For monitoring purposes, evidence of engagement with SIP beneficiaries will include practices’ success and timeliness in seeing SIP beneficiaries for an initial face-to-face visit after receiving their SIP attribution list, amount and type of services provided to SIP beneficiaries (including face-to-face and telephonic encounters), rates of hospital admission and re-admission, post-hospital discharge follow up, the quality and appropriateness of care transitions, and rates of exceptional cases of SIP attribution beyond 12 months.

CMS will monitor for: (1) practices that have a low rate of success in engaging SIP beneficiaries, as defined by whether or when the first face-to-face visit is billed, and (2) practices with a high rate of success in engaging SIP beneficiaries, but with little subsequent claims-based evidence that services are being provided. In these instances, CMS may terminate a practice’s participation in the model and seek repayment of all or a portion of professional PBPM payments, as appropriate. The requirement that a practice have an in-person visit with the beneficiary at least once every 60 days is expected to limit instances where this would occur.

CMS will also monitor for significant changes in the use of E/M services from specialists. As a result of the fragmented care criteria for identifying SIP beneficiaries, CMS expects that these beneficiaries will show high historical rates of E/M services delivered by specialists, both because they lack a primary care practitioner effectively coordinating the care they receive from specialists and because of high rates of acute hospital utilization, which often leads to specialist follow-up and related E/M charges. While some

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<sup>21</sup> The monthly payments will be geographically adjusted from its base rate of \$275.  
<sup>22</sup> Paid in following performance year  
<sup>23</sup> This amount will be geographically adjusted from its base rate of \$40.82. Applicable beneficiary coinsurance is not included in the base rate.  
<sup>24</sup> Reflects an estimated PBPM after calculating total payments over the attribution period, inclusive of the one-time payment of \$325 after a practice has the first face-to-face visit, monthly \$275 PBPM base rate (reflecting that the practice meets ALOS standard and has earned back the withhold), \$50 PBPM quality bonus, and face-to-face visits

level of E/M billing occurs in conjunction with procedures performed by specialists, CMS expects and will monitor for a rebalancing, with increased primary care engagement and decreased specialist billing.

Monitoring will also look at SIP practices' timeliness of transition notifications and SIP beneficiaries' patterns of care after they transition out of the SIP component of the model. The goal of the SIP component of the model is to provide a targeted intervention to halt a cycle of fragmented care and clinical decline, stabilize a beneficiary and develop a care plan, and then transition a beneficiary to a practitioner who can oversee longer term care maintenance. The SIP practice is therefore accountable for facilitating a warm transition, e.g. by scheduling a beneficiary's first appointment with the practitioner they are being transitioned to and arranging transportation to the appointment, to ensure that SIP beneficiaries do not revert to fragmented care patterns. CMS will monitor claims to see if SIP beneficiaries who have been transitioned receive care from the practitioner that the SIP practice transitioned them to (per SIP practice's transition notification to CMS). Furthermore, CMS will use claims to examine beneficiaries' patterns of care after transitioning out of the SIP component and compare them to beneficiaries' historical experience to ensure lasting improvement in reducing care fragmentation. Monitoring will also focus on ensuring there is not a pattern of selective transitions where a practice seeks systematically to transition higher risk, higher need beneficiaries more quickly while holding onto other beneficiaries for longer periods of time before transition. CMS will reserve the right to retain the withhold amount (and may take other corrective action) if it finds a pattern where the risk scores of beneficiaries transitioned earlier from the SIP practice are materially higher than those beneficiaries that are attributed to the practice for longer (signaling that the practice may be selectively transitioning higher risk beneficiaries relative to lower risk beneficiaries).

### Learning Systems Strategy

In Primary Care First, CMS will provide access to a learning system for participating practices, including:

1. **Technical Assistance:** Share information about how the model works and what is required for success through onboarding and support resources such as an implementation guide, newsletters, FAQs, and webinars/office hours.
2. **Use of Data for Improvement:** Support in the use of data and analytics to guide the operational and care delivery changes necessary for success.
3. **Assessment and Feedback:** Ongoing and timely assessment of practice capabilities.
4. **Learning Communities:** Management of practice networks for peer-to-peer sharing and diffusion of promising tactics, e.g., via a web-based collaboration website (PCF Connect) and a national meeting.

Practices participating in Primary Care First may invest in practice coaching to achieve their aims in Primary Care First, but these services will not be provided by CMS, because CMS generally expects that Primary Care First practices have already developed advanced primary care capabilities. Where there are opportunities for alignment, e.g., National Meeting and regional in-person meetings in the 18 existing CPC+ Track 1 and 2 regions, the Learning System for Primary Care First will be integrated into the existing learning system structure designed for CPC+ Tracks 1 and 2.

### National Payer Community

CMS-facilitated learning communities for CPC+ Tracks 1 and 2 have primarily focused on participating practices, with the expectation that payers would convene regional learning collaboratives amongst

themselves. New for Primary Care First, CMS will create a National Payer Community (NPC) to support Primary Care First payer collaboration across and within regions. Through the NPC, CMS will host and facilitate payer-specific learning events that are responsive to payers' needs and interests, and will develop educational materials targeted specifically to payers. Payers will also be able to use the NPC as a forum for networking and sharing lessons learned with one another.

## Data Sharing

In Primary Care First, CMS will offer participating practices actionable data to inform their efforts to impact patient experience, clinical quality, and utilization. Participating practices will have an opportunity to request regular Medicare FFS expenditure and utilization data conveyed in a clear and actionable way. CMS believes that the use of this data feedback will be critical for practices to perform certain health care operations, including care coordination, population health management, and quality improvement activities, that would reduce the cost of care and unnecessary utilization.

CMS will provide practices with the opportunity to request both patient-identifiable and practice-level quarterly feedback reports, as well as regionally aggregated reports, through the Data Feedback Tool that is currently provided to practices participating in CPC+ Tracks 1 and 2. These reports summarize Medicare FFS expenditure, utilization, and care delivery data. The reports are interactive and where appropriate, will offer the flexibility to access beneficiary-level data, including emergency department visits, hospitalizations, and other high-cost services used in the previous quarter (e.g., imaging). 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.

National and regional performance data from participating practices will be shared in an effort to use transparency and competitiveness to incentivize improved performance. In future reports for Primary Care First practices, CMS will provide practitioners with information on their own performance in comparison to all other practitioners' individual and practice-level performance. All data sharing and data analytics will comply with applicable law, including the regulations promulgated under HIPAA. Beneficiaries will be notified by the practice to which they have been attributed that the practice is participating in the model and the beneficiary may opt out of claims data sharing under the model.

CMS plans to pursue additional avenues of data sharing to augment the quarterly data feedback reports for Primary Care First practices:

- *Data aggregation* is intended to reduce burden on practices receiving data from multiple payers and improve practitioner insights into performance across their entire patient population. For example, in CPC+ Tracks 1 and 2, commercial payers in five regions have come together and collaborated with CMS to institute multi-payer claims databases that provide reports to the practices based on their entire CPC+ attributed populations. CMS plans to continue supporting data aggregation in these existing regions to include Primary Care First practices and payer partners. We also will respond to interest in multi-payer data aggregation in new regions. Each new region will be assessed on a case-by-case basis to determine if there is sufficient commitment and readiness for CMS participation.
- *Claims line feeds* will be offered to all Primary Care First practices that have the infrastructure to manage such data files and develop their own analytic tools. Primary Care First practices lacking

experience with claims line feeds and/or are not interested in receiving them will continue to be offered claims based reporting through the Data Feedback Tool described above.

### **Multi-payer collaboration in data sharing**

In order to reduce burden and better enable data-driven improvement, CMS encourages multi-payer collaboration around data sharing and the use of regional infrastructure to the greatest extent possible. CMS expects payer partners to make similar commitments to offer data on cost, utilization, and quality to their participating practices, and to participate in multi-payer alignment or aggregation efforts where feasible. As stated in their MOUs, payer partners are also expected to regularly provide practices with lists of their attributed enrollees and, upon request and in accordance with applicable laws, relevant claims and cost data for their attributed population.

### **Practice Monitoring, Auditing, and Termination Strategy**

#### **Monitoring**

Monitoring will help CMS ensure Primary Care First is being implemented appropriately and effectively at the practice level. CMS will use practices' self-reported care delivery measures, cost, utilization, and quality data in its monitoring strategy. The findings from monitoring will guide additional learning activities and ensure compliance with the terms of the Participation Agreement between CMS and the Primary Care First practices.

Monitoring will include the review of some or all of the following:

- *Vetting Data*: Prior to the start of the model, practices that apply to participate in the model will be subject to a program integrity screening by the CMS Center for Program Integrity to determine if they are eligible to participate. This screen will occur annually thereafter for all current model participants and at the time of any change in practices' organizational structure (e.g., merger, acquisition).
- *Care Delivery Achievement Data*: Determine whether practice attestations to CMS on a limited set of care delivery interventions are accurate.
- *Cost, Utilization, Patient Experience, and Quality Data*: Review cost, utilization, patient experience, and quality data at least annually to identify practices that are performing well, those that have low performance, and to monitor for compliance. Electronic clinical quality measure submissions will also be monitored to help ensure data is reported as required by the model.
- *Engagement with SIP beneficiaries*: CMS will conduct claims-based monitoring of practices that have accepted SIP beneficiaries. Monitoring will be designed to ensure that practices are engaging these beneficiaries on an ongoing basis through a mixture of face-to-face and telephonic encounters that are proactively deployed based on beneficiaries' current and anticipated needs. Evidence of engagement will include the practices' success and timeliness in seeing SIP beneficiaries for an initial face-to-face visit after receiving their monthly SIP-eligible beneficiary lists, amount and type of services provided to SIP beneficiaries (including face-to-face and telephonic encounters), rates of hospital admission and re-admission, post-hospital discharge follow up, and the quality and appropriateness of care transitions. Monitoring will also

look at practices' patterns of timely transition notifications and beneficiaries' patterns of care after they transition out of the SIP component of the model.

### **Auditing**

Audits will help mitigate financial and beneficiary vulnerabilities and risks associated with the professional PBP, flat visit fee, and PBA. Audits will primarily focus on, but not be limited to, the prevention, detection, and/or mitigation of improper payments and care stinting.

Analyses will be conducted using a review of claims data, medical records, beneficiary interviews, health IT reports, and practice records, and practices with anomalies will be selected for audit. Audits will help determine if patient complexity levels, quality, and utilization scores can be substantiated, which will test the alternative payment structure and risk stratification methodology.

Practices will be required to maintain copies of all documentation related to their participation in Primary Care First. Data that practices submit annually to CMS, performance on utilization and quality measures, and other practice information may also trigger an audit of any participating practice. Practices will be informed if selected for an audit.

### **Termination**

CMS reserves the right to terminate a practice's Participation Agreement at any point during the model for reasons associated with poor performance, program integrity issues, non-compliance with the terms and conditions of the applicable Participation Agreement, or if otherwise specified in the Participation Agreement or required by section 1115A(b)(3)(B) of the Social Security Act.

CMS will determine periodically whether practices should be subject to any administrative action, such as a Notice of Remedial Action (NRA). An NRA will be imposed when a practice does not meet certain terms of the Participation Agreement, but can reasonably be expected to remediate the deficiency in a timely manner. Examples of scenarios warranting an NRA include charging beneficiaries a concierge fee and failure to meet quality reporting deadlines. Practices will be required to remedy the situation within a reasonable time frame (usually 3-6 months depending on the deficiency). Termination will occur for non-remediable issues as set forth in the Participation Agreement or determined by CMS, such as identification of program integrity concerns, joining another model with a Primary Care First no-overlaps policy, or when expected remediation from a NRA does not occur.

### **Evaluation**

All participants in Primary Care First will be required to cooperate with CMS efforts to conduct an independent, federally-funded evaluation of the model, which may include participation in surveys, interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive evaluation. The evaluation will be used to inform CMS about the effect of both primary care transformation and aligned payment reform. The evaluation of this model will use a mixed-methods approach to assess both impact and implementation experience. The impact component will attempt to measure to what degree Primary Care First improved key outcomes, including lower total cost of care and improved quality of care. The implementation component will describe how the model was implemented, assessing barriers and facilitators to change.



Data for the analyses will come from sources including, but not limited to: the practice application; Medicare and Medicaid claims; patient experience surveys; site visits with practices; focus groups or interviews with beneficiaries and their caregivers, practice staff, those providing technical assistance, and others (e.g., payers); and observation of the learning system. As discussed in the Practice Selection and Seriously Ill Population sections of this RFA, CMS will also identify control groups to serve as reference populations for evaluating the SIP and PCF-General components of the model.

The evaluation will involve analyses across all regions in which it is implemented. A longitudinal study design will be used for the quantitative impact analyses, comparing intervention and comparison practices over time using quarterly fixed effects or a similar approach. In addition to quarterly effects, we will also examine cumulative and year-over-year impacts.

### **Authority to Test the Model**

Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Center for Medicare and Medicaid Innovation (Innovation Center), and provides authority for the Innovation Center to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care.

While CMS is committed to improving care for beneficiaries, the Agency reserves the right to decide not to move forward with the Primary Care First model for any reason and at any time, as is true for all models pursued under Section 1115A authority. Similarly, as implementation of Primary Care First ensues, CMS reserves the right to terminate the model if it is deemed that it is not achieving the goals and aims of the initiative.

No fraud and abuse waivers are being issued in this RFA; fraud and abuse waivers, if any, would be set forth in separately issued documentation. Thus, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued specifically for Primary Care First pursuant to section 1115A(d)(1). Any such waiver would apply solely to Primary Care First and could differ in scope or design from waivers granted for other programs or models.

### **Advanced APM and MIPS APM Status**

#### **Advanced APM Status**

As set forth in 42 CFR 414.1415, in order for an APM to be an Advanced APM, the following criteria must be met:

- (1) The APM requires at least 75 percent of eligible clinicians in each participating APM Entity to use CEHRT to document and communicate clinical care to their patients or other health care providers as set forth in 42 C.F.R. 414.1415(a);*
- (2) The APM uses quality measure performance as a factor when determining payment to participants for covered professional services under the terms of the APM as set forth in 42 C.F.R. 414.1415(b);*

- (3) The APM meets either the generally applicable financial risk and nominal amount standards, or for Medical Home Models, the Medical Home Model financial risk and nominal amount standards as set forth in 42 C.F.R. 414.1415(c).*

The general track, the hybrid track, and the SIP-only track of Primary Care First are each an Advanced APM as long as the practice complies with the CEHRT requirement for the applicable performance year. Accordingly, SIP-only practices that begin to comply with the CEHRT requirements beginning with performance year two will not be in an Advanced APM for performance year one.

As discussed below, control group practices are not considered to be participating in an Advanced APM, and will be scored under the APM scoring standard for MIPS.

The Primary Care First model meets the definition of a Medical Home Model as defined in 42 CFR 414.1305, and the Primary Care First model meets the financial risk requirements under the Medical Home Model financial risk and nominal amount standards set forth at 41 C.F.R. 414.1415(c)(2), (4). Per 42 C.F.R. 414.1415(c)(7), the Medical Home Model financial risk and nominal amount standards would only apply to an APM Entity participating in a Primary Care First practice that is owned and operated by an organization with less than 50 eligible clinicians whose Medicare billing rights have been assigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities (referred to as the "50 eligible clinician limit"). CMS will annually determine if any Primary Care First practices meet or exceed the 50 eligible clinician limit. Because Primary Care First will not qualify as an Advanced APM under the generally applicable financial risk and nominal amount standards, Primary Care First practices that meet or exceed the 50 eligible clinician limit will not be considered participants in an Advanced APM, and eligible clinicians participating in Primary Care First through these practices will not be eligible to earn Qualifying APM Participant (QP) status through participation in Primary Care First.

The first QP Performance Period through which eligible clinicians may be able to achieve QP status through the Primary Care First model will begin on January 1, 2021.

#### **MIPS APM Status**

As set forth in 42 CFR 414.1370(b), in order for an APM to be a MIPS APM, the following criteria must be met:

- (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.*

Primary Care First will satisfy all of the MIPS APM criteria and therefore will be a MIPS APM beginning on January 1, 2021.

Participating practices with MIPS eligible clinicians who are either Partial QPs participating in Primary Care First practices that elect to report to MIPS, who are neither QPs nor Partial QPs will be scored under the APM scoring standard.

Participating practices assigned to the Primary Care First control group will be scored under the APM scoring standard. Additionally, we anticipate these participating practices will receive full credit for the Improvement Activities performance category under the APM scoring standard for the year(s) in which they participate in the Primary Care First control group.

### **Program Overlap and Synergies**

For entities that simultaneously participate in other Innovation Center initiatives, CMS reserves the right to potentially include additional requirements, revise initiative parameters, or ultimately prohibit simultaneous participation in multiple initiatives, based on a number of factors, including CMS's capacity to avoid counting savings twice in overlapping initiatives and to conduct a robust evaluation of each initiative. CMS may also encourage collaboration among participants across models with the goal of enhancing the impact of models on reducing expenditures and improving quality.

### **CPC+ Model (Tracks 1 and 2)**

Practices participating in the CPC+ model will not be eligible to participate in the first performance year of Primary Care First (calendar year 2021). However, practices participating in CPC+ are eligible to participate in the second performance year of Primary Care First (calendar year 2022) for a five-year performance period (2022-2026). CMS will make available an updated Request for Application in spring 2021. Practices participating in the CPC+ model will need to meet the same eligibility requirements as all other model applicants in order to participate in Primary Care First beginning in January 2022.

### **Direct Contracting (DC)**

Practices affiliated with organizations participating in all options in the Direct Contracting (DC) model may not participate in Primary Care First. Participants in the DC model are expected to assume financial risk at significantly higher levels than those offered in Primary Care First. Furthermore, limiting participation across shared savings models within CMMI is necessary to strengthen the Center's ability to detect changes in quality and cost over time.

### **Medicare Accountable Care Organizations (ACOs)**

Consistent with Tracks 1 and 2 of the CPC+ model, practices participating in ACOs under all tracks of the Shared Savings Program and the Track 1+ ACO model will be eligible to participate in Primary Care First. Because Primary Care First model payments are intended to replace a significant share of practices' FFS billing, all Primary Care First payment amounts, including the PBA, will be treated as non-claims based expenditures by the Shared Savings Program in the concurrent performance period, and will be included when comparing ACO spending to the benchmark in any shared savings or losses calculation. The flat visit fee will be treated as a claims-based expenditure.

Primary Care First practices may not participate in the Next Generation ACO model or the Comprehensive ESRD Care model. Participants in the Next Generation ACO model are expected to assume financial risk at significantly higher levels than those offered in Primary Care First.

### **Episode Payment Models**

Potential for overlap also exists between the Bundled Payments for Care Improvement (BPCI) Advanced model, as well as with the Comprehensive Care for Joint Replacement (CJR) model, 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 (OCM), which provides participating practices with the opportunity to receive a performance-based payment for qualifying episodes of care. Practices will be permitted to participate in the Primary Care First model while simultaneously participating in either or both of these models. Any payments made on behalf of a beneficiary attributed to a Primary Care First practice will be included in the aggregate FFS spending amounts for episodes of care under these episode payment models, prorated to account for overlapping time periods.

### **Emergency Triage, Treat, and Transport Model (ET3)**

ET3 seeks to reduce avoidable ED utilization by testing two new Medicare payments to Medicare-enrolled ambulance suppliers/providers that may incentivize them to prevent unnecessary transport to the ED. One payment targets providing care to the patient in place (e.g., at the scene of a 911 emergency response or via telehealth). The other payment focuses on transporting the patient to an alternative destination other than the ED that is not currently covered by Medicare. The model payments will not overlap, as Primary Care First payments are made to primary care practices for the primary care services they furnish to Medicare beneficiaries, and ET3 payments are made to ambulance suppliers/providers that provide transport to alternative destinations or facilitate treatment in place for Medicare FFS beneficiaries that call 911. The model attribution approaches are not overlapping, though beneficiaries that receive services under the ET3 model could also be attributed to practices in Primary Care First. CMS believes these models are complementary, as they share aligned financial incentives to reduce avoidable ED visits (and subsequent inpatient admissions) and would support opportunities for Primary Care First practices to collaborate with ET3 participants around the goal of reducing unnecessary ED and hospital utilization.

### **Million Hearts™: Cardiovascular Disease Risk Reduction Model**

The Million Hearts™ Model focuses on high risk cardiovascular patients, including those treated in the primary care setting. In Million Hearts™, providers in the intervention group are paid a PBPM to support efforts to reduce the cardiovascular risk of their attributed patients. CMS expects the Million Hearts™ and Primary Care First interaction to be mutually beneficial; cardiovascular interventions can be a part of and complementary to practice transformation but are not duplicative of the work required and paid for in Primary Care First. As a result, providers may participate in both the Primary Care First and Million Hearts™ model.

### **Accountable Health Communities (AHC)**

The AHC model is testing whether the systematic identification and management of health-related social needs of Medicare and Medicaid beneficiaries through screening, referral and community navigation services will impact healthcare costs and reduce healthcare utilization. The payment structure for the AHC model (a cooperative agreement) and the entities receiving payment under that model (bridge organizations) differ from the payment structure and entities that would be receiving payment under the Primary Care First model. Given the different payment structure and requirements

of the AHC model, practices may both participate in the Primary Care First model and be paid by an AHC bridge organization.

## Appendices

### Appendix A: Practice Application Guidance and Questions

Between October 24, 2019 and January 22, 2020, CMS will accept Primary Care First applications from individual primary care practice sites that meet preliminary eligibility requirements. Practices interested in applying to Primary Care First should review the Request for Applications to learn about the design and requirements of the model. The application must be certified as true, accurate, and complete by an individual authorized to bind the practice (i.e., the legal entity submitting the application).

Primary Care First is a practice-level intervention and each practice interested in Primary Care First participation must submit a separate application. For purposes of this application, a practice is defined as the legal entity that furnishes patient care services at a particular “bricks and mortar” physical location. If the practice offers patient care services at multiple physical locations, the practice will need to submit separate applications for each practice location that it wishes to participate in Primary Care First. Each practice that is a part of a health system, ACO, or other grouping of practices must submit a separate application for each location that it wishes to participate in Primary Care First.

This document is not the application to be filled out by the applicant; **this is a DRAFT list of the questions that will be found in the online application portal.** This list is for your reference as you assemble your application. CMS reserves the right to seek additional information from applicants to Primary Care First after the application period closes.

The Application will be found online at <https://app1.innovation.cms.gov/PCF>. Questions about the Application for Primary Care First should be directed to PrimaryCareApply@telligen.com. CMS may publicly share questions or responses or compile them into a Frequently Asked Questions compendium to ensure that all interested practices have access to information regarding Primary Care First. CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at [https://www.cms.gov/AboutWebsite/02\\_Privacy-Policy.asp](https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp).

#### Preliminary Questions

The questions in this section are required to move forward with the application to Primary Care First. The answers to these questions impact your practice’s eligibility for Primary Care First and may disqualify you from completing the remainder of the application.

1. In which Primary Care First region is your practice located?
  - *Select response from drop-down options menu in online application*
2. As of January 1, 2020, will your practice be a concierge practice, a Rural Health Clinic, or a Federally Qualified Health Clinic?

*Concierge practices (any practice that charges patients a retainer fee), Rural Health Clinics, and Federally Qualified Health Centers (FQHCs) are not eligible for the model. If your practice employs a practitioner who provides concierge services, that practitioner will be excluded from participation in Primary Care First.*

- Yes
- No

3. As of January 1, 2020, will your practice be part of an ACO participating in the Medicare Shared Savings Program (Shared Savings Program)?

- a. Yes, my practice is part of an ACO that is participating in the Shared Savings Program currently and will continue participation in 2020.
- b. Yes, my practice is part of an ACO that is participating in the Shared Savings Program currently but will stop participating on or before December 31, 2019.
- c. No, but my practice is part of an ACO applied to participate in the Shared Savings Program starting July 1, 2019.
- d. No, my practice is not participating or applying to participate in Shared Savings Program.

*If answer is (a) or (b):*

ACO name: \_\_\_\_\_ ACO TIN: \_\_\_\_\_

4. As of January 1, 2020, will your practice be participating in (or have applied to participate in) any of the following CMS models/programs? Please select all that apply.

*Primary Care First practices may not have overlapping participation with the ACO investment model, the Financial Alignment Initiative, the Next Generation ACO model, or any other CMS shared savings initiative (not including the Medicare Shared Savings Program and the Track 1+ ACO model). If you are accepted to participate in Primary Care First and will, as a result, withdraw from the other initiative(s) in which you currently participate, you will be asked to enter your planned withdrawal date*

- a. ACO Investment Model (AIM)
- b. Financial Alignment Initiative (FAI) for Medicare-Medicaid Enrollees *Help Note: This includes both the Capitated Model and Managed Fee-for-Service (FFS) Model. Please refer <https://innovation.cms.gov/initiatives/Financial-Alignment/> for more information.*
- c. Next Generation ACO Model
- d. Direct Contracting (DC) Model
- e. Other CMS shared savings initiative, not including the Medicare Shared Savings Program or the Track 1+ ACO Model
- f. None of the above

5. Has your primary care practice site ever participated in CPC+ Track 1 or 2?

- a. Yes
- b. No

*If answer is yes:*

- What is/was your CPC+ Practice ID?
- As of January 1, 2019, did your practice withdraw or were you terminated from CPC+ Track 1 or 2?
  - a. No, I am still an active participant in CPC+ Track 1 or 2.
  - b. Yes, I withdrew from CPC+ Tracks 1 or 2.
  - c. Yes, I was terminated from CPC+ Tracks 1 or 2.

*If answer is (a), your practice may not participate in Primary Care First during the first performance year. However, you will have opportunities to participate in this new track in future years. We appreciate your interest.*

*If answer is (b) or (c), use the dropdown menu in the online application to provide the reason for your practices' withdrawal or termination*

## **General Questions**

This section focuses on background information about your practice. Information in this section will be used to determine whether your practice meets the baseline eligibility criteria for participation in Primary Care First. This information will also be used to determine whether your practice is under or over the 50 eligible clinician limit in 42 C.F.R. 414.1415(c)(7) as discussed on page 50 of this RFA.

If a practice is accepted to participate in Primary Care First and CMS later learns that answers to the questions in this section were not or are no longer accurate, CMS reserves the right to terminate the practice's participation in the model immediately.

Primary Care First is a practice-level intervention and a practice interested in Primary Care First participation must submit a separate application for each practice location that it wishes to participate in the model. For purposes of this application, a practice is defined as the legal entity that furnishes patient care services at a particular "bricks and mortar" physical location. If the practice offers patient care services at multiple physical locations, the practice will need to submit separate applications for each practice location that it wishes to participate in Primary Care First. In the case of a practice that provides home-based primary care and no care in an office setting, the billing address defines the practice. Each practice that is a part of a health system, ACO, or other grouping of practices must submit a separate application.

For the purposes of Primary Care First, practitioners that provide primary care services in more than one participating practice will be deemed to practice in only one participating practice.

## ***Practice Structure and Ownership***

This section asks questions about the organizational structure and ownership of your practice. If you have a question about practice structure that is not addressed in the Request for Applications (RFA) or in the Application Instructions, please contact CMS at [PrimaryCareApply@telligen.com](mailto:PrimaryCareApply@telligen.com).

This section should be filled out by someone within the practice who is familiar with practice TINs and information about practice ownership, whether a health care system or physician-owned.

1. Practice identification:
  - a. Practice Site Name:
  - b. Practice "doing business as" (DBA) Name (if different from site name):
  - c. Street Address 1:
  - d. Street Address 2:
  - e. City:
  - f. State:
  - g. County
  - h. 9-digit ZIP Code:



- i. Practice Site Phone Number:
  - j. Practice Site Fax Number:
  - k. Website (if applicable)
2. Which of the following best describes your practice? Check only one.
- a. Medical group practice
  - b. Practice within network of individual practices (e.g., IPA)
  - c. Practice within hospital system(s)
  - d. Practice within an integrated delivery system
  - e. Other, please describe
3. Is your practice owned and operated by a larger health care organization or parent organization, such as a health system or a group practice?
- Yes
  - No

*If "No," who owns this practice?*

- a. Physicians in the practice
- b. Non-physician practitioners (nurse practitioners or physician assistants) in the practice
- c. Other (Specify)

*If "Yes," complete sections 3a and 3b:*

**A. Larger Health Care Organization/Parent Organization Information**

- i. What is the name of the organization? Note: If other practices from your organization are applying to CPC+, please use identical text in this field.
- ii. Corporate Street Address 1:
- iii. Corporate Street Address 2:
- iv. Corporate County:
- v. Corporate State:
- vi. Corporate 9-digit Zip Code:
- vii. Corporate Phone Number:
- viii. Name of primary organizational contact: We will use this information to link practices within the same larger health care/parent organization. For example, if you are a practice within a health system, please provide the name of the organizational contact within your health system who would be able to provide information on each of the practices that applied to Primary Care First in your system.
  - First Name:
  - Last Name:
  - Email:
  - Phone Number:

**B. Does your organization include any of the following providers or facilities? Check all that apply:**

- i. Cancer or specialty hospitals
  - ii. Psychiatric hospital or other mental or behavioral health facility
  - iii. Hospital(s) receiving disproportionate share (DSH) payments or uncompensated care payments from Medicare or Medicaid
  - iv. Community health center (other than a federally qualified health center)
  - v. Skilled nursing facility (SNF)
  - vi. Inpatient rehabilitation facility (IRF)
  - vii. Dialysis facility
  - viii. None of the above
4. This question relates to the Quality Payment Program Advanced Alternative Payment Model financial risk and nominal amount criterion. Please note that the language in this section may be slightly different than the rest of the application because these questions use the terms found in the Quality Payment Program CY 2019 Final [Rule](#).

**How many Eligible Clinicians** (*Note: Eligible clinician means “eligible clinician” as defined in 42 C.F.R. 414.1305, which means “eligible professional” as defined in section 1848(k)(3) of the Act, as identified by a unique TIN and NPI combination and, includes any of the following: (1) A physician. (2) A practitioner described in section 1842(b)(18)(C) of the Act ((a physician assistant, nurse practitioner, or clinical nurse specialist; a certified registered nurse anesthetist; a certified nurse-midwife; a clinical social worker; a clinical psychologist; a registered dietitian or nutrition professional). (3) A physical or occupational therapist or a qualified speech-language pathologist. (4) A qualified audiologist (as defined in section 1861(II)(3)(B) of the Act).), regardless of specialty, are part of your:*

- a. Larger health care organization/Parent organization
  - a. ≤50 Eligible Clinicians
  - b. >50 Eligible Clinicians
  - c. N/A
- b. Practice Site
  - a. ≤50 Eligible Clinicians
  - b. >50 Eligible Clinicians
- c. Are other primary care practices in your larger health care organization/parent organization applying to participate in Primary Care First?
  - a. Yes
  - b. No
  - c. N/A
  - d. Unknown
- d. Does your practice share a TIN for billing with other practices that are part of the same larger health care organization/parent organization?

*Note that CMS requires primary care practices participating in Primary Care First to use one billing TIN for all primary care services provided in the participating practice. That TIN may*

*be shared with other practices within your medical group or organization; however, this arrangement has important implications for reporting on quality measures per requirements of Primary Care First.*

- ❖ Yes
- ❖ No
- ❖ N/A
- ❖ Unknown

5. Does your practice use more than one billing TIN?

- a. Yes
- b. No
- c. Unknown

6. Please provide your Practice Organizational NPI (Do not provide the NPI for the larger health care organization or parent organization): \_\_\_\_\_

7. Please provide the PTAN (Medicare ID) for your practice (Do not provide the NPI for the larger health care organization or parent organization): \_\_\_\_\_

*Note: You can find your PTAN by viewing the letter sent by your MAC when your enrollment in Medicare was approved or by logging into [Internet-based PECOS](#).*

8. As of January 1, 2020, will your practice be a Critical Access Hospital?

- Yes
- No

*If yes, please provide your CMS Certification Number (CCN). If you do not know what a CCN number is, more information can be found [here](#).*

9. In the past twelve months, have any of the practitioners at your practice worked at a hospice?

- Yes
- No

*If yes, please provide all CMS Certification Numbers (CCN) used by the hospices where your practitioners deliver care. If you do not know what a CCN number is, more information can be found [here](#).*

10. Please provide all the TINs that your practice has used to bill Medicare since January 1, 2013.

- a. List all TINs that your practice has used to bill Medicare since January 1, 2013.
- b. Select a check box for the ONE billing TIN that your practice will use to bill primary care in 2020 for Primary Care First services. This is the TIN that your practice will use to bill all services for Primary Care First.

### **Practice Contacts**

This section asks for contact information for practice contacts needed for Primary Care First. Please use the explanations provided to identify the most appropriate person for each contact field and enter their

most current contact information.

**Applicant Contact:** The applicant contact is the person who has filled out your Primary Care First application and/or is very familiar with the different sections of the application and understands the answers your practice has provided. If this contact also works in your practice (and you indicate this when filling out their contact information), they will also receive your practice's acceptance/rejection letters and be automatically signed up to get the weekly Primary Care First newsletter.

**Practice Site Contact (if applicable):** If your applicant contact does not work in your practice, you will also need to fill out the "Practice Site Contact" field. This person must work in your practice. They will receive your practice's acceptance/rejection letters and be automatically signed up to get the weekly CPC+ newsletter.

**Health IT Contact:** This should be someone, from your practice or larger health care organization, who administers your practice's EHR and other health IT and is prepared to answer specific questions about the health IT in use in your practice.

**Practice Executive Lead Contact:** This should be a leader within the practice or parent organization.

## 1. Applicant Contact

- a. First Name:
- b. Last Name:
- c. Title/Position:
- d. Does this person work in the practice? If you answer yes to this question, you will not have to fill out the "Practice Contact" section.
  - ❖ Yes
  - ❖ No
- e. Business Phone Number:
- f. Business Phone Number Extension:
- g. Alternative Phone Number (e.g., cell phone):
- h. E-mail Address:
- i. Street Address 1:
- j. Street Address 2:
- k. City:
- l. State:
- m. ZIP Code:

## 2. Practice Site Contact (if applicable)

- a. First Name:
- b. Last Name:
- c. Title/Position:
- d. Business Phone Number:
- e. Business Phone Number Extension:
- f. Alternative Phone Number (e.g., cell phone):

- g. E-mail Address:
- h. Street Address 1:
- i. Street Address 2:
- j. City:
- k. State:
- l. ZIP Code:

### **3. Health IT Contact**

- a. First Name:
- b. Last Name:
- c. Title/Position:
- d. Business Phone Number:
- e. Business Phone Number Extension:
- f. Alternative Phone Number (e.g., cell phone):
- g. E-mail Address:
- h. Street Address 1:
- i. Street Address 2:
- j. City:
- k. State:
- l. ZIP Code:

### **4. Practice Executive Lead Contact**

- a. First Name:
- b. Last Name:
- c. Title/Position:
- d. Business Phone Number:
- e. Business Phone Number Extension:
- f. E-mail Address:

### ***Practitioner and Staff Information***

This section asks questions about the practitioners in your practice and should be filled out by someone familiar with the practitioner information, including NPIs, number of practitioners, and practitioner specialty and work within the practice. Unless otherwise indicated, please answer only for the primary care practitioners that will be participating in Primary Care First. Please note that pediatricians are not eligible to participate in PCF as they do not treat Medicare beneficiaries.

Applications will be screened to determine eligibility for further review using criteria detailed in this solicitation and in applicable law and regulations. In addition, CMS may deny selection to an otherwise qualified applicant on the basis of information found during a program integrity review of the applicant, its practitioners, or any relevant individuals or entities. CMS may also deny individual practitioners or any other relevant entity participation in Primary Care First based on the results of a program integrity review. Applicants will be required to disclose any investigations of, or sanctions that have been imposed on the applicant or individuals in leadership positions in the last three years by an accrediting body or state or federal government agency. Individuals in leadership positions include key executives

who manage or have oversight responsibility for the organization, its finances, personnel, and quality improvement, including without limitation, a CEO, CFO, COO, CIO, medical director, compliance officer, or an individual responsible for maintenance and stewardship of clinical data.

1. To the best of your knowledge, has your practice or anyone employed in your practice had a final adverse legal action (as defined on page 12 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i) or been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of the Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose could be grounds for application denial or immediate termination from the initiative.  
 Yes  
 No

If yes, please explain the legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any.

Explanation:

2. Which statement best characterizes your practice (*select all that apply*):
  - a. The practice is a single-specialty primary care practice.
  - b. The practice is a single-specialty hospice and/or palliative care practice.
  - c. The practice is a primary care practice with other integrated practitioners, or is a multi-specialty practice.
  - d. The practice participates in other lines of business besides primary care, such as urgent care on weekends and/or physical exams for an insurance company.
  - e. Other

For Questions 3 and 4 below, we are exploring the total number of individual practitioners compared to the primary care practitioners in your practices by practitioner type. Please treat answers in question 3 as the “denominators” and answers in question 4 as the “numerators”

3. Please list the number of individual qualified health care practitioners who provide patient care at your practice in any specialty under their own National Provider Identifier (NPI). Specify by type of practitioner, as indicated in the answers below, and include part-time practitioners in your count.
  - a. Number of Physicians: \_\_\_
  - b. Number of Nurse Practitioners: \_\_\_
  - c. Number of Physician Assistants: \_\_\_
  - d. Number of Clinical Nurse Specialists: \_\_\_
4. In PCF, a primary care practitioner is defined as a physician, nurse practitioner, physician assistant, or Clinical Nurse Specialist with a primary specialty of family medicine, internal medicine, geriatric medicine, or hospice and palliative medicine under their own NPI. How

many practitioners in your practice are primary care practitioners? Please include full-time and part-time practitioners in your answer below.

Please note that the practitioner should be specifically certified in family medicine, internal medicine, geriatric medicine, or hospice and palliative medicine. For example, a physician who is board certified in geriatrics or a clinical nurse certified in family medicine would be considered a primary care practitioner.

- a. Number of Primary Care Physicians: \_\_
- b. Number of Primary Care Nurse Practitioners: \_\_
- c. Number of Primary Care Physician Assistants: \_\_
- d. Number of Primary Care Clinical Nurse Specialists: \_\_

The purpose of the next question is to create a roster of participating practitioners that bill under their own NPI through the TIN of your practice (i.e., they have reassigned to your practice the right to receive Medicare payments). As you add information about each of the practitioners in your practice, please create only one record, even if a practitioner works at multiple locations of your larger health care organization or multiple Practice Sites. A practitioner can only ever be on the roster for one Practice Site. If your practice is found eligible for the model, CMS will conduct a program integrity screening of all practitioners and confirm their specialty.

5. For each primary care practitioner in your practice, please provide the following information.

- a. Practitioner Name: (Last, First, MI)
- b. National Practitioner ID (NPI):  
*Note: You can look up NPIs at this link <https://npiregistry.cms.hhs.gov/>.*
- c. Practitioner Type:
  - ❖ Physician (MD or DO)
  - ❖ Clinical Nurse Specialist
  - ❖ Nurse Practitioner
  - ❖ Physician Assistant
- d. Primary Specialty:
  - ❖ Family Medicine
  - ❖ Internal/Adult Medicine
  - ❖ Geriatric Medicine
  - ❖ General Practice
  - ❖ Hospice and Palliative Medicine
  - ❖ N/A
- e. Secondary Specialty:
  - ❖ Family Medicine
  - ❖ Internal/Adult Medicine
  - ❖ Geriatric Medicine
  - ❖ General Practice

- ❖ Hospice and Palliative Medicine
- ❖ N/A
- ❖ Other

f. Is this the practitioner's primary Practice Site?

- Yes
- No

If yes, skip to "Health Information Technology" section. If No, please respond to the following questions:

g. This practitioner works at the Practice Site:

- Part-time
- Full-time

If part time, how many hours per week does this practitioner work at the Practice Site?

\_\_\_ hours

h. Does this practitioner also practice elsewhere?

- Yes
- No

If No, skip to "Health Information Technology" section. If yes, please respond to the following questions:

i. If yes, is the practitioner's billing TIN the same at any other location where he/she practices?

- Yes
- No

j. Is any other location where he/she practices also applying to participate in Primary Care First?

- Yes
- No

Name and address of other locations:

### **Health Information Technology**

This section asks questions about the health IT capabilities of your practice. The person filling out this section should be familiar with the health IT in use in your practice today. The health IT requirements are available [here](#).

1. Is your practice able to complete the health IT requirements indicated listed in the Primary Care First RFA?

- Yes
- No (*Help Note: If you cannot meet the health IT requirements for Primary Care First, your application may be disqualified. If you have questions, please contact*



[PrimaryCareApply@telligen.com](mailto:PrimaryCareApply@telligen.com))

2. Can you obtain EHR and eQIM data for your Primary Care First Practice Site and Primary Care First Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) only, distinct from health system or other practice data?  
 Yes  
 No
3. Can you obtain registry data for your CPC+ Practice Site and CPC+ Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) only, distinct from health system or other practice data?  
 Yes  
 No

### Financial Readiness

1. Please list the payers with whom you contracted in 2018 and/or 2019.
2. Please indicate the percentage of revenue in the last year derived from value-based contracts:  
\_\_\_\_\_ %  
*Note: Examples of value-based contracts include: payments based on cost, quality, and/or utilization performance, such as shared savings, performance-based incentive payments, episode-based payments, as well as alternative to FFS payments, such as full or partial capitation.*
3. Does your practice agree for CMS to share application data, including TIN(s), with Primary Care First payer partners or other programs within your state?  
 Yes  
 No
4. Does your practice plan to reduce or waive the applicable co-insurance for Primary Care First flat visit fee for the delivery of face-to-face services? *Note: Primary Care First practices will remain responsible to cover those costs (i.e., CMS will not compensate practices for any impacts on cost sharing revenue).*  
 Yes  
 No

If No, proceed to “Care Delivery” section. If yes, please answer question 5:

5. To which of the following categories of beneficiaries and/or types of clinical needs does your practice intend to provide cost sharing support? (Select all that apply)  
 Medicare beneficiaries with financial need  
 Medicare beneficiaries with complex health needs requiring frequent face-to-face care in office or at home  
 Medicare beneficiaries with recent hospitalization(s) and/or ED visit(s)  
 Other (specify):

## Care Delivery

The following questions are about your Practice Site's delivery of primary care. Answer each question as carefully and accurately as possible, based on the current activities at your Practice Site (the single "bricks and mortar" physical location where patients are seen). The person who fills out this section should be very familiar with the delivery of care in the practice, including care management, patient access, and quality improvement. For example, your practice manager might fill this section with input from others in the practice as needed. This section will likely be best answered if it represents a consensus view of the practice staff, arriving at a single "best answer" after discussion among the practice team at your site.

1. Patients
  - a. are not assigned to specific practitioner panels.
  - b. are assigned to specific practitioner panels but panel assignments are not routinely used by the practice for administrative or other purposes.
  - c. are assigned to specific practitioner panels and panel assignments are routinely used by the practice mainly for scheduling purposes.
  - d. are assigned to specific practitioner panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
2. Non-physician practice team members
  - a. play a limited role in providing clinical care.
  - b. are primarily tasked with managing patient flow and triage.
  - c. provide some clinical services such as assessment or self-management support.
  - d. perform key clinical service roles that match their abilities and credentials.
3. Follow-up by the primary care practice with patients seen in the Emergency Department (ED) or hospital
  - a. generally, does not occur.
  - b. occurs only if the ED or hospital alerts the primary care practice.
  - c. occurs because the primary care practice makes proactive efforts to identify patients.
  - d. is done routinely because the primary care practice has arrangements in place with the ED and hospital to both track these patients and ensure that follow-up is completed within a few days.
4. Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP, or nurse
  - a. is not available or limited to an answering machine.
  - b. is available from a coverage arrangement (e.g., answering service) that does not offer a standardized communication protocol back to the practice for urgent problems.
  - c. is provided by a coverage arrangement (e.g., answering service) that shares necessary patient data with and provides a summary to the practice.
  - d. is available via the patient's choice of email or phone directly with the practice team or a practitioner who has real-time access to the patient's electronic medical record.
5. Clinical leaders

- a. intermittently focus on improving quality.
  - b. have developed a vision for quality improvement, but no consistent process for getting there.
  - c. are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.
  - d. consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.
6. A standard method or tool(s) to stratify patients by risk level
- a. is not available.
  - b. is available but not consistently used to stratify all patients.
  - c. is available and is consistently used to stratify all patients but is inconsistently integrated into all aspects of care delivery.
  - d. is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.
7. Clinical care management services for high-risk patients
- a. are not available.
  - b. are provided by external care managers with limited connection to the practice.
  - c. are provided by external care managers who regularly communicate with the care team.
  - d. are systematically provided by the care manager functioning as a member of the practice team, regardless of location.
8. Care plans
- a. are not routinely developed or recorded.
  - b. are developed and recorded but reflect providers' priorities only.
  - c. are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care.
  - d. are developed collaboratively, include self-management and clinical care management goals, are routinely recorded, and guide care at every subsequent point of service.
9. This practice site discusses advance care planning (e.g., for end-of-life care and advanced directives for when patients might become too sick to make their own decisions) with
- a. none of the practice's high-risk patients.
  - b. some of the practice's high-risk patients.
  - c. many or all of the practice's high-risk patients.
  - d. many or all of the practice's high-risk patients, and patient preferences for end-of-life care are documented and accessible to the care team.
10. Practices may or may not have agreements with other care organizations (e.g., specialists) that they refer patients to. A formal, written agreement with these organizations describes expectations for timely patient visits, the frequency and type of information communicated between your primary care practice and other care organizations, and their respective roles. This practice site has formal, written agreements with

- a. no medical or surgical groups.
- b. some medical and surgical groups.
- c. many medical and surgical groups.
- d. most or all medical and surgical groups.

### Seriously Ill Population (SIP)

Primary Care First includes an initiative to engage actively Seriously Ill Population (SIP) patients lacking a primary care practitioner or care coordination. The goal is to proactively identify sick and unmanaged beneficiaries and assign them to a model participant. To accomplish this, practices that demonstrate relevant experience in their application have the option to agree to be accountable for and provide care to SIP patients identified by CMS.

If you agree to be accountable for and provide care for SIP patients in your service area, you will receive flat visit fee, a time-limited professional population-based payment, and an opportunity for a quality bonus.

1. Would your organization agree to be accountable and provide care for all SIP patients identified by CMS in your service area?
  - Yes
  - No
  
2. Is your organization only interested in receiving proactively assigned SIP patients identified by CMS in your service area, and does not wish to be considered for participation in the non-SIP components of Primary Care First, including claims-based attribution of beneficiaries?
  - Yes
  - No

If you answered yes to question 2, please note that your practice is expected to have a network of relationships with other care organizations in the beneficiary’s community in order to help ensure the beneficiary can access the care best suited to support their longer-term needs. Please complete the Care Delivery section to help us assess your relationships with other organizations.

3. CMS will identify and assign SIP patients to practices in the areas where the practice provides service (“service areas”). These service areas will be defined using zip codes. Please list all zip codes associated with the patients that your practice typically serves.

In addition to the care delivery questions, practices receiving SIP patients as well as practices caring for complex chronic populations will need to meet certain requirements. You will need to meet basic competencies to successfully manage complex patients and show expertise with these populations. The questions below assess your interest in and experience managing these populations.

4. This question is about specific care team members at this practice site. Which of the following care team members work full-time (35 hours or more per week) and/or part time (fewer than 35 hours per week) at this practice site? Select all that apply.
  - a. Care manager or care coordinator with Registered Nurse (RN) license *A care manager*

*works with high-risk patients between and during visits to provide ongoing support and education on chronic care management, and coordinates care from other providers*

- b. Care manager or care coordinator with Licensed Practice Nurse (LPN) or licensed vocational nurse (LVN) license *A care manager works with high-risk patients between and during visits to provide ongoing support and education on chronic care management, and coordinates care from other providers*
  - c. Registered Nurse
  - d. Community Services Coordinator
  - e. Referral Coordinator or Referral Specialist *This is someone who obtains prior authorizations, helps patients obtain appointments with specialists, and/or tracks referrals to specialist.*
  - f. Social Worker
  - g. Behavioral Health Specialist
  - h. Pharmacist
  - i. None of the above
5. Social and functional support needs (e.g., transportation, home equipment) of vulnerable patients, such as low-income and frail patients.
- a. are never assessed by staff at this practice site.
  - b. are rarely assessed by staff at this practice site.
  - c. are sometimes assessed by staff at this practice site.
  - d. are usually assessed by staff at this practice site.
6. Identify the community and medical resources/supports with whom you have established relationships. Select all that apply.
- a. We have not established relationships with community resources and supports.
  - b. Financial (e.g., TANF, SSDI/SSI, cash assistance)
  - c. Nutrition and Food (e.g., SNAP/WIC, food pantries, Meals on Wheels)
  - d. Health-related services (e.g., insurance, prescription assistance, home health, durable medical equipment)
  - e. Housing (e.g., shelter, public housing, transitional support)
  - f. Transportation (e.g., medical transport, public transit)
  - g. Utilities (e.g., energy assistance/subsidies [LIHEAP], telephone)
  - h. Hospice
7. Which of the following is included in your care planning with seriously ill patients? Select all that apply.
- a. Conversations about serious illness care goals and values
  - b. Hospice with length of stay greater than 14 days
  - c. Family support
  - d. Carefully titrated pain control with frequent follow-up
  - e. Non-pain symptom management
  - f. Psychosocial and spiritual support
  - g. None of the above

8. By January 2020, will your staff members or care team be trained in end-of-life and seriously ill care planning?
  - a. Yes
  - b. No

## Appendix B: Solicitation for Payer Partnership Process and Selection

### Solicitation Information

This Solicitation for Payer Partnership requests that payers detail their proposed plan to partner in Primary Care First.

Multi-payer engagement is an essential component of Primary Care First, as it enables both public and private payers to support comprehensive primary care reform. CMS will select payer partners that align with CMS' approach to changing incentives in primary care. Respondents to this solicitation may be commercial insurers (including plans offered via state or federally facilitated Health Insurance Marketplaces), Medicare Advantage plans, states (through the Medicaid and CHIP programs, state employees program, or other insurance purchasing), Medicaid/CHIP managed care plans, state or federal high risk pools, self-insured businesses or administrators of a self-insured group (Third Party Administrator (TPA)/Administrative Service Only (ASO)).

CMS expects to enter into a Memorandum of Understanding (MOU) with each selected payer. The MOUs will outline the commitments of payers that sign an MOU with CMS. All payer partners will separately enter into arrangements with the practices participating in Primary Care First.

CMS is seeking to partner with payers who are meaningfully committed to value-based reimbursement and who 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.

Table 1 below includes the detailed criteria that CMS will use to assess payer proposals and their alignment with these four requirements. For each of the criteria, the table defines what would be deemed "not sufficient alignment," "acceptable alignment," and "preferred alignment." CMS encourages prospective payer partners to design an aligned payment model that meets as many of the "preferred alignment" criteria as possible. However, CMS will still partner with payers who meet "acceptable alignment" criteria in some areas, with the expectation that these payers will work towards meeting "preferred alignment" standards. CMS will also consider proposals from payers that fall under "not sufficient alignment" on one or two criteria, and will seek follow-up conversations with those payers about the reason for the lack of sufficient alignment before making a final decision about

whether to select them as payer partners. CMS recognizes that state Medicaid agencies may face specific constraints that make it challenging to meet some of these alignment criteria, and intends to work closely with interested state agencies to facilitate their participation in the model as payer partners.



Table 1. Primary Care First Payer Alignment Criteria

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
<b>Principle 1:</b> Move away from fee-for-service payment mechanism			
<b>Minimize volume-based incentive</b>	<ul style="list-style-type: none"> <li>Partial primary care capitation with more than 50% of revenue reimbursed through capitated or other non-visit-based payment <i>OR</i></li> <li>Full primary care capitation</li> </ul>	<ul style="list-style-type: none"> <li>Primary care episodes <i>AND/OR</i></li> <li>Shared savings/shared losses <i>AND/OR</i></li> <li>Partial primary care capitation with less than 50% of revenue reimbursed through capitated or other non-visit-based payment</li> </ul>	<ul style="list-style-type: none"> <li>Fee-for-service plus care management fee <i>OR</i></li> <li>Fee-for-service plus at-risk care management fee <i>OR</i></li> <li>Reimburse additional codes for non-face-to-face services <i>OR</i></li> <li>Higher fee-for-service rates for primary care services</li> </ul>
<b>Risk adjustment</b>	<ul style="list-style-type: none"> <li>Alternative to FFS payment is risk adjusted to account for factors including but not limited to health status and patient demographics</li> </ul>	<i>Same as preferred alignment</i>	<ul style="list-style-type: none"> <li>Alternative to FFS payment is not risk adjusted</li> </ul>

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
<b>Principle 2:</b> Reward outcomes, not process			
<b>Practices' reimbursement influenced by outcomes, not process</b>	<ul style="list-style-type: none"> <li>• Performance-based payment tied to clinical quality, patient experience, health improvement, cost and/or utilization measures <i>AND</i></li> <li>• Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) <i>AND</i></li> <li>• Performance-based payment not tied to achievement of care delivery processes (though care delivery processes/ certifications may be used to determine practice eligibility at start of model)</li> </ul>	<ul style="list-style-type: none"> <li>• Performance-based payment tied to clinical quality, patient experience, cost and/or utilization measures <i>AND</i></li> <li>• Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) <i>AND</i></li> <li>• Performance-based payment tied in part to achievement of care delivery processes</li> </ul>	<ul style="list-style-type: none"> <li>• Practices' reimbursement not influenced by performance in any way <i>OR</i></li> <li>• Performance-based payment tied in full to achievement of care delivery processes <i>OR</i></li> <li>• Performance-based payment not tied to utilization and/or total-cost-of-care measure(s) in any way</li> </ul>
<b>Performance can have substantial impact on practices' payment</b>	<ul style="list-style-type: none"> <li>• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by more than 15%</li> </ul>	<ul style="list-style-type: none"> <li>• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by between 5% and 15%</li> </ul>	<ul style="list-style-type: none"> <li>• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by less than 5%</li> </ul>

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
<b>Principle 2:</b> Reward outcomes, not process			
<b>Performance-based payment adjustment can be negative if practice has poor outcomes</b>	<ul style="list-style-type: none"> <li>Performance can both increase and decrease payment, though potential upside is larger than potential downside</li> </ul>	<ul style="list-style-type: none"> <li>Performance can both increase and decrease payment; potential upside is equal to potential downside</li> </ul>	<ul style="list-style-type: none"> <li>Performance can only increase payment</li> </ul>

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
<b>Principle 2:</b> Reward outcomes, not process			
<b>Alignment with PCF measure set</b>	<ul style="list-style-type: none"> <li>• Payer uses the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance <i>AND</i></li> <li>• Payer uses few or no additional measures above and beyond the PCF measure set</li> </ul>	<ul style="list-style-type: none"> <li>• Payer uses at least three of the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance<sup>25</sup> <i>AND/OR</i></li> <li>• Payer uses no more than 10 total measures, including PCF-aligned measures and additional measures <i>AND</i></li> <li>• Additional measures are drawn from CMS’s “<a href="#">Meaningful Measures</a>” initiative, which used broad stakeholder feedback to identify the highest priority areas for quality measurement and improvement, and includes measures that are applicable across multiple CMS programs and patient populations</li> </ul>	<ul style="list-style-type: none"> <li>• Payer uses none of the same quality and utilization measures as CMS<sup>1</sup> <i>OR</i></li> <li>• Payer uses a large number of additional measures above and beyond the CMS measure set</li> </ul>

<sup>25</sup> CMS may consider additional flexibility on this requirement if payer can demonstrate that the PCF measures are not appropriate or relevant for their attributed populations

	<b>Preferred Alignment</b>	<b>Acceptable Alignment</b>	<b>Not Sufficient Alignment</b>
<b>Principle 3:</b> Deliver meaningful, actionable data reports to drive practice accountability and performance improvement			
<b>Attribution</b>	<ul style="list-style-type: none"> <li>Practices receive list of prospectively attributed members at least monthly</li> </ul>	<ul style="list-style-type: none"> <li>Practices receive list of prospectively attributed members at least quarterly</li> </ul>	<ul style="list-style-type: none"> <li>Practices receive list of attributed members less often than quarterly</li> </ul>
<b>Frequency</b> <sup>26</sup>	<ul style="list-style-type: none"> <li>Payers provide service utilization and cost data at least monthly</li> </ul>	<ul style="list-style-type: none"> <li>Payers provide service utilization and cost data at least quarterly</li> </ul>	<ul style="list-style-type: none"> <li>Payers provide service utilization and cost data less than quarterly</li> </ul>
<b>Type of data</b> <sup>26</sup>	<ul style="list-style-type: none"> <li>Payers provide practices with service utilization and cost of care data for attributed members</li> </ul>	<ul style="list-style-type: none"> <li>Payers provide practices with some limited service utilization and cost of care data for attributed members</li> </ul>	<ul style="list-style-type: none"> <li>Payers do not provide practices with service utilization or cost of care data for attributed members</li> </ul>

<sup>26</sup> For payers who participate in data aggregation, i.e. combining data from multiple payers into a single platform, the frequency, type, format, and level of data will be dictated by their data aggregation platform. Payer partners who are not participating in data aggregation should work to align with CMS and other payers in their region on these dimensions to the greatest extent possible, per the “alignment with CMS and other local payers” criteria.

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
<b>Principle 3:</b> Deliver meaningful, actionable data reports to drive practice accountability and performance improvement			
<b>Format of data</b> <sup>26</sup>	<ul style="list-style-type: none"> <li>Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities <i>AND</i></li> <li>Data is accompanied by tailored support and guidance to help practices use the data <i>AND</i></li> <li>Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools.</li> </ul>	<ul style="list-style-type: none"> <li>Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities <i>AND</i></li> <li>Data is accompanied by general (non-practice-specific) guidance about how to use the data <i>AND</i></li> <li>Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools.</li> </ul>	<ul style="list-style-type: none"> <li>Data is not formatted in a way that allows practices to readily gain actionable insights; data cannot readily be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools <i>OR</i></li> <li>No resources are provided to help practices navigate the data <i>OR</i></li> <li>Payer does not provide data reports to practices</li> </ul>
<b>Level of data</b> <sup>26</sup>	<ul style="list-style-type: none"> <li>Payers provide practices with beneficiary-level service utilization and cost data</li> </ul>	<ul style="list-style-type: none"> <li>Payers provide practices with practice-level or practitioner-level service utilization and cost data</li> </ul>	<ul style="list-style-type: none"> <li>Payers do not provide practices with utilization and cost data</li> </ul>

	<b>Preferred Alignment</b>	<b>Acceptable Alignment</b>	<b>Not Sufficient Alignment</b>
<b>Principle 3:</b> Deliver meaningful, actionable data reports to drive practice accountability and performance improvement			
<b>Alignment with CMS and other local payers</b>	<ul style="list-style-type: none"> <li>• Payer either already participates in or is actively working towards participating in regional data aggregation with CMS and other regional payers, which provides multi-payer data in a single platform</li> </ul>	<ul style="list-style-type: none"> <li>• Payer participates in efforts to align data reporting with CMS and other local payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data)</li> </ul>	<ul style="list-style-type: none"> <li>• Payer makes no effort to align data reporting with CMS and other regional payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data)</li> </ul>

	<b>Preferred Alignment</b>	<b>Acceptable Alignment</b>	<b>Not Sufficient Alignment</b>
<b>Principle 4:</b> Multi-payer alignment is critical for driving adoption of value-based care models			
<b>Participation in regional multi-payer collaborative activities</b>	<ul style="list-style-type: none"> <li>• Payer actively participates in and contributes to regional multi-payer collaborative activities related to PCF</li> </ul>	<ul style="list-style-type: none"> <li>• Payer attends multi-payer collaborative events, but does not actively participate in or contribute to them</li> </ul>	<ul style="list-style-type: none"> <li>• Payer does not participate in multi-payer collaborative activities related to PCF that are available in their region</li> </ul>
<b>Goal-setting and continuous improvement</b>	<ul style="list-style-type: none"> <li>• Payers work with their regional peers to set annual goals for regional multi-payer collaboration and alignment, and develop plan for achieving goals/alignment targets AND</li> <li>• Payers demonstrate progress towards goals throughout the year</li> </ul>	<i>Same as preferred</i>	<ul style="list-style-type: none"> <li>• Regional payers do not set annual goals for regional multi-payer collaboration and alignment or develop plan for achieving goals/alignment targets</li> </ul>



	<b>Preferred Alignment</b>	<b>Acceptable Alignment</b>	<b>Not Sufficient Alignment</b>
<b>Principle 4:</b> Multi-payer alignment is critical for driving adoption of value-based care models			
<b>Transparency on non-payment related topics</b>	<ul style="list-style-type: none"> <li>To the greatest extent possible, payer will share information about non-payment related topics, e.g. attribution and risk adjustment methodologies, quality measurement strategies, and practice coaching activities with CMS and other local payers to inform payer alignment and collaboration activities</li> </ul>	<i>Same as preferred</i>	<ul style="list-style-type: none"> <li>Payer does not make an effort to share information about non-payment related topics with CMS and other local payers in order to inform payer alignment and collaboration activities</li> </ul>
<b>Enable sufficient practice participation to drive broad-based payment and delivery reforms</b>	<ul style="list-style-type: none"> <li>Payer sets reasonable eligibility criteria, e.g. minimum attributed member thresholds, that enable most or all participating PCF practices in their region to participate in the payer’s PCF-aligned model</li> </ul>	<ul style="list-style-type: none"> <li>Payer sets moderately restrictive eligibility criteria, e.g. minimum attributed member thresholds, that would meaningfully limit the number of participating PCF practices in their region that could participate in the payer’s PCF- aligned model AND</li> <li>Payer provides data-driven to CMS rationale for how eligibility criteria is set, e.g., member threshold is set to allow for valid and reliable calculation of performance measures</li> </ul>	<ul style="list-style-type: none"> <li>Payer sets highly restrictive eligibility criteria, e.g. high minimum attributed member thresholds, that prevent the majority of participating PCF practices in its region from participating in the payer’s PCF aligned model</li> </ul>

## Questions

Questions regarding Primary Care First or the solicitation process may be sent by email to [PrimaryCareApply@telligen.com](mailto:PrimaryCareApply@telligen.com). CMS may publicly share questions or responses or compile them into a Frequently Asked Questions compendium to ensure that all interested payers have access to information regarding Primary Care First.

## Payer Statement of Interest

Interested payers are asked to submit a Statement of Interest by completing the form available at <https://innovation.cms.gov/initiatives/primary-care-first-model-options/> and emailing it to [PrimaryCareApply@telligen.com](mailto:PrimaryCareApply@telligen.com) by December 6, 2019. After the practice application period closes on January 22, 2020, payers that submitted a Statement of Interest form will receive information from CMS about how many practices submitted applications, by region and county, to help gauge where there is high practice interest in Primary Care First participation.

## Completing and Submitting Proposals to Partner in Primary Care First

Interested payers are asked to respond to this solicitation by completing an online proposal, which will be available at <https://app1.innovation.cms.gov/PCF> on December 9, 2019, when the payer solicitation period begins. Payers interested in partnering in Primary Care First in multiple regions are asked to submit separate proposals for each region if their proposed approach varies significantly between regions. Payer proposals are due on March 13, 2020.

## Review Process

Responses to this solicitation will be reviewed by CMS staff to determine the degree to which they align with CMS' approach in Primary Care First, as described above. Payers must respond with sufficient detail for CMS to evaluate and understand payers' proposed plan to partner in Primary Care First. CMS may also contact payers and request modifications to payers' proposed model as part of its review.

CMS reserves the right to reject any payer's proposal to preserve the integrity of the Medicare program, the welfare of Medicare or Medicaid beneficiaries, or the implementation of Primary Care First. Without limitation, CMS may reject an interested payer's proposal if:

- The payer does not provide sufficient information to be reasonably assessed against the selection criteria outlined in this solicitation;
- The interested payer's proposal is inconsistent with the objectives of Primary Care First.

## Withdrawal of Proposal

A payer seeking to withdraw or modify its proposal should send an email to [PrimaryCareApply@telligen.com](mailto:PrimaryCareApply@telligen.com). Payers must submit such a request by no later than one week following the submission of the proposal.

## Payer and Region Selection

CMS' selection process is summarized below. CMS may contact interested payers to request that they explain or modify their proposals. Once CMS has selected regions for the Primary Care First model, payers with lines of business in those regions will be invited to partner with CMS in Primary Care First by signing a Memorandum of Understanding.

### 1. Assessment of Payers' Alignment with Medicare's Approach

CMS will evaluate proposals based on: 1) the preferences noted above and payer alignment with CMS' payment, quality, and data sharing approaches; and 2) payer experience implementing an alternative to FFS payment.

## **2. Clarification of Proposals**

CMS may contact payers to clarify elements of their proposal or to gain additional context for payer responses.

## **3. Final Selection**

CMS will use its assessment of payer proposals to inform selection of Primary Care First payer partners.

### **Commitment to Ensuring Competitive Markets**

Competition promotes quality of care for Medicare beneficiaries and protects access to a variety of practitioners. Thus, all conversations among payers and primary care practices must comply with antitrust law. Nothing in this solicitation shall be deemed to suspend any applicable antitrust laws or regulations, all of which still apply. In Primary Care First, CMS aims to maintain a competitive environment while providing an opportunity for payer partnership.

### **Partnership with State Medicaid Agencies**

CMS recognizes the importance of states' partnership in multi-payer initiatives and invites state Medicaid agencies to apply to partner with CMS in Primary Care First. States seeking to partner with CMS in Primary Care First and offer an approach to payment that aligns with CMS' approach in Primary Care First will need to fund the non-federal share of Medicaid payments for their attributed enrollees and may need to submit proposals to CMS through State plan amendments and/or waivers in order to develop a payment arrangement that would allow the state to partner with CMS in the model.

### **Solicitation for Payer Partnership**

This document is not the online proposal to be filled out by the applicant; **this is a DRAFT list of the questions that will be found in the online solicitation portal.** This list is for your reference as you assemble your proposal. CMS reserves the right to seek additional information from applicants after the solicitation period closes.

### **Description of Payer**

1. Legal Entity Name
2. Year Established
3. Doing Business As (DBA) Name if different than Legal Entity Name
4. Corporate Address
5. Corporate City
6. Corporate State
7. Corporate Zip code
8. Website URL
9. Indicate in the below fields the points of contact for the solicitation process (Solicitation POC) and for communicating with CMS after payer selection (Payer POC), respectively. If solicitation POC and payer POC are the same person, contact information only needs to be provided once: Solicitation Point of Contact (POC)

- ❖ Name
- ❖ Title
- ❖ Email Address
- ❖ Phone Number
- ❖ Fax Number
- ❖ Street Address
- ❖ City
- ❖ State
- ❖ Zip code

a. Solicitation Point of Contact (POC)

- ❖ Name
- ❖ Title
- ❖ Email Address
- ❖ Phone Number
- ❖ Fax Number
- ❖ Street Address
- ❖ City
- ❖ State
- ❖ Zip code

*Summary of Past Experience*

We intend to select payers for Primary Care First who are similarly committed to providing opportunities for advanced practices, including:

- Reimbursing Primary Care First practices with an alternative to FFS payment, such as a population-based payment
- Providing a payment tied to practice performance on a combination of cost, quality, and/or utilization metrics, applying both upside and downside risk
- Sharing data with practices on cost, utilization, and quality at regular intervals (e.g., quarterly)
- Providing additional support for practices that focus on caring for complex, chronic and seriously ill patients

1. Please describe any past or current involvement with multi-payer or multi-stakeholder collaborations, noting if this is in the proposed region(s). In your answer, please indicate how you were/are involved in the initiatives (e.g., health information exchange, technical assistance, practice coaching).
2. Please briefly describe any advanced primary care models you are currently testing in the proposed region(s), and your involvement in any other local, state, or national initiatives to improve or transform primary care payment and care delivery.
3. Are you a current Partner Payer in the Comprehensive Primary Care Plus (CPC+) model?

- Yes
- No
- Not applicable

**4. Were you a Partner Payer in the Comprehensive Primary Care (CPC) model?**

- Yes
- No
- Not applicable

**Lines of Business**

**1. Please describe the lines of business and network reach in the region(s) in which you are proposing to partner. If proposing to partner in multiple regions and proposed approach differs significantly across regions, please submit a separate proposal for each distinct region.**

State: _____  Proposing to partner in part of state or entire state?  <input type="checkbox"/> Part of state <input type="checkbox"/> Entire state	Proposed Lines of Business:  <input type="checkbox"/> Commercial Insurance Plan <input type="checkbox"/> Health insurance Marketplace Plan <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicaid/CHIP Managed Plan <input type="checkbox"/> State/Federal High Risk Pool <input type="checkbox"/> Third Party Administration (TPA)/ Administrative Services Only (ASO) <input type="checkbox"/> Medicaid/CHIP FFS ( <b>For State Partners only</b> ) <input type="checkbox"/> Other	Total Number of Covered Lives	NAIC Number	Please provide the minimum number of your members that must be attributed to a participating practice in order for you to support that practice in this model	Please note if, and to what extent, the minimum number of members per practice changes by line of business and region
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**2. Please summarize the lines of business you offer but are not proposing to include in Primary Care First:**

State: _____  Proposing to partner in part of state or entire state?  <input type="checkbox"/> Part of state <input type="checkbox"/> Entire state	Proposed Lines of Business:  <input type="checkbox"/> Commercial Insurance Plan <input type="checkbox"/> Health insurance Marketplace Plan <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicaid/CHIP Managed Care Plan <input type="checkbox"/> State/Federal High Risk Pool <input type="checkbox"/> Third Party Administration (TPA)/ Administrative Services Only (ASO) <input type="checkbox"/> Medicaid/CHIP FFS ( <b>For State Partners only</b> ) <input type="checkbox"/> Other	Total Number of Covered Lives
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3. Using counties as the descriptor, please specify the total number of member lives in each county in which you are interested in partnering in Primary Care First.

Please include all proposed Primary Care First regions in a single spreadsheet. For example, if you are a payer submitting multiple proposals for distinct regions, please input all regions and covered lives by county and line of business into one Excel spreadsheet.

### Payment Models

#### I. Alternative to fee-for-service payment arrangement

Payers should have experience with designing and implementing a payment methodology that diverges at least in part from FFS, and should be prepared to offer Primary Care First practices an alternative to FFS payment.

1. What is the proposed structure of your Alternative to FFS payment?
  - a. 100% up-front payment of primary care services (i.e., full primary care capitation),
  - b. Moving a portion of anticipated FFS revenue to prospective payment (i.e., partial primary care capitation)
  - c. Primary care-specific episodes
  - d. Other

*If you selected a or b, please answer the following question:*

If your model is capitating specific primary care services, which services/codes will be capitated?

2. Will your proposed Alternative to FFS payment be risk-adjusted?
  - a. Yes
  - b. No
3. Will your proposed Alternative to FFS payment be greater or equal to historical spending?
  - a. Greater
  - b. Equal
  - c. Other

4. To receive the Alternative to FFS payment, is a claim required to be submitted by the practice?
  - a. Yes
  - b. No
5. What is the frequency of your Alternative to FFS payment?
  - a. Monthly
  - b. Quarterly
  - c. Annually
6. If applicable, please provide additional detail on your proposed Alternative to FFS payment, including how your methodology varies across lines of business, if at all.
7. Please select the option below that most accurately describes your experience designing and implementing an Alternative to FFS payment arrangement:
  - a. Currently providing such payments to all contracted primary care practices through an existing program;
  - b. Currently providing such payments to some contracted primary care practices through an existing program;
  - c. Currently providing such payments to some primary care practices through a pilot program;
  - d. Alternative to FFS payment approach already developed and planning implementation;
  - e. Payment approach still being developed;
  - f. Intend to design and implement such a payment in Primary Care First;
  - g. Other (please explain)

If you selected answers a, b, or c in response to question 6, please describe your current or prior experience designing and implementing an alternative payment arrangement for primary care practices that deviates from FFS.

If you selected answers d, e, or f in response to question 6, please describe in detail your plan for instituting an alternative to FFS payment arrangement, including your time frame for implementation.

## II. Complex and Seriously Ill Populations

Payers are encouraged but not required to provide an incentive for Primary Care First practices to take accountability for complex and seriously ill members.

8. Does your organization have a strategy for incentivizing Primary Care First practices to be accountable for complex and seriously ill members?
  - Yes
  - No

*If yes, please respond to the following questions:*

- a. How do you define complex and seriously ill members?

- b. How is this group being attributed to Primary Care First practices?
- c. To which lines of business would this apply?
- d. Describe your payment methodology for incorporating complex and/or seriously ill members into this model.
- e. Do the quality measures you will use to assess Primary Care First complex chronic practices, practices that accept SIP patients, and SIP-only practices differ from the quality metrics you plan to collect from Primary Care First practices with average risk patient populations? If so, please describe how they will differ.

### III. Performance Based Payment Arrangement

Payers are encouraged to include the opportunity for Primary Care First practices to qualify for both upside and downside performance-based incentive payments.

9. Please summarize your proposed performance-based incentive payment arrangement with Primary Care First practices:

- Bonus payment tied to practice performance
- Portion of revenue at risk for performance with upside and/or downside potential
- Shared savings with pooling/virtual groups
- Shared savings without pooling/virtual groups
- Episode payments
- Other

10. On what metrics will your proposed performance-based incentive payment arrangement be based? Select all that apply:

- Claims-based clinical quality measures (e.g., HEDIS)
- Electronic clinical quality measures
- Emergency department utilization
- Inpatient hospital utilization
- Patient-reported outcome measure
- Specialty utilization
- Total cost of care
- Patient Experience of Care measures (e.g., CAHPS®)
- Other

Please list the specific measures you are using to assess performance for this payment, by line of business.

11. Does your arrangement include upside and/or downside risk?

- Upside only
  - ❖ If upside only: What is the maximum % of savings/incentive practices can achieve?
- Upside and downside



❖ If upside and downside: What is the maximum % of downside and upside risk?

**12. Frequency of Payment**

- Monthly
- Quarterly
- Annually

**13. Timing of Payment**

- Prospective
- Retrospective

**14.** Please provide additional detail on your proposed performance-based payment arrangement, including how your methodology varies across lines of business, if at all.

**IV. For Payers with Self-Insured Clients:**

In order to support the enhanced delivery of primary care in the United States, it is also important for self-insured purchasers to adopt the principles of comprehensive primary care.

**15.** Do you currently provide any alternative payment arrangements (such as payments to providers for enhanced primary care, care coordination or patient centered medical home services, or other non-FFS arrangements) on behalf of your ASO clients?

- a. Yes
- b. No
- c. Not applicable

***Attribution and Data Sharing with Primary Care Practices***

Payers are encouraged to share their attribution methodologies with CMS and offer to provide participating practices with practice and member-level data regarding cost and utilization for their members attributed to participating practices at regular intervals in accordance with applicable law. Partner payers are encouraged to provide CMS with data for model evaluation and monitoring purposes at regular intervals.

**I. Attribution**

**1.** Please describe your proposed approach to identify members served by participating practices in the proposed region(s):

- a. Timing of Attribution?
  - Retrospective
  - Prospective
- b. Frequency of Attribution?
  - Monthly
  - Quarterly
  - Annually

- Other

c. Please describe your proposed attribution methodology

## II. Data Sharing

1. What level of data will you share with Primary Care First practices? E.g. Practice level or practitioner level?
2. What is your proposed frequency of data sharing with Primary Care First practices?
  - Monthly
  - Quarterly
  - Annually
  - Other (Please specify)
3. What types of data do you plan to provide to Primary Care First practices? Please specify if you are providing cost, utilization, and/or real-time hospital and ER data.
4. If applicable, please describe your current or planned involvement with local/regional multi-payer databases, direct claims line feeds, or Health Information Exchanges in the proposed region.
5. If applicable, please describe any current or planned data analytics tools or platform you provide for practices to analyze and use the data you provide.

### *Quality and Patient Experience Measures*

Partner payers are encouraged to align quality and patient experience measures with CMS and other payers in the region.

1. What types of quality measures do you plan to collect from Primary Care First practices? (select all that apply)
  - Claims-based quality measures (e.g., HEDIS)
  - Electronic clinical quality measures
  - Patient experience of care measures (e.g., CAHPS®)
  - Patient reported outcome measures
  - Structural quality measures
  - Quality measures unique to your company
  - Quality measures required by your state
  - Other
2. Please describe any quality measure alignment you have created with other payers.
3. Can your organization use any of the CMS Primary Care First Quality Measures below to align your Primary Care First quality reporting strategy?

Primary Care First Quality Measures

CMS ID#	NQF #	Measure Title	Measure Type/Data Source	Domain Name
<b>CMS 165v5</b>	0018	Controlling High Blood Pressure	Outcome/eCQM	Clinical Process/Effectiveness
<b>CMS 122v5</b>	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (eCQM)	Outcome/eCQM	Population/Public Health
<b>CMS130v6</b>	0034	Colorectal Cancer Screening (eCQM)	Process/eCQM	Effective Clinical Care
<b>N/A</b>	0005 and 0006	CPC+ Patient Experience of Care Survey (CAHPS® with supplemental items)	Outcome/Patient Survey	N/A
<b>N/A</b>	0326	Care Plan (registry measure)	Process/Registry	Communication and Care Coordination

4. Please specify what other quality metrics are relevant to your populations, if any, including complex chronic and seriously ill populations.
5. If Primary Care First practices shared PCF eCQM data with payers, would your organization be able to use these data to analyze practice quality performance?
  - Yes
  - No
  - ❖ If you selected “no,” please explain why.
  - ❖ If you selected “yes,” would the PCF eCQM data preclude the need for participating PCF practices to report or measure other quality data on your members attributed to PCF practices?
    - Yes
    - No
    - ❖ If you selected “no,” please explain why
6. Are you currently administering patient experience of care surveys to assess the quality performance of primary care practices?
  - Yes
  - No
  - ❖ If you selected “no,” please explain why
  - ❖ If you selected “yes,” are you willing to use CAHPS® as your sole measure of patient experience for practices participating in PCF?

Yes

No

❖ If you selected “no,” please explain why.

## Appendix C: Certified Health IT Requirements

### Primary Care First Practices

Primary Care First health IT requirements were designed to meet model-specific standards to promote data and health information exchange, provide patients access to electronic health information, and avoiding information blocking. Primary Care First participants will benefit from the use of interoperable health IT systems and will see the value of data sharing, both between providers and suppliers and with patients by implementing the requirements listed below. Primary Care First participants will be required to use 2015 Edition Certified Electronic Health Record Technology (CEHRT) to meet the baseline health IT requirements of the model and to report quality measures. PCF-General and hybrid practices will be required to support data exchange with other providers and health systems via Application Programming Interface (API) to eliminate the use of faxes for health information exchange and connect to their regional or national health information exchange (HIE).

### SIP-only Practices

SIP-only practices will be required to use 2015 Edition Certified Electronic Health Record Technology (CEHRT) to meet the baseline health IT requirements of the model and to report quality measures. SIP-only practices will be required to support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE) in the first year of the model. SIP-only practices that do not already meet the requirement to use 2015 Edition CEHRT will be granted 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 2.

### Requirements Table

Table C1 that follows describes the health IT requirements for Primary Care First practices and the date by which each must be accomplished. The table begins with health IT requirements for overall Certified Electronic Health Record Technology (CEHRT) adoption, followed by the requirements for clinical quality measure reporting, and model requirements. Table C2 provides health IT and interoperability requirements for SIP-only participants. Participating practices will also have to comply with certain interoperability requirements under the terms of the PCF participation agreement.

*Table C1. Health IT Requirements for PCF-General and Hybrid Practices*

Requirement	Date	Notes
<b>Overall CEHRT Adoption</b>		
Adopt and maintain, at a minimum, health IT needed to meet the CEHRT definition at 42 CFR 414.1305. <sup>27</sup>	By the start of the model performance period, ongoing.	Primary Care First requires adoption of relevant health IT for the entire Performance Year. For instance, if an upgrade to a new ONC CEHRT Edition is required to meet the CEHRT definition for a given calendar year, the upgrade must be completed by January 1.

<sup>27</sup> The CEHRT definition at 42 CFR 414.1305 requires the use of 2015 Edition CEHRT beginning in 2019.

Requirement	Date	Notes
<b>Certified Health IT for eCQM Reporting</b>		
<p>Adopt and maintain, at a minimum, health IT meeting the definition of CEHRT required by the QPP at 42 CFR 414.1305 and the certification criteria found at 45 CFR 170.315(c)(1) - (3)<sup>28</sup> for electronic clinical quality measure (eCQM) reporting, using the most recent update available on January 1 of the Measurement Period, for the eCQMs in the Primary Care First measure set.<sup>29</sup></p>	<p>For performance year one, by the start of the model performance period. No later than January 1 for each subsequent performance year.</p>	<p>For each Measurement Period, practices must use the <a href="#">eCQM specifications for eReporting listed in the eCQI Resource Center</a> as of January 1 of the performance year.</p>
<p>eCQM reporting submission in Quality Reporting Document Architecture Category III (QRDA III) format via <a href="http://qpp.cms.gov">qpp.cms.gov</a>.</p>	<p>The first expected Reporting Period is tentatively scheduled from January 1 to February 28, 2022.</p> <p>Reporting Period dates will be communicated yearly.</p>	<p>For the 2021 Measurement Period, all Primary Care First practices must report eCQMs electronically <a href="#">in the QRDA III format</a> via the <a href="http://qpp.cms.gov">qpp.cms.gov</a> website during the applicable reporting period.</p> <p>Primary Care First will require measure reporting in the QRDA III format via the <a href="http://qpp.cms.gov">qpp.cms.gov</a> website until such time as CMS offers measure reporting via the Fast Healthcare Interoperability Resources (FHIR®) standard.</p>
<p>Adopt and maintain health IT to report Advance Care Plan measure.</p>	<p>The first expected Reporting Period is tentatively scheduled from January 1 to February 28, 2022.</p> <p>Reporting Period dates will be communicated yearly.</p>	<p>Primary Care First requires the adoption of either a Quality Payment Program (QPP) qualified registry or a QPP qualified clinical data registry (QCDR) in the submission format specified by QPP at the <a href="http://qpp.cms.gov">qpp.cms.gov</a> website.</p>

<sup>28</sup> For each of these sections, (c)(1) is the certification criterion for “Record and Export”; (c)(2) is the certification criterion for “Import and Calculate; and (c)(3) is the certification criterion for “Report”.

<sup>29</sup> The Primary Care First Quality Reporting Requirements for each performance year will be made available in advance of that performance year.

Requirement	Date	Notes
Adopt and maintain technology with the capability to filter quality measure data for reporting at the PCF practice site level [practice site location, TIN(s)/NPI(s)].	For year one, by the start of the model. No later than January 1 for each subsequent performance year.	eCQM and Advanced Care Plan measure reporting must be filtered at the Primary Care First practice site level practice site location, TIN(s)/NPI(s)], and may not be filtered at the individual practitioner level <sup>30</sup>
<b>Model Reporting</b>		
Maintain Health IT Details Tab in Practice Portal.	Beginning within 30 days of the start of the model, then ongoing.	Primary Care First practices must maintain up-to-date health IT information in the Practice Portal. This includes, but is not limited to, changes in primary or quality reporting health IT vendor(s), and product information.

Table C2. Health IT Requirements for SIP-only Participants

Requirement	Date	Notes
<b>Overall CEHRT Adoption</b>		
Adopt and maintain, at a minimum, health IT needed to meet the CEHRT definition at 42 CFR 414.1305. <sup>22</sup>	The beginning of the second model performance year	SIP-only practices are required to adopt relevant health IT for the entire Performance Year. For instance, if an upgrade to a new ONC CEHRT Edition is required to meet the CEHRT definition for a given year, the upgrade must be completed by January 1.
<b>Health IT for Quality Measure Reporting</b>		
Adopt and maintain health IT to report Advance Care Plan measure.	Expected Reporting Period is tentatively scheduled from January 1 to February 28, 2022.  Reporting Period dates will be communicated yearly.	SIP requires the adoption of either a Quality Payment Program (QPP) qualified registry or a QPP qualified clinical data registry (QCDR) in the submission format specified by QPP at the qpp.cms.gov website.
Adopt and maintain health IT with the capability to filter quality measure data for reporting at the PCF practice site level [practice site location, TIN(s)/NPI(s)].	For performance year one, by the start of the model. No later than January 1 for each subsequent performance year.	The Advance Care Plan Measure reporting must be filtered at the SIP practice site level practice site location, TIN(s)/NPI(s)], and may not be filtered at the individual practitioner level <sup>25</sup> or at a group level.
<b>Model Reporting</b>		

<sup>30</sup> Primary Care First practices may adopt and maintain the 2015 Edition certification criterion found at 45 CFR 170.315(c)(4) in order to filter eCQMs for reporting at the CPC+ Practice Site level [practice site location, TIN(s), NPI(s)], but this is not required.

Requirement	Date	Notes
Maintain Health IT Details Tab in Practice Portal.	Beginning within 30 days of the start of the model, then ongoing.	SIP-only practices must maintain up-to-date health IT information in the Practice Portal. This includes, but is not limited to, changes in primary or quality reporting health IT vendor(s), and product information.



## Appendix D: Attribution Methodology

The Primary Care First attribution methodology is described below. Please note: the model uses different attribution methods for the Seriously Ill Population. Please see the sub-section *Attribution of Seriously Ill Population (SIP) & SIP Participants* below for the attribution methodology that will be used for SIP beneficiaries.

### **Voluntary Alignment and Claims-Based Attribution for non-SIP Medicare beneficiaries**

A beneficiary will be prospectively attributed to a Primary Care First practice if the beneficiary selected one of the practitioners listed on the practice's practitioner roster on MyMedicare.gov. If the beneficiary did not select any Primary Care First practice practitioner on MyMedicare.gov, the beneficiary will be attributed to the Primary Care First practice that either billed for the plurality of their primary care visits and eligible CCM services, or that billed the most recent claim (if that claim was for an Annual Wellness Visit or a Welcome to Medicare Visit) during the most recently available 24-month 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 attributed to the practice with the most recent visit. As explained below, this claims-based attribution methodology essentially means that CMS attributes beneficiaries and pays prospectively for the next quarter based on retrospective data from the last 24 months, with beneficiary lists provided to participating practices quarterly.

To be attributed to a practice, beneficiaries must:

- Have both Medicare Parts A and B;
- Have Medicare as their primary payer;
- Not have end stage renal disease (ESRD) or be enrolled in hospice at the time of initial attribution;
- Not be covered under a Medicare Advantage or other Medicare health plan;
- Not be institutionalized;
- Not be incarcerated;
- Not be aligned or otherwise attributed to an entity participating in a model that includes an opportunity to share in savings under Medicare FFS or in any other model that CMS has specified in the model overlap policy;

For all beneficiaries who meet the criteria above, CMS will assess any selections they have made in MyMedicare.gov and claims with the following qualifying CPT codes will be selected for the look-back period (the most recent 24 months) when the physician or practitioner specialty is internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine.

<b>Qualifying HCPCS Codes Eligible for Claims-based Attribution</b>	<b>Blank on Purpose</b>
<b>Office/Outpatient Visit E/M</b>	99201-99205 99211-99215
<b>Complex Chronic Care Coordination Services</b>	99487 <sup>31</sup>
<b>Chronic Care Management Services</b>	99490-99491
<b>Transitional Care Management Services</b>	99495-99496
<b>Home Care/Domiciliary Care E/M</b>	99324-99328 99334-99337 99339-99345 99347-99350
<b>Advance Care Planning</b>	99497
<b>Welcome to Medicare and Annual Wellness Visits</b>	G0402, G0438, G0439
<b>Assessment/care planning for patients requiring CCM services</b>	G0506
<b>Care management services for behavioral health conditions</b>	G0507, 99484
<b>Prolonged non-face-to-face evaluation and management services</b>	99358
<b>Cognition and functional assessment for patient with cognitive impairment</b>	G0505, 99483
<b>Collaborative Care Model</b>	G0502-G0504 99492-99494
<b>Outpatient clinic visit for assessment and management (for critical access hospital-based outpatient primary care practices)</b>	G0463

CMS will provide each practice with a list of its attributed beneficiaries prior to the start of the performance period of the participation agreement and will provide an updated list by the end of the first month of each quarter thereafter. To align with the claims-based processes, CMS will also assess selections in MyMedicare.gov every three months. A diagram of the attribution process is included below (Figure 2).

<sup>31</sup> CPT 99489 is an add-on code for an additional 30 minutes of complex chronic care management and will not count as an additional primary care service in the assessment of plurality.

Practices will be required to inform their patients in writing of their involvement in this model and the changes their practice has made or is undertaking to provide comprehensive primary care and better serve their needs. Practices will also be required to collect information on patients who opt out of data sharing and transmit this information to CMS. Medicare beneficiaries may also opt out of data sharing by calling 1-800-MEDICARE.

At all times during the initiative, though Medicare beneficiaries will be attributed to a practice, they will remain free to select the health care providers and services of their choice and will continue to be responsible for all applicable beneficiary cost-sharing. Primary Care First does not include any restrictions on or changes to Medicare FFS benefits, nor does it include provisions for beneficiaries to opt out of attribution with a participating practice for purposes of expenditure calculations and quality performance measurement.

### **Attribution of Seriously Ill Population (SIP) Beneficiaries**

Practices that apply to participate in the model and indicate that they are willing to accept SIP beneficiaries must provide a description of service area(s) in which they are interested in participating using zip codes as descriptors. The practice must also define the maximum number of attributed SIP beneficiaries that the practice has the capacity to manage. If the practice is accepted to participate in the model and signs a Participation Agreement with CMS, CMS will assign SIP beneficiaries in the SIP practice's preferred service area to the practice, starting with SIP beneficiaries that live closest to the practice. 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 (final attribution will depend on beneficiary outreach and engagement as described below, as well as practices' maximum capacity).

CMS will use claims data to identify beneficiaries who meet the two general SIP beneficiary requirements: experiencing serious illness and exhibiting a pattern of care fragmentation. The claims-based criteria for each of these requirements are set forth below.

Serious Illness—Medicare beneficiaries that meet one of the following claims-based criteria will be deemed to satisfy the serious illness requirement:

- 1) Have significant chronic or other serious illness (defined as an HCC risk score at 3.0 or greater).
- 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.
- 3) Show signs of frailty, as evidenced by a DME claim submitted to Medicare by a provider or supplier for a hospital bed or transfer equipment.

Care Fragmentation—A Medicare beneficiary will satisfy the care fragmentation requirement if, based on claims data, one of the following conditions is satisfied: no single practice (defined at the TIN level) provided more than half of their evaluation and management visits, or the beneficiary had two or more Emergency Department visits or observation stays in the previous 12 months, or such other claims-based criteria as may be set forth in the Participation Agreement.

Following identification, CMS will then reach out to beneficiaries who meet the SIP requirements in order to solicit their interest in the model. Once a beneficiary has indicated interest in the model, CMS will provide their contact information to a SIP practice through a secure information transfer method, and, depending on beneficiary and practice preferences, may even help the beneficiary schedule their first appointment. CMS will also provide a monthly list of interested SIP-eligible beneficiaries to SIP practices.

Practices are expected to reach out to beneficiaries as soon as possible, ideally within 24 hours after receiving a beneficiary's contact information, though they will have 60 days from when CMS includes a SIP beneficiary on a monthly SIP beneficiary list to engage that beneficiary, as evidenced by a Medicare claim for the first face-to-face visit with that SIP beneficiary. After the participating practice has submitted a claim for the first face-to-face visit with the SIP beneficiary, the SIP beneficiary will be attributed to the practice. Monthly SIP payments (calculated on a PBPM basis but paid quarterly) will begin the following month. CMS expects that SIP beneficiaries will require an intensive level of care; therefore, for a SIP beneficiary to remain attributed to the practice, the practice must have a face-to-face visit with the beneficiary at least once every 60 days, as defined by dates of service on claims billed under the practice's TIN. If this requirement is met, attribution (and payment) will last for up to 12 months, or until one of the following circumstances occurs:

- 1) Beneficiary opts out of the SIP component after the first face-to-face visit (in this scenario, the practice should notify CMS);
- 2) The practice notifies CMS that the beneficiary has been transitioned out of SIP;
- 3) Beneficiary began receiving hospice care, as evidenced by hospice claims
- 4) Beneficiary moved out of the practice's service area; or
- 5) Beneficiary died prior to the care transition.

Practices will also have the opportunity to request an exception to the 12-month attribution limit for individual beneficiaries. CMS expects that exceptions will be rare, and will require practices to demonstrate that continuing to receive SIP-level care is medically necessary for the beneficiary (e.g. the beneficiary still requires intensive care services and a transition of care would be harmful for the beneficiary's health). CMS may allow extensions beyond 12 months in limited increments, so long as the SIP practice continues to maintain an average SIP attribution length of no more than eight months across its entire SIP beneficiary population. This approach is designed to provide flexibility to best support beneficiary needs while ensuring that practices are not retaining beneficiaries in SIP longer than medically necessary in order to continue receiving higher payments.

CMS is aware that some SIP-eligible beneficiaries may not be identified by CMS's review of claims data, due to reasons such as new enrollment in Medicare and a resulting lack of historical data, or new and rapid onset of disease. Therefore, on a limited basis, CMS will allow SIP-only and hybrid practices to identify and refer beneficiaries for model participation under the SIP component even if they do not meet the claims-based criteria for SIP eligibility. This pathway for identifying SIP beneficiaries will be termed "direct referral."

CMS will identify non-claims-based clinical criteria that beneficiaries must meet to be eligible for direct referral. SIP practices seeking to directly refer a beneficiary to the SIP component will first seek the beneficiary's consent and then will attest to CMS that the beneficiary meets these clinical criteria. CMS will review these attestations and confirm that the beneficiary also meets general Primary Care First

beneficiary eligibility criteria, e.g. enrollment in Medicare Parts A and B. If CMS confirms that the beneficiary meets eligibility criteria and the SIP practice has a subsequent face-to-face visit with the beneficiary, the beneficiary will be attributed to the SIP practice and SIP monthly payments will begin in the following month. If CMS determines that the beneficiary does not meet eligibility criteria, the beneficiary will not be eligible for attribution to the SIP practice. Any care that the practice furnishes to a beneficiary prior to attribution, e.g., in the course of evaluating the beneficiary's eligibility for SIP, will be reimbursed under FFS.

CMS expects that beneficiaries who are good candidates for the direct referral pathway will mostly be identified by other health care providers in the community, e.g. a hospital or ED, and then referred to the SIP practice for clinical assessment. The SIP practice will ultimately be responsible for determining whether the beneficiary meets the non-claims-based clinical criteria and submitting an attestation to CMS. SIP practices cannot directly refer a patient with whom they have an existing care relationship, as the goal of the SIP component is to identify patients who are experiencing fragmented care and do not currently have a primary practitioner that they regularly visit for their care. More information on the specific non-claims-based clinical criteria for direct referral will be available in the Participation Agreement.

Consistent with Section 1802(a) of the Social Security Act, the Primary Care First practices shall not commit any act or omission, nor adopt any policy, that inhibits beneficiaries from exercising their freedom to deny engagement with SIP practices and to obtain health services from any providers and/or suppliers.

Additional detail will be outlined in the Participation Agreement.

## Appendix E: Medicare Covered Services Included in the Professional PBP and Flat Visit Fee

### Services Included in the Professional PBP

CPT 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
Chronic Care Management Services	99487, 99489-99491

### Services Included in the Flat Visit Fee

CPT 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

### Services that May Not Be Billed for Attributed Medicare FFS Beneficiaries

CPT Codes	
Chronic Care Management Services <sup>32</sup>	99487, 99489-99491

<sup>32</sup> Recognizing that Chronic Care Management (CCM) services are a critical component of primary care that contributes to better health and care for individuals, CCM has already been accounted for and built into the Professional PBP. 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.