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CENTERS FOR MEDICARE & MEDICAID SERVICES
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PCF
Primary Care First

PRIMARY CARE FIRST

Introduction to Primary Care First

Foster Independence, Reward Outcomes

Welcome

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Introduction to Primary Care First: Today's Agenda

This session will cover the following concepts to provide background on the Primary Care First Model.

- Primary Care First Model Overview
- Model Eligibility
- Payment Design and Attribution
- Data Sharing
- Timeline

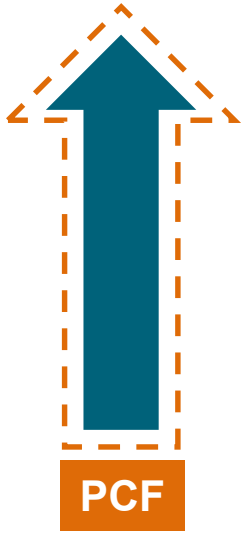
Primary Care First Model Overview

Primary Care First Builds on the Underlying Principles of Prior CMS Innovation Models

CMS primary care models offer a variety of opportunities to advance care delivery, increase revenue, and reduce reporting requirements.

Comprehensive Primary Care Plus (CPC+) Track 1 is a pathway for practices ready to build the capabilities to deliver comprehensive primary care.

CPC+ Track 2 is a pathway for practices poised to increase the comprehensiveness of primary care.



Primary Care First rewards outcomes, increases transparency and enhances care for high need populations.

Primary Care First Rewards Value and Quality Through an Innovative Payment Structure

Primary Care First Goals

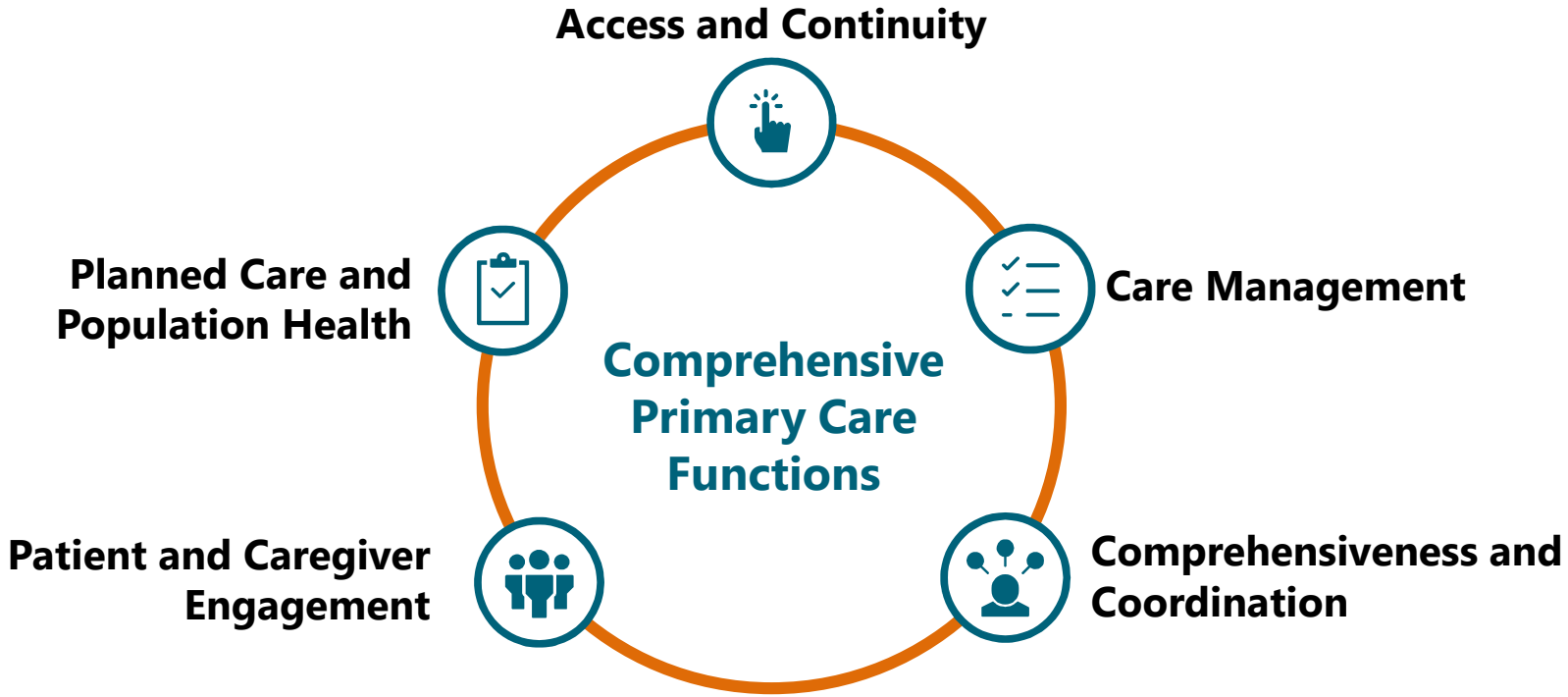
1. To **reduce Medicare spending** by preventing avoidable inpatient hospital admissions.
2. To **improve quality of care and access to care** for all patients, particularly those with complex chronic conditions.

Primary Care First Overview

- **5-year** alternative payment model.
- Offers greater **flexibility**, increased **transparency**, and **performance-based** payments to participants.
- Payment options for practices that specialize in **patients with complex chronic conditions.**
- Fosters **multi-payer alignment** to provide practices with resources and incentives to enhance care for all patients, regardless of insurer.

Participants Achieve Model Aims Through Innovations in Their Care Delivery

Primary Care First model participants are incentivized to deliver evidence-based interventions across 5 comprehensive primary care functions:

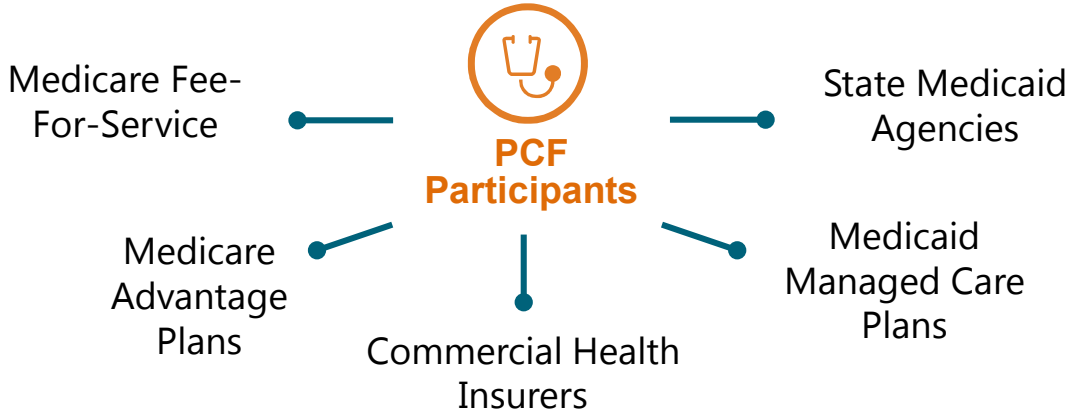


Practices Have the Freedom to Innovate While Implementing Core Functions of Comprehensive Primary Care

Comprehensive Primary Care Function	PCF Intervention
Access and Continuity	▪ Provide 24/7 access to a care team practitioner with real-time access to the Electronic Health Record (EHR).
Care Management	▪ Provide risk-stratified care management.
Comprehensiveness and Coordination	▪ Integrate behavioral health care. ▪ Assess and support patients' psychosocial needs.
Patient and Caregiver Engagement	▪ Implement a regular process for patients and caregivers to advise practice improvement.
Planned Care and Population Health	▪ Set goals and continuously improve upon key outcome measures.

CMS is Committed to Partnering with Aligned Payers in Selected Regions

CMS will encourage other payers to engage practices on similar outcomes. CMS is soliciting interested payers starting March 2021.



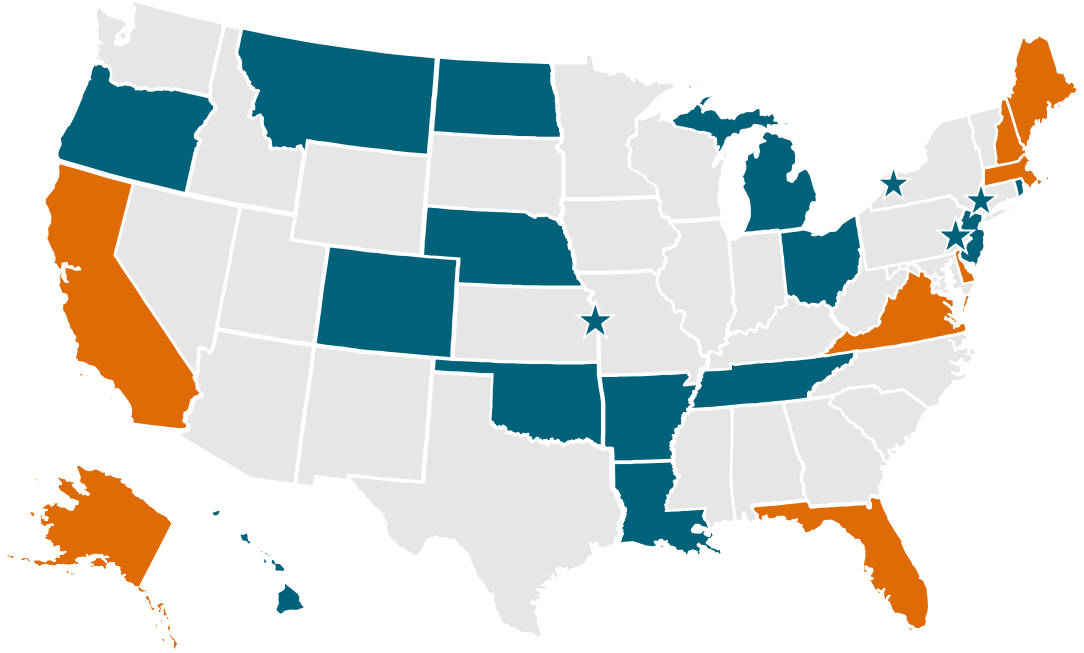
Multi-payer alignment promotes:

- An alternative to fee-for-service (FFS) payments.
- Performance-based incentive opportunity.
- Alignment on practice quality and performance measures.
- Practice- and participant-level data on cost, utilization, and quality.

Model Eligibility

Primary Care First Is Offered in 26 States and Regions

For Cohort 2, beginning January 1, 2022, Primary Care First will be offered to both CPC+ and non-CPC+ practices.



Current CPC+ Track 1 and 2 regions

New regions added in Primary Care First

PCF Participants Must Meet the Following Requirements

- ✓ Include **primary care practitioners** (i.e., MD, DO, CNS, NP, PA) in good standing with CMS.
- ✓ Provide health services to a **minimum of 125** attributed Medicare beneficiaries.
- ✓ Have primary care services account for the **predominant share** (e.g., 50%) of the practices' collective billing based on revenue.
- ✓ Demonstrate **experience with value-based payment arrangements**, such as shared savings, performance-based incentive payments, and alternative to fee-for-service payments.
- ✓ Use 2015 Edition **Certified Electronic Health Record Technology** (CEHRT), support **data exchange** with other providers and health systems via Application Programming Interface (API), and, if available, 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**, including 24/7 access to a practitioner or nurse call line, and empanelment of patients to a primary care practitioner or care team.

Overlap Between Models Leverages Incentives and Maintains Program Integrity

Current Model Participation	Potential for Simultaneous Participation with Primary Care First
Direct Contracting (DC)	• Practices cannot participate in DC and Primary Care First at the same time.
Medicare Accountable Care Organizations (ACOs)	• Primary Care First practices may also participate in ACOs in the Medicare Shared Savings Program (Shared Savings Program). • Primary Care First practices may not participate in the Next Generation ACO Model.
Kidney Care Models	• Primary Care First practices may not participate the Comprehensive End Stage Renal Disease (ESRD) Care Model. • Primary Care First practices may not participate in Kidney Care Choices Models, including Kidney Care First.
Episode Payment Models	• Practices will be permitted to participate in the Primary Care First Model while simultaneously participating in Bundled Payment for Care Improvement (BPCI) Advanced, Comprehensive Care for Joint Replacement (CJR), or Oncology Care Model (OCM).
Value in Treatment Model	• Primary Care First practices may not also participate in the Value in Treatment model.
Emergency Triage, Treat, and Transport Model (ET3)	• ET3 and Primary Care First models are complementary, and share aligned financial incentives to reduce avoidable emergency department visits and admissions. Payments do not overlap.
Accountable Health Communities (AHC)	• The payment structures for the AHC Model and Primary Care First differ. Practices may both participate in the Primary Care First Model and be paid by an AHC bridge organization.

Payment Design and Attribution

The PCF Payment Model Option Emphasizes Flexibility and Accountability

PCF Payment Model Option Goals

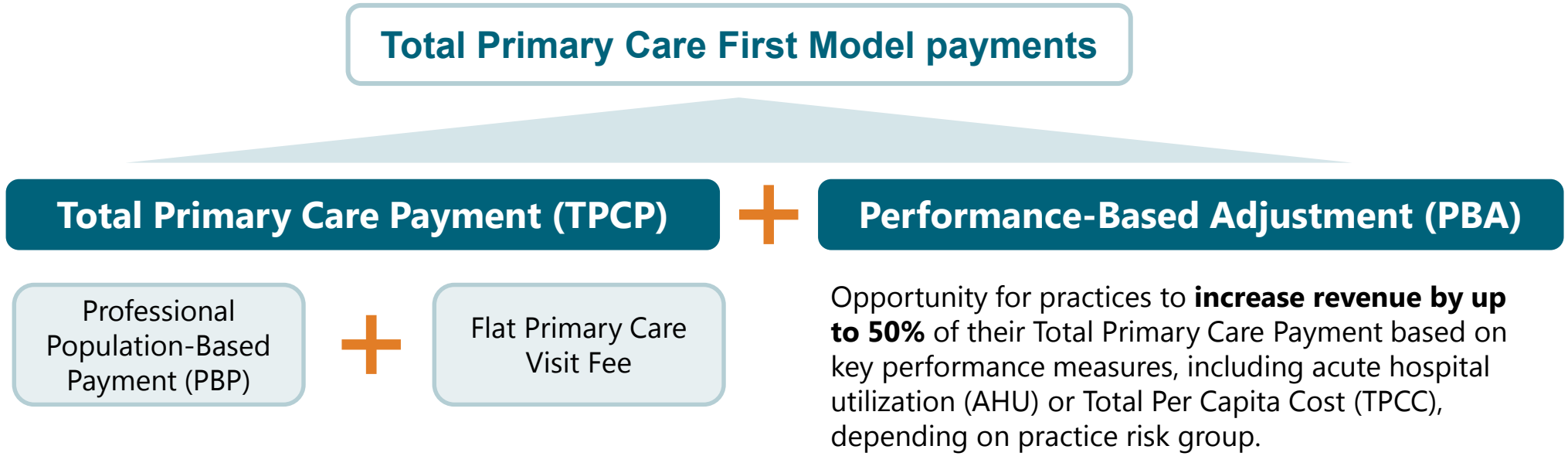
- **Promote patient access** to advanced primary care both in and outside of the office, especially for complex chronic populations.
- **Transition primary care** from fee-for-service payments to value-driven, population-based payments.
- **Reward high-quality, patient-focused care** that reduces preventable hospitalizations.

PCF Payments

Professional population-based payments and **flat primary care visit fees** to help practices improve access to care and transition from FFS to population-based payments.

Performance-based adjustments of up to 50% of revenue and a 10% downside, based on a single outcome measure, with focused quality measures.

Primary Care First Model Payments Include Two Major Components



Total Primary Care Payment Promotes Flexibility in Care Delivery

Total Primary Care Payment is a hybrid payment that incentivizes advanced primary care while compensating practices with higher-risk patients.

Population-Based Payment

Payment for service in or outside the office, adjusted for practices caring for higher risk populations. This base rate is the same for all patients attributed to the practice.

Practice Risk Group	Payment *(per beneficiary per month (PBPM)*
Group 1: Average Hierarchical Condition Category (HCC) <1.2	**$28**
Group 2: Average HCC 1.2-1.5	**$45**
Group 3: Average HCC 1.5-2.0	**$100**
Group 4: Average HCC >2.0	**$175**

Payment will be reduced through calculating a "leakage adjustment" if beneficiaries seek primary care services outside the practice.

+

Flat Primary Care Visit Fee

Payment for in-person treatment applied as a fixed amount to most face-to-face office and home visits. The base rate is:

$40.82

per face-to-face encounter*

These payments allow **practices to easily predict payments for face-to-face care.**

Note: All model payments are also subject to geographic adjustment, MIPS adjustment, and 2% Medicare sequestration, as required by federal rulemaking.

*** Beneficiary cost sharing will apply and follow traditional FFS rules.**

Flat Primary Care Visit Fee Supports Face-to-Face Care

Primary Care First practices will receive a $40.82 flat visit fee (FVF) for the following codes provided by a physician or other qualified healthcare professional:

Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Codes	
Office/Outpatient Visit E/M*	99202-99205, 99211-99215
Prolonged E/M*	99354-99355
Transitional Care Management Services	99495-99496
Home Care E/M*	99324-99328, 99334-99337, 99341-99345, 99347-99350
Advance Care Planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439

Note: Many of the FVF codes can be billed regardless of whether the service is provided in-person or via telehealth. As long as a PCF practice meets the **current Medicare requirements** to provide one of these services via telehealth (e.g., originating site requirements, as modified by **current** Medicare waivers in response to the COVID-19 public health emergency), the practice will receive the FVF for this service. Any Medicare telehealth or virtual care services that are not included on this list will be reimbursed according to Medicare FFS policies.

Beneficiary Attribution Is Performed Quarterly Through A Two-Step Process

1 Voluntary Alignment

Patients attest to their **choice of a primary care practitioner on MyMedicare.gov**

1. Patient accesses MyMedicare.gov.
2. Patient selects a practitioner (voluntary alignment).
3. Patient is attributed to selected practitioner.

Voluntary alignment will supersede claims-based alignment.

THEN

2 Claims-Based Attribution

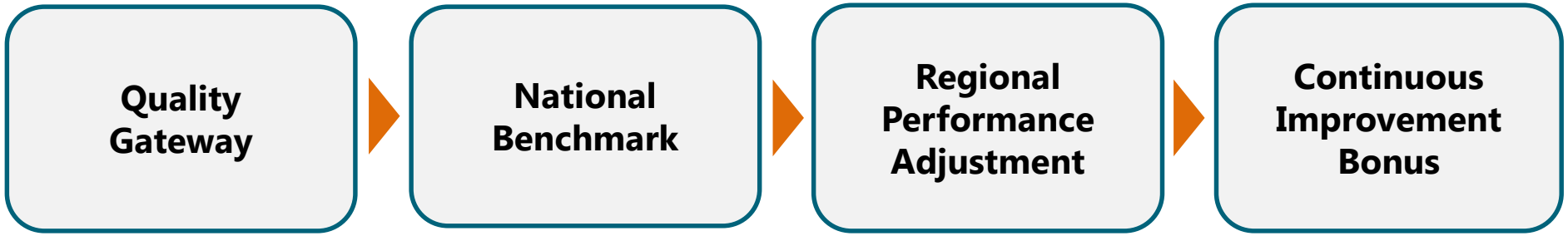
If a patient did not select a practitioner on MyMedicare.gov, they **can be attributed to the practice** based on an examination of claims from the previous 24 months.

CMS reviews practitioners on roster → CMS examines claims from performance 'look-back' period and each quarter thereafter → Prospective attribution of patients with eligible visits to Primary Care First providers → CMS applies recency and plurality rules to assign patients

Since this is a retrospective process, it may take several quarters before changes in the provider that a patient sees will result in changes to attribution.

Performance-Based Payment Adjustments Are Determined Based on a Multi-Step Process

Practices must meet or exceed the minimum performance threshold on a set of quality measures as first step; the remaining steps are based on utilization measures.



Based on **clinical quality** and **patient experience of care** measures.

- ✓ Based on **Acute Hospital Utilization** (AHU) measure for **Practice Risk Groups 1 and 2**
- ✓ Based on **Total Per Capita Cost** (TPCC) measure for **Practice Risk Groups 3 and 4**

Quality Gateway Ensures Practices are Maintaining Quality While Reducing Utilization

A practice's Quality Gateway measures depends on its practice risk group.

✓The minimum performance threshold for each measure is the **30th percentile**; practices must meet or exceed this benchmark on all measures to pass the Quality Gateway.

Practice Risk Groups 1 & 2 Quality Gateway Measures

1. **Patient Experience of Care Survey** (CAHPS® with supplemental items).
2. **Diabetes: Hemoglobin A1c** (HbA1c) **Poor Control** (>9%).*
3. **Controlling High Blood Pressure.**
4. **Colorectal Cancer Screening.**
5. **Advance Care Plan** (MIPS CQM).

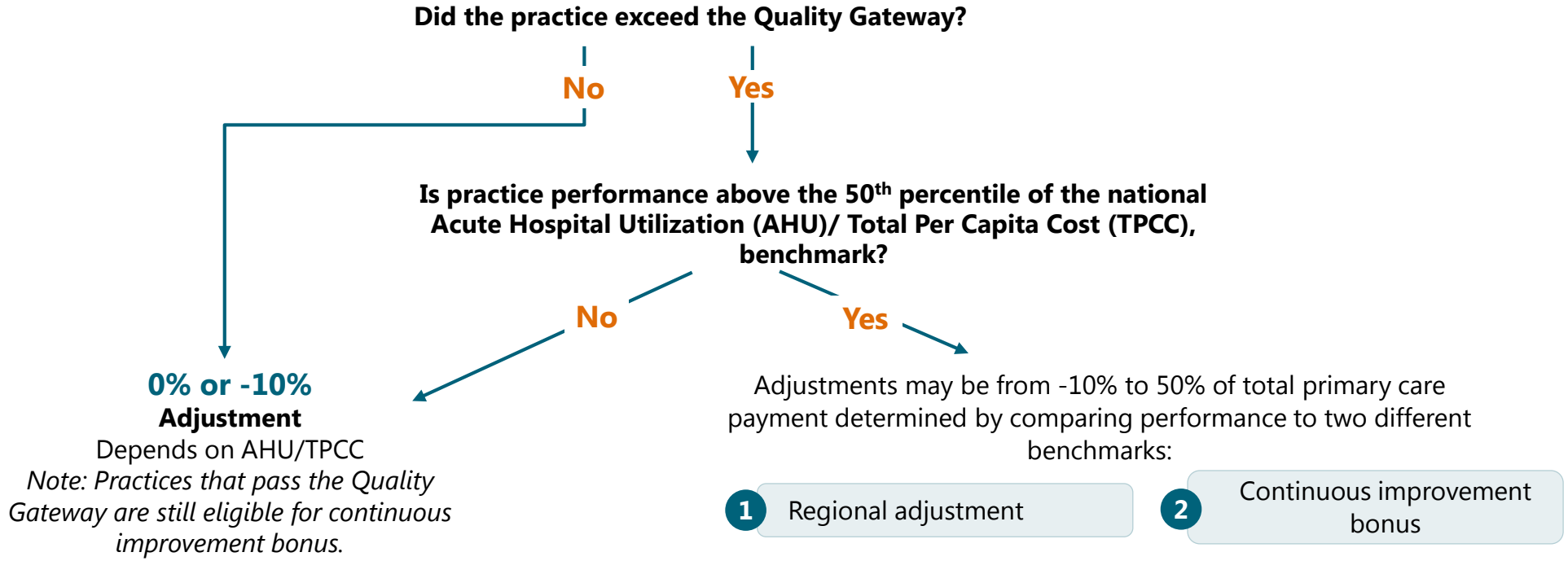
Practice Risk Groups 3 & 4 Quality Gateway Measures

1. **Patient Experience of Care Survey** (CAHPS® with supplemental items).
2. **Advance Care Plan** (MIPS CQM).
3. **Days at Home.**Δ

*Measure is reverse-scored
ΔMeasure is under development and will first be applied in performance year 2

PBA Amount Based on Utilization Measure for Practices that Pass Quality Gateway

In Year 2 (2023), adjustments are based on performance as described below. In Years 3-5, failing the Quality Gateway results in an automatic -10% adjustment.



Regional Adjustment Compares Practice Performance to a Regional Benchmark

1 Regional Performance Adjustment

Practices that exceed the 50th percentile national AHU/TPCC benchmark will earn a PBA based on how they perform relative to their peer region practices.

Top 75% of the regional reference group?

No

-10% Adjustment

(*still eligible for continuous improvement bonus*)

Yes

AHU/TPCC Performance Relative to Peer Region Benchmark	Regional Adjustment (% of TPCP)
At/above 90th percentile	34%
80th to 89th percentile	27%
70th to 79th percentile	20%
60th to 69th percentile	13%
50th to 59th percentile	6.5%
25th to 49th percentile	0%
Below 25th percentile	-10%

Practices that Achieve Improvement Targets are Eligible for a Continuous Improvement Bonus

2 Continuous Improvement Bonus

Practices are also eligible for a **continuous improvement (CI) bonus of up to 16% of the possible 50% PBA amount** if they achieve their improvement target. CMS may use statistical approaches to account for random variations over time and promote reliability of improvement data.

AHU/TPCC Regional Performance Level	Improvement Target to Earn CI Bonus	CI Bonus (% of TPCP)
Level 1: **At/above 90th percentile**	3%	16%
Level 2: **80th to 89th percentile**	3.33%	13%
Level 3: **70th to 79th percentile**	3.67%	10%
Level 4: **60th to 69th percentile**	4%	7%
Level 5: **50th to 59th percentile**	4.33%	3.5%
Level 6: **25th to 49th percentile**	4.67%	3.5%
Level 7: **Below 25th percentile**	5%	3.5%

Payment Is Timed to Be Highly Responsive to Practice Performance

1 Total Primary Care Payment (TPCP)

Professional Population-Based Payment:

- Prospective, per beneficiary per month (PBPM) payment based on practice risk group
- Paid as a quarterly lump sum

Flat Primary Care Visit Fee:

- Paid through standard Medicare claims system
- $40.82 base rate for each face-to-face visit
- Geographically adjusted with copayment applied

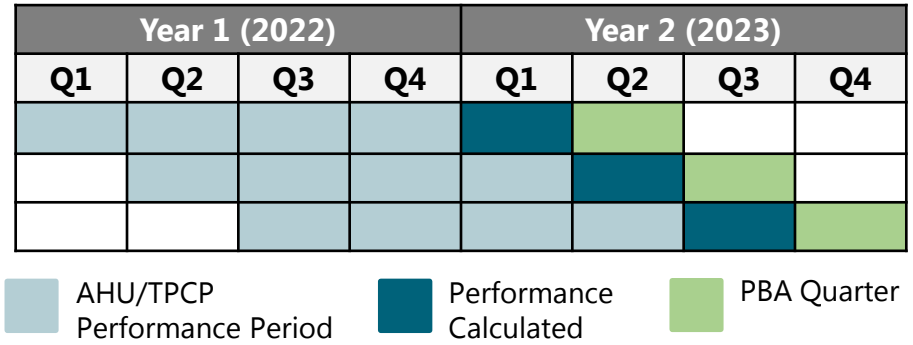
2 Performance-Based Adjustment (PBA)

PBA Frequency:

- PBA is paid in a quarterly lump sum; **the first PBA will be paid to practices in Q2 2023**

PBA Calculations:

- PBA to the TPCP is calculated quarterly using a rolling 1-year performance period of AHU/TPCC that ends 3 months before the PBA payment quarter



Example of Quarterly Payment Calculation for Practice Risk Group 1

- Total Medicare FFS beneficiaries: **800**
- # of primary care services attributed beneficiaries received outside the PCF practice last year: **750**
- # of primary care services attributed beneficiaries received at any practice last year: **5,000**

Total Primary Care Payment

Professional Population-Based Payment

$28 for Practice Risk Group 1 PBPM x 800 beneficiaries = **$22,400**

Leakage adjustment from prior year:

750 visits / 5,000 visits = 0.15
$22,400 x (1 - 0.15) = $19,040
$19,040 x 3 months = **$57,120**

Flat Primary Care Visit Fee (FVF)

$40.82 per in-person visit x 1,200 face-to-face Medicare visits = **$48,984**

Total Primary Care Payment*

$57,120 + $48,984 **= $106,104**

*PBP and FVF payments are also subject to geographic adjustment and MIPS adjustment. Beneficiary cost-sharing has been excluded from the example payment calculation but will apply to the FVF.

+ Performance-Based Adjustment

Year 2 (2023) Outcome Assumptions

- ✓ Passed Quality Gateway
- ✓ National performance: at/above the 50th percentile
- ✓ Regional performance: at/above the 90th percentile of peer region practices
- ✓ Met Acute Hospital Utilization Continuous Improvement target of 3%

Regional Performance Adjustment

34% of Total Primary Care Payment based on performance level 1: $106,104 x 0.34 = **$36,075.36**

Continuous Improvement Bonus

16% of Total Primary Care Payment based on meeting Continuous Improvement target for performance level 1: $106,104 x 0.16 = **$16,976.64**

= Total Medicare Payments

Total Primary Care Payment

$106,104

Performance-Based Adjustment

$36,075.36 + $16,976.64 = **$53,052**

$159,156 for Quarter 3+

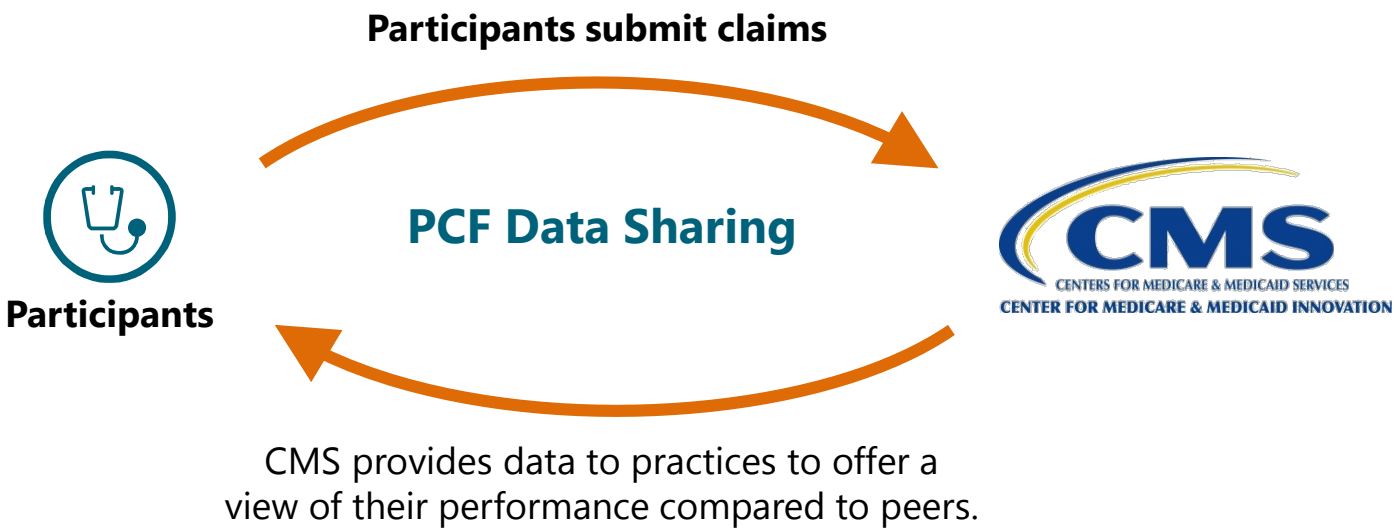
+All model payments are also subject to the 2% Medicare sequestration, as applicable

Note: Further details are outlined in the Primary Care First Payment Methodology Paper.

Data Sharing

Primary Care First Innovates Data Sharing to Inform Care Delivery

Participants get access to timely, actionable data to assess performance relative to peers and drive care improvement.



Timeline

Primary Care First Cohort 2 Will Launch in January 2022

Now!
Access the RFA on the CMS website and sign into the application portal

Spring 2021
Practice applications due **April 30, 2021** and Payer solicitation due **May 28, 2021**

Summer-Fall 2021
Accepted practices and payers will be notified

Fall-Winter 2021
Practice and payer onboarding will occur prior to model start

January 2022
Payment for Cohort 2 begins

Interested practices should review the Request for Applications (RFA) and can access the Application Portal to complete an application.

Get Your Questions Answered!

The CMS Primary Care First Model Team, noted below, will spend the rest of today's session answering your questions.

Name	Role	Name	Role
Nicholas Minter	Director, Division of Advanced Primary Care	Tammy Luo	Data Lead
Leah Hendrick	Deputy Director, Division of Advanced Primary Care	Carly Medosch	Health IT Lead
Chris Coutin	Payment Operations and Data Aggregation Lead	Yona Openden	Learning Lead
Sarah Irie	Payment Policy Lead	Christa Speicher	Payer Lead
Emily Johnson	Model Co-Lead	Carey Zhuang	Applications and Practice Management Lead

If you haven't already, please submit your questions using the Q&A box at the bottom of your Zoom screen.

Use the Following Resources to Learn More About Primary Care First

For more information about Primary Care First and to stay up to date on upcoming model events:

Visit

https://innovation.cms.gov/initiatives/primary-care-first-model-options/

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Read the Request for Applications (RFA) here

Access the model application here

Questions about the Primary Care First Model and Next Steps? Please contact PrimaryCareApply@Telligen.com
Attend the upcoming **Ready, Set, Apply Webinar on Wednesday March 31st at 3PM ET**.