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

# Primary Care First

*Foster Independence. Reward Outcomes.*

## Rhode Island - CTC

***Center for Medicare & Medicaid Innovation***

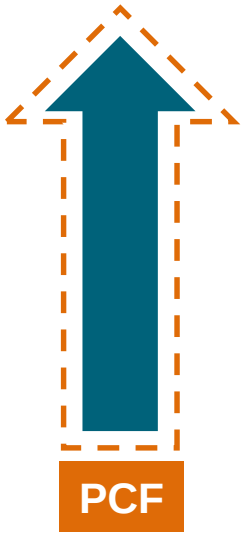
# What is Primary Care First?

# Overview of CMS Innovation Center Primary Care Models

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


**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**.




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

# Introduction to Primary Care First (PCF)

## 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 beneficiaries, particularly those with complex chronic conditions and serious illness

## Primary Care First Overview

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

# Primary Care First Payment Model Option Eligibility Criteria

The following criteria apply to practices who seek to participate in the general Primary Care First payment model or in both the general and SIP payment models.

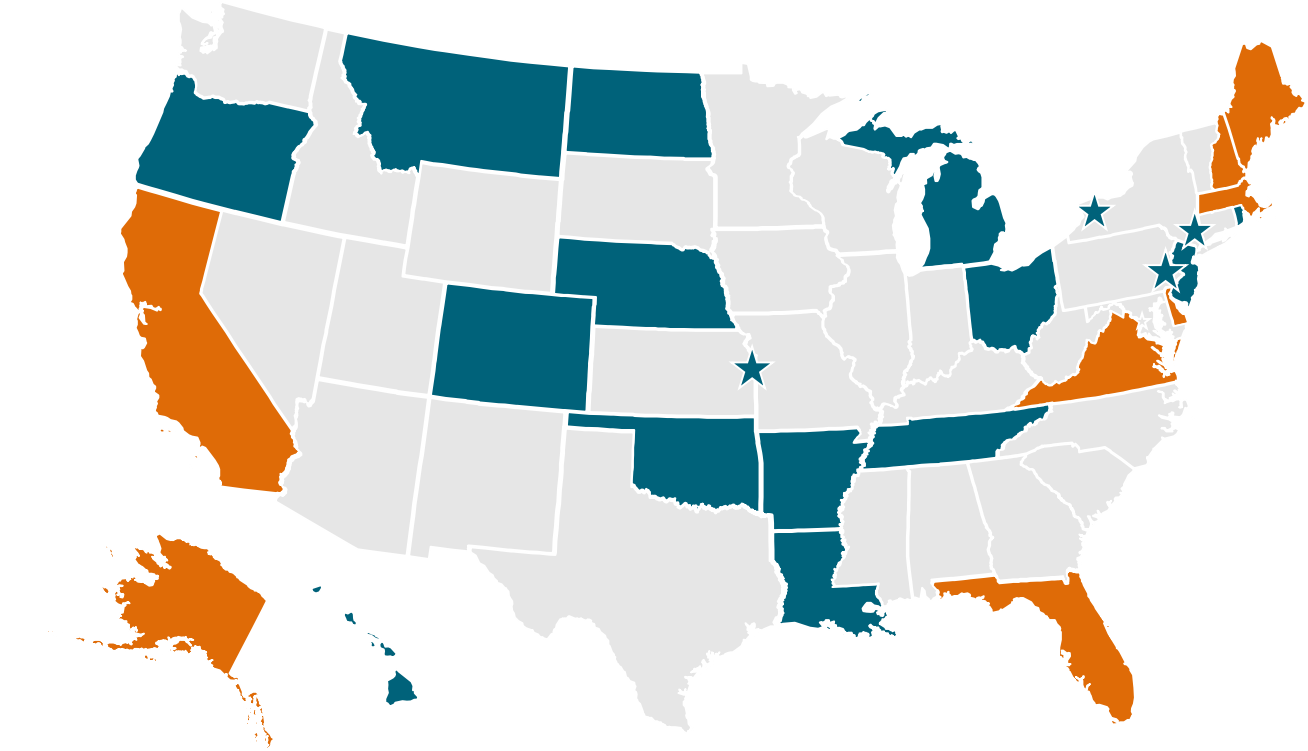
**In the application, you will need to attest that you meet the following criteria:**

- ✓ Include **primary care practitioners** (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 at least **70% of the practices' collective billing** based on revenue
- ✓ Demonstrate **experience with value-based payment arrangements**
- ✓ Meet **technology standards** for electronic medical records and data exchange
- ✓ Provide a set of **advanced primary care delivery** capabilities

**Note:** Practices participating in the SIP option will be subject to requirements discussed later in this presentation.

# Where PCF Will Be Offered in 2021

In 2021, Primary Care First will include 26 diverse regions:



Current CPC+ Track 1 and 2 regions

New regions added in Primary Care First

# How is PCF structured?

# PCF Payment Model Options

The **thee PCF payment models** accommodate a continuum of providers that specialize in care for different patient populations.

## Option 1

**PCF Payment Model**

Focuses on **advanced primary care practices ready to assume financial risk** in exchange for reduced administrative burdens and performance-based payments. Introduces new, higher payments for practices caring for complex, chronically ill patients.

## Option 2

**Seriously Ill Populations Payment Model**

Promotes care for high need, **seriously ill population (SIP)** beneficiaries who lack a primary care practitioner and/or effective care coordination.

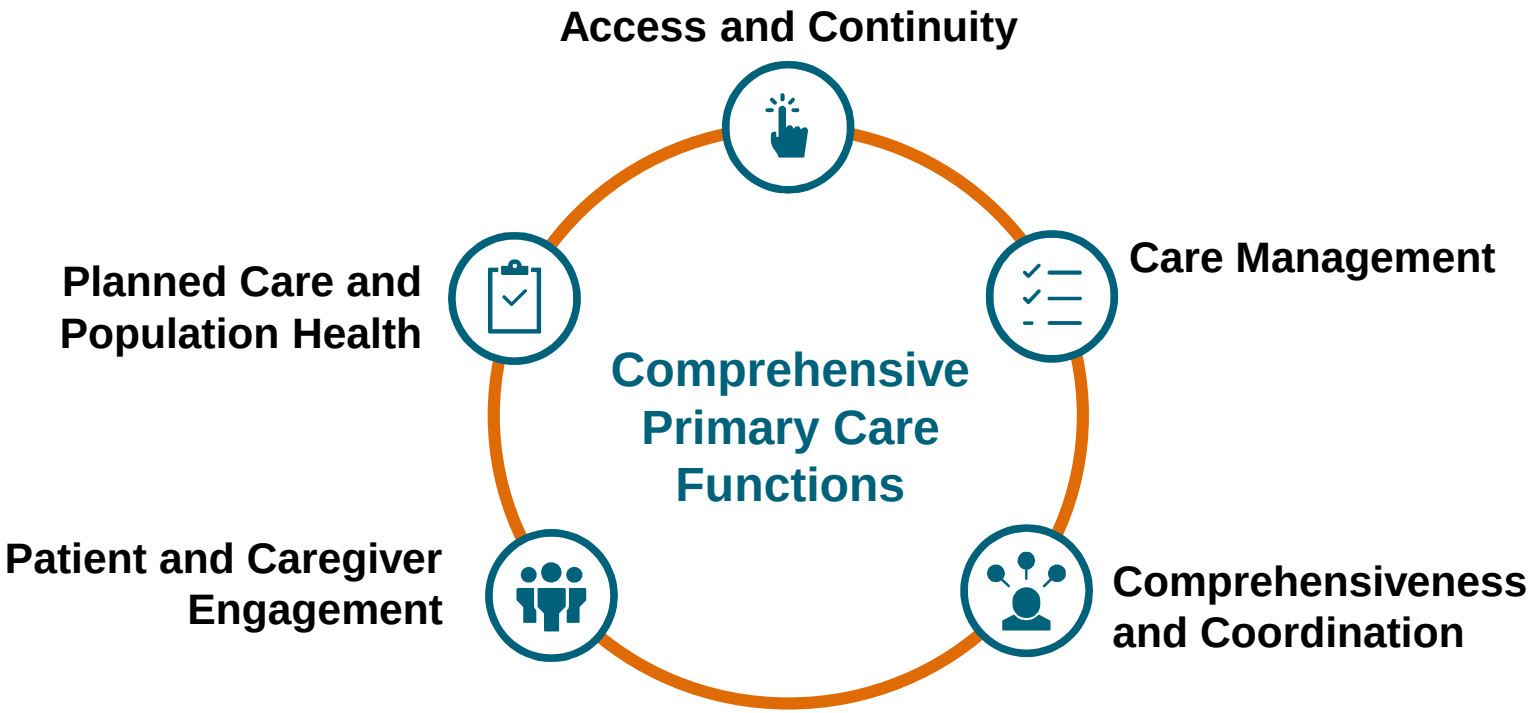
## Option 3

**Participation in both options 1 and 2**

Allows practices to **participate in both** the PCF Payment Model and the Seriously Ill Populations Payment Model.

# Comprehensive Primary Care Functions

PCF participants are incentivized to deliver evidence-based interventions across 5 comprehensive primary care functions:

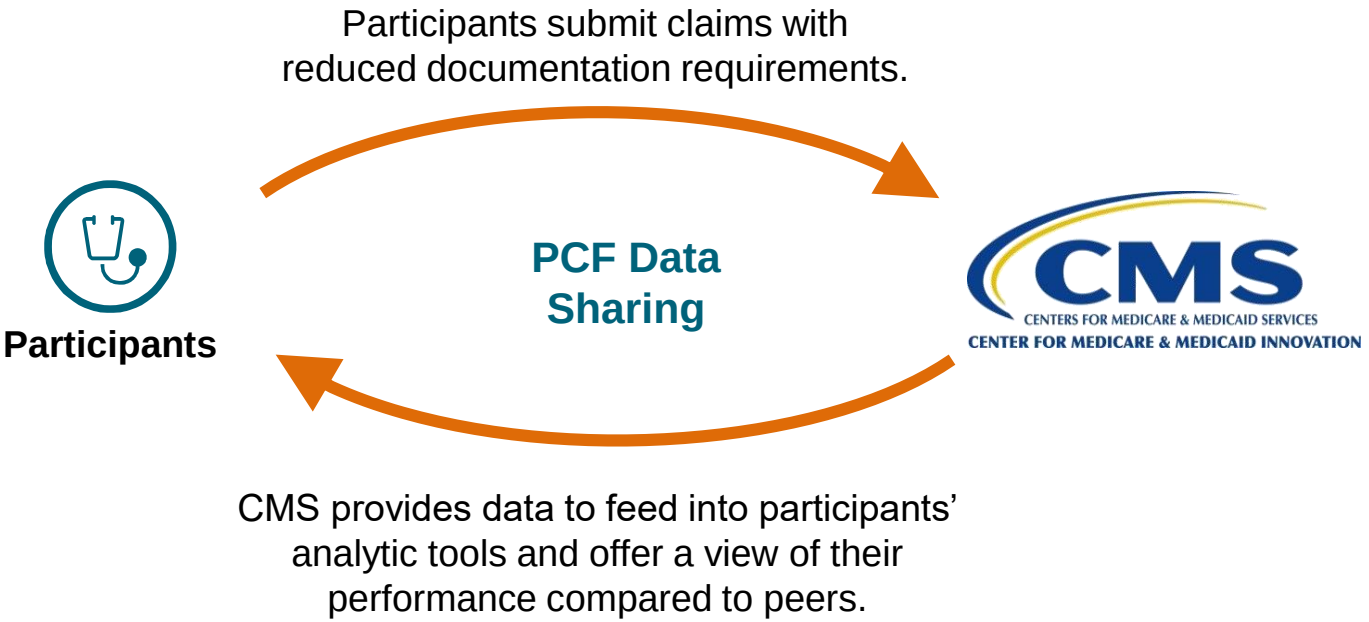


# PCF Comprehensive Primary Care Interventions

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

# PCF Data Sharing

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



# PCF Payment Model Option Emphasizes Flexibility & 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** up to 50% of revenue and a 10% downside, based on a single outcome measure, with focused quality measures

# PCF Payment Model Option Components

**Total Medicare payments**

**Total primary care payment** + **Performance-based adjustment**

Professional Population-Based Payment

Flat Primary Care Visit Fee

Opportunity for practices to **increase revenue by up to 50%** of their total primary care payment based on key performance measures, including acute hospital utilization (AHU).

1. National adjustment
2. Cohort adjustment
3. Continuous improvement adjustment

# Total Primary Care Payment (TPCP)

The 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 within a practice.

| Practice Risk Group | Payment *(per beneficiary per month*)* |
|---|---|
| **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 that reduces billing and revenue cycle burden.

**$40.82**

**per face-to-face encounter**

*Payment amount does not include copayment or geographic adjustment*

These payments allow practices to:

- Easily predict payments for face-to-face care
- Spend less time on billing and coding and more time with patients

* PBPM = Per Beneficiary Per Month

# Overview of Performance-Based Payment Adjustments

**Did the practice meet the annual quality benchmarks (i.e., Quality Gateway)?**

*Note: this begins in year 2, based on year 1 performance**

**No** →

**0% or -10%**

**Performance Based Adjustment**

*For year 2, PBA will be 0% or -10%, based on AHU measure performance; years 3-5, PBA is automatically -10%*

**Yes** ↓

**Is practice performance above the 50th percentile of the national Acute Hospital Utilization (AHU) benchmark?**

**Yes** →

| AHU Measure Performance | TPCP Adjustment |
|---|---|
| Top 10% of regional practices | 34% |
| 11-20% of regional practices | 27% |
| 21-30% of regional practices | 20% |
| 31-40% of regional practices | 13% |
| 41-50% of regional practices | 6.5% |
| 51-75% of regional practices | 0% |
| Bottom 25% of regional practices | -10% |

**No** ↓

## 1 Regional Adjustment

**Top 75% of PCF practices on AHU?**

**No** → **-10% Adjustment**

**Yes** → **0% Adjustment**

**Does the practice's AHU performance compared to their performance last year achieve the continuous improvement target?**

**Yes** →

| AHU Measure Performance | TPCP Adjustment |
|---|---|
| Top 10% of regional practices | 16% |
| 11-20% of regional practices | 13% |
| 21-30% of regional practices | 10% |
| 31-40% of regional practices | 7% |
| 41-50% of regional practices | 3.5% |
| 51-75% of regional practices | 3.5% |
| Bottom 25% of regional practices | 3.5% |

**No** → **0% Adjustment**

## 2 Continuous Improvement Adjustment

* Performance-based adjustments in year 1 are based on performance on the AHU measure only and does not follow the above process.

# Performance-Based Adjustment – Quality Gateway and National AHU

In **Year 1**, adjustments are determined based on **acute hospital utilization (AHU)** alone.
In **Years 2-5**, adjustments are based on performance as described below.

**Did the practice exceed the Quality Gateway?**

**No**

**0% or -10%**
**Adjustment**
Depends on year and/or AHU performance;
*Note: still eligible for continuous improvement adjustment if Quality Gateway exceeded*

**Yes**

**Is practice performance above the 50th percentile of the national Acute Hospital Utilization (AHU) benchmark?**

**No**

Adjustments may be from -10% to 50% of total primary care payment determined by comparing performance to three different benchmarks:

1. Regional adjustment
2. Continuous improvement adjustment

**Yes**

# Performance-Based Adjustment – Regional Adjustment

## 1 Regional adjustment

Practices that exceed the 50th percentile AHU minimum benchmark will earn an adjustment based on how they perform relative to regional practices

**Top 75% of the regional reference group?**

**No**

**-10%**
**Adjustment**
(*still eligible for continuous improvement bonus*)

**Yes**

| AHU Regional Performance Level | Regional Adjustment |
|---|---|
| Top 10 percentile of regional practices | **34%** of Total Primary Care Payment |
| 11-20 percentile of regional practices | **27%** of Total Primary Care Payment |
| 21-30 percentile of regional practices | **20%** of Total Primary Care Payment |
| 31-40 percentile of regional practices | **13%** of Total Primary Care Payment |
| 41-50 percentile of regional practices | **6.5%** of Total Primary Care Payment |
| 51-75 percentile of regional practices | **0%** of Total Primary Care Payment |

# Performance-Based Adjustment – Continuous Improvement Adjustment

## 2 Continuous improvement adjustment

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.

| Acute Hospital Utilization (AHU) Regional Performance Level | Potential Improvement Bonus |
|---|---|
| Top 10 percentile of regional practices | **16%** of Total Primary Care Payment |
| 11-20 percentile of regional practices | **13%** of Total Primary Care Payment |
| 21-30 percentile of regional practices | **10%** of Total Primary Care Payment |
| 31-40 percentile of regional practices | **7%** of Total Primary Care Payment |
| 41-50 percentile of regional practices | **3.5%** of Total Primary Care Payment |
| 51-75 percentile of regional practices | **3.5%** of Total Primary Care Payment |
| Practices performing in the bottom quartile of their region | **3.5%** of Total Primary Care Payment |

# PCF Quality Measures

The following measures will inform performance-based adjustments and assessment of model impact.

| Measure Type | Measure Title | Benchmark |
|---|---|---|
| **Utilization Measure for Performance-Based Adjustment Calculation** (Year 1-5) | **Acute Hospital Utilization** (AHU) (HEDIS measure)<br>**Total Per Capita Cost** (TPCC) for Groups 3, 4 and SIP | Non-CPC+ reference population |
| **Quality Gateway (**starts in Year 2) | **CPC+ Patient Experience of Care Survey** (modernized version of CAHPS) | MIPS |
| | **Diabetes: Hemoglobin A1c** (HbA1c) **Poor Control** (>9%) (eCQM)[1] | MIPS |
| | **Controlling High Blood Pressure** (eCQM) | MIPS |
| | **Care Plan** (registry measure) | MIPS |
| | **Colorectal Cancer Screening** (eCQM)[1] | MIPS |
| **Quality Gateway** for practices serving high-risk and seriously ill populations[1] | To be developed during model, domains could include 24/7 patient access and days at home | |

1. The following measures will apply to practices in Practice Risk Groups 3 or 4: Total Per Capita Cost for Utilization; Care Plan and CPC+ Patient Experience of Care Survey for the Quality Gateway. Other quality measures may be developed as discussed above.

# Seriously Ill Population (SIP)

# Seriously Ill Population Model Option

PCF incorporates the following unique aspects for practices electing to serve seriously ill populations to increase access to high-quality, advanced primary care.

## Eligibility and Beneficiary Attribution

Practices demonstrating relevant capabilities **can opt in to be assigned SIP patients or beneficiaries** who lack a primary care practitioner or care coordination.

Medicare-enrolled clinicians who provide **hospice or palliative care can partner** with participating practitioners.

## Payments

Payments for practices serving seriously ill populations:

| First 12 Months |
| --- |
| ▪ One-time payment for first visit with SIP patient: **$325 PBPM** |
| ▪ Monthly SIP payments for up to 12 months: **$275 PBPM with $50 withhold** |
| ▪ Flat visit fees: **$40,** plus coinsurance and geographic adjustment |
| ▪ Quality payment: up to **$50 PBPM** |

# The SIP Model Option Seeks To Address Fragmented Care Among High-Need Patients

The seriously ill population (SIP) is expected to account for roughly **2% to 3%** of Medicare beneficiaries.

**The SIP component seeks to improve care for high-need patients by addressing:**

### Fragmented, siloed care

- Poor care coordination
- Difficulty navigating care plan
- Undesired or unnecessary treatments

### Lack of care management

- Frequent visits to hospitals, skilled nursing facilities, and specialists' offices
- Frequent complications
- Increased caregiver dependency

*Which may lead to…*

**High healthcare costs, low quality, and low patient satisfaction**

# SIP Beneficiary Identification

## SIP Patient Criteria

CMS will use claims data to identify beneficiaries in designated service areas who meet **both** of the following criteria:

1. **Serious illness, defined as at least one of the following characteristics:**
   - Have significant chronic or other serious illness (defined as a Hierarchical Condition Category [HCC] risk score ≥ 3.0)
   - Have an HCC risk score greater than 2.0 and less than 3.0; AND two or more unplanned hospital admissions in the previous 12 months.
   - Show signs of frailty, as evidenced by a durable medical equipment (DME) claim submitted to Medicare by a provider or supplier for a hospital bed or transfer equipment.
2. **Fragmented pattern of care, defined as at least one of the following criteria:**
   - Proportion of evaluation and management (E&M) visits with a single practice
   - Emergency Department (ED) visits and hospital utilization patterns over the previous 12 months

Participating practices may also receive, on a limited case-by-case basis, referrals of SIP beneficiaries not identified by claims data. More information can be found in the RFA, as well as in a SIP Part 3 webinar in 2020.

# Eligibility Requirements for the SIP Payment Model Option

Practices receiving **SIP-identified patients** must provide:

- An interdisciplinary care team that includes physician/nurse practitioner, care manager, registered nurse (RN), and social worker (optional team members include behavioral health specialist, pharmacist, community services coordinator, and chaplain)
- Comprehensive, person-centered care management ability, including ability to assess social needs of patients
- Relationships with community and medical resources and support in the community to help address social determinants of health, medical, and behavioral health issues
- Wellness and healthcare planning as part of management of SIP patients
- Family and caregiver engagement
- 24/7 access to a member of the care team

# SIP Practice Journey

## Practice A

- **Quality Outcomes:** At the end of PCF Performance Year 1, average SIP attribution for the practice was 7.8 months and transition success rate was 75%; Exceeded 70% on all quality measures – earns $50 bonus.
- In the example, Tom exceeds the practice average length of stay (LOS) and the practice is paid for each month that Tom is aligned to the program.

| January | February | March-September | October | November | December-PY2 |
|---|---|---|---|---|---|
| Receives list of new SIP patients, including Tom | Conducts first face-to-face visit | Delivers comprehensive care coordination | Tom's care stabilizes; Practice A plans Tom's transition out of SIP | Transitions Tom out of SIP within Practice A; Notifies CMS | Tom receives care under PCF-General |

SIP PBPM payment reverts to practice's professional PBP for a non-SIP patient

**Initial face-to-face visit**

**$325**

**Monthly payment**
($275 - $50 withhold) x 9 months= **$2,025**

**Flat visit fee**
$40.82 x 10 visits= **$408.20**

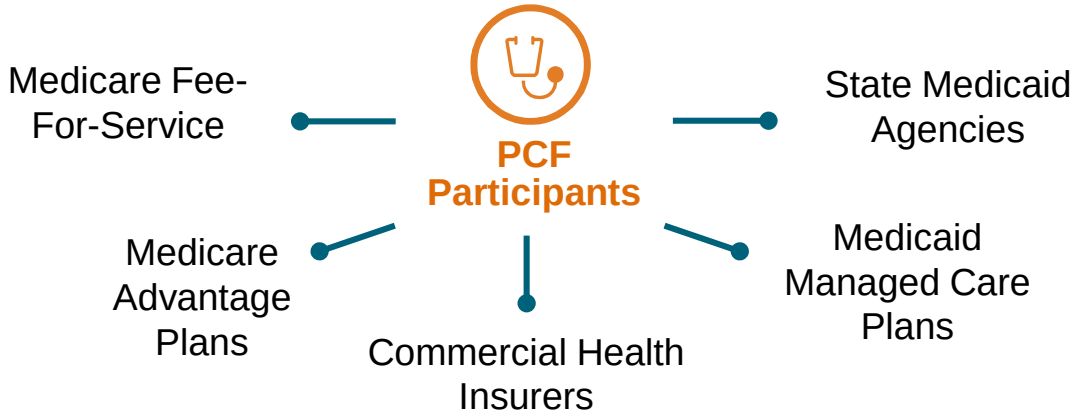
**Quality Adjustment**
($50 x 9 months return of withhold) + ($50 x 9 months bonus) = **$900**

**Approx. PBPM for Tom**: $3658.20 /10 months **= $365.82**

# PCF Multi-Payer Participation

# CMS is Committed to Partnering with Aligned Payers in Selected Regions

In PCF, CMS will encourage other payers to engage practices on similar outcomes. **CMS is soliciting interested payers starting in winter 2019.**




**Multi-payer alignment promotes:**

- An alternative to fee-for-service payments
- Performance-based incentive opportunity
- Practice- and participant-level data on cost, utilization, and quality
- Alignment on practice quality and performance measures
- Broadened support for seriously ill populations

# PCF Principles for Payer Solicitation

CMMI is seeking to partner with payers who are **aligned to PCF's core model principles**, which include:

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

For each of the above principles, this presentation **will define what would be deemed "preferred alignment"**. Please refer to the Payer Rubric on the PCF website for what would qualify as "acceptable alignment" or "not sufficient alignment".

# Evaluation Domains for Payer Alignment

CMS will evaluate payer proposals based on prospective partners' alignment to the following domains:

| Payment | Quality | Data | Collaboration |
|---|---|---|---|
| Reimburse practices through **an alternative to traditional fee-for-service (FFS)**, such as a population-based payment | Implement **performance-based payments** that reward high performance on quality and utilization outcome measures | Share data on **cost, utilization, and quality** to support continuous learning and improvement | Participate in multi-payer collaborative activities, including goal setting **for regional multi-payer collaboration and alignment** |

This presentation will be **divided into sections by the above domains** and will review important information your organization should consider when determining your alignment to PCF core model principles.

# Alignment to PCF Principle 1: Transitioning Towards Value-Based Care

We will first review the PCF payment methodology and alignment criteria associated with the first PCF principle:

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

# Preferred Alignment for Payment Approach

CMS encourages states to design an aligned payment model that meets the following “preferred alignment” criteria, as possible:

**Minimize Fee-For-Service**

Partial primary care capitation with **more than 50% of revenue reimbursed** through capitated or other non-visit-based payment

*OR*

**Full primary care capitation**

**Risk Adjustment**

Alternative to fee-for-service payment is risk adjusted to account for factors including but not limited to **health status and patient demographics**

# Alignment to PCF Principle 2: Incentivizing Improved Health Outcomes

Next, we will review PCF quality measures and alignment criteria associated with the second PCF principle:

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

# Preferred Alignment for Quality Structure

CMS encourages states to design a model that meets the following "preferred alignment" criteria for quality, as possible:

**Reimburse Outcomes, Not Process**

Performance-based payment tied to **outcomes:**

- Clinical Quality
- Patient Experience
- Health Improvement
- Costs and/or Utilization Measures
- Total-Cost-Of-Care

**Substantial Impact on Payment**

- Performance-based payment adjustment can increase practices' primary care revenue **by more than 15%**
- Performance can both **increase and decrease payment**

**Align Measures**

- Payer uses **the same quality and utilization measures** as PCF to evaluate practice performance
- Payer uses few or **no additional measures** beyond the PCF measure set

# Alignment to PCF Principle 3: Using Data-Driven Insights to Improve Care Delivery

We will now review PCF data sharing and alignment criteria associated with the third PCF principle:

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

# Preferred Alignment for Data Sharing

CMS encourages states to design a model that meets the following “preferred alignment” criteria, as possible:

**Attribution**

- Receive list of **prospectively attributed members** at least monthly

**Data Type and Format**

- Provide **beneficiary-level utilization and cost of care data** for attributed members **at least quarterly**
- Data is delivered in **user-friendly formats** and can be exported into electronic formats for analysis
- Data is accompanied by tailored **support and guidance**

**Regional Aggregation**

- Participate in or actively work towards participating in **regional data aggregation,** which provides multi-payer data in a single platform

# Alignment to PCF Principle 4: Collaborating with Other Payers to Drive Model Success

We will now review alignment criteria associated with the fourth PCF principle:

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

# Preferred Alignment for Collaboration Alignment

CMS encourages states to design an aligned payment model that meets the following “preferred alignment” criteria, as possible:

**Collaboration**

- Participate in and contribute to PCF-related **regional multi-payer collaborative activities**
- **Set and progress toward annual goals** for regional multi-payer collaboration and alignment

**Transparency**

- **Share information about non-payment related topics** with CMS and other payers to inform payer alignment and collaboration activities

**Reasonable Eligibility Criteria**

- Set **reasonable eligibility criteria** that enable participating PCF practices in their region to participate in the payer’s PCF-aligned model

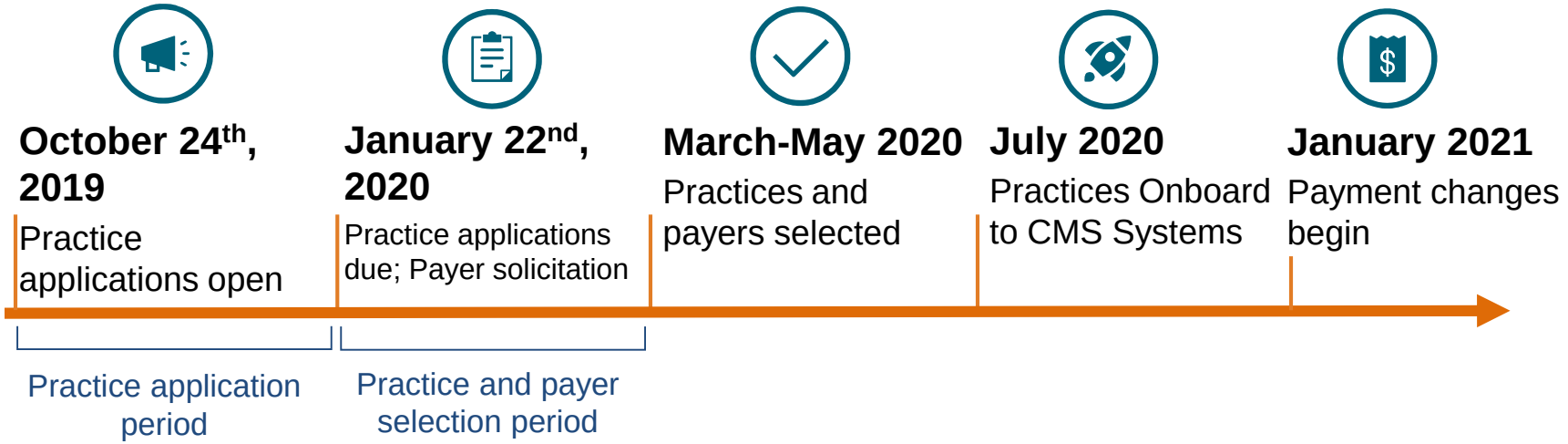
# What are the benefits of participation?

# Benefits for Participating Practices

- **Less administrative burden and more flexibility** so providers can spend more time with patients and deliver care based on patient needs
- **Ability to increase revenue** with performance-based payments that reward participants for easily understood primary care outcomes
- **Enhanced access to actionable, timely data** to inform your care transformation and assess your performance relative to peers
- **Focus on single outcome measure** that matters most to patients: acute hospital utilization
- **Opportunities** for practices that specialize in complex, chronic patients and high need, seriously ill populations
- **Potentially become a Qualifying APM Participant** by practicing in an Advanced Alternative Payment Model

# How do I apply to participate?

# Primary Care First Practice Solicitation

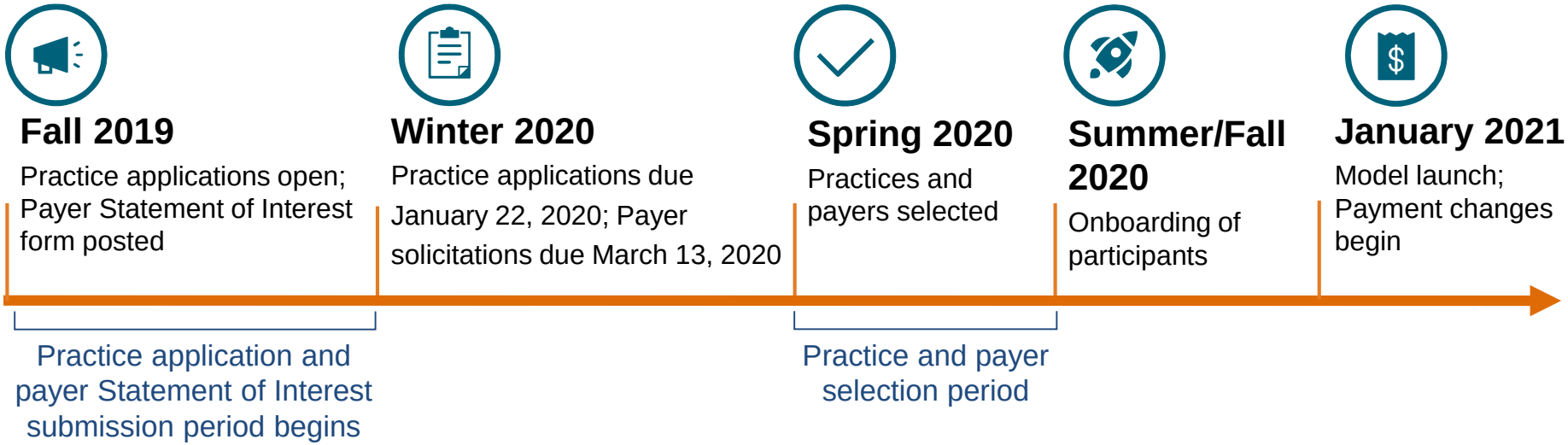



**Prepare for model application release by confirming your organization's eligibility and willingness to participate today. Join our listserv for updates on application release.**

# Primary Care First Payer Solicitation

**The PCF Payer Portal is live December 9th!**

Please complete your PCF payer proposal by **March 13, 2020.**




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

# Questions?

# 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/

## Call

1-833-226-7278

## Follow

@CMSinnovates

## Email

PrimaryCareApply@telligen.com

## Subscribe

Join the Primary Care First Listserv

## Apply

Read the Request for Applications (RFA) here

Read the Payer Rubric here

# Stakeholder Feedback Informed Primary Care First Model Changes

CMS has made the following changes to the model based on stakeholder feedback:

## Model Timeline

- **Application timeline:** Practice applications will be accepted through January 22, 2020. Payers may submit a Statement of Interest through December 6, 2019 and a formal proposal for partnership from December 9, 2019-March 13, 2020.
- **Model Launch:** Participant onboarding will take place July-December 2020. The model performance period and payments will begin in January 2021.

## SIP Payment Option

- **Patient Transition:** SIP providers will create a transition plan and conduct a warm handoff to a provider/practice that meet PCF standards for longer-term care.

## Model Payments

- **Population-Based Payment:** See new payment amounts below:

| Practice Risk Group | Payment *(PBPM)* |
|---|---|
| **Group 1:** HCC <1.2 | **$28** |
| **Group 2:** HCC 1.2-1.5 | **$45** |
| **Group 3:** HCC 1.5-2.0 | **$100** |
| **Group 4:** HCC >2.0 | **$175** |

- **Performance-Based Adjustment:** Assessment based on acute hospital utilization performance against a regional benchmark of similar practices

**The Request for Applications (RFA)** reflects all updates to the Primary Care First Model. Please reference the RFA for complete information and details.