



## ACP Primary Care First Fact Sheet

The Centers for Medicare & Medicaid Services (CMS) [announced](#) the Primary Care First (PCF) Model in April 2018. In October 2019, it posted the [Request for Applications](#) (RFA) and opened the [application portal](#) for practices interested in a Jan. 1, 2021 start date, applications for which are due Jan. 22, 2020. This fact sheet will be updated as more details are made available.

**What is it?** A voluntary, multi-payer five-year payment model that offers enhanced payments to support advanced primary care services. Practices receive larger payments for treating more complex patients and can opt into a dedicated track for seriously ill populations (SIPs). Practices may participate in the SIP track, general track, or both.

**When will it start?** Round 1 will start in 2021 and run through 2026. A second round for current CPC+ practices only will start in 2022 and run through 2027.

**Will PCF qualify as an Advanced Alternative Payment Model (APM)?** PCF is expected to qualify as a Medicare Advanced APM. Additionally, for any private payers that participate, it would count as an Other Payer Advanced APM towards the All Payer Combination Threshold. Practices must use Certified EHR Technology (CEHRT) to qualify, which is required of all Advanced APMs.

**Will it be available nationwide?** No. PCF will operate in 26 geographic regions, which includes 18 CPC+ regions plus 8 new regions (ME, NH, MA, CA, FL, DE, VA, AK). Practices in the Independence at Home demo may apply even if PCF is not offered in their region.

**How will CMS define a single participant?** Participation is defined at the “bricks and mortar” practice location. Each practice site must submit its own separate application.

**How do I apply?** Applications for a 2021 start date are due Jan. 22, 2020. These are not legally binding. Practices must sign a separate participation agreement.

**Will practices receive data?** Participants can request Medicare FFS expenditure, utilization, and care delivery data. Practices may request patient-identifiable and practice-level quarterly feedback reports, as well as regionally aggregated reports. Claims line feeds will be offered. CMS will encourage multi-payer data collaboration and aggregation to minimize burden.

**Are any waivers available under the model?** CMS intends to create waivers for practices to offer reduced copays or patient enhancements, such as transportation services, though such waivers have not yet been finalized.

**Model overlap:** PCF practices may not participate in concierge practices, Rural Health Clinics, Federally Qualified Health Centers, Method II Critical Access Hospitals, the Next Generation ACO Program, or the Comprehensive ESRD Care Model. PCF practices may participate in the Medicare Shared Savings Program and episode payment models. PCF payments would be included in shared savings/losses calculations and aggregate spending amounts for episodes of care, which would be prorated to account for overlapping time periods.

### Participation Requirements:

- Eligible clinicians are those that practice in internal medicine, general medicine, geriatric medicine, family medicine, and/or hospice and palliative medicine.
- To qualify, practices must:
  - Provide PC services to 125+ Medicare patients at location (*20 patients for SIP-only*).
  - Have experience with value- or performance-based payment arrangements.
  - Meet 2015 CEHRT and other Health IT criteria (*SIP-only practices have until 2nd year*).
  - Meet advanced primary care delivery capabilities described in RFA.
  - Have PC services account for 70%+ of collective revenue (*SIP-only practices excluded*).
- SIP practices must provide hospice or palliative care services and can partner with a participating primary care practice or participate directly.
- Practices in risk groups 3-4 and those in the SIP track must demonstrate advanced competencies and relevant clinical capabilities for managing complex patients.

### Patient Attribution:

**General Track:** PCF will prioritize voluntary patient attribution via MyMedicare.gov. If a patient does not voluntarily align with a clinician, CMS will look at the most recently billed Annual Wellness or Welcome to Medicare visit. If one of those was not billed, CMS will use a plurality of eligible primary care and chronic care management services in the last 24 months (ties broken by most recent service). Attribution is prospective; updated quarterly.

**SIP Track:** SIP practices indicate their service area and maximum number of SIP patients they can manage when they apply. SIP patients must show signs of serious illness and fragmented care. CMS proactively identifies patients and assigns them to the closest SIP practice. On a limited basis, CMS will allow SIP practices to identify and refer patients for participation (though these may not be existing patients). SIP practices will be provided with an updated list of SIP-eligible patients on a monthly basis. SIP practices have up to 60 days to contact the patient once assigned but are encouraged to do so as soon within the first 24 hours or as soon as possible. Patients are formally attributed after initial in-person visit. Patients become unattributed if: 1) they decide to opt out; 2) they transition out; 3) they begin hospice care; 4) they move out of an SIP practice's service area; or 5) they die. Default attribution lasts 12 months but practices are incentivized to maintain an average attribution of 8 months. In limited cases, they may apply for attribution exceeding 12 months.

### Quality Gateway:

To qualify for a positive Performance Based Adjustment (PBA), practices must meet or exceed average national performance thresholds for a set of quality measures. This is known as the Quality Gateway. Quality performance affects payments the following year. Accordingly, the Quality Gateway will first take effect in performance year (PY) 2 based on performance in year 1. Practices are evaluated on pre-selected set of measures that depends on whether the practice is in the SIP Track and which risk group they fall into (see below).

**Figure A: Quality Gateway Measures for Practices in Risk Groups 1-2**

Measure Title	MIPS Quality ID	NQF ID
Patient Experience of Care Survey	321	0005
Diabetes: Hemoglobin A1c Poor Control (>9%)	001	0059
Controlling High Blood Pressure	236	0018
Advance Care Plan	47	0326
Colorectal Cancer Screening	113	0034

**Figure B: Quality Gateway Measures/Phase-In for Practices in Risk Groups 3-4 and SIP Track**

Measure Title	Performance Year
Advance Care Plan (QID 47)	1
MIPS Total Per Capita Cost	1
CAHPS Measure	2
Days at Home (under development)	Tentatively 3
24/7 Access to a Practitioner (under development)	Tentatively 3

**Payment:**

- **Total Primary Care Payment (TPCP).** Comprised of:

**Professional Population-Based Payment (PBP).** Paid in lump sum on a quarterly, prospective basis based on total number of assigned patients. All patients are paid at same rate based on practice’s risk group, which is determined by average population-level Hierarchical Condition Category (HCC) score. Practices will receive preliminary risk group information prior to signing participation agreements. Adjusted geographically and by percent of services received outside practice (i.e. leakage rate). No coinsurance.

Group 1: \$28	Group 2: \$45	Group 3: \$100	Group 4: \$175
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**Flat Primary Care Visit Fee.** Per face-to-face encounter. Geographically adjusted. \$40.82 on average. Coinsurance billed at 20% of PFS allowed amount, or the practice can decide to waive. Includes Annual Wellness Visits and applies to relevant telehealth services. PCF practices may not separately bill for chronic care management services.

**Figure C: Services Paid Under the Flat Primary Care Visit Fee**

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

- Performance-Based Adjustment (PBA).** If a practice satisfies Quality Gateway requirements, they become eligible for a positive PBA, which kicks in starting in quarter 3 of performance year 1. The PBA adjusts the PBP by a factor ranging from -10% to +50% based entirely on acute hospital utilization (AHU). It is calculated on a quarterly basis based on a rolling one-year look-back period and is comprised of two parts:

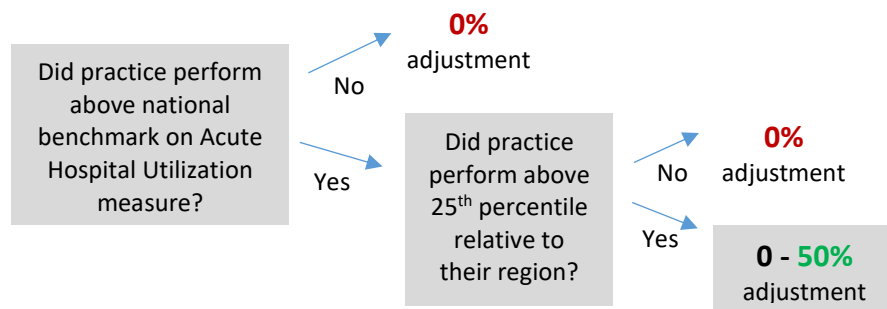
**Regional Performance Bonus.** How AHU performance compares to other regional primary care practices (PCF and non-PCF). Ranges from 0% to 34% in PYs 1-2 and -10% to 34% in PYs 3-5. Practices must surpass the national benchmark and 25<sup>th</sup> regional percentile for the AHU measure to qualify for a positive regional performance bonus.

**Continuous Improvement Bonus.** Performance relative to prospective target determined by individual practice’s performance on AHU measure in preceding year. Ranges from 0% to +16%. Practices are eligible for the improvement bonus even if they do not surpass the national benchmark or 25<sup>th</sup> percentile relative to their region.

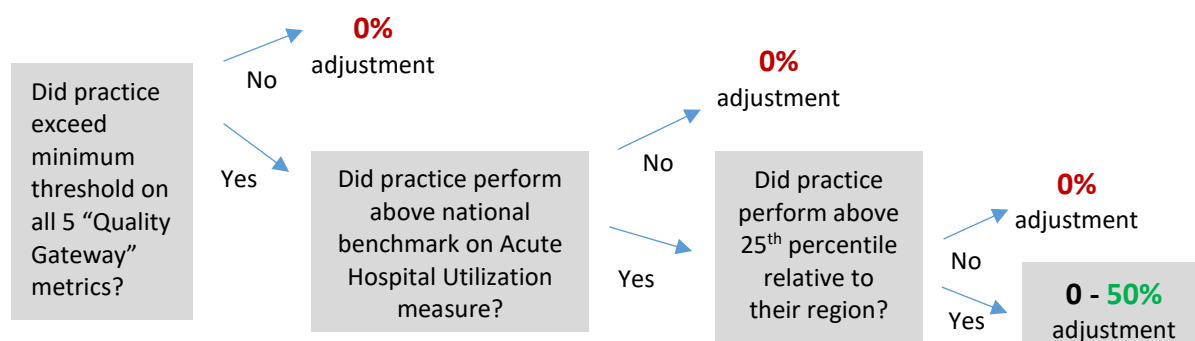
**Figure D: Implementation Schedule for Quality Gateway and Performance Based Adjustment**

PY 1 - Quarters 1&2	PY 1 - Quarters 3&4	PY 2	PY 3 Onward
<ul style="list-style-type: none"> <li>No Quality Gateway</li> <li>No PBA</li> </ul>	<ul style="list-style-type: none"> <li>No Quality Gateway</li> <li>PBA kicks in; ranges from 0% to 50%</li> </ul>	<ul style="list-style-type: none"> <li>Quality Gateway starts based on PY 1</li> <li>PBA ranges from 0% to 50%</li> </ul>	<ul style="list-style-type: none"> <li>Quality Gateway based on PY 2</li> <li>PBA ranges from -10% to +50%</li> </ul>

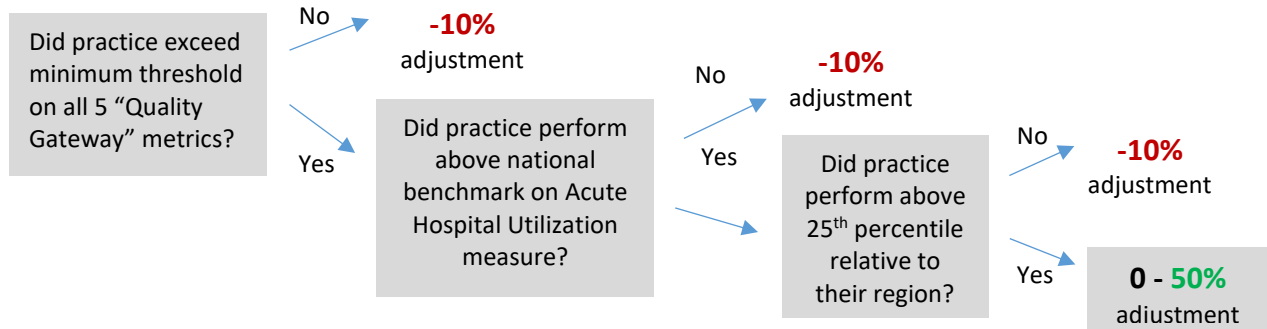
**Figure E: Regional Performance Bonus for Performance Year 1 (Q 3-4)**



**Figure F: Regional Performance Bonus for Performance Year 2**



**Figure G: Regional Performance Bonus for Performance Years 3-5**



**Figure H: Performance-Based Adjustments**

Performance compared to other primary care practices in their region	Continuous Improvement Bonus	Regional Performance Bonus	Total PBA
Top 10%	16%	34%	50%
Top 11-20%	13%	27%	40%
Top 21-30%	10%	20%	30%
Top 31-40%	7%	13%	20%
Top 41-50%	3.5%	6.5%	10%
51-75%	3.5%	0%	3.5%
Bottom 25%	3.5%	-10%	-6.5%

**Payments under the SIP Track:**

**Initial One Time Payment (\$325)** Paid after first face-to-face visit with each patient, which must occur within 60 days of assignment. Flat visit fee may not be billed concurrently, but may be billed for subsequent visits.

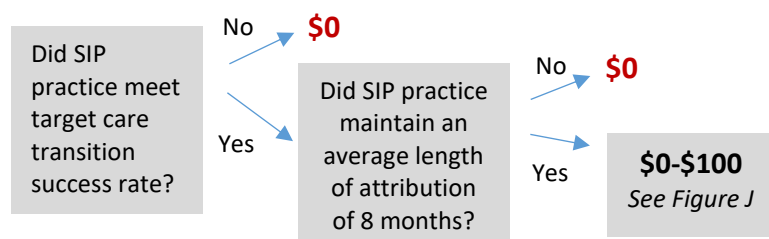
**Per Beneficiary Per Month (PBPM) Base Rate (\$225)** Calculated monthly, paid quarterly. Geographically adjusted. Begins month after initial face-to-face visit. Ends when patient is unattributed (see Patient Attribution).

**Quality Adjustment (up to \$100)** Practices retroactively receive a geographically-adjusted lump sum payment equivalent to up to \$100 PBPM for the performance year. To qualify for any end-of-the-year payment, SIP practices must:

- Meet their target Care Transition Success Rate (e.g. share of SIP patients with zero hospitalizations or ED visits in the 3 months following their transition out of SIP track).
- Maintain an 8-month annual average length of attribution for SIP patients.

Practices that satisfy both requirements will have their quality adjustment calculated based on quality performance on Quality Gateway measures.

**Figure I: SIP Quality Adjustment Eligibility Criteria**



**Figure J: SIP Quality Adjustment Amounts**

Score Relative to Reference Population	Quality Adjustment Amount
≥70 <sup>th</sup> percentile	\$100
50 <sup>th</sup> -70 <sup>th</sup> percentile	\$50
<50 <sup>th</sup> percentile	\$0

### More on SIP Track

- Designed to support an intensive, time-limited intervention to stabilize seriously ill patients who lack adequate care management to avoid unnecessary hospitalizations and ED visits.
- SIP practices must: 1) proactively engage patients; 2) discuss care goals with patients; 3) develop/execute a care plan; and 4) facilitate a relationship with a long term care clinician.
- Practices must have an in-person visit with patients at least once every sixty days.
- Intended to be temporary. Once a patient has been stabilized, the SIP practice transitions him/her to a long term care clinician at the same practice or an external practice.
- To transition a patient, the SIP practice must develop a transition plan, receive patient approval, establish a care agreement and transition plan with the patient’s long term care clinician, and help facilitate the transition, such as assist with making the first appointment. They must notify CMS of the transition, at which point elevated SIP payments would stop.

### Evaluation and Monitoring

Participants are subject to a program integrity screening and must submit cost, utilization, patient experience, and quality data to ensure patient safety and compliance. Audits will be performed on an ad hoc basis and will focus on improper payments and care stinting. Practices must retain documentation related to their PCF participation. For the SIP track, CMS will actively monitor claims during active attribution and post-transition to check for unusual billing patterns, active patient engagement, and adequate support during care transitions. Participants must cooperate with evaluation efforts by participating in surveys, interviews, site visits, and other activities. If 3,000+ eligible practices apply, CMS will randomly assign a small share of PCF practices to a control group. Control group practices will continue to be paid under the PFS as normal and scored under the MIPS APM scoring standard. They will receive \$5,000 for completing evaluation activities and may request access to Medicare claims data. For the SIP Track, CMS may similarly randomly assign a portion of SIP-eligible patients to a control group that would not be attributed to the model and would continue to be paid under FFS.

### Termination

Participation lasts 5 years. Practices that provide advance written notice of termination by Feb. 28 may terminate effective that date. Otherwise, they may terminate at the end of the year. Early termination may impact one’s ability to participate in future Innovation Center models.

- Visit the [CMS Primary Care First webpage](#) for additional information and resources. -