Primary Care First

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On April 22, 2019 the Centers for Medicare & Medicaid (CMS) announced its Primary Cares Initiative, which encompasses two new Alternative Payment Models (APMs) with five total tracks. This fact sheet overviews the Primary Care First (PCF) Model. For more information on the Direct Contracting Model, view our separate fact sheet. ACP will update this fact sheet as information evolves. Stay tuned to ACP's *Advocate Newsletter Archive*, *Advocate Blog*, and APMs practice resources webpage, and Quality Payment Program advocacy webpage for more ACP guidance and perspective.

- **What is it?** A voluntary, five-year payment model that is geared toward primary care practices and loosely based on elements of the Comprehensive Primary Care Plus (CPC+) Program.
- **When will it start?** Payments for the first round of applicants will begin in April 2020. CMS plans to solicit a second round of applicants to start in 2021. CPC+ participants must wait until 2021.
- **Will it qualify as an Advanced Alternative Payment Model (APM)?** Yes.
- **Will it be available nationwide?** No. The model will initially operate in 26 geographic regions, which includes the 18 CPC+ regions along with 8 new regions (ME, NH, MA, CA, FL, DE, VA, AK).
- **Is it a multi-payer model?** Yes. CMS plans to solicit other payers in summer/fall 2019.
- **What is the basic structure?** The model will feature two distinct tracks: 1) the Payment Model Option; and 2) the High Need Populations Payment Model Option, which is geared towards high need, seriously ill population (SIP) beneficiaries who lack a primary care practitioner and/or effective care coordination. Participants may choose to participate in either or both tracks.
- **How will CMS define a single participant?** Participation will be defined at the "bricks and mortar" practice location, similar to CPC+, with participating practitioners identified on a roster.
- **Will participants receive any data?** Participants will receive Medicare FFS expenditure and utilization data and Medicaid data, as available, on a quarterly basis at the NPI level.
- **Will CMS offer any waivers?** CMS is exploring offering certain beneficiary incentive, fraud and abuse, and payment waivers similar to those offered in CPC+ but nothing is finalized.
- **Can PCF participants also participate in the Medicare Shared Savings Program?** Yes. CMS will release more guidance with more information including how payments will be impacted.
- **Will patient cost sharing apply?** Yes. Services under the model will feature patient copays.
- **Are Federally Qualified Health Centers and Rural Health Centers eligible to participate?** No.
- **How do I apply?** Application materials and deadlines have not yet been made available. Notices of intent to apply (NOIA) will be due in late spring/early summer and applications will be due in the late summer/fall. NOIAs are non-binding but required to submit an application.

Payments:

PCF Payment Model Option participants will receive:

- ***Professional population-based payments*** for delivering advanced primary care services that will be risk-adjusted into five population-level risk tiers. Specific payment amounts are listed below on a per-beneficiary per-month (PBPM) basis from lowest risk (group 1) to highest risk (group 5).
  *Risk adjustment will be calculated annually based on the average patient population over a historic lookback period.

Group 1: $24	Group 2: $28	Group 3: $45	Group 4: $100	Group 5: $175

- ***Flat primary care visit fee*** of $50 per face-to-face patient encounter (geographically adjusted).
- ***Performance-based adjustment (PBA)*** with a maximum upside of 50% of their primary care payment (PCP) and a maximum downside of 10% of their PCP for the next applicable year.
  - In the first performance year, adjustments will be based on acute hospitalization alone.
  - In years 2-5, adjustments will be based on a combination of three factors:
    - National adjustment
    - Cohort adjustment (compared to other PCF participants)
    - Continuous improvement adjustment worth up to 1/3 of PBA

  See figures A and B below for more detail on the specific PBA amounts.

*Some infrequent primary care services will continue to be paid on a FFS basis.

High Need Population Payment Model Option Participants will receive:

- 1-time payment of $325 for 1st visit with every SIP patient
- Monthly payment of $275 for every SIP patient
- Flat fee of $50 for every visit
- Quality payment of up to $50

Figure A:

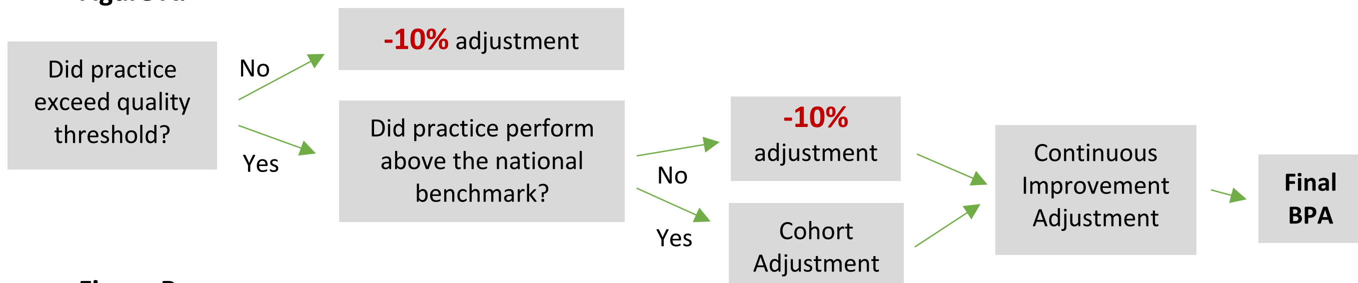

Figure B:

Performance (Compared to other PCF practices)	Cohort Adjustment	Potential Improvement Bonus	Min PBA	Max PBA
Top 10%	**34%**	**16%**	**34%**	**50%**
Top 11-20%	**27%**	**13%**	**27%**	**40%**
Top 21-30%	**20%**	**10%**	**20**	**30%**
Top 31-40%	**13%**	**7%**	**13%**	**20%**
Top 41-50%	**6.5%**	**3.5%**	**6.5%**	**10%**
Bottom 50% (above national benchmark)	**0%**	**3.5%**	**0%**	**3.5%**
Bottom 50% (below national benchmark)	**N/A**	**3.5%**	**-10%**	**-6.5%**

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Participation Requirements:

All practices must:

- Have some experience with value- or performance-based payment arrangements;
- Meet 2015 Certified EHR Technology (CEHRT) and other Health IT criteria; and
- Meet certain advanced primary care delivery capabilities.

In addition, PCF Payment Model Option practices must:

- Provide primary care services to at least 125 Medicare beneficiaries at a location; and
- Have primary care services account for 70% or more of the practice's collective revenue.
    - For multispecialty practices, this is based on primary care clinicians' combined revenue.

Practices participating in the SIP Option must:

- Demonstrate ability to manage complex patients
- Have a clinician network to meet long-term care needs
- Provide hospice or palliative care
- Be enrolled in Medicare

Patient Attribution:

- Voluntary alignment will be prioritized and supplemented with claims-based attribution based on annual wellness, welcome to Medicare, and chronic care management visits over a two-year lookback period.
- For the High Need Populations Option, practices can opt into being prospectively assigned SIP patients who lack a primary care practitioner or sufficient care coordination. They would then be responsible for reaching out to those patients to stabilize them and coordinate their care.
- SIP patients must: 1) lack primary care (i.e. receive less than 50% of E/M visits from the same clinician); and 2) be seriously ill (i.e. have an "extraordinarily high" HCC risk score, OR have an excess of two hospitalizations in the last year, OR have at least one claim for certain types of durable medical equipment in the last year, such as a hospital bed)

Quality:

- In the first year, the acute hospital utilization HEDIS measure will be the sole measure used to determine PBAs. It will be based on the non-CPC+ reference population.
- Starting in the second year, five additional MIPS measures will be added: CPC+ patient experience of care survey, diabetes hemoglobin A1c poor control, controlling high blood pressure, care plan, and colorectal cancer screening.
- Participants must meet minimum quality and experience of care thresholds to qualify for performance-based payments.
- PCF Payment Model Option practices will not have their PBAs adjusted based on quality performance, but those in the SIP Option will.
- SIP Option quality measures will be developed during the model.

Additional CMS Resources:

- CMS fact sheet
- Primary Care First CMS webpage
- CMS Primary Cares Initiative Press Release
- CMS model overview webinar slides