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CMMI Primary Care First
HFMA Overview

Summary: On April 22, 2019, the Center for Medicare and Medicaid Innovation (CMMI) announced its Primary Care First Model (PCF). The five-year model builds on CMMI's and providers' experiences with the Comprehensive Primary Care Plus (CPC+). This alternative payment model seeks to prioritize the doctor-patient relationship, enhance care for patients with complex chronic needs and high need, seriously ill patients, reduce administrative burden, and focus financial rewards on improved health outcomes. The goals of the model are to reduce Medicare spending by preventing avoidable hospitalizations and improving access and the quality of care for all beneficiaries. Similar to CPC+ and the Oncology Care Model (OCM), CMMI is seeking other purchasers to participate in the model to support primary care practice transformation.

Participation Options: The model offers three participation options.

1) *Option I*: Focuses on advanced primary care practices that are ready to assume limited financial risk in exchange for reduced administrative burden and performance-based payments. It provides higher payments for practices that care for more complex populations.

2) *Option 2*: Promotes care for high-need seriously ill population (SIP) beneficiaries who lack a primary care provider and/or effective primary care coordination. CMMI defines a SIP beneficiary as one with a high hierarchical condition category (HCC) score or at least two non-elective hospitalizations or high durable medical equipment spend. They also have less than 50% of their evaluation and management visits from one primary care provider. Practices that participate in Option 2 must include clinicians that are certified to provide palliative or hospice care. They must also have a "network of providers in the community to meet patients' long-term care needs."

3) *Option 3*: Allows practices to participate in both models. However, providers that participate in both options must meet the participation requirements for both.

CMMI is also seeking purchaser partners in the PCF regions to develop aligned models. Similar to CPC+ and the OCM, these partners might include Medicare Advantage plans, commercial insurers, state Medicaid agencies, and Medicaid managed care plans. CMMI states the advantages of poly-purchaser models includes providing an alternative to fee-for-service payments, increasing practices' performance-based incentive opportunities, increasing access to practice and participant level data on cost, quality, and utilization, improving alignment on practice quality and utilization measures, and broadened support for seriously ill populations[1]. CMMI will solicit payer participation during the summer of 2019.

Payment Model: PCF offers Option 1 participants a three-pronged payment model that aims to decrease the incentives for providers to unnecessarily see beneficiaries in their practices, allow for care model innovation, and reward reductions in avoidable hospitalizations, while improving quality across five selected measures.

[1] Note: As of 4/30/19 it is unclear if CMMI will require participating payer partners to adopt a similar payment model (e.g. partial capitation with bonus opportunities) or will accept other risk sharing structures.

1) *Per Member Per Month Payment*: Participating practices will receive a per member per month (PMPM) payment for each attributed beneficiary. The payments will be adjusted based on the average risk profile of the practice's attributed panel, and will be the same for all patients within the practice. The payment will cover services provided both inside and outside the office. Appendix I details the payment amount by risk tier. The HCC scores will be based on a historical period, not current year data.

2) *Flat Visit Fee*: To ensure that beneficiaries have access to office visits, PCF offers a flat $50 per visit payment. The flat payment will be geographically adjusted. Providers will need to bill to receive the payment. CMMI states that the administrative burden will be lower in billing for this payment compared to traditional FFS payments.

3) *Performance Based Payments*: The model includes risk-based performance payments that range from a -10% reduction to a 50% increase in the practices primary care payments (PMPM payment) for the following year. The payment determination is based on a participating practice's performance on selected hospital utilization measures compared to national, PCF cohort, and the participant's own historical performance. In the first year, the payments will be based on hospital utilization alone[2]. In the second and subsequent years, the bonus payment will be based both on hospital utilization and five quality metrics (described below).

   The calculation of the bonus is a multi-step process. The first determination is whether the practice's performance on a select set of quality measures is above a national reference group threshold of the lowest quartile. If the practice did not exceed the threshold, its primary care payments for the next applicable year would be reduced by 10%. This "gateway" begins in year 2.

   If the practice's hospital quality is above the threshold, it is eligible for a cohort adjustment. To determine the cohort adjustment, the practices performance is compared against other PCF participants. Those in the bottom half of the distribution receive no adjustment. Those in the top half of the distribution are eligible for a sliding scale increase in their total primary care payments (Appendix II) of up to 2/3 of the total bonus amount (up to 34% of total primary care payments).

   The remaining 1/3 of the bonus (up to 16% of total primary care payments) is determined based on the practice's continuous improvement compared to historical data. Appendix III provides the sliding scale performance-based distribution.

The PMPM and flat per visit payments are designed to be roughly equivalent to historical FFS payments for participating practices.

Participants in Option 2 will receive a one-time payment for the first SIP visit of $325. This is to account for the additional cost the practice incurs recruiting the patient. For the first 12 months, the practice will also receive monthly payments of $275, a geographically adjusted $50 fee for each office visit, and a quality payment of up to $50. Option 2 participants are also eligible for performance-based bonuses.

[2] Note: It is unclear if participants in the model's bonus payments for 2020 will be based on current utilization.

Additionally, physicians participating in PCF can qualify for the Advanced Alternative Payment Model 5% bonus if they meet the necessary revenue or volume requirements.

Quality Measures: The following measures will be used to inform performance-based adjustments and assess the model's impact.

Measure Type	Measure Title	Benchmark
Utilization Measure for Performance Based Adjustment Calculation (Year 1 – 5)	Acute Hospital Utilization (AHU) (HEDIS Measure)	Non-CPC+ Reference Population
Quality Gateway (Year 2)	CPC+ Patient Experience of Care	MIPS
Quality Gateway (Year 2)	Diabetes Hemoglobin A1C Poor Control (>9%) (eCQM)	MIPS
Quality Gateway (Year 2)	Controlling High Blood Pressure (eCQM)	MIPS
Quality Gateway (Year 2)	Care Plan (registry measure)	MIPS
Quality Gateway (Year 2)	Colorectal Cancer Screening (eCQM)	MIPS
Quality Gateway for practices serving high-risk and seriously ill populations	To be developed during the model. Domains could include 24/7 access and days at home.	TBD

Data: Participants will receive access to data to assess the relative performance of their peers and drive care improvements. Practices can request claims data feeds and "actionable" feedback reports. These reports will provide drill downs into emergency department visits and other high-cost services. CMMI will also provide specific sub-specialty reports to help participating practices identify high-quality, cost-efficient sub-specialists to help inform patient referrals.

Attribution: The attribution methodology will prioritize voluntary alignment over receipt of services (claims-based models). The attribution precedence rules in the PCF models are as follows: 1) Voluntary through the beneficiary portal; 2) receipt of Annual Wellness Visits or Welcome to Medicare visits; 3) plurality of primary care visits over the prior two years.

Participation Requirements: Eligible applicants are primary care practices that:

- Are located in one of the 26 selected Primary Care First regions for a 2020 start date (Appendix IV). Current CPC+ participants cannot begin participating until January 2021.
- Include primary care practitioners (MD, DO, CNS, NP, and PA), certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine.
- Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at a particular location[3]
- 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

[3] Participants in Option 2 (Seriously Ill Populations) do not need to meet the minimum beneficiary requirements.

payments, and episode-based payments, and/or alternative to fee-for-service 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 patients to a practitioner or care team. (Appendix V)
- Can meet the requirements of the Primary Care First Participation Agreement

CMS has stated that it will define a practice as the collection of National Provider Identifier at a given practice location. It appears that this definition will allow some health system employed primary care providers to participate.

Key Dates:

- Spring 2019: Application Opens
- Summer 2019: Applications Due/Payer Solicitation
- Fall/Winter 2019: Physicians/Practices Selected
- January 2020: Model Launch and Practice Onboarding
- April 2020: Payment Changes Begin.

Additional Information: CMMI is posting additional materials and webinar opportunities on the model's webpage. It can be accessed at: https://innovation.cms.gov/initiatives/primary-care-first-model-options/

Appendix I: Risk Adjusted Professional Population Based Payment for Option I Participants

Practice Risk Group	PMPM Payment
Group 1 (lowest)	$24
Group 2	$28
Group 3	$45
Group 4	$100
Group 5 (highest)	$175

Appendix II: Positive Bonus Primary Care Payment Adjustment Based on Practice Performance Relative to Other PCF Participants

Performance Level	Adjustment to Total Primary Care Payments
Top 20% of Eligible Practices	34%
21 to 40% of Eligible Practices	27%
41 to 60% of Eligible Practices	20%
61 to 80% of Eligible Practices	13%
81 to 100% of Eligible Practices	6.5%

Appendix III: Positive Bonus Primary Care Payment Adjustment Based on Practice Performance Relative to Historical Performance

Performance Level	Potential Improvement Bonus
Top 20% of Eligible Practices	16%
21 to 40% of Eligible Practices	13%
41 to 60% of Eligible Practices	10%
61 to 80% of Eligible Practices	7%
81 to 100% of Eligible Practices	3.5%
Practices Performing Above the Nationwide Benchmark but below the Top 50% of Practices	3.5%
Practices Performing Below the Nationwide Benchmark	3.5%

Appendix IV: PCF 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)
- Virginia (statewide).

Appendix V: Examples of "Advanced Practice" Capabilities

Advanced Primary Care Function	Primary Care First Intervention
Access and Continuity	• Provide 24/7 access to care team practitioner with real time access to the EHR.
Care Management	• Provide risk stratified care management.
Comprehensiveness and Coordination	• Integrate behavioral health care. • Assess and support psycho-social needs. • Builds an inventory of social supports to help serious illness population patients.
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 outcomes measures.