PRIMARY CARE FIRST MODEL OVERVIEW FOR ACOs

Background

The Primary Care First Model builds on the concepts of the Comprehensive Primary Care (CPC) Models. The payment options test whether delivery of advanced primary care can reduce total cost of care, accommodating practices at multiple stages of readiness to assume accountability for patient outcomes. Primary Care First will focus on advanced primary care practices ready to assume financial risk in exchange for reduced administrative burdens and performance-based payments. It is important to note that this model is regionally-based, therefore, the model will be limited to 26 regions, listed on the Innovation Center website here. The model is scheduled to begin January 1, 2021 and will qualify as an Advanced Alternative Payment Model (APM).

Through a second payment model option, Primary Care First also incentivizes advanced primary care practices to take responsibility for high need, seriously ill beneficiaries who currently lack a primary care practitioner and/or effective care coordination. Providers in these practices are clinicians enrolled in Medicare and who typically provide hospice or palliative care services. Under the model, these population groups are referred to as the Seriously Ill Population (SIP).

Comprehensive model details are available on the Innovation Center website. Please note that CMS expects to release more detailed model information in early 2020.

Overlap with ACO Models

Consistent with Tracks 1 and 2 of the CPC+ Model, practices participating in ACOs under all tracks of the Medicare Shared Savings Program (MSSP) and the Track 1+ ACO Model will be eligible to participate in Primary Care First. However, all Primary Care First payment amounts will be treated as non-claims-based expenditures by the MSSP in the concurrent performance period and will be included when comparing ACO spending to the benchmark in the shared savings or losses calculation. The flat visit fee will be treated as a claims-based expenditure. As expected, Next Generation (NextGen) ACOs will not be eligible to participate in the model. NAACOS is pleased to see CMS allowing dual participation in both MSSP and the Primary Care First Models.

Eligibility Requirements

The general Primary Care First payment model option is designed for primary care practices with advanced primary care capabilities that are prepared to accept increased financial risk in exchange for flexibility and potential rewards based on practice performance. There are very specific eligibility

requirements outlined by the Innovation Center. According to the RFA, eligible applicants are primary care practices that:

- Are located in one of the selected Primary Care First regions.
- 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.
- Have primary care services account for at least 70 percent of the practice's collective billing based on revenue. In the case of a multi-specialty practice, 70 percent 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 payments, and episode-based payments, and/or alternative to fee-for-service (FFS) 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.
- Can meet the requirements of the Primary Care First Participation Agreement.

Eligible practitioners (that each practice applicant must identify by National Provider Identifier (NPI) in its application) are those in internal medicine, general medicine, geriatric medicine, family medicine, and/or hospice and palliative medicine. CMS may reject an application on the basis of the results of a program integrity screening.

CMS will also encourage other payers, including Medicare Advantage Plans, commercial health insurers, Medicaid managed care plans, and state Medicaid agencies to align payment, quality measurement, and data sharing with CMS in support of Primary Care First practices.

Key Model Details

Payment Structure

The Primary Care First Model includes a two-part payment structure:

1. Total Primary Care Payment (TPCP) — The TPCP is designed to largely replace practices' traditional Fee for Service billing for primary care services. It includes two elements, a lump-sum professional population-based payment (PBP) based on average HCC risk scores paid on a quarterly basis, as well as a flat $40.82 base rate per-visit primary care fee. The TPCP will include certain adjustments such as a geographic adjustment, risk adjustment, and leakage penalty. More information on these adjustments is provided in the Request for Application (RFA) and CMS will release additional details Spring 2020. A list of the services included in the calculations of the professional PBP and for which the flat visit fee applies can be found in Appendix E of the RFA. Details regarding risk adjustment of the PBP are included in Table 3 of the RFA.

2. Performance-Based Adjustment (PBA) — In performance year two and subsequent years, a practice's TPCP will be adjusted based on performance on five quality measures as well as an additional quality measure of acute hospital utilization. Practices must meet a minimum threshold level of performance in the Quality Gateway and Acute Hospitalization Utilization (AHU) measure in order to be eligible to receive a positive PBA. A practice that meets the threshold may earn up to 50 percent additional revenue through a Regional Performance Bonus and Continuous Improvement Bonus. A practice that fails to meet either the Quality Gateway or AHU Benchmark will receive a maximum penalty of -10 percent (beginning in performance year three).

It is important to note that for practices participating dually in both MSSP and Primary Care First, CMS notes all Primary Care First payment amounts will be treated as non-claims-based expenditures by the MSSP Program in the concurrent performance period and will be included when comparing ACO spending to the benchmark in any shared savings or losses calculation. The flat visit fee will be treated as a claims-based expenditure.

Attribution

The Innovation Center will use both voluntary and claims-based attribution for Primary Care First. The first step in the model's attribution methodology is voluntary alignment. Under voluntary alignment, a beneficiary attests to his or her choice of a primary care practitioner in MyMedicare.gov. If he or she elects a Primary Care First practitioner, this attestation will supersede any future claims-based attribution of that beneficiary to another Innovation Center model, with the exception of beneficiaries aligned to the Comprehensive ESRD Care Model and similar future kidney care models.

The second step in the model's attribution methodology is claims-based attribution. With the exception of beneficiaries who have already voluntarily aligned, beneficiaries will be prospectively attributed to a Primary Care First practice if, during the most recently available 24-month period prior to the start of the performance period of the model and each quarter thereafter, that practice either billed for the plurality of the beneficiary's primary care visits and eligible chronic care management (CCM) services, or billed the most recent claim (if that claim was for an Annual Wellness Visit or a Welcome to Medicare Visit). If a beneficiary has an equal number of qualifying visits and eligible CCM services billed by more than one participating practice, the beneficiary will be attributed to the participating practice with the most recent visit. This attribution methodology is outlined in more detail in the RFA. Please note there is a separate attribution process for the SIP model option.

Seriously Ill Population Option

The Seriously Ill Population (SIP) component of Primary Care First ("SIP component") aims to identify seriously ill beneficiaries who are experiencing fragmented, uncoordinated care under Medicare FFS and deliver an intensive, episodic intervention to stabilize the patient's clinical condition. SIP practices receive higher CMS payments and are expected to: (1) proactively engage beneficiaries who have been suffering from serious illness and a lack of effective care management under Medicare FFS; (2) facilitate goals of care conversations to understand what is most important to beneficiaries; (3) develop a care plan to achieve those goals of care; (4) execute the care plan through a combination of face-to-face services and non-face-to-face care coordination; and (5) facilitate a relationship between the beneficiary

and a practitioner who will be accountable for managing the longer term care once the beneficiary has been clinically stabilized.

CMS will encourage SIP practices to maintain an eight-month annual average length of attribution (i.e., the length of time from when a beneficiary is attributed to a SIP practice to when a beneficiary has transitioned) for their SIP beneficiary populations. Such an average will allow practices the flexibility not only to appropriately transition beneficiaries in a timely manner when the practice deems them not to require SIP-level services, but also to care for beneficiaries who need more intensive services for longer than eight months in order to be stabilized. SIP participants will be assessed on the quality measures described in the Quality Measures for Practice Risk Groups 3 or 4 and SIP. Practices can participate as SIP-only or use a hybrid approach to participation in the Primary Care First model.

SIP-only practices are not required to meet the minimum threshold of 125 attributed beneficiaries or the 70 percent minimum primary care revenue threshold that is required of other practices in order to be eligible to participate in the model. Eligible practitioners are those practicing in internal medicine, general medicine, geriatric medicine, family medicine, and/or hospice and palliative medicine. Hospice and palliative care practitioners are eligible to care exclusively for SIP beneficiaries, either by participating in the model as a SIP-only practice or by joining a hybrid practice and being included on its practitioner roster.

SIP-only practices will be required to attest that they will use 2015 Edition CEHRT, support data exchange with other providers and health systems via API and connect to their HIE by January 1 of the second model performance year (2022). They will not be required to meet these health information technology (IT) requirements in the first model performance year (2021). CMS will provide general information to practices to help SIP-only practices prepare to meet health IT requirements beginning in performance year two, e.g., information about EHR platforms designed for hospice and palliative care providers that meet CEHRT requirement.

For attribution to SIP, CMS will use claims data to identify beneficiaries who meet the two general SIP beneficiary requirements: experiencing serious illness and exhibiting a pattern of care fragmentation. If this requirement is met, attribution (and SIP-level payment) will last for up to 12 months, or until one of the following circumstances occurs:

1. Beneficiary opts out of the SIP component after the first face-to-face visit (in this scenario, the practice should notify CMS).
2. The practice notifies CMS that the beneficiary has been transitioned out of the SIP component.
3. Beneficiary has begun receiving hospice care, as evidenced by hospice claims.
4. Beneficiary moved out of the practice's service area for SIP beneficiaries.
5. Beneficiary died prior to the care transition.

Practices will also have the opportunity to request an exception to the 12-month attribution limit for individual SIP beneficiaries. On a limited basis, CMS will allow SIP-only and hybrid practices to identify and refer beneficiaries for model participation under the SIP component even if they do not meet the claims-based criteria for SIP eligibility. This pathway for identifying SIP beneficiaries will be termed "direct referral." CMS will identify non-claims-based clinical criteria that beneficiaries must meet to be eligible for direct referral. SIP practices seeking to directly refer a beneficiary to the SIP component will first seek the beneficiary's consent and then will attest to CMS that the beneficiary meets these clinical

criteria. CMS will review these attestations and confirm that the beneficiary also meets general Primary Care First beneficiary eligibility criteria, e.g., enrollment in Medicare Parts A and B. If CMS confirms that the beneficiary meets eligibility criteria and the SIP practice has a subsequent face-to-face visit with the beneficiary, the beneficiary will be attributed to the SIP practice and SIP monthly payments will begin in the following month. If CMS determines that the beneficiary does not meet eligibility criteria, the beneficiary will not be eligible for attribution to the SIP practice.

To compensate participating SIP-only and hybrid practices for the additional clinical work associated with the outreach and initial engagement of SIP beneficiaries, CMS will make a one-time payment of $325 after a practice has the first face-to-face visit with the SIP beneficiary. For beneficiaries identified by CMS, this visit must occur within 60 days of the date the beneficiary was assigned to the practice on its monthly SIP beneficiary list.

Practices will not be permitted to bill the $40.82 flat visit fee base rate for the first face-to-face visit with a SIP beneficiary, regardless of whether the beneficiary is identified through the claims-based attribution algorithm or through direct referral. After the first face-to-face visit, participating practices may bill the $40.82 flat visit fee base rate for each face-to-face visit with SIP beneficiaries.

Beginning the month following the first face-to-face visit, the practice will receive a $275 per beneficiary per month (PBPM) base rate minus $50 PBPM, which will be withheld until verification after the end of the performance year that the practice meets a minimum quality standard, as described below. The monthly payment will be calculated on a PBPM basis but paid quarterly. The $50 withhold will be calculated on a PBPM basis. If the practice earns the withhold back, it will be paid in one annual lump sum after the performance year. The $275 PBPM and $50 PBPM base rates will be geographically adjusted in a similar manner to Medicare Part B Fee Schedule rates to account for nationwide variations in cost. SIP practices will continue to receive this monthly payment for a beneficiary for either 12 months, or until the beneficiary is de-attributed from the practice due to transition out of SIP, hospice enrollment, death, a move out of the practice's service area, or a gap between face-to-face visits of more than 60 days (see the attribution section above for more detail on circumstances under which a beneficiary would be de-attributed from a practice). SIP practices will have the opportunity to earn back the $50 PBPM base rate withhold from their SIP PBPM payment, as well as an additional $50 PBPM base rate quality bonus. Together, the withhold and the quality bonus make up the SIP quality adjustment, which will be calculated and paid out the following performance year. To encourage SIP practices to facilitate appropriate and timely beneficiary transitions out of SIP, whether a SIP practice is eligible to earn back the $50 PBPM withhold or the additional $50 PBPM quality bonus will depend on their average SIP beneficiary attribution length and their rate of success in care transitions.

CMS will conduct claims-based monitoring of participating practices that with attributed SIP beneficiaries. Monitoring will be designed to ensure that practices are engaging these beneficiaries on an ongoing basis through a mixture of face-to-face and telephonic encounters that are proactively deployed based on beneficiaries' current and anticipated needs. More information on the SIP participation option is available in the RFA.

Quality Assessment

The Primary Care First Model will use a "quality gateway" approach, therefore, the model will establish a threshold performance level practices must meet or exceed in order to be eligible for a positive PBA in

year two and subsequent years. CMS establishes the following five quality gateway measures and the Acute Hospitalization Utilization Benchmark (listed on Table 9 in the RFA) for the general track of the model:

1. Patient Experience of Care Survey (as measured by the Consumer Assessment of Healthcare Providers and Systems Survey, or CAHPS)
2. Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9 percent)
3. Controlling High Blood Pressure
4. Advance Care Plan
5. Colorectal Cancer Screening
6. Acute Hospital Utilization (as measured by the Healthcare Effectiveness Data and Information Set, or HEDIS)

For each of the measures, CMS will establish a threshold based on national performance. In order to pass the Quality Gateway and be eligible for a positive PBA, practices must meet or exceed the threshold for all five measures. If practices fail to meet the threshold for one or more of the measures, they will not be eligible for a positive PBA for the following year.

CMS will begin collecting data for the five Quality Gateway measures in performance year one of the model. Unlike the Acute Hospitalization Utilization measure, which will be calculated quarterly based on a rolling four-quarter look-back period, the four remaining Quality Gateway measures will be calculated annually, based on the prior performance year. If a practice fails to meet the all of the Quality Gateway thresholds in the performance year, it will receive, at a maximum, a 0 percent PBA in performance year two (based on year one performance) and an automatic -10 percent PBA in years thereafter. In contrast, if a practice meets or exceeds the Quality Gateway for the performance year, it will then be eligible for a positive PBA in the following year, and the PBA will be calculated quarterly based on the practice's Acute Hospitalization Utilization performance. Because the prior performance year's quality data for the Quality Gateway measures will not be available in year one, CMS will not evaluate practices based on the Quality Gateway in performance year one, and instead will calculate the practices' PBAs quarterly, based exclusively on the Acute Hospitalization Utilization measure, beginning in quarter three of their first performance year participating in the model. The Quality Gateway will go into effect in year two based on the practice's first performance year.

Practices in Risk Groups 3 or 4 (and SIP practices) will be evaluated on a slightly different set of quality measures to account for their patients' specific clinical and supportive needs. In performance year one, CMS will use two measures to calculate the PBA for these practices:

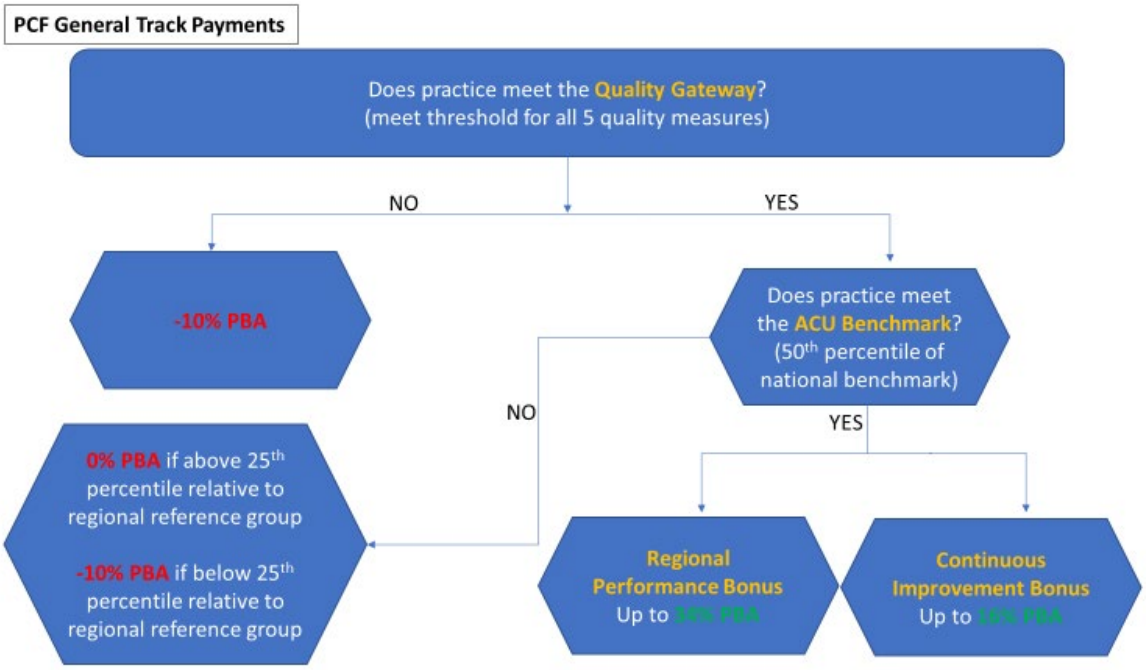
- The advance care plan Merit-based Incentive Payment System (MIPS) CQM measure (also used for practices in Risk Groups 1 and 2), which requires that a clinician discuss and/or document beneficiaries' advance directive to ensure their preferences are considered at the end of life; and
- Total per capita cost (TPCC), as used in MIPS.
- In performance year two, CMS will add a CAHPS measure to the PBA calculation, bringing the number of quality measures for these practices to three.

CMS will also begin developing two quality measures for use in later years of the model: Days at Home and 24/7 Access to a Practitioner. Days at Home (claims-based) measures the number of days a

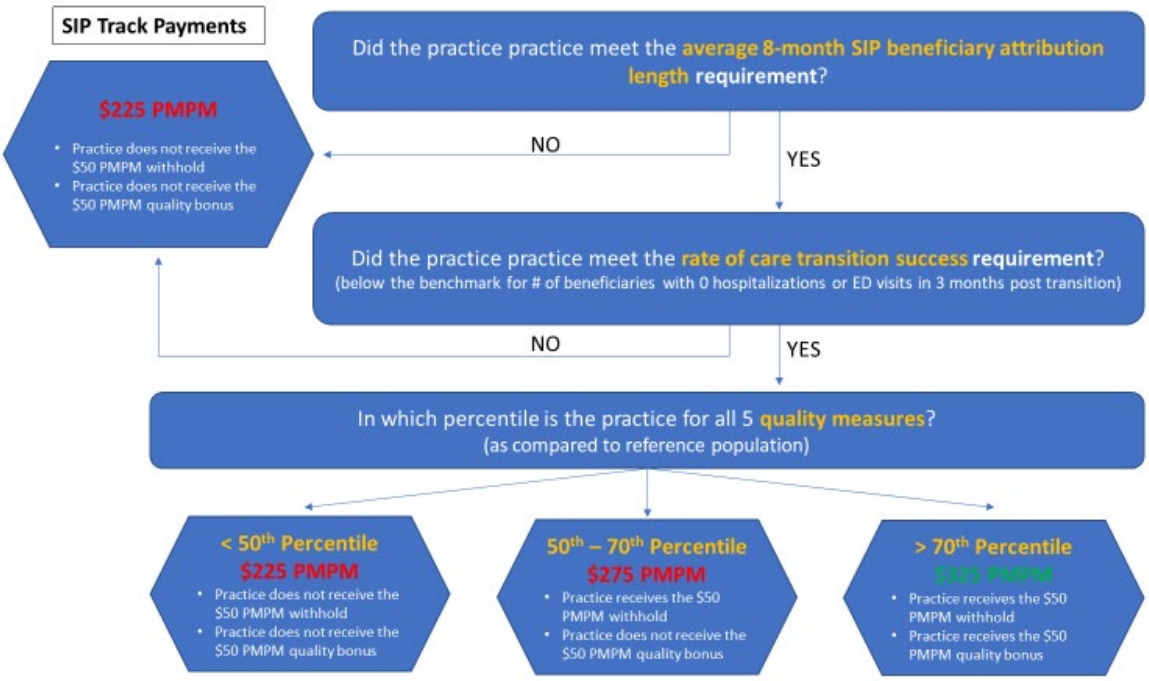
Medicare beneficiary remains outside of an institutional care setting during a standardized time period. 24/7 Access to a Practitioner (survey-based) measures beneficiaries' perception of round-the-clock access (data collected through a binary yes/no question that will be added to the CAHPS survey currently in use for Comprehensive Primary Care Plus [CPC+] and that will be used for Primary Care First). CMS will begin collecting and tracking data on these measures in performance year one in order to support the measure development and data validation process. Additionally, in performance year one, CMS will administer the CAHPS Survey in order to develop benchmarks for performance years two through five. CMS expects that these two new measures will be endorsed by the National Quality Forum (NQF) and will be ready to be incorporated into the PBA calculation in performance year three. In performance year three, the PBA for practices in Risk Groups 3 and 4 will therefore be based on five measures: (1) advance care plan MIPS CQM, (2) TPCC, (3) CAHPS, (4) 24/7 Access to a Practitioner; and (5) Days at Home.

Please refer to Table 9 in the RFA for a list of quality measures for Practice Risk Groups 1 and 2, and Table 10 for a list of quality measures for Practice Risk Groups 3 and 4.

Review of Quality Gateway Approach, Primary Care First Model



Review of Quality Gateway Approach, SIP Model Option



Application Information

The Request for Application for Primary Care First is available here. CMS will accept Primary Care First applications from individual primary care practice sites that meet preliminary eligibility requirements through January 22, 2020. Questions about the application for Primary Care First should be directed to PrimaryCareApply@telligen.com. CMS plans to hold a second round of applications for practices that would begin Primary Care First participation in January 2022; however, this second application round will only be available to current CPC+ Tracks 1 and 2 participants. With the exception of current CPC+ Tracks 1 and 2 participants, all other practices in the 26 selected regions will be ineligible to apply in the next application cycle for a January 2022 participation launch.

The payer statement of interest form is available on the Primary Care First website. Respondents to this solicitation may be commercial insurers, Medicare Advantage plans, states (through Medicaid and the Children's Health Insurance Program (CHIP), state employees program, or other insurance purchasing), Medicaid/CHIP managed care plans, state or federal high risk pools, self-insured businesses, or administrators of a self-insured group [Third Party Administrator (TPA) / Administrative Service Only (ASO)]. Interested payers are encouraged to review the Payer Alignment Rubric. Through December 6, payers will have the option to submit a non-binding statement of interest form indicating interest in partnering with CMS in Primary Care First. The payer solicitation will be conducted from December 9, 2019 – March 13, 2020.

NAACOS is interested in your feedback on this model. Please share any feedback with us by emailing naacos@advocacy.com.