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HEALTHCARE MANAGEMENT ADVISORS

Primary Care First: Frequently Asked Questions

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WHAT IS THE PRIMARY CARE FIRST PROGRAM (PCF)?

PCF is a voluntary 5-year CMS Advanced Alternative Payment Model (APM) with two care models—one for "Advanced" primary care and one for high-need, seriously ill Medicare beneficiaries (Seriously Ill Population, or SIP). The latter is aimed primarily at providers who typically provide hospice or palliative services. Practices can participate in one or both models.

Who can participate in PCF? Practices with prior experience with value-based care (e.g., performance-based incentive payments, episode-based payments, ACOs, Medicare Shared Savings Program or similar, capitation) may participate. They must be located in one of the 26 program regions. Primary care clinicians include MDs, DOs, CNS, NPs, and PAs, certified in internal medicine, general medicine, geriatric medicine, family medicine, or hospice and palliative medicine.

How is a "practice" defined in the PCF program?
A practice is defined as a single brick and mortar location, with a common TIN for all clinicians. Physicians who practice in multiple locations must be included in the location where they spend the most time. See below regarding employed physician practices.

What advanced primary care requirements must participating practices commit to meeting when serving patients? They must provide specific core functions of "advanced" primary care, including:

- 24/7 access to a care team practitioner who can access the Electronic Health Record (EHR)
- A behavioral health component including assessment of psychosocial needs

- Patient assignment to a specific practitioner or care team
- Risk-stratified care management
- A regular process for patients and caregivers to advise on practice improvement.

How will practices participating in PCF be paid? Payment has three components:

- A population-based payment (per beneficiary per month, based on the practice's average patient risk—determined by patient HCCs). The PBPM and per-visit fees are higher for SIPs than the basic program.
- A flat per-visit fee (which will be geographically adjusted).
- Performance-based adjustments of up to 50% of revenue on the upside and 10% on the downside, based on performance relative to regional benchmarks and continuous improvement benchmarks.
- Payments will be adjusted for leakage—attributed patients receiving primary care outside the practice.
- Practices will need to be very good at documenting HCCs to maximize their risk-adjustment, and they will need to have analytics capabilities available. Practices will be provided with a preliminary classification of their risk grouping before signing the participation agreement.

Will payers other than Medicare be participating in PCF? CMS will "encourage" other payers to adopt payment, quality measurement, and data sharing that align with CMS in support of Primary Care First practices. There is a separate application process for payers.

What requirements must participating practices meet? Practices must:

- Use 2015 edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers via application programming interface (API), and connect to their regional Health Information Exchange (HIE). SIP practices have an extra year to meet the CEHRT requirements.
- Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at a particular location, with primary care accounting for at least 70% of the practices' collective revenue (or 70% of the primary care physicians' revenue). This minimum does not apply to SIP practices, which must accept extremely ill patients identified by CMS as not being well-managed (based on high rate of hospital usage and care fragmented among multiple providers).
- SIP providers must have a network of care providers in place to handle patients' long-term care needs.

- Not participate in NextGen ACO, the ESRD program, or the Direct Contracting program (Direct Contracting is a set of three voluntary primary care payment model options, announced recently, that will tie care for a population of beneficiaries to capitated payments). MSSP ACO and BPCI-Advanced are acceptable, but the overlapping incentives will be complicated.
- If in the CPC+ program, not participate in PCF until 2022.

How will outcomes be measured? The primary outcome measurement, and the only one for the first year, is reduction in acute care hospitalizations. After that, practices must pass a "quality gateway" in order to obtain any bonus payments based on reductions in hospitalization, to assure that reduced costs are not achieved at the expense of quality of care. The gateway will include five basic measures:

- Control of high blood pressure
- Diabetes hemoglobin A1c control
- Colorectal cancer screening
- Patient experience of care survey
- Advance care planning

How will patient attribution work? Patients may choose to be attributed to a practice, or may be attributed up front based on where they received primary care in a 24-month look-back period. Physicians will receive a list of attributed beneficiaries, and get quarterly updates.

Application requirements: Each practice within a health system, ACO, or other grouping of practices must submit a separate application. Organizations cannot apply. Practitioners who spend time at multiple locations must be attributed to the practice where they spend the most time. Practices need to list all NPIs in the practice that have billed Medicare since 2013 (both full and part-time).

The application period is now open and the deadline is January 22, 2020 for those starting in 2021. It appears that applying commits the practice to participation if accepted in the program. (There will be entering "classes" in 2021 and 2022). Onboarding will occur from July-December 2020; the performance period starts January 1, 2021.

What are some of the questions that have not yet been clearly answered by CMS? Among the things CMS still needs to clarify are:

- How will this apply to physicians employed by hospitals? CMS has indicated that every separate mailing address—even if they only vary by a suite number—will be counted as a separate practice. This suggests that hospitals and systems with

multiple primary care practice locations could have to assist each of those practices in submitting separate applications (technically, it is the practice, not the organization, that has to submit the application). Alternatively, it is possible that only one or two locations will want to apply.

- For physicians who work at multiple locations, how will they be paid by Medicare for patients who are not seen at the address at which the physician spends the most hours? To date, CMS seems to be indicating that they would need to get their Medicare patients to use the practice address for which the PCF program was approved (which seems unlikely to be practical in most cases). However, CMS has also indicated that many people are asking about this and they still do not have a definite answer.
- How will physicians currently participating in ACOs benefit from participating in Primary Care First, given that CMS apparently intends to count revenue from the PCF program as part of clinical expenditures for the ACO? It does appear that PCF would provide a more even cash flow than an ACO alone, and patients will be attributed up front.
- Are practices that commit to Medicare PCF also committing to participate in parallel payment programs by other payers who may apply to CMS to participate in this program?