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Primary Care First

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In January 2021, The Centers for Medicare and Medicaid Services (CMS) plans to launch Primary Care First (PCF), a payment model to support the delivery of advanced primary care.[1] This voluntary five-year model aims at empowering primary care organizations to provide innovative care in 4 key areas: doctor-patient relationship; enhancing care for patients with complex and serious illness, reducing administrative burden, and focusing on financial rewards on improved health outcomes. Participants can choose to participate through one or both participation options: PCF-General and PCF-High Needs Populations.

PCF-General (Table 1). This represents the core participation option of PCF.[1] Interested practices must already have experience in providing advanced primary care for chronically ill populations and be prepared to take on financial accountability for population health performance. Payment in PCF-General, termed the Total Primary Care Payment (TPCP), consists of several parts: a fee-for-service flat fee for all in person visits; a risk adjusted Population Based Payment (PBP) that uses an per-beneficiary-per-month (PBPM) approach to reimburse practices for their patient population; and a Performance-Based Adjustment (PBA) that is calculated based on quality and utilization measure performance and used to adjust the PBP.

Table 1. Payment in PCF-General [1,2]	
Component	**Details**
Fee-for-service flat visit fees	In-person visits reimbursed a flat, geography-adjusted rate of $40.82

1. "Primary Care First Call for Applications." US Department of Health and Human Services, Centers for Medicare and Medicaid Innovation Seamless Care Models Group. October 24, 2019. https://innovation.cms.gov/Files/x/pcf-rfa.pdf
2. "Primary Care First: Foster Independence, Reward Outcomes. Model Briefing" *Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services.* https://innovation.cms.gov/Files/slides/pcf-info-webinar-series-slides.pdf

PBP	Risk-adjusted PBPM payment across the practice's eligible population, calculated based on the overall risk of a practice population (derived from Hierarchical Condition Category scores) and paid on a quarterly basis. The PBP is adjusted based on practices' leakage rate (the percent of Evaluation & Management and Chronic Care Management services provided to eligible patients outside of the PCF practice) and based on the Performance Based Adjustment (PBA). **Monthly PBP**= PBPM Base Rate x (1-leakage rate) x PBA
PBA	A factor that adjusts a PCF practice's PBP by up to + 50% or - 10%. The extent of adjustment depends on performance on the Acute Hospital Utilization (AHU) metric, through which hospitalization rates of PCF practices are compared to that of their regional peers and their own past performance. The PBA will be based solely on AHU performance in Year 1 of PCF. Beginning in Year 2, practices must first meet minimum requirements in the Quality Gateway (see Quality section below) to be eligible for a positive PBA. Practices that fail to exceed the Quality Gateway in Year 2 will face between a neutral or downward PBA of up to -10%, and will have an automatic downward 10% PBA in subsequent years.
TPCP	Total quarterly payment in PCF-General, incorporating fee-for-service flat fees, PBP, and PBA **TPCP=** PBP x Leakage Penalty x PBA + $40.82*(# of visits)

PCF-High Needs Populations (Table 2). Also referred to as the Seriously Ill Population (SIP) option, PCF-High Needs is intended to allow primary care practices to deliver high touch medical and care coordination services for patients with serious illness, many of whom experience fragmented care and/or lack a primary care provider.[3] The intent is for patients to receive care under the SIP option for a limited time period until their care can be stabilized and safely transitioned to a provider or care setting (e.g., hospice) best in line with their long-term goals. Participating practices will receive a one-time lump sum payment as well as quality-adjusted PBPM payments.

Table 2. Payment in the PCF-High Needs Populations[1,2]

Payment Component	Details
Single Lump Payment	A single $325 fee after a first face-to-face visit with a new SIP beneficiary
Fee-For-Service FFS Payment	In-person visits (excluding the initial visit) reimbursed a flat, geography-adjusted rate of $50
PBPM	A $275 PBPM minus $50 withheld until the practice is confirmed to meet minimum quality standards at the end of the year
Quality Adjustment	Up to a $50 bonus on the PBPM based on Quality Performance
Total Monthly Per-Beneficiary Payment	$325 + $225 + $50*(# of visits) +/- $50 (withhold) +/- $50 (quality bonus)

Quality (Table 3). Under both PCF participation options, accountability for the quality of care is based on quality measure performance.

Table 3. Quality Performance in PCF[1]	
Model	**Quality Elements**
PCF-General	**AHU:** Medicare will calculate the risk-adjusted observed-versus-expected hospitalization rate for a PCF practice's assigned population. In Year 1, a practice's upward or downward PBA will be based entirely on AHU performance. Beginning in Year 2, once a practice passes the Quality Gateway, the degree of that practice's PBA will depend on their AHU performance. A portion of payment tied to AHU performance will be based upon comparison of PCF practices to regional peers (up to 34% upside bonus, with performers in bottom quartile of the region receiving a downward 10% PBA), and a portion will be tied to a practice's continued compared to its own past performance (up to 16% upside bonus). **Quality Gateway:** Beginning in Year 2, in order to be eligible for a positive PBA, PCF practices must achieve a national threshold performance in the Quality Gateway, which incorporates 5 quality measures related to patient experience, A1c and blood pressure control, advance care planning, and colorectal cancer screening. In Performance Year 2, practices that fail to meet the Quality Gateway Threshold will receive between a 0-10% PBA deduction based on performance in the AHU. In subsequent years, failure to meet Quality Gateway results in an automatic 10% PBA deduction.
PCF-High Need Populations	**Average SIP Beneficiary Attribution Length:** This quality element reflects the intent for patients to receive care through the SIP option for a limited amount of time. If the average attribution length across all eligible beneficiaries is >8 months, practices will not be eligible for recuperating the withheld $50 PBPM or the $50 PBPM bonus. **Rate of Care Transition Success:** Medicare will calculate the percent of beneficiaries with 0 hospitalizations or ED visits in the first three months **after** being transitioned **out** of SIP. Practices that fail to meet a national benchmark with respect to this measure will not be eligible for the withheld $50 PBPM or the $50 quality bonus. **Quality Measures:** Practices that meet the threshold for *SIP Beneficiary Attribution Length* and *Rate of Care Transition Success* will be graded on 5 quality measures: Advance Care Plan; Total Per Capita Cost; CAHPS; 24/7 access to practitioner; and Days at Home. Practices meeting the 50th percentile will receive their withheld $50 PBPM, and those that are greater than the 70th percentile will be eligible for a $50 quality bonus payment.

Eligibility. Medicare will accept PCF applications from 26 regions around the country (of note, Washington state is not included). Practices may apply to participate in PCF-General only, PCF-High Needs Populations only, or both. Internal Medicine, General Medicine, Geriatric Medicine, Family Medicine, and/or hospice and palliative medicine providers are eligible. Practices must have primary care services comprise at least 70%

of total billing, provide care to at least 125 Medicare beneficiaries, use Certified Electronic Health Record Technology, attest to having certain advanced primary care capabilities, and have some experience with value-based payment arrangements. PCF participation counts towards participation in Advanced APMs. There will be two staggered cohorts.[4] Based on current timelines, the first cohort will participate from 2021-2025 and the second cohort will participate from 2022-2026. Of note, practices already participating in Medicare Shared Savings Program (MSSP) and bundled payment models are eligible to apply. Practices participating in CPC+ are eligible to apply for the second, but not the first, PCF cohort.

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4. "Primary Care First Frequently Asked Questions." US Department of Health and Human Services, Centers for Medicare and Medicaid Services. https://innovation.cms.gov/Files/x/pcf-faqs.pdf