Count	Design Elements	Primary Care First (PCF)	Alignment	Unresolved Items for Further Deliberation	Draft Recommendations 9/15
Payment					

1	**Total Monthly Payment**	**<u>Total Monthly Payment</u>:** Practices are paid to deliver advanced primary care in and outside of the office. Practices focused on caring for patients with complex chronic needs and the seriously ill receive increased payments to support their care for these patient populations.
		
		Total Primary Care Payment (TPCP): The TPCP will largely replace practices' traditional FFS billing for primary care services. It includes two elements, a lump-sum professional **population based payment (PBP)** paid on a quarterly basis and a flat base rate per visit primary care fee:
		
		#1 - PBP - practices will be divided into four groups based on the average hierarchical condition category (HCC) risk score of their attributed Medicare beneficiaries
		
		#2 - Flat $40.82 base rate per visit primary care fee
		
		TPCP will include some adjustments to account for variations in cost of care to encourage practices to actively manage their attributed patients to limit their need to seek care from other primary care practices, including a geographic adjustment, risk adjustment, and leakage penalty.
			Agree to Population Based Payment
			
			Agree to flat fee visit payment
				• HCC score at practice level or individual level
				
				• Maryland Model effects and complexity
				
				• Budget neutrality relative to FFS, current MDPCP program, or increased primary care spending
					• Utilize individual-level approach to determining a practice's HCC score
					  ○ Modeling to confirm approach
					
					• Budget neutrality overall with increase to primary care spending to include annual TCOC savings targets
					
					• Increase per visit (flat payment) by up to 60%
					  ○ Modeling to confirm approach

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2	**Performance Based Adjustment**	**<u>Performance-Based Adjustment (PBA):</u>** Practices are motivated to reduce acute hospital utilization (AHU) to reduce total costs of care, while meeting quality and experience of care thresholds. Performance-Based Payment Potential (Approximate % of Primary Care Revenue): The PBA has two components: a **regional performance bonus and a continuous improvement bonus**. Practices can receive up to 34% upside bonus or a -10% downside penalty through the regional performance adjustment. Practices can earn up to a 16% bonus through the continuous improvement bonus. The regional performance adjustment and the continuous improvement bonus are added together to determine a practice's quarterly PBA. **During the practice's first year of participation in the model**, the PBA will be determined based on performance on the AHU measure only. The AHU measure will be calculated quarterly based on a rolling four-quarter look-back period and applied to starting in quarter three of year one. **During performance year two and in subsequent performance years, a practice's TPCP will be adjusted based on its performance on five quality and patient experience of care measures, as well as a measure of acute hospital utilization (AHU).** The quality metrics will be incorporated into a Quality Gateway, which is a minimum threshold that practices must meet in order to be eligible for a positive PBA beginning in performance year two. If a practice meets or exceeds the Quality Gateway, its performance on the AHU will then be used to determine whether it receives a positive, negative, or neutral PBA.	Agree with National benchmarking	• Use of state based performance adjustments consistent with current model and aligned with population health goals • Simplified methods • Annual reporting • Full PBA from year one in track 3 • Using State benchmarks for quality and utilization; justification if proposing another benchmarking approach • Incorporating a TCOC performance adjustment calculation	• State-based performance adjustments consistent with current model and aligned with population health goals • Align risk level with hospital risk level and include progression over several years

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		Practices that fail to meet the Quality Gateway will receive no higher than a 0% PBA in performance year two. Whether they ultimately receive a neutral PBA (0%) or a negative PBA for each quarter of the second performance year will be determined by their AHU performance. Participating practices that exceed the Quality Gateway must also exceed the 50th percentile of a nationally constructed AHU benchmark. This is to ensure that practices receiving a PBA are above average at managing avoidable utilization across similar Medicare practices regardless of their location. Practices that fail to exceed the national benchmark but perform above the 25th percentile relative to their regional reference group will receive a 0% regional PBA. Practices that fail to exceed the national benchmark and perform in the bottom quartile of their regional reference group will receive a -10% regional PBA. Practices that exceed these minimum thresholds will be eligible to earn a positive PBA based on how they perform relative to both a regional and individual historical benchmark.			
3	**Attribution**	Beneficiary Attribution: Claims-based with voluntary alignment opportunity; proactive identification and assignment of seriously ill and unmanaged beneficiaries	Agree		
4	**Beneficiary Engagement Incentives**	CMS intends to allow practices to reduce or waive the applicable co-insurance (which will be based on the FFS rate for services provided), with practices responsible for covering those costs (i.e., CMS will not compensate practices for the loss in cost sharing revenue). Practices that wish to take advantage of this beneficiary engagement incentive must submit an implementation plan that identifies the categories of beneficiaries who will be eligible for cost sharing support, the types of services furnished by the practice that would be eligible for cost sharing support, and such other information as CMS may require. The implementation plan is subject to CMS approval. Primary Care First practices will be required to implement their cost sharing support	Agree		

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		policies in accordance with the implementation plan approved by CMS.			
Additional Considerations		*Population Based Payment (PBP)*			
Performance Measurement					

5	**Risk Group 1-2**	These measures were selected to be actionable, clinically meaningful, and aligned with CMS's broader quality measurement strategy. Measures include a patient experience of care survey, controlling high blood pressure, diabetes hemoglobin A1c poor control, colorectal cancer screening, and advance care planning.
		
		<u>Utilization</u>
		Utilization Measure for PBA Calculation Acute Hospital Utilization (AHU) (HEDIS measure)
		
		<u>Quality Gateway (starts in Year 2)</u>
		Patient Experience of Care Survey (CAHPS® with supplemental items) 0005 and 0006 / 321 AHRQ® PCF and/or non-PCF reference population Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (eCQM) 0059 / 001 NCQA® MIPS Controlling High Blood Pressure (eCQM) 0018/ 236 NCQA® MIPS Advance Care Plan (MIPS CQM measure) 0326/47 NCQA® MIPS Colorectal Cancer Screening (eCQM) 0034/113 NCQA® MIPS
				• PBA based on State's priorities
				• Creation of varying risk levels within track 3 (e.g., less than 100% capitated, similar to various levels of CPCP in track 2)
				  ○ Start at a low level consistent with the revenue risk applied under the TCOC model for hospitals (1-2%)
				  ○ Keep potential reward small but asymmetric relative to overall revenue (5-10%)
				  ○ Adjust risk and reward on an annual basis elected by practices up to maximal amount over the life of the program
				• Align risk level with hospital risk level and include progression over several years
					•

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	Risk Group 3-4	<u>Years 1- 5</u> Advance Care Plan (MIPS CQM measure) (also used for Practice Risk Groups 1-2) Total Per Capita Cost (MIPS claims measure) (CMS does not use AHU for Risk group 3-4 and instead uses Total Per Capita Cost) <u>Years 2-5 (but administered in Year 1)</u> CAHPS® (beneficiary survey) <u>Years 3-5</u> 24/7 Access to a Practitioner (beneficiary survey), Days at Home (claims measure)		• Same as above	
Additional Considerations		*Quality Measures*			
Care Delivery					
6	**General Options**	Practices have capabilities to deliver five advanced primary care functions: 1) access and continuity; 2) care management; 3) 5comprehensiveness and coordination; 4) patient and caregiver engagement; 5) planned care for population health <u>Flexibility</u> In Primary Care First, practices will have latitude to develop their own approaches to care delivery, rather than being required to meet many specific care delivery requirements under the model. Practices will be required to report some information about their care delivery capabilities to ensure program integrity and provide CMS insight into practice progress and opportunities to continuously improve the model.	Agree		
7	**Seriously Ill**	Practices focused on care for complex chronic or seriously ill patients have associated specialized capabilities.	SIP hybrid	• Include SIP as the complex tier ○ Data assessment to determine SIP number of patients not	

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				currently under care management	
Participants and Partners					
8	**Eligibility**	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.	Any Maryland qualifying practitioner	• Include the current MDPCP eligible providers using the same criteria for inclusion of 125 minimum FFS beneficiaries	
		Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at a particular location.	Agree	• Agreement to no change from PCF	
		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.	Agree	• Agreement to no change from PCF	
		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 payments such as full or partial capitation.	Agree	• Require practices to have at least one year in Track 2; or 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 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).	Agree	• Use 2015 CEHRT, support data exchange with other providers and connect to	

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				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.	Agree	• Advanced Primary Care Delivery requirements include 24/7 access, telehealth use, CRISP connectivity, ENS panels, and advanced primary care capabilities including behavioral health integration, screening for social determinants of health, referral to community based organizations to meet social needs, transitional care management, longitudinal care management, patient family advisory councils, patient self-management program access, use of data to influence care management	
		Can meet the requirements of the Primary Care First Participation Agreement.		• Meet MDPCP requirements	
		Eligible practitioners (that each practice applicant must identify by 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.		• Add full complement of MDPCP providers	
9	**Participation Options**	1) Practices may choose to participate only in the PCF-General component of Primary Care First, and not in the SIP component, i.e. “PCF-General practices”;	SIP Hybrid		

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		2) Practices may choose to participate only in the SIP component of Primary Care First, and not in the PCF-General component, i.e. "SIP-only practices"; 3) Practices may choose to participate in both the SIP and PCF-General components of Primary Care First, i.e. "hybrid practices."			
10	**Exclusions**	FQHCs		• Include FQHCs ○ Modeling to confirm approach	
11	**Payer Alignment**	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.	Agree		
12	**Application**	Practices must complete a RFA	Agree		
13	**Performance**	5 years	Agree		
14	**Other**	Although CMS is only able to assess and pay the PBA at the practice-level, the Participation Agreement will require participating practices to agree to compensate individual practitioners in their practice in a way that reflects their individual performance on meaningful outcomes-based and process clinical quality measures, patient experience, and AHU. This stipulation provides Primary Care First participants with the flexibility to determine their own compensation arrangements with their practitioners, while also ensuring that the PBA motivates practitioners to take responsibility for their personal performance.	Agree		
Seriously Ill Population (SIP)					
15	**Seriously Ill Population**	CMS will attribute SIP patients lacking a primary care practitioner or care coordination to Primary Care First practices that specifically opt to participate in this payment model option. Practices may limit their		N/A	

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		participation in Primary Care First to exclusively caring for SIP patients, but in order to do so, such practices must demonstrate in their applications that they have a network of relationships with other care organizations in the community to ensure that beneficiaries can access the care best suited to their longer-term needs. Allowances to some of the eligibility requirements for the Primary Care First general payment model option (such as with respect to historical beneficiary attribution) will be made to facilitate participation in the SIP payment model option. • One-time payment for first visit with SIP patient: $325 PBPM • Monthly SIP payments for up to 12 months: $275 PBPM • Flat visit fees: $50 • Quality payment adjustment: up to $50			
Learning System					
16	**Learning Network and System**	CMS will provide access to a learning system for participating practices, including: 1) Technical Assistance: Share information about how the model works and what is required for success through onboarding and support resources such as an implementation guide, newsletters, FAQs, and webinars/office hours. 2) Use of Data for Improvement: Support in the use of data and analytics to guide the operational and care delivery changes necessary for success. 3) Assessment and Feedback: Ongoing and timely assessment of practice capabilities. 4) Learning Communities: Management of practice networks for peer-to-peer sharing and diffusion of		• Hybrid Learning System-State and CMMI	

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		promising tactics, e.g., via a web-based collaboration website (PCF Connect) and a national meeting. Practices participating in Primary Care First may invest in practice coaching to achieve their aims in Primary Care First, but these services will not be provided by CMS, because CMS generally expects that Primary Care First practices have already developed advanced primary care capabilities. Where there are opportunities for alignment, e.g., National Meeting and regional in-person meetings in the 18 existing CPC+ Track 1 and 2 regions, the Learning System for Primary Care First will be integrated into the existing learning system structure designed for CPC+ Tracks 1 and 2.			
Data Sharing					
17	**Data Sharing**	Medicare FFS expenditure and utilization data and Medicaid data, as available, are delivered, as requested by participating practices in accordance with applicable law, clearly and actionably on a quarterly basis at the practice- and National Provider Identifier (NPI)-level with identifiable information on performance of the participating practitioners.	Agree		
18	**Reporting**	Care Delivery Achievement Data (limited, less than care delivery in MDPCP/CPC+) eCQM submissions (annual) CAHPS submissions (annual)	Agree		
Quality Payment Program and Model Overlap					
19	**AAPM**	AAPM under Medical Home model rule	Agree	• Practices in track 3 continue to be considered AAPM under the Medical Home designation	
20	**Overlaps**	See FAQs			
21	**Track 3 required or optional?**	N/A		• Track 3 will become the only track in MDPCP ○ Require practices in Track 1 to transition to	

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				Track 2 by end of third year of participation ○ Practices beginning program in Track 2 to start in 2022; required to transition by end of second year of participation ○ Practices beginning 2023 will only be accepted if qualifying for Track 2 ○ Track 2 practices with one or more years in Track 2 will be eligible to transition to Track 3 in 2023 ○ All Track 2 practices must transition to Track 3 by no later than 2026 • Needs to be sufficiently flexible in risk to accept practices that are small to large, diverse and broadly represent the State	
22	**Track 1 phase-out**		Agree		
23	**Total Cost of Care Accountability**	N/A	Agree		

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24	**CTO participation**	N/A	Yes – Agree	• Justification needed for why this business relationship should occur under the umbrella of CTOs	
25	**Track transitions**	N/A	Practices currently in the program would request a track transition and need to meet the requirements set out for the Track. The transition from Track 2 to Track 3 may be based on the practice requesting that transition without any other requirements anticipated. Practices moving from Track 1 to Track 3 would need to meet criteria similar to those established when moving from Track 2 to Track 3. Newly applying practices to MDPCP would need to request that Track and attest to meeting specified criteria in the RFA process and meet the algorithmic level of performance consistent with Track 3.	• Details needed on transition from T2 to T3 and direct entry to T3 • Mandatory or optional risk taking progression	