Primary Care First Multi-Payer Alignment Principles

Primary Care First (PCF) is a multi-payer model, like Comprehensive Primary Care Plus (CPC+) Tracks 1 and 2. CMS will partner with selected payers, including Medicare Advantage plans, commercial health insurers (including plans offered via state or federally facilitated Health Insurance Marketplaces), states (through the Medicaid and CHIP programs, state employees program, or other insurance purchasing), Medicaid/CHIP managed care organizations, state or federal high risk pools, and self-insured businesses or administrators of a self-insured group (Third Party Administrator (TPA)/Administrative Service Only (ASO)). Payer partners must commit to offering participating practices a primary care payment model that is aligned with Primary Care First.

CMS believes that multi-payer engagement is critical for amplifying the impact of PCF and driving primary care transformation. Aligned multi-payer partnerships increase the potential impact of value-based primary care models by:

1) Promoting consistent value-based incentives across a practice's entire patient population, which strengthens the influence of those incentives;
2) Encouraging practices to work towards similar objectives for their entire patient panel. This enables them to develop one comprehensive care approach rather than having to apply different care delivery models depending on payer status, which is administratively burdensome and at odds with patient-centered care; and
3) Reducing the administrative burden that practices face working with all of their payers, resulting in a larger net reduction in burden and a greater increase in resources to devote to direct patient care.

Payer partners need not offer identical primary care models in order to make progress towards these goals. Aligned models may differ on specific details, including in the mechanics of their payment methodologies, as long as they are aligned with PCF's four core model principles and objectives. The four core principles of PCF are: (1) moving away from a fee-for-service payment mechanism; (2) rewarding value based outcomes over process; (3) using data to drive practice accountability and performance improvement; and (4) leveraging multi-payer alignment as a critical tool for driving adoption of value-based care models. The table below provides a rubric for how CMS will review payer partner proposals, including specific criteria tied to each of the four core PCF principles. For each of the criteria, the table defines what would be deemed "not sufficient alignment," "acceptable alignment," and "preferred alignment." CMS encourages prospective payer partners to design an aligned payment model that meets as many of the "preferred alignment" criteria as possible. However, CMS will still accept payers who meet "acceptable alignment" criteria in some areas, with the expectation that these payers will work towards meeting "preferred alignment" standards during the course of their participation in the model. CMS will also consider proposals from payers that fall under "not sufficient alignment" on one or two criteria, and will seek follow-up conversations with those payers about the reason for the lack of sufficient alignment before making a final decision about whether to select them as payer partners. CMS recognizes that state Medicaid agencies may face specific constraints that make it challenging to meet some of these alignment criteria, and intends to work closely with interested state agencies to facilitate their participation in the model.

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Principle 1: Move away from fee-for-service payment mechanism			
Minimize volume-based incentive	• Partial primary care capitation with more than 50% of revenue reimbursed through capitated or other non-visit-based payment *OR* • Full primary care capitation	• Primary care episodes *AND/OR* • Shared savings/shared losses *AND/OR* • Partial primary care capitation with less than 50% of revenue reimbursed through capitated or other non-visit-based payment	• Fee-for-service plus care management fee *OR* • Fee-for-service plus at-risk care management fee *OR* • Reimburse additional codes for non-face-to-face services *OR* • Higher fee-for-service rates for primary care services
Risk adjustment	• Alternative to FFS payment is risk adjusted to account for factors including but not limited to health status and patient demographics	*Same as preferred alignment*	• Alternative to FFS payment is not risk adjusted
Principle 2: Reward outcomes, not process			

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Practices' reimbursement influenced by outcomes, not process	• Performance-based payment tied to clinical quality, patient experience, health improvement, cost and/or utilization measures *AND* • Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) *AND* • Performance-based payment not tied to achievement of care delivery processes (though care delivery processes/ certifications may be used to determine practice eligibility at start of model)	• Performance-based payment tied to clinical quality, patient experience, cost and/or utilization measures *AND* • Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) *AND* • Performance-based payment tied in part to achievement of care delivery processes	• Practices' reimbursement not influenced by performance in any way *OR* • Performance-based payment tied in full to achievement of care delivery processes *OR* • Performance-based payment not tied to utilization and/or total-cost-of-care measure(s) in any way
Performance can have substantial impact on practices' payment	• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by more than 15%	• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by between 5% and 15%	• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by less than 5%
Performance-based payment adjustment can be negative if practice has poor outcomes	• Performance can both increase and decrease payment, though potential upside is larger than potential downside	• Performance can both increase and decrease payment; potential upside is equal to potential downside	• Performance can only increase payment

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Alignment with PCF measure set	• Payer uses the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance *AND* • Payer uses few or no additional measures above and beyond the PCF measure set	• Payer uses at least three of the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance[1] *AND/OR* • Payer uses no more than 10 total measures, including PCF-aligned measures and additional measures *AND* • Additional measures are drawn from CMS's "Meaningful Measures" initiative, which used broad stakeholder feedback to identify the highest priority areas for quality measurement and improvement, and includes measures that are applicable across multiple CMS programs and patient populations	• Payer uses none of the same quality and utilization measures as CMS[1] *OR* • Payer uses a large number of additional measures above and beyond the CMS measure set
Principle 3: Deliver meaningful, actionable data reports to drive practice accountability and performance improvement			
Attribution	• Practices receive list of prospectively attributed members at least monthly	• Practices receive list of prospectively attributed members at least quarterly	• Practices receive list of attributed members less than quarterly

[1] CMS may consider additional flexibility on this requirement if payer can demonstrate that the PCF measures are not appropriate or relevant for their attributed populations

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Frequency[2]	• Payers provide service utilization and cost data at least quarterly	• Payers provide service utilization and cost data at least bi-annually	• Payers do not provide service utilization and cost data
Type of data[2]	• Payers provide practices with service utilization and cost of care data for attributed members	• Payers provide practices with some limited service utilization and cost of care data for attributed members	• Payers do not provide practices with service utilization or cost of care data for attributed members
Format of data[2]	• Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities *AND* • Data is accompanied by tailored support and guidance to help practices use the data *AND* • Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools.	• Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities *AND* • Data is accompanied by general (non-practice-specific) guidance about how to use the data *AND* • Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools.	• Data is not formatted in a way that allows practices to readily gain actionable insights; data cannot readily be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools *OR* • No resources are provided to help practices navigate the data *OR* • Payer does not provide data reports to practices
Level of data[2]	• Payers provide practices with beneficiary-level service utilization and cost data	• Payers provide practices with practice-level or practitioner-level service utilization and cost data	• Payers do not provide practices with utilization and cost data

[2] Note: For payers who participate in data aggregation, i.e. combining data from multiple payers into a single platform, the frequency, type, format, and level of data will be dictated by their data aggregation platform. Payers who are not participating in data aggregation should work to align with CMS and other payers in their region on these dimensions to the greatest extent possible, per the "alignment with CMS and other local payers" criteria

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Alignment with CMS and other local payers	• Payer either already participates in or is actively working towards participating in regional data aggregation with CMS and other regional payers, which provides multi-payer data in a single platform	• Payer participates in efforts to align data reporting with CMS and other local payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data)	• Payer makes no effort to align data reporting with CMS and other regional payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data)
Principle 4: Multi-payer alignment is critical for driving adoption of value-based care models			
Participation in regional multi-payer collaborative activities	• Payer actively participates in and contributes to regional multi-payer collaborative activities related to PCF	• Payer attends multi-payer collaborative events, but does not actively participate in or contribute to them	• Payer does not participate in multi-payer collaborative activities related to PCF that are available in their region
Goal-setting and continuous improvement	• Payers work with their regional peers to set annual goals for regional multi-payer collaboration and alignment, and develop plan for achieving goals/alignment targets AND • Payers demonstrate progress towards goals throughout the year	*Same as preferred*	• Regional payers do not set annual goals for regional multi-payer collaboration and alignment or develop plan for achieving goals/alignment targets

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Transparency on non-payment related topics	• To the greatest extent possible, payer will share information about non-payment related topics, e.g. attribution and risk adjustment methodologies, quality measurement strategies, and practice coaching activities with CMS and other local payers to inform payer alignment and collaboration activities	*Same as preferred*	• Payer does not make an effort to share information about non-payment related topics with CMS and other local payers in order to inform payer alignment and collaboration activities
Enable sufficient practice participation to drive broad-based payment and delivery reforms	• Payer sets reasonable eligibility criteria, e.g. minimum attributed member thresholds, that enable most or all participating PCF practices in their region to participate in the payer's PCF-aligned model	• Payer sets moderately restrictive eligibility criteria, e.g. minimum attributed member thresholds, that would meaningfully limit the number of participating PCF practices in their region that could participate in the payer's PCF-aligned model AND • Payer provides data-driven to CMS rationale for how eligibility criteria is set, e.g., member threshold is set to allow for valid and reliable calculation of performance measures	• Payer sets highly restrictive eligibility criteria, e.g. high minimum attributed member thresholds, that prevent the majority of participating PCF practices in its region from participating in the payer's PCF aligned model