



U.S. Department of Health & Human Services

Centers for Medicare & Medicaid Services

[Center for Medicare & Medicaid Innovation](#)

[Seamless Care Models Group](#)

2810 Lord Baltimore Drive, Suite 130

Baltimore, MD 21244



[Primary Care First](#)

Request for Applications

Cohort 2

Version: 3

Last Modified: [April 12, 2021](#)

Table of Contents

ABSTRACT	3
Primary Care First Overview	3
Scope	6
KEY MODEL PARTICIPANTS AND PARTNERS	7
Practices	7
Payers	10
INTERVENTION	11
Theory of Change and Driver Diagram	11
CARE DELIVERY DESIGN	14
PAYMENT REDESIGN	15
Attribution	17
Total Primary Care Payment (TCP)	17
Performance-Based Adjustment	21
Full Payment Calculation under the Primary Care First Model	25
QUALITY STRATEGY	26
Quality Measures for Practice Risk Score Groups 1-2	27
Quality Measures for Practice Risk Score Groups 3 or 4	28
LEARNING SYSTEMS STRATEGY	29
National Payer Community	30
DATA SHARING	30
PRACTICE MONITORING, AUDITING, AND TERMINATION STRATEGY	31
EVALUATION	32
AUTHORITY TO TEST THE MODEL	33
ADVANCED APM AND MIPS APM STATUS	34
PROGRAM OVERLAP AND SYNERGIES	35
APPENDICES	39
Appendix A: Practice Application Guidance and Questions	39
Appendix B: Solicitation for Payer Partnership Process and Selection	56
Appendix C: Health IT Requirements	73
Appendix D: Attribution Methodology	75
Appendix E: Medicare Covered Services Included in the Professional PBP and Flat Visit Fee ...	78

Abstract

This Request for Applications (RFA) invites applications for Primary Care First, an alternative payment model that offers an innovative payment structure to support the delivery of advanced primary care. The second cohort of Primary Care First participants will begin participation in the model in January 2022. Primary Care First is based on many of the same underlying principles as Comprehensive Primary Care Plus (CPC+), an existing Center for Medicare and Medicaid Innovation (CMMI) primary care model. CPC+ is designed to accommodate primary care practices at different stages of readiness to assume accountability for patient outcomes and currently has two tracks with different levels of payment redesign and care delivery requirements. By comparison, Primary Care First is geared towards advanced primary care practices that are ready to accept financial risk in exchange for greater flexibility, increased transparency, and performance-based payments that reward participants for outcomes. Additionally, in Primary Care First, CMS will provide payments that are higher than historical Medicare fee-for-service (FFS) payments, in the aggregate, for participating practices that care for complex, chronically ill patients. Primary Care First will be tested over six performance years, with two staggered cohorts of participating practices, each participating for five performance years—one cohort is participating in the model from 2021 through 2025 and a second will participate from 2022 through 2026. Participating practices will generally include primary care practitioners, as well as other clinicians that are managing complex, chronically ill populations. Primary Care First tests several new concepts:

- **Shifting focus of payment incentives to outcomes.** Practices will be accountable for their attributed beneficiary population through a simple two-tiered payment structure: (1) a total primary care payment, which consists of a population-based payment and flat primary care visit fee; and (2) a performance-based adjustment with greater upside than downside potential tied to one of two clear outcome measures depending on the average risk profile of practices' attributed beneficiary population—acute hospital utilization or total cost of care.
- **Increasing reimbursement for practices caring for patients with complex, chronic needs, relative to historical aggregate Medicare FFS revenue.** Practices that serve complex, chronic patient populations will receive a larger population-based payment for the Medicare covered services provided to this population. In aggregate, combined with the flat visit fee revenue, these practices' payments under the model will be larger than the Medicare FFS reimbursement they have historically received for delivering primary care services to complex, chronic patients. The larger population-based payment is intended to account for the higher disease burden in these populations and the increased resources required to serve patients with multiple chronic illnesses.

Primary Care First Overview

Under the authority of Section 1115A of the Social Security Act, CMS has designed Primary Care First, a primary care delivery and payment redesign initiative, to expand the scope of its primary care-focused Medicare innovation models. Relative to CPC+ (CMS's major existing primary care model), Primary Care First is designed for primary care practices that have already developed advanced primary care capabilities. CMS expects that practices interested in participating in the Primary Care First model will be prepared to take on greater financial risk in exchange for reduced care delivery requirements and the

possibility of higher performance-based payments.

Primary Care First will not require participating practices to adhere to a lengthy set of care delivery requirements. Because Primary Care First practices are expected to already be delivering advanced primary care at the time they apply to participate in the Primary Care First model, they will be given flexibility under the model to use their own individualized approaches to care delivery as long as they satisfy a minimum threshold of care delivery requirements. Primary Care First will also have minimal care delivery reporting requirements, reducing administrative burden for participating practices.

Primary Care First is designed to test whether changing how Medicare pays for primary care can lead to reductions in acute hospital utilization and lower total cost of care while preserving or improving quality. Primary Care First introduces a simple payment model that represents a major step away from FFS and towards paying for value. Participating practices will receive a majority of their primary care professional revenue for treating attributed beneficiaries in the form of a prospective population-based payment (PBP), or professional PBP. Practices can use these funds for innovative care delivery approaches, including those that are not dependent on office-based, face-to-face care, such as telehealth, care managers, and 24/7 primary care access. The amount of a practice's professional PBP is based in part on the practice's average risk profile of its entire attributed Medicare patient population. Practices whose patient populations are at high-risk and have complex, chronic needs receive a higher professional PBP than practices primarily serving lower-risk patients. To ensure that practices continue to provide care to their attributed patients, the professional PBP for each practice will be adjusted by a leakage rate adjustment, which is based on the percentage of qualifying visits and services that beneficiaries receive outside of the Primary Care First practice to which they have been attributed.

When practices participating in the model ("Primary Care First practices") deliver face-to-face primary care services to attributed beneficiaries, they receive a flat Medicare payment for each face-to-face encounter. The flat visit fee compensates practices for the resources necessary for in-person care and reinforces the model's focus on reducing practice reliance on revenue cycle management and offering greater operating flexibilities through a PBP and flat visit fee (FVF).

Under the model, a participating practice's professional PBP and flat primary care visit revenue will be referred to as its Total Primary Care Payment, or TPCP.

Primary Care First includes a performance-based payment adjustment (PBA) that is calculated and applied on a quarterly basis beginning in the second quarter of the second performance year. This adjustment has the potential to increase a practice's Total Primary Care Payment (TPCP) by as much as 50%, or decrease it by up to 10%. The PBA rewards practices that:

Exhibit a high standard of performance and quality. Beginning in performance year two, practices must exceed a standard known as the Quality Gateway to be eligible for a positive PBA. The Quality Gateway is a performance threshold based on a set of clinical quality and patient experience measures. For practices that exceed the Quality Gateway, CMS will use either a measure of acute hospital utilization (AHU) or total per capita cost (TPCC) to evaluate a practice's AHU or TPCC performance during a rolling 12-month period that ends three months before the PBA payment quarter. The national performance

benchmark will be the 50th percentile of national performance on AHU/TPCC. This design ensures that participating practices receiving a PBA are managing avoidable utilization at a rate that is above average when compared to other similar practices that furnish services to Medicare beneficiaries, regardless of their location.

Excel compared to peer practices and improve over time. If a participating practice exceeds both the national AHU/TPCC performance benchmark and the Quality Gateway, then the practice is eligible for a positive PBA. The specific amount of the PBA depends on the practice's AHU/TPCC performance relative to a reference group of practices in a peer region, as well as its performance relative to its own historical performance. This approach is intended to reward high achieving practices that are optimizing outcomes, while acknowledging the importance of regional characteristics of care and continuous practice improvement.

Improve or maintain high quality outcomes. If a participating practice does not meet the Quality Gateway in performance year one, the maximum PBA it can earn for all quarters of the second performance year is 0%. Whether it ultimately receives a neutral PBA (0%) or a negative PBA for each quarter of the second performance year will depend on its AHU/TPCC performance. In performance year three and beyond, failing to exceed the Quality Gateway will result in an automatic -10% PBA for all four quarters of the year, regardless of AHU/TPCC performance. The Quality Gateway penalty phases in to ensure practices continue to focus on quality outcomes as they become familiar with the model measures.

Primary Care First also involves new, higher payments for Primary Care First practices that care for complex, chronically ill beneficiaries. In particular, it focuses on two high-risk beneficiary populations:

- 1) The complex, chronically ill population, who require intensive resources due to their high disease burden and multiple comorbid conditions. Participating practices that specialize in treating complex, chronically ill patients will receive a higher professional PBP than practices with average or low risk patient populations (as measured by the average CMS hierarchical condition category [CMS-HCC] risk score of the practices' attributed beneficiaries). A higher PBP will enable these practices to use innovative care delivery strategies to better address their patients' complex care needs, reduce acute hospital utilization, and lower total cost of care.
- 2) The **seriously ill population (SIP)**, who may have a similar clinical profile to the complex, chronically ill population, but exhibit a fragmented pattern of care. The goal of the SIP component of the model is to proactively intervene with beneficiaries who appear unmanaged and on a downward clinical trajectory, stabilize them through high touch care coordination and case management, and transition them to a practitioner or other care setting (e.g. hospice) that can best meet their longer-term goals of care. Primary Care First uses a separate payment structure for practices that care for SIP beneficiaries, which will include a one-time per beneficiary payment for patient outreach and engagement, as well as monthly per beneficiary payments that include an upward or downward adjustment based on quality.

Primary Care First is also a multi-payer model. Aligned multi-payer partnership increases the potential impact of Primary Care First in three ways. It increases the likelihood that:

- Participating practices have consistent financial incentives across their entire patient population, which strengthens the influence of those incentives;
- Participating practices 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;
- Participating practices face lower administrative burden across all of their payers, resulting in a larger net reduction in burden and a greater increase in resources to devote to direct patient care.

CMS seeks payer partners that can align with the Primary Care First payment methodology, quality measurement strategy, and data sharing approach.

Overall, Primary Care First is responsive to stakeholder feedback from advanced practices that expressed interest in accepting increased financial risk in exchange for greater flexibility and fewer model requirements.

Scope

Primary Care First will be tested over six performance years, with two staggered cohorts of participating practices, each participating for five performance years—one cohort is participating in the model from 2021 through 2025 and a second will participate from 2022 through 2026.

For the second cohort, CMS is accepting applications from practices (including CPC+ Practices) located in the following 26 regions: Alaska (statewide), Arkansas (statewide), California (statewide), Colorado (statewide), Delaware (statewide), Florida (statewide), Greater Buffalo region (New York), Greater Kansas City region (Kansas and Missouri), Greater Philadelphia region (Pennsylvania), Hawaii (statewide), Louisiana (statewide), Maine (statewide), Massachusetts (statewide), Michigan (statewide), Montana (statewide), Nebraska (statewide), New Hampshire (statewide), New Jersey (statewide), North Dakota (statewide), North Hudson-Capital region (New York), Ohio and Northern Kentucky region (statewide in Ohio and partial state in Kentucky), Oklahoma (statewide), Oregon (statewide), Rhode Island (statewide), Tennessee (statewide), and Virginia (statewide). These regions were primarily selected to ensure that the model test population would be representative of the entire Medicare population for the purposes of evaluation, and to limit impact on the existing Comprehensive Primary Care Plus evaluation strategy.

The application period for practices applying to begin participation in Primary Care First in January 2022 will open on March 16, 2021 and close on May 21, 2021.

The solicitation period for payers will formally open on March 16, 2021, and will close on June 18, 2021. This timeline will allow payers to assess practice participation and the opportunity to promote aligned, value-based care in Primary Care First, and make an informed decision about their own aligned approaches as payer partners.

After the practice application period closes on May 21, 2021, CMS plans to inform interested payers of the level of primary care practice interest in participation in the model.

Practice and payer selections will take place in Spring-Summer 2021. The model cohort will begin participation in the model in January 2022. CMS will focus on onboarding participating practices and payer partners to the model from August to December 2021.

The Primary Care First applications are not legally binding contracts; selected practices will be required to sign a Participation Agreement with CMS before beginning participation in the model. Selected payer partners must sign a Memorandum of Understanding with CMS. The Participation Agreement will contain greater detail regarding the model and some aspects of the model may be modified as we continue to consider stakeholder feedback and operational issues.

The SIP component of the model is currently under review, and this Request for Applications is not soliciting applicants for the SIP Component of Primary Care First.

Key Model Participants and Partners

Practices

Primary Care First is designed for primary care practices with advanced primary care capabilities, including those that specialize in caring for complex, chronically ill patient populations, that are prepared to accept increased financial risk in exchange for greater flexibility and potential rewards based on practice performance. Eligible applicants are primary care practices that provide primary care health services at a particular location to a minimum of 125 attributed Medicare beneficiaries, and can meet the Primary Care First eligibility requirements described in this RFA. If the practice offers medical services at multiple locations, the practice will need to submit separate applications for each practice location that it wishes to participate in Primary Care First. Eligible practitioners are those practicing in internal medicine, general medicine, geriatric medicine, family medicine, and/or hospice and palliative medicine. Each practice must submit a practitioner roster that identifies, by NPI, all Primary Care First eligible practitioners that practice at the relevant location and will bill under the TIN of the practice for the purposes of the model. Each practitioner should only be included on one Primary Care First practice's practitioner roster.

Practice Application and Eligibility Criteria

Practice application questions, including deadlines and contact information, can be found in [Appendix A](#). Applicants must submit all application materials via an online portal available at <https://app.innovation.cms.gov/PCF> by the deadline. It is the responsibility of the applicant to ensure that they include all required information in their application. In order to be eligible to participate in Primary Care First, a practice must:

- Be located in one of the Primary Care First regions.
- Include primary care practitioners (MD, DO, CNS, NP, and PA) certified in internal medicine, general medicine, geriatric medicine, family medicine, or hospice and palliative medicine.
- Provide health services to a minimum of 125 attributed Medicare beneficiaries.

- Have primary care services account for at least 50% of the practices' collective billing based on revenue. In the case of a multi-specialty practice, 50% 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 FFS payments such as full or partial capitation.
- Adopt and maintain, at a minimum, health IT meeting the definition of CEHRT at 42 CFR 414.1305 and the certification criteria found at 45 CFR 170.315(c)(1) - (3)¹ for electronic clinical quality measure (eCQM) reporting, using the most recent update available on January 1 of the Measurement Period², for the eCQMs in the Primary Care First measure set; 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 beneficiaries to a practitioner or care team. Practices with an average patient complexity in the top two practice risk score groups (*out of four; see [Payment Redesign](#) section for more detail about practice risk score groups*), will need to demonstrate certain clinical capabilities. These practices must illustrate competencies in successfully managing complex patients, including through interdisciplinary care teams, comprehensive person-centered care management, care coordination, family and caregiver engagement, 24/7 access to a member of the care team, and the ability to connect beneficiaries to resources in the community to help address social determinants of health and behavioral health issues.

Practices participating in the Medicare Shared Savings Program may participate in Primary Care First if they meet the above eligibility criteria. However, practices participating in models that have a policy prohibiting overlapping participation in PCF, as described in the Program Overlaps and Synergies section below, are ineligible for PCF. Furthermore, the following practice types are not eligible to participate in the model:

- Concierge practices (any practice that currently charges patients a retainer fee, or intends to do so at any point during the 5-year performance period under the model Participation Agreement).
- Rural Health Clinics.
- Federally Qualified Health Centers (FQHCs).

¹ For each of these sections, (c)(1) is the certification criterion for "Record and Export"; (c)(2) is the certification criterion for "Import and Calculate; and (c)(3) is the certification criterion for "Report".

² "Measurement Period" means the time period for which a participating practice must report quality data to CMS in accordance with the requirements described in the participation agreement.

- Critical Access Hospitals that have elected to bill under Method II.

Practice Selection

To be selected for participation in Primary Care First, practices must first meet the eligibility criteria, as described above.

Applicants that meet the Primary Care First practice eligibility requirements and successfully complete the practice application process will be selected to participate in Primary Care First, subject to the results of a program integrity screening. The legal entity whose TIN is used to bill Medicare for services rendered at the practice site address must sign a Participation Agreement with CMS as a condition of the practice's participation in Primary Care First. If the same legal entity operates at multiple practice site addresses, it must sign a separate Participation Agreement for each participating practice site address.

Practice Termination Policy

As part of the Primary Care First model test, CMS aims to determine whether Primary Care First practices can succeed in improving quality and reducing costs over time. To that end, the Primary Care First model has a termination policy that is designed to encourage longer participation in the model. A participating Primary Care First practice may terminate its Participation Agreement upon advance written notice to CMS, which must specify the effective date of termination. However, a practice will not be permitted to specify an effective date of termination that occurs before the last day of a performance year unless it provides CMS advance written notice of termination no later than 60 days after the start of the first performance year (or February 28 of any subsequent performance year). If a practice provides a notice of termination before the end of a performance year pursuant to this exception, its payments under the model will cease as of the effective date of termination and the practice will revert to receiving Medicare FFS payments for primary care services furnished to attributed beneficiaries. In the case of other terminations by a model participant, the practice will continue to receive model payments for primary care services furnished to its attributed beneficiaries until the last day of the performance year. A practice may withdraw its notice of termination at any point before December 31st of the performance year and thereby continue its participation in the model during the next performance year.

Participating PCF practices that do not use the early termination exception described above but who terminate their participation agreements at the end of a performance year will not be able to participate in another Innovation Center model for a limited period of time that will be specified by CMS in the participation agreement. In addition, CMS may consider the amount of time that a practice participated in the Primary Care First model when reviewing a practice's potential future application to participate in other Innovation Center models. Further, to prevent organizations that own multiple affiliated participating practices from selectively terminating the participation of lower performing practices in the model, CMS may terminate all of the affiliated participating practices if CMS finds that the participating

practices are owned by an organization that owns multiple participating practices and appears to be selectively terminating the participation of its lower performing participants.

Payers

Through multi-payer engagement in Primary Care First, CMS aims to align incentives across a participating practice's entire patient population. In Primary Care First, CMS will encourage other payers—including Medicare Advantage plans, commercial health insurers (including their self-insured business), Medicaid managed care plans (to the extent permitted and consistent with the Medicaid managed care plan's contract with the state), and State Medicaid agencies—to engage practices on similar outcomes with respect to their members.

Both existing CPC+ model payer partners and new payers that have members in the eligible regions will be eligible to participate in Primary Care First. CMS will review responses to the payer solicitation and select payer partners based on how well their proposed model aligns with Primary Care First in the domains of payment, data sharing, and quality measurement.

CMS will enter into a Memorandum of Understanding (MOU) with each selected payer partner, which will memorialize the payers' agreed-upon payment approaches and state how they are expected to align with CMS on payment, quality measurement, and provision of data to practices. All payers should separately enter into agreements with the participating practices.

Payer Solicitation Information

CMS will evaluate payer proposals' based on the extent of their alignment with the following framework. Detailed information on the payer solicitation for prospective payer partners can be found in [Appendix B](#), including the specific criteria that CMS will use to evaluate payer proposal alignment. Interested payers must submit all application materials via an online portal available at <https://app.innovation.cms.gov/PCF>.

Payment

- Commit to pursuing private arrangements with participating Primary Care First practices for the entire performance period.
- Reimburse Primary Care First practices through at least a partial alternative to FFS payment, such as a population-based payment.
- Offer an opportunity for a performance-based incentive payment that aligns with the financial model outlined in the [Payment Redesign](#) section. The payment should be tied to practice performance on a combination of cost, quality, and/or utilization metrics.

Data Sharing

- Share their attribution methodologies with CMS.
- Make practice- and patient-level data available upon request to participating practices in accordance with applicable law, including data on cost, utilization, and quality for their attributed patients, either through reports or other methods of data sharing at regular intervals (e.g., quarterly).

- Participate in multi-payer collaboration around data sharing and the use of regional data infrastructure to the greatest extent possible, as outlined in the [Data Sharing](#) section.

Quality Measures

- To the greatest extent possible, align practice quality and performance measures with CMS and other payer partners, as outlined in the [Quality](#) section.

Intervention

Theory of Change and Driver Diagram

Primary Care First is a new model that shares some design elements with the current CPC+ model and also builds on the existing CPC+ model's theory of change.³ The hypothesis is that practices in Primary Care First will provide comprehensive and continuous care, thereby improving patient care and reducing acute hospital utilization, which in turn should lead to higher quality and reduced Medicare expenditures overall.

The theory of change is supported by the key design elements of the model. Improved quality, a positive experience of care, and reduced total cost of care is achieved through five drivers in the model, as described in Figure 1 below.

Figure 1: Primary Care First and CPC+ Driver Diagram

³ CMS reserves the right to change design elements of Primary Care First to comply with any future laws or regulations, or to adjust program parameters based on program, policy, or operational needs.



The primary driver centers on the practitioner-patient relationship through the *Comprehensive Primary Care Functions* (the top half of the radial diagram, shown in light blue below). Three supportive drivers give practices the tools to deliver these primary care functions: *Use of Enhanced, Accountable Payment* (shown in green); *Optimal Use of Health IT* (shown in orange); and *Continuous Improvement Driven by Data* (shown in burgundy). We are also encouraging payer partners to provide practices the resources and incentives to spend more time with patients, while reducing costs and delivering high quality care through *Aligned Payment Reform* (outer concentric circle shown in purple).

Primary Care First shifts focus to paying practices for delivering outcome improvements (rather than paying them to fulfill process-oriented care delivery requirements). The Total Primary Care Payment, TPCP, is designed to allow Primary Care First practices to get off the “FFS Treadmill”⁴ and achieve incentive neutrality (the incentive to bring a patient to the office is balanced with the incentive to provide necessary care outside of an office visit).^{5,6}

⁴ Bitton, A., Schwartz, G.R., Stewart, E.E., Henderson, D.E., Keohane, C.A., Bates, D.W., & Schiff, G.D. (2012). Off the hamster wheel? Qualitative evaluation of a payment-linked patient-centered medical home (PCMH) pilot. *Milbank Q*, 90(3), 484-515.

⁵ Ash, A.S., & Ellis, R.P. (2012). Risk-adjusted payment and performance assessment for primary care. *Med Care*, 50(8), 643-53.

Practices will be further incentivized through a performance-based adjustment (PBA) to their Total Primary Care Payment (TPCP), to improve quality of care by reducing unnecessary acute hospital utilization or total per capita cost. The amount of a practice’s PBA will be calculated largely based on their acute hospital utilization performance or total per capita cost. The PBA is made quarterly in order to motivate more responsive behavioral change. Simultaneously, the model will promote transparency and competition through frequent data insights into practitioner performance relative to other model participants.

As described in Table 1, while the CPC+ model and the Primary Care First model share the same theory of change, the models focus and organize the work of the drivers differently.

Table 1. Summary of Key Design Elements of CPC+ Model and Primary Care First Model:

Design Elements	CPC+ Track 1	CPC+ Track 2	Primary Care First
Key Model Participants and Payer Partners	Primary care practices that are in the early stages of developing advanced primary care capabilities and would benefit from upfront funds to invest in practice transformation; health care payer organizations, including Medicare Advantage plans, commercial plans, state Medicaid agencies, and Medicaid managed care plans that offer a program for CPC+ Track 1 practices that aligns with CMS’s approach	Primary care practices that have some experience with developing advanced primary care capabilities and are looking to deepen and expand their practice transformation efforts; health care payer organizations, including Medicare Advantage plans, commercial plans, state Medicaid agencies, and Medicaid managed care plans that offer a program for CPC+ Track 2 practices that aligns with CMS’s approach	Primary care practices that have developed advanced primary care capabilities and are willing to accept downside financial risk in exchange for greater flexibility, reduced administrative burden, and greater potential financial reward for positive outcomes; health care payer organizations, including Medicare Advantage plans, commercial plans, state Medicaid agencies, and Medicaid managed care plans that offer a program for Primary Care First practices that aligns with CMS’s approach
Care Delivery	Practices implement core capabilities of comprehensive primary care throughout model performance period.	Practices implement core and advanced capabilities of comprehensive primary care throughout model performance period.	Practices have capabilities to deliver advanced primary care at outset of model performance period.

⁶ Vats, S., Ash, A.S., & Ellis, R.P. (2013). Bending the cost curve? Results from a comprehensive primary care payment pilot. *Med Care*, 51(11), 964-9.

Design Elements	CPC+ Track 1	CPC+ Track 2	Primary Care First
Payment	<p><i>Care Management Fee:</i> Practices augment staffing and training to implement core care delivery model.</p> <p><i>Performance-Based Incentive Payment:</i> Practices are motivated to reduce utilization and improve quality and experience of care.</p>	<p><i>Comprehensive Primary Care Payment:</i> Practices have flexibility to deliver care based in the modality that best meets patient need.</p> <p><i>Care Management Fee:</i> Practices augment staffing and training to implement advanced care delivery model. Practices receive increased support for patients with complex needs.</p> <p><i>Performance-Based Incentive Payment:</i> Practices are motivated to reduce utilization and improve quality and experience of care.</p>	<p><i>Total Primary Care Payment:</i> Practices are paid to deliver advanced primary care in and outside of the office. Practices focused on caring for patients with complex chronic needs receive increased payments to support their care for these patient populations.</p> <p><i>Performance-Based Adjustment:</i> Practices are motivated to reduce AHU/TPCC while meeting quality and experience of care performance thresholds.</p>
Data Sharing	Medicare FFS expenditure and utilization data are delivered, if requested by participating practices, clearly and actionably on a quarterly basis. Data includes practice-level data and may include patient-level data for the practice’s attributed patient population.	Medicare FFS expenditure and utilization data are delivered, if requested by participating practices, clearly and actionably on a quarterly basis. Data includes practice-level data and may include patient-level data for the practice’s attributed patient population.	Medicare FFS expenditure and utilization data and Medicaid data, as available, are delivered, if requested by participating practices, clearly and actionably on a quarterly basis. Practices can request claims line feeds for their attributed patient population, and incorporate any claims data received into their own analytic tools.

Care Delivery Design

Primary care practitioners in CPC+, and now Primary Care First, are incentivized to achieve better care at lower costs. They accomplish this aim through delivery of five comprehensive primary care functions:

- 1) **Access and Continuity** builds on the patient-practitioner relationship to ensure patients receive the right care at the right time from the right care team member. All Primary Care First practices must provide 24/7 access to a care team practitioner with real-time access to the EHR. Practices

servicing complex, chronic beneficiaries (“Groups 3 & 4” practices) must deepen this work by additionally providing timely callbacks to beneficiaries and their other health care providers who contact the practice.

- 2) **Care Management** supports the optimal management of complex care targeted to those most likely to benefit. All Primary Care First practices must provide risk-stratified care management and timely emergency department (ED) and hospital follow-up. Practices in Groups 3 and 4 must deepen this work by engaging high-risk beneficiaries in health care planning and ensuring that beneficiaries receive appropriate services from other health care providers (e.g., DME items and services).
- 3) **Comprehensiveness and Coordination** increases the breadth and depth of primary care, while facilitating care for beneficiaries as it occurs outside of the practice. Primary Care First practices must integrate behavioral health care, and assess beneficiaries’ psychosocial needs. Practices in Groups 3 and 4 must deepen this work by ensuring coordinated referral management when patients seek specialty care, and by creating an inventory of services and supports in the community to address their complex psychosocial needs.
- 4) **Patient and Caregiver Engagement** involves patients in their own care decisions and ensures that patients guide practice improvements. Primary Care First practices must implement a regular process for patients and caregivers to advise practice improvement. Practices in Groups 3 and 4 must deepen this work by engaging families and caregivers in patient care for all beneficiaries, and with a particular focus on their high-risk beneficiaries.
- 5) **Planned care and Population Health** capabilities enable practices to meet the preventive and chronic care needs of the entire patient population. Primary Care First practices must set goals and continuously improve upon key outcome measures.

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.

Payment Redesign

The payment design for Primary Care First represents a shift from making upfront investments in care delivery functions, as CMS does through care management fees in the CPC+ model, to paying practices primarily for outcomes. It is also a significant step away from FFS and towards population-based payment. The Primary Care First payment structure is designed to be simple, with a per-beneficiary per-month payment that reduces practice reliance on revenue cycle management, gives them the flexibility to use innovative care delivery tools and tactics, and sets clear, easy-to-understand performance standards.

The payment structure has two elements, which are described in more detail in this section:

- 1) **Total Primary Care Payment (TPCP):** The TPCP will largely replace practices’ traditional FFS billing for primary care services. It includes two elements, a prospective professional population-

based payment (PBP) paid on a quarterly basis and a flat \$40.82 base rate per-visit primary care fee. Together, these payment mechanisms create an incentive to deliver advanced, patient-centered primary care while also compensating practitioners for face-to-face visits. As discussed in more detail below, these payments are subject to adjustments to account for variations in cost of care, including a geographic adjustment, risk adjustment, and a leakage adjustment to encourage practices to actively manage their attributed patients to limit their need to seek care from other primary care practices.

- 2) **Performance-Based Adjustment (PBA):** Beginning in the second quarter of performance year two, and on a quarterly basis thereafter, a practice's TPCP will be adjusted based on its performance on acute hospital utilization (AHU) or total per capita cost (TPCC), as well as whether the practice meets or exceeds minimum performance on a set of pre-defined quality measures each year. The quality measures will be incorporated into a Quality Gateway, which is a minimum threshold that practices must meet to be eligible for a positive PBA. If a practice meets or exceeds the Quality Gateway, its performance on AHU or TPCC will be used to determine their quarterly PBA. The focus on AHU or TPCC offers practices a clear outcomes-based metric, and the Quality Gateway ensures that practices are not delivering lower-quality care in an effort to reduce utilization.⁷ Practices may receive a maximum possible positive PBA of 50% and a maximum possible negative PBA of -10%. Practices that fail to meet the minimum standards of the Quality Gateway for any of the measures will receive a neutral PBA (0%) or a negative PBA (-10%) in each quarter of performance year two, depending on their AHU/TPCC performance.⁸ In performance year three and beyond, the impact of failing to meet the Quality Gateway will increase to an automatic -10% PBA for all four quarters of the year, regardless of a practice's AHU/TPCC performance.

Table 2 summarizes how the payment mechanism in Primary Care First compares to CPC+ Tracks 1 and 2. The remainder of this section discusses the components of the Primary Care First payment mechanism in greater detail.

⁷ McCarthy, D., Ryan, J., & Klein, S. (2015, October 29). Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis. Retrieved from <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/care-high-need-highcost-patients>

⁸ Practices that fail to meet the Quality Gateway in year 2 may receive a -10% PBA if they are also in the bottom quartile of their regional AHU benchmark.

Table 2. Comparison of Payment Mechanisms between Primary Care First and CPC+ Tracks

Characteristic	CPC+ Track 1	CPC+ Track 2	Primary Care First
Beneficiary Attribution	Claims-based with voluntary alignment opportunity	Claims-based with voluntary alignment opportunity	Claims-based with voluntary alignment opportunity
Care Management Fee	Yes (\$15 average)	Yes (\$28 average)	No
Performance-Based Payment Potential (% of Revenue)	~0-10%	~0-20%	-10-50%
Underlying Payments to Participating Practice	Standard FFS	Reduced FFS with prospective Comprehensive Primary Care Payment	Risk, geographic, and leakage adjusted professional PBP with a geographically adjusted flat primary care visit fee

Attribution

Medicare FFS beneficiaries who meet PCF eligibility criteria are attributed to Primary Care First practices via voluntary alignment and based on Medicare claims on a quarterly basis. Beneficiaries attributed to Primary Care First practices retain freedom of choice of practitioner.

Voluntary Alignment

To prioritize beneficiary choice in Primary Care First attribution, the first step in the model’s attribution methodology is voluntary alignment. Under voluntary alignment, a beneficiary attests to their choice of a primary care practitioner. If the beneficiary 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. This attestation will also supersede claims-based attribution in Primary Care First.

Claims-Based Attribution

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 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 [Appendix D](#).

Total Primary Care Payment (TPCP)

In Primary Care First, the TPCP is designed to move away from traditional fee-for-service (FFS) payment incentives. Under FFS payment methodologies, there is a strong incentive to bring patients into the

office to create a billable face-to-face service, even if phone calls or electronic communications would be a better means of meeting the patient’s needs or preferences.

In order to balance these incentives, the TPCP includes two payment types: (1) a professional population-based payment (PBP) paid quarterly on a prospective basis; and (2) a flat fee for each primary care visit, paid on a claim-by-claim basis. 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](#). The PCF Payment Methodologies Paper provides further detail on current payment policies and will be updated yearly with any changes.

Combined, these payments will be roughly equivalent to average historical Medicare Physician Fee Schedule (PFS) primary care revenue for practices with an average-risk beneficiary population for care furnished in an office or via telehealth. The national base rates for the PBP and flat visit fee provided in this RFA are comparable to 2021 PFS rates for the primary care services covered by the model payments. Please note that CMS may update these payment amounts for 2022 and future performance years of the model to ensure they are consistent with average primary care practice revenues from Medicare FFS, including changes to the PFS.

As summarized in Table 3 below, for the purposes of risk adjusting the professional PBP, practices will be divided into four groups based on the average hierarchical condition category (HCC) risk score of their attributed Medicare beneficiaries. The professional PBP is higher for practices assigned to higher risk groups to account for the resources needed to serve beneficiaries with increasingly complex care needs. To simplify billing and reduce coding and documentation burden, the flat primary care visit fee is the same across all four practice risk groups.⁹ However, beneficiaries in higher risk groups are expected to have more in-person visits due to their more complex care needs, resulting in a higher average per-beneficiary primary care visit fee revenue, as shown in Table 3.

Table 3. Components of the Primary Care First Total Primary Care Payment

Practice Risk Group	CMS-HCC Practice Average Risk Score Criteria	Professional PBP (PBPM) ¹⁰	Estimated Flat Visit Fee (PBPM) based on expected visit frequency ¹¹	Estimated TPCP (PBPM)
Group 1	<1.2	\$28	\$21	\$49
Group 2	1.2-1.5	\$45	\$26	\$71
Group 3	1.5-2.0	\$100	\$29	\$129
Group 4	>2.0	\$175	\$37	\$212

⁹ The national flat visit fee base rate for 2021 is \$40.82.

¹⁰ The national PBP base rates do not include geographic adjustment.

¹¹ Flat visit fee estimates based on estimated number of primary care visits per beneficiary per year (e.g., $(\$40.82 + \$18 \text{ coinsurance}) * 4.4 \text{ visits} / 12 \text{ months} = \text{approximately, } \21 PBPM). Higher practice risk groups are expected to have more frequent in-person visits than lower practice risk groups. Calculations use the national flat visit fee base rate for 2021 and an estimate of beneficiary coinsurance, and do not include geographic adjustments, MIPs adjustments, or sequestration.

Professional Population-Based Payment

The professional PBP changes the payment mechanism for primary care from FFS to population-based payment, promotes flexibility in how participating practices deliver care, and allows them to increase the breadth and depth of the primary care they deliver while focusing on continuous practitioner-patient relationships. The professional PBP also enables practices to serve patients in a way that best meets the needs of the patient, whether by email, phone, patient portal, or other telehealth modalities (like real-time audio and video), or in alternative settings such as the patient's home.

A practice's professional PBP is risk-adjusted based on the average HCC risk score of its attributed Medicare beneficiaries. Practices are assigned to one of four risk score groups annually. Each risk group is associated with a per-beneficiary per-month (PBPM) professional PBP base rate ranging from \$28 to \$175 (2021 national base rates used for illustrative purposes). Practices receive the same professional PBP for all of their attributed beneficiaries, regardless of those beneficiaries' individual risk scores.

The goal of this group-based risk adjustment methodology is to reduce practice focus on individual risk scores. Because a practice's PBPM is determined by the average risk score across its entire attributed beneficiary population, a change in an individual beneficiary's risk score will likely not impact the overall amount of the professional PBP. Our aim is to ensure that practices focusing on care for complex chronic beneficiaries are recognized and appropriately grouped in the model. Additional information on the risk adjustment approach in PCF will be provided separately.

The professional PBP will be geographically adjusted in a similar manner to the PFS rates to account for nationwide variation in cost. There is no beneficiary cost-sharing associated with the professional PBP. CMS may also adjust the PBP periodically to reflect updates to PFS rates for the services included in the professional PBP.

The professional PBP will also be adjusted to account for "leakage," or the percent of qualifying primary care services furnished by primary care practitioners outside of the practice to the Primary Care First practice's attributed beneficiaries, relative to all of their qualifying services. This adjustment incentivizes a sustained practitioner-patient relationship. Under this leakage rate construct, CMS presumes that beneficiaries will tend to increase the amount of primary care they seek elsewhere if they are not satisfied with the care they receive from the participating Primary Care First practice. Thus, an increase in primary care services received by attributed beneficiaries from practitioners outside of the practice will lead to a reduction in the participating practice's professional PBPs. See Table 4 for an illustrative example of a practice whose leakage adjustment of 25 percent is applied to its professional PBP. Note that the leakage adjustment is first applied in the second quarter of the second performance year, and will be based on the beneficiaries attributed during the first performance year and their qualifying services rendered during that same time period.

Table 4. Illustrative Example of Professional PBP with Leakage Adjustment

Number of Qualifying Services for Attributed Beneficiaries Outside PCF Practice	÷ Number of Qualifying Services for Attributed Beneficiaries (Including PCF Practice)	= Leakage Rate	Professional PBP for Group 1 Practice (PBPM) * (1 - Leakage Rate) = Paid Professional PBP (PBPM) ¹²
500	÷ (1,500 + 500)	= 0.25	\$28*(1-0.25) = \$21

Flat Primary Care Visit Fee

Primary Care First practices will receive a flat Medicare payment of \$40.82 for face-to-face primary care patient encounters with their attributed beneficiaries. This flat primary care visit fee is intended to support practices delivering primary care to patients that require a face-to-face visit and encourage practices to continue seeing beneficiaries face-to-face as appropriate. With a flat visit fee, practices can readily understand the payment they will receive for primary care furnished face-to-face to an attributed Medicare beneficiary.

Primary Care First practices will receive the flat visit fee when they bill a Healthcare Common Procedure Coding System (HCPCS) code for an eligible primary care service (listed in [Appendix E](#)) for an attributed beneficiary. Depending on the services provided, practitioners will receive an adjustment to the claims amount so that it is paid at the flat visit fee rate. Note that Medicare payment to the practice is limited to one flat visit fee per-beneficiary per-day, even if multiple eligible services are provided. The flat visit fee will be geographically adjusted in a similar manner to the PFS rates to account for nationwide variation in cost. Similar to the Professional PBP, CMS may adjust the Flat Visit Fee base rate to reflect updates to relevant Physician Fee Schedule payment rates for the services included in the Flat Visit Fee base rate calculation, including but not limited to HCPCS coding changes, changes in relative value unit assignments, and updated adjustment factors.

Beneficiary cost-sharing is based on the PFS allowed amount for the HCPCS code(s) that a practice submits on the claim, rather than the flat visit fee. Thus, the deductible and coinsurance will be equivalent to what a beneficiary would have paid under traditional FFS for the same primary care service, and will not increase or decrease as a result of their attribution to a Primary Care First practice. However, as a beneficiary engagement incentive and departing from CPC+ Tracks 1 and 2, practices can reduce or waive the applicable coinsurance as allowed by Medicare and applicable model waivers. Practices are responsible for covering those costs (i.e., CMS will not compensate practices for the loss in cost sharing revenue). This approach would incorporate certain safeguards against abuse and allow practices flexibility to better support patient engagement, while allowing practices to focus on populations that might benefit most from coinsurance support (e.g., those with frequent recent ED and hospital visits). Not all beneficiaries aligned to a PCF practice would qualify for cost-sharing support.

¹² The professional PBP is also subject to other adjustments, including geographic adjustment, Merit-based Incentive Payment System (MIPS) adjustment, and 2% Medicare sequestration required by federal rulemaking.

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 policies in accordance with the implementation plan approved by CMS.

CMS will review billing patterns and monitor flat visit fee claims adjustments on an ongoing basis and may audit outlier practices with very high visit rates to ensure that practices are not unnecessarily increasing the number of face-to-face visits for attributed beneficiaries in order to generate additional flat visit fee revenue. CMS reserves the right to modify flat visit fee policies if monitoring identifies unanticipated changes in billing patterns for services included in the flat visit fee.

Performance-Based Adjustment

The performance-based adjustment (PBA) is designed to reward practices that meet key quality standards and work continuously to reduce unnecessary acute hospital utilization (AHU) or total per capita cost of care (TPCC). The PBA is an adjustment to the TPCP, which is made up of both the professional PBP and flat visit fee. Practices will have the opportunity to increase their TPCP by up to 50% through the PBA.

The PBA is calculated quarterly and based on practices' performance during a rolling one-year performance period that ends three months before the PBA is applied to model payments. This timeline is intended to make the PBA as responsive to changes in practice performance as possible. Table 5 illustrates the timeline for applying the PBA to model payments. Note that the PBA will begin impacting practices' TPCP in the second quarter of their second performance year.

Table 5. Timeline for Applying PBA to Future Model Payments

	Year 1 Q4	Year 2 Q1	Year 2 Q2	Year 2 Q3	Year 2 Q4	Year 3 Q1
Q1						
Q2						
Q3						
Q4						
	= Last Quarter of One-Year Performance Period					
	= Performance Calculated based on Performance Period					
	= Performance-Based Adjustment Applied to Model Payments					

Depending on the practice risk group, CMS will use either a claims-based, risk-adjusted utilization measure (AHU) or a total per capita cost measure (TPCC) to calculate the PBA. The AHU measure, included in the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), is an observed-to-expected (O/E) ratio of acute inpatient admission and observation stay discharges during the performance period. CMS selected this measure because acute

hospitalizations are the primary driver of patients' total cost of care—inpatient utilization is shown to have a roughly 70% correlation with total cost of care, and inpatient admissions account for 42% of total cost of care on average.¹³ The TPCC measure, used in the Quality Payment Program (QPP), is an O/E ratio of the overall costs of care provided to the practices' attributed beneficiaries. Additionally, AHU and TPCC can be calculated at the practice level, and offers practices a clear, actionable outcomes metric, targeted to the practice population.

The PBA includes four components: (1) Quality Gateway; (2) AHU/TPCC national benchmark; (3) regional performance adjustment; and (4) a continuous improvement (CI) bonus. Based on practice performance on the minimal thresholds on the Quality Gateway and AHU/TPCC national benchmark, practices' performance on the regional performance adjustment and CI bonus are added together to determine a practice's quarterly PBA. Practices can receive up to 34% upside bonus or a -10% downside penalty through the regional performance adjustment. Practices can earn up to an additional 16% through the CI bonus.

For practices in risk groups 1 and 2, the PBA is based on performance on the AHU measure. For practices in risk groups 3 and 4, the PBA is based on the TPCC measure, adapted for Primary Care First. Each measure will be calculated quarterly based on a rolling one-year performance period and applied starting in quarter two of year two.

All practices must exceed two separate standards to be eligible for a positive PBA:

1. **Quality Gateway**, which is comprised of minimum thresholds on a set of quality metrics, as further explained in the [Quality Strategy](#) section below. The thresholds for performance will be made available to participating practices at the beginning of each performance year. This "Quality Gateway" serves as an indicator that participating practices are not decreasing their quality of care as they engage in strategies to reduce utilization/cost. Practices that do not meet the minimum standards of the Quality Gateway for any of the measures will earn no higher than a 0% PBA¹⁴ in each of the quarters in performance year two. Whether a practice ultimately receives a neutral PBA (0%) or a negative PBA for each quarter of the second performance year will depend on its AHU/TPCC performance. In performance year three and beyond, failing to exceed the Quality Gateway will result in an automatic -10% PBA for all four quarters, regardless of AHU/TPCC performance. The Quality Gateway phases in to ensure practices continue to focus on quality outcomes as they become familiar with the model measures.
2. **AHU/TPCC National Benchmark**. Participating practices that meet or exceed the Quality Gateway must also meet or exceed the 50th percentile of a nationally constructed AHU/TPCC 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

¹³ Estimates based on 2016 National Health Expenditure Data.

¹⁴ Practices that fail the Quality Gateway in Year 2 can receive a -10% regional PBA if they are in the lowest quartile of their regional AHU benchmark, as described in this section.

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 their AHU/TPCC performance compares to a peer region benchmark and their own historical performance.

- AHU/TPCC Peer Region Benchmark.** Two-thirds of the PBA will be based on practice performance compared to a peer group of practices in comparably performing PCF regions that includes both PCF and non-PCF practices. CMS will establish a benchmark using data from a regional reference group of peer practices (including practices that do not participate in Primary Care First).¹⁵ This approach incentivizes participants to provide better quality of care relative to all other practices within their region, while creating the potential for all Primary Care First practices to earn a positive regional performance adjustment (because they are competing against both PCF and non-PCF practices). A regionally-based calculation also measures practice performance in a way that accounts for patient characteristics and care patterns that are specific to a particular geographic area but may not be captured by risk adjustment.

There are seven possible regional performance levels for the regional performance adjustment, depending on practices' performance relative to their peer region group, as summarized in Table 6. Participating Primary Care First practices whose AHU/TPCC performance places them in the lowest 25% of the regional reference group will receive a -10% regional performance adjustment. Participating practices whose AHU performance falls in the top 10% of the regional reference group will receive a 34% regional performance bonus. However, as described above, practices must have exceeded the Quality Gateway and the national performance benchmark in order to receive a positive PBA.

- Continuous Improvement Bonus.** For practices that exceed the Quality Gateway, two-thirds of the PBA will be based on their regional performance, and one-third of the PBA will be based on how they perform relative to their own historical performance in the prior year. The Continuous Improvement (CI) bonus rewards a practice's individual performance improvement on the AHU or TPCC measure. The practice's current AHU/TPCC performance will be compared to its own historical performance in a 1-year base period preceding the current PBA quarter's performance period. CMS may adjust the strategy for comparability between periods based on observed trends in health care utilization. A practice's CI score is the percent improvement between the performance periods. The CI score and the practice's regional performance level determine the amount of the CI bonus. A CI bonus will be paid to eligible participating practices each quarter, as long as they achieve their improvement target. This policy creates the opportunity for lower

¹⁵ This benchmark will be based on a regionally-specific reference group composed of Medicare clinicians. The benchmark will be made available to practices at the beginning of the model and updated annually.

performing practices (relative to other practices) to receive a CI bonus if they improve over time, while it also incentivizes high-performing practices to continuously improve. As long as a participating practice passes the Quality Gateway, it is eligible for a CI bonus, even if their AHU/TPCC performance is in the lowest half of all practices nationally and lowest quartile of all peer region practices. To receive the CI bonus, the practice’s individual performance must have improved by a statistically reliable percentage threshold, determined prospectively, from the previous year. The target percentage reduction for a practice will vary based on their baseline AHU/TPCC performance level; for example, improvement targets could range from 3-5% change, year-over-year.

In order to mitigate the concern that the change in the AHU measure over time could be random variation and not actual change, particularly for small practices, CMS will use statistical approaches (e.g., a reliability adjustment) to improve the reliability of the CI score. For example, CMS may adjust a practice’s CI score using the average CI score of “like practices,” based on how confident we are in a practice’s own CI score. The approach would allow CMS to assign CI scores to practices with low patient volume, among other limiting characteristics. Under this approach, part of the CI score is based on a practice’s own performance, while adjusting the score to account for the uncertainty of the estimate. A statistical approach like the reliability adjustment is intended to address concerns that random variation could impact the calculation of the CI bonus. CMS will provide details of any potential reliability adjustment in the annual Primary Care First Payment and Attribution Methodologies Paper.

Table 6. PBA for Practices that Meet or Exceed the 50th Percentile of National Performers on AHU or TPCC¹⁶

AHU/TPCC Regional Performance Level	Continuous Improvement Bonus (% of TPCP)	Regional Performance Adjustment (% of TPCP)	Maximum Adjustment (% of TPCP)
Level 1: At or above 90th percentile of practices in each region	16%	34%	50%
Level 2: 80th to 89th percentile of practices in each region	13%	27%	40%
Level 3: 70th to 79th percentile of practices in each region	10%	20%	30%

¹⁶ This table applies only to practices that pass the Quality Gateway. For PBA quarters during Performance Year 2 (Q2 – Q4), practices that do not pass the Quality Gateway receive either a –10% or 0% PBA. Starting in Performance Year 3, practices that do not pass the Quality Gateway receive an automatic –10% adjustment and are not eligible for the CI bonus.

AHU/TPCC Regional Performance Level	Continuous Improvement Bonus (% of TPCP)	Regional Performance Adjustment (% of TPCP)	Maximum Adjustment (% of TPCP)
Level 4: 60th to 69th percentile of practices in each region	7%	13%	20%
Level 5: 50th to 59th percentile of practices in each region	3.5%	6.5%	10%
Level 6: 25th to 49th percentile of practices in each region	3.5%	0%	3.5%
Level 7: Below 25th percentile of practices in each region	3.5%	-10%	-6.5%

Table 7. PBA for Practices that Do Not Meet the 50th Percentile of National Performers on AHU or TPCC

AHU/TPCC Regional Performance Level	Continuous Improvement Bonus (% of TPCP)	Regional Performance Adjustment (% of TPCP)	Maximum Adjustment (% of TPCP)
At or above 25th percentile of practices in each region	3.5%	0%	3.5%
Below 25th percentile of practices in each region	3.5%	-10%	-6.5%

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/TPCC. 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.

Full Payment Calculation under the Primary Care First Model

The quarterly payment for a practice in Primary Care First can be calculated as follows:

- Quarterly model payment = Total Primary Care Payment (TPCP) + Performance-Based Adjustment (PBA)
 - $TPCP = (\text{Professional PBP based on practice's risk group and leakage adjustment}) * (\# \text{ of attributed beneficiaries}) + (\text{Flat Visit Fee} * \# \text{ of visits})$
 - $PBA = TPCP * (-10\% \text{ up to } 50\%, \text{ based on performance})$

As stated above, high-performing practices can increase their TPCP by up to 50%. Table 8 provides an example of a PBPM payment calculation for a practice in Risk Group 1 during the second performance year without any leakage adjustment. This is an example of a high-performing practice whose AHU performance met or exceeded the 90th percentile regional benchmark (e.g., regional performance level 1), and who met their continuous improvement target. Note that although the TPCP is described as a quarterly payment calculation for illustrative purposes, and the professional PBP will be paid quarterly, face-to-face visits will be paid on a claim-by-claim basis, as a practice bills them.

Table 8. Example of TPCP PBPM Calculation for Practice Risk Group 1 in Q2 2022

Total Primary Care Payment (TPCP)

Professional PBP for Group 1 practice	* Leakage Rate without any adjustment	= Paid Professional PBP	+ Flat Visit Fee (estimated)	= Total Primary Care Payment (PBPM)*
\$28	* 1.0	= \$28	+ \$19	= \$47

**Total Primary Care Payment is calculated on a monthly basis but paid on a quarterly basis*

PBA

Total Primary Care Payment (PBPM)	* Regional Performance Adjustment (for Level 1 performance)	= Regional Performance Adjustment (PBPM)
\$47	*0.34	= \$15.98

Total Primary Care Payment (PBPM)	* Continuous Improvement Bonus (for Level 1 performance)	= CI Bonus (PBPM)
\$47	*0.16	= \$7.52

Regional Performance Adjustment	+ Continuous Improvement Bonus	= Performance-Based Adjustment (PBPM)
\$15.98	+ \$7.52	= \$23.50

Full Primary Care First Model Payment

Total Primary Care Payment (PBPM)	+ Performance-Based Adjustment (PBPM)	= Full Primary Care First Payment (PBPM)
\$47	+ \$23.50	= \$70.50

Quality Strategy

In Primary Care First, CMS will use a focused set of clinical quality and patient experience measures to assess quality of care delivered at the practice. These measures were selected to be actionable, clinically meaningful, and aligned with CMS’s broader quality measurement strategy. See Table 9 for the complete list of Primary Care First quality measures.

As discussed above, these measures will be incorporated into a “Quality Gateway,” which is a threshold participating practices must meet or exceed starting in performance year one in order to be eligible for a positive PBA in year two that is tied to AHU or TPCC performance. The Quality Gateway serves as an indicator that practices are meeting or exceeding a threshold quality of care standard as they engage in strategies to reduce utilization or cost.

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

CMS will begin collecting data for the Quality Gateway measures in performance year one, and practices’ performance on the Quality Gateway measures will impact their quarterly PBA amounts starting in year two. Unlike the AHU and TPCC measures, which are calculated quarterly based on a rolling 12-month performance period, the Quality Gateway measures will be calculated annually, based on the prior performance year. If a practice fails to meet all the Quality Gateway thresholds in the performance year, it will receive, at a maximum, a 0% PBA in performance year two (based on year one performance) and an automatic -10% 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 AHU/TPCC performance.

Quality Measures for Practice Risk Score Groups 1-2

Table 9. Primary Care First Quality Measures

Measure Type	Measure Title	NQF /Quality ID		Benchmark
Quality Gateway	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

Measure Type	Measure Title	NQF /Quality ID	NCQA®	Benchmark
	Colorectal Cancer Screening (eCQM)	0034/113	NCQA®	MIPS
Utilization Measure for PBA Calculation	Acute Hospital Utilization (AHU) (HEDIS measure) ¹⁷	N/A	NCQA®	Non-PCF and/or PCF reference population

Quality Measures for Practice Risk Score Groups 3 or 4

Practices in Risk Groups 3 or 4 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 three measures to calculate the PBA for these practices: 1) the advance care plan MIPS CQM measure (also used for practices in risk groups 1-2), which requires that a clinician discuss and/or document their beneficiaries’ advance directive to ensure their preferences are considered at the end of life; 2) Total per Capita Cost (TPCC), as used in MIPS, and 3) the Patient Experience of Care Survey (PECS), which is based on the Clinician and Group CAHPS® with a PCMH supplement.

CMS will also begin developing a quality measure for use in later years of the model: Days at home¹⁸. This claims-based measure assesses the number of days a Medicare beneficiary remains outside of an institutional care setting during a standardized time period.

CMS expects that this new measure will be endorsed by National Quality Forum (NQF) and will be ready to be incorporated into the PBA calculation in performance year two. In performance year two, the PBA

¹⁷ The Acute Hospital Utilization and its specifications were developed by the National Committee for Quality Assurance (“NCQA”) under the Performance Measurements contract (HHS-500-2006-00060C) with CMS and are included in HEDIS® with permission of NCQA. The HEDIS measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. HEDIS measures cannot be modified without the permission of NCQA. Any use of HEDIS measures for commercial purposes requires a license from NCQA. HEDIS is a registered trademark of NCQA. Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications. The American Medical Association holds a copyright to the CPT® codes contained in the measures specifications. The American Hospital Association holds a copyright to the Uniform Billing Codes (“UB”) contained in the measure specifications. The UB Codes in the HEDIS specifications are included with the permission of the AHA. The UB Codes contained in the HEDIS specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting HEDIS measure results or using HEDIS measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other commercial use, must obtain a commercial use license directly from the AHA.

¹⁸ Groff A.C., Colla, C.H., Lee, T.H. (2016). Days Spent at Home - A Patient-Centered Goal and Outcome. *New England Journal of Medicine*, 375(17), 1610-1612.

for practices in risk score groups 3 and 4 will therefore be based on four measures: 1) Advance Care Plan MIPS CQM, 2) Total per Capita Cost, 3) CAHPS®, and 4) Days at Home.¹⁹

Table 10. Practice Risk Groups 3-4 Quality Measures

Measure	Collection Method	Model Years	Benchmark	Rationale for delayed payment application
Advance Care Plan	MIPS Registry	PY1-5	MIPS National Benchmark	N/A
CAHPS®	Beneficiary Survey	PY1-5	PCF and/or non-PCF reference population	N/A
Days at Home	Claims	PY2-5	Historical reference population	<ul style="list-style-type: none"> • Claims-based data collection through institutional dates of service • Novel measure that needs to be validated and have benchmarks established
Measure for PBA Calculation: TPCC	Claims	PY1-5	Historical performance based on a reference population	N/A

Learning Systems Strategy

In Primary Care First, 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 promising tactics (e.g., via a web-based collaboration website (PCF Connect) and a national meeting).

¹⁹ CMS will monitor 24/7 access through existing access measures found in CAHPS.

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.

National Payer Community

CMS-facilitated learning communities for CPC+ Tracks 1 and 2 have primarily focused on participating practices, with the expectation that payers would convene regional learning collaboratives amongst themselves. For Primary Care First, CMS has created a National Payer Community (NPC) to support Primary Care First payer collaboration across and within regions. Through the NPC, CMS will host and facilitate payer-specific learning events that are responsive to payers' needs and interests, and will develop educational materials targeted specifically to payers. Payers will also be able to use the NPC as a forum for networking and sharing lessons learned with one another.

Data Sharing

In Primary Care First, CMS will offer participating practices actionable data to inform their efforts to impact patient experience, clinical quality, and utilization. Participating practices will have an opportunity to request regular Medicare FFS expenditure and utilization data conveyed in a clear and actionable way. CMS believes that the use of this data feedback will be critical for practices to perform certain health care operations, including care coordination, population health management, and quality improvement activities, that would reduce the total cost of care and unnecessary utilization.

CMS will provide practices with the opportunity to view quarterly feedback reports at the patient, practice, and regional levels through a Data Feedback Tool. These reports summarize Medicare FFS expenditure, utilization, and care delivery data. The reports are interactive and where appropriate, will offer the flexibility to access beneficiary-level data, including emergency department visits, hospitalizations, and other high-cost services used in the previous quarter (e.g., imaging). CMS will also offer expenditures, top diagnosis codes, and beneficiary-level data from the claims data submitted by other practitioners from which practices' attributed beneficiaries seek care in order to help practices select cost-effective specialty partners in their region.

National and regional performance data from participating practices will be shared to use transparency and competitiveness to incentivize improved performance. In future reports for Primary Care First practices, CMS may provide practitioners with information on their own performance in comparison to all other practitioners' individual and practice-level performance. All data sharing and data analytics will comply with applicable law, including the regulations promulgated under HIPAA. Beneficiaries will be notified by the practice to which they have been attributed that the practice is participating in the model and the beneficiary may opt out of claims data sharing under the model.

CMS plans to pursue additional avenues of data sharing to augment the quarterly data feedback reports for Primary Care First practices:

- *Data aggregation* is intended to reduce burden on practices receiving data from multiple payers and improve practitioner insights into performance across their entire patient population. For example, in CPC+ Tracks 1 and 2, commercial payers and managed care organizations (MCOs) in seven regions

have come together and collaborated with CMS to develop and deliver multi-payer claims reporting to the practices based on their entire CPC+ attributed populations. CMS plans to continue supporting data aggregation under Primary Care First. We also will respond to interest in multi-payer data aggregation in new regions. Each new region will be assessed on a case-by-case basis to determine if there is sufficient commitment and readiness for CMS participation.

- *Claims line feeds* will be offered to all Primary Care First practices. Primary Care First practices lacking experience with claims line feeds and/or are not interested in receiving them will continue to be offered claims based reporting.

Multi-payer collaboration in data sharing

In order to reduce burden and better enable data-driven improvement, CMS encourages multi-payer collaboration around data sharing and the use of regional infrastructure to the greatest extent possible. CMS expects payer partners to make similar commitments to offer data on cost, utilization, and quality to their participating practices, and to participate in multi-payer alignment or aggregation efforts where feasible. As stated in their MOUs, payer partners are also expected to regularly provide practices with lists of their attributed enrollees and, upon request and in accordance with applicable laws, relevant claims and cost data for their attributed population.

Practice Monitoring, Auditing, and Termination Strategy

Monitoring

Monitoring will help CMS ensure Primary Care First is being implemented appropriately and effectively at the practice level. CMS will use practices' self-reported care delivery measures, cost, utilization, and quality data in its monitoring strategy. The findings from monitoring will guide additional learning activities and ensure compliance with the terms of the Participation Agreement between CMS and the Primary Care First practices.

Monitoring will include the review of some or all of the following:

- *Vetting Data*: Prior to the start of the model, practices that apply to participate in the model will be subject to a program integrity screening by the CMS Center for Program Integrity to determine if they are eligible to participate. This screen will occur annually thereafter for all current model participants and at the time of any change in practices' organizational structure (e.g., merger, acquisition).
- *Care Delivery Achievement Data*: Determine whether practice attestations to CMS on a limited set of care delivery interventions are accurate.
- *Cost, Utilization, Patient Experience, and Quality Data*: Review cost, utilization, patient experience, and quality data at least annually to identify practices that are performing well, those that have low performance, and to monitor for compliance. Electronic clinical quality measure submissions will also be monitored to help ensure data is reported as required by the model.

Auditing

Audits will help mitigate financial and beneficiary vulnerabilities and risks associated with the professional PBP, flat visit fee, and PBA. Audits will primarily focus on, but not be limited to, the prevention, detection, and/or mitigation of improper payments and care stinting.

Analyses will be conducted using a review of claims data, medical records, beneficiary interviews, health IT reports, and practice records, and practices with anomalies will be selected for audit. Audits will help determine if patient complexity levels, quality, and utilization scores can be substantiated, which will test the alternative payment structure and risk stratification methodology.

Practices will be required to maintain copies of all documentation related to their participation in Primary Care First. Data that practices submit annually to CMS, performance on utilization and quality measures, and other practice information may also trigger an audit of any participating practice. Practices will be informed if selected for an audit.

Termination

CMS reserves the right to terminate a practice's Participation Agreement at any point during the model for reasons associated with poor performance, program integrity issues, non-compliance with the terms and conditions of the applicable Participation Agreement, or if otherwise specified in the Participation Agreement or required by section 1115A(b)(3)(B) of the Social Security Act.

CMS will determine periodically whether practices should be subject to any administrative action, such as a Notice of Remedial Action (NRA). An NRA will be imposed when a practice does not meet certain terms of the Participation Agreement, but can reasonably be expected to remediate the deficiency in a timely manner. Examples of scenarios warranting an NRA include charging beneficiaries a concierge fee and failure to meet quality reporting deadlines. Practices will be required to remedy the situation within a reasonable time frame (usually 3-6 months depending on the deficiency). Termination will occur for non-remediable issues as set forth in the Participation Agreement or determined by CMS, such as identification of program integrity concerns, joining another model with a Primary Care First no-overlaps policy, or when expected remediation from an NRA does not occur.

Evaluation

All participants in Primary Care First will be required to cooperate with CMS efforts to conduct an independent, federally funded evaluation of the model, which may include participation in surveys, interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive evaluation. The evaluation will be used to inform CMS about the effect of both primary care transformation and aligned payment reform. The evaluation of this model will use a mixed-methods approach to assess both impact and implementation experience. The impact component will attempt to measure to what degree Primary Care First improved key outcomes, including lower total cost of care and improved quality of care. The implementation component will describe how the model was implemented, assessing barriers and facilitators to change.

Data for the analyses will come from sources including, but not limited to: the practice application; Medicare and Medicaid claims; patient experience surveys; site visits with practices; focus groups or

interviews with beneficiaries and their caregivers, practice staff, those providing technical assistance, and others (e.g., payers); and observation of the learning system.

The evaluation will involve analyses across all regions in which it is implemented. A longitudinal study design will be used for the quantitative impact analyses, comparing intervention and comparison practices over time using quarterly fixed effects or a similar approach.

Authority to Test the Model

Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Center for Medicare and Medicaid Innovation (Innovation Center), and provides authority for the Innovation Center to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care.

While CMS is committed to improving care for beneficiaries, the Agency reserves the right to decide not to move forward with the Primary Care First model for any reason and at any time, as is true for all models pursued under Section 1115A authority. Similarly, as implementation of Primary Care First ensues, CMS reserves the right to terminate the model if it is deemed that it is not achieving the goals and aims of the initiative.

Waiver and Safe Harbor Authority

Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and certain provisions of section 1934 of the Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b).

For this model and consistent with the authority under section 1115A(d)(1), the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document; fraud and abuse waivers, if any, would be set forth in separately issued documentation. Any such waiver would apply solely to the Primary Care First model and could differ in scope or design from waivers granted for other programs or models. Thus, notwithstanding any provision of this RFA, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the Primary Care First model.

In addition to or in lieu of a waiver of certain fraud and abuse provisions in sections 1128A and 1128B of the Act, CMS may determine that the anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (42 CFR § 1001.952(ii)) is available to protect remuneration exchanged pursuant to certain financial arrangements or patient incentives permitted under Primary Care First's participation documentation. No such determination has been issued. Such determination, if any, would be set forth in documentation separately issued by CMS.

Advanced APM and MIPS APM Status

Advanced APM Status

As set forth in 42 CFR 414.1415, for an APM to be an Advanced APM, the following criteria must be met:

- (1) The APM requires at least 75 percent of eligible clinicians in each participating APM Entity to use CEHRT to document and communicate clinical care to their patients or other health care providers as set forth in 42 C.F.R. 414.1415(a);*
- (2) The APM uses quality measure performance as a factor when determining payment to participants for covered professional services under the terms of the APM as set forth in 42 C.F.R. 414.1415(b);*
- (3) The APM meets either the generally applicable financial risk and nominal amount standards, or for Medical Home Models, the Medical Home Model financial risk and nominal amount standards as set forth in 42 C.F.R. 414.1415(c).*

The Primary Care First model meets the definition of a Medical Home Model as defined in 42 CFR 414.1305, and the Primary Care First model meets the financial risk requirements under the Medical Home Model financial risk and nominal amount standards set forth at 41 C.F.R. 414.1415(c)(2), (4). Per 42 C.F.R. 414.1415(c)(7), the Medical Home Model financial risk and nominal amount standards would only apply to an APM Entity participating in a Primary Care First practice that is owned and operated by an organization with less than 50 eligible clinicians whose Medicare billing rights have been assigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities (referred to as the "50 eligible clinician limit"). CMS will annually determine if any Primary Care First practices meet or exceed the 50 eligible clinician limit. Because Primary Care First will not qualify as an Advanced APM under the generally applicable financial risk and nominal amount standards, Primary Care First practices that meet or exceed the 50 eligible clinician limit will not be considered participants in an Advanced APM, and eligible clinicians participating in Primary Care First through these practices will not be eligible to earn Qualifying APM Participant (QP) status through participation in Primary Care First.

For the second PCF Cohort, the first QP Performance Period through which eligible clinicians may be able to achieve QP status through the Primary Care First model will begin on January 1, 2022.

MIPS APM Status

As set forth in 42 CFR 414.1370(b), for an APM to be a MIPS APM, the following criteria must be met:

- (1) APM Entities participate in the APM under an agreement with CMS or through a law or regulation;*
- (2) The APM is designed such that APM Entities participating in the APM include at least one MIPS eligible clinician on a Participation List;*
- (3) The APM bases payment on quality measures and cost/utilization; and*
- (4) The APM is neither an APM for which the first performance year begins after the first day of the MIPS Performance Period for the year and is not an APM in the final year of operation for which CMS determines, within 60 days after the beginning of the MIPS performance period*

for the year, that it is impracticable for APM Entity groups to report to MIPS using the APM scoring standard.

Primary Care First will satisfy all of the MIPS APM criteria and therefore will be a MIPS APM beginning on January 1, 2022.

Participating practices with MIPS eligible clinicians who are either Partial QPs participating in Primary Care First practices that elect to report to MIPS, who are neither QPs nor Partial QPs will be scored under the APM scoring standard.

Participating practices assigned to the Primary Care First control group will be scored under the APM scoring standard. Additionally, we anticipate these participating practices will receive full credit for the Improvement Activities performance category under the APM scoring standard for the year(s) in which they participate in the Primary Care First control group.

Program Overlap and Synergies

For entities that simultaneously participate in other CMS programs and models, CMS reserves the right to potentially include additional requirements, revise initiative parameters, or ultimately prohibit simultaneous participation in multiple CMS models and initiatives. CMS may make this determination based on a number of factors, including CMS's capacity to avoid counting savings twice in overlapping initiatives and to conduct a robust evaluation of each initiative. CMS may also encourage collaboration among participants across models with the goal of enhancing the impact of models on reducing expenditures and improving quality.

Direct Contracting (DC)

Participant providers in the Global and Professional Direct Contracting (GPDC) model, in either the Professional or Global Risk-Sharing Options, or in the Geographic Direct Contracting (Geo) model may not participate in Primary Care First. Participant providers in both the GPDC model and the Geo model are expected to assume financial risk at significantly higher levels than those offered in Primary Care First. Furthermore, limiting participation across similar value-based models within the Innovation Center is necessary to strengthen the Center's ability to detect changes in quality and cost over time.

Independence at Home (IAH) Demonstration

Practices participating in the Independence at Home (IAH) demonstration may not participate in PCF. PCF and IAH test separate approaches to shifting away from fee-for-service towards value. The IAH demonstration tests the effectiveness of delivering comprehensive primary care services at home to Medicare FFS beneficiaries with complex needs. Practices participating in the demonstration are eligible for incentive payments.

Medicare Accountable Care Organizations (ACOs)

Consistent with Tracks 1 and 2 of the CPC+ model, practices participating in ACOs under all tracks of the Shared Savings Program are eligible to participate in Primary Care First. Because Primary Care First model payments are intended to replace a significant share of practices' FFS billing, all beneficiary-identifiable Primary Care First payments made to the practice, including the PBA, for PCF beneficiaries

who are also assigned to the Shared Savings Program ACO, will be treated as expenditures for the purposes of financial calculations under the Shared Savings Program.

Episode Payment Models

Potential for overlap also exists with CMS models focused on testing bundled payments for certain episodes of care, where it is possible to account for the financial impact of the overlap. Examples of these episode-based payment models include the Bundled Payments for Care Improvement (BPCI) Advanced model and the Comprehensive Care for Joint Replacement (CJR) model, which involve a bundled payment for multiple services included in certain clinical episodes in order to encourage efficiency. Practices will be permitted to participate in the Primary Care First model while simultaneously participating in any of these models. Any payments made on behalf of a beneficiary attributed to a Primary Care First practice will be included in the aggregate FFS spending amounts for episodes of care under these episode payment models, prorated to account for overlapping time periods. This document does not include any new initiatives still under development or expected to start after 2022, but the Innovation Center anticipates the principles described in this guidance will apply to them, as applicable. The Innovation Center will continue to monitor for overlaps as new episode payment models are developed.

Emergency Triage, Treat, and Transport Model (ET3)

ET3 seeks to reduce avoidable Emergency Department (ED) utilization by testing two new Medicare payments to Medicare-enrolled ambulance suppliers/providers that may incentivize them to prevent unnecessary transport to the ED. One payment reimburses a participating ambulance provider/supplier's facilitation of care to the patient "in place" (i.e., at the scene of a 911 emergency response or via telehealth). The other payment reimburses participating ambulance provider/supplier's transport of the patient to an alternative destination—somewhere other than the ED that is not currently covered by Medicare. In addition to these two ET3-specific ambulance payments, Medicare-enrolled health care providers that have agreed to participate in the model can receive an upwards payment adjustment for care provided after business hours in connection with a treatment in place intervention. Generally, the ET3 model payments to ambulance suppliers/providers will not overlap with Primary Care First payments, as Primary Care First payments are made to primary care practices for the primary care services they furnish to Medicare beneficiaries, and ET3 payments are made to ambulance suppliers/providers that provide transport to alternative destinations or facilitate treatment in place for Medicare FFS beneficiaries that call 911. However, CMS recognizes that payment to providers that receive after-hours upward payment adjustments under the ET3 model could overlap with Primary Care First payments to Primary Care First model participants. CMS intends to allow this overlap between the ET3 and Primary Care First models for a few reasons. First, Primary Care First payments are made to compensate participating primary care practices for preventive longitudinal care furnished to beneficiaries, while the payments under the ET3 model are made in response to an acute care need. Furthermore, despite the potential for overlap with respect to the after-hours payment adjustments under the ET3 model, generally the covered primary care services in Primary Care First are unlikely to significantly overlap with services reimbursed under the ET3 model. CMS believes these models are complementary, as they both aim to reduce avoidable ED visits (and subsequent inpatient admissions),

and CMS would like to create opportunities for Primary Care First practices to collaborate with ET3 participants around the goal of reducing unnecessary ED and hospital utilization. The Innovation Center will monitor overlap between these models and may revisit this policy in the future.

Financial Alignment Initiative (FAI) for Medicare-Medicaid Enrollees

The Financial Alignment Initiative is designed to provide certain individuals dually enrolled for Medicare and Medicaid with a more integrated care experience and to better align the financial incentives of the Medicare and Medicaid programs. Through the Initiative, CMS partners with states to test two models for their effectiveness in accomplishing these goals. Practices that share a TIN and share provider NPIs with organizations participating in any of the models within FAI may not participate in Primary Care First. Participants in the FAI have a separate focus on the dually-eligible beneficiary population while PCF focuses specifically on the Medicare population.

Kidney Care Choices Model

The Kidney Care Choices (KCC) Model will build upon the existing Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model structure – in which dialysis facilities, nephrologists, and other health care providers form ESRD-focused accountable care organizations to manage care for beneficiaries with ESRD – by adding strong financial incentives for health care providers to manage the care for Medicare beneficiaries with chronic kidney disease (CKD) stages 4 and 5 and ESRD, to delay the onset of dialysis, and to incentivize kidney transplantation. The model will have four payment Options: CMS Kidney Care First (KCF) Option, Comprehensive Kidney Care Contracting (CKCC) Graduated Option, CKCC Professional Option, and CKCC Global Option. The design of the KCC model likewise draws from the recently announced Primary Care First and Direct Contracting models. As such, PCF practices and practitioners may not participate in PCF and any of the KCC model options simultaneously.

Community Health Access and Rural Transformation (CHART) Model

CMS is providing funding for certain Lead Organizations in rural communities to build systems of care through a Community Transformation Track and is enabling providers to participate in value-based payment models where they are paid for quality and outcomes, instead of volume, through an Accountable Care Organization (ACO) Transformation Track. Through the two tracks in the Community Health Access and Rural Transformation (CHART) Model, CMS aims to continue addressing disparities by providing a way for rural communities to transform their health care delivery systems by leveraging innovative financial arrangements as well as operational and regulatory flexibilities. PCF provides similar support for rural providers through its payment structure. PCF practices and practitioners may not participate in PCF and CHART simultaneously.

Value in Opioid Use Disorder Treatment Demonstration Program (ViT)

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (the Innovation Center) is implementing a new initiative, Value in Opioid Use Disorder Treatment Demonstration Program (Value in Treatment). Value in Treatment (ViT) is a 4-year demonstration program authorized under section 1866F of the Social Security Act (Act), which was added by section 6042 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The purpose of the demonstration, as stated in the

statute, is to “increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce [Medicare program expenditures].” ViT has a fee structure comparable to PCF, including a per beneficiary per month (PBPM) care management fee and a performance-based incentive. PCF practices and practitioners may not participate in PCF and ViT simultaneously.

Appendices

Appendix A: Practice Application Guidance and Questions

Between March 16, 2021 and May 21, 2021, CMS will accept Primary Care First applications from individual primary care practice sites that meet preliminary eligibility requirements. Practices interested in applying to Primary Care First should review the Request for Applications to learn about the design and requirements of the model. The application must be certified as true, accurate, and complete by an individual authorized to bind the practice (i.e., the legal entity submitting the application).

Primary Care First is a practice-level intervention and each practice interested in Primary Care First participation must submit a separate application. For purposes of this application, a practice is defined as the legal entity that furnishes patient care services at a particular “bricks and mortar” physical location. If the practice offers patient care services at multiple physical locations, the practice will need to submit separate applications for each practice location that it wishes to participate in Primary Care First. Each practice that is a part of a health system, ACO, or other grouping of practices must submit a separate application for each location that it wishes to participate in Primary Care First.

This document is not the application to be filled out by the applicant; this is a DRAFT list of the questions that will be found in the online application portal. This list is for your reference as you assemble your application. CMS reserves the right to seek additional information from applicants to Primary Care First after the application period closes.

The Application will be found online at <https://app.innovation.cms.gov/PCF>. Questions about the Application for Primary Care First should be directed to PrimaryCareApply@telligen.com. CMS may publicly share questions or responses or compile them into a Frequently Asked Questions compendium to ensure that all interested practices have access to information regarding Primary Care First.

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5§ 552a). For more information, please see the CMS Privacy Policy at https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp.

Preliminary Questions

The questions in this section are required to move forward with the application to Primary Care First. The answers to these questions impact your practice’s eligibility for Primary Care First and may disqualify you from completing the remainder of the application.

1. In which Primary Care First region is your practice located? A description of the regions can be found here.
 - *Select response from drop-down options menu in online application*
2. As of January 1, 2022, will your practice be a concierge practice, a Rural Health Clinic, or a Federally Qualified Health Clinic?

Concierge practices (any practice that charges patients a retainer fee), Rural Health Clinics, and Federally Qualified Health Centers (FQHCs) are not eligible for the model. If your practice employs a practitioner who provides concierge services, that practitioner will be excluded from participation in Primary Care First.

- Yes
- No

3. As of January 1, 2022, will your practice be part of an ACO participating in the Medicare Shared Savings Program (Shared Savings Program)? PCF practices participating in a Shared Savings Program ACO (any track) may continue participation in both initiatives.

- a. Yes, my practice is part of an ACO that is participating in the Shared Savings Program currently and will continue participation in 2022.
- b. Yes, my practice is part of an ACO that is participating in the Shared Savings Program currently but will stop participating on or before December 31, 2021.
- c. No, my practice is not participating or applying to participate in Shared Savings Program.

If answer is (a) or (b):

ACO name: _____ ACO TIN: _____

4. As of January 1, 2022, will your practice be participating in (or have applied to participate in) any of the following CMS models/programs? Please select all that apply.

Primary Care First practices may not have overlapping participation with any other CMS coordinated care initiative, including those with a Medicare fee-for-service shared savings opportunity or CMMI alternative payment model (not including the Shared Savings Program above). If you are accepted to participate in Primary Care First and will, as a result, withdraw from the other initiative(s) in which you currently participate, you will be asked to enter your planned withdrawal date.

- a. Financial Alignment Initiative (FAI) for Medicare-Medicaid Enrollees *Help Note: This includes both the Capitated Model and Managed Fee-for-Service (FFS) Model. Please refer to <https://innovation.cms.gov/initiatives/Financial-Alignment/> for more information.*
- b. Direct Contracting (DC) Model Options
- c. Community Health Access and Rural Transformation (CHART) Model
- d. Kidney Care Choices (KCC) Model Options
- e. Value in Treatment (ViT) Model
- f. Independence at Home (IAH) Demonstration
- g. Financial Alignment Initiative (FAI) for Medicare-Medicaid Enrollees *Help Note: This includes both the Capitated Model and Managed Fee-for-Service (FFS) Model. Please refer to <https://innovation.cms.gov/initiatives/Financial-Alignment/> for more information.*
- h. Other CMS shared savings initiative, not including the Medicare Shared Savings Program
- i. None of the above

5. Has your primary care practice site ever participated in CPC+ Track 1 or 2?

- a. Yes
- b. No

If answer is yes:

- What is/was your CPC+ Practice ID? ___

General Questions

This section focuses on background information about your practice. Information in this section will be used to determine whether your practice meets the baseline eligibility criteria for participation in PCF. This information will also be used to determine whether your practice is under or over the 50 eligible clinician limit in 42 C.F.R. 414.1415(c)(7).

If a practice is accepted to participate in PCF and CMS later learns that answers to the questions in this section were not or are no longer accurate, CMS reserves the right to terminate the practice's participation in the model immediately.

PCF is a practice-level intervention and a practice interested in PCF participation must submit a separate application for each practice location that it wishes to participate in the model. For purposes of this application, a practice is defined as the legal entity that furnishes patient care services at a particular "bricks and mortar" physical location. If the practice offers patient care services at multiple physical locations, the practice will need to submit separate applications for each practice location that it wishes to participate in PCF. In the case of a practice that provides home-based primary care and no care in an office setting, the billing address defines the practice. Each practice that is a part of a health system, ACO, or other grouping of practices must submit a separate application.

For the purposes of PCF, practitioners that provide primary care services in more than one participating practice will be deemed to practice in only one participating practice.

Practice Structure and Ownership

This section asks questions about the organizational structure and ownership of your practice. If you have a question about practice structure that is not addressed in the Request for Applications (RFA) or in the Application Instructions, please contact CMS at PrimaryCareApply@telligen.com.

This section should be filled out by someone within the practice who is familiar with practice TINs and information about practice ownership, whether a health care system or physician-owned.

1. Practice identification:
 - a. Practice Legal Name: ___
 - b. Practice Name: ___
 - c. Street Address 1: ___
 - d. Street Address 2: ___
 - e. City: ___
 - f. State: ___
 - g. County: ___

- h. 9-digit ZIP Code: __
- i. Practice Site Phone Number: __
- j. Practice Site Fax Number: __
- k. Website (if applicable): __

2. Which of the following best describes your practice? Check only one.

- a. Medical group practice
- b. Practice within network of individual practices (i.e., IPA)
- c. Practice within hospital system(s)
- d. Practice within an integrated delivery system
- e. Other, please describe: __

3. Is your practice owned and operated by a larger health care organization or parent organization, such as a health system or a group practice?

- Yes
- No

If "No," who owns this practice?

- a. Physicians in the practice
- b. Non-physician practitioners (nurse practitioners or physician assistants) in the practice
- c. Other (Specify)

If "Yes," complete sections 3a and 3b:

A. Larger Health Care Organization/Parent Organization Information

- i. What is the name of the organization? *Note: If other practices from your organization are applying to PCF, please use identical text in this field.*
- ii. Corporate Street Address 1: __
- iii. Corporate Street Address 2: __
- iv. Corporate County: __
- v. Corporate State: __
- vi. Corporate 9-digit Zip Code: __
- vii. Corporate Phone Number: __
- viii. Name of primary organizational contact: We will use this information to link practices within the same larger health care/parent organization. For example, if you are a practice within a health system, please provide the name of the organizational contact within your health system who would be able to provide information on each of the practices that applied to PCF in your system.
 - First Name: __
 - Last Name: __
 - Email: __
 - Phone Number: __

B. Does your organization include any of the following providers or facilities? Check all that apply:

- i. Cancer or specialty hospitals
- ii. Psychiatric hospital or other mental or behavioral health facility
- iii. Hospital(s) receiving disproportionate share (DSH) payments or uncompensated care payments from Medicare or Medicaid
- iv. Community health center (other than a federally qualified health center)
- v. Skilled nursing facility (SNF)
- vi. Inpatient rehabilitation facility (IRF)
- vii. Dialysis facility
- viii. None of the above

4. This question relates to the Quality Payment Program Advanced Alternative Payment Model financial risk and nominal amount criterion. Please note that the language in this section may be slightly different than the rest of the application because these questions use the terms found in the Quality Payment Program CY 2021 Final [Rule](#).

How many Eligible Clinicians regardless of specialty, are part of your:

Note: Eligible clinician means “eligible clinician” as defined in 42 C.F.R. 414.1305, which means “eligible professional” as defined in section 1848(k)(3) of the Act, as identified by a unique TIN and NPI combination and, includes any of the following: (1) A physician. (2) A practitioner described in section 1842(b)(18)(C) of the Act ((a physician assistant, nurse practitioner, or clinical nurse specialist; a certified registered nurse anesthetist; a certified nurse-midwife; a clinical social worker; a clinical psychologist; a registered dietitian or nutrition professional). (3) A physical or occupational therapist or a qualified speech-language pathologist. (4) A qualified audiologist (as defined in section 1861(l)(3)(B) of the Act).

- a. Larger health care organization/Parent organization
 - a. ≤50 Eligible Clinicians
 - b. >50 Eligible Clinicians
 - c. N/A
- b. Practice Site
 - a. ≤50 Eligible Clinicians
 - b. >50 Eligible Clinicians
- c. Are other primary care practices in your larger health care organization/parent organization applying to participate in PCF?
 - a. Yes
 - b. No
 - c. N/A
 - d. Unknown

- d. Does your practice share a TIN for billing with other practices that are part of the same larger health care organization/parent organization?

Note that CMS requires primary care practices participating in Primary Care First to use one billing TIN for all primary care services provided in the participating practice. That TIN may be shared with other practices within your medical group or organization; however, this arrangement has important implications for reporting on quality measures per requirements of PCF.

- ❖ Yes
- ❖ No
- ❖ N/A
- ❖ Unknown

5. Does your practice use more than one billing TIN?

- a. Yes
- b. No
- c. Unknown

6. Please provide your Practice Organizational NPI (Do not provide the NPI for the larger health care organization or parent organization): _____

7. Please provide the PTAN (Medicare ID) for your practice (Do not provide the NPI for the larger health care organization or parent organization): _____

Note: You can find your PTAN by viewing the letter sent by your MAC when your enrollment in Medicare was approved or by logging into [Internet-based PECOS](#).

8. As of January 1, 2022, will your practice be a Critical Access Hospital?

- Yes
- No

If yes, please provide your CMS Certification Number (CCN). *If you do not know what a CCN number is, more information can be found [here](#).*

9. In the past twelve months, have any of the practitioners at your practice worked at a hospice?

- Yes
- No

If yes, please provide all CMS Certification Numbers (CCN) used by the hospices where your practitioners deliver care *If you do not know what a CCN number is, more information can be found [here](#).*

10. Please provide all the TINs that your practice has used to bill Medicare since January 1, 2017.

- a. List all TINs that your practice has used to bill Medicare since January 1, 2017.
- b. Select a check box for the ONE billing TIN that your practice will use to bill primary care

in 2022 for Primary Care First services. This is the TIN that your practice will use to bill all services for Primary Care First.

11. Since January 1, 2020 has your practice
 - a. Acquired a practice (if available please also include the previous TIN in your TIN roster)
 - b. Received a new TIN for any reason (if available please also include your previous TIN in your TIN roster)
 - i. If yes, reason for new TIN: _____
 - c. Newly formed
 - i. If yes, date your practice opened: _____

Practice Contacts

This section asks for contact information for practice contacts needed for Primary Care First. Please use the explanations provided to identify the most appropriate person for each contact field and enter their most current contact information.

Applicant Contact: The applicant contact is the person who has filled out your PCF application and/or is very familiar with the different sections of the application and understands the answers your practice has provided. If this contact also works in your practice (and you indicate this when filling out their contact information), they will also receive your practice’s acceptance/rejection letters and be automatically signed up to get the weekly PCF newsletter.

Practice Site Contact (if applicable): If your applicant contact does not work in your practice, you will also need to fill out the “Practice Site Contact” field. This person must work in your practice. They will receive your practice’s acceptance/rejection letters and be automatically signed up to get the weekly PCF newsletter.

Health IT Contact: This should be someone from your practice or larger health care organization, who administers your practice’s EHR and other health IT and is prepared to answer specific questions about the health IT in use in your practice. The Health IT Contact must be familiar with the PCF health IT requirements and work closely with the practice’s health IT vendors, including qualified registries or qualified clinical data registries. CMS or its operations team will communicate with the Health IT Contact if any health IT-related issues arise. The Health IT Contact will also be asked to identify and provide contact information for your practice’s Primary health IT vendor, eCQM Reporting vendor, and Registry vendor. By providing this information, you authorize your health IT vendors to receive model communications on your behalf.

Practice Executive Lead Contact: This individual is the Clinician Lead located at the practice. This individual should be working at the practice site and should be listed on the practitioner roster in the Primary Care First Practice Portal. Advanced Primary Care functions are an essential component of the Primary Care First model; therefore, it is imperative that the Practice Executive Lead located at the practice directly oversees all aspects of the practice’s processes.

1. Applicant Contact

- a. First Name: __
- b. Last Name: __
- c. Title/Position: __
- d. Does this person work in the practice? If you answer yes to this question, you will not have to fill out the "Practice Contact" section.
 - ❖ Yes
 - ❖ No
- e. Business Phone Number: __
- f. Business Phone Number Extension: __
- g. Alternative Phone Number (e.g., cell phone): __
- h. E-mail Address: __
- i. Street Address 1: __
- j. Street Address 2: __
- k. City: __
- l. State: __
- m. ZIP Code: __

2. Practice Site Contact (if applicable)

- a. First Name: __
- b. Last Name: __
- c. Title/Position: __
- d. Business Phone Number: __
- e. Business Phone Number Extension: __
- f. Alternative Phone Number (e.g., cell phone): __
- g. E-mail Address: __
- h. Street Address 1: __
- i. Street Address 2: __
- j. City: __
- k. State: __
- l. ZIP Code: __

3. Health IT Contact

- a. First Name: __
- b. Last Name: __
- c. Title/Position: __
- d. Business Phone Number: __
- e. Business Phone Number Extension: __
- f. Alternative Phone Number (e.g., cell phone): __
- g. E-mail Address: __
- h. Street Address 1: __

- i. Street Address 2: __
- j. City: __
- k. State: __
- l. ZIP Code: __

4. Practice Executive Lead Contact

- a. First Name: __
- b. Last Name: __
- c. Title/Position: __
- d. Business Phone Number: __
- e. Business Phone Number Extension: __
- f. E-mail Address: __

Practitioner and Staff Information

This section asks questions about the practitioners in your practice and should be filled out by someone familiar with the practitioner information, including NPIs, number of practitioners, and practitioner specialty and work within the practice. Unless otherwise indicated, please answer only for the primary care practitioners that will be participating in Primary Care First. Please note that pediatricians are not eligible to participate in PCF as they do not treat Medicare beneficiaries.

Applications will be screened to determine eligibility for further review using criteria detailed in this solicitation and in applicable law and regulations. In addition, CMS may deny selection to an otherwise qualified applicant on the basis of information found during a program integrity review of the applicant, its practitioners, or any relevant individuals or entities. CMS may also deny individual practitioners or any other relevant entity participation in PCF based on the results of a program integrity review.

Applicants will be required to disclose any investigations of, or sanctions that have been imposed on the applicant or individuals in leadership positions in the last three years by an accrediting body or state or federal government agency. Individuals in leadership positions include key executives who manage or have oversight responsibility for the organization, its finances, personnel, and quality improvement, including without limitation, a CEO, CFO, COO, CIO, medical director, compliance officer, or an individual responsible for maintenance and stewardship of clinical data.

1. To the best of your knowledge, has your practice or anyone employed in your practice had a final adverse legal action (as defined on page 12 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i) or been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of the Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose could be grounds for application denial or immediate termination from the initiative.
 - Yes
 - No

If yes, please explain the legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any.

Explanation:

2. Which statement best characterizes your practice (*select all that apply*):
 - a. The practice is a single-specialty primary care practice.
 - b. The practice is a single-specialty hospice and/or palliative care practice.
 - c. The practice is a primary care practice with other integrated practitioners, or is a multi-specialty practice.
 - d. The practice participates in other lines of business besides primary care, such as urgent care on weekends and/or physical exams for an insurance company.
 - e. Other

For Questions 3 and 4 below, we are exploring the total number of individual practitioners compared to the primary care practitioners in your practices by practitioner type. Please treat answers in question 3 as the “denominators” and answers in question 4 as the “numerators.” *Note: An NPI is a 10-digit number issued to practitioners by CMS. More information can be found [here](#).*

3. Please list the number of individual qualified health care practitioners who provide patient care at your practice in any specialty under their own National Provider Identifier (NPI). Specify by type of practitioner, as indicated in the answers below, and include part-time practitioners in your count.
 - a. Number of Physicians: ___
 - b. Number of Nurse Practitioners: ___
 - c. Number of Physician Assistants: ___
 - d. Number of Clinical Nurse Specialists: ___
4. In PCF, a primary care practitioner is defined as a physician, nurse practitioner, physician assistant, or Clinical Nurse Specialist with a primary specialty of family medicine, internal medicine, geriatric medicine, or hospice and palliative medicine under their own NPI. How many practitioners in your practice are primary care practitioners? Please include full-time and part-time practitioners in your answer below.

Please note that the practitioner should be specifically certified in family medicine, internal medicine, geriatric medicine, or hospice and palliative medicine. For example, a physician who is board certified in geriatrics or a clinical nurse certified in family medicine would be considered a primary care practitioner.

- a. Number of Primary Care Physicians: ___
- b. Number of Primary Care Nurse Practitioners: ___
- c. Number of Primary Care Physician Assistants: ___
- d. Number of Primary Care Clinical Nurse Specialists: ___

The purpose of the next question is to create a roster of participating practitioners that bill under

their own NPI through the TIN of your practice (e.g., they have reassigned to your practice the right to receive Medicare payments). In an effort to obtain as accurate an estimate of attributed beneficiaries as possible, please include all NPIs who practiced at the practice site from (date) to current. This includes any NPI's that are currently practicing or have left the practice site. As you add information about each of the practitioners in your practice, please create only one record, even if a practitioner works at multiple locations of your larger health care organization or multiple Practice Sites. A practitioner can only ever be on the roster for one Practice Site. If your practice is found eligible for the model, CMS will conduct a program integrity screening of all practitioners and confirm their specialty. Note: for the practitioner section, please provide individual NPIs; please do not include organizational NPIs.

5. For each primary care practitioner in your practice, please provide the following information.

a. Practitioner Name: (Last, First, MI) ___

b. National Practitioner ID (NPI): ___

Note: You can look up NPIs at this link <https://npiregistry.cms.hhs.gov/>.

c. Start Date and End Date of NPI

d. Practitioner Type:

- ❖ Physician (MD or DO)
- ❖ Clinical Nurse Specialist
- ❖ Nurse Practitioner
- ❖ Physician Assistant

e. Primary Specialty:

Note: the primary specialty selected should also be the specialty listed in NPPES (<https://npiregistry.cms.hhs.gov/>). The NPPES should be one of the following codes: Family Medicine—207Q00000X, Geriatric Medicine—207QG0300X, Hospice and Palliative Medicine—207QH0002X, or General Practice—208D00000X.

- ❖ Family Medicine (207Q00000X)
- ❖ Internal/Adult Medicine (207R00000X)
- ❖ Geriatric Medicine (207QG0300X)
- ❖ General Practice (208D00000X)
- ❖ Hospice and Palliative Medicine (207QH0002X)
- ❖ N/A

f. Secondary Specialty:

- ❖ Family Medicine (207Q00000X)
- ❖ Internal/Adult Medicine (207R00000X)
- ❖ Geriatric Medicine (207QG0300X)
- ❖ General Practice (208D00000X)
- ❖ Hospice and Palliative Medicine (207QH0002X)
- ❖ N/A

❖ Other

g. Is this the practitioner's primary Practice Site?

- Yes
- No

If yes, skip to "Health Information Technology" section. If No, please respond to the following questions:

h. This practitioner works at the Practice Site:

- Part-time
- Full-time

If part time, how many hours per week does this practitioner work at the Practice Site?

___ hours

i. Does this practitioner also practice elsewhere?

- Yes
- No

If No, skip to "Health Information Technology" section. If yes, please respond to the following questions:

j. If yes, is the practitioner's billing TIN the same at any other location where he/she practices?

- Yes
- No

k. Is any other location where he/she practices also applying to participate in Primary Care First?

- Yes
- No

Name and address of other locations:

Health Information Technology

This section asks questions about the health IT capabilities of your practice. The person filling out this section should be familiar with the health IT in use in your practice today. The health IT requirements are available in Appendix C of the RFA.

1. Is your practice able to complete the health IT requirements indicated listed in the PCF RFA?

- Yes
- No (*Help Note: If you cannot meet the health IT requirements for PCF, your application may be disqualified. If you have questions, please contact PrimaryCareApply@telligen.com*)

2. Can you obtain EHR and eCQM data for your PCF Practice Site and PCF Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) only, distinct from health system or other practice data?

- Yes
- No

3. Can you obtain registry data for your PCF Practice Site and PCF Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) only, distinct from health system or other practice data?

- Yes
- No

4. Please identify your practice's Primary Health IT Vendor and provide your practice's point of contact with them.

- A. Primary Vendor Name: _____
- B. Contact First Name: _____
- C. Contact Last Name: _____
- D. Contact Email address: _____
- E. Contact Telephone Number: _____

5. Please identify your practice's eCQM Reporting Health IT Vendor and provide your practice's point of contact with them. If your eCQM Reporting Vendor is the same as your Primary Vendor and you have the same point of contact, check the box below and skip to Q6.

Same as Primary Health IT Vendor []

- A. eCQM Reporting Vendor Name: _____
- B. Contact First Name: _____
- C. Contact Last Name: _____
- D. Contact Email address: _____
- E. Contact Telephone Number: _____

6. Please identify your practices Registry (QR/QCDR) Health IT Vendor and provide your practice's point of contact with them. If your Registry Vendor is the same as your Primary Vendor and you have the same point of contact, check the box below and skip to Financial Readiness 2020.

Same as Primary Health IT Vendor []

- a. Registry Vendor Name: _____
- b. Contact First Name: _____
- c. Contact Last Name: _____
- d. Contact Email address: _____

e. Contact Telephone Number: _____

Financial Readiness

1. Please list the payers with whom you contracted in 2020.
2. Please indicate the percentage of revenue in the last year derived from value-based contracts: _____%
Note: Examples of value-based contracts include: payments based on cost, quality, and/or utilization performance, such as shared savings, performance-based incentive payments, episode-based payments, as well as alternative to FFS payments, such as full or partial capitation.
3. Does your practice agree for CMS to share application and acceptance data, including TIN(s), with current and future PCF payer partners or other programs within your state?
 Yes
 No
4. Does your practice plan to reduce or waive the applicable co-insurance for Primary Care First flat visit fee for the delivery of face-to-face services? *Note: PCF practices will remain responsible to cover those costs (i.e., CMS will not compensate practices for any impacts on cost sharing revenue).*
 Yes
 No

If No, proceed to “Care Delivery” section. If yes, please answer question 5:

5. To which of the following categories of beneficiaries and/or types of clinical needs does your practice intend to provide cost sharing support? (Select all that apply)
 Medicare beneficiaries with financial need
 Medicare beneficiaries with complex health needs requiring frequent face-to-face care in office or at home
 Medicare beneficiaries with recent hospitalization(s) and/or ED visit(s)
 Other (specify): ____

Care Delivery

The following questions are about your Practice Site’s delivery of primary care. Answer each question as carefully and accurately as possible, based on the current activities at your Practice Site (the single “bricks and mortar” physical location where patients are seen). The person who fills out this section should be very familiar with the delivery of care in the practice, including care management, patient access, and quality improvement. For example, your practice manager might fill this section with input from others in the practice as needed. This section will likely be best answered if it represents a consensus view of the practice staff, arriving at a single “best answer” after discussion among the practice team at your site.

1. Patients

- a. are not assigned to specific practitioner panels.
 - b. are assigned to specific practitioner panels but panel assignments are not routinely used by the practice for administrative or other purposes.
 - c. are assigned to specific practitioner panels and panel assignments are routinely used by the practice mainly for scheduling purposes.
 - d. are assigned to specific practitioner panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
2. Non-physician practice team members
- a. play a limited role in providing clinical care.
 - b. are primarily tasked with managing patient flow and triage.
 - c. provide some clinical services such as assessment or self-management support.
 - d. perform key clinical service roles that match their abilities and credentials.
3. Follow-up by the primary care practice with patients seen in the Emergency Department (ED) or hospital
- a. generally, does not occur.
 - b. occurs only if the ED or hospital alerts the primary care practice.
 - c. occurs because the primary care practice makes proactive efforts to identify patients.
 - d. is done routinely because the primary care practice has arrangements in place with the ED and hospital to both track these patients and ensure that follow-up is completed within a few days.
4. Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP, or nurse
- a. is not available or limited to an answering machine.
 - b. is available from a coverage arrangement (e.g., answering service) that does not offer a standardized communication protocol back to the practice for urgent problems.
 - c. is provided by a coverage arrangement (e.g. answering service) that shares necessary patient data with and provides a summary to the practice.
 - d. is available via the patient's choice of email or phone directly with the practice team or a practitioner who has real-time access to the patient's electronic medical record.
5. Clinical leaders
- a. intermittently focus on improving quality.
 - b. have developed a vision for quality improvement, but no consistent process for getting there.
 - c. are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.
 - d. consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.
6. A standard method or tool(s) to stratify patients by risk level

- a. is not available.
 - b. is available but not consistently used to stratify all patients.
 - c. is available and is consistently used to stratify all patients but is inconsistently integrated into all aspects of care delivery.
 - d. is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.
7. Clinical care management services for high-risk patients
- a. are not available.
 - b. are provided by external care managers with limited connection to the practice.
 - c. are provided by external care managers who regularly communicate with the care team.
 - d. are systematically provided by the care manager functioning as a member of the practice team, regardless of location.
8. Care plans
- a. are not routinely developed or recorded.
 - b. are developed and recorded but reflect providers' priorities only.
 - c. are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care.
 - d. are developed collaboratively, include self-management and clinical care management goals, are routinely recorded, and guide care at every subsequent point of service.
9. This practice site discusses advance care planning (e.g., for end-of-life care and advanced directives for when patients might become too sick to make their own decisions) with
- a. none of the practice's high-risk patients.
 - b. some of the practice's high-risk patients.
 - c. many or all of the practice's high-risk patients.
 - d. many or all of the practice's high-risk patients, and patient preferences for end-of-life care are documented and accessible to the care team.
10. Practices may or may not have agreements with other care organizations (e.g., specialists) that they refer patients to. A formal, written agreement with these organizations describes expectations for timely patient visits, the frequency and type of information communicated between your primary care practice and other care organizations, and their respective roles. This practice site has formal, written agreements with
- a. no medical or surgical groups.
 - b. some medical and surgical groups.
 - c. many medical and surgical groups.
 - d. most or all medical and surgical groups.

In addition to the care delivery questions, practices caring for seriously ill and complex chronic populations will need to meet certain requirements. You will need to meet basic competencies to

successfully manage complex patients and show expertise with these populations. The questions below assess your interest in and experience managing these populations.

11. This question is about specific care team members at this practice site. Which of the following care team members work full-time (35 hours or more per week) and/or part time (fewer than 35 hours per week) at this practice site? Select all that apply.
 - a. Care manager or care coordinator with Registered Nurse (RN) license *A care manager works with high-risk patients between and during visits to provide ongoing support and education on chronic care management, and coordinates care from other providers*
 - b. Care manager or care coordinator with Licensed Practice Nurse (LPN) or licensed vocational nurse (LVN) license. *A care manager works with high-risk patients between and during visits to provide ongoing support and education on chronic care management, and coordinates care from other providers*
 - c. Registered Nurse
 - d. Community Services Coordinator
 - e. Referral Coordinator or Referral Specialist *This is someone who obtains prior authorizations, helps patients obtain appointments with specialists, and/or tracks referrals to specialist.*
 - f. Social Worker
 - g. Behavioral Health Specialist
 - h. Pharmacist
 - i. None of the above

12. Social and functional support needs (e.g., transportation, home equipment) of vulnerable patients, such as low-income and frail patients.
 - a. are never assessed by staff at this practice site.
 - b. are rarely assessed by staff at this practice site.
 - c. are sometimes assessed by staff at this practice site.
 - d. are usually assessed by staff at this practice site.

13. Identify the community and medical resources/supports with whom you have established relationships. Select all that apply.
 - a. We have not established relationships with community resources and supports.
 - b. Financial (e.g., TANF, SSDI/SSI, cash assistance)
 - c. Nutrition and Food (e.g., SNAP/WIC, food pantries, Meals on Wheels)
 - d. Health-related services (e.g., insurance, prescription assistance, home health, durable medical equipment)
 - e. Housing (e.g., shelter, public housing, transitional support)
 - f. Transportation (e.g., medical transport, public transit)
 - g. Utilities (e.g., energy assistance/subsidies [LIHEAP], telephone)
 - h. Hospice

14. Which of the following is included in your care planning with complex and seriously ill

patients? Select all that apply.

- a. Conversations about serious illness care goals and values
- b. Hospice with a length of stay greater than 14 days
- c. Family support
- d. Carefully titrated pain control with frequent follow-up
- e. Non-pain symptom management
- f. Psychosocial and spiritual support
- g. None of the above

Appendix B: Solicitation for Payer Partnership Process and Selection

Solicitation Information

This Solicitation for Payer Partnership requests that payers detail their proposed plan to partner in Primary Care First.

Multi-payer engagement is an essential component of Primary Care First, as it enables both public and private payers to support comprehensive primary care reform. CMS will select payer partners that align with CMS' approach to changing incentives in primary care. Respondents to this solicitation may be commercial insurers (including plans offered via state or federally facilitated Health Insurance Marketplaces), Medicare Advantage plans, states (through the Medicaid and CHIP programs, 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)).

CMS expects to enter into a Memorandum of Understanding (MOU) with each selected payer. The MOUs will outline the commitments of payers that sign an MOU with CMS. All payer partners will separately enter into arrangements with the practices participating in Primary Care First.

CMS is seeking to partner with payers who are meaningfully committed to value-based reimbursement and who commit to:

- 1.** Reimbursing Primary Care First practices through an alternative to traditional fee-for-service (FFS), such as a population-based payment. Enhancements to FFS, e.g. paying 110% of current fee schedule rates, will not be considered an acceptable alternative to FFS payment methodology.
- 2.** Implementing performance-based payments that meaningfully reward practices for high performance on quality and utilization outcome measures, rather than process-based measures, and create accountability for poor performance on such measures.
- 3.** Sharing data with Primary Care First practices on cost, utilization, and quality at regular intervals to support continuous practice learning and improvement.

4. Participating in Primary Care First multi-payer collaborative activities, including setting shared annual goals for regional multi-payer collaboration and alignment and making progress towards those goals.

Table 1 below includes the detailed criteria that CMS will use to assess payer proposals and their alignment with these four requirements. 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 partner with payers who meet “acceptable alignment” criteria in some areas, with the expectation that these payers will work towards meeting “preferred alignment” standards. 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 as payer partners.

Table 1. Primary Care First Payer Alignment Criteria

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Principle 1: Move away from fee-for-service payment mechanism			
Minimize volume-based incentive	<ul style="list-style-type: none"> • Partial primary care capitation with more than 50% of revenue reimbursed through capitated or other non-visit-based payment <i>OR</i> • Full primary care capitation 	<ul style="list-style-type: none"> • Primary care episodes <i>AND/OR</i> • Shared savings/shared losses <i>AND/OR</i> • Partial primary care capitation with less than 50% of revenue reimbursed through capitated or other non-visit-based payment 	<ul style="list-style-type: none"> • Fee-for-service plus care management fee <i>OR</i> • Fee-for-service plus at-risk care management fee <i>OR</i> • Reimburse additional codes for non-face-to-face services <i>OR</i> • Higher fee-for-service rates for primary care services

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Risk adjustment	<ul style="list-style-type: none"> Alternative to FFS payment is risk adjusted to account for factors including but not limited to health status and patient demographics 	<i>Same as preferred alignment</i>	<ul style="list-style-type: none"> Alternative to FFS payment is not risk adjusted
Principle 2: Reward outcomes, not process			
Practices' reimbursement influenced by outcomes, not process	<ul style="list-style-type: none"> Performance-based payment tied to clinical quality, patient experience, health improvement, cost and/or utilization measures <i>AND</i> Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) <i>AND</i> 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) 	<ul style="list-style-type: none"> Performance-based payment tied to clinical quality, patient experience, cost and/or utilization measures <i>AND</i> Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) <i>AND</i> Performance-based payment tied in part to achievement of care delivery processes 	<ul style="list-style-type: none"> Practices' reimbursement not influenced by performance in any way <i>OR</i> Performance-based payment tied in full to achievement of care delivery processes <i>OR</i> 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	<ul style="list-style-type: none"> Maximum possible performance-based payment adjustment can increase practices' primary care revenue by more than 15% 	<ul style="list-style-type: none"> Maximum possible performance-based payment adjustment can increase practices' primary care revenue by between 5% and 15% 	<ul style="list-style-type: none"> Maximum possible performance-based payment adjustment can increase practices' primary care revenue by less than 5%

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Performance-based payment adjustment can be negative if practice has poor outcomes	<ul style="list-style-type: none"> Performance can both increase and decrease payment, though potential upside is larger than potential downside 	<ul style="list-style-type: none"> Performance can both increase and decrease payment; potential upside is equal to potential downside 	<ul style="list-style-type: none"> Performance can only increase payment
Alignment with PCF measure set	<ul style="list-style-type: none"> Payer uses the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance <i>AND</i> Payer uses few or no additional measures above and beyond the PCF measure set 	<ul style="list-style-type: none"> Payer uses at least three of the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance²⁰ <i>AND/OR</i> Payer uses no more than 10 total measures, including PCF-aligned measures and additional measures <i>AND</i> 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 	<ul style="list-style-type: none"> Payer uses none of the same quality and utilization measures as CMS¹ <i>OR</i> Payer uses a large number of additional measures above and beyond the CMS measure set

²⁰ 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
Principle 3: Deliver meaningful, actionable data reports to drive practice accountability and performance improvement			
Attribution	<ul style="list-style-type: none"> Practices receive list of prospectively attributed members at least monthly 	<ul style="list-style-type: none"> Practices receive list of prospectively attributed members at least quarterly 	<ul style="list-style-type: none"> Practices receive list of attributed members less often than quarterly
Frequency ²¹	<ul style="list-style-type: none"> Payers provide service utilization and cost data at least monthly 	<ul style="list-style-type: none"> Payers provide service utilization and cost data at least quarterly 	<ul style="list-style-type: none"> Payers provide service utilization and cost data less than quarterly
Type of data ²⁶	<ul style="list-style-type: none"> Payers provide practices with service utilization and cost of care data for attributed members 	<ul style="list-style-type: none"> Payers provide practices with some limited service utilization and cost of care data for attributed members 	<ul style="list-style-type: none"> Payers do not provide practices with service utilization or cost of care data for attributed members
Format of data ²⁶	<ul style="list-style-type: none"> Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities <i>AND</i> Data is accompanied by tailored support and guidance to help practices use the data <i>AND</i> Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools. 	<ul style="list-style-type: none"> Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities <i>AND</i> Data is accompanied by general (non-practice-specific) guidance about how to use the data <i>AND</i> Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools. 	<ul style="list-style-type: none"> 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 <i>OR</i> No resources are provided to help practices navigate the data <i>OR</i> Payer does not provide data reports to practices

²¹ 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. Payer partners 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
Level of data ²⁶	<ul style="list-style-type: none"> • Payers provide practices with beneficiary-level service utilization and cost data 	<ul style="list-style-type: none"> • Payers provide practices with practice-level or practitioner-level service utilization and cost data 	<ul style="list-style-type: none"> • Payers do not provide practices with utilization and cost data
Alignment with CMS and other local payers	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Payer actively participates in and contributes to regional multi-payer collaborative activities related to PCF 	<ul style="list-style-type: none"> • Payer attends multi-payer collaborative events, but does not actively participate in or contribute to them 	<ul style="list-style-type: none"> • Payer does not participate in multi-payer collaborative activities related to PCF that are available in their region
Goal-setting and continuous improvement	<ul style="list-style-type: none"> • 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 	<i>Same as preferred</i>	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> 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 	<i>Same as preferred</i>	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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

Questions

Questions regarding Primary Care First or the solicitation process may be sent by email to PrimaryCareApply@telligen.com. CMS may publicly share questions or responses or compile them into a Frequently Asked Questions compendium to ensure that all interested payers have access to information regarding Primary Care First.

Completing and Submitting Proposals to Partner in Primary Care First

Interested payers are asked to respond to this solicitation by completing an online proposal, which will be available at <https://app.innovation.cms.gov/PCF> on March 16, 2021, when the payer solicitation period begins. Payers interested in partnering in Primary Care First in multiple regions are asked to submit separate proposals for each region if their proposed approach varies significantly between regions. Payer proposals are due on June 18, 2021.

Review Process

Responses to this solicitation will be reviewed by CMS staff to determine the degree to which they align with CMS' approach in Primary Care First, as described above. Payers must respond with sufficient detail for CMS to evaluate and understand payers' proposed plan to partner in Primary Care First. CMS may also contact payers and request modifications to payers' proposed model as part of its review.

CMS reserves the right to reject any payer's proposal to preserve the integrity of the Medicare program, the welfare of Medicare or Medicaid beneficiaries, or the implementation of Primary Care First. Without limitation, CMS may reject an interested payer's proposal if:

- The payer does not provide sufficient information to be reasonably assessed against the selection criteria outlined in this solicitation;
- The interested payer's proposal is inconsistent with the objectives of Primary Care First.

Payer and Region Selection

CMS' selection process is summarized below. CMS may contact interested payers to request that they explain or modify their proposals. Once CMS has selected practices for the Primary Care First model, payers with lines of business in regions with accepted practices will be invited to partner with CMS in Primary Care First by signing a Memorandum of Understanding.

1. Assessment of Payers' Alignment with Medicare's Approach

CMS will evaluate proposals based on: 1) the preferences noted above and payer alignment with CMS' payment, quality, and data sharing approaches; and 2) payer experience implementing an alternative to FFS payment.

2. Clarification of Proposals

CMS may contact payers to clarify elements of their proposal or to gain additional context for payer responses.

3. Final Selection

CMS will use its assessment of payer proposals to inform selection of Primary Care First payer partners.

Commitment to Ensuring Competitive Markets

Competition promotes quality of care for Medicare beneficiaries and protects access to a variety of practitioners. Thus, all conversations among payers and primary care practices must comply with antitrust law. Nothing in this solicitation shall be deemed to suspend any applicable antitrust laws or regulations, all of which still apply. In Primary Care First, CMS aims to maintain a competitive environment while providing an opportunity for payer partnership.

Partnership with State Medicaid Agencies

CMS recognizes the importance of states' partnership in multi-payer initiatives and invites state Medicaid agencies to apply to partner with CMS in Primary Care First. States seeking to partner with CMS in Primary Care First and offer an approach to payment that aligns with CMS' approach in Primary Care First will need to fund the non-federal share of Medicaid payments for their attributed enrollees and may need to submit proposals to CMS through State plan amendments and/or waivers in order to develop a payment arrangement that would allow the state to partner with CMS in the model.

Solicitation for Payer Partnership

This document is not the online proposal to be filled out by the applicant; **this is a DRAFT list of the questions that will be found in the online solicitation portal.** This list is for your reference as you assemble your proposal. CMS reserves the right to seek additional information from applicants after the solicitation period closes.

Description of Payer

1. Legal Entity Name: __
2. Year Established: __
3. Doing Business As (DBA) Name if different than Legal Entity Name: __
4. Corporate Address: __
5. Corporate City: __
6. Corporate State: __
7. Corporate Zip code: __
8. Website URL: __
9. Indicate in the below fields the points of contact for the solicitation process (Solicitation POC) and for communicating with CMS after payer selection (Payer POC), respectively. If solicitation POC and payer POC are the same person, contact information only needs to be provided once: Solicitation Point of Contact (POC)
 - ❖ Name: __
 - ❖ Title: __
 - ❖ Email Address: __
 - ❖ Phone Number: __
 - ❖ Fax Number: __
 - ❖ Street Address: __
 - ❖ City: __
 - ❖ State: __
 - ❖ Zip code: __

a. Solicitation Point of Contact (POC):

- ❖ Name: __
- ❖ Title: __
- ❖ Email Address: __
- ❖ Phone Number: __
- ❖ Fax Number: __
- ❖ Street Address: __
- ❖ City: __
- ❖ State: __
- ❖ Zip code: __

Summary of Past Experience

We intend to select payers for Primary Care First who are similarly committed to providing opportunities for advanced practices, including:

- Reimbursing Primary Care First practices with an alternative to FFS payment, such as a population-based payment
 - Providing a payment tied to practice performance on a combination of cost, quality, and/or utilization metrics, applying both upside and downside risk
 - Sharing data with practices on cost, utilization, and quality at regular intervals (e.g., quarterly)
 - Providing additional support for practices that focus on caring for complex, chronic and seriously ill patients
1. Please describe any past or current involvement with multi-payer or multi-stakeholder collaborations, noting if this is in the proposed region(s). In your answer, please indicate how you were/are involved in the initiatives (e.g., health information exchange, technical assistance, practice coaching).
 2. Please briefly describe any advanced primary care models you are currently testing in the proposed region(s), and your involvement in any other local, state, or national initiatives to improve or transform primary care payment and care delivery.
 3. Are you a current Partner Payer in the Comprehensive Primary Care Plus (CPC+) model?
 - Yes
 - No
 - Not applicable
 4. Were you a Partner Payer in the Comprehensive Primary Care (CPC) model?
 - Yes
 - No
 - Not applicable

Lines of Business

1. Please describe the lines of business and network reach in the region(s) in which you are proposing to partner. If proposing to partner in multiple regions and proposed approach differs significantly across regions, please submit a separate proposal for each distinct region.

State: _____ Proposing to partner in part of state or entire state? <input type="checkbox"/> Part of state <input type="checkbox"/> Entire state	Proposed Lines of Business: <input type="checkbox"/> Commercial Insurance Plan <input type="checkbox"/> Health insurance Marketplace Plan <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicaid/CHIP Managed Plan <input type="checkbox"/> State/Federal High Risk Pool <input type="checkbox"/> Third Party Administration (TPA)/ Administrative Services Only (ASO) <input type="checkbox"/> Medicaid/CHIP FFS (For State Partners only) <input type="checkbox"/> Other	Total Number of Covered Lives	NAIC Number	Please provide the minimum number of your members that must be attributed to a participating practice in order for you to support that practice in this model	Please note if, and to what extent, the minimum number of members per practice changes by line of business and region
---	--	-------------------------------	-------------	---	---

2. Please summarize the lines of business you offer but are not proposing to include in Primary Care First:

State: _____ Proposing to partner in part of state or entire state? <input type="checkbox"/> Part of state <input type="checkbox"/> Entire state	Proposed Lines of Business: <input type="checkbox"/> Commercial Insurance Plan <input type="checkbox"/> Health insurance Marketplace Plan <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicaid/CHIP Managed Care Plan <input type="checkbox"/> State/Federal High Risk Pool <input type="checkbox"/> Third Party Administration (TPA)/ Administrative Services Only (ASO) <input type="checkbox"/> Medicaid/CHIP FFS (For State Partners only) <input type="checkbox"/> Other	Total Number of Covered Lives
---	---	-------------------------------

3. Using counties as the descriptor, please specify the total number of member lives in each county in which you are interested in partnering in Primary Care First.

Please include all proposed Primary Care First regions in a single spreadsheet. For example, if you are a payer submitting multiple proposals for distinct regions, please input all regions and covered lives by county and line of business into one Excel spreadsheet.

Payment Models

I. Alternative to fee-for-service payment arrangement

Payers should have experience with designing and implementing a payment methodology that diverges at least in part from FFS, and should be prepared to offer Primary Care First practices an alternative to FFS payment.

1. What is the proposed structure of your Alternative to FFS payment?
 - a. 100% up-front payment of primary care services (i.e., full primary care capitation),
 - b. Moving a portion of anticipated FFS revenue to prospective payment (i.e., partial primary care capitation)
 - c. Primary care-specific episodes
 - d. Other

If you selected a or b, please answer the following question:

If your model is capitating specific primary care services, which services/codes will be capitated?

2. Will your proposed Alternative to FFS payment be risk-adjusted?
 - a. Yes
 - b. No
3. Will your proposed Alternative to FFS payment be greater or equal to historical spending?
 - a. Greater
 - b. Equal
 - c. Other
4. To receive the Alternative to FFS payment, is a claim required to be submitted by the practice?
 - a. Yes
 - b. No
5. What is the frequency of your Alternative to FFS payment?
 - a. Monthly
 - b. Quarterly
 - c. Annually
6. If applicable, please provide additional detail on your proposed Alternative to FFS payment, including how your methodology varies across lines of business, if at all.

7. Please select the option below that most accurately describes your experience designing and implementing an Alternative to FFS payment arrangement:
- a. Currently providing such payments to all contracted primary care practices through an existing program;
 - b. Currently providing such payments to some contracted primary care practices through an existing program;
 - c. Currently providing such payments to some primary care practices through a pilot program;
 - d. Alternative to FFS payment approach already developed and planning implementation;
 - e. Payment approach still being developed;
 - f. Intend to design and implement such a payment in Primary Care First;
 - g. Other (please explain)

If you selected answers a, b, or c in response to question 6, please describe your current or prior experience designing and implementing an alternative payment arrangement for primary care practices that deviates from FFS.

If you selected answers d, e, or f in response to question 6, please describe in detail your plan for instituting an alternative to FFS payment arrangement, including your time frame for implementation.

II. Performance Based Payment Arrangement

Payers are encouraged to include the opportunity for Primary Care First practices to qualify for both upside and downside performance-based incentive payments.

8. Please summarize your proposed performance-based incentive payment arrangement with Primary Care First practices:
- Bonus payment tied to practice performance
 - Portion of revenue at risk for performance with upside and/or downside potential
 - Shared savings with pooling/virtual groups
 - Shared savings without pooling/virtual groups
 - Episode payments
 - Other
9. On what metrics will your proposed performance-based incentive payment arrangement be based? Select all that apply:
- Claims-based clinical quality measures (e.g., HEDIS)
 - Electronic clinical quality measures
 - Emergency department utilization
 - Inpatient hospital utilization
 - Patient-reported outcome measure
 - Specialty utilization

- Total cost of care
- Patient Experience of Care measures (e.g., CAHPS®)
- Other

Please list the specific measures you are using to assess performance for this payment, by line of business.

10. Does your arrangement include upside and/or downside risk?

- Upside only
 - ❖ If upside only: What is the maximum % of savings/incentive practices can achieve?
- Upside and downside
 - ❖ If upside and downside: What is the maximum % of downside and upside risk?

11. Frequency of Payment

- Monthly
- Quarterly
- Annually

12. Timing of Payment

- Prospective
- Retrospective

13. Please provide additional detail on your proposed performance-based payment arrangement, including how your methodology varies across lines of business, if at all.

III. For Payers with Self-Insured Clients:

14. Do you currently provide any alternative payment arrangements (such as payments to providers for enhanced primary care, care coordination or patient centered medical home services, or other non-FFS arrangements) on behalf of your ASO clients?

- a. Yes
- b. No
- c. Not applicable

Attribution and Data Sharing with Primary Care Practices

Payers are required to share their attribution methodologies with CMS and offer to provide participating practices with practice and member-level data regarding cost and utilization for their members attributed to participating practices at regular intervals in accordance with applicable law. Partner payers are required to provide CMS with data for model evaluation and monitoring purposes at regular intervals.

I. Attribution

1. Please describe your proposed approach to identify members served by participating practices in the proposed region(s):

a. Timing of Attribution?

- Retrospective
- Prospective

b. Frequency of Attribution?

- Monthly
- Quarterly
- Annually
- Other

c. Please describe your proposed attribution methodology

II. Data Sharing

1. What level of data will you share with Primary Care First practices? E.g. Practice level or practitioner level?

2. What is your proposed frequency of data sharing with Primary Care First practices?

- Monthly
- Quarterly
- Annually
- Other (Please specify)

3. What types of data do you plan to provide to Primary Care First practices? Please specify if you are providing cost, utilization, and/or real-time hospital and ER data.

4. If applicable, please describe your current or planned involvement with local/regional multi-payer databases, direct claims line feeds, or Health Information Exchanges in the proposed region.

5. If applicable, please describe any current or planned data analytics tools or platform you provide for practices to analyze and use the data you provide.

Quality and Patient Experience Measures

Partner payers are encouraged to align quality and patient experience measures with CMS and other payers in the region.

1. What types of quality measures do you plan to collect from Primary Care First practices? (select all that apply)

- Claims-based quality measures (e.g., HEDIS)
- Electronic clinical quality measures

- Patient experience of care measures (e.g., CAHPS®)
- Patient reported outcome measures
- Structural quality measures
- Quality measures unique to your company
- Quality measures required by your state
- Other

2. Please describe any quality measure alignment you have created with other payers.
3. Can your organization use any of the CMS Primary Care First Quality Measures below to align your Primary Care First quality reporting strategy?

Primary Care First Quality Measures

CMS ID#	NQF #	Measure Title	Measure Type/Data Source	Domain Name
CMS 165v5	0018	Controlling High Blood Pressure	Outcome/eCQM	Clinical Process/Effectiveness
CMS 122v5	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (eCQM)	Outcome/eCQM	Population/Public Health
CMS130v6	0034	Colorectal Cancer Screening (eCQM)	Process/eCQM	Effective Clinical Care
N/A	0005 and 0006	CPC+ Patient Experience of Care Survey (CAHPS® with supplemental items)	Outcome/Patient Survey	N/A
N/A	0326	Advance Care Plan	Process/Registry	Communication and Care Coordination

4. Please specify what other quality metrics are relevant to your populations, if any, including complex chronic and seriously ill populations.
5. If Primary Care First practices shared PCF eCQM data with payers, would your organization be able to use these data to analyze practice quality performance?
 - Yes
 - No
 - ❖ If you selected “no,” please explain why.
 - ❖ If you selected “yes,” would the PCF eCQM data preclude the need for participating PCF practices to report or measure other quality data on your members attributed to PCF practices?

- Yes
- No

❖ If you selected “no,” please explain why

6. Are you currently administering patient experience of care surveys to assess the quality performance of primary care practices?

- Yes
- No

❖ If you selected “no,” please explain why

❖ If you selected “yes,” are you willing to use CAHPS® as your sole measure of patient experience for practices participating in PCF?

- Yes
- No

❖ If you selected “no,” please explain why.

Appendix C: Health IT Requirements

PCF Practices are required to use health IT needed to meet the Certified Electronic Health Record Technology (CEHRT) definition required by the QPP at 42 CFR 414.1305 to meet the baseline health IT requirements of the model and to report quality measures. PCF Practices must also meet model-specific standards to promote interoperability, including provide patient access to their electronic health information, refrain from information blocking, and participate in a Health Information Exchange (HIE).

Table C. Health IT Requirements

Requirement	Date	Notes
Overall CEHRT Adoption		
Adopt and maintain, at a minimum, health IT needed to meet the CEHRT definition required by the QPP at 42 CFR 414.1305. ²²	By January 1, 2022	The PCF Practice must adopt relevant health IT for the entire Performance Year. For instance, if a change to a new Edition is required to meet the CEHRT definition for a given year, the upgrade must be completed by January 1 of the following year.
Health IT for eCQM Reporting (Practice Risk Groups 1 and 2 Only)		
Adopt and maintain, at a minimum, health IT meeting the definition of CEHRT required by the QPP at 42 CFR 414.1305 and the certification criteria found at 45 CFR 170.315(c)(1) - (3) ²³ for eCQM reporting, using the most recent update available on the eCQI Resource Center on January 1 of the performance year, for the eCQMs in the PCF measure set. ²⁴	By January 1, 2022.	For each Measurement Period, the PCF Practice must use the eCQM specifications for eReporting listed in the eCQI Resource Center as of January 1 of the Performance Year.

²² Since the beginning of 2019, the CEHRT definition at 42 CFR 414.1305 has required the use of 2015 Edition technology only.

²³ For each of these sections, (c)(1) is the certification criterion for "Record and Export;" (c)(2) is the certification criterion for "Import and Calculate;" and (c)(3) is the certification criterion for "Report."

²⁴ The Primary Care First quality reporting requirements for each performance year will be made available in the Quality User Manual in advance of that performance year.

Requirement	Date	Notes
Capability to submit eQMs in QRDA III format via the QPP website.	By January 2, 2023, tentatively.	For the 2022 Measurement Period, the PCF Practice must report eQMs electronically in the QRDA III format via the qpp.cms.gov website during the applicable reporting period. The PCF Practice must complete measure reporting in the QRDA III format via the qpp.cms.gov website until such time as CMS offers measure reporting via the Fast Healthcare Interoperability Resources (FHIR®) standard.
Adopt and maintain health IT with the capability to filter clinical measure data for reporting at the PCF practice site level [practice site location, TIN(s)/NPI(s)].	By January 2, 2023, tentatively.	eQm data must be filtered at the practice site level [practice site location, TIN(s)/NPI(s)], and may not be filtered at the individual practitioner level ²⁵
Health IT for MIPS CQM Reporting		
Adopt and maintain a Qualified Registry (QR) or a Qualified Clinical Data Registry (QCDR) from the MIPS final approved list to report MIPS CQM 047 Advance Care Plan. ²⁶	By January 2, 2023, tentatively	PCF requires the adoption of either a Quality Payment Program (QPP) qualified registry or a QPP qualified clinical data registry (QCDR) in the submission format specified by QPP at the qpp.cms.gov website.
Adopt and maintain a QR or a QCDR with the capability to filter clinical measure data to report at the PCF practice site level.	By January 2, 2023, tentatively	MIPS CQM data must be filtered at the practice site level [practice site location, TIN(s)/NPI(s)], and may not be filtered at the individual practitioner level. Adopting a MIPS approved qualified registry or QCDR does not guarantee that that registry has the capability to filter and report MIPS CQM data at the practice site level in PCF required format. The PCF Practice must confirm that its selected QR/QCDR has this capability before finalizing its selection.
Interoperability Requirements		

²⁵ The PCF Practice may adopt and maintain the 2015 Edition certification criterion found at 45 CFR 170.315(c)(4) in order to filter eQMs for reporting at the practice site level [practice site location, TIN(s), NPI(s)], but this is not required.

²⁶ The MIPS CQM submission format specifications for PCF will be made available in advance of each Reporting Period.

Requirement	Date	Notes
Give patients and their designated representative access to electronic health information within 1 business day.	By January 1, 2022	<p>In alignment with the 21st Century Cures Act implementation compliance timeline, the PCF Practice must provide patients access to electronic health information.</p> <p>By the start of Performance Year 3, the PCF Practice must provide patients access to electronic health information (as defined in §170.213) via a standards-based API. CMS, in partnership with the Office of the National Coordinator (ONC) for Health Information Technology, has identified HL7 FHIR Release 4.0.1 as the foundational standard to support data exchange via secure APIs as defined in the Act at 45 CFR 170.215.</p>
Refrain from information blocking as defined by section 3022(a) of the Public Health Service Act (42 U.S. Code (USC) 300jj-52), which was added by Section 4004 of the 21st Century Cures Act. This requirement is in alignment with QPP’s Promoting Interoperability requirements to exchange electronic information using CEHRT.	By January 1, 2022	The PCF Practice must attest to refraining from information blocking in the Health IT Details tab in the PCF Practice Portal.
Adopt and maintain participation in a Health Information Exchange (HIE).	By January 1, 2022	The PCF Practice must connect to a regional, national, or vendor-mediated HIE to send and receive electronic health information for all patients. The PCF Practice must attest to connecting to an HIE in the Health IT Details tab in the PCF Practice Portal.
Model Reporting		
Maintain Health IT Details tab in PCF Practice Portal.	Beginning January 31, 2022	The PCF Practice must maintain up-to-date health IT information in the PCF Practice Portal. This includes, but is not limited to, changes in primary or quality reporting health IT vendor(s), product information and attestations to health IT requirements.

Appendix D: Attribution Methodology

The Primary Care First attribution methodology is described below.

Voluntary Alignment and Claims-Based Attribution

A beneficiary will be prospectively attributed to a Primary Care First practice if the beneficiary completed the voluntary alignment process on MyMedicare.gov to select one of the practitioners listed on the practice’s practitioner roster. If the beneficiary did not select any Primary Care First practice practitioner on MyMedicare.gov, the beneficiary will be attributed to the Primary Care First practice (or non-PCF practitioner) that either billed for the plurality of their primary care visits and eligible CCM services, or that billed the most recent claim (if that claim was for an Annual Wellness or Welcome to Medicare Visit) during the most recently available 24-month period. If a beneficiary has an equal number of qualifying visits and eligible CCM services billed by more than one practice, as measured by a discrete count of services, the beneficiary will be attributed to the practice with the most recent visit. As explained below, this claims-based attribution methodology essentially means that CMS attributes beneficiaries and pays prospectively for the next quarter based on retrospective data from the last 24 months, with beneficiary lists provided to participating practices quarterly.

To be attributed to a practice, beneficiaries must:

- Have both Medicare Parts A and B;
- Have Medicare as their primary payer;
- Not have end stage renal disease (ESRD) or be enrolled in hospice at the time of initial attribution;
- Not be covered under a Medicare Advantage or other Medicare health plan;
- Not be institutionalized;
- Not be incarcerated;
- Not be aligned or otherwise attributed to an entity participating in a model that includes an opportunity to share in savings under Medicare FFS or in any other model that CMS has specified in the model overlap policy;

For all beneficiaries who meet the criteria above, CMS will assess any selections they have made in MyMedicare.gov and claims with the following qualifying HCPCS codes will be selected for the look-back period (the most recent 24 months) when the physician or practitioner specialty is internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine.

Appendix Table D-1. Primary Care Services for Attribution

Qualifying HCPCS Codes Eligible for Claims-based Attribution ²⁷	Blank on Purpose
Office/Outpatient Visit E/M	99201-99205 99211-99215
Complex Chronic Care Coordination Services	99487 ²⁸

²⁷ Qualifying HCPCS codes reflect 2021 PCF implementation and are subject to change via future rulemaking by CMS pending the 2022 PFS Final Rule.

Chronic Care Management Services	99490-99491
Transitional Care Management Services	99495-99496
Home Care/Domiciliary Care E/M	99324-99328 99334-99337 99339-99345 99347-99350
Advance Care Planning	99497
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Assessment/care planning for patients requiring CCM services	G0506
Care management services for behavioral health conditions	G0507, 99484
Prolonged non-face-to-face evaluation and management services	99358
Cognition and functional assessment for patient with cognitive impairment	G0505, 99483
Collaborative Care Model	G0502-G0504 99492-99494
Outpatient clinic visit for assessment and management (for critical access hospital-based outpatient primary care practices)	G0463

CMS will provide each practice with a list of its attributed beneficiaries prior to the start of the performance period of the participation agreement and will provide an updated list by the end of the first month of each quarter thereafter. To align with the claims-based processes, CMS will also assess selections in MyMedicare.gov every three months. A diagram of the attribution process is included below (Figure 2).

Practices will be required to inform their patients in writing of their involvement in this model and the changes their practice has made or is undertaking to provide comprehensive primary care and better serve their needs. Practices will also be required to collect information on patients who opt out of data sharing and transmit this information to CMS. Medicare beneficiaries may also opt out of data sharing by calling 1-800-MEDICARE.

At all times during the initiative, though Medicare beneficiaries will be attributed to a practice, they will remain free to select the health care providers and services of their choice and will continue to be responsible for all applicable beneficiary cost-sharing. Primary Care First does not include any restrictions on or changes to Medicare FFS benefits, nor does it include provisions for beneficiaries to

²⁸ CPT 99489 is an add-on code for an additional 30 minutes of complex chronic care management and will not count as an additional primary care service in the assessment of plurality.

opt out of attribution with a participating practice for purposes of expenditure calculations and quality performance measurement.

Appendix E: Medicare Covered Services Included in the Professional PBP and Flat Visit Fee

Services Included in the Professional PBP

CPT/HCPCS Codes	
Office/Outpatient Visit E/M	99201-99205, 99211-99215
Prolonged E/M	99354-99355
Transitional Care Management Services	99495-99496
Home and Domiciliary Visit E/M	99324-99328, 99334-99337, 99339-99345, 99347-99350
Advance Care Planning	99497-99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Chronic Care Management Services	99487, 99489-99491

Services Included in the Flat Visit Fee

CPT/HCPCS Codes	
Office/Outpatient Visit E/M	99201-99205, 99211-99215
Prolonged E/M	99354-99355
Transitional Care Management Services	99495-99496
Home and Domiciliary Visit E/M	99324-99328, 99334-99337, 99341-99345, 99347-99350
Advance Care Planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439

Services that May Not Be Billed for Attributed Medicare FFS Beneficiaries

CPT/HCPCS Codes	
Chronic Care Management Services ²⁹	99487, 99489-99491
Care Planning for CCM	G0506
Care Management Services (for behavioral health conditions)	99484
Domiciliary or Home Care Plan Oversight (CPO)	99339
Prolonged Non-Face-to-Face E/M	99358
Primary Care Add-on	G2212

Note that these tables include CPT/HCPCS codes that have been finalized in the 2021 Medicare Physician Fee Schedule Final Rule, and are subject to change for 2022.

²⁹ Recognizing that Chronic Care Management (CCM) services are a critical component of primary care that contributes to better health and care for individuals, CCM has already been accounted for and built into the Professional PBP. CCM primarily reimburses practitioners for activities that are furnished outside of a face-to-face visit, such as telephone communication, review of medical records and test results, and coordination and exchange of health information with other practitioners and providers. However, if the practitioner believes a given beneficiary would benefit from additional face-to-face care related to chronic care management, they can deliver that care in the context of an E&M visit, and that E&M visit would be paid via the flat visit fee.