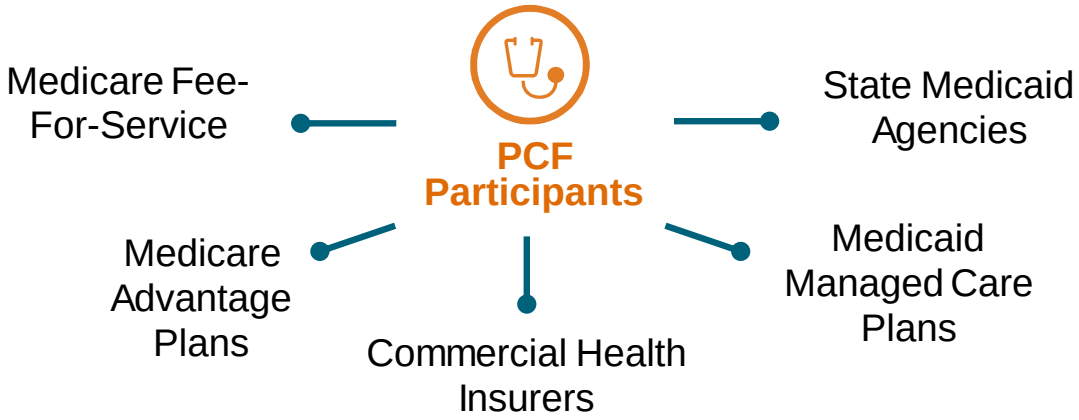
# Multi-Payer Alignment in Primary Care First

**November 7, 2019**

# CMS is Committed to Partnering with Aligned Payers in Selected Regions

In PCF, CMS will encourage other payers to engage practices on similar outcomes.




**Multi-payer alignment promotes:**

- An alternative to fee-for-service payments
- Performance-based incentive opportunity
- Practice- and participant-level data on cost, utilization, and quality
- Alignment on practice quality and performance measures
- Broadened support for seriously ill populations

# Payer Alignment Principles

- **Principle 1:** Move Away from fee-for-service payment mechanism
- **Principle 2:** Reward Outcomes, Not Process
- **Principle 3:** Deliver meaningful data reports to drive performance improvement
- **Principle 4:** Multi-payer alignment is critical for driving adoption of value-based care models

# Principle 1: Move Away from FFS Payment Mechanism

# CMS Approach: PCF Total Primary Care Payments

**Hybrid Total Primary Care Payments** replace Medicare fee-for-service payments to support delivery of advanced primary care.

## Professional Population-Based Payment

Payment for service in or outside of the office, adjusted for practices caring for higher risk populations. This payment is the same for all patients within a practice.

| Practice Risk Group | Payment *Per beneficiary per month* |
|---|---|
| **Group 1** (lowest risk) | $28 |
| **Group 2** | $45 |
| **Group 3** | $100 |
| **Group 4** | $175 |

Payment adjusted to account for beneficiaries seeking services outside the practice.

+

## Flat Primary Care Visit Fee

Flat payment for face-to-face treatment that reduces billing and revenue cycle burden

**$40**

**per face-to-face patient encounter**

These payments allow practices to:

- Easily predict payments for face-to-face care
- Spend less time on claims processing and more time with patients

# Principle 1: Move Away from FFS Payment Mechanism

| | Preferred Alignment | Sufficient Alignment | Insufficient Alignment |
|---|---|---|---|
| **Minimize volume-based incentive** | Partial primary care capitation with more than 50% of revenue reimbursed through capitated or other non-visit-based payment<br>*OR*<br>Full primary care capitation | Primary care episodes<br>*AND/OR*<br>Shared savings/shared losses<br>*AND/OR*<br>Partial primary care capitation with less than 50% of revenue reimbursed through capitated or other non-visit-based payment | Fee-for-service plus care management fee<br>*OR*<br>Fee-for-service plus at-risk care management fee<br>*OR*<br>Reimburse additional codes for non-face-to-face services<br>*OR*<br>Higher fee-for-service rates for primary care services |
| **Risk adjustment** | Alternative to FFS payment is risk adjusted to account for factors including but not limited to health status and patient demographics | *Same as preferred alignment* | Alternative to FFS payment is not risk adjusted |

# Principle 2: Reward Outcomes, Not Process

# CMS Approach: PCF Performance Based Payment Adjustments

In **Year 1**, adjustments are determined based on **acute hospital utilization (AHU)** alone.
In **Years 2-5**, adjustments are based on performance as described below.

**Did the practice exceed the Quality Gateway?**

**No**

Maximum **0%** **Adjustment** to Total Primary Care Payment for next applicable year in year one, maximum **-10%** in years 2-5

**Yes**

Adjustment of up to 50% of total primary care payment determined by comparing performance to three different benchmarks:

1. National adjustment
2. Regional adjustment
3. Continuous improvement adjustment

# CMS Approach: PCF Quality Measures

The following measures will inform performance-based adjustments and assessment of model impact.

| Measure Type | Measure Title | Benchmark |
|---|---|---|
| **Utilization Measure for Performance-Based Adjustment Calculation** (Year 1-5) | **Acute Hospital Utilization** (AHU) (HEDIS measure) | Non-CPC+ reference population |
| **Quality Gateway** (starts in Year 2) | **CPC+ Patient Experience of Care Survey** (modernized version of CAHPS) | MIPS |
| | **Diabetes: Hemoglobin A1c** (HbA1c) **Poor Control** (>9%) (eCQM)[1] | MIPS |
| | **Controlling High Blood Pressure** (eCQM) | MIPS |
| | **Care Plan** (registry measure) | MIPS |
| | **Colorectal Cancer Screening** (eCQM)[1] | MIPS |
| **Quality Gateway** for practices serving high-risk and seriously ill populations[1] | To be developed during model, domains could include 24/7 patient access and days at home | |

1. The following measures will not apply to practices in Practice Risk Groups 4 or 5 and for practices receiving SIP identified patients: (a) Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (eCQM) and (b) Colorectal Cancer Screening (eCQM)

# Principle 2: Reward Outcomes, Not Process

| | Preferred Alignment | Sufficient Alignment | Insufficient Alignment |
|---|---|---|---|
| **Practices' reimbursement influenced by outcomes, not process** | Performance-based payment tied to clinical quality, patient experience, health improvement, cost and/or utilization measures<br>*AND*<br>Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s)<br>*AND*<br>Performance-based payment not tied to achievement of care delivery processes (though care delivery processes/ certifications may be used to determine practice eligibility at start of model) | Performance-based payment tied to clinical quality, patient experience, cost and/or utilization measures<br>*AND*<br>Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s)<br>*AND*<br>Performance-based payment tied in part to achievement of care delivery processes | Practices' reimbursement not influenced by performance in any way<br>*OR*<br>Performance-based payment tied in full to achievement of care delivery processes<br>*OR*<br>Performance-based payment not tied to utilization and/or total-cost-of-care measure(s) in any way |
| **Performance can have substantial impact on practices' payment** | Maximum possible performance-based payment adjustment can increase practices' primary care revenue by more than 15% | Maximum possible performance-based payment adjustment can increase practices' primary care revenue by between 5% and 15% | Maximum possible performance-based payment adjustment can increase practices' primary care revenue by less than 5% |

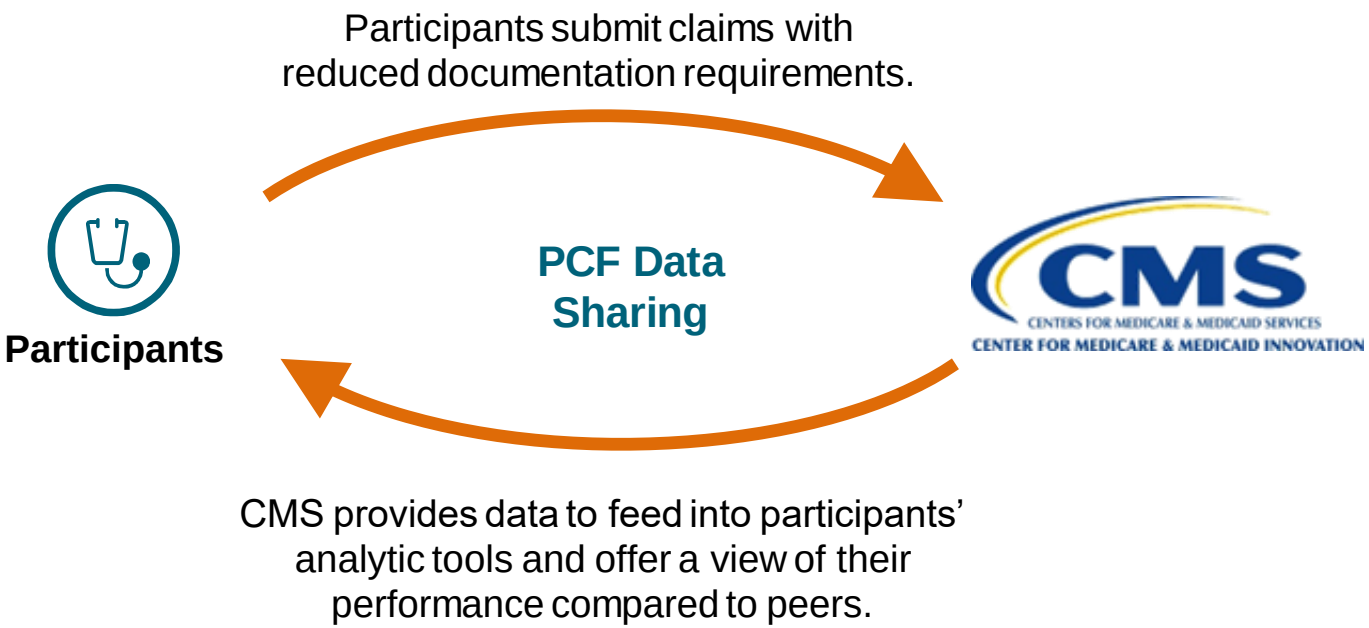
# Principle 2: Reward Outcomes, Not Process

| | Preferred Alignment | Sufficient Alignment | Insufficient Alignment |
|---|---|---|---|
| **Performance-based payment adjustment can be negative if practice has poor outcomes** | Performance can both increase and decrease payment, though potential upside is larger than potential downside | Performance can both increase and decrease payment; potential upside is equal to potential downside | Performance can only increase payment |
| **Alignment with PCF measure set** | Payer uses the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance<br>*AND*<br>Payer uses few or no additional measures above and beyond the PCF measure set | Payer uses at least three of the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance<br>*AND/OR*<br>Payer uses no more than 10 total measures, including PCF-aligned measures and additional measures<br>*AND*<br>Additional measures are drawn from CMS's "Meaningful Measures" initiative, which used broad stakeholder feedback to identify the highest priority areas for quality measurement and improvement, and includes measures that are applicable across multiple CMS programs and patient populations | Payer uses none of the same quality and utilization measures as CMS[1]<br>*OR*<br>Payer uses a large number of additional measures above and beyond the CMS measure set |

# Principle 3: Deliver meaningful data reports to drive performance improvement

# CMS Approach: PCF Data Sharing

**Participants get access to timely, actionable data** to assess performance relative to peers and drive care improvement.



# Principle 3: Deliver meaningful data reports to drive performance improvement

| | Preferred Alignment | Sufficient Alignment | Insufficient Alignment |
|---|---|---|---|
| **Attribution** | Practices receive list of prospectively attributed members at least monthly | Practices receive list of prospectively attributed members at least quarterly | Practices do not receive list of attributed members, or receive a list less than quarterly |
| **Frequency** | Payers provide service utilization and cost data at least quarterly | Payers provide service utilization and cost data at least bi-annually | Payers do not provide service utilization and cost data |
| **Type of data[2]** | Payers provide practices with service utilization and cost of care data for attributed members | Payers provide practices with some limited service utilization and cost of care data for attributed members | Payers do not provide practices with service utilization or cost of care data for attributed members |

# Principle 3: Deliver meaningful data reports to drive performance improvement

| | Preferred Alignment | Sufficient Alignment | Insufficient Alignment |
|---|---|---|---|
| **Format of data[2]** | Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities<br>*AND*<br>Data is accompanied by tailored support and guidance to help practices use the data<br>*AND*<br>Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools | Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities<br>*AND*<br>Data is accompanied by general (non-practice-specific) guidance about how to use the data<br>*AND*<br>Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools | Data is not formatted in a way that allows practices to readily gain actionable insights; data cannot readily be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools<br>*OR*<br>No resources are provided to help practices navigate the data<br>*OR*<br>Payer does not provide data reports to practices |
| **Level of data[2]** | Payers provide practices with beneficiary-level service utilization and cost data | Payers provide practices with practice-level or practitioner-level service utilization and cost data | Payers do not provide practices with utilization and cost data |
| **Alignment with CMS and other local payers** | Payer either already participates in or is actively working towards participating in regional data aggregation with CMS and other regional payers, which provides multi-payer data in a single platform | Payer participates in efforts to align data reporting with CMS and other local payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data) | Payer makes no effort to align data reporting with CMS and other regional payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data) |

# Principle 4: Multi-payer alignment is critical for driving adoption of value-based care models

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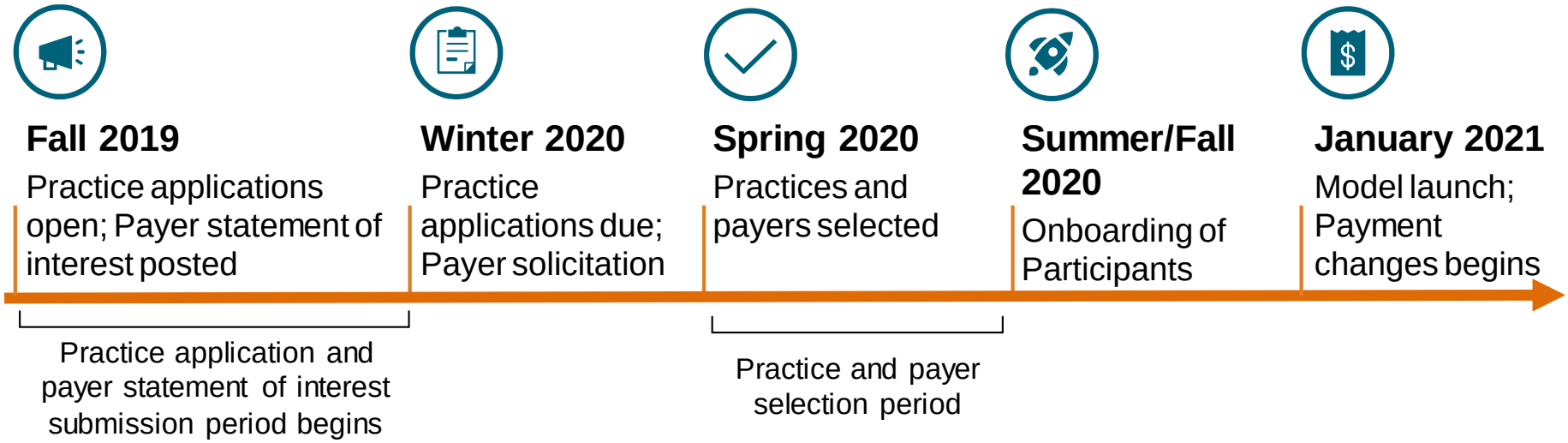
| | Preferred Alignment | Sufficient Alignment | Insufficient Alignment |
|---|---|---|---|
| **Participation in regional multi-payer collaborative activities** | Payer actively participates in and contributes to regional multi-payer collaborative activities related to PCF | Payer attends multi-payer collaborative events, but does not actively participate in or contribute to them | Payer does not participate in multi-payer collaborative activities related to PCF that are available in their region |
| **Goal-setting and continuous improvement** | Payers work with their regional peers to set annual goals for regional multi-payer collaboration and alignment, and develop plan for achieving goals/alignment targets<br>AND<br>Payers demonstrate progress towards goals throughout the year | *Same as preferred* | Regional payers do not set annual goals for regional multi-payer collaboration and alignment or develop plan for achieving goals/alignment targets |

# Principle 4: Multi-payer alignment is critical for driving adoption of value-based care models

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

# Primary Care First Timeline

**The Primary Care First application portal is now live through January 22, 2020!**




**Payer Statement of Interest Form:** https://innovation.cms.gov/Files/x/pcf-payer-soi-form.pdf
**Payer Alignment Rubric:** https://innovation.cms.gov/Files/x/pcf-payer-rubric.pdf
**Request for Applications:** https://innovation.cms.gov/Files/x/pcf-rfa.pdf

# Use the Following Resources to Learn More About Primary Care First

## Visit

https://innovation.cms.gov/initiatives/primary-care-first-model-options/

## Call

1-833-226-7278

## Email

PrimaryCareApply@telligen.com

## Follow

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Look out for additional PCF events in the coming months!