RXNT

Primary Care First Payment Model Rewards Quality and Value

Healthcare spending in the United States represents nearly 18% of all Gross Domestic Product, more than any other developed country. As a way to help curb costs, the Centers for Medicare and Medicaid Services (CMS) introduced the Primary Care First (PCF), voluntary, five-year alternative payment model. The objective is to strengthen access and quality of care through an innovative payment model.

Eligible family physicians practicing in one of the 26 states or regions selected for inclusion in the program may apply to participate in one of three payment model options. The application period for the first round occurred in January 2020, with a second round scheduled for 2022.

Why the Focus On Primary Care

Primary care physicians (PCPs) make up one-third of all practicing physicians in the U.S. However, fewer than one-fourth of current medical school graduates will go into this speciality. Despite the research that primary care results in better patient outcomes, this type of care has largely been underfunded. With an estimated population of 330 million residents, there are only 209,000 practicing primary care doctors in the U.S.

PCPs serve as a critical first point of contact for patients, often the first to note chronic care conditions, serious illnesses, mental health issues, and more. The type of care provided by these physicians is proven to lead to better patient health. In fact, adults with PCPs have 19% lower odds of premature death than those who only visit specialists. Having a primary care provider is also beneficial to patients' financial well being; they save 33% on healthcare costs annually compared to those who only see specialists.

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lower odds of premature death for adults with a primary care physician

33%

more money saved on annual healthcare costs for adults with a primary care physician

Primary caregivers and physicians are also essential to effectively coordinating the care continuum. This is one of the reasons why primary care physicians are so critical to comprehensive care plans. Regular care providers function as a hub for coordinating referrals, lab work, and additional testing.

While individual payers have made significant investments in primary care, multi-payer collaboration and contributions are required to result in a comprehensive transformation of the practice throughout the United States. The Comprehensive Primary Care (CPC) initiative sought to rectify this issue through multi-payer collaboration. A similar voluntary Medicare payment model is coming to 26 states in 2021 under the Primary Care First Model Options.

Why Primary Care Matters to CMS

Launched by CMS in October 2012, the Comprehensive Primary Care (CPC) initiative has worked with commercial and state health insurance plans to achieve five comprehensive primary care functions in seven regions. The seven regions are Arkansas, Colorado, New Jersey, New York (Capital District-Hudson Valley region), Oregon, Ohio & Kentucky (Cincinnati-Dayton region), Oklahoma (Greater Tulsa region).

The five core comprehensive primary care functions identified by the CPC initiative include the following:

1. Risk-stratified Care Management
2. Access and Continuity
3. Planned Care for Chronic Conditions and Preventive Care
4. Patient and Caregiver Engagement
5. Coordination of Care across the Medical Neighborhood

According to CMS, the seven CPC regions were selected based on payer interest and "collective market penetration of payers willing to align their payment models to support the five CPC functions." This initiative ran from the fall of 2012 to the end of 2016.

In a similar vein to the CPC initiative, the Primary Care First Model Options seeks to support advanced primary care delivery through an innovative payment structure model. It contains a set of voluntary five-year payment options centered around value and quality of care.

Primary Care First (PCF) echoes the principles of the CPC initiative through its priorities:

- Emphasizing the doctor-patient relationship
- Enhancing care for patients with complex chronic needs and seriously ill patients
- Reducing administrative burden
- Focusing financial rewards on improved health outcomes

Overall, the Primary Care First Model was created to strengthen primary care and address urgent needs while offering the support of serious illness care services to Medicare beneficiaries. The model's payment options are designed to test whether the delivery of advanced primary care can reduce the total cost of care for patients.

> *The Primary Care First Model Option seeks to support advanced primary care...it contains a set of voluntary five-year payment options centered around value and quality of care.*

The Primary Care First Model Options begin in January 2021, offered in 26 regions throughout the U.S.:

- Alaska (statewide)
- Arkansas (statewide)
- California (statewide)
- Colorado (statewide)
- Delaware (statewide)
- Florida (statewide)
- The Greater Buffalo region of New York
- The Greater Kansas City region of Kansas and Missouri
- The Greater Philadelphia region of Pennsylvania
- Hawaii (statewide)
- Louisiana (statewide)
- Maine (statewide)
- Massachusetts (statewide)
- Michigan (statewide)
- Montana (statewide)
- Nebraska (statewide)
- New Hampshire (statewide)
- New Jersey (statewide)
- North Dakota (statewide)
- The North Hudson-Capital region of New York
- Ohio and Northern Kentucky region (statewide in Ohio and partial state in Kentucky)
- Oklahoma (statewide)
- Oregon (statewide)
- Rhode Island (statewide)
- Tennessee (statewide)
- Virginia (statewide)

The second cohort will start in January 2022.

Breaking Down the Goals of the Primary Care First Model

The innovative payment structure of Primary Care First rewards value and quality through a continuum of care and interested providers. The model has several objectives, all of which center around improving the delivery of advanced primary care in the United States.

The following comprehensive primary care functions drive the model's objectives:

- Access and continuity
- Care management
- Comprehensiveness and coordination
- Patient and caregiver engagement
- Planned care and population health

> *"Advanced primary care practices ready to assume financial risk in exchange for reduced administrative burdens and performance-based payments."*

These objectives help to achieve the larger goals of PCF which range from lightening the administrative load to improving the quality of care for high-need patients.

Reduce Administrative Burdens and Increase Care Innovation

CMS explains that the model is geared toward "advanced primary care practices ready to assume financial risk in exchange for reduced administrative burdens and performance-based payments."

Part of the goal of reducing the administrative load on primary care providers is to increase the amount of time they have to spend with patients. It gives providers more freedom to innovate their methods and delivery of care to serve their unique patient needs better.

Increase Care Responsibility for High-Need, Seriously Ill Patients

It also works with advanced primary care providers to take on more care responsibility for Seriously Ill Population groups. This population group includes high-need, seriously ill Medicare beneficiaries who don't have a primary care provider and/or effective care coordination.

Reduce Expenditures

Primary Care First seeks to increase patient access to advanced primary care services, with the ultimate goals of improving patient outcomes and reducing expenditures. To achieve these goals, CMS will incentivize practices to provide care that reduces acute hospital utilization.

Improve the Quality of Care

Participating practices are assessed by clinical quality and patient experience measures to determine eligibility for performance-based incentives. According to CMS, these measures reflect the organization's broader quality measurement strategy. These measures are focused on the care needs of patients with serious illness and chronic conditions. Examples of these clinical quality and patient experience measures include patient experience of care survey, controlling high blood pressure, diabetes hemoglobin A1c poor control, colorectal cancer screening, and advance care planning.

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How does CMS Determine Eligibility for the PCF Model?

Primary Care First uses a simple payment structure to pay participating practices. Most notably, the structure prioritizes care driven by providers rather than administrative requirements and revenue cycle management. The payment structure also includes population-based payment, flat primary care visit fees, and performance-based adjustments. The CMS projects that PCF will qualify as an Advanced Alternative Payment Model (APM) for all five years of the model test.

To participate in the Primary Care First Model Options, practices must meet the following criteria:

- Located in one of the 26 PCF regions.
- Provide primary care services to at least 125 Medicare fee-for-service beneficiaries at a particular location.
- Include primary care practitioners (MD, DO, CNS, NP, and PA), certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine.
- Primary care services must account for 70 percent or more of the practice's collective billing based on revenue.
- Multi-specialty practices must demonstrate that primary care services accounted for 70 percent of the practice's eligible primary care practitioners' combined revenue.
- Have experience with value-based payment arrangements or payments based on cost, quality, or utilization performance.
- Use Certified Electronic Health Record Technology (2015 edition).
- Support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE).

What is a primary care physician?

An MD, DO, CNS, NP, or PA that is certified in internal medicine, general medicine, geriatric medicine, family medicine, or hospice and palliative medicine.

What Makes the PCF Payment Models Different?

The Primary Care First Model Options contains two payment models: the general PCF and the PCF High Need Populations. The general PCF model tests whether advanced primary care can reduce the total cost of care and improve patient outcomes. It also incentivizes practices to care for patients with complex, chronic illnesses.

This payment model differs from the traditional fee-for-service in that it offers prospective payments with potential bonuses. The total primary care payment includes a risk-adjusted population payment and flat fee for primary care visits. The population payment ranges from $28 to $175 per patient monthly. A standard fee-for-service is paid for procedures and vaccines.

The performance-based adjustments allow for an upside of 50 percent of revenue and downside of 10 percent of revenue incentives. Five quality measures and acute hospital utilization rates are assessed on a quarterly basis.

General PCF Payment Model:

Tests whether advanced primary care can reduce the total cost of care and improve patient outcomes, incentivizes practices to care for patients with complex, chronic illnesses, offers prospective payments with potential bonuses, and includes a risk-adjusted population payment and flat fee for primary care visits.

$28–$175

is the monthly population payment price range for a patient

Under the PCF High Needs Populations payment model option, participating primary care practices are incentivized to provide greater care responsibility for high-need patients. The model defines high-need, seriously ill populations as those with complex chronic conditions, a history of emergency department or hospital utilization, frailty, or lacking primary care practitioners.

Practices are rewarded for caring for these patients through higher per-beneficiary per-month (PBPM) payments. Initial visits are $325, while PBPM payments are $275 for the initial 12 months the patients are assigned to the practice. Practices participating in this model are ineligible for population and performance-based payments.

PCF High Needs Population Payment Model:

Incentivizes participating primary care practices to provide greater care responsibility for high-need patients, rewards practices through higher per-beneficiary per month (PBPM) payments, and excludes practices participating in this model from population and performance-based payments.

$275

is the PBPM price point for the initial 12 months. Initial visits cost $325.

Some practices may also participate in both models, provided they meet eligibility criteria for both.

Is PCF Right for My Practice?

Besides meeting eligibility, what practices will benefit the most from the Primary Care First Model Options? The American Academy of Family Physicians Foundation (AAFP) describes the practices with the most potential to benefit from the model:

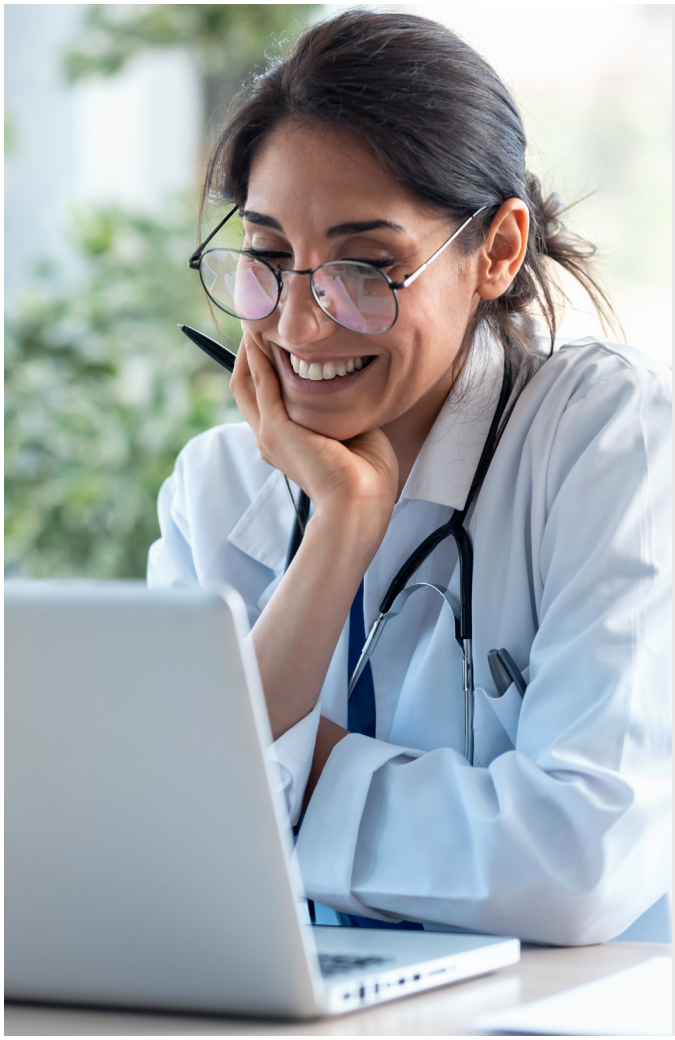
- Have no fewer than 300 Medicare fee-for-service beneficiaries, preferably with 600+.
- Are engaged in a value-based payment program with at least one commercial insurer, Medicare Advantage or Medicaid managed care organization.
- Understand hierarchical condition category risk scores.
- Know their medicare population's background, including the severity of illness and social factors.

MIPS rewards practitioners for high-quality, cost-efficient care that meets desired CMS outcomes. The PCF model may be more advantageous for practices with a high volume of Medicare beneficiaries because it can produce higher performance-based adjustments to revenues.

What about the Medicare Quality Payment Program's Merit-based Incentive Payment System (MIPS)? MIPS rewards practitioners for high-quality, cost-efficient care that meets desired CMS outcomes. However, the PCF model may be more advantageous for some practices. In particular, practices with a high volume of Medicare beneficiaries may find the PCF model produces higher performance-based adjustments to revenues.

Ready for PCF? Review Your Software Needs First

The application period to participate in the 2021 PCF model is now closed. But, practices that have already been selected to participate in the program can prepare by reviewing their software needs. Primary care physicians must monitor the administrative, revenue, and patient-care needs of their practice on a daily basis. Given the importance and broad scope of this role, it can often feel like wearing multiple hats, from business owner to chronic care provider and everything in between.



At RXNT, we can help you gather and collect the data required to meet PCF measures for assessment. The last thing your practice needs is another administrative burden. That's why we've developed our software to meet the needs of practices participating in the PCF or MIPS model. Our end-to-end cloud-based software solutions reduce the strain on resources, streamline workflows and operations, and simplify reimbursement.

We know that as a PCP, you're not only the principal care provider for patients, you're also the head of your small business. You have plenty of tasks associated with productivity, administration, revenue, and billing to deal with each day. So, while healthcare may be growing more complex, we're keeping our solutions simple to implement, use, and pay for. Our predictable low pricing includes set-up, implementation, and unlimited in-house training and support.

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