



## Primary Care First Model: Frequently Asked Questions

*This document was developed as an informational resource for AAFP, ACP, and AMA members based on a Jan 6, 2020 webinar with Centers for Medicare and Medicaid Innovation (CMMI) staff. It includes questions that were addressed during the webinar, as well as those received that we did not have time to address on the webinar itself. The application deadline to apply for a Jan. 1, 2021 start date is **Jan 22, 2020**.*

### Eligibility and Application

- 1. Two clinics in a health system plan to apply for the general track and Seriously Ill Population (SIP) track. They bill under the same Tax Identification Number (TIN). Should they apply separately or together?** The practice site is defined as the physical, i.e. “bricks and mortar” location of the practice. Since there are two separate clinic locations in this example, those practices would need to apply separately even though they bill under the same TIN.
- 2. Is the 125 beneficiary minimum based on a practice’s geographic location, or their National Provider Identifier (NPI)? Can practices apply together to meet the required minimum?** The 125 beneficiary minimum applies to each practice, including all of NPIs within that practice. Each individual “bricks and mortar” practice location must apply separately.
- 3. Will there be a future opportunity to join PCF if a practice chooses not to apply this year?** The 2021 application is open to practices that are not currently enrolled in the Comprehensive Primary Care First (CPC+) Model, which is ongoing in 18 of 26 regions in which PCF is being tested. The 2022 application window is reserved specifically for CPC+ practices. At this time, CMS has no plans to open the 2022 application window to practices outside of CPC+.
- 4. What types of payers are on board with this model, and how much of that information will practices have access to before signing participation agreements?** The payer application window closes in March 2020 so CMMI cannot yet conclusively state the full level of interest from payers, other than to say it is robust. CMS will provide as much information as possible to practices before signing participation agreements, including any updated payer information.
- 5. Are Patient Centered Medical Homes (PCMHs) eligible to participate in PCF?** Yes, PCMHs are eligible to participate in PCF. In fact, PCMHs are well-suited to be successful in this model.



6. **Are Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) eligible to participate in PCF?** No, FQHCs and RHCs are not eligible to participate in the PCF Model.
7. **What types of practitioners qualify? Do pediatricians qualify?** A primary care practitioner is defined as a physician, nurse practitioner, physician assistant, or clinical nurse specialists with a primary specialty of family medicine, internal medicine, geriatric medicine, or hospice and palliative medicine under their own NPI. Pediatricians do not qualify for the model.

#### Data

8. **What data will I receive before signing a participation agreement?** CMS aims to provide practices that are eligible to participate in PCF with a “preliminary risk group” so that they’ll have an idea of what their revenue would look like under this model. The preliminary risk group will be a point-in-time estimate based on information provided in the practice’s application.
9. **What type of data will I receive throughout my participation in PCF?** Practices will receive claims data via either a data feedback tool (similar to the one used in CPC+) or directly through the model. CMS will provide practices with quarterly attribution and payment information.

#### Model Overlap

10. **I am currently participating in CPC+. Can I apply to PCF?** Current CPC+ practices are not eligible to join the 2021 cohort but may apply for a Jan. 1, 2022 start date, which will be open exclusively to CPC+ practices. The application timeline for 2022 has not yet been announced.
11. **Will CPC+ continue beyond 2021, or is the plan for them to transition to PCF?** CPC+ is separate from PCF. While CPC+ is open to primary care practices that have no previous experience with alternative payment arrangements, PCF requires previous experience with risk-bearing models. It is CMS’ hope that CPC+ will show savings and be extended and expanded into more regions allowing practices to choose between CPC+ and PCF depending on their needs.
12. **What should we consider in terms of dual participation in a Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) and PCF? How will dual participation impact our ACO benchmark?** Clinics participating in MSSP ACOs may apply for PCF. CMS will account for overlap by including all PCF payments, including the performance-based adjustment (PBA), in determining whether or not that ACO receives savings.



13. **I am participating in the MSSP. Will PCF payments be made to my ACO?** PCF payments will be included in aggregate shared savings/losses calculations and resulting payments to the ACO.
14. **The Direct Contracting Model was also announced as part of CMS' Primary Cares Initiative and is currently accepting applications. What should our organization consider when considering PCF and DC, including but not limited to financial risk and administrative complexity?** CMS considers both of these models to be on the spectrum of risk. The Direct Contracting model carries both greater financial risk and potential financial benefits, in addition to other aspects and flexibilities. Organizations who are interested in learning more about the Direct Contracting model should visit the [CMMI website](#), read the [Request for Applications](#), and review the available Direct Contracting model webinars (available on the website).

#### **Attribution**

15. **Most advanced primary care practices use the annual wellness visit (AWV) as an opportunity to identify care gaps, develop a care plan, support team-based care, etc. Why will the AWV not be reimbursed separately, and how will this impact patient assignment?** CMS accounted for AWVs in the population-based payments and flat visit fee structure. Clinicians will receive the flat visit fee for AWVs. AWVs will continue to be important for attribution within PCF.
16. **If you choose the SIP option, are the patients automatically assigned to a primary care physician? If so, does the physician need to reach out to the patient to begin care?** Yes, patients are automatically assigned to a specific practice. Yes, it is the practice's responsibility to reach out to the patient, initiate the care relationship, and find the most appropriate long-term care clinician for the patient.

#### **Quality**

17. **What quality measures count in the first year and how are the thresholds determined? Will this change in later performance years?** PBAs are based solely on the acute hospital utilization (AHU) measure and will start in quarter 3 of performance year 1. Starting in performance year 2, PCF practices must satisfy quality gateway requirements to be eligible for a positive PBA, which means meeting or exceeding average national performance thresholds for a set of quality measures. Practices in risk groups 1 and 2 of the general track will be evaluated on five total measures. Practices in risk groups 3 or 4, along with practices in the SIP Track, will be evaluated on a different set of measures that will be phased in over the five-year model. See below. For most measures, benchmarks will be based on national averages based on MIPS data.



**Quality Gateway Measures for Practices in Standard Track, Risk Groups 1-2**

Measure Title	MIPS QID	NQF ID
Patient experience of care survey	321	0005
Diabetes: Hemoglobin A1c Poor Control	001)	0059
Controlling High Blood Pressure	236	0018
Advance Care Plan	47	0326
Colorectal Cancer Screening	113	0034

**Quality Gateway Measures/Phase-in Schedule for Risk Groups 3-4 and SIP Track**

Measure Title	Performance Years
Advance Care Plan	1-5
MIPS Total Per Capita Cost	1-5
CAHPS Measure	2-5
Days at Home (under development)	Tentatively 3-5
24/7 Access to a Practitioner (under development)	Tentatively 3-5

18. **Are there special accommodations in place to support small practices? Specifically, are there any protections in place regarding the AHU measure?** The AHU measure has been tested for both small and large practices over a 12-month period. It is risk-adjusted, includes a beneficiary minimum, and excludes data outliers to help ensure reliability.

**Risk Adjustment**

19. **How will Hierarchical Condition Category (HCC) scoring be used to determine risk scores? How often will risk scores be updated?** Practices will be divided into four risk groups based on the average HCC score of their total attributed beneficiary population (see below). Risks level will be assessed annually before each payment year. More details are expected in Spring 2020.

Risk Group	1	2	3	4
Average HCC Score	<1.2	1.2-1.5	1.5-2.0	>2.0

20. **How do I ensure I am adequately coding for HCC status to accurately reflect the risk status of my patient population?** Clinicians should not change their coding practices as a result of this model. The risk adjustment is designed to account for the disease burden within a population, and that should be accounted for with the expected documentation and treatment of medical conditions that a practice would do during standard care of their patients.

21. **Does CMS plan to audit HCC coding?** CMS will monitor claims data of all PCF participants.



## Payments

22. **What is the projected return on investment for PCF compared to fee-for-service (FFS) Medicare?** The population-based payments (PBPs) and flat visit fees are intended to be equivalent to FFS. For practices able to show value by reducing acute hospital utilization, the performance-based adjustment (PBA) is intended to provide a clear projection of how much additional revenue they can earn. There's a potential downside of 10% and a potential upside of 3.5% to 50%, based on a practice's performance.
23. **How is the "regional reference group" determined? Is it the 26 geographic regions for the model, or something else?** The regional reference groups will consist of the participant's region and other regions that are similar in geography and performance for the given measure, including practices not in the model. The model will ensure that each region has a significantly large comparator to allow for practices to differentiate themselves based on performance.
24. **How frequently will payments under the model be made and updated?** Flat visit fees are paid on a claim-by-claim basis. The PBPs are paid as a lump sum on a prospective, quarterly basis. PBAs will start in quarter 3 of performance year 1. They will also be paid on a quarterly basis, but retrospectively based on a rolling 1-year lookback period that ended two quarters prior. Quality gateway requirements will begin impacting a practice's PBA in performance year 2.
25. **How did CMS develop the payment rates for the PBPM payment as well as the flat office visit rate? With the reimbursement for E/M FFS scheduled to increase in 2021, will PCF payments rise accordingly?** CMS based payments on claims data for primary care services. CMS reserves the right to update payment amounts in 2021 to ensure they reflect average FFS revenue, including making changes to account for updates to fee schedule payments.
26. **Will patients pay a co-pay on top of the flat visit fee?** Coinsurance for the flat visit fee will be calculated as 20% of the Physician Fee Schedule (PFS) allowed amount, rather than 20% of the \$40.82 flat visit fee. In other words, coinsurance will be equivalent to what a beneficiary would have paid under traditional FFS for the same service, and will not increase or decrease as a result of their attribution to a PCF practice. CMS is seeking an internal waiver to facilitate a process in which practices would be able to waive co-pays for eligible patient populations. This would be in addition to the safe harbors that already exist which allow practices to waive co-pays for certain populations. More information will be available on that at a later date.



27. **Are flat visit fees in addition to the per-beneficiary per-month (PBPM) payments for the SIP Track?** Yes. For in-person visits between a SIP beneficiary and practice, the flat visit fee is eligible to be paid if an appropriate claim is billed.
28. **Can flat visit fees be applied to telehealth services?** Any telehealth service that is allowable under original Medicare would also be eligible to be paid out under the PCF Model. CMS is exploring future telehealth functionalities and waivers starting in the second year of the model.
29. **What specific codes are included in the flat visit fee?**
- Office/Outpatient Visits (99201-99205, 99211-99215)
  - Prolonged E/M (99354-99355)
  - Transitional Care Management (99495-99496)
  - Home Care (99324-99328, 99334-99337, 99339-99345, 99347-99350)
  - Advance Care Planning (99497-99498)
  - Welcome to Medicare Visits and Annual Wellness Visits (G04002, G0438, G0439)
30. **Are practices compensated for maintaining a low-cost, high-quality care over time?** Practices who meet or beat national benchmarks for select quality measures are eligible for a positive performance based adjustment. PCF practices could receive an annual PBA of up to 34% based on their performance on acute hospital utilization relative to their region (plus up to an additional 16% based on continuous improvement compared to their past performance).
31. **We are part of a large health system. Will facility fees be separately paid under this model?** PBPM and flat visit fees were intended to encompass primary care services, not all services. All non-primary care services not covered by the flat visit fee will be paid as normal under FFS.

### Leakage

32. **What is the leakage adjustment? When and how will it impact the PBP?** CMS will adjust the PBP by the percentage of attributed patients' primary care services received outside of the PCF practice. The leakage adjustment will start being applied in quarter 3 of performance year 2.
33. **Will an attributed patient seeing their primary care clinician at a non-PCF practice location impact the PCF practice's leakage rate?** No. Avoiding leakage does not require that a clinician be in the same physical location all the time. CMS understands care is often delivered in the home or wherever the patient finds most convenient, and this model seeks to accommodate patients and facilitate care wherever it is most needed and beneficial.



34. **How will “snowbird” patients effect leakage?** If patients receive primary care services at a practice other than the PCF practice to which they are attributed, those services would be removed from the PCF practice’s population-based payment through the leakage rate.
35. **How does the leakage rate calculation compare to the outside-of-practice reconciliation in CPC+?** Under PCF, the professional population-based payment will be reduced by the percentage of E/M or Chronic Care Management services that attributed beneficiaries receive outside of the PCF practice to which they are attributed. For outside-of-practice reconciliation in CPC+, CMS compares historic revenue and current revenue for E/M services that attributed beneficiaries received outside of the CPC+ practice. Increases in services received outside the CPC+ practice would lead to a partial recoupment of the comprehensive primary care payment.