Primary Care First Model Question & Answer Session with CMMI Staff

*This document was developed as an informational resource for AAFP, ACP, and AMA members based on an April 13, 2021, webinar with Centers for Medicare & Medicaid Innovation (CMMI) staff. It includes questions that were addressed during the webinar, as well as those received that were not addressed live due to time constraints. The application deadline to apply for a Jan. 1, 2022, start date is **May 21, 2021**.*

Eligibility and Application

1. **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.

2. **What is the scope of this program for pediatric practices?** PCF is focused on Medicare fee-for-service beneficiaries, and likely will not be applicable to pediatric practices.

3. **What is the relationship of the PCF model to the Patient-Centered Medical Home (PCMH) model?** The PCF model shares many of the same principles and goals as the PCMH model, but there is no direct relationship between the two. For example, there is no requirement that a practice have a PCMH certification to participate in PCF.

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 solicitation period for PCF Cohort 2 closes in June 2021. Payer selections will take place in summer or fall 2021. The current list of payer partners can be found here. CMS will provide as much information as possible to practices before signing participation agreements, including any updated payer information.

5. **How competitive is the selection process for participation in the model?** The application for PCF is not a competitive process and applications are non-binding. CMMI will be accepting practices based on their ability to meet the eligibility requirements of the model.

Data

6. **What data will practices receive before signing a participation agreement?** CMMI will provide practices that are eligible to participate in PCF with a preliminary risk group to allow them to assess the impact of participating in the model on their revenue. The preliminary risk group will be a point-in-time estimate based on information provided in the practice's application. CMMI will also provide a list of payer partners in the practice's region and will be sharing an updated payment methodology paper.

Model Overlap

7. **What should a practice consider in terms of dual participation in a Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) and PCF? How will dual participation impact a practice's ACO benchmark?** Practices participating in MSSP ACOs may apply for PCF. Because the 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 performance-based adjustment, for PCF beneficiaries who are also assigned to the MSSP ACO, will be treated as expenditures for the purposes of financial calculations under MSSP.

Quality

8. **What quality measures count in the first year and how are the thresholds determined? Will this change in later performance years?** Performance-based adjustments (PBAs) are based solely on the acute hospital utilization (AHU) measure for Risk Groups 1 and 2, and the total per capita cost (TPCC) measure for Risk Groups 3 and 4. PBAs will begin in the third quarter of Performance Year 2 (PY2). Starting in PY2, 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 will be evaluated on five total measures. 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. See below. For most measures, benchmarks will be based on national averages based on data from the Merit-based Incentive Payment System (MIPS).

Practice Risk Groups 1 & 2 Quality Gateway Measures

	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

Practice Risk Groups 3 & 4 Quality Gateway Measures

	MIPS QID	NQF ID
Patient experience of care survey	321	0005
Advance Care Plan	47	0326
Days at Home$^{\Delta}$	-	-

$^{\Delta}$Measure is under development and will first be applied in performance year 2

Risk Adjustment

9. **What is the distribution of the practices in Cohort 1 across the four risk groups?** Most practices in Cohort 1 fall into Group 1, with approximately 85-90% of practices in Group 1 and the remaining 10-15% of practices distributed between Groups 2-4.

10. **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). Risk levels will be reassessed annually at the practice site level before each performance year.

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

11. **What claims period is used to determine the average HCC score for the practice?** Cohort 2 Performance Year 1 will use 2020 risk scores calculated using diagnoses from 2019 Medicare claims, which will become available in Spring 2021.

Payment

12. **What specific codes are included in the flat visit fee?**
    - Office/Outpatient Evaluation and Management Visits (99202-99205, 99211-99215)
    - Prolonged E/M (99354, 99355, 99415, 99416)
    - Transitional Care Management (99495-99496)
    - Home Care (99324-99328, 99334-99337, 99341-99345, 99347-99350)
    - Advance Care Planning (99497, 99498)
    - Welcome to Medicare Visits and Annual Wellness Visits (G0402, G0438, G0439)

13. **Will Chronic Care Management (CCM) Current Procedural Terminology (CPT) codes still be payable under Primary Care First?** No. CCM has already been accounted for and built into the professional population-based payment, given that CCM services are a critical component of primary care that contributes to better health and care for individuals. CCM primarily pays physicians and clinicians 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 physicians and clinicians. However, if the physician or clinician 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.

14. **Medicare payment rates for office visits were increased in 2021. Will these increases be reflected in the PCF rates?** Medicare payment rates change every year based on the final physician fee schedule (PFS). The PCF Total Primary Care Payment (TPCP) is intended to be approximately equivalent to fee-for-service for the services included in the flat visit and the population-based payment, which make up the TPCP. As that changes year over year based on the PFS, CMMI will assess the need to update the population-based payment and flat visit fee rates. CMMI's goal is to stay current with increases in the PFS and will continue to monitor and update accordingly.

15. **Will practices be able to do annual wellness visits via telehealth?** PCF will follow broader Medicare telehealth coverage policy such that, as long as the PCF practice meets current

Medicare fee-for-service billing requirements for telehealth services, they will receive the flat visit fee for all applicable eligible services provided via telehealth to their attributed beneficiaries.

16. **Does the PCF model represent an increased investment in primary care?** The population-based payment and flat visit fees are intended to be equivalent to fee-for-service. For practices able to show value by reducing acute hospital utilization, the performance-based adjustment is intended to provide a clear projection of how much additional revenue they can earn and represents a net investment in those primary care practices.

Leakage

17. **A primary care physician sees patients at two locations but is assigned to only one PCF practice. How will an attributed patient seeing their PCP at the non-PCF practice location impact the PCF practice's leakage rate?** If the two practices are at different physical locations but share a tax identification number (TIN) and the attributed beneficiary sees the physician at the non-PCF practice site, it would not count as leakage. CMMI is calculating leakage using the combination of TIN-National provider identifiers (NPIs) for each PCF practice – so in this case the attributed beneficiary's visit is still considered within the PCF practice.

    If the PCF and non-PCF practice are within the same system but *do not* share a TIN, then any qualifying primary care service the attributed beneficiary receives at the non-PCF practice would count as leakage, even if the beneficiary is seeing their physician at the non-PCF practice site. In this case, the physician has two distinct TIN-NPIs – one for the PCF practice and one for the non-PCF practice – and the beneficiary's visit with their physician at the non-PCF practice site will count as leakage for the PCF practice site.

18. **How will "snowbird" patients affect leakage?** If patients receive a qualifying primary care service at a practice other than the PCF practice to which they are attributed, those services will count as leakage and would be included in the leakage adjustment.

General Questions

19. **What kind of support be available for solo practices participating in PCF?** PCF is designed to provide the following learning support:
    - Ensure practices have the information needed about the model, its requirements, and how it operates to be successful in the model.
    - Provide practices with opportunities and a forum to share strategies to be successful between model participants called the PCF Practice Network.
    - In contrast to CPC+, PCF does not have a CMS managed regional learning community. CMS will not provide practice facilitation, coaching, or regionally based learning events, and will not develop a single annual Implementation Guide, but rather will release written guidance on topics as needed.

20. **How is PCF different than CPC+?** CPC+ was designed for practices at beginning of their practice transformation journey with upfront funding, a robust regional learning network, and a small performance-based incentive payment. The model was prescriptive in its care delivery

requirements in exchange for upfront payments. PCF is intended for advanced primary care practices and offers more flexibility, less reporting, and the opportunity to be rewarded with a significant boost to revenue for improved outcomes.

21. **Can a practice terminate their participation in PCF during the five-year model?** Termination is allowed, though there are some restrictions around when a practice can terminate during the year. Full details on this policy are available starting on page nine of the PCF RFA.