

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10577	Date: January 20, 2021
	Change Request 11896

Transmittal 10537, dated December 30, 2020, is being rescinded and replaced by Transmittal 10577, dated, January 20, 2021, to add new HCPCS codes to appendices A and B. All other information remains the same.

SUBJECT: Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 2: FFS Payments and Other Claims-Based Adjustments

I. SUMMARY OF CHANGES: The Innovation Center has secured approval for a new Primary Care First (PCF) model with two separate but related components: (1) the PCF component and (2) the Seriously Ill Population (SIP) component. Both components will test alternative payments and the provision of technical support to primary care practices. Practices may participate in one or both components, although individual beneficiaries may only be covered under one component at a time. Primary care practices participating in PCF and/or SIP will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. With fewer reporting requirements, PCF-only practices will have the flexibility to implement their own strategies that best target outcomes within PCF. SIP-only practices will deliver care to a separate patient population that is both higher risk and shows fragmented patterns of care. This CR is a follow-on to CR 11419.

EFFECTIVE DATE: January 1, 2021 - Applicable to the PCF component (Excludes beneficiaries and providers from the SIP component); April 1, 2021 - Applicable to the SIP component

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 4, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Demonstrations

Attachment - Demonstrations

Pub. 100-19	Transmittal: 10577	Date: January 20, 2021	Change Request: 11896
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I. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act established a new Center for Medicare and Medicaid Innovation (the Innovation Center) within the Centers for Medicare & Medicaid Services (CMS) to test new payment and service delivery models that have the potential to reduce Medicare, Medicaid, and CHIP expenditures while maintaining or improving the quality of care for beneficiaries.

The Innovation Center has secured approval for a new Primary Care First (PCF) model with two separate but related components: (1) the PCF component and (2) the Seriously Ill Population (SIP) component. Both components will test alternative payments and the provision of technical support to primary care practices. These PCF and/or SIP participants will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. With fewer reporting requirements, PCF component practices will have the flexibility to implement their own strategies that best target outcomes. SIP component practices will deliver care to a separate patient population that is both higher risk and shows fragmented patterns of care.

Participants in the PCF model are primary care practices that may participate in one or both components, although individual beneficiaries may only be covered under one component at a time. A primary care practice may include one or more physicians, as well as non-physician providers such as nurse practitioners. Every participating practice will be given a unique practice ID by the CMS implementation support contractor. Providers in a practice will be uniquely defined by the combination of each provider's tax ID number (TIN) and national provider identifier (NPI).

The first cohort of PCF and SIP component participants will begin operation during the following dates:

- PCF component: January 1, 2021 – December 31, 2025
- SIP component: April 1, 2021 – December 31, 2025

The second cohort of PCF and SIP component participants will start one year after the first PCF component cohort:

- PCF and SIP components (Cohort #2): January 1, 2022 – December 31, 2026

CMS will create a provider file that lists all participating providers, their PCF component and/or SIP component practice affiliation, and the effective and termination dates of their participation in the PCF model. A given provider (as defined by the concatenation of TIN and NPI) may only be active in one PCF practice at a time. Providers within a practice may have different effective and termination dates (e.g., as they are hired or leave the practice), but the practice itself will have its own effective and termination date for participation in the model. CMS will also create a beneficiary file detailing all attributed, (which also referred to as aligned) Medicare FFS beneficiaries to participants in PCF and/or SIP components. CMS will detail all information specific to the provider and beneficiary files within the Interface Control Document (ICD). CMS will upload this file in the following location within eCHIMP:

- Change Request (CR) Form/Files/Interface Control Documents

Please note this PCF CR is a follow-on to CR 11419 and addresses the following objectives for the January 2021 Release.

- Flat Visit Fee (FVF) HCPCS codes detailed in Appendix A (Applicable to PCF and SIP components)
- HCPCS code G2020 (Applicable to only the SIP component)
- Prohibited HCPCS codes detailed in Appendix B (Applicable to PCF and SIP components)

B. Policy: Under the Primary Care First (PCF) and Seriously Ill Population (SIP) models, the Innovation Center will engage up to 8,000 primary care practices respectively. Practices may participate in either or both of the models at the same time. While beneficiaries may be eligible for both and, in fact, it is likely that some beneficiaries who start out as SIP participants will transition to participation in PCF, beneficiaries shall only participate in one component of the model at a time.

Under the model, PCF/SIP participating providers shall continue to bill evaluation and management (E&M) and other HCPCS codes (under Appendix A) for all patients as they normally do under the traditional Medicare program. For beneficiaries attributed to them, however, the payment for services covered under the model (listed in Appendix A) will be paid at a geographically adjusted flat visit fee (FVF) amount per visit. Please note the FVF will not vary by HCPCS code. Participating providers submitting multiple HCPCS codes on the same date of service for the same beneficiary will receive one FVF from Medicare. Under the PCF/SIP model, beneficiary cost sharing shall remain unchanged and should adhere to traditional fee for service.

The beneficiary attribution process will be conducted outside of the claims system although a list of beneficiaries attributed to each model shall be provided to contractors for the purposes of claims adjudication every month. Patient coinsurance and deductible will, however, be calculated based on traditional fee for service processing for the original E&M code that the provider billed. The FVF also waives the 15% reduction on claims submitted by non-physician providers. The removal of the 15% reduction shall take effect after coinsurance has been applied so that beneficiaries are not adversely impacted by increased coinsurance.

In addition, SIP participating providers shall also be eligible to bill for a one-time initial visit fee with a SIP beneficiary: HCPCS Code G2020 prolonged initial face-to-face visit. G2020 shall not be subject to coinsurance and deductible and only one SIP code shall be paid per the lifetime of each SIP beneficiary.

Similar to the FVF, the PCF model will waive the 15% non-physician provider reduction for G2020.

The G2020 service must be provided and billed at least one day before any other services subject to the flat visit fee may be reimbursed accordingly. In the event HCPCS code G2020 is provided after OR on the same date of service as FVF HCPCS codes, the following will occur for SIP beneficiaries only:

- If the HCPCS code G2020 has the same date of service as FVF HCPCS codes CMS shall deny claim lines with any FVF HCPCS codes
- If a FVF HCPCS code has been rendered prior to HCPCS code G2020 experience, the claim lines with FVF HCPCS codes will be processed under traditional FFS.

CMS acknowledges some claims are submitted non-sequentially, which will require claims reprocessing. CMS will address this specific issue in a separate instruction.

Separate from these PCF and SIP component FFS payments, PCF/SIP participating providers may receive per beneficiary per month payments for attributed beneficiaries as well as performance-based payments. These payments shall be processed outside the fee for service claims processing system and do not require input from FFS contractors.

PCF/SIP participating providers are prohibited from billing HCPCS Codes listed in Appendix B on any of their attributed beneficiaries. CMS has determined Appendix B HCPCS Codes (99487, 99489, 99490, 99491, 99339, and 99340) are duplicative of the non-claims-based payments participants are receiving under PCF and/or SIP components.

Except as otherwise specified, PCF/SIP claims shall be subject to all other adjustments (e.g. sequestration) and policies applicable to other fee for service claims.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC		H H H	D M E M A C	Shared- System Maintainers				Other	
		A	B			F I S S	M C S	V M S	C W F		
11896.1	For claims with dates of service on or after April 1, 2021, contractors shall accept claims for HCPCS code G2020 under the SIP component.		X				X		X		
11896.1.1	Contractors shall be aware of the long and short descriptors for HCPCS code G2020: Long descriptor: Services for high intensity clinical services associated with the initial engagement and outreach of beneficiaries assigned to the SIP component of the PCF model. (Do not bill with Chronic Care Management codes.)		X						X	ACO OS, CMS	

Number	Requirement	Responsibility									
		A/B MAC		H H H	D M E M A C	Shared- System Maintainers				Other	
		A	B			F I S S	M C S	V M S	C W F		
	<p>Short descriptor: Hi inten serv for SIP model</p> <p>EFF Date for testing: 10/01/2020</p> <p>EFF Date: 04/01/2021</p> <p>TOS = "01"</p> <p>Note: For testing this CR apply Effective Date of 10/01/2020 for HCPCS G2020.</p> <p>CWF shall also allow demonstration code "96" to be accepted with a date of service on or after 10/01/2020 for testing only but implementation shall be effective on 01/01/2021 for demonstration code "96". Please note the demonstration code "96" and HCPCS code G2020 have different effective dates.</p>										
11896.1.2	Contractors shall not apply coinsurance and deductible to HCPCS code G2020.		X								
11896.1.3	<p>Contractors shall use the following messages for claim lines processed and paid in accordance with the rules of the PCF/SIP model, unless otherwise specified in this CR:</p> <p>Claims Adjustment Reason Code (CARC) 132:</p> <p>"Prearranged demonstration project adjustment"</p> <p>Group Code: CO (Contractual Obligation)</p> <p>MSN 60.4: This claim is being processed under a demonstration project.</p> <p>Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.</p>		X								
11896.2	Contractors shall apply beneficiary cost-sharing based on traditional FFS rules for Appendix A procedures.		X				X				
11896.3	The Multi-Carrier System (MCS) shall apply demonstration code "96" for the PCF model (inclusive of both the PCF and SIP components) to professional						X				

Number	Requirement	Responsibility									
		A/B MAC		H H H	D M E M A C	Shared- System Maintainers				Other	
		A	B			F I S S	M C S	V M S	C W F		
	<p>claims submitted on the CMS-1500 (or electronic equivalent) where:</p> <ul style="list-style-type: none"> The beneficiary HIC Number (HICN) and billing provider Tax Identification Number (TIN) match those listed in the beneficiary file; and The billing provider TIN and rendering NPI match those listed on the PCF/SIP provider participant file; and The PCF/SIP Model Identifier match between the beneficiary and provider participant alignment files; and The date of service for the detail line is between the effective start date and end date (inclusive) for the matching records in the beneficiary alignment and provider participant files; and Medicare is the primary payer for the service. <p>AND</p> <p>Once the following situations reflect the HCPCS codes billed on the claim line:</p> <ul style="list-style-type: none"> The HCPCS code listed on the detail line is G2020 or one of the eligible codes listed in Appendix A or B of this CR; and HCPCS code G2020 listed on the detail line has dates of service on or after April 1, 2021; or Appendix A or B HCPCS code listed on the detail line has dates of service on or after January 1, 2021. 										
11896.3.1	MCS shall apply the ACO ID and benefit enhancement indicator of 'D' to aligned details with procedure G2020, and the bene has a population indicator of 'S' and the provider has a record type of 'D'.							X			IDR
11896.3.2	MCS shall apply the ACO ID and benefit enhancement 'E' to aligned details with procedures from Appendix A or B, and the provider has a record							X			IDR

Number	Requirement	Responsibility								Other
		A/B MAC		D M E M A C	Shared- System Maintainers					
		A	B		H H H	F I S S	M C S	V M S	C W F	
11896.7	<p>MCS shall add claim processing logic to apply the Flat Visit Fee (FVF) detail line allowed amount from the Medicare Physician Fee Schedule Data Base (MPFSDB) file in field 31EE to impacted claims subject to the flat visit fee (FVF).</p> <p>Note: HCPCS Code G2020 shall be added to the MPFSDB and does not apply like the HCPCS Codes from Appendix A. This only pertains to FVF HCPCS Codes from Appendix A.</p>						X			
11896.7.1	MCS shall use the 31EE value as the provider paid amount, before sequestration, for payable FVF detail procedures.						X			
11896.8	<p>Contractors shall return as unprocessable an incoming claim if the provider appends a demonstration code of "96" on the CMS-1500 (or electronic equivalent). Contractors shall use the following messages:</p> <p>Claims Adjustment Reason Code (CARC): 132</p> <p>“Prearranged demonstration project adjustment.”</p> <p>Remittance Advice Remark Code (RARC): N763</p> <p>"The demonstration code is not appropriate for this claim; resubmit without a demonstration code."</p> <p>Group Code: CO (for contractual obligation)</p>		X							
11896.9	<p>MCS shall create a new reject for a Part B claim detail line if the SIP HCPCS code G2020 is billed under the following conditions:</p> <ol style="list-style-type: none"> The beneficiary has been not identified as a SIP beneficiary during the applicable dates of service The provider is not eligible to bill the SIP HCPCS code G2020 during the applicable effective/end dates 						X			

Number	Requirement	Responsibility									
		A/B MAC		H H H	D M E M A C	Shared- System Maintainers				Other	
		A	B			F I S S	M C S	V M S	C W F		
11896.10	CWF shall create a new Part B Utilization edit to not allow more than one SIP HCPCS code G2020 per beneficiary per lifetime. CWF shall read the SURG Aux file to determine this.									X	
11896.10.1	If a submitted claim has more than one claim line with HCPCS code G2020 MCS shall handle these multiple claim lines accordingly: <ul style="list-style-type: none"> MCS shall process the G2020 claim line with the earliest date of service that meets all model requirements. MCS shall deny all subsequent claim lines with HCPCS code G2020. 						X				
11896.10.1.1	For all denied claim lines containing HCPCS code G2020, contractors shall communicate the following message: <p>Claims Adjustment Reason Code (CARC): 132</p> <p>“Prearranged demonstration project adjustment”</p> <p>Remittance Advice Remark Code (RARC): N117</p> <p>"This service is paid only once in a patient’s lifetime."</p> <p>Group Code: CO (for contractual obligation)</p> <p>MSN 20.12: This service was denied because Medicare only covers this service once a lifetime.</p> <p>Spanish Translation: Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida.</p>		X								
11896.11	A/B MACs Part B shall refer all provider inquiries regarding claims and/or claim lines subject to the rules of the PCF model (applicable to PCF and/or SIP components) to PCF Model Help Desk. Below are the contact details for the PCF Model Help Desk: <p>PCF Model Help Desk</p> <p>Telephone (Toll Free Number): 888-517-7753</p>		X							CMS	

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared- System Maintainers				Other	
		A	B	H H H		F M I S S	M C S	V M S	C W F		
	any procedure listed in Appendix A and an incoming record is accepted with a claim line for G2020 with the same date of service and demonstration code "96".										
11896.17	For claims subject to the PCF/SIP FVF adjustment, MCS shall include on the CWF claim transmission record (HUBC) the adjustment amount attributable to each line in the "Other Amounts Applied" field, using the following: <ul style="list-style-type: none"> The Other Amount Indicator 'A2' to indicate the amount by which each line was reduced for the FVF adjustment. The Other Amount Indicator 'A3' to indicate the amount by which each line was increased for the FVF adjustment. 						X				
11896.17.1	CWF shall allow an Other Amount Indicator of 'A2' and/or 'A3' for claims with dates of service on or after implementation.									X	
11896.17.1.1	CWF shall modify Part B consistency edit '92x5' to accept a reduction to the reimbursement amount when Other Amount Indicator 'A2' is received.									X	
11896.17.1.2	CWF shall modify Part B consistency edit '92x5' to accept an increase to the reimbursement amount when Other Amount Indicator 'A3' is received.									X	
11896.17.1.3	CWF shall modify Part B consistency edit '97x1' to accept the new value(s) in the Other Amount Indicator field 'A2'.									X	
11896.17.1.4	CWF shall modify Part B consistency edit '97x1' to accept the new value(s) in the Other Amount Indicator field 'A3'.									X	
11896.18	Contractors shall send the new PCF/SIP payment adjustment message and amount to the IDR claims file.		X					X			
11896.19	MCS shall process all Medicare secondary payer claims as normal FFS claims.							X			

Number	Requirement	Responsibility							
		A/B MAC		D M E M A C	Shared-System Maintainers				Other
		A	B		H H H	F I S S	M C S	V M S	
	Note: A/B MAC Part B contractors shall use any of the existing Discovery Codes based on the determination if CMS, MAC, or Provider initiated the overpayment.								
11896.29	This business requirement has been deleted.		X						HIGLAS
11896.30	This business requirement has been deleted.		X						HIGLAS
11896.31	Contractors shall handle all PCF/SIP model claims and/or claim lines as non-935 eligible. Note: PCF/SIP model claims and/or claim lines are not eligible for 935 appeal rights.		X						
11896.32	A/B MACs Part B shall use an appropriate Discovery Code and Reason Code 'O' when initiating the PCF/SIP overpayment adjustments.		X						
11896.33	A/B MACs Part B shall ensure the 935 indicator is set to 'N' for these adjustment claims as they are not eligible for the Section 935 Appeals.		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC			D M E M A C	C E D I	
		A	B	H H H			
	None						

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Donna Schmidt, donna.schmidt@cms.hhs.gov , Yani Mellacheruvu, Yani.Mellacheruvu@cms.hhs.gov , Aparna Vyas, Aparna.Vyas@cms.hhs.gov , Mark Baldwin, 410-786-8139 or mark.baldwin@cms.hhs.gov , Emily Johnson, 410-786-4015 or emily.johnson@cms.hhs.gov , Christopher Coutin, 410-786-5698 or christopher.coutin@cms.hhs.gov , Cynthia Thomas, 410-786-8169 or Cynthia.Thomas@cms.hhs.gov , Charles Campbell, Charles.Campbell@cms.hhs.gov , Tammy Luo, tammy.luo@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

Primary Care First (PCF)

Appendix A

Flat Visit Fee (FVF) HCPCS Codes

HCPCS Codes	Service Type
99201	Office/Outpatient Visit E/M
99202	Office/Outpatient Visit E/M
99203	Office/Outpatient Visit E/M
99204	Office/Outpatient Visit E/M
99205	Office/Outpatient Visit E/M
99211	Office/Outpatient Visit E/M
99212	Office/Outpatient Visit E/M
99213	Office/Outpatient Visit E/M
99214	Office/Outpatient Visit E/M
99215	Office/Outpatient Visit E/M
99324	Home Care E/M
99325	Home Care E/M
99326	Home Care E/M
99327	Home Care E/M
99328	Home Care E/M
99334	Home Care E/M
99335	Home Care E/M
99336	Home Care E/M
99337	Home Care E/M
99341	Home Care E/M
99342	Home Care E/M
99343	Home Care E/M
99344	Home Care E/M
99345	Home Care E/M
99347	Home Care E/M
99348	Home Care E/M
99349	Home Care E/M
99350	Home Care E/M
99354	Prolonged E/M
99355	Prolonged E/M
99495	Transitional Care Management Services
99496	Transitional Care Management Services
99497	Advanced Care Planning
99498	Advanced Care Planning
G0402	Welcome to Medicare
G0438	Annual Wellness Visits
G0439	Annual Wellness Visits
99415	Prolonged Clinical Services
99416	Prolonged Clinical Services

Primary Care First (PCF)

Appendix B

Prohibited HCPCS Codes

HCPCS Codes	Service Type
99487	Chronic Care Management
99489	Chronic Care Management
99490	Chronic Care Management
99491	Chronic Care Management
99339	Home Care
99340	Home Care
G2211	Primary Care Management
G2212	Prolonged Evaluation & Management
99439	Chronic Care Management