Primary Care First (PCF) Model Cohort 2
Applicant Webinar Frequently Asked Question Supplement

The objective of this document is to provide additional information about Primary Care First model topics that generated multiple questions from attendees during webinars about the second cohort of Primary Care First held by CMS in March 2021. **This document is not meant to be a comprehensive description of model policies**; it merely highlights policies that are frequently asked about by potential model applicants. For a comprehensive description of model policies, please refer to the PCF Cohort 2 Request for Applications.

Contents

Applicant Eligibility

- As outlined in Appendix A of the Request for Applications (RFA), the following types of practices **are eligible to apply for Primary Care First Cohort 2**:
    - Practices that applied and were not accepted to PCF Cohort 1.
    - Practices that applied, were accepted, and chose not to participate in Cohort 1.
- As outlined in Appendix A of the Request for Applications (RFA), the following types of practices **are not eligible for Primary Care First Cohort 2**:
    - Federally qualified health centers (FQHCs)
    - Rural health centers (RHCs)
    - Practices located outside of a PCF region

Application Process & Timeline

- Submit your practice application by **May 21, 2021.**
    - Organizations with multiple locations (i.e. brick and mortar practice sites) must apply to participate, and meet all eligibility requirements, individually for each location.
- Practices will be notified of their acceptance in late summer/early fall 2021.
- Accepted practices will receive a welcome packet which includes:
    - Preliminary, non-binding estimates of your practice's:
        - Practice risk group
        - Number of attributed beneficiaries
        - Geographic adjustment factor
    - A list of participating payer partners
    - A Participation Agreement for review and signature
- The PCF application is non-binding; practices must still sign and return the Participation Agreement to finalize their participation in PCF.

Practitioner Roster

- Applicants must submit a roster of participating practitioners that:
    - Have reassigned their billing rights to your practice's tax identification number (TIN).
    - Worked at the practice at any time from January 1, 2017 to present, even if they are not currently working at your practice (to ensure credit for past care delivered to beneficiaries at your practice, which CMS will take into account when attributing beneficiaries).

- Are not listed on more than one practice roster.
    - Practitioners that work at multiple locations should be submitted for the roster of the practice where they spend the most time.

Beneficiary Attribution

- Eligible beneficiaries are prospectively attributed to participating practices on a quarterly basis.
- CMS first attributes beneficiaries via voluntary alignment, allowing patients to choose their primary clinician through MyMedicare.gov.
- PCF-eligible beneficiaries who do not voluntarily align are attributed using medical claims from the previous 24 months, in the following order:
    - Practice with most recent Annual Wellness Visit (AWV) or Welcome to Medicare (WMV) visit.
    - If no AWV or WMV is listed, the patient is attributed to the practice billed for multiple qualifying primary care visits.
        - If a beneficiary has an equal number of qualifying visits billed by more than one practice, the beneficiary will be attributed to the practice with the most recent visit.

Cost Sharing Waiver

- In order to engage with beneficiaries that would otherwise forego care because of its associated costs, practices may choose to waive coinsurance for PCF attributed beneficiaries; CMS will not compensate practices for the loss in cost sharing revenue.
- The application question about cost sharing is non-binding; after signing the Participation Agreement, interested PCF practices must submit an implementation plan (subject to CMS approval) identifying their eligible patient populations and services under the cost sharing waiver.

Multi-Payer Partnership

- CMS partners with a variety of payers, including commercial health insurers, Medicare Advantage plans, Medicaid agencies and Medicaid managed care plans to support practices and increase PCF's potential impact on patients, regardless of payer status.
- As a result of multi-payer partnership, participating practices can develop a more streamlined approach to value-based care, receive consistent financial incentives and experience less administrative burden.
- CMS will allow for flexibility in how payers can align with PCF, meaning that other payers' models may differ with respect to payment methodology and payment rates, quality measures, and data provided.
- CMS does not intervene in private arrangements between participating practices and payers and encourages practices to contact payers directly to understand the details of their aligned models. CMS will provide accepted practices with a list of participating

payers to facilitate these conversations.

Quality Payment Program

- All Medicare clinicians have two tracks to choose from in the Medicare Quality Payment Program based on their practice size, specialty, location, or patient population:
    - **Advanced Alternative Payment Models (APMs)** – CMS anticipates that PCF will qualify as an Advanced APM for all five years. Therefore, clinicians participating in PCF will have multiple opportunities each performance year to be determined to meet Qualifying APM Participant (QP) status.
    - **Merit-based Incentive Payment System (MIPS**) – PCF clinicians who do not achieve QP or Partial QP status are required to participate in MIPS.

Medicare Shared Savings Program (MSSP)

- Practices may participate in both PCF and the Medicare Shared Savings Program (MSSP); PCF practices may not participate in any other Accountable Care Organization (ACO) program besides MSSP.
- All PCF payment amounts (including the flat visit fee, population-based payment, and performance-based adjustment) will be included as spending when comparing MSSP ACO spending to the benchmark in any shared savings or losses calculation.
- MSSP participation will have no impact on the PCF performance-based adjustment calculation.
- Participating practices will be responsible for meeting the reporting requirements for both MSSP and PCF.

PCF Payment Methodology

Flat Visit Fee

The following table lists the services, with their relevant Healthcare Common Procedure Coding System (HCPCS) codes, that will be paid the **Flat Visit Fee** for PCF-attributed beneficiaries:

Services	HCPCS Codes
Office/outpatient visit evaluation and management (E&M)	99202–99205*, 99211–99215*
Prolonged E&M	99354*, 99355*, 99415, 99416
Transitional care management services	99495*, 99496*
Home care/domiciliary care E&M	99324–99328*, 99334–99337*, 99341–

	99345*, 99347–99350*
Advance care planning	99497*, 99498*
Welcome to Medicare and Annual Wellness Visits	G0402, G0438*, G0439*
*As long as practices meet current Medicare telehealth coverage requirements, they may provide these services either in-person or via telehealth and will receive the flat visit fee regardless; if practices provide other telehealth or virtual services, such as audio-only visits, for which the CPT code billed is not a flat visit fee code, practices will be reimbursed according to traditional Medicare FFS rules.	

- Practices **do not need to bill differently** to receive the flat visit fee, and should continue to submit claims to Medicare as normal.
- **Coinsurance** for the flat visit fee will be calculated as 20% of the Medicare allowed amount for the HCPCS code that a practice bills to receive the flat visit fee, rather than 20% of the flat visit fee amount.
- **Vaccines, labs, and other ancillary services** billed by PCF participants will continue to receive the standard Medicare FFS payment.
- **Chronic care management services** are accounted for under the professional population-based payment, and may not be billed separately for PCF-attributed beneficiaries.
- CMS will only pay one flat visit fee for all eligible HCPCS codes **provided on the same date of service.**
- Under PCF, hospital-based practices may **continue to bill for the facility fee** (G0463); CMS will pay the FVF in addition to FFS reimbursement for applicable facility fees.
- PCF model payments, like Medicare Part B physician fee schedule payments, will be **geographically adjusted** to account for nationwide variations in cost.
- CMS will **evaluate and adjust PCF payment amounts for 2022** as needed based on changes observed in Medicare FFS, as well as any updates to the 2022 Physician Fee Schedule.

Professional Population-Based Payment

- Practice risk groups, which determine a practice's professional population-based payment amount, are set annually at the start of each performance year and based on the average CMS-Hierarchical Condition Category (HCC) risk score of PCF-attributed beneficiaries in the previous year.
- CMS applies a quarterly **leakage adjustment** to reconcile the population-based payment when less than 100 percent of primary care services are delivered at your practice over a given year.

- Visits to other practice sites within your practice's system count as "outside of practice", though this would be offset by the Medicare FFS rate paid to your organization in lieu of the flat visit fee.
- If a non-participating nurse practitioner, physician assistant or specialist with a primary care taxonomy code bills a qualifying primary care visit, then the visit *would* count toward the leakage adjustment calculation.
- To allow time for your practice to make changes to care continuity and reduce leakage in PCF before model payment is affected, this adjustment will first take effect in 2023 Quarter 3 based on services provided in 2022.

Quality Measurement

- As seen in CAHPS surveys for other CMS programs, PCF participants will be expected to contract with approved survey vendors for the PCF **Patient Experience of Care (PEC) Survey.**
    - Costs and services may vary among vendors; CMS will provide participants with a list of approved survey vendors to choose from.
- The **Advance Care Plan measure** is a Merit Based Incentive Payments System clinical quality measure (MIPS CQM).
    - Currently, the measure must be reported using a health IT vendor from the MIPS final approved lists of qualified registries and Qualified Clinical Data Registries (QCDR) for the respective performance year.

Data Sharing

In addition to PCF payment and attribution data, CMS will share retrospective, Medicare claims-based data with practices on a quarterly basis. CMS will make beneficiary and practice-level expenditure, utilization, and diagnosis data available through a Data Feedback Tool and/or—for practices with experience receiving and processing claims data—through Claims and Claims Line Feeds.