CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10141	**Date: May 15, 2020**
	Change Request 11419

SUBJECT: Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 1: Provider, Beneficiary and Procedure Code Files to Support Model Implementation

I. SUMMARY OF CHANGES: The Innovation Center has secured approval for the Primary Care First (PCF) and Serious Illness Patient (SIP) Models, demonstrations testing alternative payment model and technical support to primary care practices. PCF is designed to test whether changing how Medicare pays for primary care can lead to reductions in acute hospital utilization and lower total cost of care while preserving or improving quality. SIP is designed to include practices that specialize in caring for complex, chronically ill patient populations. In addition to supporting enhanced care delivery for practices' current patients, the SIP model aims to extend the reach of these advanced practices by enabling them to proactively engage sick and unmanaged Medicare fee-for-service (FFS) beneficiaries who lack a primary care practitioner and/or effective care coordination.

The purpose of this CR is to implement Flat Visit Fee (FVF) and One-Time SIP Payment, and deny billing Chronic Care Management HCPCS Codes. PCF and SIP participating providers submitting a claim eligible under the FVF will have each claim adjusted to a national base total allowed amount of $40.82. Once each claim has been adjusted to the national base rate of $40.82 each one will be adjusted according to Geographic Adjustment Factors (GAFs) from the Physician Fee Schedule (PFS). Below are some other important facts about the FVF:

- Includes Coinsurance
- Waives the 15% reduction to Fee-For-Service Claims submitted by Non-Physician Providers
- Tied to specific HCPCS Codes found in Appendix A

SIP providers must proactively engage with sick and unmanaged Medicare FFS beneficiaries showing an absence of effective care coordination. In order to receive the One-Time SIP Payment, SIP providers shall submit a G-Code HCPCS Code G2020 after rendering services from the first visit with each attributed Medicare FFS beneficiary. The One-time SIP payment is will be set to a total allowed amount of $331.63 for each beneficiary with coinsurance and deductible waived. Below are some additional facts for this payment:

- Includes the 15% reduction to Fee-For-Service Claims submitted by Non-Physician Providers
- Not geographically adjusted
- HCPCS Code G2020
- G-Code may only be billed once per Medicare FFS Beneficiary per lifetime
- HCPCS Codes from Appendix A with same date of service as HCPCS Code G2020 are ineligible and will be denied

PCF and SIP providers are receiving non-claims based payments that cover providing services under the Chronic Care Management (CCM) and some Home Health codes. In order to prevent duplicative payments, PCF and SIP are prohibited from billing CCM and some Home Health codes listed in Appendix B on any of their attributed beneficiaries. CMS will deny claims or claim lines with Appendix B HCPCS Codes for

attributed PCF and/or SIP Medicare FFS beneficiaries.

EFFECTIVE DATE: October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020

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	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: 10141	Date: May 15, 2020	Change Request: 11419

SUBJECT: Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 1: Provider, Beneficiary and Procedure Code Files to Support Model Implementation

EFFECTIVE DATE: October 1, 2020
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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 (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, or CHIP expenditures while maintaining or improving the quality of care for beneficiaries.

The Innovation Center has secured approval for a new primary care model with two separate but related component models: (1) the Primary Care First (PCF) model and (2) the Seriously Ill Population (SIP) model. Both models will test alternative payments and the provision of technical support to primary care practices. Practices may participate in one or both models although individual beneficiaries may only be covered under one model 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 participants have the flexibility to implement their own strategies that best target outcomes within the PCF. SIP only participants will deliver care to a new patient population that is higher risk, showing fragmented patterns of care.

PCF and SIP practice sites will begin operation under the models starting January 1, 2021 and will continue through 12/31/2026. New practices and providers may be added throughout the model and CMS will provide updated files of participating practices and providers as well as attributed beneficiaries on a monthly basis. Participating providers will continue to submit claims using normal fee-for-service (FFS) processing. In addition to claims-based payments, participating providers will receive quarterly per beneficiary per month payments as well as adjustments for performance-based payments. These payments shall be processed separate from the claims system and are not addressed in this CR.

Although this model will have one demonstration code applied to claims processed under either component of the model, as described in the business requirements below, for the purposes of clarity, if a requirement applies to both components the business requirement will refer to PCF/SIP. If the business requirement applies to only one of the components, the business requirement will state “PCF only” or “SIP only”.

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

Separate from these visit-based fees, 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 are not addressed in this CR.

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

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			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
11419.1	The CMS specialty/operations contractor shall send MCS the initial provider participant files detailing PCF participating providers. **NOTE**: The provider participant file will be a national file accessible by all MACs. The CMS operations contractor contacts are: Salauddin Shaik (Salauddin.Shaik@softrams.com); Vivek Trehan (Vivek.Trehan@softrams.com); Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov); Aparna Vyas (Aparna.Vyas@cms.hhs.gov)						X			ACO OS, VDC
11419.1.1	The CMS specialty/operations contractor shall include									ACO OS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	data elements on the aligned provider file as identified in the ICD.									
11419.2	The CMS specialty/operations contractor shall send CWF the initial beneficiary alignment files detailing beneficiaries aligned to the PCF participating providers. **NOTE**: The beneficiary alignment file will be a national file accessible by all MACs. The CMS operations contractor contacts are: Salauddin Shaik (Salauddin.Shaik@softrams.com); Vivek Trehan (Vivek.Trehan@softrams.com); Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov); Aparna Vyas (Aparna.Vyas@cms.hhs.gov)								X	ACO OS, VDC
11419.2.1	The CMS specialty/operations contractor shall include data elements on the aligned beneficiary file as identified in the ICD.									ACO OS
11419.3	FISS shall accept the beneficiary file layout for the PCF model processing changes.					X			X	
11419.3.1	FISS shall accept the provider file layout for the PCF model processing changes.					X	X			
11419.4	CWF shall provide the beneficiary file with the most current Health Insurance Claim Number (HICN) to MCS/FISS.					X	X		X	
11419.5	The contractors shall maintain an update date in their internal file which will reflect the date the updated files was loaded into the shared system. **NOTE:** The field shall be viewable to the MACs.						X		X	
11419.5.1	CWF shall update the ACOB auxiliary file/HIMR screen to display the beneficiary alignment data. CWF will add a new Population Indicators to identify PCF Model is ‘S’ for SIP only and blank for Non-SIP. ACO Identifier with 'P' in the first position will be								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	used to link the PCF Model.									
11419.6	The CMS specialty/operations contractor shall deliver the provider participant and beneficiary alignment files to the Virtual Data Centers (VDCs) when they become available. **NOTE:** BRs 11419.1 – 11419.5.1 shall be applicable to all test files.								X	ACO OS, CMS, VDC
11419.6.1	The CMS specialty/operations contractor shall transmit the provider participant and beneficiary alignment files through electronic file transfer (EFT). **NOTE:** The ICD shall identify the file names.									ACO OS
11419.6.2	The CMS specialty/operations contractor shall notify the contractors of the provider participant and beneficiary alignment file names when they become available						X		X	ACO OS, CMS, VDC
11419.7	Shared systems shall create response files acknowledging receipt of the provider participant and beneficiary alignment files.						X		X	ACO OS, CMS
11419.7.1	The contractors shall perform limited editing to ensure the file is well-formed. The validation checks will include: • the Header Record must be present and fields populated with valid information; • the Trailer Record must be present and fields populated with valid information; and • the actual count of detail records must match the count in the Trailer Record. **NOTE:** The Interface Control Document (ICD) will define the response file layout and detailed error conditions.						X		X	
11419.7.2	The contractors shall produce a response file that indicates the file was processed and contained no						X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	errors if no validation errors were encountered.									
11419.7.3	If validation errors are encountered, the contractors shall produce a response file that indicates specific records and fields that did not pass the validation checks using defined error codes as defined in the ICD.						X		X	
11419.8	The CMS specialty/operations contractor shall provide the initial provider participant and beneficiary alignment testing files to the Virtual Data Centers (VDCs) no later than September 1, 2020 and shall make the files available to the Part B MACs. The CMS specialty/operations contractor shall transmit the provider participant and beneficiary alignment files through electronic file transfer (EFT). The CMS operations contractor contacts are: Salauddin Shaik (Salauddin.Shaik@softrams.com); Vivek Trehan (Vivek.Trehan@softrams.com); Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov); Aparna Vyas (Aparna.Vyas@cms.hhs.gov) **NOTE #1:** Part B MACs will send beneficiary and provider information for testing by August 14, 2020 to ACO-OS. **NOTE: #2:** Effective dates for testing files need to be 10/1/2020 – 10/31/2020		X							ACO OS
11419.8.1	The Virtual Data Centers (VDCs) shall run the jobs to load the test files.									VDC
11419.9	The CMS specialty/operations contractor shall transmit the provider participant and beneficiary alignment files through electronic file transfer (EFT). **NOTE:**The ICD shall identify the file names.									ACO OS
11419.10	The CMS specialty/operations contractor shall deliver the initial provider participant and beneficiary alignment production files via electronic file transfer (EFT) to the BDC no later than October 1, 2020.									ACO OS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11419.10.1	The VDCs shall run the jobs to load the production files after the October 2020 release is fully implemented.									VDC
11419.10.2	The VDCs shall make available to the contractors testing environments for the provider participant and beneficiary alignment files.									VDC
11419.10.3	The Single Testing Contractor (STC) shall perform testing on the provider participant and beneficiary alignment file, working with the VDCs as necessary to obtain the file. **NOTE:** The STC shall begin sending test data on July 15, 2020 to ACO-OS. STC shall begin testing on August 1, 2020.									STC, VDC
11419.10.4	To assist with the testing files creation, The Part B MACs shall provide the CMS specialty/operations contractor the beneficiary and participant (provider) data to create test files by August 14, 2020. These sample of providers and beneficiaries shall include a list of 5 to 15 test HICNs, TINs, and NPIs in a single Comma Separated Value (CSV) file using a HICN, TIN, and NPI layout. The CMS specialty/operations contractor contacts: Salauddin Shaik (Salauddin.Shaik@softrams.com); Vivek Trehan (Vivek.Trehan@softrams.com); Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov); Aparna Vyas (Aparna.Vyas@cms.hhs.gov) The CMS specialty/operations contractor shall provide a template of this CSV file.		X							ACO OS
11419.10.5	The CMS specialty/operations contractor shall push the test beneficiary alignment and provider participant files to the Virtual Data Centers (VDCs) no later than September 1, 2020 and transmit these test files with the Part B MACs.									ACO OS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CMS Specialty/Operations Contractor Contacts: Salauddin Shaik (Salauddin.Shaik@softrams.com); Vivek Trehan (Vivek.Trehan@softrams.com);Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov); Aparna Vyas (Aparna.Vyas@cms.hhs.gov)									
11419.10.6	MCS shall receive a test file from the specialty contractor no later than July 1, 2020 CMS Specialty/Operations Contractor Contacts: Salauddin Shaik (Salauddin.Shaik@softrams.com); Vivek Trehan (Vivek.Trehan@softrams.com);Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov); Aparna Vyas (Aparna.Vyas@cms.hhs.gov)						X			ACO OS
11419.10.7	CWF shall receive a test file from the specialty contractor no later than July 1, 2020 CMS Specialty/Operations Contractor Contacts: Salauddin Shaik (Salauddin.Shaik@softrams.com); Vivek Trehan (Vivek.Trehan@softrams.com); Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov); Aparna Vyas (Aparna.Vyas@cms.hhs.gov)								X	ACO OS
11419.11	After the initial production provider participant and beneficiary alignment file transmission, the CMS operations/specialty contractor shall provide full replacement participant and beneficiary files the last Friday of each month.									ACO OS
11419.12	The VDCs shall transmit the provider participant and beneficiary alignment file response via electronic file transfer (EFT) for all test and production files to the CMS specialty/operations contractor, ACO-OS.									ACO OS, VDC
11419.13	MCS shall modify existing Provider Accountable Care Organization (ACO) screen (the NP Screen) and MCSDT Provider/Beneficiary Accountable Care Organization window to display the PCF and/or SIP						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	participating provider information.									
11419.13.1	MCS shall modify the Beneficiary Accountable Care Organization (ACO) screen (NB screen) and MCSDT Provider/Beneficiary Accountable Care Organization window to display the PCF/SIP participating beneficiary information and add a new indicator for SIP beneficiaries.						X			
11419.14	The CMS specialty/operations contractor shall provide a list of Flat Visit Fee (FVF) services covered under the PCF/SIP model in a file labeled "Appendix A."									ACO OS
11419.14.1	The CMS specialty/operations contractor shall provide a list of prohibited services under the PCF/SIP model in a file labeled "Appendix B."									ACO OS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sam Masters, smasters@rti.org (PCF/SIP Specialty/Operations Contractor) , 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 , Dennis Savedge, Dennis.Savedge@cms.hhs.gov , Pratyusha Katikaneni, pratyusha.katikaneni@cms.hhs.gov , Anthony Simms, asimms@aresearch.com (PCF/SIP Specialty/Operations Contractor)

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: 0

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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

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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