PRIMARY CARE FIRST: PAYMENT AND ATTRIBUTION METHODOLOGIES

Volume I, Version IV
June 2022

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Acronyms

Acronym	Term
ACO	Accountable Care Organizations
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality
AHU	Acute Hospital Utilization
APM	Alternative Payment Model
BAL	Beneficiary Attestation List
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCM	Chronic Care Management
CCN	CMS Certification Numbers
CG-CAHPS	Clinician and Group Consumer Assessment of Healthcare Providers and Systems
CI	Continuous Improvement
CMS	Centers for Medicare & Medicaid Services
CPC+	Comprehensive Primary Care Plus Model
CPT	Current Procedural Terminology
CQM	Clinical Quality Measure
E&M	Evaluation and Management
eCQI	Electronic Clinical Quality Improvement
eCQM	Electronic Clinical Quality Measures
ED	Emergency Department
EHR	Electronic Health Record
FFS	Fee-For-Service
FVF	Flat Visit Fee
GAF	Geographic Adjustment Factor
GPCI	Geographic Practice Cost Index
HCC	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
IRS	Internal Revenue Service
IT	Information Technology
MIPS	Merit-based Incentive Payment System
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifiers
NPPES	National Plan and Provider Enumeration System
NQF	National Quality Forum
PBA	Performance-Based Adjustment
PBP	Population-Based Payment
PBPM	Per-Beneficiary Per-Month
PCF	Primary Care First

PECS	Patient Experience of Care Survey
PFS	Physician Fee Schedule
PY	Performance Year
Q	Quarter
QCDR	Qualified Clinical Data Registry
QPP	Quality Payment Program
QRDA	Quality Reporting Document Architecture
SIP	Seriously Ill Population
TIN	Taxpayer Identification Number
TPCC	Total Per Capita Cost
TPCP	Total Primary Care Payment
UB	Uniform Billing Codes

Executive Summary

This Executive Summary provides an overview of the methodologies that the Centers for Medicare & Medicaid Services (CMS) uses for the **Primary Care First (PCF)** model being tested, starting in Program Year 2021. The Executive Summary and the detailed technical specifications are organized as follows:

- Chapter 1 introduces PCF **attribution** and payment elements.
- Chapter 2 describes beneficiary attribution.
- Chapter 3 describes the **Professional Population-based Payments (PBPs)**.
- Chapter 4 describes the **Flat Visit Fee (FVF)** payments.
- Chapter 5 describes the quality strategy.
- Chapter 6 describes the **Performance-based Adjustment (PBA)**.

ES.1 Introduction

Primary Care First is a new **alternative payment model (APM)** offering an innovative payment structure to support the delivery of advanced primary care. It is geared towards advanced primary care practices that are ready to accept financial risk in exchange for greater flexibility, increased transparency, and performance-based payments that reward participants for outcomes. This document (Volume 1) describes attribution, payment, and quality policies for the PCF component of Primary Care First. These policies apply to all practices participating in the PCF component, including PCF Only practices *and* Hybrid practices (which are also participating in the **Seriously Ill Population [SIP]** component). Volume 2 describes attribution, payment, and quality policies for the SIP component of Primary Care First.

Primary Care First is designed to test whether changes to how Medicare pays for primary care can lead to reductions in **acute hospital utilization (AHU)** and lower total cost of care while preserving or improving quality. The model will be tested for 6 program years with 2 staggered cohorts of participating practices, each participating for 5 program years. Primary Care First tests new concepts:

- **Shifting focus of payment incentives to outcomes.** Practices will be accountable for their attributed beneficiary population through a simple 2-tiered payment structure: (1) a **Total Primary Care Payment (TPCP)**, consisting of a Professional Population-based Payment (PBP) and **Flat Primary Care Visit Fee (FVF)** payment, and (2) a Performance-based Adjustment (PBA) tied to 1 of 2 outcome measures—AHU or **Total Per Capita Cost (TPCC)**. The TPCC measure is adapted for Primary Care First use.
- **Increasing reimbursement for practices caring for patients with complex, chronic needs relative to historical aggregate Medicare fee-for-service (FFS) revenue.** Practices that serve patient populations with complex, chronic needs will receive a larger PBP. The larger **Professional PBP** is intended to account for the higher disease burden in

these populations and the increased resources required to serve patients with multiple chronic illnesses.

This paper explains the attribution methodology, the technical specifications used to identify the Medicare FFS beneficiaries for whom participating practices are responsible. The paper also includes detailed specifications for the following elements of the PCF component payment:

1. **Professional PBPs.** Practices receive a prospective, monthly PBP (paid quarterly) for each beneficiary attributed to their practice. This prospective payment—called the Professional PBP—was designed to partially replace FFS practice revenue. Professional PBP amounts are based on the practice's average CMS **hierarchical condition category** (CMS-HCC) risk score of its attributed Medicare beneficiaries, as stratified into 1 of 4 **practice risk groups**. Practices can use these funds for innovative care delivery approaches, including those that are not dependent on office-based, face-to-face care, such as **telehealth**, care managers, and 24/7 primary care access. Practices whose patient populations are at high risk and have complex, chronic needs receive a higher Professional PBP than practices primarily serving lower-risk patients.
2. **FVF payments.** Practices receive a flat Medicare payment for all face-to-face primary care visits with their attributed beneficiaries. The flat payment only applies to the Medicare portion of the claim payment. Beneficiary cost-sharing, or coinsurance, applies and is assessed on the Medicare FFS allowed amount for all **Healthcare Common Procedure Coding System (HCPCS)** codes submitted on the claim.
3. **PBA.** The PBA incentivizes practices to improve quality of care while working to reduce unnecessary AHU or reduce TPCC. Practice Risk Groups 1 and 2 are measured on AHU, and Practice Risk Groups 3 and 4 are measured on TPCC, adapted for Primary Care First. CMS calculates the PBA quarterly based on practices' performance on their respective measure, which is assessed during a rolling 1-year performance period. Practices' quarterly performance on AHU or TPCC, as well as whether the practice meets or exceeds minimum performance on a set of pre-defined quality measures each year, the **Quality Gateway**, determines the PBA amount. The focus on AHU and TPCC offers practices a clear outcomes-based metric, and the Quality Gateway ensures practices are not delivering lower-quality care in an effort to reduce utilization (McCarthy, Ryan, & Klein, 2015).

ES.2 Chapter 2: Beneficiary Attribution

This chapter describes the methodology for attributing Medicare beneficiaries to practices' PCF component. CMS uses a prospective attribution methodology to identify the Medicare FFS beneficiaries in PCF component of the model. CMS conducts beneficiary attribution quarterly and uses the attribution to determine the practice's risk group, calculate the Professional PBP amounts, identify beneficiaries whose claims are adjusted to the FVF amounts, and identify beneficiaries included in the claims-based utilization and cost measures. CMS sends each practice a list of prospectively attributed beneficiaries within the first month of the payment quarter. Though CMS attributes Medicare beneficiaries to a single practice, beneficiaries can

still select any Medicare practitioners and services of their choice (both inside and outside the model) and continue to be responsible for all applicable beneficiary cost-sharing.

The attribution process has multiple steps. First, CMS uses Medicare administrative data to identify Medicare FFS beneficiaries eligible for attribution.

Once **PCF-eligible beneficiaries** are identified, CMS begins attribution through a process called **voluntary alignment**. Under voluntary alignment—also known as beneficiary attestation—beneficiaries specify the health care practitioner and practice that they consider to be responsible for providing and coordinating their health care. CMS begins attribution this way to prioritize beneficiaries' choices. Although any beneficiary with an account on MyMedicare.gov can make an attestation, CMS will only consider PCF-eligible beneficiaries for attribution during this process.

To attribute the remaining PCF-eligible beneficiaries, CMS uses claims-based attribution. CMS examines the most recent 24-month historical (or "lookback") period in Medicare claims data to determine which practice to attribute eligible beneficiaries to. For **Performance Year (PY)** 2021, claims-based attribution is first based on **chronic care management (CCM)–related services**, then on **Annual Wellness Visits** and **Welcome to Medicare Visits**, and then on the plurality of **eligible primary care visits** within the 24-month **lookback period**.

CMS determines beneficiary eligibility for attribution through the following steps:

1. **Eligible beneficiaries.** To be eligible for attribution to a practice's PCF component in a given quarter, beneficiaries must meet several criteria before the quarter begins.

   Beneficiaries must (1) be enrolled in **Medicare Parts A and B**, (2) have Medicare as their primary payer, (3) not have **end-stage renal disease,**[1] (4) not be enrolled in hospice,[1] (5) not be covered under **Medicare Advantage** or another Medicare health plan, (6) not be long-term institutionalized, (7) not be incarcerated, (8) be alive, (9) not be on a SIP component outreach list, and (10) not be aligned or attributed to an entity participating in any other CMS program or model with a "no overlaps" policy. If beneficiary eligibility requirements are not met, the beneficiary is not eligible for voluntary alignment or claims-based attribution.

2a. **Voluntary alignment: beneficiary attestation.** Through MyMedicare.gov, beneficiaries can attest to the health care practitioner and practice that they consider responsible for providing and coordinating their health care.

[1] Note that this criterion only applies to beneficiaries who have not been attributed to a PCF practice previously. If the beneficiary has been attributed to a PCF practice previously, then developing end-stage renal disease or enrolling in hospice does not disqualify a beneficiary from being attributed to a PCF practice.

2b. **Voluntary alignment: eligible practitioners and practices.** If all beneficiary eligibility requirements are met, CMS then confirms that the attested practitioner and practice meet attestation eligibility requirements.

Practitioners participating at a **PCF practice** site must be active at the practice site for the given quarter and listed on the practice's practitioner roster. Practitioners at a non-PCF practice site must have a primary care specialty code. If these requirements are met, the beneficiary is attributed via voluntary alignment. If these requirements are not met (e.g., a practitioner was previously listed on the practitioner roster but is no longer active), the beneficiary is attributed via the claims-based attribution process.

3. **Claims-based attribution.** For eligible beneficiaries not attributed via voluntary alignment, CMS applies the PCF component claims-based attribution algorithm.

CMS attributes the remaining beneficiaries to practices using a pool of eligible Medicare claims during a 24-month lookback period that ends 3 months before the start of the attribution quarter. For example, CMS uses claims from October 2018 through September 2020 to attribute beneficiaries to practices for Q1 2021. Table ES-1 lists the lookback periods for the 2021 quarterly attributions.

During this step, to attribute eligible beneficiaries with at least 1 eligible primary care visit in the lookback period, CMS first uses CCM-related services, then Annual Wellness Visits and Welcome to Medicare Visits, and finally the plurality of eligible primary care visits. Eligible practitioners for non-CCM-related services include those who are either active in PCF practices or have a primary care specialty code. CCM-related services do not have a specialty code restriction.

Table ES-1
Lookback Periods for 2021 Quarterly Beneficiary Attribution

Attribution Quarter	Lookback Period
Q1 2021	October 2018–September 2020
Q2 2021	January 2019–December 2020
Q3 2021	April 2019–March 2021
Q4 2021	July 2019–June 2021

ES.3 Chapter 3: Professional Population-Based Payment

This chapter describes the Professional PBP, which changes the payment mechanism for primary care from FFS to prospective PBP, promotes flexibility in care delivery, and allows practices to increase the breadth and depth of primary care they deliver while focusing on continuous practitioner-patient relationships. The Professional PBP supports traditional primary care services, improved care coordination, and targeted patient support by enabling practitioners to furnish services in a way that best meets the needs of the patient. For example, the Professional PBP supports services furnished by email, phone, patient portal, or other

telehealth modalities (like real-time audio and video), or in alternative settings, such as the patient's home.

The Professional PBP is meant to partially replace FFS revenue from specific primary care services for a practice's attributed beneficiary population. Practices whose patients have, on average, more complex conditions receive a higher Professional PBP to compensate for the more resource-intensive care these patients require.

CMS assigns practices to 1 of 4 risk groups using the average CMS-HCC risk score of their attributed Medicare beneficiaries. Each risk group is associated with a per-beneficiary per-month (PBPM) Professional PBP that ranges from $28 to $175, as shown in Table ES 2. Practices receive the same Professional PBP for all of their attributed beneficiaries, regardless of those beneficiaries' individual risk scores. These Professional PBP amounts will then be adjusted, as described below, to include:

1. **Geographic adjustment** (ES.3.1)
2. **Retrospective debits** (ES.3.2)
3. **Leakage rate adjustment** (ES.3.3)
4. **PBA of the Professional PBP** (ES.5 and ES.6)

The Professional PBP is also subject to the **Merit-based Incentive Payment System (MIPS)** adjustment. All model payment segments are also subject to the 2% Medicare sequestration, as required by federal rulemaking.

Table ES-2
Practice Risk Groups and Corresponding Professional PBP (PBPM)[a]

Practice Risk Group	CMS-HCC Practice Average Risk Score Criteria	Professional PBP (PBPM)
Group 1	Score < 1.2	$28
Group 2	1.2 ≤ Score < 1.5	$45
Group 3	1.5 ≤ Score < 2.0	$100
Group 4	Score ≥ 2.0	$175

[a] CMS reserves the right to update these payment amounts in the future to ensure they are consistent with average revenue from FFS, as well as the right to update on the basis of changes to the **Medicare Physician Fee Schedule (PFS)**.

ES.3.1 Geographic Adjustment to the Population-Based Payment

CMS geographically adjusts the Professional PBP, similar to Medicare Part B fee schedule rates, to account for nationwide variation in cost. CMS may also adjust the Professional PBP periodically to reflect updates to PFS rates for the services included in the Professional PBP. CMS pays the Professional PBP to practices without beneficiary cost-sharing.

ES.3.2 Retrospective Debits

CMS applies a retrospective debit for beneficiary ineligibility to the Professional PBPs paid each quarter. The prospective quarterly payment assumes all beneficiaries attributed for the payment quarter will continue to be eligible for the entire quarter. However, some beneficiaries become ineligible before or during the quarter. This happens, for example, if the beneficiary loses Part A or Part B coverage, joins a Medicare Advantage plan, loses Medicare as the primary payer, becomes long-term institutionalized, becomes incarcerated, or dies before or during the quarter. To account for this, in each quarterly payment cycle (beginning with Q2 2021), CMS determines whether any beneficiaries lost eligibility during any prior quarters and computes a deduction from the upcoming quarter's payment to reflect previous overpayments.

ES.3.3 Leakage Rate Adjustment

CMS applies a quarterly **leakage rate** adjustment to the Professional PBP to improve its accuracy. This adjustment reflects the percentage of qualifying visits and services a PCF practice's attributed Medicare beneficiaries received outside the given practice, relative to all their qualifying visits and services. For each practice, CMS calculates the quarterly leakage rate adjustment by dividing the number of qualifying visits and services that attributed beneficiaries received outside the practice by the total number of qualifying visits and services. This calculation is based on a rolling 1-year period of service dates, which is lagged to allow for claims processing time. CMS applies the leakage rate adjustment to the quarterly payment cycle in the third quarter after the end of the quarter for which it is assessed.

ES.4 Chapter 4: Flat Visit Fee

This chapter describes the methodology used to calculate the FVF for the PCF component. The FVF is intended to support practices delivering primary care face-to-face for attributed beneficiaries. The FVF is a flat Medicare payment currently set at $40.82 for face-to-face primary care patient encounters between PCF practices and their attributed beneficiaries. The FVF applies when practices bill HCPCS codes for an eligible primary care service for an attributed beneficiary. All PCF practitioners are subject to the FVF billing rules for their attributed beneficiaries. Medicare only pays 1 FVF per beneficiary per date of service. The flat payment only applies to the Medicare portion of claim payment. CMS applies beneficiary cost-sharing to all services submitted on the claim under standard FFS rules and rates.

Two adjustments are included in the FVF payment:

1. **National base rate adjustment**. This adjustment resets the Medicare payment amount for FVF-eligible services provided by the practice to their attributed beneficiaries to $40.82.
2. **Geographic adjustment**. To account for regional cost differences, the Medicare FFS Shared Systems applies a **geographic adjustment factor (GAF)** to the total allowed

amount of $40.82 for each submitted claim. The geographic factor is tied to the Medicare PFS.[2]

The FVF is also subject to the MIPS adjustment and any other adjustments per traditional Medicare FFS, as well as the 2% Medicare sequestration, as required by federal rulemaking. Table ES-3 displays primary care services included in the FVF payment.

Table ES-3
Services Included in the FVF

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

ES.4.1 Performance-Based Adjustment of the Flat Visit Fee Payments

CMS will also apply a PBA to the FVF payments. CMS includes these adjustments as a quarterly lump-sum payment/debit outside of the Medicare FFS system. The total FVF PBA amount is calculated by multiplying the total FVF revenue for visits that occurred during the final quarter of the PBA performance period by the quarterly PBA percentage. CMS pays the FVF portion of the PBA as a lump-sum during the quarterly payment cycle 3 months after the end of the quarter for which it is assessed.

ES.5 Chapter 5: Quality Strategy

CMS uses a focused set of clinical quality and patient experience measures to assess quality of care for practices participating in the PCF component. To account for the clinical needs of different patient populations, the practice risk group will determine the quality measures assessed in the Quality Gateway.

The Quality Gateway is 1 of the minimum thresholds participating practices must meet or exceed to be eligible for a positive PBA, which begins in Q2 2022. To pass the Quality Gateway, practices in Risk Groups 1 and 2 must meet the minimum performance threshold, the 30th percentile, for the quality measures listed in ES.5.1; practices in Risk Groups 3 and 4 must meet those listed in ES.5.3. As part of the PBA, practices may earn a **Continuous Improvement (CI)**

[2] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2020-PFS-FR-Addenda.zip Addendum E.

bonus. Practices that do not pass the current performance year Quality Gateway (based on practices' quality measure results from prior performance year) will not be eligible for the CI bonus for the performance year.

ES.5.1 Practice Risk Groups 1 and 2 Quality Gateway Measures

The Quality Gateway for Practice Risk Groups 1 and 2 consists of 5 measures:[3]

1. **Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)** (electronic Clinical Quality Measure [eCQM])
2. **Controlling High Blood Pressure** (eCQM)
3. **Colorectal Cancer Screening** (eCQM)
4. **Advance Care Plan** (MIPS Clinical Quality Measure [CQM])
5. **Patient Experience of Care Survey (PECS)**, based on a combination of questions from the Clinician and Group **Consumer Assessment of Healthcare Providers and Systems®** (CG-CAHPS®) V3.0 and CAHPS Patient-Centered Medical Home Item Set V3.0, modified for PCF

CMS begins performance measurement for the 5 Quality Gateway measures in 2021 and applies the results in 2022. Practices will report eCQM performance for 2021 in early 2022, and CMS will apply the results of the Quality Gateway to payments in 2022 (i.e., Q2 2022–Q4 2022 payments). Generally, the Quality Gateway measure performance is reported and results are calculated annually using performance data from the prior performance year. All Quality Gateway measures have a 1-year measurement period. Practice sites are required to successfully report all 3 eCQMs: (1) Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%), (2) Controlling High Blood Pressure, and (3) Colorectal Cancer Screening. Practice sites that fail to report any of the 3 eCQMs will not pass the Quality Gateway and will not qualify for a positive PBA. Practices must submit the required **Advance Care Plan** MIPS CQM via a qualified registry, or a qualified clinical data registry (QCDR), as specified in the PCF Clinical Measures Reporting Guide for the respective performance year.[4]

PECS is designed to collect reliable and representative data about patient experience of care. Practices will select from a list of approved vendors to field the survey under contract with practices. Practices that fail to provide a patient roster during the submission period will not receive a PECS score, will not pass the Quality Gateway, and will not be eligible for a positive PBA. CMS may consider additional actions, up to and including withholding model payments and termination of the practice's participation agreement, as consequences for failure to submit a valid patient roster during the submission period.

[3] For more information on eCQMs and CQMs, see the eCQI resource center page here: https://ecqi.healthit.gov/ep-ec?year=2020&field_year_value=2&keys=.

[4] The PCF Clinical Measures Reporting Guide will be released in January 2021.

Table ES-4 summarizes the measure ID, the measure steward, **benchmark** population, and benchmark for Quality Gateway measures and the utilization measure for Practice Risk Groups 1 and 2.

Table ES-4
Quality and Utilization Measures for Practice Risk Groups 1 and 2

Measure Category	Measure Title (Type)	NQF/Quality ID/CMS ID	Measure Steward	Performance Years[e]	Benchmark Population	Benchmark for Performance Year 2021
Quality Gateway[a]	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) (Intermediate Outcome eCQM)	CMS ID: CMS122	NCQA[d]	2021–2024	MIPS	30th percentile: 99.45%[f]
	Controlling High Blood Pressure (Intermediate Outcome eCQM)	CMS ID: CMS165	NCQA[d]	2021–2024	MIPS	30th percentile: 30.00%
	Colorectal Cancer Screening (Process eCQM)	CMS ID: CMS130	NCQA[d]	2021–2024	MIPS	30th percentile: 2.59%
	Advance Care Plan (MIPS CQM)	NQF ID: 0326 Quality ID: 47	NCQA[d]	2021–2024	MIPS	Pay-for-reporting[g]
	Patient Experience of Care Survey (CAHPS® with supplemental items)	NQF ID: 0005[c]	AHRQ	2021-2024	PCF population (see Chapter 5)	30th percentile: 77.52%
Utilization measure for PBA calculation	Acute Hospital Utilization (HEDIS measure)[b]	N/A	NCQA[d]	2021-2024	PCF and non-PCF Medicare reference population (see Chapter 5)	50th percentile: 1.16[h]

AHRQ = Agency for Healthcare Research and Quality; HEDIS = Healthcare Effectiveness Data and Information Set; N/A = not applicable; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.
[a] The measures in the Quality Gateway are assessed in the first performance year, and the results are applied in the following year. For example, the Quality Gateway applied in 2022 is based on performance during 2021.
[b] Please refer to footnote 5 below
[c] The PCF PECS includes a combination of items from the Clinician and Group CAHPS (NQF ID 0005) as well as from the Patient-Centered Medical Home (PCMH) CAHPS Supplement.
[d] For more information about NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures, please see Appendix D.
[e] Performance year refers to the measurement period of the measure. Each measure has a 1-year measurement period (AHU is calculated with rolling 1-year performance period). The results of quality measures in the Quality Gateway are applied to the Quality Gateway in the following year.
[f] Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) is an inverse measure; lower performance scores reflect better quality.
[g] Practices will only be assessed on their ability to report the Advance Care Plan Measure. Cohort 1 practices that fail to report via a qualified registry or Qualified Clinical Data Registry will not be eligible for a positive performance-based adjustment (PBA) in Performance Year 2022.
[h] The preliminary national benchmark for AHU is intended to illustrate potential performance thresholds. It's an inverse measure, with lower performance scores reflecting better quality.

ES.5.2 Practice Risk Groups 1 and 2 Performance-Based Adjustment Measure: Acute Hospital Utilization

AHU is a claims-based, risk-adjusted utilization measure included in the National Committee for Quality Assurance (NCQA) **Healthcare Effectiveness Data and Information Set (HEDIS)**.[5] The utilization measure is calculated from claims and does not require practice reporting. Beginning in Q2 2022, CMS calculates the measure quarterly, using a rolling 1-year performance period that ends 3 months prior to the PBA quarter. For example, the Q2 2022 PBA is based on AHU performance from January 1, 2021 through December 31, 2021 (Q1 2021 through Q4 2021).

AHU is an observed-to-expected (O/E) ratio of acute inpatient admissions and observation stay discharges. For each practice, observed utilization is compared with expected utilization, risk-adjusted for beneficiary age, sex, and comorbidities. An O/E ratio greater than 1 represents greater-than-expected utilization, and a ratio less than 1 represents less-than-expected utilization.

CMS calculates AHU quarterly for all attributed beneficiaries in Risk Group 1 and 2 practices. Each quarter, CMS compares a practice's AHU performance to a **national benchmark,** peer region group performance[6], and its own historical performance (CI bonus) to determine the practice's PBA. Details on this methodology are in Chapter 6.

ES.5.3 Practice Risk Groups 3 and 4 Quality Gateway Measures

In Performance Year 2021, the Quality Gateway for Practice Risk Groups 3 and 4 consists of 2 measures:

1. **Advance Care Plan** (MIPS CQM)
2. **PECS**, based on a combination of questions from the CG-CAHPS® V3.0 and CAHPS Patient-Centered Medical Home Item Set V3.0, modified for PCF

CMS begins performance measurement for the 2 Quality Gateway measures in 2021 and applies the results in 2022. Requirements for reporting the Advance Care Plan (MIPS CQM) measure and the PECS measure are the same for Practice Risk Groups 3 and 4 as for Practice Risk Groups 1 and 2.

An additional quality measure for the Practice Risk Groups 3 and 4 Quality Gateway, Days at Home, will be incorporated in later years of the model as it is developed and finalized. This claims-based measure will count the number of days a beneficiary remains outside of an

[5] The Acute Hospital Utilization and its specifications were developed by the National Committee for Quality Assurance ("NCQA"). For more information about NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures, please see Appendix D.. Acute Hospital Utilization is an inverse measure; lower performance scores reflect better quality.

[6] CMS calculates AHU and TPCC peer region benchmarks separately, based on performance distributions for each measure.

institutional care setting during a standardized time period. By 2023, the Practice Risk Groups 3 and 4 Quality Gateway, and practice eligibility for a positive PBA, will be based on 3 measures.

Table ES-5 summarizes the measure ID, measure steward, benchmark population, and benchmark for Quality Gateway measures and the cost measure for Practice Risk Groups 3 and 4.

Table ES-5
Quality and Cost Measures for Practice Risk Groups 3 and 4

Measure Category	Measure Title (Type)	NQF/ Quality ID	Measure Steward	Performance Years[d]	Benchmark Population	Benchmark for Performance Year 2021
Quality Gateway[a]	Advance Care Plan (MIPS CQM)	NQF ID: 0326 Quality ID:47	NCQA[c]	2021–2024	MIPS	Pay-for-reporting[e]
	Patient Experience of Care Survey (CAHPS® with supplemental items)	NQF ID: 0005[b]	AHRQ	2021–2024	PCF population (see Chapter 5)	30th percentile: 77.52%
	Days at Home	N/A	N/A	2022–2024	Historical reference population	30th percentile: N/A
Cost measure for PBA calculation	Total Per Capita Cost adapted for Primary Care First	N/A	CMS	2021–2024	PCF and non-PCF Medicare reference population (see Chapter 5)	50th percentile: 0.98[f]

AHRQ = Agency for Healthcare Research and Quality; N/A = not applicable; NQF = National Quality Forum.
[a] The measures in the Quality Gateway are assessed in the first performance year, and the results are applied in the following year. For example, the Quality Gateway applied in 2022 is based on performance during 2021.
[b] The PCF PECS includes a combination of items from the Clinician and Group CAHPS (NQF ID 0005) as well as from the Patient-Centered Medical Home (PCMH) CAHPS Supplement.
[c] For more information about NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures, please see Appendix D.
[d] Performance year refers to the measurement period of the measure. Each measure has a 1-year measurement period (TPCC is calculated with rolling 1-year performance period). The results of quality measures in the Quality Gateway are applied to the Quality Gateway in the following year.
[e] Practices will only be assessed on their ability to report the Advance Care Plan Measure. Cohort 1 practices that fail to report via a qualified registry or qualified clinical data registry will not be eligible for a positive performance-based adjustment (PBA) in Performance Year 2022.
[f] The preliminary national benchmark for TPCC is intended to illustrate potential performance thresholds.

ES.5.4 Practice Risk Groups 3 and 4 Performance-Based Adjustment Measure: Total per Capita Cost

The TPCC measure, adapted for Primary Care First, is a payment-standardized, risk-adjusted measure that evaluates the overall costs of care provided to beneficiaries attributed to practices for a specified period of time. The cost measure is calculated from claims and does not require practice reporting. Beginning in Q2 2022, CMS calculates the measure quarterly, using a rolling 1-year performance period that ends 3 months prior to the PBA quarter. For example, the Q2

2022 PBA is based on TPCC performance from January 1, 2021 through December 31, 2021 (Q1 2021 through Q4 2021).

TPCC is as an O/E ratio of total Medicare costs (excluding Part D). For each practice, observed costs are compared with expected costs, risk-adjusted for beneficiary comorbidities. An O/E ratio greater than 1 represents greater-than-expected per capita cost, and a ratio less than 1 represents less-than-expected per capita cost.

The TPCC measure serves the same function for Practice Risk Groups 3 and 4 that the AHU measure serves for Practice Risk Groups 1 and 2. CMS calculates TPCC quarterly for all attributed beneficiaries in Risk Group 3 and 4 practices. Each quarter, CMS compares a practice's TPCC performance to a national benchmark, peer region group performance[7], and its own historical performance to determine the practice's PBA. Details on this methodology are in Chapter 6.

ES.6 Chapter 6: Performance-Based Adjustment

This chapter describes the methodology for determining the PBA for payment in 2022 and the plan for subsequent performance years. The PBA, which begins in Q2 2022, is a quarterly adjustment to both the Professional PBP and the FVF, or TPCP. CMS determines the PBA using the practice's performance on the utilization (AHU) or cost (TPCC) measure (depending on practice risk group) and certain quality measures that comprise the Quality Gateway. The PBA has a potential downside adjustment of −10% of TPCP revenue and a maximum potential upside of 50% of TPCP revenue. All adjustments are calculated and applied quarterly using a rolling 1-year performance period, so practices receive rapid recurring performance feedback.

For all practice risk groups, 4 factors influence practices' PBA amounts each quarter:

1. **Annual Quality Gateway**
2. AHU/TPCC performance compared with the **National Benchmark**
3. AHU/TPCC performance compared with their peer region group (**Regional Performance Adjustment**)
4. AHU/TPCC performance compared with their own historical performance (**CI Bonus**)

In 2022, practices that do not pass the current year's Quality Gateway (based on prior year performance) will receive a −10% or 0% PBA in Q2 through Q4 of 2022, depending on their AHU/TPCC performance compared to their peer region benchmark. In 2023 and beyond, practices that do not meet the Quality Gateway will automatically receive a −10% PBA.

Starting in Q2 2022, for practices that pass the Quality Gateway, CMS compares the practice's AHU performance (for Risk Groups 1 and 2) or TPCC performance (Risk Groups 3 and 4) to the national benchmark to determine eligibility for a positive Regional Performance Adjustment. If

[7] CMS calculates AHU and TPCC peer region benchmarks separately, based on performance distributions for each measure.

the practice is below the national benchmark for its respective measure, it is only eligible for a −10% or 0% Regional Performance Adjustment, depending on their performance compared to their peer region group, but will remain eligible for a CI bonus.

For practices that pass the national benchmark for AHU or TPCC (meet or exceed the 50th percentile), there are 7 possible performance levels for the Regional Performance Adjustment, depending on practices' performance relative to their peer region group, as summarized in Table ES-6. CMS calculates the Regional Performance Adjustment by comparing a practice's AHU/TPCC performance to a peer region benchmark, established by CMS using data from a reference group of practices (including practices that do not participate in PCF).[8] Like the national benchmark, if the practice is below the 50th percentile of their peer region group, it is not eligible to receive a positive regional performance adjustment (only eligible for −10% or 0% depending on peer region group performance), but will remain eligible for a CI bonus.

All practices that pass the Quality Gateway are eligible for a CI bonus in addition to the Regional Performance Adjustment. At this time, the range of the possible total PBA will be −10% to 50%. For practices eligible for the CI bonus (i.e., pass the Quality Gateway), the amount of the total PBA will be split between the Regional Performance Adjustment and the CI bonus. To calculate the practice's amount of improvement for the CI bonus, the practice's performance on AHU or TPCC (depending on practice risk group) is compared with its own performance on the measure during a historical 1-year base period before the performance period. The amount of improvement needed to earn the CI bonus, and the amount of the CI bonus, depends on which of the 7 possible performance levels the practice achieves compared with its peer region in the current quarter.

The Regional Performance Adjustment and CI bonus are added together each quarter to determine the total amount of the quarterly PBA to the practice's TPCP. Beginning in Q2 2022, CMS calculates the PBA quarterly, using a rolling 1-year performance period that ends 3 months prior to the PBA quarter. For example, the Q2 2022 PBA is based on performance from January 1, 2021 through December 31, 2021. A practice whose AHU or TPCC performance meets or exceeds the 90th percentile of their peer region group will receive a 34% regional performance adjustment to their future quarter's TPCP, in addition to a 16% CI bonus if they achieved the CI bonus thresholds (e.g., 3% improvement target). Details on the CI methodology are in Chapter 5.

Tables ES-6 and ES-7 summarize the possible adjustments practices can receive based on their Regional Performance Adjustment and CI bonus. Table ES-6 presents the possible adjustments for practices that meet or exceed the 50th percentile national benchmark on AHU or TPCC performance. Table ES-7 presents the possible adjustments for those who do not.

[8] This peer region benchmark is based on a reference group of Medicare practitioners in comparably performing regions. The benchmark, made available to practices at the beginning of the model, is updated annually. The peer region groups are defined differently for AHU and TPCC to account for geographic variation in performance between the two measures.

Table ES-6
PBA Potential for Practices That Meet or Exceed the 50th Percentile of National Benchmark on AHU or TPCC

AHU/TPCC Regional Performance Level	Regional Performance Adjustment (% of TPCP)	CI Bonus (% of TPCP)	Maximum Adjustment (% of TPCP)
Level 1: At or above 90th percentile of practices in each region	34%	16%	50%
Level 2: 80th to 89th percentile of practices in each region	27%	13%	40%
Level 3: 70th to 79th percentile of practices in each region	20%	10%	30%
Level 4: 60th to 69th percentile of practices in each region	13%	7%	20%
Level 5: 50th to 59th percentile of practices in each region	6.5%	3.5%	10%
Level 6: 25th to 49th percentile of practices in each region	0%	3.5%	3.5%
Level 7: Below 25th percentile of practices in each region	−10%	3.5%	−6.5%

Note: This table applies only to practices that pass the Quality Gateway. In 2022, practices that do not pass the Quality Gateway receive either a −10% or 0% PBA.

Table ES-7
PBA Potential for Practices That *Do Not* Meet the 50th Percentile of National Benchmark on AHU or TPCC

AHU/TPCC Regional Performance Level	Regional Performance Adjustment (% of TPCP)	CI Bonus (% of TPCP)	Maximum Adjustment (% of TPCP)
At or above 25th percentile of practices in each region	0%	3.5%	3.5%
Below 25th percentile of practices in each region	−10%	3.5%	−6.5%

Note: This table applies only to practices that pass the Quality Gateway. In 2022, practices that do not pass the Quality Gateway receive either a −10% or 0% PBA.

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Chapter 1: Introduction

This document describes the Centers for Medicare & Medicaid Services (CMS) approach and technical methodology for payment design in the Primary Care First model. Primary Care First is based on many of the same underlying principles as the **Comprehensive Primary Care Plus (CPC+)**[9] model but represents a shift in focus to rewarding outcomes. Primary Care First is geared toward advanced primary care practices that are ready to accept financial risk in exchange for greater flexibility, increased transparency, and performance-based payments that reward outcomes. This document (Volume 1) describes attribution, payment, and quality policies for the PCF component of Primary Care First. These policies apply to all practices participating in the PCF component, including PCF Only practices *and* Hybrid practices (which are also participating in the Seriously Ill Population (SIP) component). Volume 2 describes attribution, payment, and quality policies for the SIP component of Primary Care First.

This chapter summarizes elements of Primary Care First payment design for the PCF component. Chapter 2 describes the technical methodology used to determine attribution for **Medicare fee-for-service (FFS)** beneficiaries in the PCF component. Chapter 3 describes the payment methodology for the Professional Population-based Payments (PBPs) that practices will receive. Chapter 4 describes the technical methodology for the Flat Visit Fee (FVF) payments. Chapter 5 describes the quality strategy. Chapter 6 describes the Performance-based Adjustment (PBA) technical methodology, which rewards practices for minimizing acute hospital utilization (AHU) or Total Per Capita Cost (TPCC) while also maintaining high quality of care and patient experience of care.

1.1 Payment Elements

Primary Care First payment is designed to test whether changing how Medicare pays for primary care can reduce inpatient utilization and lower the total cost of care, while preserving or improving quality. Primary Care First introduces a simple payment model that represents a major step away from FFS and toward paying for value. Primary care practices in the PCF component receive 2 different types of payment for their participation in the model.

First, practices will receive a prospective, monthly PBP (paid quarterly) for each beneficiary attributed in their practice. This prospective payment—called the Professional PBP—is designed to replace FFS revenue from specific primary care services for a practice's attributed beneficiary population. The payment depends on the average CMS hierarchical condition category (CMS-HCC) risk score of the practice's attributed Medicare beneficiaries. Therefore, practices with patients at high risk with complex, chronic conditions will receive a higher Professional PBP than practices primarily serving average-risk or low-risk patients. Practices will be able to use these funds for innovative care delivery approaches, including those not

[9] Comprehensive Primary Care Plus (CPC+) is a five-year, voluntary payment model aiming to support delivery and transformation of primary care. The model is offered in 18 regions and began in 2017.

dependent on office-based, face-to-face care, such as telehealth, care managers, and 24/7 primary care access.

Second, practices will receive a flat Medicare payment for all face-to-face primary care services delivered to attributed beneficiaries. The FVF payment is designed to cover the remaining practice revenue for these specific primary care services.

Both payments are subject to adjustments, which this methodology paper describes in detail. All model payments are subject to the 2% Medicare sequestration, as required by federal rulemaking.

1.1.1 Professional Population-Based Payments

A practice's Professional PBP is risk-adjusted on the basis of the average CMS-HCC risk score of its attributed Medicare beneficiaries. Practices are assigned to 1 of 4 risk groups annually. Each risk group is associated with a per-beneficiary per-month (PBPM) Professional PBP that ranges from $28 to $175. Practices receive the same Professional PBP for all of their attributed beneficiaries, regardless of those beneficiaries' individual risk scores.

The Professional PBP is designed to free practices from the traditional FFS payment incentives. Under FFS payment methodologies, there is a strong incentive to bring patients into the office to create a billable face-to-face service, even if phone calls or electronic communications would be a better way of meeting the patient's needs with minimal burden or be more in line with patient preferences.

The Professional PBP changes the payment mechanism for primary care from FFS to population-based, promotes flexibility in how participating practices deliver care, and allows practices to increase the breadth and depth of the primary care they deliver while focusing on continuous practitioner-patient relationships. It supports services to improve care coordination and targeted patient support by enabling practices to serve patients in a way that best meets the needs of the patient, whether by email, phone, patient portal, or other telehealth modalities (like real-time audio and video), or in alternative settings, such as the patient's home.

1.1.2 Flat Visit Fee

Practices participating in the PCF component receive a flat Medicare payment of $40.82 for face-to-face primary care patient encounters between the practice's practitioners and their attributed beneficiaries. The flat payment only applies to the Medicare portion of claim payment, which includes a GAF. Beneficiary cost-sharing is applied to whichever Healthcare Common Procedure Coding System (HCPCS) codes are submitted on the claim.

The FVF is intended to encourage practices to continue seeing beneficiaries face-to-face as appropriate, while also reducing their billing and revenue cycle burden. With the FVF, practices can readily understand the payment they will receive for primary care they furnish face-to-face for an attributed Medicare beneficiary.

1.1.3 Performance-Based Adjustment

CMS designed the PBA to incentivize improvements in quality of care by reducing unnecessary AHU or TPCC. The PBA is calculated quarterly and based on practices' performance, which is assessed during a rolling 1-year performance period that ends 3 months prior to the PBA quarter.

Starting in Q2 2022, a practice's Total Primary Care Payment (TPCP) will be adjusted on the basis of its performance on quality and patient experience of care measures (from the prior performance year), as well as AHU or TPCC. The quality and patient experience of care measures will be incorporated into a Quality Gateway, which is a minimum threshold that practices must meet to be eligible for a positive PBA. In 2022, if a practice does not meet or exceed the Quality Gateway thresholds, they are subject to a −10% or 0% adjustment (determined by AHU or TPCC performance). If a practice meets or exceeds the Quality Gateway, its performance on AHU or TPCC will also be used to determine the PBA amount.

Practices may receive a maximum possible positive PBA of 50% and a maximum possible negative PBA of −10%. In 2022, practices that fail to meet the Quality Gateway will receive no higher than a 0% adjustment. The total PBA amount for each quarter of 2022 (Q2 through Q4) will be determined by their AHU or TPCC performance. The penalty for failing to meet the Quality Gateway will increase to an automatic −10% PBA in 2023 and thereafter, regardless of a practice's AHU or TPCC performance.

The focus on AHU and TPCC offers practices a clear outcomes-based metric, and the Quality Gateway ensures that practices are not delivering lower-quality care in an effort to reduce utilization (McCarthy, Ryan, & Klein, 2015). Detailed specifications for PBA methodology and calculation are in Chapter 6.

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Chapter 2: Beneficiary Attribution

This chapter describes the methodology for attributing beneficiaries to practices participating in the PCF component. CMS uses attribution to

- determine the practice's risk group, which is based on the acuity of all beneficiaries attributed to the practice;
- calculate the Professional PBP amounts;
- identify beneficiaries for whom the FVF applies; and
- to identify beneficiaries included in the claims-based quality measures.

After an overview of attribution in Section 2.1, Section 2.2 defines PCF-eligible beneficiaries for beneficiary attribution. Section 2.3 describes voluntary alignment, as well as the claims-based attribution process for any beneficiaries not attributed in the voluntary alignment. Lastly, Section 2.4 discusses interactions with other CMS programs and models, such as the Medicare Shared Savings Program and CPC+.

2.1 Overview

Attribution is a tool used to assign beneficiaries to primary care practices. Beneficiaries can be attributed to PCF practices, non-PCF practices (such as CPC+ practices), or non-PCF practitioners.

Attribution methodologies commonly consider (1) what unit (e.g., practice, practitioner) a beneficiary is attributed to, (2) how the beneficiary is attributed, (3) the period of the attribution, and (4) how often the attribution is made.

Unit of attribution: Because the PCF component is a test of practice-level transformation and payment, CMS attributes beneficiaries to the participating practice site, rather than individual practitioners, for both voluntary alignment and claims-based attribution. A practice site is composed of a unique grouping of practitioners and billing numbers at a single "brick and mortar" physical location.[10]

How the beneficiary is attributed: CMS attributes beneficiaries using voluntary alignment and claims-based attribution. Voluntary alignment—also known as beneficiary attestation—refers to a process by which beneficiaries specify the health care practitioner and practice that they consider to be responsible for providing and coordinating their health care. If a PCF-eligible beneficiary is not attributed during the voluntary alignment step of attribution, CMS attributes the beneficiary using claims-based attribution, where Medicare claims are used to attribute

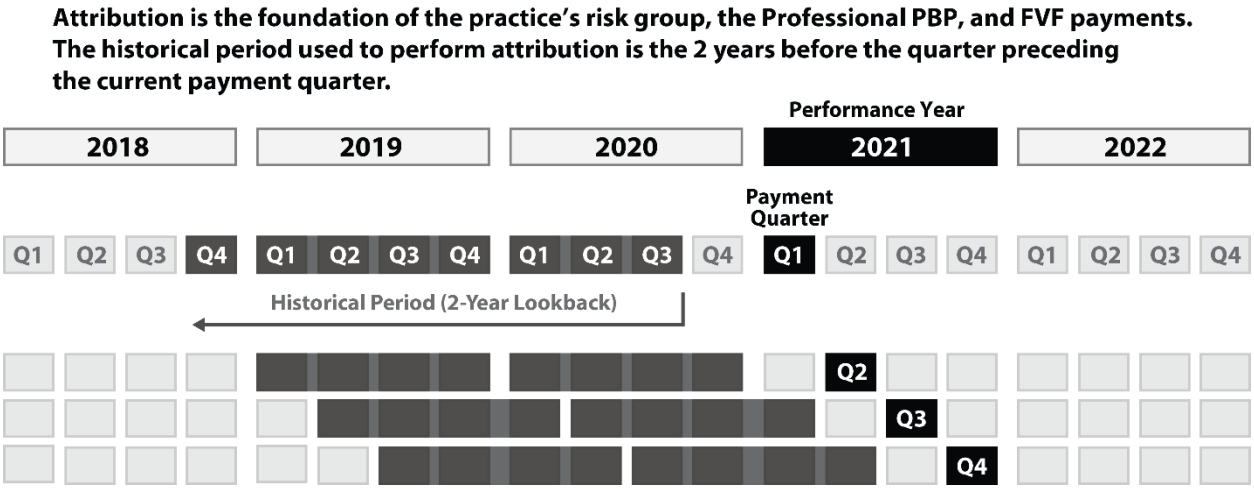
[10] The exceptions are practices providing care in the home instead of at a practice site and practices with satellite locations. Practices with satellite locations are considered 1 practice. A satellite office is a separate physical location that acts as an extension of the main practice site; the satellite has the same management, resources, certified electronic health record (EHR) technology, and practitioners as the main practice site. Practices in the same health group or system that share some practitioners or staff are not considered satellite practices.

beneficiaries to a practice by recency of chronic care management (CCM)-related services, recency of Annual Wellness or Welcome to Medicare Visits, or plurality of eligible primary care visits.

Period of attribution: To support the Primary Care First care delivery model, CMS pays practices prospectively (i.e., in advance) so that they can make investments consistent with the aims of model. To pay practices prospectively, CMS uses historical data (i.e., beneficiaries' attestations made by the end of the lookback period or beneficiaries' visits to primary care practices obtained through claims during the lookback period) to perform attribution before each payment quarter (Figure 2-1).

How often the attribution is made: Because the intent of attribution is to accurately estimate the number of beneficiaries in a practice for purposes of calculating payments, CMS performs quarterly prospective attribution to facilitate quarterly payments to practices.

Figure 2-1
What Is a Lookback Period?



2.2 Eligible Beneficiaries

To be eligible for attribution to a PCF practice in a given quarter, beneficiaries must meet the following criteria in the most recent month with available data:

- Be enrolled in both Medicare Parts A and B
- Have Medicare as their primary payer
- Not have end-stage renal disease[11]
- Not be enrolled in hospice[11]

[11] Note that this criterion only applies to beneficiaries who have not been attributed to a PCF practice previously—if the beneficiary has been attributed to a PCF practice previously, then developing end-stage renal disease or enrolling in hospice does not disqualify a beneficiary from being attributed to a PCF practice.

- Not be covered under a Medicare Advantage or other Medicare health plan
- Not be long-term institutionalized
- Not be incarcerated
- Be alive
- Not be on a Seriously Ill Population (SIP) outreach list
- Not be aligned or attributed to an entity participating in certain other CMS programs or models, as listed in Section 2.4.

CMS verifies most of these criteria using the **Medicare Enrollment Database**. CMS verifies institutional status using Medicare Skilled Nursing Facility Assessment data, known as the Minimum Data Set; CMS identifies a beneficiary as institutionalized if they have ever had a quarterly or annual assessment. CMS uses Medicare's Master Data Management system to determine attribution to other CMS programs and models.

CMS analyzes eligibility using the most recent month of data available before the quarter. Beneficiaries are determined PCF-eligible as of the first day of that month. For example, PCF-eligible beneficiaries must meet all eligibility criteria on December 1, 2020, to be eligible for attribution in the first quarter of PY 2021 (January 1, 2021–March 31, 2021).

Beneficiaries who lose eligibility before or during the quarter are later accounted for in debits to future Professional PBPs (see Chapter 3). For example, for Q1 2021, if a beneficiary met all eligibility criteria on December 1, 2020, but no longer met eligibility criteria at the start of, or during, that first quarter (January 1, 2021–March 31, 2021), CMS will debit the PBP amount that the practice was paid for the period during which the beneficiary was ineligible. CMS will apply this debit in a later quarter.

2.3 Attribution Steps

CMS attributes eligible beneficiaries to practices participating in the PCF component through 2 broad sequential processes, Voluntary Alignment and claims-based attribution.

2.3.1 Voluntary Alignment

Voluntary Alignment is a mechanism of attribution that uses a Medicare beneficiary's selected (through attestation) primary care practitioner to attribute the beneficiary to a practice. This process includes electronic retrieval of beneficiary selections, also known as attestations, and verifying the attested practitioner for applicable practitioner specialty type and active status on a PCF practice practitioner roster.

2.3.1.1 Beneficiary Attestations on MyMedicare.gov

To make an attestation, a beneficiary must create an account on MyMedicare.gov and follow the instructions in the PCF voluntary alignment beneficiary fact sheet. Beneficiaries can also view a

video demonstrating how to make an attestation[12] and our summary of best practices for engaging Medicare beneficiaries through voluntary alignment.

Although any beneficiary with an account on MyMedicare.gov can make an attestation, PCF voluntary alignment is limited to PCF-eligible beneficiaries. For the PCF-eligible beneficiaries who have made an attestation via MyMedicare.gov, CMS applies the voluntary alignment algorithm each quarter according to the steps in the next sections.

Using the beneficiary attestation list (BAL) from MyMedicare.gov, for a given quarter, CMS identifies each eligible beneficiary's most recent attested record as of the end of the lookback period (i.e., 3 months before the start of a given quarter). Table 2-1 lists the BALs and the beneficiary attestation cut-off dates for the 2021 quarterly attributions. For example, CMS used the October 2020 BAL, which included beneficiary attestations as of October 1, 2020, for voluntary alignment in Q1 2021. PCF-eligible beneficiaries who have made an attestation specifying the health care practitioner and practice as their primary practitioner are eligible for voluntary alignment.

Table 2-1
BALs Used for 2021 Quarterly Attribution

Attribution Quarter	BAL Used	Beneficiary Attestation Cutoff Date
Q1 2021	October 2020	October 1, 2020
Q2 2021	January 2021	January 1, 2021
Q3 2021	April 2021	April 1, 2021
Q4 2021	July 2021	July 1, 2021

If a PCF-eligible beneficiary's most recent eligible record indicates that the beneficiary has removed a previously-attested practitioner, but has not made a new attestation, the beneficiary is not eligible for voluntary alignment; instead, that beneficiary is attributed via claims-based attribution.

Next, CMS uses this list of PCF-eligible beneficiaries and their attested practitioners and practices to check practitioner and practice eligibility.[13]

2.3.1.2 Practitioner and Practice Eligibility Check

CMS uses the BAL file for a given quarter to verify the eligibility of the practitioner and practice the eligible beneficiary attested to. Only eligible practitioners are included in voluntary alignment. If the attested practice is a participating PCF practice site, the attested practitioner

[12] Please see https://youtu.be/w8Aj3blcxTY for a video on how to make an attestation on MyMedicare.gov.

[13] Because the BAL includes the practitioner's and practice's IDs assigned by the Provider Enrollment Chain and Ownership System, which are the data used by Physician Compare, CMS uses the Provider Master Index file and Center for Program Integrity sole proprietor file (for sole practitioners) to identify the TIN and NPI information for each attested practitioner and practice.

must also be listed as active on the practice's practitioner roster for the given quarter. If the attested practice is not a PCF practice site, the attested practitioner must have a primary care specialty code.

CMS verifies these specialties using the practitioner's **National Provider Identifier (NPI)** and the primary and secondary taxonomy codes in the most current **National Plan and Provider Enumeration System (NPPES)** file, which CMS updates monthly. See Appendix B for the list of specialty codes CMS uses to define a primary care specialty.

If the attested practitioner does not meet the eligibility criteria (including a practitioner who has left the participating PCF practice and is no longer listed as active on the practitioner roster), CMS attributes the eligible beneficiary through claims-based attribution. These requirements are described in greater detail in the section on claims-based attribution below.

2.3.1.2.1 Practitioners Participating at a PCF Component Practice

A practice in the PCF component is defined by the combinations of **Taxpayer Identification Numbers (TINs)** (or **CMS Certification Numbers [CCNs]** for **critical access hospitals**) and NPIs identified for each practitioner participating at the practice site. In voluntary alignment, CMS uses the Primary Care First practitioner roster to verify whether the attested practice's TIN and the attested practitioner's NPI match a TIN-NPI combination associated with a PCF component practice site.[14]

The attested practitioner must be active at the practice site for the given quarter. CMS considers a practitioner active at a practice for a given quarter if the practitioner is on the practice's roster on the first day of the month before a given quarter. For example, practitioners must be active on December 1, 2020, to be eligible for voluntary alignment in the first quarter of 2021 (January 1, 2021–March 31, 2021).

2.3.1.2.2 Practitioners at a Non-PCF Practice Site

Non-PCF practices are defined as individual practitioners using single TIN-NPI combinations due to the lack of information regarding how they are grouped as actual practices. If an eligible beneficiary makes an attestation to a non-PCF practitioner, their attestation can only be used if the practitioner has a primary care specialty code (see Appendix B).

Note that practitioners at a PCF practice site must have a primary care specialty code to be included on the Primary Care First roster.

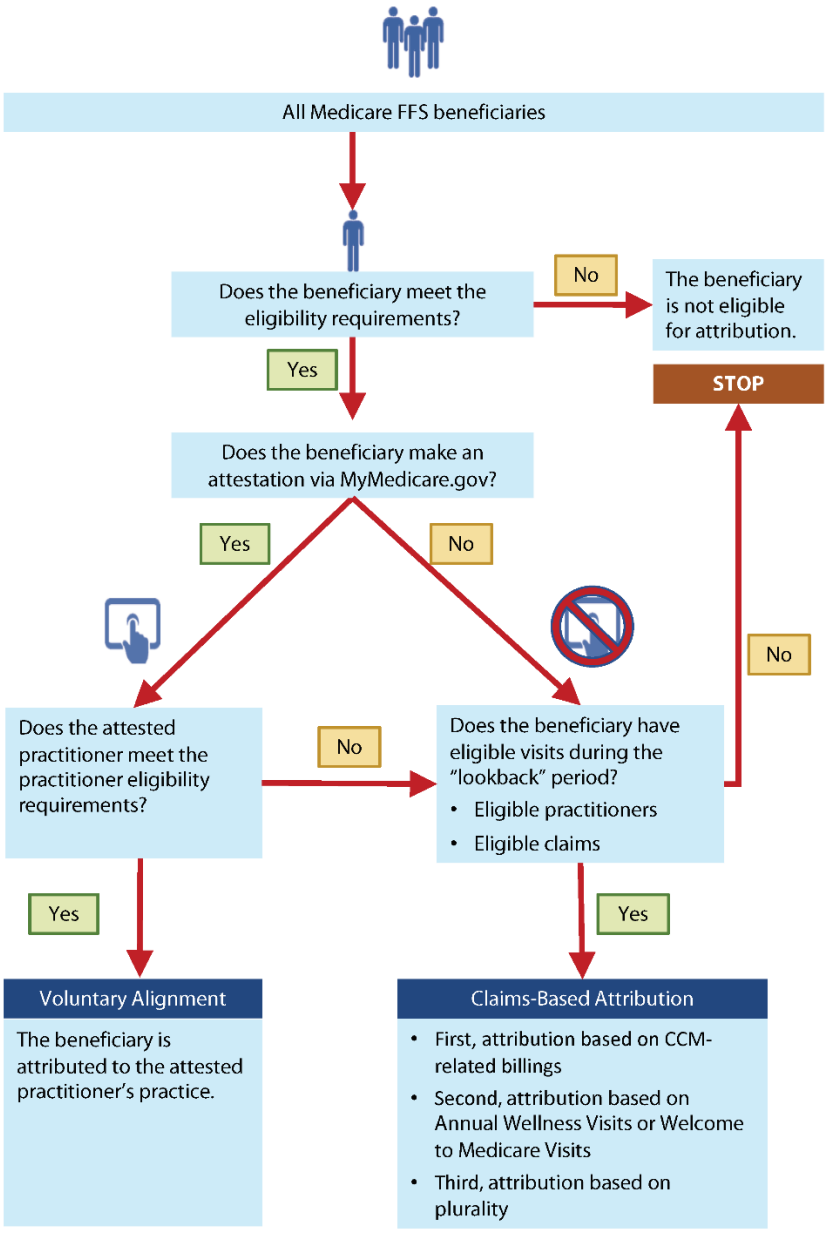
[14] Because the BAL uses data from Physician Compare, which does not include physicians who only bill Medicare through a critical access hospital, CMS uses only TIN-NPI (instead of CCN-NPI) combinations to identify the attested practitioner and practice for voluntary alignment.

2.3.1.3 Interactions with Claims-Based Attribution

If practitioner eligibility requirements are met, CMS uses the eligible beneficiary's attestation to attribute the beneficiary via voluntary alignment.

If the attested practitioner does not meet the practitioner eligibility requirements, CMS uses the claims-based attribution process for the eligible beneficiary (see Section 2.3.2 below). Figure 2-2 illustrates how the attribution process works.

Figure 2-2
PCF Component Attribution Methodology



2.3.2 Claims-Based Attribution

For remaining eligible beneficiaries, CMS attributes through the claims-based attribution process. CMS first identifies eligible primary care visits for eligible beneficiaries, then attributes them to the practice via a 3-step attribution process in the following order of priority: CCM-

related services, Annual Wellness Visits or Welcome to Medicare Visits, plurality of eligible primary care visits.

2.3.2.1 Eligible Visits

For claims-based attribution, CMS uses the pool of Medicare claims during the **lookback period** to identify eligible primary care visits to use for attribution. The lookback period is the 24-month period ending 3 months before the start of the quarter. For example, CMS uses claims with dates of service from October 2018 through September 2020 to attribute PCF-eligible beneficiaries to practices for Q1 2021 (see Figure 2-1). Table 2-2 lists the lookback periods that will be used for the 2021 quarterly attributions.

Table 2-2
Lookback Periods for 2021 Quarterly Beneficiary Attribution

Attribution Quarter	Lookback Period
Q1 2021	October 2018–September 2020
Q2 2021	January 2019–December 2020
Q3 2021	April 2019–March 2021
Q4 2021	July 2019–June 2021

CMS waits 1 month after the end of the lookback period to collect claims with service dates during the lookback period. This allows the overwhelming majority of claims that occurred during the lookback period to count toward attribution, even if they were processed and paid in the month after the lookback period ended.

CMS uses national Medicare FFS Physician and Outpatient claims with service dates during the lookback period. Most visits are in the Physician file, with the exception of claims submitted by critical access hospitals, which are found in the Outpatient file. From all Physician and Outpatient claims, CMS identifies those that are primary care visits eligible for attribution. Primary care visits eligible for attribution are those with any of the HCPCS codes in Table 2-3. In addition, Table 2-3 includes the list of CCM-related services, which are used in the first step of claims-based attribution.

Table 2-3
Primary Care Services Eligible for Attribution

Service	HCPCS Codes
Office/outpatient visit evaluation and management (E&M)	99201–99205, 99211–99215
Home care/domiciliary care E&M	99324–99328, 99334–99337, 99339–99345, 99347–99350
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Initial face-to-face visit with a SIP beneficiary	G2020[a]
Advance care planning	99497
Collaborative care model	G0502–G0504, 99492–99494
Cognition and functional assessment for patient with cognitive impairment	G0505, 99483
Outpatient clinic visit for assessment and management (critical access hospitals only)	G0463
Transitional care management services	99495, 99496
CCM-related services	
CCM services	99487, 99490, 99491
Prolonged non-face-to-face E&M services	99358
Assessment/care planning for patients requiring CCM services	G0506
Care management services for behavioral health conditions	G0507, 99484

[a] In the claims-based attribution process, CMS will include G2020 in the Welcome to Medicare/Annual Wellness Visit step, which is prioritized above the plurality step and below the CCM-related services step. Please see Figure 2-3 for a description of the claims-based attribution process. G2020 will be effective starting April 1, 2021.
Notes: Some HCPCS codes, such as G0505 and 99201, have been removed from the Physician Fee Schedule. However, CMS will continue to use these codes for attribution purposes when historical claims analysis includes periods when these codes were in use. CCM-related services are used in the first step of claims-based attribution.

Only eligible primary care visits count toward attribution. To be eligible, a primary care visit must meet 2 criteria:

1. The HCPCS code on the claim is among those listed in Table 2-3.
2. Non-CCM-related services are provided by a practitioner who meets 1 of the following criteria:[15]
    a. Active in a PCF practice when the visit occurs
    b. Has 1 of the primary care specialty codes located in Appendix B[16]

Each visit in the claims data includes (1) the TIN or CCN and (2) the NPI of the practitioner who rendered the service. For claims-based attribution, PCF practitioners must be active in a PCF practice when the visit(s) occur. To determine whether a practitioner is active in the PCF practice when the visit occurs, CMS determines whether the TIN or CCN and the NPI on the claim match a TIN-NPI or CCN-NPI combination that is effective on the claim's service date in the PCF practitioner roster. If there is a match, the visit is associated with a PCF practice. Otherwise, the visit is associated with a non-PCF practice.

Non-PCF practices are defined as individual practitioners using single TIN-NPI or CCN-NPI combinations. CMS maintains historical TINs and CCNs to associate claims with practices accurately in the lookback period. When PCF practitioners leave a practice, their NPIs remain on the PCF practitioner roster but are marked with a termination date. Although no longer "active" PCF practitioners, past visits to those practitioners during the lookback period continue to be counted toward the practice's attribution.

2.3.2.2 Claims-Based Attribution Process

PCF-eligible beneficiaries not attributed via voluntary alignment are attributed by 1 of the 3 main steps in the claims-based attribution process (Figure 2-3):

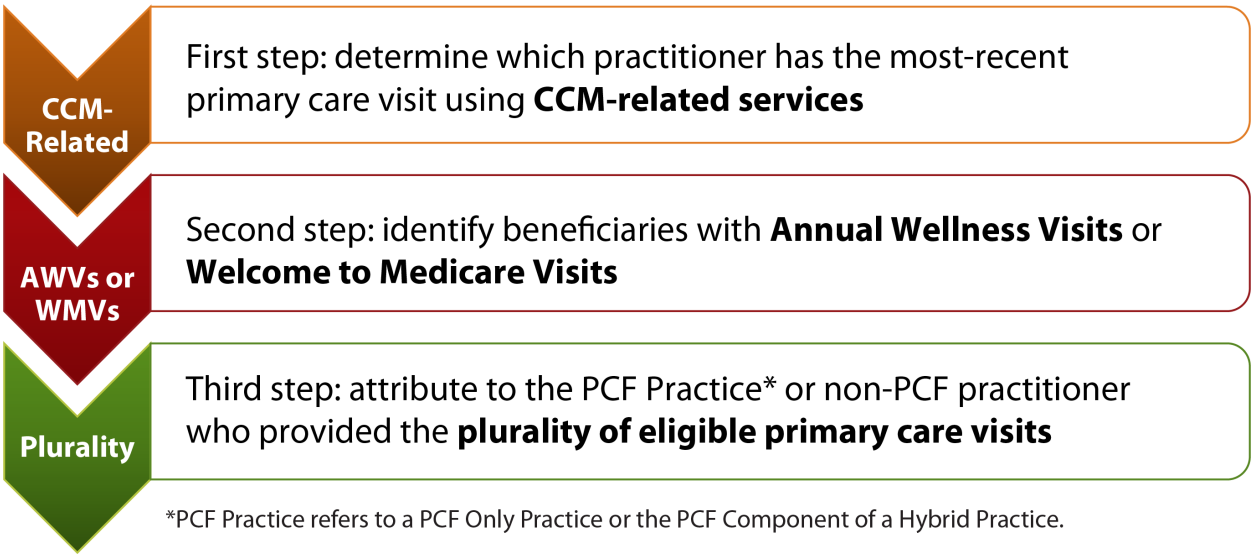
1. Attribute beneficiaries to practices using **CCM-related services**.
2. Attribute remaining beneficiaries to practices using **Annual Wellness Visits** or **Welcome to Medicare Visits**.[17]
3. Attribute all remaining beneficiaries to practices using the **plurality of eligible primary care visits**.

[15] There is no specialty code restriction on CCM-related services included in Table 2-3. Therefore, even when CCM-related services are billed by practitioners who do not have 1 of the primary care specialties listed in Appendix B, they are eligible for attribution.

[16] Note that practitioners must have a primary care specialty code to be active in a PCF practice.

[17] CMS will also include G2020, the initial face-to-face visit with a SIP beneficiary, in this Welcome to Medicare/Annual Wellness Visit step.

Figure 2-3
Three Steps in Claims-Based Attribution



2.3.2.2.1 Attribution Based on Chronic Care Management–Related Services

CCM-related services are prioritized in the PCF Attribution Methodology and are an effective way to establish attribution with new beneficiaries joining a PCF practice during the course of the model. If the most recent eligible primary care visit in the lookback period is for CCM-related services (please see Table 2-3 for the list of CCM-related services), CMS attributes the beneficiary to the PCF practice (or non-PCF practitioner) who provided the CCM-related service. If a beneficiary has CCM-related visits to both a PCF practice and 1 or more non-PCF practitioners on the most recent visit date, CMS attributes the beneficiary to the PCF practice. If there are multiple PCF practice ties, multiple non-PCF practitioner ties, or ties between PCF and CPC+ practices for the most recent CCM-related visits, CMS proceeds to Step 2 of the claims-based attribution.

If the most recent eligible primary care visit was not for CCM-related services, CMS proceeds to Step 2 of the claims-based attribution.

2.3.2.2.2 Attribution Based on Annual Wellness Visits or Welcome to Medicare Visits

For remaining PCF-eligible beneficiaries, CMS next checks whether they have Annual Wellness Visits (G0438, G0439) or Welcome to Medicare Visits (G0402) or the initial face-to-face visit with a SIP beneficiary (G2020) in the lookback period. CMS attributes the beneficiary to the PCF practice (or non-PCF practitioner) who provided the most recent such visit.[18] If there are no

[18] The SIP Initial Visit may not be billed by a non-PCF practitioner.

eligible Annual Wellness, Welcome to Medicare, or SIP Initial Visits during the lookback period, CMS proceeds to Step 3 of the claims-based attribution.

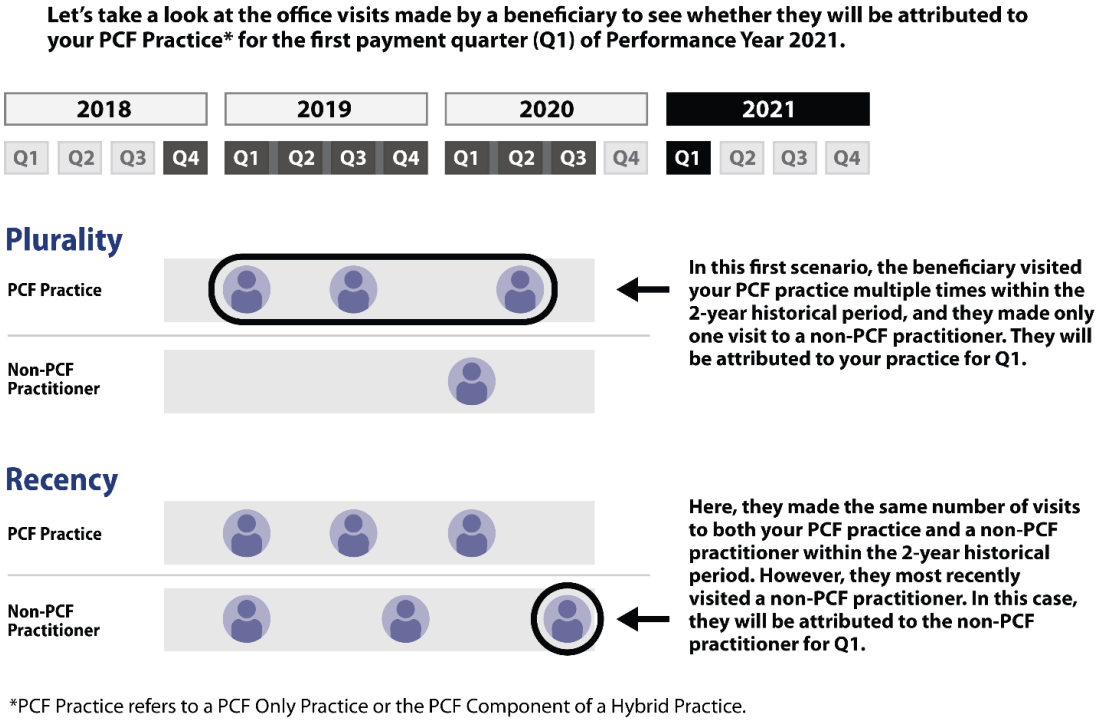
2.3.2.2.3 Attribution Based on Plurality

In this step, CMS first counts the number of eligible primary care visits the beneficiary had with each individual practitioner. CMS then combines eligible primary care visits to individual practitioners (i.e., TIN/NPI and CCN/NPI combinations) into PCF practices using the most current Primary Care First practitioner roster. For example, 2 practitioners working in a PCF practice will have their eligible primary care visits aggregated for the purposes of attribution. Finally, CMS attributes the beneficiary to the PCF practice (or non-PCF practitioner) that provided the plurality of eligible primary care visits during the lookback period.

If a beneficiary has an equal number of eligible primary care visits to more than 1 PCF practice (or non-PCF practitioner, including a CPC+ practice), the beneficiary will be attributed based on the most recent visit. If a tie remains between a PCF practice and a non-PCF practitioner, the beneficiary will be attributed to the PCF practice. If a tie remains between 2 PCF practices, or between a PCF practice and a CPC+ practice, the beneficiary is randomly attributed to 1 of the practices.

Figure 2-4 illustrates 2 examples of beneficiary claims-based attribution based on plurality of primary care visits. In one scenario, the beneficiary will be attributed to the PCF practice based on plurality; in the other, the beneficiary will be attributed to the non-PCF practitioner after applying the recency criteria to a tiebreaker.

Figure 2-4
Which Beneficiaries Are Attributed to My Practice Through Claims-Based Attribution?



*PCF Practice refers to a PCF Only Practice or the PCF Component of a Hybrid Practice.

2.4 *Overlap with Other Medicare Programs and Models*

Beneficiaries may be eligible for more than one CMS coordinated care initiative, such as PCF, CPC+, and the Medicare Shared Savings Program. This may occur if the beneficiary seeks care from health care providers who are participating in multiple initiatives or is in a certain geographical region where a model is being tested. In general, CMS prohibits beneficiary overlaps when they would interfere with CMS's ability to accurately measure the effects of each initiative and account for the effects of the overlap as part of financial reconciliation. CMS does not allow eligible beneficiaries to be attributed to PCF and certain other CMS programs and models at the same time.

2.4.1 Shared Savings Initiatives

To avoid duplicative payment of shared savings or other incentive payments, practitioners participating in certain shared savings initiatives may not simultaneously participate in PCF and beneficiaries attributed to these initiatives are not eligible for attribution to a PCF practice. Examples of shared savings initiatives include the Next Generation ACO Model, the **Direct Contracting Model**, the Comprehensive ESRD Care Model, the Kidney Care Choices Model, and the Value in Opioid Use Disorder Treatment Demonstration Program.

However, eligible PCF practices currently participating in a Medicare Shared Savings Program (Shared Savings Program) **Accountable Care Organization (ACO)** (any track) may participate

in both initiatives (please see Section 3.6 of the PCF Practice Participation Agreement for more details). Beneficiaries eligible for PCF who are attributed (either via voluntary alignment or claims-based attribution) to both the PCF practice and the Shared Savings Program ACO that the PCF practice participates in will remain attributed to both.

Beneficiaries who make an eligible attestation to a PCF practitioner on or before October 1, 2020, are attributed to their attested PCF practitioner for 2021 Q1. Voluntary alignment to PCF takes precedence over any claims-based attribution to the Shared Savings Program and the Next Generation ACO Model, but only for PCF attributions in the first quarter of each year. If PCF-eligible beneficiaries are attributed to a Shared Savings Program ACO (that is not affiliated with a PCF practice) or a Next Generation ACO during any quarter of 2021, a subsequent attestation to PCF practitioner during 2021 will lead to the eligible beneficiaries being attributed to their PCF practice in 2022.

Because CMS performs voluntary alignment quarterly for PCF and annually for the Shared Savings Program and the Next Generation ACO Model, these beneficiaries will remain with the ACO until the Shared Savings Program and Next Generation ACO Model perform voluntary alignment again for the following year (2022). When they perform voluntary alignment again the following year, if the beneficiary attestation to the PCF practice remains the most current attestation, the PCF-eligible beneficiary will be attributed to the PCF practice, rather than the ACO. For example, if an ACO-assigned beneficiary (2021 Q1) makes an attestation to a PCF practitioner in May 2021, this beneficiary remains assigned to the ACO for the remainder of 2021 (for PCF-eligible beneficiaries, May attestations would be captured in 2021 Q4 PCF attribution). If the beneficiary attestation to the PCF practitioner remains the most current attestation when the Shared Savings Program and the Next Generation ACO Model perform voluntary alignment again for 2022, the PCF-eligible beneficiary will become attributed to PCF (2022 Q1).

2.4.2 Primary Care Transformation Models

To prevent the alignment of beneficiaries to multiple primary care transformation models, beneficiaries are attributed to only one participant in these such initiatives. Examples of primary care transformation models include CPC+ and the **Independence at Home demonstration**. Because CMS will perform beneficiary attribution for PCF and CPC+ at the same time, and practitioners are only allowed to participate in one of these models, there is no overlap between PCF and CPC+. As a result, CMS will not attribute beneficiaries to both a CPC+ practice and a PCF practice for the same quarter (for more detail, see Section 2.3.2.2). Similarly, CMS will not allow beneficiaries to be attributed to both PCF and the Independence at Home demonstration at the same time.

2.4.3 Bundled/Episode Payment Models

PCF practices and PCF-attributed beneficiaries may overlap with CMS models focused on testing bundled payments for certain episodes of care, where it is possible to account for the

financial impact of the overlap. Examples of these episode-based payment models include the Bundled Payments for Care Improvement Advanced Model, Comprehensive Care for Joint Replacement Model, Oncology Care Model, Radiation Oncology Model, and End-Stage Renal Disease Treatment Choices Model.

2.4.4 State-Based Reform Efforts

PCF practices are prohibited from participating in, and cannot share PCF-attributed beneficiaries with, certain CMS state-based models, including the Vermont All-Payer ACO Model, the **Maryland Total Cost of Care Model**, and the **Financial Alignment Initiative** (FAI). FAI is a series of state-based shared savings initiatives, and dually eligible Medicare-Medicaid beneficiaries will be precluded from eligibility in PCF if they are aligned with FAI.[19]

2.4.5 Other Models

PCF practices and their PCF beneficiaries may simultaneously participate in other types of initiatives, such as the Million Hearts: Cardiovascular Disease Risk Reduction Model and the Accountable Health Communities Model. CMS may update these overlaps policies periodically to include new initiatives as they are finalized.

[19] Currently, 3 FAI Capitated Models are ongoing and scheduled to end on December 31, 2022. Two of these 3 active initiatives are in regions that overlap with PCF (California and Ohio).

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Chapter 3: Professional Population-Based Payment

Chapter 3 describes the methods used to calculate the Professional PBP for the PCF component. The Professional PBP is designed to free practices from traditional FFS payment incentives. Under FFS payment methodologies, practices have a strong incentive to bring patients into the office to create a billable face-to-face service, even if phone calls or electronic communications would be a better means of meeting the patient's needs or preferences.

The Professional PBP changes the payment mechanism for primary care from FFS to PBP, promotes flexibility in how participating practices deliver care, and allows them to increase the breadth and depth of primary care they deliver while focusing on continuous practitioner-patient relationships. It can support services to improve care coordination and target patient support by enabling practices to serve patients in a way that best meets the needs of the patient, whether by email, phone, patient portal, or other telehealth modalities (like real-time audio and video), or in alternative settings, such as the patient's home.

Table 3-1 lists services included in the calculations of the Professional PBP. The Professional PBP is meant to partially replace FFS revenue from specific primary care services for a practice's attributed beneficiary population. Practices whose patients have, on average, more-complex conditions receive a higher PBP to compensate for the more resource-intensive care these patients require.

Table 3-1
Services Included in the PBP

Services	HCPCS Codes
Office/outpatient E&M	99202–99205, 99211–99215, G2211
Prolonged E&M	99354, 99355, 99415, 99416, G2212
Transitional care management services	99495, 99496
Home care/domiciliary care E&M	99324–99328, 99334–99337, 99341–99345, 99347–99350
Home Care/Domiciliary Care Plan Oversight	99339, 99340
Advance care planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
CCM services	99487, 99489–99491, 99439

Section 3.1 describes the calculation of risk scores and how CMS assigns practice risk groups. Section 3.2 explains the **retrospective debits** to the Professional PBPs. Section 3.3 describes the leakage rate adjustment applied to the Professional PBP. Section 3.4 provides an example calculation of the Professional PBP. Lastly, Section 3.5 describes how qualifying primary care visits and services included in the Professional PBP will be monitored.

3.1 Population-Based Payment Risk Scores and Practice Risk Groups

CMS assigns practices to 1 of 4 risk groups using the average CMS-HCC risk scores of their attributed Medicare beneficiaries. For PY 2021, each risk group is associated with a PBPM Professional PBP that ranges from $28 to $175. Practices receive the same Professional PBP for each of their attributed beneficiaries, regardless of those beneficiaries' individual risk scores.

The goal of this group-based risk adjustment methodology is to reduce practice focus on individual risk scores. Because a practice's PBPM is determined by the average risk score across its entire patient population, a change in an individual beneficiary's risk score will likely not affect the overall amount of the PBP. CMS re-calculates CMS-HCC scores and practice risk group assignments annually.

3.1.1 Centers for Medicare & Medicaid Services–Hierarchical Condition Categories Risk Scores

The CMS-HCC risk adjustment model is a prospective risk adjustment model that predicts medical expenditures using demographics and diagnoses. Medical expenditures in a given 1-year period, called the risk score year, are predicted using diagnoses from the prior 12-month period, called the base period. The CMS-HCC model produces a risk score, which measures a person's or a population's health status and expected medical expenditures relative to the average of 1.0 for the entire Medicare FFS population. For example, a population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a population with a risk score of 0.5 is expected to incur medical expenditures half that of the average. For more information on the CMS-HCC model, please refer to Appendix C.

Each year, CMS uses the most recently available risk scores to assign practices to risk groups. In order to ensure that as many diagnoses are captured in the risk score as possible, CMS calculates risk scores for any year at least 12 months after the base year ends, such that final risk scores are generally available 16–18 months after the base year. For example, 2019 risk scores (based on 2018 diagnoses) are available in the summer of 2020. CMS will use 2019 V24 risk scores for Q1–Q4 2020 attributed beneficiaries to determine PY 2021 risk groups for PCF practices.

Table 3-2 shows the risk score file and claims period for all Primary Care First performance years. CMS implements updated risk score data in Q1 of each year. This schedule is subject to change if the availability of the data changes.

Table 3-2
Risk Score Data Used to Determine Risk Scores by Performance Year

PCF Performance Year	Risk Score File Year	Claims Period Used for Risk Scores
PY 2021	2019 risk scores	CY 2018
PY 2022	2020 risk scores	CY 2019
PY 2023	2021 risk scores	CY 2020
PY 2024	2022 risk scores	CY 2021
PY 2025	2023 risk scores	CY 2022
PY 2026	2024 risk scores	CY 2023

CY = calendar year; PY = performance year.

3.1.2 Assigning Practice Risk Groups

CMS uses risk scores based on the CMS-HCC community risk adjustment model, as opposed to the CMS-HCC long-term institutional model, because Primary Care First eligibility criteria for attribution exclude beneficiaries who are long-term institutionalized (e.g., long-term residing in a nursing home). For community-residing beneficiaries new to Medicare, CMS uses the new enrollee version, which is a demographic-only risk adjustment model since beneficiaries new to Medicare do not have a complete diagnostic profile during the base year. CMS uses normalized risk scores to assign practice risk groups.

To set the practice risk group each PY, CMS uses the most recent risk score file available (Table 3-2) and applies a normalization factor corresponding to that year. For example, for PY 2021, CMS uses the 2019 risk score file, which contains risk scores based on diagnosis data from claims in CY 2018. Each Medicare FFS beneficiary attributed to a PCF practice will be linked to their CMS-HCC risk score. CMS uses risk scores for beneficiaries attributed in each attribution quarter in the year before the PY for which CMS is setting practice risk groups. For example, CMS will use 2019 risk scores for Q1–Q4 2020 attributed population and use a 4-quarter average risk score for each practice in order to set the practice risk groups for PY 2021. This approach will help mitigate the effect that changes in the attributed population may have on practice average risk scores during the course of a year.

As CMS adopts newer versions of the CMS-HCC risk adjustment model, CMS may adjust the methodology as needed to set the practice risk group and compute the Professional PBP with the new models.

Each practice is assigned to 1 of 4 risk groups on the basis of the average CMS-HCC risk score of its Q1–Q4 attributed beneficiaries in the previous year. CMS defines the risk score thresholds. The practice risk group determines a practice's PBPM payments, as shown in Table 3-3. During each performance year, the PBPM is the same for all attributed beneficiaries within a practice.

The Professional PBP for Group 1 is $28 PBPM, paid quarterly on a prospective basis. The base rate Professional PBP for Groups 2 through 4 ranges from $45 to $175 PBPM, to account for the resources needed to serve patients with increasingly complex care needs (Table 3-3).

Table 3-3
Practice Risk Groups and Corresponding Professional PBP (PBPM)

Practice Risk Group	CMS-HCC Practice Average Risk Score Criteria	Professional PBP (PBPM)
Group 1	Score < 1.2	$28
Group 2	1.2 ≤ Score < 1.5	$45
Group 3	1.5 ≤ Score < 2.0	$100
Group 4	Score ≥ 2.0	$175

Note: CMS reserves the right to update these payment amounts in the future to ensure they are consistent with average revenue from FFS, as well as the right to update based on changes to the Medicare Physician Fee Schedule (PFS).

3.1.3 Risk Score Growth

CMS monitors the progression of practice average risk scores and design methodologies to prevent or correct for unexplained increases in risk scores across time. If significant, unexpected, or irregular changes in coding occur, CMS will adjust the methodology. If CMS decides to make changes, CMS will specify them before the payment quarter in which they are implemented. Examples of how CMS might address high risk score growth include the following:

- Apply a coding pattern adjustment factor to each beneficiary's risk score, as in the Medicare Advantage program.
- Cap the risk score growth rate by which each practice's risk score is allowed to change, as in the Next Generation Accountable Care Organization model.
- Use diagnosis-based risk adjustment for updating newly attributed beneficiaries' risk scores and demographic-based risk adjustment for updating continuously attributed beneficiaries' risk scores.

3.1.4 Geographic Adjustment to the Population-Based Payment

The Professional PBP is geographically adjusted in a similar manner to the Medicare Physician Fee Schedule (PFS) rates to account for nationwide variation in cost. For more detail on the methodology and data used for Medicare geographic price adjustment, refer to the PFS website.[20] CMS may also adjust the Professional PBP periodically to reflect updates to Medicare PFS rates for the services included in the Professional PBP. Because the

[20] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Locality-Configuration-and-Studies

Professional PBP is not conditional on a health care encounter, it is provided to practices without beneficiary cost-sharing.

The GAF applied to the Professional PBP is a weighted geographic adjustment based on all services in the Medicare PFS. It summarizes the combined impact of the 3 **Geographic Practice Cost Index (GPCI)** expense categories (work, practice expense, malpractice) on a locality's (state or metropolitan region's) physician reimbursement level. Regions with higher cost have higher GAFs and are thus paid more on each claim, consistent with Medicare FFS payments. The Medicare Learning Network provides more information on the GPCIs.[21] The national weighted average value for each of the 3 GPCIs is equal to 1.

The GAF cost-share weights for each GPCI element are determined by the **Medicare Economic Index** base year weights. These cost-share weights determine the relative contribution of each GPCI and are updated according to current regulation. In the illustrative example below, using the 2021 Medicare PFS Final Rule,[22] the GAF for a given locality L is calculated as:

$$GAF_L = \left(GPCI_{\text{pw},L} * 0.50866\right) + \left(GPCI_{pe,L} * 0.44839\right) + \left(GPCI_{mp,L} * 0.04295\right)$$

where

L	=	specific locality,
pw	=	work GPCI,
pe	=	practice expense GPCI, and
mp	=	malpractice GPCI.

Please refer to the 2021 PFS Final Rule for a discussion of GPCIs and the most recent update.[22]

3.2 Retrospective Debits

CMS applies debits to the Professional PBPs paid each quarter to account for prior Professional PBP overpayments.

3.2.1 Debits for Beneficiary Ineligibility

CMS determines attribution and calculates Professional PBPs before each quarter. The prospective quarterly payment assumes that all beneficiaries prospectively attributed for the quarter remain eligible for the entire quarter. However, some beneficiaries become ineligible before or during the quarter. This happens if the beneficiary loses Part A or Part B coverage,

[21] Here's information from the January 2020 Medicare Learning Network release as an example: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How_to_MPFS_Booklet_ICN901344.pdf

[22] https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f

joins a Medicare Advantage plan, loses Medicare as the primary payer, becomes long-term institutionalized, becomes incarcerated, or dies. Beneficiaries who are not eligible on the first day of a month are not eligible for Professional PBP that month. To account for this, in each quarterly payment cycle (beginning with Q2 2021), CMS determines whether a beneficiary lost eligibility during any prior quarters and computes a deduction from the upcoming quarter's payment to reflect previous overpayments.

3.2.2 Debits Resulting from Negatively Assessed Performance-Based Adjustment

CMS may adjust future quarterly payments to reconcile differences in prior payments caused by the PBA. In PY 2022, CMS may retrospectively apply a debit to the Q2 PBP depending on the practice's performance on a set of measures (Quality Gateway) in the previous performance year. In PY 2023 and beyond, CMS will apply a debit to quarterly PBPs if the practice does not meet the minimum thresholds of the Quality Gateway. Whether or not a practice meets the Quality Gateway requirements will determine the payment adjustment percentage applied to the PBP. Failure to pass the Quality Gateway may result in reversing a previous positive adjustment to a −10% or 0% PBA. Retrospective adjustments may also be made due to changes resulting from corrections to PBA measure calculations—for example, to correct for missing or incomplete TPCC data. Refer to Chapters 5 and 6 for more details on the PBA measures and requirements.

3.3 Leakage Rate Adjustment

CMS applies a quarterly leakage rate adjustment to the Professional PBP to improve its accuracy. This adjustment reflects the percentage of qualifying visits and services which attributed Medicare beneficiaries received by individuals who are not on the PCF practice's practitioner roster, relative to all their qualifying visits and services.

3.3.1 Calculation of the Leakage Rate Adjustment

For each practice, CMS calculates the leakage rate adjustment quarterly by dividing (1) the number of attributed beneficiaries' qualifying visits and services billed by any clinician outside the practice by (2) the total number of attributed beneficiaries' qualifying visits and services. This is based on a lagged, rolling 1-year **measurement period** of service dates.

$$\textbf{\textit{Leakage Rate Adjustment}} = \frac{Number\ of\ Qualifying\ Visits\ and\ Services\ for\ Attributed\ Beneficiaries\ Outside\ PCF\ Practice}{Number\ of\ Qualifying\ Visits\ and\ Services\ for\ Attributed\ Beneficiaries}$$

The leakage rate only counts qualifying visits and services billed by a primary care practitioner for beneficiaries that are attributed during the specified time period. That way, practices are not held accountable for beneficiaries before they are attributed to the practice. For example, when the practice leakage rate adjustment is first applied in Q3 2022, it will be based on the beneficiaries attributed in any quarter from January 1, 2021, to December 31, 2021, and their qualifying visits and services rendered during that same time period. Note that qualifying visits

and services will only be counted for the quarter(s) that the beneficiary is attributed during the specified time period and if the service was rendered by a primary care practitioner (refer to Appendix B for the full list of primary care taxonomies). Specialist visits will not count towards leakage if the provider does not have 1 of the eligible taxonomies for primary care. Table 3-4 lists the claims periods used for the quarterly leakage adjustment for the first 4 quarters of the leakage rate.

Table 3-4
Quarterly Leakage Adjustment Claims Periods

Quarterly Leakage Adjustment	Claims Period Used for Quarterly Leakage Adjustment
Q3 2022	Q1 2021 to Q4 2021
Q4 2022	Q2 2021 to Q1 2022
Q1 2023	Q3 2021 to Q2 2022
Q2 2023	Q4 2021 to Q3 2022

CMS applies the calculated leakage rate to the practice's corresponding Professional PBP for that quarter. For example, the Q3 2022 leakage rate is applied to the Q3 2022 Professional PBP.

$$Paid\ Professional\ PBP = Professional\ PBP\ based\ on\ practice's\ risk\ score\ group * (1 - Leakage\ Rate\ Adjustment)$$

3.3.2 Qualifying Current Procedural Terminology Codes

Table 3-5 lists the services included in the leakage rate adjustment for attributed Medicare beneficiaries.

Table 3-5
Services Included in the Leakage Rate Adjustment for Attributed Medicare Beneficiaries

Service	HCPCS Code
If billed by a primary care practitioner:	
Office/outpatient E&M	99202–99205, 99211–99215
Transitional care management services	99495, 99496
Home care/domiciliary care E&M	99324–99328, 99334–99337, 99341–99345, 99347–99350
Home Care/Domiciliary Care Plan Oversight	99339, 99340
Advance care planning	99497
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
If billed by any Medicare practitioner:	
CCM services	99487, 99490, 99491

3.3.3 Application of Leakage Rate Adjustment

To illustrate the leakage rate adjustment, say Main Street Practice billed 1,500 qualifying visits and services for its attributed beneficiaries from January 1, 2021, to December 31, 2021. During the same period, other non-PCF practitioner billed 500 qualifying visits and services for Main Street Practice's attributed beneficiary population. Table 3-6a and Table 3-6b provide an example of the calculation for the quarterly leakage adjustment for Q3 2022:

Table 3-6a
Example of Leakage Rate Adjustment for Q3 2022

Number of Qualifying Visits and Services for Attributed Beneficiaries Outside PCF Practice	÷ Number of Qualifying Visits and Services for Attributed Beneficiaries	= Leakage Rate Adjustment
500	÷ (1,500 + 500)	= 0.25

Therefore, Main Street Practice has a leakage adjustment of 25% applied to its Professional PBP for Q3 2022:

Table 3-6b
Example of Professional PBP With Leakage Rate Adjustment for Q3 2022

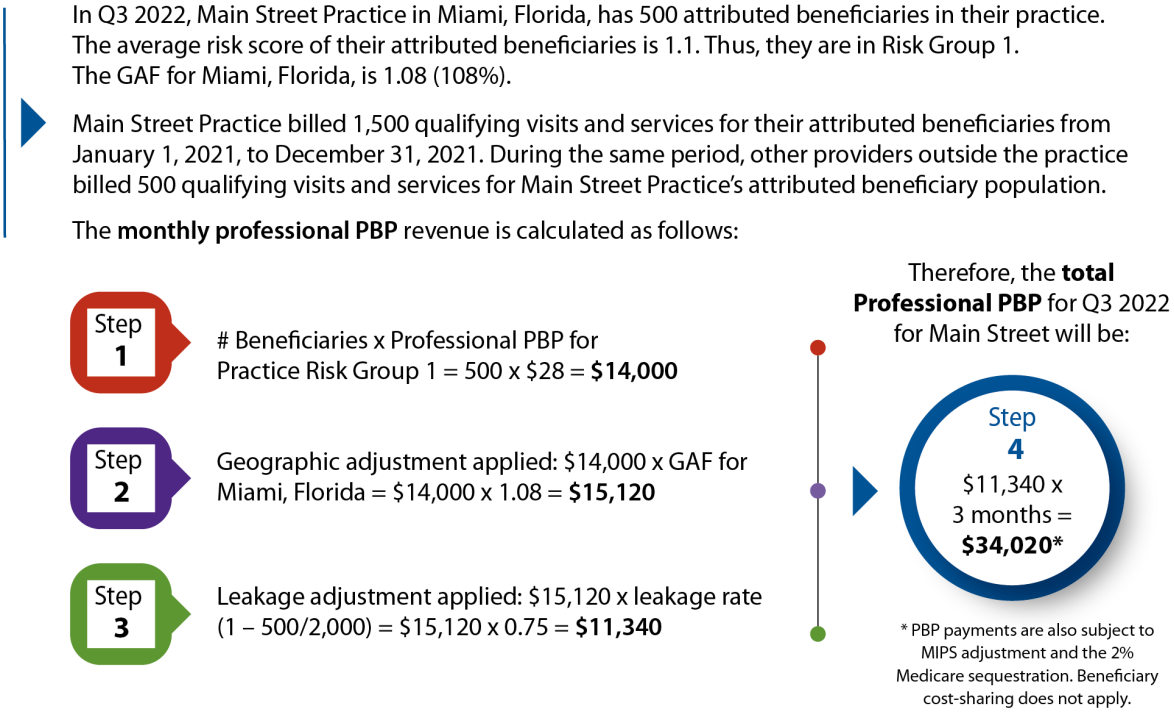
Professional PBP for Main Street Practice	* (1 − Leakage Rate Adjustment)	= Paid Professional PBP
$28	* (1 − 0.25)	= $21

3.4 Example of Professional Population-Based Payment Calculation

With annually assigned practice risk groups, CMS will quantify adjustments and generate payments for practices in each quarter. The amount of a practice's Professional PBP will be determined by of 5 key inputs: number of attributed beneficiaries, practice risk group, geographic adjustment, leakage rate adjustment, and PBA. Chapter 6 describes PBA in detail. The Professional PBP is also subject to the Merit-based Incentive Payment System (MIPS) adjustment and any other adjustments per traditional Medicare FFS, as well as the 2% Medicare sequestration as required by federal rulemaking.

Figure 3-1 provides an example of the calculation for the Professional PBP.

Figure 3-1
Example of Professional PBP Calculation



This example is used in other sections of the methodology paper when each adjustment is presented. Note that the value in Step 4 is not the final value a practice receives; practices are subject to MIPS adjustment, PBA, and Medicare sequestration. The PBA begins in Q2 2022 and is based on AHU (Practice Risk Groups 1 and 2) or TPCC (Practice Risk Groups 3 and 4), quality, and patient experience of care thresholds. Chapter 5 describes PBA measures in detail, and Chapter 6 describes PBA methodology.

3.5 Monitoring Primary Care Services Included in the Professional Population-Based Payment

CMS will routinely review billing patterns for any indications of large unanticipated changes in the volume of submitted claims for all primary care services included in the Professional PBP (see list of HCPCS codes in Table 2-3). This monitoring will use longitudinal analysis of practice-level claims billing patterns, including all qualifying primary care visits and services both at the practitioner level and as a practice. CMS will also continuously monitor the claims adjustments to ensure accurate payment. CMS may modify attribution, Professional PBP, and leakage rate adjustment methodologies (e.g., add/remove HCPCS codes included in the Professional PBP, PBP calculation, or PBP PBA) if monitoring identifies unanticipated changes in billing patterns for services included in the Professional PBP.

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Chapter 4: Flat Visit Fee Payments

Chapter 4 documents the methodology used to calculate the FVF for the PCF component. The FVF is intended to support practices delivering primary care to patients that require a face-to-face visit and encourage practices to continue seeing beneficiaries face-to-face as appropriate. The FVF base rate is $40.82 and applies to any FFS claim containing any of the procedure codes listed in Table 4-1, submitted by a practice participating in the PCF component for an attributed beneficiary. The FVF payment, which is geographically adjusted, only applies to the Medicare portion of the claim payment. Only 1 FVF is paid per patient day, even if multiple FVF services are provided; beneficiary cost-sharing is applied under standard FFS rule for each HCPCS code submitted on the claim. Practices receive the FVF when they bill HCPCS codes from the Medicare PFS for an eligible primary care service for an attributed beneficiary (described in Section 4.1). Depending on the services provided, practitioners will receive an adjustment to the claims amount so that it is paid at the FVF rate.

Section 4.1 describes the applicable FVF-eligible HCPCS codes, Section 4.2 describes the FVF adjustments, Section 4.3 estimates the FVF PBA payments, and Section 4.4 describes how FVF billing will be monitored.

4.1 Applicable Healthcare Common Procedure Coding System Codes

PCF practitioners submitting the HCPCS codes in Table 4-1 for PCF-attributed beneficiaries will be subject to the FVF. These HCPCS codes are subject to change based on updates to the PFS. Claims submitted by a practice for Medicare FFS beneficiaries not attributed to their PCF component are reimbursed according to the Medicare PFS instead of the FVF.

Table 4-1
Services Included in the FVF

Service	HCPCS Code
Office/outpatient 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

The Professional PBP that practices receive for each attributed PCF beneficiary includes payment for services defined as chronic care management (CCM)-related services, which are reimbursable under Medicare FFS. PCF providers are therefore prohibited from billing CCM-related services (99339, 99340, 99487, 99489, 99490, 99491, and any corresponding add-on

codes) as well as E&M add-on codes (G2211 and G2212) for any PCF beneficiaries, as they are already reimbursed through the Professional PBP. CMS will deny any such claims for these services if submitted by participating PCF practitioners for their PCF beneficiaries.

4.2 Flat Visit Fee

FVF claims for PCF practices are similar in processing to FFS claims. However, only 1 FVF will be paid per beneficiary per day. FVF claims are subject to the following:

1. Beneficiary Cost-Sharing (based on the original FFS allowed amount)
2. National Base Rate Adjustment
3. Geographic Adjustment
4. MIPS Adjustment
5. 2% Medicare sequestration

4.2.1 Beneficiary Cost-Sharing

CMS calculates patient deductible and coinsurance based on the Medicare PFS allowed amount for the submitted claim under traditional FFS, rather than the FVF payment amount. Thus, the deductible and coinsurance are equivalent to what a beneficiary would pay under traditional FFS for the same primary care service; in other words, the beneficiary is unaffected by their attribution to the PCF component in terms of their deductible and coinsurance. Practices can reduce or waive the applicable coinsurance based on FFS rates of the services provided as allowed by Medicare and applicable model waivers. Practices are responsible for covering the costs of cost-sharing support. Interested practices must identify the eligible beneficiaries and types of services eligible for cost-sharing support to CMS.

4.2.2 National Base Rate Adjustment

After CMS calculates the deductible and coinsurance, the National Base Rate Adjustment sets the Medicare payment amount for FVF-eligible services provided to attributed beneficiaries to the national FVF rate of $40.82. See Table 4-1 above for applicable services and HCPCS codes. All applicable services within the same visit are covered under 1 FVF. All applicable services within the same day, even if there are multiple claims, will be covered by 1 FVF. Thus, the Medicare payment amount to the practice is limited to 1 FVF per-beneficiary per-day.[23]

4.2.3 Geographic Adjustment

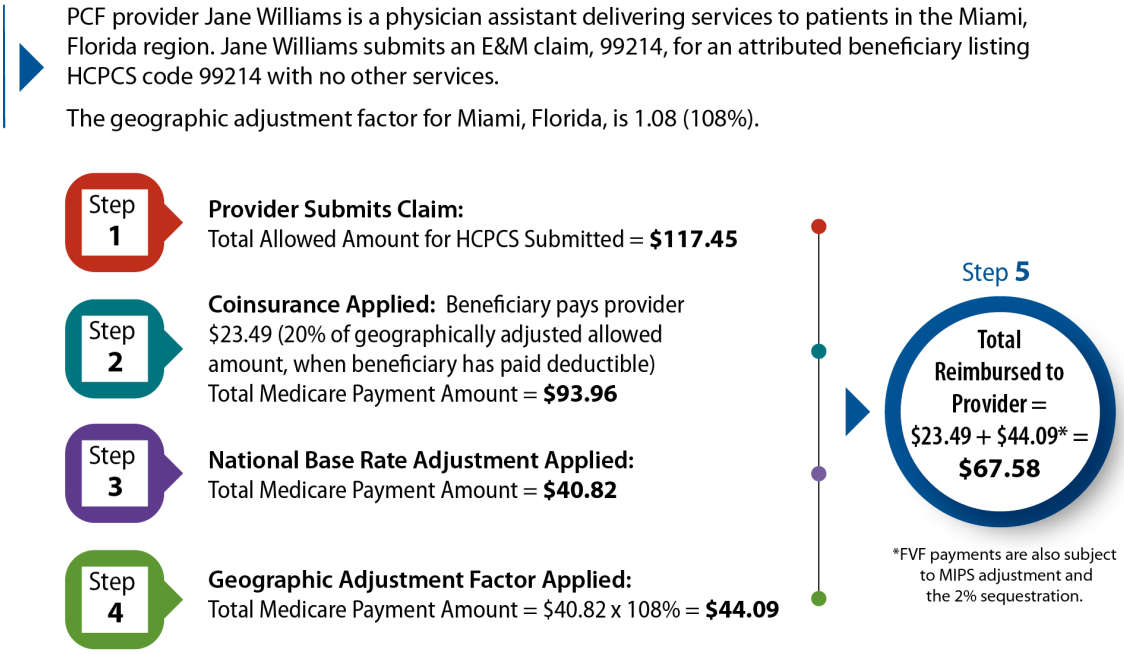
CMS accounts for regional cost variation by incorporating geographic price adjustments in the FVF. CMS applies the same GAF that it applies to the Professional PBP to the Medicare FVF payment amount for each submitted claim. For more information about the calculation and

[23] As mentioned above, CMS calculates patient deductible and coinsurance based on the Medicare PFS allowed amount for the submitted claim under traditional FFS, and all applicable Medicare FFS rules apply to provider billing and reimbursement. Therefore, total practice revenue per-beneficiary per-day may not be limited to the revenue from 1 FVF-eligible service, but may include beneficiary cost-sharing payments for multiple services rendered on the same date of service.

application of the geographic adjustment to the Professional PBP, see Section 3.1.4. More detail on the methodology and data used to calculate the GAFs and GPCIs is also available on the Medicare PFS website.[24]

The FVF is also subject to the MIPS adjustment and 2% Medicare sequestration. Figure 4-1 is an example of how the FVF calculation will work:

Figure 4-1
Example Calculation for the FVF



E&M = evaluation and management.

4.3 Flat Visit Fees and the Performance-Based Adjustment

Starting in Q2 2022, CMS calculates and allocates the PBA for FVF payments as a quarterly lump-sum payment/debit outside of the Medicare FFS system. CMS aggregates the revenue from FVF billing to a practice-specific total FVF revenue that is subject to the PBA. CMS then sums the claims payments for a practice approximately 1.5 months after the end of the quarter to allow for claims processing time. To account for incomplete claims history, CMS applies a completion factor to generate the total FVF revenue. Finally, CMS calculates the total FVF PBA amount by multiplying the total FVF revenue for visits that occurred during the final quarter of the PBA performance period by the quarterly PBA percentage, which can be either positive or negative. CMS pays the FVF portion of the PBA as a lump-sum during the quarterly payment cycle approximately 3 months after the end of the quarter for which it is assessed. For example, a practice passing the Quality Gateway might earn a 20% PBA for Q2 2022 based on its AHU or

[24] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Locality-Configuration-and-Studies

TPCC performance from January 1, 2021 through December 31, 2021. In addition to adjusting its PBP by 20%, CMS adjusts the total FVF revenue for visits that occurred during Q4 2021 (final quarter of PBA performance period) by 20%, delivered as a lump-sum FVF PBA for Q2 2022.

4.4 Monitoring Flat Visit Fee Billing

CMS will routinely review billing patterns for any indications of large unanticipated changes in the volume of submitted claims for all face-to-face visits subject to the FVF (see list of HCPCS codes in Table 4-1). This monitoring will use longitudinal analysis of practice-level claims billing patterns, including all services covered under the FVF both at the practitioner level and as a practice. CMS will also continuously monitor the claims adjustments to ensure accurate payment. CMS may modify FVF methodologies (e.g., add/remove HCPCS codes included in the FVF, FVF calculation, or FVF PBA) if monitoring identifies unanticipated changes in billing patterns for services included in the FVF.

Chapter 5: Quality Strategy

This chapter describes the quality strategy used to assess practices in the PCF component. CMS uses a focused set of clinical quality and patient experience measures to assess practice quality of care. These measures were selected to be actionable, clinically meaningful, and aligned with CMS' broader quality measurement strategy. Section 5.1 describes the quality strategy for Practice Risk Groups 1 and 2. Section 5.2 describes the quality strategy for Practice Risk Groups 3 and 4. Section 5.3 describes the timeline of performance periods for the performance-based adjustment measures for all practice risk groups.

5.1 Practice Risk Groups 1 and 2

As discussed in Section 3.1.2, practices are assigned to 1 of 4 risk groups annually based on the average CMS-HCC risk score of their attributed Medicare beneficiaries. Practices in the lowest-risk group (Practice Risk Group 1) have an average risk score of less than 1.2, and those in Practice Risk Group 2 have an average risk score between 1.2 and 1.5. In addition to determining a practice's Professional PBP amount, these groupings determine the quality measures used in the quality strategy.

5.1.1 Quality Gateway

The Quality Gateway is 1 of the minimum thresholds participating practices must meet or exceed to be eligible for a positive PBA. CMS begins performance measurement for the 5 Quality Gateway measures in Performance Year 2021, and the results are applied to payments in the following year (Q2–Q4 2022). To pass the Quality Gateway, practices in Risk Groups 1 and 2 must meet the minimum performance threshold, the 30th percentile, for all 5 of the quality measures listed below.

In 2022, practices that fail to meet the 2021 Quality Gateway will not be able to earn a positive PBA (Q2-Q4). Whether these practices receive a negative (−10%) or a neutral (0%) PBA will depend on their AHU performance each quarter, relative to their peer regions. Practices that do not pass the current performance year Quality Gateway (based on practices' quality measure results from prior performance year) will not be eligible for the CI bonus for any quarter during the year. See Section 5.1.2.2 for a description of the CI bonus.

In 2023 and beyond, practices that do not pass the Quality Gateway will automatically receive a −10% PBA for the entire year and will not be eligible for the CI bonus.

The Quality Gateway for Practice Risk Groups 1 and 2 consists of 5 measures: [25]

1. **Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)** (electronic Clinical Quality Measure [eCQM]);
2. **Controlling High Blood Pressure** (eCQM);
3. **Colorectal Cancer Screening** (eCQM);
4. **Advance Care Plan** (MIPS Clinical Quality Measure [CQM]); and
5. **Patient Experience of Care Survey (PECS)** (Consumer Assessment of Healthcare Providers and Systems® [CAHPS®]).

The Quality Gateway serves as an indicator of whether practices are meeting a quality of care threshold as they engage in strategies to reduce hospital utilization. The Quality Gateway and Acute Hospital Utilization (AHU) measures are summarized in Table 5-1 by measure ID, the measure steward, benchmark population, and benchmark. Figure 5-1 displays the timeline for performance periods, measure collection and calculation, and the Quality Gateway.

Table 5-1
Quality and Utilization Measures for Practice Risk Groups 1 and 2

Measure Category	Measure Title (Type)	NQF/Quality ID/CMS ID	Measure Steward	Performance Years[e]	Benchmark Population	Benchmark for Performance Year 2021
Quality Gateway[a]	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) (Intermediate Outcome eCQM)	Quality ID: 001 CMS ID: CMS122	NCQA[d]	2021–2024	MIPS	30th percentile: 99.45%[f]
	Controlling High Blood Pressure (Intermediate Outcome eCQM)	Quality ID: 236 CMS ID: CMS165	NCQA[d]	2021–2024	MIPS	30th percentile: 30.00%
	Colorectal Cancer Screening (Process eCQM)	Quality ID: 113 CMS ID: CMS130	NCQA[d]	2021–2024	MIPS	30th percentile: 2.59%
	Advance Care Plan (MIPS CQM measure)	NQF ID: 0326 Quality ID: 47	NCQA[d]	2021–2024	MIPS	Pay-for-reporting[g]
	Patient Experience of Care Survey (CAHPS with supplemental items)	NQF ID: 0005[c]	AHRQ	2021–2024	PCF population	30th percentile: 77.52%
Utilization Measure for PBA Calculation	Acute Hospital Utilization (HEDIS measure)[b]	N/A	NCQA[d]	2021–2024	PCF and non-PCF Medicare reference population	50th percentile: 1.16[h]

AHRQ = Agency for Healthcare Research and Quality; HEDIS = Healthcare Effectiveness Data and Information Set; N/A = not applicable; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.
[a] The measures in the Quality Gateway are assessed in the first performance year, and the results are applied in the following year. For example, the Quality Gateway applied in Q2 through Q4 2022 is based on performance during 2021.

[25] For more information on eCQMs and CQMs, see the eCQI resource center page here: https://ecqi.healthit.gov/ep-ec?year=2020&field_year_value=2&keys=&globalyearfilter=2021.

[b] Acute Hospital Utilization is an inverse measure; lower performance scores reflect better quality.
[c] The PCF PECS includes a combination of items from the Clinician and Group CAHPS (NQF ID 0005) as well as from the Patient-Centered Medical Home (PCMH) CAHPS Supplement.
[d] For more information about NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures, please see Appendix D.
[e] Performance year refers to the measurement period of the measure. Each measure has a 1-year measurement period (AHU is calculated with rolling 1-year performance period). The results of quality measures in the Quality Gateway are applied to the Quality Gateway in the following year.
[f] Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) is an inverse measure; lower performance scores reflect better quality.
[g] Practices will only be assessed on their ability to report the Advance Care Plan Measure. Cohort 1 practices that fail to report via a qualified registry or qualified clinical data registry will not be eligible for a positive performance-based adjustment (PBA) in Performance Year 2022.
[h] The preliminary national benchmark for AHU is intended to illustrate potential performance thresholds.

Figure 5-1
Timeline of Quality Gateway Performance Periods

	Quality Gateway Performance Period	Measure Collection, Reporting, Calculation	Application of Quality Gateway
Q1 2021	2021 Performance Period		
Q2 2021			
Q3 2021			No QG
Q4 2021		2021 PECS	
Q1 2022	2022 Performance Period	2021 PECS, eCQM, CQM	
Q2 2022			
Q3 2022			2021 QG Applied
Q4 2022		2022 PECS	
Q1 2023	2023 Performance Period	2022 PECS, eCQM, CQM*	
Q2 2023			
Q3 2023			2022 QG Applied*
Q4 2023		2023 PECS	
Q1 2024	2024 Performance Period	2023 PECS, eCQM, CQM*	
Q2 2024			
Q3 2024			2023 QG Applied*
Q4 2024		2024 PECS	
Q1 2025	2025 Performance Period	2024 PECS, eCQM, CQM*	
Q2 2025			
Q3 2025			2024 QG Applied*
Q4 2025			

* Days at Home measure in use for Practice Risk Groups 3 and 4

QG = Quality Gateway.

5.1.1.1 Electronic Clinical Quality Measures

PCF requires reporting of 3 eCQMs from the MIPS program: (1) Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%); (2) Controlling High Blood Pressure; and (3) Colorectal Cancer Screening. For Performance Year 2021 and beyond, practices must submit the required eCQMs through the QPP website using the file format for PCF specified in the CMS Implementation Guide Quality Reporting Document Architecture (QRDA) III: Eligible Clinicians and Eligible Professionals Programs (file format subject to change at CMS discretion).

Practices are required to successfully report all 3 eCQMs. Reporting only 1 or 2 of these measures will result in failing the Quality Gateway.

5.1.1.1.1 eCQMs: Benchmark

The eCQM benchmarks used for Performance Year 2021 are the 2020 MIPS benchmarks. The eCQMs include patients who have at least 1 visit to the practice during the measurement year and meet the denominator inclusion criteria. Patients under all payers and insurance statuses, including Medicare, are eligible. For Performance Year 2021, CMS reviewed current measures used by other CMS programs for quality reporting, such as MIPS, and identified 3 eCQMs designed to indicate quality of care specifically relevant to primary care. Because eCQM measures are reported electronically, they can be an easily accessible tool for practices and practitioners to inform, guide care improvement efforts, and support evidence-based decision making throughout the performance year. Practices report eCQMs electronically through a mechanism specified in the PCF Clinical Measures Reporting Guide for the respective performance year.

5.1.1.1.2 eCQMs: Performance Period and Scoring

Practices must successfully report the three eCQMs at the practice site level, which is identified by the PCF Practice ID, starting with Performance Year 2021, which corresponds with the measurement period (January 1, 2021, through December 31, 2021). The reporting period is expected to be January 3, 2022, to February 28, 2022. CMS calculates the measures annually. All practices are required to report data that cover the entire 12-month measurement period for each eCQM. Practices with a planned health information technology (IT) system or vendor transition during the performance year must ensure that all data are transferred from their prior health IT systems or leverage additional health IT to meet this requirement.

Practices must use the eCQM version applicable for the measurement period. Measure stewards update the **measure specifications** annually. The eCQMs for the 2021 Measurement Period can be accessed by selecting “2021” in the Select Performance Period drop-down menu at the Eligible Professional/Eligible Clinician eCQMs page on the electronic Clinical Quality Improvement (eCQI) Resource Center (https://ecqi.healthit.gov/).

The following list displays the data elements for the 3 2021 Performance Year eCQMs that practices are required to submit.

- Initial population
- Denominator
- Denominator exclusions
- Numerator
- Performance rate

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) (CMS122[26]), Controlling High Blood Pressure (CMS165), and Colorectal Cancer Screening (CMS130) are eCQMs with a single performance rate and are calculated using the following equation:

$$eCQM\ Rate = \frac{Numerator}{Denominator - Denominator\ Exclusions}$$

5.1.1.2 Advance Care Plan Clinical Quality Measure

For Performance Year 2021, CMS reviewed current measures used by other CMS programs for quality reporting, such as MIPS, and selected 1 MIPS CQM designed to indicate quality of care specifically relevant to primary care and complex patient populations. This measure, the Advance Care Plan, is a MIPS CQM, formerly known as a registry measure.

5.1.1.2.1 CQM: Requirements for Satisfying the Process Measure

To satisfy this measure, practices must use the CQM version applicable for the measurement period. The measure steward updates the measure specifications annually. Once available, the CQMs for the 2021 Measurement Period can be accessed by selecting "2021" in the Quality Measures section on the QPP website.[27]

5.1.1.2.2 CQM: Reporting Method and Instructions

Practices report the Advance Care Plan measure 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. Reporting using a health IT vendor from 1 of these lists is required. This measure is *not* submitted via a QRDA III file and instead uses the QPP JSON format for submission. Practices work with the health IT registry vendor selected from the list to submit the measure and to ensure accuracy of the submission. All practices are required to report data that cover the entire 12-month measurement period for the Advance Care Plan measure. Practices with a planned health IT system or vendor transition during the performance year must ensure that all data are transferred from their prior health IT systems or leverage additional health IT to meet this requirement.

5.1.1.2.3 CQM: Benchmark

The Advance Care Plan measure was updated to a pay-for-reporting measure status for Performance Year 2021. This means that practices will only be assessed on their ability to report this measure to pass the minimum quality threshold. Practices must report the Advance Care Plan measure using a qualified registry or QCDR for Performance Year 2021. Practices

[26] Diabetes Hemoglobin A1c (HbA1c) Poor Control (> 9%) is an inverse measure; lower performance scores reflect better quality.

[27] https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&py=2020#measures

that fail to report via a qualified registry or QCDR will not be eligible for a positive performance-based adjustment (PBA) in Performance Year 2022.

5.1.1.2.4 CQM: Performance Period and Scoring

For Performance Year 2021 and beyond, practices must successfully report the Advance Care Plan measure at the practice site level. Performance Year 2021 corresponds with the measurement period (January 1, 2021, through December 31, 2021). The measure is reported annually. The first expected reporting period is tentatively scheduled from January 3, 2022 to February 28, 2022. Reporting period dates will be communicated yearly.

5.1.1.3 Patient Experience of Care Survey Measurement

PECS is designed to collect reliable and representative data about patient experience of care. CMS uses a combination of survey items, organized into categories called "domains," to calculate performance scores on patient experience of care. The items are structured according to Clinician and Group CAHPS (CG-CAHPS) version 3.0 specifications (looking back 6 months), while the domains used to calculate performance scores on patient experience of care conform to CG-CAHPS version 2.0 domain groupings and the CAHPS® Patient-Centered Medical Home Survey Supplement. Appendix E describes the domains and questions. The PCF component version of PECS is not yet final, and it will likely include other PCF-appropriate questions currently in development.

CMS will require the practice to procure a CMS-approved PECS vendor to conduct PECS. CMS shall make available a list of approved PECS vendors. The practice will be required to

1. submit a roster for all adult patients seen at the practice (including uninsured, commercially insured, Medicaid, and Medicare patients) to CMS by a date and in a manner to be specified by CMS, which CMS will validate and provide to survey vendors directly;
2. contract with a survey vendor to administer the survey and ensure that survey results are transmitted to CMS by a date and in a manner to be specified by CMS; and
3. ensure that the survey vendor adheres to the questionnaire, survey protocol, and format for submitting PECS results to CMS.

If the survey vendor does not submit the practice's PECS results in a timely manner, or if the PECS submission is deemed invalid by CMS, CMS shall assign the practice a 0 for its yearly PECS score, and the practice will not meet the Quality Gateway.

Practices are required to provide an all-patient roster, regardless of insurance type, to CMS when requested. Practices that fail to provide a patient roster will not receive a PECS score and will not be eligible for a positive PBA. CMS may also consider additional actions up to and including withholding model payments and termination of the practice's Participation Agreement as consequences for failure to submit a valid patient roster during the submission period. Appendix E contains the current version of the PECS questions.

5.1.1.3.1 PECS: Benchmark

To benchmark PECS scoring for the PCF component, CMS uses data from PCF practices during Performance Year 2021. For Performance Year 2021, domain-specific scores for each practice are included in the benchmark. Practice surveys are scored using version 5.0 of the CAHPS Analysis Program. The domain-specific scores enable CMS to analyze case-mix-adjusted CAHPS survey data at the practice site level to make valid comparisons of performance (AHRQ, 2012).

The PECS Benchmark methodology has been updated for Performance Year 2021 for Cohort 1 practices. Previously, the PECS benchmark was a historical benchmark, derived from 3 years of CPC+ practice performance. The updates to the PECS benchmark and methodology are to account for changes in care delivery and care utilization during the COVID-19 Public Health Emergency and are favorable to PCF practices compared to continuing to use historical CPC+ practice performance as the benchmark.

The PECS benchmark will now be calculated concurrently based on PCF practice performance. For Performance Year 2021, the PECS benchmark will be based on the 30th percentile of PCF practice performance in 2021. The new 30th percentile benchmark value for Performance Year 2021 is 77.52 (previously was 79.22). The changes to the Performance Year 2021 Benchmark will only affect practices in Cohort 1.

CMS transforms each survey response into PECS domain-specific scores using numeric values assigned to responses for a given measure, following the steps outlined in the next section.

The PECS Summary Score is calculated as the average of the 5 PECS domain-specific measures, and is case-mix adjusted based on age, gender, education, self-reported physical health, proxy response, and survey mode (paper survey vs. telephone interview). The practices are then ranked based on their PECS Summary Score on a continuous 0–100 scale to establish their percentile ranking. A practice's PECS Summary Score must meet or exceed the 30th percentile for it to pass the Quality Gateway.

5.1.1.3.2 PECS: Performance

Step 1. Calculate PECS domain-specific scores.

The PECS benchmark is composed of 5 domains, and each domain contains 1 or more questions. CMS reserves the right to determine whether any domains or questions within the domains will be added or removed to the benchmarks or yearly PEC scoring, or both. CMS calculates PECS domain-specific scores using numeric values assigned to responses for a given domain. CMS first assigns a numeric value to each response option in the response scale for each survey question. For example, if there are 4 response options in a response scale, Never/Sometimes/Usually/Always, numeric values of 1 for "Never," 2 for "Sometimes," 3 for "Usually," and 4 for "Always" are assigned. If there are 2 response options in a scale, Yes/No, values of 1 for "Yes" and 0 for "No" are assigned. For PCF component PECS domains, a single response scale applies to all questions for a given domain. Second, CMS applies case-mix adjustment to the scores using the CAHPS consortium instructions and the variables listed in

Section 5.1.1.3.1. Third, CMS calculates the average case-mix-adjusted numeric response options for each domain. Finally, the case-mix-adjusted numeric average is converted to a 0–100 scale, where 0 is the lowest performance and 100 is the highest performance. Scores are converted to the 0–100 scale using the following approach:

$$Y = \frac{(X - a)}{(b - a)} * 100$$

"Y" is the converted score on the 0–100 scale, "X" is a practice's PECS Summary Score on its original numeric scale (i.e., adjusted average numeric points), "a" is the minimum possible score on the original scale, and "b" is the maximum possible score on the original scale for a given domain.

The Patients' Rating of Provider is a single-question PECS domain, meaning that only 1 question contributes to the overall domain. The original response scale is from 0 to 10. Therefore, the formula for the converted score is as follows:

$$Y = \frac{(X-0)}{(10-0)} * 100$$

Table 5-2 below illustrates this process in greater detail.

Table 5-2
Examples of Scoring Transformations for PECS Measures

Hypothetical Practices	Adjusted Mean Score in Numeric Scale	Calculation of 0–100 Score	Converted Score
4 response options for 3 domains:[a] Never = 1; Sometimes = 2; Usually = 3; Always = 4			
Practice A	2.45	[(2.45−1)/(4−1)]*100	48
Practice B	3.50	[(3.50−1)/(4−1)]*100	83
Practice C	3.90	[(3.90−1)/(4−1)]*100	97
Two response options for "Self-Management Support" domain: No = 0; Yes = 1			
Practice A	0.33	[(0.33−0)/(1−0)]*100	33
Practice B	0.50	[(0.50−0)/(1−0)]*100	50
Practice C	0.80	[(0.80−0)/(1−0)]*100	80

Hypothetical Practices	Adjusted Mean Score in Numeric Scale	Calculation of 0–100 Score	Converted Score
Patients' rating of provider: 0–10			
Practice A	6.50	[(6.50−0)/(10−0)]*100	65
Practice B	8.00	[(8.00−0)/(10−0)]*100	80
Practice C	9.00	[(9.00−0)/(10−0)]*100	90

[a] Three PECS domains with 4 response options are "Getting Timely Appointments, Care, and Information"; "How Well Providers Communicate"; and "Attention to Care from Other Providers."

Step 2. Calculate the PECS Summary Score. The average of the 5 PECS domain-specific scores from Step 1 is the PECS Summary Score.

$$PEC\ Summary\ Score = \frac{(Access + Communication + Coordination + Support + Rating)}{5}$$

The PECS Summary Score ranges from 0–100, similar to the domain-specific scores. CMS compares the practice's PECS Summary Score to the 30th percentile benchmark threshold described in Section 5.1.1.3.1 to determine whether the practice achieved the PECS portion of the Quality Gateway. Each participating practice must meet or exceed the 30th percentile to qualify for the Quality Gateway.

5.1.2 Utilization Measure (Acute Hospital Utilization)

AHU is a claims-based, risk-adjusted utilization measure included in the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS). It evaluates the overall observed-to-expected (O/E) ratio of acute inpatient and observation stay discharges. CMS calculates AHU on a quarterly basis for all beneficiaries attributed to practices in Risk Groups 1 and 2.

For Practice Risk Groups 1 and 2, CMS uses AHU performance to determine a practice's PBA based on how their performance compares against a national benchmark, peer region group performance, and its own historical performance (Chapter 6 describes this methodology in detail).

5.1.2.1 AHU: Calculation of Utilization Measure

The guiding principle for the selection of the AHU measure for the PCF component was to have an actionable measure that drives total cost of care and improves the quality of care and health outcomes of beneficiaries. CMS also seeks measures with proven validity and reliability that can be measured at the practice level for Medicare FFS populations. The utilization measure uses claims and does not require practices to report any additional data, and CMS calculates it each quarter, beginning in Q2 2022. CMS calculates this measure using Medicare claims data for Medicare FFS beneficiaries aged 18 years or older.

The AHU measure is an O/E ratio of acute inpatient admissions and observation stay discharges. For each practice, the observed utilization is compared with the expected utilization, which is risk-adjusted for beneficiary demographics and comorbidities within the practice patient population. The comparison is expressed as a ratio, dividing the observed utilization by the expected utilization. An O/E ratio greater than 1 represents greater-than-expected utilization, and a ratio less than 1 represents less-than-expected utilization. AHU is an inverse measure; lower performance scores reflect better quality.

CMS uses measure specifications from NCQA HEDIS to calculate practice-level AHU.[28] Additional details on the measure's specification can be found on the NCQA's website: https://www.ncqa.org/hedis/measures/acute-hospital-utilization/.

5.1.2.1.1 AHU: Performance Periods

Beginning in Q2 2022, CMS calculates the AHU measure each quarter, using a rolling 1-year performance period that ends 3 months prior to the PBA quarter. For example, the Q2 2022 PBA is based on AHU performance from January 1, 2021 through December 31, 2021 (Q1 2021 through Q4 2021). For an overview of the PBA performance period timeline, see Figure 5-2.

5.1.2.1.2 AHU: Benchmark

CMS publishes benchmark thresholds, so practices know how their AHU performance will be assessed. The benchmarks establish the thresholds practices must reach to earn different PBA amounts. The preliminary national and regional benchmarks for Performance Year 2021 can be found in Appendix F. CMS will continue to assess patterns of care during calendar year 2020 and may revise these benchmarks to preserve equity before and after calendar year 2020. Details on CI benchmarks are in Section 5.1.2.2.2 and Table 5-3.

To obtain practice-level AHU performance for benchmarking purposes, CMS first calculates the observed and expected number of visits for every beneficiary who is in the reference population and eligible for inclusion in the measure. CMS then aggregates both the observed and expected number of visits to the practice level and calculates the O/E ratio for each practice.

To derive the preliminary AHU benchmarks for Performance Year 2021, CMS used a 2019 national reference population. This population is made up of CPC+ practices (identified at the TIN-NPI level) and the universe of Medicare FFS practices and their attributed Medicare beneficiaries. The universe of Medicare FFS practices includes unique TIN and NPI combinations (TIN-NPIs) and unique CCN and NPI combinations (CCN-NPIs). In future years, the reference population will also include PCF practices and their attributed Medicare beneficiaries, when their data is available. Beneficiaries are attributed to these practices using the same attribution algorithm as the PCF component claims-based attribution algorithm. To

[28] The Acute Hospital Utilization and its specifications were developed by the National Committee for Quality Assurance ("NCQA"). For more information about NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures, please see Appendix D.

derive reliable benchmarks, CMS only includes Medicare FFS practices with at least 125 attributed beneficiaries eligible for the measure denominator. The preliminary AHU national benchmark for Performance Year 2021 was calculated from 68,283 practice observations, which included CPC+ practices and Medicare FFS practices (TIN-NPI and CCN-NPI combinations).

CMS calculates the national benchmark using the distribution of practice-level AHU performance for eligible beneficiaries in all practices included in the reference population and their hospital claims during the reference year.

CMS establishes regional peer group benchmarks by using AHU performance from the same practices included in the national benchmarks but limiting the practices to those in a defined region. In developing AHU peer group regions, CMS first calculates performance for each individual state. CMS then establishes peer group regions by grouping states with similar performance levels and proximal geography. Appendix H contains preliminary AHU regional peer groups.

5.1.2.2 AHU: Continuous Improvement Bonus

The historical adjustment, also known as the CI bonus, rewards a practice's individual performance improvement on the AHU measure. The CI bonus added to the Regional Performance Adjustment produces the overall PBA (Chapter 6 describes this methodology in detail).

Beginning in Q2 2022, CMS calculates the practice's amount of improvement for the CI bonus quarterly by comparing its AHU performance during the same performance period as the Regional Performance Adjustment to a historical 1-year base performance period. For the first 4 PBA quarters, calendar year 2019 will be used as the base performance period, due to the impact of COVID-19 on healthcare utilization. For all subsequent PBA quarters, CMS will use the 1-year base performance period immediately preceding the current PBA performance period that ends 3 months prior to the PBA quarter. For example, for Q2 2023, AHU performance in the 1-year performance period that ends in Q4 2022 (January 1, 2022 through December 31, 2022) is compared with the 1-year base period that ends in Q4 2021 (January 1, 2021 through December 31, 2021). If a practice sufficiently improves between those 2 periods, its CI bonus is applied to its Q2 2023 PBA (see Figure 5-2 for an overview of the CI base performance periods).

The amount of improvement needed to earn the CI bonus, and the amount of the CI bonus, depends on which of the 7 possible performance levels the practice achieves compared with its peer region in the current quarter (see Table 5-3 for CI bonus amounts and improvement targets by regional performance level). In the example above, for Q2 2023, a practice whose AHU performance meets or exceeds the 90th percentile of their peer region group will receive a 16% CI bonus if they achieved the CI bonus thresholds (e.g., 3% improvement target). Eligible participating practices receive the CI bonus each quarter, as long as they achieve their improvement target. This policy rewards participating practices that do not meet or exceed

national or regional AHU benchmarks to receive a CI bonus if they improve over time, and it also incentivizes high-performing practices to continuously improve.

To be eligible for the CI bonus, practices must pass the Quality Gateway (meeting the 30th percentile on all 5 quality measures). CI bonuses paid during the first 2 quarters of the year are recouped if the practice fails the Quality Gateway when it is calculated in the third quarter.

5.1.2.2.1 AHU CI Benchmark

To earn the CI bonus, the practice's individual performance must have improved by a statistically significant percentage threshold, which is determined prospectively based on prior performance. The benchmark for the CI bonus is based on a practice's own performance in a 1-year base period using historical claims. The target percentage change and the CI bonus amount for a practice are determined by its AHU regional performance level during the current performance period. Improvement targets range from 3% to 5% change for all practices. CI bonus amounts range from 3.5% to 16%.

To mitigate the chance that changes in AHU measure performance between base performance period and current performance period reflect random variation, rather than true improvement, CMS uses statistical bootstrapping approaches (e.g., a reliability adjustment) to improve the reliability of the CI score.

To determine the CI score, CMS estimates the AHU performance rate for each practice. To compare performance periods, CMS generates a performance rate standard error for both the base performance period and the current performance period. Standard errors represent the accuracy of a measure and are needed to calculate statistical significance. CMS calculates each practice's change in measure performance between the 2 performance periods by subtracting the measure value of the current performance period from the measure value of the base performance period. In addition to calculating the actual change between performance periods, CMS applies a bootstrapping approach to generate a standard error for the change in measure performance. The bootstrapped standard error is then used to determine whether the change between the 2 performance periods is statistically significant. The bootstrapping approach involves drawing repeated beneficiary samples from an individual practice until a distribution of the population of samples for the practice yields a bootstrapped standard error.

The standard error associated with the change in measure performance is calculated as follows. First, CMS calculates the correlation of AHU results between the 2 performance periods. Next, CMS estimates the covariance between the 2 performance periods by multiplying the correlation between the 2 performance periods by the standard errors for both performance periods. The combination of each practice's covariance and performance rate standard errors for both performance periods allows CMS to calculate the standard error for the change in performance at the practice level, which allows CMS to evaluate the significance of any change in performance between performance periods within individual practices. Statistical significance is determined using an alpha threshold of 0.05. This approach has been applied successfully in

other CMS models that include assessing improvement in performance of quality measures over time.

To ensure that assessment of the CI bonus is based on PCF practice performance improvements, rather than broader national or regional changes in healthcare utilization differences between the PBA performance period and CI base performance period, CMS may make additional adjustments. For example, if CMS determines that the ratio of AHU performance in the PBA performance period to the CI base performance period for the same PBA quarter is less than 0.95 or greater than 1.05 for non-PCF practices in a peer region group.

5.1.2.2.2 AHU CI Performance Scores

For practices passing the Quality Gateway, their AHU performance in the 1-year base period before the current performance period, compared with regional benchmarks, determines the CI threshold, or CI score, required to receive the CI bonus. Practices with AHU results that meet or exceed the 90th percentile of their region's performance have a target improvement of 3% from 1 performance period to the next, and those with results below the 25th percentile of practices have a target improvement of 5%. Practices with AHU results between the 25th percentile and 90th percentile of regional performance have a linearly scaled target improvement between 3% and 5%. Table 5-3 shows the CI bonus amount and the improvement required to earn the CI bonus for each of the 7 performance levels based on peer region group performance.

Table 5-3
CI Bonus Potential Based on Practice Improvement Performance

AHU Regional Performance Level in Base Period	CI Bonus as % of TPCP	Min. CI Score Needed to Get CI Bonus
Level 1: At or above 90th percentile of practices in each region	16%	3%
Level 2: 80th to 89th percentile of practices in each region	13%	3.33%
Level 3: 70th to 79th percentile of practices in each region	10%	3.67%
Level 4: 60th to 69th percentile of practices in each region	7%	4%
Level 5: 50th to 59th percentile of practices in each region	3.5%	4.33%
Level 6: 25th to 49th percentile of practices in each region	3.5%	4.67%
Level 7: Below 25th percentile of practices in each region	3.5%	5%

TPCP = Total Primary Care Payment.

5.2 Practice Risk Groups 3 and 4

Practices with a higher average CMS-HCC risk score of attributed Medicare beneficiaries will have a slightly different set of quality measures to account for the clinical needs of higher-risk patient populations. Practices with an average risk score between 1.5 and 2.0 are placed in Practice Risk Group 3, and those with a practice average risk score greater than 2.0 are placed in Practice Risk Group 4.

5.2.1 Quality Gateway

The Quality Gateway for Practice Risk Groups 3 and 4 functions in the same way as the Quality Gateway for Practice Risk Groups 1 and 2. However, Practice Risk Groups 3 and 4 are evaluated on a slightly different set of quality measures to account for their patients' specific clinical and supportive needs. For these 2 practice risk groups, 2 quality measures are assessed in Performance Year 2021 for application of the Quality Gateway in the following year: (1) Advance Care Plan (MIPS CQM) and (2) PECS. The PECS measure for Practice Risk Groups 3 and 4 is the same as the PECS measure used for Practice Risk Groups 1 and 2.

The set of quality measures for Risk Groups 3 and 4 practices will roll out during the first 3 performance years as they are developed and finalized.

CMS is also developing 1 additional quality measure for use in later years of the model: Days at Home. In Performance Year 2021, CMS tracks this measure to support the measure development and data validation process. CMS expects that this new measure will be endorsed by the National Quality Forum (NQF) and will be ready to be incorporated into the Quality Gateway in 2023 (based on performance during 2022).

In 2023, the Quality Gateway (based on performance during 2022) will be based on 3 measures: (1) Advance Care Plan (MIPS CQM measure), (2) PECS, and (3) Days at Home. The Quality Gateway and cost measures are summarized in Table 5-4 by measure ID, measure steward, benchmark population, and benchmark.

5.2.1.1 Advance Care Plan Clinical Quality Measure

For Performance Year 2021, CMS reviewed current measures used by other CMS programs for quality reporting, such as MIPS, and identified 1 MIPS CQM designed to indicate quality of care specifically relevant to primary care and complex patient populations. This measure, the Advance Care Plan, is a MIPS CQM, formerly known as a registry measure.

Practices that do not successfully report the Advance Care Plan measure at the practice site level will automatically fail the Quality Gateway. Practices must select a MIPS approved qualified registry or QCDR with the capability to filter and report the Advance Care Plan measure at the practice site level.

Table 5-4
Quality and Cost Measures for Practice Risk Groups 3 and 4

Measure Category	Measure Title (Type)	NQF/ Quality ID	Measure Steward	Performance Years[d]	Benchmark Population	Benchmark for Performance Year 2021
Quality Gateway[a]	Advance Care Plan (MIPS CQM measure)	NQF ID: 0326 Quality ID: 47	NCQA [b]	2021–2024	MIPS	Pay-for_Reporting[e]
	Patient Experience of Care Survey (CAHPS with supplemental items)	NQF ID: 0005[c]	AHRQ	2021–2024	PCF population	30th percentile: 77.52%
	Days at Home Measure	N/A	N/A	2022–2024	Historical reference population	30th percentile: N/A
Cost Measure for PBA Calculation	Total Per Capita Cost Measure, adapted for Primary Care First	N/A	CMS	2021–2024	PCF and non-PCF Medicare reference population	50th percentile: 0.98[f]

AHRQ = Agency for Healthcare Research and Quality; N/A = not applicable; TPCC = Total Per Capita Cost.

[a] CMS assesses the measures in the Quality Gateway in the first performance year and applies the results in the following year. For example, the Quality Gateway applied in 2022 will be based on performance during 2021.

[b] For more information about NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures, please see Appendix D.

[c] The PCF PECS includes a combination of items from the Clinician and Group CAHPS (NQF ID 0005) as well as from the Patient-Centered Medical Home (PCMH) CAHPS Supplement.

[d] Performance year refers to the measurement period of the measure. Each measure has a 1-year measurement period (TPCC is calculated with rolling 1-year performance period). The results of quality measures in the Quality Gateway are applied to the Quality Gateway in the following year.

[e] Practices will only be assessed on their ability to report the Advance Care Plan Measure. Cohort 1 practices that fail to report via a qualified registry or qualified clinical data registry will not be eligible for a positive performance-based adjustment (PBA) in Performance Year 2022.

[f] The preliminary national benchmark for TPCC is intended to illustrate potential performance thresholds.

5.2.1.1.1 CQM: Requirements for Satisfying the Process Measure

To satisfy this measure, practices must use the CQM version applicable for the measurement period. The measure steward updates the measure specifications annually. Once available, the CQMs for the 2021 Measurement Period can be accessed by selecting "2021" in the Quality Measures section on the QPP website.[29]

5.2.1.1.2 CQM: Reporting Method and Instructions

Practices report the Advance Care Plan measure using a health IT vendor from the MIPS final approved lists of qualified registries and QCDRs for the respective performance year. Practices

[29] https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&py=2020#measures

must use a health IT vendor from 1 of these lists. Practices will work with the health IT registry vendor to submit the measure and ensure accuracy of the submission. All practices are required to report data that covers the entire 12-month measurement period for the Advance Care Plan measure. Practices with a planned health IT system or vendor transition during Performance Year 2021 must ensure that all data are transferred from their prior health IT systems or leverage additional health IT to meet this requirement.

5.2.1.1.3 CQM: Benchmark

The Advance Care Plan measure was updated to a pay-for-reporting measure status for Performance Year 2021. This means that practices will only be assessed on their ability to report this measure to pass the minimum quality threshold. Practices must report the Advance Care Plan measure using a qualified registry or QCDR for Performance Year 2021. Practices that fail to report via a qualified registry or QCDR will not be eligible for a positive performance-based adjustment (PBA) in Performance Year 2022.

5.2.1.1.4 CQM: Performance Period and Scoring

Practices must successfully report the Advance Care Plan measure at the practice site level, starting with Performance Year 2021. Practices must report the measure annually. The first expected reporting period is tentatively scheduled from January 3, 2022, through February 28, 2022. CMS will communicate reporting period dates yearly.

5.2.1.2 Days at Home Measure in Development

CMS plans to begin collecting data on the intensive care coordination aspects of caring for complex chronic patients. One additional quality measure will be developed and added to the Quality Gateway for Practice Risk Groups 3 and 4 in future years:

- **Days at Home** is a claims-based measure that measures the number of days a beneficiary remains outside of an institutional care setting during a standardized time period. For this measure, the standardized time period for each beneficiary will be all days attributed to the practice.

Older adults and people experiencing serious illness have identified time spent at home and not in a hospital or nursing home as an extremely important and desirable outcome of their medical care (Barnato et al., 2007; Sayer, 2016; Xian et al., 2015). Consistent with efforts to incorporate more patient-centered measures into health services delivery and research, particularly for seriously ill populations for whom traditional CQMs may not be appropriate, Days at Home has recently been identified as a valuable new measure. It not only captures an outcome valued by patients but also is an objective measure readily calculated using claims data.

Various measures of days at home have been validated in a range of clinical populations, including adults undergoing surgical procedures, experiencing congestive heart failure, and recovering from a stroke (Bell et al., 2019; Greene et al., 2018; Jerath, Austin, & Wijeysundera, 2019; Myles et al., 2017; Quinn et al., 2008; Yu et al., 2017). These validation studies have

demonstrated significant associations between days at home and patient characteristics, objective clinical measures, and other validated measures of quality. They have also indicated that days at home has substantial prognostic value for patients. Given the value of time spent at home to patients and the promising results from validation studies, days at home measures are now being used as an outcome measure in a variety of programs and studies.

Although not in the Quality Gateway measure set until Performance Year 2023 (based on performance during 2022) at the earliest, practice performance on this measure will be monitored starting in 2021. CMS expects that this new measure will be endorsed by the NQF and will be ready for implementation in the Quality Gateway in 2023.

5.2.1.3 Days at Home: Benchmark

When the Days at Home measure is ready for implementation, CMS will evaluate performance by comparing a practice's performance with benchmarks derived using a reference population. CMS will publish benchmark thresholds for the Days at Home measure each performance year so Risk Group 3 and 4 practices know how their performance will be rewarded and can maximize their effort to be eligible for a positive PBA.

5.2.2 Cost Measure (Total per Capita Cost of Care, adapted for Primary Care First)

The TPCC measure, adapted for Primary Care First, is a payment-standardized, risk-adjusted measure that evaluates the overall observed-to-expected (O/E) ratio of costs of care provided to beneficiaries attributed to practices for a specified period of time. CMS calculates TPCC on a quarterly basis for all beneficiaries attributed to practices in Risk Groups 3 and 4.

For Practice Risk Groups 3 and 4, CMS uses TPCC performance to determine a practices' PBA based on how their performance compares against a national benchmark, peer region group performance, and its own historical performance. The TPCC measure serves the same function for Practice Risk Groups 3 and 4 that the AHU measure serves for Practice Risk Groups 1 and 2. Chapter 6 describes this methodology in detail.

5.2.2.1 TPCC: Calculation of Cost Measure

The TPCC measure is claims-based and does not require practice reporting. CMS calculates the measure each quarter, beginning in Q2 2022. The TPCC measure is reported as an O/E ratio of the overall costs of care provided to beneficiaries attributed to Risk Group 3 and 4 practices for all attributed beneficiary quarters. For each practice, the observed cost is compared with the expected cost, which is adjusted for certain factors within the practice patient population, such as age, disability, and comorbidities. The comparison is expressed as an O/E ratio. An O/E ratio greater than 1 represents greater-than-expected cost, and a ratio less than 1 represents lower-than-expected cost.

Practices are measured each quarter by the payment-standardized, risk-adjusted total costs of care incurred by attributed beneficiaries in Practice Risk Groups 3 and 4 during the performance period. All standardized allowed charges under Medicare FFS incurred by each attributed

beneficiary in the quarter count toward the measure. CMS calculates beneficiary risk scores on a rolling basis using the prior year of claims, as described in Section 3.1.2, to risk-adjust the TPCC measure within each quarter during the measurement period. CMS then calculates the annual TPCC measure by taking each practice's average TPCC across all eligible beneficiary quarters in the measurement period. Appendix G contains detailed specifications for the TPCC measure.

5.2.2.1.1 TPCC: Performance Periods

The PBA performance periods are the same for all practice risk groups; however, the PBA for Practice Risk Groups 3 and 4 is based on TPCC performance (rather than AHU performance). Beginning in Q2 2022, CMS calculates the TPCC measure each quarter, using a rolling 1-year performance period that ends 3 months before the PBA quarter. For example, the Q2 2022 PBA is based on TPCC performance from January 1, 2021 through December 31, 2021 (Q1 2021 through Q4 2021). CMS uses data from each quarter of the performance period for the cost calculation and data from the prior 4 quarters for risk adjustment. For an overview of the PBA performance period timeline, see Figure 5-2.

5.2.2.1.2 TPCC: Benchmark

CMS publishes benchmark thresholds, so practices know how their TPCC performance will be assessed. The benchmarks establish the thresholds practices must reach to earn different PBA amounts. The preliminary national and regional benchmarks for Performance Year 2021 can be found in Appendix F. CMS will continue to assess patterns of care during calendar year 2020 and may revise these benchmarks to preserve equity before and after calendar year 2020. Details on CI benchmarks are in Section 5.1.2.2.2 and Table 5-3.

To derive the preliminary TPCC benchmarks for Performance Year 2021, CMS used a 2019 national reference population. This population is made up of CPC+ practices (identified at the TIN-NPI level) and the universe of Medicare FFS practices and their attributed Medicare beneficiaries. The universe of Medicare FFS practices includes unique TIN and NPI combinations (TIN-NPIs) and unique CCN and NPI combinations (CCN-NPIs). In future years, it will also include PCF practices and their attributed Medicare beneficiaries, when their data is available. Beneficiaries are attributed to Medicare FFS practices using the same attribution algorithm as the PCF claims-based attribution algorithm, including limiting to reference practices whose practice average risk score among attributed beneficiaries met the criteria for Risk Groups 3 or 4. To derive reliable benchmarks, CMS only includes Medicare FFS practices with at least 20 attributed beneficiaries in each quarter who were eligible for inclusion in the measure. The preliminary TPCC national benchmark for Performance Year 2021 was calculated from 43,819 practice observations, which included CPC+ practices and Medicare FFS practices (TIN-NPI or CCN-NPI combinations).

CMS calculates the payment-standardized, risk-adjusted TPCC measure for all attributed beneficiary quarters in the reference population for the reference year. For the national benchmark, CMS uses all eligible beneficiaries in all reference population practices.

CMS establishes regional peer group benchmarks by using TPCC performance from practices included in the national benchmarks but located in a defined region. CMS develops TPCC peer group regions by first calculating performance for each individual state, then grouping states with similar performance levels and proximal geography. The peer group regions used for TPCC benchmarks are different than those used for AHU benchmarks because of differing performance rates. Appendix H contains preliminary TPCC regional peer groups.

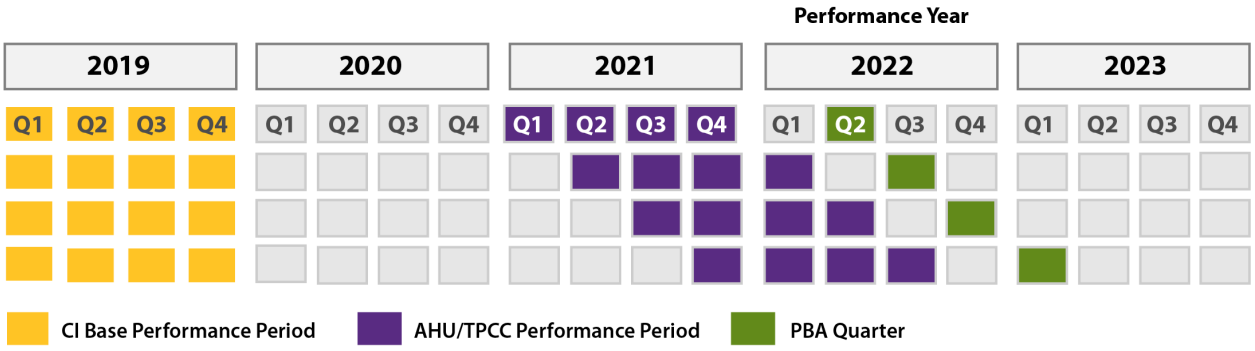
5.2.2.2 TPCC: Continuous Improvement Bonus

The CI bonus for Practice Risk Groups 3 and 4 functions the same as the CI bonus for Risk Groups 1 and 2; however, the CI bonus for Practice Risk Groups 3 and 4 is based on the TPCC measure performance for each practice (rather than the AHU measure). Beginning in Q2 2022, CMS calculates the CI bonus for all practices quarterly by comparing their TPCC performance during the same performance period as the Regional Performance Adjustment to a historical 1-year base performance period (see Figure 5-2 for an overview of the CI base performance periods). For more information on the CI bonus for Practice Risk Groups 1 and 2, see Section 5.1.2.2. The CI bonus added to the Regional Performance Adjustment produces the overall PBA (Chapter 6 describes this methodology in detail).

5.3 Timeline of PBA Performance Periods

The timeline of PBA performance periods is the same for all practice risk groups. However, the Regional Performance Adjustment and CI adjustment are based on different measures for each practice risk group. For Practice Risk Groups 1 and 2, CMS uses the AHU measure. For Practice Risk Groups 3 and 4, CMS uses the TPCC. Figure 5-2 below provides an overview of the PBA performance period timeline. For example, Q2 2022 PBA has a performance period that spans Q1–Q4 2021, and Q3 2022 PBA has a performance period from Q2 2021 through Q1 2022. For the PBA in Q2–Q4 2022, the CI Base Performance Period is the same which is from Q1–Q4 2019.

Figure 5-2
Timeline of PBA Performance Periods



Chapter 6: Performance-Based Adjustment

Chapter 6 describes the PBA methodology for the PCF component for payments in 2022 and the plan for subsequent performance years. The PBA is designed to reward practices that meet key quality standards and work continuously to reduce unnecessary hospital utilization and total cost of care. Beginning in Q2 2022, the PBA is an adjustment to both the Professional PBP and FVF, or TPCP. CMS determines the PBA using the practice's performance on 1 utilization (AHU) or cost (TPCC) measure (depending on practice risk group) and certain quality measures (Quality Gateway). The PBA has a potential downside risk of −10% of TPCP revenue and a maximum potential upside of 50% of TPCP revenue.

Section 6.1 provides an overview of the elements of the PBA. Section 6.2 describes the calculation of the estimated TPCP. Section 6.3 explains the calculation process for PBA and provides an example of an adjustment to a practice's payment.

6.1 Performance-Based Adjustment Percentage

The PBA has 2 elements: a Regional Performance Adjustment and a CI bonus. For Practice Risk Groups 1 and 2, the PBA is based on a utilization measure: AHU. For Practice Risk Groups 3 and 4, the PBA is based on a cost measure: TPCC, adapted for Primary Care First. Each measure has a 1-year performance period. CMS calculates and applies the PBA on a rolling quarterly basis, so practices receive rapid recurring performance feedback.

6.1.1 Calculation of Percentage

For all practice risk groups, 4 factors influence practices' PBA amounts each quarter:

1. Annual Quality Gateway
2. AHU/TPCC performance compared with the National Benchmark
3. AHU/TPCC performance compared with their peer region group (Regional Performance Adjustment)
4. AHU/TPCC performance compared with their own historical performance (CI Bonus)

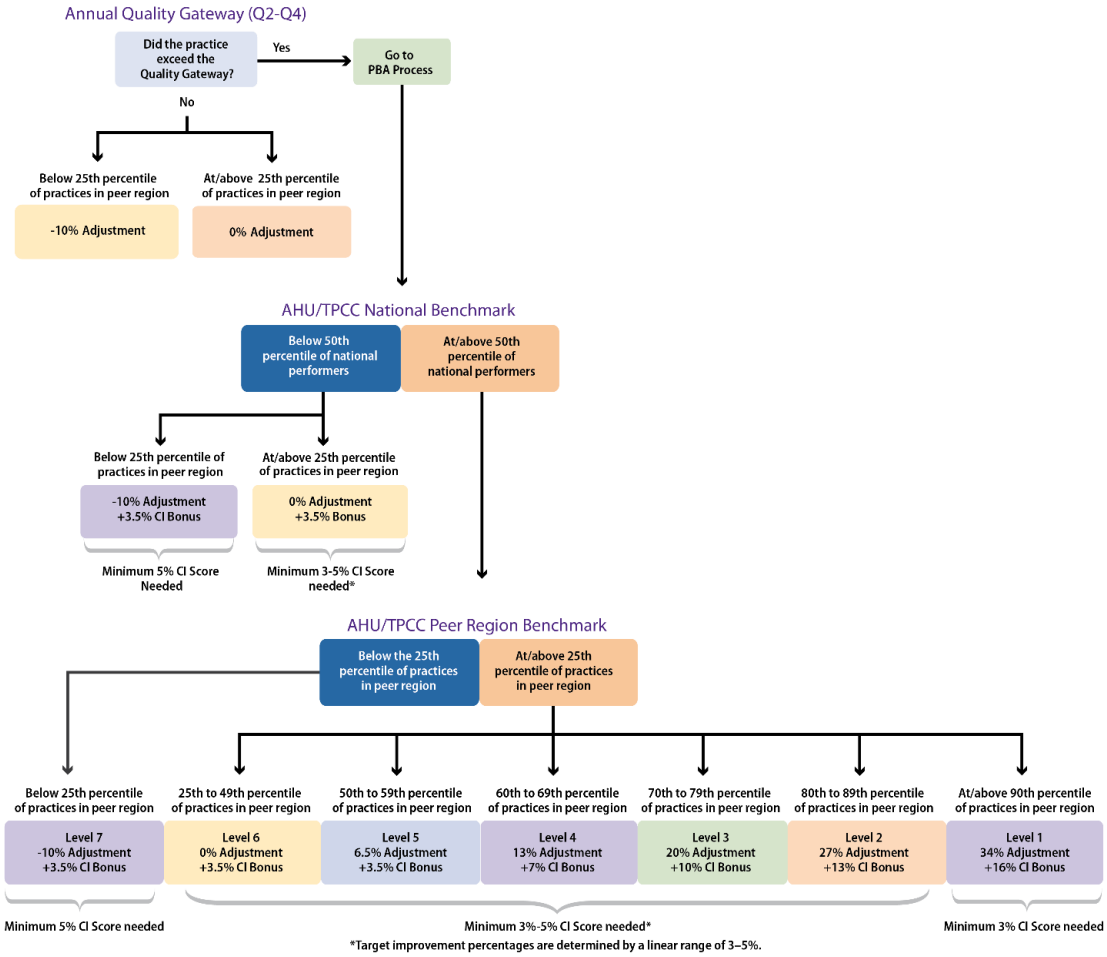
Beginning in Q2 2022, CMS will assess the Quality Gateway annually, and use the results to determine the PBA for each quarter during the calendar year[30]. For practices that meet or exceed the minimum thresholds of the Quality Gateway, CMS compares the practice's AHU performance (for Risk Groups 1 and 2) or TPCC performance (Risk Groups 3 and 4) to the national benchmark each quarter to determine eligibility for a positive Regional Performance Adjustment. CMS calculates the Regional Performance Adjustment by comparing a practice's AHU/TPCC performance to a peer region benchmark, established by CMS using data from a reference group of practices (including practices that do not participate in PCF). The CI bonus

[30] The Quality Gateway that affects payments in 2022 (Q2–Q4) is based on prior year performance on quality measures during Performance Year 2021.

also influences the PBA amount. A practice's performance relative to its peer region affects the amount of practice improvement it needs to earn the CI bonus, as well as the CI bonus amount. CMS calculates the amount of practice improvement by comparing a practice's current AHU/TPCC performance to their own historical performance on the measure.

Each quarter, CMS compares practice performance first to a national benchmark, then to peer region benchmarks, and finally CMS compares practices' performance with their historical performance to determine their CI bonus. Beginning in Q2 2022, practices that pass the Quality Gateway but are below the national benchmark for their respective measures will only be eligible for a −10% or 0% Regional Performance Adjustment, depending on their AHU/TPCC performance compared to their peer region group, but will remain eligible for a CI bonus. For practices that pass the national benchmark for AHU or TPCC (meet or exceed the 50th percentile), there are 7 possible performance levels for the Regional Performance Adjustment (as shown in Figure 6-1 below).

Figure 6-1
PBA Process for Performance Year 2022



Practices failing to pass the Quality Gateway will receive a neutral PBA (0%) or negative PBA (−10%), depending on their AHU or TPCC performance. In 2022, practices that fail the Quality Gateway (based on prior year performance) will receive either a 0% PBA if their quarterly AHU or TPCC performance is at or above the 25th percentile of practices in their peer region, or a −10% PBA if their quarterly AHU or TPCC performance is below the 25th percentile of practices in their peer region. In 2023 and beyond, practices that do not meet the Quality Gateway will automatically receive a −10% annual PBA. Only practices that pass the annual Quality Gateway will be eligible for the CI bonus.

Figure 6-1 outlines the steps of the Quality Gateway and PBA process for payments in 2022.

6.1.1.1 Quality Gateway

The Quality Gateway is first implemented in 2022, based on performance on quality measures during 2021, and it is assessed annually thereafter. To pass the Quality Gateway, practices must meet minimum thresholds on quality measures. The measures that comprise the Quality Gateway are based on the practice's risk group. See Section 5.1.1 for a detailed description of the quality measures for Practice Risk Groups 1 and 2, and Section 5.2.1 for the quality measures for Practice Risk Groups 3 and 4.

Beginning in Q2 2022, CMS will use the annual Quality Gateway results to determine whether a practice is eligible for a positive PBA for each quarter during the calendar year to which it applies. For all PBA quarters in 2022, practices that fail the Quality Gateway (based on prior year performance) will receive either a neutral PBA (0%) or negative PBA (−10%), depending on their AHU or TPCC performance. For PBA quarters starting in 2023, practices that do not meet the Quality Gateway will automatically receive a negative PBA (−10%). Only practices that pass the annual Quality Gateway will be eligible for the CI bonus. Results of the annual Quality Gateway in 2022 (based on performance during 2021) will become available in Q3 2022. CMS may revise this timeline for the Quality Gateway, pending audit results. These results will be applied retrospectively to payments made in Q2 2022. If CMS determines in Q3 that a practice does not pass the Quality Gateway, any positive PBA payments made in Q2 2022 will be debited from future quarterly payments.

6.1.1.2 National Benchmark

The national benchmark for the AHU and TPCC measures is set at the 50th percentile and, in conjunction with the Quality Gateway and peer region performance, determines practice eligibility for a positive Regional Performance Adjustment. Beginning in Q2 2022, practices that pass the Quality Gateway but are below the national benchmark for their respective measures will receive either a neutral Regional Performance Adjustment (0%) or a negative Regional Performance Adjustment (−10%), depending on their AHU or TPCC performance, but will remain eligible for a CI bonus. The specific PBA amount that a practice receives depends on its AHU or TPCC performance relative to their peer region benchmark, which CMS establishes based on AHU or TPCC performance for a reference group of practices in the same peer region

group (Regional Performance Adjustment), as well as its performance relative to its own historical experience (CI Bonus).

6.1.1.3 Regional Performance Adjustments

To calculate the Regional Performance Adjustment, CMS establishes and compares practices' AHU or TPCC performance to a peer region benchmark using data from a reference group of practices (including non-PCF practices) by geographic region.[31] This approach incentivizes PCF practices to provide better quality of care relative to all other practices within their peer region, while creating the potential for all PCF practices to earn a positive Regional Performance Adjustment (because they are competing against both PCF and non-PCF practices, as opposed to other PCF practices only). A Regional Performance Adjustment also accounts for patient characteristics and care patterns that are specific to a particular geographic area but may not be fully captured by risk adjustment.

CMS establishes 7 regional performance level thresholds, or peer region benchmarks, for the AHU and TPCC—the 90th percentile, 80th to 89th percentile, 70th to 79th percentile, 60th to 69th percentile, 50th to 59th percentile, 25th to 49th percentile, and below the 25th percentile (as shown in Figure 6-1 above). CMS calculates Regional Performance Adjustments quarterly using a rolling 1-year performance period and applies them to payments starting in Q2 2022. CMS uses AHU or TPCC performance, depending on the practice risk group, to determine the Regional Performance Adjustments.

Beginning in Q2 2022, practices that meet or exceed the national benchmark for AHU or TPCC (50th percentile) receive a Regional Performance Adjustment between −10% and 34%. Like the national benchmark, if the practice is below the 50th percentile of their peer region group, it is not eligible to receive a positive regional performance adjustment (only eligible for −10% or 0% depending on peer region group performance), but will remain eligible for a CI bonus.

The specific PBA amount that a practice receives depends on its regional performance level, as well as its performance relative to its own historical experience (CI Bonus). This approach is intended to reward high-achieving practices that are optimizing outcomes, while acknowledging the importance of regional characteristics of care and continuous practice improvement (CI bonus). Appendix H contains preliminary AHU and TPCC peer region groups.

6.1.1.4 Continuous Improvement Bonus

The CI bonus rewards a practice's individual performance improvement on the AHU or TPCC measure. Beginning in Q2 2022, CMS calculates the CI bonus quarterly. To calculate the practice's CI score, defined as the percent improvement between the performance periods, CMS compares the practice's current AHU/TPCC performance (same performance period as

[31] This region-specific benchmark is based on a reference group of Medicare providers in comparably performing regions. The benchmark, made available to practices at the beginning of the model, is updated annually. The peer region groups are defined differently for AHU and TPCC to account for geographic variation in performance between the two measures.

the Regional Performance Adjustment) to its own historical performance in a 1-year base period before the current quarter's performance period (see Figure 5-2 for an overview of the CI base performance periods). CMS uses the CI score and the practice's regional performance level to determine the amount of CI bonus. See Section 5.1.2.2.2 for details on how CI score is used to determine the CI bonus amount. CI bonus amounts are applied to quarterly PBA amounts and, with the Regional Performance Adjustment, produce the overall PBA.

Practices that pass the Quality Gateway are eligible for the CI bonus, even if their AHU/TPCC performance is in the lowest half of all practices nationally (i.e., does not meet national benchmark) and lowest quartile of all peer region practices. This policy rewards participating practices that do not meet or exceed national or regional AHU benchmarks to receive a CI bonus if they improve over time, and it also incentivizes high-performing practices to continuously improve.

6.1.2 Timeline for Performance-Based Adjustment Application

The PBA is an adjustment to the quarterly TPCP. Beginning in Q2 2022, CMS calculates the PBA quarterly. Each quarter, the PBA is based on practices' AHU/TPCC performance during a rolling 1-year performance period that ends 3 months prior to the PBA quarter. For example, the Q2 2022 PBA is based on performance from January 1, 2021 through December 31, 2021 (Q1 2021 through Q4 2021). This timeline is intended to make the PBA as responsive to changes in practice performance as possible. CMS will also assess Quality Gateway results annually, which will be applied retrospectively to payments beginning Q2 2022.[32] The annual Quality Gateway is based on practices' performance on quality measures during the prior performance year, and results will become available 3 quarters after the performance year ends. For example, the 2021 Quality Gateway is based on performance during 2021 and will become available in Q3 2022. Figure 6-2 illustrates the overall timeline for applying the Quality Gateway results to the quarterly PBA payments. For an overview of the PBA performance period timeline, see Figure 5-2.

[32] PBA amounts, including CI bonuses, paid during the first 2 quarters of each performance year are recouped if the practice fails the Quality Gateway when it is calculated in the third quarter.

Figure 6-2
Timeline for Quality Gateway Performance and Application to PBA

	Quality Gateway Performance	Application of Quality Gateway	Effects of Failing Quality Gateway
Q1 2021	2021 Performance Period		
Q2 2021			
Q3 2021			
Q4 2021			
Q1 2022	2022 Performance Period		
Q2 2022			Negative adjustment to Q2 2022 PBA
Q3 2022		2021 QG applied	Negative adjustment to Q3 2022 PBA
Q4 2022			Negative adjustment to Q4 2022 PBA
Q1 2023	2023 Performance Period		Negative adjustment to Q1 2023 PBA
Q2 2023			Negative adjustment to Q2 2023 PBA
Q3 2023		2022 QG applied	Negative adjustment to Q3 2023 PBA
Q4 2023			Negative adjustment to Q4 2023 PBA
Q1 2024	2024 Performance Period		Negative adjustment to Q1 2024 PBA
Q2 2024			Negative adjustment to Q2 2024 PBA
Q3 2024		2023 QG applied	Negative adjustment to Q3 2024 PBA
Q4 2024			Negative adjustment to Q4 2024 PBA

QG = Quality Gateway.

6.2 *Total Primary Care Payment Calculation*

The TPCP is the sum of 2 elements: the Professional PBP and the FVF.

To illustrate TPCP (before PBA is applied), High Street Practice in Risk Group 2 has 500 attributed beneficiaries in the current quarter (Q3 2022). Their leakage adjustment is calculated to be 15%, which will be applied as an adjustment to their Professional PBP for the quarter.[33] Tables 6-1a and 6-1b display this example in more detail.

[33] This example TPCP calculation is for Q3 2022 payment, to show implementation of the leakage rate adjustment.

Table 6-1a
Example of TPCP PBPM Calculation for Practice Risk Group 1 in Q3 2022

Professional PBP for Group 2 Practice	* (1 − Leakage) Rate	= Paid Professional PBP	+ FVF (Estimated)[a]	= TPCP PBPM[b]
$28	* 85%	= $23.80	+ $19	= $42.80

Table 6-1b
Example of Quarterly TPCP Calculation for Practice Risk Group 1 in Q3 2022

Q3 2022 Attributed Beneficiaries	* TPCP PBPM	= TPCP
800	* $42.80	= $34,240

PBPM = per-beneficiary per-month.
[a] FVF PBPM represents an estimated number of FVF-eligible services on a monthly basis.
[b] TPCP is calculated on a monthly basis but paid on a quarterly basis.

6.3 Performance-Based Adjustment Amount

6.3.1 Calculation of Dollar Amount

When the PBA is implemented in Q2 2022, the Regional Performance Adjustment and CI bonus are added together each quarter to determine the total PBA percentage which will be used to calculate the quarterly PBA amount based on the practice's estimated TPCP. Tables 6-2 and 6-3 summarize the possible adjustments practices can receive on the basis of their Regional Performance Adjustment and CI bonus. Table 6-2 presents the possible Regional Performance Adjustment and CI bonus percentages for practices that meet or exceed the 50th percentile national benchmark on AHU or TPCC performance. Table 6-3 presents the possible adjustments for those who do not meet or exceed the 50th percentile national benchmark.

Table 6-2
PBA Potential for Practices that Meet or Exceed the 50th Percentile of National Performers on AHU or TPCC

AHU/TPCC Regional Performance Level	Regional Performance Adjustment (% of TPCP)	CI Bonus (% of TPCP)	Maximum Adjustment (% of TPCP)
Level 1: At or above 90th percentile of practices in each region	34%	16%	50%
Level 2: 80th to 89th percentile of practices in each region	27%	13%	40%
Level 3: 70th to 79th percentile of practices in each region	20%	10%	30%
Level 4: 60th to 69th percentile of practices in each region	13%	7%	20%
Level 5: 50th to 59th percentile of practices in each region	6.5%	3.5%	10%
Level 6: 25th to 49th percentile of practices in each region	0%	3.5%	3.5%
Level 7: Below 25th percentile of practices in each region	−10%	3.5%	−6.5%

Note: This table applies only to practices that pass the Quality Gateway. For PBA quarters during Performance Year 2022 (Q2–Q4), practices that do not pass the Quality Gateway receive either a −10% or 0% PBA. Starting in Performance Year 2023, practices that do not pass the Quality Gateway receive an automatic −10% adjustment and are not eligible for the CI bonus.

Table 6-3
PBA Potential for Practices That Do Not Meet the 50th Percentile of National Performers on AHU or TPCC

AHU/TPCC Regional Performance Level	Regional Performance Adjustment (% of TPCP)	CI Bonus (% of TPCP)	Maximum Adjustment (% of TPCP)
At or above 25th percentile of practices in each region	0%	3.5%	3.5%
Below 25th percentile of practices in each region	−10%	3.5%	−6.5%

Note: This table applies only to practices that pass the Quality Gateway. For PBA quarters during Performance Year 2022 (Q2–Q4), practices that do not pass the Quality Gateway receive either a −10% or 0% PBA. Starting in Performance Year 2023, practices that do not pass the Quality Gateway receive an automatic −10% adjustment and are not eligible for the CI bonus.

To calculate the total PBA dollar amount for each quarter, the total quarterly PBA percentage is applied to the practice's estimated TPCP for that quarter (see Figure 6-3 below for an example of a quarterly payment calculation).

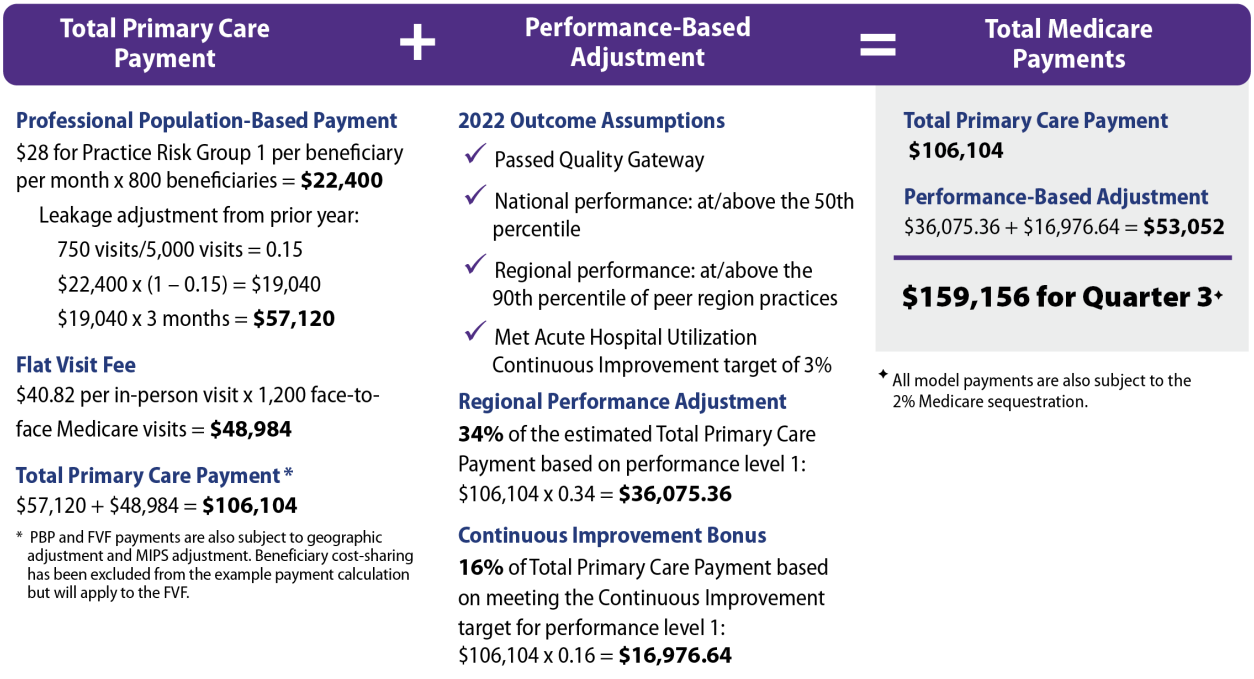
6.3.2 Example of Quarterly Payment Calculation

The quarterly payment for a practice participating in the PCF component is the sum of the TPCP and the PBA and can be calculated as follows:

- Quarterly model payment = TPCP + PBA
    - TPCP = (Professional PBP based on practice's risk group and leakage adjustment) * (# of attributed beneficiaries) + (FVF * # of visits)
    - PBA = TPCP * (−10% up to 50%, based on performance)

As stated above, high-performing practices can increase their TPCP by up to 50% by combining the Regional Performance Adjustment and CI bonus based on their AHU or TPCC performance. Figure 6-3 provides an example of a quarterly payment calculation for a practice in Risk Group 1 for Q3 2022. This includes how the TPCP is determined for a quarter and how the PBA affects that amount, based on certain performance outcomes. In the left column, it shows calculations of the 2 types of payments for TPCP: a PBP based on the number of beneficiaries attributed to the practice and leakage adjustment, and a FVF for claims submitted for office and home visits. In the middle column, the PBA is calculated based on corresponding outcome measure (i.e., AHU) for a practice in Risk Group 1. In the right column, the total Medicare payments are calculated by summing up the TPCP and PBA amounts, which equals to $159,156 in total.

Figure 6-3
Example of Quarterly Payment Calculation for Practice Risk Group 1 in Q3 2022



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Appendix A: Glossary of Terms

Accountable Care Organizations (ACOs): Groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) offers several ACO programs and models: the Medicare Shared Savings Program; the ACO Investment Model, a supplementary incentive program for selected participants in the Shared Savings Program; and the Next Generation ACO Model, designed for early coordinated care adopters.

Acute Hospital Utilization (AHU): Utilization measure for Practice Risk Groups 1 and 2 that determines their performance-based adjustment (PBA).

Advance Care Plan: A service between a Medicare physician (or other qualified health care professional) and a patient to discuss the patient's health care wishes if they become unable to make decisions about their care. Advance Care Plan is 1 of the Quality Gateway measures for all practices participating in the Primary Care First (PCF) component.

Alternative Payment Models (APMs): Payment approaches, developed in partnership with the clinician community, that provide added incentives to deliver high-quality and cost-efficient care. APMs can apply to a specific clinical condition, care episode, or population.

Annual Wellness Visit: Visit to develop or update a personalized prevention plan and perform a health risk assessment. Medicare patients are eligible for an Annual Wellness Visit once every 12 months.

Attribution: Used to align beneficiaries to primary care practices. In the PCF component, attribution is used to calculate the Professional Population-based Payments (PBPs), pay flat visit fees (FVFs), and set the practice's risk group. CMS uses Medicare claims and eligibility data to conduct beneficiary attribution.

Benchmark: Benchmarks are sustained superior performances by a practice or clinician that can be used as reference to raise the standard of care for Medicare beneficiaries. Benchmarks establish the minimum levels that participating PCF practices must reach to earn a positive PBA.

Chronic Care Management (CCM)–Related Services: Healthcare Common Procedure Coding System (HCPCS) (and corresponding add-on codes) are duplicative of the services covered by the Professional PBP. Medicare will not pay both a Professional PBP and fees for CCM-related services for any individual beneficiary in the same month.

Clinical Quality Measure (CQM): Tools that help measure and track the quality of health care services that eligible professionals, eligible hospitals, and critical access hospitals provide.

CMS Certification Number (CCN): To avoid confusion with the National Provider Identifier (NPI), the Medicare/Medicaid Provider Number (also known as the OSCAR [Online Survey,

Certification and Reporting] Provider Number, Medicare Identification Number, or Provider Number) has been renamed the CCN. The CCN continues to serve a critical role in verifying whether a clinician has been Medicare certified and for what type of services.

Cohort 1: Practices that will start participating in Primary Care First on January 1, 2021.

Cohort 2: Practices that will start participating in Primary Care First on January 1, 2022.

Comprehensive Kidney Care Contracting (CKCC) Model: A new CMS Innovation Center kidney care model that builds upon the center's existing kidney care model by adding strong financial incentives for health care providers to manage the care for Medicare beneficiaries with chronic kidney disease stages 4 and 5 and end-stage renal disease, to delay the onset of dialysis and to incentivize kidney transplantation.

Comprehensive Primary Care Plus (CPC+): CMS Innovation Center advanced primary care medical home model that aims to strengthen primary care through regionally based multipayer payment reform and care delivery transformation. CPC+ includes 2 primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. CPC+ is a 6-year model with 2 cohorts, 1 cohort that began participation in January 2017, and another that began participation in January 2018.

Consumer Assessment of Healthcare Providers and Systems® (CAHPS®): Asks consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics important to consumers and focus on aspects of quality that consumers are best qualified to assess, like providers' communication skills and ease of access to health care services. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Continuous Improvement (CI) Bonus: Rewards a practice's individual performance on the AHU or TPCC measure. The practice's performance will be compared with its own performance during a 1-year base period before the performance period. Eligible practices will earn a CI bonus to their quarterly payments. CI is part of the PBA.

Critical Access Hospital (CAH): A Medicare provider type with its own Medicare Conditions of Participation and payment method. CAHs are typically small facilities that provide outpatient services, as well as inpatient services on a limited basis, to beneficiaries in rural areas.

Direct Contracting Model: A set of voluntary Innovation Center payment model options aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare fee-for-service (FFS).

Electronic Clinical Quality Measure (eCQM): CQMs that use data from electronic health records (EHRs), health IT systems, or both to measure health care quality. CMS uses eCQMs in a variety of quality reporting and incentive programs.

Eligible Primary Care Visit: Used in the PCF attribution algorithm. Primary care visits include evaluation and management (E&M) services provided via office visits, other non-inpatient and non–emergency department (ED) settings, and initial Medicare visits and Annual Wellness Visits. Specifically, eligible primary care visits include home care; Welcome to Medicare and Annual Wellness Visits; advance care planning; the collaborative care model; cognition and functional assessments for patients with cognitive impairment; outpatient clinic visits for assessment and management (CAHs only); transitional care management services; CCM services; complex CCM services; assessment/care planning for payments with CCM services; and care management services for behavioral health conditions.

End-Stage Renal Disease: Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Evaluation & Management (E&M) Office Visits: Medicare-covered services (office visits) used in attribution and included in the PBP and FVF, furnished by a participating PCF practitioner to a PCF beneficiary and billed under the Taxpayer Identification Number (TIN)/NPI (or CCN/NPI) of the PCF practice.

Fee-For-Service (FFS): A payment system in which clinicians are paid for each service performed according to a payment fee schedule. Examples of services include tests and office visits.

Financial Alignment Initiative: An initiative designed to provide individuals dually enrolled in Medicare and Medicaid with a better care experience and to better align the financial incentives of the Medicare and Medicaid programs. Through the initiative, CMS partners with states to test 2 new models for their effectiveness in accomplishing these goals. This initiative is possible through the collaboration of the CMS Innovation Center and the CMS Medicare-Medicaid Coordination Office.

Flat Visit Fee (FVF): Flat payment to practices for each face-to-face primary care patient encounter between PCF providers and their attributed beneficiaries.

Geographic Adjustment Factor (GAF): A general term used to refer to a collection of several different geographic adjustments. Geographic adjustments are intended to ensure that CMS does not overpay certain hospitals and practitioners and underpay others as a result of geographic differences in prices for resources, such as clinical and administrative staff salaries and benefits, office or hospital space (rent), malpractice insurance (premiums), and other resources that are part of the cost of providing care. As a result, Medicare's Inpatient Prospective Payment System, other institutional prospective payment systems, and the Medicare Physician Fee Schedule (PFS, or fee schedule) all employ geographic adjustment factors. The 2 most prominent geographic adjustments are the Hospital Wage Index and the Geographic Practice Cost Indices (GPCIs).

Geographic Practice Cost Index (GPCI): An adjustment factor used to calculate payment rates under the PFS that accounts for the price of inputs in the local market where a service is furnished.

Healthcare Common Procedure Coding System (HCPCS): A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. HCPCS Level I contains numeric Current Procedural Terminology (CPT) codes that are maintained by the American Medical Association. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in Levels I or II. These are usually called "local codes" and must have "W," "X," "Y," or "Z" in the first position. HCPCS Procedure Modifier Codes can be used with all 3 levels, with the WA–ZY range used for locally assigned procedure modifiers.

Healthcare Effectiveness Data and Information Set® (HEDIS®): A comprehensive set of standardized performance measures designed to give purchasers and consumers the information they need for reliable comparison of health plan performance.

Hierarchical Condition Categories (HCC): A risk adjustment methodology used by CMS to calculate risk scores for aged and disabled Medicare beneficiaries. The conditions represent various clinical conditions that are grouped together. Within a given category, the conditions are reported hierarchically so that only the most severe condition within a given grouping is included in the risk score. The risk scores represent expected medical expenditures of a Medicare beneficiary in the next year.

Independence at Home Demonstration: A CMS program that works with medical practices to test the effectiveness of delivering comprehensive primary care services at home and whether doing so improves care for Medicare beneficiaries with multiple chronic conditions. Additionally, the demonstration will reward health care providers that provide high-quality care while reducing costs.

Leakage Rate: A quarterly adjustment to the Professional PBP. It is calculated by dividing the number of qualifying visits and services attributed beneficiaries received outside the PCF practice by the total number of qualifying visits and services the attributed beneficiaries received in the same time period.

Lookback Period: The 24-month period ending 3 months before the start of the quarter. To pay practices prospectively, CMS uses historical data (i.e., beneficiaries' attestations made by the end of the lookback period or beneficiaries' visits to primary care practices obtained through claims during the lookback period) to perform attribution before each payment quarter.

Maryland Total Cost of Care Model: Sets a per capita limit on Medicare total cost of care in Maryland. The model builds upon the Innovation Center's current Maryland All-Payer Model, which had set a limit on per capita hospital expenditures in the state. The Maryland TCOC Model sets the state of Maryland on course to save Medicare over $1 billion by the end of 2023

and creates new opportunities for a range of non-hospital health care providers to participate in this test to limit Medicare spending across an entire state.

Measurement Period: The time period, outlined in the Measure Specifications for each performance year's quality measures, for which quality data must be reported.

Measure Specification: Quality measure instructions that address

1. data elements;
2. data sources;
3. point of data collection;
4. time and frequency of data collection and reporting;
5. specific instruments to be used, if appropriate; and
6. implementation strategies.

Medicare Advantage: Type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of a beneficiary's Part A and Part B benefits.

Medicare Economic Index: An index often used in the calculation of increases in the prevailing charge levels that help determine allowed charges for physician services. This index is considered in connection with the update factor for the PFS.

Medicare Enrollment Database: CMS' database of record for Medicare beneficiary enrollment information. The Enrollment Database has information on all Medicare beneficiaries, including Social Security Retirement and Disability Insurance beneficiaries, end-stage renal disease beneficiaries, and Railroad Retirement Board beneficiaries.

Medicare Physician Fee Schedule (PFS): List of Medicare payment rates for services provided by physicians and other Part B clinicians.

Medicare Shared Savings Program (Shared Savings Program): Established by Section 3022 of the Affordable Care Act; a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act.

Medicare Part A and B: Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Merit-Based Incentive Payment System (MIPS): One of 2 payment tracks through which eligible clinicians participate in the Quality Payment Program (QPP), which seeks to reward physicians for delivering high value, high quality care. All eligible clinicians who do not qualify for the APM track participate in MIPS.

National Benchmark: One element of the calculation process for PBA. Practices will have their AHU or TPCC performance compared with the national reference group.

National Plan and Provider Enumeration System: The system that uniquely identifies a health care provider and assigns it an NPI.

National Provider Identifier (NPI): Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means the numbers do not carry other information about health care clinicians, like the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Patient Experience of Care Survey (PECS): Asks consumers and patients to report on and evaluate their experiences with health care. For PCF, the surveys are expected to combine questions from the Clinician and Group CAHPS (CG-CAHPS) Survey, the Patient-Centered Medical Home Survey Supplement, and other items appropriate for the population.

PCF-Eligible Beneficiaries: Medicare beneficiaries that are enrolled in both Medicare Parts A and B; have Medicare as their primary payer; do not have end-stage renal disease; are not enrolled in hospice; are not covered under a Medicare Advantage or other Medicare health plan; are not long-term institutionalized; are not incarcerated; are alive; are not enrolled in any other program or model that includes a Medicare FFS shared savings opportunity, except for the Medicare Shared Savings Program; and are not dually-eligible beneficiaries aligned to a demonstration under the FAI.

PCF Practice: All practices participating in the PCF component, including PCF Only practices and Hybrid practices (which are also participating in the SIP component).

Performance-Based Adjustment (PBA): Quarterly adjustment to Professional PBP and FVF, or Total Primary Care Payment (TPCP), ranging from −10% to 50%. Adjustment rate is based on utilization and quality measures and begins in Q2 2022.

Performance Year (PY): Each 12-month period of participation during which CMS pays Professional PBPs, FVFs, and PBAs to eligible practices participating in the PCF component.

Practice Risk Groups: Each practice is assigned to a risk group (1 through 4) on the basis of the average CMS-HCC risk score of its attributed beneficiaries each quarter. The practice's risk group will determine its quarterly PBPs along with the quality measures and utilization/cost metric used to calculate its PBA.

Primary Care First: Innovation Center advanced primary care model that rewards value and quality by offering an innovative payment structure to support delivery of advanced primary care. PCF is based on the underlying principles of the CPC+ model. PCF aims to improve quality, improve patient experience of care, and reduce expenditures. Primary Care First is a 5-

year model. The performance period for the first cohort of participants begins in January 2021 and in January 2022 for the second cohort of participants.

Professional Population-based Payment (PBP): Quarterly payment to practices calculated on per-beneficiary per-month (PBPM) basis. The PBP is risk-adjusted based on the average CMS-HCC risk score of the beneficiaries. Practices receive the same Professional PBP for all attributed beneficiaries regardless of the beneficiaries' individual risk scores.

Quality Gateway: Composed of quality measures that are specific to the practice risk group. Practices must meet or exceed the benchmark for each quality measure in their practice risk groups' measure set in order to pass the Quality Gateway and be eligible for a positive PBA in the year. The quality gateway does not go into effect until 2022 (based on performance during 2021).

Quality Payment Program (QPP): CMS program designed to lower costs to the Medicare program through improvement of care and health. The QPP aims to reward high-value, high-quality Medicare clinicians with payment increases while reducing payments to clinicians who are not meeting performance standards. The QPP has 2 participation tracks: (1) MIPS and (2) APM.

Quality Payment Program Final Rule: Annual rule issued by the QPP that establishes regulations, including performance benchmarks and participation requirements for MIPS and APMs, for the upcoming QPP performance year. The rule is subject to notice-and-comment rulemaking.

Quality Reporting Document Architecture Category III (QRDA III): A Health Level Seven International (HL7) clinical document architecture (CDA)–based standard that provides a format for specifying aggregate results for various types of measures, including eCQMs. Using QRDA III, calculated aggregate results may be submitted for an eCQM, which is formatted according to the applicable HL7 Health Quality Measure Format (HQMF) Implementation Guide. HQMF standardizes the representation of a health quality measure as an electronic document.

Regional Performance Adjustment: One element of the calculation process for PBA. CMS will compare practices' AHU or TPCC performance with regional reference groups.

Retrospective Debit: A debit is applied to the Professional PBPs each quarter to account for prior Professional PBP overpayments.

Seriously Ill Population (SIP): Designed as an intensive, time-limited intervention for seriously ill beneficiaries underpinned by an innovative payment structure. The SIP component of Primary Care First aims to proactively intervene with beneficiaries who are on a downward clinical trajectory, stabilize them through high-touch care coordination and case management, and connect them with a practitioner who can best meet their longer-term goals of care.

Taxpayer Identification Number (TIN): Identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration or by the IRS.

Telehealth: Services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by an eligible provider using an interactive 2-way telecommunications system (like real-time audio and video).

Total Per Capita Cost (TPCC): Cost measure for Practice Risk Groups 3 and 4 that determines their PBA. This measure is adapted for use in the Primary Care First model.

Total Primary Care Payment (TPCP): The Professional PBP and the FVF. TPCP is calculated PBPM and is prospectively paid to practices each quarter. The PBA is an adjustment of the practice's TPCP.

Vermont All-Payer ACO Model: An alternative payment model in which the most significant payers throughout the entire state—Medicare, Medicaid, and commercial health care payers—incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for most providers throughout the state's care delivery system.

Voluntary Alignment: Also known as beneficiary attestation; a process by which beneficiaries specify the health care practitioner and practice they consider responsible for providing and coordinating their health care.

Welcome to Medicare Visit: The Welcome to Medicare preventive visit is a 1-time appointment a Medicare beneficiary may choose to receive when new to Medicare. The aim of the visit is to promote general health and help prevent diseases. Medicare covers 100% of the approved amount of the Welcome to Medicare Visit, meaning there is no beneficiary deductible or coinsurance.

Appendix B: Primary Care Specialty Codes

Description	Taxonomy Code
Family Medicine	207Q00000X
Adult Medicine	207QA0505X
Geriatric Medicine	207QG0300X
Hospice and Palliative Medicine	207QH0002X
General Practice	208D00000X
Internal Medicine	207R00000X
Geriatric Medicine	207RG0300X
Hospice and Palliative Medicine	207RH0002X
Clinical Nurse Specialist	364S00000X
Acute Care	364SA2100X
Adult Health	364SA2200X
Chronic Care	364SC2300X
Community Health/Public Health	364SC1501X
Family Health	364SF0001X
Gerontology	364SG0600X
Holistic	364SH1100X
Women's Health	364SW0102X
Nurse Practitioner	363L00000X
Acute Care	363LA2100X
Adult Health	363LA2200X
Community Health	363LC1500X
Family	363LF0000X
Gerontology	363LG0600X
Primary Care	363LP2300X
Women's Health	363LW0102X
Physician Assistant	363A00000X
Medical	363AM0700X

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Appendix C: Description of the Centers for Medicare & Medicaid Services Hierarchical Condition Category Risk Adjustment Model

The Centers for Medicare & Medicaid Services (CMS) uses the CMS-HCC risk adjustment model to adjust capitation payments made to Medicare Advantage (MA) and Medicare Program of All-Inclusive Care for the Elderly (PACE) plans, with the intention of paying health plans appropriately for their expected relative costs. For example, a health plan enrolling a relatively healthy population receives lower payment than 1 enrolling a relatively sick population, all else being equal. The CMS-HCC model produces a risk score, which measures a person's or a population's health status relative to the average, as applied to expected medical expenditures. A population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a population with a risk score of 0.5 is expected to incur medical expenditures half that of the average. It is important to note that the model is accurate at the group level, and actual expenditures for any individual can be higher or lower (sometimes significantly) than those predicted.

The CMS-HCC model is a prospective model using demographic and diagnosis information from a base year to estimate expenditures in the next year. For example, risk scores for 2020 (risk score year) are calculated using diagnosis information from 2019 (base year). New Medicare enrollees (defined here as beneficiaries with less than 12 months of Medicare enrollment in the base year) receive a risk score from the new enrollee risk adjustment model, which is a demographic-only model. If a beneficiary does not have 12 months of enrollment in the base year, the beneficiary cannot have had a complete diagnosis profile in the base year, and hence the CMS-HCC model cannot be used. In order to ensure that as many diagnoses are captured in the risk score as possible, CMS calculates final risk scores for any year at least 12 months after the base year ends, such that the final risk scores are generally available 16-18 months after the base year.

The demographic characteristics used for both newly enrolled and continuously enrolled beneficiaries are age, sex, Medicaid status, and originally disabled status. The diagnosis information used for continuously enrolled beneficiaries is the set of diagnosis codes reported on Medicare claims in the base year. Not all types of Medicare claims are used—only hospital inpatient, hospital outpatient, physician, and some non-physician claims are considered. The source of a particular diagnosis code has no relevance (i.e., diagnoses from an inpatient hospitalization have equal weight as those from a physician visit), nor does the frequency with which the diagnosis code has been reported.

The CMS-HCC diagnostic classification system begins by classifying all International Classification of Diseases (ICD)-10 diagnosis codes into Diagnostic Groups, or DXGs. Each DXG represents a well-specified medical condition or set of conditions, such as the DXG for *Type II Diabetes with Ketoacidosis or Coma*. DXGs are further aggregated into Condition

Categories (CCs). CCs describe a broader set of similar diseases. Although they are not as homogeneous as DXGs, diseases within a CC are related clinically and with respect to cost. An example is the CC for *Diabetes with Acute Complications*, which includes, in addition to the DXG for *Type II Diabetes with Ketoacidosis or Coma*, the DXGs for *Type I Diabetes and Secondary Diabetes* (each with ketoacidosis or coma).

Hierarchies are imposed among related CCs so that if a person is coded with more than 1 CC from a hierarchy, only the most severe manifestation among related diseases will be coded as the HCC for the risk score calculation. After imposing hierarchies, CCs become HCCs. For example, diabetes diagnosis codes are organized in the Diabetes hierarchy, consisting of 3 CCs arranged in descending order of clinical severity and cost, from (1) *Diabetes with Acute Complications* to (2) *Diabetes with Chronic Complications* to (3) *Diabetes without Complication*. Thus, a person with a diagnosis code of *Diabetes with Acute Complications* precludes the less severe manifestations of *Diabetes with Chronic Complications* as well as *Diabetes without Complication* from being included in the risk score. Similarly, a person with a diagnosis code of *Diabetes with Chronic Complications* precludes a code of *Diabetes without Complication* from being included in the risk score. Although HCCs reflect hierarchies among related disease categories, for unrelated diseases, HCCs accumulate (i.e., the model is "additive"). For example, a female with both *Rheumatoid Arthritis* and *Breast Cancer* has (at least) 2 separate HCCs coded, and her predicted cost will reflect increments for both conditions.

Because a single individual may be coded for no HCCs, 1, or more than 1 HCC, the CMS-HCC model can individually price tens of thousands of distinct clinical profiles. The model's structure thus provides and predicts a detailed comprehensive clinical profile for each individual.

The CMS-HCC model assigns a numeric factor to each HCC and each age/sex, full benefit Medicaid/partial benefit Medicaid/non-Medicaid, aged/disabled cell. The values are summed to determine the risk score.

An illustrative hypothetical example using the CMS-HCC V22 model follows for a 70-year-old woman with HCCs *Metastatic Cancer* and *Acute Leukemia* (HCC 8) and *Bone/Joint/Muscle Infections/Necrosis* (HCC 39) who is a full-benefit dual Medicare-Medicaid enrollee:

Risk Factor	Factor
Age/Sex, Full-Benefit Dual Enrollee	0.501
HCC 8—*Metastatic Cancer and Acute Leukemia*	2.497
HCC 39—*Bone/Joint/Muscle Infections/Necrosis*	0.542
Total CMS-HCC Risk Score	**3.540**

For more information on the CMS-HCC risk model, see the following web page: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html

Appendix D: Healthcare Effectiveness Data and Information Set Measures and Specifications

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Appendix E: Patient Experience of Care Survey Domain Questions

PCF PECS Domain	Survey Question
Getting Timely Appointments, Care, and Information	• Patient always got appointment as soon as needed when contacting provider's office to get an appointment for care needed right away • Patient always got appointment as soon as needed when making an appointment for check-up or routine care • When patient contacted provider's office during regular office hours with a medical question, patient always received an answer that same day
How Well Providers Communicate	• Providers always explained things to patient in a way that was easy to understand • Provider always listened carefully to patient • Provider knew important information about patient's medical history • Provider always showed respect for what patient had to say • Provider always spent enough time with patient
Attention to Care from Other Providers	• Someone from provider's office followed up with patient to give results of blood test, x-ray, or other test • If patient visited a specialist, provider always seemed informed and up to date about the care patient received from specialists • Someone from provider's office talked with patient about all prescription medications being taken
Providers Support Patient in Taking Care of Own Health	• Someone in provider's office discussed specific health goals with patient • Someone in provider's office asked whether there were things that made it hard for patient to take care of health
Patient Rating of Provider and Care	• Patient rating of provider as best provider possible (0–10, out of a maximum of 10)

PCF = Primary Care First; PECS = Patient Experience of Care Survey.

PECS Domains and Point Scales

Domains	PECS Point Scale
Getting Timely Appointments, Care, and Information (3 questions) How Well Providers Communicate (4 questions) Attention to Care from Other Providers (2 questions)	1–4 Always = 4 Usually = 3 Sometimes = 2 Never = 1
Providers Support Patient in Taking Care of Own Health (2 questions)	0–1 Yes = 1 No = 0
Patient Rating of Provider and Care (1 question)	0–10 Patients answer on a scale of 0–10

PECS = Patient Experience of Care Survey.

Appendix F: Preliminary Acute Hospital Utilization and Total Per Capita Cost of Care Regional Benchmarks

These preliminary benchmarks are intended to illustrate potential performance thresholds; CMS may update actual benchmarks to be used for PBA quarters in PY 2022 and in future years.

Table F-1
Preliminary AHU and TPCC National Benchmarks

Measure Title	Median (50th percentile)
Acute Hospital Utilization (AHU)	1.16
Total Per Capita Cost (TPCC)	0.98

Table F-2
Preliminary AHU Peer Region Group Benchmarks

Region	Below 25th percentile	25th–49th percentile	50th–59th percentile	60th–69th percentile	70th–79th percentile	80th–89th percentile	At or Above 90th percentile
Region 1	>1.23	1.23	1.06	1.00	0.94	0.86	≤0.77
Region 2	>1.23	1.23	1.06	1.00	0.94	0.87	≤0.77
Region 3	>1.28	1.28	1.11	1.05	0.99	0.93	≤0.82
Region 4	>1.31	1.31	1.14	1.08	1.02	0.94	≤0.84
Region 5	>1.35	1.35	1.18	1.12	1.05	0.98	≤0.88
Region 6	>1.36	1.36	1.19	1.13	1.07	0.99	≤0.89
Region 7	>1.35	1.35	1.17	1.11	1.04	0.97	≤0.87
Region 8	>1.40	1.40	1.21	1.15	1.08	1.00	≤0.90
Region 9	>1.42	1.42	1.26	1.20	1.14	1.07	≤0.95
Region 10	>1.44	1.44	1.27	1.20	1.14	1.06	≤0.97

Table F-3
Preliminary TPCC Peer Region Group Benchmarks

Region	Below 25th percentile	25th–49th percentile	50th–59th percentile	60th–69th percentile	70th–79th percentile	80th–89th percentile	At or Above 90th percentile
Region A	>1.15	1.15	0.94	0.87	0.80	0.73	≤0.63
Region B	>1.13	1.13	0.92	0.86	0.79	0.72	≤0.63
Region C	>1.11	1.11	0.93	0.86	0.81	0.74	≤0.64
Region D	>1.14	1.14	0.94	0.87	0.80	0.73	≤0.65
Region E	>1.16	1.16	0.95	0.89	0.83	0.75	≤0.65
Region F	>1.17	1.17	0.97	0.91	0.84	0.77	≤0.67
Region G	>1.23	1.23	1.01	0.94	0.87	0.79	≤0.69
Region H	>1.25	1.25	1.01	0.94	0.87	0.81	≤0.69
Region I	>1.21	1.21	1.01	0.94	0.87	0.80	≤0.70
Region J	>1.31	1.31	1.08	1.01	0.94	0.86	≤0.75
Region K	>1.25	1.25	1.04	0.99	0.92	0.84	≤0.72

Appendix G: Total Per Capita Cost Technical Specifications for the PCF Component

The Total Per Capita Cost (TPCC) measure, adapted for Primary Care First (PCF), is a payment-standardized, risk-adjusted measure of the overall cost of care provided to beneficiaries in each practice. The measure is based on the Merit-based Incentive Payment System (MIPS) version but differs slightly in that it follows the PCF attribution method for assigning beneficiaries to specific PCF practices and does not standardize costs by provider specialty. Within Primary Care First, TPCC is 1 of the quality measures evaluated for practices caring for complex, chronically ill beneficiaries in the PCF Component (i.e., practices that belong to Risk Groups 3 and 4). A practice's performance on TPCC compared with both national and regional TPCC benchmarks will help determine its PBA amount. Chapter 5 includes more detail on the quality strategy for the PCF component, including the PBA (see Section 5.2.2.1.2 for more detail on TPCC benchmarking methodologies). The following describes the process for calculating the TPCC measure at the practice level for all beneficiaries attributed to each PCF practice in a given year.

Step 1: Beneficiary Attribution

CMS calculates the TPCC measure quarterly, using a rolling 1-year performance period, for all beneficiaries attributed to the practice over the course of a given year. Attribution follows the same PCF attribution methodology as the overall PCF component (described in detail in Chapter 2). If, for example, a beneficiary is attributed to a Risk Group 3 or 4 practice in Quarter 1 (Q1) of a given year, that beneficiary's claims from that quarter are included in the measure. The unit of analysis for PCF practices in Risk Groups 3 and 4 is the "beneficiary quarter," and the final measure can be interpreted as the ratio of observed costs to expected costs for a given practice across all attributed beneficiary quarters.

Step 2: Calculation of Total Observed Cost

Total cost of care is calculated as the sum of all Medicare FFS-standardized allowed charges for a particular beneficiary during a given period. In order to calculate total observed costs, the most recent available standardized payment files will be used to standardize the costs associated with claims. These costs are standardized to account for differences in Medicare payments for the same services across Medicare providers. Payment standardization also accounts for differences in Medicare payment unrelated to the care provided, such as those from payment adjustments supporting larger Medicare program goals (e.g., indirect medical education add-on payments) or variation in regional health care expenses as measured by hospital wage indexes and GPCIs.[34]

[34] For more information, please refer to the "CMS Price (Payment) Standardization—Basics" and "CMS Price (Payment) Standardization—Detailed Methods" documents posted on ResDAC: https://www.resdac.org/articles/cms-price-payment-standardization-overview

Inpatient claims are reduced to "stays" before including them in the TPCC calculation. Inpatient stays exclude managed care claims and duplicate claims. Inpatient claims that indicate the same beneficiary ID, provider ID, admission date, and discharge date are consolidated into a single stay. Finally, overlapping claims (i.e., claims with overlapping dates of service) and claims lasting longer than 1 year are removed. Total cost is then calculated by identifying all claims submitted for the beneficiary for inpatient, outpatient, professional, skilled nursing facility, home health, and hospice services, as well as durable medical equipment. The payment-standardized costs across all of these claims are first summed, and then winsorized at the 1st and 99th percentiles to adjust for outliers.

Step 3: Risk Adjustment

Risk scores calculated using a rolling 12-month lookback period of claims are used to risk-adjust the TPCC measure. For each beneficiary, risk scores are calculated using the most recent version of the CMS-HCC risk adjustment model software. Each beneficiary quarter included in the TPCC calculation is risk-adjusted using a risk score calculated with claims from the 12-month period before the performance year measured. For example, TPCC for performance year 2021 will use 2020 risk scores, which are based on 2019 claims data.

Beneficiaries are classified as either continuing or new enrollees on the basis of their enrollment date in Medicare and whether they have a full 12 months of data from which diagnosis information can be drawn. These diagnoses are used to assign beneficiaries to the HCCs that are used to calculate the risk score. Risk scores for new enrollees who lack a full year of diagnosis data are calculated using age, sex, Medicare-Medicaid dual enrollment status, and original reason for entitlement to the Medicare benefit.

Expected costs for each beneficiary period are estimated using Ordinary Least Squares regression, controlling for the beneficiary's risk. The model is specified as follows:

$$Total\ Cost = \alpha + \beta_1(CEScore) + \beta_2(CEScore)^2 + \beta_3(NEScore) + \beta_4(NEScore)^2 + \varepsilon$$

A beneficiary will only have a Continuing Enrollee risk score (CEScore) or a New Enrollee risk score (NEScore) and cannot have both. Therefore, the model estimates the effect of each type of risk score separately. Estimates β and δ can be interpreted as the average effect on total cost of an increase of 1.0 in a beneficiary's CEScore or NEScore, respectively, holding other factors constant. The linear predictions generated by this model are used as the expected cost in the final calculation of TPCC for the practice.

Step 4: Observed-to-Expected Ratio

The TPCC measure is expressed at the practice level as a ratio of observed-to-expected (O/E) cost of care. This ratio is calculated for a given practice as follows:

$$TPCC = \frac{O}{E}$$

In this equation, the sum of the practice-level observed cost (O) across all attributed beneficiary quarters is divided by the corresponding sum of the practice-level expected cost (E). Operationalizing the measure this way also gives more weight to beneficiaries who are attributed for a longer period of time. For example, a PCF beneficiary attributed for the full year would have 4 quarters in the data, whereas a PCF beneficiary attributed for only 1 quarter would contribute only 1 quarter of data for that practice.

The final ratio can be interpreted as the relative costliness of the beneficiaries attributed to a given PCF practice compared with practices with a similar overall level of patient complexity. A lower ratio in this case indicates better performance on the measure, or lower cost relative to model predictions (expected).

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Appendix H: PCF Peer Group Crosswalk for Preliminary Acute Hospital Utilization/Total Per Capita Cost Benchmarks[35]

PCF Model Region	AHU Peer Region Group (for Practice Risk Groups 1 and 2)	AHU Peer Region States	TPCC Peer Region Group (for Practice Risk Groups 3 and 4)	TPCC Peer Region States
Alaska	Group 1	**Alaska**, California, Idaho, Oregon, Washington	Group A	**Alaska**, California, Hawaii, Idaho, Oregon, Washington, Wyoming
Arkansas	Group 7	**Arkansas**, Colorado, Iowa, Missouri, Oklahoma	Group J	**Arkansas**, Kansas, Nebraska, Nevada, Oklahoma, South Dakota, Texas
California	Group 1	Alaska, **California**, Idaho, Oregon, Washington	Group A	Alaska, **California**, Hawaii, Idaho, Oregon, Washington, Wyoming
Colorado	Group 7	Arkansas, **Colorado**, Iowa, Missouri, Oklahoma	Group H	Arizona, **Colorado**, Montana, New Mexico, North Dakota, Utah
Delaware	Group 3	**Delaware**, District of Columbia, Maine, Maryland, New Jersey	Group F	Kentucky, **Delaware**, Maryland, Virginia
Florida	Group 4	**Florida**, Georgia, Louisiana, North Carolina, South Carolina, Texas	Group G	**Florida**, Georgia, Tennessee
Greater Buffalo Region	Group 8	Connecticut, **New York**, Pennsylvania, Rhode Island, Vermont	Group B	District of Columbia, **New York**, Maine, Massachusetts, North Carolina, West Virginia
Greater Kansas City Region (Kansas)	Group 10	Illinois, **Kansas**, Montana, Nebraska, Wyoming	Group J	Arkansas, **Kansas**, Nebraska, Nevada, Oklahoma, South Dakota, Texas

[35] These peer region groups are based on preliminary benchmarks for PY 2021; CMS may update AHU and TPCC peer region groups based on actual benchmarks to be used for PBA quarters in PY 2022 and in future years

PCF Model Region	AHU Peer Region Group (for Practice Risk Groups 1 and 2)	AHU Peer Region States	TPCC Peer Region Group (for Practice Risk Groups 3 and 4)	TPCC Peer Region States
Greater Philadelphia Region	Group 8	Connecticut, New York, **Pennsylvania**, Rhode Island, Vermont	Group D	**Pennsylvania**, Rhode Island, Vermont
Hawaii	Group 2	Arizona, **Hawaii**, Nevada, New Mexico, Utah	Group A	Alaska, California, **Hawaii**, Idaho, Oregon, Washington, Wyoming
Louisiana	Group 4	Florida, Georgia, **Louisiana**, North Carolina, South Carolina, Texas	Group K	Alabama, **Louisiana**, Mississippi, South Carolina
Maine	Group 3	Delaware, District of Columbia, **Maine**, Maryland, New Jersey	Group B	District of Columbia, New York, **Maine**, Massachusetts, North Carolina, West Virginia
Massachusetts	Group 9	**Massachusetts**, New Hampshire	Group B	District of Columbia, New York, Maine, **Massachusetts**, North Carolina, West Virginia
Michigan	Group 5	**Michigan**, Minnesota, North Dakota, South Dakota, Wisconsin,	Group C	Iowa, **Michigan**, Minnesota, Missouri, Wisconsin
Montana	Group 10	Illinois, Kansas, **Montana**, Nebraska, Wyoming	Group H	Arizona, Colorado, **Montana**, New Mexico, North Dakota, Utah
Nebraska	Group 10	Illinois, Kansas, Montana, **Nebraska**, Wyoming	Group J	Arkansas, Kansas, **Nebraska**, Nevada, Oklahoma, South Dakota, Texas
New Hampshire	Group 9	**Massachusetts**, New Hampshire	Group E	Connecticut, **New Hampshire**, New Jersey
New Jersey	Group 3	Delaware, District of Columbia, Maine, Maryland, **New Jersey**	Group E	Connecticut, New Hampshire, **New Jersey**

PCF Model Region	AHU Peer Region Group (for Practice Risk Groups 1 and 2)	AHU Peer Region States	TPCC Peer Region Group (for Practice Risk Groups 3 and 4)	TPCC Peer Region States
North Dakota	Group 5	Michigan, Minnesota, **North Dakota**, South Dakota, Wisconsin,	Group H	Arizona, Colorado, Montana, New Mexico, **North Dakota**, Utah
North Hudson-Capital Region	Group 8	Connecticut, **New York**, Pennsylvania, Rhode Island, Vermont	Group B	District of Columbia, **New York**, Maine, Massachusetts, North Carolina, West Virginia
Ohio and Northern Kentucky Region	Group 6	Alabama, Indiana, Kentucky, Mississippi, **Ohio**, Tennessee, Virginia, West Virginia	Group I	Illinois, Indiana, **Ohio**
Oklahoma	Group 7	Arkansas, Colorado, Iowa, Missouri, **Oklahoma**	Group J	Arkansas, Kansas, Nebraska, Nevada, **Oklahoma**, South Dakota, Texas
Oregon	Group 1	Alaska, California, Idaho, **Oregon**, Washington	Group A	Alaska, California, Hawaii, Idaho, **Oregon**, Washington, Wyoming
Rhode Island	Group 8	Connecticut, New York, Pennsylvania, **Rhode Island**, Vermont	Group D	Pennsylvania, **Rhode Island**, Vermont
Tennessee	Group 6	Alabama, Indiana, Kentucky, Mississippi, Ohio, **Tennessee**, Virginia, West Virginia	Group G	Florida, Georgia, **Tennessee**
Virginia	Group 6	Alabama, Indiana, Kentucky, Mississippi, Ohio, Tennessee, **Virginia**, West Virginia	Group F	Kentucky, Delaware, Maryland, **Virginia**

AHU = Acute Hospital Utilization; PCF = Primary Care First; TPCC = Total Per Capita Cost of Care.

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