Primary Care First

Foster Independence. Reward Outcomes.

Attribution and Payment Office Hours Session

Center for Medicare and Medicaid Innovation

Beneficiary Attribution

What is Beneficiary Attribution?

- Primary Care First (PCF) is a **practice-wide** transformation effort
- **Attribution** is a tool used to determine which primary care practice has primary responsibility for managing a beneficiary's care and assign the beneficiary to that practice

- CMS attributes **Medicare fee-for-service (FFS)** beneficiaries to practices to:
  - Estimate the number of beneficiaries they are accountable for under PCF
  - Determine their average **practice risk group**
  - Calculate their **PCF payment**
- Other payers may approach attribution differently

Note: Attribution lists will be available on the **PCF Practice Portal** under the "Payment and Attribution" tab. A preliminary estimate of your practice's number of attributed beneficiaries based on historical data is included in your acceptance letter.

Beneficiary Attribution Is Performed Quarterly Through A Two-Step Process

1 Voluntary Alignment

THEN

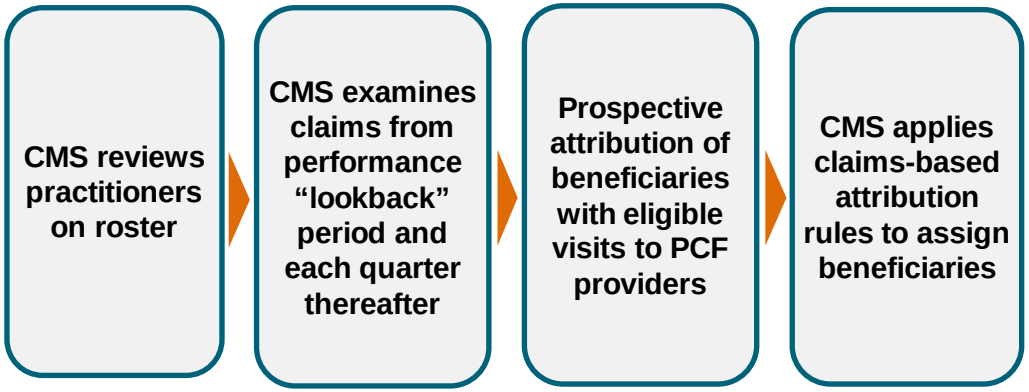
2 Claims-Based Attribution

Beneficiaries attest to their **choice of a primary care practitioner on MyMedicare.gov**

1. Beneficiary accesses MyMedicare.gov
2. Beneficiary selects a practitioner (voluntary alignment)
3. Beneficiary with eligible attestation is attributed to selected practitioner

Voluntary alignment supersedes claims-based attribution

If a beneficiary did not select a practitioner on MyMedicare.gov, the beneficiary **can be attributed to a practice** based on an examination of claims from previous 24 months



Note: *Since this is a retrospective process, it may take several quarters before changes in the provider that a beneficiary sees will result in a change in beneficiary attribution.*

What is Voluntary Alignment?

Voluntary alignment is the process that lets Medicare FFS beneficiaries select, or "voluntarily align" with, a **primary clinician**.

- Medicare FFS beneficiaries log into MyMedicare.gov and choose their primary clinician, the health care provider they believe is responsible for coordinating their overall care
- CMS will use the eligible beneficiary's selection of a primary clinician on MyMedicare.gov to take priority over the claims-based assignment methodology

For more information, please refer to the Voluntary Alignment Beneficiary Fact Sheet: https://www.cms.gov/files/document/register-mymedicaregov-and-choose-your-primary-clinician.pdf

What is Claims-Based Attribution?

If a beneficiary is not attributed by voluntary alignment, CMS will apply the following **claims-based attribution** steps to assign beneficiaries to Primary Care First practices:





PCF Practitioner

- Review practitioners on practices' rosters

Lookback

- Examine claims from lookback period

Beneficiary Visits

- Identify beneficiaries who received visits from PCF practitioners

Assign Beneficiary

- Apply Chronic Care Management (CCM), Annual Wellness Visit (AWV)/Welcome to Medicare Visit (WMV), and plurality rules to assign beneficiaries to practices

Overlaps Check

- Ensure beneficiaries are only in one CMS shared savings–like initiative, such as the Direct Contracting model

In the next several slides, we'll review each of these steps in greater detail.

Review Practitioner Roster

Beneficiaries are attributed based on primary care services provided by **primary care practitioners**

Primary Care First practitioners must be on the Practitioner Roster

- Add practitioners via the **PCF Practice Portal**
- CMS vets your additions (e.g., practitioner specialty)

Eligible practitioners must have one of the following specialties:

- Family medicine
- General medicine
- Geriatric medicine
- Internal medicine
- Hospice and palliative medicine

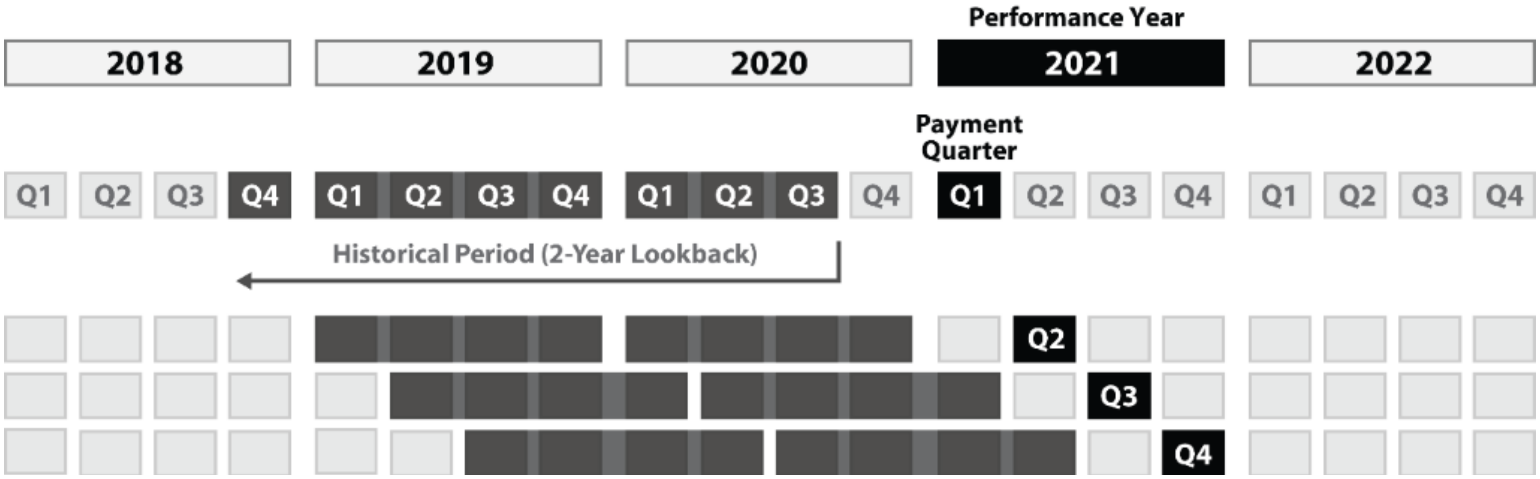
Examine Claims from Lookback Period

Performed Quarterly

2021 Q1 is the first quarter of attribution

Based on Historical Period

For 2021 Q1 payment, the lookback period is 2018 Q4 to 2020 Q3



Note: *Because this is a retrospective process, it may take several quarters before beneficiary attribution is affected by changes in the beneficiary's service use.*

Assign Beneficiary to Practice By Prioritizing Primary Care Visits

CCM-Related

First step: determine which practitioner has the most-recent primary care visit using **CCM-related services**

AWVs or WMVs

Second step: identify beneficiaries with **Annual Wellness Visits** or **Welcome to Medicare Visits**

Plurality

Third step: attribute to the PCF Practice* or non-PCF practitioner who provided the **plurality of eligible primary care visits**

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

Professional Population Based Payment (PBP)

Primary Care First Model Payments Include Two Major Components

Total Primary Care First Model Payments

Total Primary Care Payment + **Performance-Based Adjustment**

Professional Population-Based Payment (PBP) + **Flat Visit Fee (FVF)**

2020 Policy Update: Due to the Coronavirus Disease 2019 (COVID-19) public health emergency, the first Performance-Based Adjustment (PBA) is delayed by three quarters and will be paid to practices in Q2 2022. More information is included in the Primary Care First Payment and Attribution Methodologies Paper.

CMS-Hierarchical Condition Category (HCC) Risk Score Model

- Predicts healthcare expenditures of a population
- Based on **demographic characteristics** and **medical diagnoses**
- Assigns a score to each beneficiary:
  - Score = predicted expenditures divided by population average
  - Ex: **1.2 score** → predicted expenditures are 20% higher than average health expenditures for the Medicare population
- Risk scores can be used to modify payments to reflect expected costs for that population

For more information on the CMS-HCC model, please refer to Appendix C of the Payment Methodology Paper, or visit: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html

Practice Risk Group Assignment

Step 1

Normalized risk score for each attributed beneficiary calculated using 4 quarters of data from previous year

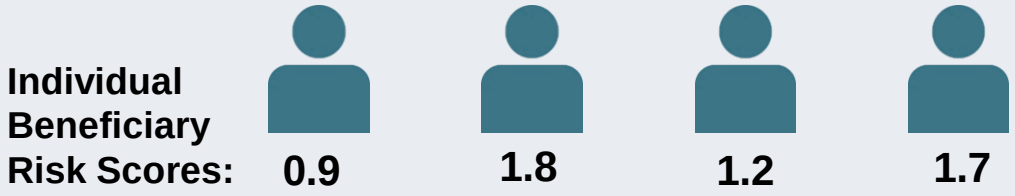
Step 2

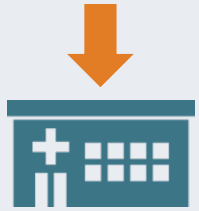
Practice's average beneficiary risk score calculated

Step 3

Practice assigned to risk group and associated PBP amount

Example PCF practice panel





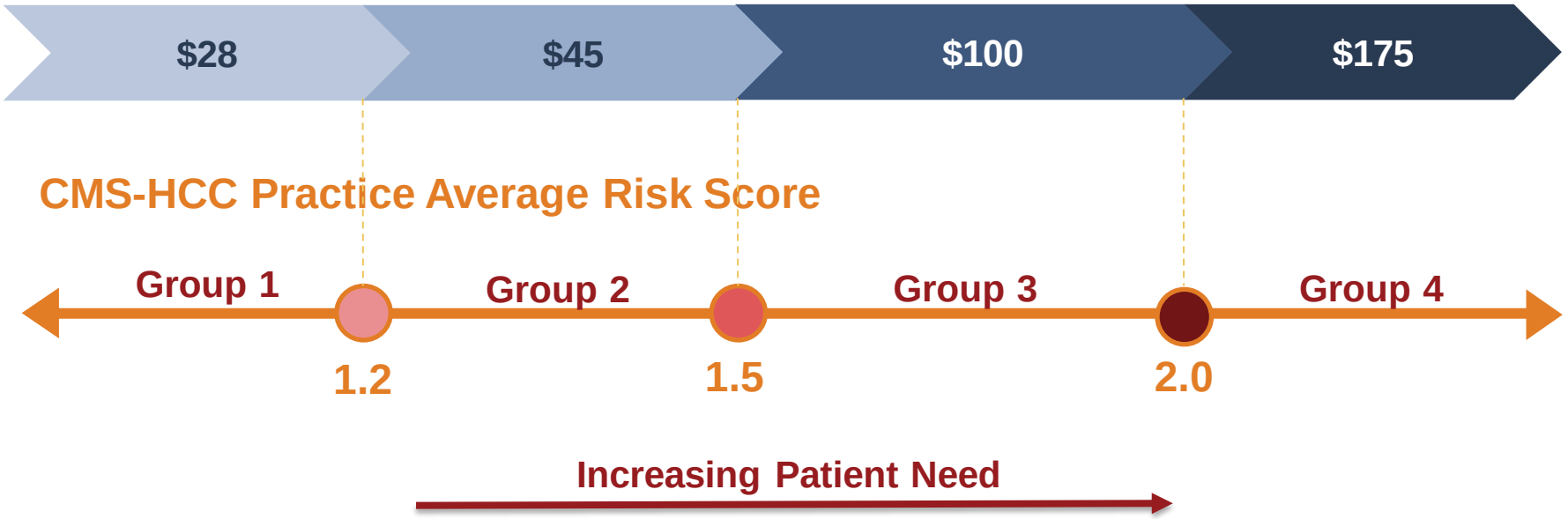
Average risk score: 1.4

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

Practice assigned to risk group 2

How Do Beneficiary Risk Scores Determine PBP Amounts?

Base PBP PBPM amount for Practice Risk Groups before adjustments



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

Primary Care Services Included in the Professional PBP

The PBP is a **quarterly** and **prospective** payment that covers the following services:

Service	HCPCS Codes
Office/outpatient evaluation & management (E&M) services	99201–99205, 99211–99215, GPC1X*
Prolonged E&M	99354, 99355, 99XXX*
Transitional care management services	99495, 99496
Home care/domiciliary care E&M	99324–99328,99334–99337, 99339–99345, 99347–99350
Advance care planning	99497, 99498
Welcome to Medicare (WMV) and Annual Wellness Visits (AWV)	G0402, G0438, G0439
Chronic care management (CCM) services	99487, 99489–99491

Note: *Prohibited CCM codes: 99339, 99340, 99487, 99489, 99490, 99491, GPC1x, and 99xxx.*
**GPC1x and 99xxx codes will be updated once the 2021 PFS is finalized.*

Adjustments to the Professional PBP

The professional PBP will be subject to the following adjustments:

- Geographic adjustment
- Leakage adjustment
- Performance-based adjustment (PBA)
- Merit Based Incentive Payment System (MIPS) adjustment
- Retrospective debits*
- 2% Medicare sequestration

**Some beneficiaries become ineligible before or during the quarter. To account for this, in each quarterly payment cycle, 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.*

Leakage Adjustment Calculation

The Professional PBP will be adjusted to account for "**leakage**," or the **percent of qualifying primary care services furnished outside of the PCF practice.** The calculation is performed annually and is as follows:

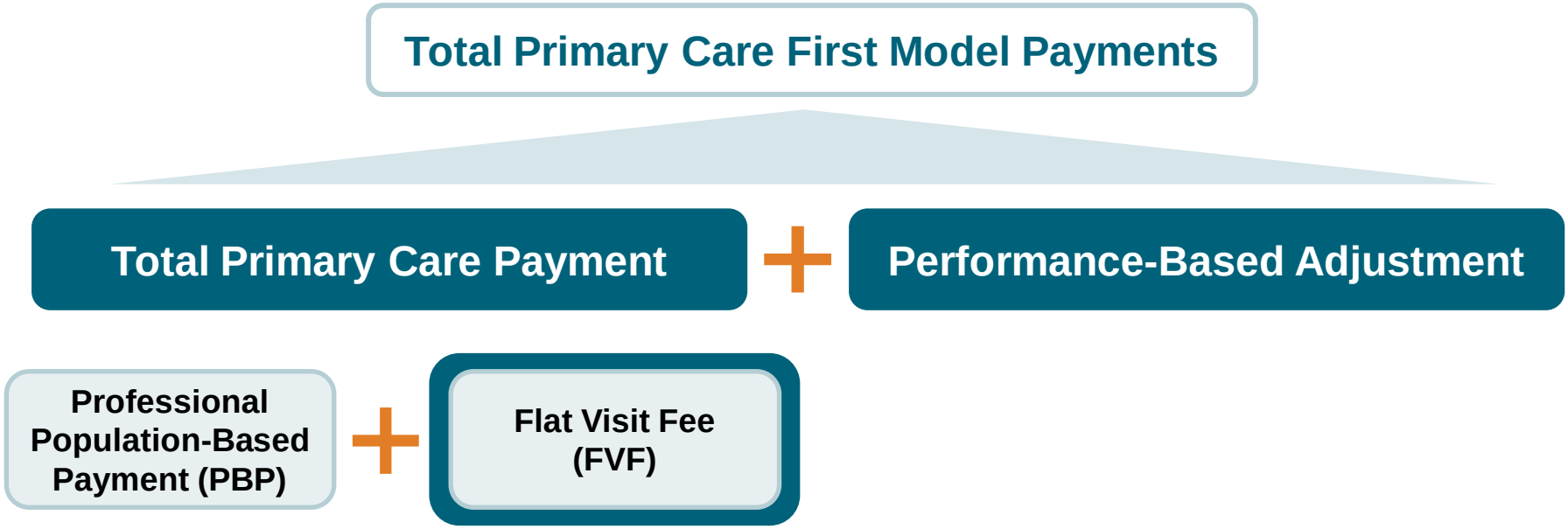
Leakage Adjustment* = **Number of qualifying primary care services for attributed beneficiaries *outside* PCF practice** / **Total number of qualifying primary care services that these beneficiaries received from *any* practice**

The leakage adjustment is meant to **incentivize sustained practitioner-patient relationships and active management of attributed beneficiaries** to limit the need for beneficiaries to seek care from other primary care practices.

***Note**: The leakage rate calculation is based on a rolling one-year lookback period that ends three quarters before the payment quarter to which the leakage rate adjustment is applied, to allow for claims processing time.*

Flat Visit Fee (FVF) and Claims-Based Payment

Primary Care First Model Payments Include Two Major Components



FVF Supports Face-to-Face Care

A fixed, per visit payment for all FVF-eligible services, regardless of HCPCS code billed, intended to:

- Provide predictable payment for face-to-face patient care
- Supports face-to-face care

National FVF Base Rate in 2021 is:

$40.82

The FVF will be subject to:

- Geographic adjustment
- Performance-based adjustment (PBA)
- Merit Based Incentive Payment System (MIPS) adjustment
- 2% Medicare sequestration

What Primary Care Services Are Eligible for the FVF?

Service	HCPCS Codes
Office/outpatient evaluation & management (E&M) services	99201-99205 99211-99215
Prolonged E&M	99354-99355
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 (AWV)	G0402, G0438, G0439

Payments for Face-to-Face Visits

- **One FVF payment per day**, even if multiple FVF-eligible services are provided (e.g. office visit and AWV)
  - Additional FVF-eligible claim lines will be **"zero paid"**
  - ***Note:*** *This is not a claim denial; beneficiary coinsurance and deductible will apply to "zero paid" claim lines based on traditional Medicare fee-for-service (FFS) allowed amounts.*
- All other non-FVF eligible HCPCS codes for attributed beneficiaries are paid under traditional Medicare FFS

Chronic Care Management (CCM)-Related Services

Payment for CCM-related services is included in the professional PBP PBPM amounts for attributed beneficiaries

Separate claims-based payment will **not** be paid for these services

- Includes codes 99339, 99340, G0506, 99487, 99489, 99490, 99491, GPC1x and 99xxx*
- Claim lines with these services will be denied; attributed beneficiaries may **not** be billed for these services

PCF providers may still provide and bill CCM-related services for non-attributed Medicare beneficiaries

** GPC1X and 99XXX are new codes proposed for 2021 in the 2020 Medicare Physician Fee Schedule (PFS) rule. Final codes will be available prior to January 2021.*

What Do Medicare Patients Pay Under Primary Care First?

For most patients, there will be no changes:

- Patient coinsurance and deductible are applied to all services billed based on Medicare PFS allowed amounts
- Coordination of Benefits (COB) with supplemental insurance does not change; supplemental insurers pay the same as under traditional Medicare FFS

Exception: *Some practices may elect to offer the Cost Sharing Support Benefit Enhancement for eligible beneficiaries.*

Summary of Claims-Based Payments

1 Most face-to-face office and home visits will be paid at the same FVF rate regardless of HCPCS code

2 Some services will not be eligible for payment via claims, as they are covered under the professional PBP PBPM amounts

NO changes to:

- How claims are submitted; no special codes or processes required
- Beneficiary payments
- All other non-FVF eligible services
- Claims for non-attributed beneficiaries

Overview of Quarterly Payment

Payment Distribution Timeline

Total Primary Care Payment

Professional PBP:

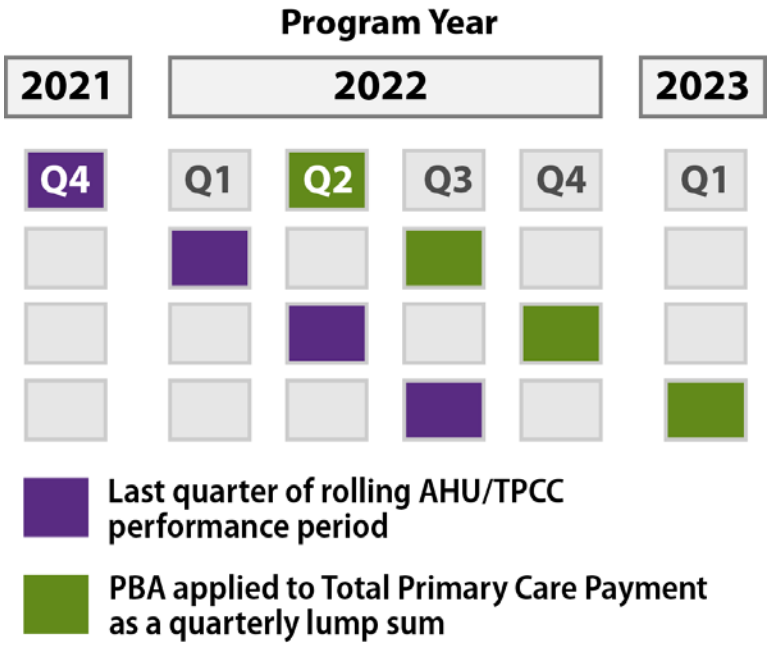
- Prospective, per-beneficiary per-month (PBPM) payment based on practice risk group
- Paid as a quarterly lump sum

FVF:

- Fixed payment for each face-to-face visit
- Paid through standard claims processing system

Performance-Based Adjustment

PBA will use a rolling lookback period that ends three months before the PBA payment quarter

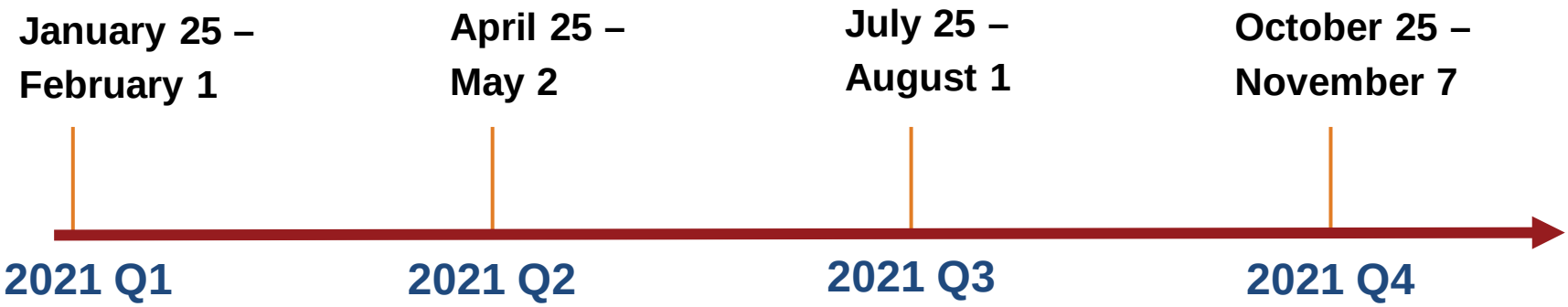


Payment to Practices

First Month of the Payment Quarter

- The **Innovation Payment Contractor (IPC)** distributes payments to practices via **electronic funds transfer (EFT)**
- Payments are released the last week of the payment month

Approximate 2021 quarterly payment dates: (similar dates expected in future years)

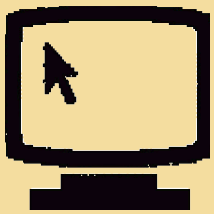


Reporting Payment to Practices

First Month of the Payment Quarter

- Payment and Attribution Summary Report for each practice is available for download on the **PCF Practice Portal**
- Each practice's portal page also includes a user interface table with "Payment and Attribution" summary information

Questions?



PCF@telligen.com

Toll-Free Number

888-517-7753

PCF Connect

Payment and Attribution Methodologies Paper

Note: Above resources are for Primary Care First practices. If beneficiaries have questions about the Primary Care First model or any other Medicare issues, they can call 1-800-MEDICARE or visit the MyMedicare.gov help page.