PRIMARY CARE FIRST: PAYMENT AND ATTRIBUTION METHODOLOGIES PY 2024

Version 2
November 2024

Center for Medicare & Medicaid Innovation
U.S. Department of Health & Human Services

Updates in This Release

Table or Section	Update	Page
4.2.1.1	Added clarification on Days at Home measure exclusion in PY 2024	63
Table 5-1 and Table 5-2	Added PY2024 AHU and TPCC benchmarks	67; 69

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Acronyms

Acronym	Term
ACO	Accountable Care Organization
ACP	Advance Care Plan adapted for PCF (claims-based measure)
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality
AHU	Acute Hospital Utilization
APM	Alternative Payment Model
AWV	Annual Wellness Visit
BAL	Beneficiary Attestation List
BPCI	Bundled Payments for Care Improvement
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBE	Consensus-Based Entity
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
COVID-19	Coronavirus 2019
CPC+	Comprehensive Primary Care Plus Model
CPT	Current Procedural Terminology
E&M	Evaluation and Management
eCQI	Electronic Clinical Quality Improvement
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
EHR	Electronic Health Record
FAI	Financial Alignment Initiative
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
HPSA	Health Professional Shortage Area
IAH	Independence at Home
IRS	Internal Revenue Service
IT	Information Technology
KCC	Kidney Care Choices

MIPS	Merit-based Incentive Payment System
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifiers
PAA	Payment Accuracy Adjustment
PBA	Performance-Based Adjustment
PBP	Population-Based Payment
PBPM	Per-Beneficiary Per-Month
PCF	Primary Care First
PEC	Patient Experience of Care
PFS	Physician Fee Schedule
PHE	Public Health Emergency
PQM	Partnership for Quality Measurement
PY	Performance Year
Q	Quarter
QCDR	Qualified Clinical Data Registry
QPP	Quality Payment Program
QRDA	Quality Reporting Document Architecture
REACH	Realizing Equity, Access, and Community Health
TCOC	Total Cost of Care
TIN	Taxpayer Identification Number
TPCC	Total Per Capita Cost
TPCP	Total Primary Care Payment
UB	Uniform Billing Codes
ViT	Value in Opioid Use Disorder Treatment
WMV	Welcome to Medicare Visit

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 for **Performance Year (PY)** 2024. The Executive Summary and the detailed technical specifications are organized as follows:

- Chapter 1 describes beneficiary **attribution**, the methodology used to identify Medicare beneficiaries for whom participating practices are responsible.
- Chapter 2 describes the **Professional Population-based Payments (PBPs)**.
- Chapter 3 describes the **Flat Visit Fee (FVF)** payments.
- Chapter 4 describes the **Quality Gateway**.
- Chapter 5 describes the **Performance-based Adjustment (PBA)**.

PCF is an **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 ready to accept financial risk in exchange for greater flexibility, increased transparency, and performance-based payments that reward participants for outcomes. The model will be tested for 6 years with 2 staggered cohorts of participating practices, each participating for 5 years (with **Cohort 1** starting in 2021 and **Cohort 2** starting in 2022). As such, PY 2024 is the fourth performance year for Cohort 1 practices and third performance year for Cohort 2 practices.

This document describes attribution, payment, and quality policies for PCF.

Under PCF, practices will be accountable for their attributed beneficiary population through a 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—**Acute Hospital Utilization (AHU)**[1] or **Total Per Capita Cost (TPCC),** adapted for PCF.

1. **Professional PBPs.** Practices receive a prospective, monthly PBP (paid quarterly) for each beneficiary attributed to their practice. 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**. CMS applies a quarterly **Payment Accuracy Adjustment (leakage rate adjustment)** to the Professional PBP to improve accuracy.

[1] Certain measures in the Primary Care First (PCF) model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found at https://www.cms.gov/priorities/innovation/about/notices-disclaimers.

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.
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 PCF. CMS calculates the PBA quarterly based on practices' performance on their respective measure, 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.

ES.1 Chapter 1: Beneficiary Attribution

This chapter describes the methodology for attributing Medicare beneficiaries to PCF. CMS uses a prospective attribution methodology to identify the Medicare **fee-for-service (FFS)** beneficiaries in PCF. CMS conducts beneficiary attribution quarterly and uses the attribution to

- determine the practice's risk group each year,
- 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, described in further detail in this section. First, CMS uses Medicare administrative data to identify Medicare FFS beneficiaries eligible for PCF attribution. Once **PCF-eligible beneficiaries** are identified, CMS begins attribution through a process called **voluntary alignment**. Then, CMS uses a claims-based attribution approach to attribute the remaining PCF-eligible beneficiaries.

1. **Eligible beneficiaries.** To be eligible for attribution to PCF 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**, (4) not be enrolled in hospice,[2] (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, and (9) not be aligned or attributed to an entity participating in any other CMS program or model with a "no overlaps" policy.

2. **Voluntary alignment.** Through Medicare.gov, beneficiaries can attest to the health care practitioner and practice they consider responsible for providing and coordinating their health care. CMS confirms the attested practitioner and practice meet attestation eligibility requirements.
3. **Claims-based attribution.** CMS applies the PCF claims-based attribution algorithm for eligible beneficiaries not attributed via voluntary alignment.

   During this step, to attribute eligible beneficiaries with at least 1 **eligible primary care visit** in the **lookback period**, CMS first uses **Annual Wellness Visits** and **Welcome to Medicare Visits** and then the plurality of eligible primary care visits.

ES.2 Chapter 2: Professional Population-Based Payment

The Professional PBP is meant to partially replace FFS revenue from specific primary care services for a practice's attributed beneficiary population and free practices from traditional FFS payment incentives to bring patients into the office. The Professional PBP promotes flexibility in care delivery and supports services to improve care coordination and target patient support by enabling practitioners to furnish services that best meet their patient's needs. For example, the Professional PBP supports services through email, phone, patient portal, or alternative settings, such as the patient's home.

ES.2.1 Population-Based Payment Risk Scores and Practice Risk Groups

At the beginning of each performance year, CMS assigns practices to 1 of 4 risk groups using their attributed Medicare beneficiaries' average CMS-HCC risk score. 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-1. Practices receive the same Professional PBP for all of their attributed beneficiaries, regardless of those beneficiaries' individual risk scores.

> Within a given performance year, your practice will receive the same PBP for all attributed PCF beneficiaries.

[2] Note that the end-stage renal disease and hospice criteria only apply 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.

Table ES-1
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

CMS-HCC = Centers for Medicare and Medicaid Services–Hierarchical Condition Categories; PBP = Population-based Payment; PBPM = per beneficiary per month.
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 make updates based on changes to the Medicare Physician Fee Schedule (PFS).

The Professional PBP is subject to the **Merit-based Incentive Payment System (MIPS)** adjustment and is geographically adjusted to account for nationwide variations in cost. The Professional PBP amounts also are adjusted to include the Payment Accuracy Adjustment (ES.2.2) and the PBA of the Professional PBP (ES.4 and ES.5). All model payment segments are also subject to the 2% Medicare sequestration, as required by federal rulemaking.

ES.2.2 Retrospective Debits

CMS conducts payment reconciliation quarterly to identify beneficiaries who lost PCF eligibility during the prior 12 months. In each quarterly payment cycle, CMS determines whether overpayments were made during a prior quarter and applies a **retrospective debit** to the upcoming quarter's payment.

ES.2.3 Payment Accuracy Adjustment

CMS applies a quarterly Payment Accuracy Adjustment (leakage rate adjustment) to the Professional PBP to improve its accuracy. For each practice, CMS calculates the quarterly Payment Accuracy 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.

ES.3 Chapter 3: Flat Visit Fee

The FVF is intended to encourage practices to continue seeing beneficiaries face-to-face as appropriate. 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 **Healthcare Common Procedure Coding System (HCPCS)** codes for an eligible primary care service for an attributed beneficiary. Medicare only pays 1 FVF per beneficiary per date of service. The FVF payment only applies to the Medicare portion of the

claim payment. CMS applies beneficiary cost-sharing to all services submitted on the claim under standard FFS rules and rates. Table ES-2 displays primary care services that receive the FVF payment.

Table ES-2
Services Included in the FVF

Services	HCPCS Codes
Office/outpatient visit evaluation and management (E&M)	99202–99205, 99211–99215
Prolonged E&M	99415, 99416
Transitional care management services	99495, 99496
Home care/domiciliary care E&M	99341, 99342, 99344, 99345, 99347–99350
Advance care planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439

E&M = evaluation and management; FVF = Flat Visit Fee; HCPCS = Healthcare Common Procedure Coding System.

The FVF payment includes 4 adjustments:

1. **National base rate adjustment**. This adjustment resets the Medicare fee schedule 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 apply 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.[3]
3. **MIPS adjustment and other adjustments.** The FVF is also subject to the MIPS adjustment and any other adjustments per traditional Medicare FFS.
4. **2% Medicare sequestration**. Finally, the FVF is subject to the 2% Medicare sequestration, as required by federal rulemaking.

ES.3.1 Performance-Based Adjustment of the Flat Visit Fee Payments

CMS applies 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 for a given quarter is calculated by multiplying the quarter's PBA percentage by the total FVF revenue for visits during the final quarter of the PBA performance period.

[3] https://www.cms.gov/files/zip/cy-2023-pfs-final-rule-addenda.zip.

ES.4 Chapter 4: Quality Gateway

CMS uses a focused set of clinical quality and patient experience measures to assess the quality of care for practices participating in PCF. 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. To pass the Quality Gateway, practices in Risk Groups 1 and 2 must meet the minimum performance threshold for the quality measures listed in ES.4.1; practices in Risk Groups 3 and 4 must meet those listed in ES.4.2.

Table ES-3 summarizes the measure ID, the measure steward, the **benchmark** population, and the benchmark for Quality Gateway measures for all practice risk groups.

Table ES-3
Quality Gateway Measures[a] for All Practice Risk Groups

Risk Groups	Measure Title (Type)	CBE ID/Quality ID/CMS ID [b]	Measure Steward	Performance Years[f]	Benchmark Population	Benchmark for 2024
1–2	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) (Intermediate Clinical Outcome eCQM)	CBE ID: 0059[b] Quality ID: 001 CMS ID: CMS122	NCQA[e]	1–4	MIPS	57.60%[h,i]
1–2	Controlling High Blood Pressure (Intermediate Clinical Outcome eCQM)	CBE ID: 0018[b] Quality ID: 236 CMS ID: CMS165	NCQA[e]	1–4	MIPS	56.61%[i]
1–2	Colorectal Cancer Screening (Process eCQM)	CBE ID: 0034[b] Quality ID: 113 CMS ID: CMS130	NCQA[e]	1–4	MIPS	34.53%[i]
1–4	Advance Care Plan adapted for PCF (claims-based measure)	CBE ID: 0326[c]	NCQA[e]	Cohort 1: 2-4 Cohort 2: 1-4	PCF and non-PCF benchmark population (see Chapter 4)	3.85%
1–4	Patient Experience of Care Survey (CAHPS® with supplemental items)	CBE ID: 0005[d]	AHRQ	1–4	PCF benchmark population (see Chapter 4)	77.00[j]
3–4	Days at Home (claims-based measure adapted for PCF; not included in PY 2024 Quality Gateway)	TBD	CMS	Cohort 1: 2–4[g] Cohort 2: 1–4[g]	PCF and non-PCF benchmark population	319.27

AHRQ = Agency for Healthcare Research and Quality; CBE = Consensus-Based Entity; eCQM = electronic Clinical Quality Measure; MIPS = Merit-based Incentive Payment System; NCQA = National Committee for Quality Assurance; PCF = Primary Care First; TBD = To be determined.

[a] The measures in the Quality Gateway are assessed for a given performance year, and the results are applied in the following year. For example, the Quality Gateway applied in the third performance year is based on performance during the second performance year.
[b] The Partnership for Quality Measurement (PQM) now serves as the CMS CBE, replacing the National Quality Forum. The CBE ID replaces the National Quality Forum ID, but the number remains the same.
Please note that although PCF eCQMs are not CBE endorsed, the chart-abstracted version of this measure is endorsed. CMS has determined that this eCQM is evidence-based, reliable, and valid and has approved the eCQM for use in the PCF model.
[c] The Advance Care Plan (ACP) measure is adapted for use in the PCF model from the Bunded Payments for Care Improvement (BPCI) Advanced ACP measure, which is a revised version of the CBE-endorsed ACP measure. See Section 4.1.1.2 for details on this measure.
[d] The PCF Patient Experience of Care Survey includes a combination of items from the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CAHPS) (CBE ID 0005) and from the Patient-Centered Medical Home CAHPS Supplement.
[e] Certain measures in the PCF model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found at https://www.cms.gov/priorities/innovation/about/notices-disclaimers.
[f] Performance years refer to the measurement periods of the measure. Each measure has a 1-year measurement period. The results of quality measures affect the Quality Gateway in the year following the Performance Year.
[g] In September 2024, CMS removed the Days at Home measure from the Quality Gateway assessment for Performance Year 2024. The measure will still be calculated for informational purposes but will not affect Performance-based Adjustment payments in 2025.
[h] Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) is an inverse measure; thus, lower performance scores reflect better quality.
[i] Each eCQM must meet or exceed the MIPS 2023 30th percentile benchmark to pass the Quality Gateway.
[j] The Performance Year 2024 PEC Survey benchmark was informed by historical PCF practice performance (Performance Year 2021 and Performance Year 2022) and is set at a threshold that CMS believes remains both motivational and achievable.

ES.4.1 Practice Risk Groups 1 and 2 Quality Gateway Measures

The Quality Gateway for Practice Risk Groups 1 and 2 consists of 5 measures:[4]

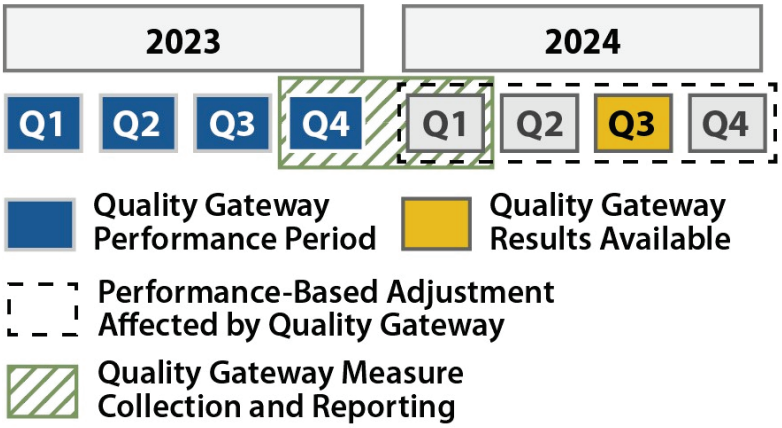
1. **Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)** (**electronic Clinical Quality Measure [eCQM]**)
2. **Controlling High Blood Pressure** (eCQM)
3. **Colorectal Cancer Screening** (eCQM)
4. **Advance Care Plan (ACP) adapted for PCF (claims-based measure)** (A claims-based measure adapted for PCF from the **Bundled Payments for Care Improvement [BPCI]** Advanced ACP measure, which is a revised version of the Consensus-Based Entity [CBE]–endorsed ACP measure [CBE ID 0326])
5. **Patient Experience of Care (PEC) Survey** (Based on a combination of questions from the **Clinician and Group Consumer Assessment of Healthcare Providers and Systems® (CG-CAHPS®)** V3.1 and CAHPS Patient-Centered Medical Home Item Set V3.0, modified for PCF)

Quality Gateway performance measured in 2023 affects PBA payments in 2024, and performance measures in 2024 affect PBA payments in 2025. Practices that report eCQMs do

[4] For more information on eCQMs, see the eCQI Resource Center page here: https://ecqi.healthit.gov/ep-ec?globalyearfilter=2024.

so in Q1 of the subsequent year. CMS calculates ACP measure performance in Q2 of the subsequent year. The PEC Survey is fielded in Q4 of the performance year, and scoring is completed in Q1 of the subsequent year.

Figure ES-1
Timeline of Quality Gateway Performance Period, Measure Collection/Reporting, and Availability of Results



Practice sites are required to successfully report all 3 eCQMs. Practices are also required to authorize a PEC Survey vendor and submit a valid patient roster to receive a PEC Survey score. Practice sites that fail to comply with eCQM and PEC Survey requirements will not pass the Quality Gateway and will not qualify for a positive PBA. CMS may consider additional actions, including withholding model payments and termination of the practice's participation agreement, as consequences for failing to meet reporting requirements before the required deadline.

ES.4.2 Practice Risk Groups 3 and 4 Quality Gateway Measures

The Quality Gateway for Practice Risk Groups 3 and 4 consists of 2 measures:

1. **ACP adapted for PCF (claims-based measure)**, a claims-based measure adapted for PCF from the BPCI Advanced ACP measure, which is a revised version of the CBE-endorsed ACP measure (CBE ID 0326).
2. **PEC Survey**, based on a combination of questions from the CG-CAHPS® V3.1 and CAHPS Patient-Centered Medical Home Item Set V3.0, modified for PCF.

ES.5 Chapter 5: Performance-Based Adjustment

The PBA 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 the Quality Gateway. The PBA has a potential downside adjustment of −10% of TPCP revenue and a 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**. To be eligible for a positive PBA, practices must meet the minimum performance threshold on a set of quality measures listed in ES.4.
2. AHU/TPCC performance compared with the **National Benchmark**. To be eligible for a positive **Regional Performance Adjustment**, practices must pass the National Benchmark.
3. AHU/TPCC performance compared with their peer region group benchmark (Regional Performance Adjustment). Practice performance against their peer region group determines which of the levels of Regional Performance Adjustment practices receive.
4. AHU/TPCC performance compared with their own historical performance (**Continuous Improvement [CI] Bonus**). Both the degree of improvement needed to earn the CI bonus and level of CI bonus are determined by which of the levels of Regional Performance Adjustment practices received.

In the third performance year and beyond, practices that do not meet the Quality Gateway will automatically receive a −10% PBA in Q1 through Q4. All practices are now in their third or fourth performance year, so they will automatically receive a –10% PBA in Q1 through Q4 if they do not pass the Quality Gateway.

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

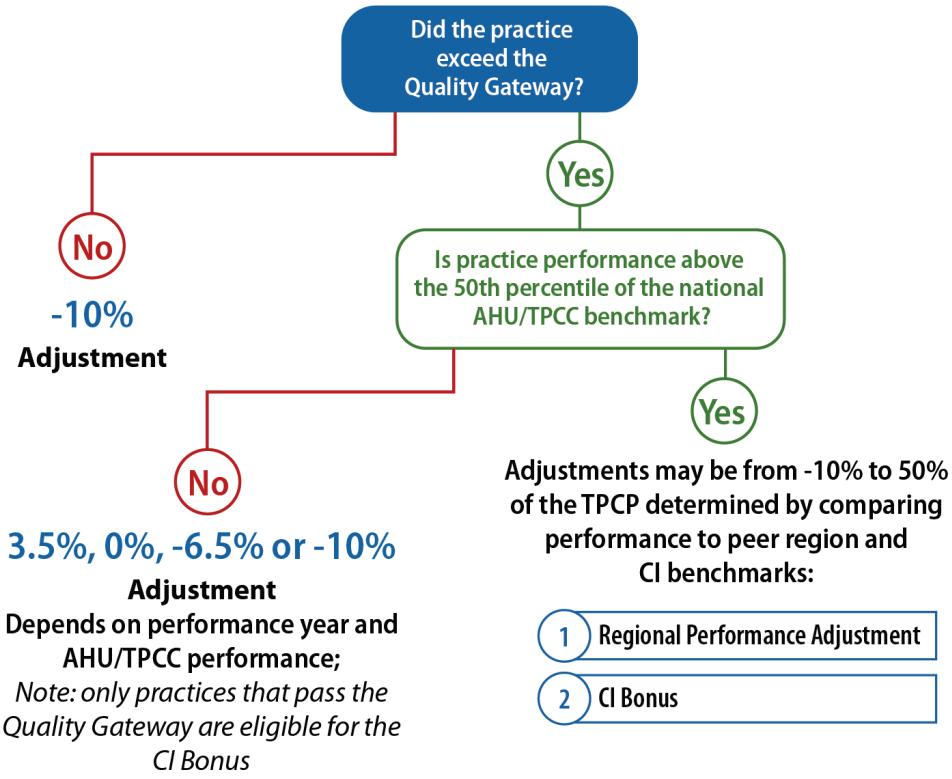
For practices that pass the national benchmark for AHU or TPCC (meet or exceed the 50th percentile), there are 7 possible performance levels for the Regional Performance Adjustment, depending on practices' performance relative to their peer region group. See Chapter 5 for more information on possible PBA performance levels.

All practices that pass the Quality Gateway are eligible for a CI bonus in addition to the Regional Performance Adjustment. To calculate the practice's amount of improvement for the CI bonus, the practice's performance on AHU or TPCC (depending on the 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 group 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.

Figure ES-3 provides a general overview of the Performance-based Adjustment process, including performance on the Quality Gateway, National Benchmark, Regional Performance Adjustment, and CI Bonus.

Figure ES-2
The PBA Process Includes the Quality Gateway, National Benchmark, Regional Performance Adjustment, and Continuous Improvement Bonus



AHU = Acute Hospital Utilization; CI = Continuous Improvement; PBA = Performance-based Adjustment; TPCC = Total Per Capita Cost; TPCP = Total Primary Care Payment.

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1. Beneficiary Attribution

This chapter describes the methodology for attributing beneficiaries to practices participating in PCF. 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
- identify beneficiaries included in the claims-based quality measures.

After an overview of attribution in Section 1.1, Section 1.2 defines PCF-eligible beneficiaries for beneficiary attribution. Section 1.3 describes voluntary alignment and the claims-based attribution process for any beneficiaries not attributed via voluntary alignment. Section 1.4 discusses interactions with other CMS programs and models, such as the Medicare Shared Savings Program.

1.1 Overview

Attribution is a tool used to assign beneficiaries to primary care practices. Beneficiaries can be attributed to PCF practices or non-PCF practitioners.

Attribution methodologies commonly consider

- what unit (e.g., practice, practitioner) a beneficiary is attributed to,
- how the beneficiary is attributed,
- the period of the attribution, and
- how often the attribution is made.

Unit of attribution: Because PCF is a test of practice-level transformation and payment, CMS attributes beneficiaries to the participating practice site rather than individual practitioners. A practice site is composed of a unique grouping of practitioners and billing numbers at a single "brick and mortar" physical location.[5]

How the beneficiary is attributed: CMS attributes beneficiaries to a PCF practice on the basis of voluntary alignment or claims-based attribution. Voluntary alignment—also known as beneficiary

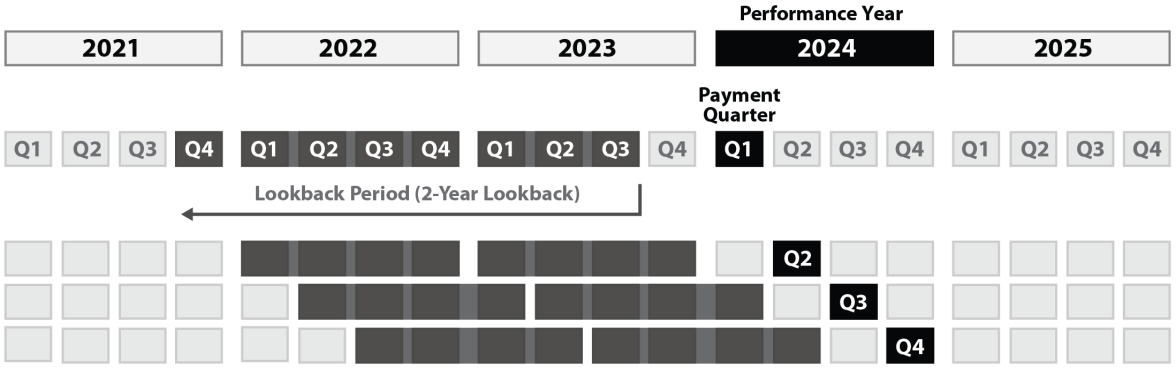
[5] The exceptions are practices providing care in the home instead of at a practice site and practices with satellite locations. Practices with satellite locations are considered 1 practice. A satellite office is a separate physical location that acts as an extension of the main practice site; the satellite 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.

attestation—refers to a process by which beneficiaries specify the health care practitioner and practice they consider responsible for providing and coordinating their health care. Suppose a PCF-eligible beneficiary is not attributed during the voluntary alignment step of attribution. In that case, CMS attributes the beneficiary using claims-based attribution, where Medicare claims are used to attribute beneficiaries to a practice by 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 model's aims. To pay practices prospectively, CMS performs attribution before each payment quarter on the basis of 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) (Figure 1-1).

Figure 1-1
What Is a Lookback Period?

Attribution is the foundation of the practice's risk group, the Professional PBP, and FVF payments. The lookback period used to perform attribution is the 2 years before the quarter preceding the current payment quarter.



FVF = Flat Visit Fee; PBP = Population-Based Payment.

The frequency of attribution: 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.

1.2 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[6]

- Not be enrolled in hospice[6]
- Not be covered under a Medicare Advantage or other Medicare health plan
- Not be long-term institutionalized
- Not be incarcerated
- Be alive
- Not be aligned or attributed to an entity participating in certain other CMS programs or models, as listed in Section 1.4.

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 begins. Beneficiaries are determined PCF-eligible as of the first day of that month. For example, beneficiaries must meet all eligibility criteria on December 1, 2023, to be eligible for attribution in the first quarter of 2024 (January 1, 2024–March 31, 2024).

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 2024, if a beneficiary met all eligibility criteria on December 1, 2023, but no longer met eligibility criteria at the start of, or during, that first quarter (January 1, 2024–March 31, 2024), 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.

1.3 Attribution Steps

CMS attributes eligible beneficiaries to practices participating in PCF through 2 broad sequential processes: voluntary alignment and claims-based attribution.

1.3.1 Voluntary Alignment

Voluntary alignment is a mechanism of attribution that uses a Medicare beneficiary's selected primary care practitioner to attribute the beneficiary to a practice. The Medicare beneficiary selects their primary care practitioner through attestation. The voluntary alignment process

[6] Note that the end-stage renal disease and hospice criteria only apply 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.

involves electronic retrieval of beneficiary attestations and verification of the eligibility of the attested practitioner.

1.3.1.1 Beneficiary Attestations on Medicare.gov

CMS created a PCF voluntary alignment beneficiary fact sheet as an informational resource for PCF practices to share with beneficiaries. Practices can review our summary of best practices for engaging Medicare beneficiaries through voluntary alignment.

Although any beneficiary with an account on Medicare.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 Medicare.gov, CMS applies the voluntary alignment algorithm each quarter according to the steps in the next sections.

Using the beneficiary attestation list (BAL) from Medicare.gov, CMS identifies each eligible beneficiary's most recent attested record for a given quarter as of the end of the lookback period (i.e., 3 months before the start of a given quarter). Table 1-1 lists the BALs and the beneficiary attestation cut-off dates for the 2024 quarterly attributions. For example, CMS used the October 2023 BAL, which included beneficiary attestations as of September 30, 2023, for voluntary alignment in Q1 2024. 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 1-1
BALs Used for 2024 Quarterly Attribution

Attribution Quarter	BAL Used	Beneficiary Attestation Cut-off Date
Q1 2024	October 2023	September 30, 2023
Q2 2024	January 2024	December 31, 2023
Q3 2024	April 2024	March 31, 2024
Q4 2024	July 2024	June 30, 2024

BAL = beneficiary attestation list.

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.[7]

[7] 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 Care 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.

1.3.1.2 Practitioner and Practice Eligibility Check

A PCF practice 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 practice site.[8] Non-PCF practices are defined as individual practitioners using single TIN-NPI combinations because they lack information regarding how they are grouped as actual practices.

CMS uses the BAL file for a given quarter to verify the eligibility of the practitioner and practice to which the eligible beneficiary attested. Only eligible practitioners are included in voluntary alignment. If the attested practice is a participating PCF practice site, the attested practitioner must also be listed as active on the practice's practitioner roster 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, 2023, to be eligible for voluntary alignment in the first quarter of 2024 (January 1, 2024–March 31, 2024). Note that practitioners at a PCF practice site must have a primary care specialty code to be included on the practice's roster. 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** file, which CMS updates monthly. See Appendix B for the list of specialty codes CMS uses to define a primary care specialty.

CMS attributes the eligible beneficiary through claims-based attribution if the attested practitioner does not meet the eligibility criteria. These requirements are described in greater detail in the section on claims-based attribution below.

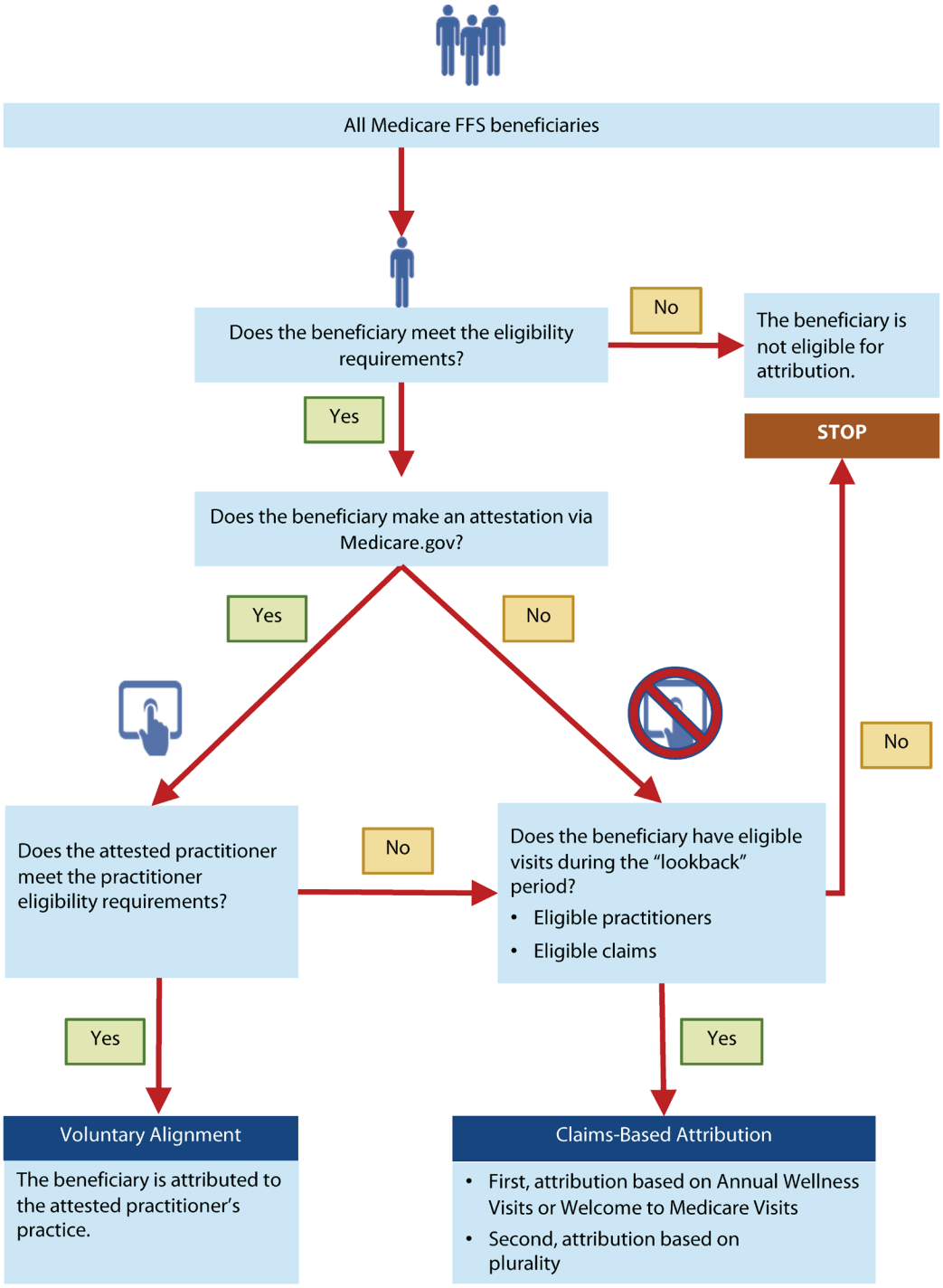
1.3.1.3 Interactions with Claims-Based Attribution

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 1.3.2 below). Figure 1-2 illustrates how the attribution process works.

[8] Because the BAL uses data from Care 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.

Figure 1-2
PCF Attribution Methodology



1.3.2 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 the eligible beneficiaries to the practice by recency of Annual Wellness Visits (AWVs) or Welcome to Medicare Visits (WMVs) or plurality of eligible primary care visits.

1.3.2.1 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 2021 through September 2023 to attribute PCF-eligible beneficiaries to practices for Q1 2024 (see Figure 1-1). Table 1-2 lists the lookback periods that will be used for the 2024 quarterly attributions.

Table 1-2
Lookback Periods for 2024 Quarterly Beneficiary Attribution

Attribution Quarter	Lookback Period
Q1 2024	October 2021–September 2023
Q2 2024	January 2022–December 2023
Q3 2024	April 2022–March 2024
Q4 2024	July 2022–June 2024

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, except for claims submitted by critical access hospitals, which are found in the Outpatient file. From all Physician and Outpatient claims, CMS identifies primary care visits eligible for attribution. Primary care visits eligible for attribution are those with any of the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1-3.

Table 1-3
Primary Care Services Eligible for Attribution

Service	HCPCS Codes
Office/outpatient visit E&M	99202–99205, 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
Advance care planning	99497
Collaborative care model	G0502–G0504, 99492–99494
Cognition and functional assessment for patient with cognitive impairment	99483
Outpatient clinic visit for assessment and management (critical access hospitals only)	G0463
Transitional care management services	99495, 99496
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

CCM = Chronic Care Management; E&M = evaluation and management; HCPCS = Healthcare Common Procedure Coding System.
Note: Some HCPCS codes, such as 99324–99340 and 99343, 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.

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 1-3.
2. Non-CCM-related services are provided by a practitioner who meets 1 of 2 criteria:[9]
   a. Active in a PCF practice when the visit occurs
   b. Has 1 of the primary care specialty codes located in Appendix B[10]

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. The visit is associated with a PCF practice if there is a match.

[9] There is no specialty code restriction on CCM-related services included in Table 1-3. 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.

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

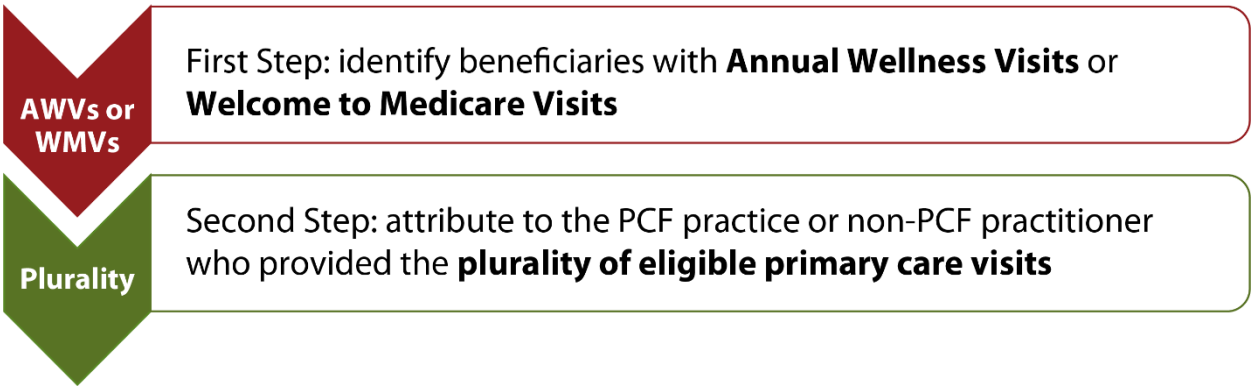
Otherwise, the visit is associated with a non-PCF practice. Any primary care practitioners billing the HCPCS codes in Table 1-3 under your TIN that are not listed on the roster will compete against your practice for attribution. For this reason, it is critical to keep your practitioner roster as up to date as possible.

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.

1.3.2.2 Claims-Based Attribution Process

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

Figure 1-3
Two Steps in Claims-Based Attribution



Attribution Based on Annual Wellness Visits or Welcome to Medicare Visits

CMS first checks whether PCF-eligible beneficiaries have Annual Wellness Visits (G0438, G0439) or Welcome to Medicare Visits (G0402) in the lookback period. CMS attributes the beneficiary to the PCF practice (or non-PCF practitioner) who provided the most recent such visit. If there are no eligible Annual Wellness or Welcome to Medicare Visits during the lookback period, CMS proceeds to Step 2 of claims-based attribution.

Attribution Based on Plurality

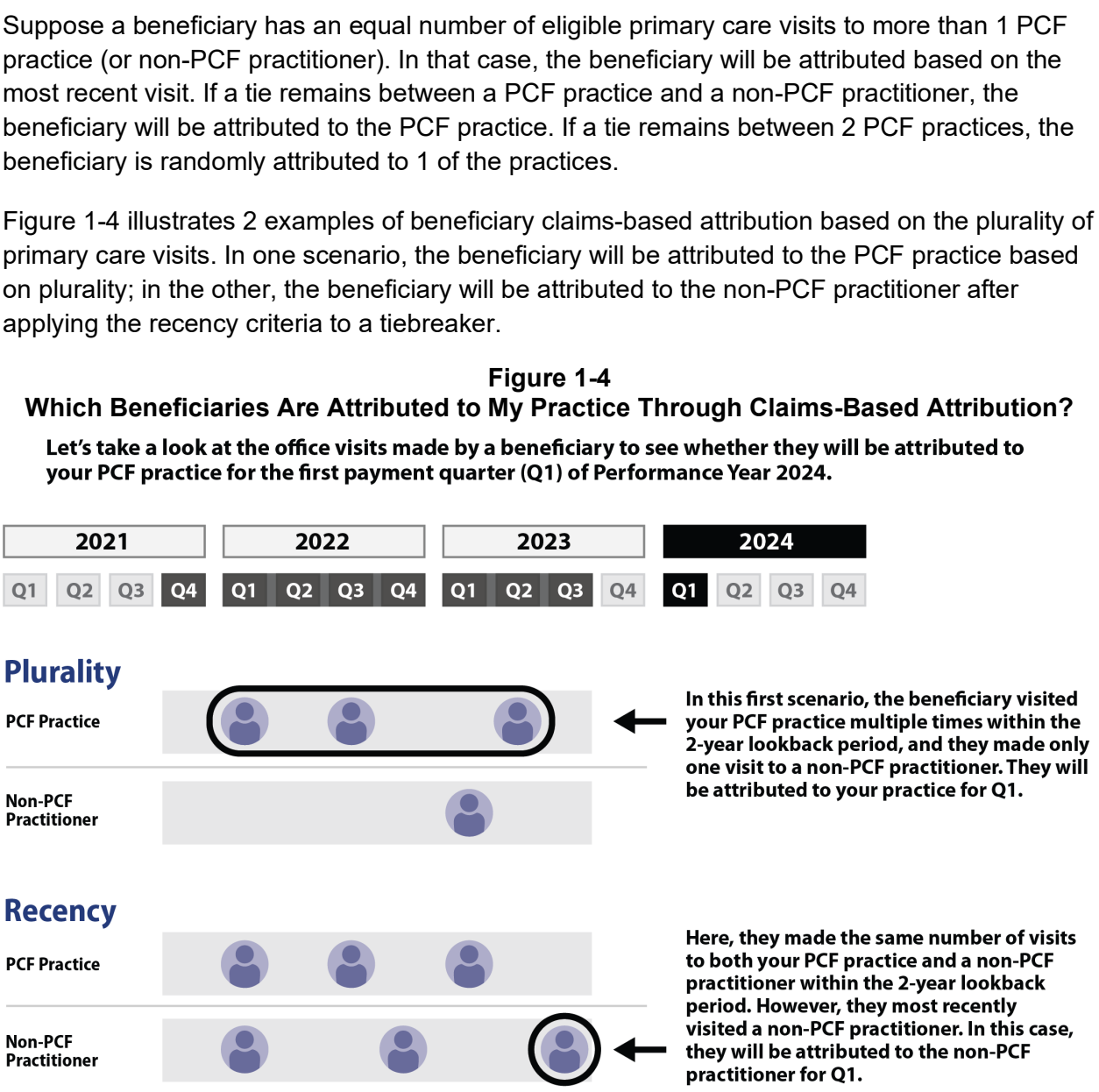
In this step, CMS first counts the number of eligible primary care visits the beneficiary had with each individual practitioner. CMS then combines eligible primary care visits to individual practitioners (i.e., TIN/NPI and CCN/NPI combinations) into PCF practices using the most current PCF practitioner roster. For example, 2 practitioners working in a PCF practice will have

their eligible primary care visits aggregated for 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.

Suppose a beneficiary has an equal number of eligible primary care visits to more than 1 PCF practice (or non-PCF practitioner). In that case, 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, the beneficiary is randomly attributed to 1 of the practices.

Figure 1-4 illustrates 2 examples of beneficiary claims-based attribution based on the 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 1-4
Which Beneficiaries Are Attributed to My Practice Through Claims-Based Attribution?



1.4 Overlap with Other Medicare Programs and Models

Beneficiaries may be eligible for more than 1 CMS coordinated care initiative, such as PCF and the **Medicare Shared Savings Program (Shared Savings Program)**. This may occur if the beneficiary seeks care from healthcare practitioners participating in multiple initiatives or within a specific geographical region where a model is being tested. In general, CMS prohibits

beneficiary overlaps when they would interfere with CMS' 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 other specific CMS programs and models at the same time.

1.4.1 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 such shared savings initiatives include the **ACO Realizing Equity, Access, and Community Health (REACH)** Model, the **Kidney Care Choices (KCC)** Model, and the **Value in Opioid Use Disorder Treatment (ViT)** Demonstration Program.

However, eligible PCF practices currently participating in a Shared Savings Program **Accountable Care Organization (ACO)** (any track) may participate in both initiatives (please see Section 3.06 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.

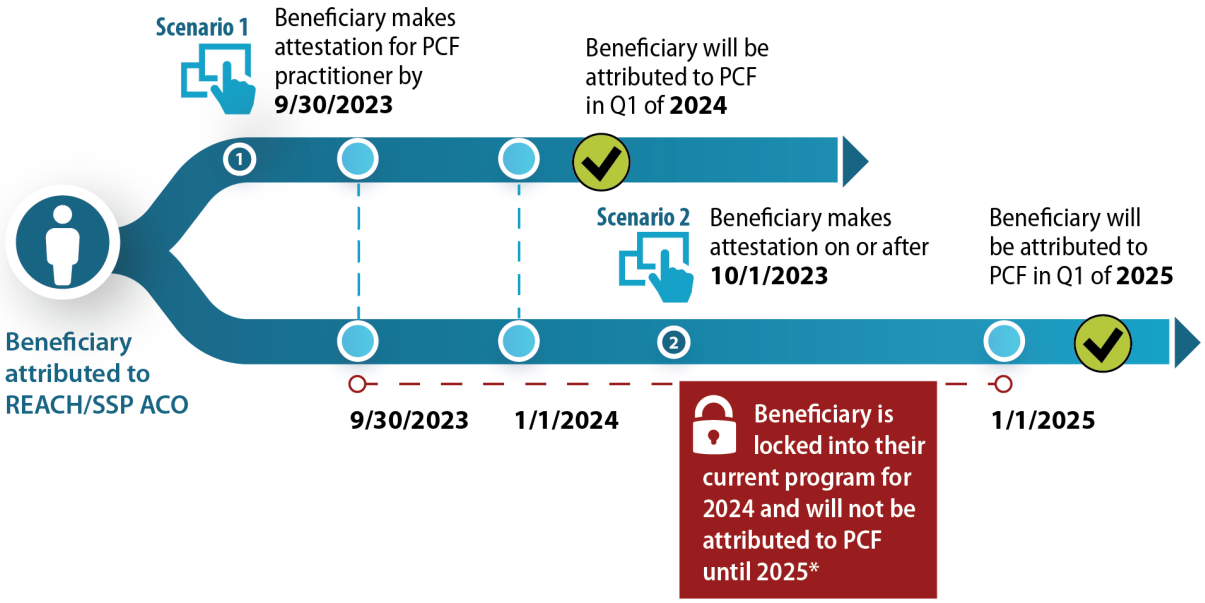
Beneficiaries who make an eligible attestation to a PCF practitioner on or before September 30, 2023, are attributed to their attested PCF practitioner for Q1 2024. Voluntary alignment to PCF takes precedence over any claims-based attribution to the Shared Savings Program and the ACO REACH Model, but only for PCF attributions in the first quarter of each year. If PCF-eligible beneficiaries have already been attributed to a Shared Savings Program ACO (that is not affiliated with a PCF practice) or a REACH ACO during any quarter of 2024, a subsequent attestation to a PCF practitioner in 2024 will not lead to their PCF attribution until 2025.

> Beneficiaries attributed to a Shared Savings Program or REACH ACO will remain attributed for the entire calendar year.

Because CMS performs voluntary alignment quarterly for PCF and annually for the Shared Savings Program and the ACO REACH Model, beneficiaries will remain with the ACO until the Shared Savings Program and ACO REACH Model perform voluntary alignment again for the following year (2025). When CMS performs 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. For example, suppose an ACO-attributed beneficiary (Q1 2024) makes an attestation in May 2024 to a PCF practitioner who does not participate in an ACO. In that case, this beneficiary remains assigned to the ACO for the remainder of 2024. Suppose the beneficiary attestation to the PCF practitioner who does not participate in an ACO remains the most current attestation when the Shared Savings Program performs voluntary alignment again for 2025. In that case, the PCF-eligible beneficiary will

become attributed to PCF (Q1 2025) (Figure 1-5). In contrast, PCF-eligible beneficiaries not attributed to an ACO and with May attestations would be captured in Q4 2024 PCF attribution.

Figure 1-5
Intersection of Voluntary Alignment for PCF and ACO REACH/SSP ACO



*In this scenario, we assume that SSP/ACO REACH does not update the beneficiary's attribution mid-year, thus the beneficiary is attributed to the ACO for the entire year (2024)

1.4.2 Primary Care Transformation Models

To prevent the attribution of beneficiaries to multiple primary care transformation models, beneficiaries are attributed to only 1 participant in these initiatives. Examples of primary care transformation models include the **Independence at Home (IAH) demonstration** and the **Making Care Primary (MCP)** model. CMS will not allow beneficiaries to be attributed to both PCF and the IAH demonstration or the MCP model at the same time.

1.4.3 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. An example of these episode-based payment models is the Bundled Payments for Care Improvement (BPCI) Advanced Model.

1.4.4 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 **Maryland Total Cost of Care (TCOC) Model** (specifically, the Maryland Primary Care Program) 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.

1.4.5 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. CMS may update these overlaps policies periodically to include new initiatives as they are finalized.

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2. Professional Population-Based Payment

Chapter 2 describes the methods used to calculate the Professional PBP for PCF. The Professional PBP is meant to partially replace FFS revenue from specific primary care services for a practice's attributed beneficiary population. 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 enable practices to serve patients in a way that best meets the needs of the patient, whether by email, phone, or patient portal or in alternative settings, such as the patient's home. 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 2-1 lists services included in the calculations of the Professional PBP.

Table 2-1
Services Included in the PBP

Services	HCPCS Codes
Office/outpatient E&M	99202–99205, 99211–99215
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, 99437, 99439

E&M = evaluation and management; CCM = Chronic Care Management; HCPCS = Healthcare Common Procedure Coding System; PBP = Population-based Payment.
Note: Some HCPCS codes, such as 99354, 99355, 99324 through 99340, and 99343, have been removed from the Physician Fee Schedule. However, CMS will continue to use these codes when historical claims analysis includes periods when these codes were in use.

Section 2.1 describes the calculation of risk scores and how CMS assigns practice risk groups. Section 2.2 outlines geographic adjustment of the Professional PBPs. Section 2.3 explains the retrospective debits to the Professional PBPs. Section 2.4 describes the Payment Accuracy Adjustment (leakage rate adjustment) applied to the Professional PBP. Section 2.5 provides an

example calculation of the Professional PBP. Lastly, Section 2.6 describes how qualifying primary care visits and services included in the Professional PBP will be monitored.

2.1 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 2024, 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.

> Within a given performance year, your practice will receive the same PBP for all attributed PCF beneficiaries.

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.

2.1.1 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 1-year period, called the base year. 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 recent risk score file available 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, 2022 risk scores (based on 2021 diagnoses) are available in the summer of 2023. CMS will use 2022 V24 risk scores for Q1–Q4 2023 attributed beneficiaries to determine 2024 risk groups for PCF practices.

Table 2-2 shows the risk score file year and base year claims period for all PCF performance years.

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

PCF Performance Year	Risk Score Year	Base Year
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.

CMS uses risk scores based on the CMS-HCC community risk adjustment model, as opposed to the CMS-HCC long-term institutional model, because PCF eligibility criteria 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. This version is a demographic-only risk adjustment model because 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.[11] A normalized risk score is a risk score divided by a normalization factor. Normalization is a mechanism used to adjust for the fact that historical data are used to initially calibrate the risk score model, yet the model is typically used to calculate risk scores for a more recent year. To account for more-recent claims data, coding, and population changes, the risk score is divided by a normalization factor, which was calculated to bring the national average FFS risk score back to 1.0 for the payment year. Risk scores must be normalized to a national average of 1.0 to ensure accurate comparison to the thresholds used to determine practice risk groups.

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 newer versions of the risk adjustment model.

2.1.2 Assigning Practice Risk Groups

To set practice risk groups each year, CMS uses the most recent risk score file available (see Table 2-2) and applies a normalization factor corresponding to that year. For example, for 2024, CMS uses the 2022 risk score file, which contains risk scores based on diagnosis data from claims in calendar year 2021. 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 quarter during the year before the performance year for which CMS is setting practice risk groups. For example, for 2024, CMS will use 2024 risk scores for Q1–Q4 2023 attributed beneficiaries and use a 4-quarter average risk score for each practice. This approach will help

[11] For more information on this, please refer to the Advance Notice of Methodological Changes for Calendar Year 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies: https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf Please refer to the 2020 CMS-HCC Model risk score for 2022, found in Table II-7, "Part C Normalization Factor Risk Scores" (page 65).

mitigate the effect that changes in the attributed population may have on practice average risk scores during the course of a year.

Each practice is assigned to 1 of 4 risk groups on the basis of the average CMS-HCC risk score of its attributed beneficiaries for Q1-Q4 of the previous year. CMS defines the risk score thresholds. The practice risk group determines a practice's PBPM payments, as shown in Table 2-3. During each performance year, the PBPM is the same for all attributed beneficiaries within a practice.

> Your practice will receive an updated practice risk group annually at the beginning of each performance year. The risk group is based on an average CMS-HCC risk score of your attributed beneficiaries during the previous 4 quarters.

The Professional PBP for Group 1 is $28 PBPM, paid quarterly on a prospective basis. The 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 (see Table 2-3).

Table 2-3
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

CMS-HCC = Centers for Medicare and Medicaid Services–Hierarchical Condition Categories; PBP = Population-Based Payment; PBPM = per beneficiary per month.
Note: CMS reserves the right to update these payment amounts in the future to ensure they are consistent with average revenue from fee-for-service (FFS), as well as the right to update based on changes to the Medicare Physician Fee Schedule (PFS).

2.1.3 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 CMS has done in other models.

- Use diagnosis-based risk adjustment for updating newly attributed beneficiaries' risk scores and demographic-based risk adjustment for updating continuously attributed beneficiaries' risk scores.

2.2 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.[12]

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.[13] 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 Medicare PFS Final Rule,[14] the GAF for a given locality L is calculated as:

$$GAF_L = \left(GPCI_{pw,L} \times 0.50238\right) + \left(GPCI_{pe,L} \times 0.45593\right) + \left(GPCI_{mp,L} \times 0.04169\right)$$

where

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

Please refer to the 2024 PFS Final Rule for a discussion of GPCIs and the most recent update.

[12] https://www.cms.gov/medicare/payment/fee-schedules/physician/locality-configuration

[13] Here is 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

[14] https://www.cms.gov/files/zip/cy-2024-pfs-final-rule-addenda.zip

2.3 Retrospective Debits

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

2.3.1 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, 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, starting with Q2 of the first performance year, 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.

Beginning in PY 2024, if a practice's PBP is debited because of beneficiary ineligibility but there are FVF-eligible visits paid at the FVF rate within the debited month, CMS will pay the remaining FFS amount for each FVF visit in the following year. For example, in mid-2024, CMS will calculate the remaining FFS amount for each practice where the beneficiary was debited during a month in calendar year 2023 and had an FVF-eligible service paid at the FVF rate. CMS will pay this difference via non-claims-based payments annually.

2.3.2 Debits Resulting from Negatively Assessed Performance-Based Adjustment

CMS may adjust quarterly payments (i.e., retrospectively apply debits) to reconcile differences in prior payments if a practice fails to meet minimum thresholds on a set of quality measures (i.e., fails the Quality Gateway) in the previous performance year. Failure to pass the Quality Gateway will reverse a previous positive adjustment to a –10% PBA. Retrospective adjustments may also be made because of changes resulting from corrections to PBA measure calculations—for example, to correct for missing or incomplete TPCC data. Refer to Chapter 5 for more details on the PBA measures and requirements.

2.4 Payment Accuracy Adjustment

2.4.1 Calculation of the Payment Accuracy Adjustment

For each practice, CMS calculates the proportion of out-of-practice services quarterly by dividing (1) the number of attributed beneficiaries' qualifying visits and services billed outside the PCF 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.

$$\textit{Proportion out of Practice Services} = \frac{\textit{Number of Qualifying Services for Attributed Beneficiaries Outside PCF Practice}}{\textit{Number of Qualifying Services for Attributed Beneficiaries}}$$

To qualify for inclusion in the Payment Accuracy Adjustment (PAA) (previously leakage rate) calculation, services must meet several criteria. First, they must be part of the set of services shown in Table 2-4. In PY 2023 and throughout the Coronavirus 2019 (COVID-19) public health emergency (PHE), services on claims related to COVID-19 testing (as defined by the presence of the cost sharing ["CS"] modifier on the claim) are excluded from the count of services outside the PCF practice. Second, these services must be provided in a setting deemed reasonable for primary care delivery. See Appendix H for the full list of eligible place-of-service codes.

Third, with the exception of CCM services, which can be billed by any Medicare practitioner regardless of specialty, the PAA calculation only includes qualifying visits and services billed by an eligible primary care practitioner. An eligible primary care practitioner is defined by having a primary care specialty code listed as their primary National Plan and Provider Enumeration System taxonomy. Primary care specialty codes considered eligible for the PAA are similar to those used for attribution (refer to Appendix B for a full list), with the following exceptions:

- Physician Assistants are excluded, both General (363A00000X) and Medical (363AM0700X). This removal is because of the inability to distinguish whether Physician Assistants are delivering primary care by taxonomy code alone.
- Nurse Practitioners registered under the Acute Care (363LA2100X) and Women's Health (363LW0102X) taxonomies are excluded. Eligible specialties are shown in Table 2-5.

Table 2-4 lists the primary care services included in the PAA.

Table 2-4
Services Included in the Payment Accuracy Adjustment for Attributed Medicare Beneficiaries[a]

Service	HCPCS Code
If billed by a primary care practitioner[b]	
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

E&M = evaluation and management; CCM = Chronic Care Management; HCPCS = Healthcare Common Procedure Coding System.

Note: Some HCPCS codes, such as 99324 through 99340 and 99343, have been removed from the Physician Fee Schedule. However, CMS will continue to use these codes when historical claims analysis includes periods when these codes were in use.
[a] If any of these HCPCS codes are billed with the COVID-19 ("CS") modifier, they will not be included in the out-of-practice service count of the Payment Accuracy Adjustment.
[b] See Section 2.4.1 for a definition of eligible primary care practitioner.

Table 2-5 lists the Nurse Practitioner specialty codes that remain eligible for the Payment Accuracy Adjustment.

Table 2-5
Nurse Practitioner Specialty Codes for Payment Accuracy Adjustment

Description	Taxonomy Code
Nurse Practitioner	363L00000X
Adult Health	363LA2200X
Community Health	363LC1500X
Family	363LF0000X
Gerontology	363LG0600X
Primary Care	363LP2300X

Finally, the PAA only includes qualifying visits and services 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. Table 2-6 lists the claims periods used for the quarterly Payment Accuracy Adjustments in 2023.

Table 2-6
Quarterly Payment Accuracy Adjustment Claims Periods

Quarterly Payment Accuracy Adjustment	Claims Period Used for Quarterly Payment Accuracy Adjustment
Q1 2024	Q3 2022 to Q2 2023
Q2 2024	Q4 2022 to Q3 2023
Q3 2024	Q1 2023 to Q4 2023
Q4 2024	Q2 2023 to Q1 2024

2.4.2 Application of Payment Accuracy Adjustment

CMS applies the calculated PAA to the practice's corresponding Professional PBP for that quarter.

Paid Professional PBP =
*Professional PBP based on practice's risk score group * (1 – Proportion out of Practice Services)*

For example, the Q3 2024 PAA is applied to the Q3 2024 Professional PBP. To illustrate the PAA, say Main Street Practice billed 1,500 qualifying visits and services for its attributed beneficiaries from January 1, 2023, to December 31, 2023. During the same period, other non-PCF primary care practitioners billed 500 qualifying visits and services for Main Street Practice's attributed beneficiary population. Tables 2-7a and 2-7b provide an example of the PAA calculation for Q3 2024:

Table 2-7a
Example of Proportion Out of Practice for Q3 2024

Number of Qualifying Services for Attributed Beneficiaries Outside PCF Practice	÷ Number of Qualifying Services for Attributed Beneficiaries	= Proportion Out of Practice
500	÷ (1,500 + 500)	= 0.25

Therefore, Main Street Practice has a 25% reduction applied to its Professional PBP for Q3 2024:

Table 2-7b
Example of Professional PBP with Payment Accuracy Adjustment for Q3 2024

Professional PBP for Main Street Practice	* (1 – Proportion Out of Practice)	= Professional PBP
$28	* (1 − 0.25)	= $21

PBP = Population-Based Payment.

2.5 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 5 key inputs:

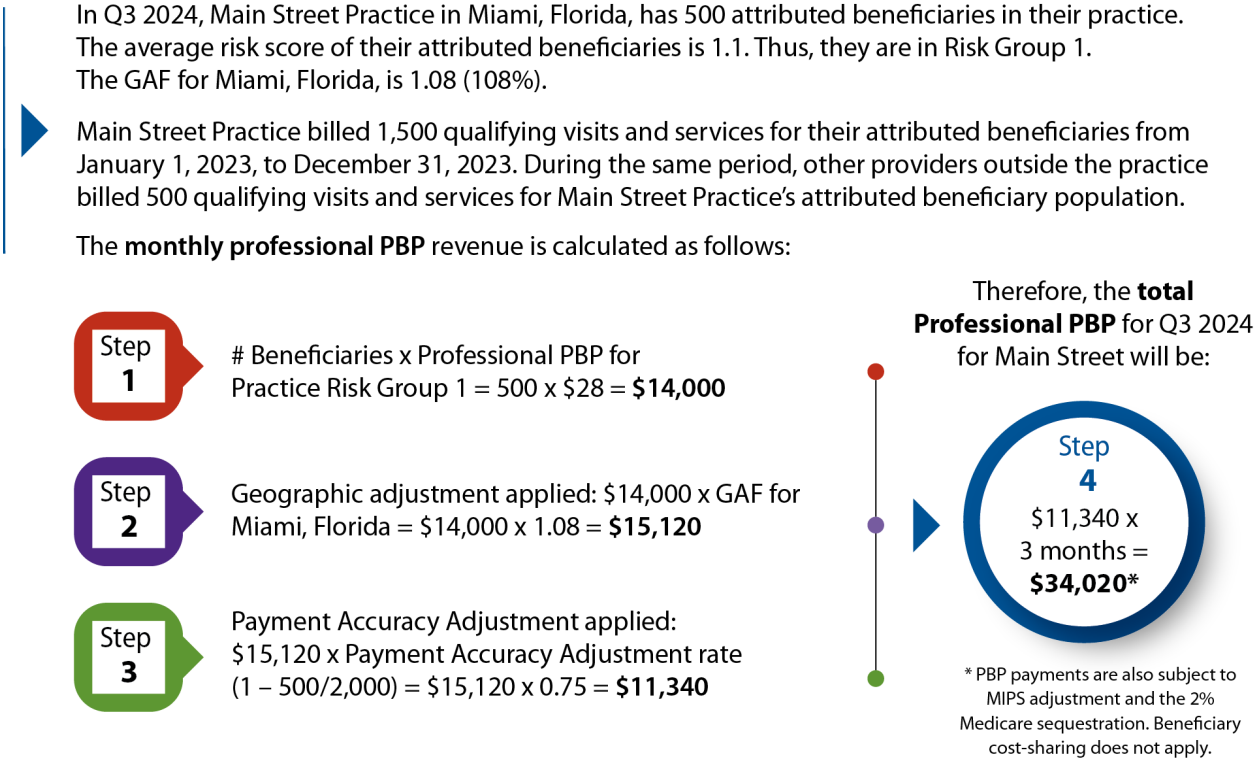
- Number of attributed beneficiaries
- Practice risk group
- Geographic adjustment
- Payment Accuracy Adjustment
- Performance-Based Adjustment

Chapter 5 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. In PCF specifically, CMS calculates a practice-level MIPS adjustment using the practitioner-level

MIPS adjustment from each practitioner listed as active on the practice's roster as of the end of the prior year. The PCF practice-level MIPS is calculated as the average practitioner MIPS adjustment weighted by the volume (dollar amount) of eligible claims billed by the respective practitioner in the MIPS measurement period.

Figure 2-1 provides an example of the calculation for the Professional PBP. Note that this example illustrates Q3 2024 payment.

Figure 2-1
Example of Professional PBP Calculation



GAF = Geographic Adjustment Factor; MIPS = Merit-based Incentive Payment System; PBP = Population-Based Payment.

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 is based on practices' performance on a set of quality measures. Chapter 4 describes the Quality Gateway in detail, and Chapter 5 describes PBA methodology.

2.6 *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 2-1) and any new primary care–focused codes introduced to the physician fee schedule. 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 may modify attribution, Professional PBP, and Payment Accuracy 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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3. Flat Visit Fee Payments

Chapter 3 documents the methodology used to calculate the FVF for PCF. 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 3-1, submitted by a practice participating in PCF 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 rules 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 3.1). Depending on the services provided, practitioners will receive an adjustment to the claim amount so that it is paid at the FVF rate.

Section 3.1 describes the applicable FVF-eligible HCPCS codes, Section 3.2 describes the FVF adjustments, Section 3.3 explains the FVF PBA payments, and Section 3.4 describes how FVF billing will be monitored. Section 3.5 explains the **telehealth** benefit enhancement in PCF.

> Practices will only receive Medicare payment for 1 FVF per beneficiary per day, even if multiple FVF services are provided. Your attributed beneficiaries will remain responsible for cost-sharing amounts for each HCPCS code submitted on a claim.

3.1 Applicable Healthcare Common Procedure Coding System Codes

PCF practitioners submitting the HCPCS codes in Table 3-1 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 practice are reimbursed according to the Medicare PFS instead of the FVF.

Table 3-1
Services Included in the FVF

Service	HCPCS Code
Office/outpatient E&M	99202–99205, 99211–99215
Prolonged E&M	99415, 99416
Transitional care management services	99495, 99496
Home care/domiciliary care E&M	99341, 99342, 99344, 99345, 99347–99350
Advance care planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439

E&M = evaluation and management; FVF = Flat Visit Fee; HCPCS = Healthcare Common Procedure Coding System.

The Professional PBP that practices receive for each attributed PCF beneficiary includes payment for services defined as **chronic care management (CCM)**-related services. CCM-related services are therefore considered duplicative of the PBP and will be denied if a PCF practice bills these services for any of their attributed beneficiaries. PCF practitioners are prohibited from billing CCM-related services (99487, 99490, 99491, and any corresponding add-on codes). PCF practices are also not allowed to bill the E&M add-on code (G2212) for any PCF beneficiaries because the service is covered by the Professional PBP.

3.2 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

3.2.1 Beneficiary Cost-Sharing

CMS calculates beneficiary 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 practice 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.

3.2.2 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 3-1 above for applicable services and HCPCS codes. All applicable services within the same day, even if there are multiple claims, will be

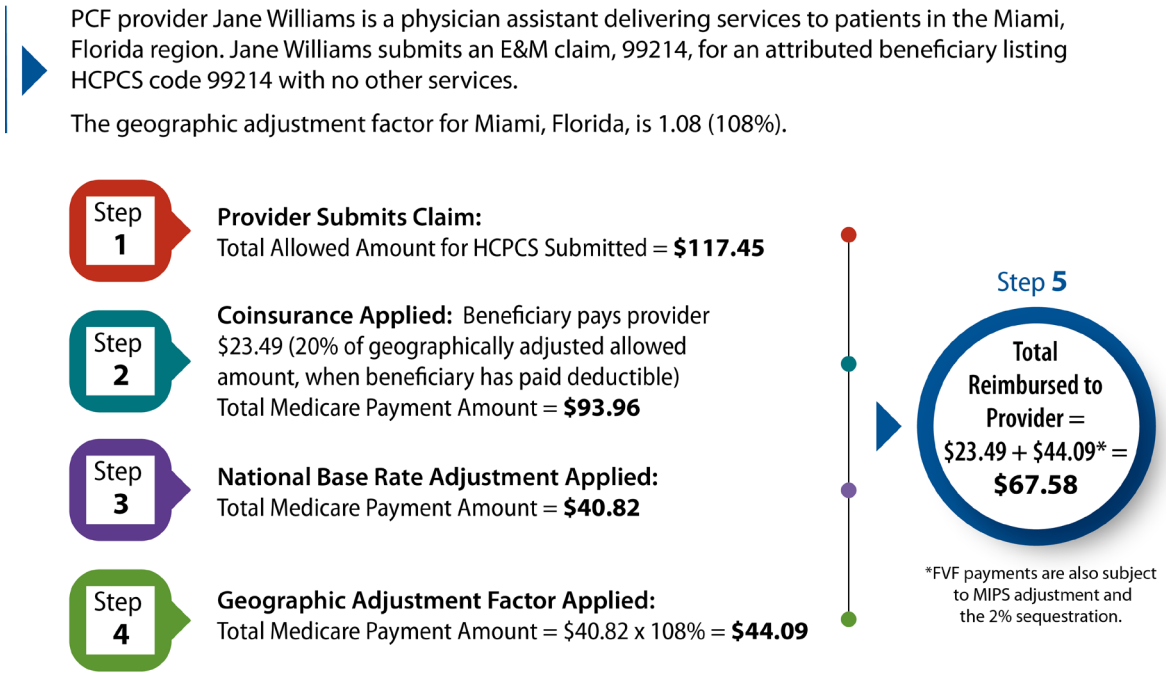
covered by 1 FVF. Thus, the Medicare payment amount to the practice is limited to 1 FVF per beneficiary per day.[15]

3.2.3 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 application of the geographic adjustment to the Professional PBP, see Section 2.2. More detail on the methodology and data used to calculate the GAFs and GPCIs is also available on the Medicare PFS website.

The FVF is also subject to the MIPS adjustment and 2% Medicare sequestration. Figure 3-1 is an example of how the FVF calculation will work:

Figure 3-1
Example Calculation for the FVF



E&M = evaluation and management; FVF = Flat Visit Fee; HCPCS = Healthcare Common Procedure Coding System; MIPS = Merit-based Incentive Payment System.

[15] 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.

3.3 Flat Visit Fees and the Performance-Based Adjustment

CMS will calculate and allocate the PBA for FVF payments as a quarterly lump-sum payment/debit outside of the Medicare FFS system. CMS will aggregate the Medicare payment amounts from FVF billing to a practice-specific total FVF amount that is subject to the PBA. To calculate total FVF payment amount, CMS will sum 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 will apply a **completion factor** to generate the total FVF payment amount. When FVF revenue is calculated each quarter, differing claim runout times exist for each month of the quarter that CMS is using to calculate total FVF PCF paid. For example, there are 3 months of runout for Month 1, 2 months of runout for Month 2, and 1 month of runout for Month 3. For that reason, CMS uses 3 different completion factors to inflate FVF claims in PCF. Completion factors are specific to each month of the quarter and multiplied by the FVF amount paid in the corresponding month. For claims with service dates within Month 1 of the quarter (3-month runout time), the completion factor used is 1.03983; for Month 2 (2-month runout time), the completion factor used is 1.05675; for Month 3 (1-month runout time), the completion factor used is 1.09914. CMS encourages PCF practices to submit their claims in a timely manner.

Finally, CMS will calculate the total FVF PBA amount by multiplying the total FVF payment amount 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 will pay 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 might earn a 20% PBA for Q2 2024 based on its AHU or TPCC performance from January 1, 2023, through December 31, 2023. In addition to adjusting the practice's Q2 2024 PBP by 20%, CMS will adjust the total FVF payment amount for visits that occurred during Q4 2023 (final quarter of PBA performance period) by 20%, delivered as a lump-sum FVF PBA for Q2 2024.

3.4 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 3-1). This monitoring will analyze practice-level claims billing patterns over time and will include 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.

3.5 Telehealth Benefit Enhancement

CMS implemented a Telehealth Benefit Enhancement in 2022. The PCF Telehealth Benefit Enhancement waives the originating site requirements for all FVF services that are also

Medicare telehealth services provided by practitioners at the participating practice.[16] Table 3-2 displays the PCF FVF codes that are also Medicare telehealth services. In practice, this means these codes can also be billed when they are provided via telehealth, using a place-of-service modifier. Any PCF practice that wants to use the telehealth waiver should submit the telehealth claim using "02" or "10" for the place of service.

Standard FVF policy, outlined in Chapter 3 of this document, will continue to apply for these telehealth FVF services that are billed with a place of service modifier of "02" or "10."

Table 3-2
Services Included in the Telehealth Benefit Enhancement

Service	HCPCS Code
Office/outpatient E&M	99202–99205, 99211–99215
Transitional care management services	99495, 99496
Advance care planning	99497, 99498
Annual Wellness Visits	G0438, G0439

E&M = evaluation and management; HCPCS = Healthcare Common Procedure Coding System.

3.6 Flat Visit Fees and the Shortage Area Bonus

The Shortage Area Bonus is an additional payment that CMS will make to certain eligible PCF practices providing services in Medicare Physician Health Professional Shortage Areas (HPSAs). This payment is designed to ensure that PCF does not diminish existing Medicare bonus payments that are in place to address disparities in geographic areas without enough health care providers to meet the health care needs of the local population. Continuing in 2024, CMS will calculate the additional Shortage Area Bonus payment to PCF practices with participating physicians who are eligible for the Medicare HPSA bonus program.[17]

Eligible PCF practices' total bonus payments (HPSA Bonus plus PCF Shortage Area Bonus) will be equivalent to the HPSA bonus payment they would have received under Medicare FFS before Flat Visit Fee adjustments. CMS will pay the PCF Shortage Area Bonus as an annual lump sum payment outside of the Medicare FFS system. To calculate the Shortage Area Bonus, CMS will compute the difference between the Flat Visit Fee-adjusted amount paid by CMS to the PCF practice for all eligible services furnished to PCF beneficiaries and the FFS amount that CMS would have paid for these services if the practice did not participate in PCF. CMS will then multiply the difference in the total payment for visits that occurred during the performance year by 10%, and this will be the amount of the practice's Shortage Area Bonus. CMS will pay the Shortage Area Bonus for 2024 claims as a lump sum no later than October 2025. The Shortage

[16] For a full list of Medicare telehealth services, please refer to this website: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

[17] For more detail on the Medicare HPSA bonus program, refer to the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses

Area Bonus paid by CMS to the PCF practice will not be included in the TPCP, and CMS will not apply the PBA to the Shortage Area Bonus.

4. Quality Gateway

This chapter describes the quality strategy used to assess PCF practices. 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 4.1 describes the quality strategy for Practice Risk Groups 1 and 2. Section 4.2 describes the quality strategy for Practice Risk Groups 3 and 4.

4.1 Practice Risk Groups 1 and 2

As discussed in Section 2.1.2, practices are assigned to 1 of 4 risk groups annually based on the average CMS-HCC risk score of their attributed Medicare beneficiaries. In addition to determining a practice's Professional PBP amount, these groupings determine the quality measures used in the Quality Gateway. Different quality measures reflect the different clinical needs of the patient populations served by Risk Group 1 and 2 practices compared with the average population in Risk Group 3 and 4 practices.

4.1.1 Quality Gateway

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 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 the first performance year, and the results are first applied to payments in the following performance year. To pass the Quality Gateway, practices in Risk Groups 1 and 2 must meet the minimum performance threshold for all 5 of the quality measures listed below.

The Quality Gateway for Practice Risk Groups 1 and 2 consists of 5 measures:[18]

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 (ACP) adapted for PCF (claims-based measure)** (A claims-based measure adapted for PCF from the Bundled Payments for Care Improvement [BPCI] Advanced ACP measure, which is a revised version of the Consensus-Based Entity [CBE]–endorsed ACP measure [CBE ID 0326])
5. **Patient Experience of Care (PEC) Survey** (Consumer Assessment of Healthcare Providers and Systems® [CAHPS®])

[18] For more information on eCQMs, see the eCQI Resource Center page here: https://ecqi.healthit.gov/ep-ec?globalyearfilter=2024.

The Quality Gateway measures are summarized in Table 4-1 by measure ID, the measure steward, benchmark population, and benchmark. Figure 4-1 displays the timeline for Quality Gateway performance periods, measure collection and calculation, and results.

Table 4-1
Quality Gateway Measures[a] for Practice Risk Groups 1 and 2

Measure Title (Type)	CBE ID/Quality ID/CMS ID[b]	Measure Steward	Performance Years[f]	Benchmark Population	Benchmark for 2024
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) (Intermediate Clinical Outcome eCQM)	CBE ID: 0059[b] Quality ID: 001 CMS ID: CMS122	NCQA[e]	1–4	MIPS	57.60%[g,h]
Controlling High Blood Pressure (Intermediate Clinical Outcome eCQM)	CBE ID: 0018[b] Quality ID: 236 CMS ID: CMS165	NCQA[e]	1–4	MIPS	56.61%[h]
Colorectal Cancer Screening (Process eCQM)	CBE ID: 0034[b] Quality ID: 113 CMS ID: CMS130	NCQA[e]	1–4	MIPS	34.53%[h]
Advance Care Plan adapted for PCF (claims-based measure)	CBE ID: 0326[c]	NCQA[e]	Cohort 1: 2-4 Cohort 2: 1-4	PCF, and non-PCF benchmark population	3.85%
Patient Experience of Care Survey (CAHPS® with supplemental items)	CBE ID: 0005[d]	AHRQ	1–4	PCF benchmark population	77.00[i]

AHRQ = Agency for Healthcare Research and Quality; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CBE = Consensus-Based Entity; eCQM = electronic Clinical Quality Measure; MIPS = Merit-based Incentive Payment System; NCQA = National Committee for Quality Assurance.

[a] The measures in the Quality Gateway are assessed for a given performance year, and the results are applied in the following year. For example, the Quality Gateway applied in Q1 through Q4 of the third performance year is based on performance during the second performance year.

[b] The Partnership for Quality Measurement (PQM) now serves as the CMS Consensus-Based Entity, replacing the National Quality Forum. The CBE ID replaces the National Quality Forum ID, but the number remains the same.

Please note that although PCF eCQMs are not CBE endorsed, the chart-abstracted version of this measure is endorsed. CMS has determined that this eCQM is evidence-based, reliable, and valid and has approved the eCQM for use in PCF model.

[c] The Advance Care Plan (ACP) measure is adapted for use in the PCF model from the Bunded Payments for Care Improvement (BPCI) Advanced ACP measure, which is a revised version of the CBE-endorsed ACP measure. See section 4.1.1.2 for details on this measure.

[d] The PCF Patient Experience of Care Survey includes a combination of items from the Clinician and Group CAHPS (CBE ID 0005) as well as from the Patient-Centered Medical Home (PCMH) CAHPS Supplement.

[e] Certain measures in the Primary Care First (PCF) model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found at https://www.cms.gov/priorities/innovation/about/notices-disclaimers.

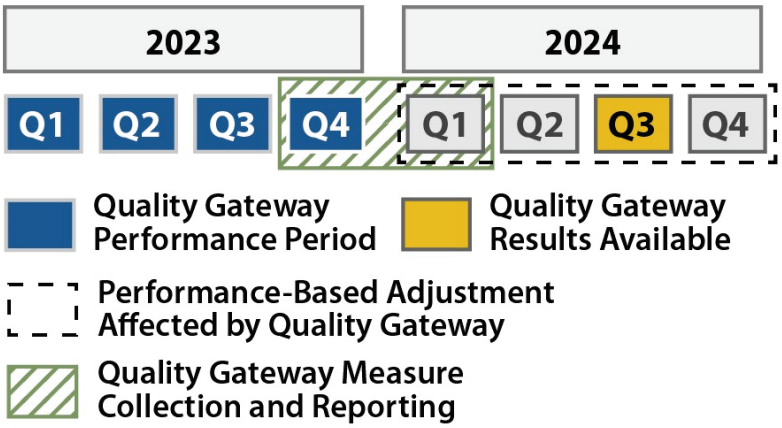
[f] Performance years refer to the measurement periods of the measure. Each measure has a 1-year measurement period. The results of quality measures impact the Quality Gateway in the year following the Performance Year.

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

[h] Each eCQM must meet or exceed the MIPS 2023 30th percentile benchmark to pass the Quality Gateway.

[i] The Performance Year 2024 PEC Survey benchmark was informed by historical PCF practice performance (Performance Year 2021 and Performance Year 2022) and is set at a threshold that CMS believes remains both motivational and achievable.

Figure 4-1
Timeline of Quality Gateway Performance Period, Measure Collection/Reporting, and Availability of Results



Note: The Patient Experience of Care Survey is fielded in Q4, and electronic Clinical Quality Measure reporting occurs in Q1.

4.1.1.1 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. Practices must submit the required eCQMs through the **Quality Payment Program (QPP)** website using the file format for PCF specified in the CMS Implementation Guide for **Quality Reporting Document Architecture (QRDA) III: Eligible Clinicians and Eligible Professionals Programs** (file format subject to change at CMS discretion).

Practices in Risk Groups 1 and 2 are required to successfully report all 3 eCQMs. Reporting only 1 or 2 of these measures will result in failing the Quality Gateway. Reporting only a partial year of data or failing to successfully report for all NPIs that delivered care at the practice during the performance year, may also result in failing the Quality Gateway.

4.1.1.1.1 eCQMs: Benchmark

For Performance Year 2024, practice performance for the 3 eCQMs will be compared to the 2023 MIPS benchmarks. The eCQMs include patients who have at least 1 visit to the practice during the measurement period and meet the initial population inclusion criteria. Patients under all payers and insurance statuses, including Medicare, are eligible. 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 eCQM Reporting Guide for the respective performance year.

4.1.1.1.2 eCQMs: Measurement Period and Scoring

Practices must successfully report the 3 eCQMs at the practice site level, which is identified by the PCF Practice ID. eCQM reporting is required starting with model participation. For practices participating in the model for PY 2024 (January 1, 2024, through December 31, 2024), the reporting period is expected to be January 2, 2025, to February 28, 2025. CMS calculates the measures annually. All practices are required to report 12 months of data covering the entire measurement period for each eCQM. Practices with a planned health information technology (IT) system or vendor transition during the year must ensure that all data are transferred from their prior health IT systems or leverage additional health IT to meet this requirement.

Measure stewards update the **measure specifications** annually. Practices must use the eCQM version appropriate for the current measurement period. The eCQMs for the 2024 Measurement Period can be accessed by selecting "2024" 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 2024 eCQMs that practices are required to submit:

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

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) (CMS122[19]), Controlling High Blood Pressure (CMS165), and Colorectal Cancer Screening (CMS130) are eCQMs with a single performance rate and are calculated using the following equation:

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

4.1.1.2 Advance Care Plan adapted for PCF (claims-based measure)

CMS reviewed current measures used by other CMS programs for quality reporting, such as MIPS, and selected the ACP measure which is designed to indicate quality of care specifically relevant to primary care and complex patient populations. This measure is a claims-based process of care measure adapted from the BPCI Advanced measure, which is a revised version of the Consensus-Based Entity (CBE)–endorsed ACP measure. Using claims submitted by a

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

provider eligible to bill for the service, the measure captures the percentage of a practice's attributed Medicare beneficiaries aged 65 years and older who have (1) an advance care plan or surrogate decision maker documented in the medical record, or (2) documentation in the medical record that an advance care plan was discussed but the patient did not wish to or was not able to provide an advance care plan or name a surrogate decision maker. Please note that advance care planning services can be provided by non-PCF practitioners.

4.1.1.2.1 ACP: Requirements for Satisfying the Process Measure

To satisfy the ACP measure, a claim for the attributed Medicare beneficiary must be observed with 1 of the qualifying Current Procedural Terminology (CPT) codes (CPT I or CPT II) and a date of service during the performance period. Table 4-2 lists the ACP-qualifying services.

Table 4-2
ACP Qualifying Services

Services	HCPCS Codes
Advance care planning (CPT I)	99497, 99498 (add-on code)
Advance care planning (CPT II)	1123F, 1124F (nonpayment tracking codes)

ACP = Advance Care Plan; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System.

4.1.1.2.2 ACP: Reporting Method and Instructions

The ACP measure is a claims-based measure and requires no additional reporting beyond what practices submit on Medicare administrative claims. CMS calculates this measure for PCF practices annually.

4.1.1.2.3 ACP: Benchmark

To derive the ACP benchmark for 2024, CMS used a 2022 national benchmark population. This population is made up of PCF Cohort 1 and 2 practices 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). Beneficiaries are attributed to national benchmark population practices using the same attribution algorithm as the PCF claims-based attribution algorithm.

To derive reliable benchmarks, CMS only includes Medicare FFS practices with at least 10 attributed beneficiaries eligible for the measure denominator. The ACP national benchmark for 2024 was calculated from 260,342 practice observations, which included PCF Cohort 1 and 2 practices and Medicare FFS practices (TIN-NPI and CCN-NPI combinations). To establish the 30th percentile benchmark threshold, CMS examines the distribution of scores across all practices in the benchmark population. CMS will continue to assess patterns of care before and after calendar year 2024 and may revise these benchmarks in future years to preserve equity.

4.1.1.2.4 ACP: Measurement Period and Scoring

CMS will calculate the ACP measure for PCF practices annually. The current Measurement Period for ACP is January 1, 2024, through December 31, 2024.

4.1.1.3 Patient Experience of Care Survey Measurement

The PEC Survey 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 3.1 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 D describes the domains and questions.[20] The PCF version of the PEC Survey also includes other PCF-appropriate questions.

CMS requires PCF practices to procure a CMS-approved PEC Survey vendor to conduct the PEC Survey. CMS shall make available a list of approved PEC Survey 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 by a date and in a manner to be specified by CMS;
3. ensure that survey results are transmitted to CMS by a date and in a manner to be specified by CMS; and
4. ensure that the survey vendor adheres to the questionnaire, survey protocol, and format for submitting PEC Survey results to CMS.

If the survey vendor does not submit the practice's PEC Survey results in a timely manner, or if the PEC Survey submission is deemed invalid by CMS, CMS shall assign the practice a 0 for its yearly PEC Survey 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 each summer. Practices that fail to provide a patient roster to CMS will not receive a PEC Survey 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.

[20] For the latest version of the full questionnaire, please visit PCF Connect or the PCF PEC Survey website: https://pcfpecs.org/.

4.1.1.3.1 PEC Survey: Benchmark

The Performance Year 2024 PEC Survey benchmark was informed by historical PCF practice performance (Performance Year 2021 and Performance Year 2022) and is set at a threshold that CMS believes remains both motivational and achievable. To inform the benchmark for Performance Year 2024, practice surveys were 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).

CMS transformed each survey response into PEC Survey domain-specific scores using numeric values assigned to responses for a given measure, following the steps outlined in the next section. The PEC Survey Summary Score was calculated as the average of the 5 PEC Survey domain-specific measures and was case-mix adjusted based on age, sex, education, self-reported physical health, proxy response, and survey mode (paper survey vs. telephone interview). The distribution of PCF practice PEC Survey Summary Scores, on a 0 to 100 continuous scale, was assessed to arrive at a final benchmark. A practice's PEC Survey Summary Score must meet or exceed the benchmark to be eligible to pass the Quality Gateway.

CMS will continue to assess PEC Survey performance before and after calendar year 2024 and may revise the PEC Survey benchmarks to preserve equity.

4.1.1.3.2 PEC Survey: Performance

Step 1. Calculate PEC Survey domain-specific scores.

The PEC Survey Summary Score 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 yearly PEC Survey scoring. Table 4-3 includes the names of the 5 PEC Survey domains.

Table 4-3
PCF PEC Survey and CAHPS® Domain Crosswalk

PCF Reference Language/Shorthand	PCF CAHPS® Domain
Access	Getting Timely Appointments, Care, and Information
Communication	How Well Providers Communicate
Coordination of Care	Attention to Care from Other Providers
Self-Management	Providers Support Patient in Taking Care of Own Health
Provider Rating	Patient Rating of Provider and Care

CMS calculates PEC Survey 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 PEC Survey domains, a single response scale applies to all questions for a given domain.

Table 4-4 illustrates the 3 different PEC Survey question measurement scales.

Table 4-4
PEC Survey Measurement Scales

<table>
<tr><th>Domains</th><th colspan="11">CAHPS® Point Scale</th></tr>
<tr><td rowspan="3">Access: Getting Timely Appointments, Care, and Information (3 questions)
Communication: How Well Providers Communicate (5 questions)
Coordination of Care: Attention to Care from Other Providers (3 questions)</td><td colspan="11">Patients answer on a scale of 1 to 4</td></tr>
<tr><td colspan="3">Never</td><td colspan="3">Sometimes</td><td colspan="3">Usually</td><td colspan="2">Always</td></tr>
<tr><td colspan="3">1</td><td colspan="3">2</td><td colspan="3">3</td><td colspan="2">4</td></tr>
<tr><td rowspan="3">Self-Management: Providers Support Patient in Taking Care of Own Health (2 questions)</td><td colspan="11">Patients answer on a dichotomous scale of 0 or 1</td></tr>
<tr><td colspan="6">0</td><td colspan="5">1</td></tr>
<tr><td colspan="6">No</td><td colspan="5">Yes</td></tr>
<tr><td rowspan="3">Provider Rating: Patient Rating of Provider and Care (1 question)</td><td colspan="11">Patients answer on a scale of 0 to 10</td></tr>
<tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td></tr>
<tr><td colspan="11">Worst Best</td></tr>
</table>

Next, CMS applies case-mix adjustment to the scores using the CAHPS consortium instructions and the variables listed in Section 4.1.1.3.1. Then, 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 PEC Survey 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 Patient's Rating of Provider is a single-question PEC Survey 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 4-5 illustrates this process in greater detail.

Table 4-5
Examples of Scoring Transformations for PEC Survey 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
2 response options for "Self-Management" 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
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

PEC = Patient Experience of Care.
[a] Three PEC Survey domains with 4 response options are Access, Communication, and Coordination of Care.

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

$$PEC\ Summary\ Score = (Access + Communication + Coordination\ of\ Care + Self\text{-}Management + Provider\ Rating)/5$$

The PEC Survey Summary Score ranges from 0–100, similar to the domain-specific scores. CMS compares the practice's PEC Survey Summary Score to the benchmark threshold described in Section 4.1.1.3.1 to determine whether the practice achieved the PEC Survey portion of the Quality Gateway. Each participating practice must meet or exceed the benchmark to qualify for the Quality Gateway.

4.2 Practice Risk Groups 3 and 4

Practices with a higher average CMS-HCC risk score of attributed Medicare beneficiaries 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.

4.2.1 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 different set of quality measures to account for their patients' specific clinical and supportive needs. For practices in Practice Risk Groups 3 and 4, 2 quality measures are assessed for Performance Year 2024 for application of the Quality Gateway in the following year: (1) ACP and (2) the PEC Survey. The ACP and PEC Survey measures for Practice Risk Groups 3 and 4 are the same as the ACP and PEC Survey measures used for Practice Risk Groups 1 and 2.

In March 2023, CMS made a policy change to remove the Days at Home measure from the Quality Gateway assessment for Performance Year (PY) 2023. Therefore, practice performance on the Days at Home measure did not affect the Performance-based Adjustment payments in 2024. In September 2024, CMS made the policy decision to remove the Days at Home Measure from PY 2024 Quality Gateway assessment as well. CMS will continue to calculate Days at Home performance for informational purposes only. Table 4-6 summarizes the Quality Gateway measures by measure ID, measure steward, benchmark population, and benchmark.

Table 4-6
Quality Gateway Measures[a] for Practice Risk Groups 3 and 4

Measure Title (Type)	CBE/ Quality ID	Measure Steward	Performance Years[e]	Benchmark Population	Benchmark for Performance Year 2024
Advance Care Plan adapted for PCF (claims-based measure)	CBE ID: 0326[b]	NCQA[d]	Cohort 1: 2–4 Cohort 2: 1–4	PCF and non-PCF benchmark population (see Chapter 4)	3.85%
Patient Experience of Care Survey (CAHPS with supplemental items)	CBE ID: 0005[c]	AHRQ	1–4	PCF benchmark population	77.00[g]
Days at Home (claims-based measure adapted for PCF; not included in PY 2024 Quality Gateway)	TBD	CMS	Cohort 1: 2–4[f] Cohort 2: 1–4[f]	PCF, and non-PCF benchmark population	319.27

AHRQ = Agency for Healthcare Research and Quality; CAHPS = Consumer Assessment of Healthcare Providers and Services; CBE = Consensus-Based Entity; PCF = Primary Care First; TBD = To be determined.
[a] CMS assesses the measures in the Quality Gateway for a given performance year and applies the results in the following year. For example, the Quality Gateway applied in the third performance year will be based on performance during the second performance year.
[b] The ACP measure is adapted for use in the PCF model from the Bunded Payments for Care Improvement (BPCI) Advanced ACP measure, which is a revised version of the CBE-endorsed ACP measure. See section 4.1.1.2 for details on this measure.

[c] The PCF Patient Experience of Care Survey includes a combination of items from the Clinician and Group CAHPS (CBE ID 0005) as well as from the Patient-Centered Medical Home (PCMH) CAHPS Supplement.
[d] Certain measures in the PCF model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found at https://www.cms.gov/priorities/innovation/about/notices-disclaimers.
[e] Performance years refer to the measurement periods of the measure. Each measure has a 1-year measurement period. The results of quality measures impact the Quality Gateway in the year following the Performance Year.
[f] The Days at Home measure will be calculated for informational purposes only during calendar year 2024, will not be assessed in the Quality Gateway in 2025, and will not affect Performance-based Adjustment payments in 2025.
[g] The Performance Year 2024 PEC Survey benchmark was informed by historical PCF practice performance and is set at a threshold that CMS believes remains both motivational and achievable.

4.2.1.1 Days at Home Measure

The Days at Home measure will not be assessed as part of the PY 2024 Quality Gateway in 2025, and therefore will not affect PBA payments in 2025. The Days at Home measure will continue to be calculated for informational purposes only.

Days at Home is a risk-adjusted claims-based measure that measures the number of days a beneficiary remains at home or in community settings and outside of an acute care setting, such as inpatient hospital or emergent care settings, or post-acute settings, such as skilled nursing facilities, during a standardized time period. This measure is limited to complex, chronically ill beneficiaries (as defined by a CMS-HCC risk score ≥ 2.0) 18 years of age and older.

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 was 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.

CMS began measuring Days at Home in PY 2022. Although the measure is not in the Quality Gateway assessed in 2024, CMS will calculate practice-level measure performance for PY 2023 and provide results to practices. CMS is providing measure performance information to allow

Risk Group 3 and 4 practices an opportunity to monitor performance and develop internal processes to better understand and improve upon performance results.

Appendix J contains additional information about the Days at Home measure.

4.2.1.2 Days at Home: Benchmark

To derive the Days at Home benchmark, CMS used a 2022 national benchmark population. This population is made up of PCF Cohort 1 and 2 practices in Risk Groups 3 and 4, the equivalent of Risk Group 3 and 4 practices among the universe of Medicare FFS practices, and Medicare beneficiaries attributed to the national benchmark population practices. The universe of Medicare FFS practices includes unique TIN and NPI combinations (TIN-NPIs) and unique CCN and NPI combinations (CCN-NPIs). Beneficiaries are attributed to national benchmark population practices using the same attribution algorithm as the PCF claims-based attribution algorithm.

To derive reliable benchmarks, CMS only includes Medicare FFS practices with at least 25 attributed beneficiaries eligible for the measure denominator. The Days at Home national benchmark for 2024 was calculated from 6,281 practice observations, which included PCF Cohort 1 and 2 practices in Risk Group 3 and 4 as well as Medicare FFS practices (TIN-NPI and CCN-NPI combinations) equivalent to Risk Group 3 and 4 practices. To establish the 30th percentile benchmark threshold, CMS examines the distribution of scores across all practices in the benchmark population.

5. Performance-Based Adjustment

Chapter 5 describes the PBA methodology for PCF payments in 2024 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. 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 (see Chapter 4: Quality Gateway). The PBA has a potential downside risk of −10% of TPCP revenue and a maximum potential upside of 50% of TPCP revenue.

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

1. **Annual Quality Gateway**. To be eligible for a positive PBA, practices must meet the minimum performance threshold on a set of quality measures listed in Chapter 4.
2. AHU/TPCC performance compared with the **National Benchmark**. To be eligible for a positive regional performance adjustment, practices must pass the National Benchmark.
3. AHU/TPCC performance compared with their peer region group (**Regional Performance Adjustment**). Practice performance against their peer region group determines which of the 7 levels of Regional Performance Adjustment practices receive.
4. AHU/TPCC performance compared with their own historical performance (**CI Bonus**). Both the degree of improvement needed to earn the CI bonus and level of CI bonus are determined by which of the 7 levels of Regional Performance Adjustment practices received.

Section 5.1 provides an overview of the 2 utilization and cost measures used to calculate PBA. Section 5.2 provides an overview of the elements of the PBA. Section 5.3 explains the calculation process for PBA and provides an example of an adjustment to a practice's payment.

5.1 Utilization and Cost Measures

For practices in Risk Groups 1 and 2, CMS will determine the PBA based on a utilization measure, AHU. For practices in Risk Groups 3 and 4, CMS will determine the PBA based on a cost measure, TPCC.

CMS calculates the AHU or TPCC measure for your practice. PCF practices are not required to calculate or separately report these claims-based measures. Practices will receive practice-level information on AHU or TPCC performance in quarterly PBA reports.

5.1.1 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.

5.1.1.1 AHU: Calculation of Utilization Measure

The guiding principle for the selection of the AHU measure for PCF 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. CMS calculates it each quarter 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.[21] Additional details on the measure's specification can be found on the NCQA's website: https://www.ncqa.org/hedis/measures/acute-hospital-utilization/.

5.1.1.2 AHU: Benchmark

Continuing in 2024, the AHU national and regional benchmarks utilize a concurrent benchmarking approach. Instead of finalizing a retrospective benchmarking approach, in which benchmarks are derived from a time period prior to the performance year, CMS will use a concurrent benchmarking approach, in which the performance and benchmark time periods are the same. In other words, CMS will use a PY 2023 performance period to develop benchmarks that are used to assess practices' PY 2023 AHU performance. Using the same time period for benchmarking and performance reduces the risk that practice performance results are caused

[21] Certain measures in the PCF model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found at https://www.cms.gov/priorities/innovation/about/notices-disclaimers.

by broader health care trends that are outside of practices' control, leading to fairer and more-accurate benchmarks.

To calculate AHU benchmarks, CMS will first calculate the observed and expected number of visits for every beneficiary who is in the benchmark population and eligible for inclusion in the measure. CMS will then aggregate both the observed and expected number of visits to the practice level and calculate the O/E ratio for each practice. Table 5-1 contains the measure steward, performance years, benchmark population, and national benchmark for 2024.

Table 5-1
Utilization Measure National Benchmark

Measure Title (Type)	Measure Steward	Performance Years[a]	Benchmark Population	50th Percentile Benchmark for 2024
Acute Hospital Utilization (HEDIS measure)[b]	NCQA	1–4	PCF and non-PCF Medicare benchmark population	0.98

PCF = Primary Care First; HEDIS = Healthcare Effectiveness Data and Information Set; NCQA = National Committee for Quality Assurance.
[a] Performance years refers to the measurement periods of the measure. The measure has a 1-year measurement period (AHU is calculated with a rolling 1-year performance period).
[b] Certain measures in the PCF model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found at https://www.cms.gov/priorities/innovation/about/notices-disclaimers.

The benchmark population will include PCF practices 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). Beneficiaries are attributed to these practices using the same attribution algorithm as the PCF claims-based attribution algorithm. To derive reliable benchmarks, CMS only includes AHU performance for Medicare FFS practices with at least 125 attributed beneficiaries who were eligible for inclusion in the measure.

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

CMS establishes peer region group benchmarks by assessing AHU performance from the same practices included in the national benchmarks but limiting the practices to those in a defined region. To develop AHU peer group regions, CMS first calculates performance for each individual state. CMS then groups states with similar performance levels and proximal geography into peer region groups. Appendix E contains PY 2024 AHU national and peer region group benchmarks based on 2023 data.

5.1.2 Cost Measure (Total Per Capita Cost, 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.

5.1.2.1 TPCC: Calculation of Cost Measure

The TPCC measure is claims-based and does not require practice reporting. CMS calculates the measure for PBA each quarter. 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 a ratio, dividing the observed cost by the expected cost. An O/E ratio greater than 1 represents greater-than-expected cost, and a ratio less than 1 represents lower-than-expected cost. TPCC is an inverse measure; lower performance scores reflect better quality.

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 2.1.2, to risk-adjust the TPCC measure within each quarter during the measurement period. CMS then calculates the TPCC measure by taking each practice's sum of the observed costs across all attributed beneficiary quarters and dividing it by the corresponding sum of the practice-level expected costs across all eligible beneficiary quarters in the measurement period. Appendix F contains detailed specifications for the TPCC measure.

5.1.2.2 TPCC Benchmark

Continuing in 2024, the TPCC national and regional benchmarks utilize a concurrent benchmarking approach. Instead of finalizing a retrospective benchmarking approach, in which benchmarks are derived from a time period prior to the performance year, CMS will use a concurrent benchmarking approach, in which the performance and benchmark time periods are the same. In other words, CMS will use a PY 2023 performance period to develop benchmarks that are used to assess practices' PY 2023 TPCC performance. Using the same time period for benchmarking and performance reduces the risk that practice performance results are caused by broader health care trends that are outside of practices' control, leading to fairer and more-accurate benchmarks.

To calculate TPCC benchmarks, CMS first calculates the observed and expected costs for every beneficiary who is in the benchmark population and eligible for inclusion in the measure. CMS then aggregates both the observed and expected costs to the practice level and calculates the O/E ratio for each practice. Table 5-2 contains the measure steward, performance years, benchmark population, and national benchmark for 2024.

Table 5-2
Cost Measure National Benchmark

Measure Title	Measure Steward	Performance Years[a]	Benchmark Population	50th Percentile Benchmark for 2024
Total Per Capita Cost, adapted for Primary Care First	CMS	1–4	PCF and non-PCF Medicare benchmark population	0.99

PCF = Primary Care First.
[a] Performance years refers to the measurement periods of the measure. Each measure has a 1-year measurement period (TPCC is calculated with rolling 1-year performance period).

The benchmark population will include PCF practices and the universe of Medicare FFS practices and their attributed Medicare beneficiaries, limited to practices whose practice average risk score among attributed beneficiaries meets the criteria for Risk Groups 3 or 4. The universe of Medicare FFS practices includes unique TIN and NPI combinations (TIN-NPIs) and unique CCN and NPI combinations (CCN-NPIs). Beneficiaries are attributed to these practices using the same attribution algorithm as the PCF claims-based attribution algorithm. To derive reliable benchmarks, CMS only includes TPCC performance from Medicare FFS practices with at least 20 attributed beneficiaries in each quarter who were eligible for inclusion in the measure.

CMS calculates the payment-standardized, risk-adjusted TPCC measure for all attributed beneficiary quarters in the benchmark population for the benchmark year. CMS then calculates the national benchmark using the distribution of practice-level TPCC performance for eligible beneficiaries in all practices included in the benchmark population during the benchmark year.

CMS establishes peer region group benchmarks by using TPCC performance from the same practices included in the national benchmarks but limiting the practices to those in a defined region. To develop TPCC peer group regions, CMS first calculates performance for each individual state. CMS then groups states with similar performance levels and proximal geography into peer region groups. Appendix E contains PY 2024 TPCC national and peer region group benchmarks based on 2023 data.

5.1.3 Continuous Improvement Bonus

The historical adjustment, also known as the CI bonus, rewards a practice's individual performance improvement on the AHU or TPCC measure. The CI bonus, added to the Regional Performance Adjustment, produces the overall PBA.

For both cohorts, CMS calculates the practice's amount of improvement for the CI bonus quarterly by comparing its AHU or TPCC performance during the same performance period as the Regional Performance Adjustment to a historical 1-year base performance period.

For both cohorts, CMS will use the 1-year base performance period immediately preceding the current PBA performance period, which ends 3 months before the PBA quarter. For example, for Q1 2024, the AHU or TPCC 1-year current performance period ends in Q3 2023 (October 1, 2022, through September 30, 2023) and is compared with the 1-year base period that ends in Q3 2022 (October 1, 2021, through September 30, 2022). If a practice sufficiently improves between those 2 periods, its CI bonus is applied to its Q1 2024 PBA (see Figure 5-5 for an overview of the CI base performance periods). See Section 5.2.2 for additional details.

Eligible participating practices receive the CI bonus each quarter, as long as they achieve their improvement target and the improvement is statistically significant. This policy rewards participating practices that do not meet or exceed the national or regional AHU or TPCC benchmark by paying them 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 benchmark on all quality measures). CI bonuses paid during the earlier quarters of the year are recouped if the practice fails the Quality Gateway when it is calculated later in the year.

Similarly, if a practice is selected for a quality audit and fails the audit, the practice is considered to have failed the Quality Gateway and any CI bonus paid during the year will be recouped.

5.1.3.1 AHU and TPCC 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.

To mitigate the chance that changes in AHU or TPCC 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 calculates the AHU or TPCC performance rate for each practice in the base performance period and the current performance period. 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 or TPCC 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.

For more information on the methodology CMS uses to determine whether a practice's CI Score is statistically significant and eligible to earn the CI Bonus, including a step-by-step overview of the statistical significance calculation and several examples using actual data, please see the PCF Primer on the Statistical Significance Calculation for the CI Score, which is available on PCF Connect.

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, CMS may make adjustments if it determines that the ratio of AHU or TPCC 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.

5.2 Elements of the Performance-Based Adjustment

CMS assesses the Quality Gateway annually and uses the results to determine the PBA for each quarter during the calendar year.[22]

For practices that meet or exceed the minimum thresholds of the Quality Gateway (see Chapter 4), 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 its peer region

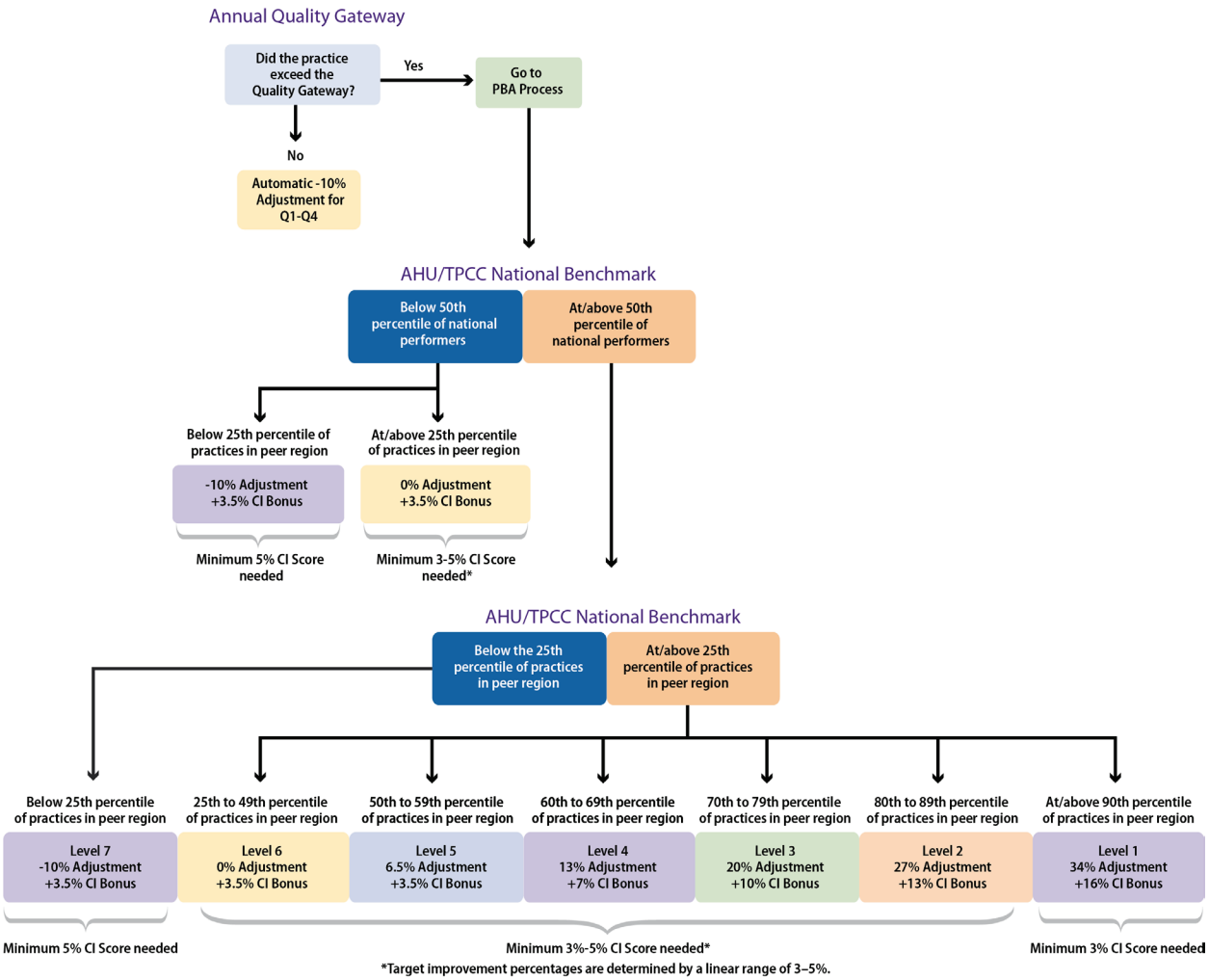
[22] The Quality Gateway that affects payments in 2024 is based on prior year performance on quality measures during 2023.

group benchmark, established by CMS using data from a reference group of practices (including practices that do not participate in PCF). 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 5-1 below).

The CI bonus also influences the PBA amount. A practice's performance relative to its peer region group 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.

Figure 5-1 outlines the steps of the Quality Gateway and PBA process for both cohorts' payments.

Figure 5-1
Quality Gateway and PBA Process



AHU = Acute Hospital Utilization; CI = Continuous Improvement; PBA = Performance-based Adjustment; TPCC = Total Per Capita Cost.

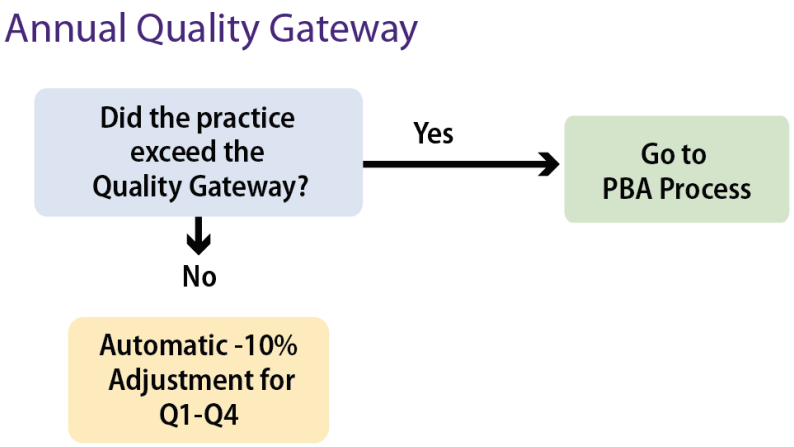
5.2.1 Quality Gateway

The annual Quality Gateway results are applied to payments during each quarter of the calendar year and are based on performance on quality measures during the previous performance year. Annual Quality Gateway results are calculated in Q3 and applied to the PBA of PCF payments each quarter of the calendar year. In other words, the PBA amounts in Quarters 1 and 2 are retrospectively updated on the basis of the results of the Quality Gateway, and Quarters 3 and 4 reflect the Quality Gateway results. To pass the Quality Gateway, practices must meet minimum thresholds on quality measures, as detailed in Chapter 4.

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. Starting in the third performance year (in PY 2024, all practices are now in their third or fourth performance year), practices that do not meet the Quality Gateway will automatically receive a negative PBA (−10%) in all PBA quarters for the performance year. Only practices that pass the annual Quality Gateway will be eligible for the CI bonus in the PBA quarters of that year. Quality Gateway results will not be available until the Q3 PBA; therefore, in earlier quarters, CMS initially assumes all practices pass the Quality Gateway when assessing the PBA. Quality audit results will not be available until the Q4 PBA; therefore, in earlier quarters, audit results are not taken into account. Practices that fail the quality audit will not pass the Quality Gateway. If CMS determines in Q3 or later that a practice does not pass the Quality Gateway, any positive PBA payments made earlier in the year will be debited from future quarterly payments.

Figure 5-2 shows the Annual Quality Gateway Process, including subsequent impact on payments.

Figure 5-2
Quality Gateway Process



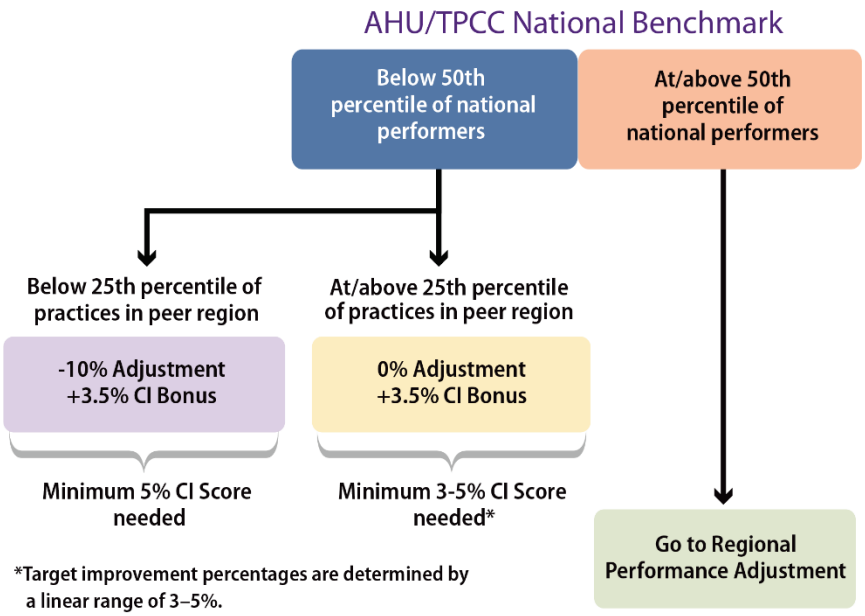
PBA = Performance-based Adjustment.

5.2.2 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 group performance, determines practice eligibility for a positive Regional Performance Adjustment. 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.

Figure 5-3 shows the National Benchmark process **for practices that pass the Quality Gateway.**

Figure 5-3
National Benchmark Process



AHU = Acute Hospital Utilization; CI = Continuous Improvement; TPCC = Total Per Capita Cost.

5.2.3 Regional Performance Adjustments

To calculate the Regional Performance Adjustment, CMS establishes and compares practices' AHU or TPCC performance to a peer region group benchmark using data from a reference group of practices (including non-PCF practices) by geographic region.[23] This approach incentivizes PCF practices to provide better quality of care relative to all other practices within their peer region group, while creating the potential for all PCF practices to earn a positive

[23] 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 2 measures.

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 group 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 5-1). CMS calculates Regional Performance Adjustments quarterly using a rolling 1-year performance period and applies them to payments. CMS uses AHU or TPCC performance, depending on the practice risk group, to determine the Regional Performance Adjustments.

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). Appendix G contains AHU and TPCC peer region groups. CMS may change peer region groups if average state performance in the current groupings shift meaningfully in a manner that would adversely impact practices in a PCF region. Appendix E contains PY 2024 AHU and TPCC national and peer region group benchmarks based on 2023 data.

5.2.4 Continuous Improvement Bonus

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 to its own historical performance in a 1-year base period before the current quarter's performance period (see Figure 5-5 below for an overview of the CI base performance periods). CMS uses the CI score and the practice's current quarter regional performance level to determine the amount of CI bonus.

Practices with AHU or TPCC results that meet or exceed the 90th percentile of their region's performance have a target improvement of 3% from one performance period to the next, and those with results below the 25th percentile of practices have a target improvement of 5%. Practices with AHU or TPCC 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.

In addition to meeting a minimum CI Score threshold, a practice's improvement must be statistically significant for a practice to be eligible for a CI Bonus. For more information on the

methodology CMS uses to determine whether a practice's CI Score is statistically significant and eligible to earn the CI Bonus, including a step-by-step overview of the statistical significance calculation and several examples using actual data, please see the PCF Primer on the Statistical Significance Calculation for the CI Score, which is available on PCF Connect.

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 group 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.

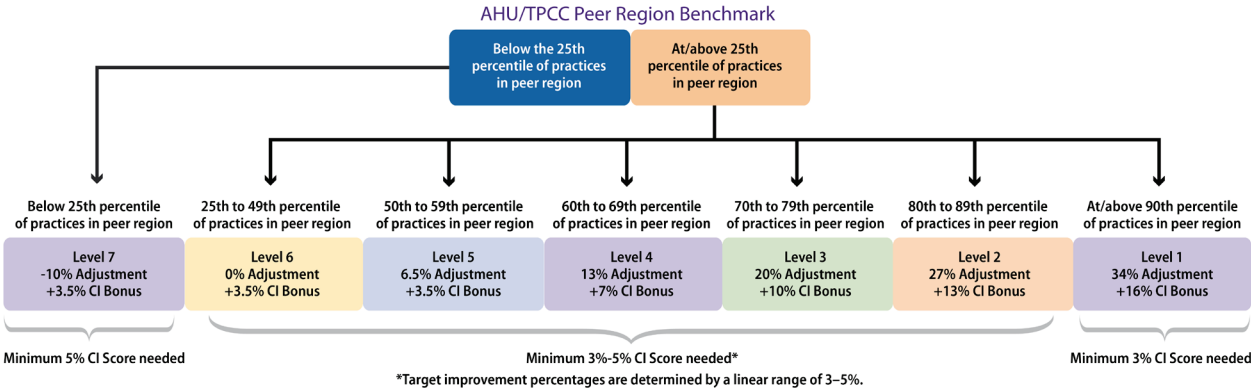
Table 5-3
Continuous Improvement Bonus Potential Based on Practice Improvement Performance

AHU or TPCC Regional Performance Level in Current 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

AHU = Acute Hospital Utilization; CI = Continuous Improvement; TPCC = Total Per Capita Cost; TPCP = Total Primary Care Payment.

Figure 5-4 shows the Regional Performance Adjustment and CI Bonus options **for practices that pass the Quality Gateway and the National Benchmark.**

Figure 5-4
Regional Performance Adjustment and CI Bonus Options



AHU = Acute Hospital Utilization; CI = Continuous Improvement; TPCC = Total Per Capita Cost.

5.3 *Timeline for Performance-Based Adjustment Application*

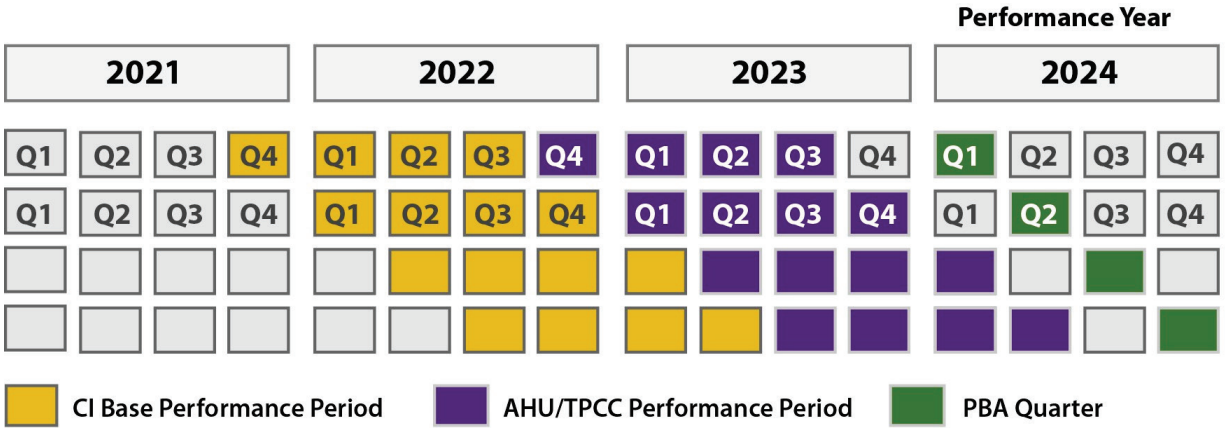
Each quarter, the PBA is based on practices' AHU/TPCC performance during a rolling 1-year performance period that ends 3 months before the PBA quarter. For example, the Q1 2024 PBA is based on AHU or TPCC performance from October 1, 2022, through September 30, 2023 (Q4 2022 through Q3 2023). This timeline (see Figure 5-5 below) 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 to Q1 and Q2 payments retrospectively and to Q3 and Q4 payments prospectively.[24] The annual Quality Gateway is based on practices' performance on quality measures during the prior performance year, and results will become available in the third quarter after the performance year ends. For example, the 2023 Quality Gateway for Cohorts 1 and 2 is based on performance during 2023 and will become available in Q3 of 2024.

Figure 5-5 provides an overview of the PBA performance period timeline.

[24] 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 results are released in the third quarter.

Figure 5-5
Timeline of PBA Performance Periods



AHU = Acute Hospital Utilization; CI = Continuous Improvement; PBA = Performance-based Adjustment; TPCC = Total Per Capita Cost.

5.4 Performance-Based Adjustment Amount

5.4.1 Calculation of Final Percentage and Dollar Amount

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 5-4 and 5-5 summarize the possible adjustments practices can receive on the basis of their Regional Performance Adjustment and CI bonus. Table 5-4 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 5-5 presents the possible adjustments for those who do not meet or exceed the 50th percentile national benchmark.

Table 5-4
PBA Potential for Practices that Meet or Exceed the 50th Percentile of National Performers on AHU or TPCC

AHU/TPCC Regional Performance Level	% of TPCP		
	Regional Performance Adjustment	CI Bonus	Maximum Adjustment
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

AHU = Acute Hospital Utilization; CI = Continuous Improvement; TPCC = Total Per Capita Cost; TPCP = Total Primary Care Payment.
Note: This table applies only to practices that pass the Quality Gateway. Practices that do not pass the Quality Gateway receive an automatic −10% adjustment and are not eligible for the CI bonus.

Table 5-5
PBA Potential for Practices That Do Not Meet the 50th Percentile of National Performers on AHU or TPCC

AHU/TPCC Regional Performance Level	% of TPCP		
	Regional Performance Adjustment	CI Bonus	Maximum Adjustment
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

AHU = Acute Hospital Utilization; CI = Continuous Improvement; TPCC = Total Per Capita Cost; TPCP = Total Primary Care Payment.
Note: This table applies only to practices that pass the Quality Gateway. 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 multiplied by the practice's estimated TPCP for that quarter (see Figure 5-6 below for an example of a quarterly payment calculation). As a reminder, the TPCP is the sum of 2 elements: the Professional PBP and the FVF. See Section 3.3 for information about how CMS aggregates Medicare payment amounts from practices' FVF billing to a total FVF amount that is subject to the PBA. See also Section 2.3.2 for more detail on quarterly payment debits resulting from negatively assessed PBA.

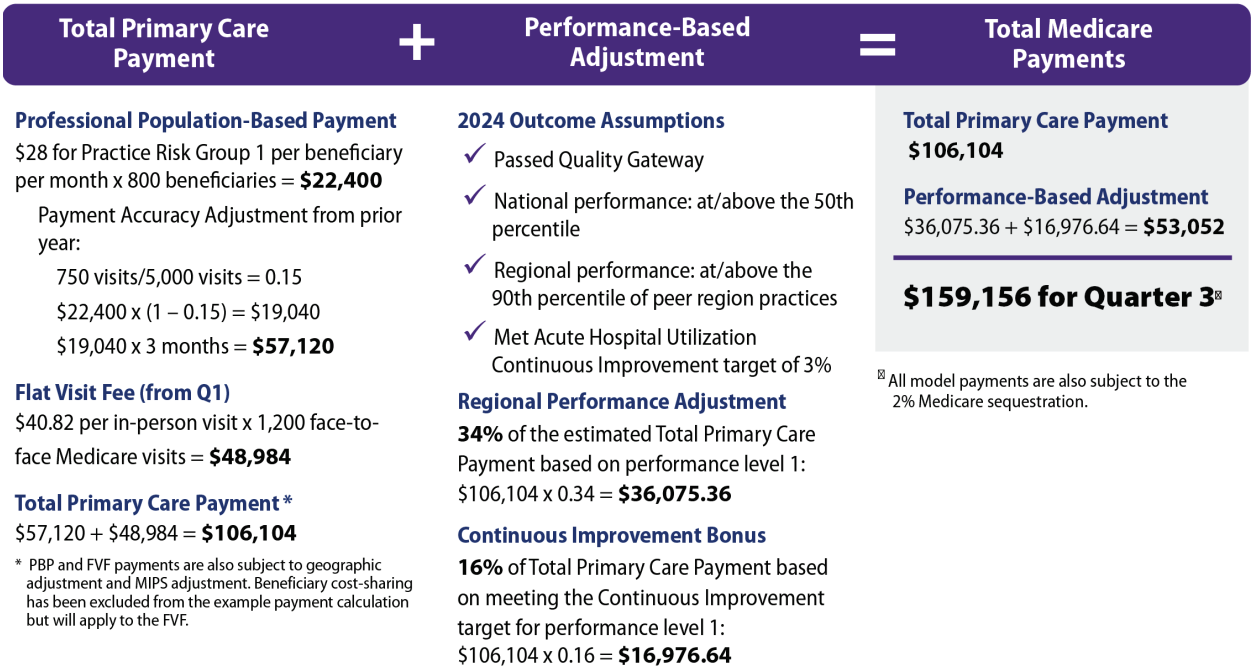
5.4.2 Example of Quarterly Payment Calculation

The quarterly payment for a practice participating in PCF 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 Payment Accuracy Adjustment) * (# of attributed beneficiaries) + (FVF * # of visits)
  - PBA = TPCP * (−10% up to 50%, based on performance)

Figure 5-6 provides an example of a quarterly payment calculation for a practice in Risk Group 1 for Q3 2024. 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 Payment Accuracy 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 5-6
Example of Quarterly Payment Calculation for Practice Risk Group 1 in Q3 2024



FVF = Flat Visit Fee; MIPS = Merit-based Incentive Payment System; PBP = Population-based Payment.

References

Agency for Healthcare Research and Quality (AHRQ). (2020, August). Instructions for analyzing data from CAHPS® Surveys: Using the CAHPS Analysis Program Version 5.0. AHRQ Publication No. 20-M019. Retrieved from Agency for Healthcare Research and Quality (AHRQ). Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/helpful-resources/analysis/2020-instructions-for-analyzing-data.pdf.

Barnato, A. E., Herndon, M. B., Anthony, D. L., Gallagher, P. M., Skinner, J. S., Bynum, J. P., & Fisher, E. S. (2007). Are regional variations in end-of-life care intensity explained by patient preferences? A study of the US Medicare Population. *Medical Care*, *45*(5), 386–393. https://doi.org/10.1097/01.mlr.0000255248.79308.41

Bell, M., Eriksson, L. I., Svensson, T., Hallqvist, L., Granath, F., Reilly, J., & Myles, P. S. (2019). Days at home after surgery: An integrated and efficient outcome measure for clinical trials and quality assurance. *EClinicalMedicine*, *11*, 18–26. https://doi.org/10.1016/j.eclinm.2019.04.011

Greene, S. J., O'Brien, E. C., Mentz, R. J., Luo, N., Hardy, N. C., Laskey, W. K., . . . Hammill, B. G. (2018). Home-time after discharge among patients hospitalized with heart failure. *Journal of the American College of Cardiology*, *71*(23), 2643–2652. https://doi.org/10.1016/j.jacc.2018.03.517

Jerath, A., Austin, P. C., & Wijeysundera, D. N. (2019). Days alive and out of hospital: Validation of a patient-centered outcome for perioperative medicine. *Anesthesiology*, *131*(1), 84–93. https://pubs.asahq.org/anesthesiology/article/131/1/84/18061/Days-Alive-and-Out-of-HospitalValidation-of-a

Myles, P. S., Shulman, M. A., Heritier, S., Wallace, S., McIlroy, D. R., McCluskey, S., . . . Forbes, A. (2017). Validation of days at home as an outcome measure after surgery: A prospective cohort study in Australia. *BMJ Open*, *7*(8), e015828. https://doi.org/10.1136/bmjopen-2017-015828

Quinn, T. J., Dawson, J., Lees, J. S., Chang, T. P., Walters, M. R., & Lees, K. R., & the GAIN and VISTA Investigators. (2008). Time spent at home poststroke: "home-time" a meaningful and robust outcome measure for stroke trials. *Stroke*, *39*(1), 231–233. https://doi.org/10.1161/STROKEAHA.107.493320

Sayer, C. (2016). "Time spent at home"—A patient-defined outcome. *NEJM Catalyst.* Retrieved from https://catalyst.nejm.org/time-spent-at-home-a-patient-defined-outcome/

Xian, Y., O'Brien, E. C., Fonarow, G. C., Olson, D. M., Schwamm, L. H., Hannah, D., . . . Hernandez, A. F. (2015). Patient-Centered Research into Outcomes Stroke Patients Prefer and Effectiveness Research: Implementing the patient-driven research paradigm to aid decision

making in stroke care. *American Heart Journal*, *170*(1), 36–45, 45.e1–45.e11. https://doi.org/10.1016/j.ahj.2015.04.008

Yu, A. Y. X., Rogers, E., Wang, M., Sajobi, T. T., Coutts, S. B., Menon, B. K., . . . Smith, E. E. (2017). Population-based study of home-time by stroke type and correlation with modified Rankin score. *Neurology*, *89*(19), 1970–1976. https://doi.org/10.1212/WNL.0000000000004631

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 ACO REACH model.

Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) 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).

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 adapted for PCF (claims-based measure) is 1 of the Quality Gateway measures for all practices participating in Primary Care First (PCF).

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 PCF, 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. Attribution and alignment can be used interchangeably. However, we use alignment when referring to voluntary alignment and attribution everywhere else.

Benchmark: Benchmarks are minimum performance thresholds that can be used as a reference to raise the standard of care for Medicare beneficiaries. Benchmarks establish the minimum performance levels on quality, utilization, or cost measures that participating PCF practices must reach to earn a 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.

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 started participating in Primary Care First on January 1, 2021.

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

Completion Factor: An adjustment made to a measurement of claims that accounts for the inherent lag in claims data for services performed but not yet processed and observed in the data. In measurements of claims expenditures, this is typically an upward adjustment, or a slight inflation of expenditures to account for partially incomplete data at the time the calculation is performed.

Comprehensive Primary Care Plus (CPC+): CMS Innovation Center advanced primary care medical home model that aimed to strengthen primary care through regionally based multi-payer payment reform and care delivery transformation. CPC+ included 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+ was a 5-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, such as 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: 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. Only Method II CAHs can participate in PCF.

Days at Home: Days when a beneficiary remains at home or in community settings and outside of acute care, such as an inpatient hospital or emergent care settings, or post-acute settings, such as skilled nursing facilities, during a standardized time period.

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 (FAI): 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 (IAH) 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.

Kidney Care Choices (KCC) Model: Builds upon the existing Comprehensive End-Stage Renal Disease Care Model structure 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.

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.

Making Care Primary (MCP) Model: A 10.5-year multi-payer CMS Innovation Center primary care model with 3 participation tracks that build upon previous primary care models such as CPC+, PCF, and the Maryland Primary Care Program. MCP aims to improve care for beneficiaries by supporting the delivery of advanced primary care services, which are foundational for a high-performing health care system. MCP will operate in 8 states: Colorado, North Carolina, New Jersey, New Mexico, New York, Minnesota, Massachusetts, and Washington. The model is expected to launch in July 2024.

Maryland Total Cost of Care (TCOC) 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, such as 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 (PEC) Survey: 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.

Payment Accuracy Adjustment (PAA) (Leakage Rate Adjustment): 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.

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 PCF.

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.

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

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 began in January 2021 for the first cohort of participants 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 the second performance year (based on performance during the first performance year).

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 Reporting Document Architecture Category III (QRDA III): A Health Level 7 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.

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 (e.g., 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.

Value in Opioid Use Disorder Treatment (ViT) Program: A demonstration program meant to increase access of applicable beneficiaries to opioid use disorder treatment services; improve physical and mental health outcomes for such beneficiaries; and, to the extent possible, reduce Medicare program expenditures.

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-Hierarchical Condition Category (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 one 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 most 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 2021 (risk score year) are calculated using diagnosis information from 2020 (base year). New Medicare enrollees (defined here as beneficiaries with less than 12 months of Medicare Part B 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 Part B 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. The current CMS-HCC model also includes a component for the number of conditions a beneficiary has. 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 V24 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	0.519
HCC 8—*Metastatic Cancer and Acute Leukemia*	2.566
HCC 39—*Bone/Joint/Muscle Infections/Necrosis*	0.588
3 Payment HCCs	0
Total CMS-HCC Risk Score	**3.673**

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. Patient Experience of Care Survey Domain Questions

PEC Survey Questions by Domain
1. Access
Q5. In the last 6 months, when you contacted this provider's office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?
Q7. In the last 6 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?
Q9. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?
2. Communication
Q13. In the last 6 months, how often did this provider explain things in a way that was easy to understand?
Q14. In the last 6 months, how often did this provider listen carefully to you?
Q15. In the last 6 months, how often did this provider seem to know the important information about your medical history?
Q16. In the last 6 months, how often did this provider show respect for what you had to say?
Q17. In the last 6 months, how often did this provider spend enough time with you?
3. Coordination of Care
Q21. In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?
Q23. In the last 6 months, how often did you and someone from this provider's office talk about all the prescription medicines you were taking?
Q30. In the last 6 months, how often did the provider named in Question 2 seem informed and up-to-date about the care you got from specialists?
4. Self-Management
Q33. In the last 6 months, did someone from this provider's office talk with you about specific goals for your health?
Q34. In the last 6 months, did someone from this provider's office ask you if there are things that make it hard for you to take care of your health?
5. Provider Rating
Q28. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?
6. Shared Decision Making
Q25. When you talked about starting or stopping a prescription medicine, did this provider talk about the reasons you might want to take a medicine?
Q26. When you talked about starting or stopping a prescription medicine, did this provider talk about the reasons you might **not** want to take a medicine?
Q27. When you talked about starting or stopping a prescription medicine, did this provider ask you what you thought was best for you?

PEC = Patient Experience of Care.

PEC Survey Domains and Point Scales

Domains	PEC Survey Point Scale
Access (3 questions) Communication (5 questions) Coordination of Care (3 questions)	1–4 Always = 4 Usually = 3 Sometimes = 2 Never = 1
Self-Management (2 questions)	0–1 Yes = 1 No = 0
Provider Rating (1 question)	0–10 Patients answer on a scale of 0–10

PEC = Patient Experience of Care.

Appendix E. PY 2024 Informational Acute Hospital Utilization and Total Per Capita Cost Regional Benchmarks

The following tables include Performance Year 2024 national and peer region group benchmarks for Acute Hospital Utilization (AHU) and Total Per Capita Cost (TPCC). These concurrent benchmarks were released in Q2 2024.

Table E-1
PY 2024 AHU and TPCC National Benchmarks

Measure Title	Median (50th percentile)
Acute Hospital Utilization (AHU)	0.98
Total Per Capita Cost (TPCC)	0.99

Table E-2
PY 2024 AHU Peer Region Group Benchmarks

Region	At or above 90th percentile	89th–80th percentile	79th–70th percentile	69th–60th percentile	59th-50th percentile	49th-25th percentile	Below 25th percentile
Region 1	≤ 0.57	> 0.57–≤ 0.67	> 0.67–≤ 0.74	> 0.74–≤ 0.81	> 0.81–≤ 0.87	> 0.87–≤ 1.05	> 1.05
Region 2	≤ 0.58	> 0.58–≤ 0.68	> 0.68–≤ 0.75	> 0.75–≤ 0.81	> 0.81–≤ 0.87	> 0.87–≤ 1.05	> 1.05
Region 3	≤ 0.67	> 0.67–≤ 0.77	> 0.77–≤ 0.85	> 0.85–≤ 0.91	> 0.91–≤ 0.97	> 0.97–≤ 1.16	> 1.16
Region 4	≤ 0.67	> 0.67–≤ 0.77	> 0.77–≤ 0.84	> 0.84–≤ 0.91	> 0.91–≤ 0.98	> 0.98–≤ 1.16	> 1.16
Region 5	≤ 0.66	> 0.66–≤ 0.78	> 0.78–≤ 0.87	> 0.87–≤ 0.94	> 0.94–≤ 1.00	> 1.00–≤ 1.19	> 1.19
Region 6	≤ 0.69	> 0.69–≤ 0.79	> 0.79–≤ 0.87	> 0.87–≤ 0.94	> 0.94–≤ 1.01	> 1.01–≤ 1.19	> 1.19
Region 7	≤ 0.66	> 0.66–≤ 0.76	> 0.76–≤ 0.83	> 0.83–≤ 0.90	> 0.90–≤ 0.96	> 0.96–≤ 1.14	> 1.14
Region 8	≤ 0.73	> 0.73–≤ 0.84	> 0.84–≤ 0.92	> 0.92–≤ 0.99	> 0.99–≤ 1.06	> 1.06–≤ 1.24	> 1.24
Region 9	≤ 0.77	> 0.77–≤ 0.88	> 0.88–≤ 0.95	> 0.95–≤ 1.03	> 1.03–≤ 1.09	> 1.09–≤ 1.28	> 1.28
Region 10	≤ 0.72	> 0.72–≤ 0.83	> 0.83–≤ 0.90	> 0.90–≤ 0.98	> 0.98–≤ 1.05	> 1.05–≤ 1.24	> 1.24

AHU = Acute Hospital Utilization.

Table E-3
PY 2024 TPCC Peer Region Group Benchmarks

Region	At or above 90th percentile	89th–80th percentile	79th–70th percentile	69th–60th percentile	59th–50th percentile	49th–25th percentile	Below 25th percentile
Region A	≤ 0.54	> 0.54–≤ 0.66	> 0.66–≤ 0.76	> 0.76–≤ 0.86	> 0.86–≤ 0.95	> 0.95–≤ 1.25	> 1.25
Region B	≤ 0.56	> 0.56–≤ 0.67	> 0.67–≤ 0.76	> 0.76–≤ 0.86	> 0.86–≤ 0.95	> 0.95–≤ 1.22	> 1.22
Region C	≤ 0.57	> 0.57–≤ 0.66	> 0.66–≤ 0.74	> 0.74–≤ 0.81	> 0.81–≤ 0.89	> 0.89–≤ 1.15	> 1.15
Region D	≤ 0.55	> 0.55–≤ 0.66	> 0.66–≤ 0.76	> 0.76–≤ 0.85	> 0.85–≤ 0.96	> 0.96–≤ 1.22	> 1.22
Region E	≤ 0.64	> 0.64–≤ 0.75	> 0.75–≤ 0.83	> 0.83–≤ 0.90	> 0.90–≤ 1.00	> 1.00–≤ 1.25	> 1.25
Region F	≤ 0.63	> 0.63–≤ 0.74	> 0.74–≤ 0.83	> 0.83–≤ 0.91	> 0.91–≤ 0.98	> 0.98–≤ 1.24	> 1.24
Region G	≤ 0.56	> 0.56–≤ 0.66	> 0.66–≤ 0.76	> 0.76–≤ 0.88	> 0.88–≤ 1.00	> 1.00–≤ 1.29	> 1.29
Region H	≤ 0.63	> 0.63–≤ 0.74	> 0.74–≤ 0.83	> 0.83–≤ 0.92	> 0.92–≤ 1.00	> 1.00–≤ 1.26	> 1.26
Region I	≤ 0.60	> 0.60–≤ 0.73	> 0.73–≤ 0.83	> 0.83–≤ 0.92	> 0.92–≤ 1.00	> 1.00–≤ 1.24	> 1.24
Region J	≤ 0.64	> 0.64–≤ 0.78	> 0.78–≤ 0.89	> 0.89–≤ 1.01	> 1.01–≤ 1.11	> 1.11–≤ 1.39	> 1.39
Region K	≤ 0.63	> 0.63–≤ 0.77	> 0.77–≤ 0.89	> 0.89–≤ 0.99	> 0.99–≤ 1.10	> 1.10–≤ 1.34	> 1.34

TPCC = Total Per Capita Cost.

Appendix F. Technical Specifications of the Total Per Capita Cost Measure for PCF

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 PCF, TPCC is 1 of the performance measures evaluated for practices caring for complex, chronically ill beneficiaries in PCF (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 Performance-based Adjustment (PBA) amount. Chapter 5 includes more detail on the quality strategy for PCF, including the PBA (see Section 5.1.2.2 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

The Centers for Medicare & Medicaid Services (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 (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.[25] 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

[25] Medicare has a new initiative that covers the cost of up to eight over-the-counter (OTC) COVID-19 tests per month, at no cost to beneficiaries, from April 4, 2022, through the end of the Public Health Emergency for COVID-19. CMS will exclude costs associated with coverage of OTC COVID-19 tests furnished under this initiative from calculation of beneficiary costs for the TPCC measure.

education add-on payments) or variation in regional health care expenses as measured by hospital wage indexes and Geographic Practice Cost Indexes (GPCIs.)[26]

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

Each beneficiary is assigned a risk score that is generated by the CMS-Hierarchical Condition Category (HCC) risk adjustment model software. Beneficiary risk scores are assigned based on whether the beneficiary is a continuing or new enrollee, and their dual eligibility status with Medicaid. The CMS-HCC risk score file is updated annually, and which risk score file is used for TPCC risk adjustment will update according to which HCC risk score file was used to create practice risk groups. For example, TPCC for 2024 Q2 will assign beneficiary risk scores using the 2022 HCC risk score file, which is based on 2021 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 can be interpreted as the average effect on total cost of an increase of 1.0 in a beneficiary's CEScore or NEScore, holding other factors constant. The

[26] 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

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 G. PCF Peer Group Crosswalk for Acute Hospital Utilization/Total Per Capita Cost Benchmarks[27]

PCF Model Region	AHU Peer Region Group (for Practice Risk Groups 1 and 2)	AHU Peer Region Group States	TPCC Peer Region Group (for Practice Risk Groups 3 and 4)	TPCC Peer Region Group 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

[27] CMS may update AHU and TPCC peer region groups based on actual benchmarks to be used for PBA quarters in future years.

PCF Model Region	AHU Peer Region Group (for Practice Risk Groups 1 and 2)	AHU Peer Region Group States	TPCC Peer Region Group (for Practice Risk Groups 3 and 4)	TPCC Peer Region Group 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 Group States	TPCC Peer Region Group (for Practice Risk Groups 3 and 4)	TPCC Peer Region Group 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.

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Appendix H. Place of Service Codes for Payment Accuracy Adjustment

Place of Service Name	Place of Service Code
Telehealth (provided other than in patient's home)	02
Indian Health Service Freestanding Facility	05
Indian Health Service	06
Tribal 638 Freestanding Facility	07
Tribal 638 Provider-Based Facility	08
Telehealth (provided in patient's home)	10
Office	11
Home	12
Assisted Living Facility	13
Group Home	14
Mobile Unit	15
Temporary Lodging	16
Walk-in Retail Health Clinic	17
Place of Employment–Worksite	18
Off Campus–Outpatient Hospital	19
Urgent Care Facility	20
On Campus–Outpatient Hospital	22
Custodial Care Facility	33
Independent Clinic	49
Federally Qualified Health Center	50
Community Mental Health Center	53
Mass Immunization Center	60
Public Health Clinic	71
Rural Health Clinic	72
Other Place of Service	99

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Appendix I. Technical Specifications of the Advance Care Plan Measure adapted for PCF (Claims-based Measure)

Beginning in PY 2022, the Advance Care Plan (ACP) adapted for Primary Care First (PCF) (claims-based measure), is a Medicare Part B claims-based, process of care measure that CMS calculates. The measure captures the percentage of a practice's attributed Medicare beneficiaries, ages 65 years and older, who have an advance care plan or surrogate decision maker documented in the medical record or who have documented that the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

The PCF ACP measure follows the specifications of the ACP measure used in the Bundled Payments for Care Improvement (BPCI) Advanced model but differs by its use of PCF-attributed beneficiaries and practices. Within PCF, the ACP measure is 1 of 5 Quality Gateway measures for practices in Risk Groups 1 and 2 and 1 of 3 Quality Gateway measures for practices in Risk Groups 3 and 4. To be eligible for a positive Performance-based Adjustment, PCF practices must meet or exceed the 30th percentile of performance among a national benchmark population on the ACP measure in the applicable performance period. Chapter 4 includes additional detail on the PCF quality strategy, including the measures assessed as part of the Quality Gateway for Risk Group 1 and 2 practices and Risk Group 3 and 4 practices and the methods used for establishing benchmarks for each measure. The following describes the process for calculating the ACP measure at the practice level for all Medicare beneficiaries attributed to each PCF practice in a given year.

Step 1: Calculation of the Measure Denominator

CMS calculates the ACP measure annually for all beneficiaries ages 65 years and older who are attributed to the practice for at least 1 quarter during the performance year. Beneficiaries with 0 Physician or Outpatient claims during the performance year are excluded from the practice's denominator.

Step 2: Calculation of the Measure Numerator

To satisfy the numerator criteria of the ACP measure for a given PCF-attributed beneficiary included in the denominator, CMS must observe a Physician or Outpatient claim for the beneficiary with 1 of the qualifying Current Procedural Terminology (CPT) codes and a date of service during the performance year. The qualifying codes for this measure are as follows:

- CPT I codes: 99497 and 99498
- CPT II codes: 1123F and 1124F

Any health care practitioner that is eligible to bill for the service may submit the qualifying claim, regardless of the practitioner's participation in PCF. The qualifying service may also be provided

in any health care setting except for the emergency department; claims with emergency department as the place of service do not satisfy the numerator criteria for the measure. Claims with both CPT II code 1123F or 1124F and an 8P modifier, indicating advance care planning was not documented in the medical record, do not satisfy the ACP numerator criteria.

Step 3: Calculation of the Practice Score

To calculate the ACP measure score for the practice, CMS divides the measure numerator by the measure denominator and multiplies by 100. The resulting score can be interpreted as the percentage of a practice's attributed beneficiaries ages 65 years and older with a numerator-qualifying claim during the performance year.

For more detailed claims guidance, visit the QPP Resource Library and search for the Part B Claims Reporting Quick Start Guide.

Please note that ACP adapted for PCF (claims-based measure) does not have a data completeness factor as part of the measure calculation.

Appendix J. Days at Home Methodology for PCF

The Days at Home measure is a claims-based, risk-adjusted measure of days at home or in community settings (e.g., not in an acute care or post-acute skilled nursing facility setting) among adult Medicare fee-for-service (FFS) beneficiaries with complex, chronic conditions who are attributed to a Primary Care First (PCF) practice. The measure includes risk adjustment for differences in beneficiary mix across PCF practices, with an additional adjustment based on beneficiaries' risk of death and beneficiaries' risk of transitioning into long-term institutional care. The latter adjustment is applied to incentivize community-based care.

The Days at Home measure is calculated for practices caring for complex, chronically ill beneficiaries in PCF (i.e., practices that belong to Risk Groups 3 and 4); these practices are eligible for a positive Performance-based Adjustment if they meet or exceed the benchmark in the applicable performance period on this measure, ACP, and the PEC Survey (described further in Chapter 4). The Days at Home benchmark is based on the performance of a national benchmark population. Chapter 4 (Quality Gateway) includes additional details on the PCF quality strategy, including the measures assessed as part of the Quality Gateway for Risk Group 3 and 4 practices and the methods used for establishing benchmarks for each measure.

The final measure result (that is, the "PCF practice-level adjusted days at home") can be interpreted as the risk factor–adjusted, mortality-adjusted, nursing home transition–adjusted days at home, averaged over all beneficiaries within a PCF practice. A higher risk-adjusted score indicates better performance.

The following describes the PCF-attributed beneficiaries that CMS will include in the measure for each PCF practice and defines a day at home. For more detailed measure specifications, please see the Days at Home Measure Information Form, available on PCF Connect.

Step 1: Included Population in the Measure Denominator

CMS calculates the Days at Home measure annually for all beneficiaries who are attributed to the practice for at least 1 quarter during the performance year and meet all of the following criteria:

- 18 years of age or older
- Alive as of the first day of the performance year
- Continuously enrolled in Medicare FFS parts A and B during the full performance year (up to date of death among beneficiaries who died) and 1 full year prior
- CMS–Hierarchical Condition Category composite risk score greater than or equal to 2.0 in the year before the performance year

Step 2: Calculation of the Measure Numerator

The outcome measured for each eligible beneficiary is days spent "at home," adjusted for clinical and social risk factors, risk of death, and risk of transitioning to a long-term nursing home. Days at home are defined as those days when a beneficiary is alive and not in care. A "day in care" is defined as any day on which a beneficiary in the denominator receives care in 1 or more of the following specified care settings: inpatient acute and post-acute skilled nursing facilities, comprising short-term acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term care hospitals, and skilled nursing facilities; emergency department visits; and observation stays. There are 2 exceptions:

- A beneficiary is always considered at home if they are enrolled in hospice, even if they receive care in settings normally counted as days in care (in other words, a beneficiary will have no measured days in care as long as they are in hospice).
- Hospital admissions for childbirth, miscarriage, or termination are not counted as days in care.

Care in settings not listed above (including outpatient visits and procedures, hospice, residential psychiatric and substance abuse facilities, assisted living facilities and group homes, and home health and telehealth services) are not considered days in care in this measure; rather, they are treated as days at home.

Finally, days spent in a long-term or residential nursing home (except for skilled care) are not counted as days in care by this definition. However, to encourage home- and community-based care, this measure includes an adjustment that accounts for beneficiaries' risk of transitioning to a long-term nursing home. Table J-1 lists the events that are included in days in care and days at home definitions.

Table J-1
Summary of Numerator Definition

Care Settings or Episodes	Outcome Definition
Planned and unplanned acute care episodes: • **Acute care hospital inpatient admissions** (excluding select obstetrical admissions) • **Emergency department** visits • **Observation** stays • **Inpatient rehabilitation facility**, **inpatient psychiatric facility**, **long-term care hospital**, or **skilled nursing facility** admissions	Days in care
• **Hospice** (delivered in home or institutional settings) • **Outpatient visits, procedures, and services** performed in hospital outpatient departments, ambulatory surgical centers, or outpatient clinics • **Nursing homes, assisted living facilities, and group homes** • **Residential psychiatric and substance abuse treatment facilities** • **Home health and telehealth services** • **Obstetrical admission** for labor and delivery, miscarriage, or elective termination	Days at home