Primary Care First Revenue Calculator
INTRODUCTION (v4.1)

CMS CMMI Request for Application (10.24.19)

The Primary Care First (PCF) Revenue Calculator ("calculator") has been designed for primary care practices (PCP) to better understand, prepare for and ultimately succeed in the Primary Care First program. This tool focuses on revenue forecasting for two CMS payment model options within the Primary Cares program, 1) PCF and 2) PCF plus Seriously Ill Populations. The calculator uses Medicare Fee for Service revenue modeling as a comparator to further inform practices' PCF business decision-making and planning whether to participate in PCF.

Important PCF Definition: Full Primary Care First Payment

Primary Care First is payment model that combines both value-based and fee-for-service components. For a given practice, the PCF revenue opportunity is a function of multiple variables as detailed in the PCF Revenue Calculator worksheet. The base PCF payment is called the Total Primary Care Payment (TPCP), a combination of an HCC risk-stratified Professional Population Based Payment (PPBP) and the PCF Flat Primary Care Visit Fee (averaged as a Per Beneficiary Per Month or "PBPM" value). This TPCP is then modified by a practice-specific "Performance Based Adjustment" (PBA) and paid out on a quarterly basis. The PBA is determined by a practice's performance on five quality measures (Quality Gateway) and on Acute Hospital Utilization (relative to a national gateway, regional performance and to the practice's improvement over time). In summary, the formula for Quarterly Payment to a PCF Practice is:

"Full Primary Care First Payment" = **TPCP** (PPBP + Flat PC Fee 'PBPM') x **PBA** (Quality and AHU Performance)

The PCF Revenue Calculator has three worksheets:

1. The first is the PCF Revenue Calculator itself and is for input of practice- and PCF-specific variables and for key Medicare and PCF participation revenue outputs.
    a. The input cells are highlighted for clarity:
        i. Practice variables are entered into *white cells* and PCF model variables into *yellow cells* (all drop-down menus).
        ii. *Gray background cells* contain intermediate output or reference data.
        iii. The key outputs around net revenue and return on investment are highlighted in *green*.
    b. Primary care practices can use two Custom Case Scenarios that allow for side-by-side modeling of practice business performance based on the follow inputs:
        i. Practice-specific known variables (e.g., number of attributed Medicare beneficiaries, average number of office visits per beneficiary per year, average office visit payment per beneficiary including Co-Insurance).
        ii. *Medicare Patient Alignment (Attribution) Adjustment*: CMS will apply a patient attribution methodology based on voluntary and claims-based data to align

beneficiaries to a PCF practice. The resulting PCF "panel" may be less than that calculated by the practice using its own data and/or another methodology. This Alignment Adjustment applies only to the PCF modeling.

iii. PCP Beneficiary (patient) *Leakage Adjustment*: PCF practices will not receive Per Beneficiary Per Month payment for patients ("beneficiaries") who receive care at other primary care practices ("leakage"). This leakage adjustment also applies to the Medicare FFS modeling to correct for patients who are receiving primary care services outside of the practice.

iv. *Co-Insurance Waiver*: CMS will permit practices to reduce or waive the applicable co-insurance (which will be based on the FFS rate for services provided), with practices responsible for covering those costs, for specific subset(s) of aligned beneficiaries defined by the practice and approved by CMS. This provision is intended to reduce a financial barrier to care for specified high-need patients. This data input field is for a practice to model the revenue impact of waiving the Co-Insurance fee for a subset (percent) of their aligned Medicare patients (after adjustment for leakage).

v. *PCF care management impact*: enhanced care management activities through PCF participation may influence the average number of patient visits per year. Proactive outreach to at-risk patients may increase the visits per year. Alternatively, the frequency of office visits may decrease, for instance, through increased "non-visit" patient care, such as that via telehealth, or improved care of patients with chronic illnesses

c. *Practice Risk Group* drop-down menu: this allows a practice to designate which of 4 Risk Groups reflect their Medicare patient population in terms of their average HCC scores.

Practice Risk Groups and Professional Population Based Payment:

Risk Group	Avg. HCC/Practice	PBPM
1	HCC <1.2	$ 28
2	HCC 1.2-1.5	$ 45
3	HCC 1.5-2.0	$ 100
4	HCC > 2.0	$ 175

The Risk Group then determines the Professional Population Based Payment (i.e., Per Beneficiary Per Month prospective payment) and the average number of office visits per year per Risk Group patient. For Scenario #1, this latter variable is calculated automatically based on the PCF RFA Practice Risk Group data; a practice-specific value can be entered for Scenario #2.

d. *Practice performance on the Quality and AHU Gateways*: to be eligible for up to a 50% Performance Based Adjustment on the Total Primary Care Payment, a practice must meet or exceed the Quality and the AHU Gateways. The Quality Gateway requires practices to pass the performance thresholds for the following five quality measures: CAHPS, Diabetes Poor Control, Controlling High Blood Pressure, Advanced Care Plan, and Colorectal Cancer Screening. These inputs may, for instance, be informed by experience in other value-based payment programs, by reports from the practice's EHR or practice management system reports or from data outputs from a practice's existing or planned "advanced capabilities" such as care management and care transitions outreach.

e. *Practices are next stratified into Regional Groups based on AHU and practice-specific Continuous Improvement performance*. These Groups determine the Bonus percentages—Performance Based Adjustment (PBA)—applied to the Total Primary Care Payment:

Regional Groups and Practice Performance Bonus Percentages:

Regional Groups	Practice Performance	Bonus % of TPCP*	CI Bonus % of TPCP**
Group 1	Top 10%	34%	16%
Group 2	11%-20%	27%	13%
Group 3	21%-30%	20%	10%
Group 4	31%-40%	13%	7%
Group 5	41%-50%	6.5%	3.5%
Group 6	51%-75%	0%	3.5%
Group 7	<Lowest 25%	-10%	3.5%

* Applies only to Practices in Top 50% National AHU.

**Applies only to Practices exceeding the Quality Gateway (and to all practices in Yr. 1)

f. *Incremental impact of adding Higher Risk Patients* to an established PCF practice: Medicare FFS pays practices more for high need, high risk patients per visit and through the Chronic Care Management (CCM) fee. This is in contrast to PCF's payment methodology with its Flat Primary Care Visit Fee and Per Beneficiary Per Month management fee that is adjusted based on the average HCC-derived risk across a practice's beneficiary panel; the PCF payment model does not allow for CCM fees. This input variable assesses the relative revenue impact of additional high-risk high-need patients: in the FFS world revenue per patient may increase more readily than in the PCF payment model.

g. *Incremental Overhead required for PCF participation*. The PCF Revenue Calculator worksheet is also designed to project an estimated PCF return on investment by including the practice's incremental overhead: the anticipated total additional investment in operations and staff required for successful PCF participation.
    a. Examples of these new costs may include a full or part-time Care Manager, a Medical Assistant added to the care team, a patient navigator, etc. These overhead costs do not apply to pre-existing "advance primary care" investments a practice may have already made.

f. Optional: *The Seriously Ill Population & PCF Option* (Total Primary Care Payment, Option Model 3). An advanced primary care practice wishing to participate in both PCF and the SIP program can use this section to model the revenue impact of accepting new high-risk (SIP) patients to their practice. In the SIP program, these patients are identified by CMS based on criteria such as their high utilization, absent primary care attribution, and/or poor coordination of care.

i. Practices in the SIP program are paid $275 PBPM, $50 of which is withheld. At the end of each performance year, these practices are then eligible to receive both their withhold and an additional $50 PBPM quality bonus if they pass two performance criteria ("Average Length of SIP Attribution" and the "Rate of Care Transitions Success") and perform well on the SIP quality measures, as described below:
    1. High Quality (>70th%): the practice gets the $50 withhold and $50 Quality bonus
    2. Satisfactory Quality (50th-70th%): $50 withhold paid but no Quality Bonus
    3. Low Quality (<50th%): $50 withhold NOT paid and no Quality Bonus

ii. Quality Measures for SIP (and PCF Risk Groups 3&4):
    1. Year 1: Advanced Care Plan (MIPS CQM), Total Per Capita Cost (MIPS)
    2. Year 2: Same as Year 1 plus CAHPS
    3. Year 3 and beyond: Days at Home (claims based); 24/7 Clinician Access (Survey question to be added to CAHPS)--in addition to Advanced Care Plan, Total Per Capita Cost, and CAHPS.

h. The *PCF Revenue Calculator Output* fields summarize the important practice-specific outcomes based on the data entry provided:
    I. Final Medicare Patient Attributions adjusted for "leakage" (Medicare FFS modeling) and for "leakage and PCF alignment" (PCF modeling)
    II. Estimated average number of PCF patient office visits per year modified by the impact of enhanced care management.
    III. Final Practice Performance Based Adjustment (PBA) percent: this is the sum of the final Regional AHU Performance and the Continuous Improvement Adjustments, both of which may vary based on Gateway performance and by year of participation (see below, <u>Overview of the PCF Performance Based Adjustments by Year).</u>
    IV. Total Primary Care Payment (risk-stratified Professional Population Based Payment plus the Flat Primary Care Visit Fees expressed as a 'PBPM' value)
    V. Performance Based Adjustment (PBA) percentages applied to the Total Primary Care Payment. The PBA is calculated based on the practice's Quality, AHU and Continuous Improvement performance. This results in the "Full PCF Payment PBPM" (prior to the inclusion of per-encounter Co-Insurance)
    VI. The Estimated Medicare FFS revenue per year (gross) based on the same Medicare patient input data.
    VII. The estimated revenue from PCF participation expressed as PCF Revenue/year (gross). This PCF revenue will automatically include SIP modeling revenue if numbers of SIP patients are entered into the SIP Revenue Calculator at the bottom of the worksheet.
    VIII. Gross practice revenue comparing PCF to Medicare FFS participation.
    IX. Net practice PCF Revenue after adjusting for any incremental practice investments required for successful participation in PCF (additional PCF overhead).
    X. Revenue Impact Scenarios #1 & #2: Column F shows the difference in projected Revenue reflecting the custom modeling used in the two scenarios.

2. The second worksheet, the Algorithms & Reference Tables, includes most of the formulae and detailed PCF model references that power the calculator.
    a. Practice Risk Groups, including the corresponding averaged HCC scores and the tiered Professional Population-Based Payments.

b. Regional AHU Performance Adjustments: AHU performance tiers (percent ranges) and corresponding "Bonus %" applied to the Total Primary Care Payment.
c. Continuous Improvement Performance Adjustments: practice AHU improvement against practice-specific benchmarks compared to regional practice performance (percent ranges) and the corresponding "CI Bonus %" applied to the Total Primary Care Payment.
d. Custom Case Scenarios #1 & #2: formulas that translate the practice Gateway input variables that drive the calculator into revenue and business modeling outputs. See Column Q for algorithm design and logic details.

3. The third worksheet contains key PCF model Details and Definitions:
   a. This worksheet provides clarification of the PCF terms used by CMMI and important details and explanations for the algorithms, inputs and outputs of the Revenue Calculator.
   b. For ease of navigation, the PCF Revenue Calculator worksheet includes hyperlinks to relevant sections on the Details and Definitions worksheet.
   c. The two tables above are also included:
      i. Practice Risk Groups: with associated average HCC and risk stratified PBPM values.
      ii. Performance percentile ranges (AHU and Continuous Improvement) & Bonus adjustments to Total Primary Care Payment.

Note that the two worksheets are "protected"—this is to help prevent inadvertent changes to the math, conditional formulas and reference tables. Only the input fields allow changes. If you wish to unprotect the worksheets--to see the underlying algorithms, formulas and links--go to the Review tab. Be careful to avoid creating computational errors in the "unprotected" calculator.

<u>Overview of the PCF Performance Based Adjustments by Year:</u>

To earn the PBA, there are two performance Gateways (thresholds) that must be met or exceeded to maximize the PBA:

1) AHU Gateway = Top 50% Nationally;
2) Quality Gateway = exceed all 5 Quality Threshold Metrics (applies to Years 2-5): CAHPS, DM Poor Control, Controlling HTN, Advanced Care Plan, CRC Screening

The application of these key gateways varies by year of participation:

<u>YEAR 1:</u> Based only on AHU Performance (no Q Gateway)

- For a positive PBA (above 3.5% and up to 50%), must meet or exceed the National AHU Gateway (>50th% Nationally).
- If AHU Performance is <50th% Nationally and >Lowest Quartile Regionally, PBA = 0% or 3.5%*
- If AHU Performance is <50th% Nationally and <Lowest Quartile Regionally, PBA =-10% or -6.5%*

*Depending on CI Performance

<u>YEAR 2:</u> Based on AHU and Quality Gateways and AHU Performance

- Practices that EXCEED BOTH the AHU and Quality Gateways (Year 1 performance) are eligible for a PBA of -10% to 50% based on Regional and CI Performance. The CI Bonus CANNOT exceed the maximum CI % of TPCP for a given Performance Group (p27).
- If Practice EXCEEDS the Quality but fails the National Gateways, the PBA will be based only on Regional AHU Performance: AHU >Lowest Quartile, PBA = 0%; AHU <Lowest Quartile, PBA = -10% (p25). Practice IS eligible for the CI Bonus (p26) but this CI Bonus CANNOT exceed 3.5%.

- If Practice FAILS the Quality Gateway (REGARDLESS of National AHU Gateway performance), the PBA will be based only on Regional AHU Performance: AHU >Lowest Quartile, PBA = 0%; AHU <Lowest Quartile, PBA -10% (p25). Practice is NOT eligible for the CI Bonus (p26).

YEARS 3-5: Based on IHU and Quality Gateways and IHU Performance

- If Practice exceeds BOTH the AHU and Quality Gateways (Year 1 performance), eligible for PBA -10% to 50% based on Regional and CI Performance.
- If Practice EXCEEDS the Quality but fails the National Gateways, the PBA will be based only on Regional AHU Performance: AHU >Lowest Quartile, PBA = 0%; AHU <Lowest Quartile, PBA -10% (p25). Practice IS eligible for the CI Bonus (p26).
- If Practice fails the Quality Gateway, PBA = -10% regardless of AHU National Gateway or Regional performance. Practice is NOT eligible for the CI Bonus (p26).

This calculator is being offered at no cost to primary care practices and delivery organizations. It may be used according to the Terms of Use (https://www.healthteamworks.org/content/terms-and-conditions-tools-and-materials/) to assist with business and organizational modeling for practices considering PCF participation.

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