

Primary Care First and the Seriously Ill Population (SIP) Option: Q&A on the New Medicare Alternative Payment Models

For basic information on where the model is available, what providers are eligible, how the payment will work, and more, please see "[FAQs on the new SIP Payment Model](#)." This document is answering questions raised based on the basic information presented.

Topic: Model Design

Do you see this program being extended to Medicaid?

The model has been developed for Medicare. Medicaid models for the seriously ill can include Health Homes and special initiatives under Medicaid ACOs. CMMI is seeking interest from payers to participate in PCF, so some managed Medicaid program could potentially participate.

Is SIP available under direct contracting?

According to the RFA released on 11/25, the SIP is not available to practices that are participating in the Direct Contracting model. We understand that this means that organizations will need to fund the intensive services needed upfront themselves.

Are Medicare Advantage (MA) patients and plans excluded from participating in the SIP?

No. SIP is a multi-payer model, and CMMI is currently recruiting for private payers to participate in the model, alongside Medicare. However, if an MA plan does not participate, then their enrollees will not be able to participate in the model.

Do we have any idea what the timeline is for states that are currently not included in the model?

The model is available only in selected states and regions. These regions include those currently participating in the Comprehensive Primary Care Plus (CPC+) demonstration project, with some important additions like Alaska, California, Florida, Maine and Virginia. The PCF demonstration will run for 5 years, and is expected to be limited to the current states and geographies for this entire time period. There is no information about model availability after the 5-year period of the model.

What states/regions were added from the original geographic areas approved for application?

There have been no changes in the selected states and geographies from when the PCF and SIP were first announced in April, to the final list in the RFA.

Topic: Patient Eligibility/Attribution

Can a patient be enrolled in home health services while on SIP?

Yes! Unlike hospice, beneficiaries in this payment model have access to all their Medicare benefits. In fact, coordinating with home health agencies when appropriate can be an effective strategy for managing seriously ill beneficiaries.

What does "transfer equipment" include in terms of DME?

We had shared this article with CMMI (<https://www.ncbi.nlm.nih.gov/pubmed/25335470>), and so they may have taken a similar approach. Please ask CMMI for the codes they are exact codes they are using.

Does CMS make the referrals directly to an individual practitioner?



CMS will make referrals to the practice, not the practitioner, who is participating in the SIP Model. Solo practitioners may not be selected as SIP practices, since the expectation is that SIP will provide care by an IDT.

How does CMS make referrals to specific SIP practices? How will CMS determine matching a beneficiary that has been determined eligible via their algorithm to a participating provider practice?

CMS will assign (or "attribute") consented beneficiaries to a participating SIP practice. If there is only one SIP participating in that beneficiary's zip code, then the match will be to that SIP practice. If there is more than participating practice in the area, beneficiary attribution would rotate among practices in the area to achieve roughly equal distribution. CMS says they will send the beneficiary's contact information via a "secure information transfer method" (e.g., secure email) within 24-48 hours.

How does the relationship work between a SIP and PFC practice?

If you are a SIP only practice, then your relationship with a PFC practice is one of referral. You can transition a SIP patient to a PCF practice once the patient is stable for their ongoing care, and if warranted, your practice can continue to consult via FFS payment. The PCF practice may also refer appropriate patients (which will be defined soon) to a SIP practice.

If you are a Hybrid practice, then you would get the SIP referrals from CMS directly, and could "step-down" to a different payment level when the patient transitions out of SIP payment model.

If you are a pal care practice that is joining a primary care practice to apply as a Hybrid practice --in other words, this is a brand new arrangement between 2 practices -- the two practices must work out payment arrangements. One possible ask is that you receive 100% of the SIP payments made.

Will organizations receive the medical and pharmacy claims history of the patients assigned to them? If so, how many years of history?

There will be data shared with the PCF practices on a quarterly basis, as described on page 46 of the RFA. Please check with CMMI for more specifics.

Under SIP Only, does the Palliative Care provider become the PCP? What if the patient has a PCP and doesn't want to switch?

Yes, a SIP practices expected to care for all primary and palliative needs of the patient during the SIP "episode" (e.g., comprehensive care management, 24/7 access).

The SIP practice cannot bill additionally, but other practices seeing the patient should be able to bill their own E&M services. Beneficiaries will need to agree to receive services from the SIP practice, but can still see any other provider if they would like to (including someone who they consider their PCP). The exception is if their PCP is participating as a PCF practice, in which case that PCP would not receive any reimbursement during the SIP episode, and conversations should be had to keep things equitable.

What happens if the patient dies after transferring out of the SIP practice? Will the SIP practice still get the quality and bonus funds, assuming it was earned?

The RFA does not include mortality as a quality measure for the SIP, so death should not affect the quality withhold or bonus payments. The SIP-only practice should receive payment (including quality withhold and bonus payments) from the time a claim for the first face-to-face encounter is made, until that beneficiary transitions. There will be more details about the "Transition Notification Process" in the participation agreement, but transitions can include transferring to another practice, enrolling in hospice, no longer accepting services, or dying.



Topic: Payment

Can Hospices be paid as SIP-only practices? How would the hospice get paid if the patient has a primary care provider?

Hospices participating only in the Medicare Hospice Benefit (Part A) cannot participate. Hospices that participate in Part B practice can apply as a SIP-only practice and be paid directly under the SIP payment methodology, or in partnership with a primary care practice as a PCF-Hybrid practice (providing both primary care and SIP services). The PCF-Hybrid practice would be paid under both SIP and PCF-General methodologies depending on the patient panel, so the hospice and primary care practice would need to contract for distribution of those payments.

To clarify: as a hospice, would this be something a hospice could bill for as palliative care if the hospice is now the PCP? If the hospice is not the PCP, then the hospice would need to work with a PCP, correct? Who bills and receives the reimbursement for this, PCP or the hospice?

Part A hospices cannot participate. A hospice with a Part B practice can bill directly as a SIP only, or include their Part B clinicians with another practice that's billing as a PCF practice.

For Primary Care Practices where physicians are paid based on RVU numbers, will there be a way to track RVU production since there will now be on flat fee for all E/M services?

Practices participating in all parts of PCF will still be reporting CPT codes for their services, so it will be possible to determine the number of RVUs that would have been generated under the fee schedule. However, there may be activity that is undertaken which is not reported as CPT but subsumed under the monthly capitation. Speak to the physician compensation team to ensure that they understand that part of the model will entail a monthly capitation whether RVUs are generated or not.

When will payments be made in relation to services delivered? How will those payments be adjusted?

The initial visit payment (\$325) and flat-fee payments (\$40.82) will be paid when billed. The monthly PBPM care management payments (\$225/patient/month) will be paid quarterly. The quality withhold (\$50) will be reconciled and bonus (additional \$50) will be reconciled yearly based on the previous year's performance on a combination of factors: maintaining an average length of beneficiary attribution of < 8 months; rate of care transition success above benchmark, and quality measure performance relative to reference groups.

Do we understand that payment is not until after 8 months?

NO! The monthly capitated payment is paid quarterly (less the quality withhold).

You may be thinking of the performance measure based on how long, on average, all patients stay in the payment model, and that is measured against an 8-month target, but no, payment for each patient in the model that you are caring for is made quarterly.

Can the flat fee billing be used for services delivered on an "incident to" basis?

If the practice can bill "incident to" currently, then the CPT codes that are covered under the flat fee will apply. If the practice currently cannot bill incident to, then the encounter cannot be billed under the SIP flat fee.

Are SIP participants beholden to the Professional PBP leakage adjustment?

The RFA does not include the leakage calculation adjustment in the SIP description. CMMI should clarify to be sure.



Can you bill for remote patient monitoring services outside of the PBP or Flat Rate fees?

The RFA specifies which CPT codes will be reimbursed as a flat fee (mostly E/M codes, ACP services, TCM, CCM). All other CPT codes should be billed and reimbursed as usually through the fee schedule.

Are tele-health flat visit fee the same as face to face visit fee?

With the exception of currently billable tele-health visits, any tele-health visits under the SIP model will not be reimbursed the \$40 flat visit fee. The PBPM payment is meant to support most of the patient care, including telehealth visits.

If an RN sees a patient but doesn't bill, will that qualify for the visit requirement for the every 60 day visit requirement?

The 60-day visit requirement must be performed by a clinician who can bill the fee schedule (physician, APRN, PA). CMMI will be monitoring compliance via the flat-visit-fee claims.

To clarify, the flat visit fee is the only payment correct? The physician does not also bill E & M?

E&M cannot also be billed for patients active in the SIP model. The practice also gets the \$225-\$325 per month as revenue.

Will the advance care planning CPT code be included in this \$42 method right and not be separate?

Yes, ACP CPT code is included in the face-to-face payment.

Topic: Quality

In terms of evaluation-- are there metrics already determined? Will there be any administrative support to track this?

There will be an Independent Evaluator, but that contract has not yet been awarded. CMMI will be evaluating on the quality measures listed in the RFA, along with cost comparisons.

The advanced care plan measure - is that defined by completed advance directive or DMOST or just a documented GOC or advanced care planning assessment?

PCF uses the Advance Care Plan measure that is endorsed by NQF and included currently in the MIPS program (NQF #0326), which reads: "Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record, or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan."

Would the quality metric on "hospitalizations" within 3 months after transitioning a patient include hospice GIP-level care in a hospital? What about if that GIP-level care is in a dedicated hospice facility?

The Successful Transitions measure outlined in the RFA is a new quality measure that has not been specified in detail. In other contexts, GIP days billed under the Medicare Hospice Benefit have been recognized as different from an acute hospitalization. Given the concept and intent of the Successful Transitions measure as stated in the RFA, we would not expect GIP-level hospice care to count as a hospitalization in the numerator of the measure, regardless of whether it is provided in a hospital, skilled nursing or dedicated hospice facility. However, as with all quality measures, the devil is in the details, and we cannot be certain about what will count as a hospitalization until the full specifications of the measure are released.



Topic: Provider Eligibility and Service Delivery

What is a “hybrid practice?”

A Hybrid practice cares for both general primary care patients and SIP patients. Please see the FAQ Blog for more information.

How do hospices operationalize participation as a SIP-only practice? A PCF-Hybrid practice?

Hospices participating in Medicare Part B can participate as PCF practice, provided they can meet the service requirements. Hospices seeking to participate as PCF-Hybrid will need to partner with a primary care practice who can meet practices requirements for PCF-General. The two organizations will need to make a separate legal agreement to determine who will be responsible for what services, how payments will be used to support which practitioners, and other important relationship parameters (eg, termination conditions). One possible starting point is for the hospice to provide the SIP services, and receive all or most of the SIP payments.

How can independent practitioners demonstrate and meet criteria and make this work?

Independent practitioners may not be eligible for SIP because participants must have an IDT (physician or NP, RN, SW). That said, if you can describe how you deliver care via an IDT as an independent practitioner that may indeed meet the criteria. Alternatively, your NPI can be included in another practice's application and serve as an expert resource to organize and coordinate care for the SIP patients in that practice.

How can supportive services be billed or bundled into care services?

The practice may provide any services that are appropriate for the patient's needs, and can use the PBPM capitated payment to help support those costs.

What role would hospitalists have in the SIP model?

This is a primary care model, not an inpatient. Hospitalists would bill as usual, and may have a role in identifying patients for direct referral.

Does this apply to pediatrics and if so why is a pediatrician not a required provider?

There are very few children covered by Medicare, and this is a Medicare only model. Many seriously ill children are covered by Medicaid, and states can now add palliative care into their health home approach, as per the ACE Kids Act that was passed this year.

Does the billing clinician have to be MIPS eligible or MIPS partially-eligible?

The billing clinician has to be eligible to bill Medicare, but may not be eligible for MIPS depending on their current volume of Medicare beneficiaries cared for (there is no minimum number of patients required to participate in SIP).

What share of PCPs are estimated to meet these criteria in the eligible regions?

There are nearly 3,000 practices now participating in CPC+. CMMI is expecting that these and other practices would be participating in the PCF.

When you say the face-to-face must occur within 60 days, is this by CMS or by the participant provider?

Once CMS shares the contact information for an interested beneficiary, the participating provider (the SIP provider) must have a face-to-face visit within 60 days in order for the practice to receive payment through the model.



Will we be able to provide the additional team members for the IDT via contract as we do today or will we need to actually hire those individuals?

The application is for medical practices, and includes questions about IDT capabilities. From what you describe, you should be able to meet the requirements for the IDT and have your practice be the SIP practice, but please check with CMMI to be sure.

If your practice is part of an ESCO (End-stage renal disease comprehensive care model) can we still apply for the SIP only program?

Any practice can participate, provided they meet the requirements. ESCO patients may not be identified by the SIP algorithm, just as ACO patients will not, but check with CMMI to be sure.

If 2 SIP providers in the same service area, how will CMS share the attribution?

In prior conversations, they said that they would rotate the attribution.

How will this model impact hospice referrals if the hospice provider is not directly involved in this model?

It may have a positive impact on hospices because all SIP providers will need to transition patients to an appropriate provider after the SIP "episode." Hospices should work closely with SIPs for hand-offs on appropriate patients. IN MCCM, 24% of patients elected to go straight to hospice.

Can a Hospice participate as a SIP only practice AND also participate in a Hybrid arrangement?

You have to list your TIN and then the billable clinicians' individualized NPIs in the application, so if you are doing only SIP, that's what you would be, and if you are also doing PCF, then you are Hybrid. Hybrid is already both.

For partnership options can you participate in option 1 and 2? Also, if you participate in option one only, who and how do you bill for your services?

If you are part of the Hybrid practice that is being created for purposes of participating in the model (e.g., it is a brand new arrangement), the two practices must work out payment arrangements. If you are caring for the SIP patients, you can ask that you receive 100% of the SIP payments made. If you are SIP only, you operate under a participation agreement that covers the rules around billing.

Are there sample participation agreements available to review?

The participation agreement has not yet been released. It will only be released to those who are selected based on their applications.

Who is a "member of the care team"? Are there staffing ratios?

The model requires an interdisciplinary care team made up of a physician or NP, nurse (RN) case manager and social worker. Other team members (chaplain, pharmacist, etc.) may be added, or shared with other practices (i.e. in the Hybrid model). There are no patient minimums, and no staffing ration requirements or limits.

As a Medicare Part A hospice provider can you apply for SIP program while your application for Part B is pending (or can one apply for SIP first and then for Part B)? In other words, is being a Part B provider a prerequisite to applying for the SIP program?

PCF practices must be Part B participants, though the model does not start until January 1, 2021 so a Part B application may be approved by then. Would contact CMMI directly to discuss.



Does SIP have a set episode period? If, so how long? Does the episode ends when you transition the patient to another provider?

The SIP does not have a defined episode length. Patients may stay on the payment model for up to 12 months and exceptions will be made for extenuating circumstances. However, the practice's ultimate payment is based on its average length-of-stay; if it's longer than 8 months, the practice will lose under the quality adjustment.

Yes, the “episode” (or the time that the patient is on the model) ends when the patient is transitioned.

Are hospice-only facilities able participate in the SIP model or can a specialty practice such as an Oncology/Hematology practice with a palliative care physician, providing palliative care services could participate in the SIP model?

As per the RFA, eligible participant practices include primary care practitioners (MD, DO, CNS, NP, and PA) certified in internal medicine, general medicine, geriatric medicine, family medicine, or hospice and palliative medicine.

If you have a physician in an oncology clinic AND see patients in the home, do you need to apply twice?

A practice is based on its Tax Identification number (TIN) and the practitioners within it are based on their National Provider Identification (NPI). Those are the units that are included in the application. If the same TIN serves the clinic and home-based patients, then you need only apply once.

*** Reminder: Questions can be submitted directly to CMMI contractor: For questions about the model or solicitation process, please email PrimaryCareApply@telligen.com or call 1-833-226-7278.***

