New Primary Care Payment Models: PCF, SIP, & DC

American Academy of Home Care Medicine (AAHCM)

Home Centered Care Institute (HCCI)

Tom Cornwell, M.D., CEO, HCCI
Eric De Jonge, M.D., President, AAHCM
Priya Lamba, J.D., Vice President, Healthsperien
John Richardson, MPP, Vice President, Healthsperien

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What We'll Cover Today

- Introductions
- Primary Care First (PCF) Overview
  - PCF- General
  - Serious Illness Population (SIP) Track
- Direct Contracting (DC) Model
- Key Considerations for Participation
- Application Timelines
  - **DC Model LOI Deadline – Friday, August 2nd**
- Questions

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Primary Care First (PCF) Overview

General and the Serious Illness Population (SIP) Tracks

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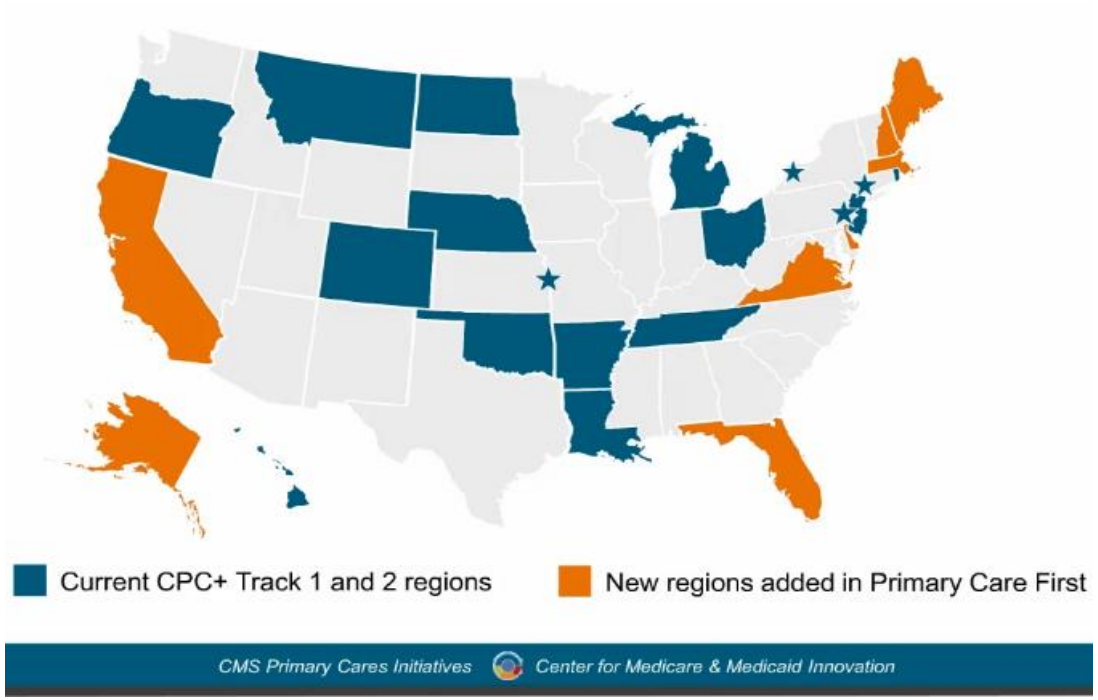
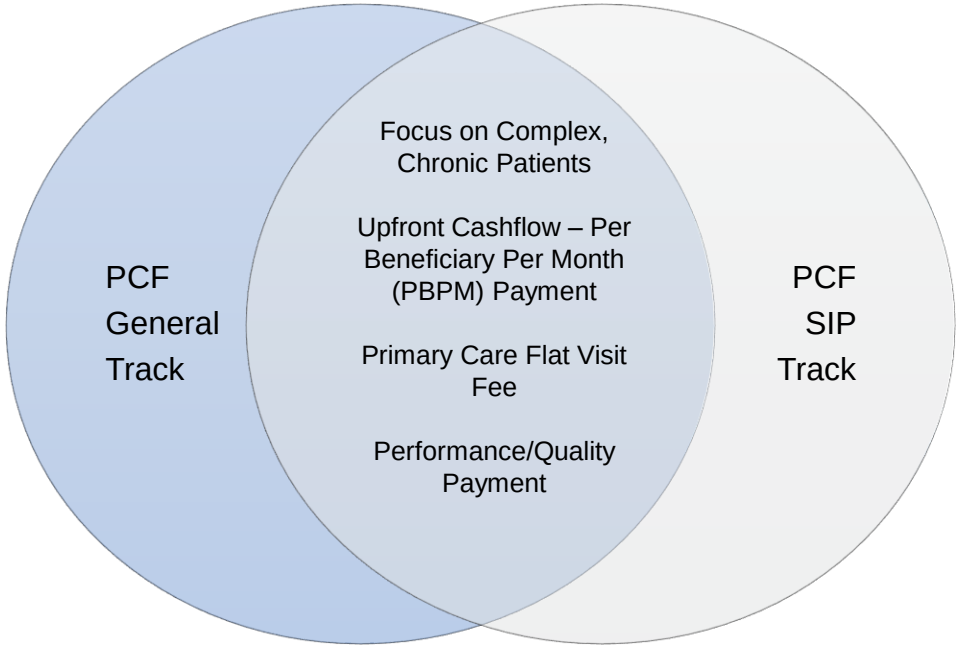
PCF Model

- Builds upon the Comprehensive Primary Care Plus (CPC+) Model
- Offered in 26 regions in 2020





Practice Participation Options

1. PCF General Only
2. SIP Only
3. Both PCF General **AND** SIP Tracks

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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

PCF Practice Criteria

PCF General Track ONLY	PCF SIP Track ONLY
In good standing with CMS	
Primary Care Practitioners	Practitioners serving SIP (can include hospice and palliative providers)
Have primary care services account for a predominant share (e.g., 70-80%) of practices collective billing based on revenue	N/A
Experience with value-based payment arrangements	
Use 2015 Edition CEHRT, support data exchange with other providers/systems via application programming interface (API), and connect to regional health information exchanges (HIEs)	
	<u>Year 1 Exception for SIP-Only Practices</u> Eligible for 1-year implementation delay for CEHRT, but use CEHRT by Year 2 (2021)
Attest to: • 24/7 access to a practitioner or nurse call line and • Empanelment of patients to primary care practitioner or care team	Meet complex patient management competencies and show relevant clinical capabilities: • Interdisciplinary Care Team (IDT) • Comprehensive, person-centered care management (including assessment of patients' social needs) • Relationships with medical and non-medical community-based resources • Wellness and healthcare planning • Family and caregiver engagement • 24/7 access to a member of the care team

For PCF General AND SIP Tracks

Must meet requirements of BOTH General and SIP Tracks

Hospice and palliative practices can participate in both working with PCF practice or through an affiliated practice that meets PCF General requirements

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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

PCF Patient Eligibility and Attribution

PCF General Track

- Must have at least 125 aligned beneficiaries
- Voluntary (MyMedicare.gov) and claims-based attribution (based on CCM, Annual Wellness, Welcome to Medicare, and plurality of E/M visits)

PCF SIP Track

1. Fragmented Pattern of Care (at least one of the following)
   - No single practice (TIN) provides more than 50% of a beneficiary's E/M visits
   - High rate of hospital visits, including ED use

   AND

2. Serious Illness (at least one of the following)
   - Medical Complexity (e.g., HCC ≥ 3.0)
   - High hospital utilization (e.g., HCC ≥ 2.0 AND 2 unplanned hospital visits in 12 months)
   - Signs of frailty (e.g., DME)

- CMS will use claims data to identify beneficiaries who meet the above criteria → CMS contacts beneficiary → Beneficiary election → CMS referral → Practice outreach to beneficiary (within 1-60 days) to schedule a face-to-face visit

- On limited case-by-base basis, practices may receive referral of SIP beneficiaries not identified by claims data

PCF General AND SIP Tracks

- No patient overlap
- Once "stable," SIP patients will transition to PCF General population or other provider
- Two different attribution methodologies will be used for the respective tracks

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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

PCF General Payment Model

Professional Population-Based Payment (PBP)

Services in/outside of the office, based on practice's average patient risk scores

Practice Risk Group	Payment (*PBPM*)
Group 1: Average Hierarchical Condition Category (HCC) <1.0	$24
Group 2: Average HCC 1.0-1.2	$28
Group 3: Average HCC 1.2-1.5	$45
Group 4: Average HCC 1.5-2.0	$100
Group 5: Average HCC >2.0	$175

Flat Primary Care Visit Fee (PCF)

In-person, face-to-face encounters

$50.52

Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Codes	
Office/Outpatient Visit E/M	99201-99205 99211-99215
Prolonged E/M	99354-99355
Transitional Care Management Services	99495-99496
Home Care E/M	99324-99328, 99334-99337, 99339-99345, 99347-99350
Advance Care Planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439

Performance Based Adjustment (PBA)

Up to 34% in Year 1 and 50% in Year 2 based on key performance measures

Measure Type	Available Years	Measure Title	Applicable Risk Groups
Utilization Measure for Performance-Based Adjustment Calculation	Year 1-5	**Acute Hospital Utilization** (AHU) (HEDIS measure)	Groups 1-5
Quality Gateway	Year 2-5	**CPC+ Patient Experience of Care Survey** (modernized version of CAHPS)	Groups 1-5 & SIP
		Diabetes: Hemoglobin A1c (HbA1c) **Poor Control** (>9%) (eCQM)[1]	Groups 1-3
		Controlling High Blood Pressure (eCQM)[1]	Groups 1-3
		Advance Care Plan (registry measure)	Groups 1-5 & SIP
		Colorectal Cancer Screening (eCQM)[1]	Groups 1-3

1. The following measures will not apply to practices in Practice Risk Groups 4 or 5 and for practices receiving SIP identified patients: (a) Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (eCQM); (b) Colorectal Cancer Screening (eCQM); and (c) Controlling High Blood Pressure (eCQM).

Source: CMMI Webinars and Fact Sheets on PCF and DC Models

PCF SIP Payment Model

Month 1

First-Visit Payment
$325

includes flat visit fee and not geographically adjusted

Months 2-12

Professional Population-Based Payment (PBP)
$275 PBPM

Minus a withhold, geographically adjusted

Flat Visit Fee
$50.52

Per face-to-face encounter, geographically adjusted

<u>Example Services Included</u>:

- Office/Outpatient E/M
- Prolonged E/M
- Transitional Care Management
- Home Care E/M
- Advance Care Planning
- Welcome to Medicare
- Annual Wellness Visits
- Face-to-Face for CCM

- **CAN bill other indirect FFS**

Quality Payment Adjustment
+/- $50 PBPM

Geographically adjusted

Proposed Measures*

- 24/7 Clinician Access
- Days at Home
- Patient Experience of Care Survey
- Advance Care Plan
- Total Per Capita Cost (TPCC Measure)

*Same measures will be used for PCF Risk Groups 4 and 5

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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

Direct Contracting (DC) Model

Professional, Global, and Potential Complex Tracks

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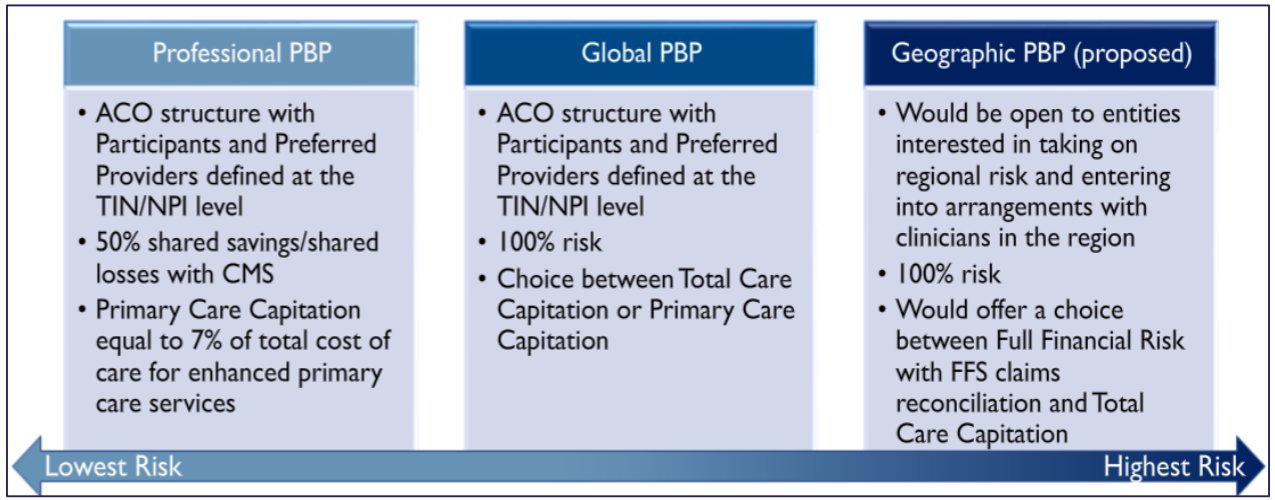
Direct Contracting (DC) Model Overview

Builds upon the Next Generation ACO model

No geographic limitations on who may apply at this time

3 voluntary risk-sharing payment model approaches offered



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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

DC Entities and Beneficiary Alignment

Who Can Participate?

- Practices, groups of providers, health systems, ACOs, Medicare Advantage (MA) plans, and Medicaid Managed Care Organizations (MCOs)
- Serve 5,000 beneficiaries (“by end of Year 3”)
- “Complex Track” for smaller practices may be an option

How Are Patients Attributed?

- Prospective Alignment – establish prior to start of performance year; beneficiaries aligned using voluntary or claims-based alignment
- Prospective Alignment “Plus” – allows DC Entity to engage in “more robust” outreach and communication in Entity’s service area

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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

DC Payment Model Elements

	Professional	Global
Payment	1) Primary Care Capitation – monthly cap for enhanced primary care services	1) Primary Care Capitation 2) Total Care Capitation - monthly cap for all Parts A/B services
	Participants and Preferred Providers continue to submit claims. DC Entity will have option to reduce FFS payments for services not covered under capitation.	
Benchmarking	Blend of historical spending and adjusted MA regional expenditures, and then adjusted to reflect other factors (e.g., population risk)	
Risk-Sharing	50% Shared Savings/Losses	**100% Shared Savings/Losses**
Risk-Mitigation Mechanisms	Risk Corridors (at aggregate expenditure level) Stop Loss (at individual beneficiary level)	
Reconciliation	Provisional Reconciliation (optional): interim shared savings/losses distributed immediately after end of performance year based on first 6 months of the performance year Final Reconciliation: traditional approach reflecting complete performance year	
Quality	Core set of measures (MIPS comparable and include 1 outcomes-based measure)	

Potential Waivers

- 3-Day SNF Rule
- Telehealth Expansion
- Post-Discharge Home Visits Rule
- Care Management Home Visits Rule
- **Allow NPs to certify eligibility for home health services**
- **Allow provision of home health services to beneficiaries who are not "homebound"**

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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

Complex Seriously Ill Patients – Potential New DC Track

- CMMI considering additional “Complex” DC track for more seriously ill patients, smaller practices
- Potentially waive some DC eligibility requirements (e.g., 5,000 beneficiary threshold)
- More details forthcoming

- No geographic limitations
- Greater potential for shared savings for HCM practices

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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

Key Considerations

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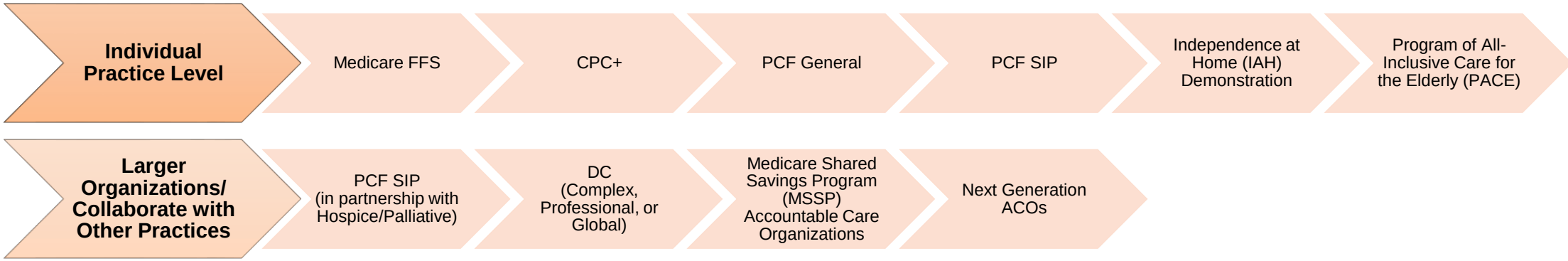
Considerations – Options



CLINICAL

- Capacity for intensive team-based care of the very ill, 24/7, across settings
- Geographic limitations– i.e., is it available in your region?
- Know average HCC / risk profiles of your population?
- Capacity to take on new patients (Varies - PCF, SIP, DC Tracks)?

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Considerations – Financial

- What amount of PBPM, plus savings and FFS, per patient, would sustain your practice?
- Average risk/ HCC profiles of your patient population?
- What level of risk are you comfortable with?
  - Shared savings (one-sided), or shared savings/losses (two-sided)
  - Ability to partner with others for greater efficiencies and risk/reward
- Need arrangements with other providers?
- Which program (PCF, SIP, DC (Large/Complex), or none) suit your population, clinical strengths, and cost structure?

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PCF Interaction with Other Models

CPC+

- CANNOT participate in Year 1
- Can participate in Year 2 (2021)

Direct Contracting

- Potential limited testing of overlap beginning in 2021

Medicare Shared Savings Program

- Can participate in MSSP ACOs
- CANNOT participate in Next Gen ACO or Comprehensive ESRD Care Model

Independence at Home (IAH) Demonstration

- Unknown at this time, Academy leadership meeting with CMMI in coming weeks to discuss

Episode Payment Models

- Can participate in BPCI Advanced, CJR, or OCM

Emergency Triage, Treat, and Transport Model (ET3)

- Complementary models, payments do not overlap

Accountable Health Communities (AHC)

- Can participate in both PCF and AHC bridge organization

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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

Application Timelines

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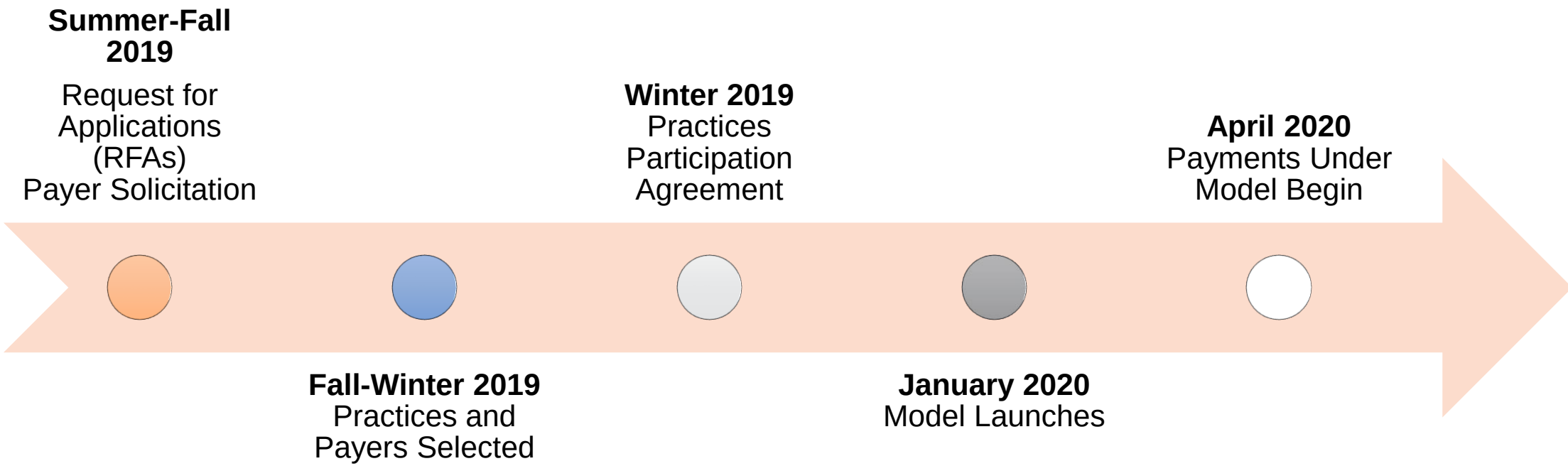
PCF / SIP Model Timeline



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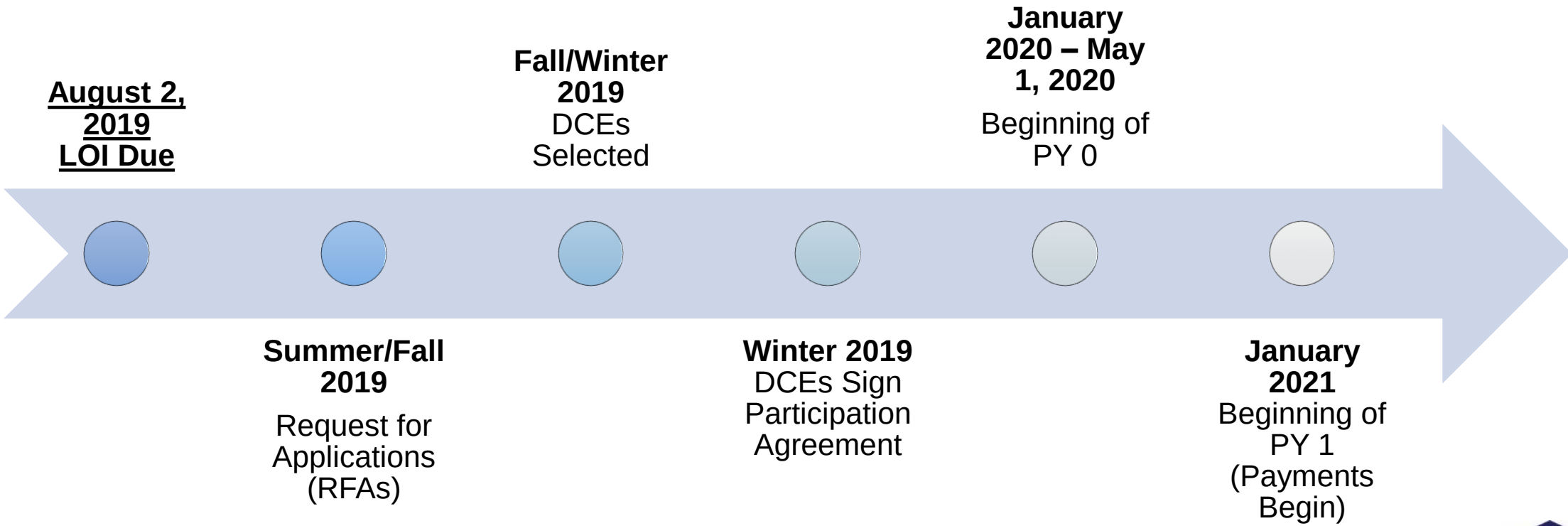
Source: CMMI Webinars and Fact Sheets on PCF and DC Models

DC Model Timeline



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DC Letters of Intent (LOIs) Due Friday!

- Deadline: Friday, August 2, by 11:59 pm ET
- Link: https://app1.innovation.cms.gov/dc
- What to Know:
  - LOI is not binding but is necessary to apply for the DC model (potentially even complex “PACE-like” track)
  - “Unsure” option available – don’t have to select “Global” or “Professional”
  - Practice profile: name, address, contact, # Medicare Part B beneficiaries served, experience in other payment models, use of CEHRT

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Source: CMMI Webinars and Fact Sheets on PCF and DC Models

Section B. Letter of Intent

All fields are required unless marked optional.

1. Please indicate whether the applicant organization, or any of the proposed participants in the organization, are currently participating, have formerly participated in, or have applied to any of the following initiatives listed below.

Available Initiatives

Health Care Payment Learning and Action Network
Health Plan Innovation Initiatives
Home Health Value-Based Purchasing Model
Independence at Home Demonstration
Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Phase Two
Maryland Total Cost of Care Model
Medicaid Innovation Accelerator Program
Medicare Care Choices Model
Medicare Demonstrations
Medicare Diabetes Prevention Program (MDPP) Expanded Model
Medicare Health Care Quality Demonstration
Million Hearts®: Cardiovascular Disease Risk Reduction Model
Next Generation ACO Model
Oncology Care Model
Part D Enhanced Medication Therapy Management Model
Partnership for Patients
State Innovation Models Initiative: Model Test Awards Round Two
State Innovation Models Initiative: Round Two
Transforming Clinical Practice Initiative
Vermont All-Payer ACO Model
Other

Available Initiatives

Selected Initiatives

2. Does your organization have prior experience working with Fee-for-Service (FFS) beneficiaries?

Please Select

3. Medicare ACO Name
(Please put N/A if this is not applicable)

4. If a Medicare ACO, what is the ID number (e.g., V123 or A1234)?
(Please put N/A if this is not applicable)

5. Which option are you interested in applying to (choose one or more of the following)?

Available	Selected
Global Professional Unsure	

6. Does the applicant organization anticipate the entire organization will transition to the new model?

Please Select

7. Current Medicare Shared Savings Program Track (Optional)

Please Select

8. End of Current Initiative Agreement (Optional)

mm/dd/yyyy

9. Is the applicant organization or are any of the proposed participants currently participating in an ACO with a payer other than Medicare?

Please Select

10. How many of the counties your organization will serve are considered rural? (If not applicable, enter "0")

All counties that are not designated as parts of Metropolitan Statistical Area (MSA) by the Office of Management and Budget (OMB) are considered rural. Large parts of many "urban" counties may be rural in nature. Therefore, census tracts with Rural Urban Commuting Area Codes (RUCA) 4 through 10 will be considered rural, and metropolitan areas will be considered rural for the purposes of the New Innovation Center Model. For information regarding Metropolitan Statistical Areas (MSAs), visit: http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/. For information regarding Rural Urban Commuting Area Codes (RUCAs), visit: http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/documentation/

11. How many Fee-for-Service Medicare beneficiaries are you currently serving?

12. Approximately which % of providers in your organization use 2015 edition Certified Electronic Health Record Technology (CEHRT)?

Please Select

13. Considering your entire organization, what % of patient health information is exchanged electronically?

Please Select

Source: CMMI Webinars and Fact Sheets on PCF and DC Models

Questions?

Tom Cornwell, M.D.
CEO, HCCI
tcornwell@hccinstitute.org

Eric De Jonge, M.D.
President, AAHCM
edejonge@capitalcaring.org

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Vice President, Healthsperien
plamba@healthsperien.com

John Richardson, MPP
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jrichardson@healthsperien.com

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