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
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
Primary Care First (PCF) Overview

General and the Serious Illness Population (SIP) Tracks
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

Source: CMMI Webinars and Fact Sheets on PCF and DC Models
# PCF Practice Criteria

## PCF General Track ONLY

- **Primary Care Practitioners**
  - In good standing with CMS
  - 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

## PCF SIP Track ONLY

- Have primary care services account for a predominant share (e.g., 70-80%) of practices collective billing based on revenue

## 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)

### Year 1 Exception for SIP-Only Practices

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

---

*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-case 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

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

- **Flat Primary Care Visit Fee (PCF)**
  - In-person, face-to-face encounters
  - $50.52

- **Performance Based Adjustment (PBA)**
  - Up to 34% in Year 1 and 50% in Year 2 based on key performance measures

---

**Practice Risk Group**

<table>
<thead>
<tr>
<th>Group</th>
<th>Condition Category (HCC)</th>
<th>Payment (PBPM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>Average Hierarchical Condition Category (HCC) &lt;1.0</td>
<td>$24</td>
</tr>
<tr>
<td>Group 2</td>
<td>Average HCC 1.0-1.2</td>
<td>$28</td>
</tr>
<tr>
<td>Group 3</td>
<td>Average HCC 1.2-1.5</td>
<td>$45</td>
</tr>
<tr>
<td>Group 4</td>
<td>Average HCC 1.5-2.0</td>
<td>$100</td>
</tr>
<tr>
<td>Group 5</td>
<td>Average HCC &gt;2.0</td>
<td>$175</td>
</tr>
</tbody>
</table>

---


- Office/Outpatient Visit E/M: 99201-99326, 99211-99219
- Prolonged E/M: 99354-99355
- Transitional Care Management Services: 99495-99496
- Home Care E/M: 99329-99332, 99334-99337, 99339-99345, 99347-99350
- Advance Care Planning: 99497, 99498
- Welcome to Medicare and Annual Wellness Visits: G0402, G0438, G0439

---

**Measure Type**

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Available Years</th>
<th>Measure Title</th>
<th>Applicable Risk Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization Measure for Performance-Based Adjustment Calculation</td>
<td>Year 1-5</td>
<td>Acute Hospital Utilization (AHU) (HEDIS measure)</td>
<td>Groups 1-5</td>
</tr>
<tr>
<td>Quality Gateway</td>
<td>Year 2-5</td>
<td>CPC+ Patient Experience of Care Survey (modernized version of CAHPS)</td>
<td>Groups 1-5 &amp; SIP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%) (eCQM)</td>
<td>Groups 1-3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Controlling High Blood Pressure (eCQM)</td>
<td>Groups 1-3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advance Care Plan (registry measure)</td>
<td>Groups 1-5 &amp; SIP</td>
</tr>
</tbody>
</table>

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

Quality Payment Adjustment +/- $50 PBPM
Geographically adjusted

Example Services Included:
• 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

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

Source: CMMI Webinars and Fact Sheets on PCF and DC Models
Direct Contracting (DC) Model

Professional, Global, and Potential Complex Tracks
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

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

Source: CMMI Webinars and Fact Sheets on PCF and DC Models
## DC Payment Model Elements

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

### 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”

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

Source: CMMI Webinars and Fact Sheets on PCF and DC Models
Key Considerations
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)?
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?
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

Source: CMMI Webinars and Fact Sheets on PCF and DC Models
Application Timelines
PCF / SIP Model Timeline

**Summer-Fall 2019**
- Request for Applications (RFAs)
- Payer Solicitation

**Winter 2019**
- Practices Participation Agreement

**April 2020**
- Payments Under Model Begin

**Fall-Winter 2019**
- Practices and Payers Selected

**January 2020**
- Model Launches

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

- **August 2, 2019**
  - LOI Due

- **Summer/Fall 2019**
  - Request for Applications (RFAs)

- **Fall/Winter 2019**
  - DCEs Selected

- **January 2020 – May 1, 2020**
  - Beginning of PY 0

- **Winter 2019**
  - DCEs Sign Participation Agreement

- **January 2021**
  - Beginning of PY 1
    - Payments Begin

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

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

Priya Lamba, J.D.
Vice President, Healthsperien
plamba@healthsperien.com

John Richardson, MPP
Vice President, Healthsperien
jrichardson@healthsperien.com