CMS Priorities For Value Based Care

Innovations Across the Care Continuum
New Jersey Hospital Association
May 17, 2019

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• No financial conflicts

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CMS is the **largest purchaser of health care in the world**.

Combined, Medicare and Medicaid pay approximately **one-third of national health expenditures**

CMS covers 100 million people through Medicare, Medicaid, the Children’s Health Insurance Program; or **roughly 1 in every 3 Americans**.

The Medicare program alone pays out over $1.5 billion in benefit payments per day.
Implications of Multiple Chronic Conditions
A Population View of Medicare

**Figure 13: Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2017**

- 0 to 1 condition: 17%
- 2 to 3 conditions: 21%
- 4 to 5 conditions: 29%
- 6+ conditions: 32%

**Figure 14: Distribution of Medicare Fee-for-Service Beneficiaries and 30-Day Medicare Hospital Readmissions by Number of Chronic Conditions: 2017**

- 0 to 1 condition: 17%
- 2 to 3 conditions: 21%
- 4 to 5 conditions: 29%
- 6+ conditions: 32%

**Percent of Beneficiaries**

**Percent of Total Medicare Spending**

**Percent of 30-Day Medicare Hospital Readmissions**
Figure 4: Prevalence of Chronic Conditions among Fee-for-Service Beneficiaries by Medicare & Medicaid Enrollment: 2017

- Hypertension: Medicare only (Non dual) 57%, Medicare & Medicaid (Dual) 59%
- Hyperlipidemia: Medicare only (Non dual) 38%, Medicare & Medicaid (Dual) 41%
- Arthritis: Medicare only (Non dual) 33%, Medicare & Medicaid (Dual) 35%
- Ischemic Heart Disease: Medicare only (Non dual) 27%, Medicare & Medicaid (Dual) 28%
- Diabetes: Medicare only (Non dual) 25%, Medicare & Medicaid (Dual) 35%
- Chronic Kidney Disease: Medicare only (Non dual) 22%, Medicare & Medicaid (Dual) 31%
- Depression: Medicare only (Non dual) 15%, Medicare & Medicaid (Dual) 31%
- Heart Failure: Medicare only (Non dual) 12%, Medicare & Medicaid (Dual) 19%
- COPD: Medicare only (Non dual) 10%, Medicare & Medicaid (Dual) 18%
- Cancer: Medicare only (Non dual) 5%, Medicare & Medicaid (Dual) 9%
- Alzheimer's Disease/Dementia: Medicare only (Non dual) 9%, Medicare & Medicaid (Dual) 18%
- Atrial Fibrillation: Medicare only (Non dual) 6%, Medicare & Medicaid (Dual) 9%
- Osteoporosis: Medicare only (Non dual) 6%, Medicare & Medicaid (Dual) 6%
- Asthma: Medicare only (Non dual) 4%, Medicare & Medicaid (Dual) 8%
- Stroke: Medicare only (Non dual) 3%, Medicare & Medicaid (Dual) 5%
- Drug Abuse/Substance Abuse: Medicare only (Non dual) 2%, Medicare & Medicaid (Dual) 5%
- Alcohol Abuse: Medicare only (Non dual) 2%, Medicare & Medicaid (Dual) 9%
- Schizophrenia/Other Psychotic Disorders: Medicare only (Non dual) 1%, Medicare & Medicaid (Dual) 11%
- Hepatitis (Chronic Viral B & C): Medicare only (Non dual) 0.4%, Medicare & Medicaid (Dual) 2%
- HIV/AIDS: Medicare only (Non dual) 0.2%, Medicare & Medicaid (Dual) 1%
- Autism Spectrum Disorders: Medicare only (Non dual) 0.0%, Medicare & Medicaid (Dual) 1.1%
A health care system that results in better accessibility, quality, affordability, empowerment, and innovation

CMS has started a national conversation about improving the health care delivery system, how Medicare can contribute to making the delivery system less bureaucratic and complex, and how we can reduce burden for clinicians, providers and beneficiaries in a way that increases quality of care and decreases costs – making the health care system more effective, simple, and accessible, while maintaining program integrity and preventing fraud.
CMS support of health care will result in patient-centered, market-driven reforms that drive quality and improve outcomes.

Key characteristics
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Key characteristics
- Patient-centered
- Incentives for outcomes
- Sustainable
- Market-driven
- Coordinated care
What is the Hospital Readmissions Reduction Program (HRRP)?

- The **HRRP is a pay-for-performance program** that reduces payments to subsection (d) hospitals with excess readmissions.
  - Supports the national goal of improving healthcare for Americans by linking payment to the quality of hospital care.
  - Provides a strong financial incentive for hospitals to **improve communication and care coordination efforts**, and to better engage patients and caregivers, with respect to post-discharge planning.
  - **Includes 6 mandatory claims-based measures of conditions and procedures** that significantly affect the lives of large numbers of Medicare patients. There is no reporting burden associated with these measures.
  - It was established with Section 3025 of the Patient Protection and Affordable Care Act.
The HRRP includes the following 30-day risk standardized readmission measures:
- Acute Myocardial Infarction (AMI)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure (HF)
- Pneumonia
- Coronary Artery Bypass Graft (CABG) Surgery
- Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA)
- HRRP does not include the Hospital-Wide All-Cause Readmission (HWR) measure, which is included in the Hospital Inpatient Quality Reporting (IQR) Program. Statute specifies that HRRP include condition-specific readmission measures.
What major policy changes did CMS make to the Hospital Readmissions Reduction Program?

• Effective Fiscal Year 2019

• Modified the payment methodology to account for impacts on providers caring for vulnerable patients in accordance with the 21st Century Cures Act.

• Stratified hospitals into quintiles (five peer groups) – under these peer groups, hospitals will be compared against hospitals serving a similar proportion of dual-eligible patients, as opposed to being compared against all hospitals nationwide.

• Implemented a change to the payment adjustment formula to ensure budget neutrality.
What measures will be used in the SNF VBP Program?

Skilled Nursing Facility 30-Day All-Cause Readmission Measure

The Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) is used in the SNF VBP Program. The SNFRM estimates the risk-standardized rate of unplanned readmissions within 30 days for:

- People with fee-for-service Medicare who were inpatients at PPS, critical access, or psychiatric hospitals.
- Any cause or condition
• Passed on September 18, 2014 and signed into law on October 6, 2014

• Requires Standardized Patient Assessment Data that will enable:
  o Quality care and improved outcomes
  o Data Element uniformity
  o Comparison of quality and data across post-acute care (PAC) settings
  o Improved discharge planning
  o Exchangeability of data
  o Coordinated care
  o Inform payment models
Driving Forces of the IMPACT Act

• **Purposes Include:**
  - Improvement of Medicare beneficiary outcomes
  - Provider access to longitudinal information to facilitate coordinated care
  - Enable comparable data and quality across PAC settings
  - Improve hospital discharge planning
  - Research

• **Why the attention to Post-Acute Care**
  - Escalating costs associated with PAC
  - Lack of data standards/interoperability across PAC settings
  - Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting
Requirements for reporting assessment data:

- Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions.
- The data must be submitted with respect to admission and discharge for each patient, or more frequently as required.

Data categories:

- Functional status
- Cognitive function and mental status
- Special services, treatments, and interventions
- Medical conditions and co-morbidities
- Impairments
- Other categories required by the Secretary

SNF: October 1, 2018
IRF: October 1, 2018
LTCH: October 1, 2018
HHA: January 1, 2019
Leveraging and mapping LTPAC assessment data elements to nationally accepted Health IT standards supports:

• Information exchange and re-use with and by:
  o Acute care hospitals and primary care providers
  o Long-term and post-acute care providers
  o Home and community based providers (HCBS)
  o Other providers
  o Health Information Exchange Organizations

• Use and re-use of assessment data in a variety of document types including:
  o Transfer documents
  o Referral documents
  o Care plans
  o LTPAC Assessment Summary Documents
The CMS Innovation Center Statute

“The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished to individuals under such titles”

Three scenarios for success from Statute:

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking
The Innovation Center portfolio aligns with broader CMS goals

**Pay Providers**

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**Deliver Care**

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**Distribute Information**

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<td>- Information to providers in CMMI models</td>
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<td>- Shared decision-making required by many models</td>
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New Direction - CMS Innovation Center Request for Information (RFI)

The RFI seeks broad input related to a new direction for the CMS Innovation Center that will promote **patient-centered care** and **test market-driven reforms** that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, and improve outcomes.

The administration plans to launch models in several focus areas:

- Expanded Opportunities for Participation in Advanced APMs
- Consumer-Directed Care & Market-Based Innovation Models
- Physician Specialty Models
  - Physician-Focused Payment Model Technical Advisory Committee (PTAC) Recommended Models
- Prescription Drug Models
- Medicare Advantage (MA) Innovation Models
- State-Based and Local Innovation, including Medicaid-focused Models
- Mental and Behavioral Health Models
- Program Integrity

**Guiding Principles**

- Choice and competition in the marketplace
- Provider choice and incentives
- Patient-centered care
- Benefit design and price transparency
- Transparent model design and evaluation
- Small scale testing
Emergency Triage, Treat, and Transport (ET3) Model

The **ET3 Model** provides greater flexibility to ambulance care teams responding to 911 calls, aimed at **reducing expenditures** while preserving or enhancing quality of care for beneficiaries.

**Goals:**

1. **Provide person-centered care** and give beneficiaries greater control of their care.
2. **Encourage appropriate utilization of services** to meet health care needs effectively.
3. **Increase efficiency in the EMS system** to more readily respond to high-acuity cases.

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CMS

Centers for Medicare & Medicaid Services
Accountable Health Communities Model addresses health-related social needs

Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs.

- Tests the **effectiveness of referrals and community services navigation** on total cost of care using a rigorous mixed method evaluative approach.

- **Partner alignment** at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs.

Model Tracks

**Assistance Track**

- **Bridge Organizations** in this track provide community service navigation services to **assist** high-risk beneficiaries with accessing services to address health-related social needs.

**Alignment Track**

- **Bridge Organizations** in this track encourage partner **alignment** to ensure that community services are available and responsive to the needs of beneficiaries.
Integrated Care for Kids Model

Addresses the impact of the opioid crisis on children

The **InCK Model** is a child-centered *local service delivery* and *state payment model* aimed at **reducing expenditures** and **improving the quality of care** for children covered by Medicaid and CHIP, especially those with or at-risk for developing significant health needs.

**Goals:**

1. Improving performance on priority measures of child health
2. Reducing avoidable inpatient stays and out-of-home placements
3. Creation of sustainable Alternative Payment Models (APMs)
Maryland All-Payer Model reports $429 million in Medicare hospital cost savings over three years

- Maryland has the nation’s only statewide all-payer hospital global budget model

- The model tests whether hospital global budgets can achieve improvements in quality and reduce per capita hospital cost growth

- The All-Payer Model has positive results to date (2014-2016)
  - The state reports approx. $429 million in Medicare hospital cost savings
  - All-payer total hospital per capita cost growth significantly below the 3.58% target
  - 30-day all cause readmission rate fell from 1.2% to 0.4% above national rate

- Hospitals began moving into All-Payer Global Budgets in July 2014
  - 95% of Maryland hospital revenue will be in global budgets
  - All 47 MD hospitals have signed agreements

- Model was initiated in January 2014; five year test period

- Maryland has proposed building on existing global budgets, towards a population-based total cost of care model.
Maryland Total Cost of Care Model

New Model in Maryland Covering Full Continuum of Care

Components of Maryland Total Cost of Care Model

- **Hospital Global Budgets**
  Population-based payments for Maryland hospitals; Continuation of policy from Maryland All-Payer Model

- **Care Redesign Program**
  Gainsharing between hospitals, hospital-based specialists, non-hospital providers

- **Maryland Comprehensive Primary Care Program**
  Financial support for primary care providers performing care management for high-risk patients

Benefits of TCOC Model

- Adds new providers and settings into care transformation effort
- Links disparate providers to create more patient-centered care
- Aligns incentives across providers to reduce hospitalizations and total cost of care

**Hospital only**  **Inpatient and outpatient settings**  **Primary care and community settings**

Performance Period begins January 1, 2019 and continues through 2026
Vermont All-Payer ACO Model - joint effort to transform health and healthcare throughout the State

First alternative payment model that aligns incentives for nearly all providers delivering care across an entire state in order to improve health, health care quality, and value for its residents that began January 1, 2017

Aligning the incentives across Vermont will create a strong business case for the healthcare system to improve health outcomes and population health and place Vermont healthcare cost growth on a more financially sustainable trajectory

Key Features:

- **Statewide Targets** - ACO scale targets, financial targets, and population health/health outcomes targets that bridge the traditional care delivery system with public health agencies and community health programs
- **Vermont Medicare ACO Initiative** - Medicare Fee-for-Service ACO initiative tailored to Vermont
- **Start-up Funding for Care Coordination** - $9.5 million of start-up funding made available in 2017 to support care coordination and bolster collaboration between practices and community-based providers

### Statewide Targets

**ACO scale targets**
At least 70% of all Vermont residents across payers, including 90% of Vermont Medicare beneficiaries, attributed to an ACO

**Population health and health outcomes targets**
- Substance use disorder
- Suicide
- Chronic conditions
- Access to care

**Financial targets**
- **Reduce per capita healthcare expenditure growth** across all payers to at most 3.5%
- **Reduce per capita Medicare healthcare expenditure growth** to 0.1%-0.2% points below projected national Medicare growth
The bundled payment model targets 48 conditions with a single payment for an episode of care

- Incentivizes providers to take **accountability for both cost and quality** of care
- **Four Models**
  - Model 1: Retrospective acute care hospital stay only
  - Model 2: Retrospective acute care hospital stay plus post-acute care
  - Model 3: Retrospective post-acute care only
  - Model 4: Prospective acute care hospital stay only

  - 261 Awardees and 983 Episode Initiators as of July 2017

- **Duration of model is scheduled for 3 years:**
  - Model 1: Awardees began Period of Performance in April 2013
  - Models 2, 3, 4: Awardees began Period of Performance in October 2013
Spotlight: Bundled Payments for Care Improvement Initiative Model 2 – St. Mary Medical Center in Langhorne, PA

St. Mary’s Medical Center is a 373 bed, Acute Care Hospital testing the Congestive Heart Failure (CHF) clinical episode since January 1, 2014

Care Redesign Efforts under the BPCI Initiative

• Focused on reducing preventable hospital readmissions through **transitional nurse assistance** with medical, behavioral, psychological, social, and environmental factors

• **Monthly meetings** with top 10 Skilled Nursing Facility partners to share quality metrics data and provide education to Skilled Nursing Facilities staff

• Established physician-led **interdisciplinary committee** to improve physician engagement in care redesign efforts

• **Transition nurse service** expanded to provide assistance to all CHF Medicare Beneficiaries

A Beneficiary Success Story

71 year old patient with CHF, CABG, sleep apnea with heavy alcohol and drug abuse history, who was estranged from family and lived alone, had no readmissions or ED visits post discharge during 6 months after clinical episode concluded
BPCI Advanced Model Overview

• BPCI Advanced is a voluntary bundled payment model that qualifies as an Advanced Alternative Payment Model (Advanced APM) with payment tied to performance on quality measures.
• Single payment and risk track with a 90-day episode period
• **33** Inpatient Clinical Episodes
• **5** Outpatient Clinical Episodes

Who can participate?

• **Convener Participants** (Medicare enrolled or non-Medicare enrolled providers)
• **Non-Convener Participants** (Medicare enrolled providers only)

Who are the Episode Initiators?

• Acute Care Hospitals (ACHs)
• Physician Group Practices (PGPs)
• **Financial Risk**: bear risk for monetary losses of more than a nominal amount
  ➢ **BPCI Advanced**: financially at risk for up to 20 percent of the final Target Price for each Clinical Episode

• **Advanced APM**: linked to quality measures comparable to Merit-Based Incentive Payment System measures
  ➢ **BPCI Advanced**: CMS calculates a quality score for each quality measure at the Clinical Episode level
  ➢ **Composite Quality Score**: These scores are volume-weighted and scaled across all Clinical Episodes attributed to a given EI
Items and Services Included in a Clinical Episode

Part A and Part B non-excluded items and services furnished:
- during the Anchor Stay or Anchor Procedure
- 90-day period following the Anchor Stay or Anchor Procedure, including hospice services and related and unrelated readmissions

Clinical Episodes triggered by an Anchor Stay:
- hospital diagnostic testing and certain therapeutic services up to three days prior to Anchor Stay
- charges from that Emergency Department (ED) visit, if transferred from another facility’s ED
Types of Items and Services Included in a Clinical Episode

- Skilled nursing facility (SNF) services
- Home health agency (HHA) services
- Clinical laboratory services
- Durable medical equipment (DME)
- Part B drugs*
- Hospice services
- Long-term care hospital (LTCH) services
- Physicians’ services

- Inpatient or outpatient hospital services that comprise the Anchor Stay or Anchor Procedure (respectively)
- Other hospital outpatient services, inpatient hospital readmission services
- Inpatient rehabilitation facility (IRF) services
The CJR model started on **April 1, 2016** and is scheduled to run for 5 years in total; ending December 2020.

CJR is an **episode-based payment model for lower extremity joint replacement (LEJR)** procedures for Medicare fee-for-service beneficiaries. CJR episodes include:

- Hospitalization for LEJR procedure assigned MS-DRG 469 or 470 and 90 days post-discharge.
- All Part A and Part B services, with the exception of certain excluded services that are clinically unrelated to the episode.

CJR model was implemented in **67** metropolitan statistical areas (MSAs)

- All participant hospitals in these selected MSAs are acute care hospitals paid under the IPPS & not currently participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for LEJR episodes
- Initial Evaluation Results for PY 1 are anticipated to be available in the fall of 2018.
Participation was mandatory for all participants for years 1 & 2. A change to the CJR model participation requirements was proposed and finalized in a final rule that took effect January 1, 2018.

- Rural and low volume providers and providers in 33 of the 67 CJR geographic areas were able to voluntarily opt into the model between January 1 and January 31, 2018.

462 total number of participating hospitals as of February 1, 2018

387 of these 462 hospitals are located in the 34 mandatory MSAs

75 of these 462 providers are located in the voluntary MSAs

Approximately 30 providers currently participating in the existing BPCI model will participate in the CJR model as of October 1, 2018 since the BPCI model ends on September 30, 2018.
BASIC track and ENHANCED track

- We redesigned the program’s participation options to offer two tracks instead of three tracks and the Track 1+ Model, which eligible ACOs enter into for an agreement period of not less than 5 years, for agreement periods beginning on July 1, 2019, and in subsequent years:
  - **BASIC track**: Includes a “glide path” for eligible ACOs consisting of five levels (called Levels A through E) that begin under a one-sided model and incrementally phase-in higher levels of risk and reward. The highest level, Level E, qualifies as an Advanced Alternative Payment Model (APM) under the Quality Payment Program.
  - **ENHANCED track**: Based on the program’s Track 3; provides greater risk in exchange for greater potential reward. This track is also an Advanced APM under the Quality Payment Program.
Primary Care First and Direct Contracting

5 Payment Models

1. Primary Care First (PCF)
2. Primary Care First – High Need Populations
3. Direct Contracting – Professional
4. Direct Contracting – Global
5. Direct Contracting – Geographic

All five payment model options focus on supporting care for patients who have chronic conditions and serious illnesses.

For additional information about Primary Care First, please visit the model website at https://innovation.cms.gov/initiatives/primary-care-first-model-options/
The Direct Contracting path, together with the Primary Care First payment model options and the updated Medicare Shared Savings Program ENHANCED Track, are part of the CMS strategy to use the redesign of primary care to drive broader delivery system reform to improve health and reduce costs.
PCF Payment Model Option Emphasizes Flexibility & Accountability

**PCF Payment Model Option Goals**

- **Promote patient access** to advanced primary care both in and outside of the office, especially for complex chronic populations
- **Transition primary care** from fee-for-service payments to value-driven, population-based payments
- **Reward high-quality, patient-focused care** that reduces preventable hospitalizations

**PCF Payments**

- **Professional population-based payments** and flat primary care visit fees to help practices improve access to care and transition from FFS to population based payments
- **Performance-based adjustments** up to 50% of revenue and a 10% downside, based on a single outcome measure, with focused quality measures
PCF: High Need Population Payment Model Option

PCF incorporates the following unique aspects for practices electing to serve seriously ill populations to increase access to high-quality, advanced primary care.

Eligibility and Beneficiary Attribution

Practices demonstrating relevant capabilities **can opt in to be assigned SIP patients or beneficiaries** who lack a primary care practitioner or care coordination.

Medicare-enrolled clinicians who provide **hospice or palliative care can partner** with participating practitioners.

Payments

Payments for practices serving seriously ill populations:

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<td>• One-time payment for first visit with SIP patient: <strong>$325 PBPM</strong></td>
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<td>• Monthly SIP payments for up to 12 months: <strong>$275 PBPM</strong></td>
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<td>• Flat visit fees: <strong>$50</strong></td>
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<td>• Quality payment: up to <strong>$50</strong></td>
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In 2020, Primary Care First will include 26 diverse regions:

- Current CPC+ Track 1 and 2 regions
- New regions added in Primary Care First
Payment Model Options

CMS will test three voluntary risk-sharing payment model options under Direct Contracting:

- Professional Population Based Payment (PBP)
- Global PBP
- Geographic PBP*

*We are seeking public input on model design elements

The Direct Contracting payment model options are expected to be Advanced APMs in 2021. All options feature enhancements aimed at encouraging organizations focused on care for those with complex chronic conditions to participate.
Stakeholder Input

Direct Contracting payment model options have been informed by stakeholder input from various sources:

- CMS Accountable Care Organizations (ACOs)
- Providers in risk-sharing arrangements in Medicare Advantage (MA) and the private sector
- Providers serving beneficiaries dually eligible for Medicare and Medicaid
- Direct Provider Contracting Request for Information (RFI)
- Innovation Center New Direction RFI
Payment Model Options

Professional PBP
- ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- 50% shared savings/shared losses with CMS
- Primary Care Capitation equal to 7% of total cost of care for enhanced primary care services

Global PBP
- ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- 100% risk
- Choice between Total Care Capitation or Primary Care Capitation

Geographic PBP (proposed)
- Would be open to entities interested in taking on regional risk and entering into arrangements with clinicians in the region
- 100% risk
- Would offer a choice between Full Financial Risk with FFS claims reconciliation and Total Care Capitation

Lowest Risk Highest Risk
Direct Contracting Entities

- Generally, must have at least 5,000 aligned Medicare FFS beneficiaries.
- “On ramp” for organizations new to Medicare FFS.
- Added flexibility for organizations serving dually eligible, chronically ill populations.

DC Participants
- Core providers and suppliers.
- Used to align beneficiaries to the Direct Contracting Entity.
- Responsible for reporting quality through the Direct Contracting Entity and improving the quality of care for aligned beneficiaries.

Preferred Providers
- Not used to align beneficiaries to the Direct Contracting Entity.
- Participate in downstream arrangements, certain benefit enhancements or payment rule waivers, and contribute to Direct Contracting Entity goals.

Geographic PBP option would be open to innovative organizations, including health plans, health care technology companies, in addition to providers and supplier organizations.
Medicare Advantage Value Based Insurance Design Model offers more flexibility to Medicare Advantage Plans

Allows MA plans to **structure enrollee cost-sharing and other health plan design elements to encourage enrollees to use clinical services that have the greatest potential to positively impact on enrollee health**

- Began on January 1, 2017 and will run for 5 years

Plans in **25 states** will be eligible to participate

- Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee
- **Starting in 2018:** Alabama, Michigan and Texas
- **Starting in 2019:** California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia.
CMS is permitting model participants to propose Part D Rewards and Incentives (RI) programs that, in connection with medication use, focus on promoting improved health, medication adherence, and the efficient use of health care resources.

Eligible: PDP and MA-PD plans, including those that offer standard or alternative Part D coverage, may apply to participate.

The goals include rewarding and incentivizing enrollees’:
- Participation in a disease state management program
- Engaging in medication therapy management with pharmacists or providers
- Receipt of preventive health services, such as vaccines
- Active engagement with their plans in understanding their medications, including clinically-equivalent alternatives that may be more cost-accessible
Bipartisan Budget Act of 2018 (BBA) allows eligible MAOs in all 50 states and territories to apply for one or more of the health plan innovations being tested in the VBID model.

- VBID by chronic condition and/or socioeconomic status
- Rewards and Incentives
- Telehealth Networks
- Wellness and Health Care Planning
- CY 2021: Hospice Benefit in Medicare Advantage
- Participating MAOs that offer Prescription Drug Plans (MA-PDs) may also propose RI programs for enrollees who take covered Part D prescription drugs.
Comprehensive ESRD Care will improve patient centered coordination of care for ESRD beneficiaries

The CEC model improves care coordination through the creation of **ESRD Seamless Care Organizations (ESCO)** that will include dialysis providers, nephrologists, and other medical providers

- CEC Model launched in 2015 and is now in Year 2 with 37 ESCOs, including 33 LDOs and 4 non-LDOs, serving 38,000 beneficiaries nationwide
- Goal is to test an ACO model centered solely around ESRD patients

![Image](image.png)

Dialysis costs account for approximately **35% of total cost of care** for ESRD patients

- Opportunity exist to improve patient centered care that coordinates dialysis care with care outside of dialysis

<table>
<thead>
<tr>
<th>ESRD beneficiaries =</th>
<th>1%</th>
<th>account for</th>
<th>7.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>of Medicare beneficiaries</td>
<td></td>
<td>of Medicare Fee-For-Service (FFS) payments</td>
<td></td>
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**Care Model**

- Improve care coordination
  - Dialysis facilities, nephrologists and other providers coordinate beneficiary care
  - Clinical and support services
  - Data driven, population care management

- Enhance communication between providers
  - Whole-patient care management
  - EHR information exchange among providers
Hospital

Payor

Family/Caretaker

PCP

Patient

Hospice

Nursing Home

Community

Home Health Agency
Questions?