Patient-Centered
Primary Care
COLLABORATIVE

May Policy and Advocacy MEETING
Tuesday, May 21 from 1:00 – 2:30 PM ET
601 13th Street NW, Second Floor (up the stairs from lobby)
For those outside of DC: Dial-In Number: (267) 930-4000, Access: 740-654-563

I. Welcome *Ann Greiner, PCPCC*

II. Co-Chair Welcome and Introduction *Shari Erickson, ACP*
Katie Martin, NPWF

a. PCPCC Member Questions (Page 2)

III. CMMI Plans for Primary Care First *Nicholas Minter, CMMI*
Gabrielle Schechter
Perry Payne

a. Slides (Page 4)
b. CMS Press Release and overview of the Primary Cares initiative
c. Primary Care First Model Options
d. Primary Care First Fact Sheet

IV. CMMI Plans for Direct Contracting *Pauline Lapin, CMMI*

a. Slides (Page 16)
b. Direct Contracting Model Options
c. Direct Contracting Fact Sheet

V. Member Discussion

a. Member Updates
b. Suggestions for PCPCC Policy/Advocacy Convenings

VI. Other Updates *Chris Adamec, PCPCC*

a. CPC+ First Annual Report Overview (Page 28)
b. PCPCC Statement on VT and CO Primary Care Laws (Page 30)

VII. Adjournment & Next Meeting

a. June Policy/Advocacy Call: Tuesday, June 11, from 1:00 - 2:00 PM ET

PCPCC Member Questions for CMMI

Program Development:

- What incentives/tools/beneficiary enhancements will be available to engage patients/consumers in the new models?
- What strategies will be used to engage leaders in new states? Government, thought leader, academic, practice transformation?
- How do you plan to be successful in driving multi-payer alignment – including state Medicaid plans?
- What incentives are there for health plans for get involved?
- How were these new markets and these new states selected to be involved? Will the number of geographic regions for Primary Care First ever be expanded?
- What information is known about the number of practices that are ready to move into value-based models?
- Any additional clarity or updates on timing for release of RFA and close of application period (current messaging has indicated the end of May for RFA release and selection in the fall/winter)?

Program Details:

- While we agree that reducing hospital visits is an important goal for quality, do you have any concerns that having this as the only utilization measure in the first year of the model will lead to accurate quality measurement? Will there be any exclusions for visits that are unlikely to be influenced?
- Are there further plans to strengthen and encourage behavioral health integration in the model?
- Will you be taking any steps to mitigate possible adverse effects on patient access, particularly with regards to social determinants of health?
- We understand that to be eligible, participants must "demonstrate experience with value-based payment arrangements." What types of arrangements qualify?
- You note that less administrative burden and more flexibility is a priority for both models. Do you have any specific examples of how you will reduce burden? How might that differ for fully capitated models versus those that retain an underlying FFS architecture?
- How will primary care services be defined for purposes of patient assignment?
- Given the advanced risk entailed in the model- will practices have an opportunity to receive any data prior to agreeing to participate (similar to BPCI Advanced?)
- Will participants in these models be able to participate in other CMS models or initiatives (such as the MSSP) simultaneously? If so, how will CMS address overlap concerns with patient assignment and attributing savings?
- Will PCF would be evaluated under the MHM standard or the standard AAPM risk standard (and more to the point- do they intended it to qualify under the MHM standard if the 50 clinician cap would apply)?
- What types of waivers will be offered to model participants?
- At the CPC+ National Meeting a question was asked about visibility to data for practices to know how risk adjustment will affect them and the CMMI team took that as a note and indicated they would try to provide a tool or report prior to practices agreeing to participate. Can CMMI clarify the timing of data availability needed for decision making?
- How can SIP practices forecast how many SIP patients may be referred to them by CMS?

- For a practice seeking to only participate in PCF:
    - Per the section of the Fact Sheet below, will SIP-eligible patients be referred away from their existing PCP if the current PCP is not in the SIP model option? How will CMS know if care coordination is occurring with a SIP practice (e.g. is this based on claims activity)? (*CMS will attribute Seriously Ill Population (SIP) patients lacking a primary care practitioner or care coordination to Primary Care First practices that specifically opt to participate in this payment model option.)*
- For practices seeking participation in both PCF options (PCF and SIP):
    a. Does the minimum of 125 beneficiaries related to eligibility in PCF include SIP patients?
    b. Are SIP patients included in risk banding (practice risk group calculations) – or are they set apart?

<u>Payment:</u>

- How did you arrive at the payment amounts for the PCF model?
- We heard on the webinar that the flat PC visit fee will be geographically adjusted. Do you have any sense how much? Will the professional population-based payments also be geographically adjusted?
- The DC fact sheet says a "meaningful percentage" of the benchmark will be tied to quality performance. How will that work? Do you have any initial interest from private payers for the PCF model? Did that factor into which geographic regions were chosen? How will you be designing patient cost sharing?
- Beyond hitting minimum required quality thresholds to qualify for performance-based payments, will participants receive any credit for delivering exceptionally high quality of care?
- How will the target or benchmark spending be determined for the DC model?
- How will program evaluation work for both models? Specifically, will the PCF model use control groups, such as was the case with CPC+?
- Will practices be penalized if a patient is identified as eligible for assignment to the model entity, but they do not wish to be assigned?
- What is the performance period / year on which the practice's average HCC risk banding will be calculated?

Primary Care First

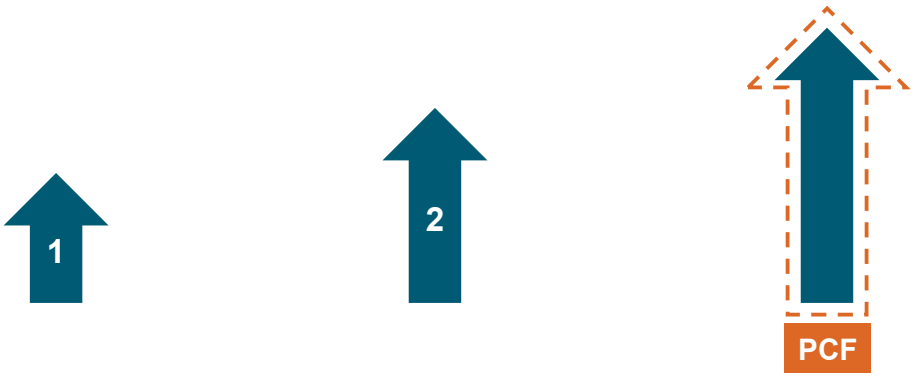
Foster Independence. Reward Outcomes.

Model Briefing

Center for Medicare & Medicaid Innovation

Primary Care First Builds on the Underlying Principles of Prior CMS Innovation Models

CMS primary care models offer a variety of opportunities to advance care delivery, increase revenue, and reduce burden.



Comprehensive Primary Care Plus (CPC+) Track 1 is a pathway for practices ready to **build the capabilities** to deliver comprehensive primary care.

CPC+ Track 2 is a pathway for practices poised to **increase the comprehensiveness** of primary care.

Primary Care First rewards **outcomes**, increases **transparency**, enhances care for **high need populations**, and reduces **administrative burden**.

Primary Care First Rewards Value and Quality Through an Innovative Payment Structure

Primary Care First Goals

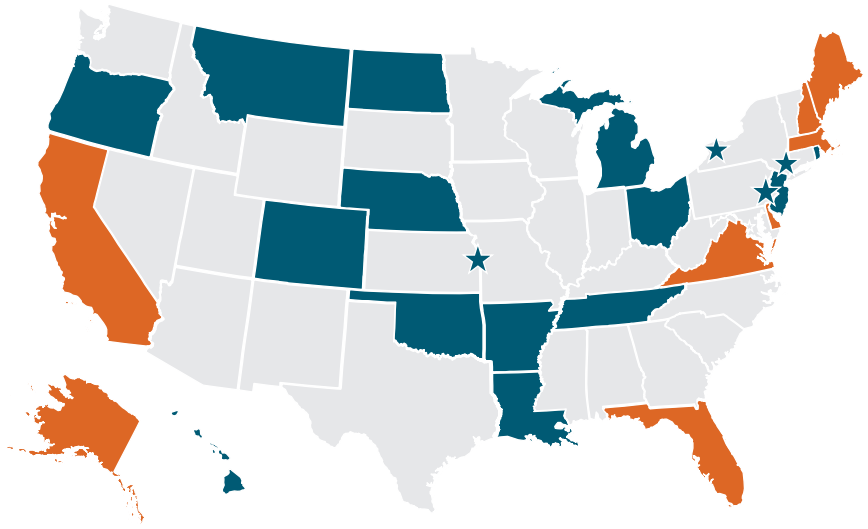
1. To **reduce Medicare spending** by preventing avoidable inpatient hospital admissions
2. To **improve quality of care and access to care** for all beneficiaries, particularly those with complex chronic conditions and serious illness

Primary Care First Overview

- **5-year** alternative payment model
- Offers greater **flexibility**, increased **transparency**, and **performance-based** payments to participants
- Payment options for practices that specialize in **patients with complex chronic conditions** and high need, **seriously ill populations**
- Fosters **multi-payer alignment** to provide practices with resources and incentives to enhance care for all patients, regardless of insurer

Primary Care First Will Be Offered in 26 States and Regions Beginning in 2020

In 2020, Primary Care First will include 26 diverse regions:



Current CPC+ Track 1 and 2 regions

New regions added in Primary Care First

PCPCC Page 5

Primary Care Practices Can Participate in One of Three Payment Model Options

The **three Primary Care First (PCF) payment models** accommodate a continuum of providers that specialize in care for different patient populations.

Option 1

PCF Payment Model

Focuses on **advanced primary care practices ready to assume financial risk** in exchange for reduced administrative burdens and performance-based payments. Introduces new, higher payments for practices caring for complex, chronically ill patients.

Option 2

PCF High Need Populations Payment Model

Promotes care for high need, **seriously ill population (SIP)** beneficiaries who lack a primary care practitioner and/or effective care coordination.

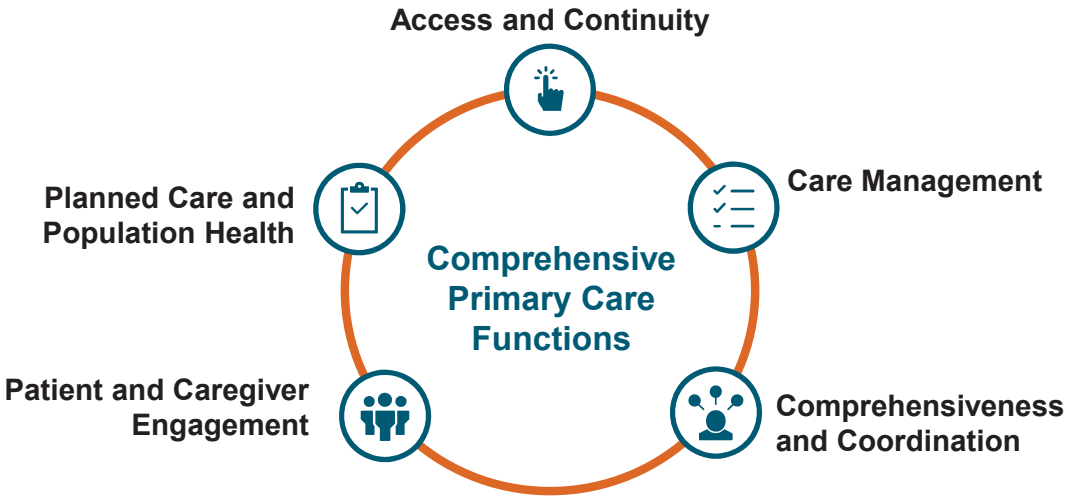
Option 3

Participation in both options 1 and 2

Allows practices to **participate in both** the PCF Payment Model and the PCF High Need Populations Payment Model.

Participants Achieve Model Aims Through Innovations in Their Care Delivery

PCF participants are incentivized to deliver evidence-based interventions across 5 comprehensive primary care functions:



Practices Have the Freedom to Innovate While Implementing Core Functions of Comprehensive Primary Care

Comprehensive Primary Care Function	PCF Intervention
Access and Continuity	▪ Provide 24/7 access to a care team practitioner with real-time access to the EHR
Care Management	▪ Provide risk-stratified care management
Comprehensiveness and Coordination	▪ Integrate behavioral health care ▪ Assess and support patients' psychosocial needs
Patient and Caregiver Engagement	▪ Implement a regular process for patients and caregivers to advise practice improvement
Planned Care and Population Health	▪ Set goals and continuously improve upon key outcome measures

The PCF Payment Model Option Emphasizes Flexibility and 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

Payments Under the PCF Payment Model Option Are Made Up of Two Major Components

Total Medicare payments

Total primary care payment + **Performance-based adjustment**

- Professional Population-Based Payment
- Flat Primary Care Visit Fee

Opportunity for practices to **increase revenue by up to 50%** of their total primary care payment based on key performance measures, including acute hospital utilization (AHU).

1. National adjustment
2. Cohort adjustment
3. Continuous improvement adjustment

Total Primary Care Payment Includes Two Payment Types: a Population-Based Payment and a Flat Visit Fee

Hybrid Total Primary Care Payments replace Medicare fee-for-service payments to support delivery of advanced primary care.

Professional Population-Based Payment

Payment for service in or outside of the office, adjusted for practices caring for higher risk populations. This payment is the same for all patients within a practice.

Practice Risk Group	Payment *Per beneficiary per month*
Group 1 (lowest average HCC)	$24
Group 2	$28
Group 3	$45
Group 4	$100
Group 5 (highest average HCC)	$175

Payment adjusted to account for beneficiaries seeking services outside the practice.

+

Flat Primary Care Visit Fee

Flat payment for face-to-face treatment that reduces billing and revenue cycle burden

$50.52

per face-to-face patient encounter

Adjusted for geography

These payments allow practices to:

- Easily predict payments for face-to-face care
- Spend less time on claims processing and more time with patients

Performance-Based Payment Adjustments Are Determined Based on a Multi-Step Process

In **Year 1**, adjustments are determined based on **acute hospital utilization (AHU)** alone.
In **Years 2-5**, adjustments are based on performance as described below.

Did the practice exceed the Quality Gateway?

No

-10%
Adjustment
to Total Primary Care Payment for next applicable year

Yes

Adjustment of up to 50% of total primary care payment determined by comparing performance to three different benchmarks:

1. National adjustment
2. Cohort adjustment
3. Continuous improvement adjustment

In the National Adjustment, Applicable Practices Are Compared to a National Benchmark of Similar Practices

1 National adjustment

The national minimum benchmark is based on the lowest quartile of Acute Hospital Utilization (AHU) performers in a national reference group.

PCF practice performance

Above national minimum benchmark

Eligible for cohort adjustment

At or below national minimum benchmark

-10%
Adjustment
(*still eligible for continuous improvement bonus*)

In the Cohort Adjustment, an Eligible Practice is Compared to Other Practices Enrolled in the Model

2 Cohort adjustment

Practice performance is next compared against other PCF participants to determine the performance-based adjustment.

Bottom 50% of PCF practices based on performance

0%
Adjustment

Top 50% of PCF practices based on performance

Performance Level	Adjustment to Total Primary Care Payment
Top 20% of eligible practices	**34%**
Top 21–40% of eligible practices	**27%**
Top 41–60% of eligible practices	**20%**
Top 61%–80% of eligible practices	**13%**
Top 81–100% of eligible practices	**6.5%**

A Continuous Improvement Bonus is Based on Whether a Practice Improved Relative to the Prior Year's Performance

3 Continuous improvement adjustment

Practices are also eligible for a **continuous improvement bonus of up to 1/3rd of total PBA amount** if they achieve their improvement target. CMS may use statistical approaches to account for random variations over time and promote reliability of improvement data.

Performance Level	Potential Improvement Bonus
Top 20% of PBA-eligible practices	**16%** of Total Primary Care Payment
Top 21–40% of PBA-eligible practices	**13%** of Total Primary Care Payment
Top 41–60% of PBA-eligible practices	**10%** of Total Primary Care Payment
Top 61%–80% of PBA-eligible practices	**7%** of Total Primary Care Payment
Top 81–100% of PBA-eligible practices	**3.5%** of Total Primary Care Payment
Practices performing above nationwide benchmark, but below top 50% of practices	**3.5%** of Total Primary Care Payment
Practices performing at or below nationwide minimum benchmark	**3.5%** of Total Primary Care Payment

The High Need Population Payment Model Option Increases Seriously Ill Populations' Access to Primary Care

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:

First 12 Months

- One-time payment for first visit with SIP patient: **$325 PBPM**
- Monthly SIP payments for up to 12 months: **$275 PBPM**
- Flat visit fees: **$50**
- Quality payment: up to **$50**

The Model's Quality Strategy Includes a Focused Set of Clinically Meaningful Measures

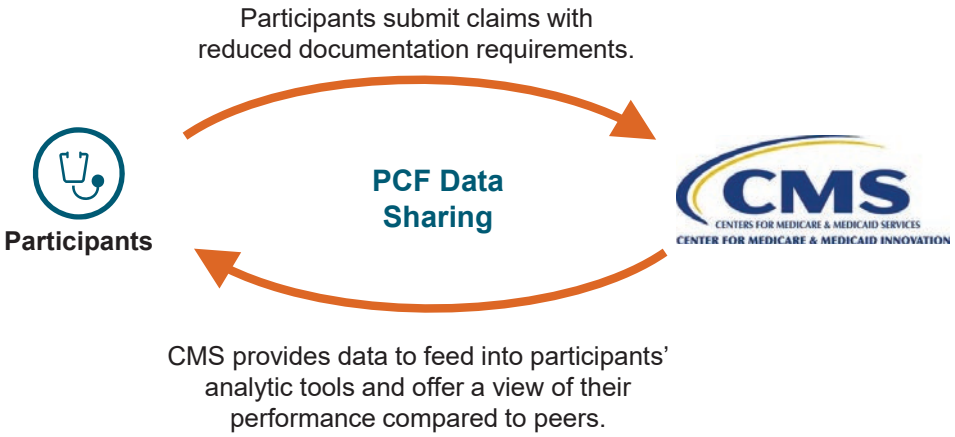
The following measures will inform performance-based adjustments and assessment of model impact.

Measure Type	Measure Title	Benchmark
Utilization Measure for Performance-Based Adjustment Calculation (Year 1-5)	**Acute Hospital Utilization** (AHU) (HEDIS measure)	PCF and Non-PCF reference population
Quality Gateway (starts in Year 2)	**CPC+ Patient Experience of Care Survey** (modernized version of CAHPS)	PCF and Non-PCF reference population
	Diabetes: Hemoglobin A1c (HbA1c) **Poor Control** (>9%) (eCQM)[1]	MIPS
	Controlling High Blood Pressure (eCQM)	MIPS
	Care Plan (registry measure)	MIPS
	Colorectal Cancer Screening (eCQM)[1]	MIPS
Quality Gateway for practices serving high-risk and seriously ill populations[1]	To be developed during model; domains could include 24/7 patient access and days at home	

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) and (b) Colorectal Cancer Screening (eCQM)

Primary Care First Innovates Data Sharing to Inform Care Delivery

Participants get access to timely, actionable data to assess performance relative to peers and drive care improvement.



Practices Participating in the PCF Payment Model Option Must Meet the Following Eligibility Requirements

Practices participating in the PCF Payment Model Option must:

- ✓ Include **primary care practitioners** (MD, DO, CNS, NP, PA) in good standing with CMS
- ✓ Provide health services to a **minimum of 125** attributed Medicare beneficiaries*
- ✓ Have primary care services account for the **predominant share** (e.g., 70) of the practices' collective billing based on revenue*
- ✓ Demonstrate **experience with value-based payment arrangements**, such as shared savings, performance-based incentive payments, and alternative to fee-for-service payments
- ✓ Use 2015 Edition **Certified Electronic Health Record Technology** (CEHRT), support **data exchange** with other providers and health systems via Application Programming Interface (API), and, if available, connect to their regional health information exchange (HIE)
- ✓ Attest via questions in the Practice Application to a limited set of **advanced primary care delivery** capabilities, including 24/7 access to a practitioner or nurse call line, and empanelment of patients to a primary care practitioner or care team

***Note:** Practices participating only in the SIP option are not subject to these specific requirements.

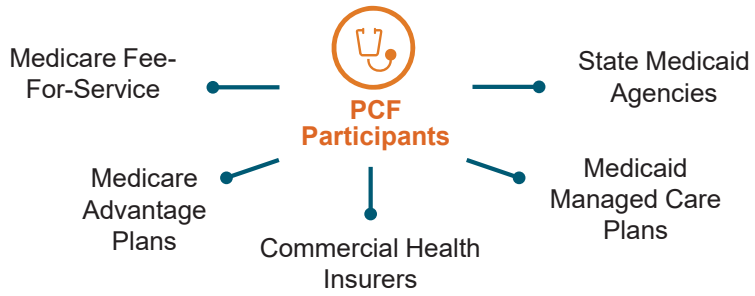
Practices Participating in the High Need Population Model Option Must Meet the Following Eligibility Requirements

Practices receiving **SIP-identified patients** (identified based on risk score) must:

- ✓ Include **practitioners serving seriously ill populations** (MD, DO, CNS, NP, PA) in good standing with CMS
- ✓ Meet **basic competencies to successfully manage complex patients** and demonstrate relevant clinical capabilities (e.g., interdisciplinary teams, comprehensive care, person-centered care, family and caregiver engagement, 24/7 access to a practitioner or nurse call line)
- ✓ **Have a network of providers in the community** to meet patients' long-term care needs for those only participating in the SIP option
- ✓ Use 2015 Edition **Certified Electronic Health Record Technology** (CEHRT), support **data exchange** with other providers and health systems via Application Programming Interface (API), and, if available, connect to their regional health information exchange (HIE)

CMS is Committed to Partnering with Aligned Payers in Selected Regions

In PCF, CMS will encourage other payers to engage practices on similar outcomes. **CMS is soliciting interested payers starting in summer 2019.**



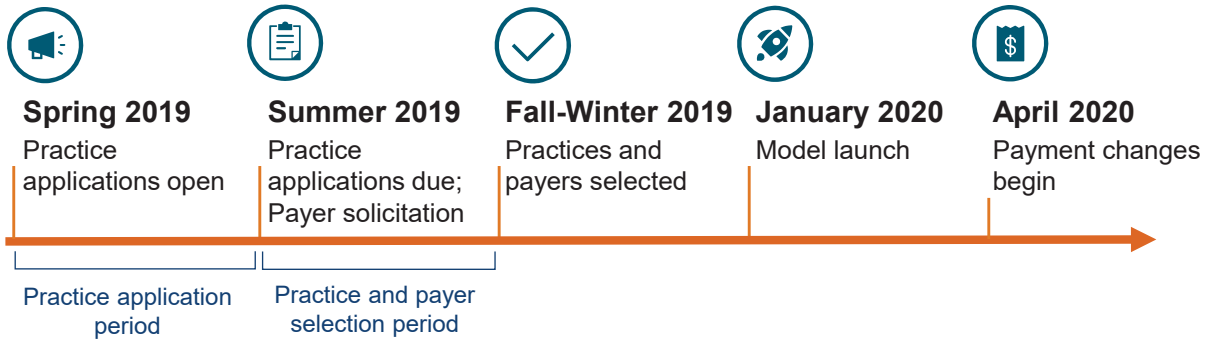
Multi-payer alignment promotes:

- An alternative to fee-for-service payments
- Performance-based incentive opportunity
- Practice- and participant-level data on cost, utilization, and quality
- Alignment on practice quality and performance measures
- Broadened support for seriously ill populations

Your Practice Can Experience Many Benefits By Participating in Primary Care First

- **Less administrative burden and more flexibility** so providers can spend more time with patients and deliver care based on patient needs
- **Ability to increase revenue** with performance-based payments that reward participants for easily understood primary care outcomes
- **Enhanced access to actionable, timely data** to inform your care transformation and assess your performance relative to peers
- **Focus on single outcome measure** that matters most to patients: acute hospital utilization
- **Opportunities** for practices that specialize in complex, chronic patients and high need, seriously ill populations
- **Potential to become a Qualifying APM Participant** by practicing in an Advanced Alternative Payment Model

Primary Care First Will Launch in Early 2020



Email us at PrimaryCareApply@telligen.com to join our listserv.

Use the Following Resources to Learn More About Primary Care First

Visit

https://innovation.cms.gov/initiatives/primary-care-first-model-options/

Call

1-833-226-7278

Email

PrimaryCareApply@telligen.com

Follow

@CMSinnovates

Look out for additional PCF events in the coming months!

Overview of Direct Contracting

May 21, 2019

PRELIMINARY – NOT FOR DISTRIBUTION

1

Payment Model Options

Professional PBP	Global PBP	Geographic PBP (proposed)
• 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	• ACO structure with Participants and Preferred Providers defined at the TIN/NPI level • 100% risk • Choice between Total Care Capitation or Primary Care Capitation	• 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

2

2

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.

3

Design Approach in Brief– Global and Professional PBP

- Build off the Next Generation Accountable Care Organization Model to offer new forms of capitated population-based payments (PBPs), enhanced payment options, and flexibilities to increase the number of tools providers have to meet beneficiaries' medical and non-medical (e.g., social determinants of health) needs.
- Expand emphasis on voluntary alignment and beneficiary choice, while retaining claims-based alignment approaches.
- Reduce burden by focusing quality reporting on select measures.
- Create a more predictable, prospective spending target by capitalizing on Medicare Advantage rate calculations for various benchmarking steps.
- Focus on dually eligible, complex chronic and seriously ill patients.
- Create participation opportunities for organizations new to Medicare FFS, and for Medicaid Managed Care Organizations interested in taking accountability for Medicare cost and quality where already accountable for Medicaid spending.

4

New Opportunities for Alignment

Enhanced Voluntary Alignment

- Empowers beneficiary choice and promotes competition among providers.
- Permits more robust outreach and communication for DCEs to promote voluntary alignment to beneficiaries. This outreach is limited to a DCE's service area.
- Beneficiary must designate a DC Participant as a primary clinician for purposes of enhanced voluntary alignment.
- Will test an alternative approach for beneficiaries *newly aligned* (not aligned to the DCE through claims-based alignment) as part of enhanced voluntary alignment.

MCO Enrollment-based Alignment

- Provides new alignment opportunities for Medicaid Managed Care Organizations (MCOs) to serve as, or affiliate with, a DCE to manage Medicare expenditures for full benefit dual-eligible beneficiaries that receive their Medicaid benefits through MCOs.
- Opportunity to better integrate care between Medicare FFS and Medicaid MCOs. Minimizes incentives to cost shift between Medicare and Medicaid programs.
- Aligns dual-eligible beneficiaries to DCE on the basis of enrollment in the affiliated Medicaid MCO. However, alignment to a DCE through enhanced voluntary alignment or claims-based alignment will take priority.
- CMS anticipates that DCEs under this option would draw from experience managing integrated Medicare and Medicaid services and spending via affiliated MCOs.

5

Prospective Alignment Options

Prospective Alignment

- Alignment is established prior to the start of the Performance Year
- Beneficiaries are aligned to DC Participants through two alignment mechanisms:
  - Claims-based alignment using qualifying Evaluation & Management (E&M) services
  - Enhanced Voluntary Alignment
- Partial year beneficiary experience (a beneficiary that loses alignment eligibility during the Performance Year – e.g., by enrolling in MA – will contribute fewer than 12 months of experience and will not be retroactively excluded).

Prospective Alignment "Plus"

- In addition to the features above, provides additional opportunities for enhanced voluntary alignment.
- Beneficiaries that align to a DCE through enhanced voluntary alignment will be added on a quarterly basis throughout the performance year.

6

Considerations for High Need Populations

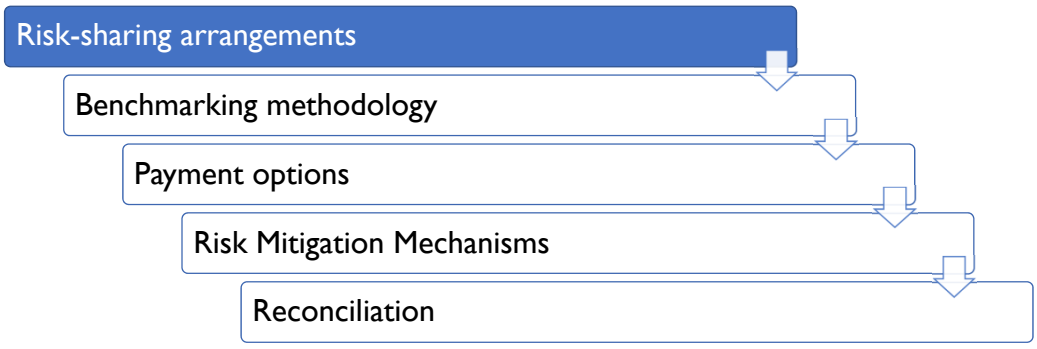
- Complex chronic and seriously ill patients and DCEs focused on those populations.
- Dually eligible for Medicare and Medicaid with complex needs:
  - PACE-like populations and PACE-like clinical approach with focus on interdisciplinary team.
  - Allowance with minimum alignment thresholds.
  - Experience in providing range of Medicaid-covered services and Medicaid coordination.
- Dually eligible enrolled in Medicaid managed care and FFS Medicare.
  - Direct Contracting Entities convened by or affiliated with Medicaid Managed Care Organizations, draw on dually eligible population experience and take accountability for Medicare costs and quality in addition to Medicaid spending under existing arrangements.

7

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

7

Payment Methodology Components



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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Risk-Sharing Arrangement

Depending on the payment option chosen, DCEs will be at risk for either a portion or all of the total cost of care for Parts A and B services for aligned beneficiaries.

Option	Risk Arrangement
Professional PBP	50% Savings/Losses
Global PBP	100% Savings/Losses
Geographic PBP (proposed)	100% Savings/Losses

The aggregate amount of shared savings or losses that DCEs will be eligible to receive, if their actual performance year expenditures are lower or higher than their total cost of care benchmark, will be determined through payment reconciliation.

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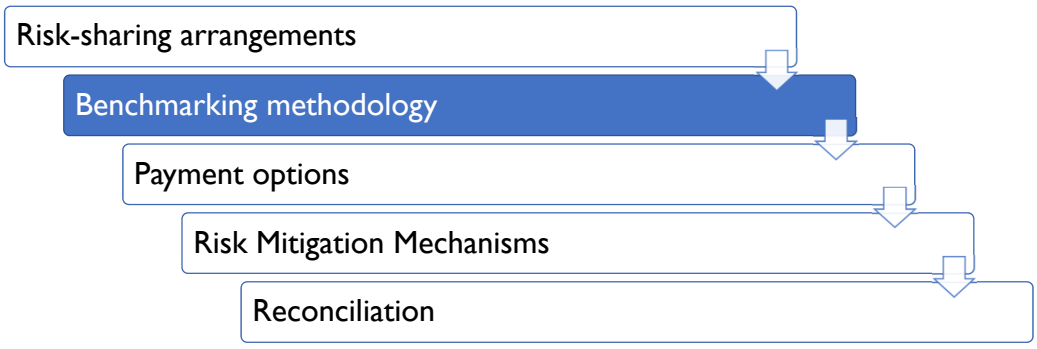
Payment Methodology Components



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Benchmarking Methodology

Professional PBP and Global PBP	Geographic PBP (proposed)
• A blend of historical spending and adjusted MA regional expenditures are used to develop the benchmark (segmented by Aged & Disabled and ESRD) • Benchmarks will be adjusted to reflect factors, such as, the risk of the population • Payments will be subject to quality performance • We are considering innovative approaches to risk adjustment for complex and chronically ill populations.	• Would be based on a one-year historical per capita Parts A/B FFS spend in the target region trended forward (no historical/regional blend) with negotiated discounts • Final methodology would be informed by the Request for Information (RFI) responses

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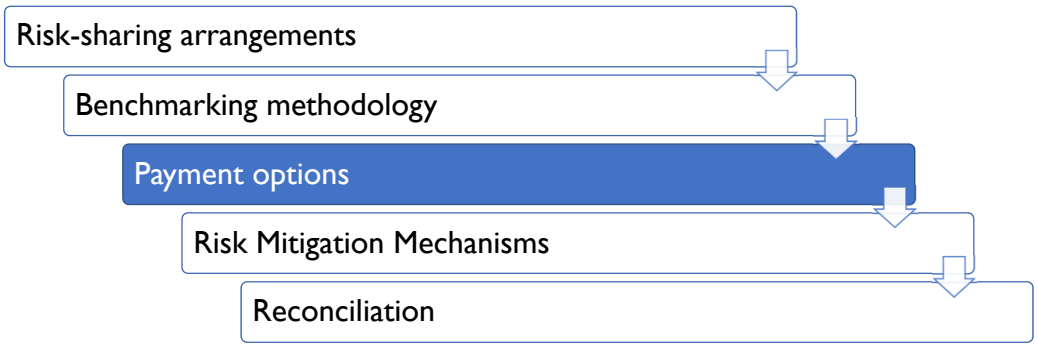
Payment Methodology Components



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Payment Model Options

- DCEs in the Professional and Global options must participate in a capitation arrangement:
  - Total Care Capitation: Monthly capitation payments for all services furnished by Participants and optionally Preferred Providers.
  - Primary Care Capitation: Monthly capitation payments for enhanced primary care services furnished by Participants and optionally Preferred Providers.
- All Participants and Preferred Providers must continue to submit claims to CMS. We are exploring ways to simplify administrative claims submission for primary care services included under a capitated arrangement.
- CMS will continue to pay claims for services made outside of the DCE (non-associated providers).
- Organizations will have added flexibility to reduce fee-for-service payments not covered under the capitation arrangements. DCE and providers must agree in writing to the percentage reduction.
- CMS will provide benchmark reports on a regular basis to enable DCEs to maintain a notional accounting system similar to private sector arrangements.

13

13

Payment Model Options

		What payment options are available?		
		Full Financial Risk with FFS claims processing	Primary Care Capitation	Total Care Capitation
Payment Model Options	Professional PBP		X	
	Global PBP		X	X
	Geographic PBP (proposed)	X		X

** All Direct Contracting Entities will be able to supplement these choices with a "claims reduction with advanced payment option"*

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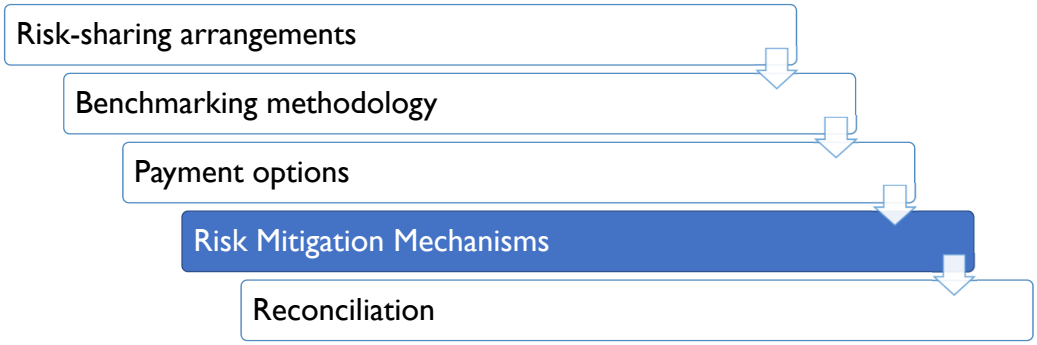
Payment Methodology Components



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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Risk Mitigation Mechanisms

Two financial protections will be offered to Global PBP and Professional PBP DCEs:

Risk corridors

- Aggregate amount of shared savings or losses that DCEs will be eligible to receive, if their actual performance year expenditures are lower or higher than the benchmark,
- Calculated as an aggregate expenditure amount, relative to the total cost of care benchmark.

Stop loss

- Intended to reduce financial uncertainty associated with infrequent, but high-cost, expenditures for aligned DCE beneficiaries.
- Calculated at the level of the individual beneficiary.

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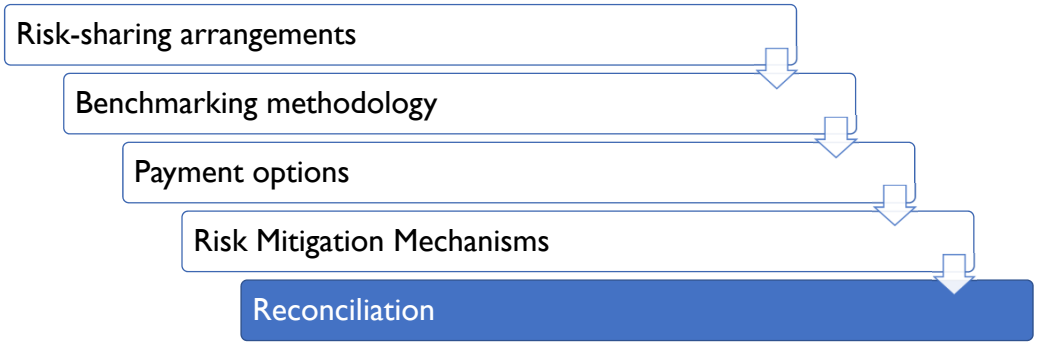
Payment Methodology Components



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Reconciliation

- In an effort to provide more timely distribution of shared savings/losses, CMS will provide the option for DCEs to select a provisional reconciliation option (selected at the start of the Performance Year).
- Under this provisional reconciliation, CMS will distribute interim shared losses/savings, with a final reconciliation taking place once full data are available.

Provisional Reconciliation (optional)

Immediately following the performance year, reflecting cost experience through first six months (with seasonality and claims run-out adjustments)

Final Reconciliation

Following full claims run out and data availability, reflecting complete performance year

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Quality Performance

Quality strategy reduces clinician burden…

Professional PBP and Global PBP

- DCEs report a focused, core set of measures (Measures are MIPS comparable and include at least one outcome measure)
- DCEs' quality performance impact discounted benchmark amounts in Global PBP and final shared savings or losses in Professional PBP

…and focuses on relevant, actionable measures.

Direct Contracting is expected to be an Advanced APM in 2021.

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Benefit Enhancements and Payment Rule Waivers

- DC is considering the same benefit enhancements and payment rule waivers offered in NGACO, such as
  - 3-Day SNF Rule Waiver;
  - Telehealth Expansion Waiver;
  - Post-Discharge Home Visits Rule Waiver; and
  - Care Management Home Visits Rule Waiver.
- DC also intends to build upon those offerings and explore additional enhancements and payment rule waivers such as:
  - Allowing Nurse Practitioners to certify that a patient is eligible for home health services; and
  - Allowing the provision of home health services to beneficiaries who are not "homebound."
- ***These benefit enhancements and payment rule waivers are still in development and not finalized. The DC Team will release more information, as it becomes available.***

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Timeline and Next Steps

Activity	Professional PBP & Global PBP	Geographic PBP (anticipated)
Post Letter of Intent (LOI)	Spring 2019	TBD
Release Geographic PBP RFI	NA	Spring 2019
Post Request for Applications (RFA)	Summer/Fall 2019	Fall 2019
DCEs selected for participation notified	Fall/Winter 2019	Winter 2019
DCEs sign Participation Agreements	Winter 2019	April 1, 2020
Performance Year 0	January 1, 2020	May 1, 2020
Performance Year 1 (Payments begin)	January 1, 2021	January 1, 2021
Performance Year 5	January 1, 2025	January 1, 2025

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How can I apply for Global PBP and Professional PBP Options?

Letter of Intent (LOI)

- CMS Innovation Center is requesting a Letter of Intent (LOI) from organizations interested in either the Global or Professional payment options. The DC LOI for the Global PBP and Professional PBP model options **is available on the DC website**.
- While submitting a LOI is required in order to apply, a LOI will not bind an interested organization to participate in the model.
- **The LOI must be received by Friday, August 2, 2019 at 11:59 pm EDT.** Failure to submit an LOI during the allowed timeframe will result in the organization being ineligible to apply during the initial application period.

Request for Applications (RFA)

- CMS will subsequently release a Request for Applications (RFA) for organizations interested in applying.
- The RFA will describe the eligibility requirements, payment methodology, available waivers, and selection criteria.
- CMS may entertain additional application rounds for future years for all model options.

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Geographic PBP Option: Request for Information (RFI)

- CMS posted an RFI to gather additional input from the public about their perspectives on design parameters for the Geographic PBP model option.
- Responses to the RFI are now being accepted and can be submitted electronically to DPC@cms.hhs.gov. Responses must be received by Thursday, May 23, 2019 11:59 pm.
- The Geographic PBP model option will have a separate application process.

Learn More

- Direct Contracting Website—Letter of Intent, Geographic PBP RFI
  https://innovation.cms.gov/initiatives/direct-contracting-model-options/
- Future Webinar Topics
  - Payment Methodology
  - Alignment and Overlap
  - Benefit Enhancements and Payment Rule Waivers
  - High Needs Populations and Medicaid MCOs
- Subscribe
  - CMS Listserv

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Findings at a Glance

Evaluation of the Comprehensive Primary Care Plus Initiative (CPC+)

First Annual Report

OVERVIEW

GOALS OF CPC+

Increase access to—and improve the quality and efficiency of—primary care, which ultimately is intended to achieve better health outcomes at lower cost

CPC+ is the largest and most ambitious primary care payment and delivery reform ever tested in the United States.

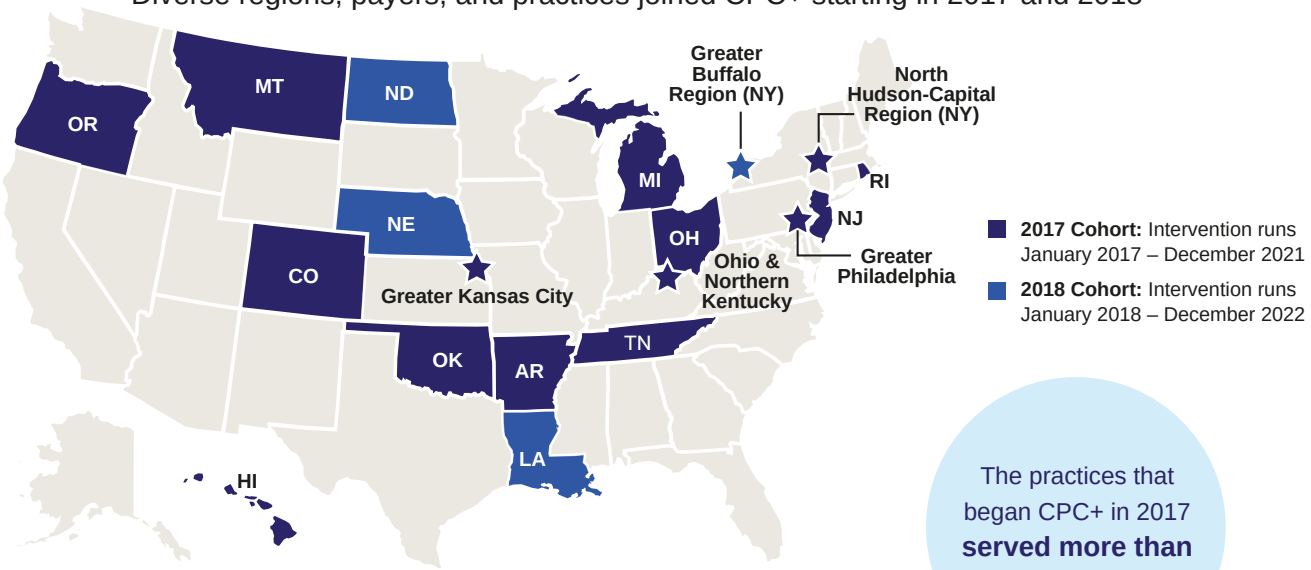
Primary care practices are transforming across five care delivery functions: (1) access and continuity, (2) care management, (3) comprehensiveness and coordination, (4) patient and caregiver engagement, and (5) planned care and population health.

CPC+ practices are split evenly into two practice tracks, with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices across the country.

To bolster support for practices, CMS partnered with 79 public and private payers across 18 CPC+ regions. CMS and other payers provide CPC+ practices with enhanced and alternative payments, data feedback, and learning activities. Health information technology (IT) vendors also partnered with CPC+ practices to help them use health IT to improve primary care.

PARTICIPANTS

Diverse regions, payers, and practices joined CPC+ starting in 2017 and 2018



The practices that began CPC+ in 2017 **served more than 15 million patients**

Payers
2017: **63**
2018: **16**
Total: **79**

Practices
2017: **2,905**
2018: **165**
Total: **3,070**

Practitioners
2017: **13,209**
2018: **1,135**
Total: **14,344**

FINDINGS

- **CPC+ provided practices with significant supports in the first year.** These include payments over and above what they already receive for providing care, data feedback, individualized and group learning supports, and health IT vendor support. Most significantly, the median practice received CPC+ care management fees of over $88,000 per Track 1 and $195,000 per Track 2 practice, on top of traditional payments.

- **CPC+ practices started changing care delivery in 2017.** Many CPC+ practices focused on risk stratifying patients, hiring and deploying care managers, and integrating behavioral health into primary care in 2017. Prior transformation experience (e.g., a Patient-Centered Medical Home model), and access to resources and supports from a larger health care organization facilitated implementation.

- **Practices thought their work was making a difference, but found aspects challenging.** Nearly all practices (93 percent) reported that CPC+ improved quality of care. However, many practices found meeting the care delivery, financial reporting, and health IT requirements to be burdensome.

- **Primary care transformation takes time to implement.** As expected, CPC+ had minimal effects on Medicare fee-for-service (FFS) beneficiaries served by practices that began CPC+ in 2017. There were few, very small differences in service use and quality-of-care outcomes or total Medicare expenditures without enhanced CPC+ payments. When including enhanced payments CMS made to practices for participating in CPC+, expenditures for Medicare FFS beneficiaries were 2 to 3 percent higher for CPC+ practices than for comparison practices.

TAKEAWAYS

In the first year, CPC+ provided primary care practices with substantial supports and the practices began the hard work of transforming care delivery. However, as expected, there were few effects on cost, service use, and quality for Medicare FFS beneficiaries in the first year. Effects on patient outcomes may emerge with more time as CPC+ practices deepen and expand care delivery changes.

This document summarizes the evaluation report prepared by an independent contractor. To learn more about CPC+ and to download the full evaluation report, visit: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/.

Statement from The Patient-Centered Primary Care Collaborative
Washington, DC, May 17, 2019

The Patient-Centered Primary Care Collaborative (PCPCC) applauds Colorado Governor Jared Polis and Vermont Governor Phil Scott for signing into law legislation in their respective states that will enhance primary care services and payment.

The separate bills approved by each state's legislature have a similar goal: strengthening primary care access and capability in ways that will benefit all patients. Both bills align with PCPCC's advocacy efforts to increase primary care investment in order to realize the kind of care envisioned by the Shared Principles, care that improves population health and helps to curbs costs.

Colorado and Vermont are part of a growing movement among states—Oregon, Delaware, and Rhode Island have already enacted changes – and proposals are being considered in several other states to drive more resources into primary care services.

"PCPCC is excited to see Colorado and Vermont join the ranks of states that have made primary care investment a top priority, and we look forward to working with other state leaders on similar initiatives," said Ann Greiner, PCPCC President and CEO. "The bills that Govs. Polis and Scott have signed into law will transform their healthcare systems in ways that will better provide high-value, relationship-based care that keeps people healthy instead of waiting until they get sick. We are committed to begin and continue work with more states on these vital issues and applaud the leadership shown by Colorado and Vermont."

In Colorado, HB 19-1233, *Investments in Primary Care to Reduce Health Costs* sets targets for investment in primary care and establishes a state-run primary care payment reform collaborative.

"We were pleased to see a diverse set of stakeholders come together in Colorado to support strong primary care in our state," said John Cawley, MD Colorado Academy of Family Physicians President. "The legislation that Governor Polis has signed into law demonstrates that ensuring access to affordable, quality primary care services is a bipartisan priority for all Coloradans, one that voters, clinicians, hospitals, health plans, and other interested parties agree on."

In Vermont, S.53 will analyze spending with the intent of increasing the proportion of healthcare spending allocated to primary care.

"This is a significant step that builds on Vermont's already extensive primary care infrastructure," said Susan Barrett, Executive Director of the Green Mountain Care Board. "The legislation signed into law by Governor Scott aligns with the focus of the Green Mountain Care Board to increase access to primary care and reduce health care costs for all Vermonters."

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About the Patient-Centered Primary Care Collaborative

Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is a not-for-profit, multi-stakeholder membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. Representing a broad group of public and private organizations, PCPCC's mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care and achieve the "Quadruple Aim:" better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.