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Our Presentation:

CMS's Direct Contracting and Primary Care First Models – Overview of the Innovation Center's New Alternative Payment Models

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Advisor Live Webinar: CMS's Direct Contracting and Primary Care First Models

Overview of the Innovation Center's New Alternative Payment Models

Monday, May 13, 2019: 1:00 p.m. EDT

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Faculty

Aisha PITTMAN

M.P.H.

Senior Director,
Payment and Quality Policy,
Premier, Inc.

Seth EDWARDS

M.H.A.

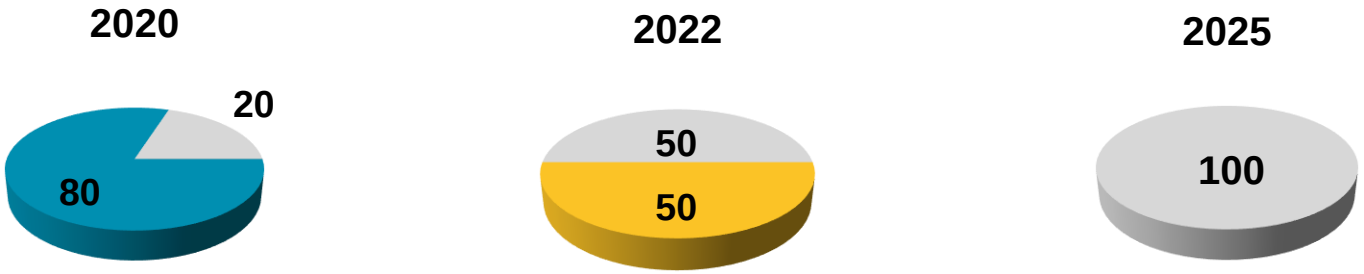
Vice President,
Population Health
Premier, Inc.

Agenda

- Value-based payment landscape
- Direct Contracting model
- Primary Care First model
- Strategic considerations

The Movement to 2-Sided Risk

CMS goal: Move Medicare payments to risk-based models



***2-Sided Risk* =** If fail to meet quality and cost savings targets, must pay back the lesser of ≤ 8% of the Medicare part A/B revenue of the entity or ≤ 3% of APM spending benchmark or target.

CMS is working on a "menu" of new models

1. Redesigned Medicare Shared Savings Program
2. Next Generation, Next Generation ACO
3. BPCI Advanced (Opportunity for MY3- Jan, application due 6/24)
4. Primary Care First (primary care capitation)
5. Direct Contracting (ACO-like partial and full capitation; regional capitation)
6. Radiation oncology, cardiac bundles (mandatory)
7. Emergency Treat, Triage and Transfer model (patients to non-hospital sites)
8. CKD/ESRD (ESCO) models
9. Rural, Stark, AKB and Others?

= Announced = Certain = Potential

Private Payers Are Shifting Risk in New Models

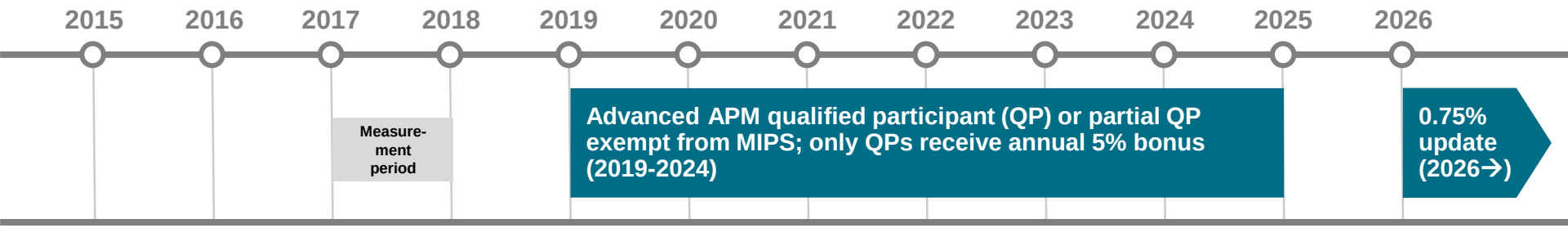
Consistent Message	Approximately 50%+ of total payment for each payer is value-based (does not include quality incentives). Each payer has unique strategies but all have aggressive goals to shift an even greater portion of their payment to value-based models

	Global strategy	Focus / goal
aetna	• 57% of payment is value-based • Committed to 75% by 2020 • 10% of MA is "full risk"	• "Meeting providers where they are" – wide range of Models • Purchased Stanson Health's pre-authorization product • CVS – primary care and chronic disease management services
Humana	• 57% of payment is value-based • Committed to improve healthcare costs and clinical outcomes by 20% by 2020	• Intently focused on driving provider performance in Medicare Advantage • Enhancing bundled payment offerings • Keen focus and investment in addressing social determinants
Cigna	• 30 active bundled models • 240 collaborative arrangements • Aggressive value proportion targets	• Merged with Express Scripts • No two-sided risk models yet but planning to introduce soon • Vast majority of business is self-funded health plans – Key area of focus is reducing specialist group spend (57% of their spend)
UnitedHealthcare	• 49% of payment is value-based • Enhancing bundled payment offerings	• Focused on partnering with providers that are of "like-mind and focus" / limited flexibility or willingness to customize • One of the largest employers of primary care providers
Anthem	• 63% of total medical spend tied to value • < 89,000 providers in shared savings or shared risk arrangements	• Focused on improving capabilities to support two-sided risk (e.g. attribution methodologies, revising pre-authorization, mandatory PCP selection policies, ensuring timely and complete data)

Advanced APMs and Qualified Participant Status

Advanced Alternative Payment Models (APM) for 2019:

- Comprehensive ESRD (2-sided risk)
- Medicare Shared Saving Program (Tracks 1+, 2, 3, Basic Level E & Enhanced)
- Next Generation ACO
- Oncology Care Model (2-sided risk)
- Comprehensive Primary Care Plus
- Comprehensive Care for Joint Replacement (Track 1)
- BPCI Advanced



Advanced APM Entities Must:

1. Use certified EHR technology,
2. Pay based on MIPS comparable quality measures, *and*
3. Bear more than "nominal" financial risk for losses.

Inclusion in Advanced APMs may trigger MIPS exclusion.

Threshold of payments in an Advanced APM to reach QP status

2019-20	*Medicare only*	25%	*Or, 20% beneficiary count*
2021-22	*Medicare* and all-payer*	50%	*Or, 35%*
2023 +	*Medicare* and all-payer*	75%	*Or, 50%*

Total payments exclude payments made by the Secretaries of Defense/Veterans Affairs and Medicaid payments in states without medical home programs or Medicaid APMs.

* All Payer Option: Minimum of 25% of Medicare payments must be in AAPM in all years for QP; 20% for Partial QP; Bonus only for QP and MIPS-exempt; No bonus for Partial QP but is MIPS-exempt unless elects to opt-in to MIPS

Total Cost of Care Models

	Medicare Shared Savings Program					Next Generation ACO	Direct Contracting		
	Level A / B	**C**	**D**	**E**	**ENHANCED**		**Professional**	**Global**	**Geographic**
Shared Savings (Max savings)	**40%**; (10% of bench mark)	**50%**; (10%)	**50%** (10%)	**50%** (10%)	**75%**, (20%)	**80%** (partial) **or 100%** (full)	**50%**	**100%**	**100%**
Shared Losses (max loss)	N/A	**30%**, (2% ACO revenue/ 1% bench mark)	**30%**, (4% / 2%)	**30%,** (8% / 4%)	**40% - 75%**; (15% of bench mark)	**80%** [partial] **or 100%** [full]	**50%**	**100%**	**100%**
Benchmark	Risk-adjusted and trended historical FFS spending. (MSR of 2.0% or 3.9% for A – B based on population size; 0.5-2% or 2.0-3.9% based on population size selected by the ACO for C – ENHANCED)					Risk-adjusted and trended historical FFS spending (0.5% baseline discount for partial, 1.25% baseline discount for full)	Risk-adjusted and trended historical FFS spending + adjusted MA regional expenditures		One-year trended FFS spending with negotiated discounts
Beneficiary alignment	Prospective OR prospective with retrospective reconciliation; + voluntary					Prospective + voluntary	Prospective*+ voluntary		TBD
Payment Options	FFS + reconciliation					1. Infrastructure 2. Population-based payment (PBP)	Primary Care Capitation (PCC) = 7% of total cost of care	1. Total Care Capitation (TCC) 2. PCC	1. Full financial risk + FFS reconciliation 2. TCC
Advanced APM status	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Model years	Permanent *Notice of Intent to Apply due June 28, 2019* *Application due July 29, 2019*					Jan. 2016 – Dec. 2020	Jan. 2021 – Dec. 2025 *LOI due Aug. 2, 2019* *Application expected Summer 2019*		Jan. 2021 – Dec. 2025 *RFI responses due May 23, 2019;* *Application Fall 2019*

* option for prospective or prospective plus

Primary Care-focused Models

	Comprehensive Primary Care Plus	PCF – General	PCF – High Need Populations
Participants	2,912 primary care practices 56 aligned payer partners	Primary care practices	Primary care practices hospice/palliative care clinicians
Payment	Track 1: FFS + care management fee, Track 2: Reduced FFS + care management fee + capitated primary care payment	Population-based payment + flat per visit fee	
Downside/ Upside	Performance-based incentive payment No downside	Downside: -10% for failure to meet acute hospitalization benchmark Upside: up to +50% based on quality (34% cohort, 16% improvement)	
Geographic eligibility	*States*: AR, CO, HI, LA, MI, MT, NE, ND, NJ, OK, OR, RI, TN *Regions*: Greater Buffalo, North Hudson-Capital (NY), Greater Kansas City, Ohio and Northern Kentucky, Greater Philadelphia	*States and Regions included in CPC+* *AND* AK, CA, DE, FL, MA, ME, NH, VA	
Model years	January 2017 – December 2022	January 2020– December 2024 January 2021 for current CPC+ practices *Application expected Summer 2019*	

Episode-based Models Based on Fee-for-service

	BPCI Advanced	CJR	OCM	ESCO
Participants	1299 hospitals and physician group practices	465 hospitals	176 oncology practices, 11 payers	36 groups of dialysis clinics, nephrologists, other providers
Episode focus	37 clinical episodes *(33 prior to Y3)*	Lower-extremity joint replacements *(MS-DRGs 469/470)*	Chemotherapy	End-stage renal disease
Episode length	Admission/outpatient procedure + 90 days afterward	IP admission + 90 days post-discharge	6 months	N/A – claims-based attribution
Geographic eligibility	Nationwide	67 metropolitan statistical areas (MSAs)	Nationwide	Nationwide
Mandatory?	No	Yes, in 34 MSAs No, in 33 MSAs	No	No
Target price discount	3%	3%	4% in upside only 2.5-2.75% in two-sided risk	3% from 2019 onward (+/-75% sharing) *(no mandatory discount for smaller ESCOs; +50% sharing)*
Model years	Oct. 2018 – Dec. 2024 *2nd cohort application due June 24, 2019*	Apr. 2016 – Dec. 2020	July 2016 – June 2021	Sept. 2015 – Dec. 2020

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Direct Contracting

Overview

- Builds upon foundation of ACOs to enhance risk
  - Incorporates risk-sharing data and benchmarking from Medicare Advantage
  - Potential for integration of benefits for dual eligibles
- CMS encouraging additional entities to engage in Medicare payment models
- Application for Professional and Global models expected Summer 2019; Professional in Fall 2019
- Performance period for all models starts on Jan. 1, 2021
  - Optional PY0 starting Jan 2020 for Professional and Global, May 2020 for Geographic
- More information expected from CMS over the next month
  - Payment and benchmarking methodology
  - Alignment and overlap
  - Benefit announcement and payment rules
  - Special needs populations and Medicaid MCOs

Three Options

	Professional	Global	Geographic
Structure	ACO, with participants and preferred providers identified by TIN/NPI		Regional risk with provider arrangements
Minimum Aligned Beneficiaries	5,000		75,000 (proposed)
Geography	National		Four regions TBD (proposed)
Participants (Direct Contracting Entities)	1. Healthcare providers under common governance structure 2. Providers and organizations in Medicare Advantage but do not currently operate in FFS 3. Medicaid Managed Care Organizations interested in managing benefits for dually-eligible beneficiaries		1. Provider networks 2. Health plans 3. Health care technology companies 4. Other entities
Key Dates	Jan. 1, 2021 (performance year [PY] 0 starts Jan. 1, 2020) *Letter of Intent due Aug. 2, 2019* *Application expected Summer 2019*		Jan. 1, 2021 (PY0 starts May 1, 2020) *CMS accepting comments on Geographic model through May 23, 2019* *Application expected Fall 2019*

Direct Contracting Entities

Direct Contracting Entities

- Umbrella organization that contracts with CMS and is responsible for performance
- Includes both Participants and Preferred Providers (optional)
- Must have at least 5,000 aligned Medicare beneficiaries

New-to-Medicare FFS Participants

- Physician managed organizations currently operating only in MA
- Medicaid MCOs for dual-eligibles
- Additional risk-bearing entities for Geographic option

Participants

- Core providers and suppliers
- Source of aligning beneficiaries to the DCE
- Responsible for reporting quality through the DCE and improving care quality

Preferred Providers

- Not used to align beneficiaries
- Can participate in downstream arrangements, certain benefit enhancements or waivers

Beneficiary Alignment

Prospective Alignment option

- Aligned through:
  - Claims-based qualifying evaluation and management services
  - Enhanced voluntary beneficiary alignment, including outreach and communication to beneficiaries to promote alignment
- Beneficiaries that lose alignment during the performance year will still have their partial year experience included

Prospective Alignment "Plus" option

- Above features plus additional opportunities for enhanced voluntary alignment
- Beneficiaries can be added to a DCE on a quarterly basis

Medicaid Managed Care Organization (MCO) Enrollment-based Alignment opportunity

- For duals, alignment based on enrollment with DCE-participant or affiliated MCO
- Alignment based on enhanced voluntary or claims-based alignment takes priority

DCEs must select beneficiary alignment option prior to start of PY

Payment Options

Primary Care Capitation	Total Care Capitation	Full Financial Risk + FFS Reconciliation
• Capitated payment (7% TCOC) for primary care services • Monthly • Available in Professional and Global	• Capitated payment for all services • Monthly • Available in Global and Geographic	• Capitated payment or FFS provider payment • Both options include reconciliation • Available in Geographic

- Participants and preferred providers must continue to submit claims to CMS
- CMS will pay claims for services outside of the DCE (non-associated providers)
- CMS will utilize risk corridors (limit gains/losses) and stop loss (limit financial losses for outlier beneficiaries)

Benchmarking

Professional and Global Models

- Blend of historical spending and adjusted MA regional expenditures
  - Segmented by Aged & Disabled and ESRD
  - Calculations from MA ratebook, established prospectively
  - Trended forward with per capita cost and growth rates
- Adjusted to reflect population risk factors
- Subject to quality performance
- CMS examining approaches for risk adjusting for complex and chronically-ill populations

Geographic Model

- Based on a one-year historical per capita Part A & B spend in target region trended forward with negotiated discounts
- Details to be informed by RFI responses

Reconciliation Process

- CMS will provide benchmark reports on regular basis – goal of providing accounting system similar to private sector arrangements

Two reconciliation options

- Final reconciliation
  - Reconciliation occurs after claims are finalized for full PY, with distribution of shared savings/losses
- Provisional and final reconciliation
  - Reconciliation occurs immediately after close of PY
  - Reflects cost experience for first six months of PY, with seasonality and claims-run out adjustments
  - CMS will distribute interim shared savings/losses
  - Final reconciliation occurs once full PY data is available

Quality Measures and Waivers

Quality Measures

Measure set TBD

- Core set will be MIPS comparable, include at least one outcome measure

Performance impacts:

1) Global: discounted benchmark amounts
2) Professional: final shared savings/losses

Waivers

Waiver set not finalized

Current NextGen waivers:

- 3-day SNF
- Telehealth expansion
- Post-discharge home visits
- Care management home visits

CMS exploring:

- Allowing NPs to certify for HHA services
- Allowing HHA services to patients that are not “homebound”

Geographic Option

Full risk for total cost of care, with two payment options

- Capitated payment + reconciliation (allows contracting and paying providers and directly for services used by aligned beneficiaries)
- FFS payment + reconciliation
  - In both options, providers not contracted with the DCE will be paid FFS by Medicare (to be reconciled against DCE benchmark)

Limited to four target regions in first year of program

- Will align with administrative (city, county) or statistical (MSA) geographic units
- One or more DCEs will be selected per region, with 2+ preferred

Minimum savings target of 3-5% off historical Part A + B per capita FFS spending in the target region

- Calculate historical expenditures for geographically aligned beneficiaries
- Trended forward to performance year
- Discount incorporated into benchmark

Questions in Geographic Model RFI

1. **Model design**
   - Addressing social determinants of health
   - Constructing comparison groups for target regions
2. **Target region selection**
   - Appropriate criteria (ex: low APM penetration, higher cost)
   - Benefits/risks to access, quality, cost for target region including rural area?
3. **DCE eligibility**
   - Should state governments be able to participate as DCE? Other entities?
4. **Alignment**
   - Random or voluntary? Stratified random?
5. **Program integrity and beneficiary protections**
   - Appropriate monitoring of access and quality of care
   - Needed regulatory flexibilities
6. **Payment**
   - Trend factor, range of discounts
   - Inclusion of Part D?
   - Cost-sharing arrangements with downstream providers
   - Accounting for utilization occurring outside of target region

Comments due to CMS by May 23, 2019

Unknowns

- Benchmarks
- Risk adjustment
- Overlap of Models
- Details of the geographic model
- Claims payment approach for capitation

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Primary Care First

Overview

- Five-year model with start date of Jan. 1, 2020
  - Q1 2020 focused on onboarding; payment changes in Q2 2020
  - Current CPC+ participants unable to participate until Jan. 2021

- Total Primary Care Payments (TPCP) = per beneficiary per month (PBPM) payment for attributed population + flat per visit fee
  - TPCP to be adjusted based on performance measures

- Two models – General and High Need Populations
  - PCF High Need Population participants need to have, or partner with a provider that has, hospice and/or palliative care capabilities
  - Practices can choose one of the two options, or both
  - Status as AAPM likely, but not confirmed

- Application expected Spring/Summer 2019
  - Model overlap policy forthcoming; likely to reflect similar standards to CPC+

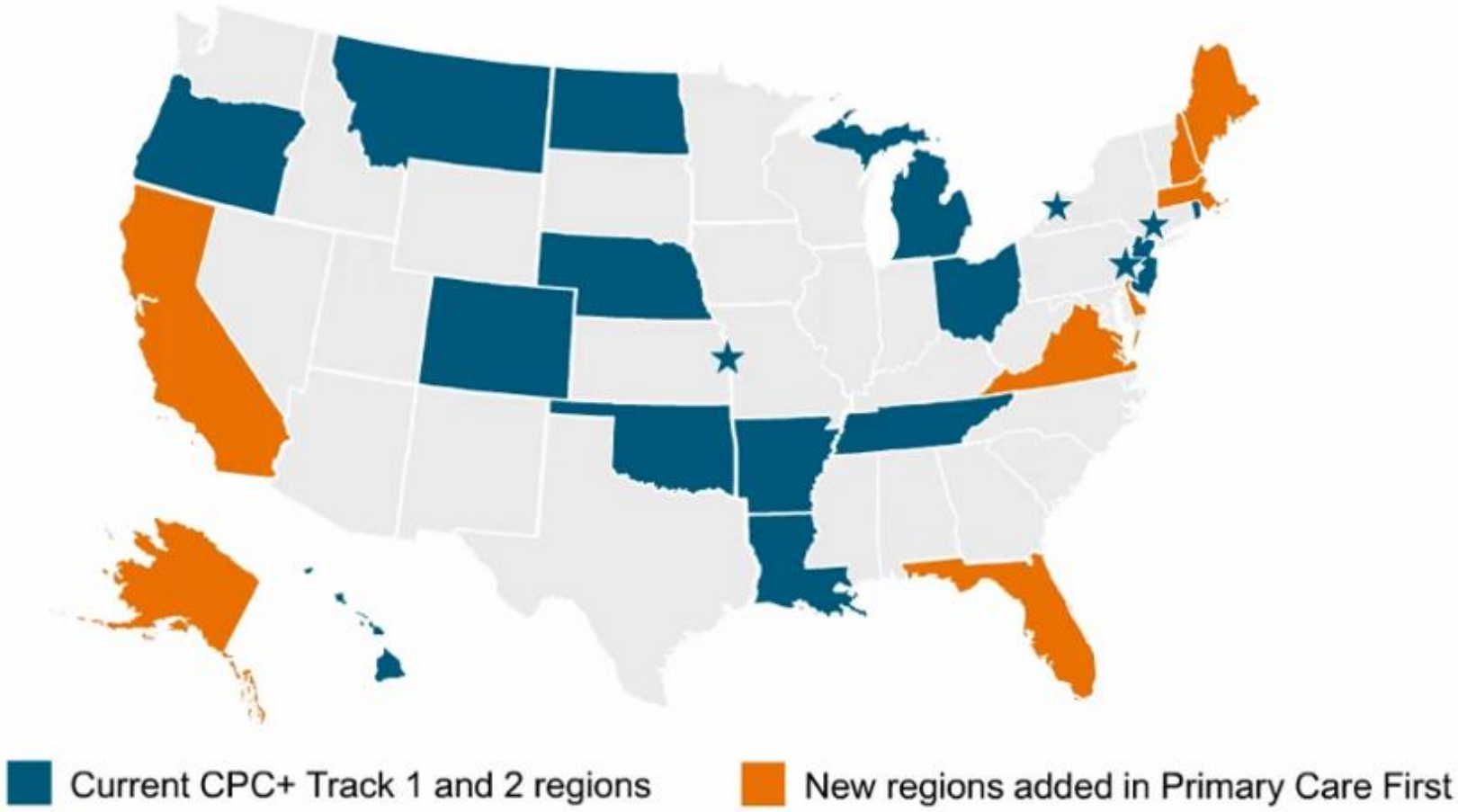
- CMS to solicit other payers to adopt similar structure/incentives starting in Summer 2019

Practice Eligibility Requirements

	PCF – General	PCF – High Need Population
Practices must include at least one of the following:	MD, DO, CNS, NP, PA in good standing with CMS	
Minimum Medicare beneficiaries	125	N/A
Revenue requirements	Primary care services must account for at least 70% of a PGP's billing (based on revenue)	N/A
Advanced capabilities	24/7 access to practitioner or nurse call line Empanelment of patients to PCP or care team	Complex patient management 1. 24/7 access to practitioner or nurse call line 2. Comprehensive care 3. Interdisciplinary teams 4. Family and caregiver engagement
Other requirements	Prior experience with value-based payment arrangements	Community provider network to meet long-term care needs (if only in HNP option)
Health IT requirements	1. Use 2015 Certified Electronic Health Record Technology 2. Support data exchange via Application Programming Interface (API) 3. Connect to regional health information exchange (HIE)	

Regions Included in PCF

In 2020: 18 regions in CPC+, plus 8 additional states

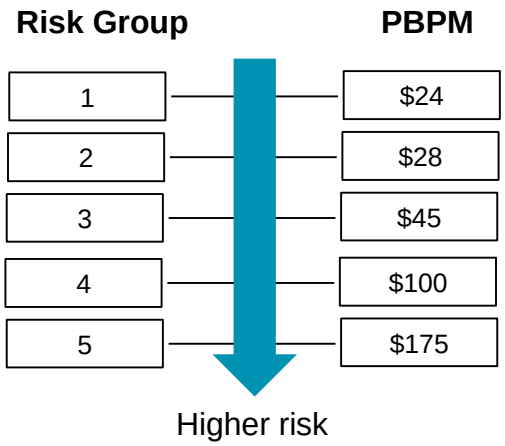


PCF Payment Basics

Total primary care payment (TPCP)

Professional population based payment

Practice risk groups based on average HCC score for services inside or outside of the office

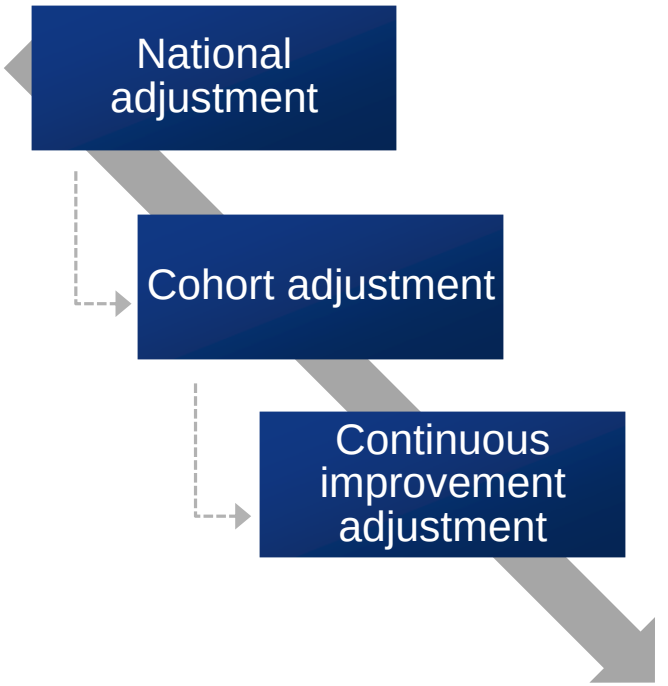


Flat primary care visit fee

Flat fee of $50, adjusted for geography

Performance-based adjustment (PBA)

Quality Gateway



PCF Performance-based Adjustment Process

Quality Gateway
Year 1: Acute Care Hospitalization
Following years: five quality measures

Gateway exceeded?

No

Penalty

-10%
adjustment to Total Primary Care Payment (TPCP) in following year
&
not eligible for performance bonus in current year

Yes

National Adjustment

-10% (not eligible for cohort, still eligible for continuous improvement) **or** **0%**

Cohort Adjustment

Up to +34%

Continuous Improvement Adjustment

Up to +26%

PCF Performance-based Adjustment Process

National adjustment

based on Acute Hospital Utilization rates

Lowest Quartile

Penalty

-10%

adjustment to TPCP

Top 3 Quartiles

Cohort Adjustment

Up to +34%

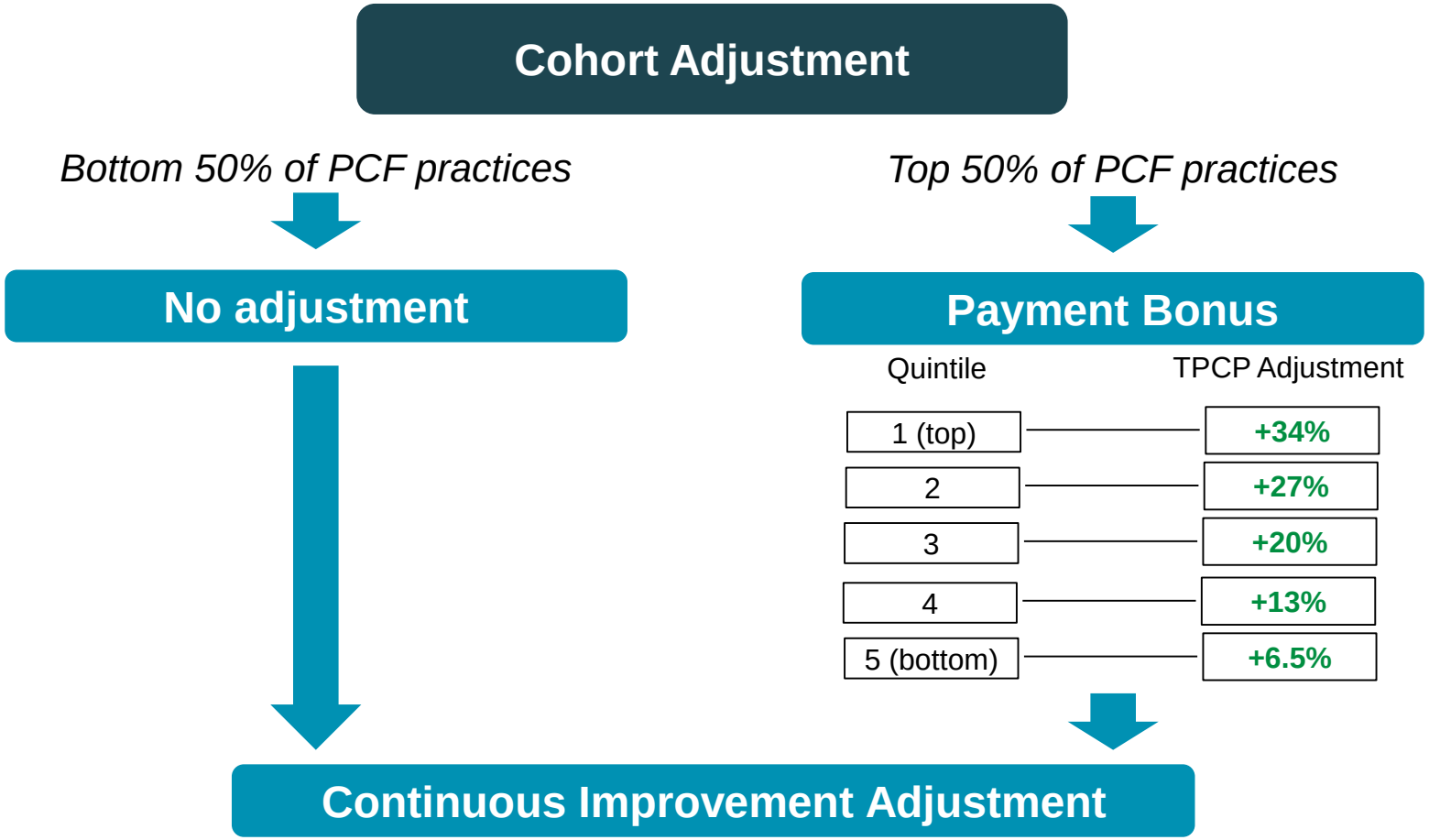
adjustment to TPCP

Continuous Improvement Adjustment

Up to +26%

adjustment to TPCP

PCF Performance Adjustments - Cohort



PCF Performance Adjustments – Continuous Improvement

Continuous Improvement Adjustment

Quintile	TPCP Adjustment
1	+16%
2	+13%
3	+10%
4	+7%
5	+3.5%
Practices above national benchmark, but below top 50% of practices	+3.5%
Practices at or below nationwide minimum benchmark	+3.5%

PCF Quality Measures

Type	Measure	Benchmark
Measure for Performance-based Adjustment Calculation (Years 1-5)	Acute Hospital Utilization (HEDIS measure)	Non-CPC+ reference population
Quality Gateway* (Years 2-5)	CPC+ Patient Experience of Care Survey (modified CAHPS)	MIPS
	Diabetes: Hemoglobin A1c Poor Control (>9%) (eCQM)	MIPS
	Controlling High Blood Pressure (eCQM)	MIPS
	Care Plan (registry measure)	MIPS
	Colorectal Cancer Screening (eCQM)	MIPS
Quality Gateway for HNP Option*	TBD, could include 24/7 patient access and days at home	

*For practices in annual TPCP classification of risk group 4 or 5, or in the HNP population, the following measures will not apply:
(1) Diabetes: Hemoglobin A1c Poor Control (>9%) (eCQM)
(2) Colorectal Cancer Screening (eCQM)

PCF High Risk Populations

- In the High Risk Populations model, CMS will be assigned seriously-ill patients (SIPs) that lack a primary care practitioner AND care coordination.
  - Participants will be responsible for reaching out to and initiating care relationships with the assigned beneficiaries
- High need population participants need to have, or partner with a provider that has, hospice and/or palliative care capabilities

Additional Payment for First 12 Months	
Type	**Additional Payment**
One-time payment for first visit with SIP patient	**$325 PBPM**
Monthly SIP payments (for up to 12 months)	**$275 PBPM**
Flat visit fee	**$50**
Quality payment	**$50**

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Strategic Considerations

Continued Move to Risk and Redefine Primary Care

Direct Contracting Model

Benefits of participation	Considerations	Awaiting more detail
Ability to receive capitation payments from CMS, either for primary care or total cost of care, and the potential ability to negotiate rates with participants for covered and non-covered services	The exposure to downside risk is greater than MSSP ENHANCED, and potential upside is not significantly higher in the professional model	Benchmarking methodology, especially related to inclusion of MA regional expenditures
Model participants are selected at the TIN-NPI level, allowing organizations to select specific, high-value providers to participate	With the model being administered by CMMI the model can be modified more quickly without a chance for comment compared to the rule making process CMS must go through	Assignment methodology including expansion of voluntary alignment and “Prospective Alignment ‘Plus’”
All level of the DC model are considered an Advanced APM	There is a short timeline for analysis, modeling and strategic planning related to the decision to participate.	Payment calculation and distribution requirements related to both the primary care and total cost of care capitation payments
Multiple benefit enhancements and payment rule waivers (SNF 3-day, telehealth, home visit)		Requirements for the Direct Contracting Entity, specifically the structure
		The timing and process related to how current MSSP participants can switch to the model

Primary Care First Model

Benefits of participation	Considerations	Awaiting more detail
Tiered monthly per beneficiary per month payment made to the practice to support population health management	The model is geographically restricted and not available nationwide	The specific services that are covered under the $50 payment per face-to-face encounter, and details on geographic adjustment to per visit fee
Asymmetric two-sided risk (+50%, -10%) on future payment rather than reconciled performance with shared savings / shared losses	Administration by CMMI means the model can be modified more quickly without a chance for comment, compared to the rule making process CMS must go through	How the model will interact with other Medicare ACO models, which model components will remain, which will be removed, impact on QPP reporting designation
Likely to be considered an Advanced APM under the Quality Payment Program	Due to the per beneficiary per month payments the inclusion of a PCF practice within an ACO could significantly impact the ACO's ability to reduce overall expenditures	
Potentially simplified primary care services billing due to $50 payment for each face-to-face patient encounter	For PCF practices in a health system's service area, recognition that practices are explicitly incentivized to reduce acute hospital utilization.	

Important Links

CMS Primary Cares Initiative:

- Presentation from CMS Primary Cares announcement
- CMS press release
- Premier press statement

Direct Contracting:

- Premier DC model summary
- CMS model fact sheet
- CMS model homepage
- CMS DC webinar slides
- CMS DC webinar recording
- CMS DC Letter of Intent form

Primary Care First:

- Premier PFC model summary
- CMS model fact sheet
- CMS model homepage

Questions

Aisha Pittman, MPH
Senior Director, Quality Policy and Analysis
202.879.8013
Aisha_Pittman@premierinc.com

Seth Edwards, MHA
Vice President, Population Health
202.879.8006
Seth_Edwards@premierinc.com