Update on CMS Primary Care and ACO Initiatives: From CPC+ to Primary Care First and Next Generation ACO to Direct Contracting

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CMS Innovation Center Statute

"The purpose of the [CMS Innovation 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 under the statute:

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

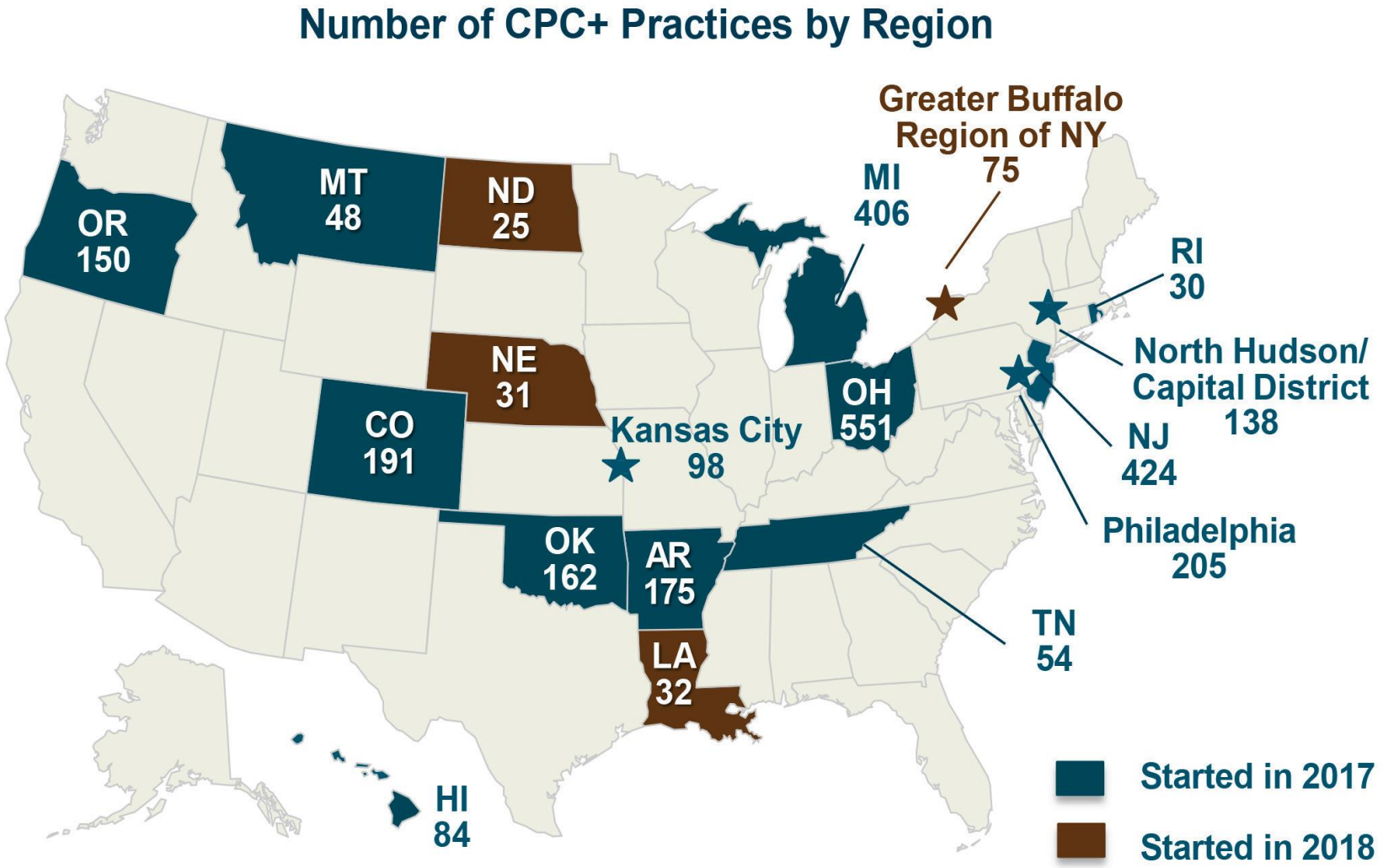
If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking.

Update on Primary and Accountable Care Models

Comprehensive Primary Care Plus

Year 1 Evaluation

- Practices focused on risk stratifying patients, hiring care managers, behavioral health integration
- Few, very small differences in service use and quality-of-care outcomes or total Medicare expenditures



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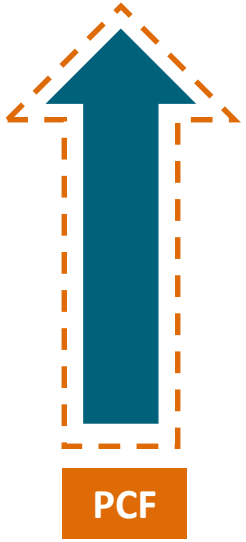
Primary Care First builds on CPC+

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**.



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

Introduction to Primary Care First

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

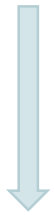
PCF Payment Model Emphasizes Flexibility and Accountability

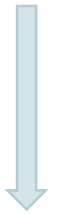
PCF Payment Model Option Goals

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





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 Needs Population Option

Seriously Ill Population

Engage **newly identified seriously ill population (SIP) patients** who lack a primary care practitioner or care coordination

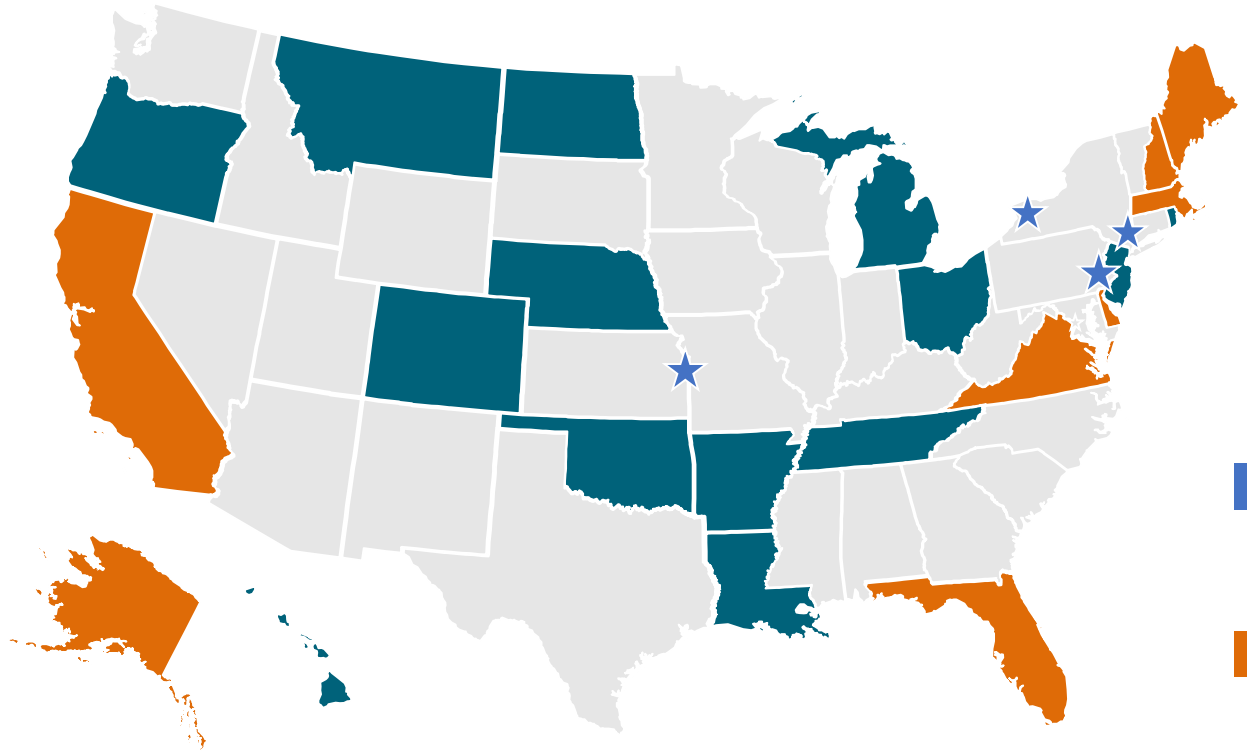
Enhanced payments to ensure that care is coordinated and SIP patients are clinically stabilized

Participation Options

Multiple pathways to participate: practices may limit participation to exclusively caring for SIP patients

Opportunity for clinicians enrolled in Medicare who typically provide **hospice or palliative care services** to participate

Where PCF will be offered in 2020



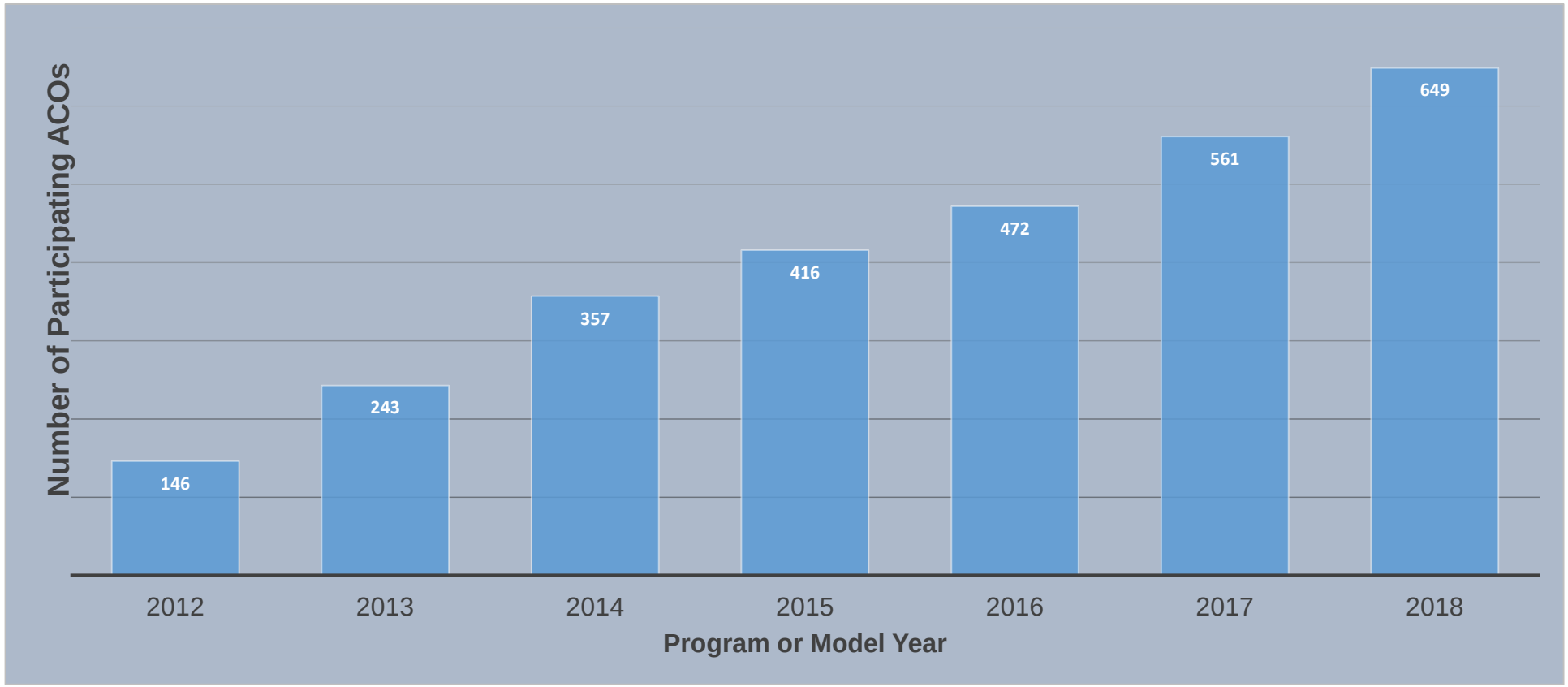
Current Track 1 and 2 regions

New regions added in Primary Care First

PCF Timeline

Activity	Timeline
Solicit practices and payers	Summer 2019
Select practices and payers	Fall/winter 2019
Launch model	January 2020
Payment changes begin	April 2020

Growth in CMS ACOs



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Comprehensive ESRD Care Model

- Performance Year 1 (2016) **actuarial** results based on 13 ESCOs
  - 13 ESCOs generated savings, 0 losses
  - Net savings to the Medicare Trust Funds were more than $23.9 million
- Performance Year 1 (2016) **evaluation** results based on 11 ESCOs
  - CEC had approximately $29 million in aggregate savings, or 2% of Medicare spending
  - Savings appear to be related to reduced hospitalizations and post-acute care

Next Generation ACO: Results to Date

Performance Year 1 (2016)

- **Actuarial** results based on 18 ACOs
  - 11 ACOs earned shared savings, while 7 ACOs incurred shared losses.
  - Net savings to the Medicare Trust Funds was more than $63 million for PY1.
- **Evaluation** results based on 18 ACOS
  - Consistent with actuarial results with $62 million in net savings or a 1.1% reduction in Medicare spending.
  - Savings appear to be related to reduced hospitalizations and post-acute care.

Performance Year 2 (2017)

- **Actuarial** results based on 44 ACOs
  - In aggregate, NGACOs' costs were approximately 1.47% below benchmark expenditures
  - Net savings to the Medicare Trust Funds were more than $164 million
  - Year 2 cohort (16 ACOs) improved from 1.18% of benchmark in 2016 to 2.25% in 2017
- **Quality** results for the Year 2 cohort
  - Average score was 94.37% and scores improved on 15 out of 27 measures
- **Evaluation** results not yet available

Direct Contracting: Model Goals

Transform risk-sharing arrangements in Medicare Fee-For-Service (FFS)

Empower beneficiaries to personally engage in their own care delivery.

Reduce provider burden to meet health care needs effectively.

Direct Contracting: Design Approach in Brief

- Build off the Next Generation Accountable Care Organization Model to offer new forms of population-based payments (PBPs), enhanced cash flow options, and flexibilities to increase providers' tools 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 purposes of the regional component to the benchmark and the trend adjustment
- 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

Direct Contracting 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 for all services provided by Participants (and optionally Preferred Providers), or Primary Care Capitation	• Would be open to entities interested in taking on regional risk and entering into arrangements with providers 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

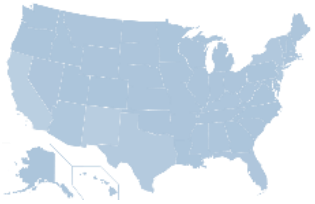
- Generally, must have at least 5,000 aligned Medicare FFS beneficiaries
- "On ramp" for organizations new to Medicare FFS
- Added flexibility for organizations serving dually eligible, chronically ill populations

Participant Providers

- 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 and/or payment rule waivers, and contribute to Direct Contracting Entity goals



Geographic PBP model option would be open to innovative organizations, including health plans, health care technology companies, in addition to providers and supplier organizations.

Benchmarking Methodology

- Professional PBP and Global PBP
  - Prospective blend of historical spending and adjusted Medicare Advantage regional expenditures used to develop benchmark (segmented by Aged & Disabled and ESRD)
  - Historical baseline expenditures trended forward by US Per Capita Cost growth, with adjustments to account for population risk and geographic price factors
  - Discount applied in Global PBP with potential for quality bonus
  - Considering innovative approaches to risk adjustment, including for complex and chronically ill populations
- Geographic PBP (proposed)
  - Would be based on a one-year historical per capita FFS spend in the target region trended forward (no historical/regional blend) with negotiated discounts
  - Final methodology would be informed by responses to the Request for Information

Quality

Quality strategy reduces clinician burden…

Professional PBP and Global PBP	Geographic PBP (proposed)
• DCEs report a focused, core set of measures • DCEs' quality performance impact discounted benchmark amounts in Global PBP and final shared savings or losses in Professional PBP	• DCEs would propose focused, core set of measures to be reported on their geographically aligned FFS population • The measures would have to be approved by the CMS Innovation Center prior to participation and be tied to payment

…and focuses on relevant, actionable measures.

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

Expanded Voluntary Alignment Approach

In addition to claims-based alignment . . .

- Greater emphasis placed on voluntary alignment, empowering beneficiary choice of providers with whom they want to have a care relationship and further promoting care coordination
- Mid-year alignment opportunities allows beneficiaries to be newly aligned during most of the performance year
- Potentially attractive to innovative providers who have similar arrangements with Medicare Advantage organizations, but have not been eligible for the Medicare Shared Shavings Program or the Next Generation Accountable Care Organization Model due to an insufficient number of alignment-eligible Medicare FFS beneficiaries
- Facilitates prospective benchmarking process

Considerations for High Need Populations

- Complex chronic and seriously ill patients
- 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 Medicare FFS
  - 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
- For Geographic PBP model option, we would assess, as part of the application process, the level of engagement and support from state Medicaid agencies to address potential for cost-shifting across Medicare and Medicaid, among other considerations

DC: 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

Learn More

- Direct Contracting website:

https://innovation.cms.gov/initiatives/direct-contracting-model-options/

- Email Direct Contracting – DPC@cms.hhs.gov

- Primary Care First website:

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

- Email Primary Care First – Primarycareapply@telligen.com

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