AMERICA'S PHYSICIAN GROUPS

Now What? Operating under Tomorrow's Value-Based Care Payment Models

June 18, 2019

Don Crane is President and CEO of APG

Valinda Rutledge is Senior Vice President of Federal Affairs for APG

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Panelists

Niyum Gandhi – Executive Vice President and Chief Population Health Officer at Mount Sinai, former Partner at Oliver Wyman

Gaurov Dayal – President of New Markets and Chief Growth Officer at Chen Med

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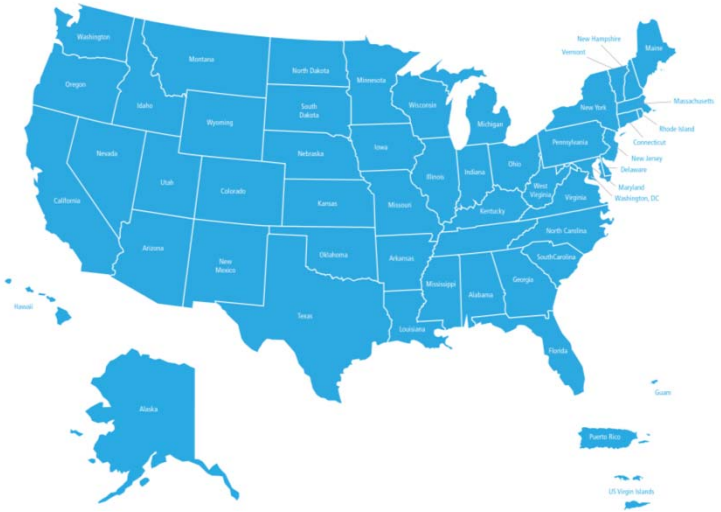
WHO WE ARE

AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

- 300+ physician organizations
- National
- Capitation is the destination
- "Taking Responsibility for America's Health"



America's Physician Groups (APG)

- Resources
  - Advocacy
    - Representation on Capitol Hill
    - Healthcare on the Hill Weekly Update
    - Federal comment letters
  - Education
    - Standards of Excellence
    - RETF (Risk Evolution Task Force)
    - Regional Meetings

Mission Statement

The mission of America's Physician Groups is to assist accountable physician groups to improve the quality and value of healthcare provided to patients. America's Physician Groups represents and supports physician groups that assume responsibility for clinically integrated, comprehensive, and coordinated healthcare on behalf of our patients. ***Simply, we are taking responsibility for America's health.***

Strategic Vision

America's Physician Groups and its member groups will continue to drive the evolution and transformation of healthcare delivery throughout the nation.

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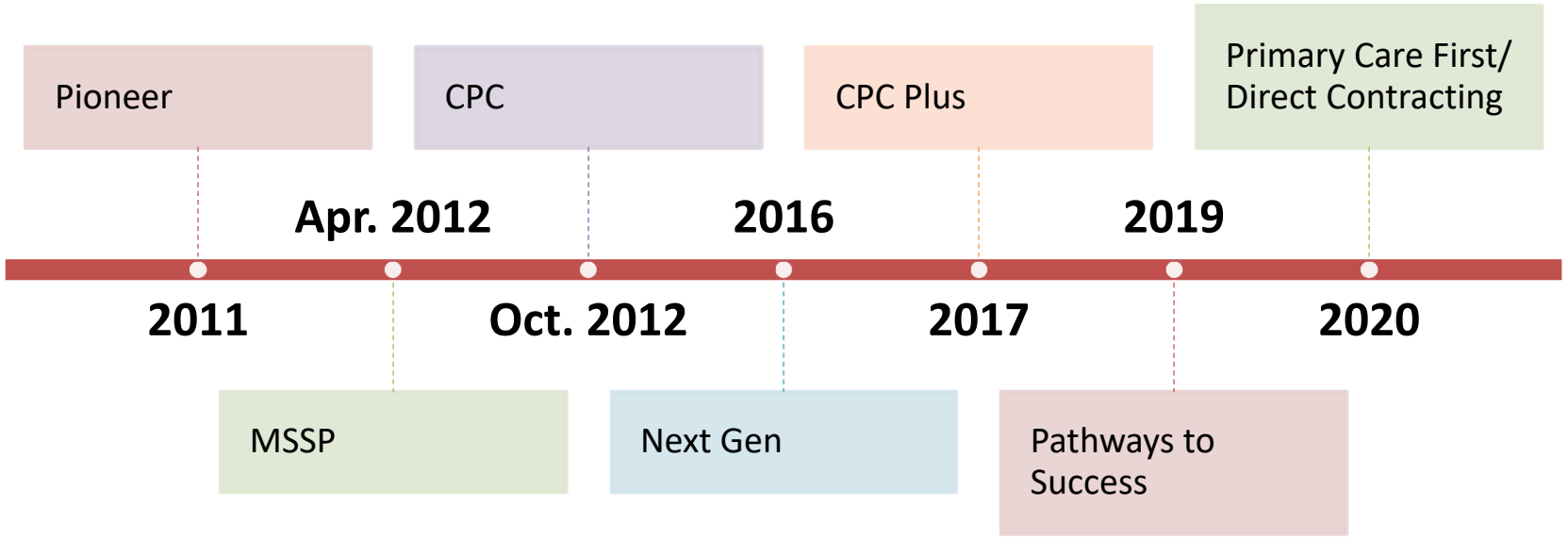
Agenda

- Introductions
- Primary Care First- Valinda
- Direct Contracting- Valinda
- Perspectives from the Field- Don Crane
- Q/A –Don Crane

APM History



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New Primary Care Centered Models

Primary Care First

Primary Care First

High Needs Population

Direct Contracting

Professional

Global (Primary Care or Total Cost of Care)

Geographic

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Primary Care First

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Overview Of Primary Care First

5 year regionally based multipayer voluntary model to begin in 2020

Builds on CPC+ Model; add predictable payments and performance bonus. Goal is to spend less time on claims processing

Three Options:

"Base" Model

Seriously Ill Populations (SIP) Focus

Both

Primary Care First Payment Model

Population Based Payment (PBP)

Intended to provide more flexibility in how primary care is provided

$24- $175

Per beneficiary per month based upon risk group of practice using average HCCs. Payment will be same for all patients in practice.

Flat Fee for Primary Care Visits

50 dollars per visit adjusted for geography (co-pay is required)

Performance-Based Adjustment

Max upside of 50% of revenue

Max downside: 10% of revenue

Based on Acute Hospital Utilization (AHU) performance to 3 benchmarks (national, cohort, and improvement)

Must surpass quality gateway (5 measures)to be eligible for upward adjustment

Assessed and paid quarterly

SIP Payment Model

Population Based Payment (PBP)

one time payment of 325 dollars then 275 PBPM

Flat Fee for Primary Care Visits

50 dollars per visit adjusted for geography (co-pay is required)

Performance-Based Adjustment

Up to 50 dollars

Eligibility Criteria of Primary Care First

MUST BE LOCATED IN ONE OF 26 APPROVED REGIONS (MAY ADD MORE FOR 2021)

MINIMUM OF 125 ATTRIBUTED BENEFICIARIES

2015 CEHRT AND OTHER DATA EXCHANGE REQUIREMENTS

PRIMARY CARE SERVICES MUST ACCOUNT FOR 70% OF PRACTICE REVENUE

ADVANCED PRIMARY CARE CAPABILITIES AND EXPERIENCE WITH VALUE BASED ARRANGEMENTS

*Current CPC+ Practices are not eligible to participate until 2021

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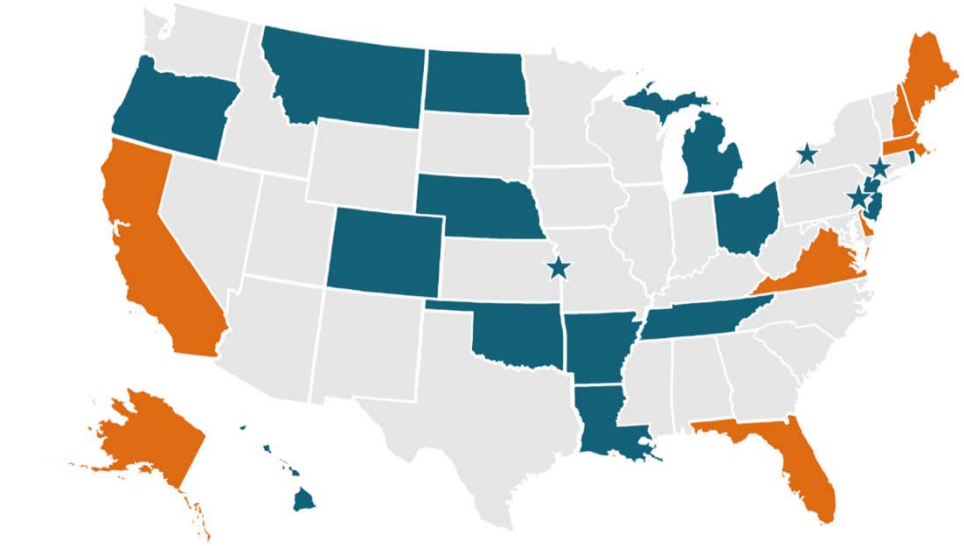
2020 Geographic Area

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



Current CPC+ Track 1 and 2 regions

New regions added in Primary Care First

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Seriously Ill Population Option

Different payment model than primary care First

Practices must demonstrate specific capabilities

Option for hospice and palliative care providers to participate directly or as partners

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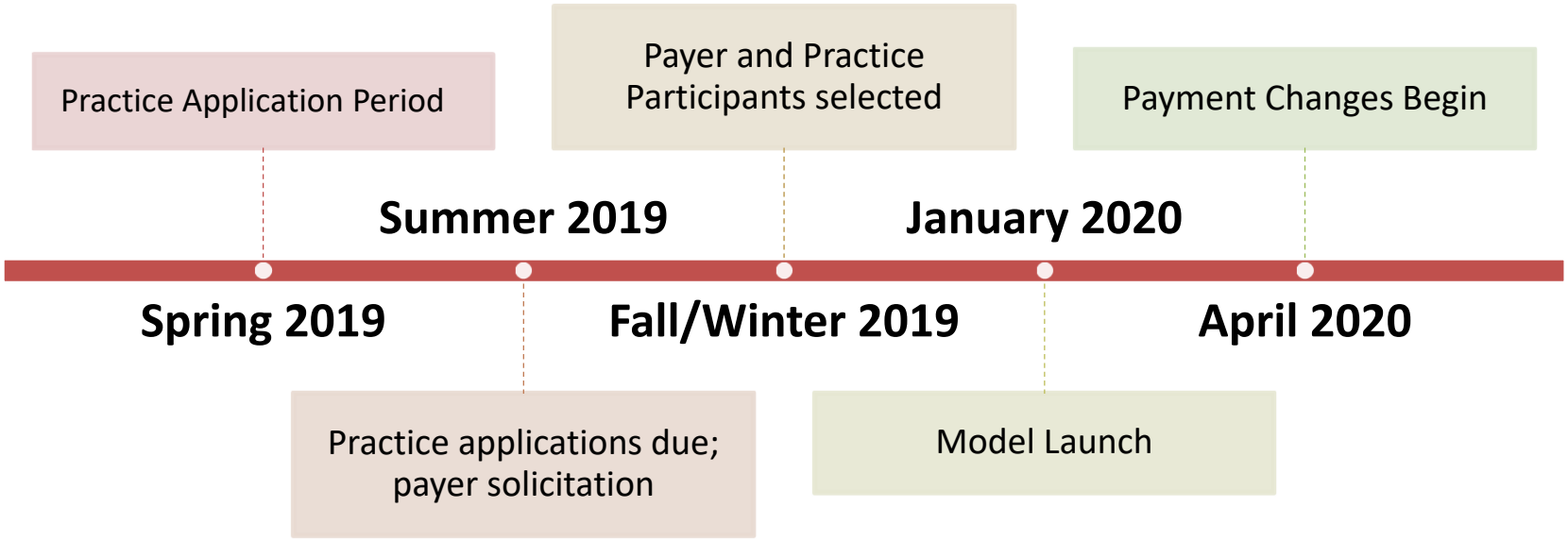
Primary Care First Timeline



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Primary Care First Open Questions

- What is methodology for determining practice risk level? Does it rebase?
- Details on Seriously Ill Population option regarding assignment ?
- Billing/Documentation Requirements?
- Attribution for Voluntary Alignment?
- What benefit enhancements and payment waivers?
- Overlap Rules with other Models including ACOs and Bundled Payments?

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Direct Contracting

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Progression to Risk

Direct Contracting Overview

DESIGNED FOR MORE ADVANCED PROVIDERS AND ORGANIZATIONS THAT HAVE NOT TYPICALLY PARTICIPATED IN OTHER MODELS

5 YEAR VOLUNTARY MODEL

SIMILAR TO MEDICARE ADVANTAGE

QUALIFY AS ADVANCED APM IN 2021

BENEFICIARIES MUST HAVE FREEDOM OF CHOICE

PROSPECTIVE BENEFICIARY ALIGNMENT (MUST HAVE AT LEAST 5,000)

HIGHER LEVEL QUALITY MEASURES

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Unique DC Characteristics

PROSPECTIVE POPULATION BASED PAYMENTS (CAPITATION)

CASH FLOW OPTIONS

ENHANCED OPPORTUNITIES FOR BENEFICIARY ENGAGEMENT – WAIVERS AND ACTIVE ENROLLMENT (WILL RETAIN CLAIMS BASED)

BENCHMARKING AND RISK ADJUSTMENT MODIFICATIONS

ON-RAMP YEAR WITH NO RISK IF NEW TO MEDICARE FFS

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Type	Risk Sharing	Cash Flow	Structure	Benchmarking
Professional	50%	7% of TCOC for "enhanced" primary care services	Participants and Preferred Providers defined at TIN/NPI	Blend of historical and adjusted MA regional. Also risk adjusted
Global	100%	Partial (Primary Care) or Total Capitation Payments	Same as Professional	Blend of historical and adjusted MA regional. Risk adjusted
Geographic (proposed)	100%	Total Cap or CMS	N/A	Historical per capita FFS

Categories of Direct Contracting Entities

PARTICIPANTS

USED FOR ALIGNMENT

ACCOUNTABLE TO REPORT QUALITY MEASURES

PREFERRED PROVIDERS

NOT USED TO ALIGN

CAN PARTICIPATE IN DOWNSTREAM ARRANGEMENTS

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Payment Methodology

Reconciliation

- Provisional (end of PY but only includes 1st 6 months)
- Final

Risk Mitigation Mechanisms

- Risk Corridors at aggregate level
- Stop Loss at individual beneficiary level

Geographic RFI

- Encourage non traditional organizations like health care technology companies
- TCOC risk for geographic area (at least 75,000). Will start with 4 regions in the nation
- Discount (3%-5%) required
- Benchmarking based on one year historical FFS per capita spend
- Need to have at least 2 participants in the region selected
- Responses accepted through May 23, 2019

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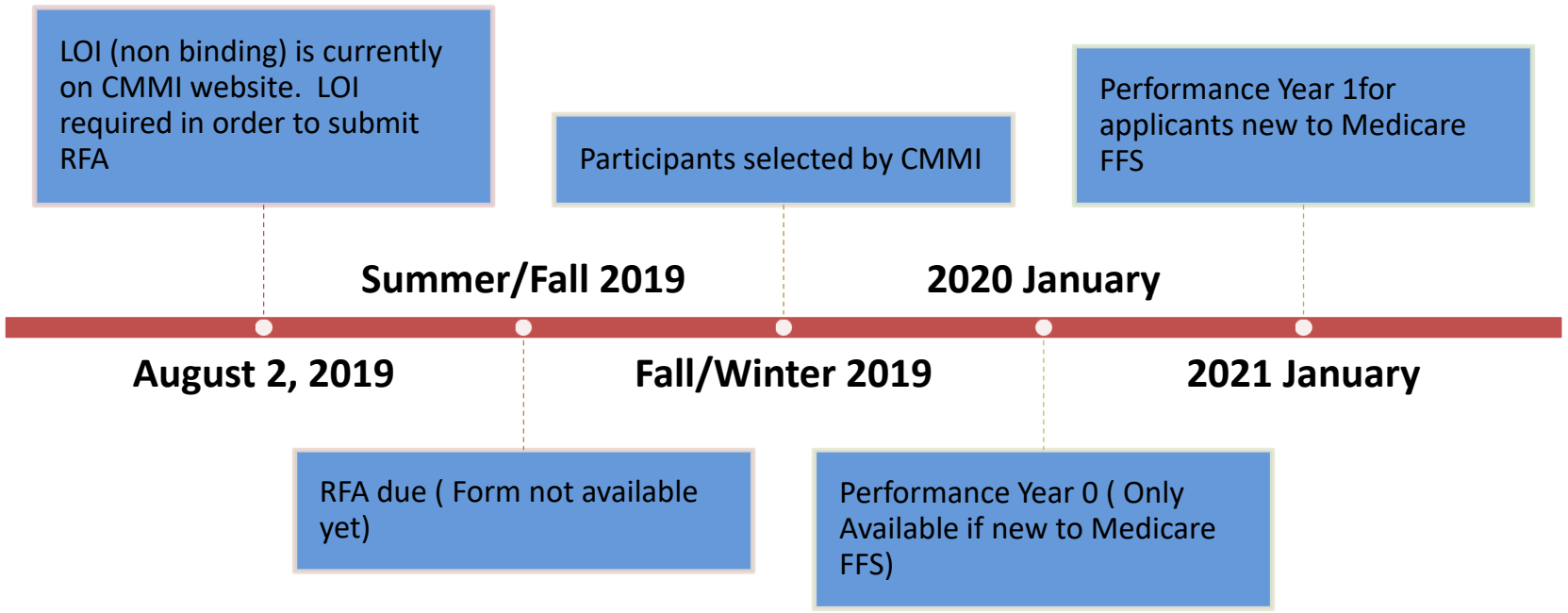
Timeline for Professional/Global



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Direct Contracting Open Questions

- What codes are included in “Enhanced Primary Care Services” ?
- What are the claims data submission requirements?
- What are the Marketing guidelines for Active Enrollment?
- What will be the attribution Logic for Claims Alignment?
- What kind of Benefit Enhancements Waivers will be available for SDOH?
- Overlap Rules with other Models (especially Mandatory models)?
- What strategies/incentives are permitted to encourage beneficiaries (who have freedom of choice) to remain in Network ?

What competencies do you need to develop with these new models?

ASSUMING GLOBAL RISK AND ABILITY TO PROCESS CLAIMS

MANAGE THE TRANSITION OF BENCHMARKING FROM HISTORICAL TO REGIONAL

EVALUATE EFFECTIVE BENEFICIARY INCENTIVES AND HOW TO IMPLEMENT SUCCESSFULLY

MANAGE COMPLEX WAIVERS BEYOND TRADITIONAL LIKE 3DAY SNF

IMPLEMENT STRATEGIES FOR BENEFICIARY ACTIVE ENROLLMENT

5 Takeaways

Complete LOI and Application by Timeline. Sign up for CMMI listservs

Assess model variables and levers for success in your practice and market

Assess New Infrastructure and Competencies Needed for the New Models

Benchmark Cost Savings Opportunities using historical and regional FFS as well as MA data

Join Learning Collaboratives – APG Risk Evolution Task Force, Learn from experienced practices!

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Questions?

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- **DC Inbox**| DPC@cms.hhs.gov
- **Primary Care First** | Primarycareapply@telligen.com

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SAVE THE DATE!
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Colloquium 2019
November 11 – 13, 2019
Grand Hyatt Washington, Washington, DC
https://www.apg.org/conferences-colloq/