Primary Cares Initiative

Overview of Direct Contracting: Global PBP and Professional PBP Options

INFORMATIONAL WEBINAR

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Agenda

- CMS Innovation Center
- Background
- Goals and Design
- Participation Opportunities
- Beneficiary Alignment
- Payment Methodology
- Quality and Benefit Enhancements
- Timeline and Next Steps

The Center for Medicare and Medicaid Innovation (CMS Innovation Center)

Introductions

- Presenters
  - Pauline Lapin, Director, Seamless Care Models Group (SCMG)
  - Jennifer Harlow, Senior Advisor, Model Lead
  - Perry Payne, Jr., Model Lead
  - Paul Trompke, Payment Lead
  - Melanie Dang, Legal Lead

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.

Background

Background

The Direct Contracting path, together with the Primary Care First payment model options and the updated Medicare Shared Savings Program ENHANCED Track, are part of the CMS strategy to use the redesign of primary care to **drive broader delivery system reform to improve health and reduce costs.**

Stakeholder Input

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

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

High Level Themes for Global and Professional PBP

- Prospective benchmarking that aligns with Medicare Advantage
- Multiple risk-sharing arrangements
- Flexible beneficiary alignment options
- Move toward capitation
- Benefit enhancements and payment rule waivers to improve care coordination and service delivery
- Options for organizations that have not participated in Medicare FFS previously
- Focus on complex chronic, seriously ill, and dually eligible beneficiaries

Goals and Design

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.

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.

Model Goals

Goal	Examples of how Direct Contracting will achieve these goals
Transform risk-sharing arrangements	• Flexible cash flows • Payment that recognizes the challenges of caring for complex chronically ill populations and dual eligible beneficiaries
Empower and engage beneficiaries	• Enhanced voluntary alignment • Various benefit enhancements and payment rule waivers
Reduce provider burden	• Small set of core quality measures • Waivers to facilitate care delivery

Participation Opportunities

Payment Model Options

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

Professional Population Based Payment (PBP)

Global PBP

Geographic PBP*

**We are seeking public input on model design elements*

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

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

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Direct Contracting Entities

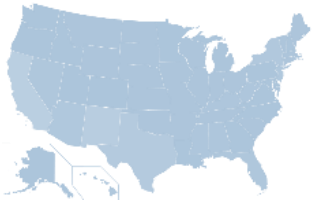
- Generally, must have at least 5,000 aligned Medicare FFS beneficiaries.
- "On ramp" for organizations new to Medicare FFS.
- Added flexibility for organizations serving dually eligible, chronically ill populations.

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.

Beneficiary Alignment
Global and Professional PBP Options

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.

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"

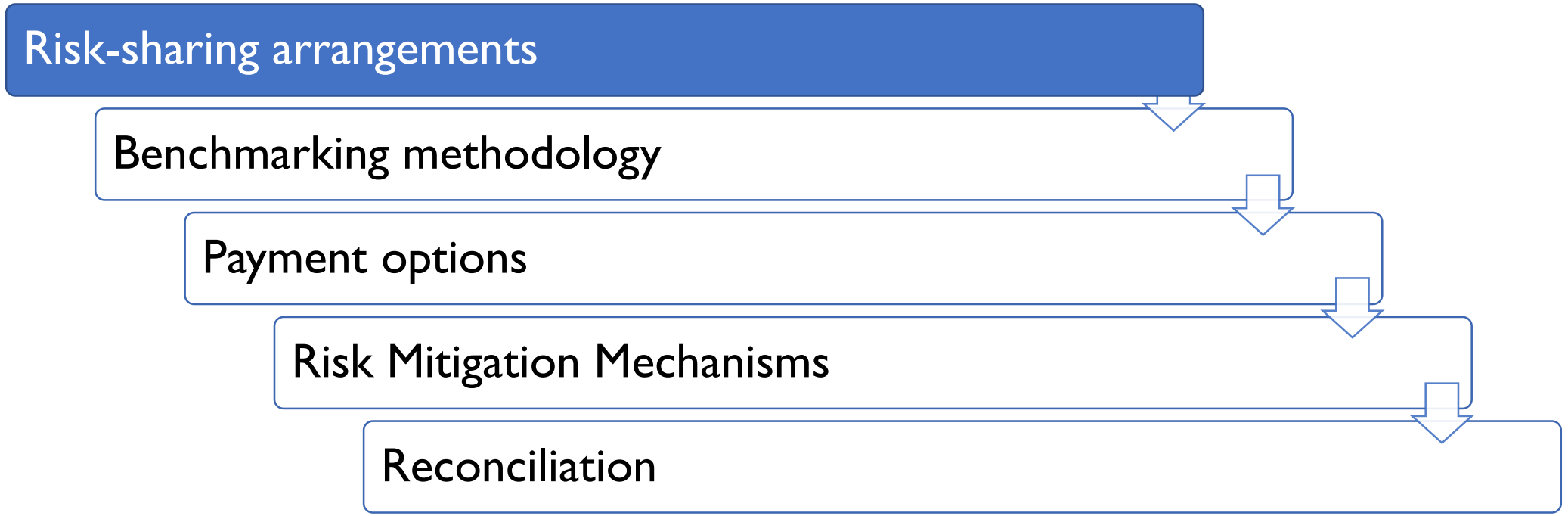
- In addition to the features above, provides additional opportunities for enhanced voluntary alignment.
- Beneficiaries that align to a DCE through enhanced voluntary alignment will be added on a quarterly basis throughout the performance year.

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.

Payment Methodology

Payment Methodology Components



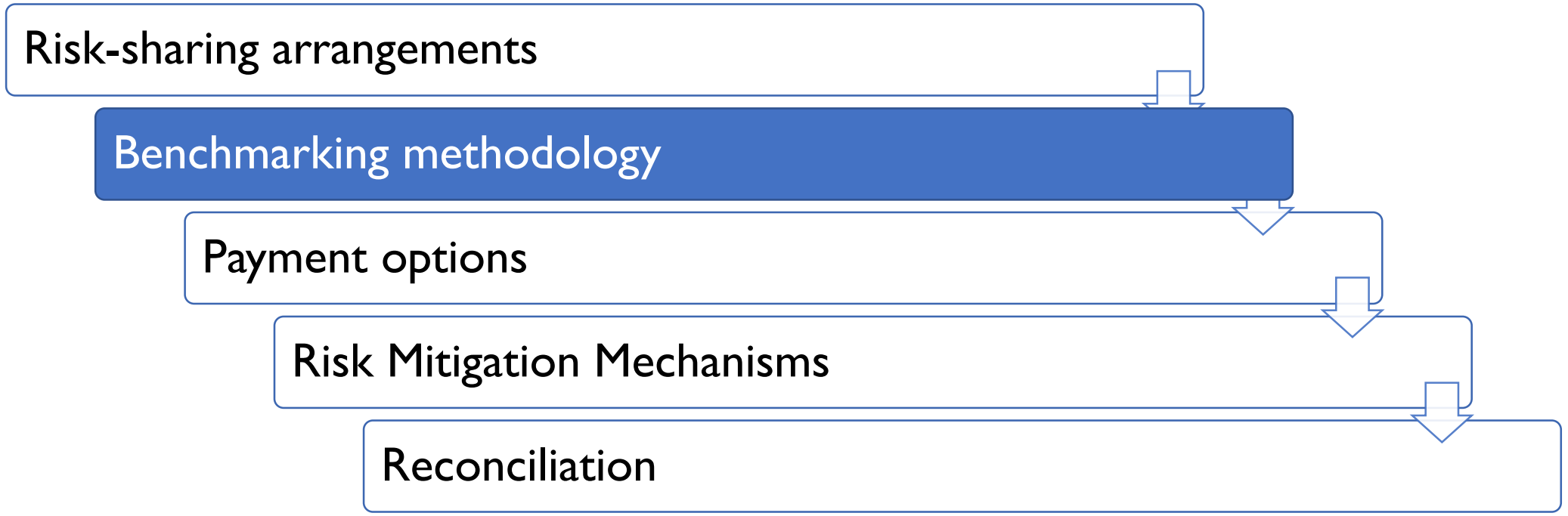
Risk-Sharing Arrangement

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.

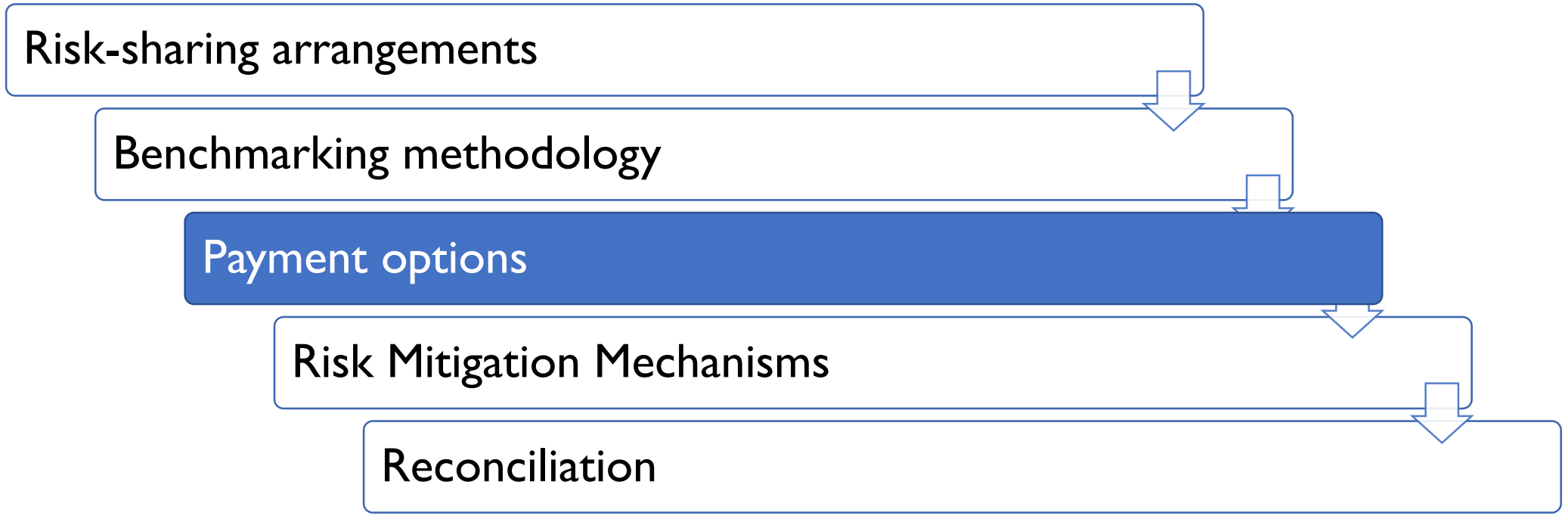
Payment Methodology Components



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

Payment Methodology Components



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.

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"*

Payment Methodology Components

Risk Mitigation Mechanisms

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

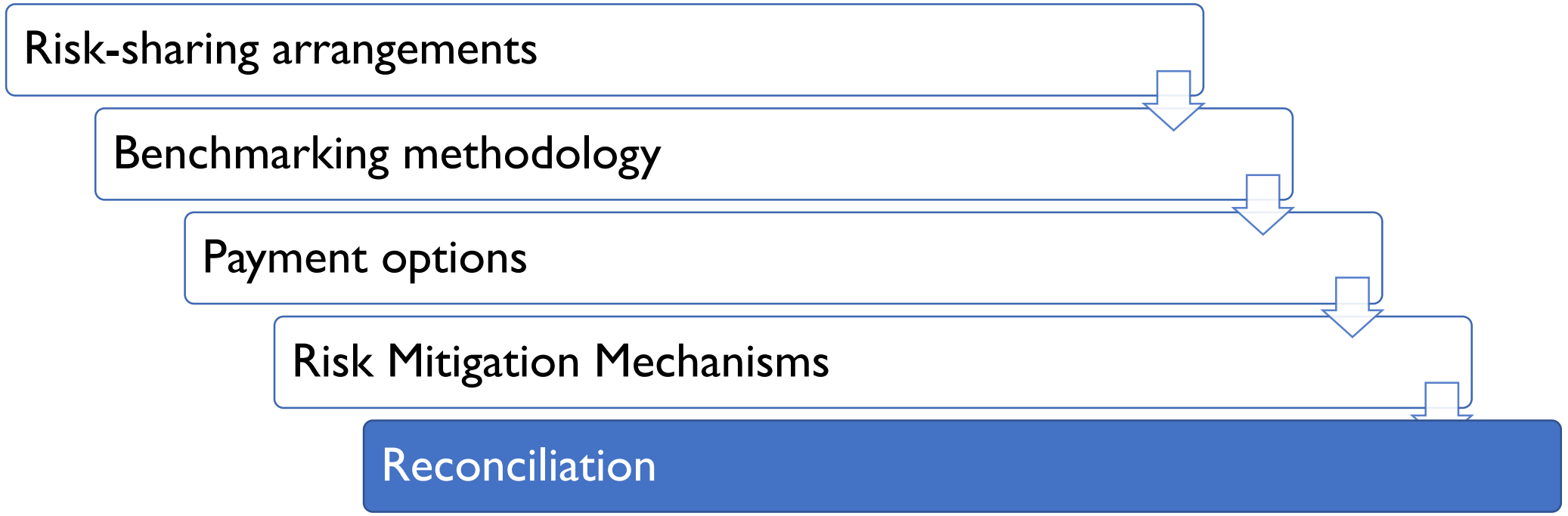
Risk corridors

- 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.

Payment Methodology Components



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

Quality and Benefit Enhancements

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.

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.***

Timeline and Next Steps

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 **will be available May 2, 2019 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.

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

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

- Letter of Intent
- Geographic PBP RFI
- Direct Contracting Website
- Questions for Direct Contracting Model
- DPC@cms.hhs.gov
- Webinar Registration (Overview of Direct Contracting)
  - Thursday, May 2, 3 p.m. EDT – Register Here
  - Tuesday, May 7, 3 p.m. EDT – Register Here

- Future Webinar Topics
  - Payment Methodology
  - Alignment and Overlap
  - Benefit Enhancements and Payment Rule Waivers
  - Special needs populations and Medicaid MCOs
- Subscribe
  - CMS Listserv

Questions?