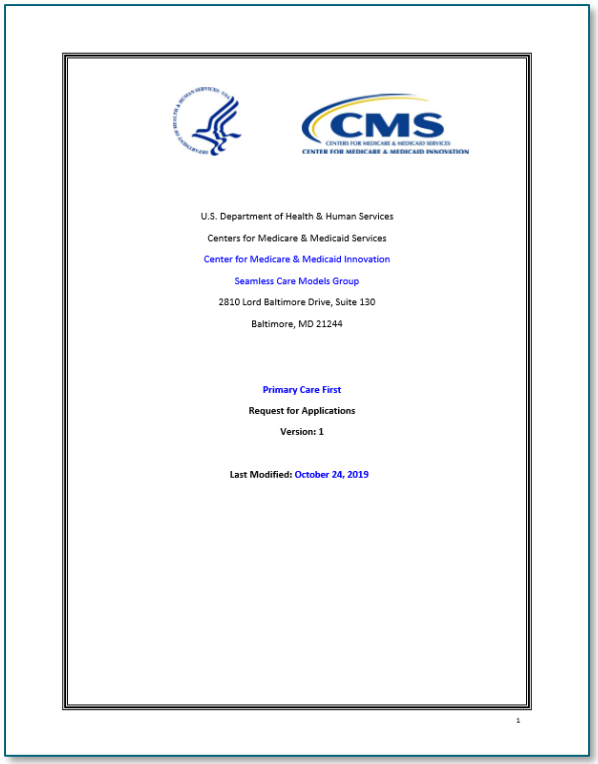
Primary Care First

Foster Independence. Reward Outcomes.

Seriously Ill Population (SIP) Part II Webinar

Center for Medicare & Medicaid Innovation

The Primary Care First Request for Applications (RFA) is Now Live!



U.S. Department of Health & Human Services

Centers for Medicare & Medicaid Services

Center for Medicare & Medicaid Innovation

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Primary Care First

Request for Applications

Version: 1

Last Modified: October 24, 2019

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Now Available: Primary Care First Request for Applications (RFA)

Access the RFA on the model website at the link below.

https://innovation.cms.gov/Files/x/pcf-rfa.pdf

This Presentation Reviews Model Details Related to the SIP Intervention of Primary Care First

- Review of Seriously Ill Population (SIP) Part I Webinar
- Beneficiary Attribution and Transition
- SIP Payment and Quality Methodology
- Sample SIP Participant Experience
- Next Steps Your Practice Can Take
- Questions

Practices Will Participate in One of Three Primary Care First Components

Option 1

PCF-General Component

Focuses on **advanced primary care practices ready to assume financial risk** in exchange for reduced administrative burden and performance-based payments.

Option 2

SIP Component

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

Option 3

Both PCF-General and SIP Components

Allows practices to **participate in both** the PCF-General and the SIP components of Primary Care First

This presentation reviews details for practices accepting Seriously Ill Population (SIP) patients, which include **SIP-only** practices (Option 2) and **hybrid** practices (Option 3)

The SIP Model Option Seeks To Address Fragmented Care Among High-Need Patients

The seriously ill population (SIP) is expected to account for roughly **2% to 3%** of Medicare beneficiaries.

The SIP component seeks to improve care for high-need patients by addressing:

Fragmented, siloed care

- Poor care coordination
- Difficulty navigating care plan
- Undesired or unnecessary treatments

Lack of care management

- Frequent visits to hospitals, skilled nursing facilities, and specialists' offices
- Frequent complications
- Increased caregiver dependency

Which may lead to…

High healthcare costs, low quality, and low patient satisfaction

The SIP Model Option Aims To Support Practices in Achieving Clinical Stabilization For High-Need Patients

Goals of SIP Model Option*

- **Offer a transitional high touch, intensive intervention** to help stabilize SIP patients, promote relief from symptoms, pain, and stress, develop a care plan, and transition them to a provider who can take responsibility for their longer-term care needs

- **Provide participating practices with additional financial resources** to proactively engage SIP patients, address their intensive care needs, and help them achieve clinical stabilization and transition

- **Transform high-need patient care into a replicable population-health initiative** that is patient-centered and supports long-term chronic care management

*Aligned with Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommendations

Eligibility Requirements for the SIP Component Differ Slightly from the PCF-General Component

Practices receiving **SIP-identified patients** must provide:

- An interdisciplinary care team that includes physician/nurse practitioner, care manager, registered nurse (RN), and social worker (optional team members include behavioral health specialist, pharmacist, community services coordinator, and chaplain)
- Comprehensive, person-centered care management ability, including ability to assess social needs of patients
- Relationships with community and medical resources and supports in the community to help address social determinants of health, medical, and behavioral health issues
- Wellness and healthcare planning as part of management of SIP patients
- Family and caregiver engagement
- 24/7 access to a member of the care team

These Q&As Cover Important Details Related to Practices' Support of SIP Patients

Q **Is there a limit to how many SIP beneficiaries CMS can align to my practice?**

A **CMS will not set a limit on the number of SIP beneficiaries** that can be aligned to your practice; however, CMS will ask **your practice to specify the target number of SIP beneficiaries you prefer to accept** and will take this number into account when attributing SIP beneficiaries.

Q **Is there a way I can continue to see my SIP patients after I transition them out of SIP?**

A Yes – a SIP practice that also participates in Primary Care First (PCF) General, i.e. a "**hybrid practice,**" can continue to care for SIP beneficiaries after transition under its PCF-General component. Patients attributed to a hybrid practice may not notice a significant difference in their care management or care team post-transition. While the hybrid option is a good choice for practices that are interested in a longitudinal model of care with an alternative payment methodology, SIP-only practices can also continue to see patients post-transition and receive traditional fee-for-service reimbursement.

Beneficiary Attribution and Transition

CMS Uses Claims Data to Identify Beneficiaries Who Meet Two General SIP Beneficiary Requirements

SIP Patient Criteria

CMS will use claims data to identify beneficiaries in designated service areas who meet **both** of the following criteria:

1. **Serious illness, defined as at least one of the following characteristics:**
   - Have significant chronic or other serious illness (defined as a Hierarchical Condition Category [HCC] risk score ≥ 3.0)
   - Have an HCC risk score greater than 2.0 and less than 3.0; AND two or more unplanned hospital admissions in the previous 12 months.
   - Show signs of frailty, as evidenced by a durable medical equipment (DME) claim submitted to Medicare by a provider or supplier for a hospital bed or transfer equipment.
2. **Fragmented pattern of care, defined as at least one of the following criteria:**
   - Proportion of evaluation and management (E&M) visits with a single practice
   - Emergency Department (ED) visits and hospital utilization patterns over the previous 12 months

Participating practices may also receive, on a limited case-by-case basis, referrals of SIP beneficiaries not identified by claims data. More information can be found in the RFA, as well as in a SIP Part 3 webinar in 2020.

CMS Follows a Series of Steps to Identify and Engage SIP Patients

Once CMS validates that beneficiaries meet claims-based SIP eligibility criteria, beneficiaries are engaged in the model through the following steps:

- Beneficiaries will be contacted to introduce the SIP component
- If the beneficiary expresses interest in receiving the additional support available through SIP, the SIP practice will then be responsible for engaging the beneficiary in a timely manner.
- Participating practices seek to make contact as soon as possible with interested SIP patients (e.g., within 24 hours) but no later than 60 days, as evidenced by a Medicare claim for a face-to-face visit.
- Patient becomes attributed to a practice after the first face-to-face visit and expression of interest from the beneficiary that he/she wishes to receive services under SIP.

Practices Are Expected to Transition Patients Out of the SIP Component

The SIP component is an intensive, time-limited intervention, and the average SIP episode is expect to last approximately 8 months. However, the actual length of time will vary by individual patient, based on their needs.

Process for SIP Beneficiary Transitions:

Initiate transition out of the SIP component as clinical stabilization and a resulting step-down in care intensity occurs

Develop a transition plan, communicate plan to the beneficiary, and obtain his or her approval

Ensure warm handoffs: Transfer records and socialize the beneficiary's care plan to the receiving practitioner (if different than the SIP practitioner)

Conduct final face-to-face SIP appointment

Notify CMS when transition occurs

After the practice notifies CMS that a beneficiary has been transitioned out of the SIP component, the **SIP payments will end** for that beneficiary.

Practices Should Consider the Below Factors When Transitioning Patients Out of SIP

The following considerations should be kept in mind when transitioning a SIP beneficiary:

The receiving practice should **demonstrate advanced competencies and clinical capabilities** for successfully managing complex patients, such as an interdisciplinary care team and 24/7 access.

For hybrid practices, CMS expects most beneficiaries to **remain with the same practice and receive care under the PCF-General component.**

For SIP-only practices, beneficiaries may be **transitioned to an external practice**. Additionally, the practice may continue to provide care for the beneficiary to be reimbursed through Medicare Fee-for-Service (FFS)**.**

SIP practices should prepare beneficiaries for transition by **facilitating a warm hand-off to receiving provider** (i.e. help schedule first appointment and arrange transportation, if needed).

SIP Payment and Quality Methodology

The SIP Payment Components and Quality Measures Aim to Support SIP Model Goals

The PCF SIP Component provides **time-limited step-up in payments** relative to both Medicare FFS and the PCF-General Component to accomplish the following goals:

- Focus on **identifying beneficiaries** with high needs that are not currently being met and **bringing care to them**
- **Support practices** to deliver the high-intensity care necessary to **stabilize the seriously ill beneficiary**
- Encourage SIP practices to facilitate **appropriate and timely beneficiary transitions**

The PCF SIP Component **quality measures** were selected to accomplish the following goals:

- Account for seriously ill patients' **specific clinical and supportive needs**
- Provide measures that are **actionable, clinically meaningful, and aligned** to CMS's broader quality measurement strategy

The SIP Payment Model Option Includes Four Payment Components

SIP Payments

One time payment for first visit	+	Monthly professional population-based payment	+	Flat visit fee	+	Quality bonus
$325 *(not geographically adjusted; inclusive of flat visit fee)*		**$275 PBPM* base rate** minus a $50 withhold *(both geographically adjusted)*		**$40.82 base rate + coinsurance** per face-to-face encounter *(begins after attribution; geographically adjusted)*		**$50 PBPM*** base rate *(geographically adjusted)*

By default, SIP practices will receive up to 12 months† of SIP payments per SIP patient, unless the beneficiary is transitioned or de-attributed sooner. Additional payments beyond 12 months may be allowed as appropriate on a per patient basis subject to CMS approval and practice eligibility.

*PBPM = per beneficiary per month
† Exceptions may apply. Please see the Request For Applications (RFA) for more details.

Practices Receive a One-Time Payment For Their Initial Visit with a SIP Patient

SIP Payments

One time payment for first visit + **Monthly professional population-based payment** + **Flat visit fee** + **Quality bonus**

$325
for initial visit with SIP patient

- This payment aims to **compensate for additional clinical work and outreach** for initial engagement of new SIP patients.
- This payment **replaces the Primary Care First flat visit fee for the first visit** to account for additional time spent with SIP patients.
- Payment is made if the **first face-to-face visit occurs within 60 days of beneficiary assignment**. Practices are encouraged to promptly engage new SIP patients.

The Monthly Professional Population-Based Payment Begins the Month After the First Visit

SIP Payments

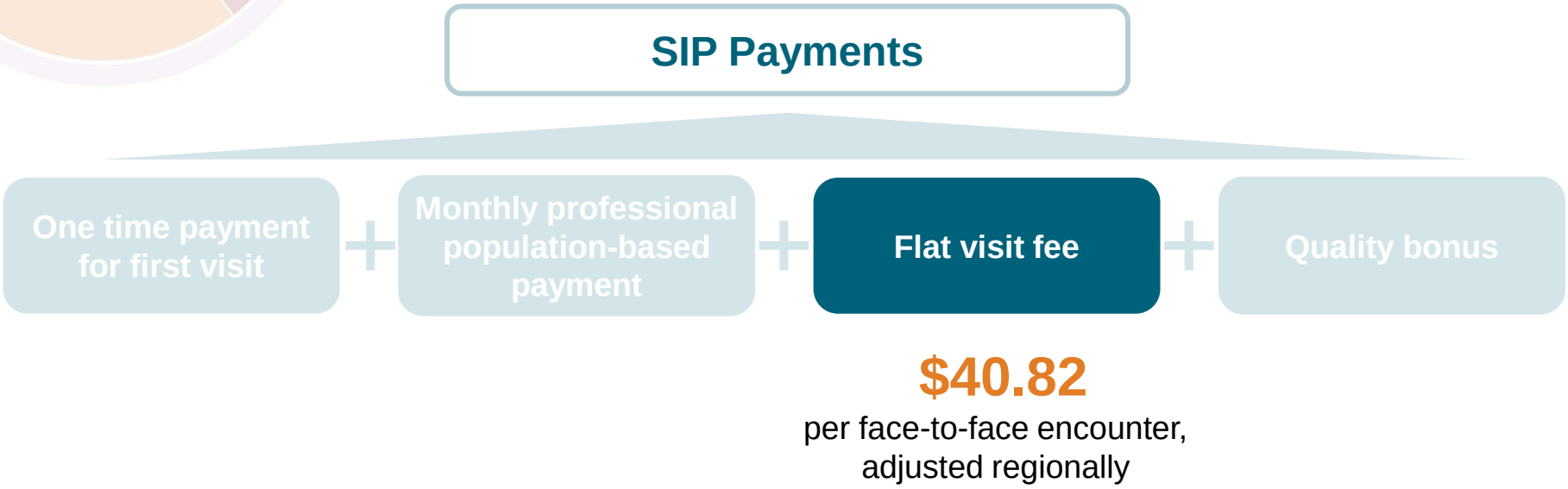
One time payment for first visit + **Monthly professional population-based payment** + Flat visit fee + Quality bonus

$275

PBPM base rate minus
a **$50 PBPM withhold**

- **Beginning the month following the first face-to-face visit**, the practice will receive $275 per beneficiary per month payment for SIP patients.
- **$50 PBPM will be withheld** until the end of the performance year, when it is determined if quality standards for length of stay and successful transitions were met.
- SIP practices will continue to receive this monthly payment as long as they see the beneficiary for a **face-to-face visit at least once every 60 days**. A 60-day lapse will result in the beneficiary's de-attribution from the practice.

Practices Receive a Flat Visit Fee for Each Face-to-Face Visit with a SIP Patient



$40.82

per face-to-face encounter, adjusted regionally

- Practices start to receive the standard flat visit fee **after the first face-to-face visit occurs** and continue for as long as they are attributed as a SIP patient.
- The flat visit fee will be **geographically adjusted, with a base rate of $40.82** for each face-to-face visit with a SIP patient.
- In addition to the $40.82 payment from CMS, practices will **receive 20% coinsurance associated with the visit level billed**. CMS intends to allow practices to reduce or waive the applicable coinsurance.

The Flat Visit Fee Applies to a Variety of Patient Care Services

Practices may bill the $40.82 flat visit fee base rate for **face-to-face and qualifying telehealth visits.** Examples of services that will be paid the flat visit fee:

- **Office/Outpatient Visit E/M***
- **Prolonged E/M***
- **Transitional Care Management Services**
- **Home and Domiciliary Care E/M***
- **Advanced Care Planning**
- **Welcome to Medicare and Annual Wellness Visits**
- **Face-to-Face Visits Related to Chronic Care Management**

This payment is designed to promote delivery of face-to-face care as clinically necessary and support practices in delivering high-intensity care to stabilize and help seriously ill beneficiaries overcome a history of fragmented care.

*E/M = evaluation and management

SIP Practices are Eligible for a Bonus Payment Based on Quality of Care Delivered

SIP Payments

One time payment for first visit + **Monthly professional population-based payment** + **Flat visit fee** + **Quality bonus**

$50
per beneficiary per month

- Participating SIP practices will be **eligible to receive an additional $50 PBPM** based on quality of care. A set of quality measures are shown on the following slide.
- Practices who meet standards for achieving high quality, as measured by average length of stay, and successful transitions **may also earn back the full amount withheld from the monthly professional population-based payment** ($50 PBPM).

The Quality Bonus is Based on Practice Performance Against a Set of Quality Measures

The following measures will determine a **practice's quality bonus:**

Measure Title	Goal	Applies in:
Patient Experience of Care Assessment, CAHPS* *(survey-based)*	Emphasizes patient experience; includes timely appointments, care & information, quality communication with providers, patient rating of provider and care	Years 2-5
Advance Care Plan *(registry measure)*	Ensures that patients' wishes regarding medical treatment be established	Years 1-5
Total Per Capita Cost, TPCC *(claims-based)*	Provides meaningful information about total Medicare Part A and Part B costs associated with delivering care	Years 1-5
24/7 Clinician Access *(survey-based)* †	Measures beneficiaries' perception of round-the-clock access	Later Years
Days at Home *(claims-based)* †	Leverages a patient-defined goal and system measure of success; measures the days a patient remains outside of an institutional care setting	Later Years

*CAHPS = Consumer Assessment of Healthcare Providers and Systems
† CMS will develop these measures

The SIP Payment Components Encourage Appropriate and Timely Beneficiary Transitions

To encourage **appropriate and timely beneficiary transitions** out of SIP, eligibility to earn back the **$50 PBPM* withhold** and to earn the additional **$50 PBPM quality bonus** will depend on:

Average SIP beneficiary attribution length

- The SIP program is designed around **an 8-month average length** of attribution across its entire SIP beneficiary population; this is calculated annually for all beneficiaries attributed and transitioned during the performance year.

Rationale: Such an average will allow practices the flexibility to appropriately transition beneficiaries in a timely manner based on beneficiary needs. This approach allows attribution for an individual beneficiary to last for more than 12 months, where appropriate and with CMS approval.

Rate of success in care transition

- A practice's transition success rate will be defined as the share of its SIP beneficiaries with **zero hospitalizations or emergency department (ED) visits** in the three months following their transition out of the SIP component.

Rationale: A hospitalization or ED visit within three months of transition may be a sign the beneficiary was not ready to be transitioned, or that the SIP practice did not adequately facilitate a relationship between the beneficiary and a practitioner who could be accountable for their long-term care management.

*PBPM = per beneficiary per month

SIP Transitions for Hybrid Practices May Involve Continuing Care Under PCF-General

For hybrid practices, which participate in both SIP and PCF-General, transition may look more like a step-down in care intensity

- Hybrid practices can continue to SIP patients post-transition through their PCF-General component, which is a more **longitudinal** care model
- Alignment between SIP and PCF-General **creates a seamless care continuum**
- Other patients that a hybrid practice might typically see can also be **aligned directly** to the PCF panel through voluntary alignment or claims-based alignment

The SIP Quality Adjustment is Calculated Using a Two-Step Process

Quality Adjustment Step 1

Average SIP beneficiary attribution length

Rate of care transition success

Average SIP beneficiary attribution length ≤ 8 months for SIP Episodes ending in program year?

No → Ineligible for withhold and bonus ($225 PBPM total SIP payment)

Yes

At or above benchmark for SIP transition success rate for program year?

No → Ineligible for withhold and bonus ($225 PBPM total SIP payment)

Yes

Quality Adjustment Step 2

Advance Care Plan Measure

Total Per Capita Cost Measure

≤ 50th percentile in the reference groups	Between 50th and 70th percentile in the reference groups for at least one measure, and not below the 50th percentile for either measure	≥ 70% in the reference groups for both measures

Total SIP Payment with Quality Adjustment (PBPM base rate)

No withhold, no bonus = $225 PBPM	**Receive withhold back, no bonus = $275 PBPM**	**Earn back withhold & receive bonus = $325 PBPM**

Sample SIP Participant Experience

The Practice Journey Begins with Applying to SIP and Ends with SIP Patient Transitions

Practice Submits SIP Payment Model Option Application: Applicant indicates in their application whether they intend to accept SIP patients. CMS approves the practice's participation in the model based on eligibility requirements.

Participation Begins: Following model launch, practice completes onboarding activities for the SIP payment model option.

CMS Identifies SIP Patients: CMS uses claims data to identify beneficiaries in designated service areas. Practice seeks to make contact as soon as possible with interested SIP patients.

Practice Engages New SIP Patients: Practice administers a face-to-face visit with patient within 60 days of identification.

Practice Administers Care: Practice provides treatment and care coordination for attributed SIP patients. Practice receives payment adjustments based on quality of care.

Patient Transitioned Out of SIP Payment Model Option: Practice transitions patient to long-term care setting or other eligible provider. Practice no longer receives SIP payment for transitioned patients.

The SIP Component is Aimed at Helping Beneficiaries Like Tom

Tom

SIP Beneficiary

Age: **87**

Diagnosis: End stage chronic obstructive pulmonary disease (COPD), Congestive Heart Failure (CHF), Osteoarthritis

Care History: Seeing multiple specialists; Had 5 emergency department (ED) visits and 2 hospitalizations in the past six months

Practice A

PCF Participant

PCF Model Option: Hybrid Practice, Risk Group 4

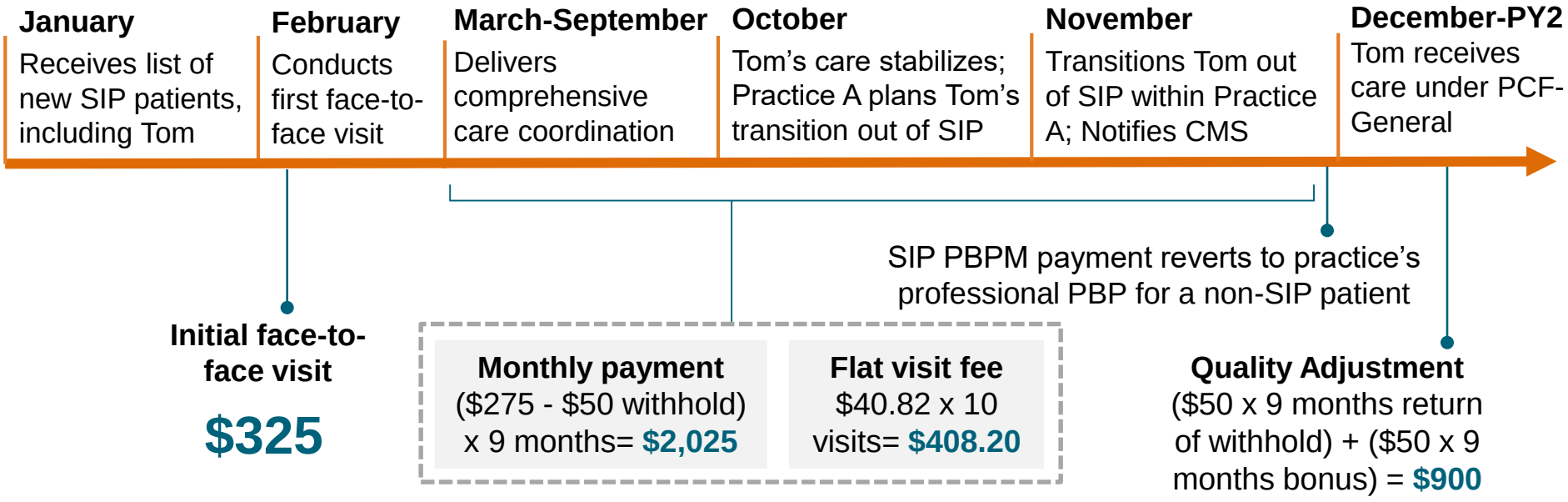
Interdisciplinary Team: Physician, Registered Nurse, Social Worker and Chaplain

During an initial visit, Practice A determines that Tom has faced **challenges in receiving timely care**, **lacks care coordination and care plan**, and has **transportation barriers and difficulty managing medications.**

Practice A Provides Care Under the SIP Component Based on Tom's Unique Needs

Practice A

- **Quality Outcomes:** At the end of PCF Performance Year 1, average SIP attribution for the practice was 7.8 months and transition success rate was 75%; Exceeded 70% on all quality measures – earns $50 bonus.
- In the example, Tom exceeds the practice average length of stay (LOS) and the practice is paid for each month that Tom is aligned to the program.



Approx. PBPM for Tom: $3658.20 /10 months **= $365.82**

Patient Outcomes and Care Experience Have Potential to Improve as a Result of SIP Model Option Participation

Tom

Age: **87**

Diagnosis: COPD, CHF and Osteoarthritis

As a result of SIP:

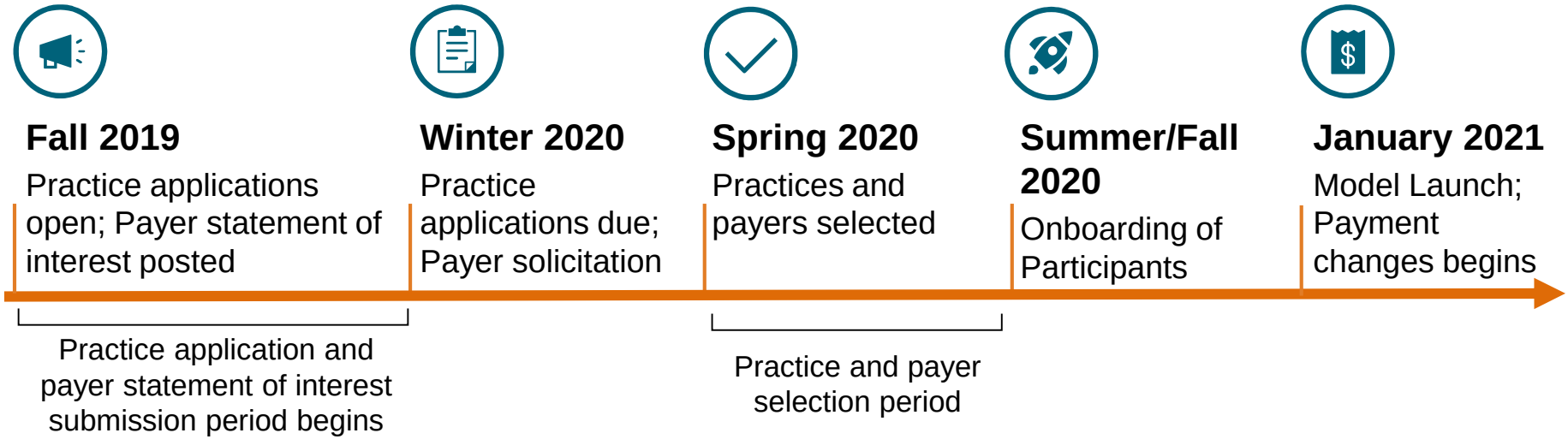
- ✓ **Tom's primary care provider is closely coordinating care** with specialists, and he receives timely appointments; Coordinated with caregivers and transportation
- ✓ Tom had 2 chronic obstructive pulmonary disease (COPD) exacerbations managed in the outpatient setting and **no emergency department (ED) visits** in the past 3 months
- ✓ Tom knows what to do and who to call if symptoms worsen, with a **clinician available 24/7**
- ✓ Tom developed a long-term plan specific to his goals, **created an advance care plan** (which includes his end-of-life care preferences), and identified a healthcare proxy
- ✓ **Home safety evaluation** was performed, and Tom's bedroom was moved to the first floor
- ✓ Through **medication reconciliation,** expired medications were discarded. Tom now uses a pill organizer and carries his medication list with him
- ✓ **After stabilization,** Tom was transitioned to be part of the **PCF-General Payment Model Option**

What Are Next Steps That My Practice Can Take to Participate?

Primary Care First Launches in 2021

The Primary Care First application portal is now live!

Please complete your practice application by **January 22, 2020.**



Stay tuned for a SIP Component Part III Webinar in 2020

Use the Following Resources to Learn More About Primary Care First

For more information about Primary Care First and to stay up to date on upcoming model events:

Visit

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

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