The National Coalition of Hospice and Palliative Care presents

New Medicare Alternative Payment Models: Options and Opportunities for Hospice and Palliative Care Programs

In partnership with:
American Academy of Hospice and Palliative Medicine
Center to Advance Palliative Care
Hospice and Palliative Nurses Association
National Hospice and Palliative Care Organization

Coalition Members: Cooperation, Communication & Collaboration
Payment Education Collaborative

- Initiative for the “field”: Share information, be transparent, speak with one voice to the field, to policy makers
- Organizations w/in Coalition working together over the past year and have been a united voice to CMMI in person and in writing
- Today:
  - Overview of the Model, PCF-SIP
  - Patient Eligibility and Enrollment, SIP
  - Provider Eligibility (brief Q and A)
  - Quality Measures and Monitoring
  - Payment
  - Partnerships Necessary
  - Application Process
  - Q AND A

Gary Bacher
Chief Strategy Officer for the CMS Innovation Center

&

Michael Lipp
Chief Medical Officer for the CMS Innovation Center
The Primary Care First Request for Applications (RFA) is Now Live!

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

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*
For SIP patients, **CMS** will identify eligible beneficiaries and assign them to the SIP Practice

- **Claims Review**
  - CMS identifies a beneficiary for SIP option
  - Claims eligibility is based on both care fragmentation and serious illness (see next slide)

- **First Contact**
  - CMS contacts beneficiary to determine interest

- **Practice Assignment**
  - CMS provides interested beneficiary contact info to SIP practice within 24-48 hours

- **Engagement**
  - SIP practice reaches out to beneficiary (ideally within 24 hours)
  - First face-to-face must occur in 60 days
SIP Beneficiary Identification Through Claims Analysis

**FRAGMENTATION**
- No single practice has provided more than half of their E&M visits in the last 12 months
- OR
- 2 or more ED visits or observation stays in the last 12 months

**SERIOUS ILLNESS**
- Has an HCC Score of 3.0 or greater
- OR
- Has an HCC Score of 2.0+ and had 2+ unplanned hospital admissions in last 12 months
- OR
- Had a DME claim for transfer equipment or hospital bed

Limited Direct Referral Will Be Allowed

- May originate from any provider
  - E.g., hospital, ED, specialty practice
- SIP practice must obtain the beneficiary’s consent to participate in the model and attest to CMS that the beneficiary meets the criteria (non-claims-based clinical criteria)
- CMS will then confirm eligibility
- Subsequent face-to-face visit will start the payment model
The Model Requires Patient Transition –
The Goal is Under 8 Months

- CMMI stresses that this is a “transitional intensive intervention”
- Hybrid Practices may transition the patient to its general PCF roster
- SIP-only practices must have written agreements with providers in the community with advanced competencies in managing complex patients
- SIP-only practices can also transition patients to themselves; they would receive Medicare FFS payment for all care provide post-transition

Lori Bishop, MHA, BSN, RN
Vice President of Palliative and Advanced Care
National Hospice and Palliative Care Organization

PROVIDER ELIGIBILITY
In 2021, Primary Care First Model Will Include 26 Diverse Regions

**Regions**
- Greater Buffalo (NY)
- Greater Kansas City (KS and MO)
- Greater Philadelphia (PA)
- North Hudson-Capital region (NY)
- Ohio and Northern Kentucky (OH and KY)

**States**
- Alaska
- Arkansas
- California
- Colorado
- Delaware
- Florida
- Hawaii
- Louisiana
- Maine
- Massachusetts
- Michigan
- Montana
- Nebraska
- New Hampshire
- New Jersey
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Rhode Island
- Tennessee
- Virginia

Provider Eligibility Criteria for PCF

- Be located in one of the Primary Care First regions.
- Include primary care practitioners (MD, DO, CNS, NP, and PA) certified in internal medicine, general medicine, geriatric medicine, family medicine, or hospice and palliative medicine.
- Provide health services to a minimum of 125 attributed Medicare beneficiaries (waived for SIP only participants)
- Have primary care services account for at least 70% of the practices’ collective billing based on revenue (waived for SIP only participants) Have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to FFS payments such as full or partial capitation.
- Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE) (Waived for first year for SIP only participants)
- Attest via questions in the Practice Application to a limited set of advanced primary care delivery capabilities, such as 24/7 access to a practitioner or nurse call line and empanelment of beneficiaries to a practitioner or care team.
Provider Eligibility Requirements for SIP

Demonstrate advanced competencies and relevant clinical capabilities for successfully managing complex patients:

- interdisciplinary care teams
- ability to fulfill requirements such as comprehensive, person-centered care management
- family and caregiver engagement
- 24/7 access to a member of the care team
- connect these beneficiaries to resources in the community to help address social determinants of health and behavioral health issues.

Other Considerations

- Practitioners must be enrolled in Part B in order to participate
- Identify health care partners you will contract with for transition of patients
- A SIP only participant can still follow patients after transition to a primary care provider (billing Medicare FFS)
Q & A Break

• Model Overview and Eligibility

Joe Rotella, MD, MBA, HMDC, FAAHPM
Chief Medical Officer
American Academy of Hospice and Palliative Medicine

QUALITY MEASURES AND MONITORING
SIP Quality Measures

- Excluded from following QMs for PCF risk score groups 1 and 2: colorectal CA screening, acute hospital utilization, control of diabetes and hypertension
- 5 QMs, same as for PCF risk score groups 3 and 4

<table>
<thead>
<tr>
<th>QM</th>
<th>Method</th>
<th>Monitoring Yrs</th>
<th>Adjust Payment Yrs</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Plan</td>
<td>MIPS Registry</td>
<td>None</td>
<td>PY1 - PY5</td>
<td>MIPS National</td>
</tr>
<tr>
<td>Total Per Capita Cost</td>
<td>Claims</td>
<td>None</td>
<td>PY1 - PY5</td>
<td>Historical</td>
</tr>
<tr>
<td>CAHPS</td>
<td>Beneficiary Survey</td>
<td>PY1</td>
<td>PY2 - PY5</td>
<td>Prior year</td>
</tr>
<tr>
<td>24/7 Practitioner Access</td>
<td>Beneficiary Survey</td>
<td>PY1 - PY2</td>
<td>PY3 - PY5</td>
<td>Historical</td>
</tr>
<tr>
<td>Days at Home</td>
<td>Claims</td>
<td>PY1 - PY2</td>
<td>PY3 - PY5</td>
<td>Historical</td>
</tr>
</tbody>
</table>

$50 PBPM is withheld and is returned after annual reconciliation if practice:

- Performs above the 50th percentile on all QMs compared to reference population, and
- Averages length of stay of 8 months or less, and
- Meets benchmark for share of discharged patients with no hospital or ED visit in three months post transition (Successful Transition)

Additional $50 PBPM bonus is awarded after annual reconciliation if practice:

- Performs at or above the 70th percentile on all QMs, and
- Averages length of stay of 8 months or less, and
- Meets Successful Transition benchmark
SIP Practice Monitoring and Audits

Monitoring
- Screen for program integrity (initial and annual)
- Verify practice attestations of care delivery interventions
- Review cost, utilization, patient experience and quality data
- Review claims for engagement with SIP beneficiaries including success and timeliness in seeing for first face-to-face

Audits
- Focus primarily on prevention, detection, mitigation of improper payments and care stinting
- Issue Notice of Remedial Action or terminate Participation Agreement for poor performance, integrity concerns or non-compliance

Phil Rodgers, MD, FAAHPM
Professor, Family Medicine and Internal Medicine
Director, Adult Palliative Care Clinical Programs
University of Michigan

PAYMENT
The SIP Payment Model Option Includes Four Payment Components

- **One time payment for first visit**
  - $325 (not geographically adjusted; inclusive of flat visit fee)

- **Monthly professional population-based payment**
  - $275 PBPM* base rate minus a $50 withhold (both geographically adjusted)

- **Flat visit fee**
  - $40.82 base rate + coinsurance per face-to-face encounter (begins after attribution; geographically adjusted)

- **Quality bonus**
  - $50 PBPM* base rate (geographically adjusted)

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

By default, SIP practices will receive up to 12 months of SIP payments per SIP patient, unless the beneficiary is transitioned or deattributed sooner.

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

- **One time payment for first visit**
  - $325 for initial visit with SIP patient

- **Monthly professional population-based payment**

- **Flat visit fee**

- **Quality bonus**

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.

Exceptions may apply. Please see the Request For Applications (RFA) for more details.
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-attrition from the practice.

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

### SIP Payments

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

**$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.

*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).
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.

*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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average SIP beneficiary attribution length ≤ 8 months for SIP Episodes ending in program year?</td>
<td>No</td>
</tr>
<tr>
<td>Rate of care transition success ≤ 8 months for SIP Episodes ending in program year?</td>
<td>No</td>
</tr>
</tbody>
</table>

If either condition is met, the participant is ineligible for withhold and bonus ($225 PBPM total SIP payment).

### Quality Adjustment Step 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>Requirement</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Plan Measure</td>
<td>≤ 50th percentile in the reference groups</td>
<td>No withhold, no bonus = $225 PBPM</td>
</tr>
<tr>
<td>Total Per Capita Cost Measure</td>
<td>Between 50th and 70th percentile in the reference groups for at least one measure, and not below the 50th percentile for either measure</td>
<td>Receive withhold back, no bonus = $275 PBPM</td>
</tr>
<tr>
<td>Total SIP Payment with Quality Adjustment (PBPM base rate)</td>
<td>≥ 70% in the reference groups for both measures</td>
<td>Earn back withhold &amp; receive bonus = $325 PBPM</td>
</tr>
</tbody>
</table>

Allison Silvers, MBA  
VP Payment & Policy  
Center to Advance Palliative Care

**PARTICIPATING IN PARTNERSHIP**
Primary Care First offers terrific partnership opportunities for palliative care clinicians!

Partnership Option 1: Jointly Apply as Hybrid Practice

- Hospice and palliative care clinicians can be listed in the partner’s Primary Care First application
- Palliative care clinicians can assume primary responsibility – and revenue – for the SIP beneficiaries assigned to the practice
- Patients can be retained in the practice after transition

5. For each primary care practitioner in your practice, please provide the following information.
   a. Practitioner Name: (Last, First, MI)
   b. National Practitioner ID (NPI):
      Note: You can look up NPIs at this link [link]
   c. Practitioner Type:
      - Physician (MD or DO)
      - Clinical Nurse Specialist
      - Nurse Practitioner
      - Physician Assistant
   d. Primary Specialty:
      - Family Medicine
      - Internal Medicine
      - Geriatric Medicine
      - General Practice
      - Hospice and Palliative Medicine
      - N/A
Partnership Option 2: SIP-Only and Formal Agreements

PCF Practice
SIP Practice

Direct Referrals
Successful Transitions
Support for High-Risk Pts

Partnership Possibilities Exist with Other CMMI Model Participants – as Hybrid, SIP, and FFS!

• “Direct Contracting Models”
  – Another new APM announced Spring 2019
  – Organization receives capitated (fixed) payment and shares in savings and losses
  – Flexible opportunities for those focusing on dually-eligible and chronically-ill

• Accountable Care Organizations
• Oncology Care Model / Oncology Care First Model
• Comprehensive Primary Care Plus
Partnership Best Practices Still Apply

1. Use data to describe your program and how you benefit payers
   - Collect your outcomes
   - Enhance with a compelling patient story
   - Supplement with the literature

2. Know your costs (PMPM)
   What funding do you need to be both financially sustainable and reliable?

Phil Rodgers, MD, FAAHPM
Professor, Family Medicine and Internal Medicine
Director, Adult Palliative Care Clinical Programs
University of Michigan

THE APPLICATION PROCESS
Application Process and Details

• Non-binding provider application is due on January 22, 2020.
  – Non-binding Payer LOI due March 13, 2020

• Be prepared to select participation option (non-binding):
  – ‘PCF-General’, ‘SIP-only’, or PCF and SIP (or ‘Hybrid’)
  – Apply for the model you think you want, even if you’re not sure

• CMS will select practices in Spring 2020, who will then need to execute a Participation Agreement later in 2020, for model launch on January 1, 2021

What Information is Needed to Apply

• Practice characteristics, ownership, service area, Medicare enrollment information

• Ability to meet 2015 CEHRT requirements by January 1, 2021 for hybrid, and by January 1, 2022 for SIP only

• Demonstrate financial readiness, including experience with value-based payment

• Documented ability to meet service requirements (IDT, 24/7 access, care planning, social and community supports, etc.)
What Should You Be Doing Now?

• Get familiar with the details of the PCF-SIP model and RFA

• Carefully evaluate your practice capacities, your partners, your ability to participate (and in which way)

• Identify key members of your team (including administrators) to assemble necessary data for application
  – Application: [https://app1.innovation.cms.gov/PCF/CPCPlusLogin](https://app1.innovation.cms.gov/PCF/CPCPlusLogin)

*Application deadline is January 22, 2020*

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Q & A

• General Questions
Upcoming Webinar-Office Hours
Primary Care First Seriously - Ill Population Model Option

To prepare your organization to apply, the Coalition team will be hosting an office hour session to answer your questions related to the PCF-SIP model and the application. Applications due Jan 22, 2020

Thursday, December 12th
12:30 PM ET – 2:00 PM ET

Registration Opening Soon