The National Coalition of Hospice and Palliative Care presents

New Medicare Alternative Payment Models: Virtual Town Hall

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 policymakers
• Organizations within Coalition working together over the past year and have been a united voice to CMMI in person and in writing
• Today, we focus on FAQs regarding key elements of the PCF-SIP:
  – Model Design
  – Patient Eligibility and Attribution
  – Provider Eligibility and Service Delivery
  – Quality
  – Payment
  – More Q AND A!

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Director, Adult Palliative Care Clinical Programs
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MODEL DESIGN
FAQs – Model Design

• Is the model limited only to beneficiaries enrolled in traditional (fee-for-service) Medicare, or will those enrolled Medicare Advantage be eligible as well? How about Medicaid? Commercial health plans? Pediatrics?

• Is SIP available under the Direct Contracting Model?

• Which states are included in the model, and will others be added?

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

<table>
<thead>
<tr>
<th>Regions</th>
<th>States</th>
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<tbody>
<tr>
<td>Greater Buffalo (NY)</td>
<td>• Alaska</td>
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<tr>
<td>Greater Kansas City (KS and MO)</td>
<td>• Arkansas</td>
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<tr>
<td>Greater Philadelphia (PA)</td>
<td>• California</td>
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<tr>
<td>North Hudson-Capital region (NY)</td>
<td>• Colorado</td>
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<tr>
<td>Ohio and Northern Kentucky (OH and KY)</td>
<td>• Delaware</td>
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<td>• Florida</td>
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<td>• Hawaii</td>
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<td>• Tennessee</td>
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<td>• Virginia</td>
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PATIENT ELIGIBILITY AND ATTRIBUTION

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

- **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
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

FAQs – Patient Eligibility and Attribution

- How does CMS make referrals to specific SIP practices?
- How will the relationship work between the SIP practice and the Primary Care Practice in the SIP-only option? The Hybrid option?
- Under the SIP-only option, does the palliative care provider become the PCP? What if the patient has a PCP and doesn't want to switch?
- What happens if the patient dies after transferring out of the SIP practice? Will the SIP practice still get the quality and bonus funds, assuming it was earned?
FAQs – Provider Eligibility and Service Delivery

• If two SIP providers operate in same service area, how will CMS divide the attributed beneficiaries?

• How do hospices operationalize participation as a SIP-only practice? A PCF-hybrid practice? Can a palliative care team participate as both?

• How will this model impact hospice referrals if the hospice provider is not directly involved in this model?

• Do telehealth visits qualify as ‘face-to-face’ visits to receive the flat fee payment? Can they fulfill the 60-day visit requirement?
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

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Chief Medical Officer
American Academy of Hospice and Palliative Medicine

QUALITY MEASURES AND MONITORING
FAQs – Quality Measurement

• Are the quality measures already defined?

• Will there be any administrative support to track quality measures?

• Is the Advance Care Plan measure defined by a completed advance directive or POLST/MOSLT/MOST form, or just a documented goals of care discussion?

SIP Quality Measures

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

<table>
<thead>
<tr>
<th>QM</th>
<th>Method</th>
<th>Monitoring Yrs</th>
<th>Adjust Payment Yrs</th>
<th>Benchmark</th>
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</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>
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

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Director, Adult Palliative Care Clinical Programs
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**PAYMENT**
FAQs – Payment

• Can hospices get paid as SIP-only practices? Do they need to be Part B providers?

• When will payments be made in relation to services delivered? How will those payments be adjusted

• What services qualify for the flat-fee payment? Can SIP practices bill for any other services?

• Given the lower flat-fee payment and the low monthly payment, can’t practices get paid more in traditional fee-for-service than in PCF-SIP?

The SIP Payment Model Option Includes Four Payment Components

$325 (not geographically adjusted; inclusive of flat visit fee)

$275 PBPM* base rate minus a $50 withhold (both geographically adjusted)

$40.02 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.

*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**

- **One time payment for first visit**
  - $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**

- **Monthly professional population-based payment**
  - $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

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

**$40.82**

per face-to-face visit, 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.

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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 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

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
- Rate of success in care transition

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.

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

### Quality Adjustment Step 1

<table>
<thead>
<tr>
<th>Average SIP beneficiary attribution length</th>
<th>Average SIP beneficiary attribution length ≤ 8 months for SIP Episodes ending in program year?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>At or above benchmark for SIP transition success rate for program year?</td>
</tr>
<tr>
<td>Yes</td>
<td>Ineligible for withhold and bonus (≤ $225 PBPM total SIP payment)</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Quality Adjustment Step 2

<table>
<thead>
<tr>
<th>Advance Care Plan Measure</th>
<th>≤ 50th percentile in the reference groups</th>
</tr>
</thead>
<tbody>
<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>
</tr>
<tr>
<td>Total SIP Payment with Quality Adjustment (PBPM base rate)</td>
<td>≥ 70% in the reference groups for both measures</td>
</tr>
</tbody>
</table>

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

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### 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
Q & A

• General Questions

FAQ Document Coming Soon!