



## Primary Care First

*Foster Independence. Reward Outcomes.*

### Seriously Ill Population (SIP) Part II Webinar

*Center for Medicare & Medicaid Innovation*



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## Request for Applications Now Live!



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

Access the RFA on the model website at the link below or download it from the pod at the bottom right of your screen.

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

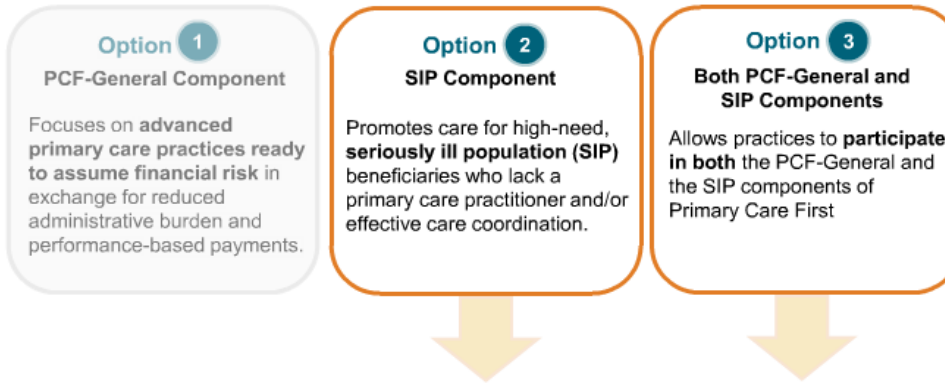


## Presentation Overview

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



## Primary Care First (PCF) Payment Model Options



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 SIP population 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 Transform Care 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 Payment Model Option



### 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



## Frequently Asked Questions



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



**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.



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



Yes – a SIP practice that also participates in 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



## SIP Patients Experience Siloed Care and Serious Illness

### 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 an HCC risk score  $\geq 3.0$ )
  - 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 DME claim submitted to Medicare by a provider or supplier for a hospital bed or transfer equipment.
- 2 **Fragmented pattern of care, including characteristics:**
  - Proportion of E&M visits with a single practice
  - ED visits and inpatient 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

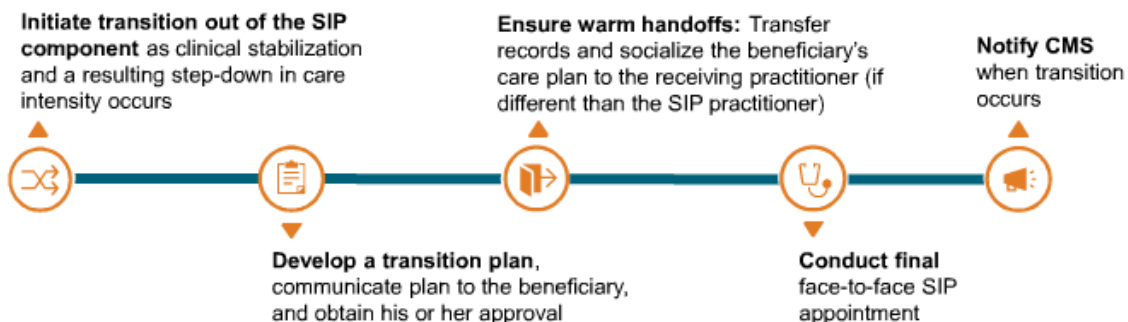
Once CMS validates that beneficiaries meet claims-based SIP eligibility criteria, beneficiaries are engaged in the model through the following steps:

-  ▶ 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.
- 

## The SIP Beneficiary Transition Process

The SIP component is an intensive, time-limited intervention, and the average SIP episode is expected 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:



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

## Considerations for Transitioning Care

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 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



## Goals of Payment and Quality



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**

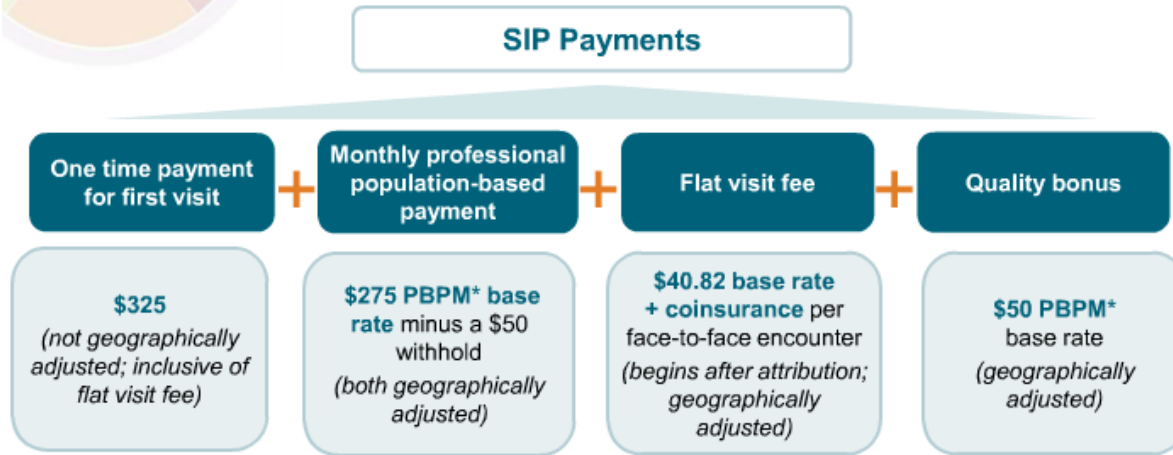


The PCF SIP Component **quality measures** were selected to accomplish the following goals:

- ✓ 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 Model Option Includes Four Different Payment Components



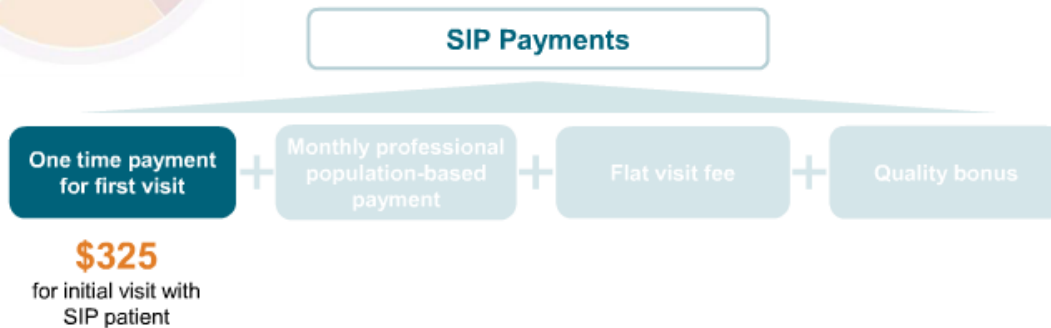
*SIP practices generally receive up to 12 months<sup>†</sup> of SIP payments per SIP patient, depending on when the patient transitions out of the SIP practice. Additional payments beyond 12 months may be allowed as appropriate on a per patient basis subject to CMS approval and practice eligibility.*

\*PBPM = per beneficiary per month

† Exceptions may apply. Please see the Request For Applications (RFA) for more details.



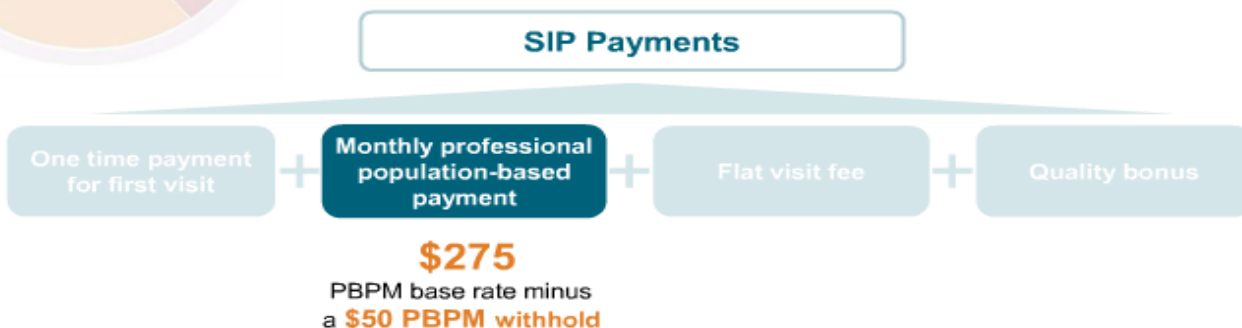
## Primary Care First SIP Payment Design: First-Time Visit Payment



- ✓ 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.



## Primary Care First SIP Payment Design



- ✓ **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.



## Flexibility for Flat Visit Fee Base Payments

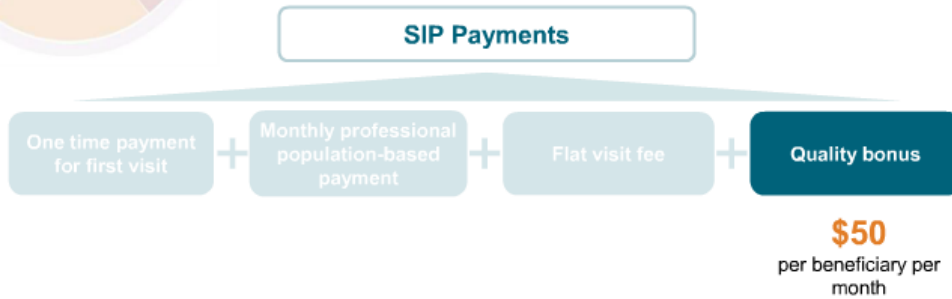
Practices may bill the \$40.82 flat visit fee base rate for **face-to-face** and **qualifying telehealth visits**. Examples of services that will be paid the flat visit fee:



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.



## Primary Care First SIP Payment Design



- ✓ 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).



## Quality Measures for SIP Model Options

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

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

\*CMS will develop these measures



## Encouraging Appropriate and Timely 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

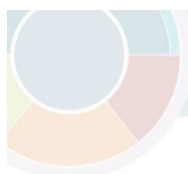
- ✓ The SIP program is designed around an **8-month average length** of attribution across its entire SIP beneficiary population; this is calculated annually for all beneficiaries attributed and transitioned during the performance year.

**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.



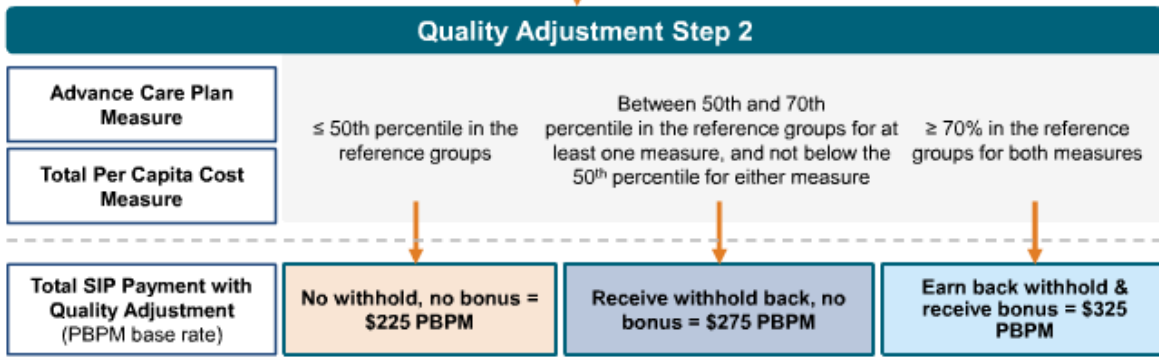
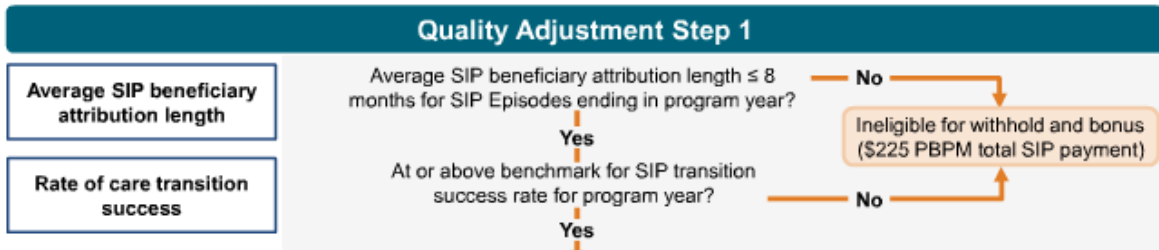
## Hybrid Model Option and SIP Patient Transitions

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



# SIP Quality Adjustment in Year 1



## Sample SIP Participant Experience



## Overview of the SIP Practice Journey



**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.



## Introduction to Tom and Practice A



### 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 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**.

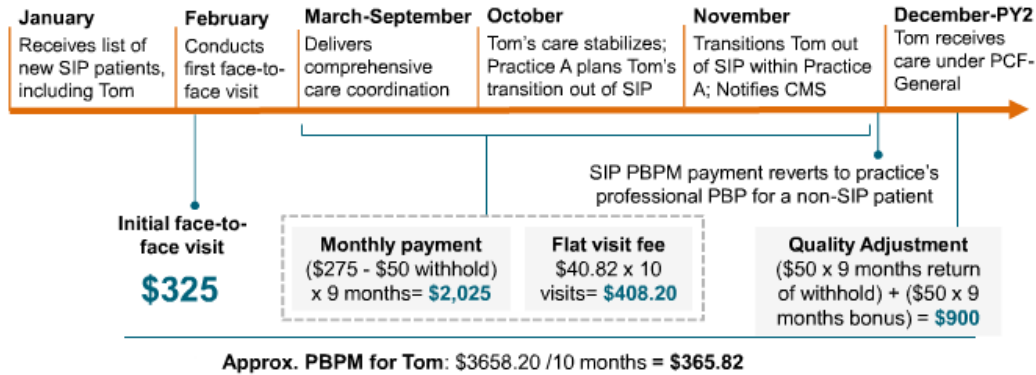


## SIP Practice Journey



### 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 LOS and the practice is paid for each month that Tom is aligned to the program.



## SIP Impact on Tom



### 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 COPD exacerbations managed in the outpatient setting and **no 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 Timeline

**The Primary Care First application portal is now live!**

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



#### Fall 2019

Practice applications open; Payer statement of interest posted



#### Winter 2020

Practice applications due; Payer solicitation



#### Spring 2020

Practices and payers selected



#### Summer/Fall 2020

Onboarding of Participants



#### January 2021

Model Launch; Payment changes begins

Practice application and payer statement of interest submission period begins

Practice and payer selection period

Stay tuned for a SIP Component Part III Webinar in 2020



## Thank you for Joining Us Today

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