AMERICA'S PHYSICIAN GROUPS

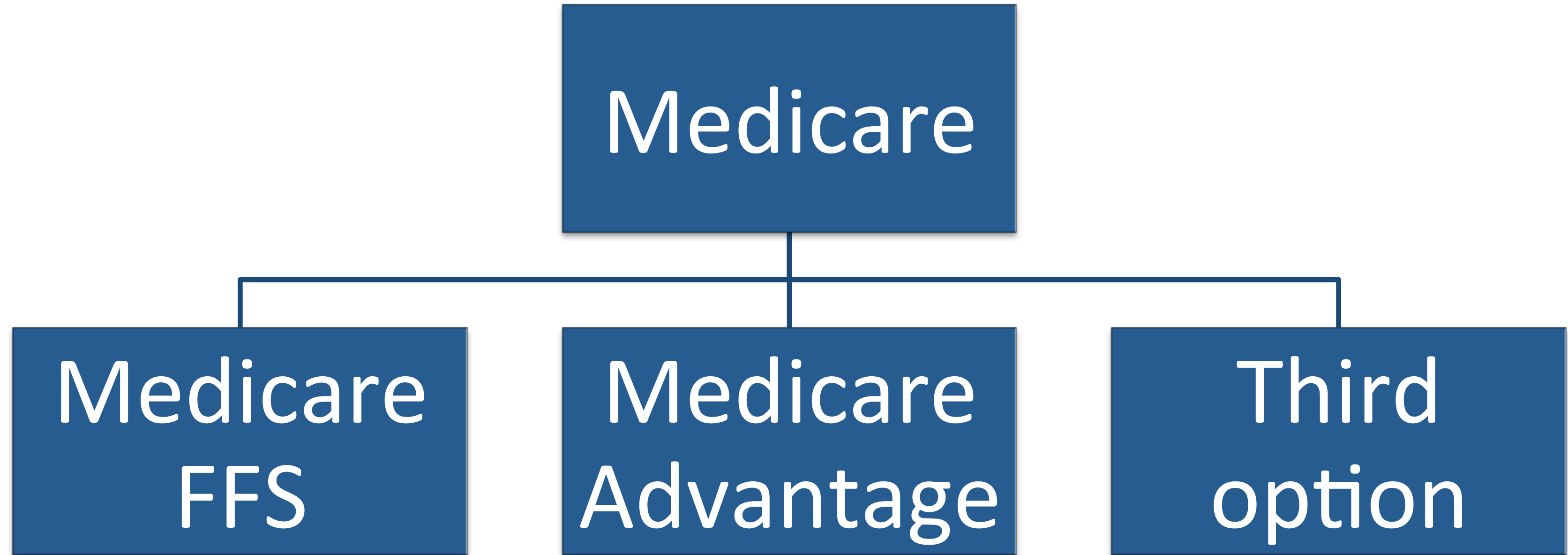
Fireside Chat With CMS: The Future of Primary Care Models

Valinda Rutledge
Stacey Hrountas
Don Rebhun, MD
Pauline Lapin

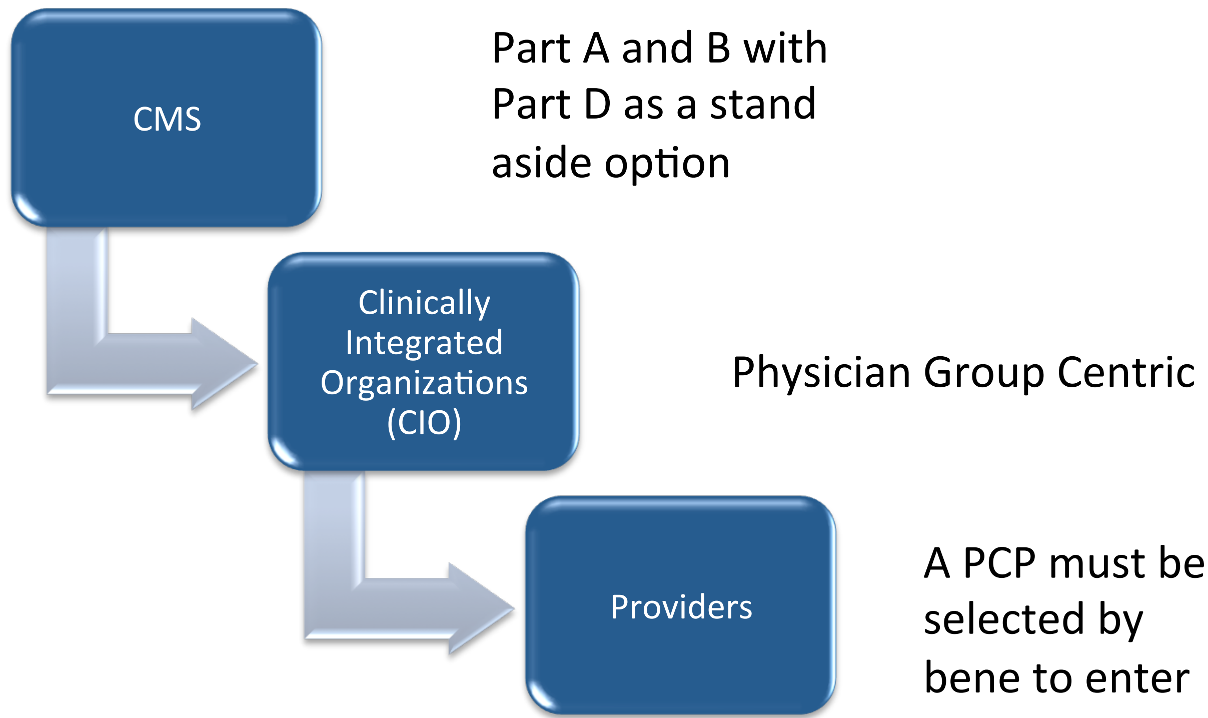
Agenda

- 5 minutes - Valinda Rutledge
- 5 minutes – Stacey Hrountas
- 5 min- Don Rebhun, MD
- 15 min - Audience Q/A
- 15 min -Pauline will discuss conceptual vision of primary care models at CMMI
- 30 min- Pauline will lead listening session with audience

Third Option



Flow of Capitated Dollars



Unique Characteristics

Services

- Freedom of choice (Point of Service Plan)
- Preventive services have no co-pay
- Supplemental plans would only cover in network

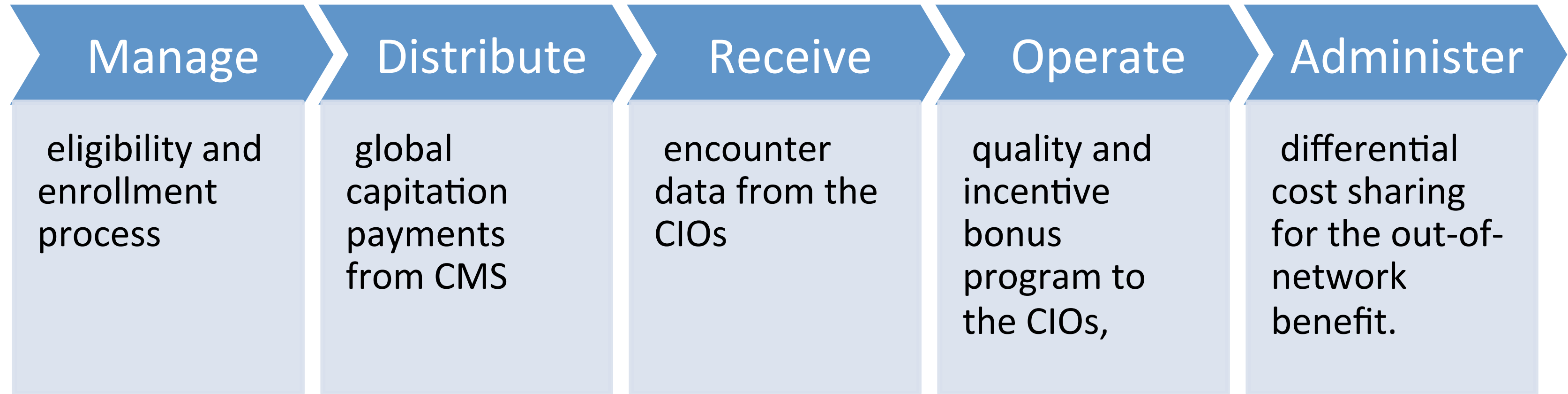
Beneficiary

- Active enrollment
- Committed for 1 year
- Part B Premium will be reduced if Third option is selected

Benchmarking Methodology

Using regional and historical Part A and B cost information, CMS would each year establish an actuarially sound, risk adjusted, global capitation payment to be made to the CIO for the entire population assigned to it

Affiliated Service Organizations (ASO)

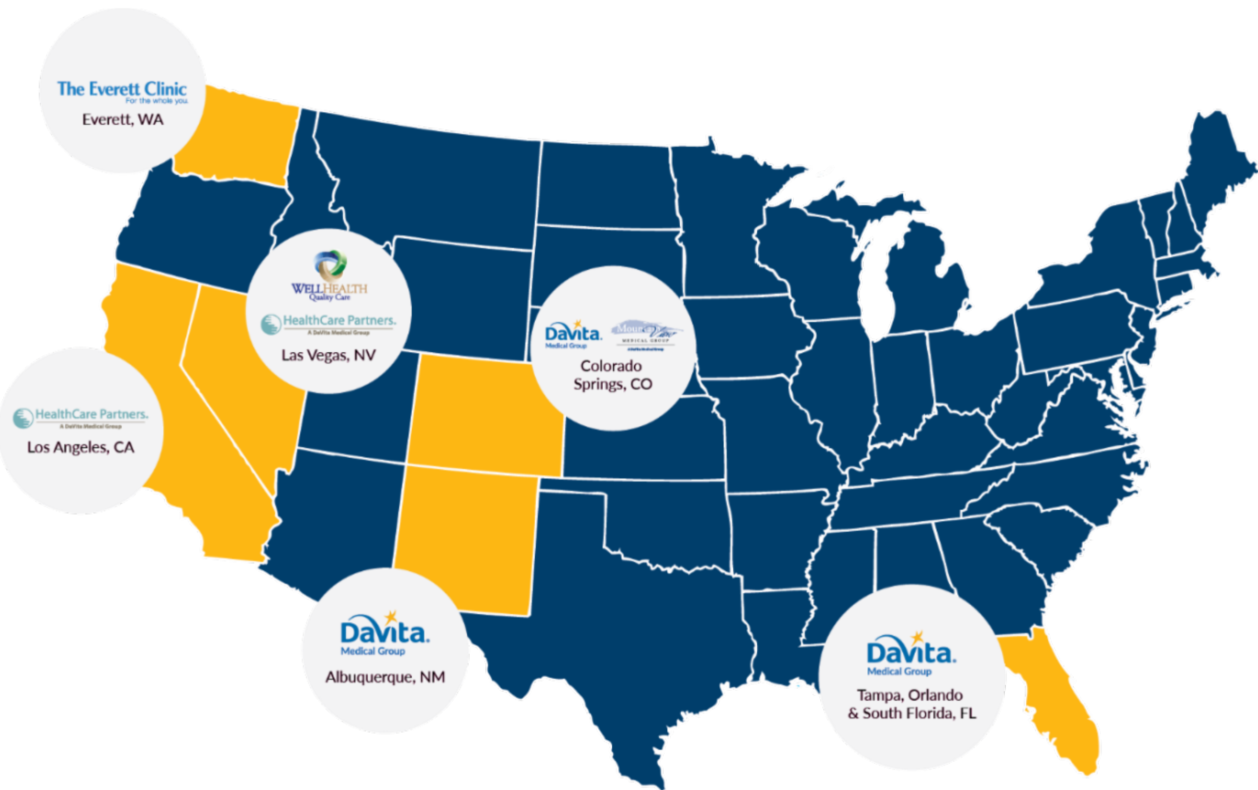


Donald J. Rebhun, MD, MSPH

Regional Medical Director

DaVita HealthCare Partners

DaVita HealthCare Partners



270 Group Clinics

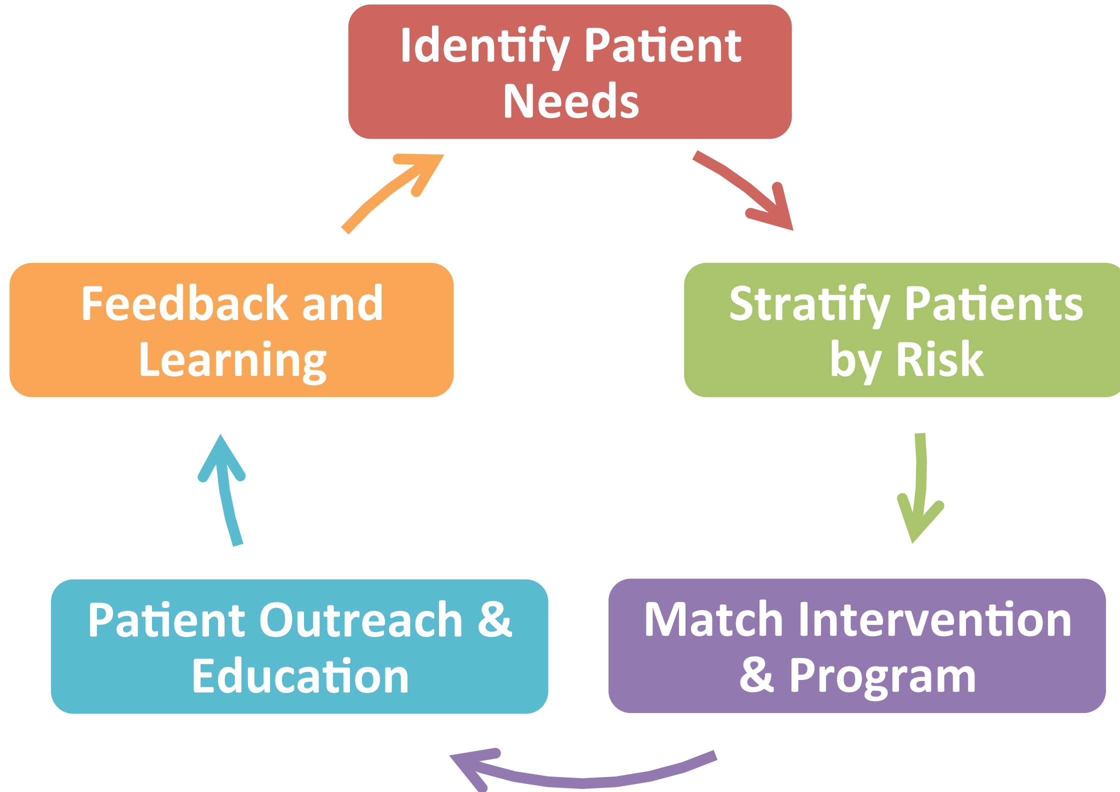
2K Team Clinicians

13K Affiliated Physicians

200 Network Hospitals

1.7M Patients

Proactive Population Management



Requires:

- Robust IT System
- PCP led clinical workforce
- Stratification of population and appropriate resource allocation
- Patient engagement (Care Teams)
- Actionable Data for the Population
- Traditional and Innovative Programs to Improve Outcomes

Produces:

- Better Care
- Better Quality
- Better Efficiency
- Better Experience

Takeaways

- Value-based healthcare is here and growing
- Coordinated, integrated physician groups who take risk have demonstrated better outcomes, satisfaction, and efficiency

Stacey Hrountas

Chief Executive Officer

Sharp Rees- Stealy Medical Group

Sharp HealthCare

- Not-for-profit serving 3.2 million residents of San Diego County
- Over three decades of experience managing care under population-based payment structures
- Largest private employer in San Diego
  - 18,000 employees, 2,600 affiliated physicians, 3,000 volunteers
- 4 acute care hospitals, 3 specialty hospitals, 3 affiliated medical groups & a not-for-profit health plan

Sharp Rees-Stealy Medical Group

Multi-Specialty Foundation Model

- First multi-specialty medical group in San Diego
- 22 clinic facilities, 5 urgent care centers & 7 retail pharmacies across San Diego County
  - Owned and operated by Sharp Rees-Stealy Medical Centers, a division of Sharp HealthCare
- Physicians and nurse practitioners are employees of the multi-specialty medical group
  - 186 primary care physicians, 341 specialists & 99 advanced practitioners
- Average enrollment of 192,874, 13,162 ACO lives & 1.4m physician visits
- Top 10% by IHA of 199 medical groups in CA in both clinical, quality & patient experience, per IHA value based P4P program

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Pearls of Wisdom

- MA outperformed Medicare Fee-For-Service in clinical quality measures and at a lower total cost of care.* In California, the majority of MA plans capitate accountable providers
- Beneficiary engagement via primary care physician selection/ enrollment and cost of care differentials is crucial
- Clinical quality, efficiency and patient experience transparency
- Physician and care team culture under value based care

*California Regional Health Care Cost & Quality Atlas

Pauline J. Lapin, MHS

Director, Seamless Care Models
Center for Medicare and Medicaid Innovation

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The Future of Primary Care Models

Pauline J. Lapin, MHS

Director, Seamless Care Models

Center for Medicare and Medicaid Innovation

October 11, 2018

Primary Care Models—Where We Are Today

- Next Generation ACO is in its 3rd performance year with 51 ACOs participating in the model.
- Comprehensive ESRD Care Model is in its 3rd performance year with 37 ESCOs participating in the model.
- Comprehensive Primary Care Plus (CPC+) is in its 2nd performance year for round 1 starters in 14 regions and 1st year for round 2 starters in 4 regions.
- Maryland Total Cost of Care Model, which includes the Maryland Primary Care Program, begins January 1, 2019.
- Direct Provider Contracting Request for Information in may 2018 provided useful feedback for future models.

Next Generation ACO Model

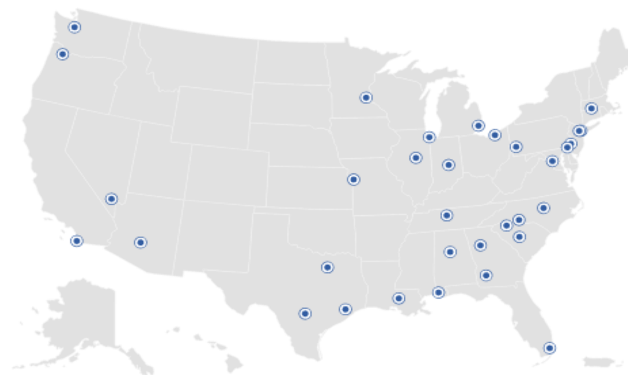
- The Next Generation ACO Model builds upon successes from Pioneer and Shared Savings Program ACOs
- Designed for ACOs with experience coordinating care for patient populations
- NGACOs assume higher levels of financial risk and reward than other Medicare ACO initiatives while maintaining high quality standards
- Menu of options for NGACOs to select level of risk, cash flow mechanism, and benefit enhancements best suited to each organization
- Prospective alignment and voluntary alignment

Source: Centers for Medicare & Medicaid Services

- **51 ACOs serving 1.8 million beneficiaries in Performance Year (PY) 2018**

Comprehensive ESRD Care Model

- Launched in 2015 and now in Year 3, the model includes 37 ESCOs--33 large dialysis organizations and 4 non-large dialysis organizations.
- Dialysis facilities, nephrologists and other providers coordinate beneficiary care
- Quality strategy is based around quality measures of special importance to ESRD beneficiaries, including quality of life.
- Beneficiary inducement waivers allow ESCOs to give nutritional supplements, transportation services, and technology.



Source: Centers for Medicare & Medicaid Services

- The model serves ~46,000 beneficiaries in 28 states and DC (~10% of all Medicare ESRD beneficiaries)
- 1,291 physicians and 792 dialysis facilities are in the model, including 75 rural dialysis facilities from 21 of 37 ESCOs.

Results to Date

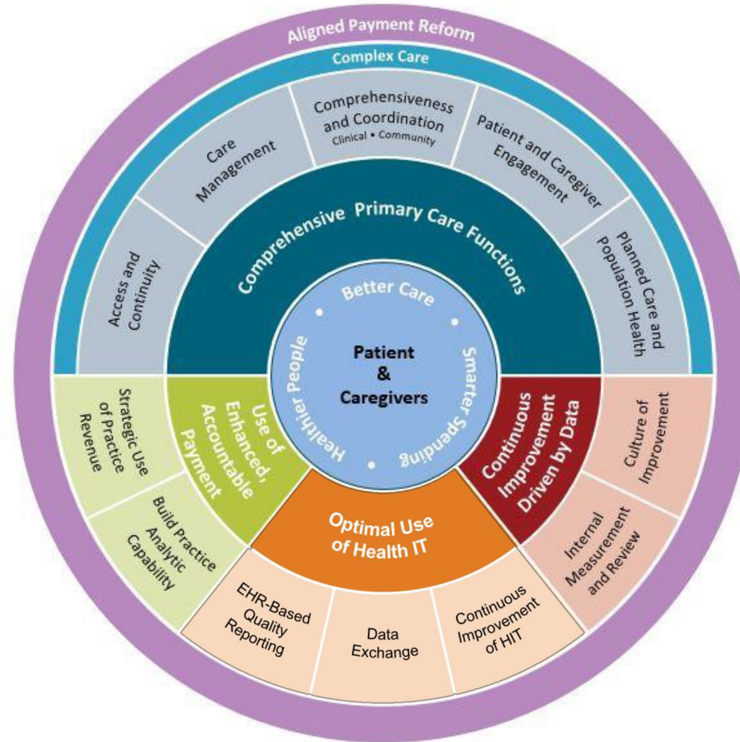
Next Generation ACO

- Performance Year 1 (2016) **actuarial** results based on 18 ACOs
  - 11 ACOs earned shared savings, while 7 ACOs incurred shared losses.
  - Net savings to the Medicare Trust Funds was more than $63 million for PY1.
- Performance Year 1 (2016) **evaluation** results based on 18 ACOS
  - Consistent with actuarial results with $62 million in net savings or a 1.1% reduction in Medicare spending.
  - Savings appear to be related to reduced hospitalizations and post-acute care.

Comprehensive ESRD Care

- Performance Year 1 (2016) **actuarial** results based on 13 ESCOs
  - 13 ESCOs generated savings, 0 losses
  - Net savings to the Medicare Trust Funds were more than $23.9 million
- Performance Year 1 (2016) **evaluation** results based on 11 ESCOs
  - CEC had approximately $29 million in aggregate savings, or 2% of Medicare spending
  - Savings appear to be related to reduced hospitalizations and post-acute care

Comprehensive Primary Care Plus



CPC+
2018 National Meeting

Comprehensive Primary Care Plus (CPC+)

CMS's largest-ever initiative to transform how primary care is delivered and paid for in America

Goals

1. Strengthen primary care through multi-payer payment reform and care delivery transformation.
2. Support clinicians to provide comprehensive care that meets the needs of all patients.
3. Improve quality, access, and efficiency of care.

Participants and Partners

- Advanced primary care practices in two rounds:
  - Round 1: 14 regions
  - Round 2: 4 regions
- Two tracks to accommodate diversity of practices
- 61 public and private payers in CPC+ regions
- Health IT vendors partner with CMS and Track 2 practices
- 5 year model: 2017-2021; 2018-2022

Care Transformation Functions

Access and continuity

Care management

Comprehensiveness and coordination

Patient and caregiver engagement

Planned care and population health

Payment Redesign Components

PBPM risk-adjusted care management fees

Performance-based incentive payments for quality, experience, and utilization measures that drive total cost of care

For Track 2, hybrid of reduced fee-for-service payments and up-front "Comprehensive Primary Care Payment" to offer flexibility in delivering care outside traditional office visits

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Comprehensive Primary Care Plus

America's largest-ever initiative to transform primary care

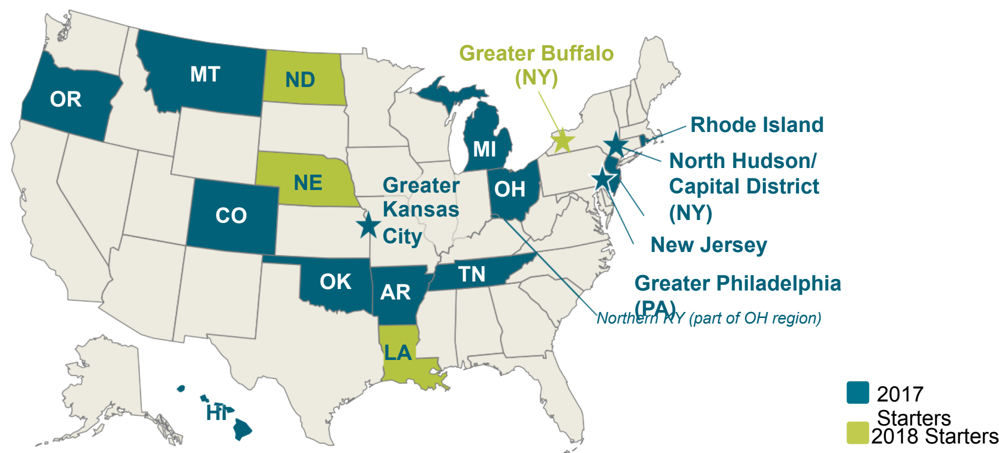
2,988
primary care practices

18
regions

OVER **2.0M**
Medicare patients

APPROX **14,600**
practitioners

APPROX **7,400**
Qualifying APM Participants (QPs)



5	**2**	**61**	OVER **55**
Years	Tracks	paye r partner	h e a

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CPC+ Practices are Highly Varied

Demographics and Participation in other CMS Models

1 in 6

Practices

Located in a rural area

1 in 4

Practices

Owned by practitioners at the practice

46%

Practices

Also participate in the Shared Savings Program (SSP)

96%

Practices in the Original CPC

Continued into CPC+

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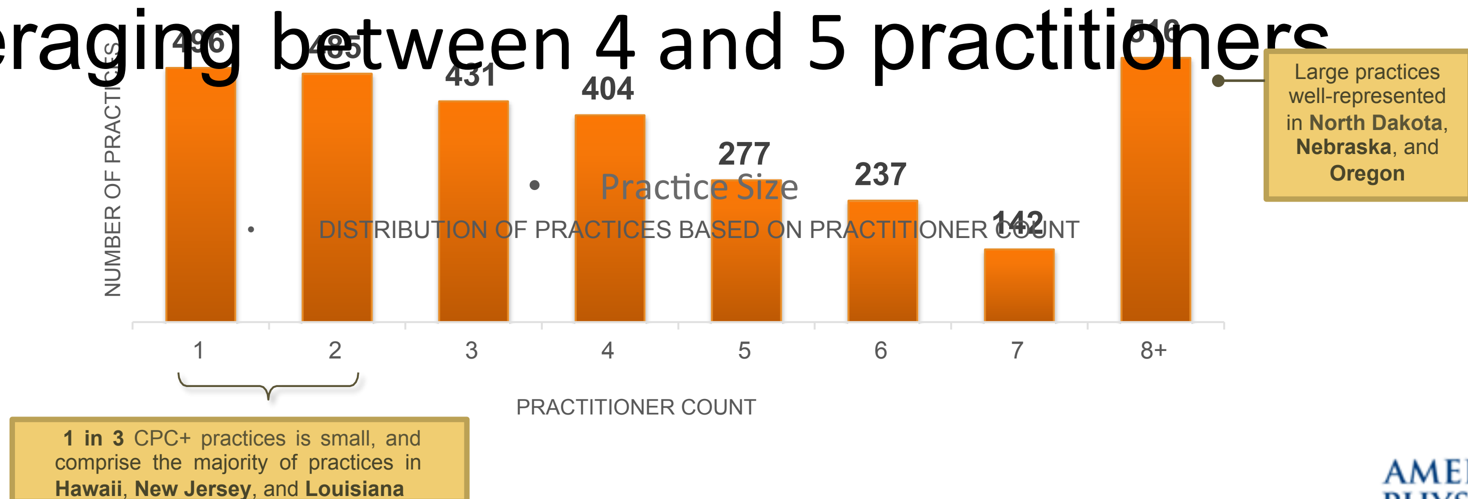
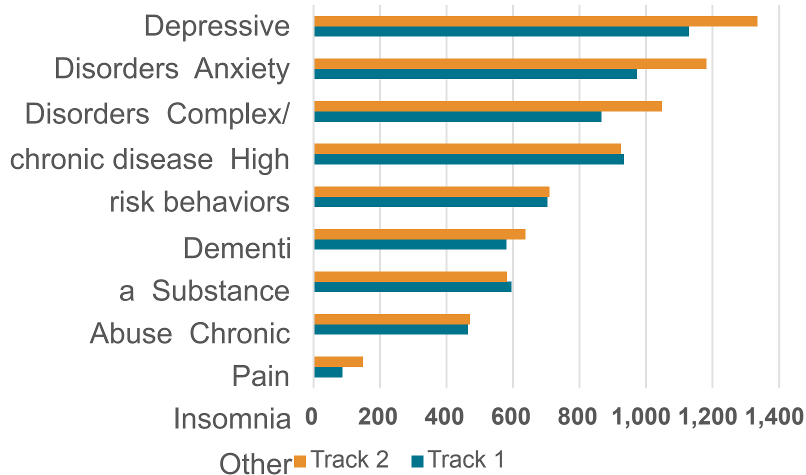
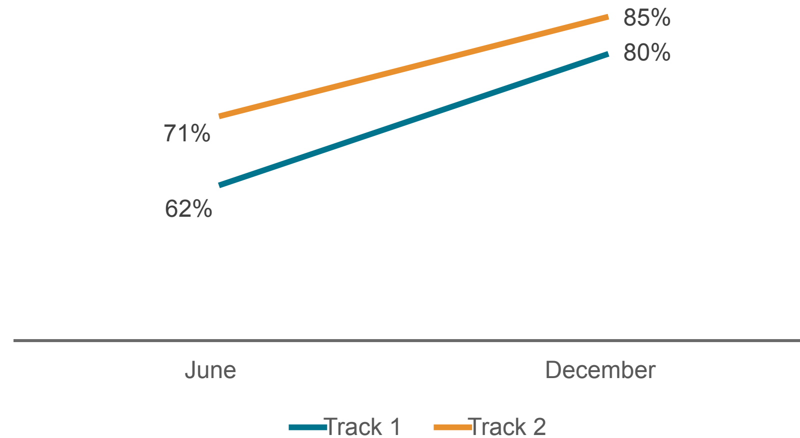
CPC+ Practices are Highly Varied

- Practice size ranges from 1 to 74 primary care practitioners,
- averaging between 4 and 5 practitioners



Behavioral Health Integration & Social Needs Screening



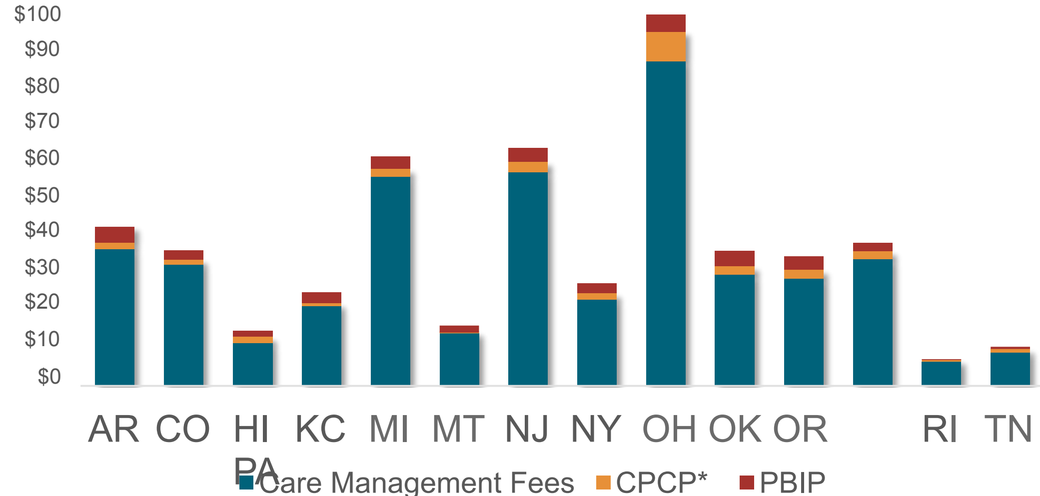


Enhanced Financial Support

2017 MEDICARE PAYMENTS

1,839,282
Medicare FFS Beneficiaries

$23.90
Total CPC+ Payments Per Beneficiary Per Month (PBPM)



** CPCP values represent 9 months of payment. Track 2 practices began receiving the CPCP in Quarter 2 2017.*
*** Estimated Medicare FFS expenditures based on a 12-month average from Jul 2016 – Jun 2017*

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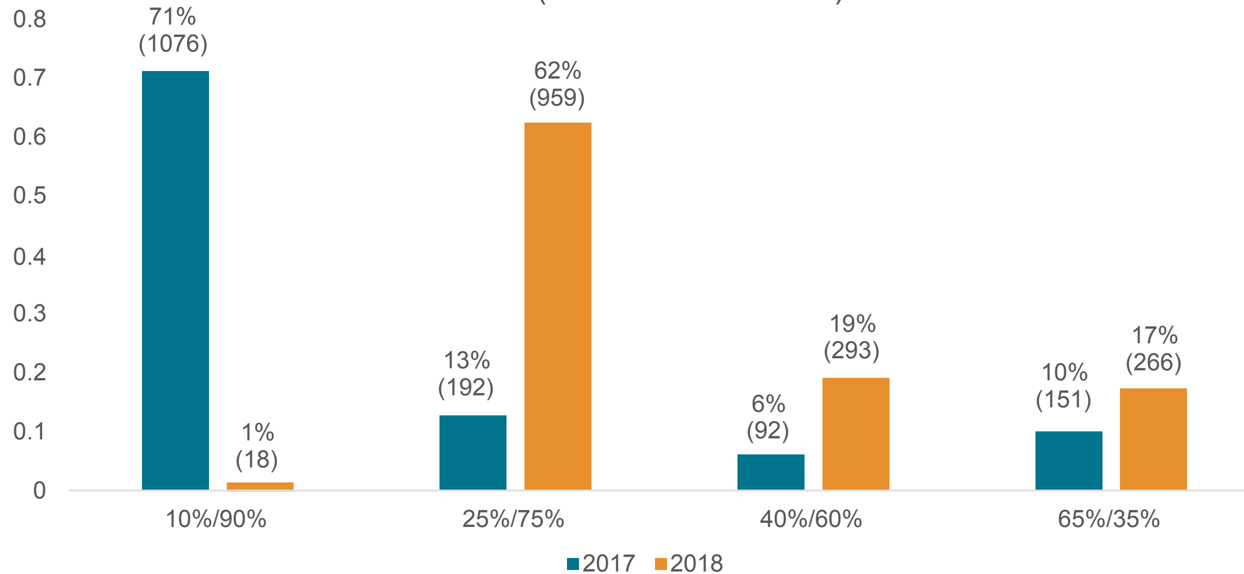
Hybrid Payment Choices



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Direct Contracting-High Level Themes

- Applaud CMMI's attention to further investment in primary care
- Recognize variability in practices with regards to size, type of practice and readiness for risk
- Be more strategic about how models overlap and interact with each other.
- Inform beneficiaries about the model, including quality and performance information, as well as benefits
- Ensure both beneficiaries and providers are protected
- Seek additional, more targeted stakeholder feedback
- Consider APG's "Third Option"

Questions for you

- What mechanisms might we use to better support primary care delivery to achieve greater value—lower costs and better health?
- What do you see as the next step in the continuum of CMMI's primary care and ACO strategy?
- What benefit enhancements and administrative relief would help facilitate our goals of a healthcare system that encourages practice flexibility in order to best meet a patient's needs?
- What do participants need to be successful in our models?

Patients Over *Paperwork*

We are working with the private sector towards patient-centered care and market-driven reform that: *empowers beneficiaries as consumers, provides price transparency, increases choices and competition to drive quality, and improves outcomes.*

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