CMMI model overview: Making Care Primary

Dr. Judy Zerzan-Thul

October 26, 2023

Washington State Health Care Authority

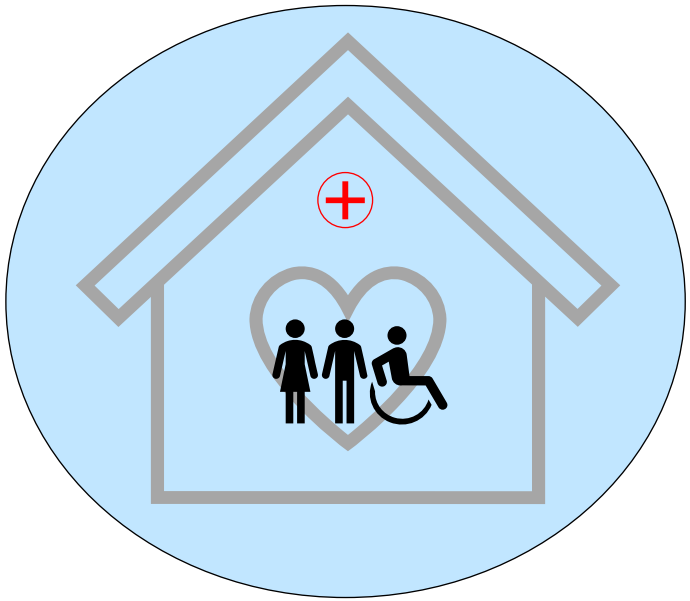
Today's Agenda

- 12:00 – 12:25
  - Overview of primary care efforts and Making Care Primary from Center for Medicare and Medicaid Innovation (CMMI)
    - Judy Zerzan-Thul, MD, CMO Washington Health Care Authority
- 12:25 – 12:35
  - The importance of primary care and Making Care Primary
    - Mike Myint, MD, Chief Population Health Officer, UW Medicine
    - Jonathan Wells, MD, Washington Academy of Family Physicians
    - Eleanor Escafi, Director of Network Innovation, Regence
    - Angela Sparks, MD, CMO, United Healthcare WA
- 12:35 – 1:00
  - Question and answer with CMS Innovation Center (CMMI)
    - Megan Loucks, MCP Quality Lead, CMS Innovation Center
    - Leah Hendrick, Deputy Director of the Division of Advanced Primary Care, CMS Innovation Center

Problem Statements

- Primary care practices struggle with capacity.
- Primary care has the potential to prevent and reduce downstream costs
  - Needs to reform capabilities, capacity, and financing.
- Primary care is not prepared to support the overwhelmed behavioral health system. Primary care should offer:
  - Prevention
  - Early intervention
  - Coordination with behavioral health specialists
  - Chronic condition management post-stabilization

Why a focus on primary care?



- Ample evidence that investment and access to primary care can produce:
  - Higher quality
  - Higher patient satisfaction
  - Lower costs
    - Fewer hospitalizations
    - Fewer emergency department visits
    - Improved health
  - More equitable care

This is an investment in the communities we live in, our friends, our families, and those for whom we are responsible.

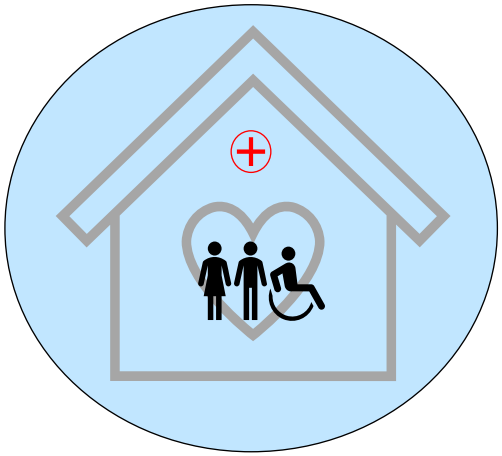
Transforming Primary Care in WA

- **WA Health Care Cost Transparency Board** is working on defining, measuring, and monitoring progress toward a **primary care expenditure target**
- **WA Health Care Authority** is leveraging efforts as a purchaser through supporting:
  - Accountable Communities of Health (ACHs) - health equity, behavioral health, care coordination, and SDOH
  - Value -based payment models - Medicaid and Employee Retirement Board
  - Improved behavioral health Integration through the WA Integrated Care Assessment
- **Multi-payer/Sector Primary Care Model Implementation**
  - WA Multi -payer Collaborative (MPC) created the *Primary Care Transformation Model* (PCTM) to standardize expectations for primary care delivery and collaborate on supports and payment policies to support providers
  - Federal CMS Innovation Center's *Make Care Primary* Model (forthcoming) seeks to bring Medicare collaboration and payment into multi-payer primary care efforts such as the PCTM

How Do Washington's Primary Care Transformation Model Fit In?

PCTM

- Aligned Metrics
- Provider Supports
- Provider Accountabilities and Certification
- Payment Models



- Patient education
- Insurance Coverage
- EHR investments
- Workforce Development
- Primary Care Spend Target
- Behavioral Health Integration

The PCTM is a collection of strategies that, in tandem with other strategies, creates an environment where primary care can succeed.

How does the Primary Care Transformation Model (PCTM) fit in?

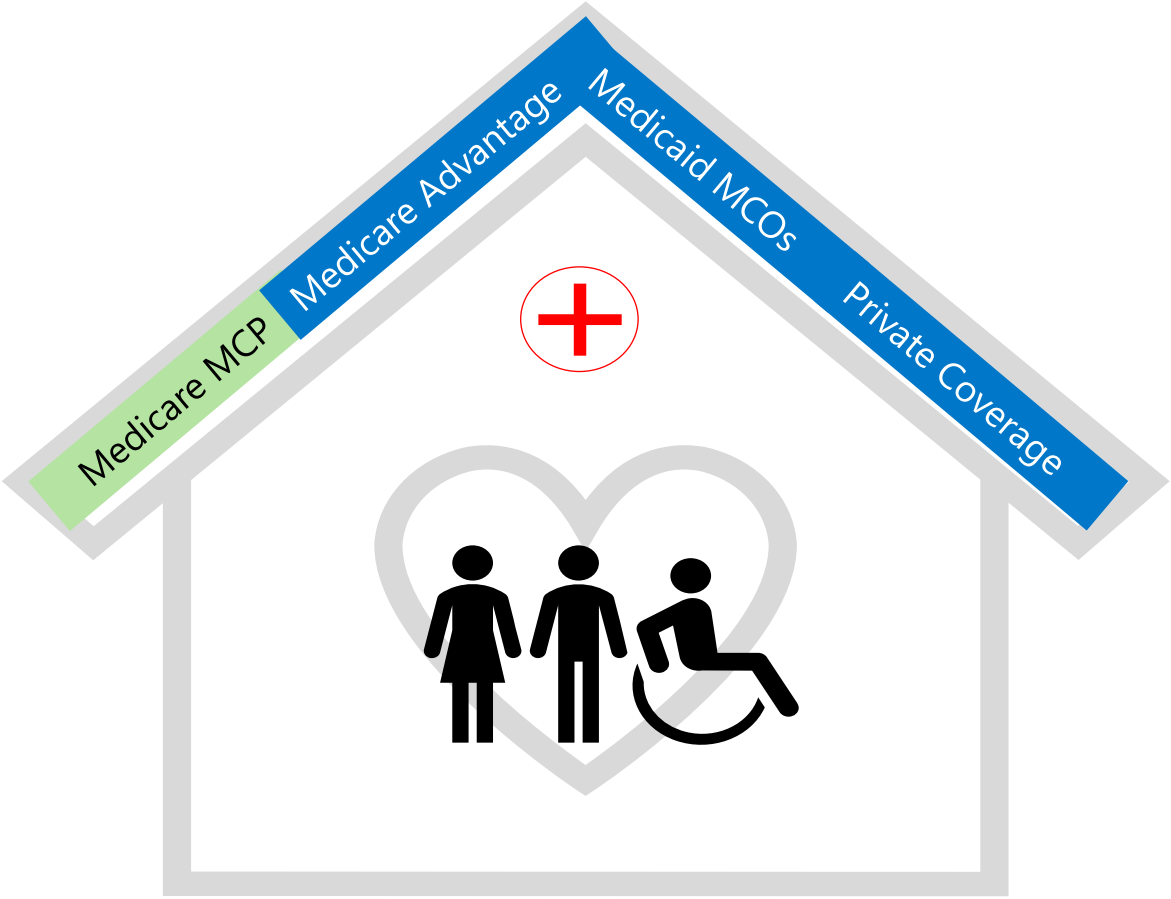
- PCTM is a collection of strategies that, in tandem with other strategies, create an environment where primary care can succeed.
- Primary Care Transformation Model
  - Aligned metrics
  - Provider supports
  - Provider accountabilities and certifications
  - Payment models

Primary care spend target	Behavioral health integration	Patient education	Insurance coverage	Workforce development	EHR investments

Merging of WA's and Medicare's Efforts

The WA PCTM is the State initiative to align primary care efforts across all coverage sources

The Medicare Making Care Primary initiative brings Medicare fee-for-service funding and additional alignment to Washington's efforts



Washington State Health Care Authority

Making Care Primary (MCP) Summary

Goals

- 10.5 years
- Cost neutral
- Improve quality
- Sustainable transformation
- Pathway for more practices to enter in value-based care arrangements

Care teams

- Care management and coordination
- Specialty care integration
- Behavioral health integration
- Address health related social needs and equity

Flexible payment

- Progression to prospective payment
- Progression in accountability
- Specialty integration payments
- Reward quality outcomes

Benefits to Providers of Participation in MCP

CMS Innovation Center designed MCP with lessons learned from previous primary care models to build a supportive payment and care delivery structure to advance health equity. The following are national and state level supports for participants to achieve model goals.

On-Ramp to VBC

Resources for organizations new to VBC to build accountability over time

Key features:

- Upfront Infrastructure Payment
- Phased in shift from FFS to population-based payment over Tracks 1 and 2
- No downside adjustment based on performance, rewards are focused on key clinical outcomes first

Tools to Improve Care Coordination

Data to improve patient care integration and learning tools to drive care transformation

Key features:

- Specialty care performance data sharing, prioritizing cardiology, orthopedics, and pulmonology
- New specialty integration payments to improve communication and collaboration
- Connection to health information exchange

Health Equity Advancement

Support to deliver coordinated, high-quality health care to diverse populations

Key features:

- Process for identifying and addressing health disparities in the populations that practices serve
- Increased payment for patients that require more intensive services to meet health goals.
- Focus on screening and referrals to address Health Related Social Needs (HRSNs)

Collaboration & Learning

National and state level supports for participants to achieve model goals

Key features:

- Payers partnering to support participants needs for success, including technical assistance, data, and peer-to-peer learning
- Access to independent practice facilitation and coaching, especially for small and safety net organizations who request it

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Eligibility to participate in Medicare FFS demo

Organizations that provide primary care services to patients may be eligible to apply to MCP. Due to MCP's payment and quality reporting design, certain organizations are not eligible to participate in MCP.

Organizations eligible for MCP

- Independent or solo primary care practices
- Group practices
- Federally Qualified Health Centers (FQHCs)
- Health systems
- Indian health programs
- Certain CAHs
- Organizations operating in the listed MCP states
- Organizations with at least 125 attributed Medicare FFS beneficiaries

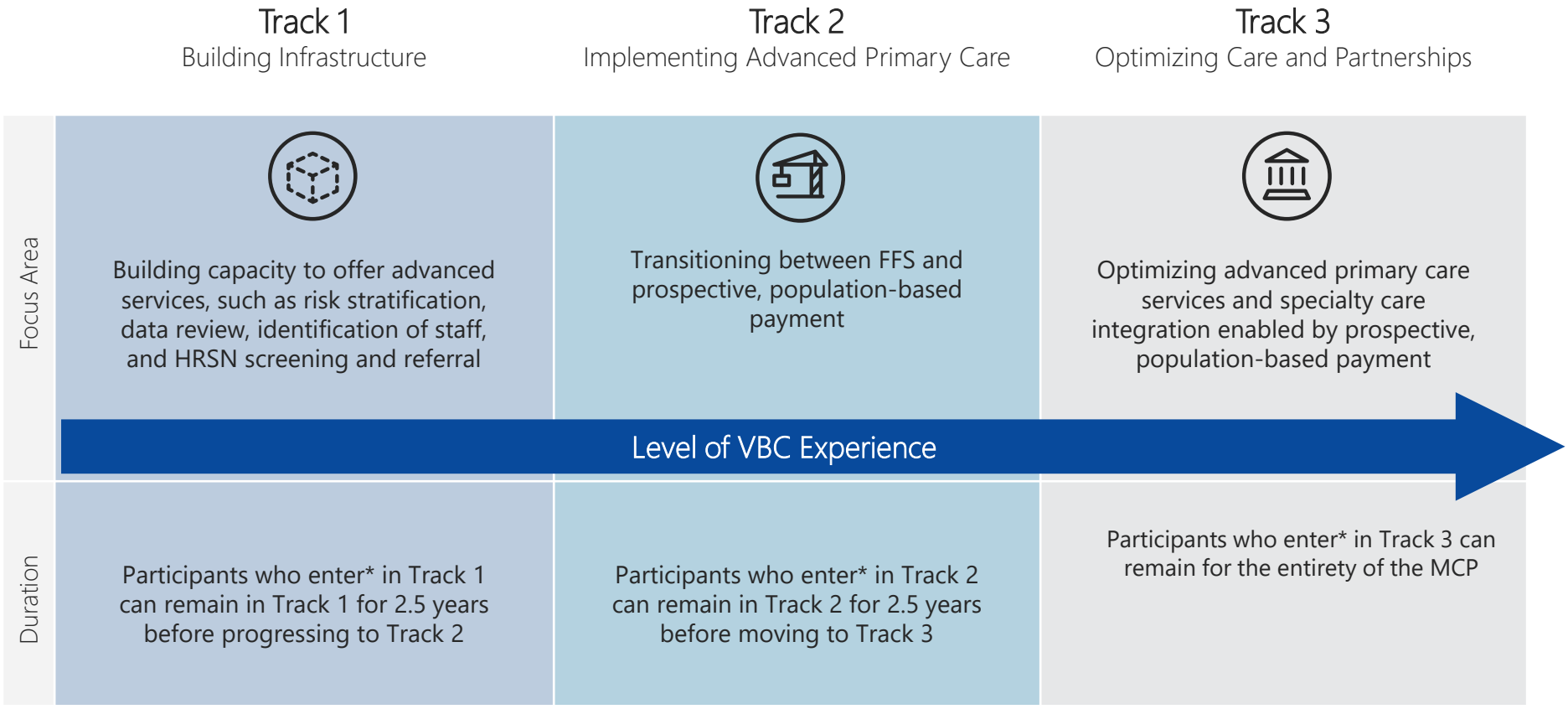
Organizations not eligible for MCP

- Rural health clinics
- Concierge practices
- Grandfathered Tribal FQHCs
- Primary Care First (PCF) practices and ACO REACH Participant Providers active as of 5/31/23
- Organizations not operating in the listed MCP states
- In general, organizations enrolled in CMMI models (such as MSSP and ACO REACH) will not be allowed to simultaneously participate in MCP, with the exception of bundled payment models

Other payers can adopt model with pediatric practices, RHCs, etc.

Participation Track Options Overview

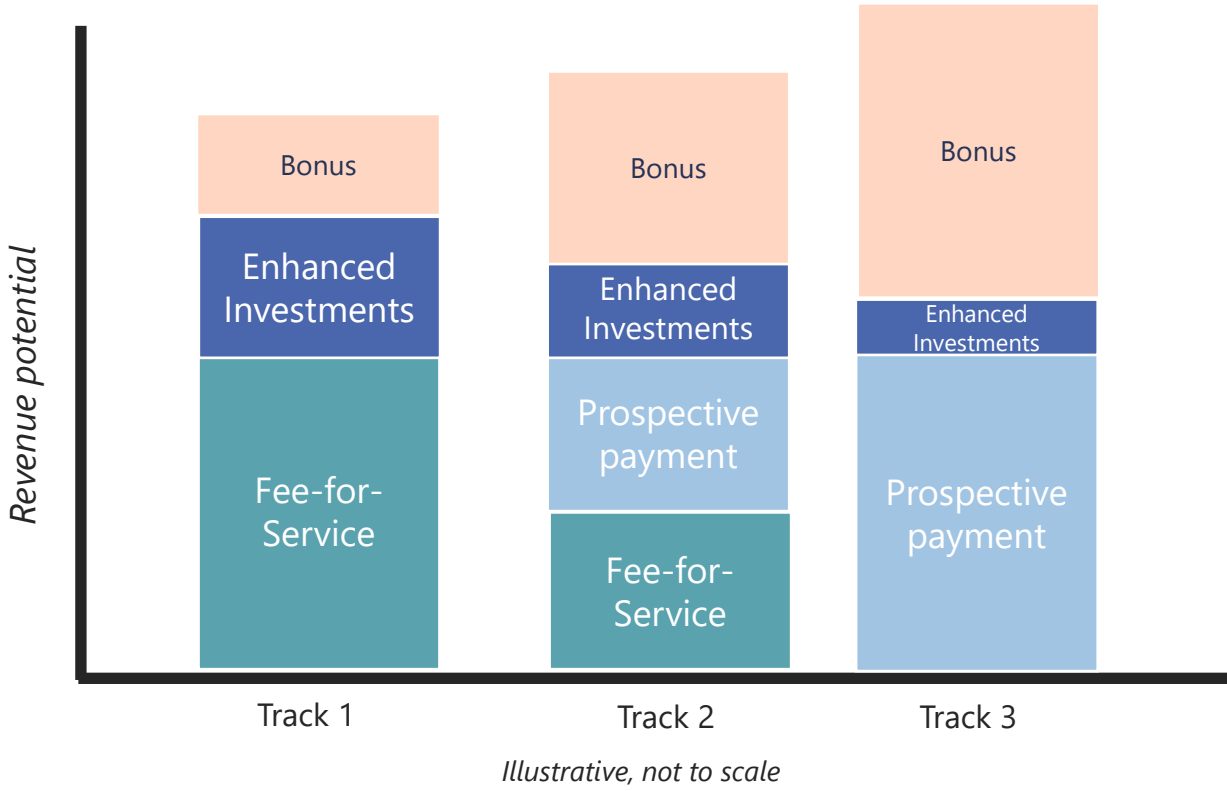
MCP includes three tracks that health care organizations can select from when applying to the model. An organization's prior experience with VBC will determine their eligibility for individual tracks. The tracks provide opportunities for organizations with differing levels of care delivery and value-based payment experience to enter the model at a point that matches their capabilities at the start.



**Organizations that start in Track 1, 2, or 3 will have an additional 6 months (or half of a year) in that track, given the mid-year start date for the model. A participant's length of time in a track depends on which track they started in.*

Payment Approach

- **Prospective Primary Care Payment** (PPCP) **increases** over time, while Fee-for-Service *decreases*, to support the interprofessional team.
- **Enhanced Services Payments** (ESP) ***decrease*** over time as practices become more advanced, and potential for payments tied to quality performance increases.
- **Performance Incentive Payment** (PIP) *potential* greatly **increases** over time to make up for decreases in guaranteed payments.



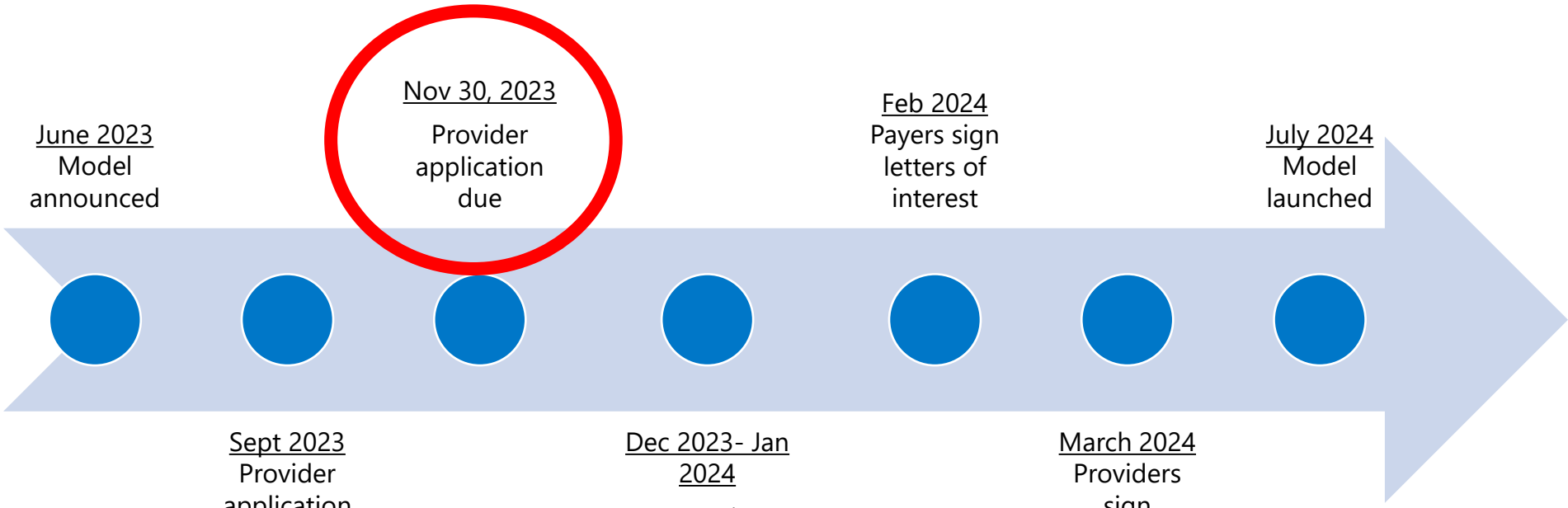
Performance Measures

Mirroring CMS's broader quality measurement strategy, measures for Medicare were selected to be actionable, clinically meaningful, and aligned with other CMS quality programs, including the Universal Foundation Measure Set *(as indicated below with an asterisk "*")*, Quality Payment Program (QPP) and other existing measure sets. **Payer Partners may adapt measure set below to target their population health needs.**

Focus	Measure	Mode	Track		
			1	2	3
Chronic Conditions	Controlling High Blood Pressure*	eCQM	X	X	X
	Diabetes Hba1C Poor Control (>9%)*	eCQM	X	X	X
Wellness and Prevention	Colorectal Cancer Screening*	eCQM	X	X	X
Person-Centered Care	Person-Centered Primary Care Measure (PCPCM)	Survey	X	X	X
Behavioral Health	Screening for Depression with Follow Up Plan*	eCQM		X	X
	Depression Remission at 12 months	eCQM		X	X
Equity	Screening for Social Drivers of Health*+	TBD		X	X
Cost/ Utilization	Total Per Capita Cost (TPCC)	Claims		X	X
	Emergency Department Utilization (EDU)	Claims		X	X
	TPCC Continuous Improvement (CI) *(Non-Health Centers and Non-Indian Health Programs)*	Claims		X	X
	EDU CI *(Health Centers and IHPs only)*	Claims		X	X

+Screening for Social Drivers of Health (Quality ID#487) is a new, evolving measure focused on assessing the percent of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The measure specifications are currently under development and CMS will work with participants to ensure they have the appropriate health IT infrastructure information to successfully report this measure.

Making Care Primary Timeline



Request for application from providers: https://innovation.cms.gov/media/document/mcp-rfa

Washington State Health Care Authority

HCA participation in Making Care Primary

- Traditional (original or FFS) Medicare is testing this model in Washington.
- HCA is interested in aligning with the Medicare model principles
  - Comparable to the PCTM and primary care case management (PCCM) efforts with Medicare at the table
  - Make the investments worthwhile for practices
- HCA does not yet have funding or legislative direction to require participation in its PEBB/SEBB or Medicaid populations.
- Our contracted carriers could choose to launch this model anytime.

Opportunity with CMMI's Making Care Primary

- Making Care Primary closely aligns with Washington's Primary Care Transformation Model
  - Expectations of provider and payer capabilities
  - Advancing care teams
  - Transitioning to risk-based prospective payments
- Brings federal oversight and buy-in to primary care transformation
- Aligned payment model with traditional Medicare on board can attract providers that have been hesitant to participate

Myths vs. Facts

Myth 1: You must sign up through HCA

- For Medicare you must sign up by November 30 through CMS
- innovation.cms.gov/innovation-models/making-care-primary

Myth 2: MCP is only for Medicare FFS

- The application is due November 30 for Medicare
- Application for other payers and Medicaid will come later
- If you sign up for Medicare you will be automatically shared with commercial and Medicaid payers

Myth 3: There is nothing in here for kids

- Not for this Medicare deadline
- But coming soon! Stay engaged.

Myth 4: I can sign up later

- For Medicare, this is a ONE-TIME entry
- For commercial and Medicaid, there will be more opportunities

Myth 5: There is nothing that will impact my patients

- Specialist primary care interaction
- SDOH screening
- Increased primary care resources

Practice Viewpoints

What is the Washington Multi-payer Collaborative (MPC)?

- MPC is a group of Washington payers working to build collective approaches to support patients and providers to yield greater results than independent action
  - Focus on transformation of primary care delivery and payment
- Current MPC focus is primary care, recognizing:
  - The importance of primary care to improve outcomes
  - Opportunity to improve access to high-quality comprehensive primary care

Washington Multi-payer Collaborative Members

- Amerigroup
- Community Health Plan of Washington
- Coordinated Care
- Kaiser Permanente
- Molina Healthcare
- PacificSource
- Premera
- Regence
- UnitedHealthcare
- Washington State Health Care Authority

Payer Viewpoints

More information and resources

CMS

Visit

https://innovation.cms.gov/innovation-models/making-care-primary

Help Desk

MCP@cms.hhs.gov

HCA

Visit

https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/multi-payer-primary-care-transformation-model

Help Desk

HCAPCTM@hca.wa.gov

Washington State Health Care Authority

Discussion and Questions

Contact

Dr. Judy Zerzan-Thul
HCA Medical Director
judy.zerzan@hca.wa.gov

Washington State Health Care Authority

Appendices

Washington State Health Care Authority

MCP Payment Types

MCP will introduce six payment types to support MCP participants as they work to reach their patient care goals.

Prospective Primary Care Payment (PPCP)

Track 1 | **Track 2** | **Track 3**

Quarterly per-beneficiary-per-month (PBPM) payment (calculated based on historical billing) to support a gradual progression from FFS payment to a population-based payment structure

Enhanced Services Payment (ESP)

Track 1 | **Track 2** | **Track 3**

Non-visit-based per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's level of clinical (CM-HCC) and social (ADI) risk to provide proportionally more resources to organizations that serve high-needs patients.

Performance Incentive Payment (PIP)

Track 1 | **Track 2** | **Track 3**

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures. Structured to maximize revenue stability (half of estimated PIP will be paid in the first quarter of performance year).

Upfront Infrastructure Payment (UIP)

Track 1 | Track 2 | Track 3

One-time payment for select Track 1 participants to support organizations with fewer resources to invest in staffing, SDOH strategies, and HIT infrastructure.

MCP E-Consult (MEC)

Track 1 | **Track 2** | **Track 3**

Ambulatory Co-Management (ACM)

Track 1 | Track 2 | **Track 3**

Payments to support specialty integration strategy to support communication and collaboration for longitudinal primary care and short-term specialized care for chronic conditions. MEC code billable by MCP primary care clinicals, while ACM is billable by specialty care partners.

Upfront Infrastructure Payment (UIP)

Start-up funding to support smaller organizations with fewer resources participate in and be successful in MCP through investments in infrastructure to support MCP's transformational goals as they take on the Model's care delivery and health IT capabilities. Optional payment only available to eligible Track 1 participants.

Eligibility: "Low-revenue" Track 1 participants and Track 1 applicants without an e-consult platform
("Low revenue" criteria will be specified in the Request for Applications)

Timing: Initial $72,500 distributed as a lump sum at the start of model; second payment of $72,500 distributed as a lump sum one year later

Amount: $145,000 per eligible Track 1 participant

MCP participants will submit a spend plan with anticipated spending prior to receiving the UIP, and report on how the UIP funds were spent

Reconciliation: Any unspent or misused UIPs must be repaid to CMS at the end of the participant's 30-month Track 1 participation period and can be recouped if the participant withdraws or CMS terminates its participation in the model prior to entering Track 3

Examples of Permitted Uses

- ***Increased staffing*** such as hiring nurse care managers to implement SDOH screening, behavioral health clinicians to integrate behavioral health treatment into primary care setting; or encouraging partnerships with healthcare systems and local CBOs to connect individuals with culturally and linguistically tailored, accessible health care services and supports
- ***SDOH strategies*** such as partnering with CBOs to address SDOH needs; providing patient caregiver supports; or implementing systems to provide and track patient referrals to community-based social services that assess and address social needs, as well as enable coordination and measurement of health and social care across communities where beneficiaries reside
- ***Health care clinician infrastructure*** such as investing in CEHRT system enhancements and upgrades; expanding HIT systems to include patient portals, telehealth systems for video visits, and/or e-consult technology; or developing infrastructure that would enhance sociodemographic data collection

Enhanced Services Payment (ESP)

Quarterly per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's risk level to provide proportionally more resources to organizations that serve high-needs patients, as they develop capabilities and provide enhanced services. Designed to support care management, patient navigation, connection to behavioral health, and other enhanced care coordination services, according to specific needs of patient population.

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Prospective quarterly payment

Potential Amount: Track-based amount based on participant's MCP attributed population and adjusted for social and clinical risk factors, including CMS Hierarchical Condition (HCC), Low Income Subsidy (LIS), and Area Deprivation Index (ADI). *Estimated average* ESP PBPM amounts will be $15 in Track 1, $10 in Track 2, and $8 in Track 3.

See *Calculation Details* for more information on how CMS will determine ESP payment amounts.

Calculation Details

The decision tree below describes the steps CMS will use to determine ESP payment for each MCP patient:

Enrolled in Low-Income Subsidy?	
No	**Yes**
Amount varies based on patient's HCC and ADI-designated risk tier (see table below)	$25

CMS-HCC Clinical Risk Tier (Risk Score Percentile)	ADI Social Risk Tier (ADI Percentile)	Track 1	Track 2	Track 3
Tier 1 (< 25th)	NA±	$9	$4	$2
Tier 2 (25th – 49th)	NA±	$11	$5	$2.50
Tier 3 (50th – 74th)	NA±	$14	$7	$3.50
Tier 4 (≥75th)	Tier 1, Tier 2, or Tier 3 (< 75th)	$18	$8	$4
	Tier 4 (≥75th)	$25		

Notes: 1) MCP payments are for Medicare FFS beneficiaries attributed to the MCP and will be subject to geographic adjustments.
2) ± Listed as NA, or Not Applicable, because payment for patients in HCC tiers 1 to 3 is only based on LIS or HCC.

Prospective Primary Care Payment (PPCP)

Quarterly per-beneficiary-per-month (PBPM) payment that is calculated for each participant's patient population and is designed to support a gradual progression from fee-for-service (FFS) payment for primary care services* to a population-based payment structure. These payments are designed to allow practices to deliver enhanced, comprehensive services without the incentive to increase volume of patients or services to achieve a favorable financial outcome.

Eligibility: Participants in Tracks 2 and 3

Timing: Prospective quarterly payment

Potential Amount: For the first two PYs, the amount is based on each participant's historical billing data for its attributed Medicare beneficiaries over a two year period and will be updated annually; CMS will introduce a regional component to the payment methodology by PY3.

Reconciliation: Amount is partially reconciled against actual claims expenditures based on portion of primary care services sought by beneficiaries outside the participant organization. See *Calculation Details* for more information on how CMS will determine PPCP amounts.

Calculation Details

The type of payment for primary care services will vary based on an organization's MCP Track.

Payment Type for Primary Care Services	Track 1	Track 2	Track 3
Prospective Primary Care Payment (PPCP)	0%	50%	100%
Fee-for-Service (FFS)	100%	50%	0%

Data sources for billing calculation differs by organization type:

- **FQHCs:** PPCP based on services billed under the Medicare FQHC Prospective Payment System (PPS)
- **Non-FQHCs:** PPCP based on services billed under the Physician Fee Schedule (PFS)

**The primary care services included in or affected by the PPCP will be shared in the MCP Request for Applications (RFA) that will be released in August 2023.*

Performance Incentive Payment (PIP)

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Half of estimated PIP will be paid in the first quarter of each performance year and second half will be paid in the third quarter of the following performance year

Potential Amount: Track-based percentage adjustment to the sum of payments for primary care services (FFS and/or PPCP)

Risk: Upside only; paid up-front and reconciled based on performance

See *Calculation Details* for more information on how CMS will determine PIP.

Calculation Details

Track 1	Track 2	Track 3
Potential to receive upside-only PIP of up to **3%** sum of fee-for-service (FFS)	Potential to receive upside-only PIP of **up to 45%** sum of FFS and prospective primary care payments (PPCP)	Potential to receive upside-only PIP of **up to 60%** sum of prospective primary care payments (PPCP)

- MCP participants must report all required quality measures and achieve the national 30th percentile on TPCC to *qualify* for any PIP
- Quality measures will have varying degree of impact on the PIP calculation based on the participant's track*
- Full credit for a measure for exceeding upper benchmark (70th percentile in Tracks 1 and 2, 80th percentile in Track 3). Half credit for exceeding lower benchmark (50th percentile)
- Participants in Tracks 2 and 3 will have the opportunity to receive additional PIPs for continuous improvement (CI) in utilization/cost

**More information on how MCP's quality measures will impact the PIP calculation, refer to the MCP Request for Applications (RFA) that will be released in August 2023.*

Specialty Care Integration Strategy

MCP provides participants with payment mechanisms, as well as data, learning tools, and peer-to-peer learning opportunities to support the Specialty Integration Care Delivery requirements, focused on coordination and improving patient care.

Payment: Once MCP participants enter Tracks 2 and 3, they are expected to implement e-consults as part of their care delivery requirements.

Data: CMS will provide participants with performance data on specialists in their region, prioritizing measures related to cardiology, pulmonology, and orthopedics.

Learning Tools: CMS will partner with stakeholders, state Medicaid programs, and other payer partners to connect MCP participants with each other, specialty practices, and CBOs.

Peer-to-Peer Learning: CMS will provide a collaboration platform and other forums to help participants learn from each other.

Payment Details

MCP will feature two payment types to encourage specialty care integration and support participants as they take on care delivery requirements:

	MCP eConsult (MEC) Code *Billable by MCP Primary Care Clinicians*	**Ambulatory Co-Management (ACM) Code** *Billable by Specialty Care Partners*
Goal	Address current barriers to eConsult billing, including its inclusion of post-service time to implement the specialist's recommendation	Support ongoing communication and collaboration of shared MCP patients who require both longitudinal primary care and also short-term specialized care to stabilize an exacerbated chronic condition
Eligibility	Participants in Tracks 2 and 3 *(These codes are absorbed into the capitated prospective primary care payments (PPCPs) in Track 3).*	Rostered Specialty Care Partner clinicians *(whose TIN has a Collaborative Care Arrangement (CCA) in place with an MCP Participant)*
Potential Amount	$40 per service (subject to geographic adjustment)*	$50 per month (subject to geographic adjustment)*

**To account for regional cost differences, MCP will apply a geographic adjustment factor (GAF) to the MEC and ACM.*