Centers for Medicare & Medicaid Services
Physicians, Nurses and Allied Health Professionals Open Door Forum
Moderator: Jill Darling
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2:00 pm ET

Coordinator: Good afternoon and thank you all for holding. Your lines have been placed on a listen-only mode until the question-and-answer portion. And I would like to remind all parties the call is now being recorded. If you have any objections, please disconnect at this time. And I would now like to turn the call over to Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you, (Elam). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications and welcome to today's Physicians and Nurses and Allied Health Professionals Open Door Forum.

Before we get into the agenda today, I have one brief announcement. This open door forum is open to everyone. But if you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries, please contact CMS at press@cms.hhs.gov.

And as always, we thank you for your patience in waiting to get into the call. We know you all have busy schedules, but we always appreciate it. Thank you so much.

And we will get into our agenda right now. We have Amy Hammond who will talk about open payments, prepublication review and dispute reminder.

Amy Hammond: Thank you, Jill, and thank you, everyone, for having me on the call today. If you've been on this call before, you've probably heard of open payments a

time or two. But in case if you're new, I'll give a brief definition of what our program is.

The definition that we like to run with and you will see on our Web site is that open payments is a national disclosure program that promotes a transparent and accountable health care system by making the financial relationship between drug and medical device companies, which we call reporting entities, and health care providers, which we refer to as covered recipients, available to the public.

Through the open payments data, health care consumers have insight into the provider industry relationship. Each year the reporting entities collect data regarding payments or transfers of value that they have made to covered recipients.

In the following calendar year, the reporting entities must submit this information to CMS for publication. Covered recipients do have a chance to review this data within the open payment system before it is published.

And that is what brings me on this call today because we are actually in the review and dispute period now.

So the reporting entities completed submitting their program year 2020 data on Wednesday, March 31, 2021, and their prepublication review and dispute period opened on April 1.

It is currently available for physicians and teaching hospitals to review their attributed data before we do the data publication which will take place on or by June 30 of this year.

The review and dispute period for covered recipients is a 45 day period where covered recipients may review the data again before it is published.

During this period covered recipients or their authorized representatives may go into the open payment system and review, affirm and if necessary initiate disputes on records that they believe to be incomplete or inaccurate in any way.

I would also like to note that CMS does not mediate the dispute. So for any initiated dispute, the covered recipients are expected to work directly with the reporting entity to reach dispute resolution.

The prepublication review and dispute period will close on May 15. Any disputes that are initiated after the May 15 deadline will be reflected in a later data refresh.

Disputes that are initiated by May 15 will be reflected in the upcoming publication this June.

Also covered recipient review of the data is voluntary, but we do strongly encourage it since it does ensure that the data is reported accurately.

In order to participate in the review and dispute process, covered recipients do need to be registered in the CMS Enterprise Identity Management System. And they also need to have access to the open payment system.

So if you have not previously registered and would like to have access, you may visit the open payments Web site. We have some tutorials on there explaining how to register in the IBM system and gain access to the open payment system as well.

If you have previously registered in the open payment system, you don't have to re-register, but you should make sure that you have current access to your account.

If you haven't accessed your account in 180 days or more, your account is in a deactivated status and in order to re-activate it you will need to call the open payments help desk.

And, of course, if you have any questions about the program or how to participate in review and dispute activities, you can visit our Web site. We have a number of resources that will walk you through the registration process, what the program is all about.

Also we recently released a video that gives an overview of the program so if you're new to the program you can watch that and get a really great understanding of the timeline and what the data actually means and everything that's included in it.

And finally I would like to provide some help desk contact information in case if you need that. You can call the help desk directly at 1-855-326-8366 or you may email the help desk at openpayments@cms.hhs.gov.

Our help desk is currently offering extended hours since we are in our peak program time. So they are currently open 8:30 am until 7:30 pm Eastern Standard Time.

And those are all of my open payment updates and reminders for today. At this time, I will turn the call over to our next presenter, Nicholas, and I will answer any questions at a later time in this call. Thank you.

Nicholas Minter: Thank you very much. My name is Nicholas Minter. And I'm the Director of the Division of Advanced Primary Care at the CMS Innovation Center.

And I give that introduction by way of saying that the CMS Innovation Center, our mission is to test new ways to deliver health care in an effort to improve quality and reduce costs compared to the fee for service or existing models of care.

And I say that because I have the opportunity today to talk about one of our health care models that we are currently recruiting new participants for and that model is called Primary Care First.

So what I would like to do today is talk a little bit about the model, what our goals are, the differences that we are testing as part of the model and give an overview of our timeline for accepting new applicants and then, of course, stand open for questions and give answers that may stem from that introduction.

So I wanted to start by saying Primary Care First is a primary care practice focused model that tests pushing our primary care practices in Medicare in specific regions, which we'll go over in just a moment, to receive payment in a different primarily capitated manner and to sort of focus less on fee for service revenue, the hope being that by doing that primary care practices will be able to target their care to those patients that need it, focus on patient centered care and less on the revenue cycle associated with fee for service.

Upon hitting certain quality goals, they will also be able show greater value by reducing hospital utilization and showing - I should say, improved quality

outcomes in blood pressure control and diabetes, HbA1C control and as a result be rewarded by making significantly more revenue over fee for service.

We'll get into some of those details in just a moment. But that's the high line of what we're testing with the Primary Care First model.

The Primary Care First model which began in 2021 and currently has 850 participants is really built upon the foundation of the model that we began testing five years ago, the Conference of Primary Care Plus model.

And that model sought to provide practices with additional learning, payment and data resources in an effort to transform the primary care that they were providing in fee for service and drive improvements in quality and cost along many of the same lines that I just described in Primary Care First.

We have learned several lessons from that model, which is in its fifth year and will sunset soon. And have applied those to Primary Care First to design a model that rewards outcomes but also increases transparency in terms of how primary care practices are paid and enhances care for high need populations while also encouraging practices to take a robust step away from fee for service and into a value-based care environment.

So as I said, Primary Care First originally began in 2021. It currently has 850 practices in it. I'm talking to you today because we are also soliciting new practices to begin on January 1, 2022. And those practices also include participants in our current Comprehensive Primary Care Plus model.

As I said, the Primary Care First goals are to reduce Medicare spending, specifically by preventing avoidable inpatient hospital admissions and to

improve quality of care and access to care for all patients, specifically those with complex chronic conditions, although I should there's an emphasis on.

Some specific stats about the model. It is a five year advanced alternative payment model. It focuses on providing greater flexibility of care.

Compared to Comprehensive Primary Care Plus, we are being less prescriptive and requiring less reporting so that providers are able to focus on providing more personal, more targeted care to their population and drive outcomes as a result.

We are trying to provide payment options that are stratified by the acuity of health of a patient's population.

And we are also testing this in a multi-payer format, which is to say that we are working with other payers across, you know, additional lines of business, to align our payment strategies, our quality strategies and the data that we provide to our participants in the Primary Care First model so that practices are able to transform their care with a streamlined set of incentives as opposed to needing, you know, to track differing incentives and sometimes countervailing motivations across lines of business.

Primary Care First is being offered in 26 states. And as I said, we have a second cohort that is open to both CPC Plus practices as well as new practices that have not been in a prior primary care model run by the Innovation Center.

It's being offered in 26 states and regions. Eighteen of those states are carryovers, if you will, from the CPC Plus model. So if you're familiar with that model, then you will know that those regions are carrying over into Primary Care First. And we are also eight additional regions, California,

Alaska, Florida, Virginia, Delaware, Massachusetts, New Hampshire and Maine.

And I will note a lot of the statistics that I'm giving, there is a Web site, I believe, in the agenda that will take you to the Primary Care First Web site. And there is a request for applications on that site that includes this map as well as a lot of additional information that I am covering pretty quickly today to make sure I can get in all the information.

But if you're interested in what those 26 states and regions are and are less familiar with CPC Plus, then please go look at that map. It will be incredibly informative.

So a little bit more about who we are looking to test this model with as participants. This model is targeted at primary care practitioners. That includes physicians, certified nursing assistants, nurse practitioners, PAs, (unintelligible) and CNAs.

Practices that join the model must have a minimum of 125 Medicare beneficiaries that visit them regularly.

They must be primary care practices both in terms of their practitioner designations but also the types of services they provide. And that's a measurement that we will make once folks apply to the model so it's not something you need to know beforehand.

They have to have demonstrated experience with value-based payment arrangements. One feature of the model is that it has a limited downside but a much higher upside.

So we want to make sure that our participants are comfortable and experienced in value-based payment arrangements so that they are in a position to succeed if they join this model for testing over the next five years.

Participants also have to implement and have a health IT that meets that the current definition of CEHRT. And they have to answer a number of questions that validate that they do provide some advanced primary care delivery capabilities going into the model.

This is a model that is really focused on practices that are able and willing to accept limited downside risk for much higher rewards. And so we want to see those advanced primary care delivery capabilities upfront.

I want to speak a little bit about the payment model in Primary Care First. There are two main components.

One is what we call the total primary care payment. And these two components, one is a capitated payment that is essentially 60% of what fee for service pays to the average Medicare practice in our model now.

That population-based payment that I just mentioned is paid on a quarterly basis per member per month, which is to say that we will look at the number of Medicare members in your practice, pay a specific rate and then pay three months' worth of that payment at one time at the beginning of a quarter.

So you get that money upfront and then can stratify care based on those resources.

We will also pay a flat primary care visit fee based on claims that come in, that is a reduced reimbursement compared to the normal fee for service.

Because we're paying around 66% or so of the revenue upfront, we reduced the flat primary care visit fee to a flat amount so that there's less concern about billing and the specifics thereof.

So for 2021, that amount is $40.82 before you add in geographic adjustments and coinsurance. So that's the total primary care payment.

And those two components - or sorry. Those two elements of the primary care payment are meant to be roughly equivalent to what a practice gets in fee for service.

We also add to that a performance-based adjustment, which is an opportunity for practices to increase their revenue by up to 50% of their total primary care payment based on excelling and performing above their peers on specific performance measures, most notably acute hospital utilization and/or total per capita cost depending on what risk group the practice is in.

So that adjustment can be negative 10% for practices that are in the bottom quartile of their peer practices across Medicare in their specific regions to which they are being compared or can be up to 50% more.

So there's an asymmetric pay out there that I think is intended to equal the net investment in primary care overall on behalf of CMS.

Just a few more details on the population-based payment in particular. We actually stratify the payment that we are making to practices based on a number of risk groups that we classify the practice into.

At the onset of the model and every year thereafter, we look at the average risk score of patients that are attributed to a model or I should say of patients that are attributed to a specific practice in the model.

And based on that stratification, we will then assign them a risk group and pay them a PBP that is correlated to the relative acuity of their patients.

So for instance if the average HCC of a practice in our model is less than 1.2, they would get $28 per member per month and that goes up in Group 2, 3 and all the way up to Group 4 where in Group 2 if you're in between 1.2 and 1.5 HCC, you would get paid $45 per member per month in between 1.2 and 2.0.

An average HCC, it goes up to $100. And for those practices that are caring for patients that on average have an HCC above 2, the payment tops out at $175 per member per month.

So we target higher reimbursement because we know that sicker patients need more care.

Moving on, I want to say a few more - I want to give a few more details on the performance-based payment adjustment. We determine whether or not a practice qualifies for the up to 50% additional payment based on a few steps.

First, we want to make sure that a practice is meeting some minimum quality standards and we call these standards the quality gateway. And you have to get through the quality gateway to earn a bonus.

We look at a set of five quality measures for most of our practices. And those measures include blood pressure control, HbA1C below 9.0 or I should say

above 9.0 is the actual measure, colorectal cancer screening, advanced care planning and a patient experience of care survey.

And if a practice exceeds the 30th percentile MIPS benchmark for all of those, then we look at their acute hospital utilization performance. And if they are in the top half of performance, then we will look at how they compare to their regional peers.

And depending on whether or not they are above the 50th percentile on the regional performance benchmark and how high they are, they will qualify for a plus 10% up to a 50% bonus as long as they are continuing to improve themselves.

One-third of the performance-based payment adjustment also requires them to perform better over time against themselves. But we also moderate that based on where they start so that higher performers aren't stuck topped out in terms of their own performance.

So it's a four step process. But in essence what we are saying is if you are willing to work hard and you're willing to perform, you know, above and beyond those that are not in the model, then you can make - you will get paid for the additional value that you are rendering to the health care continuum in a way that we believe fee for service may not currently accommodate for primary care.

So I want to sort of not give too many details because I know I said a lot already. I do want to share some of the timeline that we are looking at for our January 2022 cohort, which as I said, we are currently soliciting applications for.

As I mentioned, there's a lot of detail at the link that is included in the agenda, including the link to the request for applications and a link to the application portal for those practices that would amount to, you know, research further what it takes to join the model and begin to think about whether or not this model makes sense for where they are.

Practice applications are due to us to be submitted via the electronic portal linked on that Web site by May 21, 2021 and we are also talking to payers. And their application deadline isn't until mid-June at this point.

In the summer and fall we will look at the applications that have been submitted and do eligibility checks. And then we will let practices know that they are eligible and have been accepted.

And then in the fall and winter, practices and payers will sign their participation agreements and begin to onboard to the model to begin in January 2022.

Again I want to stress, if you have questions, please reach out either to me directly or to primarycareappl at telligen, T-E-L-L-I-G-E-N, dot com. They are helping us manage the many requests for additional information that is coming in. Or please go to that Web site in the agenda, look at the materials there and then reach out to the pertinent resources on that site, of which there are many.

So I want to thank you all very much for your time and I'll turn it back over to Jill.

Jill Darling: Great. Thank you Nicholas and thank you to Amy. (Elam), will you please open the lines for Q&A?

Coordinator: And at this time if you would like to ask a question, please press star 1. Please unmute your phone and record your name clearly when prompted. Once again, that is star 1 if you would like to ask a question.

And our first question is from (Ronald Hirsch).

(Ronald Hirsch): Hello, there. I'm wondering if we have a date yet when Secretary Becerra is going to sign an extension to the 1135 waivers that physicians are now using during the COVID pandemic? It's going to expire in a week and I think people are starting to get really nervous.

(Gift): Ron, thank you for that question. This is (Gift). I'm not sure that we have this information at the moment. But you can submit your question to our mailbox. And as we get more information, we'll certainly be sharing. But I don't know that any of us can answer that right now.

(Ronald Hirsch): Okay. I know you said earlier...

Jill Darling: This is Jill. I filed your question through the inbox already.

(Ronald Hirsch): Oh. You already pulled it out for attention. Thank you, Jill. I appreciate it.

Jill Darling: You called it. Yes.

(Ronald Hirsch): Okay. I'll watch. Thanks, guys.

Eugene Freund: And this is Gene Freund. We can definitely relay that there is extreme interest in when that comes out. We probably won't be able to give you a whole lot of

advanced information just because that's the way things can tend to work but we'll do our best.

(Ronald Hirsch): Certainly. Thank you all.

Coordinator: And once again, if you would like to ask a question, please press star 1. One moment please for the next question.

And I am showing no further questions at this time. Once again, that is star 1 if you would like to ask a question. And I am showing no further questions in the queue.

Jill Darling: All right, everyone. Well as always, we appreciate you joining the call. If you did have any feedback, questions, comments, you can email the email that Nicholas provided and it's also in the agenda and also to our partnership@cms.hhs.gov.

So we thank you. And if nothing else from (Gift) or from Gene, we can conclude today's call.

Eugene Freund: Thank you all very much.

Coordinator: Thank you. This does conclude today's conference. You may disconnect at this time.

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