Direct Contracting: Professional and Global Options

Benefit Enhancements and Patient Engagement Incentives

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Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services (CMS)

Today's Presenter

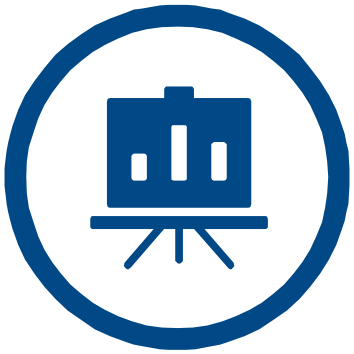
Sarah Wheat, Direct Contracting Model Benefit Enhancements Lead

Agenda

1. Background and Overview
2. Current Benefit Enhancements Tested Under the Innovation Center
3. Current Patient Engagement Incentives Tested Under the Innovation Center
4. Newly Proposed Benefit Enhancements for Performance Year One
5. Possible Future Benefit Enhancements and Patient Engagement Incentives

The benefit enhancements and patient engagement incentives described in this webinar are proposed and subject to change. CMS will release more information as it becomes available.

Audience Poll



Is your organization eligible to participate in the Direct Contracting model?

a) Yes
b) No
c) Unsure

Background and Overview

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Background of Direct Contracting

- Direct Contracting Model (Direct Contracting), together with the Primary Care First Model and the updated Medicare Shared Savings Program ENHANCED Track, are part of the CMS strategy to use the redesign of primary care to drive broader delivery system reform to improve health and reduce costs.
- The model builds off the Next Generation Accountable Care Organization (ACO) Model and innovations from Medicare Advantage and private sector risk sharing arrangements.

Model Goals and Approach

The information below represents Direct Contracting model goals and how CMS expects to achieve these goals.

Transform risk-sharing arrangements

- Flexible cash flows
- Predictable, prospective spending targets
- Payment that recognizes the challenges of caring for complex chronically ill populations

Empower and engage beneficiaries

- Enhanced voluntary alignment
- Various benefit enhancements and patient engagement incentives

Reduce provider burden

- Small set of core quality measures
- Waivers to facilitate care delivery
- Opportunities for organizations new to Medicare FFS to participate

Benefit Enhancement and Patient Engagement Incentives

CMS is seeking to emphasize high-value services and support the ability of DCEs to manage the care of beneficiaries through benefit enhancements and patient engagement incentives.

- DCEs may choose which, if any, of these benefit enhancements and patient engagement incentives to implement.
- Applicants must provide information regarding the implementation of selected benefit enhancements and patient engagement incentives in their applications.

Building on the Next Generation ACO Model

Direct Contracting proposes to offer the same benefit enhancements and patient engagement incentives available in the Next Generation ACO model as well as three newly proposed benefit enhancements.

Currently in Next Generation ACO Model

1. Telehealth Expansion Benefit Enhancement
2. Post-Discharge Home Visits Benefit Enhancement
3. Care Management Home Visits Benefit Enhancement
4. 3-Day SNF Rule Waiver Benefit Enhancement
5. Chronic Disease Management Reward
6. Cost Sharing Support for Part B Services

Newly Proposed for Performance Year 1 of Direct Contracting

1. Home Health Services Certified by Nurse Practitioners
2. Homebound Requirement Waiver for Home Health
3. Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit

Current Benefit Enhancements Tested Under the Innovation Center

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Benefit Enhancements

Benefit Enhancements are conditional waivers of certain Medicare payment rules. CMS uses the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements.

Goals of these benefit enhancements are to:

Emphasize high-value services

Support care management and closer care relationships

Allow DCE flexibility

Telehealth Expansion

Overview

- This waiver will:
  - Eliminate the rural geographic component of originating site requirements,
  - Allow the originating site to include a beneficiary's home, and
  - Permit the use of asynchronous telehealth services in the specialties of teledermatology and teleophthalmology provided that certain requirements are met.
- An aligned beneficiary will be eligible for the Telehealth Expansion Waiver if the beneficiary is located at their home or one of the CMS) defined telehealth originating sites.
- Asynchronous ("store and forward") telehealth ophthalmology and dermatology services includes transmission of recorded health history through a secure electronic communications system to a practitioner who uses the information to evaluate the case, or render a service outside of a real-time interaction.

Implementation

Waiver will apply to both new and existing beneficiaries aligned to a Direct Contracting Entity.

- Distant site practitioners will bill for these new services using Innovation Center specific asynchronous telehealth codes.
- Distant site practitioner must be a DC Participant Provider or Preferred Provider who has elected to use this benefit enhancement, and beneficiaries must be aligned to a DCE that has selected this benefit enhancement.

Post-Discharge Home Visits

Overview

- Physicians (or other practitioners)* can currently provide certain post-discharge services in patients' homes
  - This is not a home health (or homebound) service
- Under existing regulations, this service must be provided ***under direct physician supervision*** (i.e., physician/other practitioner is present at time service is provided to patient)
- Under the Post-Discharge Home Visits Benefit Enhancement, the service may be provided ***under general supervision***—physician (or other practitioner) may contract with auxiliary personnel to provide this service and the service is billed by the physician's (or other practitioner's) office
  - Provides flexibility during this critical time post-discharge for patients

Implementation

- Auxiliary personnel (as that term is defined under 42 CFR 410.26(a)(1)) under the *general* – instead of direct – supervision of a DC Participant Provider or Preferred Provider (i.e., physician or other practitioner) may furnish "incident to" services at an aligned beneficiary's home.
- Up to a total of nine post-discharge visits may be furnished within 90 days following discharge from an inpatient facility (e.g., hospital, CAH, SNF, IRF).
- DCEs are required to abide by their state's laws regarding the provision of incident to services.

**Note: When the post-discharge home visit waiver and physician are referred to together, we are also including "or other practitioner" as eligible to bill for services furnished "incident to" their own services per 42 C.F.R. § 410.26(b)(5)*

Care Management Home Visits

Overview

- **Care Management Home Visits** are home visits that can be provided by auxiliary personnel (as that term is defined under 42 CFR 410.26(a)(1)) under the general supervision of a DC Participant Provider or Preferred Provider who has initiated a care treatment plan for an aligned beneficiary.
- This benefit enhancement provides flexibility in billing for home visits provided to beneficiaries to prevent possible hospitalization
  - Eliminates requirement that these services be furnished under direct supervision.
- Beneficiaries who are eligible or currently in a home health episode are not eligible for Care Management Home Visits; it is not a home health service.

Implementation

- A beneficiary will be eligible to receive up to 12 Care Management Home Visits within a performance year.
- Care Management Home Visit services are considered to be “incident to” services currently allowable through Medicare.
  - DC Participant Providers and Preferred Providers should follow the Medicare documentation rules surrounding “incident to” services.

Care Management Home Visits: Beneficiary Eligibility

This benefit enhancement is available for aligned beneficiaries under the following circumstances:

1. Beneficiary is at risk of hospitalization;
2. Beneficiary does not qualify for Medicare coverage of home health services (unless living in a medically underserved area is the sole basis for qualification);
3. Services are furnished in home after DC Participant Provider or Preferred Provider has initiated a care treatment plan; and
4. Beneficiary is not receiving services under the Post-discharge Home Visits benefit enhancement.

3-Day SNF Rule Waiver: Overview

The 3-day SNF Rule Waiver conditionally waives the requirement of a 3-day inpatient stay prior to SNF (or swing-bed hospital) admission.

Beneficiaries must meet the clinical criteria for admission.

- E.g., beneficiary must be medically stable with confirmed diagnosis and identified skilled nursing or rehabilitation need.

SNF must have overall quality rating of three or more stars in 7 out of the past 12 months under the CMS 5-Star Quality Rating System.

- Star ratings are reviewed at the time the Proposed DC Participant Provider list or Preferred Provider list is submitted.

SNF must be listed on the Proposed DC Participant Provider list or Preferred Provider List with the SNF benefit enhancement indicated.

3-Day SNF Rule Waiver: Beneficiary Eligibility

1. Beneficiary is not residing in a SNF or long-term care facility at the time of SNF admission under this waiver.
   - For purposes of this waiver, independent living facilities and assisted living facilities shall not be deemed long term care facilities.
2. Beneficiary is medically stable and has confirmed diagnoses.
3. Beneficiary has skilled nursing or rehabilitation need identified by a physician or other practitioner that cannot be provided on an outpatient basis.

- **For direct admission**, beneficiary has an evaluation within 3 days prior to SNF admission by a physician or another practitioner licensed to perform the evaluation.
- **For direct admission**, the beneficiary does not require inpatient hospital evaluation or treatment.
- **For admission following fewer than 3 days of inpatient hospitalization**, beneficiary does not require further inpatient hospital evaluation or treatment.

Current Patient Engagement Incentives Tested Under the Innovation Center

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Chronic Disease Management Reward

This patient engagement incentive allows DCEs to provide gift cards (annual limit of $75) to eligible beneficiaries to incentivize participation in a chronic disease management program.

In order to participate, an eligible beneficiary must have a clinically diagnosed chronic disease targeted by a qualifying Chronic Disease Management Program in the DCE's Implementation Plan

A gift card may be provided under the Chronic Disease Management Reward Program benefit enhancement only if:

- Beneficiary was an eligible beneficiary at time enrolled in, or began participating in, the Chronic Disease Management Program.
- Beneficiary satisfied all criteria for obtaining gift card, as set forth in the DCE's Implementation Plan.
- Gift card is provided to the beneficiary directly by the DCE.
- Cost of the gift card is funded entirely by the DCE.
- Gift card is programmed to prevent the purchase of tobacco and/or alcohol products.

The gift card cannot be offered in the form of cash or monetary discounts or rebates, including reduced cost-sharing or reduced premiums and cannot be redeemable for cash.

Qualifying Chronic Disease Management Programs

A Chronic Disease Management Program is a program described in the DCE's Implementation Plan that focuses on promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources for individuals with the chronic diseases targeted by the program.

For example, a Chronic Disease Management Program may include:

- Utilizing particular services or preventive screening benefits
- Adhering to prescribed treatment regimens
- Attending education or self-care management lessons, and
- Meeting nutritional goals

A survey alone does not constitute a Chronic Disease Management Program.

Cost Sharing Support for Part B Services

This patient engagement incentive allows the DCE to enter into arrangements with DC Participant Providers and Preferred Providers under which the DC Participant Providers and Preferred Providers would reduce or eliminate beneficiary cost sharing amounts (in whole or in part) for categories of aligned beneficiaries and for categories of Part B services identified by the DCE.

- DCEs will make payments to those DC Participant Providers and Preferred Providers to cover some or all of the amount of beneficiary cost sharing not collected.
- The goal of offering this cost sharing support is to reduce financial barriers so that certain beneficiaries may obtain needed care and better comply with treatment plans, thereby improving their own health outcomes.

Cost Sharing Support for Part B Services (Continued)

Eligible Services may include any Part B service identified in the DCE's Implementation Plan, which must not include durable medical equipment or prescription drugs.

Eligible Beneficiaries may include, without limitation, one or more of the following:

- Aligned Beneficiaries without Medicare supplemental insurance (i.e., Medigap),
- Aligned Beneficiaries experiencing high health care costs, and/or
- Aligned Beneficiaries who require certain Part B services, the receipt of which could reduce the individual's overall health care costs.

The Cost Sharing Support must advance one or more of the following clinical goals:

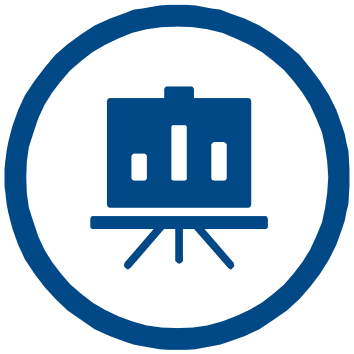
- Adherence to a treatment regime,
- Adherence to a drug regime,
- Adherence to a follow-up care plan, or
- Management of a chronic disease or condition.

Cost Sharing Arrangement

The DCE must have an agreement with each DC Participant Provider and Preferred Provider who has agreed to provide Cost Sharing Support for Part B Services and must specify the following:

- Categories of eligible beneficiaries and eligible services where they may provide Cost Sharing Support;
- Requirement that the DC Participant Provider or Preferred Provider provide Cost Sharing Support in accordance with the DCE's Implementation Plan; and
- Amount and frequency with which DCE will reimburse DC Participant Provider or Preferred Provider for the cost sharing amounts not collected.

Audience Poll



How likely are you to apply to participate in the Direct Contracting model?

a) Very likely
b) Likely
c) Unlikely
d) Very unlikely
e) Unsure

Newly Proposed Benefit Enhancements for Performance Year One

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Home Health Services Certified by Nurse Practitioners

Current Requirements

Under current Medicare rules, nurse practitioners can order home health services, but Medicare will not pay for those services unless a physician certifies a beneficiary's eligibility for the home health benefit.

As a result, **nurse practitioners must locate a physician to document the nurse practitioner's assessment,** even though the physician is not necessarily involved in the assessment.

For example, a beneficiary who lacks access to a primary care physician and is instead under the care of a nurse practitioner may first be admitted to a facility and placed under the care of a facility-based physician before home health services can be ordered.

Proposed Waiver

CMS would allow Nurse Practitioners that are DC Participant Providers or Preferred Providers to certify home health benefit eligibility for aligned beneficiaries.

- **Provides a streamlined approach** to certifying home health patients and avoiding duplicative work;
- **Reduces impediments** that hinder care coordination and transition of care for patients; and
- Is **consistent with CMS' aim** of allowing greater use of non-physician practitioners and supporting existing patient-provider relationships

Home Health Services Certified by Nurse Practitioners: Implementation

Under this waiver, DCEs may allow nurse practitioners to certify that aligned beneficiaries are eligible to receive the home health benefits in accordance with Section 1814(a)(2)(C) of the Act and 42 CFR §424.22(a)(1).

However, this waiver would only apply for DCEs in those states that allow nurse practitioners to order home health care for beneficiaries within their scope of practice.

Medicare would continue to assume costs for these home health services.

- This waiver would broaden the category of medical personnel that can certify home health care services for aligned beneficiaries.

Homebound Requirement Waiver for Home Health

Current Requirements

A beneficiary **must be confined to the home** ("homebound") as defined in § 1814(a) and § 1835(a) in order for Medicare to cover and pay for home health services.

This requirement can limit access to home health services, as it focuses on a beneficiary's mobility limitations rather than the underlying health conditions or comorbidities often present in this population.

Proposed Waiver

The proposed waiver of this rule would:

- Permit Medicare reimbursement of home health services for beneficiaries with **certain clinical risk factors that are not homebound.**
- Enhance patients' **ability to return to, remain in, and receive care in their home.**

Providing access to home health services is expected to reduce hospital readmissions, improve patient outcomes, and reduce costs for this population.

This additional flexibility also would aid DCEs in developing alternative payment arrangements with home health agencies, promoting innovation.

Homebound Requirement Waiver for Home Health: Eligibility

CMS proposes aligned beneficiaries would be eligible for this conditional waiver if they:

1. Otherwise qualify for home health services under 42 C.F.R. § 409.42 except that the beneficiary is not required to be confined to the home; and

2. Have a combination of clinical risks, which will be determined by CMS at a later date.

Beneficiaries that are receiving services under the post-discharge visits or care management home visits benefit enhancements would not be eligible to receive covered home health services under this benefit enhancement.

Homebound Requirement Waiver for Home Health: Implementation

DCEs would identify home health providers that are DC Participant Providers or Preferred Providers to provide these services to eligible aligned beneficiaries.

All other requirements regarding Medicare coverage and payment for home health services would continue to apply.

Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit

Current Requirements

Under current Medicare rules, when electing **hospice, beneficiaries must waive Medicare coverage for services that are considered curative** in favor of receiving services that are more palliative in nature.

However, studies have shown that offering both palliative and curative care in hospice can result in better pain and symptom management, care coordination, and shared decision making as well as timelier incorporation of patient-centered goals into the plan of care.

In addition, the stark decision required between curative and hospice care negatively impact a beneficiary's access and ease of transition to hospice.

Proposed Waiver

Under the proposed waiver of the requirements in Section 1812 and 42 CFR Section 418.24(d)(2), DCEs would work with hospice providers, as well as non-hospice providers, to define and provide a set of concurrent care services.

Services would be related to a hospice enrollee's terminal condition and associated conditions that align with the enrollee's wishes and are appropriate to provide on a transitional basis.

This waiver is expected to ease the transition of care and enhance beneficiary choice for beneficiaries, providing a tool for DCEs to improve the quality of care.

Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit: Requirements

This benefit enhancement would only be available to DCEs participating in the Global option of Direct Contracting. Additional information regarding the Global option can be found in the Direct Contracting Request for Application.

To be eligible, the concurrent care services that the DCE elects to make available must be specified in the beneficiary's plan of care and provided by designated DC Participant Providers or Preferred Providers.

- These expenditures would be included as part of the total cost of care for the relevant performance year for purposes of the Model financial calculations.

Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit: Implementation

Medicare would continue existing claims-based edits to prevent non-hospice claims from processing while a beneficiary is under hospice election, except with respect to those hospice and non-hospice organizations identified by the DCE.

The Medicare FFS claims submitted by these organizations will be paid by Medicare if they are otherwise appropriate for payment absent the restriction for paying claims for a beneficiary that has elected hospice.

Possible Future Benefit Enhancements and Patient Engagement Incentives

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Possible Future Benefit Enhancements and Patient Engagement Incentives

- Tiered Cost Sharing Reduction
- Alternative Sites of Care
- Cost-sharing Support for SNF Services
- Long-Term Care Hospital 25-day Length of Stay and Other Site of Care Restrictions

Model Timeline

Timeline	Implementation Period (IP) DCE Applicants	Performance Period (PY1) DCE Applicants
Application Period	November 25, 2019 – February 25, 2020 (Application tool available December 20, 2019 [tentative])	March 2020 – May 2020
DCE Selection	April 2020	September 2020
Deadline for applicants to sign and return Participant Agreement (PA)	Late April 2020 (Implementation Period PA) December 2020 (Performance Period PA)	December 2020
Initial Voluntary Alignment Outreach and start of IP or PY	May 2020	January 2021

This timeline may be subject to change. Please check the Directing Contracting webpage for webinar and office hour dates and times.

Questions

Upcoming Webinars

Webinar	Date
Application Overview	January 7, 2020
Office Hour Session for Questions and Answers - 2	January 8, 2020
Payment – Part 1 (Risk sharing, Risk Mitigation Cash Flow)	January 15, 2020
Payment – Part 2 (Risk Adjustment, Benchmarking, Quality)	January 22, 2020
Office Hour Session for Questions and Answers - 3	January 28, 2020
Office Hour Session for Questions and Answers - 4	February 11, 2020

**This timeline may be subject to change. Please check the Direct Contracting webpage for webinar and office hour dates and times.*

Contact Information

Direct Contracting Webpage

(includes link to application):
https://innovation.cms.gov/initiatives/direct-contracting-model-options/

Email:

DPC@cms.hhs.gov

Salesforce Support:

CMMIForceSupport@cms.hhs.gov