Michigan Commercial Multipayer

CPC+

Comprehensive Primary Care Plus

Michigan Multistakeholder CPC+ Briefing
May 2021

This briefing is authored by the Michigan Multipayer CPC+ Team (*and not by CMS*) and is made possible through support from our commercial payer partners, BCBSM and Priority Health as well as CMS to support CPC+ success in our state. To be added to the distribution list, email MichiganMultipayerCPCPlus@med.umich.edu with "Add Me to the MI CPC+ Newsletter Distribution" in the subject line. For additional multipayer information please visit https://cpcplusmichigan.org. To share your ideas and experiences, contact the CPC+ Michigan Convener, Diane Marriott (dbechel@umich.edu or 734 740 0511). Thank you!

Primary Care First (PCF) Practice Application Deadline of May 21st Nears

The Primary Care First (PCF) application deadline of **Friday May 21st for practices** is less than two weeks away! The PCF RFA provides details and answers to questions you might have. The application portal will be accepting submissions from **practices** until Friday May, 21st. The portal will accept applications from **payers** until June 18th.

Applications are non-binding and after you submit a complete application, you will receive a welcome packet that includes additional information about the program and a Participation Agreement, which outlines the terms of model participation. Practices would then have the opportunity to review, sign and return the Participation Agreement to finalize their participation in the PCF model.

The following resources are intended to be helpful in understanding the program and helping you to make decisions:

- Primary Care First Model Website
- Welcome to Primary Care First Webinar
- Intro to PCF Webinar
- Ready, Set, Apply Webinar

If you have any questions or need assistance completing your application, please contact PCF Support at 1-833-226-7278 or PrimaryCareApply@telligen.com.

Payers Want to Know How to Help - Please Complete this Short Survey Today!

As we plan for 2022, our payers want to know what you need to be successful and how we can help. Whether you are a provider, practice team member, physician organization representative, or have another role, your opinion is important. It only takes five minutes to complete the short survey web link **here**. The link will be open until **May 26, 2021.** Responses will then be aggregated and tabulated to inform 2022 strategy planning. Please take a moment today to give us your valuable input.

CMS Stops Accepting New Direct Contracting Application

CMS has announced that it will not be accepting new applications for the Global and Professional Direct Contracting (GPDC) Models slated to launch on January 1, 2022. Organizations that applied in the previous application cycles—either for the Implementation Period or PY2021—and deferred their start date to January 1, 2022 will be permitted to start

participating in the model as planned on January 1, 2022, as long as they continue to meet model requirements. However, organizations that were planning to submit new applications for 2022 will not be able to do so.

GPDC is sometimes described as the next iteration of CMS' NextGen ACO and similar models. Participants choose from two levels of risk:

- **Professional** offers the lower risk-sharing arrangement—50% savings/losses—and provides Primary Care Capitation, a capitated, risk-adjusted monthly payment for primary care services provided by DC Participant Providers and those Preferred Providers that have agreed to participate in capitation (by accepting FFS claims reductions and agreeing to receive compensation from the DCE).
- **Global** offers the highest risk sharing arrangement—100% savings/losses—and provides two payment options: Primary Care Capitation (described above) or Total Care Capitation, a capitated, risk-adjusted monthly payment for all covered services provided by DC Participant Providers and those Preferred Providers that have agreed to participate in capitation (by accepting FFS claims reductions and agreeing to receive compensation from the DCE).

Additional information about the GPDC model is at CMS model webpage.

Groundbreaking Report from the National Academy of Medicine on Implementing High-Quality Primary Care Released

High-quality primary care is the foundation of a strong health care system and essential for improving the health of the population. However, only about five percent of healthcare expenditures go to primary care today, its workforce pipeline is shrinking, and unequal access to primary care pervades. In light of this, the National Academies of Sciences, Engineering and Medicine organized a committee to study the state of primary care today and to develop a consensus report. To rebuild a strong foundation for the U.S. healthcare system, the committee's recommendations focus on implementation actions rather than concepts. The report includes objectives and actions targeting primary care stakeholders and balancing national needs for scalable solutions while allowing for local fit. The implementation plan includes five objectives to make high-quality primary care available for everyone in the United States:

1. Pay for primary care teams to care for people, not doctors to deliver services.
    - Payers (i.e., Medicaid, Medicare, commercial insurers, and self-insured employers) should evaluate and disseminate payment models based on the ability of those models to promote the delivery of high-quality primary care, not on achieving short-term cost savings.
    - Payers using a fee-for-service model should shift primary care payment toward hybrid (part fee-for-service, part capitated) models and make them the default payment model over time.
    - The Centers for Medicare & Medicaid Services (CMS) should increase the overall portion of spending on primary care.
    - States should implement primary care payment reform by facilitating multipayer collaboration and by increasing the overall portion of health care spending in their state going to primary care.

2. Ensure that high-quality primary care is available to every individual and family in every community.
    - All individuals should have the opportunity to have a usual source of primary care. Payers should ask all covered individuals to declare a usual source of primary care annually and should assign nonresponding enrollees. Community health centers, hospitals, and primary care practices should assume and document an ongoing clinical relationship with the uninsured people they are treating.
    - The Department of Health and Human Services (HHS) should target sustained investment in creating new health centers (including federally qualified health centers [FQHC], FQHC look alikes, and school-based health centers), rural health clinics, and Indian Health Service facilities in areas with a shortage of primary care.
    - CMS should revise and enforce its fee-for-service and managed care access standards for primary care for

Medicaid beneficiaries. CMS should also assist state Medicaid agencies with implementing and attaining these standards, as well as measure and publish state performance on standards.
    - CMS should continue to support the COVID-19–era rule revisions and interpretations of Medicaid and Medicare benefits that have facilitated integrated team-based care, enabled more equitable access to telephone and virtual visits, provided equitable payment for non–in-person visits, eased documentation requirements, expanded the role of interprofessional care team members, and eliminated other barriers to high-quality primary care.
    - Primary care practices should move toward a community-oriented model.

3. Train primary care teams where people live and work.
    - Health care organizations and local, state, and federal government agencies should expand and diversify the primary care workforce, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the workforce with the communities they serve.
    - CMS, the Department of Veterans Affairs, the Health Resources and Services Administration, and states should redeploy or augment funding to support interprofessional training in community-based, primary care practice environments.

4. Design information technology that serves the patient, family, and interprofessional care team.
    - The Office of the National Coordinator for Health Information Technology (ONC) and CMS should develop the next phase of electronic health record certification standards to align with the functions of primary care; account for the user experience of clinicians and patients to ensure that health systems are interoperable; ensure equitable access and use of digital health systems; include highly usable automated functions that aid in decision-making; ensure that base products meet certification standards with minimal need for modification; and hold health information technology vendors and state and national support agencies financially responsible for failing to meet the standards.
    - ONC and CMS should plan for and adopt a comprehensive aggregate patient data system to enable primary care clinicians and interprofessional teams to easily access comprehensive patient data needed to provide whole-person care.

5. Ensure that high-quality primary care is implemented in the United States.
    - The HHS secretary should establish a Secretary's Council on Primary Care to enable the vision of primary care captured in the committee's definition.
    - A list of upcoming training sessions, including live webinars, can be found in the News and Events section of MICMT's website: https://micmt-cares.org/events. For an at a glance view, please find the event calendars and event flyers in the "News" section here.
    - HHS should form an Office of Primary Care Research at the National Institutes of Health and prioritize funding of primary care research at the Agency for Healthcare Research and Quality, via the National Center for Excellence in Primary Care Research.
    - Primary care professional societies and consumer groups at the national and state levels should assemble and regularly compile and disseminate a "high-quality primary care implementation scorecard," based on the 5 key implementation objectives.

Highlighted Resource from MICMT

The following resource is a great tool for enhancing team-based primary care. By simply clicking the link below you will be able to access the slides from the session:

- Addressing the Rising Risk Population (by MNO and IHP)

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"News" section here.

Please do not hesitate to reach out with any questions or concerns: micmt-requests@med.umich.edu

Michigan Data Collaborative CPC+ Dashboard Update

The Michigan Data Collaborative (MDC) are working to prepare the 5th release of the CPC+ Dashboard slated for late June. The newest release will include

- 12-month measurement period: January 1, 2020 through December 31, 2020 (includes all three payers)
- Medical claims data paid through February 2021 (allowing for a two-month run-out period).
- BCBSM and Priority Health drug claims data paid through February 2021 (allowing for a two-month run-out period). CMS does not provide prescription drug claims.

We are continuing to implement risk-adjusted expenditure measures as well as upgrade utilization measures to HEDIS 2019.

If you would like access and have not yet completed the Data Use Agreement(DUA) or the User Account Request to allow access to the CPC+ Dashboards for your organization, please contact the Michigan Data Collaborative and we will work with you to complete.

Additional information, such as an Online Tutorial, Release Announcements, Release Notes, User Guide, and CPC+ Measures Technical Guide can all be found on both the CPC+ Support page of the MDC Website and the User Guide & Technical Guide tabs of the Dashboard itself.

If you have any questions or suggestions regarding the dashboard, please contact MDC at MichiganDataCollaborative@med.umich.edu.

Contact Us! How Can We Help? Supporting CPC+ POs and Practices in Michigan

The joint commercial CPC+ payers in Michigan are working together to support multipayer alignment with the University of Michigan. We advocate with CMS to emphasize the important role that POs play in supporting CPC+ and work with them as partners in the Michigan CPC+ community, work with all participating payers in Michigan to create consistency in payer policy and approach wherever possible, and work to remove roadblocks that practices and POs face in CPC+ implementation and operations. We are interested in learning about your successes, challenges and questions. **Please contact the CPC+ Michigan Regional Convener, Diane Marriott (dbechel@umich.edu or 734 740 0511) at any time to share your ideas and experiences.**