# Considerations In Creating Your Value-based Strategy

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# Agenda

- **Overview of new CMS models**
  - Primary Care First
  - Direct Contracting
  - Medicare Advantage Changes and Value-Based Insurance Design (VBID)
- **What to watch**
- **Things to consider while setting strategy**

# Review of Recent CMS Innovations

# Poll Question 1

Have you seen either of the recent CMS webinars – Primary Care First or Direct Contracting?

- One of them
- Both of them
- None

# The CMS Primary Cares Initiative (4/22/2019): Primary Care First and Direct Contracting

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- HHS and CMS announced a set of new payment models called the Primary Cares Initiative to **transform primary care through value-based options** and to **test financial risk and performance-based payments for primary care providers**
- The payment model options are provided under two paths: **Primary Care First (PCF)** and **Direct Contracting (DC)**

| Primary Care First | Direct Contracting |
|---|---|
| • Addresses importance of primary care by creating a seamless continuum of care and accommodating interested providers at multiple stages of readiness to assume accountability for patient outcomes<br>• Two payment model options:<br>  • Primary Care First (PCF) – General<br>  • Primary Care First – High Need Populations | • Set of three voluntary payment model options aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare FFS<br>  • Three payment model options<br>  • Direct Contracting – Professional<br>  • Direct Contracting – Global<br>  • Direct Contracting – Geographic |

Sources: cms.gov, *Delivering Value-Based Transformation in Primary Care*, https://innovation.cms.gov/Files/x/primary-cares-initiative-onepager.pdf; HealthExec.com, CMS launches 5 primary care models in new value-based push, Amy Baster, 4/29/19 https://www.healthexec.com/topics/policy/cms-launches-primary-cares-initiative

# What Is Primary Care First (PCF)?

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- PCF is a set of **voluntary five-year payment model options** intended to reward value and quality by offering innovative payment model structures to support delivery of advanced primary care

- PCF is based on the underlying principles of the existing CPC+ model design:
  - **Prioritizing the doctor-patient relationship; enhancing care for patients with complex chronic needs and high need, seriously ill patients, reducing administrative burden, and focusing financial rewards on improved health outcomes**

- CMS will encourage other payers (including Medicare Advantage Plans, commercial health insurers, Medicaid managed care plans, and State Medicaid agencies) to align payment, quality measurement, and data sharing with CMS in support of Primary Care First practices

Source: cms.gov, *Primary Care First: Foster Independence, Reward Outcomes,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes

# What Is the PCF Payment Model?

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- Most sweeping attempt to date to change primary care--per Secretary Azar, **"the new primary care experiment will transform the U.S. health system"**
- **Capitated payment structure is simplified**
  - ✓ Capitated risk-based payment along with flat primary care visit fee
  - ✓ Performance-based adjustments providing upside of up to 50%
  - ✓ Small downside (10%) incentivizes practices to reduce costs and improve quality
  - ✓ Includes a payment model option that provides higher payments to practices that specialize in care for high need patients
- **Model seeks to reduce regulatory and administrative burdens for primary care physicians by increasing panel size capacity and promoting attribution and retention of patients**
- **Capitated payment model incentivizes proactive team outreach and non-visit care**
  - ✓ Establishes more options for patient engagement, such as secure text, email, and virtual visits
  - ✓ Increases convenience for patients by providing access to care teams through multiple channels
  - ✓ Allows for regular communication and closer collaboration between patients and care teams
  - ✓ Leaves office appointments open for longer, more detailed and complex patient encounters

Source: cms.gov, *Primary Care First: Foster Independence, Reward Outcomes,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes

# Who Can Participate in PCF?

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## Participation

The general Primary Care First payment model option is designed for primary care practices with advanced primary care capabilities that are prepared to accept increased financial risk in exchange for flexibility and potential rewards based on practice performance. Eligible applicants are primary care practices that:

- Are located in one of the selected Primary Care First regions.
- Include primary care practitioners (MD, DO, CNS, NP, and PA), certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine.
- Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at a particular location
- Have primary care services account for at least 70% of the practices' collective billing based on revenue. In the case of a multi-specialty practice, 70% of the practice's eligible primary care practitioners' combined revenue must come from primary care services.
- Have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to fee-for-service payments such as full or partial capitation.
- Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE).
- Attest via questions in the Practice Application to a limited set of advanced primary care delivery capabilities, such as 24/7 access to a practitioner or nurse call line and empanelment of patients to a practitioner or care team.
- Can meet the requirements of the Primary Care First Participation Agreement

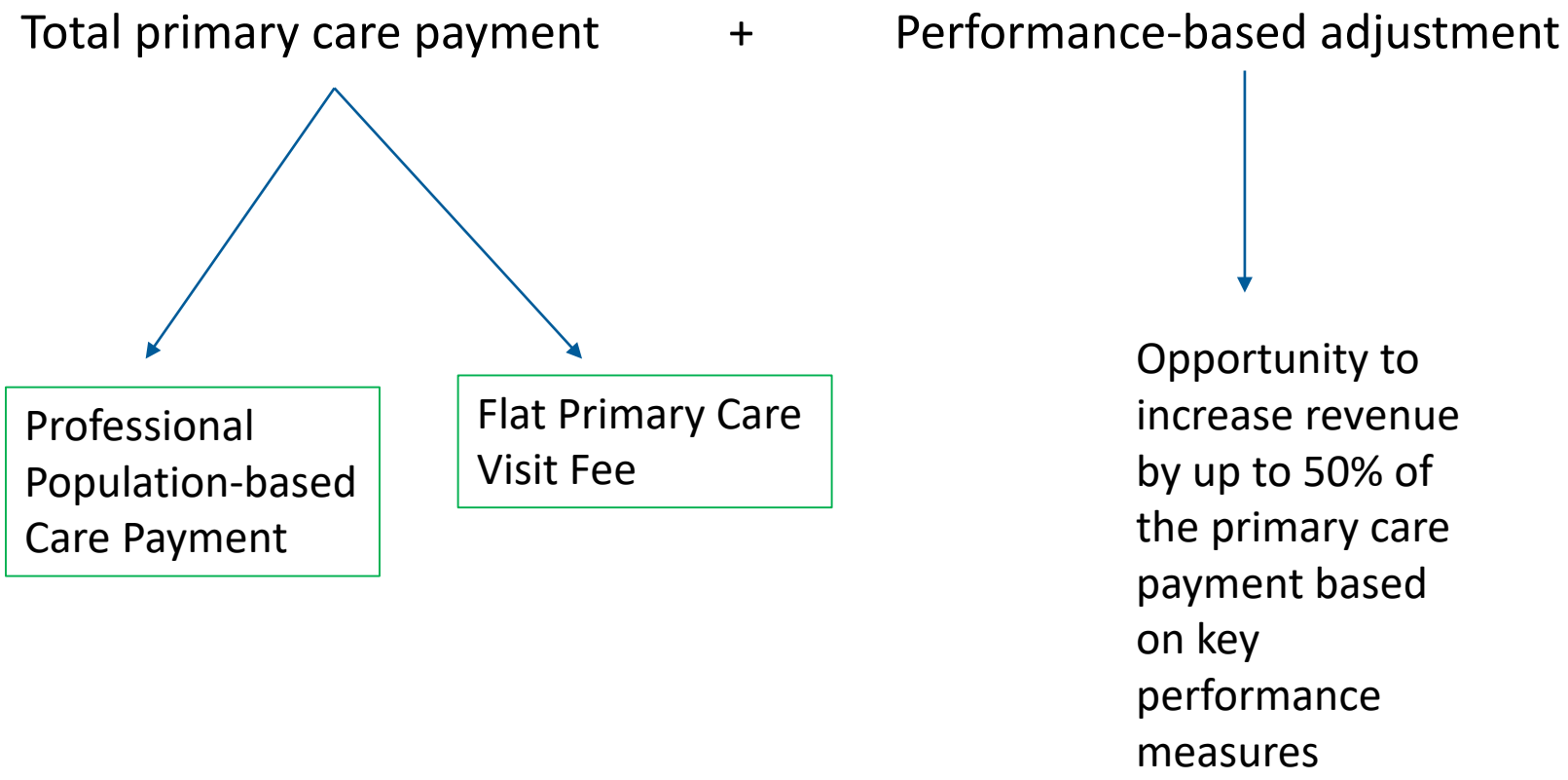
Source: cms.gov, *Primary Care First: Foster Independence, Reward Outcomes,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes

# Primary Care First Regions

- Alaska (statewide), Arkansas (statewide), California (statewide), Colorado (statewide), Delaware (statewide), Florida (statewide), Greater Buffalo region (New York), Greater Kansas City region (Kansas and Missouri), Greater Philadelphia region (Pennsylvania), Hawaii (statewide), Louisiana (statewide), Maine (statewide), Massachusetts (statewide), Michigan (statewide), Montana (statewide), Nebraska (statewide), New Hampshire (statewide), New Jersey (statewide), North Dakota (statewide), North Hudson-Capital region (New York), Ohio and Northern Kentucky region (statewide in Ohio and partial state in Kentucky), Oklahoma (statewide), Oregon (statewide), Rhode Island (statewide), Tennessee (statewide), and Virginia (statewide)

https://innovation.cms.gov/initiatives/primary-care-first-model-options/

# Primary Care First – Total Medicare Payments



# PCF Total Primary Care Payments

Hybrid Total Primary Care Payments replace Medicare FFS payments to support delivery of advanced primary care.

**Professional Population-Based Payment**

Payment for service in or outside of the office, adjusted for practices caring for higher risk populations. This payment is the same for all patients within a practice. (Payment adjusted to account for beneficiaries seeking services outside the practice.

| Practice Risk Group | Payment *Per beneficiary per month* |
|---|---|
| Group 1 (lowest risk) | $24 |
| Group 2 | $28 |
| Group 3 | $45 |
| Group 4 | $100 |
| Group 5 (highest risk) | $175 |

+

**Flat Primary Care Visit Fee**

Flat payment for face-to-face treatment that reduces billing and revenue cycle burden.

$50

Per face-to-face patient encounter

These payments allow practices to:

- Easily predict payments for face-to-face care
- Spend less time on claims processing and more time with patients

# PCF Performance-Based Payment Adjustments

- Year 1 – adjustments based on acute hospital utilization (AHU) only
- Years 2-5, adjustments based on performance as described below.

Did practice exceed the Quality Gateway?

**No**

-10% Adjustment to Total Primary Care Payment for next applicable year

**Yes**

Adjustment up to 50% of Total Primary Care Payment determined by comparing performance to three different benchmarks:

- National Adjustment
- Cohort Adjustment
- Continuous Improvement Adjustment

# Primary Care First

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## Cohort adjustment

Practice performance is next compared against other PCF participants to determine the performance-based adjustment.


- 0% Adjustment

| Performance Level | Adjustment to Total Primary Care Payment |
|---|---|
| Top 20% of PBA-eligible practices | 34% |
| Top 21-40% of PBA-eligible practices | 27% |
| Top 41-60% of PBA-eligible practices | 20% |
| Top 60-80% of PBA-eligible practices | 13% |
| Top 81-100% of PBA-eligible practices | 6.5% |

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# Primary Care First

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- Practices are also eligible for a continuous improvement bonus **of up to 1/3 of total PBA amount** if they achieve their improvement target. CMS may use statistical approaches to account for random variations over time and promote reliability of improvement data.

| Performance Level | Potential Improvement Bonus |
|---|---|
| Top 20% of PBA-eligible practices | 16% of Total Primary Care Payment |
| Top 21-40% of PBA-eligible practices | 13% of Total Primary Care Payment |
| Top 41-60% of PBA-eligible practices | 10% of Total Primary Care Payment |
| Top 60-80% of PBA-eligible practices | 7% of Total Primary Care Payment |
| Top 81-100% of PBA-eligible practices | 3.5% of Total Primary Care Payment |
| Practices performing above nationwide benchmarks but below top 50% of practices | 3.5% of Total Primary Care Payment |
| Practices performing at or below nationwide minimum benchmark | 3.5% of Total Primary Care Payment |

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# Primary Care First – High Need Population

- PCF incorporates the following unique aspects for practices electing to serve seriously ill populations to increase access to high-quality, advanced primary care.

| Eligibility and Beneficiary Attribution | Payments |
|---|---|
| • Practices demonstrating relevant capabilities **can opt to be assigned SIP patients or beneficiaries** who lack a primary care practitioners or care coordination<br>• Medicare-enrolled clinicians who provide **hospice or palliative care can partner** with participating practitioners. | Payments for practices serving seriously ill populations<br>First 12 months;<br>• One-time payment for first visit with SIP patient: $325 PBPM<br>• Monthly SIP payments for up to 12 months<br>• Flat visit fees: $50<br>• Quality payment: up to $50 |

# PCF Quality Measures

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The following measures will inform performance-based adjustments and assessment of model impact.

| Measure Type | Measure Title | Benchmark |
|---|---|---|
| **Utilization Measure for Performance-Based Adjustment Calculation (Year 1-5)** | Acute Hospital Utilization (AHU) (HEDIS measure) | Non-CPC+ Reference population |
| **Quality Gateway (starts in Year 2)** | **CPC+ Patient Experience of Care Survey** (modernized version of CAHPS)<br>**Diabetes: Hemoglobin A1c (HbA1c) Poor Control** (> 9%) (eCQM)*<br>**Controlling High Blood Pressure** (eCQM)<br>**Care Plan** (registry measure)<br>**Colorectal Cancer Screening** (eCQM)*_ | MIPS<br>MIPS<br>MIPS<br>MIPS<br>MIPS |
| **Quality Gateway** for practices serving high-risk and seriously ill populations* | To be developed during model: domains could include 24/7 patient access and days at home | |

*The following measures will not apply to practices in Practice Risk Groups 4 or 5 and for practices receiving SIP identified patients: (a) Diabetes: Hemoglobin A1c (HbA1c), Poor Control (greater than 9%) (eCQM), and (b) Colorectal Cancer Screening (eCQM)



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# Comprehensive Primary Care Functions

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- PCF is oriented around 5 comprehensive primary care functions:

**Patient Access and Continuity**
- 24 hour access to care team with real-time EHR access

**Care Management**
- Population risk-stratified

**Comprehensiveness and Coordination**
- Integrated Behavioral Health
- Psych-Social needs addressed

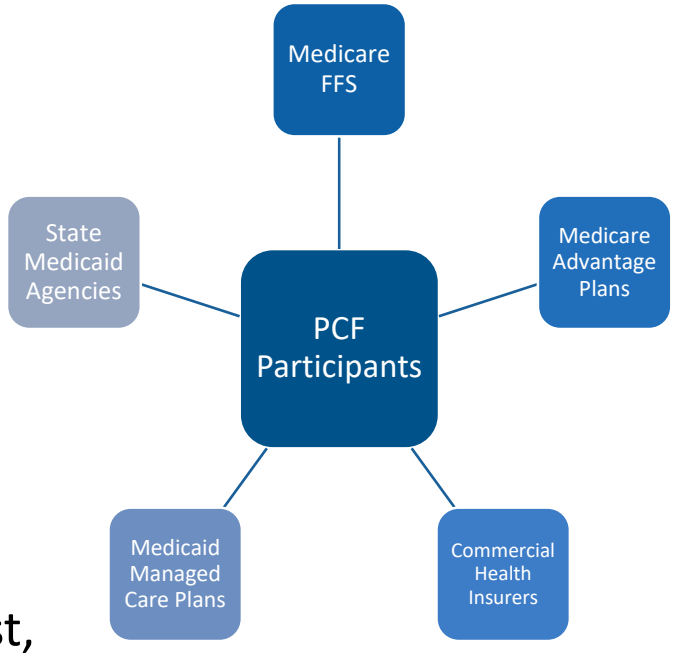
**Patient and Caregiver Engagement**
- Regular process for input into practice improvement

**Planned Care and Population Health**
- Set goals and continuously improve on key outcome measures

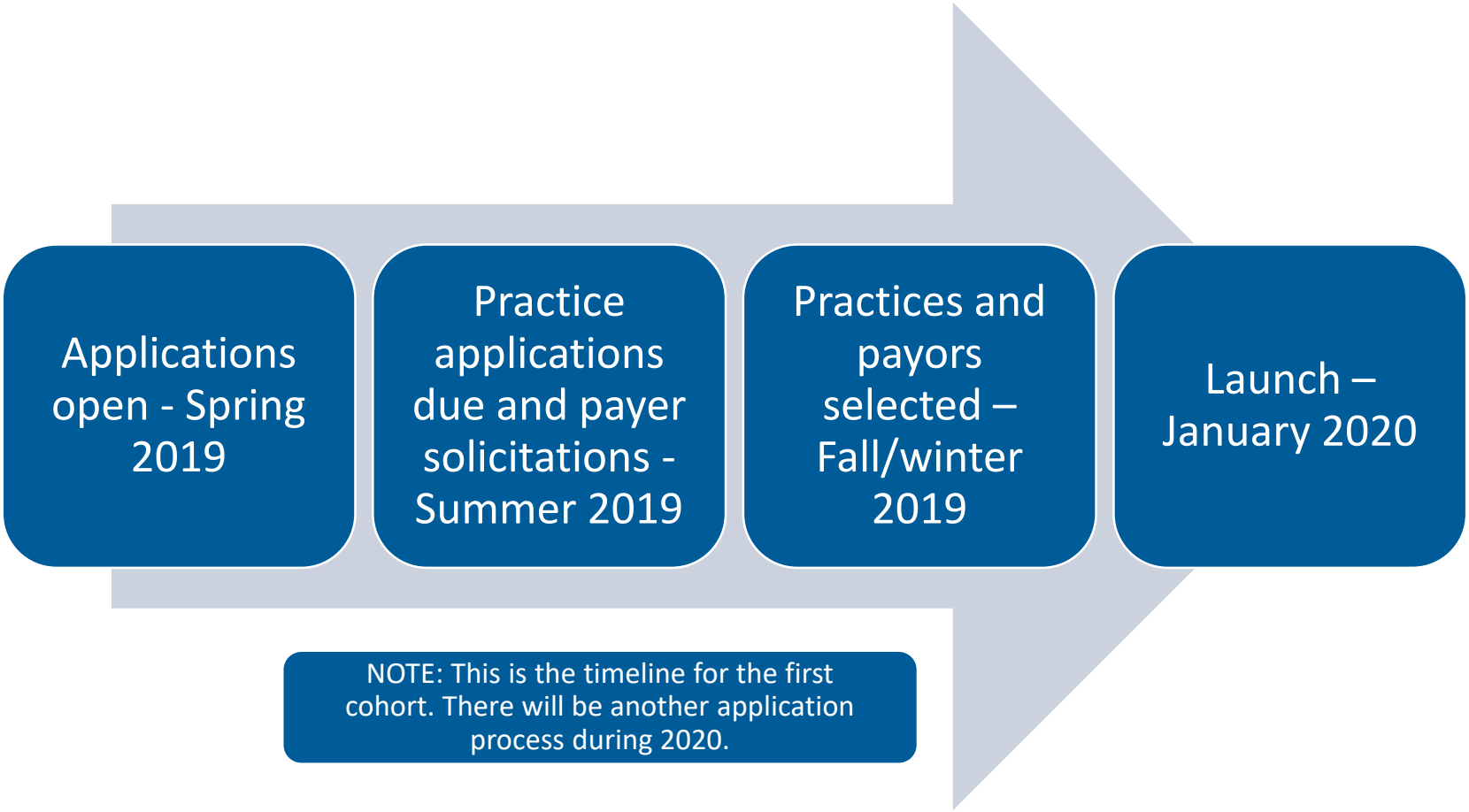
Source: cms.gov, *Primary Care First: Foster Independence, Reward Outcomes,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes

# CMS Will Encourage Payer Partners

- CMS will solicit interested payers during the summer of 2019
- Possible participants:
  - Medicare Advantage Plans
  - Commercial Health Insurers
  - Medicaid Managed Care Plans
  - State Medicaid Agencies
- Intended to promote:
  - Alternatives to FFS
  - Performance-based incentives
  - Practice- and participant-level data on cost, utilization, and quality
  - Alignment on quality and performance measures
  - Broadened support for seriously ill populations



# Primary Care First Timeline



# Primary Care First Reimbursement Model Summary

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Three parts to reimbursement:

1. The population based payment ranges from $24 - $175 PBPM
   - The amount depends on the practice's **overall** patient risk category. CMS has defined 5 levels of risk, 1 being the lowest. The PBPM will therefore be the same for all patients in the practice.
   - **CMS has not yet released the details regarding the services and CPT codes included in these models' cap rates**
2. There is a flat fee of $50 per face-to-face patient encounter
3. Performance-based adjustment of up to 50% of primary care payment depending on quality and outcome metric
   - Gateway threshold met – no, then 10% reduction, if met may be eligible for up to 50% adjustment
   - Up to 34% based on cohort adjustment
   - Up to 16% based on continuous improvement adjustment

# Poll Question 2

In which value-based models, if any, do you currently participate?

- MSSP
- Next Gen
- CPC+
- Other
- None

# Direct Contracting Path

# What Is Direct Contracting?

- Direct Contracting (DC) is a **set of voluntary payment model options** aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare FFS
- The payment model options available under DC create opportunities for organizations to participate in testing the next evolution of risk-sharing arrangements to produce value and high quality health care
- DC creates **three payment model options for participants** to take on risk and earn rewards, and provides them with choices related to cash flow, beneficiary alignment, and benefit enhancements
- The payment model options are anticipated to
  - Reduce burden
  - Support a focus on beneficiaries with complex, chronic conditions
  - Encourage participation from organizations that have not typically participated in Medicare FFS or CMS Innovation Center models
  - Broaden participation in CMS Innovation Center models



Source: cms.gov, *Fact Sheet: Direct Contracting,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/direct-contracting

# Direct Contracting: Three Payment Models

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**Professional PBP**

- Offers the lower risk-sharing arrangement—50% savings/losses
- Provides Primary Care Capitation, a capitated, risk-adjusted monthly payment for enhanced primary care services
- CMS will offer primary care capitation equal to 7 percent of the total cost of care for enhanced primary care services, along with 50 percent shared savings/shared losses with CMS

**Global PBP**

- Offers the highest risk sharing arrangement—100% savings/losses
- Provides two payment options:
  - Primary Care Capitation
  - Total Care Capitation, capitated, risk-adjusted monthly payment for all services provided by DC Participants and preferred providers with whom the DCE has an agreement
- CMS will offer the choice of Primary Care Capitation or Total Care Capitation, in addition to 100 percent shared savings/losses

**Geographic PBP**

- CMS is seeking public input through an RFI
- Would offer a similar risk-arrangement as the Global PBP option as potential participants would assume responsibility for the total cost of care for all Medicare FFS beneficiaries in a defined target region.



Source: cms.gov, *Fact Sheet: Direct Contracting,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/direct-contracting

# Direct Contracting: Payment Model Goals

- Intended to **engage a broader variety of organizations than have previously participated in CMS models and programs**
- While CMS expects that current NGACO and MSSP participants may participate, **CMS also seeks to attract organizations that are new to Medicare FFS,** such as those who are currently only in MA, and Medicaid MCOs that are ready to take on accountability for Medicare FFS spending for their dually eligible members
- DC's current design seeks to create **a competitive delivery system environment** based on regional payment neutrality, in which organizations bear appropriate risk, and population-based benchmarks are applied equitably across all model participants in the same market (i.e., accounting for risk adjustment factors)

| *Flexible Risk-Sharing and Payment Model Options* | *Benefit Enhancements* | *Voluntary Alignment* |
|---|---|---|
| • Aligns payment and benchmarks consistently across organizations through use of regional payment rates and patient-level adjustment factors.<br>• Offers greater payment predictability through prospective beneficary alignment. | • Offers a suite of tools that increases beneficiary engagement and affordability, as well as improves quality of care. | • Enables and encourages beneficiaries to choose the providers with whom they want to have a care relationship.<br>• Empowers beneficiaries to seek high value providers i.e., providers that offer high quality services at low cost. |



Source: cms.gov, *Fact Sheet: Direct Contracting,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/direct-contracting

# Direct Contracting Entities

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- Have at least **5000** aligned Medicare FFS beneficiaries for Professional and Global Models, **75,000** for Geographic
- "On ramp" for organizations new to Medicare FFS (organizations in MA only or Medicaid MCOs)
- Added flexibility for organizations serving dually eligible, chronically ill populations

| DC Participants | Preferred Providers |
|---|---|
| • Core providers and suppliers<br>• Used to align beneficiaries to the Direct Contracting Entity<br>• Responsible for reporting quality through the Direct Contracting Entity and improving the quality of care for aligned beneficiaries | • Not used to align beneficiaries to the Direct Contracting Entity<br>• Participate in downstream arrangements, certain benefit enhancements or payment rule waivers, and contribute to Direct Contracting Entity goals. |

Geographic PBP option would be open to innovative organizations, including health plans, health care technology companies, in addition to providers and supplier organizations

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# Direct Contracting Model Options

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| | | What payment options are available? | | |
|---|---|---|---|---|
| | | Full Financial Risk with FFS claims processing | Primary Care Capitation | Total Care Capitation |
| Payment Model Options | Professional PBP | | X | |
| | Global PBP | | X | X |
| | Geographic PBP (proposed) | X | | X |

** All Direct Contracting Entities will be able to supplement these choices with a "claims reduction with advance payment option"*

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# Direct Contracting Benchmarking Methodology

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| Professional PBP and Global PBP | Geographic PBP (proposed) |
| --- | --- |
| • A blend of historical spending and adjusted MA regional expenditures are used to develop the benchmark (segmented by Aged & Disabled and ESRD)<br>• Benchmarks will be adjusted to reflect factors such as the risk of the population<br>• Payments will be subject to quality performance<br>• We are considering innovative approaches to risk adjustment for complex and chronically ill populations. | • Would be based on a one-year historical per capita Parts A/B FFS spend on the target region trended forward (no historical/ regional blend) with negotiated discounts<br>• Final methodology would be informed by the Request for Information (RFI) responses |

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# Direct Contracting Benefit Enhancements

- **Benefit Enhancements and Payment Rule Waivers**
  - DC is considering the same benefit enhancements offered in NGACO, such as
    - 3-Day SNF Rule Waiver
    - Telehealth Expansion Waiver
    - Post-Discharge Home Visits Rule Waiver
    - Care Management Home Visits Rule Waiver
  - DC also intends to build upon those offerings and explore additional enhancements and payment rule waivers such as
    - Allowing Nurse Practitioners to certify that a patient is eligible for home health services
    - Allowing the provision of home health services to beneficiaries who are not "homebound"
  - ***These benefit enhancements and payment rule waivers are still in development and not finalized. The DC Team will release more information as it becomes available.***

# Direct Contracting Timeline

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Letter of intent is due to CMS by Friday, August 2, 2019

# Poll Question 3

Have you considered participating in or becoming a Medicare Advantage plan as part of your strategy?

- Yes
- No

# Medicare Advantage

# Medicare Advantage

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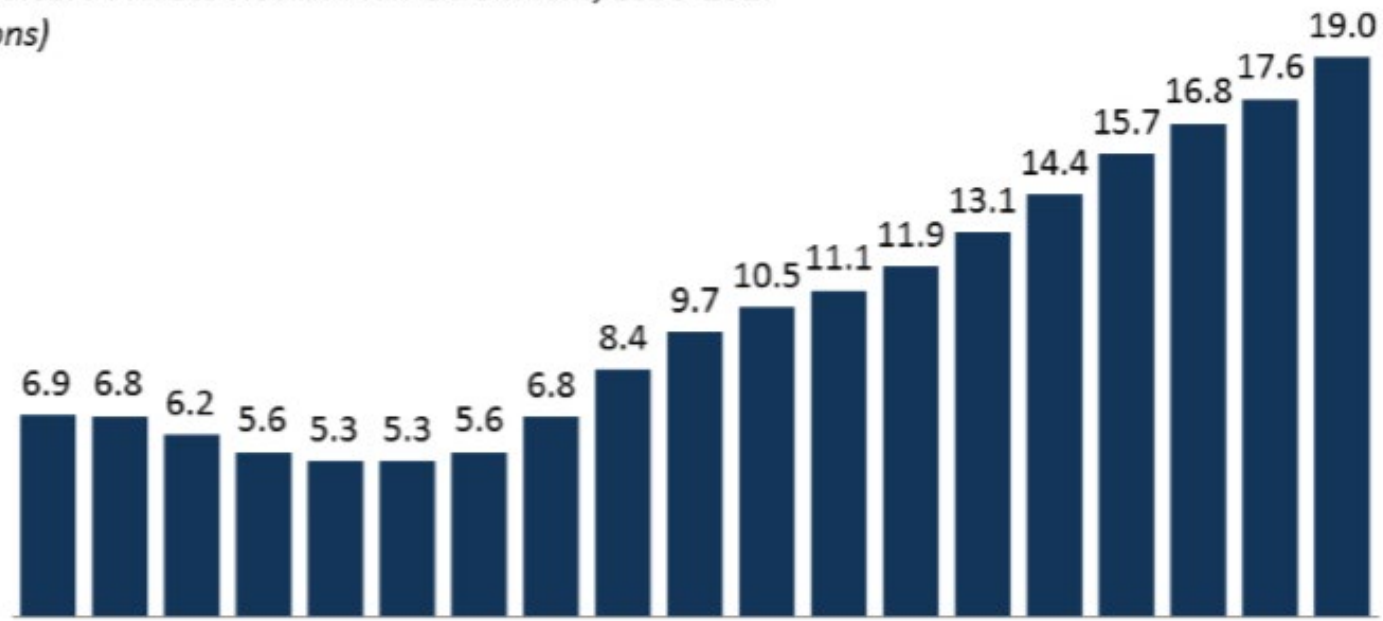
Figure 1

## Enrollment in Medicare Advantage plans has steadily increased since 2004

*Total Medicare Private Health Plan Enrollment, 1999-2017*
*(in millions)*




NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS Medicare Advantage enrollment files, 2008-2017, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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# Medicare Advantage Plans

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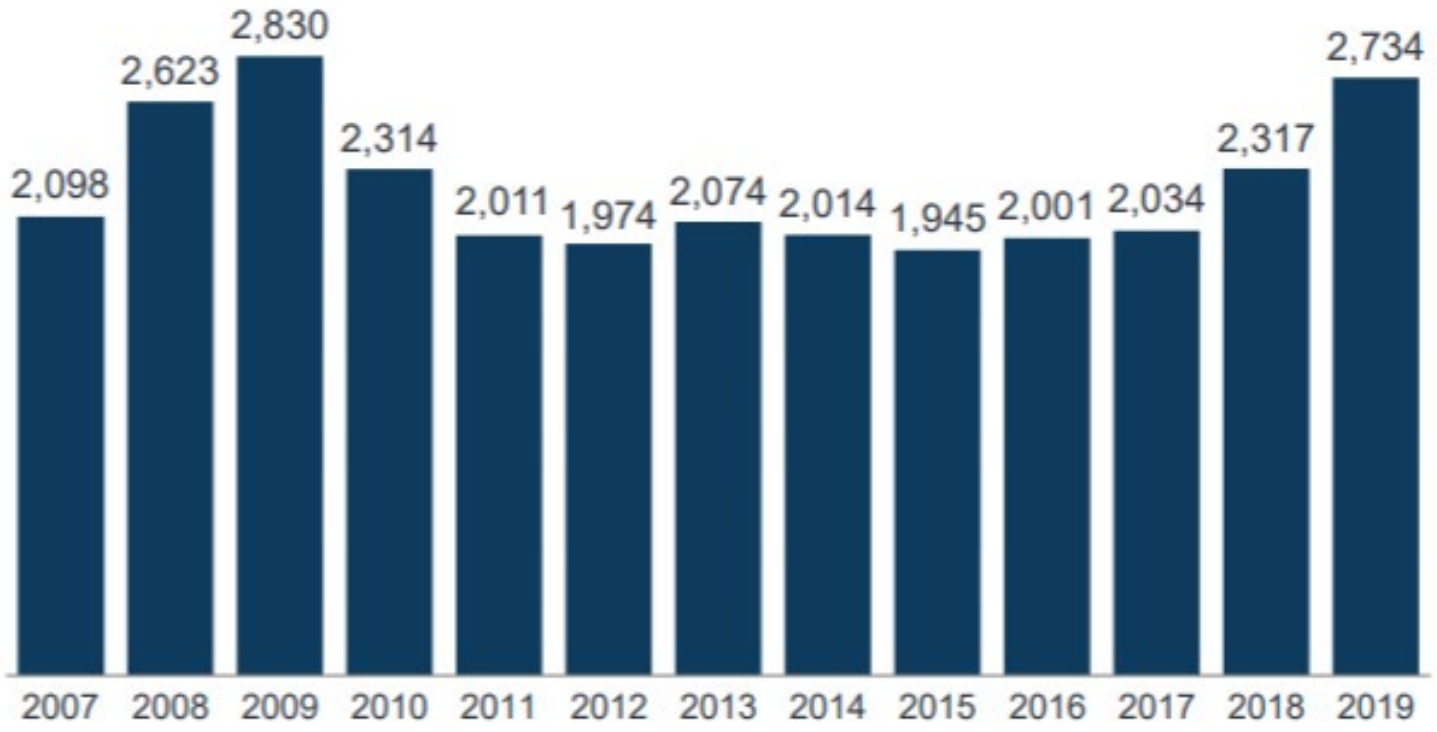
ES-Figure 1

## More Medicare Advantage plans are available in 2019 than in any year since 2009

*Number of Medicare Advantage plans generally available, 2007-2019*




NOTE: Excludes SNPs, employer-sponsored group plans, demonstrations, HCPPs, PACE plans, and plans for special populations. Other category includes cost plans and Medicare MSAs.
SOURCE: Kaiser Family Foundation analysis of CMS's Landscape Files for 2007 – 2019.

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# Medicare Advantage

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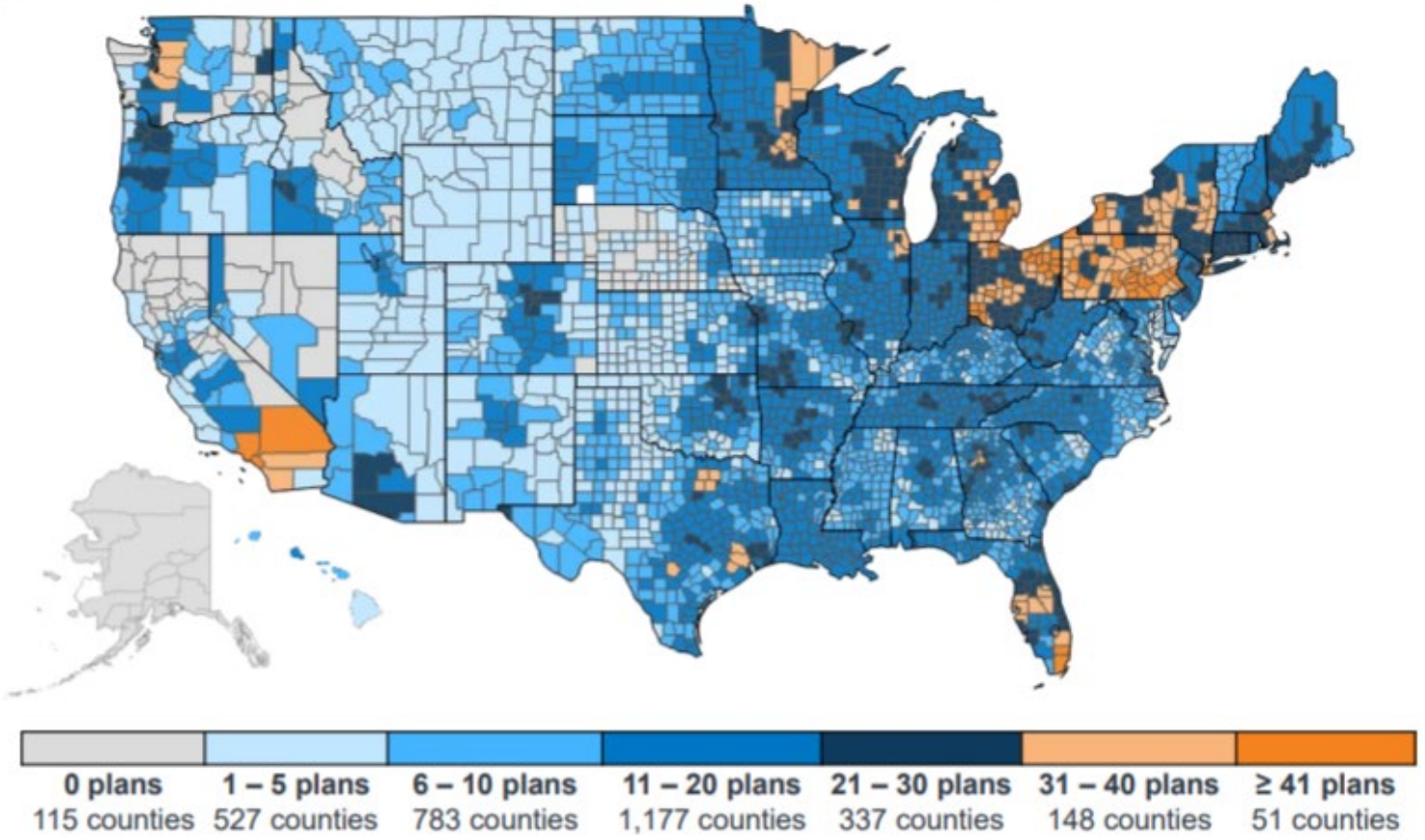
Figure 3

## In about one-fifth of counties, beneficiaries can choose among 5 or fewer Medicare Advantage plans in 2019




NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, and PACE plans.
SOURCE: Kaiser Family Foundation analysis of CMS's Landscape Files for 2019.

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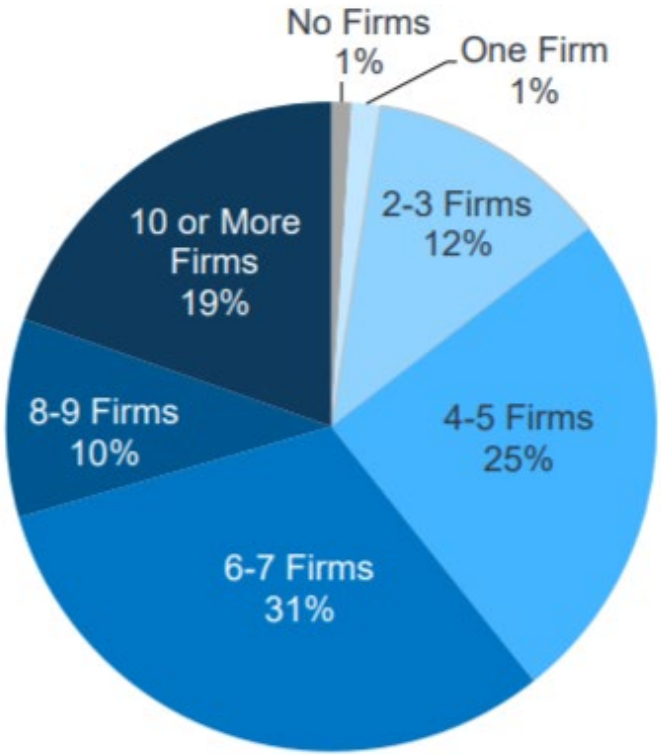
# Medicare Advantage

Figure 5

## More than half of Medicare beneficiaries can choose among Medicare Advantage plans offered by at least 6 firms in 2019

*Distribution of Beneficiaries by the Number of Firms Offering Medicare Advantage Plans, 2019*




The average beneficiary can choose among Medicare Advantage plans offered by **7** firms

**Total Number of Medicare Beneficiaries= 62 Million**

NOTE: Excludes SNPs, employer-sponsored group plans, demonstrations, HCPPs, PACE plans, and plans for special populations. Numbers may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of CMS's Landscape and Penetration Files for 2019.

# Medicare Advantage

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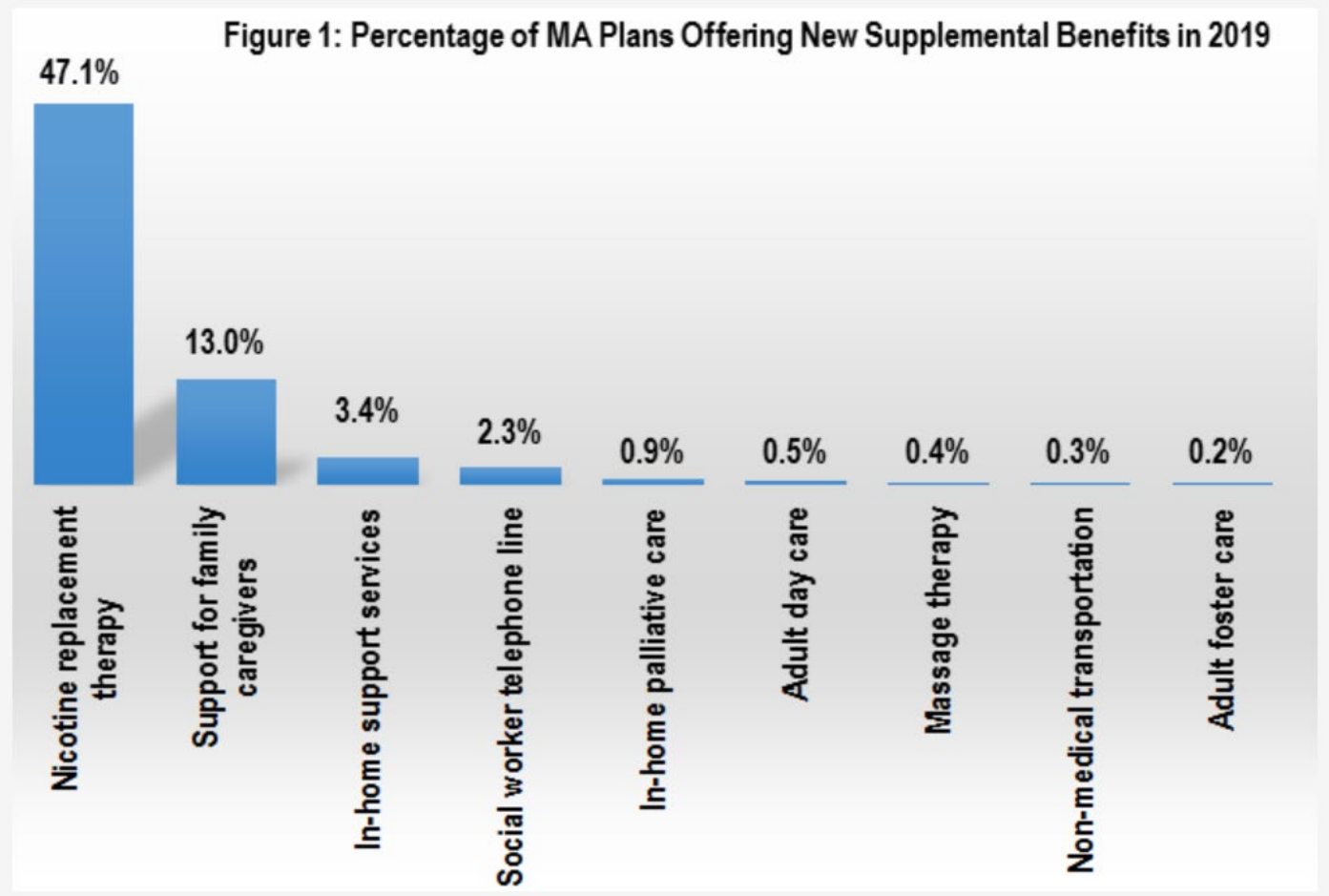


AARP Posted on 10/30/2018

**Supplemental Benefits in Medicare Advantage: What's Changing in 2019 and What's Not**

by Jane Sung and Claire Noel-Miller

# Medicare Advantage 2020

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Given the urgency and scope of the continuing national opioid epidemic, CMS is finalizing a number of additional policies for 2020 to help Medicare plan sponsors prevent and combat prescription opioid overuse. Those include:

- **Pain Management and Complementary and Integrative Treatments in Medicare Advantage:** CMS is encouraging plans to take advantage of the new flexibilities to offer targeted benefits and cost sharing reductions for patients with chronic pain or undergoing addiction treatment.
- **Access to Opioid Reversal Agents:** CMS is strongly encouraging Part D sponsors to provide lower cost sharing for opioid-reversal agents, such as naloxone.
- **Star Ratings:** CMS is taking steps to advance Medicare Part D opioid-related measures through the Star Ratings development process. We are updating the specifications for the Use of Opioids at High Dosage and/or from Multiple Providers, and Concurrent Use of Opioids and Benzodiazepines measures, and adding them to the display page. Reporting measures on the display page is a necessary step before the measure can be formally adopted as part of the Star Ratings through rulemaking.

**2020 Medicare Advantage and Part D Rate Announcement and Final Call Letter Fact Sheet**
**CMS FACT SHEET** April 1, 2019

# Value-Based Insurance Design Model (VBID) 2020

| VBID Intervention | Description |
|---|---|
| Value-Based Insurance Design by Condition, Socioeconomic Status, or both | Non-uniform benefit design to provide reduced cost-sharing or additional supplemental benefits for enrollees based on condition and/or certain socioeconomic (i.e. low-income subsidy eligibility or dual-eligible) status |
| Medicare Advantage and Part D Rewards and Incentives Programs | Meaningful and focused Medicare Advantage and Part D Rewards and Incentives programs |
| Telehealth Networks | Increased access to telehealth services by allowing plans to propose using access to telehealth services instead of in-person visits, as long as an in-person option remains, to meet certain requirements for the provider network |
| Wellness and Health Care Planning | Timely, coordinated approaches to wellness and health care planning, including advance care planning. This is a required component for all VBID participating MA plans. |

Value-Based Insurance Design Model (VBID) Fact Sheet CY 2020
CMS Fact sheet Jan 18, 2019 Innovation models

# Between the Lines and Emerging Patterns

- Increase competition
- Merging characteristics
  - Modeling after prior innovations and lessons learned
  - Direct Contracting and Medicare Advantage – 100% risk, benchmarking method starting to overlap
- Overlapping models and can they be used in combination
- Member engagement and incentives
- Population specific models and incentives
- Waivers and inclusion of non-traditional services

# Things to Watch

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**For CMS models:**

- Submit letters of intent on time – non-binding and must have
- Watch for CMS guidelines on overlapping models
- Watch for details on benchmarking and attribution methodologies
- Watch for details on the services and codes including in cap. rates
- Watch for details on the 5 practice population risk groups in Primary Care First
- Watch for CMS changes to claims/encounter filing requirements
- Watch for available waiver options

# Strategy Considerations

- **Incentive redesign and alignment are key**
  - Physician and staff incentives need to align with the reimbursement models
  - Current revenue centers become cost centers
- Infrastructure and **maturity of your population health management processes will matter greatly**
- If you have not paid attention yet to HCC scoring, start immediately
  - **Optimizing HCC scoring** should ideally be done prior to entering some of these models and must be continued on an annual basis
- **Analyze capitation** arrangements very carefully – **know the codes and services included**
- Understand how **benchmarks** will be set and the impact on your organization
- **Consider multiple models** - Some of these models may work well together once we have more details
- **Analyze all your options** - know your market as you may have other strategic options to consider:
  - Medicare Advantage
  - Commercial payer products and any value-based contracting in your market
  - State Medicaid changes
  - Local and regional ACOs and associated networks
  - Go it solo or affiliate with a larger network or ACO

# Questions