



The Comprehensive Primary Care Initiative: New Payment Models Will Rely on Use of Health IT



Richard J. Baron, MD, MACP
Group Director, Seamless Care Models
Innovation Center, CMS

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Value Proposition

- This initiative is testing the idea that more support for primary care will lead to:
 - Better health
 - Better care
 - Decreased health system costs
- Payers are willing to invest in a test of enhanced primary care with other payers and CMS
- This test may inform national payment policy for primary care

Practice and Payment Redesign in the CPC initiative

- A major barrier to transformation in practice is transformation in payment
- The CPC initiative will test a practice redesign model supported by a new payment model over 4 years:

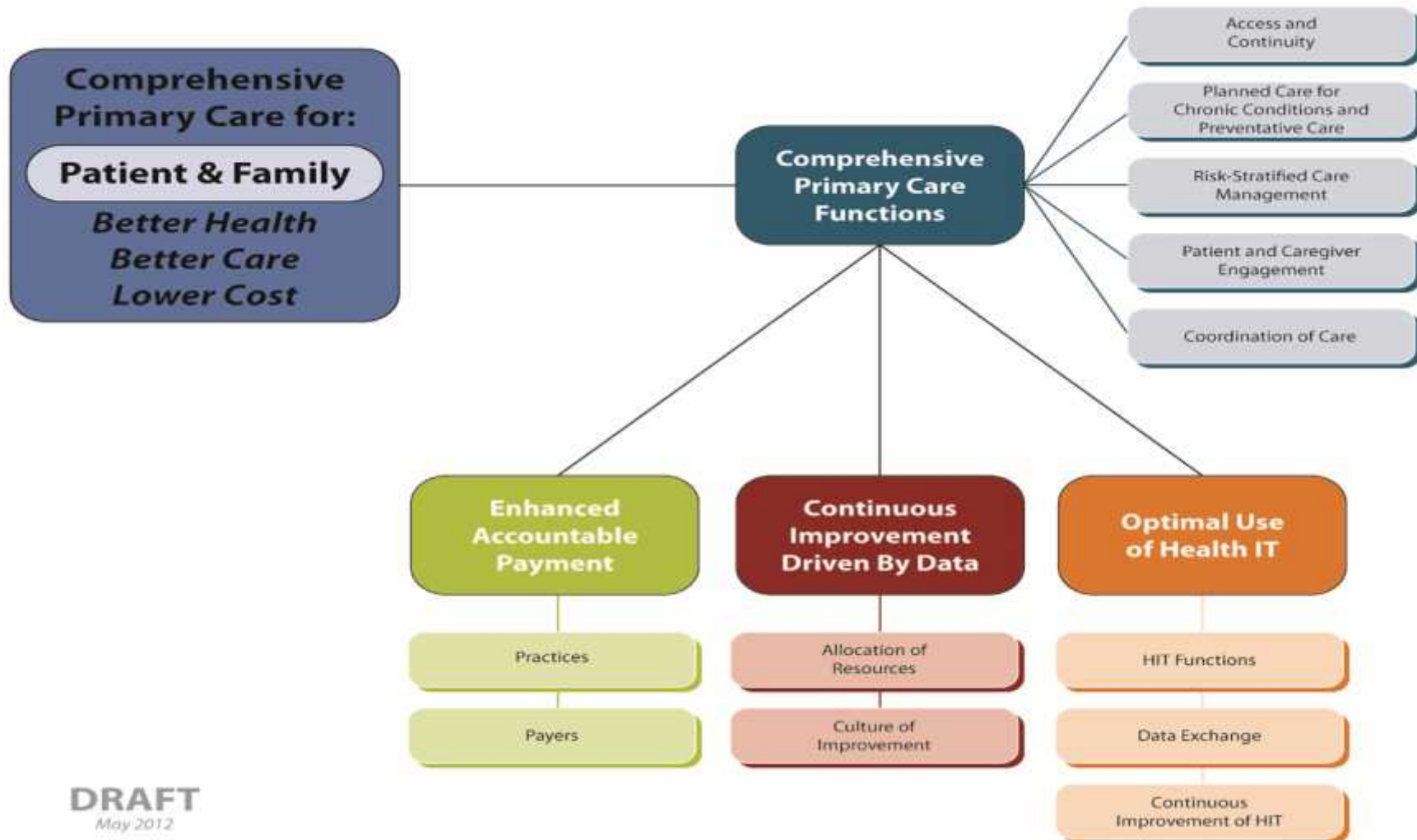
Practice Redesign

- Provision of comprehensive primary care functions
- Effective use of data to guide care

Payment Redesign

- Per-beneficiary-per-month (PBPM) care management fee
- Shared Savings opportunity

Practice and Payment Redesign through the CPC initiative



Practice Redesign: Five Comprehensive Primary Care Functions

1. Risk-stratified care management
2. Access and continuity
3. Planned care for chronic conditions and preventive care
4. Patient and caregiver engagement
5. Coordination of care across the medical neighborhood

Payment Redesign: 3 Components of Medicare Payment

- Medicare fee-for-service remains in place
- Average \$20 PBPM fee (risk-adjusted) to support increased infrastructure to provide CPC for first 2 years - reduced to an average of \$15 PBPM in years 3 and 4
- Opportunity for Shared Savings in years 2, 3, and 4
 - Calculated at the market level
 - Practice share determined by size, acuity and quality metrics

Participating Payers and Purchasers

- Commercial Insurers
- Medicare Advantage plans
- States
- Medicaid Managed Care plans
- State/federal high risk pools
- Self-insured businesses
- Administrators of self-insured group (TPA/ASO)

Payment Redesign: Participating Payers

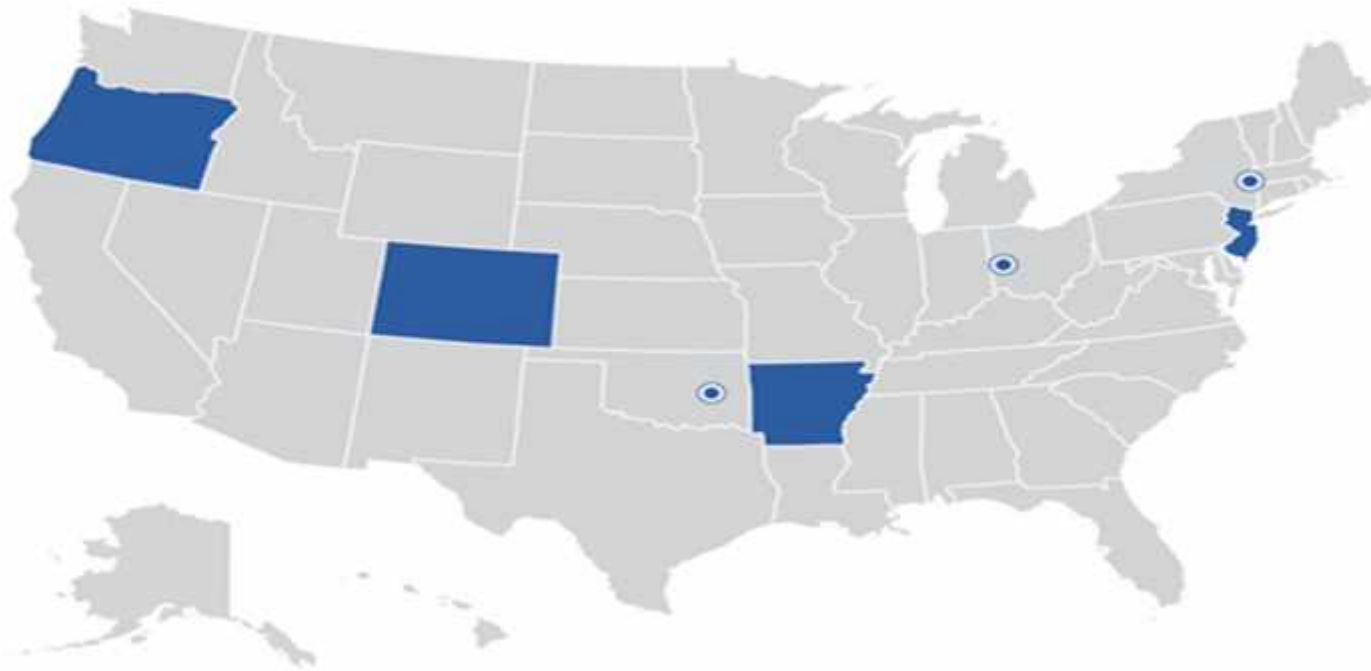
- The level and method of enhanced payment and shared savings methods of other payers will vary within the market.
 - That's between each practice and the private payer.
- Payers individually responded to the CPC solicitation and were not able to coordinate payment methods or levels.
 - This approach maintains a competitive environment.
- Each selected practice is expected to have contracts in place for at least 60% of total revenues (including Medicare).

The final markets:

- New York (Capital District and Hudson Valley)
- New Jersey: Statewide
- Cincinnati-Dayton, OH and adjacent Northern KY
- Arkansas: Statewide
- Greater Tulsa, OK
- Colorado: Statewide
- Oregon: Statewide

CPCi Practice Locations

The Participating Practices



Source: Centers for Medicare & Medicaid Services

CPCi Practice Locations



Arkansas: Statewide

66 Primary Care Practices | 228 Providers | 4 Payers
Estimated 51,000 Beneficiaries Served | [Learn More](#)



Colorado: Statewide

73 Primary Care Practices | 335 Providers | 9 Payers
Estimated 41,000 Beneficiaries Served | [Learn More](#)



New Jersey: Statewide

73 Primary Care Practices | 252 Providers | 5 Payers
Estimated 42,000 Beneficiaries Served | [Learn More](#)



New York: Capital District-Hudson Valley Region

75 Primary Care Practices | 286 Providers | 6 Payers
Estimated 40,500 Beneficiaries Served | [Learn More](#)

CPCi Practice Locations



Ohio & Kentucky: Cincinnati-Dayton Region

75 Primary Care Practices | 261 Providers | 10 Payers
Estimated 44,500 Beneficiaries Served | [Learn More](#)



Oklahoma: Greater Tulsa Region

68 Primary Care Practices | 265 Providers | 3 Payers
Estimated 45,000 Beneficiaries Served | [Learn More](#)



Oregon: Statewide

70 Primary Care Practices | 517 Providers | 6 Payers
Estimated 49,000 Beneficiaries Served | [Learn More](#)

The Final Payers: 44 MOUs + Medicare

- **New Jersey**
 - Amerigroup
 - AmeriHealth New Jersey
 - Horizon Blue Cross Blue Shield of New Jersey
 - Teamsters Multi-Employer Taft Hartley Funds
 - UnitedHealthcare
- **New York: Capital District- Hudson Valley Region**
 - Aetna
 - Capital District Physicians' Health Plan
 - Empire BlueCross
 - Hudson Health Plan
 - MVP Health Care
 - Teamsters Multi-Employer Taft Hartley Funds

The Final Payers: 44 MOUs + Medicare

Arkansas

- Arkansas Blue Cross and Blue Shield
- Arkansas Medicaid
- Humana
- QualChoice of Arkansas

Oklahoma: Greater Tulsa Region

- Blue Cross and Blue Shield of Oklahoma
- CommunityCare
- Oklahoma Health Care Authority

The Final Payers: 44 MOUs + Medicare

Ohio and Kentucky: Cincinnati-Dayton Region

- Aetna
- Amerigroup
- Anthem Blue Cross
Blue Shield of Ohio
- CareSource
- Centene Corporation
- HealthSpan
- Humana
- Medical Mutual
- Ohio Medicaid within
the Ohio Department
of Job and Family
Services
- UnitedHealthcare

The Final Payers: 44 MOUs + Medicare

Colorado

- Anthem Blue Cross Blue Shield of Colorado
- Cigna
- Colorado Access
- Colorado Choice Health Plans
- Colorado Medicaid*
- Humana
- Rocky Mountain Health Plans
- Teamsters Multi-Employer Taft Hartley Funds
- UnitedHealthcare

The Final Payers: 44 MOUs + Medicare

Oregon

- CareOregon
- Oregon Health Authority
- Providence Health Plans
- Regence Blue Cross Blue Shield of Oregon
- Teamsters Multi-Employer Taft Hartley Funds
- Tuality Health Alliance



Primary Care Practice Eligibility and Selection

Primary Care Practice Eligibility

- Each individual practice site must apply separately (e.g. bricks and mortar or office suite)
- Geographically located in a selected CPC market
- Submits claims to CMS under a common TIN, using the form CMS 1500 (formerly HCFA 1500)
- Serves a minimum of 150 Medicare fee-for-service beneficiaries
- Practices owned by a health system, IPA, academic institution, insurance entity, or other parent owner must attach a commitment letter from their parent owner committing to segregate funds paid in conjunction with the CPC initiative

Application Scoring

Use of Electronic Health Records

Percentage of revenue from
CPC initiative payers

Recognition as a
medical home

Participation in
practice
transformation

Uses of enhanced compensation

- Practices will have discretion to use enhanced, non-visit based compensation to support:
 - Non-billable practitioner time
 - Care teams (e.g. care managers, social workers, health educators, pharmacists, nutritionists, behavioralists) embedded in the practice
 - Community health teams
 - Investment in technology



Milestones for Year 1

Achieving Milestones

- There are 9 primary care practice milestones embedded in the terms and conditions
- The milestones are designed to indicate active testing and implementation of changes in the practice
 - aim of achieving better health, better care, and lower total health system costs
- The initial set of milestones address the first year of the program
- Future milestones will be developed informed by progress by the practices

Milestone #2

Provide care management for high risk patients

- Indicate the methodology used to assign a risk status to every empanelled patient
 - The methodology can use a global risk score or a set of risk indicators to segment the population.
- Establish and track a baseline metric for percent assignment of risk status and proportion of population in each risk category
- Provide practice-based care management capabilities and indicate:
 - Who provides care management services
 - Process for determining who receives care management services
 - Examples of care management plans on request.

Milestone #3

Provide 24/7 patient access guided by the medical record

- Telephone access to nurses or providers affiliated with the practice
 - Ensure real-time, 24/7 access to practice's medical record to inform patient advice and care provided by other professionals

Milestone #5

Use data to guide improvement in care at the provider/
care team level

- Produce panel-based reports at least quarterly with at least one quality measure and one utilization measure.
- These metrics would be chosen by the practice based on their clinical importance and/or improvement potential.

Milestone #6

Demonstrate active engagement and care coordination across the medical neighborhood

- Create a measurement – with numerator and denominator data – to assess impact and guide improvement in at least one transitions of care domain.

Example: Notification of emergency visits at local hospitals in timely fashion

Denominator = All practice patients seen in ED

Numerator = All practice patients seen in local hospital ED for whose visit ED report was received within 48 hours of the visit.

Milestone #7

Improve patient shared decision-making capacity

- Identify a priority condition, decision, or test for the practice
- Use panel-level data to generate a metric for the proportion of patients who received a decision aid

For lists of participating payers, practices and maps of practice distribution

- Visit <http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html>