

Working Definition of Comprehensive Primary Care Payment (CPCP)

Comprehensive Primary Care Payment (CPCP) is a fixed, periodic payment for services delivered over a period of time. This is an up-front comprehensive payment to provide high-quality and high-value primary care services to a patient population. CPCP is adjusted for chronic disease burden, social determinants of health, quality and utilization.

This payment gives doctors the freedom to deliver the care that best meets the needs of their patients. CPCP stands in contrast to the fee-for-service system that limits care to face-to-face visits and is solely driven by the documentation requirements to support billing of an office visit. The CPCP payment model incentivizes doctors to focus on health outcomes rather than the volume of visits or tests.

Comprehensive primary care uses an extended health care team to provide the following:

- ▶ Services are readily accessible, responsive to an individual's preference, and patients can take advantage of enhanced in-person hours and 24/7 telephone or electronic access. (See Table A for a proposed list of services.)
- ▶ Patients receive proactive, relationship-based care management services to improve outcomes through payment for a defined set of primary care services rather than individual components of services.
- ▶ Care is comprehensive, and practices can meet the vast majority of each individual's preventive, physical and mental health care needs.
- ▶ Care is coordinated across the health care system, including specialty care and community services; and patients receive timely follow-up after emergency room or hospital visits.
- ▶ Care is patient-centered, recognizing that patients and their loved ones are core members of the care team. The team actively engages patients to design care that best meets their needs.
- ▶ Quality, utilization, and outcomes of services are measured, and data is analyzed to identify opportunities for improvements in care and to develop new capabilities.

CPCP can be a useful methodology for primary care compensation, whether the physician is in an independent practice, employed, or participating in an alternative payment model.

Table A outlines a possible list of services that would be rendered by a primary care physician and team for* a population of patients in the CPCP model. Specific services provided are likely to be modified based on the needs of the market in which the primary care provider and team are working as well as in negotiations with specific payers.

Table A:

Possible Services Included in Comprehensive Primary Care Payment* (*This is intended to be a possible list of services, not a complete or definitive list. A complete list of services will be a result of negotiations between a specific practice and payer.)
<p>Direct Services</p> <ol style="list-style-type: none"> 1. Patients have 24/7 access to their primary care team through a variety of mediums (e.g., face-to-face visits, internet tele-visits, emails, phone calls, etc.) and their personal health information (i.e., patient portals) 2. Ongoing and appropriate wellness and prevention planning (including vaccine recommendations and other accepted prevention measures) 3. Chronic care management (including ongoing management of chronic diseases such as hypertension and diabetes, medication management, ordering and monitoring of appropriate labs, and coordination with specialists when appropriate) 4. Urgent/episodic care to address acute needs 5. Care is provided in a continuous patient-centered model that prioritizes relationships with a primary care team as the usual source of care 6. Care takes into consideration the social determinants of health affecting the patient and the broader community
<p>Coordination of Care Responsibilities</p> <ol style="list-style-type: none"> 7. Coordination of specialty care, diagnostic services, etc., across the healthcare continuum for conditions beyond the scope of the primary care physician 8. Connecting patients with locally available community resources 9. Coordination of transitions of care as appropriate (admissions to hospital/nursing home/etc., discharges, transfers) 10. Coordination of hospice, home health, and other healthcare outreach services 11. Connecting patients to non-physician care management resources (patient education, health coaching, care coordination, etc.)
<p>Quality Improvement Requirements</p> <ol style="list-style-type: none"> 12. Participates in continuous quality improvement activities 13. Participates in data analysis and reporting programs 14. Uses data analytics to optimize health for individuals AND the broader population of patients attributed to the primary care team