Learn about the Comprehensive Primary Care Initiative:
A Webinar for Primary Care Practitioners

CMS Innovation Center

Agenda

- Introduction
- Overview of Comprehensive Primary Care Initiative
- Primary Care Practice Application and Selection Process

The CMS Mission

CMS is a constructive force and a trustworthy partner for the continual improvement of health and health care for all Americans.

CPC Initiative: The Vision

Through the leadership of public and private payers working together, we will establish a new national model for the purchase and delivery of comprehensive primary care that will improve health and reduce costs across our country.

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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

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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

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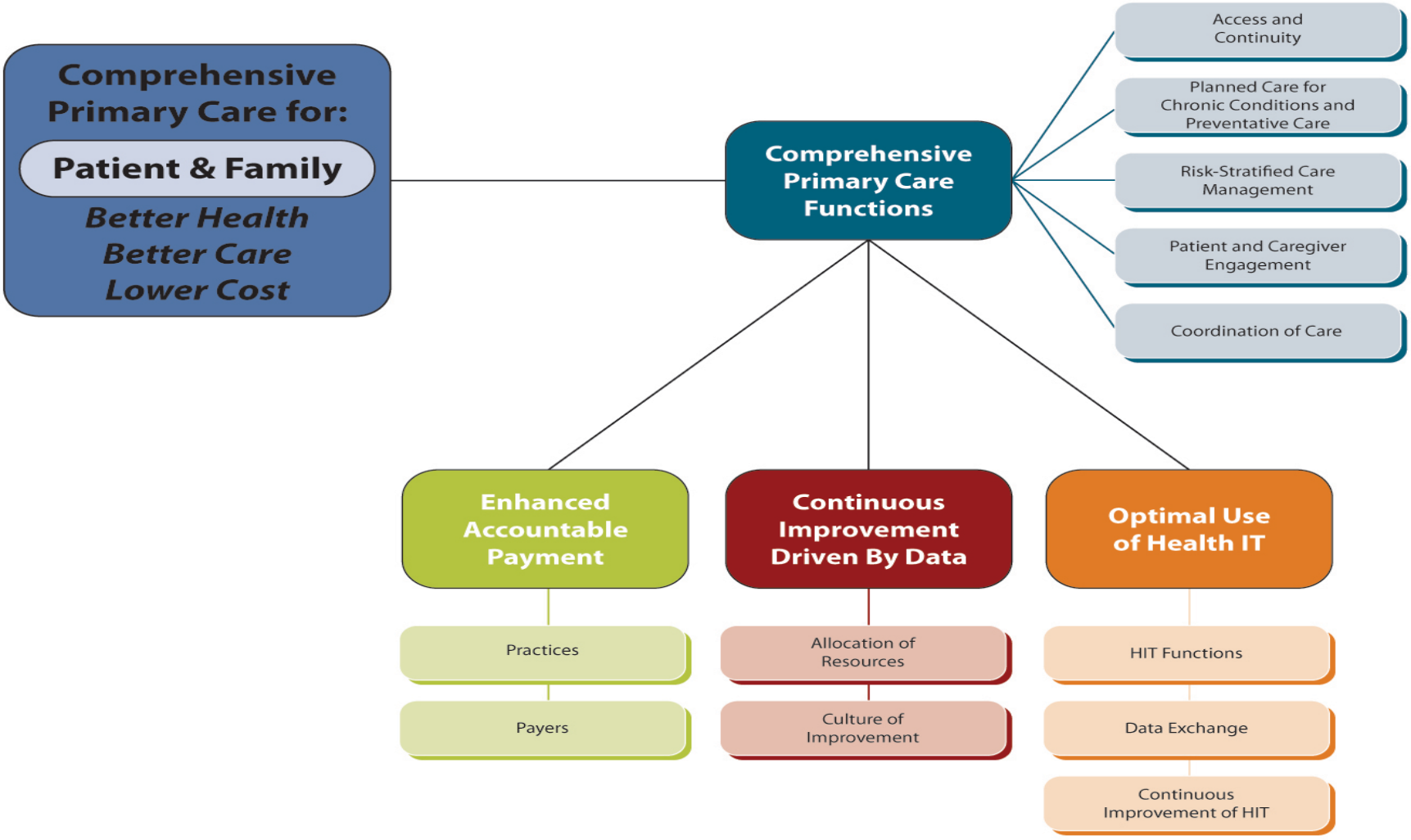
Practice and Payment Redesign in the CPC initiative



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

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1. Risk-stratified care management

- Assessing the health risks for each patient
- Engaging patients to create a plan of care that addresses individual health risks, circumstances, and values
- Intensive care management for the sickest patients with highest needs
- Use of evidence-based pathways for care and decision aids to support clinical decision-making

2. Access and continuity

- Patient access to care and advice 24/7 guided by the medical record when needed
- Continuity of care to build trusted relationships
- A population-based approach to care, with care teams and providers responsible for care of a defined patient panel

3. Planned care for chronic conditions & preventive care

- Use of team-based care to meet the patient's needs
- Development of a personalized plan of care for each patient
- Systematic medication reconciliation and management
- Planned care for chronic conditions and preventive services

4. Patient & caregiver engagement

- Engaging patients and their families in active participation in goal setting and shared decision making
- Building robust support for self-management of health and chronic conditions into daily practice
- Engaging the patient and their families in adopting practice changes that better meet needs

5. Coordination of care across the medical neighborhood

- Comprehensive primary care, with the primary care provider as the lead in coordinating care
- Establish clear mechanisms for exchange of critical information with specialists, emergency care, and hospitals
- Build linkages to community-based resources to help patients meet their health goals

Practice Redesign: Additional Support for Practices

- CMS and the participating payers have made a commitment to share data with practices on utilization and the cost of care for aligned beneficiaries
- Provide market-based learning opportunity to help practices effectively share their experiences, track their progress and rapidly adopt new ways improving
  - 5 comprehensive primary care functions

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Helping Practices Succeed

- The Innovation Center is leveraging local and national expertise to develop local learning communities
- Practices will receive support to test and implement the changes required for comprehensive primary care.
  - participate in periodic calls and in-person meetings
  - actively share resources, tools, and ideas in an online collaboration site, developed for this Initiative
  - report on the online collaboration site key measures that are of importance to the practice

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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*

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Payment Redesign: Medicaid payment

In the following states, the state will receive funding from the Innovation Center to support enhanced, non-visit-based payments to participating practices who also serve fee-for-service (FFS) Medicaid beneficiaries.

- **Arkansas** - average $3.63 PBPM *(1115 waiver population, building on PCCM program)*
- **Colorado** - to be determined
- **Ohio** - average $15.00 PBPM *(Aged, Blind, Disabled population)*
- **Oregon** - average $4.00 PBPM *(population not eligible for Medicaid Health Home)*

State will conduct beneficiary attribution.

Shared savings will not be offered as part of the CPC payment redesign in Medicaid.

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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).

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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)

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7 Selected Markets with 44 Payers

	Effective Start Date
Arkansas: Statewide (4 Payers)	Oct. 1, 2012
Colorado: Statewide (9 Payers)	Nov. 1, 2012
New Jersey: Statewide (5 Payers)	Nov. 1, 2012
New York: Capital District-Hudson Valley Region (6 Payers)	Nov. 1, 2012
Ohio and Kentucky: Cincinnati-Dayton Region (10 Payers)	Nov. 1, 2012
Oklahoma: Greater Tulsa Region (3 Payers)	Oct. 1, 2012
Oregon: Statewide (7 Payers)	Nov. 1, 2012

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What would it mean for you practice to participate in the CPC Initiative?

- New resources
  - Multiple payers, including CMS, will be paying a monthly care management fee to support the 5 primary care functions
- More data about your population of patients
  - Each payer will provide data on cost of care and resource use for attributed patients
- Opportunity to share in savings with CMS and other payers.

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How would your practice be different?

- Harness the power of your EHR to:
  - Access the patient information you need when you need it to manage the healthcare of your patients
  - Assure your patients seamless, coordinated care
  - Use your clinical data to know how well your patients are doing
- Proactive risk assessment for your patients
- Dedicated staff to support care management, transitions
- Payment for high-value care, not based on visits

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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

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

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Milestone #1

Complete an annual budget or forecast

- Project new CPC Initiative practice revenue flow
- Indicate how it will be used for anticipated expenses associated with practice change
  - practices can submit their own budgets with defined domains, or build off of a template provided by the Innovation Center

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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 #4

Assess and improve patient experience of care

- Practices will select at least one of the following:
  - Provide at least 2 quarters of focused survey data based on at least one CG-CAHPS survey domain chosen by the practice after review of initial survey results done under this initiative; or
  - Provide evidence of guidance from a patient advisory council that meets at least quarterly, along with specific discussion of how this feedback was used to change practice workflow or policy.

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.

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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.

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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

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Milestone #8

Participate in the market-based learning community:

- Attendance at three face to face meetings annually
- Web-based meetings at least monthly
- Sharing of materials or resources on the collaboration site
- Reporting on the collaboration site at least 6 key measures identified by the practice to guide active testing of change
  - These may include measures required for patient experience, risk status assignment, care coordination, etc., as described above

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Milestone #9

Attest to the requirements for Stage 1 of Meaningful Use for the EHR Incentive Program

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Primary Care Practice Eligibility and Selection

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Application Process for Primary Care Practices

- Application Period: June 15 – July 20, 2012
- Go to Innovation Center webpage to begin the practice application: http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html
- Innovation Center will select approximately 75 primary care practices in each market
- Selected practices agree to meet the Innovation Center's program criteria (terms and conditions) for which they will receive enhanced payment
- Selected practices will separately enter into agreements with participating payers

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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

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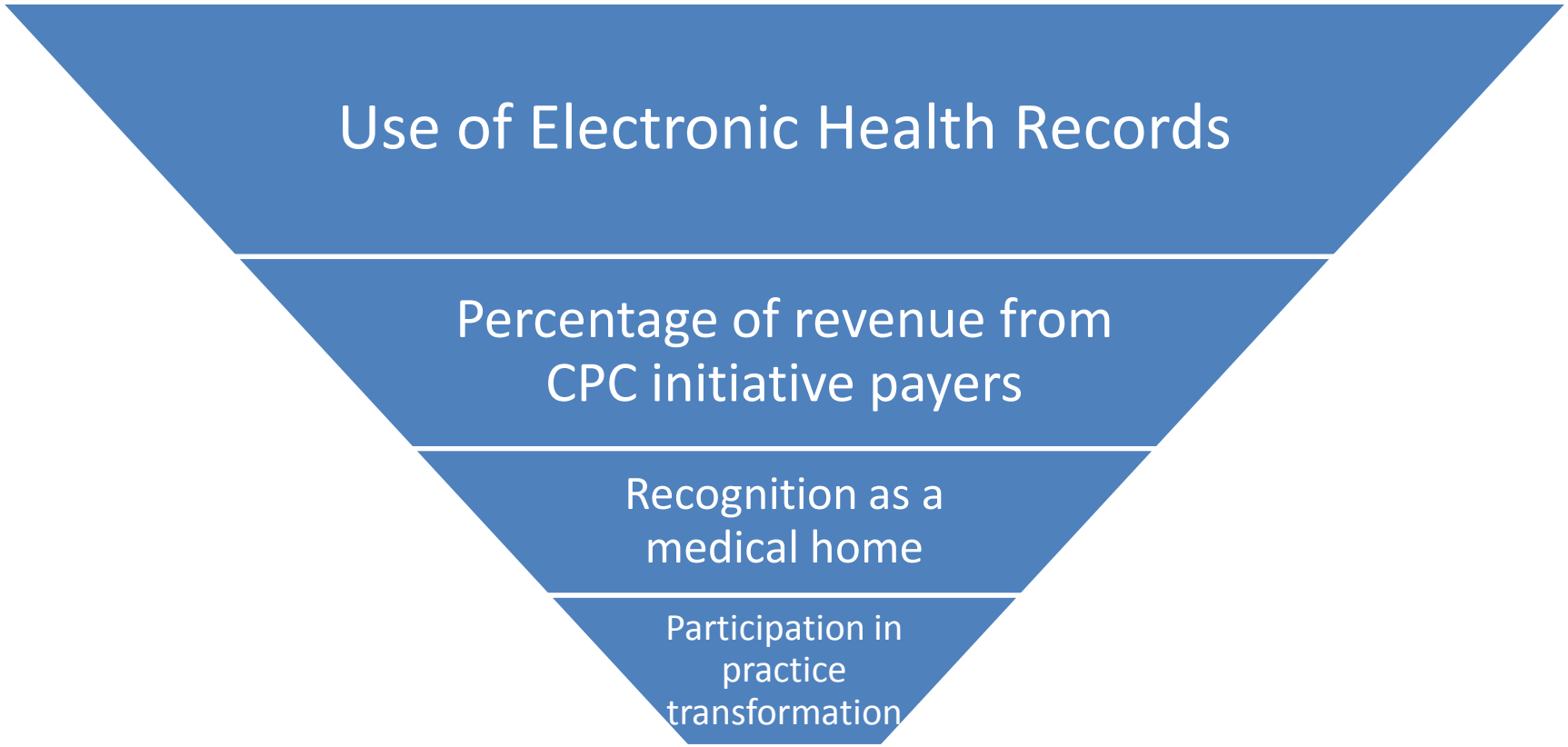
Eligibility of Medicare Beneficiaries

- Not necessary to enroll beneficiaries.
- The Innovation Center will attribute eligible beneficiaries to a primary care practice through a claims-based process.
- CMS must be able to attribute patients uniquely to a single practice and group of primary care practitioners.
  - A practitioner who practices in multiple locations can only select one location for participation in the CPC initiative.
  - This practitioner may, however, continue to practice at other locations.

Participation in other Medicare programs, initiatives, models, or demonstrations

- A primary care practice may not participate in the CPC Initiative if:
  - it participates in any other initiative or program that includes shared savings with Medicare
  - its Tax Identification Number (TIN) is the same as any other entity participating in the Medicare Shared Savings Program
- Participation in the CPC Initiative may make the practice and/or practitioners in the practice ineligible to apply for other CMS or Innovation Center initiatives

Application Scoring



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Content of Primary Care Practice Application

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Contents of the Practice Application

Section I: Demographic Information of the Practice

- Practice Name
- Address
- Contact Information
- Tax Identification Number (TIN)

Section II: Staffing and Structure of Practice

- National Provider ID for all primary care practitioners
- Meaningful use status of each primary care practitioner
- Composition of other practitioners that work in the practice (if a practice is multi-specialty)
- Ownership of practice

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Contents of the Practice Application

Section III: Use of Health Information Technology

- Description of practice's current utilization of electronic health records
- Name of EHR vendor and product
- Use of electronic registry to track and identify gaps in care

Section IV: Patient Panel Characteristics

- Description and composition of patients served by the practice

Contents of the Practice Application

Section V: Practice Revenue Sources

- List all revenue (insurance and copays) generated by services provided to patients
  - *Practices should use their billing system or billing vendor to generate this information*

Section VI: Practice Recognition/Certification and Participation in Other Programs

- List all certifications or accreditations
- Describe participation in learning collaboratives and quality improvement activities

Contents of the Practice Application

Section VII: Terms and Conditions for Participating in the Comprehensive Primary Care Initiative

– By submitting an application for the CPC Initiative, applicants are agreeing to all of the terms and conditions for participation.

Section VIII: Upload Submission Letter

– To finalize the application, upload a scanned, dated one-page PDF statement on your organization's letterhead stating: "I certify that all information and statements provided in this proposal are true, complete, and accurate to the best of my knowledge and are made in good faith."

– The letter needs to be signed by each of the primary care practitioners in the practice.

Join Us

CPC Vision:

Through the leadership of public and private payers working together, we will establish a new national model for the purchase and delivery of comprehensive primary care that will improve health and reduce costs across our country.

We look forward to working with primary care practices, public and private payers, and other community stakeholders to realize this vision.

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Questions

Contact CPCi@cms.hhs.gov for any additional questions