Primary Care Transformation in the Era of Value

CMS Innovation Center & Primary Care

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Center for Medicare & Medicaid Innovation ● Centers for Medicare & Medicaid Services
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Introductions

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Your Turn

• Who are you?
• What organization do you represent? What is your role there?
• What do you hope to get out of the session?
Topics for Our Time Together

1 Where does primary care fit in the alternative payment landscape?
   - A vision for the future of primary care in the Comprehensive Primary Care model
   - Experiences with alternative payment models supporting care delivery approaches that meet the aims of better care, smarter spending, and healthier people

2 How do practices move beyond the fee-for-service treadmill?
   - High leverage changes in care delivery
   - Payment strategies that incentivize and support that care
   - Strategies for practice change

3 What does primary care need to succeed?
   - Lessons learned from the Comprehensive Primary Care initiative

Alternative Payment Landscape

Policy:
- Affordable Care Act
- Delivery System Reform Goals
- MACRA & MIPS

CMS:
- MSSP
- Pioneer ACO
- MAPCP
- NGACO
- TCPi
- CPC
- CPC+
Comprehensive Primary Care initiative

Theory of Change
CPC tests whether the provision of comprehensive primary care at the practice site, supported by multi-payer payment reform, continuous use of data, and meaningful use of health information technology, can achieve better care, smarter spending, and healthier people.

Participants and Partners
- **4 year model**: 2012-2016
- **7 regions**: 4 states and portions of 3 states
- **442 participating practices** comprised of 2,200 practitioners, supporting 2.7 million patients, including 335,000 Medicare beneficiaries and 78,000 Medicaid beneficiaries
- **38** public and private payers
- Learning Community and faculty to support transformation

CPC Driver Diagram
CPC Care Delivery Model: High-Leverage Practice Changes

<table>
<thead>
<tr>
<th>CPC Milestones</th>
<th>Tactics</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ Budget</td>
<td>Prioritization of investment, staffing, EHR</td>
</tr>
<tr>
<td>! Risk-Stratified Care Management</td>
<td>Empanelment, risk stratification, care management</td>
</tr>
<tr>
<td>Access</td>
<td>24/7 access, asynchronous communication</td>
</tr>
<tr>
<td>! Patient Engagement</td>
<td>Patient Family Advisory Councils, surveys</td>
</tr>
<tr>
<td>Use Data to Guide Improvement</td>
<td>Data-driven quality improvement</td>
</tr>
<tr>
<td>Care Coordination across the Medical Neighborhood</td>
<td>Hospital/ED follow-up, specialty care compacts</td>
</tr>
<tr>
<td>! Shared Decision Making</td>
<td>Decision aid use in preference sensitive care</td>
</tr>
<tr>
<td>Meaningful Use of Health IT</td>
<td>EHR Incentive Program, eCQM reporting</td>
</tr>
<tr>
<td>Participation in Learning Community</td>
<td>All teach, all learn, use of data to drive improvement</td>
</tr>
</tbody>
</table>

CPC Care Delivery Model: Assessing Transformation

Percent of active patients empanelled at CPC practices. **99%**

Empanelment assigns patients to a practitioner or care team, as a foundation for relationships with patients and population health.

**1 in 5** empanelled patients receive care management for high or rising risk.

Care management is a primary care function tailored to patients at highest risk for adverse, preventable outcomes.

Nearly **1 in 5** practices have care compacts with local specialists, most commonly:

- Cardiology (50 practices)
- Gastroenterology (34 practices)
- Orthopedic surgery (32 practices)
- Obstetrics/gynecology (24 practices)

**108** practices have **BEHAVIORAL HEALTH SPECIALISTS** in the practice.
CPC Care Delivery Model: What Have We Learned?

Leveraging Works Forward & Backward
- Some changes require foundational work and can guide future change productively
- Required steps should be a solution, not the problem itself

More Is Not Better
- Focus efforts on smaller set of high leverage changes

The Work of the Practice Is Patient Care
- Changes must have a clear link to patient care

Different Kinds of Change Have a Different Pace
- Need centralized infrastructure with local market governance to support operations
- Integrate data for comprehensive reporting

CPC Payment Design

<table>
<thead>
<tr>
<th>Year</th>
<th>Care Management Fee (PBPM*)</th>
<th>Shared Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$20 average</td>
<td>Not measured</td>
</tr>
<tr>
<td>Year 2</td>
<td>$20 average</td>
<td>Regional financial outcomes eCQM scored for reporting</td>
</tr>
<tr>
<td>Year 3</td>
<td>$15 average</td>
<td>Regional financial outcomes eCQM scored for performance</td>
</tr>
<tr>
<td>Year 4</td>
<td>$15 average</td>
<td>Regional financial outcomes eCQM scored for performance</td>
</tr>
</tbody>
</table>

* PBPM: per-beneficiary per month
CPC Payment Design: What Have We Learned?

Change is Limited in a Fee-For-Service Environment
- Volume still matters too much

The “Commons” is An Uncommonly Complicated Place
- Shared opportunity promotes transparency and collaboration, but...
- Individuals act independently in their own self-interest

Practices Need “Line of Sight” from Investments to Returns
- Change requires investments of time, energy, staff, and financial resources
- Shared savings based on total cost of care doesn’t provide that “line of sight”
- The line between changes in practice organization and utilization outcomes is clearer

Learning Support for Practices in CPC

- Practice
- Regional Community
- National Community

Communications of requirements
- Regional Learning Sessions
- Practice networking
- Shared data, shared savings, shared aims
- HIE and engagement with regional stakeholders
- Alignment with regional reform

Fundamental changes in care delivery
- Facilitation & coaching

Web-based collaboration platform
- Topic-focused Action Groups (collaboratives)
- National Stakeholder Meeting
CPC Learning System: What Have We Learned?

Practices Valued and Felt Benefit With Practice Coaching
- Difficult to deliver at scale with consistency and reliability
- Data-driven targeting puts resources where needed

Successful Practices Built Internal Change Management Capability
- Coaching from within
- Keep the practice in the driver’s seat for change

National Learning Communities Are Best At...
- Clear consistent messaging
- Cross-regional collaboration
- Allow a diversity of offerings (e.g., Action Groups) to meet practices where they are

Regional Learning Communities Are Best At...
- Networking, relationships, trust
- Alignment with regional reform
- Connection to payers

CPC Data Feedback

Beneficiary Attribution
- List of Medicare FFS beneficiaries attributed to the practice, by risk tier
- Quarterly financial support amounts

Multi-Payer Aligned Data Feedback

Patient-Level Cost and Utilization
- Expenditures: professional services, inpatient, outpatient, labs, imaging, SNFs
- Utilization: inpatient, 30-day readmission, ED utilization

Practice Financial and Quality Performance
- eCQM and patient experience results
- Expenditures and utilization results

Practice and Region-Level Cost and Utilization
- Quarterly report comparing practice to regional performance
- Quarterly report comparing each region to other regions’ performance
CPC Data Feedback: What Have We Learned?

Multiple Pathways to Regional Payer Alignment on Data
- Data aggregation vs. data alignment

Transparency Grows On You
- Regions increased interest in and willingness to share data, with limits

Definition of “Actionable Data” Depends on Practice Capabilities

Other Things We’ve Learned

CMS as payer/regulator and as transformation partner

Donabedian
Structure
Process
Outcomes

Model for Improvement (API)
Process
Outcome
Balancing

Productive tension
Meet Requirements

Test into better outcomes
Build and Maintain Essential Capabilities
Achieve Desired Aims
Summary of Lessons Learned

1. Adequately supporting primary care takes robust commitment and real incentives.

2. Practices need to make business choices to best leverage new opportunities in alternative payments.

3. Meaningful change takes time and requires building internal change management capabilities.

4. Feedback loops between payers and practices: data, data, data.

2:30 – 3:00 pm

Break
Buzz Session

You Are Faced With a Challenge
Based on lessons learned, develop key elements that support comprehensive primary care transformation.

Topics and Questions to Consider

Payment
- What kind(s) of payment will support comprehensive primary care?
- What should the underlying payment system look like?
- What is the best alignment of incentives for practices?

Care Delivery
- What are the patterns of practice that will enable practices to best meet their patients’ needs?
- What are the high leverage practice changes?
- How should practices target their efforts (e.g., specific patient populations, etc.)?

Practice Support
- What types of support do practices need from payers, regulators, and other stakeholders?
- How do we incorporate learning and data effectively?
- Are there other non-financial supports critical to success?

Evolution of Comprehensive Primary Care Model
Looking Ahead to CPC+

<table>
<thead>
<tr>
<th></th>
<th>CPC</th>
<th>CPC+ Track 1</th>
<th>CPC+ Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope</td>
<td>7 regions; 500 practices</td>
<td>14 Regions; ≤2,500 practices</td>
<td>14 Regions; ≤2,500 practices</td>
</tr>
<tr>
<td>Duration</td>
<td>4 Years (2012-2016)</td>
<td>5 Years (2017-2021)</td>
<td>5 Years (2017-2021)</td>
</tr>
<tr>
<td>Multi-Payer Support</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HIT Partnership</td>
<td>No requirement</td>
<td>No requirement</td>
<td>Required</td>
</tr>
<tr>
<td>Medicare Care Management Fee (PBPM)</td>
<td>$20 average (PY 1-2), $15 average (PY 3-4); 4 risk tiers</td>
<td>$15 average; 4 risk tiers</td>
<td>$28 average; 5 risk tiers with $100 for highest-risk tier</td>
</tr>
<tr>
<td>Medicare Payment Structure</td>
<td>Standard FFS</td>
<td>Standard FFS</td>
<td>Upfront Comprehensive Primary Care Payment (CPCP) with reduced FFS</td>
</tr>
<tr>
<td>Medicare Performance Incentive</td>
<td>Retrospective regional shared savings based on quality and regional COC</td>
<td>Prospective but at-risk practice-level incentive payment based on quality and utilization</td>
<td>Prospective but at-risk practice-level incentive payment based on quality and utilization</td>
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Streamlined Requirements

<table>
<thead>
<tr>
<th>CPC Milestones</th>
<th>CPC+ Requirements</th>
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<tbody>
<tr>
<td>$ Budget</td>
<td>$ Annual Forecast</td>
</tr>
<tr>
<td>Risk Stratification and Care Management (and advanced primary care strategies)</td>
<td>Access and Continuity</td>
</tr>
<tr>
<td>Access</td>
<td>Care Management</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Comprehensiveness and Coordination</td>
</tr>
<tr>
<td>Use Data to Guide Improvement</td>
<td>Planned Care and Population Health</td>
</tr>
<tr>
<td>Care Coordination across the Medical Neighborhood</td>
<td>Patient and Caregiver Engagement</td>
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<td>Shared Decision Making</td>
<td>Optimal Use of Health IT</td>
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<td>Meaningful Use of Health IT</td>
<td>Participation in Learning Community</td>
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Enhanced Health IT Functionality Supports Care Delivery

**Access and Continuity**
- Patient Empanelment
- 24/7 Access
- Out-of-Office Care Options

**Care Management**
- Risk Stratification
- Hospital/ED Discharge Follow-Up
- Care Plans

**Comprehensiveness and Coordination**
- Coordination with Other Providers
- Integrated Behavioral Health
- Psychosocial Needs Assessment

**Patient and Caregiver Engagement**
- Patient and Family Advisory Council
- Self-Management Support Tools

**Planned Care and Population Health**
- Practice and Payer Data Insight
- Full Care Team Data Review

**Evolution of Payment Redesign**

<table>
<thead>
<tr>
<th></th>
<th>CPC</th>
<th>CPC+ Track 1</th>
<th>CPC+ Track 2</th>
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<tbody>
<tr>
<td><strong>PBPM Risk-Adjusted Care Management Fee</strong></td>
<td>$20 average (PY 1-2); $15 average (PY 3-4)</td>
<td>$15 average</td>
<td>$28 average</td>
</tr>
<tr>
<td><strong>Underlying Payment Structure</strong></td>
<td>Standard FFS</td>
<td>Standard FFS</td>
<td>Prospective Comprehensive Primary Care Payment (CPCP) with reduced FFS</td>
</tr>
<tr>
<td><strong>Quality &amp; Cost Performance Incentive</strong></td>
<td>Retrospective regional shared savings</td>
<td>Prospective, at-risk practice-level incentive payment ($2.50 opportunity)</td>
<td>Prospective, at-risk practice-level incentive payment ($4.00 opportunity)</td>
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Many Opportunities for Learning, Collaboration, and Support

Learning Communities

National Learning Community
- Cross-region collaboration
- Live and on-demand learning opportunities: action groups, webinars, affinity groups, office hours
- Durable written products: Implementation Guide, newsletters, FAQs, case studies/spotlights
- Annual Stakeholder Meeting

Regional Learning Communities
- Virtual and in-person learning sessions
- Outreach to and support for practices
- Clinical and administrative leadership engagement
- Payer engagement
- Alignment with regional reform

Centralized Data Feedback

<table>
<thead>
<tr>
<th>Financial Data</th>
<th>Cost &amp; Utilization Data</th>
<th>Quality Data</th>
<th>Care Delivery Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attributed Beneficiaries</td>
<td>(Beneficiary/Practice/Regional)</td>
<td>eCQM &amp; CAHPS Results</td>
<td>Milestone Reporting</td>
</tr>
<tr>
<td>Track 1 &amp; 2 Payments</td>
<td>Expand (inpatient, outpatient, professional services, etc.)</td>
<td>Forecast &amp; Reconciliation Reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Utilization (inpatient, ED utilization, etc.)</td>
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CPC+ Practice

Regional Learning Community
Learn more about CPC+

Visit
https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus

Email
CPCplus@cms.hhs.gov