MATHEMATICA Policy Research

Paying for Primary Care: Two CMS/CMMI payment experiments

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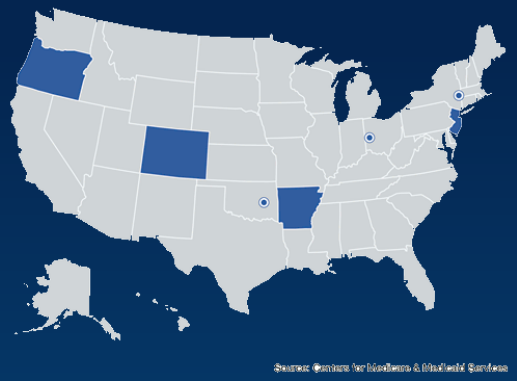
The Comprehensive Primary Care Initiative

CPC seeks to strengthen primary care

- **Improve health, lower costs, and improve patient and provider experiences by providing resources to help practices enhance primary care in 5 areas:**
  - **Risk-stratified care management**
  - **Improved access and continuity of care**
  - **Planned care for chronic conditions and preventive care**
  - **Patient and caregiver engagement**
  - **Coordination of care across the medical neighborhood**

Organization of the CPC initiative

- **4-year multi-payer model launched by CMS in October 2012 to test advanced primary care**
  - **31 payers, ranging from 3 to 9 per region, plus CMS**
  - **Provides capital through care-management fees and incentives through shared savings opportunity**
  - **Payers share data through feedback reports**
- **315,000 Medicare patients**
- **Technical assistance and collaborative learning networks**
  - AR, CO, OH/KY, OK, OR, NJ, NY



- **Evaluation will assess CPC effect on quality, cost, patient wellbeing, practice behavior, and providers, and identify factors associated with success**

The CPC payment model

- **Per member/per month payment in the initial stages, regionally-determined shared savings model in later stages**
  - **CMS payments average $20 per member/per month**
  - **Payments are risk adjusted**
  - **Shared savings model – in development**

CPC learning network and data feedback

- **Learning and diffusion contractors in each region provide technical assistance to support practice transformation**
  - **Webinars**
  - **Collaboration website**
  - **Learning collaborative meetings**
  - **In-person visits**
- **Data feedback to practices**
  - **Quarterly reports on Medicare costs and utilization**

How are practices transforming?

- **Must meet annual milestones designed to improve care in the 5 functional areas to remain in the program**
- **Budget for and use CPC funding from CMS and other payers to achieve milestones**
- **Practices use resources for:**
  - **Risk-stratifying their patient panel**
  - **Hiring care coordinators**
  - **Improving health IT**
  - **Expanding access and office hours**
  - **Coordinating care across the medical neighborhood**
  - **Assessing and improving patient experience**
- **Too early for estimates of program effects; first annual report out this year**

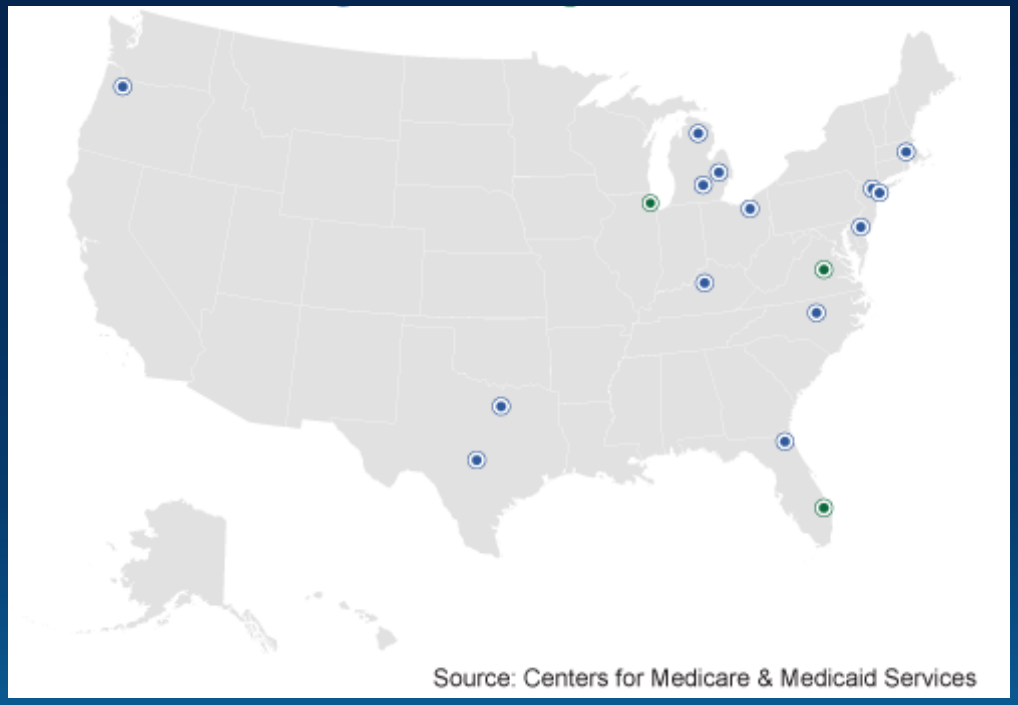
The Independence at Home Demonstration

IAH tests a home-based primary care model

- **Mandated by Section 3024 of the Affordable Care Act *(P.L. 111-148)***
- **Does home-based primary medical care providing comprehensive, coordinated, continuous and accessible care to high-need populations at home and coordinating care across all treatment settings to improve health outcomes and reduce expenditures for high-risk Medicare beneficiaries:**
  - **Reduce preventable hospitalizations**
  - **Prevent hospital readmissions**
  - **Reduce emergency room visits**
  - **Improve health outcomes**
  - **Improve efficiency of care**
  - **Reduce costs of health care services**
  - **Achieve beneficiary and caregiver satisfaction**

Organization of the IAH demonstration

- **15 practices started in June 2012, 3 in September 2012**
  - **Chosen to reflect geographic (15 states and DC), size, affiliation, and care model variation**



IAH patients

- **Must…**
  - **be entitled to Medicare Part A benefits and be enrolled in Part B benefits**
  - **NOT be enrolled in a Medicare Advantage (MA) plan under Part C**
  - **NOT be enrolled in a Program of All-inclusive Care for the Elderly (PACE) under SSA Title 18 Sec 1894**
  - **have two or more chronic conditions**
  - **have had a hospital admission within the past 12 months**
  - **have received acute or subacute rehabilitation services within the past 12 months (including skilled nursing facility, home health, or inpatient and outpatient rehabilitation services)**

AND

  - **require the assistance of another person (assistance may include supervision, cueing, or hands-on help) for two or more activities of daily living (ADLs)**

IAH quality measures

- **Inpatient admissions for ambulatory care sensitive conditions (ACSCs)**
- **Readmissions within 30 days**
- **Emergency department (ED) visits**
- **In-home medication reconciliation**
- **Documentation of patient preferences**
- **Contact with beneficiaries within 48 hours of admission to the hospital and visit within 48 hours after discharge from the hospital or ED.**

IAH payment model

To be eligible for incentive payments, practices must…

- **Enroll 200 patients**
- **Achieve at least 3 of the 6 Quality Measures**
  - 6 of 6 – eligible for 100% of the incentive payment*
  - 5 of 6 – eligible for 83%
  - 4 of 6 – eligible for 67%
  - 3 of 6 – eligible for 50%
- **Meet the practice-specific Minimum Savings Requirement (MSR) relative to practice-specific target expenditures**
  - Practices that exceed their specific MSR at the 5% significance level are eligible for payments of up to 80% of the remaining savings
- **Too early for estimates of program effects; initial report out this year**

Conclusions

- **CMS/CMMI experimenting with new payment models as a way to motivate major changes in primary care delivery and outcomes**
- **CMS appears to be moving toward a system that ties new payments for primary care to improved processes and outcomes**
- **Evaluation of results from these initiatives will improve understanding of:**
  - **How payment changes affect quality, costs, and patient satisfaction with care**
  - **The role of technical assistance and data feedback in supporting change**
  - **Which models of primary care support the "triple aim"**

For More Information

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