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Advanced Primary Care Models: An Update from the Center for Medicare and Medicaid Innovation

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Alliance for Health Reform

Why We All Care—Meet My Dad

17 meds/vitamins

(Glipizide, Doxazosin mesylate, Micardis, Amlodipine besylate, Furosemide, Metroprolol succinate, Niaspan, Trilypix, Omega 3, Pantoprazole sodium, Xalatan, Vitamin D, Iron, Warfarin, Pramosone lotion, Microlet lancets, Jalyn)

- **Primary care**
- **Endocrinologist**
- **Cardiologist**
- **Coumadin clinic**
- Urologist
- Ophthalmologist
- Physical therapist

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2

Primary Care Models and Demos

- Comprehensive Primary Care (CPC) Initiative
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home
- Graduate Nurse Education Demonstration

CMMI Primary Care Initiatives

- Comprehensive Primary Care (CPC) Initiative
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home
- Health Care Innovation Awards
- State Innovation Models
- Graduate Nurse Education Demonstration

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Multi-payer Advanced Primary Care Practice Model

GOAL: Test the effectiveness of offering providers a common payment method from Medicare, Medicaid, and private health plans.

- Medicare will participate in existing State multi-payer health reform initiatives.
- Must include participation from Medicaid and private health plans.
- Monthly care management fee for beneficiaries receiving primary care from Advanced Primary Care practices.
- Eight states selected: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan and Minnesota.

Federally Qualified Health Center (FQHC) Advanced Primary Care Demonstration

GOAL: Evaluate impact of the advanced primary care practice model in the Federally Qualified Health Center (FQHC) setting and show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs.

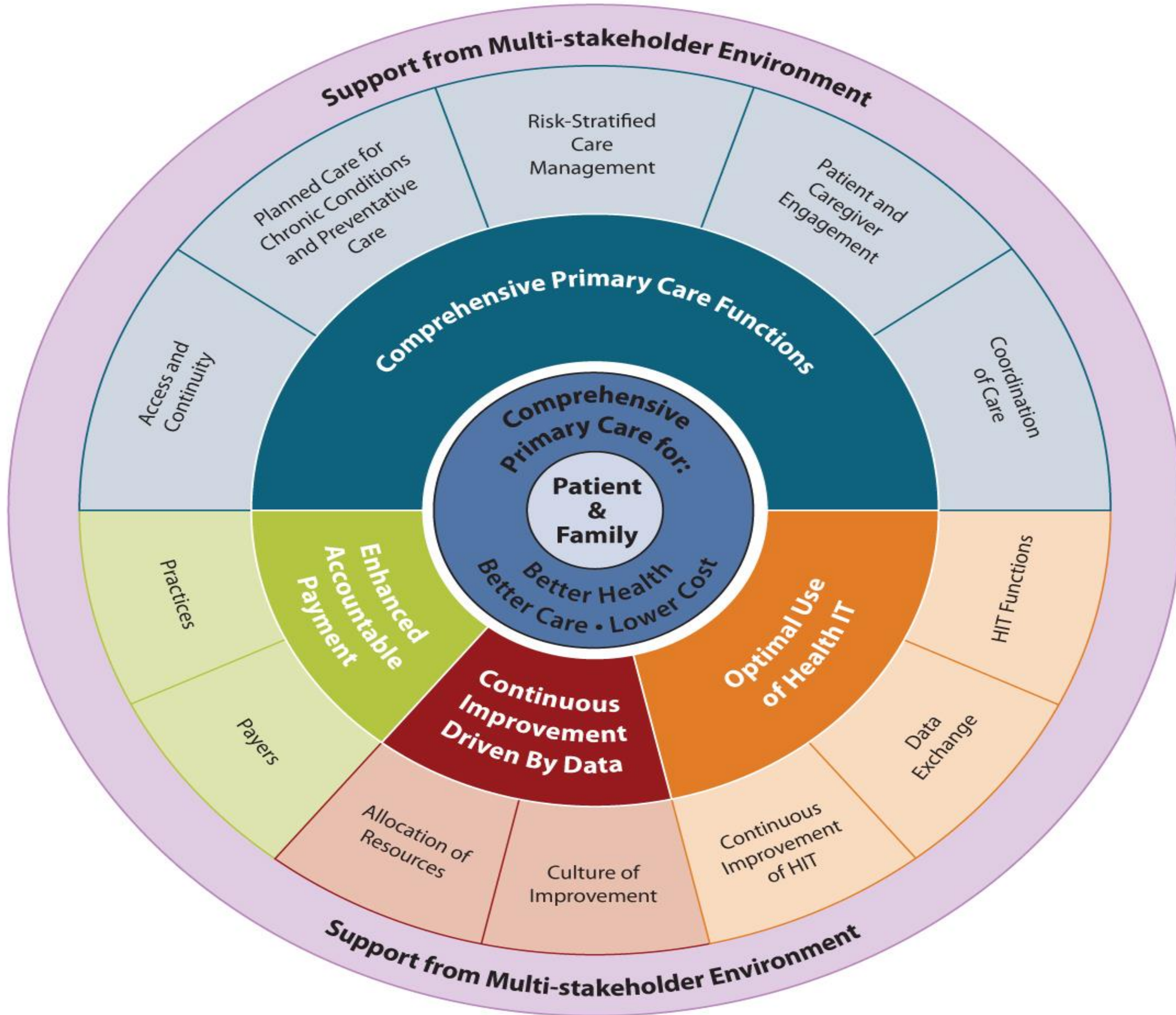
- FQHCs selected must have provided medical services to **at least 200 Medicare beneficiaries.**
- FQHC receives care management fee for each Medicare beneficiary enrolled.
- 500 FQHCs selected are in 46 states.
- Performance year started Nov 1, 2011.

Comprehensive Primary Care Initiative

GOAL: Test a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care.

- **Practice redesign** involves provision of “comprehensive primary care” characterized by 5 core functions, better use of data and HIT by practices, and learning opportunities to support practice transformation.
- **Payment redesign** involves multi-payer investment in selected primary care practices, with Medicare paying an average $20 per beneficiary per month (PBPM) in first 2 years, moving to a $15 PBPM in years 3 and 4, and a shared savings opportunity in years 2-4 of the program.
- **Participants:** 40+ payers, including Medicaid, OPM, TriCare; 7 regions—States of AR, CO, NJ, OR; regions of Cincinnati, OH & 4 northern counties in KY; Hudson Valley, NY; and Tulsa, OK; 483 primary care practices, 2,514 PCPs; ~370,000 FFS Medicare and Medicaid beneficiaries

Comprehensive Primary Care Initiative



The 9 CPC Milestones

- Annual budget
- Care management for high risk patients
- 24/7 access by patients
- Assess/improve patient experience
- Use data to guide improvement
- Care coordination
- Shared decision making
- Participation in learning community
- Meaningful use (if not already there)

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Year 1 Milestones—A Few Highlights

- Care management: 2.6 million active patients and 2.3 million are empanelled to CPC providers
- 24/7 access: 62% remote access to EHR through VPN; 35% remote access to EHR through web or cloud
- Patient experience/engagement: 100 patient family advisory councils formed; Over 300 practices regularly surveying patients
- Care coordination: 76% focused on post-hospital actions; 24% focused on coordination of ambulatory specialist care

Thank You

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