New Pathways for Primary Care: An Update on Primary Care Programs From the Innovation Center at CMS

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ABSTRACT

Those in practice find that the fee-for-service system does not adequately value the contributions made by primary care. The Center for Medicare and Medicaid Innovation (Innovation Center) was created by the Affordable Care Act to test new models of health care delivery to improve the quality of care while lowering costs. All programs coming out of the Innovation Center are tests of new payment and service delivery models. By changing both payment and delivery models and moving to a payment model that rewards physicians for quality of care instead of volume of care, we may be able to achieve the kind of health care patients want to receive and primary care physicians want to provide.

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Primary care could be so much more than it is today. Those in practice aspire to deliver excellent care all the time, yet many feel frustrated by constraints of time and money as they struggle to incorporate burgeoning responsibilities.[1] Physician organizations and some policy makers have argued that the fee-for-service system does not adequately value the contributions made by primary care.[2] Meanwhile, many practicing primary care physicians have, out of necessity, oriented and organized their practices around the very payment systems they decry. Initiatives throughout the country, however, appear to be demonstrating that if we change both payment and delivery models, we may be able to achieve the kind of health care patients want to receive and primary care physicians want to provide.[3-5]

The Center for Medicare and Medicaid Innovation (Innovation Center) was created by the Affordable Care Act to test new models of health care delivery to improve the quality of care while lowering costs. We have a number of programs in various stages of development and implementation that are directly focused on testing whether new models of enhanced primary care payment and delivery can achieve improved quality at reduced costs. Collectively they communicate a vision for the future of primary care. All these programs have been designed to be synergistic with and supportive of models that are being developed and implemented in the private sector, and each model tests different features of primary care payment or practice redesign.

One of the unique features of the Innovation Center, in addition to its flexibility and resources, is a pathway for scaling up successful initiatives. If one of the payment or service delivery models tested by the Innovation Center successfully demonstrates, to the satisfaction of the Medicare Actuary and the Secretary of Health and Human Services, improvement in quality and lower costs, the Secretary is able to expand the initiative within the Medicare, Medicaid, and Children's Health Insurance Program (CHIP) programs through Department of Health and Human Services rule-making and without needing further authorization or action by Congress. This powerful pathway for institutionalizing and sustaining suc-

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cessful programs makes it particularly important that the Innovation Center programs be designed to be rigorously evaluated and positioned to succeed. Thus Innovation Center programs are not just free-standing tests; they can be a vehicle leading directly to change in the payment system.

The Innovation Center announced the Multi-Payer Advanced Primary Care (MAPCP) demonstration in November 2010.[6] Under this program, authorized by federal statute (42 USC 1395b-1), the Centers for Medicare and Medicaid Services (CMS) sought states that had successfully initiated—or would be ready to implement within a specified time frame—multipayer primary care payment and practice redesign initiatives and offered to join those initiatives on the same basis as other participating payers. Because of antitrust barriers forbidding coordinated pricing—even when the intention is to pay more—it has been difficult for insurers within communities to develop a common strategy for purchasing advanced primary care. Some states have resorted to formal legislative or executive action to overcome these barriers, but this approach has not been widespread.

Each state participating in MAPCP has a somewhat different set of expectations for the participating practices and varies in how much direct financial support each insurer is paying to the practices. States are the conveners and leaders in this program; most states expect participating practices to achieve recognition by the National Committee for Quality Assurance (NCQA), or similar recognition from another entity, as an accredited Patient-Centered Medical Home (PCMH), but states also have supplemental expectations for participating practices. Medicare is paying fees up to $10 per beneficiary per month to contribute its share of support for the infrastructure the practices need to build to deliver high-value primary care activities, including quality reporting and improvement, care management, and expanded access. By the end of the third year of the demonstration, up to 1,200 practices in 8 states are expected to be participating, caring for up to 900,000 Medicare beneficiaries.

In partnership with the Health Resources and Services Administration (HRSA), the Innovation Center announced the Federally Qualified Health Center (FQHC) demonstration in July 2011.[7] Under this program, participating FQHCs are offered support, on behalf of fee-for-service Medicare beneficiaries in their practices, of $6 per beneficiary per month to undergo practice transformation using the NCQA process as a framework and achieve recognition as a PCMH. The expectation is that they will provide an enhanced level of services to the vulnerable population served by FQHCs. Five hundred FQHCs are participating in this demonstration, reaching approximately 195,000 beneficiaries; the first enhanced payments were distributed in December 2011.

The Innovation Center recently announced the Comprehensive Primary Care initiative. This initiative is designed to build on what we have already learned from the private sector and the implementation of the other programs and to test rigorously the hypothesis that larger, strategic investment in primary care will lead to improved care and improved health at lower overall costs.[8] It will operate in selected communities with approximately 75 practices per community. For most practices, developing the infrastructure to reliably deliver advanced primary care requires additional staff, technology, and physician time devoted to non–visit-based care. Although Medicare and Medicaid fee-for-service beneficiaries are the focus of the Innovation Center, most physicians care for patients covered by a diverse set of both public and private insurers. Consequently, what one or even a few payers attempt to support with payment changes designed to reward high-quality care and lower costs will represent a change in only a small fraction of most typical physicians' full patient panel and revenue stream.

One result of piecemeal transformation of the payment system has been a "3-foot rope for a 10-foot hole": practices find support for required investments from only a limited number of payers covering only a limited portion of their practice. Transformation to a new model of primary care is not economically feasible with fragmented, uncoordinated payment. Acting on the assumption that a major barrier to transformation in practice is the need for corresponding transformation in payment, the Innovation Center invited public and private insurers around the United States to collaborate in supporting high-value primary care in the communities they serve.

Under this initiative, the Innovation Center is transparent about the kind of support it is prepared to offer for comprehensive primary care on behalf of Medicare fee-for-service beneficiaries, and what services it expects the practice to offer to be eligible for this enhanced payment (Table 1). There are 3 components of primary care payment offered by CMS on behalf of fee-for-service Medicare beneficiaries to practices selected to participate in this program. The first is traditional Medicare fee-for-service payment, which remains in place for all participants. The second is a monthly care management fee (up to $20 per beneficiary per month, on average, risk adjusted within a practice), designed to provide the support needed for practices to expand their infrastructure and take on new non–visit-based clinical effort. The third is a shared savings component. Part of what we are test-

ing is whether this kind of investment in primary care leads to a decrease in total health system costs.

Because much of the variation in cost of care occurs at the individual practice level, CMS will calculate shared savings at the community level and distribute shares to practices based on their size and their performance on quality measures. By placing this incentive at the community level, we want to encourage clinicians and patients to make wise choices about necessary and appropriate care, and share successful strategies for effective care delivery. Evidence suggests, for example, that engaging patients with shared decision-making tools often leads them to choose less risky, invasive, and expensive options than physicians assume patients want.[10-13] Providing resources to create and support models where primary care practices have the space and staff to make this a routine part of care will engage patients in making better, more informed choices that reflect their actual preferences even as it may lower total cost of care.

Private insurers, Medicare Advantage Plans, and other health care payers are invited to join this initiative by committing to collaborate with CMS and other payers in their marketplace in providing enhanced support for comprehensive primary care. Individual payers responded to the call for proposals by describing how they would align with the Innovation Center approach to supporting comprehensive primary care, outlining what they are already doing, and describing what they are prepared to provide in support of comprehensive primary care in the community or communities they serve. Insurers must also commit to sharing data with participating practices, including utilization and total cost of care data.

CMS is analyzing the aggregate responses and identifying communities in which a preponderance of payers is offering to support a comprehensive primary care model and will select communities that have a critical mass of aligned insurers. CMS will also look at other aspects of the community that make it likely comprehensive primary care models will be supported: Is there a regional quality collaborative[9] that includes payers? Is the state interested in participating, either through Medicaid or through their insurance plan for public employees? Are consumers engaged in community delivery system reform efforts? Is there an existing data exchange that includes participation by multiple payers? Under this initiative, CMS will not be providing direct financial support to any participating payer.

Once promising communities have been selected, the consortium of payers in that community, along with clinician representatives and consumers, will build alignment on specific quality metrics and implementation milestones for the project. Then practices will be selected by CMS and invited to apply to join the initiative, sign independent agreements with the other aligned payers, and commit to delivering the 5 primary care functions and achieving the agreed-upon milestones. Were all payers in a given community to align with the CMS payment approach, our models suggest that participating practices could see a 30% to 50% increase in total practice revenues through payments received from CMS and other aligned payers committed to this program. Those practices will need to demonstrate the capacity to deliver high-value primary care services through such efforts as meeting Meaningful Use criteria, offering extended hours and continuous care. We expect that physicians will

Table 1. Comprehensive Primary Care Services Expected by Medicare Fee-for-Service Beneficiaries for Innovation Center Enhanced Payment Eligibility

Primary Care Functions	Description
1. Risk-stratified care management	Patients with serious or multiple medical conditions need more support to ensure they are getting the medical care and/or medications they need. Participating primary care practices will deliver intensive care management for these patients with high needs. By engaging patients, primary care clinicians can create a plan of care that uniquely fits each patient's individual circumstances and values
2. Ensure access to and continuity of care	Because health care needs and emergencies are not restricted to office operating hours, primary care practices must be accessible to patients 24/7 and be able to utilize patient data tools to give real-time, personal health care information to patients in need. Patients are best served when they receive their care from the same clinician or health team with whom they build a trusted relationship
3. Deliver planned care for chronic conditions and preventive care	Primary care practices will be able to proactively assess their patients to determine their needs and provide appropriate and timely preventive care. With disease registry capacity, practices can better track their chronically ill patients and provide the full range of timely and appropriate health services
4. Engage patients and caregivers	Primary care practices will have the ability to engage patients and their families in active participation in goal setting and decision making. Through a variety of policies and tools, patients can be full partners in truly patient-centered care
5. Coordinate care across the medical neighborhood	Primary care is the first point of contact for many patients and takes the lead in coordinating care as the center of patients' experiences with medical care. Under this initiative, primary care physicians and nurses will work together and with a patient's other health care clinicians and the patient to make decisions as a team. Access to and meaningful use of electronic health records should be used to support these efforts

devote an appreciable portion of their professionally active time to delivering non–visit-based services, such as e-mail and proactive telephone outreach, as well as taking on leadership and oversight of team-based care. They will also need to make a commitment to use the extra resources made available through this project to achieve the aims of better health, better health care, and decreased total health system costs for their entire practice population. In addition to reporting standard clinical quality metrics in the domains of prevention and chronic care, all participating practices will measure patient experience of care in a rigorous way.

How we pay for care sends powerful signals about what we value. We believe, as do many others, that responsible stewardship of health care resources is a core attribute of excellent modern practice.[14] Creating a sustainable health care system is going to require all clinicians to be sensitive to the choices they make even as they keep patient welfare at the center of their practice. By moving to a payment model that rewards physicians for quality of care instead of volume of care, we are signaling our expectation that practices participating in this initiative will be using the expertise they have to assure that patients get what they need—not more and not less.

All the programs coming out of the Innovation Center are tests of new payment and service delivery models. They all rely on collaboration among multiple stakeholders in the interest of better, more affordable patient care. We have an opportunity on an unprecedented scale to test whether increased support for comprehensive models of primary care can be part of the broad strategy for making our health system sustainable and better. Though Innovation Center programs only operate with some selected communities or providers—the Comprehensive Primary Care Program Initiative will, for example, roll out in only 5 to 7 communities in the United States—their impact is far broader because they change the national conversation. Many communities engage in preparing for these programs, and even if not selected by CMS, they are taking important steps to prepare for a different future. And many constituents in the payment and service delivery worlds look at Innovation Center programs as a road map for the future and use them to support their own strategic planning and institutional transformation efforts. We hope those participating in our initiatives, payers and practitioners alike, will rise to the challenge these opportunities present and demonstrate what can be achieved when many stakeholders come together to improve care. The world will be watching.

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Key words: primary health care; administration; management of health care; health care delivery; health services research; health policy research; health policy; health care economics and organizations; Center for Medicare & Medicaid Innovation; Agency for Health Care Research and Quality

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References

1. Baron RJ. The chasm between intention and achievement in primary care. *JAMA*. 2009;301(18):1922-1924.
2. American College of Physicians. *Solutions to the Challenges Facing Primary Care Medicine*. [Policy monograph.] Philadelphia, PA: American College of Physicians; 2009.
3. Zastrow R, Van Gilder T, Quadracci LJ. Practice profile. An employer-directed health plan that seeks to reenergize primary care. *Health Aff (Millwood)*. 2010;29(5):976-978.
4. Reid RJ, Coleman K, Johnson EA, et al. The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Aff (Millwood)*. 2010;29(5):835-843.
5. Meyer H. Report from the field. Group Health's move to the medical home: for doctors, it's often a hard journey. *Health Aff (Millwood)*. 2010;29(5):844-851.
6. Centers for Medicare and Medicaid Services. Multi-payer advanced primary care initiative 1995-2011. Baltimore, MD: CMS; 2011. https://www.cms.gov/DemoProjectsEvalRpts/MD/ItemDetail.asp?ItemID=CMS1230016. [Updated Apr 12, 2011]. Accessed Oct 4, 2011.
7. Centers for Medicare and Medicaid Services. Details for federally qualified health center advanced primary care practice demonstration. Baltimore, MD: CMS; 2011. https://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=CMS1230557. [Updated Aug 31, 2011]. Accessed Oct 4, 2011.
8. Centers for Medicare and Medicaid Services. Comprehensive primary care initiative. Baltimore, MD: CMS; 2011. http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/cpci/. Accessed Oct 4, 2011.
9. Agency for Healthcare Research and Quality. Community quality collaboratives. Rockville, MD: AHRQ; 2011. http://www.ahrq.gov/qual/value/localnetworks.htm. Accessed Oct 4, 2011.
10. Barry MJ, Fowler FJ Jr, Mulley AG Jr, Henderson JV Jr, Wennberg JE. Patient reactions to a program designed to facilitate patient participation in treatment decisions for benign prostatic hyperplasia. *Med Care*. 1995;33(8):771-782.
11. Wagner EH, Barrett P, Barry MJ, Barlow W, Fowler FJ Jr. The effect of a shared decisionmaking program on rates of surgery for benign prostatic hyperplasia. Pilot results. *Med Care*. 1995;33(8):765-770.
12. Barry MJ, Cherkin DC, Chang YC, Fowler FJ, Skates S. A randomized trial of a multimedia shared decision-making program for men facing a treatment decision for benign prostatic hyperplasia. *Disease Management and Clinical Outcomes*. 1997;1(1):5-114.
13. Morgan MW, Deber RB, Llwellyn-Thomas HA, et al. Randomized, controlled trial of an interactive videodisc decision aid for patients with ischemic heart disease. *J Gen Intern Med*. 2000;15(10):685–693.
14. ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136(3):243-246.