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TRANSFORMING MEDICAL PRACTICES

In a Bold Effort Medicare & Medicaid Invite Health Plans to Join in Supporting the Promise of Primary Care

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Summary: With the release of the Comprehensive Primary Care Initiative (CPCI), the Center for Medicare and Medicaid Innovation (CMI) has defined the future of care delivery in America. This announcement signals that the Centers for Medicare & Medicaid Services (CMS) will lead the industry in reforming health care delivery and supporting primary care to drive improvement in population health. The requirements for multi-payer participation and new payment methodology, with an emphasis on primary care, supports this reformation effort.

TransforMED's mission is the transformation of health care delivery to achieve optimal patient care, professional satisfaction and success of primary care practices.

For practices that have been contemplating moving toward the patient-centered medical home (PCMH) model or who are trying to participate in an accountable care implementation, the CPCI provides an immediate, actionable road map that frames meaningful practice transformation and how to pay for it. This road map for practices seeking to take the first steps in transformation and be compensated for providing effective primary care builds on the work TransforMED has been involved in throughout the United States.

The Fundamental Principles of Family Medicine

- Access to Care
- Continuity of Care
- Comprehensive Care
- Coordination of Care
- Contextual Care

Principles of Family Medicine (Saultz, 2000)

There are two elements touched on in the solicitation that require expansion in order to ensure the success of the CPCI. First, CMI must establish a platform of consistent technical assistance to assist participating plans, providers, and community stakeholders in fulfilling the promise of the CPCI. There is enough inherent flexibility designed into the comprehensive primary care model to ensure effective developments to meet the localized market environment. Secondly, absent full participation from the primary care provider community, this promising model will fail. Such a failure of the CPCI would undoubtedly hamper meaningful transformation of American health care delivery. CMI should be working to position all primary care practices to be ready to test the notion of value-based payment of comprehensive primary care. If communication is too narrowly limited to those few practices that have fully implemented PCMH elements of practice currently equipped to participate in the CPCI, the vast majority of primary care providers will elect to sit on the fence until the close of the Initiative which will doom any momentum developed during the course of the CPCI.

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What is the Comprehensive Primary Care Initiative?

On September 28, 2011, CMI released the solicitation for public and private insurance plans to apply for the CPCI. The initiative will simultaneously test a delivery model and a primary care compensation structure that will drive improvements of both health care quality and financial outcomes on a population basis. As stated in the solicitation, the CPCI is merely the most promising of a myriad of paths for primary care practices to achieve the three-part aim of better health, better care, and lowered costs through practice improvement and reasonable expectations for compensation. The three-part aim is designed to help primary care practices deliver on the promise of high quality, well-coordinated, and patient-centered care.

Within this new model, primary care providers will be expected to incorporate “five functions” of comprehensive care: care management; enhanced access; planned care for chronic conditions and preventative care; patient engagement and proactive patient planning; and care coordination across the medical neighborhood. Furthermore, primary care practices are expected to be recognized as patient-centered medical homes and meaningful users of health information technology (HIT). In short, health care delivery is being “redefined” to fulfill the original promise of primary care — best captured by the fundamental principles of family medicine, but empowered by HIT and a new perspective on population health.

One payer-sponsored PCMH pilot already using the blended compensation model incorporated into the CPCI has projected that the **total compensation rate, per provider, will increase by approximately 40%.**

Though the comprehensive primary care model is a sincere genuflection to the founding vision of American primary care, it would lack cohesion if it were not paired with an equally powerful redefinition of how primary care providers should be compensated. The envisioned compensation program will need to move away from paying for volume to rewarding value. The CPCI solicitation specifies that CMI and participating payers from selected markets will implement, test, and study a blended payment model comprised of three core components:

- Fee-for-service
- Risk-adjusted care coordination per-member-per-month (PMPM) payments to support value-added non-billable practitioner time, advanced care team functionality, or investments in HIT utilization. On behalf of Medicare beneficiaries, CMS shall pay an average of $20 per-beneficiary-per-month (PBPM) at the start of the initiative. Payers can elect to provide direct support for services provided at the practice level which strengthen the infrastructure required to accomplish the five comprehensive primary care functions.
- Eligibility to share in savings achieved by the target patient population. Medicare payments will be calculated on a market level and distributed to participating primary care practices on the basis of practice level quality and utilization metrics, practice size, and the risk adjustment profile of the practice.

It is important to understand that merely “throwing money” at the problem of health care has not worked. That is why the model framed by the CPCI has been drawn specifically from organizations such as the American Academy of Family Physicians (AAFP) and the Patient Centered Primary Care Collaborative (PCPCC) which have been advocating this framework as the most appropriate way to compensate primary care providers. The blended model will empower practices to invest in building the appropriate infrastructure and to align resources to improve health care outcomes at the population level.

The Success of the Comprehensive Primary Care Model?

The true impact of the CPCI extends far beyond the scope of a national demonstration project — no matter how extensive that scope may be. In reality, CMS has used the release of the CPCI and the final rules for the Medicare Shared Savings Program to signal to the entire health care industry that there is a definitive vision for what the future of health care in our nation will look like. No matter what road we take to achieve the three-part aims of better health, better care, and lowered costs, it will be built on a foundation of primary care providers addressing the needs of patients on a population basis and being rewarded for doing so. The comprehensive primary care model is the most promising path forward to this future of health care delivery.

The power of the CPCI is that it builds on the existing groundswell of reform stemming from the patient-centered medical home model, concepts of Accountable Care Organizations (ACOs), the industry-accepted Meaningful Use standards, and the broad adoption of HIT across the health care industry. The CPCI provides a practical framework that captures the most powerful tenets of these disparate elements and distills them into a single, understandable, and *actionable* model. Each of these earlier models struggled to garner wide-scale provider adoption in large part because providers felt that they were too conceptualized or that the transformation was too complicated to undertake while maintaining day-to-day patient care.

TransforMED's work in the field of PCMH implementation provides a context for understanding the power of what is broadly termed as decision paralysis. Every day, we engage with primary care providers who want to move toward the PCMH model but simply don't know how or where to begin. The Joint Principles of the PCMH are informative, having motivated tens of thousands of primary care providers to undertake PCMH exploration, but they certainly are not simple. TransforMED continuously urges primary care practices to begin adopting broadly accepted business practices to combat growing inefficiencies, but the health policy stakeholder community should be more actively working to do the same. As the authors Dan and Chip Heath wrote in an analysis based on a 1995 JAMA article[1] on physician decision-making behavior, "… you don't need to embrace simplicity just so your people can comprehend your message. The point of simplicity is more fundamental: Simplicity allows people to act." (Heath, 2007)

Why are the five functions of comprehensive primary care "simple" when compared to the Joint Principles of the PCMH or the myriad of existing accountable care models? It is because the five functions are designed to be actionable and achievable. CMI defines each of the five functions (HHS News, 2011):

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 providers can create a plan of care that uniquely fits each patient's individual circumstances and values.
   Markers of success: Policies and procedures that describe routine risk assessment
   Presence of appropriate care plans informed by the risk assessment
2) ***Access and continuity***: Because health care needs and emergencies are not restricted to office operating hours, primary care practices must be accessible to patients at all times and be able to access patient data tools to give real-time, personal health care information to patients in need.
   Markers of success: Continuity of visits with same provider
   Access to EHR when office is closed
3) ***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.
   Markers of success: Provision of Medicare's Annual Wellness Visit
   Documentation of medication reconciliation
4) ***Patient and caregiver engagement***: Primary care practices will have the ability to engage patients and their families in active participation in their care. Comprehensive primary care providers should be equipped to provide effective patient self-management support.
   Markers of success: Policies and procedures designed to ensure that patient preferences are sought and incorporated into treatment decisions
5) ***Coordinate care across the medical neighborhood***: Primary care is the first point of contact for many patients and assumes the lead in coordinating care as the center of patients' experiences in the health care system. As CPCI participants, primary care doctors and nurses will work together with a patient's other health care providers 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.
   Markers of success: Use of processes and documents for communicating key information during care transitions or upon referral to other providers

If the CPCI fulfills the potential of the comprehensive primary care model proposed in the solicitation, it will be a true triumph for primary care providers and other health care industry stakeholders. Who are the real benefactors of this effort? Nearly all current health care industry stakeholders. Patients will be assured high quality, accessible primary care; Medicare will be more sustainable; commercial payers will have proof of concept that will support their goals; providers will have a more sustainable and rewarding practice model. It is, in fact, this win-win-win nature of the underlying PCMH model that has allowed for its rapid propagation across the nation since 2007.

[1] Donald A. Redelmeier, MD and Eldar Shafir, PhD. (1995). Medical Decision Making in Situations That Offer Multiple Alternatives. *The Journal of the American Medical Association* , 302-305. http://jama.ama-assn.org/content/273/4/302.short

Industry payers quickly realized that it allows them to begin bending their cost curves, while employers have already stated that an improved primary care system is critical for their competitiveness in an ever flatter, competitive business landscape. Many have already declared, categorically, that they will be unwilling to pay for health care "business as usual" for their employees. In large part, TransforMED's success in driving the PCMH model of care has been our ability to communicate with all three stakeholder groups — providers, payers, and employers — effectively empowering them to define and achieve common goals.

How Can Practice Transformation and Progress Be Made Easier?

It will be up to organizations like TransforMED to identify the best path forward for practices seeking to move toward providing comprehensive primary care. Ultimately, this is about developing a method for practice transformation that eases the burden of change management by building on progressive implementation phases (i.e., "wins") which guide practices down the path of least resistance to success.

TransforMED's experience is supporting practices in their efforts to become patient-centered medical homes, implementing meaningful use-certified technology, and convening stakeholder-driven learning collaboratives across the nation. It has shaped our central methodology for assisting practices in becoming providers of comprehensive primary care. This methodology (Figure 1) provides an example of a simple road map which empowers practice providers and office staff to overcome decision paralysis and to "act". This type of road map must be further supported by a detailed transformation plan that guide practices toward comprehensive primary care. A detailed transformation plan is critical to their success.

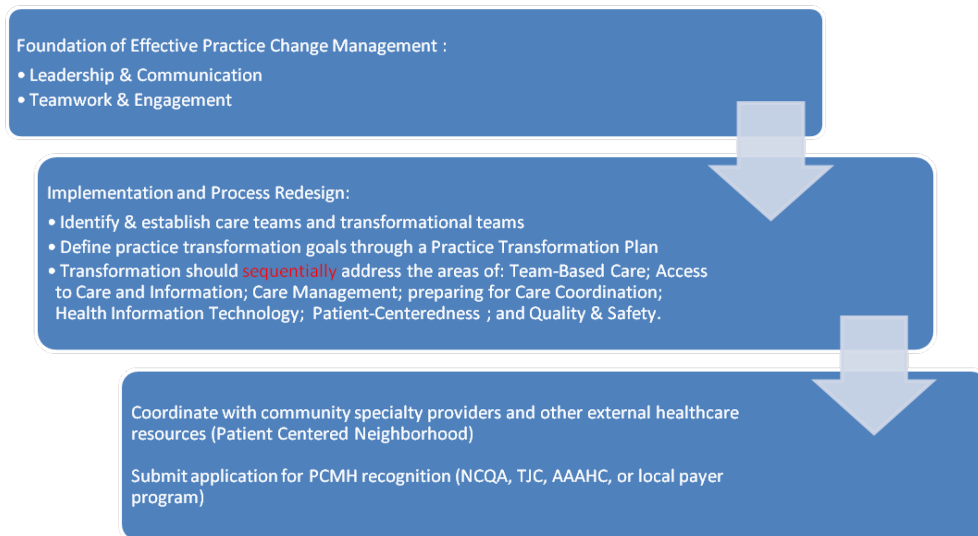

Figure 1 - TransforMED Comprehensive Primary Care Transformation Model

To date, in the PCMH field, we have been witness to a true blossoming of early adopters. These were the practices and health care providers that had the internal capital — financial, social, and emotional — to attempt to battle with the non-linear PCMH transformation process. These early adopters included the practices that participated in the AAFP-sponsored National Demonstration Project before the vision of health care reform and revised compensation models for primary care were expected. By focusing providers and practices on accessible and actionable road maps, like TransforMED's Comprehensive Primary Care Transformation methodology, we can bridge the chasm that separates early adopters from "early majorities" (Moore, 1999).

Ensuring Optimal Outcomes of the Comprehensive Primary Care Initiative

The extensive body of evidence supporting the improved outcomes of the PCMH model of care, accountable care models, HIT, and care coordination strongly indicate that the CPCI will achieve the three-part aim of better health, better care, and lowered costs through practice improvement. In large part, the potential success is due to the fact that the comprehensive primary model — as defined in the CPCI solicitation — provides clarity in practice functionality, but is flexible enough to avoid being overly prescriptive. CMI's decision to push the final determination of a myriad of the CPCI's key success factors, such as PCMH recognition program selection or the development of the complete quality metrics set, to the level of individual selected markets will guarantee that participating stakeholder communities have the bandwidth to meet local health care needs. However, to ensure that the overarching Initiative achieves optimal

results, CMI must begin developing a consistent platform of technical assistance services and educational resources to be made available to all participants in the selected market.

This fundamental requirement for inter-market resources and assistance can be ascertained from the experience of organizations, such as TransforMED, which have led large multi-region or national-scale PCMH demonstration programs or, even more germane, the experience of the Office of the National Coordinator (ONC) of Health Information Technology. The Health Information Technology for Economic and Clinical Health (HITECH) Act established programs to be administered by ONC to accelerate the meaningful use of HIT. These include the Beacon Community Program and Regional Extension Centers (RECs) program. The challenge that ONC is currently facing with both programs is a lack of consistent deployment methodologies or outcomes. This disparity further limits ONC's current ability to optimize the national impact of either the RECs or Beacon Community programs as they are caught trying to retroactively build in the necessary national infrastructure and consistently available resources.

Ensuring Optimal Outcomes of the Comprehensive Primary Care Model

No matter how successful the CPCI is judged to be in improving health care outcomes and bending the cost curve upon completion of the program in four years, it will be ultimately stunted unless CMI can engage the primary care providers and health plans **not** participating in any of the selected markets. As previously stated, the power of the CPCI is that CMI has used it as a platform to engage payers and providers from across the nation in moving toward the comprehensive primary care framework — both the delivery model and the compensation system which rewards value over volume. There is a very real possibility that unless CMI continues to engage these non-participant stakeholders, the benefit of broad-scale health care transformation will be irreparably delayed.

CMI needs to maintain open communication with non-participant health plans and primary care providers to equip these actors to pursue comprehensive primary care transformation beyond the CPCI's select markets. Private sector consulting firms will be able act as intermediaries between CMI and the broader health care industry, but only to a limited degree. However, because many primary care providers remain distrustful of most private sector firms, it will remain the role of organizations such as the AAFP, PCPCC, and TransforMED to engage and empower providers in continuously moving toward the comprehensive primary care model.

The reality is that primary care practices will not be ready to adopt the comprehensive primary care model by the close of the CPCI if they do not start meaningful transformation *now*. If primary care providers continue to "wait and see what happens" or only make incremental progress toward providing comprehensive care, the overarching effort to transform primary care and the U.S. health care system will be for naught. Primary care practices across the nation, not just in five to seven markets, must start transforming to comprehensive primary care practices today.

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