

CPCI Webinar Q & A

February 1, 2012

1) When you speak of “risk stratified care management,” is that insurance-specific?

How the risk stratification is designed and supported may vary by payer; however, the idea of identifying the patients in the practice who are most likely to benefit from intensified care management and care coordination should be common to all.

2) How would we know whether anyone in our region has applied for CPCI, or when would we receive notification that there our specific region is one of the five eligible?

CMS has said that they will announce the five to seven markets in March; however, it is likely to be delayed until summer because of the need for CBO oversight. In the meantime, there is little chance of leaked information and it should not be trusted if you hear any. We suggest that you start a conversation in your community with other practices to see who will be the likely players. This discussion will serve you well whether your market is selected by CMS or not because it will serve as a sounding board for how primary care can succeed as we move forward from volume to value. As evidenced by recent announcements from WellPoint, Aetna and others, payers are ready to change the way they pay for primary care services with or without the CMS program.

3) Will multi-specialty groups that have a strong primary care component be eligible?

Yes, of course, but it needs to be the primary care capabilities that carry the strength of their potential to participate in the program. Systems that have built a community reputation for hospital and specialty care while ignoring primary care “need not apply.”

4) Could you confirm the projected shared savings compensation opportunity per PCP?

I thought I heard \$100K.

We do not think anyone should be making generalizations about the potential for shared savings in this program. There is tremendous variation from market to market in the current levels of waste, overuse and inefficiency. For well integrated systems that have already moved toward operational efficiencies, there may be less “savings” to share. The opposite is true as well. The other two components seem to be more reliable and that would be payment of some kind of a care management fee on a PMPM basis (ideally pre-paid) and bonuses for hitting quality targets on clinical measures. It is best to think of the whole package as a sincere effort to fortify primary care.

5) When will the CPCI markets be announced?

Officially, CMS says by the end of March but the final selection has to be reviewed by the CBO which may add some time. You should be ready to go by early summer!

6) I am more than 50% ready but I cannot afford the money involved to put the program in place. What should I do next?

Work on all the stuff that does not cost much money. Develop a true team approach to care, use a free online registry for two or three common chronic diseases in your practice, map out a plan to identify high risk individuals in the practice, develop a strategy for monitoring quality measures as a by-product of the registry use and discuss how you are going to use systems to help provide care management and care coordination. These all take considerable time but little money.

7) We do not feel that EMR makes for a better healthcare system. Would it be possible to participate without EMR, but will meet all the other requirements for this initiative?

Officially the program requires either an EMR or an electronic registry. It is clear that the designers of this program do not agree with your assessment of the contribution of an EMR to the health system. If there are choices to be made or competition among practices to be selected, CMMI has made it clear that preference will be given to practices with advanced IT capabilities or at least well on the way along that path.

8) How do we find out if it will be done in our area?

No one will know until the official announcement is made. In the meantime, work to acquire the capabilities outlined in the proposal because they will be valued in the new payment environment whether this CMS project plays out in your market or not.

9) If no one in your market applied, can you assume this initiative will not launch in your area?

If you have reliable information that no payers in your market have expressed any interest or applied for the program, you can be confident that CMS will not choose your market. That does not mean that the capabilities and requirements of the program should be ignored. They do provide a blueprint for the new payment model for primary care both in Medicare and on the commercial side.

10) Can care management fee be used to hire staff who help provide the five primary care functions?

Yes! It is not clear how CMS will determine how the money is spend but the clear intent is that it go to building systems and processes to accomplish the five key functions. There is no question that some of this requires staff time, rearrangement of work responsibilities or possibly new employees. Other infrastructure improvements like adding registry functionality to the EMR would also be appropriate.

11) Is there an expectation that primary care pre-invest in hiring/implementing care management/coordination before they will be able to recoup the care management fee since that money cannot go toward salaries?

Dr. McGeeney mentioned that the money for the care management fee was not intended to go directly into physician salary enhancement. It is reasonable to use that income to support other staff salaries. It would be prudent to plan out the roles, responsibilities and systems you will implement if your market is chosen or if other resources in the form of care management fees become available under other programs in your community. It would not be wise to hire new employees and hope your market is selected.

12) Do you think that PCMH is what the CPCI will be looking for to select practices for participation, or can a practice without PCMH accreditation but is doing planned care model, EMR, advanced access, etc. still be considered?

We suggest you focus on the five key capabilities that were discussed on the webinar. If you are doing all those things, PCMH recognition from any agency should be a low hurdle. Although PCMH certification/recognition will be a marker for a practice with advanced capabilities, it does not appear to be a requirement for participation or a guarantee of acceptance into the program.

13) You mentioned that a practice with 600 Medicare patients could receive \$100,000+ per year in the potential future CMS model. Do you think that is what the pilot practices that are selected for initial CPCI should expect to receive?

For the care management fee portion of the enhanced payment, you can just do the math! Multiply \$20 per member per month (\$240 per member per year) times the number of fee-for-service Medicare patients in your practice. Medicare Advantage patients do not count. (200 patients=\$48,000; 300 patients=\$72,000; etc.) Private payers may also offer per member per month care management fees but they are likely to be a considerably lesser amount commensurate with the lower burden of disease that requires extra care management and care coordination services.

14) Solo doc here. 2,000 patients. Higher than national averages for office visits and gross receipts last year. Approx 22% mix of Medicare-age. I have only 163 patients that are Medicare NOT in an advantage plan. Easily more than double that number when including advantage plan members.

See #13

15) I don't meet the 200 patient minimum requirement. Recommendations/thoughts? What is the likelihood that the AAFP could convince CMS to lower that patient requirement?

No way to know for sure but we think there may be some adjustment in this requirement when CMS begins to recruit practice and has trouble enrolling the total number of benefi-

ciaries that is their target. They may do this by enlisting more practices with less than 200 patients. The number of patients was precisely specified so that the CBO could estimate the cost of the program. It is not critical to the functions they are trying to promote.

16) How does one find out if / where Transformed projects are ongoing in my area?

<http://www.transformed.com/practiceTransformation.cfm>

17) Which states are even in consideration for the CPCI project?

Although some markets may be more favorable than others it is fair to say that this program represents a new model for payment in all areas so just because the CPCI is unlikely to play out in your area does not mean that you should sit idly by and wait for something else to come along.

18) Can you expand on the \$40,000/provider/year increase in revenue seen by PCP practices? What practice changes are most likely to lead to these improvements?

See #11, #12 and #13 above and look at the five key capabilities mentioned on the webinar.

19) I am wondering if there are restrictions or requirements with these initiatives/programs with Rural Health Clinics. Any thoughts?

The current plan is to have at least two of the chosen markets include at least 50% of the practices in rural environments. There are restrictions on "double dipping" in the sense that programs that already receive enhanced or cost based reimbursement from CMS may be excluded.

20) As a primary care provider in a rural area...how is participating in your program going to benefit my practice now or in the future? It seems like a GREAT deal of effort on our part without ANY guarantee that it will translate to making our life easier seeing the Giant patient load that I already have.

You always have the option of continuing to do as you are doing. Enjoy!

21) Also, being from a Rural area, a significant portion of our population can't even read much less operate a computer or understand why this would be a benefit for them to participate with.

Let's be clear: the information technology is supposed to help make your job easier, more efficient and more reliable in terms of patient care and patient service. It appears that there are a lot of people out there who are doing perfectly fine with smart phones, text messaging, iPads and computers but may not be able to pass a reading comprehension test.

22) How are Small Business Owners like myself supposed to implement all these “pixie dust” policies that, I agree, are wonderful on paper....but in the real world WHERE is the help going to come from...I am working 11 hour days as it is and I don't have the resources to hire all these people you talk about in order to do these things you mention? Are there Advisers? Magic Genies ? available to Real Rural Practices without hiring a TEAM of computer-savvy people that don't expect a salary in exchange for the self satisfaction of helping their fellow man? Really...it sounds wonderful but I don't think you're doing anything but wishing.

See #21

23) What LOGISTICAL support will you be providing small rural practices?

TransforMED has a number of products and services that are currently available to support the necessary changes in practice. In addition, we are developing specific products and programs to assist practices which end up being chosen for the CPCI program from CMS.

24) You mention need for Primary care physicians to be ready for these initiatives. We are very close, but a lot of practices are having difficulty finding qualified staff they can afford, to participate in high functioning teams. Any resource advice or specific training for our staff that may be available?

This is an important and critical question without a great answer. Many of your current staff have been hired and trained to fill very limited roles in the office flow. We all face the major challenge of hiring and training people to function in new roles and with new levels of responsibility. Cross training and a true team approach will help. TransforMED and others understand this changing need and are developing training programs for care management, care coordination and patient coaching. Keep in mind that these are skills that team members should possess and do not necessarily represent one FTE for each function.

25) Do you anticipate another round of CPCI applications?

Not at this time. We understand there has been significant payer response to this program. If the program is successful, CMS has the option to roll it out as the new way to pay for primary care everywhere if they choose.

26) What source do you recommend to gather information for Care Management Instruction?

There are few freely available resources on this currently. TransforMED is working on a care management curriculum that will compliment the patient-centered medical home model. There's also a Care Management workbook available at <http://www.transformed.com/publications.cfm>. There's also a Guided Care Model that's available from Johns Hopkins. You can learn more at <http://www.transformed.com/MedicalHome-Marketplace/JohnsHopkins.cfm>

27) Will joining CPCI prevent a practice from pursuing any other PCMH-related payer initiatives???

This will be very market-specific. CMS cannot pay enhanced fees from two different programs for service to the same patient. Commercial and Medicaid payers will all have their own rules, but you can be sure there will be ways to prevent “double dipping.”

28) Is CPCI the same thing as the Medicare Demonstration?

The CPCI is a CMS Innovation Center program. It is separate from other CMS demonstrations past, present or future.

29) Where are the application materials for this program?

Applications for practices will not be available until the specific markets are chosen. There may be some release of the application format or requirements prior to that date but we do not know any specifics.

30) Can a provider in an ACO be in the CPCI also?

There may be some restrictions within the rules for Medicare ACO Shared Savings Program that would preclude enhanced payment from both programs for the same patients to prevent “double dipping.”

31) What is the service agreement mentioned on a slide?

This refers to formal or informal agreements between primary care practices and specialty or hospital services regarding timely referral services and a shared responsibility for quality and cost.

32) How do you apply to be in a CPCI market?

Practices cannot apply to be in a CPCI market. The markets will be chosen by a CMS determination of a “favorable multi-payer environment.” Once the markets are announced, then practices will be recruited.

33) How does one sign up for CPCI?

See #33

34) With a large PCMH with all the bell and whistles and ability to develop multiple blended rate contracts and CPCI, why will we need ACOs?

You may not. That is actually one of the advantages of the program, in our view. Even if you are dealing with an ACO, the CPCI payment model and requirements are likely to be used as an internal payment structure.

35) Is there a comprehensive list of programs currently active or in the planning stages that we can access in our specific area?

See the TransforMED project map at <http://www.transformed.com/practiceTransformation.cfm> and the PCPCC pilot project page at <http://www.pcpcc.net/pcpcc-pilot-projects>.

36) Am I understanding correctly that this is for privately owned primary care offices? We are part of an LLC that is owned by our local hospital. Would our LLC be eligible?

If your practice or the hospital bills for your services under fee-for-service Medicare rules, you should be eligible.