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CENTER FOR IMPROVING VALUE IN HEALTH CARE

May 17, 2012

TO: Colorado Primary Care Practices, Interested Parties
CC: Marjie Harbrecht, HealthTeamWorks
FR: Edie Sonn, VP-Strategic Initiatives, CIVHC
RE: Updated CPCI Information

CPCI Stakeholders –
This document provides updated information regarding practice eligibility and other issues regarding CPCI. This document updates previous versions sent May 11 and 15. **Key new information in this document is in the "Practice Eligibility/Selection" section below.**

In addition, you'll find attached the following resources:

- DRAFT quality/outcomes measures (this is the same document we sent last week). Please bear in mind that this measure set is a draft and subject to change.
- Two new documents developed by the CMS Innovation Center consultants:
    - CPCI project summary with embedded link to the practice eligibility screening tool. Remember, you must complete the brief screening tool in order to get on the list to receive the CPCI application.
    - PPT slide deck describing project goals and practice selection criteria. While most of the information here is not new, please pay particular attention to slides 17-20, which outline selection criteria that had not previously been announced. That information is also summarized in the "Practice Eligibility/Selection" section below.

While the information here and in the accompanying documents came from CMS staff, please be aware that they do not constitute official CMS guidance. CMS is preparing additional guidance for practices; as soon as we get that, we'll distribute.

CPCI Colorado – Notes from telephone and e-mail exchanges with CMMI Colorado Market Lead, May 11 and May 17, 2012; additional info from market lead consultants

Overview of commercial payer role, MOU process

- As part of original application, commercial payers submitted confidential bids for their payments (both PMPM and share savings opportunities) to practices. CMS evaluates these bids but is not negotiating these amounts with payers as part of the MOU process; they can't waive anti-trust law.
- MOU negotiations are focused on start date, reporting, sharing data with practices and quality measures. CMS recognizes that they probably won't be able to achieve alignment with payers on the latter two issues by the end of May, so the MOUs will indicate, basically, that the parties agree to reach agreement before the initiative launches and during the course of the initiative. That will enable CMS to move forward with practice contracting.

Practice eligibility and selection overview

- Basic practice eligibility criteria:
    - Geographically located in a selected CPC market
    - Declares willingness to transform to meet 5 key elements of comprehensive primary care
    - Has at least 60% of their revenues generated by payers participating in this initiative
    - Submits claims using CMS 1500 (formerly HCFA 1500) form
    - Does not participate in other Medicare shared savings program
    - Serves a minimum of 150 Medicare fee-for-service beneficiaries
- For practices owned by a health system, IPA, academic institution, insurance entity, or other parent owner:
    - Each individual practice site must apply separately
    - If the same combination of TIN and NPIs use multiple physical sites, we will treat all physical locations as one site
    - Each individual practice site must attach a commitment letter from their parent owner:
        - Committing to segregate funds paid in conjunction with the CPC initiative.
        - Assuring that all funds flowing through this initiative will be used to support infrastructure and/or provide salary support in this practice
- Initial selection criteria:
    - Electronic health records (EHR) system
        - Preference for Stage 1 Meaningful Users
    - Derive a minimum of 60% of their current payer mix from participating payers
        - Preference for practices with the highest participating payer mix
    - Any Primary Care Medical Home Recognition
        - Preference for practices in the highest tier/level
    - Any participation in practice transformation activities in the last three years

- Additional selection criteria:
    - Geographic Diversity
    - Serving a high number of Medicaid beneficiaries
    - Diversity of practice ownership structures

Q&A

- Definition of "practice," other eligibility info:
    - When CMS says it will contract with 75 practices, does that mean 75 individuals? Or 75 practice sites?
        - 75 sites.
    - Is it possible for a group of rural practices within one geographic area that share management services to apply as a "community," or for multiple practices within an IPA that each have their own TIN to apply as one entity?
        - At this point, CMS is defining a "practice" as a bricks and mortar facility, unless a group of practices operates under one TIN. Any looser confederation of practices would need to make a strong case to CMS for why they should be considered one practice.
    - If an IPA has multiple practice sites but does not operate under one TIN, must each site apply individually?
        - Yes. Each practice will need to apply separately at the site level.
    - Will CMS accept an application from a PHO entity, or only applications from individual practice entities?
        - Same answer. Individual practice entities will need to be the applicants.
    - If a hospital system employs PCPs at multiple locations, will CMS accept applications from only select clinic sites or must there be one umbrella application that includes all sites?
        - Same answer: each individual practice that wants to participate will need to apply. They don't all need to apply.
        - Each practice site will be eligible or not eligible according to CPCI criteria, so the fact that one site is ineligible (e.g., if it is an RHC) doesn't disqualify others from applying if they meet the criteria.
    - What are the guidelines for FQHCs? Are they completely barred from participating in CPCI, or are there circumstances under which they can participate? (We have received differing answers to this question.)
        - FQHCs and RHCs are not eligible to participate in CPCI.
    - Electronic Health Record usage: Does a practice have to be MU certified (submitted to CMMI) by July to be eligible for CPCI? If a practice is planning on certifying in third quarter of CY 2012, is use of a certified EMR sufficient at this point?
        - MU not a deal-breaking criterion but it is heavily emphasized in the hierarchy of our selection criteria. There is also a concrete expectation that the practice must meet it by end of year 1. CMS views MU as the foundation of all 5 primary care functions.

- Commercial payers' role:
    - Will commercial payers be expected to pay a PMPM for all their members in a participating practice? Or will they segment them somehow?
        - Payers will develop an alignment methodology for determining which of their members w/I a practice will be attributed to CPCI. CMS will use a lookback period; some payers may use this approach, others may have an enrolment methodology: both in principle are "aligned" approaches with CMMI. .
    - If a practice bills all the participating payers in CPCI, will that practice be eligible to collect a PMPM from each of those payers?
        - If at least 60% of the practice's revenue comes from participating payers and the practice meets all other eligibility criteria, then the practice is eligible to apply for the initiative. NOTE: MEETING ELIGIBILITY CRITERIA DOES NOT MEAN THAT A PRACTICE WILL BE ACCEPTED INTO THE INITIATIVE.
        - A practice that applies successfully can expect PMPM payments from all participating payers with whom it has contractual arrangements.
        - CMS is NOT expecting payers to add new practices.
    - Is there a maximum number of commercial patients for whom a practice can collect PMPM from the commercial payers?
        - No maximum. Number of eligible patients will be determined by the alignment methodology.

- Medicare issues:
    - Will the Medicare PMPM apply only to a maximum of MC FFS patients within a practice? Or, if the practice has more than 150 patients who would qualify, will Medicare pay the PMPM for all those patients?
        - 150 is the threshold for alignment, not the ceiling; Medicare will pay the PMPM for each. Medicare PMPM will be risk-adjusted. Starts at $20 average, goes down to $15 average years 3-4.
    - What if a practice sees both Medicare Advantage and Medicare FFS patients? Can they still participate in CPCI, as long as they meet the threshold number of Medicare FFS patients?
        - Yes.

- Medicaid issues:
    - Will Medicaid's participation extend only to dual eligibles? What about other adult enrollees? (For example, Colorado recently expanded Medicaid coverage to adults w/o dependent children – could they be included in CPCI?)
        - Dual eligibles will be aligned as Medicare, not Medicaid beneficiaries (had to avoid double payments). Medicaid portion excludes duals. Medicaid managed care (obviously a small chunk of the Colorado market) will work just like the commercial payers. Medicaid FFS – CMS will fund the state to make PMPM

payments to the practices. CO Medicaid and CMS currently negotiating these terms.

- Program structure:
  - Are there any requirements or exclusions on practices' use of the PMPM (e.g., care managers, informatics, etc.)?
    - Yes there will be; details forthcoming in practice application guidelines. In general, want to see investment to be in the 5 comprehensive primary care functions.
  - What is envisioned for the shared savings after year two? Is it full savings against historic benchmark? Is this shared savings opportunity also for commercial plan partners?
    - Still working out details of methodology for calculating shared savings.
  - Will the CPCI initiative follow the Pioneer ACO rubric, i.e.:
    - National comparison
    - 2% savings threshold before shared savings kick in
    - 50% shared savings (after two years)
    - 2 year rolling average
    - No risk adjustment
    - Prospective attribution (if so, will the attribution be based solely on primary care utilization?)
    - Governance

    Comparison, savings model, governance and other elements are still being worked out. CMS will use a lookback for its attribution; commercial payers may use other methodologies.
    Rick adjustment:
    - For Medicare FFS, risk-adjusting using HCC methodology
    - Medicaid – up to the state but CMS must approve to ensure it aligns with aims in the program
    - Private payers – up to them and it's not a dealbreaker if they don't, but CMS encouraging the commercial payers to consider risk-adjusting.

- Measurement:
  - Great concern from practices about the need for consistent objectives and metrics across Medicare and commercial payers. Practices are already doing PQRS and MU reporting. Need to overlap efforts and keep to a smaller, focused set of measures that overlap with MU, PQRS and across populations.
    - See attached DRAFT quality measures. These are a subset of the Medicare Shared Savings Program metrics that are considered particularly applicable to primary care. PLEASE NOTE THAT THESE ARE NOT FINAL AND THE ATTACHED DOCUMENT IS A DRAFT. CMS is engaged in discussions with the payers about these, does not expect to finalize the measures by the time MOUs are signed this month but will do so by the time provider contracts are signed in late summer.

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