Patient-Centered Primary Care
FAQ & Answers for Providers

Revised July 2017
Contents
Overview ................................................................. 2
Q1: What is Patient-Centered Primary Care? ......................... 2
Q2: Are medical specialists invited to participate? .................. 2
Q3: How does Patient-Centered Primary Care help patients? .... 3
Q4: How does UniCare identify my patients? ......................... 4
Q5: What is required of providers who participate? ................. 4
Q6: How do you measure quality? ...................................... 5
Commercial Membership ........................................... 6
Q7: What can I do to make sure my practice succeeds in improving quality and lowering costs? ............... 7
Q8: How do you set PMPMs and determine shared savings? ....... 8
Q9: What if my patients have unusually high medical expenses? ... 9
Q10: How do I find data and see reports about my attributed patients? ......................................................... 9
Related Programs ...................................................... 10
Q11: I’ve heard about something called CPC, sponsored by the Centers for Medicare and Medicaid Services (CMS). Are you participating? ......................................................... 10

Proprietary and Confidential
Claims are administered by UniCare Life & Health Insurance Company
pr400 11/2017
Overview

Q1: What is Patient-Centered Primary Care?

Patient-Centered Primary Care is the name we give to arrangements between our health plan and participating providers when the arrangements include three things:

1) Value-based payment that rewards high quality and efficiency
2) Exchange of clinical data, and
3) A mutual commitment to ensuring our members receive patient-centered care.

Patient-Centered Primary Care arrangements are flexible enough to accommodate organizations of all sizes, and run the gamut from agreements with solo primary care physicians to accountable care agreements with large integrated systems.

Patient-Centered Primary Care builds and expands on those successes by offering practice care teams access to tools, information and resources designed to support a proactive coordinated care model built around each patient’s needs.

Under Patient-Centered Primary Care, in most cases, practices that participate in the program will receive per-member, per-month clinical coordination payments that will help offset the time and resources they invest in care management outside traditional face-to-face visits.

In all cases, participating primary care practices that achieve cost savings while maintaining or improving quality will have the opportunity to earn additional revenue through a shared savings payment model.

Patient-Centered Primary Care is available to small primary care practices as well as to large multi-specialty groups and ACOs – regardless of the practice’s technological sophistication – that already have established a strong foundation in patient-centered care. We are committed to meeting each primary care practice or organization wherever it may be in the transformation toward patient-centered care, and to supporting providers’ efforts to get to the next level.

Q2: Are medical specialists invited to participate?

We believe primary care is the foundation of the health care system. For that reason, we designed Patient-Centered Primary Care around the idea of primary care providers managing the overall health of their patients.

However, in most cases we contract at the organizational level. Any organization, including hospitals, multi-specialty groups or ACOs, that include primary care providers are eligible to participate in our program. In some special circumstances, patients may be attributed to a non-primary care specialist who is part of a multi-specialty group. We expect those specialists to coordinate care with their primary
care provider colleagues, and for that patient to eventually move into a relationship with a primary care provider, to whom they would eventually be attributed.

We encourage primary care providers – even those who practice within a group or organization that includes specialists – to develop a compact regarding how they will work together with the specialists in their “medical neighborhoods.” This agreement describes the ways both primary care providers and their colleagues in other specialties will support a proactive and coordinated care model and share information in support of that model.

Q3: How does Patient-Centered Primary Care help patients?

Patient-Centered Primary Care, is designed to address the Triple Aim: improved quality, lower cost of care and a better patient experience. All of these three goals serve patients – our members, who trust us to help them access a health care system that works for them.

We understand that value-based payment – that is, compensation for care that is dependent on efficiency, on outcomes and how closely it follows evidence-based guidelines – is not enough to ensure our members will receive high quality care delivered in an efficient, patient-centered way.

For that reason, Patient-Centered Primary Care does not rely solely on payment mechanism to make needed changes in our health care system. Alongside value-based payment, we have invested our most valuable resources – our people and our information – to help providers succeed in changing the health care delivery system from the inside out.

Our own evaluation of the first year of Patient-Centered Primary Care showed us that patients who see participating providers notice the difference. Compared to patients who saw non-participating providers, they were more likely to say their physicians listen to them with respect, and were more likely to report that they had easy access to care from their physicians even after office hours.

We know patient-centered, evidence-based care also translates into a better care experience and better patient outcomes. Patients benefit when they get a call from their regular primary care provider as a follow-up to an emergency room visit. They benefit when a social worker funded by our care coordination payments calls from the primary care provider’s office, as a follow up to a hospital admission or discharge. They benefit when their premiums remain affordable, thanks to a system-wide focus on cutting out waste.

The transformation and care management team members in each of our markets work hard to help providers successfully improve every patient’s health care experience through not only evidence-based care, but through adopting a patient-centered approach to care. This transition to a patient-centered care model will happen more quickly and more broadly if payers and providers work together with the understanding that the people we serve are the ultimate beneficiary.
Q4: How does UniCare identify my patients?

In order to offer you useful data about your UniCare patients and compensate you for care coordination activities, we must identify your patients who are covered by UniCare.

We match your UniCare patients to your practice either when a member selects you as PCP, when they are assigned to your practice, or when claims records allow us to identify a primary care relationship. The UniCare patients assigned or matched to you are referred to as your “attributed” patients. Your Program Description outlines the process more fully, including some exceptions to the general rules. Typically attribution follows the pathway below:

1) Members who are in some HMO-style plans are required to select a primary care provider, and if they do not, we auto-assign one to the member. In either case, the member is attributed to the designated primary care provider.

2) Optional PCP selection allows members enrolled in a non-gatekeeper plan, such as a PPO, to tell us which doctor should be considered their primary care provider. Members can make this optional designation via our online member portal or by calling Customer Service. This selection then attributes the member to his or her selected provider.

3) Where a PCP hasn’t been identified or assigned, we examine patterns of visits for patients and attribute patients according to their visit patterns. We first look for evidence of a relationship with a provider in a primary care specialty. If none exists, a medical specialist, then a surgical specialist.1

Where Optional PCP selection or HMO assignment of a PCP apply, those attribution methods take precedence over the visit-based attribution method. If a patient does not select a PCP, is not in a “gatekeeper” plan and we cannot identify a pattern of visits that indicates a patient-provider relationship, a member will not be attributed to a provider.

Q5: What is required of providers who participate?

As a model designed to promote effective partnership between payers and providers, Patient-Centered Primary Care does not succeed without the engagement of provider participants, from leadership to support staff.

Requirements and expectations begin with a commitment to patient-centered care and to continual improvement. A full set of requirements for participants varies somewhat by the type of arrangement in place.

A full listing of program requirements can be found in your Program Description.

It is important to note that participating providers are not required to purchase new software or hardware, or pay for consulting services from our health plan.
Some key expectations:

- Establish, maintain and use a population health patient registry. Simply stated, a registry is a mechanism for keeping all pertinent information about a specific group of patients at your fingertips. The information can be used to schedule visits, labs, educational sessions, and generate reminders and guidance around the care of patients (both in groups and individually).

- Access reports via our web-based reporting tool, PCMS. Doing so does not require any type of paid subscription or new software; PCMS is accessed via the multi-payer portal Availity. Many PCMS reports can be exported to Excel. You may continue to use your existing EMR.

- Use the Patient-Centered Primary Care reports to manage your patient population. Develop interventions based your patient population needs, which will in turn support your success in the shared savings program.

- Designate a care coordinator. This person may be and often is a current staff member who takes on care coordination duties in addition to existing responsibilities.

- Participate in learning collaborative opportunities. Many of the sessions we offer are available in recorded format on demand, and are accompanied by available CME/CEU credit.

- Identify segments of your patient population who may benefit from intervention. This may include patients with a particular chronic illness, those who are transitioning out of an inpatient setting, or those who frequently use the emergency room. We offer a multi-part series of Intervention Bundles that can help your practice accomplish this step.

- Manage referrals to direct patients to high-quality, cost-effective laboratories, radiology services and specialty care.

- Meet with the market staff and field staff regularly based on mutually agreed upon timelines and your organization’s needs.

**Q6: How do you measure quality?**

Patient-Centered Primary Care is designed to reward high-quality care that also is efficient and patient-centered. For more details about how we measure quality, see your Measurement Period Handbook. A high-level overview of our methodology follows below:

In order to qualify for shared savings payments, practices must meet a minimum performance threshold—referred to as a “Quality Gate.”

After the quality gate is satisfied, the portion of shared savings the provider receives will vary depending on performance against clinical quality measures, and in some cases, on the degree of improvement on these metrics. The payment will also depend in part on utilization measures such as the volume of
In selecting metrics by which to measure the quality of care delivered to our members, we considered metrics in the CMS Accountable Care Organization set, the Medicare Stars Scorecard, state-specific Medicaid performance guarantees, accreditation metrics and metrics used to rank health plans nationally and locally, along with other programs we sponsor.

**Commercial Membership**
In most cases, we measure clinical quality under the following metrics:

**Acute and chronic care (15 metrics):**

- **Medication Adherence**
  - Proportion of Days Covered (PDC): Oral Diabetes
  - Proportion of Days Covered (PDC): Hypertension (ACE or ARB)
  - Proportion of Days Covered (PDC): Cholesterol (Statins)

- **Diabetes Care**
  - Diabetes: Urine Protein Screening
  - Diabetes: HbA1c Testing
  - Diabetes: Eye Exam

- **Annual Monitoring for Persistent Medications**
  - Annual Monitoring for Patients on Persistent Medications: Digoxin
  - Annual Monitoring for Patients on Persistent Medications: ACE/ARB
  - Annual Monitoring for Patients on Persistent Medications: Diuretics

- **Other Acute and Chronic Care Measurement**
  - Appropriate Testing for Children with Pharyngitis
  - Appropriate Treatment for Children with Upper Respiratory Infection
  - Use of imaging for lower back pain
  - Medication Management for people with Asthma
  - New Episode of Depression: Effective Acute Phase Treatment
  - New Episode of Depression: Effective Continuation Phase Treatment
  - Appropriate treatment for Adult Bronchitis

**Preventive care (8 metrics)**

- **Pediatric Prevention**
  - Childhood Immunization Status: MMR
  - Childhood Immunization Status: VZV
  - Well-Child Visits Ages 0-15 Months
  - Well-Child Visits Ages 3-6 Years Old
  - Well-Child Visits Ages 12-21 Years Old
o Adult Prevention
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Chlamydia Screening

• Utilization (3 metrics)
  o Potentially Avoidable ER visits
  o Generic dispensing rate
  o Ambulatory-sensitive condition admission rate per 1,000 members (Pediatric and Adult)

Q7: What can I do to make sure my practice succeeds in improving quality and lowering costs?

We are committed to providers’ success, and want to help you maximize shared savings and continually improve the quality of care your patients receive.

We have carefully designed Patient-Centered Primary Care so that practices that are new to practice transformation may perform well, even as those that already have excellent outcomes and quality scores can find ways to improve.

Some of the elements most crucial to success include:

• Working under a team-based care model, which maximizes the effectiveness of your organization or practice’s providers and staff.
• Adopting and consistently delivering patient-Centered Care, which engages your patients in their care.
• Identifying discrete interventions likely to deliver higher quality care and lower the overall cost of care.
• Ensuring your patient population is appropriately risk-adjusted.
• Taking advantage of regular learning opportunities offered to your practice.
• Meeting with the Patient-Centered Primary Care field staff to review data, determine a Transformation Action Plan and implement interventions to support your patients.
• Using nationally recognized quality improvement methodologies such as “Plan, Do, Study, Act” cycles to test your interventions.

We provide tools that can aid in population management and help you chart your own success because we recognize it can be difficult for providers to identify and hone in on interventions likely to have the greatest impact on quality and cost. These tools include:

• Provider Care Management Solutions, (PCMS), our web-based clinical reporting tool
• Patient360, a longitudinal patient record that is available through the multi-payer portal Availity and is integrated into PCMS for information on your attributed patients
• Intervention Bundles – short, focused sets of information and action plans designed to
address single chronic diseases or identified cost drivers Practice Essentials, our web-
based curriculum for practice transformation.

Q8: How do you set PMPMs and determine shared savings?

Our care coordination payments and shared savings opportunities are designed to support investment
in quality improvement and care coordination, and to reward the positive result of those investments.

Care coordination payments

Clinical coordination payments compensate providers for the work they do on behalf of patients outside
of face-to-face patient visits. Those services could include care planning, maintaining patient registries,
enhancing access (such as responding to emails, offering web-based visits or following up with patients
via phone or e-mail). This type of proactive clinical coordination improves health and reduces costs.

We generally calculate PMPM rates as follows:

• When a care coordination PMPM applies, a base rate is used as the starting point for payment.

• The PMPM base rate is adjusted based on the risk score of each patient in the population to
arrive at a risk-adjusted PMPM. The base rate may be thought of as a payment for a patient of
average risk. For example, the risk score for a healthy 25-year old would be less than 1, whereas
the risk score for a 55-year old with diabetes and hypertension would be greater than 1. The
risk score and the PMPM payment amount itself are subject to an upper and lower limit.

Shared savings

Shared savings payments reward providers for successfully improving the quality and lowering overall
health care costs for their population of our patients. Generally speaking, shared savings works like this:

• We will project expected costs by reviewing historical medical costs for the medical panel’s
attributed population to reach a Medical Cost Target (MCT). We sometimes group providers
together to ensure that the Medical Cost Targets are calculated on the basis of a statistically
valid pool of our patients.

• At the end of a 12-month measurement period, we calculate actual costs incurred for the
medical panel’s attributed population. This amount is known as the Medical Cost Performance
(MCP).

• If the actual costs are less than the medical cost targets by an amount greater than a
predetermined Risk Corridor, AND the provider meets a quality threshold, then the provider
group becomes eligible to receive a portion of any savings, known as a shared savings bonus. If

Proprietary and Confidential
Claims are administered by UniCare Life & Health Insurance Company
pr400 11/17
a provider does not meet the quality threshold, the provider is NOT entitled to any shared savings bonus, regardless of the savings generated.

- The quality threshold means scoring at or above the 20th percentile for all network providers in a given market.

- If the provider meets the quality threshold and, therefore, is eligible to earn a shared savings payment, the amount earned varies based on the provider’s performance on the quality measures combined with utilization measures, patient engagement metrics, or both. The better the quality scores, the higher the percentage of the shared savings providers earn, subject to a maximum payment amount.

Any shared savings bonuses owed are based on the performance during an annual measurement period. Therefore, when a bonus, if earned, will be paid depends on when the annual measurement period started. Generally, provider bonus payments - if owed - will be paid on an annual basis.

**Q9: What if my patients have unusually high medical expenses?**

We recognize and account for differences in relative risk between different patient populations. As outlined above, care coordination payments are risk-adjusted in most cases, as a way to account for higher than average medical risk levels in providers’ patient panels.

When we calculate Performance Scorecards, we exclude members with especially high allowed claims costs (generally, those exceeding $250,000 during a Measurement Period), as well as members with certain types of transplant claims during the Measurement Period.

For specific high-claims cost amounts and a list of diagnosis-related codes that apply to your arrangement, please see your Program Description or contact your Network Director.

**Q10: How do I find data and see reports about my attributed patients?**

Participating providers have access to a wealth of information about their patient population through one or more platforms, ranging from a longitudinal health record to full data exchange for large organizations.

Provider Care Management Solutions (PCMS) is a robust web-based reporting tool that should be used by all participating providers. Through alerts, dashboards, and reports, PCMS supports both population management as well as program-specific financial performance management.

PCMS can help stratify your attributed patient population based on risk and prevalence of chronic conditions; and it also offers actionable clinical insights, such as care gap messaging and preemptive flagging of patients with high risk for readmission.
Available reporting views include:

- Attribution – Active and Inactive
- Chronic and Readmission Hot Spotters
- Care Opportunities
- Inpatient Authorizations
- Emergency Room visits and Inpatient Admissions

PCMS is designed to help you monitor and improve your performance in the program’s payment model, connecting the dots for you between the actionable activities that tie to the program’s financial incentives. The tool will show frequently-refreshed information reflecting your quality and utilization data, along with your annual Performance Scorecard.

PCMS data can be exported in a variety of ways, and does not require any special equipment or purchases; it is fully accessible via the multi-payer portal Availity.

Other mechanisms available for sharing actionable information include:

- Data exchange, for large organizations able to independently analyze patient claims data
- Patient360, our longitudinal patient health record

Related Programs

**Q11: I’ve heard about something called CPC, sponsored by the Centers for Medicare and Medicaid Services (CMS). Are you participating?**

No, UniCare is not participating in CPC.