Comprehensive Primary Care Plus (CPC+)

A CMS Center for Medicare & Medicaid Innovation (CMMI) care delivery and payment redesign model

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Senior Program Director
Continuum of Care

July 28, 2016
Housekeeping

1. **Using the control panel** - Use the control panel on the right side of your screen to minimize and expand this panel by clicking on the arrow in the upper right corner.

2. **Ask Questions** - You can submit questions using the Question section located near the bottom of the control panel. We will take time to answer as many questions as we can during Q&A at the end of the presentation. If your question was not answered, we will respond to you individually after the event.

3. **After the webinar** - We want your feedback! Please take the short survey at the completion of the webinar. Also, all registrants will receive a copy of the presentation, and the recording for on-demand replay.
Polling Question

Q: Are you or your organization planning to submit an application for the Comprehensive Primary Care Plus (CPC+)?

Responses:
- Definitely
- Possibly
- Probably Not
- I Don’t Know
- Not Applicable (e.g., not a member of a practice)
MACRA (QPP)
Providers Have Choices Regarding Medicare Payment Under MACRA

MIPS
Merit-Based Incentive Payment System
- APMs (not advanced)
- Not First Year Medicare Part B participation
- >$10K charges to Medicare per year
- >100 empaneled Medicare pts per year

ADVANCED
Alternative Payment Models
- Medicare Shared Savings Program, Tracks 2&3 (MSSP)
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM)
On April 11, 2016, CMS announced the latest and largest investment in Advanced Primary Care: Comprehensive Primary Care Plus (CPC+)

50% of all Medicare fee-for-service payments to be made via alternative payment methods by 2018

Improved care coordination and management for Medicare beneficiaries

*Predicted to save up to $2 Billion in healthcare expenditures by 2022* (Diamond, 2016).
What is Comprehensive Primary Care Plus (CPC+)?

*New Advanced Primary Care Medical Home Model*

- 5 year initiative
- Regionally-based
- Multi-payer
- Comprehensive Primary Care Delivery
CPC+ Timeline to Launch

April 2016
Model announced

July 2016
Payers selected

October 2016
Practices selected

January 1, 2017
Model launch

Payer solicitation and review period
Practice application, vendor letter of support and review period

# Differences between CPC & CPC+

## Table. Comparison of the Design Features of CPC and CPC+ Tracks 1 and 2

<table>
<thead>
<tr>
<th></th>
<th>CPC</th>
<th>CPC+ Track 1</th>
<th>CPC+ Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size</strong></td>
<td>7 Regions; ≤500 practices</td>
<td>≤20 Regions; ≤2500 practices</td>
<td>≤20 Regions; ≤2500 practices</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>4 y (2012-2016)</td>
<td>5 y (2017-2021)</td>
<td>5 y (2017-2021)</td>
</tr>
<tr>
<td><strong>Medicare care management fee</strong></td>
<td>$20 PBPM PY1-2; $15 PBPM PY3-4; average across 4 risk tiers</td>
<td>$15 PBPM average across 4 risk tiers</td>
<td>$27 PBPM average across 5 risk tiers; $100 for highest-risk tier</td>
</tr>
<tr>
<td><strong>Medicare payment for office visits</strong></td>
<td>100% FFS</td>
<td>100% FFS</td>
<td>100% FFS for non-evaluation and management; reduced FFS + up-front payment for evaluation and management</td>
</tr>
<tr>
<td><strong>Medicare incentive payment</strong></td>
<td>Shared savings based on quality metrics and TCOCb</td>
<td>$2.50 PBPM based on quality and utilization metrics</td>
<td>$4 PBPM based on quality and utilization metrics</td>
</tr>
<tr>
<td><strong>HIT partners</strong></td>
<td>Not required</td>
<td>Not required</td>
<td>Required</td>
</tr>
</tbody>
</table>

Abbreviations: CPC, Comprehensive Primary Care; CPC+, Comprehensive Primary Care Plus; FFS, fee for service; HIT, health information technology; PBPM, per beneficiary per month; TCOC, total cost of care.

a Paid only for Medicare FFS beneficiaries attributed to participating practices based on plurality of primary care visits.
b Savings calculated based on any reduction in Medicare Part A and B expenditures.

Goals of CPC+

Advance care delivery and payment to allow practices to provide more comprehensive care that meets the needs of all patients, particularly those with complex needs.

Accommodate practices at different levels of transformation readiness through two program tracks, both offered in every region.

Achieve the Delivery System Reform core objectives of **better care, smarter spending, and healthier people** in primary care.

**5 Years**
Beginning 2017, progress monitored quarterly

**Up to 20 Regions**
Selection based on payer interest and coverage

Framework for Payer Partnership

- Enhanced, non-fee-for-service support for Track 1 and 2 practices to meet the aims of the care delivery model
- Change in cash flow mechanism from fee-for-service to at least a partial alternative payment methodology for Track 2 practices
- Performance-based incentive payments for Track 1 and 2 practices
- Aligned quality and patient experience measures with Medicare FFS and other payers in the region
- Practice and member-level cost and utilization data at regular intervals for all practices

Practices Apply to Participate in 1 of 2 Tracks

**Track 1**
- Up to 2,500 primary care practices.
- Pathway for practices ready to build the capabilities to deliver comprehensive primary care.

**Track 2**
- Up to 2,500 primary care practices.
- Pathway for practices poised to increase the comprehensiveness of care through enhanced health IT, improve care of patients with complex needs, and inventory resources and supports to meet patients’ psychosocial needs.

CPC+ Practice Eligibility Criteria

CMS will accept practice applications from **July 15 through September 1** **August 1 through September 15, 2016**.
Practices should apply for the Track they believe they are eligible.*

**Track 1**
- Use of CEHRT
- Payer interest and coverage
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities.

**Track 2**
- Use of CEHRT
- Payer interest and coverage
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities, while also developing and recording care plans, following up with patients after emergency department (ED) or hospital discharge, and implementing a process to link patients to community-based resources.
- Letter of support from health IT vendor that outlines the vendor’s commitment to support the practice in optimizing health IT.

*CMS reserves the right to ask a practice that applied to Track 2 to instead participate in Track 1 if CMS believes that the practice does not meet the eligibility requirements for Track 2 but does meet the requirements for Track 1.

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Practices will Engage Health IT Vendors

Both tracks require use of certified Health IT.

Health IT vendors can sign a Memorandum of Understanding with CMS.

Track 2 practices will apply with a letter of support from an Health IT vendor to facilitate the use of emerging health IT capabilities, required in Track 2.

Health IT vendors are invited to participate in relevant Learning System activities with practices and payers.

CPC+ Functions Guide Transformation towards Comprehensive Primary Care

- Access and Continuity
- Care Management
- Comprehensiveness and Coordination
- Patient and Caregiver Engagement
- Planned Care and Population Health

**What is a Function?**
The five CPC functions act as “corridors of action” leading to practices’ capability to deliver comprehensive primary care.

**Why do Track 1 and 2 have the same Functions?**
The outline to support better care, smarter spending, and healthier people is the same for all primary care practices in CPC+. However, specific requirements within these “corridors of action” vary by track.

Comprehensive Primary Care Functions - Enhanced

Access and Continuity
- 24/7 patient access
- Assigned care teams
- Expanded office hours

Care Management
- Risk stratify patient population
- Short and long-term care management
- Care plans for high-risk chronic disease patients

Comprehensiveness and Coordination
- Identify high volume/cost specialists serving population
- Behavioral health integration
- Follow-up on patient hospitalizations
- Psychosocial needs assessment and inventory resources and supports

Examples for Track 1
Additional examples for Track 2

Comprehensive Primary Care Functions - Enhanced

Examples for Track 1

Patient and Caregiver Engagement

Convene a Patient and Family Advisory Council

Additional examples for Track 2

Support patients’ self-management of high-risk conditions

Planned Care and Population Health

Analysis of payer reports to inform improvement strategy

Practice activities may include, but are not limited to, the above examples.

Track 2 capabilities are inclusive of and build upon Track 1 examples.

Who are Your Attributed Patients?

- Office or other Outpatient visit for Evaluation & Management of a new patient: 99201-99205
- Office or other Outpatient visit for Evaluation & Management of an established patient: 99211-99215
- Welcome to Medicare and Annual Wellness Visits: G0402, G0438, G0439
- Complex Chronic Care Coordination services: 99487-99489
- Transitional care management services: 99495-99496
- Home visit for the Evaluation & Management of a New Patient: 99341-99350
- Chronic Care Management services: 99490

## Three Payment Innovations Support Practice Transformation

<table>
<thead>
<tr>
<th></th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment</th>
<th>Underlying Payment Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>Standard FFS</td>
</tr>
<tr>
<td><strong>Track 2</strong></td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>

Care Management Fees Determined by Risk Tier

**Track 1: Four Risk Tiers (Average $15)**

- $6
- $8
- $16
- $30

**Track 2: Five Risk Tiers (Average $28)**

- $9
- $11
- $19
- $33

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**Complex Tier: $100**
Top 10% of risk or dementia diagnosis

- Risk adjusted, non-visit-based payment
- Designed to augment staffing and training, according to specific needs of patient population
- Paid by all payer partners (support amount will vary by payer)
- No beneficiary cost sharing
- Risk tiers relative to regional population
Two Performance-Based Incentive Payment Opportunities

Two Components of Incentive Payment

- **Quality** and patient experience measures
  - Examples: eCQMs, CAHPS
  - Measured at practice level

- **Utilization** measures that drive total cost of care
  - Examples: inpatient admissions, ED visits
  - Measured at practice level

<table>
<thead>
<tr>
<th></th>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (PBPM)</td>
<td>$1.25</td>
<td>$2.00</td>
</tr>
<tr>
<td>Utilization (PBPM)</td>
<td>$1.25</td>
<td>$2.00</td>
</tr>
<tr>
<td>Total (PBPM)</td>
<td>$2.50</td>
<td>$4.00</td>
</tr>
</tbody>
</table>

Prospectively paid (based on defined targets and PBPMs), retrospectively reconciled based on performance.

No-overlaps policy with Medicare shared savings programs or models.
Track 2 Payment Offers More Flexibility in Care Delivery

New Hybrid FFS and FFS Rollup (CPCP) “Comprehensive Primary Care Payment”

2016

FFS

CPCP

40%

FFS

60%

OR

2019

CPCP

65%

FFS

35%

CPCP is ~10% larger than historical FFS to compensate for more comprehensive services

- May allow practices to deliver enhanced, comprehensive services without the incentive to increase volume of patients or services to achieve a favorable financial outcome
- Practices select the pace at which they will progress towards one of two hybrid payment options by 2019

### Example of CPC+ Total Payments

#### Let’s assume:

<table>
<thead>
<tr>
<th>Provider Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000 Medicare Covered Lives, per Provider</td>
</tr>
<tr>
<td>Procedure Billing makes up 50% of Total Billing</td>
</tr>
<tr>
<td>Average E&amp;M Billing Yr.4 in CPCI = $15.00 PBPM</td>
</tr>
</tbody>
</table>

#### Per Provider Per Year*

<table>
<thead>
<tr>
<th></th>
<th>E&amp;M Billing</th>
<th>Procedure Billing</th>
<th>MACRA 5%**</th>
<th>Care Management Fee (CMF)</th>
<th>Performance-based Incentive Payment</th>
<th>TOTAL Potential $$</th>
<th>Upfront $$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FFS</strong></td>
<td>$180,000</td>
<td>$180,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$360,000 (average)</td>
<td>$0</td>
</tr>
<tr>
<td><strong>CPC+ Track 1</strong></td>
<td>$180,000</td>
<td>$180,000</td>
<td>$18,000</td>
<td>$180,000 ($15 pbpm)</td>
<td>$30,000 ($2.50 pbpm)</td>
<td>$588,000 (average)</td>
<td>$180,000 (CMF)</td>
</tr>
<tr>
<td><strong>CPC+ Track 2 (@65%/35%)</strong></td>
<td>~$198,000</td>
<td>$180,000</td>
<td>$18,900***</td>
<td>$336,000 ($28 pbpm)</td>
<td>$48,000 ($4.00 pbpm)</td>
<td>$780,900 (average)</td>
<td>$464,700 (65% CPCP + CMF)</td>
</tr>
</tbody>
</table>

*Subject to change based on release of technical methodology anticipated to be released late 2016.

**Subject to change based on the final rule.

***It is unclear if the 5% bonus from MACRA will include the 10% increase in historical E&M billing.

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Proposed CPC+ Quality Measure Set

- CPC practices must meet the certified Health IT requirements in order to report measures.
- The final list of measures will be determined no later than November 2016.
- Providers will be required to report a subset of these measures.

<table>
<thead>
<tr>
<th>CMS ID#</th>
<th>NQF#</th>
<th>MEASURE TITLE</th>
<th>MEASURE TYPE/ DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS169v5</td>
<td>0710</td>
<td>Depression Remission at Twelve Months</td>
<td>Outcome/ECQM</td>
</tr>
<tr>
<td>CMS165v5</td>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
<td>Outcome/ECQM</td>
</tr>
<tr>
<td>CMS131v5</td>
<td>0055</td>
<td>Diabetes: Eye Exam</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS149v5</td>
<td>N/A</td>
<td>Dementia: Cognitive Assessment</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS127v5</td>
<td>0043</td>
<td>Pneumococcal Vaccination Status for Older Adults</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS137v5</td>
<td>0004</td>
<td>Initiation and Engagement of Alcohol and other Drug Dependence Treatment</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS125v5</td>
<td>2372</td>
<td>Breast Cancer Screening</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS124v5</td>
<td>0032</td>
<td>Cervical Cancer Screening</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS130v5</td>
<td>0034</td>
<td>Colorectal Cancer Screening</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS156v5</td>
<td>0022</td>
<td>Use of High-Risk Medications in the Elderly</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS139v5</td>
<td>0101</td>
<td>Falls: Screening for Future Falls Risk</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS88v6</td>
<td>0410</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS2v6</td>
<td>0418</td>
<td>Preventive Care and Screening: Screening for Depression and Follow-Up Plan</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS122v5</td>
<td>0059</td>
<td>Diabetes: Hemoglobin HbA1c Poor Control (&gt;9%)</td>
<td>Outcome/ECQM</td>
</tr>
<tr>
<td>CMS138v5</td>
<td>0028</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td>CMS147v6</td>
<td>0041</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EFFICIENT USE OF HEALTHCARE RESOURCES (1)</td>
<td></td>
</tr>
<tr>
<td>CMS168v6</td>
<td>0052</td>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>Process/ECQM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CARE COORDINATION (1)</td>
<td></td>
</tr>
<tr>
<td>CMS50v6</td>
<td>N/A</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Process/ECQM</td>
</tr>
</tbody>
</table>

CMS knows that practices are the primary drivers of change

CMS will provide online learning tools so ensure:

- Practice ownership and management of CPC+ implementation
- Practices are able to make Assessments and give feedback
- Support from CMS staff
- Alignment with national and regional health care reform efforts

Practices Rely upon Frequent Data Feedback from CMS, Payer Partners and IBM Watson Health
<table>
<thead>
<tr>
<th>CPC+ Function</th>
<th>Key Strategy</th>
<th>IBM Watson Health Solutions Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and Continuity</td>
<td>24/7 access Care teams eVisits Expanded hours</td>
<td>Operational support only</td>
<td>IBM Watson Care Manager</td>
</tr>
<tr>
<td>Care Management</td>
<td>Risk stratification Event triggers Care planning</td>
<td>IBM Phytel Insight, IBM Phytel Outreach Plus, IBM Phytel Coordinate, IBM Explorys Measure, IBM Explorys Inform</td>
<td>IBM Phytel Insight, IBM Phytel Outreach Plus IBM Phytel Coordinate, Watson Care Manager</td>
</tr>
<tr>
<td>Comprehensiveness and</td>
<td>Identify high volume/high cost F/up on hospitalizations Behavioral health Psychosocial needs</td>
<td>IBM Explorys Measure, IBM Explorys Inform IBM Explorys SuperMart, IBM Explorys Population Assessment</td>
<td>IBM Watson Care Manager IBM Explorys Measure, IBM Explorys Inform IBM Explorys SuperMart, IBM Explorys Population Assessment</td>
</tr>
<tr>
<td>Coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient and Caregiver</td>
<td>Patient and Family Advisory Council (PFAC) Self-management support</td>
<td>IBM Phytel Coordinate, IBM Watson Care Manager</td>
<td>IBM Phytel Coordinate, IBM Watson Care Manager</td>
</tr>
<tr>
<td>Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Care and</td>
<td>Measure and act on evidence-based care needs Weekly team meetings</td>
<td>IBM Explorys Measure, IBM Explorys Inform IBM Explorys SuperMart, IBM Explorys Population Assessment</td>
<td>IBM Phytel Insight, IBM Phytel Coordinate, IBM Explorys Measure, IBM Explorys Inform IBM Explorys SuperMart, IBM Explorys Population Assessment</td>
</tr>
<tr>
<td>Population Health</td>
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</tbody>
</table>
For more information and resources on CPC+, visit:
https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus

or email:
CPCplus@cms.hhs.gov

or call the CPC+ Help Desk:
1-844.442.2672
8:30a.m. – 7:30p.m. ET
Questions?
References


THANK YOU!

The recording and handouts will be sent to you via email within 2 business days

Questions? Contact Shawn Auer at sauer@us.ibm.com