**CPC+ Model Overview**

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

- **14 Regions**
  Selection based on payer interest and coverage

- **2 Program Tracks**
  2,900+ practice selected, based on practices’ readiness for transformation
CPC+ Regions Selected Based on Multi-Payer Support

Partner Payers Aligned With But Not Identical to Medicare

Payers Invited to Partner

Required Payer Alignment

- Enhanced, non-FFS support
- Change in cash flow mechanism from fee-for-service to at least a partial alternative payment methodology for Track 2 practices
- Performance-based incentive
- 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
CPC+ Offered in 14 Regions in 2017

Only Practices in Selected States/Counties Were Eligible

- North Hudson/Capital District (NY)
- Northern Kentucky (part of Ohio region)
- New Jersey
- Greater Philadelphia (PA)
- Greater Kansas City
- OR
- MT
- CO
- OK
- AR
- TN
- Hawaii

- = Statewide region
- = Region comprising contiguous counties
Five Functions Guide CPC+
Care Delivery Transformation

- Access and Continuity
- Care Management
- Comprehensiveness and Coordination
- Patient and Caregiver Engagement
- Planned Care and Population Health
CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

Requirements for

**Track 1**
- Empanelment
- 24/7 patient access
- Assigned care teams

**Additional Requirements for**

**Track 2**
- Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.

**Access and Continuity**

**Care Management**

- Risk stratified patient population
- Short-term and targeted, proactive, relationship-based care management
- ED visit and hospital follow-up

- Two-step risk stratification process for all empanelled patients
- Care plans for high-risk chronic disease patients

*Track 2 capabilities are inclusive of and build upon Track 1 requirements.*
## CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

<table>
<thead>
<tr>
<th>Requirements for</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
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<tr>
<td><strong>Track 2</strong></td>
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</tbody>
</table>

### Comprehensiveness and Coordination
- Identification of high volume/cost specialists
- Improved timeliness of notification and information transfer from EDs and hospitals

### Patient and Caregiver Engagement
- At least annual Patient and Family Advisory Council
- Assessment of practice capabilities to support patient self-management
- At least biannual Patient and Family Advisory Council
- Patient self-management support for at least three high-risk conditions

### Planned Care and Population Health
- At least quarterly review of payer reports on utilization measures and practice data on eCQMs to inform improvement strategy
- At least weekly care team review of all population health data

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*Track 2 capabilities are inclusive of and build upon Track 1 requirements.*
Enhanced Health IT Functionality Supports Care Delivery

**Access and Continuity**
- Patient Empanelment
- 24/7 Access
- Out-of-Office Care Options

**Care Management**
- Risk Stratification
- Hospital/ED Discharge Follow-Up
- Care Plans

**Comprehensiveness and Coordination**
- Coordination with Other Providers
- Integrated Behavioral Health
- Psychosocial Needs Assessment

**Patient and Caregiver Engagement**
- Patient and Family Advisory Council
- Self-Management Support Tools

**Planned Care and Population Health**
- Practice and Payer Data Insight
- Full Care Team Data Review

**Track 1 requirements**

**Additional requirements for Track 2**

**Integrated with enhanced Health IT for Track 2**
Practices Will Use Advanced Health IT to Improve Patient Care

All Practices Must Adopt Certified EHR Technology

**General Requirements**

- Adopt certified health IT modules which meet the definition of CEHRT according to the timeline and requirements finalized for use in CMS programs supporting certified EHR use (e.g. EHR Incentive Programs, proposed Quality Payment Program)

- Use 2015 Edition technology (may use 2014 Edition in 2017 only)

**Quality Reporting Requirements**

- Adopt health IT certified to the (c)(1) – (c)(3) certification criteria for all eCQMs in the CPC+ measure set

- Use the latest annual measure update for the CPC+ measures

- Be able to filter eCQM data by practice site location and TIN/NPI beginning in 2017. Beginning in 2018, adopt 2015 Edition health IT certified to the criterion 45 CFR 170.315(c)(4) to filter eCQMs.

**Additional For Track 2**

By January 1, 2019 (beginning of CPC+ PY3), adopt health IT certified to the 2015 Edition “Care Plan” criterion found at 45 CFR 170.315(b)(9) and the 2015 Edition “Social, Behavioral, and Psychosocial Data” criterion found at 45 CFR 170.315(a)(15)
### Three Payment Innovations Support CPC+ Practice Transformation

<table>
<thead>
<tr>
<th>Objective</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment (PBPM)</th>
<th>Payment Structure Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td>Support augmented staffing and training for delivering comprehensive primary care</td>
<td>Reward practice performance on utilization and quality of care</td>
<td>Reduce dependence on visit-based fee-for-service to offer flexibility in care setting</td>
</tr>
<tr>
<td></td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>N/A (Medicare 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>
Many Opportunities for Learning, Collaboration, and Support

Learning Communities

National Learning Community
- Cross-region collaboration
- Live and on-demand learning opportunities: action groups, webinars, affinity groups, office hours
- Durable written products: Implementation Guide, newsletters, FAQs, case studies/spotlights
- Annual Stakeholder Meeting

Regional Learning Communities
- Virtual and in-person learning sessions
- Outreach to and support for practices
- Clinical and administrative leadership engagement
- Payer engagement
- Alignment with regional reform

Web-based platform for CPC+ stakeholders to share ideas, resources, and strategies for practice transformation.
Centralized Data Feedback

Financial Data
- Attributed Beneficiaries
- Track 1 & 2 Payments

Cost & Utilization Data
(Beneficiary/Practice/Regional)
- Expenditures (inpatient, outpatient, professional services, etc.)
- Utilization (inpatient, ED utilization, etc)

Quality Data
- eCQM & CAHPS Results

Care Delivery Assessment
- Milestone Reporting
- Forecast & Reconciliation Reporting

CPC+ Practice

Regional Learning Support
Assessing Practice Transformation Progress & Improvement Opportunities

Learning From Practices

**Monitoring Strategy**
- Automated tracking in Practice Portal to ensure compliance with program requirements
- In-depth audits to confirm accuracy of self-reported data and appropriate use of funds
- Practice notification of noncompliance and eligibility for remedial action or termination

**Evaluation Methodology**
- Examine implementation and what impact it has on providers and Medicare FFS beneficiaries
- Collect extensive primary data, including site visits, patient interviews, and surveys of beneficiaries and providers
- Employ a randomized design, if possible
Evaluating the Impact and Implementation Experience of CPC+

Mixed methods, customized to each track to assess both impact and implementation experience

- **Impact**: key outcomes: total costs and quality of care
- **Implementation**: barriers and facilitators to model implementation
- If possible, randomized control group using longitudinal design

### Data Reviewed

In-depth annual analysis of practice-level transformation, as well as regional and national trends for CPC+ practices, through:

- Surveys of practices and staff
- “Deep dives” into a few practices in each region
- Interviews with payer partners

Patient-level quality outcomes

- Population-wide assessment of quality performance and improvement using CAHPS and eCQMs

Changes in cost of care and utilization of health services

- Note: limited to Medicare FFS data
- Many payers conduct own analyses
Payment Under the Medicare Quality Payment Program

Both Paths Offer Advantages for CPC+ Participants

Eligible Clinician in the Merit-based Incentive Payment System (MIPS)

- PFS adjusted based on performance in four categories
- Includes most Medicare clinicians
- Evaluated as individual or as group

Qualifying APM Participant in an Advanced Alternative Payment Model (APM)

- Clinician(s) must reach minimum thresholds for either payments or number of patients under Part B through a designated Advanced APM

Physician Fee Schedule + MIPS adjustment

Physician Fee Schedule + 5% lump sum bonus

CPC+ Payments

Participation in CPC+ increases MIPS score

CPC+ Payments
**CPC+ Timeline**

- **April 2016**: Model announced
- **August 2016**: Payers & regions selected
- **November 2016**: Practices selected
- **January 1, 2017**: Model launch
- **Future Opportunities to Join CPC+**
Improving Payment Accuracy in the Medicare Physician Fee Schedule

CMS finalized coding and payment changes to better value primary care, care management, and cognitive services:

1. Adjustments to existing CPT codes
   - Make separate payments to certain CPT codes describing non-face-to-face prolonged E&M services
   - Revalue existing CPT codes describing face-to-face prolonged services
   - Make separate payment for codes describing chronic care management for patients with greater complexity

2. Separate payments through new CPT codes
   - Make separate payments using a new code to describe the comprehensive assessment and care planning for patients with cognitive impairment (e.g., dementia)
   - Make separate payments using new codes to pay practices that use interprofessional care management resources to treat patients with behavioral health conditions, including codes within behavioral health integration models of care

3. Reduce administrative burden
   - Make several changes to reduce administrative burden associated with the CCM codes to remove barriers to furnishing and billing these services
For More on CPC+

Visit
https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus

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