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CENTERS FOR MEDICARE & MEDICAID SERVICES
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CPC+
Comprehensive Primary Care Plus

Comprehensive Primary Care Plus

Value Based Payment for Comprehensive Primary Care

The Association of Chiefs and Leaders of General Internal Medicine

December 6, 2016

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CPC+ Model Overview

5 Years

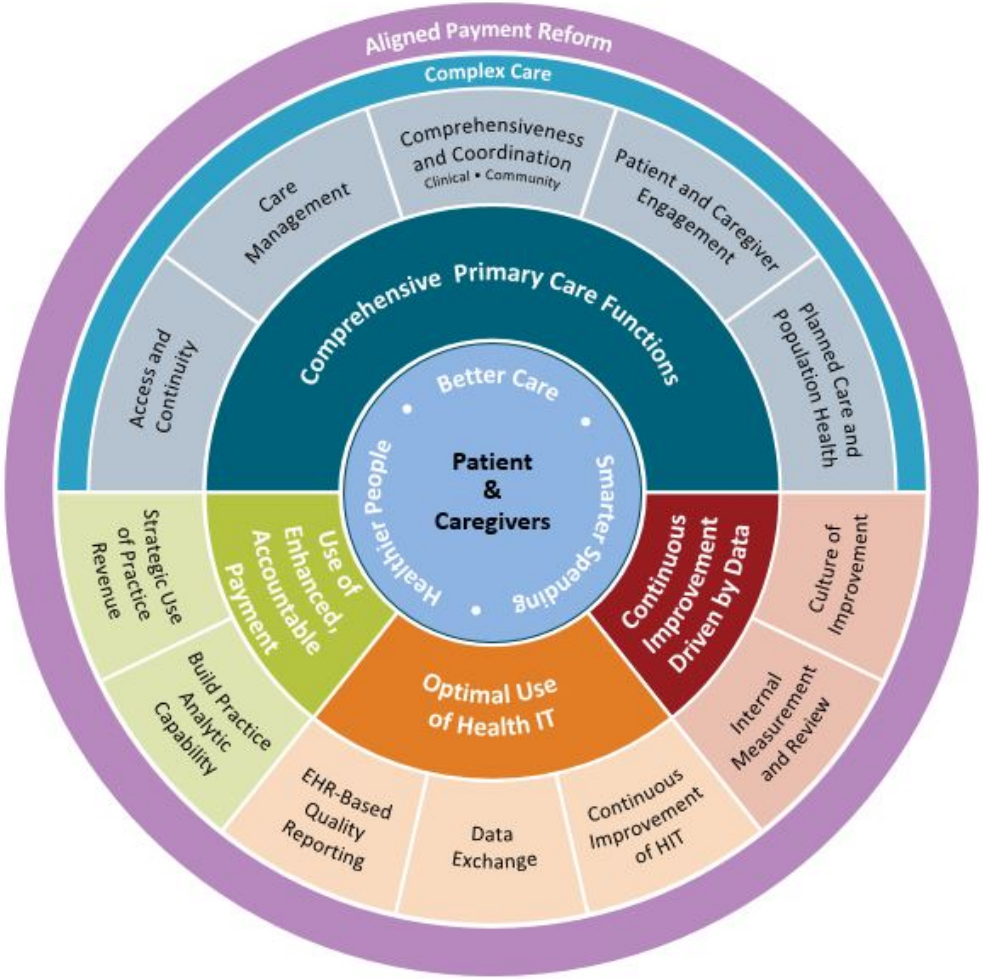
Beginning 2017, progress monitored quarterly

14 Regions

Selection based on payer interest and coverage

2 Program Tracks

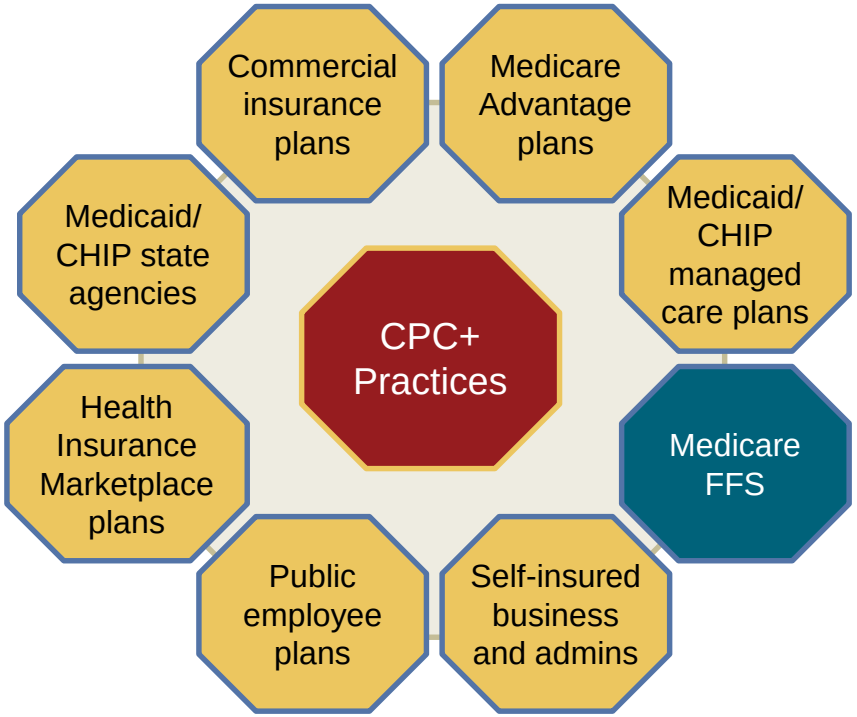
2,900+ practice selected, based on practices' readiness for transformation



CPC+ Regions Selected Based on Multi-Payer Support

Partner Payers Aligned With But Not Identical to Medicare

Payers Invited to Partner

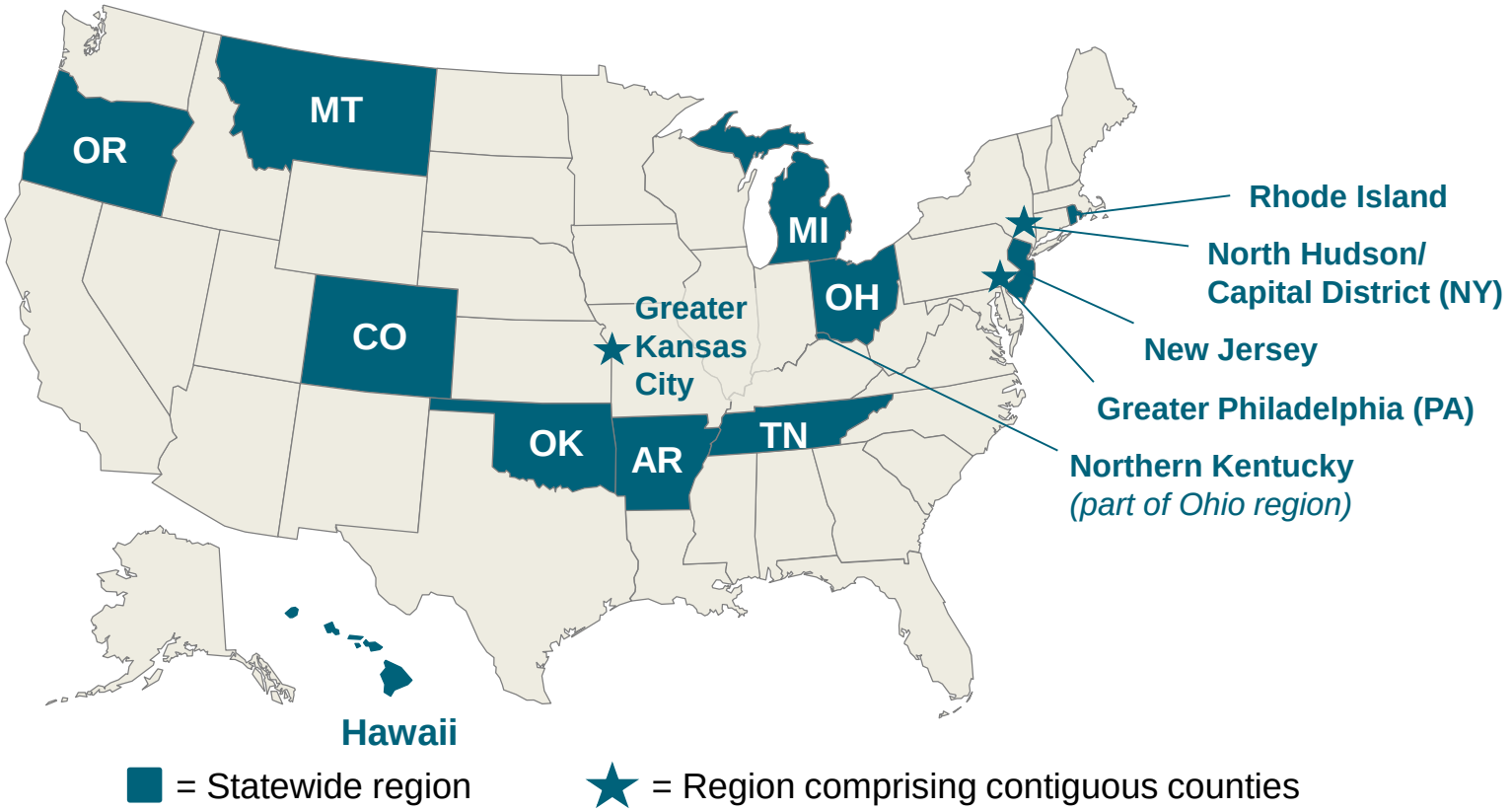


Required Payer Alignment

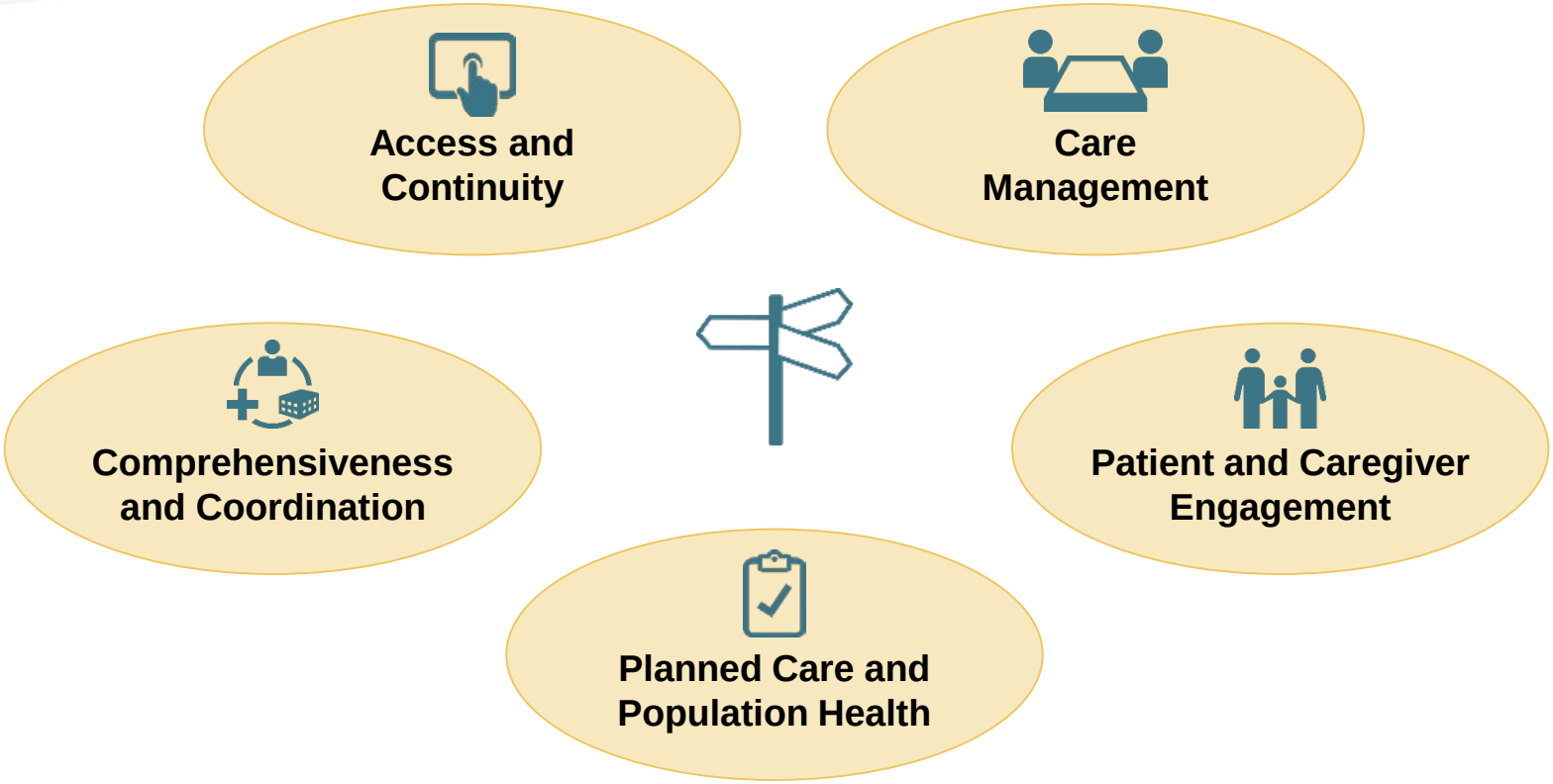
- Enhanced, non-FFS support
- Change in cash flow mechanism from fee-for-service to at a least a partial alternative payment methodology for Track 2 practices
- Performance-based incentive
- Aligned quality and patient experience measures with Medicare FFS and other payers in the region
- Practice- and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

CPC+ Offered in 14 Regions in 2017

Only Practices in Selected States/Counties Were Eligible



Five Functions Guide CPC+ Care Delivery Transformation



CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

	Requirements for Track 1	Additional Requirements for Track 2
Access and Continuity	Empanelment 24/7 patient access Assigned care teams	Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.
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

	Requirements for Track 1	Additional requirements for Track 2
Comprehen-siveness and Coordination	Identification of high volume/cost specialists Improved timeliness of notification and information transfer from EDs and hospitals	Behavioral health integration Psychosocial needs assessment and inventory of resources and supports to meet psychosocial needs Collaborative care agreements Development of practice capability to meet needs of high-risk populations
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

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

	Care Management Fee (PBPM)	Performance-Based Incentive Payment (PBPM)	Payment Structure Redesign
Objective	*Support augmented staffing and training for delivering comprehensive primary care*	*Reward practice performance on utilization and quality of care*	*Reduce dependence on visit-based fee-for-service to offer flexibility in care setting*
Track 1	$15 average	$2.50 opportunity	N/A (Medicare FFS)
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)

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

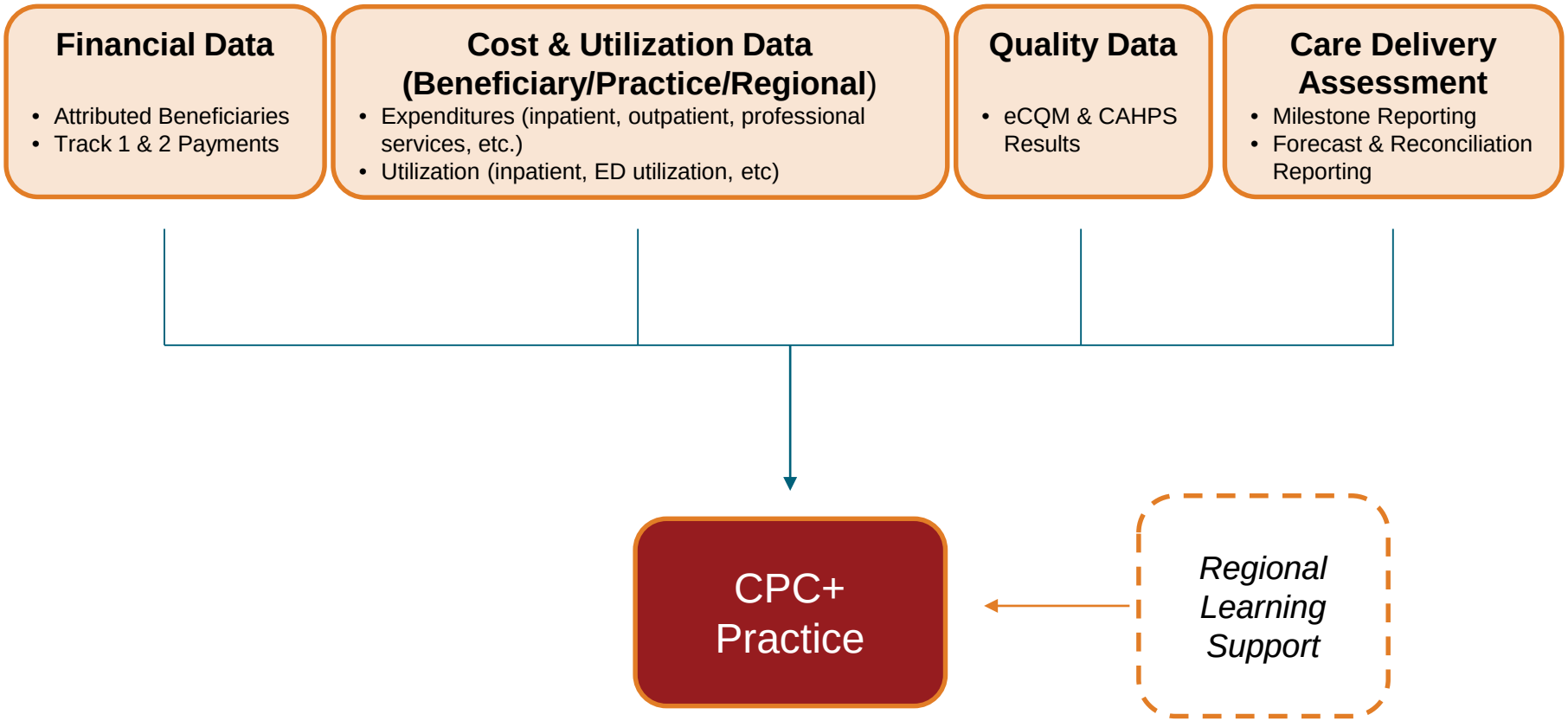
CPC+ Connect

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

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

Centralized Data Feedback



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

Physician Fee Schedule
+ MIPS adjustment

Participation in CPC+ increases MIPS score

+

CPC+ Payments

OR

Qualifying APM Participant in an

<u>Advanced</u> Alternative Payment Model (APM)

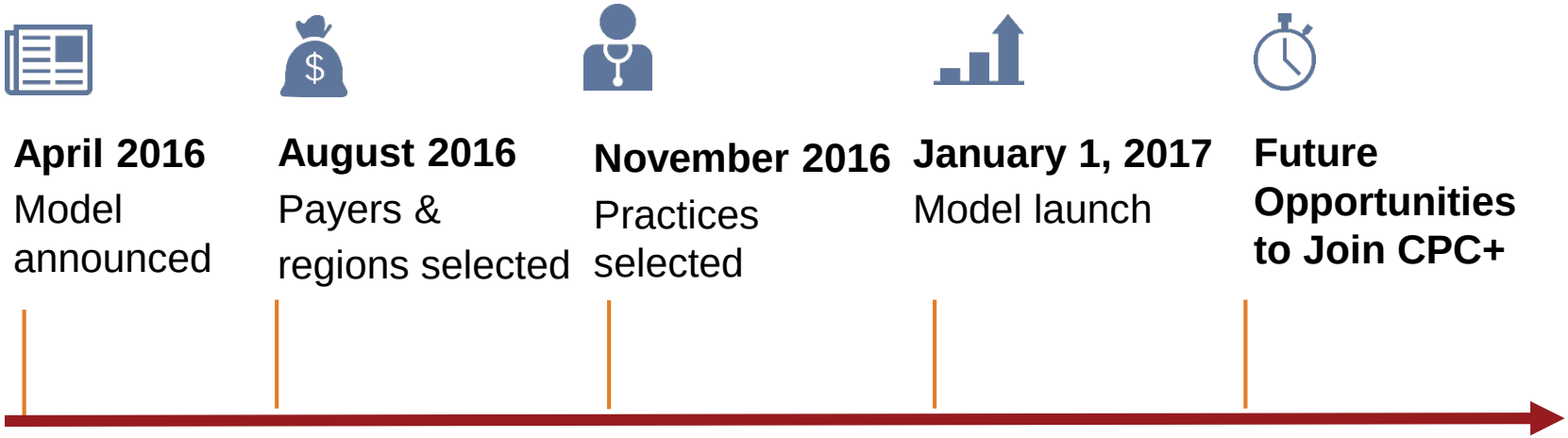
- Clinician(s) must reach minimum thresholds for either payments or number of patients under Part B through a designated Advanced APM

Physician Fee Schedule
+ 5% lump sum bonus

+

CPC+ Payments

CPC+ Timeline



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

Changes

- 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

Changes

- 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

Changes

- Make several changes to reduce administrative burden associated with the CCM codes to remove barriers to furnishing and billing these services

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