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## **Comprehensive Primary Care Plus (CPC+) Model Announcement**

CMS Webinar

Thursday, April 14, 2016, 3:00 – 4:00 p.m. ET

### **CPC+ Model Update**

On Friday, May 26, 2016, CMS announced that since the unveiling of CPC+ in April, it has received feedback from a variety of stakeholders expressing interest in the dual participation of primary care practices in both an ACO and in CPC+. As a result, CMS will now offer the opportunity for up to 1,500 eligible primary care practices currently participating or applying for participation in Tracks 1, 2, or 3 of the Medicare Shared Savings Program (MSSP) as of January 1, 2017, to also participate in CPC+. For more details about this policy, please review the [updated FAQs](#) on the CPC+ website. The Payer Solicitation materials are unchanged from the version posted on Monday, May 23<sup>rd</sup>. CMS appreciates stakeholders' input on this issue and believes dual participation in CPC+ and an MSSP ACO may enhance the coordination of care for Medicare beneficiaries, and help to achieve its aims of better care, smarter spending, and healthier people.

### **Overview**

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. The model builds upon the lessons learned from the Comprehensive Primary Care (CPC) initiative, and input from the 2015 Request for Information on Advanced Primary Care Model Concepts. The focus of this call was to provide an overview of the aspects of the model relevant to three major groups: health plans, vendors, and primary care practices. Aimed at achieving the delivery system reform core objectives of better care, smarter spending, and healthier people in primary care, the model's advanced care delivery and payment will allow practices to provide more comprehensive care to meet the needs of all patients, particularly, those with more complex healthcare needs.

Noteworthy application dates for the model are as follows:

- CMS will solicit health plan proposals to partner with Medicare in CPC+ (April 15-June 1, 2016).

- CMS will publicize the CPC+ regions, and solicit applications from practices within these regions (July 15-Sept. 1, 2016).

### **Model Design**

Considering the varying levels at which practices are ready to participate in the care delivery redesign, CMS is offering a two-track option, each with different eligibility and care redesign requirements. The model will exist for five years, (2017 to 2021), and encompass up to 20 regions across the country. Regions selected will be those with a density of health plans that are interested in partnering with CMS in the model. It will be a multi-payer model to ensure that practices have the financial resources from the health plans that insure the patients they serve, and other support needed to provide the care that CMS expects.

### **Partner Alignments**

CMS intends to engage a myriad aligned public and private health plan partners to work with under the model. CMS notes that *the health plan application period runs from April 15 – June 1, 2016.*

CMS has learned from the current CPC model that when health plans work together to support primary care practices, better outcomes are achieved than when practices work alone. Thus, the agency is looking for health plans willing to align with them in order to reach the model's goals. These partners will include:

- Commercial insurance plans
- Medicare Advantage plans
- Medicaid/CHIP managed care plans
- Medicare fee-for-service (FFS)
- Administrators of self-insured groups
- Self-insured businesses
- Public employee plans
- Medicaid/CHIP state agencies

### Partnership Framework

Health plans must be willing to align their payment structures, quality metrics, and data sharing with those of Medicare to meet the goals of CPC+. The elements need not be identical, but aligned in both principle and goal.

1. Payments - CMS seeks alignment in the three features of CPC+ payment:
  - Enhanced non-FFS support for each track in the model

- Partial alternative for FFS methodology that can help practices deliver care more efficiently (**Track 2 only**)
  - An incentive payment based on performance outcomes
2. Quality Measures - Aligned quality and patient experience measures with Medicare FFS and other health plans in each region.
  3. Data Sharing – Provision of practice and member-level cost and utilization data at regular intervals.

Practice Participation Eligibility

Once CMS has selected and announced up to 20 regions that are selected for the model, it will immediately solicit the primary care practices within those regions. The practice application period will begin on July 15, 2016, with applications due by Sept. 1, 2016. Practices will apply directly to the track for which they are interested and believe that they are eligible. Accepted practices will be announced in October 2016. The model will launch **Jan. 1, 2017**.

- **Track 1:** CMS will accept up to 2,500 primary care practices – Eligible practices must be ready to build the capabilities to deliver comprehensive primary care.
- **Track 2:** CMS will also accept up to 2,500 primary care practices – Eligible practices must be ready to increase the comprehensiveness of care through enhanced health IT, improve care of patients with complex needs, and provide support to meet patients’ unmet psychosocial needs.

Practices applying to Track 1 or Track 2 must:

- Demonstrate the use of certified electronic health record technology (CEHRT)
- Have health plan interest and coverage
- Have existing care activities that must include:
  - Assigning patients to provider panels
  - Providing 24/7 access for patients
  - Supporting quality improvement activities

In addition to the above requirements listed for Track 1, Track 2 applicants **must** also experience:

- Developing and recording care plans
  - Following up with patients after emergency department or hospital discharge
  - Implementing a process to link patients to community-based resources
- Apply with a letter of support from a health IT vendor outlining their commitment to support the practice in optimizing health IT. This is a new concept for many practices and health IT vendors.

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

Health IT Vendor Engagement

Health IT vendor engagement is a critical component of the model, since both tracks require practices to use certified health IT. Health IT that supports the care of a population of patients by a care team is critical to efficient delivery of advanced primary care, but is often not available. After practices are selected, the vendors will sign a simple memorandum of understanding with CMS. CMS will offer innovative opportunities to bring together vendors and practices to optimize health IT for primary care delivery. This collaboration will be jointly managed by CMS and the Office of the National Coordinator for Health IT. Practices that apply will be provided with a list of all health IT vendors who have indicated interest, and vendor contact information will be posted on the website that practices will use to apply to the model.

Care Delivery Work

CMS has organized the care delivery provided by participating practices in both tracks into five functions or “corridors of action,” which enhance their capability to deliver comprehensive primary care. Track 1 and Track 2 both have the same functions because the goals of supporting better care, smarter spending, and healthier people are the same for all primary care practices in CPC+. However, specific requirements within these corridors of action vary by track. Track 2 will work more deeply into each of the functions. According to CMS, the final care delivery requirements, which will look very similar to those provided in the following chart, will be available on the CPC+ website soon.

Function	Track 1 (examples)	Track 2 (additional examples)
Access and Continuity	<ul style="list-style-type: none"> <li>• 24/7 patient access</li> </ul>	<ul style="list-style-type: none"> <li>• E-visits</li> </ul>
	<ul style="list-style-type: none"> <li>• Assigned care teams</li> </ul>	<ul style="list-style-type: none"> <li>• Expanded office hours</li> </ul>
Care Management	<ul style="list-style-type: none"> <li>• Risk-stratify patient population</li> </ul>	<ul style="list-style-type: none"> <li>• Care plans for high-risk chronic disease patients</li> </ul>
	<ul style="list-style-type: none"> <li>• Short and long-term care management</li> </ul>	
Comprehensiveness and Coordination	<ul style="list-style-type: none"> <li>• Identify high volume/cost specialists serving population</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral health integration</li> </ul>
	<ul style="list-style-type: none"> <li>• Follow-up on patient hospitalizations</li> </ul>	<ul style="list-style-type: none"> <li>• Psychosocial needs assessment and inventory resources and supports</li> </ul>
Patient and Caregiver Engagement	<ul style="list-style-type: none"> <li>• Convene a Patient and Family Advisory Council (PFAC)</li> </ul>	<ul style="list-style-type: none"> <li>• Supports patients’ self-management of high-risk conditions</li> </ul>
Planned Care and Population Health	<ul style="list-style-type: none"> <li>• Analysis of health plan reports to inform improvement strategy</li> </ul>	<ul style="list-style-type: none"> <li>• At least weekly care team review of all population health data</li> </ul>

Practice activities may include, but are not limited to, the above examples. Track 2 capabilities are inclusive of and build upon, Track 1 examples.

Payment Design

The CPC+ payment design comprises three elements, which are:

1. **Care Management Fee** – This is a prospective risk-adjusted payment meant to support the hiring and work related to care management. It is calculated on a per-beneficiary-per-month (PBPM) basis, and is higher in Track 2 than Track 1 because of the amount of work that is required in Track 2. This is a non-visit-based prospective payment designed to augment staffing and training, according to specific needs of the patient population. It is paid to practices for beneficiaries attributed to them. The beneficiary will have no cost sharing of the care management fee. Medicare FFS is attributing patients and determining risk tiers for payment purposes only. Track 1 has four risk tiers and Track 2 has five risk tiers. The risk quartile payments are higher in Track 2 because of the increased work expected of these practices. The payments are calculated PBPM, and average \$15 for Track 1, and \$28 for Track 2. Track 2 includes a \$100 PBPM payment for patients with the top 10 percent of risk or dementia diagnosis. Practices will use these care management fees to provide care to patients as they best see fit.

Risk Tier	Attribution Criteria	Track 1	Track 2
Tier 1	1 <sup>st</sup> risk quartile	\$6	\$9
Tier 2	2 <sup>nd</sup> risk quartile	\$8	\$11
Tier 3	3 <sup>rd</sup> risk quartile	\$16	\$19
Tier 4	4 <sup>th</sup> risk quartile for Track 1; 75-89% for Track 2	\$30	\$33
<b>Complex Tier</b> (Track 2 only)	Top 10% of risk or dementia diagnosis	N/A	\$100
<b>Average PBPM</b>		<b>\$15</b>	<b>\$28</b>

2. **Performance-Based Incentive Payment** – This is a prospectively paid PBPM payment, and is also higher in Track 2 than Track 1. This payment focus practices on clinical quality, and utilization, and is split into these two pieces. CMS is pre-paying this incentive. How much of the payment practices get to keep is based on performance utilization and quality measurements. Unlike the current CPC model and other ACO models and demonstrations, there is no shared savings. Therefore, CMS is not allowing practices to be in a shared savings model like an ACO.

The table below illustrates the payment amounts for the two components of the incentive payment.

	Track 1	Track 2
Quality (PBPM)	\$1.25	\$2.00
Utilization (PBPM)	\$1.25	\$2.00
<b>Total (PBPM)</b>	<b>\$2.50</b>	<b>\$4.00</b>

The quality component is based on electronic clinical quality measures (eCQMs) and the patient experience survey (CAHPS). Practice performance on these two types of measures combine to a score that determines their eligibility for the quality component of the performance-based incentive payment. The utilization component consists of hospitalizations and emergency department visits. Performance on these claims-based measures compute to a score on the utilization component of the incentive payment. Combined performance on these components determine whether practices can keep all, some, or none of the incentive payments. Practices will be required to choose a subset of measures from a comprehensive list of eCQMs, which will be finalized no later than November 2016. This list, which can be found in Appendix D of the Request for Application (RFA) encompasses five domains:

- Clinical process/effectiveness
- Patient safety
- Population/public health
- Efficient use of healthcare resources
- Care coordination

3. **Hybrid Payment Structure (Applicable to Track 2 only)** – This is a departure from FFS, and is a hybrid payment that is a mix of FFS and what CMS refers to as a comprehensive primary care payment (CPCP). It offers practices greater flexibility in how they deliver patient primary care, which will be particularly helpful for the provision of care to patients with complex needs. Practices will work toward one of two hybrid payment options, both around 50/50, which means that practices will get around half of their expected FFS up front in the CPCP, and their subsequent FFS billings will be reduced by the amount pre-paid. Practices can select the pace at which they will progress toward one of the two hybrid payment options by 2019.

CMS will look at a practice’s historical evaluation and management (E&M) billing for attributed beneficiaries. Then, it will inflate the expectation slightly to account for the increased comprehensiveness of care it expects Track 2 practices to deliver. Practices will then choose from several hybrid payment options. According to an email communication with CMS staff, there are several options available to practices. The two ultimate options include, 40 CPCP/60 FFS, or 65 CPCP/35 FFS. Practices will receive their chosen CPCP amount up front, and when a patient presents for an E&M service, the payment amount would be reduced by the amount pre-paid. So, for example, if a practice chose the 40/60 hybrid payment option, they would receive a CPCP payment of 40 percent up front, and their FFS would be paid at 60 percent of the normal amount. Payer alignment is expected by the end of performance year one, and does not

have to match the payment model design exactly, but has to include a departure from FFS. Details about the CPCP can be found starting on page 19 of the RFA at the following link: <https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf>.

According to an email communication with CMS staff, CMS clarified that the CPCP will be paid to practices in a lump sum on a quarterly basis. CMS will conduct a reconciliation based only on E&M services delivered in an office setting by primary care physicians outside the CPC practice. Under this partial reconciliation construct, CMS presumes that beneficiaries will tend to increase the amount of primary care they seek elsewhere if they are not satisfied with the care they receive from their CPC practice. Thus, increases in E&M services delivered by primary care physicians outside of the CPC practice to CPC practice attributed beneficiaries would lead to a partial recoupment of the CPCP (as well as heightened monitoring and/or auditing to evaluate the situation more closely). Conversely, significant decreases in E&M services delivered by primary care physicians in an office setting outside of the CPC practice could also lead to an additional payment to CPC+ practices (whether this would be incorporated into the CPCP would depend on the design of the CPCP). This type of partial reconciliation would protect CMS from spending significantly more on E&M services across all primary care practices.

#### Data Feedback

Medicare and health plan partners will align efforts to deliver actionable and timely data to practices at regular intervals. The data will include patient-level cost and utilization information. Practices as well as health plans and vendor partners will work together to track the changes encouraged by CPC+ in both payment and delivery.

#### Learning Platforms

Model participants will be provided with several opportunities for education, support, and collaboration through several core platforms:

- CPC+ Practice Portal – Online tool for reporting feedback, and assessment of practice progress.
- CPC Connect – Web-based platform for CPC+ stakeholders to share ideas, resources, and strategies for practice transformation. This will be like a Facebook for primary care transformation.
- Learning Communities – Includes robust national webinars, on-site coaching, and annual national stakeholder meetings. These communities will promote collaboration and engagement across regions, as well as coordinate the national learning opportunities.

## **Question & Answer Session**

***Question: Will practices be eligible to apply if they are involved in CMMI programs like the Transforming Clinical Practices Initiative (TCPI)?***

***Answer:*** Practices involved in TCPI as a teacher are eligible for CPC+. However, if involved in TCPI as a learner, they can apply for CPC+ and if accepted, they will graduate into CPC+ from TCPI.

***Question: IS CPC+ limited to physicians who accept Medicare only, or can providers like pediatricians participate?***

***Answer:*** CMS does require providers to have Medicare FFS beneficiaries to be eligible for this model, but the practice population will likely consist of many patients covered by other health plans participating in the model.

***Question: Is it assumed that practices will only have one HIT vendor supporting the program, or could they be partnered with more than one?***

***Answer:*** Track 2 practices can partner with one or more vendors. CMS is not limiting the numbers of vendors with which they can partner. According to an email communication with CMS staff, CMS clarifies that it does require Track 1 practices to use certified EHR technology, but does not anticipate that Track 1 practices will use their health IT to the same extent as that required for Track 2 practices. Therefore, CMS is not signing MOUs with health IT vendors that serve Track 1 practices.

***Question: Is participation of vendors limited to EMR vendors or open to other HIT vendors?***

***Answer:*** CMS is not limiting it to EMR vendors, and it is open to all HIT vendors. You can read more about the HIT expectations for Track 2 in Appendix B of the RFA.

***Question: How do I know if my city will be one of the participating sites?***

***Answer:*** CMS will announce the regions that will be involved in CPC+ right before the practice application period opens, and will broadcast that as widely as possible, and include that information on its website.

***Question: Does patient centered medical home (PCMH) recognition have any impact on acceptance?***

***Answer:*** No. Not directly. CMS is not looking directly to see whether you have been certified by any organization to be a PCMH, but work that you may have done to obtain this certification could help you be eligible for CPC+.

***Question: Do private health plans choose which track they want to participate in or must they partner with both tracks and support practices in both tracks?***

***Answer:*** As outlined in Appendix A of the RFA, CMS is encouraging private health plans to participate and align on both tracks. CMS expects to offer both tracks in all regions.

***Question: Are the current seven regions of CPC automatically accepted?***

**Answer:** For the current CPC regions to be included in CPC+, health plans must agree to partner with Medicare to participate in CPC+, and thereby, provide sufficient coverage of the practice population, so that's a first step before existing CPC regions can be accepted.

**Question: Can a multi-practice health system have practices in each of the tracks?**

**Answer:** Yes. Practices in the same system can participate in different tracks.

**Question: Which risk adjuster will be used, and is there a specific risk stratification methodology?**

**Answer:** The care management fee in both tracks is risk adjusted, and Medicare is using the hierarchical condition categories to determine risk tiers, but other health plans can use that or another methodology, and practices can adopt CMS's, or the health plan's, or apply their own intuition.

**Question: Can you participate in CPC+ if you're already a Medicare Shared Savings Plan (MSSP) ACO provider?**

**Answer:** You cannot be in both MSSP and CPC+ at the same time. You can apply, but you cannot be in both at the same time.

**Question: Will participation in CPC+ make physicians eligible for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)?**

**Answer:** Further MACRA regulations will be a proposed rule-making coming out shortly, so CMS encourages people to look out for that, but at this time, it is not determined.

## **General Resources**

More information about the model, including requests for applications, FAQs, memoranda of understanding, and webinar announcements and materials, can be found on the CPC+ web site at: <https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus>

Frequently Asked Questions

<https://innovation.cms.gov/Files/x/cpcplus-faqs.pdf>

CMS encourages comments and questions to be directed to the model e-mail inbox at:

[CPCplus@cms.hhs.gov](mailto:CPCplus@cms.hhs.gov).