Comprehensive Primary Care Plus

Advancing the Delivery of
and Payment for Primary Care

Information for Payers

Three Main Goals Underlie CPC+

1 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.

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

3 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

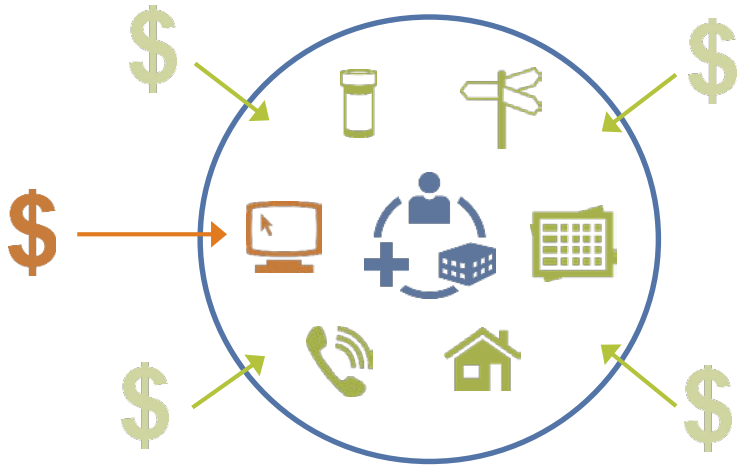
Selection based on payer interest and coverage

Multi-Payer Partnership Essential for Primary Care Reform

Multi-payer engagement is an essential component of CPC+

Support from any one payer covers only a portion of a practice's population

True comprehensive primary care possible only with the support of multiple payers



In CPC+, CMS will partner with payers that share Medicare's interest in strengthening primary care to achieve the aim of better care, smarter spending, and healthier people.

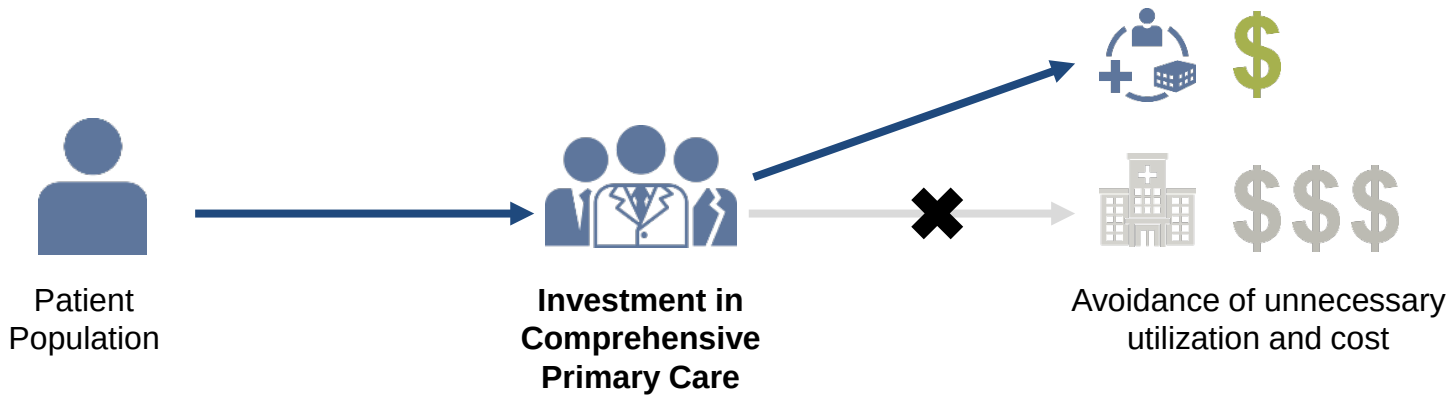
Multi-Payer Collaboration in CPC

Since 2012, **Comprehensive Primary Care (CPC) initiative** brings together Medicare fee-for-service and **38 payer partners** across **7 regions** to support primary care practice transformation

- **95% of payers** continue to partner in CPC into its 4th year
- **Lines of business**: commercial, Medicare Advantage, Medicaid managed care, self-insured clients (TPA/ASO)
- Partnership with **4 State Medicaid agencies**

Why Should Payers Partner with Medicare in CPC+?

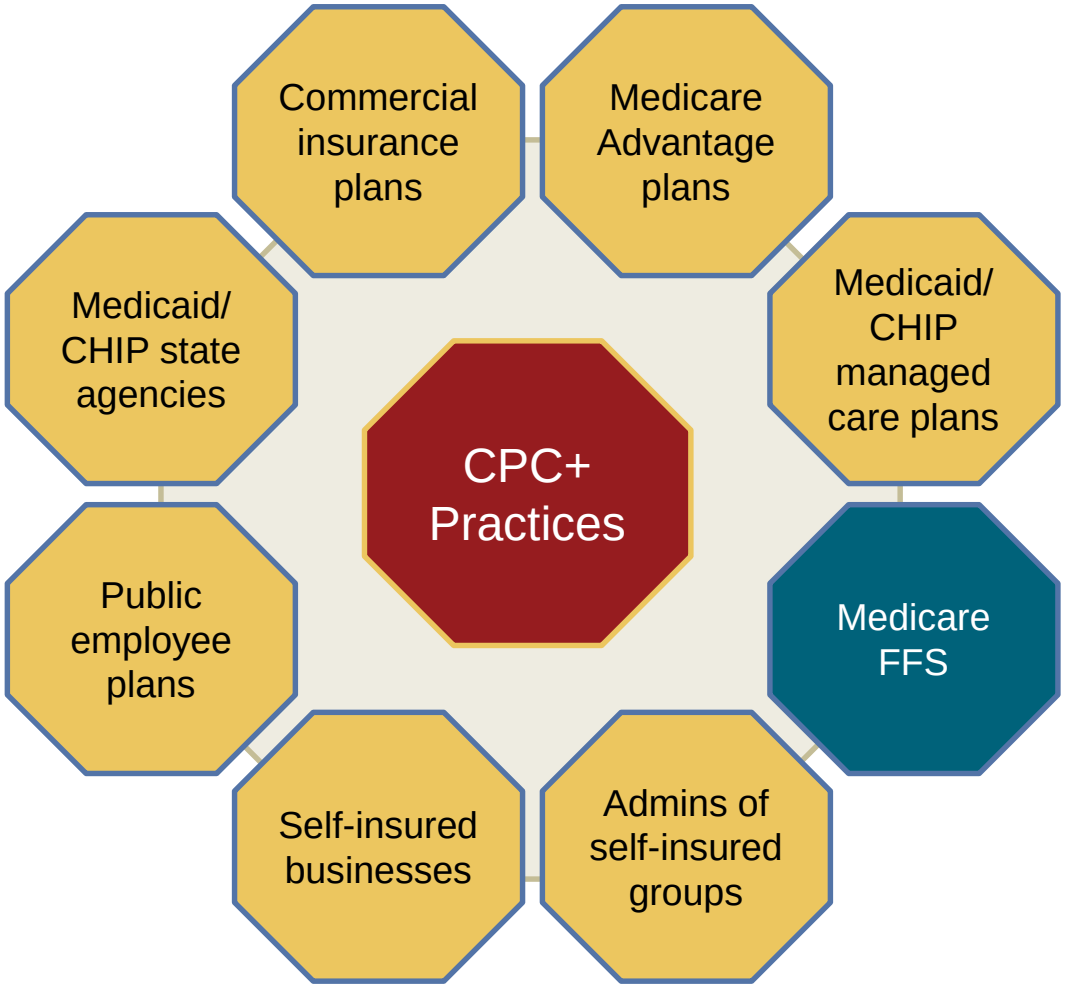
Investment in Primary Care Can Improve Quality, Reduce Total Cost of Care



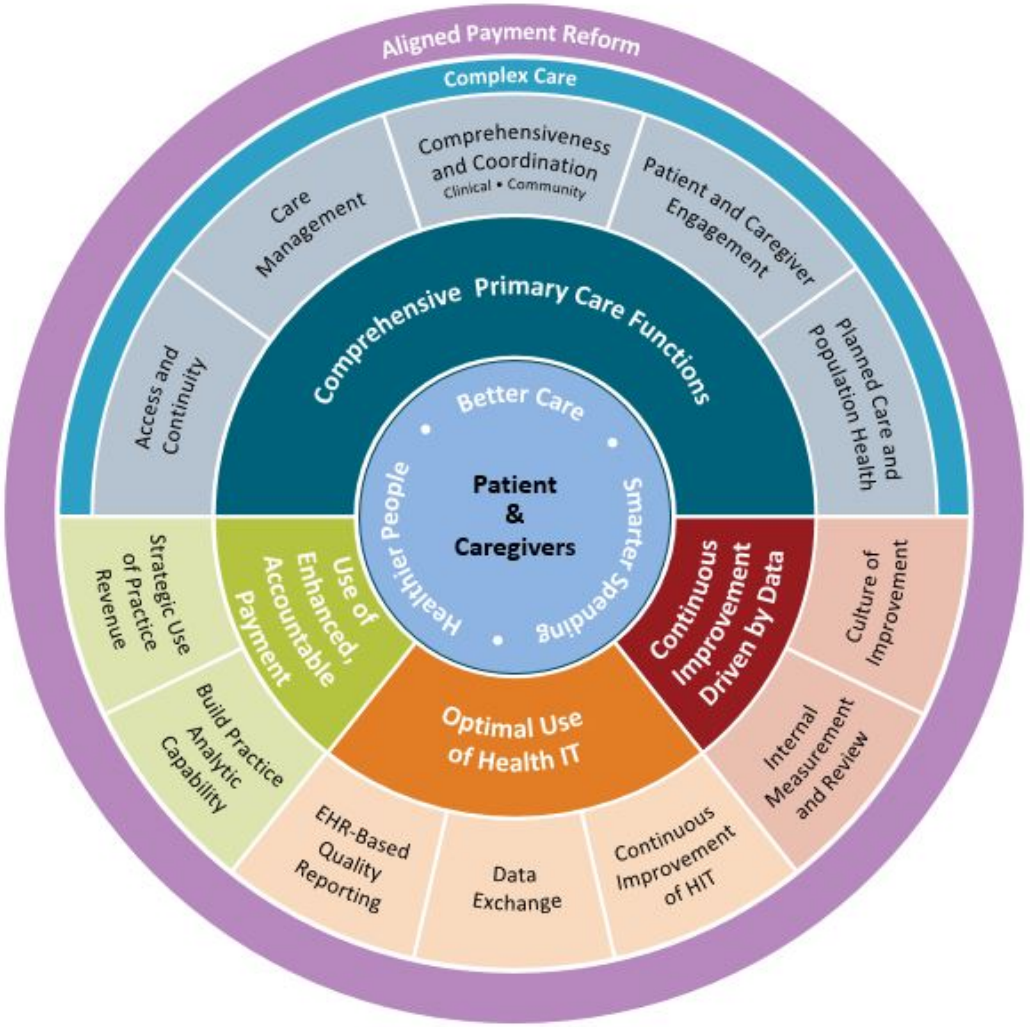
There is abundant evidence that improved care and improved patient experience can be delivered by modest investments in primary care. CPC+ strategically invests in the kind of primary care most likely to have a **favorable impact on total cost of care** and aligning payment incentives to **reward value rather than volume**.

Medicare Will Align with Public and Private Payer Partners

CMS is soliciting interested payer partners: April 15 – June 1, 2016



CPC+ Logic Model



CPC+ Aligned Payer Approach

*For each payer in the model, these elements **need not be identical,** but should be oriented so that the practice incentives and goals match those of the model.*

Financial

1. Commit to pursuing private arrangements with practices participating in both Tracks 1 and 2 of CPC+ for the model's full duration.
2. Share attribution methodologies with CMS.
3. Provide a care management fee or similar payment to allow practices to meet the aims of the care delivery model.
4. Change the cash flow mechanism from fee-for-service to at least a partial alternative, in whatever arrangement the payer favors, before the end of the first performance year to support Track 2 practices.
5. Offer an opportunity for a performance-based incentive payment.

Quality Measurement

6. To the greatest extent possible, align practice quality and performance measures with the model.

Data Sharing

7. Supply participating practices with practice- and patient-level cost and utilization data for their attributed patients via reports or other methods of data sharing at regular intervals (e.g., quarterly).

Model Assessment

8. Describe monitoring, auditing, and evaluation report, and share data with CMS under 42 C.F.R. 403.1110.

1

Participation in Both Program Tracks

CMS will solicit **applications from practices** within the regions chosen, beginning July 15, 2016, with applications due by September 1, 2016 at 11:59pm ET.

Track 1

Up to **2,500** primary care practices.

Choice for practices ready to build the capabilities to deliver comprehensive primary care.

Track 2

Up to **2,500** primary care practices.

Choice 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.**

2

Attribution Methodology

Medicare Approach

- **Prospective alignment** methodology to identify Medicare FFS beneficiaries attributed to CPC+ practices
- Methodology attributes beneficiaries to the practice that **billed for the plurality** of their primary care allowed charges during the most recent **24-month period**
- CMS will give CPC+ practices a list of attributed beneficiaries prior to January 2017 and each performance year thereafter
- Attributed beneficiaries are **free to select the clinicians** and services of their choice

Aligned Payer Approach

- Partner payers may use Medicare's attribution methodology or describe their own approach to identifying members served by CPC+ practices.
- CMS is interested in knowing attribution:
  - Timing
  - Frequency
  - Approach for notifying practices

3 Enhanced Non-Fee-For-Service Support

Medicare Approach

Medicare Care Management Fee:

	Track 1	Track 2
Risk Methodology	HCC risk scores	HCC risk scores; claims data for high-risk diagnoses
Number of Risk Tiers	4	5
PBPM Amount	$15 average ($6 to $30)	$28 average ($9 to $100)
Purpose	Staffing and training related to the model requirements, according to the needs of the attributed Medicare patient population	

Aligned Payer Approach

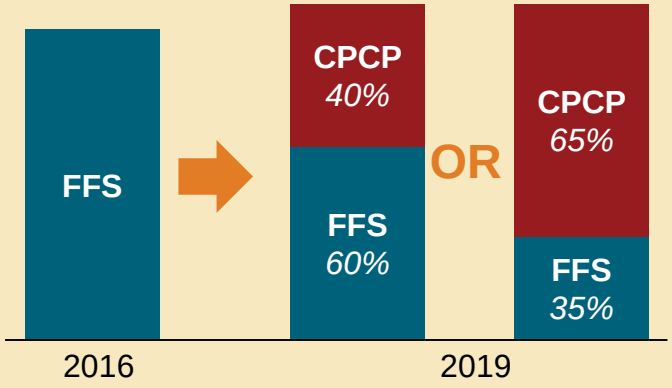
- Offer non-fee-for-service support to allow Track 1 and 2 practices to **provide care management, care coordination, and similar "wraparound" services to all patients, agnostic of payer**.
- **Increase support for Track 2 compared to Track 1** to reflect advancement in practice transformation and care of patients with complex needs.

4 Alternative to FFS for Track 2 Practices: Medicare and Payer Alignment

Medicare Approach

Medicare Hybrid FFS and "Comprehensive Primary Care Payment" (CPCP):

- Based on past E&M payments - increased 10%
- Paid upfront and partially reconciled
- FFS E&M reduced proportionately
- Practices select the pace of transition to one of two hybrid payments
- Compensates for traditional clinical care yet allows flexibility for care delivery in/outside an office visit



Aligned Payer Approach

- By the end of the first performance year, **change the cash flow mechanism** for reimbursing practices via at least a partial alternative to traditional FFS payment.
  - Examples: **partial, full, or sub-capitation without downside risk, episodic payment, etc**.
- Goals:
  - Compensate for **proactive, comprehensive care** previously require to be furnished in an office setting.
  - Allow practices to provide care in a way that **best meets patient needs**, including by email, phone, patient portal, or other alternative visit modalities.

5

Performance-Based Incentive Payment

Medicare Approach

Practices at risk for two prospectively paid practice-level performance components; incentives partially or wholly reconciled retrospectively based on performance

Clinical **quality** and patient experience
- Track 1: $1.25 PBPM
- Track 2: $2.00 PBPM
- Examples: eCQMs, CAHPS

Utilization measures that drive total cost of care
- Track 1: $1.25 PBPM
- Track 2: $2.00 PBPM
- Examples: inpatient admissions, ED visits
- Must pass quality benchmark to receive

Aligned Payer Approach

- Track 1 and 2 practices have the ability to qualify for performance-based incentive payments, based on a combination of utilization, cost of care, and/or quality metrics.
- Approaches could include **shared savings, bonuses, or other financial arrangements,** either prospectively or retrospectively.

6

Quality and Performance Measures

Medicare Approach

Medicare will use **quality and patient experience** measures to identify gaps in care, target quality improvement activities, and assess quality performance:

1. **Electronic clinical quality measures** (eCQMs)
2. **Patient experience of care** (CAHPS) surveys fielded by CMS or its contractors

- Practices will annually **report a subset** of eCQMs
- Practices must use **EHR technology** that meets the certification requirements specified in the Medicare EHR Incentive Program final rule.
- Final CPC+ measures TBA by November 2016.

Aligned Payer Approach

Payers are encouraged to align quality and patient experience measures with Medicare and other payers in the region.

CMS has aligned its quality reporting programs to **reduce provider reporting burden** by choosing eCQMs which:

- Focus on a primary care population
- Encompass many National Quality Strategy domains
- Are included in **other CMS quality reporting programs**

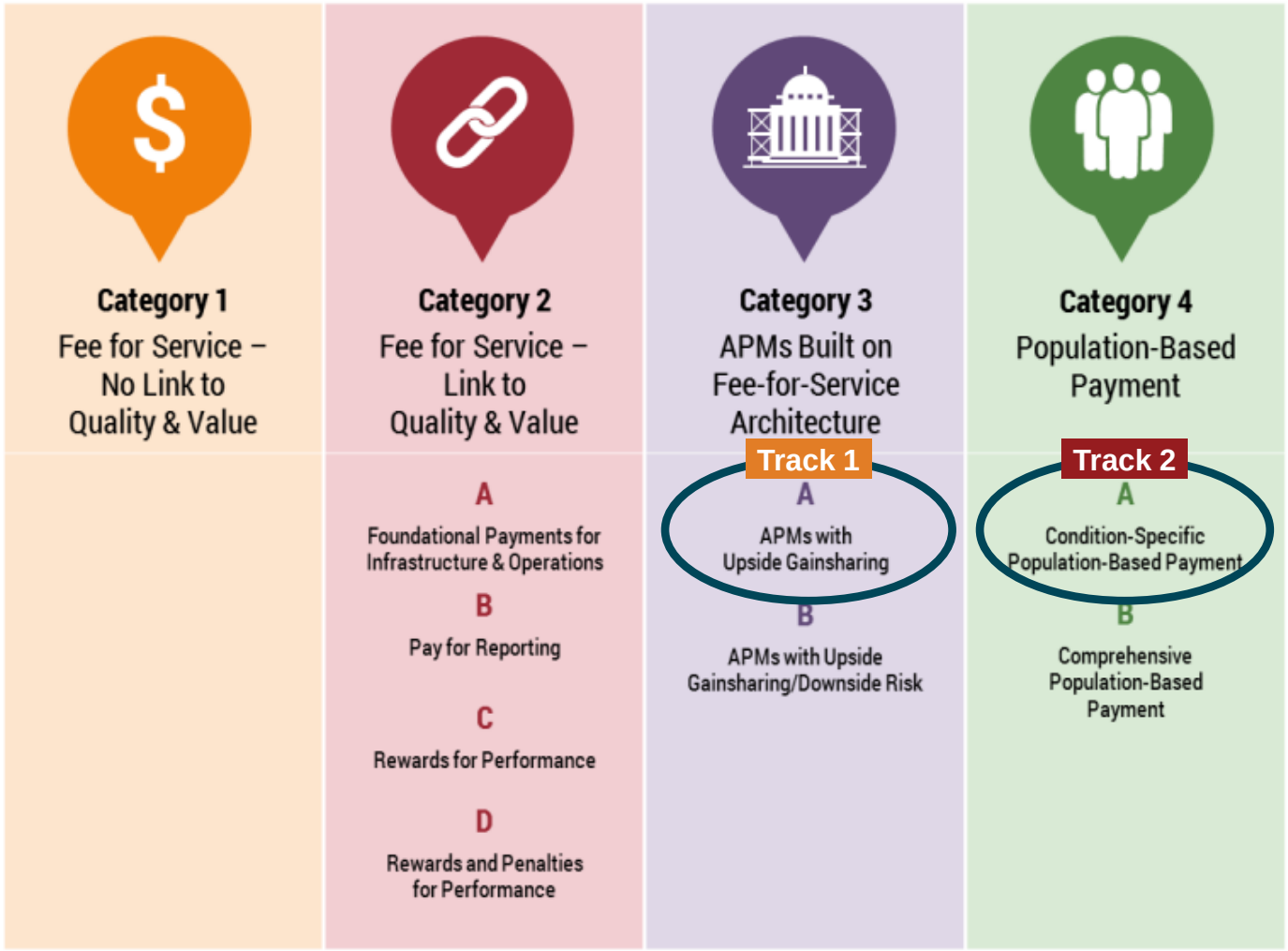
CMS included many **recommended measures** from the Core Quality Measures Collaborative Workgroup measure set

Tentative 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.

CMS ID#	NQF#	MEASURE TITLE	MEASURE TYPE/ DATA SOURCE
CLINICAL PROCESS/EFFECTIVENESS (9)			
CMS159v5	0710	Depression Remission at Twelve Months	Outcome/ECQM
CMS165v5	0018	Controlling High Blood Pressure	Outcome/ECQM
CMS131v5	0055	Diabetes: Eye Exam	Process/ECQM
CMS149v5	N/A	Dementia: Cognitive Assessment	Process/ECQM
CMS127v5	0043	Pneumococcal Vaccination Status for Older Adults	Process/ECQM
CMS137v5	0004	Initiation and Engagement of Alcohol and other Drug Dependence Treatment	Process/ECQM
CMS125v5	2372	Breast Cancer Screening	Process/ECQM
CMS124v5	0032	Cervical Cancer Screening	Process/ECQM
CMS130v5	0034	Colorectal Cancer Screening	Process/ECQM
PATIENT SAFETY (3)			
CMS156v5	0022	Use of High-Risk Medications in the Elderly	Process/ECQM
CMS139v5	0101	Falls: Screening for Future Falls Risk	Process/ECQM
CMS68v6	0419	Documentation of Current Medications in the Medical Record	Process/ECQM
POPULATION/PUBLIC HEALTH (4)			
CMS2v6	0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process/ECQM
CMS122v5	0059	Diabetes: Hemoglobin HbA1c Poor Control (>9%)	Outcome/ECQM
CMS138v5	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/ECQM
CMS147v6	0041	Preventive Care and Screening: Influenza Immunization	Process/ECQM
EFFICIENT USE OF HEALTHCARE RESOURCES (1)			
CMS166v6	0052	Use of Imaging Studies for Low Back Pain	Process/ECQM
CARE COORDINATION (1)			
CMS50v5	N/A	Closing the Referral Loop: Receipt of Specialist Report	Process/ECQM

CPC+ and the Alternative Payment Model (APM) Framework



7

Data Feedback to CPC+ Practices

Medicare Approach

Medicare will provide **cost and utilization data** on attributed Medicare FFS beneficiaries, including:

- **Historical cost and utilization**
- **Quarterly reports on services and financial expenditures**
- **Annual per-capita expenditure and quality reports on a beneficiary level**

Medicare is committed to participating in multi-payer **data aggregation**, if available in a region

Aligned Payer Approach

Payers are encouraged to align with Medicare and other regional payers on the structure, format, and schedule of sharing data with practices, including:

- Data on **cost, utilization, and quality**
- Distributed at **regular intervals**
- At the **practice population and member-levels** for all members attributed to CPC+ practices
- With guidance to help practices use these data

Payers may also propose a common platform for sharing data with practices through an existing multi-payer database, payer health information exchange, or other capable **data system within a region**.

8

Monitoring, Auditing, and Evaluation

Medicare Approach

Monitoring

CMS will use data from various sources to help ensure that practices understand their progress towards meeting care delivery requirements and highlights opportunities for additional learning activities.

Auditing

CMS will use program integrity data to ensure practice compliance with the terms of the Participation Agreement and highlight noncompliant practices for heightened CMS scrutiny.

Evaluation

CMS will contract with an independent evaluator that will use mixed-methods approach, for each track to evaluate:

- **Implementation**: How the model was implemented, assessing barriers and facilitators to change.
- **Impact**: The degree to which each track improved key outcomes, including lower total cost of care and improved quality of care.

Aligned Payer Approach

- Share with CMS the proposed monitoring and evaluation strategy to track practice progress in implementing CPC+ as well as assessing changes in cost of care, quality improvement, and patient experience of care.

Opportunities for Stakeholder Learning, Collaboration, and Support

CPC+ Practice Portal

Online tool for reporting, feedback, and assessment on practice progress.

CPC Connect

Comprehensive Primary Care

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

Learning Communities

National webinars and annual National Stakeholder Meeting

- Cross-region collaboration.

Virtual and in-person regional learning sessions

- Engagement with CPC+ stakeholders.
- Outreach and support from regional learning faculty.

CPC+ Region Selection

What is a region?

Overlapping, contiguous geographic locales covered by multiple payers interested in partnering in CPC+

How will CMS choose up to 20 regions?

Choice will be contingent upon market penetration by interested payers and payer alignment with the CPC+ model

- Aim **for geographic diversity**
- **Existing CPC regions** will be included in CPC+, contingent on payer support
- **Preference for MAPCP and SIM Model Test states** where Medicaid is a participating payer
- All regions with **Medicaid partnership** receive extra points in proposal scoring

Timeline for Partner Payers

1. **April 2016**
   Payers respond to the CPC+ Payer Solicitation and outline their covered lives, geographic scope, and commitment to aligning with CPC+

2. **July 2016**
   CMMI makes a determination of which regions have sufficient payer interest – both in covered lives and in alignment of proposals. CMS signs MOUs with those payers. The practice application opens in selected regions.

3. **October 2016:** Practice participants are selected

4. **January 1, 2017**
   CPC+ goes live; payers begin aligned payment and support for participating practices

5. **December 2017**
   Deadline for all payers to align with the Track 2 departure from traditional FFS

For More Information on CPC+

Visit

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

for Payer Solicitation, Payer MOU, FAQs

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