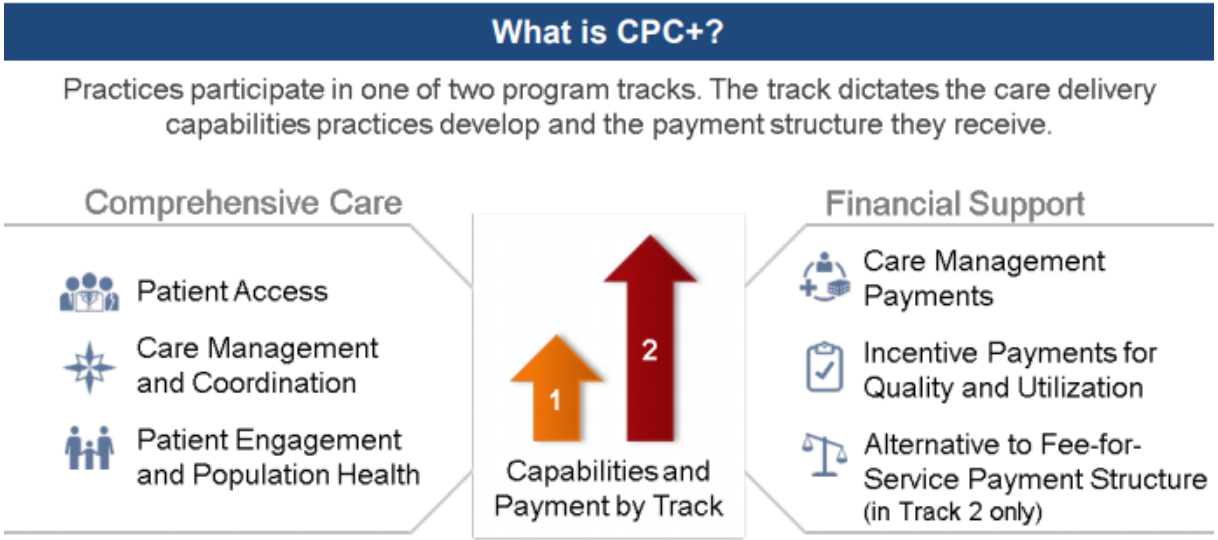
CPC+ Comprehensive Primary Care

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR MEDICARE & MEDICAID INNOVATION

Comprehensive Primary Care Plus

Advancing the Delivery of and Payment for Primary Care



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

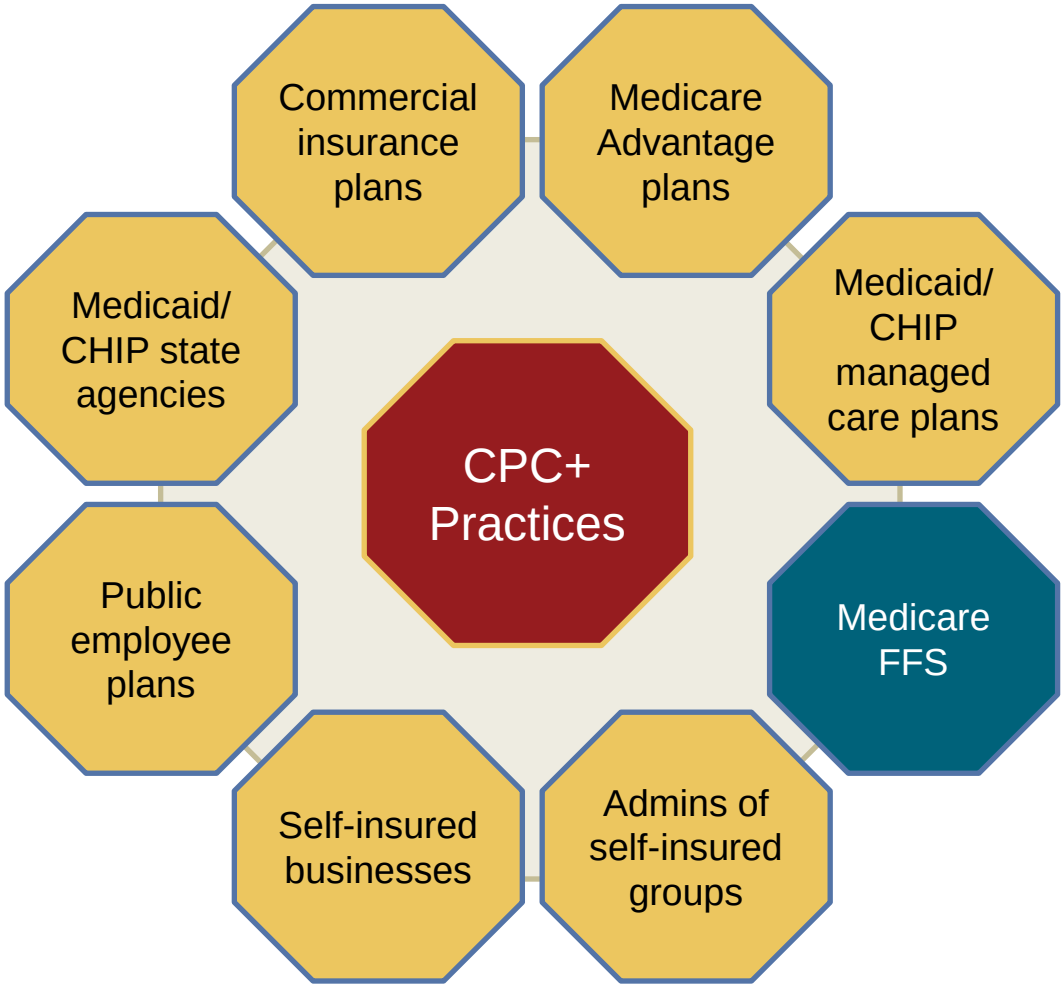
Beginning 2017, progress monitored quarterly

Up to 20
Regions

Selection based on payer interest and coverage

Medicare Will Partner with Aligned Public and Private Payers

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



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 a least a **partial alternative payment methodology** for Track 2 practices

Performance-based incentive payments for Track 1 and 2 practices

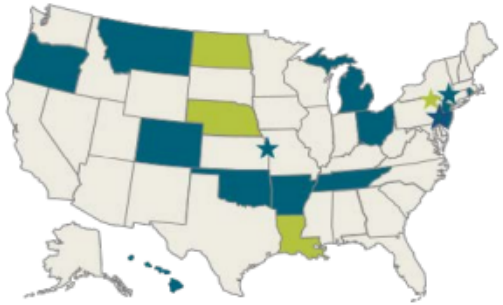
Aligned **quality and patient experience measures** with Medicare FFS and other payers in the region

Practice and member-level **cost and utilization data** at regular intervals for all practices

Practices Apply to Participate in One of Two Tracks

Where is CPC+ being tested?

Practices and payers are partnering in 18 regions.



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 **compreh ensiveness** of care through enhanced **health IT**, improve care of patients with **complex needs**, and inventory resources and supports to meet patients' **psychosocial needs.**

Practice Eligibility Requirements Vary by Track

- 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.
- Practices will apply directly to the track for which they are interested and 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 <u>also</u> 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.*

Engaging Health Information Technology 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.

Overview of Vendor Partnership

CPC+ will feature innovative opportunities to bring together vendors and practices to optimize Health IT for primary care delivery.

- Track 2 engagement focuses on a core set of advanced capabilities for health IT.
- Collaboration is jointly managed by CMS and the Office of the National Coordinator for Health IT (ONC).

Benefits of Participation

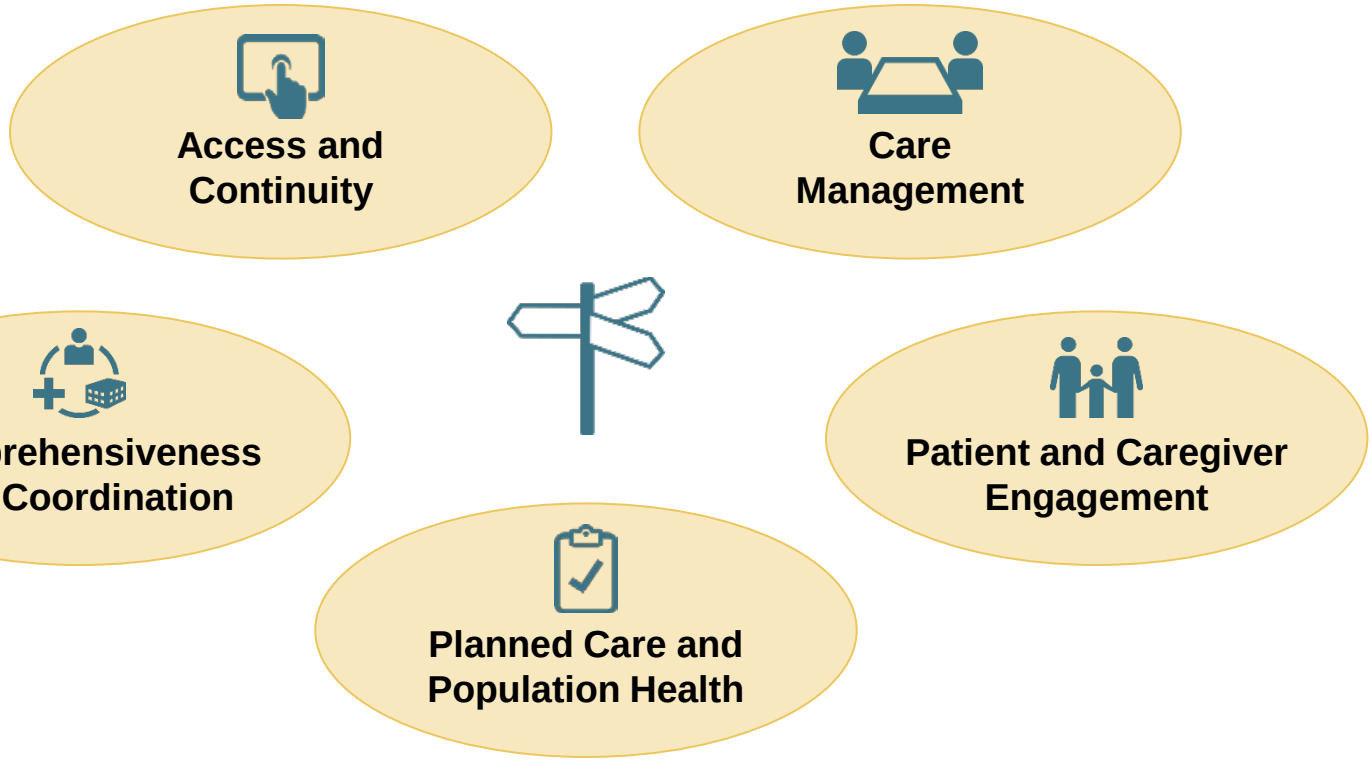
- Gain an accelerated understanding of the technology needs of practices that are delivering advanced primary care
- Participate alongside practices, payers, and other stakeholders in a wide range of national learning activities

If you are an HIT vendor **interested in partnering** with CPC+ practices, please send the following information as soon as possible to CPCplus@cms.hhs.gov:

HIT Vendor Company Name
Contact Person (Name, Telephone Number, and Email Address)
Type of HIT Products (e.g., EHR)

- Practices that apply to CPC+ will be given a list of all HIT vendors who have indicated interest
- Vendor contact information will be posted to the website primary care practices use to apply to CPC+

CPC+ Functions Guide Transformation



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.

CPC+ Practices Will Enhance Care Delivery Capabilities

	Examples for Track 1	Additional examples for Track 2
Access and Continuity	24/7 patient access	E-visits
	Assigned care teams	Expanded office hours
Care Management	Risk stratify patient population	Care plans for high-risk chronic disease patients
	Short and long-term care management	
Comprehen-siveness 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

CPC+ Practices Will Enhance Care Delivery Capabilities

Examples for **Track 1**

Additional examples for **Track 2**

Patient and Caregiver Engagement

Convene a Patient and Family Advisory Council

Support patients' self-management of high-risk conditions

Planned Care and Population Health

Analysis of payer reports to inform improvement strategy

At least weekly care team review of all population health data

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

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

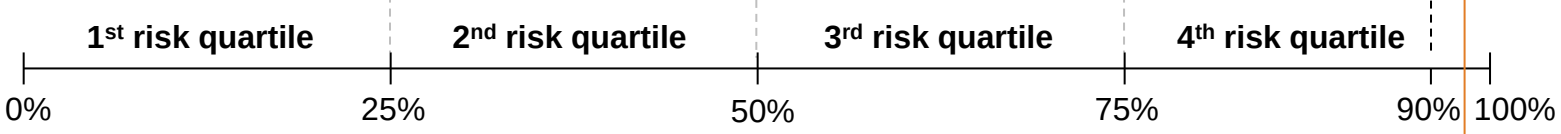
Three Payment Innovations Support Practice Transformation

	Care Management Fee (PBPM)	Performance-Based Incentive Payment	Underlying Payment Structure
Track 1	$15 average	$2.50 opportunity	Standard 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)

Care Management Fees Determined by Risk Tier

Track 1: Four Risk Tiers (Average $15)

Track 2: Five Risk Tiers (Average $28)



- 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

Complex Tier: $100

Top 10% of risk or dementia diagnosis

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

	Track 1	Track 2
Quality (PBPM)	$1.25	$2.00
Utilization (PBPM)	$1.25	$2.00
Total (PBPM)	**$2.50**	**$4.00**

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

No-overlaps policy with Medicare shared savings programs or models

CPC+ Quality Strategy for Performance-Based Incentive Payment

Electronic Clinical Quality Measures (eCQMs)

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Patient Experience Survey (CAHPS)

Practice Quality Score

Utilization measures that drive total cost of care, measured at the practice level

Strengthen Quality Improvement Efforts

Retain Pre-Paid Performance-Based Incentive Payments

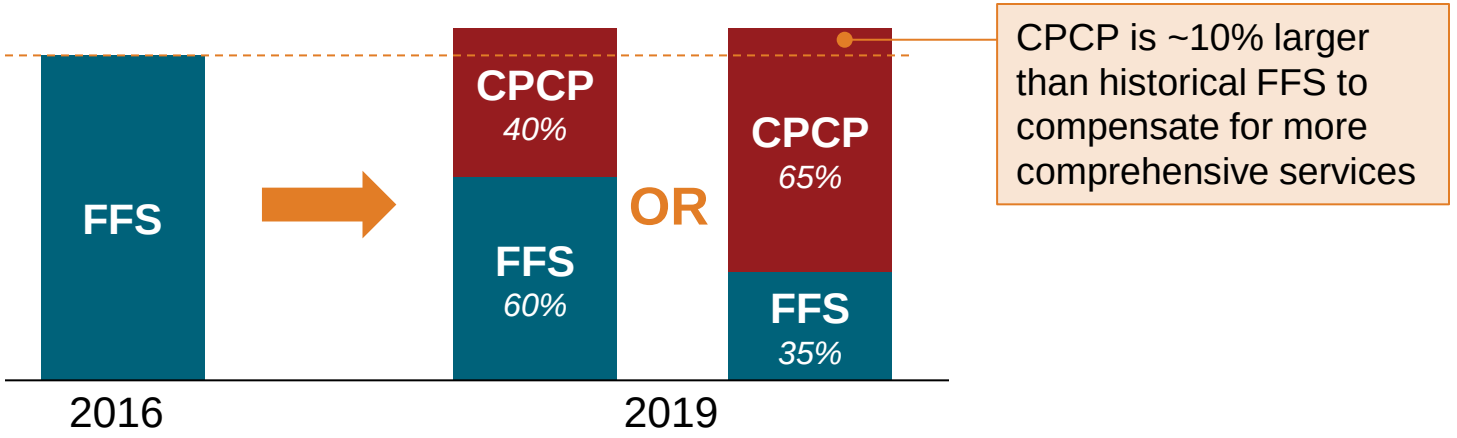
CPC+ Quality Measure Set

- 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

Track 2 Payment Offers More Flexibility in Care Delivery

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



- 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

Practices Receive Frequent Data Feedback from CMS and Payer Partners

Patient-Level Cost and Utilization Data

Actionable and Timely

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Multi-Payer Alignment

Many Opportunities for 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

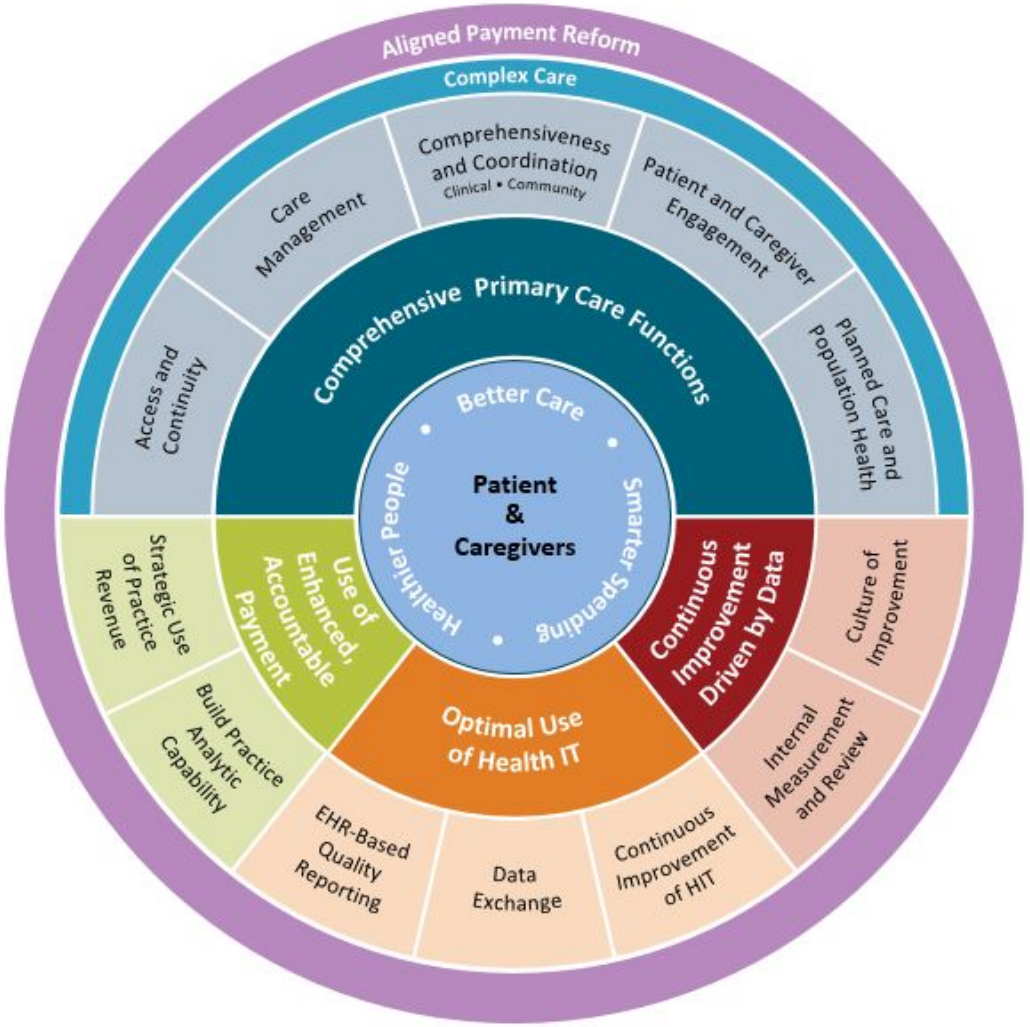
National webinars and annual National Stakeholder Meeting

- Cross-region collaboration.

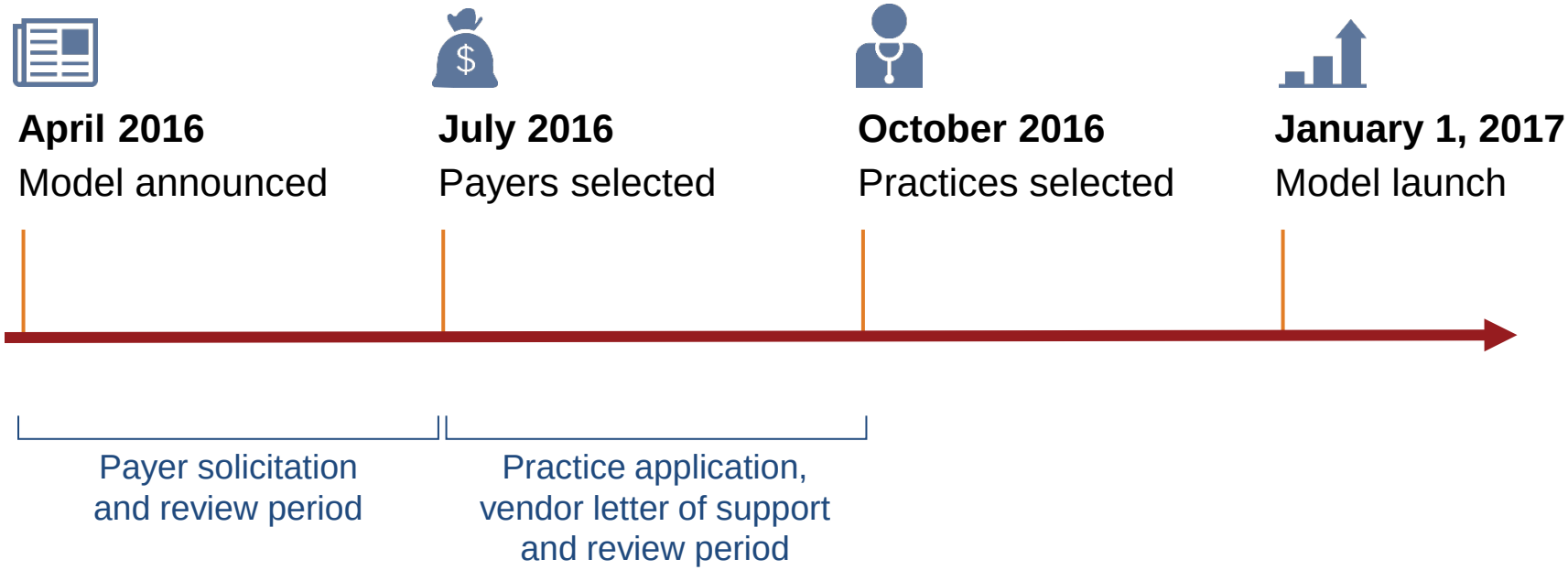
Virtual and in-person regional learning sessions

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

CPC+ Logic Model



CPC+ Launch Timeline



Learn more about CPC+

Visit

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

for Request for Applications, FAQs, Fact Sheet

Email

CPCplus@cms.hhs.gov