CPC+: REDESIGNING CARE DELIVERY

In healthcare, the only constant is change — and the new Comprehensive Primary Care Plus (CPC+) program is focused on making positive changes to primary care. CPC+, introduced by the Centers for Medicare & Medicaid Services (CMS), incentivizes primary care providers to rethink how they deliver care.

CMS developed CPC+ to reinforce the principles and lessons learned from the preceding Comprehensive Primary Care Initiative (CPCI), while promoting the "Triple Aim" — improving population health, lowering costs and improving the provider/patient experience.

This guide will walk you through some of the most important elements of the program.

Overview

Overall, the program redesigns care delivery so that participating practices have the infrastructure to manage patients’ conditions over time — with the ultimate goal of improving health outcomes.

CPC+ will include up to 2,500 practices per track, 20,000 clinicians, and 25 million patients. It will cover a total of 20 regions, seven of which were initially included in CPCi. RHCs and FQHCs are ineligible. Practices will participate for 5 years.

Practices can choose to participate in one of the primary care practice tracks. Each carries different care delivery requirements and payment options, with Track 2 offering higher levels of risk and reward.

To ensure success of the program and its goals, CMS will create a learning system that organizations can use to share best practices. To further reinforce continuous improvement, CMS will provide practices with actionable, practice-level and patient-level cost and utilization data.

Payers involved in the program include CMS, commercial plans, and state Medicaid programs. CMS will enter into a memorandum of understanding (MOU) with select payers to document a shared commitment on payment, data sharing and quality metrics alignment. The first payer proposals were accepted April 2016. Eligible practices may apply July 15 – Sept. 1.

Care delivery redesign

Participating practices must change the way they deliver care according to the program’s four drivers of care. Each driver will have measurable milestones, which will gradually increase in intensity over time. Participants will report the requirements to CMS through a web portal so CMS can assess the practices’ progress.

Driver 1: Comprehensive care

The first driver is separated into five elements. CMS refers to them as the Five Primary Care Functions. They include 1) access and continuity, 2) care management, 3) comprehensiveness and coordination of care, 4) patient and caregiver engagement, and 5) planned care and population health. Both Track 1 and Track 2 will include these elements, but Track 2 will require them to a greater degree. Track 2 must also redesign visit- and non-visit-based care to offer more comprehensive care to more complex patients.

1. Access/continuity

- In Tracks 1 and 2, clinicians must offer 24/7 access to their practice
- Patients must have multiple points of access
- Patients must have real-time access to their electronic health record
- Patients must be assigned to a care team to establish therapeutic relationships
- Track 2 is expected to include more care options, including e-visits, phone visits, group visits, home visits, and visits in alternate locations

2. Care management

- Assign all active patients to practitioners or care teams, then stratify the population by risk and identify who could benefit from longitudinal care plans and provide that care
- Track 1 will build capability in behavioral health, self-management support and medication management.

- Track 2 will provide additional capabilities for complex patients, such as those with cognitive impairment, frailty or multiple chronic conditions

3. Comprehensiveness and coordination

- Practices are required to understand where patients receive care in the medical neighborhood
- Track 1 will work more closely with hospitals, EDs and one high-volume specialty provider
- Track 2 aligns with CCM and includes a systematic assessment of patients’ psychological needs, inventory of patient supports, and referrals to identified community/social services.

4. Patient/caregiver engagement

- Engage patients/families in care redesign
- Engage patients in goal setting and shared decision-making with decision aids and specific techniques (e.g., motivational interviews)

5. Planned care and population health

- Offer timely and appropriate preventive care, as well as reliable, evidence-based management of chronic conditions
- Track 1 will integrate support for self-management

Driver 2: Use of enhanced, accountable payment

Participants in Track 1 must build analytic capability, project revenue, perform budgeting exercises, use the care management fee to support the delivery of comprehensive care, and use claims data to identify opportunities for continued improvement.

Participants in Track 2 must use analytics and claims data to identify opportunities to enhance comprehensiveness of care and coordination of services.

Driver 3: Continuous improvement driven by data

Practices must consistently measure quality at practice, panel or care team level. They are expected to develop skills in change management to improve quality. Participants in both tracks will need to test and implement new workflows based on data.

Driver 4: Optimal use of HIT

Both tracks require certified health IT. Practices are required to have remote access to their EHR to ensure 24/7 access. You can find more details in Appendix C of the Request for Applications.

How practices get paid

CPC+ introduces three different payment streams to support the program:

- The care management fee (CMF), which is calculated as a per beneficiary per month stipend based on your patients’ risk level, defined by HCC coding. These payments must be used to invest in staffing, technology and training related to CPC+ requirements.
- Quality incentives, which are calculated as per beneficiary per month payments. The total incentive awarded depends on quality performance.
- There will be a minimum threshold on the scores (e.g., 30%). However, to keep 100% of the incentive,
there will be a score set lower than 100%, since attaining a perfect score may be impossible. Otherwise it will tier accordingly (e.g., those who score 60% will receive 60% of the incentive).  

- The Comprehensive Primary Care Payments (CPCPs) (Track 2 only), which reduce fee-for-service payments and pay the projected FFS reductions with a 4-5% increase to the practice as an upfront/capitated payment.

- The purpose of this structure is to encourage offering non-billable remote visits and to give the practice greater flexibility in how they manage care over time.

- In 2017, CMS will inflate practice’s historical revenue from E/M services by 10% and will pay part of this amount as the CPCP.

The care management fee: crosswalk

<table>
<thead>
<tr>
<th>Risk Tier</th>
<th>Attribution Criteria</th>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>1st quartile HCC</td>
<td>$4 PBPM</td>
<td>$9 PBPM</td>
</tr>
<tr>
<td>Tier 2</td>
<td>2nd quartile HCC</td>
<td>$9 PBPM</td>
<td>$11 PBPM</td>
</tr>
<tr>
<td>Tier 3</td>
<td>3rd quartile HCC</td>
<td>$16 PBPM</td>
<td>$19 PBPM</td>
</tr>
<tr>
<td>Tier 4</td>
<td>4th quartile HCC for Track 1, 75-89 for track 2</td>
<td>$30 PBPM</td>
<td>$33 PBPM</td>
</tr>
<tr>
<td>Complex</td>
<td>Top 10% HCC or Dementia</td>
<td>$100 PBPM</td>
<td>$100 PBPM</td>
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Quality incentives: crosswalk

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<thead>
<tr>
<th>Utilization PBPM</th>
<th>Quality PBPM</th>
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<tbody>
<tr>
<td>Track 1</td>
<td>$1.25</td>
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<td>Track 2</td>
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Comprehensive Primary Care Payments: crosswalk

<table>
<thead>
<tr>
<th>CPCP%/FFS%</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
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</thead>
<tbody>
<tr>
<td>10%/90%</td>
<td>25%/75%</td>
<td>25%/75%</td>
<td>40%/60%</td>
<td>40%/60%</td>
<td>40%/60%</td>
</tr>
<tr>
<td>65%/35%</td>
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<td>65%/35%</td>
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</tbody>
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Technology and the vendor relationship

Vendors are required to work directly with primary care practice participants to develop necessary HIT. Vendors supporting practices in Track 2 must enter into an MOU with CMS and provide a letter of support to the practice. Vendors will not receive any direct compensation from CMS for their involvement. They are also expected to engage in the learning activities mentioned earlier in this guide. CMS may contact the vendor for additional information, so a vendor must specify a point of contact.

The Greenway Health Advantage

Greenway Health will support practices participating in CPC+ in either Track 1 or Track 2. We will also enter into a MOU with CMS to support practices in Track 2.

Our population health solution, Greenway Community, can provide actionable insight into the data you need to successfully capitalize on CPC+. It aggregates claims and clinical data, presents that data in an easy-to-understand heat map, and pushes the insights from that data to the point of care with an integrated care management system.

Learn more...

by visiting [greenwayhealth.com](http://greenwayhealth.com) or calling 877-466-3859.