COMPREHENSIVE PRIMARY CARE PLUS (CPC+):

TRANSFORMATIONAL PHYSICIAN MANAGED CARE

June 2016

Natalie Burton | Katelyn de Lisle | Shawn Matheson | David Muhlestein

LEAVITT PARTNERS

SUMMARY

While primary care is the foundation for effective population health management, traditional reimbursement structures under fee-for-service (FFS) do not facilitate the delivery of high-quality primary care. The April 11, 2016 announcement[1] of the Comprehensive Primary Care Plus (CPC+) program by the Centers for Medicare and Medicaid Services (CMS) marked a sweeping move to transform the payment methodology for primary care in the United States.

CPC+—the latest addition to the CMS value-based program portfolio—is a five-year, region-based, multi-payer model aimed at supporting advanced primary care by redesigning the payment structure to enable and even reward it. The agency's largest investment in primary care to date, CPC+ targets up to 20 regions to reach more than 20,000 clinicians and includes a range of payer partners and up to 25 million beneficiaries.[2] With these ambitious goals, the success of the new program depends on the active participation of payers, providers, and health information technology (HIT) vendors to transform the current payment and delivery processes. This paper provides an overview of the new CPC+ program and its implications for stakeholders and the health care industry.

BACKGROUND OF CPC+

The CPC+ model was developed by the Center for Medicare and Medicaid Innovation (CMMI) to meet the United States Department of Health and Human Services' (HHS) goal to tie 50% of Medicare payments to quality or value through alternative payment models (APMs) by 2018.[1] CMMI was established by section 3021 of the Affordable Care Act (which added section 1115A to the Social Security Act), to test innovative payment and service delivery models in an effort to apply learnings that will reduce CMS program expenditures and improve quality for beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[3] Because CMMI operates outside of the legislative rule-making process, CMS uses CMMI to expedite pilot programs in order to accelerate the development, testing, and expansion of new models.

CPC INITIATIVE

While CPC+ is *technically* a new model, it relies heavily on the Comprehensive Primary Care (CPC) initiative, a CMMI demonstration that began in 2012 and runs through 2016. Like CPC+, the CPC initiative is a region-based, multi-payer model that aims to improve primary care by using alternative payment methodologies. CPC practices receive monthly care management fees and can earn shared savings payments depending on their cost and quality outcomes relative to their region. On a much smaller scale than CPC+, CPC includes roughly 500 practices and 38 health plans in seven regions. Initial results are positive, but modest, and show improved health outcomes and reduced hospitalizations, but

FIGURE 1. COMPARING THE CPC AND CPC+ MODELS[4]

	CPC	CPC+
Size	7 Regions ~500 Practices	20 Regions ~5,000 Practices
Duration	4-year model	5-year model
# Tracks	One	Two
Incentive Structure	Regional shared savings	Prospective Performance-Based Incentive Payment
Care Delivery	5 Comprehensive Care Functions – Access & Continuity – Planned Care for Chronic Conditions & Preventative Care – Risk-Stratified Care Management – Patient & Caregiver Engagement – Coordination of Care Across the Medical Neighborhood	5 Comprehensive Care Functions – Access & Continuity – Care Management – Comprehensiveness and Coordination – Patient & Caregiver Engagement – Planned Care and Population Health

without significant reductions in total costs. Some critics of CPC+ have argued against the continued development of programs based on a model that has failed to demonstrate net savings.

With this new iteration, CMS applied the successes and lessons learned from the CPC initiative to create CPC+ as an alternative approach to comprehensive and enhanced primary care. CPC+ differs from its predecessor in a variety of ways, including the payment structure, the resources offered to providers, and most notably, the choice of participation tracks (Figure 1).

MODEL OVERVIEW FOR CPC+

Unlike CPC's one-size-fits-all approach, CPC+ accommodates two tracks for providers based on their transformational readiness to meet the program requirements.[5] Track 1 most closely resembles CPC, with its lower care management fees and FFS chassis, and is designed for providers who are building the capabilities to deliver comprehensive primary care under an alternative payment model. Track 2 is intended for practices with more experience delivering advanced primary care, including managing patients with complex needs, including psychosocial concerns. CPC+ is a multi-payer model which requires providers to enter into similar contracts with both Medicare and commercial or Medicaid payers so that more of their practice will be covered under comparable payment models.

In both tracks, practices receive prospective monthly care management fees that are risk-adjusted for patient acuity. Participants in both tracks also receive prospective performance-based incentive payments (of varying amounts), which are contingent upon reaching quality and utilization thresholds. Failure to meet quality standards requires a payback of a portion or all of the prospective incentive payment. CMS hopes that tying the CPC+ incentive structure to the individual practice level – rather than regional shared savings – will more likely affect improvement.

Also new to CPC+ is the introduction of a hybrid payment structure that blends FFS with a global payment for evaluation and management (E&M) services. Under this payment structure, practices receive increased upfront payments based on a portion of their expected

TABLE 1. THE TWO TRACKS FOR THE PROVIDERS OF CPC+

	Track 1	Track 2
Practice Capabilities	For practices ready to build the capabilities to deliver comprehensive primary care	For practices with more experience delivering advanced primary care including enhanced HIT, caring for complex patients, and having an inventory of resources for patients with psychosocial needs
Medicare Payment structure	Regular FFS payments	Comprehensive Primary Care Payments (CPCP), a hybrid payment that blends FFS and global payment for E&M services; increasingly global
Medicare Care Management Fee	~$15 PBPM	~$28 PBPM ($100 for complex patients)
Medicare Performance-Based Incentive Payment	$2.50 PBPM	$4.00 PBPM
HIT Vendor Partner	N/A	Provide a letter of support from their HIT vendor(s)

FIGURE 2. CPC+ PAYMENT STRUCTURE

	PROSPECTIVE PAYMENTS		RETROSPECTIVE PAYMENTS	RETROSPECTIVE ADJUSTMENTS
	Monthly	Annual		
Track 1	Care Management Fee	Performance-Based Incentive Payment	Full Comprehensive Primary Care Payments (E&M)	All or portion of pre-paid performance-based incentive will be recouped for failure to meet thresholds for quality and utilization performance
Track 2	Care Management Fee % Comprehensive Primary Care Payments (E&M)	Performance-Based Incentive Payment	% Comprehensive Primary Care Payments (E&M)	All or portion of pre-paid performance-based incentive will be recouped for failure to meet thresholds for quality and utilization performance

E&M services, independent of claims, coupled with reduced FFS payments. This approach is only used in Track 2, and includes options for practices to select their ratio of FFS to global payment, allowing flexibility in the size of up-front payments.

CPC+'s prospective payments, including the care management fee, performance-based incentive payment, and the hybrid global payment approach of Track 2, enable providers to deliver high-value primary care in ways that are not possible under the traditional FFS model since significant funds are not tied to a specific services. Such flexibility could allow longer visits, increased use of telemedicine, and even hiring additional staff. The shift in incentives coupled with the upfront payments are intended to enable providers to focus on holistic patient-centered care, prevention, and population health.

Through a staged application process, CMS will solicit payers, providers, and HIT vendors to partner in this initiative (see key dates in Figure 5). Payers will enter

FIGURE 3. CPC+ HYPOTHETICAL PAYMENTS BY TRACK

CPC+ Hypothetical 5-Year Payments by Track

	2017	2018	2019	2020	2021	5-year Total
Track 1 Provider	CMF = $15k FFS = $100k PBI = $2,500	CMF = $15k FFS = $100k PBI = $2,500	CMF = $15k FFS = $100k PBI = $2,500	CMF = $15k FFS = $100k PBI = $2,500	CMF = $15k FFS = $100k PBI = $2,500	**$587,500**
Track 2 Provider (40% CPCP / 60% FFS)	CMF = $42,400 FFS = $60k CPCP = $40k PBI = $4k	CMF = $42,400 FFS = $60k CPCP = $40k PBI = $4k	CMF = $42,400 FFS = $60k CPCP = $40k PBI = $4k	CMF = $42,400 FFS = $60k CPCP = $40k PBI = $4k	CMF = $42,400 FFS = $60k CPCP = $40k PBI = $4k	**$732,000**

CMF = Care Management Fee
FFS = Fee-For-Service (E&M Billing)
CPCP = Comprehensive Primary Care Payment
PBI = Performance Based Incentive

Assumptions: 1,000 Medicare Patients; Track 1 average CMF $15, Track 2 CMF 95% $28 PBPM, 5% Complex $100 PBPM; Provider meets all year-end performance bonus targets (no claw-back of PBI)

into a Memorandum of Understanding (MOU) with CMS to support the CPC+ program with a commitment to the five-year duration, alignment on payment, data sharing, quality metrics, and provision of financial support for practice care delivery. Participating payers will *not* be held to the same specific payment structure and quality measurement that CMS will follow, and can design their own approaches as long as it aligns with the goals of CPC+. CMS will select payers based on their market penetration and the extent to which their proposed activities align with the CMS approach. Unlike the providers, participating payers will not receive any financial incentives from CMS. However, there is still value for payers to participate in CPC+, as multi-payer improvement initiatives allow each of the payers to achieve more than any one of them could individually.

To qualify for the CPC+ program, providers must demonstrate multi-payer support by the CMS-selected payer partners, use Certified EHR Technology (CEHRT), and exhibit certain quality of care capabilities, including 24-hour patient access to care and information and other metrics for managing and coordinating care.

To qualify for the more advanced Track 2, providers must be proficient in advanced primary care, with the ability to care for patients with complex behavioral, psychosocial, and medical needs. With the increased prospective payments of Track 2, participating practices will be held to a higher standard than those in Track 1, and will be expected to provide enhanced services (see

FIGURE 4. TRACK 2 HIT VENDOR AND CPC+ PROVIDER ENGAGEMENT

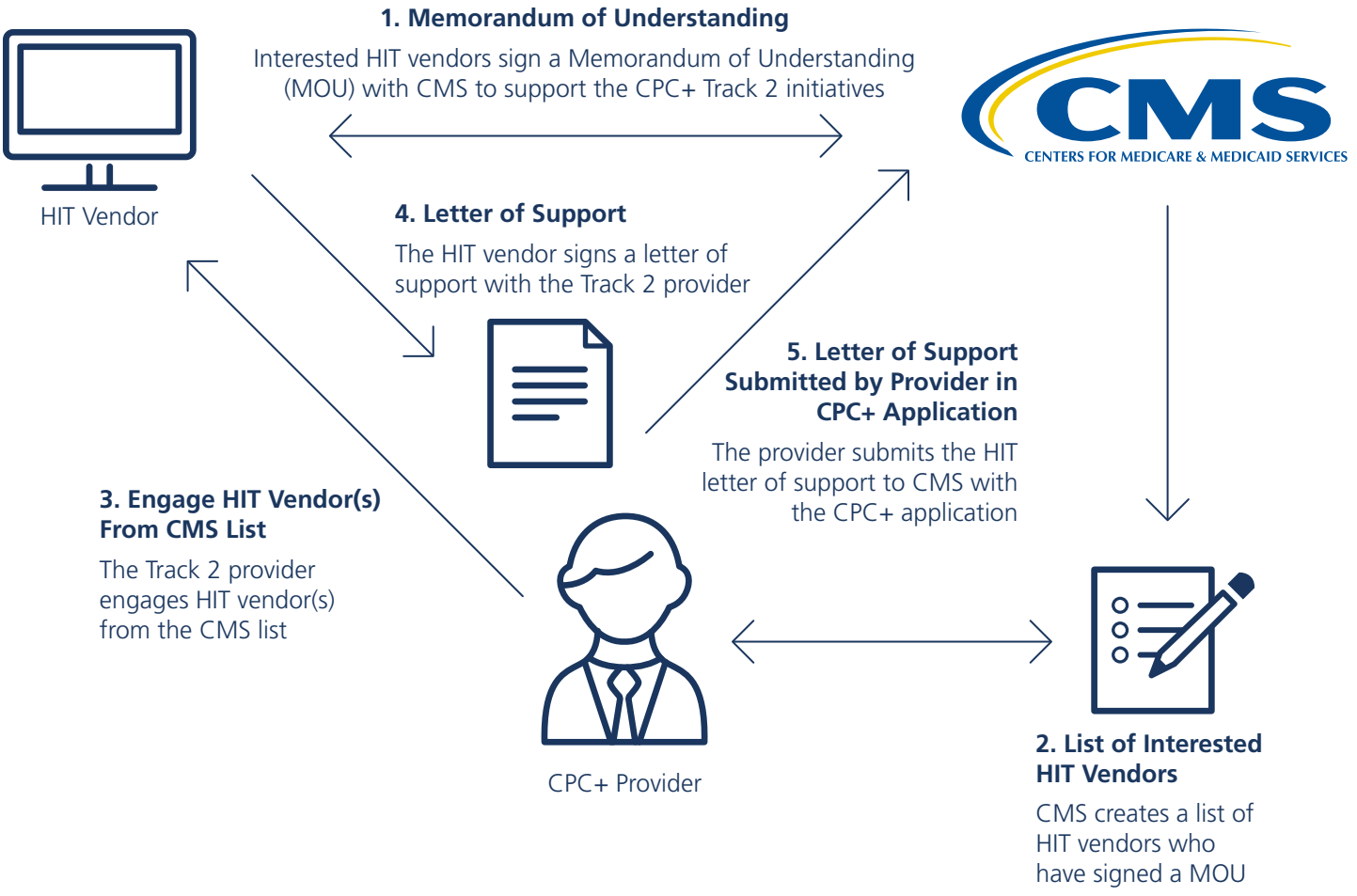

FIGURE 5. CPC+ KEY DATES

figure 1). Track 2 practices must also have a collaborative partnership with one or more HIT vendors who have committed to supporting the practice.[5] After Track 2 practices are selected, each practice's HIT vendor(s) will sign an MOU with CMS that indicates their willingness to participate in CPC+. Vendor involvement is voluntary and without payment from CMS.

It is worth noting that with CPC+, CMS is targeting the types of primary care practices that would otherwise likely not engage in population-based models, including Medicare's more advanced ACO programs. CMS originally stipulated that practices participating in either of the CPC+ tracks could not simultaneously participate in the primary care model and certain other CMS initiatives, including Medicare Shared Savings Program and Next Generation ACO. However, after receiving feedback from multiple stakeholders, as many as 1,500 primary care practices will have the opportunity to be dual participants in the Medicare Shared Savings Program (MSSP) and the new Comprehensive Primary Care Plus (CPC+) initiative.

IMPLEMENTATION

The CPC+ implementation timeline is fairly aggressive, giving CMS only eight and a half months to solicit and select payers, establish the demonstration regions, and review and accept eligible practices within those regions. CMS will face a number of hurdles in implementation, including the model's large scale, aggressive timeline, and the administrative activities associated with addressing the potential overlap between Medicare's many ongoing initiatives.

Some payers will face state insurance regulations that raise hurdles to their participation in Track 2 due to restrictions in risk-based payments. Delays in any part of the staging process could impact the ability of CMS to qualify CPC+ practices as participating in Advanced APMs under the Medicare Access and CHIP Reauthorization Act (MACRA).

IMPLICATIONS

CPC+ has the potential of affecting multiple segments of the health care industry through direct and indirect means.

Physicians

Flexibility to manage populations outside of fee-for-service (FFS). CPC+ enables better population management by providing practices with prospectively paid care management fees and performance-based incentive payments, as well as the hybrid prospective payment in Track 2. These prospective payments equip primary care providers with the funding and incentives for meaningful practice redesign. Practices might offer non-face-to-face visits, work with community organizations, or simply provide longer office visits for patients with complex needs. CMS does not prescribe specific approaches to transformation, but instead puts practice redesign decisions in the hands of those who know their patients and practice best: primary care physicians.

Alternative way to quality for an Advanced APM bonus payment under MACRA. Under recently proposed rules for Medicare Access and CHIP Reauthorization Act (MACRA), CPC+ meets the

criteria to qualify as an Advanced APM due to the model's medical home status. Because of this, CPC+ providers can be eligible to receive an Advanced APM Incentive Payment and are exempt from the reporting requirements of the Merit-Based Incentive Payment System (MIPS). Essentially, being a CPC+ practice is a low-risk way to enter into a population-level plan that can qualify as an Advanced APM under MACRA. While this is certainly welcomed news for CPC+ practices, some providers are upset by the proposed regulation that would allow CPC+ to qualify and exclude other Medicare models, like Medicare Shared Savings Program (MSSP) Track 1 ACOs.

Limited effect on specialists to improve quality or reduce costs. While CPC+ does allow primary care physicians some flexibility in how they create relationships with specialists to help manage their patients, CMS will need to develop more value-based programs specifically designed for specialist providers to effectively engage them in payment and delivery reform.

Hospitals

Incentives to partner with or acquire primary care practices. While hospitals cannot be the direct recipients of CPC+ prospective payments, hospitals that are moving toward risk-based, population-level payments would benefit from having the effective primary care facilitated by the CPC+ program.

Payers

Joint contracting with CMS increases the likelihood of achieving goals. Public and private payers share a common goal to help providers to reduce unnecessary and costly care. By participating in CPC+, payers can utilize the framework set by CMS to work with practices that have demonstrated a commitment to high-value primary care. Primary care practices benefit greatly from multi-payer unity in program design, rather than being pulled in different directions by multiple payment models, quality measures, and approaches to data sharing. When payers work together to align initiatives, both from a quality and utilization perspective, and give providers sufficient resources to reach those goals, practices are more likely to succeed.

Risk of not joint contracting with CMS for CPC+ may slow payer progress toward primary care objectives. Payers that are planning to pursue improvements in primary care through medical home models should consider the risks of not contracting, or at least aligning, with CMS on CPC+. It is likely that practices participating in CPC+ will favor that program over the potentially misaligned initiatives of other payers. However, payers and practices that are already actively engaged in a successful medical home model should take into consideration that the move to CPC+ would require re-contracting and re-calibrating, a labor-intense process for both parties.

Advisable to join the movement toward joint measures and payments. Increasingly, CMS is organizing multi-payer models (e.g., Multi-Payer Advanced Primary Care Practice,[6] Comprehensive Primary Care, Comprehensive Primary Care Plus, Oncology Care Model[7]) and other multi-payer initiatives (e.g., Core Quality Measures Collaborative,[8] Advanced APM All-Payer Combination Option[9]) to align health care payment and delivery improvement efforts across the public and private sectors. CMS understands that in order for value-based payment to become the dominant model, and with its changed incentives truly transform care delivery, providers will need to move a majority of their patient panels to APMs and away from FFS. Aligned payment methods, quality measures and performance standards can quicken the shift to value-based payments by advancing the interest of payers and providers. At this time, CMS is creating opportunities for multi-payer alignment with voluntary participation, but both providers and payers would be wise to gain early entrance and experience under these models before participation becomes mandatory.

Technology Vendors

Incentives to develop primary care-centric solutions. Effective population health management needs HIT, but these tools have largely been designed for hospitals and health systems. The CPC+ model incentivizes HIT vendors to create primary care-focused solutions built for population health management. HIT vendors in a partnership with a CPC+ group will have some exclusivity and an

additional opportunity to learn from other groups via the CPC+ Practice Portal, CPC Connect, and CPC Learning Communities.

Meaningful Use will become more meaningful. Electronic medical records have been designed to meet the requirements of Meaningful Use (MU), but primary care practices have not done much with the collected information. CPC+ will make that data more valuable to care coordination efforts. The data focus of the CPC+ practice will be less on reporting and more on actionable intelligence.

Pharmaceutical and Life Science Vendors

No major impacts. CPC+ does not include Part D or have any provisions related to medical devices or biotech. The payment and incentive structure of CPC+ may result in more care coordination, medication reconciliation, and medication therapy management, which could lead to a decrease in polypharmacy, and any loss of prescriptions should be more than offset by the rising demand for primary care services driven both by aging demographics and Medicaid expansion.

CONCLUSION

The Comprehensive Primary Care Plus (CPC+) program illustrates a sweeping move to transform the payment methodology of primary care in the United States. The program impacts every segment of the health care industry, including payers, providers, pharmaceutical and life science vendors, and health information technology (HIT) vendors. While the implications of the CPC+ model on each stakeholder group is different, the program's success - and its ability to support HHS' goal to tie 50 percent of Medicare payments to quality or value through alternative payment models (APMs) by 2018 -is dependent upon the stakeholders collectively engaging in this payment and delivery transformation.

CITATIONS

1. Medicare C for, Baltimore MS 7500 SB, Usa M. CMS launches largest-ever multi-payer initiative to improve primary care in America [Internet]. 2016 [cited 2016 May 31]. Available from: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-04-11.html
2. Medicare C for, Baltimore MS 7500 SB, Usa M. Comprehensive Primary Care Plus (CPC+) Fact Sheet [Internet]. 2016 [cited 2016 Apr 29]. Available from: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-11.html
3. Medicare the C for, Boulevard MSS, Baltimore, Baltimore M 21244 7500 SB, Usa M 21244. About the CMS Innovation Center | Center for Medicare & Medicaid Innovation [Internet]. [cited 2016 May 31]. Available from: https://innovation.cms.gov/about/index.html
4. External Frequently Asked Questions for Clearance Template - cpcplus-faqs.pdf [Internet]. [cited 2016 Apr 29]. Available from: https://innovation.cms.gov/Files/x/cpcplus-faqs.pdf
5. Comprehensive Primary Care Plus (CPC+) Request For Applications - cpcplus-rfa.pdf [Internet]. [cited 2016 Apr 29]. Available from: https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf
6. Medicare the C for, Boulevard MSS, Baltimore, Baltimore M 21244 7500 SB, Usa M 21244. Multi-Payer Advanced Primary Care Practice | Center for Medicare & Medicaid Innovation [Internet]. [cited 2016 May 31]. Available from: https://innovation.cms.gov/initiatives/Multi-payer-Advanced-Primary-Care-Practice/
7. Oncology Care Model [Internet]. [cited 2016 May 31]. Available from: https://cmmicoordinator.polldaddy.com/s/was-this-helpful?iframe=https%3A%2F%2Finnovation.cms.gov%2Finitiatives%2Foncology-care%2F&ft=1
8. Medicare C for, Baltimore MS 7500 SB, Usa M. Core Measures [Internet]. 2016 [cited 2016 May 31]. Available from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html
9. Quality Payment Program - NPRM-QPP-Fact-Sheet.pdf [Internet]. [cited 2016 May 31]. Available from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf

LEAVITT

PARTNERS

LeavittPartners.com