Understanding and Preparing for CPC+

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Thomas Jefferson University
The 17th Population Health Colloquium
March 29, 2017
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- To protect the integrity of certification, ABIM enforces strict confidentiality and ownership of exam content.
- As the current Chair of the SEP Committee on Internal Medicine, I agree to keep exam information confidential.
- As is true for any ABIM candidate who has taken an exam for certification, I have signed the Pledge of Honesty in which I have agreed to keep ABIM exam content confidential.

- No exam questions will be disclosed in my presentation.
Overview

1. Overview of the CPC+ Program

2. Why practices may or may not want to participate

3. The Jefferson experience and lessons learned, so far
CPC+: Program Overview

5-year CMMI/CMS program.

“Payment redesign by payers, both public and private, will offer the ability for greater cash flow and flexibility for primary care practices to deliver high quality, whole-person, patient-centered care and lower the use of unnecessary services that drive total costs of care.”

Began on January 1, 2017

- 2,983 primary care practices accepted with 13,090 clinicians
- serving 1.76 Million Medicare beneficiaries
- individual practices apply
- must have 150 Medicare beneficiaries

Both CMS and private insurers participating

Practices split into 2 Tracks (Basic and Advanced)
CPC+: Program Overview

Qualifies as an **Advanced** APM under MACRA
  - due to small “at risk component”
  - not for Track 1 MSSP ACOs, however

Must have a certified EHR

Geared to support smaller practices
CPC+: 14 Regions

1. Arkansas: Statewide
2. Colorado: Statewide
3. Hawaii: Statewide
4. Kansas and Missouri: Greater Kansas City Region
5. Michigan: Statewide
6. Montana: Statewide
7. New Jersey: Statewide
8. New York: North Hudson-Capital Region
9. Ohio: Statewide and Northern Kentucky:
10. Oklahoma: Statewide
11. Oregon: Statewide
12. Pennsylvania: Greater Philadelphia Region
13. Rhode Island: Statewide
14. Tennessee: Statewide
CPC+

Who is in the collaborative?

CPC+ Practices Span 14 Regions

- Oregon: 156 practices, 1087 clinicians, 15 payers
- Montana: 54 practices, 354 clinicians, 3 payers
- Michigan: 448 practices, 2002 clinicians, 2 payers
- Ohio: 562 practices, 2566 clinicians, 12 payers
- Rhode Island: 31 practices, 209 clinicians, 3 payers
- Colorado: 207 practices, 1229 clinicians, 5 payers
- Kansas City: 109 practices, 674 clinicians, 1 payer
- New York: 157 practices, 593 clinicians, 3 payers
- Philadelphia: 219 practices, 995 clinicians, 2 payers
- New Jersey: 436 practices, 1407 clinicians, 3 payers

Accessed at CMS.gov
CPC+: Program Round #2

2nd Round of Applications Underway
- payers have until April 17 to apply
- up to 10 new regions will be accepted
- practice applications anticipated this summer
- start date January 2018

2nd round will include randomization

Maximum of 5,500 practices to be included in combination of Round 1 + Round 2
# Three Payment Innovations Support CPC+ Practice Transformation

<table>
<thead>
<tr>
<th>Objective</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment (PBPM)</th>
<th>Payment Structure Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td>Support augmented staffing and training for delivering comprehensive primary care</td>
<td>Reward practice performance on utilization and quality of care</td>
<td>Reduce dependence on visit-based fee-for-service to offer flexibility in care setting</td>
</tr>
<tr>
<td></td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>N/A (Standard FFS)</td>
</tr>
<tr>
<td><strong>Track 2</strong></td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>

- **Not at Risk**
- **At Risk**
- **Not at Risk**
PBPM Care Management Fees Determined by Patient Risk Levels

Payments Support Practice Capabilities to Better Manage Care

Track 1: Four Risk Tiers (Average $15)

- $6: 0.117-0.503
- $8: 0.504-0.727
- $16: 0.766-1.247
- $30: 1.248 and over

Track 2: Five Risk Tiers (Average $28)

- $9: 0.117-0.503
- $11: 0.504-0.765
- $19: 0.766-1.247
- $33: 1.248-1.991

Complex Tier: $100
Top 10% of risk or dementia diagnosis
1.992+ and Dementia

- Risk adjusted, PBPM (non-visit-based) payment
- Designed to augment staffing and training, according to specific needs of patient population
- No beneficiary cost sharing
- Risk tiers relative to regional population
CPCP Payment Explained

- 2015 Medicare Billings
- 2017 Medicare Billings
- FFS reduced compared to prior rate
- 10% up front
- 25%
- 40% or 65% by 2019

10% up front
CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

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

Requirements for Track 1

- Empanelment
- 24/7 patient access
- Assigned care teams

Requirements for Track 2

- Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.

Access and Continuity

- Much aligns with PCMH

Care Management

- Risk stratified patient population
- Short-term and targeted, proactive, relationship-based care management
- ED visit and hospital follow-up

Online Resources: Care Delivery Transformation Brief, Video, and Practice Requirements

Upcoming Open Door Forums: Care Delivery Overview and Q&A: Fri, Aug 12, 9:30-10:30am ET
**CPC+ Practices Will Enhance Care Delivery Capabilities in 2017**

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Track 2</th>
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<tbody>
<tr>
<td><strong>Comprehensiveness and Coordination</strong></td>
<td></td>
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<tr>
<td>Identification of high volume/cost specialists</td>
<td>Behavioral health integration</td>
</tr>
<tr>
<td>Improved timeliness of notification and information transfer from EDs and hospitals</td>
<td>Psychosocial needs assessment and inventory of resources and supports to meet psychosocial needs</td>
</tr>
<tr>
<td><strong>Patient and Caregiver Engagement</strong></td>
<td></td>
</tr>
<tr>
<td>At least annual Patient and Family Advisory Council</td>
<td>At least biannual Patient and Family Advisory Council</td>
</tr>
<tr>
<td>Assessment of practice capabilities to support patient self-management</td>
<td>Patient self-management support for at least three high-risk conditions</td>
</tr>
<tr>
<td><strong>Planned Care and Population Health</strong></td>
<td></td>
</tr>
<tr>
<td>At least quarterly review of payer utilization reports and practice eCQM data to inform improvement strategy</td>
<td>At least weekly care team review of all population health data</td>
</tr>
</tbody>
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## Practice Example

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If Track 2:
500 Medicare patients in past 2 years = $28 x 500 x 12 mos = $168,000
10% FFS increase = approximately $20,000
PBIP = up to $24,000
Contributions from Commercial payers = $?????????

Total: Likely over $200,000+
CPC+
CMS Sponsored Education Programs

National, Regional and Online Forums

<table>
<thead>
<tr>
<th>Learning Opportunities</th>
<th>Description</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Webinars</td>
<td>Interactive web-based platform that includes presentations from subject matter experts, strategies from participating practices, and resources and tools. Webinars will be available live or on demand, and all live webinars will be recorded and made available for practices to download and watch at a later time.</td>
<td>Please refer to the Upcoming Learning Events Calendar</td>
</tr>
<tr>
<td>Action Groups</td>
<td>Live, virtual sessions with practices that are actively working on a similar set of changes, featuring opportunities to share ideas, approaches, solutions, tools, resources, and experiences in a facilitated, data-driven online learning community.</td>
<td>End of Q1 2017/Beginning of Q2 2017</td>
</tr>
<tr>
<td>Affinity Groups</td>
<td>Practice- or facilitator-led online discussions with health IT vendors and partners to share resources and experiences on using health IT to meet CPC+ aims</td>
<td>End of Q1 2017/Beginning of Q2 2017</td>
</tr>
<tr>
<td>CPC+ Connect</td>
<td>Secure web-based platform for all practices to share ideas, resources, and strategies for care delivery transformation</td>
<td>Available starting January 2017</td>
</tr>
<tr>
<td>On the Plus Side Weekly Update</td>
<td>Newsletter sent to all practices that includes CPC+ program updates, resources, answers to frequently asked questions, and upcoming CPC+ events</td>
<td>Weekly</td>
</tr>
<tr>
<td>Office Hours</td>
<td>Virtual sessions that provide practices with an opportunity to ask questions</td>
<td>As needed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Webinar Topics</th>
<th>Target Date</th>
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</thead>
<tbody>
<tr>
<td>Overview of Care Delivery Model</td>
<td>January 19, 2017 @ 4:00 pm ET</td>
</tr>
<tr>
<td>Practice Portal and CPC+ Connect</td>
<td>January 25, 2017 @ 4:00 pm ET</td>
</tr>
<tr>
<td>Care Management</td>
<td>February 2, 2017 @ 4:00 pm ET</td>
</tr>
<tr>
<td>Optimal Use of Health IT</td>
<td>February 8, 2017 @ 4:00 pm ET</td>
</tr>
<tr>
<td>Comprehensiveness and Coordination</td>
<td>February 16, 2017 @ 4:00 pm ET</td>
</tr>
<tr>
<td>Planned Care and Population Health</td>
<td>March 2, 2017 @ 4:00 pm ET</td>
</tr>
<tr>
<td>Requirements, Reporting, and Monitoring</td>
<td>March 8, 2017 @ 4:00 pm ET</td>
</tr>
<tr>
<td>Patient and Caregiver Engagement</td>
<td>March 16, 2017 @ 4:00 pm ET</td>
</tr>
<tr>
<td>Continuous Improvement Driven By Data</td>
<td>March 22, 2017 @ 4:00 pm ET</td>
</tr>
</tbody>
</table>
How to Meet requirements

Access Function:

Figure 1: Roadmap for First Year of Care Delivery Redesign

- **Q1**
  - Ensure patients have 24/7 access to a care team practitioner with real-time access to the Electronic Health Record (EHR).

- **Access and Continuity**
  - **Q1**
    - Identify roles and responsibilities of care teams.
  - **Q2**
    - Organize care by practice-identified teams responsible for a specific, identifiable panel of panelists to optimize continuity.
  - **Q3**
    - Begin to empanel patients to clinicians and/or care teams.
  - **Q4**
    - Achieve 95% empanelment to practitioner and/or care teams.

- **Q4**
  - Maintain 95% empanelment to practitioner and/or care teams.

- **TRACK 2 ONLY**
  - **Q1**
    - Identify at least one alternative office strategy.
  - **Q2**
    - Plan and test at least one alternative office strategy.
  - **Q3**
    - Implement at least one alternative office strategy.
  - **Q4**
    - Regularly offer at least one alternative office strategy.
Must Report on 9 of 14 metrics

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Outcomes Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression Remission at Twelve Months</td>
</tr>
<tr>
<td></td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td></td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt; 9%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 2</th>
<th>Complex Care Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use of High-Risk Medications in the Elderly</td>
</tr>
<tr>
<td></td>
<td>Dementia: Cognitive Assessment</td>
</tr>
<tr>
<td></td>
<td>Falls: Screening for Future Fall Risk</td>
</tr>
<tr>
<td></td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 3</th>
<th>Remaining Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
</tr>
<tr>
<td></td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Diabetes: Eye Exam</td>
</tr>
<tr>
<td></td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td></td>
<td>Use of Imaging Studies for Low Back Pain</td>
</tr>
<tr>
<td></td>
<td>Breast Cancer Screening</td>
</tr>
</tbody>
</table>
Participate in CPC+?

1) We saw tremendous opportunity to participate
2) Opportunity to qualify as an Advanced-APM (not if in MSSP)
   - PBIP payment is “at risk”, otherwise no downside
3) Further transform our primary care model
4) Cooperative with goals of our ACO
5) Preparation for increased risk
6) PMPM Care Management Fee is real $
7) CPCP payment is potentially transformative away from volume payments
Participate in CPC+?

1) Apply for Track 2 only if an experienced PCMH site

2) Even for Track 1 sites, workload and reporting requirements are significant and expected to grow

3) EMR “add-on” fee can be significant, so check first

4) Unable to bill for some services, such as CCM fee
Jefferson and CPC+

65 owned or CIN-affiliated practices accepted
- 18% track 1, 82% Track 2
- some practices did not apply
- a few were rejected by CMMI (in error?)

Ineligible for PBIP due to MSSP participation

Central strategic team among our campuses
Hiring central project manager, analysts

Subcommittees on provider integration, BH, EHR and Care coordination to organize and decide on use of care management fee and CPCP
Lessons Learned (So Far)

1. Very complex program requires close coordination
2. Many program requirements remain unclear
3. Supplanted our ACO requirement for PCMH recognition
4. Patient attribution lower than anticipated (57-85% of MSSP)
5. HCC scores very important but impact is delayed
6. Online tools & education potentially useful?
7. Quality reporting requirements may be significant
   – Quarterly and annual may be burdensome for small practices
   – Not much difference between track 1 and track 2
8. Little patient data given other than demographics and risk stratification
   – Rely on your EMR or other payer data
## Initial Risk Analysis

### Jefferson Health Total CPC+ Risk Summary

<table>
<thead>
<tr>
<th>Age</th>
<th>Complex</th>
<th>Non-Complex</th>
<th>Totals</th>
<th>% All Campuses</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;65</td>
<td>3640</td>
<td>12%</td>
<td>3813</td>
<td>12%</td>
</tr>
<tr>
<td>65-69</td>
<td>6089</td>
<td>21%</td>
<td>8446</td>
<td>26%</td>
</tr>
<tr>
<td>70-74</td>
<td>7884</td>
<td>27%</td>
<td>15629</td>
<td>27%</td>
</tr>
<tr>
<td>75-79</td>
<td>5054</td>
<td>17%</td>
<td>576</td>
<td>15%</td>
</tr>
<tr>
<td>80+</td>
<td>6628</td>
<td>23%</td>
<td>1996</td>
<td>52%</td>
</tr>
<tr>
<td>Totals</td>
<td>33108</td>
<td></td>
<td>33108</td>
<td>100%</td>
</tr>
</tbody>
</table>

### CCHG Patients Pct

<table>
<thead>
<tr>
<th>Condition</th>
<th>Patients</th>
<th>Pct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Cancer</td>
<td>922</td>
<td>24%</td>
</tr>
<tr>
<td>Dementia</td>
<td>555</td>
<td>15%</td>
</tr>
<tr>
<td>Severe HF/Transplant/Rheumatic Heart Disease</td>
<td>387</td>
<td>10%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>309</td>
<td>8%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>203</td>
<td>5%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>198</td>
<td>5%</td>
</tr>
<tr>
<td>CAD &amp; Diabetes</td>
<td>119</td>
<td>3%</td>
</tr>
<tr>
<td>Neurologic disorder</td>
<td>105</td>
<td>3%</td>
</tr>
<tr>
<td>Severe Rheumatism</td>
<td>87</td>
<td>2%</td>
</tr>
<tr>
<td>Major Psychosis</td>
<td>83</td>
<td>2%</td>
</tr>
<tr>
<td>CAD &amp; Diabetes</td>
<td>62</td>
<td>2%</td>
</tr>
<tr>
<td>Liver Disease (Hepatitis)</td>
<td>60</td>
<td>2%</td>
</tr>
<tr>
<td>COPD</td>
<td>41</td>
<td>1%</td>
</tr>
<tr>
<td>MSK/Osteoarthritis/Osteoporosis</td>
<td>39</td>
<td>1%</td>
</tr>
<tr>
<td>Hemophilia/Sickle Cell/Chronic Blood Disorder</td>
<td>33</td>
<td>1%</td>
</tr>
<tr>
<td>Asthma</td>
<td>12</td>
<td>0%</td>
</tr>
<tr>
<td>Other or Blank/No CCHG</td>
<td>598</td>
<td>16%</td>
</tr>
</tbody>
</table>

70% (n=1380) are 85+ years old
Key Plans for Success

1. Embedded Mental Health
2. Time to review data and meet with Teams
3. Patient-Family Advisory Council
4. Care Coordination
   – Develop care plans
   – Acute and long term care management
   – Referral to community resources
5. Risk Stratification
6. Non-traditional office visits
Questions?

Participating in MSSP

- Multispecialty Practice
- PCP Practice
- Multispecialty Practice
- PCP Practice
- Multispecialty Practice
- Independent PCP Practice
- Independent oncology practice
- Independent radiology practice
- Owned by health system or large independent medical group
- Participating in CPC+ Track one
- Participating in CPC+ Track two

Contact: Lawrence.Ward@jefferson.edu