Jefferson

Understanding and Preparing for CPC+

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The 17th Population Health Colloquium
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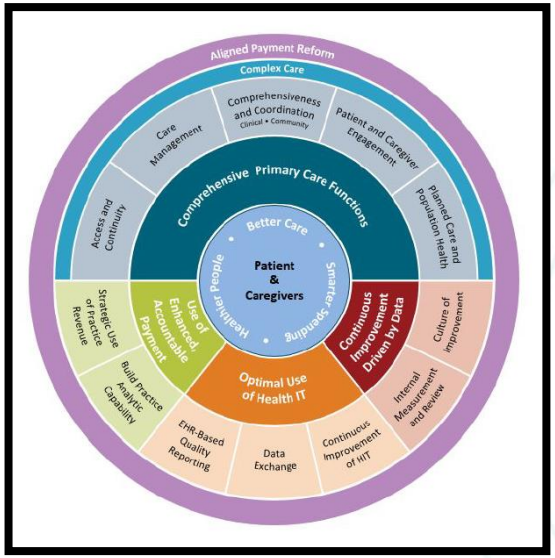
- I am the current Chair of the SEP Committee on Internal Medicine.
- To protect the integrity of certification, ABIM enforces strict confidentiality and ownership of exam content.
- As the current Chair of the SEP Committee on Internal Medicine, I agree to keep exam information confidential.
- As is 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

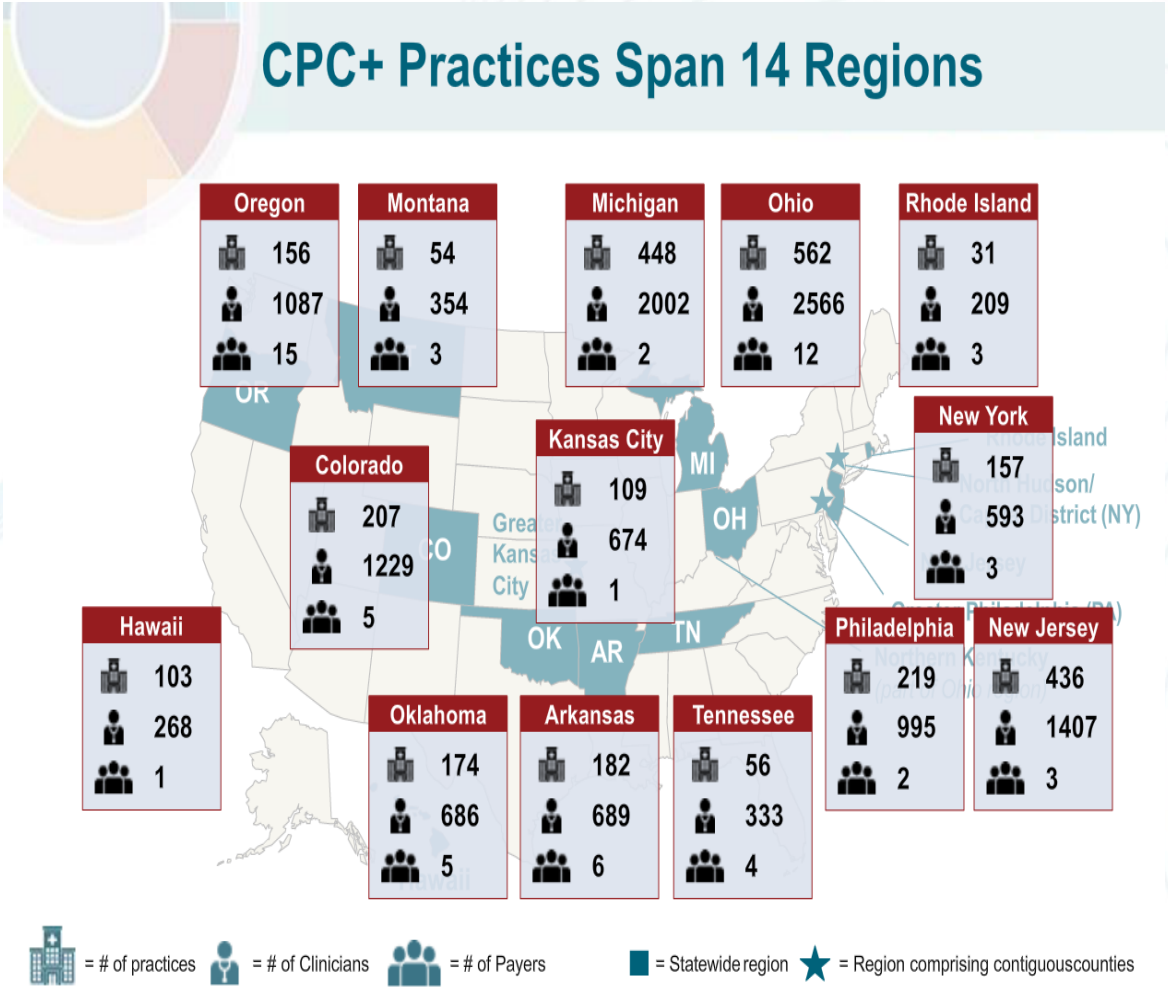
CPC+: 14 Regions

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

Source: Centers for Medicare & Medicaid Services

CPC+

Who is in the collaborative?



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

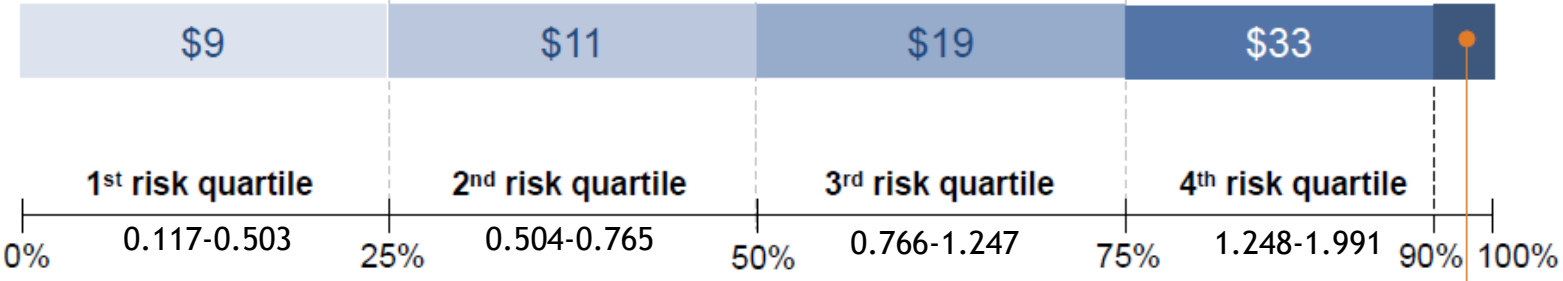
	Care Management Fee (PBPM)	Performance-Based Incentive Payment (PBPM)	Payment Structure Redesign
Objective	*Support augmented staffing and training for delivering comprehensive primary care*	*Reward practice performance on utilization and quality of care*	*Reduce dependence on visit-based fee-for-service to offer flexibility in care setting*
Track 1	$15 average	$2.50 opportunity	N/A (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)
	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)

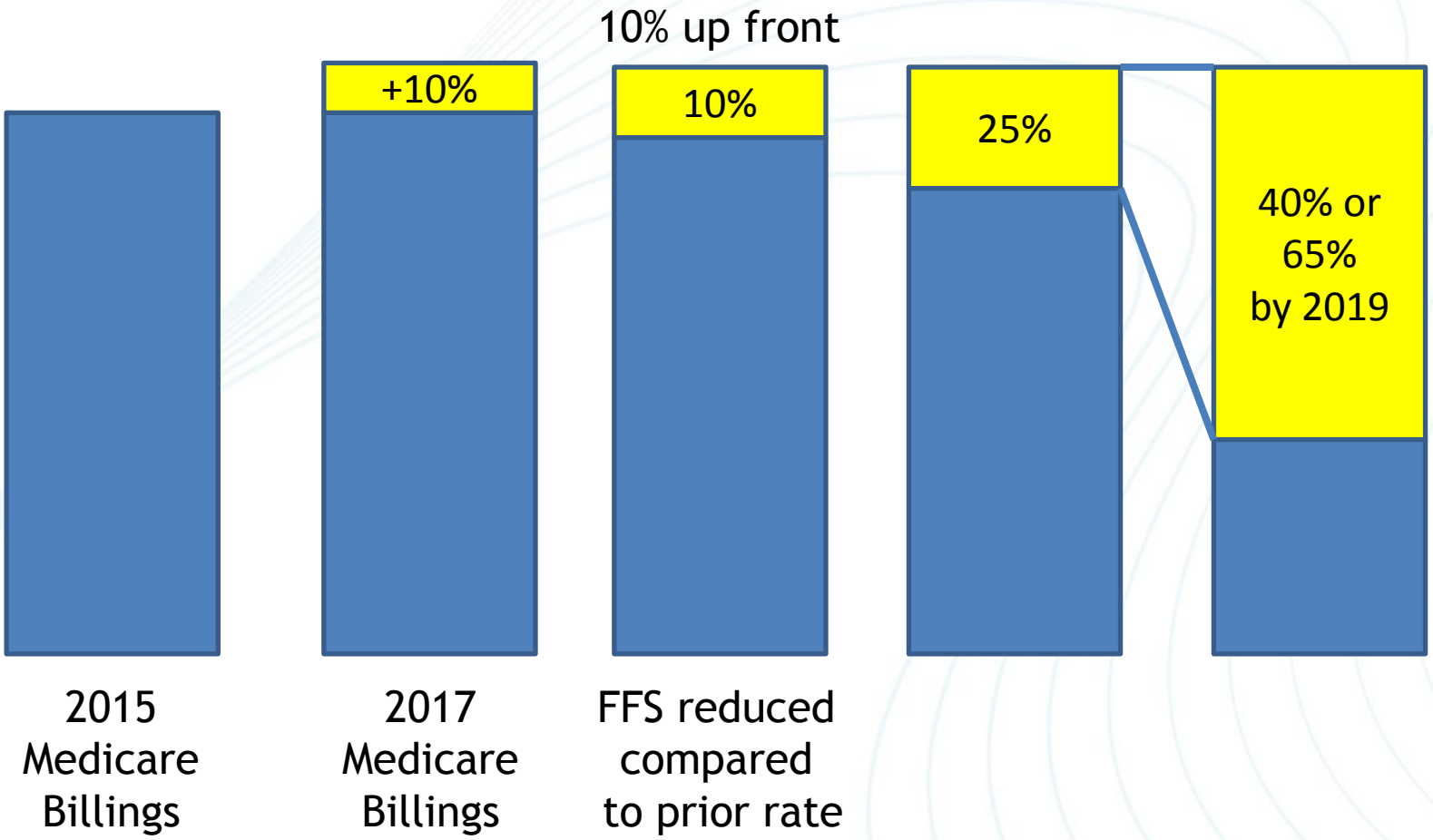
Track 2: Five Risk Tiers (Average $28)



- 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

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

CPCP Payment Explained



CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

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

✓ Much aligns with PCMH

	Requirements for Track 1	Requirements for Track 2
Access and Continuity	✓ Empanelment ✓ 24/7 patient access ✓ Assigned care teams	✓ Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.
Care Management	✓ Risk stratified patient population ✓ Short-term and targeted, proactive, relationship-based care management ✓ ED visit and hospital follow-up	Two-step risk stratification process for all empanelled patients ✓ Care plans for high-risk chronic disease patients

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

Much aligns with PCMH

	Requirements for Track 1	Requirements for Track 2
Comprehen-siveness and Coordination	Identification of high volume/cost specialists Improved timeliness of notification and information transfer from EDs and hospitals	Behavioral health integration Psychosocial needs assessment and inventory of resources and supports to meet psychosocial needs Collaborative care agreements Development of practice capability to meet needs of high-risk populations
Patient and Caregiver Engagement	At least annual Patient and Family Advisory Council Assessment of practice capabilities to support patient self-management	At least biannual Patient and Family Advisory Council Patient self-management support for at least three high-risk conditions
Planned Care and Population Health	At least quarterly review of payer utilization reports and practice eCQM data to inform improvement strategy	At least weekly care team review of all population health data

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+

RN Care Coordinator
MA
Social Worker

CPC+
CMS Sponsored Education Programs

National, Regional and Online Forums

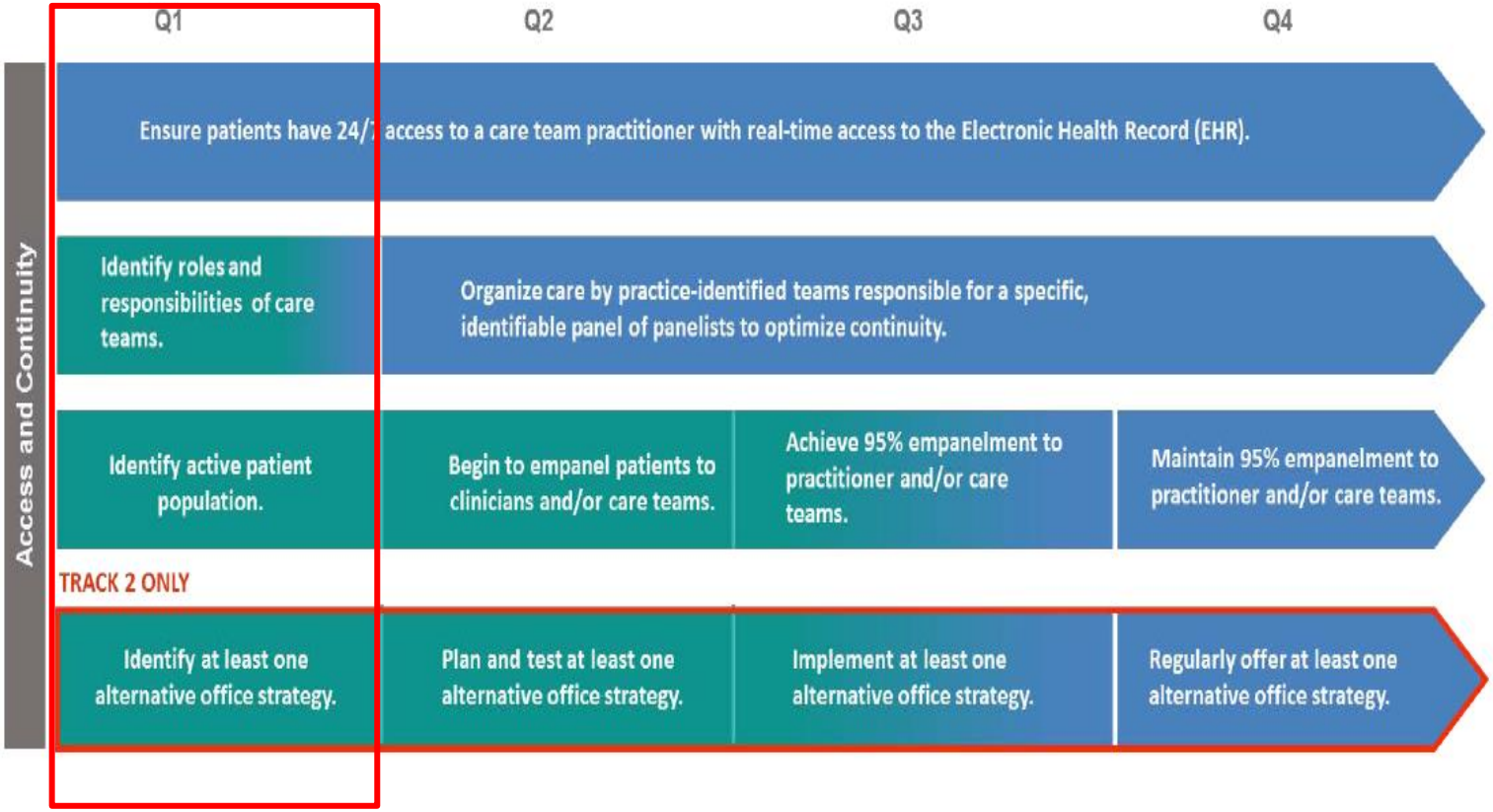
National Learning Opportunities	Description	Approximate Timing
National Webinars	Interactive web-based platform that includes presentations from subject matter experts, strategies from participating practices, and resources and tools. Webinars will be available live or on demand, and all live webinars will be recorded and made available for practices to download and watch at a later time	Please refer to the Upcoming Learning Events Calendar
Action Groups	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	End of Q1 2017/Beginning of Q2 2017
Affinity Groups	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	End of Q1 2017/Beginning of Q2 2017
CPC+ Connect	Secure web-based platform for all practices to share ideas, resources, and strategies for care delivery transformation	Available starting January 2017
On the Plus Side Weekly Update	Newsletter sent to all practices that includes CPC+ program updates, resources, answers to frequently asked questions, and upcoming CPC+ events	Weekly
Office Hours	Virtual sessions that provide practices with an opportunity to ask questions	As needed

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

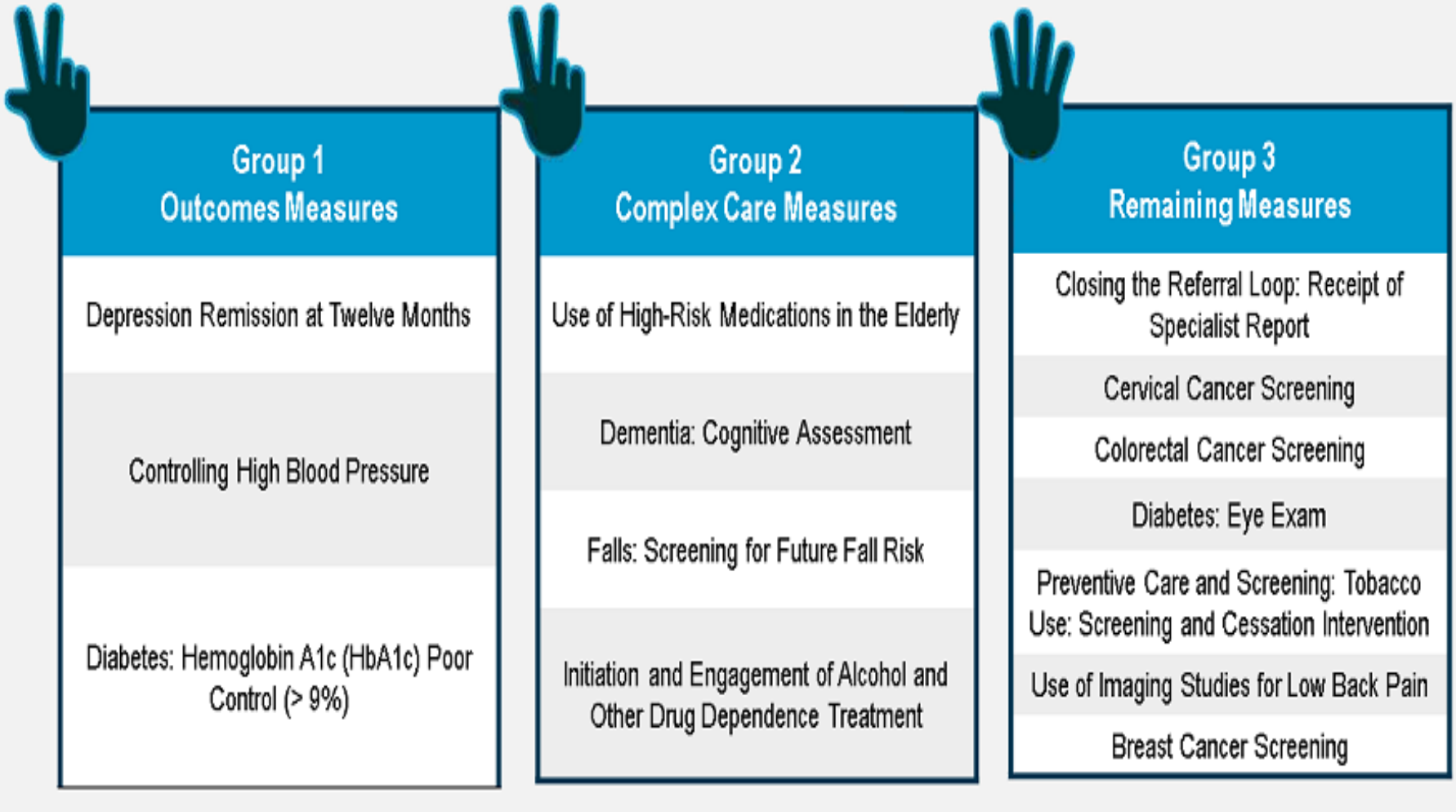
How to Meet requirements

Access Function:

Figure 1: Roadmap for First Year of Care Delivery Redesign



Must Report on 9 of 14 metrics



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	Totals	% All Campuses
	Totals	
Complex	3813	12%
High	4400	13%
Medium-High	7680	23%
Medium-Low	8446	26%
Low	8769	26%
Totals	33108	100%

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

Age view

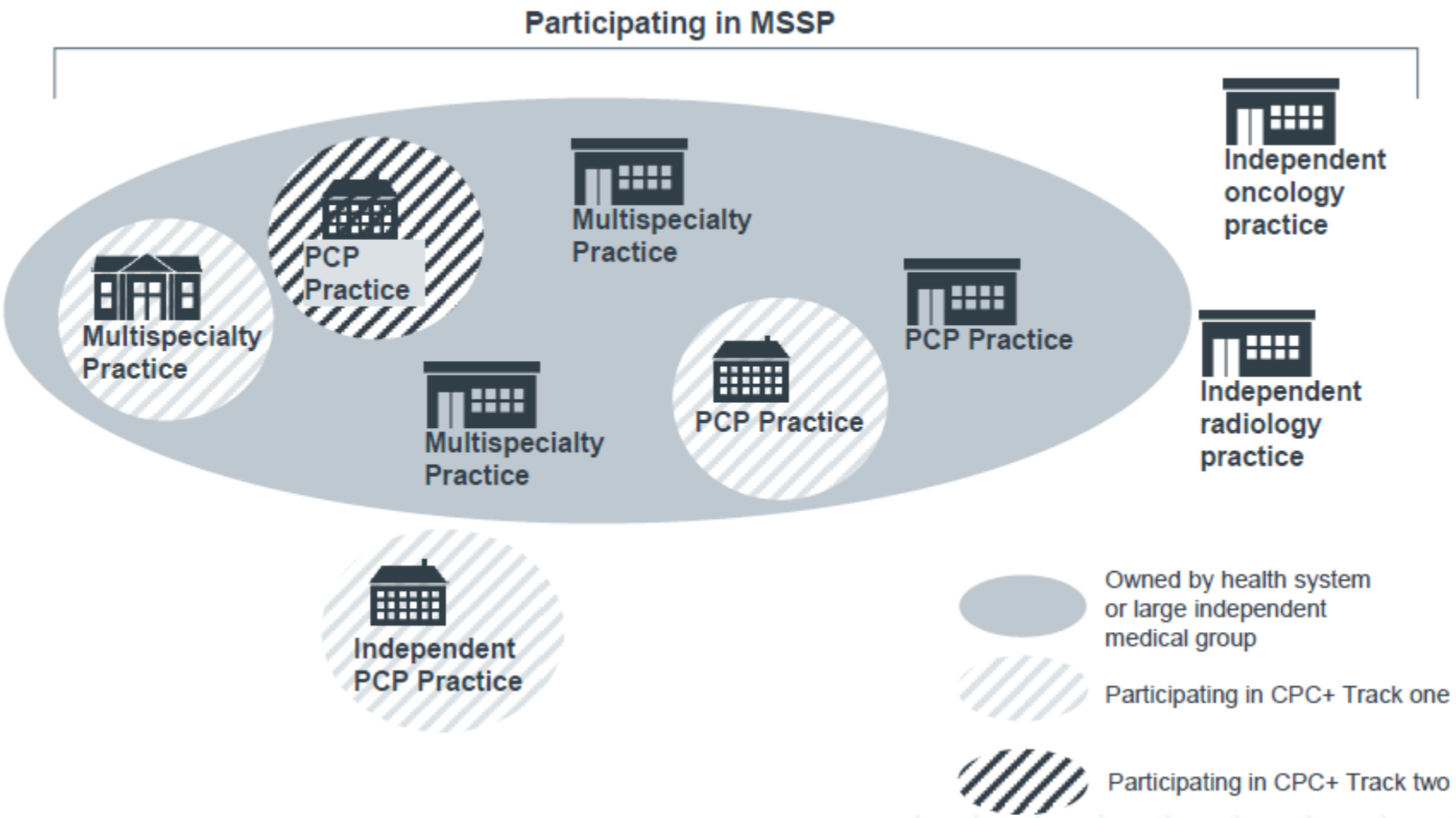
Age	Non-Complex Pts	NC Pct	Complex Pts	Complex Pct
<65	3640	12%	449	12%
65-69	6089	21%	256	7%
70-74	7884	27%	537	14%
75-79	5054	17%	576	15%
80+	6628	23%	1996	52%

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?



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