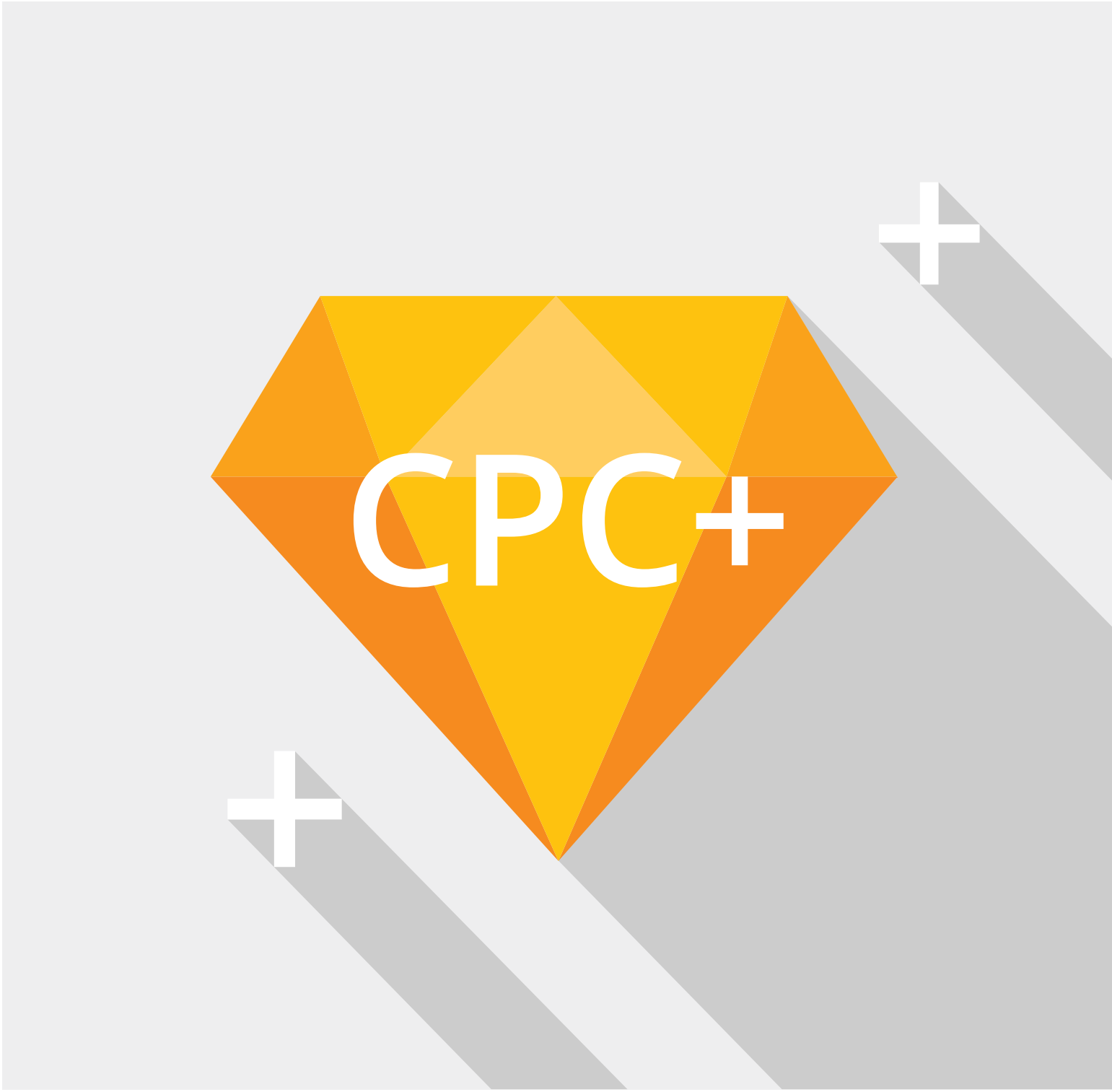



caresync

A GUIDE TO CPC+:

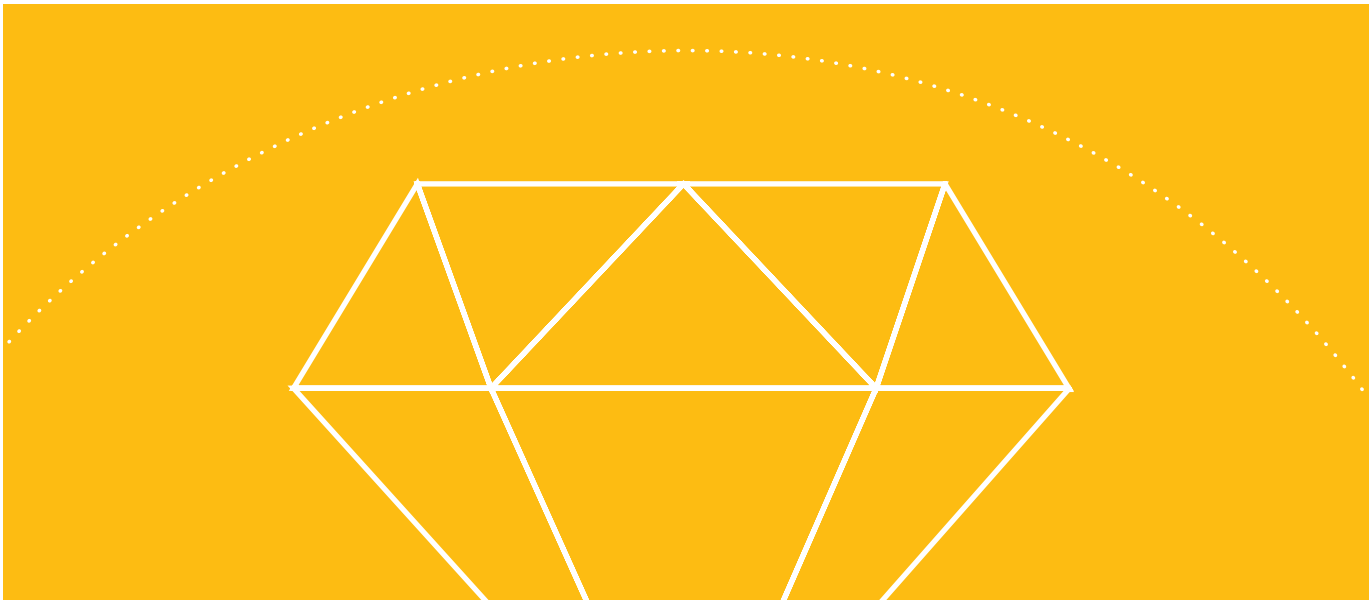
# Getting Back to the Business of MEDICINE

# Overview

Comprehensive Primary Care Plus (CPC+), a national advanced primary care medical home model, has been described by the Centers for Medicare and Medicaid Services (CMS) as the "largest-ever initiative to improve primary care in America."

To participate in CPC+, primary care practices transform how they deliver care and public and private payers transform how they pay for care.

This guide will not only help you understand the requirements of CPC+, but also ways you can maximize your performance and reimbursements. Plus, you'll discover how a program like CPC+ moves us all closer to an individualized, value-based healthcare system that improves health outcomes and lets doctors get back to the business of medicine.



# Table of Contents

# What Is CPC+?

> The CPC+ model represents a fundamental change in the way primary care practices and payers do business with each other.

CPC+ is a national advanced primary care medical home model. Combining regionally-based multi-payer payment reform and care delivery transformation, **the CPC+ model represents a fundamental change in the way primary care practices and payers do business with each other.**

It reorganizes and enhances care delivery to support truly patient-centered care. It allows for measurable, robust data to drive quality improvements, inform clinical and practice decisions, identify high risk patients, and manage population health. **And it makes it easier than ever for clinicians to provide and be rewarded for the type of comprehensive, "whole-person" care they have always wanted to give.**

For some clinicians, it can even help them feel like they are getting back to the "patient-first" ideals that originally drew them to primary care, before issues like lack of cash flow, limited resources, mountains of paperwork, and limited time got in the way.

## HIGHLIGHTS OF THE PROGRAM

### Important things to note about CPC+ include the fact that it:

+ Builds upon the successes of the original Comprehensive Primary Care initiative (CPCi) that CMS launched in late 2012 and input from the 2015 Request for Information on Advanced Primary Care Model Concepts
+ Leverages payment redesign that focuses on creating greater cash flow and flexibility for primary care practices that deliver on the promise of high quality care, efficient resource use, and lower costs
+ Includes care delivery redesign, supported by multi-payer alignment, health information technology (health IT), and cost and utilization data, to ensure practices have the necessary infrastructure and care processes in place to be successful
+ Integrates many lessons learned from CPCi, including insights into practice readiness, care delivery redesign, performance-based incentives, health IT, and claims data sharing with practices

> CPC+ allows practices to provide more comprehensive care that meets the needs of all patients, particularly those with complex needs.

+ Holds practices accountable for the cost and quality of the care their patients receive

+ Allows practices to provide more comprehensive care that meets the needs of all patients, particularly those with complex needs

+ Encourages the following payer partners to align payment models and work together to support primary care practices:
  - Medicare
  - Commercial insurance plans
  - Medicare Advantage plans
  - Medicaid/CHIP managed care plans
  - Medicare Fee-For-Service (FFS)
  - Admins of self-insured groups
  - Self-insured businesses
  - Public employee plans
  - Medicaid/CHIP state agencies

+ Allows providers to deliver the type of care they believe will yield the best possible health outcomes and pays them for achieving those results

+ Aligns payment incentives with the changes needed to provide high quality, whole-person, patient-centered care

+ Supports the goal of having 50 percent of all Medicare fee-for-service payments made via Alternative Payment Models (APMs) by 2018

+ Makes major strides toward achieving the core objectives of Delivery System Reform: better care, smarter spending, and healthier people

+ Provides participating practices with robust learning tools and actionable patient-level cost and utilization data to guide their decision making

+ Provides a secure web portal where CPC+ practices will report their progress regularly, giving both practices and CMS insight into practice capabilities and program success

# CPC+ MAKES MAJOR STRIDES TOWARD ACHIEVING THE CORE OBJECTIVES OF DELIVERY SYSTEM REFORM:

## BETTER CARE

## SMARTER SPENDING

## HEALTHIER PEOPLE

## CPC+ AND MACRA

CPC+ is considered an Advanced APM in the Quality Payment Program (QPP) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This means CPC+ practices have the opportunity to qualify for the Advanced APM incentive payment and avoid participation in the Merit-Based Incentive Payment System (MIPS).

# CPC+ By The Numbers

## 2 TRACKS

CPC+ accommodates practices at different levels of "transformation readiness" by offering two program Tracks.

CMS describes Track 1 practices as those that are ready to build the capabilities to deliver comprehensive primary care and better meet the needs of their patients. Track 1 is the most similar to the original CPC model of CPCi, but CMS has incorporated lessons learned with the earlier initiative by refining the eligibility criteria, care delivery requirements, and incentive payment opportunities.

> Each Track features incrementally advanced care delivery requirements and payment options.

Track 2 practices have those capabilities in place, but are ready to increase their comprehensiveness of care by enhancing health IT, heightening their focus on caring for patients with complex medical, behavioral, and psychosocial needs, and creating a network to provide whole-person care, such as community resources, services that address psychosocial needs, outreach programs, and support groups.

**In Track 2, practices must be prepared to increase the depth, breadth, and scope of medical care they deliver.** They also face more stringent requirements, including needing a Letter of Support from their health IT vendor(s) that outlines the vendor's commitment to support the practice in making health IT enhancements.

Practices in both Tracks are required to use Certified Electronic Health Record Technology (CEHRT) and are expected to provide more comprehensive and continuous care, with the hope of reducing patients' complications and overutilization, particularly in higher cost settings. This, in turn, is expected to result in higher quality and lower cost of healthcare overall.

**Each Track features incrementally advanced care delivery requirements and payment options.** Practices cannot move between Tracks during the five-year model.

Although CMS expects practices will participate in CPC+ for the full five years of the model, participation in CPC+ is voluntary. Practices may withdraw from the model during the five-year program by notifying CMS at least 90 calendar days before the planned day of withdrawal. Departing the program before completion of a performance year puts a practice at risk for recoupment of the prospectively paid performance-based incentive payment.

# 2 ANNOUNCED ROUNDS

Round 1 of this 5-year multi-payer model began on January 1, 2017, and runs through 2021.

## The makeup of Round 1 includes:

+ 14 regions (some "regions" are statewide, like Tennessee, while others are more localized, such as the greater Kansas City region):
  - Arkansas: Statewide
  - Colorado: Statewide
  - Hawaii: Statewide
  - Kansas and Missouri: Greater Kansas City Region
  - Michigan: Statewide
  - Montana: Statewide
  - New Jersey: Statewide
  - New York: North Hudson-Capital Region
  - Ohio: Statewide and Northern Kentucky Region
  - Oklahoma: Statewide
  - Oregon: Statewide
  - Pennsylvania: Greater Philadelphia Region
  - Rhode Island: Statewide
  - Tennessee: Statewide
+ 54 payers aligning on payment, data sharing, and quality metrics
+ Nearly 2,900 primary care practices of all sizes and ownership structures, including 1,056 small practices with under 3 clinicians, 781 independently owned practices, 467 rural practices, and 408 practices that previously participated in CPCi
+ More than 13,000 primary care clinicians, including doctors, nurse practitioners, and physician assistants
+ Approximately 1.75 million attributed Medicare beneficiaries in CPC+
+ 1,378 practices participating in Track 1
+ 1,515 practices participating in Track 2

Round 2, also a 5-year multi-payer model, will begin January 1, 2018, and run through 2022. Round 2 will expand the program to 4 new regions, including the Greater Buffalo Region (Erie and Niagara Counties) of New York, as well as the states of Louisiana, Nebraska, and North Dakota. Eligible practices located in these new regions may apply to participate in Round 2 by July 13, 2017.

# 5 CARE DELIVERY FUNCTIONS

Practices that participate in CPC+ are expected to deepen their ability to provide comprehensive primary care throughout the five-year model. There are incremental care delivery requirements that will serve as the framework for how they will do this.

## These "corridors of action," as CMS has called them, will guide practices through the 5 Comprehensive Primary Care Functions of CPC+:

+ Access and Continuity
+ Care Management
+ Comprehensiveness and Coordination
+ Patient and Caregiver Engagement
+ Planned Care and Population Health

*These additions will be discussed in more detail in a separate chapter.*

# 3 PAYMENT INCENTIVES

Delivering better care at lower cost requires healthcare providers to make fundamental changes in their day-to-day operations. Incentivizing them to do so through payments is only one part of the equation.

To ensure success with an APM or other payment reform, you need buy-in among the payers involved. The more a provider has to navigate different payment strategies for different payers, the less incentive there is to make changes. But if payers work together and agree to collectively align their payment strategies, barriers are removed and the benefits of committing to the changes needed are increased.

This is the idea behind CPC+ multi-payer reform. **Aligning the way all payers involved with a practice pay allows every patient in the practice to participate in CPC+, not just the Medicare patients.** This is also the reason CMS selected CPC+ regions based on payer interest and market density… to ensure sufficient payer supports would be in place for participating practices.

## In CPC+, payer partners are expected to:

+ Align with the CMS payment model
+ Participate in multi-payer collaboration within a region around data sharing and aggregating data reports
+ Achieve multi-payer alignment within a region for cost, utilization, quality, and patient experience metrics
+ Provide attribution lists

## In addition, payer partners are encouraged to:

+ Support practices in both Tracks
+ Share attribution methodologies
+ Regularly provide CMS with data for model evaluation and monitoring

## The three payment methods that are part of the CPC+ program are:

+ Care Management Fee (CMF)
+ Performance-Based Incentive Payments (PBIP)
+ Payment Under the Medicare Physician Fee Schedule (PFS)

*Details about these three payment methods and payer support will be covered in the next chapter.*

# Payment Methods

CPC+ offers three payment elements, including incentives for providing higher quality of care. Payment designs vary slightly between Track 1 and Track 2.

The following information about the three types of CPC+ payments is sourced from CMS' CPC+ FAQs and payment methodology information.[1]

## CARE MANAGEMENT FEE

As part of CPC+, practices are expected to provide "wrap-around" primary care services. CMFs are prospective monthly fees (paid quarterly) designed to support the non-visit-based and historically non-billable services involved in doing so. According to CMS, "These include activities to improve care coordination, implement data-driven quality improvement, and enhance targeted care management for patients identified as high risk."

### The CMF amount practices receive from CMS is determined by:

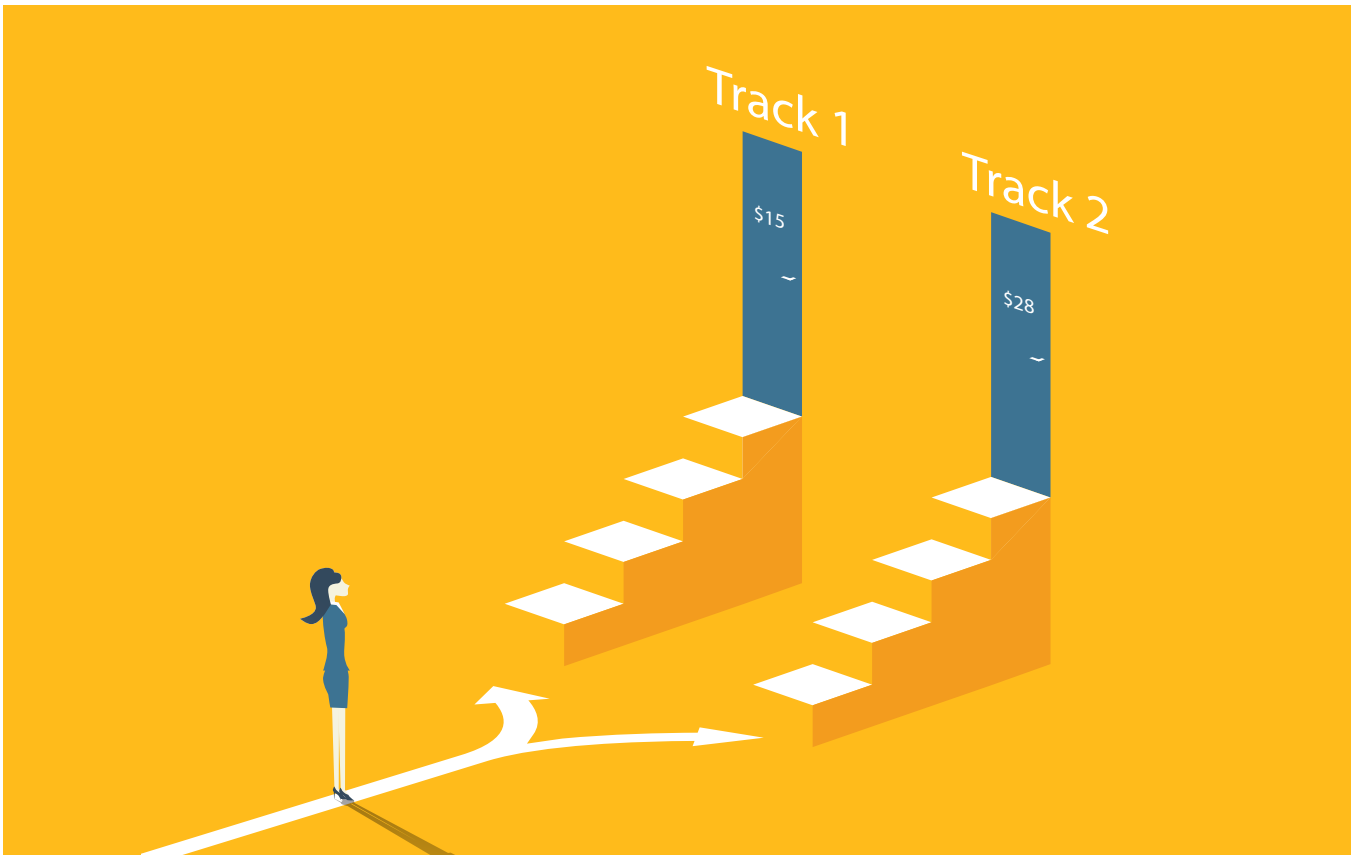
+ The number of beneficiaries attributed to a given practice per month
+ The risk case mix of the attributed beneficiary population
+ Which CPC+ Track the practice is on

[1] CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule, Version 2, February 17, 2017, CMS; CPC+ Practice Frequently Asked Questions, CMS

CMS assigns beneficiaries to risk tiers to determine the CMF payment amount. Because practices that serve more high-risk beneficiaries will need to provide more intensive care management and practice support, **the CMF amount is risk-adjusted to reflect the attributed population's risk level.**

For Track 1, the CMF is based on four risk tiers with an average of $15 per beneficiary per month (PBPM) across the four tiers.

For Track 2, the CMF is based on five risk tiers with an average of $28 PBPM. This includes an additional complex risk tier that pays $100 PBPM to support the enhanced services beneficiaries with complex needs require. Complex beneficiaries who fall within the top 10% of the risk score pool and those who, based on Medicare claims, have a diagnosis of dementia will be assigned to the highest risk tier.



## Other things to note about CMFs:

+ To be eligible for attribution to a CPC+ practice in a given quarter, beneficiaries must meet several criteria three months prior to the start of the quarter. These criteria include: enrolled in Medicare Parts A and B; Medicare as primary payer; not have end stage renal disease (ESRD) and not enrolled in hospice[2]; not covered under a Medicare Advantage; or other Medicare health plan; not long-term institutionalized; not incarcerated; and not enrolled in any other program or model that includes a Medicare FFS shared savings opportunity, except for the Medicare Shared Savings Program.
+ Beneficiary risk score is based on the CMS Hierarchical Condition Categories (CMS-HCC) prospective risk adjustment model. The CMS-HCC model predicts medical expenditures based on demographics and diagnoses, where medical expenditures in a given year are predicted using diagnoses from the prior year.
+ CMS will need to debit the CMF paid to correct for overpayments or duplicate payments quarterly.
+ CPC+ payer partners are expected to provide non-visit based financial supports to practices based on their own methods.

### Risk Tier Criteria and CMF Payments (per beneficiary per month)

| Risk Tier | Risk Score Criteria | Track 1 | Track 2 |
|---|---|---|---|
| Tier 1 | Risk score < 25th percentile | $6 | $9 |
| Tier 2 | 25th percentile ≤ risk score < 50th percentile | $8 | $11 |
| Tier 3 | 50th percentile ≤ risk score < 75th percentile | $16 | $19 |
| Tier 4 | Track 1: Risk score ≥ 75th percentile<br>Track 2: 75th percentile ≤ risk score < 90th percentile | $30 | $33 |
| Tier 5<br>(Track 2 only) | Risk score ≥ 90th percentile<br>or Dementia diagnosis | N/A | $100 |

*Source: CMS*

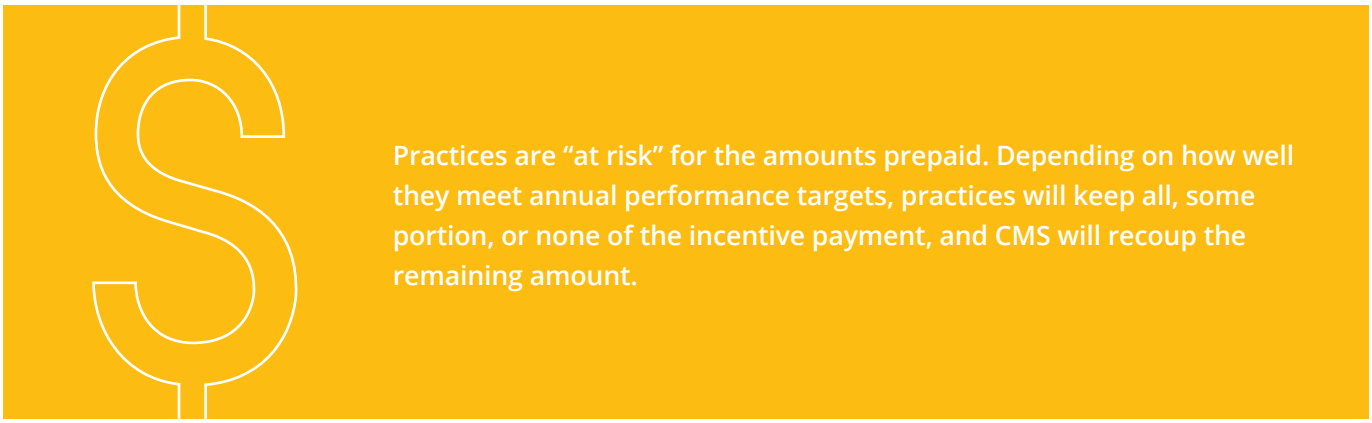
[2]Note that this criterion only applies to beneficiaries that have not been attributed to the CPC+ practice previously—if the beneficiary has been attributed to the CPC+ practice previously, then developing ESRD or enrolling in hospice does not disqualify a beneficiary from being attributed to the CPC+ practice.

# PERFORMANCE-BASED INCENTIVE PAYMENTS

Annually, CMS will prospectively pay a PBIP to CPC+ practices for each attributed beneficiary. PBIPs are used to encourage and reward accountability for clinical quality, patient experience of care, and utilization measures that impact total cost of care.

## The amount of PBIP earned is determined by:

+ The number of beneficiaries attributed to a given practice per month
+ The CPC+ Track to which the practice belongs
+ The practice's performance on the measures listed above



**Practices are "at risk" for the amounts prepaid. Depending on how well they meet annual performance targets, practices will keep all, some portion, or none of the incentive payment, and CMS will recoup the remaining amount.**

For Track 1, PBIP payments are $2.50 PBPM ($1.25 PBPM on quality/patient experience of care and $1.25 PBPM on utilization performance). For Track 2, PBIP payments are $4 PBPM ($2 PBPM on quality/patient experience of care and $2 PBPM on utilization performance).

## Other things to note about PBIPs:

+ PBIPs are paid to practices in both Tracks at the beginning of each program year.

+ After each program year ends, CPC+ will retrospectively reconcile the amount of PBIP that a practice earned.

+ Practices will be compared to performance thresholds derived from the reference population. The incentive payments will be calculated using a continuous approach with a minimum and a maximum score. Practices that score under the minimum earn none of the incentive, while practices that score above the maximum earn the entire incentive.

+ There are two components of performance: quality (including patient experience of care) and utilization. Quality and utilization will be scored and financially reconciled separately.

+ CMS measures quality via patient experience of care surveys and Electronic Clinical Quality Measures (eCQMs).

+ CMS plans to measure utilization via risk-adjusted inpatient admissions and emergency department visits. Practices don't have to calculate or report these measures as CMS will use claims to do this. As the program evolves, additional utilization measures may be used.

+ Practices participating in both CPC+ and in a Medicare Shared Savings Program Accountable Care Organization (ACO) will not receive a PBIP. Instead, they will be eligible to earn shared savings under the ACO's arrangement with the Shared Savings Program.

+ CPC+ payer partners are expected to provide their own form of incentives to practices based on quality, patient experience, utilization, and/or cost of care.

# PAYMENT UNDER THE MEDICARE PFS

Track 1 practices will continue to bill and receive payment from Medicare FFS as usual.

Track 2 practices will receive a hybrid of Medicare FFS payments and a Comprehensive Primary Care Payment (CPCP). This hybrid payment, made quarterly, compensates practitioners for clinical services that have traditionally been billable, but offers flexibility for these services to be delivered inside or outside of an office visit.

The CPCP is an upfront payment for a percentage of expected Medicare payments for evaluation and management (E&M) services provided through the Medicare PFS to attributed beneficiaries. E&M visits billed during the program year will be correspondingly decreased. All other services will be paid according to the Medicare PFS and are not included in the CPCP.

## Other things to note about the hybrid payment:

+ The goal is to achieve incentive neutrality so a practitioner can choose to deliver a service in person or via another modality to meet patient preferences.

+ The flexibility is meant to allow more time for practices to focus on population health improvement and increasing the breadth and depth of services provided at the practice site.

+ CPC+ payer partners are expected to alter their payment structures accordingly, aligning their payments with the goal of the CPCP.

## RECONCILING SPEND

As CMS has stated, "CPC+ practices will be required to both forecast their spending of the CMF and CPCP and, at the end of the performance year, provide an account of actual CMF and CPCP revenue received and actual expenditures. This reporting will help practices understand and optimize their use of these alternative payments and will also help CMS to understand how practices use the revenue they receive from Medicare to perform the care delivery work the model requires."

## PARTICIPATING PAYER SUPPORT

It is important to note CMS intends for the care delivery transformation CPC+ practices make to be practice-wide for the benefit of all patients, not just Medicare beneficiaries. To facilitate this, **CMS has solicited payer partners to collectively support the model and the way it transforms payments to primary care practices.**

CMS has made specific commitments to how it will pay practices in Track 1 and Track 2 of CPC+, but it does not control what payer partners do. Payers do not have to implement the same model design approach as CMS. Instead, CMS asks that payers "align" their approach with CMS.

As CMS has stated in its Payer Solicitation FAQs, "CMS' goal in CPC+ is to align with all payers on key payment, quality, and data-sharing elements. By alignment, CMS means that, for each payer in the model, these elements need not be identical, but should be oriented so that the practice incentives and goals are consistent across all payers partnering in the model. CMS also wants to ensure that the model allows for sufficient flexibility for payers to implement approaches that are aligned with the needs of their members and/or beneficiaries." [3]

[3] https://innovation.cms.gov/Files/x/cpcplus-payersolicitationfaq.pdf

To that end, the commitment participating payers in the CPC+ model make to financially supporting practices is outlined in CMS' Memorandum of Understanding (MOU) with the payers.[4] The following information is sourced from that MOU. In it, payers agree to provide enhanced financial support for participating primary care practices in the following ways:

1. **Non-visit-based financial support:** Payers will provide enhanced non-visit-based financial support to participating practices that provide health services to the payer's attributed members. "The amount of this financial support will be larger for Track 2 participating practices than it will be for Track 1 participating practices."

2. **Performance-based incentive payments:** Beginning in the first performance year of the model, payers will offer participating practices PBIPs "using a methodology designed to assess the practice's performance on measures of utilization, cost of care, and/or quality of care during a 12-month performance period."

3. **Alternative to visit-based reimbursement methodology (Track 2 only):** No later than 12 months after the start of the model, payers will begin to reimburse Track 2 participating practices for care furnished to the payer's members "using, at least in part, a reimbursement methodology that is different from its current, visit-based, reimbursement methodology." The reimbursement methodology the payers use "will allow these participating practices flexibility to deliver traditional face-to-face care outside of an office visit."

The level and method of financial support payers commit to providing practices in each Track is detailed by the payer in an Appendix to the MOU with CMS. The MOU is a public document, with the exception of the payer's intended financial commitments provided in the Appendix, which CMS considers proprietary in nature.

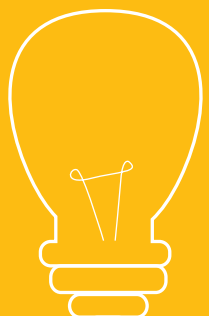
[4] https://innovation.cms.gov/Files/x/cpcplus-payermou.pdf

# Comprehensive Primary Care Functions

## ACCESS AND CONTINUITY

A hallmark of effective primary care is a trusting and continuous relationship built among patients, their family members, their caregivers, the provider, and the practice staff. Not only do patients feel more comfortable when there is continuity of care, but they also benefit when there are multiple points of access to primary care and the members of their care team.

Practices in both Tracks will need to meet certain requirements in the Access and Continuity category, including ensuring patients have 24/7 access to care by their care team (or covering care team) members with real-time access to the electronic medical record. To make care more accessible, practices might offer e-visits, phone visits, group visits, or home visits. They could provide 24/7 telephone or electronic access to a specific member of the care team, offer telemedicine services, extend practice hours for in-person access, or ensure patients have a simple way to get guidance for urgent needs day or night.



**The idea is that the more access a patient has to primary care and members of their care team (who know them and their needs best), the more likely they'll get the care they need when they need it, and the less likely they'll turn to expensive urgent care or find themselves needing emergency care.**

Goals associated with this function include providing expanded access to primary care services, ensuring the practice's patient population is empaneled, and organizing care by teams to optimize continuity.

# CARE MANAGEMENT

In addition to managing the care of their entire patient base, CPC+ practices will place significant emphasis on providing targeted care management for their high-risk, high-need patients.

Practices will first empanel all of their active patients to practitioners or care teams, and then systemically risk stratify their patient population. **They'll identify which high-risk patients will likely benefit the most from proactive, relationship-based (longitudinal) care management.** And they'll identify event triggers, such as transitions in care or a new diagnosis, which will allow them to provide episodic (short-term) care management regardless of risk status.

In addition, to better meet the needs of high-risk, high-need patients, Track 1 practices are expected to build capabilities in behavioral health, self-management support, and medication management. **Track 2 practices will provide more intensive care management and expand practice capabilities in assessing and managing patients with complex needs.**

The approach practices take in managing the care of their patients will also be guided by analysis of both practice and payer data, and a care plan that takes into account goals and strategies that are aligned with a patient's desires and values.

Goals associated with this function include providing longitudinal and episodic care management, supporting patients through transitions in care, and targeting care management based on risk stratification.

## COMPREHENSIVENESS AND COORDINATION

Comprehensiveness in primary care is about meeting the majority of patients' medical, behavioral, and psychosocial needs. Coordination is about facilitating and managing the care involved in doing so.

### Some of the ways CPC+ practices can achieve comprehensiveness and coordination include:

+ Leveraging analytics to identify population health needs and the best ways to meet those needs
+ Ensuring patients have access to services through the practice or through an established network of providers, community-based resources, and other support systems
+ Improving how transitions in care are experienced, from interactions with specialists and other referral sources, to hospital and emergency room discharges
+ Building capabilities outside of the practice, with services like care coordination
+ Improving transitions in care and the way their patients experience them by working more closely with hospitals and emergency departments
+ Establishing good working relationships with high volume specialty service providers
+ Identifying community or social services resources that can be helpful to patients and referring them to these resources as appropriate
+ Recognizing that some health-related issues are precipitated by previously unmet social needs, and learning how to spot and resolve those unmet social needs


Goals associated with this function include building strong and coordinated referral networks, making healthcare easier to navigate, using resources effectively, and identifying ways to improve health outcomes and lower overall costs.

## PATIENT AND CAREGIVER

**Achieving optimal health outcomes is a team effort.** Naturally, this includes putting patients at the center of their care and actively involving them, their families, and their caregivers in the management of the patient's health, the creation of the care plan, and the best ways to improve care delivery.

To take it a step further, CPC+ practices will need to establish a Patient and Family Advisory Council (PFAC). The PFAC is designed to help practices gain insight from patients and caregivers about delivery of care, the effectiveness of their services, and any recommendations they might have. Practices will then use the recommendations to guide their decisions about improving patient care and service offerings.

Goals associated with this function include getting patients and their caregivers engaged in care decision-making, and providing care that is driven

## PLANNED CARE AND POPULATION

Care is expected to meet the needs of the entire patient population and be organized, team-based, and proactive.

**CPC+ practices in both Tracks will provide timely and appropriate preventive care and evidence-based management of chronic conditions.** They'll need to understand their patient population and learn to measure and act on the quality of care they provide at both the practice and panel level. Care gaps in population health will be identified and improved.

Finally, practices in Track 2 will need to integrate support for self-management of care and understand the health disparities in their population.

A goal associated with this function is leveraging data to determine strategies that will improve population health.

# Care Delivery Requirements

> Over the course of the program, the care delivery requirements in each of the five functions will evolve and deepen.

While the same functions are required for practices in both Tracks, the intensity and focus of delivery differs in each Track. Track 1 practices will add the services behind the five functions to visit-based, FFS care. Track 2 practices will be expected to offer more comprehensive care overall by redesigning the visit and non-visit based care (e.g., phone, email, text message, secure portal) they provide.

The following reflects the care delivery requirements for the first year of CPC+ (PY2017). Over the course of the program, the care delivery requirements in each of the five functions will evolve and deepen.

## Care Delivery Requirements 2017

### Access and Continuity

#### TRACK 1

Achieve and maintain at least 95% empanelment to practitioner and/or care teams.

Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.

Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity.

#### TRACK 2

In addition to the three requirements under Track 1, Track 2 practices will do the following:

Regularly offer at least one alternative to traditional office visits to increase access to the care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends.

# Care Management

## TRACK 1

Risk stratify all empanelled patients.

Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management.

Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empanelled patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management.

Ensure patients with ED visits receive a follow-up interaction within one week of discharge.

Contact at least 75% of patients who were hospitalized in target hospital(s) within two business days.

## TRACK 2

In addition to all but the first requirement under Track 1, Track 2 practices will do the following:

Use a two-step risk stratification process for all empanelled patients:

Step 1 - based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition);

Step 2 - adds the care team's perception of risk to adjust the risk stratification of patients, as needed.

Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management.

## Comprehensiveness and Coordination

### TRACK 1

Using CMS/other payer's data, systematically identify high-volume and/or high-cost specialists serving the patient population.

Using CMS/other payer's data, identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer.

### TRACK 2

In addition to the two requirements under Track 1, Track 2 practices will do the following:

Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer's reports.

Choose and implement at least one option from a menu of options for integrating behavioral health into care.

Systematically assess patients' psychosocial needs using evidence-based tools.

Conduct an inventory of resources and supports to meet patients' psychosocial needs.

Characterize important needs of sub-populations of high-risk patients and identify a practice capability to develop that will meet those needs and can be tracked over time.

## Patient and Caregiver Engagement

### TRACK 1

Convene a PFAC at least once in PY2017 and integrate recommendations into care, as appropriate.

Assess the practice's current capabilities in supporting patient self-management, and plan for how they will support it moving forward.

### TRACK 2

Convene a PFAC in at least two quarters in PY2017 and integrate recommendations into care, as appropriate.

Implement self-management support for at least three high risk conditions.

## Planned Care and Population Health

### TRACK 1

CMS and other payers will provide feedback reports at least quarterly on at least two utilization measures at the practice-level. They will also provide practice data on at least three electronic clinical quality measures (derived from the EHR) at both the practice- and panel-level. Track 1 practices will use the feedback reports to inform strategies to improve population health management.

### TRACK 2

In addition to the requirement listed under Track 1, Track 2 practices will do the following:

Conduct care team meetings at least weekly to review practice- and panel-level data from payers and internal monitoring. They will use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.

# The Use of Data in CPC+

CPCi, which involved payers in seven regions, tested whether the support of multi-payer payment reform, improvement guided by the continuous use of data, and the meaningful use of health IT could help primary care practices achieve the triple aim: **better care, smarter spending, and healthier people.**

One of the lessons learned was that aggregated data does indeed help clinicians get a bigger picture of their patient population so they can identify care gaps and target areas for population health improvement. Additionally, it helps reduce unnecessary burdens on the staff, saving them time, and helps primary care providers deliver higher quality care.

This is one of the reasons data is such a huge part of CPC+ and why there is

## DATA SHARING REQUIREMENTS

### Data sharing requirements associated with CPC+ include:

+ In an effort to motivate performance improvements, performance results of each practice will be published openly (not blind) by CMS and provided to all CPC+ practices
+ CMS will provide feedback data from Medicare FFS cost and utilization data quarterly
+ CMS expects payer partners to provide their FFS cost and utilization feedback data quarterly as well
+ CMS expects payer partners to regularly provide practices with lists of attributed members
+ CMS expects payer partners to, upon request, provide relevant claims and costs data (part of MOU with CMS)
+ CMS will work to align or aggregate data sharing with payers where possible

# IDENTIFYING AND LEVERAGING ACTIONABLE DATA

Along with cost and utilization data from CMS and other payers, CPC+ practices will generate their own data about their patients individually and as a patient population. They'll have data that supports their attribution list as well as the efficiency of their workflows. And they'll have the type of data that is generated through the nature of care coordination and the collection of medical histories… data that informs them about the patient population's between-visit approach to self-management and adherence to their care plan.

How will they leverage data to improve the health of their patient population, enhance care delivery, engage patients and caregivers, and alter processes and workflows? With risk stratification tied to how they coded in the last 12 months, how can they determine if they have under-coded patients? Is there data to support patients being on their attribution list that aren't?

**With so much useful data associated with CPC+, participating practices should consider how they will operationalize all that data** and whether or not they want a strategic partner to help them identify which data is actionable and which quality improvement activities should rise to the top.

# Ways to Boost CPC+ Practice Performance

**Medicare is counting on the CPC+ program to change the way primary care is delivered and reduce the financial burden on the healthcare system.** The physicians and nurses at these practices are deeply committed to supporting those goals, but their resources are often stretched thin. How do they make the most of this opportunity so they can serve as role models for healthcare system reform without compromising the services they currently deliver? This chapter covers tips to help CPC+ practices optimize their efforts.

## BUILD A NETWORK OF SERVICES

Providing comprehensive care, including prevention, wellness, acute care, and chronic care, brings added revenue and value to the practice. To do it effectively requires providing access to a team of healthcare professionals. That team might be made up of physicians, physician assistants, nurses, advanced practice nurses, pharmacists, social workers, care coordinators, nutritionists, and more.

Whether a CPC+ practice brings together such a team under one roof or does it through a network of healthcare professionals, community service providers, and companies that deliver care coordination services on the practice's behalf, the point is to ensure patients have access to comprehensive care in a manner that achieves continuity. **The more practices are able to partner with and count on other resources, the more time they will have to focus on building meaningful patient relationships and increasing practice revenue.**

## BE PATIENT-CENTRIC

Make sure everyone involved in the patient's care understands and respects that each patient is a unique individual, with his or her own needs, culture, values, and preferences to take into consideration when providing care.

Don't just build relationships with patients. Become true partners with them, their caregivers, and any family members they choose to be involved in their care. Demonstrate that their opinions and suggestions are valuable to the practice. Invite input. Support patients in understanding their care needs and learning to manage or organize their own care at a level they are comfortable with.

**To be truly patient-centric, everyone involved in the patient's care should be treated as a core member of the care team and as a fully informed partner in determining how care should be delivered.**

## ENHANCE QUALITY AND SAFETY

Making a significant commitment to providing safe, high-quality care includes practicing population health management, and publicly sharing quality and safety data. It involves using evidence-based medicine and the aid of clinical decision support tools to help engage and guide patients and their family members in making decisions about care. It also involves measuring performance, patient experiences, and patient satisfaction, and being accountable for making improvements.

Capturing a patient's between-visit data through care coordination services can also help improve patient safety and quality of care. Gaining insight into how well a patient is adhering to a medication regimen or following through on referral appointments and tests allows physicians to take action and try to resolve concerns before they become complications.

**Additionally, services that aggregate a patient's medical records and reconcile medications across multiple providers can help prevent potential, possibly fatal, drug interactions.**

# SUPPORT THE USE OF HEALTH IT

CPC+ practices must embrace health IT for quality improvements and data-driven change. Adopting health IT is like adopting any other new core value, function, or process for an organization - it has to happen on a practice culture level. **Simply deciding to use health IT or directing others to use it is only part of the equation. Leadership has to champion the cause.**

This involves ensuring everyone understands the value health IT brings to the practice, such as the ability to provide "actionable" data that can be tracked, measured, and shared. This data can be used to help practices streamline their processes and workflows and determine which changes will be meaningful to the practice, the staff, and the patients. It can help the practice set performance expectations and hold individuals accountable for meeting goals. And it can spotlight areas where improvements have been made and where patient outcomes have been improved.

This can lead to successful efforts being duplicated across the practice, a higher level of job satisfaction for practice team members, and a higher level of satisfaction for patients.

# HELP PATIENTS NAVIGATE THE HEALTHCARE SYSTEM

CPC+ practices need to recognize that in a fragmented healthcare system, patients are often left navigating the points between care on their own.

To improve patient health, reduce costs, and truly transform healthcare in this country, patients need their care coordinated across the healthcare system and their entire healthcare journey. This means coordinating care with any specialists or other healthcare providers the patient sees and managing transitions in care, such as between physician offices, or when patients are discharged from a hospital and need follow-up care or home health services.

Choosing a care coordination company that works closely with the practice to deliver between-visit care to patients - one that follows provider preferences and protocols to ensure continuity of care, integrates with the practice's certified EHR, and acts a true extension of the practice - is an allowable expense for CPC+.

**The ideal care coordination company can leverage not just technology, but human resources on a practice's behalf.** They support patients and providers by coordinating care across all members of the care team, creating and maintaining individualized care plans, consolidating medical histories, encouraging self-management and care plan adherence, providing medication reconciliation, supporting Transitional Care Management, and more. And their ability to offer streamlined workflows, proven patient engagement tools, and services that boost the bottom line make them an integral part of the practice's care team.

# CPC+ and Care Coordination

The care coordination solutions CareSync™ has offered since 2011 are at the heart of CPC+ and are aligned with the program's care delivery requirements and quality and utilization measures.

We offer specific clinical protocols to support CPC+ measures and meet reporting requirements, technology that seamlessly integrates with all certified EHRs, 24/7/365 access to a team of compassionate healthcare professionals, and unparalleled support in delivering high quality, whole-person, patient-centered care.

By choosing CareSync to support their CPC+ program, practices in either Track benefit from the knowledge and experience we've gained caring for a patient population across more than 40 states and over 1,000 contracted physicians.

## We can help CPC+ practices:

+ Coordinate care for all risk groups
+ Provide longitudinal and episodic care management
+ Evaluate and maximize cost and utilization data
+ Identify clinical practice and quality improvement opportunities
+ Ensure continuity of care by following practitioner preferences and protocols
+ Empower patients to be active participants in their care
+ Facilitate patient self-management
+ Support collaborative care agreements and close the feedback loop
+ Determine appropriate risk stratification
+ Take action on PFAC recommendations, goals, and plans
+ Provide Chronic Care Management (CCM) services to unattributed patients, a precursor to CPC+ attribution
+ Expand their scope and breadth of services with offerings such as Annual Wellness Visits, Transitional Care Management, and care coordination for non-Medicare patients

In addition, CareSync makes it easy for CPC+ practices to reconcile spend of their Care Management Fees. CMS stated, "CPC+ CMFs are intended to pay for CCM covered services." As the leader in providing CCM services under Medicare, CareSync has the staff, capability, and scalability to deliver what CPC+ practices need throughout the five-year program and help them not just succeed with CPC+, but excel.

**CPC+ changes the way clinicians approach primary care, payers pay for it, and patients experience it. Let CareSync help you change the way you deliver on its promise.**

**Call us at 800-501-2984 or email us at sales@caresync.com.**

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800-501-2984
sales@caresync.com
www.caresync.com

**Disclaimer**

At the time this guide was published or uploaded to the web, the information included was current. This guide was written to provide you with a general summary of CPC+ and is not intended to take the place of written laws or specific statutes as they evolve. CareSync encourages you to visit CareSync.com and CMS.gov for updates regarding CPC+.

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