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The Comprehensive Primary Care Plus Model

OVERVIEW

On April 11th, the Centers for Medicare and Medicaid Services (CMS) announced that the Comprehensive Primary Care Plus (CPC+) model will succeed the existing Comprehensive Primary Care (CPC) initiative, which is due to expire on January 1, 2017. The new advanced primary care medical home model will be tested through the Center for Medicare and Medicaid Innovation in up to 5,000 practices across 20 to-be-selected regions. To support participating primary care practices in the implementation of delivery redesign and payment reform, CMS will partner with multiple public and private payers, including: commercial insurers, Medicare Advantage, Medicaid fee-for-service (FFS), and Medicaid managed care. CMS will not fund these payers but will align payment methodologies and program requirements so all payers benefit by making aligned investments in practices committed to transformation.

More information on CPC+ can be found in the Request for Applications, available here.

ADVANCED CARE DELIVERY REDESIGN

Under the new model, practices will participate in one of two tracks. Practices in both tracks will be expected to deliver the Five Comprehensive Primary Care Functions currently prioritized in the existing CPC model: Care Management; Access and Continuity; Planned Care for Population Health; Patient and Family Caregiver Engagement; and Comprehensiveness and Coordination.

The care delivery requirements and payment methodologies of Track 1 will be similar to those in the original CPC model. The requirements and payment structure of Track 2 will be more challenging than Track 1, but Track 2 practices will be eligible to earn higher performance-based incentive payments. Practices will apply to a specific track, but CMS may invite a practice to participate in Track 1 if it is determined the practice cannot meet the more advanced requirements of Track 2.

Track One

Care Delivery Requirements:

Track 1 participants will be required to have the support of multiple payers, use Certified Electronic Health Record Technology (CEHRT), and have the ability to deliver the following office-based comprehensive primary care services:

- Enhanced care for patients with serious or chronic diseases;
- 24-hour access to care and health information;
- Preventive care;
- Patient and caregiver engagement; and
- Coordinated care with hospitals and other clinicians.

Payment Structure:

Track 1 practices will be reimbursed with a monthly Medicare care management fee (CMF) on top of regular Medicare FFS payments. The CMF will be risk-adjusted according to the level of need of each attributed FFS beneficiary. There will be four patient risk tiers for Track 1 and the CMF will range from $6 PBPM for Tier 1 to $30 PBPM for Tier 4.

At the beginning of each performance year, participating practices will receive a prospective incentive payment of $30 per beneficiary ($2.50 PBPM). However, practices that do not meet quality and utilization thresholds will have to repay their incentive payment.

Track Two

Care Delivery Requirements:

Track 2 participants will be required to meet all of the eligibility criteria of Track 1 applicants, plus demonstrate the ability to implement advanced Health IT capabilities and serve patients with complex medical, behavioral, and psychosocial needs. Track 2 practices will be required to provide more comprehensive primary care services in the form of office-based visits and non-office-based visits. Additional services include:

- Developing and recording care plans;
- Following up with patients after emergency department or hospital discharge; and
- Implementing a process to connect patients with community-based resources.

Payment Structure:

Track 2 practices will be reimbursed with a monthly CMF that is risk-adjusted according to the level of need of each attributed FFS beneficiary. There will be five patient risk tiers for Track 2 and the CMF will range from $9 PBPM for Tier 1 to $100 PBPM for Tier 5.

In addition to the monthly CMF, Track 2 practices will receive a hybrid combination of Comprehensive Primary Care Payments (CPCPs) and Medicare FFS payments for Evaluation and Management (E&M) services. The CPCPs will be based on historical E&M services among attributed Medicare beneficiaries at each practice and will be paid prospectively in a lump sum on a quarterly basis. The FFS payments will be issued upon claims submission for face-to-face E&M visits. The CPCP is intended to promote flexibility in the delivery of care by reimbursing practices for services that can be rendered outside of the office, but have traditionally required a face-to-face visit under FFS. Over the five performance years, the proportion of CPCPs will incrementally increase, while the proportion of FFS payments will decrease.

Track 2 practices will also be eligible for a performance-based incentive payment in addition to the CMF payment and the hybrid CPCP/FFS payments. At the beginning of each performance year, participating practices will receive a prospective incentive payment of $48 per beneficiary ($4 PBPM). However, practices that do not meet quality and utilization thresholds will have to repay their incentive payment.

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MULTI-PAYER PAYMENT REDESIGN

The CPC+ model requires the participation of multiple payers and CMS requires participating payers to partner with primary care practices in both Track 1 and 2. Payers will be expected to provide the financial support for practices to transform their delivery systems. Payers will further support practices by sharing cost, utilization, and quality data so that practices may better understand the needs of their patient population. As has been the case in the existing CPC model, CMS will not provide any funding to payer partners. Payers will be expected to enter into a private agreement with each practice that they partner with.

Payers that are selected to participate in CPC+ will enter into a Memorandum of Understanding with CMS that documents the payer's commitment to the model's payment methodologies, data sharing, and quality metrics.

REGIONAL SCOPE AND APPLICATION PROCESS

CMS will accept payer proposals from April 15th through June 1st. CPC+ regions will be designated in areas where there is sufficient interest from payers to support the model. Regions that are currently participating in the original CPC, including New York's Capital District and Hudson Valley Region, may be re-selected for CPC+ if there is sufficient interest from payers. CMS also indicates that it will give preference to states participating in Multi-Payer Advanced Primary Care Demonstrations, such as New York and Vermont.

After the CPC+ regions are announced, CMS will accept applications from primary care practices in selected regions from July 15th through September 1st. The five-year model is scheduled to begin on January 1, 2017.