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Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

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Comprehensive Primary Care Plus – A Rural Commentary

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Introduction

The Comprehensive Primary Care Plus (CPC+) program is a new Center for Medicare & Medicaid Innovation (CMMI) initiative designed to advance the Department of Health and Human Services' plan to shift volume-based health care payment (e.g. fee-for-service) to value-based health care payment (e.g., payment that rewards better care, smarter spending, and healthier people). Value-based payment, in turn, is designed to support and advance value-based care. CPC+ will be the largest CMMI investment in primary care to date, and builds on the Comprehensive Primary Care Initiative that ends this year. CPC+ will include up to 5,000 primary care practices, beginning January 1, 2017 and continuing for five years. To expand CPC+ influence, CMMI will encourage multiple other payers (e.g., Medicaid, commercial payers, Medicare Advantage plans, self-insured businesses) to participate in new CPC+ primary care payment strategies. The purpose of this Rural Health Value brief is to review CPC+ program details and provide a rural commentary.

Goals and Function

The CPC+ program is designed to advance the delivery of, and payment for, primary care. This agenda is particularly important to rural providers since the predominant rural practice is primary care focused. CPC+ goals include:

1. Advance care delivery and payment to allow practices to provide more comprehensive care that meets the needs of all patients, particularly those with complex needs.
2. Accommodate practices at different levels of transformation readiness.
3. Achieve the Delivery System Reform core objectives of better care, smarter spending, and healthier people in primary care.[1]

[1] Comprehensive Primary Care Plus. CMMI Webinar. April 19, 2016. https://innovation.cms.gov/Files/x/cpcplus-modeloverviewslides.pdf

The CPC+ has five functions that are characteristic of advanced primary care medical homes, that is, "practices supported by payment, health information technology, and data that transform their delivery of care while accountable for the cost and quality of care their patients receive."[2]

- Access and continuity
- Care management
- Comprehensiveness and coordination
- Planned care and population health
- Patient and caregiver engagement

Tracks and New Payments

CPC+ offers two tracks that differ by initiative requirements and payment strategies. Both tracks require certified electronic health record (EHR) technology[3] utilization, patient assignment to provider panels, 24/7 patient access to the practice, and practice quality improvement activities. In addition to the aforementioned practice capacities, Track 2 requires additional care management and coordination capacity (see details at https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf).

CPC+ introduces a three-part primary care payment system that includes a Care Management Fee (capitation), a Performance-Based Incentive Payment (performance incentive), and an underlying payment structure (fee-for-service). CPC+ Tracks 1 and 2 differ by the proportion each of these three payments contribute to overall Medicare practice revenue. Although other payers are expected to follow a similar payment strategy, CMMI has not stipulated a specific payment structure for other payers.

1. **Care Management Fee** – A prospectively paid, per-beneficiary per-month (PBPM) payment that is patient risk-adjusted. The average PBPM payment is $15 in Track 1 and $18 in Track 2. Track 2 additionally includes a $100 PBPM care management fee for patients with "the most complex needs."
2. **Performance-Based Incentive Payment** – A prospectively paid incentive payment based on clinical quality (and patient experience) and utilization. Performance will be measured for all patients cared for by a practice. Performance data will be submitted via electronic clinical quality measures (eCQMs) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Track 1 provides up $2.50 PBPM incentive payments and Track 2 provides up to $4.00 PBPM incentive payments. Although paid prospectively, the incentive payment will be reclaimed if quality and utilization performance thresholds are not met.
3. **Underlying Payment** – Track 1 will continue to receive established Medicare fee-for-service (FFS) payments based on the Medicare Physician Fee Schedule. Track 2 will receive a hybrid payment that blends a prospectively paid Comprehensive Primary Care Payment (CPCP) and

[2] Sessums, LL, McHugh, SJ, Rajkumar, R. Medicare's Vision for Advanced Primary Care – New Directions for Care Delivery and Payment. *JAMA.* Published online April 11, 2016.

[3] For information regarding, and a list of Certified Electronic Health Record vendors, see The Office of the National Coordinator for Health Information Technology at http://oncchpl.force.com/ehrcert. Accessed May 3, 2016.

a proportionally reduced FFS payment. Track 2 practices will have some flexibility to select the proportion of CPCP and FFS payments that will sum to established Medicare FFS payments.

Timeline

CMMI will first solicit other payers to participate in CPC+ (payer applications accepted April 15, 2016 – June 1, 2016). Additional payer involvement will be important to participating practices; practice success under CPC+ is dependent on participation of a significant proportion of patients (and respective payers) to spread fixed costs of population health care investments. After CMMI determines adequate payer participation, CPC+ regions will be established (CMMI anticipates developing up to 20 regions) and practices within those regions will be invited to apply for either Track 1 or Track 2 (practice applications accepted July 15, 2016 – September 1, 2016). Up to 2,500 practices will be accepted into Track 1 and up to 2,500 practices will be accepted into Track 2. The program will begin January 1, 2017 and extend for five years.

Learning Opportunities

CPC+ will include multiple learning opportunities for practice participants. These include the CPC+ Practice Portal (online tool for reporting and feedback), CPC Connect (web-based platform for CPC+ participants to share practice transformation ideas), and Learning Communities (national and regional conference, webinars, and outreach). Additionally, CPC+ implementation and performance will be evaluated for quality improvement and cost savings.

Rural Commentary

CPC+ is an innovative primary care payment model that supports the volume-to-value transformation in one of the most important components of rural health care – primary care. Primary care practices interested in developing population health capacity, and being rewarded for population health care investments, should be cautiously enthusiastic about CPC+. However, several rural challenges remain.

- **Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are not eligible to participate in CPC+** – CMMI states, "Because FQHCs and RHCs do not submit claims on a Medicare Physician/Supplier claim form (HCFA 1500) and are not paid according to the Medicare Physician Fee schedule for routine office visits, they are not eligible for participation."[4] Since RHCs and FQHCs care for a significant proportion of rural Medicare beneficiaries, RHC/FQHC ineligibility for CPC+ is a critical rural concern.
- **Potentially limited rural participation opportunities due to CPC+ region locations** – The CPC+ regions (to be determined by CMMI based on additional payer participation) may or may not include a representative number of rural practices. This potential rural participation limitation is particularly crucial due to RHC/FQHC ineligibility for CPC+.

[4] https://innovation.cms.gov/Files/x/cpcplus-faqs.pdf and CMMI CPC+ Team reply to email inquiry May 17, 2016.

- **Underdeveloped rural practice medical home capacity** – CPC+ participation requires relatively advanced primary care practice infrastructure. Rural primary care practices that have not developed comprehensive medical home capacity may be ineligible for CPC+ participation.
- **Absent performance measurement and reporting standardization** – CPC+ involves multiple payers, yet does not standardize payment policy specifics or practice performance measures. Consequently, participating providers will be accepting a high administrative burden and related costs. Further, although Medicare performance measurement is to be via eCQMs, performance measurement and reporting may still be more burdensome for rural practices with less performance measurement and reporting experience and capacity.
- **Accountable Care Organization (ACO) and CPC+** – Initially, primary care providers participating in Medicare shared savings programs (Medicare Shared Savings Program, Next Generation ACO, and Independence at Home demonstration) could not participate in CPC+. However, CMS recently removed this exclusion. CMS will now offer the opportunity for up to 1,500 eligible primary care practices currently participating or applying for participation in Tracks 1, 2, or 3 of the Medicare Shared Savings Program (MSSP) as of January 1, 2017, to also participate in CPC+. Additional details about this policy are outlined in the updated FAQs on the CPC+ website.
- **Certified EHR technology availability** – Small and rural practices may be less likely to employ a certified EHR, potentially making them ineligible for CPC+ participation.
- **Medicare and CHIP Reauthorization Act (MACRA)** – MACRA dramatically changes how physicians are paid by Medicare. Although details are being developed, physicians will either participate in a Merit-Based Incentive Payment System (MIPS) or receive a bonus for participation in an Alternative Payment Model (APM) under the Quality Payment Program. In the proposed rule, CMS states that CPC+ is an APM. Thus, if the proposed rules become final, practices participating in the CPC+ initiative would not be subject to MIPS.
- **Patient attribution** – It is unclear from CMMI-provided material how patients will be prospectively attributed to a practice. This may be particularly important to rural practices where a significant number of patients travel during the year.

Resources

- Comprehensive Primary Care Plus webpage:
  https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/
  With links to:
  - https://innovation.cms.gov/Files/x/cpcplus-modeloverviewslides.pdf
  - CPC+ Request for Applications (PDF)
  - CPC+ Payer Solicitation (PDF) | Payer Solicitation Instructions (PDF)
  - CPC+ Payer Memorandum of Understanding (PDF)
  - CPC+ Vendor Memorandum of Understanding (PDF)
  - CPC+ Practice Care Delivery Requirements (PDF)
  - CPC+ Press Release
  - CPC+ Fact Sheet
  - Updated Frequently Asked Questions (PDF)

- JAMA article: "Medicare's Vision for Advanced Primary Care: New Directions for Care Delivery and Payment" (April 11, 2016)

- AAFP Embraces Largest Initiative to Test Physician Payment Model: http://www.aafp.org/news/practice-professional-issues/20160413cpcplus.html
- CMS launches Comprehensive Primary Care Plus, value-based model for primary care practices, multiple insurers: http://www.healthcarefinancenews.com/news/cms-launches-comprehensive-primary-care-plus-value-based-model-primary-care-practices-multiple
- The Advisory Board: The unanswered questions that will impact the success of CPC+ https://www.advisory.com/health-policy/health-policy-vitals/2016/04/the-unanswered-questions-that-will-impact-the-success-of-cpc

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