Physician-Focused & Advanced Payment Models

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Patients, Payers, Providers and Purchasers
Committed to Better Value Now

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Executive Director
Who we are: Our mission to achieve results in value-based care

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change, both for ourselves and our country.

We aspire to have 75% of our respective businesses operating under value-based payment arrangements by 2020.
Our Members: Patients, Payers, Providers and Purchasers committed to better value
Political Landscape for Value-based Payment

- AHCA: all eyes on the Senate
- Value agenda not directly addressed in ACA repeal and replace efforts to date
- Coverage will impact private sector investment in value-based care
- Value-based payment advancement through MACRA retains bipartisan support
- CHRONIC Care Act reintroduced in the Senate
Administrative Actions on Value-based Payment

• Continued MACRA implementation and physician focus: Quality Payment Program or Advanced APMs?
  • Next QPP proposed rule eagerly anticipated

• Focus on reduced provider burden through regulatory reform

• Center for Medicare & Medicaid Innovation “2.0”

• State-based innovation

• Mandatory vs voluntary bundled payment models
Physician-Focused Payment Model Technical Advisory Committee

• Private stakeholders bringing physician-focused APMs forward for consideration

• PTAC took action on a first set of proposals in April

• Anticipate refinements to the PTAC proposal process

• How CMS will proceed remains an open question
Comprehensive Primary Care Plus (CPC+)

Transforming Primary Care in America

American Academy of Family Physicians
May 22, 2017

Laura L. Sessums, JD, MD, FACP
Center for Medicare & Medicaid Innovation
1. **CPC+ Model Overview**
   - Key statistics
   - Geographic regions
   - Multi-payer partnership

2. **Practice Transformation Activities and Supports**
   - Medicare financial supports
   - Care delivery and health IT requirements
   - Data feedback and learning support

3. **Impact of the Medicare Quality Payment Program on CPC+**
   - Alternative Payment Models (APMs)
   - Timeline of potential payment adjustments
Comprehensive Primary Care Plus

America’s Largest-Ever Initiative to Transform Primary Care

ROUND 1

- 5 Years
- 2 Tracks
- 14 Regions
- 2,891 Practice Sites
- 13,090 Clinicians
- >1.76 million Medicare Beneficiaries
- 53 Payer Partners
- 58 HIT Vendor Partners

ROUND 2

- 5 Years
- 4 New Regions
- 12 New Payers
- Up to 1,000 New Practices

- Selected based on payer commitment to partnership
- Including 5 supporting Round 1 regions
- Depending on interest and eligibility

From 2018-2022
CPC+ Now Offered in 18 Regions

Round 1 Region
- Sub-state region comprising contiguous counties

Round 2 Region
- Sub-state region comprising contiguous counties

- North Hudson/Capital District (NY)
- Northern KY (part of OH region)
- New Jersey
- Greater Philadelphia (PA)
- Greater Buffalo (NY)
- Rhode Island
- Greater Kansas City

- Round 1 Regions:
  - MT
  - ND
  - NE
  - CO
  - OK
  - AR
  - TN
  - LA
  - OR

- Round 2 Regions:
  - MI
  - OH

- Other:
  - Hawaii

★ = Sub-state region comprising contiguous counties
Multi-payer engagement is an essential component of CPC+.

Support from any one payer covers only a portion of a practice’s population.

True comprehensive primary care possible only with the support of multiple payers.

In CPC+, CMS partners with payers that share Medicare’s commitment to strengthening primary care in America.
Five Functions Guide CPC+
Care Delivery Transformation

**Access and Continuity**
- Patient Assignment to Care Teams
- 24/7 Patient Access
- Out-of-Office Care Options

**Care Management**
- Patient Risk Stratification
- Hospital/ED Discharge Follow-Up
- Care Plans for Chronic Disease Patients

**Patient and Caregiver Engagement**
- Patient and Family Advisory Councils
- Self-Management Support Tools

**Planned Care and Population Health**
- Practice and Payer Data Insight
- Full Care Team Data Review

**Comprehensiveness and Coordination**
- Coordination with Other Providers
- Integrated Behavioral Health
- Psychosocial Needs Assessment

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*Track 1 requirements*

*Additional requirements for Track 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><strong>Track 2</strong></td>
<td>$15 average; including $100 to support patients with complex needs</td>
<td>$2.50 opportunity</td>
<td>$4.00 opportunity</td>
</tr>
<tr>
<td></td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td></td>
<td>Payment enhanced 10%; split roughly 50/50 between upfront “Comprehensive Primary Care Payment” and reduced FFS claims</td>
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*CPC+ practices also in the Medicare Shared Savings Program participate in their ACO’s shared savings/loss arrangement INSTEAD of receiving CPC+ incentive payments.*
Track 2 Reimbursement Redesign Offers Flexibility in Care Delivery

Designed to Promote Population Health Beyond Office Visits

Traditional practice paid only through FFS; must see patients in office to receive reimbursement

CPC+ Track 2 practice paid roughly half of FFS payments upfront in “Comprehensive Primary Care Payment” (CPCP) to give clinicians more flexibility in how/where they deliver care
Both CPC+ Tracks require use of **certified health IT.**

Track 2 practices apply with a **letter of support from their health IT vendor(s)** committing to facilitate the development of advanced health IT capabilities.

Health IT vendors supporting Track 2 practices must sign a **Memorandum of Understanding (MOU)** with CMS.

Health IT vendor partners are invited to participate in relevant **learning activities** with practices and payers.
Required Health IT Functionalities in CPC+ Track 2

Health IT vendor partners commit to supporting Track 2 Practices in developing these advanced functionalities across the five years of CPC+.

- Risk stratify the practice site patient population
- Empanel patients to the practice site care team
- Establish patient focused care plans to guide care management
- Screen for social and community support needs and link the identified need(s) to practice identified resources
- Produce and display eCQM results at the practice level to support continuous feedback
- Document and track patient reported outcomes
Centralized and Aligned Comprehensive Data Feedback

**Attribution/Payment Data**
- Quarterly list of Medicare FFS beneficiaries attributed, by risk tier
- Quarterly financial support amounts

**Quality Data**
- Performance on Electronic Clinical Quality Measures and CAHPS surveys, compared to other practices

**Cost and Utilization Data**
- **Expenditures**: professional services, inpatient, outpatient, SNFs, etc.
- **Utilization**: inpatient, 30-day readmission, ED utilization

**Care Delivery Assessment**
- Quarterly report on care delivery requirements, compared to other practices
- Practice budget requirement analysis

**Multi-Payer Aligned Data Feedback**

**Resource: CPC+ Practice Portal**
Online tool for reporting, feedback, and assessment on practice progress
Many Opportunities for Learning, Collaboration, and Support

Learning Communities

**National Learning Community**
- Cross-region collaboration
- Live and on-demand learning opportunities: action groups, webinars, affinity groups, office hours
- Durable written products: Implementation Guide, newsletters, FAQs, case studies/spotlights
- Annual Stakeholder Meeting

**Regional Learning Networks**
- Virtual and in-person learning sessions
- Outreach to and support for practices
- Clinical and administrative leadership engagement
- Payer and health IT vendor engagement
- Alignment with regional reform

Web-based platform for CPC+ stakeholders to share ideas, resources, and strategies for practice transformation.
CPC+ Payment for 2017 Under the Medicare Quality Payment Program

CPC+ is Both an Advanced APM and a MIPS APM; Participating Practitioners Receive MIPS Exemption or Special Scoring.

**Qualifying APM Participant (QP) in an Advanced APM**

- Of all your Medicare patients eligible for CPC+, 25% of Medicare Part B professional services payments or 20% of Medicare Part B patients seen by your CPC+ Practice are attributed to CPC+.
- You are exempt from MIPS reporting and scoring.
- In addition to CPC+ Payments and your physician fee schedule reimbursement, CMS will make a lump sum payment that is equal to 5% of the payments for your Part B professional services one year prior.

**Merit-based Incentive Payment System (MIPS) Eligible Clinician in a MIPS APM**

- You are a physician, PA, NP, or CNS
- You have more than one year of Medicare Part B participation (or opted in)
- You bill over $30,000 to Medicare and care for over 100 Medicare patients annually
- You are not a QP in an Advanced APM

Eligibility

Reporting

Payment

In addition to CPC+ Payments, CMS will adjust your physician fee schedule payments during the payment year based on your MIPS final score two years prior.
In 2019, MIPS payment adjustment based on 2017 performance; 5% lump sum bonus based on 2018 services

In 2019, QP status based on 2017 performance; 5% lump sum bonus based on 2018 services

Higher maximum opportunity in MIPS

CPC+ participants in MIPS receive a special “APM Scoring Standard” for their MIPS adjustments
Interested in CPC+?

Visit
https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus
to learn more and apply.

Contact
CPCPlusApply@telligen.com
1-877-309-6114

Practice Applications due July 13, 2017
Physicians and Accountable Care Organizations: the Basics

• Accountable Care Organizations are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the patients they serve.

• Key operational and financial components of an ACO:
  • Financial Structures:
    • Type of financial risk: one sided (upside only) v. two-sided (upside and downside)
    • Benchmarks: Spending targets against which savings is determined.
    • Sharing rates/Performance payment limits:
    • Minimum savings rates/Minimum loss rates/limits: applicability depends on type of financial risk
Physicians and Accountable Care Organizations: the Basics

- Key operational and financial components of an ACO:
  - **Beneficiaries and Data Reports**
    - Patient assignment: prospective or retrospective
    - Minimum beneficiary number
  - **Quality reporting**
    - Quality measures, EHR usage, and patient satisfaction
  - **Waivers**
    - Regulatory waivers to help facilitate effective operations (telehealth, SNF 3-day, home bound, primary care co-pay)
Physicians and ACOs: Medicare’s Options

• Multiple Medicare ACO options:
  • Medicare Shared Savings Program Tracks 1, 2, and 3.
  • NEW ACO 1+ model (to be implemented for 2018).
  • “Next Gen” (formerly the Pioneer ACO)

• The different ACO options are broadly defined by the level of downside risk that the ACO must undertake.
  • Upside-only vs two-sided risk

• System intended to create Incentives for move toward two-sided risk models.
  Higher levels of risk create potential for higher returns.
The Purpose of ACO 1+ Model

• A new two-sided risk model which qualifies participating physicians for Advanced APM status, resulting in a 5% payment bonus instead of the QPP’s +4/-4 payment formula.

• The parameters for two-sided risk are less onerous than more mature models like MSSP Tracks 2 & 3 and Next Gen ACO.

• Recognizes there is a big leap between MSSP Track 1 and existing two-sided risk models, and provides a more reasonable step to keep organizations moving toward full population health/capitated type models.
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