

Lab 1: CPC+ Model Design

Virtual Meeting 2 of 5

Primary Care Payer Action Collaborative

September 14, 2017

3:30-5:00pm (EST)

1. Session Objectives

- a. Define each of the key design decisions involved in developing any alternative to fee-for-service (FFS) payment for primary care practices.
- b. Identify problems and peer solutions at each step.

2. Relevant Article in September *Health Affairs*

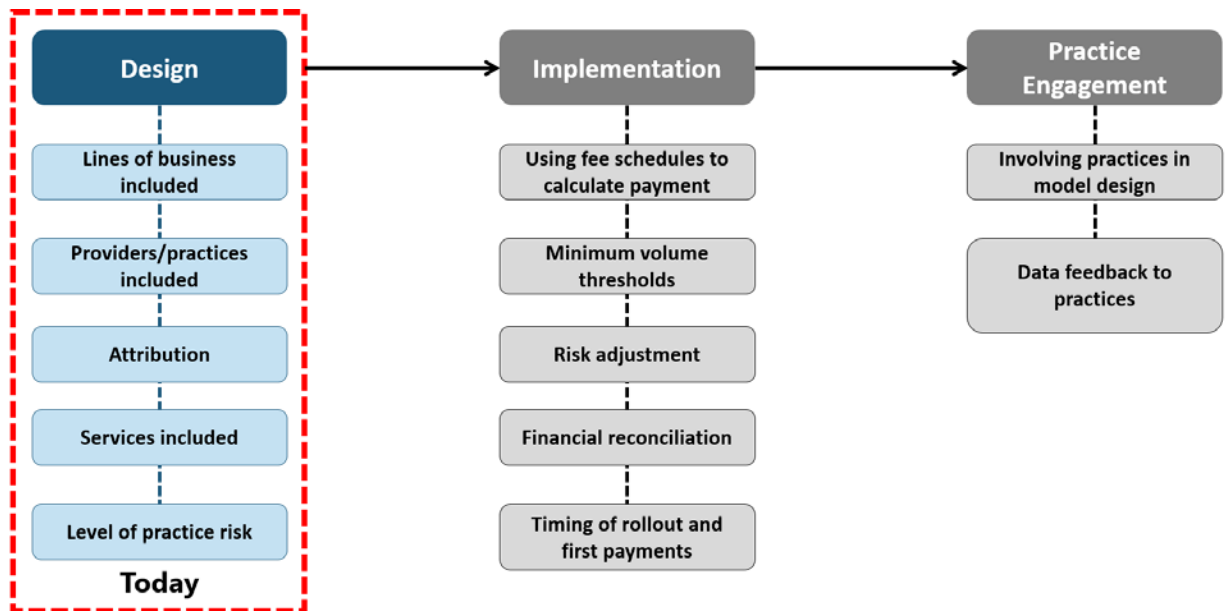
[“High Levels of Capitation Payments Needed to Shift Primary Care toward Proactive Team and Nonvisit Care”](#)

Take-home: Simulation modeling of practice revenues and costs suggests shifting to a majority-prospective payment model will help shift incentives to team-based and non-visit forms of care.

3. Speaker Panel

- a. Christiane LaBonte, Payment, Policy, and Operations Analyst for CPC+ at CMMI
 - i. The Medicare payment design for CPC+ is a comprehensive primary care payment (CPCP), which emphasizes flexibility, comprehensiveness, and multiple payer involvement.
 - ii. More information can be found on [CMS' CPC+ webpage](#). For a discussion of the CPCP methodology see [CMMI's CPC+ Payment Methodologies](#) document, Chapter 5: Payment under the Medicare Physician Fee Schedule.
- b. Eileen Wood, Senior Vice President for Clinical Integration and Chief Pharmacy Officer, Capital District Physicians' Health Plan (CDPHP), Albany New York
 - i. CDPHP began its own Advanced Primary Care Alternative Fee-For-Service (FFS) model in 2009 and was a CPC Classic participant. The plan launched a comprehensive CPC+ program across its network in 2012, expanding to 45,000 patients at 19 practices. Today, 75-80% of CDPHP's payments for its more than 250,000 attributed lives are made via an alternate payment model.
- c. Ann Pentkowski, Senior Vice President, Network and Performance Management, Independent Health, Buffalo New York
 - i. Independent Health is joining CPC+ in Round 2. Beginning in January 2018, more than 400,000 commercial, Medicare, Medicaid, and self-funded Independent Health members will use practices participating in CPC+.

4. Alternative-to-FFS Work Flow



Lines of business included:

What lines of business should you include in your alternative-to-FFS Payments?

- a. CDPHP is implementing the CPC+ Track 2 model across all lines of business (Medicare, Medicaid, and commercial). Administrative services only (ASO) arrangements were added to CPC+ starting in mid-2016. Prior to ASO outreach, CDPHP looked to accrue data that could demonstrate the benefits to ASO clients of opting into CPC+. New York CPC+ payers are not subject to New York State “capitation” regulatory requirements, because CPC+ participants are not held responsible for full patient panel costs.
- b. Similarly, Independent Health will not initially include self-funded clients in its model when it moves to CPC+ in January 2018. Many self-funded clients requested information on their potential return on investment before considering joining. Independent Health will analyze its year 1 data for ASO members and look to bring in that population in year 2.

Providers/practices included:

a. What is the unit for calculation and payment of the Alternative-to-FFS payment?

- i. Under the Medicare Physician Fee Schedule, payment units are a group of National Provider Identifiers (NPIs) at a physical location operating as a care team. CMS runs attribution to the location quarterly. Similarly, CDPHP bases patient attribution, measurements, and payments at the physical location level to calculate CPC+ performance-based incentive payments.
- ii. Based on provider feedback, Independent Health rolls up payment units to the Tax ID level, though data can be broken out at the physician level if needed.

b. How are you dealing with small practices?

- i. CMS has no special rules or payment models based on practice size, only requiring that practices see 125 cumulatively attributed beneficiaries over the course of a year. Similarly, Independent Health providers participating in the CPC+ model must have 200 attributed members for any one line of business, or 400 members across all lines of business to participate.
 - ii. CDPHP's practices range in size from small independent practices to large health systems, all of which participate separately.
- c. How are you dealing with mid-level providers?**
- i. Mid-level providers may bill the Medicare Physician Fee schedule, and are included in payment models. Similarly, CDPHP attributes patients to mid-level participating providers.
 - ii. Independent Health assigns mid-level providers to a primary care physician (PCP), and the mid-level provider's patients are attributed at the PCP level.
- d. How do outcomes for practices with capitated total cost of care (TCOC) arrangements for attributed patients compare to FFS practices in your network?**
- i. Independent Health has found that provider groups participating in capitated programs have lower TCOC. Efficiency, cost, and quality data are shared with providers.
 - ii. CDPHP has experienced rapid growth in practices participating in TCOC, adding more than 100 since 2012, and has found that savings do not tend to accrue until after the first year. Generally, practices begin to earn money via alternative-to-FFS payment by year three of implementation.
 - iii. CMS is reviewing TCOC outcomes as part of its CPC+ evaluation process. Under performance-based incentive payment measurements, CMS will use utilization measures as proxies to capture TCOC spending.

Attribution: How should patient attribution be designed to construct the alternative-to-FFS payment?

- a. What attribution methodology are you using or planning to use?**
- i. CMS recently announced a shift in its attribution methodology, effective January 2018, which will prioritize annual wellness and Welcome to Medicare visits. CMS' modeling has shown that focusing on those visits and services will reduce the potential for attribution loss. Additionally, this shift will counteract underestimates that are masked by hybrid payments.
 - ii. CDPHP's attribution methodology is driven by patient claims/encounters. PCP attribution is derived based on patient claims, as well as patient engagement within the Medicaid line of business.
- b. What pitfalls, if any, have you encountered with attribution and any unintended consequences of Track 2 alternative-to-FFS payments?**
- i. Attribution for mid-level providers has been challenging for Independent Health. Since some mid-level providers work with PCPs and specialists at different locations,

Independent must check to ensure members are attributed appropriately (i.e., to a mid-level provider’s affiliated PCP) and that mid-level providers working in multiple capacities are reviewed on every claim.

- ii. Both Independent Health and CDPHP have had challenges with Medicaid attribution. New York Medicaid requires members to select a primary care physician (PCP), or the member’s plan must assign the member to one. However, Medicaid patients do not always see their chosen or assigned PCP, making PCP attribution under CPC+ difficult. CDPHP has worked around this issue by informing participating PCPs of their assigned Medicaid members, but withholding prospective payments until the Medicaid member engages with the PCP.

Services included: Which services should CPC+ organizations include in their Alternative-to-FFS Payments?

a. What services are included in the payment?

CMS’ CPCP includes [office evaluation and management](#) (E&M) services; all other services are paid in FFS. In developing the scope of the CPCP, CMS looked to include services broadly agreed-upon as primary care. CDPHP similarly covers E&M codes as well as small tests that most providers perform (strep test, dip urine analysis, etc.)

b. Which services are excluded and why?

CMS chose to exclude all non-E&M services from the CPCP due to the wide variation in service delivery amongst primary care practices. Similarly, Independent Health has excluded many services that not all PCPs offer. CDPHP chose to exclude from the CPCP any lab services often performed in primary care offices that require lab personnel so as not to disadvantage providers that offer those services. In general, CDPHP excludes services in which the practice is procuring an item or service (such as vaccines) and passing that along to the patient. Both CDPHP and Independent Health have excluded injectable drugs.

For both CDPHP and Independent Health, different lines of business sometimes cover different aspects of primary care, presenting a challenge when determining services to include under CPC+. For example, Medicare and Medicaid vary in their use of consultation codes, making consistency under CPC+ difficult. In choosing services to include in the CPC+ payment, presenters recommended plans closely review service codes so as not to unfairly advantage or disadvantage providers. Generally, consistent codes across all lines of business would ease plan service selection under CPC+.

c. Has your health plan refined the included or excluded services over time? If so, why?

In the initial years of CPC Classic, CDPHP worked with PCPs to choose which codes and services to include in its alternative-to-FFS payment. As new codes have been introduced, CDPHP has reviewed and adapted the codes and services included.

Level of practice risk: Conceptually, how much will practices and payers be at risk under alternative-to-FFS payments compared to FFS?

- a. **Under your design, what financial risk is the practice exposed to? Is this risk separate from, or tied to, your performance-based incentive payments?**

When initially implementing CPC+, CDPHP aimed to both increase PCP payment and subsequently incentivize providers to join the field, and to increase capacity at the primary care practice level. CDPHP established a 40% “raise,” half of which was delivered as the upfront payment and half of which was awarded based on performance. CDPHP sees provider risk as the risk that PCPs take on to deliver care correctly after receiving the upfront payment. The financial risk lies in changing the PCP’s payment structure, not in how the PCP delivers care.

b. How does your health plan limit and/or monitor practice financial risk when they start out in this new payment model?

CDPHP invests significant funds into primary care physician payment to limit physician risk.

c. How have you communicated with practices about risk in the model?

- i. As Independent Health has moved toward CPC+, it has worked with providers to communicate expectations, including by modeling each practice’s potential performance for 2018, based on their previous year’s FFS experience.
- ii. CDPHP works closely with outlier primary care practices to identify issues and educate providers on potential negative consequences of their actions.

Session Recording: http://hcp-lan.org/workproducts/pac/PAC-Lab1_Model-Design.mp4 (Due to technical issues, the first 10 or so minutes of this Lab weren’t recorded)

Link to previous session: http://hcp-lan.org/workproducts/PAC1-Session.mp4?utm_source=PAC+Survey+List+Round+1&utm_campaign=fbef8c2d68-PAC+Webinar+1+Round+1+Session+1+Follow-Up&utm_medium=email&utm_term=0_3a9c292bf9-fbef8c2d68-150344701

Link to following session: <https://protect-us.mimecast.com/s/6RMqBvcgYAALiE?domain=hcp-lan.org>