Comprehensive Primary Care Plus (CPC+)

JENNIFER RIEDEN

MEMBER HEALTH MANAGEMENT BUREAU CHIEF

Program Objective

Comprehensive Primary Care Plus (CPC+) is an advanced primary care medical home model that rewards value and quality through innovative payments that support comprehensive care.

An initiative developed by CMS that transitions Medicare fee-for-service to value-based payments in collaboration with Medicaid and commercial payers in selected regions.

Montana was *1 of only 14 regions* selected across the country to participate with Medicare in this 5-year test demonstration that will support primary care in Montana. Blue Cross Blue Shield of Montana, PacificSource and Allegiance Life and Health have also partnered with Medicaid and Medicare in this model.

CPC+ payer partners and providers are collaborating around the goals of smarter healthcare spending, more effective healthcare delivery, and healthier patients.

The CPC+ advanced primary care medical home model is centered on five key functions:

- Access and Continuity;
- Care Management;
- Comprehensiveness and Coordination;
- Patient and Caregiver Engagement; and
- Planned Care and Population Health.

Population Focus

48 primary care practices throughout the state are enrolled CPC+ providers.

Members in the Passport to Health Program choose a primary care provider when enrolled in Medicaid

If they choose a provider who is a CPC+ provider they are enrolled in the program.

Members are assigned a health risk score based on their score of potential risk across the entire population and are divided into tiers.

Track 1 has four tiers and Track 2 has five tiers with tier one being those with the lowest risk score.

Program Description

In the end of 2016 practices applied to CMS to participate in this program.

The program includes Track 1 and Track 2 practices; Track 2 practices have additional care delivery requirements so their payments are slightly higher.

Track 2 practices also receive alternative FFS payments starting in 2019 that they are required to use for non-traditional face-to-face visits.

Providers are reimbursed a per member per month (PMPM) care management fee based on a member's risk score.

Program Description cont.

- Providers may receive a quality bonus retrospectively at the end of the quality of care and utilization measurement period annually.
- The amount will be based on the practice's level of meeting the performance benchmarks, based on national standards and regional alignment with other payers.
- Practices that meet quality and utilization thresholds will be rewarded with per member per year (PMPY) payments.

Care Management Staff

The team is determined by the primary care practice, it must be team based and patient centered.

The teams usually consists of the primary care provider, a nurse, a social worker and in some cases a behavioral health specialist.

Care Management Requirements

CPC+ focuses on 5 key elements:

Access and Continuity:

- Track 1: population health management, 24/7 patient access, assigned care teams.
- Track 2: Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, and/or expanded hours.

Care Management:

- Track 1: Risk stratified patient population, short-term and targeted relationship-based care management, emergency and inpatient follow-up.
- Track 2: Two-step risk stratification process, care plans for high-risk patients with chronic disease.

Care Management Requirements, cont.

Comprehensiveness and Coordination:

- Track 1: Identification of high volume/cost specialist, improved timelines of notification from ED and inpatient stays.
- Track 2: Behavioral health integration, psychosocial needs assessment and inventory resources and supports to meet psychosocial needs, collaborative care agreements, development of practice capability to meet needs of high risk population.

Patient and Caregiver Engagement:

- Track 1: Annual patient and family advisory council, assessment of practice capabilities to support patient self-management.
- Track 2: Patient self-management support for at least three high-risk conditions.

Planned Care and Population Health

- Track 1: At least quarterly review payer utilization reports and practice specific reports to inform improvement strategy.
- Track 2: At least weekly care team review all population health data.

Program Demographics

There are currently 48 practices enrolled in CPC+ and approximately 62,000 Medicaid members including Medicaid expansion members.

HMK members are also enrolled through BCBS.

Program Measurement

CPC+ providers report quality measures annually to the Department. Medicaid merges claims data with the providers' clinical data for each measure to determine performance rates for each measure.

There are 21 measures for CPC+ that are focused on preventive services.

Emergency room and inpatient hospital utilization are included as a quality measure. These reports are provided by the Department for providers.