

The Comprehensive Care Physician Payment Model (CCP-PM)

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Physician-Focused Payment Model Technical Advisory Committee (PTAC)
C/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
PTAC@hhs.gov

Re: The Comprehensive Care Physician Payment Model (CCP-PM)

Dear Committee Members,

On behalf of the Comprehensive Care Physician (CCP) Program at the University of Chicago, I am pleased to submit for your review this proposal for a Physician-Focused Payment Model, entitled “The Comprehensive Care Physician Payment Model” (CCP-PM). The CCP-PM was developed with the goal to incentivize the adoption of CCP programs and similar models that seek to defragment care for patients at increased risk of hospitalization by making it possible for these patients to receive care from the same physician in the hospital and in clinic.

The proposed CCP-PM incentivizes physicians to provide continuing care across the inpatient and outpatient settings by paying them a care continuity fee for providing the majority of inpatient and outpatient care for a panel of high-risk Medicare beneficiaries. We propose to launch the CCP-PM for physicians caring for Medicare Part A and B beneficiaries at the University of Chicago Medicine and up to 20 other sites. We also propose options for evaluation of the CCP-PM that we hope will generate evidence of the program’s effectiveness that would justify the program’s expansion nationally.

We are excited by the prospect of engaging with the PTAC Advisory committee to consider and eventually evaluate the proposed CCP-PM. We look forward to your guidance and partnership in considering this innovative payment model.

Sincerely,

David O. Meltzer, MD, PhD
Chief, Section of Hospital Medicine
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Abstract

A large fraction of health care spending in the United States is concentrated in a small part of the population. Not surprisingly, these high cost patients are much more frequently hospitalized than the population as a whole. In an effort to improve outcomes and decrease health care spending for frequently hospitalized patients, we established the Comprehensive Care Physician (CCP) Program at the University of Chicago. The program seeks to defragment care for patients at increased risk of hospitalization by providing them with a physician who will care for them both in clinic and the hospital. In a CMMI-funded trial of CCP compared to standard care with different doctors in the inpatient and outpatient setting, we found CCP significantly improves patient satisfaction with care and self-rated mental health status, decreases hospitalization 15-20% and lowers annual Medicare spending care by ~\$3,000 per patient per year. Estimated savings are even larger for patients with the highest risk of hospitalization.

The Comprehensive Care Physician Payment Model (CCP-PM) is designed to increase the uptake of programs such as CCP in which patients can receive both inpatient and outpatient care from the same physician. To incentivize this behavior, the CCP-PM provides a care continuity fee for participating physicians who meet benchmarks for providing their patients with both inpatient and outpatient care. Participating clinicians who do not meet these targets are subject to a fine. To ensure that these incentives encourage CCP physicians to care for patients at increased risk of hospitalization, patients must have been hospitalized at least once in the past year to be eligible for the program, and CCP-PM panels are capped at 300 patients per physician.

In addition to the novelty of the CCP program in integrating inpatient and outpatient care under one physician, the CCP-PM is innovative in its structure. Because of the evidence that CCP-like programs may substantially reduce Medicare spending, one could imagine developing a stand-alone CCP-based ACO that incentivizes shared savings. However, since the CCP model works best for the sickest patients, challenges of risk adjustment could create perverse incentives for CCP-ACOs to avoid caring for the patients that could most benefit from CCP care or to shift high-risk patients into such an arrangement to improve profitability in another Medicare alternative payment model. To avoid this, we designed the proposed CCP-PM as a supplemental payment/fine that would be added on top of incentives created by existing Medicare payment models, including Medicare alternative payment models or the Medicare Shared Savings Program (MSSP). That this model can be added on to MSSP has the advantage of expanding access to physicians and patients who may not have had exposure to risk-based contracting in the past.

In this proposal, we describe several promising approaches to evaluate the effects of the CCP-PM on the uptake of CCP-like models, improving patient outcomes and decreasing Medicare spending. If implemented, we look forward to working with CMS to identify a preferred evaluation strategy. If the pilot is successful and CCP-PM were scaled to its potential nationally, we estimate that up to 3.8 million Medicare beneficiaries would be eligible for the program. Assuming similar clinical outcomes, we would expect participating patients to experience improved satisfaction, mental health status and decreased utilization. Extrapolating based on the \$3,000 per patient per year savings we have found with the University of Chicago CCP program, savings at the national level could exceed \$11 billion per year.

I. Model Description

1. Model Overview

A small percentage of Medicare patients accounts for a large fraction of Medicare spending and adverse outcomes. Improving the efficiency and effectiveness of care among this group of patients is essential to controlling Medicare cost growth and improving outcomes. This group of patients is at increased risk of hospitalization. This is especially important, because the fragmented provision of inpatient and outpatient care in the US likely contributes to the high cost of care and adverse outcomes among this group. To improve outcomes and reduce costs for patients at increased risk of hospitalization, the Comprehensive Care Physician (CCP) Program was created with CMMI funding in 2012 to defragment care by providing patients at increased risk of hospitalization access to care from a physician who will care for them in both the inpatient and outpatient settings. CCPs focus their practices on a small panel of patients at increased risk of hospitalization so that they have enough patients in the hospital each day to justify spending mornings in the hospital while having a small enough panel of ambulatory patients that they can provide them with the primary care they need while limiting their time in clinic to the afternoons. The ability to provide their patients with both inpatient and outpatient care reduces costly and error-prone handoffs between inpatient and outpatient care and helps CCPs develop strong relationships with their patients, increasing their knowledge of the patient, and the trust, communication and interpersonal relationship between the doctor and patient.

Since 2012, we have enrolled 2,000 Medicare patients at increased risk of hospitalization in a randomized clinical trial at the University of Chicago Medicine (UCM) to study this reconfiguration of primary care for this patient population through the use of CCPs. Findings to date suggest that this model yields significant improvements in patient satisfaction and health outcomes and reduces costs to Medicare by about \$3,000 per patient per year. We expect to present these results publicly at a scientific meeting in June and will submit a scientific manuscript to a peer-reviewed journal later this year.

Based on these highly promising results, we propose that CMS establish a physician focused payment model to incentivize development of practice models like the CCP model that increase opportunities for patients to receive both inpatient and outpatient care from the same physician. We propose to call this payment model the Comprehensive Care Physician Payment Model (CCP-PM) and that it include the following core elements:

- 1) Eligible physicians can enroll a panel of CCP-PM patients for which they intend to provide an increased proportion of inpatient and outpatient general medical care.
- 2) Eligible patients join the program by enrolling in the CCP-PM panel of a participating physician, thereby indicating their desire to have the same physician care for them in both the inpatient and outpatient setting.
- 3) Participating physicians receive a payment per enrolled patient per month payable annually dependent upon meeting determined benchmarks for the percent provision of inpatient care and outpatient general medicine care for their enrolled patients.

- 4) Participating physicians will be subject to a penalty per enrolled patient per month due annually dependent upon failing to meet determined benchmarks for the percent provision of inpatient and outpatient general medicine care.

We propose the CCP-PM as a supplement that can integrate with existing payment models to strengthen incentives to adopt the CCP model while avoiding incentives that a separate payment model for high-risk patients could create to avoid caring for the most complex patients in the CCP-PM model or to remove these patients from existing population-based models. Under the CCP-PM, physicians would continue to be responsible for both the financial and quality measures associated with their umbrella payment model, such as the Merit-based Incentive Payment System (MIPS) or Medicare Shared Savings Program (MSSP) models. Billing systems and processes would require minimal change.

2. Implementation Strategy

As a result of the CCP program's positive preliminary outcomes, we have been contacted by more than a dozen healthcare institutions, nationally and internationally, that are interested in implementing a CCP program or one similar to it. Current CCP program dissemination efforts have included the creation of a CMS-funded Comprehensive Care Learning Collaborative, which is part of the Transforming Clinical Practice Initiative and includes more than one dozen health systems across the country who engage in learning sessions to discuss key components of the CCP model. We have also had expressions of interest in adopting the CCP model from multiple participants in the Hospital Medicine Reengineering Network (HOMERUN). We expect interest in the CCP model to increase even further when we present the results publically for the first time at scientific meetings in the coming months. We also have had strong interest in the model from the popular press and expect major coverage in the near future. We expect this to substantially increase interest in the model even further.

If the CCP-PM is approved, we expect that it would initially be applied within the established CCP program at the University of Chicago Medicine (UCM) and a CCP program that we are helping to develop at Ingalls Hospital, a community hospital affiliated with UCM. We would then seek additional sites interested in applying the CCP-PM, with the expectation that some institutions participating in the existing Comprehensive Care Learning Collaborative might be early sites. As new sites decide that they would like to utilize the CCP-PM, each would need to apply to CMS, which would need to approve their application to use the CCP-PM before it could be initiated. An application could come from a single physician or group of physicians or from a hospital or health system. Though we would not propose to set a hard limit on the number of participating physicians per site, we would expect a maximum of 10 per site. In addition, we propose criteria for site approval below that would maximize the potential for valid evaluation of the program's effectiveness. We would welcome opportunities to partner with CMS to support program implementation and evaluation if desired, but would assume that CMS would engage an external evaluator to assess the program's effectiveness. We propose that this CCP-PM pilot be planned to last 5 years, with the understanding that it would be reviewed annually over that period. The 5 year period would allow programs sufficient time to adapt practice structure to utilize the CCP-PM, and for CMS to evaluate the impact of these changes.

As we discuss further below, we estimate that the maximum cost of this proposed pilot would be \$30 million per year, but would likely be closer to \$5 million per year. The modest scope of this initial implementation plan in terms of the number of sites and the emphasis on rigorous evaluation is intended to minimize the costs to Medicare of this pilot phase while maximizing the potential impact in terms of evidence generated. We think an investment by CMS of \$5 - \$30 million per year to prove that the CCP-PM is effective could generate savings of as much as \$11 billion per year if the CCP-PM were found to be as effective as our pilot data suggests it to be and was then rolled out nationally. The extraordinarily large magnitude of these potential savings compared to the cost of testing this model implies that even if savings were found to be substantially less than we estimate or the intervention ended up being implemented only in a very modest fraction of all potentially eligible patients, then the expected return on investment for CMS testing the CCP-PM model would remain very high.

We have designed the CCP-PM to easily integrate well with existing payment models. As a result, we anticipate a smooth implementation process, but we would hope to work closely with CMS and clinical institutions interested in CCP to promote sharing of information about any challenges that arise in implementation and potential solutions to those challenges.

3. Expected Participants

Participants in the CCP-PM would consist of the following:

- Physician participants would include any primary care physician who (1) opts into the CCP-PM, (2) is willing to provide inpatient and outpatient care for patients enrolled in his/her CCP-PM panel, and (3) receives CMS approval to participate.
- Patients are eligible to participate if they have Medicare Part A and B, are identified as at increased risk of hospitalization and both the physician and patient (or their proxy) agree to the patient's enrollment in the physician's CCP-PM panel. As we describe further below, we propose that patients be identified as at increased risk of hospitalization primarily by having been hospitalized at least once in the year prior to enrollment. This has been the primary criterion for enrollment in the study we have executed at UCM, and has produced a patient population with high rates of hospitalization. However, we also think that CMS should be open to considering other risks factors for hospitalization that a potential CCP-PM organization might propose. For example, at UCM we have found that patients recruited in the part of our emergency department that excludes urgent care visits also have high rates of hospitalization in the following year. Should CMS consider other risk factors besides recent hospitalization, we would advise that they do so based on evidence of that patients meeting such criteria did indeed historically have substantially increased rates of hospitalization. Additionally, we propose an enrollment cap of 300 patients per participating physician in order to cap costs to Medicare and incentivize the enrollment of patients who are frequently hospitalized and are likely to benefit most from the program.

We also note that the model we propose should give providers and provider organizations strong incentives to focus limited CCP-PM spots per physician on patients at high risk of hospitalization. There are two reasons for this. First, in an MSSP context, these patients at

high risk of hospitalization are likely to be those that benefit most from the program in terms of the potential to produce shared savings. Second, because we will require that providers provide the majority of hospital care for patients they enroll in the program in order for them to receive care continuity fees and avoid penalties, they will need to block time in their schedules to be able to reliably see these patients in the hospital. A physician who failed to focus their CCP-PM panel on patients at high risk of hospitalization would have an inadequate volume of patients in the hospital to make reserving time to see patients in the hospital each day economically viable. A low volume of patients in the hospital would be problematic because of the time costs of traveling to the hospital, the high variability in inpatient volumes, and because the amount time in the hospital each day would be too brief to consistently provide high quality care. We should also note that a physician whose panel was at lower risk of hospitalization would also quickly have their care continuity fees decline over time, making the model far less economically attractive. For all these reasons, we think that the CCP-PM model we propose will provide excellent incentives for participating providers to focus their practice on the desired population of patients at increased risk of hospitalization.

The CCP-PM would be implemented at the following locations:

- University of Chicago Medicine, Comprehensive Care Physician (CCP) program
- Ingalls Hospital and affiliated practices
- Up to 20 other sites in the United States, subject to CMS approval

II. Response to Criteria

1. Scope (High Priority Criterion)

Our proposal will expand the scope of the PFFPM portfolio by A) incentivizing the CCP model as a novel and effective approach to better coordinate inpatient and outpatient care, B) demonstrating how an “add-on” PFFPM overlaid on existing payment models could complement and enhance existing payment models and C) expanding opportunities to participate in an APM for small and high-risk practices that might find some other APMs difficult to adopt.

A. Incentivize Novel and Effective Approach to Coordinate Inpatient and Outpatient Care

The CCP-PM is novel clinically because it encourages an approach to practice that specifically improves the quality and lowers costs for Medicare patients at high risk of hospitalization, who are a substantial fraction of Medicare’s highest utilizers. No other Medicare APMs currently attempt to specifically target this population at increased risk of hospitalization with an evidence-based intervention that has strong evidence of effectiveness, as we describe below.

Given that the CCP model is most relevant for patients at increased risk of hospitalization, we expect that the physicians who choose to participate in it will disproportionately care for such individuals. In the CCP Program at UCM, we have primarily identified Medicare beneficiaries as at increased risk of hospitalization if they have been hospitalized within the past year. We estimate that 10% of the Medicare population would qualify as at increased risk of

hospitalization, constituting over 60% of all Medicare spending. Given traditional Medicare's covered population of 38.3 million people, we would expect about 3.83 million eligible patient participants nationally at full scale.

We expect that the vast majority of physicians participating in the CCP-PM would be general internal medicine physicians, hospitalists or family practitioners, though some medical sub-specialists and physicians from other specialties that provide primary care (e.g., gynecology) might be appropriate candidates to serve as CCPs under a CCP-PM in some instances.

The eligible patient population is so large that a very large number of physicians could potentially adopt this model if it were brought to scale nationally; assuming that a CCP's panel includes an average of 200 patients, up to 19,150 clinicians could participate in the model if expanded to full scale nationally. This proposed pilot, with a maximum of 22 locations and maximum of 10 physicians per location, but a likely average of 5 physicians per location, would be expected to include about 100 physicians and 20,000 patients at any time once fully implemented, with a maximum of 200 physicians and 60,000 patients. We estimate that the absolute maximum this pilot could cost Medicare given these numbers and the maximum proposed payment levels per patient (based on recent hospitalization) would be \$30 million per year, but expect a more realistic estimate would be \$5 million per year with 20,000 participating patients and a more likely mix of monthly payment levels per patient.

This expected enrollment in the proposed pilot is less than 1% of the potential national market for the CCP model, keeping costs low to Medicare. However, the proposed pilot is designed to be large enough to generate information that would meaningfully inform a decision about potential adoption nationally.

Finally, we note that we have adopted a somewhat similar payment model at UCM to support use of the CCP model in patients insured by the City of Chicago. This is administered by the City of Chicago with support by Health Care Services Corporation, the parent Corporation for Blue Cross Blue Shield in Illinois. While initially designed for Medicare, we envision the potential for similar models to be implemented across other payer types, including Medicaid and private payers.

B. Demonstrate how an "add-on" PFPM model overlaid on existing payment models could complement and enhance existing payment models

As we considered how to develop a physician-focused payment model (PFPM) to incentivize the uptake of CCP models, we determined that structural innovation in the payment model was needed. Initially, we considered a stand-alone ACO-type model, but this had problems of risk selection and concerns of durability moving forward. The reason for this is that our work to date with the CCP model at UCM has shown us that it is most beneficial for patients who have the highest levels of utilization. We were concerned that a stand-alone APM that was primarily focused on attracting these patients could suffer from significant adverse selection that would cause actual utilization to far exceed predicted utilization and that this would undermine incentives in shared savings programs even if the program succeeded in reducing utilization. We were also concerned that an APM focused on the CCP model would only apply to patients at

increased risk of hospitalization, and that the presence of multiple risk contracts, including Advanced APMs, in a single system or even geographic area would incentivize systems to exploit this by strategically allocating patients to different payment models, producing profits for the systems, but not savings for Medicare.

In light of these concerns, we propose the CCP-PM in the form of an “APM Supplement” (APMS) that would establish specific incentives to improve care and reduce costs by adopting the CCP model within the context of the broader incentives to improve care and reduce costs created by other APMs. Thus, the CCP-PM would allow a Medicare provider to participate both in the CCP-PM and another APM. Consistent with the requirements of Advanced APMs, the CCP-PM would require the provider meet certain requirements that would reflect investments of its resources and would receive additional rewards if their efforts were successful. What is different is that the CCP-PM would specifically incentivize particular actions and rewards that would be embedded within the APM models to which it would be added, while maintaining the broader structure of the underlying risk contract. We recognize that – in principle - individual organizations could provide internal incentives that could mimic those of the CCP-PM, raising the question of whether the CCP-PM is necessary. However, we think that there are multiple reasons that CMS approval of the CCP-PM is more likely to be beneficial to CMS than an alternative of hoping that existing APMs will cause providers to adopt CCP on their own:

- 1) Providers may not be aware that a CCP program may benefit their organization and may therefore not adopt it on their own in the absence of specific incentives to do so. The prominence that the CCP-PM would give the CCP model would likely encourage providers and institutions to consider a CCP program that might not have otherwise done so.
- 2) Providers may lack confidence that a CCP model will benefit them or their organization and therefore may not adopt it on their own in the absence of specific incentives. The added payments for CCP-like practice should encourage institutions to try the model.
- 3) Payments specifically to adopt the CCP model would increase the incentives to use it even when a system is part of an APM. Such incentives might be reduced by several factors, including that savings is shared, rather than being all received by the ACO, and that ACOs may lack confidence that they will be able to earn the shared savings because of factors that are difficult to control, such as risk selection.
- 4) Providers not in an APM would not have significant incentives to adopt the CCP model in the absence of the CCP-PM, so the CCP-PM care continuity fees would be an essential incentive.
- 5) Similarly, adoption of the CCP model due to the CCP-PM by a provider or provider organization that is not in an APM could better position a provider/organization to succeed in an APM if they choose to enter one. The CCP-PM could therefore be a natural “bridge” into APMs for providers not currently in an APM.
- 6) The applicability of the CCP-PM across APMs and in MIPS would create stable incentives to use the CCP model even in the context of changing payment models. In contrast, organizations that are unsure if they would continue in a particular APM might well be reluctant to establish a CCP model on their own in the absence of the CCP-PM. Given that the value of the CCP model is almost certainly greatest when the relationships between patients and providers are sustained, the stable incentives for CCP use across

payment models is especially important so that both providers and patients can invest in the model with confidence that the incentives to maintain it will be sustained.

- 7) Even ACOs that are motivated to adopt a CCP model on their own might not have a clear sense of how to incentivize physicians to adopt a CCP practice model. The CCP-PM could provide a model for doing that.
- 8) Better data on the effectiveness of the CCP model should increase the adoption of the model if it is found to be effective. The proposal to link participation in the CCP-PM with evaluation will improve the quality of evidence about the effectiveness of the CCP model so that more providers will adopt it if it is shown to be effective. The CCP-PM might be considered a form of “coverage with evidence development.”

For all these reasons, we think that the “add-on” nature of the CCP-PM is likely to be superior to relying on shared savings alone as an incentive to adopt CCP-like models.

C. Expand Opportunities for Small and High-Risk Practices to Participate in APMs

The proposed CCP-PM expands opportunities for physicians in small and high-risk practices to participate in APMs. Small practices may have more difficulty than larger ones in participating in APMs because of challenges in configuring current billing, accounting and quality management systems.

We believe that the type of supplemental payment we propose would provide greater flexibility and customization potential than traditional APMs for many physicians in solo or small practices because of its ability to integrate with both MIPS and a range of APMs currently offered, as well as potential future supplemental payment models. The add-on nature of the CCP-PM allows practices to participate in the new model without reconfiguring current billing, accounting and quality management systems. This flexibility would likely be especially relevant for smaller practices looking to participate in APM models. In addition, the CCP-PM would allow large academic medical centers, which are often hesitant to participate in risk-based contracting due to the complexity of their patient population, to trial a new payment model. Such an approach would also allow for a greater degree of rapid-cycle innovation by allowing new ideas to be tested without the administrative challenge of creating an entirely new payment model. The value of this opportunity for testing is enhanced by the fact that the CCP-PM can allow CMMI to incentivize specific changes in health care delivery that can then be evaluated to assess their effectiveness. Unlike many ACO-type models that incentivize savings but rely on a health system to figure out how to achieve them, the CCP-PM is structured to specifically incentivize behaviors that are likely to lead to such savings, so that it is possible to test the effects of those changes.

2. Quality and Cost (High Priority Criterion)

The CCP-PM is anticipated to both improve health outcomes and patient experience, and to reduce costs.

A. Expected measures of and effects on health outcomes and patient experience, and utilization/costs.

As described, the CCP-PM is meant to incentivize the use of CCP-like models, which decrease the fragmentation of care for patients at increased risk of hospitalization. To date, the UCM study has shown significant improvements in patient experience, health outcomes and decrease in hospital utilization. The results to date are striking: care ratings on HCAHPS measures move from the 20th percentile when enrolled to the 95th with care from a CCP physician, self-rated mental health improves by 1 point on a 5 point scale (e.g., from good to very good), for 11% of CCP patients compared to control patients and hospitalizations are 15-20% lower, corresponding to savings of about \$3,000/patient/year, potentially producing savings of more than \$10 billion annually if scaled nationally. We are in the process of preparing these analyses for submission for publication in a peer-reviewed journal and will gladly provide CMS with additional details upon request.

Within the CCP-PM, we propose that quality measures be established specific to the model with respect to the structure and process of care, and that outcome measures within the CCP-PM be limited, restricted to measures incorporated within current payment models to allow for increased flexibility, simplicity and ease of implementation, and to avoid distorting incentives established by other payment models.

- 1) Structure of Care: We propose that the CCP-PM offers its care continuity fees only when patients are empaneled on the panel of a physician who has structured their care to be able to care for that patient in clinic and in the hospital. The empanelment process itself is therefore a structural measure of quality.
- 2) Process of Care: As described below, we propose that the CCP-PM condition the care continuity fees based on reaching established benchmarks for the percentage of inpatient and outpatient general medical care provided by the participating clinician. This condition for receipt of the care continuity fee effectively creates a high stakes measure of process of care.
- 3) Outcomes: Based on the results described above, we expect that the CCP-PM will improve patient experience (HCAHPS scores), and self-rated mental health status, and decrease hospitalization rates and the total cost of care. Providers are often already held accountable for some of these outcomes measures of quality by the agreements they establish with CMS based on their APM or MIPS participation. For example, in the MSSP Track 1 ACO, specific metrics that are likely to be directly impacted by the CCP-PM include: number of unplanned hospitalizations, number of ambulatory care sensitive hospitalizations, patients' rating of provider and depression remission at 12 months. In

the context of MIPS, we would expect physicians participating in the CCP-PM to perform comparably to their peers on most metrics. Given the strong relationships that the CCP-PM promotes, we expect CCP-PM participants to perform especially well on the MIPS care plan metric. We propose that providers continue to be incentivized or penalized for these outcomes measures of quality based on the incentives/penalties in their current model (e.g., meeting agreed upon quality outcomes measures as a condition of receiving shared savings in MSSP, etc.), but that the care continuity fees themselves not be at risk so that providers not be penalized twice should they fail to meet these measures after making the effort to reorganize their practice to follow a CCP model.

We note that while we strongly considered developing specific outcomes metrics for the CCP-PM that would put the CCP-PM care continuity fees at risk, we chose not to propose this for several reasons: First and foremost, the high risk population the CCP-PM targets poses significant challenges to appropriately risk adjusting quality metrics. Second, many of the relevant outcomes are already incentivized by the APMs on which the CCP-PM would be layered, and we did not want penalize/reward providers twice for these metrics. We were concerned about linking the CCP-PM to the ACO metrics, because those were established to consider the entire population, and many of the metrics might not apply well to this patient population. For instance, a measure of screening colonoscopy would be an inappropriate intervention for a patient with multiple comorbidities and expected life expectancy of less than 3 years. Furthermore, various APMs have different quality measures. Given that the CCP-PM is structured to function across various payment models, we wanted to avoid introducing new metrics and an increased burden of quality reporting with respect to the CCP-PM as providers may transition between APMs.

4) Cost Savings

As noted above, our results from UCM suggest savings of about \$3,000/patient/year, potentially producing savings of more than \$10 billion annually if scaled nationally.

Assuming that a patient is enrolled in the CCP-PM for a full year and that the patient qualified for the maximum care continuity fee of \$40 per month (vs. \$10 per month for patients who have not been hospitalized in the past year), total CCP-PM payments would be \$480 per patient. With the maximum panel size of 300 patients, this would limit the total potential payout to a physician to \$148,000 per physician, but with a typical panel size of 200 patients and under the likely mix of care continuity fees based on expected hospitalization rates (assuming half of participating are hospitalized in a year), the average care continuity fee would be \$25 per month (\$300/year), a more likely payout per participating physician would be \$60,000 per physician for a physician whose entire panel of 200 patients was devoted to CCP-PM patients.

Actuarial effects of this payment on Medicare would vary depending on a participating provider's umbrella payment model. In MIPS, assuming Medicare spending reductions of \$3,000 per patient and a 200-person panel size, this would yield spending reductions of \$600,000 per physician, for a net savings to Medicare of \$540,000 per physician after

accounting for care continuity fees, a net savings of \$9 per dollar spent on the program. For physicians participating in an ACO, any payments or fines accrued through the CCP-PM would also be counted as positive or negative expenditure in a system's ACO accounting. Because care continuity fees count against shared savings and can contribute to loss sharing, the risk to Medicare is lower when participating organizations are part of an ACO. Specific examples of the actuarial impact of the CCP-PM on ACO accounting are reported in Appendix A.

From the perspective of a participating physician, two types of risk would be present. From a payment perspective, \$10 per participating patient per month, or \$24,000 total per year for a panel of 200 patients would be at risk.¹ From an operational perspective, participating clinicians would also be putting their time at risk by structuring clinic schedules to allow time to round on patients in the hospital each morning, sacrificing a significant fraction of their potential ambulatory revenue. These risks are clearly significant, but reasonable even for small or independent practices.

B. Potential Barriers

a. Physician Participation

For the CCP-PM to successfully impact patient experience, outcomes and utilization, physicians must choose to practice in a model similar to the CCP program. Given that practices in which physicians care for patients in both the inpatient and outpatient setting have become less common, it is unclear whether the CCP-PM will provide enough of an incentive for physicians to restructure their practices in this way to care for patients at the highest risk of hospitalization. Our perspective is that this care model is on the decline because traditional primary care groups do not target high utilizing patients, therefore making it economically challenging to justify seeing only a few patients in the hospital on a given morning. We believe that the CCP-PM will encourage a meaningful number of physicians to adopt the CCP model of practice. To the extent we are wrong, the model will not produce savings. However, it will also not produce costs as physicians will not sign up for the CCP-PM and therefore no costs of the CCP-PM will be incurred.

In the CCP-PM, we propose care continuity fee of \$40 per patient per month to incentivize physicians to care for patients in and out of the hospital. We intentionally chose this figure to provide a small incentive to drive CCP-like models. Our goal in doing so was to encourage physicians who are considering models like CCP to undertake them, but not to encourage inappropriate practice change. We are not certain whether this incentive will be enough to promote the practice change we desire but expect that it will be based on the estimated additional revenues described above. Should the experience with the CCP-PM suggest that the model is promising but insufficient to attract enough physicians into the model, the size of the care continuity fee could certainly be increased while still producing very large savings for Medicare.

¹ These numbers assume physician participation in MIPS and would vary slightly in the context of an ACO.

b. Patient Participation

The CCP model is most effective for patients at increased risk of hospitalization. We have structured the CCP-PM to require prior year hospitalization for patient eligibility. We have also limited physician panel size to encourage a focus on high utilizers. In addition, for the reasons we discuss on page 3, several aspects of the CCP-PM specifically incentivize providers to focus their panel on patients at increased risk of hospitalization. As the model is piloted, we would encourage Medicare to further assess whether these criteria are sufficient or others should be required to ensure that patient panels are high risk.

c. Programmatic Effect

The CCP program has only been formally tested at the University of Chicago. As such, the impact of relational continuity in other settings has not been established. However, the excitement of many other institutions to develop CCP-like programs has suggested the potential relevance of the model elsewhere. The fundamental drivers of the CCP model's success include strong relationships between patients and their providers that support shared decision-making as well as the lack of information loss that comes with defragmenting care are likely to be applicable in any care setting.

3. Payment Methodology (High Priority Criterion)

A. *Payment Model Overview*

Payment of the CCP-PM care continuity fee is contingent on the participating physicians providing a high percentage of their patients' inpatient and outpatient internal medicine care. Participation in the CCP-PM would not directly alter any payments related to other MIPS, ACO, or APM models in which the clinician participates. For clinicians participating in fee-for-service based contracts, the care continuity fee would be in addition to current Medicare bills.

Fee Criteria: Participating physicians will receive a payment of \$40 per new and renewed enrolled patient per month and \$10 per continued enrolled patient per month payable at the end of each year if they meet the below criteria. Any payments would be included in the total cost of care for those participating in other payment models. Additionally, as described below, care continuity fees will depend on if patients have been hospitalized at least once in the past 12 months.

- 1) The percent provision of inpatient care for their panel of enrolled patients exceeds 50%²
- 2) The percent provision of outpatient general medical care for their panel of enrolled patients exceeds 67%

² These percentages were derived from an analysis of the degree of continuity attained by the University of Chicago CCP program. Given other hospitals in an institutions catchment area, it not likely to be feasible for a single provider to provide more of an individual's medical care.

Penalty Criteria: Participating physicians will be subject to a penalty of \$10³ per enrolled patient per month due at the end of each year of they meet the following criteria:

- 1) The percent provision of inpatient care for their panel of enrolled patients falls below 25%
- 2) The percent provision of outpatient general medical care for their panel of enrolled patients falls below 33%

Calculation of Inpatient Care: The population of enrolled patients for a participating physician over the course of each year shall be used to calculate whether the proportion of inpatient and care provided by the physician is sufficient to warrant payment of CCP-PM payments for that year. This proportion will be calculated for each participating physician in the CCP-PM as the total number of patient-days of inpatient care (including inpatient general medicine consultation and observation care) provided by participating physicians to their participating patients during their periods of participation during that year divided by the total number of patient-days of inpatient care received by those patients during their periods of participation during that year.

Calculation of Percent Provision of Outpatient General Medical Care: The population of enrolled patients for any participating physician over the course of each calendar year shall be used to calculate whether the proportion of outpatient care provided by the physician is sufficient to warrant payment of CCP-PM payments over that year. This proportion will be calculated for each participating physician in the CCP-PM as the total number of outpatient general medicine encounters provided by participating physicians to their participating patients during the periods of participation during that year divided by the total number of outpatient general medicine encounters received by those patients during their periods of participation during the year.⁴

Look-back period/payment schedule: Physicians would be paid / penalized annually in alignment with their “home institution’s” ACO or APM yearly payment cycle. For physicians at institutions that do not participate in an ACO or APM, the performance year would correspond with the MIPS year. There would be a performance period followed by a period of CMS’s evaluation resulting in a payment / penalty period.

B. Payment Model Eligibility

To be eligible for the CCP-PM, both physicians and patients must enroll.

Physician Enrollment: Physicians may choose to enroll in the CCP-PM at the beginning of any month in the year. Physician enrollment in the CCP-PM does not preclude enrollment in another CMS payment model. Similar to enrollment in an ACO with downside risk, physicians or

³ The care continuity fee and penalty were determined to be large enough to be meaningful but not more than needed to motivate change. On average we would expect half of a provider’s panel to include new or renewed enrollees and half continued enrollees yielding an average continuity fee of \$25 per patient per month. Assuming a panel size of 200 patients, this would yield \$60,000 per year. As mentioned in the evaluation of this proposal, we support further testing of the payment and fine amounts.

⁴ Calculations of percent provision of inpatient and outpatient care is based on the National Uniform Claim Committee (NUCC) healthcare provider taxonomy codes and relevant CPT codes. Please see Appendix A for further details.

systems must demonstrate to Medicare sufficient capital availability to cover potential CCP-PM fines.

Physician Disenrollment: Physicians can disenroll from the CCP-PM at the end of any month. To avoid misuse of the CCP-PM, physicians who disenroll would be unable to participate in the CCP-PM for 12 months following disenrollment.

Patient Eligibility: To be eligible for the program, patients must have been hospitalized (either for observation or for a full inpatient stay) at least once in the 12 months before enrollment and be covered by Medicare Parts A and B. Evidence of prior hospitalization includes a paid claim for inpatient or observation care by Medicare or another third-party payer or other objective, verifiable evidence of hospitalization (e.g., hospital records) during the prior 12 months. Certification of eligibility may be made by a participating physician or his / her proxy. CMS could have the discretion to consider alternative eligibility criteria that predicted high rates of hospitalization. In the University of Chicago CCP pilot, patients who had not been hospitalized within the year but enrolled while presenting to the emergency department were included as eligible based on evidence that persons presenting to the emergency department were at sufficiently increased risk of hospitalization.

Patient Enrollment: Eligible patients may enroll for CCP-PM participation with a specific physician participating in the CCP-PM at any point in time by completing an agreement that is signed by both the participating physician or his / her proxy and an eligible patient or his / her proxy. Once enrolled, a patient remains enrolled as a “new enrollee” for the remainder of the year of enrollment and the following year unless disenrolled. Monthly payments for the CCP-PM accrue with each month the patient is enrolled. We propose that no additional copays be incurred on the part of the patient as a result of their participation in CCP-PM.

Patient Cap: The number of patients who can be enrolled in a participating physician’s panel is capped at 300 patients. The purpose of the cap is to incentivize participating physicians to enroll patients who are frequently hospitalized and are likely to benefit most from the program. The CCP model at University of Chicago has worked well with a patient panel of 200 complex patients, but we want to provide flexibility for individual providers to set a panel size most appropriate for their practice. We expect the average CCP to have a panel of 200 patients under the CCP-PM in steady state. Clearly panels will be much smaller initially as practices are established and patients participating in the CCP-PM are accrued.

Patient Disenrollment: Patients can be disenrolled from CCP-PM program participation at any time at the request of either the patient or their proxy. Physicians may disenroll patients for the following reasons: 1) If patients move more than 15 miles from the patient’s current home, 2) If patients have not been seen in the ambulatory setting for at least 6 months, 3) Upon enrollment renewal as described below.

Disenrollment would cause monthly payments for CCP-PM to the CCP for that patient to cease starting the month after disenrollment. Patients who are not expected to receive a sufficient proportion of their hospital care for the remainder of their enrollment period at an institution served by his or her participating physician would generally be recommended for disenrollment.

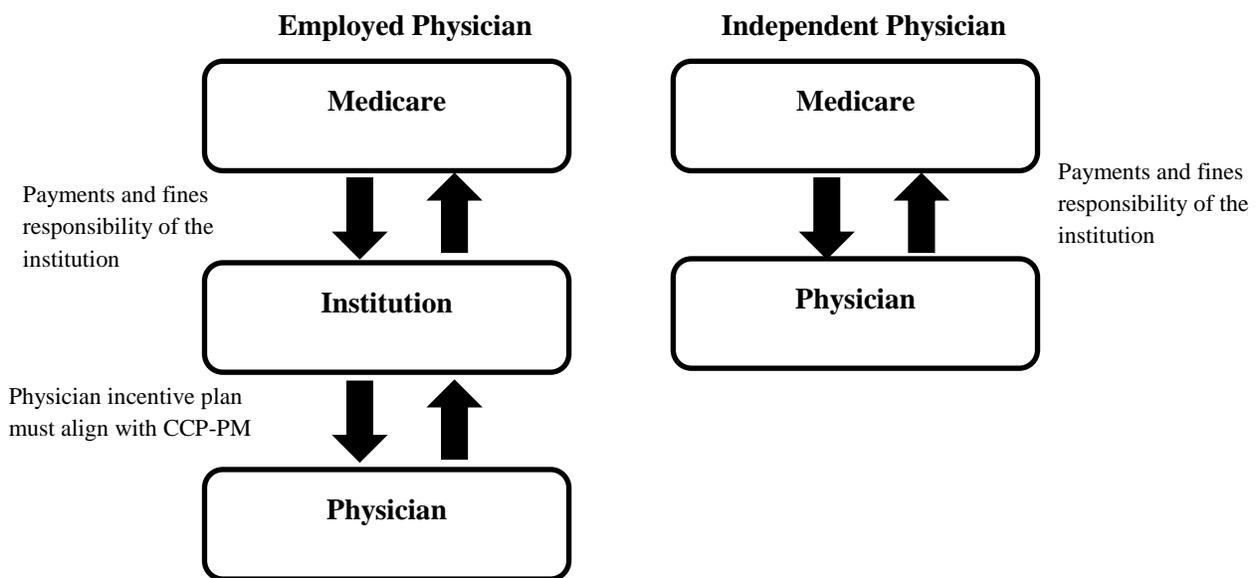
Patients are automatically disenrolled upon death.

Renewal of Enrolled Patients: An enrolled patient may be reenrolled as a “renewed enrollee” with the same provider after two years for additional two year periods if the patient has been hospitalized at least once during that two year period. Patients may be enrolled as a “continued enrollee” with the same provider after two years for additional two year periods if they have not been hospitalized during that two-year period. A continued enrollee transitions automatically to a “renewed enrollee” for the remainder of the current two-year enrollment period if he or she is hospitalized. Patient enrollment in CCP-PM does not alter enrollment in any other CMS payment model.

C. Cash Flow of the CCP-PM

For physicians participating in a practice group, incentive payments or fines would be paid or billed to the individual physician’s umbrella institution similar to current fee-for-service Medicare payments. For these participants, we would expect but not require incentive plans for physicians to reflect these payments or fines to some degree. For solo practitioners, payments would be made directly to the provider.

CCP-PM Cash Flow Diagram:



D. Integration with Umbrella Payment Model

For physicians participating in a risk-based contract, incentive payments or fines would be included in patients’ total cost of care.

4. Value over Volume

The CCP-PM financially incentivizes developing CCP-like models, wherein physicians see patients in the hospital and clinic. As noted above, this model has been shown to improve high value care. We believe the basis of this increased value is both operational and relationship-driven. From an operations perspective, CCP-like models reduce the coordination cost associated with sharing information between the inpatient and outpatient settings. From a relationship perspective, CCP-like models encourage physicians to develop strong relationships with their patients and patients to develop increased trust with their physicians. These relationships may motivate both parties to strive for better health outcomes over time. In our experience with the CCP program, patients and clinicians have expressed the importance of this relational continuity.

CCP-like models also promote unique staffing models. Given the concentration of high risk patients within a given practice, clinicians are encouraged to incorporate a variety of providers including social workers, community health workers and nurses into the patient care team as well as a variety of services including social service navigation and education programming. We have considered the possibility that higher care coordination fees might be justified to support greater use of care coordinators, social workers, community health workers or other non-physician members of the care team, but elected not to do so because the contributions of such individuals can be understood as already being incentivized by existing APMs and other incentive systems upon which the CCP-PM will be layered.

By structuring the CCP-PM as a per member per month supplement rather than an add on to either an inpatient or outpatient charge, the model is designed to encourage a novel approach to care rather than any increase in a particular type of service.

5. Flexibility

A. CCP-PM Integration with other Payment Models

The CCP-PM is structured to function alongside both current and future payment models. For example, if an institution is a Track 1 MSSP ACO, the CCP-PM would provide additional incentive payments to participating clinicians which would count as cost to the ACO as a whole. It is our expectation that shared savings would substantially outweigh these costs for both Medicare and the healthcare institution. Additionally, the ACO's quality metrics would continue to be applied to clinicians participating in the CCP-PM. As the CCP-PM includes two-sided risk, participation in this model could help transition institutions toward taking on additional risk.

For clinicians participating in MIPS or traditional fee-for-service Medicare, the CCP-PM would integrate similarly and would likely provide an institution's first exposure to a risk-based contract. It is our hope that such an experience would provide these organizations more confidence to participate in contracts with higher degrees of risk.

B. Infrastructure Flexibility

The key challenge to implementing the CCP-PM is developing an operational model that allows physicians to see patients in both the inpatient and outpatient settings. To accommodate this change in workflow, the CCP-PM provides significant flexibility in allowing individual practices to decide how and how quickly to make this transition. While our experience has suggested that CCP-like programs are more efficient when the majority of a provider's patient pool consists of patients at increased risk of hospitalization, the CCP-PM allows participating providers to create a patient pool that works best for them. Furthermore, the speed at which practices transition to a CCP model is flexible as patients are empaneled on an individual basis.

Continuity measurement infrastructure required to determine CCP-PM payments or fines would be housed within Medicare systems and based on claims data. Physicians would simply need to enroll along with their patients. As described above, the CCP-PM does not require program-specific quality reporting for outcomes. Quality measurement would be based on existing infrastructure in place to support required reporting of a system's umbrella payment model.

C. CCP-PM Integration with Various Practice Models and Patient Populations

The CCP program at University of Chicago currently functions at an urban academic medical center. Community hospitals have also expressed interest in developing CCP-like programs. It is likely that off-hour hospital coverage would differ across such settings. For example, at University of Chicago, hospitalists provide overnight coverage of CCP patients. In a community or rural setting, overnight coverage may be provided by hospitalists but could also be provided by the primary physician or a colleague in their practice with whom call is shared. We recognize that in many community and rural settings, some primary care physicians currently function in a similar practice model to the one we propose, albeit often without an adequate number of inpatients on most days because their practice does not focus on patients at high risk of hospitalization. Given the progressive decline in this style of practice, we believe that the CCP-PM is a critical tool to support this model for patients to whom relational continuity matters most.

Additionally, the CCP program has defined its patient population broadly as those who are at increased risk of hospitalization, that is, who have been hospitalized at least once in the past year. While our program has targeted a general population, the CCP-PM is designed to be flexible to accommodate subspecialty populations as well. For examples, oncology patients with high utilization could be excellent targets for participation in the CCP-PM.

6. Ability to be Evaluated

Once implemented, we propose working with CMS to develop a CCP-PM evaluation strategy across several stages within the proposed 5-year pilot of the CCP-PM. Such a strategy to evaluate a new program has a precedent in the concept of "coverage with evidence development." First, we would propose evaluation of the appeal of the overall model by examining enrollment in the CCP-PM. Concurrent with this phase of evaluation, we would also expect further refinement of the model by examining both threshold levels for continuity

payments as fines as well as payment and penalty amounts. Specifically, various care continuity payment levels and fine amounts could be tested to evaluate their impact on program participation and practice structure change. As a second stage of evaluation, we propose examining whether participating physicians changed their practice structure based on the payment model. Specifically, we would suggest studying whether participating physicians change their inpatient versus outpatient billing volumes and performing a qualitative analysis of practice structures and schedules.

We would also propose a last stage of evaluation that would measure the outcomes associated with the CCP-PM. Ideally, this stage would focus on a direct comparison of utilization, quality and experience of participants in the CCP-PM versus persons eligible but not participating. Given the challenges of setting up a randomized clinical trial at this scale, this analysis could be done with a case control study or a stepped wedge analysis wherein interested sites implement the CCP-PM at different time periods. Sites for a case control or stepped wedge analysis could be identified from within the broad network of organizations that have expressed interest in implementing CCP-like programs. Should any site propose to perform an RCT, however, we think such a site should be given extra consideration in the process of selecting sites in which to test the CCP-PM.

Given that the CCP model was developed as part of a randomized control trial (RCT), we have gained significance experience to guide the evaluation of related models such as the CCP-PM. In particular, our experience suggests that the metrics most likely to be impacted by a CCP-like model include patient experience, self-rated health status, and hospital utilization and total costs of care.

7. Integration and Care Coordination

The foundation of the CCP-PM is relational continuity between the inpatient and outpatient setting, specifically having a single provider see his or her patients in both settings. In addition to the participating clinician, our experience has suggested the value of additional clinical team members to promote care coordination. For example, for the CCP program at University of Chicago, the same social worker sees patients across care settings. The clinic coordinator also develops strong relationships with patients, proactively connecting with admitted patients to ensure a smooth transition to the outpatient setting.

While the main emphasis of the CCP-PM is promoting continuity between traditional inpatient and outpatient settings, the incentive program is also structured to encourage physicians to see their patients both in the home and rehabilitation settings when appropriate, as these visits are included in the calculation of percent provision of outpatient general medical care.

In addition to the traditional care coordination impact described above, the CCP-PM also requires system level support to ensure that participating physicians know when their patients are admitted to the hospital. For example, at the University of Chicago, an electronic medical record alert is triggered to alert CCP physicians that one of their patients is in the emergency room.

Further, our experience with the CCP program at University of Chicago has highlighted the importance of non-physician members of the CCP team. While these members are not directly incentivized through the CCP-PM, it is our hope that in the case that shared savings are generated from this program that they are passed on to support and motivate these providers as appropriate.

8. Patient Choice

The CCP-PM accommodates patient choice in a number of ways. First, unlike many other payment models, patients must elect to participate in the model alongside a participating physician. This is clearly a contrast with the hospitalist model that has become the norm in most settings, in which patients typically do not get to choose their hospitalist. Patients can also choose to leave the model for any reason at any time.

Secondly, the CCP-PM has been developed on the basis that strong relationships are key to accommodating patient preferences and meeting patients' specific needs. By spending time with patients in both the intensive inpatient and longitudinal outpatient settings, participating physicians develop greater insight into patient needs and preferences and are better able to address them long-term. Effectively meeting these needs is especially important in CCP-PM participants given the higher degree of vulnerability inherently present in many high risk patients.

In addition, given the CCP-PM's flexibility and ability to be implemented in community and rural settings, the model would expand the demographic, clinical and geographic diversity of participation in alternative payment models.

9. Patient Safety

Transitions of care between the inpatient and outpatient setting have been clearly identified as periods of heightened risk to patient safety. The CCP model reduces these transitions of care with respect to provider continuity and therefore would be expected to increase patient safety. The greatest patient safety concern with development of practices participating in the CCP-PM might be if patients chose to leave existing primary care relationships to enter a CCP-practice. However, the experience with this at the University of Chicago has suggested to us that many patients who choose to enter CCP do not have highly desirable primary care arrangements at the time they enter the program. Given the voluntary nature of enrollment in CCP at the University of Chicago, this may not be surprising. We think that voluntary patient enrollment in CCP is essential for its success. We would propose that models in which patients were required to move their care to a CCP not be eligible for the CCP-PM.

10. Health Information Technology

The CCP-PM interacts with health information technology (HIT) in a number of ways. First, quality reporting relies on HIT systems; however, given that the CCP-PM is supplemental to existing payment models and quality measurement infrastructure, this capability likely already exists.

In addition, the CCP-PM is likely to drive HIT innovation. For instance, creating alerts to track patients across care settings would support the incentivized practice model. Given that the CCP-PM practice model concentrates inpatient and outpatient care with one physician, the model provides a network with lower barriers to uptake of novel healthcare technology, for example virtual visits.

The CCP-PM also circumvents a number of challenges commonly associated with current HIT infrastructure. By having one physician see patients in both the inpatient and outpatient setting there is less need to transfer records across settings, a common challenge in the current HIT system.

Appendix A: Actuarial Impact of the CCP-PM

The actuarial impact of the CCP-PM on both Medicare and participating providers will vary depending on the umbrella payment model in which the provider is participating. Below we illustrate the impact of the PFPM in the context of both MIPS and the MSSP Track 1+ ACO. For both payment models, we illustrate a scenario in which predicted Medicare savings are achieved (highest expected savings for Medicare) and one in which no savings are achieved (highest expected loss for Medicare). Each scenario is modeled at the physician panel level, assuming a panel of 200 patients and an average care continuity fee of \$25 (assumes half of panel is new or renewed enrollees and half of panel is continued enrollees). For the MSSP Track 1+ ACO, we further delineate an example where the ACO is eligible for shared savings and one in which the ACO is subject to loss sharing.

Under MIPS, all savings and cost generated by the CCP-PM accrue to Medicare directly.

A. MIPS

		Medicare Costs	Participating Organization Revenue
Scenario 1: program saves \$600,000 per physician	Care Continuity Fees	\$60,000	\$60,000
	Decreased Shared Savings	n/a	n/a
	Decreased Spending	-\$600,000	n/a
	Increased Shared Savings	n/a	n/a
	Total Impact	-\$540,000	\$60,000
Scenario 2: program does not generate savings	Care Continuity Fees	\$60,000	\$60,000
	Decreased Shared Savings	n/a	n/a
	Decreased Spending	\$0	n/a
	Increased Shared Savings	n/a	n/a
	Total Impact	\$60,000	\$60,000

In the context of an MSSP Track 1+ ACO, actuarial impact is further affected by whether an organization is eligible for shared savings or loss sharing. Example B demonstrates a situation where the ACO is eligible for shared savings. In this context, any savings generated by the CCM-PM are shared between the ACO and Medicare. If the program does not generate savings, Medicare costs are shared with the organization in the form of decreased shared savings.

B. MSSP Track 1+ ACO Eligible for Shared Savings⁵

		Medicare Costs	Participating Organization Revenue
Scenario 1: program saves \$600,000 per physician	Care Continuity Fees	\$60,000	\$60,000
	Decreased Shared Savings	-\$30,000	-\$30,000
	Decreased Spending	-\$600,000	n/a
	Increased Shared Savings	\$300,000	\$300,000
	Total Impact	-\$270,000	\$330,000
Scenario 2: program does not generate savings	Care Continuity Fees	\$60,000	\$60,000
	Decreased Shared Savings	-\$30,000	-\$30,000
	Decreased Spending	\$0	n/a
	Increased Shared Savings	\$0	\$0
	Total Impact	\$30,000	\$30,000

⁵ Assume shared savings rate of 50%.

Example C illustrates a situation where an ACO is not eligible for shared savings and is eligible for loss sharing. In this context, CCP-PM savings are shared between the ACO and Medicare, as they reduce the burden of the organization’s loss sharing. If the program does not generate shared savings, Medicare losses are shared with the ACO in the form of loss-sharing.

C. MSSP Track 1+ ACO Not Eligible for Shared Savings and Eligible for Loss-Sharing⁶

		Medicare Costs	Participating Organization Revenue
Scenario 1: program saves \$600,000 per physician	Care Continuity Fees	\$60,000	\$60,000
	Decreased Shared Savings ⁷	-\$18,000	-\$18,000
	Decreased Spending	-\$600,000	n/a
	Increased Shared Savings	\$0	\$180,000 ⁸
	Total Impact	-\$558,000	\$222,000
Scenario 2: program does not generate savings	Care Continuity Fees	\$60,000	\$60,000
	Decreased Shared Savings	-\$18,000	-\$18,000
	Decreased Spending	\$0	n/a
	Increased Shared Savings	\$0	\$0
	Total Impact	\$42,000	\$42,000

⁶ Assume shared savings rate of 50% and shared loss rate of 30%.

⁷ In the context of an MSSP Track 1+ ACO, not eligible for shared savings and eligible for loss-sharing, negative decreased shared savings represent an increase loss sharing.

⁸ In the context of an MSSP Track 1+ ACO, not eligible for shared savings and eligible for loss-sharing, increased shared savings, in the context of overall program savings, represents at risk revenue that would have been owed to Medicare had the savings generated by the program not been attained.

Appendix B: Calculation of Inpatient and Outpatient Care

A. Provider Taxonomy of General Medical Clinicians

Provider Taxonomy Code	Provider Taxonomy Description: Type Classification, Specialization
207Q00000X	Allopathic & Osteopathic Physicians, Family Medicine
207QA0505X	Allopathic & Osteopathic Physicians, Family Medicine, Adult Medicine
207QG0300X	Allopathic & Osteopathic Physicians, Family Medicine, Geriatric
207R00000X	Allopathic & Osteopathic Physicians, Internal Medicine
207RG0300X	Allopathic & Osteopathic Physicians, Internal Medicine, Geriatric
208D00000X	Allopathic & Osteopathic Physicians, General Practice
208M00000X	Allopathic & Osteopathic Physicians, Hospitalist

**Nurse practitioner and physician assistant billing would be classified under the taxonomy of a supervising physician*

B. Outpatient visits are the following CPT codes when billed by physicians with the provider taxonomy noted above.

CPT Codes	Description
99201 – 99215; 99495, 99496	Office and other outpatient visit
99304 - 99337	Nursing facility, domiciliary, rest home or custodial care
99341 - 99350	Home visits

C. Inpatient visits are the following CPT codes when billed by physicians with the provider taxonomy noted above.

CPT Codes	Description
99215 - 99236	Inpatient and Observation E&M
99251 - 99255	Consultation

Please note that this taxonomy and CPT code list is based on currently available information and subject to change based on CMS input.

Appendix C: Letters of Support



Kenneth S. Polonsky, MD
*Richard T. Crane Distinguished Service Professor
Dean of the Division of the Biological Sciences
and the Pritzker School of Medicine
Executive Vice President for Medical Affairs*

February 12, 2018

David Meltzer, MD, PhD
Chief, Section of Hospital Medicine
University of Chicago Hospital

Dear David:

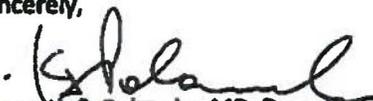
We are writing in enthusiastic support of your proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to establish a new type of payment mechanism called the Comprehensive Care Physician Payment Model (CCP-PM).

We are delighted that you are developing an innovative payment model that is directly aligned with our efforts at University of Chicago Medicine (UCM) to better manage the populations we serve. As you know, we participate in a Medicare Shared Savings Program Accountable Care Organization (MSSP-ACO) in which we are focused on implementing and supporting value-based programs that address high-risk patients, including the Comprehensive Care Physician (CCP) program. We have been impressed with the CCP program's ability to impact important outcomes such as patient satisfaction, mental health status and hospital utilization. We see great potential for CCP-like models to be disseminated across the country.

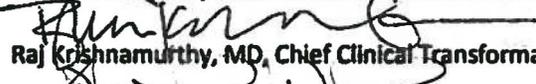
The CCP-PM is a novel payment model because it provides a care continuity fee that incentivizes more physicians to structure their practices such that they provide the majority of care for complex patients in both the hospital and the clinic. In addition, the payment model is designed to easily integrate with the existing payment models of participating institutions, such as our MSSP ACO. This feature will motivate a range of practice types and institutions to participate in advanced APMs. Should the CCP-PM be implemented, we expect to build mechanisms to bill and monitor evaluation of this payment model at UCM. Furthermore, we plan to work closely with our affiliate, Ingalls Hospital, to implement the CCP-PM there as well.

We strongly encourage PTAC to support this highly innovative payment model and are glad to answer any questions the Committee might have.

Sincerely,


Kenneth S. Polonsky, MD, Dean University of Chicago Medicine, EVP Medical Affairs


Titus Daniels, MD, Chief Ambulatory Medical Officer


Raj Krishnamurthy, MD, Chief Clinical Transformation Officer


Stephen Weber, MD, Chief Medical Officer

February 14, 2018

Dear David,

It is with great enthusiasm that we write in support of your proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to develop a physician-focused payment model to support development of Comprehensive Care Physician (CCP) programs or similar care delivery models.

The CCP clinical team at University of Chicago Medicine (UCM) is a multidisciplinary group made up of 5 CCP physicians, 2 nurses, a social worker and clinic coordinator who care for patients at increased risk of hospitalization. To date, we have had the opportunity to provide care to over 1,000 patients since the start of the program in 2012. As you know, the core tenant of the CCP model is having one physician care for patients in the inpatient and outpatient settings. Our experience delivering care in this way has shown tremendous value in strengthening the patient-physician relationship. As you are aware, findings from the CCP study are impressive, showing significantly improved patient satisfaction, health outcomes and decreased hospital utilization.

At UCM we have been able to develop the CCP program with the support of a CCMI innovation grant. While the program is now largely self-sufficient, we envision the CCP-PM as a critical step in enabling other providers in implementing CCP-like programs. Transitions to new models of care are challenging and often costly as we have learned from the development of our own program. As such, the CCP-PM will offer an important element of support to encourage practices to take risks and provide more integrated care. Further, the supplemental nature of the CCP-PM will enable it to be accessible to the broadest array colleagues regardless of current payment model participation.

We urge PTAC to support this important endeavor.

Sincerely,



Anshu Verma, MD
Comprehensive Care Physician, University of Chicago
Medical Director, Comprehensive Care Physician (CCP) Program

February 12, 2018

Dear Dr. Meltzer,

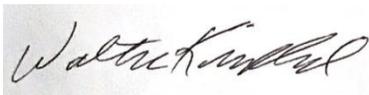
I am thrilled to write this letter in support of your proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) so that you can develop a way to encourage more doctors to see their patients in and out of the hospital.

Having grown up on the south side of Chicago, I have experienced care in many different settings and from many different doctors. It is difficult to be in the hospital and not know the person who is taking care of me. In those situations, I would worry about how the different doctors communicated my needs effectively to one another. However, the Comprehensive Care Program (CCP) solves this problem for me. I joined the program on August 5th, 2014 and since then have been overwhelmingly pleased with the care I have received and the relationship I have built with my doctor, Dr. Verma. This relationship and the relationships I have built with many members of the CCP team have grown to mean more to me than I could have imagined in a healthcare setting.

Because of my positive experience with CCP, I have become increasingly involved with the program. I was pleased to be able to share my experience as a CCP patient at a recent meeting organized by the American Board of Internal Medicine. I am also an active member of the recently created Comprehensive Care, Community and Culture Community Advisory Board. In this role, I am able to share my perspective as a patient and a proud community member and have seen my feedback be quickly incorporated into the programming.

As a CCP patient and community advocate, I see firsthand the difference CCP can play in the lives of patients and their families. Therefore, I strongly support this application and hope that programs like CCP can become available for patients like me throughout the country.

Very sincerely,

A handwritten signature in black ink that reads "Walt Kindred". The signature is written in a cursive style and is positioned above a light gray rectangular background.

Walt Kindred



February 14, 2018

David Meltzer, MD, PhD
Chief, Section of Hospital Medicine Professor of Medicine
University of Chicago Hospital 5841 S. Maryland, MC 5000
Chicago, IL 60637

Dear Dr. Meltzer:

I am excited to support your application to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to create a novel alternative payment model, called the Comprehensive Care Physician Payment Model (CCP-PM), that will incentivize more physicians to provide the majority of both inpatient and outpatient care to patients at increased risk of hospitalization.

Vanderbilt is thrilled to be implementing a version of the Comprehensive Care Program (CCP) to better manage complex patients. The CCP program is innovative in its approach to delivering coordinated medical care from a team of health care providers who are able to build strong relationships with their patients. We appreciated our visit to the University of Chicago to meet with various members of the CCP team and better understand the clinical and research responsibilities. We anticipate that the outcomes for our patients will improve under this program, and we look forward to sharing those exciting and positive results with you. We also are glad to be participating in the Comprehensive Care Learning Collaborative you recently launched to learn more about mechanisms of the CCP program and share learnings of our own.

We support your important proposal to create an add-on payment model to incentivize the establishment of CCP-like models of care throughout the country. If implemented, the CCP-PM will encourage the restructuring of practices to better manage patients at increased risk of hospitalization and foster the movement of more entities towards participation in Alternative Payment Models (APMs). If your proposal is approved, implementation of the CCP-PM at Vanderbilt could be an important source of revenue that would support our complex care management program.

As part of a hospital system whose patients will benefit greatly from your program's success, I am pleased to support your proposed payment model. Consider us your advocates and supporters along this journey. My best,

A handwritten signature in black ink, appearing to read 'Eduard Vasilevskis'.

Eduard Vasilevskis, MD, MPH
Chief, Section of Hospital Medicine
Vanderbilt University Medical Center
Tel. 615-936-1935
Eduard.vasilevskis@vanderbilt.edu

February 12, 2018

David Meltzer, MD, PhD
Chief, Section of Hospital Medicine Professor of Medicine
University of Chicago Hospital 5841 S. Maryland, MC 5000
Chicago, IL 60637

Dear Dr. Meltzer:

I am pleased to support your proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to create the Comprehensive Care Physician Payment Model (CCP-PM), an alternative payment model that encourages providers to care for their patients in both hospital and outpatient settings.

As a general internist who provided continuity to her patients in both the hospital and in the clinic for nearly three decades I see great promise in the model you propose. The Comprehensive Care Physician (CCP) program, which provides patients at increased risk of hospitalization with one physician who cares for them in and out of the hospital, has the potential to meaningfully improve patient experience and health outcomes while also decreasing costs. The CCP program's success stems from its recognition of the importance of the physician-patient relationship and continuity across outpatient and inpatient domains. This continuity leads to more effective care delivery and a more rewarding care experience for patients, families and providers.

I am impressed with the CCP model and support its dissemination and the development of similar care models. If implemented, your proposed CCP-PM will encourage physicians from both small and large practices to synthesize, rather than defragment care for complex patients in their communities. Doing so, could have significant impacts on healthcare spending and health outcomes nationally.

Kind Regards,



Christine Sinsky, MD
Vice President of Professional Satisfaction at the American Medical Association
Director of the American Board of Internal Medicine
Internist at Medical Associates Clinic and Health Plans in Dubuque, Iowa



AT THE FOREFRONT

**UChicago
Medicine**

Ingalls Memorial

February 15, 2018

David Meltzer
Comprehensive Care Program
University of Chicago
Chicago, IL 60637

Dear Dr. David Meltzer,

I am excited to support your application to the Physician-Focused Payment Model Technical Advisory Committee (PCTAC) to create the Comprehensive Care Physician Payment Model (CCP-PM), an alternative payment model that encourages physicians to provide comprehensive care to their patients in both the hospital and the clinic.

As President of Ingalls Memorial Hospital, a community hospital in the south suburbs of Chicago, I am especially focused on developing value-based programming to better care for our communities. Ingalls has taken steps through our Medicare Shared Savings Program Accountable Care Organization (MSSP-ACO) to address issues of fragmented care through the implementation of our own care management program. Similarly, the Comprehensive Care Physician (CCP) program coordinates care for patients at increased risk of hospitalization and has produced impressive results, significantly improving patient satisfaction, health outcomes and decreasing hospital utilization and associated costs to the system.

Given our shared goals to impact measures of patient care and utilization, we have spent the past year collaborating with you and your team to develop a model similar to CCP that will integrate with our current programs and serve complex patients at Ingalls. Participation in a payment model like the CCP-PM will further incentivize physicians to manage care for complex patients by providing a care continuity fee to participating physicians. If implemented, we would be excited to develop mechanisms to support Ingalls physician participation in the CCP-PM.

Sincerely,

Kurt Johnson
President

One Ingalls Drive | Harvey, IL 60426

t 708-333-2300

Ingalls.org

Appendix D: Submission Checklist

Requirement	Checkbox	Pages
Letter of intent submitted 30 days before the proposal	<input checked="" type="checkbox"/>	
Name and address of the submitter (individual or organization)	<input checked="" type="checkbox"/>	
Name, address, phone number, and e-mail address for the primary point of contact	<input checked="" type="checkbox"/>	
Title Page	<input checked="" type="checkbox"/>	
Table of Contents	<input checked="" type="checkbox"/>	
Abstract	<input checked="" type="checkbox"/>	
If the submitter is an organization, a letter of support from the governing board or responsible officer is included.	<input type="checkbox"/>	n/a
Main body of the proposal is ordered by and includes the following sections:		
Model Description		
Background and Model Overview	<input checked="" type="checkbox"/>	1 - 4
How the model would work from the patient's perspective	<input checked="" type="checkbox"/>	1 - 4
How the model would work from the perspective of participating eligible professionals, the patient's primary care provider, and other providers (including hospitals, post-acute care providers, etc.) who would participate in or be affected by the model	<input checked="" type="checkbox"/>	1 - 4
Response to Criteria		
Scope	<input checked="" type="checkbox"/>	4 - 7
Quality and Cost	<input checked="" type="checkbox"/>	8 - 11
Payment Methodology	<input checked="" type="checkbox"/>	11 - 14
Value over Volume	<input checked="" type="checkbox"/>	15
Flexibility	<input checked="" type="checkbox"/>	15 - 16
Ability to be Evaluated	<input checked="" type="checkbox"/>	16 - 17
Integration and Care Coordination	<input checked="" type="checkbox"/>	17 - 18
Patient Choice	<input checked="" type="checkbox"/>	18
Patient Safety	<input checked="" type="checkbox"/>	18
Health Information Technology	<input checked="" type="checkbox"/>	18 - 19
Main body of the proposal does not exceed 25 pages and formatting requirements are met.	<input checked="" type="checkbox"/>	