

**Comprehensive Primary Care Plus (CPC+) Round 2
July 10, 2017**

GENERAL

Q: Why is CMS testing CPC+?

CMS believes that through multi-payer payment reform and practice transformation, primary care practices will be able to build capabilities and care processes to deliver patient-centered, high quality care and lower the use of unnecessary services that drive total costs of care. Payment redesign by payers, both public and private, will offer the ability for greater cash flow and flexibility for primary care practices.

Q: When will CPC+ Round 2 start and how long will it last? Can my practice join later?

CPC+ Round 2 is expected to begin on January 1, 2018. Eligible practices located in the CPC+ Round 2 regions can apply from May 18-July 13, 2017.

CPC+ Round 2 consists of five performance years, as identified in the table below. CMS expects practices to participate for the full five years of their respective round of the model and will not allow practices to join the model after CMS selects practices to participate in each round of the Model.

PERFORMANCE YEARS FOR CPC+ Round 2

Calendar Year	Round 2 Performance Year
2018	1
2019	2
2020	3
2021	4
2022	5

Q: Are practices required to participate in CPC+ for the full five years?

CMS expects practices to participate in CPC+ for the full five years. However, participation in CPC+ is voluntary and practices may withdraw from the model without penalty during the five-year performance period. Practices are required to notify CMS at least 90 calendar days before the planned day of withdrawal. Departing the model before completion of a performance year (PY) puts a practice at risk for recoupment of unearned CPC+ payments.

Q: Where will CPC+ Round 2 be implemented?

CPC+ Round 2 will be implemented in four regions throughout the U.S.:

1. Louisiana: Statewide
2. Nebraska: Statewide
3. North Dakota: Statewide

4. New York: Greater Buffalo Region

The CPC+ Round 2 regions were selected based on payer alignment and market density to ensure that CPC+ practices have sufficient payer support to make fundamental changes in their primary care delivery.

Q: How is CMS defining the “Greater Buffalo Region (NY)”?

Based on payer alignment and market density, CMS is defining the Greater Buffalo region with the following counties:

- New York: Greater Buffalo Region: Erie County, NY; Niagara County, NY

Only practices located in these counties are eligible to apply and participate in CPC+ Round 2.

Q: Which payers have been selected to partner in CPC+ Round 2?

CPC+ Round 2 payer partners in the four new CPC+ Round 2 regions:

1. Louisiana: Amerigroup Louisiana, Inc., AmeriHealth Caritas Louisiana, Inc., Blue Cross Blue Shield of Louisiana
2. Nebraska: Blue Cross Blue Shield of Nebraska
3. New York: Greater Buffalo Region: HealthNow New York Inc., Independent Health Association, Inc.
4. North Dakota: Blue Cross Blue Shield of North Dakota

Q: When and how can a practice apply to participate in CPC+ Round 2?

Based on payer interest and proposed alignment, CMS announced four regions for CPC+ Round 2. Practices located in these regions are eligible to apply via an online portal (<https://app1.innovation.cms.gov/cpcplus/>) from May 18-July 13, 2017. For questions about the Model or the solicitation process, please email CPCPlusapply@telligen.com or call 1-877-309-6114.

Q: How many practices will be accepted in CPC+ Round 2?

CMS expects to accept up to 1,000 practices in CPC+ Round 2.

Q: Why will new practice applications only be accepted in CPC+ Round 2 regions?

CPC+ is a voluntary test of primary care payment and delivery system changes at the practice level, and will be independently evaluated throughout the five years of each Round of the model. The evaluation compares practices in each region to similar practices in the same region. CMS is unable to add new practices in the existing regions without potentially compromising the evaluation. Therefore, new practices will only be able to apply for participation in CPC+ in new regions selected for CPC+ Round 2, not in the 14 Round 1 regions.

Q: What is expected of the control group practices in CPC+ Round 2?

CMS will randomly assign eligible practices to an intervention group and a control group. The control group practices will not be required to implement the CPC+ care delivery practice changes, will not receive CPC+ Payments, and will not participate in the CPC+ learning communities, and will sign a different CPC+ Participation Agreement with CMS than the

intervention group. Additionally, they will not be considered participants in an Advanced APM through participation in the CPC+ control group, but may otherwise be Advanced APM participants through their participation in other CMS models or programs. Control group practices may be compensated for their participation in CPC+ evaluation-related activities. CMS also expects to promulgate a rule that could allow for control group practices to potentially receive favorable scoring under the Improvement Activities category of the Merit-based Incentive Payment System (MIPS), subject to notice and comment rulemaking. More details for control group practices will be announced in late 2017.

Q: Are practices outside of the CPC+ Round 2 regions eligible to apply and participate in CPC+?

Practices will only be eligible to apply to Round 2 if they are located in one of the selected Round 2 regions. The purpose of the CPC+ multi-payer design is to ensure that primary care practices receive the adequate support from multiple payers to change care delivery for a practice’s entire panel of patients. The CPC+ regions were carefully selected to ensure adequate payer support for participating practices.

My primary care practice site is located in:	Was I eligible for Round 1 (2017-2021)?	Am I eligible to apply for Round 2 (2018-2022)?
<ul style="list-style-type: none"> • Arkansas Region • Colorado Region • Hawaii Region • Greater Kansas City Region^a • Michigan Region • Montana Region • New Jersey Region • North Hudson-Capital Region^b • Ohio-Northern Kentucky Region^c • Oklahoma Region • Oregon Region • Greater Philadelphia Region^d • Rhode Island Region • Tennessee Region 	Yes	No, even if you: <ul style="list-style-type: none"> • Applied for Round 1 but were not accepted • Did not apply for Round 1
<ul style="list-style-type: none"> • Louisiana Region • Nebraska Region • North Dakota Region • Greater Buffalo Region^e 	No	Yes

^aGreater Kansas City Region is defined as Johnson County, KS; Wyandotte County, KS; Clay County, MO; Jackson County, MO; Platte County, MO

^bNorth Hudson-Capital Region of New York is defined as Albany County, NY; Columbia County, NY; Dutchess County, NY; Greene County, NY; Montgomery County, NY; Orange County, NY; Rensselaer County, NY; Saratoga County, NY; Schenectady County, NY; Schoharie County, NY; Sullivan County, NY; Ulster County, NY; Warren County, NY; Washington County, NY

^cOhio-Northern Kentucky Region is defined as all counties in Ohio; Boone County, KY; Campbell County, KY; Grant County, KY; Kenton County, KY

^dGreater Philadelphia Region is defined as Bucks County, PA; Chester County, PA; Delaware County, PA; Montgomery County, PA; Philadelphia County, PA

^eGreater Buffalo Region is defined as Erie County, NY and Niagara County, NY

Q: Is CPC+ an Advanced APM under the Quality Payment Program?

CPC+ is included on the list of Advanced APMs. This determination was based on medical home model-specific requirements. For payment years 2019 through 2024, clinicians who meet the threshold for sufficient participation in Advanced APMs and who meet requirements, as applicable for 2018 onward, regarding parent organization size are excluded from the Merit-based Incentive Payment System (MIPS) reporting requirements and payment adjustments and qualify for a five percent APM incentive payment.

Q: Where can practices find more information about the QPP and Advanced APMs?

More information about the QPP and Advanced APMs can be found on the new website from CMS: <https://qpp.cms.gov>.

Q. What role do other payers play in CPC+?

Multi-payer engagement is an essential goal of CPC+, as it enables both public and private payers to sponsor comprehensive primary care reform. CMS will partner with payers that share Medicare's interest in strengthening primary care in each of the CPC+ regions. Payer partners, both public and private, will provide their own financial support to practices, separate from that of Medicare Fee-for-Service (FFS). Any questions regarding non-Medicare payer support should be directed to the payer partner.

PAYMENT DESIGN

Q: How will primary care practices be paid in CPC+?

CPC+ practices will receive a risk-adjusted, prospective, monthly care management fee (CMF) for their attributed CPC+ Medicare beneficiaries. Practices will use this enhanced, non-visit-based compensation to augment staffing and training in support of population health management and care coordination. Track 1 practices will receive a CMF that averages \$15 per beneficiary per month (PBPM) to support their transformation efforts. Track 2 practices will receive an average of approximately \$28 PBPM, including a \$100 PBPM for a highest risk tier to support the enhanced services beneficiaries with complex needs require.

CPC+ Care Management Fees

Risk Tier	Attribution Criteria	Track 1	Track 2
Tier 1	1 st quartile HCC	\$6	\$9
Tier 2	2 nd quartile HCC	\$8	\$11
Tier 3	3 rd quartile HCC	\$16	\$19
Tier 4	4 th quartile HCC for Track 1; 75-89% HCC for Track 2	\$30	\$33
Complex (Track 2 only)	Top 10% HCC OR Dementia	N/A	\$100
Average PBPM		\$15	\$28

In Track 1, practices will also continue to receive regular Medicare fee-for-service payments for covered evaluation and management services. In Track 2 of CPC+, CMS is introducing a hybrid of fee-for-service and Comprehensive Primary Care Payment (CPCP). This hybrid payment will pay for covered evaluation and management (E&M) services, but allows flexibility for the care to be delivered both in and out of an office visit. Track 2 practices will receive a percentage of their expected Medicare E&M payment upfront in the form of a CPCP and a reduced fee-for-service payment for face-to-face E&M claims. In an effort to recognize practice diversity in readiness for this change in payment, CMS will allow practices to move to one of these final two proposed hybrid payment options (40 percent or 65 percent CPCP, paired with 60 percent or 35 percent FFS, respectively), at their preferred pace, pursuant to the options shown in this table:

CPCP and FFS Options

	PY1	PY2	PY3	PY4	PY5
CPCP%/FFS%	10%/90%				
options available to practices, by year	25%/75%	25%/75%			
	40%/60%	40%/60%	40%/60%	40%/60%	40%/60%
	65%/35%	65%/35%	65%/35%	65%/35%	65%/35%

Q: How will primary care practices be encouraged and rewarded for their accountability for patient experience, clinical quality, and utilization?

CMS will prospectively pay a performance-based incentive payment, which practices may keep if they meet annual performance thresholds. Practices that do not meet the annual thresholds would be required to repay all or a portion of the prepaid amount. Practices will thus be “at risk” for the amounts prepaid. The payment will be broken into two distinct components, both paid prospectively: incentives for performance on clinical quality/patient experience measures and incentives for performance on utilization measures that drive total cost of care. The quality/experience component will be based on performance on electronic clinical quality measures (eCQM) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) metrics. The utilization component will be based on claims-based outcome measures that are measurable at the practice level, including: inpatient admissions and emergency department visits that are available in the Healthcare Effectiveness Data and Information Set (HEDIS).

CMS will provide larger performance-based incentive payments in Track 2 than in Track 1, as outlined in the following table. However, all practices are at risk for repaying all or a portion of the prepaid amount to CMS depending on their performance. The methodology for calculating the prepaid amounts and repayment amounts are outlined in a [CPC+ Payment Methodology Paper](#).

CPC+ Performance Based Incentive Payment

	Utilization (PBPM)	Quality (PBPM)	Total (PBPM)
Track 1	\$1.25	\$1.25	\$2.50
Track 2	\$2.00	\$2.00	\$4.00

Q: What are the differences between the three payment elements?

- 1) **Care Management Fee (CMF):** Both tracks provide a non-visit based CMF paid PBPM. The amount is risk-adjusted for each practice to account for the intensity of care management services required for the practice’s specific population. The CMFs will be paid to the CPC+ practice on a quarterly basis.
- 2) **Performance-based incentive payment:** CPC+ will prospectively pay and retrospectively reconcile a performance-based incentive payment based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care. The performance-based incentive payment will be paid to the CPC+ practice on an annual basis.
- 3) **Payment under the Medicare Physician Fee Schedule:**
 - a. Track 1 continues to bill and receive payment from Medicare FFS as usual.
 - b. Track 2 practices also continue to bill as usual, but the FFS payment for evaluation and management services will be reduced to account for CMS shifting a portion of Medicare FFS payments into **Comprehensive Primary Care Payments (CPCPs)**, which will be paid in a lump sum on a quarterly basis. Given our expectations that Track 2 practices will increase the comprehensiveness of care delivered, the CPCP amounts will be larger than the FFS payment amounts they are intended to replace.

CPC+ Financial Summary Table

Track	Care Management Fees, PBPM	Performance-Based Incentive Payments	Payment under Medicare Physician Fee Schedule
1	\$15 average	Utilization and Quality/Experience Components	FFS
2	\$28 average; \$100 for complex	Utilization and Quality/Experience Components	↓FFS + ↑CPCP

Q: Will practices be responsible for reporting their Medicare spending to CMS?

Yes, CPC+ practices will be required to both forecast their spending of the CPC+ Payments and, at the end of the performance year, provide an accounting of actual CPC+ expenditures. This reporting will help practices understand and optimize their use of these alternative payments and will also help CMS to understand how practices use the revenue they receive to perform the care delivery work the model requires.

Q: How will Medicare beneficiaries be attributed to CPC+ practices?

Eligible beneficiaries will be attributed to the practice that either billed for the plurality of their primary care allowed charges, or for the most recent claim for Chronic Care Management (CCM) services during the most recently available 24-month period. If a beneficiary has an equal number of claims for Primary Care Services at more than one CPC+ practice, the beneficiary will be attributed to the practice with the most recent claim for a primary care service. CMS will provide each practice with a list of its prospectively attributed beneficiaries for each quarter. More details of the Medicare attribution methodology are available in Appendix E of the [CPC+ Request for Applications](#).

Q: How are Medicare FFS beneficiaries assigned to the various risk tiers?

CMS assigns beneficiaries to a risk tier based on the individual's hierarchical condition category (HCC) score. HCC scores are generated for all Medicare beneficiaries, and are updated annually based on the beneficiaries' claims history. CMS will use the most recent HCC scores available in the CMS claims databases at the time of attribution. A beneficiary's HCC score will determine to which risk quartile the beneficiary will be assigned (see [CPC+ Care Management Fees table](#)), primarily based on comparison to the population of Medicare FFS beneficiaries in that region. In Track 2, the complex tier will be based on a combination of HCC score and beneficiaries with assigned diagnoses of dementia within the CMS Chronic Conditions Warehouse.

Q: What kind of patients will be included in the “complex tier” of top 10 percent HCC for the CPC+ care management fee?

The top 10 percent of the HCC risk pool will represent patients who are the “sickest of the sick,” with multiple conditions and high expected costs. The exact range of HCC scores and number of beneficiaries assigned to the complex tier will vary based on region, due to different populations and variations in coding practices. For a more detailed description of the HCC methodology, as well as detailed information on what diagnoses are included in the HCC scores, please refer to this [independent evaluation report](#).

In addition to beneficiaries in the top 10 percent of HCC risk scores, beneficiaries who have a diagnosis of dementia will also be assigned to the complex tier. Dementia diagnosis is assigned based on a chronic condition flag generated annually based on a set of diagnoses codes present in the prior three years. For detailed information, please refer to the [Chronic Conditions Warehouse](#). The detailed HCC calculation and dementia flag identification methodology will be included in a technical methodology paper distributed to CPC+ practices in January 2017.

Q: Will CPC+ practices be allowed to bill the new chronic care management and behavioral health integration codes in the 2017 Physician Fee Schedule update?

CMS released the 2017 Physician Fee Schedule Final Rule in November 2016, which included new codes for chronic care management and behavioral health integration (BHI) services. In some cases, practices will be allowed to bill the codes for their CPC+ attributed beneficiaries when they do not pay for the same services as the CPC+ CMF. Additionally, practices may bill all of these codes for their unattributed beneficiaries. The relevant codes are summarized below:

Codes	Short Description	May CPC+ Practices Bill for Attributed Beneficiaries?
99487, 99489, 99450	Chronic Care Management	No
G0502- G0504	Collaborative Care Model	Yes
G0505	Cognition and functional assessment for patient with cognitive impairment	Yes
G0506	Assessment/care planning for patients requiring CCM services	No
G0507	Care management services for behavioral health conditions	No
99358- 99359	Prolonged non-face-to-face evaluation and management services	No

CARE DELIVERY DESIGN

Q: What are the main design features of the CPC+ care delivery model?

In CPC+, practices will be guided by Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health. In Track 2, the practices will heighten their focus on caring for patients with complex medical, behavioral, and psychosocial needs. Thus, Track 2 practices will increase the breadth and depth of services offered, as well as inventory resources and supports necessary to meet their psychosocial needs, as appropriate. Because comprehensive primary care requires advanced health information technology (health IT) support for its population-health focus and team-based structure, CMS will require Track 2 practices to engage directly with health IT vendors about model goals and requirements.

Q: What does it mean that practices will enhance the comprehensiveness of care in the primary care setting?

Comprehensiveness in the primary care setting refers to the practice meeting the majority of its patient population's medical, behavioral, and psychosocial needs. Strategies to achieve comprehensiveness involve the use of analytics to identify needs at a population level and developing processes to meet those needs. This includes building capability within the practice, as well as building strong and coordinated referral networks within the medical neighborhood and with community-based services.

Comprehensiveness adds both breadth and depth to the delivery of primary care services; builds on the patient-practitioner relationship that is at the heart of effective primary care; and is associated with less fragmented care, better health outcomes, and lower overall costs.

Q: What changes will practices be expected to make in their care delivery in the first performance year?

The CPC+ care delivery requirements are intended to provide a framework for practices to deepen their capabilities throughout the five performance years. These incremental requirements will guide practices through the five comprehensive primary care functions and will serve as markers for regular, measureable progress toward CPC+ model aims. Track 2 care delivery requirements are inclusive of and build upon the Track 1 requirements, as the framework for delivering better care, smarter spending, and healthier people in CPC+ is the same across both tracks. Track 2 includes additional requirements that will help practices increase the depth, breadth, and scope of care offered, with particular focus on their patients with complex needs.

For a detailed description, please refer to the [PY1 CPC+ Care Delivery Requirements](#).

Q: What learning and technical assistance supports will CPC+ offer to participating practices?

CPC+ will offer participating practices a variety of learning opportunities to support their transformation needs with in-person, virtual, and on-demand events and information. National and regional learning communities will provide CPC+ practices with opportunities for in-person and web-based learning. Learning events and materials will orient practices to CPC+ Model requirements and guide practices through the CPC+ five comprehensive primary care functions. Online collaboration tools and web-based portals will facilitate practice sharing. Regional learning communities will also offer targeted, practice-level technical assistance to support practices to enhance their capabilities.

QUALITY MEASUREMENT

Q: How will CPC+ measure the improvement in the quality of care and patient experience of care?

CPC+ aims to improve the quality and experience of care that patients receive and decrease the total cost of care. To assess quality performance and eligibility for the CPC+ performance-based incentive payment, CMS will require Track 1 and 2 practices to annually report electronic clinical quality measures (eCQMs). In addition, CMS or its contractors will survey a sample of patients in each CPC+ practice (Track 1 and Track 2) annually using the Consumer Assessment of Healthcare Providers & Systems [CAHPS] survey to assess patient experience of care. eCQMs must be reported at the practice-site level for all patients seen at the practice site, regardless of payer or insurance status. CMS will also work with Track 2 practices to develop a patient reported outcome measure.

Q: How does a multi-specialty practice complete practice-site quality reporting?

CPC+ practitioners may share physical space and an electronic health record (EHR) with other practitioners who do not participate in CPC+. All CPC+ practice sites must have functionality to filter electronic clinical quality measure (eQCM) data by the CPC+ practice site location as well

as Taxpayer Identification Number/National Provider Identifier (TIN/NPI). The CPC+ practice site level reporting requirement means that any patient who is seen at least one time at the practice during the calendar year by a CPC+ practitioner is eligible to be included in the denominator of a measure. If a patient was only seen by a non-CPC+ practitioner at the practice, the patient will not be included in the denominator of the measure.

HEALTH IT REQUIREMENTS

Q: What are the certified health IT requirements for Track 1 and 2 practices?

Practices in both Tracks 1 and 2 are required to adopt the following health IT to participate in CPC+:

- All CPC+ practices must use health IT meeting the CEHRT definition finalized for the Quality Payment Program at [42 CFR 414.1305](#) throughout all five years of CPC+. In line with the CEHRT definition, starting on January 1, 2017, practices are required to use 2014 or 2015 Edition Technology, or a combination of the two. Starting January 1, 2018, practices must exclusively use 2015 Edition technology.

Practices in both Tracks 1 and 2 also need to meet certain health IT requirements in order to report on required eQMs under CPC+:

- Practices are required to adopt health IT certified to the 45 CFR 170.315(c)(1) – (c)(3) certification criteria for all of the electronic clinical quality measures in the CPC+ measure set. As with the overall CEHRT requirements, practices should follow the requirements and timeline of the Quality Payment Program.
- For the CPC+ measures, practices must use the latest annual measure update. For instance, for the 2017 performance period, practices must use the eCQM specifications contained in the [2016 annual update](#), released in April 2016.
- Finally, practices must be able to filter their electronic clinical quality measure data by CPC+ practice site location and TIN/NPI. Beginning in 2018, practices will demonstrate their ability to conduct this filtering by adopting 2015 Edition health IT certified to the criterion found at 45 CFR 170.315(c)(4).

To support specific Track 2 advanced health IT functions, Track 2 practices will also be expected to meet two additional certified technology requirements:

- Adopt health IT certified to the 2015 Edition “Care Plan” criterion found at 45 CFR 170.315(b)(9) by January 1, 2019 (the beginning of performance year (PY) 3 of CPC+).
- Adopt health IT certified to the 2015 Edition “Social, Psychological, and Behavioral Data” criterion found at 45 CFR 170.315(a)(15) by January 1, 2019 (the beginning of PY3 of CPC+).

Q: What are the advanced health IT functions for Track 2 practices?

In addition to the certified health IT requirements for all practices and the additional certified health IT requirements for Track 2 practices, Track 2 practices are required to adopt health IT that provides additional enhanced functionality for advanced practices. These requirements can be found [on the CPC+ website](#).

Q: Can Track 2 practices whose primary health IT vendor will not be supporting CPC+ functionality use another health IT vendor to meet the advanced health IT requirements for CPC+?

Yes. Practices may work with multiple vendors to meet the health IT requirements listed in the [Request for Applications](#) in order to participate in CPC+. Track 2 practices do not need to have a Vendor Letter of Support or any other guaranteed support from their primary EHR vendor, as long as this vendor meets the overall CEHRT requirements.

The other requirements (e.g., eCQM reporting) do not need to be fulfilled solely in the practice's primary CEHRT. Another application or service, such as a third-party registry, can be used to fulfill the 45 CFR 170.315 (c)(1) – (c)(4) certification criteria as long as it is certified for those functions. The practice is responsible for ensuring that the registry meets the 45 CFR 170.315 (c)(1) – (c)(4) certification criteria, and for ensuring that the registry can report the specific eCQMs at the CPC+ Practice Site level as required in CPC+. However, though not required, CMS recommends that practices document (record) the clinical data using CEHRT, and that 45 CFR 170.315(c)(1) [requirements of “Record and Export”](#) are achieved through the practice's primary CEHRT.

Q: Does changing a practice's health IT system affect their performance-based incentive payments while participating in CPC+?

Practices changing CEHRT systems or other certified health IT for eCQM reporting after the start of any performance year in CPC+ may affect their ability to receive a performance-based incentive payment, which is based in part on eCQM reporting. When switching health IT systems and vendors, practices must adhere to a process and a set of requirements. The process includes notifying CMS of its plan to switch health IT systems, and providing CMS with a plan for meeting all eCQM reporting requirements. In addition, there are certain requirements that must be met if the practice is unable to report 12 months of quality data due to switching health IT systems. If the practice fails to give notice in a timely manner and is not able to report the required eCQM data, the practice may become ineligible for continued participation in CPC+. It is the responsibility of CPC+ practices to maintain continuous usage of CEHRT and other required health IT. Detailed policy guidelines for switching health IT systems will be issued to practices after acceptance and onboarding to CPC+.

Q: May a practice in Track 2 switch to a different vendor to support an enhanced health IT function while participating in CPC+?

Yes, if a vendor withdraws support for the practice for a specific health IT function after the model begins, or if the practice decides to work with a different vendor, the practice may find a new vendor to support that specific health IT function. The new vendor identified by the practice will also need to commit to supporting the practice for one or more of the specific health IT functions listed in Appendix C of the [CPC+ Request for Applications](#) and will be asked to sign an MOU with CMS. Track 2 practices must have continuous vendor support for all health IT functions listed to remain in the model.

Q: Can practices use a third party, such as a registry, health information exchange (HIE), or other service to submit electronic clinical quality measures required under the model?

Yes, as long as the third party vendor meets the certified health IT requirements for CPC+.

Q: Can a practice work with more than one health IT vendor to meet the requirements of the model?

Yes, practices in both tracks may partner with the vendor or vendors they believe will best help them to meet the requirements of the model.

Q: Can practices use other health IT solutions beyond the EHR to carry out the Track 2 health IT functions?

Yes. All practices are required to meet the basic health IT requirements; to carry out the Track 2 health IT functions, practices may use their EHR and/or other health IT solutions.

Q: Does a Track 2 practice need to purchase software or have an agreement in place with a vendor in order to identify that vendor as supporting their participation in Track 2 as part of the application?

No, the letter of support only indicates that a vendor is willing to partner with the practice to support a given function and communicates to CMS that the practice has a strategy in place to address the Track 2 health IT requirements.

Q: Does a Track 2 practice need to have all of the Track 2 health IT functionality implemented by the start of the model?

No, CMS expects that these functions will be developed over the course of the model, with all functions implemented by the beginning of performance year 3 of the model. CMS will provide more detailed information about timelines for specific functions over the course of the CPC+ model.

Q: Must practices already work with the health IT vendor whose letter of support is included in the practice application? Are practices committed to working with the health IT vendor whose letter of support is included in the practice application?

No, practices may include vendor letters of support in their application for CPC+ even if they are not currently using the product. Further, practices are not required to adopt or purchase any specific health IT product, or work with any health IT vendor, even if they have included a letter of support from the vendor in their application.

PARTICIPATION IN CPC+ AND OTHER MODELS AND PHYSICIAN FEE SCHEDULE CODES

Q: Can practices bill for the Medicare Chronic Care Management services (CCM) codes if they are participating in CPC+?

The CPC+ CMFs are intended to pay for CCM covered services, so CPC+ participating practices cannot bill for CCM services furnished to any attributed CPC+ beneficiary. However, CPC+ practices may bill for CCM covered services under the Physician Fee Schedule if those services are provided to a Medicare beneficiary that is not attributed to that practice for purposes of the CPC+ model.

Q: Can practices participate in both CPC+ and other CMS or Innovation Center models?

Rules regarding practice participation in CPC+ and other CMS initiatives, models, or demonstrations are outlined as follows:

- CPC+ practices may participate in Model 2 and Model 3 of the Bundled Payments for Care Improvement Initiative and the Oncology Care Model. While they would not be participants themselves, CPC+ practices may also engage in sharing arrangements with participant hospitals in the Comprehensive Care for Joint Replacement Model.
- Medicare beneficiaries may be attributed to both CPC+ and Million Hearts® Cardiovascular Disease Risk Reduction model practices, as cardiovascular interventions can be part of, and complementary to, practice transformation.
- CPC+ practices may participate in the Accountable Health Communities (AHC) Model as a bridge organization or be paid through the AHC model by a bridge organization.
- Clinical Practices enrolled in and receiving technical assistance through Transforming Clinical Practice Initiative (TCPI) can apply for CPC+, but, if selected into the CPC+ model, the practice and clinicians must have exited or “graduated” from TCPI effective December 31, 2016. A clinician or practice cannot participate in CPC+ and receive technical assistance from TCPI at the same time. Practitioners providing the technical assistance or serving as faculty resources as part of a TCPI Practice Transformation Network or Support and Alignment Network may participate in CPC+.

Q: Are practices participating in State Innovation Model (SIM) initiatives allowed to participate in CPC+?

Practices participating in SIM initiatives are eligible to participate in CPC+. One state—New York—that is receiving a SIM Model Test Award and the Greater Buffalo Region of New York was selected as a CPC+ Round 2 region, so SIM practices in New York are encouraged to apply to the CPC+ track for which they believe they are eligible.

Q: Are practices that were in the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration allowed to participate in CPC+?

MAPCP practices are invited to participate in CPC+ Round 2. The Greater Buffalo Region of New York was selected as a CPC+ Round 2 region, and MAPCP practices in that region of New York that are encouraged to apply to the track for which they believed they are eligible.

Q: Are practices participating in the Agency for Healthcare Research and Quality (AHRQ) EvidenceNOW initiative eligible to participate in CPC+?

Yes, practices participating in EvidenceNOW are invited to apply to participate in CPC+.

DUAL PARTICIPATION IN CPC+ AND THE MEDICARE SHARED SAVINGS PROGRAM (Shared Savings Program)

Q: Can a primary care practice currently participating, or considering participation, in the Medicare Shared Savings Program also participate in Comprehensive Primary Care Plus (CPC+)?

Yes, primary care practices currently participating, or considering participation in ACO Tracks 1, 2, or 3 or the Track 1+ Model that meet the eligibility requirements of CPC+ may participate in both initiatives. Practices participating in Shared Savings Program Accountable Care Organizations (ACOs) can participate in either track of CPC+.

Practices within ACOs participating in the ACO Investment Model (AIM), Next Generation ACO Model, or other Medicare initiatives that involve shared savings may not participate in CPC+.

Q: How will payment change for primary care practices that participate in both a Shared Savings Program ACO and CPC+?

CPC+ payment flows consist of three elements. Changes in these elements to accommodate dual participation in the Shared Savings Program and CPC+ are explained below:

- 1) *Care management fee (CMF)*: Primary care practices within Shared Savings Program ACOs will receive the same CMFs as all other CPC+ practices. These payments are made to the TIN but are to be used in the CPC+ Practice to invest in care delivery at the participating CPC+ practice site. Like larger group practices or health systems, any CPC+ practices within an ACO will be required to provide a letter signed by ACO leadership that commits to segregate funds paid as a result of participation in CPC+. The CMF paid on behalf of beneficiaries that are also aligned with an ACO will be included in the ACO's total expenditures for shared savings and shared loss calculations.
- 2) *Performance-based incentive payment*: Primary care practices within Shared Savings Program ACOs will forego the CPC+ prospectively paid, retrospectively reconciled performance-based incentive payment, and instead will participate in the ACO's shared savings/shared losses arrangement. If a CPC+ practice leaves an ACO mid-year, the practice is not eligible to receive a pro-rated or any CPC+ performance-based incentive payment for the remainder of that performance year. If a CPC+ practice joins an ACO mid-year, the practice must return the performance-based incentive payment in full.
- 3) *Payment under the Medicare Physician Fee Schedule*: Practices in Track 2 of CPC+ will shift a portion of Medicare fee-for-service (FFS) payments for evaluation and management (E&M) services into Comprehensive Primary Care Payments (CPCPs) and have a reduction in payment for E&M services. The CPCP and reduced FFS payments together will be calculated based on an amount 10 percent larger than historical billings to support increased comprehensiveness of care. The CPCP will be included in the ACO's total expenditures for shared savings and shared losses calculations.

CPC+ payments (CMF and CPCP) for ACO-aligned beneficiaries will be included in the ACO's expenditures for purposes of establishing the financial benchmark and determining performance year expenditures.

Q: Payments in the ACO Investment Model (AIM) are recouped from Shared Savings Program ACOs. Will CPC+ payments be similarly recouped from Shared Savings Program ACOs?

No. Instead of recouping from shared savings, as is generally done in AIM, CPC+ payments made for ACO-aligned beneficiaries will count towards the ACO's expenditures.

Q: How will the CPC+ care delivery and quality reporting requirements change for primary care practices within Shared Savings Program ACOs?

Primary care practices participating in both a Shared Savings Program ACO and CPC+ must adhere to the ACO's required care processes and implement the CPC+ care delivery requirements. Practices must also adhere to quality reporting requirements for both CPC+ and the Shared Savings Program.

Q: Will practices in CPC+ and a Shared Savings Program ACO be considered Advanced APM Entities participating in an Advanced APM under the Quality Payment Program?

Under the Quality Payment Program, CPC+ will be evaluated as an Advanced APM using the special financial risk and nominal amount standards for medical home models. Primary care practices within Shared Savings Program ACOs will forego the CPC+ prospectively paid, retrospectively reconciled performance-based incentive payment, and instead will participate in the ACO's shared savings/shared losses arrangement. As such, for practices participating in CPC+ and the Shared Savings Program, determinations about the Advanced APM incentive will be based upon the track of the Shared Savings Program in which the practice participates.

- Track 1 of the Shared Savings Program is not an Advanced APM. As a result, participation by eligible clinicians in a CPC+ practice participating in an ACO under Track 1 of the Shared Savings Program will not be considered in determining whether the clinician would qualify for the APM incentive payment. Eligible clinicians in practices that do not participate in Advanced APMs or do not meet the participation thresholds to qualify for the APM incentive for a year will be subject to MIPS reporting requirements and payment adjustments.
- The ACO Track 1+ Model, and Tracks 2 and 3 of the Shared Savings Program are Advanced APMs. Eligible clinicians in CPC+ practices that are part of an ACO in the Track 1+ Model or in and Tracks 2 or 3 will be evaluated at the ACO level to determine whether they are eligible for the APM incentive payment and exemption from MIPS.

Q: If a CPC+ practice participating in an ACO leaves that ACO during CPC+, will the determinations about the APM incentive payment under the Quality Payment Program be made based on participation in CPC+ or the ACO?

For practices participating in CPC+ and a Shared Savings Program ACO, determinations about the APM incentive payment will be based on their participation in the Shared Savings Program, not CPC+, including practices that terminate participation in an ACO.

PRACTICE APPLICATION

Q: How can practices apply to participate in CPC+?

The [Round 2 application](#) opens on May 18, 2017. Eligible practices in the four CPC+ Round 2 regions will be able to submit applications from May 18 – July 13, 2017 to participate in CPC+ Round 2.

Practices in the Round 2 regions will apply directly to the track for which they are interested and believe they are eligible; however, CMS reserves the right to offer practices entrance into Track 1 if they apply and do not meet the eligibility requirements for Track 2. CMS also reserves the right to offer practices entrance into the control group.

Q: What is the definition of a “practice site”?

For the purposes of CPC+, CMS defined a primary care “practice site” as the single “bricks and mortar” physical location where patients are seen, unless the practice has a satellite office. A satellite is a separate office that acts as a geographic extension of the single practice site. In the

case of a practice that provides home-based primary care and no care in an office setting, the billing address is the practice site for the purposes of payment and participation in the Model. In order to participate in CPC+, each practice site must complete a separate application and an individual with the authority to legally bind the practice site must execute a separate CPC+ Participation Agreement for each practice site.

Eligible applicants for CPC+ Round 2 are primary care practices (all NPIs billing under a TIN at a practice site address who are included on a Participant List, as defined in Appendix B of the [CPC+ Request for Applications](#)) that pass program integrity screening, provide primary care services, as defined by the CPC+ Participation Agreement, to a minimum of 125 attributed Medicare beneficiaries, and can meet the requirements of the CPC+ Participation Agreement. Practices will apply directly to the track for which they believe they are ready; however, CMS reserves the right to randomize applicants out of the Model, or offer a practice entrance into Track 1 if they apply to but do not meet the eligibility requirements for Track 2.

Q: What is a primary care practitioner for purposes of CPC+?

In CPC+, CMS defines “practitioner” as a physician (MD or DO), nurse practitioner (NP), physician assistant (PA), or Clinical Nurse Specialist (CNS), and one of the requirements of a participating CPC+ practitioner is that the individual must have a primary specialty designation of family medicine, internal medicine, general medicine, or geriatric medicine under their own NPI.

Q: Are offers to assist practices in preparing for and completing their application affiliated with CPC+?

No, any offers to assist practices in enhancing their eligibility and completing their application are not affiliated with CPC+. CMS does not endorse, encourage, or discourage prospective applicants from seeking application assistance from external vendors. Reference to any specific commercial product, process, or service by trade name, trademark, manufacturer, or otherwise, does not necessarily constitute or imply its endorsement, recommendation, or favoring by the U.S. Government, CMS, or any of their employees or contractors.

Q: Are specialists within a primary care practice considered participating practitioners in CPC+?

No, only primary care practitioners that are identified on a CPC+ Practice’s Practitioner Roster will be considered participants in CPC+. For example, if a multispecialty practice participates in CPC+, CMS will only attribute beneficiaries who receive the plurality of their primary care services from a primary care practitioner who bills under the TIN of the practice at that practice site, or for whom a primary care practitioner that bills under the TIN of the practice billed the most recent claim for CCM services at that practice site. CPC+ is designed to attract those practices offering comprehensive primary care for an entire population of patients. Through CPC+, CMS intends to support practices that are predominantly – but not exclusively – composed of primary care practitioners for whom primary care services collectively accounted for at least 40 percent of billing under the Medicare Physician Fee Schedule.

Q: Can different practice sites within the same health system or medical group, or ACO apply to CPC+?

Yes, CMS encourages all practice sites, including those with the same owner, or within the same medical group or ACO to apply to CPC+. Each practice application completed for a practice that is part of a health system, medical group, or ACO that has multiple practice sites applying to CPC+ is required to identify the practice name, TIN, and practice site address of each affiliated applicant on each CPC+ application. Each application submitted for a practice that is part of a health system, medical group, or ACO must include a letter signed by the applicant's leadership or owner that commits to segregate funds paid by CMS to the health system, medical group, or ACO as a result of participation in CPC+. More details about selection of affiliated practices is [available below](#).

Q: Can practice sites within the same health system, or medical group, or ACO join different tracks of CPC+?

Yes, CMS encourages all practice sites, including those with the same owner, or within the same medical group, or ACO to apply to the model track in which they feel best qualified to participate.

Q: How does a practice demonstrate that they have multi-payer support?

In their CPC+ Round 2 applications, practices will have the opportunity to outline their 2016 revenue generated by services provided to patients covered by the payers with whom we expect to partner in their region. Practices that have approximately 45 percent or more of their current revenue generated from these payers and Medicare will be better positioned to implement the CPC+ service delivery model and meet the CPC+ practice requirements. Medicare alone cannot provide the adequate supports that practices need to make significant changes in the way they deliver care, as primary care practices serve patients whose health care is paid for by many different insurers.

Q: Can practices participating in CPC+ use more than one billing TIN when billing for primary care services provided to CPC+ beneficiaries?

No, CMS requires CPC+ practices to use one billing TIN when billing for primary care services provided to CPC+ Medicare beneficiaries.

Q: Can a TIN of a CPC+ practice be used by other practitioners within the CPC+ practice's medical group or organization that are not participating in CPC+?

Yes, a practice's TIN may be shared with other practitioners within a medical group or organization that are not participating in CPC+. The CPC+ practice application will require practice applicants to identify specific practitioners by their National Provider Identifier (NPI) who bill under that TIN and are interested in participating in CPC+.

Q: What is a Medicare Eligible Professional (EPs) and Eligible Clinician? Are they different?

Eligible Clinician is the term used for purposes of the Quality Payment Program APM incentive and encompasses certain types of Medicare physicians and suppliers specified in the final rule. MIPS Eligible Clinician has the same meaning as the term Eligible Professional (EP). EP is defined in [Section 1848\(k\)\(3\)\(b\)](#) and is specific to current Medicare programs (Physician Quality Reporting System, Value-based Modifier, and Meaningful Use) that, by statute, will sunset at the

end of 2018. The language found in the Quality Payment Program CY 2017 Final Rule is excerpted below:

Eligible clinician means “eligible professional” as defined in section 1848(k)(3) of the Act, as identified by a unique TIN and NPI combination and, includes any of the following: (1) A physician. (2) A practitioner described in section 1842(b)(18)(C) of the Act. (3) A physical or occupational therapist or a qualified speech-language pathologist. (4) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

PRACTICE ELIGIBILITY

Q: What are the eligibility criteria for Tracks 1 and 2 of CPC+?

In order to participate, all CPC+ practices must have multi-payer support, Certified EHR Technology (CEHRT), and other infrastructural capabilities. When they apply, Track 2 practices must demonstrate additional clinical capabilities to deliver comprehensive primary care.

CPC+ Practice Eligibility Criteria:

- | Track 1 | Track 2 |
|--|--|
| <ul style="list-style-type: none">• Is a legal entity and operates as a CPC+ practice site within one of the CPC+ regions;• Provides primary care services, as defined by the CPC+ Participation Agreement, to a minimum of 125 attributed Medicare FFS beneficiaries;• Passes a program integrity screening;• Uses a single TIN for billing all primary care services furnished to CPC+ beneficiaries and all CPC+ Payments;• Demonstrates that at least 40 percent of billings by participating CPC+ practitioners are for primary care services;• Use of CEHRT;• Sufficient percentage of revenue generated by Medicare and CPC+ payer partners;• Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities. | <ul style="list-style-type: none">• Is a legal entity and operates as a CPC+ practice site within one of the CPC+ regions;• Provides primary care services, as defined by the CPC+ Participation Agreement, to a minimum of 125 attributed Medicare FFS beneficiaries;• Passes a program integrity screening;• Uses a single TIN for billing all primary care services furnished to CPC+ beneficiaries and all CPC+ Payments;• Demonstrates that at least 40 percent of billings by participating CPC+ practitioners are for primary care services;• Use of CEHRT;• Sufficient percentage of revenue generated by Medicare and CPC+ payer partners;• Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities, while also developing and recording care plans, following up with patients after emergency department (ED) or hospital discharge, and implementing a process to link patients to community based resources. |

Track 1

Track 2

- Letter of support from health IT vendor that outlines the vendor’s commitment to support the practice in optimizing health IT.

Q: Are pediatric practitioners eligible to participate in CPC+?

Eligible practitioners are those who have a primary specialty designation of family medicine, internal medicine, general medicine, or geriatric medicine. However, even if pediatric practitioners have those specialty designations, and the practice meets the requirement that at least 40 percent of billing under the Medicare Physician Fee Schedule is for primary care services, it is unlikely that the practice where the pediatric practitioner bills, if primarily comprised of pediatric practitioners, will be eligible to participate due to the CPC+ eligibility requirement that CPC+ practices must have at least 125 attributed Medicare fee for service beneficiaries.

Q: Are federally qualified health centers (FQHCs) and rural health clinics (RHCs) eligible to participate in CPC+?

No, CPC+ is designed to test payment reform for traditional fee-for-service payment, and the billing and reimbursement processes for FQHCs and RHCs are distinct from other primary care practices. FQHCs and RHCs are not eligible to participate in CPC+.

Q: Do CPC+ practices have to be a certified Patient Centered Medical Home (PCMH)?

No, practices are not required to be PCMH-certified to participate in CPC+. However, the care delivery eligibility requirements under CPC+ may align with criteria for PCMH certification. The care delivery eligibility criteria are:

Track 1

- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities.

Track 2

- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities, while also developing and recording care plans, following up with patients after emergency department (ED) or hospital discharge, and implementing a process to link patients to community based resources.

Q: Are hospital owned practices eligible to apply to CPC+?

Yes, practices owned by hospitals and health systems are eligible to apply to CPC+. CPC+ is a practice-level transformation and each practice owned by a hospital must provide a letter signed by hospital leadership that commits to segregate funds paid by CMS to the practice as a result of participation in CPC+ (i.e., the CPC+ care management fee, performance-based incentive payment, and Comprehensive Primary Care Payment (Track 2 only)).

Q: Are practices within Independent Practice Associations (IPAs) eligible to apply to CPC+?

Yes, practices within an IPA are eligible to apply to CPC+. Each practice within an IPA that is interested in participating in CPC+ must apply separately, as CPC+ is a practice-level transformation.

Q: Can a practice participate in a commercial ACO or a commercial Clinically Integrated Network (CIN) while participating in CPC+?

Yes, CPC+ practices may participate in other programs and have other relationships with private payers.

Q: Are concierge primary care practices eligible to participate?

No, concierge practices, or any practice that charges patients a retainer fee may not participate in CPC+.

Q: Is a practice that offers other lines of business, such as urgent care on weekends and/or physical exams for an insurance company eligible for CPC+?

Yes, practices may offer other lines of business while participating in CPC+. However, payments provided by CMS as a result of participation in CPC+ may not be used for these other lines of business. CPC+ practices will work to ensure patients have access to care and build long-term continuous relationship with patients, while they closely manage and provide comprehensive care for their patients, particularly those with complex needs.

Q: Are practices engaged in training future primary care practitioners and staff eligible to apply to CPC+?

Yes, CMS encourages all practices to apply, especially those engaged in training future primary care practitioners and staff.

Q: Can practices move from Track 1 to Track 2 throughout the course of the CPC+ model?

No, practices will remain in their respective tracks and may not change tracks throughout the course of the five performance years. Practices are invited to apply directly to the track for which they are interested and believe they are eligible; however, CMS reserves the right to ask a practice that applied to Track 2 to instead participate in Track 1 if CMS believes that the practice does not meet the eligibility requirements for Track 2 but does meet the requirements for Track 1.

PRACTICE SELECTION

Q: How will practices be selected for CPC+ Round 2?

First, CMS will complete a program integrity screening of all practice applicants. Then, CMS will review all applications to determine if a practice meets the eligibility criteria for the CPC+ track for which they are applying. If a practice is determined not to meet the requirements for Track 2, but also expressed interest in Track 1, CMS will consider the practice's application for Track 1 instead. Next, CMS will review financial information provided by the practice to determine if they meet the threshold for payer support. Practices should have at least 45 percent of their total practice revenue from both Medicare and CPC+ payer partners. Practices must also

have a minimum number of Medicare beneficiaries and primary care services must account for a certain percentage of the practices' collective billing. CMS will also evaluate the practice's health IT capabilities and vendor information (Track 2 only) based on information provided by the practice in their application. In CPC+ Round 2, CMS will randomize eligible practices to participate in the intervention group (Track 1 or 2 of the Model) or in the control group. CMS will separate eligible practices into their respective tracks and randomize each track separately. CMS will strive to maximize the number of eligible practices that are selected for the intervention group in CPC+ Round 2, while maintaining the rigor of the randomized design.

Q: In the practice randomization process, will practice sites within the same health system, ACO, or medical group be randomized together?

For Round 2, CMS is striving to maintain the rigor of the CPC+ evaluation by randomly selecting practices to participate in the intervention group of CPC+. Because CMS is interested in testing the impact of CPC+ in system-wide primary care practice transformation, CMS will, to the extent possible, randomize as a group all eligible practices owned by the same entity (e.g., health system or medical group) and all eligible practices participating in the same ACO. Practices in IPAs and other affiliation groups will be selected at the practice level.

Because CPC+ is a practice-level intervention, every practice applying to CPC+ must submit its own application and will be evaluated individually at the practice level for both initial eligibility and all performance-based incentive payments.