Comprehensive Primary Care Plus (CPC+) Payer Solicitation
February 17, 2017

GENERAL

Q: What is the deadline for payers to apply to partner in the Comprehensive Primary Care Plus (CPC+) model?
A: Payers must respond to this solicitation by submitting a proposal to partner in CPC+ by April 3, 2017 at 5:00pm ET.

Q: When is Round 2 of CPC+ expected to begin?
A: The first performance period for CPC+ Round 1 began on January 1, 2017. CPC+ Round 2 is expected to begin on January 1, 2018 and run through 2022.

Q: Who will partner and participate in CPC+ Round 2?
A: CPC+ will bring together Medicare with commercial and State payer partners in the 14 existing Round 1 CPC+ regions and payers in up to 10 additional Round 2 regions around the country to support eligible practices in both tracks. A variety of payers are invited to respond to the CPC+ Round 2 Solicitation for Payer Partnership, including: commercial insurers (including plans offered via state or federally facilitated Health Insurance Marketplaces), Medicare Advantage plans, states (through the Medicaid and CHIP programs, state employees programs, or other insurance purchasing), Medicaid/CHIP managed care plans, state or federal high risk pools, and administrators of a self-insured group.

CPC+ is intended for primary care practices with varying capabilities and levels of experience. In order to participate, all CPC+ practices will have multi-payer support, Certified EHR Technology (CEHRT), and other infrastructural capabilities. Practices must also have a minimum number of Medicare beneficiaries and primary care services must account for at least 40 percent of the collective billing of the practitioners in the practice. When they apply, Track 2 practices must demonstrate the clinical capabilities to deliver comprehensive primary care and the availability of enhanced health IT, which will lay the foundation to increase the depth, breadth, and scope of care offered, with particular focus on their patients with complex needs. Track 2 practices will also be asked to submit letters of support from their health IT vendors and vendors will also memorialize their commitment to supporting Track 2 practices in a MOU with CMS.

Q: When will a payer be notified that their proposal was accepted for Round 2?
A: CMS expects to notify payers in late spring or early summer 2017 on the status of their proposal. We plan to execute a Memorandum of Understanding with payers selected for partnership.

Q: When will CMS announce the selected CPC+ regions?
A: CMS expects to publicly announce selected regions in late spring or early summer 2017. CMS will select up to 10 additional regions in CPC+ Round 2.

Q: When can practices apply for CPC+ Round 2?
A: After payers and regions are selected and CMS enters into MOUs with payers, CMS will release a primary care practice online application portal in up to 10 additional regions selected for CPC+. Practices are expected to be able to apply for CPC+ Round 2 from late summer through fall 2017, once regions and payer partners within those regions have been determined. Practices in the existing Round 1 regions will not be able to apply for Round 2.

Q: Where will CPC+ Round 2 be implemented?
A: CPC+ Round 2 will be implemented in up to 10 additional Round 2 regions throughout the U.S. The CPC+ Round 2 regions will be selected based on the locations of the payers that submit proposals to partner in CPC+ Round 2. CMS will select regions where there is sufficient interest from multiple payers to support practices that participate in Tracks 1 and 2 of CPC+ Round 2.

CMS is committed to supporting the development and testing of innovative health care payment and service delivery models throughout the country, particularly in states and regions where there has been a foundational investment. Thus, CMS will give preference to states that have participated in the Multi-Payer Advanced Primary Care Demonstration, as well as states receiving State Innovation Models (SIM) Initiative Model Test Awards, if Medicaid is a participating payer and if sufficient payers in these states indicate their interest in partnering in CPC+ and propose an aligned approach to CMS.

Q: How many practices will be accepted in CPC+ Round 2?
A: CMS will accept up to approximately 2,600 practices in CPC+ Round 2, with 2,893 practices selected in CPC+ Round 1 and a maximum of 5,500 practices across both rounds.

Q: How does CPC+ Round 2 differ from CPC+ Round 1?
A: CPC+, including model design and practice eligibility, is expected to be the same in Round 1 and Round 2, with one exception: CMS will randomize eligible Round 2 practice applicants and randomly select certain practices to participate in the CPC+ intervention group, while other practices will be placed into a comparison group. Those practices that are placed in the comparison group will not receive the CPC+ payments (Care Management Fees, Performance-Based Incentive Payments, or Comprehensive Primary Care Payments) or participate in the CPC+ learning communities. The randomized design of CPC+ Round 2 will strengthen CMS' evaluation of the model.

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

The comparison 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. Additionally, they will not be considered participants in an Advanced APM through participation in the CPC+ comparison group, but may otherwise be Advanced APM participants through their participation in other CMS models or programs. Comparison group practices will be compensated for their participation in CPC+ evaluation-related activities and may receive favorable scoring under Improvement Activities category of the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program. More details for comparison group practices will be announced in later this year.

Q: What is the value proposition for a private or public insurer to join CPC+?

A: Many payers share CMS' interest in strengthening primary care, yet support by any one payer has only a limited impact within a primary care practice. Leveraging the efforts of multiple payers has the potential to transform primary care practices and improve our health care system.

For patients, primary care is the entry point of health care, the setting in which they can create continuous healing relationships that support and guide them throughout their interactions with the health care system. There is abundant evidence that improved care and improved patient experience can be achieved by modest investments in primary care; this model seeks to build on that knowledge by strategically investing in the kind of primary care most likely to have a favorable impact on total cost of care and aligning payment incentives to reward value rather than volume. CPC+ coordinates and focuses commitment from multiple payers to demonstrate that the model aims can be achieved when a community of payers collectively support a comprehensive model of primary care.

Further, CPC+ is built on lessons learned from the Comprehensive Primary Care (CPC) initiative, and results from the first three years of CPC are promising. Overall, the CPC initiative results indicate improvements in patient experience and care quality, and a reduction in total cost of care over the first two years of the initiative offsetting a substantial portion of care management fees paid by CMS. Payer partners may also see significant changes in quality and cost of care by investing in primary care reform.

PERFORMANCE-BASED INCENTIVE PAYMENT

Q: Why is CMS testing a performance-based incentive payment in CPC+, rather than shared savings?
A: The intent of the performance-based incentive payment that Medicare Fee-For-Service (FFS) provides in CPC+ is the same as traditional shared savings: motivate providers by rewarding outcomes that reduce beneficiaries' total cost of care. However, unlike retrospectively paid shared savings measured at the region-level, the CPC+ performance-based incentive payment focuses on quality and utilization measures that are calculated at the practice-level and are actionable for primary care practices.

Q: If a payer partner chooses to use a shared savings incentive, would that be considered "aligned" with CMS's performance-based incentive payment? Does a payer's shared savings incentive need to be prospectively paid?
A: Payers need not use an identical incentive design to be considered "aligned" (see the Eligibility section of this FAQ for more information on payer alignment). Payer partners may propose shared savings, bonuses, or alternate incentive designs. Incentives may be paid to practices prospectively or retrospectively.

Q: Which utilization measures will CMS use to calculate performance based incentive payments?
A: CMS will use Healthcare Effectiveness Data and Information Set (HEDIS) utilization measures that are based upon emergency department visits and utilization of inpatient hospital/acute care.

Q: Which quality measures will CMS use to calculate performance based incentive payments?
A: CMS will use electronic clinical quality measures (eCQMs), patient experience of care surveys, and claims-based utilization metrics.

Q: Must payer partners use the same utilization and quality measures as CMS?
A: Payers are encouraged to use aligned, but not identical, utilization and quality measures as CMS. In recognition of the fact that there exists a variety of measure sources and lack of alignment on required measures across payers and programs, we hope that market-level discussions will drive harmonization of any additional quality measures and reduce administrative burden to participating practices through a shared approach to quality assurance and improvement.

DUAL PARTICIPATION IN CPC+ AND THE MEDICARE SHARED SAVINGS PROGRAM (MSSP)

Q: I am a payer in a region with a density of primary care practices participating in Medicare ACOs and would like to support these practices in CPC+. Is this possible?
A: Yes, it is possible to support primary care practices currently participating, or considering participation in Tracks 1, 2, or 3 of the Shared Savings Program or the ACO Track 1+ Model. Such practices that meet the eligibility requirements of CPC+, may participate in these 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, the Medicare-Medicaid ACO Model, or other shared savings programs may not participate in CPC+.

Q: How will payment change for primary care practices within ACOs that participate in CPC+?
A: CPC+ payment flows consist of three elements. Changes in these elements to accommodate ACO practices in 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 will be made directly to practices to invest in care delivery at the participating CPC+ practice site. Because of the CPC+ practice's relationship with an ACO, 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+ if they are paid to the parent organization rather than the individual practice. Payments for beneficiaries assigned to both the CPC+ practice and the 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 that bills through the TIN of an ACO participant leaves an ACO mid-year, the practice is not eligible to receive a pro-rated or any performance-based incentive payment for the remainder of that performance year.

3. *Payment under the Medicare Physician Fee Schedule*: Practices participating in an ACO and in Track 2 of CPC+ will receive payments for evaluation and management (E&M) services in the form of Comprehensive Primary Care Payments (CPCPs) and a reduced FFS payment for E&M services. The CPCP and reduced FFS payments will be calculated based on an amount 10 percent larger than E&M revenue during a historical reference period. The CPCP will be included in the ACO's total expenditures for shared savings and shared losses calculations for beneficiaries assigned to both the CPC+ practice and the ACO.

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

Q: How will the CPC+ care delivery and quality reporting requirements change for primary care practices within Shared Savings Program ACOs?
A: All primary care practices that are participating in CPC+ will be required to implement the CPC+ care delivery model and adhere to the ACO's required care processes. Participating practices that are also participating in an ACO must also adhere to quality reporting requirements for both CPC+ and the Shared Savings Program.

PAYER ELIGIBILITY

Q: What does "payer alignment" mean? Must payers implement the same model design approach as CMS?
A: Multi-payer partnership is an essential goal of CPC+, as it makes full practice-level transformation of care delivery possible. CMS will partner with payers that share Medicare's interest in strengthening primary care. CMS' goal in CPC+ is to align with all payers on key payment, quality, and data-sharing elements. By alignment, CMS means that, for each payer in the model, these elements need not be identical but should be oriented so that the practice incentives and goals are consistent across all payers partnering in the model. CMS also wants to ensure that the model allows for sufficient flexibility for payers to implement approaches that are aligned with the needs of their members and/or beneficiaries.

Q: Must a payer currently have experience with non-fee-for-service support, or performance-based incentive payments?
A: No, previous experience with alternative payments is not required.

Q: We would only like to partner with Track 1 practices. Is that acceptable?
A: Partnering with practices in both Tracks 1 and 2 of the model is crucial to providing the necessary CPC+ practice supports and is a significant component in the CMS evaluation of payer proposals. While CMS cannot require payer partners to make payments to both Track 1 and Track 2 practices, it is less likely a payer supporting only Track 1 practices will be selected as a payer partner.

Q: We would like to partner with CMS in supporting CPC+ practices that are participating in both tracks, but our state prohibits non-HMO plans from offering

capitated or risk-based payments to physicians. Is there any way we can still align with Track 2?
A: Please note that aligned approaches need not include capitated or risk-based payments. Payer partners' aligned arrangements could be, for example, partial population-based payments without downside risk, full population-based payments without downside risk, and episodic payment.

Whether a payer can offer a capitated or risk-based arrangement will depend on the laws and regulations in place in your state. In states with regulations that prohibit capitated or risk-based payments, we encourage payers to consider alternate arrangements that will support flexibility in the delivery of primary care. We anticipate that each Track 2 practice will be supported by multiple payers, which will assist practices in delivering enhanced, comprehensive services both during and outside of an office visit in a manner that would reduce unnecessary utilization for all of the practice's patients.

Q: Will CMS provide payers with any financial incentives to partner in CPC+?
A: No, payers will not receive any funding from CMS for their work as payer partners; however, we anticipate that payer partners may see improvements in quality and cost of care by investing in primary care reform.

PAYER PARTNER PROPOSALS

Q: Will payers' proposals be publicly available?
A: No. All information submitted within the proposal is considered confidential. Therefore, CMS will not release the information to the general public unless required by applicable law.

Q: Is a payer's proposal binding?
A: No, the payer proposal is not binding. If a payer is chosen for a selected region, the payer will then sign a MOU to memorialize their commitment to the Model. The MOU outlines certain respective commitments of the parties to strengthen primary care through the CPC+ Model.

Q: Are interested payers able to discuss their potential participation in this model with other payers and providers in a market?
A: CMS anticipates that Round 2 of CPC+ will stimulate a market-wide conversation among payers, providers, and community quality collaboratives. We encourage relevant parties to begin that conversation prior to submitting a response to this solicitation. We expect that all conversations among payers and providers would comply with antitrust law. Nothing in this solicitation shall be deemed to suspend any applicable antitrust laws or regulations, all of which still apply.

Q: Do state Medicaid agencies need to submit a payer proposal for partnering in CPC+ or can they submit alternative documentation expressing their interest?
A: All interested payers, including state Medicaid Agencies must submit a completed proposal to be considered for partnership in CPC+. CMS will not accept other documents, such as letters of intent, in lieu of a proposal.

REGIONAL SELECTION

Q: How many regions will you choose for CPC+?
A: We expect to select up to ten additional regions for Round 2 of this Model.

Q: How are regions defined in this solicitation?
A: Regions are defined as overlapping, contiguous geographic locales covered by multiple payers interested in partnering in CPC+. A region may encompass multiple areas within a state or may extend across states; the definition will largely depend on the proposals we receive and where payer interest lies. Within the CPC+ Round 2 Solicitation for Payer Partnership, payers are asked to propose regions using counties as descriptors.

Q: How will CMS consider payer proposals for new counties in states where there are existing CPC+ Round 1 partial state regions?
A: If a payer submits a proposal that includes an existing CPC+ partial state region and/or additional counties that were not previously selected in the state in Round 1, the new counties will be considered as a separate CPC+ region. For example, if a payer proposes partnering in Pennsylvania in a county other than Bucks, Chester, Delaware, Montgomery, or Philadelphia counties, the new county in question will be assessed as a separate CPC+ region so practices may apply to participate in that new region (whereas they cannot in the existing Philadelphia counties that were selected for Round 1).

Q: What is CMS' process for receiving and reviewing payer proposals?
A: CMS' selection process will map interested payers into overlapping regions and assess expected market share in these regions. Payer proposals in regions with sufficient market penetration will then be evaluated based on the degree to which they align with CMS' approach to alternative payment and quality measurement in this Model. Once regions have been selected and approved, payers with proposals that demonstrate sufficient alignment with the Model will be selected and invited to partner with CMS by signing a MOU. Additional details on payer selection are outlined in the 'Payer and Region Selection' section of the CPC+ Request for Applications.

Q: What does CMS consider to be sufficient market penetration in a region?
A: CMS will calculate market penetration by dividing the number of lives covered by all interested payers in the region plus the number of Medicare FFS beneficiaries by the total number of covered lives in the region, according to the best available Census data. A market penetration rate of 50% or greater will be considered sufficient penetration.

Q: Does CMS give preference to any regions for Round 2 of CPC+?
A: CMS is committed to supporting the development and testing of innovative health care payment and service delivery models throughout the country, particularly in states and regions where there has been a foundational investment. CMS will give preference to the states that have participated in the Multi-Payer Advanced Primary Care Demonstration, as well as states receiving State Innovation Models (SIM) Initiative Model Test Awards, if Medicaid is a participating payer, and if sufficient other payers in these states indicate their interest in partnering in CPC+.

Q: Is it worth the time to submit a proposal if a payer plans to operate in a region that is not currently in the CPC, MAPCP or SIM regions?
A: Yes. While CMS aims for transparency regarding its preference for regions with active CMS primary care demonstrations, we welcome market interest in a region not currently participating in those initiatives, as we plan for up to 10 additional regions in CPC+ Round 2

ADMINISTRATIVE

Q: How do I submit a proposal to partner in Round 2 of CPC+?
A: To submit a proposal for partnership, please complete a proposal online using the following portal: https://app1.innovation.cms.gov/cpcplus

Q: If an existing CPC+ Round 1 payer partner is interested in partnering in additional regions for CPC+ Round 2, do they have to submit a new proposal?
A: If a payer partner chooses to supplement their partnership along the *same terms* of their MOU with new regions or new lines of business in an existing region(s), they can email CPCPlus@cms.hhs.gov and indicate which regions and/or lines of business they would like to add. However, if the payer partner wants to propose partnership with *differing terms* from their existing MOU, they must use the online portal to submit their proposal.

Q: If I'm a payer planning to partner with CPC+ in ten states, do I need to submit ten separate proposals even though most answers are the same across most of my states?
A: If the payer's proposals for all ten states in this example have similar approaches to alternative payments), points of contact, and practice reporting requirements, they may submit a single proposal. However, if there are significant differences in approach from state to state, payers should submit separate proposals describing each of these differing approaches.

Q: Are supporting documents required?
A: The online application portal will accommodate the complete collection of payer information as well as submissions of the Addendum to the CPC+ Round 2 Solicitation for Payer Partnership, therefore supporting documents are not required. Separate submissions are allowed if payers feel additional documentation will best support their proposal. Supplemental material is optional and must not exceed a total of 10 pages in length.

Q: Are there minimum word counts or expectations on response length for the solicitation questions?
A: The character counts are specific to the question. They range from 50 to 5,000 characters. Each question will indicate how many characters are available.

Q: Can a self-insured employer directly submit a proposal to partner in CPC+, or should their Third Party Administrator (TPA) or Administrative Services Only (ASO) submit a proposal?
A: CMS looks forward to partnering with self-insured employers in CPC+. Because TPAs/ASOs execute the partnership described in the MOU, we request that the TPA/ASO submit a payer proposal on behalf of one or multiple employers in a market. The TPA/ASO should identify the employer(s) in the market in its payer proposal. We encourage employer participation in any

relevant discussions between CMS and the TPAs or ASOs that act as payer partners in the CPC+ Model.

MEDICAID

Q: What is a "region" in this context?
A: Regions are defined as overlapping, contiguous geographic locales covered by multiple payers interested in partnering in CPC+. A region may encompass multiple areas within a state or may extend across states; the definition will largely depend on the proposals we receive and where payer interest lies. Current CPC+ Round 1 regions include whole states and partial states. Within the CPC+ Round 2 Solicitation for Payer Partnership, payers are asked to propose regions using counties as descriptors.

States proposing to implement services in geographies that are not statewide - through a State Plan Amendment (SPA) - can apply for a 1915(b)(4) waiver for "selective contracting." CMCS will provide technical assistance (TA) to states that submit applications for CPC+ to help identify if this waiver is necessary. Once additional CPC+ regions are identified, States selected that need this waiver will begin the waiver application process.

Q: Does a State Medicaid agency (SMA) that wishes to participate in CPC+ need a State Plan Amendment (SPA) or waiver to do so?
A: States can participate in CPC+ with their entire Medicaid program through either a SPA, a section 1115 demonstration project, or contract amendments with Medicaid Managed Care Organizations, depending on the proposed model and whether the state partners with its fee for service or managed care Medicaid population. Unlike the original Comprehensive Primary Care initiative, CPC+ will not pay for any portion of the Medicaid care management fees or other payments to providers. In order to receive federal match on those payments, the SMA would be required to obtain an approved SPA or waiver through established mechanisms so that they could claim the match on the CMS-64. There is no special mechanism for SMA participation in CPC+ outside the normal SPA/waiver process.

Q: How does CPC+ fit into Medicaid managed care states, and what is the state role there?
A: Even if a state Medicaid program does not participate as a whole, Medicaid managed care plans may submit a proposal to partner with CMS in the same manner as commercial plans, by using the same payer solicitation. SMAs may work with them on any contractual issues, if applicable. Please note that any necessary contract amendments for a Medicaid Managed Care Organization (MCO) to partner in CPC+ would be subject to normal, established mechanisms for CMS review and approval of the contract action.

Q: How does CPC+ align or interact with the State Innovation Models (SIM) Initiative? What if a state's SIM grant does not align with CPC+?
A: CMS welcomes CPC+ applications from SIM states. States should find that CPC+ fits well with many SIM models and builds on the work already done. Both CPC+ and SIM are multi-payer initiatives. If payers engaging in a SIM partner with CMS in CPC+, and states that have received SIM grants are selected as CPC+ regions, practices in these states may apply to participate in CPC+.

In states where the SIM grant is not aligned with CPC+, the payers, including the SMA, will decide whether to pursue SIM alone or to modify their SIM model to align with CPC+.

Q: Is Medicare participation automatic, or will a state have to seek Medicare participation only after the payers apply, as with SIM?
A: CMS is inviting payers to submit proposals to partner with CMS in CPC+ Round 2. States do not have to seek Medicare participation in this Model.

Q: Are federally qualified health centers (FQHCs) and rural health clinics (RHCs) eligible to participate in CPC+?
A: CPC+ is designed to model payment reform for traditional fee-for-service payment, and the billing and reimbursement processes for FQHCs and RHCs are different from traditional primary care practices. FQHCs and RHCs are not eligible to participate in CPC+.

Q: What will happen if commercial payers in a state apply for CPC+ but Medicaid does not?
A: CMS will evaluate the proposals of interested payers to see whether there is sufficient market share coverage. CMS' selection process will map interested payers into overlapping regions and assess expected market share in these regions. The formula to calculate market share will be the same whether or not Medicaid is among the payers that submitted proposals. Regions will be selected based on the payers who respond to the solicitation. A state Medicaid agency could encourage other payers to partner with CMS in this Model; however, SMAs should be careful to abide by anti-trust regulations when talking to payers and avoid discussing specific prices. In CPC+ Round 1, some regions include Medicaid as a payer and others do not.

Q: If a Medicaid managed care plan submitted a proposal as a payer partner, would they have to participate in both Tracks 1 and 2?
A: Like commercial payers, an organization (e.g. issuer) that offers a Medicaid managed care plan and submits a proposal should indicate which lines of business are included in its proposal. Within those lines of business (including, if applicable, the Medicaid managed care line), the organization would have to agree to pay practices in each Track for each covered life in those lines of business.

Q: What is the match rate for Medicaid payments to providers paid under CPC+?
A: There is no special match rate for Medicaid payments under CPC+. SMAs would have to seek approval through established mechanisms (e.g., SPAs, demonstration projects, or managed care contracts) in order to receive the appropriate match rate(s) for CPC+ expenditures.

Q: What is the impact on Medicaid Health Homes?
A: CMS encourages States to continue and/or begin Medicaid Health Homes as part of their CPC+ model given their alignment with CPC+. Health Homes were created as part of the Affordable Care Act to coordinate care for eligible beneficiaries with chronic conditions. If Medicaid Health Homes are initially authorized for a population as part of the state CPC+ model, the state will be eligible to receive a 90% enhanced FMAP for expenditures for health home services the first eight quarters the health home program is effective. Please note that Medicaid Health Homes do not need to be state-wide; they can be implemented regionally, in limited geographic areas.

Q: Does partnering in CPC+ impact the Medicaid Managed Care rules that apply to my MCO?
A: No, CPC+ does not alter or supersede any existing Medicaid rules, including those that apply to Medicaid managed care plans.

Q: Can a practice be both a CPC+ practice and a Medicaid ACO practice?
A: Yes, however states will need to ensure that there is appropriate oversight and safeguards in place to prevent duplicative effort and payments to the practice.

Q: Would a Medicaid agency's per-member-per-month (PMPM) payments to providers be considered administrative costs or service costs?
A: To the extent a PMPM methodology is approved in the State plan and pays for a Medicaid covered service, the PMPM may be claimed at the applicable federal matching assistance percentage for the service. Care coordination activities conducted by providers are generally not for the proper and efficient administration of the Medicaid state plan and federal participation is not available at the administrative claiming rate for those activities.

Q: Would participation in CPC+ impact a State's ability to get an 1115 demonstration project to fund Medicaid community-based ACOs in the future?
A: Partnering in CPC+ does not preclude a states' ability to receive approval for an 1115 demonstration project for another care coordination model in the future. The specific circumstances of a demonstration project request would need to be reviewed to determine whether it is approvable, and duplication of federal payment for the same service or activity is not allowed.

Q: Our Medicaid beneficiaries are covered primarily through MCOs. These MCOs want to join CPC+ Round 2. Does the SMA need to fill out a companion proposal for Medicaid MCOs?
A: The state can choose to participate with its entire Medicaid program, or can permit individual MCOs to participate. So the SMA does not need to fill out a proposal to mirror the MCO's proposal for MCO beneficiaries, but could elect to do so if it determines to require all Medicaid MCOs to participate in CPC+. Please note that any contract amendments required for an MCO to join CPC+ would be subject to normal, established mechanisms for CMS review.

Q: Do Medicaid rules allow for prepayment of Track 2 incentives and reduction of FFS rates in the state plan and if states do not provide prepayment, will they still be considered "aligned" for the purpose of the application review?
A: CMS believes there are a number of ways states can provide payments that align with Track 2 of the CPC+ Model that are consistent with Medicaid rules, including through per episode or bundled payments. These payment models will still be considered aligned and states will not be disadvantaged in the selection process if they pursue a payment model that fits the goals of the Track 2 payments but is not identical to the hybrid CPCP/FFS payment outlined in the CPC+ Request for Applications.

Q: Will the state be required to risk adjust Medicaid care management fee rates for each participating practice?
A: No. CMS will risk adjust the CPC+ Care Management Fees (as described in the RFA), other payers and Medicaid are not required to do the same.