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Comprehensive Primary Care Plus (CPC+)

Request for Applications

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Abstract

Strengthening primary care is critical to promoting health and reducing overall health care costs in the U.S. Building on lessons learned from the Original Comprehensive Primary Care (Original CPC) Model and input from the 2015 Request for Information on Advanced Primary Care Model Concepts, the Centers for Medicare & Medicaid Services (CMS) introduced the Comprehensive Primary Care Plus (CPC+) model on April 11, 2016. The first round of this five-year multi-payer model begins in January 2017 and runs through 2021. CMS is offering a second round of CPC+ to begin in January 2018 and run through 2022.

CPC+ will support practices along the continuum of their transformation to deliver better health and smarter spending. CPC+ will allow practices to apply for one of two program tracks, with increasing payment and care redesign expectations from Tracks 1 to 2.

CPC+ Overview

Under the authority of section 1115A of the Social Security Act, CMS designed CPC+, a care delivery and payment redesign model, to include two different tracks. The tracks involve different care delivery requirements and payment options that reflect the diversity of transformation experience among U.S. primary care practices. The care delivery redesign ensures practices in each track have the infrastructure and care processes in place to deliver better care and result in a healthier patient population. The payment redesign will facilitate investment in primary care by aligning payment incentives with the changes primary care practices need to make to deliver high quality, whole-person, patient-centered care and to reduce total costs of care. CMS will guide practice transformation via learning and monitoring systems with increasing practice expectations and payment from one track to another.

Multi-payer involvement is essential to CPC+, as it ensures adequate financial support for practices to make fundamental changes to their care delivery. Further, when payers share cost, utilization, and quality data[1] with practices at regular intervals, it facilitates practices' ability to manage their patient population's health, leading to smarter spending, better care, and healthier people. CPC+ Round 2 will be regionally based and there will be a staged application process (six week payer solicitation period beginning in mid-February; six week practice application period beginning in late spring or early summer 2017). The selection of payers will inform the selection of regions; the practice application will be open in only these to-be-determined regions. Payers must support practices in both tracks. Practices will apply for the track (1 or 2) for which they are eligible.

[1] All data sharing and data analytics in the CPC+ will comply with applicable law, including the privacy and security requirements promulgated under the Health Insurance Portability and Accountability Act (HIPAA)

Track 1 targets practices with multi-payer support that have the health information technology and other basic infrastructure necessary to deliver comprehensive primary care. In Track 1, participating practices will work for five years to implement and develop comprehensive primary care capabilities. In addition to their Medicare fee-for-service (FFS) payments, Track 1 practices will receive a care management fee (CMF) that averages $15 per beneficiary per month (PBPM) in support of this work. Track 1 is the most similar to the Original CPC Model, but CMS has refined the eligibility criteria, care delivery requirements, and incentive payment opportunities to incorporate lessons learned in the Original CPC Model.

Track 2 targets practices proficient in comprehensive primary care that are prepared to increase the depth, breadth, and scope of medical care delivered to their patients, particularly those with complex needs. In support of this advanced work, payment is redesigned to be a hybrid of FFS paid at the time of the visit and FFS prospectively paid through what CMS is calling Comprehensive Primary Care Payments (CPCPs). Beyond the FFS/CPCP payments, Track 2 practices will also receive an enhanced care management fee averaging $28 PBPM to support care management, enhanced to support the more stringent requirements for Track 2 practices and to enable more comprehensive care for their patients with more complex needs.

Both Tracks 1 and 2 will offer a prospective performance-based incentive payment to reward practices for performance on quality and utilization measures that lead to reductions in total costs of care.

All practices in the model will use health information technology (health IT) to strengthen their ability to deliver comprehensive primary care. Track 2 will place substantial emphasis on the optimal use of health IT and practices will thus be required to apply with a Letter of Support from their health IT vendor(s). Practice/vendor collaboration in Track 2 on health IT enhancements in CPC+ will support comprehensive primary care delivery.

Scope

For the 2017 performance year, CMS is partnering with 54 distinct payers. In mid-February 2017, CMS will welcome proposals from payers in up to 10 new regions, as well as new payers in any of the existing 14 CPC+ regions. CMS will select new payer partners in existing and new regions for CPC+ Round 2 based on payer density and alignment with CMS' approach to payment, care delivery, data sharing, and quality measurement. Only practices located within new Round 2 regions may apply.

CMS offered CPC+ Round 1 in 14 regions and will offer Round 2 in up to ten additional regions. CMS will accept up to 5,500 practices total across both rounds. Both tracks will be offered in all of the selected regions. In aggregate, up to 3.9 million Medicare FFS beneficiaries, as well as millions of other Medicare Advantage, Medicaid, and commercial patients, could be impacted over the course of this model.

Key Model Participants and Partners

Practices

Primary care practices are key participants in CPC+. Eligibility criteria are coordinated between the tracks and increase incrementally from Tracks 1 to 2. Practices select the track of the model to which they would like to apply.

Eligible applicants 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) that:

1. Pass program integrity screening,
2. Provide health services to a minimum of 150 attributed Medicare fee-for-service beneficiaries,
3. Submit claims on a Medicare Physician/Supplier claim form (CMS 1500) and are paid according to the Medicare Physician Fee Schedule for office visits, and
4. Can meet the requirements of the CPC+ Participation Agreement.

Eligible NPIs are those in internal medicine, general medicine, geriatric medicine, and/or family medicine. Medicare's FFS attribution methodology is outlined in Appendix E. Practices will apply directly to the track for which they believe they are ready; however, CMS reserves the right to offer a practice entrance into Track 1 if they apply to but do not meet the eligibility requirements for Track 2. CMS will randomize entry into the model in Round 2, as described below.

Practice Application Information

Practice application questions, including deadlines and contact information, can be found in Appendix B. As outlined in Appendix B, all practices must submit a letter of support from their clinical leadership demonstrating a commitment to CPC+ and a willingness to provide leadership in support of the program. There are some track-specific application questions, as noted in Appendix B.

All applicants must demonstrate track-appropriate readiness in the following areas to be eligible for the model:

1. Care management
2. Patient access
3. Quality improvement

Practices currently participating or planning to participate in Tracks 1, 1+, 2, or 3 of the Medicare Shared Savings Program may apply to either track. Practices participating or planning to participate in the Next Generation ACO Model or the Advanced Payment ACO Model are not eligible for CPC+. Concierge practices (any practice that charges patients a retainer fee), Rural

Health Clinics, and Federally Qualified Health Centers (FQHCs) are also not eligible for the model. More information is available in Appendix B.

Track 1

To be eligible to join Track 1, practices must be located in regions where there is sufficient private payer interest in the model and must be poised to deliver the Five Primary Care Functions, described in the Care Delivery section below and demonstrated via their answers to the application questions. They must also use certified health IT as described in Appendix C. Track 1 runs for five years. Information about the payment redesign for Track 1 can be found in the Payment Redesign section below.

Track 2

To be eligible to join Track 2, practices must be located in regions where there is sufficient private payer interest in the model and must demonstrate capability to deliver the Five Primary Care Functions, described in the Care Delivery section below and demonstrated via their answers to the application questions. Track 2 runs for five years. Information about the payment redesign for Track 2 can be found in the Payment Redesign section below.

Track 2 practices must use certified health IT. Track 2 requires enhanced health IT to accomplish the health care delivery changes that are the focus of this track. CMS has outlined the required health IT capabilities in Appendix C. Practices will need to apply with a "Letter of Support" from their health IT vendor(s) that outlines the vendor's commitment to support the practice in optimizing health IT further as specified in Appendix C. Once practices are selected, and concurrent with practices signing a Participation Agreement with CMS, each practice's health IT vendor(s) will sign a memorandum of understanding (MOU) with CMS that indicates the vendor's willingness to participate in CPC+ and partner with their respective practice(s) in the initiative. Vendor involvement in CPC+ is voluntary and without any payment from CMS.

Practice Selection and Randomized Entry for Round 2

Practices must be in good standing with CMS and meet the eligibility criteria, as described above. To ensure a robust evaluation of the model, CMS will randomize entry into CPC+ for Round 2. Eligible practice applicants for each track will be randomly assigned to either the intervention group or to the control group. CMS plans to randomize fewer practices into the control group.

Practices assigned to the control group will have the opportunity to enter a control practice-specific Participation Agreement with CMS and, pursuant to terms of that Participation Agreement, CMS will pay those practices an annual flat fee of $5,000 for time spent on evaluation activities, such as data collection and reporting. In addition, CMS will propose in rulemaking in 2017 to establish a new MIPS Improvement Activity that may give credit to

participants in CPC+ control group practices with an active control practice-specific Participation Agreement.

The control practices will continue to receive their usual payment under the Medicare physician fee schedule and 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+ control group, but may otherwise be Advanced APM participants through their participation in other CMS models or programs.

CMS also requires all CPC+ applicants to disclose any sanctions, investigations, probations, actions or corrective action plans that the applicant, its physicians/practitioners, its owners or managers, and/or other participating organizations, entities, or individuals are currently undergoing or have undergone in the last five years.

Multi-Payer Strategy

Multi-payer engagement is an essential component of CPC, as it makes full practice-level transformation of care delivery possible. CMS will coordinate with other payers who share Medicare's interest in strengthening primary care. CMS seeks partners from Medicaid FFS, Medicare Advantage Plans, Medicaid managed care, and commercial health insurers—including self-insured lines of business—to engage CPC+ practices in similar activities with respect to their own enrollees.

CMS will enter into an MOU that outlines the expectations of qualifying payers, to help ensure that the parameters of CPC+ are consistent within each region. CMS will not provide any funding to these payer partners. All payers, including CMS, will separately enter into agreements with the participating practices. This process is complete for Round 1.

CMS will stagger applications from payers and practices. For Round 2, CMS will solicit applications from payers for a six week period beginning in mid-February 2017. The choice of CPC+ Round 2 regions will be informed by the geographic reach of eligible payers selected to participate. Continuing regions from Original CPC, current and former MAPCP, and SIM states with participation of their State Medicaid Agencies will all be given preference when CMS evaluates proposals. Next, CMS will determine and publicize the Round 2 regions, and then solicit applications from practices within those regions for a six week period beginning in late spring or early summer 2017. In this way, practices can assess whether affiliated payers in their geographic region are partnering with CMS for CPC+ before submitting an application.

Payer Solicitation Information

Multi-payer engagement is an essential component 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. Detailed non-Medicare FFS payer

solicitation information can be found in Appendix A. CMS will evaluate payer proposals' based on the extent of their alignment with the following framework:

Operational

- Commit to pursuing private arrangements with practices participating in both Tracks 1 and 2 of CPC+ for the model's full duration.
- Provide enhanced non-fee-for-service support to allow practices to focus on and meet the aims of the CPC+ care delivery model in Track 1 and Track 2.
- Offer an opportunity for a performance-based incentive payment that aligns with the financial model outlined in the Payment Redesign section.
- To align with Medicare in Track 2, change the cash flow mechanism from fee-for-service to at least a partial alternative, in whatever arrangement the payer favors, before the end of the first performance year.

Data Sharing

- Share with CMS their attribution methodologies.
- Supply participating practices with practice- and patient-level data about cost and utilization for their attributed patients, either through reports or other methods of data sharing at regular intervals (e.g., quarterly).
- Provide CMS with practice and patient-level data to be used for monitoring and evaluation purposes, as required under 42 C.F.R. 403.1110.

Quality Measures

- To the greatest extent possible, align practice quality and performance measures with those under the model, as outlined in the Quality section.

Vendors

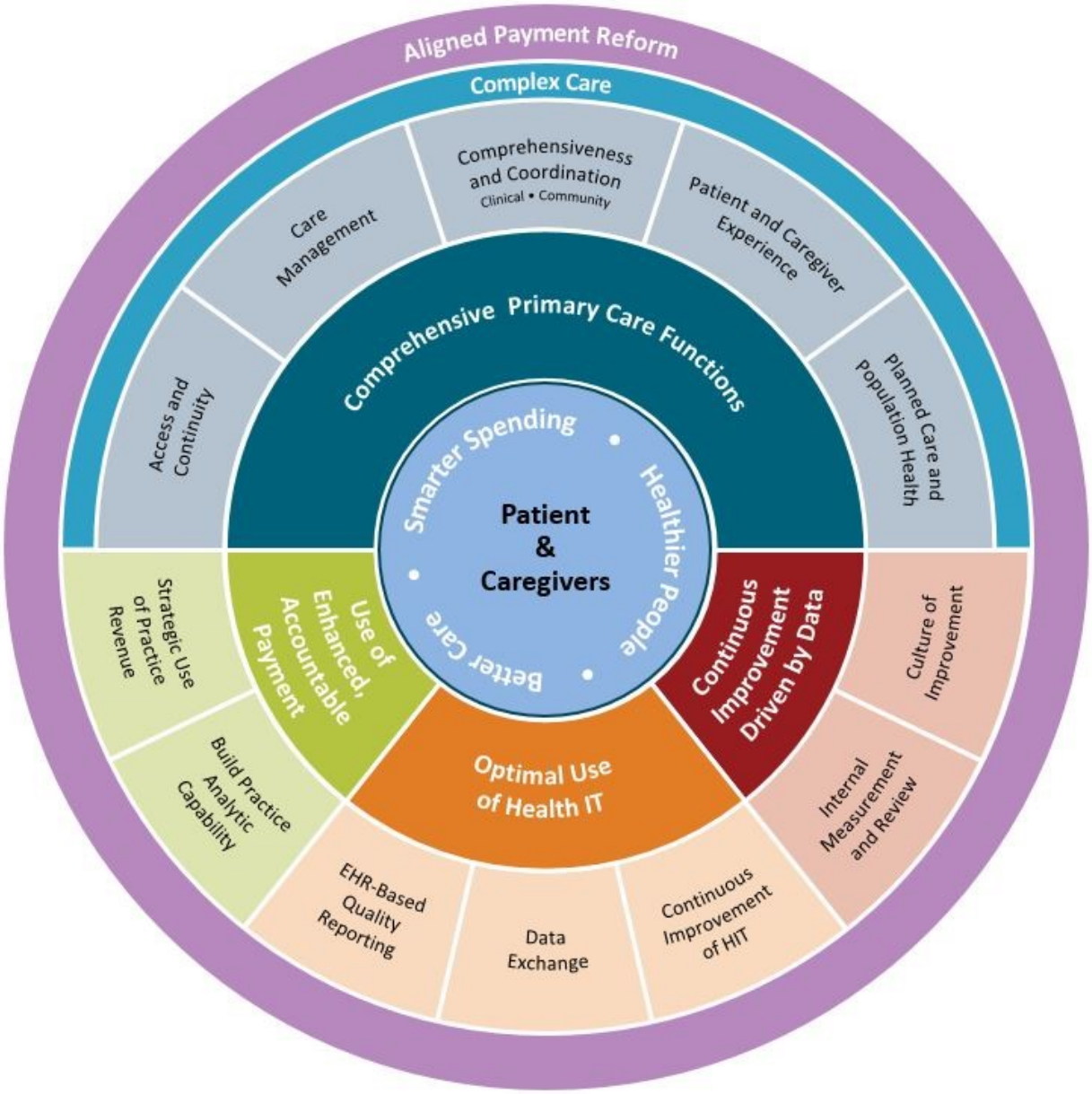
Health IT vendors will be invited to support practices who participate in Track 2. The care delivery CMS expects in Track 2 is reliant upon the use of advanced health IT capabilities that practices will need to attain through EHR enhancements or by adding or securing additional health IT services/tools. Thus, practices will engage their vendors to support the attainment and optimization of health IT to meet the goals and objectives of practice transformation. Vendor partnership is described further in Appendix C.

Intervention

Note: CMS reserves the right to change design elements of CPC+ to comply with any future laws or regulations, or to adjust program parameters based on program, policy, or operational needs. As such, Participation Agreements may be amended after the start of the model.

Theory of Action and Driver Diagram

By focusing practices on specific care delivery functions and aligning payment accordingly, CMS expects practices will provide more comprehensive and continuous care, thereby reducing patients' complications and overutilization in higher cost settings—which, in turn, should lead to higher quality and lower cost of health care overall. The theory of action for both tracks in CPC+ is outlined below and the broad overview of the model is visually represented by the driver diagram below. (Diagram design is subject to change.)



The general outline of the care delivery CMS believes is necessary to produce the desired outcomes (smarter spending, better care, and healthier people) is the same across both tracks. These are found in Driver 1: the Five Primary Care Functions (the top half of the radial diagram, shown in light blue above). The underlying practice structures and processes required for practices to deliver these functions (shown in the lower half of the radial diagram above) are found in Driver 2: Use of Enhanced Accountable Payment (shown in green), Driver 3: Continuous Improvement Driven by Data (shown in burgundy), and Driver 4: Optimal Use of Health IT (shown in orange). Finally, multi-payer payment reform that provides the financial

resources for these changes in the practice is found in Driver 5: Aligned Payment Reform (outer concentric circle shown in purple above).

Despite these similarities, each CPC+ track focuses and organizes the work in Drivers 1, 2, 3, and 4 differently, and these differences are linked to and supported by differences in the payment reform through Driver 5.

Care Delivery Design

Practices in both tracks will make changes to the way they deliver care. The care delivery design in CPC+ is described below and is centered on the Five Primary Care Functions tested in the Original CPC Model. While both tracks in CPC+ require practices to employ the same functions, the intensity and focus of delivery differs in each track.

Track 1 practices will deliver the Five Primary Care Functions, adding these services to visit-based, FFS care. Track 2 practices will be asked to redesign visit and non-visit based care (e.g., phone, email, text message, secure portal) to offer more comprehensive care overall.

CMS will require practices to perform the primary care functions using a framework of gradually increasing requirements with markers for regular, measureable progress towards the necessary practice capabilities. Practices will report their progress on these requirements regularly through a secure web portal that will provide both the practices themselves and CMS insight into practice capabilities. CMS will support practices in their work through the requirements with robust learning communities at the regional and national level, and, upon request, with data feedback for practices to use in care coordination and quality assessment and improvement activities.

Driver 1: The Comprehensive Primary Care Functions

1. **Care Management**

   A hallmark of comprehensive primary care is the provision of targeted care management for high-risk, high-need patients. Track 1 and 2 practices will identify these patients in two ways. After empaneling all of their active patients to practitioners or care teams, they will systematically risk stratify their population, identifying the high-risk patients most likely to benefit from longitudinal, relationship-based care management, and they will identify event triggers (e.g., hospitalization, ED visit, new diagnosis) for short term, episodic care management for patients regardless of risk status. Practices will provide both longitudinal, relationship-based care management and short term, goal-directed care management as appropriate for these identified patients. Track 1 practices will build capabilities in behavioral health, self-management support, and medication management to better meet the needs of these patients. Track 2 practices will also provide more intensive care management for their patients with complex needs and will build additional practice capabilities in

assessment and management of patients with complex needs, such as those with cognitive impairment, frailty, or multiple chronic conditions.

2. Access and Continuity

Effective primary care is built on the relationship between a patient, his or her caregivers, and the team of professionals who provide care for the patient. This care must be informed by the critical and specific information contained in the patient's electronic health record (EHR). Multiple points of access to primary care increase the likelihood that the patient will get the care he or she needs when it is needed, potentially avoiding costly urgent and emergent care. Tactics that increase access to care may increase continuity in relationship; the opposite is also true. Track 1 and 2 practices will ensure 24/7 access to care by care team (or covering care team) members with real-time access to the electronic medical record. Practices in both tracks will empanel (or assign) all active patients to a practitioner or care team so that every patient has the opportunity to build a therapeutic relationship, and the practitioner and care team understand their patient population. Access to care and continuity of relationship are especially important in the management of patients with complex needs. Track 2 practices will be expected to explore alternative means of access to reduce barriers to timely care, such as e-visits, phone visits, group visits, home visits, and visits in alternate locations (e.g., senior centers and assisted living centers).

3. Planned Care for Population Health

CPC+ practices will be organized to deliver care for the population of patients served by the practice. Using team-based care, the practice will proactively offer timely and appropriate preventive care and reliable, evidence-based management of chronic conditions. Use of evidence-based protocols in team-based care and attention to health disparities will improve population health. Through this approach, Track 1 and 2 practices will develop an understanding of their patient population and develop the capability to measure and act on the quality of care at both the practice and panel level. Track 2 practices will also integrate support for self-management of care into the routine fabric of care and to understand and address health disparities in their population.

4. Patient and Family Caregiver Engagement

Optimal care and health outcomes require patients and families to be fully engaged in the design and improvement of care delivery. Track 1 and 2 practices will engage patients and families in the design and improvement of care, using Patient and Family/Caregiver Advisory Councils and other strategies to elicit the voice of the patient and integrate the patient into efforts to improve care. To increase patient engagement, practices will engage patients in goal setting and shared decision-making, using decision aids and specific

techniques (e.g., motivational interviewing) to support patients in the process. Track 2 practices may also more directly involve patients and families in quality improvement initiatives, and must provide self-management support as well as support for caregivers of persons with functional disabilities (e.g., dementia).

5. Comprehensiveness and Coordination

Practices in CPC+ are asked to play an indispensable role in helping patients and families navigate and coordinate care and services. The "medical neighborhood" is the totality of provider facilities and other health care services in an area, and primary care can be seen as the hub of the medical neighborhood. But patients' needs extend well beyond medical services, and unmet social needs can be detrimental to health. To be effective in improving the care of patients with complex needs, practices participating in CPC+ will need to provide comprehensive primary care services.

"Comprehensiveness" in the primary care setting refers to the availability of a wide range of services in primary care, as well as care for the depth and breadth of the health needs in the population of a primary care practice. Higher levels of comprehensive care are associated with lower overall utilization and costs, as well as better health outcomes. For some aspects of care, the primary care practices can best achieve that comprehensiveness by building additional practice capabilities internally. However, other care or services are best obtained outside of the practice, with coordination or even co-management.

All participating practices will understand where in the medical neighborhood their patients receive care and will organize the practice to facilitate coordination of that care. Track 1 practices will address the opportunities available in improving the transitions of care by working more closely with hospitals and emergency departments, as well as with at least one high volume specialty service provider. Because Track 2 practices will not be paid through FFS alone, they will have the flexibility to offer more comprehensive services. Track 2 practices will be paid additional resources to offer the most comprehensive care, which must include, (as appropriate and consistent with chronic care management (CCM) services covered under Section 1862(a)(1)(A) of the Social Security Act), a systematic assessment of these patients' psychosocial needs and an inventory of resources and supports to meet those needs. Practices will also be encouraged to provide referrals to identified community/social services as needed. Beneficiaries, especially those with complex medical needs, may benefit from practices' capability to identify health-related issues that are precipitated by previously unmet social needs.

The Five Primary Care Functions described above are a primary driver (Driver 1) toward achieving the aims of CPC+, but require additional changes in participating practices, as

illustrated in the CPC Driver Diagram and discussed in the Theory of Action sections. The additional changes are described below as Drivers 2-4.

Driver 2: Use of Enhanced, Accountable Payment

Track 1 practices will be required to build analytic capability, project revenue and perform budgeting exercises, and use the CMF to support delivery of comprehensive care, using the claims data provided to identify opportunities for continued improvement. Track 2 practices will be required to improve analytic capability to use claims data to identify opportunities to enhance comprehensiveness of care, coordination of services, and better meet the complex health care needs of their patient population.

Driver 3: Continuous Improvement Driven by Data

Practices in both tracks will reliably and systematically measure quality at the practice level and panel or care team level, and will develop skills and capabilities in managing changes required to improve quality. In Tracks 1 and 2, the practices will acquire new improvement capabilities, which will require testing and implementing new workflows. Track 2 practices will have the opportunity to use advanced innovation strategies to test new opportunities to expand services and better meet the complex health care needs of their patients.

Driver 4: Optimal Use of Health IT

In both tracks, practices will use certified Health IT and will be required to have remote access to the EHR to ensure 24/7 access to care team (or covering care team) members with real time access to the medical record. Practices in both tracks will report on electronic clinical quality measures (eCQMs) and generate quality reports, both at the practice and panel/care team level. Track 2 practices will be required to implement enhanced tools that support more comprehensive and coordinated care of patients with complex needs. More detail is available in Appendix C.

Payment Redesign

As described above, the intensity and breadth of care delivery requirements increase from Track 1 to Track 2 and the accompanying payments provide practices with appropriately increasing resources structured to align with the requirements and focus of each Track. **Practices will be required to document use of funds and care delivery work under the model.**

The payment flows consist of three elements, which are described in more detail in this section and summarized in Table I (below):

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.

2) **Performance-based incentive payment:** CPC+ will prospectively pay and retrospectively reconcile a performance-based incentive 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 is discussed further below.
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 will receive **a hybrid** payment. They also continue to bill as usual, but the FFS reimbursement amounts will be reduced to account for CMS shifting a portion of Medicare FFS payments into **Comprehensive Primary Care Payments (CPCP)**, which will be paid in a lump sum on a quarterly basis absent a claim. Given our expectation that Track 2 practices will increase the comprehensiveness of care delivered, the CPCP amounts will be larger than the FFS reimbursement amounts they are intended to replace, as discussed in more detail below.

Table I. CPC+ Financial Summary Table.

Track	Care Management Fees, PBPM	Performance-Based Incentive Payments, PBPM	Visit and Non-Visit Based Payments
1	$15 average	$2.50; Utilization and Quality/Experience Components	CMF + FFS
2	$28 average; $100 for complex	$4.00; Utilization and Quality/Experience Components	CMF + ↓FFS + ↑CPCP

Attribution

CMS will use a prospective attribution methodology based on a plurality of primary care claims over the prior two years to identify the population of Medicare FFS beneficiaries for which each participating primary care practice is accountable. To ensure practices are eligible, CMS will run attribution for applicant practices before they sign their Participation Agreements. The attribution methodology can be found in Appendix E.

Care Management Fee (CMF)

CMS will pay practices in both tracks a monthly care management fee (CMF) for attributed Medicare FFS beneficiaries without any beneficiary cost-sharing on the CMF. Given the similarity in services, practices in both tracks will not be permitted to bill the Chronic Care Management (CCM) for attributed patients.

Table II illustrates the proposed CMF amounts and risk tiers. The CMF will be risk-adjusted to reflect the increased resources required to target care management to patients with more complex needs. Beneficiary risk will be based on HCC risk scores and, in Track 2, claims data for

diagnoses. CMS will determine risk tier cutoffs for CPC+ using a regional or national pool of Medicare FFS beneficiaries.

There will be four patient risk tiers in Track 1 and five risk tiers in Track 2, as shown with CMF amounts in Table II below. Both Tracks' CMFs will remain constant over the duration of the program. The Track 2 CMF levels will be $3 more than the Track 1 CMF for each corresponding risk tier, in order to account for the estimated increase in labor necessary to meet the more demanding requirements in Track 2 as compared to Track 1.

Practices in Track 2 will receive a $100 CMF for an additional complex risk tier to support the enhanced services beneficiaries with high-costs and high-needs require. CMS will assign to the complex tier patients who fall within the top 10 percent of the HCC pool and those who, according to Medicare claims, have lower HCC scores but have a diagnosis of dementia. This is due to the higher level of care coordination patients with dementia require, as well as to correct for the omission of dementia diagnoses in the CMS-HCC algorithm. An analysis of Original CPC attributed beneficiaries' HCC scores and diagnoses informed an estimate that approximately 14 percent of Track 2 practices' beneficiaries would constitute the complex tier.

Table II. Proposed Risk Tiers and Care Management Fee Levels (PBPM) for CPC+.

Risk Tier	Attribution Criteria	Track 1	Track 2
Tier 1	1st quartile HCC	$6	$9
Tier 2	2nd quartile HCC	$8	$11
Tier 3	3rd quartile HCC	$16	$19
Tier 4	4th 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		**$15**	**$28**

Practices in CPC+ will not be required to target intensive care management services to the same Medicare beneficiaries as are identified in the CMF risk calculation. The CMF gives practices the flexibility to provide historical non-billable and non-visit based services to their attributed beneficiaries, as described in the Five Primary Care Functions. The CMF must be used to support augmented staffing and training related to the model requirements, and practices will have flexibility to balance these options according to the needs of their patient population.

CMS will monitor coding and HCC score changes closely throughout the program and, if significant, unexpected, or irregular upcoding is found to occur, will adjust the payment methodology in order to ensure the actuarial soundness of the CPC+ model. In the event that CMS decides to make changes, they will be specified prior to the payment quarter in which they are implemented.

Performance-Based Incentive Payment (PBIP)

To encourage and reward accountability for patient experience, clinical quality, and utilization measures that drive total cost of care, CPC+ will include a PBIP rather than shared savings.

CMS will pay prospectively a PBIP but only allow practices to keep the funds if they meet annual performance thresholds. Practices will thus be "at risk" for the amounts prepaid, and CMS will recoup unwarranted payments. 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 eCQM and CAHPS metrics. The utilization component will be based on claims-based measures of inpatient admissions and emergency department visits, which are available in the Healthcare Effectiveness Data and Information Set (HEDIS) and have been demonstrated to be primary drivers of patients' total cost of care under Original CPC. We will prioritize quality such that there is no utilization performance reward unless practices meet the minimum total score for quality.

CMS will provide larger payments in Track 2 than in Track 1, as outlined in the following table. Practices may keep less than these amounts depending on their performance. The final methodology will be outlined in the Participation Agreement so practices understand the payment mechanism prior to the start of the model.

Table III. Proposed PBIP Amounts

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

CMS will pay for performance on each individual eCQM and utilization measure, and on CAHPS as a single measure. In order to be eligible to retain the PBIP, the practice must successfully and completely report on nine CPC+ eCQMs as specified in the CPC+ Participation Agreement. The payment for each measure will be based on performance against national external benchmarks. The final scoring methodologies will be available in early January in the CPC+ Payment Methodologies paper.

As a non-monetary strategy to spur practice performance, CMS plans to publish unblinded performance results to all CPC+ practice participants to motivate the practices to perform well compared to their peers.

CMS wants to avoid paying shared savings and performance-based incentive payments for the same beneficiary. If a practice is a dual participant in CPC+ and the Medicare Shared Savings Program (MSSP), the CPC+ practice no longer receives the PBIP and instead their costs are included in the ACO expenditure calculations. Practices cannot participate in CPC+ and be a part

of MSSP ACOs that are in the ACO Investment Model (AIM). CPC+ will maintain a no-overlaps policy with all other CMS shared savings programs and models. This means, for example, that if a practice is participating in CPC+, it is not permitted to participate in the Next Generation Accountable Care Organization Model or Comprehensive End Stage Renal Disease Care Model at the same time.

Track 2 Hybrid Payment: Comprehensive Primary Care Payments (CPCPs) and FFS Reduction

FFS will remain unchanged in Track 1. In Track 2, to support the flexible delivery of even more comprehensive care, we are paying practices in a hybrid fashion – part upfront per-beneficiary-per-month (paid quarterly) and part fee-for-service (paid based on claims submission). We hypothesize a "sweet spot" between upfront payments and reduced FFS, where practices will be will be "incentive neutral" with regard to physically bringing a patient into the office for a billable service.

This upfront payment, the "Comprehensive Primary Care Payment" (CPCP), is paid based on a practice's per-beneficiary-per-month revenue during a historical period, described below, without any beneficiary cost-sharing on the CPCP. Fee-for-service payments during the year are then reduced proportionately to account for the upfront payment (though beneficiary cost-sharing will apply to the full amount prior to the proportional reduction). We will test two hybrid payment options: one will pay 40% upfront and 60% of the applicable FFS payment, and the other will pay 65% upfront and 35% of the applicable FFS payment.

The CPCP and reduced FFS will only apply to office Evaluation and Management (E&M) codes. It is important to retain some full FFS to protect patient access as well as incentivize certain services (such as vaccine administration).

In an effort to recognize practice diversity, we will allow practices to accelerate to one of these two proposed hybrid payment options, at their preferred pace, pursuant to the options shown in Table V below

Table V. Round 2 Track 2 Payment Choices by Year

	2018	*2019*	*2020*	*2021*	*2022*
CPCP%/FFS% options available to practices	10%/90%				
	25%/75%	25%/75%			
	40%/60%	40%/60%	40%/60%	40%/60%	40%/60%
	65%/35%	65%/35%	65%/35%	65%/35%	65%/35%

What is the CPCP for?

Practices will receive payment for visits through reduced FFS and the CPCP, with partial reconciliation (to be further explicated in the Participation Agreement). This methodology changes the payment mechanism, promotes flexibility in how practices deliver care traditionally

required to be provided face-to-face, and requires practices to increase the depth and breadth of primary care they deliver. While the CMF gives practices the flexibility to provide "wrap-around" services that were not traditionally considered to be separately billable, the CPCP, by contrast, compensates the practitioner for clinical services that have always been separately billable but allows flexibility for the care to be delivered in or outside of an office visit.

The CPCP can replace practices' claims foregone as a result of clinical care being delivered outside of the office and it encourages practices to furnish proactive and comprehensive care that would otherwise be required under Medicare to be furnished in an office setting. The CPCP also enables services to be furnished in a way that best meets the needs of the patient, whether that be by email, phone, patient portal, etc. The CPCP allows flexibility for a portion of services previously delivered in face-to-face visits and billed under FFS to be delivered in ways other than face-to-face and thus, without submission of a claim. Face-to-face visits will still require submission of a claim. CMS will require practices to preserve documentation of their use of funds and their care delivery work under the model. We may also consider grouping the CPCP with the CMF as a single disbursement.

How will the CPCP be calculated?

As stated previously, the CPCP will be calculated based on historical E&M services for attributed Medicare patients at the practice site. (In later years of the model, we may revise the calculation methodology to incorporate the actual value of services delivered based on a study CMS valuing comprehensive primary care costs in the Original CPC and CPC+).

To account for increased depth and breadth of primary care expected under Track 2, in the calculation of the CPCP for 2018, CMS will inflate the practice's historical revenue from E&M services by 10% and will pay part of this amount as the CPCP (consistent with each practice's applicable percentage in Table IV above). The choice of an increase of 10% is informed by the Affordable Care Act's Incentive Payments for Primary Care Services.

When both the upfront and reduced FFS payments are taken together, the payment scheme is designed to increase revenue by between 4-6.5% over historical, not including revenues associated with the CMF and performance-based incentive payments. An increase of 6.5% is expected for practices that choose the 65% upfront option, while 4% is expected for those that choose the 40% upfront option.

We will conduct a reconciliation based only on E&M services delivered in an office setting by primary care physicians outside the CPC+ practice. Under this partial reconciliation construct, we presume that beneficiaries will tend to increase the amount of primary care they seek elsewhere if they are not satisfied with the care they receive from their CPC+ practice. Thus, increases in E&M services delivered by primary care physicians outside of the CPC+ practice to CPC+ practice attributed beneficiaries would lead to a partial recoupment of the CPCP (as well

as heightened monitoring and/or auditing to evaluate the situation more closely). Conversely, significant decreases in E&M services delivered by primary care physicians in an office setting outside of the CPC+ practice could also lead to an additional payment to CPC+ practices (whether this would be incorporated into the CPCP would depend on the design of the CPCP). This type of partial reconciliation would protect CMS from spending significantly more on E&M services across all primary care practices.

Overall, approximately 75-80% of E&M services from primary care physicians is delivered within the practice in Original CPC (average is $16-17 PBPM within the CPC practice and $4-5 PBPM outside the CPC practice). Given the magnitude of out-of-practice expenditures, this provision may have a small impact.

Business Case for Practices

The model design makes persuasive business cases for practices to participate in the CPC+ model and choose the track that best meets their needs.

In Track 1, if a practice is the average size of Original CPC practices (700 attributed beneficiaries), the $15 average Medicare CMF comes to $10,500 monthly and $126,000 annually. Practices will be guided by the care delivery expectations to invest these funds into practice transformation. The learning system and expectations will support the sort of care and management that will increase likelihood of practice eligibility for incentives that could reach $21,000 annually ($2.50, 700 attributed beneficiaries).

In Track 2, if a practice is the average size of Original CPC practices, the $28 average CMF comes to $19,600 monthly and $235,200 annually. Track 2 practices will also have the opportunity to earn incentives based on performance that could reach $33,600 annually ($4.00 PBPM, 700 attributed beneficiaries).

In Track 2, prepaid FFS via the CPCP will also increase practice flexibility to deliver care in the best setting for patients and providers. Practices may anticipate “lost revenue” from patient cost-sharing on an in-person visit that is replaced by remote monitoring or care. By contrast, we expect practices will replace those services with more efficient comprehensive services paid for by the CPCP and their efforts could be rewarded by the incentive payment. Practices could also take on more patients. The Track 2 financial model empowers practices to employ more efficient manners of care delivery and delinks a substantial portion of payment from visit-based claims.

Learning Systems Strategy

Overview

CPC+ will include a robust learning system to support practices through their care delivery transformations. The overall goals of the CPC+ Learning System are as follows:

1. **Orient practices** to CPC+, aim, key drivers and changes, and requirements of participation.
2. **Provide actionable data and feedback** on cost and utilization, quality, patient experience of care, and practice transformation by facilitating practice and regional learning community use of the CPC+ Feedback Report, data from payer partners, eCQMs, CAHPS data, and data from practices reported to CMS.
3. **Provide benchmarks and track progress in the development of practice capability** to deliver comprehensive and advanced primary care through the CPC+ care delivery requirements.
4. **Network practices** within and across regions to foster peer-to-peer learning and innovation and to create communities of primary care practices.
5. **Coach and facilitate practices** requiring tailored support to build the capabilities required and to use these capabilities to improve care and health outcomes and reduce total cost of care.
6. **Identify exemplar practices and successful practice tactics** to highlight useful strategies in comprehensive primary care and encourage adoption by other practices.
7. **Collaborate in the regional environment** to maintain aligned payment reform, leverage health IT and multi-payer data capabilities, and to join efforts to build community and stakeholder engagement, all in an effort to support practices in delivering comprehensive and advanced primary care.
8. **Provide critical feedback** to CMS on structural and process changes in CPC+ practices, the specific tactics deployed by these practices to achieve the CPC+ aims, and critical practice needs, so as to guide adjustments in the learning system and adjustments in CMS processes for managing the initiative.

The CPC+ Learning System will include for both tracks the following:

1. A **web-based collaboration site (CPC+ Connect)** for robust online collaboration and sharing among practices, within and across tracks.
2. **The online CPC+ Practice Portal** on which practices report their activity on the required care delivery requirements. The practice reporting allows the CPC+ team and regional learning staff to track practice progress through the relevant expectations and to understand the practice capabilities. The reporting structure also provides CPC+ practices with valuable assessment and feedback so that they can understand their progress in building the capabilities required to deliver comprehensive and advanced primary care.

The National Learning Community

All CPC+ practices will be part of the National Learning Community. The National Learning Community offers the opportunity to provide consistent orientation and information across regions and supports cross-region sharing and collaboration.

The practices themselves will be the primary drivers of practice change. The National Learning Community will provide orientation to operational requirements and to the logic and purpose of the key drivers, change concepts, and specific tactics in the delivery of comprehensive primary care through national webinars and regular communication including case studies and briefs that spotlight specific practice tactics. As a primary strategy to drive practice change, Rapid-Cycle Action Groups will bring together groups of practices working on similar process changes related to the key drivers of CPC+ for cross regional sharing and collaboration. Action Groups will be facilitated and guided by subject matter experts and support practices as they work on specific changes in their practice to build practice capability in support of model aims.

While each track will have its own focus and targeted support within the National Learning Community, there will be opportunities for learning across tracks.

The Regional Learning Communities

CPC+ practices will be part of Regional Learning Communities, supporting networking and shared learning virtually and in person among practices in the region, engagement with the regional payers supporting CPC+, and alignment with regional efforts in health care reform. Visibility and communication across tracks within the Regional Learning Communities will encourage practices at every stage in the transformation process to further develop the capabilities they need to deliver comprehensive and advanced primary care.

The key features of the Regional Learning Communities are 1) practice ownership and management of the change process, 2) opportunities for practices to learn from and with each other in their region, 3) integration with the CMS regional staff, and 4) alignment with regional health care reform efforts.

The regional organization of practices supports: (1) better alignment with regional health care reform initiatives (e.g., the State Innovation Models (SIM) Initiative); (2) practice sharing and collaboration; and (3) practice outreach and support by regional faculty. The regional staff will support struggling practices and identify exemplar practices and successful tactics.

All practices will be expected to identify the individuals who will function within the practice, or within a group of practices, to facilitate practice change. In addition, they will be asked to identify a clinical leader who is the CPC+ champion or senior sponsor. The Regional Learning System will bring these practice-identified facilitation resources together regularly as a primary coaching strategy and will facilitate engagement of clinical leadership. This approach maintains control and ownership of practice change at the practice level, fosters regional learning, and

allows regional faculty to concentrate their limited practice coaching and facilitation resources on practices at risk. This approach offers the model a test for scaling the learning system support in CPC+.

Data Sharing

In CPC+, CMS will offer practices regular feedback data to inform their efforts to impact patient experience, clinical quality measures, and utilization measures that drive total cost of care. The CPC+ model will aim to provide regular Medicare FFS cost and utilization data in a clear, actionable way and, where possible, to align or aggregate data sharing with CPC+ payer-partners. Improving how healthcare cost and utilization data is shared will be critical for practices to reduce both the cost of care and unnecessary utilization, and provide better care coordination and population health management.

We expect participating primary care practices will have widely varying resources and technical capabilities to interpret and use data from disparate sources and payers, as we saw in the Original CPC model. While some Original CPC practices have internal technical and analytic resources to manipulate and understand their cost and utilization data, many practices have just begun to use these kinds of data in their work. Building on lessons learned in the Original CPC model, we recognize the need to pursue multiple approaches to data sharing to accommodate the broad range of practices' needs and capabilities, existing regional resources, and regional payer priorities.

CMS will provide practices with at least quarterly practice-level feedback reports and regionally aggregated reports per such practices' request. These reports will summarize Medicare FFS cost and utilization, as well as provide beneficiary-level lists of emergency department visits, hospitalizations, and other high-cost services used in the previous quarter (e.g., imaging). CMS will also offer reports that would include these data as well as cost and quality data about subspecialists in participants' regions to help practices select cost-effective specialty partners. CMS may also share with all practice participants the performance data of the participating practices in an effort to use transparency and competitiveness to incentivize performance. Further, we may explore offering claims data directly to practices via a claims line feed for practices with highly sophisticated data-capabilities to retrieve and input into their own data analytic systems (an approach often used by large systems and ACOs). All data sharing and data analytics in CPC+ will comply with applicable law, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Multi-Payer Collaboration in Data-Sharing

In the CPC+ model, we will continue our efforts to improve aligned approaches for data sharing with participating primary care practices across payers. Where regional data aggregation and

performance capabilities do exist, we intend to leverage them as part of a broader effort to support and sustain infrastructure to enable multi-payer alternative payment models.

In order to reduce burden and better enable data driven improvement, we encourage multi-payer collaboration around data-sharing and use of regional infrastructure, to the extent possible. We expect payer-partners to make similar commitments to offer data on cost and utilization to their participating practices, and to participate in multi-payer alignment or aggregation efforts where feasible. As stated in their MOUs, payer partners are also expected to regularly provide practices with lists of their attributed members, and upon request and in accordance with applicable laws, relevant claims and cost data for their attributed population.

As in several of the Original CPC regions, CMS hopes to join in efforts of aligned data-sharing where the commercial payers have or plan to collaborate in order to institute multi-payer claims databases that provide unified reports to practices based on their entire attributed populations. This data aggregation is typically performed by independent vendors who receive and manipulate the data from each commercial payer partner and, in some regions, State Medicaid Agencies and Medicare, and create practice- and patient-level reports for practices to use in their quality improvement efforts. Aggregated feedback reports are intended to reduce the burden on practices to review their feedback data from payers and improve the practice view of data on their entire active patient population. Data aggregated from a practice's entire attributed population allows greater opportunity to understand trends across their patient population, and flexibility to view potential areas for improvement for specific sub-populations (e.g., patients with a certain diagnosis or adverse event). Other opportunities in multi-payer collaboration include data alignment, wherein regional payers report on the same measures using a common format for their attributed population, but continue to send individual reports; this effort is intended to improve the clarity for and reduce the administrative burden on the participating practices.

Quality Strategy

The test of payment and service delivery redesign in CPC+ will only be successful if patient experience of care and quality of care delivered are preserved or enhanced. To that effect, the model will use eCQMs, patient experience of care measures, utilization measures, and patient reported outcome measures (PROMs) to track experience and quality of care, identify gaps in care, and focus quality improvement activities. High quality of care, quality improvement, or both, will also be rewarded with a performance-based incentive payment, as outlined in the Payment Redesign section, for Tracks 1 and 2.

Reporting Requirements: To assess quality performance and determine the amount of the CPC+ performance-based incentive payment, Track 1 and 2 practices will be required to report annually the practice-level eCQMs listed in Appendix D. This list is considered a draft list and

may be changed to reflect a subset of the eCQMs included in the 2018 Quality Payment Program final rule for use in the Merit-based Incentive Payment System (MIPS). The final measure list for each performance year will be communicated to practices accepted in the model in advance of the first performance period. Practices will be required to report all eCQMs at the practice site level to CMS and at the panel level for internal practice improvement. The eCQMs, utilization measures, and patient experience of care measures will be included as pay for performance measures. Practices must use ONC certified health IT. All requirements are described in Appendix C. CAHPS surveys will be administered to all patients who have in-person office visits. The PROM will be administered to Track 2 patients only and will not be included as a pay for performance measure until the measure is fully developed and tested.

eCQMs: The use of eCQMs ensures clinicians and practices have a view of performance on an ongoing basis at the point of care. All eCQMs in this measure set were selected from the portfolio of health IT-enabled measures included in other CMS quality reporting programs. Measures from each of the six quality domains of the National and CMS quality strategies (i.e., patient safety, effective clinical care, person and caregiver-centered experience and outcomes, communication and care coordination, community/population health, and efficiency and cost reduction) are included in the set. The measures target a primary care patient population, and, where feasible, are outcome measures instead of process measures. The measure set is available in Appendix D. As indicated above, CMS will communicate the final list of eCQMs to be reported for the first performance year (CY 2018) for submission to CMS in 2019 prior to the start of the performance period.

Patient Experience of Care: A subset of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey will be administered by CMS to measure experience of care across the patient population in CPC+ practices.

Patient Reported Outcome Measures (PROMs): A PROM is an instrument, scale, or single item measure to assess outcomes of interest (Patient Reported Outcomes or PROs) as perceived by the patient and obtained directly from patient self-reporting. PROMs will be used to screen for and capture the patient's reported clinical outcomes for some common medical/social problems that are disease agnostic, such as depression, problems with physical functioning, social isolation, or pain, instead of only focusing on patients with a specific disease or condition. The PROM surveys will be administered to Track 2 patients only. PROMs will be used as a tool to enhance practices' medical care and care management for patients with complex needs. PROMs are distinct from CAHPS in that they ask what patients are able to do or how they feel as opposed to their perception or experience of the care received. Targeting patients with complex needs, CMS and/or practices will administer the patient reported outcome surveys at specified intervals during the year but no less than two times.

A PRO Performance Measure (PRO-PM) is a performance measure based on PROM data that is aggregated for an accountable health care entity. CMS expects to develop a PRO-PM with CPC PROM data collected during the model. Once a PRO-PM is developed, CMS may use it to assess quality performance in the later years of CPC+ Track 2.

Electronic Clinical Quality Measure (eCQM) Set: The measure set was chosen according to the principles and priorities outlined in the previous sections and can be found in Appendix D.

Practice Monitoring, Auditing, and Termination Strategy

Monitoring is essential to ensure that patients' experience and quality of care is either preserved or enhanced and that practices are compliant with the Participation Agreement. Documentation requirements and robust monitoring will help CMS ensure that CPC+ is being implemented appropriately and effectively at the practice level, specifically whether practices are using payments to meet the model requirements. Moreover, monitoring confirms that practices understand and can track their progress towards meeting the care delivery requirements. CMS will use program integrity, cost, utilization, and quality data in its monitoring strategy, as well as reports submitted from practice coaches (CMS contractors) and the practices themselves. The findings from monitoring will guide the selection of additional learning activities.

Monitoring will include the review of some or all of the following:

- Program Integrity Data: Prior to the start of the model and annually thereafter, practices that apply to participate in the model will be subject to a program integrity screening by the Center for Program Integrity to determine if they are eligible to participate in the model.
- Care Delivery Requirements Achievement Data: Quarterly practice attestations of care delivery achievements to CMS. Practices may attest less than quarterly for certain care delivery requirements (e.g., 24/7 access to EHR).
- Care Delivery Flag Report: Quarterly "Flag Report" based on practices' submissions to CMS that identifies areas of concern and areas of high quality performance.
- Practice Revenue and Expense Data: Bi-annual practice submissions to CMS, including a prospective view and a retrospective look at the practices' prior use of CMFs and CPCPs.
- Cost, Utilization, Patient Experience, and Quality Data: Review of cost, utilization, patient experience, and quality data at least annually to identify practices that are performing well and those that are performing poorly.

Track 2 practices may be subject to increased monitoring and/or feedback to ensure no stinting of care occurs under the CPCP.

CMS will determine periodically whether practices should be subject to any administrative action, such as a Corrective Action Plan (CAP) or termination. A CAP will be imposed when a practice does not meet certain terms of the Participation Agreement, is found to be "gaming" the model, or is not meeting quality standards. Practices will be expected to remedy the situation within a reasonable time frame (usually six months). Termination will occur for non-remediable failures as set forth in the Participation Agreement or determined by CMS, or when expected remediation does not occur. Any administrative action will be shared with practices, regional learning staff (explained in the Regional Learning Communities section), and payers.

In most cases and at CMS' discretion, practices will be given approximately six months to address any areas of concern. Practices that cannot address areas of concern or are unable to meet the requirements of their Practice Agreement will be subject to termination. CMS will reserve the right to terminate practices at any time for any reason.

In addition to quarterly monitoring of practice performance, practices will also be subject to audit. Practices will be informed of these potential audits and will be required to maintain copies of all documentation related to their use of CPC funds and their care delivery work for CPC requirements. A risk score based on budget data practices submit annually to CMS, performance on utilization and quality measures, and reporting may trigger CMS to audit any participating practice.

Evaluation

All participants in CPC+ will be required to cooperate with efforts to conduct an independent, federally funded evaluation of the model, which may include: participation in surveys; interviews; site visits; and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation. The evaluation will be used to inform CMS about the effect of both primary care transformation and aligned payment reform. The evaluation of this model will use a mixed-methods approach, customized to each track to assess both impact and implementation experience. The impact component will attempt to measure to what degree each track improved key outcomes, including lower total cost of care and improved quality of care. The implementation component will describe how the model was implemented, assessing barriers and facilitators to change.

Authority to Test Model

Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Center for Medicare and Medicaid Innovation (Innovation Center), and provides authority for the Innovation Center to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care.

While CMS is committed to improving care for beneficiaries, the Agency reserves the right to decide not to move forward with the Comprehensive Primary Care Plus model for any reason and at any time, as is true for all models pursued under Section 1115A authority. Similarly, as implementation of CPC+ ensues, CMS reserves the right to terminate the Model if it is deemed that it is not achieving the goals and aims of the initiative.

No fraud and abuse waivers are being issued in this RFA; fraud and abuse waivers, if any, would be set forth in separately issued documentation. Thus, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued specifically for CPC+ pursuant to section 1115A(d)(1). Any such waiver would apply solely to CPC+ and could differ in scope or design from waivers granted for other programs or models.

Solicitation Type

CPC+ will use two rounds to solicit first payer partners, and then practice participants and health IT vendor partners. The applications are not legally binding contracts for the organizations that apply to be part of CPC+.

Program Overlap and Synergies

Quality Payment Program (QPP)

Under the Quality Payment Program (QPP), CPC+ will be evaluated as an Advanced Alternative Payment Model (APM) using the special financial risk and nominal amount standards for medical home models. For payment years 2019 through 2024, clinicians who meet the threshold for sufficient participation in Advanced APMs and who meet requirements 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.

The special financial risk and nominal amount standards for medical home models will only apply to APM Entities in CPC+ that have 50 or fewer eligible clinicians in the organization through which the APM Entity is owned and operated.

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 they participate.

More information about QPP is available here: https://qpp.cms.gov/

Accountable Care Organizations (ACOs)

Primary care practices currently participating, or considering participation in Tracks 1, 1+, 2, or 3 of MSSP, that meet the eligibility requirements of CPC+, may participate in both initiatives. Practices participating in MSSP can participate in either track of CPC+. Practices within ACOs participating in the ACO Investment Model (AIM), Next Generation ACO Model, or other shared savings programs may not participate in CPC+.

Independence at Home (IAH)

The Independence at Home (IAH) demonstration targets homebound Medicare FFS beneficiaries with complex needs. Practices participating in the demonstration are eligible for shared savings. CPC+ will maintain a no-overlaps policy with IAH practices and beneficiaries will not be attributed to both programs.

Bundled Payments

There is potential for overlap with Model 2 and Model 3 of the Bundled Payments for Care Improvement (BPCI) Initiative, as well as with the Comprehensive Care for Joint Replacement Model, which involve a single payment for multiple services included in certain medical episodes in order to encourage efficiency. While unlikely, there is also potential for overlap with the Oncology Care Model, which will provide participating practices with the opportunity to receive a performance-based payment for qualifying episodes of care. Practices and patients will be permitted to participate in CPC+ while simultaneously participating in one of these models because these models do not use a shared savings payment arrangement.

Million Hearts: Cardiovascular Disease Risk Reduction Model

The Million Hearts Model targets high risk cardiovascular patients, including those treated in the primary care setting. In Million Hearts, providers are paid a PBPM to support efforts to reduce the cardiovascular risk of their attributed patients. CMS expects the Million Hearts and CPC interaction to be mutually beneficial; cardiovascular interventions can be a part of and complementary to practice transformation but are not duplicative of the work required and paid for in CPC. Therefore, beneficiaries can be attributed to both CPC and Million Hearts.

Accountable Health Communities (AHC)

Track 2 of CPC+ and Accountable Health Communities (AHC) model both include a focus on unmet health-related social needs. But, given the different payment types and model requirements of AHC and CPC+, practices may be in both CPC+ and paid by an AHC bridge organization (or be a bridge organization).

Transformation Clinical Practices initiative (TCPI)

Participation in a TCPI Practice Transformation Network or Support and Alignment Network is permitted for practices participating in CPC+; however, participation in the learning activities provided through the TCPI is not.

Physician Fee Schedule Codes

Practices are not allowed to bill codes related to chronic care management for CPC+-attributed beneficiaries under the Physician Fee Schedule (PFS) given these codes' similarity with the CPC+ Care Management Fee. The codes are outlined in the table below.

Codes	Short Description
99487, 99489	Chronic Care Management
G0506	Assessment/care planning for patients requiring CCM services
G0507	Care management services for behavioral health conditions
99358-99359	Prolonged non-face-to-face evaluation and management services

CPC+ practices may bill the Transitional Care Management codes (TCM)[2] and the Collaborative Care Model[3] codes for attributed beneficiaries.

Financial Alignment Initiatives

Because CMS defers to the more specific intervention when determining priority between two models, dually eligible Medicare-Medicaid beneficiaries will be precluded from eligibility in the CPC+ model if they are aligned with a Financial Alignment Initiative (FAI).

[2] Transitional Care Management (TCM) fee is outlined in the Federal Register – 77 Fed. Reg. 68891, 69380 (November 16, 2012) https://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf

[3] The Collaborative Care model is G0502-G0504 and is outlined in the Federal Register https://www.federalregister.gov/documents/2016/11/15/2016-26668/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#h-106

Appendices

Appendix A: Solicitation for Payer Partnership Process and Selection

Solicitation Information

This Solicitation for Payer Partnership requests that payers detail their proposed plan to partner with CMS in supporting practices in both Tracks of Comprehensive Primary Care Plus (CPC+) to start in January 2018. Track 1 targets practices poised to deliver the comprehensive primary care functions, detailed in Section IV of the CPC+ Request for Applications. Track 2 targets practices proficient in comprehensive primary care that are prepared to increase the depth, breadth, and scope of medical care delivered to their patients, particularly those with complex needs.

Multi-payer engagement is an essential component 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. Respondents to this solicitation may be 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 program, or other insurance purchasing), Medicaid/CHIP managed care plans, state or federal high risk pools, self-insured businesses or administrators of a self-insured group (Third Party Administrator (TPA)/Administrative Service Only (ASO)).

Payers are encouraged to partner in both Tracks of CPC+.

CMS expects to enter into Memoranda of Understanding with payers in up to 10 geographic regions in addition to new payers in the 14 existing CPC+ regions selected in Round 1. Memoranda of Understanding will outline the expectations of payers, to help ensure that the parameters of CPC+ are consistent within each region. All payers, including Medicare, will separately enter into agreements with the participating practices.

CMS will select regions where there is sufficient interest from multiple payers to support practices that participate in Tracks 1 and 2 of this model. This solicitation is directed to payers nationally. 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.

- A region including the counties in New York involved in the *Original CPC model* but not included in CPC+ Round 1will be included in CPC+, if sufficient payers indicate their interest in partnering in CPC+ and propose an aligned approach to Medicare. CMS will give preference to the eight states (or applicable regions within states) that have participated in the *Multi-Payer Advanced Primary Care Demonstration*: Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and

Vermont, where Medicaid is a participating payer, if sufficient payers respond to this solicitation and propose an aligned approach to Medicare.

- CMS will also give preference to states receiving State Innovation Models (SIM) Initiative Model Test Awards, where Medicaid is a participating payer, if sufficient payers indicate their interest in partnering in CPC+ and propose an aligned approach to Medicare.

Review Process

Responses to this solicitation will be reviewed by CMS staff to determine the degree to which they align with the Medicare approach in CPC+, as described below. Payers must respond with sufficient detail for CMS to evaluate and understand payers' proposed plan to partner in CPC+. CMS may also contact payer respondents and request modifications as part of its review.

CMS reserves the right to reject any payer to preserve the integrity of the Medicare program, the welfare of its beneficiaries, or the efficient and advantageous administration of CPC+. Without limitation, CMS may reject a proposal wherein:

2. The interested payer does not provide sufficient information to be reasonably considered;
3. The interested payer's proposal is inconsistent with the objectives of CPC+.

Payer and Region Selection

Outlined in full in Steps 1-6 below, 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 to engage in CPC+ will then be evaluated based on the degree to which they align with the Medicare approach. CMS may contact interested payers to explain or modify their proposals. Once regions have been selected and approved, payers will be invited to partner with CMS by signing a Memorandum of Understanding.

- **Step 1: Mapping Interested Payers into Overlapping Regions**

Using county as the descriptor, CMS will identify overlapping, contiguous geographic regions in which multiple payer respondents have proposed to partner.

- **Step 2: Regional Score**

CMS will assign each region a score, based on the market penetration of all interested payers.

CMS will employ the following approach to develop a Regional Score:

  - Step 2a: CMS will divide the number of lives covered by all interested payers in the region plus the number of Medicare fee-for-service (FFS) beneficiaries (numerator) by the total number of insured people living in the region, according to the best available Census data (denominator).

Market Penetration Rate =

$$\frac{\textit{Medicare FFS + Payer A + Payer B +…}}{\textit{All insured lives in region}}$$

- Step 2b: Each region will be assigned a score according to the penetration rate, as follows:

Penetration Rate	Regional Score
15-30%	1
30-39%	2
40-44%	3
45-49%	4
50-54%	5
55-59%	6
60-64%	7
65-69%	8
70-74%	9
75% or greater	10

Additional points will be included in the Regional Score Calculation (Step 2b) for State Medicaid partnership in CPC+.

- **Step 3: Assessment of Payers' Alignment with Medicare's Approach**

Next, CMS will evaluate and score proposals. CMS may only review proposals in regions that have earned a Regional Score of 5 or above (i.e., market penetration rate of 50% or above). During this step, CMS may contact interested payers to clarify items in their proposals.

Scoring will be based on the extent which to the framework for partnership is met, as well as the degree to which payers' proposed activities align with the CMS approach. Scores will not be released to payers.

- **Step 4: Weighting of Payers' Scores with Number of Covered Lives**

Each payer's proposal score (Step 3) will be weighted by the number of covered lives they propose to include in the region(s) to create a "Weighted Payer Score".

Weighted Payer Score =

$$\frac{\textit{No. of interested payer's covered lives in region}}{\textit{Total covered lives among all interested payers in region}} * \textit{Proposal Score (Step 3)}$$

(including Medicare FFS beneficiaries)

- **Step 5: Summing Regional Score and Weighted Payer Score**

CMS will sum the Regional Score (Step 2b) and Weighted Payer Score (Step 4) and use the final score to make a determination of regional participation in CPC+.

- **Step 6: Regional Selection**

CMS will use the final score (Step 5) to inform the recommendation of regions to include in CPC+. CMS plans to include up to 10 new CPC+ regions and aims to ensure geographic diversity.

Recommendations must be approved by the CMS Administrator \. Once regions have been approved for selection, payers within those regions will be invited to partner in CPC+.

Commitment to Ensuring Competitive Markets

Competition in the marketplace promotes quality of care for Medicare beneficiaries and protects access to a variety of practitioners. Thus, all conversations among payers and primary care practices must comply with antitrust law. Nothing in this solicitation shall be deemed to suspend any applicable antitrust laws or regulations, all of which still apply. In CPC+, CMS aims to maintain a competitive environment while providing an opportunity for payer partnership.

Partnership with State Medicaid Agencies

CMS recognizes the importance of states' partnership in multi-payer initiatives and aims to provide support to states consistent with its mission to serve Medicare and Medicaid populations. CMS invites state Medicaid agencies to partner in CPC+. However, unlike the Original CPC Model, in CPC+, CMS will not provide support through a per-beneficiary-per-month (PBPM) care management fee for Medicaid FFS beneficiaries utilizing or attributed to participating practices. Furthermore, CMS will not provide an upfront percentage of revenue in the form of a risk adjusted "comprehensive primary care payment" for Medicaid FFS beneficiaries. CMS would expect states to engage in similar activities as other interested payers as part of their partnership in this model. States will need to fund the non-federal share of Medicaid payments and may be required to submit necessary proposals through State plans and/or waivers to participate in the model.

Solicitation Questions

Please note: this section includes the content of the forthcoming online CPC+ Round 2 Solicitation for Payer Partnership. Wording is subject to change.

To begin a Comprehensive Primary Care Plus (CPC+) Payer Proposal or to continue an existing Payer Proposal, select the correct links below. For more information about CPC+, please visit https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Payer respondents may submit one single proposal for multiple regions. In other words, payers may complete one proposal to partner with CMS in three separate regions, so long as there are no significant differences in approach across these geographic regions. For the purposes of this solicitation, regions are defined as overlapping, contiguous geographic locales. A region may encompass multiple areas within a state, an entire state, or may extend across states; the definition will largely depend on the proposals we receive and where payer interest lies. As an example, a current CPC+ region is "Ohio and Northern Kentucky", which encompasses all counties in Ohio and four counties in northern Kentucky.

Existing CPC+ Round 1 payer partners only need to submit a proposal if it would result in changes to the terms of their existing MOU(s). If existing payer partners choose to add regions or new lines of business in their existing region(s) with the same terms as their current CPC+ MOU, they can email CPCPlus@cms.hhs.gov and indicate which regions and/or lines of business they would like to include.

Please highlight any features of the proposal that vary by line of business throughout the proposal. We expect the Lines of Business section of the solicitation will capture most variance between the proposed Lines of Business. Please submit separate proposals for regions where there are significant differences in the proposed approach (e.g., differing enhanced, non-fee-for-service supports).

CPC+ Solicitation

This Solicitation for Payer Partnership requests that payers detail their proposed plan to partner with CMS in supporting practices in both Track 1 and Track 2 of CPC+ Round 2, which will start on January 1, 2018. Payers must offer support to practices in both tracks of CPC+. Payers must also align their care delivery expectations of CPC+ practices with the CPC+ care delivery approach.

Multi-payer engagement is an essential component of CPC, as it makes full practice-level transformation of care delivery possible.CMS is excited to partner with payers who share Medicare's interest in strengthening primary care. Respondents to this solicitation may be 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 program, or other insurance purchasing), Medicaid/CHIP managed care plans, state or federal high risk pools, self-insured businesses or administrators of a self-insured group (via Third Party Administrators or Administrative Service Only arrangements).

CMS is partnering with 54 payers in 14 regions for CPC+ Round 1. CMS expects to enter into Memoranda of Understanding with new payer partners in the existing Round 1 regions in addition to new payer partners in up to 10 new geographic regions. CMS will select regions where there is sufficient interest from multiple payers to support practices that participate in Tracks 1 and 2 of this model. This solicitation is directed to payers within the United States.

For technical issues, please contact Help Desk support at CMMIForcesupport@cms.hhs.gov **or call 1-888-724-6433, option 5. For all other inquiries, please contact CPCPlus@cms.hhs.gov.**

Description of Payer

Required fields *

* Legal Entity Name
* DBA Name
* Year Established
* Corporate Address, City, State

Website

Indicate in the below fields the points of contact for the CPC+ solicitation process (Solicitation POC) and for communicating with CMS after payer selection (Payer POC), respectively.

* Solicitation Point of Contact (POC) Name
* Solicitation POC Title
* Solicitation POC Address
* Solicitation POC City
* Solicitation POC State
* Solicitation POC Phone
* Solicitation POC Email

Solicitation POC Fax

* Payer POC Name
* Payer POC Title
* Payer POC Address
* Payer POC City
* Payer POC State
* Payer POC Phone
* Payer POC Email

Payer POC Fax

Indicate if Solicitation and Payer POC information is the same

Summary of Intent and Past Experience

1. *As a payer partner in CPC+, you will be expected to:

    - Provide enhanced, non-fee-for-service support to both Track 1 and 2 practices to allow practices to meet the aims of the care delivery model and provide care management, care coordination, and similar "wraparound" services to all patients, agnostic of payer.
    - Provide Track 1 and 2 practices with performance-based incentive payments, based on a combination of utilization, cost of care, and/or quality metrics.
    - Reimburse Track 2 practices using a payment format that is at least a partial alternative to traditional fee-for-service (FFS) payment by the end of 2018.
    - Share data with practices on cost, utilization, and quality at regular intervals (e.g., quarterly)
    - Employ for CPC+ practices a care delivery design consistent with the CPC+ approach.

    Check this box to acknowledge payer partner expectations and to commit to providing the above resources.

2. ***Please provide a summary of your intent to partner with CMS in CPC+.** Your summary should address why you would like to be a payer partner in CPC+.

3. **Please describe any past or current involvement with multi-payer or multi-stakeholder collaborations, noting if this is in the proposed region(s). In your answer, please indicate how you were/are involved in the initiatives (e.g., health information exchange, technical assistance, practice coaching).**

4. **Please briefly describe any primary care models you are currently testing in the proposed region(s), and your involvement in any other local, state, or national initiatives to improve or transform primary care payment and care delivery.**

5. ***Were you a Payer Partner in the Comprehensive Primary Care (CPC) Model?** Yes/No

6. ***Were you a Payer Partner in the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration?**
   Yes/No

7. *** Were you a Payer Partner in a State Innovation Model (SIM) Test Awards State with Medicaid Participation?**
   Yes/No

Lines of Business

8. ***Please describe the lines of business and network reach in each region where you are proposing to partner:**
   - State
   - Proposed line(s) of business
   - Total number of covered lives
   - NAIC number
   - Proposed payment model description
     - Amount of enhanced non-FFS payment (i.e., Care Management Fee)
       - Is your non-FFS payment risk-stratified? (If yes, provide minimum and maximum amounts.)
     - Performance-Based Incentive Payment
       - Type: bonus payment, episode payment, shared savings, other
       - Amount (percentage or dollar amount)
     - Track 2 Only: Alternative to Fee-for-Service Payment
       - Are you committed to pursuing an alternative to FFS by 2019? (Yes/No)
       - List methods you are considering for this payment: partial capitation without downside risk, full capitation without downside risk, sub-capitation without downside risk, and episodic payment , Medicare FFS Hybrid Payment, other

9. ***Please describe how you arrived at the amount of the proposed Care Management Fees (CMF). Include any calculation or cost build up you used to ensure that the proposed care management fee is adequate to support participating practices in each track of this model and for each line of business.**

10. **Please summarize the lines of business you offer but are not including in CPC+:**

State (Drop down list) Proposing to partner in part of state or entire state? (conditional, check box offered for each state)	Proposed LOBs (dropdown, options: Commercial Insurance Plan, Health insurance Marketplace Plan, Medicare Advantage, Medicaid/CHIP Managed Plan, State/Federal High Risk Pool, Third Party Administration (TPA)/ Administrative Services Only (ASO), Medicaid/CHIP FFS **(For State Partners only)** Other)	Total Number of Covered Lives
Response	**Response**	**Response**

11. ***Please provide the minimum number of your members that must be attributed to a participating practice in order for you to support that practice in this model.** Please note if, and to what extent, the minimum number of members per practice changes by line of business and region.

12. ***Using counties as the descriptor, please specify the total number of member lives in each county in which you are interested in partnering in CPC+. Use the Excel spreadsheet entitled 'Addendum to CPC+ Solicitation for Payer Partnership: Covered Lives by County and Line of Business' (**https://innovation.cms.gov/Files/x/cpcplus-payeraddendum.xls**).**

    Please include all proposed CPC+ regions in a single spreadsheet. For example, if you are a payer submitting multiple PDF proposals for distinct regions, please input all regions and covered lives by county and line of business into one Excel spreadsheet.

Payment Models

13. ***Will you base your proposed performance-based incentive payments on any of the following metrics:** Clinical quality, Utilization, Total cost of care, Other

14. ***Please describe your proposed performance-based incentive arrangement with Track 1 and 2 practices**.
    Please include the following information in your answer, as applicable:
    - Calculation
    - Frequency
    - Expected Amount
    - Timing of Payment

- Cost of Care Calculation
- Impact of Quality
- Utilization Measures
- Aggregation Methodology, if any

15. *** Please describe your proposed alternative payment scheme for Track 2 practices in lieu of a FFS payment.**
    Your answer should include the following information:
    - Timeline for Instituting Alternative Payment Arrangement
    - Rationale for Approach
    - Method for Calculating Amount of Alternative Payment

For Payers with Self-Insured Clients:
In order to support the enhanced delivery of primary care in the United States, it is also important for self-insured purchasers to adopt the principles of comprehensive primary care.

16. **In addition to your fully insured business, do you currently provide Administrative Services Only (ASO) arrangements to purchasers?** (Yes/No).
17. **What proportion of the lines of business included in this proposal are ASO arrangements**?
18. **Do you currently provide any alternative payment arrangements (such as payments to providers for enhanced primary care, care coordination or patient centered medical home services, or other non-FFS arrangements) on behalf of your ASO clients?** (Yes/No).

Attribution and Data Sharing with Primary Care Practices

19. ***Please describe your proposed approach to identify members served by participating practices in the proposed region(s)**:
    - Timing of Attribution (options: retrospective or prospective)
    - Attribution Frequency (options: monthly, quarterly, annually, other)
    - Attribution Approach

20. ***Please describe your current strategy for sharing data with primary care practices in your proposed region(s):**
    - The level of data shared (Select all that apply)
        - Individual
        - Aggregate (across the practice)

    - Other (textbox)
- Reporting frequency (Select one)
    - Monthly
    - Quarterly
    - Annually
    - Other
- Data on the following:
    - Cost data
    - Utilization data
    - Real-time hospital and ER data

21. *Please describe your proposed strategy for sharing data with your primary care practices in your proposed region(s) and please include the following information:

- The level of data shared (Select all that apply)
    - Individual
    - Aggregate (across the practice)
    - Other
- Reporting frequency (Select one)
    - Monthly
    - Quarterly
    - Annually
    - Other
- Data on the following:
    - Cost data,
    - Utilization data,
    - Real-time hospital and ER data

22. If applicable, please describe your current or planned involvement with local/regional multi-payer databases, direct claims line feeds, or Health Information Exchanges in your proposed region(s).

23. If applicable, please describe any current or planned data analytics tools or platform which you provide for practices to analyze and use the data that you provide.

Quality and Patient Experience Measures

24. *What types of quality measures do you plan to collect from CPC+ practices? (select all that apply)

- Claims related quality measures (such as HEDIS)
- Clinical Quality Measures
- Patient experience measures (such as CAHPS)
- Patient reported quality measures
- Structural quality measures
- Quality measures unique to your organization
- Quality measures required by your state
- Other (with text field, 50 characters max.)

25. Please describe any quality measure alignment you have created with other payers.

26. Please review the list of CPC+ Quality Measures. Based on this list below, can the CMS measures replace any of your existing quality measures? If not, which other quality metrics are relevant to your populations?

CMS ID#	NQF#	MEASURE TITLE	MEASURE TYPE/DATA SOURCE	DOMAIN NAME
CMS159v5	0710	Depression Remission at Twelve Months	Outcome/eCQM	Clinical Process/Effectiveness
CMS165v5	0018	Controlling High Blood Pressure	Outcome/eCQM	Clinical Process/Effectiveness
CMS122v5	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	Outcome/eCQM	Population/Public Health
CMS156v5	0022	Use of High-Risk	Process/eCQM	Patient Safety

CMS ID#	NQF#	MEASURE TITLE	MEASURE TYPE/DATA SOURCE	DOMAIN NAME
		Medications in the Elderly		
CMS149v5	N/A	Dementia: Cognitive Assessment	Process/eCQM	Clinical Process/Effectiveness
CMS139v5	0101	Falls: Screening for Future Fall Risk	Process/eCQM	Patient Safety
CMS137v5	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process/eCQM	Clinical Process/Effectiveness
CMS50v5	N/A	Closing the Referral Loop: Receipt of Specialist Report	Process/eCQM	Care Coordination
CMS124v5	0032	Cervical Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
CMS130v5	0034	Colorectal Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
CMS131v5	0055	Diabetes: Eye Exam	Process/eCQM	Clinical Process/Effectiveness
CMS138v5	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/eCQM	Population/Public Health
CMS166v6	0052	Use of Imaging Studies for Low Back Pain	Process/eCQM	Efficient Use of Healthcare Resources

CMS ID#	NQF#	MEASURE TITLE	MEASURE TYPE/DATA SOURCE	DOMAIN NAME
CMS125v5	2372	Breast Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
N/A	0005	Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Outcome/Patient Survey	N/A
N/A	N/A	Patient Reported Outcome Measures (TBD)	Outcome/Patient Survey	N/A

Measures in this table were captured from the reporting requirements of CPC+ eCQMs for the PY2017 and the CAHPS.

27. ***If CPC+ practices shared CPC+ electronic clinical quality measure (eCQM) data with payers, would your organization be able to use these data to analyze practice quality performance?** (Yes/No)

    a. If you selected "no," please explain why.
    b. If you selected "yes," would the CPC+ eCQM data preclude the need for participating CPC+ practices to report or measure other quality data on your members attributed to CPC+ practices? (Yes/No)
        i. If you selected "no," please explain why.

28. ***Are you currently administering patient experience surveys to assess the quality performance of primary care practices?** (Yes/No)

    - If you selected "yes", are you willing to use CAHPS as your sole measure of patient experience for practices participating in CPC+? (Yes/No)
    - If you selected "no," please explain why.

Appendix B: Practice Application Guidance and Questions

Please note: this section includes the content of the Round 1 Practice Application. In early 2017, CMS will release a revised version of this application for Round 2.

Comprehensive Primary Care Plus (CPC+) is accepting applications from individual primary care practice sites that are geographically located in a selected market. Practices interested in applying to CPC+ Round 2 should review the Request for Applications to learn about the design and requirements of the model, and to determine which track of the model is best suited for the practice.

Track 1 of CPC+ targets practices poised to deliver the five primary care functions, detailed in Care Delivery Design Section of the CPC+ Request for Applications. Track 2 of CPC+ targets practices proficient in comprehensive primary care that are prepared to increase the depth, breadth, and scope of medical care delivered to their patients, particularly those with complex needs.

Practices applying to Track 2 of CPC+ must answer all questions. Practices applying to Track 1 of CPC+ must answer all questions, other than those indicated as "Track 2 only." CMS reserves the right to seek additional information from applicants to CPC+ after the application period closes.

Questions about the Application for CPC+ should be directed to CPCPlus@cms.hhs.gov. CMS may publicly share questions or responses or compile them into a Frequently Asked Questions compendium to ensure that all interested payers have access to information regarding CPC+.

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp.

Preliminary Questions

1. In which CPC+ region is your practice located?

2. For which Track is your practice applying?

    a. Track 1
    b. Track 2

3. If you are a Track 2 applicant but are not eligible for Track 2, would you like your application considered for Track 1?

a. Yes
b. No

4. Will your practice be a concierge practice, a Rural Health Clinic, or a Federally Qualified Health Clinic as of January 1, 2017?

    a. Yes
    b. No

5. Will your practice be participating in any of the Medicare initiatives below as of January 1, 2017? Please select all that apply. For more information about program overlap policies, please see the Frequently Asked Questions document located here.

    a. Transformation Clinical Practice Initiative (TCPi) – participation in learning activities
    b. Transformation Clinical Practice Initiative (TCPi) – participation as part of a PTN or SAN
    c. Next Generation ACO Model
    d. Another Medicare ACO program (please specify)
    e. Accountable Health Communities
    f. None of the above

    5a. If you are accepted to participate in CPC+ and you intend to withdraw from a program that has a no-overlaps policy with CPC+, please list the program and planned withdrawal date below:

Program: _____ Planned withdrawal date: _____

6. Will your practice be participating in, or is your practice part of an ACO currently applying to participate in, the Medicare Shared Savings Program (MSSP), as of January 1, 2017?

    a. Yes, my practice is part of an ACO that is participating in MSSP currently and will continue participation in 2017.
        i. ACO name
        ii. Taxpayer Identification Number (TIN)
    b. Yes, my practice is part of an ACO that is currently applying to participate in MSSP starting January 1, 2017.
        i. ACO Name

ii. TIN

c. No

General Questions

This section focuses on background information about your practice. Information in this section will be used to determine whether your practice meets the baseline eligibility criteria for participation in CPC+. If a practice is accepted to participate in CPC+ and CMS later learns that answers to the questions in this section have changed or were not or are no longer accurate, CMS reserves the right to terminate the practice's participation in the model immediately.

For purposes of this application, a practice site is defined 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 purely as a geographic extension of a single practice site; the satellite shares management, resources, EHR, practitioners, and attributed beneficiaries with the main practice location. Practices that are part of the same medical group or health system, even if they share some practitioners or staff, are generally not considered satellites of one practice site.

Where applicable, please answer these questions for the practice site that is applying to participate in CPC+ (rather than the parent organization, group, or health system).

Practice Structure and Ownership

This section asks questions about the organizational structure and ownership of your practice. If you have a question about practice structure that is not addressed in the Request for Applications (RFA) or in the Application Instructions, please contact CMS at CPCPlus@cms.hhs.gov.

7. Practice identification:
    a. Practice Site Name:
    b. Practice "doing business as" (DBA) Name:
    c. Street Address 1:
    d. Street Address 2:
    e. City:
    f. State:
    g. 9-digit ZIP Code:
    h. Practice Site Phone Number:
    i. Practice Site Fax Number:
    j. Website (if applicable):
    k. Does your practice have satellite offices?
        i. Yes
        ii. No

iii. Unknown

8. Is your practice owned by a larger health care organization, such as a group practice or health system?

    i. Yes
    ii. No
        1. If Yes:
            a. What is the name of the organization?
            b. Corporate Street Address 1:
            c. Corporate Street Address 2:
            d. Corporate County
            e. Corporate State
            f. Corporate 9-digit Zip Code
            g. Corporate Phone Number
            h. How many other primary care practice sites are part of this organization?
            i. How many physicians are part of this organization?
            j. How many Medicare Eligible Professionals (EPs) are part of this organization?
            k. Are other primary care practices in this organization applying to participate in CPC+?
                i. Yes (Please identify them by Practice Name and TIN:
                ii. No
                iii. Unknown
            l. Do all practice sites that are part of this organization share one Electronic Health Record system?
                i. Yes
                ii. No
                iii. Unknown
            m. Does your practice share a TIN for billing with other practices that are part of the same health group or system?
                i. Yes
                ii. No
                iii. Unknown
        2. If no
            a. Who owns this your practice? SELECT ALL THAT APPLY
                i. Physicians in the practice

ii. Non-physician practitioners (nurse practitioners or physician assistants) in the practice
iii. Other (Specify)

9. Does your practice use more than one billing TIN?

    a. Yes
    b. No
    c. Unknown

10. Please list all TINs your practice has used to bill Medicare since January 1, 2014 :

11. What billing TIN will your practice use to bill primary care services in your practice?

Model Participation

This section asks questions about the practice's proposed participation in CPC+ and about the practice's current or previous participation in other CMS programs. Please see specific question instructions for more information about participation in other CMS programs.

12. Has your practice participated in the Comprehensive Primary Care (CPC) initiative?
    a. Yes
    b. No
    c. Unknown

    If yes, what was your eight-digit practice ID number (two letter region code + six digit number - example: XX000666)?

    Termination or withdrawal date (if applicable):

13. Has your practice participated in the Multi-Payer Advanced Primary Care Practice Demonstration?
    a. Yes
    b. No
    c. Unknown

    If yes, what was your practice ID number? _____

14. Applicant Contact (*This should be the person filling out the application*)
    a. First Name:
    b. Last Name:
    c. Title/Position:

d. Does this person work in the practice?
    i. Yes
    ii. No
e. Relationship with the practice:
f. Business Phone Number:
g. Business Phone Number Extension:
h. Alternative Phone Number (e.g. cell phone):
i. E-mail Address:
j. Street Address 1:
k. Street Address 2:
l. City:
m. State:
n. ZIP Code:
o. Primary Point of Contact for the practice?
p. This application requires a letter of support from a clinical leader in your practice. Please enter the name of the clinical leader that will sign this letter. More information about the letter can be found on the "Letter of Support" tab.

15. Practice Contact (if applicable)

Please provide the name of a contact who works in the practice

a. First Name:
b. Last Name:
c. Title/Position:
d. Business Phone Number:
e. Business Phone Number Extension:
f. Alternative Phone Number (e.g. cell phone):
g. E-mail Address:
h. Street Address 1:
i. Street Address 2:
j. City:
k. State:
l. ZIP Code:

16. Health Information Technology Contact

_____ *This is the same person as listed in question #14*
_____ *This is the same person as listed in question #15*
_____*Other*

a. First Name:
b. Last Name:

c. Title/Position:
d. Business Phone Number:
e. Business Phone Number Extension:
f. Alternative Phone Number (e.g. cell phone):
g. E-mail Address:
h. Street Address 1:
i. Street Address 2:
j. City:
k. State:
l. ZIP Code:

Practitioner and Staff Information

This section asks questions about the practitioners in your practice. Unless otherwise indicated, please answer only for the primary care practitioners that will be participating in CPC+.

17. To the best of your knowledge, has your practice or anyone employed in your practice had a final adverse legal action (as defined on page 12 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i) or been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of the Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose could be grounds for application denial or immediate termination from the initiative.
    a. Yes
    b. No

    If yes, please explain the legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any.

18. What is the total number of individual physicians (MD or DO), nurse practitioners (NPs), physician assistants (PAs), and Clinical Nurse Specialists (CNSs) who provide patient care at your practice and practice under their own National Provider ID (NPI)? Please include all full-time and part-time practitioner staff, regardless of their practice specialty.

    a. Fill in number of Physicians
    b. Fill in number of NPs
    c. Fill in number of PAs
    d. Fill in number of CNSs

19. For purposes of CPC+, a primary care practitioner is defined as a physician (MD or DO),

nurse practitioner (NP), physician assistant (PA), or Clinical Nurse Specialist (CNS) who has a primary specialty designation of family medicine, internal medicine, or geriatric medicine. Of the total individual practitioners who provide patient care at your practice site, how many are primary care practitioners? Please include full-time and part-time physician staff.

a. Fill in number of Physicians
b. Fill in number of NPs
c. Fill in number of PAs
d. Fill in number of CNSs

20. Do any of the primary care practitioners who practice at your site also practice at other locations?
    a. Yes
    b. No

    Explanation:

21. For each primary care practitioner in your practice that would participate in CPC+, please provide the following information.
        i. Practitioner Name (Last, First, MI)
        ii. National Practitioner ID (NPI)
        iii. Practitioner Type:
            i. Physician (MD or DO)
            ii. Clinical Nurse Specialist or Nurse Practitioner
            iii. Physician Assistant
        iv. Primary Specialty
            i. Family Medicine
            ii. Internal/Adult Medicine
            iii. Geriatric Medicine
            iv. General Practice
            v. N/A
        v. Is this practitioner board certified in this specialty?
            i. Yes
            ii. No
            iii. Unknown
            iv. N/A
        vi. If applicable, is the practitioner current with maintenance of certification?
            i. Yes
            ii. No
            iii. Unknown

iv. N/A

vii. This practitioner works at the practice (or satellite office):

i. Part time

ii. Full time

If part time, how many hours per week does this practitioner work at the practice site?

viii. Does this practitioner also practice at another practice location (besides a satellite office)?

i. Yes

ii. No

ix. If yes, is the practitioner's billing TIN the same at all practices?

x. Is the other site applying to participate in CPC+?

a. Yes

b. No

Name of site:

22. Please describe current Meaningful Use attestation progress among the primary care practitioners in your practice who are Eligible Professionals (EPs) under the EHR Incentive Program(s).
    a. Total number of Medicare EPs:
    b. For the 2016 reporting year, total number of Medicare EPs who plan to attest to Meaningful Use Stage 2:
    c. Total number of Medicaid-only EPs:
    d. For the 2016 reporting year, total number of Medicaid EPs who plan to attest to Meaningful Use Stage 2:

Practice Activities

This section asks about the various activities that occur at your practice, including types of care provided, teaching and training, and certifications that your practice may have.

23. Which statement best characterizes your practice (*select mark all that apply*):
    a. The practice is a single-specialty primary care practice.
    b. The practice is a primary care practice with other integrated practitioners, or is a multi-specialty practice.
    c. The practice participates in other lines of business besides primary care, such as urgent care on weekends and/or physical exams for an insurance company.

    If the above answer is b:

    - Do the primary care practitioners in your practice share an EHR with other types of practitioners in the practice?
      - Yes

- No
- Unknown

If the above answer is c:

- Please describe the other lines of business in which your practice participates:

24. Is your practice engaged in training future primary care practitioners and staff?
    a. Yes
    b. No
    c. Unknown

    Please briefly describe the engagement (e.g., family medicine residency clinic, occasional rotating NP students)

25. Please select all organizations through which your practice has achieved Medical Home recognition:
    a. National Committee for Quality Assurance (NCQA-PCMH)
    b. The Joint Commission (TJC), previously known as Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
    c. Accreditation Association for Ambulatory Healthcare (AAAHC-Triple A)
    d. Utilization Review Accreditation Commission (URAC)
        - Specify recognition level received _____
    e. State-based Recognition Program
        a. Specify State and Program_____
        b. Specify recognition level received _____
    f. Insurance Plan-based Recognition Program
    g. Other (Specify):
    h. My practice does not have recognition as a “medical home.”

Health Information Technology

This section asks questions about the Health Information Technology (health IT) capabilities of your practice. You may need input from your health IT vendor to complete the questions in this section. The health IT requirements for each Track are available here.

26. Is your practice able to complete health IT Requirements indicated for the track to which your practice is applying that are listed in the table titled “Certified Health IT Requirements” in the RFA if the practice is accepted to participate in the model?

- Yes
- No

27. Please provide the following information regarding the primary certified EHR system used by your practice site, as well as any additional health IT tools that your practice uses:

Vendor Name	Product Name	Version	Function (if applicable)	Primary

28. What is your CMS EHR Certification ID?

29. Does your practice currently have plans to purchase a new EHR in 2017 or a subsequent year?
    a. Yes
    b. No
    c. Unknown

Patient Demographics

This section asks questions about the demographic makeup of your patient population. Please answer these questions to the best of your ability.

30. Percentage of patients of Hispanic, Latino, or Spanish origin (*including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, Argentinian, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, etc.)* _____%
31. Percentage of patients by race:
    a. Alaska Native or Native American (*for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.*) _____%
    b. Asian *(for example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, Hmong, Laotian, Thai, Pakistani, Cambodian, etc.)* _____%
    c. Black or African American (*for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somalian, etc.)* _____%
    d. Native Hawaiian or other Pacific Islander (*for example, Samoan, Guamanian or Chamorro, Tongan, Fijian, Marshallese, etc.*) _____%
    e. White _____%
    f. Other race: _____ _____%

g. Unknown _____%
h. Is this based on collected data or best estimate?
    - Collected
    - Best Estimate

32. Percentage of patients by preferred language:
    a. English ____%
    b. Non-English ____%
       If non-English, what is the most common non-English language spoken among your patient population? _____
    c. Is this based on collected data or best estimate?
        i. Collected
        ii. Best Estimate

Practice Revenue and Budget

As described in the RFA, eligibility for CPC+ is based on a number of factors, one of which is the proportion of practice revenue generated by payers participating in CPC+. Practices that have a majority of their current revenue generated from payers that are participating in CPC+ (including Medicare) will be better positioned to implement the service delivery model and meet the practice milestones.

To the best of your ability, please list all revenue (insurance and copays) generated by services provided to patients covered by the following payers in the 2015. Exclude any bonus payments. Please use your billing system or billing vendor to generate this information.

33. Total revenue for 2015 from all lines of business: _____

34. Total revenue for 2015 by type listed payer:

Insurance Type	Business Type*	2015 Annual Revenue ($)
Medicare Fee-For-Service (not managed care)		
Medicaid/CHIP Fee-For-Service (not managed care)		
Payer 1		

Insurance Type	Business Type*	2015 Annual Revenue ($)
Payer 2		
Payer 3		
TRICARE		

35. Percentage of patients by insurance type:
    1. Commercial or private __%
    2. Medicare __%
    3. Medicaid __%
    4. Uninsured __%
    5. Other __%
    6. Is this based on collected data or best estimate?
        i. Collected
        ii. Best Estimate

Care Delivery

The following questions gather information about your practice site's delivery of primary care. Please answer the following questions based on the current activities at your practice site.

Care Management

36. Patients
    a. …are not assigned to specific practitioner panels.
    b. …are assigned to specific practitioner panels but panel assignments are not routinely used by the practice for administrative or other purposes.
    c. …are assigned to specific practitioner panels and panel assignments are routinely used by the practice mainly for scheduling purposes.
    d. …are assigned to specific practitioner panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.

37. Non-physician practice team members
    a. …play a limited role in providing clinical care.
    b. …are primarily tasked with managing patient flow and triage.
    c. …provide some clinical services such as assessment or self-management support.

d. …perform key clinical service roles that match their abilities and credentials.

38. Care plans
    a. …are not routinely developed or recorded.
    b. …are developed and recorded but reflect practitioners' priorities only.
    c. …are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care.
    d. …are developed collaboratively, include self-management and clinical management goals, are routinely recorded, and guide care at every subsequent point of service.

39. A standard method or tool(s) to stratify patients by risk level
    a. …is not available.
    b. …is available but not consistently used to stratify all patients.
    c. …is available and is consistently used to stratify all patients but is inconsistently integrated into all aspects of care delivery.
    d. …is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.

40. Follow-up by the primary care practice with patients seen in the Emergency Department (ED) or hospital
    a. ...generally does not occur.
    b. …occurs only if the ED or hospital alerts the primary care practice.
    c. …occurs because the primary care practice makes proactive efforts to identify patients.
    d. …is done routinely because the primary care practice has arrangements in place with the ED and hospital to both track these patients and ensure that follow-up is completed within a few days.

41. Linking patients to supportive community-based resources
    a. …is not done systematically.
    b. …is limited to providing patients a list of identified community resources in an accessible format.
    c. …is accomplished through a designated staff person or resource responsible for connecting patients with community resources.
    d. …is accomplished through active coordination between the health system, community service agencies, and patients and accomplished by a

designated staff person.

Access

42. Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP, or nurse

    a. ...is not available or limited to an answering machine.
    b. …is available from a coverage arrangement (e.g., answering service) that does not offer a standardized communication protocol back to the practice for urgent problems.
    c. …is provided by a coverage arrangement (e.g., answering service) that shares necessary patient data with and provides a summary to the practice.
    d. …is available via the patient's choice of email or phone directly with the practice team or a practitioner who has real-time access to the patient's electronic medical record.

Quality Improvement

43. Quality improvement activities

    a. …are not organized or supported consistently.
    b. …are conducted on an ad hoc basis in reaction to specific problems.
    c. …are based on a proven improvement strategy in reaction to specific problems.
    d. …are based on a proven improvement strategy and used continuously in meeting organizational goals.

44. Staff, resources, and time for quality improvement activities

    - …are not readily available in the practice.
    - …are occasionally available but are limited in scope (due to some deficiencies in staff, resources, or time).
    - …are generally available and usually at the level needed.
    - …are all fully available in the practice.

Letters of Support

Practices will need to submit several letters of support with their application:

1. Letter of support from clinical leadership:

    Skilled leaders with high levels of emotional engagement and intellectual commitment are essential for successful cultural changes that drive improvements toward better care, smarter spending, and healthier people. In addition to answering all questions in the application and providing any required supporting documentation, all practices applying to participate in the CPC+ must attach a letter of support from at least one physician, nurse practitioner, or physician assistant leader in the practice. This letter shall describe

how the clinician intends to engage with the care team(s) to provide ongoing leadership in support of CPC+. The letter shall also define the planned time commitment and briefly describe ongoing strategies to share and address results, challenges, progress, and successes with practice staff and the patient community. This letter shall be no more than one page.

2. Letter of support from parent of owner organization:

   If your practice is owned by a person, entity, or organization OTHER than a clinical or other leader that works in the practice site, your practice must attach a letter of support from the parent/owner committing to segregate funds that are paid in conjunction with CPC+, and assuring that all funds flowing through this initiative will be used for infrastructure and/or salaries in the participating practice. The letter of support must also demonstrate a commitment to compensate the practitioners and staff in practices participating in Track 2 of CPC+ in a manner that rewards quality of care, not just patient visit volume, and is consistent with the Comprehensive Primary Care Payment (CPCP).

3. Letter of support from health IT vendor – ***Track 2 only***:

   In order to be considered for participation, Track 2 applicants must provide a "Letter of Support" from their health IT vendor that indicates that the vendor (a) has reviewed the information contained in this document and (b) is willing to support the practice to meet the health IT requirements for Track 2 either by optimizing the practice's Electronic Health Records (EHR) or providing the practice with other health IT solutions. The letter of support should be signed and dated by an authorized official of the vendor organization. The letter of support should include a signature from each health IT vendor whose product is used in the practice.

Application Checklist

Below is a checklist detailing the documents that your practice is required to submit for consideration in CPC+. Not all documents are required from all applicants; some documents are specific to the Track for which an applicant is applying, and some are required only from practices with specific ownership organization. It is the responsibility of the applicant to ensure that you include all documents that are required for your specific circumstances. All documents must be signed, scanned, and uploaded to the application portal at [LINK]. Please retain the original, signed letters. If you have any questions about what your practice is required to submit, please contact CMS at [EMAIL].

a. Completed Application
b. Letter of support from your practice's clinical leader (instructions)
c. Letter of commitment regarding funding (question 4)
d. Letter of support from Health Information Technology vendor (Track 2 applicants only; RFA)

Appendix C: Supplemental Information for Practices and Vendors Regarding Health IT Requirements

Health IT requirements for CPC+ are divided into three areas:

1. **Certified Health IT Requirements for both Tracks.** Practices in both tracks will be required to demonstrate adoption of certified health IT. While these requirements largely align with the requirements of the Medicare EHR Incentive Program, several requirements are specific to the timing/requirements of the CPC program.
2. **Requirements for reporting eCQMs for both Tracks.** Practices in both tracks will use electronic clinical quality measures (eCQMs) for reporting performance results to CMS.
3. **Optimized EHR/Health IT for Track 2.** Track 2 practices will work with vendors to support the development and optimization of a set of advanced health IT functions.

Certified Health IT Requirements (Revised January 2017)

The following are the certified health IT requirements for the CPC+ Track 1 and 2 practice sites.

REQUIREMENT	DATE	NOTES
OVERALL CERTIFIED HEALTH IT ADOPTION REQUIREMENT		
Adopt, at a minimum, the certified health IT needed to meet the certified EHR technology (CEHRT) definition required by the Medicare EHR Incentive program at 42 CFR 495.4.	Practices must adopt the health IT meeting this requirement. All practices must upgrade to 2015 Edition technology by January 1, 2018.	Practices should adopt the certified health IT modules which meet the definition of CEHRT according to the timeline and requirements finalized for use in CMS programs supporting certified EHR use (e.g. EHR Incentive Programs, Quality Payment Program).
CERTIFIED HEALTH IT REQUIREMENTS FOR REPORTING		
Adopt health IT meeting 2015 Edition certification criteria found at 45 CFR 170.315(c)(1) - (3), using the 2017 annual update, for all of the electronic clinical quality measures in the CPC+ measure set.	By January 1, 2018	For the 2018 performance period, practices must use the latest eCQM specifications contained in the 2017 annual update, released in April 2017 (https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html).
Adopt health IT meeting the 2015 Edition eCQM certification criterion at 45 CFR 170.315(c)(4).	By January 1, 2018	--
TRACK 2 ENHANCED HEALTH IT FUNCTION REQUIREMENTS		
TRACK 2 ONLY: Adopt health IT certified to the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9).	By January 1, 2019	Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.
TRACK 2 ONLY: Adopt health IT certified to the 2015 Edition "Social, Behavioral and Psychological Data" criterion found at 45 CFR 170.315(a)(15).	By January 1, 2019	Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.

Requirements for Reporting eCQMs

Practices will be required to report on a set of the measures listed in Appendix D. (The last two measures are not EHR measures but are measures that will be included in the CPC+ model.) The final list of measures will be determined no later than November 2017, if not before. CPC+ practices must meet the certified health IT requirements described above in order to report measures. eCQM requirements are outlined in the following table:

First eCQM Performance Period	CY2018 (January 1-December 31, 2018)
First eCQM Submission Period	Begins January 1, 2019to CMS
eCQM version	eCQM version published as the annual update in spring 2017
eCQM Reporting Method	As specified by CMS.

Optimized EHR/Health IT for Track 2

CPC+ offers opportunities to align multi-payer payment reform and health IT support with practice transformation. Primary care practices require advanced health IT capabilities that are not always available in current systems or required by ONC certification. As part of Track 2, practices will have an opportunity to develop and optimize these functions to support clinical objectives. To support this work, CPC+ participants, CMS, and ONC will collaborate with vendors that are willing to work with Track 2 practices to meet core health IT requirements as well as develop and optimize enhanced capabilities appropriate to test the model.

Track 2 practices should share this appendix with EHR or other health IT vendor(s) whom you are soliciting to support your participation in Track 2. Vendors should carefully review these requirements in order to complete the Vendor Letter of Support that needs to accompany the provider's CPC+ application.

Overview of Vendor Partnership

As part of CPC+ Track 2, vendors will work directly with primary care practice participants to develop the necessary health IT functionality to support practices in the delivery of advanced primary care. Vendors who are selected by practices to support their participation in the model will enter into a memorandum of understanding (MOU) with CMS. The MOU will further outline the details of their involvement. Vendors will not be paid by CMS for their involvement in the model.

While CMS expects some practices will seek support from a single vendor for all of their relevant health IT needs, others may identify multiple vendors or service providers delivering

required capabilities. Other health IT vendors and service providers might include vendors delivering population health management, analytics, and care management solutions.

CMS and the Office of the National Coordinator for Health IT in the Department of Health and Human Services (ONC) will review the responses to the practice applications and letters of vendor support, and, if necessary, may contact the vendor to obtain additional information. All vendors who agree to support an eligible CPC+ practice site will be eligible to enter into a MOU with CMS. The point of contact listed in the application will be notified of the selection decision and CMS will forward the MOU for signature.

CPC and the ONC will communicate to EHR and other health IT vendors an overview of CPC Track 2 and its health IT requirements.

Why Include EHR and Other Health IT Vendors in CPC Track 2?
The inclusion of vendors in CPC+ Track 2 is based on lessons learned from the Original CPC Model around the importance of greater partnership with health IT vendors. Both health care providers and EHR vendors have indicated the need to develop closer partnerships to achieve successfully the goals of practice transformation for alternative payment models. Track 2 presents an opportunity for primary care practices to collaborate directly with their vendors so that the resulting products meets the practices' needs efficiently and effectively.

Benefits of Vendor Partnership with CPC Practices and CMS
Partnership with CPC+ offers a unique opportunity for EHR and other health IT vendors to work with advanced primary care practices participating in an important new CMS alternative payment model.

Through engagement with the model, CMS expects vendors will:

- Gain an accelerated understanding of the technology needs of primary care practices that are delivering advanced primary care, undergoing payment re-design, and implementing clinical practice transformation activities;
- Participate alongside practices, payers, and other stakeholders in a wide range of national learning activities that the CMS Innovation Center will deploy for this model;
- Gain an acute understanding of the types of health IT and functionality needed to deliver optimal primary care and, in collaboration with primary care practices, be part of the solution.

Vendor Letter of Support and Memorandum of Understanding (MOU) for Track 2

Vendors who are willing to support a CPC+ practice applicant for Track 2 will be asked to do the following:

1) Provide a "Letter of Support," either a "Global Letter of Support" or "Letter of Support" specific to a CPC+ practice applicant that indicates the vendor (a) has reviewed the information contained in this document and (b) is willing to support the practice(s) to meet the health IT requirements for Track 2 either by optimizing the practice's EHR or providing the practice with other health IT solutions. The letter of support should be signed and dated by an authorized official of the vendor organization.
2) If the practice is selected to participate in Track 2, the vendor will enter into a MOU with CMS. CMS will not provide any funding to vendors that agree to support practices participating in this model. The CMS MOU will state that vendor partnership is voluntary and the commitment is for the five year duration of the model, although CMS anticipates most of the Health IT enhancements will be completed in the first two-three years of the model.

Health IT Functionalities/Enhancements Expected in Round 2 Track 2

Practices in Track 2, supported by participating vendors, will be asked to develop the following health IT functions/enhancements. CMS will not prescribe how the health IT enhancement is accomplished, rather only that the health IT solution meets the CPC objective for use of the health IT by the CPC practice site team. CMS anticipates that some of these requirements will be completed in the first 6-12 months of model start-up while others will take longer. CMS expects that all health IT enhancements listed below will be completed no later than 24 months after practices start their first performance year.

Health IT Technical Enhancement	CPC+ Objective for Use of Health IT
Risk-stratify practice site patient population; identify and flag "Patients with Complex Needs"	1. Enable the practice site to assign a risk score/label that reflects assignment based on the practice's risk stratification methodology. 2. The methodology used to stratify practices should be clear and meet basic guidelines established by CMS. 3. The practice site practice team should be able to sort patients by score and update risk scores as needed. 4. Based on stratification results, the practice site should be able to flag patients they identify as "complex patients" and/or as requiring episodic, short term care management, and generate reports or lists of patients using those labels to support clinic workflow.

Health IT Technical Enhancement	CPC+ Objective for Use of Health IT
Produce and display eCQM results at the practice level to support continuous feedback	1. Enable the entire practice team to view eCQMs results at the practice site level to support continuous feedback on quality improvement efforts. 2. Measure results should be updated as frequently as possible so that measures reflect current progress. 3. This capability should present results in a usable, actionable manner that the care team can use to effectively manage population health.
Systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs	1. Enable primary care practices to electronically assess patients' psychosocial needs. 2. Enable primary care practices to capture or access electronically an inventory of resources and supports to meet patients' identified psychosocial needs. 3. To support this objective practices must adopt certified health IT that meets the 2015 Edition criterion "Social, Behavioral and Psychological Data" found at 45 CFR 170.315(a)(15), within the first two years of the program.
Document and track patient reported outcomes	CMS is evaluating a patient reported outcome survey instrument that will be sent to CPC+ Track 2 patients to identify specific care needs requiring intervention/management by the CPC+ practice site team. CMS plans to use the data collected from the patient-reported outcome survey to develop a patient-reported outcome performance measure that may be included in CPC+ measure set in the later years of the model. The modes of administration are yet to be determined. 1. The health IT tool should provide the care team with the ability to administer the survey, store and track patient responses, and score results longitudinally for each patient surveyed. 2. The practice should be able to review the patient responses/results in their EHR or other health IT tool and, as appropriate, establish care plans /interventions for positive findings.
Empanel patients to the practice site care team	1. Enable the practice to assign each patient to a care team or practitioner and sort and review the patients by assignment. 2. The assigned provider should be visible in the patient record to members of the care team.

Health IT Technical Enhancement	CPC+ Objective for Use of Health IT
Establish a patient focused care plan to guide care management	CPC+ practices should utilize an IT-enabled, patient-centered care planning tool in order to support holistic care and a focus on beneficiary goals and preferences. 1. Enable providers to electronically capture the following care plan elements: a. Advance directives and preferences for care b. Patient health concerns, goals and self-management plans c. Action plans for specific conditions d. Interventions and health status evaluations and outcomes e. Identified care gaps 2. The practice should have the ability to customize which of these elements are included within the care plan and how these elements are displayed. 3. Providers should be able to incorporate relevant triggers (e.g. a risk score or event) that indicate different care management actions. 4. The care plan tool should facilitate version control across care team members by capturing the date of the last review or change in plan and generating a scheduled date for reviewing and updating the plan. 5. Practices should be able to populate the care plan using data entered in the patient's record (e.g. without duplicative data entry). 6. The care plan should be available to the patient on paper and electronically, and available in electronic format to care team members outside of the practice that are involved in the patient's care. Care plan information should also be remotely accessible to practice team members delivering care outside of normal business hours. 7. To support this objective, practices must adopt certified health IT that meets the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9), within the first two years of the program.

Health IT Technical Enhancement	CPC+ Objective for Use of Health IT
Optional: CPC+ practice site care delivery and documentation of the care touch documentation *Please note: if vendor cannot support this functionality, the practice can still be in Track 2 as this is not mandatory health IT.*	Current systems are designed for capturing office-based care encounters and payment. Presently, claims are used to understand which physicians are seeing a patient the most (i.e. attribution), what proportion of primary care services are provided at the assigned practice versus other practices, and other key parameters. However, as programs like CPC+ Track 2 encourage the use of non-visit-based services, providers as well as CMS will lose a key source of data for understanding primary care activity. As part of Track 2, CMS will work with vendors and providers to explore identifiers for non-visit-based care activities that will allow practices and the program to quantify the overall provision of care to the patient (such as emails, telehealth interactions, telephone encounters, text reminders, letters etc.).

Appendix D: Measures for 2017 Performance-Based Incentive Payment (PBIP)

CMS will prospectively pay CPC+ practices a PBIP, which practices may keep if they meet annual performance thresholds. Practices that do not meet the annual thresholds will be required to repay all or a portion of the prepaid amount.

CMS will provide a larger PBIP in Track 2 than in Track 1; however, all practices are at risk for repaying all or a portion of the prepaid amount to CMS depending on their performance.

The PBIP is broken into two distinct components, both paid prospectively:

1. Incentives for performance on quality/experience measures
2. Incentives for performance on utilization measures that drive total cost of care

Please note that this list is a list of measures for 2017. The final measure list will be communicated to practices accepted in the model in advance of the performance period beginning January 1, 2018.

Utilization Measures	
HEDIS	Ambulatory care: summary of utilization of ambulatory care in the following categories: ED visits
HEDIS	Inpatient utilization – general hospital/acute care: summary of utilization of acute inpatient care and services in the following categories: total inpatient, maternity, surgery, and medicine

Patient and Caregiver Engagement Measures	
NQF #0005	Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

CPC+ eCQM Set - 2017 Performance Period[4]					
CMS ID#		NQF#	Measure Title	Measure Type/ Data Source	Domain
Report 2 of the Group 1 outcome measures:					
Group 1	CMS159v5	0710	Depression Remission at Twelve Months	Outcome/eCQM	Clinical Process/Effectiveness
	CMS165v5	0018	Controlling High Blood Pressure	Outcome/eCQM	Clinical Process/Effectiveness
	CMS122v5	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	Outcome/eCQM	Population/Public Health
Report 2 of the Group 2 complex care measures:					
Group 2	CMS156v5	0022	Use of High-Risk Medications in the Elderly	Process/eCQM	Patient Safety
	CMS149v5	N/A	Dementia: Cognitive Assessment	Process/eCQM	Clinical Process/Effectiveness
	CMS139v5	0101	Falls: Screening for Future Fall Risk	Process/eCQM	Patient Safety
	CMS137v5	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process/eCQM	Clinical Process/Effectiveness

[4] *CPC+ practices must meet the certified Health IT requirements described in Appendix C in order to report measures. CPC+ practices will be required to report on a subset of the eCQMs and on both the utilization and CAHPS. Required measures will take into consideration availability of measures supported by CPC+ CEHRT vendors. PROM is applicable to Track 2 practices only and is not included as a PBIP measure.*

CPC+ eCQM Set - 2017 Performance Period[5]					
CMS ID#		NQF#	Measure Title	Measure Type/ Data Source	Domain
Report 5 of the 10 remaining measures (choice of Group 3 and remaining Groups 1 and 2 measures):					
Group 3	CMS50v5	N/A	Closing the Referral Loop: Receipt of Specialist Report	Process/eCQM	Care Coordination
	CMS124v5	0032	Cervical Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
	CMS130v5	0034	Colorectal Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
	CMS131v5	0055	Diabetes: Eye Exam	Process/eCQM	Clinical Process/Effectiveness
	CMS138v5	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/eCQM	Population/Public Health
	CMS166v6	0052	Use of Imaging Studies for Low Back Pain	Process/eCQM	Efficient Use of Healthcare Resources
	CMS125v5	2372	Breast Cancer Screening	Process/eCQM	Clinical Process/Effectiveness

[5] *CPC+ practices must meet the certified Health IT requirements described in Appendix C in order to report measures. CPC+ practices will be required to report on a subset of the eCQMs and on both the utilization and CAHPS. Required measures will take into consideration availability of measures supported by CPC+ CEHRT vendors. PROM is applicable to Track 2 practices only and is not included as a PBIP measure.*

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Appendix E: Attribution Methodology

Beneficiaries will be aligned with the practice that either billed for the plurality of their primary care allowed charges, or that billed the most recent claim (if that claim was for CCM services) during the most recently available 24-month period. If a beneficiary has an equal number of qualifying visits to more than one practice, the beneficiary will be aligned to the practice with the most recent visit.

To be eligible for this initiative and aligned with a practice, beneficiaries must:

- Have both Medicare Parts A and B;
- Have Medicare as their primary payer;
- Not have end stage renal disease (ESRD) or be enrolled in hospice;
- Not be covered under a Medicare Advantage or other Medicare health plan;
- Not be institutionalized;
- Not be incarcerated;
- May be enrolled in the Medicare Shared Savings Program (if the ACO is dually participating in both CPC+ and MSSP);
- Not be enrolled in the Next Generation ACO Model, the ACO Investment Model, or the Advanced Payment ACO Model; or any other program or model that includes a shared savings opportunity with Medicare FFS initiative;
- Reside in one of the regions selected for this model;

For all beneficiaries who meet the criteria above, claims with the following qualifying CPT codes will be selected for the look-back period (the most recent 24 months) when the physician or practitioner specialty is internal medicine, general medicine, geriatric medicine, family medicine:

Qualifying CPT Codes	
Office/Outpatient Visit E&M	99201-99205 99211-99215
Complex Chronic Care Coordination Services	99487-99489
Transitional Care Management Services	99495-99496
Home Care	99324-99328 99334-99337 99339-99345 99347-99350
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Chronic Care Management Services	99490
Assessment/care planning for patients requiring CCM services	G0506
Care management services for behavioral health conditions	G0507
Prolonged non-face-to-face evaluation and management services	99358-99359

The following information will be needed to conduct beneficiary alignment.
For a practice:

- Practice name;
- Practice Address (street, city, state, zip);
- Group Provider Transaction Provider Number (PTAN) (Group Provider Identification Number (PIN));
- Group National Provider Identifier (NPI) (If the practice is a solo practitioner, relevant Billing P-Tan or Individual Billing P-Tan/PIN information would be needed);
- Tax ID.

For each individual practitioner:

- Practice affiliation;
- Practice name;
- Individual NPI;
- Effective start date of participation;

- Effective termination date of participation.

CMS will provide each practice with a list of its claims-based aligned patients prior to the start of the initiative and each performance year. In addition, the beneficiary assignment algorithm will be run every three months with reports provided to the practice within 15 business days of the end of the look back period and applicable to payments starting 30 days after the end of the look back period.

Practices will be required to inform their patients in writing of their involvement in this initiative, and the changes their practice has made or is undertaking to provide comprehensive primary care and better serve their needs. Patients may opt out of data sharing.

At all times during the initiative, though Medicare beneficiaries will be attributed to a practice, they will remain free to select the providers and services of their choice and will continue to be responsible for all applicable beneficiary cost-sharing. CPC+ does not include any restrictions on or changes to Medicare FFS benefits, nor does it include provisions for beneficiaries to opt out of alignment with a participating practice for purposes of expenditure calculations and quality performance measurement.