

Comprehensive Primary Care Plus (CPC+)

Payer Frequently Asked Questions

July 15, 2016

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## DEADLINES AND IMPORTANT DATES

**Q: What is the deadline for payers to apply to the Comprehensive Primary Care Plus (CPC+) model?**

Payers must respond to this solicitation by June 8, 2016 at 5:00pm ET.

**Q: When is the CPC+ initiative expected to begin?**

CPC+ will begin on January 1, 2017.

**Q: When will a payer be notified that their proposal was accepted?**

CMS expects to notify payers in June 2016 on the status of their proposal. We plan to work with payers selected for partnership with CPC+ in early July 2016 to execute the [Memorandum of Understanding \(MOU\)](#).

**Q: When will CMS announce the selected CPC+ regions?**

CMS expects to publicly announce selected regions by July 15, 2016.

**Q: When can practices apply for the CPC+ initiative?**

After payers and regions are selected and CMS enters into an MOU with payers, CMS will release a primary care practice Request for Application (RFA) via an online portal in up to 20 regions selected for CPC+. Practices are expected to be able to apply for CPC+ from late July through mid-September, once regions and partner payers within those regions have been determined.

## MODEL DESIGN

**Q: What is the value proposition for a private or public insurer to join the Comprehensive Primary Care Plus initiative?**

Many payers share CMS' interest in strengthening primary care, yet support by any one payer has only a limited impact within a primary care practice. Leveraging the efforts of multiple payers has the potential to transform primary care practices and achieve the aim of better care, smarter spending, and healthier people.

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

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

**Q: I am a payer in a region with a density of primary care practices participating in Medicare ACOs and would like to support these practices in CPC+. Is this possible?**

Currently, primary care practices may not participate in both CPC+ and MSSP or other Medicare ACO models. However, CMS would like to understand how, if at all, your proposed regions, lines of business,

and number of covered lives would change if CPC+ accommodated primary care practices currently participating, or seeking participation, in an ACO in Track 1, 2, or 3 of the Medicare Shared Savings Program (MSSP).

The Payer Solicitation has been updated to include questions related to this issue. Payers must submit the Updated Payer Solicitation by 5pm EST on June 8; CMS will contact payers that submitted the previous version of the Solicitation to request further information.

**Q: Which utilization measures will CMS use to distribute performance based incentive payments?**

CMS will use Healthcare Effectiveness Data and Information Set (HEDIS) utilization measures that are based upon emergency department visits and utilization of inpatient hospital/acute care.

**Q: Which quality measures will CMS use to distribute performance based incentive payments?**

CMS will use electronic clinical quality measures (eCQMs) that are currently part of other CMS and HHS initiatives.

**Q: Must partner payers use the same utilization and quality measures as CMS?**

In recognition of the fact that there exists a variety of measure sources and lack of alignment on required measures across payers and programs, we hope that market-level discussions will drive harmonization of any additional quality measures and reduce administrative burden to participating practices through a shared approach to quality assurance and improvement.

**Q: Why is CMS testing a performance-based incentive payment in CPC+, rather than shared savings? If a payer partner chooses to use a shared savings incentive, would that be considered “aligned”? Should a shared savings incentive be prospectively paid?**

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

Payers need not use an identical incentive design to be considered “aligned” (See the Eligibility section for more information on payer alignment). Partner payers may propose shared savings, bonuses, or alternate incentive designs. Incentives may be paid to practices prospectively or retrospectively.

## ELIGIBILITY

**Q: What does “payer alignment” mean? Must payers implement the same model design approach as CMS?**

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

**Q: Is it required for a payer to currently have experience with non-fee-for-service support, or performance-based incentive payments?**

No, previous experience with alternative payments is not required.

**Q: We would only like to partner with Track 1 practices. Is that allowed?**

Payers are strongly encouraged to partner in both tracks of CPC+. CMS will evaluate proposals and select regions where there is sufficient interest from multiple payers to support practices that participate in both Tracks 1 and 2 of the model.

**Q: We would like to partner with both tracks, but do not believe there will be a sufficient number of practices in our regions participating in Track 2. Are we still eligible to participate in CPC+?**

CMS intends to offer both tracks in every region. We will not know if there will be sufficient practice participation within a region until the practice application period is complete (September 1, 2016).

**Q: We would like to partner with both tracks, but our state prohibits non-HMO plans from offering capitated or risk-based payments to physicians. Is there any way we can still align with Track 2?**

Please note that aligned approaches need not include capitated or risk-based payments. The CPC+ comprehensive primary care payments will be partially reconciled so it is not traditional capitation. Partner payers' aligned arrangements could be, for example, partial capitation without downside risk, full capitation without downside risk, sub-capitation without downside risk, and episodic payment.

Whether a payer can offer a capitated or risk-based arrangement will depend on the NAIC regulations in place in your state. Please contact your state insurance department regarding this matter. In states with regulations that prohibit capitated or risk-based payments, we encourage payers to consider alternate arrangements that will support flexibility in the delivery of primary care. We anticipate that Track 2 practices will be paid by multiple payers that allows practices to deliver enhanced, comprehensive services both in and outside of an office visit without the incentive to increase volume of patients or services.

**Q: Is it possible for a payer to lose eligibility during the five year period due to changes among various lines of business (ex: loss of State Medicaid/CHIP Contract)**

In order to continue to partner in CPC+, payers must cover members and/or beneficiaries attributed to practices in their respective regions. Payer partners are also expected to honor the terms of the Memorandum of Understanding with CMS. Withdrawals or changes in payer status will be considered on a case-by-case basis.

**Q: Is it possible for a partner payer to also be a practice participant?**

Yes, payers are allowed to participate in CPC+ as both a practice and a payer, provided they complete both the payer solicitation and the practice application, are eligible, and are selected. Examples may include self-insured health systems or primary care practices that also offer Medicare Advantage plans.

**Q: Can an integrated delivery system or an employer who is also a provider of primary care submit a proposal for CPC+?**

We are looking for proposals from payers and purchasers for this initiative. Therefore, an integrated delivery system may apply for the CPC+ initiative by encouraging the administrator of their employee health plan to apply; or if the system also has an affiliated health plan, the health plan may apply. If the region and insurer are selected for participation, then primary care practices associated with the integrated delivery system could apply in the subsequent practice RFA.

**Q: Will CMS provide payers with any financial incentives to partner in CPC+?**

No, payers will not receive any additional funding from CMS for their work; however, we anticipate that payer partners may see improvements in quality and cost of care by investing in primary care reform.

## PROPOSALS

**Q: Will payers' proposals be publicly available?**

No. All information submitted within the proposal is considered confidential. Therefore, CMS will not release the information to the general public.

**Q: Is a payer's proposal binding?**

No, the Solicitation is not binding. If a payer is chosen for a selected region, the payer will then sign a MOU to memorialize their commitment to the model. The MOU outlines certain respective commitments to strengthen primary care through CPC+.

**Q: Are interested payers able to discuss their potential participation in this initiative with other payers and providers in a market?**

CMS anticipates that CPC+ will stimulate a market-wide conversation among payers, providers, and community quality collaboratives. We encourage relevant parties to begin that conversation prior to submitting a response to this solicitation. We expect that all conversations among payers and providers would comply with antitrust law. Nothing in this solicitation shall be deemed to suspend any applicable antitrust laws or regulations, all of which still apply.

**Q: Are payers able to participate in the CPC+ practice selection process?**

Given the time constraints for reviewing practice applications, CMS is unable to include payers in the CPC+ practice selection. However, in their applications to participate in CPC+, practices must report their revenue generated from payers partnering in CPC+. We anticipate that many of the practices that apply and are eligible for CPC+, will be participating in or interested in future engagement in payers' primary care efforts. CMS will continue to communicate with payers throughout the practice application process.

**Q: Do state Medicaid agencies need to submit a proposal for partnering in CPC+ or can they submit alternative documentation expressing their interest?**

All interested payers, including State Medicaid Agencies must submit a completed proposal to be considered for partnership in CPC+. CMS will not accept other documents, such as letters of intent.

## REGIONAL SELECTION

**Q: How many regions will you choose for CPC+?**

We expect to select up to twenty regions to participate in this initiative.

**Q: How are regions defined in this solicitation?**

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

**Q: What is CMS' process for receiving and reviewing payer proposals?**

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 FFS approach. Once regions have been selected and approved, payers with proposals that sufficiently align with the Medicare FFS approach will be selected and invited to partner with CMS by signing a MOU. Additional details on payer selection are outlined in the 'Payer and Region Selection' section of the CPC+ Request for Applications.

**Q: What does CMS consider to be sufficient market penetration in a region?**

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

**Q: Are current CPC regions guaranteed to continue in CPC+?**

Not necessarily. The CPC+ regions will be selected based on the locations of the payers that apply. CMS will select regions where there is sufficient interest from multiple payers to support practices that will participate in Tracks 1 and 2 of CPC+.

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

**Q: Is it worth the time to submit a proposal if a payer plans to operate in a region that is not currently in the CPC, MAPCP or SIM regions?**

Yes. While CMS aims for transparency regarding its preference for regions with active CMS primary care demonstrations, we welcome market interest in a region not currently participating in those initiatives, as we plan for up to 20 regions.

### ADMINISTRATIVE

**Q: If a payer is interested in partnering in multiple CPC+ regions, do they have to submit multiple proposals?**

Yes, a payer should submit a proposal for each distinct region for which they wish to be considered. A payer's single geographic service area may include multiple states, so payers should submit that geographic grouping under a single application. Please do not combine distinct service areas in a single application.

**Q: If I'm a payer planning to partner with CPC+ in twelve states, do I need to submit twelve separate proposals even though most answers are the same across most of my states?**

If the twelve states in this example fall under distinct geographic services areas, then the payer will need to submit twelve separate solicitations. To reduce administrative burden associated with re-entering data, payers are encouraged to save digital copies of their completed PDF and modify only the information that varies across regions. Please see the [CPC+ Payer Solicitation Instructions](#) for any additional questions regarding submissions involving multiple states/regions.

**Q: Are supporting documents required?**

In most cases, the PDF form will be able to accommodate the complete collection of payer information, therefore supporting documents are not required. Separate submissions are allowed if payers feel additional documentation will best support their proposal. Supplemental material is optional and must not exceed a total of 15 pages in length.

**Q: Are there minimum word counts or expectations on response length for the solicitation questions?**

No, there is no minimum or maximum amount of response text. We encourage payers to complete the solicitation in the manner that best showcases their proposal. It may be that a shorter, more succinct answer best captures a payer's understanding and grasp of the question and therefore a longer answer would not offer a superior response.

**Q: If a payer is currently partnering with CMS on the existing CPC initiative and is interested in being a CMS partner in CPC+, do they need to complete an additional proposal to participate in CPC+?**

Yes. CPC and CPC+ are distinct models, hence any interested payers must complete a new proposal to be considered for partnership in CPC+. Note that continuing regions from CPC will be given preference when CMS evaluates proposals, provided regions have sufficient market penetration and the proposal in question is in alignment with the Medicare FFS approach.

**Q: Can an employer directly submit a proposal for CPC+, or should their Third Party Administrator (TPA) or Administrative Services Only (ASO) submit a proposal?**

CMS looks forward to partnering with employers in the CPC+ initiative. Because payment reform requires TPAs/ASOs to execute the payment agreement described in the MOU, we request that the TPA/ASO apply on behalf of one or multiple employers in a market. The TPA/ASO should identify the employer(s) in its application. We encourage employer participation in any relevant discussions between CMS and payers.

**Q: My CPC+ proposal does not change after accounting for the possible CMS inclusion of primary care practices participating in MSSP. How do I complete the Addendum to the CPC+ Solicitation?**

If your proposed regions, lines of business, and number of covered lives would not change if CMS accommodated practices participating or seeking participation in Track 1, 2, or 3 of MSSP, please complete the worksheet entitled 'Covered Lives Non-MSSP' and leave the worksheet entitled 'Covered Lives MSSP' blank.

**Q: We previously submitted a proposal, but would like to update it with more current information. How do we do that?**

Payer respondents requesting to modify a pending proposal should submit a written request on the organization's letterhead signed by the primary point of contact indicated on the submitted form. If at any time during the solicitation period you need to modify a previous submission, email [CPCplus@cms.hhs.gov](mailto:CPCplus@cms.hhs.gov) with the subject heading "\*\*RESUBMISSION\* Payer Partner Solicitation for CMS" to indicate that CMS should use the new version as the final proposal for consideration. We recommend that updates to proposals be submitted within one week of the initial submission, in order for the changes to be considered in CMS review and scoring. Modifications will not be considered after the June 8, 2016 deadline.

**Q: We previously submitted a proposal, but would like to withdraw it. How do we do that?**

To request that your proposal be withdrawn, payers must email [CPCplus@cms.hhs.gov](mailto:CPCplus@cms.hhs.gov), with the subject heading "\*\*RESCIND\* Payer Partner Solicitation for CMS" along with additional notes or clarifications in the body of the email. In order for your withdrawal requests to be considered, please submit such requests no later than one week following submission.

**Q: I submitted my proposal to the CPC+ inbox but my PDF was not successfully transmitted. How do I resolve this?**

If you submitted your proposal via a personal email account as opposed to your organization's email account, you may have a higher likelihood of encountering technical issues when sending the fillable PDF. To minimize this risk, please submit your proposal using your organizational email address.

## MEDICAID

### **Q: What is a “region” in this context?**

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

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

### **Q: Does a State Medicaid agency (SMA) that wishes to participate in CPC+ need a State Plan Amendment (SPA) or waiver to do so?**

States can participate in CPC+ through either a SPA or a waiver, depending on the proposed model. Unlike the original Comprehensive Primary Care initiative, CPC+ will not pay for any portion of the Medicaid care management fees or other payments to providers. In order to receive federal match on those payments, the SMA would be required to obtain an approved SPA or waiver through established mechanisms so that they could claim the match on the CMS-64. There is no special mechanism for SMA participation in CPC+ outside the normal SPA/waiver process.

### **Q: How does CPC+ fit into Medicaid managed care states, and what is the state role there?**

Medicaid managed care plans were able to apply to participate like commercial plans using the same payer solicitation. SMAs can work with them on any contractual issues, if applicable. Please note that any necessary contract amendments for a Managed Care Organization (MCO) to join CPC+ would be subject to normal, established mechanisms for CMS review and approval.

### **Q: How does CPC+ align or interact with the State Innovation Models (SIM) Initiative? What if a state’s SIM grant does not align with CPC+?**

CMS welcomed CPC+ applications from SIM states. States should find that CPC+ fits well with many SIM models and builds on the work already done. Both CPC+ and SIM are multi-payer initiatives. If payers engaging in a SIM partner with CMS in CPC+, and states that have received SIM grants are selected as CPC+ regions, practices in these states may participate in CPC+.

In states where the SIM grant is not aligned with CPC+, the payers, including the SMA, will decide which models to pursue.

### **Q: Is Medicare participation automatic, or will a state have to seek Medicare participation after the payers apply, as with SIM?**

CMS is inviting payers to submit proposals to partner with Medicare Fee-For-Service in CPC+. Within those regions, practices will be invited to partner in each of the two tracks. CMS is committed to providing alternative payments, as described in Track 1 and Track 2, for eligible Medicare beneficiaries to selected practices in selected regions. No additional application for Medicare participation is required after region and practice selection.

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

CPC+ is designed to model payment reform for traditional fee-for-service payment, and the billing processes for FQHCs and RHCs are distinct from other primary care practices. Because FQHCs and

RHCs do not submit claims on a Medicare Physician/Supplier claim form (HCFA/Medicare 1500) and are not paid according to the Medicare Physician Fee schedule for routine office visits, they are not eligible for participation.

**Q: What will happen if commercial payers in a state apply for CPC+ but Medicaid does not?**

CMS will evaluate the proposals of interested payers in each region/market to see whether there is sufficient market share coverage to qualify. The formula to calculate market share will be the same whether or not Medicaid is among the payers who submitted proposals. Markets will be selected based on the payers who respond to the solicitation. A state Medicaid agency could encourage other payers to partner with Medicare FFS; however, SMAs should be careful to abide by anti-trust regulations when talking to payers and avoid discussing specific prices. In the original CPC initiative, some markets include Medicaid and others do not.

**Q: If a Medicaid managed care plan submitted a proposal as a payer partner, would they have to participate in both Tracks 1 and 2?**

Yes. Like commercial payers, a Medicaid managed care plan that applied would have indicated which lines of business were included in their proposal. Within those lines of business (including, if applicable, the Medicaid managed care line), the plan would have to agree to pay practices in each Track for each covered life in those lines of business.

**Q: What is the match rate for Medicaid payments to providers paid under CPC+?**

There is no special match rate for Medicaid payments under CPC+. SMAs would have to seek approval through established mechanisms (e.g., SPAs and waivers) in order to receive the appropriate match rate(s) outlined in the state plan.

**Q: What is the impact on Medicaid Health Homes?**

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

While a CPC+ practice may also be a Medicaid Health Home, CMS will not pay twice for care coordination services for the same beneficiary. In states with a Medicaid Health Home program, the SMA should work with CMS to outline a plan to prevent duplication of payment.

**Q: Does partnering in CPC+ impact the Medicaid Managed Care rules that apply to my MCO?**

No, CPC+ does not alter or supersede any existing Medicaid rules.

**Q: Can a practice be both a CPC+ practice and a Medicaid ACO practice?**

Yes, however states will need to ensure that there is appropriate oversight and safeguards in place to prevent duplicative effort and payments to providers.

**Q: Would a Medicaid agency's Per Member Per Month (PMPM) payments to providers be considered administrative costs or service costs?**

To the extent a PMPM methodology is approved in the State plan and pays for a Medicaid covered service, the PMPM may be claimed at the applicable federal matching assistance percentage for the service. Care coordination activities conducted by providers are generally not for the proper and efficient administration of the Medicaid state plan and federal participation is not available at the administrative claiming rate for those activities.

**Q: Would participation in CPC+ impact a State's ability to get an 1115 waiver to fund Medicaid community-based ACOs in the future?**

Participation in CPC+ does not preclude a states' ability to receive a waiver for another care delivery model in the future. The specific circumstances of a waiver request would need to be reviewed to determine whether it is approvable, and duplication of federal payment for the same service or activity is not allowed.

**Q: Our Medicaid beneficiaries are covered primarily through MCOs. These MCOs want to join CPC+. Does the SMA need to fill out a companion proposal for Medicaid MCOs?**

No. Only the payer should submit an application. In this situation, the SMA is the purchaser and the MCO is the payer, so the SMA does not need to fill out a proposal to mirror the MCO's proposal for MCO beneficiaries. If the SMA has, for example, fee-for-service beneficiaries as well and wishes to include them in CPC+, then the SMA should fill out a proposal as the payer for the FFS line of business. Please note that any contract amendments required for an MCO to join CPC+ would be subject to normal, established mechanisms for CMS review.

**Q: Do Medicaid rules allow for prepayment of Track 2 incentives and reduction of FFS rates in the state plan and if states do not provide prepayment, will they still be considered "aligned" for the purpose of the application review?**

Medicaid rules do not allow for prepayment in the state plan however, CMS believes there are a number of ways states can provide payments in Track 2 of the CPC+ model that are consistent with Medicaid rules, including through episode or bundled payments. These payment models will still be considered aligned and states will not be disadvantaged in the selection process if they pursue a payment model that fits the goals of the Track 2 payments but is not identical to Medicare FFS's hybrid CPCP/FFS outlined in the RFA.

States seeking to make prepayment for the Track 2 incentives and to reduce FFS payments only to CPC+ providers must obtain CMS 1115 waiver authority to do so.

**Q: Will the state be required to risk adjust Medicaid case management fee rates for each participating practice?**

No. Medicare FFS will risk adjust their care management fees (as described in the RFA), other payers and Medicaid are not required to the same.