

Comprehensive Primary Care Plus (CPC+) Round 1 Practice Participants

Fact Sheet

Strengthening primary care is critical to promoting health and reducing overall health care costs in the U.S. Building on lessons learned from the Comprehensive Primary Care (CPC) initiative 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 began on January 1, 2017 and runs through 2021. CMS will also offer a second round of CPC+ to begin in January 2018 and run through 2022.

CPC+ aims to enable primary care practices to care for their patients the way they think will deliver the best outcomes and to pay them for achieving results and improving care. CPC+ is an advanced primary care medical home model that rewards value and quality by offering an innovative payment structure to support delivery of comprehensive primary care. The model will contribute to the Administration's goals of having 50 percent of all Medicare fee-for-service payments made via alternative payment models (APMs) by 2018. The model offers two tracks with different care delivery requirements and payment methodologies to meet the diverse needs of primary care practices.

CMS is partnering with [54 payers in 14 regions](#) for CPC+ Round 1. Regions were selected based on payer alignment and market density to ensure that CPC+ practices have sufficient payer supports to make fundamental changes in their primary care delivery. Practices in these regions submitted applications to participate in CPC+ Round 1. In Round 1, CPC+ supports 2,893 primary care practices of all sizes and ownership structures, including 1,056 small practices with under 3 clinicians at the practice-site, 781 independently owned practices, and 467 rural practices. These CPC+ practices comprise more than 13,000 primary care clinicians, including doctors, nurse practitioners, and physician assistants, serving approximately 1.75 million attributed Medicare beneficiaries in CPC+.

To broaden opportunities for Medicare primary care clinicians to participate in Advanced APMs under the Quality Payment Program, CMS will offer a round of solicitations in 2017 for payers and practices to partner in CPC+ Round 2 for a 2018 performance year start. 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. Based on payer interest and alignment, CMS will select new payer partners in both existing and new regions. Practices located within new Round 2 regions may apply in late spring or early summer 2017. In order to ensure a robust evaluation of CPC+, CMS will not accept Round 2 applications from practices located in CPC+ Round 1 regions.

General Model Overview

Model Design

CPC+ is a regionally-based, multi-payer care delivery and payment model that includes two separate tracks. Depending on their care delivery and health IT capabilities, practices may apply to participate in either Track 1 or Track 2 of CPC+. In Track 1, practices will build the capabilities to deliver comprehensive primary care and better meet the needs of patients. In 2017, 1,378 practices are participating in Track 1 of CPC+. Track 2 practices have already built these capabilities and will increase the comprehensiveness of care they deliver, with a heightened

focus on the assessment and management of patients with complex needs. In 2017, 1,515 practices are participating in Track 2 of CPC+.

The [model requirements](#) ensure that practices in each track will be able to build capabilities and care processes to deliver better care in order to achieve a healthier patient population. [Payment redesign](#) will offer the ability for greater cash flow and flexibility for primary care practices to deliver high quality, whole-person, patient-centered care and lower the use of unnecessary services that drive total costs of care. CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data, to guide their decision making.

Practices in both tracks are expected to make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.

Care Management Fee

CMS pays prospective monthly care management fees (CMFs) to Track 1 and 2 CPC+ practices. As highlighted in the table below, the CMFs will average \$15 per-beneficiary per-month (PBPM) across 4 risk tiers in Track 1. In Track 2, the CMFs will average \$28 PBPM across 5 risk tiers, which includes a \$100 CMF to support care for CPC+ beneficiaries with the most complex needs. Practices may use this enhanced, non-visit-based compensation to support augmented staffing and training needed to meet the model requirements according to the needs of their patient population.

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

CPC+ payer partners also provide non-visit based financial supports to practices based on their own methods.

Comprehensive Primary Care Payments

Track 1 practices continue to receive Medicare fee-for-service payments. In Track 2 of CPC+, CMS is introducing a hybrid of Medicare fee-for-service and “Comprehensive Primary Care Payment” (CPCP). The CPCP changes the cash flow mechanism for Track 2 practices, promotes flexibility in how practices deliver care that is traditionally provided face-to-face, and requires practices to increase the depth and breadth of primary care they deliver. Track 2 practices receive a percentage of their expected Medicare payment for Evaluation & Management (E&M) claims payment upfront in the form of a quarterly CPCP along with a reduction in Medicare fee-for-service payments for their billed E&M claims for services furnished to CPC+ beneficiaries.

CPC+ payer partners are expected to make changes to their underlying payment structures in ways that align with the goal of the CPCP and allow practices to deliver care in more flexible ways to their entire population of patients.

Performance-Based Incentive Payment

CPC+ rewards practices using incentive payments based on their performance on patient experience, clinical quality, and utilization measures. The CPC+ performance-based incentive payments are \$2.50 PBPM for Track 1 and \$4 PBPM for Track 2. Performance-based incentive payments are prospectively paid at the beginning of a performance year, but CMS may recoup payments made to the CPC+ practices if they do not meet thresholds for quality and utilization performance.

CPC+ payer partners are expected to provide practices with their own incentives based on quality, patient experience, utilization, and/or cost of care.

Partners and Participants

Multi-Payer Partnership

CPC+ brings together Medicare and other payers, including commercial insurance plans and state Medicaid agencies, in 14 regions in CPC+ Round 1 to provide the necessary financial support for practices to make significant changes in their care delivery. In Round 1, CMS is partnering with 54 payers that will align on payment, data sharing, and quality metrics.

CMS expects to release the CPC+ Round 2 Solicitation for Payer Partnership in mid-February 2017. CMS welcomes proposals from payers in up to 10 new regions, as well as new payers in any of the existing 14 CPC+ regions. Existing payer partners in the 14 CPC+ regions do not need to submit new proposals in those regions. CMS will select new payer partners in existing and new regions for CPC+ Round 2 in spring 2017, based on payer density and alignment with CMS' approach to payment, data sharing, and quality measurement.

Primary Care Practices

CPC+ targets primary care practices with varying capabilities to deliver comprehensive primary care. In order to participate, all CPC+ practices must demonstrate multi-payer support, use Certified Electronic Health Record (EHR) Technology, and have other capabilities.

Eligible practices within the 14 existing regions applied to participate in CPC+ Round 1 between August 1-September 15, 2016. 2,893 practices across all 14 regions will participate in CPC+ Round 1, including 408 that previously participated in the Comprehensive Primary Care initiative.

Number of CPC+ Practices, By Region

Region	AR	CO	HI	KC	MI	MT	NJ	NY	OH	OK	OR	PA	RI	TN	Total
Practices	182	207	103	109	447	54	436	157	562	174	156	219	31	56	2893

CPC+ supports primary care clinicians to deliver better care and achieve better outcomes for their patients, including approximately 1.75 million attributed Medicare beneficiaries expected to be served by CPC+. Over 13,000 primary care clinicians, including doctors, nurse practitioners, and physician assistants, will participate in CPC+ Round 1.

Number of Primary Care Clinicians Participating in CPC+, By Region

Region	AR	CO	HI	KC	MI	MT	NJ	NY	OH	OK	OR	PA	RI	TN	Total
Clinicians	689	1229	268	674	2000	354	1407	593	2566	686	1087	995	209	333	13090

Beginning in late spring or early summer 2017, practices located within the new CPC+ Round 2 regions may apply to participate in Track 1 or 2 of CPC+ Round 2. CMS will randomly assign the eligible applicants into an intervention group (Track 1 or Track 2 of the Model) or the control group. Practices randomized into the control group will not receive the CPC+ payments or participate in the learning communities. Practices assigned to the control group will have the opportunity to enter a control group practice-specific Participation Agreement with CMS and, pursuant to terms of that Participation Agreement, CMS intends to pay those practices an annual amount of \$5,000 to cover time spent on evaluation activities, such as data collection and reporting. In addition, CMS expects to propose in rulemaking in 2017 a new MIPS Improvement Activity that may give credit to participants in CPC+ control group practices with an active control practice-specific Participation Agreement.

Practices located in the 14 CPC+ Round 1 regions are not eligible to apply for Round 2. CMS will accept up to 2,607 practices in CPC+ Round 2, with a maximum of 5,500 practices across both rounds.

Health Information Technology (Health IT) Vendors

Comprehensive primary care requires efficient, advanced health IT to support its population-health focus and team-based structure. Practices in both tracks will qualify for the model based, in part, on having met certain Certified EHR Technology requirements, and will be expected to report electronic clinical quality measures at the practice-level. CMS also expects Track 2 practices to work with vendors to develop and optimize a set of advanced health IT functions. Nineteen health IT vendors have memorialized their commitment to supporting Track 2 practices and participating in model activities in a Memorandum of Understanding (MOU) with CMS, including: Allscripts, Applied Research Works, athenahealth, Caravan, Cerner, eClinical Works, e-MDs, Epic, GE Healthcare, Greenway Health, IBM Watson Health, Lightbeam Health Solutions, MEDITECH, MyHealth Access Network, NextGen Healthcare, Ohio Health Information Partnership (OHIP), Philips Wellcentive, STI Computer Services, and Verinovum.

Quality Payment Program and CPC+

Tracks 1 and 2 of CPC+ are included on the list of Advanced Alternative Payment Models (APMs) under the [Quality Payment Program](#) (QPP), and this determination was based on medical home model-specific requirements. For payment years 2019 through 2024, clinicians who meet the threshold for sufficient participation in Advanced APMs and who meet requirements, as applicable for 2018 onward, regarding parent organization size are excluded from the Merit-based Incentive Payment System (MIPS) reporting requirements and payment adjustments and may qualify for a five percent APM incentive payment. More information about the QPP and Advanced APMs can be found on the QPP website: <https://qpp.cms.gov>.

Further Information

For questions about the model or the application process, visit <http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus> or email CPCplus@cms.hhs.gov

Innovation Center

CPC+ was developed by the Center for Medicare and Medicaid Innovation (Innovation Center), which was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and the Children's Health Insurance Program beneficiaries.

In January 2015, the Administration announced its goals to help drive Medicare and the health care system at large towards rewarding the quality of care as opposed to the quantity of care provided to beneficiaries. The goals include tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements, by the end of 2016 and tying 50 percent of payments to these models by the end of 2018. Alignment between HHS, private sector payers, employers, providers, and consumers will help health care payments transition more quickly from pure fee-for-service payments to alternative payment models – a critical step toward better care, smarter spending, and healthier people.