

Comprehensive Primary Care Plus (CPC+)

Frequently Asked Questions

December 15, 2016

GENERAL

Q: Why is CMS testing CPC+?

CMS believes that through multi-payer payment reform and practice transformation, primary care practices will be able to build capabilities and care processes to deliver better care, which will result in a healthier patient population. Payment redesign by payers, both public and private, 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.

Q: When will CPC+ start and how long will it last? Can I join later?

The first performance period for CPC+ Round 1 begins on January 1, 2017. CPC+ Round 2 begins on January 1, 2018.

CPC+ consists of five performance years, per the table below. CMS expects practices to participate for the full five years of their respective round of the model and will not allow practices to join the model after each round’s application cycle.

PERFORMANCE YEARS FOR CPC+

Calendar Year	Round 1 Performance Year	Round 2 Performance Year
2017	1	N/A
2018	2	1
2019	3	2
2020	4	3
2021	5	4
2022	N/A	5

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

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

Q: Where will CPC+ Round 1 be implemented?

CPC+ Round 1 will be implemented in 14 regions throughout the U.S:

1. Arkansas: Statewide
2. Colorado: Statewide
3. Hawaii: Statewide

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4. Kansas and Missouri: Greater Kansas City Region
5. Michigan: Statewide
6. Montana: Statewide
7. New Jersey: Statewide
8. New York: North Hudson-Capital Region
9. Ohio: Statewide and Northern Kentucky: Ohio and Northern Kentucky Region
10. Oklahoma: Statewide
11. Oregon: Statewide
12. Pennsylvania: Greater Philadelphia Region
13. Rhode Island: Statewide
14. Tennessee: Statewide

The CPC+ Round 1 regions were selected based on payer alignment and market density to ensure that CPC+ practices have sufficient payer support to make fundamental changes in their primary care delivery.

Q: How is CMS defining the “Greater Kansas City (KS & MO)”, “North Hudson-Capital Region (NY)”, “Ohio and Northern Kentucky”, and “Greater Philadelphia (PA)” regions?

Based on payer alignment and market density, CMS is defining the regions located in partial states with the following counties:

- Kansas and Missouri: Greater Kansas City Region: Johnson County, KS; Wyandotte County, KS; Clay County, MO; Jackson County, MO; Platte County, MO
- New York: North Hudson-Capital Region: Albany County, NY; Columbia County, NY; Dutchess County, NY; Greene County, NY; Montgomery County, NY; Orange County, NY; Rensselaer County, NY; Saratoga County, NY; Schenectady County, NY; Schoharie County, NY; Sullivan County, NY; Ulster County, NY; Warren County, NY; Washington County, NY
- Ohio: Statewide and Northern Kentucky: Ohio and Northern Kentucky Region: All counties in Ohio; Boone County, KY; Campbell County, KY; Grant County, KY; Kenton County, KY
- Pennsylvania: Greater Philadelphia Region: Bucks County, PA; Chester County, PA; Delaware County, PA; Montgomery County, PA; Philadelphia County, PA.

Only practices located in these counties were eligible to apply and participate in CPC+ Round 1.

Q: Which payers have been selected to partner in CPC+ Round 1?

1. Arkansas: Arkansas BlueCross BlueShield, Arkansas Health & Wellness Solutions, Arkansas Medicaid, Arkansas Superior Select, HealthSCOPE Benefits, QualChoice Health Plan Services, Inc.
2. Colorado: Anthem, Colorado Choice Health Plans, Colorado Medicaid, Rocky Mountain Health Plans, UnitedHealthcare
3. Hawaii: Hawaii Medical Service Association
4. Kansas and Missouri: Greater Kansas City: BlueCross BlueShield of Kansas City
5. Michigan: BlueCross BlueShield of Michigan, Priority Health
6. Montana: BlueCross BlueShield of Montana, Montana Medicaid, PacificSource Health Plans
7. New Jersey: Amerigroup New Jersey, Inc., Horizon BlueCross BlueShield of New Jersey, UnitedHealthcare
8. New York: Hudson Valley Region: Capital District Physicians’ Health Plan, Empire BlueCross BlueShield, MVP Health Plan, Inc.

9. Ohio and Northern Kentucky: Aetna, Anthem, AultCare, Buckeye Health Plan, CareSource, Gateway Health Plan of Ohio, Inc., Medical Mutual of Ohio, Molina Healthcare of Ohio, Inc., Ohio Medicaid, Paramount Health Care, SummaCare, Inc., UnitedHealthcare
10. Oklahoma: Advantage Medicare Plan, BlueCross BlueShield of Oklahoma, CommunityCare HMO, Inc., Oklahoma Medicaid, UnitedHealthcare
11. Oregon: AllCare Health, Inc., ATRIO Health Plans, Inc., CareOregon, Eastern Oregon Coordinated Care Organization, FamilyCare Health, Moda Health Plan, Inc., Oregon Medicaid, PacificSource Health, PrimaryHealth of Josephine County, Providence Health Plan, Tuality Health Alliance, Umpqua Health, Western Oregon Advanced Health, Willamette Valley Community Health Organization, Yamhill Community Care Organization, Inc.
12. Pennsylvania: Greater Philadelphia: Aetna, Independence BlueCross/Keystone Health Plan East
13. Rhode Island: BlueCross BlueShield of Rhode Island, Rhode Island Medicaid, UnitedHealthcare
14. Tennessee: Amerigroup Tennessee, Tennessee Medicaid, United Healthcare, Volunteer State Health Plan

Q: Where will CPC+ Round 2 be implemented?

CPC+ Round 2 regions have not yet been selected. CMS will solicit interested payers early in 2017, and select and announce the Round 2 regions in late spring or early summer 2017. The CPC+ Round 2 regions will be selected based on payer alignment and market density to ensure that practices have sufficient payer support to make fundamental changes in their primary care delivery. CMS will select up to 10 additional regions in CPC+ Round 2.

Q: How does CPC+ Round 2 differ from CPC+ Round 1?

The CPC+ model, including model design and practice eligibility, will be the same in Round 1 and Round 2, with one exception: CMS will randomize eligible Round 2 practice applicants, randomly selecting which practices are chosen to participate in the CPC+ intervention group versus the comparison group. Those practices that are not randomized into the intervention group of CPC+ will be placed in a comparison group, and will not receive the CPC+ payments or participate in the learning communities. The randomized trial design of CPC+ Round 2 will strengthen the evaluation of the model.

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

CMS plans to accept a maximum of 5,500 practices into CPC+ across both Rounds 1 and 2. Once the final number of Round 1 practices has been announced in early 2017, CMS will release the maximum number of CPC+ Round 2 practices.

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

The comparison group practices will not be required to implement the CPC+ care delivery practice changes, will not receive CPC+ Payments, and will not participate in the CPC+ learning communities. Additionally, they will not be considered participants in an Advanced APM through participation in the CPC+ comparison group, but may otherwise be Advanced APM participants through their participation in other CMS models or programs. Comparison group practices will be compensated for their participation in CPC+ evaluation-related activities and may receive favorable scoring under Improvement Activities category of the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program. More details for comparison group practices will be announced in 2017.

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

CPC+ is a voluntary test of primary care payment and delivery system changes at the practice level, and will be independently evaluated throughout the five years of each Round of the model. The study compares practices in each region to similar practices in the same region. CMS is unable to add new practices in the existing regions without potentially compromising the evaluation. Therefore, new

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practices will only be able to apply for participation in CPC+ in new regions to be selected in Round 2, not in the existing 14 Round 1 regions.

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

Practices were only eligible to apply to CPC+ Round 1 if they were located in one of the 14 selected CPC+ regions for that round (see list above). Practices will only be eligible to apply to Round 2 if they are located in one of the Round 2 regions, which have not yet been selected. The purpose of the CPC+ multi-payer design is to ensure that primary care practices receive the adequate support from multiple payers to change care delivery for a practice’s entire panel of patients. The CPC+ regions were carefully selected to ensure adequate payer support for participating practices.

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

Both tracks of CPC+ are included on the list of an Advanced APMs 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 qualify for a five percent APM incentive payment.

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

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

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

Multi-payer engagement is an essential goal of CPC+, as it enables both public and private payers to sponsor comprehensive primary care reform. CMS will partner with payers that share Medicare’s interest in strengthening primary care in each of the CPC+ regions.

Payer partners, both public and private, will provide their own financial support to practices, separate from that of Medicare Fee-for-Services (FFS). Any questions regarding non-Medicare payer support should be directed to the payer partner.

COMPREHENSIVE PRIMARY CARE INITIATIVE AND CPC+

Q: What are the major differences between CPC and CPC+?

CPC+ builds upon the lessons learned from the CPC initiative, CMS’ largest investment in primary care to date. Notable changes for Round 1 of CPC+ include:

	CPC	CPC+ Round 1, Track 1	CPC+ Round 1, Track 2
Size	7 Regions; ≈ 500 practices	14 Regions; ≤2500 practices	14 Regions; ≤2500 practices
Duration	4 years (2012-2016)	5 years (2017-2021)	5 years (2017-2021)
Medicare care management fee^a	\$20 PBPM PY1-2; \$15 PBPM PY3-4; average across 4 risk tiers	\$15 PBPM average across 4 risk tiers	\$28 PBPM average across 5 risk tiers; \$100 for highest-risk tier

	CPC	CPC+ Round 1, Track 1	CPC+ Round 1, Track 2
Medicare payment for office visits	100% FFS	100% FFS	100% FFS for non-evaluation and management; reduced FFS + up-front comprehensive primary care payment for evaluation and management
Medicare incentive payment	Shared savings based on quality metrics and Total cost of care (TCOC) ^b	\$2.50 PBPM performance-based incentive payment based on quality and utilization metrics	\$4 PBPM performance-based incentive payment based on quality and utilization metrics
HIT partners	Not required	Not required	Required

^aPaid only for Medicare FFS beneficiaries attributed to participating practices.

^bSavings calculated based on any reduction in Medicare Part A and B expenditures.

Citation: Sessums LLS, McHugh, SJ, Rajkumar R. Medicare’s vision for advanced primary care: New directions for care delivery and payment. *JAMA*. 2016;315(24):2665-2666.

Q: How does CPC+ impact the prospects of expanding the original CPC initiative?

Though CPC ends in December 2016, CMS will continue to consider all available data from CPC as it becomes available, including shared savings results, quality performance, and the results of the independent evaluation, to determine whether to scale the model in accordance with the statutory requirements for expansion under section 1115A of the Social Security Act.

Q: What were practices’ experiences with the original CPC initiative?

Since 2012, the original CPC initiative has built collaborative relationships between payers, primary care clinicians, and other regional stakeholders in each of its seven regions. These relationships took time to build. Nonetheless, practice and payer involvement has remained remarkably stable into the fourth year of CPC. Nearly 90 percent of practices remain in the model at the start of the fourth year, and only a few small payers are no longer involved in CPC or merged with other participating payers since 2012. Many payers remain engaged in supporting CPC and some have increased their focus on supporting primary care since CPC began.

Additional information regarding practice and payer experience in CPC can be found in the independent evaluation reports:

- o [First Annual Report](#)
- o [Second Annual Report](#)

PAYMENT DESIGN

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

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

CPC+ Care Management Fees

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

In Track 1, practices will also continue to receive regular Medicare fee-for-service payments for covered evaluation and management services. In Track 2 of CPC+, CMS is introducing a hybrid of fee-for-service and Comprehensive Primary Care Payment (CPCP). This hybrid payment will pay for covered evaluation and management (E&M) services, but allows flexibility for the care to be delivered both in and out of an office visit. Track 2 practices will receive a percentage of their expected Medicare E&M payment upfront in the form of a CPCP and a reduced fee-for-service payment for face-to-face E&M claims. In an effort to recognize practice diversity in readiness for this change in payment, CMS will allow practices to move to one of these final two proposed hybrid payment options (40 percent or 65 percent CPCP, paired with 60 percent or 35 percent FFS, respectively), at their preferred pace by 2021, pursuant to the options shown in this table:

CPCP and FFS Options

	2017	2018	2019	2020	2021
CPCP%/FFS% options available to practices, by year	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%

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

CMS will prospectively pay a performance-based incentive payment, which practices may keep if they meet annual performance thresholds. Practices that do not meet the annual thresholds would be required to repay all or a portion of the prepaid amount. Practices will thus be “at risk” for the amounts prepaid. The payment will be broken into two distinct components, both paid prospectively: incentives for performance on clinical quality/patient experience measures and incentives for performance on utilization measures that drive total cost of care. The quality/experience component will be based on performance on electronic clinical quality measures (eCQM) and Consumer Assessment of Healthcare Providers and

Systems (CAHPS) metrics. The utilization component will be based on claims-based outcome measures that are measurable at the practice level, including: inpatient admissions and emergency department visits that are available in the Healthcare Effectiveness Data and Information Set (HEDIS).

CMS will provide larger performance-based incentive payments in Track 2 than in Track 1, as outlined in the following table. However, all practices are at risk for repaying all or a portion of the prepaid amount to CMS depending on their performance. The final methodology for calculating the prepaid amounts and repayment amounts will be outlined in a technical methodology paper, so practices understand the payment mechanism prior to the start of the model.

CPC+ Performance Based Incentive Payment

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

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

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

CPC+ Financial Summary Table

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

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

Yes, CPC+ practices will be required to both forecast their spending of the CPC+ Payments and, at the end of the performance year, provide an accounting of actual CPC+ expenditures. This reporting will help practices understand and optimize their use of these alternative payments and will also help CMS to

understand how practices use the revenue they receive to perform the care delivery work the model requires.

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

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

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

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

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

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

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

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

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

Codes	Short Description	May CPC+ Practices Bill for Attributed Beneficiaries?
99487, 99489	Chronic Care Management	No
G0502-G0504	Collaborative Care Model	Yes

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

CARE DELIVERY DESIGN

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

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

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

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

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

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

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

For a detailed description, please refer to the [Performance Year 1 CPC+ practice care delivery requirements](#).

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

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

QUALITY MEASUREMENT

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

This model aims to improve the quality and experience of care that beneficiaries receive and decrease the total cost of care. To assess quality performance and eligibility for the CPC+ performance-based incentive payment, CMS will require Track 1 and 2 practices to annually report electronic clinical quality measures (eCQMs) and patient experience of care measures (Consumer Assessment of Healthcare Providers & Systems [CAHPS]). eCQMs must be reported at the practice-site level and are specified to include all practice population patients, regardless of payer or insurance status. CAHPS surveys will be administered by CMS or its contractors to patients in practices in Track 1 and Track 2. In future years, Track 2 practices may also use a patient reported outcome measure survey.

The provisional Quality and Utilization Measure Set for CPC+ is available in Appendix D of the [Request for Applications](#). The quality reporting requirements may undergo changes prior to the start of CPC+.

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

CPC+ practitioners may share physical space and an electronic health record (EHR) with other practitioners who do not participate in CPC+. By 2018, all CPC+ practice sites must have functionality to filter electronic clinical quality measure (eCQM) data by the practice site location as well as Taxpayer Identification Number/National Provider Identifier (TIN/NPI). This filtering functionality (C4 certification) will allow practices to include in the measure calculation only patients seen by CPC+ practitioners. The CPC+ practice site level reporting requirement means that any patient who is seen at least one time at the practice during the calendar year by a CPC+ practitioner is eligible to be included in the denominator of a measure. If a patient was only seen by a non-CPC+ practitioner at the practice, the patient will not be included in the denominator of the measure.

HEALTH IT REQUIREMENTS

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

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

- Practices should adopt the certified health IT modules that meet the definition of CEHRT according to the timeline and requirements of the EHR Incentive Programs. Consistent with the EHR Incentive Program practices can use either 2015 Edition or 2014 Edition technology in 2017, but must use only 2015 Edition technology starting in 2018.

Practices in both Tracks 1 and 2 also need to meet certain technology requirements in order to report on required electronic clinical quality measures (eCQMs) under CPC+

- Practices will need to adopt health IT certified to the 45 CFR 170.315 (c)(1) – (c)(3) certification criteria for all of the electronic clinical quality measures in the CPC+ measure set. As with the overall [CEHRT requirements](#), practices should follow the requirements and timeline of the EHR Incentive Program (i.e., practices can use either 2015 Edition or 2014 Edition technology in 2017, but must use only 2015 Edition technology starting in 2018).
- For the CPC+ measures, practices must use the latest annual measure update. For instance, for the 2017 performance period, practices must use the eCQM specifications contained in the 2016 annual update, released in April 2016 (https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html).
- Finally, practices must be able to filter their electronic clinical quality measure data by practice site location and TIN/NPI beginning in 2017. Beginning in 2018, practices will demonstrate their ability to conduct this filtering by adopting 2105 Edition health IT certified to the criterion found at 45 CFR 170.315(c)(4).

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

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

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

In addition to the certified health IT requirements for all practices and the additional certified health IT requirements for Track 2 practices, Track 2 practices are expected to adopt health IT that meets additional enhanced functionality for advanced practices. This functionality is not certified health IT. These requirements can be found at: <https://innovation.cms.gov/Files/x/cpcplus-hit-track2reqs.pdf>.

Q: Can practices apply for Track 2 even if their health IT vendor is not included on the [CPC+ Vendor List](#)?

Yes, the Vendor List is purely voluntary and provided for informational purposes. Practices may indicate support from a vendor regardless of whether they are on the informational list.

Vendors may submit information about their health IT product and contact information to be included in the CPC+ Vendor List. Vendors should email CPCPlus@CMS.HHS.gov with a brief paragraph about their health IT product, the [CPC+ Track 2 advanced health IT functions](#) they support, and their contact information for interested practices.

Vendors with products that support one or more of the advanced health IT functions for Track 2 may also submit a [global vendor letter of support](#) to CPCPlus@CMS.HHS.gov. CMS is providing the letters of support for the convenience of the CPC+ practices. The letter of support is designed to let CMS know that an applicant practice has a plan for meeting the requirements of the model. Please note that the vendor’s business relationship with a practice is solely between the vendor and that practice; it does not include CMS.

CMS does not endorse any health IT vendors or products, and recommends that practices verify product applicability to the advanced health IT requirements in Track 2.

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

Yes. Practices need to meet the health IT requirements listed in the [Request for Applications](#) in order to participate in CPC+. The first requirement states, “Adopt at a minimum, the certified health IT need to meet the certified EHR technology (CEHRT) definition required by the Medicare EHR Incentive Program

at 42 CFR 495.4.” This means that practices may use either a 2014 or 2015 Edition CEHRT in 2017 but must have adopted a 2015 CEHRT by January 2018. Practices do not need to have a Vendor Letter of Support or any other guaranteed support from their primary EHR vendor, as long as this vendor meets the CEHRT requirements.

The other requirements (e.g., electronic clinical quality measure [eCQM] reporting) do not need to be fulfilled solely in the practice’s primary EHR, except for the 45 CFR 170.315 (c)(1) [requirement of “Record and Export”](#). This requirement means that the practice is documenting (recording) the clinical data in their practice CEHRT. Another application or service, such as a third-party registry, can be used to fulfill the 45 CFR 170.315 (c)(2) – (c)(4) certification criteria as long as it is certified for those functions. The practice is responsible for ensuring that the registry meets the 45 CFR 170.315 (c)(2) – (c)(4) certification criteria, and for ensuring that the registry can report the specific eQMs at the CPC+ Practice Site level as required in CPC+.

Q: What is the effect on quality reporting of a practice’s change of EHR while participating in CPC+?

A practice’s change of EHRs after the start of any performance year in CPC+ may affect the practice’s ability to receive a performance-based incentive payment that is based on the reporting of electronic clinical quality measures. After the launch of the model, CMS will provide additional guidance about how practices should approach changing systems to minimize effects on reporting and payment.

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

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

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

Yes, as long as the third party meets the health IT requirements described above.

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

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

Q: Is the practice required to use certified technology for the Track 2 functions where there are no corresponding certification criteria in the 2015 Edition?

No, the Track 2 functions are designed to include capabilities beyond those included in the Office of the National Coordinator (ONC) certification program.

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

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

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

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

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

No, CMS expects that these functions will be developed over the course of the model, with all functions implemented by the beginning of performance year 3 of the model (2019). CMS will provide more detailed information about timelines for specific functions once CPC+ begins in 2017.

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

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

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

Q: Are practices eligible to bill the Medicare Chronic Care Management code (CCM) if they are participating in CPC+?

No, because the CPC+ CMFs are intended to pay for CCM covered services, CPC+ participating practices cannot also bill for the same services using the CCM code under the Physician Fee Schedule. However, CPC+ practices may bill for CCM covered services under the Physician Fee Schedule if those services are provided to a Medicare beneficiary that is not attributed to that practice for purposes of the CPC+ model.

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

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

- CPC+ practices may participate in Model 2 and Model 3 of the Bundled Payments for Care Improvement Initiative and the Oncology Care Model. While they would not be participants themselves, CPC+ practices may also engage in sharing arrangements with participant hospitals in the Comprehensive Care for Joint Replacement Model.
- Medicare beneficiaries may be attributed to both CPC+ and Million Hearts® Cardiovascular Disease Risk Reduction model practices, as cardiovascular interventions can be part of, and complementary to, practice transformation.
 - Despite the recent change to allow Million Hearts model participants to receive payment from both the Chronic Care Management (CCM) fee and the Million Hearts model for the same beneficiary, CPC+ will not allow a CPC+ practice to bill for CCM covered services for an attributed CPC+ beneficiary. However, practices may still get CPC+ and Million Hearts payment for the same beneficiary.
- Because of differences in payment in these two models, CPC+ practices may participate in the Accountable Health Communities (AHC) Model as a bridge organization or be paid through the AHC model by a bridge organization .
- Clinical Practices enrolled in and receiving technical assistance through Transforming Clinical Practice Initiative (TCPI) can apply for CPC+, but, if selected into the CPC+ program, the practice and clinicians must exit or “graduate” from TCPI effective December 31, 2016. A clinician or practice cannot participate in CPC+ and receive technical assistance from TCPI at the same time. Practitioners providing the technical assistance or serving as faculty resources as part of a TCPI Practice Transformation Network or Support and Alignment Network may participate in CPC+.

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

Practices participating in SIM initiatives are invited to participate in CPC+. Eight states receiving SIM Model Test Awards were selected as CPC+ Round 1 regions, and SIM practices in these states were encouraged to apply to the track for which they believed they are eligible.

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

MAPCP practices are invited to participate in CPC+. Four states that participated in MAPCP were selected as CPC+ Round 1 regions, and MAPCP practices in these states were encouraged to apply to the track for which they believed they are eligible.

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

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

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

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

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

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

Q: How will payment change for primary care practices within ACOs that participate in CPC+?

CPC+ payment flows consist of three elements. Changes in these elements to accommodate ACO practices in CPC+ are explained below:

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

amount 10 percent larger than historical billings to support increased comprehensiveness of care. The CPCP will be included in the ACO's total expenditures for shared savings and shared losses calculations.

There will be no changes to the Shared Savings Program ACO financial benchmark calculations. CPC+ payments (CMF and CPCP) for ACO-aligned beneficiaries will be included in the ACO's expenditures for purposes of establishing the financial benchmark and determining performance year expenditures.

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

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

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

Primary care practices within ACOs will be required to implement the CPC+ care delivery model. Practices must also adhere to quality reporting requirements for both CPC+ and the Shared Savings Program.

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

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

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

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

For practices participating in CPC+ and a Shared Savings Program ACO, determinations about the APM incentive payment will be based on their participation in the Shared Savings Program, not CPC+. For practices participating only in CPC+, determinations about the APM incentive payment will be based on their participation in CPC+. Tracks 1 and 2 of CPC+ are included on the list of Advanced APMs posted on the Quality Payment Program website and this determination was based on are medical home model-specific requirements. For 2019 through 2024, clinicians who meet the annual statutory thresholds for sufficient participation in Advanced APMs and who meet requirements, as applicable for 2018 onward,

regarding parent organization size are exempt from MIPS reporting requirements and payment adjustments and will qualify for a five percent APM incentive payment.

PRACTICE APPLICATION

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

Eligible practices within the 14 CPC+ Round 1 regions submitted applications to CMS to participate in CPC+ (August 1 – September 15, 2016). The Round 1 application period has now closed.

For CPC+ Round 2, CMS will solicit applications only from practices within the new regions chosen after the preliminary payer solicitation is complete in late spring or early summer 2017. Practices within the existing 14 CPC+ Round 1 regions are not eligible to apply to CPC+ Round 2. Practices in the Round 2 regions will apply directly to the track for which they are interested and believe they are eligible; however, CMS reserves the right to offer practices entrance into Track 1 if they apply and do not meet the eligibility requirements for Track 2.

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

For the purposes of applying to Round 1 of the CPC+ Model, CMS defined a primary care “practice site” as the single “bricks and mortar” physical location where patients are seen, unless the practice has a satellite office or provides patient care in the home instead of at a practice site. A satellite office is a separate physical location that is a “duplicate” of the applying practice; the satellite shares resources, EHR technology, and practitioners with the original applicant site. Practices with satellite locations are permitted to participate in the CPC+ Model and will be considered one practice in CPC+. Practices that are part of the same health group or system that share some practitioners are generally not considered satellite practices and will be counted as separate practices for the purposes of CPC+. Practices that see all or the majority of their patients in the home are eligible for participation in CPC+ and are expected to meet the same care delivery and EHR technology requirements as office-based practices. Despite not seeing all their patients in a single physical location, practices with satellite locations or who see patients in their home must still use a single address for billing.

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

Q: What is the definition of a primary care practitioner?

In CPC+ Rounds 1 and 2, CMS defines “primary care practitioner” 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.

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

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

Q: Are specialists within a primary care practice considered participating providers in CPC+ Rounds 1 and 2?

No, only primary care practitioners will be considered participants in CPC+. For example, if a multispecialty practice participates in CPC+, CMS will only attribute beneficiaries who are in treatment relationships with the primary care practitioners at the practice. CPC+ is designed to attract those practices offering comprehensive primary care for an entire population of patients. CMS intends to support practices that are predominantly – but not exclusively – composed of primary care practitioners for whom primary care services accounted for at least 40 percent of billing under the Medicare Physician Fee Schedule.

Q: Can practices in the same health system or medical group apply to CPC+ Rounds 1 and 2?

Yes, CMS encourages all practices, including those with the same owner, medical group, or ACO to apply to CPC+. Practices owned by health systems will be required to identify the practice names and TINs of each primary care practice within the system that is applying to CPC+. Each practice owned by a health system must provide a signed letter by system leadership that commits to segregate funds paid as a result of participation in CPC+. More details about selection of affiliated practices is [available below](#).

Q: Can practices in the same health system or medical group join different tracks of CPC+ Rounds 1 and 2?

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

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

In their CPC+ Round 2 applications, practices will have the opportunity to outline their 2016 revenue generated by services provided to patients covered by the payers with whom we expect to partner with in their region. Practices that have approximately 50 percent or more of their current revenue generated from these payers and Medicare will be better positioned to implement the service delivery model and meet the practice requirements. Medicare alone cannot provide the adequate supports that practices need to make significant changes in the way they deliver care, as primary care practices serve patients whose health care is paid for many different insurers.

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

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

Q: Can practices participating in CPC+ share a TIN with another practice or practitioners within their group or organization that are not participating in CPC+?

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

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

Eligible Clinician is the term used for purposes of the Quality Payment Program and encompasses certain types of Medicare suppliers specified in the final rule. Eligible Clinician has the meaning of the term Eligible Professional (EP). EP is defined in [Section 1848\(k\)\(3\)\(b\)](#) and is specific to current Medicare

programs (Physician Quality Reporting System, Value-based Modifier, and Meaningful Use) that, by statute, will sunset at the end of 2018.

PRACTICE ELIGIBILITY

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

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

CPC+ Practice Eligibility Criteria:

Track 1

- Practice structure and ownership requirements, including number of practice sites and practitioners in the organization, practice TINs, participation in Medicare programs and demonstrations, information and NPIs for each primary care practitioner in the practice;
- Use of CEHRT;
- Sufficient percentage of revenue generated by Medicare and CPC+ payer partners;
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities.

Track 2

- Practice structure and ownership requirements, including number of practice sites and practitioners in the organization, practice TINs, participation in Medicare programs and demonstrations, information and NPIs for each primary care practitioner in the practice;
- Use of CEHRT;
- Sufficient percentage of revenue generated by Medicare and CPC+ payer partners;
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities, while also developing and recording care plans, following up with patients after emergency department (ED) or hospital discharge, and implementing a process to link patients to community based resources.
- Letter of support from health IT vendor that outlines the vendor's commitment to support the practice in optimizing health IT.

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

Eligible practitioners are those who have a primary specialty designation of family medicine, internal medicine, or geriatric medicine, and for whom primary care services accounted for at least 40 percent of billing under the Medicare Physician Fee Schedule. Even if pediatric practitioners have those specialty designations, it is unlikely that pediatric practices will be eligible to participate due to the CPC+ requirement that primary care practices must have at least 125 attributed Medicare fee for service beneficiaries to be eligible for this model.

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

No, CPC+ is designed to test payment reform for traditional fee-for-service payment, and the billing 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 (CMS 1500) and are not paid according to the Medicare Physician Fee schedule for office visits, they are not eligible for participation.

Q: Are practices only eligible if they are a certified Patient Centered Medical Home (PCMH)?

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

Track 1

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

Track 2

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

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

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

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

Yes, practices within an IPA are eligible to apply to CPC+. Practices within an IPA must apply separately to participate in CPC+, as CPC+ is a practice-level transformation.

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

Yes, CPC+ participating practices may participate in other programs with private payers.

Q: Are concierge primary care practices eligible to apply?

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

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

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

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

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

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

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

PRACTICE SELECTION

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

First, CMS will screen all practices for program integrity issues. Then, CMS will review all applications to determine if a practice meets the eligibility criteria for the CPC+ track for which they are applying. If a practice is determined not to meet the requirements for Track 2, but also expressed interest in Track 1, CMS will consider the practice's application for Track 1 instead. Next, CMS will review financial information provided by the practice to determine if they meet the threshold for payer support. Practices should have at least approximately 50 percent of their total practice revenue from both Medicare and CPC+ payer partners. Practices must also have a minimum number of Medicare beneficiaries and primary care services must account for a certain percentage of the practices' collective billing. CMS will also evaluate the practice's health IT capabilities and vendor information (Track 2 only) based on information provided by the practice in their application. In CPC+ Round 2, CMS will randomize eligible practices to participate in the intervention group or in the comparison group. CMS will separate eligible practices into their respective tracks and randomize each track separately. CMS will strive to maximize the number of eligible practices that are selected for CPC+ Round 2, while maintaining the rigor of the randomized design.

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

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

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