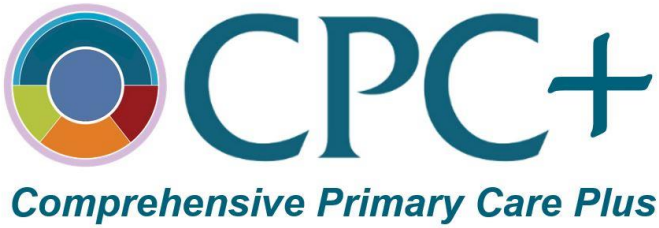

CPC+ PAYMENT AND ATTRIBUTION METHODOLOGIES FOR PROGRAM YEAR 2021

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Acronyms

Acronym	Term
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
AHU	Acute Hospital Utilization
APM	Alternative Payment Model
BAL	Beneficiary Attestation List
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCM	Chronic Care Management
CCN	CMS Certification Number
CCW	Chronic Conditions Warehouse
CF	Conversion Factor
CG	Clinician and Group
CMF	Care Management Fee
CMS	Centers for Medicare & Medicaid Services
CPC	Comprehensive Primary Care
CPC+	Comprehensive Primary Care Plus
CPCP	Comprehensive Primary Care Payment
CY	Calendar Year
DXG	Diagnosis Group
E&M	Evaluation and Management
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
EDU	Emergency Department Utilization
EHR	Electronic Health Record
ESRD	End-Stage Renal Disease
FFS	Fee-for-Service
GPCI	Geographic Price Cost Index
HCC	Hierarchical Condition Categories
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
ICD	International Classification of Diseases
MIPS	Merit-Based Incentive Payment System
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
O/E	Observed-to-Expected
PBIP	Performance-Based Incentive Payment
PBPM	Per-Beneficiary Per-Month
PCF	Primary Care First
PEC	Patient Experience of Care
PFS	Physician Fee Schedule

Acronym	Term
Q1	Quarter 1
Q2	Quarter 2
Q3	Quarter 3
Q4	Quarter 4
QRDA	Quality Reporting Document Architecture
RVU	Relative Value Unit
TIN	Taxpayer Identification Number
VBPM	Value-Based Payment Modifier

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Executive Summary

This Executive Summary provides an overview of the methodologies that the Centers for Medicare & Medicaid Services (CMS) will use for the Comprehensive Primary Care Plus (CPC+) payment model being tested in Medicare fee-for-service (FFS) in Program Year 2021. The Executive Summary and the detailed technical specifications for each of the methodologies are organized as follows:

- Chapter 1 introduces the CPC+ attribution and payment elements.
- Chapter 2 describes the beneficiary attribution.
- Chapter 3 describes the care management fee (CMF).
- Chapter 4 describes the performance-based incentive payment (PBIP).
- Chapter 5 describes payment under the Medicare Physician Fee Schedule (PFS).
- Chapter 6 presents conclusions.

CPC+ payer partners will offer their own payment arrangements, aligned with the CMS CPC+ model, to CPC+ practices.

ES.1 Introduction

CPC+ is a national advanced primary care medical home model, tested under the authority of the Center for Medicare & Medicaid Innovation, that aims to strengthen primary care through multipayer payment reform and care delivery transformation. This five-year model includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. CPC+ aims to improve beneficiaries' health and quality of care and decrease total cost of care. To this end, CPC+ offers three payment elements to support and incentivize practices to better manage beneficiaries' health and provide a higher quality of care. The payment designs vary slightly for Track 1 and Track 2 CPC+ practices. The three payment elements are the same for 2017 Starters and 2018 Starters.

This methodology paper explains the attribution methodology, the technical specifications used to identify the Medicare FFS beneficiaries for whom participating primary care practices are responsible. The paper also includes detailed specifications for the following three elements of CPC+ payments:

1. **Care management fee (CMF).** CMF is a non-visit-based fee paid to both Track 1 and Track 2 practices quarterly. The amount of CMF is determined by (1) the number of beneficiaries attributed to a given practice per month; (2) the case mix of the attributed beneficiary population; and (3) the CPC+ track to which the practice belongs. Practices serving a greater number of high-risk beneficiaries are expected to provide more intensive care management and practice support. Thus, the CMF amount is risk adjusted to reflect the attributed population's risk level. Track 2 practices will receive a higher CMF for beneficiaries with complex needs.

2. **Performance-based incentive payment (PBIP).** CPC+ pays the PBIP prospectively. After each Program Year ends, CPC+ retrospectively reconciles the amount of PBIP that a practice earned. Earnings are based on how well the practice performed on patient experience of care measure, clinical quality measures, and utilization measures that drive total cost of care. Practices will either keep their entire PBIP, repay a portion, or repay all of it. The full amount of PBIP that is prospectively paid is determined by (1) the number of beneficiaries attributed to a given practice in Quarter 1 (Q1) and (2) the CPC+ track to which the practice belongs. The PBIP amount earned in a Program Year is determined by (1) the number of beneficiaries attributed to a given practice in Q1; (2) the CPC+ track to which the practice belongs; and (3) the practice's performance on the measures listed above. PBIP is calculated separately for the Quality (including patient experience of care and clinical quality measures) and Utilization Components.
3. **Payment under the Medicare PFS.**
    a. Track 1 practices continue to bill and receive payment from Medicare FFS as usual.
    b. Track 2 practices receive a hybrid payment, meaning they are prospectively paid Comprehensive Primary Care Payments (CPCPs) with reduced FFS payments. CPCP is a lump sum, quarterly payment based on historical FFS payment amounts for selected primary care services. Track 2 practices continue to bill as usual, and the FFS payment amount is reduced proportionally to offset the CPCP. The CPCP amounts are larger than the historical FFS payment amounts they are intended to replace because Track 2 practices are expected to increase the breadth and depth of services they offer.

Practices' eligibility to receive each of these three payment types depends on their CPC+ tracks, as summarized in Table ES-1.

Table ES-1
CPC+ Payment Summary

Track	CMFs	PBIP	Medicare PFS
1	$15 average per-beneficiary per-month (PBPM)	$1.25 PBPM for quality/patient experience of care and $1.25 PBPM for utilization performance	Regular FFS
2	$28 average PBPM, including $100 PBPM to support patients with complex needs	$2 PBPM for quality/patient experience of care and $2 PBPM for utilization performance	Hybrid payment: Reduced FFS with a prospective CPCP

ES.2 Chapter 2: Beneficiary Attribution

Collectively, CPC+ payments from Medicare, Medicaid, and commercial payer partners are intended to support practice-wide transformation for all patients at the practice, regardless of insurance type. As such, CPC+ Medicare attribution is the mechanism for determining the

approximate size and acuity of the Medicare FFS population receiving regular continuous care within the CPC+ practice. This chapter describes the methodology for attributing Medicare beneficiaries to CPC+ practices. CPC+ uses a prospective attribution methodology to identify the Medicare FFS beneficiaries in CPC+ practices. CMS conducts beneficiary attribution on a quarterly basis and uses the attribution for CMF, PBIP, and CPCP payment calculation as well as to identify beneficiaries for FFS claims reductions (i.e., hybrid payment). CMS sends each practice a list of prospectively attributed beneficiaries within the first month of the payment quarter. Though Medicare beneficiaries are attributed to a practice, beneficiaries remain free to select the practitioners and services of their choice and continue to be responsible for all applicable beneficiary cost-sharing.

The attribution process uses multiple steps to assign beneficiaries to practices. Using Medicare administrative data, we first identify Medicare FFS beneficiaries eligible for attribution.

Once beneficiaries are identified, CMS prioritizes beneficiary choice in CPC+ attribution by using a process called voluntary alignment. Voluntary alignment—also known as beneficiary attestation—refers to a process by which beneficiaries specify the health care practitioner and practice that they consider to be responsible for providing and coordinating their health care. Although any beneficiary with an account on MyMedicare.gov can make an attestation, only attestations by eligible beneficiaries will be considered for attribution.

Eligible beneficiaries not attributed using voluntary alignment will be attributed using claims-based attribution. We examine the most recent 24-month historical (or "lookback") period in Medicare claims data to determine which practice to attribute eligible beneficiaries to. Claims-based attribution is first based on chronic care management (CCM)–related services, then on Annual Wellness Visits and Welcome to Medicare Visits, and then on the plurality of eligible primary care visits within the 24-month lookback period.

Below is an overview of how CMS determines beneficiary eligibility for CPC+ and CPC+ attribution steps:

1. Eligible Beneficiaries—To be eligible for attribution to a CPC+ practice in a given quarter, beneficiaries must meet several criteria before the start of the quarter.

Beneficiaries must (1) be enrolled in Medicare Parts A and B; (2) have Medicare as primary payer; (3) not have end-stage renal disease (ESRD);[1] (4) not be enrolled in hospice;[1] (5) not be covered under a Medicare Advantage or other Medicare health plan; (6) not be long-term institutionalized; (7) not be incarcerated; (8) be alive; and (9) not be aligned or attributed to an entity participating in any other CMS coordinated care initiative including those with a Medicare FFS shared savings opportunity or CMMI Alternative Payment Model, except for the Medicare Shared Savings Program.

[1] Note that this criterion only applies to beneficiaries who have not been attributed to a CPC+ practice previously. If the beneficiary has been attributed to a CPC+ practice previously, then developing ESRD or enrolling in hospice does not disqualify a beneficiary from being attributed to a CPC+ practice.

2a. Voluntary Alignment: Beneficiary Attestation—Via MyMedicare.gov, beneficiaries can attest to the health care practitioner and practice that they consider to be responsible for providing and coordinating their health care.

Any beneficiary with an account on MyMedicare.gov can make an attestation. However, if beneficiary eligibility requirements are not met, the beneficiary is not eligible for voluntary alignment or claims-based attribution. If all beneficiary eligibility requirements are met, CMS will also confirm that the attested practitioner and practice meet attestation eligibility requirements.

2b. Voluntary Alignment: Eligible Practitioners and Practices—If eligible beneficiaries make attestations, the attested practitioner and practice must meet certain requirements for the beneficiary's attestation to be used.

For practitioners participating at a CPC+ practice site, the attested practitioner must be active at the CPC+ practice site for the given quarter and listed on the practice's practitioner roster. In addition, the attested practitioner's CPC+ practice must have signed and returned the Mutual Amendment to the CPC+ Participation Agreement on voluntary alignment. For practitioners at a non-CPC+ practice site, the attested practitioner must have a primary care specialty code. If these practitioner attestation eligibility requirements are met, the beneficiary's attestation is used to attribute the beneficiary via voluntary alignment. If these requirements are not met (e.g., a practitioner was previously listed on the practitioner roster but is no longer active or a practitioner is participating in a CPC+ practice that did not sign and return the Mutual Amendment), the beneficiary is attributed using the claims-based attribution process.

3. Claims-Based Attribution—For eligible beneficiaries not attributed via voluntary alignment, the CPC+ claims-based attribution algorithm is applied.

Eligible beneficiaries not attributed by voluntary alignment are attributed via a pool of eligible Medicare claims during a 24-month lookback period. The attribution lookback period is the 24-month period ending three months before the start of the attribution quarter. For example, CMS will use claims from October 2018 through September 2020 to attribute beneficiaries to CPC+ practices for the first quarter of 2021. The lookback periods that will be used for the 2021 CPC+ quarterly attributions are listed in Table ES-2.

Table ES-2
Lookback Periods for 2021 Quarterly Beneficiary Attribution

Attribution Quarter	Lookback Period
2021 Q1	October 2018–September 2020
2021 Q2	January 2019–December 2020
2021 Q3	April 2019–March 2021
2021 Q4	July 2019–June 2021

Eligible beneficiaries who are not voluntarily aligned and have at least one eligible primary care visit in the lookback period are attributed to practices first based on CCM-related services, then on Annual Wellness Visits and Welcome to Medicare Visits, and then on the plurality of eligible primary care visits. To be eligible for beneficiary attribution for non-CCM-related services, a practitioner must either be active in a CPC+ practice or have a primary care specialty code. CCM-related services do not have a specialty code restriction. Please review Table 2-3 for specific information about eligible codes.

ES.3 Chapter 3: Care Management Fees

This chapter describes the CMF, which practices use to support augmented staffing and training related to non-visit-based and historically nonbillable services that align with the transformation aims of CPC+ care delivery. These include activities to improve care coordination, implement data-driven quality improvement, and enhance targeted care management for beneficiaries identified as high risk.

- CMS assigns beneficiaries to regional risk tiers to determine the CMF payment amount.

All Medicare FFS beneficiaries attributed to a CPC+ practice will be assigned to one of four risk tiers for Track 1 CPC+ practices or one of five risk tiers for Track 2 CPC+ practices (shown in Table ES-3).

Each risk tier corresponds to a monthly CMF payment. Higher risk tiers are associated with higher beneficiary risk, as determined by the CMS Hierarchical Condition Categories (CMS-HCC) risk score, and higher CMFs.

Table ES-3
Risk Tier Criteria and CMF Payments (PBPM)

Risk Tier	Risk Score Criteria	Track 1	Track 2
Tier 1	Risk score < 25th percentile	$6	$9
Tier 2	25th percentile ≤ risk score < 50th percentile	$8	$11
Tier 3	50th percentile ≤ risk score < 75th percentile	$16	$19
Tier 4	Track 1: Risk score ≥ 75th percentile Track 2: 75th percentile ≤ risk score < 90th percentile	$30	$33
Tier 5 (Track 2 only)	Risk score ≥ 90th percentile *or* Dementia diagnosis	N/A	$100

- Beneficiary risk score is based on the CMS-HCC risk adjustment model.

The CMS-HCC model is a prospective risk adjustment model that predicts medical expenditures in a given year based on demographics and diagnoses from the prior year.[2]

For each quarter, the risk tier threshold for each region is based on the most current available risk scores. Risk scores are collected for all beneficiaries who are attributed to a participating CPC+ practice each quarter, and risk tier assignment will be based on the most current available risk scores.

- Risk tier assignment is based on a regional reference population.

Risk scores for attributed CPC+ beneficiaries are compared with the risk scores for all Medicare FFS beneficiaries in the same region who meet CPC+ eligibility requirements.

A beneficiary is assigned to a risk tier on the basis of where their risk score falls within the regional distribution, as shown in Table ES-3.

- Track 2 CPC+ practices receive a higher CMF for beneficiaries assigned to an additional complex risk tier.

For Track 2 practices, CMS pays up to a $100 per-beneficiary per-month (PBPM) CMF to support the enhanced services that beneficiaries with complex needs require.

Complex beneficiaries who fall within the top 10 percent of the risk score distribution or those who, based on Medicare claims, have a diagnosis of dementia are assigned to the highest risk tier.

We include beneficiaries with dementia to account for the omission of dementia diagnoses in the CMS-HCC algorithm and to account for the higher level of care coordination these beneficiaries require.

- Quarterly, CMS debits the CMF paid to correct for overpayments or duplicate payments.

The first type of retrospective debit is to account for prior CMF overpayments.

In each quarterly payment cycle (beginning with the second quarter of the model), CMS determines whether a beneficiary lost eligibility during any prior quarters and computes a deduction from the forthcoming quarter's payment to reflect previous overpayments.

The second type of debit addresses duplication of services covered by CPC+ CMFs and the Medicare CCM-related services.[3]

Per the CPC+ Participation Agreement, for attributed beneficiaries for a given quarter, CPC+ practices will not receive payment for CCM-related services furnished in that quarter to any attributed CPC+ beneficiary.

If a CPC+ practitioner bills a CCM-related service for a beneficiary attributed to his or her CPC+ practice in the same month, CMS recoups the Medicare payment for the CCM-related service.

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[2] For more information about the risk adjustment model, see https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RTC-Dec2018.pdf.

[3] CPC+ practices may not bill the following CCM-related services (or corresponding add-on codes) for their attributed beneficiaries: Healthcare Common Procedure Coding System (HCPCS) codes 99358, 99484, 99487, 99490, 99491, G0506, and G0507. CPC+ practices may bill these services for beneficiaries not attributed to them.

If a practitioner *not at the beneficiary's attributed CPC+ practice* bills a CCM-related service for a beneficiary attributed to a CPC+ practice in the same month, CMS debits the CMF paid for that month from the CPC+ practice's future CMF payment.

ES.4 Chapter 4: Performance-Based Incentive Payment

This chapter describes CMS' approach and technical methodology for the CPC+ PBIP in Program Year 2021. To encourage and reward accountability for clinical quality, patient experience of care, and utilization measures that affect total cost of care, practices receive a prospective incentive payment and are allowed to keep all, or a portion of these funds, based on performance against national benchmarks. Practices are thus "at risk" for the amounts prepaid, and CMS recoups unearned payments. Practices participating in both CPC+ and in a Medicare Shared Savings Program Accountable Care Organization (ACO) are referred to as **dual practices** and do not receive a PBIP. Instead, they are eligible to earn shared savings under the ACO's arrangement with the Medicare Shared Savings Program. CPC+ practices not jointly participating in a Medicare Shared Savings Program ACO are also known as **standard practices** and are eligible for PBIP.

The PBIP has four key principles:

1. CMS prospectively pays practices incentives for quality and utilization.

There are two components of performance: quality (including patient experience of care and clinical quality) and utilization.

CMS pays both components prospectively and reconciles them retrospectively, based on practice performance, the following year when performance results become available.

2. CMS measures quality via Patient Experience of Care (PEC) surveys and electronic Clinical Quality Measures (eCQMs).

CMS uses questions from the Consumer Assessment of Healthcare Providers and Systems Clinician and Group (CG-CAHPS) Survey and the Patient-Centered Medical Home Survey Supplement in the CPC+ PEC survey. Dual practices, or those participating in both the Medicare Shared Savings Program and CPC+, are not sampled for the survey. CMS surveys a representative population of each standard practice's patients, including non-Medicare FFS patients. Standard CPC+ practices must provide an all-patient roster, regardless of insurance type, to CMS when requested. Standard CPC+ practices that fail to provide a patient roster do not receive a PEC Summary Score and do not qualify to retain the Quality Component or the Utilization Component of the PBIP. Additional actions up to and including withholding CPC+ payments and/or termination of the CPC+ practice's Participation Agreement may also be considered as a consequence of failing to provide a valid patient roster during the submission period.

CMS assesses eCQMs in accordance with measure specifications, which include all practice patients.

In 2021, all practices (including those in a Shared Savings Program ACO) must successfully report both CPC+ eCQMs in a manner consistent with CPC+ reporting requirements.

3. CMS measures utilization via acute hospital utilization (AHU) and emergency department utilization (EDU).

Acute hospital admissions and emergency department (ED) visits are significant drivers of total cost of care. Therefore, CMS measures risk-adjusted acute hospital admissions and ED visits for attributed Medicare FFS beneficiaries in the CPC+ practice. Practices are not responsible for calculating or reporting the utilization measures. CMS uses claims to calculate these measures at the CPC+ practice level.

4. To retain the incentive payments, practices must meet performance thresholds.

After the Program Year ends, CMS assesses practices' performance. Performance thresholds are the same for both Track 1 and Track 2 practices.

Quality and Utilization Components are scored and financially reconciled separately.

Practices are compared with national performance benchmark thresholds available before the start of the Program Year.

In general, the amount of incentive payment a practice retains is calculated along a continuous scale with a minimum and a maximum benchmark for each measure. Practices that score below the minimum are ineligible to keep the incentive, and practices that meet or exceed the maximum earn the entire incentive.

The amount of PBIP earned is then aggregated across each individual measure for which a practice is eligible to keep payment.

ES.5 Chapter 5: Payment Under the Medicare Physician Fee Schedule

This chapter describes the up-front CPCPs and corresponding FFS claims reduction, together termed the "hybrid payment," for CPC+ Track 2 practices in Program Year 2021. CPC+ Track 1 will continue to bill and receive payment from Medicare FFS as usual. The hybrid payment has six key principles:

1. The hybrid payment is designed to promote flexibility in support of comprehensive care.

The CPCP compensates practitioners for clinical services that have been traditionally billable but offers flexibility for these services to be delivered inside or outside of an office visit. CMS' goal is to achieve financial incentive neutrality, not to financially influence a practice's decision on whether to deliver a service in person or via another modality. That way, the care can be delivered according to beneficiary preferences.

The flexibility is intended to allow more time to be devoted to increasing the breadth and depth of services provided at practice sites and for population health improvement.

The CPCP is an up-front payment for a percentage of expected Medicare payments for evaluation and management (E&M) services provided through the Medicare PFS to attributed beneficiaries. E&M visits billed during the Program Year are correspondingly decreased. All other services are paid according to the Medicare PFS and are not included in the CPCP.

2. Practices choose their hybrid payment ratio.

Practices select a hybrid payment option each Program Year. In Program Year 2021, all practices were required to select between 40 percent CPCP/60 percent FFS or 65 percent CPCP/35 percent FFS.[4]

Practices select the percentage they wish to receive up front in their CPCPs before the beginning of each Program Year and cannot change their selection midyear. Practices that do not make a CPCP selection for 2021 will continue to receive their 2020 CPCP percentage.

CMS implements the CPCP and corresponding FFS reductions (described below) simultaneously. Practices receive their CPCP quarterly.

3. CMS uses claims history to determine the expected payment for E&M services. CMS uses claims for two years for beneficiaries attributed to the CPC+ practice to calculate historical PBPM revenue. The two-year historical claims period differs for 2017 and 2018 Starters. For 2017 Starters, for Program Year 2021 claims from mid-2014 through mid-2016 will be used. For 2018 Starters, for Program Year 2021 claims from mid-2015 through mid-2017 will be used. CMS uses claims for E&M office visits for both new and established beneficiaries using the following Healthcare Common Procedure Coding System (HCPCS) codes (Table ES-4):

Table ES-4
Office Visit E&M HCPCS Codes and Descriptions

HCPCS Code	Description
99201[a] –99205	Office or other outpatient visit for new patient
99211–99215	Office or other outpatient visit for established patient
99354–99355	Prolonged care for outpatient visit

[a] Effective January 1, 2021, CMS will no longer cover HCPCS code 99201 under the Medicare PFS. However, this code will continue to be used for attribution or payment purposes, when historical claims analysis includes periods before 2021, during which this code was in use.

The CPCP must also account for any adjustments that practices are eligible for under the Merit-based Incentive Payment System (MIPS). Practices participating in CPC+ are generally exempt from MIPS because of their participation in an Advanced Alternative Payment Model. However, there are some exceptions. For example, practices concurrently participating in the Medicare Shared Savings Program may be eligible for MIPS adjustments, and CPCPs must therefore be adjusted accordingly.

To account for the increased depth and breadth of primary care required of Track 2 practices, CMS inflates each practice's historical annual PBPM by 10 percent before

[4] All 2017 Starters were required to reach 40 percent CPCP/60 percent FFS or 65 percent CPCP/35 percent FFS by 2019, and 2018 Starters were required to reach one of these goals by 2020.

determining the CPCP amounts. CMS also adjusts the inflated calculation year PBPM to reflect 2021 Medicare prices.[5]

CMS pays the CPCP each quarter according to the following calculation: CPCP each quarter = PBPM in 2021 prices * MIPS Adjustment (if applicable) * CPCP% Option * Number of Attributed Beneficiaries for the Quarter * 3 months.

4. Practices bill office visit E&Ms as normal and are paid at a reduced rate.

Office visit E&Ms require the submission of a claim and beneficiary cost-sharing.

When a claim is submitted for an office visit E&M, CMS pays CPC+ practices at a reduced rate, commensurate with their previously selected up-front CPCP.

For office visit E&Ms, typical cost-sharing requirements for beneficiaries are still in place. The model exempts beneficiaries from being responsible for co-insurance for non-office-visit care funded through the CPCP.

CMS reduces the claim only when there is an office visit E&M service by a CPC+ practitioner for an attributed beneficiary.

5. To correct for overpayments in prospectively paid CPCPs that are later determined to be overpayments due to a loss of beneficiary eligibility, CMS debits the CPCP quarterly.

This retrospective debit is to account for prior prospective CPCPs that are later determined to be overpayments caused by a loss of eligibility.

In each quarterly payment cycle, CMS determines whether a beneficiary lost eligibility during any prior quarters and computes a deduction from the forthcoming quarter's payment to reflect previous overpayments.

6. CMS conducts an annual outside-of-practice partial reconciliation on the CPCP. For all Track 2 practices (both 2017 and 2018 Starters), Program Year 2019 partial reconciliation will be applied to CPCPs beginning in 2021.[6]

CMS is performing the partial reconciliation to (1) protect CMS against paying more-than-expected amounts for office visit E&M services for CPC-attributed beneficiaries; (2) protect practices in specifically defined situations from financial risk from the hybrid payment (risks not present with pure FFS); and (3) maintain incentive neutrality for practices. We expect a small minority of CPC+ practices to be subject to partial reconciliation. If more than a small minority require reconciliation, we may adjust this methodology to protect against undue burden on practices.

Outside-of-practice partial reconciliation is to account for the difference between (1) historical year PBPM revenue and (2) current Program Year PBPM revenue for office visit E&M services for attributed beneficiaries from primary care practitioners delivered outside the CPC+ practice.

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[5] HCPCS Code 99201 has been retired and consolidated with 99202, effective January 1, 2021. Claims for 99201 from the historical period continue to be included, inflated to 2021 payment rates for 99202.

[6] Beginning in 2019, the outside-of-practice partial reconciliation calculated for Program Year 2017 was applied to CPCPs for 2017 Starters only. Thus, partial reconciliation in 2019 only affected 2017 Starters who received a CPCP in 2017. Partial reconciliation in 2020 affected all practices (both 2017 and 2018 Starters) that received a CPCP in 2018.

ES.6 Conclusions

CPC+ payment system redesign aims to ensure that practices have the infrastructure to improve quality, access, and efficiency of primary care. With the combination of CMF, PBIP, and Medicare FFS payment (regular FFS for Track 1 or hybrid payment for Track 2), CMS provides strong financial support to practices to expand the breadth and depth of the services they provide to better meet the needs of their beneficiary population.

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Chapter 1: Introduction

This document describes the Centers for Medicare & Medicaid Services (CMS) approach and technical methodology for payment design in **Comprehensive Primary Care Plus (CPC+)** Program Year 2021. CPC+ payment design aims to ensure that practices have the infrastructure to deliver better care at lower costs. This chapter provides an overview for elements of CPC+ payment design. Chapter 2 describes the technical methodology used to determine **attribution** for Medicare **fee-for-service (FFS)** beneficiaries at CPC+ practices. Chapter 3 describes the technical methodology on **care management fees (CMFs)**, which supports CPC+ practices to provide "wrap-around" primary care services. Chapter 4 describes the technical methodology of the **performance-based incentive payment (PBIP)**, which rewards CPC+ practices for high quality of care, patient experience of care, and reduction in unnecessary utilization. Chapter 5 describes the CPC+ Track 2 practice **hybrid payment** technical methodology, intended to promote flexibility in support of comprehensive care. Note that terms are introduced and defined throughout the document; Appendix A is a glossary of these terms, for easy reference.

1.1 CPC+ Payment Design Overview

CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through multipayer payment reform and care delivery transformation. This five-year model includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. CPC+ aims to improve patients' health and quality of care and decrease total cost of care. To this end, CPC+ offers three payment elements to support and incentivize practices to better manage patients' health and provide higher quality care: CMFs, PBIPs, and hybrid payments. CMFs and PBIPs are available to CPC+ practices in both tracks, whereas hybrid payments are only for Track 2 practices. The CMF and PBIP designs vary slightly for **Track 1** and **Track 2** CPC+ practices. The three alternative payment elements are the same for **2017 Starters** and **2018 Starters**.

CMS uses Medicare claims to conduct beneficiary attribution and a prospective beneficiary assignment methodology to identify CPC+ practices' populations of Medicare FFS beneficiaries. The Medicare beneficiary attribution is the basis for the three elements of payment designs. CMS uses attribution to calculate the amount of CMFs, PBIPs, and, for Track 2 practices, the hybrid payment. Detailed specifications for the attribution methodology are in Chapter 2.

1.2 CPC+ Payment Elements

CPC+ offers alternative payment elements to support and incentivize practices to better manage patients' health and to provide higher quality of care. Elements include the following:

CMF: CMS provides the CMF to CPC+ practices to support them in the expectation that CPC+ practices provide wrap-around primary care services. CMF is a prospective non-visit-based fee

paid to CPC+ practices quarterly. The CMF amount is determined by (1) the number of beneficiaries attributed to a given practice per month; (2) the case mix of the attributed beneficiary population; and (3) the CPC+ practice track. Practices that serve a greater volume of high-risk beneficiaries are expected to provide more intensive care management and practice support; thus, the CMF amount is risk adjusted to reflect the practice's attributed beneficiary population case mix. Track 2 practices receive a higher CMF for beneficiaries with complex needs. Detailed specifications for CMF methodology and calculation are in Chapter 3.

PBIP: CMS offers CPC+ practices a PBIP to encourage and reward accountability for patient experience of care, clinical quality, and utilization measures that drive total cost of care. CMS prospectively pays the PBIP. After each Program Year ends, CMS retrospectively reconciles the amount of PBIP that a practice earned on the basis of how well the practice performed on patient experience of care measures, clinical quality measures, and utilization measures that drive total cost of care. The amount of PBIP earned is determined by (1) the number of beneficiaries attributed to a given practice in Quarter 1 (Q1), which is intended to approximate the total attributed beneficiaries for the calendar year; (2) the practice's CPC+ track; and (3) the practice's performance on the above-listed measures. PBIP is paid separately for quality measures (including clinical quality and patient experience of care) and for utilization measures. Track 2 practices receive a higher per-beneficiary per-month (PBPM) payment. Detailed specifications for PBIP methodology and calculation are in Chapter 4.

Payment under the Medicare Physician Fee Schedule (PFS): CMS pays Track 1 practices under regular **Medicare PFS** and pays Track 2 practices under the hybrid payment to promote flexibility in support of comprehensive care.

- Track 1 practices continue to bill and receive payment from Medicare FFS as usual.
- Track 2 practices are prospectively paid **Comprehensive Primary Care Payments (CPCPs)** with a reduced FFS payment. The CPCP is a lump sum quarterly payment based on historical FFS payment. Track 2 practices continue to bill as usual, but the FFS payment amount is reduced to account for the CPCP. The CPCP amounts are expected to be larger than the historical FFS payment amounts they are intended to replace, as Track 2 practices are expected to increasingly provide services that are not billable to Medicare. Detailed specifications for hybrid payment methodology and calculation are in Chapter 5.

Table 1-1 summarizes the CPC+ payment design for Track 1 and 2 practices. The payment design is the same for 2017 Starters and 2018 Starters.

The CPC+ payment system redesign is aimed to ensure practices have the infrastructure to deliver better care at lower costs. With the combination of CMF, PBIP, and Medicare FFS payment (regular FFS for Track 1 or hybrid payment for Track 2), CMS financially supports practices to expand the breadth and depth of the services they provide to better meet the needs of their beneficiary population.

Table 1-1
CPC+ Payment Summary

Track	CMFs	PBIP	Medicare PFS
1	$15 average PBPM	$1.25 PBPM for quality/patient experience of care and $1.25 PBPM for utilization performance	Regular FFS
2	$28 average PBPM, including $100 PBPM to support patients with complex needs	$2 PBPM for quality/patient experience of care and $2 PBPM for utilization performance	Reduced FFS with a prospective CPCP

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Chapter 2: Beneficiary Attribution

This chapter describes the purpose and methodology for attributing beneficiaries to CPC+ practices. In CPC+, attribution is used for the following purposes:

- To calculate quarterly CMF payments
- To calculate the annual PBIPs
- To calculate quarterly CPCPs and perform FFS claims reductions for Track 2 practices[7]

After an overview of attribution in Section 2.1, Section 2.2 defines **CPC+-eligible beneficiaries** for beneficiary attribution. Section 2.3 describes the first step in the attribution process: voluntary alignment. Section 2.4 describes the claims-based attribution process for any beneficiaries not attributed in the voluntary alignment step of attribution. Lastly, Section 2.5 discusses interactions with other CMS programs and models, including the **Medicare Shared Savings Program** and Primary Care First (PCF).[8] The methodologies for calculating the quarterly CMF payments, the annual PBIP payments, and, for Track 2 practices, the quarterly CPCPs are located in Chapters 3, 4, and 5, respectively.

2.1 Attribution

Attribution is a tool used to assign beneficiaries to primary care practices. Beneficiaries can be assigned to either CPC+ practices or non-CPC+ practices (or non-CPC+ practitioners). We use attribution to calculate the amount of CMFs, PBIPs, and, for Track 2 practices, the hybrid payments.

CMS prioritizes beneficiary choice in CPC+ attribution by placing voluntary alignment as the initial step in attribution. **Voluntary alignment**—also known as beneficiary attestation—is a process by which beneficiaries specify the health care practitioner and practice that they consider to be responsible for providing and coordinating their health care. CPC+-eligible beneficiaries not attributed in this step are attributed using claims-based attribution.

Attribution methodologies commonly consider (1) what unit (e.g., practice, practitioner) a beneficiary is assigned to; (2) how the beneficiary is assigned; (3) the period of the assignment; and (4) how often the assignment is made:

- **Unit of assignment.** Because CPC+ is a test of practice-level transformation and payment, CMS attributes beneficiaries to the CPC+ practice site, rather than individual practitioners, for both voluntary alignment and claims-based attribution. A CPC+ practice

[7] Beneficiary attribution is also used to calculate historical evaluation and management payments, which the CPCP calculation is based on. See Chapter 5 for details.

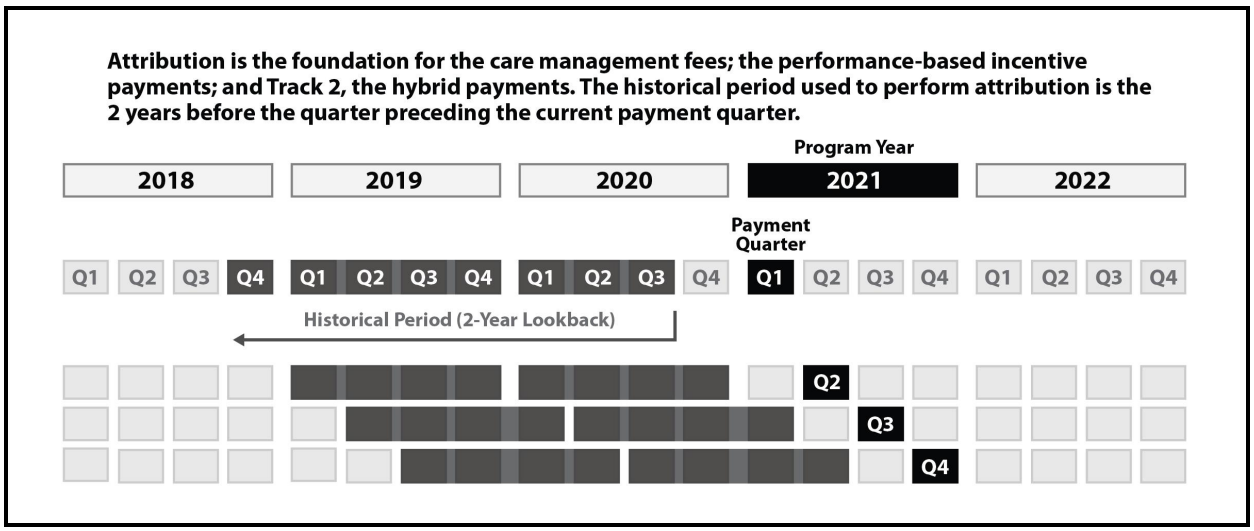
[8] PCF is a five-year, voluntary payment model aiming to support the delivery and transformation of advanced primary care. The model will be offered in 26 regions and begin in 2021.

site is composed of a unique grouping of practitioners and billing numbers (described in more detail in Section 2.3.3.1) at a single "bricks and mortar" physical location.[9]

- **How the beneficiary is assigned.** For voluntary alignment, a beneficiary must first register for MyMedicare.gov. Once registered, a beneficiary can attest to a practitioner and practice (referred to below as the "attested practitioner" and the "attested practice"). If both the beneficiary and practitioner are eligible for CPC+ voluntary alignment, we use the attestation to attribute the beneficiary. However, if a CPC+-eligible beneficiary is not attributed during the voluntary alignment step of attribution, the beneficiary is attributed using claims-based attribution, in which we use Medicare claims to attribute beneficiaries to a practice by recency of chronic care management (CCM) services, recency of Annual Wellness or Welcome to Medicare Visit, or by plurality of eligible primary care visits for that beneficiary.
- **Period of assignment.** Because CMS pays practices to support the CPC+ care delivery model, practices are paid prospectively (i.e., in advance) so that they may make investments consistent with the aims of CPC+. To pay practices prospectively, CMS uses historical data to perform attribution before each payment quarter (Figure 2-1). CMS uses beneficiaries' attestations made by the end of the lookback period or beneficiaries' visits to primary care practices; the latter are obtained through claims during the lookback period.
- **How often the assignment is made.** Because the intent of assignment is to accurately estimate the number of beneficiaries in a CPC+ practice for purposes of calculating quarterly payments, CPC+ performs prospective attribution each quarter.

[9] The exceptions are practices providing care in the home instead of at a practice site and practices with satellite locations. Practices with satellite locations are considered one practice in CPC+. A satellite office is a separate physical location that acts as an extension of the main practice site; the satellite has the same management, resources, and certified electronic health record technology, and has identical practitioners as the main practice site. Practices that are part of the same health group or system and share some practitioners or staff are not considered satellite practices in CPC+.

Figure 2-1
What Is a Lookback Period?



2.2 *Eligible Beneficiaries*

To be eligible for CPC+ voluntary alignment and claims-based attribution in a given quarter, beneficiaries must meet the following criteria with the most recent month's data available:

- Be enrolled in both Medicare Parts A and B
- Have Medicare as their primary payer
- Not have end-stage renal disease (ESRD)[10]
- Not be enrolled in hospice[10]
- Not be covered under a Medicare Advantage or other Medicare health plan
- Not be long-term institutionalized
- Not be incarcerated
- Be alive
- Not be aligned or attributed to an entity participating in any other CMS coordinated care initiative, including those with a Medicare FFS shared savings opportunity or CMMI Alternative Payment Model, except for the Medicare Shared Savings Program (see further details in Section 2.5).[11]

Most of these criteria are verified using the Medicare Enrollment Database. CMS verifies institutional status using Medicare Skilled Nursing Facility Assessment data, known as the

[10] Note that this criterion only applies to beneficiaries who have not been attributed to a CPC+ practice previously. If the beneficiary has been attributed to a CPC+ practice previously, then developing ESRD or enrolling in hospice does not disqualify a beneficiary from being attributed to a CPC+ practice.

[11] Note that this criterion does not apply to beneficiaries who have been aligned to the Medicare Shared Savings Program and are eligible for CPC+ attribution to a "dual participant" that is participating in both CPC+ and the Shared Savings Program.

Minimum Data Set; CMS identifies beneficiaries as institutionalized if they have ever had a quarterly or annual assessment. CMS determines attribution to other Medicare programs and models using Medicare's Master Data Management system.

CMS analyzes eligibility using the most recent month of data available before the quarter. Beneficiaries are deemed CPC+ eligible as of the first day of that month. For example, CPC+-eligible beneficiaries must meet all eligibility criteria on December 1, 2020, to be eligible for attribution in the first quarter of Program Year 2021 (January 1, 2021–March 31, 2021).

Beneficiaries who lose eligibility before the quarter begins or during the quarter are later accounted for in debits to future CMF and CPCP (for Track 2 practices) payments (see Chapter 3 and Chapter 5, respectively). For example, for Q1 2021, if a beneficiary met all eligibility criteria on December 1, 2020, but no longer met eligibility criteria at the start of, or during, that first quarter (January 1, 2021–March 31, 2021), CMS will debit the CMF and CPCP amounts that the practice was paid for the period during which the beneficiary was ineligible. CMS will apply this debit in a later quarter.

2.3 Voluntary Alignment

2.3.1 Making an Attestation on MyMedicare.gov

To make an attestation, a beneficiary must create an account on MyMedicare.gov and follow a set of instructions as described in the CPC+ Voluntary Alignment beneficiary fact sheet. Beneficiaries can also view a video demonstrating how to make an attestation.[12] For more resources on voluntary alignment, please refer to the CPC+ Voluntary Alignment provider fact sheet and our summary of best practices for engaging Medicare beneficiaries through voluntary alignment.

Although any beneficiary with an account on MyMedicare.gov can make an attestation, voluntary alignment to a CPC+ practice is limited to CPC+-eligible beneficiaries. For the CPC+-eligible beneficiaries who have made an attestation via MyMedicare.gov, CMS applies the voluntary alignment algorithm each quarter according to the steps in the next sections.

2.3.2 Beneficiary Attestation List From MyMedicare.gov

Using the beneficiary attestation list (BAL) from MyMedicare.gov, for a given quarter, CMS identifies each CPC+-eligible beneficiary's most recent attested record as of the end of the lookback period (i.e., three months before the start of a given quarter). Table 2-1 lists the BALs and the beneficiary attestation cut-off dates for the 2021 quarterly CPC+ attributions. For example, CMS uses the October 2020 BAL, which includes beneficiary attestations as of October 1, 2020, for voluntary alignment in the first quarter of Program Year 2021 (see

[12] Please see https://youtu.be/w8Aj3blcxTY for a video on how to make an attestation on MyMedicare.gov.

Table 2-1). CPC+-eligible beneficiaries who have made an attestation specifying the health care practitioner and practice as their primary practitioner are eligible for voluntary alignment.

Table 2-1
BALs Used for 2021 Quarterly Attribution

Attribution Quarter	BAL Used	Beneficiary Attestation Cut-Off Date
2021 Q1	October 2020	October 1, 2020
2021 Q2	January 2021	January 1, 2021
2021 Q3	April 2021	April 1, 2021
2021 Q4	July 2021	July 1, 2021

If a beneficiary's most recent eligible record indicates that the CPC+-eligible beneficiary has removed a previously attested practitioner and practice without adding a new practitioner and practice, the beneficiary is not eligible for voluntary alignment; instead, the CPC+-eligible beneficiary is attributed via claims-based attribution.

CMS uses this list of CPC+-eligible beneficiaries and attested practitioners/practices and proceeds to the next step to check practitioner/practice eligibility.[13]

2.3.3 Practitioner and Practice Eligibility Check

CMS verifies the eligibility of the practitioner and practice to which the CPC+-eligible beneficiary attested in the BAL file for a given quarter. Only eligible practitioners are included in voluntary alignment. If the attested practice is a participating CPC+ practice site, the attested practitioner must also be active at the CPC+ practice site for the given quarter and listed on the practice's practitioner roster. In addition, a practice must sign and return the Mutual Amendment to the CPC+ Participation Agreement on voluntary alignment no later than six weeks before the start of the next quarter (e.g., February 18, 2021, for 2021 Q2), to be included in voluntary alignment for subsequent quarters. If the attested practice is a non-CPC+ practice site, the attested practitioner must have a primary care specialty code.

CMS verifies these specialties by using the practitioner's National Provider Identifier (NPI) and the primary and secondary taxonomy codes in the most current National Plan and Provider Enumeration System file, which CMS updates monthly. See Appendix B for the list of specialty codes CMS uses to define a primary care specialty.

[13] Because the BAL includes the practitioner's and practice's IDs assigned by the Provider Enrollment Chain and Ownership System, which are the data used by Physician Compare, CMS uses the Provider Master Index file and Center for Program Integrity sole proprietor file (for sole practitioners) to identify the Taxpayer Identification Number and National Provider Identifier information for each attested practitioner and practice.

If the attested practitioner does not meet the eligibility criteria (e.g., a practitioner was previously listed on the practitioner roster but is no longer active or a practitioner is participating in a CPC+ practice that did not sign and return the Mutual Amendment), the CPC+-eligible beneficiary is attributed through claims-based attribution. We describe these requirements in greater detail below.

2.3.3.1 Practitioners Participating at a CPC+ Practice Site

A CPC+ practice is defined by the combinations of **Taxpayer Identification Numbers (TINs)** (or **CMS Certification Numbers [CCNs]** for **critical access hospitals [CAHs]**) and **NPIs** identified for each practitioner participating at a CPC+ practice site. In voluntary alignment, CMS uses the CPC+ practitioner roster to verify whether the attested practice's TIN and the attested practitioner's NPI match a TIN/NPI combination associated with a CPC+ practice site.[14]

The attested practitioner must be active at the CPC+ practice site for the given quarter. CMS considers a practitioner active at a practice for a given quarter if the practitioner is on the practice's roster on the first day of the month before a given quarter. For example, CPC+ practitioners must be active on December 1, 2020, to be eligible for voluntary alignment in the first quarter of 2021 (January 1, 2021–March 31, 2021).

2.3.3.2 Practitioners at a Non-CPC+ Practice Site

There are two types of non-CPC+ practices: (1) individual practitioners using single TIN/NPI combinations (because of lack of information regarding how they are grouped as actual practices) and (2) practice sites not selected for CPC+ (for whom we have information on practitioner groupings). If a CPC+-eligible beneficiary makes an attestation to a practitioner at a non-CPC+ practice, the practitioner must have a primary care specialty code for the beneficiary's attestation to be used to attribute the beneficiary to the non-CPC+ practice (see Appendix B).

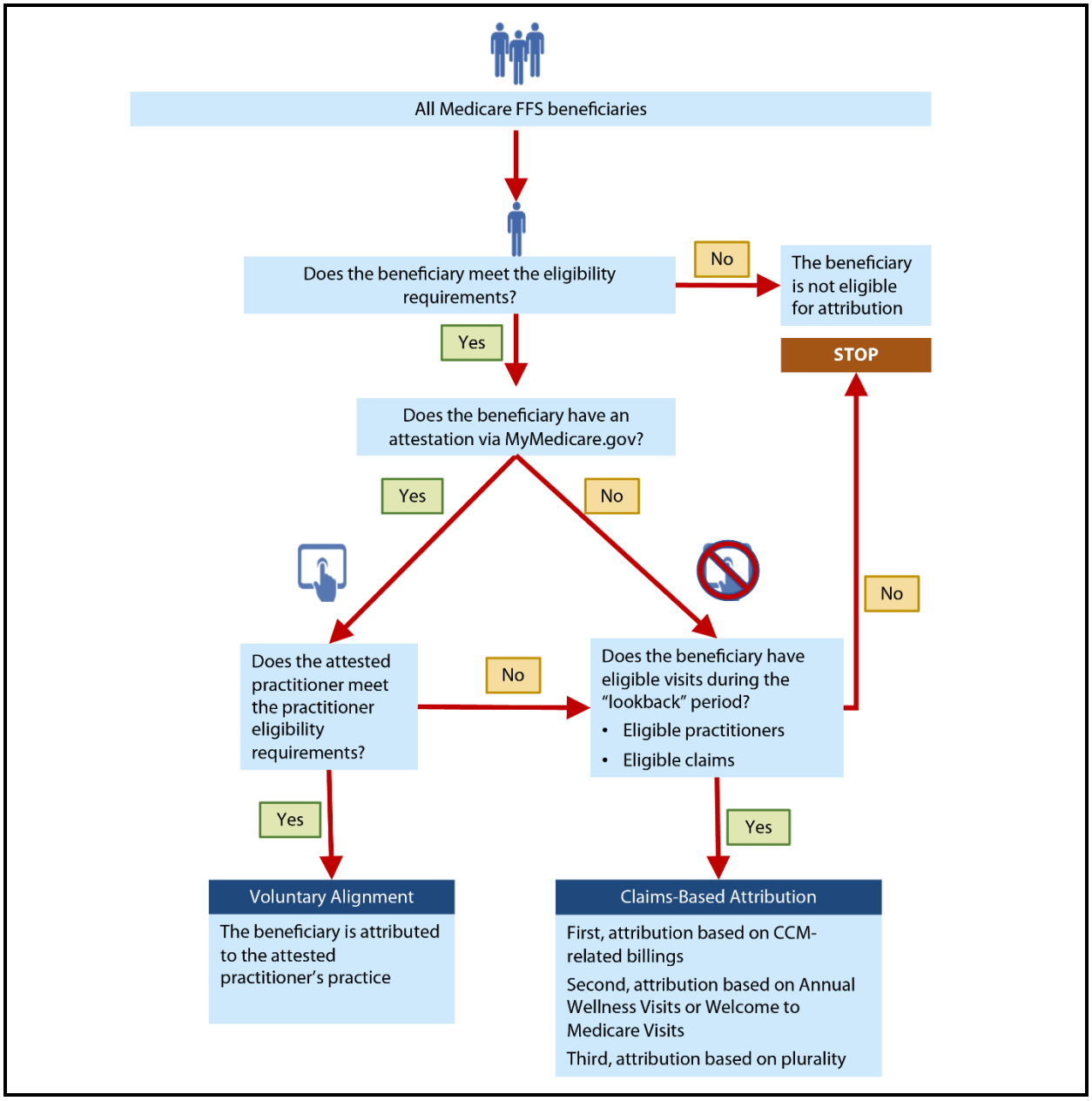
Note that practitioners at a CPC+ practice site must have a primary care specialty code to be included on the CPC+ roster.

Figure 2-2 illustrates how the attribution process works.[15]

[14] Because the BAL uses data from Physician Compare, which does not include physicians who only bill Medicare through a CAH, only TIN/NPI (instead of CCN/NPI) combinations are used to identify attested practitioner and practice for voluntary alignment.

[15] Claims-based attribution is described in Section 2.4.

Figure 2-2
CPC+ Attribution Methodology



2.3.4 Interactions With Claims-Based Attribution

If practitioner eligibility requirements are met, the CPC+-eligible beneficiary's attestation is used to attribute the beneficiary via voluntary alignment.

If the attested practitioner does not meet the practitioner eligibility requirements, the CPC+-eligible beneficiary is attributed using the claims-based attribution process (see Section 2.4).

2.4 Claims-Based Attribution

2.4.1 Eligible Visits

For claims-based attribution, CMS uses the pool of Medicare claims during the 24-month **lookback period** to identify eligible primary care visits to use for attribution. The lookback period is the 24-month period ending three months before the start of the quarter. For example, CMS uses claims from October 2018 through September 2020 to attribute CPC+-eligible beneficiaries to CPC+ practices for the first quarter of 2021 (see Figure 2-1). Table 2-2 lists the lookback periods for the 2021 quarterly CPC+ attributions.

Table 2-2
Lookback Periods for 2021 Quarterly Beneficiary Attribution

Attribution Quarter	Lookback Period
2021 Q1	October 2018–September 2020
2021 Q2	January 2019–December 2020
2021 Q3	April 2019–March 2021
2021 Q4	July 2019–June 2021

CMS waits one month after the end of the lookback period to collect claims with service dates in the lookback period. This allows the overwhelming majority of claims that occurred during the lookback period to count toward attribution, even if they were processed and paid in the month after the lookback period ended.

CMS uses national Medicare FFS physician and outpatient claims with service dates during the lookback period. Most visits are in the physician file, with the exception of claims submitted by CAHs, which are found in the outpatient file. From all physician and outpatient claims, CMS identifies those that are primary care visits eligible for attribution. Primary care visits eligible for attribution are those with any of the Healthcare Common Procedure Coding System (HCPCS) codes in Table 2-3.

Table 2-3 includes HCPCS codes 99358, 99484, 99487, 99490, 99491, G0506, and G0507—these services, referred to as "**CCM-related services**," are prioritized in the CPC+ Attribution Methodology and are an effective way to establish attribution with new beneficiaries joining a CPC+ practice during the course of the model. However, CPC+ practitioners may not bill CCM-related services and their add-on codes or beneficiaries that have already been attributed to their CPC+ practice, as these are duplicative of the services covered by the CPC+ CMF. As such, Medicare will not pay both a CPC+ CMF and CCM-related services for any individual CPC-attributed beneficiary in the same month (for details, see Chapter 3).[16] However, CPC+

[16] If any add-on code associated with these nonbillable codes is billed, payment for the add-on code will be deducted.

practitioners are free to bill CCM codes for nonattributed beneficiaries if all other billing requirements for those codes in the Medicare PFS are met.

Table 2-3
Primary Care Services Eligible for Attribution

Service	HCPCS Codes
Office/outpatient visit evaluation and management (E&M)	99201[a]–99205, 99211–99215
Home care/domiciliary care E&M	99324–99328, 99334–99337, 99339–99345, 99347–99350
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Advance care planning	99497
Collaborative care model	G0502–G0504, 99492–99494
Cognition and functional assessment for patients with cognitive impairment	G0505, 99483
Outpatient clinic visit for assessment and management (CAHs only)	G0463
Transitional care management services	99495, 99496
Prolonged non-face-to-face E&M services	99358
CCM services	99490, 99491
Complex CCM services	99487
Assessment/care planning for patients requiring CCM services	G0506
Care management services for behavioral health conditions	G0507, 99484

[a] Effective January 1, 2021, CMS will no longer cover HCPCS code 99201 under the Medicare PFS. However, this code will continue to be used for attribution or payment purposes when historical claims analysis includes periods before 2021 during which this code was in use.
Please note that the above HCPCS codes are current as of November 2020 and are subject to change based on the calendar year 2021 Medicare PFS Final Rule.

Only **eligible primary care visits** count toward attribution. An eligible primary care visit is defined as follows:

1. The HCPCS code on the claim is among those listed in Table 2-3.
2. Non-CCM-related services are provided by a practitioner who meets one of the following criteria:[17]
    a. The practitioner is active in a CPC+ practice at the time the visit occurs.

[17] There is no specialty code restriction on CCM-related services. Note that only claims with CCM-related codes on them are eligible for practitioners who do not have one of the primary care specialties listed in Appendix B.

b. The practitioner has one of the primary care specialty codes located in Appendix B.[18]

Each visit in the claims data includes (1) the TIN or CCN and (2) the NPI of the practitioner who rendered the service. For claims-based attribution, CPC+ practitioners must be active in a CPC+ practice when the visit(s) occur. To determine whether a practitioner is active in the CPC+ practice when the visit occurs, CMS checks whether the TIN or CCN and the NPI on the claim match a TIN/NPI or CCN/NPI combination that is effective on the claim's service date in the CPC+ practitioner roster. If there is a match, the visit is associated with a CPC+ practice. Otherwise, the visit is associated with a non-CPC+ practice.

Non-CPC+ practices are individual practitioners using single TIN/NPI or CCN/NPI combinations. CMS maintains historical TINs and CCNs to associate claims with practices in the lookback period to make accurate attributions. When CPC+ practitioners leave a practice, their NPIs remain on the CPC+ practitioner roster and are marked with a termination date. In this way, past visits to those practitioners during the lookback period continue to be counted toward the practice.

2.4.2 Claims-Based Attribution Process

CPC+-eligible beneficiaries not attributed via voluntary alignment are attributed by one of three steps in the claims-based attribution process (Figure 2-3):

1. Attribute beneficiaries to practices based on CCM-related services.
2. Attribute beneficiaries to practices based on Annual Wellness Visits or Welcome to Medicare Visits.
3. Attribute all remaining beneficiaries to practices using the plurality of eligible primary care visits.

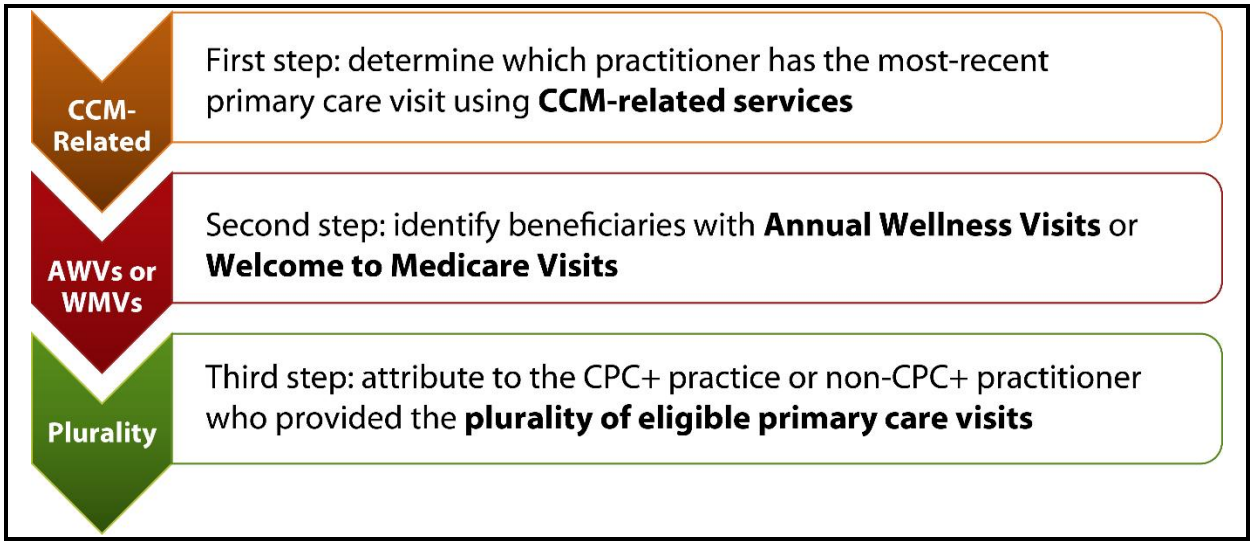
2.4.2.1 Attribution Based on Chronic Care Management–Related Services

If the most recent eligible primary care visit in the lookback period is for CCM-related services, CMS attributes the beneficiary to the CPC+ practice (or non-CPC+ practitioner) who provided the CCM-related service. If a beneficiary has CCM-related visits to both a CPC+ practice and one or more non-CPC+ practitioners on the most recent visit date, CMS attributes the beneficiary to the CPC+ practice. If there are multiple CPC+ practice ties, ties between CPC+ and PCF practices, or multiple non-CPC+ practitioner ties for the most recent CCM-related visits, CMS proceeds to Step 2 of the claims-based attribution.

If the most recent eligible primary care visit was not for CCM-related services, CMS proceeds to Step 2 of the claims-based attribution.

[18] Note that practitioners must have a primary care specialty code to be active in a CPC+ practice.

Figure 2-3
Three Steps in CPC+ Claims-Based Attribution



AWV = Annual Wellness Visit; WMV = Welcome to Medicare Visit

2.4.2.2 Attribution Based on Annual Wellness Visits or Welcome to Medicare Visits

For remaining CPC+-eligible beneficiaries, if there are Annual Wellness Visits (G0438, G0439) or Welcome to Medicare Visits (G0402) in the lookback period, CMS attributes the beneficiary to the CPC+ practice (or non-CPC+ practitioner) who provided the most recent such visit. If there are no eligible Annual Wellness or Welcome to Medicare Visits during the lookback period, CMS proceeds to Step 3 of the claims-based attribution.

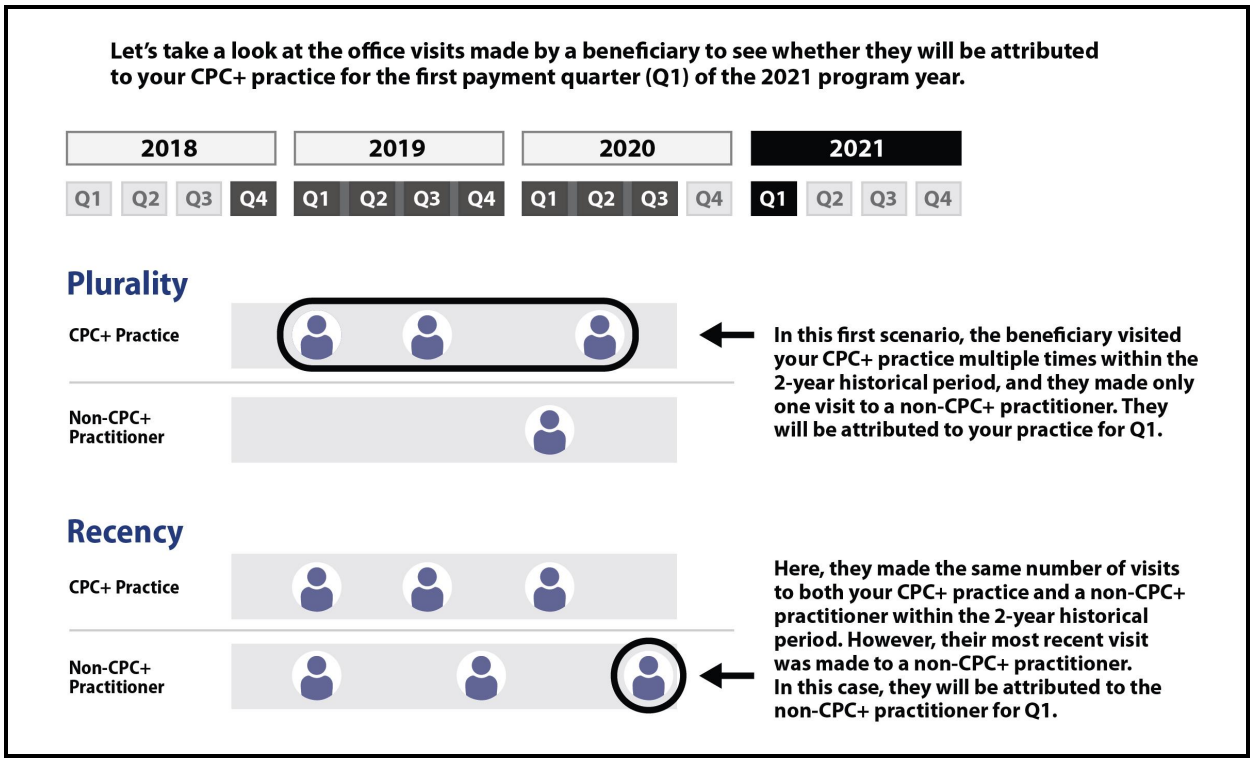
2.4.2.3 Attribution Based on Plurality

If a CPC+-eligible beneficiary is not attributed in Step 1 or Step 2 above, CMS first counts the number of eligible primary care visits the beneficiary had with each individual practitioner. CMS then combines eligible primary care visits to individual practitioners (i.e., TIN/NPI and CCN/NPI combinations) into CPC+ practices using the most current CPC+ practitioner roster. For example, two practitioners working in a CPC+ practice will have their eligible primary care visits aggregated for the purposes of attribution. Finally, CMS attributes the beneficiary to the CPC+ practice (or non-CPC+ practitioner) who provided the plurality of eligible primary care visits during the lookback period.

If a beneficiary has an equal number of eligible primary care visits to more than one CPC+ practice (or non-CPC+ practitioner, including a PCF practice), the beneficiary will be attributed based on the most recent visit. If a tie remains between a CPC+ practice and a non-CPC+ practitioner, the beneficiary will be attributed to the CPC+ practice. If a tie remains between two CPC+ practices, or between a CPC+ practice and a PCF practice, the beneficiary is randomly attributed to one of the practices.

Figure 2-4 illustrates two examples of beneficiary claims-based attribution based on plurality of primary care visits. In one scenario, the beneficiary will be attributed to the CPC+ practice based on plurality; in the other, the beneficiary will be attributed to the non-CPC+ practitioner after applying the recency criteria to a tiebreaker.

Figure 2-4
Which Beneficiaries Are Attributed to My Practice Through Claims-Based Attribution?



2.5 Overlap with Other Medicare Programs and Models

CMS does not allow Medicare FFS beneficiaries to be attributed to CPC+ and other CMS coordinated care initiatives at the same time, including those with a Medicare FFS shared savings opportunity or CMMI Alternative Payment Model, such as Primary Care First. This beneficiary attribution eligibility criterion has been established to avoid duplicative Medicare payment for shared savings and/or performance-based incentives for the same beneficiary under more than one CMS program or model. One exception to this "no overlaps" policy is if the beneficiary is aligned to the Medicare Shared Savings Program and eligible for CPC+ attribution to a "dual participant" that is participating in both CPC+ and the Shared Savings Program.

2.5.1 Medicare Shared Savings Program

If a CPC+ practice is also participating in a Shared Savings Program Accountable Care Organization (ACO) (a dual participant), CPC+-eligible beneficiaries who are attributed (either

via voluntary alignment or claims-based attribution) to both the CPC+ practice and the Shared Savings Program ACO that the CPC+ practice participates in will remain attributed to both.

However, CPC+-eligible beneficiaries who are attributed via claims-based attribution to a CPC+ practice not participating in a Shared Savings Program ACO (standard participant) and are also already attributed to a Shared Savings Program ACO will only be attributed to the Shared Savings Program and will lose CPC+ eligibility.

Beneficiaries who make an eligible attestation to a CPC+ practitioner on or before October 1, 2020, are attributed to their attested CPC+ practitioner for 2021 Q1. Voluntary alignment to CPC+ takes precedence over any claims-based attribution to the Shared Savings Program, but only for CPC+ attributions in the first quarter of each year.

If CPC+-eligible beneficiaries are attributed to a Shared Savings Program ACO (that is not affiliated with a CPC+ practice) during any quarter of 2021, a subsequent attestation to a CPC+ practitioner during 2021 will lead to the eligible beneficiaries being attributed to their CPC+ practice in 2022. Because CMS performs voluntary alignment quarterly for CPC+ and annually for the Shared Savings Program, these beneficiaries will remain with the Shared Savings Program ACO until the Shared Savings Program performs voluntary alignment again for the following year (2022). When the Shared Savings Program performs voluntary alignment again the following year, if the beneficiary attestation to the CPC+ practice remains the most current attestation, the CPC+-eligible beneficiary will be attributed to the CPC+ practice, rather than the Shared Savings Program ACO. For example, if an ACO-assigned beneficiary (2021 Q1) makes an attestation to a CPC+ practitioner in May 2021, this beneficiary remains assigned to the Shared Savings Program ACO for the remainder of 2021 (for CPC+-eligible beneficiaries, May attestations would be captured in 2021 Q4 CPC+ attribution). If the beneficiary attestation to the CPC+ practitioner remains the most current attestation when the Shared Savings Program performs voluntary alignment again for 2022, the CPC+-eligible beneficiary will become attributed to CPC+ (2022 Q1).

2.5.2 Primary Care First

Because CMS will perform attribution for CPC+ and PCF at the same time, CMS will attribute beneficiaries to a CPC+ practice, PCF practice, or other practice. Because CMS does not allow practitioners to participate in CPC+ and PCF at the same time, there is no overlap between CPC+ practices and PCF practices. As a result, CMS will not attribute beneficiaries to both a CPC+ practice and a PCF practice for the same quarter.

2.5.3 Other Models

Beneficiaries attributed to other CMS coordinated care initiatives, including those with a Medicare FFS shared savings opportunity or CMMI Alternative Payment Model, during the same performance period are not eligible for attribution to a CPC+ practice. Examples of these initiatives include the Next Generation ACO Model, the Direct Contracting Model, the Comprehensive ESRD Care Model, and the Kidney Care Choices Model. Beneficiaries

attributed to other CMS initiatives or models, without a Medicare FFS shared savings opportunity, may be eligible for attribution to a CPC+ practice.

Chapter 3: Care Management Fee

Chapter 3 documents the methodology used to calculate the **CMF** in CPC+. The CMF is intended to support augmented staffing and training related to non-visit-based and historically nonbillable services that align with the CPC+ care delivery transformation aims. These include activities to improve care coordination, implement data-driven quality improvement, and enhance targeted support to beneficiaries identified as high risk. Section 3.1 describes risk scores and regional risk tiers; Section 3.2 details assigning risk score tiers; Section 3.3 explains retrospective debits; and Section 3.4 addresses risk score growth.

3.1 Regional Risk Scores and Risk Tiers

All Medicare FFS beneficiaries attributed to a CPC+ practice are assigned to one of four risk tiers for Track 1 or one of five risk tiers for Track 2. Risk score tier thresholds are defined separately for each CPC+ region. Each risk tier corresponds to a specific monthly CMF payment. Higher risk tiers are associated with higher beneficiary risk and higher CMFs. Beneficiary risk is generally determined by the CMS Hierarchical Condition Categories (HCC) risk adjustment model. For Track 2 beneficiaries, risk tier is also determined by a diagnosis of dementia, as described in greater detail below.

Risk scores for attributed beneficiaries are compared with the distribution of risk scores for all FFS beneficiaries in the same region who meet CPC+ eligibility requirements and who have had an eligible primary care visit. This group of beneficiaries is called the **CMF reference population**. Beneficiaries are assigned to risk tiers on the basis of where their risk score falls within the regional distribution, as shown in Table 3-1.

Table 3-1
Risk Tier Criteria and CMF Payments (PBPM)

Risk Tier	Risk Score Criteria	Track 1	Track 2
Tier 1	Risk score < 25th percentile	$6	$9
Tier 2	25th percentile ≤ risk score < 50th percentile	$8	$11
Tier 3	50th percentile ≤ risk score < 75th percentile	$16	$19
Tier 4	Track 1: Risk score ≥ 75th percentile Track 2: 75th percentile ≤ risk score < 90th percentile	$30	$33
Tier 5 (Track 2 only)	Risk score ≥ 90th percentile *or* Dementia diagnosis	N/A	$100

The sections below detail the CMS-HCC risk adjustment model, the determination of the region-specific CMF reference population, and the determination of the CMF amounts for each tier within each track. The sections also address retrospective debits of the CMFs and the interaction between CMFs and CCM-related billings.

3.1.1 Centers for Medicare & Medicaid Services–Hierarchical Condition Categories Risk Scores

The CMS-HCC risk adjustment model is a prospective risk adjustment model that predicts medical expenditures using beneficiary demographics and diagnoses, where medical expenditures in a given year (risk score year) are predicted using diagnoses from the prior year (called the base year). The CMS-HCC model produces a risk score, which measures a person's or a population's health status relative to the average of 1.0, as applied to expected medical expenditures. For example, a population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a population with a risk score of 0.5 is expected to incur medical expenditures half that of the average. Appendix C includes more detail on the CMS-HCC model.

Each quarter, CMS uses the most current available risk scores to assign beneficiaries to risk tiers. Because of the amount of time required to ensure that as many diagnoses are captured in the risk score as possible, CMS calculates risk scores for any year at least 12 months after the close of the base year. Final risk scores are generally available 16–18 months after the close of the base year. For example, 2020 risk scores (based on 2019 diagnoses) will be available in the spring of 2021.

Table 3-2 shows the risk score data used for all CPC+ quarters. CMS implements updated risk score data in the third payment quarter of each year. This schedule is subject to change if the availability of the data changes.

Table 3-2
Risk Score Data Used to Determine CMF Payments, by Quarter

Quarters	Months	Risk Score Year
2017 Q1–2017 Q2	January 2017–June 2017	CY 2015
2017 Q3–2018 Q2	July 2017–June 2018	CY 2016
2018 Q3–2019 Q2	July 2018–June 2019	CY 2017
2019 Q3–2020 Q2	July 2019–June 2020	CY 2018
2020 Q3–2021 Q2	July 2020–June 2021	CY 2019
2021 Q3–2022 Q2	July 2021–June 2022	CY 2020
2022 Q3–2022 Q4	July 2022–December 2022	CY 2021

CY = calendar year.

3.1.2 Setting the Risk Tier Thresholds

Risk tiers are determined for each region using the distribution of risk scores in the reference population for that region. The reference population includes all beneficiaries residing in each region who meet the eligibility criteria for attribution (see Chapter 2 for details). In addition, to approximate the utilization patterns of the CPC+-attributed population, beneficiaries included in the reference population must have had at least one eligible primary care visit in the prior 24-month period. The required primary care visit must meet all of the same criteria as eligible primary care visits used for attribution.

The reference population is defined using parameters for a Q3 (July–September) attribution. For example, beneficiaries included in the reference population used for 2021 Q3 through 2022 Q2 must (1) meet eligibility criteria on June 1, 2021, and (2) have had an eligible primary care visit in the lookback period used for 2021 Q3 attribution, April 2018–March 2021. We use Q3 because it is a midyear capture of the "average" population and risk scores are typically released around this time.

Once CMS has determined the reference population for each region, their risk scores are used to determine the risk tier thresholds. CMS uses risk scores based on the CMS-HCC community risk adjustment model, as opposed to the CMS-HCC long-term institutional model, on the premise that CPC+ eligibility criteria for attribution exclude beneficiaries who are long-term institutionalized (e.g., long-term residing in a nursing home). For community-residing beneficiaries new to Medicare, CMS uses the new enrollee risk adjustment model, which is a demographic-only risk adjustment model. Because beneficiaries new to Medicare during the risk score year do not have a complete diagnostic profile in the base year, the diagnosis-based CMS-HCC risk adjustment model cannot be used for these beneficiaries.

CMS sorts the risk scores and identifies the 25th, 50th, 75th, and 90th percentiles in each region. These values are the thresholds that are used until the next risk score update. Regional risk tier risk score threshold updates are shared with practices annually. The 2020 Q3–2021 Q2 risk tier thresholds are listed in Appendix D.

3.2 Assigning Risk Tiers

Most beneficiaries are assigned to a risk tier on the basis of their risk score. Beneficiaries attributed to practices in Track 2 who are determined to have a diagnosis of dementia are assigned to Tier 5 regardless of their risk score, as described below.

3.2.1 Assigning Risk Tiers 1–5 Based on Risk Score

Each quarter, CMS uses risk scores for all beneficiaries attributed to a CPC+ practice to assign beneficiaries to risk tiers. Beneficiaries, including those who are eligible for both Medicare and Medicaid (i.e., dual eligible), are assigned to a risk tier based on the thresholds that apply for that quarter and the criteria shown in Table 3-1. There are two exceptions to this process.

First, because of the inherent lag in the calculation and availability of risk score data, beneficiaries who have newly joined Medicare after the risk score year do not have a risk score in the most recent risk score file. Such beneficiaries are placed into Tier 1.

Second, beneficiaries attributed to a Track 1 practice who have developed ESRD since their initial attribution to a CPC+ practice are placed into Track 1, Tier 4. Beneficiaries attributed to a Track 2 practice who have developed ESRD since their initial attribution to a CPC+ practice are placed into Track 2, Tier 4, unless their risk score is higher than the Tier 5 lower bound, in which case they are placed into Track 2, Tier 5. This is to account for the higher level of support and coordination ESRD beneficiaries require. Beneficiaries with an ESRD diagnosis before attribution to CPC+ are ineligible for attribution.

3.2.2 Assigning Risk Tier 5 Based on Dementia Diagnosis (Track 2 Only)

The criteria for Risk Tier 5 (Track 2 only) include having a risk score at or above the 90th percentile of risk scores in the CMF reference population *or* having a diagnosis of dementia or related disorder. Dementia diagnoses are determined using information from CMS' Chronic Condition Warehouse (CCW).[19]

CMS assigns beneficiaries to Tier 5 if the most recent information from the CCW reflects a dementia flag. The CCW updates chronic condition information annually and generates flags representing presence of certain chronic conditions as of December 31 of each year. The CCW uses a three-year historical period to determine the presence of dementia. For example, to determine the 2020 dementia flag, claims during the three-year period (January 2018–December 2020) are used. The criterion for dementia is the presence of any International Classification of Diseases (ICD)-10 diagnosis code in the list below on at least one inpatient, skilled nursing facility, outpatient, home health, or carrier claim in the three-year period.

- **ICD-10 diagnoses indicating the presence of Alzheimer's disease and related disorders or senile dementia:** F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, G13.8, F05, F06.1, F06.8, G30.0, G30.1, G30.8, G30.9, G31.1, G31.2, G31.01, G31.09, G94, R41.81, R54

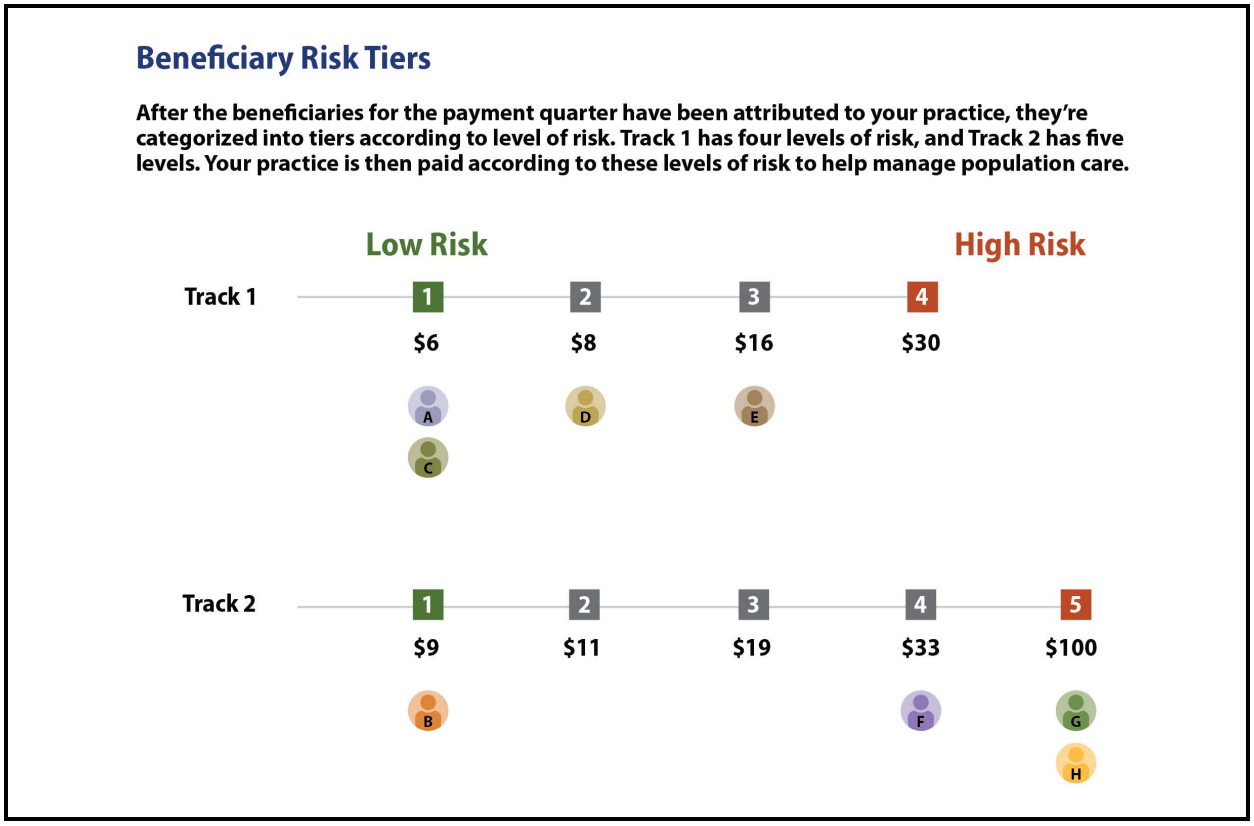
CMS uses the most recent CCW information available each quarter to determine whether beneficiaries attributed to a Track 2 practice have a diagnosis of dementia. For 2021 Q1, the most recently available CCW data used to identify diagnosis of dementia is from December 31, 2019. Assignments to Tier 5 from a dementia diagnosis are based on claims data from January 2017–December 2019. CMS will update to the 2020 CCW data for diagnosis of dementia as soon as they become available.

[19] https://www.ccwdata.org/documents/10280/19022436/codebook-mbsf-cc.pdf

Track 2 beneficiaries with ESRD who also have a dementia diagnosis are placed into Tier 5 rather than Tier 4. For beneficiaries who are in Track 2, the dementia diagnosis supersedes the ESRD diagnosis.

Figure 3-1 illustrates beneficiary risk tiers for the CMF.

Figure 3-1
Beneficiary Risk Tiers



3.3 Retrospective Debits

CMS applies two types of debits to the CMFs paid each quarter. The first is a debit to account for prior CMF overpayments, and the second is a debit due to duplication of services covered by CPC+ CMFs and the Medicare CCM-related services.

3.3.1 Debits for Beneficiary Ineligibility

CMS determines attribution and calculates quarterly CMFs in advance of each quarter. The prospective quarterly payment assumes that all beneficiaries attributed for the payment quarter continue to be eligible for the entire quarter. However, some beneficiaries become ineligible before or during the quarter, for example, if the beneficiary loses Part A or Part B coverage,

joins a Medicare Advantage plan, loses Medicare as the primary payer, becomes incarcerated, becomes long-term institutionalized, or dies before or during the payment quarter.

Beneficiaries not meeting CPC+ eligibility criteria on the first day of a month are not eligible for CMF payment in that month. To account for this, in each quarterly payment cycle, CMS determines whether a beneficiary lost eligibility during the previous four quarters and computes a deduction from the upcoming quarter's payment to reflect previous overpayments. See Section 2.2 for a complete list of beneficiary eligibility requirements.

If a CPC+ practice leaves the model and overpayments are calculated for previously attributed beneficiaries, a demand letter is sent to the practice notifying them of the model debt they must repay.

3.3.2 Debits for Duplication of Services

Per the CPC+ Participation Agreement, for attributed beneficiaries for a given quarter, CPC+ practices may not bill for CCM-related services for any attributed CPC+ beneficiary. Each quarter, CMS reviews claims data from prior quarters to determine whether any CPC+ or non-CPC+ practice billed CCM-related services for any beneficiary attributed to a CPC+ practice in the same month. If duplication is detected, we deduct the duplicative services as follows:

- If a CPC+ practitioner bills a CCM-related service for a beneficiary attributed to his or her CPC+ practice in the same month, CMS recoups the Medicare claim on which the CCM-related service was billed (which includes payment for any add-on code).
- If any practitioner bills a CCM-related service for a beneficiary attributed to a CPC+ practice in the same month, *and it is not a practitioner at the beneficiary's attributed CPC+ practice,* CMS deducts the CMF paid for that month from the CPC+ practice's future CMF payment. The practitioner who billed the CCM-related service retains the Medicare payment for the service.[20]

Table 3-3 lists the CCM-related services and associated HCPCS codes that are considered duplicative of the services covered by the CPC+ CMF.

[20] Medicare beneficiaries must positively consent to receiving CCM-related services at the time they are received. As a result, the assumption is that the practice providing the CCM-related services is the beneficiary's current primary care practice. Thus, if there are two payments (a CCM claim payment to one practice and a CPC+ CMF to a CPC+ practice) for the same beneficiary in the same period, the CCM claim payment takes precedence and is paid to that practice. The CMF is recouped from the CPC+ practice for that period.

Table 3-3
CCM-Related Services Duplicative of CPC+ CMF[a]

Service	HCPCS Codes
CCM services	99490, 99491
Complex chronic care coordination services	99487
Prolonged non-face-to-face E&M services	99358
Assessment/care planning for patients requiring CCM services	G0506
Care management services for behavioral health conditions	G0507, 99484

[a] If any add-on code associated with these nonbillable codes is billed, payment for the add-on code will be deducted.

3.4 Risk Score Growth and Care Management Fee Cap

CMS will continue to monitor coding and HCC risk score changes closely throughout the program, and if significant, unexpected, or irregular changes in coding are found to occur, will adjust the payment methodology. If the rate of change for risk scores is significantly different for CPC+ practices than for the CPC+ reference population, it would potentially skew the CMF payments and decrease the actuarial soundness of CPC+. If CMS decides to make changes, they will be specified prior to the payment quarter in which they are implemented. Examples of how CMS might address high risk score growth, based on experiences in other Medicare programs, include the following:

- Apply a coding pattern adjustment factor to each beneficiary's risk score, as in the Medicare Advantage program.
- Cap the risk score growth rate by which each practice's risk score is allowed to change, as in the Next Generation ACO Model.
- Use diagnosis-based risk adjustment for updating newly attributed beneficiaries' risk scores and demographic-based risk adjustment for updating continuously attributed beneficiaries' risk scores, as in the Shared Savings Program.

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Chapter 4: Performance-Based Incentive Payment

This section describes the CPC+ **PBIP** technical methodology for Program Year 2021. To encourage and reward accountability for patient experience of care, clinical quality, and utilization measures that drive total cost of care, practices receive a prospective incentive payment, and they are allowed to retain a portion or all of these funds based on performance against national benchmarks. Practices are thus "at risk" for the amounts prepaid, and CMS recoups unearned payments. The rest of this chapter provides basic information on the PBIP. Section 4.1 describes the **design principles and general features**, Section 4.2 describes the **Quality Component** of the PBIP, Section 4.3 describes the **Utilization Component** of the PBIP, Section 4.4 describes the **performance standards**, Section 4.5 describes **benchmark thresholds** for Program Year 2021, and Section 4.6 provides an illustrative example of **PBIP calculation**.

4.1 Design Principles and General Features

This section describes the rationale for the PBIP; overarching principles of design; and general criteria for practice performance scoring, which determines the amount of the PBIP that practices are eligible to retain.

4.1.1 Principles of Design

The incentive structure is designed to motivate practices to work toward improving quality of care and patient experience of care and to reduce unnecessary beneficiary utilization that drives a higher total cost of care. The design principles underpinning the incentive structure were informed by current behavioral economics theory and existing evidence from PBIP programs (Audet & Zenna, 2015; Khullar et al., 2015). The incentive structure employs the following design principles and general features:

- Timing of incentive payments encourages immediate practice engagement.
- Performance goals are transparent and known to practices early in the performance period.
- Practices are rewarded on a continuous scale and for **absolute performance thresholds**.
- Practices must meet minimum quality thresholds before they are rewarded for reducing utilization.
- Performance goals are closely related to primary care practice and measured at the practice level.

Provisions for Practices in ACOs and the Quality Payment Program—Primary care practices also participating in Medicare Shared Savings Program ACOs do not receive the PBIP. Instead, these practices participate in the ACOs' shared savings/shared losses arrangement. CPC+ practices also in Shared Savings Program ACOs must report two **electronic Clinical Quality Measures (eCQMs)** as part of their CPC+ participation. To

minimize duplication and survey burden, practices dually participating in ACOs are not sampled for the Patient Experience of Care (PEC) measure (which uses the Consumer Assessment of Healthcare Providers and Systems [CAHPS] survey) and are not required to provide an all-patient roster. Therefore, for a CPC+ practice also participating in the Shared Savings Program, the rest of this chapter is not applicable.

Under the **Quality Payment Program Final Rule**, for a model to be considered an **Advanced Alternative Payment Model (APM)**, a certain amount of model revenue must be considered "at risk." The PBIP qualifies CPC+ as an Advanced APM. For CPC+ practices also participating in the Shared Savings Program, determinations about the Advanced APM incentive are based on the track of the Shared Savings Program ACO in which they participate.

4.1.2 Prospective Payment

At the beginning of each Program Year, practices receive a prospective incentive payment that they are eligible to earn during the Program Year. After the close of each Program Year, CMS calculates the incentive amount earned based on performance compared to a set of benchmarks, and CMS recoups the unearned portion, if necessary. As a result, practices know prospectively the maximum PBIP amount they may keep for a given Program Year.

CMS is testing whether prospective incentive payment is an effective way to ensure reward timeliness and fully leverage loss aversion in a manner that engages practices immediately in CPC+ objectives (Audet & Zenna, 2015).

CMS expects that prospective payment will support practice planning and budgeting, especially for small practices. Prospective payment has the added advantage of giving practices enough information early in the Program Year to help them create an internal bonus structure for delivering incentives to individual clinicians (Chung et al., 2010). Incentives at the individual clinician level are expected to have a significant impact on practice-level performance (Petersen et al., 2013). Internal bonus structures, if set up early, may increase the chances that individual clinicians will engage in behavior changes quickly and improve practices' overall performance.

Incentive Payment Use—The PBIP amount is meant to exceed the cost of implementation of the desired behaviors and should be treated as a bonus to the practice. Unlike the CMF, CMS places no restrictions on the use of the PBIP. Practices may decide, for example, to invest a portion of the PBIP in support of CPC+ objectives or to implement an internal bonus structure. It is important to note that the practice is contractually "at risk" for returning up to the full amount, in the event that the practice does not meet the minimum performance goals.[21] In light of the associated risk, practices may decide to set aside some or all of the PBIP until the payment reconciliation.

[21] Some practices may be selected for an eCQM audit. Depending on audit findings, there may be PBIP repercussions for practices not meeting certain requirements.

4.1.3 Transparency of Performance Goals

The CPC+ incentive structure and payment are intended to support full transparency of performance goals. The objective is to provide enough information early in the Program Year so that practices understand how their effort will be rewarded and can maximize their chances of retaining the full PBIP.

CMS publishes performance thresholds prior to the beginning of each Program Year. These thresholds represent the following:

- Minimum thresholds practices must reach to retain any (non-zero) PBIP
- Maximum thresholds practices must attain to keep 100 percent of the PBIP

4.1.4 Incentive Structure

Incentives for practices are designed with three important features. First, all high performers are rewarded. Practice performance is measured against absolute performance thresholds. The minimum and maximum thresholds are determined from a reference population external to CPC+ participation. In turn, a practice's own performance relative to these thresholds determines the incentive amount the practice retains. Practices are not scored on a relative-performance basis, and the amount of payment each practice retains is not determined by performance of its peers.

Second, minimum and maximum performance goals are established using absolute thresholds that are the same for all practices. The performance goals are the same for both tracks and for all Starters. In Program Year 2021, the minimum threshold is set to the 30th percentile of performance in the reference population for clinical quality and patient experience of care and to the 50th percentile of performance in the reference population for utilization. Practices are not eligible to retain any of the PBIP for the relevant measure if their performance score on an individual measure falls below this minimum threshold. This requirement ensures that practices are not rewarded for poor performance and encourages practices to place the highest priority on measures with very low scores to bring them above the minimum threshold.

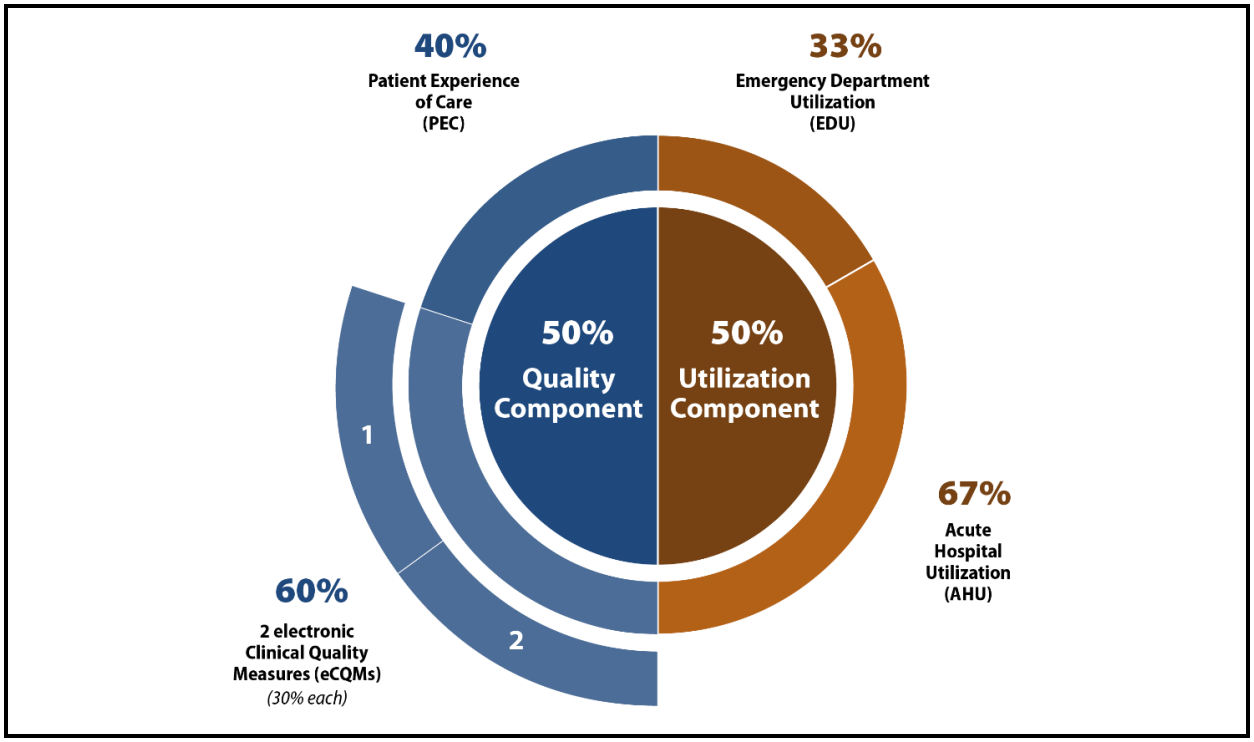
The maximum threshold is set to the 70th percentile of performance on the measure in the reference population for clinical quality and patient experience of care and the 80th percentile of performance in the reference population for utilization. Generally, practices will retain the full PBIP for the relevant individual measure if they are eligible for the incentive and attain the maximum threshold. Simulation analyses using data from Program Year 2017 of CPC+ suggest that a minimum performance score of 30th–50th percentile and a maximum threshold in the 70th–90th percentile are both motivational and achievable. Throughout CPC+, CMS continues to monitor practice performance, and in future Program Years, CMS may raise or change these thresholds. CMS will communicate any changes to performance thresholds to practices before the relevant Program Year. Practices that perform at high levels still have an incentive to improve their scores well above the maximum threshold to better position their practice for the following year's performance, in the event that the maximum threshold is raised.

Third, practices are rewarded on a continuous scale when scoring between the 30th and 70th percentile thresholds for clinical quality and patient experience of care or between the 50th and 80th percentile thresholds for utilization. In general, practices are eligible to receive a percentage of the PBIP for this range of performance. The amount retained increases as performance approaches the maximum threshold. The methodology to calculate the proportion of PBIP retained for scores between the minimum and maximum threshold is described in greater detail in Section 4.4.

4.1.5 Incentive Payment Components

As shown in Figure 4-1, practices retain the PBIP based on two distinct components of performance: (1) clinical quality and patient experience of care and (2) utilization. These two components contribute equally to the PBIP amount retained. However, performance on clinical quality and patient experience of care is prioritized over utilization. Practices that meet performance goals for utilization must meet the minimum thresholds for at least two of the three quality measures (i.e., quality measures refer to two eCQMs and the Patient Experience of Care [PEC] Summary Score) to receive any PBIP for the Utilization Component. Practices that reach the maximum performance goals for clinical quality and patient experience of care are eligible for the full Quality Component of the PBIP, equal to one-half of the total PBIP, whether or not they meet performance goals for the Utilization Component.

Figure 4-1
Components of the PBIP



4.1.6 Incentive Payment Amounts

The amount of the PBIP is based on the number of beneficiaries attributed to the practice in Q1 and is calculated as a **PBPM** amount. Track 1 practices are eligible for a PBIP equal to $2.50 PBPM. Track 2 practices are eligible for $4.00 PBPM, as indicated in Table 4-1. The PBIP PBPM is the same for all Starters.

Table 4-1
PBIP PBPM by Component for CPC+ Track 1 and Track 2 Practices

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

Conversations with subject matter experts suggest that the size of a motivational incentive should be approximately 10 percent of revenue to provide an adequate incentive to drive desired behaviors, support improvement, and exceed the cost of implementation of the desired behaviors (Damberg et al., 2008). To determine the PBIP PBPM amounts in Table 4-1, CMS considered the distribution of all Medicare FFS revenue among practices in the CPC Classic, a model separate from CPC+, in 2013, which averaged $24.57 PBPM (with an interquartile range of $18.45–$28.52 PBPM), 10 percent of which is approximately $2.46 PBPM, which was rounded to $2.50 for Track 1. CMS raised the incentive amount to $4.00 PBPM for Track 2 based on the rationale that Track 2 practices should receive an added bonus for greater effort of implementation and to keep Track 2 practices focused on outcomes. CMS also recognizes that the revenue history of CPC Classic practices may reflect primary care utilization that is lower than could occur under Track 2 CPC+ performance. Providing the PBIP to practices prospectively helps to maximize the effect of the payment size.

The PBIP amount paid prospectively to CPC+ practices equals the number of attributed beneficiaries in Q1 for a Program Year multiplied by the PBPM amount, multiplied by 12 months.

4.2 Quality Component

The Quality Component consists of two segments: (1) the PEC survey, measured by responses to questions from the Consumer Assessment of Healthcare Providers and Systems Clinician and Group (CG-CAHPS) Survey Version 3.0 and the Patient-Centered Medical Home Survey Supplement, and (2) clinical quality, measured by two **eCQMs**. The eCQMs contribute 60 percent of the CPC+ practice site's score for the Quality Component, and the PEC Summary Score contributes the remainder (40 percent).

Although clinical quality is weighted more heavily when determining the amount of PBIP Quality Component retained, patient experience of care and clinical quality measures are treated as

equally important when determining practice eligibility to retain the Utilization Component of the PBIP. To be eligible to keep the Utilization Component, practices must meet the minimum performance threshold for at least two of the three quality measures (i.e., quality measures refer to the two eCQMs and the PEC Summary Score). This is referred to as the utilization gateway. Additional details are provided in Section 4.4.

4.2.1 Patient Experience of Care Survey Measurement

PEC surveys are designed to collect reliable and representative data about patient experience of care. CMS uses a combination of items from version 3.0 (with a six-month lookback) of the **CG-CAHPS** and the Patient-Centered Medical Home Survey Supplement to calculate performance scores on patient experience of care. The survey is fielded by a CMS contractor for a sample of all patients seen at the practice, including commercial, Medicaid, and Medicare patients. The domains and questions are described in Appendix E. Only standard CPC+ practices are required to provide an all-patient roster, regardless of insurance type, to CMS when requested. CPC+ practices that fail to provide a patient roster will not receive a PEC survey score and will not qualify to retain the Quality or Utilization Component of the PBIP. Additional actions up to and including withholding CPC+ payments and/or termination of the CPC+ practice's Participation Agreement may also be considered as consequences for failure to submit a valid patient roster during the submission period.

4.2.2 Electronic Clinical Quality Measure Measurement

Achieving high performance in clinical quality is a central objective in CPC+. In Program Year 2021, practice sites are required to successfully report both eCQMs in the CPC+ measurement set, aligning with the reporting criteria (see Table 4-2 for more information). These reporting criteria were established to provide practice sites a view of performance on an ongoing basis at the point of care and were limited to only two measures to minimize provider burden, a concern heard from many CPC+ practices. The measures target a primary care patient population and are outcome measures (one is an intermediate outcome measure), rather than process measures. As described in the 2021 eCQM reporting requirements,[22] practices must report both CPC+ eCQMs. Practice sites that fail to report both eCQMs will not qualify to retain the Quality Component or the Utilization Component of the PBIP. As in Program Year 2020, practices must submit eCQMs using a Quality Reporting Document Architecture (QRDA) III file through the **Quality Payment Program** Website for Program Year 2021 (attestation in the eCQM Module of the CPC+ Practice Portal is no longer an option).

[22] CPC+ eCQM reporting requirements for Program Year 2021 can be found at the eCQI Resource Center.

Table 4-2
CPC+ Electronic Clinical Quality Measure Set—Program Year 2021

CMS ID #	MIPS ID #	Measure Title	Measure Type/ Data Source	Domain
CMS122[a]	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)[a]	Outcome/eCQM	Effective Clinical Care
CMS165	236	Controlling High Blood Pressure	Intermediate Outcome/eCQM	Effective Clinical Care

[a] This measure is reverse scored.

For the purposes of determining the amount of PBIP Quality Component retained, practices are eligible for payment for each individual eCQM, independent of the other. This approach is intended to reward practices for performance demonstrated in clinical quality for each measure, up to the maximum performance threshold of the 70th percentile. For each measure, the percentage retained is based on the amount that the performance exceeds the minimum threshold. A practice will not keep any amount for a given measure if its score is less than the 30th percentile, and a practice will keep half of the amount for a given measure if its score is equal to the 30th percentile. A practice will keep the full amount for a given measure if its score is greater than or equal to the 70th percentile. If a practice's score is between the 30th and 70th percentiles, the practice will keep a percentage of the amount for a given measure. The percentage is calculated by converting the 30th to 70th percentile range to 50 percent to 100 percent payment (see Section 4.4.1). The two eCQM measures together represent 60 percent of the Quality Component or 30 percent of the full PBIP (0.60 x 0.5 = 0.30). Both eCQMs are weighted equally so that each eCQM represents 30 percent of the PBIP for Quality (0.60/2 = 0.30) or 15 percent of the full PBIP (0.30/2 = 0.15). The amount earned is aggregated across the measures for which a practice is eligible to keep payment.

4.3 Utilization Component

The guiding principle for the selection of utilization measures for CPC+ is a parsimonious list of actionable measures that drive total cost of care. CMS also seeks measures that can be measured at the practice level for a Medicare FFS population and are validated for use. Based on the past two Program Years of CPC+, CMS expects that a typical CPC+ practice will average four clinicians and 700 beneficiaries. Practices must have at least 125 attributed Medicare beneficiaries to be eligible for CPC+. CMS is using two measures that meet these criteria: **emergency department utilization (EDU)** and **acute hospital utilization (AHU).** The AHU measure is a version that was reissued by Healthcare Effectiveness Data and Information Set (HEDIS) in 2019 to replace the inpatient hospital utilization (IHU) measure.[23] The measures

[23] The AHU and EDU measures and specifications were developed by the National Committee for Quality Assurance (NCQA) under the Performance Measurements contract (HHSM-500-2006-00060C) with CMS and are included in HEDIS® with permission of CMS. The HEDIS measures and specifications are not clinical guidelines.

are reported as observed-to-expected (O/E) utilization ratios. These two measures are available in the National Committee for Quality Assurance (NCQA) HEDIS. Hospitalizations are the largest driver of total cost of care, are actionable, and can be reliably measured at the practice level; therefore, they are suitable as a performance measure for primary care practice. Inpatient hospital services were identified as a major cost driver in CPC Classic at more than 35 percent of total cost of care.[24] Emergency department (ED) visits are also a larger driver of total cost of care compared with other outpatient health care utilization.

Utilization measures are claims-based and require no reporting on the part of practices. Both measures are calculated by CMS at the end of each Program Year. AHU receives twice the weight of EDU in the calculation of the performance score to reflect the disproportionate cost of inpatient stays relative to ED outpatient visits. The EDU is limited to outpatient visits that do not result in hospital admission so that ED visits resulting in a hospitalization are not counted in both utilization measures. Utilization for each CPC+ practice is calculated for Medicare beneficiaries attributed to the practice for any quarter during the Program Year. The measure specifications, including details on risk adjustment for age, gender, and presence of comorbid conditions, are available on the NCQA website.

4.4 Calculation of Performance Scores

To support incentive structure transparency, CMS aimed to design a scoring methodology that is uncomplicated and that uses benchmarks known to practices before the beginning of the Program Year. CMS sought to balance simplicity with motivating performance and improvement in the reward structure. To the extent feasible, CMS established uniform standards across all measures using a comparable scoring methodology to make performance objectives transparent at the beginning of practice participation. The methodology for calculating practice performance scores and determining PBIP amount retained is detailed as follows.

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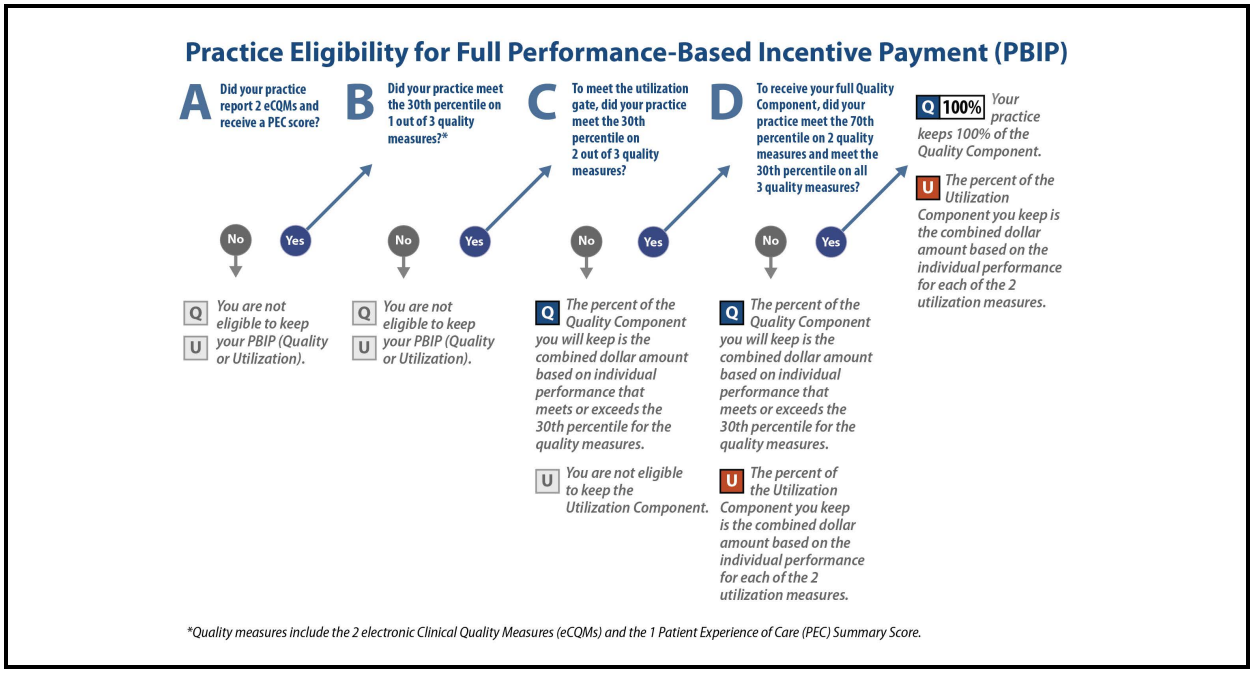
[24] For further information, please see the CPC Evaluation Reports at https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/.

CMS adopted a modified pay for performance on each individual measure approach to retaining the PBIP. Under the simple pay-per-measure approach, each measure is worth a percentage of the PBIP. Therefore, practices would need to attain the 70th percentile on all measures to retain 100 percent of the Quality Component. To avoid demotivating practices to improve performance on quality, CMS modified the simple pay-per-measure approach with less restrictive criteria to retain the full PBIP Quality Component. These criteria preserve the intent to reward practices demonstrating significant progress toward program objectives. To retain 100 percent of the Quality Component, standard practices must meet the following requirements:

- Successfully report both eCQMs (according to the CPC+ Participation Agreement).
- Have a PEC Summary Score, which includes providing a patient roster to CMS.
- Meet the 30th percentile (i.e., minimum threshold) on all three quality measures, (quality measures refer to the two reported eCQMs that meet the reporting criteria and the PEC Summary Score).
- Achieve the 70th percentile (i.e., maximum threshold) or higher on two out of three quality measures.

These criteria and their relationship to the PBIP Utilization Component are summarized in Figure 42. A PBIP tracking worksheet is listed in Appendix F. Practices that are not eligible to retain 100 percent of the Quality Component of the PBIP remain eligible to retain a percentage of the Quality Component of the PBIP if at least one of the eCQM measures or the PEC Summary Score achieves the 30th percentile (i.e., the minimum threshold).

Figure 4-2
Overview of Practice Eligibility to Retain Quality and Utilization Components of the PBIP



4.4.1 Calculation of Quality Performance Score

Step 1. Calculate PEC survey domain-specific scores.

The PEC survey benchmark is composed of five domains: Access to Care, Communication, Coordination of Care, Self-Management Support, and Overall Provider Rating. Each domain contains one or more questions. CMS reserves the right to determine whether any domains or questions within the domains will be added or removed to the benchmarks and/or yearly PBIP scoring. For example, for Program Years 2017–2021 scoring, the Shared Decision Making domain was dropped because of insufficient reliability and lower overall performance. PEC survey domain-specific scores are calculated using numeric values assigned to responses for a given domain. CMS first assigns a numeric value to each response option in the response scale for each survey question. For example, if there are four response options in a response scale, Never/Sometimes/Usually/Always, numeric values of 1 for "Never," 2 for "Sometimes," 3 for "Usually," and 4 for "Always" are assigned. If there are two response options in a scale, Yes/No, a value of 1 for "Yes" and 0 (zero) for "No" is assigned. For CPC+ PEC survey domains, a single response scale applies to all questions for a given domain. Second, CMS applies case-mixed adjustment to the scores using the CAHPS consortium instructions. Third, CMS calculates the average among case-mix-adjusted numeric response options for each domain. Finally, the case-mix-adjusted numeric average is converted to a 0–100 scale, where zero is the lowest performance and 100 is the highest performance. Scores are converted to the 0–100 scale using the following approach:

$$Y = \frac{(X - a)}{(b - a)} * 100$$

"Y" is the converted score in the 0–100 score, "X" is a CPC+ practice's PEC Summary Score on its original numeric scale (i.e., adjusted average numeric points), "a" is the minimum possible score on the original scale, and "b" is the maximum possible score on the original scale, for a given domain.

The Patients' Rating of Provider is a single-question PEC survey domain, meaning that only one question contributes to the overall domain. The original response scale is a numeric scale from 0 to 10. We convert the original scale to a 0–100 scale using the following formula:

$$Y = \frac{(X - 0)}{(10 - 0)} * 100$$

where "Y" is the 0–100 score and "X" is a CPC+ practice's score on its original numeric scale.

Step 2. Calculate the PEC Summary Score. The average of the five PEC survey domain-specific scores from Step 1 is the PEC Summary Score.

$$PEC\ Summary\ Score = \frac{(Access + Communication + Coordination + Support + Rating)}{5}$$

The PEC Summary Score is compared with the minimum and maximum performance thresholds derived from a reference population. The minimum and maximum performance thresholds are the 30th and 70th percentile of the PEC Summary Score, respectively. When reviewing the data in your PBIP or PEC Reports, we encourage practices to keep in mind that although the PEC scores will appear as rounded values, the PBIP scoring calculations for PEC use unrounded values to maximize precision in determining whether a practice has met the predefined thresholds.

Step 3. Calculate eCQM measure-specific scores. Note that the calculation for each eCQM differs. Some measures contain exclusions or exceptions that must be subtracted from the denominator (for example, a certain condition may exclude an otherwise eligible patient).

$$Performance\ Score\ = \frac{Numerator}{Denominator - Denominator\ Exclusion - Denominator\ Exception}$$

The performance score for each eCQM is compared with benchmarks to attain a percentile score. Performance rates for the eCQMs are rounded to the second decimal point, per CPC+ reporting requirements.

Step 4. Assess full payment criteria for the Quality Component of the PBIP:

- Successfully report both eCQMs (according to the CPC+ Participation Agreement).
- Have a PEC Summary Score, which includes providing a patient roster to CMS.
- Meet the 30th percentile on all three quality measures (quality measures refer to both eCQMs and the PEC Summary Score).
- Achieve the 70th percentile or higher on two out of three quality measures.

Step 5. If criteria to retain full PBIP Quality Component are not met, practices retain the PBIP Quality Component based on the PEC Summary Score and individual eCQM performance. The amount of PBIP earned then is added across each individual measure for which a practice is eligible to keep payment.

Practices can retain up to 40 percent of the Quality Component on the basis of the percentile threshold attained on the PEC Summary Score, as described in Table 4-3.

Table 4-3
Practice Performance and Percentage of PBIP for Patient Experience of Care

Performance of PEC Summary Score	Percentage of Quality Component of the PBIP Retained for Patient Experience of Care
< 30th percentile	0%
30th–70th percentile	20%–40%
70th percentile and above	40%

Practices performing below the 30th percentile for the PEC Summary Score will not retain the PEC survey portion of the Quality Component. Practices performing between the minimum and maximum performance threshold will receive scores along a continuous distribution normalized to values between 20 percent and 40 percent using the following formula:

$$PEC\ Percent\ Payment = \left(\frac{Measure\ Score - 30th\ percentile}{70th\ percentile - 30th\ percentile} * 50 + 50\right) * 0.40$$

Given that the PEC Summary Score has a narrow range between deciles, we set the minimum and maximum performance thresholds at the 30th and 70th percentiles for patient experience of care.

The eCQMs together comprise 60 percent of the PBIP Quality Component. Each of the two required measures is thus worth 30 percent of the Quality Component. Based on the threshold attained for each eCQM, the practice retains a percentage of the measure's share of the Quality Component PBIP, as shown in Table 4-4. For each measure that falls below the 30th percentile, the amount retained for that measure is $0.

Table 4-4
Practice Performance and Percentage of Quality Component of the PBIP Retained for Individual eCQMs

Performance for Clinical Quality Relative to Benchmark	Percentage of Quality Component of the PBIP Retained for Individual eCQM
< 30th percentile	0%
30th–70th percentile	15%–30%
70th percentile and above	30%

Practices performing below the 30th percentile for an individual eCQM will not retain the portion of the PBIP Quality Component for that measure. Practices performing between the 30th and the 70th percentile will receive scores along a continuous distribution normalized to values between 15 percent and 30 percent according to the following formula:

$$eCQM\ Percent\ Payment = \left(\frac{Measure\ Score - 30th\ percentile}{70th\ percentile - 30th\ percentile} * 50 + 50\right) * 0.30$$

For a "reverse-scored" measure, where a lower score reflects better performance (e.g., Diabetes: Hemoglobin A1c [HbA1c] Poor Control [> 9%]), the percent payment is normalized using the following formula:

$$Reverse\ Scored\ eCQM\ Percent\ Payment = \left(\frac{30th\ percentile - Measure\ Score}{30th\ percentile - 70th\ percentile} * 50 + 50\right) * 0.30$$

Some practices may be selected for an eCQM audit. Depending upon the severity of the eCQM audit findings, audit results may affect your practice's eCQM performance rates and ability to retain PBIP Quality and Utilization components.[25] If audit results indicate a practice did not meet certain audit standards, a practice may have eCQM performance rates changed to 0 percent. Although this does not affect the amount of PBIP a practice may keep from the PEC portion of the Quality Component, it does result in full recoupment of the eCQM portion of the Quality Component and renders a practice ineligible for the Utilization Component. Audit repercussions are subject to change per CMS decisions.

4.4.2 Calculation of Utilization Performance Score

Controlling for beneficiary risk factors that predict utilization is critical to designing incentive structures that reward practice behavior for beneficiary care decisions rather than natural variation in beneficiary populations. In CPC+, practice performance on utilization is scored against standard benchmarks common to all practices, as patient experience of care and clinical quality are scored. The measures are reported as O/E utilization ratios. For each practice, the observed utilization is compared with the expected utilization, which is adjusted for comorbidities within the practice population. The comparison is expressed as a ratio, dividing the observed utilization by the expected utilization. An O/E ratio greater than one represents greater-than-expected utilization, and a ratio less than one represents less-than-expected utilization. Therefore, CMS calculates O/E ratios for the benchmark population and uses the 50th and 80th percentiles as benchmarks for CPC+ practices.

To retain all or a portion of the PBIP Utilization Component, practices must completely report quality and must meet the 30th percentile on at least two of the three quality measures (quality measures refer to the two reported eCQMs and the PEC Summary Score). This is informally known as the "utilization gate." The hospitalization measure is double weighted and counts for two-thirds of the Utilization Component. The practice is assigned a score equivalent to the percentage of the Utilization Component the practice qualifies to retain, as described in Table 4-5.

[25] Findings ranging from manually calculated eCQM rates to lack of practice site–level reporting functionality may result in repercussions, such as a warning letter, a Corrective Action Plan, or PBIP recoupment.

Table 4-5
Practice Performance and Percentage of PBIP for Utilization

Utilization Measure	Practice Performance on Utilization Relative to Benchmark	Percentage of PBIP for Utilization Retained
Acute hospital	< 50th percentile	0%
	50th–80th percentile	33%–67%
	80th percentile and above	67%
Emergency department	< 50th percentile	0%
	50th–80th percentile	16.5%–33%
	80th percentile and above	33%

Practices performing below the 50th percentile for utilization for an individual measure will not retain the portion of the PBIP Utilization Component for that measure. The amount a practice is eligible to keep for each utilization measure is added together to obtain an overall PBIP Utilization Component amount. Practices performing between the 50th and the 80th percentile for AHU receive scores along a continuous distribution normalized to values between 33 percent and 67 percent according to the following formula:

$$AHU\ Percent\ Payment = \left(\frac{50th\ percentile - Measure\ Score}{50th\ percentile - 80th\ percentile} * 50 + 50\right) * 0.67$$

Practices performing between the 50th and the 80th percentile for EDU receive scores along a continuous distribution normalized to values between 16.5 percent and 33 percent according to the following formula:

$$EDU\ Percent\ Payment = \left(\frac{50th\ percentile - Measure\ Score}{50th\ percentile - 80th\ percentile} * 50 + 50\right) * 0.33$$

When reviewing the data in PBIP Reports, we encourage practices to keep in mind that although the utilization scores will appear as values rounded to two decimal places, the PBIP scoring calculations for these two measures use unrounded values to maximize the precision in determining whether a practice has met the predefined thresholds.

Illustrative Example—This methodology is illustrated for an example practice, Main Street CPC+ in Section 4.6.

4.5 Benchmarking Overview

The PBIP retained is calculated by comparing a CPC+ practice's performance with benchmark performance thresholds derived using a reference population. CPC+ practices may set goals by comparing their performance with benchmark performance thresholds. Practices may also use

these benchmarks to track their performance over time. CMS publishes annual benchmark thresholds before each Program Year so that practices know how their performance is rewarded and can maximize their effort to retain the full PBIP. The benchmarks establish the minimum thresholds that CPC+ practices must reach to retain a portion of the incentive payment and the maximum thresholds that practices must achieve to retain the full incentive payment.

Table 4-6 summarizes the 2021 quality and utilization measures that are benchmarked for CPC+ practices. As we described in Section 4.4.1, the PEC survey items are scored as one PEC Summary measure by averaging the PEC survey domain-specific scores. Clinical quality is measured using eCQMs, which quantify outcomes of care. Group practices and eligible professionals report eCQMs electronically through **QRDA Category III** to the Merit-based Incentive Payment System (MIPS) program. The clinical quality measure benchmarks align with MIPS benchmarks.

Table 4-6
CPC+ Quality and Utilization Measures for Benchmarking

Measure Component	Measure Segments	Number of Measures	Data Source for Benchmarking	Year Used to Derive Benchmark
Quality	Patient experience of care[a]	1	CPC+ PEC Survey performance	2017, 2018, and 2019
	Clinical quality	2	MIPS	2018
Utilization	Medicare acute care utilization	2	Medicare claims data	2018

[a] The PEC Summary Score is the average of the five domain-specific scores.

As we described in Section 4.3, CMS is using the O/E utilization ratios for both AHU and EDU. Both measures are calculated using Medicare FFS claims data.

4.5.1 Data Source for Benchmarking

4.5.1.1 Quality Component

PEC Survey. CMS used PEC Survey performance from CPC+ Program Years 2017–2019 to create the 2021 PEC Benchmark.

These data allow CMS to set benchmarks that reflect the typical performance of practices participating in CPC+. Thresholds are also largely consistent with prior benchmarks, which were established using an external sample from the Agency for Healthcare Research and Quality (AHRQ) CG-CAHPS database. The specific questions are listed in Appendix E.

eCQMs. The eCQM benchmarks for Program Year 2021 will be updated to 2020 MIPS benchmarks. CPC+ clinical quality measures cover patients insured by all payers, including but not limited to Medicare, who have at least one visit to the CPC+ practice during the measurement year and meet the denominator inclusion criteria. For Program Year 2021, CMS reviewed current measures used by other CMS programs for quality reporting, such as MIPS,

and identified two eCQM measures designed to indicate quality of care specifically relevant to primary care. Because eCQM measures are reported electronically, they can be an easily accessible tool for practices and practitioners to inform, guide improvement, and support evidence-based decision making. Electronic submission occurs through the data transmission method called QRDA Category III. QRDA Category III reports are aggregated measures for group practice or eligible professionals. CMS has evaluated the QRDA Category III data and determined that they (1) match CPC+ measure specifications; (2) include patients from all payers; (3) have a similar reporting period to CPC+; (4) include the aggregated practice level and the eligible professional level in the reports; (5) include primary care specialty; and (6) have acceptable data quality and statistical reliability. MIPS derived clinical quality benchmarks from 2017 performance files for the electronic health record (EHR) reporting option. For these reasons, CMS adopted MIPS EHR reporting option benchmarks for eCQM benchmarks in CPC+.

A summarized process for MIPS EHR reporting option benchmark calculation is described in Section 4.5.2.1.

Utilization Component. CMS will continue to use the Program Year 2020 benchmarks for Program Year 2021, based on 2018 national Medicare FFS claims data. CMS uses measure specifications provided by NCQA to calculate practice-level AHU and EDU (measure specifications are available on the NCQA website). These measures are calculated using Medicare claims data for Medicare beneficiaries aged 18 years or older and are risk adjusted for beneficiary demographics and comorbidities within the practice population.

To derive the utilization measure benchmarks, CMS used a reference population from the universe of Medicare FFS TINs in combination with the NPI and their attributed Medicare beneficiaries. The universe of TINs/NPIs is identified as those with a valid TIN and at least one eligible practitioner who had positive charges in 2018. Beneficiaries are attributed to these TINs/NPIs using a plurality of care attribution algorithm similar to the CPC+ claims-based attribution algorithm. CMS used this national reference population because it is comparable to CPC+ attributed beneficiaries and is readily available for the benchmark calculation.

4.5.2 Benchmarking Methods

4.5.2.1 Quality Component

PEC Survey Measurement. CMS calculated scores for each of the CPC+ PEC survey domain-specific scores for each practice in the Program Years 2017, 2018, and 2019 of CPC+ using version 4.1c of the CAHPS Analysis Program. Each survey response was transformed into PEC survey domain-specific scores using numeric values assigned to responses for a given measure following the steps outlined in Section 4.4.1. Table 4-7 presents examples of scoring transformations for PEC survey measures in various response scales.

Table 4-7
Hypothetical Examples of Scoring Transformations for PEC Survey Measures

Hypothetical Practices	Adjusted Mean Score in Numeric Scale	Calculation of 0–100 Score	Converted Score
Four response options for three domains:[a] Never = 1; Sometimes = 2; Usually = 3; Always = 4			
Practice A	2.45	[(2.45−1)/(4−1)]*100	48
Practice B	3.50	[(3.50−1)/(4−1)]*100	83
Practice C	3.90	[(3.90−1)/(4−1)]*100	97
Two response options for "Self-Management Support" domain: No = 0; Yes = 1			
Practice A	0.33	[(0.33−0)/(1−0)]*100	33
Practice B	0.50	[(0.50−0)/(1−0)]*100	50
Practice C	0.80	[(0.80−0)/(1−0)]*100	80
Patients' rating of provider: 0–10			
Practice A	6.50	[(6.50−0)/(10−0)]*100	65
Practice B	8.00	[(8.00−0)/(10−0)]*100	80
Practice C	9.00	[(9.00−0)/(10−0)]*100	90

[a] Three domain-specific measures with four response options are "Getting Timely Appointments, Care, and Information;"; "How Well Providers Communicate;" and "Attention to Care from Other Providers."

For CPC+ practices, the PEC Summary Score benchmark is set at the 30th and 70th percentiles of the PEC Summary Score of all practices participating in each corresponding Program Year of CPC+. The PEC Summary Score is calculated as the average of the five PEC survey domain-specific measures. To develop the benchmark, CMS used actual CPC+ practice performance, scored following the steps outlined above and in Section 4.4.1, with risk adjustment on age, gender, education, self-reported physical health, and, for Program Years 2018 and 2019, proxy response and survey mode (paper survey versus telephone interview). The practices are then ranked based on their PEC Summary Score on a continuous 0–100 scale to establish their percentile ranking.

eCQM Measurement. For Program Year 2021, CMS is using the 2020 MIPS benchmarks for eCQM measures. These eCQM benchmarks are set at the 30th and 70th percentiles based on performance submitted via the EHR reporting option to MIPS in 2018.

A summary of the MIPS methodology is listed as follows:

- Measure scores are calculated at the practice TIN or aggregated TIN/NPI level using the following formula:

$$Measure\ Score\ = \frac{Numerator}{Denominator - Denominator\ Exclusion - Denominator\ Exception}$$

- Measures with invalid or zero performance rates are excluded from MIPS benchmarks calculation. For inverse-scored measures, performance rates of 100 are excluded.
- At least 20 reporting practitioners or groups must meet the MIPS eligible clinician criteria for contributing to MIPS benchmarks for a benchmark to be created. These practitioners or groups must also each have a minimum case size of 20 beneficiaries.
- Details on MIPS eCQM benchmarks calculations can be downloaded from https://qpp.cms.gov/about/resource-library.

4.5.2.2 Utilization Component

Utilization Measurement. Both utilization measures are reported as practice-level O/E utilization ratios. To derive reliable benchmarks, only TINs/NPIs with at least 125 attributed beneficiaries eligible for the measure denominator are included to calculate the measure's benchmark. There are 54,932 TINs/NPIs included in the AHU benchmark and 55,308 TINs/NPIs included in the EDU benchmark.

To obtain practice-level benchmarks for the utilization measures, CMS first calculates the observed and expected number of visits for every beneficiary who is eligible for inclusion in the denominator of the measure. CMS then aggregates to the TIN/NPI level for both observed and expected number of visits and calculates the O/E ratio for each TIN/NPI.

The 50th and 80th percentiles of TIN/NPI O/E ratios among the national FFS reference population are the utilization measure benchmarks. Note that performance for both utilization measures is reverse scored, so lower O/E ratios represent desirable performance and are denoted as higher percentiles for both measures.

4.5.3 Benchmark Results

Table 4-8 lists the 30th and 70th percentiles of eCQMs and PEC survey measure benchmarks and the 50th and 80th percentiles of utilization measure benchmarks. Note that all benchmarks are rounded to two decimal places.

Table 4-8
Benchmark Results for the Quality and Utilization Measures in CPC+

CMS ID#	MIPS ID #	Measure Title	Benchmarks	Benchmarks
PEC			P30	P70
N/A	N/A	PEC Summary Score	79.22%	83.16%
eCQMs			P30	P70
CMS165	236	Controlling High Blood Pressure	43.05%	83.65%
CMS122	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)[a]	99.45%	46.84%
Utilization			P50	P80
N/A	N/A	Acute hospital utilization[a]	1.16	0.96
N/A	N/A	Emergency department utilization[a]	1.03	0.81

[a] This measure is reverse scored.

4.6 Illustrative Example of Performance Incentive Retained

4.6.1 Calculation of Performance Incentive Retained for Quality Component

Table 4-9 shows the quality measures that Main Street CPC+ reported, the corresponding performance rates, the CPC+ minimum and maximum threshold for Program Year 2021, and the normalized score for each eCQM and PEC survey measure.

Table 4-9
Percent Payment Retained by Quality Measure—Illustrative Example for Main Street CPC+

Measure	Performance Rate	2021 Minimum Threshold (30th percentile)	2021 Maximum Threshold (70th percentile)	Meet Minimum Threshold (30th percentile)	Meet Maximum Threshold (70th percentile)	Percent Payment Retained	Max Amount of Quality Component Payment
PEC Summary Score	81.00%	79.22%	83.16%	Yes	No	29.04%	40%
MIPS 236, Controlling High Blood Pressure	68.00%	43.05%	83.65%	Yes	No	24.22%	30%
MIPS 001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)[a]	50.00%	99.45%	46.84%	Yes	No	29.10%	30%

[a] This is an inverse measure, for which a lower performance rate means better performance.

In this example, we highlight that MIPS 001 is an example of a reverse-scored measure, meaning that a lower performance rate corresponds to better performance.

Step 1: Address multiple performance rates, if applicable.

Step 2: Calculate the Quality Component of the PBIP retained. The PEC Summary Score is 81 percent, and the two rates below it in the same column are the two reported outcome eCQM performance rates.

Even though Main Street CPC+ met the minimum for all three quality measures, it is not eligible to retain the full Quality Component of the PBIP because none of the three performance scores met the 70th percentile. Main Street CPC+ will retain the Quality Component of the PBIP by individual measure performance because the two reported eCQMs and PEC survey measure meet the minimum threshold.

$$Total\ Quality\ Component\ \% = 29.04\% + 24.22\% + 29.10\% = 82.36\%$$

4.6.2 Calculation of Performance Incentive Retained for Utilization Component

Table 4-10 shows the utilization measures that Main Street CPC+ reported, the corresponding performance rates, the CPC+ minimum and maximum threshold for Program Year 2021, and the normalized score for each eCQM and PEC survey measure.

Table 4-10
Percent Payment Retained by Utilization Measure—Illustrative Example for Main Street CPC+

Measure	O/E Ratio	2021 Minimum Threshold (50th percentile)	2021 Maximum Threshold (80th percentile)	Meet Minimum Threshold (50th percentile)	Meet Maximum Threshold (80th percentile)	Percent Payment Retained	Max Amount of Utilization Component Payment
AHU[a]	0.92	1.16	0.96	Yes	Yes	67.00%	67%
EDU[a]	0.98	1.03	0.81	Yes	No	20.25%	33%

[a] A lower performance rate means better performance.

Step 1. Calculate O/E ratio of hospitalizations per 1,000 beneficiaries.

Main Street CPC+ has an actual rate of 110 events and an expected rate of 120 events per 1,000 beneficiaries based on risk factors as specified.

$$AHU\frac{O}{E}Ratio = \frac{110}{120} = 0.92$$

Step 2. Transform AHU O/E ratio per 1,000 beneficiaries to a percentile ranking based on AHU benchmarks (Table 4-8).

$$AHU\ Measure\ Percent\ Payment\ = \left(\frac{(1.16 - 0.92)}{(1.16 - 0.96)} \times 50 + 50\right) \times 0.67 = 73.70$$

We show this formula only as an example. Because Main Street CPC+ performed better than the maximum threshold, its AHU Measure Percent Payment *automatically* becomes 67.00 percent, or full credit for this measure. Because AHU is an *inverse* measure, the 0.92 O/E ratio being less than the 0.96 O/E ratio 80th percentile benchmark indicates *better* performance.

Step 3. Calculate the same for ED visits per 1,000 beneficiaries.

$$EDU\ \frac{O}{E}\ Ratio\ = \frac{392}{400} = 0.98$$

Step 4. Transform the EDU O/E ratio per 1,000 beneficiaries to a percentile ranking based on EDU benchmarks (Table 4-8).

$$EDU\ Measure\ Percent\ Payment\ = \left(\frac{(1.03 - 0.98)}{(1.08 - 0.81)} \times 50 + 50\right) \times 0.33 = 20.25$$

Step 5. Combine AHU and EDU scores.

$$Total\ Utilization\ Component\ \%\ = 67.00\% + 20.25\% = 87.25\%$$

4.6.3 Calculation of Performance Incentive Retained

On the basis of the illustrative example above, Main Street CPC+ has a Quality Component Score of 82.36 percent and a Utilization Component Score of 87.25 percent. One-half of the full PBIP is retained on the basis of practice performance on the Quality Component, and one-half is retained on the basis of practice performance on the Utilization Component.

The PBPM amount retained by Main Street CPC+ for the Quality Component of the PBIP is equal to

$$\text{Total}\ PBPM\ Quality\ \text{Component}\ PBIP\ Retained = 82.36\% * \$2.00\ PBPM = \$1.65\ PBPM$$

The corresponding annual amount retained is equal to

$$PBIP\ earned\ for\ Quality\ = \$1.65 * 12\ months * 500\ beneficiaries = \$9{,}883.20$$

The PBPM amount retained by Main Street CPC+ for the Utilization Component of the PBIP is equal to

$$Total\ PBPM\ Utilization\ Component\ PBIP\ Retained\ = 87.25\% * \$2.00 = \$1.75\ PBPM$$

The corresponding annual amount retained is equal to

$$PBIP\ earned\ for\ Utilization = \$1.75 * 12\ months * 500\ beneficiares = \$10{,}470.00$$

The total retained by Main Street CPC+ in the Program Year 2018 is equal to

$$Total\ PBIP\ earned\ = \$9{,}883.20 + \$10{,}470.00 = \$20{,}353.20$$

Main Street CPC+ received the full incentive amount for Program Year 2021 at the beginning of the year. As a CPC+ Track 2 participating practice, Main Street CPC+ was prospectively paid a PBIP amount equal to $4.00 PBPM based on having 500 beneficiaries attributed to its practice in Q1 of Program Year 2021:

$$Prospective\ PBIP\ payment = 500\ beneficiaries * \ \$4.00\ PBPM * 12\ months = \$24{,}000$$

Because Main Street CPC+ retained $20,353.20 of the full incentive, CMS will recoup an amount equal to $24,000 − $20,353.20 = $3,646.80.

Note: If Main Street CPC+ had not passed the utilization gate (attained a performance score at the 30th percentile or higher on two of the three quality measures), it would not have been eligible to retain any of the Utilization Component of the PBIP. Therefore, it would have to pay back to CMS *the full amount of the Utilization Component: $12,000*.

Chapter 5: Payment Under the Medicare Physician Fee Schedule

Chapter 5 describes and explains the **hybrid payment** for CPC+ Track 2 practices. Practices participating in Track 1 will continue to bill and receive payment from Medicare FFS as usual. Section 5.1 explains the purpose and intent of the hybrid payment, differences from other CPC+ payments, and implications for Track 2 CPC+ practices. Sections 5.2 and 5.3 describe the parameters of the **CPCP**—Section 5.2 outlines the approach for determining historical expenditures for the CPCP using a historical calculation year, while Section 5.3 describes the Program Year 2021 CPCP. Sections 5.4 and 5.5 describe the corresponding claims reduction and the 2019 **partial reconciliation**, respectively.

5.1 Purpose and Intent

5.1.1 Purpose and Aims

The goal of the hybrid payment is to support the flexible delivery of comprehensive primary care to promote population health beyond traditional **evaluation and management office visits** (henceforth, office visit E&Ms). Under current exclusive FFS payment methodologies, there is a strong incentive rewarding face-to-face office visit E&Ms for billable revenue generation, even if virtual encounters (e.g., phone calls, electronic communications) would better meet the beneficiary's needs or align with beneficiary preferences. Conversely, a fully population-based payment for primary care services without FFS payment for office visit E&Ms may present an undesirable incentive to minimize all office visit E&Ms.

In Track 2 of CPC+, CMS uses a **hybrid payment** that allows practices the flexibility to deliver care in the most appropriate mechanism that is also in accordance with beneficiary preferences (Davis et al., 2005; Goroll et al., 2007; Vats et al., 2013;). The hybrid payment includes a prospectively paid PBPM payment (paid quarterly) and a corresponding FFS claims reduction on payments for specific claims submitted during the Program Year. The prospective, up-front payment, or **CPCP**, is paid based on a practice's average PBPM E&M payments during the **historical calculation period**. The **historical PBPM** is trended (for Medicare FFS price inflation/deflation) to reflect the **Program Year**.[26] FFS payments during the Program Year are reduced proportionately to match a practice's selected percentage of the historical PBPM payment (i.e., the CPCP). The hybrid payment is limited to services that are billed using selected office visit E&M codes under the PFS. To protect beneficiary access and incentivize preventive and other services (e.g., influenza vaccination), it is important to retain some full primary care FFS payment.

The hybrid payment changes the payment mechanism, promotes flexibility in how practices deliver care traditionally required to be provided via an office visit E&M, and supports the CPC+

[26] The historical PBPM is also adjusted by the comprehensiveness supplement, which accounts for the increased depth and breadth of primary care services under Track 2. See Section 5.3.1 for details.

requirement for practices to increase the depth and breadth of primary care they deliver (i.e., **comprehensiveness**). In contrast to the CMF (described in Chapter 3), the up-front CPCP component of the hybrid payment compensates the practitioner for transitioning clinical services that have traditionally been separately billable office visit E&Ms to commonly nonbillable care delivery modalities such as telephone calls or secure messaging. The hybrid payment is intended to mitigate the financial incentives for office visit E&M volume by giving these practices the flexibility to deliver care via commonly nonbillable modalities in accordance with beneficiary preferences, while encouraging practices to furnish proactive and comprehensive care that traditionally has been limited to an office setting. We anticipate that the hybrid payment will achieve **incentive neutrality**, in which the incentive to bring a beneficiary to the office is balanced with the incentive to provide the needed care outside of an office visit, making a practice agnostic as to whether it delivers a service in person or via another modality.

5.1.2 Payment Choices by Year

Track 2 practices select their **hybrid payment ratio**, which is the annual pace at which they will progress toward one of two hybrid payment options: one option will pay 40 percent up front and 60 percent of the applicable FFS payment, and the other will pay 65 percent up front and 35 percent of the applicable FFS payment. Practices select a hybrid payment option each year.

5.1.3 Implications of Comprehensive Primary Care Payment for Practices and Beneficiaries

The hybrid payment is intended to increase beneficiary access, improve efficiency in addressing health issues, improve patient experience, and reduce cost-sharing, as beneficiaries do not have to pay co-insurance for care received outside of an office visit. For regular office visit E&Ms, beneficiaries are responsible for typical cost-sharing. For the practice, a benefit of the CPCP is a reduction in billing documentation requirements for the care delivered outside of an office visit and support for delivering more comprehensive care. That said, practices are still required to document their use of funds to achieve the care delivery requirements. Practices are also required to report their progress on practice transformation regularly through the CPC+ Practice Portal, which provides both the practices and CMS insight into practice capabilities. Although the practices are expected to experience a reduction in revenue from fewer co-insurance for office visit E&Ms, the hybrid payment is intended to mitigate this loss.

5.2 Historical per-Beneficiary per-Month

The historical PBPM represents each CPC+ practice's E&M payments received from CMS for a group of beneficiaries in a 24-month period before the start of CPC+. The historical PBPM is used to estimate the amount of primary care represented by these E&M payments that practices will likely deliver during the Program Year.

There are two major steps in creating the historical PBPM:

1. Define the historical time period, **historical population**, and the conditions under which beneficiaries are eligible.
2. Define the types of payments included among the historical population during the historical time period.

The historical calculation period is a two-year time period. For 2017 Starters, it is defined as the last two quarters of calendar year 2014 through the first two quarters of calendar year 2016. For 2018 Starters, it is defined as the last two quarters of calendar year 2015 through the first two quarters of calendar year 2017.

5.2.1 Historical Population and Eligibility

The historical population includes all beneficiaries attributed to a selected CPC+ practice during the historical calculation period. To determine the historical population, we use historical claims to attribute beneficiaries to practices quarterly during the historical calculation period. To the extent possible, we require attribution for the historical calculation period population to be the same as attribution for the Program Year population to reduce potential differences between these two groups.

CMS uses the attribution methodology described in Chapter 2, which involves identifying eligible beneficiaries and eligible primary care visits and then applying the attribution algorithm (see Chapter 2 for details). The TINs-NPIs[27] for each CPC+ practice are used in the attribution, including the TINs-NPIs that were active during the historical period. Beneficiaries are included in the historical calculation for only the applicable portion of the year for which they were eligible.[28]

5.2.2 Historical Payments

CMS calculates **historical payments** from all applicable Medicare Part B E&M payments made to the CPC+ practice for its historical population during the historical calculation period. Claims are eligible if

1. the service date[29] on the claim is during a period when the beneficiary was eligible,
2. the claim includes an office visit E&M service (Appendix G), and
3. the service is provided by an eligible primary care practitioner (Appendix B).

For each CPC+ practice, CMS sums the Medicare FFS payment amount for eligible office visit E&M claims. The Medicare FFS payment amount is the amount of the claim that was actually paid, reflecting applicable payment adjustments (e.g., adjustments for practitioner type, geography, and performance in quality programs). Because **sequestration** is included in

[27] CCNs may also apply for CPC+ practices with CAHs. Throughout this chapter, when the term TIN is used, it can be interpreted to mean TIN or CCN.

[28] Details on the eligibility criteria are provided in Chapter 2.

[29] The service date for most claims is the date the beneficiary received the service (referred to as the “from date” on the claim).

historical payments, CMS increases historical payments based on historical sequestration amounts. The CPCPs are then subject to any current sequestration.

Most practices have two years of historical data to create PBPM estimates. However, if a practice does not, the most recent year of the historical period is used. If a practice has fewer than 125 beneficiaries attributed per quarter, on average, for at least the entirety of the most recent year of the historical period, then the practice is assigned a historical PBPM equal to the median PBPM among CPC+ practices in its region.

5.2.3 Example Practice Illustration—Main Street CPC+

Throughout this chapter, we will illustrate the hybrid payment calculations using a sample practice, which we call Main Street CPC+. Please note that these examples should not be interpreted as representing a "typical practice" or an "average impact."

Main Street CPC+ has 3,600 eligible, attributed beneficiary months over the two-year historical calculation period and a corresponding $65,455 of E&M claim payments for these beneficiary months over the two-year historical calculation period. Thus, the historical PBPM for Main Street CPC+ is as follows:

$$Historical\ E\&M\ PBPM = \frac{Total\ E\&M\ claim\ payments}{Number\ of\ attributed\ beneficiary\ months} = \frac{\$65{,}455}{3{,}600} = \$18.18\ PBPM$$

5.3 Comprehensive Primary Care Payment Program Year Calculation

The 2021 CPCP calculation is constructed by adjusting each practice's historical payments and expressing them in 2021 dollars, as detailed in this section. The historical payments are adjusted to account for comprehensiveness (increased by 10 percent) and PFS updates. The CPCP payment will be calculated annually and will be paid quarterly on the basis of the number of attributed beneficiaries for that quarter. At the end of Section 5.3, we illustrate our calculations with Main Street CPC+, which we introduced in Section 5.2.3.

5.3.1 Comprehensiveness Supplement

To account for increased depth and breadth, or comprehensiveness, of primary care expected under Track 2, CMS includes a 10 percent increase to the historical payment, termed the **comprehensiveness supplement**. The Affordable Care Act's Incentive Payments for Primary Care Services informed the 10 percent increase (Polsky et al., 2015).[30] Therefore, in the calculation of the CPCP for 2021, CMS will multiply the historical PBPM payments from E&M services by 110 percent.

[30] Section 5501(a) of The Affordable Care Act.

5.3.2 Physician Fee Schedule Updates and Revaluation Changes

Under the PFS, CMS regularly updates the national **conversion factor (CF)** to set payment rates. In addition, CMS regularly updates the **relative value unit (RVU)** for each E&M code and the **geographic cost price index (GPCI)** for each locality.[31] Because the historical calculation period uses 2014/2015/2016 payment rates for 2017 Starters and 2015/2016/2017 payment rates for 2018 Starters, CMS adjusts the CPCP calculation using the finalized 2021 payment parameters (CF, RVU, GPCI)[32] to express the **adjusted historical PBPM** in 2021 dollars.

Finally, CMS occasionally introduces new codes into the PFS that may affect primary care and CPC+. We will assess these codes as they become finalized for their relevance to the CPCP.

5.3.3 Merit-Based Incentive Payment Adjustment

The CPCP must also account for any adjustments individual practitioners are eligible for under the MIPS. Practices and their practitioners participating in CPC+ are generally exempt from MIPS because of their participation in an Advanced APM. However, practices concurrently participating in the Medicare Shared Savings Program (dual practices) may be eligible for MIPS adjustments, and CPCPs must therefore be adjusted accordingly.

Each year, using NPIs, CMS identifies individual practitioners who are eligible for MIPS adjustment within dual CPC+ practices. If, within a specific practice, multiple practitioners have different MIPS adjustment amounts, CMS calculates a weighted average adjustment based on the volume of Medicare claims submitted by each NPI. CMS then applies this adjustment to the practice's calculated historical PBPM amount, which it in turn applies to CPCPs for the year.

5.3.4 Adjusted Historical per-Beneficiary per-Month

A CPC+ practice's historical PBPM is adjusted. Specifically, the adjusted historical PBPM is the historical PBPM adjusted for the comprehensiveness supplement (Section 5.3.1), PFS changes (Section 5.3.2), and MIPS adjustments (Section 5.3.3). In Section 5.2.3, we calculated Main Street CPC+'s historical calculation period PBPM as $18.18. For this example, let us assume a 2 percent PFS update in CF and no change in prices for RVUs or GPCIs (from historical period to 2021). Let us also assume that Main Street CPC+ is a standard practice and not eligible for MIPS adjustment. Then the adjusted historical PBPM is as follows:

[31] For details on the Medicare physician payment formula, see http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_physician_final.pdf?sfvrsn=0.

[32] The finalized Physician Fee Schedule rates for 2021 can be found at https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/.

$$
\begin{aligned}
&Adjusted\ Historical\ E\&M\ PBPM \\
&\qquad = Historical\ Calculation\ Period\ PBPM\ (per\ section\ 5.2) \\
&\qquad * Comprehensiveness\ Supplement\ (per\ section\ 5.3.1) \\
&\qquad * PFS\ Update\ (per\ section\ 5.3.2) \\
&\qquad = \$18.18 * 110\% * 102\% = \$20.40
\end{aligned}
$$

The 2021 Adjusted Historical E&M PBPM is $20.40.

5.3.5 Calculation for Main Street CPC+

Let us assume Main Street CPC+ had 290 attributed beneficiaries for Q1 of 2021. Main Street CPC+ chose to receive 40 percent up front as the CPCP for 2021.

$$
\begin{aligned}
&Quarterly\ CPCP \\
&\qquad = 2021\ PBPM * number\ of\ attributed\ beneficiaries * 3\ months\ per\ beneficiary \\
&\qquad * up\text{-}front\ CPCP\ election = \$20.40 * 290 * 3 * 40\% = \$7{,}099
\end{aligned}
$$

Therefore, in January 2021, Main Street CPC+ will receive $7,099 for its up-front Q1 2021 CPCP payment.

5.3.6 Frequency of Comprehensive Primary Care Payment Calculation and Payment

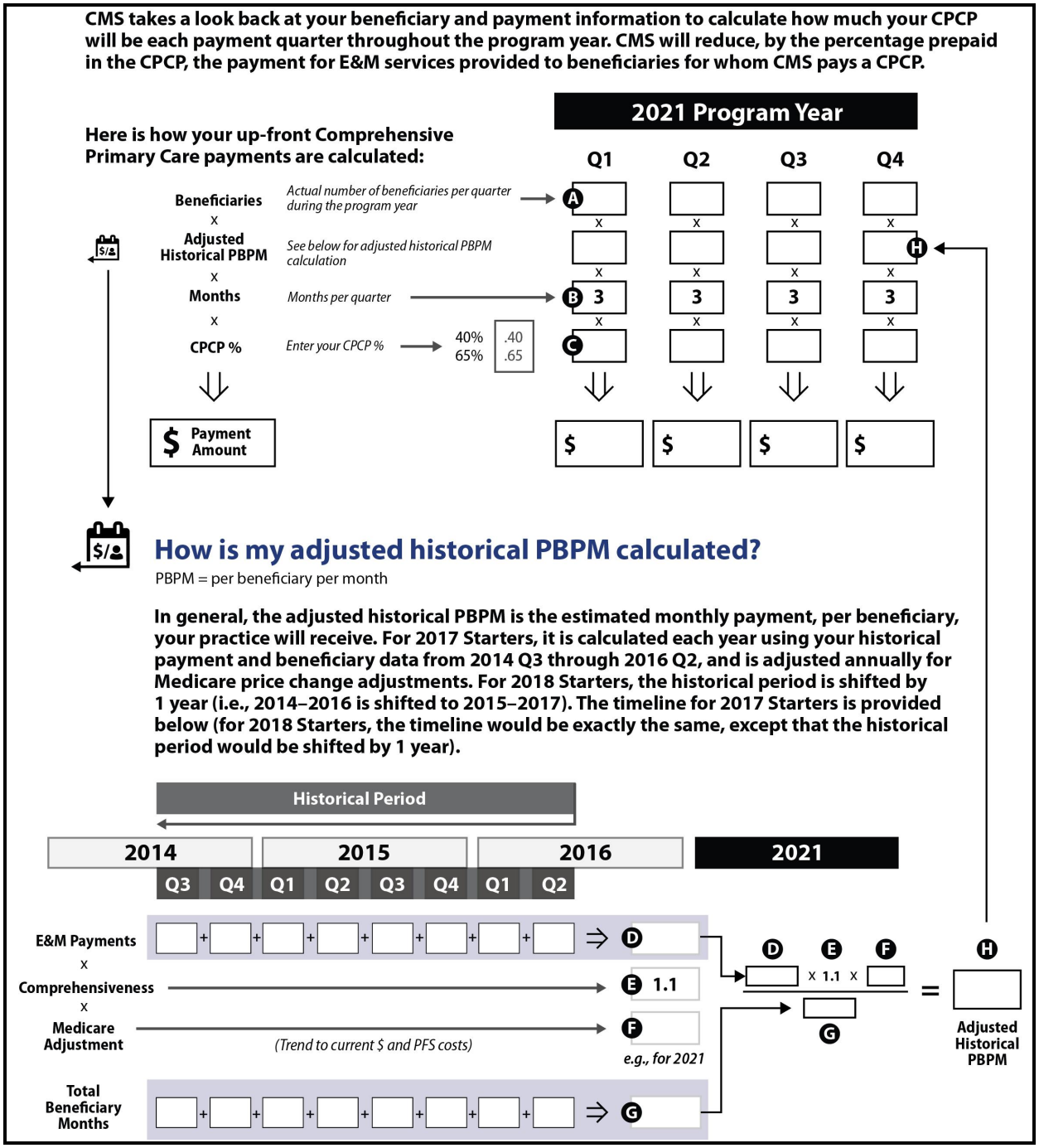
CMS calculates the CPCP as a PBPM and makes payments to practices quarterly. Track 2 practices receive CPCPs when they receive their quarterly CMF payments.

Figure 5-1 provides a general graphical illustration of the CPCP calculation and payment for Track 2 CPC+ practices during Program Year 2021, including how the adjusted historical PBPM is calculated as well as how the CPCP is calculated. Then Figure 5-2 provides a graphical representation of the CPCP calculation and payment for the Main Street CPC+ example that has been used throughout this chapter.

5.3.7 Debits for Beneficiary Ineligibility

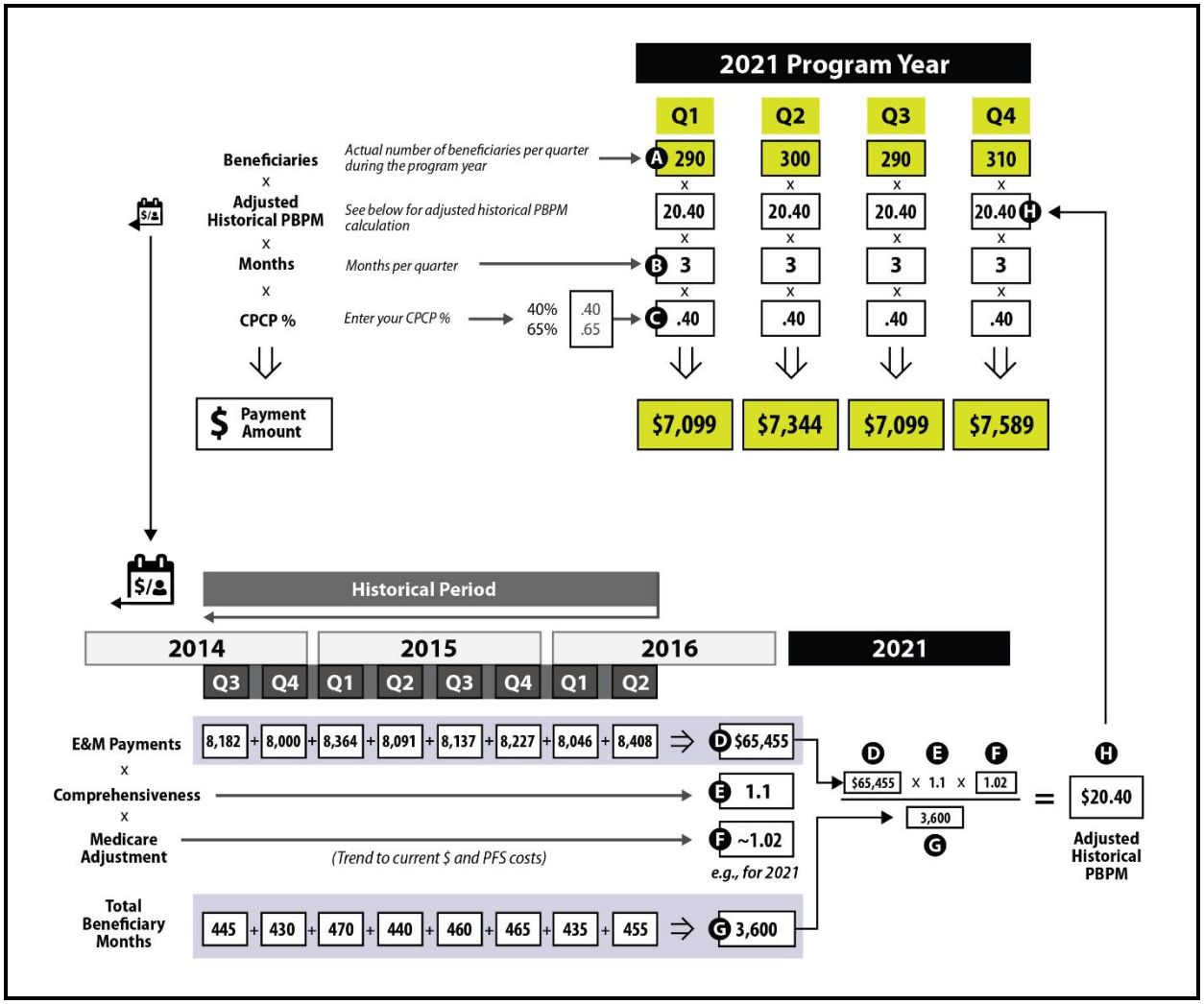
CMS determines attribution and calculates quarterly CPCPs in advance of each quarter. This follows the same process as retrospective debits for beneficiary ineligibility for the CMF. See section 3.3.1 for additional information.

Figure 5-1
How Does the CPCP in Track 2 Get Calculated?



Note: The historical calculation period is a two-year period before the start of a Program Year. For 2017 Starters, it is defined as the last two quarters of calendar year 2014 through the first two quarters of calendar year 2016 for Program Year 2021. For 2018 Starters, it is defined as the last two quarters of calendar year 2015 through the first two quarters of calendar year 2017 for Program Year 2021.

Figure 5-2
CPCP—Main Street CPC+ Example



Note: Figure 5-2 is for 2017 Starters. For 2018 Starters, the figure would be identical, but the historical period would shift by one year (i.e., 2014–2016 would shift to 2015–2017).

5.4 Fee-for-Service Reduction

For Program Year 2021, there will be a corresponding set of reductions to practices' FFS payments for the applicable E&M services covered under the CPCP. These reductions are described herein.

As described in Section 5.1.2, Track 2 practices select the annual pace at which they progress toward one of two hybrid payment options. This selection occurs during the fall preceding the Program Year. Although the CPCP is paid at the practice level, the corresponding **FFS reduction** occurs at the practitioner level. CMS claims systems reduce a Medicare PFS claim billed to Part B only when there is an office visit E&M service by a CPC+ practitioner for an

attributed beneficiary during a payment quarter. Otherwise, the claims systems do not reduce the claim.

CMS reduces office visit E&M claims only for attributed beneficiaries with a visit to the primary care practitioners on the CPC+ practitioner roster (i.e., TIN/NPI combinations) as reported to CMS. If a CPC+ practitioner bills an office visit E&M for an attributed beneficiary at a non-CPC+ practice site with the same TIN as the participating CPC+ practice, the CMS claims systems applies the CPCP reduction.

As stated in Section 5.1.3, the CPCP does not affect beneficiary co-insurance for office visits. Additionally, it does not alter Medicare FFS allowed amounts. The claims reduction follows any other CMS adjustments (e.g., **physician value-based payment modifier**, **Physician Quality Reporting System**) and precedes sequestration. The paid amount field of the processed claim indicates to the CPC+ practitioner the post-CPCP reduction amount and final payable amount. Practitioners continue to receive electronic remittance advice or standard paper remittance.

5.4.1 Fee-for-Service Calculation for Main Street CPC+

Recall that Main Street CPC+ chose to receive 40 percent up front as the CPCP for 2021 with the corresponding 60 percent in FFS claims. Suppose a CPC+ practitioner at Main Street CPC+ is normally paid $50 for an office visit E&M provided to an attributed beneficiary. In 2021, the practice will receive $30 ($50 * 60 percent = $30) for each office visit E&M claim.

5.5 Partial Reconciliation

CMS conducts annual outside-of-practice partial reconciliations to mitigate risks for both CMS and CPC+ practices, which could arise in the absence of reconciliation. Partial reconciliation is meant to accomplish three aims: (1) protect CMS against paying more than expected amounts for office visit E&M services for CPC+ attributed beneficiaries; (2) protect practices in specifically defined situations from financial risk from the hybrid payment compared with pure FFS; and (3) maintain incentive neutrality for practices, ensuring that they are free to deliver enhanced services but are not incentivized to increase FFS billings to achieve a more favorable financial outcome.

Outside-of-practice partial reconciliation considers the office visit E&Ms beneficiaries receive from practitioners who are not on the CPC+ practice site roster to which the beneficiary is attributed. It is important for both CMS and CPC+ practices to consider the extent to which an attributed beneficiary's practice increases or decreases office visit E&M services delivered outside of the CPC+ practice.

CMS presumes that beneficiaries tend to increase the amount of primary care they seek elsewhere if they are dissatisfied with the care they receive from their CPC+ practice. Thus, increases in office visit E&M services delivered by primary care practitioners outside of the CPC+ practice to CPC+ practice attributed beneficiaries would lead to a partial downward adjustment of the CPCP. Conversely, significant decreases in office visit E&M services

delivered by primary care practitioners in an office setting outside of the CPC+ practice could also lead to an additional payment to CPC+ practices. In rare cases, a practice could see substantial decreases in office visit E&M volume if services were being delivered by other practices that previously were delivered by the CPC+ practice. The CPCP should not reward a practice in this situation. Conversely, in rare cases, a CPC+ practice could see substantial increases in office visit E&M volume by delivering services to its attributed beneficiaries, which previously were delivered by other primary care practices. The CPCP should not penalize a practice in this situation. Thus, the purpose of the outside-of-practice partial reconciliation is to account for the difference between (1) adjusted historical PBPM revenue and (2) Program Year PBPM revenue for office visit E&M services for attributed beneficiaries from primary care practitioners delivered *outside* the CPC+ practice.

There are three major steps to conducting the outside-of-practice partial reconciliation:

1. Calculate the office visit E&M PBPM expenditures for attributed beneficiaries delivered outside the CPC+ practice during the historical calculation period.
2. Calculate the office visit E&M PBPM expenditures for attributed beneficiaries delivered outside the CPC+ practice during the Program Year.
3. Determine the partial reconciliation amount based on comparison of the PBPM from the historical calculation period and the PBPM from the Program Year (from Steps 1 and 2).[33]
    a. If the outside-of-practice PBPM is between $2 and $7 PBPM *more* in the year being reconciled than it was in the historical calculation period, then CMS will *reduce* payment to the CPC+ practice down to the $2 PBPM difference. In 2021, CMS will reconcile CPCPs from 2019.
    b. If the outside-of-practice PBPM is between $2 and 7 PBPM *less* in 2019 than it was in the historical calculation period, then CMS will increase payment to the CPC+ practice up to the $2 PBPM difference.
    c. We cap reconciliation at $7 PBPM, such that the maximum amount to be credited or debited through future CPCPs is $5 PBPM.
    d. We also cap the reconciliation at the CPCP paid during the Program Year. For example, if a practice received a CPCP of $1,000 in 2019, then the maximum reconciliation (either positive or negative) the practice can receive (or have to pay) is $1,000.
    e. If the absolute difference is not greater than $2 PBPM, then no reconciliation occurs.

CMS expects a minority of practices to be subject to this reconciliation. We chose $2–7 PBPM as our reconciliation corridor through an analysis of the data from the CPC Classic. Overall,

[33] Note that as subsequent Program Years become more distant from the historical calculation period, it may become necessary to adjust the historical calculation period for this reconciliation to improve the comparability of the historical calculation period to the Program Year. Because this reconciliation is calculated independently of the other components of the CPCP calculation, this can be done without changing the historical calculation period used for other aspects of this methodology. CMS will monitor whether it is necessary to adjust the calculation year for calculating outside-of-practice reconciliation and inform practices in advance of any changes. Changes will be made if distortions between the historical calculation period and the Program Year start to penalize practices.

approximately 75–80 percent of office visit E&M services from primary care practitioners were delivered within the practice in the CPC Classic. The average was $16–17 PBPM within the CPC Classic practice and $4–5 PBPM outside the CPC Classic practice. Approximately 10 percent of practices had changes in outside-of-practice expenditures greater than $2 PBPM (in either direction), whereas less than 3 percent of practices had changes in outside-of-practice expenditures greater than $7 PBPM (in either direction). We will modify subsequent CPCPs by any change beyond +/− $2 and lower than +/− $7. For those with changes greater than $7, CMS is capping the reconciliation because such large changes are more likely because of changes in provider billing (e.g., billing under different TINs, only one of which is in the CPC+ practice). We also cap the total reconciliation amount at the CPCP amount paid during the year being reconciled. For example, if a practice received a CPCP of $1,000 in 2019, then the maximum reconciliation (either positive or negative) the practice can receive is $1,000.

We now explain in more detail the three major steps to conducting the outside-of-practice partial reconciliation:

Step 1: Calculate the office visit E&M PBPM expenditures for attributed beneficiaries delivered outside the CPC+ practice *during the historical calculation period*. CMS calculates total office visit E&M PBPM expenditures from all primary care practitioners not on the CPC+ practitioner roster (including primary care practitioners not participating in CPC+) for beneficiaries attributed to the practice.

When calculating office visit E&M expenditures during the historical calculation period, CMS will consider only beneficiary months of experience for when the beneficiary was eligible and attributed, as we described in Section 5.2. CMS will adjust for PFS updates and revaluation changes from the historical period (from Section 5.3.2). Because we compare historical calculation period expenditures with Program Year expenditures, the historical calculation period expenditures must be expressed in current Program Year dollars. Finally, CMS does not include the comprehensiveness supplement because practices outside of CPC+ do not receive it.

To illustrate, in the historical calculation period, Main Street CPC+ has a historical population of 3,600 attributed beneficiary months. The attributed beneficiaries received $21,600 of office visit E&M services outside of Main Street CPC+ for these beneficiary months (after adjusting the historical E&M to Program Year prices). The PBPM of office visit E&M services delivered outside of Main Street CPC+ for attributed beneficiaries in the historical calculation period is $6 PBPM or $21,600/3,600 beneficiary months.

Step 2: Calculate the office visit E&M PBPM expenditures for attributed beneficiaries delivered outside of the CPC+ practice *during the Program Year being reconciled.* Each year, CMS will calculate any positive or negative reconciliations for the prior year and implement them in the following year. In 2021, CMS will reconcile CPCPs from 2019 that were calculated in 2020.

CMS calculates total office visit E&M PBPM expenditures for attributed beneficiaries from primary care practitioners not participating in CPC+.

In the Program Year, Main Street CPC+ has a population of 3,500 attributed beneficiary months with $7,000 worth of E&M services received outside of Main Street CPC+ for these beneficiary months. The office visit E&M PBPM delivered outside of Main Street CPC+ in the Program Year is $2 PBPM or $7,000/3,500 beneficiary months.

Step 3: Determine the reconciliation amount based on comparison of the PBPM from the historical calculation period and the PBPM from the current Program Year (from Steps 1 and 2).

There are three possible scenarios when comparing the PBPM from the historical calculation period and the PBPM from the Program Year. Below, we discuss these scenarios and how they may or may not result in outside-of-practice reconciliation.

Step 3, Scenario 1: If the outside-of-practice PBPM is between $2 and $7 PBPM *more* in the Program Year than it was in the historical calculation period, then CMS will *reduce* payment to the CPC+ practice down to the $2 PBPM difference.

Step 3, Scenario 2: If the outside-of-practice PBPM is between $2 and $7 PBPM *less* in the current Program Year than it was in the historical calculation period, then CMS will *increase* payment to the CPC+ practice up to the $2 PBPM difference.

Step 3, Scenario 3: If the absolute difference is not greater than $2 PBPM, then no reconciliation occurs.

In both Scenarios 1 and 2, if the total calculated partial reconciliation amount is greater than the CPCP paid in the Program Year, then the partial reconciliation will be capped at the CPCP paid. This is true for both positive and negative reconciliation values.

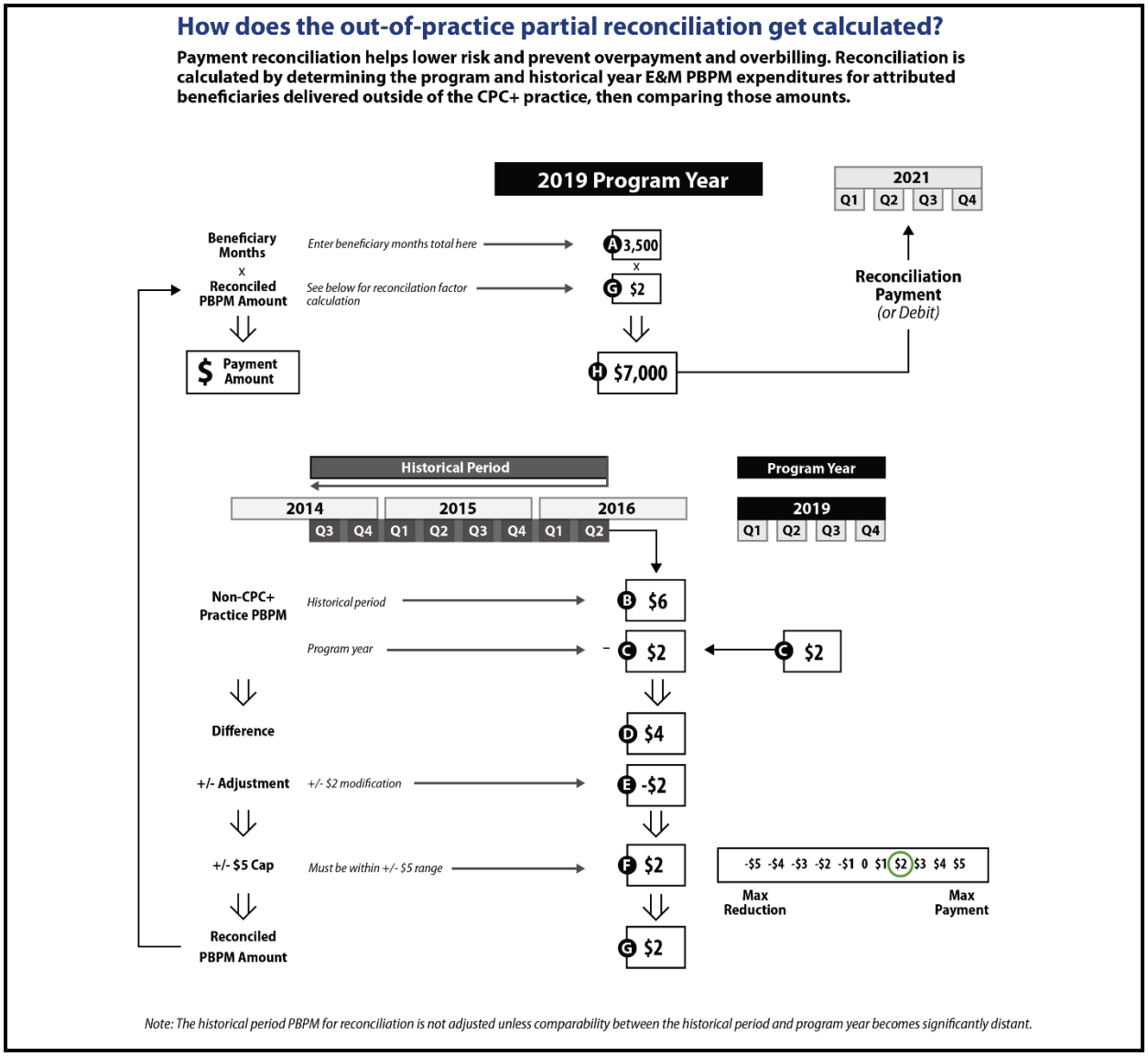
Based on simulations of the CPCP, CMS expects only a minority of practices within a given Program Year to fall outside this range and to be subject to outside-of-practice reconciliation. If a larger-than-expected share of practices fall outside this range, we may adjust the methodology for this reconciliation to protect against undue financial and other burdens on practices.

Outside-of-Practice Partial Reconciliation Calculation for Main Street CPC+. The PBPM for outside E&M services in the historical calculation period was $6 (Step 1), and the PBPM for outside E&M services in the Program Year was $2 (Step 2). Therefore, the difference between the two PBPM amounts is $4 ([Step 1] − [Step 2] = $6 − $2). Therefore, Main Street CPC+ falls into outside-of-practice partial reconciliation Scenario 2 and will receive an increase in payment. For this scenario, $4 PBPM is the absolute difference between the $6 Program Year PBPM and $2 historical period PBPM and is less than the $5 maximum amount that could be credited or debited through future payment. Because the Program Year and historical period PBPMs are allowed to vary up to $2, the total adjustment is $4 − $2 = $2.

Therefore, the payment increase to Main Street CPC+ will be $2 * (3,500 beneficiary months) = $7,000.

The outside-of-practice partial reconciliation is conducted annually at the practice level. CMS incorporates the reconciliations in the quarterly CPCPs two years after the Program Year (e.g., Program Year 2019 reconciliation will occur in 2021) as an increase or decrease in CPCP. If the reconciliation is sufficiently large, CMS may spread the reconciliation amount over subsequent quarterly payments (Figure 5-3).

Figure 5-3
Payment Reconciliation



Note: Figure 5-3 is for 2017 Starters. For 2018 Starters, the figure would be identical, except the historical period would shift by one year (i.e., 2014–2016 would be shifted to 2015–2017).

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Chapter 6: Conclusions

CPC+ payment system redesign aims to ensure practices have the infrastructure to deliver better care at lower costs. With the combination of the CMF, PBIP, and Medicare FFS payment (regular FFS for Track 1 or hybrid payment for Track 2), CMS provides strong financial support to practices to expand the breadth and depth of their services to better meet the needs of their beneficiary population.

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Appendix A: Glossary of Terms

Absolute Performance Thresholds: Minimum and maximum thresholds against which practices are measured for performance-based incentive payment (PBIP). In Program Year 2020, the minimum threshold is the 30th percentile in the benchmark population for clinical quality and patient experience of care and the 50th percentile in the benchmark population for utilization, whereas the maximum threshold is the 70th percentile in the benchmark population for clinical quality and patient experience of care and the 80th percentile in the benchmark population for utilization. The thresholds are determined by a benchmark population external to Comprehensive Primary Care Plus (CPC+) participation for electronic Clinical Quality Measures (eCQMs) and utilization measures. The Patient Experience of Care (PEC) benchmark is calculated using internal CPC+ practice performance in Program Years 2017, 2018, and 2019.

Accountable Care Organizations (ACOs): Groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) offers several ACO programs and models, including the Medicare Shared Savings Program, ACO Investment Model (a supplementary incentive program for selected participants in the Shared Savings Program), and Next Generation ACO Model (designed for early adopters of coordinated care).

Acute Hospital Utilization (AHU): The component of the performance-based incentive payment that measures practice performance on AHU.

Adjusted Historical Per-Beneficiary Per-Month (PBPM): Historical PBPM for a CPC+ practice adjusted for both the comprehensiveness supplement and for Medicare Physician Fee Schedule (PFS) updates between the historical calculation period and the Program Year.

Alternative Payment Models (APMs): Payment approaches, developed in partnership with the clinician community, which provide added incentives to deliver high-quality and cost-efficient care. APMs can apply to a specific clinical condition, care episode, or population.

Advanced Alternative Payment Model (Advanced APM): APM that requires participants to use Certified Electronic Health Record (EHR) Technology, that bases payment on quality measures comparable with those in the Merit-based Incentive Payment System (MIPS), and where participants bear more than nominal financial risk; or, an APM Medical Home Model expanded under Innovation Center authority.

Attribution: Tool to assign beneficiaries to primary care practices. In CPC+, attribution is used to estimate the amount of care management fees (CMFs), PBIP, and, for Track 2 practices, the hybrid payment. CMS uses Medicare claims and eligibility data to conduct beneficiary attribution.

Benchmark Thresholds: Sustained superior performance by a medical care clinician that can be used as a reference to raise the mainstream of care for Medicare beneficiaries. Benchmarks

establish the minimum levels CPC+ practices must reach to retain a portion of the PBIP and the maximum levels that practices must achieve to retain the full PBIP.

Consumer Assessment of Healthcare Providers and Systems® (CAHPS®): Asks consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics important to consumers and focus on aspects of quality that consumers are best qualified to assess, like providers' communication skills and ease of access to health care services. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CAHPS Clinician and Group (CG-CAHPS) Survey: Assesses patients' experiences with health care providers and staff in doctors' offices. Survey results can be used to improve care provided by individual providers, sites of care, medical groups, or provider networks and to equip consumers with information they can use to choose physicians and other health care providers, physician practices, or medical groups.

Care Management Fee (CMF): Pays selected primary care practices a CMF to support enhanced, coordinated services for Medicare beneficiaries. CPC+ practices will receive a risk-adjusted, prospective, monthly CMF for their attributed Medicare fee-for-service (FFS) beneficiaries. Practices will use this enhanced, non-visit-based compensation to augment staffing and training in support of population health management and care coordination.

Chronic Care Management (CCM)–Related Services: Healthcare Common Procedure Coding System (HCPCS) codes 99358, 99484, 99487, 99490, 99491, G0506, and G0507 (and their corresponding add-on codes) are duplicative of the services covered by the CPC+ CMF. Medicare will not pay both a CPC+ CMF and fees for CCM-related services for any individual CPC+-attributed beneficiary in the same month.

CMF Reference Population: Determines the risk tier thresholds on which care management fees are based. For a given region, the CMF reference population includes Medicare FFS beneficiaries in that region who meet CPC+ eligibility requirements and who have had an eligible primary care visit.

CMS Certification Number (CCN): Renamed from the Medicare/Medicaid Provider Number to avoid confusion with the National Provider Identifier (NPI; also known as the OSCAR Provider Number, Medicare Identification Number, or Provider Number). The CCN continues to serve a critical role in verifying a clinician has been Medicare certified and for what type of services.

Comprehensiveness: Increased depth and breadth (length and/or intensity) of primary care services furnished by the CPC+ practice.

Comprehensiveness Supplement: Increase of 10 percent in historical PBPM to account for comprehensiveness.

Comprehensive Primary Care (CPC) Classic: CPC Classic was a multipayer initiative designed to strengthen primary care. CPC Classic ran from October 2012 through December 2016 and preceded CPC+.

Comprehensive Primary Care Payment (CPCP): Up-front payment to a Track 2 CPC+ practice for a percentage of expected Medicare payments for evaluation and management (E&M) services provided through the PFS to aligned beneficiaries. E&M visits billed during the Program Year are correspondingly decreased. The CPCP compensates clinicians for clinical services that have been traditionally billable but offers flexibility for these services to be delivered inside or outside of an office visit and in accordance with patient preferences. The flexibility allows more time to be devoted to increasing the breadth and depth of services provided at the CPC+ practice site and for population health improvement.

Comprehensive Primary Care Plus (CPC+): National advanced primary care medical home model that aims to strengthen primary care through a regionally based multipayer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. The care delivery redesign ensures practices in each track have the infrastructure to deliver better care, resulting in a healthier beneficiary population. The multipayer payment redesign gives practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care and reduce unnecessary health care utilization. CPC+ provides practices with a robust National Learning Network and actionable beneficiary-level cost and utilization data feedback to guide their decision making. CPC+ is a five-year model that began in January 2017 for 2017 Starters and began in January 2018 for 2018 Starters.

Conversion Factor (CF): In calculating payment rates under the PFS, each of the three relative value units (RVUs) is adjusted to reflect the price of inputs in the local market where the service is furnished. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule CF.

CPC+-Eligible Beneficiaries: Medicare beneficiaries who are enrolled in both Medicare Parts A and B, have Medicare as their primary payer, do not have End Stage Renal Disease and are not enrolled in hospice, are not covered under a Medicare Advantage or other Medicare health plan, are not long-term institutionalized, are not incarcerated, and are not enrolled in any other program or model that includes a Medicare FFS shared savings opportunity, except for the Medicare Shared Savings Program if the practice is a dual participant with the Shared Savings Program (see **Medicare Shared Savings Program** below).

Dual Practices: Practices participating in both the CPC+ and in a Medicare Shared Savings Program ACO.

Electronic Clinical Quality Measure (eCQM): Clinical quality measures that use data from EHR and/or health information technology systems to measure health care quality. CMS uses

eCQMs in numerous quality reporting and incentive programs; two eCQMs are used for PBIP determinations.

Eligible Primary Care Visit: Primary care visit used in the CPC+ attribution algorithm. Primary care services include E&M services, provided in office and other noninpatient and non–emergency room settings, initial Medicare visits, and Annual Wellness Visits. Specifically, eligible primary care visits include home care, Welcome to Medicare and Annual Wellness Visits, advance care planning, collaborative care model, cognition and functional assessment for payment with cognitive impairment, outpatient clinic visit for assessment and management (Critical Access Hospitals only), transitional care management services, CCM services, complex CCM services, assessment/care planning for payments with CCM services, and care management services for behavioral health conditions.

Emergency Department Utilization (EDU): Component of the PBIP that measures practice performance on EDU.

Evaluation and Management (E&M) Office Visits: Medicare-covered services (office visits) used to calculate CPCP, furnished by a Participating CPC+ Practitioner to a CPC+ Beneficiary and billed under the Taxpayer Identification Number (TIN)/NPI (or CCN/NPI) of the CPC+ Practice using one or more of the following HCPCS codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354 (replaced with 99415 in 2021), and 99355 (replaced with 99416 in 2021).

Fee-for-Service (FFS): Clinicians are paid for each service performed based on a payment fee schedule. Examples of services include tests and office visits.

Fee-for-Service (FFS) Reduction: Percentage by which a Track 2 CPC+ Practice's payment for E&M services is reduced if a Participating CPC+ Practitioner furnishes the services to a CPC+ Beneficiary and bills them under the TIN/NPI (or CCN/NPI) of the CPC+ Practice for its attributed beneficiaries.

Geographic Price Cost Index (GPCI): Used to calculate payment rates under the PFS. Each of the three RVUs is adjusted to reflect the price of inputs in the local market where the service is furnished. Separate GPCIs are used for this purpose.

Historical PBPM: Represents each CPC+ practice's E&M payments received from CMS for a similar group of beneficiaries in a 24-month period before the start of CPC+.

Historical Calculation Period: Period for which historical payments are calculated for a CPC+ practice's historical population (July 2014 to June 2016 for 2017 Starters, and July 2015 to June 2017 for 2018 Starters).

Historical Payment: Applicable Medicare Part B E&M payments made to the CPC+ practice for its historical population during the historical calculation period.

Historical Population: Includes all beneficiaries attributed to a selected CPC+ practice during the historical calculation period. To determine the historical population, historical claims are used to attribute beneficiaries to practices quarterly during the historical calculation year.

Hybrid Payment: CPCP and the corresponding FFS reduction are termed the "hybrid payment" for practices participating in CPC+ Track 2.

Hybrid Payment Ratio: Annual pace at which a Track 2 CPC+ practice progresses toward one of two hybrid payment options: one option will pay 40 percent up front and 60 percent of the applicable FFS payment, and the other will pay 65 percent up front and 35 percent of the applicable FFS payment.

Incentive Neutrality: Incentive to bring a patient to the office is balanced with the incentive to provide the needed care outside of an office visit, making a practice agnostic as to whether it delivers a service in person or via another modality so the care can be delivered according to patient preferences.

Lookback Period: Period of 24 months ending three months before the start of the quarter. To be attributed to a practice, a beneficiary must have received the plurality of primary care health services at the practice during this lookback period.

Medicare Physician Fee Schedule (PFS): Medicare Part B PFS, used to pay physicians and other Part B clinicians.

Medicare Shared Savings Program: Established by section 3022 of the Affordable Care Act. The Shared Savings Program is a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act and is a new approach to the delivery of health care.

Merit-Based Incentive Payment Systems (MIPS): One of two avenues to reward the delivery of high-quality patient care for eligible clinicians or groups under the PFS in the Quality Payment Program Final Rule. MIPS consolidates components of three existing programs, the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare EHR Incentive Program for Eligible Professionals (EPs) and continues the focus on quality, cost, and use of Certified EHR Technology in a cohesive program that avoids redundancies.

National Provider Identifier (NPI): The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (i.e., 10-digit number). This means that the numbers do not carry other information about health care clinicians, like the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Partial Reconciliation: CMS conducts an annual outside-of-practice partial reconciliation of the hybrid payment to mitigate risks for both CMS and CPC+ practices that could arise in the absence of reconciliation. Partial reconciliation is meant to accomplish three aims: (1) protect CMS against paying more-than-expected amounts for office visit E&M services for CPC+ attributed beneficiaries; (2) protect practices in specifically defined situations from financial risk from the hybrid payment compared with pure FFS; and (3) maintain incentive neutrality for practices, ensuring that they are free to deliver enhanced services but are not incentivized to increase FFS billings to achieve a more favorable financial outcome.

Per-Beneficiary Per-Month (PBPM): Per-beneficiary per-month.

Performance-Based Incentive Payment (PBIP): Prospective performance-based payment made by CMS to the CPC+ practice for a Program Year dependent on a practice's track and number of beneficiaries. The amount of PBIP a practice is eligible to keep depends on quality, patient experience of care, and utilization measures.

Performance Standards: CMS established and approved objectives that are uniformly established and must be met at a particular level.

Physician Quality Reporting System: Encourages individual EPs and group practices to report information on the quality of care to Medicare. The system gives participating EPs and group practices the opportunity to assess the quality of care they provide to their patients, helping to ensure that patients get the right care at the right time.

Program Year: Year during which CMS pays CPCPs, PBIP, and/or CMFs to eligible practices participating in CPC+.

Quality Component: Component of the PBIP that measures practice performance on clinical quality and patient experience of care. Clinical quality is measured using two eCQMs whereas patient experience of care is measured using items from the CG-CAHPS and the Patient-Centered Medical Home Survey Supplement. The PEC survey measures contribute 40 percent to a practice's score for the Quality Component, and the eCQMs contribute 60 percent.

Quality Payment Program Final Rule: New approach to payment that rewards the delivery of high-quality patient care through two avenues: Advanced APMs and the MIPS for eligible clinicians or groups under the PFS. This final rule with comment period establishes incentives for sufficient participation in certain APMs and includes criteria for use by the Physician-Focused Payment Model Technical Advisory Committee in making comments and recommendations on physician-focused payment models.

Quality Reporting Document Architecture Category III (QRDA III): Aggregate quality report using data collected in patient-level QRDA I reports. Each QRDA III report contains calculated summary data for one or more measures for a specified population of patients within a particular health system over a specific period. Summary data in the QRDA III report are defined in the

HL7 Health Quality Measures Format, which standardizes the representation of a health quality measure as an electronic document.

Relative Value Unit (RVU): Under PFS, payment rates are based on relative weights, called RVUs, which account for the relative costliness of the inputs used to provide physician services like physician work, practice expenses, and professional liability insurance.

Sequestration: Spending reductions to enforce certain budget policy goals. Percentage payment reductions (2 percent) made under Medicare Part B to individual payments to clinicians for services (e.g., hospital and physician services) rather than to fee schedule allowable charges; the patient's cost-sharing amount remains unchanged.

Standard Practices: CPC+ practices not jointly participating in a Medicare Shared Savings Program.

Taxpayer Identification Number (TIN): Identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration or IRS.

Track 1: One of two payment options participating practices may select under CPC+. Track 1 is the choice for practices ready to build the capabilities to deliver comprehensive primary care. Practices that select Track 1 will receive a CMF of $15 PBPM average across four risk tiers and a $2.50 PBPM PBIP based on quality and utilization metrics; they will continue to receive 100 percent Medicare FFS payment for E&M office visits. (See **Track 2** below.)

Track 2: One of two payment options participating practices may select under CPC+. Track 2 is targeted to practices that have built the capabilities for comprehensive primary care and are poised to increase the comprehensiveness of care and improve care for patients with complex needs. Practices that select Track 2 will receive a CMF of $28 PBPM average across five risk tiers and $100 for the highest risk tier as well as a $4.00 PBPM PBIP based on quality and utilization metrics. In addition, Track 2 practices will receive a hybrid payment that includes a prospective CPCP and a corresponding reduction of their Medicare FFS payment for specific E&M office visits provided to aligned beneficiaries. (See **Track 1** above.)

Utilization Component: Component of the PBIP that measures practice performance on two measures: AHU and EDU. AHU is given twice the weight of EDU. To be eligible for the Utilization Component of the incentive payment, practices must meet the minimum performance required for each segment of the Quality Component.

Value-Based Payment Modifier (VBPM): Provides for differential payment to a physician or group of physicians under the Medicare PFS based upon the quality of care furnished compared with the cost of care during a performance period. The VBPM is an adjustment made to Medicare payments for items and services under the Medicare PFS. It is applied at the TIN level to physicians (and beginning in 2018, to certain nonphysician EPs billing under the TIN).

Voluntary Alignment: Also known as beneficiary attestation, this refers to a process by which beneficiaries specify the health care practitioner and practice they consider responsible for providing and coordinating their health care.

2017 Starters: Practices that started participating in CPC+ at the beginning of 2017. These practices are located in the 14 CPC+ Round 1 participating regions.

2018 Starters: Practices that started participating in CPC+ at the beginning of 2018. These practices are located in the four CPC+ Round 2 participating regions.

Appendix B: Primary Care Specialty Codes

Description	Taxonomy Code
Family Medicine	207Q00000X
Adult Medicine	207QA0505X
Geriatric Medicine	207QG0300X
Hospice and Palliative Medicine	207QH0002X
General Practice	208D00000X
Internal Medicine	207R00000X
Geriatric Medicine	207RG0300X
Hospice and Palliative Medicine	207RH0002X
Clinical Nurse Specialist	364S00000X
Acute Care	364SA2100X
Adult Health	364SA2200X
Chronic Care	364SC2300X
Community Health/Public Health	364SC1501X
Family Health	364SF0001X
Gerontology	364SG0600X
Holistic	364SH1100X
Women's Health	364SW0102X
Nurse Practitioner	363L00000X
Acute Care	363LA2100X
Adult Health	363LA2200X
Community Health	363LC1500X
Family	363LF0000X
Gerontology	363LG0600X
Primary Care	363LP2300X
Women's Health	363LW0102X
Physician Assistant	363A00000X
Medical	363AM0700X

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Appendix C: Description of Centers for Medicare & Medicaid Services–Hierarchical Condition Categories Risk Adjustment Model

The Centers for Medicare & Medicaid Services (CMS) uses the CMS-Hierarchical Condition Categories (HCC) risk adjustment model to adjust capitation payments made to Medicare Advantage and Medicare Program of All-Inclusive Care for the Elderly plans, with the intention of paying health plans appropriately for their expected relative costs. For example, a health plan enrolling a relatively healthy population receives lower payments than a similar plan enrolling a relatively sick population. The CMS-HCC model produces a risk score, which measures a person's or population's health status relative to the average, as applied to expected medical expenditures. A population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a population with a risk score of 0.5 is expected to incur medical expenditures half that of the average. It is important to note that the model is accurate at the group level, and actual expenditures for any individual can be higher or lower (sometimes significantly) than those predicted.

The CMS-HCC model is prospective, using demographic and diagnosis information from a base year to estimate expenditures in the next year. For example, risk scores for 2020 (risk score year) are calculated using diagnosis information from 2019 (base year). New Medicare enrollees (defined here as beneficiaries with less than 12 months of Medicare enrollment in the base year) receive a risk score from the new enrollee risk adjustment model, which is a demographic-only model. If a beneficiary does not have 12 months of enrollment in the base year, the beneficiary cannot have a complete diagnosis profile in the base year, hence the CMS-HCC model cannot be used. In order to ensure that as many diagnoses are captured in the risk score development as possible, CMS calculates final risk scores for any year at least 12 months after the base year ends, such that the final risk scores are generally available 16–18 months after the base year.

The demographic characteristics used for both newly enrolled and continuously enrolled beneficiaries are age, sex, Medicaid status, and originally disabled status. The diagnosis information used for continuously enrolled beneficiaries is the set of diagnosis codes reported on Medicare claims in the base year. Not all types of Medicare claims are used—only Hospital Inpatient, Hospital Outpatient, Physician, and some non-Physician claims are considered. The source of a particular diagnosis code has no relevance (i.e., diagnoses from an inpatient hospitalization have equal weight as those from a physician visit) and neither does the frequency with which the diagnosis code has been reported.

The CMS-HCC diagnostic classification system begins by classifying all International Classification of Diseases (ICD)-10-CM diagnosis codes into Diagnostic Groups, or DXGs. Each DXG represents a well-specified medical condition or set of conditions, such as the DXG for *Type II Diabetes with Ketoacidosis or Coma*. DXGs are further aggregated into Condition

Categories (CCs). CCs describe a broader set of similar diseases. Although they are not as homogeneous as DXGs, diseases within a CC are related clinically and with respect to cost. An example is the CC for *Diabetes with Acute Complications*, which includes, in addition to the DXG for *Type II Diabetes with Ketoacidosis or Coma,* the DXGs for *Type I Diabetes* and *Secondary Diabetes* (each with ketoacidosis or coma).

Hierarchies are imposed among related CCs so that if a person is coded with more than one CC from a hierarchy, only the most severe manifestation among related diseases will be coded as the HCC for the risk score calculation. After imposing hierarchies, CCs become HCCs. For example, diabetes diagnosis codes are organized in the Diabetes hierarchy, consisting of three CCs arranged in descending order of clinical severity and cost, from (1) *Diabetes with Acute Complications* to (2) *Diabetes with Chronic Complications* to (3) *Diabetes without Complication*. Thus, a person with diagnosis code of *Diabetes with Acute Complications* precludes the less severe manifestations of *Diabetes with Chronic Complications* and *Diabetes without Complication* from being included in the risk score. Similarly, a person coded for *Diabetes with Chronic Complications* precludes a code of *Diabetes without Complication* from being included in the risk score. Although HCCs reflect hierarchies among related disease categories, for unrelated diseases, HCCs accumulate (i.e., the model is "additive"). For example, a woman with both *Rheumatoid Arthritis* and *Breast Cancer* has (at least) two separate HCCs coded, and her predicted cost will reflect increments for both conditions.

Because a single individual may be coded for no HCCs, one, or more than one HCC, the CMS-HCC model can individually price tens of thousands of distinct clinical profiles. The model's structure thus provides and predicts a detailed comprehensive clinical profile for each individual.

The CMS-HCC model assigns a numeric factor to each HCC and each age/sex, full-benefit Medicaid/partial benefit Medicaid/non-Medicaid, aged/disabled cell. The values are summed to determine the risk score.

An illustrative hypothetical example using the CMS-HCC V22 model follows a 70-year-old woman who is a full-benefit dual Medicare-Medicaid enrollee with HCCs *Metastatic Cancer and Acute Leukemia* (HCC 8) and *Bone/Joint/Muscle Infections/Necrosis* (HCC 39):

Risk Factor	Factor
Age/Sex, Full-Benefit Dual Enrollee	0.501
HCC 8—*Metastatic Cancer and Acute Leukemia*	2.497
HCC 39—*Bone/Joint/Muscle Infections/Necrosis*	0.542
Total CMS-HCC Risk Score	**3.540**

For more information on the CMS-HCC risk model, see https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

Appendix D: Risk Tier Thresholds for First and Second Quarters in 2021

Region	25th Percentile Risk Score	50th Percentile Risk Score	75th Percentile Risk Score	90th Percentile Risk Score
AR	0.514	0.774	1.289	2.124
CO	0.452	0.680	1.192	2.031
GB	0.522	0.902	1.445	2.370
HI	0.478	0.697	1.164	1.862
KC	0.514	0.735	1.280	2.178
LA	0.514	0.800	1.343	2.215
MI	0.522	0.843	1.421	2.389
MT	0.449	0.674	1.157	1.915
ND	0.511	0.702	1.201	1.989
NE	0.478	0.707	1.233	2.074
NJ	0.522	0.817	1.380	2.274
NY	0.514	0.797	1.342	2.237
OH	0.514	0.770	1.335	2.215
OK	0.516	0.806	1.374	2.297
OR	0.483	0.746	1.250	2.045
PA	0.514	0.781	1.337	2.196
RI	0.516	0.797	1.338	2.170
TN	0.514	0.766	1.293	2.135

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Appendix E: Patient Experience of Care Survey Domain Questions

CPC+ Patient Experience of Care (PEC) Survey Domain	Survey Question
Getting Timely Appointments, Care, and Information (abbreviated as Access)	• Patient always got appointment as soon as needed when contacting provider's office to get an appointment for care needed right away • Patient always got appointment as soon as needed when making an appointment for check-up or routine care • When patient contacted provider's office during regular office hours with a medical question, patient always received an answer that same day
How Well Providers Communicate (abbreviated as Communication)	• Providers always explained things to patient in a way that was easy to understand • Provider always listened carefully to patient • Provider knew important information about patient's medical history • Provider always showed respect for what patient had to say • Provider always spent enough time with patient
Attention to Care From Other Providers (abbreviated as Coordination)	• Someone from provider's office followed up with patient to give results of blood test, x-ray, or other test • If patient visited a specialist, provider always seemed informed and up-to-date about the care patient received from specialists • Someone from provider's office talked with patient about all prescription medications being taken
Providers Support Patient in Taking Care of Own Health (abbreviated as Self-management Support)	• Someone in provider's office discussed specific health goals with patient • Someone in provider's office asked whether there were things that made it hard for patient to take care of health
Patient Rating of Provider and Care (abbreviated as Provider Rating)	• Patient rating of provider as best provider possible (0–10, out of a maximum of 10)

PEC Survey Domains and Point Scales

Domains	PEC Survey Point Scale
Getting Timely Appointments, Care, and Information (3 questions) How Well Providers Communicate (4 questions) Attention to Care From Other Providers (2 questions)	1–4 Always = 4 Usually = 3 Sometimes = 2 Never = 1
Providers Support Patient in Taking Care of Own Health (2 questions)	0–1 Yes = 1 No = 0
Patient Rating of Provider and Care (1 question)	0–10 Patients answer on a scale of 0–10

Appendix F: Performance-Based Incentive Payment Tracking Worksheet

Figure F-1
How to Keep the Quality Component of Your Performance-Based Incentive Payment (PBIP) and Qualify for the Utilization Component

Please note: If you are a dual participant (a CPC+ practice also participating in the Medicare Shared Savings Program), you will not have received a Performance-based Incentive Payment (PBIP); however, we strongly encourage all CPC+ practices to utilize this worksheet to track your progress for your practice's quality improvement efforts.

How to keep the Quality Component of your PBIP

The Quality Component of your PBIP is based on your performance for 2 electronic clinical quality measures (eCQMs) and your Patient Experience of Care (PEC) score. You must report *both* eCQMs for 2021, and receive a PEC Summary Score for 2021, to be eligible to keep *any* of your 2021 PBIP. You will receive a partial Quality Component of your PBIP if you achieve *at least* the 30th percentile on 1 quality measure; you will receive the full Quality Component of your PBIP if you achieve *at least* the 30th percentile on all quality measures *and* you achieve at least the 70th percentile on 2 or more quality measures.

If you reach this benchmark → X%

Then you keep this percent of the PBIP allotted to this measure → 50% 60% 70% 80% 90% 100%

The 30th and 70th percentiles of your quality measure are:

			30th	70th	Track Your Progress Q1	Q2	Q3	Q4
eCQMs	☐ CMS122	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) *(MIPS001)*[a]	99.45%	46.84%				
eCQMs	☐ CMS165	Controlling High Blood Pressure *(MIPS236)*	43.05%	83.65%				
PEC	☐ Summary Score		79.22%	83.16%	2019 Score			
					2020 Score			

[a] *This measure is reverse-scored.*

2020 PEC Score will become available during Program Year 2021

How to keep the Utilization Component of your PBIP

Eligibility to retain the Utilization Component depends on your quality measures. If you (1) report both eCQMs, (2) receive a PEC Summary Score, and (3) achieve *at least* the 30th percentile on at least 2 quality measures, you are eligible to retain your Utilization Component. You will receive a partial Utilization Component of your PBIP if you achieve *at least* the 50th percentile on at least 1 of your utilization measures, and you will receive the full Utilization Component of your PBIP if you achieve *at least* the 80th percentile on both utilization measures.

The 50th and 80th percentiles of your utilization measure are:

		50th	80th	Track Your Progress Q1	Q2	Q3	Q4
Utilization	☐ Acute Hospital Utilization	1.16	0.96				
Utilization	☐ Emergency Department Utilization	1.03	0.81				

The total PBIP your practice can keep increases as you achieve greater performance on your quality and utilization measures.

To be eligible to keep *any* of your PBIP, you must report both eCQMs and receive a PEC Summary Score.

	Quality		Utilization	
	Partial Payment	Full Payment	Partial Payment	Full Payment
You achieve ≥ 30th percentile on 1 or more quality measures[b]	✗			
You achieve ≥ 30th percentile on 3 quality measures, but < 2 quality measures reach the 70th percentile	✗		✗ if you achieve 50th percentile on ≥ 1 utilization measures	✗ if you achieve 80th percentile on 2 utilization measures
You achieve ≥ 30th percentile on all 3 quality measures, and 2 or more quality measures achieve ≥ 70th percentile		✗	✗ if you achieve 50th percentile on ≥ 1 utilization measures	✗ if you achieve 80th percentile on 2 utilization measures

[b] *Quality measures include the 2 eCQMs and the 1 PEC Summary Score.*

This document is meant to help you track your 2021 performance on the eCQMs and utilization measures. Because the PEC Survey happens yearly, we have included space for your 2019 PEC Summary Score, which you can access in your Program Year 2019 PBIP report, and one for your 2020 PEC Summary Score, which you will receive in your Program Year 2020 PBIP report in the fall of 2021.

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Appendix G: Evaluation and Management Claims in Hybrid Payment

HCPCS Code	Evaluation and Management Office Visits Description
99201[a]	OFFICE VISITS—NEW (EVALUATION AND MANAGEMENT)
99202	OFFICE VISITS—NEW (EVALUATION AND MANAGEMENT)
99203	OFFICE VISITS—NEW (EVALUATION AND MANAGEMENT)
99204	OFFICE VISITS—NEW (EVALUATION AND MANAGEMENT)
99205	OFFICE VISITS—NEW (EVALUATION AND MANAGEMENT)
99211	OFFICE VISITS—ESTABLISHED (EVALUATION AND MANAGEMENT)
99212	OFFICE VISITS—ESTABLISHED (EVALUATION AND MANAGEMENT)
99213	OFFICE VISITS—ESTABLISHED (EVALUATION AND MANAGEMENT)
99214	OFFICE VISITS—ESTABLISHED (EVALUATION AND MANAGEMENT)
99215	OFFICE VISITS—ESTABLISHED (EVALUATION AND MANAGEMENT)
99354[b] (replaced by 99415 in 2021)	OFFICE VISITS—ESTABLISHED (EVALUATION AND MANAGEMENT)
99355[b] (replaced by 99416 in 2021)	OFFICE VISITS—ESTABLISHED (EVALUATION AND MANAGEMENT)

[a] Code 99201 has been retired and consolidated with 99202, effective January 1, 2021. Claims for 99201 from the historical period continue to be included, inflated to 2021 payment rates for 99202.

[b] Codes 99354 and 99355 can no longer be billed with office visits, effective January 1, 2021. Claims for these codes from the historical period will continue to be included, inflated to 2021 payment rates for 99415 and 99416, respectively.

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