U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Seamless Care Models Group
2810 Lord Baltimore Drive, Suite 130
Baltimore, MD 21244

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Request for Applications

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Abstract

Building on lessons learned from the Original Comprehensive Primary Care (Original CPC) Model, CMS is introducing the new **Comprehensive Primary Care Plus** (**CPC+**) **Model** to support practices along the continuum of their transformation to deliver better health and smarter spending. CPC+ will allow practices to apply for one of two program tracks, with increasing payment and care redesign expectations from Tracks 1 to 2.

CPC has engendered enthusiasm and loyalty among participants and stakeholders, and, based on early results, holds promise as an alternative approach to support the enhanced delivery of primary care in the United States. CMS will build on CPC's success and the promise of primary care in CPC+ by (1) accommodating practices at different levels of readiness for and interest in transformation, and (2) innovating care delivery and payment to empower primary care practices to provide more comprehensive care that meets the needs of all their patients, particularly those with complex needs.

CPC+ Overview

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

Multi-payer involvement is essential to CPC+, as it ensures adequate financial support for practices to make fundamental changes to their care delivery. Further, when payers share cost, utilization, and quality data[1] with practices at regular intervals, it facilitates practices' ability to manage their patient population's health, leading to smarter spending, better care, and healthier people. CPC+ will be regionally based and there will be a staged application process (payer solicitation period April 15, 2016 to June 1, 2016; practice application period expected July 15, 2016 to September 1, 2016). The selection of payers will inform the selection of regions; the practice application will be open in only these to-be-determined regions. Payers must support practices in both tracks. Practices will apply for the track (1 or 2) for which they are eligible.

Track 1 targets practices with multi-payer support that have the health information technology and other basic infrastructure necessary to deliver comprehensive primary care. In Track 1, participating practices will work for five years to implement and develop comprehensive primary care capabilities. In addition to their Medicare fee-for-service (FFS) payments, Track 1 practices will receive a care management fee (CMF) that averages $15 per beneficiary per month (PBPM)

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

in support of this work. Track 1 is the most similar to the Original CPC Model, but CMS has refined the eligibility criteria, care delivery requirements, and incentive payment opportunities to incorporate lessons learned in the Original CPC Model.

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

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

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

Scope

CMS hopes to partner with payers in the seven existing CPC regions as well as up to 13 new regions. Both tracks will be offered in all of the selected regions. CMS will accept up to 2,500 practices into each Track. In aggregate, up to 3.5 million Medicare FFS beneficiaries, as well as millions of other Medicare Advantage, Medicaid, and commercial patients, could be impacted over the course of this model.

Key Model Participants and Partners

Practices

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

Eligible applicants are primary care practices (all NPIs billing under a TIN at a practice site address who are included on a Participant List, as defined in Appendix B) that pass program integrity screening, provide health services to a minimum of 150 attributed Medicare beneficiaries, and can meet the requirements of the CPC+ Participation Agreement. Eligible

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

Practice Application Information

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

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

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

Practices currently participating in the Original CPC Model may apply to either track. Practices participating in any Medicare shared savings program are ineligible to participate in CPC+. Concierge practices (any practice that charges patients a retainer fee), Rural Health Clinics, and Federally Qualified Health Centers (FQHCs) are also not eligible for the model. More information is available in Appendix B.

Track 1

To be eligible to join Track 1, practices must be located in regions where there is sufficient private payer interest in the model and must be poised to deliver the Five Primary Care Functions, described in the Care Delivery section below and demonstrated via their answers to the application questions. They must also use certified health IT as described in Appendix C. CMS will accept up to 2,500 practices to participate in Track 1. Track 1 runs for five years. Information about the payment redesign for Track 1 can be found in the Payment Redesign section below.

Track 2

To be eligible to join Track 2, practices must be located in regions where there is sufficient private payer interest in the model and must demonstrate capability to deliver the Five Primary Care Functions, described in the Care Delivery section below and demonstrated via their answers to the application questions. CMS will accept up to 2,500 practices to participate in Track 2. Track 2 runs for five years. Information about the payment redesign for Track 2 can be found in the Payment Redesign section below.

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

Practice Selection

Practices must be in good standing with CMS and meet the eligibility criteria, as described above. If CMS receives more eligible applicants than available spots for a given track, final participant selection will be conducted by a lottery.

CMS will select participating practices for each track from the pool of eligible practices based on factors that will maximize the robustness of the test of this model. To that end, CMS is interested in ensuring that the selected practices represent the diversity of primary care practices and patients in the U.S., considering factors that may include:

- System affiliation
- Patient characteristics
- Geographic location (e.g. rural/urban)
- Practice size
- Practice engagement with students, residents, or other trainees
- Percentage of coverage of practice population by CPC+ payers

CMS may stratify practices into pools according to these characteristics and conduct a lottery within each pool, thus creating balanace on key factors.

Applicants who are not ultimately selected to participate in CPC+ may be used as a control group to help evaluate the success of the intervention. The control group practices will not be model participants and so will not participate in the model learning, receive payments under the model, or otherwise obtain any benefits of model participation. They may, however, be asked to complete surveys or contribute data voluntarily and may receive an incentive payment for such activities.

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

Multi-Payer Strategy

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

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

CMS will stagger applications from payers and practices. First, CMS will solicit applications from payers (from April 15th to June 1st). The choice of CPC+ regions will be informed by the geographic reach of eligible payers selected to participate. Continuing regions from Original CPC, current and former MAPCP, and SIM states with participation of their State Medicaid Agencies will all be given preference when CMS evaluates proposals. Next, CMS will determine and publicize the regions, and then solicit applications from practices within those regions (July 15th to September 1st). In this way, practices can assess whether affiliated payers in their geographic region are partnering with CMS for CPC+ before submitting an application.

Payer Solicitation Information

Multi-payer engagement is an essential component of CPC+, as it enables both public and private payers to sponsor comprehensive primary care reform. CMS will partner with payers that share Medicare's interest in strengthening primary care. Detailed non-Medicare FFS payer solicitation information can be found in Appendix A. CMS will evaluate payer proposals' based on the extent of their alignment with the following framework:

Operational

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

Data Sharing

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

Quality Measures

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

Vendors

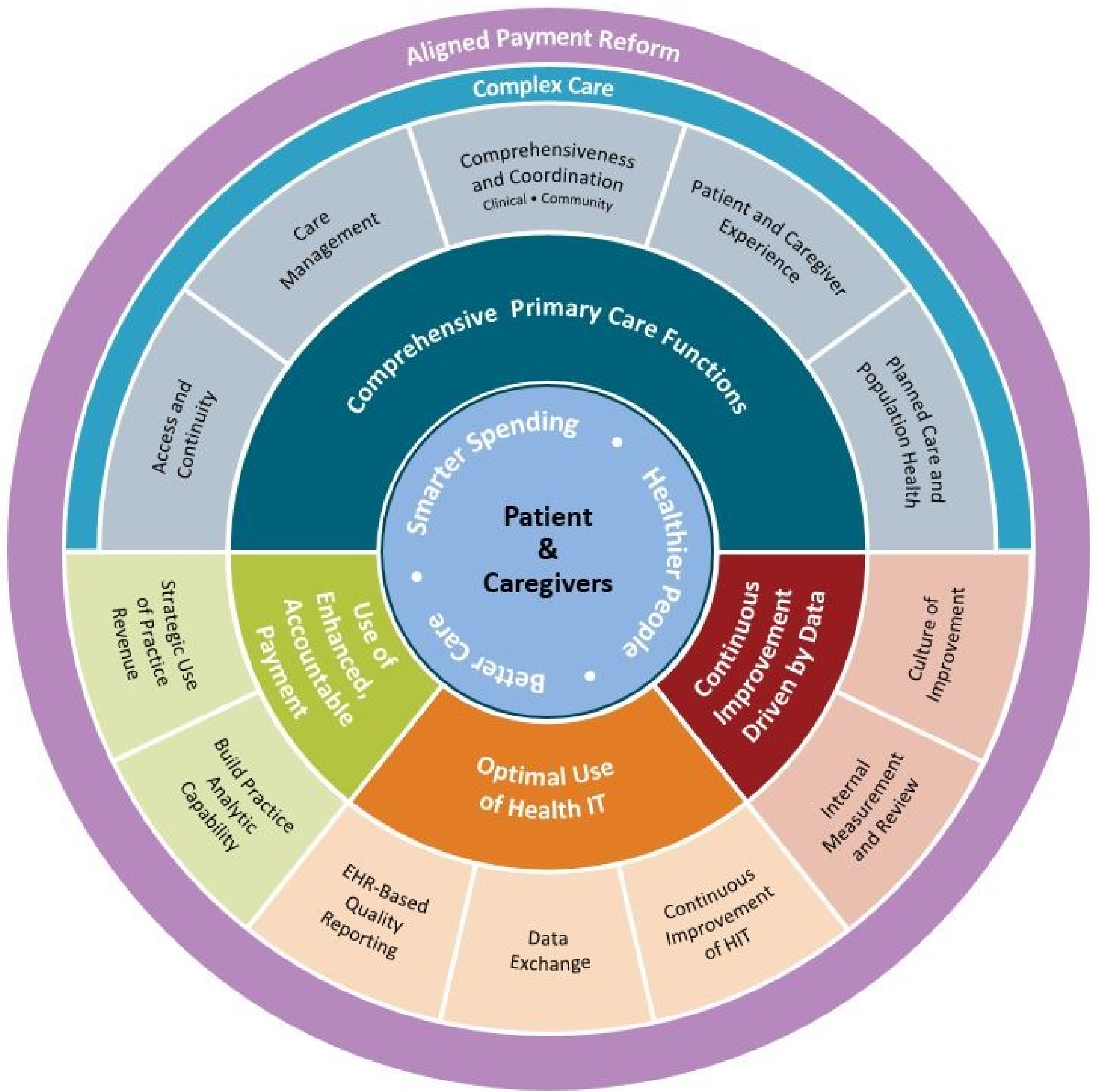
Health IT vendors will be invited to support practices who participate in Track 2. The care delivery CMS expects in Track 2 is reliant upon the use of advanced health IT capabilities that practices will need to attain through EHR enhancements or by adding or securing additional health IT services/tools.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

Intervention

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

Theory of Action and Driver Diagram

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



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

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

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

Care Delivery Design

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

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

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

Driver 1: The Comprehensive Primary Care Functions

1. **Care Management**

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

their patients with complex needs and will build additional practice capabilities in assessment and management of patients with complex needs, such as those with cognitive impairment, frailty, or multiple chronic conditions.

2. Access and Continuity

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

3. Planned Care for Population Health

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

4. Patient and Family Caregiver Engagement

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[2] Ivbijaro, G.O., Enum, Y., Khan, A.A., Lam, S.S., & Gabzdyl, A. (2014). Collaborative care: models for treatment of patients with complex medical-psychiatric conditions. *Curr Psychiatry Rep, 16*(11), 506.

Optimal care and health outcomes require patients and families to be fully engaged in the design and improvement of care delivery. Track 1 and 2 practices will engage patients and families in the design and improvement of care, using Patient and Family/Caregiver Advisory Councils and other strategies to elicit the voice of the patient and integrate the patient into efforts to improve care. To increase patient engagement, practices will engage patients in goal setting and shared decision-making, using decision aids and specific techniques (e.g., motivational interviewing) to support patients in the process. Track 2 practices may also more directly involve patients and families in quality improvement initiatives, and must provide self-management support as well as support for caregivers of persons with functional disabilities (e.g., dementia).

5. Comprehensiveness and Coordination

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

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

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

from practices' capability to identify health-related issues that are precipitated by previously unmet social needs.

The Five Primary Care Functions described above are a primary driver (Driver 1) toward achieving the aims of CPC+, but require additional changes in participating practices, as illustrated in the CPC Driver Diagram and discussed in the Theory of Action sections. The additional changes are described below as Drivers 2-4.

Driver 2: Use of Enhanced, Accountable Payment

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

Driver 3: Continuous Improvement Driven by Data

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

Driver 4: Optimal Use of Health IT

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

Payment Redesign

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

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

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

Table I. CPC+ Financial Summary Table.

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

Attribution

CMS will use a prospective attribution methodology based on a plurality of primary care claims over the prior two years to identify the population of Medicare FFS beneficiaries for which each participating primary care practice is accountable. To ensure practices are eligible and to inform practice' decisions to join sub-regional aggregation groups (discussed in the Regional Learning Communities section below), CMS will run attribution for applicant practices before they sign their Participation Agreements. The attribution methodology can be found in Appendix E.

Care Management Fee (CMF)

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

Table II illustrates the proposed CMF amounts and risk tiers. The CMF will be risk-adjusted to reflect the increased resources required to target care management to patients with more complex needs. Beneficiary risk will be based on HCC risk scores and, in Track 2, claims data for diagnoses. CMS will determine risk tier cutoffs for CPC+ using a regional or national pool of Medicare FFS beneficiaries.

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

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

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

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

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

CMS will monitor coding and HCC score changes closely throughout the program and, if significant, unexpected, or irregular upcoding is found to occur, will adjust the payment

methodology in order to ensure the actuarial soundness of the CPC+ model. In the event that CMS decides to make changes, they will be specified prior to the payment quarter in which they are implemented.

Performance-Based Incentive Payments

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

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

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

Table III. Proposed Incentive Payment Amounts

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

While the final methodologies are still being refined, the incentive payments will be scored using a continuous approach with a minimum, under which a practice keeps none of the incentive, and a maximum, over which a practice keeps the entire incentive. That is, if a practice's total score is 60%, then the practice keeps 60% of the incentive. However, if the minimum threshold is 30% and the total score is 29% or lower, the practice must return the entire incentive. Because a 100% total score may not be achievable, we will set a maximum score (u nder 100%), over which practices keep 100% of the incentive.

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

CMS wants to avoid paying shared savings and performance-based incentive payments for the same beneficiary, so CPC+ will maintain a no-overlaps policy with CMS shared savings programs and models. This means that if a practice is participating in CPC+, it is not permitted to participate in the Medicare Shared Savings Program, Next Generation Accountable Care Organization Model, or Comprehensive End Stage Renal Disease Care Model at the same time.

Track 2 Comprehensive Primary Care Payments (CPCPs)

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

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

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

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

Table V. Track 2 Payment Choices by Year

	2017	*2018*	*2019*	*2020*	*2021*
CPCP%/FFS% options available to practices	10%/90%	-	-	-	-
	25%/75%	25%/75%	-	-	-
	40%/60%	40%/60%	40%/60%	40%/60%	40%/60%
	65%/35%	65%/35%	65%/35%	65%/35%	65%/35%

What is the CPCP for?

Practices will receive payment for visits through reduced FFS and the CPCP, with partial reconciliation (to be further explicated in the Participation Agreement). This methodology changes the payment mechanism, promotes flexibility in how practices deliver care traditionally required to be provided face-to-face, and requires practices to increase the depth and breadth of primary care they deliver. While the CMF gives practices the flexibility to provide "wrap-around" services that were not traditionally considered to be separately billable, the CPCP, by contrast, compensates the practitioner for clinical services that have always been separately billable but allows flexibility for the care to be delivered in or outside of an office visit.

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

How will the CPCP be calculated?

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

To account for increased depth and breadth of primary care expected under Track 2, in the calculation of the CPCP for 2017, CMS will inflate the practice's historical revenue from E&M services by 10% and will pay part of this amount as the CPCP (consistent with each practice's applicable percentage in Table IV above). The choice of an increase of 10% is informed by the Affordable Care Act's Incentive Payments for Primary Care Services.

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

We will conduct a reconciliation based only on E&M services delivered in an office setting by primary care physicians outside the CPC practice. Under this partial reconciliation construct, we presume that beneficiaries will tend to increase the amount of primary care they seek elsewhere

if they are not satisfied with the care they receive from their CPC practice. Thus, increases in E&M services delivered by primary care physicians outside of the CPC practice to CPC practice attributed beneficiaries would lead to a partial recoupment of the CPCP (as well as heightened monitoring and/or auditing to evaluate the situation more closely). Conversely, significant decreases in E&M services delivered by primary care physicians in an office setting outside of the CPC practice could also lead to an additional payment to CPC+ practices (whether this would be incorporated into the CPCP would depend on the design of the CPCP). This type of partial reconciliation would protect CMS from spending significantly more on E&M services across all primary care practices.

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

Business Case for Practices

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

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

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

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

Learning Systems Strategy

Overview

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

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

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

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

The National Learning Community

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

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

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

The Regional Learning Communities

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

The key features of the Regional Learning Communities are 1) practice ownership and management of the change process, 2) opportunities for practices to learn from and with each other in their region, 3) Opportunities for practices to partner in sub-regional aggregation groups to facilitate practice change 4) integration with the CMS regional staff, and 5) alignment with regional health care reform efforts.

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

CMS will encourage practices within each region to consider partnering with some of the other practices within their region to build improvement infrastructure and share staffing resources to support practice transformation. All practices within a region are eligible to participate in such a group. Based on the experience in CPC, we expect practices within the same system are likely to choose to pool resources within the system. We believe that this sub-regional aggregation policy

may be especially beneficial to smaller independent practices that lack the support of a health system. CPC+ is explicitly designed to support a diversity of practice sizes, and CMMI models should not be designed in such a way that consolidation or integration with larger systems is the only option for success.[3] [4]

To form these sub-regional aggregation groups, practices accepted to CPC+ will submit a list of their aggregation partners to CMS in conjunction with their Participation Agreements and will agree to remain in their designated aggregation groups for at least one year. All practices will be expected to identify the individuals who will function within the practice, or within a group of practices, to facilitate practice change. In addition, they will be asked to identify a clinical leader who is the CPC+ champion or senior sponsor. The Regional Learning System will bring these practice-identified facilitation resources together regularly as a primary coaching strategy and will facilitate engagement of clinical leadership. This approach maintains control and ownership of practice change at the practice level, fosters regional learning, and allows regional faculty to concentrate their limited practice coaching and facilitation resources on practices at risk. This approach offers the model a test for scaling the learning system support in CPC+.

Data Sharing

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

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

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[3] Casalino, L.P. et al. (2013). Independent Practice Associations and Physician-Hospital Organizations Can Improve Care Management for Smaller Practices. Health Affairs. vol. 32 no. 8 1376-1382.
[4] Casalino, L.P. & Bishop, T.F. (2015). Symbol of Health System Transformation? Assessing the CMS Innovation Center. New England Journal of Medicine. 372;21.

range of practices' needs and capabilities, existing regional resources, and regional payer priorities.

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

Multi-Payer Collaboration in Data-Sharing

In the CPC+ model, we will continue our efforts to improve aligned approaches for data sharing with participating primary care practices across payers. Where regional data aggregation and performance capabilities do exist, we intend to leverage them as part of a broader effort to support and sustain infrastructure to enable multi-payer alternative payment models.

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

As in several of the Original CPC regions, CMS hopes to join in efforts of aligned data-sharing where the commercial payers have or plan to collaborate in order to institute multi-payer claims databases that provide unified reports to practices based on their entire attributed populations. This data aggregation is typically performed by independent vendors who receive and manipulate the data from each commercial payer partner and, in some regions, State Medicaid Agencies and Medicare, and create practice- and patient-level reports for practices to use in their quality improvement efforts. Aggregated feedback reports are intended to reduce the burden on practices to review their feedback data from payers and improve the practice view of data on their entire active patient population. Data aggregated from a practice's entire attributed population allows greater opportunity to understand trends across their patient population, and

flexibility to view potential areas for improvement for specific sub-populations (e.g., patients with a certain diagnosis or adverse event). Other opportunities in multi-payer collaboration include data alignment, wherein regional payers report on the same measures using a common format for their attributed population, but continue to send individual reports; this effort is intended to improve the clarity for and reduce the administrative burden on the participating practices.

Quality Strategy

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

Reporting Requirements: To assess quality performance and eligibility for the CPC+ performance-based incentive payment, Track 1 and 2 practices will be required to report annually the practice-level measures listed in Appendix D. The final measure list for each performance year will be communicated to practices accepted in the model in advance of the first performance period beginning January 1, 2017. Practices will be required to report all eCQMs at the practice site level to CMS and at the panel level for internal practice improvement. The eCQMs and patient experience of care measures will be included as pay for performance measures. Practices must use ONC certified health IT meeting the requirements of the EHR Incentive Programs, as defined at 42 C.F.R. § 495.4. All requirements are described in Appendix C. CAHPS surveys will be administered to all patients who have in-person office visits. The PROM will be administered to Track 2 patients only and will not be included as a pay for performance measure until the measure is fully developed and tested.

eCQMs: The use of eCQMs ensures clinicians and practices have a view of performance on an ongoing basis at the point of care. All eCQMs in this measure set were selected from the portfolio of HIT-enabled measures included in other CMS quality reporting programs such as MU Stages 2 and 3, and the Physician Quality Reporting System program, and align with the "CMS Strategic Vision for Quality Reporting Programs." Measures from each of the six quality domains of the National and CMS quality strategies (i.e., patient safety, effective clinical care, person and caregiver-centered experience and outcomes, communication and care coordination, community/population health, and efficiency and cost reduction) are included in the set. The measures target a primary care patient population, and, where feasible, are outcome measures instead of process measures. The measure set is available in Appendix D. As indicated above,

CMS will communicate the final list of eCQMs to be reported for the first performance year (CY 2017) for submission to CMS in 2016 prior to the start of the performance period.

CAHPS: A subset of the Clinician and Group (CG) CAHPS survey will be administered by CMS to capture patients' experience of care.

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

A PRO-based Performance Measure (PRO-PM) is a performance measure based on PROM data that is aggregated for an accountable health care entity. CMS expects to develop a PRO-PM with CPC PROM data from performance year one or performance years one and two, depending on the amount of data needed for analysis. CMS will then assess quality performance using one or more of the PRO-PMs in the later years of CPC+ Track 2.

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

Practice Monitoring, Auditing, and Termination Strategy

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

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

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

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

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

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

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

Evaluation

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

Authority to Test Model

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

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

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

Solicitation Type

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

Program Overlap and Synergies

Accountable Care Organizations (ACOs)

The Medicare Shared Savings Program, Innovation Center ACO models, and CPC+ all target Medicare FFS beneficiaries. However, unlike ACOs and Original CPC, CPC+ will not employ shared savings—instead opting for a performance-based incentive payment. While not a traditional shared savings design, the intent of the performance-based incentive is the same, so CPC+ will maintain a no-overlaps policy with CMS shared savings programs and models, and practices will not be able to participate in CPC+ if they are participating in any CMS shared savings programs or models.

Independence at Home (IAH)

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

Bundled Payments

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

Million Hearts: Cardiovascular Disease Risk Reduction Model

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

Accountable Health Communities (AHC)

Track 2 of CPC+ and Accountable Health Communities (AHC) model both include a focus on unmet health-related social needs. But, given the different payment types and model

requirements of AHC and CPC+, practices may be in both CPC+ and paid by an AHC bridge organization (or be a bridge organization).

Transformation Clinical Practices initiative (TCPI)

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

Physician Fee Schedule Codes

Currently, practitioners in the Original CPC Model bill the Chronic Care Management fee (CCM)[5] under the Physician Fee Schedule (PFS) only for non-attributed beneficiaries. The CPC+ CMF is meant to support the services which overlap with the CCM, so billing them for the same patients would be duplicative, and will not be permitted.

CPC+ practices may bill the Transitional Care Management codes (TCM)[6] for attributed beneficiaries. New codes for advanced care planning introduced in the 2016 Medicare Physician Fee Schedule Proposed Rule may overlay CPC+, as these services will occur in the primary care setting. CMS will track the development of new codes to decide overlaps policy before CPC+ starts in January 2017.

Appendices

Appendix A: Solicitation for Payer Partnership Process and Selection

Solicitation Information

This Solicitation for Payer Partnership requests that payers detail their proposed plan to partner with CMS in supporting practices in both Tracks of Comprehensive Primary Care Plus (CPC+) to start in January 2017. Track 1 targets up to 2,500 practices poised to deliver the comprehensive primary care functions, detailed in Section IV of the CPC+ Request for Applications. Track 2 targets up to 2,500 practices proficient in comprehensive primary care that are prepared to increase the depth, breadth, and scope of medical care delivered to their patients,

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[5] Chronic Care Management (CCM) fee is outlined in the Federal Register --79 Fed. Reg. 67547, 67721 (November 13, 2014): http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf

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

particularly those with complex needs. Please see Section II in the CPC+ Request for Applications for further information about primary care practice participation in Tracks 1 and 2 of CPC+.

Multi-payer engagement is an essential component of CPC+, as it enables both public and private payers to sponsor comprehensive primary care reform. CMS will partner with payers that share Medicare's interest in strengthening primary care. Respondents to this solicitation may be commercial insurers (including plans offered via state or federally facilitated Health Insurance Marketplaces), Medicare Advantage plans, states (through the Medicaid and CHIP programs, state employees program, or other insurance purchasing), Medicaid/CHIP managed care plans, state or federal high risk pools, self-insured businesses or administrators of a self-insured group (Third Party Administrator (TPA)/Administrative Service Only (ASO)).

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

CMS expects to enter into a Memorandum of Understanding with payers in up to 20 geographic regions. Memoranda of Understanding will outline the expectations of payers, to help ensure that the parameters of CPC+ are consistent within each region. All payers, including Medicare, will separately enter into agreements with the participating practices.

CMS will select regions where there is sufficient interest from multiple payers to support practices that participate in Tracks 1 and 2 of this model. This solicitation is directed to payers nationally. CMS is committed to supporting the development and testing of innovative health care payment and service delivery models throughout the country, particularly in states and regions where there has been a foundational investment.

- The seven regions involved in the *Original CPC model*: Arkansas (statewide), Colorado (statewide), New Jersey (statewide), New York (Capital District-Hudson Valley region), Ohio (Cincinnati-Dayton region), Oklahoma (greater Tulsa region), and Oregon (statewide), will be included in CPC+, if sufficient payers indicate their interest in partnering in CPC+ and propose an aligned approach to Medicare. Thus, all payers that engaged in the Original CPC model, must submit a proposal for CPC+.
- CMS will give preference to the eight states (or applicable regions within states) that have participated in the *Multi-Payer Advanced Primary Care Demonstration*: Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont, where Medicaid is a participating payer, if sufficient payers respond to this solicitation and propose an aligned approach to Medicare.
- CMS will also give preference to states receiving State Innovation Models (SIM) Initiative Model Test Awards, where Medicaid is a participating payer, if sufficient payers indicate their interest in partnering in CPC+ and propose an aligned approach to Medicare.

Questions

Questions regarding CPC+ or the solicitation process may be sent by email to CPCplus@cms.hhs.gov. CMS may publicly share questions or responses or compile them into a Frequently Asked Questions compendium to ensure that all interested payers have access to information regarding CPC+.

Completing and Submitting Proposals to Partner in CPC+

Interested payers are asked to respond to this solicitation by completing a form available on April 15, 2016. CMS will only accept proposals completed in this form, which can be retrieved at the CMMI website and may be submitted via secure email to CPCplus@cms.hhs.gov. For ease of reference, the questions included in the form are provided in blue boxes throughout this document.

Payers interested in partnering in CPC+ in multiple regions are asked to submit separate proposals for each region. However, a payer may submit one proposal, if a payer's lines of business and proposed approaches to each of the CPC+ design components do not vary across regions.

When submitting their proposals to CPCplus@cms.hhs.gov, payers may also attach any supplemental material necessary for answering the solicitation questions. Supplemental material is optional and must not exceed a total of 15 pages in length.

Deadlines for Submittal

Payers must respond to this solicitation by **June 1, 2016 at 11:59pm ET**.

After payers and regions are selected and CMS enters into Memoranda of Understanding with payers, CMS will release a primary care practice Request for Application (RFA) in regions selected for CPC+.

- Primary care practices in selected regions may apply to participate from July 15 – September 1, 2016 via an online portal. Practices will be notified of their selection on October 1, 2016.
- Health information technology (HIT) vendors will be asked to write a letter of support for practices applying to participate in Track 2. CMS will enter into a Memorandum of Understanding by October 15, 2016 with those HIT vendors supporting Track 2 practices selected to participate in CPC+.

Review Process

Responses to this solicitation will be reviewed by CMS staff to determine the degree to which they align with the Medicare approach in CPC+, as described below. Payers must respond with

sufficient detail for CMS to evaluate and understand payers' proposed plan to partner in CPC+. CMS may also contact payer respondents and request modifications as part of its review.

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

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

Withdrawal of Proposal

Payer respondents seeking to withdraw an entire proposal or requesting to modify a pending proposal should submit a written request on the organization's letterhead that is signed by the primary point of contact named on the submitted form. To submit a withdrawal request, interested payers must send the request in a PDF format by email to CPCplus@cms.hhs.gov. Payers must submit such request by no later than one week following submission.

Payer and Region Selection

Outlined in full in Steps 1-6 below, CMS' selection process will map interested payers into overlapping regions and assess expected market share in these regions. Payer proposals in regions with sufficient market penetration to engage in CPC+ will then be evaluated based on the degree to which they align with the Medicare approach. CMS may contact interested payers to explain or modify their proposals. Once regions have been selected and approved, payers will be invited to partner with CMS by signing a Memorandum of Understanding.

1. Mapping Interested Payers into Overlapping Regions

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

2. Regional Score

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

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

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

Market Penetration Rate =

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

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

Table: Penetration and Scoring

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

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

3. Assessment of Payers' Alignment with Medicare's Approach

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

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

4. Weighting of Payers' Scores with Number of Covered Lives

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

Weighted Payer Score =

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

5. Summing Regional Score and Weighted Payer Score

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

6. Regional Selection

CMS will use the final score (Step 5) to inform the recommendation of regions to include in CPC+. CMS plans to include up to 20 regions and aims to ensure geographic diversity.

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

Commitment to Ensuring Competitive Markets

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

Partnership with State Medicaid Agencies

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

Solicitation for Payer Partnership

Payer Information

Description of Payer

Legal Entity Name:

Year Established:

NAIC Number:

Corporate Address:

Corporate City:

Corporate State:

Payer Website (URL):

Point of Contact (POC) Name:

POC Title:

POC Address:

POC City:

POC State:

POC Phone:

POC Email:

POC Fax:

Proposal Completed by: Name ______________ Title: ______________

Partner Payer in CPC? *___Yes __ No*

Partner Payer in the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration?
___Yes ___No

Payer in a State Innovation Model (SIM) Test Award State with Medicaid Participation?
___Yes ___No

Executive Summary (1 page maximum)

1. *Please provide an Executive Summary of your proposal.*

- *Please include the following information in your Executive Summary:*
  - *Why you would like to be a payer partner in CPC+;*
  - *Any information relevant to your partnership in CPC+ that was not addressed in your responses to the questions below.*

Description of Payer

Legal Entity Name:

Year Established:

NAIC Number:

Corporate Address:

Corporate City:

Corporate State:

Payer Website (URL):

Point of Contact (POC) Name:

POC Title:

POC Address:

POC City:

POC State:

POC Phone:

POC Email:

POC Fax:

Proposal Completed by: Name ______________ Title: ______________

Partner Payer in CPC? *___Yes __ No*

Partner Payer in the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration?
___Yes ___No

Payer in a State Innovation Model (SIM) Test Award State with Medicaid Participation?
___Yes ___No

Executive Summary (1 page maximum)

1. *Please provide an Executive Summary of your proposal.*
- *Please include the following information in your Executive Summary:*
  - *Why you would like to be a payer partner in CPC+;*
  - *Any information relevant to your partnership in CPC+ that was not addressed in your responses to the questions below.*

Proposed Region(s)

The final definition of a "region" will be based on the overlapping, contiguous geographic service areas of partnering payers.

Definition of Region(s)

2. *Using counties as the descriptor, please propose the region(s) in which you are interested in partnering in CPC+.*

3. *Please describe the lines of business in the region(s) in which you are proposing to partner.*

- *Commercial insurance plan*

  LINE OF BUSINESS OFFERED?
  _______N/A, line of business not offered
  _______Line of business offered, will not partner in CPC+
  If so, why?
  _______ Line of business offered, will partner in CPC+

  INFORMATION ABOUT LINE OF BUSINESS, IF PARTNERING IN CPC+
  _______ Number of Covered Lives
  _______ Number of Primary Care Practices*
  _______ Number of Primary Care Practitioners**

- *Health Insurance Marketplace plan (including state-run and federally facilitated Health Insurance Marketplaces)*

  LINE OF BUSINESS OFFERED?
  _______N/A, line of business not offered
  _______Line of business offered, will not partner in CPC+
  If so, why?
  _______ Line of business offered, will partner in CPC+

  INFORMATION ABOUT LINE OF BUSINESS, IF PARTNERING IN CPC+
  _______ Number of Covered Lives
  _______ Number of Primary Care Practices*
  _______ Number of Primary Care Practitioners**

- *TPA/ASO*

  LINE OF BUSINESS OFFERED?
  _______N/A, line of business not offered
  _______Line of business offered, will not partner in CPC+
  If so, why?
  _______ Line of business offered, will partner in CPC+

  METHOD FOR PURSUING TPA/ASO CLIENT PARTNERSHIP
  _______Require all self-insured clients to partner in CPC+
  _______Allow self-insured clients to opt out of CPC+
  _______Encourage self-insured clients to opt in to CPC+

  INFORMATION ABOUT LINE OF BUSINESS, IF PARTNERING IN CPC+
  _______ Number of Covered Lives
  _______ Number of Primary Care Practices*
  _______ Number of Primary Care Practitioners**

- *Medicare Advantage plan*

  LINE OF BUSINESS OFFERED?
  _______N/A, line of business not offered
  _______Line of business offered, will not partner in CPC+
  If so, why?
  _______ Line of business offered, will partner in CPC+

  INFORMATION ABOUT LINE OF BUSINESS, IF PARTNERING IN CPC+
  Contract number(s)

*In CPC+, CMS defines a "Primary Care Practice" site as the single "bricks and mortar" physical location where patients are seen, unless the practice has a satellite office. A satellite office is a separate physical location that is a "duplicate" of the application practice; the satellite shares resources and certified EHR technology, and has identical staff and practitioners as the original applicant site. Practices with satellite locations are permitted to participate and will be considered one practice in CPC+. Practices that are part of the same health group or system that share some practitioners or staff are not considered satellite practices and will be counted as separate practices for the purposes of CPC+.

**In CPC+, CMS defines "Primary Care Practitioner" as a physician (MD or DO), nurse practitioner (NP), physician assistant (PA), or Clinical Nurse Specialist (CNS) who has a primary specialty designation of family medicine, internal medicine, or geriatric medicine.

CPC+ Payer Framework and Questions

The following section includes the payer framework and questions that CMS will use to assess the interested payer's alignment in CPC+.

Framework for Partnership

Please see below descriptions of the "Aligned Payer Approach" for each design element.

5. *Will you provide enhanced, non-fee-for-service support to both Track 1 and 2 practices to allow practices to meet the aims of the care delivery model and provide care management, care coordination, and similar "wraparound" services to all patients, agnostic of payer?*
   - ***a.*** Yes
   - ***b.*** No

6. *Will you reimburse Track 2 practices using at least a partial alternative to traditional fee-for-service payment by the end of the first performance year?*
   - ***a.*** Yes
   - ***b.*** No

7. *Will you share data with practices on cost, utilization, and quality at regular intervals (e.g., quarterly)?*
   - ***a.*** Yes
   - ***b.*** No

Enhanced, Non-Fee-For-Service Support

Payers are encouraged to provide enhanced, non-fee-for-service support to both Track 1 and 2 practices to allow practices to meet the aims of the care delivery model and provide care management, care coordination, and similar "wraparound" services to all patients, agnostic of payer.

Medicare Approach

Medicare will pay practices in Tracks 1 and 2 a per beneficiary risk-adjusted, monthly care management fee without any beneficiary cost-sharing, for attributed Medicare FFS beneficiaries. Beneficiary risk will be based on a hierarchical condition category (HCC) risk scores and, in Track 2, claims data for particular diagnoses.

For Track 1, Medicare will pay an average $15 per beneficiary per month (PBPM), ranging from $6-$30, with beneficiaries separated into risk quartiles, based on HCC scores. For Track 2, Medicare will pay an average $28 PBPM, with beneficiaries separated into five risk tiers ranging from $9-$100. Practices in Track 2 will receive $100 PBPM for an additional complex risk tier to support the enhanced services beneficiaries with high-costs and high-needs require. Medicare will assign to the complex tier those beneficiaries who fall into the top 10% of the HCC pool and may also include those who, according to Medicare claims, have lower HCC scores but have persistent and severe mental illness and/or dementia.

Practices must use the care management fee to support augmented staffing and training related to the model requirements. Practices will have flexibility to balance these options according to the needs of their attributed Medicare patient population.

Aligned Payer Approach

Partner payers are encouraged to provide enhanced, non-fee-for-service support that would allow Track 1 and 2 practices to meet the aims of CPC+, provide care management, care coordination, and similar “wraparound” services to all patients, agnostic of payer. Enhanced, non-fee-for-service support should be larger, on average, in Track 2 compared to Track 1, to reflect advancement in practice transformation and care of patients with complex needs. Additionally, payers are encouraged to clearly identify to practices the amount of enhanced support provided, at the time that these supports are being furnished to practices.

Proposed Non-Fee-For-Service Support

8. *Please describe any non-fee-for-service support you currently provide to primary care practices in the proposed region(s), such as, but not limited to, a per-member-per month (PMPM) payment, quality-based incentive payment, or direct support such as an embedded care manager.*

9. *For each line of business, please describe the non-fee-for-service support you propose to provide to primary care practices in the proposed region for both Tracks 1 and 2.*

10. *Please provide a specific, quantitative "build-up" for support offered to Tracks 1 and 2 practices, by line of business. The "build-up" should include a calculation of this support and your proposed method of risk adjustment, if applicable.*

- ***a.*** *How does your build-up align with the Track 1 goal to support practices to develop capabilities to deliver comprehensive primary care?*
- ***b.*** *How does your build-up align with the Track 2 goal to support practices to increase the depth, breadth, and scope of medical care delivered to their patients, particularly those with complex needs?*

Performance-Based Incentive Payment

Payers are encouraged to include the opportunity for Track 1 and 2 practices to qualify for performance-based incentive payments in their practice compensation contracts.

Medicare Approach

In Tracks 1 and 2, across all five years of the initiative, practices will be eligible to receive performance-based incentive payments based on: (1) utilization metrics and (2) clinical quality/patient experience performance assessed by Medicare at the practice-level. Medicare will pay prospectively all of the incentive payment, but only allow practices to keep funds if they meet annual performance thresholds. Practices will thus be "at risk" for the amounts prepaid and Medicare will recoup unwarranted payments. The payments will be in two distinct components: utilization and quality. The utilization portion will focus practices on primary drivers of patients' total cost of care. More information about the performance-based incentive payment arrangement is available in Section V. We will also prioritize quality such that there is no utilization performance reward unless practices meet the minimum total score for quality.

Aligned Payer Approach

Partner payers are encouraged to provide Track 1 and 2 practices with performance-based incentive payments, based on a combination of utilization, cost of care, and/or quality metrics. Payers are asked to provide CMS with a description of their approach to providing a performance-based incentive payment to practices. Performance-based incentives may include

shared savings, bonuses, or other financial arrangements. Payers may propose to pay these performance-based incentive payments prospectively or retrospectively.

Proposed Methods of Performance-Based Incentive Payment

11. *Please describe your prior experience providing performance-based incentive payments to primary care practices in the proposed region(s).*

12. *Please describe your proposed performance-based incentive arrangement with Track 1 and 2 practices.*

- *Please include the following information in your answer, as applicable:*
  - *Calculation*
  - *Frequency*
  - *Expected Amount*
  - *Timing of Payment*
  - *Cost of Care Calculation*
  - *Impact of Quality*
  - *Utilization Measures*
  - *Aggregation Methodology, if any*
  - *Relation to Individual Practice Performance*

Track 2 Alternative to Fee-for-Service Payment

Payers are encouraged to change the cash flow mechanism from fee-for-service to at least a partial alternative payment methodology for Track 2 practices.

Medicare Approach

Beginning in the first performance year, Track 2 practices will receive an upfront "Comprehensive Primary Care Payment" (CPCP), paid based on a practice's per-beneficiary-per-month office Evaluation and Management (E&M) revenue during a historical period. Practices' fee-for-service E&M payments will be reduced proportionately to account for the upfront payment. Practices will receive the CPCP in addition to the care management fee, with partial reconciliation.

CMS will offer two hybrid payment options: one will pay 40% upfront and 60% of the applicable FFS payment, and the other will pay 65% upfront and 35% of the applicable FFS payment. In an effort to recognize practice diversity, practices may accelerate to one of these two proposed arrangements at their preferred pace, pursuant to the options shown in the table below.

Track 2 Payment Choices by Year

	2017	*2018*	*2019*	*2020*	*2021*
CPCP%/FFS% options available to practices	10%/90%	-	-	-	-
	25%/75%	25%/75%	-	-	-
	40%/60%	40%/60%	40%/60%	40%/60%	40%/60%

	2017	2018	2019	2020	2021
	65%/35%	65%/35%	65%/35%	65%/35%	65%/35%

The CPCP will compensate the care team for traditional clinical care, but allows flexibility for the care to be delivered both in and outside of an office visit.

Aligned Payer Approach

Partner payers are encouraged to change the cash flow mechanism for reimbursing Track 2 practices that is at least a partial alternative to traditional FFS payment by the end of the first performance year. Examples of alternative payment arrangements could include, but are not limited to, partial capitation without downside risk, full capitation without downside risk, sub-capitation without downside risk, and episodic payment. Enhanced fee-for-service support (e.g., PMPM care management fees) and performance-based incentive payments (e.g., shared savings opportunities) do not change the cash flow mechanism for Track 2 practices and thus would not be considered aligned with the Medicare approach. These payments are intended to compensate the care team for proactive and comprehensive care that Medicare would otherwise require to be furnished in an office setting. These payments should allow practices to provide care in a way that best meets the needs of the patient, including by email, phone, patient portal, or other alternative visits.

Proposed Methods for Alternative Payment to Track 2 Primary Care Practices

13. *Please describe your previous experience in changing the cash flow mechanism from traditional FFS payment arrangements to primary care practices in the proposed region(s).*

14. *Please describe your proposed departure from FFS payment for Track 2 practices.*
- *Please include the following information in your answer:*
  - *Timeline for Instituting Alternative Payment Arrangement*
  - *Rationale for Approach*
  - *Method for Calculating Amount of Alternative Payment*

Attribution Methodology

Payers are encouraged to share their attribution methodologies with CMS.

Medicare Approach

Medicare will use a prospective alignment methodology to identify the population of Medicare FFS beneficiaries for whom primary care practices are accountable for utilization and quality in CPC+. Medicare's methodology can be found in Appendix H.

Aligned Payer Approach

Partner payers may elect to use Medicare's methodology or describe their own approach to identify members served by practices.

Proposed Attribution Methodology

15. *Please describe your proposed methodology to identify members served by participating practices in the proposed region(s).*

- *Please include the following information in your answer:*
    - *Timing*
    - *Frequency*
    - *Approach to Notifying Practices of Members For Whom They Are Accountable*

Data Sharing

Payers are encouraged to provide participating practices with practice and member-level data at regular intervals regarding cost and utilization for their members attributed to participating practices.

Medicare Approach

Medicare will provide cost and utilization data on Medicare FFS beneficiaries attributed to primary care practices selected for this initiative. Data provided to the practices will include historical cost and utilization, quarterly reports on services and financial expenditures, and annual reports on per-capita expenditure and quality on a beneficiary-level. Further, Medicare is committed to participating in multi-payer data aggregation, as may be available in a geographic region or state.

Aligned Payer Approach

Partner payers are encouraged to share data with practices on cost, utilization, and quality at regular intervals at the practice and member-level. Payers are encouraged to provide guidance and support to practices to assist their use of these data. Payers are encouraged to create alignment with Medicare (and other payers in the region) on the structure, format, and schedule of sharing data with practices. Payers could also propose a common platform for sharing data with practices through an existing multi-payer database, payer health information exchange, or other capable data system within a region.

Proposed Approaches to Data Sharing

16. *Please describe your current strategy and proposed plan for sharing data with primary care practices in the proposed region(s), including the level of data shared (individual or aggregate), as well as the frequency of reporting. In your answer, please include information regarding feedback on cost data, utilization data, and real-time hospital and ER data in the proposed region(s).*

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

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

Sharing of Data with CMS

Payers are encouraged to provide CMS with data for model evaluation and monitoring purposes at regular intervals.

Partner payers are encouraged to provide CMS with data related to covered lives in each line of business, as well as payment provided to each practice when the payer distributes enhanced non-FFS support for participating practices, alternative to FFS payments, and information regarding their performance-based incentive payments. These data will be used by CMS for evaluation and monitoring purposes, and will not be shared with practices or other payer partners.

Quality and Patient Experience Measurement

Payers are encouraged to align quality and patient experience measures with Medicare and other payers in the region.

Medicare Approach

Medicare will use electronic clinical quality measures (eCQMs), patient experience of care measures (Consumer Assessment of Healthcare Providers & Systems [CAHPS]), and a patient reported outcome measure (PROM) survey to identify gaps in care, focus on quality improvement activities, and assess quality performance in CPC+.

To assess quality performance and eligibility for the CPC+ performance-based incentive payment, Track 1 and 2 practices will be required to annually report a subset of the measures listed in Appendix G. CMS anticipates that the quality reporting requirements may undergo changes prior to the start of CPC+, after the final list of the Merit-Based Incentive Payment System (MIPS) measures are published.

eCQMs must be reported at the practice-site level (rather than the individual provider level) and are specified to include all patients in the measure population, regardless of payer or insurance status. The eCQMs and patient experience of care measures will be included as pay-for-performance measures. CAHPS surveys will be administered by CMS or its contractors to patients in practices participating in both Tracks 1 and 2. The PROM survey will be administered to Track 2 patients only. Moreover, practices must use EHR technology that meets the certification requirements specified in the Medicare EHR Incentive Program final rule.

Further details regarding the CPC+ Quality Strategy are available in Section VIII.

Aligned Payer Approach

Partner payers are encouraged to align with the CPC+ measures. To ensure practices can focus on achieving the goals of CPC+, CMS has aligned its quality reporting programs to reduce provider reporting burden. Medicare selected eCQMs that (1) focus on a primary care population; (2) encompass many of the National Quality Strategy domains; and (3) are included in and align with other CMS quality reporting programs. Furthermore, the Core Quality Measures Collaborative Workgroup (including representatives from CMS, America's Health Insurance Plans members, and the National Quality Forum) has included many of the CPC+ measures in its recommended "Accountable Care Organization, Patient Centered Medical Homes, and Primary Care" measure set.

Proposed Methods for Aligning Quality Measures

19. *Please describe your proposed process for collecting quality measures from practices.*

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

21. *Please review the list of CPC+ Quality Measures.*

CMS ID#	NQF#	MEASURE TITLE	MEASURE TYPE/ DATA SOURCE	Included Performance Payment Assessments(Y/N)
CLINICAL PROCESS/EFFECTIVENESS (9)				
CMS159	0710	Depression Remission at Twelve Months	Outcome/ECQM	Y
CMS165	0018	Controlling High Blood Pressure	Outcome/ECQM	Y
CMS131	0055	Diabetes: Eye Exam	Process/ECQM	Y
CMS149	N/A	Dementia: Cognitive Assessment	Process/ECQM	Y
CMS127	0043	Pneumococcal Vaccination Status for Older Adults	Process/ECQM	Y
CMS137	0004	Initiation and Engagement of Alcohol and other Drug Dependence Treatment	Process/ECQM	Y
CMS125	2372	Breast Cancer Screening	Process/ECQM	Y
CMS124	0032	Cervical Cancer Screening	Process/ECQM	Y
CMS130	0034	Colorectal Cancer Screening	Process/ECQM	Y
PATIENT SAFETY (3)				
CMS156	0022	Use of High-Risk Medications in the Elderly	Process/ECQM	Y
CMS139	0101	Falls: Screening for Future Falls Risk	Process/ECQM	Y
CMS68	0419	Documentation of Current Medications in the Medical Record	Process/ECQM	Y
POPULATION/PUBLIC HEALTH (4)				
CMS2	0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process/ECQM	Y
CMS122	0059	Diabetes: Hemoglobin HbA1c Poor Control (> 9%)	Outcome/ECQM	Y
CMS138	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/ECQM	Y
CMS147	0041	Preventive Care and Screening: Influenza Immunization	Process/ECQM	Y

Supplemental Questions

The following information will be used as supplemental information to help CMS further assess payer alignment.

Monitoring and Evaluation

Payers are encouraged to share with CMS their monitoring and evaluation strategy to track practice progress in the CPC+.

Medicare Approach

Monitoring will help CMS ensure that the CPC+ is being implemented appropriately and effectively at the practice level. Moreover, monitoring ensures that practices understand and can track their progress towards meeting the care delivery requirements.

CMS will use program integrity, cost, utilization, and quality data in its monitoring strategy, as well as reports submitted from practice coaches and the practices themselves. The findings from monitoring will guide additional learning activities and ensure practice compliance with the terms of the Participation Agreement.

The evaluation of CPC+ will use a mixed-methods approach, customized to each track to assess both impact and implementation experience. The impact component will attempt to measure to what degree each track improved key outcomes, including lower total cost of care and improved quality of care. The implementation component will describe how the model was implemented, assessing barriers and facilitators to change.

Aligned Payer Approach

Partner payers are encouraged to share with CMS their proposed monitoring and evaluation strategy to track practice progress in implementing CPC+, as well as to assess changes in cost of care, quality improvement, and patient experience of care.

Proposed Monitoring and Evaluation Strategy

24. *Please describe how you propose to monitor practices' progress towards achieving the goals of the CPC+.*

- ***a.*** *Please describe any actions you would take towards practices not achieving the goals of the program based on your assessment.*

25. *Please describe how you plan to evaluate the impact of your investment in CPC+.*

- ***a.*** *Please describe your willingness to share your evaluation findings with CMS.*

Involvement in Multi-Payer, Multi-Stakeholder, and Primary Care Transformation Initiatives

Payers are encouraged to describe their involvement to date in multi-payer, multi-stakeholder, and/or primary care transformation initiatives.

CMS is interested in engaging with payers new to multi-payer programs, as well as those that have previously partnered in national or regional multi-payer, multi-stakeholder, and/or primary care transformation initiatives. CMS will assess interested payers based on any past involvement in such efforts and the extent of alignment achieved with CMS' existing multi-payer efforts (e.g., the Original CPC Model, the Multi-Payer Advanced Primary Care Practice Demonstration, and State Innovation Models).

Involvement in Multi-Payer, Multi-Stakeholder, and Primary Care Transformation Initiatives

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

27. *Please describe your vision for how multi-payer collaboration will transform primary care.*

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

Appendix B: Practice Application Guidance and Questions

Between July 15 and September 1, 2016, Comprehensive Primary Care Plus (CPC+) will accept applications from individual primary care practice sites that are geographically located in a selected market. Practices interested in applying to CPC+ should review the Request for Applications to learn about the design and requirements of the model, and to determine which track of the model is best suited for the practice.

Track 1 of CPC+ targets up to 2,500 practices poised to deliver the five primary care functions, detailed in Care Delivery Design Section of the CPC+ Request for Applications above. Track 2 of CPC+ targets up to 2,500 practices proficient in comprehensive primary care that are prepared to increase the depth, breadth, and scope of medical care delivered to their patients, particularly those with complex needs. This document is not the application to be filled out by the applicant; **this is a DRAFT list of the questions that will be found in the online application portal**. This list is for your reference as you assemble your application. Practices applying to Track 2 of CPC+ must answer all questions. Practices applying to Track 1 of CPC+ must answer all questions other than those marked "Track 2 only." CMS reserves the right to seek additional information from applicants to CPC+ after the application period closes.

The Application will be found online once CMS begins accepting practice applications this summer. Questions about the Application for CPC+ should be directed to CPCPlus@cms.hhs.gov CMS may publicly share questions or responses or compile them into a Frequently Asked Questions compendium to ensure that all interested payers have access to information regarding CPC+.

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

Letters of Support

Practices will need to submit several letters of support with their application, and we have provided an application checklist at the end of this document to help applicants ensure that they have all the required materials prior to submitting their application. Incomplete applications will not be accepted.

1. Letter of support from clinical leadership:

   Skilled leaders with high levels of emotional engagement and intellectual commitment are essential for successful cultural changes that drive improvements toward better care, smarter spending, and healthier people. In addition to answering all questions in the

application and providing any required supporting documentation, all practices applying to participate in the CPC+ must attach a letter of support from at least one physician, nurse practitioner, or physician assistant leader in the practice. This letter shall describe how the clinician intends to engage with the care team(s) to provide ongoing leadership in support of CPC+. The letter shall also define the planned time commitment and briefly describe ongoing strategies to share and address results, challenges, progress, and successes with practice staff and the patient community. This letter shall be no more than one page.

2. Letter of support from parent of owner organization:

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

3. Letter of support from HIT vendor:

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

Preliminary Questions

The questions in this section are required to move forward with the application to CPC+. The answers to questions 2 and 3 impact your practice's eligibility for CPC+ and may disqualify you from completing the remainder of the application.

1. For which Track is your practice applying?

   a. Track 1

b. Track 2

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

   If you select yes below, CMS may consider your practice for Track 1 participation. This is not necessarily a guarantee of Track 1 participation, even if the practice is found eligible for Track 1.

   a. Yes
   b. No

3. Is your practice a concierge practice, a Rural Health Clinic, or a Federally Qualified Health Clinic?

   Concierge practices (any practice that charges patients a retainer fee), Rural Health Clinics, and Federally Qualified Health Centers (FQHCs) are also not eligible for the model. If your practice employs a practitioner who provides concierge services, that practitioner will be excluded from participation in CPC+.

   a. Yes
   b. No
   c. Unknown

4. Is your practice currently participating in any of the Medicare initiatives below? Please check all that apply.

   Participation in a TCPi Practice Transformation Network or Support and Alignment Network is permitted for practices participating in CPC+; however, participation in the learning activities provided through the TCPi is not. Participation in any other of the below programs renders the applicant practice ineligible to participate in this model unless they intend to withdraw from the program in order to participate in CPC+.

   a. Transformation Clinical Practice Initiative (TCPi) – participation in learning activities
   b. Transformation Clinical Practice Initiative (TCPi) – participation as part of a PTN or SAN
   c. Pioneer ACO Model

d. Next Generation ACO Model
e. Medicare Shared Savings Program (MSSP) ACO
f. Another Medicare ACO program (please specify)
g. Accountable Health Communities
h. None of the above
i. My practice currently participates in the following program, but we plan to withdraw from the program upon acceptance into CPC+:

   Program: ______________________ Withdrawal date: ______________________

General Questions

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

For purposes of this application, a practice site is defined as the single "bricks and mortar" physical location where patients are seen, unless the practice has a satellite office. A satellite office is a separate physical location that is a "duplicate" of the applicant practice; the satellite shares resources and certified EHR technology, and has identical staff and practitioners as the original applicant site. Practices with satellite locations are permitted to participate and will be considered one practice in CPC+. Practices that are part of the same health organization, group, or system that share some practitioners or staff are not considered satellite practices and will be counted as separate practices for the purposes of CPC+. For purposes of CPC+, practitioners that provide primary care services in more than one participating practice will be deemed to practice in only one participating practice.

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

Practice Structure and Ownership

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

5. Practice identification:
   a. Practice Site Name:

b. Practice "doing business as" (DBA) Name:
c. Street Address 1:
d. Street Address 2:
e. City:
f. State:
g. 10-digit ZIP Code:
h. Practice Site Phone Number:
i. Practice Site Fax Number:
j. Does your practice site belong to a larger health care organization, such as a group practice, health system, or independent practice association?
    i. Yes
    ii. No
        1. What is the name of the organization?
        2. How many other primary care practice sites are part of this entity?
        3. How many physicians are part of this entity?
        4. How many [Medicare Eligible Professionals (EPs)] are part of this entity?
        5. Are other primary care practices in this entity applying to participate in CPC+?
            a. Yes (Please identify them by Business Name, Address, and Taxpayer Identification Number (TIN)):
            b. No
            c. Unknown
                i. Are all practices from this entity applying for the same Track of CPC+? *Practices participating as part of a health system or organization must all participate in the same track of the model.*
                    1. Yes
                    2. No
                    3. Unknown
        6. Do all practice sites that are part of this entity share one Electronic Health Record system?
            a. Yes
            b. No
            c. Unknown
        7. Do other practices that are part of this entity belong to a Medicare Accountable Care Organization (ACO)?
k. Does your practice have satellite offices?
    i. Yes

ii. No
iii. Unknown

l. Website (if applicable):

6. Does your practice share a TIN for billing with other practices that are part of the same health group or system?

Note that CMS requires primary care practices participating in CPC+ to use one billing TIN for all primary care services provided in the participating practice. That TIN may be shared with other practices within your medical group or organization; however, this arrangement has important implications for reporting on quality measures per requirements of CPC+. More information regarding quality reporting for organizations that share one billing TIN will be available soon.

a. Yes
b. No
c. Unknown

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

a. Yes
b. No
c. Unknown

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

____

9. Who owns this practice? MARK ALL THAT APPLY
   a. Physicians in the practice
   b. Non-physician practitioners (nurse practitioners or physician assistants) in the practice
   c. Another physician organization
   d. Public or private hospital, health system, or foundation owned by a hospital
   e. Insurance company, health plan or HMO
   f. Medical school or university
   g. Other (Specify)

Model Participation

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

instructions for more information about participation in other CMS programs.

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

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

    ____

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

    If yes, what was your practice ID number? ______________________

12. Primary Contact (*This should be the person filling out the application*)
    a. First Name:
    b. Last Name:
    c. Title/Position:
    d. Does this person work in the practice?
        i. Yes
        ii. No
    e. Relationship with the practice:
    f. Business Phone Number:
    g. Business Phone Number Extension:
    h. Alternative Phone Number (e.g. cell phone):
    i. E-mail Address:
    j. Street Address 1:
    k. Street Address 2:
    l. City:
    m. State:
    n. ZIP Code:

13. Secondary Contact (if applicable)

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

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

14. Health Information Technology Contact

___________ *This is the same person as listed in question #11*

___________ *This is the same person as listed in question #12*

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

Practitioner and Staff Information

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

15. To the best of your knowledge, has your practice or anyone employed in your practice had a final adverse legal action (as defined on page 12 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i) or been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of the Inspector General, U.S. Department of Justice, or any other

Federal or State enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose could be grounds for application denial or immediate termination from the initiative.

a. Yes
b. No

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

Explanation:

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

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

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

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

18. Are all of the primary care practitioners that are applying to participate in CPC+ practicing at the same physical address?

    a. Yes
    b. No

Explanation:

19. For each primary care practitioner in your practice, please provide the following information.
    a. Practitioner Name (Last, First, MI)
    b. National Practitioner ID (NPI)
    c. Practitioner Type:
        i. Physician (MD or DO)
        ii. Clinical Nurse Specialist or Nurse Practitioner
        iii. Physician Assistant
    d. Primary Specialty
        i. Family Medicine
        ii. Internal/Adult Medicine
        iii. Geriatric Medicine
        iv. General Practice
    e. Is this practitioner board certified in this specialty?
        i. Yes
        ii. No
        iii. Unknown
    f. If applicable, is the physician current with maintenance of certification?
        1. Yes
        2. No
        3. Unknown
    g. This practitioner works at the practice (or satellite office):
        i. Part time
        ii. Full time

    If part time, how many hours per week does this practitioner work at the practice site?
    h. Does this practitioner also practice at another practice location (besides a satellite office)?
        i. Yes
        ii. No
    i. If yes, is the practitioner's billing TIN the same at both practices?
    j. Is the other site applying to participate in CPC+?
        i. Yes
        ii. No

        Name of site:

20. Please describe current Meaningful Use attestation progress among the primary care practitioners in your practice who are Eligible Professionals (EPs) under the EHR Incentive Program(s).
    a. Total number of Medicare EPs:

b. For the 2016 reporting year, total number of Medicare EPs who plan to attest to Meaningful Use Stage 2:
c. Total number of Medicaid-only EPs:
d. For the 2016 reporting year, total number of Medicaid EPs who plan to attest to Meaningful Use Stage 2:

Practice Activities

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

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

    If the above answer is b:

    - Do the primary care practitioners in your practice share an EHR with other types of practitioners in the practice?
        - Yes
        - No
        - Unknown

    If the above answer is c:

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

      ____

22. Is this practice engaged in training future primary care practitioners and staff?
    a. Yes
    b. No
    c. Unknown
    d. Please briefly describe the engagement (e.g., family medicine residency clinic, occasional rotating NP students):

23. The practice currently is recognized as a “medical home” by:
    a. National Committee for Quality Assurance (NCQA-PCMH)
    b. The Joint Commission (TJC), previously known as Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
    c. Accreditation Association for Ambulatory Healthcare (AAAHC-Triple A)
    d. Utilization Review Accreditation Commission (URAC)
        - Specify recognition level received _________
    e. State-based Recognition Program
        - Specify State and Program_______
        - Specify recognition level received __________
    f. Insurance Plan-based Recognition Program
    g. Other (Specify)
    h. Does not have recognition as a “medical home”

Health Information Technology

This section asks questions about the Health Information Technology (HIT) capabilities of your practice. You may need input from your HIT vendor to complete the questions in this section. The HIT requirements for each Track in Appendix E of the Request for Applications.

24. Is your practice able to complete HIT Requirements indicated for the track to which your practice is applying that are listed in the table titled “Certified Health IT Requirements” in Appendix E if the practice is accepted to participate in the model?
    a. Yes
    b. No

25. Please provide the following information regarding the primary certified EHR system used by your practice site.

Vendor Name	Product Name	Version

26. Please provide the most up-to-date CMS EHR Certification ID for your practice’s certified products: _________________________

    Detailed instructions on how to obtain your CMS EHR Certification ID can be found here:

27. Please list any other health IT tools or services your practice currently uses (e.g.,

population health management tools, care management tools, data analytics, services provided by a health information exchange or a data registry).

Vendor	Product Name	Version	Function (if applicable)

28. Does your practice currently have plans to purchase a new EHR in 2017 or a subsequent year?

Changing EHRs after the start of any calendar year in which the practice participating in CPC+ may affect the practice's ability to receive a performance-based incentive payment that is based in whole or in part on the reporting of clinical quality measures.

a. Yes
b. No
c. Unknown

Patient Demographics

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

29. Percentage of patients of Hispanic, Latino, or Spanish origin (*including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, Argentinian, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, etc.)* ______________________%

30. Percentage of patients by race:

a. White _____________%
b. Black or African American (*for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somalian, etc.)* ______________%
c. Alaska Native or Native American (*for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.*) _____________%
d. Asian *(for example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, Hmong, Laotian, Thai, Pakistani, Cambodian, etc.)* ___________%
e. Native Hawaiian or other Pacific Islander (*for example, Samoan, Guamanian or Chamorro, Tongan, Fijian, Marshallese, etc.*) _______________%
f. Other race: _______________________ ______________%
g. Is this based on collected data or best estimate?

- Collected
- Best Estimate
- Both

31. Percentage of patients by preferred language:
    a. English ____%
    b. Non-English ____%
       If non-English, what is the most common non-English language spoken among your patient population?

       ____

    c. Is this based on collected data or best estimate?
       - Collected
       - Best Estimate
       - Unknown

Practice Revenue and Budget

As described in the RFA, eligibility for CPC+ is based on a number of factors, one of which is the proportion of practice revenue generated by payers participating in CPC+. Practices that have 60% or more of their current revenue generated from payers that are participating in CPC+ (including Medicare) will be better positioned to implement the service delivery model and meet the practice milestones.

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

32. Total revenue for 2015 from all lines of business:

    ____

33. Total revenue for 2015 by type of business:

    Business Types include Commercial PPO, Commercial HMO, Medicare Advantage, Medicaid Managed Care, Other, Unknown

Insurance Type	Business Type*	2015 Annual Revenue ($)
Medicare Fee-For-Service (not managed care)		
Medicaid/CHIP Fee-For-Service (not managed care)		
Payer 1		
Payer 2		
Payer 3		
TRICARE		

34. Percentage of patients by insurance type:
    a. Commercial or private __%
    b. Medicare __%
    c. Medicaid __%
    d. Uninsured __%
    e. Other __%
    f. Is this based on collected data or best estimate?
        - Collected
        - Best Estimate
        - Unknown

Care Delivery

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

Care Management

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

routinely used for scheduling purposes and are continuously monitored to balance supply and demand.

36. Non-physician practice team members
    a. …play a limited role in providing clinical care.
    b. …are primarily tasked with managing patient flow and triage.
    c. …provide some clinical services such as assessment or self-management support.
    d. …perform key clinical service roles that match their abilities and credentials.

37. *Track 2 only:* Care plans
    a. …are not routinely developed or recorded.
    b. …are developed and recorded but reflect practitioners' priorities only.
    c. …are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care.
    d. …are developed collaboratively, include self-management and clinical management goals, are routinely recorded, and guide care at every subsequent point of service.

38. *Track 2 only:* A standard method or tool(s) to stratify patients by risk level
    a. …is not available.
    b. …is available but not consistently used to stratify all patients.
    c. …is available and is consistently used to stratify all patients but is inconsistently integrated into all aspects of care delivery.
    d. …is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.

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

40. *Track 2 only:* Linking patients to supportive community-based resources

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

Access

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

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

Quality Improvement

42. Quality improvement activities

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

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

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

Application Checklist

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

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

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

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

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

Certified Health IT Requirements

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

Certified Health IT Criterion/Criteria	Date Required	Notes
Adopt, at a minimum, the certified health IT needed to meet the certified EHR technology (CEHRT) definition required by the Medicare EHR Incentive program at 42 CFR 495.4.	Practices must adopt the health IT meeting this requirement. All practices must complete a full upgrade to 2015 Edition technology by January 1, 2018.	
At a minimum, adopt health IT meeting 2015 Edition certification criteria found at 45 CFR 170.315(c)(1) - (3), for all of the electronic clinical quality measures in the CPC+ measure set.	By January 1, 2017	• These capabilities will support quality reporting on the CPC+ measure set for the 2017 performance year. • Practices will attest that these capabilities have been adopted and that they are ready to begin capturing data. • Vendors do not need to have completed certification for these capabilities by January 1, 2017; however, they will be expected to complete certification for those capabilities by January 1, 2018, prior to the submission of the data to CMS.
Adopt health IT meeting the 2015 Edition eCQM certification criterion at 45 CFR 170.315(c)(4) which allows filtering of data by at least practice site	By January 1, 2017	• In order to successfully report eCQMs as part of CPC+, practices will need to be able to filter their data by practice

Certified Health IT Criterion/Criteria	Date Required	Notes
address and TIN/NPI.		site address and TIN/NPI using functionality meeting the (c)(4) criterion. • Vendors do not need to have completed certification for the (c)(4) filter by January 1, 2017, however, they will be expected to complete certification for (c)(4) by January 1, 2018, prior to the submission of the data to CMS.
TRACK 2 ONLY: Adopt health IT certified to the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9).	By January 1, 2019 – beginning year 3 of model	• Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.
TRACK 2 ONLY: Adopt health IT certified to the 2015 Edition "Social, Behavioral and Psychological Data" criterion found at 45 CFR 170.315(a)(15).	By January 1, 2019 – beginning year 3 of model	• Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.

Requirements for Reporting eCQMs

Practices will be required to report on a set of the measures listed in Appendix D. (The last two measures are not EHR measures but are measures that will be included in the CPC+ model.) The final list of measures will be determined no later than November 2016, if not before. CPC+ practices must meet the certified health IT requirements described above in order to report measures. eCQM requirements are outlined in the following table:

First eCQM Performance Period	CY2017 (January 1-December 31, 2017)
First eCQM Submission Period	Begins January 1, 2018 to CMS
eCQM version	eCQM version published as the annual update in April-June 2016
eCQM Reporting Method	QRDA III – using direct EHR or a certified EHR data submission vendor, or as may be specified by CMS

Optimized EHR/Health IT for Track 2

CPC+ offers opportunities to align multi-payer payment reform and health IT support with practice transformation. Primary care practices require advanced health IT capabilities that are not always available in current systems or required by ONC certification. As part of Track 2, practices will have an opportunity to develop and optimize these functions to support clinical

objectives. To support this work, CPC+ participants, CMS, and ONC will collaborate with vendors that are willing to work with Track 2 practices to meet core health IT requirements as well as develop and optimize enhanced capabilities appropriate to test the model.

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

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

While CMS expects some practices will seek support from a single vendor for all of their relevant health IT needs, others may identify multiple vendors or service providers delivering required capabilities. Other HIT vendors and service providers might include vendors delivering population health management, analytics, and care management solutions.

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

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

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

Benefits of Vendor Partnership with CPC Practices and CMS
Partnership with CPC+ offers a unique opportunity for EHR and other health IT vendors to work

with advanced primary care practices participating in an important new CMS alternative payment model.

Through engagement with the model, CMS expects vendors will:

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

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

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

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

Health IT Functionalities/Enhancements Expected in Track 2

Practices in Track 2, supported by participating vendors, will be asked to develop the following health IT functions/enhancements. CMS will not prescribe how the health IT enhancement is accomplished, rather only that the health IT solution meets the CPC objective for use of the health IT by the CPC practice site team. CMS anticipates that some of these requirements will be completed in the first 6-12 months of model start-up while others will take longer. CMS expects that all health IT enhancements listed below will be completed no later than 24 months after model kick-off in January 2017.

Health IT Technical Enhancement	CPC+ Objective for Use of Health IT
Risk-stratify practice site patient population; identify and flag "Patients with Complex Needs"	1. Enable the practice site to assign a risk score/label that reflects assignment based on the practice's risk stratification methodology. 2. The methodology used to stratify practices should be clear and meet basic guidelines established by CMS. 3. The practice site practice team should be able to sort patients by score and update risk scores as needed. 4. Based on stratification results, the practice site should be able to flag patients they identify as "complex patients" and/or as requiring episodic, short term care management, and generate reports or lists of patients using those labels to support clinic workflow.
Produce and display eCQM results at the practice level to support continuous feedback	1. Enable the entire practice team to view eCQMs results at the practice site level to support continuous feedback on quality improvement efforts. 2. Measure results should be updated as frequently as possible so that measures reflect current progress. 3. This capability should present results in a usable, actionable manner that the care team can use to effectively manage population health.
Systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs	1. Enable primary care practices to electronically assess patients' psychosocial needs. 2. Enable primary care practices to capture or access electronically an inventory of resources and supports to meet patients' identified psychosocial needs. 3. To support this objective practices must adopt certified health IT that meets the 2015 Edition criterion "Social, Behavioral and Psychological Data" found at 45 CFR 170.315(a)(15), within the first two years of the program.
Document and track patient reported outcomes	CMS is evaluating a patient reported outcome survey instrument that will be sent to CPC+ Track 2 patients to identify specific care needs requiring intervention/management by the CPC+ practice site team. CMS plans to use the data collected from the patient-reported outcome survey to develop a patient-reported outcome performance measure that may be included in CPC+ measure set in the later years of the model. The modes of administration are yet to be determined. 1. The health IT tool should provide the care team with the ability to administer the survey, store and track patient responses, and score results longitudinally for each patient surveyed. 2. The practice should be able to review the patient responses/results in their EHR or other health IT tool and, as appropriate, establish care plans /interventions for positive

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

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

Appendix D: Quality and Utilization Measure Set

CMS ID#	NQF#	MEASURE TITLE	MEASURE TYPE/ DATA SOURCE	Included Performance Payment Assessments(Y/N)
CLINICAL PROCESS/EFFECTIVENESS (9)				
CMS159	0710	Depression Remission at Twelve Months	Outcome/ECQM	Y
CMS165	0018	Controlling High Blood Pressure	Outcome/ECQM	Y
CMS131	0055	Diabetes: Eye Exam	Process/ECQM	Y
CMS149	N/A	Dementia: Cognitive Assessment	Process/ECQM	Y
CMS127	0043	Pneumococcal Vaccination Status for Older Adults	Process/ECQM	Y
CMS137	0004	Initiation and Engagement of Alcohol and other Drug Dependence Treatment	Process/ECQM	Y
CMS125	2372	Breast Cancer Screening	Process/ECQM	Y
CMS124	0032	Cervical Cancer Screening	Process/ECQM	Y
CMS130	0034	Colorectal Cancer Screening	Process/ECQM	Y
PATIENT SAFETY (3)				
CMS156	0022	Use of High-Risk Medications in the Elderly	Process/ECQM	Y
CMS139	0101	Falls: Screening for Future Falls Risk	Process/ECQM	Y
CMS68	0419	Documentation of Current Medications in the Medical Record	Process/ECQM	Y
POPULATION/PUBLIC HEALTH (4)				
CMS2	0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process/ECQM	Y
CMS122	0059	Diabetes: Hemoglobin HbA1c Poor Control (> 9%)	Outcome/ECQM	Y
CMS138	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/ECQM	Y
CMS147	0041	Preventive Care and Screening: Influenza Immunization	Process/ECQM	Y
EFFICIENT USE OF HEALTHCARE RESOURCES (1)				
CMS166	0052	Use of Imaging Studies for Low Back Pain	Process/ECQM	Y
CARE COORDINATION (1)				
CMS50	N/A	Closing the Referral Loop: Receipt of Specialist Report	Process/ECQM	Y
PATIENT AND FAMILY ENGAGEMENT (2)				
N/A	0005	Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Outcome/Patient Survey	Y
N/A	N/A	Patient Reported Outcomes Measure (TBD)	Outcome/Patient Survey	N – performance measure will be developed during model lifecycle. Once it is fully developed and tested it may be

CMS ID#	NQF#	MEASURE TITLE	MEASURE TYPE/ DATA SOURCE	Included Performance Payment Assessments(Y/N)
				used in model for performance.
UTILIZATION (2)				
HEDIS	N/A	Ambulatory care: summary of utilization of ambulatory care in the following categories: ED visits	Utilization	Y
HEDIS	N/A	Inpatient utilization—general hospital/acute care: summary of utilization of acute inpatient care and services in the following categories: total inpatient, maternity, surgery, and medicine.	Utilization	Y

** The list of eCQMs in the table above will be finalized based on whether they are included on the final list of eCQMs in MIPS. CPC+ practices must meet the certified Health IT requirements described in Appendix C in order to report measures. CPC+ practices will be required to report on a subset of the eCQMs and on both the utilization and CAHPS. Required measures will take into consideration availability of measures supported by CPC CEHRT vendors. PROM is applicable to Track 2 practices only.*

Appendix E: Attribution Methodology

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

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

- Have both Medicare Parts A and B;
- Have Medicare as their primary payer;
- Not have end stage renal disease (ESRD) or be enrolled in hospice;
- Not be covered under a Medicare Advantage or other Medicare health plan;
- Not be institutionalized;
- Not be incarcerated;
- Not be enrolled in any other program or model that includes a shared savings opportunity with Medicare FFS initiative;
- Reside in one of the regions selected for this model;

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

Qualifying CPT Codes	
Office/Outpatient Visit E&M	99201-99205 99211-99215
Complex Chronic Care Coordination Services	99487-99489
Transitional Care Management Services	99495-99496
Home Care	99341-99350
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Chronic Care Management Services	99490

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

- Practice name;

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

For each individual practitioner:

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

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

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

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