FREQUENTLY ASKED QUESTIONS (FAQ) – PAYMENT POLICY

June 13, 2017

Table of Contents

List of Tables

Frequently Asked Questions (FAQ) – Payment Policy

This document addresses common questions about the CPC+ Attribution and Payment Methodologies and use of CPC+ payments. More granular questions are included later in this document. If your question is not answered in this document, please refer to the more detailed CPC+ Attribution and Payment Methodologies paper and the CPC+ Participation Agreement.

1. General

1.1 *What payments will I get as a participant in CPC+?*

The three CPC+ payment types are care management fee (CMF), performance-based incentive payment (PBIP), and a hybrid payment of a Comprehensive Primary Care Payment (CPCP) paired with reduced fee-for-service (FFS). Depending on (1) which CPC+ track you are in, and (2) whether or not you are also in a Shared Savings Program Accountable Care Organization (ACO), your eligibility to receive each of these three payment types will differ, as summarized in Table 1.

Table 1: Payment Types by CPC+ Track and ACO Participation

	CMF	PBIP	FFS
CPC+ Track 1 not in an ACO (Standard Participant)	$6–$30 PBPM	$2.50 PBPM	Regular FFS
CPC+ Track 2 not in an ACO (Standard Participant)	$9–$100 PBPM	$4 PBPM	Hybrid Payment
CPC+ Track 1 in an ACO (Dual Participant)	$6–$30 PBPM	N/A	Regular FFS
CPC+ Track 2 in an ACO (Dual Participant)	$9–$100 PBPM	N/A	Hybrid Payment

1.2 *What is the CMF?*

The CMF is an enhanced, non-visit-based payment meant to augment staffing and training in support of population health management and care coordination. It is a risk-adjusted prospective payment that is based on the health risk and number of Medicare FFS beneficiaries attributed to your practice. Track 1 practices receive a CMF ranging from $6.00 to $30.00 per beneficiary per month (PBPM). Track 2 practices receive a CMF ranging from $9.00 to $100.00 PBPM; the $100.00 PBPM is for the highest risk tier to support the enhanced services beneficiaries with complex needs require. The CMFs are paid quarterly.

1.3 *What is the PBIP?*

The PBIP is meant to focus practices' attention on patient experience, clinical quality, and utilization measures that drive total cost of care. The PBIP is paid in the first quarter of each year and is at risk, based on your practice's performance during that year, as compared to annual benchmarks. If your practice does not meet or exceed the annual benchmarks, you are required to repay all or a portion of the prepaid amount. Your practice site is thus at risk for the PBIP. The PBIP is $2.50 PBPM for Track 1 Practices and $4.00 PBPM for Track 2 Practices. The PBIP is reconciled early the next year.

1.4 *What is the hybrid payment?*

The Centers for Medicare & Medicaid Services (CMS) pays the hybrid payment only to Track 2 practices. The hybrid payment has two components: a CPCP for a percentage of covered Office Visit Evaluation and Management (E&M) services and a reduced FFS payment. Your practice selects from a few options the percentage you want to receive via the CPCP: 10%, 25%, 40%, and 65% in Program Year (PY)1; 25%, 40%, and 65% in PY2; and then between only 40% and 65% in PY3-5. CMS then reduces the payment for billed E&M services provided to attributed beneficiaries by the CPCP percentage your practice chose. For example, if your practice chooses a CPCP of 25%, payment for billed E&M services is 75 percent of the usual amount you are paid. The CPCP compensates practitioners for clinical services that have been traditionally billable, but offers flexibility for these services to be delivered outside of a traditional office visit. The CPCP is paid quarterly.

1.5 *When and how will I receive Medicare CPC+ Payments?*

Medicare CPC+ practice payments are deposited in the account designated in your Electronic Funds Transfer (EFT) Authorization Agreement, referred to as the CMS 588 Form. There is one deposit for each payment type received and the specifics of each payment will be outlined in the remittance report.[1] Depending on how many characters your bank allows on the EFT, the remittance notes payment information in this format: 1C-CPC+-[CMF/PBIP/CPCP]-[Practice ID]-[Practice Name]. You can also find the breakdown of your CPC+ practice payment amounts in the CPC+ Practice Portal.

The CMF and CPCP are paid quarterly. The PBIP is paid annually in the first quarter of each year. If your practice must repay any of the PBIP, because of not meeting the annual benchmarks, CMS will send you a demand letter in the second or third quarter of the following year outlining how much you must repay.

[1] For 2017 Quarters 1 and 2, all payment types were made in a single deposit per practice.

All payments are disbursed between the 23rd and 27th day of the first month of each payment quarter, though the timing of the availability of the funds will depend on your practice's bank processes. The monthly schedule of payments and demand letters are outlined in Table 2.

Table 2: Schedule of Payment Dates

Calendar Year (CY)	Payment Quarter	Payment Delivery Date	Payments, as Applicable
2017	1st	Late Jan/Early March	CMF, PBIP
2017	2nd	Late April	CMF, CPCP
2017	3rd	Late July	CMF, CPCP
2017	4th	Late October	CMF, CPCP
2018	1st	Late Jan	CMF, CPCP, PBIP
2018	2nd	Late April	CMF, CPCP
2018	2nd or 3rd	April-July	PY1 PBIP Demand Letter
2018	3rd	Late July	CMF, CPCP
2018	4th	Late October	CMF, CPCP
2019	1st	Late Jan	CMF, CPCP, PBIP
2019	2nd	Late April	CMF, CPCP
2019	2nd or 3rd	April-July	PY2 PBIP Demand Letter
2019	3rd	Late July	CMF, CPCP
2019	4th	Late October	CMF, CPCP
2020	1st	Late Jan	CMF, CPCP, PBIP
2020	2nd	Late April	CMF, CPCP
2020	2nd to 3rd	April-July	PY3 PBIP Demand Letter
2020	3rd	Late July	CMF, CPCP
2020	4th	Late October	CMF, CPCP
2021	1st	Late Jan	CMF, CPCP, PBIP
2021	2nd	Late April	CMF, CPCP
2021	2nd or 3rd	April-July	PY4 PBIP Demand Letter
2021	3rd	Late July	CMF, CPCP
2021	4th	Late October	CMF, CPCP
2022	2nd or 3rd	April-July	PY5 PBIP Demand Letter

2. Use of Medicare CPC+ Payments

2.1 *Does CMS have general guidance for how we should spend our CPC+ payments?*

CPC+ payments are provided to support your practice's work to deliver care that improves the quality and experience of health care and ultimately reduces total costs of care by avoiding unnecessary utilization, especially hospitalizations and emergency department (ED) visits. A

good way to think about this is to consider which of the myriad possible investments in the CPC+ care delivery requirements would deliver the most value to your patients and practice. You should consider what is unique to your practice and in what ways you may already be meeting the care delivery requirements. For example, if your practice already has frequent Patient and Family Advisory Council (PFAC) meetings and provides 24/7 access, you may decide to spend your CPC+ payments on other requirements. Each practice has different needs and populations, so the investment decisions you make may be different from the choices your peers make.

For each investment, you should ensure it is both a permitted use of CPC+ payments as described in this document and in the CPC+ Participation Agreement (permissible use varies for each of the three payment types: CMF, CPCP, and PBIP) and that it supports the aims of the model to improve quality of care and patient experience, and to lower overall costs.

2.2 *Should I use the CPC+ payments to get every single staff, support, and item listed here in the permitted use of payments?*

You should make strategic choices about how the investment of CPC+ payments will be most useful for your practice to meet the aims of the model. Your decisions will reflect your existing infrastructure, processes, and staff, as well as the needs of your patient population. The CPC+ payments your practice receives are not intended to be used to procure everything listed in this document, but should be used to make strategic investments that are consistent with the CPC+ Participation Agreement and that effectively support your practice in meeting the aims of the model.

2.3 *Do I need to spend all of my Medicare CPC+ payments? Can I have any left over at the end of the year?*

Although there is no requirement to spend all of the CPC+ payments each quarter or by the end of each program year, CMS strongly encourages you to fully leverage these payments to successfully deliver care in a manner consistent with the care delivery requirements described in the Participation Agreement. We believe that these payments are necessary to support the care delivery transformation CPC+ is intended to achieve. However, we recognize that some of the payments you plan to use for hiring, training, or other infrastructure may be earmarked during the year, but not actually spent until early the following year.

2.4 *Are there any restrictions on the use of CPC+ payments from any of the partnering payers?*

CMS does not intervene in the contractual relationship between CPC+ practice participants and CPC+ payer partners. Restrictions, if there are any, will come directly from each payer. We do not impose any restrictions on CPC+ partner payer payments. Therefore, the guidance described in this document is limited to Medicare FFS and will not necessarily be the same as

restrictions that other payers impose. We encourage you to reach out to your payer partners for more information on possible restrictions on use of CPC+ payments.

2.5 *Can I share CPC+ payments with other non-CPC+ practices in my system?*

No. Your CPC+ payments are to be exclusively used for resources in your practice. We know that staff may work on both CPC+ and non-CPC+ activities. In those cases, please use CPC+ payments only for the portion of time the staff is doing CPC+ work. For example, if your practice hires a care manager who spends 20 percent of her time on CPC+ care delivery requirements, you can use your CMF to pay 20 percent of her salary. We also know that your practice may share staff or resources with other, non-CPC+ practices. In this case, you may use CPC+ payments to pay for only the portion of time your practices uses the shared staff member or resource.

2.6 *Can I use my CPC+ payments to pay for items or services that I provide to a CPC+ beneficiary to support the care delivery requirements?*

Yes, if the provision of such items and services complies with all applicable laws and regulations, including section 1128A(a)(5) of the Social Security Act and sections 1128B(b)(7) and (2) of the Social Security Act. For more information on these laws, see Department of Health & Human Services (HHS) Office of the Inspector General. We note that the Secretary of HHS has not issued any waivers of the fraud and abuse laws for this model.

2.7 *What services may I spend my CMF on?*

The CMF is intended to help your practice deliver comprehensive primary care, providing support for "wrap-around" services. You will want to think about what sorts of investments will deliver the most value to your practice in meeting the CPC+ care delivery requirements. The CMF can also be used for services that were non-billable prior to the 2015 introduction of the Chronic Care Management (CCM) code. These "wrap-around" services include, but are not necessarily limited to:

- Care management, such as hiring/paying staff, empanelment, risk stratification, tracking of patients, hospital and ED follow-up, medication reconciliation, proactive monitoring, and creation/updating care plans
- Assessing patients' psychosocial needs and identifying community-based and social services that could meet those needs
- Planned care for chronic conditions and preventive care (e.g., pre-visit planning, identifying gaps in care via data analysis)

- Care coordination (e.g., developing communication flows with hospitals and EDs, establishing collaborative care agreements with outside practices)
- Enhanced access (e.g., 24/7 access and alternative visits), measuring, and schedule management to improve continuity with practitioner and/or care team
- Otherwise non-billable visits (e.g., at home, in the hospital or skilled nursing facility) for care management activities
- Patient and caregiver engagement (e.g., PFACs, patient surveys)
- Wages for staff to perform CPC+ care delivery requirements, such as a care manager, care coordinator, pre-visit planner, quality/data analyst, community health worker, electronic health record (EHR) scribe, pharmacist, or behavioral health specialist, and overhead associated with new staff
- Wages for existing staff to support care delivery reporting or other CPC+ operational activities
- Care delivery tools related to care delivery requirements, such as instruments used for patient assessments or self-management support
- Training and travel directly related to the implementation of care delivery requirements, such as attending CPC+ learning meetings

2.8 *How can I spend my CPC+ CMFs?*

Please refer to Table 3 through Table 7 for guidance on how you can spend your practice's CMFs.

Table 3: CMF Use Guidance: Types of Patients and Visits

Patient Type	Can I Use CMFs?
Non-Medicare patients	Yes. The CMF provides support for "wrap-around" services that could be provided to all patients in the practice and are not restricted to Medicare FFS beneficiaries.
Increasing access through longer face-to-face visits[2]	Yes. This includes longer office visits that are more extensive or time-consuming than the billable code(s) cover, walk-in hours, increases in availability of same day visits, expanded hours, or having a care manager in your practice make home visits or visits to other facilities.
Increasing access through non-face-to-face visits, such as telemedicine, e-visits, text messages, group visits[3]	Yes.

[2] Track 2 practices may also spend their CPCP on these activities.
[3] Track 2 practices may also spend their CPCP on these activities.

Table 4: CMF Use Guidance: Labor Costs for Practice Employees

Labor Costs for Practice Employees	Can I Use CMFs?
Salary/benefits for a physician or staff able to (1) bill for services themselves or (2) engaging in billable activities	It depends. You cannot use the CMF to compensate practitioners for work they are doing that is billable. However, if you determine that a billable practitioner would most appropriately deliver certain non-billable services, then CMFs can be used to compensate the practitioner for those non-billable services. For example: • Your CMF may compensate a practitioner for the 2 hours per week spent developing quality improvement projects using your payer data feedback reports. • Your CMF may compensate a practitioner for identifying high-volume and/or high-cost specialists in your medical neighborhood and enacting collaborative care agreements with those specialists. • Your CMF may not compensate non-CPC+ practitioners, such as an ophthalmologist reading retinal scans one day a week in your practice. Instead, ophthalmologists may bill for those services.
Additional labor costs for billing staff for "wrap-around" services that are included in the CPC+ care delivery requirements	Yes. The CMF is intended to pay for "wrap-around" activities that can be performed by billing practitioners, such as a psychologist who provides non-visit-based, integrated behavioral health services under the CPC+ care delivery requirements. Because these activities were traditionally not considered billable,[4] the CMF can be used to compensate practitioners for engaging in this work.
Salary/benefits/indirect costs for staff engaging in only non-billable activities or in "wrap-around" activities to support the CPC+ care delivery requirements	Yes. The CMF is intended to support the advanced capabilities necessary to deliver comprehensive primary care, as outlined in the CPC+ care delivery requirements. This includes indirect costs, such as benefits, withholding, payroll taxes, furniture, computer, supplies, and additional office space. Note that wages, benefits, and indirect costs must be in proportion to the time the employee is performing CPC+ care delivery duties (e.g., 20 percent of the employee's salary and benefit costs are allowable expenditures for an employee who spends 20 percent of his or her time performing care delivery duties). The following are illustrative examples: • Your CMF may support hiring a care manager with clinical training (e.g., a registered nurse) to identify patients with chronic conditions who have not had an office visit in the previous 12 months and those who were recently hospitalized or had a recent ED visit. You may also use your CMF for any indirect costs associated with employing a care manager, such as benefits, withholding payroll taxes, furniture, computer, supplies, and additional office space. • Your CMF may support your team's efforts to improve the timeliness of notification and information transfer from EDs visited frequently by your patients.

[4] Prior to the advent of the chronic care management code.

Labor Costs for Practice Employees	Can I Use CMFs?
Shared services for multiple practices, such as those provided by a parent organization	Yes. CPC+ practice sites are permitted to pay for their respective portion of services shared with other CPC+ practices (e.g., data analysts shared by a group of CPC+ practices in a medical group). Part-time services are permitted, but it is important to remember that the CPC+ payments paid to each CPC+ practice site must be used for the practice transformation efforts within the practice itself, and the practice must have input into how payments are allocated to ensure the needs of its individual patient population are met. Finally, CPC+ payments cannot be used to fund services in a practice that does not participate in CPC+.
Payment to Practitioners/staff for bonuses	No. The CMF is intended to support the advanced capabilities necessary to deliver comprehensive primary care, outlined in the CPC+ care delivery requirements. The PBIP is available to use for bonuses.
Payment to specialists	No. The CMF is intended to support the advanced capabilities necessary to deliver comprehensive primary care, outlined in the CPC+ care delivery requirements. Specialists may bill Medicare FFS if they provide billable services.

Table 5: CMF Use Guidance: Consultants, Contractors, and Vendors

Types of Consultants, Contractors, and Vendors	Can I Use CMFs?
Contracted services with oversight by the practitioners in your practice and integrated into the care team	Yes. Staff, such as a care manager from a health plan, social worker from a local public health agency, psychologist from a behavioral health center, or other support, is a permissible use of CMFs if these staff members function as part of your practice's care team and have regular communication with and oversight from the CPC+ practitioners in your practice.
Contracted services with no oversight by the practitioners in your practice, such as from a care management company	No. For example, a "care management company" is an entity that provides care management or other services (e.g., care coordination or behavioral health integration) related to the CPC+ care delivery requirements remotely (from outside the practice) in exchange for a fee paid by the CPC+ practice site. CPC+ requires direct CPC+ practitioner oversight of all care management activities (and all other work related to CPC+) that are performed by an individual or entity not directly employed by the practice. These requirements are inconsistent with outsourcing care management services.
Indirect costs associated with consultants, contractors, or vendors	Any indirect costs should be included in the contract (e.g., social workers from a local public health agency would use their own agency-provided computer and equipment; training costs would be incurred by their employer).

Table 6: CMF Use Guidance: Tools/Products to Implement the CPC+ Care Delivery Requirements

Tools/Products to Implement the CPC+ Care Delivery Requirements	Can I Use CMFs?
Tools/resources from a vendor	The CMF may be used to purchase a non-health IT product from a vendor, such as instruments for patient assessments or self-management support tools.
Fees for accreditation	No. The CPC+ care delivery requirements do not require your practice to become accredited by any other organization.
Durable medical equipment[5]	No. Medicare Part B covers medically necessary durable medical equipment that physicians prescribe for patients' home use.
Diagnostic and imaging equipment	No. These expenses are reimbursable under Medicare FFS.
Non-billable tools to provide patients for self-management support	Yes, if these tools are used to implement CPC+ care delivery requirements.

Table 7: CMF Use Guidance: Other Expenses

Other Expenses	Can I Use CMFs?
Medications	No.
Training	Yes, if the training is specific to CPC+ care delivery requirements, such as CPC+ Regional Learning Network Learning Sessions, or training for practice staff to provide patients with self-management support.
Continuing Medical Education (CME)	Yes, but only if the CME is directly related to CPC+ care delivery requirements. Non-CPC+-specific CME should be covered by other revenue sources.
Income and business tax payments[6]	No. These are normal operating expenses and not traceable to the CPC+ care delivery activities. Practices should use other revenue sources for these expenses.
Health IT hardware and software	No. Your practice site may not use Medicare CMFs on health IT purchases or upgrades, including hardware, population management, and care coordination modules, as well as population health analytics and IT-based patient engagement tools. Your practice site may purchase these or other health IT products with your regular FFS revenue or other funding streams; however, you are not permitted to use your Medicare CMFs to do so.

[5] Durable medical equipment coverage: https://www.medicare.gov/coverage/durable-medical-equipment-coverage.htm

[6] Non-allowable taxes include business/corporate taxes, employment taxes (e.g., FUTA), self-employment taxes, real estate, and sales taxes.

2.9 *Are there any restrictions on the use of the PBIP?*

There are no restrictions on the use of the PBIP; however, please note that these payments are at risk of recoupment so you should only use these payments in advance of the determination of your practice's eligibility to keep them if you can pay them back.

2.10 *What does the Track 2 CPCP pay for?*

Because the CPCP is calculated from your historical Medicare FFS revenue, it can be used to pay for activities that are billable under the Medicare Physician Fee Schedule for Medicare beneficiaries. The CPCP gives your practice additional flexibility in how you provide medical care to the Medicare beneficiaries in your practice. For example, you may use your CPCP to provide care outside of the traditional office visit, such as telemedicine, e-visits, text messages, and group visits.

When you use your CPCP, you are not required to submit a bill for the services and your documentation should be what is needed for the clinical care you provide. You may also use your CPCP for office visits that are more extensive or time-consuming than the billable code(s) cover and, in that event, you would submit a claim for the billable portion of the service provided. The CPCP can only pay for care delivered by your practice.

2.11 *How do I bill for care outside of a traditional office visit delivered using modalities that can be billed under certain circumstances, such as home or group visits, or using telemedicine?*

While the goal of the hybrid payment is to support the flexible delivery of comprehensive care, being in Track 2 does not actually change any Medicare billing requirements. For example, to bill Medicare for telemedicine services,[7] you must meet the usual billing requirements and file a claim. However, you can also provide telemedicine services to Medicare beneficiaries using the resources of your CPCP without having to meet the usual billing requirements or file a claim. The hybrid payment offers the opportunity for you to use the CPCP to address your patients' needs in whatever modality you and the patient prefer, be that telemedicine, e-visit, or another form. When you use the resources of the CPCP to fund the delivery of care, you do not file claims or bill for those services.

2.12 *Can the CPCP be used to pay for care for non-Medicare patients?*

No. Because the CPCP is derived from your historical Office Visit E&M revenue at your practice for Medicare FFS beneficiaries, it can only be used to pay for services provided to Medicare FFS beneficiaries. However, you can and should use the aligned payments from CPC+ payer

[7] For information on telemedicine, please see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243327.html

partners to deliver care similarly to their members. A few payer partners are already making similar payments; however, the majority will begin these payments in early 2018.

2.13 *Are there any additional restrictions on how I can use my CPC+ payments?*

We have provided guidance in this FAQ document about how you can strategically use your CPC+ payments to further the aims of the model. We have also included information about uses of CPC+ payments that are specifically prohibited. All CPC+ payments, however, must still be used in a manner that complies with existing laws and regulations. If you have questions on how your practice may use its CPC+ payments, you should review the CPC+ Participation Agreement, as well as this document. You may wish to seek guidance from your own legal counsel to ensure that your use of CPC+ payments complies with the CPC+ Participation Agreement and all applicable laws and regulations.

3. Payment Reporting and Monitoring

3.1 *Will my practice need to report how we spend the CPC+ payments?*

Yes. In the CPC+ Practice Portal, you will report on your practice's CPC+ revenue from Medicare and payer partners. For example, your revenue from Medicare will include CMFs and, for Track 2 practices, the hybrid payment. You will also report on your CPC+ expenses. You are not required to report on your Medicare PBIP payments or other incentive/at-risk payments from payer partners. This financial reporting includes both a prospective forecast for the upcoming year and a retrospective report of actual revenues and expenditures in the prior year. Fore-casting is intended to help practices understand and optimally plan their use of these alternative payments. CMS uses this reporting to understand how practices allocate new streams of revenue and prioritize resources to different aspects of CPC+ practice transformation.

Practices will submit their financial forecast in December 2017. CMS will release a template and reporting guide in the summer of 2017. Practices will submit their retrospective report of actual revenues and expenditures in February 2018. Your practice site should track the use of CMF and CPCP payments (as well as the aligned payments your practice receives from CPC+ payer partners) throughout the year to prepare for reporting, and must retain documentation for use in the event that you are audited. CMS will not audit practices on their financial forecast.

3.2 *How will CMS monitor the use of the CPCP from Medicare and similar alternatives to FFS payments from payer partners?*

Track 2 practices will report their revenue and expenditures in the CPC+ Practice Portal. You will also tell us about how the CPCP and other alternatives to FFS payments from CPC+ payers have helped you reorganize how you deliver care, such as provision of services outside of a traditional office visit. CMS is asking these questions to better understand how practices are

innovating in delivering primary care services. CMS will monitor your use of the CPC+ payments at the practice level; you will not need to recreate patient-level documentation for work supported by the CMF or CPCP.

3.3 *What should my practice do to be prepared for a potential CPC+ audit of our revenue and expenses?*

Practices should take the following steps to prepare for a potential audit:

- Retain documentation to support your spending of CMF and CPCP payments paid to you by Medicare and payer partners (e.g., receipts, invoices, paystubs, W-2s, cancelled checks, contracts), including documentation of the approach used to assign overhead costs to CPC+.
- Record CPC+ revenues and expenses separately in your practice's accounting system.
- If your practice is part of a larger health system, ensure CPC+ revenues and expenses are accounted for separately and at the practice-level.
- Consider automating your accounting processes.

4. Attribution

4.1 *Why does Medicare attribute beneficiaries to my practice?*

We use attribution to approximate the size and risk of your Medicare patient population so we can pay your practice appropriately. Attribution is necessary in Medicare FFS alternative payment models (APMs), such as CPC+ and ACOs, because Medicare FFS beneficiaries retain freedom of choice of practitioner and are not "locked into" any practice or network. As such, CMS must estimate, based on beneficiaries' Medicare claims histories, how many beneficiaries receive the majority of their primary care at your practice. Even if a patient is attributed to your practice, they still can receive care from any practitioner they may choose.

4.2 *How does CMS attribute beneficiaries to my practice?*

In CPC+, eligible beneficiaries are attributed in two steps. First, attribution is based on CCM-related services (Current Procedural Terminology (CPT) codes 99487, 99489, 99490, G0506, and G0507). Because the CCM-related service requires that beneficiaries provide consent, if the CCM-related service was the most recent primary care visit in the 24-month look-back period, CMS assumes that the practitioner (including specialty practitioners[8]) providing the CCM-related service is the beneficiary's current practitioner and takes priority for payment. Second, if a beneficiary is not attributed in the first step, attribution is based on plurality of visits.

[8] All practitioners eligible to bill the Medicare Physician Fee Schedule may bill CCM-related services.

CMS attributes the beneficiary to the CPC+ practice site or non-CPC+ individual/group practitioner that provided the plurality of eligible primary care visits.

4.3 *Why doesn't CMS do practitioner-level, instead of practice-level, attribution?*

Because CPC+ is a practice-level intervention, rather than an intervention at the level of the individual practitioner, CMS attributes beneficiaries to the practice and not to a specific practitioner. Practice-level attribution is also more advantageous than practitioner-level attribution because multiple practitioners can pull a patient to a practice. Your work empaneling patients to their practitioner or care team can serve as a proxy for practitioner-level attribution.

4.4 *What are the look-back periods for CPC+ 2017 quarterly beneficiary attribution?*

The look-back periods for 2017 are shown in Table 8.

Table 8: Look-Back Periods for 2017 Quarterly Beneficiary Attribution

Attribution Quarter	Look-Back Period
2017 Q1	October 2014–September 2016
2017 Q2	January 2015–December 2016
2017 Q3	April 2015–March 2017
2017 Q4	July 2015–June 2017

4.5 *What beneficiaries are eligible to be attributed?*

To be eligible for attribution to a CPC+ practice, Medicare beneficiaries must meet the following criteria at the end of the look-back period:

- Enrolled in Medicare Part A and Part B
- Have Medicare as primary payer
- Not have end stage renal disease (ESRD)
- Not covered under a Medicare Advantage or another Medicare health plan
- Not long-term institutionalized or enrolled in hospice
- Not be incarcerated
- Not enrolled in any other program or model that includes a Medicare FFS shared savings opportunity, except for the Medicare Shared Savings Program when attributed to practices that are dual participants in the Shared Savings Program

4.6 *What if I think CMS did not attribute the correct number or the correct beneficiaries to my practice? Is there an appeals process?*

There is no appeals process for attribution. CMS uses a claims-based attribution methodology using the most recent administrative data available. Because the methodology relies on claims data, we understand there are likely to be discrepancies in the attribution list and your records, such as beneficiaries attributed to your practice site to whom you no longer provide primary care services and beneficiaries not attributed to your practice site to whom you do provide primary care services. These discrepancies are expected. For example, beneficiaries who have died may appear on your attribution list until CMS administrative data has a record of death. In other words, we are constantly updating your beneficiaries each quarter to reflect the most recently available data. We use attribution to get an approximate picture of your practice on which we can base payments; it is not intended to be an exact or prescriptive list of every Medicare beneficiary you treat.

4.7 *How does CPC+ attribution compare to the Medicare Shared Savings Program ACO attribution?*

In general, the CPC+ and Shared Savings Program ACO attribution methodologies are similar in several aspects. The two programs:

- Use very similar criteria to identify eligible Medicare beneficiaries
- Use Medicare physician and outpatient claims data for attribution
- Define eligible visits using primary care services
- Attribute beneficiaries based on plurality of visits (or allowed charges)

There are some differences. As described above, in CPC+, eligible beneficiaries are attributed in two steps. First, attribution is based on CCM-related services (CPT codes 99487, 99489, 99490, G0506, and G0507). Second, if a beneficiary is not attributed in the first step, attribution is based on plurality of visits. CMS attributes the beneficiary to the CPC+ practice site or non-CPC+ individual/group practitioner that provided the plurality of eligible primary care visits.

In the Shared Savings Program, eligible beneficiaries are attributed in two steps, based on Medicare allowed charges. If a beneficiary gets at least one primary care service from a physician used in assignment within the ACO, the beneficiary may be assigned to the ACO based on a two-step process. The first step assigns a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from primary care practitioners (e.g., primary care physicians, nurse practitioners, clinical nurse specialists, physician assistants, ACO professionals providing services at a Federally Qualified Health Center/Rural Health Clinic) within the ACO. The second step only considers beneficiaries who have not received a primary care service from a primary care physician or non-physician either inside or outside the ACO. During the second step, CMS assigns the beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from certain ACO professionals within the ACO. Elements of the attribution methodologies are compared in Table 9.

Table 9: CPC+ Attribution vs. Shared Saving Program Assignment

Attribution Element	CPC+	Shared Savings Program
Unit of Attribution	Set of Tax Identification Number(TIN)/National Provider Identifier (NPI) and CMS Certification Number (CCN)/NPI combinations	TIN or CCN
Look-back Period	24 months	12 months
Beneficiary Eligibility Criteria	• Medicare Part A and Part B enrollment • Medicare as primary payer • Not have ESRD • Not covered under a Medicare Advantage or other Medicare health plan • Not long-term institutionalized or enrolled in hospice • Not be incarcerated • Not enrolled in any other program or model that includes a Medicare FFS shared savings opportunity, except for the Medicare Shared Savings Program for practices that are dual participants in the Shared Savings Program	• Have at least one month of both Part A and Part B enrollment • Do not have any months of Part A or B only enrollment • Not be covered under a Medicare Group Health Plan • Reside in the United States or U.S. territories and possessions • Not be in another Medicare initiative that involves shared savings payments
Frequency	Quarterly	Annually
Practitioner Eligibility	Practitioners include primary care physicians (with a primary specialty designation of family medicine, adult medicine, geriatric medicine, hospice and palliative medicine, general practice, or internal medicine), nurse practitioners, physician assistants (in medicine), and clinical nurse specialists.	All Medicare enrolled practitioners are eligible to participate. However, the Shared Savings Program assignment methodology only includes primary care physicians (general practice, family practice, internal medicine, pediatric medicine, and geriatric medicine), specialist physicians,[9] and non-physician practitioners (nurse practitioner, clinical nurse specialist, or physician assistant).

[9] Specialist physicians are defined as those with a primary specialty designation of cardiology, osteopathic medicine, neurology, obstetrics/gynecology, sports medicine, physical medicine and rehabilitation, psychiatry, geriatric psychiatry, pulmonology, nephrology, endocrinology, addiction medicine, hematology, hematology/oncology, preventive medicine, neuropsychiatry, medical oncology, gynecology/oncology.

Attribution Element	CPC+	Shared Savings Program
Period of Assignment	Prospective (beneficiaries are attributed to the practice prior to the start of each quarter)	• Retrospective for Tracks 1 and 2 (beneficiaries are attributed to the ACO after the program year has ended using all claims data with dates of service during the program year, with three months of claims run-out) • Prospective for Track 3 (beneficiaries are attributed based upon claims with dates of service within a 12-month period that ends before the program year begins (October 1 to September 30))

5. Attribution/Payment Reports on the CPC+ Practice Portal

5.1 *What is a "dropped" beneficiary in the attribution/payment reports that can be downloaded on the CPC+ Practice Portal?*

Dropped beneficiaries were attributed in the previous quarter, but are not attributed in the current payment quarter, meaning you will not be receiving a payment for them. In your Q2 report, the dropped tab for Q2 reflects beneficiaries who were attributed and you received payment for in Q1, but you will not be receiving payment for in Q2.

5.2 *What is a debited beneficiary in the attribution/payment reports?*

Debited beneficiaries became ineligible during a previous quarter. The CPC+ prospective payments are made under the assumption that all attributed beneficiaries continue to be eligible during the entire quarter. However, some beneficiaries may become ineligible during the quarter. Deductions (debits) are computed to reflect previous overpayment. Reasons for debit include: losing Part A or B coverage, joining Medicare Advantage, becoming incarcerated, losing Medicare as the primary payer, or dying. For example, a beneficiary may have died in January 2017; therefore, CPC+ would debit the payments you received for this beneficiary for February and March, given that you did not care for this beneficiary.

5.3 *Is a debited beneficiary always a dropped beneficiary in the attribution/payment reports?*

In most cases, debited beneficiaries are not currently attributed to your practice; however, in rare cases, a debited beneficiary may remain on your attribution for the current quarter because of the timing of the ineligibility check. Your practice will receive payment for these beneficiaries for the current quarter and subsequently be debited for these beneficiaries in the next quarter,

assuming they remain ineligible. Also, assuming they remain ineligible, they should become dropped beneficiaries in the following quarter.

6. Risk Scores

6.1 *What is a risk score? What is the Hierarchical Condition Category (HCC) model?*

Risk scores predict patient health care costs. CMS uses the HCC model, which uses demographic and diagnosis information from the most recent year's (i.e., diagnosis year) claims and administrative data to estimate expenditures in a subsequent year. The HCC model produces a risk score that, based on a person's or a population's health status relative to the average, predicts expected medical expenditures. The HCC risk score is used as a multiplier to predict expenditures and the average risk score is 1.0. A patient with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a patient with a risk score of 0.5 is expected to incur medical expenditures half that of the average.

6.2 *How is the HCC risk score used in CPC+?*

All beneficiaries attributed to a CPC+ practice are assigned to one of four risk tiers for Track 1 or one of five risk tiers for Track 2. Attributed beneficiaries are assigned to risk tiers based on where their risk score falls compared to all Medicare beneficiaries in the region. Each risk tier corresponds to a specific PBPM CMF payment. Higher risk tiers are associated with higher beneficiary risk and higher CMFs to support the increased level of care management and care coordination we expect these beneficiaries require. For Track 2, beneficiaries with a dementia diagnosis are also placed into the highest risk tier, regardless of their risk score.

6.3 *How does an attributed beneficiary's risk score correspond to the care management expected of the CPC+ practice for that beneficiary?*

CMS pays a tiered CMF to reflect the higher level of support and care management beneficiaries with higher risk require. However, the attribution and risk tiering used to determine CMF payments are intended to produce the best possible estimate of your practice's patient population size and health status. Though the overall amount of the CMFs your practice receives from CMS is determined based on specific individual attributed beneficiaries, your practice is expected to pool these payments with those from our payer partners to support clinically indicated care management and other practice-level efforts to enhance care, consistent with the CPC+ model and aims.

6.4 *Which Medicare beneficiaries receive an HCC risk score?*

All continuing Medicare enrollees receive an HCC risk score. Continuing Medicare enrollees are defined as beneficiaries with 12 months of Medicare enrollment in the diagnosis year. Medicare enrollees who have fewer than 12 months of Medicare enrollment in the diagnosis year receive a demographic risk score only (omitting diagnoses).

6.5 *How are HCC risk scores determined?*

The risk adjustment model for new Medicare beneficiaries uses demographic information—including age, sex, original reason for Medicare entitlement, and dual Medicare-Medicaid enrollment—to estimate expenditures. New Medicare enrollees do not have complete diagnosis information and, thus, receive only a demographic risk score.

CMS updates risk scores every year. Risk scores are available 16–18 months after the close of the diagnosis year, which refers to the year used to collect diagnoses information from claims. For example, risk scores determined in 2015 are based on 2014 diagnoses, and were released in spring of 2016.

For each risk score year, CMS uses specific models for HCC risk adjustment and demographic risk adjustment. For further details see: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

6.6 *How long is the lag between a diagnosis and the risk score update?*

For CPC+, CMS will implement updated risk score data in the third payment quarter of each year. This schedule is subject to change based on changes in the availability of the data. Table 10 provides information on what risk score year and diagnosis year are used for risk scores for each CPC+ quarter. Risk score year refers to the year in which the risk score is released. Diagnosis year refers to the year used to collect diagnoses information from claims.

Table 10: Risk Score Release Schedule

CPC+ Quarters	Months	Risk Score Year	Diagnosis Year
2017 Q1-2017 Q2	January 2017-June 2017	CY 2015	CY 2014
2017 Q3-2018 Q2	July 2017-June 2018	CY 2016	CY 2015
2018 Q3-2019 Q2	July 2018-June 2019	CY 2017	CY 2016
2019 Q3-2020 Q2	July 2019-June 2020	CY 2018	CY 2017

6.7 *What specific HCC risk adjustment model will be used for CPC+ in 2017?*

A variety of HCC versions exist. For 2017 Quarter 1 and Quarter 2, CPC+ will use risk scores based on the Version 12 clinical classification HCC prospective risk-adjustment model from risk

score year 2015 (based on 2014 diagnoses). The Version 12 clinical classification model includes 70 HCCs.

For 2017 Quarter 3 and Quarter 4, CPC+ will use risk scores based on the Version 22 clinical classification HCC prospective risk-adjustment model from risk score year 2016 (based on 2015 diagnoses). The Version 22 clinical classification model includes 79 HCCs.

6.8 *Are risk scores provided to CPC+ practices? If so, are they in aggregate or specific to individual beneficiaries?*

Yes, risk scores for a CPC+ practice's attributed beneficiaries are provided to the practice each quarter, beginning with 2017 Quarter 2. Each beneficiary will receive either a full risk score or a demographic risk score, depending on if the beneficiary was a new Medicare enrollee or not.

6.9 *Is the risk score used to calculate CPC+ CMF payments the same risk score that will be provided to the CPC+ practices?*

Yes, the risk score used to calculate CPC+ CMF payments is the same as what will be provided to CPC+ practices.

6.10 *Is HCC risk adjustment used in CPC+ payments other than for CMF calculations?*

Yes, HCC risk adjustment is used for the risk adjustment of the utilization measures that are included in the CPC+ PBIP calculations.

6.11 *Are the risk scores provided the most recently available final risk scores?*

Yes, the risk scores provided to CPC+ practices are the most recently available final risk scores. Risk scores are available 16–18 months after the close of the diagnosis year. For example, risk scores for risk score year 2015 (based on 2014 diagnoses) were available in spring of 2016.

Note for dual participants: Both the CPC+ and the Shared Savings Program use the most recently available final risk scores.

6.12 *What is the major difference between CPC+ risk scores and the risk scores used by the Shared Savings Program ACOs?*

If your practice is in both CPC+ and the Shared Savings Program, you will receive beneficiary risk scores from both programs. Keep in mind that there are several differences between risk scores provided to CPC+ practices and risk scores provided to Shared Savings Program ACOs. The risk scores are not directly comparable, even for the same beneficiaries. The risk scores

provided to CPC+ practices are “raw” risk scores prior to any adjustments. However, instead of raw scores, the Shared Savings Program provides adjusted risk scores to ACOs for each of four Medicare enrollment categories used in the Shared Savings Program to determine ACO financial performance: ESRD, disabled, aged/Medicare-Medicaid dual eligible, and aged/non-dual eligible. For each risk score year, the Shared Savings Program adjusts the risk scores for each enrollment category so that the average risk score for the national assignable FFS population for that enrollment category equals 1.0.

The risk scores are compared side by side in Table 11.

Table 11: Comparison of CPC+ and Shared Savings Program Risk Scores

Components	CPC+	Shared Savings Program
Risk adjustment model clinical classification	HCC Version 12 clinical classification (70 HCC model) in risk score year 2015, and HCC Version 22 clinical classification (79 HCC model) starting in risk score year 2016	Blend of HCC Version 12 clinical classification and HCC Version 22 clinical classification (67% and 33%, respectively) in risk score year 2015, and HCC Version 22 clinical classification starting in risk score year 2016
Time period of diagnoses	Prospective (based on diagnosis codes from the year preceding the risk score year)	Prospective (based on diagnosis codes from the year preceding the risk score year)
HCC risk adjustment model	• Continuing enrollee, non-ESRD, community-residing (i.e., not long-term institutional) HCC risk adjustment model • New enrollee, non-ESRD, demographic risk adjustment model	Uses model that is relevant for beneficiary's risk adjustment status in each month of the risk score year and at the time for performance year financial reconciliation.
HCC risk score	Non-adjusted or “raw” risk score.	Adjusted risk score. Risk score for each Shared Savings Program enrollment category (ESRD, disabled, aged/dual Medicare-Medicaid, aged/nondual) is divided by the mean national assignable FFS risk score for that Shared Savings Program enrollment category.
Risk score comparability	Risk scores provided to CPC+ practices are directly comparable across all CPC+ attributed beneficiaries. However, risk scores provided to CPC+ practices are not comparable to risk scores provided to Shared Savings Program ACOs, even for the same beneficiaries.	Risk scores provided to Shared Savings Program ACOs are directly comparable across all Shared Savings Program attributed beneficiaries with the same Shared Saving Program enrollment category (ESRD, disabled, aged/dual Medicare-Medicaid, aged/nondual). However, risk scores provided to Shared Savings Program ACOs are not comparable to risk scores provided to CPC+ practices, even for the same beneficiaries.

7. Care Management Fee (CMF)

7.1 *How does CMS calculate the CMF?*

The amount of the CMF is determined by: (1) the number of beneficiaries attributed to your practice site per month, (2) the mix of risk scores of the attributed beneficiary population, and (3) the CPC+ track to which your practice site belongs.

All beneficiaries are placed in a risk tier based on the beneficiary's HCC score as compared to the population of Medicare FFS beneficiaries in that region. In Track 2, the complex tier is based on a combination of HCC score and beneficiaries with assigned diagnoses of dementia. Table 12 lists the risk score criteria and corresponding payment level for each track.

Table 12: Risk Tier Criteria and CMF Payments (PBPM)

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 PBPM		**$15**	**$28**

7.2 *How are risk tiers determined for each region?*

Risk tiers are determined for each region using the distribution of risk scores in the reference population for that region. The reference population is established and then divided into quartiles to determine the tiers. In Track 2, the top 10 percent in the Tier 4 quartile determine the complex tier.

The reference population includes all beneficiaries residing in each region who meet the eligibility criteria for attribution to a CPC+ practice (whether or not they are actually attributed). In addition, beneficiaries included in the reference population must also have had at least one eligible primary care visit in a prior 24-month period to approximate the utilization patterns of CPC+ attributed beneficiaries. The required primary care visit must meet all of the same criteria eligible primary care visits used for CPC+ attribution.

7.3 *What kind of patients will be included in the "complex tier" of top 10 percent HCC for the CPC+ care management fee?*

The top 10 percent of the HCC risk pool represents patients who are the "sickest of the sick," with multiple conditions and high expected costs. The exact range of HCC scores and number

of beneficiaries assigned to the complex tier vary based on region, due to different populations and variations in coding practices. For a more detailed description of the HCC methodology, as well as detailed information on what diagnoses are included in the HCC scores, please refer to this independent evaluation report.

In addition to beneficiaries in the top 10 percent of HCC risk scores, beneficiaries who have a diagnosis of dementia are assigned to the complex tier. Dementia diagnosis is assigned based on a set of diagnosis codes present in the prior three years. For detailed information, please refer to the Chronic Conditions Warehouse.

8. Performance-Based Incentive Payment (PBIP)

8.1 *How does the PBIP work?*

At the beginning of the year, your practice (unless you are a dual participant in the Shared Savings Program) receives the PBIP. Your practice site's performance is measured on two distinct components: (1) clinical quality and patient experience of care and (2) utilization. Each component corresponds to a portion of the PBIP, as noted in Table 13. After the close of each year, your performance is calculated on quality and utilization metrics. If your practice does not meet the annual benchmarks, CMS recoups a portion or all of each component of the PBIP, as applicable.

Table 13: PBIP PBPM by Component for CPC+ Track 1 and Track 2 Practices

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

8.2 *What are the tax implications for the PBIP if I have to pay some of it back?*

We recognize that possible repayment of the PBIP is going to have different tax implications for different types of entities. You may wish to seek guidance from your tax advisor for how the recoupment of the PBIP and risk of loss rules affect your practice.

8.3 *On what does CMS base my practice's performance when determining if I owe any of the PBIP back?*

For the Utilization Component, CMS measures inpatient hospitalization utilization (IHU) per 1,000 attributed beneficiaries and emergency department utilization (EDU) per 1,000 attributed beneficiaries. These two measures are available in the Healthcare Effectiveness Data and Information Set (HEDIS). Hospitalizations are the largest driver of Medicare beneficiaries' total

cost of care, are actionable, and can be reliably measured at the practice level, and are therefore suitable as a performance measure for primary care practices.

For the Quality Component, CMS measures patient experience of care and clinical quality measures. For patient experience of care, CMS uses version 3.0 of the Clinician & Group Customer Assessment of Healthcare Provider and Systems (CG-CAHPS). A CMS contractor fields the survey on a sample of all patients seen at the practice, including commercial, Medicaid, and Medicare patients. For clinical quality, your practice will submit a minimum of nine electronic clinical quality measures (eCQMs) from the CPC+ measurement set. The measures target a primary care patient population; patients with complex needs; and, where feasible, are outcome measures rather than process measures.

8.4 *How does CMS compare my performance to that of other practices?*

CMS compares your practice performance to benchmark performance thresholds derived using a reference population. Your practice may also set internal quality improvement goals by comparing your performance with benchmark performance thresholds and then use these benchmarks to track your performance over time. CMS publishes annual benchmark thresholds early in each program year so practices know how their performance is rewarded and can maximize their effort to retain the full PBIP. The benchmarks establish the minimum thresholds your practice must reach to retain a portion of the incentive payment and the maximum thresholds your practice site must achieve to retain the full incentive payment. Table 14 summarizes the 2017 CPC+ quality and utilization measures that are benchmarked.

CAHPS surveys, approved and overseen by the Agency for Healthcare Research and Quality (AHRQ), are designed to collect reliable and representative data about patient experience of care. The CAHPS items are scored as one CAHPS Summary measure by averaging the six CAHPS domain-specific scores. Clinical quality is measured using eCQMs that are relevant to primary care. The eCQM benchmarks are calculated individually.

Utilization measures include inpatient hospital and EDU, which are available in the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (NCQA, 2017). Both measures are calculated using Medicare claims data.

Table 14: CPC+ Quality and Utilization Measures for Benchmarking, 2017

Measure Component	Measure Segments	Number of Measures	Data Source for Benchmarking	Year Used to Derive Benchmark
Quality	Patient experience of care[10]	1	AHRQ CAHPS	2013, 2014, and 2015
	Clinical quality	14	Physician Quality Reporting System (PQRS)	2015
Utilization	Medicare utilization	2	Medicare claims data	2015

[10] The CAHPS summary measure is the average of the six domain-specific scores.

8.5 *What are the purpose and intent of CMS' benchmarks?*

Practice performance is measured against absolute performance thresholds. The minimum and maximum thresholds are determined from a benchmark population external to CPC+ participation. In turn, your practice site's own performance relative to this benchmark determines the incentive amount your practice site retains. Your practice site is not scored on a relative-performance basis, nor is the size of the payment your practice retains determined by performance of your peers. The intent of the external benchmarks is to reward practices for reporting challenging measures, even when actual measure performance has opportunity for improvement.

8.6 *What is the minimum threshold?*

Minimum performance goals are established using absolute thresholds that are the same for all practices and measures. In program year one, the minimum threshold is set to the 50th percentile of performance in the benchmark population for clinical quality and utilization, and the 30th percentile of performance in the benchmark population for patient experience of care. Your practice site is not eligible to retain the relevant portion of the PBIP if your performance score on an individual measure falls below this minimum threshold. This requirement ensures that practices are not rewarded for poor performance and encourages practices to place the highest priority on measures with very low scores to bring them above the minimum threshold.

8.7 *What is the maximum threshold?*

The maximum threshold is set to the 80th percentile of performance on the measure in the benchmark population for clinical quality, patient experience of care, and utilization. Generally, your practice site retains the full PBIP for the relevant individual measure if you are eligible for the incentive and attain the maximum threshold.

8.8 *What if my performance is between the minimum and maximum threshold?*

Your practice site will be rewarded on a continuous scale when scoring between the 50th and 80th percentile thresholds for clinical quality and utilization measures, or 30th and 80th percentile thresholds for patient experience of care. In general, your practice site is eligible to receive a percentage of the PBIP for this range of performance. The amount retained increases as performance approaches the maximum threshold. Data from the 2015 program year of Comprehensive Primary Care Classic (CPC Classic) suggest that a minimum performance score of 30th–50th percentile and a maximum threshold in the 80th–90th percentile would be both motivational and achievable.

8.9 *What are the benchmarks CMS is using?*

Table 15 lists the 50th and 80th percentiles of eCQMs and utilization measure benchmarks and the 30th and 80th percentiles of CAHPS measure benchmarks. Benchmarks for one CPC+ eCQM are not yet available, but will be set once 2016 data are available.

Table 15: Benchmark Results for the Quality and Utilization Measures in the CPC+ Program

CMS ID#	NQF#	Measure Title (MIPS ID#)	Performance Percentile	
CAHPS			**P30**	**P80**
N/A	N/A	CAHPS Summary Score	78.77	83.44
eCQMs			**P50**	**P80**
CMS159v5	0710	Depression Remission at 12 Months – (370)	Not Available	Not Available
CMS165v5	0018	Controlling High Blood Pressure – (236)	63.60%	75.34%
CMS122v5	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)[11] – (1)	19.33%	3.33%
CMS156v5	0022	Use of High-Risk Medications in the Elderly[11] – (238)	9.39%	0.01%
CMS149v5	N/A	Dementia: Cognitive Assessment – (281)	56.26%	95.56%
CMS139v5	0101	Falls: Screening for Future Fall Risk – (318)	47.87%	90.21%
CMS137v5	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – (305)	2.11%	6.99%
CMS50v5	N/A	Closing the Referral Loop: Receipt of Specialist Report – (374)	18.16%	51.18%
CMS124v5	0032	Cervical Cancer Screening – (309)	28.84%	54.78%
CMS130v5	0034	Colorectal Cancer Screening – (113)	33.46%	67.92%
CMS131v5	0055	Diabetes: Eye Exam – (117)	94.12%	99.99%
CMS138v5	28	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention – (226)	90.16%	96.59%
CMS166v6	0052	Use of Imaging Studies for Low Back Pain – (312)	100.00%	100.00%
CMS125v5	2372	Breast Cancer Screening – (112)	40.87%	63.07%
Utilization			**P50**	**P80**
N/A	N/A	Inpatient hospital utilization[11]	1.17	0.89
N/A	N/A	EDU[11]	1.42	1.07

[11] This measure is reverse-scored

8.10 *What is the source of the CPC+ benchmarks? Are they based on data from actual clinicians?*

Benchmarks were calculated using the performance of clinicians who submitted eCQMs to the PQRS program in 2015. In an effort to align quality reporting across CMS program, the CPC+ eCQM benchmarks used are the same benchmarks developed and used by the Merit-based Incentive Payment System (MIPS) for 2017.

8.11 *For the eCQM Use of High-Risk Medications in the Elderly (CMS 156v5) there are two performance rates. Which performance rate is the benchmark based on?*

The benchmark for CMS 156v5 is calculated using only the first numerator (patients with an order for at least one high-risk medication during the measurement period).

Benchmark Performance Rate = Numerator 1 / Denominator

NOTE: This measure does not have any Denominator Exclusions or Exceptions.

8.12 *For the eCQM Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (CMS 137v5), there are two performance rates. Which performance rate is the benchmark based on?*

The benchmark for CMS 137v5 is calculated using the average of the two numerators:
1) patients who initiated treatment within 14 days of the diagnosis and 2) patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. You can calculate this benchmark performance rate in two steps:

Step 1: Calculate the numerator average:

Numerator Average = (Numerator 1 + Numerator 2) / 2

Step 2: Divide that average by the denominator value:

Benchmark Performance Rate = Numerator Average / (Denominator – Denominator Exclusion)

NOTE: This measure does not have any Denominator Exceptions.

8.13 *How should CPC+ practices use performance benchmarks?*

Your practice can compare your current performance as tracked in your EHR or other certified health IT with benchmark performance thresholds, and can use this information over time to for internal quality improvement.

9. Hybrid Payment for Track 2 CPC+ Practices

9.1 *What is the goal of hybrid payment?*

The goal of the hybrid payment is to support the flexible delivery of comprehensive care to promote population health beyond traditional evaluation and management office visits. FFS payment methodologies usually do not provide payment for care delivery outside of face-to-face Office Visit E&Ms, even if care delivery via other methods (e.g., phone calls, electronic communications) meets the patient's needs more efficiently or aligns with patient preferences. Conversely, a fully population-based payment for primary care services without FFS payment for Office Visit E&Ms may present an undesirable incentive to minimize all Office Visit E&Ms. The advance payment of a portion of expected E&M services, paired with a commensurate reduction in FFS payments for these same E&M services, is intended to strike a balance between exclusive FFS and full population-based payment that encourages innovative, efficient, patient-centered care, while also reimbursing for costs of needed office visits.

9.2 *If the CPCP leads to fewer visits and thus less revenue, how does CPC+ help my practice compensate for this potential loss?*

Your practice can avoid a loss of revenue in a variety of ways. There is a 10 percent increase on historical payments built into the hybrid payment calculation to mitigate this risk. Additionally, the hybrid payment increases the flexibility for practices and, by addressing an increasing number of health care needs outside of an office visit, we expect you will become more efficient in your care delivery and require fewer resources. That increased efficiency may result in your ability to use existing practice resources to see new patients by increasing your active practice population and, thus, generate additional revenue.

The flexibility in care delivery could also allow you to spend more on your patients' most complex needs, including addressing needs that you might otherwise have referred. This could mean you could be reimbursed for addressing a greater depth and breadth of the health care needs of your patient population.

Lastly, but most importantly, the hybrid payment puts more control in your hands. Now that the revenue is, in part, untethered from the visit, you can practice medicine in ways that meet your and your patients' preferences.

9.3 *What are the payment choices by year?*

During each year's third quarter reporting, Track 2 practices will select their hybrid payment ratio for the next year. The options are outlined in Table 16. By 2019, all Track 2 practice sites will be paid either 40 percent or 65 percent up front via the CPCP.

Table 16: Hybrid Payment Ratio (CPCP %/FFS %) Options Available to Practices, by Year

2017	2018	2019	2020	2021
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%

9.4 *Can I lower my CPCP percentage from year to year?*

You can lower your percentage only from 65% CPCP to 40% CPCP. You cannot change from either of these percentages to 10%or 25% CPCP.

9.5 *How is the CPCP calculated?*

The 2017 CPCP calculation is constructed by calculating your practice's June 2014 through July 2016 payments for Office Visit E&M visits. The historical payments are then adjusted to account for comprehensiveness (increased by 10 percent) and Physician Fee Schedule updates to express them in 2017 dollars. The CPCP payment is calculated annually, and paid quarterly based on the number of attributed beneficiaries for that quarter.

9.6 *Is CMS making any changes to beneficiary cost sharing?*

Beneficiaries do not pay coinsurance for care received outside of an office visit. For regular Office Visit E&Ms, beneficiaries are responsible for typical cost sharing.

9.7 *Is CMS making any changes to documentation?*

A significant benefit of the CPCP is the elimination of documentation and billing requirements for the care delivered outside of an office visit using the CPCP. However, your practice is required to maintain general documentation on your use of the CPCP to deliver care to Medicare beneficiaries and to report this to CMS at the practice (not patient) level in the CPC+ Practice Portal. Your financial reporting will help CMS learn how practices are innovating on care delivery using alternative payments.

9.8 *How does the FFS reduction work?*

CMS reduces payment to Track 2 practices by the amount selected in the CPCP for every service:

- That is listed in the Current Procedural Terminology (CPT) table (Table 17),
- That is provided by a practitioner on the CPC+ Practitioner Roster, and
- That is provided to a Medicare beneficiary is attributed to your practice.

Although the CPCP is paid at the practice level, the corresponding FFS reduction occurs at the practitioner level. CMS cannot retroactively adjust previously paid claims.

Table 17: CPTs Eligible for FFS Reduction

CPT	E&M Office Visits Description
99201	OFFICE VISITS – NEW (EVALUATION AND MANAGEMENT)
99202	OFFICE VISITS – NEW (EVALUATION AND MANAGEMENT)
99203	OFFICE VISITS – NEW (EVALUATION AND MANAGEMENT)
99204	OFFICE VISITS – NEW (EVALUATION AND MANAGEMENT)
99205	OFFICE VISITS – NEW (EVALUATION AND MANAGEMENT)
99211	OFFICE VISITS – ESTABLISHED (EVALUATION AND MANAGEMENT)
99212	OFFICE VISITS – ESTABLISHED (EVALUATION AND MANAGEMENT)
99213	OFFICE VISITS – ESTABLISHED (EVALUATION AND MANAGEMENT)
99214	OFFICE VISITS – ESTABLISHED (EVALUATION AND MANAGEMENT)
99215	OFFICE VISITS – ESTABLISHED (EVALUATION AND MANAGEMENT)
99354	OFFICE VISITS – ESTABLISHED (EVALUATION AND MANAGEMENT)
99355	OFFICE VISITS – ESTABLISHED (EVALUATION AND MANAGEMENT)

9.9 *What will the Medicare Beneficiaries' Summary Notice report for a visit for which the payment was reduced?*

The following notice will appear on their Medicare Summary Notice: MSN 60.4 – This claim is being processed under a demonstration project.

9.10 *What will the remittance say for a claim for which the payment was reduced?*

Your remittance advice will include one of the following:

- For details lines adjusted: CARC 132 – Prearranged demonstration project adjustment; Group Code: CO (Contractual Obligation)

- For the unprocessable claims returned: CARC: 111 – Not covered unless the provider accepts assignment; Group Code: CO (Contractual Obligation)
- For the unprocessable claims returned if the provider appends a demonstration code of 78 in Item 19 of the CMS-1500 or comparable field on the electronic claim format: CARC 132 – “Prearranged demonstration project adjustment.”
- RARC: N763 – "The demonstration code is not appropriate for this claim; resubmit without a demonstration code; Group Code: CO (Contractual Obligation)

10. Chronic Care Management (CCM) Codes and CPC+

10.1 *Can we bill the Medicare CCM-related services?*

For attributed beneficiaries, CPC+ practices may not bill the codes listed in Table 18.

Table 18: CCM-Related Services Not Billable for Attributed Beneficiaries

Codes	Description
99487, 99489, 99490	CCM
G0506	Assessment/care planning for patients requiring CCM services
G0507	Care management services for behavioral health conditions
99358-99359	Prolonged non-face-to-face evaluation and management services

These services, referred to as CCM-related services for purposes of CPC+, are duplicative of the services covered by the CPC+ CMF. As such, Medicare will not pay both a CPC+ CMF and CCM-related services for any beneficiary in the same month.

You are free to bill any other codes, including the Collaborative Care Model and cognition and functional assessment for patient with cognitive impairment (G0502-G0505), for your attributed beneficiaries if all other billing requirements for those codes are met.

You are free to bill any code (including the CCM codes) for non-attributed beneficiaries if all other billing requirements for those codes are met. Because CCM codes are included in the CPC+ attribution algorithm, billing the CCM for non-attributed beneficiaries may result in those beneficiaries being attributed to your practice in future quarters.

For more information about these codes, please refer to these fact sheets and FAQs.

10.2 *What happens if my practice bills a CCM-related service for a Medicare beneficiary who is attributed to my practice?*

CMS will monitor claims paid. If your practice has billed a CCM-related service when the beneficiary was attributed to the practice and for which it received a CPC+ CMF, the Medicare Administrative Contractor that paid the CCM-related claim will recoup the CCM

payment as an “overpayment.” However, you will continue to receive your CPC+ CMFs as long as the beneficiary continues to be attributed to your practice.

10.3 *What happens if another practice bills a CCM-related service for a beneficiary who is attributed to my practice?*

If a CCM-related payment is made to one practice and a CPC+ CMF is paid to a CPC+ practice for the same beneficiary in the same period, the CCM-related claim takes precedence. The CPC+ CMF will be recouped from the CPC+ practice. CMS considers the practitioner billing the CCM-related service to be the one where the beneficiary is currently receiving primary care and, therefore, gives priority to that practitioner. This is because beneficiaries must provide consent prior to beginning receipt of CCM-related services.

10.4 *What happens if my practice bills a CCM-related service for a beneficiary who is assigned to another CPC+ practice?*

Because CCM-related services require consent from beneficiaries prior to beginning receipt of CCM-related services, CMS considers the practice billing the CCM-related service to be the one where the beneficiary is currently receiving primary care. Therefore, if you are providing and billing for CCM-related services for a beneficiary who is attributed to another practice, CMS will recoup the CPC+ CMF from the other practice. You will be allowed to keep the CCM payment for that month and for future months if your practice site continues to provide CCM-related services to the beneficiary, your practice site continues to meet all the billing requirements, and for as long as the beneficiary is not attributed under CPC+ to your practice site. Because CCM codes are included in the CPC+ attribution algorithm, billing the CCM for non-attributed beneficiaries may result in those beneficiaries being attributed to your practice in future quarters.

10.5 *Will the CCM code impact which Medicare beneficiaries CMS attributes to my practice?*

Yes. The CMS attribution algorithm gives priority in attribution to the practice that has billed the most recent CCM-related service in the look-back period, if the CCM-related service is the most recent claim billed. If the CCM-related service is not the most recent claim in the attribution look-back period or no CCM-related services have been billed, the beneficiary will be attributed to the practice with the plurality of visits (or the most recent visit if there is a tie). To clarify, if CCM-related services have been billed during the look-back period, but are not the most recent claim, they will be counted as visits in the look-back period, but not given special priority.

10.6 *What happens if a patient I have billed CCM-related services for this month is attributed to my practice next quarter?*

If your practice bills a CCM-related service for a beneficiary not yet attributed to your practice, you will be paid for the CCM-related service. Your practice may continue to provide and bill for CCM-related services unless the beneficiary becomes attributed to your practice. Once a beneficiary is attributed to your practice, you should not bill CCM-related codes since you are receiving a CPC+ CMF for that beneficiary. If your practice bills a CCM-related code in error, the CCM-related payment will be recouped as an overpayment. Your practice will keep the CPC+ CMF and will continue to receive that payment for as long as the beneficiary is attributed to your practice.

10.7 *How will I know if a beneficiary who is not attributed to my practice is also seeing another practitioner who may be billing CCM-related services?*

It is important for practitioners to talk with their patients about the CCM services and gain their consent to bill for them. When practitioners have this discussion, they should ask their patients about other practitioners they may be seeing and whether they have given consent to another practitioner to provide CCM-related services. CMS does not have the capability to notify CPC+ practices when another practitioner bills a CCM-related code for a patient attributed to them. The only notification you will receive is when CMS identifies the overpayment and sends you a letter asking you to pay back the overpayment. Because the overpayment will be determined based on a retrospective analysis of all claims paid, it may be a few months before you receive a letter notifying you that an overpayment was made. You are also responsible for refunding any cost-sharing the beneficiary paid to you.