**Comprehensive Primary Care Plus (CPC+) Fact Sheet**

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**Title**

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Strengthening primary care is critical to promoting health and reducing overall health care costs. Building on lessons learned from the Comprehensive Primary Care (CPC) initiative and input from the 2015 Request for Information on Advanced Primary Care Model Concepts, the Centers for Medicare & Medicaid Services (CMS) is introducing the Comprehensive Primary Care Plus (CPC+) model. CPC+ integrates many insights from the CPC initiative, including the critical role of practice readiness, aligned payment reform, actionable performance-based incentives, and robust data sharing.

CPC+ is an advanced primary care medical home model that rewards value and quality by offering an innovative payment structure to support delivery of comprehensive primary care. The model will offer two tracks with different care delivery requirements and payment methodologies to meet the diverse needs of primary care practices. The model will contribute to the goals set by the Administration of having 50 percent of all Medicare fee-for-service payments made via alternative payment models by 2018.

CPC+ is a five-year multi-payer model that will begin in January 2017. CMS will first solicit payer proposals beginning in April 2016 in order to select regions with high payer interest. Once CPC+ regions are selected, eligible practices may apply beginning in July 2016.

**General Model Overview**  
*Innovation Center*  
CPC+ was developed by the Center for Medicare and Medicaid Innovation (Innovation Center), which was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center to test innovative payment and service delivery models – including primary care payment and care delivery reform – to reduce CMS program expenditures and improve quality for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries.

*CPC+ Builds on the Foundation of CPC*  
Since the launch of the CPC initiative in 2012, CMS has collaborated with 38 commercial and state health insurance plans across seven U.S. regions to support 500 primary care practices in testing aligned payment for the delivery of a single model of comprehensive primary care. In addition to regular fee-for-service payments, Medicare and other CPC payers provide a non-visit-based care management fee paid per member per month and an opportunity to share in savings generated in each of the CPC regions. This care management fee has provided CPC practices with the necessary financial resources to create new workflows, hire care management staff, and develop new relationships necessary to coordinate care.

CPC+ builds on CPC with advances in payment to support primary care practices to provide more comprehensive care that meets the needs of all their patients, particularly those with complex needs.

*Model Design*  
CPC+ is a regionally-based, multi-payer care delivery and payment model that includes two separate tracks. The program requirements ensure that practices in each track will be able to build capabilities and care processes to deliver better care, which will result in a healthier patient population. Payment redesign will offer the ability for greater cash flow and flexibility for primary care practices to deliver high quality, whole-person, patient-centered care and lower the use of unnecessary services that drive total costs of care. CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data, to guide their decision making.

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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** |

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

*Performance-Based Incentive Payment*  
CPC+ will reward practices based on their performance on patient experience, clinical quality, and utilization measures through performance-based incentive payments. The CPC+ incentive payments will be $2.50 PBPM for Track 1 and $4 PBPM for Track 2, based on practice performance on utilization metrics and quality, measured at the practice level. Performance-based incentive payments will be prepaid at the beginning of a performance year, but CMS will recoup all or a portion of payments made to the practices if they do not meet thresholds for quality and utilization performance.

**Partners and Participants**  
*Multi-Payer Partnership*  
CPC+ will bring together Medicare and other payers, including commercial insurance plans and state Medicaid agencies, in up to 20 regions, to provide the necessary financial support for practices to make significant changes in their care delivery. CMS will enter into a Memorandum of Understanding (MOU) with selected payer partners to document a shared commitment to align on payment, data sharing, and quality metrics throughout the five-year initiative.

*Primary Care Practices*  
Eligible practices in up to 20 regions around the country may apply for participation in one of two tracks. CPC+ will accommodate up to 2,500 practices in each track for a total of 5,000 practices across all regions and encompass approximately 20,000 clinicians and 25 million patients.

CPC+ targets primary care practices with varying capabilities to deliver comprehensive primary care. In order to participate, all CPC+ practices must demonstrate multi-payer support, use Certified EHR Technology (CEHRT), and demonstrate other capabilities. Track 1 practices will work for five years to develop more fully the capabilities necessary to deliver comprehensive primary care. Track 2 practices must demonstrate Track 1 clinical capabilities and commitment to enhanced health IT when they apply, and commit to increasing the depth, breadth, and scope of care offered, with particular focus on patients with complex needs.

*Health Information Technology (Health IT) Vendors*  
Comprehensive primary care requires efficient, advanced health IT to support its population-health focus and team-based structure. Practices in both tracks will be required to use CEHRT , and will be expected to report electronic clinical quality measures at the practice-level. We also expect Track 2 practices to work with vendors to develop and optimize a set of health IT functions that work for their practices. Health IT vendors will memorialize their commitment to support Track 2 practices in a Memorandum of Understanding (MOU) with CMS.

**Payer and Practice Solicitation Process**  
CMS will stagger the payer solicitation and practice application. First, CMS will solicit payer proposals to partner in CPC+ (April 15-June 1, 2016). The choice of up to 20 CPC+ regions will be informed by the geographic reach of eligible payers. Next, CMS will publicize the CPC+ regions, and solicit applications from practices within these regions (July 15-September 1, 2016). Practices may apply directly to the track for which they believe they are ready; however, CMS may ask a practice that applied to Track 2 to participate in Track 1 instead if CMS believes that the practice does not meet the eligibility requirements for Track 2 but does meet the requirements for Track 1. Practices applying to Track 2 will ask their health IT vendors to write a letter of support that outlines their commitment to supporting the practice(s) required health IT capabilities.

**Further Information**  
For questions about the model or the application process, visit [http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus or email CPCplus@cms.hhs.gov](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus%20or%20email%20CPCplus@cms.hhs.gov).

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