Comparison of CPC+ and Medicare ACOs

According to information from the Centers for Medicare & Medicaid Services (CMS), Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. The CPC+ program offers two tracks with different payment structures and requirements.

CMS initially precluded ACO practices from participating in CPC+. However, in response to strong objections from NAACOS, the agency reversed this decision in May 2016 and updated its FAQs indicating that ACO primary care practices could participate simultaneously in CPC+ and the Medicare Shared Savings Program (MSSP). Specifically, MSSP ACO primary care practices in CPC+ regions are eligible to apply and participate in CPC+. Practices participating in the ACO Investment Model (AIM) and Next Generation model are not eligible to participate in CPC+.

CPC+ Round 1 Regions

- Arkansas: Statewide
- Colorado: Statewide
- Hawaii: Statewide
- Kansas and Missouri: Greater Kansas City Region
- Michigan: Statewide
- Montana: Statewide
- New Jersey: Statewide
- New York: North Hudson-Capital Region
- Ohio: Statewide and Northern Kentucky: Ohio and Northern Kentucky Region
- Oklahoma: Statewide
- Oregon: Statewide
- Pennsylvania: Greater Philadelphia Region
- Rhode Island: Statewide
- Tennessee: Statewide

Learn more about the Round 1 regions and payers here.

CPC+ Round 2 Regions

- Louisiana: Statewide
- Nebraska: Statewide
- North Dakota: Statewide
- New York: Greater Buffalo Region (Erie and Niagara Counties)

CPC+ Application Details

CPC+ is a five-year program that began in January 2017. CMS began with Round 1 by soliciting payers and identifying specific CPC+ regions, then the agency selected practices in those regions for

participation starting in 2017. For Round 2, CMS is accepting applications from primary care practices in the Round 2 regions through July 13, 2017 for a 2018 participation start date.

CPC+ Payments

Program participants receive risk-adjusted, prospective monthly care management fees (CMF) for their attributed Medicare fee-for-service (FFS) beneficiaries. CMS has estimated it will pay CPC+ Track 1 practices an average of $15 per beneficiary per month (PBPM) while Track 2 practices will receive an estimated average $28 PBPM with additional funds for highest risk tier patients to support enhanced services for beneficiaries with complex needs. CMS requires Track 2 practices to engage more directly with health IT vendors on model goals. Therefore, Track 2 vendors sign a memorandum of understanding with CMS to outline vendors' commitment to partnering with primary care practices participating in CPC+. Track 2 practices must also submit letters of support from their health IT vendors.

Track 1 practices continue to receive regular Medicare FFS payments for covered services. However, Track 2 practices receive a percentage of their expected Medicare evaluation and management (E&M) payments upfront in the form of a Comprehensive Primary Care Payment (CPCP) and a reduced FFS payment for face-to face E&M claims. See the CMS FAQs on "payment design" for further details. CMS also pays prospective performance-based incentive payments, but practices are required to pay back funds if they are not able to meet annual performance thresholds. While CPC+ payments are slightly modified for ACO practices participating in CPC+, which is outlined later in this document, there are three major payment elements in CPC+:

- **Care Management Fee (CMF):** Both tracks have a risk-adjusted PBPM CMF paid, and the CMF for Track 1 is approximately $15 and $28 for Track 2, although for Track 2 the payment could go up to $100 PBPM for the sickest patients.
- **Performance-based Incentive Payment:** CMS pays a prospective and retrospectively reconciled performance-based incentive based on certain patient experience, clinical quality and utilization measures. The payment for Track 1 is $2.50 PBPM and $4.00 PBPM for Track 2.
- **Medicare Physician Fee Schedule Payments:** Track 1 practices continue to bill and receive payment from Medicare FFS. Track 2 practices continue to bill Medicare FFS, however FFS payments are reduced to account for CPCPs. CPCPs are paid as lump-sum quarterly payments, and amounts are larger than FFS amounts they are intended to replace.

CPC+ Program Eligibility

CPC+ practices must have multi-payer support, use EHR technology, and meet infrastructure capabilities for the applicable CPC+ Track. Specifically, to be eligible, a practice must meet the following criteria.

CPC+ Track 1 participation

- Provide practice structure and ownership information
- Use Certified Electronic Health Record Technology (CEHRT)
- Have sufficient payer interest and coverage
- Have existing care delivery activities including assigning patients to provider panel providing 24/7 access and supporting quality improvement activities

CPC+ Track 2 participation (in addition to the above criteria)

- Develop and record care plans, follow up with patients after emergency department or hospital discharge, and implement processes to link patients to community-based resources
- Provide a letter of support from the health IT vendor that outlines the vendor's commitment to support the practice in optimizing health IT

Please reference the CMS Practice Care Delivery Requirements document for a complete list of practice requirements. Note that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are not eligible for participation at this time.

Practice Size Considerations

For 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 are 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 are counted as separate practices for the purposes of CPC+.

Payment for ACO Practices in CPC+

- **Care Management Fee (CMF):** Primary care practices within ACOs receive the same CMFs as all other CPC+ practices. These payments are made directly to practices to invest in care delivery at the participating CPC+ practice site. Like larger group practices or health systems, any CPC+ practices within an ACO are required to provide a signed letter by ACO leadership that commits to segregate funds paid as a result of participation in CPC+. The CMF is included in the ACO's total expenditures for shared savings and shared loss calculations.
- **Performance-based Incentive Payment:** Primary care practices within ACOs must forego the CPC+ prospectively paid, retrospectively reconciled performance-based incentive payment, and instead participate in the ACO's shared savings and shared loss arrangement.
- **Payment under the Medicare Physician Fee Schedule**: Practices in Track 2 of CPC+ must shift a portion of Medicare FFS payments for E&M services into CPCPs and have a commensurate reduction in payment for E&M services. The CPCP and reduced FFS payments together are calculated based on an amount 10 percent larger than historical billings to support increased comprehensiveness of care. The CPCP, including the 10 percent increase, is included in the ACO's total expenditures for shared savings and shared loss calculations.

There are no changes to the ACO financial benchmark calculations, and CPC+ payments (CMF and CPCP) for ACO-aligned beneficiaries are included in the ACO's expenditures.

Comparison of Key CPC+ and MSSP ACO Criteria

Issue	CPC+	MSSP ACO
MACRA Advanced APM Status (eligible to earn 5% bonus 2019 – 2024)	The CPC+ model is included on the Advanced APM list and CPC+ practices are thus eligible for Advanced APM bonuses, should they meet other criteria (i.e., the Qualifying APM Professional thresholds)	MSSP Track 1 is not included on CMS's Advanced APM list. Practices that participate in both CPC+ and Track 1 are not eligible for Advanced APM bonuses. Track 2 and 3 ACOs are on the Advanced APM list and are eligible for Advanced APM bonuses, should they meet other criteria.
2017 Application Timeframe	July 15 – September 1, 2016	July 1 – July 29, 2016
2018 Application Timeframe	May 18 – July 13, 2017	July 1 – July 31, 2017
Geographic Requirements	Primary care practices must be in the CPC+ geographic regions selected by CMS	No geographic restrictions
Size Requirements	Primary care practices (all National Provider Identifiers billing under a TIN at a "bricks and mortar" practice site address who are included on a participant list) that provide health services to a minimum of 150 attributed Medicare beneficiaries. CMS considers practice size as part of the CPC+ evaluation criteria, and the program is designed for relatively smaller practices. CMS finalized that for MACRA Advanced APMs qualifying under the Medical Home Model standard, which includes CPC+, participating practices can only have 50 or fewer eligible clinicians in their parent organization beginning in 2018. Barring changes from CMS, CPC+ practices above the 50 clinician threshold will no longer be eligible for the Advanced APM bonus in 2018 based on CPC+ participation.	No specific size requirements related to the number of practitioners, but ACOs must provide health services to at least 5,000 attributed Medicare beneficiaries. ACO primary care practices in CPC+ would be evaluated based on the "bricks and mortar" physical location of the practice, not on the ACO as a whole.

Payment Structure	CPC+ practices receive monthly Care Management Fees which vary based on track and patient health status. They are eligible for performance-based incentives and still receive FFS payments. Track 2 CPC+ practices have FFS payments reduced to account for lump sum, quarterly payments called CPCPs, which are intended to replace foregone FFS payments.	No up-front payments for MSSP ACOs (aside from those participating in the ACO Investment Model). ACOs that meet quality thresholds and earn savings beyond their minimum savings rate can qualify to share savings with Medicare. The shared savings rates vary based on track, from 50 to 75%. ACOs continue to receive FFS reimbursement.
Agreement Periods	Five years	Three years
Quality Requirements	Annually report electronic clinical quality measures (eCQMs) and patient experience of care measures through the Consumer Assessment of Healthcare Providers and Systems (CAHPS). eCQMs must be reported at the practice-site level and include all practice population patients, regardless of payer or insurance status. In future years, Track 2 practices may also use a patient-reported outcome measure survey.	Annually report, and for ACOs in their second or subsequent participation years, meet performance standards for quality measures. Measures are reported through the CMS Web Interface as well as evaluated from claims data. CMS also evaluates ACOs on CAHPS. Most ACO measures only consider traditional Medicare beneficiaries, not those in Medicare Advantage or covered by payers outside Medicare. ACOs primary care practices that participate in CPC+ must meet quality requirements for both MSSP and CPC+.
EHR Requirements	At a minimum, CPC+ practices must adopt CEHRT editions specified by CMS. Track 2 practices must submit letter(s) of support from health IT vendor(s) along with their applications, which outline their vendor's commitment to support the practice in optimizing health IT.	ACOs must use CEHRT editions specified by CMS. Beginning in 2017, MSSP Quality Measure 11 requires that ACO participants must report data on Advancing Care Information on behalf of all eligible clinicians billing through the TIN of the ACO participant.
Risk Adjustment	CMFs are risk adjusted using the CMS-Hierarchical Condition Category (HCC) model. CMS-HCC risk scores are generated annually, but the update does not align with the beginning of the CPC+ performance years. For example, assuming a beneficiary stays attributed to the same CPC+ practice every quarter, the CMF payment for that beneficiary would only change after the risk score update mid-year.	Historical benchmark expenditures adjusted based on CMS HCC model. Newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone during an agreement period unless CMS-HCC risk scores result in a lower risk score.

Patient Attribution	Beneficiaries are aligned with the practice that either billed for the plurality of their primary care allowed charges or billed the most recent Chronic Care Management (CCM) 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 is aligned to the practice with the most recent visit. Attribution is run quarterly, so beneficiaries are attributed to a practice for the next prospective quarter.	Track 1 and 2: Preliminary prospective assignment with retrospective reconciliation. Two-step process: First, assign a beneficiary if the beneficiary receives the plurality of their primary care services from a primary care provider or ACO professional providing services at a FQHC/RHC. Second, (only if beneficiaries did not receive any primary care services from a PCP inside or outside of the ACO), these beneficiaries are assigned to an ACO if they receive the plurality of PC services from ACO professionals in the ACO. Track 3: Similar evaluation of where beneficiaries receive plurality of PCP services, but under Track 3 there is prospective beneficiary assignment for the year.
CCM: non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions	CPC+ practices may not bill CCM for attributed CPC+ patients. They may bill these services for non-attributed CPC+ patients, should they meet other CCM criteria.	ACOs may furnish and bill CCM for any of their Medicare beneficiaries, should they meet other CCM criteria.

Additional Resources

CPC+ Resources:

- CMS CPC+ webpage
- CMS CPC+ FAQs
- CMS CPC+ Request for Applications

MSSP Resources:

- CMS MSSP webpage
- CMS MSSP FAQs
- NAACOS ACO Comparison Chart
- NAACOS resource: The ACO Guide to MACRA

Should you have feedback on this resource or further questions, please contact us at advocacy@naacos.com.