

# Montana CPC+ FAQ for Practices

## Recommended Resources:

<b>CMS Practice FAQ</b>	<a href="https://innovation.cms.gov/Files/x/cpcplus-faqs.pdf">https://innovation.cms.gov/Files/x/cpcplus-faqs.pdf</a>
<b>CPC+ Fact Sheet</b>	<a href="https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-11.html">https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-11.html</a>
<b>CPC+ Website</b>	<a href="https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus">https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus</a>
<b>Practice information session call calendar</b>	<a href="https://innovation.cms.gov/Files/x/cpcplus-practiceeventscalendar.pdf">https://innovation.cms.gov/Files/x/cpcplus-practiceeventscalendar.pdf</a>
<b>Overview flyers for management, stakeholders</b>	<a href="https://innovation.cms.gov/Files/x/cpcplus-brief.pdf">https://innovation.cms.gov/Files/x/cpcplus-brief.pdf</a> <a href="https://innovation.cms.gov/Files/x/cpcplus-caredeliverybrief.pdf">https://innovation.cms.gov/Files/x/cpcplus-caredeliverybrief.pdf</a>
<b>CPC+ Application Help</b>	Email <a href="mailto:CPCplus@cms.hhs.gov">CPCplus@cms.hhs.gov</a> or call the CPC+ Help Desk from 8:30a.m. – 7:30p.m. EDT at 1-844-442-2672
<b>Application</b>	<a href="https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf">https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf</a>

## Comprehensive Primary Care Plus (CPC+)

Strengthening primary care is critical to promoting health and reducing overall health care costs. CPC+, the largest-ever initiative of its kind, is a five-year, multi-payer initiative to improve primary care in America.

There is abundant evidence that improved care and improved patient experience can be delivered by modest investments in primary care. CPC+ strategically invests in the kind of primary care most likely to have a favorable impact on total cost of care and aligning payment incentives to reward value rather than volume.

Through CPC+, Medicaid, PacificSource Health Plans, and BCBS of Montana will partner with Medicare in strengthening primary care to achieve the aim of better care, smarter spending, and healthier people.

Montana was chosen after Medicaid and commercial payers worked together to highlight the public-private partnerships Montana has built to advance health care reforms in Montana, such as Montana’s patient-centered medical home model and the Governor’s Council on Health Care Innovation. Montana is one of only 14 locations across the U.S. to join the initiative. Practices now have the opportunity to apply to participate in CPC+. The option offers increased flexibility and decreased regulations for doctors while incentivizing quality of care over volume.

### Why should my practice apply?

Practices should apply if they:

- ✓ Want the freedom to care for patients the way they think is best and would like to work on innovations such as ECHO-enhanced collaborative care and Community Resource Teams.
- ✓ Would like resources and flexibility to innovate and deliver high quality patient-centered care that goes beyond the traditional visit-based structure and fee-for-service reimbursements.
- ✓ Would like a greater voice with CMS and CMMI – as a partner in one of CMS’s leading test programs, rather than a provider-at-large.
- Want to receive substantial incentive payments for meeting certain quality milestones.
  - CMS estimates the total Medicare revenue increase alone (not counting Medicaid and commercial insurance) for an average practice site of 700 Medicare FFS beneficiaries will be \$126,000 annually plus up to \$21,000 in bonuses.

There is no downside to applying – your application doesn’t obligate you to participate, is not legally binding, and you can always opt-out later. However, this is the **only** time to apply.

The application is fairly short ([1.5 pages – see lower half of page 52, 53](#)) and doesn’t require special technical expertise or hired assistance.

#### What kinds of practices are eligible?

- Primary care practices that are not FQHCs or RHCs. CMS is interested in supporting practices that are mostly or entirely comprised of primary care providers, as opposed to specialists.
- Practices that have about 150 or more Medicare clients, and about half of 2015 revenue from CPC+ payers (BCBS, Medicaid, Medicare, and PacificSource). The CMS application says 50 percent of revenue, but even practices who are close (e.g., 40 percent) should consider applying.
- Tribal health centers, Urban Indian Clinics, and IHS providers. These practices are eligible unless they use the FQHC payment model.
- Practices of any size are encouraged to apply. If close to half of a practice’s 2015 revenue came from CPC+ payers, and providers have the capabilities and goals above, consider applying.

#### What kinds of practices are NOT eligible?

- FQHCs and RHCs are not eligible because they are paid differently by Medicare (on a cost basis, not the Part B fee schedule), so the CPC+ payment methodology wouldn’t work for them.

#### What capabilities should our practice have?:

- Use Certified Electronic Health Record (EHR) Technology.
- Empanel patients, and work toward 100% empanelment.

- Risk stratify an empaneled population.
- Apply care management to those with increased risk.
- Willing to [work for five years to develop more fully the capabilities necessary](#) to deliver comprehensive primary care (Track 1).
- There is also a “Track 2” for practices who can, must [demonstrate Track 1 clinical capabilities](#) and make a commitment to enhanced health IT at the time they apply, and commit to increasing the depth, breadth, and scope of care offered, with particular focus on patients with complex needs.

CMS lists all the desired [CPC+ clinical capabilities here](#).

The most important component, however, is leadership, vision, and willingness to improve. Providers do not need to have all systems in place and operating by January 1.

[Does participation in CPC+ grant practices any reprieve from MIPS, the new Medicare physician reimbursement and data reporting program set to begin in 2019?](#)

- Both Tracks 1 and 2 of CPC+ count as an Advanced Alternative Payment Model (as a medical home model) under MACRA. This earns providers an exemption from the Merit-based Incentive Payment System (MIPS) reporting requirements through 2024, and qualifies them for a 5% APM incentive payment (5% of payment from Medicare). Note that there are different rules for those planning to apply for dual participation with the Medicare Shared Savings program.
- CPC+ is the only APM designed for primary care. It’s an opportunity and funding for providers to restructure and reorganize care around the patient—the kind of care practices may have wanted to provide but didn’t have the resources to deliver.

[Do practices have to apply now or can they decide later?](#)

Practices must apply now. CPC+ will be a 5-year project, from 2017-2021. CMS expects practices to participate for the full five years of the model and, at this time, does not plan to add new practices after 2017. There is no risk to applying; practices can withdraw from the program if it turns out to not be a good fit.

[What is the timeline?](#)

**Practices must apply by September 15.** CMS will review applications and hopes to make its selection by November. CMS will set up an on-boarding process this fall to help practices prepare.

[What kind of up-front money will practices need?](#)

No up-front spending is required. Practices need the capabilities above, and those that are able to invest up-front will be able to transform their capabilities faster, but it is not required. The program provides some advance quality bonus payments to help provide practices with the resources they need, and practices can also invest their own funds for faster transformation.

### What are the payments and how much will they be?

**Medicare:** CMS provides practices with non-visit based payments as well as an annual bonus payment based on performance on specified measures relative to benchmarks/targets. This will be paid in advance, but must be returned at the end of the year if quality targets aren't met.

[See more information about Medicare's payments here.](#)

**Medicaid:** Montana Medicaid will pay a PMPM care management fee. It will align its payments as possible, with other state payers. Track 1: Four tiers of PMPM payments, depending on patient risk and level of care management required. Track 2: Five tiers of PMPM payments; top tier is for most complex patients, including the top 5% of the CPC+ pool and other members with persistent and severe mental illness and/or dementia. These payments will be increased from the current Passport to Health care management fees because providers are expected to offer increased services and reporting to Medicaid.

**PacificSource:** Payment rates will be negotiated between PacificSource and providers.

**BCBSMT:** CPC+ aligned reimbursement rates are outlined in BCBSMT's value based care program contracts. Please contact Julie Sakaguchi at [Julie\\_Sakaguchi@bcbsmt.com](mailto:Julie_Sakaguchi@bcbsmt.com) or 437-6122 for more information.

### Do payments go to practices or health systems?

This is a question to ask CMS. The CMS FAQ document includes ability to distribute payments to practices as one of the criteria for participation.

### What are the performance-based measures? Will they be the same for all payers?

Payers commit to using CMS' specific measures – and will work to align other measures with other payers to the greatest extent possible. CMS measures include utilization, cost of care, and quality/outcomes measures. Payers may consider whether it makes sense to align any additional measures with the current Montana PCMH reporting measures. Medicaid and the commercial carriers may consider adding some children's health-specific measures. PacificSource plans to use measures similar to the PCMH measures, but will work with other payers to align.

This area is an opportunity for state alignment across payers.

### What if a practice does not meet quality measures?

Practices who do not meet quality measures could have to return the advance (prospective) quality bonus payments to Medicare. Other payers have different requirements.

### Once payments start, can providers drop out later if it turns out it isn't a good fit?

Yes, as long as they give 90 calendar days' notice – and understand that CMS may recoup the up-front quality performance payments made by Medicare.

### How is CPC + different from the original Comprehensive Primary Care Initiative?

- CPC required practices to have certain criteria at the beginning. CPC+ provides a way to move toward these standards over time.
- The new CPC+ also includes more regions, quality bonus payments paid in advance instead of shared savings (if standards aren't met, the quality bonus payments must be paid back), and two tiers or "tracks" of payment. For more information, see the CMS [FAQ](#).

## Questions Specific to MT Payers

### Who should provider practices contact with additional questions?

**Medicaid:** Mary LeMeiux, 406-444-5938, [MLeMieux2@mt.gov](mailto:MLeMieux2@mt.gov) or Kelley Gobbs, 406-444-1292, [kgobbs@mt.gov](mailto:kgobbs@mt.gov)

**BCBS:** Julie Sakaguchi, 406-437-6122, [Julie\\_Sakaguchi@bcbsmt.com](mailto:Julie_Sakaguchi@bcbsmt.com)

**PacificSource:** Justin Murgel, 406-441-2142, [Justin.Murgel@pacificsource.com](mailto:Justin.Murgel@pacificsource.com)

### Does every Montana payer offer track 1 and track 2?

Yes. Participating providers are required, by CMS, to support both Tracks 1 and 2.

### What will the data sharing mechanisms be?

Payers are working to determine this. CPC+ is a great start for payers and practices throughout the state to work towards a common data sharing mechanism.

BCBSMT will utilize existing flat file exchange mechanisms and emerging health information exchange capabilities for CPC+ aligned value based care program reporting requirements. PacificSource plans to enhance current data sharing arrangements for practices participating in CPC+ to achieve greater information exchange.

### What's the population each payer is including?

Medicaid: Standard Medicaid, HELP, CHIP—approximately 200,000 members, all depending on practice participation and other factors.

PacificSource: Population to be included is still being defined

BCBSMT: CPC+ aligned value based care programs include attributed commercial, Federal Employee Program (FEP), HELP, and Medicare Advantage populations.

### Are payers able to include Medicare Advantage plans?

Yes, commercial payers can include Medicare Advantage members in CPC+. BCBSMT plans to include their Medicare Advantage members.

How are patients attributed?

Payer attribution models vary. Each payer will provide a list of attributed patients at least quarterly.

**Medicare:**

Beneficiaries will be attributed to the practice that either billed for the plurality of their primary care allowed charges, or that billed the most recent claim (if that claim was for Chronic Care Management (CCM) services) during the most recently available 24-month period. If a beneficiary has an equal number of qualifying visits to more than one practice, the beneficiary will be attributed to the practice with the most recent visit. CMS will provide each practice with a list of its prospectively attributed beneficiaries for each quarter. More details of the Medicare attribution methodology are available in Appendix E of the CPC+ Request for Applications. Attributed beneficiaries are free to select the clinicians and services of their choice.

**Medicaid:**

CPC+ attribution process will follow the Passport algorithm – and assign Passport members – Medicaid may decide to change or align this with other payers and the project develops.

CPC+ Auto-assignment Algorithm:

Each family member may select a different provider. If they do not, they are auto-assigned to a provider appropriate to the member’s age, sex, and location based on: Previous provider enrollment; Claims information; Family provider enrollment; or randomly, to a provider in the member’s geographic area who is accepting new members.

Montana Medicaid will provide each participating practice with a quarterly report containing all members attributed to their practice in the designated time frame.

**PacificSource:**

PacificSource plans to use an attribution model similar to what it uses for its PCMH program, copied below, but will work to align its model with other payers as possible. Rosters of attributed patients, sorted by priority based on chronic and other disease categories, will be shared with providers.

*PCMH Attribution Methodology*

- A. PacificSource will regard any member as a Provider Attributed Member for the purposes of this PCMH Agreement if such member is required to select a primary care provider, and has chosen a Provider Clinic.
- B. For PacificSource members who are not required to select a Primary Care Provider, PacificSource will attribute the member to a Provider Clinic Primary Care Provider as follows:

Primary Care providers are imputed for a member by looking back twelve months of claims for specific evaluation and management codes for primary care type providers. The provider with the most visits is attributed unless there is a tie and in that case the provider with the most recent claim is attributed. If there are no claims for the member in the last twelve months, the lookback increases to 24 months based on the same type of logic. Primary care provider types are defined as those providers who print the directory as PCP for managed care line of business as well as providers who have the following specialties: Family Practice, Internal Medicine, Pediatrics, Geriatrics, General Practice and include credentials MD, DO, PA, NP) as well as Rural Health Facilities. Note that these claims with place of service Emergency Department, Urgent Care and Ambulatory Surgery Center are excluded from the logic.

- 1) Identify all providers that are PCPs using the following three methods:
  - Provider type (Primary Care, excluding OB)
  - Provider is setup to be a PCP and listed in the directory as a PCP
  - FQHC's & RHC's providers and/or the Facilities
  
- 2) Review identified CPT Code Services & Calculate Counts for PCPs
  - Only include Providers that are identified as PCP in logic under step 1
  - Find Provider ID by Member; using Service Counts looking back 12 months on claims
    - Eliminate Duplicates by choosing the Member-Provider combo with the most recent Service Date
    - For members not assigned a PCP using the 12 month look back repeat steps but look back 24 months instead of 12 months.

**BCBSMT:**

Attribution will remain the same as is currently outlined in its value based care program base contracts. Please contact Julie Sakaguchi at [Julie\\_Sakaguchi@bcbsmt.com](mailto:Julie_Sakaguchi@bcbsmt.com) for more information.