CPC+ PAYMENT METHODOLOGIES: BENEFICIARY ATTRIBUTION, CARE MANAGEMENT FEE, PERFORMANCE-BASED INCENTIVE PAYMENT, AND PAYMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE

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Acronyms

Acronym	Term
ACO	Accountable Care Organization
APM	Alternative Payment Model
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCM	Complex Care Management
CCN	CMS Certification Number
CCW	Chronic Conditions Warehouse
CF	Conversion Factor
CG	Clinician and Group
CMF	Care Management Fee
CMS	Centers for Medicare & Medicaid Services
CPC	Comprehensive Primary Care
CPC+	Comprehensive Primary Care Plus
CPCP	Comprehensive Primary Care Payment
CPT	Current Procedural Terminology
CY	Calendar Year
DX	Diagnosis
E&M	Evaluation & Management
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
EDU	Emergency Department Utilization
ESRD	End Stage Renal Disease
FFS	Fee For Service
GPCI	Geographic Price Cost Index
HCC	Hierarchical Condition Categories
HEDIS	Healthcare Effectiveness and Information Data Set
ICD	International Classification of Diseases
IHU	Inpatient Hospital Utilization
MDS	Minimum Data Set
NCQA	National Committee For Quality Assurance
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NQF	National Quality Forum
PBIP	Performance Based Incentive Payment
PBPM	Per Beneficiary Per Month
PFS	Physician Fee Schedule
PQRS	Physician Quality Reporting System
Q1	Quarter 1

Acronym	Term
Q2	Quarter 2
Q3	Quarter 3
Q4	Quarter 4
RVU	Relative Value Unit
TIN	Tax Identification Number
VBPM	Value Based Payment Modifier

Executive Summary

This Executive Summary provides an overview of the methodologies that the Centers for Medicare & Medicaid Services (CMS) will use for the Comprehensive Primary Care Plus (CPC+) payment model being tested in Medicare fee-for-service (FFS). The Executive Summary and the detailed technical specifications for each of the methodologies are organized as follows:

- Chapter 1 introduces the CPC+ attribution and payment elements;
- Chapter 2 describes the Beneficiary Attribution;
- Chapter 3 describes the Care Management Fee;
- Chapter 4 describes the Performance-Based Incentive Payment;
- Chapter 5 describes the Payment under the Medicare Physician Fee Schedule; and
- Chapter 6 provides conclusions.

CPC+ payer partners will offer their own aligned arrangements to CPC+ practices.

ES.1 Introduction

CPC+ is a national advanced primary care medical home model, tested under the authority of the Center for Medicare & Medicaid Innovation (Innovation Center), that aims to strengthen primary care through multipayer payment reform and care delivery transformation. CPC+ is a five-year model that includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. CPC+ aims to improve patients' health and quality of care and decrease total cost of care. To this end, CPC+ offers three payment elements to support and incentivize practices to better manage patients' health and to provide higher quality of care. The payment designs vary slightly for Track 1 and Track 2 CPC+ practices.

In addition to the attribution methodology, which describes the technical specifications used to identify the Medicare FFS beneficiaries for whom participating primary care practices are responsible, this methodology paper will provide detailed specifications for the following three elements of CPC+ payments:

1. **Care management fee (CMF):** CMF is a non-visit-based fee that will be paid to practices in both tracks quarterly. The amount of CMF is determined by (1) the number of beneficiaries attributed to a given practice per month, (2) the case mix of the attributed beneficiary population, and (3) the CPC+ track to which the practice belongs. Practices who serve more high-risk beneficiaries are expected to provide more intensive care management and practice support. Thus, the CMF amount is risk-adjusted to reflect the attributed population's risk level. Track 2 practices will receive a higher CMF for patients with complex needs.
2. **Performance-based incentive payment (PBIP):** CPC+ will prospectively pay the full amount of PBIP at the beginning of each program year. After each program year ends, CPC+ will retrospectively reconcile the amount of PBIP that a practice earned based on

how well the practice performed on patient experience of care measures, clinical quality measures, and utilization measures that drive total cost of care. Practices will either keep their entire PBIP, repay a portion, or repay all of it. The amount of PBIP earned is determined by (1) the number of beneficiaries attributed to a given practice per month, (2) the CPC+ track to which the practice belongs, and (3) the practice's performance on the measures listed above. PBIP is calculated separately for each of the quality, patient experience of care, and utilization measures.

3. **Payment under the Medicare Physician Fee Schedule:**
    a. Track 1 practices will continue to bill and receive payment from Medicare FFS as usual.
    b. Track 2 practices will receive a hybrid payment, meaning they will be prospectively paid Comprehensive Primary Care Payments (CPCPs) with reduced FFS payments. CPCP is a lump sum quarterly payment based on historical FFS payment amounts for selected primary care services. Track 2 practices will continue to bill as usual, but the FFS payment amount will be reduced to account for the CPCP. The CPCP amounts will be larger than the historical FFS payment amounts they are intended to replace, as Track 2 practices are expected to increase the breadth and depth of services they offer.

An example of the payment flow for each element is summarized in Table ES-1.

Table ES-1
CPC+ Payment Summary

Track	CMFs	PBIP	Medicare Physician Fee Schedule
1	$15 average per beneficiary per month (PBPM)	$1.25 PBPM on quality/ patient experience of care and $1.25 PBPM on utilization performance	Regular FFS
2	$28 average PBPM, including $100 PBPM to support patients with complex needs	$2 PBPM on quality/patient experience of care and $2 PBPM utilization performance	Hybrid payment: Reduced FFS with a prospective CPCP

ES.2 Chapter 2: Beneficiary Attribution

This chapter describes the methodology for attributing beneficiaries to CPC+ practices. CPC+ uses a prospective attribution methodology to identify the Medicare FFS beneficiaries at CPC+ practices. CMS will provide each practice with a list of prospectively attributed patients within the first month of the payment quarter. Though Medicare beneficiaries will be attributed to a practice, beneficiaries are free to select the providers and services of their choice and continue to be responsible for all applicable beneficiary cost-sharing. Collectively, CPC+ payments from Medicare and commercial payer partners are intended to support practice-wide transformation

for all patients at the practice, regardless of insurance type. As such, CPC+ Medicare attribution is a proxy for the size and acuity of the Medicare FFS population seen by that practice.

Beneficiary attribution will be conducted on a quarterly basis throughout CPC+ and used for each of the three payment elements: CMF, PBIP, and CPCP with FFS reduction (i.e., hybrid payment). The attribution process uses two steps to assign beneficiaries to practices. Using Medicare administrative data, we first identify which CMS beneficiaries are eligible to be included in CPC+. We then examine the most recent 24-month historical (or "look back") period in Medicare claims data to determine which practice to attribute eligible beneficiaries to. Beneficiary attribution to a practice is determined by where the beneficiary received the plurality of eligible primary care visits within the 24-month period.

1. Eligible Beneficiaries—To be eligible for attribution to a CPC+ practice in a given quarter, beneficiaries must meet several criteria three months prior to the start of the quarter.

These criteria include (1) enrolled in Medicare Parts A and B; (2) Medicare as primary payer; (3) not have end stage renal disease (ESRD) and not enrolled in hospice[1]; (4) not covered under a Medicare Advantage or other Medicare health plan; (5) not long-term institutionalized; (6) not incarcerated; and (7) not enrolled in any other program or model that includes a Medicare FFS shared savings opportunity, except for the Medicare Shared Savings Program.

2. Eligible Visits—Once CMS has identified all beneficiaries eligible for attribution in a given quarter, a pool of Medicare claims during a 24-month "look back" period are used to identify eligible primary care visits to use for attribution.

The attribution look back period is the 24-month period ending three months prior to the start of the quarter. For example, CMS will use claims from October 2014–September 2016 to attribute beneficiaries to CPC+ practices for the first quarter of 2017. The look back periods that will be used for the 2017 quarterly CPC+ attributions are listed in Table ES-2.

Table ES-2
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

[1] Note that this criterion only applies to beneficiaries that have not been attributed to the CPC+ practice previously—if the beneficiary has been attributed to the CPC+ practice previously, then developing ESRD or enrolling in hospice does not disqualify a beneficiary from being attributed to the CPC+ practice.

3. Attribution Algorithm—Once CMS has determined all eligible beneficiaries and all eligible primary care visits with CPC+ and non-CPC+ practices, the CPC+ attribution algorithm is applied.

- For eligible beneficiaries with at least one eligible primary care visit in the look back period, beneficiaries are attributed to practices based on the plurality of eligible primary care visits.[2]
- If two or more practices have the same amount of eligible visits during the look back period, then the tie is broken by which practice provided the most recent eligible visit.

ES.3 Chapter 3: CMFs

This chapter describes the CMF, which practices will use to support augmented staffing and training related to non-visit-based and historically non-billable services that align with the CPC+ care delivery transformation aims. These include activities to improve care coordination, implement data-driven quality improvement, and enhance targeted care management for patients identified as high risk.

- **CMS assigns beneficiaries to risk tiers to determine the CMF payment amount.**
  - All Medicare FFS beneficiaries attributed to a CPC+ practice will be assigned to one of four risk tiers for Track 1 or one of five risk tiers for Track 2 for that CPC+ practice's region (shown in Table ES-3).
  - Each risk tier corresponds to a monthly CMF payment. Higher risk tiers are associated with higher beneficiary risk, as determined by the CMS Hierarchical Condition Categories (CMS-HCC) risk score, and higher CMFs.

Table ES-3
Risk Tier Criteria and CMF Payments (per Beneficiary per Month)

Risk tier	Risk score criteria	Track 1	Track 2
Tier 1	Risk score < 25th percentile	$6	$9
Tier 2	25th percentile ≤ risk score < 50th percentile	$8	$11
Tier 3	50th percentile ≤ risk score < 75th percentile	$16	$19
Tier 4	Track 1: Risk score ≥ 75th percentile Track 2: 75th percentile ≤ risk score < 90th percentile	$30	$33
Tier 5 (Track 2 only)	Risk score ≥ 90th percentile *or* Dementia diagnosis	N/A	$100

[2] Note, however, that if the most-recent eligible visit in the look back period was for a Chronic Care Management (CCM)-related service (CPT codes 99487, 99489, 99490, G0506, and G0507), then the beneficiary is aligned to the practice that provided that CCM-related service, regardless of which practice had the plurality of the beneficiary's eligible visits during the look back period.

- **Beneficiary risk score is based on the CMS-HCC risk adjustment model.**
    - The CMS-HCC model is a prospective risk adjustment model that predicts medical expenditures based on demographics and diagnoses, where medical expenditures in a given year are predicted using diagnoses from the prior year.[3]
    - For each quarter, the risk tier criteria for each region will be based on the most recent risk scores available. Risk scores will be collected for all beneficiaries who are attributed to a participating CPC+ practice each quarter, and risk tier assignment will also be based on the most recent risk scores available.
- **Risk tier assignment will be based on a regional reference population.**
    - Risk scores for attributed CPC+ beneficiaries will be compared to the risk scores for all Medicare FFS beneficiaries in the same region who meet CPC+ eligibility requirements.
    - A beneficiary is assigned to a risk tier based on where their risk score falls within the regional distribution, as shown in Table ES-3.
- **Practices in Track 2 will receive a higher CMF for beneficiaries assigned to an additional complex risk tier.**
    - For Track 2 practices, CMS will pay a $100 per-beneficiary-per-month (PBPM) CMF to support the enhanced services that beneficiaries with complex needs require.
    - Complex beneficiaries who fall within the top 10% of the risk score pool and those who, based on Medicare claims, have a diagnosis of dementia will be assigned to the highest risk tier.
    - We include beneficiaries with dementia to account for the omission of dementia diagnoses in the CMS-HCC algorithm and to account for the higher level of care coordination these patients require.
- **Quarterly, CMS will need to debit the CMF paid to correct for overpayments or duplicate payments.**
    - The first type of retrospective debit is to account for prior CMF overpayments.
        - In each quarterly payment cycle (beginning with the second quarter of the model), CMS will determine whether a beneficiary lost eligibility during any prior quarters, and will compute a deduction from the upcoming quarter's payment to reflect previous overpayments.
    - The second type of debit is due to duplication of services covered by CPC+ CMFs and the Medicare Chronic Care Management (CCM)-related services.[4]
        - Per the CPC+ Participation Agreement, for attributed beneficiaries for a given quarter, CPC+ practices may not bill for Chronic Care Management (CCM)-related services furnished in that quarter to any attributed CPC+ beneficiary.

[3] For more information about the risk adjustment model, see https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/evaluation_risk_adj_model_2011.pdf.

[4] During any given quarter of a program year, CPC+ practices may not bill the following CCM-related services for their attributed beneficiaries during that quarter: CPT codes 99487, 99489, 99490, G0506, and G0507. CPC+ practices may bill these services for beneficiaries not attributed to them.

- If a CPC+ practitioner bills a CCM-related service for a beneficiary attributed to his or her CPC+ practice in the same month, CMS will recoup the Medicare payment for the CCM-related service.
- If a practitioner *not at the beneficiary's attributed CPC+ practice* bills a CCM-related service for a beneficiary attributed to a CPC+ practice in the same month, CMS will recoup the CMF paid for that month from the CPC+ practice's future CMF payment.

ES.4 Chapter 4: PBIP

This chapter describes the CMS approach and technical methodology for the PBIP in CPC+. To encourage and reward accountability for clinical quality, patient experience of care, and utilization measures that impact total cost of care, practices will receive an incentive payment annually, but will only be allowed to keep all or a portion of these funds if they meet annual performance targets. Practices will thus be "at risk" for the amounts prepaid, and CMS will recoup unearned payments. Practices participating in both CPC+ and in a Medicare Shared Savings Program Accountable Care Organization (ACO) will not receive a PBIP. Instead, they will be eligible to earn shared savings under the ACO's arrangement with the Shared Savings Program.

The PBIP has four key principles:

- **CMS prospectively pays practices incentives for quality and utilization.**
  - There are two components of performance: quality (including patient experience of care) and utilization.
  - The entirety of both components will be paid at the beginning of the program year and reconciled retrospectively based on practice performance.
- **CMS measures quality via patient experience of care surveys and electronic clinical quality measures (eCQMs).**
  - CMS will use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Patient-Centered Medical Home Survey to measure patient experience of care. CMS will survey a representative population of each practice's patients, including non-Medicare FFS patients.
  - eCQMs are assessed in accordance with measure specifications, and include non-Medicare FFS patients at the practice.
  - All practices (including those in a Shared Savings Program ACO) must report at least nine of the 14 CPC+ eCQMs.
  - In future years of CPC+, CMS may add a patient-reported outcome measure for practices participating in Track 2 only and will communicate this addition prior to the beginning of the applicable program year.
- **CMS measures utilization via inpatient admissions and emergency department visits.**
  - Inpatient admissions and emergency department visits are significant drivers of total cost of care. Therefore, CMS will measure risk-adjusted inpatient admissions

and emergency department visits for attributed Medicare FFS beneficiaries in the CPC+ practice.
    - Practices do not have to calculate or report these measures. CMS will use claims to calculate these measures at the CPC+ practice level.
    - Additional utilization measures may be added in later years if they are validated for adoption. Any changes will be communicated prior to the beginning of the applicable program year.
- **To keep the incentive payments, practices must meet performance thresholds.**
    - Following the program year, CMS will assess practices' performance. Requirements are the same for both Track 1 and Track 2.
    - Quality and utilization will be scored and financially reconciled separately.
    - Practices will be compared to performance thresholds derived from external data.
    - The incentive payments will be calculated using a continuous approach with a minimum and a maximum score. Practices who score under the minimum earn none of the incentive, while practices who score above the maximum earn the entire incentive.
    - Practices will keep all, some portion, or none of the incentive payment depending on their performance, and CMS will recoup the remaining amount.

ES.5 Chapter 5: Payment under the Medicare Physician Fee Schedule

This chapter describes the upfront CPCPs and corresponding FFS claims reduction, together termed the "hybrid payment," for practices participating in Track 2 of CPC+ for the 2017 program year. Practices participating in Track 1 will continue to bill and receive payment from Medicare FFS as usual. The hybrid payment has five key principles:

- **The hybrid payment is designed to promote flexibility in support of comprehensive care.**
    - The CPCP compensates practitioners for clinical services that have been traditionally billable but offers flexibility for these services to be delivered inside or outside of an office visit. CMS' goal is to achieve incentive neutrality, making a practice agnostic as to whether they deliver a service in person or via another modality so the care can be delivered according to patient preferences.
    - The flexibility is intended to allow more time to be devoted to increasing the breadth and depth of services provided at the practice site and for population health improvement.
    - The CPCP is an upfront payment for a percentage of expected Medicare payments for evaluation and management (E&M) services provided through the Medicare Physician Fee Schedule (PFS) to attributed beneficiaries. E&M visits billed during the program year will be correspondingly decreased. All other services will be paid according to the Medicare PFS and are not included in the CPCP.

- **Practices choose their hybrid payment ratio.**
    - Practices will select a hybrid payment option each year, and can increase their CPCP ratio at their own pace. Practices must reach either 40% CPCP/60% FFS or 65% CPCP/35% FFS by 2019, as illustrated in Table ES-4.

Table ES-4
Track 2 Possible Payment Choices by Year

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

    - Practices will select the percentage they wish to receive up front in their CPCPs prior to the beginning of each program year and cannot change their selection midyear.
    - Practices at the 40% CPCP/60% FFS or 65% CPCP/35% FFS amounts may switch between these options in any year, but once at the 40%/60% ratio, they cannot switch to a lower percentage upfront.
    - CMS will implement the CPCP and corresponding FFS reductions (described below) simultaneously, beginning April 2017. Practices will receive their CPCP quarterly.
- **CMS uses claims history to determine the expected payment for E&M services.** CMS uses claims for two years for beneficiaries attributed to the CPC+ practice to calculate historic PBPM revenue. For example, for the 2017 program year, claims from mid-2014 through mid-2016 will be used. CMS uses claims for E&M office visits for both new and established patients using the following current procedural terminology (CPT) codes (Table ES-5):

Table ES-5
Office Visit E&M CPT Codes and Descriptions

CPT code	Description
99201–99205	Office or other outpatient visit for new patient
99211–99215	Office or other outpatient visit for established patient
99354–99355	Prolonged care for outpatient visit

    - To account for the increased depth and breadth of primary care required of Track 2 practices, CMS inflates each practice's historical annual PBPM by 10% before determining the CPCP payment amounts. CMS also adjusts the inflated calculation year PBPM to reflect 2017 Medicare prices.

    - CMS will pay the CPCP each quarter according to the following calculation: CPCP each quarter = PBPM in 2017 prices * CPCP% Option * Number of Attributed Beneficiaries for the Quarter * 3 months.
- **Practices bill office visit E&Ms as normal and are paid at a reduced rate.**
    - Office visit E&Ms require the submission of a claim and beneficiary cost sharing.
    - When a claim is submitted for an office visit E&M, CMS will pay CPC+ practices at a reduced rate, commensurate with their previously selected upfront CPCP.
    - For office visit E&Ms, typical cost sharing requirements for beneficiaries will still be in place. The model exempts beneficiaries from being responsible for coinsurance for non-office-visit care funded through the CPCP.
    - CMS will reduce the claim only when there is an office visit E&M service by a CPC+ practitioner for an attributed beneficiary.
- **CMS will conduct an outside-of-practice partial reconciliation on the CPCP beginning in 2018.**
    - Beginning in 2018, CMS will perform an annual outside-of-practice partial reconciliation of the CPCPs disbursed in 2017. Practices will be credited or debited through subsequent quarterly CPCP payments.
    - CMS is performing the partial reconciliation to (1) protect CMS against paying more than expected amounts for office visit E&M services for CPC-attributed beneficiaries, (2) protect practices in specifically defined situations from financial risk from the hybrid payment compared with pure FFS, and (3) maintain incentive neutrality for practices. We expect a small minority of CPC+ practices to be subject to partial reconciliation. If more than a small minority require reconciliation, we may adjust this methodology to protect against undue burden on practices.
    - Outside-of-practice partial reconciliation is to account for the difference between (1) historical year PBPM revenue and (2) 2017 PBPM revenue for office visit E&M services for attributed beneficiaries from primary care practitioners delivered outside the CPC+ practice.

ES.6 Conclusions

CPC+ payment system redesign aims to ensure that practices have the infrastructure to deliver better care, smarter spending, and healthier people. With the combination of CMF, PBIP, and Medicare FFS payment (regular FFS for Track 1 or hybrid payment for Track 2), CMS provides strong financial support to practices to expand the breadth and depth of the services they provide to better meet the needs of their patient population.

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Chapter 1: Introduction

This document describes the Centers for Medicare & Medicaid Services (CMS) approach and technical methodology for payment design in the **Comprehensive Primary Care Plus (CPC+)**. CPC+ payment design aims to ensure that practices have the infrastructure to deliver better care, smarter spending, and healthier people. This chapter provides an overview for elements of CPC+ payment design. Chapter 2 describes the technical methodology used to determine **attribution** for Medicare **fee-for-service (FFS)** beneficiaries at CPC+ practices. Chapter 3 describes the technical methodology on **care management fees (CMFs)**, which supports CPC+ practices to provide "wrap-around" primary care services. Chapter 4 describes the technical methodology of the **performance-based incentive payment (PBIP)**, which rewards CPC+ practices for high quality of care, patient experience of care, and reduction in unnecessary utilization. Chapter 5 describes the technical methodology of **hybrid payment**, which is offered to Track 2 practices to promote the flexibility in support of comprehensive care. Note that terms are introduced and defined throughout the document; for easy reference, these terms are included in a glossary in Appendix A.

1.1 CPC+ Payment Design Overview

CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through multipayer payment reform and care delivery transformation. CPC+ is a five-year model that will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. CPC+ aims to improve patients' health and quality of care and decrease total cost of care. To this end, CPC+ offers three payment elements to support and incentivize practices to better manage patients' health and to provide higher quality of care. The three payment elements are available to CPC+ practices in both tracks, but payment designs vary slightly for **Track 1** and **Track 2** CPC+ practices.

CMS uses a prospective attribution methodology to identify the population of Medicare FFS beneficiaries at CPC+ practices. The Medicare beneficiary attribution is the basis for the three elements of payment designs. CMS uses attribution to estimate the amount of care management fees (CMFs), PBIPs, and, for Track 2 practices, the hybrid payment. CMS uses Medicare claims to conduct beneficiary attribution. Detailed specifications for the attribution methodology are in Chapter 2.

1.2 CPC+ Payment Elements

The three payment elements CPC+ offers to support and incentivize practices to better manage patients' health and to provide higher quality of care include the following:

CMF: CMS is providing the CMF to CPC+ practices to support them in the expectation that CPC+ practices provide "wrap-around" primary care services. CMF is a non-visit-based fee that will be paid to practices in both tracks quarterly. The amount of the CMF is determined by (1) the number of beneficiaries attributed to a given practice per month, (2) the case mix of the attributed beneficiary population, and (3) the CPC+ track to which the practice belongs.

Practices who serve more high-risk beneficiaries are expected to provide more intensive care management and practice support; thus, the CMF amount is risk-adjusted to reflect the practice's attributed beneficiary population case mix. Track 2 practices will receive a higher CMF for patients with complex needs. Detailed specifications for CMF methodology and calculation are in Chapter 3.

PBIP: CMS offers a PBIP to CPC+ practices to encourage and reward accountability for patient experience of care, clinical quality, and utilization measures that drive total cost of care. CMS prospectively pays the full amount of PBIP at the beginning of each program year. After each program year ends, CMS retrospectively reconciles the amount of PBIP that a practice earned based on how well the practice performed on patient experience of care measures, clinical quality measures, and utilization measures that drive total cost of care. The amount of PBIP earned is determined by (1) the number of beneficiaries attributed to a given practice per month, (2) the CPC+ track the practice belongs to, and (3) the practice's performance on the measures listed above. PBIP is paid separately for quality and patient experience of care measures and for utilization measures. Detailed specifications for PBIP methodology and calculation are in Chapter 4.

Payment under the Medicare Physician Fee Schedule (PFS): CMS pays Track 1 practices under regular **Medicare Physician Fee Schedule**, and CMS pays Track 2 practices under hybrid payment to promote flexibility in support of comprehensive care.

- Track 1 practices continue to bill and receive payment from Medicare FFS as usual.
- Track 2 practices are prospectively paid **Comprehensive Primary Care Payments (CPCPs)** with a reduced FFS payment. CPCP is a lump sum quarterly payment based on historical FFS payment amounts. Track 2 practices continue to bill as usual, but the FFS payment amount is reduced to account for the CPCP. The CPCP amounts are expected to be larger than the historical FFS payment amounts they are intended to replace, as Track 2 practices are expected to increasingly provide services that are not billable to Medicare. Detailed specifications for hybrid payment methodology and calculation are in Chapter 5.

Table 1-1 summarizes the payment design of CPC+ for Track 1 and 2 practices.

The CPC+ payment system redesign is aimed to ensure practices have the infrastructure to deliver better care, smarter spending, and healthier people. With the combination of CMF, PBIP, and Medicare FFS payment (regular FFS for Track 1 or hybrid payment for Track 2), CMS provides financial support to practices to expand the breadth and depth of the services they provide to better meet the needs of their patient population.

Table 1-1
CPC+ Payment Summary

Track	CMFs	PBIP	Medicare Physician Fee Schedule
1	$15 average per beneficiary per month (PBPM)	$1.25 PBPM on quality/patient experience of care and $1.25 PBPM on utilization performance	Regular FFS
2	$28 average PBPM, including $100 PBPM to support patients with complex needs	$2 PBPM on quality/patient experience of care and $2 PBPM on utilization performance	Reduced FFS with a prospective CPCP

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Chapter 2: Beneficiary Attribution

This chapter describes the purpose and methodology for beneficiary attribution to CPC+ practices. In CPC+, attribution will be used for the following purposes:

- To calculate quarterly CMF payments,
- To calculate the annual PBIPs, and
- To calculate quarterly CPCPs and perform FFS claims reductions for Track 2 practices.[5]

After an overview of attribution in Section 2.1, Sections 2.2 and 2.3 define eligible beneficiaries and eligible primary care services for beneficiary attribution. Then Section 2.4 describes the beneficiary attribution algorithm. The methodologies for calculating the quarterly CMF payments, the annual PBIP payments, and (for Track 2 practices) the quarterly CPCPs are located in Chapters 3, 4, and 5, respectively.

2.1 Attribution

Attribution is a tool used to assign beneficiaries to primary care practices. We use attribution to estimate the amount of CMFs, PBIPs, and, for Track 2 practices, the hybrid payment. In Medicare FFS **alternative payment models (APMs)** such as CPC+ and **Accountable Care Organizations (ACOs)**, CMS uses Medicare claims to conduct beneficiary attribution.

Attribution methodologies commonly consider (1) what unit (e.g., practice, practitioner) a patient is assigned to, (2) how the patient is assigned, (3) the period of the assignment, and (4) how often the assignment is made.

- **Unit of assignment:** Since CPC+ is a test of practice-level transformation and payment, CMS attributes beneficiaries to the CPC+ Practice Site, rather than individual practitioners. A practice site is composed of a unique grouping of practitioners and billing numbers (described in more detail below).
- **How the beneficiary is assigned:** CMS uses Medicare claims to attribute beneficiaries to the practice by recency of Chronic Care Management (CCM) services or plurality of eligible primary care visits for that beneficiary.
- **Period of assignment:** Because CMS pays practices to support the CPC+ care delivery model, practices are paid prospectively (i.e., in advance) so that they may make investments consistent with the aims of CPC+. To pay practices prospectively, CMS uses historical data (patient visits to primary care practices obtained through claims during a "look back" time period) to make attributions prior to the start of each payment quarter (Figure 2-1).
- **How often the assignment is made:** Because the intent is to estimate accurately the number of beneficiaries in a CPC+ practice for purposes of calculating payments, CMS attributes beneficiaries to practices every quarter.

[5] Beneficiary attribution is also used to calculate historical evaluation and management (E&M) payments which the CPCP calculation is based. See Chapter 5 for details.

In the future, CMS plans to implement **Voluntary Alignment**, a method by which beneficiaries confirm their primary care practitioner, in the attribution methodology. Voluntary Alignment is currently being tested in ACO models, and could be used to augment the claims-based CPC+ attribution methodology in order to strengthen a beneficiary's relationship with their primary care practice, and to increase their likelihood of receiving the enhanced care the practice will provide as a participant in this model.

2.2 Eligible Beneficiaries

To be eligible for attribution to a CPC+ practice in a given quarter, beneficiaries must meet the following criteria three months prior to the start of the quarter:

- Be enrolled in both Medicare Parts A and B;
- Have Medicare as their primary payer;
- Not have end stage renal disease (ESRD) and not be enrolled in hospice;[6]
- Not be covered under a Medicare Advantage or other Medicare health plan;
- Not be long-term institutionalized;
- Not be incarcerated; and
- Not be enrolled in any other program or model that includes a Medicare FFS shared savings opportunity, except for the **Medicare Shared Savings Program**.[7]

Most of these criteria are verified using the Medicare Enrollment Database. Institutional status is verified using Medicare Skilled Nursing Facility Assessment data, known as the Minimum Data Set (MDS). Using the MDS data, CMS identifies a beneficiary as institutionalized if they have had a quarterly or annual assessment in the previous year. Enrollment in other Medicare FFS shared savings models is determined using Medicare's Master Data Management system.

CMS analyzes eligibility three months prior to the beginning of a quarter. Beneficiaries are determined to be eligible as of the first day of that month. For example, beneficiaries must meet all eligibility criteria on October 1, 2016, to be eligible for attribution in the first quarter of 2017 (January 1, 2017–March 30, 2017).

Beneficiaries who lose eligibility before the quarter begins are later accounted for in payment reconciliations for the CMF and CPCP.

2.3 Eligible Visits

Once all beneficiaries eligible for attribution in a given quarter have been identified, CMS uses the pool of Medicare claims during the 24-month **"look back" period** to identify eligible primary care visits to use for attribution. The look back period is the 24-month period ending three

[6] Note that this criterion only applies to beneficiaries that have not been attributed to the CPC+ practice previously—if the beneficiary has been attributed to the CPC+ practice previously, then developing ESRD or enrolling in hospice does not disqualify a beneficiary from being attributed to the CPC+ practice.

[7] Beneficiary overlap with the Medicare Shared Savings Program is only allowed for CPC+ practices that are participating in both CPC+ and the Medicare Shared Savings Program.

months prior to the start of the quarter. For example, CMS uses claims from October 2014–September 2016 to attribute beneficiaries to CPC+ practices for the first quarter of 2017 (see Figure 2-1). The look back periods that will be used for the 2017 quarterly CPC+ attributions are listed in Table 2-1.

Figure 2-1
What Is a Look Back Period?

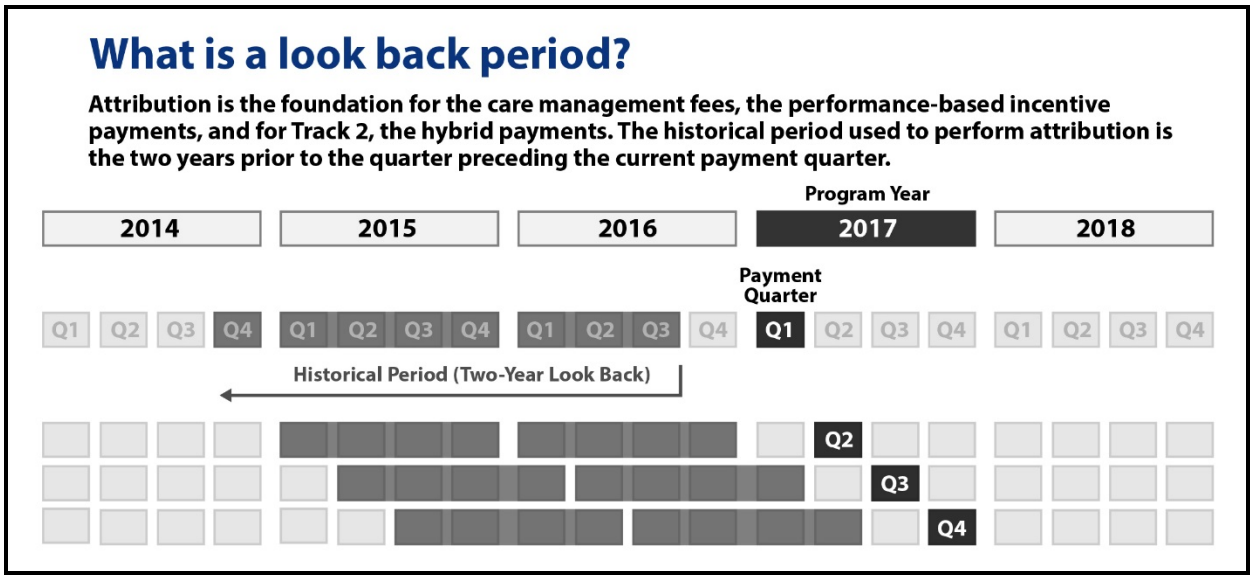


Table 2-1
Look Back Periods for 2017 Quarterly Beneficiary Attribution

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

CMS waits one month after the end of the look back period to collect claims with service dates in the look back period. This allows the overwhelming majority of claims that occurred during the look back period to count toward attribution, even if they were processed and paid in the month after the look back period ended.

CMS uses national Medicare FFS Physician and Outpatient claims with service dates during the look back period. Most visits are in the Physician file, with the exception of claims submitted by Critical Access Hospitals (CAHs), which are found in the Outpatient file. From all Physician and Outpatient claims, CMS identifies those that are primary care visits. Primary care visits are those with any one of the current procedural terminology (CPT) codes in Table 2-2.

Table 2-2
Primary Care Services Eligible for Attribution

Service	CPT codes
Office/outpatient visit evaluation and management (E&M)	99201–99205 99211–99215
Home care	99324-99328 99334–99337 99339–99345 99347–99350
Welcome to Medicare and annual wellness visits	G0402, G0438, G0439
Advance care planning	99497
Collaborative care model	G0502–G0504
Cognition and functional assessment for patient with cognitive impairment	G0505
Outpatient clinic visit for assessment and management (CAHs only)	G0463
Transitional care management services	99495-99496
CCM services	99490
Complex CCM services	99487, 99489
Assessment/care planning for patients requiring CCM services	G0506
Care management services for behavioral health conditions	G0507

For attributed beneficiaries to a CPC+ practice in a given quarter, the CPC+ practice may not bill CPT codes 99487, 99489, 99490, G0506, and G0507 for those attributed beneficiaries in that quarter. However, they are free to bill these codes for non-attributed beneficiaries if all other billing requirements for those codes in the Medicare PFS are met. These services, referred to as "**Chronic Care Management (CCM)-related services**," 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 individual beneficiary in the same month (for details, see Chapter 3).

Only **"eligible" primary care visits** count toward attribution. An eligible primary care visit is a visit where:

1. The CPT code on the claim is among those listed in Table 2-2, and
2. For non-CCM-related services, the service was provided by a practitioner who meets one of the following criteria:[8]
    a. The practitioner was participating in a CPC+ practice at the time the visit occurred; or
    b. The practitioner has one of the primary care specialty codes located in Appendix B.

[8] There is no specialty code restriction on CCM services. Note that only claims with CCM codes on them are eligible for practitioners who do not have one of the primary care specialties listed in Appendix B.

A CPC+ practice is defined by the combinations of **Taxpayer Identification Number (TIN**) or **CMS Certification Number (CCN)** for CAHs, and **National Provider Identifiers (NPIs)** identified for each practitioner participating at a practice site. Each visit in the claims data includes (1) the TIN or CCN and (2) the NPI of the practitioner that rendered the service. To determine whether a practitioner was participating in the CPC+ practice at the time the visit occurred, CMS determines whether the TIN or CCN and the NPI on the claim match a TIN-NPI or CCN-NPI combination in the CPC+ roster that was effective on the claim's service date. If there is a match, the visit is associated with a CPC+ practice. Otherwise, the visit is associated with a non-CPC+ practice.

Non-CPC+ practices are defined as individual practitioners using single TIN-NPI or CCN-NPI combinations (because of lack of information regarding how they are grouped as actual practices), or practice sites who applied for CPC+ but were not selected for CPC+ (for whom we have information on practitioner groupings). Though each practice may have only one TIN or CCN at a given point in time, CMS maintains historical TINs and CCNs to associate claims with practices in the look back period to make accurate attributions. When CPC+ practitioners leave a practice, their NPIs remain on the CPC+ practice roster and are marked with a termination date. In this way, past visits to those practitioners during the look back period continue to be counted toward the practice.

The specialties of participating CPC+ practitioners are verified by CMS and are included in the specialty codes listed in Appendix B. The specialties of new CPC+ practitioners will be verified as they join CPC+ throughout the model. Specialty codes are verified using the practitioners' NPIs and the primary and secondary taxonomy codes in the most current National Plan and Provider Enumeration System (NPPES) file, which CMS updates monthly.

2.4 Attribution Methodology

Once CMS has determined all eligible beneficiaries and all eligible primary care visits with CPC+ (and, as applicable, non-CPC+) practices, the CPC+ attribution algorithm is then applied. There are two major steps in the attribution algorithm:

1. Attribute beneficiaries to practices based on CCM-related billings.
2. Attribute remaining beneficiaries to practices on the basis of the plurality of eligible primary care visits.

2.4.1 Attribution Based on CCM-Related Billings

If the most recent eligible primary care visit in the look back period was for CCM-related services (CPT codes 99487, 99489, 99490, G0506, and G0507), CMS attributes the beneficiary to the CPC+ practice or non-CPC+ practitioner that provided the CCM-related service. Because CMS has determined that the CPC+ CMF and the CCM are duplicative services, it is important to note again that for a CPC+ practice's attributed beneficiaries in a given quarter, CPC+ practices cannot bill for CCM-related services for their CPC+ attributed beneficiaries (again, see Chapter 3 for details). CPC+ practices are free to bill CCM-related services for any non-attributed beneficiary, which may result in future attribution to the CPC+ practice.

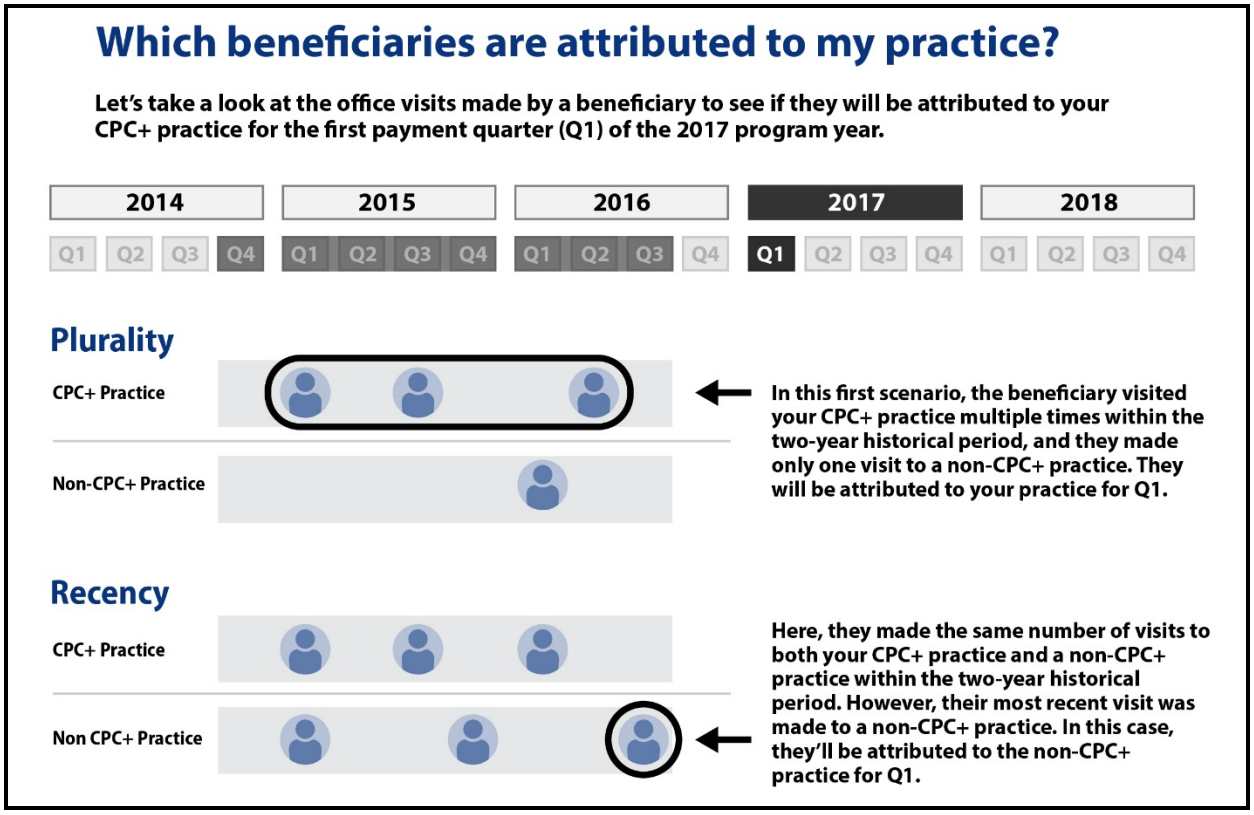
If the most recent eligible primary care visit was not for CCM-related services, CMS proceeds to Step 2 of the attribution.

2.4.2 Attribution Based on Plurality

If a beneficiary is not attributed on the basis of CCM-related billings, CMS first counts the number of eligible primary care visits the beneficiary had to each individual practitioner that provided eligible primary care services to the beneficiary. CMS then combines eligible primary care visits to individual practitioners (i.e., TIN/NPI and CCN/NPI combinations) into CPC+ practices by using the most current CPC+ practitioner roster. For example, two practitioners working in a CPC+ practice will have their eligible primary care visits aggregated for the purposes of attribution. Finally, CMS attributes the beneficiary to the CPC+ practice or non-CPC+ practitioner that provided the plurality of eligible primary care visits during the look back period. If a beneficiary has an equal number of eligible primary care visits to more than one CPC+ practice or non-CPC+ practitioner, the beneficiary will be attributed to the practice with the most recent visit.

Figure 2-2 provides illustrative examples of beneficiary attribution to a CPC+ practice.

Figure 2-2
Which Beneficiaries Are Attributed to My Practice?



Chapter 3: Care Management Fee

Chapter 3 documents the methodology used to calculate the **care management fee (CMF)** under CPC+. The CMF is intended to support augmented staffing and training related to non-visit-based and historically non-billable services that align with the CPC+ care delivery transformation aims. These include activities to improve care coordination, implement data-driven quality improvement, and enhance targeted support to patients identified as high risk. Section 3.1 describes risk scores and risk tiers; Section 3.2, details assigning risk score tiers; Section 3.3, explains retrospective debits; and Section 3.4, addresses risk score growth.

3.1 Risk Scores and Risk Tiers

All Medicare FFS beneficiaries attributed to a CPC+ practice will be assigned to one of four risk tiers for Track 1 or one of five risk tiers for Track 2 for that CPC+ practice's region. Each risk tier corresponds to a specific monthly CMF payment. Higher risk tiers are associated with higher beneficiary risk and higher CMFs. Beneficiary risk will generally be determined by the CMS Hierarchical Condition Categories (HCC) risk adjustment model. For Track 2 beneficiaries, risk tier will also be determined by a diagnosis of dementia, as described in more detail below.

Risk scores for attributed beneficiaries will be compared to the distribution of risk scores for all FFS beneficiaries in the same region who meet CPC+ eligibility requirements and who have had an eligible primary care visit. This group of beneficiaries is called the **CMF reference population**. Beneficiaries will be assigned to risk tiers on the basis of where their risk score falls within the regional distribution, as shown in Table 3-1.

Table 3-1
Risk Tier Criteria and CMF Payments (per Beneficiary per Month)

Risk tier	Risk score criteria	Track 1	Track 2
Tier 1	Risk score < 25th percentile	$6	$9
Tier 2	25th percentile ≤ risk score < 50th percentile	$8	$11
Tier 3	50th percentile ≤ risk score < 75th percentile	$16	$19
Tier 4	Track 1: Risk score ≥ 75th percentile Track 2: 75th percentile ≤ risk score < 90th percentile	$30	$33
Tier 5 (Track 2 only)	Risk score ≥ 90th percentile *or* Dementia diagnosis	N/A	$100

In the sections below, CMS provides detail on the CMS-HCC risk adjustment model, the determination of the region-specific CMF reference population, and the determination of the CMF amounts for each tier within each track. The retrospective reconciliation of the CMFs and the interaction between CMFs and CCM-related billings is also addressed.

3.1.1 CMS-HCC Risk Scores

The CMS-HCC risk adjustment model is a prospective risk adjustment model that predicts medical expenditures using demographics and diagnoses, where medical expenditures in a given year (risk score year) are predicted using diagnoses from the prior year (called the base year). The CMS-HCC model produces a risk score, which measures a person's or a population's health status relative to the average of 1.0, as applied to expected medical expenditures. For example, a population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a population with a risk score of 0.5 is expected to incur medical expenditures half that of the average. More detail on the CMS-HCC model is included in Appendix C.

For each quarter, CMS will use the most recently available risk scores to assign beneficiaries to risk tiers. Because of the amount of time required to ensure that as many diagnoses are captured in the risk score as possible, CMS calculates risk scores for any year at least 12 months after the close of the base year. Final risk scores are generally available 16–18 months after the close of the base year. For example, 2016 risk scores (based on 2015 diagnoses) will be available in the spring of 2017.

Table 3-2 shows the risk score data that will be used for all CPC+ quarters. CMS will implement updated risk score data in the third payment quarter of each year. This schedule is subject to change on the basis of changes in the availability of the data.

Table 3-2
Risk Score Data Used to Determine CMF Payments, by Quarter

Quarters	Months	Risk score year
2017 Q1–2017 Q2	January 2017–June 2017	CY 2015
2017 Q3–2018 Q2	July 2017–June 2018	CY 2016
2018 Q3–2019 Q2	July 2018–June 2019	CY 2017
2019 Q3–2020 Q2	July 2019–June 2020	CY 2018
2020 Q3–2021 Q2	July 2020–June 2021	CY 2019
2021 Q3–2021 Q4	July 2021–December 2021	CY 2020

Note: CY = calendar year.

3.1.2 Setting the Risk Tier Thresholds

Risk tiers will be determined for each region using the distribution of risk scores in the reference population for that region. The reference population will include all beneficiaries residing in each region who meet the eligibility criteria for attribution (see Chapter 2 for details). 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, in order to approximate the utilization patterns of CPC+ attributed beneficiaries. The required primary care visit must meet all of the same criteria as eligible primary care visits used for attribution.

The reference population will be defined using parameters for a Q3 (July–September) attribution. For example, beneficiaries included in the reference population used for 2017 Q3 through 2018 Q2 must meet eligibility criteria on April 1, 2017, and also must have had an eligible primary care visit in the look back period used for 2017 Q3 attribution, April 2015–March 2017. We use Q3 because it is a mid-year capture of the "average" population, as risk scores tend to decrease over the calendar year, and risk scores are typically released around this time.

Once CMS has determined the reference population for each region, their risk scores will be used to determine the risk tier thresholds. CMS will use risk scores based on the CMS-HCC community risk adjustment model, as opposed to the CMS-HCC long-term institutional model, on the premise that CPC+ eligibility criteria for attribution exclude beneficiaries who are long-term institutionalized (e.g., long-term residing in a nursing home). For community-residing beneficiaries new to Medicare during the base year, CMS will use the new enrollee risk adjustment model, which is a demographic-only risk adjustment model. Because beneficiaries new to Medicare during the risk score year will not have had a complete diagnostic profile in the base year, the diagnosis-based CMS-HCC risk adjustment model cannot be used for these beneficiaries.

CMS will sort the risk scores and identify the 25th, 50th, 75th, and 90th percentiles in each region. These values are the thresholds that will be used until the next risk score update, and we will release them to practices annually.

3.2 Assigning Risk Tiers

Most beneficiaries will be assigned to a risk tier on the basis of their risk score. Beneficiaries attributed to practices in Track 2 who are determined to have a diagnosis of dementia will be assigned to Tier 5 regardless of their risk score, as described below.

3.2.1 Assigning Risk Tiers 1–5 Based on Risk Score

Each quarter, CMS will use risk scores for all beneficiaries attributed to a CPC+ practice to assign beneficiaries to risk tiers. Beneficiaries, including those who are eligible for both Medicare and Medicaid (i.e., dual eligible), will be assigned to a risk tier based on the thresholds that apply for that quarter and the criteria shown in Table 3-1. There are two exceptions to this process, as described below.

First, because of the inherent lag in the calculation and availability of risk score data, beneficiaries who have newly joined Medicare after the risk score year will not have a risk score in the most recent risk score file. Such beneficiaries will be placed into Tier 1.

Second, beneficiaries who have developed ESRD since their initial attribution to CPC+ will be placed into Tier 4 for the attributed practice's track. This is to account for the higher level of support and coordination ESRD patients require. Beneficiaries with an ESRD diagnosis prior to attribution to CPC+ are ineligible for attribution.

3.2.2 Assigning Risk Tier 5 Based on Dementia Diagnosis (Track 2 Only)

The criteria for Risk Tier 5 (Track 2 only) include having a risk score at or above the 90th percentile of risk scores in the CMF reference population *or* having a diagnosis of dementia or related disorder. Dementia diagnoses will be determined using information from CMS's Chronic Condition Warehouse (CCW).[9]

CMS will assign beneficiaries to Tier 5 if the most recent information from the CCW reflects a dementia flag. The CCW updates chronic condition information annually and generates flags representing presence of certain chronic conditions as of December 31 of each year. The CCW uses a three-year historical period to determine the presence of dementia. For example, to determine the 2016 dementia flag, claims during the three-year period (January 2014–December 2016) will be used. The criterion for dementia is the presence of any International Classification of Diseases (ICD)-9 diagnosis code (prior to October 1, 2015) or ICD-10 diagnosis code (on or after October 1, 2015) in the list below on at least one inpatient, skilled nursing facility, outpatient, home health, or carrier claim in the three-year period.

- **ICD-9 diagnoses indicating the presence of Alzheimer's disease and related disorders or senile dementia:** 331.0, 331.11, 331.19, 331.2, 331.7, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 294.0, 294.10, 294.11, 294.20, 294.21, 294.8, 797
- **ICD-10 diagnoses indicating the presence of Alzheimer's disease and related disorders or senile dementia:** DX F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, G13.2, G13.8, F05, F06.1, F06.8, G30.0, G30.1, G30.8, G30.9, G31.1, G31.2, G31.01, G31.09, G91.4, G94, R41.81, R54

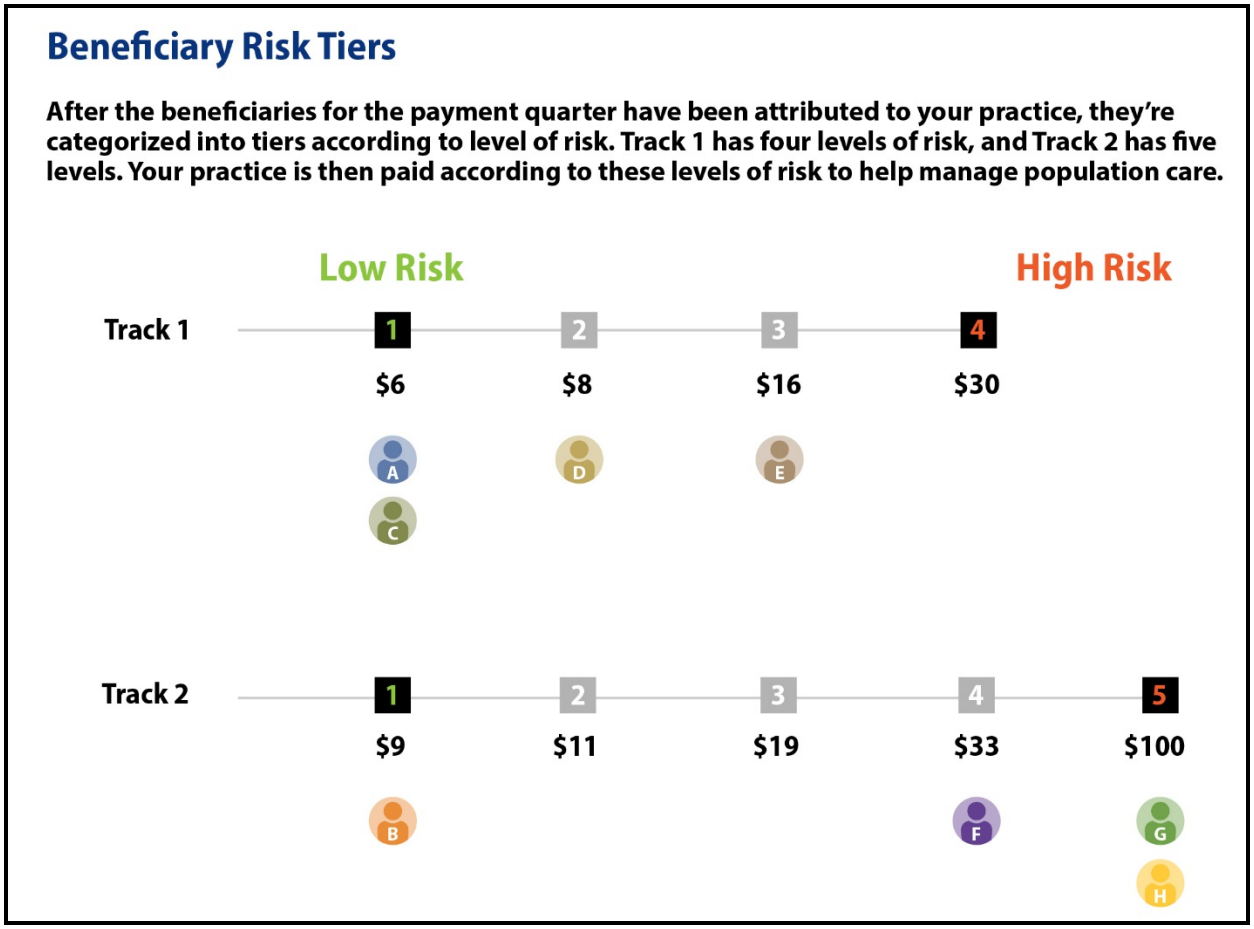
CMS will use the most recent CCW information available each quarter to determine whether beneficiaries attributed to a Track 2 practice have a diagnosis of dementia. For the first quarter of CPC+, the most recently available CCW data is as of December 31, 2015. Assignments to Tier 5 on the basis of dementia diagnosis will be based on claims data from January 2013–December 2015. CMS will update the 2016 CCW data as soon as it becomes available.

Track 2 beneficiaries with ESRD who also have a dementia diagnosis will be placed into Tier 5 rather than Tier 4. For beneficiaries who are in Track 2, the dementia diagnosis supersedes the ESRD diagnosis.

Figure 3-1 provides an illustrative example of beneficiary risk tiers for the CMF.

[9] https://www.ccwdata.org/cs/groups/public/documents/document/mbsf_datadictionary_cc.xls

Figure 3-1
Beneficiary Risk Tiers



3.3 Retrospective Debits

There are two types of debits that CMS will apply to the CMFs paid each quarter. The first is a debit to account for prior CMF overpayments, and the second is a debit due to duplication of services covered by CPC+ CMFs and the Medicare CCM-related services.

3.3.1 Debits for Beneficiary Ineligibility

CMS determines attribution and calculates quarterly CMFs in advance of each quarter. The prospective quarterly payment assumes that all beneficiaries attributed for the quarter will continue to be eligible for the entire three months of the quarter. However, some beneficiaries will become ineligible before or during the quarter. This happens if the beneficiary loses Part A or Part B coverage, joins a Medicare Advantage plan, loses Medicare as the primary payer, becomes incarcerated, or dies before or during the payment quarter. Beneficiaries meeting any of these criteria on the first day of a month are not eligible for CMF payment in that month. To account for this, in each quarterly payment cycle (beginning with the second quarter of the model), CMS will determine whether a beneficiary lost eligibility during any prior quarters, and

will compute a deduction from the upcoming quarter's payment to reflect previous overpayments.

3.3.2 Debits for Duplication of Services

Per the CPC+ Participation Agreement, for attributed beneficiaries for a given quarter, CPC+ practices may not bill for CCM-related services for any attributed CPC+ beneficiary. Each quarter, CMS will review claims data from prior quarters to determine whether any CPC+ or non-CPC+ practice billed CCM-related services for any beneficiary attributed to a CPC+ practice in the same month. If duplication is detected, we will deduct the duplicative services as follows:

- If a CPC+ practitioner bills a CCM-related service for a beneficiary attributed to his or her CPC+ practice in the same month, CMS will recoup the Medicare claim on which the CCM-related service was billed.
- If any practitioner bills a CCM-related service for a beneficiary attributed to a CPC+ practice in the same month, *and it is not a practitioner at the beneficiary's attributed CPC+ practice,* CMS will deduct the CMF paid for that month from the CPC+ practice's future CMF payment. The practitioner who billed the CCM-related service will retain the Medicare payment for the service.[10]

Table 3-3 lists the services and associated codes that are considered duplicative of the services covered by the CPC+ CMF.

Table 3-3
CCM-Related Services Duplicative of CPC+ CMF

Service	CPT codes
CCM services	99490
Complex chronic care coordination services	99487, 99489
Prolonged non-face-to-face evaluation and management (E&M) services	99358, 99359
Assessment/care planning for patients requiring CCM services	G0506
Care management services for behavioral health conditions	G0507

3.4 Risk Score Growth and CMF Cap

CMS will monitor coding and HCC risk score changes closely throughout the program and, if significant, unexpected, or irregular changes in coding are found to occur, will adjust the

[10] Medicare beneficiaries must positively consent to receiving CCM-related services at the time they are received. As a result, the assumption is that the practice providing the CCM-related services is the beneficiary's current primary care practice. Thus, if there are two payments (a CCM claim payment to one practice, and a CPC+ CMF to a CPC+ practice) for the same beneficiary in the same period of time, the CCM claim payment takes precedence and will be paid to that practice. The CMF will be recouped from the CPC+ practice for that time period.

payment methodology. If the rate of change for risk scores is significantly different for CPC+ practices than for the CPC+ reference population, it would potentially skew the CMF payments and decrease the actuarial soundness of CPC+. If CMS decides to make changes, they will be specified prior to the payment quarter in which they are implemented. Examples of how CMS might address high risk score growth, based on experiences in other Medicare programs, include the following:

- Apply a coding pattern adjustment factor to each beneficiary's risk score, as in the Medicare Advantage program.
- Cap the risk score growth rate by which each practice's risk score is allowed to change, as in the Next Generation ACO model.
- Use diagnosis-based risk adjustment for updating newly attributed beneficiaries' risk scores and demographic-based risk adjustment for updating continuously attributed beneficiaries' risk scores, as in the Shared Savings Program.

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Chapter 4: Performance-Based Incentive Payment

This section describes the CMS approach and technical methodology for the **performance-based incentive payment (PBIP)** in CPC+. To encourage and reward accountability for patient experience of care, clinical quality, and utilization measures that drive total cost of care, practices will receive an incentive payment annually, but will only be allowed to retain a portion or all of these funds if they meet annual performance targets. Practices will thus be "at risk" for the amounts prepaid, and CMS will recoup unearned payments. The rest of this chapter provides basic information on the incentive payment. Section 4.1 describes the design principles and general features; Section 4.2 describes the **Quality Component** of the PBIP; Section 4.3 describes the **Utilization Component** of the PBIP; and finally, Section 4.4 describes the performance standards.

4.1 Design Principles and General Features

This section describes the rationale for the PBIP; overarching principles of design; and general criteria for practice performance scoring, which determines the amount of the PBIP that practices are eligible to retain.

4.1.1 Principles of Design

The incentive structure is designed to keep practices motivated and working towards improving quality of care and patient experience of care, and reducing unnecessary beneficiary utilization that drives a higher total cost of care. The design principles underpinning the incentive structure were informed by current behavioral economics theory and existing evidence from PBIP programs (Audit and Zenna, 2015; Khuller et al., 2015). The incentive structure employs the following design principles and general features:

- Timing of incentive payments encourages immediate practice engagement.
- Performance goals are transparent and known to practices early in the performance period.
- Practices are rewarded on a continuous scale and for **absolute performance thresholds.**
- Practices must meet minimum quality thresholds before they are rewarded for reducing utilization.
- Performance goals are closely related to primary care practice and measured at the practice level.

Provisions for Practices in ACOs and the Quality Payment Program—Primary care practices that are also participating in Shared Savings Program ACOs will not receive the PBIP. Instead, these practices will participate in the ACO's shared savings/shared losses arrangement. CPC+ practices that are also in ACOs must report **electronic clinical quality measures (eCQMs)** as part of their participation in CPC+. In addition, CPC+ practice patients

will be sampled to fulfill the patient experience of care Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.[11]

Under the **Quality Payment Program Final Rule**, for a model to be considered an **advanced alternative payment model (APM)**, a certain amount of model revenue must be considered "at risk." The PBIP qualifies CPC+ as an advanced APM. For CPC+ practices also participating in the Shared Savings Program, determinations about the advanced APM incentive will be based on the track of the Shared Savings Program in which they participate.

4.1.2 Prospective Payment

At the beginning of each program year, practices will receive the full amount of incentive payment that they are eligible to earn over the program year. After the close of each program year, the incentive amount earned based on performance will be calculated, and CMS will recoup the unearned portion, if necessary. As a result, practices will know at the beginning of the year the maximum amount they may keep for that program year.

CMS is testing whether prospective incentive payment is an effective way to ensure reward timeliness and fully leverage loss aversion in a manner that engages practices immediately in CPC+ objectives (Audit and Zenna, 2015).

CMS expect that prospective payment will support practice planning and budgeting, especially for small practices. Prospective payment has the added advantage of giving practices enough information early in the program year to help them create an internal bonus structure for delivering incentives to individual clinicians (Chung et al., 2010). Incentives at the individual clinician level are expected to have a significant impact on practice-level performance (Petersen et al., 2013). Internal bonus structures, if set up early, may increase the chances that individual clinicians will engage in behavior changes quickly and improve practices' overall performance.

Incentive Payment Use—The PBIP amount is meant to exceed the cost of implementation of the desired behaviors and should be treated as a bonus to the practice. Unlike the CMF, CMS places no restrictions on the use of the PBIP. Practices may decide, for example, to invest a portion of the PBIP in support of CPC+ program objectives or to implement an internal bonus structure. It is important to note that the practice is contractually "at-risk" for returning up to the full amount, in the event that the practice does not meet the minimum performance goals. In light of the risk they will carry, practices may decide to retain some or all of the PBIP until the payment reconciliation.

4.1.3 Transparency of Performance Goals

The CPC+ incentive structure and payment are intended to support full transparency of performance goals. The objective is to provide enough information early in the program year so that practices understand how their effort will be rewarded and can maximize their chances of retaining the full PBIP.

[11] CMS will work to minimize potential survey burden.

CMS will publish performance thresholds early in each program year. These thresholds will represent the following:

- Minimum thresholds practices must reach to receive any (non-zero) PBIP.
- Maximum thresholds practices must attain to receive 100% of the PBIP.

The objective of transparency affects other design features of the incentive structure. Primarily, performance goals had to be established using data available prior to the start of the program year. This decision placed limits on how program year one CPC+ performance goals were determined. CMS sought to design a scoring methodology for program year one performance that takes these data limitations into account and protects practices from unintended consequences. However, CMS recognizes that some outcomes cannot be managed prospectively. CMS will use the experience of program year one to evaluate the scoring methodology and reserves the right to modify its details, while adhering to the general incentive structure. CMS's objective in future years will be to minimize unintended consequences of performance-based payments and better support improved practice performance.

4.1.4 Incentive Structure

Incentives for practices are designed with three important features. First, all good performers will be rewarded. 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, a practice's own performance relative to this benchmark determines the incentive amount the practice retains. Practices are not scored on a relative-performance basis, nor is the size of the payment each practice retains determined by performance of their peers.

Second, minimum and maximum 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, patient experience of care, and utilization. Practices are not eligible to retain the relevant portion of the PBIP if their 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.

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, practices will retain the full PBIP for the relevant individual measure if they are eligible for the incentive and attain the maximum threshold. Data from the 2015 program year of the **Comprehensive Primary Care (CPC) initiative** suggest that a minimum performance score of 50th percentile and a maximum threshold in the 80th–90th percentile would be both motivational and achievable. The intent of the external benchmarks is to reward practices for reporting challenging measures, even when actual measure performance has opportunity for improvement. Throughout CPC+, CMS will monitor practice performance, and in future program years, CMS may raise these thresholds. CMS will communicate any changes to performance

thresholds to practices in advance of the relevant program year. Practices that perform at high levels will still have an incentive to improve their scores well above the maximum threshold to better position their practice for the following year's performance, in the event that the maximum threshold is raised. CMS also recognizes that certain measures may become "topped out." Therefore, CMS reserves the right to convert to **flat percentages** on an individual measure (i.e., 50%, 80%) for purposes of measure scoring and PBIP calculations when that measure appears "topped out."

Third, practices will be rewarded on a continuous scale when scoring between the 50th and 80th percentile thresholds. In general, practices are eligible to receive a percentage of the PBIP for this range of performance. The amount earned increases as performance approaches the maximum threshold. The methodology to calculate the proportion of PBIP earned for scores between the minimum and maximum threshold is described in more detail in Section 4.4.

4.1.5 Incentive Payment Components

Practices earn the PBIP based on two distinct components of performance: (1) clinical quality and patient experience of care and (2) utilization. These two components contribute equally to the PBIP amount earned. Performance on clinical quality and patient experience of care, however, is prioritized over utilization. Practices that meet all performance goals for utilization must meet the minimum thresholds for quality and patient experience of care to receive any PBIP for the utilization component. Practices that reach the maximum performance goals for clinical quality and patient experience of care are eligible for the full Quality Component of the PBIP, equal to one-half of the total PBIP, whether or not they meet performance goals for the Utilization Component.

4.1.6 Incentive Payment Amounts

The amount of the PBIP is based on the number of beneficiaries attributable to the practice and is calculated as a **per-beneficiary-per-month (PBPM)** amount. Track 1 practices are eligible for a PBIP equal to as much as $2.50 PBPM. Track 2 practices are eligible for as much as $4.00 PBPM, as indicated in Table 4-1.

Table 4-1
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

Conversations with subject matter experts suggest the size of a motivational incentive should be approximately 10% of revenue to provide an adequate incentive to drive desired behaviors, support improvement, and exceed the cost of implementation of the desired behaviors

(Damberg et al., 2008). To determine the PBIP amounts in Table 4-1 above, CMS considered the distribution of all Medicare FFS revenue among practices in the CPC initiative, a model separate from CPC+, in 2013, which averaged $24.57 PBPM (with an interquartile range of $18.45–$28.52 PBPM), 10% of which is approximately $2.46 PBPM, which was rounded to $2.50 for Track 1. CMS raised the incentive amount to $4.00 PBPM for Track 2 based on the rationale that Track 2 practices should receive an added bonus for greater effort of implementation and to keep Track 2 practices focused on outcomes. CMS also recognizes that the revenue history of CPC Classic practices may reflect primary care utilization that is lower than could occur under Track 2 CPC+ performance. Providing the full PBIP to practices in a lump sum at the beginning of each program year helps to maximize the effect of the payment size.

4.2 Quality Component

The Quality Component of the PBIP consists of two segments: Patient Experience of Care, using measures from the **CAHPS Clinician and Group Patient-Centered Medical Home Survey (CG CAHPS)**, and Clinical Quality, using **eCQMs**. The CG CAHPS measures will contribute 25% to the practice's score for the Quality Component, and the eCQM measures will contribute 75%.

Although Clinical Quality is weighted more heavily when determining the amount of PBIP earned from the Quality Component, Patient Experience of Care and Clinical Quality are treated as equally important when determining practice eligibility for the Utilization Component of the PBIP. To be eligible for the Utilization Component of the PBIP, practices must meet the minimum performance required for each segment of the Quality Component, both Patient Experience of Care and Clinical Quality. Details are provided in Section 4.4.

4.2.1 CAHPS Measurement

CMS will use version 3.0 of the **CG CAHPS** to calculate performance scores on patient experience of care. The survey will be fielded by a CMS contractor on a sample of all patients seen at the practice, including commercial, Medicaid, and Medicare patients. The measures are described in Appendix D.

4.2.2 eCQM Measurement

Achieving high performance in clinical quality is a central objective in CPC+. Practices are required to submit a minimum of nine eCQMs out of 14 eCQMs included in the CPC+ measurement set. The nine measures a practice chooses to submit must align with the reporting criteria set forth in Appendix E. These reporting criteria were established to provide practices a view of performance on an ongoing basis at the point of care. The measures target a primary care patient population and, where feasible, are outcome measures rather than process measures. As described in the eCQM reporting requirements,[12] practices are strongly encouraged to report all CPC+ measures in their electronic health record even though they are

[12] CPC+ eCQM reporting requirements: https://innovation.cms.gov/Files/x/cpcplus-qualrptpy2017.pdf.

only required to report nine measures. This will allow practices to continue reporting nine required measures in the event that one or more eCQMs are removed from the CPC+ measure list in the future. Practices that fail to report at least nine eCQMs that meet reporting criteria will not qualify to retain the Quality Component or the Utilization Component of the PBIP.

For the purposes of determining the amount of PBIP earned for the Quality Component, practices will be eligible for payment on each individual eCQM measure, independent of the others. This approach is intended to reward practices for performance demonstrated in clinical quality for each measure, up to the maximum performance threshold of the 80th percentile. For each measure, the percentage earned is based on the amount that the performance exceeds the minimum threshold. The nine eCQM measures together represent 75% of the Quality Component or 37.5% of the full PBIP (0.75 x 0.5 = .375). Each eCQM is weighted equally so that each eCQM represents 8.33% of the PBIP for Quality (0.75/9 = 0.0833) or 4.167% of the full PBIP (0.375/9 = 0.04167).

4.3 Utilization Component

The guiding principle for the selection of utilization measures for CPC+ is a parsimonious list of actionable measures that drive total cost of care. CMS also seeks measures that can be measured at the practice level for a Medicare FFS population and are validated for use. Based on the CPC initiative, CMS expects that a typical CPC+ practice will average four clinicians and 700 beneficiaries. Practices are required to have a minimum of 125 attributed Medicare beneficiaries to be eligible for CPC+. CMS is using two measures that meet these criteria: **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 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 practice. Inpatient hospital services were identified as a major cost driver under the CPC initiative at more than 35% of total cost of care.[13] Emergency department (ED) visits are also a larger driver of total cost of care than other outpatient health care utilization.

Utilization measures require no reporting on the part of practices and will be calculated by CMS and its contractor at the end of each program year. Inpatient utilization is given twice the weight of EDU in the calculation of the performance score because of the disproportionate cost of inpatient stays relative to emergency department outpatient visits. The EDU is limited to outpatient visits that do not result in hospital admission so that emergency department visits resulting in a hospitalization are not counted in both utilization measures. Utilization for each CPC+ practice will be calculated for Medicare beneficiaries, age 65 and above, attributed to the practice. The National Committee for Quality Assurance (NCQA) provided specifications to CMS

[13] For further information, please see the CPC Evaluation Reports at https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/.

to include risk adjustment for age, gender, and presence of co-morbid conditions. The NCQA Technical Specifications for these measures are reproduced in Appendix F.

Should additional utilization measures become available in future years, CMS reserves the right to add or substitute other measures.[14] CMS will notify practices of any changes prior to the start of a program year. At this time, there are few utilization measures that can be measured at the practice site level and are actionable for primary care.

4.4 Calculation of Performance Scores

To support incentive structure transparency, CMS aimed to design a scoring methodology that is uncomplicated and that uses benchmarks known to practices early in the program year. CMS sought to balance simplicity against motivating performance and improvement in the reward structure. To the extent feasible, CMS established uniform standards across all measures using a comparable scoring methodology to make performance objectives transparent at the beginning of practice participation. The methodology for calculating practice performance scores and determining PBIP amount retained is described in detail below.

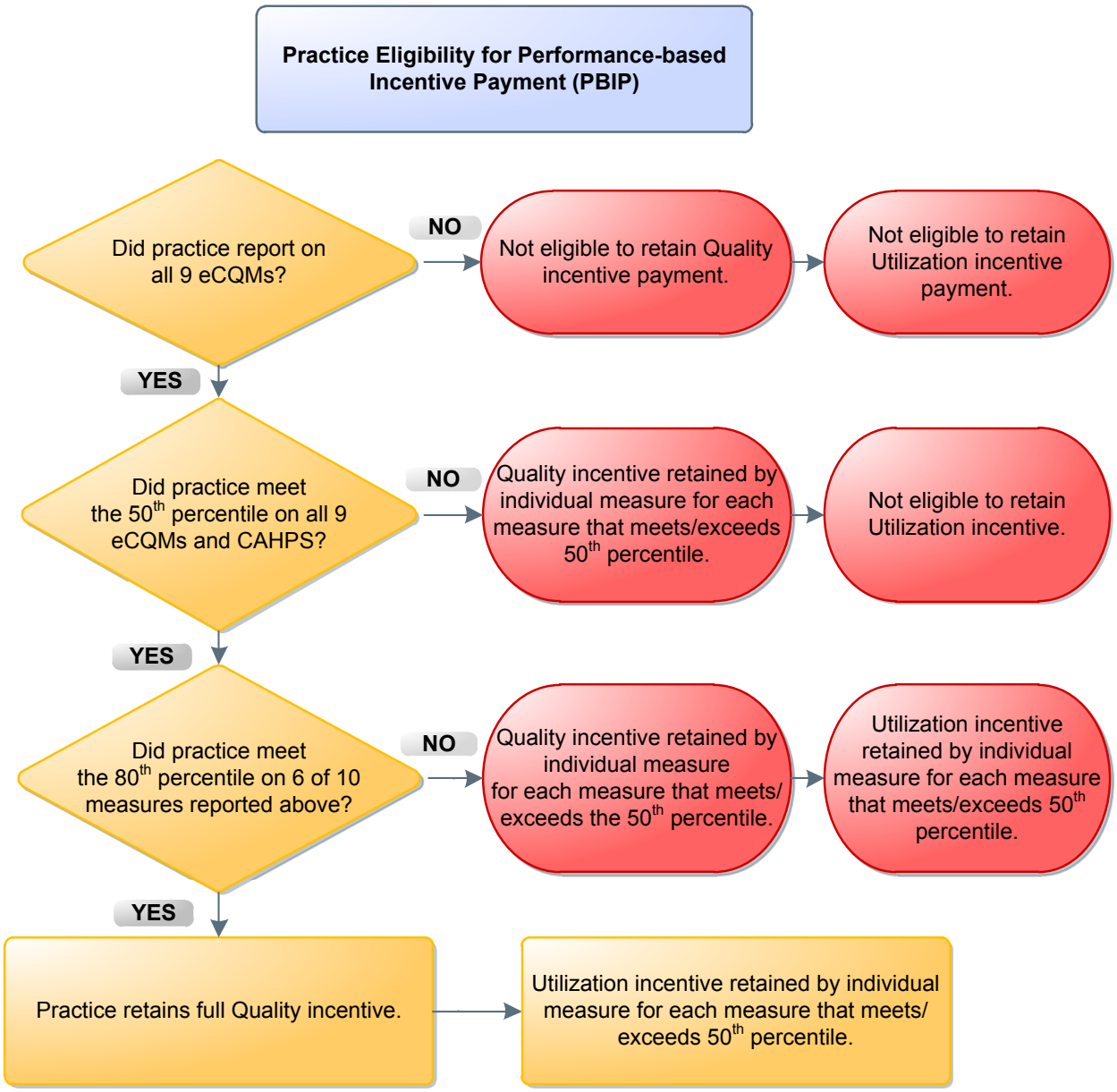
CMS adopted a modified pay for performance on each individual measure approach to earning the PBIP. Under the simple pay per measure approach, each measure is worth a percentage of the PBIP. Therefore, practices would need to attain the 80th percentile on all measures to retain 100% of the Quality Component of the PBIP. To avoid demotivating practices to improve performance on quality, CMS modified the simple pay-by-measure approach with a different set of criteria to retain the full Quality Component of the PBIP. These criteria preserve the intent to reward practices demonstrating significant progress toward program objectives. To retain 100% of the Quality Component of the PBIP, practices must meet the following requirements:

- Successfully report at least nine eCQMs (according to participation agreement).
- Achieve the 50th percentile on nine eCQMs and the CAHPS Summary Score.
- Achieve the 80th percentile (or higher) on six of 10 items (nine eCQMs + CAHPS Summary Score).

These criteria and their relationship to the Utilization Component PBIP are summarized below in Figure 4-1. Practices that are not eligible to retain 100% of the Quality Component of the PBIP remain eligible to retain a percentage of the Quality Component of the PBIP where at least one of the eCQM measures or the CAHPS Summary Score achieves the minimum threshold.

[14] Potential resources for new measures include measures in development for the Quality Payment Program, measures of resource use in post-acute settings in development pursuant to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, and measures suggested by other entities that are considered to be actionable and primary care–focused. For some examples, see Yu, Mehrotra, and Adams (2013).

Figure 4-1
Overview of Practice Eligibility to Retain Quality and Utilization Components of the PBIP



4.4.1 Calculation of Quality Performance Score

Step 1. Calculate CAHPS measure-specific score.

CAHPS is composed of six domains, and each domain contains one or more questions. CAHPS domain-specific scores will generally be calculated using numeric values assigned to responses for a given measure. CMS first assigns a numeric value to each response option in the response scale for each survey question. For example, if there are four response options in a response scale, Never/Sometimes/Usually/Always, numeric values of 1 for “Never,” 2 for

"Sometimes," 3 for "Usually," and 4 for "Always" are assigned. If there are two response options in a scale, Yes/No, a value of 1 for "Yes" and 0 (zero) for "No" is assigned. For CPC+ adopted CAHPS measures, a single response scale applies to all questions for a given measure. Second, CMS adjusts the numeric values for sampling weights, non-response weight, and case-mixed adjustment using the CAHPS consortium instructions. Third, CMS calculates the average among adjusted numeric assigned response options for each measure. Finally, the numeric average is converted to a 0–100 scale, where zero is the lowest performance and 100 is the highest performance. Scores are converted to the 0–100 scale using the following approach:

$$Y = \frac{(X - a)}{(b - a)} * 100$$

"Y" is converted score in the 0–100 score, "X" is a CPC+'s practice CAHPS score on its original numeric scale (i.e., adjusted average numeric points), "a" is the minimum possible score on the original scale, and "b" is the maximum possible score on the original scale, for a given measure.

The Patients' Rating of Provider is a single-question CAHPS measure, meaning that only one question contributes to the overall measure. The original response scale is a numeric scale from 0–10. We convert the original scale to a 0–100 scale using the following formula:

$$Y = \frac{(X-0)}{(10-0)} * 100$$

where "Y" is the 0–100 score and "X" is a CPC+'s practice score on its original numeric scale.

Step 2. Calculate CAHPS Summary Score. The average of the six CAHPS domain-specific scores from Step 1 is the CAHPS Summary Score.

$$CAHPS\ Summary\ Score = \frac{(CAHPS1 + CAHPS2 + CAHPS3 + CAHPS4 + CAHPS5 + CAHPS6)}{6}$$

The CAHPS Summary Score will be compared to the minimum and maximum performance thresholds derived from an external population. The minimum and maximum performance thresholds are the 50th and 80th percentile of the CAHPS Summary Score, respectively. If performance rate for the CAHPS measures appear topped out, CMS may use flat percentages as the minimum and maximum performance thresholds (i.e., 50%, 80%).

Step 3. Calculate eCQM measure-specific scores

$$Performance\ Score = \frac{Numerator}{Denominator - Denominator\ Exclusion - Denominator\ Exception}$$

The Performance Score for each eCQM will be compared to external benchmarks to attain a percentile score.

Step 4. Assess full payment criteria for the Quality Component of the PBIP:

- Successfully report at least nine eCQMs (according to participation agreement).

- Achieve the 50th percentile on nine eCQMs according to reporting requirements and the CAHPS Summary measure.
- Achieve the 80th percentile (or higher) on six of 10 items (nine eCQMs + CAHPS Summary measure).

Step 5. If criteria to retain full Quality Component of the PBIP are not met, retain Quality Component of the PBIP on CAHPS Summary Score and individual eCQM performance.

Practices can retain up to 25% of the Quality Component of the PBIP on the basis of the percentile threshold attained, as described in Table 4-2.

Table 4-2
Practice Performance and Percentage of PBIP for Patient Experience of Care

Performance for patient experience of care (summary CAHPS score)	Percentage of Quality Component of the PBIP retained for patient experience of care
< 50th percentile	0%
50th–79th percentile	12.5–25%
80th percentile and above	25%

Practices performing below the 50th percentile for the CAHPS Summary Score will not retain the portion of the Quality Component of the PBIP for CAHPS. Practices performing between the minimum and maximum performance threshold will receive scores along a continuous distribution normalized to values between 12.5 and 25% using the following formula:

$$CAHPS\ Percent\ Payment = \left[\frac{Measure\ Score - 50th\ percentile}{80th\ percentile - 50th\ percentile} * 50 + 50\right] * 0.25$$

To be consistent with clinical quality measurement, we set the minimum and maximum performance thresholds of 50th and 80th percentile for patient experience of care. This approach serves the goal of simplicity and transparency.

The eCQMs together comprise 75% of the Quality Component of the PBIP. Each of the nine required measures is thus worth 8.33% of the Quality Component of the PBIP. Based on the threshold attained for each eCQM, the practice retains a percentage of the measure's share of the Quality Component PBIP, as shown in Table 4-3. For each measure that falls below the 50th percentile, the amount retained for that measure is $0.

Table 4-3
Practice Performance and Percentage of Quality Component of the PBIP Retained for Individual eCQMs

Performance for clinical quality relative to benchmark	Percentage of Quality Component of the PBIP retained for individual eCQM
< 50th percentile	0%
50th–79th percentile	4–8.33%
80th percentile and above	8.33%

Practices performing below the 50th percentile for an individual eCQM will not retain the portion of the Quality Component of the PBIP for that measure. Practices performing between the 50th and the 79th percentile will receive scores along a continuous distribution normalized to values between 4 and 8.33% according to the following formula:

$$Measure\ Percent\ Payment = \left[\frac{Measure\ Score - 50th\ percentile}{80th\ percentile - 50th\ percentile} * 50 + 50\right] * 0.0833$$

If a measure is reverse scored, where a lower score reflects better performance (e.g., high-risk medications), then the percent payment is normalized using this formula:

$$Reverse\ Scored\ Measure\ Percent\ Payment = \left[\frac{50th\ percentile - \ Measure\ Score}{50th\ percentile - 80th\ percentile} * 50 + 50\right] * 0.0833$$

Illustrative Example—This methodology is illustrated for an example practice, Main Street CPC.

Table 4-4 shows the measures that Main Street CPC reported, the corresponding performance rates, hypothetical 50th and 80th percentiles, and the normalized score for each measure.

Table 4-4
Percent Payment Earned by Measure—Illustrative Example for Main Street CPC

Measure	Performance rate	Example 50th percentile	Example 80th percentile	Meet 50th percentile	Meet 80th percentile	Percent payment earned
CAHPS Summary Score	83%	80%	87%	Yes	No	17.86%
NQF 18, Controlling High Blood Pressure	68%	63%	71%	Yes	No	6.77%
NQF 59, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	91%	29%	98%	Yes	No	7.91%
NQF 0022, Use of High-Risk Medications in the Elderly	S1:12% S2: 8%	S1: 16% S2: 3%	S1:1% S2: < 1%	Yes No	No No	S1: 5.28% S2: 0%
NQF 0101, Falls: Screening for Future Fall Risk	10%	3%	67%	Yes	No	4.62%
NQF 0034, Colorectal Cancer Screening	61%	27%	61%	Yes	Yes	8.33%
NQF 0055, Diabetes: Eye Exam	85%	3%	87%	Yes	No	8.23%
NQF 0028, Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	94%	85%	94%	Yes	Yes	8.33%
NQF 0052, Use of Imaging Studies for Low Back Pain	95%	95%	99%	Yes	No	4.17%
NQF 2372, Breast Cancer Screening	65%	30%	61%	Yes	Yes	8.33%

Note: NQF = National Quality Forum S1=Strata1 S2=Strata2.

In this example, we show NQF 0022 as an example of a measure with multiple performance rates and as an example of measures that are “reverse-scored,” meaning that a lower performance rate corresponds to better performance.

Step 1: Address Multiple Performance Rates

For measures with multiple performance rates, we average the two performance rates and then insert the combined performance rate into the Quality Total % Payment equation. The illustration follows:

$$COMBINED\ RATE = \frac{\text{Score for NQF 0022 Part 1} + \text{Score for NQF 0022 Part 2}}{2}$$

$$= (5.28 + 0)/2$$

$$= 2.64\%$$

Step 2: Calculate the Quality Component of the PBIP retained. The 83% represents the CAHPS Summary Score, and the subsequent nine rates represent the nine reported eCQM performance rates.

Main Street CPC is not eligible to retain the full Quality Component of the PBIP because only 3/10 measures meet 80th percentile. Main Street CPC will retain the Quality Component of the PBIP by individual measure performance because the nine reported eCQM and CAHPS meet the 50th percentile (minimum threshold)

Total Quality Component % = 17.86% + 6.77% + 7.91% + 2.64% + 4.62% + 8.33% + 8.23% + 8.33% + 4.17% + 8.33% = 77.19%

Total % Quality Component of the PBIP Retained = 77.19% * $2.00 = $1.54 PBPM

4.4.2 Calculation of Utilization Performance Score

Controlling for patient risk factors that predict utilization is critical to designing incentive structures that reward practice behavior for patient care decisions rather than natural variation in patient populations. In CPC+, practice performance on utilization will be scored against standard benchmarks common to all practices, as patient experience of care and clinical quality are scored. The utilization experience of patients attributed to the practice will be compared to the utilization experience of patients that meet eligibility requirements for CPC+ assignment but are assigned to non-CPC+ practices (i.e., the benchmark population). The measures are reported as observed-to-expected utilization ratios. For each practice, the observed utilization is compared to the expected utilization, which is adjusted for comorbidities within the practice population. The comparison is expressed as a ratio, dividing the observed utilization by the expected utilization. An observed-to-expected ratio greater than one represents greater-than-expected utilization, and a ratio less than one represents less-than-expected utilization. Therefore, CMS will calculate observed-to-expected ratios for the benchmark population and use the 50th and 80th percentiles as benchmarks for CPC+ practices.

To retain all or a portion of the Utilization Component of the PBIP, practices must completely report quality and meet a minimum threshold for all Clinical Quality measures and the CAHPS Summary Score. Specifically, practices must achieve the 50th percentile of performance on nine of nine required eCQMs and the CAHPS Summary Score to be eligible to retain the Utilization Component PBIP. The hospitalization measure is double weighted and counts for two-thirds of the Utilization Component of the PBIP. The practice is assigned a score equivalent to the percentage of the Utilization Component of the PBIP the practice qualifies to retain, as described in Table 4-5.

Practices performing below the 50th percentile for utilization for an individual measure will not retain the portion of the Utilization Component of the PBIP for that measure. Practices performing between the 50th and the 79th percentile for IHU will receive scores along a continuous distribution normalized to values between 33 and 66% according to the following formula:

$$IHU\ Percent\ Payment = \left[\frac{50th\ percentile - \ Measure\ Score}{50th\ percentile - 80th\ percentile} * 50 + 50\right] * 0.66$$

Table 4-5
Practice Performance and Percentage of PBIP for Utilization

Utilization measure	Practice performance on utilization relative to benchmark	Percentage of PBIP for utilization earned
Inpatient hospital	< 50th percentile	0%
	50th–79th percentile	33–66%
	80th percentile and above	66%
Emergency department	< 50th percentile	0%
	50th–79th percentile	16.5–33%
	80th percentile and above	33%

Practices performing between the 50th and the 79th percentile for EDU will receive scores along a continuous distribution normalized to values between 16.5 and 33% according to the following formula:

$$EDU\ Percent\ Payment = \left[\frac{50th\ percentile - \ Measure\ Score}{50th\ percentile - 80th\ percentile} * 50 + 50\right] * 0.33$$

Illustrative Scenario—

Step 1. Calculate observed to expected ratio (O/E ratio) of hospitalizations per 1,000 beneficiaries.

Main Street CPC has an actual rate of 100 events and an expected rate of 120 events per 1,000 beneficiaries based on risk factors as specified.

$$IHU\ O/E\ Ratio = \frac{100}{120} = 0.83$$

Step 2. Transform observed to expected ratio per 1,000 beneficiaries to a percentile ranking. (Assuming 1.0 = 50th percentile and 0.3 = 80th percentile.)

$$Measure\ Percent\ Payment = \left[\frac{(1.0 - \ 0.83)}{(1.0 - 0.3)} * 50 + 50\right] * 0.66 = 41.01$$

Step 3. Calculate the same for emergency department visits per 1,000 beneficiaries.

$$EDU\ O/E\ Ratio = \frac{200}{415} = 0.48$$

Step 4. Transform the observed to expected ratio per 1,000 beneficiaries to a percentile ranking. (Assuming 1.0 = 50th percentile and 0.4 = 80th percentile.)

$$Measure\ Percent\ Payment = \left[\frac{(1.0 - 0.48)}{(1.0 - 0.4)} * 50 + 50\right] * 0.33 = 30.80$$

Step 5. Combine IHU and EDU scores.

Utilization Total % = 41.01 + 30.80 = 71.81%

Total % Utilization PBIP Retained = 71.81% * $2.00 = $1.44 PBPM

4.4.3 Calculation of Performance Incentive Earned

On the basis of the illustrative example above, Main Street CPC has a Quality Component Score of 77.19% and a Utilization Component Score of 71.81%. Half of the full PBIP is earned on the basis of practice performance on the Quality Component, and half is earned on the basis of practice performance on the Utilization Component.

The PBPM amount earned by Main Street CPC for the Quality Component of the PBIP is equal to

$$PBIP\ earned\ for\ Quality = 77.19\% \times \$2.00 = \$1.54\ PBPM$$

The corresponding annual amount earned is equal to

$$PBIP\ earned\ for\ Quality = \$1.54 * 12\ months * 500\ beneficiaries = \$9{,}240$$

The PBPM amount earned by Main Street CPC for the Utilization Component of the PBIP is equal to

$$PBIP\ earned\ for\ Utilization = 71.81\% \times \$2.00 = \$1.44\ PBPM$$

The corresponding annual amount earned is equal to

$$PBIP\ earned\ for\ Utilization = \$1.44 * 12\ months * 500\ beneficiaries = \$8{,}640$$

The total earned by Main Street CPC B in the first program year is equal to

$$Total\ PBIP\ earned = \$9{,}240 + \$8{,}640 = \$17{,}880$$

Main Street CPC received the full incentive amount for the first program year at the beginning of the year. As a CPC+ Track 2 participating practice, Main Street CPC was prospectively paid a PBIP amount equal to $4.00 per beneficiary per month based on having 500 beneficiaries attributed to their practice in quarter one of the first program year:

$$Prospective\ PBIP\ payment = 500\ beneficiaries \times \$4.00\ PBPM \times 12\ months = \$24{,}000$$

Because Main Street CPC earned $17,880 of the full incentive, CMS will recoup an amount equal to $24,000 − $17,880 = $6,120.

Note: If Main Street CPC had attained a performance score for the CAHPS Summary Score or any eCQM below the 50th percentile, it would not have been eligible to retain any of the Utilization Component of the PBIP. Therefore, it would not have been eligible for the PBIP for Utilization, and would have to pay back to CMS *the full amount: $12,000*.

Chapter 5: Payment under the Medicare Physician Fee Schedule

Chapter 5 describes and explains the **hybrid payment** for CPC+ Track 2 practices. Practices participating in Track 1 will continue to bill and receive payment from Medicare FFS as usual. Section 5.1 explains the purpose and intent of the hybrid payment, differences from other CPC+ payments, and implications for Track 2 CPC+ practices. Sections 5.2 and 5.3 describe the parameters of the **comprehensive primary care payment (CPCP)**—Section 5.2 outlines the approach for determining historical expenditures for the CPCP using a historical calculation year, while Section 5.3 describes the 2017 program year CPCP. Sections 5.4 and 5.5 describe the corresponding claims reduction and the **partial reconciliation**, respectively.

5.1 Purpose and Intent

5.1.1 Purpose and Aims

The goal of the hybrid payment is to support the flexible delivery of comprehensive primary care to promote population health beyond traditional **evaluation and management office visits** (henceforth, office visit E&Ms). Under current exclusive FFS payment methodologies, there is a strong incentive rewarding face-to-face office visit E&Ms for billable revenue generation, even if virtual encounters (e.g., phone calls, electronic communications) would better meet the patient's needs or align 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.

In Track 2 of CPC+, CMS will use a **hybrid payment** that will allow practices the flexibility to deliver care in the most appropriate mechanism that is also in accordance with patient preferences (Davis, Schoenbaum, and Audet, 2005; Vats, Ash, and Ellis, 2013; Goroll et al., 2007). The hybrid payment will include a prospectively paid PBPM payment (paid quarterly) and a corresponding FFS claims reduction on payments for specific claims submitted during the program year. Starting in Quarter 2 (Q2, April 2017), the prospective, upfront payment, or **CPCP**, is paid based on a practice's average PBPM E&M payments during the **historical calculation period**.[15] The **historical PBPM** is trended (for Medicare FFS price inflation/deflation) to reflect the **program year**. FFS payments during the program year are reduced proportionately to match a practice's selected percentage of the historical PBPM payment (i.e., the CPCP). The hybrid payment will be limited to services that are billed using selected office visit E&M codes under the PFS. To protect patient access and incentivize preventive and other services (e.g., influenza vaccination), it is important to retain some full primary care FFS payment.

The hybrid payment changes the payment mechanism, promotes flexibility in how practices deliver care traditionally required to be provided via an office visit E&M, and supports the CPC+

[15] For CPC+ years 2018–2021, the hybrid payment is expected to apply to each quarter of the year (Q1–Q4). However, in CPC+ year 2017, the hybrid payment will only apply to quarters Q2–Q4.

requirement for practices to increase the depth and breadth of primary care they deliver (i.e., **comprehensiveness**). In contrast to the CMF (described in Chapter 3), the upfront CPCP component of the hybrid payment compensates the practitioner for transitioning clinical services that have traditionally been separately billable office visit E&Ms to commonly non-billable care delivery modalities such as telephone calls or secure messaging. The hybrid payment is intended to mitigate the financial incentives for office visit E&M volume by giving these practices the flexibility to deliver care via commonly non-billable modalities in accordance with patient preferences, while encouraging practices to furnish proactive and comprehensive care that traditionally has been limited to an office setting. We anticipate that the hybrid payment will achieve **incentive neutrality**, in which the incentive to bring a patient to the office is balanced with the incentive to provide the needed care outside of an office visit, making a practice agnostic as to whether they deliver a service in person or via another modality.

5.1.2 Payment Choices by Year

Track 2 practices select their **hybrid payment ratio**, which is the annual pace at which they will progress towards one of two hybrid payment options: one option will pay 40% upfront and 60% of the applicable FFS payment, and the other will pay 65% upfront and 35% of the applicable FFS payment. Recognizing the diversity among practices, practices have the option to transition to either upfront CPCP percentage options (40% or 65%) by starting at a smaller CPCP percentage (Table 5-1) in 2016 and 2017. By 2019, all Track 2 practices will be paid under one of the two hybrid payment options. The gradual buildup of the hybrid payment helps some practices get used to this payment mechanism over time, while other practices can choose to immediately begin receiving a higher CPCP.

Table 5-1
Track 2 Payment Choices by Year

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

5.1.3 Implications of CPCP for Practices and Beneficiaries

The hybrid payment is intended to increase beneficiary access, improve efficiency in addressing health issues, improve patient experience, and reduce cost-sharing, as beneficiaries will not have to pay coinsurance for care received outside of an office visit. For regular office visit E&Ms, beneficiaries will be responsible for typical cost-sharing. For the practice, a benefit of the CPCP is a reduction in billing documentation requirements for the care delivered outside of an office visit and support for delivering more comprehensive care. That said, practices will still be required to document their use of funds to achieve the care delivery requirements. Practices will also be required to report their progress on practice transformation regularly through the CPC+

Practice Portal, which will provide both the practices and CMS insight into practice capabilities. Although the practices are expected to experience a reduction in revenue from fewer coinsurance for office visit E&Ms, the hybrid payment is intended to mitigate this loss.

5.2 Historical PBPM

The historical PBPM represents each CPC+ practice's E&M payments received from CMS for a group of beneficiaries in a 24-month period before the start of CPC+. The historical PBPM is used to estimate the amount of primary care represented by these E&M payments that practices will likely deliver during the program year.

There are two major steps in creating the historical PBPM:

1. Define the historical time period, **historical population**, and the conditions under which beneficiaries are eligible.
2. Define the types of payments included among the historical population during the historical time period.

The historical calculation period is a two-year time period defined as the last two quarters of calendar year 2014 through the first two quarters of calendar year 2016.

5.2.1 Historical Population and Eligibility

The historical population includes all beneficiaries attributed to a selected CPC+ practice during the historical calculation period. To determine the historical population, we use historical claims to attribute beneficiaries to practices quarterly during the historical calculation period. To the extent possible, we require attribution for the historical calculation period population to be the same as attribution for the program year population to reduce potential differences between these two groups.

CMS uses the attribution methodology described in Chapter 2, which involves identification of eligible beneficiaries, eligible primary care visits, and then application of the attribution algorithm (see Chapter 2 for details). The Tax Identification Numbers and National Provider Identifiers (TINs/NPIs)[16] for each CPC+ practice will be used in the attribution, including the TINs/NPIs that were active during the historical period. Beneficiaries are included in the historical calculation for only the applicable portion of the year for which they were eligible.[17]

[16] CCNs may also apply for CPC+ practices with CAHs. Throughout this chapter, when the term TIN is used, it can be interpreted to mean TIN or CCN.

[17] Details on the eligibility criteria are provided in Chapter 2.

5.2.2 Historical Payments

CMS will calculate **historical payments** from all applicable Medicare Part B E&M payments made to the CPC+ practice for its historical population during the historical calculation period (July 2014 to June 2016). Claims are eligible if

1. the service date[18] on the claim is during a time period when the beneficiary was eligible,
2. the claim includes an office visit E&M service (Appendix G), and
3. the service is provided by an eligible primary care practitioner (Appendix B).

For each CPC+ practice, CMS sums the Medicare FFS payment amount for eligible office visit E&M claims. The Medicare FFS payment amount is the amount of the claim that was actually paid, reflecting applicable payment adjustments (e.g., adjustments for provider type, geography, and performance in quality programs). Because **sequestration** is already accounted for in historical payments, CMS will not separately account for sequestration in the CPCP program year calculation.

5.2.3 Example Practice Illustration—Main Street CPC

Throughout this chapter, we will illustrate the hybrid payment calculations using a sample practice, which we call Main Street CPC. Please note that these examples should not be interpreted as representing a "typical practice" or an "average impact."

Main Street CPC has 3,600 eligible, attributed beneficiary months over the two-year historical calculation period, and a corresponding $65,455 of E&M claim payments for these beneficiary months over the two-year historical calculation period. Thus, the historical PBPM for Main Street CPC is as follows:

$$Historical\ E\&M\ PBPM = \frac{Total\ E\&M\ claim\ payments}{Number\ of\ attributed\ beneficiary\text{-}months}$$

$$= \$65{,}455 \,/\, 3{,}600 = \$18.18\ PBPM$$

5.3 CPCP Program Year Calculation for 2017

The 2017 CPCP calculation is constructed by adjusting each practice's historical payments and expressing them in 2017 dollars, as detailed in this section. The historical payments are adjusted to account for comprehensiveness (increased by 10%) and PFS updates. The CPCP payment will be calculated annually, and will be paid quarterly on the basis of the number of attributed beneficiaries for that quarter. At the end of Section 5.3, we illustrate our calculations with Main Street CPC, which we introduced in Section 5.2.3.

[18] The service date for most claims is the date the beneficiary received the service (referred to as the "from date" on the claim).

5.3.1 Comprehensiveness Supplement

To account for increased depth and breadth, or comprehensiveness, of primary care expected under Track 2, CMS includes a 10% increase to the historical payment, termed the **comprehensiveness supplement**. The 10% increase was informed by the Affordable Care Act's Incentive Payments for Primary Care Services (Polsky et al., 2015).[19] Therefore, in the calculation of the CPCP for 2017, CMS will multiply the historical PBPM payments from E&M services by 110%.

5.3.2 Physician Fee Schedule (PFS) Updates and Revaluation Changes

Under the PFS, CMS regularly updates the national **conversion factor (CF)** to set payment rates. In addition, CMS regularly updates the **relative value unit (RVU)** for each E&M code and the **geographic cost price index (GPCI)** for each locality.[20] Because the historical calculation period uses 2014, 2015, and 2016 payment rates, CMS adjusts the CPCP calculation using the finalized 2017 payment parameters (CF, RVU, GPCI)[21] to express the **adjusted historical PBPM** in 2017 dollars.

Finally, CMS occasionally introduces new codes into the PFS that may affect primary care and CPC+. We will assess these codes as they become finalized for their relevance to the CPCP.

5.3.3 Adjusted Historical PBPM

A CPC+ practice's historical PBPM will be adjusted. Specifically, the adjusted historical PBPM is the historical PBPM adjusted for the comprehensiveness supplement (Section 5.3.1) and PFS changes (Section 5.3.2). In Section 5.2.3, we calculated Main Street CPC's historical calculation period PBPM as $18.18. For this example, let's assume a 2% PFS update in CF and no change in prices for RVUs or GPCIs (from historical period to 2017). Then the adjusted historical PBPM is as follows:

$$\begin{aligned} &Adjusted\ Historical\ E\&M\ PBPM \\ &\quad = Historical\ Calculation\ Period\ PBPM\ (per\ section\ 5.2) \\ &\quad * Comprehensiveness\ Supplement\ (per\ section\ 5.3.1) \\ &\quad * PFS\ Update\ (per\ section\ 5.3.2) \\ &\quad = \$18.18 * 110\% * 102\% = \$20.40 \end{aligned}$$

The 2017 Adjusted Historical E&M PBPM is $20.40.

[19] Section 5501(a) of The Affordable Care Act.

[20] For details on the Medicare physician payment formula, see http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_physician_final.pdf?sfvrsn=0.

[21] The finalized Physician Fee Schedule rates for 2017 can be found at https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/.

5.3.4 2017 Program Year Calculation for Main Street CPC

Let us assume Main Street CPC had 300 attributed beneficiaries for Q2 of 2017. Main Street CPC chose to receive 25% upfront as the CPCP for 2017.

$$\begin{aligned} &Quarterly\ CPCP \\ &\quad = 2017\ PBPM * number\ of\ attributed\ beneficiaries \\ &\quad * 3\ months\ per\ beneficiary * upfront\ CPCP\ election \\ &\quad = \$20.40 * 300 * 3 * 25\% = \$4{,}590 \end{aligned}$$

Therefore, in April 2017, Main Street CPC will receive $4,590 for its upfront quarterly 2017 CPCP payment.

5.3.5 Frequency of CPCP Calculation and Payment

CMS will calculate the CPCP as a PBPM and make payments to practices quarterly. CPCP payments will start in April 2017, and practices should expect to receive this payment when they receive their quarterly CMF payments.

Figure 5-1 provides a general graphical illustration of the CPCP calculation and payment for Track 2 CPC+ practices during program year 2017, including how the adjusted historical PBPM is calculated, as well as how the CPCP is calculated. Then Figure 5-2 provides a graphical representation of the CPCP calculation and payment for the Main Street CPC example that has been used throughout this chapter.

5.4 FFS Reduction

For the 2017 CPCP program year, there will be a corresponding set of reductions to practice's FFS payments for the applicable E&M services covered under the CPCP. These reductions are described in this section.

As we described in Section 5.1.2, Track 2 practices will select the annual pace at which they will progress towards one of two hybrid payment options. This selection will occur during the fall preceding the program year. Although the CPCP will be paid at the practice level, the corresponding **FFS reduction** will occur at the practitioner level. CMS claims systems will reduce a Medicare PFS claim billed to Part B only when there is an office visit E&M service by a CPC+ practitioner for an attributed beneficiary during a payment quarter. Otherwise, the claim system will not reduce the claim.

CMS will reduce office visit E&M claims only for attributed beneficiaries with a visit to the primary care practitioners on the CPC+ practice roster (i.e., TIN/NPI combinations) as reported to CMS. In the event a CPC+ practitioner bills an office visit E&M for an attributed beneficiary at a non-CPC+ Practice Site with the same TIN as the participating CPC+ practice, the CMS claims systems will apply the CPCP reduction. Finally, the system will not retroactively adjust previously paid claims.

Figure 5-1
How does the Comprehensive Primary Care Payment (CPCP) in Track 2 Get Calculated?

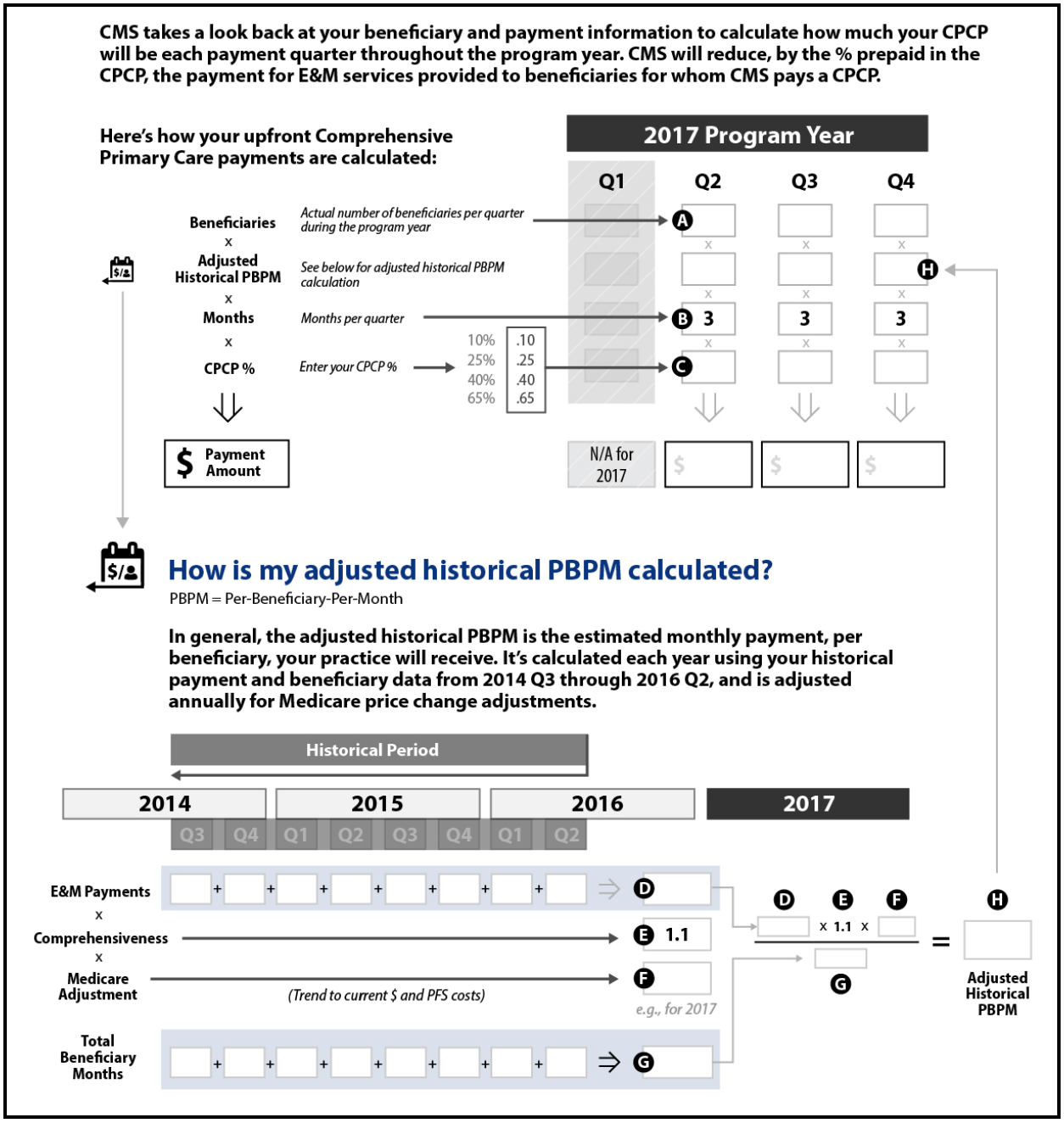
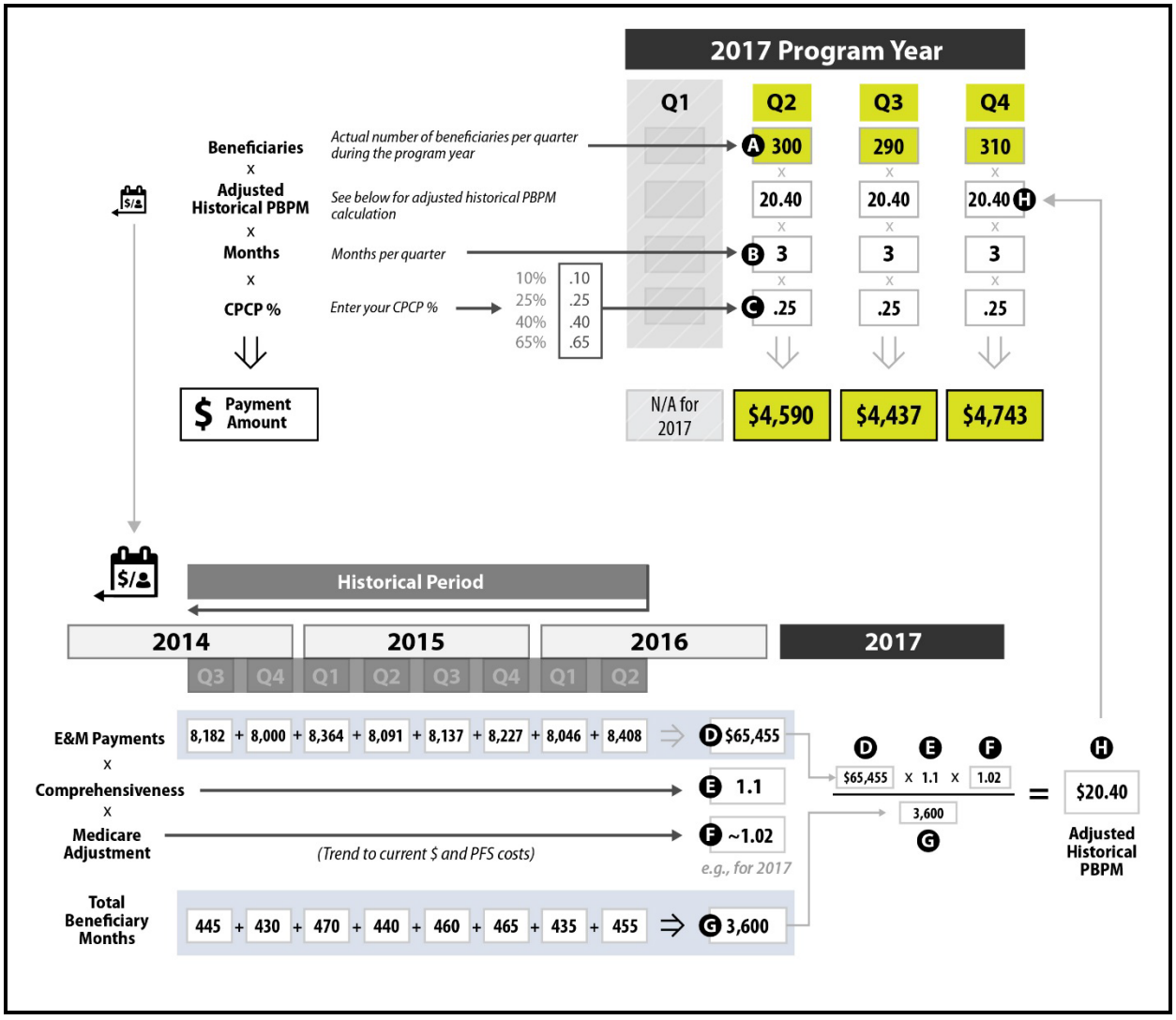


Figure 5-2
Comprehensive Primary Care Payment (CPCP)—Main Street CPC Example



As stated in Section 5.1.3, the CPCP will not affect beneficiary co-insurance. Additionally, it will not alter Medicare FFS allowed amounts. The claims reduction will follow any other CMS adjustments (e.g., physician **value-based payment modifier**, **Physician Quality Reporting System [PQRS]**) and precede sequestration. The paid amount field of the processed claim will indicate to the CPC+ practitioner the post-CPCP reduction amount and final payable amount. Practitioners will continue to receive electronic remittance advice or standard paper remittance.

5.4.1 2017 FFS Calculation for Main Street CPC

Recall that Main Street CPC chose to receive 25% upfront as the CPCP for 2017 with the corresponding 75% in FFS claims. Suppose a CPC+ practitioner at Main Street CPC is normally paid $50 for an office visit E&M provided to an attributed beneficiary. In 2017, the practice will receive $37.50 ($50 * 75% = $37.50) for each office visit E&M claim.

5.5 Partial Reconciliation

We will conduct an annual outside-of-practice partial reconciliation to mitigate risks for both CMS and CPC+ practices that could arise in the absence of reconciliation. Partial reconciliation is meant to accomplish three aims: (1) protect CMS against paying more than expected amounts for office visit E&M services for CPC+ attributed beneficiaries; (2) protect practices in specifically defined situations from financial risk from the hybrid payment compared with pure FFS; and (3) maintain incentive neutrality for practices, ensuring that they are free to deliver enhanced services but are not incentivized to increase FFS billings to achieve a more favorable financial outcome.

Outside-of-practice partial reconciliation considers the office visit E&Ms that beneficiaries receive from practitioners who are not inside the CPC+ Practice Site to which the beneficiary is attributed to. It is important for both CMS and CPC+ practices to consider the extent to which an attributed beneficiary's practice is increasing or decreasing office visit E&M services that are being delivered outside of the CPC+ practice.

CMS presumes that beneficiaries will tend to increase the amount of primary care they seek elsewhere if they are not satisfied with the care they receive from their CPC+ practice. Thus, increases in office visit E&M services delivered by primary care practitioners outside of the CPC+ practice to CPC+ practice attributed beneficiaries would lead to a partial downward adjustment of the CPCP. Conversely, significant decreases in office visit E&M services delivered by primary care practitioners in an office setting outside of the CPC+ practice could also lead to an additional payment to CPC+ practices. For instance, in rare cases, a practice could see substantial decreases in office visit E&M volume if services were being delivered by other practices that previously were delivered by the CPC+ practice. The CPCP should not reward a practice in such a situation. Conversely, in rare cases, a CPC+ practice could see substantial increases in office visit E&M volume by delivering services that previously were delivered by other primary care practices to its attributed beneficiaries. The CPCP should not penalize a practice in such a situation. Thus, the purpose of the outside-of-practice partial reconciliation is to account for difference between (1) adjusted historical PBPM revenue and (2) program year PBPM revenue for office visit E&M services for attributed beneficiaries from primary care practitioners delivered *outside* the CPC+ practice.

There are three major steps to conducting the outside-practice reconciliation:

1. Calculate the office visit E&M PBPM expenditures for attributed beneficiaries delivered outside of the CPC+ practice during the historical calculation period.
2. Calculate the office visit E&M PBPM expenditures for attributed beneficiaries delivered outside of the CPC+ practice during the program year.
3. Determine reconciliation amount based on comparison of the PBPM from the historical calculation period and the PBPM from the program year (from Steps 1 and 2).[22]

[22] Note that as subsequent program years become more distant from the historical calculation period, it may become necessary to adjust the historical calculation period for this reconciliation to improve the

a. If outside-of-practice PBPM is between $2–7 PBPM *larger* in 2017 than it was in the calculation period, then CMS will *reduce* payment to the CPC+ practice down to the $2 PBPM difference.
b. If outside-of-practice PBPM is between $2–7 PBPM *smaller* in 2017 than it was in the calculation period, then CMS will *increase* payment to the CPC+ practice up to the $2 PBPM difference.
c. We are capping reconciliation at $7 PBPM, such that the maximum amount to be credited or debited through future CPCPs is $5 PBPM.
d. If the absolute difference is not greater than $2 PBPM, then no reconciliation occurs.

CMS expects a small minority of practices to be subject to this reconciliation. We chose $2 PBPM-$7 PBPM as our reconciliation corridor through an analysis of the data from the CPC initiative. Overall, approximately 75–80% of office visit E&M services from primary care practitioners were delivered within the practice in the CPC initiative. The average was $16–17 PBPM within the CPC practice and $4–5 PBPM outside the CPC practice. Approximately 10% of practices had changes in out-of-practice expenditures greater than $2 per beneficiary per month (in either direction), while less than 3% of practices had changes in out-of-practice expenditures greater than $7 per beneficiary per month (in either direction). We will modify subsequent CPCP payments by any change beyond +/− $2 and lower than +/− $7. For those with changes greater than $7, CMS is capping the reconciliation because such large changes are likely due more to changes in provider billing (e.g., billing under different TINs, only one of which is in the CPC+ practice).

We now proceed in explaining in more detail the three major steps to conducting the outside-practice reconciliation:

Step 1: Calculate the office visit E&M PBPM expenditures for attributed beneficiaries delivered outside of the CPC+ practice *during the historical calculation period*.

Step 1.1: CMS starts by considering office visit E&M PBPM expenditures within the CPC+ practice for beneficiaries attributed to the practice. We calculated this amount in Section 5.2.

Step 1.2: CMS then calculates total office visit E&M PBPM expenditures from all primary care practitioners (including primary care practitioners not participating in CPC+) for beneficiaries attributed to the practice.

comparability of the historical calculation period to the program year. Because this reconciliation is calculated independently of the other components of the CPCP calculation, this can be done without changing the historical calculation period used for other aspects of this methodology. CMS will monitor whether it is necessary to adjust the calculation year for calculating outside-of-practice reconciliation and inform practices in advance of any changes. Changes will be made if distortions between the historical calculation period and the program year start to penalize practices.

Step 1.3: To calculate the amount of office visit E&M expenditures delivered outside the CPC+ practice, CMS subtracts office visit E&M PBPM expenditures within the CPC+ practice (Step 1.1) from office visit E&M PBPM expenditures from all primary care practitioners (Step 1.2).

When calculating office visit E&M expenditures during the historical calculation period, CMS will consider only beneficiary months of experience for when the beneficiary was eligible and attributed, as we described in Section 5.2. CMS will adjust for PFS updates and revaluation changes from 2014–2016 (from Section 5.3.2). Because we will be comparing historical calculation period expenditures to program year expenditures, the historical calculation period expenditures must be expressed in 2017 dollars. Finally, CMS will not include the Comprehensiveness Supplement because practices outside of CPC+ will not be receiving it.

To illustrate, in the historical calculation period, Main Street CPC has a historical population of 3,600 attributed beneficiary months. The attributed beneficiaries received $18,000 worth of office visit E&M services outside of Main Street CPC for these beneficiary months. The PBPM of office visit E&M services delivered outside of Main Street CPC for attributed beneficiaries in the historical calculation period is $6 PBPM, or $18,000/3,600 beneficiary months.

Step 2: Calculate the office visit E&M PBPM expenditures for attributed beneficiaries delivered outside of the CPC+ practice *during the program year*.

CMS calculates total office visit E&M PBPM expenditures for attributed beneficiaries from primary care practitioners not participating in CPC+.

In the program year, Main Street CPC has a historical population of 4,000 attributed beneficiary months with $8,000 worth of E&M services received outside of Main Street CPC for these beneficiary months. The office visit E&M PBPM delivered outside of Main Street CPC in the program year is $2 PBPM, or $8,000/4,000 beneficiary months.

Step 3: Determine reconciliation amount based on comparison of the PBPM from the historical calculation period and the PBPM from the program year (from Steps 1 and 2).

There are three possible scenarios when comparing the PBPM from the historical calculation period and the PBPM from the program year. Below, we discuss these scenarios and how they may or may not result in outside-of-practice reconciliation.

Step 3, Scenario 1: If outside-of-practice PBPM is between $2–7 PBPM *larger* in the program year than it was in the historical calculation period, then CMS will *reduce* payment to the CPC+ practice down to the $2 PBPM difference.

Step 3, Scenario 2: If outside-of-practice PBPM is between $2–7 PBPM *smaller* in 2017 than it was in the historical calculation period, then CMS will *increase* payment to the CPC+ practice up to the $2 PBPM difference.

Step 3, Scenario 3: If the absolute difference is not greater than $2 PBPM, then no reconciliation occurs.

On the basis of our simulations of the CPCP, CMS expects only a small minority of practices within a given program year to fall outside of this range and be subject to outside-of-practice reconciliation. If a larger-than-expected share of practices fall outside this range, we may adjust the methodology for this reconciliation to protect against undue financial and other burdens on practices.

Outside-of-Practice Reconciliation Calculation for Main Street CPC—The PBPM for outside E&M services in the historical calculation period was $6 (Step 1), and the PBPM for outside E&M services in the program year was $2 (Step 2). Therefore, the difference between the two PBPM amounts is $4 ([Step 1] − [Step 2] = $6 − $2). Therefore, Main Street CPC falls into the outside-of-practice reconciliation Scenario 2 and will receive an increase in payment. For this scenario, $4 PBPM is the absolute difference between $6 PBPM, and $2 PBPM and is less than the $5 maximum amount that could be credited or debited through future payment.

Therefore, the increase in payment to Main Street CPC will be:

$2 * (4,000 beneficiary months) = $8,000

The outside-of-practice reconciliation will be conducted annually at the practice level. CMS plans to incorporate the reconciliations for 2017 in 2018 Q3 payments as an increase or decrease to a subsequent CPCP. If the reconciliation is sufficiently large, CMS may spread the reconciliation amount over subsequent quarterly payments.

Chapter 6: Conclusions

CPC+ payment system redesign is aimed to ensure practices have the infrastructure to deliver better care, smarter spending, and healthier people. With the combination of the CMF, PBIP, and Medicare FFS payment (regular FFS for Track 1 or hybrid payment for Track 2), CMS provides strong financial support to practices to expand the breadth and depth of the services they provide in order to better meet the need of their patient population.

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Appendix A: Glossary of Terms

Absolute Performance Thresholds: The minimum and maximum thresholds that practices are measured against for the performance-based incentive payment measures. In program year 1, the minimum threshold is the 50th percentile of performance in the benchmark population for clinical quality, patient experience of care, and utilization while the maximum threshold is the 80th percentile. The thresholds are determined by a benchmark population external to CPC+ participation.

Accountable Care Organizations (ACOs): Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. CMS offers several ACO programs and models: the Medicare Shared Savings Program; ACO Investment Model—a supplementary incentive program for selected participants in the Shared Savings Program; and Next Generation ACO Model—designed for early adopters of coordinated care.

Adjusted Historical PBPM: The historical PBPM for a CPC+ practice adjusted for both the comprehensiveness supplement and for Medicare Physician Fee Schedule updates between the historical calculation period and the program year.

Alternative Payment Models (APMs): Payment approaches, developed in partnership with the clinician community, that provide added incentives to deliver high-quality and cost efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Advanced Alternative Payment Model (Advanced APM): An alternative payment model that requires participants to use certified EHR technology, bases payment on quality measures comparable to those in the Merit Based Incentive Payment System (MIPS), and where participants bear more than nominal financial risk; or an APM Medical Home Model expanded under Innovation Center authority.

Attribution: A tool used to assign beneficiaries to primary care practices. In the CPC+ Model, attribution is used to estimate the amount of care management fees, performance-based incentive payments, and, for Track 2 practices, the hybrid payment. CMS uses Medicare claims and eligibility data to conduct beneficiary attribution.

CAHPS®: Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The acronym "CAHPS" is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CG CAHPS: The CAHPS Clinician & Group Survey (CG-CAHPS) assesses patients' experiences with health care providers and staff in doctors' offices. Survey results can be used to: Improve care provided by individual providers, sites of care, medical groups, or provider

networks; and to equip consumers with information they can use to choose physicians and other health care providers, physician practices, or medical groups.

Care Management Fee (CMF): CMS pays selected primary care practices a care management fee to support enhanced, coordinated services for Medicare beneficiaries. CPC+ practices will receive a risk-adjusted, prospective, monthly care management fee (CMF) for their attributed Medicare fee-for-service patients. Practices will use this enhanced, non-visit-based compensation to augment staffing and training in support of population health management and care coordination.

Chronic Care Management (CCM)–Related Services: (CPT codes 99487, 99489, 99490, G0506, and G0507) that are duplicative of the services covered by the CPC+ Care Management Fee (CMF). Medicare will not pay both a CPC+ CMF and fees for CCM-related services for any individual beneficiary in the same month.

CMF Reference Population: The region-specific population is used to determine the risk tier thresholds on which the care management fees are based. For a given region, the CMF reference population includes Medicare FFS beneficiaries in that region who meet CPC+ eligibility requirements and who have had an eligible primary care visit.

CMS Certification Number: In order to avoid confusion with the National Provider Identifier, the Medicare/Medicaid Provider Number (also known as the OSCAR Provider Number, Medicare Identification Number or Provider Number) has been renamed the CMS Certification Number (CCN). The CCN continues to serve a critical role in verifying that a provider has been Medicare certified and for what type of services.

Comprehensiveness: Increased depth and breadth (length and/or intensity) of primary care services furnished by the CPC+ practice.

Comprehensiveness Supplement: Increase of 10% in historical PBPM to account for comprehensiveness.

Comprehensive Primary Care (CPC) Initiative: The Comprehensive Primary Care (CPC) initiative (also called “CPC Classic”) was a multi-payer initiative designed to strengthen primary care. The CPC initiative ran from October 2012 through December 2016, and was a predecessor to CPC+.

Comprehensive Primary Care Payment (CPCP): The CPCP is an upfront payment to a Track 2 CPC+ practice for a percentage of expected Medicare payments for Evaluation and Management (E&M) services provided through the Physician Fee Schedule (PFS) to aligned beneficiaries. E&M visits billed during the performance year will be correspondingly decreased. The CPCP compensates clinicians for clinical services that have been traditionally billable but offers flexibility for these services to be delivered inside or outside of an office visit and in accordance with patient preferences. The flexibility is intended to allow more time to be devoted to increasing the breadth and depth of services provided at the practice site and for population health improvement.

Comprehensive Primary Care Plus (CPC+): 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. CPC+ will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. The care delivery redesign ensures practices in each track have the infrastructure to deliver better care to result in a healthier patient population. The multi-payer payment redesign will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback, to guide their decision making. CPC+ is a five-year model that will begin in January 2017.

Conversion Factor (CF): In calculating payment rates under the physician fee schedule, each of the three relative value units is adjusted to reflect the price of inputs in the local market where the service is furnished. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule conversion factor (CF).

CPCP: Comprehensive primary care payment (See Comprehensive Primary Care Payment (CPCP) above).

eCQM: Electronic clinical quality measure. (See Electronic Clinical Quality Measure (eCQM) below.)

Electronic Clinical Quality Measure (eCQM): Clinical quality measures that use data from electronic health records (EHR) and/or health information technology systems to measure health care quality. The Centers for Medicare & Medicaid Services (CMS) use eCQMs in a variety of quality reporting and incentive programs.

Eligible Primary Care Visit: A primary care visit that is used in the CPC+ attribution algorithm. Primary care services include evaluation and management services provided in office and other non-inpatient and non–emergency-room settings, as well as initial Medicare visits and annual wellness visits. Specifically, eligible primary care visits include home care; welcome to Medicare and annual wellness visits; advance care planning; collaborative care model; cognition and functional assessment for payment with cognitive impairment; outpatient clinic visit for assessment and management (CAHs only); transitional care management services; chronic care management services; complex chronic care management services; assessment/care planning for payments with CCM services; and care management services for behavioral health conditions.

Emergency Department Utilization (EDU): The component of the performance-based incentive payment that measures practice performance on emergency department utilization.

Evaluation & Management (E&M) Office Visits: Medicare covered services (office visits) used in the calculation of the CPCP, furnished by a Participating CPC+ Practitioner to a CPC+ Beneficiary and billed under the TIN/NPI (or CCN/NPI) of the CPC+ Practice using one or more

of the following Current Procedural Terminology (CPT) codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, and 99355.

Fee-For-Service (FFS): A method in which doctors and other health care providers are paid for each service performed based on a payment fee schedule. Examples of services include tests and office visits.

Fee-For-Service (FFS) Reduction: The percentage by which a Track 2 CPC+ Practice's payment for Evaluation and Management Services is reduced if such services are furnished by a Participating CPC+ Practitioner to a CPC+ Beneficiary and billed under the TIN/NPI (or CCN/NPI) of the CPC+ Practice for its attributed beneficiaries.

Flat percentages: Absolute percentages values that may be used as the minimum and maximum performance measurement thresholds for the performance-based incentive payment.

Geographic Price Cost Index (GPCI): In calculating payment rates under the physician fee schedule, each of the three relative value units is adjusted to reflect the price of inputs in the local market where the service is furnished. Separate geographic practice cost indexes (GPCIs) are used for this purpose.

Historical PBPM: The historical PBPM represents each CPC+ practice's E&M payments received from CMS for a similar group of beneficiaries in a 24-month period before the start of CPC+.

Historical Calculation Period: The time period for which historical payments are calculated for a CPC+ practice's historical population (July 2014 to June 2016).

Historical Payment: Applicable Medicare Part B E&M payments made to the CPC+ practice for its historical population during the historical calculation period.

Historical Population: The historical population includes all beneficiaries attributed to a selected CPC+ practice during the historical calculation period. To determine the historical population, historical claims are used to attribute beneficiaries to practices quarterly during the historical calculation year.

Hybrid Payment: Together, the Comprehensive Primary Care Payment (CPCP) and the corresponding Fee-For-Service (FFS) Reduction are termed the "hybrid payment," which is for practices participating in Track 2 of CPC+.

Hybrid Payment Ratio: The annual pace at which a Track 2 CPC+ practice will progress towards one of two hybrid payment options: one option will pay 40% upfront and 60% of the applicable FFS payment, and the other will pay 65% upfront and 35% of the applicable FFS payment.

Incentive Neutrality: The incentive to bring a patient to the office is balanced with the incentive to provide the needed care outside of an office visit, making a practice agnostic as to whether

they deliver a service in person or via another modality so the care can be delivered according to patient preferences.

Inpatient Hospital Utilization (IHU): The component of the performance-based incentive payment that measures practice performance on inpatient hospital utilization.

Look Back Period: The attribution look back period is the 24-month period ending three months prior to the start of the quarter. To be attributed to a practice, a patient must have received the plurality of their primary care health services at the practice during this look back period.

Medicare Physician Fee Schedule: Medicare Part B Physician Fee Schedule (PFS), used to pay physicians and other Part B providers.

Medicare Shared Savings Program: The Medicare Shared Savings Program (Shared Savings Program) was established by section 3022 of the Affordable Care Act. The Shared Savings Program is a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act and is a new approach to the delivery of health care.

National Provider Identifier (NPI): The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Partial Reconciliation: CMS will conduct an annual outside-of-practice partial reconciliation of the hybrid payment to mitigate risks for both CMS and CPC+ practices that could arise in the absence of reconciliation. Partial reconciliation is meant to accomplish three aims: (1) protect CMS against paying more than expected amounts for office visit E&M services for CPC+ attributed beneficiaries; (2) protect practices in specifically defined situations from financial risk from the hybrid payment compared with pure FFS; and (3) maintain incentive neutrality for practices, ensuring that they are free to deliver enhanced services but are not incentivized to increase FFS billings to achieve a more favorable financial outcome.

Per Beneficiary Per Month (PBPM): Per Beneficiary Per Month.

Performance Based Incentive Payment (PBIP): An annual prospective performance-based payment made by CMS to the CPC+ Practice for a Performance Year that reflects the performance score that CMS expects the CPC+ Practice to achieve during that Performance Year based on its performance on quality measures, patient experience of care measures, and utilization measures.

Physician Quality Reporting System (PQRS): The Physician Quality Reporting System (PQRS) is a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare. PQRS gives participating EPs and group practices the opportunity to assess the quality of care they provide to their patients, helping to ensure that patients get the right care at the right time.

Program Year: A year in which The Centers for Medicare and Medicaid (CMS) makes Comprehensive Primary Care Payments (CPCP) and/or Performance-Based Incentive Payment (PBIP) and/or Care Management Fees (CMF) to eligible practices participating in CPC+.

Quality Component: The component of the performance-based incentive payment that measures practice performance on clinical quality and patient experience of care. Clinical quality will be measured using nine electronic Clinical Quality Measures (eCQMs) while patient experience will be measured using Consumer Assessment of Healthcare Providers and Systems Clinician and Group Patient-Centered Medical Home Survey (CG CAHPS). The CG CAHPS measures contributes 25% to the practice's score for the Quality Component, and the eCQM measures contribute 75%.

Quality Payment Program Final Rule: New approach to payment that rewards the delivery of high-quality patient care through two avenues: Advanced Alternative Payment Models (Advanced APMs) and the Merit-based Incentive Payment System (MIPS) for eligible clinicians or groups under the PFS. This final rule with comment period establishes incentives for sufficient participation in certain Alternative Payment Models (APMs) and includes the criteria for use by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in making comments and recommendations on physician focused payment models (PFPMs).

Relative Value Unit (RVU): Under the physician fee schedule, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide physician services: physician work, practice expenses, and professional liability insurance.

Sequestration: A process of spending reductions to enforce certain budget policy goals. Percentage payment reductions (2%) made under Medicare Part B made to individual payments to providers for services (e.g., hospital and physician services) rather than to fee schedule allowable charges; the patient's cost sharing amount remains unchanged.

Taxpayer Identification Number (TIN): A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS.

Track 1: One of two payment options that participating practices may select under the CPC+ Model. Track 1 is the choice for practices ready to build the capabilities to deliver comprehensive primary care. Practices that select Track 1 will receive a care management fee (CMF) of $15 per-beneficiary-per-month (PBPM) average across 4 risk tiers, a $2.50 PBPM performance-based incentive payment (PBIP) based on quality and utilization metrics, and will

continue to receive 100% Medicare fee-for-service (FFS) payment for Evaluation and Management (E&M) office visits. (See definition of Track 2 below.)

Track 2: One of two payment options that participating practices may select under the CPC+ Model. Track 2 is targeted to practices that have built the capabilities for comprehensive primary care and are poised to increase the comprehensiveness of care and improve care for patients with complex needs. Practices that select Track 2 will receive a care management fee (CMF) of $28 per-beneficiary-per-month (PBPM) average across five risk tiers and $100 for the highest-risk tier, and a $4.00 PBPM performance-based incentive payment (PBIP) based on quality and utilization metrics. In addition, Track 2 practices will receive a hybrid payment that includes a prospective comprehensive primary care payment (CPCP) and a corresponding reduction of their Medicare FFS payment for specific Evaluation and Management (E&M) office visits provided to aligned beneficiaries. (See definition of Track 1 above.)

Utilization component: The component of the performance-based incentive payment that measures practice performance on two measures, inpatient hospital utilization and emergency department utilization. Inpatient utilization is given twice the weight of emergency department utilization. To be eligible for the Utilization component of the incentive payment, practices must meet the minimum performance required for each segment of the Quality component.

Value Based Payment Modifier (VBPM): The Value Based Payment Modifier provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to the cost of care during a performance period. The Value Modifier is an adjustment made to Medicare payments for items and services under the Medicare PFS. It is applied at the Taxpayer Identification Number (TIN) level to physicians (and beginning in 2018, to certain non-physician eligible professionals (EPs) billing under the TIN.

Voluntary Alignment: A method by which a Medicare FFS beneficiary confirm their primary care practitioner. It is currently being tested in certain Medicare ACO models.

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Appendix B: Primary Care Specialty Codes

Family Medicine—207Q00000X
Adult Medicine—207QA0505X
Geriatric Medicine—207QG0300X
Hospice and Palliative Medicine—207QH0002X

General Practice—208D00000X

Internal Medicine—207R00000X
- Geriatric Medicine—207RG0300X
- Hospice and Palliative Medicine—207RH0002X

Clinical Nurse Specialist—364S00000X
- Acute Care—364SA2100X
- Adult Health—364SA2200X
- Chronic Care—364SC2300X
- Community Health/Public Health—364SC1501X
- Family Health—364SF0001X
- Gerontology—364SG0600X
- Holistic—364SH1100X
- Women's Health—364SW0102X

Nurse Practitioner—363L00000X
- Acute Care—363LA2100X
- Adult Health—363LA2200X
- Community Health—363LC1500X
- Family—363LF0000X
- Gerontology—363LG0600X
- Primary Care—363LP2300X
- Women's Health—363LW0102X

Physician Assistant—363A00000X
- Medical—363AM0700X

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Appendix C: Description of CMS-HCC Risk Adjustment Model

The Centers for Medicare & Medicaid Services (CMS) uses the CMS Hierarchical Condition Categories (HCC) risk adjustment model to adjust capitation payments made to Medicare Advantage (MA) and Medicare Program of All-Inclusive Care for the Elderly (PACE) plans, with the intention of paying health plans appropriately for their expected relative costs. For example, a health plan enrolling a relatively healthy population receives lower payments than one enrolling a relatively sick population, other things equal. The CMS-HCC model produces a risk score, which measures a person's or a population's health status relative to the average, as applied to expected medical expenditures. A population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a population with a risk score of 0.5 is expected to incur medical expenditures half that of the average. It is important to note that the model is accurate at the group level and that actual expenditures for any individual can be higher or lower (sometimes significantly) than those predicted.

The CMS-HCC model is a prospective model using demographic and diagnosis information from a base year to estimate expenditures in the next year. For example, risk scores for 2016 (risk score year) are calculated using diagnosis information from 2015 (the base year). New Medicare enrollees (defined here as beneficiaries with less than 12 months of Medicare enrollment in the base year) receive a risk score from the new enrollee risk adjustment model, which is a demographic-only model. If a beneficiary does not have 12 months of enrollment in the base year, the beneficiary cannot have had a complete diagnosis profile in the base year, and hence the CMS-HCC model cannot be used for the beneficiary. Because of the amount of time required to ensure that as many diagnoses are captured in the risk score development as possible, risk scores for any year are not available until at least twelve months after the close of the base year.

The demographic characteristics used are age, sex, Medicaid status, and originally disabled status. The diagnosis information used is the set of diagnosis codes reported on Medicare claims in the base year. Not all types of Medicare claims are used—only Hospital Inpatient, Hospital Outpatient, Physician, and some non-Physician claims are considered. The source of a particular diagnosis code has no relevance (i.e., diagnoses from an Inpatient hospitalization have equal weight as those from a Physician visit), nor does the frequency with which the diagnosis code has been reported.

The CMS-HCC diagnostic classification system begins by classifying all ICD-9-CM diagnosis codes into Diagnostic Groups, or DXGs. Each ICD-9-CM code maps to exactly one DXG, which represents a well-specified medical condition or set of conditions, such as the DXG for *Type II Diabetes with Ketoacidosis or Coma*. DXGs are further aggregated into Condition Categories (CCs). CCs describe a broader set of similar diseases. Although they are not as homogeneous as DXGs, diseases within a CC are related clinically and with respect to cost. An example is the CC for *Diabetes with Acute Complications*, which includes, in addition to the DXG for *Type II Diabetes with Ketoacidosis or Coma*, the DXGs for *Type I Diabetes* and *Secondary Diabetes* (each with ketoacidosis or coma).

Hierarchies are imposed among related Clinical Conditions (CCs) so that a person is coded for only the most severe manifestation among related diseases. After imposing hierarchies, CCs become Hierarchical Condition Categories (HCCs). For example, diabetes diagnosis codes are organized in the Diabetes hierarchy, consisting of three CCs arranged in descending order of clinical severity and cost, from (1) *Diabetes with Acute Complications* to (2) *Diabetes with Chronic Complications* to (3) *Diabetes without Complication*. Thus, a person with diagnosis code of *Diabetes with Acute Complications* is excluded from being coded with *Diabetes with Chronic Complications* and is also excluded from being coded with *Diabetes without Complication*. Similarly, a person with a diagnosis code of *Diabetes with Chronic Complications* is excluded from being coded with *Diabetes without Complication*. Although HCCs reflect hierarchies among related disease categories, for unrelated diseases, HCCs accumulate, i.e., the model is "additive." For example, a female with both *Rheumatoid Arthritis* and *Breast Cancer* has (at least) two separate HCCs coded, and her predicted cost will reflect increments for both conditions.

Because a single individual may be coded for no HCCs, one, or more than one HCC, the CMS-HCC model can individually price tens of thousands of distinct clinical profiles. The model's structure thus provides, and predicts from, a detailed comprehensive clinical profile for each individual.

The CMS-HCC model assigns a numeric factor to each HCC and each age/sex, Medicaid/non-Medicaid, originally disabled/non-originally disabled cell. The values are summed to determine the risk score.

An illustrative hypothetical example follows for a 70-year-old woman with HCCs Metastatic Cancer and Acute Leukemia (HCC 8) and Bone/Joint/Muscle Infections/Necrosis (HCC 39) who is on Medicaid who is not originally disabled:

Risk Factor	Factor
Age/Sex	0.346
Medicaid	0.213
HCC 8—Metastatic Cancer and Acute Leukemia	2.425
HCC 39—Bone/Joint/Muscle Infections/Necrosis	0.423
Total CMS-HCC Risk Score	**3.407**

For more information on the CMS-HCC risk model, see the following web page: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html

Appendix D: CAHPS Benchmarking Methodology

The Agency for Healthcare Research and Quality's (AHRQ's) Consumer Assessment of Healthcare Providers and Systems (CAHPS) database was used as the data source for calculation of the CAHPS benchmarks. We chose this database because:

1. The sampling frame, as in CPC+, includes all patients in the practice;
2. The survey items included in the CAHPS database were most similar to the patient survey used in CPC+;
3. It includes a large amount of geographically representative data (546 out of 833 potential practices are either 100% primary care or multispecialty practices that include primary care practitioners); and
4. It includes variables needed to conduct risk adjustment to account for differences in performance, rather than differences in patient characteristics obfuscating those differences in performance.

We calculated CAHPS domain-specific scores measures for each practice using the CAHPS Analysis Program, version 4.1, which allows users to analyze CAHPS survey data to make valid comparisons of performance. AHRQ developed and tested the CAHPS Analysis Program code to generate practice-level output from CAHPS survey results. This code is easily adjusted using parameters to generate composite scores from CAHPS survey results. Documentation for the CAHPS Analysis Program can be found here: https://cahpsdatabase.ahrq.gov/files/CGGuidance/Instructions%20for%20Analyzing%20CAHPS%20Surveys.pdf

Patient Experience Composite Measures and Point Scales

Composite Measure	CAHPS Point Scale
Getting Timely Appointments, Care, and Information (3 questions) How Well Providers Communicate (4 questions) Attention to Care from Other Providers (2 questions) Shared Decision Making (3 questions)	1–4 "always" = 4 "usually" = 3 "sometimes" = 2 "never" = 1
Providers Support Patient in Taking Care of Own Health (2 questions)	0–1 "yes" = 1 "no" = 0
Patient Rating of Provider and Care (1 question)	0–10 (patients answer on a scale of 0–10)

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Appendix E: CPC+ eCQM Set—2017 Performance Period

CMS ID#		NQF#	Measure Title	Measure Type/Data Source	Domain
Report 2 of the Group 1 outcome measures:					
Group 1	CMS159v5	0710	Depression Remission at Twelve Months	Outcome/ eCQM	Clinical Process/ Effectiveness
	CMS165v5	0018	Controlling High Blood Pressure	Outcome/ eCQM	Clinical Process/ Effectiveness
	CMS122v5	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control > 9%)	Outcome/ eCQM	Clinical Process/ Effectiveness
Report 2 of the Group 2 complex care measures:					
Group 2	CMS156v5	0022	Use of High-Risk Medications in the Elderly	Outcome/ eCQM	Patient Safety
	CMS149v5	N/A	Dementia: Cognitive Assessment	Outcome/ eCQM	Clinical Process/ Effectiveness
	CMS139v5	0101	Falls: Screening for Future Fall Risk	Outcome/ eCQM	Patient Safety
	CMS137v5	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Outcome/ eCQM	Clinical Process/ Effectiveness
Report 5 of the 10 remaining measures (choice of Group 3 and remaining Groups 1 and 2 measures):					
Group 3	CMS50v5	N/A	Closing the Referral Loop: Receipt of Specialist Report	Outcome/ eCQM	Care Coordination
	CMS124v5	0032	Cervical Cancer Screening	Outcome/ eCQM	Clinical Process/ Effectiveness
	CMS130v5	0034	Colorectal Cancer Screening	Outcome/ eCQM	Clinical Process/ Effectiveness
	CMS131v5	0055	Diabetes: Eye Exam	Outcome/ eCQM	Clinical Process/ Effectiveness
	CMS138v5	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Outcome/ eCQM	Population/Public Health
	CMS166v6	0052	Use of Imaging Studies for Low Back Pain	Outcome/ eCQM	Efficient Use of Healthcare Resources
	CMS125v5	2372	Breast Cancer Screening	Outcome/ eCQM	Clinical Process/ Effectiveness

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Appendix F: Utilization Measure Technical Specifications

Inpatient Hospital Utilization (IHU)

Summary of Changes to HEDIS 2016

- First-year measure.

Description

For members 18 years of age and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year reported by Surgery, Medicine, and Total.

Definitions

Classification period	The year prior to the measurement year.
PPD	Predicted probability of discharge. The predicted probability of a member having any discharge in the measurement year.
PUCD	Predicted unconditional count of discharge. The predicted unconditional count of discharges for members during the measurement year.

Eligible Population

Product lines	Commercial, Medicare (report each product line separately).
Ages	18 and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Calculation of Observed Events

For organizations that use Medicare Severity-Diagnosis Related Groups (MS-DRGs):

- Identify all acute inpatient stays with a discharge date during the measurement year for the following categories:
  - Surgery (Surgery MS-DRG Value Set).
  - Medicine (Medicine MS-DRG Value Set).
  - Total Inpatient (the sum of Surgery and Medicine).

For organizations that do not use MS-DRGs, follow these steps to identify inpatient discharges.

Step 1 Identify all acute inpatient discharges during the measurement year. To identify acute inpatient discharges:

e. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
f. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
g. Identify the discharge date for the stay.

Step 2 Exclude discharges with:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- A principal diagnosis of live-born infant (Deliveries Infant Record Value Set).
- A maternity-related principal diagnosis (Maternity Diagnosis Value Set).
- A maternity-related stay (Maternity Value Set).
- Inpatient stays with a discharge for death.

Step 3 Calculate total inpatient using all discharges identified after completing steps 1 and 2.

Step 4 Calculate surgery. Identify the surgery discharges (Surgery Value Set) from the total inpatient discharges (step 3).

Step 5 Calculate medicine. Categorize any remaining discharges after removing surgery discharges under medicine.

Risk Adjustment Determination

For each member in the eligible population, use the following steps to identify risk adjustment categories based on presence of comorbidity, age, and gender.

Step 1 Use the following value sets to identify all encounters during the classification period based on the discharge date.

- Outpatient visits (Outpatient Value Set).
- Observation visits (Observation Value Set).
- Nonacute inpatient encounters (Nonacute Inpatient Value Set).
- Acute inpatient encounters (Acute Inpatient Value Set).
- Emergency department (ED) visits (ED Value Set).

Step 2 Assign each diagnosis to one comorbid Clinical Condition (CC) category using Table CC—Comorbid.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3

Determine Hierarchical Condition Categories (HCCs) for each comorbid CC identified. Refer to Table HCC—Rank.

For each member's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: *One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.*

Step 4

Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the *Rank* column (1 is the highest rank possible).

Drop all other HCCs in each ranking group and de-duplicate the HCC list if necessary.

Note: *Refer to the Plan All-Cause Readmissions (PCR) measure for a comorbid CC calculation example.*

Step 5

Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes and congestive heart failure (CHF) are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each stay's list of unique HCCs to those in the HCC column in Table HCC—Comb and assign any additional HCC conditions.

For fully nested combinations (e.g., the diabetes/CHF combination is nested in the diabetes/CHF/renal combination), use only the more comprehensive pattern. In this example, only the diabetes/CHF/renal combination is counted.

For overlapping combinations (e.g., the CHF, chronic obstructive pulmonary disease [COPD] combination overlaps the CHR/renal/ diabetes combination), use both sets of combinations. In this example, both CHF/COPD and CHF/renal/ diabetes combinations are counted.

Based on the combinations, a member can have none, one, or more than one of these added HCCs.

Example

Refer to the PCR measure for a combination HCC calculation example.

Risk Adjustment Weighting and Calculation of Expected Events

Calculation of risk-adjusted outcomes (counts of discharges) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many discharges each member may have during the measurement year, given age, gender, and presence or absence of a comorbid condition. Refer to the Risk Adjustment Weight Process diagram for an overview of the process.

For each member in the eligible population, assign Predicted Probability of Discharge (PPD) risk weights. Calculate the PPD for each service utilization category: Surgery, Medicine, Total.

Step 1 For each member with a comorbidity HCC category, link the PPD weights.

- *For the Medicare product line,* use the following tables:
  - *For Surgery:* Use Table IHUS-MA-PPD-ComorbidHCC.
  - *For Medicine*: Use Table IHUM-MA-PPD-ComorbidHCC.
  - *For Total:* Use Table IHUT-MA-PPD-ComorbidHCC.
- *For the commercial product line,* use the following tables:
  - *For Surgery*: Use Table IHUS-Comm-PPD-ComorbidHCC.
  - *For Medicine:* Use Table IHUM-Comm-PPD-ComorbidHCC.
  - *For Total:* Use Table IHUT-Comm-PPD-ComorbidHCC.

Step 2 Link the age-gender PPD weights for each member.

- *For the Medicare product line,* use the following tables:
  - *For Surgery:* Use Table IHUS-MA-PPD.
  - *For Medicine*: Use Table IHUM-MA-PPD.
  - *For Total:* Use Table IHUT-MA-PPD.
- *For the commercial product line,* use the following tables:
  - *For Surgery*: Use Table IHUS-Comm-PPD.
  - *For Medicine:* Use Table IHUM-Comm-PPD.
  - *For Total:* Use Table IHUT-Comm-PPD.

Step 3 Identify the base PPD risk weight for each member.

- *For the Medicare product line,* use the following tables:
  - *For Surgery:* Use Table IHUS-MA-PPD.
  - *For Medicine*: Use Table IHUM-MA-PPD.
  - *For Total:* Use Table IHUT-MA-PPD.
- *For the commercial product line,* use the following tables:
  - *For Surgery*: Use Table IHUS-Comm-PPD.
  - *For Medicine:* Use Table IHUM-Comm-PPD.
  - *For Total:* Use Table IHUT-Comm-PPD.

Step 4 Sum all PPD weights (i.e., HCC, age, gender, base weight) associated with the member for each category (Medicine, Surgery, Total).

Step 5 Calculate the predicted probability of having at least one discharge in the measurement year based on the sum of the weights for each member, for each category (Surgery, Medicine, Total), using the formula below.

$$\text{PPD} = \frac{e^{(\sum \text{PPD WeightsForEachMember})}}{1+e^{(\sum \text{PPD WeightsForEachMember})}}$$

Note: *The risk adjustment tables will be released on November 2, 2015, and posted to www.ncqa.org.*

For each member in the eligible population, assign Predicted Unconditional Count of Discharge (PUCD) risk weights.

Step 1

For each member with a comorbidity HCC Category, link the PUCD weights.

- *For the Medicare product line,* use the following tables:
  - *For Surgery:* Use Table IHUS-MA-PUCD-ComorbidHCC.
  - *For Medicine*: Use Table IHUM-MA-PUCD-ComorbidHCC.
  - *For Total:* Use Table IHUT-MA-PUCD-ComorbidHCC.
- *For the commercial product line,* use the following tables:
  - *For Surgery*: Use Table IHUS-Comm-PUCD-ComorbidHCC.
  - *For Medicine:* Use Table IHUM-Comm-PUCD-ComorbidHCC.
  - *For Total:* Use Table IHUT-Comm-PUCD-ComorbidHCC.

Step 2

Link the PUCD age-gender weights for each member.

- *For the Medicare product line,* use the following tables:
  - *For Surgery*: Use Table IHUS-MA-PUCD.
  - *For Medicine:* Use Table IHUM-MA-PUCD.
  - *For Total:* Use Table IHUT-MA-PUCD.
- *For the commercial product line,* use the following tables:
  - *For Surgery*: Use Table IHUS-Comm-PUCD.
  - *For Medicine:* Use Table IHUM-Comm-PUCD.
  - *For Total*: Use Table IHUT-Comm-PUCD.

Step 3

Identify the base PUCD risk weight.

- *For the Medicare product line,* use the following tables:
  - *For Surgery:* Use Table IHUS-MA-PUCD.
  - *For Medicine*: Use Table IHUM-MA-PUCD.
  - *For Total:* Use Table IHUT-MA-PUCD.
- *For the commercial product line,* use the following tables:
  - *For Surgery*: Use Table IHUS-Comm-PUCD.
  - *For Medicine:* Use Table IHUM-Comm-PUCD.
  - *For Total:* Use Table IHUT-Comm-PUCD.

Step 4

Calculate the predicted unconditional count of discharges in the measurement year, by multiplying all PUCD weights (i.e., HCC, age, gender, and base weight) associated with the member for each category (Surgery, Medicine, Total) together. Use the following formula

*PUCD = Base Weight * Age/gender Weight * HCC Weight*

Note: *Multiply by each HCC associated with the member. For example, assume a member with HCC-2, HCC-10, HCC-47. The formula would be:*

*PUCD = Base Weight * Age/gender Weight * HCC-2 * HCC-10 * HCC_47*

Expected count of hospitalization

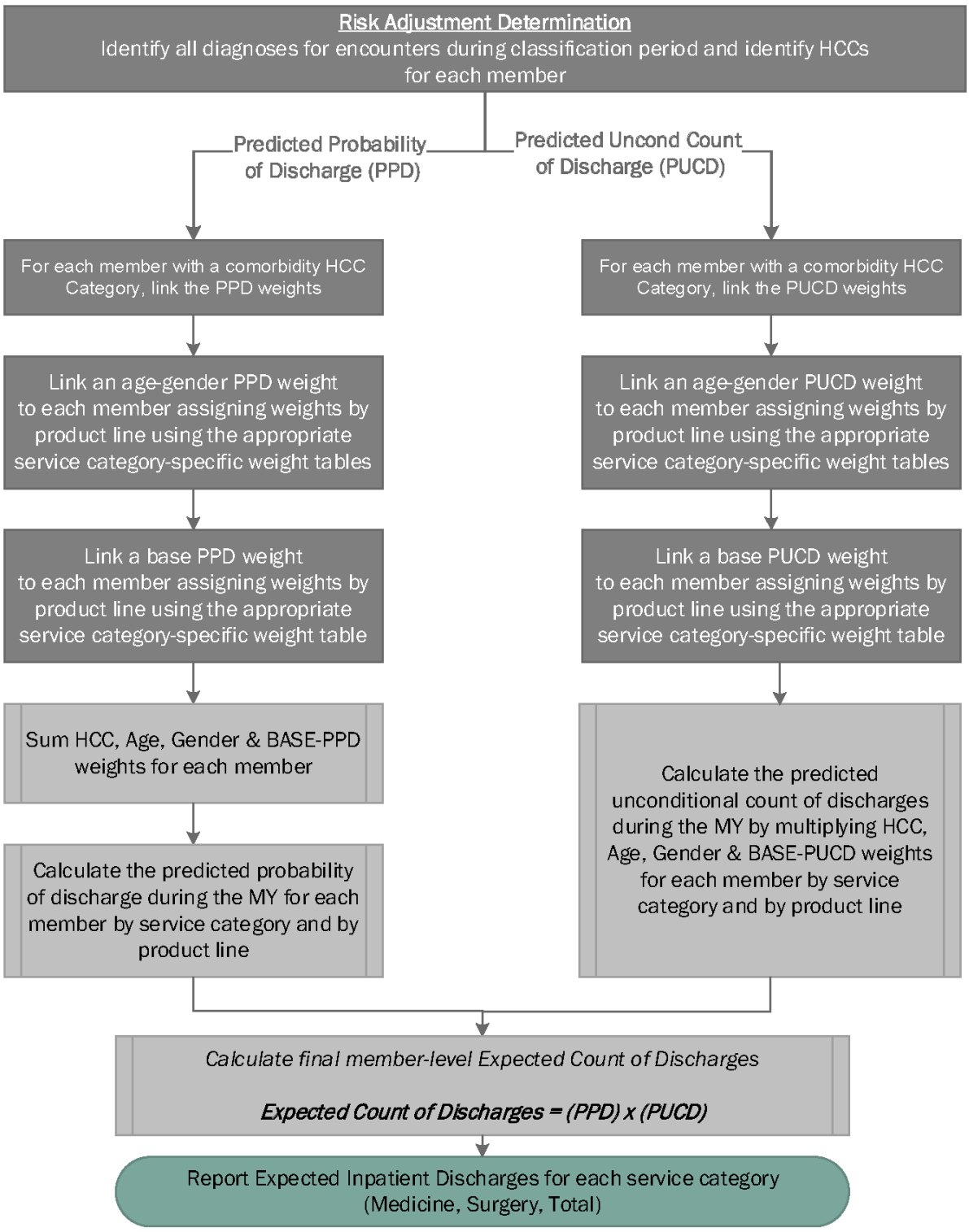
Report the final member-level expected count of discharges for each category using the formula below:

Expected Count of Discharges = PPD x PUCD

Note: *Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for this measure. The IHU measurement model was developed and tested using only claims-based diagnoses, and diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.*

Risk Adjustment Weighting Process

Attachment A:



Reporting: Number of Members in the Eligible Population

The number of members in the eligible population for each age and gender group and the overall total. Enter these values into the reporting table (Table IHU-A-2/3).

Reporting: Number of Observed Events

The number of observed discharges within each age and gender group and the overall total for each category (Surgery, Medicine, Total).

Reporting: Observed Discharges per 1,000 Members

The number of observed discharges divided by the number of members in the eligible population, multiplied by 1,000 within each age and gender group and the overall total for each category (Surgery, Medicine, Total).

Reporting: Number of Expected Events

The number of expected discharges within each age and gender group and the overall total for each category (Surgery, Medicine, Total).

Emergency Department Utilization (EDU)

Summary of Changes to HEDIS 2016

- First-year measure.

Description

For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.

Definitions

Classification period	The year prior to the measurement year.
PPV	Predicted probability of a visit. The predicted probability of a member having an emergency department visit in the measurement year.
PUCV	Predicted unconditional count of visits. The unconditional count of emergency department visits for members during the measurement year.

Eligible Population

Product lines	Commercial, Medicare (report each product line separately).
Ages	18 and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Calculation of Observed Events

Step 1 Count each visit to an ED that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify all ED visits during the measurement year using either of the following:

- An ED Visit (ED Value Set).
- A procedure code (ED procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Step 2 Exclude encounters with any of the following:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- Psychiatry (Psychiatry Value Set).
- Electroconvulsive Therapy (Electroconvulsive Therapy Value Set).
- Alcohol or drug rehabilitation or detoxification (AOD Rehab and Detox Value Set).

Risk Adjustment Determination

For each member in the eligible population, use the following steps to identify risk adjustment categories based on presence of comorbidity, age, and gender.

Step 1 Identify all diagnoses for encounters during the classification period. Include the following when identifying encounters:

- Outpatient visits (Outpatient Value Set).
- Observation visits (Observation Value Set).
- Nonacute inpatient encounters (Nonacute Inpatient Value Set).
- Acute inpatient encounters (Acute Inpatient Value Set).
- ED visits (ED Value Set).

Step 2 Assign each diagnosis to one comorbid CC category using Table CC—Comorbid.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3 Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each member's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: *One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.*

Step 4 Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the Rank column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

Step 5 Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each stay's list of unique HCCs to those in the HCC column in Table HCC—Comb and assign any additional HCC conditions.

For fully nested combinations (e.g., the diabetes/CHF combination is nested in the diabetes/CHF/renal combination), use only the more comprehensive pattern. In this example, only the diabetes/CHF/renal combination is counted.

For overlapping combinations (e.g., the CHF, COPD combination overlaps the CHR/renal/diabetes combination), use both sets of combinations. In this example, both CHF/COPD and CHF/renal/diabetes combinations are counted.

Based on the combinations, a member can have none, one, or more than one of these added HCCs.

Example Refer to the PCR measure for a HCC calculation example.

Risk Adjustment Weighting and Calculation of Expected Events

Calculation of risk-adjusted outcomes (counts of ED visits) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many visits each member may have during the measurement year. Refer to the Risk Adjustment Weight Process diagram for an overview of the process.

For each member in the eligible population, assign PPV risk weights.

Step 1 For each member with a comorbidity HCC Category, link the PPV weights.

- *For the Medicare product line:* Use Table EDU-MA-PPV-ComorbidHCC.
- *For the commercial product line:* Use Table EDU-Comm-PPV-ComorbidHCC.

Step 2 Link the age-gender PPV weights for each member using the following tables.

- *For the Medicare product line:* Use Table EDU-MA-PPV.
- *For the commercial product line:* Use Table EDU-Comm-PPV.

Step 3 Identify the base PPV risk weight for each member using the following tables.

- For the Medicare product line: Use Table EDU-MA-PPV.
- For the commercial product line: Use Table EDU-Comm-PPV.

Step 4 Sum all PPV weights associated with the member (i.e., HCC, age, gender, base weight).

Step 5 Calculate the predicted probability of each member having at least one visit based on the sum of the weights for each member using the formula below.

$$\text{PPV} = \frac{e^{(\sum \text{PPV WeightsForEachMember})}}{1+e^{(\sum \text{PPV WeightsForEachMember})}}$$

Note: *The risk adjustment tables will be released on November 2, 2015, and posted to www.ncqa.org.*

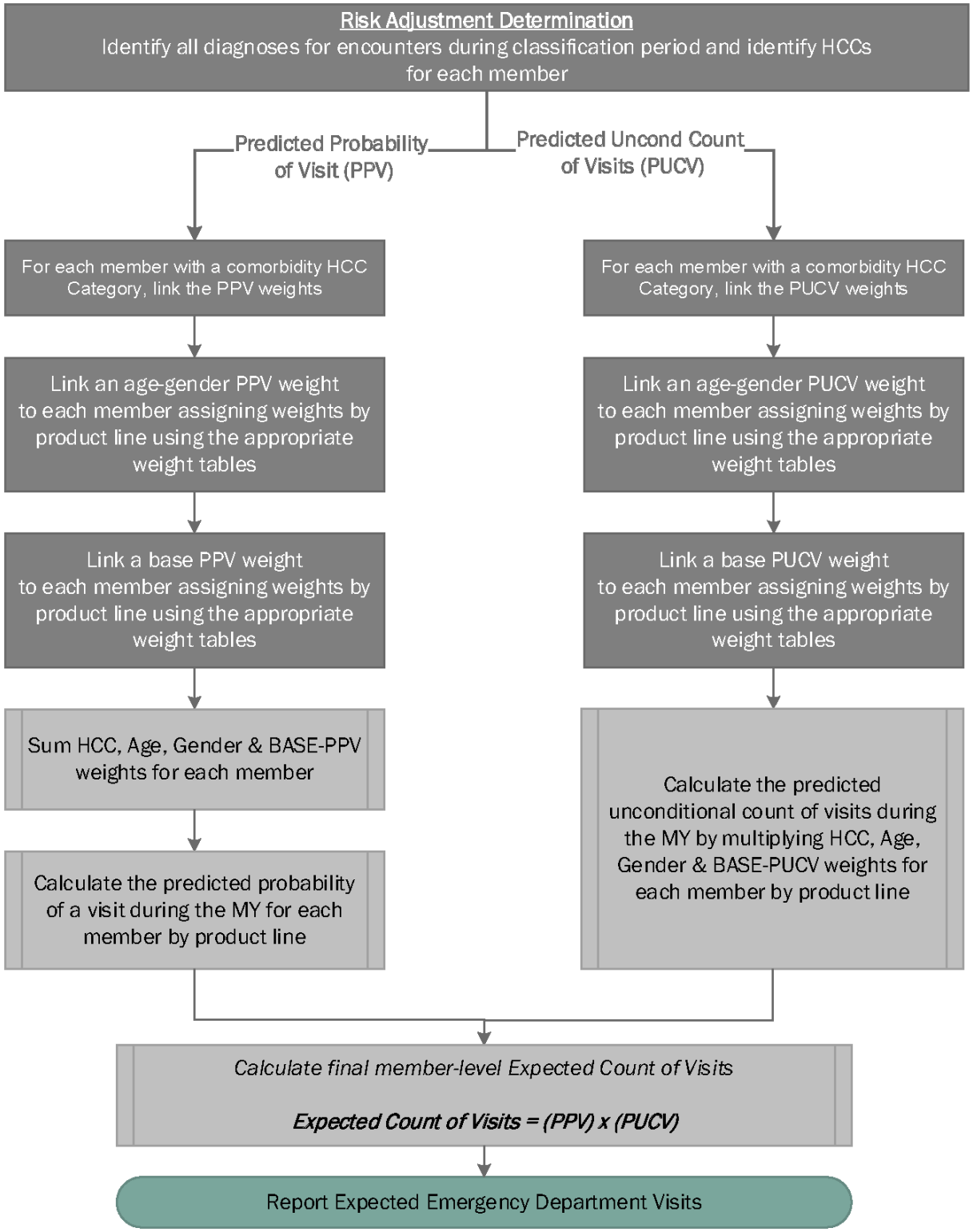
For each member in the eligible population, assign PUCV risk weights.

Step 1	For each member with a comorbidity HCC Category, link the PUCV weights. • *For the Medicare product line:* Use Table EDU-MA-PUCV-ComorbidHCC. • *For the commercial product line:* Use Table EDU-Comm-PUCV-ComorbidHCC.
Step 2	Link the PUCV age-gender weights for each member using the following tables. • *For the Medicare product line:* Use Table EDU-MA-PUCV. • *For the commercial product line:* Use Table EDU-Comm-PUCV.
Step 3	Identify the base PUCV risk weight for each member using the following tables. • *For the Medicare product line:* Use Table EDU-MA-PUCV. • *For the commercial product line:* Use Table EDU-Comm-PUCV.
Step 4	Calculate the predicted unconditional count of ED visits in the measurement year, by multiplying all PUCV weights (i.e., HCC, age, gender, and base weight) for each member together. Use the following formula *PUCD = Base Weight * Age/gender Weight * HCC Weight* ***Note:*** *Multiply by each HCC associated with the member. For example, assume a member with HCC-2, HCC-10, HCC-47. The formula would be*: *PUCV = Base Weight * Age/gender Weight * HCC-2 * HCC-10 * HCC_47*
Expected count of hospitalization	Report the final member-level expected count of ED visits for each category using the formula below: Expected Count of ED Visits = PPV x PUCV

Note: *Organizations may not use Risk Assessment Protocols to supplement diagnoses for calculation of the risk adjustment scores for this measure. The EDU measurement model was developed and tested using only claims-based diagnoses, and diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.*

Risk Adjustment Weighting Process

Attachment B:



Reporting: Number of Members in the Eligible Population

The number of members in the eligible population for each age and gender combination and enter these values into the reporting table (Table EDU-A-2/3).

Reporting: Number of Observed Events

The number of observed ED visits within each age and gender group and the overall total.

Reporting: Observed Visits per 1,000 Members

The number of observed ED visits divided by the number of members in the eligible population, multiplied by 1,000 within each age and gender group and the overall total.

Reporting: Number of Expected Events

The number of expected ED visits within each age and gender group and the overall total.

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Appendix G: Evaluation and Management (E&M) Claims in Hybrid Payment

CPT	E&M OFFICE VISTS 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)

Note: *CPT stands for Current Procedural Terminology.*

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