Center for Medicare and Medicaid Innovation
Comprehensive Primary Care Initiative
ACP Summary: Updated September 29, 2011

On September 28, 2011 the Centers for Medicare & Medicaid Services (CMS) Innovation Center announced a new initiative intended to foster collaboration between public and private health care payers to strengthen primary care in the U.S.—the Comprehensive Primary Care (CPC) Initiative. The CPC initiative extends and builds upon the patient-centered medical home (PCMH) concept (as defined by the Joint Principles of the Patient-Centered Medical Home) to include payment reform to support practice transformation. In addition, the initiative is intended to achieve the three-part aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care within primary care. Five functions have been identified as forming the framework for comprehensive primary care:

1. Risk-stratified Care Management;
2. Access and Continuity;
3. Planned Care for Chronic Conditions and Preventative Care;
4. Patient and Caregiver Engagement;
5. Coordination of Care Across the Medical Neighborhood.

To kick off this 4 year initiative, the CMS Innovation Center has invited other payers, including commercial insurers, Medicare Advantage plans, the states (via Medicaid, state employees programs, or other insurance purchasing), Medicaid managed care plans, and self-insured businesses, to apply for participation. Payers will be selected based on the alignment of their proposal with the Innovation Center's goals, their impact within a market, and their geographic locations. CMS expects to enter into Memoranda of Understanding with payers in 5 to 7 markets across the country. Once these payers and markets are identified, the Innovation Center will then solicit applications from primary care practices that wish to participate in the initiative. It is expected that approximately 75 practices will be selected in each market. Additional information about this initiative is summarized below.

Payer Eligibility Criteria

As noted above, payers may be commercial insurers, Medicare Advantage plans, states (through the Medicaid program, state employees program, or other insurance purchasing), Medicaid managed care plans, state or federal high risk pools, self-insured businesses, or administrators of a self-insured group. To be eligible, payers must meet the following requirements:

1. **Payers must commit to enter into compensation contracts with primary care practices selected for the initiative. All practices selected must support the five comprehensive primary care functions (listed above and described in detail in Section E of the CPC Initiative solicitation—http://innovations.cms.gov/documents/pdf/cpc_initiative_solicitation.pdf). The method of enhanced, non-visit-based support proposed by payers must**

enable the primary care functions to be delivered at the point of care and integrated into the practice workflow.

- On behalf of Medicare fee-for-service beneficiaries, the Innovation Center will pay an average $20 per-beneficiary-per-month for the first two years of the initiative (PBPM) care management payment to participating practices in addition to traditional fee-for-service payments.
    - Note: All Medicaid fee-for-service PBPM payments provided with Innovation Center funding will go directly to providers on a monthly basis. A State Medicaid program that participates in the initiative must reimburse eligible practices 100 percent of the total computable amount of the Innovation Center funding; no amount may be withheld or otherwise remitted by providers to the States.
- The specific PBPM payments will range from $8 to $40 and will be risk-adjusted based on a one-time retrospective look at the three years of prior claims data and hierarchical condition category (HCC) scores.
    - The Innovation Center will risk adjust the care management fees for Medicare beneficiaries at the start of the initiative based on a retrospective look at two years of prior claims data and HCC scores for all Medicare beneficiaries in a market.
- In years 3 and 4 of the initiative, the Medicare PBPM fee for fee-for-service beneficiaries will be reduced to an average $15 (adjusted for local costs and respective reduction in the risk tiers) to reflect efficiencies gained and to shift reliance to accountable forms of payment (shared savings).
- Practices will have discretion to use this enhanced, non-visit-based compensation to support non-billable practitioner time, augment care teams (e.g. care managers, social workers, health educators, pharmacists, nutritionists, behavioralists) through direct hiring or community health teams, and/or invest in technology or data analysts.
- Collaborating private payers will be expected to make contributions through payment and/or embedded services to support the infrastructure necessary to accomplish the five comprehensive primary care functions.

2. **Payers must commit to enter into compensation contracts with primary care practices selected for this initiative that includes the opportunity for practices to qualify for shared savings (with the exception of Medicaid fee-for-service).**
    - Practices will be eligible to share in savings achieved for their Medicare fee-for-service beneficiaries in years two, three and four of the initiative.
    - The total amount of shared savings will be calculated at the market level (not the individual practice level) and then distributed to the practices based on a calculation that includes performance on practice level quality and utilization metrics, practice size, and practice level risk adjustment.

3. **Payers must share with CMS their attribution methodologies.**
    - The Innovation Center is proposing to use a prospective alignment methodology to identify the population of Medicare fee-for-service

beneficiaries for whom primary care practices within a market are accountable for care and costs in this initiative.

- CMS will provide each practice with a list of its claims-based aligned patients prior to the start of the initiative and each performance year.
- The beneficiary alignment algorithm will be run every 3 months, adjusting corresponding PBPM amounts, with reports provided to the practice within 15 business days of the end of the look back period and applicable to payments starting 30 days after the end of the look back period.
- Practices will be required to inform their patients in writing of their involvement in this initiative, and the changes their practice has made or is undertaking to provide comprehensive primary care and better serve their needs.
- CMS plans to encourage participating practices to deliver the annual wellness visit (AWV) or initial preventive physical examination ("Welcome to Medicare Visit") to all eligible patients as an opportunity to not only obtain a comprehensive health history and identify those at high risk, but also to share information regarding the practice's more comprehensive approach to primary care, including office hours and access and care coordination features.
- At all times during the initiative, Medicare beneficiaries will remain free to select the providers and services of their choice. The CPC initiative does not include any restrictions on or changes to Medicare fee-for-service benefits, nor does it include provisions for beneficiaries to opt out of alignment with a participating provider for purposes of expenditure calculations and quality performance measurement.

- Payers may elect to use our methodology or describe their own approach to identifying members served by practices

4. **Payers must be willing to provide participating practices with aggregate and member-level data about cost and utilization for their members receiving care from practices participating in the initiative, at regular intervals**
   - CMS will provide cost and utilization data on Medicare fee-for-service beneficiaries aligned to primary care practices selected for this initiative.
   - Data provided to the practices will include historical cost and utilization, quarterly reports on services and financial expenditures, and annual reports on per-capita expenditure and quality.
   - Payers could propose a common platform for sharing data with practices through an existing multi-payer database, payer health information exchange or other capable data system within a market.
   - Payers could also propose creating alignment with the Innovation Center (and other payers in the market) on the structure, format, and schedule of sharing data with practices

5. **Payers must be willing to align quality, practice improvement and patient experience measures with the Innovation Center and other payers in their market for purposes of monitoring implementation milestones, quality improvement, and patient experience of care from practices participating in this initiative**
    - The Innovation Center will seek to align with other CMS and HHS initiatives such as the Physician Quality Reporting System, the Shared Savings Program, the Medicaid Health Home Initiative, the Federal Interagency Workgroup on Health Care Quality, and quality measures required by the Medicare and Medicaid EHR Incentive Programs for meaningful use of health information technology.
    - These measures to be used will include the domains:
        - Patient experience
        - Care coordination
        - Preventive health
        - At-risk populations
    - For purposes of distributing shared savings, CMS will use no more than 25 measures.
    - The Innovation Center hopes that market-level discussions will drive harmonization of quality measures and reduce administrative burden to participating practices

6. **Payers must provide information on the markets in which they are interested in participating**
    - The Innovation Center is interested in testing this model of comprehensive primary care in diverse environments with strong multi-payer support and alignment.

The Innovation Center will ultimately be selecting 5 to 7 markets where there is sufficient interest from a number of payers to support a comprehensive model of primary care.

Coordinated Actions to Support the CPC Model: Market-Level Discussions

After the Innovation Center has selected the five to seven markets, it will invite all willing and eligible payer applicants to participate in market-level discussions. The Innovation Center will also invite local practitioner representatives and local patient and consumer representatives to participate in these discussions with Medicare.

The objective of the market-level discussions is to agree on:

- A common approach to data sharing, and
- A common approach to monitoring implementation milestones and quality improvement through aligned metrics.

The participants of these discussions will also have an opportunity to inform the selection criteria and process that the Innovation Center will use to select practices for this Initiative. Of note is that pricing of health care services by private payers is proprietary and will not be discussed in market-level conversations or publicly disclosed by the Innovation Center

Payer Agreements and Timeline

After market-level agreement has been reached, the Innovation Center will enter into a Memorandum of Understanding with each payer that outlines roles, responsibilities, and defines our shared commitment to practices selected as part of this agreement. The payers will not be required to enter into agreements with each other, though the content of the Memorandum of Understanding between the Innovation Center and each payer will be consistent within each market. The Memorandum of Understanding will include:

1. A commitment to perform what each payer proposed in its application (and any attachments) to the Innovation Center; and
2. Common approaches to data sharing and quality measurement.

The Memorandum of Understanding will not include information about the pricing of health care services. In addition, it is important to note that no federal funds will be obligated in the Memoranda of Understanding. The Innovation Center will not provide financial support to payers, and will only provide financial support to primary care practices within markets that the payers will also be supporting. After agreement has been reached with all willing participating payers in a market, the selection of primary care practices will begin.

Payers interested in submitting applications for the CPC Initiative must submit a letter of intent and a completed Microsoft Excel table (i.e., the Geographic Service Area worksheet) via email to CPCi@cms.hhs.gov. **All letters of intent must be received by 5:00pm EST on November 15, 2011. Letters of intent will only be accepted via email.**

The CPC initiative payer application will then be available through an online portal beginning in November 2011. Payers that submit a timely letter of intent will receive a link and account details to access the application. Applications will be accepted only via the online portal. All applications must be submitted by **5:00 pm EST on January 17, 2012.**

Primary Care Practice Eligibility

For practices to be eligible for the Comprehensive Primary Care initiative, they must meet the following criteria.

1. A practice must be a primary care practice and as such:
    a) Provide the first point of contact for patients and ongoing care.
    b) Be led by a board-certified general practitioner, internist, family physician, geriatrician or advanced practice nurse (as allowed by state law).
    c) Composed of predominantly, but not necessarily exclusively, primary care providers, defined as one of the following: a physician who has a primary specialty designation of family medicine, internal medicine, or geriatric medicine; a nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60% of allowed charges under the Physician Fee Schedule (as outlined in the codes listed below).
        - Note: Clarification is needed from CMS as to whether the denominator for the 60% calculation includes all fee schedule services, or all fee schedule services minus allowed charges for

hospital and emergency department E/M services. The latter approach was taken for the Medicare Primary Care Bonus program and is strongly recommended by ACP, so as not to unfairly exclude many office-based general internists who derive revenue from in-office laboratory services and other ancillary procedures, or who bill for hospital visits to their patients.

   d) Provide predominantly, but not necessarily exclusively, primary care services. These services may include those denoted by the following codes: 99201-99215; 99304-99318; 99324-99340; 99341-99350; GO402, G0438, and G0439; 99241-99245; 99354-99355; 99358-99359; 99381-88387; 99391-99397; 99401-99404; 99406-99409; 99411-99412; 99420; 99429; 99374-99380; and G0008-G0010.
   e) May have multiple sites as long as these sites function as an integrated entity with centralized decision making, shared office space, facilities, clinical records, equipment, and personnel.

2. Have National Provider Identifiers (NPIs) and Tax Identification Numbers (TINs).
3. Be geographically located in a selected market.
4. Have at least 60% of their revenues generated by payers participating in this initiative.
5. Have a minimum of 200 eligible non-institutionalized Medicare beneficiaries, who are eligible for Part A and enrolled in Part B, but who are not enrolled in a Part C plan, Medicare Cost Plan, Demonstrations Plan, or PACE Plan, and who do not have end-stage renal disease (ESRD). Medicare must be the primary insurer for these beneficiaries.
6. Use an electronic health record (EHR) system or electronic registry, ideally one that has achieved stage 1 meaningful use and is certified by the Office of the National Coordinator for Health IT (see "Primary Care Practice Selection Process" below for more details).

In addition, each primary care provider must be exclusively affiliated with one primary care practice for purposes of beneficiary alignment. CMS will use claims data to determine where beneficiaries received the plurality of their primary care services and attribute them to that practice and therefore must be able to align patients to a single practice and group of providers. Services billed by the providers in the practice must be able to be uniquely and accurately assigned to their practice.

The CPC initiative is designed to model payment reform for traditional fee-for-service reimbursement. Practices that do not submit claims on a Medicare Physician/Supplier claim form (HCFA 1500) and that are not paid according to the Medicare Physician Fee schedule for routine office visits, such as federally qualified health centers, are <u>not</u> eligible for participation.

Primary Care Practice Selection Process

CMS notes that, during the market-level discussion, payers and stakeholders will have an opportunity to inform the Innovation Center's practice selection criteria and review process.

In addition, the Innovation Center is employing a selection criterion for health information technology. The Innovation Center will first review applicants that have achieved stage 1 meaningful use in the Medicare EHR Incentive Program. If there is not a sufficient number of practices within a market that meet this criterion, only then will they review applicants that have a certified EHR (as defined by the Office of the National Coordinator for Health IT) and have registered with their local Regional Extension Center. Practices that do not use a certified EHR system or electronic registry are not eligible for this initiative.

The Innovation Center will use a practice application to identify practices to participate in the initiative. In addition to recruiting practices for the intervention, they may also recruit practices for a comparison group for evaluation purposes. In constructing a comparison group, providers will be selected in a deliberate way so that they match the awardees along a variety of measurable dimensions, including but not limited to provider and market specific characteristics. The application will request information about practice characteristics and readiness to provide comprehensive primary care in the five functional areas:

1. Risk-stratified Care Management;
2. Access and Continuity;
3. Planned Care for Chronic Conditions and Preventative Care;
4. Patient and Caregiver Engagement;
5. Coordination of Care Across the Medical Neighborhood.

These functional areas are described in more depth in Section E of the CPC Initiative solicitation (http://innovations.cms.gov/documents/pdf/cpc_initiative_solicitation.pdf).

Primary Care Practice Exclusions

The Medicare Shared Savings Program (MSSP), established under Section 3022 of the Affordable Care Act, will offer accountable care organization (ACO) incentives to produce improvements in three-part aim outcomes for their Medicare fee-for-service patients through payment arrangements of shared savings and shared financial risk. The law states that providers that participate in a model being tested under section 1115A of the Social Security Act that involves shared savings is not eligible to participate in the MSSP. Therefore, practices participating in the Comprehensive Primary Care initiative will NOT be able to jointly participate in MSSP. The Pioneer ACO Program, an Innovation Center initiative, will test an approach to shared risk that transitions payment away from traditional fee-for-service to a population-based payment. Practices participating in the Pioneer ACO program also will NOT be eligible to participate in this initiative.

In addition to its ACO initiatives, CMS also has several initiatives to test models that include the patient-centered medical home or enhanced primary care. Primary care providers and practices participating in the following programs may NOT participate in the CPC initiative and practices currently enrolled in these programs will not be permitted to withdraw from one of these programs to enroll in CPC initiative:

- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home
- Medicare High Cost Demonstration

- Multi-payer Advanced Primary Care Practice Demonstration
- Physician Group Practice Demonstration

Practices that serve as a Medicaid Health Home (Section 2703 of ACA) will be eligible to participate in the CPC initiative as long as they also meet the eligibility criteria for this initiative.

Primary Care Practice Agreements and Requirements

Agreements:

The Innovation Center will enter into an agreement with selected practices that include terms and conditions of participation. Practices will be monitored continuously, and the Innovation Center reserves the right to terminate its participation with practices that are not performing according to the requirements established at the outset of the initiative. Payers and practices will enter into agreements of their own with the practices.

Monitoring:

The purpose of monitoring is to ensure that implementation is occurring safely and appropriately at the practice level, and that adequate patient protections are in place. The Innovation Center will monitor primary care practices participating in this initiative to ensure that access to care is not being compromised, that practices are either building or have built the capacity and infrastructure to deliver comprehensive primary care, and that the Innovation Center is receiving data from practices demonstrating their engagement in continuous improvement.

The Innovation Center will monitor the program on a continuous basis with performance and outcome ―gates" for practices at six month intervals:

- At six months – practices provide documentation that key implementation infrastructure (e.g., staff, equipment, etc.) is in place. This might be accomplished through a practice readiness assessment survey.
- At 12 and 18 months – payers sharing data with the practices, practices reporting measures and on improvement path. This might be accomplished through tracking practice participation in learning sessions.
- At 24 months, and every 6 months thereafter – practice Medicare patients' cost and utilization trends compared to market target and an evaluation of process and quality measures.

From year 2 on, the Innovation Center may discontinue its participation agreement with any practice failing to meet these requirements, or any market in which the majority of practices are failing to meet these requirements.

Shared Learning:

The Innovation Center will require selected primary care practices to actively participate in shared learning opportunities. The Innovation Center will test various approaches to group learning and exchange, helping program participants to effectively share their experiences, track their progress and rapidly adopt new ways of achieving

improvements in quality, efficiency and population health for Medicare, Medicaid and CHIP beneficiaries.

The Innovation Center expects participating payers to support learning systems and technical assistance to practices at the market level. And they will also support shared learning amongst payers as to how best to support transformation of primary care.

Evaluation of the Initiative

The Innovation Center will hire an independent contractor to evaluate the impact of this initiative on health, care experience and costs. Collaborating payers must agree to cooperate in an independent formal evaluation of the demonstration by an evaluation contractor, including submission of cost and other program data and making relevant staff of participating organizations available for site visits and/or phone calls conducted by the Innovation Center and/or its contractor.

The evaluation of the CPC initiative will inform any decision by the Secretary to expand through rulemaking the duration and scope of the model.

SOURCE: CMS Innovation Center Solicitation for the Comprehensive Primary Care Initiative (http://innovations.cms.gov/documents/pdf/cpc_initiative_solicitation.pdf). Accessed on September 29, 2011.