

Summary of the CMS Innovation Center Comprehensive Primary Care (CPC) Initiative

On September 28, 2011, the Center for Medicare and Medicaid Innovation announced the Comprehensive Primary Care Initiative to test a multi-payer care payment reform to strengthen primary care practices. Five to seven markets will be selected from across the country, and in each of those markets, 75 primary care practices will be selected to participate for four years. Full information is available at: <http://www.innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/cpci/>

Medicare and Medicaid Support for Participating Physician Practices:

Monthly, Non-Visit-Based Payments to PCPs for Medicare Beneficiaries: Participating Primary Care Practices will receive a monthly care management payment for each “aligned” Medicare beneficiary receiving primary care from the practice. Practices will have flexibility to use this payment for any kinds of services or activities that will improve patient care. The care management payment will range from \$8 to \$40; the actual amount for a patient will be based on a combination of that patient’s prior expenditures and the number of health conditions the patient has. The payment is expected to average \$20 per beneficiary per month in Years 1 and 2 of the Initiative, and then be reduced to an average of \$15 per beneficiary per month in Years 3 and 4.

Monthly Payments to PCPs for Medicaid Recipients: The Innovation Center will also make funding available to states to make monthly care management payments to the participating Practices for Medicaid fee-for-service recipients (i.e., not for Medicaid recipients in managed care plans). No state match required, but payments must be in addition to any existing Medicaid care management payments. The amount of the payment is not specified; states are asked to propose an amount that they are prepared to share in the cost of *after* the Initiative ends.

Bonus Payments Based on Market-Wide Savings for Medicare: Primary Care Practices will be eligible for a bonus “shared savings” payment in Years 2-4 of the Initiative. CMS will calculate whether the total Medicare Part A and Part B spending for all of the aligned beneficiaries in *all* of the participating practices in a Market is lower than would otherwise be predicted; Primary Care Practices will receive a share of the savings based on each Practice’s performance on quality measures, using a formula that will be consistent with what is used for Accountable Care Organizations. There will be no shared savings bonus for Medicaid recipients.

Which Medicare Beneficiaries Are Included: A Practice will receive a monthly payment for a Medicare beneficiary if the plurality of primary care expenditures on that beneficiary during the prior 24 months were for services provided by that Practice (these will be referred to as the “aligned beneficiaries”). A Practice will not be paid for a new patient until the patient has received a plurality of primary care services from the Practice. Even if a patient leaves the Practice, the Practice will still be paid for that patient (and be held accountable for all spending associated with the patient) until the alignment calculation assigns them to a different PCP.

Data Sharing: The Innovation Center will provide data to participating Primary Care Practices on the cost and utilization of services by their aligned patients. This could be done directly or through a state/regional multi-payer database.

How Communities Will Be Selected

Primary Care Practices will only have an opportunity to participate in this Initiative if the “Market” where they are located is first selected to participate. A Market can be a Metropolitan Statistical Area, a county, a group of zip codes, or combination thereof, but a Market cannot cross state lines. CMS will select Markets based in part on how many of the other payers (commercial insurers, Medicare Advantage plans, state Medicaid programs, self-insured businesses, etc.) in the Market agree to pay participating Primary Care Practices on a basis *similar* to the methodology Medicare plans to use. Payers will be expected to provide Practices with (a) some kind of non-visit based payment or support (CMS explicitly allows Payers to place their own staff in Practices rather than pay the Practices to hire staff themselves), and (b) some method of sharing savings. Payers will also be expected to commit to sharing data on cost and utilization with Practices, such as through a multi-payer database.

The Innovation Center will use an eight step process for selecting participating Markets:

Step 1: Submission of Letters of Intent from Non-Medicare Payers. Payers must submit Letters of Intent by 5:00 p.m. ET on November 15. The Letter of Intent is not binding in any way, but if a payer does not submit a Letter of Intent by the deadline, it cannot submit an Application in Step 2 and this could reduce the chances of a Market being selected. The only information that needs to be provided in the Letter of Intent is a list of the geographic areas where the Payer has provider networks and is considering participating.

Step 2: Submission of Applications by Non-Medicare Payers. Payers must submit an Application by 5:00 p.m. ET on January 17, 2012. The Application is also not binding, i.e., it does not contractually commit a payer to participate in the Initiative or to change its payments for primary care practices, but it defines what the payer is at least prepared to commit so that CMS can determine whether there are enough committed payers in a Market to move to later steps in the selection process. In the Application, a payer must describe (1) the Market(s) in which it is willing to participate, (2) the payment model it is prepared to use to support Primary Care Practices that are selected to participate, (3) its plan for sharing data with Practices, (4) its willingness to align quality measures with other payers and CMS, and (5) its past involvement with multi-stakeholder efforts.

Step 3: Evaluation of Payer Applications. CMS will score each Payer's application on a 15 point scale based on (a) the extent to which the Payer's proposed payment methodology for Practices aligns with the Medicare payment methodology, (b) the Payer's willingness to share data with participating Practices, and (c) the Payer's past work with Regional Health Improvement Collaboratives and other multi-stakeholder initiatives. Only applications that score 11 or higher will be considered further.

Step 4: Scoring of Markets. In each Market in which at least one Payer applies to participate, CMS will score the Market based on two factors (a) a weighted average of the scores from Step 3 of all of the participating Payers in that Market, with the weighting based on the relative number of patients covered by the Payer in that Market, and (b) the proportion of the residents in the region covered by participating Payers (including Medicare).

Step 5: Selection of Two Markets in Each HHS Region. The two Markets with the highest scores in each of the 10 HHS multi-state regions will then be chosen for further evaluation.

Step 6: Selection of 5-7 Markets Nationwide. The up to 20 Markets selected in Step 5 will be further evaluated based on (a) their Market Score from Step 5, (b) whether the State is participating (either through Medicaid or through the state employees insurance program or both), and (c) the proportion of primary care practitioners that are meaningful users of electronic health records in the Medicare EHR Incentive Program. CMS intends to have at least two Markets which have at least 50% of their Practices located in rural counties or Census tracts.

Step 7: Market-Level Discussions in Selected Markets. The Innovation Center will then invite all of the Payer Applicants in the chosen 5-7 Markets, along with representatives of healthcare practitioners and patient/consumer representatives, to develop a common approach to data sharing, a method of selecting participating Primary Care Practices, and a common approach to quality measurement/improvement.

Step 8: Memoranda of Understanding With Payers. After a "market-level agreement" has been reached, the Innovation Center will enter into a Memorandum of Understanding with each Payer in the Market defining the Payer's commitment to the payment methodology, data sharing, etc. they will use.

How Physician Practices Will Be Selected

Once the 5-7 Markets have been identified, a final method for selecting physician practices will be developed with input from the payers and stakeholders in those Markets. In order to participate, Practices must be located in the selected Market and have at least 60% of their revenue generated by participating payers. They will be required to use either an EHR or an electronic registry, and they will be selected based on an evaluation of their ability to provide comprehensive primary care via five core functions: (1) risk-stratified care management; (2) an assigned care team and 24/7 patient access; (3) planned care for chronic conditions and preventive care; (4) patient and caregiver engagement; and (5) coordination of care across the "medical neighborhood."

Physician practices participating in other CMS medical home and shared savings programs will not be eligible to participate in the Comprehensive Primary Care Initiative. Federally Qualified Health Centers will also not be eligible to participate. Practices may be dropped if they fail to meet implementation milestones.