

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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**Table of Contents**

<b>I. Background/General Information .....</b>	<b>3</b>
A. Scope.....	3
B. Statutory Authority .....	4
C. General Approach .....	5
D. Deadlines for Letter of Intent and Application .....	5
<b>II. Description of Comprehensive Primary Care (CPC) Initiative .....</b>	<b>6</b>
A. Purpose.....	6
B. The Comprehensive Primary Care Initiative and the Patient Centered Medical Home (PCMH) Concept.....	8
C. Definition of a Market.....	9
D. Innovation Center Collaborations with Public and Private Payers .....	9
1. Eligibility Criteria .....	9
2. Payer and Market Selection Process .....	13
3. Coordinated Action to Support Comprehensive Primary Care Model .....	16
4. Commitment to Ensuring Competitive Markets.....	17
5. Type of agreement.....	17
6. States .....	18
E. Comprehensive Primary Care Functions.....	18
F. Enhanced Support for Comprehensive Primary Care Functions.....	20
1. Payment for Medicare Fee-for-Service Beneficiaries.....	21
2. Payment for Medicaid Fee for Service Beneficiaries.....	22
3. Dual Eligible Beneficiaries .....	24
4. Medicare Beneficiary Alignment for Monthly Care Management Fee .....	25
5. Risk Adjustment .....	26
G. Data Sharing, Program Monitoring, and Reporting .....	26
1. Data Sharing .....	26
2. Program Monitoring.....	27

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

---

3. Quality and Patient Experiences of Care .....	28
H. Shared Learning .....	29
<b>III. Evaluation .....</b>	<b>29</b>
<b>IV. Payer Application—Content Outline .....</b>	<b>29</b>
A. Description of Payer .....	30
B. Proposed Market(s).....	30
C. Primary Care Support.....	30
D. Data Sharing .....	30
E. Implementation Milestones and Quality Improvement Measures .....	30
F. Involvement in Multi-payer/Multi-stakeholder Efforts.....	30
G. Participation in Other Initiatives.....	30
<b>V. Application Submission Information.....</b>	<b>31</b>
<b>VI. Application Review Process .....</b>	<b>31</b>
<b>Appendix I: Primary Care Practice Eligibility, Selection and Agreements ..</b>	<b>32</b>
<b>Appendix II: Letter of Intent .....</b>	<b>35</b>
<b>Appendix III: Payer Application.....</b>	<b>38</b>

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

---

## **I. Background/General Information**

### **A. Scope**

There are many paths to a health care system focused on achieving the three-part aim of better health, better care, and reduced expenditures through improvement for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries; all of them will involve stronger primary care than we have now. Whether this enhanced primary care capacity comes to exist as a structurally integrated function of a broader delivery system or through a free standing capacity, success will require a coordinated approach to both practice and payment re-design. Many payers share our interest in strengthening primary care, yet support by any one payer has only a limited impact within a primary care practice. Leveraging the efforts of multiple payers has the potential to transform primary care practices and achieve the three-part aim.

The Comprehensive Primary Care (CPC) initiative will seek to strengthen free-standing primary care capacity by testing a model of comprehensive, accountable primary care supported by multiple payers. In order to fully test the ability of this model to achieve the three-part aim, the Center for Medicare and Medicaid Innovation (Innovation Center) at the Centers for Medicare and Medicaid service (CMS) is soliciting other payers, including Medicaid and the states, that are also interested in investing in comprehensive primary care focused on continuous improvement.

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; and
- 5) Coordination of care across the medical neighborhood.

Building on the "medical home" concept, the CPC initiative intentionally aligns multi-payer payment reform with practice transformation, holding practices accountable for total cost of care. Under this initiative, practices will be able to engage in systematic data sharing and collaborative learning experiences and will also have an opportunity to share savings achieved at the market level as a result of participation. CMS is seeking to collaborate with other payers in five to seven

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

---

markets, with approximately 75 practices in each market, and serve up to 330,750 Medicare and Medicaid beneficiaries over the course of this four-year initiative.

This solicitation is directed to public and private health care payers who will respond individually to the Innovation Center. The Innovation Center will collaborate with payers interested in using a coordinated multi-payer approach to support enhancements in primary care at practice sites in selected market areas. Once payers and markets have been selected (described in detail in [Section D](#)), practices will be recruited and selected in each of these markets.

**B. Statutory Authority**

Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act (ACA)) authorizes the Innovation Center to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care (42 U.S.C. 1315a). Under the law, preference is to be given to models that improve coordination, efficiency and quality. Suggested models referenced in section 1115A(b)(2)(B)(i) in the statute include those "promoting broad payment and practice reform in primary care." Section 1115A(b)(2)(C) of the statute also encourages the Innovation Center to consider the following:

- "(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.
- (ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.
- (iii) Whether the model provides for in-person contact with applicable individuals.
- (iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.
- (v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

---

(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

(viii) Whether the model demonstrates effective linkage with other public sector or private sector payers.”

The CPC initiative incorporates all of these elements. Through this initiative the Innovation Center will use its authority to test alternative models for payment; provide technical support to promote comprehensive primary care; engage and protect beneficiaries; and facilitate learning and diffusing best practices. The evaluation of the CPC initiative will inform any decision by the Secretary to expand through rulemaking the duration and scope of the model, as specified under Section 1115A(c).

### **C. General Approach**

The purpose of this initiative is to achieve the three-part aim within primary care. To date, medical home models have tended to focus on care processes, health outcomes and patient and provider satisfaction, with only limited attention to the underlying payment environment. By intentionally aligning multi-payer payment reform with practice transformation, this initiative represents a significantly more robust pathway to the three-part aim than has so far been modeled for primary care practices. Under this four-year initiative, CMS will make enhanced payments to primary care practices for up to 330,750 Medicare and Medicaid beneficiaries, in the context of a collaborative multi-payer environment within five to seven defined geographical markets. Participating primary care practices will be free to choose how they use the enhanced funding, provided they invest within the framework of the five comprehensive primary care functions listed above. The initiative will incorporate systematic data sharing with practices about cost and utilization, common quality metrics and learning and diffusion activities.

### **D. Deadlines for Letter of Intent and Application**

This solicitation is for public and private health care payers. Primary care practices will be recruited and selected after markets have been defined; eligibility requirements for primary care practices are outlined in [Appendix I](#); final practice applications will be developed in consultation with relevant stakeholders in the selected markets.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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Letter of Intent: Interested payers must submit a letter of intent (LOI) and a completed Microsoft Excel table attachment via email to [CPCi@cms.hhs.gov](mailto:CPCi@cms.hhs.gov) by **5:00 PM EST on November 15, 2011** using the LOI template provided in [Appendix II](#). The LOI template is provided in Appendix II and the formatted Microsoft Excel table is available on the Innovation Center website: <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/cpci/>. The purpose of the letter of intent is to allow CMS to understand the level of interest from payers and the geographic spread of potential multi-payer collaborations. The letter of intent will be used only for planning purposes only and will not be binding. Applications from payers that do not submit a timely letter of intent will not be considered.

Applications: The CPC initiative payer application will 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**. The questions that will be asked in the online application are provided in [Appendix III](#) for your information. CMS reserves the right to request additional information from applicants in order to assess their applications.

CMS considers all information submitted in the Letter of Intent and Application as exempt under the Freedom of Information Act. Therefore, CMS will not release this information to the general public. If you are selected to participate in this initiative, CMS may release publicly available demographic information (e.g. name, location, etc.) for informational purposes.

Limitations on Amount of Federal Financial Support: The Innovation Center expects to enter into a Memorandum of Understanding (MOU) with each individual participating payer. The Innovation Center will not provide financial support to payers, but to primary care practices within markets that the payers will also be supporting.

## **II. Description of Comprehensive Primary Care (CPC) Initiative**

### **A. Purpose**

The Comprehensive Primary Care (CPC) initiative will provide a new opportunity for multiple payers to support augmented, high-performing primary care. The Innovation Center will collaborate with payers that are currently providing, or willing to provide, enhanced support above and beyond visit-based fee-for-service

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

---

(FFS) payments (e.g., care management fees, or other non-visit-based and non-volume-based compensation, incentives for effective stewardship of resources, etc.) for primary care practices in their networks. Each payer applying for this initiative will propose a strategy that is aligned with the Innovation Center's to support these fundamental elements of comprehensive primary care aimed at reducing total health system costs while achieving better health and improved experience of care. Selected markets will be comprised of areas in which a preponderance of payers has offered aligned strategies.

The Innovation Center will invite primary care practices to apply to participate in this Initiative in a separate solicitation. We will seek the participation of practices that agree to provide comprehensive primary care services to Medicare beneficiaries as well as those served by collaborating payers. In order for practices to effectively deliver comprehensive primary care, four fundamental elements must be in place:

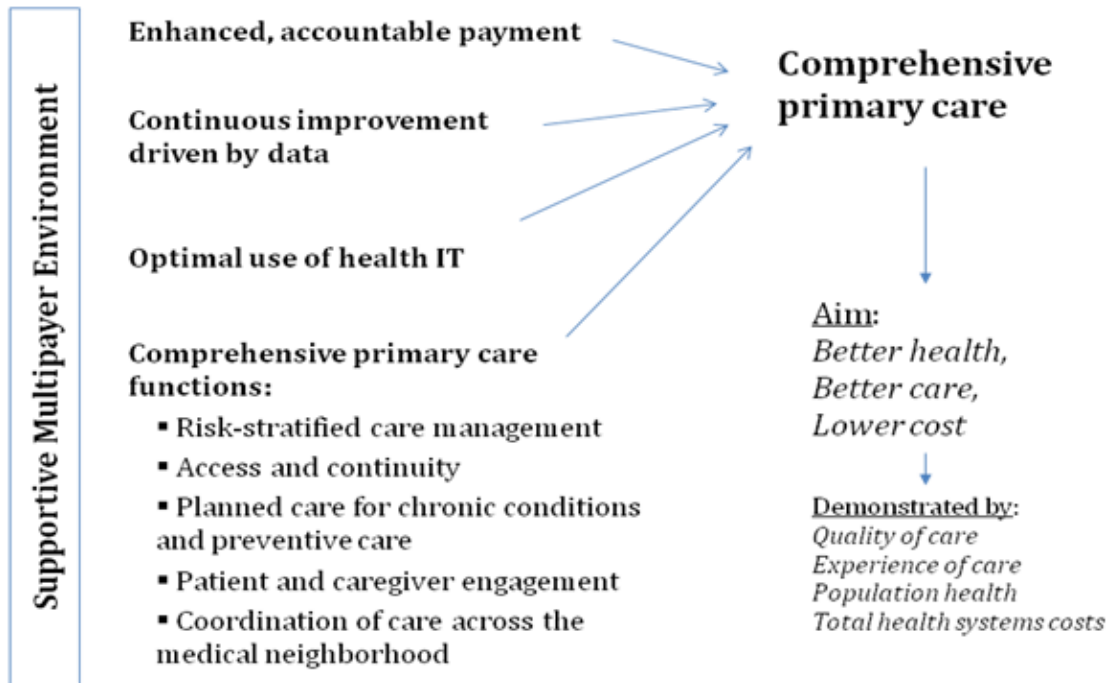
- 1) Enhanced, accountable payment;
- 2) Continuous improvement driven by data;
- 3) Optimal use of health IT; and
- 4) A set of five comprehensive primary care functions.

(See [Figure 1](#) for a graphical description).

The goals of the CPC initiative are:

- To collaborate with other payers to encourage those payers to develop and implement supporting strategies aligned with the strategies under the CPC initiative for comprehensive primary care services provided by practices participating in the initiative.
- To test whether a set of comprehensive primary care functions, coupled with payment reform, use of data to guide improvement, and meaningful use of health information technology can achieve the three-part aim of better care, improved health, and reduced costs that could ultimately be adopted by Medicare and Medicaid.

**Figure 1. Theoretical Framework for Comprehensive Primary Care initiative**



**B. The Comprehensive Primary Care Initiative and the Patient Centered Medical Home (PCMH) Concept**

The Comprehensive Primary Care initiative extends and builds upon the patient-centered medical home concept (as defined in the *Joint Principles of the Patient-Centered Medical Home*, by ACP/AAFP/AAP/AAOP, by the NCQA and others) to include payment reform to support practice transformation, an explicit focus on accountability for total cost of care with data to support care improvement and efficiency, and a requirement that all practices have an electronic health record system or electronic registry. Preference will be given to practices that have achieved stage 1 meaningful use of certified EHRs as defined by the Health Information Technology for Economic and Clinical Health (HITECH) Act. We are testing whether these additional drivers can deliver lower total costs through improvement for Medicare and Medicaid when implemented with the support of payer collaborations that comprise the majority of a practice’s revenue. Having a majority of a practice’s payers supporting enhanced primary care will ensure that a practice can implement a more consistent and comprehensive approach to treating patients. Without that majority, practices risk not having enough sustained support to provide the services we are seeking, and our investment – if not coordinated with other payers – will not be as likely to generate savings or improved services for beneficiaries.



Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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**C. Definition of a Market**

The final definition of a “market” will be based on the overlapping, contiguous geographic service areas of participating payers. To discern those geographic areas, applicants will be asked to propose a market using a combination of Department of Commerce Metropolitan Statistical Areas (MSAs), counties, and/or zip codes to describe the service area in which they are interested in participating in the CPC initiative. The use of MSAs is consistent with the Department of Justice, which has used MSAs as a basis for defining geographic markets for insurance company mergers<sup>1</sup>. For purposes of this initiative, the final definition of a market will remain within one state, but may span multiple MSAs and/or counties. The final boundary of a market cannot span two states. We will give preference to markets where the payers are interested in including rural counties in the final boundary of a market.

**D. Innovation Center Collaborations with Public and Private Payers**

**1. Eligibility Criteria**

The Innovation Center is interested in collaborating with other payers to support comprehensive, high-performing primary care.

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 (Third Party Administrator(TPA)/Administrative Service Only (ASO)). The Innovation Center believes that additional support for practices serving Medicaid fee-for-service beneficiaries is integral to building primary care capacity within practices selected for this initiative. As part of our solicitation process, we will invite state Medicaid programs to apply to participate in the multi-payer approach (see [Section F, part 2](#)). To be eligible, payers must meet the following requirements:

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<sup>1</sup> Improving Health Care: A Dose of Competition. Department of Justice and the Federal Trade Commission. July 2004. [http://www.justice.gov/atr/public/health\\_care/204694.pdf](http://www.justice.gov/atr/public/health_care/204694.pdf).

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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**a) Payers must commit to enter into compensation contracts with primary care practices selected for the initiative. All practices selected must support the comprehensive primary care functions described in [Section E](#). 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.**

*Innovation Center approach:* On behalf of Medicare fee-for-service beneficiaries, the Innovation Center will pay an average \$20 per-beneficiary-per-month (PBPM) care management payment to participating practices in addition to traditional fee-for-service payments. 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. In years three and four 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. Contingent upon a state's application, Medicaid fee-for-service may also be included in the Innovation Center's approach. See [Section F](#) for all Medicare and Medicaid details.

*Complementary, aligned approaches that we would expect from payer applicants:* Collaborating 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. We would expect that this support would include a level of risk adjustment. One approach could be to provide non-visit-based compensation such as a per-member-per-month (PMPM) care management fee. Another approach could be to provide direct support for services provided at the practice, such as embedded care managers, health educators or pharmacists. The Innovation Center is looking for methods of support that are not segmented by payer and can be integrated into the practice workflow.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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**b) 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.<sup>2</sup>**

*Innovation Center approach:* 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. Given the small numbers of patients associated with individual practices, we do not feel we can accurately calculate savings at the practice level. See [Section F](#) for details.

*Complementary, aligned approaches that we would expect from payer applicants:* Payers will be expected to provide the Innovation Center with a description of their approach to sharing savings with practices.

**c) Payers must share with CMS their attribution methodologies.**

*Innovation Center approach:* 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. See [Section F](#) for details.

*Complementary, aligned approaches that we would expect from payer applicants:* Payers may elect to use our methodology or describe their own approach to identifying members served by practices.

**d) 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.**

*Innovation Center approach:* 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

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<sup>2</sup> States will be exempt from this requirement for their Medicaid fee-for-service program.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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historical cost and utilization, quarterly reports on services and financial expenditures, and annual reports on per-capita expenditure and quality. The precise approach to data sharing is likely to vary by market, depending on the local data infrastructure available, but for operational purposes, the schedule of CMS data reporting will be consistent across markets. See [Section G](#) for details.

Complementary, aligned approaches that we would expect from payer applicants: 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.

**e) 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.**

Innovation Center approach: The Innovation Center will identify implementation milestones as well as measures within the domains of patient and caregiver experience, preventive health, care coordination and care transitions, and practice transformation. In doing so, we 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. We expect a subset of these measures will be “core” and used in each market, and a subset will be a “menu” and could vary by market.

Complementary, aligned approaches that we would expect from payer applicants: In recognition of the fact that there exists a variety of measure sources and lack of alignment on required measures across payers and programs, the Innovation Center hopes that market-level discussions will drive harmonization of quality measures and reduce administrative burden to participating practices.

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Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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**f) 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. To calculate the total interest within a market, we will need information about the lines of business and number of members (i.e. covered lives) covered by a payer within the geography the payer is proposing for this initiative.

**2. Payer and Market Selection Process**

Although this solicitation is directed to payers nationally, the Innovation Center will ultimately be selecting markets where there is sufficient interest from a number of payers to support a comprehensive model of primary care. Our selection process will start with scoring individual payer applications to evaluate the degree to which they align with our approach in this Initiative. High scoring payer applications proposing overlapping market areas will be aggregated to assess the expected market share of enhanced support for comprehensive primary care. Once markets have been selected and approved, all payer applicants within those markets that earned 11 points or greater, using the application scoring systems described below, will be invited to participate.

a) Alignment of Payer Proposal with Innovation Center Goals

In the first step of the selection process, each application will be evaluated and scored. There will be a total of 15 points available. Applications that score 11 or greater will be considered synergistic with our initiative, scores of 6-10 will need further refinement by applicants, and scores of 1-5 will be considered inadequate. Individual scores will not be released to payers. Scoring will be based on:

1. The extent to which each of the eligibility criteria (listed in [Section D](#)) are met and the degree to which they align with our approach in this Initiative; and
2. Past work with community quality collaboratives<sup>3</sup> and multi-stakeholder efforts. For example, has the payer participated in community-based

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<sup>3</sup> Community quality collaboratives are community-based organizations of multiple stakeholders, including health care providers, purchasers (employers, employer coalitions, Medicaid and others),

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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organizations of multiple stakeholders, including health care practitioners, purchasers (employers, employer coalitions, Medicaid and others), other health plans in the market, and consumer advocacy organizations, that are working together to transform health care at the local level? Examples of these organizations include regional health information organizations, regional health improvement initiatives, Chartered Value Exchanges, and Beacon Communities.

b) Weighted Payer Impact within a Market

Applications will then be clustered by market based on CPC initiative's ultimate definition of a market. Each applicant's score from step a) will be weighted by the ratio of the payer to the market applicants.

*Example:*

	<b>Number of covered lives in this market included in application</b>	<b>Weight</b>	<b>Score from step a)</b>	<b>Weighted payer impact score</b>
Applicant payer A	100	25%	13	3.25
Applicant payer B	200	50%	11	5.5
Medicare FFS	100	25%	N/A	N/A
<b>TOTAL</b>	<b>400</b>	<b>100%</b>	<b>N/A</b>	<b>N/A</b>

c) Market Impact

The Innovation Center will then assign each market a score, based on the total market penetration of all applicant payers, as follows: the Innovation Center will divide the number of lives covered by all payer applicants in the market plus the number of Medicare fee-for-service beneficiaries (numerator) by the total number of people living in the market, according to the best available Census MSA and tract data (denominator). This produces a penetration rate.

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health plans, and consumer advocacy organizations. The Agency for Healthcare Research and Quality (AHRQ) has a compendium of tools available at <http://www.ahrq.gov/qual/value/localnetworks.htm>.

Centers for Medicare & Medicaid Services  
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Solicitation for the Comprehensive Primary Care Initiative

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*Example (continued):*

$$\frac{\text{Medicare FFS} + \text{Payer A} + \text{Payer B}}{\text{All lives in market}} = \frac{400}{500} = 80\% \text{ penetration rate}$$

Each market will be assigned a market impact score according to the penetration rate, as follows:

Penetration rate	Market impact score
15-30%	1
30-39%	2
40-44%	3
45-49%	4
50-54%	5
55-59%	6
60-64%	7
65-69%	8
70-74%	9
75% or greater	10

*Example (continued):*

*80% penetration rate produces a collective market impact score of 10.*

d) Market Score Calculation

The Innovation Center will then calculate a score for each market which is the sum of all the weighted payer impact scores in b) above and the market impact score in c) above.

*Example (continued): Payer A payer impact score + Payer B payer impact score + collective market impact score = 3.25 + 5.5 + 10 = **18.75***

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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e) Geographic Selection

Market Impact Scores from d) above will be grouped into HHS regions and ranked from highest to lowest market impact score within each region. The markets with the highest and second-highest scores in each HHS region will move on to the final part of the selection process.

For the remaining markets competing for selection, additional points will be added to the Market Impact Score from d), as follows:

- Markets that include state participation will receive 2 extra points: “state participation” could mean the state applying to participate through Medicaid and/or the health plan(s) for public employees.
- Using the National Level Repository (NLR) database, the Innovation Center will evaluate the proportion of primary care practitioners within the remaining markets that have attested to meaningful use of electronic health records as part of the Medicare EHR Incentive Program. The 5 markets with the highest proportion of meaningful users of EHR will receive an extra 2 points.

Finally, the Innovation Center will use these scores to inform our recommendation of five to seven markets, with no more than two markets in an HHS region. Recommendations must be approved by the CMS Administrator and the Office of Management and Budget. We will aim to have at least two markets with significant rural areas (at least 50% of practices located in rural counties or rural Census tracts).

Once markets have been approved for selection, all payer applicants within those markets that earned 11 points or greater on their initial or amended application (not weighted) will be considered as meeting the eligibility criteria and invited to participate in the multi-payer initiative.

**3. Coordinated Action to Support Comprehensive Primary Care Model**

After the Innovation Center has selected the five to seven markets, the Innovation Center 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.



Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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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.

The resulting market-level approach will take into account the unique health system resources (such as the existence of a multi-payer database, payer health information exchange, or other capable data systems to support data sharing with practices or existing alignment of quality metrics). 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.

#### **4. Commitment to Ensuring Competitive Markets**

Competition in the marketplace promotes quality of care for Medicare beneficiaries and protects access to a variety of practitioners. The Innovation Center anticipates that this initiative's approach will stimulate a market-wide conversation among payers, providers, and community quality collaboratives. We encourage the parties to begin that conversation prior to submitting a response to this solicitation. We expect that all conversations among payers and providers would comply with antitrust law. Nothing in this solicitation shall be deemed to suspend any applicable antitrust laws or regulations, all of which still apply. The Innovation Center will consult with FTC and DOJ as necessary to minimize the potential of harm to competition. It is the objective of this initiative to maintain a competitive environment while providing an opportunity for healthy collaboration.

#### **5. Type of agreement**

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 participating payers should understand that this initiative will only work if all payers are committed to provide support in line with their proposal.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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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. After agreement has been reached with all willing participating payers in a market, the selection of primary care practices will commence.

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.

## **6. States**

The Innovation Center recognizes the importance of having states participate in multi-payer initiatives and wants to provide support to states consistent with our mission to serve Medicare and Medicaid populations. The Innovation Center will provide support through a PBPM care management fee for Medicaid fee-for-service beneficiaries utilizing or assigned to participating practices for the duration of this initiative (see [Section F, part 2](#) for details about conditions and restrictions). At the end of the four year initiative, the Innovation Center payment for monthly care management fees for Medicaid fee-for-service patients will cease. As part of their participation in this initiative, the Innovation Center would expect states to: 1) share data on cost and utilization; 2) collaborate with CMS in conversations with their states' Medicaid managed care organizations to encourage them to consider applying to participate in this initiative; and 3) commit to working with CMS in its evaluation of the initiative. The Innovation Center will work with states that have legacy data systems that may not be equipped to provide all of the data we aim to share in this Initiative to develop a modified or alternate approach. Shared savings will not be part of the payment methodology for Medicaid fee-for-service.

## **E. Comprehensive Primary Care Functions**

The Innovation Center has identified an evidence-based set of five core functions essential to comprehensive primary care:

### 1. Risk-stratified Care Management

One of the hallmarks of comprehensive primary care is the provision of intensive care management for high-risk, high-need, high-cost patients. Providers must

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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provide routine, systematic assessment of all patients to identify and predict which patients need additional interventions. In consultation with their patients, they should create a plan of care to assure care that is provided is congruent with patient choices and values. Once needs – including social needs and functional deficits – have been identified, they should be systematically addressed. Markers of success include policies and procedures describing routine risk assessment and the presence of appropriate care plans informed by the risk assessment.

## 2. Access and Continuity

Health providers who treat a patient should be accessible when a patient needs care. Providers must have access to patient data even when the office is closed so they can continue to participate in care decisions with their patients. Every patient should be assigned to a designated provider or care team with whom they are able to get successive appointments, and should have access to the patient care team 24/7. Markers of success include care continuity and availability of the EHR when the office is closed.

## 3. Planned Care for Chronic Conditions and Preventive Care

Primary care must be proactive. Providers must systematically assess all patients to determine their needs (e.g. through the annual wellness visit<sup>4</sup>) and provide proactive, appropriate care based on that assessment. Pharmaceutical management, including medication reconciliation and review of adherence and potential interactions, should be a routine part of all patient assessments. Markers of success include claims for the Annual Wellness Visit and documentation of medication reconciliation.

## 4. Patient and Caregiver Engagement

Truly patient-centered care assumes the mantra “nothing about me without me.” Providers should establish systems of care that include patients in goal setting and decision making, creating opportunities for patient engagement

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<sup>4</sup> Section 4103 of the Affordable Care Act (ACA) created the annual wellness visit for Medicare beneficiaries through which they are to receive a personalized prevention plan. The ACA also provides that certain insurers and group health plans cover preventive services recommended by the US Preventive Services Taskforce without cost sharing. Section 2713 of the Public Health Service Act.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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throughout the care delivery process. Markers of success include policies and procedures designed to ensure that patient preferences are sought and incorporated into treatment decisions.

5. Coordination of Care Across the Medical Neighborhood

The “medical neighborhood” is the totality of providers, related non-health services and patients in an area, and the ways in which they work together.<sup>5</sup> Primary care can be seen as the hub of the neighborhood and must take the lead in coordinating care. In particular, primary care providers must move towards leadership of health teams both within and outside their practice’s walls. Providers must have the ability to access a single medical record shared by the whole team; the content of this record can be leveraged to manage communication and information flow in support of referrals to other clinicians, transitions of care and when care is received in other health settings. Markers of success include the presence of standard processes and documents for communicating key information during care transitions or upon referral to other providers.

Through the market-level discussions with payers, local provider representatives, and local patient and consumer representatives, the Innovation Center will develop a common market-level approach to the implementation milestones and quality improvement strategies for the purpose of monitoring and evaluating achievement of the comprehensive primary care functions.

Some payers may have existing programs or contracts with practices to support certain aspects of comprehensive primary care functions (e.g., an embedded care manager for complex patients). Through the application process payers will have an opportunity to describe those existing investments.

**F. Enhanced Support for Comprehensive Primary Care Functions**

Collaborating payers will work with the Innovation Center to develop coordinated, enhanced support within defined markets for comprehensive primary care functions aimed at reducing total health system costs while achieving better health and

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<sup>5</sup> “Coordinating Care in the Medical Neighborhood” White Paper. Agency for Healthcare Research and Quality, June 2011.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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improved experience of care. Medicare will pay selected practices traditional fee-for-service payments and a new care management fee, and provide the opportunity for shared savings, which will be distributed based on quality measures. This payment approach is designed to decrease reliance on visit-based payment.

**1. Payment for Medicare Fee-for-Service Beneficiaries**

Non-visit-based payment:

Various models suggest that the comprehensive primary care functions that we are seeking to support require an initial investment of approximately \$20 per beneficiary per month (PBPM), on average, for a Medicare population. In years three and four of the initiative, the PBPM will be reduced to an average of \$15 to reflect efficiencies gained and to shift reliance to accountable forms of payment (shared savings). When markets have been selected, we will adjust this average to reflect variation in geographic costs. The care management fee will also be risk-adjusted ranging from \$8 to \$40. We invite other payers to risk adjust their payments in a way that effectively meets the needs of their member population and fairly shares the overall cost to the participating practices of enhanced primary care support.

We understand that some payers may have existing enhanced compensation contracts with practices that move beyond fee-for-service compensation and we ask that those arrangements be described in the application. Our intention is to recognize such existing programs as part of the total support for comprehensive primary care being offered by a payer.

Primary care investments that we would recognize must be provided at the point of care, integrated into the practice's workflow, and not be segmented by payer. For example, telephonic disease management by a third-party vendor would not be recognized, while a care manager that is assigned to a practice and has access to the electronic health record and can interact with all patients in the practice would be recognized.

Shared Savings

CMS is interested in testing alternative payment arrangements that promote value over volume, include financial accountability, and are projected by CMS to generate Medicare savings. For all practices, shared savings will be calculated at the market level— not the individual practice level—based on Medicare Parts A and B expenditures. Given the small numbers of patients associated with individual practices, we do not feel we can accurately calculate savings at the practice level and plan instead to do it at the market level.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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The amount of shared savings earned by primary care providers will be allocated based on quality measures reported by the practice, which are likely to be a subset of those included in the final rule for the Medicare Shared Savings Program. We also expect to use an approach to establishing the expenditure baseline and benchmark that is consistent with other CMS programs, such as the approach taken in the final rule for the Medicare Shared Savings Program or the Pioneer ACO Program. The shared savings methodology will be finalized in the subsequent provider solicitation.

**2. Payment for Medicaid Fee for Service Beneficiaries**

The Innovation Center believes that additional support for practices serving Medicaid fee for service beneficiaries is integral to building primary care capacity within practices selected for this initiative. As part of our solicitation process, we will invite state Medicaid programs to apply to participate in the multi-payer approach. This funding opportunity is available to States that wish to enhance primary care delivery, such as existing Primary Care Case Management (PCCM) payment or to initiate a PCCM payment for care provided to beneficiaries covered by Medicaid-only. Dual eligible beneficiaries (individuals with both Medicaid and Medicare coverage) would be included in the alignment and PBPM payments to practices based on their Medicare fee-for-service coverage. States have the ability to implement payment without regard to state-wideness as this provision is waived at section 1115(A)(d)(1) of the Social Security Act for the testing of models by the Innovation Center. Participating states may need to apply to obtain additional waivers or amend state plans depending on what the states propose in their applications to this Initiative. Shared savings will not be part of the payment methodology for Medicaid fee-for-service.

Medicaid Reimbursement Methodology and Funding

To the extent that selected practices in selected markets serve Medicaid beneficiaries on a fee-for-service basis, CMS, through the Innovation Center will make funding available for enhancements to primary care, such as newly initiated or enhanced PCCM services under this agreement. States with existing programs supporting primary care must maintain their current level of funding and use Innovation Center funding only for purposes of providing more services to current beneficiaries or increasing the number of beneficiaries served by such programs.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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In making this funding opportunity available, CMS wishes to make States aware that the cost principles contained in OMB Circular A-87 apply. Specifically, a State may not supplant state funding for services authorized through the Medicaid state plan with funding from the Innovation Center; however, a State may supplement/enhance a current payment. For example, a State currently reimbursing PCCM services would continue to receive Federal matching funds at the established rate for services authorized through the State's approved Medicaid program and 100 percent federal financial participation (FFP) for any amount above the State's approved Medicaid payment rate. [In consideration of the requirements cited above](#), the Innovation Center will [require States to offset the State plan payment that was in effect on July 1, 2011](#).

All Medicaid PBPM payments provided with Innovation Center funding will go directly to providers. A State 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. Funds from the CPC initiative will be made available only to the State Medicaid agency (not a "sister" agency) for monthly payment to the eligible practices.

In its application, a state should specify the proposed level of payment. The State must explain in its application how participation in this program will impact existing primary care services. For example, will the increased funding provided under this initiative be used to increase the scope of activities, and/or increase the number of beneficiaries served by an existing program? We expect the proposed amount to represent a cost that a State would be willing to share upon completion of this demonstration, if the initiative meets its established goals. Consequently, we anticipate the amount of payment funded by the Innovation Center will vary by state. The participation of the state and its proposed support will be considered part of the criteria for overall scoring of a potential market.

The State Medicaid agency will engage in the following activities:

1. Utilize the Innovation Center funding to reimburse eligible practices 100 percent of the total computable amount of the Innovation Center funding for PCCM services; no amount may be withheld or otherwise remitted by providers to the States.
2. Provide the Innovation Center with a list of Medicaid-only fee-for-service beneficiaries receiving care at participating practices.
3. Work with CMS and the practices to develop a uniform process for reporting the beneficiaries for whom the PCCM payment would be made.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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4. If applicable, collaborate with CMS in conversations with their states' Medicaid managed care organizations to encourage them to consider applying to participate in this initiative.
5. Share data on service utilization and cost with the affected practices. CMS will provide technical assistance in support of activities related to data sharing.
6. Commit to working with CMS in its evaluation of the initiative.

Medicaid beneficiaries with coverage through a Medicaid managed care organization may be included in this initiative if they reside in a selected market and their Medicaid managed care organization applies and is selected to participate. The support provided on behalf of a Medicaid managed care beneficiary to a participating primary care practice will be based on the application from the Medicaid managed care organization.

### **3. Dual Eligible Beneficiaries**

The Innovation Center will align dual eligible beneficiaries who have coverage through Medicare fee-for-service to practices selected for the CPC initiative based on the methodology used to align Medicare fee-for-service beneficiaries.

Dual eligible beneficiaries with coverage through a Medicare Advantage plan may be included in this initiative if they reside in a selected market and their Medicare Advantage plan applies and is selected to participate. The support provided on behalf of a Medicare Advantage beneficiary to a participating primary care practice will be based on the application from the Medicare Advantage plan.

CMS is working on multiple initiatives to pursue the three-part aim of better health, better care, and lower costs for dual eligible beneficiaries, including demonstrations for states to pursue integration of primary care, behavioral health, and long term care services and supports for dually eligible Medicare-Medicaid enrollees. To minimize disruption to initiatives, states, and beneficiaries, a dual eligible beneficiary that has coverage through Medicare fee-for-service will remain aligned to whichever program he/she was first aligned for the duration of the respective initiative (e.g. 4 years for the CPC initiative, 3 years for State duals demonstrations). A beneficiary may not be aligned to two shared savings programs.



Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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**4. Medicare Beneficiary Alignment for Monthly Care Management Fee**

CMS 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. The Medicare beneficiary alignment informs the amount of care management fees paid to practices each month as well as the shared savings calculation. Beneficiaries will be aligned with the practice of primary care providers who billed for the plurality of their primary care allowed charges during the most recent 24-month period. If a beneficiary has an equal number of qualifying visits to more than one practice, the beneficiary will be assigned to the practice with the most recent visit.

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. In addition, 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. CMS will monitor claims for these services and provide feedback to practices regarding the percentage of their claims-based aligned population that have had claims submitted for either of these services.

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.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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## **5. Risk Adjustment**

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. This will then be separated into risk quartiles. The risk adjusted PBPM rates will range from \$8 to \$40. Individual payers will define their own risk adjustment approach and CMS will evaluate their approach as part of the application scoring.

## **G. Data Sharing, Program Monitoring, and Reporting**

### **1. Data Sharing**

All participating payers and the Innovation Center will provide cost and utilization data to primary care practices selected for this initiative. Medicare beneficiaries will be notified that their data is being shared with their primary care practice.

We propose to distribute the following schedule of standardized reports to practices, and market-level discussions will allow an opportunity for modification based on input from participating payers and other stakeholders:

- Historical data summaries of aligned beneficiaries;
- Quarterly reports with beneficiary identifiers of services delivered by providers inside and outside of the primary care practice; financial reports on the most recent and cumulative expenditures; and aggregated reports at the primary care practice and community level on the utilization of key services, as well as total per-capita expenditures; and
- Annual primary care practice specific reports on per-capita expenditures and performance on quality of care measures.

The Innovation Center is considering two methods of sharing cost and utilization data with practices. In the first method, the Innovation Center will support a consistent, streamlined approach for data reporting to practices, including potentially using a web portal that will allow practices to review data and a market-tested feedback report. We will work with other payers to provide similarly formatted feedback reports to simplify burden on practices. This web portal will give practices limited ability to download their information.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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In the second method of sharing cost and utilization data, if a market has a multi-payer database, payer health information exchange or other capable data systems, the Innovation Center is prepared to provide CMS's proportionate share of support for an existing infrastructure around data sharing between the payer and participating practices (not amongst payers).

Additionally, if a state Medicaid Fee-for-Service program applies and is selected for this initiative, the Innovation Center will provide support for data sharing.

After input from the market-level discussions with payers and stakeholders, the Innovation Center will determine a schedule for sharing data for Medicare fee-for-service beneficiaries with selected practices which will be consistent across the markets. In developing the schedule, we will seek to align with payers as much as possible, but for operational purposes, the Innovation Center will have a single reporting schedule and a single approach to formatting reports for all markets.

## **2. Program 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. To safeguard against reductions of necessary care, the Innovation Center will routinely analyze comparative data on Medicare service utilization, and will investigate Medicare utilization patterns which may include comparison surveys of beneficiaries aligned with the primary care practice and those in the general beneficiary population, medical record audits, or other means. Additionally, the Innovation Center will conduct a baseline CAHPS survey to evaluate aligned patients' experience of care; this will be repeated two years into the initiative. The Innovation Center will also determine whether there are systematic differences in health status or other characteristics between Medicare patients who remain aligned with a given primary care practice over the course of the initiative, and those who do not.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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To the extent that Medicaid fee-for-service beneficiaries are also included in the CPC initiative, the Innovation Center will include those beneficiaries in its monitoring activities.

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.

### **3. Quality and Patient Experiences of Care**

Several types of quality and patient experience measures will inform improvement. These measures will include the domains:

- Patient experience
- Care coordination
- Preventive health
- At-risk populations

CMS will use well-established quality measures that are currently a part of other CMS and HHS initiatives. For purposes of distributing shared savings, CMS will use no more than 25 measures.

In recognition of the fact that there exists a variety of measure sources and lack of alignment on required measures across payers and programs, we hope that market-level discussions will drive harmonization of any additional quality

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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measures and reduce administrative burden to participating practices through a shared approach to quality assurance and improvement.

#### **H. Shared Learning**

The Innovation Center and collaborating payers will support primary care practices in accelerating their progress by providing them with opportunities to learn how care delivery organizations can achieve performance improvements quickly and effectively, and opportunities to share their experiences with one another and with participants in other Innovation Center initiatives. 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 therefore requires selected primary care practices to actively participate in these shared learning opportunities.

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

### **III. Evaluation**

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.

### **IV. Payer Application—Content Outline**

Each applicant payer will complete an application online. The questions that will be asked in the online application can be found in [Appendix III](#). Supplemental materials may be included with the application, but they must not exceed an additional 15 pages.

The application form contains the following headings:

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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**A. Description of Payer**

The profile of the payer must be described, including its corporate address and point of contact.

**B. Proposed Market(s)**

The applicant must provide a description of service area(s) in which they are interested in participating in the CPC initiative using MSAs, counties, and/or zip codes as descriptors. The applicant must also provide information about its line(s) of business, the number of members covered by the application and a description of covered lives – e.g., state employees, large industry, small employers, Medicare Advantage, Medicaid managed care, etc.

**C. Primary Care Support**

The applicant must describe both any current approach to primary care support, and a plan for enhanced support for comprehensive primary care aligned with the goals of this initiative.

**D. Data Sharing**

The applicant must describe existing data feedback to primary care practices (aggregate and/or by member) and provide a plan for new or enhanced regular data feedback. The applicant must also describe any established data use agreements with local multi-purchaser databases or Health Information Exchanges.

**E. Implementation Milestones and Quality Improvement Measures**

The applicant is asked to indicate willingness to align metrics with other payers in the market and/or with national initiatives (for example, the National Quality Strategy).

**F. Involvement in Multi-payer/Multi-stakeholder Efforts**

The applicant must describe any current approaches to multi-payer or multi-stakeholder collaboration in which it is involved in the relevant market (including any Community Quality Collaboratives) and provide a description of how it could participate in new or enhanced multi-payer collaboration around comprehensive primary care in that market.

**G. Participation in Other Initiatives**

The applicant is asked if it is testing any other primary care/medical home models, or participating in any other local, state or national initiatives.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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## V. Application Submission Information

The CPC initiative payer application will 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**. The questions that will be asked in the online application are available in [Appendix III](#) for your information.

Payers applying to the initiative for multiple markets will be able to use one online portal account for all markets. The online portal will include instructions for how to submit applications for multiple markets. The online portal will include capability and instructions for attaching any supplemental material necessary for answering the application questions. Supplemental material must not exceed a total of 15 pages in length.

### Requests to Withdraw a Pending Application or a Provider:

Applicant organizations seeking to withdraw an entire application or modify a pending application should submit a written request on the organization's letterhead that is signed by an authorized corporate official.

To submit a withdrawal request, send the request in a PDF format by email to [CPCi@cms.hhs.gov](mailto:CPCi@cms.hhs.gov).

The following information must be included:

- Applicant Organization's Legal Name
- Full and Correct Address and Point of Contact information
- Exact Description of the Nature of the Withdrawal:
  - E.g., Withdrawal of entire application or change in selected markets

## VI. Application Review Process

CMS expects to enter into Memoranda of Understanding with payers in five to seven markets. Applications will be reviewed by CMS staff to determine whether they meet the eligibility requirements outlined in [Section IID](#) and scored based on the degree in which they align with the Innovation Center's approach in this initiative. CMS may contact you for more information or to respond to questions about the application.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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## **Appendix I: Primary Care Practice Eligibility, Selection and Agreements**

**Eligibility Requirements:** 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.
  - 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; 99391-99387; 99401-99404; 99406-99409; 9941-99412; 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.



Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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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. CMS 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 not eligible for participation.

**Selection Process:** During the market-level discussion, payers and stakeholders will have an opportunity to inform the Innovation Center's practice selection criteria and review process.

At this time, the Innovation Center is considering a selection criterion for health information technology. Effective use of health information technology is central and essential to support the delivery of high-value primary care. The primary care functions we aim to model are all supported most reliably with health information technology. For this reason, we 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 we 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, we 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 described in [Section IIE](#).

**Participation in Other CMS Programs:** CMS has several initiatives seeking to promote care coordination and/or offering shared savings to providers. The Medicare Shared Savings Program (MSSP), established under Section 3022 of the

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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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 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.

**Type of Agreement:** 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.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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## Appendix II: Letter of Intent

Payers interested in submitting applications for the Comprehensive Primary Care (CPC) Initiative are asked to submit a letter of intent and a completed Microsoft Excel table via email to [CPCi@cms.hhs.gov](mailto:CPCi@cms.hhs.gov) . CMS is unable to consider applications from payers who did not submit a timely letter of intent. **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 purpose of the letter of intent is to allow CMS to understand the level of interest from payers and the geographic spread of potential multi-payer collaborations. Your letter of intent will be used for internal planning purposes only, and will not be binding. After submitting your letter of intent, you may choose not to apply to the initiative, or to change or add market(s) in your application. Applications from payers that do not submit a timely letter of intent will not be considered.

CMS considers all information submitted in the Letter of Intent and Application as exempt under the Freedom of Information Act. Therefore, CMS will not release this information to the general public. If you are selected to participate in the Comprehensive Primary Care initiative, CMS may release publicly available demographic information (e.g. name, location, etc.) for informational purposes.

Please submit your letter of intent in an email to [CPCi@cms.hhs.gov](mailto:CPCi@cms.hhs.gov). For verification purposes, please ensure that your letter is signed in hard copy, then scanned as a PDF. CMS is unable to accept any other form of signature. The letter of intent and the completed Microsoft Excel table (a formatted Microsoft Excel template can be found on the CPC Initiative website) should both be attached to the same email.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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**Submitting your letter of intent**

For ease of CMS processing, please use the following naming conventions when submitting your letter of intent:

- Please use your organization's name in the subject line of the email
- Please name your PDF letter: LOI\_Applicant Organization Name
- Please name your Excel attachment: LOI\_Applicant Organization Name

For example, if "Payer X" was the applicant organization: use "LOI\_PayerX" in the file name for both the PDF letter as well as the Excel attachment.

**Required content**

Your letter of intent must contain all of the following information:

- Payer name
- Corporate Address
- Corporate City
- Corporate State
- Point of Contact (POC) name, title and address (if different)
- Point of Contact email address
- Information about the areas in which you have provider network(s) and are considering participating in the initiative. You are asked to use a combination of Department of Commerce Metropolitan Statistical Areas (MSAs), counties and zip codes to describe the service area(s) in which you are interested in participating in the CPC initiative. Please submit this information in two forms:

Please include a narrative description of the market(s) in your letter of intent; To facilitate mapping of overlapping areas of multi-payer interest, please also enter the requested information in the Excel template available on the CPC initiative website at <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/cpci/>.

States submitting a letter of intent may elect either to specify markets or to indicate "statewide" interest: in this case, market(s) would be subsequently defined by the interest of other payers in particular areas. CMS will ultimately define multi-payer "markets" based on the overlapping, contiguous geographic service areas of participating payers. Please note that for the purposes of this initiative, the final boundary of a "market" will remain within one state (i.e. in no case may cross state lines), but may span multiple MSAs and/or counties. CMS will give

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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preference to markets where the payers are interested in including rural counties.

*Optional:* Your letter of intent may name any specific lines of business (e.g. Medicare Advantage), details of the population(s) served or information about the practices.

**Accessing the Online Application Portal**

Submission of your letter of intent will allow you to gain access to the payer application online portal. Please note that your online portal account will be associated with the email address of the point of contact you named in your letter of intent, unless you specify another email address for this purpose in your letter. CMS will send you details of how to log onto the online portal after your letter of intent has been received.

Any questions regarding the CPC initiative, the letter of intent, or the application process should be submitted by email to: [CPCi@cms.hhs.gov](mailto:CPCi@cms.hhs.gov). Responses to any questions will be de-identified and shared publicly to ensure that all applicants have access to clarifying information regarding the initiative and the application process. Questions and answers will also be posted on the CPC Initiative website, <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/cpci/>.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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## **Appendix III: Payer Application**

### **Instructions for Application Submission**

The CPC initiative payer application will 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**. The questions that will be asked in the online application are available below for your information.

The eligibility criteria for this initiative are set out in [Section IID](#) of the Solicitation.

Payers applying to the initiative for multiple markets will be able to use one online portal account for all markets. The online portal will include instructions for how to submit applications for multiple markets.

In place of a written signature, applicants will have the opportunity to submit an electronic signature. The online portal will include instructions for electronic signing.

The online portal will include capability and instructions for attaching any supplemental material necessary for answering the application questions. Supplemental material must not exceed a total of 15 pages in length.

CMS considers all information submitted in the Letter of Intent and Application as exempt under the Freedom of Information Act. Therefore, CMS will not release this information to the general public. If you are selected to participate in the Comprehensive Primary Care initiative, CMS may release publicly available demographic information (e.g. name, location, etc.) for informational purposes.

### **Questions**

If you have any questions regarding the Comprehensive Primary Care initiative or application process, please email your questions to: [CPCi@cms.hhs.gov](mailto:CPCi@cms.hhs.gov). Responses to questions will be shared publicly to ensure that all applicants have access to clarifying information regarding the initiative and the application process.

Questions and answers will be posted on the CPC initiative website, <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/cpci/>.

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Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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**Comprehensive Primary Care Initiative Payer Application Contents:**

Description of Payer

- Payer Name:
- Year Established:
- Corporate Address:
- Corporate City:
- Corporate State:
- Point of Contact (POC) Name:
- POC Title:
- POC Address:
- POC City:
- POC State:
- POC Phone:
- POC Email:
- POC Fax:

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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Proposed Market(s)

*This section will be used to discern the overlapping geographic areas in which there is interest in participating in the CPC initiative from multiple payers.*

- 1.** Please propose a “market” for this initiative by describing the service area(s) in which you are interested in participating in the CPC initiative using MSAs and/or rural county as descriptors.
- 2.** Within this service area, how many primary care practices and providers (e.g. physician, nurse practitioner, etc) are in your network?
- 3.** Please describe your lines of business and the number of members within each line of business in the market you are proposing in your application:

- |                                                                 |                                            |
|-----------------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> <i>Commercial insurance plan</i>       | Number of members in proposed market: ____ |
| <input type="checkbox"/> <i>Medicare Advantage plan</i>         | Number of members in proposed market: ____ |
| <input type="checkbox"/> <i>Medicaid managed care plan</i>      | Number of members in proposed market: ____ |
| <input type="checkbox"/> <i>Medicaid fee-for-service</i>        | Number of members in proposed market: ____ |
| <input type="checkbox"/> <i>State or federal high-risk pool</i> | Number of members in proposed market: ____ |
| <input type="checkbox"/> <i>TPA/ASO</i>                         | Number of members in proposed market: ____ |
| <input type="checkbox"/> <i>Direct purchaser/business</i>       | Number of members in proposed market: ____ |
| <input type="checkbox"/> <i>Other: _____</i>                    | Number of members in proposed market: ____ |

Total number of members in proposed market: \_\_\_\_\_

- 4.** (Optional) If applicable, please describe your reasoning for not wanting to collaborate with the Innovation Center in existing line(s) of business not checked above.



Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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Primary Care Support

*If selected for the Comprehensive Primary Care initiative, you will be asked to commit to perform what you describe in response to section C through a Memorandum of Understanding with CMS.*

- 1.** Please explain why you want to be part of the Comprehensive Primary Care Initiative. For states applying for their Medicaid fee-for-service beneficiaries, please describe how participating in this initiative would impact existing primary care services.
  
- 2. a.** Please describe any non-fee-for-service support you currently provide to primary care practices in the proposed market, such as but not limited to a PMPM payment, quality-based bonuses, or direct support such as an embedded care manager.  
  
**b.** (Optional) Please describe one specific instance in which your additional support for primary care transformation led to improvements in quality, outcome, and/or costs in primary care.
  
- 3.** Please describe the method by which you propose to build on the support method described above or adopt a new method of support to align with the Innovation Center's approach under the Comprehensive Primary Care initiative.
  
- 4.** Please provide a specific, quantitative "support build up" (including a calculation of PMPM support and your proposed method of risk adjustment) laying out your financial commitment to comprehensive primary care services in the proposed market for the duration of this initiative.

For states applying for their Medicaid fee-for-service beneficiaries, please indicate how you would augment existing PCCM payments or any other payments to primary care practices (you may answer this question as a separate attachment if necessary).

- 5.** How does your support build-up align with each of the enhanced primary care functions upon which this initiative is based (described in Section IIE)?
  - Risk-based management
  - Access and continuity

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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- Planned care for chronic conditions and preventive care
  - Patient and family engagement
  - Coordination of care across the medical neighborhood
- 6.** How will your proposed support strategy be fully integrated at the practice level and delivered at the point of care so as to support practice transformation?
- 7.** How do you intend to work with providers to enhance primary care services?
- 8.** Describe past successes in supporting primary care transformation for fee-for-service or managed care members.
- 9.** Describe your methodology for associating your members served by participating practices. CMS' beneficiary alignment methodology is described in Section IIF of the solicitation. You have the option of using the same attribution methodology as CMS.
- a.** Describe any current shared savings program or other accountable payment arrangements with primary care practices (including pay-for-performance or bonus payments).
- b.** *(Not applicable to states)* Please describe your proposed shared savings arrangement if selected to be part of the Comprehensive Primary Care Initiative

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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*The following questions in Section D-G will be used to ascertain your interest in achieving common approaches to data sharing, monitoring implementation milestones, and quality measurement through market level discussions.*

Data Sharing

- 1.** Please indicate your current strategy for sharing data with primary care practices in the proposed market, including the level of data shared (individual or aggregate) as well as the frequency of reporting.
- 2.** Please describe your plan for enhanced data feedback to practices in the proposed market, including cost data, utilization data, and real-time hospital and ER data.
- 3.** Please describe any involvement with local multi-purchaser databases or Health Information Exchanges.

Implementation Milestones and Quality Improvement Measures

- 1.** Please list specific quality metrics that you are currently using in pay-for-performance programs or in other payment programs for primary care practices in any market.
- 2. a.** Please describe any alignment you have created with other payers in your region or state around quality measures.
  - b.** Please describe your willingness to align quality measures with CMS, particularly around practice transformation milestones.
- 3.** Please describe how you would propose to monitor that participating in achieving the goals of practice transformation.
- 4.** Please describe how you plan to evaluate the impact of your investment in supporting primary care transformation.

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Solicitation for the Comprehensive Primary Care Initiative

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Involvement in Multi-payer/Multi-stakeholder Efforts

- 1.** Please describe any past or current involvement with multi-payer or multi-stakeholder collaborations in the proposed market. Please indicate the various functions of any collaboratives in which you are currently supporting (e.g. data exchange, technical assistance, learning and diffusion, etc.).
  
- 2.** Please describe your vision for how multi-payer collaboration will transform primary care in the proposed market.

Participation in Other Initiatives

Please describe your participation any other primary care models you are currently testing, or if you are participating in any other local, state, or national initiatives (e.g. medical home or primary care programs, transitional care programs, accountable care organizations, local community health teams, HIT meaningful use programs, chronic disease self-management).