Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

Comprehensive Primary Care (CPC) Initiative:
Primary Care Practice Solicitation

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I. Scope

The Comprehensive Primary Care (CPC) Initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. The four-year Initiative will test a service delivery model that is supported by enhanced payment provided by multiple payers.

Through this Initiative the Center for Medicare and Medicaid Innovation (Innovation Center), a component of the Centers for Medicare & Medicaid Services (CMS), 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 diffusion of best practices in the following markets:

- **Arkansas**: Statewide
  Effective Market Start Date – October 1, 2012
- **Colorado**: Statewide
  Effective Market Start Date – November 1, 2012
- **New Jersey**: Statewide
  Effective Market Start Date – November 1, 2012
- **New York**: **Capital District-Hudson Valley Region** (counties within this region include: Albany, Columbia, Duchess, Greene, Orange, Putnam, Rensselaer, Rockland, Schenectady, Sullivan, Ulster, Westchester)
  Effective Market Start Date – November 1, 2012
- **Ohio and Kentucky: Cincinnati-Dayton Region** (counties within this region are the Ohio counties of Adams, Brown, Butler, Champaign, Clark, Clermont, Clinton, Greene, Hamilton, Highland, Miami, Montgomery, Preble, Warren and the Kentucky counties of Boone, Campbell, Grant, and Kenton)
  Effective Market Start Date – November 1, 2012
- **Oklahoma: Greater Tulsa Region** (counties within this region include: Adair, Atoka, Cherokee, Craig, Creek, Delaware, Hughes, Lincoln, Mayes, McIntosh, Muskogee, Noble, Nowata, Okfuskee, Okmulgee, Osage, Pawnee, Payne, Pittsburg, Pushmataha, Rogers, Sequoyah, Tulsa, Wagoner, Washington)
  Effective Market Start Date – October 1, 2012
- **Oregon**: Statewide
  Effective Market Start Date – November 1, 2012

The effective market start dates listed above reflects when the Innovation Center and participating payers intend to begin payment to selected practices for the CPC Initiative in each market. The Initiative will test the comprehensive primary care service delivery and payment model for four years, ending December 31, 2016.

Approximately 75 primary care practice sites will be selected to participate in each market, with the goal of serving approximately 45,000 Medicare fee-for-service beneficiaries in each

market. Selected primary care practices will be given resources by the Innovation Center to better coordinate primary care for their Medicare fee-for-service patients and, in select States, for Medicaid-only fee-for-service beneficiaries. Other participating payers, including Medicare and Medicaid managed care plans, will provide separate support on behalf of their members.

II. Statutory Authority

Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) 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. 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."

III. General Approach

Primary care is critical to promoting health, improving care, and reducing overall health system costs. It is often difficult for one health plan – covering only its own members and offering support only for its segment of the total practice population – to provide enough resources to transform entire primary care practices and make expanded services available to all patients served by those practices. We believe it is important to obtain a significant investment in primary care across multiple payers.

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: multi-payer 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 in which all, or some, of the primary care practitioners have attested to stage 1 meaningful use of certified electronic health records (EHR) in the Medicare and Medicaid EHR Incentive Programs, as defined in 42 CFR 495.4 of our regulations. Information about stage 1 meaningful use can be found at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/#BOOKMARK2. For practitioners participating in the Medicaid EHR Incentive Program, practitioners must attest to stage 1. Practitioners that have only adopted, implemented, or upgraded certified EHR technology are not eligible for this preference. We are testing whether these additional drivers can deliver lower total costs through improvement in 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 help ensure a practice will be able to 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.

IV. Deadline for Applications

This solicitation is for primary care practices. Practices will need to apply for the CPC Initiative. The first step to applying is to complete a quick eligibility checklist which can be found at: http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html. If the practice meets the initial criteria, practices will receive a link to complete an **online application starting June 15, 2012**. All applications must be submitted by **5:00 pm EST on July 20, 2012.** The questions in the online application are provided in Appendix I for your information. CMS reserves the right to request additional information from applicants in order to assess their applications.

If you are selected to participate in this Initiative, CMS may release publicly available demographic information (e.g. name, location, etc.) for informational purposes.

V. Description of the Comprehensive Primary Care Initiative

Building on the "medical home" concept referenced in section III, the CPC Initiative aligns multi-payer payment reform with practice transformation to achieve better health, better care, and lower health system costs through improvement. Under this Initiative, practices will engage in systematic data sharing, collaborative learning experiences, and have an opportunity to share savings achieved at the market level.

The CPC Initiative will test a service delivery model supported by a new payment model.

Service Delivery Model
The service delivery model is characterized as having the following five functions.

- **Risk stratified care management:** Participating primary care practices will provide care management of appropriate intensity to meet the complex healthcare needs of patients with multiple chronic conditions and unstable episodes of illness and to support patients safely through transitions in care. With routine, systematic assessment of all patients, practices will identify those patients who will most likely benefit from additional support and use patient values and preferences and the best medical evidence to guide their care.
- **Access and continuity:** Access to care and to the information necessary to provide that care are both critical elements of comprehensive primary care. Practices will be available to answer questions and guide patient care, informed by availability of the medical record when the need arises, even when the office is closed. Patients can expect they will have the opportunity to build the relationships that are the foundation of effective primary care.
- **Planned care for chronic conditions and preventative care:** Primary care practices will support patients managing chronic conditions and meet their preventive health goals with proactive, planned care. Every patient will have the opportunity to develop a personalized plan to meet their health goals collaboratively

with his or her team of providers. Medication lists will be actively managed for safety and effectiveness.

- **Patient and caregiver engagement:** Practices will actively support patients in managing their health care to meet their personal health goals and integrate culturally competent self-management support into everyday care. Practices will engage patients and families in shared decision-making in all aspects of care and will give them the opportunity to guide the practice to better meet their healthcare needs.
- **Coordination of care across the medical neighborhood:** Comprehensive primary care will be the basis for coordination of care across the medical neighborhood. Practices will use standard processes to ensure critical information flows effectively between providers of care so the patient experiences seamless care. Community-based resources to support patient health and wellness, including behavioral health, will be integrated into care.

Payment in Medicare Fee-For-Service
The CPC Initiative's Medicare payment model builds on fee-for-service and adds the following two components:

- Monthly care management fees for Medicare fee-for-service beneficiaries (paid prospectively, on a quarterly basis)
- Shared savings in Medicare fee-for-service

The Innovation Center will pay an average $20 per-beneficiary per-month (PBPM) care management payment to the selected primary care practices for each of their attributed fee-for-service Medicare beneficiaries. 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 of the attributed beneficiaries. More information about HCC scores is available at:
http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Evaluation_Risk_Adj_Model_2011.pdf

The Innovation Center will attribute to practices selected for the CPC Initiative dual eligible beneficiaries who have coverage through Medicare fee-for-service based on the methodology used to attribute Medicare fee-for-service beneficiaries, unless the State has a separate program for dual eligible beneficiaries through the Financial Alignment Initiative.

In years three and four of the Initiative, the Medicare PBPM payment for fee-for-service beneficiaries will be reduced to an average $15 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. Practices will be required to submit a budget describing how these funds and other enhanced funding from participating payers will be used to support the delivery of the 5 primary care functions.

Shared savings will be calculated at the market level (not the practice-level) based on the aggregate of Medicare Parts A and B expenditures for beneficiaries attributed to the approximately 75 practices participating in the Initiative in each market. The first performance period for shared savings will start in year 2. Further details about the methodology for calculating shared savings will be available in advance of practices signing the terms and conditions for participation in year 2.

Medicaid Payment

All states had the opportunity to apply for the CPC Initiative as a public payer in this multi-payer initiative. In every market, there is Medicaid participation in the CPC Initiative, either directly through the state fee-for-service program or through the participation of Medicaid managed care plans. In several of the markets, states have already instituted payment models that support "medical home" services for their Medicaid beneficiaries.

States also had the option to request Innovation Center funding to test a payment model that supports the comprehensive primary care service delivery model in Medicaid fee-for-service (not managed care) in markets selected for the CPC Initiative. In the following states, the Innovation Center will support enhanced, non-visit-based payments (per-beneficiary per-month or PBPM) to primary care practices selected for the Initiative who also serve eligible fee-for-service (non-managed care) Medicaid beneficiaries:

- Arkansas – average $3.63 PBPM *(1115 waiver population enrolled in the primary care case management (PCCM) program)*
- Colorado – to be determined
- Ohio – average $15.00 PBPM *(Aged, Blind, Disabled population)*
- Oregon – average $4.00 *(population not eligible for Medicaid Health Home)*

Payment from Other Participating Payers

It is the intention of the Initiative that practices will also receive non-visit-based financial support from other public and private payers participating in the Initiative, which will allow practices to integrate multi-payer funding streams to strengthen their capacity to implement practice-wide quality improvement. The level and method of enhanced payment by other payers will vary within markets. In an effort to maintain a competitive environment, payers individually responded to the CPC solicitation without coordinating payment methods or amounts. Therefore, while all payers committed to providing enhanced payment to selected practices, the payment methods and amounts differ.

As part of its application to participate in this program, each participating payer has outlined how it is prepared to provide enhanced support for selected primary care practices and will communicate this support directly to practices. Though the specific representations they made to CMS are proprietary and will not be shared by CMS, participating payers are expected to offer the terms to each participating practice they described in their application to CMS.

In the first stage of the Initiative, payers submitted proposals that outlined their aligned approaches to supporting primary care for selected practices. When practices are selected,

these selected practices will have the opportunity to enter into separate agreements with payers participating in the CPC Initiative. Agreements between practices and participating payers are not subject to review by the Innovation Center, but are expected to conform to the terms the participating payer committed to in its Memorandum of Understanding with the Innovation Center.

Each selected practice is expected to have contracts in place with participating payers covering at least a 60% of total revenues (including Medicare) and must agree to make a good faith effort to complete such contracting in advance of the Effective Market Start Date of the market, as stated in the terms and conditions for participation with the Innovation Center.

A list of participating payers is available on the CPC Initiative's website at: http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html

VI. Eligibility of Medicare and Medicaid Beneficiaries

Medicare Fee-for-Service

Practices will not be required to enroll beneficiaries in the program. The Innovation Center will attribute eligible beneficiaries through a claims-based process which is the basis for selecting practices and paying the care management fee. The CMS will use Medicare claims data to determine where beneficiaries receive the plurality of their primary care services (denoted by the following codes: 99201-99205; 99211-99215; 99304-99310; 99315-99316; 99318; 99324-99328; 99334-99337; 99339-99345; 99347-99350; G0402 (Welcome to Medicare Preventive Visit); G0438 (initial annual wellness visit); G0439 (annual wellness visit)) during the most recent 24 month period.

CMS must be able to attribute patients uniquely to a single practice and group of primary care practitioners. A practitioner who practices in multiple locations must select only one location for participation in the CPC Initiative. However, this does not mean the practitioner can no longer practice at other locations.

At the time of selection, each practice site must have a minimum of 150 eligible Medicare beneficiaries attributed to the practice. Medicare beneficiaries will not be attributed to more than one shared savings program.

To be eligible, beneficiaries must be:

- Entitled to Part A and enrolled in Part B Medicare; and
- Have Medicare coverage as the primary insurer.

CMS will provide each practice site with a list of its claims-based attributed patients prior to the start of the Initiative and quarterly thereafter.

Beneficiaries that have both Medicare and Medicaid coverage ("dual eligibles") may be included in this Initiative. The Innovation Center will attribute to practices selected for the CPC Initiative dual eligible beneficiaries who have coverage through Medicare fee-for-service based on the methodology used to attribute Medicare fee-for-service beneficiaries, unless

the State has a separate program for dual eligible beneficiaries through the Financial Alignment Initiative. Dual eligible beneficiaries may not be attributed to both the CPC Initiative and the Financial Alignment Initiative.

Medicare beneficiaries in an institutional setting, such as a nursing facility or rehabilitation facility, diagnosed with end-stage renal disease (ESRD), or receiving hospice benefits are not eligible for initial attribution. Beneficiaries enrolled in a Part C Medicare Advantage plan, Medicare Cost plan, or PACE plan will not be attributed by CMS as part of the CPC Initiative, but may be supported by other payers involved in the Initiative.

At all times during the Initiative, Medicare beneficiaries will remain free to select the providers and services of their choice.

Medicaid Fee-For-Service
Four states will receive support from the Innovation Center on behalf of their Medicaid-only, fee-for-service (non-managed care) beneficiaries which will be distributed to selected practices in: Arkansas, Colorado, Ohio, and Oregon. Each state is responsible for attributing Medicaid fee-for-service beneficiaries. All Medicaid PBPM payments provided with Innovation Center funding will go directly to primary care practitioners; no amount may be withheld by the States.

VII. Eligibility Criteria for Primary Care Practices

The CPC Initiative is testing a service and delivery model for primary care practices at the individual primary care practice site level. Each physical location (e.g. bricks and mortar or office suite) will need to apply separately, providing a single tax identification number (TIN) and national provider IDs (NPIs) for all primary care practitioners.

The CPC Initiative defines a primary care practice as the following:

a. Composed of predominantly, but not necessarily exclusively, primary care practitioners, defined as one of the following: a physician (MD or DO) who has primary specialty designation of family medicine, internal medicine, general practice, or geriatric medicine; a nurse practitioner; clinical nurse specialist; or physician assistant for whom primary care services accounted for at least 60% of allowed revenue charges under the Physician Fee Schedule. Attribution of eligible Medicare beneficiaries will be based on claims to the provider types listed and does not include pediatricians or OB/GYNs.

b. Must provide predominantly, but not necessarily exclusively, primary care services as denoted by the following codes: 99201-99205; 99211-99215; 99304-99310; 99315-99316; 99318; 99324-99328; 99334-99337; 99339-99345; 99347-99350; G0402 (Welcome to Medicare Preventive Visit); G0438 (initial annual wellness visit); G0439 (annual wellness visit).

c. Must be paid according to the Medicare Physician Fee schedule for routine office visits and submit claims on a Medicare Physician/Supplier claim form (CMS 1500, formerly HCFA 1500). Please note that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are not eligible for the CPC Initiative.

d. Must serve a minimum of 150 eligible Medicare fee-for-service beneficiaries.

e. Must be geographically located in a CPC Initiative selected market.

The Innovation Center will provide each practice with a list of its attributed beneficiaries prior to the start of the Initiative and quarterly thereafter. The attributed Medicare beneficiary population will fluctuate from quarter to quarter and there will be variation throughout the Initiative. If a participating practice's attributed Medicare beneficiary population falls below 150 and continues for three quarters, the Innovation Center will review whether the practice remains eligible for the CPC Initiative. The Innovation Center will have discussions with the practice prior to any termination.

The practice must continue to serve traditional fee-for-service Medicare beneficiaries for the duration its participation in the Initiative.

At all times during the Initiative, Medicare beneficiaries will remain free to select the providers and services of their choice.

Eligibility of primary care practices with multiple sites/locations with the same tax identification number (TIN)

Each site or location must apply individually to the CPC Initiative. Additionally, a primary care practitioner affiliated with multiple primary care practice sites must be exclusively affiliated with one practice site for purposes of beneficiary attribution in the CPC Initiative. Therefore, when completing an application, the primary care practitioner must select one primary location for the purpose of the CPC Initiative. Please note that this does not mean the primary care practitioner needs to cease practicing at other locations.

If the primary care practitioner(s) regularly work in multiple sites that operate under the same TIN, such as a second "satellite office" that uses the same EHR platform, please contact us at CPCi@cms.hhs.gov for further guidance.

A primary care practice will not be able to participate in the CPC Initiative if its Tax Identification Number (TIN) is the same as any other entity participating in the Medicare Shared Savings Program.

Eligibility of primary care practices associated with a hospital, academic medical center, health system, insurance entity, or non-physician corporation which employ primary care practitioners

Primary care practice sites owned or associated with a hospital, academic medical center, health system, insurance entity, or other entity may apply for the CPC Initiative. As part of their application, the practice will be required to attach a letter of support from any parent companies that own the practice, committing to segregate funds paid in conjunction with the CPC Initiative and assuring all funds flowing through this Initiative will be used to support infrastructure and/or provide salary support in the participating practice.

A practice will not be able to participate in the CPC Initiative if its Tax Identification Number (TIN) is the same as any other entity participating in the Medicare Shared Savings Program.

Eligibility of multi-specialty practices
Multi-specialty practice sites that include primary care practitioners may participate in the CPC Initiative as long as the predominance of claims and services from the practice site are for primary care. The enhanced payments received as part of the CPC Initiative must be used to support infrastructure for the delivery of the five primary care functions and not for other purposes. The attribution of eligible Medicare fee-for-service beneficiaries will only be based on the primary care practitioners.

VIII. Primary Care Practice Selection

CMS will select approximately 75 primary care practice sites in a given market. Of the practices that meet the stated eligibility requirements, CMS will conduct the following activities:

1. Confirm that the practice currently bills Medicare and is composed of predominantly, but not necessarily exclusively, primary care practitioners;
2. Run the CMS algorithm for beneficiary attribution to verify that each primary care practice site meets the minimum requirement of 150 eligible Medicare fee-for-service beneficiaries;
3. Verify the practice is not participating in another CMS shared savings program, such as the Medicare Shared Savings Program (known as the Medicare ACO), Advance Payment or Pioneer ACO Model, Independence at Home, or other shared savings initiative; and
4. Review other information submitted on the application, including any adverse actions taken against the practice.

For practices that meet the eligibility requirements, CMS will consider the following criteria in making final selections. Failure to meet any one criterion will not necessarily disqualify a practice:

a) Use of health information technology reflected through the following criteria, in descending order of preference:

   i. All eligible primary care practitioners in the practice have attested to Stage 1 Meaningful Use.

      - Medicare EHR Incentive Program
      - State Medicaid EHR Incentive Program (practitioners that have only adopted, implemented, or upgraded certified EHR technology do not qualify)

   ii. Some, but not all eligible, primary care practitioners have attested to Stage 1 Meaningful Use.

      - Medicare EHR Incentive Program
      - State Medicaid EHR Incentive Program (practitioners that have only adopted, implemented, or upgraded certified EHR technology do not qualify)

iii. The practice's practitioners have not achieved Meaningful Use, but the practice has registered with the local Regional Extension Center (REC) and uses an EHR that is certified by the Office of the National Coordinator (certified EHR technology).

iv. The practice's practitioners have not achieved Meaningful Use or registered with the Regional Extension Center (REC), but the practice uses an EHR that is certified by the Office of the National Coordinator (certified EHR technology).

v. The practice uses an EHR that is not certified by the Office of the National Coordinator.

vi. None of the above.

b) Participating payer penetration, which is the percentage of revenue a practice earns from payers participating in the CPC Initiative;

c) Recognition of advanced primary care through "medical home" recognition programs such as AAHCC, the Joint Commission, NCQA, URAC, or a state-based recognition program;

d) Participation in practice transformation in the past three years through quality improvement organizations, Regional Extension Centers, or local or national learning collaboratives;

e) Diversity of practices within a market (e.g. geographic location, practice characteristics, etc.). After scoring each practice, ranking will be adjusted to ensure geographic and other dimensions of diversity; and

f) Program integrity issues.

IX. Participation in Other Medicare Programs, Initiatives, Models or Demonstrations

A primary care practice may not participate in the CPC Initiative if it participates in any other initiative or program that includes shared savings with Medicare. Therefore, a practice is not eligible to participate in the CPC Initiative if it is currently participating or plans on participating in such programs, including any of the following CMS initiatives, models, or programs or any other initiatives that involve shared savings:

- Medicare Shared Savings Program (also known as the Medicare ACO Program);
- Advance Payment or Pioneer ACO Model; or
- Independence at Home

In addition, a primary care practice will not be able to participate in the CPC Initiative if its Tax Identification Number (TIN) is the same as any other entity participating in the Medicare Shared Savings Program. Medicare beneficiaries will not be attributed/aligned to more than one shared savings program.

Participation in the CPC Initiative may make the practice and/or providers in the practice ineligible to apply for other CMS or Innovation Center initiatives, depending on the initiative.

X. Time Frames of Initiative

The application process for primary care practices in the seven selected markets will begin in June 15, 2012 and end July 20, 2012. Practices are encouraged to apply early.

To expedite participating payers' processes for amending existing contracts between selected practices and the payer, payers have requested that CMS share some of the data collected in this application (only what would be required for practice identification purposes) at the time the application is received, prior to practice selection. Providing this authorization to CMS is optional for practices at the time of application, however, once primary care practice sites are selected, we will release the practice names and locations publicly.

CMS anticipates making final practice selection on a market-by-market basis and will send applicants notices of selection or non-selection no later than August 2012. When primary care practice sites are selected, they will have the opportunity to enter into separate agreements with payers participating in the CPC Initiative. Agreements between practices and participating payers are not subject to review by the Innovation Center, but are expected to conform to the terms the participating payer committed to in its Memorandum of Understanding with the Innovation Center. For a practice to participate with the Innovation Center, the practice is expected to have contracts in place with participating payers covering at least 60% of total revenues and must agree to make a good faith effort to complete such contracting in advance of the Effective Market Start Date of each market.

A list of participating payers is posted on the CPC Initiative's website at: http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html.

The duration of the CPC Initiative will be for four years, ending December 31, 2016.

XI. Primary Care Practice Revenue Sources

In the primary care practice application for the CPC Initiative, practice sites are required to estimate, to the best of their ability, all revenue (insurance and copays) generated by services provided to patients broken down by payer (Medicare, Medicaid, private health plans, TRICARE, and self-pay patients) in the last calendar year. This information will be used by the Innovation Center to determine eligibility and selection for the CPC Initiative by evaluating the degree to which a practice's payer mix includes payers participating in the CPC Initiative, what we refer to as "participating payer penetration". This multipayer initiative is based on the understanding that transformation of a primary care practice requires the support of multiple payers. Practices that have 60% or more of their current revenue generated from payers that are participating in the CPC Initiative will be better positioned to implement the service delivery model and meet the practice milestones.

We would expect that practices applying for this Initiative are billing payers in an electronic format. The practice's billing system or billing vendor should be able to generate a report that breaks down the sources of practice revenue by payer.

We recognize that there will be variation in participating payer penetration throughout the Initiative. If a primary care practice's participating payer penetration falls below 60%, the practice will initially remain eligible to participate in the CPC Initiative. However, if the participating payer penetration remains below 60% for three quarters, the Innovation Center will review whether the practice remains eligible for participation in the CPC Initiative. The Innovation Center will have discussions with the practice prior to any termination.

Additionally, the Innovation Center's decision to test the CPC Initiative in each of the 7 markets relied, in part, on the commitments made by other payers to also support the Initiative. To the extent that these commitments are not carried out, the Innovation Center may terminate its participation in an entire market. All payers participating in the CPC Initiative have a shared interest in other payers fulfilling their commitments.

XII. Amending Contracts with Participating Payers

A practice is not required to contract with all participating payers in the market, but a selected practice is expected to have contracts in place with participating payers covering at least 60% of total revenues and must agree to make a good faith effort to complete such contracting in advance of the Effective Market Start Date of the market, as stated in the terms and conditions for participation with the Innovation Center.

When practices are selected, these selected practices will have the opportunity to enter into separate agreements with payers participating in the CPC Initiative. Agreements between practices and participating payers are not subject to review by the Innovation Center, but are expected to conform to the terms the participating payer committed to in its Memorandum of Understanding with the Innovation Center.

A list of participating payers will be posted on the CPC Initiative's website http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html.

XIII. Learning and Diffusion Resources

The Innovation Center is working with national experts in practice transformation and primary care to develop resources and activities to support the CPC Initiative's practices to achieve the aims of the program. At the center of these activities will be a collaborative learning community involving all of the practices in each market. This learning community will provide the CPC Initiative's practices in each market with technical assistance training in specific, critical topic areas as well as the opportunity to share resources, tools, and experience with each other. Just as importantly, the market-based learning communities will help practices to set up a routine schedule of testing and implementation of changes to support the fundamental transformation required for comprehensive primary care.

Whenever possible, the market-based learning communities will be built around existing efforts and resources supporting practice transformation in the market. National resources will complement or supplement the local resources as needed and integrate the market-based learning communities into a national learning community. This will allow us to bring

national expertise and training resources to each market and provide practices in each market the opportunity to learn from participating primary care practices in the other markets across the country.

In order to fulfill the terms and conditions of the Initiative, all selected primary care practices are expected to participate in periodic conference calls, at least monthly to learn from each other. Practices will also be expected to actively share resources, tools, and ideas with each other in an online collaboration site being developed for the CPC Initiative. Finally, selected primary care practices are expected to report on the online collaboration site key measures that are of importance to the practice and which will be used by the practice to guide active testing of changes. All of these activities will be targeted at helping selected primary care practices make the practice changes necessary to deliver comprehensive primary care, accomplish the required program milestones, and achieve shared savings and improved quality in the second year of the program.

XIV. Terms and Conditions for Participation

By submitting an application for the CPC Initiative, applicants are agreeing to all of the terms and conditions for participation. During the Initiative, the primary care practice must meet or maintain all of the below conditions. Please review these carefully and, if agreeable, submit an application for the CPC Initiative. CMS may terminate the primary care practice's participation in the CPC Initiative at any time, including but not limited to at such time as the primary care practice fails to meet or maintain any of the below conditions:

- The primary care practice intends to participate in the Initiative for the 4-year duration beginning on the Effective Market Start Date unless this agreement is terminated earlier by CMS. If the primary care practice decides to withdraw from the CPC Initiative prior to the end of the 4-year program period it must notify CMS at least 90 calendar days before the planned day of withdrawal and termination of its participation. Since this Initiative requires practices to adopt changes that impact the manner in which beneficiaries access care, the primary care practice also must notify attributed beneficiaries at least 60 calendar days before the planned day of withdrawal via a letter approved by CMS explaining any impacts.
- The primary care practice acknowledges that the Initiative involves other payers in the market and that, if selected, the primary care practice will have contracts in place with participating payers covering at least 60% of total revenues (including Medicare) and must agree to make a good faith effort to complete such contracting in advance of the Effective Market Start Date.
- The primary care practice agrees to fulfill the following milestones by the end of 2013:
    - I. Complete an annual budget or forecast with projected new CPC Initiative practice revenue flow and plan for anticipated practice expenses associated with practice change (practices can submit their own budgets with defined domains, or build off of a template provided by the Innovation Center). This is due to the Innovation Center within 3 months of enrollment.
    - II. Provide information about care management of high risk patients:

a. Indicate the methodology used to assign a risk status to every empanelled patient. ("Empanelled" means that all attributed patients have a designated provider/ care team within the practice and that systems are in place to produce reports based on provider/care team). *The methodology can use a global risk score or a set of risk indicators (e.g. number of medications, problems, ER/hospitalization use, or a systematic assessment of psychosocial complexity).*

b. Establish and track a baseline metric for percent assignment of risk status and proportion of population in each risk category.

c. Provide practice-based care management capabilities and indicate the following:

- Who provides care management services
- Process for determining who receives care management services
- Examples of care management plans on request.
- Be able to generate lists of patients by risk category

III. Provide and attest to 24 hour, 7 days a week patient access to nurse or practitioner who has real-time access to practice's medical record for patient advice and to inform care by other professionals.

IV. Assess and improve patient experience of care by selecting at least one of the following:

a. Provide at least 2 quarters of focused survey data based on at least one CG-CAHPS domain chosen by the practice after review of results from the initial CG-CAHPS survey (https://www.cahps.ahrq.gov/Surveys-Guidance/CG.aspx) results done under this Initiative;

b. Provide evidence of guidance from a patient and family advisory council that meets at least quarterly, along with specific discussion of how this feedback was used to change practice workflow or policy. A description of a patient and family advisory council can be found at https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Customer-Service/Listening-Posts/Advisory-Councils.aspx

V. At least quarterly, generate and review practice- or provider-based reports with a minimum of one quality measure and one utilization measure. These 2 measures may be derived from the list of measures that practices will be reporting to the Innovation Center for purposes of calculating a quality score for shared savings distribution, or the practice may choose any NQF endorsed measures based on clinical importance and/or improvement potential.

VI. Demonstrate active engagement and care coordination across the medical neighborhood by creating and reporting a measurement – with numerator and denominator data – to assess impact and guide improvement in one of the following areas. For each measure, sample definitions of numerators and

denominators that might be chosen to calculate that measure are provided for illustrative purposes only.

a. Notification of ED visit in timely fashion.

   Example: Denominator = All practice patients seen in ED;

   Numerator = All practice patients seen in ED for whose visit ED report was received within 48 hours of the visit.

b. Practice medication reconciliation process completed within 72 hours of hospital discharge.

   Example: Denominator= All practice patients discharged from hospital;

   Numerator = All practice patients for whom medication reconciliation was completed within 72 hours.

c. Notification of admission and clinical information exchange at the time of admission.

   Example: Denominator = All practice patients admitted to a local hospital

   Numerator = All practice patients admitted to that local hospital who had information about admission exchanged with practice within 24 hours

d. Notification of discharge, clinical information exchange, and care transition management at hospital discharge.

   Example: Denominator = All practice patient discharges from a local hospital

   Numerator = All practice patients discharged from that local hospital who had notification of discharge, clinical information exchange through discharge summary, and care transition plan received by the practice within 72 hours

e. Information exchange between primary care and specialty care related to referrals to specialty care.

   Example: Denominator = All practice patients referred to a chosen specialty service line or site

   Numerator = All practice patients for whom a referral question and summary of information was provided to the specialty practice, and notification regarding that visit (i.e. consult note) was received back from the specialty care team

The milestone for Year 1 is to select and report on the measurement (this reporting is not related to the reporting required for shared savings in Year 2). In Year 2, the practice will need to describe activities they undertook to improve the results.

VII. Identify a priority condition, decision, or test that would benefit from shared decision making and the use of a decision aid. Make a decision aid available to appropriate patients and generate a metric for the proportion of patients who

received the decision aid for this priority area. Information about shared decision making is available at https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Communication/Shared-Decision-Making.aspx

VIII. Participate in the market-based learning collaborative and share knowledge, tools, and expertise with other practices in the market as indicated by:

a. Attendance at three face to face meetings annually and in web-based meetings at least monthly.

b. Sharing of materials or resources on the collaboration site.

c. Reporting on the Innovation Center's on-line Collaboration Site of at least 6 key measures that are of importance to the practice and which will be used to guide active testing of changes in the practice. These may include measures required for patient experience, risk status assignment, care coordination, etc., as described above.

IX. Attest to the requirements for Stage 1 of Meaningful Use for the EHR Incentive Programs (for practitioners participating in the Medicaid EHR Incentive Program, adopting, implementing, or upgrading certified EHR technology is not sufficient, the practitioner must attest to Stage 1).

- The primary care practice agrees to submit a readiness assessment upon selection and annually thereafter.

- The primary care practice acknowledges that practices currently involved in the Medicare Shared Saving Program (Medicare ACO program), Pioneer ACO model, Independence at Home, or other CMS initiatives that involve shared savings are not eligible for this Initiative. The primary care practice acknowledges that this Initiative includes shared savings, and therefore, a participating practice is not permitted to participate in this Initiative and a Medicare accountable care organization (ACO) or other programs that include shared savings.

- The primary care practice acknowledges that participation in the Initiative may make the practice and/or practitioners in the practice ineligible to apply for other Innovation Center initiatives.

- The primary care practice agrees to notify CMS within 30 days of any change in the composition of practitioners, contact information for primary point of contact within the practice, and/or practice business/ownership structure. The primary care practice acknowledges that CMS may terminate the practice's participation in the Initiative in the event of a change in the practice business/ownership structure (such as, but not limited to, a merger with another practice or acquisition by another entity).

- The primary care practice agrees to notify (using a template provided by CMS) all Medicare fee-for-service beneficiaries that have been attributed to the practice for the purposes of this Initiative about the practice's involvement in this Initiative and the beneficiary's ability to opt-out of data-sharing. As part of this Initiative, CMS will be providing practices with feedback reports based on attributed beneficiaries, a portion of which will include personally-identifiable information to support the practices' quality

improvement efforts. The primary care practice agrees to promptly inform CMS of beneficiaries that communicate to the practice their preference to opt-out of having their personally-identifiable data shared.

- The primary care practice agrees to comply with all monitoring requirements. This may include providing additional information, requests for interviews, or other items needed to monitor and evaluate the initiative.
- The primary care practice agrees to cooperate with the organization CMS engages to evaluate the Initiative. This may include providing additional information or data.
- The primary care practice agrees to attest annually to meeting the terms and conditions of the Initiative and sign terms and conditions for years 2, 3, and 4 of the Initiative, by the date required.
- The primary care practice agrees to sign a Data Use Agreement with CMS annually, by the date required, and comply with relevant privacy and security laws and regulations.
- The primary care practice agrees to provide CMS with current banking information for receipt of the care management fee and update CMS with any changes, as necessary.
- The primary care practice acknowledges that CMS can deny or terminate participation in the Initiative of, or specify other remedial measures in lieu of termination (such as a corrective action plan), for any primary care practice or individual physician or non-physician practitioner if CMS determines that the primary care practice or individual physician or non-physician practitioner has program integrity issues such that the practice's, physician's, or practitioner's participation is not in the best interests of the Comprehensive Primary Care Initiative.
- The primary care practice acknowledges that failure to comply with any terms and conditions may result in termination from the Initiative or other remedial measures as CMS may deem appropriate.
- These terms and conditions are subject to change in the interest of improving results under the model. The Innovation Center will provide at least 30 days' advance notice of such changes.

XV. Appeals Process

We intend to provide feedback to practices that were not selected for participation. All questions from practices that were not selected should be submitted to CPCi@cms.hhs.gov. Unfortunately, appeals are not available as the Administrator's selections are final.

XVI. Termination

Applicants should intend to participate in the Initiative for the 4-year duration beginning on the Effective Market Start Date. If a primary care practice site selected for this Initiative decides to withdraw prior to the end of the 4-year program period, it must notify CMS at least 90 calendar days before the planned day of withdrawal and termination of its participation. Since this Initiative requires practices to adopt changes that impact the manner in which beneficiaries access care, the primary care practice also must notify

attributed beneficiaries at least 60 calendar days before the planned day of withdrawal via a letter approved by CMS explaining any impacts. The Innovation Center may terminate a practice's participation in the CPC Initiative, as outlined in the Terms and Conditions.

Appendix 1: Application Questions

This is not the application; this is only the list of questions that will be asked in the online application. The first step to applying is to complete a quick eligibility checklist which can be found at: http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html. If the practice meets the initial criteria, practices will receive a link to complete an online application starting June 11, 2012. All applications must be submitted by 5:00 pm EST on July 20, 2012.

Only applications received through the online application will be reviewed by the Innovation Center.

I. Demographic Information of the Practice

The CPC Initiative is accepting applications from individual primary care practice sites that are geographically located in a CPC Initiative selected market.

If your primary care practice has multiple sites that operate under the same tax identification number (TIN), each physical site that is located in a CPC Initiative selected market should complete a separate application. If the primary care practitioner(s) regularly work in multiple sites that operate under the same TIN, please email CPCi@cms.hhs.gov for guidance.

1. Practice Name: ____
   (Legal entity associated with the accompanying Medicare TIN)

   Practice Site Name: ____

   (Leave blank if same as above)

   Practice Site Address: ____

   (Physical location where patients are seen)

   City: ________ State: ________ Zip Code: ________

   Practice Site Phone Number: ________ Practice Site Fax Number: ________

   Please check here if the practice will submit additional applications for other locations:_

2. Please provide contact information for the primary contact, meaning the individual(s) responsible for administering this Initiative for the practice (e.g. receiving attribution lists and feedback reports).

   Practice Site Primary Contact Name: _______ Title: ________

   Telephone Number: _______ E-mail: _________

   Practice Site Secondary Contact Name: _______ Title: ________

Telephone Number: _______ E-mail: _________

3. Practice Tax Identification Number (TIN) used to bill Medicare: ________

   If this practice has billed Medicare under a different TIN since Jan 1, 2010, please provide that TIN: ________

   Please explain why the TIN changed:

4. To the best of your knowledge, is or has your practice or anyone employed in your practice had a final adverse legal action (as defined on pg. 12 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i) or been the subject of an investigation, prosecution by, or settlement with the HHS Office of the Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last 5 years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? *Failure to disclose could be grounds for application denial or immediate termination from the Initiative.*
   - ☐ Yes
   - ☐ No

   **If yes, please provide summaries of legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any.

II. Staffing and Structure of Practice

Applicant primary care practices should be composed of predominantly, but not necessarily exclusively, primary care practitioners. A primary care practitioner is defined as one of the following: a physician (MD or DO) who has a primary specialty designation of family medicine, internal medicine, general practice or geriatric medicine; a nurse practitioner, clinical nurse specialist, or physician assistant who provides first point of contact and ongoing care. The Innovation Center will review the services billed to Medicare by applicants to confirm eligibility. The list of CPT and G codes we will use to determine eligibility and attribute Medicare beneficiaries can be found in our solicitation in Section VI.

***Federally-qualified health centers (FQHCs) and Rural Health Clinics (RHCs) are not eligible for this Initiative. Further information about eligibility can be found in our solicitation.*

1. For each primary care practitioner in your practice (using the same TIN and practicing at the same site), please provide the following information. Primary care practitioners include physicians (MD or DO), clinical nurse specialist and nurse practitioners, and/or physician assistants:

   a. Practitioner Name (Last, First M)
   b. Individual national provider ID (NPI)
   c. Has the practitioner attested for Meaningful Use Stage 1 Certification (Y/N)

- Date of stage 1 MU attestation

d. Practitioner Type:
   - Physician (MD or DO)
   - Clinical Nurse Specialist or Nurse Practitioner
   - Physician Assistant

e. Primary Specialty
   - Family Medicine
   - Internal/Adult Medicine
   - Geriatric Medicine
   - General Practice
   - NA

f. For Physicians Only: Are you board certified in this specialty? If yes, are you in good standing with your maintenance of certification

2. Which statement best characterizes your practice:
   - ☐ The practice is a single-specialty primary care practice.
   - ☐ The practice is a multi-specialty practice. If yes, please list the number of other providers by type listed below:

     Allergy/Immunology _____
     Anesthesiology _____
     Cardiology _____
     Dermatology _____
     Endocrinology _____
     Gastroenterology _____
     Hospice _____
     Infectious Disease _____
     Nephrology _____
     Neurology _____
     Obstetrics/Gynecology _____
     Hematology/Oncology_____
     Ophthalmology _____
     Palliative Care _____
     Pathology _____
     Pediatric Medicine _____
     Pediatric Sub-Specialty _____
     Physical/Occupational/Speech Therapy _____
     Psychiatry _____
     Preventive Medicine _____
     Pulmonary Disease _____
     Radiology _____
     Rheumatology _____
     Surgical Specialties _____
     Urology _____
     Other, specify _______________ _______

3. In order to ensure a diversity of practices and a detailed evaluation of the initiative, we are seeking information about the ownership of your practice. Please select the appropriate description of the practice's owners:

   1. Practice owned by one physician
   2. Practice owned by two or more physicians
   3. Practice owned by one or more nurse practitioners or physician assistants
   4. Practice owned by both physicians and nurse practitioners or physician assistants
   5. Practice owned by non-clinicians
   6. Practice owned by a hospital, hospital system, academic institution or other health system
   7. Practice owned by an insurance entity
   8. Practice is part of a government entity (specify: ______________________________)
   9. Other _____________________________________

If a practice selects options 6, 7, or 8, the practice will be required to attach a letter of support from the parent owner, committing to segregate funds that are paid in conjunction with the CPC Initiative and assure that all funds flowing through this Initiative will be used to support infrastructure and/or provide salary support in the participating practice.

III. Use of Health Information Technology

Effective use of health information technology is central and essential to support the high-value primary care delivery model in the CPC Initiative. For this reason, use of health information technology will be a major factor in the scoring of practice applications, as set forth in the solicitation.

1. Which category best describes your practice's current utilization of electronic health records (EHRs)?
   - All eligible primary care practitioners in the practice have attested to Stage 1 Meaningful Use.
     a) Medicare EHR Incentive Program
     b) State Medicaid EHR Incentive Program (practitioners that have only adopted, implemented, or upgraded certified EHR technology do not qualify)
   - Some, but not all eligible, primary care practitioners have attested to Stage 1 Meaningful Use.
     a) Medicare EHR Incentive Program
     b) State Medicaid EHR Incentive Program (practitioners that have only adopted, implemented, or upgraded certified EHR technology do not qualify)
   - The practice's practitioners have not achieved Meaningful Use, but the practice has registered with the local Regional Extension Center (REC) and uses an EHR

that is certified by the Office of the National Coordinator (certified EHR technology).

- The practice's practitioners have not achieved Meaningful Use or registered with the Regional Extension Center (REC), but the practice uses an EHR that is certified by the Office of the National Coordinator (certified EHR technology).
- The practice uses an EHR that is not certified by the Office of the National Coordinator.
- None of the above.

2. If you use an EHR, what is the name of your vendor and version of your product?

3. Do you use a free-standing electronic registry (separate from your EHR) to track and identify gaps in screening/prevention, chronic disease management, or high risk patients?

    - ☐ Yes
    - ☐ No

4. Do you use E-Prescribing functionality?
    - ☐ Yes
        - o The E-Prescribing functionality is within a free standing platform
        - o The E-Prescribing functionality is integrated into the EHR
    - ☐ No

IV. Patient Panel Characteristics

To the best of your ability, please provide the following estimates:

1. Total number of patients the practice saw at least once in 2011:

Medicare (traditional FFS)	_______
Medicare Advantage or other Medicare Health Plan	_______
Medicaid FFS	_______
Medicaid Managed Care Plan	_______
Children's Health Insurance Program (CHIP)	_______
Commercially insured	_______
Uninsured/Self Pay	_______
Others	_______

2. Total number of patients by age:

<17 years	_______
18 – 35 years	_______
36 – 64 years	_______
65+	_______
Unknown	_______

3. Percentage of patients by gender:

Female	____%
Male	____%

4. Percentage of patients by race or ethnicity

Alaska Native or Native American	____%
Asian	____%
Black/African American	____%
Hawaiian or other Pacific Islander	____%
Non-White Hispanic or Latino	____%
White	____%
Other	____%
Unknown	____%

Is this based on: ▫ collected data ▫ best estimate

5. Percentage of patients by primary language

English	____%
Non English	____%

V. Practice Revenue Sources

The CPC Initiative is a multipayer initiative, based on the understanding that transformation of a primary care practice requires the support of multiple payers. As described in the practice solicitation, selection of practices for the CPC Initiative will be based on a number of factors, one of which is the proportion of revenue generate by payers participating in the CPC Initiative. Practices that have 60% or more of their current revenue generated from payers that are participating in the CPC Initiative (including Medicare) will be better positioned to implement the service delivery model and meet the practice milestones.

To the best of your ability, please list all revenue (insurance and copays) generated by services provided to patients covered by the following payers in the last calendar year. Please use your billing system or billing vendor to generate this information.

Medicare:

Medicare Fee-For-Service *(not managed care)*	$______	______ %

Medicaid

Medicaid/CHIP Fee-For-Service *(not managed care)*	$______	______ %

Commercial:

Participating Payer 1	$______	______ %

This includes the following lines of business:

- ☐ Commercial PPO

- ☐ Commercial HMO
- ☐ Medicare Advantage
- ☐ Medicaid managed care
- ☐ Other: ___________________
- ☐ I am not able to answer which lines of business this includes.

+ Other $______ ______ %

____

This includes the following lines of business:

- ☐ Commercial PPO
- ☐ Commercial HMO
- ☐ Medicare Advantage
- ☐ Medicaid managed care
- ☐ Other: ___________________
- ☐ I am not able to answer which lines of business this includes.

TRICARE	$______	______ %
Self-Pay	$______	______ %
Other: ___________________	$______	______ %
Total	$______	______ %

VI. Practice Recognition/Certification and Participation in Other Programs

The CPC Initiative is testing an advanced model of primary care delivery. Practices that have achieved recognition/certification as a "medical home" or other advanced care delivery programs will be better positioned to implement the service delivery model and meet the practice milestones.

1. Does the practice currently have or is the practice in the process of applying for recognition/ certification as a "medical home" by a state-based program, national body, or other?

   _____Yes ____ No

   If yes, please identify which recognition/certification the practice has applied for or achieved. If the practice has an application for certification submitted and in process, please explain in the corresponding text field.

   - ☐ **Accreditation Association for Ambulatory Healthcare (AAAHC-Triple A)**
     Initial Date of Recognition:
     Due Date for Renewal:
     - o Application submitted and in process

- [ ] **The Joint Commission**
  Initial Date of Recognition:
  Due Date for Renewal:
  - o Application submitted and in process

- [ ] **National Committee for Quality Assurance Primary Care Medical Home designation (NCQA-PCMH)**
  - o Level 1
  - o Level 2
  - o Level 3
  - o Application submitted and in process

  Initial Date of Recognition:
  Currently recognized under 2008 or 2011 standards? ____2008 ____2011
  Due Date for Renewal:

- [ ] **Utilization Review Accreditation Commission (URAC)**
  Initial Date of Recognition:
  Due Date for Renewal:
  - o Application submitted and in process

- [ ] **State-based Recognition Program:**
  Level of certification (if applicable):
  Initial Date of Recognition:
  Due Date for Renewal:
  - o Application submitted and in process

- [ ] **Insurance plan-based recognition:**
  Initial Date of Recognition:
  Due Date for Renewal:
  - o Application submitted and in process

- [ ] **Disease-based Recognition/Certification:**
  Organization: ________________
  Subject area: ___________________
  Initial Date of Recognition:
  Due Date for Renewal:
  Application submitted and in process

- [ ] **Other ____________________________________**
  Initial Date of Recognition:
  Due Date for Renewal:
  - o Application submitted and in process

2. Has your practice participated in quality improvement or practice transformation activities in the last three years? *(For example, Quality Improvement Organization (QIO) activities, Regional Extension Centers, or local or national learning collaboratives)*
   - ☐ Yes
   - ☐ No

   If yes, please describe:

3. Is your practice currently participating in any other model, demonstration, pilot program, or research study? ****Please note that CMS has restrictions about participation in multiple initiatives. Because the CPC Initiative includes shared savings, a participating practice is not permitted to participate in both the CPC and a Medicare accountable care organization (ACO) or other programs that include shared savings. A practice will not be able to participate in the CPC Initiative if its Tax Identification Number (TIN) is the same as any other entity participating in the Medicare Shared Savings Program.**

   CMS-Sponsored:
   - Medicare Shared Savings Program (also known as the Medicare ACO program)
   - Health Care Innovation Awards
   - Independence at Home
   - Medicaid Health Home
   - Advance Payment or Pioneer ACO Model
   - Other:

   **If a practice selects Medicare Shared Savings Program, Independence at Home, Advance Payment or Pioneer ACO model, they will see an alert in the online application that reads, "Thank you for your interest in the CPC, but if your practice is already involved in this Medicare program, you are not eligible to participate in the CPC," and will be unable to submit.

   State-sponsored
   - Please list:

   Other Federally-Sponsored Initiatives
   - Please list:

   Demonstrations, pilots, or research studies supported by a commercial health plan or medical society
   - Please list:

VII. Terms and Conditions for Participating in the Comprehensive Primary Care Initiative

By submitting an application for the CPC Initiative, applicants are agreeing to all of the terms and conditions for participation. During the Initiative, the primary care practice must meet or maintain all of the below conditions. Please review these carefully and, if agreeable,

submit an application for the CPC Initiative. CMS may terminate the primary care practice's participation in the CPC Initiative at any time, including but not limited to at such time as the primary care practice fails to meet or maintain any of the below conditions

- The primary care practice intends to participate in the Initiative for the 4-year duration beginning on the Effective Market Start Date unless this agreement is terminated earlier by CMS. If the primary care practice decides to withdraw from the CPC Initiative prior to the end of the 4-year program period it must notify CMS at least 90 calendar days before the planned day of withdrawal and termination of its participation. Since this Initiative requires practices to adopt changes that impact the manner in which beneficiaries access care, the primary care practice also must notify attributed beneficiaries at least 60 calendar days before the planned day of withdrawal via a letter approved by CMS explaining any impacts.

- The primary care practice acknowledges that the Initiative involves other payers in the market and that, if selected, the primary care practice will have contracts in place with participating payers covering at least 60% of total revenues (including Medicare) and must agree to make a good faith effort to complete such contracting in advance of the Effective Market Start Date.

- The primary care practice agrees to fulfill the following milestones by the end of 2013:

  I. Complete an annual budget or forecast with projected new CPC Initiative practice revenue flow and plan for anticipated practice expenses associated with practice change (practices can submit their own budgets with defined domains, or build off of a template provided by the Innovation Center). This is due to the Innovation Center within 3 months of enrollment.

  II. Provide information about care management of high risk patients:

    a. Indicate the methodology used to assign a risk status to every empanelled patient. ("Empanelled" means that all attributed patients have a designated provider/ care team within the practice and that systems are in place to produce reports based on provider/care team). *The methodology can use a global risk score or a set of risk indicators (e.g. number of medications, problems, ER/hospitalization use, or a systematic assessment of psychosocial complexity).*

    b. Establish and track a baseline metric for percent assignment of risk status and proportion of population in each risk category.

    c. Provide practice-based care management capabilities and indicate the following:

      - Who provides care management services
      - Process for determining who receives care management services
      - Examples of care management plans on request.
      - Be able to generate lists of patients by risk category

III. Provide and attest to 24 hour, 7 days a week patient access to nurse or practitioner who has real-time access to practice's medical record for patient advice and to inform care by other professionals.

IV. Assess and improve patient experience of care by selecting at least one of the following:

   a. Provide at least 2 quarters of focused survey data based on at least one CG-CAHPS domain chosen by the practice after review of results from the initial CG-CAHPS survey (https://www.cahps.ahrq.gov/Surveys-Guidance/CG.aspx) results done under this Initiative;

   b. Provide evidence of guidance from a patient and family advisory council that meets at least quarterly, along with specific discussion of how this feedback was used to change practice workflow or policy. A description of a patient and family advisory council can be found at https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Customer-Service/Listening-Posts/Advisory-Councils.aspx

V. At least quarterly, generate and review practice- or provider-based reports with a minimum of one quality measure and one utilization measure. These 2 measures may be derived from the list of measures that practices will be reporting to the Innovation Center for purposes of calculating a quality score for shared savings distribution, or the practice may choose any NQF endorsed measures based on clinical importance and/or improvement potential.

VI. Demonstrate active engagement and care coordination across the medical neighborhood by creating and reporting a measurement – with numerator and denominator data – to assess impact and guide improvement in one of the following areas. For each measure, sample definitions of numerators and denominators that might be chosen to calculate that measure are provided for illustrative purposes only.

   a. Notification of ED visit in timely fashion.
   Example: Denominator = All practice patients seen in ED;
   Numerator = All practice patients seen in ED for whose visit ED report was received within 48 hours of the visit.

   b. Practice medication reconciliation process completed within 72 hours of hospital discharge.
   Example: Denominator= All practice patients discharged from hospital;
   Numerator = All practice patients for whom medication reconciliation was completed within 72 hours.

   c. Notification of admission and clinical information exchange at the time of admission.
   Example: Denominator = All practice patients admitted to a local hospital

Numerator = All practice patients admitted to that local hospital who had information about admission exchanged with practice within 24 hours

d. Notification of discharge, clinical information exchange, and care transition management at hospital discharge.

   Example: Denominator = All practice patient discharges from a local hospital
   Numerator = All practice patients discharged from that local hospital who had notification of discharge, clinical information exchange through discharge summary, and care transition plan received by the practice within 72 hours

e. Information exchange between primary care and specialty care related to referrals to specialty care.

   Example: Denominator = All practice patients referred to a chosen specialty service line or site
   Numerator = All practice patients for whom a referral question and summary of information was provided to the specialty practice, and notification regarding that visit (i.e. consult note) was received back from the specialty care team

The milestone for Year 1 is to select and report on the measurement (this reporting is not related to the reporting required for shared savings in Year 2). In Year 2, the practice will need to describe activities they undertook to improve the results.

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VIII. Participate in the market-based learning collaborative and share knowledge, tools, and expertise with other practices in the market as indicated by:

   a. Attendance at three face to face meetings annually and in web-based meetings at least monthly.

   b. Sharing of materials or resources on the collaboration site.

   c. Reporting on the Innovation Center's on-line Collaboration Site of at least 6 key measures that are of importance to the practice and which will be used to guide active testing of changes in the practice. These may include measures required for patient experience, risk status assignment, care coordination, etc., as described above.

IX. Attest to the requirements for Stage 1 of Meaningful Use for the EHR Incentive Programs (for practitioners participating in the Medicaid EHR Incentive Program,

adopting, implementing, or upgrading certified EHR technology is not sufficient, the practitioner must attest to Stage 1).

- The primary care practice agrees to submit a readiness assessment upon selection and annually thereafter.
- The primary care practice acknowledges that practices currently involved in the Medicare Shared Saving Program (Medicare ACO program), Pioneer ACO model, Independence at Home, or other CMS initiatives that involve shared savings are not eligible for this Initiative. The primary care practice acknowledges that this Initiative includes shared savings, and therefore, a participating practice is not permitted to participate in this Initiative and a Medicare accountable care organization (ACO) or other programs that include shared savings.
- The primary care practice acknowledges that participation in the Initiative may make the practice and/or practitioners in the practice ineligible to apply for other Innovation Center initiatives.
- The primary care practice agrees to notify CMS within 30 days of any change in the composition of practitioners, contact information for primary point of contact within the practice, and/or practice business/ownership structure. The primary care practice acknowledges that CMS may terminate the practice's participation in the Initiative in the event of a change in the practice business/ownership structure (such as, but not limited to, a merger with another practice or acquisition by another entity).
- The primary care practice agrees to notify (using a template provided by CMS) all Medicare fee-for-service beneficiaries that have been attributed to the practice for the purposes of this Initiative about the practice's involvement in this Initiative and the beneficiary's ability to opt-out of data-sharing. As part of this Initiative, CMS will be providing practices with feedback reports based on attributed beneficiaries, a portion of which will include personally-identifiable information to support the practices' quality improvement efforts. The primary care practice agrees to promptly inform CMS of beneficiaries that communicate to the practice their preference to opt-out of having their personally-identifiable data shared.
- The primary care practice agrees to comply with all monitoring requirements. This may include providing additional information, requests for interviews, or other items needed to monitor and evaluate the initiative.
- The primary care practice agrees to cooperate with the organization CMS engages to evaluate the Initiative. This may include providing additional information or data.
- The primary care practice agrees to attest annually to meeting the terms and conditions of the Initiative and sign terms and conditions for years 2, 3, and 4 of the Initiative, by the date required.
- The primary care practice agrees to sign a Data Use Agreement with CMS annually, by the date required, and comply with relevant privacy and security laws and regulations.

- The primary care practice agrees to provide CMS with current banking information for receipt of the care management fee and update CMS with any changes, as necessary.
- The primary care practice acknowledges that CMS can deny or terminate participation in the Initiative of, or specify other remedial measures in lieu of termination (such as a corrective action plan), for any primary care practice or individual physician or non-physician practitioner if CMS determines that the primary care practice or individual physician or non-physician practitioner has program integrity issues such that the practice's, physician's, or practitioner's participation is not in the best interests of the Comprehensive Primary Care Initiative.
- The primary care practice acknowledges that failure to comply with any terms and conditions may result in termination from the Initiative or other remedial measures as CMS may deem appropriate.
- These terms and conditions are subject to change in the interest of improving results under the model. The Innovation Center will provide at least 30 days' advance notice of such changes.

VIII. Upload Submission Letter

To finalize your application:

Please upload a scanned, dated one-page PDF statement on your organization's letterhead stating: **"I certify that all information and statements provided in this proposal are true, complete, and accurate to the best of my knowledge and are made in good faith."** This statement must be signed by each of the primary care practitioners in the practice. You will not be able to submit your application without uploading this letter.

To expedite participating payers' processes for amending existing contracts between selected practices and the payer, payers have requested that CMS share some of the data collected in this application (only what would be required for practice identification purposes) at the time the application in received, prior to practice selection. Your practice may choose to authorize CMS to share only this identifying information (practice name, address, Tax Identification Number, all practitioners' NPIs and Meaningful Use status) with participating payers in your market. If you wish to provide this authorization to CMS at the time the application in received, prior to practice selection, please check the box below:

- ☐ The primary care practice authorizes CMS to share information from this application sufficient to enable participating payers to identify the practice and expedite the payer's process for amending existing contracts between the practice and the payer, should the practice be selected by CMS.

Please note that providing this authorization to CMS is optional for practices at the time of application, however, once applications are selected, we will release the practice names and locations publicly.