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CMS Comprehensive Primary Care Initiative
Brief Overview

Overview of the Primary Care Initiative

- **CMS' Primary Care Initiative is a four year pilot incenting multi-payer[1] collaboration in primary care for ultimately decreasing reliance on the traditional fee-for-service payment structure**
  - Per-beneficiary-per-month care management payment (in addition to FFS payments) for comprehensive primary care services[2]
  - Opportunity for shared savings (distributed based on quality measures) in later years
  - Letter of intent due by November 15, 2011 and application needed by January 17, 2012

- **CMS' efforts are geared towards players with large market share today and an ability to collaborate well with market constituents**
  - Goal is to include 5-7 other payers, with 75 practices in each market, and target 300-350K Medicare/Medicaid beneficiaries overall
  - Applicants will be assessed based on the extent to which they meet the eligibility criteria and have previous experience working in multi-stakeholder efforts
  - Payers invited to participate will work jointly with CMS to determine the process for engaging provider practices as part of the program

Source: CMS, Center for Medicare & Medicaid Innovation – Solicitation for the Comprehensive Primary Care Initiative
Notes: [1] includes Commercial insurers, MA plans, states, Medicaid managed care, state/federal high risk pools, self insured businesses or TPAs
[2] services provided to Medicare FFS beneficiaries and Medicaid beneficiaries

To be eligible to participate in this Primary Care initiative, payers must meet the following requirements

1 Enter compensation contracts with primary care practices	• For years 1 and 2, CMS will pay an average $20 per beneficiary per month (ranges from $8-$40) care management fee in addition to all FFS payments* • For years 3 and 4, CMS will reduce the payments to reflect efficiencies and shift to shared savings models
2 Practices must have a way to become eligible for shared savings	• Practices will be eligible to share in savings in years 2, 3 and 4 • Amount of shared savings will be calculated at a market level and distributed based on a metric derived by quality, utilization, practice size and risk adjustment
3 Payers must share attribution methodologies with CMS	• CMS proposes a prospective alignment methodology but payers can create a new approach as desired
4 Provide practices with regular cost / utilization data	• CMS will provide cost / utilization data on Medicare FFS beneficiaries including historical cost, utilization, financial expenses and per-capita expenditure, and quality • Payers could propose a common platform for sharing data through a multi-payer database, or other health information exchange
5 Align quality, practice improvement,,and patient experience measures with CMS	• CMS will identify implementation milestones, patient / caregiver experience measures, preventive health, care coordination / transition, and practice transformation measures • Some measures will be “core” while others will be a variable menu across unique markets • CMS will use no more than 25 measures (across 4 domains: patient experience, care coordination, preventive health, at-risk populations) to determine distribution of shared savings
6 Provide list of intended markets	• Payers must provide information about the lines of business and number of members with each geography the payer is proposing so that CMS can ultimately choose a diverse set of environments with strong multi-payer support / alignment

Source: CMS, Center for Medicare & Medicaid Innovation – Solicitation for the Comprehensive Primary Care Initiative
Notes: *Dual beneficiary payments will be based on Medicare FFS beneficiaries; Shared savings will not apply to Medicaid FFS

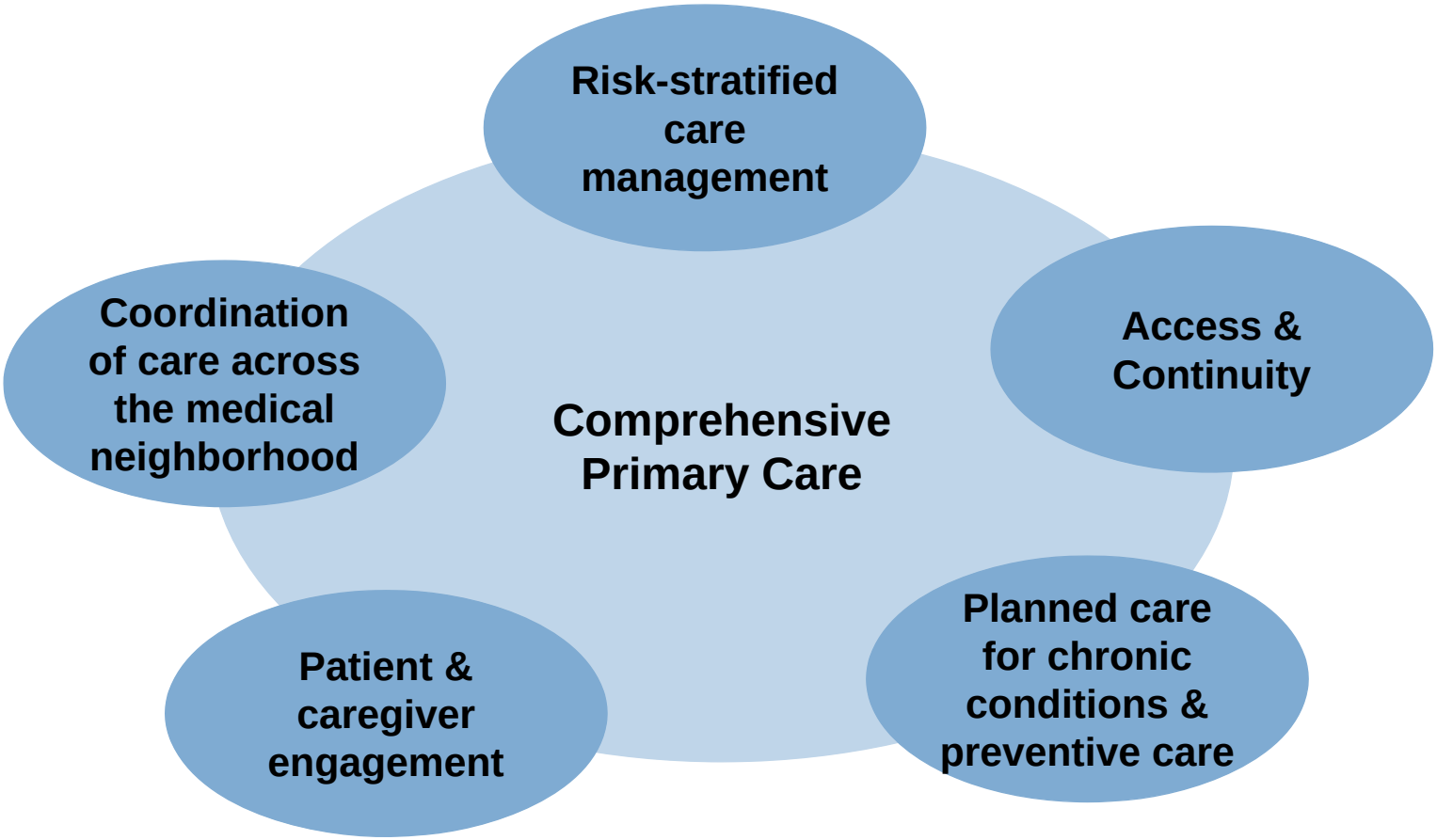
CMS will select target markets / payers where there is sufficient interest to create a comprehensive model of primary care

CMS Process for Implementation:

- ***Evaluate each payer applicant*** based on the extent to which they meet the eligibility criteria and have a history of working in community quality collaboratives or multi-stakeholder efforts
- Scoring criteria will be as follows:
  - Up to 15 points for ***"alignment with innovation center goals",*** based on meeting eligibility criteria and experience working in collaboratives / multi-stakeholder efforts
  - ***Applications will be clustered by market*** and each applicant's score from above will be weighted by the ratio of the payer to the market applicants
  - ***Each market will receive a (market impact) score*** based on total market penetration of all payers
  - Sum of all weighted payer impact scores and the total market score will be grouped into regions and the ***markets with the highest and second highest scores will move forward*** in the process
  - Markets that include state participation or high meaningful use of EHRs will receive additional ***bonus points***
  - Once markets have been approved for selection, ***all payers that received above the threshold number of points will be invited to participate***
- Upon market selection, ***payer applicants will participate in market-level discussion to agree on a common approach*** to data-sharing, monitoring implementation milestones and quality metrics
- ***Payer applicants and CMS will also jointly determine the forward process for selecting the physician practices*** that will become part of the initiative (e.g., selection criteria for use of health information technology, etc.)

Source: CMS, Center for Medicare & Medicaid Innovation – Solicitation for the Comprehensive Primary Care Initiative

CMS has identified an evidence-based set of five core functions they believe essential to comprehensive primary care, through which the market approach and evaluation metrics will be defined



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