

FAQ: The CPC initiative and participation in other CMS initiatives

Can payers within Multi-payer Advanced Primary Care Practice demonstration (MAPCP) States apply to the Comprehensive Primary Care (CPC) initiative?

CMS will not choose markets for the Comprehensive Primary Care (CPC) initiative that overlap with sites participating in the Multi-payer Advanced Primary Care Practice demonstration (MAPCP). Therefore, payers in States in which the State was selected for MAPCP as a statewide initiative (Maine, Michigan, Minnesota, Rhode Island, and Vermont) will not be eligible for participation in the CPC initiative even if only a limited number of practices are participating in MAPCP or the State is incrementally phasing in its program. Where a State was selected for MAPCP and restricted involvement to a specific region of a State (New York, Pennsylvania, and North Carolina), that region will not be eligible for participation in the CPC initiative, but payers could apply for the CPC initiative in non-MAPCP regions.

What are the differences between the CPC initiative and MAPCP?

There are several major differences between the CPC initiative and the MAPCP demonstration in terms of the design and implementation of each program, and the payment and service delivery models being tested.

Multi-payer Collaboration

Under the MAPCP demonstration, CMS joined State-led multi-payer reform initiatives that were designed by States to make advanced primary care practices more broadly available. Through the States' work with other payers, each State had already defined the service delivery and payment models and was prepared to implement the model within 6 months of being selected for MAPCP. Each State had its own approach to multi-payer participation with Medicare's participation being aligned with other payers to the extent it was administratively possible.

Like MAPCP, the CPC initiative uses a multi-payer approach. However, in the CPC initiative the Innovation Center, not the State, has defined the service delivery and payment model and is seeking to align with multiple payers to evaluate a specific payment and delivery model. CMS is inviting payers that are currently providing or willing to provide enhanced support above and beyond visit based fee-for-service payments (e.g., care management fees, or other non-visit-based and non-volume-based compensation, shared savings or similar incentives for effective stewardship of resources) for comprehensive primary care. Selected markets will be comprised of areas in which a preponderance of payers has offered aligned strategies. We are also using a new model in which CMS is playing a key role in

convening multiple payers to implement community-wide payment and delivery reform, while maintaining a competitive environment.

Service Delivery Model

Both initiatives are testing a similar service delivery model. In the CPC initiative, CMS defined a specific, consistent service delivery model of comprehensive primary care and identified a specific set of functions to be supported by payers at the practice level in all markets.

In MAPCP, each State defined its service delivery model for advanced primary care. In some States, the service delivery model includes the use of community health teams to support practices; in others, the infrastructure for advanced primary care is expected to be located within the practice.

Payment Models

Both initiatives maintain current fee-for-service payments and introduce a new monthly care management payment for aligned beneficiaries. In MAPCP, the solicitation specified a total per-beneficiary-per-month (PBPM) payment of up to \$10, although a higher amount would be considered if it could be justified by the State. The amount of Medicare payments for care management fees to participating practices varies by State. In addition, to the extent permitted by applicable statutes, payments are also allowed for community-based practice support and/or for Medicare's share of the operating expenses of the State initiative. The \$10 amount was based on the limited existing literature about the cost of implementing patient-centered medical home (PCMH) models, and in most cases, was largely consistent with existing PCMH pilot programs. And finally, only the Pennsylvania payment model includes the opportunity for shared savings.

In the CPC initiative, CMS is testing a consistent payment methodology on behalf of Medicare fee-for-service beneficiaries and in some cases Medicaid fee-for-service beneficiaries in all markets, which includes a monthly care management fee and shared savings. CMS will also evaluate whether a larger investment by Medicare and other payers for comprehensive primary care services yields savings within a community. The amount of payment for the care management fee will average approximately \$20 PBPM and will be risk-adjusted ranging from \$8 to \$40. Additionally, the Innovation Center is willing to support States in testing payments for comprehensive primary initiative for Medicaid fee-for-service programs. In years three and four of the initiative, the care management fee will be reduced to an average of \$15. When markets have been selected, we will adjust the average payment to reflect variation in geographic costs. CPC will not provide separate payments to community health teams, as is being done in the MAPCP demonstration in some states. In addition to monthly care management fees, CMS is also testing shared savings for practices, which will be calculated at the market level— not the individual practice level—based on Medicare Parts A and B expenditures. Any earned shared savings will be distributed to practices based on practice size, acuity of beneficiaries and quality metrics.

The MAPCP and CPC initiatives are being conducted by CMS under different statutory authorities. The MAPCP demonstration is being conducted under CMS' statutory

demonstration authority in Section 402 of PL 90-248, the Social Security Amendments of 1967 (as amended). A State's advanced primary care model must provide credible evidence of projected budget neutrality for the duration of the demonstration. The CPC initiative is being conducted under Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act), and under this authority, budget neutrality is not initially required for testing; however, the model may not be expanded or scaled unless the Chief Actuary of CMS certifies that such expansion would not result in any increase in net program spending.

Size of Initiatives

The CPC initiative is a 4-year initiative in which CMS seeks to collaborate with payers in 5-7 markets. Once payers and markets have been selected, approximately 75 practices will be recruited and selected in each of these markets (approximately 525 practices in total). Approximately 330,750 Medicare and Medicaid beneficiaries will be served by the practices in these markets.

The MAPCP demonstration is a 3-year demonstration in 8 States. Based on the projections provided by each of the 8 States, we expect the demonstration to start with approximately 950 practices and grow to over 1,200 by the end of the third year. In some States the demonstration will be limited to certain geographic areas, but in others it will involve practices across the State. CMS expects the MAPCP demonstration to serve approximately one million beneficiaries over three years.

Enrollment of Practices

In MAPCP, each State is enrolling the practices into the MAPCP demonstration, each using its own process and criteria. All practices in each State will not be participating in the demonstration. In order to participate, practices will have to meet certain requirements to become an advanced primary care practice, as specified by each State's program. In some States, practices are required to be accredited by the National Committee for Quality Assurance (NCQA) as a Patient-Centered Medical Home and in some instances payment is based on level of accreditation or NCQA score.

In the CPC initiative, once markets are selected, CMS will solicit practices in those markets to participate and expects to use standard criteria for practice selection across all markets. Effective use of health information technology is central and essential to support the delivery of high-value comprehensive primary care in this initiative. For this reason, preference will be given to practices that have achieved stage 1 meaningful use of certified EHR technology in the EHR Incentive Programs.

May practices participate in CPC and other CMS demonstrations or other shared savings programs?

Providers in the CPC initiative may not participate in any other CMS initiative, demonstration, or program that involves shared savings. This means that providers that participate in CPC may not participate in accountable care organization (ACO) models, such

as the Medicare Shared Savings Program or the testing of the Pioneer ACO Model, or any other model or demonstration that includes the opportunity to earn shared savings.

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 Transition Demonstration
- Medicare Coordinated Care Demonstration
- Demonstrations authorized under section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)

This is not meant to be an exhaustive list. As new initiatives are released, there may be other exclusions.

Practices that serve as a Medicaid Health Home in accordance with Section 2703 of the Affordable Care Act will be eligible to participate in the CPC initiative as long as they also meet the eligibility criteria for this initiative (e.g., is in a market that is selected, meets other requirements).

May States participate in the CPC initiative?

Yes, States may participate in a variety of ways. As a purchaser of health care for their public employees, States may apply for this initiative just like any other payer and propose aligned strategies for supporting comprehensive primary care. They may also apply for their Medicaid fee-for-service program, as described in the solicitation.

States do not need to apply on behalf of fee-for-service Medicare beneficiaries who are dually eligible for Medicaid, as they will be aligned to participating practices based on their Medicare coverage. 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 States participating in the Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees initiative). A beneficiary may not be aligned with two shared savings programs.