Medicare Alternative Payment Models for Primary Care

The largest current Medicare Alternative Payment Model that is intended specifically to improve payment for primary care practices is Comprehensive Primary Care Plus (CPC+). It is a 5-year demonstration that began operations in 2017, and it is only open to primary care practices in 18 regions (both states and metropolitan areas). It has two different "Tracks" with different payment structures. (CPC+ replaced the "CPC Classic" initiative, which was terminated after an evaluation showed it caused a net increase in Medicare spending.)

In April 2019, CMS announced the "Primary Cares" initiative, with 5 payment model options:

- The two "Primary Care First" (PCF) options will be available in the 18 CPC+ regions plus 8 additional states. The "Seriously Ill Population" (SIP) option is focused exclusively on patients with serious illnesses who have no current primary care provider.
- The three "Direct Contracting" (DC) options are only available to practices with at least 5,000 Medicare patients, far more than solo and small primary care practices will have and more than the number of Medicare beneficiaries living in many rural counties.

The basic Primary Care First model is based in part on two proposals for Alternative Payment Models (APMs) that were developed by the American Academy of Family Physicians (AAFP) and Jean Antonucci, MD and recommended for implementation by the Physician Focused Payment Model Technical Advisory Committee (PTAC). The Seriously Ill Population option is based in part on APMs for palliative care that were developed by the American Academy of Hospice and Palliative Medicine (AAHPM) and the Coalition to Transform Advanced Care (C-TAC) and recommended for implementation by PTAC.

Problem with Current FFS	Comprehensive Primary Care Plus	Primary Care First
Lack of flexibility for PCPs to deliver services other than traditional face-to-face office visits	**Track 1:** Monthly Care Management Fee (CMF) + Performance-Based Incentive Payment (PBIP) + standard E/M payments **Track 2:** CMF + PBIP + Quarterly Comprehensive Primary Care Payment (CPCP) equal to 40%-65% of historical E/M payment revenues + 35%-60% lower E/M payments	Monthly Professional Population-Based Payment in place of all E/M payments + $50.52 for each office visit
Inadequate resources to support primary care services for patients	The Care Management Fee increases the payment per patient between $6 and $100 per month based on the individual patient's risk score The Performance-Based Incentive Payment (PBIP) increases the payment per patient by up to $2.50 per month (Track 1) or $4.00 (Track 2) In Track 2, the Comprehensive Primary Care Payment is increased by 10% compared to a practice's historical E/M revenue	Monthly payment ranges from $24 to $175 depending on average risk score of entire patient panel. (CMS has indicated that the monthly payments plus office visit payments are intended to equal a practice's current E/M revenues.) In the SIP option, monthly payments per patient are $275 for up to one year.
Bonuses/penalties based on total spending and quality measures that PCPs cannot fully control	The Performance-Based Incentive Payment (PBIP) is reduced by up to 50% if risk-adjusted rates of ED visits and total hospitalizations are higher (worse) than non-CPC+ practices. PBIP is reduced by up to 100% if experience and quality measures are worse than national averages	The monthly payment is increased by up to 50% if minimum quality performance is met and the risk-adjusted rate of total hospitalizations is lower than other PCF practices; 10% reduction in payment if quality is poor or hospitalizations are high.

Similarities Between CPC+ and Primary Care First

- Primary care physicians/practices (PCPs) receive a significant portion of their revenues through monthly payments that can be used for a wide range of services other than face-to-face visits with physicians. However, a significant proportion of a practice's revenues is still tied to face-to-face office visits.
- The practice's payment is increased or decreased based on aspects of quality and utilization that a PCP can influence, not for factors outside their control, such as the price of drugs.
- Patients can voluntarily agree to be assigned to a primary care practice, in addition to patients being "attributed" to a practice if they receive most of their primary care visits there.
- Payment amounts are risk adjusted based on the number and types of diseases patients have.

Differences Between Primary Care First and CPC+

- The Primary Care First (PCF) monthly payments and office visit payments are intended to provide approximately the same amount of revenue for most practices as they receive from current Medicare payments. A PCP will only receive more revenue if (a) it has a lower hospitalization rate than other PCF practices, or (b) if it decides to specialize in patients with high risk scores. Under CPC+, all practices receive higher payments than under standard Medicare payments regardless of their performance on quality and utilization measures.
- The PCF monthly payment is the same for every patient in the practice, regardless of the patient's needs. In CPC+, the practice receives a higher payment for each individual patient who has a high risk score, whereas in PCF, the practice receives a higher payment for every patient if the average risk score for the entire patient panel is sufficiently high.
- The monthly payments under the PCF Seriously Ill Population option are much larger than the largest Care Management Fees under CPC+, and thereby better able to support palliative care services to patients with advanced illnesses.
- The PCF office visit payment is the same regardless of the length or complexity of the visit. In CPC+, the practice continues to be paid higher amounts for more complex visits.
- A PCF practice will only receive higher payments if its risk-adjusted rate of total hospitalizations is lower than other practices participating in PCF. Only 50% of PCF practices can receive any bonus at all, and only 10% of PCF practices can receive 50% bonuses. In CPC+, all practices receive the Performance Based Incentive Payments in advance, and they can all retain the full payment if their performance is high.
- A PCF practice will not know in advance what rate of hospitalizations will result in a bonus because success is based on the rates for other PCF practices. In CPC+, practices are compared to non-CPC+ practices, and the benchmarks are set in advance.
- In PCF, an increase in payment for a practice is based solely on having a low rate of hospitalizations for its patients; there is no change in payment for high performance on quality. In CPC+, a practice will receive a higher Performance-Based Incentive Payment (PBIP) if it performs well on either utilization or quality measures.
- In PCF, the highest performing practices could receive significant increases in payment, higher than the maximum they could receive under CPC+.
- In PCF, payments to practices could vary significantly from quarter to quarter based on changes in hospitalization rates relative to other practices. In CPC+, payments are more stable.

Note: The points above are based on the details that have been released about Primary Care First as of August 9.