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 five-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 five payment model options:

- The two "Primary Care First" (PCF) options are available in the 18 CPC+ regions plus eight 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.

In October 2019, CMS released a request for applications (RFA) for Primary Care First. Practices that wish to participate must apply by Jan. 22, 2020. Practices selected to participate will begin doing so in January 2021. This comparison of CPC+ and PCF may help physicians decide if their practice should consider applying for PCF.

Problem with current FFS	Comprehensive Primary Care Plus	Primary Care First
Lack of flexibility for primary care physicians 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 office E/M payments + $40.82 for each office visit or care management service regardless of E/M code used + Patient cost-sharing equal to 20% of standard FFS amount for the E/M code billed for the visit unless waived by the practice
Inadequate resources to support primary care services for patients	Care management fee increases the payment per patient between $6 and $100 per month based on the *individual patient's* HCC risk score Performance-based incentive payment increases the payment per patient by up to $2.50 per month (Track 1) or $4 (Track 2) In Track 2, comprehensive primary care payment is increased by 10% compared to a practice's historical E/M revenue	Monthly payment ranges from $28 to $175 per patient depending on the average HCC risk score of the entire *patient panel*. (CMS says monthly payments plus office visit payments are intended to equal practices' 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 primary care physicians cannot fully control	Performance-based incentive payment (PBIP) is reduced by up to 50% if risk-adjusted rates of emergency department visits and total hospitalizations are higher (worse) than non-CPC+ practices PBIP is reduced up to 100% if experience and quality measures are worse than national averages	The monthly payment is increased by up to 50% on a quarterly basis if minimum quality performance is met, the risk-adjusted rate of total hospital admissions is lower than other primary care practices in the region, and the rate of admissions is decreasing; the payment is reduced by 10% if quality is poor or the hospitalization rate is 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 portion of practice revenue 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 completely 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 adjusted using Hierarchical Condition Category (HCC) risk scores that are calculated based on chronic condition diagnoses assigned to patients in the previous year.

Differences between Primary Care First and CPC+

- The 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. In PCF, a primary care practice will only receive more revenue if (a) its patients are hospitalized at a lower rate than other primary care practices, (b) its hospitalization rate decreases by a significant amount, or (c) if it decides to specialize in patients with high-risk scores. Under CPC+, all practices receive higher payments than under the standard Medicare payment schedule 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 individual patient's needs. In PCF, the practice receives a higher monthly payment for *every* patient if the *average* HCC risk score for the practice's *entire* patient panel is sufficiently high. In CPC+, the practice receives a higher monthly care management fee for each *individual* patient who has a high HCC risk score. In standard Medicare fee-for-service payment, a practice can receive an additional monthly chronic care management payment for each patient with multiple chronic conditions and a higher payment for patients who require more complex services.
- The monthly payments under the PCF Seriously Ill Population (SIP) option are much larger than the largest care management fees under CPC+ and, thereby, are better able to support more intensive services to patients with advanced illnesses, but the SIP payments can only last for an average of eight months and are primarily for patients whom CMS determines have not been receiving coordinated primary care.
- The PCF visit payment from Medicare does not differ based on the complexity of the visit or whether the patient is new; although, such patients can be required to pay more in cost-sharing. In CPC+, the practice receives higher Medicare payments for visits with new patients, for more complex visits and for annual wellness visits.
- In PCF, the highest performing practices could receive bonus payments up to 50% ($14 to $87.50 per patient per month, depending on their patient panel's risk score), much more than the maximum performance-based payment of either $2.50 or $4 per patient per month provided under CPC+. Low-performing practices could face 10% penalties. Bonuses are revised quarterly, so PCF payments could vary by as much as 60% from quarter to quarter based on changes in relative hospitalization rates. In CPC+, because performance-based payments are smaller and are paid in advance, total practice revenues are more stable and predictable.
- A PCF practice will receive the "regional performance" portion of the bonus payment if the risk-adjusted rate of total hospital admissions for its patients is lower than the rates for the majority of other primary care practices in the geographic region. A PCF practice will receive the maximum regional performance bonus payment (34% of its monthly payments) if its hospitalization rate is lower than 90% of the practices in the region. If a high percentage of the primary care practices in the region are participating in PCF, this means that as many as half of the PCF practices will be unable to receive this portion of the bonus, and as few as 10% of the PCF practices will be able to receive the maximum bonus. In CPC+, practices are compared only against non-participating practices, and all practices can receive performance-based payments for high performance.

- A PCF practice will receive the "continuous improvement" portion of the bonus payment if the PCF practice has reduced its hospitalization rate by a statistically significant amount compared to the prior year. A practice will receive the maximum continuous improvement bonus (16%) if its improvement is larger than 90% of primary care practices in the region. Practices with low hospitalization rates will have a harder time making additional reductions, and small practices will have a harder time making statistically significant reductions, so these practices will have a harder time earning the full potential bonus payment than other practices. In CPC+, practices are only compared to other practices, not themselves, and a practice can receive the full performance-based payment each year if it achieves and maintains a low rate of hospitalizations.
- In PCF, a bonus payment for a practice is based solely on having a low rate of hospitalizations for its patients; there is no bonus for high performance on quality. In CPC+, a practice will receive a higher performance-based payment if it performs well on quality measures.