

# **Summary of the CMMI Comprehensive Primary Care Plus (CPC+) Alternative Payment Model**

The Center for Medicare and Medicare Innovation (CMMI) announced on April 11, 2016 that it would implement a new payment demonstration called Comprehensive Primary Care Plus (CPC+) beginning in January 2017. CMMI plans to select up to 5,000 primary care practices in up to 20 regions to participate. The regions selected will depend on the willingness of private health plans in those regions to make payments to the practices in ways that create similar financial incentives for the practices as the payment model CMMI plans to use.

In the CMS Notice of Proposed Rulemaking for MACRA announced on April 27, 2016, CMS indicated that CPC+ would qualify as an “Advanced Alternative Payment Model” and that physicians participating in CPC+ at the minimum levels required in the law and regulation would be exempt from the Merit-Based Incentive Payment System (MIPS), qualify for 5% lump sum bonuses from 2019 to 2024, and receive higher annual fee for service payment updates beginning in 2026.

Primary care practices would be selected to participate in one of two “Tracks” and the payment model would differ in each track.

## **“Track 1” Payment Model**

Primary care practices in “Track 1” of the CPC+ initiative would receive three categories of payment:

1. **Current FFS:** The practice can continue to bill for and be paid at standard Medicare rates for all CPT codes on the Physician Fee Schedule except for the Chronic Care Management fee.
2. **Care Management Fee (CMF):** In addition to FFS payments, the practice will receive a CMF payment each month for each Medicare patient, which is expected to average \$15 per beneficiary per month. The actual amount of the CMF payment will be different for different patients depending on the risk tier in which the patient is classified using the CMS Hierarchical Condition Category (HCC) risk adjustment system:
  - **Tier 1:** \$6 for patients with an HCC score in the first (lowest) quartile among Medicare beneficiaries
  - **Tier 2:** \$8 for patients with an HCC score in the second quartile
  - **Tier 3:** \$16 for patients with an HCC score in the third quartile
  - **Tier 4:** \$30 for patients with an HCC score in the fourth quartile
3. **Performance-Based Incentive Payment:** In addition to FFS payments and the Care Management Fee, the practice would receive a \$2.50 payment each month for each Medicare patient. The practice would have to return all or part of this payment to Medicare depending on the practice’s performance on utilization and quality measures:
  - **Quality-Based Incentive:** the practice’s ability to keep one half (\$1.25) of the payment would depend on whether the practice meets annual performance thresholds on quality and patient experience measures. The practice would have to return between 0% and 100% of this payment based on its percentage score on the performance measures.
  - **Utilization-Based Incentive:** the practice’s ability to keep the other half (\$1.25) of the payment would depend on whether the practice meets annual performance thresholds on measures of inpatient admissions and emergency department visits for its patients and also on whether the practice met minimum standards of quality.

## “Track 2” Payment Model

Primary care practices in “Track 2” of the CPC+ initiative would receive four categories of payment:

1. **Reduced FFS:** The practice can continue to bill for all CPT codes except for the Chronic Care Management fee (CPT 99490). The amount of payment for Evaluation & Management Services (E&M) codes (i.e., office visits) would be reduced by either 40% or 65%. (Practices would be divided into two groups with different reductions.) These reductions would be phased in between 2017 and 2019, with three options available for how quickly the phase-in would occur. All other CPT codes would be paid at standard rates.
2. **Comprehensive Primary Care Payment (CPCP):** The practice would receive a per-beneficiary per month payment, paid quarterly. The amount of this payment would differ by practice and would be equal to either 40% or 65% of the revenues the practice had received for E&M services prior to the start of the CPC+ program (in order to offset the 40% and 65% reductions in E&M payments) plus 10%. The amount of this payment could be reduced if the practice’s patients increase their use of primary care from physicians who are not part of the practice receiving the CPCP.
3. **Care Management Fee (CMF):** In addition to FFS payments and the CPCP, the practice will receive a CMF payment each month for each Medicare patient, which is expected to average \$28 per beneficiary per month. The actual amount of the CMF payment will be different for different patients depending on the risk tier in which the patient is classified using the CMS Hierarchical Condition Category (HCC) risk adjustment system and diagnosis:
  - **Tier 1:** \$9 for patients with an HCC score in the first (lowest) quartile among Medicare beneficiaries
  - **Tier 2:** \$11 for patients with an HCC score in the second quartile
  - **Tier 3:** \$19 for patients with an HCC score in the third quartile
  - **Tier 4:** \$33 for patients with an HCC score in the 75-89% range of the distribution
  - **Complex:** \$100 for patients with an HCC score in the top (highest) decile 10% OR a diagnosis of dementia regardless of their HCC score.
4. **Performance-Based Incentive Payment:** In addition to FFS payments and the Care Management Fee, the practice would receive a \$4.00 payment each month for each Medicare patient. The practice would have to return all or part of this payment based on its performance on utilization and quality measures:
  - **Quality-Based Incentive:** the practice’s ability to keep one half (\$2.00) of the payment would depend on whether the practice meets annual performance thresholds on quality and patient experience measures. The practice would have to return between 0% and 100% of this payment based on its percentage score on the performance measures.
  - **Utilization-Based Incentive:** the practice’s ability to keep the other half (\$2.00) of the payment would depend on whether the practice meets annual performance thresholds on measures of inpatient admissions and emergency department visits for its patients and also on whether the practice met minimum standards of quality.

## How CPC+ Meets the Requirement for “More Than Nominal Financial Risk”

In the proposed rules for implementing MACRA issued by CMS in April, a practice with fewer than 50 clinicians would meet the MACRA requirements for “more than nominal financial risk” if it is (a) participating in a primary care medical home model where (b) the practice could lose all or part of an otherwise guaranteed payment and (c) the practice could lose 2.5% or more of its Medicare revenues in 2017, increasing to 5% or more in 2020 and later. If the practice has 50 or more clinicians, the proposed rules require the practice to be at risk for 4% of total Medicare spending on the patients.

CMS estimates that if CPC+ practices are similar in size to the practices that participated in the previous/current Comprehensive Primary Care Initiative, Track 1 practices would receive \$126,000 annually from the \$15 average CMF and \$21,000 from the Performance Based Payment on top of about \$140,000 in revenue from E&M services. Since the practice could lose the \$21,000 if its performance is poor, that would represent 7.3% of its total Medicare revenue (other than non-E&M revenues). Track 2 practices would have an estimated \$33,600 at risk on total revenues of \$415,000, or 8%. These loss amounts would meet the requirements for practices under 50 clinicians but not for larger practices.