



## New CMMI Primary Care Plus Payment Program

*Brittany La Couture*

April 26, 2016

Comprehensive Primary Care Plus (CPC+) is a new five-year payment model—proposed recently by the Center for Medicare and Medicaid Innovations (CMMI)—that relies on multi-payer payment reform and changes to care delivery. It is one of several programs expected to be introduced by the Administration in an attempt to meet their goal of transitioning 50 percent of Medicare fee-for-service (FFS) payments to alternative payment models (APMs) by 2018.

### **Background**

The Affordable Care Act (ACA) established CMMI to design and test APMs. One of CMMI's initiatives is to improve quality and reduce costs in primary care payment and delivery.

In 2012 CMS launched the Comprehensive Primary Care (CPC) payment program—a precursor to CPC+. CPC was a collaboration of 38 private and government health insurers in seven different geographical regions using a single reimbursement model: on top of their FFS reimbursements, participating payers pay a fee to participating providers for each enrollee to manage individual patients' overall care. Providers are then given a portion of any savings generated by successful care management in the region.

The early program reported 91 percent of participating physician practices were eligible to share in generated savings. However, the program overall reported a net loss of 1.7 percent, with regional losses ranging from 0.9 percent to 6.3 percent.

### **CPC Plus**

The new CPC+ program's objective is to improve provider performance in five stated functions: access and continuity; care management; comprehensiveness and coordination; patient and caregiver engagement; and planned care and population health. To achieve these ends, CMMI is seeking volunteer payers and providers; the geographic regions that demonstrate the most interest from both groups will be selected to participate.



## RESEARCH

Once selected, provider practices (this model is currently only open to group practices), will be placed into Track 1 or Track 2.

### *Track 1*

Track 1 is a less risky model for practices that have not yet fully implemented all necessary capabilities of the program. The Medicare care management fee for practices on this track will range from \$6 to \$30 per beneficiary per month, depending on the beneficiaries' risk scores. This non-visit based payment is intended to be used for additional staffing and training needs.

Practices that meet all requirements in Track 1 will be eligible for a performance-based incentive payment of \$2.50 per beneficiary per month. Practices are pre-paid these funds at the beginning of the participation year and will be required to pay back these funds if they do not meet the quality threshold. Participating practices must also meet the utilization threshold estimated at the beginning of the plan year.

While participating in Track 1, practices will continue to be reimbursed using FFS.

### *Track 2*

Track 2 offers more risks and reward for participating practices. These providers must have enhanced capabilities such as advanced Health IT, psychological care resources, and the ability to provide comprehensive care to patients with complex needs.

The care management fee for Track 2 will range from \$9 to \$33 for patients with risk ratings corresponding to those in Track 1. However, Track 2 practices will also receive a fee of \$100 per beneficiary per month for patients with the most complex needs, such as advanced dementia.

Practices that meet all performance and utilization requirements in Track 2 will receive an incentive payment of \$4 per beneficiary per month. Like in Track 1, these incentives are paid at the beginning of the plan year and must be repaid if all standards are not met.

During participation in Track 2 of CPC+, practices will be reimbursed in the form of Comprehensive Primary Care Payments (CPCPs). A percentage of



these payments are made up-front at the beginning of the plan year to cover a portion of expected Evaluation and Management (E&M) payments, which will be deducted from Medicare reimbursement for E&M claims at the end of the year. This will supplement continued FFS reimbursement.

### **Areas of Interest and Concern**

Thought projects of this sort are important for finding new, more appropriate ways of reimbursing providers for health care services, it is also imperative that these programs are approached with a critical eye. For instance, the question must be raised as to why CMS will be making payments in advance when it is not clear how or if the agency will be able to recover improper payments (the government's record on clawbacks is notoriously poor, and the results of the CPC project may indicate that this program is likely to cost significantly more than it saves).

Another question raised by CMS' implementation of other APM projects is whether the quality and utilization threshold requirements are likely to be enforced as described. [The Accountable Care Organization](#) demonstration projects were attended by one enforcement delay after another when participants failed to meet the [quality standards](#) set out for them—quality standards that are very similar to those set out in CPC+. Similarly, enforcement delays for individuals and families who owed money as a result of the ACA's individual mandate penalty, and the administration's failure to clawback overly generous subsidy payments both demonstrate the administration's reluctance to try to recoup taxpayer dollars where such action might jeopardize the popularity of the federal program.

### **Conclusion**

CMMI's efforts to generate APMs that can improve patient outcomes while lowering costs are important and admirable. As CMMI continues rolling out new programs to envelope their target of 50 percent of Medicare payments in these programs, however, it will be equally important to carefully study and follow-up on these potentially expensive new programs.