

CMS Perspective:

Comprehensive Primary Care Plus (CPC+) Model Third Annual Evaluation Report

January 2021

The Perspective associated with this report is an update to and replaces a previous one published with the Second Annual report for this model. For information on the model and to download the independent evaluation report discussed in this document, please visit <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/>



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Strengthening primary care is critical to an effective health care system. Because of its importance, CMS has established primary care models as cornerstones of the Center for Medicare and Medicaid Innovation portfolio.

The Comprehensive Primary Care Plus (CPC+) Model is one of the Innovation Center's ongoing model tests of primary care payment and care delivery reform. CPC+ is built on lessons learned from the Comprehensive Primary Care (CPC) initiative, which ran from 2012 through 2016. Launched in 2017, CPC+ began with 14 regions. CMS added 4 additional regions in 2018. The model aims to support over 3,000 primary care practices through regionally-based multi-payer payment reform and care delivery transformation. Taking a key learning from CPC that primary care practices are at different stages of readiness for practice transformation, CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of practices.

The third annual independent evaluation report of CPC+ finds that participating practices received substantial supports from CMS and payer partners. The participating practices leveraged these supports to begin to fundamentally change the way they provide care. But, as expected, participating practices have more work to do in the remaining years to further transform their care and begin to meaningfully affect the ultimate outcomes of the model, including improving beneficiary care quality and reducing unnecessary service utilization and expenditures.

Consistent with CMS's expectations, the report did not find major changes in Medicare beneficiary outcomes three years into the five-year model. The report did find a few, very small impacts on service use and quality of care for Medicare fee-for-service (FFS) beneficiaries that were attributed to participating practices. But, when excluding CPC+ payments, Medicare expenditures for Medicare FFS beneficiaries attributed to practices participating in CPC+ were similar to Medicare expenditures for beneficiaries attributed to comparison practices outside of the Model over the first three years. After factoring in CPC+ payments, Medicare expenditures were 2 to 3 percent higher, or just over \$1.5 billion higher, for CPC+ practices as compared to comparison practices outside of the CPC+ Model. Future reports will assess whether favorable outcomes emerge as participating practices deepen their care transformation.

Independent evaluations are critical to understanding how CMS Innovation Center models are working and how they might be strengthened. The report highlighted a number of areas for improvement that CMS is addressing in CPC+ and other primary care models, such as [Primary Care First](#):

- **Multi-Payer Support:** CPC+ was designed as a unique public-private partnership in which practices are supported by aligned payer partners alongside CMS in the 18 regions. CMS believes that if payers work together to align their value-based primary care payment efforts, they can have a greater impact on practice performance than if they pursue independent initiatives. According to this theory of change, practices are more likely to transform in response to value-based payments when they face the same incentives across a large share of their patient population.

While the report found 79 private and public payers partnered with CMS, multi-payer support was not as aligned as we had hoped. For example, only one-fifth of payer partners met their commitment to provide an alternative to fee-for-service payment by the start of the second year of the model.

Based on this finding, CMS has taken the following steps to enhance multi-payer support:

- Beginning in the fourth year, 2020, CMS engaged with neutral, third-party conveners in the CPC+ regions to facilitate regional multi-payer collaboration to achieve greater alignment.



- In Primary Care First, CMS explicitly defines our [alignment principles](#) and CMS expects payers to meet these standards from the model outset.

- **Payment Incentive:** To encourage and reward accountability for patient experience of care, clinical quality, and utilization measures that drive total cost of care, practices that are participating in CPC+ only (and not dually participating in the Medicare Shared Savings Program) receive a prospectively paid performance-based incentive payment annually, and retain a part or all of these funds if they meet performance targets. The incentive payment includes both a quality and a utilization component with Track 1 practices eligible to retain up to \$2.50 per beneficiary per month (PBPM) and Track 2 practices eligible to retain up to \$4 PBPM.

The report indicated that the payment incentive structure may not be as motivating to practices as hoped. Specifically, practices reported putting only a limited amount of effort into retaining the performance-based incentive payment, with their efforts focused on the quality component and not service use.

CMS is continuing to explore and test a meaningful balance of “at risk” incentives and upfront investments (e.g., care management fees) for primary care. For example, in Primary Care First, CMS is incentivizing improvements in patient experience of care, clinical quality, and acute hospital utilization through a significant quarterly performance-based adjustment to participants’ Medicare payments with up to 50% upside and up to 10% downside potential.

- **Care Management:** CPC+ is designed to support the delivery of five comprehensive primary care functions: 1) access and continuity; 2) care management; 3) comprehensiveness and coordination; 4) patient and caregiver engagement; and 5) planned care and population health. CPC+ practices receive care management fees that average \$15 PBPM for Track 1 and \$28 PBPM for Track 2. In return, practices are required to ensure the delivery of a variety of promising, evidenced-based approaches. One of these requirements is that patients who have complex needs and are likely to benefit from “longitudinal” care management receive it. Longitudinal care management is long-term, proactive, relationship-based care management that augments routine and acute visits with intentional, proactive outreach intensifying primary care interactions during exacerbations of illness and transitions of care.

Though a key component of CPC+, the report shows that a small proportion of beneficiaries receive longitudinal care management, which raises the question of whether this is enough to move the needle on key outcomes, like service use. The report highlights that it may be difficult to detect effects across the entire CPC+ population of attributed Medicare beneficiaries, if only a small proportion are receiving longitudinal care management.

While the precise amount of care management within a patient population required to change outcomes remains an open question, CMS is continuing to hone our requirements for care management. For example, in 2019, CPC+ practices received guidance and notices of potential model termination if levels of care management fell below a defined threshold (i.e., 1% of all empaneled patients receiving longitudinal care management). Additionally, CMS continues to require additional evidence-based primary care interventions, such as behavioral health integration, hospital and emergency department follow-up contact, and 24/7 access to care team members with real-time EHR access.

Primary care is the foundation of high functioning health care systems, which underscores its importance to the Innovation Center’s mission. The results of this report provide valuable lessons which inform the refinement of CPC+ and development of future primary care models. CMS continues to learn from evaluation findings to advance opportunities that accommodate diverse primary care practices in the United States, with varying levels of care delivery capability and readiness for alternative payments, and ultimately aim to improve the lives of patients.