CMS Perspective:

Comprehensive Primary Care Plus (CPC+)

Second Annual Evaluation Report and Next Steps on Primary Care

July 2020

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.

Comprehensive Primary Care Plus (CPC+) is the Innovation Center's ongoing test of primary care reform. CPC+ followed the Comprehensive Primary Care (CPC) initiative, which ran from 2012 through 2016 and laid the foundation for CPC+. Launched in 2017, CPC+ began with 14 regions and added 4 additional regions in 2018. The model aims to support 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 second annual independent evaluation report of CPC+ finds that practices received substantial supports from CMS and payer partners. The practices leveraged these supports to begin to fundamentally change the way they provide care. But, as expected, practices have more work to do in the remaining three 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.

Further, consistent with CMS's expectations, the report did not find major changes in beneficiary outcomes this early in the model. The report did find a few, very small impacts on service use and quality of care for Medicare fee-for-service (FFS) beneficiaries. But, when excluding enhanced CPC+ payments, expenditures for Medicare FFS beneficiaries were similar for CPC+ and comparison practices over the first two years. After factoring in enhanced payments, expenditures were just over $1 billion higher for CPC+ practices. Future reports will be required to assess whether favorable outcomes emerge, as practices deepen their care transformation.

Independent evaluations are critical to understanding how CMS 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 upcoming primary care models:

- **Multi-Payer Support:** CPC+ was designed as a unique public-private partnership in which practices are supported by aligned payers 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 majority of their patient population.

  However, the report found that multi-payer support was not as substantial 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 2020, CMS is engaging with neutral, third-party conveners in the CPC+ regions to facilitate regional multi-payer collaboration to achieve greater alignment.
  - In future primary care models, such as Primary Care First, CMS explicitly defines our alignment principles and CMS expects to hold prospective payers to 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 strong 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 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 raises the question of what proportion of beneficiaries must receive longitudinal care management 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, 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 received 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.

Evidence strongly suggests that primary care is the foundation of high functioning health care systems, which underscores its importance to CMMI'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.