CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Findings at a Glance

Comprehensive Primary Care Plus (CPC+) Model

Evaluation of the Fifth Year (2021)

MODEL OVERVIEW

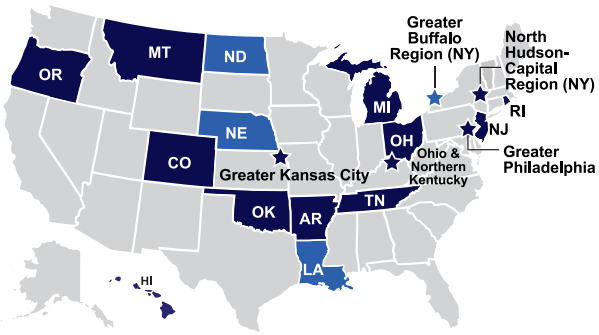
GOALS OF CPC+

Increase access to—and improve the quality and efficiency of—primary care, which ultimately is intended to achieve better health outcomes at lower cost

CPC+ was the largest primary care payment and delivery reform model ever tested in the United States. Through CPC+, the Centers for Medicare & Medicaid Services (CMS) tested whether multipayer payment reform, actionable data feedback, robust learning activities, and health information technology (IT) vendor support enabled primary care practices to transform how they deliver care and improve patient outcomes. CPC+ required practices to transform across five care delivery 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+ included two tracks. Compared to Track 1, Track 2 practices had more advanced care delivery requirements, received additional financial support, and were required to gradually shift from a fee-for-service (FFS) approach toward population-based payment, all intended to better support patients with complex needs.

PARTNERS AND PARTICIPANTS

CMS launched CPC+ in 2017 in 14 regions and added 4 more regions in 2018—along with 79 public and private payers and 68 health IT vendors. CPC+ ran through December 2021.



CPC+ ran January 2017 – December 2021

CPC+ ran January 2018 – December 2021

Across the 2017 and 2018 regions at the start of CPC+, CMS supported 3,070 primary care practices' efforts to improve the care they provide to over 17 million patients. Participation remained relatively steady throughout CPC+.

	Payers	Practices	Practitioners
Start of PY 1	63	2,905	13,204
End of PY 2	64	2,716	13,528
End of PY 3	60	2,675	13,739
End of PY 4	57	2,599	13,766
End of PY 5	57	2,419	13,090

For simplicity, the evaluation focuses on practices that joined CPC+ in 2017, which represents 95% of all CPC+ practices.

KEY TAKEAWAYS

CPC+ reduced emergency department (ED) visits, acute inpatient hospitalizations, and acute inpatient expenditures. These reductions were not sufficient in either track to reduce total Medicare expenditures or achieve net savings, after accounting for increased expenditures in other areas, such as physician services, inpatient rehabilitation, and hospice, and enhanced CPC+ payments. We did not observe any systematic differences in primary outcomes between Track 1 and Track 2 practices despite greater funding and care delivery requirements for Track 2 practices. Independent practices and those participating in the Medicare Shared Savings Program (SSP) at baseline tended to have more favorable results. We observed limited improvements in quality of care measured using Medicare claims).

Without direct incentives for specialists and hospitals to reduce costs, primary care practitioners lack control over critical aspects of care that drive large portions of unnecessary utilization and total Medicare expenditures. Primary care is critical and central to an organized health care system but may not be sufficient to move the needle on total Medicare expenditures. Achieving health care system transformation will continue to require more support for primary care in parallel with work to right-size payments for low-value services, specialists, and hospitals, and to increase professional and other incentives for primary and specialty care coordination.

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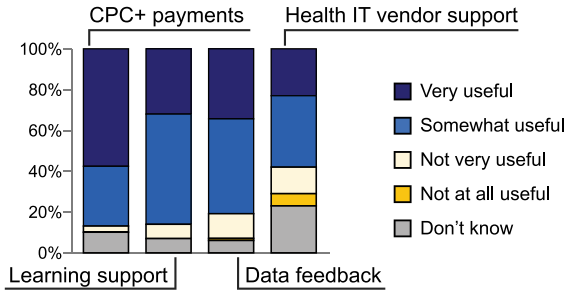
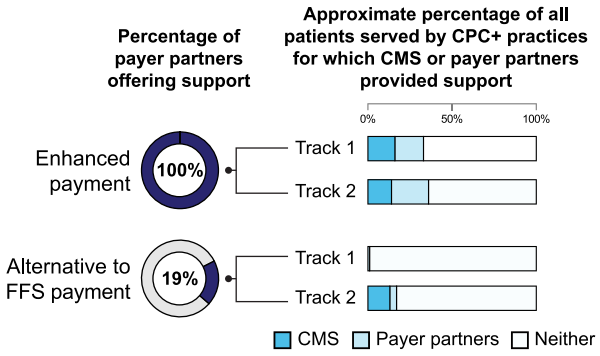
FINDINGS

What supports did CMS, payer partners, and health IT vendors provide and were they useful to the CPC+ practices?

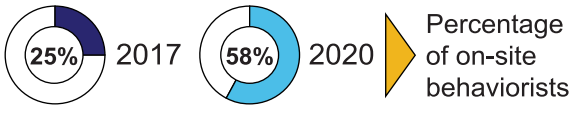


CPC+ practices widely found the CPC+ payment, learning, and data feedback supports they received to be useful for improving primary care. Fewer practices found health IT vendor support useful.



Most or all payer partners provided enhanced payments for one-third of the total patients CPC+ practices served. Few payer partners implemented FFS alternative payments; correspondingly, practices received alternative payments for only one-sixth of all patients served by Track 2 CPC+ practices.

Care improved for beneficiaries with care transitions and for beneficiaries with behavioral health needs



Practices in CPC+ increased use of on-site behaviorists each year of the model, and to a greater degree than did comparison group practices. CPC+ practices also increased their episodic care management to provide timely follow-up after hospital and ED visits, especially in Program Years 1–3. Accordingly, more beneficiaries in Track 2 CPC+ than comparison practices reported timely follow-up after an ED visit.

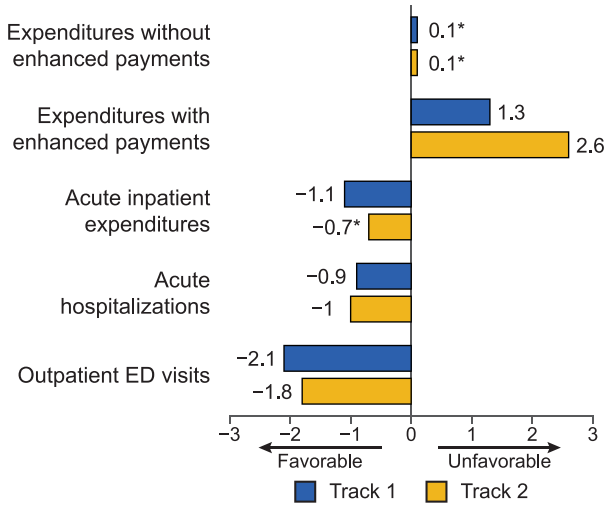
Plans for sustaining care delivery changes

Practices reported plans to continue some of the processes they put in place for CPC+ after the model ended: (1) ensuring a range of options for accessing primary care from the practice, (2) using data to guide practice improvements, and (3) providing episodic care management for patients who had a recent hospital admission or ED visit. Still, practices expect to need ongoing supports from payers to continue many aspects of this work, including behavioral health integration.

What were the effects on Medicare FFS beneficiaries' outcomes?

Over the five program years, CPC+ reduced key acute care utilization measures. Average annual acute hospitalizations and their expenditures declined by about 1 percent and ED visits declined by about 2 percent among both Track 1 and Track 2 practices.

Percentage change in average annual outcomes by track for 5 years



* Percentage change not different from zero relative to non-participating primary care practices.

This document summarizes the evaluation report prepared by an independent contractor. To learn more about CPC+ and to download the full evaluation report, visit: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/.