Editorial

Transforming Primary Care Through Innovations in Medicare

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The Affordable Care Act authorized the US Centers for Medicare & Medicaid Services (CMS) to create the Center for Medicare and Medicaid Innovation (more recently known as the CMS Innovation Center) to improve the quality of care and control health care spending in the Medicare and Medicaid programs. Since 2011, this center has advanced and implemented value-based payment programs to reform the long-standing focus on fee-for-service payments in traditional Medicare. These efforts have emphasized alternative payment models (APMs) such as accountable care organizations (ACOs), episode-based bundled payments, and support for innovative approaches to comprehensive primary care.1 A strength of the APMs has been a congressional mandate for CMS to conduct rigorous evaluations of health care spending and quality of care in these programs. To underscore the importance of the evaluations, Congress has authorized the US Secretary of Health and Human Services to expand and extend APMs that are shown to be associated with decreased spending without reduced quality of care or improved quality without increased spending.

The earliest endeavor by the CMS Innovation Center to reform primary care was its Comprehensive Primary Care (CPC) Initiative (subsequently known as CPC Classic), which was conducted from 2012 through 2016. Working with approximately 500 primary care practices serving more than 400,000 Medicare beneficiaries in 7 US regions, CPC Classic provided ongoing coaching, feedback, and care management fees to engage practices in transforming their care models to improve quality and better control spending.2,3 These efforts focused on enhancing patients’ primary care access and coordination of care; promoting preventive services and chronic disease management; and reducing avoidable emergency department (ED) visits, hospitalizations, and readmissions.

Practices participating in CPC Classic made substantial efforts to transform their care. However, in the initial CMS-authorized evaluation, no substantial differences were noted between CPC Classic practices and matched comparison practices in Medicare spending (after accounting for care management fees), ED visits, hospitalizations, or measures of quality during the first 2 years.2,3 The final 4-year evaluation reported substantially slower growth in ED visits in CPC Classic, but the interim 2-year findings were otherwise largely confirmed, particularly the lack of substantial reductions in spending or improvements in quality of care.4 A subsequent study found substantial reductions in the growth of ED visits and hospitalizations over 6 years in CPC Classic practices compared with comparison practices, but no significant differences in total Medicare spending were noted between these groups.5 In 2017, the CMS Innovation Center launched Comprehensive Primary Care Plus (CPC Plus) as a new 5-year initiative, building on lessons learned in CPC Classic.

In this issue of JAMA, a new study presents key findings from the final evaluation of the CPC Plus initiative.6 Compared with CPC Classic, the CPC Plus initiative provided more financial and tactical support for participating practices, along with greater expectations for change. It also shifted performance-based financial incentives from the regional level to the practice level. About 85% of primary care practices that participated in CPC Classic chose to continue participating in CPC Plus, demonstrating their commitment to ongoing practice transformation and the associated financial incentives.

Practices participating in CPC Plus were expected to improve care in 5 domains: access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and planned care and population health.6 The CPC Plus practices could opt into track 1 with basic expectations regarding access, teamwork, and quality improvement or track 2, which had...
more advanced expectations for treating patients with complex needs, connecting patients with community resources, and shifting compensation to partial capitation payments. Track 2 practices received larger care management fees than track 1 practices ($28 per beneficiary per month [PBPM] vs $15 PBPM) that comprised a larger median proportion of practice revenue (14% vs 9%).

Using rigorous propensity score matching and difference-in-difference methods with adjustment for beneficiary characteristics, practice fixed effects, and COVID-19–associated variables, Singh and colleagues6 compared more than 1300 track 1 practices and 1100 track 2 practices in CPC Plus (together caring for 5.9 million traditional Medicare beneficiaries) with more than 8000 nonparticipating practices caring for nearly 9.9 million beneficiaries.6 The primary study outcomes were annualized Medicare Part A and Part B expenditures PBPM before and after including enhanced payments to participating practices. Prespecified secondary outcomes included 7 expenditure categories, 8 utilization measures, and 27 quality measures, such as diabetes care and breast cancer screening, that were all derived from Medicare claims data.

The findings of Singh and colleagues6 were largely consistent with the prior evaluations of CPC Classic.2-6 Before accounting for enhanced payments to CPC Plus practices, no significant differences were evident in adjusted total expenditures for either track 1 or track 2 practices vs comparison practices. After accounting for the enhanced payments, total expenditures were significantly higher in CPC Plus practices in track 1 (+$13 PBPM; 90% CI, $7-$18) and track 2 (+$24 PBPM; 90% CI, $18-$31). Among CPC Plus practices in both tracks, significantly fewer ED visits occurred during all 5 years of the evaluation, and in track 1, fewer hospitalizations occurred beginning in the third year. Significant improvements of small magnitude (about 1 percentage point) were noted in process measures of diabetes quality of care and breast cancer screening among CPC Plus practices in both tracks.

In subgroup analyses, spending growth was lower among CPC Plus practices that also participated in Medicare Shared Savings Program ACOs compared with those participating only in CPC Plus, suggesting potential synergies between primary care transformation and value-based payments incentives at a broader organizational level. Singh and colleagues6 noted that the least favorable spending and utilization outcomes occurred in hospital-owned or system-owned practices that were not participating in Medicare ACOs. Although not a central focus of their study, the authors also presented survey and interview findings from their associated CMS evaluation.6 CPC Plus physicians reported greater attention to timely follow-up of patients after ED visits and hospitalizations, and Medicare beneficiaries in track 2 practices concurred with these assessments.

The study by Singh and colleagues6 is published at a time when US primary care practices and their physicians are increasingly viewed as beleaguered and essential for effective care. In 2021, the National Academies of Science, Engineering and Medicine (NASEM) published an extensive report on implementing high-quality primary care.7,8 This report emphasized that high-quality primary care is “the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual’s health and wellness needs across settings and through sustained relationships with patients, families, and communities.”8

The NASEM report also underscored the need for a new Secretary’s Council on Primary Care in the US Department of Health and Human Services to coordinate federal policies to revitalize primary care in the US.7 The US Department of Health and Human Services is now responding with new policies to bolster primary care, including payment reform, workforce training, and access to community health centers and behavioral health care.10 Many of the NASEM report recommendations are consistent with the objectives of ongoing CMS programs to support comprehensive primary care, including a greater focus on health equity.11-14

CMS has set a goal of having all traditional Medicare beneficiaries in accountable care relationships by 2030,13 including advanced primary care models, such as Primary Care First (the ongoing successor to CPC Plus) and the recently announced Making Care Primary model that will launch in July 2024.14,15 However, as of June 2023, fewer than half of US primary care practices were participating in APMs, such as Medicare ACOs or Primary Care First.13 Thus, without broader
engagement of primary care practices in APMs and practice transformation, CMS will have a steep
challenge to achieve its ambitious goal of accountable care for all traditional Medicare beneficiaries
by 2030. Even if achieving this goal is not cost saving for Medicare, it will still be beneficial for
patients and primary care physicians if it leads to improved access and coordination of care and
prevents avoidable ED visits and hospitalizations, particularly for medically and socially complex
patients with the greatest health care needs. Putting primary care first remains elusive and essential
for achieving a more effective and equitable US health care system.

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