Addressing Challenges in Primary Care—Lessons to Guide Innovation
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The Centers for Medicare & Medicaid Services (CMS) is committed to advancing health equity, expanding coverage, and improving health outcomes. To support this vision, the CMS Innovation Center announced an ambitious goal for the year 2030: to have 100% of beneficiaries in traditional Medicare and most Medicaid beneficiaries in accountable care relationships with providers who are responsible for the quality and the total cost of care, mostly through advanced primary care or accountable care organizations.1

The National Academies of Sciences, Engineering, and Medicine (NASEM) report on primary care in 2021 highlighted its vital role in the health care system in promoting better population health and equitable outcomes.2 However, Medicare beneficiaries are facing greater clinical and system complexity requiring better coordination of primary and specialty care. Nearly 30% of beneficiaries have 2 or 3 chronic conditions, 22% have 4 or 5, and 18% have 6 or more.3 Furthermore, the proportion of beneficiaries seeing 5 or more physicians annually increased from 18% to 30% between 2000 and 2019.4

The Innovation Center has tested models to increase access to advanced, integrated primary care in many communities. In doing so, it reviewed data and practice feedback from several primary care initiatives: the Comprehensive Primary Care (CPC) (2012-2015) and Comprehensive Primary Care Plus (CPC+) (2017-2021) models and the Primary Care First (PCF) (2021-2026) model. Five major lessons emerged from this review.

Primary Care Practices Can Meaningfully Change How They Organize and Deliver Care

Independent evaluation findings from CPC demonstrated that nearly 500 practices, 61% of which were not state- or National Committee for Quality Assurance–recognized medical homes, changed their care delivery to a greater degree than comparison practices, with large changes in risk-stratified care management, access, and continuous data-driven improvement. Importantly, practice change was not associated with burnout or workforce stress.5 Participating practices reported that CPC supported a better way to deliver care for patients and staff, and they expected that the changes would be sustainable with future payment reform. Interim findings from nearly 3000 practices in CPC+ show similar changes in care delivery and substantial behavioral health integration.6 Practices with limited prior experience with value-based payment can make needed changes to deliver advanced primary care.

Changes in Quality and Total Cost of Care Are Challenging to Detect Within a 5-Year Period

The independent CPC evaluation found no significant difference from control practices on claims-based measures of diabetes care processes or continuity of care among attributed Medicare beneficiaries. Among the 11 core electronic clinical quality measures (eCQMs), improvements for 3 measures were greater in CPC practices than practices that formed the benchmark.7 However, the evaluation could not assess performance based on eCQMs because data were unavailable for comparison practices. Moving forward, the Innovation Center seeks to harmonize model evaluation
measures with quality measures used to determine payment to the greatest extent possible and better capture the impact of care delivery changes on quality and beneficiary experience, including through patient-reported outcome measures.

Comprehensive Primary Care practices significantly slowed growth in emergency department (ED) visits but not hospitalizations relative to comparison practices. Nearly all CPC practices continued into CPC+, and the reductions in ED visits persisted and grew significantly over time. However, net savings for CMS were not achieved within 5 years because enhanced payments, including care management fees, to participating practices were greater than reductions in service use. The Innovation Center will consider expectations for the period during which savings can develop and the role of primary care clinicians in generating savings, alone or in coordination with other parts of the health care system.

**Equity Must Be an Explicit Aim of Primary Care Models**

In CPC+ and PCF, Black and Hispanic beneficiaries are underrepresented and White beneficiaries are overrepresented compared with the national Medicare average. American Indian/Alaska Native beneficiaries are well represented in CPC+ but not in PCF because the 3 Indian Health Service and Tribal clinics in CPC+ opted not to participate in PCF. Comprehensive Primary Care Plus had higher penetration in more rural than urban areas, in part because federally qualified health centers were ineligible to participate. State Medicaid agencies participated as payer partners in 7 of the 18 CPC+ regions. These 7 regions had greater participation from practices in very rural, predominantly White and rural/suburban areas.

The Innovation Center will examine ways to reach a more representative cohort of beneficiaries, including by providing a range of supports, resources, and payment incentives to participating practices.

**Multipayer Alignment Is Necessary to Support Advanced Primary Care**

Multipayer alignment, including among state Medicaid agencies and commercial payers, was a core feature of CPC. The NASEM report emphasizes the need to align payment models, quality measurement, and data feedback across payers to reduce practice burden and operational costs. At least 63% of revenue may be needed from nonvisit or capitated sources for most practices to deliver team-based care without losing money. In CPC, 39 payers participated across 7 regions, representing greater than 60% of revenue for the participating practices in these regions.

Multipayer participation does not ensure meaningful alignment on design features, however. Most of the 71 payers participating in CPC+ had been CPC payer partners, and 11 new CPC+ regions were added after payer participation could be ensured. However, only 17% of payers offered partial capitation payment aligned with CPC+. In PCF, payer participation is lower than in CPC+ because the selection of regions was not contingent on payer participation.

Bringing state Medicaid agencies and commercial payers into the design of models earlier will support multipayer alignment. The Health Care Payment Learning and Action Network (LAN) is also providing a venue for multistakeholder collaboration to support care transformation through alternative payment models.

**Regional Context Matters for Care Transformation**

Practice transformation takes shape locally, and regional context matters for effective implementation. Important factors include practice organization and experience with care delivery changes, availability of health information exchange, experience with regional data aggregation, and state population health and equity initiatives.
Effective primary care also relies on access to and coordination with specialty services and community-based organizations that address health-related social needs (HRSNs). Comprehensive Primary Care and CPC+ addressed these needs with general approaches, such as care management and coordination, and specific tactics, such as agreements between primary care and specialty clinicians that outline referral protocols, care transition and management responsibilities, integration of behavioral health care, and screening and referral for HRSNs. However, the effectiveness of these tactics depended highly on informal and organizational relationships and resources, local referral patterns and practices, and workforce availability.6

The Innovation Center will continue to consider the practice characteristics that contribute to success as well as the regional context necessary for care transformation, including fostering better coordination and integration of primary care with specialty-care and community-based services. The LAN and its state transformation collaboratives offer an opportunity to drive change regionally and understand the factors and conditions that enable a range of practices to deliver advanced primary care.

These lessons are guiding future primary care initiatives in Medicare that increase participation among practices, include a broader population of beneficiaries, and consider the primary care clinician’s role in generating savings. These insights will be critical as the Innovation Center seeks to test population-based models that bring together more clinicians across settings to deliver patient-centered, accountable care.

ARTICLE INFORMATION
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