

U.S. Health Reform—Monitoring and Impact

Medicare's Evolving Approach to Paying for Primary Care

December 2017

By Rachel Burton, Robert A. Berenson, Stephen Zuckerman



Robert Wood Johnson
Foundation

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.



With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org.

IN BRIEF

Relatively few physicians choose to go into primary care in the United States, partly because of large disparities in the salaries of primary care physicians and specialists. Medicare has long recognized its role in reducing this payment disparity and introduced its Physician Fee Schedule in 1992 in an attempt to fix this, yet the compensation disparities persist. On top of this, research shows that a growing share of the activities that primary care clinicians do in a day are not recognized for payment.

Policymakers disagree over whether to increase payments for current primary care services or to provide additional payments only for innovative new services not currently recognized in the fee schedule. The Centers for Medicare & Medicaid Services (CMS) has favored the latter approach, adding new billing codes to the Medicare Physician Fee Schedule and conducting demonstrations to test new primary care payment and delivery models, such as activities included in the patient-centered medical home model of primary care.

Each approach has distinct advantages and disadvantages. Adding new codes to the annually updated fee schedule allows CMS to tweak practitioners' incentives through a relatively nimble and quick process. Demonstrations allow CMS to rigorously evaluate the impacts of paying for new services or paying for current services differently, and they allow CMS to test more outside-the-box payment models that give practitioners greater flexibility in how they care for patients. Demonstrations also give providers a financial incentive to engage in activities that may otherwise be hard to define or include in a fee schedule (e.g., calling patients). Demonstration payment models include flat monthly fees that cover the cost of a broad range of activities as well as performance bonuses that can be spent on anything.

In this paper, we review CMS's strategy of expanding billing codes and conducting demonstrations to better support primary care. The billing codes added in recent years suggest that CMS has become increasingly comfortable with paying for non-face-to-face services for beneficiaries, recognizing that not all useful work requires a physical interaction between the patient and the clinician. We also see a shift in the fee schedule to a more diversified approach to paying for primary care, with separate fees still used for many services, but also monthly payments to cover packages of low-cost activities that would be impractical to bill for separately (e.g., emails, phone calls, and brief conversations among staff that are all related to managing the care of a complex patient).

Looking at demonstrations, we find higher and higher monthly payments offered to primary care practitioners for increasingly broad segments of the Medicare population, and a shift from end-of-year bonuses to up-front payments. We also see that practitioners are held accountable for a growing range of outcomes (including patient satisfaction, care quality, and appropriate utilization) but, increasingly, are not expected to independently influence the total cost of all care received by Medicare beneficiaries.

CMS's new primary care billing codes and primary care demonstrations suggest a willingness to pay increasingly large amounts to primary care practitioners for managing the care of patients with chronic conditions. CMS has clearly placed a priority on identifying a payment amount generous enough to incentivize primary care practitioners to more closely manage these high-need, high-cost beneficiaries. As CMS states in the final rule for the 2018 Medicare Physician Fee Schedule (PFS), the agency is engaging in an "ongoing incremental effort to identify gaps in appropriate coding and payment for care

management/coordination, cognitive services, and primary care within the PFS.”

Using new billing codes and demonstrations concurrently allows CMS to do two things at once: (1) incentivize specific activities that the agency knows it wants clinicians to engage

in (through billing codes), and (2) test whether it can achieve favorable outcomes by paying for promising new delivery reforms (through demonstrations). Only time will tell what payment amount will be sufficient to convince practitioners to deliver these services and what effect these services will have on patients’ quality of care.

WHY IS PRIMARY CARE PAYMENT REFORM NEEDED?

Health care systems oriented toward primary care have better health outcomes, lower spending, and more satisfied patients.^{1,2} Yet millions of Americans live in an area with an inadequate supply of primary care practitioners; an additional 7,000 - 16,400 practitioners would be needed to rectify this shortage.^{3,4} One reason for the primary care shortage is the income disparity between primary care physicians and specialists: According to various surveys, primary care physicians’ median incomes range from \$225,000 to \$250,000, but top-earning specialists (including interventional cardiologists, orthopedic surgeons, and radiologists) have median incomes as high as \$550,000.⁵

As the largest and most influential insurer in the United States, Medicare has long recognized its role in reducing payment disparities among physicians and increasing the attractiveness of working in primary care. To that end, Medicare introduced the Physician Fee Schedule in 1992.^{6,7} Yet large compensation disparities have persisted.⁸

Moreover, research shows that a growing share of the activities that primary care clinicians do in a day are not recognized for fee schedule–based payment.^{9,10} Before electronic health records (EHRs) became widespread, one study found that 25 percent of the activities that primary care physicians did in a day were unbillable;¹¹ a more recent study used EHR time stamps to determine that primary care physicians now evenly divide their time between office visits and “desktop medicine” (defined as corresponding with patients online, ordering tests, reviewing test results, and emailing other staff).¹²

Physicians also consider the nature of their work when they choose specialties. Physicians in primary care specialties such as general internal medicine and family medicine report some of the lowest levels of career satisfaction¹³ and some of the highest levels of professional burnout;¹⁴ unsurprisingly, physicians in these two primary care specialties are the most likely to wish they had picked a different specialty.¹⁵ Physician burnout is enough of a concern that some physicians have called for the “triple aim” of improving the health care system (which currently refers to improving population health,

reducing per capita costs, and improving patient experience¹⁶) to be expanded to the “quadruple aim,” with improving the work life of clinicians and staff as the fourth aim.¹⁷

Policymakers disagree over whether to increase payments for current primary care services or to only provide additional payments for innovative new services not currently recognized in the fee schedule. The Centers for Medicare & Medicaid Services (CMS) has demonstrated little success in using the former approach; it has allowed apparent distortions in the relative value units that determine fees in the Medicare Physician Fee Schedule to persist. These distortions result in overpayments for procedures and test interpretations and underpayments for time spent evaluating and managing patients^{18–22} and contribute to the income disparities across specialties.²³ In recent years, CMS has added new billing codes and launched demonstrations that encourage primary care practitioners to engage in previously unbillable activities, such as activities included in the patient-centered medical home model of primary care.

Each of these two approaches has distinct advantages and disadvantages. Adding new billing codes to the annually updated fee schedule allows CMS to alter practitioners’ incentives nimbly and quickly, but it does not allow for the types of impact evaluations that are feasible in multiyear demonstrations. But not all services can be crisply defined and easily included in a fee schedule; some activities that could produce value (e.g., returning patient phone calls about medical concerns) may not be easy to pay for separately through a fee schedule because the transaction and documentation costs of billing for them often would exceed the costs of providing the service. In contrast, demonstrations allow CMS to test more innovative payment models that give practitioners greater flexibility in how they care for patients. Such payment models include flat monthly fees that cover the cost of a broad range of activities and performance bonuses that can be spent on anything. These models must be tested and proven to be effective before they can be rolled out nationally.^{24,25}

In this paper, we review CMS's strategy for expanding billing codes and conducting demonstrations to better support primary care. The codes added in recent years suggest that CMS has become more comfortable with paying for non-face-to-face services for beneficiaries, recognizing that not all useful work requires a physical interaction between the patient and the clinician. We also see a shift in the fee schedule to a more diversified approach to paying for primary care, with separate fees still used for many services, but also monthly payments to cover packages of low-cost activities that would be impractical to bill for separately (e.g., emails, phone calls, and brief

conversations among staff that are related to managing the care of a complex patient).

We also examine the evolution of demonstration payment models. We find higher and higher monthly payments offered to primary care practitioners for increasingly broad segments of the Medicare population, and a growing shift from end-of-year bonuses to up-front payments. We also see that practitioners are held accountable for a growing range of outcomes (including patient satisfaction, care quality, and appropriate utilization) but, increasingly, are not expected to independently influence the total cost of all care received by Medicare beneficiaries.

ADDING BILLING CODES TO THE MEDICARE PHYSICIAN FEE SCHEDULE

Most fee schedule payments for primary care practitioners offer compensation for face-to-face office visits. Payments for these visits cover time spent interacting with patients, as well as clinician and staff time spent doing prep work before and follow-up work after the visit, or pre- and post-service work respectively. Many of the new primary care billing codes that CMS has added in recent years (see **Table 1**) allow the agency to pay separately for, and thus incentivize, non-face-to-face activities that the agency previously considered to be included in the pre- or post-service work associated with a visit.

Some early forays into adding new codes for primary care practitioners occurred back in 2001, when CMS began paying physicians to certify that homebound Medicare beneficiaries qualified for home health services (G0180, G0179) and to oversee the care received by home health patients (G0181) and hospice patients (G0182) on an ongoing, monthly basis. Except for these examples, the codes available to primary care practitioners were essentially frozen for more than a decade, while dozens of new codes were added for procedures, imaging, and tests for other types of clinicians.

This has changed in recent years. Additions to the fee schedule have covered new primary care services for increasingly broad segments of the Medicare population. In 2013, CMS began paying practices to manage care transitions for patients recently discharged from a hospital or other facility (99495, 99496). These codes, which are mostly used by primary care practitioners, pay for one face-to-face visit with a patient within a specified time frame, as well as non-face-to-face services that can include communicating with patients about their care, educating them about their medical condition, assessing and supporting patients as they try to adhere to their treatment regimen and adjust to new medications, and communicating with patients' other clinicians to ensure care coordination.

In 2015, CMS began paying for ongoing chronic care management (CCM) of patients with multiple chronic conditions (99490). This group of patients accounts for a disproportionately high amount of Medicare spending. According to CMS, 69 percent of traditional Medicare beneficiaries have multiple chronic conditions, yet they generate 93 percent of Medicare spending.²⁶ In creating this new billing code, CMS acknowledged that the existing payments for some patient visits did not provide sufficient compensation to cover all the prep and follow-up work required for such visits.²⁷ New care management payments are intended to cover the cost of developing and/or revising patient care plans, reviewing lab results and other studies, communicating with other health care professionals outside the practitioner's practice, and making ongoing adjustments to a patient's treatment regimen—all of which can, and often should, be performed without requiring patients to come in for a face-to-face visit. CMS allowed some of these services to be conducted by nonphysician staff under the general supervision of a physician, in what may be seen as an endorsement of the team-based approach to care.²⁸

When CMS first adopted the chronic care management billing code, the agency established many requirements for practitioners attempting to claim this fee in an effort to ensure that only advanced primary care practices would do so. Before submitting a claim, practitioners had to furnish a qualifying visit to a beneficiary, obtain written consent from the beneficiary (because the beneficiary would have to pay coinsurance for this service), and meet certified electronic health record standards, including the ability to share care plans and clinical summaries electronically. The practitioner also had to offer 24/7 access and continuity of care, comprehensive care management, development of a comprehensive care plan, management of care transitions, home- and community-

Table 1: Innovative Primary Care Billing Codes Added to the Medicare Physician Fee Schedule

Year Added	Billing Code	Description of Service	Payment Amount*
Certifying and overseeing care for patients needing home health and hospice services			
2001	G0180	Physician certification of a patient's need for home health services	\$54.55
2001	G0179	Physician recertification of a patient's need for home health services, done every 60 days	\$41.99
2001	G0181	Physician care plan oversight for patients receiving home health services, involving at least 30 min. per month	\$109.46
2001	G0182	Physician care plan oversight for patients receiving hospice services, involving at least 30 min. per month	\$110.18
Managing patients' care transitions			
2013	99495	Transitional care management services with moderate medical decision complexity, and a face-to-face visit within 14 days of discharge	\$165.45
2013	99496	Transitional care management services with high medical decision complexity, and a face-to-face visit within 7 days of discharge	\$233.99
Managing care for patients with chronic conditions			
2015	99490	Chronic care management services, involving spending at least 20 min. per month establishing, implementing, revising, or monitoring a comprehensive care plan for a high-risk patient with multiple chronic conditions	\$42.71
2017	99487	Complex chronic care management services, involving spending at least 60 min. per month and moderate- or high-complexity medical decision-making	\$93.67
2017	+99489	Each additional 30 min.	\$47.01
Advance care planning			
2016	99497	Advance care planning, involving 30 min. with a patient explaining and discussing advance directives, and completing forms specifying end-of-life care preferences	\$82.90
2016	+99498	Each additional 30 min.	\$72.50
Managing care for patients with cognitive impairment and behavioral health conditions			
2017	G0505	Creating a care plan for patients with cognitive impairment (e.g., Alzheimer's, dementia)	\$238.30
2017	G0502	Initial psychiatric collaborative care management, for the first 70 min.	\$142.84
2017	G0503	Psychiatric collaborative care management in a subsequent month, for at least 60 min.	\$126.33
2017	+G0504	An additional 30 min. of behavioral health care manager activities in a given month, conducted in accordance with the psychiatric collaborative care model	\$66.04
2017	G0507	Care management of behavioral health conditions for at least 20 min. per month, not necessarily conducted in accordance with the psychiatric collaborative care model	\$47.73
Prolonged non-face-to-face services			
2017	99358	Prolonged E/M service without face-to-face contact with a patient, conducted before and/or after direct patient care and lasting 31–60 min.	\$113.41
2017	+99359	Each additional 30 min.	\$54.55

* Dollar amounts are national payment amounts for nonfacility (i.e., office) settings in 2017. Actual payment amounts vary based on a payment formula that includes the geographic location of the practitioner and other factors.

Source: Physician Fee Schedule search. CMS website. <https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>. Updated January 19, 2017. (We expect 2018 amounts to be available at this source in mid-January 2018.)

based care coordination, and enhanced communication opportunities (e.g., secure messaging or another asynchronous communication method).

Practitioners responded that these requirements were unnecessarily burdensome and hindered use of the care management code, and that the fee amount (\$42.71/month) was not sufficient to pay for the time required to provide the care management services and collect the necessary documentation. Given these concerns, it is not surprising that the uptake of the care management codes has been slow. CMS estimates that 69 percent of Medicare fee-for-service beneficiaries—roughly 26.5 million people²⁹—have two or more chronic conditions, making their primary care practitioners eligible to be paid for chronic care management services. But by November 2016, CMS reported that it had only received CCM claims for about 500,000 beneficiaries who each received the service an average of four times, with payments totaling \$93 million over nearly two years.³⁰ (For reference, primary care practitioners who treat adults received about half of the \$16.6 billion in allowed Medicare charges for the two most common office visits.³¹)

In response to stakeholder concerns, and in order to increase use of the CCM billing codes, CMS reduced some of the administrative requirements for using the codes for 2017, easing the billing and documentation requirements related to patient consent and use of electronic technology. CMS also added a new, more generous billing code for working with especially complex patients (99487, paid at \$93.67/month).³²

Taking a closer look at this billing code sheds some light onto CMS's evolving approach to primary care payment reform. In the final rule for the 2017 Physician Fee Schedule (PFS), CMS indicated that when it first adopted the CCM code in 2015, the agency had "sought to make certain that the newly payable PFS code(s) would provide beneficiary access to appropriate care management services that are characteristic of *advanced primary care*" (emphasis added).³³ However, CMS expressed concern that imposing too many requirements on practitioners using the CCM billing code could create disparities between this billing code and others in the fee schedule; thus, the agency decided to reduce billing requirements associated with the CCM code to increase its use. In so doing, CMS enunciated a different standard for new billing codes, stating

that they should "facilitate beneficiaries' access to reasonable and necessary CCM services that improve health outcomes"; specifically, the code would no longer require adherence to standards of advanced primary care.

CMS determined that adding new fee schedule codes should not exact an unreasonable burden on fee schedule billers, but acknowledged that some delivery system enhancements can be achieved more successfully through alternative payment models. The complementary approach could both increase payment to traditional primary care practices and encourage the formation of advanced primary care practices.

CMS has recently recognized many additional primary care services that it had never paid separately for, including discussions identifying patients' end-of-life care preferences (99497, 99498), management of the care of patients with behavioral health conditions (G0505, G0502, G0503, G0504, G0507), and prolonged evaluation and management (E/M) services conducted before and/or after direct patient care, such as time spent reviewing a patient's medical records (99358, 99359).

CMS has continued the approach of adding primary care-friendly billing codes in its recently published 2018 final rule for the Medicare Physician Fee Schedule. Medicare will now pay for time spent engaging in remote monitoring of patients' physiological data (e.g., blood pressure, glucose; 99091) and for a variety of telehealth services (e.g., caregiver health risk assessments [96161], care planning for chronic care management [G0506], and interacting with complex patients [90785]). CMS also finalized billing codes for community health workers to use when coaching beneficiaries with prediabetes to lose weight.³⁴

Monitoring the degree to which practitioners use the billing codes identified in this section should give some indication of whether the current payment levels offered are high enough and the current documentation requirements reasonable enough to encourage practitioners to engage in these activities. Meanwhile, monitoring beneficiaries' utilization of expensive downstream services such as hospital admissions may also provide some hints about whether paying practitioners to engage in the various activities mentioned above improves beneficiaries' health and lowers total spending.

TESTING NEW PRIMARY CARE PAYMENT MODELS THROUGH DEMONSTRATIONS

Beyond the fee schedule, CMS has also implemented many Medicare demonstrations in recent years. Below, we describe demonstrations that focus on primary care and have the potential to change the way primary care clinicians are paid.³⁵ Broadly speaking, these demonstrations have focused on identifying the impact of awarding end-of-year bonuses, paying modest supplemental monthly payments, and combining these two approaches. They have primarily been conducted under CMS's new demonstration authority under the Affordable Care Act (ACA) to test payment and service delivery models through its Innovation Center. Innovation Center models that are found to reduce costs without harming quality, or that improve quality without incurring added costs, can be expanded in scope or duration by the Department of Health and Human Services.²⁵

Independence at Home Demonstration

Mandated in its own dedicated section of the ACA, the Independence at Home (IAH) Demonstration encourages primary care clinicians to make house calls to frail Medicare beneficiaries to more intensively manage and coordinate these beneficiaries' care. The demonstration does this by awarding annual shared savings bonuses if practices lower their patients' total cost of care while meeting quality targets. In this payment model, standard fee schedule payments are maintained, including pre-existing billing codes available for home visits. The size of IAH bonuses vary based on how much savings participants generate and how many quality measure targets they meet; if participants fail to meet targets, they are not at risk for financial penalties.³⁶ By increasing incentives to engage in home visiting, CMS hopes to prevent emergency department (ED) visits and hospitalizations and to offer more holistic care by allowing practice staff to observe how patients function in their home and to identify unmet health and social needs.³⁷

An important difference between the IAH Demonstration and the new CCM fees is that the IAH Demonstration is targeted at a specialized subset of practices and frailer beneficiaries. The IAH Demonstration is only open to practices that already specialize in making house calls, and eligible Medicare beneficiaries must have at least two chronic conditions, need assistance with at least two functional dependencies (e.g., walking, eating), and have had a nonelective hospital admission and acute or subacute rehabilitation service in the year before enrollment in the demonstration.

CMS and other proponents have hailed the IAH Demonstration as a success story because it generated net savings for Medicare right out of the gate. After accounting for the IAH bonus payments it made to practices, Medicare netted \$13.3 million in savings in the demonstration's first year (2012), and \$2.7 million in its second year (2013), relative to a matched comparison group of beneficiaries not receiving home-based primary care.³⁸ These results prompted proponents to call on Congress to make this a permanent Medicare program. From the provider perspective, the IAH demonstration offers a nice bonus, but only about half the participating organizations have earned bonuses in the two years for which results are available. The size of the bonuses earned by the highest-performing provider organizations has also diminished in these two years, from a high of nearly \$3 million in 2012 to only about \$1.3 million in 2013.³⁸⁻⁴¹

Multi-Payer Advanced Primary Care Practice Demonstration

The Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration encouraged primary care practices to adopt the patient-centered medical home (PCMH) model of care and to more closely manage chronically ill patients. In late 2011, CMS joined eight state-initiated multi-payer demonstrations that were already planned or established, yielding some variation across states. The eight states participated through the end of 2014; the demonstration was then extended in five states through the end of 2016.

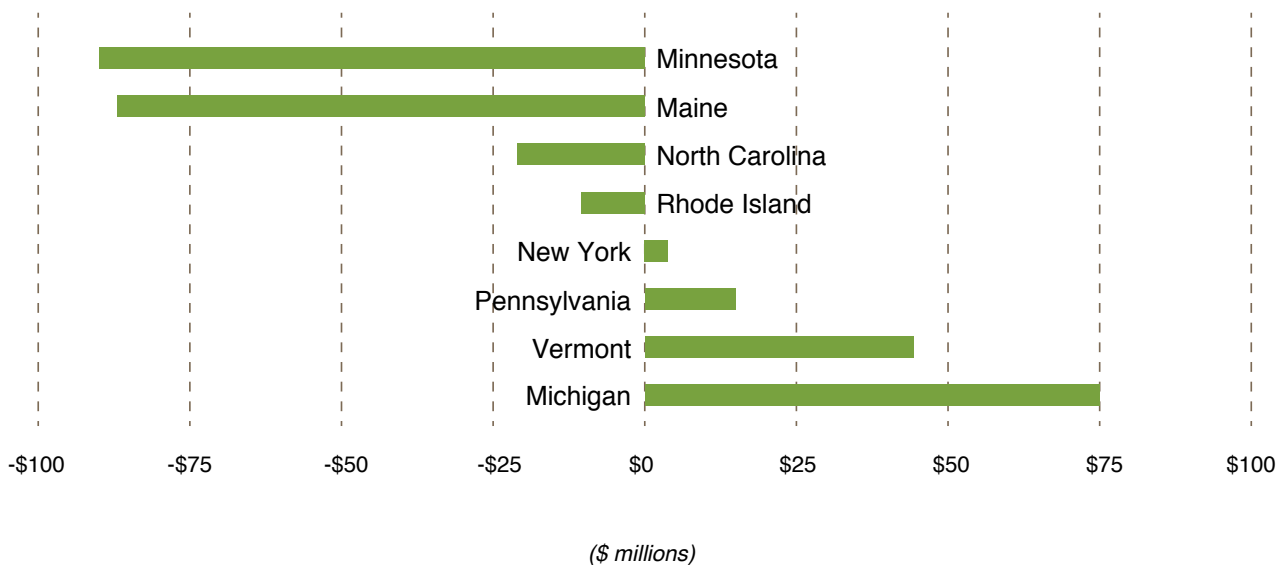
To receive new supplemental monthly payments from traditional Medicare, Medicaid, and participating commercial payers, practices in each of the participating MAPCP states generally had to adopt some version of the PCMH model of care. Supplemental payments, on top of those made through existing payment models, were usually disbursed automatically to practices based on the number of patients attributed to them, and varied based on different factors in different states (e.g., a patient's age or number of chronic conditions, a practice's PCMH recognition level, the degree to which a practice met quality measure performance targets). Demonstration payments were meant to cover such practice expenses as care manager salaries, EHR upgrades, and extended office hours. In five states, other organizations that supported or supplemented practices' primary care services in some way were also eligible for new payments. Together, CMS

expected Medicare’s demonstration payments to total no more than \$10 per beneficiary per month (PBPM) on average.

In its first three years, the demonstration reached 1.5 million Medicare beneficiaries and 725,000 Medicaid beneficiaries served by 849 primary care practices across eight states, as well as commercially insured patients. Practice participation varied by state, ranging from 16 practices in Rhode Island to 312 in Michigan.

A comprehensive evaluation found that the MAPCP Demonstration generated net savings for Medicare in four states and net losses in the other four, relative to comparison groups of non-PCMH practices (see **Figure 1**), with total losses exceeding total savings for the overall demonstration.⁴² For most states and most metrics, the demonstration practices’ care quality was no better than that of comparison practices. Even focusing only on patients with multiple chronic conditions, the demonstration’s impacts were mixed and mostly not statistically significant.

Figure 1: Net Medicare Savings and Losses Generated by the Eight MAPCP Demonstration States Over Three Years



Perhaps the main problem with the MAPCP Demonstration was the stinginess of payments offered to practices. Practice staff interviewed by evaluators often complained that demonstration fees were insufficient to cover the costs of operating as a patient-centered medical home, including hiring care managers. In its next medical home demonstration, called the Comprehensive Primary Care Initiative, CMS offered more generous payments for care coordination.

Comprehensive Primary Care Initiative

In late 2012, CMS launched a second multi-payer PCMH initiative called the Comprehensive Primary Care Initiative (CPCI). Unlike the MAPCP Demonstration, which allowed for state discretion, CPCI required all practices to document compliance with the PCMH care delivery model specified by CMS and used a specific payment model for all participating Medicare beneficiaries.⁴³ The delivery model is based on a concept of advanced primary care that includes five

comprehensive primary care functions: (1) risk-stratified care management, focused on high-risk, high-need, high-cost patients; (2) access and continuity, including 24/7 access to the care team; (3) planned care for chronic conditions and preventive care, with development of personalized care plans; (4) patient and caregiver engagement, aimed at helping patients meet their health goals; and (5) coordination of care across the “medical neighborhood,” relying on communication and information flow to support referrals and care received in other settings.⁴⁴

CMS assessed how well other proposed payers’ payment models aligned with CMS’s model as part of their criteria for selecting the seven regions where this intervention was ultimately pursued.⁴⁵ CMS also covered the cost of CPCI payments to Medicaid beneficiaries in some regions.

Payments to CPCI practices were markedly higher than those offered to MAPCP practices, at an average of \$20 PBPM in the first two years of the initiative. (Payments were \$8,

\$11, \$21, or \$40, depending on a Medicare beneficiary’s risk profile.) Average monthly payments dropped to \$15 PBPM in the third and fourth years of CPCI, but practices could receive annual shared savings bonuses starting in the second year if the spending in a region was lower than expected and quality measure targets were met.⁴⁶ The median CPCI practice received over \$200,000 in new, all-payer payments per year in the first two years, or about \$65,000 per clinician. Despite this, some small practices still reported difficulty affording new care managers’ salaries.⁴⁷

Evaluation findings from the first three years of CPCI are underwhelming. Although CPCI practices’ patients used the emergency department slightly less than patients in comparison practices did, and patient experience improved slightly, the demonstration had little impact on clinical quality measures and did not generate net savings for the Medicare program.⁴⁸

Nevertheless, some regions did generate net savings. In 2014, the first year that practices could qualify for shared savings bonuses, practices in only one of the seven regions generated total spending low enough to earn a bonus: Tulsa, Okla., which had one of the higher (and thus easier-to-achieve) spending targets.^{49,50} Practices had greater success in 2015, with four regions qualifying for bonuses, including regions with harder-

to-achieve spending targets.⁵¹ In 2016, only two regions qualified for shared savings.⁵²

Building on lessons learned through CPCI, CMS launched a refined version of this model in the form of CPC+.⁵³

Comprehensive Primary Care Plus Model

Although the CPCI model had mixed results, CMS found enough positive delivery innovation in the demonstration to justify another attempt, with somewhat altered design features. In January 2017, CMS launched the successor demonstration, the multi-payer Comprehensive Primary Care Plus (CPC+) model, which departs from CPCI in some important ways. Practices applying to participate must have experience with population health management and a demonstrated ability to meet the CPC+ model requirements. The five core elements of comprehensive primary care that defined the CPCI delivery model have been maintained, but CPC+ lets practices pick one of two payment tracks depending on their readiness to move away from a predominantly fee schedule–based payment model (see **Table 2**).⁵⁴ CPC+ also focuses more on behavioral health integration: Track 1 practices that previously participated in CPCI and all Track 2 practices will be required to engage in care management of a targeted mental health condition or co-locate a behavioral health professional in their office and make warm handoffs of patients to this professional.⁵⁵

Table 2: Payment Models for CPC+ Tracks 1 and 2, Compared With CPCI

Medicare	CPCI	CPC+ Track 1	CPC+ Track 2
Care management fee	\$20 PBPM in Y1, Y2 \$15 PBPM in Y3, Y4 average across 4 risk tiers (\$30 for highest-risk tier)	\$15 PBPM average across 4 risk tiers (\$30 for highest-risk tier)	\$28 PBPM average across 5 risk tiers (\$100 for highest-risk tier)
Payment for office visits	100% FFS	100% FFS	Reduced E/M FFS payments and new up-front quarterly payment for E/M services
Incentive payment	Shared savings based on quality metrics and total cost of care	\$2.50 PBPM based on quality and utilization metrics (paid at start of year; recouped if targets not met)	\$4 PBPM

Notes: E/M = evaluation and management services; FFS = fee-for-service; PBPM = per beneficiary per month; Y = year.

Source: CMS. *CPC+ Practice Frequently Asked Questions*. Baltimore: CMS; 2016. <https://innovation.cms.gov/Files/s/cpcplus-practiceapplicationfaq.pdf>. Accessed February 24, 2017. CMS. *CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule, Version 2*. Baltimore: CMS; 2017. <https://innovation.cms.gov/Files/s/cpcplus-methodology.pdf>. Accessed March 29, 2017.

Under CPC+, CMS continues to pay practices a non-visit-based, monthly, risk-adjusted care management fee (averaging \$15 PBPM for practices in Track 1). CMS continues to specify its own PCMH care delivery model, with capabilities that practices must adopt each year to continue to receive care management fees.^{53,56} CMS continues to offer practices learning opportunities and data feedback and now intends to share cost data, which CPCI practices complained was not included in their feedback reports.⁴⁷ CPC+ continues to expect practices to use certified EHRs and to report EHR-based clinical quality measures. And CMS continues to allow other payers to specify their own payment model, while encouraging them to align core aspects of their model with CMS's CPC+ payment model.

Practices that are selected for CPC+'s more advanced Track 2 receive more generous monthly care management fees, averaging \$28 PBPM, because they are expected to "increase the depth, breadth, and scope" of primary care they deliver, including providing a more comprehensive set of services.⁵⁶ To move practices further away from fee-for-service payment approaches, CMS gives these Track 2 practices an additional set of quarterly lump sum "comprehensive primary care payments" in exchange for accepting lowered Medicare Physician Fee Schedule rates. This is expected to give practices more flexibility to engage in "non-visit-based care" for patients with complex needs, and eventually make them "incentive neutral" on whether care is provided through an office visit or other means. As CMS puts it, "[t]o support a fundamental change in care delivery, practices require a fundamental change in payment structure."⁵³

CPC+ also abandons end-of-year regional shared savings bonuses in favor of start-of-the-year pay-for-performance bonuses (worth \$2.50 PBPM in Track 1 and \$4.00 PBPM in Track 2). These bonuses are then retrospectively reconciled for each practice at the end of the year, and recouped if performance targets are not met. Bonuses are tied to performance on 14 primary care clinical quality measures, patient experience survey measures, and two utilization metrics that primary care practices should be able to influence (inpatient hospitalizations and emergency department visits).^{57,58} Paying incentives based only on a practice's performance, rather than a whole region's, is designed to give clinicians more "actionable" incentives. And paying these performance bonuses up front and then recouping them if targets are not met takes advantage of behavioral economics: People respond more strongly to the threat of *losing* money than the possibility of *gaining* it.⁵³

CMS's switch from tying bonuses to total-cost-of-care spending targets to tying them to performance on clinical quality, patient experience, and utilization measures suggests an evolving view that models that do not involve specialists and hospitals may have a hard time influencing all of a patient's health

care spending. Moving away from shared savings spending targets allows CMS to identify performance targets from the outset (e.g., the 30th, 50th, or 80th percentile of a measure) and avoid the time-consuming process of obtaining and aggregating practices' cost data at the regional level, which kept CPCI practices in the dark about their spending targets for a given year until after the year had ended.⁵⁴ Up-front incentive payments could also improve practices' cash flow,⁵⁹ which may further CMS's objective of ensuring that the CPC+ model works for practices of all sizes, "including small, independent, and rural practices."⁶⁰

One of the more unusual requirements of CPC+ is that EHR vendors write letters of support for Track 2 applicants and enter into memoranda of understanding with CMS, committing to working with practices to modify their EHRs to add in more advanced functionalities. This requirement suggests that CPCI practices may have had trouble getting large EHR vendors to pay attention to their requests in the past.

Finally, under CPC+, Medicare no longer makes demonstration payments on behalf of Medicaid; it instead encourages state Medicaid programs to participate in CPC+ by submitting state plan amendments or waivers or by encouraging their Medicaid managed care plans to participate.⁶¹

CMS considers CPC+ "the future of primary care,"⁶⁰ designed to "help practices move away from one-size-fits-all, fee-for-service health care."⁶² CMS intends for CPC+ to be much larger than CPCI, with a target enrollment of 5,500 practices (up from 481 in CPCI) in 24 regions (up from seven in CPCI) to serve 3.5 million Medicare beneficiaries (up from 376,000 in CPCI). Including patients insured through Medicaid and private payers, CMS hopes to reach 25 million patients with CPC+.⁶⁰ As of mid-2017, CMS was partway to its goal, with nearly 3,000 participating practices serving 1.75 million Medicare beneficiaries participating in 13 states and five substate regions. In total, 61 payers are participating, with 1 to 15 payers participating in any given market, and Blue Cross plans participating in 15 of the 18 areas.⁶³

CMS appears to have great confidence in its CPC+ payment model, given the large number of practitioners it hopes to enroll in this demonstration. Interest in CPC+ is likely to increase in coming months because it is currently the lowest-risk advanced alternative payment model (APM) that practitioners can participate in to avoid Medicare financial penalties and guarantee themselves a 5 percent bonus under 2015's Medicare Access and CHIP Reauthorization Act (MACRA). (Advanced APMs are CMS payment models that require participants to adopt the PCMH model of care or bear "more than nominal" financial risk tied to patient outcomes, tie payment to performance on quality measures similar to those used in MACRA's Merit-based

Incentive Payment System, and require participants to use certified EHRs.⁶⁴)

It's notable that CPC+ qualifies as an advanced APM under MACRA, while only subjecting participating practitioners to the financial risk of repaying their up-front incentive payments. Given how generous Medicare's CPC+ payments will be (in the regions where this demonstration is running), driving a large number of primary care practitioners into this untested

payment model may be risky. If, like MAPCP and CPCI, CPC+ fails to generate net savings in aggregate, Medicare could end up paying substantially more than it otherwise would have in the absence of the CPC+ model. Then again, if CPC+ payments are generous enough to cause many primary care practitioners to engage in the type of robust care management of complex patients that earlier models have tried to incentivize, CMS could win big and fast with CPC+.

DISCUSSION

While CMS has demonstrated little success in correcting misvalued fee schedule billing codes, the agency has actively pursued new billing codes and primary care demonstrations that suggest a strong interest in modernizing the way primary care practitioners are paid. Based on the 2018 final rule for the Medicare Physician Fee Schedule, this trend shows no signs of changing; in this rule, CMS states that it is engaging in an "ongoing incremental effort to identify gaps in appropriate coding and payment for care management/coordination, cognitive services, and primary care within the PFS."³⁴ These efforts offer new payments for activities that clinicians were already doing but not getting paid for, and pay for new activities that CMS would like clinicians to start doing. The new primary care billing codes and demonstrations show the agency's willingness to pay increasingly generous amounts to primary care clinicians for managing the care of patients with chronic conditions. CMS initially paid \$10 PBPM for care management services in the MAPCP Demonstration, which was then doubled to \$20 in CPCI, doubled again in 2015 when the chronic care management fee was added to the fee schedule (at \$42.71), and doubled yet again in 2017 when the *complex* chronic care management fee was added (at \$93.67). Through these efforts, it's possible CMS may begin to shrink the wide disparities between the salaries of primary care physicians and specialists over time.

Concurrently, CMS has attempted to achieve higher value in the demonstrations and the billing codes we profiled. We also see a clear emphasis on shifting some, but not all, compensation into flat monthly payments that give clinicians more flexibility in the type and location of activities they engage in, while maintaining a role for fee-for-service payment for other services. This blended payment approach should allow CMS to more finely tune the financial incentives it directs to practitioners.

The two broad approaches that CMS is using to reform primary care payment—new billing codes and demonstrations—suggest two different philosophies about practitioner accountability. Billing codes hold practitioners accountable for documenting that a service was in fact provided, and they tend to be quite prescriptive in identifying the activities that should be conducted. Demonstrations often aim to implement new care delivery approaches and hold practitioners accountable for achieving favorable quality and spending outcomes. With new billing codes and new demonstrations, CMS can do two things at once: incentivize specific activities that the agency wants clinicians to engage in, and test promising new services that the agency may be less familiar with.

ENDNOTES

1. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457–502.
2. Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence and costs of health care. *Health Aff*. 2005;29(5):766–772.
3. IHS Inc. *The Complexities of Physician Supply and Demand: Projections from 2014 to 2025*. Washington, DC: Association of American Medical Colleges, 2016, Exhibit 22. https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf. Accessed Nov. 29, 2017.
4. Carroll A. A Doctor Shortage? Let's Take a Closer Look. *New York Times*. Nov. 7, 2016. https://www.nytimes.com/2016/11/08/upshot/a-doctor-shortage-lets-take-a-closer-look.html?_r=0. Accessed Nov. 29, 2017.
5. Conn J. Competition for new docs pushing pay higher. *Modern Healthcare*. July 16, 2016. <http://www.modernhealthcare.com/article/20160716/MAGAZINE/307169981>.
6. This paper focuses on traditional Medicare. The payment approaches and fee amounts used by Medicare Advantage plans vary by plan and are not publicly available.
7. Physician Payment Review Commission. *Annual Report to Congress*. Washington: Physician Payment Review Commission; 1989.
8. For example, compare the compensation levels cited earlier to these compensation data from 1989: Pope GC, Schneider JE. Trends in physician income. *Health Aff*. 1992;11(1):181–193. See also: Berenson RA, Zuckerman S, Stockley K, Nath R, Gans D, Hammons T. *What if All Physician Services Were Paid Under the Medicare Physician Fee Schedule? An Analysis Using Medical Group Management Association Data*. Washington: MedPAC; 2010. <https://www.urban.org/research/publication/what-if-all-physician-services-were-paid-under-medicare-fee-schedule>. Accessed December 1, 2016. Berenson RA, Goodson JD. Finding value in unexpected places—fixing the Medicare Physician Fee Schedule. *N Engl J Med*. 2016;374:1306–1309. Maxwell S, Zuckerman S, Berenson RA. Use of physicians' services under Medicare's resource-based payments. *N Engl J Med*. 2007;356:1853–1861.
9. Gottschalk A, Flocke SA. Time spent in face-to-face patient care and work outside the examination room. *Ann Fam Med*. 2005;3(6):488–493.
10. Farber J, Siu A, Bloom P. How much time do physicians spend providing care outside of office visits? *Ann Intern Med*. 2007;147(10):693–698.
11. Gilchrist V, McCord G, Schrop SL, et al. Physician activities during time out of the examination room. *Ann Fam Med*. 2005;3(6):494–499.
12. Tai-Seale M, Olson CW, Li J, et al. Electronic health record logs indicate that physicians split time evenly between seeing patients and desktop medicine. *Health Aff*. 2017;36(5):655–662. See also: Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. *Ann Intern Med*. 2016;165(11):753–760.
13. Peckham C. How do physicians rank by overall career satisfaction? *Medscape Physician Compensation Report 2016*. New York: Medscape; 2016. <http://www.medscape.com/features/slideshow/compensation/2016/public/overview#page=17>. Accessed December 1, 2016.
14. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med*. 2012;172(18):1377–1385.
15. In contrast, the survey shows pediatricians remain more positively committed to and satisfied with their work. See: Peckham C. I would choose the same specialty. *Medscape Physician Compensation Report 2016*. New York: Medscape; 2016. <http://www.medscape.com/features/slideshow/compensation/2016/public/overview#page=32>. Accessed December 1, 2016.
16. IHI Triple Aim Initiative. Institute for Healthcare Improvement website. <http://www.ihio.org/Engage/Initiatives/TripleAim/Pages/default.aspx>. Accessed February 7, 2017.
17. Bodenheimer T, Sinsky C. From Triple to Quadruple Aim: care of the patient requires care of the provider. *Ann Fam Med*. 2014;12(6):573–576.
18. Bodenheimer T, Berenson RA, Rudolf P. The primary care—specialty income gap: why it matters. *Ann Intern Med*. 2007;146(4):301–306.
19. Berenson RA, Goodson JD. Finding value in unexpected places—fixing the Medicare Physician Fee Schedule. *N Engl J Med*. 2016;374:1306–1309.
20. Zuckerman S, Merrell K, Berenson RA, Mitchell S, Upadhyay D, Lewis R. *Collecting Empirical Physician Time Data: Piloting an Approach for Validating Work Relative Value Units*. Washington: Urban Institute; 2016. <https://www.urban.org/research/publication/collecting-empirical-physician-time-data-piloting-approach-validating-work-relative-value-units>.
21. Wynn BO, Burgette LF, Mulcahy AW, et al. Development of a model for the validation of work relative value units for the Medicare Physician Fee Schedule. Santa Monica, CA: RAND; 2015. https://www.rand.org/content/dam/rand/pubs/research_reports/RR600/RR662/RAND_RR662z1.execsum.pdf.
22. Through the Achieving a Better Life Experience Act of 2014, Congress set a target for savings from adjustments to misvalued codes in the fee schedule that could have resulted in increases in fees for services often provided by primary care physicians. However, in 2017 and 2018, CMS did not have the savings to meet those targets. See: American College of Physicians. *Summary of the Final Rule for the Medicare Physician Fee Schedule for CY 2017*. Washington: American College of Physicians; 2017. https://www.acponline.org/system/files/documents/advocacy/where_we_stand/assets/summary_of_the_pfs_final_rule_2017.pdf. Final policy, payment, and quality provisions in the Medicare Physician Fee Schedule for Calendar Year 2018 [news release]. Baltimore: Centers for Medicare & Medicaid Services; November 2, 2017. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-02.html>.
23. The Medicare Payment Advisory Commission (MedPAC) has concluded that the fee schedule is an "important source of the disparities in compensation among specialties." MedPAC. *Report to the Congress: Medicare Payment Policy*. Washington: MedPAC; March 2017, pg. 120. http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf.
24. Demonstration payments also do not trigger the 20 percent coinsurance that Medicare beneficiaries usually face for most services under the Medicare Physician Fee Schedule.
25. Sec. 3021, Patient Protection and Affordable Care Act, P.L. 111-148, March 23, 2010. If a demonstration succeeds in improving quality at no additional cost or decreasing spending with no compromise in quality, it can be more broadly adopted. Before the ACA, the Department of Health and Human Services had the authority to conduct demonstrations, but not to expand successful demonstrations without explicit statutory authority.
26. CMS. *Chronic Conditions Among Medicare Beneficiaries Chartbook: 2012 Edition*. Baltimore: CMS; 2013. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>. Accessed Nov. 29, 2017.
27. Medicare program; revisions to payment policies under the Physician Fee Schedule and other revisions to Part B for CY 2016; final rule. *Fed Regist*. 2015;80(220):70918.
28. Medicare program; revisions to payment policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule and other revisions to Part B for CY 2014. *Fed Regist*. 2013;78(237):74426. 42 CFR 425.
29. Authors' calculations, drawing on these sources: CMS. *Chronic Conditions Among Medicare Beneficiaries Chartbook: 2012 Edition*. Baltimore: CMS; 2013. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>. Accessed Nov. 29, 2017. CMS. *Medicare Enrollment Dashboard*. Baltimore: CMS; 2017. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.html>. Accessed Nov. 29, 2017.
30. Medicare program; revisions to payment policies under the Physician Fee Schedule and other revisions to Part B for CY 2017; Medicare Advantage bid pricing data release; Medicare Advantage and Part D medical loss ratio data release; Medicare Advantage provider network requirements; expansion of Medicare Diabetes Prevention Program model; Medicare Shared Savings Program requirements. *Fed Regist*. 2016;81(220):80244.
31. Authors' calculations, using numbers from this source: CMS. *Medicare Part B Physician/Supplier National Data CY2015 Evaluation and Management Codes by Specialty*. Baltimore: CMS. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeForSvcPartsAB/Downloads/EMSpecialty2015.pdf>.
32. Medicare Learning Network. *Chronic Care Management Services Changes for 2017*. Baltimore: CMS; 2016. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Chronic-Care-Management-Services-Changes-2017-Text-Only.pdf>.
33. Medicare program; revisions to payment policies under the Physician Fee Schedule and other revisions to Part B for CY 2017; Medicare Advantage bid pricing data release; Medicare Advantage and Part D medical loss ratio data release; Medicare Advantage provider network requirements; expansion of Medicare Diabetes Prevention Program model; Medicare Shared Savings Program requirements. *Fed Regist*. 2016;81(220):80243–80251.
34. Medicare program; revisions to payment policies under the Physician Fee Schedule and other revisions to Part B for CY 2018; Medicare Shared Savings Program requirements; and Medicare Diabetes Prevention Program; final rule. *Fed Regist*. 2017. To be codified at 42 CFR §§ 405, 410, 414, 424, and 425. <https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23953.pdf>. Accessed November 3, 2017.

35. As of a 2015 proposed rule, CMS considered the following demonstrations to be advancing new ways of paying for primary care: the Medicare Shared Savings Program (including the Advanced Payment model option), Pioneer Accountable Care Organizations (ACOs), the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration, the FQHC Advanced Primary Care Practice Demonstration, the Comprehensive Primary Care Initiative, and the Primary Care Incentive Payment Program. Although ACOs are designed around primary care–based attribution of beneficiaries to ACOs, we do not include ACO payment models in this paper because ACO payment models do not explicitly incentivize particular primary care services or specify particular payment levels for particular services. ACOs also have received substantial attention elsewhere. Instead, we focus on the Independence at Home Demonstration, as well as the advanced and comprehensive primary care demonstrations noted by CMS. See: Medicare program; revisions to payment policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, access to identifiable data for the Center for Medicare and Medicaid Innovation Models and other revisions to Part B for CY 2015; final rule. *Fed Regist.* 2014;79(219):67547–68092. <https://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf>. Accessed February 24, 2017.
36. To qualify for an IAH bonus, the Medicare Parts A and B spending of IAH practices' eligible patients must be at least 2.2 to 11.4 percent lower than expected (with different minimum thresholds depending on the size of a practice's panel). After the first 5 percentage points of savings, which Medicare keeps, the share of savings that practices are eligible to receive ranges from 25 to 80 percent, depending on how much savings they generate and how many quality measure targets they meet. The six quality measures used to calculate payments assess whether a practice's beneficiaries had higher-than-average rates of inpatient admissions and ED visits for ambulatory-sensitive conditions and higher-than-average rates of hospital readmissions; and whether, at least 80 percent of the time, patients were contacted within 48 hours of a hospital admission and a hospital or ED discharge, have their medications reconciled at home, and have patient preferences documented in their medical record. CMS also monitors practices' performance on eight other quality measures, which are not tied to payment. See: CMS. Independence at Home Demonstration Solicitation. Baltimore: CMS. <https://innovation.cms.gov/Files/Migrated-Medicare-Demonstration-x/IAH-solicitation.pdf>. Accessed October 12, 2016. CMS. *Independence at Home Demonstration Fact Sheet*. Baltimore: CMS. <https://innovation.cms.gov/Files/fact-sheet/iah-fs.pdf>. Accessed October 12, 2016.
37. CMS. *Independence at Home Demonstration Solicitation*. Baltimore: CMS. <https://innovation.cms.gov/Files/Migrated-Medicare-Demonstration-x/IAH-solicitation.pdf>. Accessed February 24, 2017.
38. Independence at Home Demonstration corrected performance year 2 results [news release]. Baltimore: CMS; January 19, 2017. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-19.html>.
39. Affordable Care Act payment model saves more than \$25 million in first performance year [news release]. Baltimore: CMS; June 18, 2015. <https://www.cms.gov/newsroom/mediareleasedatabase/press-releases/2015-press-releases-items/2015-06-18.html>. Accessed October 12, 2016.
40. CMS. *Independence at Home (IAH) Demonstration Year 1 Practice Results*. Baltimore: CMS; June 2015. <https://innovation.cms.gov/files/x/iah-yroneresults.pdf>. Accessed October 12, 2016.
41. Bahrapour T. Doctors prescribe old-fashioned house calls when treating the old and frail. *Washington Post*. December 6, 2015. https://www.washingtonpost.com/local/social-issues/doctors-prescribe-old-fashioned-house-calls-when-treating-the-old-and-frail/2015/12/06/e0b476fc-9aa2-11e5-8917-653b65c809eb_story.html. Accessed December 14, 2016.
42. Nichols D, Haber S, Romaine M, et al. *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Final Report*. Baltimore: CMS; 2017. <https://downloads.cms.gov/files/cmimi/mapcp-finalevalrpt.pdf>. Published June 2017.
43. Private payers were free to specify their own monthly payment amounts and shared savings methodologies.
44. Medicare program; revisions to payment policies under the Physician Fee Schedule and other revisions to Part B and CY 2016. *Fed Regist.* 2015;80(220):71262. <https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf>.
45. CMS. *Solicitation for the Comprehensive Primary Care Initiative*. Baltimore: CMS. <https://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Solicitation.pdf>. Accessed February 24, 2017.
46. If a region's spending was 1.0 to 2.3 percent lower than expected, the region's CPCI practices were eligible to earn shared savings payments worth 10 percent of the savings generated beyond the first 1 percentage point. If a region's spending was 2.3 to 3.5 percent lower than expected, practices were eligible to receive 10 percent of the savings generated after the first 1 percent and up to 2.3 percent below the spending target, plus 20 percent of the savings between 2.3 and 3.5 percent below their spending target. If the region's spending was more than 3.5 percent lower than expected, practices were eligible for 50 percent of the savings on a first-dollar basis. The share of a region's shared savings payment to any one practice was equal to the practice's total monthly CPCI fees divided by the total CPCI fees paid in that region, yielding a proportional distribution of shared savings payments that took into account not only the number of patients a practice served, but also how sick they were (because monthly CPCI fees were already risk adjusted, with sicker patients generating higher monthly CPCI payments for practices). To receive shared savings payments, CPCI practices also had to meet quality targets starting in the second year of the demonstration, including performance targets for CAHPS patient experience survey measures, claims-based quality measures, and EHR-based clinical quality measures.
47. Peikes D, Fries Taylor E, Dale S, et al. *Evaluation of the Comprehensive Primary Care Initiative: Second Annual Report*. Baltimore: CMS; April 2016. <https://innovation.cms.gov/files/reports/cpci-evalrpt2.pdf>. Accessed October 13, 2016.
48. Peikes D, Anglin G, Fries Taylor E, et al. *Evaluation of the Comprehensive Primary Care Initiative: Third Annual Report*. Baltimore: CMS; December 2016. <https://innovation.cms.gov/Files/reports/cpci-evalrpt3.pdf>. Accessed April 5, 2017.
49. CMS. *Comprehensive Primary Care (CPC) Initiative 2014 Shared Savings & Quality Results*. Baltimore: CMS. <https://innovation.cms.gov/Files/x/cpci-ssqualdatasummary2014.pdf>. Updated October 2016. Accessed October 14, 2016.
50. CMS's process for setting spending targets is described in: CMS. *Comprehensive Primary Care Initiative Shared Savings Methodology, Version 4.0*. Baltimore: CMS. <https://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Shared-Savings-Methodology-PDF.pdf>. Updated September 2017. Accessed March 29, 2017.
51. Conway P. Medicare's investment in primary care shows progress. CMS Blog. Posted October 17, 2016. <https://blog.cms.gov/2016/10/17/medicares-investment-in-primary-care-shows-progress/>. Accessed October 20, 2016.
52. CMS. *Comprehensive Primary Care (CPC) Initiative 2016 Shared Savings & Quality Results*. Baltimore: CMS; 2017. <https://innovation.cms.gov/Files/x/cpci-2016sharedsavings-qualitydata.pdf>. Accessed September 28, 2017.
53. Sessums LL, McHugh SJ, Rajkumar R. Medicare's vision for advanced primary care: new directions for care delivery and payment. *JAMA*. 2016;315(24):2665–2666.
54. Comprehensive Primary Care Plus. CMS website. <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/>. Updated September 8, 2017. Accessed October 14, 2016.
55. CMS. *CPC+ Behavioral Health Integration Menu of Options (2017)*. Baltimore: CMS. <https://innovation.cms.gov/Files/x/cpcplus-bhinteg-options.pdf>. Accessed October 14, 2016.
56. CMS. *CPC+ Practice Care Delivery Requirements*. Baltimore: CMS. <https://innovation.cms.gov/files/x/cpcplus-practicecaredelvreqs.pdf>. Accessed October 14, 2016.
57. CMS. *CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule*. Version 2. Baltimore: CMS; 2017. <https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf>. Accessed February 24, 2017.
58. CMS. *CPC+ Quality Reporting Overview for Performance Year (PY) 2017*. Baltimore: CMS; 2017. <https://innovation.cms.gov/Files/x/cpcplus-qualrptpy2017.pdf>. Accessed February 24, 2017.
59. Comprehensive Primary Care Plus (CPC+) fact sheet [news release]. Baltimore: CMS; April 11, 2016. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-11.html>. Accessed October 14, 2016.
60. CMS announces next phase in largest-ever initiative to improve primary care in America [news release]. Baltimore: CMS; August 1, 2016. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-08-01.html>. Accessed October 14, 2016.
61. CMS. *CPC+ Payer Frequently Asked Questions*. Baltimore: CMS; July 15, 2016. <https://innovation.cms.gov/files/x/cpcplus-payersolicitationfaq.pdf>. Accessed October 14, 2016.
62. CMS launches largest-ever multi-payer initiative to improve primary care in America [news release]. Baltimore: CMS; April 11, 2016. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-04-11.html>. Accessed March 29, 2017.
63. CMS. *CPC+ Round 1 Participating Regions & Provisional Payer Partners*. Baltimore: CMS. <https://innovation.cms.gov/Files/x/cpcplus-payerregionlist.pdf>. Accessed March 29, 2017.
64. The Quality Payment Program [news release]. Baltimore: CMS; October 25, 2016. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-25.html>. Accessed October 25, 2016.

Copyright© December 2017. The Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.

About the Authors and Acknowledgements

The authors are all researchers in the Urban Institute's Health Policy Center. They appreciate the research assistance provided by Divvy Upadhyay and the comments and suggestions of Kent Moore at the American Academy of Family Physicians. The authors are grateful to the Robert Wood Johnson Foundation for supporting this research.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at [www.rwjf.org/twitter](https://twitter.com/rwjf) or on Facebook at [www.rwjf.org/facebook](https://www.facebook.com/rwjf).

About the Urban Institute

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information, visit www.urban.org. Follow the Urban Institute on [Twitter](https://twitter.com/urban) or [Facebook](https://www.facebook.com/urban). More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at www.healthpolicycenter.org.