Comprehensive Primary Care Plus (CPC+) is America’s largest ever initiative to transform primary care and is the only Medicare medical home Advanced Alternative Payment Model (AAPM).

**CPC+ BEGINS**

2,876 primary care practices

14 regions

OVER 1.8M Medicare patients

12,370 CPC+ practitioners

APPROX. 7,400 Qualifying APM Participants (QPs)

5 Years

2 Tracks

53 payer partners

OVER 55 health IT vendors

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**What CPC+ Practices Look Like**

36% of CPC+ participants are small practices comprised of one or two practitioners

1 in 4 practices are practitioner-owned

1 in 6 practices are in a rural area

46% of practices also participate in the Medicare Shared Savings Program

96% of practices that participated in the Original CPC initiative continued into CPC+

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**Tracks Based on Practice Readiness for Transformation**

For practices ready to **build the capabilities** to deliver comprehensive primary care.

**1365 Track 1 Practices**

For practices with Track 1 capabilities, **ready to increase the breadth and depth of care**, with a focus on patients with complex needs.

**1511 Track 2 Practices**

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Figures based on data from the first year of CPC+ (2017). These figures do not represent an evaluation of this work or CPC+ itself. For more information, visit: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
CPC+ 2017 Year in Review

Care Delivery Transformation

Focus on Foundational Changes
Practices started CPC+ with varied levels of experience in alternative payment models. In the first year, practices established core capabilities and built the infrastructure to support CPC+ implementation.

1. Care for Those with Highest Need
Knowing who your patients are and understanding their health needs is the basis for managing preventive, acute, and chronic care.

   - Average empanelment and risk stratification rates grew steadily
   - Empanelment pairs patients with a practitioner or care team as a foundation for population health management and patient relationships.
   - Risk Stratification assigns a risk score to empaneled patients based on clinical data and other factors to effectively target care support.

2. Care Where the Patient is
Improving coordination and communication with patients and clinicians, outside of the primary care office.

   - 72% of practices established a collaborative care agreement with a specialist
   - MOST COMMON: Cardiology, 36%; Gastroenterology, 31%; Behavioral Health, 28%
   - 87% of practices had information on admissions, discharges, and transfers from at least one hospital within one day
   - 96% of practices had 24/7 coverage by a clinician with real-time access to patients’ medical records

3. Care for What Matters Most
Using data and engaging patients and caregivers to guide practice goals and drive decision-making.

   - 90% of practices convened a patient and family advisory council (PFAC) that met at least once
   - 63% of practices measured progress on quality improvement projects at least monthly

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CPC+ 2017 Year in Review

Care Delivery Transformation

Advanced Capabilities
Practices in Track 2 began developing advanced strategies to improve quality and comprehensiveness of care for patients with complex needs.

OVER 4 in 5 practices that participated in the Original CPC initiative are Track 2 CPC+ participants

Addressing Social Needs
85% Track 2 practices implemented screening for unmet social needs in their first year of CPC+

Alternative Care Approaches
65% Track 2 practices provided care outside of the traditional office-based visit

Most Common
Alternative location (e.g., senior center), 33%
Telehealth and e-Visits, 34%
Home visits, 31%

Leveraging Health IT
94% Track 2 practices had health IT systems that supported empanelment
85% Track 2 practices had health IT systems that supported risk stratification

Other Enhanced Health IT Functions
Establishing care plans, 81%
Tracking patient reported outcomes, 63%
Social needs screening, 51%

Building a Culture of Continuous Improvement

Many Forums for Shared Learning
CMS provided tailored technical assistance and a wide range of opportunities for practices to connect with each other to build a sustainable community of learning.

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85% of practices indicated they left the learning session with ideas to take action at their organization

100k CPC+ Connect resource downloads by practices

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CPC+ 2017 Year in Review

Payer, Health IT, and Data Supports

Multi-Payer Collaboration for Practice Success
Payers provided valuable financial and non-financial practice supports. In several regions, payers are meeting regularly. Most payers started working on payment design in the first year.

53 Payer partners in 2017
8 State Medicaid Agencies

Lines of Business
MOST COMMON
- Commercial
- Medicare Advantage
- Medicaid Managed Care

In the first year, over 50% of payers regularly joined the HCP-LAN action collaborative focused on designing their Alternative to FFS payments for Track 2 practices.

Data to Guide Improvement

1. Providing Quarterly Claims Data
CMS and payer partners provided practices robust quarterly claims data on expenditures, utilization, and specialist use, at both the practice and patient-level.

2. Sharing Streamlined Multi-Payer Data
Several CPC+ regions used aggregated tools that combined claims data from multiple payers into a single report.

VENDOR TYPES
- Electronic Health Records
- Population Health
- Management Platforms
- Clinical Data/Specialty Registries

99% of practices reported 12 months of electronic clinical quality measures (eCQMs) using Certified EHR Technology

Four Key Areas of Payer Alignment with CMS
- Payment to provide practices with financial support
- Data-sharing to help practices manage their patient population
- Quality Measurement to reduce practice reporting burden
- Care Delivery to streamline clinical requirements

Health IT as a Robust Resource

OVER 50 health IT vendors

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