Strengthening primary care is critical to promoting health and reducing overall health care costs in the U.S. CPC+ brings together Medicare, commercial insurance plans, and State Medicaid agencies to support primary care practices in transforming the way they care for patients.

How will CPC+ practices transform care delivery?

Primary care practices will enter one of two program tracks. The track dictates the care delivery capabilities practices will develop and the payment structure they will receive.

### Comprehensive Care

- Patient Access
- Care Management and Coordination
- Patient Engagement and Population Health

### Financial Support

- Care Management Payments
- Incentive Payments for Quality and Utilization
- Alternative to Fee-for-Service Payment Structure (in Track 2 only)

### Capabilities and Payment by Track

1. Track 1 practices will add these services to visit-based, FFS care.
2. Track 2 practices will be asked to redesign visit and non-visit based care, to increase the depth, breadth, and scope of care with particular focus on patients with complex needs.

### Comprehensive Primary Care Functions

- Access and Continuity
- Care Management
- Comprehensive and Coordinated Care
- Data-Driven Population Health Management
- Patient and Caregiver Engagement

Practices will focus their efforts on the **Comprehensive Primary Care Functions.** Practices in both tracks will employ the same functions to transform care delivery; however, the intensity and focus of delivery will differ in each track.
## Examples of CPC+ Transformation Activities

### Track 1

<table>
<thead>
<tr>
<th>Access and Continuity</th>
<th>Care Management</th>
<th>Comprehensive and Coordinated Care</th>
<th>Patient and Caregiver Engagement</th>
<th>Data-Driven Population Health Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>24/7 patient access</td>
<td>Risk stratified patient population</td>
<td>Identifying high volume/cost specialists serving population</td>
<td>Convening a Patient and Family Advisory Council</td>
<td>Analysis of payer reports to inform improvement strategy</td>
</tr>
<tr>
<td>Assigned care teams</td>
<td>Short and long-term care management</td>
<td>Behavioral health integration</td>
<td></td>
<td>At least weekly care team review of all population health data</td>
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<td>Follow-up on patient hospitalizations</td>
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<td></td>
<td></td>
<td>Psychosocial needs assessment and inventory resources and supports</td>
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</tr>
</tbody>
</table>

### Track 2

|                      |                      | E-visits                          |                      |                       |
|                      |                      | Expanded office hours             |                      |                       |
|                      |                      | Care plans for high-risk chronic disease patients | |                       |
|                      |                      | | |                       |

**For More Information:**

- CPC+ Website
- Care Delivery Video