CPC+ 2017 Year in Review

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

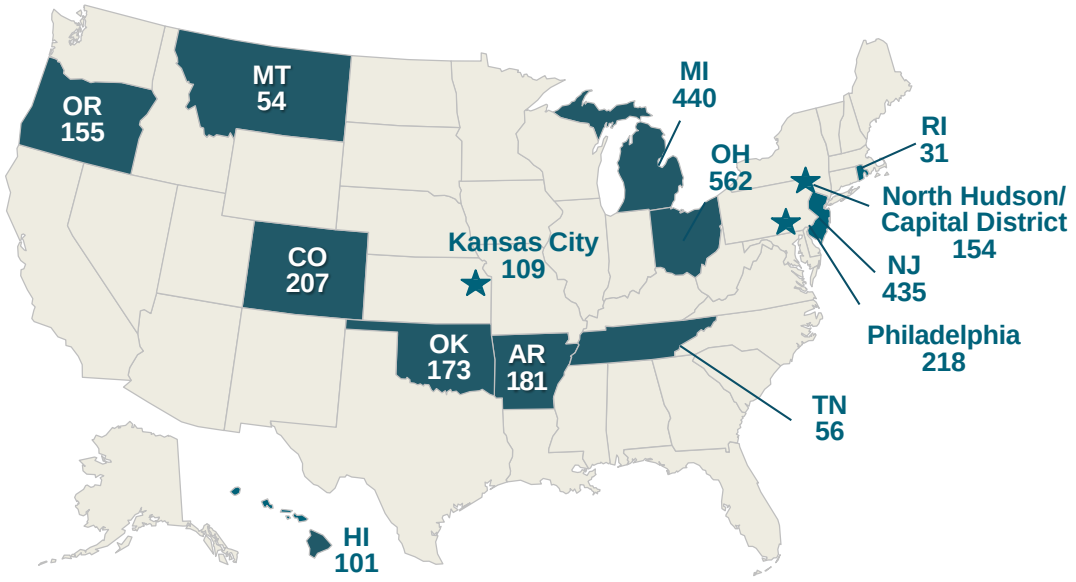
2,876
primary care practices

14
regions

OVER 1.8M
Medicare patients

12,370
CPC+ practitioners

Number of CPC+ Practices by Region



APPROX. 7,400
Qualifying APM Participants (QPs)

5
Years

2
Tracks

53
payer partners

OVER 55
health IT vendors

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+

Tracks Based on Practice Readiness for Transformation

TRACK 1
For practices ready to **build the capabilities** to deliver comprehensive primary care.
1365 Track 1 Practices

TRACK 2
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

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

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CPC+ 2017 Year in Review

Care Delivery Transformation

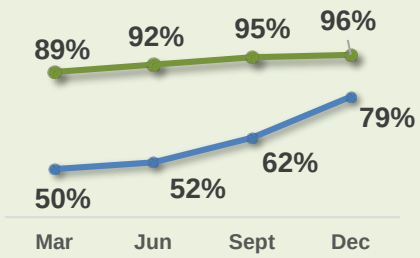
Focus on Foundational Changes

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%

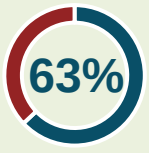
87% of practices had **information** on admissions, discharges, and transfers from at least one hospital **within one day**

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

of practices convened a **patient and family advisory council (PFAC)** that met at least once



of practices **measured progress** on quality improvement projects **at least monthly**

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Care Delivery Transformation

Advanced Capabilities

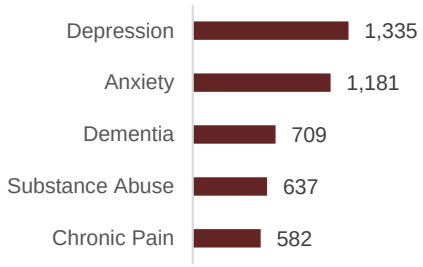
Practices in Track 2 began developing advanced strategies to improve quality and comprehensiveness of care for patients with complex needs.

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

Behavioral Health Integration

Integrating behavioral health in primary care reduces silos to better address patients' behavioral and medical needs.

Targeted Mental Health Conditions
Number of Track 2 Practices



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.

- CPC+ Connect — Online platform for sharing ideas
- Direct Practice Coaching
- Weekly Webinars
- Regional Learning Sessions

87% 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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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

INCLUDING

8
State Medicaid Agencies

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

Lines of Business

MOST COMMON

- Commercial
- Medicare Advantage
- Medicaid Managed Care

Payers in **11** of **14** CPC+ regions reached mutual consensus on their regional alignment goals by end of 2017

HCP LAN
Health Care Payment Learning & Action Network

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.

Health IT as a Robust Resource

OVER **50** health IT vendors

VENDOR TYPES

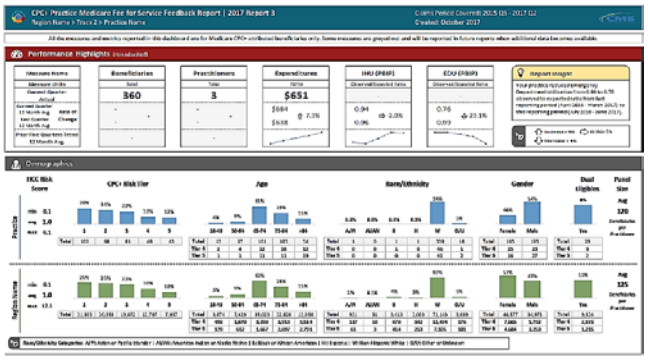
- Electronic Health Records
- Population Health Management Platforms
- Clinical Data/Specialty Registries

99%

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

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.

REGIONS

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