



Independent Evaluation of Comprehensive Primary Care Plus (CPC+):

**Appendices to the
Final Report, Volume I**
December 2023

Independent Evaluation of Comprehensive Primary Care Plus (CPC+):

Appendices to the Final Report, Volume I December 2023

Lead authors:

Jessica Laird	Eugene Rich	Eunhae Shin	Mariel Finucane	Nancy Duda
Lori Timmins	Caroline Mack	Lianlian Lei	Priya Bajaj	Kristin Geonnotti
Ning Fu	Ellie Holland	Amanda Markovitz	Sean Orzol	Mynti Hossain
Julia Embry	Arkadipta Ghosh	Carol Urato	Stacy Dale	Genna Cohen
Brianna Sullivan	Melanie Au	Wenjia Zhu	Pragya Singh	Nancy McCall
Priya Shanmugam	Breanna Arndt	Anthony Austin	Rosalind Keith	Ann O'Malley
Nikkilyn Morrison	Jelena Zurovac	Joel Earlywine	Ha Tu	Dana Petersen
Geraldine Haile	Irina Degtiar	Christopher Fleming		

Contributing authors (in alphabetical order):

Rocky Aikens	Claire Burkhardt	Gillian Giudice	Andrew McGuirk	Mike Rudacille
Mattan Alalouf	Saomya Chatrath	Sabitha Gopalsamy	Katie Morrison Lee	Rumin Sarwar
Sophia Artis	Christine Cheu	Laura Hanson	Keep Nathanson	John Schurrer
Megan Baker	Jared Coopersmith	Natalie Hazelwood	Maya Palakal	Christina Sintek
Jennifer Baskwell	Eric Dehus	Heather Ingraham	Christopher Palo	Xiaofan Sun
Tom Bell	Kathryn Dewitt	Alex Kobrin	Margaret Raskob	Kaylyn Swankoski
Laura Blue	James Drury	Timothy Lake	Carol Razafindrakoto	Tobi Tandeciarz
Ellen Bouchery	Sheena Flowers	Mark Lee	Lauryn Ringwood	Dan Thal
Jonathan Brown	Jan Genevro	Marlena Luhr	Michelle Roozeboom-Baker	Jacob Thomas
Sarah Brunskill	Cindy George	Jeff McCartney	Tyler Rose	Haixia Xu

Submitted to:

U.S. Department of Health and Human Services
Center for Medicare & Medicaid Innovation
7500 Security Blvd.
Baltimore, MD 21244-1850
Project Officer: Timothy Day
Contract number: HHSM-500-2014-00034/
HHSM-500-T0010

Submitted by:

Mathematica
P.O. Box 2393
Princeton, NJ 08543-2393
Telephone: (609) 799-3535
Facsimile: (609) 799-0005
Project Director and Principal Investigator: Nancy McCall
Deputy Project Director: Nancy Duda
Co-Principal Investigators: Ann O'Malley and Stacy Dale
Reference Number: 50319

Contents

CHAPTER 2 APPENDIX	1
2.A. 2018 Starter participation	2
CHAPTER 3 APPENDIX	3
3.A. CPC+ Payer Survey	4
3.A.1. Survey fielding	4
A. Timing of survey administration.....	4
B. Survey mode, fielding procedures, length, and incentive.....	4
3.A.2. Sampling, sample sizes, and response rates.....	5
3.A.3. Survey content.....	6
3.A.4. Data cleaning and data tables.....	10
A. Data cleaning steps	10
B. Software.....	10
C. Data tables.....	10
C.1. COVID-19 pandemic and payment policies.....	12
C.2. Payer partnership in CPC+	15
C.3. Payment approaches offered by payers partnering in CPC+	17
C.4. Quality measures, data feedback, and technical assistance.....	30
C.5. Plans for future primary care supports	34
3.A.5. Survey instrument	35
3.B. CPC+ Practice Survey.....	79
3.B.1. Survey fielding	79
A. Timing of survey administration.....	79
B. Survey mode, fielding procedures, length, and incentive.....	80
3.B.2. Sampling and weighting methods	83
A. Sampling, sample sizes, and response rates.....	83
B. Eligibility and weighting	86
3.B.3. Survey content.....	87
3.B.4. Analytic methods	87
3.B.5. Data tables	89
3.B.6. Survey instrument.....	172
3.C. CPC+ Physician Survey	215
3.C.1. Survey fielding	215
3.C.2. Sampling and weighting methods	216

A.	Sampling methods	216
B.	Eligibility and weighting	219
C.	Weighting and nonresponse adjustment	222
3.C.3.	Survey content.....	227
3.C.4.	Analytic methods	241
3.C.5.	Data tables	241
3.C.6.	Physician Survey Instrument.....	329
3.D.	Background information about payments made by CMS and CPC+ payer partners.....	355
3.D.1.	CMS payments	355
A.	The Quality Payment Program	355
B.	Risk adjustment of CMS’s CPC+ care management fees.....	355
C.	Comprehensiveness supplement	356
3.D.2.	Payer partners’ payments	356
Memorandum of understanding		356
3.D.3.	Comparison of CPC+ care management fees paid by CMS versus payer partners	357
3.E.	Payment policy changes made by CPC+ payer partners in response to the COVID-19 pandemic	358
3.E.1.	Patient cost-sharing policies.....	358
3.E.2.	Coverage of and reimbursement for telehealth services.....	359
3.E.3.	Temporary financial supports	361
3.F.	Trends in Performance-based Incentive Payment (PBIP) scores.....	363
	Key findings	364
3.G.	Incorporating Health Information Technology into Primary Care Transformation: Reflections on Vendor and Practice Experiences in CPC+	368
3.G.1.	Introduction.....	368
3.G.2.	Methods.....	369
A.	Setting.....	369
B.	Data collection and analysis	370
C.	Practice interviews.....	370
D.	Practice portal care delivery reporting data.....	370
E.	Health IT vendor interviews	370
3.G.3.	Results.....	370
3.G.4.	Discussion	372
Limitations		373
3.G.5.	Conclusion.....	374

CHAPTER 4 APPENDIX	375
4.A. Methods Used for the Deep-Dive Practice Study.....	376
4.A.1. Overview of deep-dive data collection in PYs 1, 2, and 4.....	376
4.A.2. Deep-dive data collection in PY 5.....	377
A. Interview guide for deep-dive telephone interviews	377
B. Selection of deep-dive practices.....	377
4.A.3. Analysis of deep-dive data interview data	378
4.B. Care Delivery Requirement Data That CPC+ Practices Reported to CMS in 2021: CPC+ Practices That Started in 2017	379
4.C. How CPC+ Supported Patient Care During the COVID-19 Pandemic: Lessons for Alternative Payment Models.....	416
4.C.1. Research objective	416
4.C.2. Methods.....	416
A. Setting.....	416
B. Data sources.....	417
C. Quantitative methods.....	418
D. Qualitative methods.....	418
4.C.3. Results.....	419
A. Characteristics of practice and physician survey respondents	419
B. Overall perceptions of CPC+	420
C. Perceptions of CPC+ components	422
C.1. Care management	422
C.2. Access	422
C.3. Alternative payment	423
C.4. Staffing.....	423
C.5. Other helpful mechanisms.....	423
C.6. No effect.....	424
C.7. Negative.....	424
4.C.4. Discussion	424
4.C.5. Conclusion.....	425
4.D. Implementation of Comprehensive Medication Management in a National Primary Care Transformation Model.....	426
4.D.1. Introduction.....	426
CMM and Comprehensive Primary Care Plus	427
4.D.2. Methods.....	427
A. Quantitative analysis	427

B. Qualitative analysis.....	428
4.D.3. Results.....	429
A. Identifying patients for CMM.....	430
B. Pharmacist collaboration	430
C. Perceived benefits of CMM	431
D. Challenges of implementing CMM.....	431
4.D.4. Discussion	432
Strengths and limitations	432
4.E. CPC+ Beneficiary Survey.....	434
4.E.1. Survey fielding	434
A. Timing of survey administration.....	434
B. Survey mode, length, incentive, fielding procedures, and fielding plan	435
4.E.2. Sampling and weighting methods	436
A. Sampling methods.....	436
B. Eligibility and weighting	438
C. Sample sizes and response rates	441
D. Assessing the potential impact of COVID-19 on respondent eligibility	444
4.E.3. Survey content and measures.....	445
A. Survey content.....	445
B. Measures	446
4.E.4. Analytic methods	457
4.E.5. Data tables	462
4.E.6. The Medicare Health Care Opinion Survey	544
4.F. Pandemic-Related Physician and Practice Site Service Interruptions in CPC+ and Comparison Practice Sites	557
4.F.1. Introduction.....	557
4.F.2. Methods.....	559
A. Study design.....	559
B. Data and study cohort	560
C. Measures	560
C.1. Outcomes for physician and practice service interruption.....	560
C.2. Covariates.....	561
D. Statistical analysis	562
4.F.3. Results.....	563
A. Trend in physician and practice service interruption rates over time	563

B.	Summary statistics for physician and practice site service interruption outcomes	566
C.	Impact of CPC+ on physician service interruption outcomes during the COVID-19 pandemic	568
D.	Results from sensitivity tests and subgroup analysis	569
4.F.4.	Discussion	571
4.F.5.	Supplement. Additional Tables and Figures	574
REFERENCES	586

Tables

Chapter 3

3.A. Payer Survey

3.A.1. Survey administration dates.....	4
3.A.2. Fielding procedures for PY 5 CPC+ Payer Survey ^a	5
3.A.3. CPC+ Payer Survey sample sizes and response rates.....	5
3.A.4. Content of the PY 5 CPC+ Payer Survey	7
3.A.5. COVID-19 pandemic and payment policies, Program Year 5	12
3.A.6. CPC+ payer partnership: lines of business, attribution and self-insurance, Program Year 5.....	15
3.A.7. CPC+ payer partner payments overview: payment approaches and payment metrics, Program Year 5.....	17
3.A.8. Proportion of primary care practices receiving care management fees from payers, among payers offering care management fees, Program Year 5.....	20
3.A.9. CPC+ payers' approach to care management fees, among payers offering care management fees to CPC+ practices, Program Year 5	21
3.A.10. Proportion of primary care practices that are eligible for payers' performance-based incentive payments, among payers offering performance-based incentive payments to CPC+ practices, Program Year 5.....	23
3.A.11. CPC+ payers' approaches to performance-based incentive payments, among payers offering them to CPC+ practices, Program Year 5	24
3.A.12. Proportion of primary care practices qualifying for payers' performance-based incentive payments, among payers offering performance-based incentive payments to CPC+ practices, Program Year 5	25
3.A.13. Proportion of primary care practices participating in a shared savings program, among payers offering shared savings programs to CPC+ practices, Program Year 5.....	26
3.A.14. CPC+ payers' approach to shared savings programs, among payers offering shared savings programs to CPC+ practices, Program Year 5.....	27
3.A.15. Proportion of primary care practices receiving shared savings payments, among payers offering shared savings programs to CPC+ practices, Program Year 5.....	29
3.A.16. CPC+ payer partner data feedback, Program Year 5.....	30
3.A.17. CPC+ payer partner learning support, Program Year 5	32
3.A.18. Other CPC+ payer partner initiatives and supports, Program Year 5.....	33
3.A.19. Plans for Future Primary Care Supports, Program Year 5	34

3.B. CPC+ Practice Survey	
3.B.1. CPC+ Practice Survey administration dates.....	79
3.B.2. Fielding procedures for CPC+ Practice Survey	80
3.B.3. CPC+ Practice Survey sample sizes and response rates	85
3.B.4a. Mean CPC+ practice care delivery score, overall and by track (2017 Starters).....	91
3.B.4b. Mean CPC+ practice care delivery score, within track by SSP status (2017 Starters)	92
3.B.5a. Distribution of CPC+ practices' responses to questions about their approaches to care delivery, overall and by track (scale: 1 [least advanced approach] - 4 [most advanced approach]) (2017 Starters).....	93
3.B.5b. Distribution of CPC+ practices' responses to questions about their approaches to care delivery, within track by SSP status (scale: 1 [least advanced approach] - 4 [most advanced approach]) (2017 Starters)	103
3.B.6a. CPC+ practice characteristics, overall and by track (2017 Starters).....	116
3.B.6b. CPC+ practice characteristics, within track by SSP status (2017 Starters).....	127
3.B.7a. CPC+ practices' responses to questions about their experience with CPC+ payments, overall and by track (2017 Starters).....	138
3.B.7b. CPC+ practices' responses to questions about their experience with CPC+ payments, within track by SSP status (2017 Starters)	140
3.B.8a. CPC+ practices' responses to questions about their experiences with learning activities and assistance and supports from payers, overall and by track (2017 Starters).....	143
3.B.8b. CPC+ practices' responses to questions about their experiences with learning activities and assistance and supports from payers, within track by SSP status (2017 Starters)	147
3.B.9a. CPC+ practices' responses to questions about their experiences in CPC+, including their overall perceptions of CPC+, burden, and sustainability, overall and by track (2017 Starters)	151
3.B.9b. CPC+ practices' responses to questions about their experiences in CPC+, including their overall perceptions of CPC+, burden, and sustainability, within track by SSP status (2017 Starters)	157
3.B.10. Changes in item and response category wording over time (differences in red text).....	164
3.C. CPC+ Physician Survey	
3.C.1. Fielding plan for the PY 5 Physician Survey	216
3.C.2. Number of CPC+ and comparison practices whose primary care physicians were identified for the sample frame using each data source	217
3.C.3. Sample size and response rates for the PY 5 Physician Survey, CPC+ and comparison practices, by track	221
3.C.4. Characteristics of the responding physician and their practice ^a	225
3.C.5. Content of the PY 5 CPC+ Physician Survey	228
3.C.6. Questions in the PY 5 CPC+ Physician Survey	230

3.C.7a. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Overall	243
3.C.7b. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Practice Ownership ¹	255
3.C.7c. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Practice size ¹	259
3.C.7d. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Prior primary care practice transformation experience ¹	261
3.C.7e. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Medicare SSP Status ¹	262
3.C.8a. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Overall	266
3.C.8b. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Practice ownership ¹	277
3.C.8c. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Practice size ¹	286
3.C.8d. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Prior primary care practice transformation experience ¹	298
3.C.8e. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Medicare SSP Status ¹	307
3.C.9. CPC+ and comparison physician characteristics and compensation, by track (2017 starters)	318
3.D. Background information about payments made by CMS and CPC+ payer partners	
3.D.1. Average PBPM QPP adjustments received by CPC+ practitioners, by track, PY 3 through PY 5	355
3.D.1. CPC+ payers' average PBPM and median PMPM care management fees, by CPC+ track and line of business, PY 5	357
3.E. Payment policy changes made by CPC+ payer partners in response to the COVID-19 pandemic	
3.E.1. CPC+ payer partners' patient cost-sharing requirements for primary care COVID-19 treatment, PY 4 and PY 5	358
3.E.2. CPC+ payer partners' patient cost-sharing requirements for primary care telehealth visits, PY 4 and PY 5	359
3.E.3. CPC+ payer partners' coverage of telehealth visits, by type of visit, PY 4 and PY 5	359
3.E.4. CPC+ payer partners' coverage of telehealth visits, by type of technology used, PY 4 and PY 5	360
3.E.5. CPC+ payer partners' reimbursement rates for telehealth visits, PY 4 and PY 5	361
3.E.6. CPC+ payer partners' temporary financial supports to practices, PY 4 and PY 5	362

Chapter 4

4.A. Methods Used for the Deep-Dive Practice Study

4.A.1. Characteristics of deep-dive practices and all CPC+ practices that started in 2017 and were interviewed about PY 5 experiences.....	378
--	-----

4.B. Care Delivery Requirement Data That CPC+ Practices Reported to CMS in 2021: CPC+ Practices That Started in 2017

4.B.0. Participation in CPC+ for 2017 Starters, by track and SSP status	379
4.B.1.1. Access and continuity: Empanelment, Program Year 5, 2017 Starters (percentages).....	381
4.B.1.2. Access and continuity: 24/7 access, Program Year 5, 2017 Starters (percentages).....	382
4.B.1.3. Access and continuity: Continuity of care, Program Year 5, 2017 Starters (percentages).....	383
4.B.1.4. Access and continuity: Enhanced access and communication, Program Year 5, 2017 Starters (percentages)	384
4.B.1.4.b. Access and continuity: Enhanced access and communication in Track 2 by SSP status, Program Years 3 and 4, 2017 Starters (percentages).....	388
4.B.2.1. Targeted care management: Risk stratification, Program Year 5, 2017 Starters (percentages)	389
4.B.2.2. Targeted care management: Identifying patients for care management, Program Year 5, 2017 Starters (percentages)	391
4.B.2.2.b. Targeted care management: Identifying patients for care management, Program Year 5, 2017 Starters.....	392
4.B.2.3. Targeted care management: Care management staffing and activities, Program Year 5, 2017 Starters (percentages)	393
4.B.2.3.b. Targeted care management: Care plans, Program Year 5, 2017 Starters (percentages).....	396
4.B.3.1. Comprehensiveness and coordination: Coordinated referral managements, Program Year 5, 2017 Starters (percentages).....	397
4.B.3.3. Comprehensiveness and coordination: Comprehensive medication management, Program Year 5, 2017 Starters (percentages).....	399
4.B.3.4. Comprehensiveness and coordination: Behavioral health integration, Program Year 5, 2017 Starters (percentages)	400
4.B.3.5. Comprehensiveness and coordination: Linkages with social services, Program Year 5, 2017 Starters (percentages)	402
4.B.3.6. Comprehensiveness and coordination: Comprehensiveness, Program Year 5, 2017 Starters (percentages)	405
4.B.4.1. Patient and caregiver engagement: Engaging patients and caregivers in your practice, Program Year 5, 2017 Starters (percentages).....	406
4.B.4.2. Patient and caregiver engagement: Advance care planning, Program Year 5, 2017 Starters (percentages)	407
4.B.5.1. Planned care and population health: Team-based care, Program Year 5, 2017 Starters (percentages)	408

4.B.5.2. Planned care and population health: Use of data to plan care, Program Year 5, 2017 Starters (percentages)	409
4.B.5.3. Planned care and population health: Continuous quality improvement, Program Year 5, 2017 Starters (percentages)	412
4.B.5.4. Planned care and population health: Culture of improvement at your practice, Program Year 5, 2017 Starters (percentages).....	414
4.C. How CPC+ Supported Patient Care During the COVID-19 Pandemic: Lessons for Alternative Payment Models	
4.C.1. Characteristics of practice and physician survey respondents	419
4.C.2. Percentage of CPC+ practices and physicians that reported they were better positioned to meet patients' care needs during the coronavirus pandemic because of CPC+, by practice characteristics.....	421
4.D. Implementation of Comprehensive Medication Management in a National Primary Care Transformation Model	
4.D.1. Characteristics of all Track 2 practices that participated in all years of CPC+ and the sample that participated in the qualitative interviews.....	428
4.D.2. CMM qualitative interview topics.....	429
4.D.3. Description of services provided by practices conducting CMM that aligned with CMS's definition.....	430
4.E. CPC+ Beneficiary Survey	
4.E.1. CPC+ Beneficiary Survey administration dates	435
4.E.2. Fielding procedures for CPC+ Beneficiary Survey	435
4.E.3. Characteristics used in adjusting for CPC+ Beneficiary Survey noncompletion	440
4.E.4. Attributed Medicare FFS CPC+ Beneficiary Survey sample and response rates, by treatment status and track	443
4.E.5a. Experiences included in the PY 5 CPC+ Beneficiary Survey composite measures.....	447
4.E.5b. CPC+ Beneficiary Survey questions.....	449
4.E.6. Control variables used in regressions.....	458
4.E.7a. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to composites and individual items, PY 2, PY 3, and PY 5 (Track 1).....	464
4.E.7b. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to composites and individual items, PY 2, PY 3, and PY 5 (Track 2).....	472
4.E.8a. Predicted standardized average responses (0 to 1) for composite measures and individual items for Medicare FFS beneficiaries attributed to CPC+ and comparison practices, PY 2, PY 3, and PY 5 (Track 1).....	482

4.E.8b. Predicted standardized average responses (0 to 1) for composite measures and individual items for Medicare FFS beneficiaries attributed to CPC+ and comparison practices, PY 2, PY 3, and PY 5 (Track 2).....	491
4.E.9a. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): SSP status ^a (Track 1)	499
4.E.9b. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): SSP status ^a (Track 2)	501
4.E.10a.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): practice ownership ^a (Track 1)	503
4.E.10a.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): practice ownership ^a (Track 2)	505
4.E.10b.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): practice size ^a , Track 1	507
4.E.10b.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): practice size ^a , Track 2	509
4.E.10c.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): geographic locations (Track 1) ^a	512
4.E.10c.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): geographic locations (Track 2) ^a	515
4.E.10d.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): prior primary care transformation ^a , Track 1	518
4.E.10d.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): prior primary care transformation ^a , Track 2	520
4.E.11a.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries (HCC score in top quartile), Track 1	522
4.E.11a.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries (HCC score in top quartile), Track 2	524
4.E.11b.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries (HCC score in top 10 percent or has Dementia), Track 1	526

4.E.11b.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries (HCC score in top 10 percent or has Dementia), Track 2 528

4.E.11c.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries based on having a serious mental illness^a (Track 1) 530

4.E.11c.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries based on having a serious mental illness^a (Track 2) 532

4.E.11d.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): race (Track 1) 534

4.E.11d.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): race (Track 2) 537

4.E.12a. Descriptive characteristics of Medicare FFS beneficiaries attributed to CPC+ and comparison practices, by track (Track 1) 540

4.E.12b. Descriptive characteristics of Medicare FFS beneficiaries attributed to CPC+ and comparison practices, by track (Track 2) 542

4.F. Pandemic-Related Physician and Practice Site Service Interruptions in CPC+ and Comparison Practice Sites

4.F.1. Physician and practice service interruption outcomes 561

4.F.2. Rates of physician and practice site service interruption in CPC+ and comparison practices before and after COVID-19 (percentages) 567

4.F.3. Impact of CPC+ on physician service interruption outcomes during the COVID-19 pandemic in 2020: difference-in-differences analysis, coefficients in percentage points (SE) 569

4.F.4. Impact of CPC+ on physician service interruption outcomes during the COVID-19 pandemic in 2020: sensitivity analysis, coefficients in percentage points (SE) 570

4.F.5. Impact of CPC+ on physician service interruption outcomes during COVID-19 pandemic: subgroup analysis, coefficients in percentage points (SE) 571

4.F.Supp.1. Physician, practice, and community characteristics included as control variables in regressions for physician service interruption outcomes 574

4.F.Supp.2. Impact of CPC+ on physician service interruption outcomes during COVID-19 pandemic: full regression results from difference-in-differences analysis, coefficients (SE) 577

Figures

2.A.1. Stakeholders involved in CPC+ in PY 1 through PY 4, 2018 Starters.....	2
3.F.1. Median PBIP scores, all years of CPC+	364
3.F.2. Median PBIP scores stratified by practice ownership status, all years of CPC+	367
4.C.1. Percentage of CPC+ practices and physicians that reported they were better positioned to meet patients' care needs during the coronavirus pandemic because of CPC+	420
4.F.1. Monthly physician service interruption rate, by CPC+ status and track.....	564
4.F.2. Monthly practice site service interruption rate for any primary care physician in the practice site, by CPC+ status and track.....	565
4.F.Supp.1. Monthly complete practice service interruption rate for all primary care physicians in the practice site, by treatment status and track	584
4.F.Supp.2. Monthly complete practice service interruption rate for all primary care practitioners in the practice site, by treatment status and track	585

Chapter 2 Appendix

2.A. 2018 Starter participation

In the four regions that joined CPC+ in 2018, CMS partnered with eight private and public payers and nine health IT vendors to support the efforts of 168 primary care practices to achieve the Comprehensive Primary Care Functions. Like the cohort that joined CPC+ in 2017, the cohort that started in 2018 showed fairly steady participation over the course of the model. At the end of the model, CMS was still partnering with eight payers and eight vendors to support 148 primary care practices serving approximately 1.2 million patients (Figure 2.A.1). Overall, the numbers of practices and practitioners participating have decreased by 10 and 6 percent, respectively, but the number of patients has increased by 4 percent. The same numbers of payer partners and health IT vendors have partnered with this cohort since the start of CPC+.

Figure 2.A.1. Stakeholders involved in CPC+ in PY 1 through PY 4, 2018 Starters

	Payers ^a	Practices	Practitioners	Patients ^b	Health IT vendors ^c
Start of PY 1	8	165	1,135	1.1M	8
End of PY 2	8	156	1,100	1.3M	8
End of PY 3	8	153	1,080	1.2M	8
End of PY 4	8	148	1,070	1.2M	8
Change from PY 1	-0%	-10%	-6%	+4%	0%

Source: Mathematica's analysis of CPC+ practice, payer, and health IT tracking data provided by CMS; practice-reported financial data; and CMS Medicare FFS attribution data.

^a Payer partners that operated in more than one region are counted separately for each region in which they partnered.

^b Patient count for PY 1 reflects the number of patients served by CPC+ practices at the end of the first program year.

^c Health IT vendors include vendors that formed partnerships with Track 2 practices. The health IT vendor count for PY 1 reflects the number of health IT vendors that partnered with Track 2 practices at the end of the first program year.

FFS = fee-for-service; IT = information technology; M = million; PY = Program Year.

Chapter 3 Appendix

3.A. CPC+ Payer Survey

This Appendix describes the Comprehensive Primary Care Plus (CPC+) Payer Survey used to assess the details of payer partners' involvement in CPC+ in Program Year (PY) 5. It includes survey fielding (Section 1), sampling methods (Section 2), survey content and measures (Section 3), and data tables (Section 4). Section 5 contains the PY 5 survey instrument.

3.A.1. Survey fielding

A. Timing of survey administration

Mathematica administers the CPC+ Payer Survey annually to the payers partnering with CMS in the regions that began CPC+ in 2017.¹ The first wave of the survey was administered from September through December 2017 (PY 1), 9 to 12 months after CPC+ began (Table 3.A.1). The most recent wave of the survey was administered from September through December 2021 (PY 5).

Table 3.A.1. Survey administration dates

Program year	Survey wave	Fielding dates
PY 1	Wave 1	September–December 2017
PY 2	Wave 2	September 2018–January 2019
PY 3	Wave 3	September–December 2019
PY 4	Wave 4	August–November 2020
PY 5	Wave 5	September–December 2021

PY = Program Year.

B. Survey mode, fielding procedures, length, and incentive

We administered all five waves of the survey online. At the start of CPC+ and annually afterwards, CMS provided Mathematica with a list of contacts for each CPC+ payer partner – including name and email address. This contact was typically someone from the payer's senior leadership team who was knowledgeable about the organization's decision making and CPC+ partnership, for example, the director of value-based programs.

We administered the surveys over a 14-week field period. At the start of fielding, we sent the payer contacts² an email invitation to complete the survey and a link to access it. We sent four email reminders and made telephone reminder calls to any payers that had not completed the survey by Week 6 (Table 3.A.2).

¹ Mathematica also administered the first three waves of the CPC+ Payer Survey to payers in regions that began CPC+ in 2018, but because this annual report focuses on the regions that started CPC+ in 2017, this Appendix reports information about the surveys administered to payers partnering in the 2017 regions only.

² In PY 3, PY 4, and PY 5, we also emailed the survey invitation to the person who completed the survey the previous year, if that was someone different from the primary payer contact for that year.

The survey required 30 to 60 minutes to complete, depending on the number of questions each payer partner had to answer, and—in later rounds—how much data we could prepopulate from prior rounds.³ Payers were informed that, although their survey responses would be shared with CMS, we would not share them with any other payers or with any primary care practices. Payers were not required to complete the survey, but CMS strongly encouraged them to respond. We did not offer an incentive to complete the survey.

Table 3.A.2. Fielding procedures for PY 5 CPC+ Payer Survey^a

Week of field period	Fielding activity
Week 1	Initial web survey email invitation mailing
Week 3	Email reminder
Week 4	Second email reminder
Week 6	Telephone reminder call
Week 8	Second telephone reminder call
Week 10	Third reminder email
Week 11	Final reminder email
End of Week 14	Payer survey data collection ended

^a Similar fielding plans were used for the PY 1, PY 2, PY 3, PY 4, and PY 5 CPC+ Payer Surveys.

3.A.2. Sampling, sample sizes, and response rates

For each survey wave, we administered the survey to all payer partners involved in CPC+ at the time of survey administration (Table 3.A.3). We obtained response rates between 84 and 95 percent in each wave.

Table 3.A.3. CPC+ Payer Survey sample sizes and response rates

	PY 1	PY 2	PY 3	PY 4	PY 5
Number of CPC+ payer partners					
Partnering in CPC+ at the time of the survey ^a	63	64	60	58	56
Sent surveys	63	64	60	58	56
Returned surveys	52 ^b	59	55	51	47
In analysis sample ^c	60 ^b	54	53	50	47
Response rate (percentage, unweighted)	95.2	84.3	88.3	86.2	83.9

^a One payer partner in eight CPC+ regions filled out only one survey because they follow a common approach in all eight regions in which they partner. During data cleaning, we duplicated these survey responses for each region in which this payer partners, and we counted them separately.

^b Only 52 of 63 payer partners responded to the PY 1 survey. However, we interviewed 60 of the 63 payer partners in PY 1 and used responses to these interviews to impute survey responses for 8 of the 11 payers that did not respond to the survey; the other 3 payers that did not respond to the survey withdrew from CPC+ before we conducted the interviews.

^c Our analysis sample excludes payers that had zero attributed lives in each program year and therefore could not provide CPC+ supports.

CPC+ = Comprehensive Primary Care Plus; PY = Program Year.

³ Beginning in PY 2, to reduce respondent burden for payers, we prepopulated answers based on answers to the prior survey waves.

3.A.3. Survey content

The CPC+ Payer Survey instrument was developed by Mathematica specifically for the evaluation. The PY 5 CPC+ Payer Survey content was largely the same as the surveys used in the previous program years.⁴ The PY 5 survey included questions regarding five general concepts (Table 3.A.4 details the questions in each of the survey's five sections):

1. **COVID-19.** Questions about how the coronavirus 2019 (COVID-19) pandemic may have affected payers' payment policies for all primary care practices they contract with, regardless of whether the practice participates in CPC+.
2. **Payer partnership in CPC+.** Questions about how payers are contracting with CPC+ practices and attributing members to CPC+ practices.
3. **Payers' approach to CPC+ payments.** Questions about the payers' payment approaches for CPC+ and primary care generally, including the types of payments the payers use for primary care practices, the extent to which payers provide care management fees and Performance-based Incentive Payments to CPC+ practices, and the extent to which payers provide other types of payments such as shared savings, enhanced payments, and alternative to FFS payments to CPC+ and non-participating practices.
4. **Payers' approach to using and providing quality measures, data feedback, and technical assistance to primary care practices.** Questions about the extent to which payers use quality measures to calculate primary care payments and provide data feedback and technical assistance to CPC+ and non-participating practices.
5. **Payers' plans for future primary care supports.** Questions about whether payers are planning to make changes to their primary care practice supports (e.g., the amount of payments to practices or the amount of technical assistance or practice coaching offered to practices) after CPC+ ends, and if so, how much those changes may have been influenced by partnering in CPC+.

Table 3.A.4 lists the survey sections, survey question content, and number of survey questions per section.

⁴ The PY 4 survey added questions about the COVID-19 pandemic, which were also included in the PY 5 survey. The PY 3 survey was based largely on the PY 2 survey, which built upon the PY 1 survey. The changes for the PY 2 survey included (1) refinements to how we described the payment approaches throughout many of the questions, as we learned from interviews that payer partners used different terminology to describe their approaches; and (2) seven additional questions focused on data feedback and concurrent primary care transformation initiatives. We made these changes to address the relatively large amount of missing data in the PY 1 survey.

Table 3.A.4. Content of the PY 5 CPC+ Payer Survey

Survey section	Content	Number of questions
1	<p>COVID-19</p> <ul style="list-style-type: none"> • Whether payers waive patient cost-sharing for treatment of COVID-19 or primary care services provided via telehealth • Changes payers have made to their approaches to patient cost-sharing and reimbursing for primary care telehealth services and visits since the COVID-19 pandemic • Whether payers provide any temporary financial supports or interim payment programs to primary care practices or providers since the COVID-19 pandemic • Any differences across payers' lines of business in their approach to COVID-19 cost sharing, reimbursement approaches, and/or financial supports 	9
A	<p>Payer partnership in CPC+</p> <ul style="list-style-type: none"> • Lines of business offered • Whether payers attribute or assign members to CPC+ practices • Length of lookback period • Payers' primary claims-based attribution methodology and the frequency with which payers rerun CPC+ attribution • Proportion of self-insured clients who participate in CPC+ and how they are recruited 	9
B	<p>Payment approaches for CPC+</p> <p>Questions asked about all payment approaches:</p> <ul style="list-style-type: none"> • For each type of CPC+ payment (care management fees, Performance-based Incentive Payments, shared savings payments, enhanced FFS payments, and alternative to FFS payments): • The proportion of practices that receive each payment • The lines of business in which payers offer each payment • Whether payers have different approaches to providing each payment to different practices or lines of business • Whether payers impose restrictions on how practices can use each payment • What specific expenses practices are not allowed to spend each payment on <p>Care management fees:</p> <ul style="list-style-type: none"> • Whether payers adjust care management fees based on patient factors, and if so, which patient factors payers use to do so • Whether care management fees are tied to practice performance factors, and if so, which practice metrics or accreditation standards payers use to determine eligibility or adjust fees • If care management fees are adjusted by either patient or practice factors, whether the per member per month (PMPM) care management payment is adjusted by PCMH tiers/categories or by continuous values • Average PMPM care management payments (asked separately for Track 1 and Track 2 practices) • If applicable: Adjusted PMPM care management payment by tier or adjusted average and range of values for PMPM care management payment 	62

Table 3.A.4. (continued)

Survey section	Content	Number of questions
	<p>Performance-based Incentive Payments:</p> <ul style="list-style-type: none"> • Whether payers provide upfront Performance-based Incentive Payments to CPC+ practices • Whether practices are subject to payment recoupsments the following year if they do not meet prespecified quality or efficiency benchmarks • Whether payers have finalized Performance-based Incentive Payment calculations based on practices' performance the previous year • Proportion of practices that qualified for Performance-based Incentive Payments based on their performance the previous year <p>Shared savings:</p> <ul style="list-style-type: none"> • Whether payers have finalized shared savings payments based on practices' performance the previous year • Proportion of practices that received shared savings payments based on their performance the previous year • Whether payers include downside risk sharing • The typical maximum percentage of savings and losses payers would share or pass on to practices • Whether payers use a minimum savings rate, and if so, the rate they use • Whether payers made significant changes to their shared savings approach from the previous year, and if so, the significant changes payers made <p>Enhanced FFS</p> <ul style="list-style-type: none"> • Whether payers provide enhanced FFS payments based on practices' performance the previous year • Adjustments payers make when calculating enhanced FFS rates or alternative payment amounts for practices • The percentage by which payers adjust the FFS rate for participation in CPC+ or another primary care transformation initiative • The percentage by which payers adjust FFS payments for performance on utilization, cost, or quality metrics <p>Alternative to FFS:</p> <ul style="list-style-type: none"> • Whether practices receive prospective, alternative payments instead of some or all FFS payments for all, some, or no primary care services • The primary care-specific episodes for which practices are receiving prospective, alternative payments instead of some or all FFS payments • The primary care-specific episodes for which practices are receiving alternative or bundled payments • The maximum adjustment amount for alternative payments based on the following: participation in CPC+ or another primary care transformation initiative; utilization, cost, or quality metrics; and practices' tracks or PCMH recognition tiers • The percentage of payments to primary care practices that are paid through FFS versus an alternative to FFS payment approach 	

Table 3.A.4. (continued)

Survey section	Content	Number of questions
C	<p data-bbox="407 289 1073 317">Quality measures, data feedback, and technical assistance</p> <ul data-bbox="407 327 1268 1098" style="list-style-type: none"> <li data-bbox="407 327 1227 380">• The metrics payers use to calculate primary care payments and risk-adjust those payments <li data-bbox="407 390 1227 464">• The primary care-specific episodes payers use to calculate the amount of CPC+ payments or to determine if practices qualify for Performance-based Incentive Payments <li data-bbox="407 474 1260 527">• Whether payers share data feedback on cost, use, or quality with primary care practices, and the types of data included in their data feedback <li data-bbox="407 537 1260 642">• The frequency with which payers provide data at the system, practice, practitioner, and patient levels; the format payers use to share data feedback; and whether payers' method of sharing data feedback allows practices to export data <li data-bbox="407 653 1268 705">• Proportion of practices not participating in CPC+ that receive data feedback on their system, practice, practitioners, or patients <li data-bbox="407 716 1252 768">• How data feedback provided under other primary care programs compares to data feedback for CPC+ practices <li data-bbox="407 779 1170 831">• Whether payers offer CPC+ practices technical assistance or practice coaching, and the types of assistance payers offer <li data-bbox="407 842 1252 894">• Whether payers coordinate technical assistance for CPC+ practices with their Regional Learning Network <li data-bbox="407 905 1227 978">• Proportion of practices not participating in CPC+ that receive technical assistance, and how it differs from the technical assistance CPC+ practices receive <li data-bbox="407 989 1170 1041">• The supports or services payers offer to CPC+ practices and to CPC+ attributed patients <li data-bbox="407 1052 1252 1098">• The types of alternative visits for which payers provide FFS reimbursement to primary care practices 	18
D	<p data-bbox="407 1123 846 1150">Plans for future primary care supports</p> <ul data-bbox="407 1161 1268 1451" style="list-style-type: none"> <li data-bbox="407 1161 1235 1234">• Whether payers are considering or planning to change how much enhanced funding they provide directly to primary care practices to support practice transformation after CPC+ ends <li data-bbox="407 1245 1268 1318">• Whether payers are considering or planning to change the amount of technical assistance or practice coaching they offer to primary care practices after CPC+ ends <li data-bbox="407 1329 1219 1381">• The extent to which payers' experience partnering in CPC+ has influenced their decisions about what they offer primary care practices <li data-bbox="407 1392 1219 1451">• The extent to which payers' experience partnering in CPC+ has influenced their decisions about participating in future payer collaboration efforts 	6
Total number of questions		104

FFS = fee-for service; PCMH = patient-centered medical home; PMPM = per member per month; PY = Program Year.

3.A.4. Data cleaning and data tables

A. Data cleaning steps

In addition to standard data entry quality control and data quality checks, Mathematica also executed several other cleaning steps for the CPC+ Payer Survey in each wave. The additional data cleaning steps for PY 5 included:

1. *Duplicated payers' responses to ensure payers operating in multiple regions had a completed survey for each region.* In PY 5, one payer operating in multiple regions requested to complete one survey to represent their responses for all regions in which they are partnering (n = 8), and indicated they used a uniform approach across regions. We duplicated this payer's responses for each of these 8 regions. All other payers completed one survey for each region in which they were partnering.
2. *Revised responses for payers whose involvement in CPC+ was only as a Medicaid managed care organization (MCO).* In two regions, the state Medicaid agencies set the payment policy for Medicaid MCOs in their respective states. If a payer was only participating in CPC+ as a Medicaid MCO in these regions, we overwrote their responses to payment-related questions with the responses we received from the state Medicaid agencies, because the state Medicaid agencies set the attribution and payment policies for Medicaid MCOs in each state. We applied this step for 5 payers in one region and 3 payers in a second region. For these 8 payers, we confirmed using interview data from both state agencies that the MCOs implemented the payment policies as intended. Both state agencies also received and monitored regular data feeds showing the MCOs were attributing patients, paying CMFs, and implementing performance-based programs as prescribed.
3. *Revised responses for payers that made confirmed errors in their responses.* We reviewed each payer's completed survey and compared responses to previous years' surveys. In some instances, we identified potential errors in payers' responses based on discrepancies with prior years' responses. In those cases, we reached out to the payer via email to (1) confirm our understanding of their response and suggest potential factual corrections, or (2) schedule a brief interview to discuss the supports these payers were providing to CPC+ practices. If a payer agreed with our suggested change, we updated their survey response accordingly.
4. *Backcoding free text responses.* A few survey questions allowed payers to provide "other" (free-text) responses if they felt they would like to elaborate on their approach beyond the response options in the survey. In many instances, we recoded these "other" responses into one of the available categorical responses, because they did indeed fit into one of the available response options.

B. Software

We conducted all data cleaning using SAS version 9.4.

C. Data tables

In PY 5, 56 payers partnered in CPC+ in 2017 regions, and provided supports to practices. This section presents data tables showing the responses for the 47 (of 56) payer partners that responded to the CPC+ PY 5 Payer Partner Survey. In the data tables, we present the number of payer partners that selected each response option and the relevant data statistics (e.g., percentage of payers, median response) for most questions in the CPC+ PY 5 Payer Partner Survey. We do not present data in instances when (1) questions have fewer than 11 respondents due to fewer payer partners qualifying to respond to that question based

on their responses to earlier questions, and (2) questions that asked payer partners to report the average per member per month care management payments by tiers, lines of business, and their minimum savings rate, because we found that payer partners inconsistently interpreted the questions. The data tables included in this section are as follows:

- Table 3.A.5 presents payer partners’ responses to questions in the first section of the survey, “COVID-19.”
- Table 3.A.6 presents payer partners’ responses to questions in Section A of the survey, “Payer Partnership in CPC+.”
- Tables 3.A.7–3.A.15 present payer partners’ responses to questions in Section B of the survey, “Payment approaches for CPC+.”
- Tables 3.A.16–3.A.18 present payer partners’ responses to questions in Section C of the survey, “Quality Measures, Data Feedback, and Technical Assistance.”
- Table 3.A.19 presents payer partners’ responses to questions in Section D of the survey, “Plans for Future Primary Care Supports.”

C.1. COVID-19 pandemic and payment policies

Table 3.A.5. COVID-19 pandemic and payment policies, Program Year 5

	n	%
In 2021, is your organization waiving patient cost-sharing for treatment of COVID-19?		
Yes, all patient cost-sharing for COVID-19 treatment is being waived	19	43
Yes, some patient cost-sharing for COVID-19 treatment is being waived or reduced	5	11
No, all standard patient cost-sharing for COVID-19 treatment still applies	7	16
No waivers necessary; our coverage prior to the COVID-19 pandemic did not require patient cost-sharing for treatments like those for COVID-19	13	30
N	44	--
In 2021, is your organization waiving patient cost-sharing for primary care services provided via telehealth? Please note, this question is asking about any primary care telehealth service, not just telehealth for COVID-19.		
Yes, all patient cost-sharing for primary care telehealth is being waived	17	39
Yes, some patient cost-sharing for primary care telehealth is being waived or reduced	4	9
No, all standard patient cost-sharing for primary care telehealth still applies as before the COVID-19 pandemic	10	23
No waivers necessary; our coverage prior to the COVID-19 pandemic did not require patient cost-sharing for primary care telehealth services	13	30
N	44	--
In 2021, percent of organizations reimbursing for... (select all that apply)		
Telehealth visits conducted by physicians (MD's and DO's)	44	100
Telehealth visits conducted by other clinical staff (NP's, PA's, or others)	44	100
Telehealth behavioral health visits conducted by physicians or other clinical staff	43	98
Telehealth visits conducted via HIPAA-compliant technology	44	100
Telehealth visits conducted via non-HIPAA compliant technology (for example, Skype, Zoom, Facetime, or comparable technologies)	38	86
Telehealth visits conducted via telephone	36	82
N	44	--
Among payers reimbursing for the following primary care telehealth visits in 2021, percent of payers that changed this approach due to COVID-19		
Telehealth visits conducted by physicians (MD's and DO's)	16	36
N	44	--
Telehealth visits conducted by other clinical staff (NP's, PA's, or others)	20	45
N	44	--
Telehealth behavioral health visits conducted by physicians or other clinical staff	11	26
N	43	--
Telehealth visits conducted via HIPAA-compliant technology	7	16
N	44	--
Telehealth visits conducted via non-HIPAA compliant technology (for example, Skype, Zoom, Facetime, or comparable technologies)	36	95
N	38	--
Telehealth visits conducted via telephone	32	89
N	36	--
Among payers reimbursing for primary care practices or providers for telehealth visits conducted by physicians in 2021, percent of payers that are likely to continue reimbursing for telehealth visits conducted by physicians (MD's and DO's) after the COVID-19 pandemic has ended		
Definitely will continue	20	54
Probably will continue	17	46
Probably will not continue	0	0
Definitely will not continue	0	0
Unsure	0	0
N	37	--

Table 3.A.5. (continued)

	n	%
Among payers reimbursing for primary care practices or providers for telehealth visits conducted by physicians in 2021, percent of payers that are likely to continue reimbursing for telehealth visits conducted by other clinical staff (NPs, PAs, or others) after the COVID-19 pandemic has ended		
Definitely will continue	18	49
Probably will continue	18	49
Probably will not continue	0	0
Definitely will not continue	0	0
Unsure	1	3
N	37	--
Among payers reimbursing for primary care practices or providers for telehealth visits conducted by physicians in 2021, percent of payers that are likely to continue reimbursing for telehealth behavioral health visits conducted by physicians or other clinical staff after the COVID-19 pandemic has ended		
Definitely will continue	20	56
Probably will continue	16	44
Probably will not continue	0	0
Definitely will not continue	0	0
Unsure	0	0
N	36	--
How does your reimbursement rate for primary care telehealth visits in 2021 compare to your reimbursement rates for in-person visits?		
We reimburse all telehealth visits at rates on par with in-person visits	32	73
We reimburse some, but not all, telehealth visits at rates on par with in-person visits	10	23
We reimburse all of our telehealth visits at rates lower than on par with in-person visits	2	5
N	44	--
Is your approach to reimbursement rates for primary care telehealth visits in 2021 compared to your reimbursement rates for in-person visits a change due to COVID-19?		
Yes	21	48
No	23	52
N	44	--
Among payers who are reimbursing at least some telehealth visits at rates on par with in-person visits in 2021, how likely are they to continue reimbursing this way in the future after the COVID-19 pandemic has ended?		
Definitely will continue	11	31
Probably will continue	18	51
Probably will not continue	3	9
Definitely will not continue	0	0
Unsure	3	9
N	35	--

Table 3.A.5. (continued)

	n	%
In 2021, is your organization providing any of the following temporary financial supports or interim payment programs to primary care practices or providers in response to the COVID-19 pandemic? (select all that apply)		
Increased fee-for-service (FFS) payment rates	4	9
Increased capitation payment rates	1	2
Increased care management fee payment rates	0	0
Providing accelerated payments of any kind to practices or providers (for example, providing care management fee payments ahead of schedule to help practices implement COVID-19 responses or ease cash flow problems)	17	39
Postponing recoupment of funds owned by practices or providers	10	23
Ease the requirements for practices or providers to earn performance-based payments (such as shared savings or bonus payments)	6	14
Providing loans directly to practices or providers	2	5
Providing loan guarantees, meaning loans that practices/providers receive from financial institutions that your organization is guaranteeing	1	2
Providing grants directly to practices or providers	7	16
No, we are not providing any financial supports to primary care practices or providers due to the COVID-19 pandemic	11	25
Other	7	16
N	44	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

C.2. Payer partnership in CPC+

Table 3.A.6. CPC+ payer partnership: lines of business, attribution and self-insurance, Program Year 5

	n	%
Percentage of payers offering the following line(s) of businesses in 2021 (select all that apply)		
Commercial: Fully Insured Products	32	70
Commercial: Self-Insured Products [Third Party Administrator (TPA) / Administrative Services Only (ASO)]	29	63
Health Insurance Marketplace Plan(s)	20	43
State/Federal High-Risk Pools	3	7
Medicare Advantage	28	61
Medicaid/CHIP Managed Care Plan(s)	25	54
Medicaid/CHIP Managed Care Organization (MCO) only ^a	6	13
Medicaid/CHIP fee-for-service (FFS)	15	33
N	46	--
How do you attribute or assign members to CPC+ practices? (select all that apply)		
Members select or are assigned to a primary care provider (typically at enrollment)	28	62
Members are attributed to a CPC+ practice using a claims-based attribution methodology	35	78
Other	14	31
N	45	--
	n	Number of months
Among payers with claims-based attribution, how many months do you use for the look back period to attribute members to CPC+ practices?		
Primary look back period (1-48 months)		
Median	--	18
Minimum	--	6
Maximum	--	27
N	35	--
If no visits during primary look back period, secondary look back period (0-48 months)		
Median	--	12
Minimum	--	0
Maximum	--	48
N	21	--
	n	%
Among payers with claims-based attribution, what is your primary claims-based attribution methodology?		
Members are attributed to the primary care practice they visited most frequently during the look back period (i.e., plurality of visits)	26	74
Members are attributed to the primary care practice they last visited during the look back period	9	26
Other	0	0
N	35	--
Among payers with claims-based attribution, how frequently do you rerun CPC+ attribution?		
Monthly	18	51
Quarterly	16	46
Twice a year	1	3
Yearly	0	0
Other	0	0
N	35	--

Table 3.A.6. (continued)

	n	%
Among payers with claims-based attribution, can CPC+ practices appeal attribution of certain members?		
Yes	13	37
No	22	63
N	35	--
Among payers with commercial self-insured lines of business, how many commercial self-insured clients participate in CPC+?		
All commercial self-insured clients	4	15
Most commercial self-insured clients	6	22
Some commercial self-insured clients	15	56
No commercial self-insured clients	2	7
N	27	--
Among payers with self-insured lines of business, percentage of payers using a given strategy for enrolling self-insured clients to participate in CPC+		
All commercial self-insured clients are required to participate in CPC+	5	19
Commercial self-insured clients are enrolled in CPC+ unless they opt out of participation	12	46
Commercial self-insured clients can opt into CPC+ participation	9	35
N	26	--

Source: Mathematica’s analysis of the independent evaluation’s CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

FFS = fee-for-service. MCO = managed care organization.

^a Medicaid/CHIP Managed Care Organization (MCO) only includes payers who offer just one line of business, which is a Medicaid/CHIP managed care plan.

C.3. Payment approaches offered by payers partnering in CPC+

Table 3.A.7. CPC+ payer partner payments overview: payment approaches and payment metrics, Program Year 5

	n	%
Percentage of payers using a payment approach for any CPC+ practices in 2021 (select all that apply)		
Care management fees	43	91
Performance-based incentive payments or pay for performance	37	79
Shared savings model	30	64
Enhanced FFS payments	4	9
CPCP payments or capitation (partial or full) or global payments	12	26
Prospective bundled payments for primary-care focused episodes of care	0	0
Other	5	11
N	47	--
Percentage of payers <u>planning</u> to use care management fees for any CPC+ practices after CPC+ ends		
Definitely will use approach	21	47
Probably will use approach	16	36
Probably will not use approach	2	4
Definitely will not use approach	1	2
Other	5	11
N	45	--
Percentage of payers <u>planning</u> to use performance-based incentive payments or pay for performance for any CPC+ practices after CPC+ ends		
Definitely will use approach	23	51
Probably will use approach	9	20
Probably will not use approach	1	2
Definitely will not use approach	4	9
Other	8	18
N	45	--
Percentage of payers <u>planning</u> to use shared savings model for any CPC+ practices after CPC+ ends		
Definitely will use approach	26	58
Probably will use approach	7	16
Probably will not use approach	3	7
Definitely will not use approach	4	9
Other	5	11
N	45	--
Percentage of payers <u>planning</u> to use enhanced fee-for-service (FFS) payments for any CPC+ practices after CPC+ ends		
Definitely will use approach	4	9
Probably will use approach	8	18
Probably will not use approach	15	33
Definitely will not use approach	7	16
Other	11	24
N	45	--
Percentage of payers <u>planning</u> to use comprehensive primary care payments or capitation (partial or full) or global payments for any CPC+ practices after CPC+ ends		
Definitely will use approach	13	29
Probably will use approach	7	16
Probably will not use approach	14	31
Definitely will not use approach	3	7
Other	8	18
N	45	--

Table 3.A.7. (continued)

	n	%
Percentage of payers <u>planning</u> to use prospective bundled payments for primary-care focused episodes of care for any CPC+ practices after CPC+ ends		
Definitely will use approach	3	7
Probably will use approach	2	4
Probably will not use approach	18	40
Definitely will not use approach	5	11
Other	17	38
N	45	--
Percentage of payers <u>planning</u> to use other payment approaches for any CPC+ practices after CPC+ ends		
<i>Questions with fewer than 11 total responses have been suppressed.</i>		
Percentage of payers providing...		
Any CPC+ payments	47	100
Any CPC+ payments for participation (care management fees)	44	94
Any performance-based CPC+ payments (performance-based incentive payment or pay for performance, shared savings model, and performance-adjusted enhanced FFS payments)	46	98
Any alternative to FFS payment in current year (CPCP payments, capitation or global payments, prospective bundled payments for primary-care focused episodes of care)	12	26
N	47	--
Among payers providing any CPC+ payments for participation, percentage of payers providing any CPC+ payments for participation with...		
CPC+ care management fees not tied to performance factors	27	61
CPC+ care management fees where practices have to meet performance benchmarks to be eligible for CMF	15	34
CPC+ care management fees where practices have to meet performance benchmarks to determine amount of CMF	5	11
CPC+ enhanced FFS adjusted based on participation in CPC+ or another primary care transformation	2	5
N	44	--
Among payers providing any CPC+ payments for performance, percentage of payers providing any CPC+ payments for performance with performance-adjusted enhanced FFS		
Performance-adjusted enhanced FFS	3	7
N	46	--
Among payers providing any alternative to FFS payments to CPC+ practices, percentage of payers offering pilot or full alternative to FFS CPC+ payment programs in 2021 based on information from 2021 payer interviews		
Pilot alternative to FFS	4	31
Full alternative to FFS	9	69
N	13	--
In 2021, are you using these metrics to calculate primary care payments? (select all that apply)		
Claims-based cost and utilization measures	35	78
Average cost for primary care specific episodes	0	0
Claims-based quality measures	27	60
Electronic Clinical Quality Measures (eCQMs)	20	44
Patient experience measures (e.g., CAHPS)	7	16
Other	1	2
N	45	--

Table 3.A.7. (continued)

	n	%
Among payers using each metric to calculate primary care payments, do you risk-adjust any of the following metrics?		
Claims-based cost and utilization measures	17	49
N	35	--
Average cost for primary care specific episodes	s.s	s.s
N	s.s	--
Claims-based quality measures	2	7
N	27	--
Electronic Clinical Quality Measures (eCQMs)	0	0
N	20	--
Patient experience measures (e.g., CAHPS)	s.s	s.s
N	s.s	--
Other	s.s	s.s
N	s.s	--

Among payers using average cost for primary care specific episodes to calculate primary care payments, what primary care-specific episodes are you using to calculate the amount of CPC+ payments or to determine if practices qualify for performance-based incentive payments in 2021? (select all that apply)

Questions with fewer than 11 total responses have been suppressed.

Source: Mathematica's analysis of the independent evaluation of CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.
s.s. = Small sample. Cells with fewer than 11 responses have been suppressed.

CPCP = Comprehensive Primary Care Payments. FFS = fee-for-service. CAHPS = Consumer Assessment of Healthcare Providers and Systems.

Table 3.A.8. Proportion of primary care practices receiving care management fees from payers, among payers offering care management fees, Program Year 5

	CPC+ Track 1		CPC+ Track 2		Non-CPC+ primary care practices	
	n	%	n	%	n	%
How many practices are receiving care management fees?						
None	0	0	1	2	8	19
Some	4	9	4	9	21	49
Most	10	23	10	23	4	9
All	29	67	28	65	10	23
N	43	--	43	--	43	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

Table 3.A.9. CPC+ payers' approach to care management fees, among payers offering care management fees to CPC+ practices, Program Year 5

	n	%
In 2021, for which line(s) of business are you offering your CPC+ care management fees? (select all that apply)		
Commercial: Fully Insured Products	27	63
Commercial: Self-Insured Products (Third Party Administrator (TPA) / Administrative Services Only (ASO)	24	56
Health Insurance Marketplace Plan(s)	11	26
State/Federal High-Risk Pools	1	2
Medicare Advantage	16	37
Medicaid/CHIP Managed Care Plan(s)	21	49
Medicaid/CHIP fee-for-service (FFS)	7	16
N	43	--
Among payers providing care management fees across multiple lines of business, do your 2021 CPC+ care management fees for CPC+ practices differ by line of business?		
Yes	19	73
No	7	27
N	26	--
Do you adjust your care management fees based on any patient factors such as demographics, patient risk score, patient category, or patient health status?		
Yes	24	56
No	19	44
N	43	--
Among payers adjusting care management fees based on patient factors, what patient factors do you use to adjust your care management fees? (select all that apply)		
Adjust for demographic characteristics (such as age or sex)	4	17
Adjust for patient risk score (such as Hierarchical Condition Category [HCC] risk score, 3M Clinical Risk Groups [CRG], Milliman Advanced Risk Adjusters [MARA], or DxCG)	21	88
Adjust for patients' prior cost or service use	0	0
Other	6	25
N	24	--
In addition to CMS CPC+ requirements, do you use any factors tied to practice or practitioner performance – such as utilization, cost, or quality metrics, or accreditation standards such as Patient-Centered Medical Home (PCMH) participation – to determine... (select all that apply)		
If practices are eligible to receive any care management fees	15	35
The amount of care management fees a practice may receive	5	12
None of the above	27	63
N	43	--
Among payers using practice or practitioner performance factors to determine practice eligibility to receive care management fees, which metrics or accreditation standards do you use to determine practice eligibility to receive care management fees? (select all that apply)		
Practice performance on utilization metrics	11	73
Practice performance on cost metrics	10	67
Practice performance on quality metrics	15	100
Achieving Patient-Centered Medical Home (PCMH) recognition or by PCMH tier	3	20
Other	0	0
N	15	--
Among payers using practice or practitioner performance factors to determine the amount of care management fees a practice may receive, which metrics or accreditation standards do you use to adjust the specific care management fee amount a practice receives? (select all that apply)		
<i>Questions with fewer than 11 total responses have been suppressed.</i>		

Table 3.A.9 (continued)

	n	%
Among payers using practice or practitioner performance factors to determine the amount of care management fees a practice may receive, percentage of 2021 care management fees dependent on practice performance for a typical CPC+ practice		
<i>Questions with fewer than 11 total responses have been suppressed.</i>		
Among payers adjusting care management fees based on patient factors or practice/practitioner performance, how did you adjust the PMPM care management payments provided to your Track 1 CPC+ practices in 2021?		
Tiers or categories	17	77
Continuous values	5	23
N	22	--
Among payers providing care management fees to both CPC+ Track 1 and Track 2 practices, are your 2021 care management fees different for Track 1 and Track 2 CPC+ practices?		
Yes	19	45
No	20	48
N	42	--
Do you impose any restrictions on how practices can use the CPC+ care management fees you provide them?		
Yes	0	0
No	43	100
N	43	--
Among payers that impose restrictions on how practices use care management fees, what expenses are practices NOT allowed to spend CPC+ care management fees on? (select all that apply)		
<i>Questions with fewer than 11 total responses have been suppressed.</i>		
Among payers providing care management fees to CPC+ Track 1 and non-CPC+ practices, how do your care management fee payment levels for other non-CPC+ practices compare to your payments for Track 1 CPC+ practices?		
Payments under other programs are generally higher than CPC+ payments for Track 1	2	6
Payments under other programs are about the same as CPC+ payments for Track 1	24	69
Payments under other programs are generally lower than CPC+ payments for Track 1	9	26
N	35	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

FFS = fee-for-service. MCO = managed care organization.

Table 3.A.10. Proportion of primary care practices that are eligible for payers' performance-based incentive payments, among payers offering performance-based incentive payments to CPC+ practices, Program Year 5

	CPC+ Track 1		CPC+ Track 2		Non-CPC+ primary care practices	
	n	%	n	%	n	%
How many practices are potentially eligible to receive performance-based incentive payments?						
None	1	3	0	0	6	17
Some	9	25	12	33	17	47
Most	11	31	10	28	8	22
All	15	42	14	39	5	14
N	36	--	36	--	36	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

Table 3.A.11. CPC+ payers' approaches to performance-based incentive payments, among payers offering them to CPC+ practices, Program Year 5

	n	%
In 2021, for which line(s) of business are you offering CPC+ performance-based incentive payments? (select all that apply)		
Commercial: Fully Insured Products	21	58
Commercial: Self-Insured Products (Third Party Administrator (TPA) / Administrative Services Only (ASO)	12	33
Health Insurance Marketplace Plan(s)	1	3
State/Federal High-Risk Pools	14	39
Medicare Advantage	16	44
Medicaid/CHIP Managed Care Plan(s)	13	36
Medicaid/CHIP fee-for-service (FFS)	7	19
N	36	--
Among payers providing performance-based incentive payments to both CPC+ and non-CPC+ practices, do you have a different approach to providing performance-based incentive payments for CPC+ practices versus other primary care practices that are not participating in CPC+?		
Yes	2	7
No	28	93
N	30	--
Among payers providing performance-based incentive payments to both CPC+ Track 1 and Track 2 practices, do you have a different approach to providing performance-based incentive payments for Track 1 CPC+ practices versus Track 2 CPC+ practices?		
Yes	7	20
No	28	80
N	35	--
Among payers offering performance-based incentive payments across multiple lines of business, do you have a different approach to providing performance-based incentive payments for different lines of business?		
Yes	8	42
No	11	58
N	19	--
In 2021, are you providing upfront performance-based incentive payments to CPC+ practices?		
Yes, practices receive an upfront, prospective incentive payment later reconciled based on performance	3	8
No, payments made at end of performance period	33	92
N	36	--
Among payers providing upfront performance-based incentive payments to CPC+ practices, will practices be subject to a payment recoupment the following year if they do not meet prespecified quality or efficiency benchmarks?		
<i>Questions with fewer than 11 total responses have been suppressed.</i>		
Have you finalized your performance-based incentive payment calculations based on practices' performance in 2020?		
Yes	26	72
No	10	28
N	36	--
Do you impose any restrictions on how practices can use the CPC+ performance-based incentive payments you provide them?		
Yes	0	0
No	36	100
N	36	--
What expenses are practices NOT allowed to spend CPC+ performance-based incentive payments on? (select all that apply)		
<i>Questions with fewer than 11 total responses have been suppressed.</i>		

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

Table 3.A.12. Proportion of primary care practices qualifying for payers' performance-based incentive payments, among payers offering performance-based incentive payments to CPC+ practices, Program Year 5

	CPC+ Track 1		CPC+ Track 2		Non-CPC+ primary care practices	
	n	%	n	%	n	%
What proportion of practices qualified for performance-based incentive payments based on their performance in 2020?						
None	6	23	7	27	8	31
Some	4	15	4	15	9	35
Most	12	46	10	38	7	27
All	4	15	5	19	2	8
N	26	--	26	--	26	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

Table 3.A.13. Proportion of primary care practices participating in a shared savings program, among payers offering shared savings programs to CPC+ practices, Program Year 5

	CPC+ Track 1		CPC+ Track 2		Non-CPC+ primary care practices	
	n	%	n	%	n	%
How many practices are participating in a shared savings program?						
None	2	7	2	7	2	7
Some	12	40	12	40	14	47
Most	4	13	5	17	12	40
All	12	40	11	37	2	7
N	30	--	30	--	30	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

Table 3.A.14. CPC+ payers' approach to shared savings programs, among payers offering shared savings programs to CPC+ practices, Program Year 5

	n	%
In 2021, for which line(s) of business are you offering your shared savings program? (select all that apply)		
Commercial: Fully Insured Products	21	72
Commercial: Self-Insured Products (Third Party Administrator (TPA) / Administrative Services Only (ASO)	8	28
Health Insurance Marketplace Plan(s)	0	0
State/Federal High-Risk Pools	19	66
Medicare Advantage	9	31
Medicaid/CHIP Managed Care Plan(s)	13	45
Medicaid/CHIP fee-for-service (FFS)	1	3
N	29	--
Among payers providing shared savings for both CPC+ and non-CPC+ practices, do you have a different approach to providing shared savings for CPC+ practices versus other primary care practices that are not participating in CPC+?		
Yes	8	30
No	19	70
N	27	--
Among payers providing shared savings for both CPC+ Track 1 and Track 2 practices, do you have a different approach to providing shared savings for Track 1 CPC+ practices versus Track 2 CPC+ practices?		
Yes	6	22
No	21	78
N	27	--
Among payers offering shared savings across multiple lines of business, do you have a different approach to providing shared savings for different lines of business?		
Yes	12	60
No	8	40
N	20	--
For 2021, what is the typical maximum percent of savings you would share with practices?		
Median	--	50
Minimum	--	10
Maximum	--	70
N	27	--
In 2021, will you include downside risk sharing?		
Yes	3	10
No	26	90
N	29	--
Among payers including downside risk sharing, what is the maximum typical percent of losses you would pass on to practices for 2021?		
<i>Questions with fewer than 11 total responses have been suppressed.</i>		
For 2021, do you use a minimum savings rate (that is, a threshold that must be surpassed before savings are shared with practices)?		
Yes	13	45
No	16	55
N	29	--
What is the minimum savings rate?		
Median	--	1
Minimum	--	0
Maximum	--	3
N	12	--

Table 3.A.14 (continued)

	n	%
Have you finalized your shared savings payment calculations based on practices' performance in 2020?		
Yes	25	86
No	4	14
N	29	--
Compared to 2020, did you make any other significant changes to your shared savings approach in 2021?		
Yes	7	24
No	22	76
N	29	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

Table 3.A.15. Proportion of primary care practices receiving shared savings payments, among payers offering shared savings programs to CPC+ practices, Program Year 5

	CPC+ Track 1		CPC+ Track 2		Non-CPC+ primary care practices	
	n	%	n	%	n	%
What proportion of practices received shared savings payments based on their performance in 2020?						
None	13	52	13	52	7	28
Some	8	32	8	32	15	60
Most	3	12	3	12	2	8
All	1	4	1	4	1	4
N	25	--	25	--	25	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

C.4. Quality measures, data feedback, and technical assistance

Table 3.A.16. CPC+ payer partner data feedback, Program Year 5

	n	%
Do you currently share data feedback on cost, use, and/or quality with primary care practices?		
Yes	44	98
No, but will before end of year	0	0
No, will not provide	1	2
N	45	--
Among payers who are or will be providing data feedback, what type of data are included in your data feedback in 2021? (select all that apply)		
Claims-based cost and utilization measures	44	100
Average cost for primary care specific episodes	8	18
Claims-based quality measures	41	93
eCQMs	19	43
Patient experience measures (e.g. CAHPS)	6	14
Specialists cost data	18	41
Hospital cost data	19	43
Other	3	7
N	44	--
Among payers who are or will be providing data feedback, percentage of payers providing data feedback at the following levels (select all that apply)		
System-level	29	66
Practice-level	42	95
Practitioner-level	40	91
Patient-level	40	91
N	44	--
Among payers who are or will be providing data feedback, percentage of the most frequent data provided		
Quarterly	16	36
Monthly	20	45
Weekly	1	2
Real-time	4	9
Other	3	7
N	44	--
Among payers who are or will be providing data feedback, how frequently do you provide data at the system level?		
Never, data not provided at that level	15	34
Quarterly	12	27
Monthly	12	27
Weekly	1	2
Real-time	1	2
Other	3	7
N	44	--
Among payers who are or will be providing data feedback, how frequently do you provide data at the practice level?		
Never, data not provided at that level	2	5
Quarterly	19	43
Monthly	18	41
Weekly	1	2
Real-time	1	2
Other	3	7
N	44	--

Table 3.A.16. (continued)

	n	%
Among payers who are or will be providing data feedback, how frequently do you provide data at the practitioner level?		
Never, data not provided at that level	4	9
Quarterly	17	39
Monthly	16	36
Weekly	1	2
Real-time	2	5
Other	4	9
N	44	--
Among payers who are or will be providing data feedback, how frequently do you provide data at the patient level?		
Never, data not provided at that level	4	9
Quarterly	15	34
Monthly	17	39
Weekly	1	2
Real-time	4	9
Other	3	7
N	44	--
Among payers who are or will be providing data feedback, percentage of payers sharing data feedback in the following formats:		
Static only	14	32
Interactive data portal only	14	32
Other only	0	0
Both static and interactive data portal	8	18
Both interactive data portal and other	1	2
N	44	--
Among payers who are or will be providing data feedback, what format do you use for sharing data feedback? (select all that apply)		
Static report	29	66
Interactive data portal	29	66
Other	8	18
N	44	--
Among payers who are or will be providing data feedback, does your method of sharing data feedback allow practices to export the data or receive a data dump to manipulate the data themselves?		
Yes	40	93
No	3	7
N	43	--
Among payers who are or will be providing data feedback, how many practices that are NOT participating in CPC+ are receiving data feedback on their system, practice, practitioners, or patients in 2021?		
None	4	9
Some	14	32
Most	22	50
All	4	9
N	44	--
Among payers providing data feedback to at least some practices not participating in CPC+, how does your data feedback provided under other primary care programs compare to your data feedback for CPC+ practices?		
Data feedback is more comprehensive than feedback provided to CPC+ practices	7	18
Data feedback is about the same as feedback provided to CPC+ practices	33	83
Data feedback is less comprehensive than feedback provided to CPC+ practices	0	0
N	40	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents. eCQM = electronic clinical quality measures. CAHPS = Consumer Assessment of Healthcare Providers and Systems.

Table 3.A.17. CPC+ payer partner learning support, Program Year 5

	n	%
Are you offering CPC+ practices technical assistance or practice coaching?		
Yes	38	84
No	7	16
N	45	--
Among payers providing technical assistance or practice coaching, what type of assistance are you offering CPC+ practices in 2021? (select all that apply)		
In-person group learning sessions	19	50
Web-based group learning sessions	31	82
Individualized practice coaching	32	84
Other	4	11
N	38	--
Among payers providing technical assistance or practice coaching, are you coordinating technical assistance for CPC+ practices with your regional learning network?		
Yes	21	55
No	17	45
N	38	--
Among payers providing technical assistance or practice coaching, how many practices that are NOT participating in CPC+ are receiving technical assistance in 2021?		
None	4	11
Some	30	79
Most	3	8
All	1	3
N	38	--
Among payers providing technical assistance or practice coaching to non-CPC+ practices, how does your technical assistance provided under other primary care programs compare to your technical assistance for CPC+ practices?		
Technical assistance is more intensive than the support provided to CPC+ practices	0	0
Technical assistance is about the same as the support provided to CPC+ practices	30	88
Technical assistance is less intensive than the support provided to CPC+ practices	4	12
N	34	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

Table 3.A.18. Other CPC+ payer partner initiatives and supports, Program Year 5

	n	%
Do you offer any of the following other supports or services to CPC+ practices or directly to CPC+ attributed patients? (select all that apply)		
Care managers for practices	13	30
Practice coaching	16	36
Social services supports (e.g., assessments and/or referral to social services agencies)	20	45
Behavioral health integration supports (e.g., embedded behavioral health staff, reimbursement for behavioral health services provided in primary care settings)	12	27
Embedded pharmacists for practices	3	7
Fee for service reimbursement for alternative visits (such as home-based care, video-based conferencing, or e-visits)	17	39
Other	3	7
None of the above	9	20
N	44	--
Among payers that offer fee-for-service reimbursement for alternative visits, percentage of payers providing FFS reimbursement to primary care practices for the following types of alternative visits: (select all that apply)		
Visits in alternative locations (for example, nursing facilities or senior centers)	7	41
Home-based care (i.e., primary care home visits)	8	47
Medical group visits (i.e., shared medical appointments)	5	29
Video-based conferencing (i.e., telehealth or telemedicine)	15	88
Medical visit over an electronic exchange (for example, e-visit, portal)	8	47
Medical visit via telephone (i.e. phone visit)	14	82
Other	0	0
N	17	--
Do you offer any of the following other supports or services directly to CPC+ attributed patients? (select all that apply)		
Advance care planning	11	25
Telephonic care management	24	55
Medication therapy reviews	14	32
Disease management programs	28	64
Health and wellness services	29	66
None of the above	11	25
N	44	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

C.5. Plans for future primary care supports

Table 3.A.19. Plans for Future Primary Care Supports, Program Year 5

	n	%
Are you considering or planning to change how much enhanced funding you provide directly to primary care practices to support practice transformation after CPC+ ends?		
Yes, considering or planning to increase the amount of funding to support practice transformation	2	5
Yes, considering or planning to decrease the amount of funding to support practice transformation	0	0
Yes, considering or planning to discontinue offering funding to support practice transformation	1	2
No, considering or planning to maintain the current amount of funding to support practice transformation	24	55
Unsure or undecided	10	23
Other	7	16
N	44	--
How much has your experience partnering in CPC+ influenced your decisions about providing enhanced funding to primary care practices to support practice transformation after CPC+ ends?		
Not at all influenced	13	30
Influenced somewhat	30	68
Strongly influenced	1	2
N	44	--
Are you considering or planning to change the amount of technical assistance or practice coaching you offer to primary care practices after CPC+ ends?		
Yes, considering or planning to increase the amount of technical assistance or practice coaching we offer	2	5
Yes, considering or planning to decrease the amount of technical assistance or practice coaching we offer	0	0
Yes, considering or planning to discontinue offering technical assistance or practice coaching	1	2
No, considering or planning to maintain the current amount of technical assistance or practice coaching we offer	37	84
Unsure or undecided	4	9
Other	0	0
N	44	--
How much has your experience partnering in CPC+ influenced your decisions about the amount of technical assistance or practice coaching you offer to primary care practices?		
Not at all influenced	13	30
Influenced somewhat	29	66
Strongly influenced	2	5
N	44	--
How much has your experience with payer collaboration in CPC+ influenced your decisions about participating in future payer collaboration efforts? By payer collaboration, we mean regional convening meetings, regional multi-payer collaboratives, National Payer Community events, etc.		
Not at all influenced	5	13
Influenced somewhat	29	76
Strongly influenced	4	11
N	38	--

Source: Mathematica's analysis of the independent evaluation's CPC+ PY 5 Payer Partner Survey.

Note: n = number of payers that selected each response option to the question; N = total number of respondents.

3.A.5. Survey instrument



**FOR REFERENCE ONLY
PLEASE COMPLETE WEB VERSION**

**2021 WEB SURVEY FOR PAYERS
PARTICIPATING IN CPC+**

Welcome to the Payer Survey for the independent evaluation of Comprehensive Primary Care Plus (CPC+)! We appreciate you taking the time to complete the survey. Your input will help us understand the critical supports your organization is providing CPC+ practices.

If you have questions about this survey, please contact Brianna Sullivan at Mathematica (BSullivan@mathematica-mpr.com or 671-715-9953).

INTRODUCTION

Thank you again for completing Mathematica's CPC+ payer survey in 2019! Your participation in this 2021 survey will help us understand what has and has not changed about the supports you provide to CPC+ practices in 2021.

[FOR MULTI-REGION PAYERS WITH MULTIPLE RESPONDENTS: We understand that [PAYER]'s approach to supporting practices is different across CPC+ regions. You are receiving this survey because you were selected by [PAYER] to complete this survey specifically for [REGION SURVEY IS ASKING ABOUT].]

Most of the questions in the 2021 survey are the same as the questions in the 2020 survey. To reduce reporting burden, we have retained your 2020 responses in the 2021 survey. You will have the opportunity to review those responses and, if your approach has changed, to update your answer to reflect your new approach.

The 2021 survey will cover several topics:

NEW: How the COVID-19 pandemic may have impacted your payment approaches

- A. Details of payer participation in CPC+
- B. Payer's approach to CPC+ payments
- C. Payer's approach to data feedback and learning support to practices
- D. How supports for primary care practices may have changed since partnering in CPC+

Please make sure to fill out the questions in the new survey section.

Mathematica and the Centers for Medicare & Medicaid Services (CMS) regularly collect information from payers in CPC+ to track the model's progress and aid in its evaluation. To further reduce reporting burden on payers, Mathematica and CMS are working to align their data collection efforts for 2021.

We plan to share the information you provide in this survey with CMS. Neither Mathematica nor CMS will share your answers with any other payer, nor with any practice participating in CPC+. If you prefer for all or some information to not be shared with CMS, you will have the opportunity to indicate this preference at the end of the survey.

To help us understand the details of your CPC+ participation, please fill out the 2021 Payer Survey. Your insights will help CMS better understand the role that non-Medicare payers play in practice and payment transformation and will guide CMS' design of initiatives in the future. Mathematica staff will also be conducting telephone interviews with a subset of CPC+ payers this fall. If you are selected to participate in an interview, a Mathematica staff member will reach out to you with additional details. For your reference, frequently asked questions (FAQs) related to the CPC+ Payer Survey can be found [here](#).

IMPORTANT

- Most of the questions in the 2021 survey are the same as the questions in the 2020 survey. To reduce reporting burden, we have retained your 2020 responses in the 2021 survey. You will have the opportunity to review those responses and, if your approach has changed, to update your answer to reflect your new approach.
- The survey also includes a few new questions. Those questions will be clearly indicated as new and we ask that you provide responses to these questions.

INSTRUCTIONS TO COMPLETE THE SURVEY

- The survey works best on a desktop computer, and is best viewed in Chrome, or the latest versions of Safari, Firefox, or Internet Explorer, or Edge. The survey works best on a desktop computer, and is best viewed in the latest versions of Chrome, Safari, Firefox, or Internet Explorer (IE 11 or Edge).
- If you answer “Other” for a question, please specify by typing what you mean in the “Specify” box.
- Click on “Back” at the bottom of the screen to go back to a previous question.
- Use the “Next” button to proceed to the next question. Your answers are saved each time you click the “Next” button.
- You do not have to complete the survey all at once. Be sure to click the “Next” button to save your answers before exiting the survey. You will resume at the next unanswered question when you return to the survey.
- After about 20 minutes of idle time, the survey may time out, but your answers will be saved. If that happens, you will be redirected to the login page prior to resuming the survey where you left off.
- If you have any questions while taking the survey, please click on “FAQ” at the bottom of the screen at any time. If the FAQ document does not answer your question, you may email Brianna Sullivan at BSullivan@mathematica-mpr.com.
- Once you have completed the survey, you will have the opportunity to review and/or print your answers before submitting the survey. Please note that once you submit the survey, you cannot go back in to change your answers.
- Instructions to submit the survey when you have finished answering all of the questions are listed after the last survey question.

Before we start the survey, please provide the following contact information for the person completing this survey:

Please update this information if no longer correct.

Payer Organization:

Name:

Title:

Email Address:

Telephone:

COVID-19

We are interested in understanding how the COVID-19 pandemic may have affected your 2021 payment policies for **all of the primary care practices with which you contract, regardless of whether they participate in CPC+**. We are only asking about your fully insured lines of business, not your commercial self-insured products.

If your payment approaches differ between lines of business, please answer each question for the most common approach across your lines of business, or the approach for your largest line of business. At the end of this section you will have the opportunity to describe any differences by line of business.

1. **In 2021, is your organization waiving patient cost-sharing for treatment of COVID-19?**
Please note this question is asking about COVID-19 treatment only, not COVID-19 testing.

Select one only

- Yes, **all** patient cost-sharing for COVID-19 treatment is being waived..... 1
- Yes, **some** patient cost-sharing for COVID-19 treatment is being waived or reduced..... 2
- No, all standard patient cost-sharing for COVID-19 treatment **still applies**..... 3
- No **waivers necessary**; our coverage prior to the COVID-19 pandemic did not require patient cost-sharing for treatments like those for COVID-19 4

2. **In 2021, is your organization waiving patient cost-sharing for primary care services provided via telehealth?** Please note, this question is asking about any primary care telehealth service, not just telehealth for COVID-19.

Select one only

- Yes, **all** patient cost-sharing for primary care telehealth is being waived 1
- Yes, **some** patient cost-sharing for primary care telehealth is being waived or reduced..... 2
- No, all standard patient cost-sharing for primary care telehealth **still applies as before** the COVID-19 pandemic..... 3
- No waivers necessary**; our coverage prior to the COVID-19 pandemic did not require patient cost-sharing for primary care telehealth services..... 4

3. **Please briefly describe any other changes your organization has made in 2021 to your approach to patient cost-sharing in response to the COVID-19 pandemic.**

4. Please indicate (1) if your organization is reimbursing for primary care practices or providers for any of the following primary care telehealth visits in 2021, and (2) whether this reimbursement approach is a change in response to COVID-19.

	1. In 2021, is your organization reimbursing for...?	2. Is this approach a change due to COVID-19?
Telehealth services and provider types		
a. Telehealth visits conducted by physicians (MD's and DO's)	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
b. Telehealth visits conducted by other clinical staff (NP's, PA's, or others)	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
c. Telehealth behavioral health visits conducted by physicians or other clinical staff	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
Technology used		
d. Telehealth visits conducted via HIPAA-compliant technology	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
e. Telehealth visits conducted via non-HIPAA compliant technology (for example, Skype, Zoom, Facetime, or comparable technologies)	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
f. Telehealth visits conducted via telephone	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No



- 4b. You said your organization reimbursed for the following type(s) of telehealth visits in 2021. How likely is your organization to continue reimbursing for these types of telehealth visits after the COVID-19 pandemic has ended?

[ONLY ANSWER FOR ANY TYPES OF VISITS YOUR ORGANIZATION IS REIMBURSING FOR]

Likelihood of continuing reimbursement after COVID-19 for these types of visits	Definitely will continue	Probably will continue	Probably will not continue	Definitely will not continue	Unsure
a. Telehealth visits conducted by physicians (MDs and DOs)	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³	<input type="radio"/> ⁴	<input type="radio"/> ⁵
b. Telehealth visits conducted by other clinical staff (NPs, PAs, or others)	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³	<input type="radio"/> ⁴	<input type="radio"/> ⁵
c. Telehealth behavioral health visits conducted by physicians or other clinical staff	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³	<input type="radio"/> ⁴	<input type="radio"/> ⁵

5. How does your reimbursement rate for primary care telehealth visits in 2021 compare to your reimbursement rates for in-person visits?

Select one only

- We reimburse all telehealth visits at rates **on par** with in-person visits 1
- We reimburse some, but not all, telehealth visits at rates **on par** with in-person visits..... 2
- We reimburse all of our telehealth visits at rates **lower than on par** with in-person visits..... 3

6. You said [ANSWER TO PREVIOUS QUESTION: you reimburse all telehealth visits at rates on par with in-person visits/you reimburse some, but not all, telehealth visits at rates on par with in-person visits/you reimburse all of your telehealth visits at rates lower than on par with in-person visits].

Is this approach a change in response to COVID-19?

Select one only

- Yes..... 1
- No 2



6b. [ONLY ANSWER IF YOU REIMBURSE ALL OR SOME TELEHEALTH VISITS ON PAR WITH IN-PERSON VISITS]

How likely are you to continue reimbursing this way in the future after the COVID-19 pandemic has ended?

Select one only

- Definitely will continue 1
- Probably will continue 2
- Probably will not continue..... 3
- Definitely will not continue 4
- Unsure 5

7. Please briefly describe any other changes your organization has made in 2021 to your approach to reimbursing for primary care telehealth services and visits in response to the COVID-19 pandemic.

8. **In 2021, is your organization providing any of the following temporary financial supports or interim payment programs to primary care practices or providers in response to the COVID-19 pandemic?**

Select all that apply

- Increased fee-for-service (FFS) payment rates..... 1
- Increased capitation payment rates 2
- Increased care management fee payment rates..... 3
- Providing accelerated payments of any kind to practices or providers (for example, providing care management fee payments ahead of schedule to help practices implement COVID-19 responses or ease cash flow problems)..... 4
- Postponing recoupment of funds owned by practices or providers..... 5
- Ease the requirements for practices or providers to earn performance-based payments (such as shared savings or bonus payments) 6
- Providing loans directly to practices or providers..... 7
- Providing loan guarantees, meaning loans that practices/providers receive from financial institutions that your organization is guaranteeing..... 8
- Providing grants directly to practices or providers..... 9
- No, we are not providing any financial supports to primary care practices or providers due to the COVID-19 pandemic 0
- Other (SPECIFY)..... 99

Specify

9. **[ONLY ANSWER IF YOU OFFER TWO OR MORE LINES OF BUSINESS]**

Lastly, please use the space below to briefly describe any differences across your lines of business in your approach to COVID-19 cost sharing, reimbursement approaches, and/or financial supports for primary care practices or providers in 2021.

A. PAYER PARTNERSHIP IN CPC+

In this section, we ask about the details of your CPC+ partnership in [REGION SURVEY IS ABOUT]. Specifically, we are interested in hearing about how you are contracting with CPC+ practices and your approach to attributing members to CPC+ practices.

A1. In 2021, did you offer the following line(s) of businesses in [REGION SURVEY IS ABOUT]?

	Select one per row	
	Yes	No
a. Commercial: Fully Insured Products	<input type="radio"/> ¹	<input type="radio"/> ⁰
b. Commercial: Self-Insured Products (Third Party Administrator (TPA) / Administrative Services Only (ASO))	<input type="radio"/> ¹	<input type="radio"/> ⁰
c. Health Insurance Marketplace Plan(s)	<input type="radio"/> ¹	<input type="radio"/> ⁰
d. State/Federal High-Risk Pool(s)	<input type="radio"/> ¹	<input type="radio"/> ⁰
e. Medicare Advantage	<input type="radio"/> ¹	<input type="radio"/> ⁰
f. Medicaid/CHIP Managed Care Plan(s)	<input type="radio"/> ¹	<input type="radio"/> ⁰
g. Medicaid/CHIP fee-for-service (FFS)	<input type="radio"/> ¹	<input type="radio"/> ⁰

A2. How do you attribute or assign members to CPC+ practices?

Select all that apply

- Members select or are assigned to a primary care provider (typically at enrollment)..... 1
- Members are attributed to a CPC+ practice using a claims-based attribution methodology 2
- Other (SPECIFY)..... 99
Specify

[GO TO A8 IF OPTION 2 NOT SELECTED ABOVE]

A3. [ONLY ANSWER IF USING CLAIMS-BASED ATTRIBUTION METHODOLOGY (A2=2)]

How many months do you use for the look back period to attribute members to CPC+ practices? If you have a primary and a secondary look back period, please indicate both.

	Number of months in look back period (1-48 months)
	Number of months in secondary look back period (if no visits during primary look back period) (0-48 months)

A4. [ONLY ANSWER IF USING CLAIMS-BASED ATTRIBUTION METHODOLOGY (A2=2)]

What is your primary claims-based attribution methodology?

- Members are attributed to the primary care practice they visited most frequently during the look back period (i.e., plurality of visits)..... 1
- Members are attributed to the primary care practice they last visited during the look back period 2
- Other (SPECIFY)..... 99
Specify

A5. [ONLY ANSWER IF USING CLAIMS-BASED ATTRIBUTION METHODOLOGY (A2=2)]

How frequently do you rerun CPC+ attribution?

- Monthly 1
- Quarterly 2
- Twice a year 3
- Yearly 4
- Other (SPECIFY)..... 99
Specify

A6. [ONLY ANSWER IF USING CLAIMS-BASED ATTRIBUTION METHODOLOGY (A2=2)]

Can CPC+ practices appeal attribution of certain members? In other words, can practices request that a patient that is not attributed be attributed, or vice versa?

- Yes..... 1
- No 0

A8. [ONLY ANSWER IF OFFERING COMMERCIAL SELF-INSURED (TPA OR ASO) LINE OF BUSINESS (A1b=1)]

How many of your commercial self-insured (TPA/ASO) clients in [REGION SURVEY IS ABOUT] participate in CPC+?

- All commercial self-insured clients 3
- Most commercial self-insured clients 2
- Some commercial self-insured clients 1
- No commercial self-insured clients 0

A9. [ONLY ANSWER IF OFFER COMMERCIAL SELF-INSURED (TPA OR ASO) LINE OF BUSINESS (A1b=1)]

Please select the option that best describes your strategy for recruiting commercially self-insured (TPA/ASO) clients to participate in CPC+.

- All commercial self-insured clients are **required** to participate in CPC+ 1
- Commercial self-insured clients are enrolled in CPC+ unless they **opt out** of participation 2
- Commercial self-insured clients can **opt in** to CPC+ participation 3

B. PAYMENT APPROACHES FOR CPC+

In this section, we are interested in learning about your 2021 payment approaches for primary care practices.



B1. For each of the following payment approaches, please indicate if (1) you are using the payment approach for any primary care practices in [REGION SURVEY IS ABOUT] in 2021, and (2) you are planning to use the payment approach for any of your practices after CPC+ ends.

These payment approaches could be used for CPC+ and/or for other programs that you have in place to support primary care practices.

Payment Approach	1. Using approach in 2021?	2. Planning to use this approach for any of your practices after CPC+ ends?
a. Care management fees. Care management fees are non-visit based PMPM payments to primary care practices to support enhanced, coordinated services. These fees are paid in addition to usual payments for services. This fee may be risk-adjusted. (For capitated payments made for services in lieu of FFS select "e.")	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
b. Performance-based incentive payments or pay for performance. <i>(Note: This category is separate from shared savings).</i> Bonus payments and/or payment recoupments used to incentivize practices to meet benchmarks (for example, on utilization, cost, or quality). These payments can be made prospectively or at the end of the performance period.	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
c. Shared savings model. Payers calculate savings on total cost of care or on cost of a subset of services (such as a primary-care focused episode of care), which are compared to an expenditure target or to costs for another group. A proportion of savings (or losses) are shared with (or recouped from) practices/groups. These payments or withholds are made retrospectively.	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
d. Enhanced fee-for-service (FFS) payments. Payer pays practices an enhanced FFS payment rate (for example, 105% of normal FFS rates) to support enhanced, coordinated services and/or for meeting benchmarks (for example, on utilization, cost, or quality) during the prior year.	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
e. Comprehensive Primary Care Payments or Capitation (partial or full) or Global Payments. Practices receive lump sum payments for attributed patients in lieu of all or some portion of FFS payments. FFS payments for primary care services are correspondingly reduced or eliminated.	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
f. Prospective bundled payments for primary-care focused episodes of care. Payer determines a target price for a primary-care focused episode of care. Payers pay that lump sum prospectively (eliminating or reducing FFS payments for that episode of care).	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
g. Other (SPECIFY)	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No	<input type="radio"/> ¹ Yes <input type="radio"/> ⁰ No
<div style="border: 1px solid black; width: 200px; height: 20px; margin: 0 auto;"></div>		

Care Management Fees

[THIS SECTION ASKED ONLY IF PAYER IS USING CMF APPROACH IN 2021 (B1a1=YES)]

The next set of questions will focus on your care management fees. Care management fees are non-visit based PMPM payments to practices to support enhanced, coordinated services. This fee may be adjusted but is not dependent on utilization, cost, or quality measures. Please focus on how you are paying the CPC+ practices you contract with during 2021.

B3. For a given practice type, please indicate how many practices receive care management fees.

Select one per row

	None	Some	Most	All
a. Track 1 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
b. Track 2 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
c. Other primary care practices in [REGION SURVEY IS ABOUT] that are NOT participating in CPC+	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³

[IF ANSWER NO TO ALL B3a-c QUESTIONS, PLEASE GO TO PERFORMANCE-BASED INCENTIVE PAYMENT SECTION ON PAGE 19, QUESTION B22]

The remaining questions in this section focus on your approach in all of your CPC+ regions.

For these next questions about care management fees:

- Please focus on your approach for **your CPC+ practices**, not your approach for other primary care practices that are not participating in CPC+.
- Unless otherwise specified, please focus on the approach used **most commonly with your CPC+ practices**, even if you have different approaches for Track 1 and Track 2.

B6. In 2021, for which line(s) of business are you offering CPC+ care management fees?

Select all that apply

- Commercial: Fully Insured Products 1
- Commercial: Self-Insured Products (TPA/ASO)..... 4
- Health Insurance Marketplace Plan(s) 2
- State/Federal High-Risk Pool(s)..... 3
- Medicare Advantage..... 5
- Medicaid/CHIP Managed Care Plan(s) 6
- Medicaid/CHIP fee-for-service (FFS) 7

B7. [ONLY ANSWER IF YOU ARE OFFERING CMFS TO MORE THAN ONE LINE OF BUSINESS]

Do your 2021 care management fees for CPC+ practices differ by line of business?

- Yes..... 1
- No 0

B8. Do you adjust your care management fees based on any patient factors such as demographics, patient risk score, patient category, or patient health status?

- Yes..... 1
- No 0

B9. [ONLY ANSWER IF YOU ADJUST YOUR CARE MANAGEMENT FEES BASED ON PATIENT FACTORS (B8=1)]

What patient factors do you use to adjust your care management fees?

Select all that apply

- Adjust for demographic characteristics (such as age or sex)..... 1
- Adjust for patient risk score (such as Hierarchical Condition Category [HCC] risk score, 3M Clinical Risk Groups [CRG], Milliman Advanced Risk Adjusters [MARA], or DxCG)..... 2
- Adjust for patients' prior cost or service use 3
- Other (SPECIFY)..... 99

Specify

B10. As you may know, CMS sets requirements that practices must meet to participate in CPC+.

In addition to these CPC+ requirements, do you use any factors tied to practice or practitioner performance – such as utilization, cost, or quality metrics, or accreditation standards such as Patient-Centered Medical Home (PCMH) participation – to determine:

Select all that apply

- If practices are **eligible** to receive any care management fees? (e.g., you set a quality floor for receiving any care management fees)..... 1
- The **amount** of care management fees a practice may receive? (e.g., better performance equals higher fees) 2
- None of the above. Care management fees are not tied to any practice performance factors..... 0

B11. [ONLY ANSWER IF CMFS ARE TIED TO PRACTICE PERFORMANCE FACTORS (B10=1 OR 2)]

Please indicate below which practice metrics or accreditation standards you use to [1) determine practice eligibility to receive care management fees and/or 2) adjust the specific care management fee amount a practice receives].

<i>Metric or standard</i>	Used to determine practice eligibility to receive care management fees?	Used to adjust the specific care management fee amount a practice receives?
a. Practice performance on utilization metrics	<input type="checkbox"/>	<input type="checkbox"/>
b. Practice performance on cost metrics	<input type="checkbox"/>	<input type="checkbox"/>
c. Practice performance on quality metrics	<input type="checkbox"/>	<input type="checkbox"/>
d. Achieving Patient-Centered Medical Home (PCMH) recognition or by PCMH tier	<input type="checkbox"/>	<input type="checkbox"/>
e. Other (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>
<div style="border: 1px solid black; height: 20px; width: 250px;"></div>		

B12. [ONLY ANSWER IF YOU INDICATED YOU USE ANY METRIC OR STANDARD IN B11 TO ADJUST THE SPECIFIC FEE AMOUNT]

You indicated that you adjust the specific care management fee amount a practice receives based on the following practice performance factors:

- Practice performance on utilization metrics
- Practice performance on cost metrics
- Practice performance on quality metrics
- Achieving Patient-Centered Medical Home (PCMH) recognition or by PCMH tier
- Other

For a typical CPC+ practice, what percent of your 2021 care management fees are dependent on these factors?

PERCENT (RANGE 0 to 100)

B.12.b [ONLY ANSWER IF CMFS ARE ADJUSTED BASED ON PATIENT FACTORS (B8=1) OR IF FACTORS ARE USED TO DETERMINE THE AMOUNT OF CMFS A PRACTICE MAY RECEIVE (B10=2)].

How did you adjust the PMPM care management payments provided to your Track 1 CPC+ practices in 2021?

- Tiers or categories..... 1
- Continuous values 2

B13. [ONLY ANSWER IF YOUR TRACK 1 PRACTICES RECEIVE CMFS (B3a=1, 2, OR 3) AND IF YOU DO NOT USE CONTINUOUS VALUES TO ADJUST THE PMPM CARE MANAGEMENT PAYMENTS TO TRACK 1 PRACTICES (B12b=NOT 2)]

This question is about the 2021 care management fees for your Track 1 CPC+ practices.

For [your care management fees/ other LOBs chosen in B6]...

What is the average per member per month (PMPM) care management payment for your Track 1 practices in 2021?

Do NOT include performance-based incentive payments.

\$ Average PMPM payment (RANGE 0-50)

B14. [ONLY ANSWER IF YOUR TRACK 1 PRACTICES RECEIVE CMFS (B3a=1, 2, OR 3) AND YOU ADJUST YOUR CMF PAYMENTS AND YOU DO NOT USE CONTINUOUS VALUES TO ADJUST THE PMPM CARE MANAGEMENT PAYMENTS TO TRACK 1 PRACTICES (B12b=NOT 2)]

What is the adjusted Track 1 PMPM care management payment for each tier [for CYCLE THROUGH EACH LINE OF BUSINESS SELECTED AT B6]?

Use only the number of tiers that are applicable for your organization.

Tier 1: \$		PMPM payment (RANGE 0-50)
Tier 2: \$		PMPM payment (RANGE 0-50)
Tier 3: \$		PMPM payment (RANGE 0-50)
Tier 4: \$		PMPM payment (RANGE 0-50)
Tier 5: \$		PMPM payment (RANGE 0-50)

Please note, you will be asked items B13 and B14 for each line of business you selected at item B6

B14.b. [ONLY ANSWER IF YOUR TRACK 1 PRACTICES RECEIVE CMFS (B3a=1, 2, OR 3) AND YOU ADJUST YOUR CMF PAYMENTS AND IF YOU ADJUST THE PMPM CARE MANAGEMENT PAYMENTS TO TRACK 1 PRACTICES USING CONTINUOUS VALUES (B12b=2)]

What are the adjusted average and range of values of your Track 1 PMPM care management payments[for CYCLE THROUGH EACH LINE OF BUSINESS SELECTED AT B6]?

Average: \$ _____

Range: Minimum \$ _____; Maximum \$ _____

B15. [ONLY ANSWER IF YOU HAVE BOTH TRACK 1 AND TRACK 2 PRACTICES THAT RECEIVE CMFS (B3a=1, 2, or 3 AND B3b=1, 2, or 3)]

Please confirm whether your 2021 care management fees are different for Track 1 and Track 2 CPC+ practices.

- Yes, they are different 1
- No, they are the same 0

B16. [ONLY ANSWER IF YOUR TRACK 2 PRACTICES RECEIVE CMFS (B3b=1, 2, OR 3) AND PAYMENTS RECEIVED BY TRACK 2 PRACTICES ARE DIFFERENT THAN TRACK 1 (B15=1)]

This question is about the 2021 care management fees for your Track 2 CPC+ practices.

For [your care management fees/CYCLE THROUGH EACHLINE OF BUSINESS SELECTED IN B6]...

What is the average per member per month (PMPM) care management payment for your Track 2 practices in 2021?

Do NOT include performance-based incentive payments.

\$ Average PMPM payment (RANGE 0-50)

B17. [ONLY ANSWER IF YOUR TRACK 2 PRACTICES RECEIVE CMFS (B3b=1, 2, or 3), PAYMENTS RECEIVED BY TRACK 2 PRACTICES ARE DIFFERENT THAN TRACK 1 (B15=1), AND YOU ADJUST YOUR CMF PAYMENTS AND YOU DO NOT USE CONTINUOUS VALUES TO ADJUST THE PMPM CARE MANAGEMENT PAYMENTS TO TRACK 1 PRACTICES (B12b=NOT 2)]

What is the adjusted Track 2 PMPM care management payment for each tier for [CYCLE THROUGH EACH LINE OF BUSINESS SELECTED IN B6]?

Use only the number of tiers that are applicable for your organization.

Tier 1: \$ PMPM payment (RANGE 0-50)

Tier 2: \$ PMPM payment (RANGE 0-50)

Tier 3: \$ PMPM payment (RANGE 0-50)

Tier 4: \$ PMPM payment (RANGE 0-50)

Tier 5: \$ PMPM payment (RANGE 0-50)

B17.b. [ONLY ANSWER IF YOUR TRACK 2 PRACTICES RECEIVE CMFS (B3b=1, 2, or 3), PAYMENTS RECEIVED BY TRACK 2 PRACTICES ARE DIFFERENT THAN TRACK 1 (B15=1), AND YOU ADJUST THE PMPM CARE MANAGEMENT PAYMENTS TO TRACK 2 PRACTICES USING CONTINUOUS VALUES (B12b=2)]

What are the adjusted average and range of values of your Track 2 PMPM care management payments[for CYCLE THROUGH EACH LINE OF BUSINESS SELECTED IN B6]?

Average: \$ _____

Range: Minimum \$ _____; Maximum \$ _____

B18. Do you impose any restrictions on how practices can use the CPC+ care management fees you provide them?

- Yes..... 1
- No 0

B19. [ONLY ANSWER IF YOU IMPOSE RESTRICTIONS ON HOW PRACTICES CAN USE CMFS (B18=1)]

Below, we list the types of expenses CMS does *NOT* allow practices to spend Medicare FFS care management fees on. Please check the expenses practices are *NOT* allowed to spend your CPC+ care management fees on.

Select all that apply

- Our restrictions are identical to CMS..... 0
- Bonus payments to primary care practitioners or staff 1
- Payments to specialists 2
- Contracted services without practice oversight, such as from a care management company 3
- Health information technology 4
- Fees for accreditation 5
- Durable medical equipment..... 6
- Diagnostic and imaging equipment 7
- Medications..... 8
- Practitioner or staff training or continuing medical education credits 9
- Income and business tax payments 10
- Other (SPECIFY)..... 99

Specify

B21. [ONLY ANSWER IF YOU ARE PROVIDING CMFS TO NON-CPC+ PRACTICES (B3c=1, 2, OR 3)]

You indicated earlier that [some/most/all] non-CPC+ practices receive care management fees. How do your care management fee payment levels for those practices compare to your payments for Track 1 CPC+ practices?

- Payments under other programs are generally higher than CPC+ payments for Track 1..... 1
- Payments under other programs are about the same as CPC+ payments for Track 1..... 2
- Payments under other programs are generally lower than CPC+ payments for Track 1..... 3

Performance-Based Incentive Payments

[COMPLETE THIS SECTION IF PERFORMANCE-BASED INCENTIVE PAYMENTS OR PAY FOR PERFORMANCE WAS SELECTED IN B1 FOR 2021]

The next set of questions will focus on your performance-based incentive payments for primary care practices. Performance-based incentive payments or pay-for-performance programs include bonus payments and/or payment recoupments used to incentivize practices to meet benchmarks (for example, on utilization, cost or quality). These payments can be made prospectively or at the end of the performance period. Please focus on how you are rewarding practices during 2021.

B22. For a given practice type, please indicate how many practices are potentially eligible to receive performance-based incentive payments. Please note that for this survey “CPC+ practices” refer to practices that were selected by CMS to participate in CPC+.

<i>Select one per row</i>				
	None	Some	Most	All
a. Track 1 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
b. Track 2 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
c. Other primary care practices in [REGION SURVEY IS ABOUT] that are NOT participating in CPC+	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³

[IF NONE SELECTED FOR A, B, AND C, SKIP TO B33 ON PAGE 22 (SHARED SAVINGS SECTION)]

The remaining questions in this section focus on your approach in all of your CPC+ regions.

B24. In 2021, for which line(s) of business are you offering CPC+ performance-based incentive payments?

Select all that apply

- Commercial: Fully Insured Products Insurance Plan(s) 1
- Commercial: Self-Insured Products (TPA/ASO)..... 4
- Health Insurance Marketplace Plan(s) 2
- State/Federal High-Risk Pool(s)..... 3
- Medicare Advantage..... 5
- Medicaid/CHIP Managed Care Plan(s) 6
- Medicaid/CHIP fee-for-service (FFS) 7

B25. [ONLY ANSWER IF PROVIDING PBIPS TO MULTIPLE TYPES OF PRACTICES (TRACK 1, TRACK 2, AND/OR OTHER PRIMARY CARE PRACTICES NOT PARTICIPATING IN CPC+)]

You have indicated that you provide performance-based incentive payments [Track 1 CPC+ practices / Track 2 CPC+ practices / other primary care practices that are not participating in CPC+/multiple lines of business]. Do you have a different approach to providing performance-based incentive payments for:

	<i>Select one per row</i>	
	Yes	No
a. CPC+ practices versus other primary care practices that are not participating in CPC+ practices?	<input type="radio"/> ¹	<input type="radio"/> ⁰
b. Track 1 CPC+ practices versus Track 2 CPC+?	<input type="radio"/> ¹	<input type="radio"/> ⁰
c. Different lines of business?	<input type="radio"/> ¹	<input type="radio"/> ⁰

For these next questions about performance-based incentive payments:

- Please focus on your approach for **your CPC+ practices**, not your approach for other primary care practices that are not participating in CPC+.
- Unless otherwise specified, please focus on **the approach used most commonly with your CPC+ practices**, not your separate approaches for Track 1 and Track 2 practices.
- Please think about **your line of business with the greatest number of patients attributed to CPC+ practices**.

B26. / PBIP_PRO [Performance-Based Incentive Payments]

In 2021, are you providing upfront performance-based incentive payments to CPC+ practices?

- Yes, practices receive an upfront, prospective incentive payment (e.g., bonus) that is later reconciled based on their performance. 1
- No, we pay these payments at the end of a performance period..... 0

B27. [ONLY ANSWER IF YOU ARE PROVIDING UPFRONT PERFORMANCE-BASED INCENTIVE PAYMENTS (B26=1)]

Will practices be subject to a payment recoupment the following year if they do not meet prespecified quality or efficiency benchmarks?

- Yes..... 1
- No 0

B28. Have you finalized your performance-based incentive payment calculations based on practices' performance in 2020?

- Yes..... 1
- No 0

B29. [ONLY ANSWER IF YOU HAVE FINALIZED YOUR PBIP CALCULATIONS (B28=1)]

What proportion of practices qualified for performance-based incentive payments based on their performance in 2020?

Select one per row

	None	Some	Most	All
a. Track 1 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
b. Track 2 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
c. Other primary care practices in [REGION SURVEY IS ABOUT] that are NOT participating in CPC+	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³

B30. Do you impose any restrictions on how practices can use the CPC+ performance-based incentive payments you provide them?

- Yes 1
- No 0

B31. [ONLY ANSWER IF YOU IMPOSE RESTRICTIONS ON HOW PRACTICES CAN SPEND THEIR PBIPS (B30=1)]

What expenses are practices NOT allowed to spend CPC+ performance-based incentive payments on?

Select all that apply

- Bonus payments to primary care practitioners or staff 1
 - Payments to specialists 2
 - Contracted services without practice oversight, such as from a care management company 3
 - Health information technology 4
 - Fees for accreditation 5
 - Durable medical equipment 6
 - Diagnostic and imaging equipment 7
 - Medications 8
 - Practitioner or staff training or continuing medical education credits 9
 - Income and business tax payments 10
 - Other (SPECIFY) 99
- Specify

Shared Savings Model

[COMPLETE THIS SECTION IF SHARED SAVINGS MODEL WAS SELECTED IN B.1 FOR 2021]

The next set of questions ask about your shared savings program. Shared savings models are gain (or risk) sharing arrangements in which costs of care for CPC+ practices are compared to an expenditure target or to costs for another group of practices and a proportion of any savings are shared with practices. Payers calculate savings on total cost of care or on cost of a subset of services, which are compared to an expenditure target or to costs for another group. A proportion of savings (or losses) are shared with (or recouped from) practices/groups. These payments or withholds are made retrospectively. Please focus on how you are analyzing savings accrued for 2021.

B33. For a given practice type, please indicate how many practices are participating in a shared savings program. Please note that for this survey “CPC+ practices” refers to practices that were selected by CMS to participate in CPC+.

Select one per row

	None	Some	Most	All
a. Track 1 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
b. Track 2 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
c. Other primary care practices in [REGION SURVEY IS ABOUT] that are NOT participating in CPC+	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³

[IF NONE SELECTED FOR A, B, AND C, SKIP TO B47 ON PAGE 25 (ENHANCED FFS SECTION)]

The remaining questions in this section focus on your approach in all of your CPC+ regions.

B35. In 2021, for which line(s) of business are you offering your shared savings program?

Select all that apply

- Commercial: Fully Insured Products 1
- Commercial: Self-Insured Products (TPA / ASO) 4
- Health Insurance Marketplace Plan(s) 2
- State/Federal High-Risk Pool(s) 3
- Medicare Advantage 5
- Medicaid/CHIP Managed Care Plan(s) 6
- Medicaid/CHIP fee-for-service (FFS) 7

B36. [ONLY ANSWER IF YOU ARE PROVIDING SHARED SAVINGS TO MORE THAN 1 TYPE OF PRACTICE (TRACK 1, TRACK 2, AND/OR NON-CPC+ PRACTICES)]

You have indicated that you provide shared savings to [Track 1 CPC+ practices / Track 2 CPC+ practices / other primary care practices that are not participating in CPC+/multiple lines of business]. Do you have a different approach to providing shared savings for:

	Select one per row	
	Yes	No
a. CPC+ practices versus other primary care practices that are not participating in CPC+ practices?	<input type="radio"/> ¹	<input type="radio"/> ⁰
b. Track 1 CPC+ practices versus Track 2 CPC+?	<input type="radio"/> ¹	<input type="radio"/> ⁰
c. Different lines of business?	<input type="radio"/> ¹	<input type="radio"/> ⁰

For these next questions about shared savings payments:

- Please focus on your approach for **your CPC+ practices**, not your approach for other primary care practices that are not participating in CPC+.
- Unless otherwise specified, please focus on **the approach used most commonly with your CPC+ practices**, not your separate approaches for Track 1 and Track 2 practices.
- Please think about **your line of business with the greatest number of patients attributed to CPC+ practices**.

B37. For 2021, what is the typical maximum percent of savings you would share with practices?

PERCENT OF SAVINGS

B38. In 2021, will you include downside risk sharing? In other words, will CPC+ practices also share in losses?

- Yes..... 1
- No 0

B39. [ONLY ANSWER IF YOU ARE INCLUDING DOWNSIDE RISK SHARING (B38=1)]

FOR 2021, WHAT IS THE MAXIMUM TYPICAL PERCENT OF LOSSES WOULD YOU PASS ON TO PRACTICES?

PERCENT OF LOSSES

B40. For 2021, do you use a minimum savings rate (that is, a threshold that must be surpassed before savings are shared with practices)?

- Yes..... 1
- No 0

B41. [ONLY ANSWER IF YOU USE A MINIMUM SAVINGS RATE (B40=1)]

What is the minimum savings rate?

PERCENT MINIMUM SAVINGS RATE

B42. Have you finalized your shared savings calculations based on practices' performance in 2020?

- Yes..... 1
- No 0

B43. What proportion of practices received shared savings payments based on their performance in 2020?

Select one per row

	None	Some	Most	All
a. Track 1 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
b. Track 2 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
c. Other primary care practices in [REGION SURVEY IS ABOUT] that are NOT participating in CPC+	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³

B44. Compared to 2020, did you make any other significant changes to your shared savings approach for 2021?

- Yes..... 1
- No 0

B45. [ONLY ANSWER IF YOU MADE SIGNIFICANT CHANGES TO YOUR SHARED SAVINGS APPROACH IN 2021 (B44=1)]

Please briefly describe these other changes to your shared savings program for 2021.

Enhanced FFS Payments

[COMPLETE THIS SECTION IF ENHANCED FEE-FOR-SERVICE (FFS) PAYMENTS WAS SELECTED IN B1 FOR 2021]

The next set of questions will focus on your 2021 enhanced FFS payments. Under enhanced FFS payment programs, payers pay practices an enhanced FFS payment rate (e.g., 105% of normal FFS rates) to support enhanced, coordinated services and/or for meeting benchmarks (for example, on utilization, cost, or quality) during the prior year.

B47. For a given practice type, please indicate how many practices are potentially eligible to receive enhanced FFS payments. Please note that for this survey “CPC+ practices” refers to practices that were selected by CMS to participate in CPC+.

Select one per row

	None	Some	Most	All
a. Track 1 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
b. Track 2 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
c. Other primary care practices in [REGION SURVEY IS ABOUT] that are NOT participating in CPC+	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³

[IF NONE SELECTED FOR A, B, AND C, SKIP TO B57 ON PAGE 28 (ALTERNATIVE FEE-FOR-SERVICE SECTION)]

The remaining questions in this section focus on your approach in all of your CPC+ regions.

B49. In 2021, for which line(s) of business are you offering enhanced FFS payments?

Select all that apply

- Commercial: Fully Insured Products 1
- Commercial: Self-Insured Products (TSA/ASO)..... 4
- Health Insurance Marketplace Plan(s) 2
- State/Federal High-Risk Pool(s)..... 3
- Medicare Advantage..... 5
- Medicaid/CHIP Managed Care Plan(s) 6
- Medicaid/CHIP fee-for-service (FFS) 7

B50. [ONLY ANSWER IF YOU ARE PROVIDING ENHANCED FFS PAYMENTS TO MULTIPLE TYPES OF PRACTICES (TRACK 1, TRACK 2, AND/OR PRIMARY CARE PRACTICES NOT PARTICIPATING IN CPC+)]

You have indicated that you provide enhanced FFS payments to [Track 1 CPC+ practices / Track 2 CPC+ practices / other primary care practices that are not participating in CPC+/multiple lines of business]. Do you have a different approach to providing enhanced FFS payments for:

	<i>Select one per row</i>	
	Yes	No
a. CPC+ practices versus other primary care practices that are not participating in CPC+ practices?	<input type="radio"/>	<input type="radio"/>
b. Track 1 CPC+ practices versus Track 2 CPC+?	<input type="radio"/>	<input type="radio"/>
c. Different lines of business?	<input type="radio"/>	<input type="radio"/>

For these next questions about enhanced FFS payments:

- Please focus on your approach for **your CPC+ practices**, not your approach for other primary care practices that are not participating in CPC+.
- Unless otherwise specified, please focus on **the approach used most commonly with your CPC+ practices**, not your separate approaches for Track 1 and Track 2 practices.
- Please think about **your line of business with the greatest number of patients attributed to CPC+ practices**.

B51. Are you providing enhanced FFS payments in 2021 based on performance in CPC+ in 2020?

- Yes..... 1
- No 0

B52. In 2021, what adjustments (if any) are you making when calculating the enhanced FFS rate for practices?

Select all that apply

- Adjust for practice participation in CPC+ or another practice transformation initiative..... 1
- Adjust for practice performance on utilization, cost, quality metrics..... 2
- Adjust rate by practice status as it relates to CPC+ Tracks (e.g., CPC+ Track 1 or Track 2) or tiers (e.g., achieving a certain PCMH recognition level) 3
- None of the above. Adjusted rate negotiated with practices but is not tied to CPC+ participation or utilization, cost, or quality metrics 3
- Other (SPECIFY)..... 99
Specify

B53. [ONLY ANSWER IF YOU ARE ADJUSTING ENHANCED FFS BASED ON PRACTICE PARTICIPATION IN CPC+ (B52=1)]

By how much are you adjusting the 2021 FFS rate for participation in CPC+ or another primary care transformation initiative?

PERCENT

B54. [ONLY ANSWER IF YOU ARE ADJUSTING ENHANCED FFS FOR PRACTICE PERFORMANCE ON UTILIZATION, COST, OR QUALITY METRICS (B52=2)]

By how much are you adjusting 2021 FFS payments for performance on utilization, cost, and/or quality metrics?

PERCENT

B55. [ONLY ANSWER IF YOU ARE ADJUSTING ENHANCED FFS FOR PRACTICE PERFORMANCE UTILIZATION, COST, OR QUALITY METRICS (B52=2)]

If you are using quality tiers, please describe below.

B56. If relevant, use the space below to note any differences in your approach to enhanced FFS payments across CPC+ regions.

Alternative to FFS Payments

[COMPLETE THIS SECTION IF COMPREHENSIVE PRIMARY CARE PAYMENTS OR CAPITATION OR BUNDLED PAYMENTS FOR PRIMARY CARE-FOCUSED EPISODES OF CARE WAS SELECTED IN B1 FOR 2021]

The next set of questions will focus on your alternative payment approach, such as comprehensive primary care payments (CPCP), partial or full capitation, or bundled payments for episodes. Under these models, practices receive lump sum payments for attributed patients instead of all or some portion of fee-for-service payments. Please focus on your alternative payments to practices during 2021.

B57. For a given practice type, please indicate how many practices are included in your alternative to FFS approach. Please note that for this survey “CPC+ practices” refers to practices that were selected by CMS to participate in CPC+.

Select one per row

	None	Some	Most	All
a. Track 1 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
b. Track 2 CPC+ in [REGION SURVEY IS ABOUT]	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³
c. Other primary care practices in [REGION SURVEY IS ABOUT] that are NOT participating in CPC+	<input type="radio"/> ⁰	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³

[IF NONE SELECTED FOR A, B, AND C, SKIP TO C1A ON PAGE 33 (QUALITY MEASURES, DATA FEEDBACK, AND TECHNICAL ASSISTANCE SECTION)]

The remaining questions in this section focus on your approach in all of your CPC+ regions.

B59. In 2021, for which line(s) of business are you using an alternative payment approach?

Select all that apply

- Commercial: Fully Insured Products 1
- Commercial: Self-Insured Products (TPA/ASO)..... 4
- Health Insurance Marketplace Plan(s) 2
- State/Federal High-Risk Pool(s)..... 3
- Medicare Advantage..... 5
- Medicaid/CHIP Managed Care Plan(s) 6
- Medicaid/CHIP fee-for-service (FFS) 7

B60. [ONLY ANSWER IF YOU ARE PROVIDING ALTERNATIVE TO FFS PAYMENTS TO MULTIPLE TYPES OF PRACTICES (TRACK 1, TRACK 2, AND/OR NON-CPC+ PRACTICES NOT PARTICIPATING IN CPC+)]

You have indicated that you provide alternative to FFS payments to [Track 1 CPC+ practices / Track 2 CPC+ practices / other primary care practices that are not participating in CPC+/multiple lines of business]. Do you have a different approach to providing alternative to FFS payments for:

	<i>Select one per row</i>	
	Yes	No
a. CPC+ practices versus other primary care practices that are not participating in CPC+ practices?	<input type="radio"/> ¹	<input type="radio"/> ⁰
b. Track 1 CPC+ practices versus Track 2 CPC+	<input type="radio"/> ¹	<input type="radio"/> ⁰
c. Different lines of business?	<input type="radio"/> ¹	<input type="radio"/> ⁰

For these next questions about alternative to FFS payments:

- Please focus on your approach for **your CPC+ practices**, not your approach for other primary care practices that are not participating in CPC+.
- Unless otherwise specified, please focus on **the approach used most commonly with your CPC+ practices**, not your separate approaches for Track 1 and Track 2 practices.
- Please think about **your line of business with the greatest number of patients attributed to CPC+ practices**.

B61. Do practices receive prospective, alternative payments instead of some or all FFS payments for...

Select one only

- All primary care services with few exceptions (such as immunizations or screeners)..... 1
- Some primary care services (such as Evaluation and Management office visits or primary care specific episodes)..... 2
- No primary care services. We do not use an alternative to FFS payment approach (such as full or partial capitation, or bundled payments) for our CPC+ primary care practices 0

B62. [ONLY ANSWER IF PRACTICES ARE RECEIVING PROSPECTIVE, ALTERNATIVE PAYMENTS FOR SOME PRIMARY CARE SERVICES (B61=2)]

For what primary care specific episodes are practices receiving prospective, alternative payments instead of some or all FFS payments?

Select all that apply

- Evaluation and Management office visits 1
 - Primary care specific episodes (e.g., urinary tract infections, depression, low back pain)..... 2
 - Other (SPECIFY)..... 99
- Specify

B63. [ONLY ANSWER IF PRACTICES ARE RECEIVING PROSPECTIVE ALTERNATIVE PAYMENTS FOR PRIMARY CARE SPECIFIC EPISODES (B62=2)]

In 2021, for what primary care specific episodes are practices receiving alternative or bundled payments?

Select all that apply

- Urinary tract infection..... 1
 - Cellulitis 2
 - HIV 3
 - Hepatitis C 4
 - Bronchiolitis and RSV pneumonia..... 5
 - Hemophilia..... 6
 - CAD and angina 7
 - Sickle cell..... 8
 - Hypotension..... 9
 - Dermatitis/urticarial..... 10
 - Upper respiratory infection (outpatient)..... 11
 - Attention-deficit/hyperactivity disorder (ADHD)..... 12
 - Oppositional defiant disorder (ODD) 13
 - Otitis Media..... 14
 - Depression..... 15
 - Anxiety..... 16
 - Headache 17
 - Low back pain..... 18
 - Asthma..... 19
 - Chronic obstructive pulmonary disease (COPD)..... 20
 - Perinatal care 21
 - Other (SPECIFY)..... 99
- Specify

B64. In 2021, what adjustments (if any) are you making when calculating alternative payment amounts for CPC+ practices?

Select all that apply

- Adjust for practice participation in CPC+ or another practice transformation initiative..... 1
- Adjust for practice performance on utilization, cost, or quality metrics 2
- Adjust rate by practice status as it relates to CPC+ Tracks (e.g., CPC+ Track 1 or Track 2) or tiers (e.g., achieving a certain PCMH recognition level) 3
- Adjust for patient demographic characteristics (such as age/sex) 4
- Adjust for patient or population risk (such as HCC risk score)..... 5
- Other (SPECIFY)..... 99
Specify
- None 6

B65. [ONLY ANSWER IF ADJUSTING ALTERNATIVE PAYMENTS FOR ELIGIBLE PRACTICES BASED ON PARTICIPATION IN CPC+ OR ANOTHER PRIMARY CARE TRANSFORMATION INITIATIVE]

What is the maximum adjustment amount for 2021 alternative payments based on participation in CPC+ or another primary care transformation initiative ?

PERCENT

B66. [ONLY ANSWER IF ADJUSTING ALTERNATIVE PAYMENTS FOR ELIGIBLE PRACTICES BASED ON UTILIZATION, COST, OR QUALITY METRICS]

What is the maximum adjustment amount for 2021 alternative payments based on utilization, cost, or quality metrics?

PERCENT

B67. [ONLY ANSWER IF ADJUSTING ALTERNATIVE PAYMENTS FOR ELIGIBLE PRACTICES BASED ON PRACTICES' TRACKS OR TIERS]

What is the maximum adjustment amount for 2021 alternative payments based on practices' Tracks or tiers (e.g., Track 1 and Track 2 for CPC+ or achieving a PCMH recognition level)?

PERCENT

B68. [ONLY ANSWER IF ADJUSTING ALTERNATIVE PAYMENTS FOR ELIGIBLE PRACTICES BASED ON PRACTICES' TRACKS OR TIERS]

If you are using quality tiers, please describe below.

B69. We want to understand the percentage of payments to primary care practices that are paid through FFS versus an alternative to FFS payment approach.

Thinking of the payments made to a typical primary care practice during the period from January – June 2021, please estimate the percentage of these payments that was paid using (1) FFS and (2) an alternative payment approach. Examples of alternative to FFS payments include prospective comprehensive primary care payments, capitated payments, and bundled payments for episodes of care.

OF JANUARY – JUNE 2021 PAYMENTS TO PRIMARY CARE PRACTICES, APPROXIMATE PERCENT PAID USING	
---	--

1. FFS (%)	2. An alternative to FFS payment approach (%)
---------------	---

a. Track 1 CPC+ practices in [REGION SURVEY IS ABOUT]

b. Track 2 CPC+ practices in [REGION SURVEY IS ABOUT]

c. Other primary care practices in [REGION SURVEY IS ABOUT] that are NOT participating in CPC+

C. QUALITY MEASURES, DATA FEEDBACK, AND TECHNICAL ASSISTANCE

C1a. In 2021, are you using these metrics to calculate primary care payments? These metrics could be used to calculate care management fees, performance-based payments, shared savings payments, and/or enhanced FFS or capitation rates.

<i>Select one per row</i>		
	Yes	No
a. Claims-based cost and utilization measures	<input type="radio"/> ¹	<input type="radio"/> ⁰
b. Average cost for primary care specific episodes (e.g., urinary tract infections, depression, low back pain)	<input type="radio"/> ¹	<input type="radio"/> ⁰
c. Claims-based quality measures	<input type="radio"/> ¹	<input type="radio"/> ⁰
d. Electronic Clinical Quality Measures (eCQMs)	<input type="radio"/> ¹	<input type="radio"/> ⁰
e. Patient experience measures (e.g., CAHPS)	<input type="radio"/> ¹	<input type="radio"/> ⁰
f. Other (SPECIFY)	<input type="radio"/> ¹	<input type="radio"/> ⁰
<div style="border: 1px solid black; width: 300px; height: 20px; margin-left: 20px;"></div>		

C1b. [ANSWER ONLY FOR ROWS THAT YOU ANSWERED “YES” IN C1a]

Do you risk-adjust any of the following metrics?

<i>Select one per row</i>		
	Yes	No
a. Claims-based cost and utilization measures	<input type="radio"/> ¹	<input type="radio"/> ⁰
b. Average cost for primary care specific episodes (e.g., urinary tract infections, depression, low back pain)	<input type="radio"/> ¹	<input type="radio"/> ⁰
c. Claims-based quality measures	<input type="radio"/> ¹	<input type="radio"/> ⁰
d. Electronic Clinical Quality Measures (eCQMs)	<input type="radio"/> ¹	<input type="radio"/> ⁰
e. Patient experience measures (e.g., CAHPS)	<input type="radio"/> ¹	<input type="radio"/> ⁰
f. [OTHER SPECIFY FROM C1a IF SELECTED]	<input type="radio"/> ¹	<input type="radio"/> ⁰

C1c. [ONLY ANSWER IF YOU USE PRIMARY CARE SPECIFIC EPISODES TO CALCULATE PRIMARY CARE PAYMENTS (C1b.b=1)]

In 2021, what primary care-specific episodes are you using to calculate the amount of CPC+ payments or to determine if practices qualify for performance-based incentive payments?

Select all that apply

- Urinary tract infection..... 1
 - Cellulitis 2
 - HIV 3
 - Hepatitis C 4
 - Bronchiolitis and RSV pneumonia..... 5
 - Hemophilia..... 6
 - CAD and angina 7
 - Sickle cell..... 8
 - Hypotension..... 9
 - Dermatitis/urticarial..... 10
 - Upper respiratory infection (outpatient)..... 11
 - Attention-deficit/hyperactivity disorder (ADHD)..... 12
 - Oppositional defiant disorder (ODD) 13
 - Otitis Media..... 14
 - Depression..... 15
 - Anxiety 16
 - Headache 17
 - Low back pain..... 18
 - Asthma..... 19
 - Chronic obstructive pulmonary disease (COPD)..... 20
 - Perinatal care 21
 - Other (SPECIFY)..... 99
- Specify

C2. Do you currently share data feedback on cost, use, and/or quality with primary care practices? Please select “Yes” if you provide feedback directly to practices or if you provide it through a data aggregator.

Select one only

- Yes..... 1
- No, but data feedback will be provided before the end of 2021..... 2
- No, data feedback will not be provided in 2021..... 3

C4. [ONLY ANSWER IF YOU CURRENTLY SHARE OR WILL SHARE DATA FEEDBACK IN 2021 (C2=1 OR 2)]

For 2021, what type of data [are/will be] included in your data feedback?

	Select one per row	
	Yes	No
a. Claims-based cost and utilization measures	<input type="radio"/> ¹	<input type="radio"/> ⁰
b. Average cost for primary care specific episodes (e.g., urinary tract infections, depression, low back pain)	<input type="radio"/> ¹	<input type="radio"/> ⁰
c. Claims-based quality measures	<input type="radio"/> ¹	<input type="radio"/> ⁰
d. Electronic Clinical Quality Measures (eCQMs)	<input type="radio"/> ¹	<input type="radio"/> ⁰
e. Patient experience measures (e.g., CAHPS)	<input type="radio"/> ¹	<input type="radio"/> ⁰
f. Specialists cost data	<input type="radio"/> ¹	<input type="radio"/> ⁰
g. Hospital cost data	<input type="radio"/> ¹	<input type="radio"/> ⁰
h. Other (SPECIFY)	<input type="radio"/> ¹	<input type="radio"/> ⁰
<input style="width: 200px; height: 20px;" type="text"/>		

C5. [ONLY ANSWER IF YOU CURRENTLY SHARE OR WILL SHARE DATA FEEDBACK IN 2021 (C2=1 OR 2)]

How frequently [will/do] you provide data at the system, practice, practitioner, and patient levels?

	Select one per row						(SPECIFY)
	Never, data not provided at that level	Quarterly	Monthly	Weekly	Real-time	Other	
a. System-level	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³	<input type="radio"/> ⁴	<input type="radio"/> ⁵	<input type="radio"/> ⁶	
b. Practice-level	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³	<input type="radio"/> ⁴	<input type="radio"/> ⁵	<input type="radio"/> ⁶	
c. Practitioner-	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³	<input type="radio"/> ⁴	<input type="radio"/> ⁵	<input type="radio"/> ⁶	
d. Patient-level	<input type="radio"/> ¹	<input type="radio"/> ²	<input type="radio"/> ³	<input type="radio"/> ⁴	<input type="radio"/> ⁵	<input type="radio"/> ⁶	

C6a. [ONLY ANSWER IF YOU CURRENTLY SHARE OR WILL SHARE DATA FEEDBACK IN 2021 (C2=1 OR 2)]

What format [will/do] you use for sharing data feedback?

Select all that apply

- Static report 1
- Interactive data portal 2
- Other (SPECIFY) 99

Specify

C6b. [ONLY ANSWER IF YOU CURRENTLY SHARE OR WILL SHARE DATA FEEDBACK IN 2021 (C2=1 OR 2)]

Does your method of sharing data feedback allow practices to export the data or receive a data dump to manipulate the data themselves?

- Yes..... 1
- No 0

C8. [ANSWER IF YOU CURRENTLY SHARE OR WILL SHARE DATA FEEDBACK IN 2021 (C2=1 OR 2)]

In 2021, how many practices that are NOT participating in CPC+ in [REGION SURVEY IS ABOUT] are receiving data feedback on their system, practice, practitioners, or patients?

- None 0
- Some 1
- Most 2
- All..... 3

C9. [ONLY ANSWER IF YOU CURRENTLY SHARE OR WILL SHARE DATA FEEDBACK IN 2021 (C2=1 OR 2) AND ARE PROVIDING DATA FEEDBACK TO NON-CPC+ PRACTICES (C8=1, 2, OR 3)]

How does your data feedback provided under other primary care programs compare to your data feedback for CPC+ practices?

Select one only

- Data feedback is more comprehensive than feedback provided to CPC+ practices 1
- Data feedback is about the same as feedback provided to CPC+ practices 2
- Data feedback is less comprehensive than feedback provided to CPC+ practices 3

C10. Are you offering CPC+ practices technical assistance or practice coaching?

- Yes..... 1
- No 0

C11. [ONLY ANSWER IF PROVIDING TECHNICAL ASSISTANCE OR PRACTICE COACHING (C10=1)]

In 2021, what type of assistance are you offering CPC+ practices?

Select all that apply

- In-person group learning sessions 1
- Web-based group learning sessions 2
- Individualized practice coaching..... 3
- Other 99

Specify

C12. [ONLY ANSWER IF PROVIDING TECHNICAL ASSISTANCE OR PRACTICE COACHING (C10=1)]

Are you coordinating technical assistance for CPC+ practices with [YOUR REGIONAL LEARNING NETWORK]?

- Yes 1
- No 0

C14. [ONLY ANSWER IF PROVIDING TECHNICAL ASSISTANCE OR PRACTICE COACHING (C10=1)]

In 2021, how many practices that are NOT participating in CPC+ are receiving technical assistance?

Select one only

- None 0
- Some 1
- Most 2
- All 3

C15. [ONLY ANSWER IF PROVIDING TECHNICAL ASSISTANCE TO NON-CPC+ PRACTICES IN OTHER PRIMARY CARE PROGRAMS (C14=1, 2, OR 3)]

How does your technical assistance provided under other primary care programs compare to your technical assistance for CPC+ practices?

Select one only

- Technical assistance is more intensive than the support provided to CPC+ practices 1
- Technical assistance is about the same as the support provided to CPC+ practices 2
- Technical assistance is less intensive than the support provided to CPC+ practices 3

C16a. Some payers are offering other supports to practices or directly to CPC+ patients.

Do you offer any of the following other supports or services to CPC+ practices?

Select all that apply

- Care managers for practices 1
- Practice coaching 6
- Social service supports (e.g., assessments and/or referral to social services agencies)..... 7
- Behavioral health integration supports (e.g., embedded behavioral health staff, reimbursement for behavioral health services provided in primary care settings) 2
- Embedded pharmacists for practices 3
- Fee for service reimbursement for alternative visits (such as home-based care, video-based conferencing, or e-visits)..... 4
- Other (SPECIFY)..... 99
Specify
- None of the above 5

C16b. [ONLY ANSWER IF PROVIDING FFS REIMBURSEMENT FOR ALTERNATIVE VISITS (C16a=4)]

Do you provide FFS reimbursement to primary care practices for the following types of alternative visits?

Select all that apply

- Visits in alternative locations (for example, nursing facilities or senior centers)..... 1
- Home-based visits (i.e., primary care home visits)..... 2
- Medical group visits (i.e., shared medical appointments) 3
- Video-based conferencing (i.e., telehealth or telemedicine) 4
- Medical visit over an electronic exchange (for example, e-visit, portal)..... 5
- Medical visit via telephone (i.e. phone visit)..... 6
- Other (SPECIFY)..... 99
Specify

C16c. Do you offer any of the following other supports or services directly to CPC+ attributed patients?

Select all that apply

- Advance care planning 6
- Telephonic care management 1
- Medication therapy reviews 2
- Disease management programs 3
- Health and wellness services (e.g., smoking cessation counseling, weight loss support) 4
- None of the above 5

D. PLANS FOR FUTURE PRIMARY CARE SUPPORTS



D1a. We are interested in understanding your plans for providing primary care practice supports in the future.

Are you considering or planning to change how much enhanced funding you provide directly to primary care practices to support practice transformation after CPC+ ends?

By enhanced funding, we mean payments such as care management fees, pay-for-performance bonuses, or shared savings earnings you provide to practices in addition to regular payments for services provided.

- Yes, we are considering or planning to **increase** the amount of funding to support practice transformation 1
- Yes, we are considering or planning to **decrease** the amount of funding to support practice transformation 2
- Yes, we are considering or planning to **discontinue** offering funding to support practice transformation 3
- No, we are considering or planning to **maintain** the current amount of funding to support practice transformation 4
- Unsure or undecided 5
- Something else; Please describe 6



D1b. How much has your experience partnering in CPC+ influenced your decisions about providing enhanced funding to primary care practices to support practice transformation after CPC+ ends?

- Not at all influenced 1
- Influenced somewhat 2
- Strongly influenced 3



D2a. Are you considering or planning to change the amount of technical assistance or practice coaching you offer to primary care practices after CPC+ ends?

- Yes, we are considering or planning to **increase** the amount of technical assistance or practice coaching we offer 1
- Yes, we are considering or planning to **decrease** the amount of technical assistance or practice coaching we offer 2
- Yes, we are considering or planning to **discontinue** offering technical assistance or practice coaching 3
- No, we are considering or planning to **maintain** the current amount of technical assistance or practice coaching we offer 4
- Unsure or undecided 5
- Something else; Please describe 6



D2b. How much has your experience partnering in CPC+ influenced your decisions about the amount of technical assistance or practice coaching you offer to primary care practices?

- Not at all influenced 1
- Influenced somewhat..... 2
- Strongly influenced 3



D3. How much has your experience with payer collaboration in CPC+ influenced your decisions about participating in future payer collaboration efforts? By payer collaboration, we mean regional convening meetings, regional multi-payer collaboratives, National Payer Community events, etc.

- Not at all influenced 1
- Influenced somewhat..... 2
- Strongly influenced (*if selected, please specify how*)..... 3

D4. Please provide any additional relevant details on how partnering in CPC+ may have influenced your plans for providing primary care practice supports in the future after CPC+ ends.

CAUTION: Your survey has not been submitted until you click “Next” below and receive a confirmation number. You will not be able to make any changes after you click "Next".

Before clicking submit, you have the option to [view and print a copy of your completed survey](#). This printable version of the survey will open in a new tab. Please come back to this tab and click “Submit” below to submit your survey.

If there are any responses that you do not wish to share with CMS, please list the question(s) below.

Thank you for completing the payer survey!

Your confirmation number is: _____

If you have questions about this survey, please contact Brianna Sullivan at Mathematica (BSullivan@mathematica-mpr.com or 617-715-9953).

3.B. CPC+ Practice Survey

This Appendix describes the CPC+ Practice Survey used to assess how practices that began participating in CPC+ in 2017 have changed the way they deliver care in response to CPC+, as well as their organizational characteristics and experiences with CPC+ (including with data feedback, learning supports, and CPC+ payments). It details survey fielding (Section 3.B.1), sampling and weighting methods (Section 3.B.2), survey content (Section 3.B.3), analytic methods (Section 3.B.4), and data tables (Section 3.B.5), and it includes the Program Year (PY) 5 Practice Survey instrument (Section 3.B.6).

3.B.1. Survey fielding

A. Timing of survey administration

We administered five waves of the CPC+ Practice Survey to practices that began CPC+ in 2017, one survey in each program year. The first survey was administered to practices from March 30, 2017, through September 24, 2017, three to nine months after CPC+ began (Table 3.B.1). The second, third, fourth, and fifth waves were administered roughly 1.5, 2.5, 3.5, and 4.5 years into CPC+.

Table 3.B.1. CPC+ Practice Survey administration dates

PY	Wave	Fielding dates	Months after CPC+ began (program year)
1	Wave 1	March 30, 2017–September 25, 2017	3–9 months ^a
2	Wave 2	June 6, 2018–September 25, 2018	18–21 months
3	Wave 3	July 16, 2019–November 18, 2019	31–35 months
4	Wave 4	September 15, 2020–December 14, 2020	45–48 months
5	Wave 5	July 20, 2021–October 20, 2021	55–58 months

^a The PY 1 field period was longer than the periods for other waves because we fielded the survey to comparison practices two months after fielding it to CPC+ practices, due to the comparison practice selection timeline. We allowed CPC+ practices to respond up to the end of the fielding period for comparison practices, though 99 percent of CPC+ practices had responded by the end of July 2017.

PY = Program Year.

We also administered the PY 1 and PY 3 CPC+ Practice Surveys to comparison practices that were selected via propensity score matching to have similar characteristics to the CPC+ practices before CPC+ began. See Appendix 6.C of the CPC+ second annual report (Ghosh et al. 2020) for more information on comparison practice selection, and Appendix 3.B of the CPC+ third annual report (Orzol et al. 2021) for more information on the comparison Practice Survey.

B. Survey mode, fielding procedures, length, and incentive

Survey mode. Mathematica designed the CPC+ Practice Survey; it was fielded primarily over the web, though a small number of practices that were no longer participating in CPC+⁵ completed a paper questionnaire.

Fielding procedures. Depending on practice type and survey wave, Telligen, another CMS contractor, or Mathematica fielded the survey to practices using practice-updated contact information from Telligen. We used different fielding procedures for practices that were actively participating in CPC+ and those that had withdrawn or were terminated from CPC+. Practices that were actively participating in CPC+ were required to complete the questionnaire; they received reminders in CPC+-wide communications such as CPC+ newsletters, in addition to reminder emails sent by Telligen or Mathematica. Withdrawn or terminated CPC+ practices received more reminders, including some hard copy letter mailings, to maximize survey visibility and response rates; practices for which we did not have a valid email address received only hard copy mailings and fewer reminders, due to cost. See Table 3.B.2 for an overview of fielding procedures by survey wave and sample group.

Table 3.B.2. Fielding procedures for CPC+ Practice Survey

	Participating CPC+ practices	Withdrawn/terminated CPC+ practices <i>with</i> email address available ^a	Withdrawn/terminated CPC+ practices <i>without</i> email address available ^a
All survey waves			
Survey invitation mode and content	<ul style="list-style-type: none"> Email with log-in and FAQs 	<ul style="list-style-type: none"> Mailed letter with log-in, CPC+ fact sheet, and FAQs Email with log-in and FAQs 	<ul style="list-style-type: none"> Mailed letter with log-in, CPC+ fact sheet, and FAQs
Approximate reminder frequency	<ul style="list-style-type: none"> Weekly to biweekly 	<ul style="list-style-type: none"> Weekly to biweekly 	<ul style="list-style-type: none"> Biweekly
PY 1 follow-up to non-responding practice managers			
Who fielded survey	<ul style="list-style-type: none"> Telligen 	<ul style="list-style-type: none"> Mathematica 	<ul style="list-style-type: none"> Mathematica
Length of fielding period	<ul style="list-style-type: none"> 26 weeks 	<ul style="list-style-type: none"> 26 weeks 	<ul style="list-style-type: none"> 26 weeks
Number of reminders	<ul style="list-style-type: none"> Six reminder emails between weeks 2 and 10 of fielding 	<ul style="list-style-type: none"> Eight reminder emails, one mailed reminder postcard, and three mailed reminder letters between weeks 2 and 16 of fielding 	<ul style="list-style-type: none"> Four mailed reminder postcards and six mailed reminder letters between weeks 2 and 16 of fielding
Telephone outreach	<ul style="list-style-type: none"> Started 11 weeks into fielding 	<ul style="list-style-type: none"> Started 9 weeks into fielding 	<ul style="list-style-type: none"> Started 9 weeks into fielding
Other reminders or outreach	<ul style="list-style-type: none"> Survey announced in weekly CPC+ newsletter (“CPC+ roundup”) twice before fielding and nine times throughout fielding 	<ul style="list-style-type: none"> Survey endorsement letters^b were linked in reminder emails in weeks 2 and 3, and mailed with the reminder letter in week 4 	<ul style="list-style-type: none"> Survey endorsement letters^b were mailed with the reminder letter in week 4
Paper questionnaire (included in reminder contact)	<ul style="list-style-type: none"> Not offered or sent 	<ul style="list-style-type: none"> Offered 8 weeks into fielding by request and mailed to all non-responders in week 15 	<ul style="list-style-type: none"> Offered 8 weeks into fielding by request and mailed to all non-responders in week 15

⁵ Practices no longer participating in CPC+ include those that were once in CPC+ but withdrew or were terminated before the survey was administered.

Table 3.B.2. (continued)

	Participating CPC+ practices	Withdrawn/terminated CPC+ practices <i>with</i> email address available ^a	Withdrawn/terminated CPC+ practices <i>without</i> email address available ^a
PY 2 follow-up to non-responding practice managers			
Who fielded survey	• Telligen	• Mathematica	• Mathematica
Length of fielding period	• 16 weeks	• 16 weeks	• 16 weeks
Number of reminders	• Same as PY 1	• Nine reminder emails and one mailed reminder letter between weeks 2 and 16 of fielding	• One mailed reminder postcard and four mailed reminder letters between weeks 2 and 16 of fielding ^c
Telephone outreach	• Same as PY 1	• None	• None
Other reminders or outreach	• Survey announced in weekly CPC+ newsletter (renamed "On the Plus Side"), posted on the CPC+ calendar, and CPC+ All Connect chatter post once before fielding and nine times throughout fielding	• None	• None
Paper questionnaire (included in reminder contact)	• Not offered or sent	• Not offered or sent	• Not offered or sent
PY 3 follow-up to non-responding practice managers			
Who fielded survey	• Telligen	• Mathematica	• Mathematica
Length of fielding period	• 18 weeks	• 18 weeks	• 18 weeks
Number of reminders	• Same as PY 1	• Seven reminder emails, and two mailed reminder letters between weeks 2 and 16 of fielding	• Seven mailed reminder letters between weeks 2 and 15 of fielding
Telephone outreach	• Started 7 weeks into fielding	• Started 6 weeks into fielding	• Started 6 weeks into fielding
Other reminders or outreach	• Survey announced in weekly CPC+ newsletter ("On the Plus Side"), posted on the CPC+ calendar, and CPC+ All Connect chatter post twice before fielding and eight times throughout fielding	• Advance email sent three weeks prior to fielding to gauge quality of email addresses • Survey endorsement letters ^b were linked in reminder emails in weeks 2 and 3, and mailed with the reminder letter in week 4	• Survey endorsement letters ^b were mailed with the reminder letter in week 4
Paper questionnaire (included in reminder contact)	• Not offered or sent	• Sent in week 11 of fielding	• Sent in week 11 of fielding
PY 4 follow-up to non-responding practice managers			
Who fielded survey	• Mathematica	• Mathematica	• Mathematica
Length of fielding period	• 13 weeks	• 13 weeks	• 13 weeks
Number of reminders	• Seven reminder emails between weeks 2 and 11 of fielding	• Five reminder emails, and two mailed reminder letters between weeks 2 and 12 of fielding	• Five mailed reminder letters between weeks 2 and 11 of fielding
Telephone outreach	• Started 8 weeks into fielding (conducted by Telligen)	• None	• None

Table 3.B.2. (continued)

	Participating CPC+ practices	Withdrawn/terminated CPC+ practices with email address available ^a	Withdrawn/terminated CPC+ practices without email address available ^a
Other reminders or outreach	<ul style="list-style-type: none"> Survey announced in weekly CPC+ newsletter (“On the Plus Side”), posted on the CPC+ calendar, and CPC+ All Connect chatter post twice before fielding and nine times throughout fielding 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> None
Paper questionnaire (included in reminder contact)	<ul style="list-style-type: none"> Not offered or sent 	<ul style="list-style-type: none"> Not offered or sent 	<ul style="list-style-type: none"> Not offered or sent
PY 5 follow-up to non-responding practice managers			
Who fielded survey	<ul style="list-style-type: none"> Mathematica 	<ul style="list-style-type: none"> Mathematica 	<ul style="list-style-type: none"> Mathematica
Length of fielding period	<ul style="list-style-type: none"> 13 weeks 	<ul style="list-style-type: none"> 13 weeks 	<ul style="list-style-type: none"> 13 weeks
Number of reminders	<ul style="list-style-type: none"> Seven reminder emails between weeks 2 and 10 of fielding 	<ul style="list-style-type: none"> Five reminder emails, and two mailed reminder letters between weeks 2 and 12 of fielding 	<ul style="list-style-type: none"> Five mailed reminder letters between weeks 2 and 11 of fielding
Telephone outreach	<ul style="list-style-type: none"> Started 8 weeks into fielding (conducted by Telligen) 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> None
Other reminders or outreach	<ul style="list-style-type: none"> Survey announced in weekly CPC+ newsletter (“On the Plus Side”), posted on the CPC+ calendar, and CPC+ All Connect chatter post twice before fielding and nine times throughout fielding 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> None
Paper questionnaire (included in reminder contact)	<ul style="list-style-type: none"> Not offered or sent except to practices that participated in survey pretesting in the summer of 2021^d 	<ul style="list-style-type: none"> Not offered or sent 	<ul style="list-style-type: none"> Not offered or sent

^a All withdrawn or terminated CPC+ practices had valid email addresses at the start of the PY 1 and 2 surveys, but by the PY 3 survey, 11 percent did not have a valid email address; we obtained email addresses for all practices by the PY 4 survey, but by the end of the PY 5 survey, 5 percent did not have a valid email address.

^b We sent a letter from the American College of Physicians and one from the American Academy of Family Physicians endorsing the survey to practice managers to encourage survey completion.

^c Because all practices had a valid email address at the beginning of fielding the PY 2 survey, we mailed reminders to these practices only if messages to email addresses bounced back or practice managers changed.

^d Four practices completed the PY 5 survey during survey pretesting.

Length. The questionnaire was designed to be completed in 30 to 60 minutes, depending on the respondent and the survey wave. In PY 2 and PY 3, a shorter questionnaire was administered to practices that withdrew or were terminated more than a year before survey fielding. The questionnaire was shorter for these practices because we did not ask them the additional questions about their experiences with CPC+ that we asked currently participating and recently withdrawn or terminated practices (see Section 3.B.3 for information on survey content).⁶ The questionnaire was only administered to practices that participated in the CPC+ in the past year (those that were still participating or recently withdrawn or were terminated from CPC+) in PY 1, PY 4, and PY 5.

⁶ In PY 4 and PY 5, the questionnaire was only fielded to CPC+ practices that were currently participating or practices that participated in CPC+ in the past year.

Respondent. The questionnaire was sent to the practice manager. The instructions encouraged the practice manager to discuss the survey with the practice’s practitioners and staff to deliver responses that reflected a consensus view.

Incentive. CPC+ practices were required to respond to the survey as a condition of participation, so we did not compensate them for doing so. Practices that had withdrawn from CPC+ prior to survey completion were offered \$100 to complete the PY 1 survey and \$200 to complete the PY 2 through PY 5 surveys.⁷

Confidentiality. Practices were told that their identifiable responses would not be shared with CMS or other payers; their responses would not have any consequences for payment or affect practices’ participation in CPC+, but would be shared with the CPC+ learning team so it could provide learning support. Mathematica provided responses about learning supports to the learning team only in aggregate to encourage candid responses.

3.B.2. Sampling and weighting methods

A. Sampling, sample sizes, and response rates

We surveyed practices that began participating in CPC+ in 2017 and did not withdraw in the first quarter of CPC+, regardless of whether they were still participating in CPC+ at the time of the survey. Each year, we also added to the survey any new practices that split off from these “2017 Starters” to operate as their own CPC+ practice; however in PY 5, we did not field the survey to new practices that withdrew or were terminated. We did not send questionnaires to CPC+ practices that closed or were no longer providing primary care at the start of survey fielding. See Table 3.B.3 for sample sizes and response rates per survey wave.

Below, we describe our process for sampling practices for the CPC+ Practice Survey by wave; in Section B, we describe how we further refined the sample for the analysis.

PY 1 survey. Telligen and Mathematica⁸ fielded the PY 1 survey to the 2,888 CPC+ practices that began CPC+ in January 2017 and did not withdraw from CPC+ by the end of the first quarter: 1,373 in Track 1 and 1,515 in Track 2. Of those practices, 19 did not respond to the survey or answer enough questions to consider their response complete, for a response rate of 99.3 percent (see Section B for our definition of a complete survey).

PY 2 survey. In PY 2, Telligen and Mathematica fielded the survey to the 2,833 practices that were still participating in CPC+ or had withdrawn or been terminated from CPC+ in the past year and were offering primary care at the start of fielding: 1,349 in Track 1 and 1,484 in Track 2. Of those practices, 62 did not

⁷ We increased the incentive payment for the PY 2 through PY 5 surveys because we increased the length of the survey to include new questions on the primary care functions and new sections on data feedback and participation in CPC+.

⁸ In PY 1 through PY 3, Telligen fielded the survey to CPC+ practices that were actively participating in CPC+ and Mathematica fielded it to those that had withdrawn or were terminated from CPC+. If a practice withdrew or was terminated during the survey fielding period, Mathematica took over fielding after receiving approval from CMS that the practice could be contacted. In PY 4 and PY 5, Mathematica fielded the survey to all surveyed practices.

respond to the survey or answer enough questions for the survey team to consider their response complete, for a response rate of 97.8 percent.

PY 3 survey. In PY 3, Telligen and Mathematica fielded the survey to 2,776 CPC+ practices: 1,312 in Track 1 and 1,464 in Track 2. This included all CPC+ practices that were open at the start of fielding. Of those 2,776 practices, 114 did not respond to the survey or answer enough questions for the survey team to consider their response complete, for a response rate of 95.9 percent.

PY 4 survey. In PY 4, Mathematica fielded the survey to 2,576 CPC+ practices: 1,185 in Track 1 and 1,391 in Track 2. This included all practices actively participating in CPC+ and those that had withdrawn or been terminated from CPC+ in the past year and were still open at the start of fielding. Of those 2,576 practices, 56 did not respond to the survey or answer enough questions for the survey team to consider their response complete, for a response rate of 97.8 percent.

PY 5 survey. In PY 5, Mathematica fielded the survey to 2,496 CPC+ practices: 1,136 in Track 1 and 1,360 in Track 2. These included (1) all practices actively participating in CPC+ and (2) originally selected 2017 Starter practices that had withdrawn or been terminated from CPC+ in the past year that had completed the PY 4 CPC+ Practice Survey and were open at the start of fielding. The sample excluded withdrawn or terminated practices that split off from 2017 Starter practices. Of those 2,496 practices, 148 did not respond to the survey or answer enough questions for the survey team to consider their response complete, for a response rate of 94.1 percent.

Table 3.B.3. CPC+ Practice Survey sample sizes and response rates

	Track 1	Track 2	Total
PY 1			
In sample frame	1,373	1,515	2,888
Sent surveys	1,373	1,515	2,888
Returned surveys	1,367	1,508	2,875
Returned eligible and complete surveys	1,364	1,505	2,869
In analytic sample ^a	1,129	1,342	2,471
Response rate (percentage, unweighted)	99.3	99.3	99.3
Percentage of eligible practices included in analysis	82.2	88.6	85.6
PY 2			
In sample frame	1,349	1,484	2,833
Sent surveys	1,349	1,484	2,833
Returned surveys	1,311	1,463	2,774
Returned eligible and complete surveys	1,308	1,463	2,771
In analytic sample ^a	1,129	1,342	2,471
Response rate (percentage, unweighted)	97.0	98.6	97.8
Percentage of eligible practices included in analysis	83.7	90.4	87.2
PY 3			
In sample frame	1,312	1,464	2,776
Sent surveys ^b	1,312	1,464	2,776
Returned surveys	1,239	1,427	2,666
Returned eligible and complete surveys	1,237	1,425	2,662
In analytic sample ^a	1,129	1,342	2,471
Response rate (percentage, unweighted)	94.3	97.3	95.9
Percentage of eligible practices included in analysis	86.1	91.7	89.0
PY 4			
In sample frame	1,185	1,391	2,576
Sent surveys ^b	1,185	1,391	2,576
Returned surveys	1,163	1,357	2,520
Returned eligible and complete surveys	1,163	1,357	2,520
In analytic sample ^a	1,129	1,342	2,471
Response rate (percentage, unweighted)	98.1	97.6	97.8
Percentage of eligible practices included in analysis	95.3	96.5	95.9
PY 5			
In sample frame	1,136	1,360	2,496
Sent surveys ^b	1,136	1,360	2,496
Returned surveys	1,090	1,259	2,349
Returned eligible and complete surveys	1,089	1,259	2,348
In analytic sample ^a	1,056	1,234	2,290
Response rate (percentage, unweighted)	96.0	92.6	94.1
Percentage of eligible practices included in analysis	93.0	90.7	91.7

^a The analytic sample is smaller than the number of completed surveys because it excludes practices that did not respond in all survey waves and those that withdrew from CPC+ more than a year before any survey wave was fielded.

^b Additional practices that split off from existing CPC+ practices were sent questionnaires in PY 3, PY 4, and PY 5. This amounted to an additional 72 CPC+ practices (39 in Track 1 and 33 in Track 2) in PY 3, 83 (38 in Track 1 and 45 in Track 2) in PY 4, and 87 (40 in Track 1 and 47 in Track 2) in PY 5. These practices are not included in the counts, as they were sent questionnaires solely to provide feedback to the CPC+ learning network and were not included in practice survey analyses.

B. Eligibility and weighting

Eligibility. For each survey wave, all CPC+ practices were eligible to participate in the survey if they provided primary care and were open at the time of fielding. In PY 4 and PY 5, however, we did not send questionnaires to practices that had stopped participating in CPC+ more than one year before fielding, even though they were eligible to participate in the survey. We did not survey these practices in PY 4 because the survey questions focused on practices' experience with CPC+ and these practices had not participated in CPC+ since the last time they were asked to complete the survey. In PY 5, given that the analytic sample includes only the CPC+ practices that submitted a completed survey for all five survey waves, we did not send the PY 5 survey to practices no longer participating in CPC+ that did not receive the PY 4 survey.⁹ More details about the analytic sample are below.

Completed questionnaires. Our definition of a completed questionnaire changed in relation to the questions included in each program year's survey. The PY 1, PY 2, PY 3, and PY 5 questionnaires contained the modified Patient-Centered Medical Home Assessment (M2-PCMH-A) composite measure (for more information on the M2-PCMH-A, see Appendix 3.B of the third annual CPC+ report [Orzol et al. 2021]). For these surveys, we defined a completed questionnaire based on the number of M2-PCMH-A questions in the survey, to help ensure the statistical reliability of the M2-PCMH-A summary score for the care delivery approaches. For the PY 1 through PY 3 surveys, we considered a questionnaire complete if the practice responded to 29 of the 38 questions (more than 75 percent) included in the original (PY 1) M2-PCMH-A composite measure.¹⁰ Because we removed nine items from the M2-PCMH-A in the PY 5 survey, we considered a questionnaire complete if the practice responded to 22 of the 29 questions (more than 75 percent) included in the PY 5 M2-PCMH-A composite measure. For the PY 4 survey, which did not include the M2-PCMH-A to reduce the burden on respondents, we considered a questionnaire complete if the practice responded to any of the items.

Analytic sample. To be included in this analysis, CPC+ practices had to submit a completed questionnaire for all five survey waves.¹¹ In our analytic sample, we included survey responses from 2,290 CPC+ practices: 1,056 practices in Track 1 and 1,234 in Track 2. Among the 2,290 practices, we included responses from 51 practices that withdrew or were terminated from CPC+ within the year before fielding. (Practices that stopped participating in CPC+ earlier were not eligible to receive the PY 5 questionnaire.) Table 3.B.3 reports counts of practices in the analytic sample.

The practices included in the analysis represent 82 to 95 percent of eligible Track 1 CPC+ practices and 89 to 97 percent of eligible Track 2 CPC+ practices, depending on the survey wave.

Calculating weights. We applied practice-level weights to survey data to account for differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and 2020

⁹ Practices that were withdrawn at the time of survey completion in PY 4 were also not sent a questionnaire in PY 5.

¹⁰ Because the questions changed with each wave of the survey, if an item was not asked in a given wave, we counted it as answered for the purposes of determining whether a questionnaire was complete.

¹¹ The analytic sample does not include CPC+ practices that merged with another CPC+ practice after completing one survey wave and did not respond to all subsequent surveys. It also excludes "new" CPC+ practices that resulted from splitting from another CPC+ practice.

SSP participation, the most recent data available for all practices.¹² For 36 of the 56 subgroups, response rates were 95 percent or higher. Only two subgroups had response rates lower than 75 percent: NY Track 2 SSP participants had a 23 percent response rate and OH Track 2 non-SSP practices had a 61 percent response rate. Because this survey analysis is designed to infer to all currently or recently active CPC+ practices, such low response rates in certain subgroups means those practices will be under-represented in the analysis, potentially leading to biased estimates. The nonresponse weights adjust for all subgroups that did not achieve a 100 percent response rate.

To calculate the weights, we grouped the practices by CPC+ region, track, and 2020 SSP participation and then calculated response rates within each group. The numerator in this calculation was the number of practices responding in all five survey waves and the denominator was the total number of currently or recently active CPC+ practices that could have responded in all survey waves. We then calculated the nonresponse weight as the inverse of the proportion responding in each subgroup. For example, a subgroup with a response rate of 50 percent would get nonresponse weights equal to $1/0.5 = 2$, whereas a subgroup with a 100 percent response rate would get nonresponse weights equal to 1. The responding practices were assigned the nonresponse weight calculated for their subgroup. The nonresponse weights ranged from 1 to 4.33 with a design effect of 1.03, which indicates the weights increased the variance of survey estimates by only 3 percent overall.

3.B.3. Survey content

The survey collects general information about practices' characteristics, care delivery approaches, and experience with CPC+. The PY 5 survey questionnaire was divided into 10 sections. The sections, in order, covered practice characteristics, approaches to providing primary care, care management, data feedback, health information technology, sources of practice revenue, CPC+ payments, CPC+ learning activities and assistance, practice staff involvement in implementing CPC+, and perceptions of CPC+.

See Table 3.B.10 for details on the nine survey items that had wording changes over time and Section 3.B.6 for the full PY 5 Practice Survey instrument.

3.B.4. Analytic methods

Care delivery overall scores. We created a summary score (the overall M2-PCMH-A score) as a weighted average of each practice's response to the 29 underlying questions on their approaches to care delivery. We determined weights for each question using a confirmatory factor analysis (CFA) that we conducted on responses from 2017 Starter CPC+ practices to the PY 1 survey. CFA assigns weights to a question based on its correlation with other questions in the domain, meaning that items that better represented the domain received a higher relative weight than items that correlated more weakly. In our previous analyses, the summary scores generated by CFA achieved better construct validity than did the basic scoring method that takes a simple average of the question responses (Poznyak et al. 2015; Gellar et al. 2017). Therefore, CFA-weighted scores for each practice might reflect more accurately the primary care delivery approaches the practice uses.

As stated above, most questions were scored on a four-point scale, with higher scores indicating more advanced approaches to care delivery. Before calculating summary scores, we rescaled questions that

¹² We examined response rates in previous waves and found no differences large enough to require weighting adjustments.

used different response scales to follow the same four-point scale. For example, for questions with a two-point scale (such as yes/no), we recoded *yes* responses to equal 4 on the four-point scale and *no* responses to equal 1. We calculated weighted mean scores among the non-missing responses. The percentage of practices that skipped the questions included in the summary score was small: at most, 0.1 percent. Once we rescaled items, we calculated the “overall M2-PCMH-A score” by taking a weighted average of the items using the weights calculated by the CFA. The weights for individual questions in the total score ranged from 1 to 5 percent. Twenty-four percent of the questions had a weight of 1 to 2 percent, 62 percent of the questions had a weight of 3 or 4 percent, and 14 percent had a weight of 5 percent. The overall M2-PCMH-A score had adequate reliability with a McDonald’s omega score of 0.89 (Nunnally and Bernstein 1994; Lance et al. 2006).

Statistical estimation. We tested whether the overall M2-PCMH-A scores based on responses in the PY 5 survey differed statistically from those in the PY 1 survey separately by track. We tested whether a dummy for PY 1 versus PY 5 was a statistically significant predictor of the summary score in an ordinary least squares regression. Regressions included practice fixed effects to control for time invariant practice characteristics, and cluster robust standard errors. For other items, to reduce the risk of false positives from multiple comparisons, we did not statistically test differences over time or between groups. Instead, we drew inferences based on findings across related questions and in the presence of substantial difference (which we determined to be 10 percentage points or more).

Subgroups. For selected questions where subgroup analysis could be important from a clinical, implementation, or policy perspective, we also analyzed data by key subgroups of practices based on their characteristics. We did not perform subgroup analysis for all questions, nor did we perform the same subgroup analyses across each question. We considered the following practice characteristics for subgroup analysis:

- Practice ownership by a hospital or a health system, or independently owned¹³
- Practice size (measured by number of primary care practitioners at practice site): large (six or more practitioners), medium (three to five practitioners), or small (one or two practitioners)¹⁴
- Whether the practice site is in a rural, suburban, or urban area¹⁵

¹³ Practice ownership comes from the SK&A and OneKey databases, both managed by IQVIA, a marketing organization that collects information directly from all health care practices in the United States. IQVIA updates this information on an ongoing basis; we pulled practice ownership information in October 2020 from OneKey. If the database did not report practice ownership as of October 2020, we used the most recent data available in the SK&A database, from October 2019, October 2018, November 2017, or November 2016.

¹⁴ Practice size is determined from the number of primary care practitioners (PCPs) as of December 2020. Practices self-reported this information to CMS in roster files. If practice size was missing, we used the number of PCPs reported on the December 2019, December 2018, December 2017, or January 2017 roster files, taking the most recently available.

¹⁵ Geographic location is derived from the 2015–2016 Department of Health and Human Services’ Area Health Resource File (AHRF). The variable used reflects 2013 data. The AHRF provides a 9-point rural-urban continuum code (RUCC) from the USDA Economic Research Service. From these codes, we defined urban as a county in a metro area of more than 250,000 people (RUCC=1 or 2), suburban as a county in a metro area that has less than 250,000 people or has an urban population of 20,000 or more and is adjacent to a metro area (RUCC = 3 or 4), or rural if it does not meet the urban or suburban classifications (RUCC = 5–9).

- Whether the practice site participated in CPC Classic¹⁶
- Whether the practice site participated in prior practice transformation activities (was recognized as a medical home or participated in the Multi-Payer Advanced Primary Care Practice [MAPCP] or CPC Classic initiatives)¹⁷

Counts of practitioners and staff. The survey asked practices to provide counts of full- and part-time practitioners regardless of specialty (Question A1), primary care practitioners (Question A2), and care managers or care coordinators (Question C1). To estimate the full-time equivalent (FTE) number of employees, we counted part-time practitioners and staff as 0.5 FTE.

Software. We used SAS version 9.4 to clean and prepare the data for analysis and Mplus Version 8 to conduct the CFA. We constructed the data tables and performed statistical tests using Stata version 17.

3.B.5. Data tables

This section presents five sets of tables showing results from the PY 1 through PY 5 practice surveys. The tables include only the questions asked in the PY 5 survey.

- **Tables 3.B.4. Care delivery mean scores**
 - Table 3.B.4a. Mean CPC+ practice care delivery score, overall and by track (2017 Starters)
 - Table 3.B.4b. Mean CPC+ practice care delivery score, within track by SSP status (2017 Starters)
- **Tables 3.B.5. Care delivery distributions**
 - Table 3.B.5a. Distribution of CPC+ practices' responses to questions about their approaches to care delivery, overall and by track (2017 Starters)
 - Table 3.B.5b. Distribution of CPC+ practices' responses to questions about their approaches to care delivery, within track by SSP status (2017 Starters)
- **Tables 3.B.6. Practice characteristics**
 - Table 3.B.6a. CPC+ practice characteristics, overall and by track (2017 Starters)
 - Table 3.B.6b. CPC+ practice characteristics, within track by SSP status (2017 Starters)
- **Tables 3.B.7. Practice payments**

¹⁶ We considered a practice to have participated in CPC Classic if it enrolled in CPC Classic and did not drop out within the first five months of the model.

¹⁷ We determined a practice to have prior transformation experience if the practice participated in CPC Classic (as described in footnote 14) or CMMI's Multi-payer Advanced Primary Care Practice (MAPCP) initiative, or has medical home recognition. We considered a practice to be an MAPCP participant if it participated in any year, 2011–2014 for 2017 Starters, as determined by a file from CMS. A practice was considered to have medical home recognition if at least one of its primary care providers was listed as having recognition at some point in 2014–2017 from the National Committee for Quality Assurance (NCQA), a state, the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), or the Utilization Review Accreditation Commission (URAC), as determined by the June 2016 (for 2017 Starters) NCQA PCMH file and data extracted from the websites of TJC, AAAHC, URAC, and state-specific sources between October 2016 and February 2017.

- Table 3.B.7a. CPC+ practices’ responses to questions about their experience with CPC+ payments, overall and by track (2017 Starters)
- Table 3.B.7b. CPC+ practices’ responses to questions about their experience with CPC+ payments, within track by SSP status (2017 Starters)
- **Tables 3.B.8. CPC+ supports**
 - Table 3.B.8a. CPC+ practices’ responses to questions about their experiences with learning activities and assistance and supports from payers, overall and by track (2017 Starters)
 - Table 3.B.8b. CPC+ practices’ responses to questions about their experiences with learning activities and assistance and supports from payers, within track by SSP status (2017 Starters)
- **Tables 3.B.9. CPC+ experience**
 - Table 3.B.9a. CPC+ practices’ responses to questions about their experiences in CPC+, including their overall perceptions of CPC+, burden, and sustainability, overall and by track (2017 Starters)
 - Table 3.B.9b. CPC+ practices’ responses to questions about their experiences in CPC+, including their overall perceptions of CPC+, burden, and sustainability, within track by SSP status (2017 Starters)
- **Table 3.B.10. Changes in item and response category wording over time.** Describes differences in item wording and response categories in questions that were asked in multiple survey waves but experienced wording changes.

Table 3.B.4a. Mean CPC+ practice care delivery score, overall and by track (2017 Starters)

	Combined tracks						Track 1 overall						Track 2 overall					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 (2021) ¹	Diff	p-value	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 (2021) ¹	Diff	p-value	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 (2021) ¹	Diff	p-value
CARE DELIVERY SCORE² (scale: 1 [least advanced approach] - 4 [most advanced approach])																		
Overall M2-PCMH-A Score	3.03	3.29	3.40	3.47	0.44	0.00	2.90	3.19	3.32	3.43	0.53	0.00	3.14	3.37	3.46	3.51	0.37	0.00
N ³	2,290	2,290	2,290	2,290			1,056	1,056	1,056	1,056			1,234	1,234	1,234	1,234		

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation’s key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ Questions in this table were not included in the PY 4 survey.

² The overall scores are regression-adjusted weighted averages of practices’ response to all questions in the M2-PCMH-A. The weights were derived from a factor analysis conducted on the responses of 2017 Starter CPC+ practices to the PY 1 survey. Factor analysis uses the correlation between the individual questions to reflect the reliability of each question in measuring the overall care delivery score. We used ordinary least squares regression with practice fixed effects and cluster-robust standard errors, clustering at the practice level. P-values are based on a two-sided t-test.

³ The sample sizes presented here are the largest sample sizes for each track across all M2-PCMH-A questions. Question-by-question sample sizes can be found in Table 3.B.5a.

Diff = difference in mean score between PY 1 and PY 5; PY = program year; SSP = Medicare Shared Savings Program.

Table 3.B.4b. Mean CPC+ practice care delivery score, within track by SSP status (2017 Starters)

	Track 1 – SSP						Track 1 – not SSP						Track 2 – SSP						Track 2 – not SSP					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 (2021) ¹	Diff	p-value	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 (2021) ¹	Diff	p-value	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 (2021) ¹	Diff	p-value	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 (2021) ¹	Diff	p-value
CARE DELIVERY SCORE² (scale: 1 [least advanced approach] - 4 [most advanced approach])																								
Overall M2-PCMH-A Score	2.91	3.20	3.31	3.44	0.52	0.00	2.88	3.17	3.32	3.43	0.54	0.00	3.13	3.36	3.50	3.53	0.39	0.00	3.15	3.37	3.42	3.49	0.34	0.00
N ³	547	547	547	547			509	509	509	509			612	612	612	612			622	622	622	622		

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020, and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation’s key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ Questions in this table were not included in the PY 4 survey.

² The overall scores are regression-adjusted weighted averages of practices’ response to all questions in the M2-PCMH-A. The weights were derived from a factor analysis conducted on the responses of 2017 Starter CPC+ practices to the PY 1 survey. Factor analysis uses the correlation between the individual questions to reflect the reliability of each question in measuring the overall care delivery score. We used ordinary least squares regression with practice fixed effects and cluster-robust standard errors, clustering at the practice level. P-values are based on a two-sided t-test.

³ The sample sizes presented here are the largest sample sizes for each track and group (SSP or not SSP) across all M2-PCMH-A questions. Question-by-question sample sizes can be found in Table 3.B.5b.

Diff = difference in mean score between PY 1 and PY 5; PY = program year; SSP = Medicare Shared Savings Program (reflects 2021 [PY 5] participation, or, for practices that withdrew from CPC+, their participation at the time of withdrawal).

Table 3.B.5a. Distribution of CPC+ practices' responses to questions about their approaches to care delivery, overall and by track (scale: 1 [least advanced approach] - 4 [most advanced approach]) (2017 Starters)

Question ²	Combined tracks				Track 1 overall				Track 2 overall			
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)
Care delivery score³												
Overall M2-PCMH-A Score												
3.75 to 4	2%	5%	8%	14%	1%	3%	5%	14%	3%	7%	10%	15%
3.5 to <3.75	10%	19%	29%	35%	5%	13%	20%	29%	14%	24%	36%	40%
3 to <3.5	44%	60%	56%	46%	36%	58%	64%	51%	50%	62%	49%	41%
2.5 to <3	33%	15%	7%	5%	38%	26%	11%	7%	29%	6%	4%	4%
<2.5	11%	1%	<1%	<1%	19%	1%	<1%	<1%	4%	<1%	<1%	0%
N	2,290	2,290	2,290	2,290	1,056	1,056	1,056	1,056	1,234	1,234	1,234	1,234
M2-PCMH-A items												
Access and continuity												
A11	Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP, or nurse...											
	...is available via the patient's choice of email or phone directly with the practice team or a practitioner who has real-time access to the patient's electronic medical record.											
	47%	58%	62%	62%	39%	53%	62%	59%	54%	63%	61%	64%
	...is provided by a coverage arrangement (e.g., answering service) that shares necessary patient data with and provides a summary to the practice.											
	48%	40%	37%	37%	55%	45%	36%	39%	42%	37%	38%	35%
	...is available from a coverage arrangement (e.g., answering service) that does not offer a standardized communication protocol back to the practice for urgent problems.											
	4%	1%	1%	1%	6%	2%	1%	2%	3%	1%	<1%	<1%
	...is not available or is limited to an answering machine.											
	<1%	<1%	<1%	<1%	1%	<1%	1%	<1%	<1%	<1%	<1%	<1%
N	2,290	2,286	2,285	2,284	1,056	1,054	1,053	1,054	1,234	1,232	1,232	1,230
B1	Same-day appointments for patients who need them are available at this practice site for...											
	...most or all of this practice's patients.											
	77%	79%	81%	77%	74%	78%	80%	76%	80%	81%	83%	79%
	...many of this practice's patients.											
	16%	18%	16%	19%	16%	18%	18%	20%	15%	17%	13%	18%
	...some of this practice's patients.											
	7%	3%	3%	4%	10%	4%	2%	5%	5%	2%	4%	3%
	...none of this practice's patients.											
	<1%	<1%	0%	0%	0%	<1%	0%	0%	<1%	0%	0%	0%
N	2,287	2,287	2,285	2,290	1,056	1,055	1,053	1,056	1,231	1,232	1,232	1,234

Table 3.B.5a. (continued)

Question ²	Combined tracks				Track 1 overall				Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
B2	Communicating with the practice team through email, text messaging, or accessing a patient portal occurs for...												
	...most or all of this practice's patients.	30%	27%	37%	44%	29%	21%	32%	43%	31%	32%	41%	45%
	...many of this practice's patients.	36%	41%	43%	42%	32%	38%	42%	39%	39%	43%	45%	45%
	...some of this practice's patients.	33%	32%	19%	13%	37%	40%	25%	18%	28%	25%	15%	10%
	...none of this practice's patients.	2%	1%	1%	<1%	2%	1%	1%	<1%	1%	<1%	<1%	0%
	N	2,289	2,281	2,282	2,283	1,056	1,053	1,051	1,055	1,233	1,228	1,231	1,228
B3	Scheduled phone or video visits with a physician...												
	...are generally available, and patients are regularly asked about their preferences for in-person versus phone/video visits.	2%	3%	5%	56%	1%	2%	3%	52%	2%	5%	7%	59%
	...are generally available at a patient's request.	11%	14%	16%	37%	7%	10%	12%	39%	14%	18%	20%	34%
	...are available on a limited basis to patients.	15%	17%	20%	5%	13%	12%	14%	7%	16%	21%	24%	4%
	...are not regularly available to patients.	73%	66%	59%	2%	78%	77%	71%	2%	68%	57%	49%	3%
	N	2,290	2,287	2,286	2,290	1,056	1,055	1,052	1,056	1,234	1,232	1,234	1,234
A6	Patients...												
	...are assigned to specific practitioner panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.	42%	50%	57%	57%	41%	46%	53%	54%	43%	53%	60%	59%
	...are assigned to specific practitioner panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	49%	45%	39%	38%	46%	47%	40%	38%	52%	44%	38%	38%
	...are assigned to specific practitioner panels but panel assignments are not routinely used by the practice for administrative or other purposes.	6%	3%	2%	2%	9%	4%	3%	3%	3%	2%	1%	1%
	...are not assigned to specific practitioner panels.	3%	2%	2%	3%	5%	3%	4%	4%	2%	1%	1%	2%
	N	2,290	2,279	2,280	2,286	1,056	1,051	1,053	1,053	1,234	1,228	1,227	1,233

Table 3.B.5a. (continued)

Question ²	Combined tracks				Track 1 overall				Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
B4	Patients...												
	...have a specific physician, and the patient is almost always scheduled with that physician.	67%	72%	71%	72%	67%	73%	71%	74%	67%	71%	71%	70%
	...have a specific physician, and the patient is frequently scheduled with that physician.	31%	26%	27%	26%	31%	25%	27%	24%	30%	27%	27%	29%
	...have a specific physician, and the patient is sometimes scheduled with that physician.	2%	1%	2%	1%	2%	2%	1%	2%	2%	1%	2%	1%
	...do not have a specific physician that they see at this practice.	<1%	<1%	<1%	<1%	<1%	<1%	1%	<1%	<1%	<1%	<1%	<1%
	N	2,285	2,278	2,283	2,290	1,054	1,053	1,051	1,056	1,231	1,225	1,232	1,234
B5	When patients contact the practice with clinical questions or concerns (e.g., a new problem or questions about their treatment) between scheduled encounters...												
	...their specific physician or practice care team that has primarily worked with the patient almost always responds.	82%	84%	88%	85%	80%	82%	85%	82%	84%	86%	90%	87%
	...their specific physician or practice care team that has primarily worked with the patient frequently responds.	17%	15%	12%	15%	19%	17%	14%	17%	15%	13%	10%	13%
	...their specific physician or practice care team that has primarily worked with the patient sometimes responds.	1%	1%	<1%	<1%	1%	1%	<1%	<1%	1%	1%	<1%	<1%
	...they do not have a specific physician that they see at the practice, so any member of the practice responds.	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	0%	<1%
	N	2,284	2,285	2,288	2,287	1,055	1,052	1,054	1,054	1,229	1,233	1,234	1,233
Care management													
A8	A standard method or tool(s) to stratify patients by risk level...												
	...is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.	28%	54%	57%	64%	14%	41%	50%	60%	39%	64%	62%	67%
	...is available and is consistently used to stratify all patients but is inconsistently integrated into all aspects of care delivery.	31%	39%	39%	31%	33%	49%	45%	34%	30%	31%	35%	30%
	...is available but not consistently used to stratify all patients.	28%	7%	3%	4%	35%	9%	5%	6%	22%	4%	2%	3%
	...is not available.	13%	<1%	1%	<1%	18%	<1%	1%	<1%	9%	<1%	1%	<1%
	N	2,290	2,284	2,287	2,287	1,056	1,052	1,055	1,054	1,234	1,232	1,232	1,233

Table 3.B.5a. (continued)

Question ²	Combined tracks				Track 1 overall				Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
B6	Care management services for high-risk patients...												
	...are provided by a care manager located at this practice site.	57%	72%	76%	63%	49%	68%	70%	65%	64%	75%	81%	62%
	...are provided by a care manager within this practice's organization who is not physically located at this practice site.	25%	24%	23%	35%	23%	25%	28%	33%	27%	22%	18%	37%
	...are provided by care managers from an outside organization (e.g., a health insurance plan).	8%	2%	1%	1%	11%	3%	2%	1%	5%	2%	1%	1%
	...are not provided at this practice.	10%	2%	<1%	<1%	16%	4%	1%	<1%	5%	1%	0%	1%
	N	2,287	2,284	2,288	2,290	1,054	1,053	1,054	1,056	1,233	1,231	1,234	1,234
B15	Self-management support is help for patients to better manage their health on a day-to-day basis. At this practice site, self-management support for most patients who have chronic conditions...												
	...is provided by practice staff who set specific goals with patients and are trained in assessing how ready patients are to change their health behavior and how to motivate patient behavior change.	35%	48%	53%	56%	27%	42%	40%	49%	41%	54%	63%	61%
	...is provided by practice staff who set specific goals with patients but are not trained in assessing how ready patients are to change their health behavior and how to motivate patient behavior change.	22%	24%	28%	28%	18%	21%	31%	30%	25%	27%	25%	27%
	...is provided by practice staff but they do not set specific goals with patients (e.g., they just offer patient education).	29%	19%	15%	14%	33%	25%	21%	18%	25%	14%	10%	11%
	...is limited to either (1) the distribution of information (e.g., pamphlets, booklets) with no or little discussion or (2) referral to self-management classes or educators.	15%	8%	4%	2%	22%	12%	8%	3%	9%	5%	1%	1%
	N	2,282	2,283	2,283	2,284	1,052	1,055	1,054	1,053	1,230	1,228	1,229	1,231
E3a	With how many hospitals where most of your patients obtain care does this practice site electronically send and receive patient clinical data?												
	All	19%	18%	23%	29%	18%	16%	21%	25%	21%	19%	25%	33%
	Most	48%	53%	53%	52%	46%	51%	53%	54%	50%	55%	52%	49%
	Some	24%	23%	20%	16%	29%	26%	23%	17%	20%	20%	18%	15%
	None or don't know	8%	6%	4%	3%	7%	7%	4%	4%	9%	6%	5%	2%
	N	2,284	2,282	2,279	2,284	1,052	1,054	1,053	1,051	1,232	1,228	1,226	1,233

Table 3.B.5a. (continued)

Question ²	Combined tracks				Track 1 overall				Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
B8	Receipt of clinical information (e.g., a discharge summary) from an emergency department (ED) about this practice's patients who had an ED visit...												
	...usually occurs within a day of the visit.	38%	56%	63%	68%	30%	51%	59%	67%	44%	59%	67%	69%
	...usually occurs 1–3 days after the visit.	49%	39%	34%	30%	53%	43%	38%	31%	46%	36%	31%	29%
	...usually occurs more than 3 days after the visit.	5%	2%	1%	1%	9%	4%	2%	1%	2%	1%	1%	1%
	...does not occur consistently.	8%	3%	1%	<1%	8%	3%	1%	1%	7%	4%	1%	<1%
	N	2,287	2,287	2,286	2,288	1,054	1,054	1,055	1,054	1,233	1,233	1,231	1,234
B10	Receipt of clinical information (e.g., a discharge summary) from hospitals about this practice's patients who had a hospital visit...												
	...usually occurs within a day of discharge.	36%	50%	59%	66%	31%	46%	53%	64%	39%	53%	65%	67%
	...usually occurs 1–3 days after discharge.	51%	44%	38%	32%	49%	48%	44%	34%	53%	40%	33%	31%
	...usually occurs more than 3 days after discharge.	8%	4%	2%	2%	12%	3%	2%	2%	5%	5%	2%	1%
	...does not occur consistently.	5%	2%	1%	<1%	7%	2%	<1%	0%	3%	2%	1%	1%
	N	2,288	2,285	2,287	2,290	1,056	1,054	1,053	1,056	1,232	1,231	1,234	1,234
B9	Outreach by this practice site to patients within one week of an ED visit occurs...												
	...for most or all of this practice's patients.	45%	66%	78%	77%	38%	64%	75%	79%	51%	68%	81%	74%
	...for many of this practice's patients.	23%	26%	19%	19%	22%	26%	21%	16%	24%	27%	18%	22%
	...for some of this practice's patients.	28%	7%	2%	4%	34%	9%	4%	5%	23%	6%	1%	3%
	...for none of this practice's patients.	3%	1%	<1%	<1%	5%	1%	0%	<1%	1%	0%	<1%	<1%
	N	2,283	2,288	2,287	2,288	1,053	1,055	1,053	1,054	1,230	1,233	1,234	1,234
B11	Outreach by this practice site to patients within 3 days of hospital discharge occurs...												
	...for most or all of this practice's patients.	56%	72%	83%	82%	47%	67%	79%	80%	63%	76%	87%	84%
	...for many of this practice's patients.	28%	25%	16%	17%	31%	30%	20%	19%	26%	22%	12%	15%
	...for some of this practice's patients.	16%	3%	1%	1%	21%	3%	1%	1%	11%	2%	1%	1%
	...for none of this practice's patients.	1%	<1%	0%	<1%	1%	<1%	0%	0%	<1%	0%	0%	<1%
	N	2,276	2,279	2,287	2,289	1,051	1,054	1,053	1,056	1,225	1,225	1,234	1,233

Table 3.B.5a. (continued)

Question ²	Combined tracks				Track 1 overall				Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
A9	Follow-up by this primary care practice with patients seen in the emergency department (ED) or hospital...												
	...is done routinely because this primary care practice has arrangements in place with the ED and hospital to both track these patients and ensure that follow-up is completed within a few days.												
	48%	69%	78%	78%	38%	62%	78%	81%	56%	75%	78%	76%	
	...occurs because this primary care practice makes proactive efforts to identify patients.												
	31%	26%	19%	19%	30%	30%	17%	16%	32%	23%	21%	22%	
	...occurs only if the ED or hospital alerts this primary care practice.												
	20%	4%	3%	3%	31%	7%	5%	4%	12%	2%	2%	2%	
	...generally does not occur.												
	1%	<1%	0%	0%	2%	<1%	0%	0%	<1%	0%	0%	0%	
	N	2,290	2,287	2,287	2,287	1,056	1,055	1,055	1,053	1,234	1,232	1,232	1,234
A7	Non-physician practice team members...												
	...perform key clinical service roles that match their abilities and credentials.												
	59%	75%	80%	80%	53%	70%	73%	75%	63%	79%	86%	85%	
	...provide some clinical services such as assessment or self-management support.												
	31%	20%	15%	13%	31%	22%	19%	15%	30%	18%	11%	11%	
	...are primarily tasked with managing patient flow and triage.												
	10%	4%	5%	6%	15%	6%	7%	10%	6%	2%	3%	4%	
	...play a limited role in providing clinical care.												
	1%	1%	1%	1%	1%	2%	1%	1%	1%	1%	<1%	1%	
	N	2,290	2,268	2,273	2,281	1,056	1,045	1,048	1,050	1,234	1,223	1,225	1,231
B18	Pre-visit planning (gathering and organizing patient information to prepare for the visit) prior to the day of the visit...												
	...is done and includes (1) reviewing test results and consultation reports from specialists, (2) identifying gaps in health care, and (3) conducting outreach before the visit, to ask the patient to obtain needed tests prior to the visit.												
	25%	31%	35%	35%	22%	25%	29%	32%	28%	36%	40%	38%	
	...is done and includes (1) reviewing test results and consultation reports from specialist referrals, and (2) identifying gaps in health care (e.g., a needed flu shot or cancer screenings).												
	48%	51%	53%	55%	47%	50%	55%	57%	50%	52%	51%	53%	
	...is done but primarily focuses on reviewing test results and consultation reports from specialist referrals.												
	17%	12%	9%	8%	19%	15%	12%	9%	16%	9%	6%	8%	
	...is not done.												
	9%	6%	3%	2%	13%	9%	4%	2%	6%	3%	3%	2%	
	N	2,288	2,286	2,283	2,290	1,055	1,053	1,051	1,056	1,233	1,233	1,232	1,234

Table 3.B.5a. (continued)

Question ²	Combined tracks				Track 1 overall				Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
Comprehensiveness and coordination													
B13	Practices may or may not have agreements with specialists they refer patients to. A formal, written agreement with a specialist describes expectations for timely patient visits, the frequency and type of information communicated between the primary care practice and specialist, and their respective roles. This practice site has formal written agreements with...												
	...most or all medical and surgical specialist groups.	6%	8%	9%	15%	7%	6%	6%	12%	6%	10%	12%	18%
	...many medical and surgical specialist groups.	11%	12%	18%	25%	9%	10%	17%	23%	12%	15%	18%	27%
	...some medical and surgical specialist groups.	27%	62%	67%	53%	24%	55%	69%	56%	29%	67%	66%	50%
	...no medical or surgical specialist groups.	56%	18%	6%	7%	60%	29%	9%	10%	52%	9%	4%	4%
	N	2,284	2,281	2,286	2,286	1,055	1,054	1,054	1,054	1,229	1,227	1,232	1,232
B12	Timely receipt of information (e.g., consultation reports, diagnoses, new medications) about your patients after they visit specialists occurs...												
	...for most or all of this practice's patients.	25%	31%	35%	43%	23%	27%	34%	42%	26%	35%	36%	44%
	...for many of this practice's patients.	52%	47%	54%	46%	50%	48%	54%	48%	53%	46%	54%	44%
	...for some of this practice's patients.	23%	22%	11%	11%	27%	25%	12%	9%	20%	19%	10%	12%
	...for none of this practice's patients.	<1%	<1%	<1%	0%	<1%	<1%	<1%	0%	<1%	0%	0%	0%
	N	2,285	2,279	2,285	2,287	1,053	1,053	1,055	1,056	1,232	1,226	1,230	1,231
E3b	With how many specialist practices where most of your patients obtain care does this practice site electronically send and receive patient clinical data?												
	All	11%	9%	12%	16%	10%	8%	11%	14%	11%	10%	12%	17%
	Most	47%	54%	52%	57%	45%	53%	48%	55%	49%	54%	56%	58%
	Some	36%	33%	32%	24%	40%	34%	35%	26%	32%	31%	30%	23%
	None or don't know	6%	5%	4%	3%	5%	5%	6%	5%	8%	4%	2%	2%
	N	2,280	2,285	2,279	2,287	1,052	1,054	1,053	1,054	1,228	1,231	1,226	1,233

Table 3.B.5a. (continued)

Question ²	Combined tracks				Track 1 overall				Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
E3c	With how many diagnostic service facilities where most of your patients obtain care does this practice site electronically send and receive patient clinical data?												
	All	21%	18%	22%	26%	21%	17%	21%	27%	21%	18%	23%	26%
	Most	60%	62%	60%	58%	59%	61%	57%	56%	60%	63%	62%	60%
	Some	16%	17%	16%	13%	17%	19%	19%	15%	14%	15%	13%	12%
	None or don't know	4%	3%	3%	3%	3%	3%	3%	3%	5%	3%	2%	2%
	N	2,279	2,284	2,280	2,286	1,051	1,054	1,053	1,054	1,228	1,230	1,227	1,232
B14	This practice site assesses the social and functional support needs (e.g., transportation, home equipment)...												
	...for most or all of this practice's patients.	19%	24%	32%	47%	19%	19%	26%	42%	19%	28%	37%	51%
	...for many of this practice's patients.	32%	32%	35%	35%	32%	32%	30%	36%	32%	32%	39%	34%
	...for some of this practice's patients.	46%	41%	32%	18%	45%	44%	42%	22%	47%	39%	24%	14%
	...for none of this practice's patients.	3%	2%	1%	<1%	4%	5%	1%	1%	2%	1%	<1%	0%
	N	2,285	2,284	2,288	2,290	1,054	1,054	1,055	1,056	1,231	1,230	1,233	1,234
A10	Linking patients to supportive community-based resources...												
	...is accomplished through active coordination between the health system, community service agencies, and patients and accomplished by a designated staff person.	17%	27%	31%	39%	12%	22%	27%	37%	21%	31%	34%	40%
	...is accomplished through a designated staff person or resource responsible for connecting patients with community resources.	43%	52%	52%	48%	38%	49%	48%	47%	47%	54%	56%	49%
	...is limited to providing patients a list of identified community resources in an accessible format.	32%	19%	16%	12%	39%	25%	23%	14%	26%	14%	10%	10%
	...is not done systematically.	8%	2%	1%	1%	12%	3%	1%	2%	5%	1%	<1%	<1%
	N	2,290	2,286	2,282	2,287	1,056	1,055	1,051	1,053	1,234	1,231	1,231	1,234
Patient and caregiver engagement													
B16	Feedback to the practice from a patient and family advisory council... ⁴												
	...is collected and is consistently used to guide practice improvements.	45%	56%	55%	44%	39%	50%	46%	44%	51%	60%	62%	43%
	...is collected and is occasionally used to guide practice improvements.	37%	42%	44%	49%	38%	46%	52%	48%	37%	38%	37%	50%
	...is collected but is not used to guide practice improvements.	4%	1%	1%	2%	5%	2%	2%	2%	3%	1%	<1%	2%
	...is not collected.	14%	1%	1%	5%	19%	2%	1%	6%	10%	1%	<1%	5%
	N	2,289	2,286	2,282	2,286	1,056	1,055	1,054	1,054	1,233	1,231	1,228	1,232

Table 3.B.5a. (continued)

Question ²	Combined tracks				Track 1 overall				Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
Planned care and population health													
E2	Does this practice site use data extracts or reports generated from the EHR to guide quality improvement (QI) efforts? ⁵												
	Yes	95%	98%	98%	97%	93%	97%	97%	96%	97%	99%	99%	98%
	No	3%	1%	1%	1%	5%	2%	1%	2%	2%	<1%	<1%	1%
	Don't know	2%	1%	1%	2%	3%	1%	1%	2%	1%	1%	1%	1%
	N	2,284	2,279	2,274	2,285	1,053	1,051	1,050	1,053	1,231	1,228	1,224	1,232
B17	At this practice site, registry data to assess or manage care for groups of patients...												
	...are available for 6 or more diseases and/or risk states.	40%	45%	49%	54%	36%	39%	40%	49%	44%	50%	57%	58%
	...are available for 3-5 diseases and/or risk states.	29%	32%	29%	33%	27%	29%	34%	33%	31%	34%	26%	33%
	...are available for 1-2 diseases and/or risk states.	12%	10%	11%	7%	10%	12%	15%	8%	14%	9%	8%	6%
	...are not available.	18%	13%	10%	7%	27%	20%	12%	11%	11%	8%	9%	4%
	N	2,286	2,281	2,276	2,275	1,055	1,054	1,048	1,046	1,231	1,227	1,228	1,229
A12	Quality improvement (QI) activities...												
	...are based on a proven improvement strategy and used continuously in meeting organizational goals.	50%	65%	73%	75%	41%	57%	67%	72%	57%	71%	78%	78%
	...are based on a proven improvement strategy in reaction to specific problems.	27%	23%	18%	18%	30%	27%	22%	21%	26%	20%	15%	16%
	...are conducted on an ad hoc basis in reaction to specific problems.	22%	12%	9%	6%	28%	16%	11%	7%	17%	8%	7%	6%
	...are not organized or supported consistently.	1%	<1%	<1%	<1%	2%	<1%	1%	<1%	<1%	<1%	0%	<1%
	N	2,290	2,284	2,285	2,288	1,056	1,053	1,054	1,055	1,234	1,231	1,231	1,233
A13	Staff, resources, and time for QI activities...												
	...are all fully available in the practice.	19%	28%	34%	34%	14%	22%	29%	31%	23%	34%	38%	37%
	...are generally available and usually at the level needed.	39%	46%	46%	43%	37%	49%	50%	44%	42%	43%	42%	42%
	...are occasionally available but are limited in scope (due to some deficiencies in staff, resources, or time).	38%	25%	20%	23%	43%	29%	20%	25%	34%	23%	19%	21%
	...are not readily available in this practice.	4%	1%	<1%	<1%	6%	1%	<1%	<1%	2%	<1%	<1%	<1%
	N	2,290	2,285	2,286	2,289	1,056	1,055	1,053	1,055	1,234	1,230	1,233	1,234

Table 3.B.5a. (continued)

Question ²	Combined tracks				Track 1 overall				Track 2 overall			
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)
Questions not included in the M2-PCMH-A score												
B7 (PYs 2, 3 and 5 only)	Among practices where care management services for high-risk patients are provided, care managers engage in meetings, huddles, or conversations with the physicians at the practice site about the high-risk patients they manage...											
...daily.	n.a.	35%	38%	35%	n.a.	33%	36%	35%	n.a.	36%	40%	35%
...weekly.	n.a.	35%	39%	33%	n.a.	30%	33%	26%	n.a.	40%	44%	39%
...a few times a month.	n.a.	22%	21%	28%	n.a.	28%	28%	32%	n.a.	17%	15%	25%
...never or rarely.	n.a.	8%	2%	4%	n.a.	10%	4%	6%	n.a.	6%	1%	2%
N	n.a.	2,232	2,278	2,281	n.a.	1,015	1,046	1,054	n.a.	1,217	1,232	1,227

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ The M2-PCMH-A was not included in the PY 4 survey.

² The question numbering is based on the PY 5 survey.

³ The overall scores are weighted averages of practices' response to all questions in the M2-PCMH-A. The weights were derived from a factor analysis conducted on the responses of 2017 Starter CPC+ practices to the PY 1 survey. Factor analysis uses the correlation between the individual questions to reflect the reliability of each question in measuring the overall care delivery score.

⁴ The wording of this question changed from the PY 1 to the PY 2 survey. In the PY 1 survey, the question asked "Feedback to the practice from patient surveys or from a patient and family advisory council..."

⁵ To aggregate into the M2-PCMH-A we converted the responses to a four-point scale, where "Yes" equaled 4 and "No" and "Don't know" equaled 1.

n.a. = not applicable, because the survey question was not asked in that wave or to the specified group of practices; PY = Program Year; SSP = Medicare Shared Savings Program.

Table 3.B.5b. Distribution of CPC+ practices' responses to questions about their approaches to care delivery, within track by SSP status (scale: 1 [least advanced approach] - 4 [most advanced approach]) (2017 Starters)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)
Care delivery score³																
Overall M2-PCMH-A Score																
3.75 to 4	1%	4%	4%	16%	1%	1%	5%	12%	4%	8%	14%	15%	2%	6%	6%	15%
3.5 to <3.75	5%	11%	20%	31%	6%	14%	19%	27%	12%	24%	38%	41%	16%	24%	35%	39%
3 to <3.5	35%	59%	66%	47%	38%	57%	63%	54%	48%	61%	46%	42%	52%	63%	52%	41%
2.5 to <3	44%	26%	10%	6%	32%	25%	11%	7%	31%	6%	2%	2%	27%	6%	7%	5%
<2.5	15%	<1%	0%	<1%	23%	2%	1%	0%	5%	<1%	0%	0%	3%	<1%	<1%	0%
N	547	547	547	547	509	509	509	509	612	612	612	612	622	622	622	622
M2-PCMH-A items																
Access and continuity																
A11	Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP, or nurse...															
	...is available via the patient's choice of email or phone directly with the practice team or a practitioner who has real-time access to the patient's electronic medical record.															
	32%	56%	61%	59%	46%	50%	64%	58%	60%	62%	64%	62%	49%	63%	58%	67%
	...is provided by a coverage arrangement (e.g., answering service) that shares necessary patient data with and provides a summary to the practice.															
	63%	43%	38%	37%	46%	46%	33%	41%	37%	37%	35%	38%	47%	36%	41%	33%
	...is available from a coverage arrangement (e.g., answering service) that does not offer a standardized communication protocol back to the practice for urgent problems.															
	5%	1%	1%	3%	7%	4%	2%	1%	3%	1%	1%	<1%	4%	1%	<1%	<1%
	...is not available or is limited to an answering machine.															
	<1%	0%	<1%	0%	2%	<1%	1%	<1%	<1%	0%	<1%	<1%	0%	<1%	0%	0%
N	547	545	545	547	509	509	508	507	612	612	610	609	622	620	622	621
B1	Same-day appointments for patients who need them are available at this practice site for...															
	...most or all of this practice's patients.															
	75%	78%	76%	76%	72%	77%	84%	75%	82%	77%	84%	77%	78%	84%	81%	81%
	...many of this practice's patients.															
	15%	20%	22%	19%	18%	17%	14%	20%	13%	21%	12%	22%	17%	14%	14%	14%
	...some of this practice's patients.															
	10%	2%	2%	5%	10%	6%	2%	4%	4%	2%	3%	1%	5%	2%	5%	5%

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)
...none of this practice's patients. N	0%	<1%	0%	0%	0%	0%	0%	0%	<1%	0%	0%	0%	0%	0%	0%	0%
547	547	547	547	547	509	508	506	509	611	611	612	612	620	621	620	622
B2	Communicating with the practice team through email, text messaging, or accessing a patient portal occurs for...															
...most or all of this practice's patients.	27%	18%	30%	44%	30%	23%	33%	42%	34%	31%	44%	43%	29%	32%	37%	47%
...many of this practice's patients.	36%	35%	41%	39%	27%	41%	44%	40%	36%	41%	45%	50%	42%	45%	44%	40%
...some of this practice's patients.	35%	46%	28%	17%	40%	34%	22%	18%	29%	28%	11%	6%	28%	23%	18%	13%
...none of this practice's patients. N	1%	<1%	1%	<1%	3%	2%	1%	<1%	1%	1%	0%	0%	1%	0%	1%	0%
547	545	543	546	509	508	508	509	612	608	611	610	621	620	620	618	
B3	Scheduled phone or video visits with a physician...															
...are generally available, and patients are regularly asked about their preferences for in-person versus phone/video visits.	1%	2%	3%	55%	1%	1%	2%	49%	3%	6%	11%	65%	2%	3%	4%	53%
...are generally available at a patient's request.	6%	12%	11%	38%	9%	7%	12%	41%	20%	22%	21%	28%	8%	14%	19%	41%
...are available on a limited basis to patients.	14%	9%	10%	5%	12%	15%	19%	9%	16%	19%	23%	2%	16%	22%	25%	6%
...are not regularly available to patients. N	79%	78%	76%	2%	78%	76%	66%	1%	61%	52%	45%	5%	75%	62%	52%	1%
547	546	546	547	509	509	506	509	612	611	612	612	622	621	622	622	

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
A6	Patients...																
	...are assigned to specific practitioner panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.	41%	52%	53%	55%	40%	40%	54%	54%	48%	54%	67%	69%	38%	51%	53%	50%
	...are assigned to specific practitioner panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	46%	43%	41%	35%	46%	51%	40%	41%	47%	43%	31%	29%	56%	45%	43%	46%
	...are assigned to specific practitioner panels but panel assignments are not routinely used by the practice for administrative or other purposes.	9%	3%	3%	5%	8%	6%	3%	2%	3%	2%	1%	1%	3%	3%	2%	2%
	...are not assigned to specific practitioner panels.	4%	2%	4%	6%	6%	3%	4%	3%	1%	1%	1%	1%	3%	1%	2%	2%
	N	547	545	545	547	509	506	508	506	612	610	609	612	622	618	618	621
B4	Patients...																
	...have a specific physician, and the patient is almost always scheduled with that physician.	66%	75%	69%	77%	67%	70%	73%	71%	68%	75%	79%	74%	66%	68%	63%	66%
	...have a specific physician, and the patient is frequently scheduled with that physician.	31%	22%	28%	20%	30%	28%	26%	27%	30%	24%	19%	25%	31%	31%	35%	31%
	...have a specific physician, and the patient is sometimes scheduled with that physician.	2%	2%	2%	2%	2%	2%	1%	1%	2%	1%	2%	<1%	3%	1%	2%	2%
	...do not have a specific physician that they see at this practice.	1%	1%	1%	<1%	<1%	0%	<1%	<1%	<1%	<1%	<1%	0%	<1%	0%	<1%	<1%
	N	546	546	545	547	508	507	506	509	610	610	612	612	621	615	620	622

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)
B5	When patients contact the practice with clinical questions or concerns (e.g., a new problem or questions about their treatment) between scheduled encounters...															
	...their specific physician or practice care team that has primarily worked with the patient almost always responds.															
	79%	81%	84%	77%	81%	84%	87%	88%	83%	85%	90%	89%	85%	87%	89%	84%
	...their specific physician or practice care team that has primarily worked with the patient frequently responds.															
	20%	18%	16%	22%	17%	15%	13%	11%	16%	14%	10%	11%	14%	12%	11%	16%
	...their specific physician or practice care team that has primarily worked with the patient sometimes responds.															
	1%	1%	<1%	<1%	1%	1%	0%	1%	2%	1%	<1%	0%	1%	<1%	<1%	<1%
	...they do not have a specific physician that they see at the practice, so any member of the practice responds.															
	<1%	<1%	0%	<1%	0%	0%	<1%	<1%	<1%	0%	0%	0%	<1%	<1%	0%	<1%
N	546	544	547	547	509	508	507	507	608	611	612	611	621	622	622	622
Care management																
A8	A standard method or tool(s) to stratify patients by risk level...															
	...is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.															
	16%	39%	49%	65%	12%	44%	51%	54%	29%	59%	61%	64%	47%	69%	64%	71%
	...is available and is consistently used to stratify all patients but is inconsistently integrated into all aspects of care delivery.															
	33%	51%	45%	27%	32%	46%	45%	41%	36%	37%	36%	32%	25%	26%	33%	27%
	...is available but not consistently used to stratify all patients.															
	38%	10%	6%	7%	32%	9%	3%	5%	22%	4%	1%	4%	23%	4%	3%	2%
	...is not available.															
	13%	<1%	<1%	<1%	23%	1%	1%	<1%	13%	0%	1%	<1%	5%	<1%	<1%	<1%
N	547	545	546	546	509	507	509	508	612	612	611	612	622	620	621	621

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
B6	Care management services for high-risk patients...																
	...are provided by a care manager located at this practice site.																
	49%	69%	70%	64%	49%	67%	70%	67%	64%	76%	81%	58%	64%	75%	82%	66%	
	...are provided by a care manager within this practice's organization who is not physically located at this practice site.																
	29%	26%	29%	35%	18%	25%	26%	32%	28%	23%	19%	42%	25%	21%	17%	32%	
	...are provided by care managers from an outside organization (e.g., a health insurance plan).																
	7%	2%	1%	1%	15%	4%	2%	1%	3%	<1%	<1%	<1%	7%	3%	1%	2%	
	...are not provided at this practice.																
	15%	3%	<1%	0%	18%	4%	1%	<1%	5%	<1%	0%	<1%	4%	2%	0%	1%	
	N	546	547	545	547	508	506	509	509	611	611	612	612	622	620	622	622
B15	Self-management support is help for patients to better manage their health on a day-to-day basis. At this practice site, self-management support for most patients who have chronic conditions...																
	...is provided by practice staff who set specific goals with patients and are trained in assessing how ready patients are to change their health behavior and how to motivate patient behavior change.																
	30%	43%	41%	51%	24%	40%	39%	47%	48%	59%	73%	68%	35%	50%	55%	55%	
	...is provided by practice staff who set specific goals with patients but are not trained in assessing how ready patients are to change their health behavior and how to motivate patient behavior change.																
	18%	22%	30%	27%	18%	20%	33%	33%	26%	23%	18%	25%	25%	30%	32%	28%	
	...is provided by practice staff but they do not set specific goals with patients (e.g., they just offer patient education).																
	29%	21%	20%	19%	38%	29%	22%	17%	21%	13%	8%	6%	28%	15%	12%	15%	
	...is limited to either (1) the distribution of information (e.g., pamphlets, booklets) with no or little discussion or (2) referral to self-management classes or educators.																
	23%	14%	10%	3%	20%	11%	6%	3%	6%	5%	1%	1%	12%	5%	2%	1%	
	N	545	547	545	546	507	508	509	507	609	608	610	611	621	620	619	620

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)
E3a	With how many hospitals where most of your patients obtain care does this practice site electronically send and receive patient clinical data?															
All	15%	15%	18%	22%	22%	18%	24%	28%	20%	21%	29%	33%	21%	17%	21%	33%
Most	45%	52%	59%	59%	47%	51%	45%	49%	52%	51%	52%	50%	48%	58%	53%	49%
Some	32%	29%	20%	18%	25%	23%	25%	16%	20%	25%	16%	16%	20%	16%	20%	15%
None or don't know	8%	5%	3%	1%	6%	9%	6%	7%	7%	3%	3%	1%	11%	9%	7%	3%
N	546	546	547	544	506	508	506	507	611	609	611	611	621	619	615	622
B8	Receipt of clinical information (e.g., a discharge summary) from an emergency department (ED) about this practice's patients who had an ED visit...															
...usually occurs within a day of the visit.	27%	56%	61%	69%	33%	45%	58%	66%	44%	62%	78%	74%	45%	57%	57%	65%
...usually occurs 1–3 days after the visit.	59%	37%	37%	30%	47%	48%	39%	32%	46%	31%	21%	25%	47%	40%	40%	33%
...usually occurs more than 3 days after the visit.	8%	5%	2%	1%	10%	3%	1%	2%	2%	1%	1%	1%	3%	2%	2%	1%
...does not occur consistently.	7%	2%	<1%	1%	10%	3%	2%	<1%	8%	6%	<1%	<1%	6%	1%	2%	1%
N	545	546	547	545	509	508	508	509	612	611	610	612	621	622	621	622
B10	Receipt of clinical information (e.g., a discharge summary) from hospitals about this practice's patients who had a hospital visit...															
...usually occurs within a day of discharge.	33%	54%	56%	66%	29%	38%	50%	62%	38%	56%	75%	71%	40%	51%	56%	63%
...usually occurs 1–3 days after discharge.	51%	40%	42%	31%	48%	56%	47%	37%	52%	35%	24%	28%	53%	45%	40%	34%
...usually occurs more than 3 days after discharge.	11%	4%	2%	3%	14%	2%	2%	1%	7%	7%	1%	1%	3%	3%	3%	2%
...does not occur consistently.	5%	1%	<1%	0%	9%	3%	1%	0%	2%	2%	0%	<1%	4%	1%	1%	1%
N	547	547	546	547	509	507	507	509	611	612	612	612	621	619	622	622

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
B9	Outreach by this practice site to patients within one week of an ED visit occurs...																
	...for most or all of this practice's patients.																
	33%	64%	73%	81%	44%	63%	78%	78%	43%	58%	79%	70%	59%	76%	83%	78%	
	...for many of this practice's patients.																
	26%	25%	24%	13%	19%	26%	18%	18%	27%	33%	20%	25%	22%	21%	16%	20%	
	...for some of this practice's patients.																
	38%	8%	3%	6%	31%	11%	5%	3%	28%	9%	2%	4%	19%	2%	1%	2%	
	...for none of this practice's patients.																
	3%	2%	0%	<1%	7%	<1%	0%	0%	3%	0%	<1%	0%	<1%	0%	0%	<1%	
	N	546	546	547	545	507	509	506	509	610	611	612	612	620	622	622	622
B11	Outreach by this practice site to patients within 3 days of hospital discharge occurs...																
	...for most or all of this practice's patients.																
	42%	66%	75%	76%	51%	68%	83%	85%	53%	65%	88%	83%	73%	85%	86%	84%	
	...for many of this practice's patients.																
	39%	33%	24%	23%	23%	26%	16%	14%	34%	33%	12%	15%	18%	12%	12%	15%	
	...for some of this practice's patients.																
	19%	1%	1%	1%	24%	5%	1%	1%	13%	2%	<1%	1%	9%	2%	2%	1%	
	...for none of this practice's patients.																
	1%	0%	0%	0%	2%	<1%	0%	0%	<1%	0%	0%	<1%	<1%	0%	0%	<1%	
	N	546	547	546	547	505	507	507	509	607	608	612	611	618	617	622	622
A9	Follow-up by this primary care practice with patients seen in the emergency department (ED) or hospital...																
	...is done routinely because this primary care practice has arrangements in place with the ED and hospital to both track these patients and ensure that follow-up is completed within a few days.																
	35%	61%	78%	78%	40%	64%	78%	83%	47%	70%	73%	69%	64%	79%	82%	83%	
	...occurs because this primary care practice makes proactive efforts to identify patients.																
	31%	31%	15%	17%	29%	29%	18%	14%	37%	28%	25%	28%	27%	19%	16%	17%	
	...occurs only if the ED or hospital alerts this primary care practice.																
	33%	7%	7%	4%	28%	7%	4%	3%	15%	2%	1%	3%	8%	1%	2%	1%	
	...generally does not occur.																
	1%	<1%	0%	0%	3%	0%	0%	0%	<1%	0%	0%	0%	<1%	0%	0%	0%	
	N	547	547	546	546	509	508	509	507	612	610	611	612	622	622	621	622

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)
A7	Non-physician practice team members...															
	...perform key clinical service roles that match their abilities and credentials.															
	55%	70%	74%	71%	51%	71%	72%	79%	56%	77%	88%	85%	70%	81%	84%	84%
	...provide some clinical services such as assessment or self-management support.															
	30%	25%	21%	18%	32%	19%	17%	11%	38%	21%	10%	12%	23%	16%	12%	10%
	...are primarily tasked with managing patient flow and triage.															
	15%	4%	5%	10%	15%	8%	9%	10%	5%	2%	2%	3%	7%	2%	4%	5%
	...play a limited role in providing clinical care.															
	1%	1%	<1%	1%	2%	2%	1%	1%	<1%	<1%	<1%	<1%	1%	1%	1%	1%
	N															
	547	543	542	546	509	502	506	504	612	607	608	611	622	616	617	620
B18	Pre-visit planning (gathering and organizing patient information to prepare for the visit) prior to the day of the visit...															
	...is done and includes (1) reviewing test results and consultation reports from specialists, (2) identifying gaps in health care, and (3) conducting outreach before the visit, to ask the patient to obtain needed tests prior to the visit.															
	25%	26%	27%	27%	18%	25%	32%	37%	27%	29%	38%	40%	28%	42%	42%	36%
	...is done and includes (1) reviewing test results and consultation reports from specialist referrals, and (2) identifying gaps in health care (e.g., a needed flu shot or cancer screenings).															
	44%	49%	59%	62%	50%	51%	50%	51%	50%	62%	57%	51%	49%	43%	46%	54%
	...is done but primarily focuses on reviewing test results and consultation reports from specialist referrals.															
	19%	17%	10%	7%	18%	14%	15%	10%	18%	8%	4%	7%	15%	10%	8%	8%
	...is not done.															
	12%	8%	5%	3%	14%	10%	3%	2%	5%	2%	1%	2%	7%	5%	4%	2%
	N															
	546	546	544	547	509	507	507	509	611	612	611	612	622	621	621	622

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
Comprehensiveness and coordination																	
B13	Practices may or may not have agreements with specialists they refer patients to. A formal, written agreement with a specialist describes expectations for timely patient visits, the frequency and type of information communicated between the primary care practice and specialist, and their respective roles. This practice site has formal written agreements with...																
	...most or all medical and surgical specialist groups.	8%	7%	7%	14%	5%	4%	4%	10%	7%	13%	16%	22%	4%	7%	8%	15%
	...many medical and surgical specialist groups.	11%	12%	18%	26%	7%	7%	15%	20%	17%	19%	21%	30%	8%	11%	16%	24%
	...some medical and surgical specialist groups.	24%	54%	67%	51%	24%	57%	71%	61%	26%	61%	61%	46%	33%	72%	69%	54%
	...no medical or surgical specialist groups.	56%	26%	8%	9%	64%	33%	10%	10%	50%	8%	2%	2%	55%	10%	7%	7%
	N	546	546	546	546	509	508	508	508	612	608	611	611	617	619	621	621
B12	Timely receipt of information (e.g., consultation reports, diagnoses, new medications) about your patients after they visit specialists occurs...																
	...for most or all of this practice's patients.	22%	27%	37%	44%	23%	27%	30%	40%	29%	32%	34%	43%	23%	38%	37%	45%
	...for many of this practice's patients.	53%	49%	49%	47%	48%	47%	59%	50%	52%	47%	58%	46%	54%	46%	51%	43%
	...for some of this practice's patients.	25%	24%	13%	9%	29%	26%	10%	10%	18%	22%	7%	11%	22%	16%	12%	12%
	...for none of this practice's patients.	<1%	<1%	<1%	0%	<1%	0%	0%	0%	<1%	0%	0%	0%	<1%	0%	0%	0%
	N	546	546	547	547	507	507	508	509	612	609	611	611	620	617	619	620
E3b	With how many specialist practices where most of your patients obtain care does this practice site electronically send and receive patient clinical data?																
	All	9%	5%	11%	12%	12%	10%	12%	16%	10%	13%	15%	21%	13%	8%	9%	13%
	Most	44%	58%	50%	63%	46%	48%	46%	47%	53%	54%	58%	57%	45%	54%	55%	58%
	Some	43%	33%	34%	22%	36%	36%	36%	30%	29%	30%	26%	20%	34%	33%	33%	26%
	None or don't know	4%	4%	6%	3%	6%	6%	6%	7%	8%	3%	1%	2%	7%	5%	3%	3%
	N	547	546	547	546	505	508	506	508	610	611	611	611	618	620	615	622

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)
E3c	With how many diagnostic service facilities where most of your patients obtain care does this practice site electronically send and receive patient clinical data?															
All	20%	17%	17%	24%	22%	16%	25%	30%	16%	18%	24%	27%	26%	18%	22%	25%
Most	59%	62%	61%	64%	59%	60%	52%	47%	67%	63%	65%	58%	54%	64%	60%	62%
Some	18%	19%	20%	11%	17%	19%	19%	18%	14%	18%	10%	13%	14%	13%	15%	11%
None or don't know	3%	2%	2%	1%	3%	5%	4%	4%	3%	1%	1%	2%	6%	5%	3%	3%
N	546	547	547	546	505	507	506	508	608	611	611	611	620	619	616	621
B14	This practice site assesses the social and functional support needs (e.g., transportation, home equipment)...															
...for most or all of this practice's patients.	20%	17%	26%	43%	17%	23%	26%	40%	15%	31%	40%	54%	23%	26%	35%	49%
...for many of this practice's patients.	32%	36%	29%	35%	31%	28%	33%	37%	29%	31%	39%	38%	34%	33%	38%	31%
...for some of this practice's patients.	44%	43%	44%	21%	46%	44%	40%	22%	54%	37%	21%	9%	41%	40%	27%	20%
...for none of this practice's patients.	3%	4%	1%	1%	5%	5%	1%	1%	2%	<1%	<1%	0%	2%	1%	<1%	0%
N	545	547	547	547	509	507	508	509	611	609	612	612	620	621	621	622
A10	Linking patients to supportive community-based resources...															
...is accomplished through active coordination between the health system, community service agencies, and patients and accomplished by a designated staff person.	11%	23%	27%	43%	12%	21%	27%	31%	20%	31%	37%	44%	23%	31%	31%	36%
...is accomplished through a designated staff person or resource responsible for connecting patients with community resources.	40%	51%	45%	46%	35%	47%	52%	48%	46%	54%	56%	46%	48%	54%	56%	51%
...is limited to providing patients a list of identified community resources in an accessible format.	38%	23%	27%	9%	40%	28%	20%	20%	29%	14%	8%	9%	24%	14%	12%	12%
...is not done systematically.	11%	3%	1%	2%	13%	4%	2%	1%	6%	<1%	<1%	1%	5%	1%	<1%	<1%
N	547	547	544	546	509	508	507	507	612	611	609	612	622	620	622	622

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
Patient and caregiver engagement																	
B16	Feedback to the practice from a patient and family advisory council... ⁴																
	...is collected and is consistently used to guide practice improvements.																
	42%	48%	37%	44%	35%	52%	56%	44%	49%	58%	56%	39%	52%	62%	67%	47%	
	...is collected and is occasionally used to guide practice improvements.																
	36%	48%	62%	46%	40%	44%	41%	50%	37%	40%	43%	51%	37%	37%	32%	49%	
	...is collected but is not used to guide practice improvements.																
	3%	2%	<1%	1%	6%	2%	3%	3%	3%	1%	<1%	2%	3%	1%	<1%	2%	
	...is not collected.																
	18%	3%	1%	9%	19%	2%	1%	2%	12%	1%	<1%	7%	8%	<1%	<1%	2%	
	N	547	547	546	546	509	508	508	508	611	611	608	611	622	620	620	621
Planned care and population health																	
E2	Does this practice site use data extracts or reports generated from the EHR to guide quality improvement (QI) efforts? ⁵																
	Yes																
	92%	98%	98%	96%	93%	95%	97%	96%	98%	98%	99%	99%	97%	99%	99%	98%	
	No																
	5%	1%	1%	1%	5%	3%	2%	3%	2%	1%	<1%	<1%	2%	<1%	1%	1%	
	Don't know																
	3%	1%	1%	3%	2%	2%	2%	2%	1%	<1%	1%	1%	1%	1%	1%	1%	
	N	546	546	546	546	507	505	504	507	611	609	611	611	620	619	613	621
B17	At this practice site, registry data to assess or manage care for groups of patients...																
	...are available for 6 or more diseases and/or risk states.																
	37%	36%	37%	46%	35%	42%	43%	52%	48%	51%	61%	64%	40%	49%	53%	52%	
	...are available for 3-5 diseases and/or risk states.																
	25%	29%	35%	34%	28%	29%	33%	32%	28%	33%	19%	27%	34%	35%	31%	37%	
	...are available for 1-2 diseases and/or risk states.																
	8%	15%	17%	9%	12%	9%	12%	7%	12%	11%	7%	6%	16%	7%	9%	5%	
	...are not available.																
	30%	20%	11%	11%	24%	19%	12%	10%	12%	6%	13%	2%	10%	10%	6%	5%	
	N	546	545	542	543	509	509	506	503	612	607	608	610	619	620	620	619

Table 3.B.5b. (continued)

Question ²	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 5 ¹ (2021)	
A12	Quality improvement (QI) activities...																
	...are based on a proven improvement strategy and used continuously in meeting organizational goals.																
	42%	61%	72%	77%	39%	54%	61%	67%	57%	75%	82%	83%	57%	68%	74%	73%	
	...are based on a proven improvement strategy in reaction to specific problems.																
	32%	22%	18%	17%	27%	31%	26%	25%	26%	15%	11%	11%	25%	25%	19%	21%	
	...are conducted on an ad hoc basis in reaction to specific problems.																
	24%	17%	10%	6%	32%	15%	12%	7%	17%	10%	7%	7%	18%	7%	7%	6%	
	...are not organized or supported consistently.																
	2%	<1%	0%	<1%	2%	<1%	1%	<1%	<1%	<1%	0%	0%	<1%	0%	0%	<1%	
	N	547	544	547	547	509	509	507	508	612	611	612	611	622	620	619	622
A13	Staff, resources, and time for QI activities...																
	...are all fully available in the practice.																
	13%	23%	32%	33%	16%	21%	27%	28%	22%	37%	38%	40%	24%	31%	38%	34%	
	...are generally available and usually at the level needed.																
	37%	48%	48%	42%	37%	49%	54%	46%	38%	40%	42%	38%	45%	47%	43%	45%	
	...are occasionally available but are limited in scope (due to some deficiencies in staff, resources, or time).																
	44%	28%	21%	25%	42%	29%	19%	26%	39%	23%	20%	22%	29%	22%	18%	20%	
	...are not readily available in this practice.																
	6%	1%	0%	<1%	6%	1%	<1%	<1%	1%	1%	<1%	0%	2%	<1%	1%	<1%	
	N	547	547	546	547	509	508	507	508	612	610	612	612	622	620	621	622
Questions not included in the M2-PCMH-A score																	
B7 (PYs 2, 3 and 5 only)	Among practices where care management services for high-risk patients are provided, care managers engage in meetings, huddles, or conversations with the physicians at the practice site about the high-risk patients they manage...																
	...daily.																
	n.a.	33%	36%	37%	n.a.	32%	36%	34%	n.a.	28%	33%	27%	n.a.	44%	47%	42%	
	...weekly.																
	n.a.	33%	34%	26%	n.a.	26%	32%	26%	n.a.	51%	53%	48%	n.a.	31%	36%	30%	
	...a few times a month.																
	n.a.	28%	27%	32%	n.a.	27%	28%	33%	n.a.	15%	13%	24%	n.a.	20%	17%	25%	
	...never or rarely.																
	n.a.	6%	3%	5%	n.a.	15%	5%	7%	n.a.	6%	1%	<1%	n.a.	5%	1%	4%	
	N	n.a.	529	544	547	n.a.	486	502	507	n.a.	610	610	610	n.a.	607	622	617

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Table 3.B.5b. (continued)

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ The M2-PCMH-A was not included in the PY 4 survey.

² The question numbering is based on the PY 5 survey.

³ The overall scores are weighted averages of practices' response to all questions in the M2-PCMH-A. The weights were derived from a factor analysis conducted on the responses of 2017 Starter CPC+ practices to the PY 1 survey. Factor analysis uses the correlation between the individual questions to reflect the reliability of each question in measuring the overall care delivery score.

⁴ The wording of this question changed from the PY 1 to the PY 2 survey. In the PY 1 survey, the question asked "Feedback to the practice from patient surveys or from a patient and family advisory council..."

⁵ To aggregate into the M2-PCMH-A we converted the responses to a four-point scale, where "Yes" equaled 4 and "No" and "Don't know" equaled 1.

n.a. = not applicable, because the survey question was not asked in that wave or to the specified group of practices; PY = Program Year; SSP = Medicare Shared Savings Program (reflects 2021 [PY 5] participation, or, for practices that withdrew from CPC+, their participation at the time of withdrawal).

Table 3.B.6a. CPC+ practice characteristics, overall and by track (2017 Starters)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
Practice size and staffing																
A1	Number of full-time equivalent ² practitioners ³ (primary care and specialty) at the practice site															
	0-1.5	16%	14%	13%	13%	13%	19%	17%	16%	17%	17%	13%	11%	10%	10%	10%
	2-2.5	18%	18%	18%	16%	16%	18%	18%	18%	17%	16%	18%	18%	17%	16%	16%
	3-3.5	16%	17%	16%	14%	15%	16%	17%	17%	16%	17%	15%	16%	15%	13%	13%
	4-6.5	29%	28%	29%	32%	31%	27%	27%	27%	30%	30%	30%	29%	31%	34%	32%
	7+	22%	23%	24%	24%	25%	19%	20%	21%	21%	20%	23%	26%	27%	27%	29%
	N	2,290	2,289	2,284	2,289	2,286	1,056	1,056	1,053	1,055	1,055	1,234	1,233	1,231	1,234	1,231
A1a	Number of full-time equivalent ² physicians (primary care and specialty) at the practice site															
	0-1.5	29%	29%	28%	29%	30%	32%	32%	32%	32%	33%	25%	26%	26%	26%	27%
	2-2.5	22%	22%	22%	21%	20%	23%	23%	23%	22%	22%	21%	21%	20%	20%	18%
	3-3.5	16%	16%	16%	15%	15%	15%	15%	15%	15%	15%	17%	17%	16%	15%	14%
	4-6.5	21%	21%	22%	22%	22%	19%	19%	20%	20%	18%	23%	23%	24%	25%	25%
	7+	12%	12%	12%	13%	13%	11%	11%	10%	12%	12%	12%	14%	14%	14%	14%
	N	2,290	2,289	2,284	2,289	2,286	1,056	1,056	1,053	1,055	1,055	1,234	1,233	1,231	1,234	1,231
A1b-e	Number of full-time equivalent ² non-physician practitioners ³ (primary care and specialty) at the practice site															
	0-1.5	69%	65%	62%	60%	60%	71%	67%	66%	64%	63%	67%	63%	58%	57%	57%
	2-2.5	14%	16%	17%	17%	18%	12%	15%	16%	16%	18%	16%	16%	18%	17%	18%
	3-3.5	6%	7%	8%	10%	8%	6%	6%	7%	8%	8%	5%	7%	9%	11%	9%
	4-6.5	6%	6%	6%	6%	7%	6%	6%	5%	6%	6%	6%	6%	7%	7%	8%
	7+	5%	7%	6%	7%	7%	5%	6%	5%	6%	5%	5%	7%	7%	8%	8%
	N	2,290	2,289	2,284	2,289	2,286	1,056	1,056	1,053	1,055	1,055	1,234	1,233	1,231	1,234	1,231
A2	Number of full-time equivalent ² primary care practitioners with own NPI at the practice site															
	0-1.5	16%	15%	13%	14%	14%	20%	18%	17%	18%	17%	14%	12%	10%	10%	10%
	2-2.5	19%	18%	18%	17%	17%	19%	18%	19%	17%	17%	19%	18%	17%	17%	16%
	3-3.5	16%	17%	17%	15%	16%	17%	18%	17%	16%	17%	16%	17%	16%	14%	15%
	4-6.5	30%	29%	31%	33%	32%	28%	28%	29%	30%	31%	31%	30%	32%	35%	32%
	7+	19%	21%	22%	22%	22%	17%	18%	18%	18%	18%	21%	24%	25%	25%	26%
	N	2,290	2,290	2,290	2,290	2,290	1,056	1,056	1,056	1,056	1,056	1,234	1,234	1,234	1,234	1,234

Table 3.B.6a. (continued)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
A2a	Number of full-time equivalent ² primary care physicians with own NPI at the practice site															
	0-1.5	30%	30%	29%	30%	31%	34%	33%	33%	33%	34%	26%	27%	26%	27%	28%
	2-2.5	23%	22%	22%	21%	21%	24%	24%	23%	22%	22%	22%	21%	21%	21%	19%
	3-3.5	17%	17%	16%	15%	15%	15%	16%	15%	16%	18%	17%	17%	16%	15%	
	4-6.5	22%	22%	23%	23%	23%	20%	18%	20%	19%	24%	24%	25%	25%	26%	
	7+	9%	10%	10%	11%	11%	8%	9%	8%	9%	10%	11%	11%	12%	12%	
	N	2,290	2,290	2,290	2,290	2,290	1,056	1,056	1,056	1,056	1,056	1,234	1,234	1,234	1,234	1,234
A2b-e	Number of full-time equivalent ² non-physician primary care practitioners ³ with own NPI at the practice site															
	0-1.5	71%	67%	63%	62%	62%	72%	69%	67%	66%	66%	69%	65%	60%	58%	59%
	2-2.5	14%	16%	18%	17%	19%	13%	15%	17%	17%	15%	16%	19%	18%	19%	
	3-3.5	6%	6%	8%	9%	8%	6%	6%	6%	7%	6%	7%	9%	11%	8%	
	4-6.5	5%	6%	6%	6%	7%	4%	5%	5%	5%	6%	7%	6%	6%	8%	
	7+	4%	5%	5%	6%	5%	4%	5%	4%	5%	4%	6%	6%	7%	6%	
	N	2,290	2,290	2,290	2,290	2,290	1,056	1,056	1,056	1,056	1,056	1,234	1,234	1,234	1,234	1,234
A3	Among practices with changes to the number of primary care practitioners from PY 4 to PY 5, the change was primarily due to the coronavirus pandemic															
	Yes	n.a.	n.a.	n.a.	n.a.	5%	n.a.	n.a.	n.a.	n.a.	6%	n.a.	n.a.	n.a.	n.a.	5%
	No	n.a.	n.a.	n.a.	n.a.	88%	n.a.	n.a.	n.a.	n.a.	84%	n.a.	n.a.	n.a.	n.a.	90%
	Don't know	n.a.	n.a.	n.a.	n.a.	7%	n.a.	n.a.	n.a.	n.a.	10%	n.a.	n.a.	n.a.	n.a.	6%
	N	n.a.	n.a.	n.a.	n.a.	989	n.a.	n.a.	n.a.	n.a.	413	n.a.	n.a.	n.a.	n.a.	576
	Practice site has full- or part-time:															
A4a	Clinical psychologist, psychiatrist, or clinical social worker (behavioral health specialists)	26%	43%	50%	58%	58%	19%	27%	34%	46%	47%	32%	56%	64%	68%	67%
A4b	Quality Improvement (QI) specialist	32%	43%	45%	49%	51%	29%	43%	41%	46%	46%	35%	42%	48%	52%	56%
A4c	Health educator, dietitian, or nutritionist	26%	32%	34%	34%	36%	19%	25%	28%	27%	27%	32%	37%	40%	40%	43%
A4d	Clinical pharmacist or doctor of pharmacy	17%	21%	32%	40%	41%	14%	16%	20%	25%	25%	19%	26%	43%	52%	54%
	N	2,282	2,286	2,276	2,275	2,282	1,054	1,054	1,053	1,046	1,051	1,228	1,232	1,223	1,230	1,232

Table 3.B.6a. (continued)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
A5	Practice is part of a larger health care system that includes a hospital															
	Yes	n.a.	n.a.	n.a.	64%	65%	n.a.	n.a.	n.a.	63%	63%	n.a.	n.a.	n.a.	65%	66%
	No	n.a.	n.a.	n.a.	36%	35%	n.a.	n.a.	n.a.	37%	37%	n.a.	n.a.	n.a.	35%	34%
	N	n.a.	n.a.	n.a.	2,284	2,288	n.a.	n.a.	n.a.	1,055	1,055	n.a.	n.a.	n.a.	1,229	1,233
Care management																
C1a-b	Number of full-time equivalent ² care managers/care coordinators ⁴															
	0	19%	5%	3%	3%	3%	28%	7%	5%	4%	4%	11%	3%	2%	2%	2%
	0.5	23%	23%	22%	18%	16%	22%	27%	22%	20%	18%	24%	20%	21%	17%	15%
	1-1.5	38%	39%	45%	46%	45%	36%	38%	45%	47%	45%	40%	40%	44%	45%	44%
	2-2.5	12%	19%	16%	17%	20%	8%	16%	16%	15%	18%	15%	21%	16%	19%	21%
	3+	8%	14%	15%	16%	16%	7%	12%	15%	15%	14%	10%	16%	17%	17%	18%
	N	2,275	2,276	2,280	2,287	2,285	1,046	1,052	1,054	1,053	1,053	1,229	1,224	1,226	1,234	1,232
C1a-b	Presence of care managers/care coordinators ⁴															
	Has at least one full-time care manager/care coordinator	49%	65%	64%	65%	67%	41%	61%	61%	60%	61%	56%	67%	66%	70%	72%
	Has at least one part-time (but no full-time) care manager/care coordinator	32%	30%	32%	32%	30%	31%	32%	33%	36%	34%	33%	29%	31%	28%	26%
	Has no care manager/care coordinator	19%	5%	3%	3%	3%	27%	7%	5%	4%	4%	11%	3%	2%	2%	2%
	N	2,290	2,290	2,290	2,290	2,290	1,056	1,056	1,056	1,056	1,056	1,234	1,234	1,234	1,234	1,234
C2	Among practices with a care manager/coordinator, clinical background of care managers/care coordinators (multiple responses possible)															
	Registered nurse (RN)	75%	76%	77%	79%	79%	71%	73%	74%	77%	75%	77%	78%	80%	82%	83%
	Licensed practical nurse (LPN) or licensed vocational nurse (LVN)	20%	20%	21%	21%	21%	17%	18%	22%	21%	22%	22%	22%	21%	22%	20%
	Medical assistant (MA)	22%	24%	26%	23%	25%	25%	28%	32%	30%	31%	20%	20%	21%	18%	20%
	Social worker	11%	17%	19%	23%	27%	9%	14%	19%	22%	28%	12%	20%	19%	24%	25%
	Other clinical background	9%	12%	12%	15%	15%	9%	10%	10%	12%	14%	10%	13%	14%	17%	17%
	No clinical background	5%	4%	5%	5%	8%	5%	3%	4%	3%	5%	4%	5%	6%	6%	9%
	N	1,834	2,166	2,199	2,220	2,214	751	980	998	1,011	1,008	1,083	1,186	1,201	1,209	1,206

Table 3.B.6a. (continued)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
C2a	Among practices with a care manager/coordinator, care managers and/or care coordinators have behavioral health training														
Yes	n.a.	43%	53%	57%	60%	n.a.	38%	50%	55%	58%	n.a.	48%	55%	59%	62%
No	n.a.	57%	47%	43%	40%	n.a.	62%	50%	45%	42%	n.a.	52%	45%	41%	38%
N	n.a.	2,156	2,186	2,218	2,209	n.a.	977	992	1,012	1,007	n.a.	1,179	1,194	1,206	1,202
C3	Among practices with a full-time care manager/ coordinator, number of patients currently under longitudinal care management per full-time care manager ⁵														
Mean	n.a.	n.a.	n.a.	145	127	n.a.	n.a.	n.a.	130	112	n.a.	n.a.	n.a.	156	137
Median	n.a.	n.a.	n.a.	100	90	n.a.	n.a.	n.a.	90	78	n.a.	n.a.	n.a.	110	100
N	n.a.	n.a.	n.a.	1,461	1,505	n.a.	n.a.	n.a.	611	632	n.a.	n.a.	n.a.	850	873
C4	Among practices with only a full-time care manager/coordinator, number of hours worked per week on longitudinal care management per full-time care manager ⁵														
Mean	n.a.	n.a.	n.a.	n.a.	24	n.a.	n.a.	n.a.	n.a.	22	n.a.	n.a.	n.a.	n.a.	25
Median	n.a.	n.a.	n.a.	n.a.	24	n.a.	n.a.	n.a.	n.a.	20	n.a.	n.a.	n.a.	n.a.	25
N	n.a.	n.a.	n.a.	n.a.	1,514	n.a.	n.a.	n.a.	n.a.	637	n.a.	n.a.	n.a.	n.a.	877
C5	Among practices with only a part-time care manager/coordinator, number of patients currently under longitudinal care management per part-time care manager ⁵														
Mean	n.a.	n.a.	n.a.	93	79	n.a.	n.a.	n.a.	85	81	n.a.	n.a.	n.a.	101	78
Median	n.a.	n.a.	n.a.	56	50	n.a.	n.a.	n.a.	55	57	n.a.	n.a.	n.a.	58	44
N	n.a.	n.a.	n.a.	714	674	n.a.	n.a.	n.a.	374	358	n.a.	n.a.	n.a.	340	316
C6	Among practices with only a part-time care manager/coordinator, number of hours worked per week on longitudinal care management per part-time care manager ⁵														
Mean	n.a.	n.a.	n.a.	15	14	n.a.	n.a.	n.a.	14	13	n.a.	n.a.	n.a.	16	15
Median	n.a.	n.a.	n.a.	14	12	n.a.	n.a.	n.a.	12	10	n.a.	n.a.	n.a.	15	12
N	n.a.	n.a.	n.a.	723	674	n.a.	n.a.	n.a.	380	357	n.a.	n.a.	n.a.	343	317

Table 3.B.6a. (continued)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
C3-6	Number of minutes spent per week on longitudinal care management per patient in longitudinal care management ⁶														
Mean	n.a.	n.a.	n.a.	n.a.	23	n.a.	n.a.	n.a.	n.a.	24	n.a.	n.a.	n.a.	n.a.	23
Median	n.a.	n.a.	n.a.	n.a.	14	n.a.	n.a.	n.a.	n.a.	14	n.a.	n.a.	n.a.	n.a.	14
N	n.a.	n.a.	n.a.	n.a.	2,172	n.a.	n.a.	n.a.	n.a.	986	n.a.	n.a.	n.a.	n.a.	1,186
C7	Among practices with a care manager/coordinator, the amount of time typically spent by care managers on longitudinal care management activities for patients at this practice site changed during the coronavirus pandemic														
Yes	n.a.	n.a.	n.a.	n.a.	45%	n.a.	n.a.	n.a.	n.a.	47%	n.a.	n.a.	n.a.	n.a.	43%
No	n.a.	n.a.	n.a.	n.a.	38%	n.a.	n.a.	n.a.	n.a.	35%	n.a.	n.a.	n.a.	n.a.	40%
Don't know	n.a.	n.a.	n.a.	n.a.	18%	n.a.	n.a.	n.a.	n.a.	18%	n.a.	n.a.	n.a.	n.a.	17%
N	n.a.	n.a.	n.a.	n.a.	2,208	n.a.	n.a.	n.a.	n.a.	1,002	n.a.	n.a.	n.a.	n.a.	1,206

Table 3.B.6a. (continued)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
C8	Among practices with a care manager/coordinator, major challenges practice faces in providing longitudinal care management for chronic conditions (multiple responses possible)															
	Risk stratification methods used to identify patients for longitudinal care management are sometimes inaccurate or do not allow adjustment based on clinical judgment	n.a.	n.a.	n.a.	6%	3%	n.a.	n.a.	n.a.	5%	3%	n.a.	n.a.	n.a.	7%	2%
	Insufficient care manager staff time to provide longitudinal care management for chronic conditions	n.a.	n.a.	n.a.	15%	15%	n.a.	n.a.	n.a.	15%	16%	n.a.	n.a.	n.a.	15%	14%
	Insufficient community-based resources to meet patient needs	n.a.	n.a.	n.a.	19%	21%	n.a.	n.a.	n.a.	17%	21%	n.a.	n.a.	n.a.	20%	22%
	Logistical obstacles to reaching patients (such as incorrect patient contact information, hard to reach)	n.a.	n.a.	n.a.	8%	10%	n.a.	n.a.	n.a.	6%	9%	n.a.	n.a.	n.a.	10%	11%
	Lack of patient interest in interacting with a care manager	n.a.	n.a.	n.a.	9%	11%	n.a.	n.a.	n.a.	11%	13%	n.a.	n.a.	n.a.	8%	9%
	Insufficient practitioner buy-in of benefit of longitudinal care management services to patients	n.a.	n.a.	n.a.	3%	3%	n.a.	n.a.	n.a.	3%	2%	n.a.	n.a.	n.a.	3%	3%
	Insufficient organizational buy-in of benefit of longitudinal care management services to patients	n.a.	n.a.	n.a.	4%	4%	n.a.	n.a.	n.a.	4%	4%	n.a.	n.a.	n.a.	4%	4%
	Other challenge	n.a.	n.a.	n.a.	2%	2%	n.a.	n.a.	n.a.	3%	3%	n.a.	n.a.	n.a.	2%	2%
	N	n.a.	n.a.	n.a.	2,267	2,257	n.a.	n.a.	n.a.	1,046	1,029	n.a.	n.a.	n.a.	1,221	1,228

Table 3.B.6a. (continued)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
C9	Among practices that reported insufficient care manager staff time as a major or minor challenge, the main reason the practice does not have sufficient care manager staff time for longitudinal care management															
	Amount of CPC+ care management fees is not enough to support hiring more care managers	n.a.	n.a.	n.a.	26%	24%	n.a.	n.a.	n.a.	23%	24%	n.a.	n.a.	n.a.	28%	23%
	Health care system does not provide practice with as much care manager time as their patient population needs	n.a.	n.a.	n.a.	10%	14%	n.a.	n.a.	n.a.	12%	14%	n.a.	n.a.	n.a.	9%	13%
	Care manager staff time is focused on episodic care management (e.g., follow-up after hospital or ED visits)	n.a.	n.a.	n.a.	35%	32%	n.a.	n.a.	n.a.	34%	33%	n.a.	n.a.	n.a.	36%	30%
	Inadequate supply of qualified care managers available to hire	n.a.	n.a.	n.a.	12%	17%	n.a.	n.a.	n.a.	9%	14%	n.a.	n.a.	n.a.	14%	20%
	Other	n.a.	n.a.	n.a.	17%	14%	n.a.	n.a.	n.a.	22%	15%	n.a.	n.a.	n.a.	13%	13%
	N	n.a.	n.a.	n.a.	1,181	1,287	n.a.	n.a.	n.a.	544	615	n.a.	n.a.	n.a.	637	672
C1c	Among practices without a care manager/coordinator, the main reason the practice does not have a care manager/coordinator working as part a care team															
	Amount of CPC+ care management fees is not enough to support hiring care managers	n.a.	n.a.	n.a.	14%	9%	n.a.	n.a.	n.a.	12%	11%	n.a.	n.a.	n.a.	17%	7%
	Health care system does not provide practice with care manager time	n.a.	n.a.	n.a.	3%	6%	n.a.	n.a.	n.a.	2%	8%	n.a.	n.a.	n.a.	4%	3%
	Practice or health care system does not think practice needs a care manager	n.a.	n.a.	n.a.	11%	3%	n.a.	n.a.	n.a.	12%	4%	n.a.	n.a.	n.a.	8%	0%
	Inadequate supply of qualified care managers available to hire	n.a.	n.a.	n.a.	18%	7%	n.a.	n.a.	n.a.	16%	6%	n.a.	n.a.	n.a.	20%	7%
	Insufficient space at practice to accommodate a care manager	n.a.	n.a.	n.a.	5%	12%	n.a.	n.a.	n.a.	5%	9%	n.a.	n.a.	n.a.	4%	17%
	Other	n.a.	n.a.	n.a.	50%	63%	n.a.	n.a.	n.a.	52%	62%	n.a.	n.a.	n.a.	46%	64%
	N	n.a.	n.a.	n.a.	66	75	n.a.	n.a.	n.a.	42	48	n.a.	n.a.	n.a.	24	27

Table 3.B.6a. (continued)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
Data feedback on practice site's performance																
D1	Practice site received data feedback on the performance of the practice or physicians within the practice site in the past 12 months. This data feedback may have been provided by private health insurers, Medicaid, Medicare, practice's own organization, state health agencies, or others.															
	Yes	n.a.	97%	98%	n.a.	96%	n.a.	96%	98%	n.a.	96%	n.a.	98%	99%	n.a.	97%
	No	n.a.	3%	2%	n.a.	4%	n.a.	4%	2%	n.a.	4%	n.a.	2%	1%	n.a.	3%
	N	n.a.	2,290	2,282	n.a.	2,288	n.a.	1,056	1,054	n.a.	1,055	n.a.	1,234	1,228	n.a.	1,233
D2	Percentage of practices that reported receiving...															
	Data feedback on patient experience (from surveys)	n.a.	89%	95%	n.a.	92%	n.a.	86%	93%	n.a.	90%	n.a.	91%	96%	n.a.	94%
	Data feedback on quality of care	n.a.	94%	96%	n.a.	94%	n.a.	93%	95%	n.a.	94%	n.a.	96%	97%	n.a.	95%
	Data feedback on cost	n.a.	90%	92%	n.a.	91%	n.a.	90%	91%	n.a.	90%	n.a.	90%	93%	n.a.	92%
	Data feedback on utilization	n.a.	92%	94%	n.a.	94%	n.a.	92%	94%	n.a.	94%	n.a.	92%	95%	n.a.	94%
	N	n.a.	2,290	2,290	n.a.	2,290	n.a.	1,056	1,056	n.a.	1,056	n.a.	1,234	1,234	n.a.	1,234
Among practices that reported receiving each type of data feedback, practice site has changed how it delivers care in response to...																
D2a	...Data feedback on patient experience (from surveys)															
	Yes, major changes	n.a.	15%	18%	n.a.	10%	n.a.	14%	15%	n.a.	8%	n.a.	15%	21%	n.a.	11%
	Yes, minor changes	n.a.	77%	70%	n.a.	70%	n.a.	77%	73%	n.a.	72%	n.a.	78%	67%	n.a.	69%
	No change	n.a.	5%	9%	n.a.	17%	n.a.	6%	11%	n.a.	16%	n.a.	5%	7%	n.a.	17%
	Don't know if changes were made	n.a.	3%	3%	n.a.	3%	n.a.	3%	2%	n.a.	4%	n.a.	3%	4%	n.a.	3%
	N	n.a.	2,037	2,169	n.a.	2,105	n.a.	915	985	n.a.	947	n.a.	1,122	1,184	n.a.	1,158
D2b	...Data feedback on quality of care															
	Yes, major changes	n.a.	30%	32%	n.a.	16%	n.a.	33%	29%	n.a.	12%	n.a.	27%	34%	n.a.	20%
	Yes, minor changes	n.a.	62%	57%	n.a.	63%	n.a.	58%	60%	n.a.	65%	n.a.	66%	55%	n.a.	61%
	No change	n.a.	7%	10%	n.a.	18%	n.a.	7%	10%	n.a.	19%	n.a.	6%	9%	n.a.	17%
	Don't know if changes were made	n.a.	1%	1%	n.a.	3%	n.a.	2%	1%	n.a.	4%	n.a.	1%	2%	n.a.	3%
	N	n.a.	2,158	2,192	n.a.	2,163	n.a.	978	999	n.a.	990	n.a.	1,180	1,193	n.a.	1,173

Table 3.B.6a. (continued)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
D2c	...Data feedback on cost															
	Yes, major changes	n.a.	8%	13%	n.a.	7%	n.a.	7%	11%	n.a.	4%	n.a.	10%	16%	n.a.	10%
	Yes, minor changes	n.a.	55%	52%	n.a.	47%	n.a.	59%	55%	n.a.	46%	n.a.	52%	50%	n.a.	47%
	No change	n.a.	22%	27%	n.a.	33%	n.a.	24%	28%	n.a.	36%	n.a.	21%	27%	n.a.	31%
	Don't know if changes were made	n.a.	14%	7%	n.a.	13%	n.a.	11%	7%	n.a.	14%	n.a.	17%	8%	n.a.	12%
	N	n.a.	2,062	2,112	n.a.	2,091	n.a.	952	962	n.a.	954	n.a.	1,110	1,150	n.a.	1,137
D2d	...Data feedback on utilization															
	Yes, major changes	n.a.	20%	21%	n.a.	16%	n.a.	19%	20%	n.a.	12%	n.a.	22%	23%	n.a.	20%
	Yes, minor changes	n.a.	63%	62%	n.a.	56%	n.a.	64%	62%	n.a.	60%	n.a.	62%	61%	n.a.	53%
	No change	n.a.	12%	13%	n.a.	20%	n.a.	13%	13%	n.a.	21%	n.a.	11%	12%	n.a.	19%
	Don't know if changes were made	n.a.	5%	4%	n.a.	8%	n.a.	4%	4%	n.a.	8%	n.a.	6%	4%	n.a.	8%
	N	n.a.	2,112	2,157	n.a.	2,146	n.a.	972	988	n.a.	989	n.a.	1,140	1,169	n.a.	1,157
Use of health information technology																
E1	Practice site uses an Electronic Health Record (EHR) system															
	Yes	100%	100%	100%	n.a.	100%	100%	100%	100%	n.a.	100%	100%	100%	100%	n.a.	100%
	No	<1%	<1%	<1%	n.a.	<1%	<1%	<1%	<1%	n.a.	<1%	0%	<1%	0%	n.a.	0%
	N	2,282	2,276	2,276	n.a.	2,280	1,050	1,047	1,051	n.a.	1,050	1,232	1,229	1,225	n.a.	1,230

Table 3.B.6a. (continued)

Question ¹	Combined tracks					Track 1 overall					Track 2 overall					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
Completion of the survey																
J1	Who provided input in completing the survey (multiple responses possible)															
	Practice or office manager	82%	74%	74%	73%	64%	82%	72%	72%	74%	63%	83%	77%	76%	72%	65%
	Lead physician	32%	22%	17%	18%	15%	31%	21%	18%	17%	14%	33%	22%	16%	19%	15%
	Other physicians	7%	4%	3%	4%	2%	6%	3%	3%	1%	2%	7%	4%	2%	6%	3%
	Nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA)	6%	3%	3%	3%	3%	6%	3%	3%	2%	2%	7%	3%	3%	4%	4%
	Care manager/coordinator	36%	30%	26%	37%	31%	31%	32%	27%	35%	26%	41%	29%	24%	39%	36%
	Nursing staff, including nurse manager or supervisor	13%	6%	5%	5%	4%	13%	8%	6%	6%	4%	13%	4%	4%	4%	4%
	Medical assistant staff	14%	7%	4%	4%	3%	16%	10%	5%	4%	3%	13%	4%	3%	3%	2%
	Quality improvement staff	29%	31%	31%	36%	38%	33%	34%	30%	33%	32%	26%	28%	32%	39%	42%
	Administrative support staff (e.g., billing or finance staff, front desk staff)	24%	19%	15%	17%	16%	27%	19%	14%	16%	11%	22%	19%	16%	19%	20%
	Non-physician owner of practice	n.a.	1%	<1%	<1%	<1%	n.a.	<1%	<1%	<1%	<1%	n.a.	1%	<1%	<1%	<1%
	Leadership or staff from larger health care system or medical group	22%	18%	20%	18%	18%	22%	15%	14%	19%	16%	23%	20%	25%	17%	19%
	Data analytics staff	n.a.	19%	17%	16%	15%	n.a.	20%	16%	15%	10%	n.a.	18%	17%	17%	19%
	CPC+ lead	n.a.	34%	38%	36%	33%	n.a.	35%	35%	33%	30%	n.a.	33%	40%	38%	36%
	Patients	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	0%	<1%	0%	<1%	<1%	<1%	<1%
	Other	12%	4%	3%	2%	3%	13%	3%	3%	3%	2%	11%	4%	3%	1%	3%
	N	2,289	2,287	2,282	2,283	2,283	1,055	1,055	1,050	1,054	1,053	1,234	1,232	1,232	1,229	1,230

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ The question numbering is based on the PY 5 survey.

² Practices entered number of full time and part time staff separately. Full time equivalent counts were estimated by counting all full-time staff as 1 FTE and all part-time staff as 0.5 FTE.

³ Practitioners include physicians (MD or DO, not including psychiatrists), physician residents or fellows (trainees), nurse practitioners, physician assistants, and clinical nurse specialists. Non-physician practitioners include all types of practitioners listed but physicians.

⁴ Item wording changed during the PY 1 survey to clarify that it was asking about care managers/coordinators who work as part of the practice's care team, regardless of where they physically work. Out of 2,833 2017 Starter practices who responded to this question, 799 practices responded before the wording change.

Table 3.B.6a. (continued)

⁵ These questions only asked about the patient count for one care manager. If the practice had any full-time care managers, the patient count and hours worked are for a full-time care manager (reported in C3 and C4). If the practice only had part-time care managers, the patient count and hours worked are for a part-time care manager (reported in C5 and C6). If the practice had more than one care manager that fit either of these descriptions, they were asked to report patient counts and hours worked for the care manager whose first name came first alphabetically. The hours worked per week on longitudinal care management (reported in C4 or C6) is for the care manager with the patient count reported in C3 or C5. Nine practices answered at the top of the survey-allowed range, which may not accurately reflect their actual patient count: 4 responded that the patient count for their full-time care manager was 999 (reported in C3), and 5 responded that the patient count for their part-time care manager was 500 (reported in C5); these are included in the mean and median calculations.

⁶ These values were calculated by taking the number of reported hours one care manager spends in an average week on longitudinal care management divided by the number of patients currently under longitudinal care management with that care manager. This was multiplied by 60 to produce the number of minutes.

FTE = full-time equivalent; n.a. = not applicable because the survey question was not asked in that wave or to the specified group of practices; NPI = National Provider Identifier; PY = Program Year; SSP = Medicare Shared Savings Program.

Table 3.B.6b. CPC+ practice characteristics, within track by SSP status (2017 Starters)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
Practice size and staffing																					
A1	Number of full-time equivalent ² practitioners ³ (primary care and specialty) at the practice site																				
	0-1.5	21%	19%	18%	19%	17%	18%	16%	14%	15%	16%	14%	12%	10%	10%	11%	11%	9%	9%	9%	9%
	2-2.5	21%	20%	20%	18%	19%	15%	16%	17%	15%	14%	19%	17%	16%	16%	16%	18%	19%	18%	15%	16%
	3-3.5	16%	20%	18%	17%	19%	16%	13%	16%	14%	15%	14%	15%	15%	12%	12%	17%	17%	15%	14%	15%
	4-6.5	26%	24%	26%	28%	27%	29%	31%	29%	33%	33%	29%	28%	30%	32%	30%	32%	31%	32%	36%	33%
	7+	17%	17%	17%	18%	18%	23%	24%	24%	23%	23%	24%	28%	29%	31%	22%	24%	25%	25%	27%	27%
	N	547	547	545	547	546	509	509	508	508	509	612	611	611	612	612	622	622	620	622	619
A1a	Number of full-time equivalent ² physicians (primary care and specialty) at the practice site																				
	0-1.5	34%	35%	35%	33%	35%	31%	29%	28%	30%	31%	26%	25%	24%	24%	25%	25%	26%	27%	29%	29%
	2-2.5	25%	24%	24%	24%	23%	22%	23%	23%	20%	20%	20%	19%	19%	18%	17%	23%	23%	22%	21%	20%
	3-3.5	15%	16%	16%	15%	16%	15%	14%	14%	15%	15%	16%	16%	16%	15%	14%	19%	18%	16%	16%	15%
	4-6.5	17%	16%	16%	18%	16%	21%	21%	23%	22%	21%	24%	24%	23%	27%	26%	23%	22%	25%	23%	25%
	7+	10%	8%	9%	10%	11%	12%	13%	12%	14%	13%	14%	16%	17%	17%	18%	11%	11%	10%	11%	11%
	N	547	547	545	547	546	509	509	508	508	509	612	611	611	612	612	622	622	620	622	619
A1b-e	Number of full-time equivalent ² non-physician practitioners ³ (primary care and specialty) at the practice site																				
	0-1.5	74%	72%	70%	70%	68%	67%	61%	60%	58%	58%	70%	67%	61%	60%	61%	64%	60%	56%	54%	54%
	2-2.5	13%	14%	14%	13%	15%	12%	17%	19%	20%	21%	14%	13%	17%	16%	16%	18%	18%	20%	19%	20%
	3-3.5	5%	5%	7%	7%	6%	8%	8%	8%	9%	10%	5%	6%	8%	9%	6%	6%	8%	9%	13%	11%
	4-6.5	4%	5%	4%	5%	5%	8%	8%	6%	7%	6%	5%	5%	5%	8%	8%	8%	8%	9%	8%	9%
	7+	5%	5%	5%	6%	5%	5%	7%	6%	6%	6%	6%	8%	9%	10%	9%	4%	7%	6%	6%	6%
	N	547	547	545	547	546	509	509	508	508	509	612	611	611	612	612	622	622	620	622	619
A2	Number of full-time equivalent ² primary care practitioners with own NPI at the practice site																				
	0-1.5	21%	20%	19%	20%	18%	19%	16%	15%	16%	17%	15%	13%	10%	11%	11%	12%	10%	10%	10%	10%
	2-2.5	22%	21%	21%	19%	20%	16%	16%	16%	15%	14%	19%	17%	16%	17%	16%	19%	19%	18%	17%	16%
	3-3.5	17%	20%	18%	18%	19%	17%	16%	17%	15%	16%	14%	16%	16%	13%	13%	17%	17%	16%	15%	16%
	4-6.5	27%	25%	28%	28%	28%	29%	31%	30%	33%	34%	30%	29%	31%	35%	31%	32%	31%	33%	35%	34%
	7+	13%	15%	14%	16%	16%	20%	21%	21%	21%	20%	22%	25%	27%	25%	28%	20%	22%	24%	24%	25%
	N	547	547	547	547	547	509	509	509	509	509	612	612	612	612	612	622	622	622	622	622

Table 3.B.6b. (continued)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
A2a	Number of full-time equivalent ² primary care physicians with own NPI at the practice site																			
0-1.5	35%	36%	35%	35%	35%	32%	30%	30%	31%	32%	27%	26%	24%	24%	26%	26%	28%	27%	29%	30%
2-2.5	25%	24%	25%	25%	23%	22%	23%	22%	20%	20%	20%	19%	19%	20%	18%	23%	23%	23%	22%	21%
3-3.5	16%	16%	17%	15%	16%	14%	15%	14%	15%	15%	17%	16%	17%	15%	15%	18%	18%	16%	16%	15%
4-6.5	17%	16%	17%	18%	16%	22%	21%	23%	22%	22%	24%	26%	26%	27%	27%	23%	23%	24%	23%	25%
7+	6%	7%	6%	7%	9%	9%	11%	10%	11%	10%	12%	13%	14%	14%	15%	9%	8%	9%	10%	9%
N	547	547	547	547	547	509	509	509	509	509	612	612	612	612	612	622	622	622	622	622
A2b-e	Number of full-time equivalent ² non-physician primary care practitioners ³ with own NPI at the practice site																			
0-1.5	75%	73%	71%	71%	70%	69%	64%	62%	60%	61%	73%	69%	63%	62%	62%	66%	61%	57%	56%	56%
2-2.5	12%	14%	15%	14%	16%	13%	16%	20%	20%	20%	13%	14%	17%	16%	18%	18%	18%	19%	19%	20%
3-3.5	5%	4%	6%	6%	5%	7%	8%	7%	8%	9%	5%	6%	8%	9%	6%	6%	7%	10%	13%	10%
4-6.5	3%	4%	4%	4%	4%	6%	6%	6%	6%	6%	5%	5%	5%	5%	7%	6%	8%	8%	8%	8%
7+	5%	5%	4%	5%	5%	4%	6%	4%	5%	3%	5%	6%	7%	8%	8%	4%	5%	6%	5%	5%
N	547	547	547	547	547	509	509	509	509	509	612	612	612	612	612	622	622	622	622	622
A3	Among practices with changes to the number of primary care practitioners from PY 4 to PY 5, the change was primarily due to the coronavirus pandemic																			
Yes	n.a.	n.a.	n.a.	n.a.	6%	n.a.	n.a.	n.a.	n.a.	5%	n.a.	n.a.	n.a.	n.a.	4%	n.a.	n.a.	n.a.	n.a.	5%
No	n.a.	n.a.	n.a.	n.a.	88%	n.a.	n.a.	n.a.	n.a.	81%	n.a.	n.a.	n.a.	n.a.	88%	n.a.	n.a.	n.a.	n.a.	92%
Don't know	n.a.	n.a.	n.a.	n.a.	6%	n.a.	n.a.	n.a.	n.a.	14%	n.a.	n.a.	n.a.	n.a.	8%	n.a.	n.a.	n.a.	n.a.	3%
N	n.a.	n.a.	n.a.	n.a.	204	n.a.	n.a.	n.a.	n.a.	209	n.a.	n.a.	n.a.	n.a.	296	n.a.	n.a.	n.a.	n.a.	280
	Practice site has full- or part-time:																			
A4a	Clinical psychologist, psychiatrist, or clinical social worker (behavioral health specialists)																			
A4b	Quality Improvement (QI) specialist																			
A4c	Health educator, dietitian, or nutritionist																			
A4d	Clinical pharmacist or doctor of pharmacy																			
N	545	545	547	542	546	509	509	506	507	507	608	611	609	609	611	620	621	614	622	621

Table 3.B.6b. (continued)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
A5	Practice is part of a larger health care system that includes a hospital																			
Yes	n.a.	n.a.	n.a.	71%	72%	n.a.	n.a.	n.a.	53%	54%	n.a.	n.a.	n.a.	77%	80%	n.a.	n.a.	n.a.	54%	54%
No	n.a.	n.a.	n.a.	29%	28%	n.a.	n.a.	n.a.	47%	46%	n.a.	n.a.	n.a.	23%	20%	n.a.	n.a.	n.a.	46%	46%
N	n.a.	n.a.	n.a.	546	546	n.a.	n.a.	n.a.	509	509	n.a.	n.a.	n.a.	612	612	n.a.	n.a.	n.a.	617	621
Care management																				
C1a-b	Number of full-time equivalent ² care managers/care coordinators ⁴																			
0	23%	5%	6%	4%	5%	32%	8%	4%	4%	3%	11%	3%	2%	2%	1%	12%	3%	2%	2%	3%
0.5	26%	33%	25%	21%	20%	18%	19%	18%	18%	16%	31%	27%	25%	18%	16%	18%	15%	18%	17%	13%
1-1.5	42%	41%	47%	51%	47%	29%	36%	44%	44%	43%	36%	35%	43%	47%	43%	44%	44%	45%	43%	45%
2-2.5	6%	12%	14%	12%	16%	10%	20%	17%	18%	21%	14%	22%	15%	18%	17%	15%	20%	16%	20%	24%
3+	2%	8%	7%	12%	11%	11%	17%	17%	17%	17%	8%	13%	15%	15%	22%	12%	18%	18%	18%	15%
N	541	545	547	547	546	505	507	507	506	507	611	608	607	612	612	618	616	619	622	620
C1a-b	Presence of care managers/care coordinators ⁴																			
Has at least one full-time care manager/care coordinator	40%	56%	56%	60%	62%	42%	66%	67%	60%	60%	47%	59%	60%	67%	66%	63%	75%	72%	72%	77%
Has at least one part-time (but no full-time) care manager/care coordinator	36%	38%	38%	37%	32%	25%	25%	28%	36%	36%	42%	37%	37%	31%	33%	25%	21%	26%	26%	20%
Has no care manager/care coordinator	23%	5%	6%	4%	5%	32%	8%	4%	4%	3%	11%	3%	2%	2%	1%	12%	3%	2%	2%	3%
N	547	547	547	547	547	509	509	509	509	509	612	612	612	612	612	622	622	622	622	622
C2	Among practices with a care manager/coordinator, clinical background of care managers/care coordinators (multiple responses possible)																			
Registered nurse (RN)	76%	75%	76%	80%	78%	65%	71%	72%	73%	71%	86%	87%	88%	89%	89%	70%	70%	72%	75%	78%
Licensed practical nurse (LPN) or licensed vocational nurse (LVN)	19%	19%	24%	20%	22%	15%	18%	20%	22%	22%	18%	19%	18%	21%	19%	25%	24%	23%	22%	20%
Medical assistant (MA)	22%	20%	29%	29%	27%	30%	37%	35%	30%	35%	16%	13%	15%	14%	13%	23%	27%	27%	23%	27%
Social worker	3%	11%	14%	17%	24%	17%	19%	23%	27%	31%	10%	20%	19%	29%	28%	14%	19%	18%	19%	24%
Other clinical background	5%	7%	6%	6%	9%	14%	13%	13%	18%	18%	7%	10%	10%	20%	14%	12%	16%	17%	15%	19%
No clinical background	5%	2%	2%	3%	5%	5%	4%	6%	4%	6%	4%	4%	3%	6%	9%	5%	6%	9%	5%	10%
N	414	514	510	524	516	337	466	488	487	492	543	591	596	600	604	540	595	605	609	602

Table 3.B.6b. (continued)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
C2a	Among practices with a care manager/coordinator, care managers and/or care coordinators have behavioral health training																			
Yes	n.a.	34%	47%	53%	54%	n.a.	41%	53%	57%	62%	n.a.	51%	61%	68%	72%	n.a.	45%	49%	52%	54%
No	n.a.	66%	53%	47%	46%	n.a.	59%	47%	43%	38%	n.a.	49%	39%	32%	28%	n.a.	55%	51%	48%	46%
N	n.a.	514	511	524	515	n.a.	463	481	488	492	n.a.	588	595	599	601	n.a.	591	599	607	601
C3	Among practices with a full-time care manager/coordinator, number of patients currently under longitudinal care management per full-time care manager ⁵																			
Mean	n.a.	n.a.	n.a.	121	101	n.a.	n.a.	n.a.	139	125	n.a.	n.a.	n.a.	164	136	n.a.	n.a.	n.a.	149	138
Median	n.a.	n.a.	n.a.	88	71	n.a.	n.a.	n.a.	94	85	n.a.	n.a.	n.a.	114	94	n.a.	n.a.	n.a.	103	100
N	n.a.	n.a.	n.a.	316	331	n.a.	n.a.	n.a.	295	301	n.a.	n.a.	n.a.	402	394	n.a.	n.a.	n.a.	448	479
C4	Among practices with only a full-time care manager/coordinator, number of hours worked per week on longitudinal care management per full-time care manager ⁵																			
Mean	n.a.	n.a.	n.a.	n.a.	21	n.a.	n.a.	n.a.	n.a.	24	n.a.	n.a.	n.a.	n.a.	25	n.a.	n.a.	n.a.	n.a.	24
Median	n.a.	n.a.	n.a.	n.a.	20	n.a.	n.a.	n.a.	n.a.	25	n.a.	n.a.	n.a.	n.a.	25	n.a.	n.a.	n.a.	n.a.	25
N	n.a.	n.a.	n.a.	n.a.	334	n.a.	n.a.	n.a.	n.a.	303	n.a.	n.a.	n.a.	n.a.	395	n.a.	n.a.	n.a.	n.a.	482
C5	Among practices with only a part-time care manager/coordinator, number of patients currently under longitudinal care management per part-time care manager ⁵																			
Mean	n.a.	n.a.	n.a.	93	80	n.a.	n.a.	n.a.	76	83	n.a.	n.a.	n.a.	124	71	n.a.	n.a.	n.a.	76	87
Median	n.a.	n.a.	n.a.	55	57	n.a.	n.a.	n.a.	50	57	n.a.	n.a.	n.a.	65	42	n.a.	n.a.	n.a.	50	50
N	n.a.	n.a.	n.a.	196	173	n.a.	n.a.	n.a.	178	185	n.a.	n.a.	n.a.	192	202	n.a.	n.a.	n.a.	148	114
C6	Among practices with only a part-time care manager/coordinator, number of hours worked per week on longitudinal care management per part-time care manager ⁵																			
Mean	n.a.	n.a.	n.a.	13	12	n.a.	n.a.	n.a.	14	13	n.a.	n.a.	n.a.	16	16	n.a.	n.a.	n.a.	15	14
Median	n.a.	n.a.	n.a.	12	8	n.a.	n.a.	n.a.	15	12	n.a.	n.a.	n.a.	13	12	n.a.	n.a.	n.a.	15	15
N	n.a.	n.a.	n.a.	196	172	n.a.	n.a.	n.a.	184	185	n.a.	n.a.	n.a.	192	201	n.a.	n.a.	n.a.	151	116

Table 3.B.6b. (continued)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
C3-6	Number of minutes spent per week on longitudinal care management per patient in longitudinal care management ⁶																			
Mean	n.a.	n.a.	n.a.	n.a.	23	n.a.	n.a.	n.a.	n.a.	24	n.a.	n.a.	n.a.	n.a.	23	n.a.	n.a.	n.a.	n.a.	23
Median	n.a.	n.a.	n.a.	n.a.	14	n.a.	n.a.	n.a.	n.a.	14	n.a.	n.a.	n.a.	n.a.	15	n.a.	n.a.	n.a.	n.a.	13
N	n.a.	n.a.	n.a.	n.a.	502	n.a.	n.a.	n.a.	n.a.	484	n.a.	n.a.	n.a.	n.a.	593	n.a.	n.a.	n.a.	n.a.	593
C7	Among practices with a care manager/coordinator, the amount of time typically spent by care managers on longitudinal care management activities for patients at this practice site changed during the coronavirus pandemic																			
Yes	n.a.	n.a.	n.a.	n.a.	47%	n.a.	n.a.	n.a.	n.a.	47%	n.a.	n.a.	n.a.	n.a.	45%	n.a.	n.a.	n.a.	n.a.	41%
No	n.a.	n.a.	n.a.	n.a.	37%	n.a.	n.a.	n.a.	n.a.	33%	n.a.	n.a.	n.a.	n.a.	37%	n.a.	n.a.	n.a.	n.a.	43%
Don't know	n.a.	n.a.	n.a.	n.a.	16%	n.a.	n.a.	n.a.	n.a.	21%	n.a.	n.a.	n.a.	n.a.	19%	n.a.	n.a.	n.a.	n.a.	16%
N	n.a.	n.a.	n.a.	n.a.	512	n.a.	n.a.	n.a.	n.a.	490	n.a.	n.a.	n.a.	n.a.	604	n.a.	n.a.	n.a.	n.a.	602

Table 3.B.6b. (continued)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
C8 Among practices with a care manager/coordinator, major challenges practice faces in providing longitudinal care management for chronic conditions (multiple responses possible)																				
Risk stratification methods used to identify patients for longitudinal care management are sometimes inaccurate or do not allow adjustment based on clinical judgment	n.a.	n.a.	n.a.	4%	1%	n.a.	n.a.	n.a.	6%	5%	n.a.	n.a.	n.a.	12%	2%	n.a.	n.a.	n.a.	3%	3%
Insufficient care manager staff time to provide longitudinal care management for chronic conditions	n.a.	n.a.	n.a.	13%	11%	n.a.	n.a.	n.a.	17%	21%	n.a.	n.a.	n.a.	14%	10%	n.a.	n.a.	n.a.	16%	17%
Insufficient community-based resources to meet patient needs	n.a.	n.a.	n.a.	16%	20%	n.a.	n.a.	n.a.	18%	22%	n.a.	n.a.	n.a.	19%	23%	n.a.	n.a.	n.a.	21%	21%
Logistical obstacles to reaching patients (such as incorrect patient contact information, hard to reach)	n.a.	n.a.	n.a.	6%	9%	n.a.	n.a.	n.a.	6%	9%	n.a.	n.a.	n.a.	15%	16%	n.a.	n.a.	n.a.	6%	7%
Lack of patient interest in interacting with a care manager	n.a.	n.a.	n.a.	9%	12%	n.a.	n.a.	n.a.	12%	14%	n.a.	n.a.	n.a.	5%	9%	n.a.	n.a.	n.a.	10%	9%
Insufficient practitioner buy-in of benefit of longitudinal care management services to patients	n.a.	n.a.	n.a.	4%	3%	n.a.	n.a.	n.a.	3%	2%	n.a.	n.a.	n.a.	3%	4%	n.a.	n.a.	n.a.	2%	2%
Insufficient organizational buy-in of benefit of longitudinal care management services to patients	n.a.	n.a.	n.a.	3%	2%	n.a.	n.a.	n.a.	6%	5%	n.a.	n.a.	n.a.	<1%	1%	n.a.	n.a.	n.a.	7%	8%
Other challenge	n.a.	n.a.	n.a.	3%	2%	n.a.	n.a.	n.a.	3%	4%	n.a.	n.a.	n.a.	1%	1%	n.a.	n.a.	n.a.	2%	2%
N	n.a.	n.a.	n.a.	544	528	n.a.	n.a.	n.a.	502	501	n.a.	n.a.	n.a.	606	611	n.a.	n.a.	n.a.	615	617

Table 3.B.6b. (continued)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
C9	Among practices that reported insufficient care manager staff time as a major or minor challenge, the main reason the practice does not have sufficient care manager staff time for longitudinal care management																			
	n.a.	n.a.	n.a.	20%	23%	n.a.	n.a.	n.a.	27%	24%	n.a.	n.a.	n.a.	24%	23%	n.a.	n.a.	n.a.	31%	24%
	Amount of CPC+ care management fees is not enough to support hiring more care managers																			
	n.a.	n.a.	n.a.	9%	15%	n.a.	n.a.	n.a.	14%	13%	n.a.	n.a.	n.a.	7%	18%	n.a.	n.a.	n.a.	12%	8%
	Health care system does not provide practice with as much care manager time as their patient population needs																			
	n.a.	n.a.	n.a.	42%	35%	n.a.	n.a.	n.a.	27%	31%	n.a.	n.a.	n.a.	42%	32%	n.a.	n.a.	n.a.	30%	29%
	Care manager staff time is focused on episodic care management (e.g., follow-up after hospital or ED visits)																			
	n.a.	n.a.	n.a.	9%	11%	n.a.	n.a.	n.a.	9%	18%	n.a.	n.a.	n.a.	12%	13%	n.a.	n.a.	n.a.	16%	27%
	Inadequate supply of qualified care managers available to hire																			
	n.a.	n.a.	n.a.	21%	16%	n.a.	n.a.	n.a.	23%	13%	n.a.	n.a.	n.a.	16%	13%	n.a.	n.a.	n.a.	11%	13%
	n.a.	n.a.	n.a.	279	300	n.a.	n.a.	n.a.	265	315	n.a.	n.a.	n.a.	308	323	n.a.	n.a.	n.a.	329	349

Table 3.B.6b. (continued)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
C1c	Among practices without a care manager/coordinator, the main reason the practice does not have a care manager/coordinator working as part a care team																			
	Amount of CPC+ care management fees is not enough to support hiring care managers					Health care system does not provide practice with care manager time					Practice or health care system does not think practice needs a care manager					Inadequate supply of qualified care managers available to hire				
	Insufficient space at practice to accommodate a care manager					Other					N									
	n.a.	n.a.	n.a.	5%	3%	n.a.	n.a.	n.a.	20%	23%	n.a.	n.a.	n.a.	9%	s.s.	n.a.	n.a.	n.a.	25%	10%
	n.a.	n.a.	n.a.	4%	13%	n.a.	n.a.	n.a.	0%	0%	n.a.	n.a.	n.a.	0%	s.s.	n.a.	n.a.	n.a.	8%	0%
	n.a.	n.a.	n.a.	9%	3%	n.a.	n.a.	n.a.	16%	6%	n.a.	n.a.	n.a.	8%	s.s.	n.a.	n.a.	n.a.	8%	0%
	n.a.	n.a.	n.a.	23%	10%	n.a.	n.a.	n.a.	9%	0%	n.a.	n.a.	n.a.	24%	s.s.	n.a.	n.a.	n.a.	16%	6%
	n.a.	n.a.	n.a.	5%	3%	n.a.	n.a.	n.a.	5%	18%	n.a.	n.a.	n.a.	8%	s.s.	n.a.	n.a.	n.a.	0%	24%
	n.a.	n.a.	n.a.	55%	68%	n.a.	n.a.	n.a.	49%	52%	n.a.	n.a.	n.a.	50%	s.s.	n.a.	n.a.	n.a.	42%	60%
	n.a.	n.a.	n.a.	22	31	n.a.	n.a.	n.a.	20	17	n.a.	n.a.	n.a.	12	8	n.a.	n.a.	n.a.	12	19
Data feedback on practice site's performance																				
D1	Practice site received data feedback on the performance of the practice or physicians within the practice site in the past 12 months. This data feedback may have been provided by private health insurers, Medicaid, Medicare, practice's own organization, state health agencies, or others.																			
	Yes																			
	No																			
	N																			
	n.a.	97%	97%	n.a.	97%	n.a.	95%	98%	n.a.	95%	n.a.	99%	99%	n.a.	97%	n.a.	96%	99%	n.a.	96%
	n.a.	3%	3%	n.a.	3%	n.a.	5%	2%	n.a.	5%	n.a.	1%	1%	n.a.	3%	n.a.	4%	1%	n.a.	4%
	n.a.	547	547	n.a.	546	n.a.	509	507	n.a.	509	n.a.	612	612	n.a.	612	n.a.	622	616	n.a.	621

Table 3.B.6b. (continued)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP				
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
D2	Percentage of practices that reported receiving...																			
Data feedback on patient experience (from surveys)	n.a.	91%	92%	n.a.	91%	n.a.	81%	94%	n.a.	88%	n.a.	96%	97%	n.a.	95%	n.a.	87%	95%	n.a.	93%
Data feedback on quality of care	n.a.	95%	94%	n.a.	94%	n.a.	90%	95%	n.a.	93%	n.a.	98%	97%	n.a.	95%	n.a.	94%	96%	n.a.	95%
Data feedback on cost	n.a.	91%	90%	n.a.	90%	n.a.	89%	92%	n.a.	90%	n.a.	88%	92%	n.a.	94%	n.a.	91%	95%	n.a.	90%
Data feedback on utilization	n.a.	92%	93%	n.a.	94%	n.a.	91%	94%	n.a.	93%	n.a.	91%	93%	n.a.	95%	n.a.	93%	96%	n.a.	92%
N	n.a.	547	547	n.a.	547	n.a.	509	509	n.a.	509	n.a.	612	612	n.a.	612	n.a.	622	622	n.a.	622
Among practices that reported receiving each type of data feedback, practice site has changed how it delivers care in response to...																				
D2a	...Data feedback on patient experience (from surveys)																			
Yes, major changes	n.a.	12%	16%	n.a.	6%	n.a.	17%	13%	n.a.	10%	n.a.	12%	19%	n.a.	13%	n.a.	18%	23%	n.a.	10%
Yes, minor changes	n.a.	82%	73%	n.a.	75%	n.a.	71%	74%	n.a.	68%	n.a.	83%	72%	n.a.	66%	n.a.	73%	63%	n.a.	72%
No change	n.a.	4%	10%	n.a.	14%	n.a.	8%	11%	n.a.	18%	n.a.	4%	6%	n.a.	19%	n.a.	6%	8%	n.a.	15%
Don't know if changes were made	n.a.	2%	<1%	n.a.	4%	n.a.	3%	3%	n.a.	3%	n.a.	1%	2%	n.a.	3%	n.a.	4%	6%	n.a.	2%
N	n.a.	501	506	n.a.	499	n.a.	414	479	n.a.	448	n.a.	588	592	n.a.	582	n.a.	534	592	n.a.	576
D2b	...Data feedback on quality of care																			
Yes, major changes	n.a.	36%	35%	n.a.	12%	n.a.	30%	22%	n.a.	13%	n.a.	31%	40%	n.a.	24%	n.a.	24%	29%	n.a.	16%
Yes, minor changes	n.a.	57%	57%	n.a.	65%	n.a.	59%	64%	n.a.	65%	n.a.	64%	46%	n.a.	57%	n.a.	68%	63%	n.a.	64%
No change	n.a.	5%	8%	n.a.	19%	n.a.	10%	12%	n.a.	20%	n.a.	4%	12%	n.a.	17%	n.a.	7%	7%	n.a.	17%
Don't know if changes were made	n.a.	2%	<1%	n.a.	5%	n.a.	2%	2%	n.a.	2%	n.a.	1%	2%	n.a.	2%	n.a.	1%	1%	n.a.	3%
N	n.a.	522	513	n.a.	514	n.a.	456	486	n.a.	476	n.a.	598	594	n.a.	583	n.a.	582	599	n.a.	590
D2c	...Data feedback on cost																			
Yes, major changes	n.a.	9%	13%	n.a.	3%	n.a.	5%	8%	n.a.	6%	n.a.	10%	19%	n.a.	9%	n.a.	10%	12%	n.a.	10%
Yes, minor changes	n.a.	63%	61%	n.a.	47%	n.a.	54%	48%	n.a.	45%	n.a.	49%	50%	n.a.	56%	n.a.	55%	50%	n.a.	39%
No change	n.a.	20%	22%	n.a.	34%	n.a.	28%	34%	n.a.	37%	n.a.	15%	25%	n.a.	23%	n.a.	26%	28%	n.a.	37%
Don't know if changes were made	n.a.	8%	5%	n.a.	17%	n.a.	13%	9%	n.a.	11%	n.a.	26%	6%	n.a.	11%	n.a.	9%	10%	n.a.	14%
N	n.a.	498	494	n.a.	494	n.a.	454	468	n.a.	460	n.a.	541	561	n.a.	575	n.a.	569	589	n.a.	562
D2d	...Data feedback on utilization																			
Yes, major changes	n.a.	19%	22%	n.a.	14%	n.a.	19%	17%	n.a.	10%	n.a.	25%	25%	n.a.	24%	n.a.	18%	21%	n.a.	15%
Yes, minor changes	n.a.	66%	63%	n.a.	58%	n.a.	62%	62%	n.a.	61%	n.a.	62%	59%	n.a.	53%	n.a.	62%	63%	n.a.	53%
No change	n.a.	12%	11%	n.a.	17%	n.a.	14%	16%	n.a.	24%	n.a.	7%	12%	n.a.	18%	n.a.	14%	12%	n.a.	21%
Don't know if changes were made	n.a.	4%	4%	n.a.	10%	n.a.	5%	5%	n.a.	5%	n.a.	6%	3%	n.a.	5%	n.a.	6%	4%	n.a.	11%
N	n.a.	506	510	n.a.	514	n.a.	466	478	n.a.	475	n.a.	559	571	n.a.	581	n.a.	581	598	n.a.	576

Table 3.B.6b. (continued)

Question ¹	Track 1 – SSP					Track 1 – Not SSP					Track 2 – SSP					Track 2 – Not SSP					
	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 1 (2017)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
Use of health information technology																					
E1	Practice site uses an Electronic Health Record (EHR) system																				
	Yes	100%	100%	100%	n.a.	100%	100%	100%	n.a.	100%	100%	100%	100%	n.a.	100%	100%	100%	100%	n.a.	100%	
	No	<1%	0%	<1%	n.a.	0%	<1%	0%	n.a.	<1%	0%	0%	0%	n.a.	0%	<1%	0%	0%	n.a.	0%	
	N	544	543	545	n.a.	545	506	504	506	n.a.	505	611	609	610	n.a.	611	621	620	615	n.a.	619
Completion of the survey																					
J1	Who provided input in completing the survey (multiple responses possible)																				
	Practice or office manager	82%	68%	70%	72%	63%	82%	76%	75%	76%	64%	83%	75%	78%	73%	63%	82%	78%	74%	72%	66%
	Lead physician	26%	13%	12%	12%	11%	37%	29%	23%	23%	18%	27%	21%	12%	16%	14%	38%	23%	20%	22%	16%
	Other physicians	5%	2%	3%	1%	1%	7%	4%	3%	1%	3%	4%	4%	2%	9%	3%	10%	5%	3%	4%	3%
	Nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA)	6%	2%	2%	1%	1%	6%	4%	5%	2%	3%	6%	3%	2%	4%	4%	8%	4%	5%	4%	3%
	Care manager/coordinator	33%	34%	27%	40%	30%	29%	29%	28%	30%	21%	41%	28%	25%	47%	49%	41%	30%	23%	32%	25%
	Nursing staff, including nurse manager or supervisor	11%	4%	3%	5%	3%	15%	12%	8%	6%	4%	10%	4%	3%	4%	5%	15%	5%	5%	5%	4%
	Medical assistant staff	14%	7%	2%	3%	2%	18%	14%	7%	5%	4%	10%	6%	2%	1%	1%	14%	3%	5%	4%	3%
	Quality improvement staff	36%	35%	34%	40%	34%	31%	33%	26%	25%	30%	25%	30%	39%	49%	50%	26%	27%	26%	30%	35%
	Administrative support staff (e.g., billing or finance staff, front desk staff)	30%	24%	13%	20%	15%	23%	14%	14%	11%	6%	21%	28%	23%	23%	32%	23%	12%	9%	14%	9%
	Non-physician owner of practice	n.a.	<1%	0%	0%	0%	n.a.	1%	<1%	1%	1%	n.a.	1%	<1%	0%	<1%	n.a.	1%	1%	<1%	0%
	Leadership or staff from larger health care system or medical group	27%	21%	17%	21%	15%	16%	9%	12%	16%	17%	28%	23%	38%	24%	26%	18%	17%	14%	11%	13%
	Data analytics staff	n.a.	24%	19%	18%	11%	n.a.	15%	13%	11%	10%	n.a.	24%	23%	26%	26%	n.a.	13%	11%	10%	13%
	CPC+ lead	n.a.	39%	40%	39%	32%	n.a.	32%	31%	26%	28%	n.a.	39%	50%	53%	49%	n.a.	27%	30%	25%	23%
	Patients	<1%	<1%	<1%	0%	<1%	1%	1%	<1%	0%	0%	<1%	<1%	<1%	0%	0%	0%	1%	<1%	<1%	<1%
	Other	11%	2%	1%	2%	1%	15%	4%	6%	5%	3%	14%	5%	2%	2%	3%	8%	3%	4%	1%	3%
	N	546	547	543	545	545	509	508	507	509	508	612	611	612	609	612	622	621	620	620	618

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ The question numbering is based on the PY 5 survey.

Table 3.B.6b. (continued)

² Practices entered number of full time and part time staff separately. Full time equivalent counts were estimated by counting all full-time staff as 1 FTE and all part-time staff as 0.5 FTE.

³ Practitioners include physicians (MD or DO, not including psychiatrists), physician residents or fellows (trainees), nurse practitioners, physician assistants, and clinical nurse specialists. Non-physician practitioners include all types of practitioners listed but physicians.

⁴ Item wording changed during the PY 1 survey to clarify that it was asking about care managers/coordinators who work as part of the practice's care team, regardless of where they physically work. Out of 2,833 2017 Starter practices who responded to this question, 799 practices responded before the wording change.

⁵ These questions only asked about the patient count for one care manager. If the practice had any full-time care managers, the patient count and hours worked are for a full-time care manager (reported in C3 and C4). If the practice only had part-time care managers, the patient count and hours worked are for a part-time care manager (reported in C5 and C6). If the practice had more than one care manager that fit either of these descriptions, they were asked to report patient counts and hours worked for the care manager whose first name came first alphabetically. The hours worked per week on longitudinal care management (reported in C4 or C6) is for the care manager with the patient count reported in C3 or C5. Nine practices answered at the top of the survey-allowed range, which may not accurately reflect their actual patient count: 4 responded that the patient count for their full-time care manager was 999 (reported in C3), and 5 responded that the patient count for their part-time care manager was 500 (reported in C5); these are included in the mean and median calculations.

⁶ These values were calculated by taking the number of reported hours one care manager spends in an average week on longitudinal care management divided by the number of patients currently under longitudinal care management with that care manager. This was multiplied by 60 to produce the number of minutes.

FTE = full-time equivalent; n.a. = not applicable because the survey question was not asked in that wave or to the specified group of practices; NPI = National Provider Identifier; PY = Program Year; s.s. = small sample. Cells with fewer than 11 responses have been suppressed; SSP = Medicare Shared Savings Program (reflects 2021 [PY 5] participation, or, for practices that withdrew from CPC+ their participation at the time of withdrawal).

Table 3.B.7a. CPC+ practices' responses to questions about their experience with CPC+ payments, overall and by track (2017 Starters)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
Sources of practice revenue												
F1	Percentage of practice site's revenue that came from fee-for-service (FFS) payments in [the prior year]											
Mean	77.14	77.21	75.76	72.64	78.19	78.71	80.02	76.38	76.25	75.97	72.21	69.54
Median	85.00	85.00	85.00	80.00	90.00	89.00	88.00	85.00	82.00	80.00	80.00	78.00
N	2,142	2,192	2,223	2,202	999	1,005	1,021	1,012	1,143	1,187	1,202	1,190
CPC+ payments from Medicare FFS												
G1	Considering the amount of work required by CPC+, the adequacy of the CPC+ payments from Medicare FFS											
More than adequate	1%	1%	3%	3%	1%	1%	2%	2%	1%	1%	3%	4%
Adequate	46%	48%	52%	52%	40%	40%	48%	50%	51%	54%	55%	54%
Less than adequate	43%	43%	39%	34%	47%	48%	43%	36%	39%	39%	36%	33%
Don't know - not familiar with CPC+ payments from Medicare FFS or costs of doing CPC+ work	11%	8%	6%	10%	12%	10%	7%	12%	10%	6%	6%	9%
N	2,272	2,275	2,277	2,274	1,051	1,049	1,055	1,048	1,221	1,226	1,222	1,226
The Performance-Based Incentive Payment (PBIP) is paid prospectively by CMS at the beginning of each program year²...												
G2a	...Practice understands how Medicare FFS calculates the proportion of the PBIP the practice will retain and the proportion CMS recoups											
Strongly agree	9%	16%	20%	18%	9%	14%	23%	17%	9%	17%	18%	18%
Agree	62%	65%	70%	71%	59%	62%	67%	71%	65%	67%	71%	71%
Disagree	24%	16%	9%	7%	27%	19%	9%	6%	21%	14%	10%	8%
Strongly disagree	5%	3%	1%	4%	5%	5%	1%	6%	5%	2%	1%	3%
N	1,160	1,346	1,297	1,283	476	520	544	548	684	826	753	735
G2b	...Practice feels that Medicare FFS's methodology is fair in how it determines the proportion of the PBIP the practice retains and the proportion CMS recoups											
Strongly agree	2%	5%	5%	5%	3%	7%	6%	4%	2%	4%	4%	6%
Agree	44%	48%	56%	57%	42%	47%	56%	56%	45%	49%	57%	58%
Disagree	20%	25%	24%	20%	18%	24%	24%	23%	22%	26%	23%	18%
Strongly disagree	6%	6%	4%	2%	5%	7%	5%	2%	6%	5%	4%	2%
Don't know	28%	15%	11%	15%	32%	16%	9%	15%	25%	15%	12%	15%
N	1,181	1,369	1,307	1,297	486	525	547	551	695	844	760	746
The Comprehensive Primary Care Payment (CPCP) is paid quarterly as a lump sum to Track 2 practices for evaluation and management services³...												
G3a	...Practice understands how Medicare FFS calculated its CPCPs											
Strongly agree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	10%	19%	15%	15%
Agree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	68%	64%	72%	76%
Disagree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	18%	16%	12%	8%
Strongly disagree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3%	1%	1%	2%
N	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1,166	1,189	1,187	1,195

Table 3.B.7a. (continued)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
G3b	...Practice feels that Medicare FFS's methodology is fair in how it calculates CPCPs												
	Strongly agree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	4%	6%	6%	7%
	Agree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	51%	57%	66%	66%
	Disagree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	17%	22%	14%	13%
	Strongly disagree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3%	2%	2%	1%
	Don't know	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	25%	13%	13%	13%
	N	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1,221	1,222	1,228	1,227
CPC+ payments from CPC+ payer partners (not Medicare FFS)													
G4	Practice contracts with CPC+ payer partners (payers other than Medicare FFS) for CPC+ ⁴												
	Yes	81%	79%	89%	77%	76%	72%	86%	70%	85%	85%	92%	82%
	No	19%	21%	11%	23%	24%	28%	14%	30%	15%	15%	8%	18%
	N	2,248	2,269	2,285	2,266	1,032	1,047	1,055	1,044	1,216	1,222	1,230	1,222
G4a	Among practices that contract with CPC+ payer partners for CPC+, considering the amount of work required by CPC+, the adequacy of the CPC+ payments from CPC+ payer partners ⁵												
	More than adequate	<1%	1%	2%	2%	1%	1%	1%	1%	<1%	1%	3%	3%
	Adequate	31%	39%	40%	43%	29%	35%	40%	41%	33%	41%	41%	44%
	Less than adequate	56%	50%	43%	43%	55%	49%	44%	41%	57%	51%	42%	44%
	Don't know - not familiar with CPC+ payments from CPC+ payer partners or costs of doing CPC+ work	12%	10%	15%	13%	15%	15%	16%	16%	10%	7%	15%	10%
	N	1,823	1,801	2,031	1,730	793	759	903	727	1,030	1,042	1,128	1,003

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ Survey questions in this table were not asked in the PY 1 survey. The question numbering is based on the PY 5 survey.

² Practices participating in the SSP every year from 2019 to 2021 did not receive the Performance-based Incentive Payment for any of those years and therefore were not asked these questions.

³ The Comprehensive Primary Care Payment (CPCP) is a lump sum quarterly payment paid to Track 2 practices based on their historical fee-for-service (FFS) payment amounts for evaluation and management services. Track 2 practices' FFS payments for these services are reduced to account for the CPCP. Track 1 practices do not receive CPCPs and therefore were not asked these questions.

⁴ The question changed significantly between PY 3, PY 4, and PY 5. In PY 3, the question asked whether the practice contracted with payer partners. In PY 4, the question asked which specific payers the practice contracted with. PY 4 responses are counted as a "yes" response in this table if any of the payers were selected. The PY 5 question reverted to the PY 3 wording.

⁵ Practices were asked to consider this question across all payers they contracted with for CPC+, even if they did not provide a separate CPC+ payment.

n.a. = not applicable, because the survey question was not asked in that wave or to the specified group of practices; PY = Program Year; SSP = Medicare Shared Savings Program.

Table 3.B.7b. CPC+ practices' responses to questions about their experience with CPC+ payments, within track by SSP status (2017 Starters)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
Sources of practice revenue																
F1	Percentage of practice site's revenue that came from fee-for-service (FFS) payments in [the prior year]															
Mean	77.35	78.93	80.63	76.62	79.06	78.48	79.37	76.12	78.71	79.74	74.71	71.91	74.25	72.51	69.94	67.33
Median	90.00	90.00	89.00	85.00	90.00	86.00	87.00	85.00	85.00	84.00	85.00	85.00	80.00	79.00	78.00	75.00
N	510	513	526	519	489	492	495	493	539	597	600	603	604	590	602	587
CPC+ payments from Medicare FFS																
G1	Considering the amount of work required by CPC+, the adequacy of the CPC+ payments from Medicare FFS															
More than adequate	1%	1%	2%	2%	1%	2%	2%	2%	1%	1%	5%	7%	<1%	1%	1%	2%
Adequate	40%	38%	48%	49%	40%	42%	49%	51%	48%	61%	53%	49%	53%	48%	57%	59%
Less than adequate	46%	49%	43%	35%	49%	46%	43%	38%	41%	35%	39%	38%	37%	42%	33%	27%
Don't know - not familiar with CPC+ payments from Medicare FFS or costs of doing CPC+ work	13%	11%	7%	14%	10%	9%	7%	9%	9%	3%	3%	6%	10%	9%	9%	12%
N	543	544	546	543	508	505	509	505	603	611	607	611	618	615	615	615
The Performance-Based Incentive Payment (PBIP) is paid prospectively by CMS at the beginning of each program year²...																
G2a	...Practice understands how Medicare FFS calculates the proportion of the PBIP the practice will retain and the proportion CMS recoups															
Strongly agree	8%	20%	15%	13%	10%	13%	24%	17%	10%	17%	8%	8%	8%	17%	20%	21%
Agree	54%	53%	82%	78%	60%	64%	65%	71%	62%	65%	89%	90%	66%	67%	68%	67%
Disagree	31%	17%	3%	9%	26%	19%	10%	6%	18%	13%	3%	2%	23%	15%	11%	10%
Strongly disagree	7%	10%	0%	0%	4%	4%	2%	6%	10%	6%	0%	1%	3%	1%	1%	3%
N	94	112	68	46	382	408	476	502	195	244	143	133	489	582	610	602
G2b	...Practice feels that Medicare FFS's methodology is fair in how it determines the proportion of the PBIP the practice retains and the proportion CMS recoups															
Strongly agree	5%	16%	9%	7%	2%	5%	6%	3%	1%	5%	3%	1%	2%	4%	4%	7%
Agree	47%	45%	57%	50%	41%	47%	55%	56%	46%	52%	55%	72%	45%	48%	57%	56%
Disagree	15%	22%	25%	27%	18%	24%	24%	23%	18%	12%	34%	18%	23%	31%	21%	18%
Strongly disagree	8%	8%	1%	2%	4%	7%	6%	2%	17%	9%	1%	1%	2%	4%	4%	3%
Don't know	25%	9%	7%	15%	34%	17%	9%	15%	18%	22%	7%	9%	27%	13%	13%	17%
N	97	113	69	46	389	412	478	505	195	249	142	133	500	595	618	613

Table 3.B.7b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
The Comprehensive Primary Care Payment (CPCP) is paid quarterly as a lump sum to Track 2 practices for evaluation and management services^{3...}																	
G3a	...Practice understands how Medicare FFS calculated its CPCPs																
	Strongly agree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	13%	26%	16%	15%	8%	13%	13%	15%
	Agree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	64%	61%	73%	79%	72%	67%	71%	72%
	Disagree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	19%	12%	10%	5%	18%	19%	14%	10%
	Strongly disagree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	4%	1%	1%	1%	2%	1%	2%	3%
	N	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	580	595	585	592	586	594	602	603
G3b	...Practice feels that Medicare FFS's methodology is fair in how it calculates CPCPs																
	Strongly agree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	7%	11%	6%	6%	2%	1%	5%	7%
	Agree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	55%	59%	69%	69%	48%	55%	63%	62%
	Disagree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	16%	18%	12%	14%	19%	26%	15%	12%
	Strongly disagree	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3%	2%	<1%	<1%	2%	2%	3%	2%
	Don't know	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	19%	9%	12%	10%	29%	16%	13%	17%
	N	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	604	607	608	608	617	615	620	619
CPC+ payments from CPC+ payer partners (not Medicare FFS)																	
G4	Practice contracts with CPC+ payer partners (payers other than Medicare FFS) for CPC+ ⁴																
	Yes	75%	69%	81%	70%	78%	76%	90%	70%	83%	87%	90%	82%	86%	84%	94%	82%
	No	25%	31%	19%	30%	22%	24%	10%	30%	17%	13%	10%	18%	14%	16%	6%	18%
	N	537	543	546	539	495	504	509	505	597	607	610	605	619	615	620	617
G4a	Among practices that contract with CPC+ payer partners for CPC+, considering the amount of work required by CPC+, the adequacy of the CPC+ payments from CPC+ payer partners ⁵																
	More than adequate	<1%	1%	1%	1%	1%	2%	1%	1%	<1%	1%	4%	4%	0%	1%	1%	1%
	Adequate	26%	28%	40%	43%	32%	42%	39%	40%	36%	44%	41%	41%	31%	39%	40%	45%
	Less than adequate	58%	53%	44%	38%	52%	45%	45%	45%	55%	50%	36%	47%	58%	51%	46%	41%
	Don't know - not familiar with CPC+ payments from CPC+ payer partners or costs of doing CPC+ work	15%	18%	16%	18%	15%	11%	16%	14%	9%	5%	18%	7%	11%	9%	13%	13%
	N	405	376	443	374	388	383	460	353	500	532	547	497	530	510	581	506

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ Survey questions in this table were not asked in the PY 1 survey. The question numbering is based on the PY 5 survey.

² Practices participating in the SSP every year from 2019 to 2021 did not receive the Performance-based Incentive Payment for any of those years and therefore were not asked these questions.

Table 3.B.7b. (continued)

³ The Comprehensive Primary Care Payment (CPCP) is a lump sum quarterly payment paid to Track 2 practices based on their historical fee-for-service (FFS) payment amounts for evaluation and management services. Track 2 practices' FFS payments for these services are reduced to account for the CPCP. Track 1 practices do not receive CPCPs and therefore were not asked these questions.

⁴ The question changed significantly between PY 3, PY 4, and PY 5. In PY 3, the question asked whether the practice contracted with payer partners. In PY 4, the question asked which specific payers the practice contracted with. PY 4 responses are counted as a "yes" response in this table if any of the payers were selected. The PY 5 question reverted to the PY 3 wording.

⁵ Practices were asked to consider this question across all payers they contracted with for CPC+, even if they did not provide a separate CPC+ payment.

n.a. = not applicable, because the survey question was not asked in that wave or to the specified group of practices; PY = Program Year; SSP = Medicare Shared Savings Program (reflects 2021 [PY 5] participation, or, for practices that withdrew from CPC+, their participation at the time of withdrawal).

Table 3.B.8a. CPC+ practices' responses to questions about their experiences with learning activities and assistance and supports from payers, overall and by track (2017 Starters)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
CPC+ learning activities and assistance													
H1	Rating of services from regional learning network organizations in meeting practice site's CPC+-related needs and helping improve primary care												
	Excellent	15%	15%	20%	19%	16%	13%	19%	18%	14%	18%	22%	20%
	Very good	29%	29%	31%	33%	29%	32%	32%	33%	30%	26%	30%	32%
	Good	39%	39%	34%	34%	39%	36%	33%	34%	39%	42%	36%	34%
	Fair	15%	15%	12%	13%	14%	17%	14%	13%	15%	13%	10%	12%
	Poor	2%	2%	2%	1%	2%	2%	2%	2%	2%	1%	3%	1%
	N	2,274	2,272	2,272	2,278	1,048	1,048	1,050	1,050	1,226	1,224	1,222	1,228
Rating of usefulness of assistance received in the past six months from the CPC+ national learning community and regional learning network in improving primary care...													
H2a	...Webinars ²												
	Very useful	25%	26%	20%	17%	29%	28%	22%	18%	22%	24%	18%	16%
	Somewhat useful	55%	55%	38%	41%	47%	51%	35%	40%	62%	58%	40%	42%
	Not very useful	9%	8%	7%	11%	10%	8%	7%	10%	9%	9%	8%	12%
	Not at all useful	1%	1%	2%	1%	1%	1%	1%	1%	1%	2%	3%	2%
	Never received or attended	9%	10%	33%	29%	14%	11%	35%	31%	6%	8%	31%	28%
	N	2,281	2,269	2,193	2,203	1,056	1,048	1,011	1,013	1,225	1,221	1,182	1,190
H2b	...One-on-one telephone/virtual coaching with the practice site to improve practice processes and workflows												
	Very useful	34%	34%	38%	34%	36%	38%	42%	35%	32%	31%	35%	33%
	Somewhat useful	23%	27%	22%	25%	19%	25%	17%	24%	25%	29%	25%	25%
	Not very useful	7%	5%	4%	7%	5%	5%	3%	5%	9%	4%	4%	8%
	Not at all useful	3%	1%	1%	2%	3%	1%	1%	3%	3%	1%	1%	2%
	Never received or attended	34%	33%	36%	33%	37%	32%	37%	34%	31%	35%	35%	32%
	N	2,272	2,266	2,272	2,270	1,047	1,051	1,047	1,047	1,225	1,215	1,225	1,223
H2c	...CPC+ Connect (the online information resource and collaboration website)												
	Very useful	38%	41%	39%	38%	42%	41%	44%	39%	34%	41%	35%	36%
	Somewhat useful	45%	42%	46%	46%	40%	39%	40%	46%	50%	44%	50%	46%
	Not very useful	9%	8%	8%	8%	10%	10%	7%	7%	8%	8%	8%	9%
	Not at all useful	2%	3%	2%	2%	2%	3%	2%	2%	2%	2%	1%	1%
	Never received or attended	6%	6%	6%	6%	7%	7%	7%	7%	6%	6%	6%	6%
	N	2,274	2,269	2,279	2,282	1,048	1,052	1,052	1,050	1,226	1,217	1,227	1,232
H2d	...CPC+ Implementation Guides												
	Very useful	57%	61%	59%	62%	53%	59%	56%	60%	60%	63%	61%	64%
	Somewhat useful	33%	31%	31%	28%	35%	32%	33%	30%	32%	30%	29%	27%
	Not very useful	5%	4%	4%	4%	7%	5%	4%	5%	3%	4%	4%	3%
	Not at all useful	<1%	1%	<1%	<1%	<1%	1%	1%	<1%	<1%	1%	<1%	<1%
	Never received or attended	5%	4%	6%	5%	4%	4%	6%	5%	5%	3%	5%	5%

Table 3.B.8a. (continued)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
N	2,274	2,266	2,275	2,280	1,050	1,050	1,047	1,051	1,224	1,216	1,228	1,229
H2e	...CPC+ Support (CPC+ help desk)											
Very useful	52%	62%	59%	63%	48%	63%	57%	63%	55%	62%	60%	63%
Somewhat useful	31%	24%	25%	23%	34%	23%	25%	23%	28%	25%	25%	22%
Not very useful	5%	4%	3%	4%	7%	4%	3%	3%	3%	3%	3%	5%
Not at all useful	1%	1%	1%	<1%	1%	1%	1%	1%	2%	1%	1%	<1%
Never received or attended	11%	9%	12%	10%	11%	9%	14%	11%	11%	9%	11%	10%
N	2,278	2,264	2,277	2,285	1,052	1,048	1,049	1,053	1,226	1,216	1,228	1,232
H2f	...Group coaching											
Very useful	n.a.	n.a.	22%	19%	n.a.	n.a.	25%	22%	n.a.	n.a.	20%	17%
Somewhat useful	n.a.	n.a.	23%	29%	n.a.	n.a.	20%	29%	n.a.	n.a.	25%	30%
Not very useful	n.a.	n.a.	5%	8%	n.a.	n.a.	7%	8%	n.a.	n.a.	4%	9%
Not at all useful	n.a.	n.a.	1%	2%	n.a.	n.a.	1%	2%	n.a.	n.a.	1%	1%
Never received or attended	n.a.	n.a.	49%	42%	n.a.	n.a.	47%	40%	n.a.	n.a.	50%	43%
N	n.a.	n.a.	2,278	2,282	n.a.	n.a.	1,053	1,051	n.a.	n.a.	1,225	1,231
CPC+ payer partner support and assistance												
Rating of usefulness of assistance received in the past six months from CPC+ payer partners in improving primary care³...												
H3a	...On-site care manager provided by the payer											
Very useful	8%	11%	8%	9%	10%	13%	8%	11%	7%	9%	8%	8%
Somewhat useful	7%	10%	9%	9%	7%	11%	10%	9%	7%	10%	8%	9%
Not very useful	2%	2%	2%	2%	2%	2%	1%	1%	2%	3%	3%	2%
Not at all useful	1%	1%	2%	1%	<1%	<1%	1%	1%	1%	1%	3%	1%
Never received or attended	82%	76%	79%	79%	80%	74%	79%	78%	83%	78%	79%	80%
N	1,835	1,799	2,021	1,744	810	761	893	732	1,025	1,038	1,128	1,012
H3b	...Telephone-based care manager provided by the payer											
Very useful	9%	10%	9%	8%	8%	9%	9%	11%	10%	11%	8%	7%
Somewhat useful	14%	19%	18%	19%	13%	18%	16%	24%	15%	19%	19%	16%
Not very useful	6%	8%	8%	8%	5%	9%	9%	8%	6%	8%	8%	8%
Not at all useful	1%	2%	3%	2%	1%	1%	2%	1%	2%	3%	4%	2%
Never received or attended	70%	61%	62%	62%	73%	63%	65%	57%	67%	59%	60%	66%
N	1,833	1,775	2,016	1,741	810	757	891	729	1,023	1,018	1,125	1,012
H3c	...Explanation of payers' CPC+ payment methodologies											
Very useful	12%	12%	14%	15%	15%	12%	14%	15%	10%	11%	15%	15%
Somewhat useful	30%	35%	33%	32%	28%	32%	34%	35%	31%	37%	33%	29%
Not very useful	8%	11%	8%	8%	8%	12%	8%	7%	9%	10%	8%	9%
Not at all useful	2%	2%	2%	2%	1%	4%	1%	2%	2%	1%	3%	2%
Never received or attended	48%	40%	43%	43%	48%	41%	43%	41%	48%	40%	42%	44%
N	1,835	1,796	2,015	1,742	808	760	892	730	1,027	1,036	1,123	1,012

Table 3.B.8a. (continued)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
H3d	...Training on how to access data feedback provided by the payer												
	Very useful	14%	13%	17%	20%	16%	16%	18%	18%	12%	11%	17%	22%
	Somewhat useful	33%	40%	33%	36%	29%	32%	30%	39%	37%	45%	35%	34%
	Not very useful	7%	8%	7%	5%	9%	10%	7%	5%	6%	6%	6%	5%
	Not at all useful	1%	3%	2%	1%	1%	3%	1%	<1%	1%	3%	2%	1%
	Never received or attended	45%	37%	42%	39%	45%	39%	44%	38%	44%	35%	41%	39%
	N	1,834	1,797	2,019	1,745	809	759	892	734	1,025	1,038	1,127	1,011
H3e	...Training on how to use data feedback provided by the payer												
	Very useful	14%	13%	15%	18%	16%	15%	15%	17%	12%	11%	15%	19%
	Somewhat useful	31%	38%	33%	35%	30%	33%	32%	35%	32%	41%	34%	34%
	Not very useful	7%	10%	8%	7%	7%	11%	8%	6%	7%	9%	8%	7%
	Not at all useful	2%	3%	2%	1%	1%	2%	1%	1%	2%	3%	2%	1%
	Never received or attended	46%	37%	42%	40%	45%	38%	43%	42%	46%	36%	40%	39%
	N	1,835	1,798	2,019	1,744	811	759	892	733	1,024	1,039	1,127	1,011
H3f	...Coaching on how to improve practice processes and workflows												
	Very useful	12%	15%	14%	16%	15%	16%	15%	17%	9%	15%	13%	15%
	Somewhat useful	26%	29%	28%	27%	24%	28%	29%	32%	27%	29%	28%	24%
	Not very useful	10%	9%	6%	8%	9%	9%	5%	6%	10%	8%	8%	10%
	Not at all useful	1%	4%	4%	1%	1%	3%	3%	1%	1%	4%	4%	1%
	Never received or attended	51%	44%	47%	47%	51%	44%	49%	43%	52%	43%	46%	50%
	N	1,833	1,796	2,019	1,742	808	757	892	732	1,025	1,039	1,127	1,010
Usefulness of CPC+ supports in improving primary care (supports from all payers)													
I6a	Financial support												
	Very useful	49%	50%	58%	57%	47%	49%	57%	53%	50%	50%	59%	60%
	Somewhat useful	30%	36%	31%	29%	30%	34%	32%	32%	30%	37%	30%	26%
	Not very useful	8%	5%	4%	3%	9%	7%	6%	5%	6%	4%	3%	2%
	Not at all useful	1%	1%	<1%	<1%	1%	1%	<1%	<1%	1%	1%	<1%	<1%
	Don't know	12%	9%	6%	10%	12%	9%	5%	10%	12%	8%	8%	11%
	N	2,280	2,271	2,281	2,280	1,054	1,046	1,053	1,051	1,226	1,225	1,228	1,229
I6b	Learning support												
	Very useful	33%	32%	35%	32%	34%	33%	35%	36%	31%	30%	35%	29%
	Somewhat useful	55%	58%	53%	54%	51%	54%	52%	50%	58%	61%	54%	57%
	Not very useful	6%	6%	6%	7%	7%	7%	8%	6%	5%	5%	5%	8%
	Not at all useful	1%	<1%	1%	<1%	1%	1%	1%	1%	1%	<1%	1%	<1%
	Don't know	6%	4%	5%	7%	6%	4%	4%	8%	5%	4%	5%	7%
	N	2,280	2,276	2,280	2,280	1,053	1,046	1,053	1,051	1,227	1,230	1,227	1,229

Table 3.B.8a. (continued)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
I6c	Data feedback												
	Very useful	37%	32%	34%	34%	37%	34%	33%	34%	37%	31%	34%	34%
	Somewhat useful	47%	52%	47%	46%	46%	50%	48%	47%	47%	54%	46%	46%
	Not very useful	10%	10%	12%	12%	11%	10%	12%	10%	10%	11%	13%	14%
	Not at all useful	1%	1%	2%	1%	2%	1%	3%	2%	1%	1%	2%	<1%
	Don't know	5%	4%	5%	6%	5%	4%	4%	7%	6%	3%	5%	6%
	N	2,279	2,279	2,280	2,279	1,055	1,048	1,052	1,051	1,224	1,231	1,228	1,228
I6d	Health IT vendor support												
	Very useful	17%	18%	20%	23%	16%	19%	19%	24%	18%	17%	20%	23%
	Somewhat useful	35%	40%	35%	35%	32%	36%	34%	32%	37%	45%	37%	38%
	Not very useful	21%	17%	14%	13%	21%	18%	15%	15%	22%	16%	13%	11%
	Not at all useful	5%	6%	9%	6%	8%	5%	10%	5%	3%	7%	8%	6%
	Don't know	21%	18%	22%	23%	22%	23%	22%	23%	20%	15%	22%	22%
	N	2,281	2,276	2,279	2,279	1,055	1,047	1,053	1,051	1,226	1,229	1,226	1,228

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ Survey questions in this table were not asked in the PY 1 survey. The question numbering is based on the PY 5 survey.

² Question wording changed between PY 3 and PY 4. In PYs 2 and 3, it asked about any webinars, but in PYs 4 and 5 specified national webinars.

³ The screening survey question (G4), which determined which practices received question H3, changed between PY 3, PY 4, and PY 5. In PYs 2, 3, and 5, it asked whether practices contracted with CPC+ payer partners. If practices selected "no", they were not asked H3. In PY 4, the screener question asked practices to select the payer partners it contracted with. If practices did not select any payer partners, they were not asked H3. These changes in the wording of the screening question resulted in slightly more practices being asked H3 in PY 4 compared to previous PYs.

n.a. = not applicable, because the survey question was not asked in that wave or to the specified group of practices; PY = Program Year; SSP = Medicare Shared Savings Program.

Table 3.B.8b. CPC+ practices' responses to questions about their experiences with learning activities and assistance and supports from payers, within track by SSP status (2017 Starters)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
CPC+ learning activities and assistance																	
H1	Rating of services from regional learning network organizations in meeting practice site's CPC+-related needs and helping improve primary care																
	Excellent	22%	10%	19%	17%	10%	16%	18%	19%	15%	22%	32%	26%	13%	14%	13%	15%
	Very good	25%	31%	35%	34%	33%	32%	30%	32%	32%	26%	31%	35%	29%	27%	29%	30%
	Good	38%	38%	31%	38%	41%	34%	35%	31%	36%	42%	31%	31%	41%	42%	40%	37%
	Fair	14%	18%	13%	10%	14%	16%	16%	16%	17%	9%	5%	7%	14%	16%	14%	17%
	Poor	1%	2%	3%	2%	2%	3%	2%	2%	1%	1%	<1%	1%	2%	1%	5%	1%
	N	540	545	545	544	508	503	505	506	610	609	609	611	616	615	613	617
Rating of usefulness of assistance received in the past six months from the CPC+ national learning community and regional learning network in improving primary care...																	
H2a	...Webinars ²																
	Very useful	33%	27%	24%	17%	24%	30%	20%	20%	23%	26%	19%	18%	22%	21%	17%	13%
	Somewhat useful	45%	53%	36%	40%	49%	50%	34%	39%	65%	61%	46%	45%	59%	55%	34%	40%
	Not very useful	8%	6%	4%	10%	11%	10%	9%	9%	7%	5%	5%	9%	11%	11%	11%	15%
	Not at all useful	<1%	<1%	1%	1%	1%	1%	1%	2%	<1%	2%	2%	1%	2%	2%	3%	2%
	Never received or attended	13%	13%	35%	32%	15%	9%	36%	29%	5%	6%	27%	27%	6%	11%	35%	29%
	N	547	544	526	526	509	504	485	487	608	606	591	591	617	615	591	599
H2b	...One-on-one telephone/virtual coaching with the practice site to improve practice processes and workflows																
	Very useful	44%	37%	43%	30%	28%	39%	40%	40%	39%	36%	42%	41%	27%	26%	29%	27%
	Somewhat useful	18%	28%	18%	29%	21%	22%	17%	18%	29%	37%	23%	28%	22%	22%	27%	23%
	Not very useful	6%	4%	4%	5%	3%	6%	2%	5%	12%	1%	3%	6%	5%	7%	6%	10%
	Not at all useful	1%	1%	2%	3%	5%	1%	1%	2%	<1%	<1%	1%	2%	5%	1%	2%	1%
	Never received or attended	32%	31%	33%	33%	42%	33%	40%	35%	20%	26%	31%	23%	41%	43%	38%	40%
	N	541	546	544	542	506	505	503	505	605	601	606	610	620	614	619	613
H2c	...CPC+ Connect (the online information resource and collaboration website)																
	Very useful	47%	45%	51%	41%	36%	38%	36%	37%	39%	44%	39%	42%	30%	38%	32%	32%
	Somewhat useful	37%	35%	34%	42%	42%	44%	47%	49%	49%	43%	49%	43%	51%	45%	51%	49%
	Not very useful	5%	10%	6%	8%	15%	9%	8%	5%	6%	4%	6%	10%	9%	10%	10%	9%
	Not at all useful	1%	3%	3%	2%	3%	4%	2%	1%	2%	4%	1%	2%	2%	1%	1%	1%
	Never received or attended	9%	8%	6%	6%	5%	5%	7%	7%	4%	5%	5%	4%	8%	6%	6%	9%
	N	541	547	543	544	507	505	509	506	607	605	608	612	619	612	619	620

Table 3.B.8b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
H2d	...CPC+ Implementation Guides															
Very useful	54%	63%	62%	61%	52%	54%	50%	59%	68%	71%	67%	71%	53%	55%	57%	58%
Somewhat useful	35%	29%	28%	28%	35%	36%	38%	31%	24%	24%	24%	23%	38%	35%	33%	31%
Not very useful	6%	3%	3%	5%	9%	6%	4%	5%	3%	2%	5%	3%	3%	6%	3%	2%
Not at all useful	<1%	1%	1%	1%	1%	1%	1%	<1%	<1%	1%	<1%	0%	<1%	<1%	<1%	<1%
Never received or attended	5%	5%	6%	5%	3%	4%	7%	5%	5%	2%	4%	3%	6%	4%	7%	8%
N	543	546	542	542	507	504	505	509	608	604	609	611	616	612	619	618
H2e	...CPC+ Support (CPC+ help desk)															
Very useful	47%	61%	58%	61%	50%	64%	56%	65%	62%	73%	71%	72%	49%	53%	51%	54%
Somewhat useful	34%	24%	26%	24%	33%	22%	24%	22%	27%	20%	17%	16%	30%	29%	31%	27%
Not very useful	7%	4%	3%	3%	6%	5%	4%	2%	3%	<1%	3%	6%	4%	6%	3%	4%
Not at all useful	1%	1%	1%	1%	1%	1%	<1%	1%	<1%	1%	<1%	0%	4%	1%	1%	1%
Never received or attended	11%	10%	11%	11%	10%	8%	16%	10%	9%	6%	8%	6%	13%	11%	15%	14%
N	543	543	542	545	509	505	507	508	608	604	609	612	618	612	619	620
H2f	...Group coaching															
Very useful	n.a.	n.a.	25%	18%	n.a.	n.a.	25%	25%	n.a.	n.a.	24%	17%	n.a.	n.a.	15%	17%
Somewhat useful	n.a.	n.a.	18%	30%	n.a.	n.a.	22%	27%	n.a.	n.a.	19%	31%	n.a.	n.a.	30%	28%
Not very useful	n.a.	n.a.	8%	7%	n.a.	n.a.	5%	9%	n.a.	n.a.	3%	10%	n.a.	n.a.	5%	8%
Not at all useful	n.a.	n.a.	2%	3%	n.a.	n.a.	1%	2%	n.a.	n.a.	1%	1%	n.a.	n.a.	2%	1%
Never received or attended	n.a.	n.a.	47%	42%	n.a.	n.a.	47%	37%	n.a.	n.a.	52%	41%	n.a.	n.a.	47%	45%
N	n.a.	n.a.	545	542	n.a.	n.a.	508	509	n.a.	n.a.	608	612	n.a.	n.a.	617	619
CPC+ payer partner support and assistance																
Rating of usefulness of assistance received in the past six months from CPC+ payer partners in improving primary care³...																
H3a	...On-site care manager provided by the payer															
Very useful	8%	9%	9%	12%	13%	16%	8%	11%	5%	11%	6%	6%	8%	8%	9%	9%
Somewhat useful	8%	10%	10%	11%	6%	12%	11%	6%	8%	8%	9%	10%	7%	11%	7%	7%
Not very useful	2%	2%	1%	1%	3%	2%	2%	1%	1%	2%	2%	2%	3%	3%	4%	3%
Not at all useful	<1%	1%	2%	1%	<1%	0%	1%	2%	1%	1%	4%	1%	1%	1%	1%	2%
Never received or attended	82%	79%	78%	75%	78%	70%	79%	80%	85%	79%	79%	82%	81%	77%	78%	78%
N	412	378	444	379	398	383	449	353	500	527	548	505	525	511	580	507
H3b	...Telephone-based care manager provided by the payer															
Very useful	6%	5%	7%	10%	11%	13%	11%	11%	15%	17%	8%	7%	6%	6%	9%	6%
Somewhat useful	15%	19%	17%	25%	10%	17%	15%	22%	18%	16%	24%	19%	13%	22%	15%	14%
Not very useful	5%	11%	12%	8%	5%	7%	5%	7%	6%	6%	9%	8%	7%	9%	8%	8%
Not at all useful	1%	1%	2%	1%	1%	1%	2%	2%	1%	2%	4%	1%	2%	3%	4%	4%
Never received or attended	73%	64%	63%	55%	74%	61%	66%	58%	61%	59%	55%	64%	72%	60%	64%	69%
N	412	374	444	377	398	383	447	352	499	508	546	505	524	510	579	507
H3c	...Explanation of payers' CPC+ payment methodologies															
Very useful	15%	10%	9%	12%	14%	13%	19%	19%	12%	12%	14%	15%	8%	11%	16%	15%
Somewhat useful	25%	22%	35%	35%	32%	42%	33%	35%	24%	32%	30%	26%	38%	42%	36%	33%
Not very useful	7%	17%	7%	8%	9%	7%	8%	6%	4%	6%	9%	8%	13%	13%	7%	10%

Table 3.B.8b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
Not at all useful	<1%	6%	1%	1%	3%	2%	2%	3%	1%	1%	4%	1%	3%	2%	1%	2%
Never received or attended	53%	45%	49%	45%	42%	37%	38%	36%	59%	50%	44%	50%	38%	32%	41%	39%
N	412	377	444	377	396	383	448	353	500	526	546	505	527	510	577	507
H3d ...Training on how to access data feedback provided by the payer																
Very useful	15%	11%	15%	16%	18%	21%	21%	19%	14%	8%	17%	24%	10%	13%	16%	19%
Somewhat useful	23%	30%	29%	38%	34%	34%	30%	39%	35%	50%	33%	32%	38%	41%	36%	35%
Not very useful	9%	12%	8%	6%	9%	8%	7%	4%	2%	3%	7%	4%	10%	8%	6%	7%
Not at all useful	<1%	1%	1%	<1%	1%	4%	1%	1%	2%	1%	3%	<1%	1%	5%	1%	1%
Never received or attended	52%	46%	48%	39%	38%	32%	41%	37%	48%	38%	40%	40%	41%	32%	41%	38%
N	411	376	444	381	398	383	448	353	500	527	548	504	525	511	579	507
H3e ...Training on how to use data feedback provided by the payer																
Very useful	14%	12%	13%	16%	18%	18%	16%	18%	15%	9%	14%	21%	10%	12%	16%	17%
Somewhat useful	28%	27%	31%	35%	32%	39%	34%	36%	28%	42%	36%	35%	36%	40%	33%	33%
Not very useful	4%	14%	7%	6%	10%	9%	10%	5%	3%	7%	7%	5%	11%	10%	9%	10%
Not at all useful	<1%	<1%	1%	<1%	2%	4%	2%	1%	2%	1%	3%	<1%	2%	5%	1%	1%
Never received or attended	53%	47%	48%	43%	38%	30%	38%	40%	53%	40%	39%	39%	41%	33%	42%	39%
N	413	376	444	381	398	383	448	352	498	528	548	504	526	511	579	507
H3f ...Coaching on how to improve practice processes and workflows																
Very useful	12%	11%	13%	19%	17%	21%	17%	16%	7%	20%	13%	19%	12%	11%	13%	12%
Somewhat useful	26%	30%	31%	36%	22%	26%	26%	28%	28%	22%	24%	20%	27%	36%	32%	28%
Not very useful	5%	8%	3%	4%	13%	11%	6%	9%	5%	5%	5%	5%	14%	11%	10%	14%
Not at all useful	<1%	1%	1%	1%	4%	4%	4%	1%	2%	2%	3%	1%	1%	6%	5%	2%
Never received or attended	56%	51%	51%	41%	46%	38%	46%	46%	58%	51%	54%	55%	46%	36%	40%	45%
N	411	374	444	379	397	383	448	353	499	528	548	504	526	511	579	506
Usefulness of CPC+ supports in improving primary care (supports from all payers)																
I6a Financial support																
Very useful	45%	48%	56%	46%	50%	50%	58%	61%	54%	52%	61%	61%	47%	49%	57%	60%
Somewhat useful	30%	35%	30%	37%	30%	34%	33%	26%	31%	37%	32%	26%	30%	37%	28%	27%
Not very useful	12%	8%	8%	7%	6%	5%	3%	2%	5%	3%	1%	3%	7%	4%	4%	2%
Not at all useful	1%	1%	<1%	<1%	2%	1%	<1%	1%	1%	1%	<1%	<1%	1%	1%	1%	<1%
Don't know	11%	9%	5%	10%	12%	10%	5%	10%	9%	7%	5%	10%	15%	9%	10%	12%
N	546	544	545	544	508	502	508	507	606	607	610	610	620	618	618	619
I6b Learning support																
Very useful	37%	36%	38%	38%	31%	31%	32%	33%	31%	30%	36%	32%	31%	30%	34%	26%
Somewhat useful	50%	56%	49%	48%	52%	53%	54%	52%	60%	62%	56%	57%	55%	59%	52%	57%
Not very useful	6%	5%	10%	5%	9%	10%	7%	6%	4%	5%	2%	5%	6%	6%	7%	10%
Not at all useful	1%	1%	1%	1%	2%	1%	1%	1%	<1%	0%	2%	<1%	1%	<1%	<1%	0%
Don't know	6%	3%	3%	8%	7%	6%	5%	8%	5%	2%	4%	6%	6%	5%	7%	7%
N	545	545	545	544	508	501	508	507	607	610	608	610	620	620	619	619

Table 3.B.8b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
I6c																
Data feedback																
Very useful	38%	31%	33%	34%	35%	38%	33%	33%	36%	24%	31%	33%	37%	37%	37%	35%
Somewhat useful	47%	55%	48%	48%	46%	45%	49%	46%	47%	59%	47%	45%	47%	49%	46%	47%
Not very useful	9%	10%	13%	8%	12%	10%	11%	12%	11%	13%	18%	17%	9%	9%	9%	12%
Not at all useful	1%	1%	4%	4%	2%	1%	2%	1%	<1%	2%	1%	1%	1%	<1%	2%	<1%
Don't know	5%	3%	3%	6%	6%	6%	5%	8%	5%	2%	3%	5%	6%	5%	7%	7%
N	546	545	544	544	509	503	508	507	606	611	609	609	618	620	619	619
I6d																
Health IT vendor support																
Very useful	16%	20%	19%	25%	16%	18%	20%	23%	22%	20%	18%	17%	15%	15%	21%	28%
Somewhat useful	35%	38%	33%	34%	28%	33%	34%	30%	34%	43%	37%	43%	39%	46%	36%	33%
Not very useful	18%	13%	12%	7%	25%	24%	18%	24%	21%	14%	8%	7%	22%	18%	18%	15%
Not at all useful	4%	3%	9%	3%	12%	7%	10%	8%	3%	12%	10%	9%	4%	3%	6%	4%
Don't know	27%	26%	27%	30%	18%	19%	18%	16%	20%	12%	27%	24%	20%	17%	18%	20%
N	546	544	545	544	509	503	508	507	607	609	608	610	619	620	618	618

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation’s key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ Survey questions in this table were not asked in the PY 1 survey. The question numbering is based on the PY 5 survey.

² Question wording changed between PY 3 and PY 4. In PYs 2 and 3, it asked about any webinars, but in PYs 4 and 5 specified national webinars.

³ The screening survey question (G4), which determined which practices received question H3, changed between PY 3, PY 4, and PY 5. In PYs 2, 3, and 5, it asked whether practices contracted with CPC+ payer partners. If practices selected “no”, they were not asked H3. In PY 4, the screener question asked practices to select the payer partners it contracted with. If practices did not select any payer partners, they were not asked H3. These changes in the wording of the screening question resulted in slightly more practices being asked H3 in PY 4 compared to previous PYs.

n.a. = not applicable, because the survey question was not asked in that wave or to the specified group of practices; PY = Program Year; SSP = Medicare Shared Savings Program (reflects 2021 [PY 5] participation, or, for practices that withdrew from CPC+, their participation at the time of withdrawal).

Table 3.B.9a. CPC+ practices' responses to questions about their experiences in CPC+, including their overall perceptions of CPC+, burden, and sustainability, overall and by track (2017 Starters)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
Overall perception of CPC+												
13	Given practice's overall experience in CPC+, likelihood practice would participate in CPC+ if practice could do it all over again											
Very likely	65%	67%	66%	66%	63%	60%	60%	59%	67%	72%	71%	71%
Somewhat likely	28%	27%	28%	28%	28%	32%	33%	34%	27%	22%	24%	24%
Not very likely	5%	5%	4%	5%	7%	6%	6%	5%	4%	4%	3%	4%
Not at all likely	2%	2%	1%	1%	2%	2%	2%	2%	1%	1%	1%	1%
N	2,279	2,276	2,284	2,279	1,054	1,051	1,056	1,052	1,225	1,225	1,228	1,227
14	The extent to which participation in CPC+ improved the quality of care that the practice provides to its patients											
A lot	46%	55%	56%	53%	42%	52%	52%	47%	49%	57%	59%	58%
Somewhat	47%	41%	41%	44%	48%	42%	44%	49%	46%	40%	38%	40%
Not very much	6%	4%	3%	3%	8%	6%	3%	4%	4%	2%	3%	2%
Not at all	1%	<1%	<1%	<1%	1%	<1%	<1%	1%	<1%	1%	<1%	<1%
N	2,282	2,276	2,283	2,278	1,053	1,054	1,056	1,051	1,229	1,222	1,227	1,227
Staff involvement in implementing CPC+												
11a	Medical director or clinician lead at the practice site											
Very involved	63%	64%	62%	65%	57%	59%	58%	61%	68%	67%	65%	68%
Somewhat involved	29%	30%	32%	29%	34%	33%	34%	31%	26%	28%	30%	27%
Not very involved	6%	4%	5%	5%	7%	5%	5%	6%	4%	3%	5%	4%
Not at all involved	2%	2%	2%	2%	3%	3%	3%	3%	2%	2%	1%	1%
N	2,270	2,261	2,272	2,277	1,046	1,042	1,048	1,049	1,224	1,219	1,224	1,228
11b	Physicians											
Very involved	41%	43%	45%	50%	38%	43%	45%	50%	44%	43%	45%	50%
Somewhat involved	48%	49%	44%	40%	50%	48%	45%	40%	47%	50%	44%	41%
Not very involved	9%	7%	9%	9%	11%	7%	9%	9%	8%	6%	9%	8%
Not at all involved	1%	1%	2%	1%	2%	2%	2%	1%	1%	1%	2%	1%
N	2,276	2,266	2,270	2,279	1,052	1,049	1,050	1,050	1,224	1,217	1,220	1,229
11c	Nurse practitioners (NPs), clinical nurse specialists (CNSs), or physician assistants (PAs)											
Very involved	25%	26%	31%	32%	20%	23%	25%	26%	30%	29%	35%	37%
Somewhat involved	34%	37%	32%	32%	35%	35%	31%	31%	32%	38%	33%	33%
Not very involved	8%	7%	8%	7%	9%	6%	9%	7%	7%	7%	8%	7%
Not at all involved	2%	1%	1%	1%	2%	2%	2%	2%	2%	1%	1%	1%
No NPs/PAs/CNSs	31%	29%	28%	28%	34%	34%	33%	34%	29%	25%	23%	23%
N	2,278	2,281	2,283	2,280	1,051	1,054	1,055	1,052	1,227	1,227	1,228	1,228
11d	Clinical support staff											
Very involved	47%	53%	55%	54%	42%	50%	53%	51%	52%	56%	57%	57%
Somewhat involved	47%	41%	37%	39%	51%	44%	37%	41%	43%	38%	37%	37%

Table 3.B.9a. (continued)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
	Not very involved	5%	6%	7%	6%	6%	5%	8%	7%	4%	6%	5%	6%
	Not at all involved	1%	1%	1%	1%	1%	1%	2%	1%	1%	<1%	1%	1%
	N	2,284	2,273	2,281	2,281	1,055	1,049	1,054	1,052	1,229	1,224	1,227	1,229
11e	Clerical support staff												
	Very involved	36%	36%	38%	38%	31%	34%	33%	32%	41%	38%	42%	43%
	Somewhat involved	48%	47%	43%	41%	52%	49%	43%	43%	44%	46%	43%	39%
	Not very involved	13%	15%	15%	16%	14%	15%	20%	20%	12%	14%	11%	14%
	Not at all involved	3%	2%	4%	4%	3%	2%	4%	4%	3%	1%	4%	4%
	N	2,280	2,275	2,279	2,281	1,053	1,051	1,052	1,051	1,227	1,224	1,227	1,230
12	System-level leadership (e.g., chief executive officer or chief medical officer)												
	Very involved	51%	46%	49%	49%	41%	39%	40%	44%	59%	53%	56%	54%
	Somewhat involved	21%	26%	22%	22%	23%	28%	24%	26%	19%	24%	20%	19%
	Not very involved	7%	6%	8%	8%	9%	9%	11%	6%	5%	4%	6%	9%
	Not at all involved	2%	1%	2%	3%	4%	1%	3%	3%	1%	1%	2%	2%
	Practice site is independent and not part of a system	19%	20%	19%	18%	22%	23%	22%	21%	17%	18%	16%	16%
	N	2,282	2,268	2,286	2,283	1,052	1,047	1,056	1,053	1,230	1,221	1,230	1,230
Extent to which CPC+ requirements are burdensome													
15a	Meeting care delivery requirements												
	Not at all burdensome	4%	6%	8%	7%	4%	5%	6%	8%	5%	6%	9%	7%
	Not very burdensome	28%	28%	31%	33%	30%	28%	28%	29%	26%	29%	35%	36%
	Somewhat burdensome	50%	52%	48%	49%	46%	54%	54%	55%	52%	51%	44%	43%
	Very burdensome	17%	13%	11%	10%	18%	12%	12%	7%	16%	13%	11%	12%
	Don't know	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	2%	2%
	N	2,283	2,282	2,283	2,276	1,052	1,052	1,054	1,048	1,231	1,230	1,229	1,228
15b	Completing care delivery reporting requirements												
	Not at all burdensome	3%	4%	5%	6%	2%	3%	5%	6%	5%	5%	5%	7%
	Not very burdensome	20%	27%	28%	28%	20%	25%	26%	26%	21%	28%	30%	30%
	Somewhat burdensome	49%	50%	44%	47%	50%	49%	47%	52%	48%	51%	42%	42%
	Very burdensome	26%	18%	21%	17%	27%	22%	21%	15%	25%	15%	21%	19%
	Don't know	2%	2%	2%	2%	2%	1%	1%	1%	2%	2%	3%	2%
	N	2,284	2,284	2,282	2,279	1,053	1,052	1,055	1,052	1,231	1,232	1,227	1,227
15c	Completing financial reporting requirements												
	Not at all burdensome	2%	2%	3%	4%	1%	2%	2%	4%	2%	2%	4%	4%
	Not very burdensome	12%	16%	17%	17%	13%	16%	16%	17%	11%	15%	19%	17%
	Somewhat burdensome	28%	33%	36%	39%	25%	34%	38%	44%	30%	32%	35%	35%
	Very burdensome	48%	42%	36%	32%	48%	39%	38%	30%	48%	45%	35%	34%
	Don't know	11%	7%	7%	8%	13%	9%	7%	6%	9%	6%	8%	9%
	N	2,280	2,284	2,281	2,279	1,050	1,052	1,055	1,052	1,230	1,232	1,226	1,227

Table 3.B.9a. (continued)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
15d	Meeting health IT requirements												
	7%	12%	16%	19%	7%	12%	15%	19%	7%	11%	16%	19%	
	30%	35%	35%	37%	32%	36%	33%	38%	28%	35%	38%	36%	
	33%	34%	34%	30%	30%	33%	39%	31%	36%	35%	30%	29%	
	20%	12%	9%	6%	19%	10%	9%	6%	20%	13%	9%	7%	
	10%	7%	6%	8%	11%	8%	4%	7%	9%	6%	7%	9%	
	N	2,281	2,283	2,284	2,278	1,052	1,051	1,055	1,051	1,229	1,232	1,229	1,227
CPC+ and coronavirus pandemic													
17	Practice was better positioned to meet patients' care needs during the coronavirus pandemic because of practice's participation in CPC+												
	Strongly agree	n.a.	n.a.	13%	15%	n.a.	n.a.	7%	12%	n.a.	n.a.	18%	17%
	Agree	n.a.	n.a.	30%	35%	n.a.	n.a.	30%	36%	n.a.	n.a.	30%	35%
	Neither agree nor disagree	n.a.	n.a.	47%	40%	n.a.	n.a.	50%	42%	n.a.	n.a.	44%	39%
	Disagree	n.a.	n.a.	7%	5%	n.a.	n.a.	9%	7%	n.a.	n.a.	6%	4%
	Strongly disagree	n.a.	n.a.	4%	5%	n.a.	n.a.	4%	4%	n.a.	n.a.	3%	5%
	N	n.a.	n.a.	2,285	2,282	n.a.	n.a.	1,056	1,054	n.a.	n.a.	1,229	1,228
Sustainability and spread of CPC+													
Among practices still participating in CPC+, how much of the practice's current process the practice is likely to maintain after CPC+ ends...													
18a	...Risk stratify patients												
	Most or all of the process	n.a.	n.a.	65%	73%	n.a.	n.a.	61%	71%	n.a.	n.a.	68%	76%
	A lot of the process	n.a.	n.a.	18%	15%	n.a.	n.a.	18%	15%	n.a.	n.a.	17%	14%
	Some of the process	n.a.	n.a.	13%	8%	n.a.	n.a.	14%	9%	n.a.	n.a.	11%	7%
	None of the process	n.a.	n.a.	2%	1%	n.a.	n.a.	3%	1%	n.a.	n.a.	1%	1%
	Not currently doing this process at all	n.a.	n.a.	<1%	0%	n.a.	n.a.	<1%	0%	n.a.	n.a.	<1%	0%
	Don't know	n.a.	n.a.	3%	3%	n.a.	n.a.	3%	4%	n.a.	n.a.	2%	2%
	N	n.a.	n.a.	2,267	2,205	n.a.	n.a.	1,045	1,014	n.a.	n.a.	1,222	1,191
18b	...Provide short-term ("episodic") care management for patients who had a recent hospital admission or ED visit												
	Most or all of the process	n.a.	n.a.	71%	78%	n.a.	n.a.	70%	75%	n.a.	n.a.	72%	80%
	A lot of the process	n.a.	n.a.	20%	15%	n.a.	n.a.	22%	19%	n.a.	n.a.	19%	12%
	Some of the process	n.a.	n.a.	6%	5%	n.a.	n.a.	7%	5%	n.a.	n.a.	5%	6%
	None of the process	n.a.	n.a.	<1%	<1%	n.a.	n.a.	0%	<1%	n.a.	n.a.	<1%	<1%
	Not currently doing this process at all	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	0%
	Don't know	n.a.	n.a.	2%	2%	n.a.	n.a.	1%	2%	n.a.	n.a.	3%	1%
	N	n.a.	n.a.	2,268	2,216	n.a.	n.a.	1,045	1,017	n.a.	n.a.	1,223	1,199

Table 3.B.9a. (continued)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
18c	...Work with a care manager to provide proactive, long-term, relationship-based ("longitudinal") care management											
Most or all of the process	n.a.	n.a.	65%	75%	n.a.	n.a.	65%	70%	n.a.	n.a.	66%	79%
A lot of the process	n.a.	n.a.	20%	16%	n.a.	n.a.	19%	19%	n.a.	n.a.	20%	13%
Some of the process	n.a.	n.a.	11%	6%	n.a.	n.a.	12%	7%	n.a.	n.a.	9%	5%
None of the process	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	<1%
Not currently doing this process at all	n.a.	n.a.	1%	<1%	n.a.	n.a.	1%	<1%	n.a.	n.a.	<1%	<1%
Don't know	n.a.	n.a.	3%	2%	n.a.	n.a.	2%	2%	n.a.	n.a.	4%	2%
N	n.a.	n.a.	2,280	2,224	n.a.	n.a.	1,055	1,022	n.a.	n.a.	1,225	1,202
18d	...Provide advance care planning											
Most or all of the process	n.a.	n.a.	n.a.	68%	n.a.	n.a.	n.a.	63%	n.a.	n.a.	n.a.	73%
A lot of the process	n.a.	n.a.	n.a.	19%	n.a.	n.a.	n.a.	21%	n.a.	n.a.	n.a.	17%
Some of the process	n.a.	n.a.	n.a.	9%	n.a.	n.a.	n.a.	9%	n.a.	n.a.	n.a.	8%
None of the process	n.a.	n.a.	n.a.	<1%	n.a.	n.a.	n.a.	1%	n.a.	n.a.	n.a.	<1%
Not currently doing this process at all	n.a.	n.a.	n.a.	2%	n.a.	n.a.	n.a.	3%	n.a.	n.a.	n.a.	<1%
Don't know	n.a.	n.a.	n.a.	2%	n.a.	n.a.	n.a.	4%	n.a.	n.a.	n.a.	1%
N	n.a.	n.a.	n.a.	2,224	n.a.	n.a.	n.a.	1,021	n.a.	n.a.	n.a.	1,203
18e	...Provide comprehensive medication management for high-risk patients											
Most or all of the process	n.a.	n.a.	n.a.	58%	n.a.	n.a.	n.a.	48%	n.a.	n.a.	n.a.	67%
A lot of the process	n.a.	n.a.	n.a.	18%	n.a.	n.a.	n.a.	19%	n.a.	n.a.	n.a.	17%
Some of the process	n.a.	n.a.	n.a.	14%	n.a.	n.a.	n.a.	14%	n.a.	n.a.	n.a.	13%
None of the process	n.a.	n.a.	n.a.	1%	n.a.	n.a.	n.a.	2%	n.a.	n.a.	n.a.	<1%
Not currently doing this process at all	n.a.	n.a.	n.a.	7%	n.a.	n.a.	n.a.	13%	n.a.	n.a.	n.a.	1%
Don't know	n.a.	n.a.	n.a.	3%	n.a.	n.a.	n.a.	4%	n.a.	n.a.	n.a.	2%
N	n.a.	n.a.	n.a.	2,226	n.a.	n.a.	n.a.	1,023	n.a.	n.a.	n.a.	1,203
18f	...Provide on-site behavioral health care that is integrated into primary care services											
Most or all of the process	n.a.	n.a.	48%	49%	n.a.	n.a.	38%	43%	n.a.	n.a.	55%	55%
A lot of the process	n.a.	n.a.	15%	19%	n.a.	n.a.	18%	20%	n.a.	n.a.	13%	18%
Some of the process	n.a.	n.a.	16%	14%	n.a.	n.a.	18%	15%	n.a.	n.a.	15%	13%
None of the process	n.a.	n.a.	3%	2%	n.a.	n.a.	5%	2%	n.a.	n.a.	2%	2%
Not currently doing this process at all	n.a.	n.a.	9%	10%	n.a.	n.a.	12%	13%	n.a.	n.a.	7%	8%
Don't know	n.a.	n.a.	8%	6%	n.a.	n.a.	8%	7%	n.a.	n.a.	9%	5%
N	n.a.	n.a.	2,282	2,227	n.a.	n.a.	1,054	1,024	n.a.	n.a.	1,228	1,203
18g	...Assess patients' health-related social service needs and refer them to community resources											
Most or all of the process	n.a.	n.a.	57%	69%	n.a.	n.a.	51%	61%	n.a.	n.a.	63%	75%
A lot of the process	n.a.	n.a.	22%	19%	n.a.	n.a.	24%	22%	n.a.	n.a.	21%	16%
Some of the process	n.a.	n.a.	16%	10%	n.a.	n.a.	20%	13%	n.a.	n.a.	13%	7%
None of the process	n.a.	n.a.	1%	<1%	n.a.	n.a.	2%	1%	n.a.	n.a.	1%	<1%
Not currently doing this process at all	n.a.	n.a.	1%	1%	n.a.	n.a.	2%	1%	n.a.	n.a.	<1%	<1%
Don't know	n.a.	n.a.	2%	2%	n.a.	n.a.	2%	2%	n.a.	n.a.	2%	1%
N	n.a.	n.a.	2,279	2,225	n.a.	n.a.	1,053	1,021	n.a.	n.a.	1,226	1,204

Table 3.B.9a. (continued)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
18h	...Coordinate care with specialists												
	Most or all of the process	n.a.	n.a.	69%	77%	n.a.	n.a.	65%	72%	n.a.	n.a.	72%	81%
	A lot of the process	n.a.	n.a.	21%	15%	n.a.	n.a.	23%	17%	n.a.	n.a.	19%	13%
	Some of the process	n.a.	n.a.	9%	7%	n.a.	n.a.	11%	10%	n.a.	n.a.	7%	5%
	None of the process	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	<1%
	Not currently doing this process at all	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	<1%	n.a.	n.a.	0%	<1%
	Don't know	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	1%	n.a.	n.a.	2%	1%
	N	n.a.	n.a.	2,281	2,225	n.a.	n.a.	1,055	1,023	n.a.	n.a.	1,226	1,202
18i	...Use formal written agreements with specialists to set expectations about roles and information sharing												
	Most or all of the process	n.a.	n.a.	34%	37%	n.a.	n.a.	31%	34%	n.a.	n.a.	36%	40%
	A lot of the process	n.a.	n.a.	21%	18%	n.a.	n.a.	19%	20%	n.a.	n.a.	22%	17%
	Some of the process	n.a.	n.a.	24%	24%	n.a.	n.a.	29%	25%	n.a.	n.a.	21%	24%
	None of the process	n.a.	n.a.	10%	9%	n.a.	n.a.	11%	9%	n.a.	n.a.	10%	8%
	Not currently doing this process at all	n.a.	n.a.	4%	4%	n.a.	n.a.	5%	5%	n.a.	n.a.	3%	2%
	Don't know	n.a.	n.a.	7%	8%	n.a.	n.a.	5%	8%	n.a.	n.a.	9%	8%
	N	n.a.	n.a.	2,281	2,223	n.a.	n.a.	1,053	1,021	n.a.	n.a.	1,228	1,202
18j	...Ensure a range of options for how and when patients can access primary care from practice (for example, phone visits or extended office hours)												
	Most or all of the process	n.a.	n.a.	74%	82%	n.a.	n.a.	72%	79%	n.a.	n.a.	76%	85%
	A lot of the process	n.a.	n.a.	18%	12%	n.a.	n.a.	20%	14%	n.a.	n.a.	16%	10%
	Some of the process	n.a.	n.a.	7%	4%	n.a.	n.a.	6%	5%	n.a.	n.a.	7%	3%
	None of the process	n.a.	n.a.	1%	<1%	n.a.	n.a.	1%	1%	n.a.	n.a.	<1%	<1%
	Not currently doing this process at all	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	<1%
	Don't know	n.a.	n.a.	1%	1%	n.a.	n.a.	<1%	1%	n.a.	n.a.	1%	1%
	N	n.a.	n.a.	2,280	2,227	n.a.	n.a.	1,054	1,024	n.a.	n.a.	1,226	1,203
18k	...Track and use quality measures and other data to guide practice improvements												
	Most or all of the process	n.a.	n.a.	73%	83%	n.a.	n.a.	71%	81%	n.a.	n.a.	76%	84%
	A lot of the process	n.a.	n.a.	18%	11%	n.a.	n.a.	20%	12%	n.a.	n.a.	16%	10%
	Some of the process	n.a.	n.a.	7%	4%	n.a.	n.a.	7%	5%	n.a.	n.a.	6%	3%
	None of the process	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	1%	n.a.	n.a.	<1%	<1%
	Not currently doing this process at all	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	0%
	Don't know	n.a.	n.a.	1%	2%	n.a.	n.a.	1%	2%	n.a.	n.a.	1%	2%
	N	n.a.	n.a.	2,279	2,226	n.a.	n.a.	1,053	1,023	n.a.	n.a.	1,226	1,203

Table 3.B.9a. (continued)

Question ¹	Combined tracks				Track 1 overall				Track 2 overall				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
18l	...Use Patient and Family Advisory Councils (PFAC) to better understand what matters most to patients and to guide improvements at practice												
	Most or all of the process	n.a.	n.a.	30%	33%	n.a.	n.a.	28%	31%	n.a.	n.a.	32%	34%
	A lot of the process	n.a.	n.a.	23%	22%	n.a.	n.a.	21%	18%	n.a.	n.a.	24%	26%
	Some of the process	n.a.	n.a.	28%	27%	n.a.	n.a.	30%	32%	n.a.	n.a.	27%	23%
	None of the process	n.a.	n.a.	12%	8%	n.a.	n.a.	14%	9%	n.a.	n.a.	10%	7%
	Not currently doing this process at all	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	2%
	Don't know	n.a.	n.a.	6%	9%	n.a.	n.a.	7%	8%	n.a.	n.a.	6%	9%
	N	n.a.	n.a.	2,281	2,226	n.a.	n.a.	1,055	1,023	n.a.	n.a.	1,226	1,203
19a	Among practices in systems with other CPC+ primary care practices, these other CPC+ practices in system adopted some of the CPC+ changes made by practice												
	Yes	n.a.	n.a.	n.a.	76%	n.a.	n.a.	n.a.	74%	n.a.	n.a.	n.a.	78%
	No	n.a.	n.a.	n.a.	1%	n.a.	n.a.	n.a.	2%	n.a.	n.a.	n.a.	1%
	Don't know	n.a.	n.a.	n.a.	22%	n.a.	n.a.	n.a.	25%	n.a.	n.a.	n.a.	21%
	N	n.a.	n.a.	n.a.	1,449	n.a.	n.a.	n.a.	641	n.a.	n.a.	n.a.	808
19b	Among practices in systems with other non-CPC+ primary care practices, these other non-CPC+ practices in system adopted some of the CPC+ changes made by practice												
	Yes	n.a.	n.a.	n.a.	58%	n.a.	n.a.	n.a.	51%	n.a.	n.a.	n.a.	64%
	No	n.a.	n.a.	n.a.	4%	n.a.	n.a.	n.a.	5%	n.a.	n.a.	n.a.	3%
	Don't know	n.a.	n.a.	n.a.	39%	n.a.	n.a.	n.a.	45%	n.a.	n.a.	n.a.	34%
	N	n.a.	n.a.	n.a.	1,392	n.a.	n.a.	n.a.	619	n.a.	n.a.	n.a.	773
19c	Among practices in systems with specialty care practices, these other specialty care practices in system adopted some of the CPC+ changes made by practice												
	Yes	n.a.	n.a.	n.a.	19%	n.a.	n.a.	n.a.	17%	n.a.	n.a.	n.a.	21%
	No	n.a.	n.a.	n.a.	15%	n.a.	n.a.	n.a.	16%	n.a.	n.a.	n.a.	13%
	Don't know	n.a.	n.a.	n.a.	66%	n.a.	n.a.	n.a.	67%	n.a.	n.a.	n.a.	66%
	N	n.a.	n.a.	n.a.	1,471	n.a.	n.a.	n.a.	660	n.a.	n.a.	n.a.	811

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ Survey questions in this table were not asked in the PY 1 survey. The question numbering is based on the PY 5 survey.

n.a. = not applicable, because the survey question was not asked in that wave or to the specified group of practices; PY = Program Year; SSP = Medicare Shared Savings Program.

Table 3.B.9b. CPC+ practices' responses to questions about their experiences in CPC+, including their overall perceptions of CPC+, burden, and sustainability, within track by SSP status (2017 Starters)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
Overall perception of CPC+																	
I3	Given practice's overall experience in CPC+, likelihood practice would participate in CPC+ if practice could do it all over again																
	Very likely	66%	63%	64%	62%	59%	57%	55%	56%	68%	79%	74%	71%	67%	66%	69%	72%
	Somewhat likely	26%	31%	29%	32%	30%	33%	37%	36%	29%	16%	25%	24%	25%	28%	23%	24%
	Not very likely	6%	4%	5%	4%	8%	7%	6%	6%	2%	4%	1%	5%	5%	5%	5%	4%
	Not at all likely	2%	1%	2%	2%	3%	3%	2%	2%	1%	1%	0%	<1%	2%	2%	2%	1%
	N	545	546	547	544	509	505	509	508	610	611	610	611	615	614	618	616
I4	The extent to which participation in CPC+ improved the quality of care that the practice provides to its patients																
	A lot	48%	57%	59%	48%	36%	46%	46%	46%	49%	61%	60%	58%	50%	53%	58%	57%
	Somewhat	46%	37%	38%	49%	51%	47%	50%	48%	48%	37%	39%	41%	45%	42%	38%	40%
	Not very much	5%	6%	3%	2%	12%	6%	3%	6%	3%	1%	1%	1%	5%	3%	4%	3%
	Not at all	1%	<1%	<1%	1%	1%	<1%	1%	1%	<1%	0%	0%	0%	1%	1%	<1%	<1%
	N	545	547	547	542	508	507	509	509	609	607	609	611	620	615	618	616
Staff involvement in implementing CPC+																	
I1a	Medical director or clinician lead at the practice site																
	Very involved	56%	57%	55%	58%	58%	61%	62%	63%	67%	66%	62%	66%	69%	69%	67%	70%
	Somewhat involved	35%	35%	37%	34%	33%	31%	31%	28%	29%	31%	34%	32%	23%	25%	25%	23%
	Not very involved	8%	5%	5%	4%	7%	5%	6%	8%	3%	2%	3%	2%	6%	4%	6%	5%
	Not at all involved	2%	3%	4%	3%	3%	2%	1%	2%	1%	1%	<1%	1%	2%	2%	2%	1%
	N	542	542	545	542	504	500	503	507	607	608	606	610	617	611	618	618
I1b	Physicians																
	Very involved	36%	43%	45%	53%	40%	44%	45%	47%	36%	34%	39%	45%	52%	52%	51%	55%
	Somewhat involved	52%	49%	44%	38%	47%	46%	46%	42%	57%	61%	50%	45%	38%	41%	39%	37%
	Not very involved	11%	6%	9%	9%	10%	8%	8%	9%	7%	5%	11%	10%	9%	7%	7%	6%
	Not at all involved	1%	2%	2%	<1%	2%	1%	1%	2%	1%	1%	<1%	<1%	1%	<1%	2%	2%
	N	543	546	543	543	509	503	507	507	606	610	603	612	618	607	617	617
I1c	Nurse practitioners (NPs), clinical nurse specialists (CNSs), or physician assistants (PAs)																
	Very involved	17%	20%	24%	26%	22%	26%	26%	27%	22%	20%	28%	31%	36%	38%	41%	41%
	Somewhat involved	35%	37%	29%	30%	36%	33%	34%	31%	35%	47%	36%	34%	30%	29%	30%	32%
	Not very involved	8%	5%	8%	5%	10%	8%	9%	9%	9%	6%	10%	8%	6%	8%	6%	7%
	Not at all involved	1%	1%	2%	2%	2%	2%	1%	2%	1%	1%	<1%	1%	3%	1%	2%	1%
	No NPs/PAs/CNSs	39%	37%	37%	37%	29%	31%	30%	30%	33%	26%	26%	26%	25%	23%	20%	20%
	N	545	547	546	545	506	507	509	507	608	610	608	612	619	617	620	616

Table 3.B.9b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
11d	Clinical support staff																
	Very involved	40%	46%	55%	49%	44%	54%	50%	53%	48%	53%	56%	56%	55%	59%	59%	57%
	Somewhat involved	53%	48%	35%	41%	50%	39%	39%	41%	47%	39%	37%	36%	40%	37%	36%	37%
	Not very involved	7%	4%	7%	9%	5%	6%	9%	5%	4%	9%	7%	8%	4%	4%	4%	4%
	Not at all involved	<1%	2%	2%	1%	1%	<1%	1%	2%	1%	<1%	<1%	<1%	2%	<1%	1%	1%
	N	546	546	546	544	509	503	508	508	609	610	608	612	620	614	619	617
11e	Clerical support staff																
	Very involved	31%	30%	34%	30%	32%	38%	32%	35%	41%	36%	44%	44%	41%	40%	40%	42%
	Somewhat involved	52%	53%	43%	44%	52%	44%	44%	42%	44%	45%	40%	37%	45%	47%	45%	41%
	Not very involved	15%	14%	19%	22%	13%	16%	22%	18%	12%	18%	11%	13%	11%	11%	12%	14%
	Not at all involved	3%	3%	5%	3%	2%	2%	2%	5%	3%	1%	5%	6%	3%	1%	3%	3%
	N	545	547	545	544	508	504	507	507	608	611	608	612	619	613	619	618
12	System-level leadership (e.g., chief executive officer or chief medical officer)																
	Very involved	45%	39%	39%	45%	38%	39%	41%	43%	69%	60%	70%	60%	50%	46%	44%	48%
	Somewhat involved	22%	32%	29%	28%	25%	24%	19%	24%	14%	23%	16%	16%	23%	25%	24%	21%
	Not very involved	11%	10%	11%	7%	7%	7%	11%	6%	5%	4%	3%	12%	5%	5%	8%	7%
	Not at all involved	4%	<1%	3%	3%	5%	1%	3%	3%	1%	<1%	1%	1%	1%	1%	3%	3%
	Practice site is independent and not part of a system	18%	19%	18%	18%	25%	28%	26%	24%	12%	13%	11%	12%	21%	23%	21%	20%
	N	546	545	547	545	506	502	509	508	609	605	610	612	621	616	620	618
Extent to which CPC+ requirements are burdensome																	
15a	Meeting care delivery requirements																
	Not at all burdensome	5%	5%	6%	9%	3%	6%	6%	7%	5%	7%	10%	5%	5%	6%	9%	8%
	Not very burdensome	29%	26%	23%	23%	32%	30%	33%	35%	25%	29%	38%	39%	27%	28%	32%	34%
	Somewhat burdensome	47%	61%	58%	61%	46%	45%	49%	49%	49%	49%	36%	39%	55%	53%	51%	46%
	Very burdensome	18%	8%	12%	7%	18%	17%	11%	8%	20%	14%	15%	16%	11%	12%	7%	9%
	Don't know	2%	<1%	<1%	<1%	1%	2%	1%	1%	1%	1%	1%	1%	1%	1%	2%	3%
	N	545	545	545	543	507	507	509	505	611	609	610	610	620	621	619	618

Table 3.B.9b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
15b	Completing care delivery reporting requirements															
	3%	3%	5%	5%	2%	4%	6%	6%	5%	6%	4%	5%	5%	4%	5%	9%
	19%	27%	23%	24%	20%	23%	29%	27%	22%	28%	27%	24%	20%	28%	33%	35%
	48%	46%	46%	53%	51%	52%	47%	52%	44%	49%	44%	47%	51%	52%	40%	37%
	28%	24%	26%	17%	26%	18%	16%	13%	27%	16%	24%	23%	22%	13%	18%	16%
	2%	<1%	<1%	1%	1%	2%	2%	2%	2%	1%	1%	1%	2%	2%	4%	3%
	545	546	546	544	508	506	509	508	611	611	608	610	620	621	619	617
15c	Completing financial reporting requirements															
	2%	2%	2%	4%	1%	3%	2%	4%	2%	2%	3%	4%	2%	2%	4%	5%
	14%	14%	13%	15%	12%	19%	18%	18%	13%	12%	16%	12%	10%	18%	21%	23%
	20%	33%	30%	41%	30%	34%	47%	46%	26%	32%	33%	42%	33%	33%	37%	29%
	48%	44%	49%	32%	48%	34%	26%	27%	52%	50%	43%	38%	44%	40%	27%	31%
	15%	8%	6%	7%	10%	10%	7%	5%	7%	4%	4%	5%	11%	8%	11%	12%
	544	546	546	544	506	506	509	508	610	611	607	609	620	621	619	618
15d	Meeting health IT requirements															
	7%	11%	12%	14%	8%	13%	18%	25%	7%	11%	18%	19%	6%	12%	15%	19%
	31%	38%	28%	35%	34%	35%	38%	40%	25%	35%	38%	32%	30%	34%	37%	40%
	32%	36%	47%	39%	28%	30%	30%	23%	37%	38%	31%	36%	34%	33%	29%	23%
	18%	8%	9%	5%	21%	12%	9%	7%	24%	12%	10%	8%	18%	14%	8%	6%
	13%	7%	3%	7%	9%	10%	5%	6%	7%	4%	3%	5%	12%	8%	11%	12%
	545	546	546	543	507	505	509	508	611	611	610	609	618	621	619	618
CPC+ and coronavirus pandemic																
17	Practice was better positioned to meet patients' care needs during the coronavirus pandemic because of practice's participation in CPC+															
	n.a.	n.a.	9%	12%	n.a.	n.a.	5%	12%	n.a.	n.a.	18%	17%	n.a.	n.a.	18%	18%
	n.a.	n.a.	29%	36%	n.a.	n.a.	30%	36%	n.a.	n.a.	28%	38%	n.a.	n.a.	31%	32%
	n.a.	n.a.	51%	42%	n.a.	n.a.	48%	41%	n.a.	n.a.	48%	35%	n.a.	n.a.	40%	43%
	n.a.	n.a.	7%	5%	n.a.	n.a.	11%	9%	n.a.	n.a.	4%	3%	n.a.	n.a.	7%	4%
	n.a.	n.a.	4%	5%	n.a.	n.a.	5%	2%	n.a.	n.a.	3%	7%	n.a.	n.a.	4%	4%
	n.a.	n.a.	547	545	n.a.	n.a.	509	509	n.a.	n.a.	610	610	n.a.	n.a.	619	618

Table 3.B.9b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
Sustainability and spread of CPC+																
Among practices still participating in CPC+, how much of the practice's current process the practice is likely to maintain after CPC+ ends...																
I8a	...Risk stratify patients															
			64%	73%	n.a.	n.a.	59%	68%	n.a.	n.a.	71%	82%	n.a.	n.a.	66%	70%
			18%	14%	n.a.	n.a.	19%	17%	n.a.	n.a.	17%	10%	n.a.	n.a.	17%	18%
			14%	7%	n.a.	n.a.	15%	11%	n.a.	n.a.	11%	7%	n.a.	n.a.	12%	8%
			2%	1%	n.a.	n.a.	4%	1%	n.a.	n.a.	<1%	<1%	n.a.	n.a.	2%	1%
			0%	0%	n.a.	n.a.	<1%	0%	n.a.	n.a.	0%	0%	n.a.	n.a.	<1%	0%
			3%	5%	n.a.	n.a.	3%	3%	n.a.	n.a.	1%	1%	n.a.	n.a.	3%	3%
			543	537	n.a.	n.a.	502	477	n.a.	n.a.	608	598	n.a.	n.a.	614	593
I8b	...Provide short-term ("episodic") care management for patients who had a recent hospital admission or ED visit															
			71%	78%	n.a.	n.a.	68%	70%	n.a.	n.a.	75%	83%	n.a.	n.a.	70%	78%
			20%	15%	n.a.	n.a.	23%	23%	n.a.	n.a.	19%	9%	n.a.	n.a.	20%	15%
			7%	5%	n.a.	n.a.	8%	4%	n.a.	n.a.	4%	8%	n.a.	n.a.	5%	4%
			0%	<1%	n.a.	n.a.	0%	<1%	n.a.	n.a.	<1%	0%	n.a.	n.a.	<1%	<1%
			<1%	0%	n.a.	n.a.	<1%	<1%	n.a.	n.a.	0%	0%	n.a.	n.a.	<1%	0%
			1%	1%	n.a.	n.a.	1%	2%	n.a.	n.a.	2%	1%	n.a.	n.a.	4%	2%
			541	538	n.a.	n.a.	504	479	n.a.	n.a.	609	602	n.a.	n.a.	614	597
I8c	...Work with a care manager to provide proactive, long-term, relationship-based ("longitudinal") care management															
			67%	77%	n.a.	n.a.	63%	63%	n.a.	n.a.	69%	84%	n.a.	n.a.	63%	74%
			16%	14%	n.a.	n.a.	23%	24%	n.a.	n.a.	17%	10%	n.a.	n.a.	22%	17%
			13%	7%	n.a.	n.a.	10%	7%	n.a.	n.a.	9%	5%	n.a.	n.a.	10%	6%
			1%	1%	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	0%	n.a.	n.a.	<1%	1%
			1%	<1%	n.a.	n.a.	<1%	1%	n.a.	n.a.	1%	1%	n.a.	n.a.	<1%	0%
			2%	1%	n.a.	n.a.	2%	3%	n.a.	n.a.	3%	1%	n.a.	n.a.	5%	3%
			546	540	n.a.	n.a.	509	482	n.a.	n.a.	608	605	n.a.	n.a.	617	597
I8d	...Provide advance care planning															
			n.a.	67%	n.a.	n.a.	n.a.	58%	n.a.	n.a.	n.a.	74%	n.a.	n.a.	n.a.	73%
			n.a.	21%	n.a.	n.a.	n.a.	21%	n.a.	n.a.	n.a.	18%	n.a.	n.a.	n.a.	16%
			n.a.	7%	n.a.	n.a.	n.a.	12%	n.a.	n.a.	n.a.	7%	n.a.	n.a.	n.a.	9%
			n.a.	1%	n.a.	n.a.	n.a.	1%	n.a.	n.a.	n.a.	<1%	n.a.	n.a.	n.a.	<1%
			n.a.	2%	n.a.	n.a.	n.a.	4%	n.a.	n.a.	n.a.	0%	n.a.	n.a.	n.a.	0%
			n.a.	2%	n.a.	n.a.	n.a.	5%	n.a.	n.a.	n.a.	1%	n.a.	n.a.	n.a.	2%
			n.a.	540	n.a.	n.a.	n.a.	481	n.a.	n.a.	n.a.	606	n.a.	n.a.	n.a.	597

Table 3.B.9b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
I8e	...Provide comprehensive medication management for high-risk patients															
Most or all of the process	n.a.	n.a.	n.a.	48%	n.a.	n.a.	n.a.	47%	n.a.	n.a.	n.a.	71%	n.a.	n.a.	n.a.	63%
A lot of the process	n.a.	n.a.	n.a.	16%	n.a.	n.a.	n.a.	23%	n.a.	n.a.	n.a.	15%	n.a.	n.a.	n.a.	19%
Some of the process	n.a.	n.a.	n.a.	15%	n.a.	n.a.	n.a.	14%	n.a.	n.a.	n.a.	12%	n.a.	n.a.	n.a.	14%
None of the process	n.a.	n.a.	n.a.	2%	n.a.	n.a.	n.a.	2%	n.a.	n.a.	n.a.	<1%	n.a.	n.a.	n.a.	<1%
Not currently doing this process at all	n.a.	n.a.	n.a.	15%	n.a.	n.a.	n.a.	11%	n.a.	n.a.	n.a.	1%	n.a.	n.a.	n.a.	1%
Don't know	n.a.	n.a.	n.a.	4%	n.a.	n.a.	n.a.	3%	n.a.	n.a.	n.a.	1%	n.a.	n.a.	n.a.	3%
N	n.a.	n.a.	n.a.	541	n.a.	n.a.	n.a.	482	n.a.	n.a.	n.a.	605	n.a.	n.a.	n.a.	598
I8f	...Provide on-site behavioral health care that is integrated into primary care services															
Most or all of the process	n.a.	n.a.	41%	44%	n.a.	n.a.	36%	42%	n.a.	n.a.	63%	51%	n.a.	n.a.	49%	58%
A lot of the process	n.a.	n.a.	20%	18%	n.a.	n.a.	17%	22%	n.a.	n.a.	12%	24%	n.a.	n.a.	13%	13%
Some of the process	n.a.	n.a.	17%	13%	n.a.	n.a.	19%	16%	n.a.	n.a.	11%	17%	n.a.	n.a.	18%	9%
None of the process	n.a.	n.a.	5%	2%	n.a.	n.a.	4%	3%	n.a.	n.a.	1%	1%	n.a.	n.a.	2%	2%
Not currently doing this process at all	n.a.	n.a.	12%	14%	n.a.	n.a.	12%	12%	n.a.	n.a.	4%	4%	n.a.	n.a.	9%	11%
Don't know	n.a.	n.a.	5%	9%	n.a.	n.a.	11%	4%	n.a.	n.a.	8%	4%	n.a.	n.a.	9%	7%
N	n.a.	n.a.	546	542	n.a.	n.a.	508	482	n.a.	n.a.	610	606	n.a.	n.a.	618	597
I8g	...Assess patients' health-related social service needs and refer them to community resources															
Most or all of the process	n.a.	n.a.	49%	66%	n.a.	n.a.	52%	57%	n.a.	n.a.	65%	78%	n.a.	n.a.	61%	71%
A lot of the process	n.a.	n.a.	23%	17%	n.a.	n.a.	25%	28%	n.a.	n.a.	19%	13%	n.a.	n.a.	23%	19%
Some of the process	n.a.	n.a.	22%	14%	n.a.	n.a.	18%	11%	n.a.	n.a.	15%	7%	n.a.	n.a.	11%	7%
None of the process	n.a.	n.a.	2%	1%	n.a.	n.a.	2%	1%	n.a.	n.a.	<1%	0%	n.a.	n.a.	1%	<1%
Not currently doing this process at all	n.a.	n.a.	3%	1%	n.a.	n.a.	1%	2%	n.a.	n.a.	<1%	0%	n.a.	n.a.	<1%	<1%
Don't know	n.a.	n.a.	2%	2%	n.a.	n.a.	2%	2%	n.a.	n.a.	1%	1%	n.a.	n.a.	4%	2%
N	n.a.	n.a.	544	540	n.a.	n.a.	509	481	n.a.	n.a.	609	606	n.a.	n.a.	617	598
I8h	...Coordinate care with specialists															
Most or all of the process	n.a.	n.a.	63%	77%	n.a.	n.a.	66%	66%	n.a.	n.a.	77%	86%	n.a.	n.a.	68%	76%
A lot of the process	n.a.	n.a.	22%	9%	n.a.	n.a.	24%	26%	n.a.	n.a.	17%	10%	n.a.	n.a.	20%	16%
Some of the process	n.a.	n.a.	13%	13%	n.a.	n.a.	9%	7%	n.a.	n.a.	6%	4%	n.a.	n.a.	7%	6%
None of the process	n.a.	n.a.	1%	<1%	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	<1%	n.a.	n.a.	<1%	<1%
Not currently doing this process at all	n.a.	n.a.	<1%	0%	n.a.	n.a.	0%	<1%	n.a.	n.a.	0%	0%	n.a.	n.a.	0%	<1%
Don't know	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	1%	n.a.	n.a.	0%	<1%	n.a.	n.a.	4%	2%
N	n.a.	n.a.	546	542	n.a.	n.a.	509	481	n.a.	n.a.	609	605	n.a.	n.a.	617	597

Table 3.B.9b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP			
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)
18i	...Use formal written agreements with specialists to set expectations about roles and information sharing															
Most or all of the process	n.a.	n.a.	37%	38%	n.a.	n.a.	25%	30%	n.a.	n.a.	40%	46%	n.a.	n.a.	33%	34%
A lot of the process	n.a.	n.a.	16%	15%	n.a.	n.a.	23%	25%	n.a.	n.a.	18%	13%	n.a.	n.a.	25%	22%
Some of the process	n.a.	n.a.	29%	25%	n.a.	n.a.	29%	24%	n.a.	n.a.	23%	26%	n.a.	n.a.	18%	22%
None of the process	n.a.	n.a.	9%	8%	n.a.	n.a.	13%	10%	n.a.	n.a.	8%	7%	n.a.	n.a.	12%	9%
Not currently doing this process at all	n.a.	n.a.	5%	4%	n.a.	n.a.	4%	6%	n.a.	n.a.	2%	1%	n.a.	n.a.	3%	4%
Don't know	n.a.	n.a.	4%	10%	n.a.	n.a.	6%	6%	n.a.	n.a.	8%	7%	n.a.	n.a.	9%	9%
N	n.a.	n.a.	545	541	n.a.	n.a.	508	480	n.a.	n.a.	610	605	n.a.	n.a.	618	597
18j	...Ensure a range of options for how and when patients can access primary care from practice (for example, phone visits or extended office hours)															
Most or all of the process	n.a.	n.a.	71%	84%	n.a.	n.a.	73%	73%	n.a.	n.a.	77%	88%	n.a.	n.a.	74%	82%
A lot of the process	n.a.	n.a.	21%	8%	n.a.	n.a.	20%	20%	n.a.	n.a.	13%	8%	n.a.	n.a.	19%	12%
Some of the process	n.a.	n.a.	7%	6%	n.a.	n.a.	5%	4%	n.a.	n.a.	10%	3%	n.a.	n.a.	5%	3%
None of the process	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	1%	n.a.	n.a.	<1%	0%	n.a.	n.a.	<1%	<1%
Not currently doing this process at all	n.a.	n.a.	<1%	<1%	n.a.	n.a.	0%	0%	n.a.	n.a.	<1%	0%	n.a.	n.a.	0%	<1%
Don't know	n.a.	n.a.	<1%	1%	n.a.	n.a.	1%	1%	n.a.	n.a.	<1%	1%	n.a.	n.a.	2%	2%
N	n.a.	n.a.	546	542	n.a.	n.a.	508	482	n.a.	n.a.	609	606	n.a.	n.a.	617	597
18k	...Track and use quality measures and other data to guide practice improvements															
Most or all of the process	n.a.	n.a.	72%	83%	n.a.	n.a.	70%	78%	n.a.	n.a.	82%	87%	n.a.	n.a.	70%	82%
A lot of the process	n.a.	n.a.	20%	9%	n.a.	n.a.	20%	15%	n.a.	n.a.	12%	8%	n.a.	n.a.	20%	12%
Some of the process	n.a.	n.a.	7%	6%	n.a.	n.a.	8%	4%	n.a.	n.a.	5%	3%	n.a.	n.a.	7%	3%
None of the process	n.a.	n.a.	1%	<1%	n.a.	n.a.	<1%	1%	n.a.	n.a.	0%	<1%	n.a.	n.a.	<1%	<1%
Not currently doing this process at all	n.a.	n.a.	<1%	<1%	n.a.	n.a.	0%	0%	n.a.	n.a.	0%	0%	n.a.	n.a.	<1%	0%
Don't know	n.a.	n.a.	1%	1%	n.a.	n.a.	2%	2%	n.a.	n.a.	1%	1%	n.a.	n.a.	2%	3%
N	n.a.	n.a.	545	542	n.a.	n.a.	508	481	n.a.	n.a.	608	605	n.a.	n.a.	618	598
18l	...Use Patient and Family Advisory Councils (PFAC) to better understand what matters most to patients and to guide improvements at practice															
Most or all of the process	n.a.	n.a.	28%	33%	n.a.	n.a.	27%	29%	n.a.	n.a.	34%	28%	n.a.	n.a.	30%	40%
A lot of the process	n.a.	n.a.	20%	20%	n.a.	n.a.	22%	17%	n.a.	n.a.	25%	34%	n.a.	n.a.	23%	18%
Some of the process	n.a.	n.a.	34%	29%	n.a.	n.a.	26%	36%	n.a.	n.a.	25%	25%	n.a.	n.a.	29%	21%
None of the process	n.a.	n.a.	13%	8%	n.a.	n.a.	14%	10%	n.a.	n.a.	8%	3%	n.a.	n.a.	12%	10%
Not currently doing this process at all	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	1%	n.a.	n.a.	1%	2%	n.a.	n.a.	1%	1%
Don't know	n.a.	n.a.	4%	8%	n.a.	n.a.	9%	8%	n.a.	n.a.	7%	8%	n.a.	n.a.	5%	10%
N	n.a.	n.a.	546	541	n.a.	n.a.	509	482	n.a.	n.a.	608	606	n.a.	n.a.	618	597

Table 3.B.9b. (continued)

Question ¹	Track 1 – SSP				Track 1 – Not SSP				Track 2 – SSP				Track 2 – Not SSP				
	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	PY 2 (2018)	PY 3 (2019)	PY 4 (2020)	PY 5 (2021)	
I9a Among practices in systems with other CPC+ primary care practices, these other CPC+ practices in system adopted some of the CPC+ changes made by practice	Yes	n.a.	n.a.	n.a.	75%	n.a.	n.a.	n.a.	72%	n.a.	n.a.	n.a.	81%	n.a.	n.a.	n.a.	75%
	No	n.a.	n.a.	n.a.	3%	n.a.	n.a.	n.a.	0%	n.a.	n.a.	n.a.	<1%	n.a.	n.a.	n.a.	2%
	Don't know	n.a.	n.a.	n.a.	22%	n.a.	n.a.	n.a.	28%	n.a.	n.a.	n.a.	19%	n.a.	n.a.	n.a.	23%
	N	n.a.	n.a.	n.a.	373	n.a.	n.a.	n.a.	268	n.a.	n.a.	n.a.	483	n.a.	n.a.	n.a.	325
I9b Among practices in systems with other non-CPC+ primary care practices, these other non-CPC+ practices in system adopted some of the CPC+ changes made by practice	Yes	n.a.	n.a.	n.a.	47%	n.a.	n.a.	n.a.	57%	n.a.	n.a.	n.a.	67%	n.a.	n.a.	n.a.	59%
	No	n.a.	n.a.	n.a.	7%	n.a.	n.a.	n.a.	1%	n.a.	n.a.	n.a.	2%	n.a.	n.a.	n.a.	4%
	Don't know	n.a.	n.a.	n.a.	47%	n.a.	n.a.	n.a.	42%	n.a.	n.a.	n.a.	31%	n.a.	n.a.	n.a.	37%
	N	n.a.	n.a.	n.a.	374	n.a.	n.a.	n.a.	245	n.a.	n.a.	n.a.	472	n.a.	n.a.	n.a.	301
I9c Among practices in systems with specialty care practices, these other specialty care practices in system adopted some of the CPC+ changes made by practice	Yes	n.a.	n.a.	n.a.	20%	n.a.	n.a.	n.a.	13%	n.a.	n.a.	n.a.	20%	n.a.	n.a.	n.a.	22%
	No	n.a.	n.a.	n.a.	14%	n.a.	n.a.	n.a.	19%	n.a.	n.a.	n.a.	9%	n.a.	n.a.	n.a.	18%
	Don't know	n.a.	n.a.	n.a.	66%	n.a.	n.a.	n.a.	68%	n.a.	n.a.	n.a.	71%	n.a.	n.a.	n.a.	59%
	N	n.a.	n.a.	n.a.	385	n.a.	n.a.	n.a.	275	n.a.	n.a.	n.a.	487	n.a.	n.a.	n.a.	324

Source: CPC+ Practice Survey administered to the 2017 Starter CPC+ practices March through September 2017 (PY 1), June through September 2018 (PY 2), July through November 2019 (PY 3), September through December 2020 (PY 4), and July through October 2021 (PY 5). Differences between the surveys by PY could change how practices respond to questions; these differences are indicated with footnotes.

Notes: The data presented in this table represent responses from the practices that began CPC+ in 2017 (2017 Starters) and had completed all five waves of surveys, regardless of whether they were still participating in CPC+ at the time of their response. Presented data is weighted to account for sizable differences in survey response rates between the evaluation's key subgroups of practices: CPC+ region, track, and SSP participation; Ns are unweighted.

¹ Survey questions in this table were not asked in the PY 1 survey. The question numbering is based on the PY 5 survey.

n.a. = not applicable, because the survey question was not asked in that wave or to the specified group of practices; PY = Program Year; SSP = Medicare Shared Savings Program (reflects 2021 [PY 5] participation, or, for practices that withdrew from CPC+, their participation at the time of withdrawal).

Table 3.B.10. Changes in item and response category wording over time (differences in red text)

PY 5 Question number	PY 1 question stem and response categories	PY 2 question stem and response categories, if changed	PY 3 question stem and response options, if changed	PY 4 question stem and response options, if changed	PY 5 question stem and response options, if changed
A1	<p>This question is about all practitioners at this practice site, regardless of specialty. How many total practitioners work full-time (35 hours or more per week) and part time (fewer than 35 hours per week) at this practice site?</p> <p>Please include all practitioners who work at this practice site, regardless of who employs them. Please enter "0" if there are no such practitioners at this practice site.</p> <p>Total Practitioners a. Physician (MD or DO), not including psychiatrist b. Physician resident or fellow (trainee) c. Nurse practitioner (NP) d. Physician assistant (PA) e. Clinical Nurse Specialist (CNS)</p>	<p>MODIFIED QUESTION STEM AND RESPONSE CATEGORIES</p> <p>This question is about all practitioners at this practice site, regardless of specialty or whether they are involved in CPC+^a. How many total practitioners work full-time (35 hours or more per week) and part time (fewer than 35 hours per week) at this practice site?</p> <p>Please include all practitioners who work at this practice site, regardless of who employs them. Please enter "0" if there are no such practitioners at this practice site.</p> <p>Total Practitioners a. Physician (MD or DO), not including psychiatrist b. Physician resident or fellow (trainee) c. Nurse practitioner (NP) d. Physician assistant (PA) e. Clinical nurse specialist (CNS)^a</p>	No change	No change	No change
B16	<p>Feedback to the practice from patient surveys or a patient and family advisory councilis not collected ...is collected but is <u>not used</u> to guide practice improvements. ...is collected and is <u>occasionally</u> used to guide practice improvements. ...is collected and is <u>consistently</u> used to guide practice improvements.</p>	<p>MODIFIED QUESTION STEM</p> <p>Feedback to the practice from a patient and family advisory council (PFAC)... A PFAC is a formal committee of patients, family, and caregivers that provides patient feedback to the practice.</p>	No change	No change	No change

Table 3.B.10. (continued)

PY 5 Question number	PY 1 question stem and response categories	PY 2 question stem and response categories, if changed	PY 3 question stem and response options, if changed	PY 4 question stem and response options, if changed	PY 5 question stem and response options, if changed
G2	<i>Not asked.</i>	<p>NEW</p> <p>The Performance-Based Incentive Payment (PBIP) is paid by CMS prospectively at the beginning of each program year. After each program year ends, CMS retrospectively reconciles the amount of PBIP that a practice earned based on how well the practice performed on patient experience of care measures, clinical quality measures, and utilization measures that drive total cost of care.</p> <p>Thinking about this practice's experience with the PBIP payments from Medicare FFS, please indicate how much you agree or disagree with the following statements.</p> <p>a. Our practice understands how Medicare FFS calculates the proportion of the Performance-Based Incentive Payment (PBIP) my practice will retain and the proportion CMS will recoup</p> <p>b. Our practice feels that Medicare FFS's methodology is fair in how it determines the proportion of the Performance-Based Incentive Payment (PBIP) my practice will retain and the proportion CMS will recoup</p> <p>Strongly disagree Disagree Agree Strongly agree Don't know</p>	<p>MODIFIED QUESTION STEM</p> <p>The Performance-Based Incentive Payment (PBIP) is paid by CMS prospectively at the beginning of each program year. After each program year ends, CMS retrospectively reconciles the amount of PBIP that a practice earned based on how well the practice performed on patient experience of care measures, clinical quality measures, and utilization measures that drive total cost of care.</p> <p>Thinking about this practice's experience with the PBIP payments and recoupments^a from Medicare FFS, please indicate how much you agree or disagree with the following statements.</p> <p>a. Our practice understands how Medicare FFS calculates the proportion of the Performance-Based Incentive Payment (PBIP) my practice retains^a and the proportion CMS recoups^a</p> <p>b. Our practice feels that Medicare FFS's methodology is fair in how it determines the proportion of the Performance-Based Incentive Payment (PBIP) my practice retains^a and the proportion CMS recoups^a</p>	No change	No change

Table 3.B.10. (continued)

PY 5 Question number	PY 1 question stem and response categories	PY 2 question stem and response categories, if changed	PY 3 question stem and response options, if changed	PY 4 question stem and response options, if changed	PY 5 question stem and response options, if changed
G3	<i>Not asked.</i>	<p>NEW</p> <p>The Comprehensive Primary Care Payment (CPCP) is a lump sum quarterly payment paid to Track 2 practices based on their historical FFS payment amounts for evaluation and management (E&M) services. Track 2 practices' FFS payments for these services are reduced to account for the CPCP.</p> <p>Thinking about this practice's experience with the 2017 CPCP payments from Medicare FFS for CPC+, please indicate how much you agree or disagree with the following statements.</p> <p>a. Our practice understands how Medicare FFS calculated its Comprehensive Primary Care Payments (CPCPs)</p> <p>Strongly disagree Disagree Agree Strongly agree Don't know</p> <p>b. Our practice feels that Medicare FFS' methodology is fair in how it calculates Comprehensive Primary Care Payments (CPCPs)</p> <p>Strongly disagree Disagree Agree Strongly agree Don't know</p>	No change	<p>MODIFIED QUESTION STEM</p> <p>The Comprehensive Primary Care Payment (CPCP) is a lump sum quarterly payment paid to Track 2 practices based on their historical FFS payment amounts for evaluation and management (E&M) services. Track 2 practices' FFS payments for these services are reduced to account for the CPCP.</p> <p>Thinking about this practice's experience with the 2017 CPCP payments from Medicare FFS for CPC+, please indicate how much you agree or disagree with the following statements.</p> <p>a. Our practice understands how Medicare FFS calculates its Comprehensive Primary Care Payments (CPCPs)</p> <p>b. Our practice feels that Medicare FFS' methodology is fair in how it calculates Comprehensive Primary Care Payments (CPCPs)</p>	No change

Table 3.B.10. (continued)

PY 5 Question number	PY 1 question stem and response categories	PY 2 question stem and response categories, if changed	PY 3 question stem and response options, if changed	PY 4 question stem and response options, if changed	PY 5 question stem and response options, if changed
G4	<i>Not asked.</i>	<p>NEW</p> <p>CPC+ payer partners are payers other than Medicare FFS that participate in CPC+. The next set of questions is about CPC+ payments from CPC+ payer partners. These payers include private health insurers, Medicare Advantage, Medicaid FFS, and Medicaid Managed Care.</p> <p>Does this practice contract with CPC+ payer partners for CPC+?</p> <p>Yes No</p>	No change	<p>MODIFIED QUESTION STEM AND RESPONSE CATEGORIES</p> <p>The next set of questions is about CPC+ payments from non-CMS payers. We define these as CPC+ payers other than CMS/Medicare FFS. These payers may contract in CPC+ for your commercially insured, Medicare Advantage, Medicaid FFS, or Medicaid Managed Care patients.</p> <p>Below is a list of the non-CMS CPC+ payers in your region. Which of these does your practice contract with, even if you don't receive a separate CPC+ payment from them?</p> <p>[List of payers in practice region.]^a</p>	MODIFIED QUESTION STEM AND RESPONSE CATEGORIES [Reverted to PY 2 and PY 3 wording.]
G4a	<i>Not asked.</i>	<p>NEW</p> <p>Overall, considering the amount of work required by CPC+, how adequate or inadequate are the CPC+ payments across the CPC+ payer partners you work with on CPC+?</p> <p>CPC+ payments from these payers could include care management fees; full or partial capitated, global, or bundled payments; or payments that reward cost or quality performance.</p> <p>More than adequate Adequate Less than adequate Don't know – not familiar with CPC+ payments from CPC+ payer partners or costs of doing CPC+ work</p>	No change	<p>MODIFIED QUESTION STEM</p> <p>[These payers/This payer] may provide payments unique to CPC+ or payments made under their patient-centered medical home (PCMH) or value-based programs for your CPC+ patients. ^a</p> <p>CPC+ payments from [these payers/this payer] can include care management fees; full or partial capitated, global, or bundled payments; or payments that reward cost or quality performance. ^a</p> <p>Overall, considering the amount of work required by CPC+, how adequate or inadequate are the CPC+ payments [across these payers, including the payers that /from this payer, even if they] do not provide a separate CPC+ payment?^a</p>	MODIFIED QUESTION STEM [Reverted to PY 2 and PY 3 wording.]

Table 3.B.10. (continued)

PY 5 Question number	PY 1 question stem and response categories	PY 2 question stem and response categories, if changed	PY 3 question stem and response options, if changed	PY 4 question stem and response options, if changed	PY 5 question stem and response options, if changed
H2	Not asked.	<p>NEW</p> <p>The CPC+ National Learning Community and Regional Learning Network offer assistance to practices in a variety of ways. For each of the following types of assistance that this practice site may have received in the past six months, please rate how useful this assistance has been to this practice site in improving primary care.</p> <ul style="list-style-type: none"> a. Webinars (for example, Action Groups or Practices in Action meetings) b. Health IT Affinity Groups (groups enabling CPC+ practices to network with their health IT vendors or other practices that use the same health IT) c. In-person learning sessions d. In-person coaching at this practice site to improve practice processes and workflows e. One-on-one telephone/virtual coaching with this practice site to improve practice processes and workflows f. CPC+ Connect (the online information resource and collaboration website for CPC+) g. CPC+ Implementation Guides h. CPC+ Practice Spotlights (articles highlighting the work of individual CPC+ practices) i. CPC+ Support (CPC+ help desk managed by Telligen) <p>Not at all useful Not very useful Somewhat useful Very useful Never received or attended</p>	<p>MODIFIED QUESTION STEM</p> <p>The CPC+ National Learning Community and Regional Learning Network offer assistance to practices in a variety of ways. For each of the following types of assistance that this practice site may have received in the past six months, please rate how useful this assistance has been to this practice site in improving primary care.</p> <ul style="list-style-type: none"> a. Webinars (for example, Action Groups, Practices in Action meetings, or national webinars)^a b. Health IT Affinity Groups (groups enabling CPC+ practices to network with their health IT vendors or other practices that use the same health IT) c. In-person learning sessions d. In-person coaching at this practice site e. One-on-one telephone/virtual coaching with this practice site to improve practice processes and workflows f. CPC+ Connect (the online information resource and collaboration website for CPC+) g. CPC+ Implementation Guides h. CPC+ Practice Spotlights (articles highlighting the work of individual CPC+ practices) i. CPC+ Support (CPC+ help desk managed by Telligen) j. Regional Implementation Networking Groups (also called RINGs; attended by care managers and practice managers) ^a 	<p>MODIFIED QUESTION STEM</p> <p>The CPC+ National Learning Community and Regional Learning Network offer assistance to practices in a variety of ways. For each of the following types of assistance that this practice site may have received in the past six months, please rate how useful this assistance has been to this practice site in improving primary care.</p> <ul style="list-style-type: none"> a. National webinars^a b. One-on-one telephone/virtual coaching with this practice site to improve practice processes and workflows c. CPC+ Connect (the online information resource and collaboration website for CPC+) d. CPC+ Implementation Guides e. CPC+ Support (CPC+ help desk managed by Telligen) f. Group coaching (coaching with a small number of practices, directed by a practice facilitator)^a 	No change

Table 3.B.10. (continued)

PY 5 Question number	PY 1 question stem and response categories	PY 2 question stem and response categories, if changed	PY 3 question stem and response options, if changed	PY 4 question stem and response options, if changed	PY 5 question stem and response options, if changed
I1	Thinking of the different types of staff at this practice site, how involved is each staff type in implementing CPC+? a. Clinical leadership b. Physicians c. Clinical support staff d. Administrative support staff Very involved Somewhat involved Not very involved Not at all involved	MODIFIED QUESTION STEM Thinking of the different types of staff at this practice site, how involved is each type of staff in implementing CPC+? a. Medical director or clinician lead at this practice site^a b. Physicians c. Nurse practitioners (NPs), clinical nurse specialists (CNSs), or physician assistants (PAs)^a d. Clinical support staff e. Clerical support staff^a	No change	No change	No change

Table 3.B.10. (continued)

PY 5 Question number	PY 1 question stem and response categories	PY 2 question stem and response categories, if changed	PY 3 question stem and response options, if changed	PY 4 question stem and response options, if changed	PY 5 question stem and response options, if changed
F1	<p>During the 2016 calendar year, did any portion of this practice site's revenue come from the following sources?</p> <p>a. Fee-for-service payments (payments for specific services billed to insurers)^a b. Care management fees (per-patient per-month payments to support care management for patients) c. Capitation (per-patient per-month payment for specific patients, intended to cover costs of all services provided regardless of amount or type). Do not include the care management fees described in b above d. Episode-based payments (a fixed payment for all services needed for a patient with a particular condition, such as a hip fracture) e. Financial rewards or bonuses from insurers for improving quality of care, patient experience, and/or controlling costs f. Other payments (please describe)</p> <p>Yes No Don't know</p>	<p>MODIFIED QUESTION STEM AND RESPONSE OPTIONS</p> <p>During the 2017 calendar year, what percentage of this practice site's revenue came from fee-for-service (FFS) payments? Please include FFS payments from all insurers. Your best estimate is fine.</p> <p>[Open percentage]</p> <p>During the 2017 calendar year, did any portion of this practice site's revenue come from the following sources?</p> <p>a. Care management fees (prospective payments to support care management for patients, paid in addition to usual payments for services)^a b. Capitation (per-patient per-month payment for specific patients, intended to cover costs of some or^a all services provided, regardless of amount or type, in lieu of fee-for-service payments).^a Do not include the care management fees described in item a. above. [Track 2 CPC+ PRACTICES ONLY: Please include the CPC+ Comprehensive Primary Care Payment (CPCP) here.]^a c. Episode-based payments (a fixed payment for all services needed for a patient with a particular condition, such as an upper respiratory infection or urinary tract infection) d. Shared savings, in which costs of care are compared to an expenditure target or to costs for another group of practices and a proportion of any savings are shared with practices.^a e. Financial rewards or bonuses from insurers for improving quality of care, patient experience, and/or controlling costs, not including shared savings. [NON-SSP CPC+ PRACTICES ONLY: Please include the CPC+ Performance-Based Incentive Payment (PBIP) here.]^a f. Other payments (please describe)</p> <p>Yes No Don't know</p>	<p>MODIFIED QUESTION STEM</p> <p>During the 2018 calendar year, what percentage of this practice site's revenue came from fee-for-service (FFS) payments? Please include FFS payments from all insurers. Your best estimate is fine.</p> <p>During the 2018 calendar year, did any portion of this practice site's revenue come from the following sources?</p> <p>a. Care management fees (prospective payments to support care management for patients, paid in addition to usual payments for services) b. Capitation (per-patient per-month payment for specific patients, intended to cover costs of some or all services provided, regardless of amount or type, in lieu of fee-for-service payments). Do not include the care management fees described in item a. above. [TRACK 2^a CPC+ PRACTICES ONLY: Please include the CPC+ Comprehensive Primary Care Payment (CPCP) here.] c. Episode-based payments (a fixed payment for all services needed for a patient with a particular condition, such as an upper respiratory infection or urinary tract infection) d. Shared savings, in which costs of care are compared to an expenditure target or to costs for another group of practices and a proportion of any savings are shared with practices. e. Financial rewards or bonuses from insurers for improving quality of care, patient experience, and/or controlling costs, not including shared savings. [NON-SSP (FOR 2018)^a CPC+ PRACTICES ONLY: Please include CMS's CPC+ Performance-Based Incentive Payment (PBIP) here./ NON-SSP (FOR 2018) WITHDRAWN/TERMINATED PRACTICES ONLY: Please include CMS's CPC+ Performance-Based Incentive Payment (PBIP) unless your practice stopped participating in CPC+ during the 2018 calendar year]^a</p>	<p>REMOVED FOLLOW-UP QUESTION ON REVENUE SOURCES</p>	<p>No change</p>

Table 3.B.10. (continued)

PY 5 Question number	PY 1 question stem and response categories	PY 2 question stem and response categories, if changed	PY 3 question stem and response options, if changed	PY 4 question stem and response options, if changed	PY 5 question stem and response options, if changed
J1	<p>Who provided input in completing this survey?</p> <ol style="list-style-type: none"> 1. Practice manager 2. Lead physician 3. Other physicians 4. Nurse practitioner (NP), Clinical Nurse Specialist (CNS), or physician assistant (PA) 5. Care manager/coordinator 6. Staff from our larger health care system or medical group 7. Quality improvement staff 8. Nursing staff 9. Medical assistant staff 10. Administrative support staff (e.g., billing staff, front desk staff) 11. Patients 99. Other (specify) 	<p>MODIFIED QUESTION STEM AND RESPONSE OPTIONS</p> <p>Who filled out this survey or provided input to complete this survey?^a</p> <ol style="list-style-type: none"> 1. Practice or office manager (e.g., Clinic manager, office coordinator, office supervisor)^a 2. Lead physician 3. Other physicians 4. Nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) 5. Care manager/coordinator 6. Nursing staff, including nurse manager or supervisor^a 7. Medical assistant staff 8. Quality improvement staff 9. Administrative support staff (e.g., billing or finance staff, front desk staff) 10. Nonphysician owner of practice 11. Leadership or staff from our larger health care system or medical group (e.g., CEO, CMO) 12. Data analytics staff (e.g., EMR analyst, health IT team) 13. CPC+ lead^a 14. Patients 99. Other (specify) 	No change	No change	No change

^a Red, bolded text indicates differences.

3.B.6. Survey instrument



Comprehensive Primary Care Plus (CPC+)

2021 Survey of Primary Care Practices

FINAL – June 16, 2021

**Sponsored by
The Centers for Medicare & Medicaid Services (CMS)**

Citation: Mathematica. "Evaluation of the Comprehensive Primary Care Plus (CPC+) Model: 2021 Survey of Primary Care Practices." Princeton, NJ: Mathematica, administered starting July 2021.

[INSTRUCTIONS FOR TREATMENT PRACTICES]

The 2021 Comprehensive Primary Care Plus (CPC+) Practice Survey is a critical component of the independent study sponsored by the Centers for Medicare & Medicaid Services (CMS), and its completion is a condition of your participation in CPC+. This survey is being conducted by Mathematica, an independent research company hired by CMS to conduct the study of CPC+.

The practice manager (or the person most knowledgeable about the practice) should complete the survey. **We strongly encourage you to get input from others in your practice**; for example, you may ask others to review answers to questions and discuss the survey at a practice meeting. The survey will be most helpful to you—and most accurate—if it represents a consensus view of your practice site's clinical and support staff, arriving at the best answers after discussion.

Please complete all questions in the survey to the best of your knowledge and that of others in the practice from whom you seek input.

- For practices that have more than one physical location/practice site that participates in CPC+, we will contact each site to complete the survey.
- If this practice has multiple locations/practice sites, please respond only about the site identified at the top of the screen and be as accurate as possible.

We encourage your candid responses and remind you that there is no “passing grade” for this survey. This survey was developed to understand how practices provide patient care. While this survey covers some of the general topics that you've reported on to CMS in the CPC+ Practice Portal, this survey asks about more nuanced aspects of these topics.

Your responses to this survey will never be tied to your name or your practice in any report to CMS, other payers, or the public. Your responses will only be reported to CMS in aggregate (with all CPC+ practices combined). Your responses will **not** have any consequences for payment or for your participation in CPC+. We are genuinely interested in your observations of how your practice operates today.

For the purposes of providing learning support, both nationally and in your region, your practice's name and answers **will be shared with the CPC+ learning team who will not share this information with CMS or other payers.** This information will also be shared with independent researchers to study the effects of CPC+.

Questions? Contact Mathematica by email at CPCPlusPracticeSurvey@mathematica-mpr.com or by telephone (toll-free) at 1-844-684-9433.

[INSTRUCTIONS FOR TREATMENT WITHDRAWN PRACTICES]

The 2021 Comprehensive Primary Care Plus (CPC+) Practice Survey is an important part of the study of the CPC+ initiative, sponsored by the Centers for Medicare & Medicaid Services (CMS), which seeks to improve the quality of primary care (<https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>). This survey is being conducted by Mathematica, an independent research company hired by CMS to conduct the study of CPC+.

Even though your practice is no longer participating in CPC+, we must collect information from practices that are participating in CPC+ and practices that are not to study the impact of how CPC+ is changing how primary care practices deliver care. We are asking you to complete the survey to help us understand how primary care practices deliver care. It is vital to the study that we understand the range of current approaches to the delivery of primary care and organizational characteristics across primary care practices.

You will receive \$200 for completing this survey.

The practice manager (or the person most knowledgeable about the practice) should complete the survey. **We strongly encourage you to get input from others in your practice**; for example, you may ask others to review answers to questions and discuss the survey at a practice meeting. The survey will be most accurate if it represents a consensus view of your practice site's clinical and support staff, arriving at the best answers after discussion.

Please complete all questions in the survey to the best of your knowledge and that of others in the practice from whom you seek input. If this practice has multiple locations/practice sites, please respond only about the site identified at the top of the screen and be as accurate as possible.

We encourage your candid responses and remind you that there is no “passing grade” for this survey. This survey was developed to understand how practices provide patient care.

Your responses to this survey will never be tied to your name or your practice in any report to CMS, other payers, or the public. Your responses will only be reported to CMS in aggregate (with all practices combined). Your responses will **not** have any consequences for Medicare payments. We are genuinely interested in your observations of how your practice operates today.

If you have difficulty or questions when completing this survey, please contact Mathematica by email at CPCPlusPracticeSurvey@mathematica-mpr.com or by telephone (toll-free) at 1-844-684-9433.

IMPORTANT

- If this practice has multiple physical locations/practice sites, **please respond *only* about the site identified at the top of the screen**, and be as accurate as possible.
- The survey has been optimized to run on a desktop computer, and is best viewed in the latest versions of Chrome, Safari, Firefox, or Internet Explorer (IE 11 or Edge).

INSTRUCTIONS TO COMPLETE THE SURVEY

- To preview the survey: [Click Here](#).
- Answer all questions to the best of your ability.
- If you answer “Other” for a question, please specify by typing what you mean in the “Specify” box.
- Click on “Back” at the bottom of the screen to go back to a previous question.
- Use the “Save and Next” button to proceed to the next question. Your answers are saved each time you click the “Save and Next” button.
- You do not have to complete the survey all at once. Be sure to click the “Save and Next” button to save your answers before exiting the survey. You will resume at the next unanswered question when you return to the survey.
- After about 20 minutes of idle time, the survey may time out, but your answers will be saved. If that happens, you will be redirected to the login page prior to resuming the survey where you left off.
- If you have any questions while taking the survey, please click on “FAQ” at the bottom of the screen at any time. If the FAQ document does not answer your question, you may email the CPC+ Practice Survey Help Desk by clicking on “Contact us” at the bottom of the screen.
- Once you have completed the survey, you will have the opportunity to review and/or print your answers before submitting the survey.
- Instructions to submit the survey when you have finished answering all the questions and reviewing your responses are listed after the survey review screen.

A. INFORMATION ABOUT THIS PRACTICE SITE

These questions focus on background information about this practice site.

PRACTITIONERS AT THIS PRACTICE SITE

A1. This question is about all practitioners at this practice site, regardless of specialty or whether they are involved in CPC+. How many total practitioners work full-time (35 hours or more per week) and part-time (fewer than 35 hours per week) at this practice site?

Please include all practitioners who work at this practice site, regardless of who employs them. Please enter "0" if there are no such practitioners at this practice site.

Total Practitioners	NUMBER FULL-TIME AT PRACTICE SITE	NUMBER PART-TIME AT PRACTICE SITE
a. Physician (MD or DO), not including psychiatrist	_ _ _	_ _ _
b. Physician resident or fellow (trainee)	_ _ _	_ _ _
c. Nurse practitioner (NP)	_ _ _	_ _ _
d. Physician assistant (PA)	_ _ _	_ _ _
e. Clinical nurse specialist (CNS)	_ _ _	_ _ _

A2. This question focuses on the primary care practitioners at this practice site. A primary care practitioner is defined as a physician (MD or DO), nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) who has a primary specialty designation of family medicine, internal medicine, or geriatric medicine, and who practices under their own National Provider ID (NPI).

How many primary care practitioners work *full-time* (35 hours or more per week) and *part-time* (fewer than 35 hours per week) at this practice site?

Please include all primary care practitioners who work at this practice site, regardless of who employs them. Please enter "0" if there are no such primary care practitioners at this practice site.

Primary Care Practitioners with Own NPI	NUMBER FULL-TIME AT PRACTICE SITE	NUMBER PART-TIME AT PRACTICE SITE
a. Physician (MD or DO)	_ _ _ _	_ _ _ _
b. Physician resident or fellow (trainee)	_ _ _ _	_ _ _ _
c. Nurse practitioner (NP)	_ _ _ _	_ _ _ _
d. Physician assistant (PA)	_ _ _ _	_ _ _ _
e. Clinical nurse specialist (CNS)	_ _ _ _	_ _ _ _

A3. [If counts for one staff type (A2a, A2c, or A2d) in W4 survey is different than count in A2 in W5 survey]

Based on your responses to this year's and last year's fall survey, there has been a change in the number of primary care [physicians/nurse practitioners/physician assistants].

In last year's survey, this practice site reported it had:

- [X primary care physician(s)]
- [X primary care nurse practitioner(s)]
- [X primary care physician assistant(s)]

Your response to question A2 indicates this practice site currently has:

- [Y primary care physician(s)]
- [Y primary care nurse practitioner(s)]
- [Y primary care physician assistant(s)]

Is this change in the number of primary care [physicians/nurse practitioners/physician assistants] primarily due to the coronavirus pandemic?

- 1 Yes
- 0 No → GO TO A4
- d Don't know → GO TO A4



A3a. [If A3 = 1 (Yes)] Please describe how the coronavirus pandemic led to changes in the number of primary care [physicians/nurse practitioners/physician assistants] at this practice site since fall 2020.

PRACTICE STAFF

A4. Does this practice site have individuals working full-time or part-time in any of the following job roles? Please include all staff who work at this practice site, regardless of who employs them.

MARK ONE RESPONSE PER ROW

	YES	NO
a. Clinical psychologist, psychiatrist, or clinical social worker (behavioral health specialists)	1 <input type="checkbox"/>	0 <input type="checkbox"/>
b. Quality improvement (QI) specialist	1 <input type="checkbox"/>	0 <input type="checkbox"/>
c. Health educator, dietitian, or nutritionist	1 <input type="checkbox"/>	0 <input type="checkbox"/>
d. Clinical pharmacist or doctor of pharmacy	1 <input type="checkbox"/>	0 <input type="checkbox"/>

A5. Is your practice part of a larger health care system that includes a hospital?

- 1 Yes
- 0 No

KEY APPROACHES TO PROVIDING PRIMARY CARE

General Instructions. In this section, each row pertains to a particular aspect of primary care. The four response boxes in each row represent different approaches to providing a specific aspect of primary care.

For each row, **please mark the box** that best describes the level of care that this practice site currently provides.

A6. Patientsare not assigned to specific practitioner panels. <input type="checkbox"/>	...are assigned to specific practitioner panels but panel assignments are <u>not routinely used</u> by the practice for administrative or other purposes. <input type="checkbox"/>	...are assigned to specific practitioner panels and panel assignments are <u>routinely used</u> by the practice mainly for scheduling purposes. <input type="checkbox"/>	...are assigned to specific practitioner panels and panel assignments are routinely used for scheduling purposes and are <u>continuously monitored</u> to balance supply and demand. <input type="checkbox"/>
A7. Non-physician practice team membersplay a limited role in providing clinical care. <input type="checkbox"/>	...are primarily tasked with managing patient flow and triage. <input type="checkbox"/>	...provide some clinical services such as assessment or self-management support. <input type="checkbox"/>	...perform <u>key</u> clinical service roles that match their abilities and credentials. <input type="checkbox"/>
A8. A standard method or tool(s) to stratify patients by risk levelis not available. <input type="checkbox"/>	...is available but not consistently used to stratify all patients. <input type="checkbox"/>	...is available and is consistently used to stratify all patients, but is <u>inconsistently integrated</u> into all aspects of care delivery. <input type="checkbox"/>	...is available, consistently used to stratify all patients, and is <u>integrated</u> into all aspects of care delivery. <input type="checkbox"/>
A9. Follow-up by this primary care practice with patients seen in the emergency department (ED) or hospitalgenerally does not occur. <input type="checkbox"/>	...occurs only if the ED or hospital alerts this primary care practice. <input type="checkbox"/>	...occurs because this primary care practice makes proactive efforts to identify patients. <input type="checkbox"/>	...is done routinely because this primary care practice has arrangements in place with the ED and hospital to both track these patients and ensure that follow-up is completed within a few days. <input type="checkbox"/>

A10. Linking patients to supportive community-based resourcesis not done systematically. <input type="checkbox"/>	...is limited to <u>providing patients a list</u> of identified community resources in an accessible format. <input type="checkbox"/>	...is accomplished through a <u>designated staff person or resource</u> responsible for connecting patients with community resources. <input type="checkbox"/>	...is accomplished through <u>active coordination</u> between the health system, community service agencies, and patients, and accomplished by a designated staff person. <input type="checkbox"/>
A11. Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP, or nurseis not available or is limited to an answering machine. <input type="checkbox"/>	...is available from a coverage arrangement (e.g., answering service) that <u>does not</u> offer a standardized communication protocol back to the practice for urgent problems. <input type="checkbox"/>	...is provided by a coverage arrangement (e.g., answering service) that shares necessary patient data with and provides a summary to the practice. <input type="checkbox"/>	...is available via the patient's choice of email or phone directly with the practice team or a practitioner who has real-time access to the patient's electronic medical record. <input type="checkbox"/>
A12. Quality improvement (QI) activitiesare not organized or supported consistently. <input type="checkbox"/>	...are conducted on an ad hoc basis in reaction to specific problems. <input type="checkbox"/>	...are based on a proven improvement strategy in reaction to specific problems. <input type="checkbox"/>	...are based on a proven improvement strategy and used continuously in meeting organizational goals. <input type="checkbox"/>
A13. Staff, resources, and time for QI activities...	...are not readily available in this practice. <input type="checkbox"/>	...are occasionally available but are limited in scope (due to some deficiencies in staff, resources, or time). <input type="checkbox"/>	...are generally available and usually at the level needed. <input type="checkbox"/>	...are all fully available in the practice. <input type="checkbox"/>

B. CURRENT APPROACHES TO PROVIDING PRIMARY CARE

General Instructions. In this section, each row pertains to a particular aspect of primary care. The four response boxes in each row represent different approaches to providing a specific aspect of primary care.

For each row, **please mark the box** that best describes the level of care that this practice site currently provides.

ACCESS

B1. Same-day appointments for patients who need them are available at this practice site fornone of this practice's patients. <input type="checkbox"/>	... <u>some</u> of this practice's patients. <input type="checkbox"/>	... <u>many</u> of this practice's patients. <input type="checkbox"/>	... <u>most or all</u> of this practice's patients. <input type="checkbox"/>
B2. Communicating with the practice team through email, text messaging, or accessing a patient portal occurs fornone of this practice's patients. <input type="checkbox"/>	... <u>some</u> of this practice's patients. <input type="checkbox"/>	... <u>many</u> of this practice's patients. <input type="checkbox"/>	... <u>most or all</u> of this practice's patients. <input type="checkbox"/>
B3. Scheduled phone or video visits with a physicianare not regularly available to patients. <input type="checkbox"/>	...are available on a <u>limited</u> basis to patients. <input type="checkbox"/>	...are <u>generally available</u> at a patient's request. <input type="checkbox"/>	...are generally available, and <u>patients are regularly asked about their preferences</u> for in-person versus phone/video visits. <input type="checkbox"/>

CONTINUITY

B4. Patientsdo not have a specific physician that they see at this practice. <input type="checkbox"/>	...have a specific physician, and the patient is <u>sometimes</u> scheduled with that physician. <input type="checkbox"/>	...have a specific physician, and the patient is <u>frequently</u> scheduled with that physician. <input type="checkbox"/>	...have a specific physician, and the patient is <u>almost always</u> scheduled with that physician. <input type="checkbox"/>
B5. When patients contact the practice with clinical questions or concerns (e.g., a new problem or questions about their treatment) between scheduled encountersthey do not have a specific physician that they see at the practice, so any member of the practice responds. <input type="checkbox"/>	...their specific physician or practice care team that has primarily worked with the patient <u>sometimes</u> responds. <input type="checkbox"/>	...their specific physician or practice care team that has primarily worked with the patient <u>frequently</u> responds. <input type="checkbox"/>	...their specific physician or practice care team that has primarily worked with the patient <u>almost always</u> responds. <input type="checkbox"/>

CARE MANAGEMENT

Care management is a set of activities designed to assist patients and their caregivers in managing medical conditions and related psychosocial problems. Care management activities include providing support and education to high-risk patients to monitor and manage their chronic condition(s), working with patients during primary care visits and between visits (e.g., by phone), and monitoring transitions in care such as after a hospitalization.

B6. Care management services for high-risk patientsare not provided at this practice. <input type="checkbox"/>	...are provided by care managers from an <u>outside organization</u> (e.g., a health insurance plan). <input type="checkbox"/>	...are provided by a care manager <u>within this practice's organization</u> who is not physically located at this practice site. <input type="checkbox"/>	...are provided by a care manager <u>located at this practice site</u> . <input type="checkbox"/>
B7. [IF B6 = 2-4] Care managers engage in meetings, huddles, or conversations with the physicians at this practice site about the high-risk patients they manage ... <input type="checkbox"/> Not applicable – care management services for high-risk patients are not provided	...never or rarely. <input type="checkbox"/>	...a few times a month. <input type="checkbox"/>	...weekly. <input type="checkbox"/>	...daily. <input type="checkbox"/>

COORDINATION OF CARE ACROSS PROVIDERS AND SETTINGS IN YOUR COMMUNITY

Please answer the questions in this section based on the providers that serve most of your patients.

B8. Receipt of clinical information (e.g., a discharge summary) from an <u>emergency department (ED)</u> about this practice's patients who had an <u>ED visit</u>does not occur consistently. <input type="checkbox"/>	...usually occurs <u>more than 3 days</u> after the visit. <input type="checkbox"/>	...usually occurs <u>1–3 days</u> after the visit. <input type="checkbox"/>	...usually occurs <u>within a day</u> of the visit. <input type="checkbox"/>
B9. Outreach by this practice site to patients within <u>one week of an ED visit</u> occurs fornone of this practice's patients. <input type="checkbox"/>	... <u>some</u> of this practice's patients. <input type="checkbox"/>	... <u>many</u> of this practice's patients. <input type="checkbox"/>	... <u>most or all</u> of this practice's patients. <input type="checkbox"/>
B10. Receipt of clinical information (e.g., a discharge summary) from <u>hospitals</u> about this practice's patients who had a <u>hospital visit</u>does not occur consistently. <input type="checkbox"/>	...usually occurs <u>more than 3 days</u> after discharge. <input type="checkbox"/>	...usually occurs <u>1–3 days</u> after discharge. <input type="checkbox"/>	...usually occurs <u>within a day</u> of discharge. <input type="checkbox"/>
B11. Outreach by this practice site to patients within <u>3 days of hospital discharge</u> occurs fornone of this practice's patients. <input type="checkbox"/>	... <u>some</u> of this practice's patients. <input type="checkbox"/>	... <u>many</u> of this practice's patients. <input type="checkbox"/>	... <u>most or all</u> of this practice's patients. <input type="checkbox"/>

<p>B12. Timely receipt of information (e.g., consultation reports, diagnoses, new medications) about your patients <u>after they visit specialists</u> occurs for...</p>	<p>...<u>none</u> of this practice's patients.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...<u>some</u> of this practice's patients.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...<u>many</u> of this practice's patients.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...<u>most or all</u> of this practice's patients.</p> <p style="text-align: center;"><input type="checkbox"/></p>
<p>B13. Practices may or may not have agreements with specialists they refer patients to. A formal, written agreement with a specialist describes expectations for timely patient visits, the frequency and type of information communicated between the primary care practice and specialist, and their respective roles.</p> <p>This practice site has formal, written agreements with ...</p>	<p>...no medical or surgical specialist groups.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...<u>some</u> medical and surgical specialist groups.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...<u>many</u> medical and surgical specialist groups.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...<u>most or all</u> medical and surgical specialist groups.</p> <p style="text-align: center;"><input type="checkbox"/></p>
<p>B14. This practice site assesses the social and functional support needs (e.g., transportation, home equipment) for ...</p>	<p>...<u>none</u> of this practice's patients.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...<u>some</u> of this practice's patients.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...<u>many</u> of this practice's patients.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...<u>most or all</u> of this practice's patients.</p> <p style="text-align: center;"><input type="checkbox"/></p>

PATIENT AND CAREGIVER ENGAGEMENT

<p>B15. Self-management support is help for patients to better manage their health on a day-to-day basis.</p> <p>At this practice site, self-management support for most patients who have chronic conditions ...</p>	<p>...is limited to either (1) the distribution of information (e.g., pamphlets, booklets) with no or little discussion or (2) referral to self-management classes or educators.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...is provided by practice staff but they do <u>not</u> set specific goals with patients (e.g., they just offer patient education).</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...is provided by practice staff <u>who set specific goals</u> with patients but are not trained in assessing how ready patients are to change their health behavior and how to motivate patient behavior change.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...is provided by practice staff who set specific goals with patients and are <u>trained</u> in assessing how ready patients are to change their health behavior and how to motivate patient behavior change.</p> <p style="text-align: center;"><input type="checkbox"/></p>
<p>B16. Feedback to the practice from a patient and family advisory council (PFAC)...</p> <p><i>A PFAC is a <u>formal committee</u> of patients, family, and caregivers that provides patient feedback to the practice.</i></p>	<p>...is not collected.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...is collected but is <u>not used</u> to guide practice improvements.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...is collected and is <u>occasionally</u> used to guide practice improvements.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...is collected and is <u>consistently</u> used to guide practice improvements.</p> <p style="text-align: center;"><input type="checkbox"/></p>

PLANNED CARE FOR CHRONIC CONDITIONS AND POPULATION HEALTH

<p>B17. A registry is a data system that identifies and tracks patients with specific health conditions, risk states, or medications.</p> <p>At this practice site, registry data to assess or manage care for groups of patients ...</p>	<p>...are not available.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...are available for <u>1–2</u> diseases and/or risk states.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...are available for <u>3–5</u> diseases and/or risk states.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...are available for <u>6 or more</u> diseases and/or risk states.</p> <p style="text-align: center;"><input type="checkbox"/></p>
<p>B18. Pre-visit planning (gathering and organizing patient information to prepare for the visit) <u>prior to the day of the visit</u> ...</p>	<p>...is not done.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...is done but primarily focuses on reviewing test results and consultation reports from specialist referrals.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...is done and includes (1) reviewing test results and consultation reports from specialist referrals, and (2) <u>identifying gaps in health care (e.g., a needed flu shot or cancer screenings)</u>.</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>...is done and includes (1) reviewing test results and consultation reports from specialists, (2) identifying gaps in health care, and (3) <u>conducting outreach before the visit</u>, to ask the patient to obtain needed tests prior to the visit.</p> <p style="text-align: center;"><input type="checkbox"/></p>

C. CARE MANAGEMENT

C1. This question is about care managers/care coordinators who work as part of a practice’s care team, regardless of who employs them or where they are located.

A care manager/care coordinator works with high-risk patients between and during visits to provide ongoing support and education on chronic care management, and coordinates care from other providers. A care team consists of staff who regularly work together to provide patient care.

How many full-time and part-time care manager(s) and/or care coordinator(s) work as part of a care team at this practice site to address the needs of its patients? Please include all staff who work at this practice site, regardless of who employs them. Please enter “0” if no care managers or care coordinators work as part of a care team at this practice site.

	NUMBER OF STAFF
a. Full-time care managers and care coordinators	_ _ _ _
b. Part-time care managers and care coordinators	_ _ _ _

C1c. [IF C1a+C1b = 0 OR M; no care managers work as part of a care team at this practice site, or respondent left C1 blank]

What is the main reason your practice does not have a care manager or care coordinator working as part of a care team at this practice site?

[ONLY DISPLAY OPTION 2 AND FILL IN OPTION 3 IF A5 = 1; practice is part of a larger health care system]

MARK ONE ONLY

- 1 Amount of CPC+ care management fees is not enough to support hiring care managers
- 2 Our health care system does not provide us with care manager time]
- 3 Our practice [or health care system] does not think we need a care manager
- 4 Inadequate supply of qualified care managers available to hire
- 5 Insufficient space at our practice to accommodate a care manager
- 6 Other (Specify) _____

C2. [IF C1a>0 OR C1b>0; has care managers/care coordinators]

What is the clinical background of the care managers or care coordinators at this practice site?

MARK ALL THAT APPLY

- 1 Registered nurse (RN)
- 2 Licensed practical nurse (LPN) or licensed vocational nurse (LVN)
- 3 Medical assistant (MA)
- 4 Social worker
- 5 Other clinical background
- 6 No clinical background

C2a. [IF C1a>0 OR C1b>0; has care managers/care coordinators]

Do any care managers and/or care coordinators at this practice site have behavioral health training (such as screening for and monitoring of mental health conditions, and providing education and self-management support)?

- 1 Yes
- 0 No

[If C1a>1 (more than one F/T care manager)] We understand that care management for this practice site may be provided by more than one care manager. However, we are going to ask the next two questions about only one of the care managers.

C3. [If C1a>0; has at least one F/T care manager]

[Fill if C1a>1 (more than one F/T care manager)] The next two questions are about one of the full-time care managers/care coordinators for this practice site. In order to randomly select which care manager/care coordinator to answer these questions for, please select the one whose first name comes first alphabetically.

How many patients from this practice site are currently under longitudinal care management for chronic conditions with [this/the] full-time care manager/care coordinator?

Do not include patients who are receiving only episodic care management (for example, follow-up after hospital or ED visits).

Your best estimate is fine.

Number of patients currently under longitudinal care management with full-time care manager/care coordinator: |_|_|_|_|

C4. [If C1a>0; has at least one F/T care manager]

About how many hours does [this/the] full-time care manager/care coordinator work on longitudinal care management for this practice in an average week?

Your best estimate is fine.

Number of hours full-time care manager/care coordinator works on longitudinal care management in a week: |_|_|_|_|

[If C1a=0 or blank AND C1b>1 (has only P/T care managers AND more than one P/T care manager)] We understand that care management for this practice site may be provided by more than one care manager. However, we are going to ask the next two questions about only one of the care managers.

C5. [If C1a=0 or blank AND C1b>0; has only P/T care managers]

[Fill if C1b>1 (more than one P/T care manager)] The next two questions are about one of the part-time care managers/care coordinators for this practice site. In order to randomly select which care manager/care coordinator to answer these questions for, please select the one whose first name comes first alphabetically.

How many patients from this practice site are currently under longitudinal care management for chronic conditions with [this/the] part-time care manager/care coordinator?

Do not include patients who are receiving only episodic care management (for example, follow-up after hospital or ED visits).

Your best estimate is fine.

Number of patients currently under longitudinal care management with part-time care manager/care coordinator: |_|_|_|

C6. [If C1a=0 or blank AND C1b>0; has only P/T care managers]

About how many hours does [this/the] part-time care manager/care coordinator work on longitudinal care management for this practice in an average week?

Your best estimate is fine.

Number of hours part-time care manager/care coordinator works on longitudinal care management in a week: |_|_|_|

C7. [IF C1a>0 OR C1b>0; has care managers/care coordinators] Please think now about all the care managers and care coordinators at this practice site. Did the amount of time typically spent by care managers and/or care coordinators on longitudinal care management activities for patients at this practice site change during the coronavirus pandemic?

Do not include episodic care management (for example, follow-up after hospital or ED visits).

- 1 Yes
- 0 No → GO TO C8
- 4 Don't know → GO TO C8

C7a. [If C7 = 1 (Yes)] Please describe how and why the amount of time typically spent by care managers and/or care coordinators on longitudinal care management activities for patients at this practice site changed during the pandemic.

C8. [C8: only if (C1a+C1b > 0) OR if Number of care managers in W4 > 0 (i.e., practice reported in wave 4 or wave 5 survey that they had at least one care manager)]

Please indicate if any of the following are challenges that your practice faces in providing longitudinal care management for chronic conditions.

	IS THIS A CHALLENGE TO PROVIDING LONGITUDINAL CARE MANAGEMENT?		
	NO, NOT A CHALLENGE	YES, MINOR CHALLENGE	YES, MAJOR CHALLENGE
a. Risk stratification methods used to identify patients for longitudinal care management are sometimes inaccurate or do not allow adjustment based on clinical judgment	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b. Insufficient care manager staff time to provide longitudinal care management for chronic conditions	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c. Insufficient community-based resources to meet patient needs	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d. Logistical obstacles to reaching patients (such as incorrect patient contact information, hard to reach)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
e. Lack of patient interest in interacting with a care manager	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
f. Insufficient <u>practitioner</u> buy-in of benefit of longitudinal care management services to patients	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
g. Insufficient <u>organizational</u> buy-in of benefit of longitudinal care management services to patients	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
h. Other (Specify) _____	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

C9. [IF C8b = 1 OR 2 (INSUFFICIENT CARE MANAGER TIME TO PROVIDE LONGITUDINAL CARE MANAGEMENT IS A MINOR OR MAJOR CHALLENGE)]

What is the main reason your practice does not have sufficient care manager staff time for longitudinal care management?

MARK ONE ONLY

[ONLY DISPLAY OPTION 2 IF A5 = 1; practice is part of a larger health care system]

- 1 Amount of CPC+ care management fees is not enough to support hiring more care managers
- 2 Our health care system does not provide us with as much care manager time as our patient population needs]
- 3 Care manager staff time is focused on episodic care management (for example, follow-up after hospital or ED visits)
- 4 Inadequate supply of qualified care managers available to hire
- 5 Other (*Specify*) _____

D. DATA FEEDBACK ON PRACTICE SITE'S PERFORMANCE

Practices may receive data feedback on the performance of the practice, including feedback on patient experience, quality, cost, or utilization. This data feedback may be provided by private health insurers, Medicaid, Medicare, your own organization, state health agencies, or others.

D1. In the past 12 months, has this practice site received any data feedback on the performance of the practice or physicians within the practice site?

1 Yes

0 No → **GO TO NEXT SECTION**



D2. For each type of data feedback that this practice site may have received in the past 12 months, please indicate if this practice site has changed how it delivers care in response to this feedback.

MARK ONE RESPONSE PER ROW

DID PRACTICE SITE CHANGE HOW IT DELIVERS CARE IN RESPONSE TO DATA FEEDBACK?					
	DID NOT RECEIVE THIS TYPE OF DATA FEEDBACK	YES, MAJOR CHANGES	YES, MINOR CHANGES	NO CHANGE	DON'T KNOW IF CHANGES WERE MADE
a. Patient experience (from surveys)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	d <input type="checkbox"/>
b. Quality of care	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	d <input type="checkbox"/>
c. Cost	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	d <input type="checkbox"/>
d. Utilization	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	d <input type="checkbox"/>

E. HEALTH INFORMATION TECHNOLOGY

E1. Does this practice site use an Electronic Health Record (EHR) system?



1 Yes

0 No → **GO TO NEXT SECTION**

E2. Does this practice site use data extracts or reports generated from the EHR to guide quality improvement (QI) efforts?

1 Yes

0 No

d Don't know

E3. For each of the following types of providers, please think of the specific providers where most of your patients obtain care. With how many of these providers does this practice site electronically send and receive patient clinical data?

MARK ONE RESPONSE PER ROW

		ELECTRONICALLY SENDS AND RECEIVES PATIENT CLINICAL DATA WITH...				
		NONE	SOME	MOST	ALL	DON'T KNOW
a.	Hospitals	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	d <input type="checkbox"/>
b.	Specialist practices	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	d <input type="checkbox"/>
c.	Diagnostic service facilities (lab or imaging)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	d <input type="checkbox"/>

F. PRACTICE SITE REVENUES

F1. During the 2020 calendar year, what percentage of this practice site's revenue came from fee-for-service (FFS) payments? Please include FFS payments from all insurers.

Your best estimate is fine.

PERCENTAGE OF 2020 PRACTICE REVENUE FROM FEE-FOR-SERVICE |__|__|__|%

G. CPC+ PAYMENTS

The following sections are about your practice's experience with CPC+. The questions in this section are about this practice site's CPC+ payments from CMS/Medicare FFS and non-CMS payers. Please note that we will NOT share practice-identifiable responses to this section (or any of your other responses to this survey) with CMS or non-CMS payers.

[CPC+ PRACTICES THAT HAVE WITHDRAWN WITHIN ONE YEAR OR LESS: We are aware that this practice site is no longer participating in CPC+. Please answer the questions in this section to the best of your ability based on this practice site's experience when it was participating in CPC+.]

CMS/MEDICARE FFS – CPC+ PAYMENTS

G1. [IF TRACK 1 AND PARTICIPATED IN MEDICARE SHARED SAVINGS PROGRAM [SSP] IN 2019 AND 2020 AND 2021 (ALL THREE YEARS): This question]/[ALL OTHERS: The first set of questions] is about CPC+ payments from Medicare fee-for-service (FFS).

[ALL TREATMENT PRACTICES AND TWD PRACTICES THAT HAVE WITHDRAWN WITHIN ONE YEAR OR LESS] Overall, considering the amount of work required by CPC+, how adequate or inadequate are the CPC+ payments from Medicare FFS?

- 1 More than adequate
- 2 Adequate
- 3 Less than adequate
- 4 Don't know – not familiar with CPC+ payments from Medicare FFS or costs of doing CPC+ work

G2. [IF DID NOT PARTICIPATE IN SSP IN AT LEAST ONE OF THE YEARS BETWEEN 2019 - 2021]: The Performance-Based Incentive Payment (PBIP) is paid by CMS prospectively at the beginning of each program year. After each program year ends, CMS retrospectively reconciles the amount of PBIP that a practice earned based on how well the practice performed on patient experience of care measures, clinical quality measures, and utilization measures that drive total cost of care.

Thinking about this practice’s experience with the PBIP payments and recoups from Medicare FFS, please indicate how much you agree or disagree with the following statements.

MARK ONE RESPONSE PER ROW

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	DON'T KNOW
a. Our practice <u>understands</u> how Medicare FFS calculates the proportion of the Performance-Based Incentive Payment (PBIP) my practice retains and the proportion CMS recoups	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
b. Our practice feels that Medicare FFS's methodology <u>is fair</u> in how it determines the proportion of the Performance-Based Incentive Payment (PBIP) my practice retains and the proportion CMS recoups	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>

G3. [IF TRACK 2]: The Comprehensive Primary Care Payment (CPCP) is a lump sum quarterly payment paid to Track 2 practices based on their historical FFS payment amounts for evaluation and management (E&M) services. Track 2 practices' FFS payments for these services are reduced to account for the CPCP.

Thinking about this practice's experience with the CPCP payments from Medicare FFS for CPC+, please indicate how much you agree or disagree with the following statements.

MARK ONE RESPONSE PER ROW

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	DON'T KNOW
a. Our practice <u>understands</u> how Medicare FFS calculates its Comprehensive Primary Care Payments (CPCPs)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
b. Our practice feels that Medicare FFS' methodology is <u>fair</u> in how it calculates Comprehensive Primary Care Payments (CPCPs)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>

NON-CMS CPC+ PAYERS – CPC+ PAYMENTS

- G4.** CPC+ payer partners are payers other than Medicare FFS that participate in CPC+. The next set of questions is about CPC+ payments from CPC+ payer partners. These payers include private health insurers, Medicare Advantage, Medicaid FFS, and Medicaid Managed Care.

Does this practice contract with CPC+ payer partners for CPC+?

1 Yes

0 No → GO TO SECTION H

- G4a.** Overall, considering the amount of work required by CPC+, how adequate or inadequate are the CPC+ payments across the CPC+ payer partners you work with on CPC+?

CPC+ payments from these payers could include care management fees; full or partial capitated, global, or bundled payments; or payments that reward cost or quality performance.

1 More than adequate

2 Adequate

3 Less than adequate

4 Don't know– not familiar with CPC+ payments from CPC+ payer partners or costs of doing CPC+ work

H. LEARNING ACTIVITIES AND ASSISTANCE IN CPC+

These questions are about the learning activities and assistance that the CPC+ National Learning Community and Regional Learning Network provided to this practice site as part of CPC+. Please note, we will NOT share practice-identifiable responses to these questions with the National Learning Community or Regional Learning Network.

[CPC+ PRACTICES THAT HAVE WITHDRAWN WITHIN ONE YEAR OR LESS: We are aware that this practice site is no longer participating in CPC+. Please answer the questions in this section to the best of your ability based on this practice site's experience when it was participating in CPC+.]

H1. Overall, how would you rate the quality of all services from [NAMES OF REGIONAL LEARNING NETWORK ORGANIZATIONS] in meeting this practice site's CPC+-related needs and helping improve primary care?

MARK ONE ONLY

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

H2. The CPC+ National Learning Community and Regional Learning Network offer assistance to practices in a variety of ways. For each of the following types of assistance that this practice site may have received in the past six months, please rate how useful this assistance has been to this practice site in improving primary care.

MARK ONE RESPONSE PER ROW

	NOT AT ALL USEFUL	NOT VERY USEFUL	SOMEWHAT USEFUL	VERY USEFUL	NEVER RECEIVED OR ATTENDED
a. National webinars	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. One-on-one telephone/virtual coaching with this practice site to improve practice processes and workflows	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. CPC+ Connect (the online information resource and collaboration website for CPC+)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. CPC+ Implementation Guides	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e. CPC+ Support (CPC+ help desk managed by Telligen)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f. Group coaching (coaching with a small number of practices, directed by a practice facilitator)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

H3. [IF HAD CPC+ PAYER PARTNERS]: In addition to the support from the CPC+ National Learning Community and Regional Learning Network, CPC+ payer partners may provide their own support and assistance. For each of the following types of assistance that this practice site may have received from CPC+ payer partners in the past six months, please rate how useful this assistance has been to this practice site in improving primary care.

CPC+ payer partners are payers other than Medicare FFS that participate in CPC+.

MARK ONE RESPONSE PER ROW

	NOT AT ALL USEFUL	NOT VERY USEFUL	SOMEWHAT USEFUL	VERY USEFUL	NEVER RECEIVED OR ATTENDED
a. On-site care manager provided by the payer	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Telephone-based care manager provided by the payer	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Explanation of payers' CPC+ payment methodologies	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. Training on how to access data feedback provided by the payer	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e. Training on how to use data feedback provided by the payer	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f. Coaching on how to improve practice processes and workflows	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

I. PRACTICE SITE INVOLVEMENT AND PERCEPTIONS OF CPC+

[CPC+ PRACTICES THAT HAVE WITHDRAWN WITHIN ONE YEAR OR LESS: We are aware that this practice site is no longer participating in CPC+. Please answer the questions in this section to the best of your ability based on this practice site's experience when it was participating in CPC+.]

I1. Thinking of the different types of staff at this practice site, how involved is each type of staff in implementing CPC+?

MARK ONE RESPONSE PER ROW

	VERY INVOLVED	SOMEWHAT INVOLVED	NOT VERY INVOLVED	NOT AT ALL INVOLVED
a. Medical director or clinician lead at this practice site	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Physicians	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Nurse practitioners (NPs), clinical nurse specialists (CNSs), or physician assistants (PAs)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Clinical support staff	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Clerical support staff	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

I2. Thinking about this practice organization, how involved are system-level leadership (e.g., chief executive officer (CEO) or chief medical officer (CMO)) in implementing CPC+?

- 0 Practice site is independent and not part of a system
- 1 Very involved
- 2 Somewhat involved
- 3 Not very involved
- 4 Not at all involved

I3. In answering this question, please consider the:

- Improvements made to the practice site’s care delivery,
- CPC+ participation requirements (including care delivery, health IT, and reporting requirements), and
- CPC+ supports (payments, learning activities, data feedback, and health IT vendor support).

Given this practice’s overall experience participating in CPC+, how likely is it that this practice would participate in CPC+ if this practice could do it all over again?

MARK ONE ONLY

- 1 Very likely
- 2 Somewhat likely
- 3 Not very likely
- 4 Not at all likely

I4. How much has participation in CPC+ improved the quality of care that this practice currently provides to its patients?

MARK ONE ONLY

- 1 A lot
- 2 Somewhat
- 3 Not very much
- 4 Not at all

I5. How burdensome are the following requirements in CPC+?

MARK ONE RESPONSE PER ROW

	NOT AT ALL BURDENSOME	NOT VERY BURDENSOME	SOMEWHAT BURDENSOME	VERY BURDENSOME	DON'T KNOW
a. Meeting care delivery requirements	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
b. Completing care delivery reporting requirements	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
c. Completing financial reporting requirements	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
d. Meeting health IT requirements	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>

16. How useful are the following supports provided by CPC+ in improving primary care? Please consider supports from all payers participating in CPC+.

MARK ONE RESPONSE PER ROW

	NOT AT ALL USEFUL	NOT VERY USEFUL	SOMEWHAT USEFUL	VERY USEFUL	DON'T KNOW
a. Financial support	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
b. Learning support	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
c. Data feedback	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
d. Health IT vendor support	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>

CPC+ AND CORONAVIRUS PANDEMIC

17. Please indicate how much you agree or disagree with the following statement.

Your practice was better positioned to meet patients' care needs during the coronavirus pandemic because of your participation in CPC+.

- 1 Strongly disagree
- 2 Disagree
- 3 Neither agree nor disagree
- 4 Agree
- 5 Strongly agree

17a. Please describe how, if at all, participation in CPC+ affected your ability to meet patients' care needs during the coronavirus pandemic.

YOUR PRACTICE'S PLANS AFTER CPC+ ENDS

18. For each of the following care delivery processes, how much of your practice's current process are you likely to maintain after CPC+ ends?

For processes that your practice is not currently doing at all, please select the response option in the first column.

		AFTER CPC+ ENDS, YOUR PRACTICE IS LIKELY TO MAINTAIN...					
		NOT CURRENTLY DOING THIS PROCESS AT ALL	NONE OF THE PROCESS	SOME OF THE PROCESS	A LOT OF THE PROCESS	MOST OR ALL OF THE PROCESS	DON'T KNOW
a.	Risk stratify patients	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
b.	Provide short-term ("episodic") care management for patients who had a recent hospital admission or ED visit	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
c.	Work with a care manager to provide proactive, long-term, relationship-based ("longitudinal") care management	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
d.	Provide advance care planning <i>Having and documenting conversations with patients about their end-of-life care preferences if they become unable to speak for themselves.</i>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
e.	Provide comprehensive medication management for high-risk patients <i>Comprehensive medication management (CMM) includes action plans, individualized therapy goals, planned follow-up strategy, in addition to a full medication review for high-risk patients (for appropriateness, effectiveness, safety, and ability to be taken by the patient as intended).</i>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
f.	Provide on-site behavioral health care that is integrated into your primary care services	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>

AFTER CPC+ ENDS, YOUR PRACTICE IS LIKELY TO MAINTAIN...

	NOT CURRENTLY DOING THIS PROCESS AT ALL	NONE OF THE PROCESS	SOME OF THE PROCESS	A LOT OF THE PROCESS	MOST OR ALL OF THE PROCESS	DON'T KNOW
g. Assess patients' health-related social service needs and refer them to community resources	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
h. Coordinate care with specialists	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
i. Use formal written agreements with specialists to set expectations about roles and information sharing	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
j. Ensure a range of options for how and when patients can access primary care from this practice (for example, phone visits or extended office hours)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
k. Track and use quality measures and other data to guide practice improvements	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
l. Use Patient and Family Advisory Councils (PFAC) to better understand what matters most to patients and to guide improvements at your practice	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>

CPC+ AND YOUR SYSTEM

19. [If A5=Yes (practice is part of a larger health care system)]

You indicated previously that your practice is part of a larger health care system.

Which of the following types of providers in your system have adopted some of the changes your practice has made for CPC+? If you are not aware of these other providers' activities, please mark "Don't know if changes were made" for each.

	ADOPTED SOME OF THE CPC+ CHANGES MADE BY YOUR PRACTICE?			
	NOT APPLICABLE, NO SUCH PROVIDER IN MY SYSTEM	YES	NO	DON'T KNOW IF CHANGES WERE MADE
a. Other primary care practices that are participating in CPC+	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	d <input type="checkbox"/>
b. Primary care practices that are <u>not</u> participating in CPC+	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	d <input type="checkbox"/>
c. Specialty care practices	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	d <input type="checkbox"/>

J. PRACTICE SITE CONTACT INFORMATION AND SURVEY COMPLETION

J1. Please provide the following information for this practice site.

Practice Site Name: _____

Physical Street Address: _____

City: _____ State: _____ Zip Code: _____

Practice Site Telephone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

J2. Please provide the name, title, email, and phone number of the person who completed this survey so we know who to contact if we have any questions.

Name: _____

Title: _____

Email: _____

Telephone Number: _____

J3. [Only for treatment withdrawn practices] Please confirm the name and address of the person who should receive the check for completing the survey. You may enter your practice name in the "Name of Check Recipient" field if you prefer that the check be made out to your practice. If you are unable to accept payment, please mark the box that says, "Do not send payment" and leave the remaining fields blank.

Do not send payment

Name of Check Recipient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

J4. Who filled out this survey or provided input to complete this survey?

MARK ALL THAT APPLY

- 1 Practice or office manager (e.g., clinic manager, office coordinator, office supervisor)
- 2 Lead physician
- 3 Other physicians
- 4 Nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA)
- 5 Care manager or coordinator
- 6 Nursing staff, including nurse manager or supervisor
- 7 Medical assistant staff
- 8 Quality improvement staff (e.g., quality manager or coach, population health staff)
- 9 Administrative support staff (e.g., billing or finance staff, front desk staff)
- 10 Non-physician owner of practice
- 11 Leadership or staff from our larger health care system or medical group (e.g., CEO, CMO)
- 12 Data analytics staff (e.g., EMR analyst, health IT team)
- 13 CPC+ lead
- 14 Patients
- 99 Other (*specify*) _____

J5. Please add any comments about this survey here. If you have feedback about a specific survey question, please include the question number in your comment.

Thank you for completing the survey!

3.C. CPC+ Physician Survey

This appendix describes the 2021 CPC+ Physician Survey used to assess the experiences of primary care physicians in practices that began participating in Comprehensive Primary Care Plus (CPC+) in 2017 and physicians in comparison (nonparticipating) practices. It details survey fielding (Section 3.C.1), sampling and weighting methods (Section 3.C.2), survey content (Section 3.C.3), and analytic methods (Section 3.C.4). Data tables are in Section 3.C.5 and the survey instrument is in Section 3.C.6. Mathematica previously administered the 2019 CPC+ Physician Survey, which was covered in the [CPC+ Third Annual Report](#).

3.C.1. Survey fielding

Timing of survey administration. Mathematica administered the 2021 CPC+ Physician Survey to a sample of primary care physicians in CPC+ and comparison practices during Program Year (PY) 5 from April 2021 through August 2021, about 4 to 4.5 years after CPC+ began.

Survey mode, fielding procedures, length, and incentives. Mathematica designed and administered the survey as both a web survey and a paper survey. IQVIA, a marketing organization that collects information directly from all health care practices and physicians in the United States, provided mailing and email addresses for most CPC+ and comparison physicians in the sample (described in Section 3.C.2). The mailing address was the address of the practice. If IQVIA could not provide a mailing address for sampled CPC+ physicians, we obtained this information from CPC+ practitioner tracking data. We obtained email addresses from IQVIA for 88.5 percent of the physicians in the sample. At the start of the fielding period, we mailed all physicians selected to participate in the survey an invitation packet describing how to complete the web survey; we also emailed the packet to physicians for whom we had email addresses. We later sent paper surveys to physicians who did not complete the web survey within a pre-set period. Our fielding process included six reminder emails, as many as five reminder postcards, and three reminder letters (Table 3.C.1). The survey required 20 to 25 minutes to complete for physicians in CPC+ practices and 15 to 20 minutes for physicians in comparison practices. All physicians received a \$100 check as an incentive to complete the survey.

To encourage physicians to respond candidly, the survey introduction explained that responses would be confidential and anonymous in all reports (that is, they would never be linked to a physician's name or practice in any reports to a practice, the Centers for Medicare & Medicaid Services [CMS], other payers, or the public). In addition, respondents were told that their responses would not affect payment or their participation in CPC+.

Table 3.C.1. Fielding plan for the PY 5 Physician Survey

Week of field period	Date	Physicians with email address	Physicians without email address
Week 1	4/19/2021	Invitation packet, including \$100 check Email invitation	Invitation packet, including \$100 check
Week 2	4/26/2021	No communication	Postcard Reminder 1
Week 3	5/3/2021	Email Reminder 1	No communication
Week 4	5/10/2021	Reminder Letter 1 ^a	Reminder Letter 1 ^a
Week 5	5/17/2021	Email Reminder 2	Postcard Reminder 2
Week 6	5/24/2021	No communication	No communication
Week 7	5/31/2021	Email Reminder 3	No communication
Week 8	6/7/2021	Hardcopy Survey 1, including replacement \$100 check ^b	Hardcopy Survey 1, including replacement \$100 check ^b
Week 9	6/14/2021	Postcard Reminder 1 Email Reminder 4	Postcard Reminder 3
Week 10	6/21/2021	No communication	No communication
Week 11	6/28/2021	Reminder Letter 2 Email Reminder 5	Reminder Letter 2
Week 12	7/5/2021	No communication	No communication
Week 13	7/12/2021	Hardcopy Survey 2	Hardcopy Survey 2
Week 14	7/19/2021	Postcard Reminder 2	Postcard Reminder 4
Week 15	7/26/2021	No communication	No communication
Week 16	8/2/2021	Reminder Letter 3	Reminder Letter 3
Week 17	8/9/2021	Postcard Reminder 3 Email Reminder 6	Postcard Reminder 5

^a This letter included targeted communication to 984 physician who participated in the W1 Physician Survey.

^b This mailing included endorsement letters from American Academy of Family Physicians and American College of Physicians.

3.C.2. Sampling and weighting methods

A. Sampling methods

Sample frame. We surveyed a sample of primary care physicians from CPC+ and comparison practices. To be eligible for inclusion in the sample, we required physicians to have their own National Provider Identifier (NPI), to be a medical doctor (MD) or a doctor of osteopathic medicine (DO), and to have a primary specialty of primary care. We identified the physicians at CPC+ and comparison practices using data from four sources: (1) an October 2020 extraction of IQVIA's OneKey database; (2) a February 2019

extraction of IQVIA’s OneKey database; (3) an October 2018 extraction of OneKey’s SK&A (a legacy of OneKey) database; and (4) for physicians in CPC+ practices that we could not locate in the OneKey, a February 2020 extraction of the CPC+ practitioner tracking data.¹

In total, we identified physicians for our sampling frame from 2,520 (87 percent) of the 2,888 CPC+ practices² and 5,622 (81 percent) of the 6,921 comparison practices. Using the OneKey database, we were able to identify physicians for 2,373 out of 2,888 CPC+ practices and 5,330 out of 6,921 comparison practices (Table 3.C.2). We then searched the SK&A database for the 515 CPC+ and 1,591 comparison practices that were not in OneKey. Using the SK&A database, we identified physicians for 36 of the 515 CPC+ practices and 292 of the 1,591 comparison practices. Finally, we used CPC+ practitioner tracking data to obtain the list of physicians in 111 of the remaining 479 CPC+ practices that were not in the SK&A or OneKey databases. Table 3.C.2 lists the sources of the sample frame. More specific details on the sample frame and selected physician sample are available in Table 3.C.3.

Table 3.C.2. Number of CPC+ and comparison practices whose primary care physicians were identified for the sample frame using each data source

Sample frame source	CPC+ practices			Comparison practices		
	Track 1	Track 2	Total	Track 1	Track 2	Total
Total number of study practices	1,382	1,515	2,888	5,267	3,801	6,921
Total number of study practices in sample frame^a	1,167	1,353	2,520	4,246	3,154	5,622
October 2020 OneKey	1,086	1,278	2,364	3,973	2,975	5,267
February 2019 OneKey	6	3	9	51	33	63
October 2018 SK&A	20	16	36	222	146	292
February 2020 CPC+ practitioner tracking data	55	56	111	--	--	--

Note: Counts of practices in each track are not mutually exclusive. There are 9 CPC+ practices included in both tracks in total, but none of these practices is in the sample frame. Among comparison practices, there are 2,147 practices in both tracks, and 1,778 of these are in the sample frame.

^a The number of practices for which we were able to identify primary care physicians at the practice site for the survey using one of the four data sources listed.

Inclusion criteria. To be eligible for inclusion in the sample frame, in addition to having their own NPI and being an MD or DO, we required physicians to have one of the primary specialty descriptions listed below, defined using the National Plan & Provider Enumeration System. Requirements varied depending on whether we identified the physician in OneKey, SK&A, or the CPC+ practitioner tracking data. In addition, we required physicians to have at least 100 evaluation and management claims through Medicare in 2020, and we did not include physicians who indicated in their American Medical Association database entry that they did not want to be contacted for marketing purposes.

¹ CPC+ practices maintain practitioner rosters on the CPC+ Practice Portal that they update quarterly for CMS, for payment eligibility.

² Of the 368 CPC+ practices that were not included in the final sample, 150 were determined to be closed or merged with another practice. The remaining 218 CPC+ practices were excluded because they had no primary care physicians (MDs or DOs) eligible for sample selection.

If we identified a physician in the OneKey database, we required them to have one of the following primary specialty designations:

- Family medicine
- Geriatric medicine (family medicine)
- General practice
- Internal medicine/family medicine
- Internal medicine
- Geriatric medicine (internal medicine)
- Internal medicine/preventive medicine
- Internal medicine/emergency medicine
- General preventive medicine
- Internal medicine/pediatrics
- Hospice and palliative medicine (internal medicine)
- Hospice and palliative medicine
- Hospice and palliative medicine (emergency medicine)
- Hospice and palliative medicine (family medicine)
- Hospice and palliative medicine (OB/GYN)
- Hospice and palliative medicine (pediatrics)

If we identified a physician in the SK&A database, we required them to have one of the following primary specialty designations:

- Internal medicine
- Geriatrics
- General practice
- Family/medicine practice
- Internal medicine/pediatrics

If we identified a physician using the CPC+ practitioner tracking data, we required them to be actively working at the practice as of April 2021, if the practice was still actively participating in CPC+. If the practice was no longer participating in CPC+, the physician's termination date had to be the same as the practice's withdrawal date. We assumed all physicians reported in the CPC+ practitioner tracking data were primary care physicians.

Sampling CPC+ physicians. We first stratified the physicians by the number of eligible physicians in each practice. For practices with seven or more eligible physicians, we randomly selected two physicians per practice for the survey. For practices with six or fewer physicians who met the eligibility criteria, we

stratified by track and within each track drew a systematic sample of physicians across the practices for the survey. We sampled physicians from about 27 percent of practices in each track (see Table 3.C.3).

Sampling comparison physicians. Our goal for sampling the comparison physicians was to select a sample of physicians from comparison practices that had a similar distribution of practice-level characteristics as the CPC+ physicians. We focused on obtaining comparable practice-level characteristics for CPC+ and comparison physicians because we had very limited physician-level data (that is, physician characteristics) for our sampling frame. We selected physicians from comparison practices with a probability proportional to their practice’s matching weight. The practice’s matching weight indicates how similar the practice’s characteristics are to those of the CPC+ practices. Therefore, physicians in comparison practices that most resembled CPC+ practices (that is, had large matching weights) had greater probability of being selected for the survey. On average, we selected about 0.1 physicians per comparison practice, with a minimum of 0 and a maximum of 5 physicians from each comparison practice. We sampled physicians from about 12 percent of Track 1 comparison practices and about 16 percent of Track 2 comparison practices (see Table 3.C.3).

B. Eligibility and weighting

Before determining eligibility, we made the following decisions, which differed from how we determined eligibility for the 2019 survey³:

- We treated physicians from closed, merged practices as nonrespondents (rather than ineligible, as we did in 2019) if the closure or merger occurred after the start of the field period and if they did not return a survey, because there is likely some time when they could have responded about that practice.
- If a physician completed the survey for a practice site in our analytic sample, but the physician was not sampled from that site, we treated the physician as eligible (rather than ineligible, as we did in 2019). We made this decision because we would still be capturing the experience of a physician from a sampled practice. Physicians that answered about a different practice site that was *not* in the analytic sample were considered ineligible respondents.

Determining eligibility. After we received submitted questionnaires, we classified the eligibility status of all survey respondents as eligible, ineligible, or unknown eligibility using **survey responses and other information from data collection**.

We considered a case **eligible** if we could discern that the respondent is a physician who provided primary care at the practice from which we sampled them or at another practice site in our sample. There are three pathways to eligibility:

1. The respondent indicated on the survey that they were either a MD or DO and provided primary care to patients at the practice site listed on the survey.
2. The respondent did not answer the question about which practice site they provide primary care at, but they (a) confirmed that they are either an MD or a DO, (b) indicated that their practice name and

³ Please refer to [Third Annual Report Appendices](#) for more information on 2019 survey eligibility determination.

address were listed correctly on the survey, and (c) responded to most non-demographic survey questions.

3. The respondent reported providing primary care at a different practice site than the one listed on the survey but confirmed that they were either an MD or a DO and relocated to a practice site that is in our analytic sample.

We considered a case **ineligible** if we could discern that the respondent was not a primary care physician or did not provide primary care at the practice from which we sampled them or a different practice in the analytic sample. There are five pathways to ineligibility:

1. The respondent indicated on the survey that they were neither an MD or a DO.
2. The respondent indicated on the survey that they did not provide primary care to patients at the practice site listed on the survey, and we determined that the practice where they provide care was not in the analytic sample.
3. We received notification via undeliverable mail, email, or phone call that the respondent did not provide primary care at the practice.
4. We received notification via email or phone call that the respondent was deceased.
5. The practice closed before the survey was fielded.

We considered a case to have **unknown eligibility** if we could not assign it as eligible or ineligible, meaning that we do not know whether the physician provides primary care at the sampled practice. When we calculated weighting adjustments for nonresponse and response rates, we used additional data sources to provide more information on the status of physicians who were originally identified as having unknown eligibility. We used this information to reduce the number of those with unknown eligibility, improving the weighting adjustments and the accuracy of the response rates. Below, we provide more information on these adjustments for weighting and nonresponse.

Sample sizes and response rates. We invited 993 physicians⁴ (453 in Track 1 and 540 in Track 2)⁵ of the 7,760 physicians in CPC+ practices, and 900 physicians (717 in Track 1 and 677 in Track 2)⁶ of the 16,103 physicians in comparison practices to participate in the survey (Table 3.C.3).⁷

⁴ One physician from a CPC+ practice asked Mathematica not to contact them for CPC+ surveys. We included this physician as an eligible nonrespondent in our response rate calculations.

⁵ There are nine CPC+ practices included in both tracks in total, but no physicians from these practices are in the sample frame.

⁶ There are 494 physicians sampled from 442 comparison practices in the sample frame that are in both tracks. Of those physicians, 222 responded to the survey and are included in the analysis for both tracks.

⁷ The number of CPC+ physicians includes 67 physicians from 58 practices that withdrew from CPC+ before the start of survey fielding. Forty-three of these physicians are considered recent withdrawals because their practice withdrew from CPC+ within one year before survey fielding. These physicians received a survey similar to the survey CPC+ physicians received, but with survey language that referenced their practice's previous participation in CPC+, not current participation. Twenty-three of these physicians were in practices that withdrew from CPC+ more than one year before the start of the survey. These physicians received a survey similar to the comparison physicians received.

Table 3.C.3. Sample size and response rates for the PY 5 Physician Survey, CPC+ and comparison practices, by track

	CPC+			Comparison		
	Track 1	Track 2	Total	Track 1	Track 2	Total
Number of physicians						
In sampling frame ^a	3,297	4,463	7,760	11,913	10,209	16,103
Sent surveys	453	540	993	717	677	900
Returned surveys	256	296	552	327	321	422
In analysis sample (returned eligible and complete survey response)	253	293	546	320	318	416
Response rate ^b (percentage, unweighted)	60.5	57.7	59.0	49.2	51.5	50.5
Response rate ^b (percentage, weighted)	61.4	59.8	60.4	49.2	51.5	50.5
Number of practices						
Total number of study practices ^c	1,382	1,515	2,888	5,267	3,801	6,921
In sampling frame (percentage, of total practices)	1,167 (84%)	1,353 (89%)	2,520 (87%)	4,246 (81%)	3,154 (83%)	5,622 (81%)
In selected sample (percentage, of total practices)	368 (27%)	414 (27%)	782 (27%)	652 (12%)	603 (16%)	813 (12%)
With at least one eligible, completed survey in analysis sample (percentage, of practices in sample)	225 (61%)	253 (61%)	478 (61%)	299 (46%)	292 (48%)	386 (47%)

^a The number of physicians in the sampling frame is the number of physicians in the CPC+ and comparison practices identified using the data sources described in Table 3.C.1. Because we could not identify physicians in 13 percent of CPC+ and 19 percent of comparison practices, the number of physicians in the sampling frame is not the number of physicians in all CPC+ and comparison practices.

^b The response rate is the number of eligible and complete survey responses, divided by the eligible sample. The eligible sample includes a proportion of the sample with unknown eligibility whom we estimate are eligible following the guidelines of the American Association for Public Opinion Research (AAPOR 2016).

^c The number of study practices reflects the practices that the impact evaluation uses in its intent-to-treat analysis.

PY = program year.

Before calculating response rates, we obtained data from a more recent extraction of OneKey data, Medicare claims, and primary care specialty and NPI deactivation data from the National Plan & Provider Enumeration System to update the eligibility for the nonresponding physicians who were originally determined to have an unknown eligibility status (described above). We did this to reduce the number of nonresponding physicians with unknown eligibility, meaning our calculated response rates would rely less on the estimated eligibility rate for those with unknown status. Specifically, we used OneKey data extracted in October 2021, verification of at least 100 evaluation and management claims in the previous 12 months, verification of primary care specialty, and their NPI deactivation date. If they did not have at least 100 claims in the previous 12 months, they did not have a primary care specialty, or NPI deactivation occurred before fielding the survey, we considered the physician ineligible. If they met these criteria, we considered the physician eligible. If the physician had no NPI deactivation date, we did not change their eligibility status. These additional determinations are independent of the roster-based determinations made for weighting.

We obtained response rates of about 60.4 percent for physicians in CPC+ practices (61.4 percent for Track 1 and 59.8 percent for Track 2) and 50.5 percent for comparison physicians in each track. These figures represent weighted response rates.

For the Track 1 analysis, our analytic sample includes responses from 253 CPC+ physicians and 320 comparison physicians. These respondents provide primary care in 225 (or 61 percent) of the 368 sampled Track 1 CPC+ practices and 299 (46 percent) of the 652 sampled comparison practices.

For the Track 2 analysis, our analytic sample includes responses from 293 CPC+ physicians and 318 comparison physicians. These respondents provide primary care in 253 (or 61 percent) of the 414 sampled Track 2 CPC+ practices and 292 (48 percent) of the 603 comparison practices.

C. Weighting and nonresponse adjustment

We applied weights to survey responses from CPC+ and comparison physicians to reflect the sampling process, account for survey nonresponse, and ensure that the responding CPC+ and comparison physicians were comparable on various physician- and practice-level characteristics (using physician-level characteristics gathered in the 2019 CPC+ Physician Survey). Because the survey was fielded during the coronavirus 2019 (COVID-19) pandemic, we included three scales related to public health and the pandemic, based on the county where the practice was located, to adjust for possible effects of the pandemic. These were the government response index²⁵, the social vulnerability index²⁶, and the pandemic vulnerability index²⁷. Before calculating weights for the CPC+ physicians, we used the CPC+ practitioner tracking data from August 2021 to determine the eligibility for the CPC+ physicians whose initial status (using the criteria described above) was unknown. If the physician was listed as active in the most recent extract of the practitioner tracking data, we considered them eligible; if they were listed as inactive, we considered them ineligible. Using this method, we were able to classify all but 8.5 percent of the CPC+ physicians in our sample as eligible or ineligible. These remaining physicians were among a

²⁵ Government Response Index - <https://www.bsg.ox.ac.uk/research/research-projects/covid-19-government-response-tracker>

²⁶ CDC/ATSDR Social Vulnerability Index - <https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>.

²⁷ NIEHS COVID-19 Pandemic Vulnerability Index Dashboard - <https://www.niehs.nih.gov/research/programs/coronavirus/covid19pvi/index.cfm>.

small portion of the CPC+ physicians whom we identified using the OneKey records, but were never listed in the CPC+ practitioner tracking data. We did not make similar determinations for the comparison physicians whose eligibility was originally identified as unknown because the weights we constructed for comparison physicians were designed to ensure comparability between CPC+ and comparison physician respondents (described below) and not to ensure that responding physicians represented all physicians in comparison practices. This additional information from the CPC+ practitioner tracking extract had no impact on the set of respondents from CPC+ or comparison practices.

Calculating weights for CPC+ physicians. Reflecting the sampling process, we weighted the responses from CPC+ physicians by the inverse of their probability of selection. Therefore, among practices with seven or more physicians, those from larger practices received more weight than physicians from smaller practices, as we assumed their responses reflected the physicians at their practice who were not selected for the survey. For physicians sampled from practices with six or fewer physicians, we drew an unstratified systematic sample. Therefore, all of these physicians have the same sample weight. To reduce the possibility of biased estimates from survey nonresponse, we applied two adjustments to these weights. First, we adjusted the weights for the probability of having a known eligibility status, which adjusts for the 2 percent of CPC+ physicians with unknown eligibility. Then we adjusted the weights to account for survey nonresponse among the eligible nonrespondents. For both adjustments, we used a combination of nonparametric tests and logistic regressions to estimate response propensities, then used these estimated propensities to form cells for the weighting adjustments.

Calculating weights for comparison physicians. We constructed weights for the eligible responding comparison physicians so they were similar to the responding CPC+ physicians, after weighting to adjust for nonresponse among the CPC+ physicians, on a range of key practice- and physician-level characteristics. To construct the weights, we needed only the comparison physicians who responded to the survey and were considered eligible; thus, we excluded all ineligible or nonresponding comparison physicians from this process. We first assigned all responding comparison physicians a weight equal to 1, then adjusted this weight using iterative proportional fitting, also known as raking.

Raking makes small adjustments to the weights to bring the weighted distribution of a set of variables in line with a set of target values—in this case, the weighted totals of the treatment physicians. The process repeats until it achieves the target values. We adjusted the comparison physician weights on practice-level Medicare Shared Savings Program participation and primary care transformation experience, and physician-reported gender, race, and age. After adjustments, the weighted distribution of these variables were the same for the treatment and comparison physicians. We also confirmed that balance on other practice-level characteristics was acceptable. (We also tested propensity-score based weights generated via boosted regression but found they did not provide adequate balance and increased the variation in the weights.)

This process resulted in weights for the responding comparison physicians that enabled our comparison physicians to resemble the physicians from CPC+ practices in terms of practice- and physician-level characteristics. Table 3.C.4 presents the weighted characteristics of the responding physicians from CPC+ and comparison practices, and shows that, after weighting, CPC+ and comparison physicians were similar on all key practice- and physician-level characteristics.

Question (item) nonresponse. Respondents were not required to answer each question in the survey. Across all questions in the survey, the rate of question nonresponse among respondents varied from 0 to 4 percent, with 61 percent of questions having less than 1 percent item nonresponse. Because of this low rate, we did not adjust responses for question nonresponse and instead calculated results only among question respondents, using survey nonresponse weights described above.

Table 3.C.4. Characteristics of the responding physician and their practice^a

	Track 1			Track 2		
	CPC+	Comparison	p-value ^b	CPC+	Comparison	p-value ^b
Physician characteristics (at time of survey response)^c						
Male	54.8	55.8	0.83	53.1	53.1	1.00
Race/ethnicity			0.96			1.00
Hispanic/Latino	3.3	3.4		2.8	2.8	
Non-Hispanic White	81.0	80.5		79.1	79.4	
Non-Hispanic Black	0.8	1.4		0.4	0.4	
Other or multiple races (non-Hispanic)	14.9	14.7		17.7	17.4	
Current age			1.00			1.00
30–39	10.6	11.6		12.8	12.9	
40–49	28	28.2		30	28.8	
50–59	30.8	29.6		28	28.5	
60–69	24.9	25.1		27	27.5	
70 years or older	5.7	5.6		2.3	2.4	
Hours worked per week			0.77			0.55
Less than 40	29.3	30.0		37.1	33.9	
40 hours	29.7	32		33.6	32.2	
More than 40 hours	41.1	38		29.3	33.9	
Practice characteristics (before CPC+ began)						
Physicians' average practice size	7.0	6.8	0.80	8.1	8.6	0.72
Percentage of physicians in practices that are: ^d			0.50			0.99
Small (1–2 primary care practitioners)	24.1	19.5		15.1	15.2	
Medium (3–5 primary care practitioners)	31.4	32.6		35.5	36.2	
Large (6+ primary care practitioners)	44.5	48		49.4	48.6	
Meaningful EHR use ^e	5.8	4.7	0.60	2.6	2.3	0.79
Multispecialty practice ^f	20.6	22.2	0.68	24.9	21.5	0.40
Percentage owned by a health system or a hospital ^g	60.0	54.2	0.22	55.2	60.3	0.28
Participant in SSP ACO	52.4	52.2	0.97	46.6	47.0	0.95
Prior primary care transformation experience ^h	57.0	56.7	0.96	83.4	83.4	0.98
Modified U.S. Census Region ⁱ			0.79			0.68
Midwest	33.0	35.4		37.5	33.0	
Northeast	26.5	27.8		23.8	27.8	
South	20.9	17.0		20.2	19.3	
West	19.6	19.8		18.6	19.9	
Median household income of the county	\$58,802.69	\$59,165.19	0.80	\$58,429.43	\$58,116.85	0.82
Medicare Advantage penetration rate in the practice's county	31.1	32.2	0.42	33.7	33.2	0.72
Hospital beds in the county per 10,000 population	30.2	31.1	0.61	32.9	32.7	0.93
Percentage of county's population in poverty	13.8	13.5	0.59	14.1	13.9	0.70
Percentage of adults 25 or older in the county with 4-year college degree	32.2	32.4	0.82	32.9	32.1	0.39

Table 3.C.4. (continued)

^a We adjusted all results for the probability of selection into the sample, comparison group matching, and survey nonresponse. (CPC+ results are weighted by their nonresponse-adjusted sample weights. Comparison results are weighted using the matching weights for respondents.)

^b We used two-tailed t-tests or chi-square tests to statistically test differences between CPC+ and comparison physicians within each track. We performed t-tests for differences in median household income, Medicaid Advantage penetration rate, hospital beds in the county per 10,000 people, percentage of population in poverty in the county, and percentage of adults 25 or older in the county with a four-year college degree. We performed chi-square tests for differences in gender, race/ethnicity, age, hours worked per week, practice size, meaningful EHR use, multispecialty practice, percentage owned by a health system or a hospital, participation in SSP ACO, prior primary care transformation experience, and modified U.S. Census Region.

^c These characteristics were self-reported by physicians in the survey.

^d We calculated the number of primary care practitioners (PCPs) at the practice site using a November 2016 pull of SK&A data and the National Plan & Provider Enumeration System (NPPES). We counted a provider as a PCP if they met criteria in either the SK&A data or the NPPES data; we did not require them to be considered a PCP in both data sources. Using the SK&A data, we defined PCPs as a physician (MD or DO), nurse practitioner, or physician assistant who bill under their own National Provider Identifier and have a specialty of general practitioner, family practitioner, internist, internal medicine/pediatrics, or geriatrician. In NPPES, we defined PCPs as physicians, nurse practitioners, physician assistants, or clinical nurse specialists with 1 of 56 primary care taxonomy codes.

^e At least one practitioner at the practice attested to meaningful use under the Centers for Medicare & Medicaid Services (CMS) Medicare EHR Incentive Program, from 2011–2015 for 2017.

^f The medical organization that employs physicians at the practice site is a multispecialty group that includes both specialists and primary care physicians.

^g Practice ownership comes from the SK&A database, managed by IQVIA, a marketing organization that collects information directly from all health care practices in the United States. IQVIA updates this information on an ongoing basis; we pulled practice ownership information in November 2016.

^h We considered a practice to be a Multi-Payer Advanced Primary Care Practice participant if it participated in any year from 2011 to 2014 for 2017 Starters, as determined by a file from CMS. A practice was considered to have medical home recognition if it at least one of its primary care providers was listed as having recognition at some point in 2014–2017 from the National Community for Quality Assurance (NCQA), a state, the Accreditation Association for Ambulatory Health Care (AAAHC), the Joint Commission (TJC), or Utilization Review Accreditation Commission (URAC), as determined by the June 2016 (for 2017 Starters) NCQA Patient-Centered Medical Home file and data extracted from the websites of TJC, AAAHC, URAC, and state-specific sources from October 2016 to February 2017.

ⁱ For the 2017 Starters, we grouped CPC+ regions into four market areas using the four U.S. Census Regions as our starting point. We moved two CPC+ 2017 regions from their given census region to a neighboring census region. The Northern Kentucky–Ohio region spans two census regions; therefore, we moved CPC+ practices in Northern Kentucky to the Midwest region. Because of its geographic proximity to CPC+ regions in the South (Arkansas, Oklahoma, and Tennessee), we moved the Kansas City region from the Midwest region to the South. For face validity, we excluded several states from the external market areas from which we could draw comparison practices. We also assigned three external states to a geographic region different from their census region, to mirror the CPC+ regions' market characteristics more closely.

ACO = accountable care organization; DO = doctor of osteopathic medicine; EHR = electronic health record; MD = medical doctor; SSP = Medicare Shared Savings Program.

3.C.3. Survey content

The physician survey asks primary care physicians about their approaches to care delivery, job satisfaction and burnout, teamwork and staffing, compensation, use of health information technology, and data feedback. In addition, physicians in CPC+ practices were asked about their experience with CPC+. Survey content came largely from the 2016 CPC Clinician survey.²⁸ Additional details on survey content are available in the [CPC+ Third Annual Report Appendices](#).

Additional screening questions were added to the 2021 CPC+ Physician Survey, as well as CPC+ practice-specific questions about staff contributions to care delivery changes and practices' experience during the COVID-19 pandemic. The 2021 survey administered to physicians in participating or recently withdrawn CPC+ practices (practices that withdrew from CPC+ on or after April 19, 2020) was divided into 10 sections and contained 64 questions, compared with 9 sections and 58 questions in the 2019 survey. The survey administered to physicians in comparison practices or in practices that withdrew from CPC+ more than one year before fielding did not contain the section about CPC+, leaving 9 sections with 56 questions, compared with 8 sections and 53 questions in the 2019 survey.²⁹ We conducted two rounds of cognitive interviews with 13 physicians to pre-test the new or revised 2021 survey questions. See Tables 3.C.5 and 3.C.6 for information on survey content. The full survey instrument is presented in Section 3.C.7.

²⁸ Mathematica Policy Research. "Evaluation of the Comprehensive Primary Care Initiative 2016 Clinician Survey." Princeton, NJ: Mathematica Policy Research, administered starting June 2016.

²⁹ We administered the CPC+ version of the survey to physicians in practices that withdrew from CPC+ within a year of fielding and the comparison survey to physicians in CPC+ practices that withdrew more than one year before fielding, because physicians whose practices withdrew earlier might not be able to reliably recall their experience with CPC+.

Table 3.C.5. Content of the PY 5 CPC+ Physician Survey

Survey section	Content	Number of questions	
		CPC+	Comparison
0	Practice site and physician information Confirm contact information for the physician's practice site Whether physician is an MD or DO in primary care Whether physician provides primary care at the practice	5	5
A	Job satisfaction and burnout Physician's level of satisfaction with their current job Extent to which physician is experiencing burnout or stress at work Likelihood physician will leave their current practice within two years	4	4
B	Approaches to providing primary care Availability of on-site counseling for behavioral or mental health problems Proportion of physician's adult patients who are screened at least once a year with a formal screening tool for depression, anxiety, substance use, adult attention-deficit/hyperactivity disorder, and dementia (for patients 65+) Physician's use of phone, video, e-visits, or home visits Extent to which physician visits hospitalized patients How often physician's patients see them when they come to the practice for acute care Patient after-hours access to a coverage team or the practice, and availability of patient's EHR Practice staff follow-up with patients within a few days of an emergency department or hospital visit How practices link patients to supportive community-based resources Extent to which patients' advance care preferences are documented in the EHR Extent to which physician sends and receives useful information about referred patients to/from specialists Extent to which selected factors limit physician's ability to provide optimal care for patients	15	15
C	Teamwork and staffing at your practice site Physician's ratings of different elements of teamwork at the practice Extent to which medical assistants and nurses are paired with the physician How often physician has huddles with care team Whether the practice uses designated care managers to help with high-risk patients The number of designated care managers who work on site, and whether the practice uses designated care managers who are always located off site How often designated care managers engage in meetings, huddles, or conversations with the physician about their high-risk patients	8	8
D	Care management at your practice site Use of a standard method, tool, or algorithm to characterize patient risk, and use of risk level to identify patients for care management Extent to which care plans are developed for high-risk patients Extent to which various elements are included in care plans for high-risk patients Physician's use of care plans for high-risk patients	5	5
E	Physician compensation Percentage of physician's compensation for clinical activities based on seven ways physicians can be paid	1	1
F	Health information technology (IT) Whether physician or someone from their team routinely use practice's EHR or other health IT to perform selected key activities Extent to which the practice's EHR is a big help to the physician in providing quality care	2	2

Table 3.C.5. (continued)

Survey section	Content	Number of questions	
		CPC+	Comparison
G	Data feedback you received Whether the physician reported receiving data feedback on quality of care, health care service use, and total cost of health care for their patients in the past 12 months Whether physician made any changes to how they deliver care in response to data feedback received Whether physician received data on what insurers paid individual specialists for their patient, and whether physician considers these cost data in deciding which specialists to refer a patient to	8	8
H	Physician's impressions of CPC+ (CPC+ physicians only) Extent to which physician thinks CPC+ improved the quality of care they provide their patients Extent to which physician thinks CPC+ reduced the overall costs of all health care their patients received Adequacy of CPC+ payments from all payers Likelihood of recommending that physician's practice participate in CPC+ again Individuals at practice site who have made substantive contribution to implement CPC+ care delivery changes Extent to which physician thinks CPC+ helped meet patients health care needs during the coronavirus pandemic	7	0
I	Physician's background characteristics Gender, age, ethnicity, race Participation in practice leadership and, for CPC+ physicians, in CPC+ leadership How long the physician has worked at the practice Number of hours per week worked at practice Number of patients seen at practice	9	8
Total number of questions		64	56

DO = doctor of osteopathic medicine; EHR = electronic health record; IT = information technology; MD = medical doctor; PY = program year.

Table 3.C.6. Questions in the PY 5 CPC+ Physician Survey

Question number	CPC+ question text	Source	Modified from original source	Domain
Practice site and physician information				
1	Please review the contact information below for your practice site. Is all of this information correct? [Y/N]	2019 CPC+ Physician Survey	Yes	Physician Characteristics
1a	Please provide updated contact information for your practice site.	2019 CPC+ Physician Survey	Yes	Physician Characteristics
2	Are you a physician (MD or DO)? [Y/N]	2019 CPC+ Physician Survey	Yes	Physician Characteristics
3	Do you provide any primary care to patients at the practice site listed at 1 or 1a above? [Y/N]	2016 CPC Clinician Survey PACT	Yes	Physician Characteristics
4	What is your email address? (We will only use this information to follow-up with you about the survey, if needed.)	2019 CPC+ Physician Survey	Yes	Physician Characteristics
A. Job satisfaction				
A1	Please indicate how much you agree or disagree with the following statement: Overall, I am satisfied with my current job. [Strongly disagree, Disagree, Neither disagree nor agree, Agree, Strongly agree]	2016 CPC Clinician Survey FQHC APCP MEMO	No	Physician Satisfaction, Burnout, and Likelihood to Leave the Practice
A2	Using your own definition of “burnout,” please indicate which statement best describes your situation at work. 1 I enjoy my work. I have no symptoms of burnout. 2 Occasionally I am under stress, and I don’t always have as much energy as I once did, but I don’t feel burned out. 3 I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion. 4 The symptoms of burnout that I’m experiencing won’t go away. I think about frustrations at work a lot. 5 I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	2016 CPC Clinician Survey FQHC APCP MEMO Schmoldt	No	Physician Satisfaction, Burnout, and Likelihood to Leave the Practice
A3	How much stress, if any, do you experience due to each of the following factors? [None, A little, Some, A lot] a. Burdensome administrative tasks (such as paperwork related to insurance, pre-authorizations) b. Excessive time demands of using EHRs or other health IT c. Insufficient compensation and reimbursement d. Lack of control or autonomy e. Inadequate staff support	Mathematica	New	Physician Satisfaction, Burnout, and Likelihood to Leave the Practice
A4	What is the likelihood that you will leave your current practice within two years? [Very likely, Somewhat likely, Not very likely, Not at all likely]	2016 CPC Clinician Survey FQHC APCP MEMO	No	Physician Satisfaction, Burnout, and Likelihood to Leave the Practice

Table 3.C.6 (continued)

Question number	CPC+ question text	Source	Modified from original source	Domain
B. Approaches to providing primary care				
B1	Is counseling for behavioral or mental health problems available to your patients on-site, at your office? [Y/N]	2016 CPC Clinician Survey NAMCS	Yes	Comprehensiveness and Coordination
B2	How many of your adult patients (age 18 and older) are screened at least once a year with a formal screening tool for each of these conditions? [None/Some/Many/Most or All] a. Depression (such as PHQ-2 or PHQ-9) b. Anxiety (such as GAD-7) c. Substance use (such as CAGE, AUDIT-C, or DAST) d. Adult attention-deficit/hyperactivity disorder (such as Adult ADHD self-report tool)	2018 CPC+ Practice Survey	Yes	Comprehensiveness and Coordination
B3	How many of your patients age 65 and older are screened for dementia at least once a year with a formal screening tool (such as Mini-Mental State Examination or Mini-Cog)? [None, Some, Many, Most or all]	2018 CPC+ Practice Survey	Yes	Comprehensiveness and Coordination
B4	For how many of your patients do you (or someone from your care team) offer scheduled phone, video, or e-visits? [None, Some, Many, Most or all]	2017 and 2018 CPC+ Practice Surveys 2016 CPC Practice Survey	Yes	Access and Continuity
B4a	How often do these scheduled phone, video, or e-visits replace what would have been face-to-face office visits for these patients? [Never or rarely, Sometimes, Frequently, Usually or always]	2017 and 2018 CPC+ Practice Surveys 2016 CPC Practice Survey	Yes	Access and Continuity
B5	For how many of your frail or homebound patients do you (or someone from your care team) offer home visits? [None, Some, Many, Most or all]	2017 and 2018 CPC+ Practice Surveys	Yes	Access and Continuity
B6	How many of your hospitalized patients do you (or someone from your care team) visit in the hospital in a professional capacity? [None, Some, Many, Most or all]	2016 CPC Clinician Survey 2018 CPC+ Practice Survey	Yes	Access and Continuity
B7	When your patients come to your practice for acute care, they see you ... 1 Never or rarely 2 Sometimes 3 Frequently 4 Usually or always	2017 and 2018 CPC+ Practice Surveys	Yes	Access and Continuity

Table 3.C.6 (continued)

Question number	CPC+ question text	Source	Modified from original source	Domain
B8	<p>Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP/CNS, or answering service ...</p> <p>1 ...is not available or is limited to an answering machine.</p> <p>2 ...is (1) always available, but (2) the practitioner on call does not regularly communicate problems and decisions back to you.</p> <p>3 ...is (1) always available, and (2) the practitioner on call regularly communicates problems and decisions back to you, but (3) does not have real-time access to the practice's electronic health record (EHR) system.</p> <p>4 ...is (1) always available, and (2) the practitioner on call regularly communicates problems and decisions back to you, and (3) does have real-time access to the practice's EHR system.</p>	<p>2017 and 2018 CPC+ Practice Surveys</p> <p>PCMH-A</p>	Yes	Access and Continuity
B9	<p>Follow-up by you or your practice with your patients who had emergency department (ED) or hospital visits ...</p> <p>1 ...generally does not occur.</p> <p>2 ...occurs only if the ED or hospital alerts you or your practice.</p> <p>3 ...occurs because you or your practice makes proactive efforts to identify these patients.</p> <p>4 ...is done routinely because you or your practice has arrangements in place with the ED and hospital to track these patients and ensure that follow-up occurs within a few days.</p>	<p>2017 and 2018 CPC+ Practice Surveys</p> <p>PCMH-A</p>	Yes	Care Management
B10	<p>Linking your patients to supportive community-based resources (e.g., transportation, caregiver support, housing) ...</p> <p>1 ...is not done systematically by you or your practice.</p> <p>2 ...is limited to providing your patients a list of identified community resources.</p> <p>3 ...is accomplished by a designated staff person who is responsible for connecting your patients with community resources.</p> <p>4 ...is accomplished by a designated staff person who actively coordinates and follows up with the community service agencies and your patients.</p>	<p>2017 and 2018 CPC+ Practice Surveys</p> <p>PCMH-A</p>	Yes	Comprehensiveness and Coordination
B11	<p>You (or someone from your care team) document advance care preferences (e.g., for end-of-life care and/or advance directives for when patients might become too sick to make their own decisions) in your electronic health record (EHR) for ...</p> <p>1 ...none of your high-risk patients.</p> <p>2 ...some of your high-risk patients.</p> <p>3 ...many of your high-risk patients.</p> <p>4 ...most or all of your high-risk patients.</p>	2018 CPC+ Practice Survey	Yes	Patient and Caregiver Engagement
B12	<p>When you refer a patient to a specialist, how often do you send the specialist notification of the patient's history and reason for the consultation?</p> <p>[Always or most of the time, Sometimes, Seldom or never, Not applicable]</p>	Mathematica	New	Comprehensiveness and Coordination
B13	<p>How often do you receive useful information about your referred patients from specialists?</p> <p>[Always or most of the time, Sometimes, Seldom or never, Not applicable]</p>	<p>2017 and 2018 CPC+ Practice Surveys</p> <p>2016 CPC Practice Survey</p>	Yes	Comprehensiveness and Coordination

Table 3.C.6 (continued)

Question number	CPC+ question text	Source	Modified from original source	Domain
B14	How much does each of the following factors limit your ability to provide optimal care for your patients? [Does not limit/limits somewhat/limits a great deal] a. Lack of available behavioral health specialists for consultations and/or referrals b. Lack of available medical or surgical specialists for consultations and/or referrals c. Inadequate reimbursement from insurers for primary care services d. Inadequate time to spend with patients during visits	2016 CPC Clinician Survey PACT	Yes	Barriers to Providing Optimal Patient Care
C. Teamwork and staffing at your practice site				
C1	How much do you agree or disagree with each of the following statements related to teamwork at your practice site? [Strongly disagree/Disagree/Neither disagree or agree/Agree/Strongly agree] a. The group of staff and providers I work with the most at this practice site work well together as a team b. We have a “we are in it together” attitude at my practice site c. My professional skills are used to the fullest at my practice site d. It is hard to get things to change at my practice site e. I can rely on other people at my practice site to do their jobs well f. We regularly take time to consider ways to improve how we do things at my practice site	2016 CPC Clinician Survey PACT SOAPC	Yes	Teamwork
C2	At this practice site, how are medical assistants organized to work with you? 1 You are paired with the same medical assistant(s) most days 2 You are not paired with the same medical assistant(s) most days 3 You don't work with medical assistants	2017 CPC+ Practice Survey	Yes	Teamwork
C3	At this practice site, how are nurses organized to work with you? 1 You are paired with the same nurse(s) most days 2 You are not paired with the same nurse(s) most days 3 You don't work with nurses	2017 CPC+ Practice Survey	Yes	Teamwork
C4	Care team huddles are brief meetings among physicians and staff such as nurses and medical assistants. They are typically held before morning or afternoon patient visits to discuss patient-specific issues and keep the core clinical team informed. How often do you have huddles with your care team? 1 Never 2 On some days 3 On most days 4 Every day	2017 and 2018 CPC+ Practice Surveys	Yes	Teamwork
C5	Does your practice use designated care managers, as defined above? [Y/N]	2017 and 2018 CPC+ Practice Surveys PCMH-A	Yes	Care Management

Table 3.C.6 (continued)

Question number	CPC+ question text	Source	Modified from original source	Domain
C6	How many designated care managers work on-site, at the practice site listed [on the cover of this questionnaire/at the top of this web page]? Please include only staff who are located on-site at least once per week, regardless of who employs them. Please enter "0" if you do not have any designated care managers who work on-site. Number of designated care managers who work on-site	2017 and 2018 CPC+ Practice Surveys 2016 CPC Practice Survey	Yes	Care Management
C7	Does your practice use any designated care managers who are always located off-site? [Y/N]	2017 and 2018 CPC+ Practice Surveys	Yes	Care Management
C8	On average, about how often do designated care managers engage in meetings, huddles, or conversations with you about your high-risk patients whom they manage? Please consider on-site and off-site designated care managers. 1 Daily 2 Weekly 3 Monthly 4 A few times per year 5 Less than once per year or never	2018 CPC+ Practice Survey	Yes	Care Management
D. Care management at your practice site				
D1	Some practices or health systems categorize their entire patient population into groups (such as high, medium, or low risk) based on the patients' overall risk level for adverse and potentially preventable outcomes, such as ED visits or hospitalizations. Does your practice or health system categorize your patients into risk levels using a standard method, tool, or algorithm? [Y/N]	2017 and 2018 CPC+ Practice Surveys 2016 CPC Practice Survey	Yes	Care Management
D1a	Do you (or someone from your care team) use the overall risk level to identify patients for care management? [Y/N]	2017 and 2018 CPC+ Practice Surveys 2016 CPC Practice Survey	Yes	Care Management
D2	A care plan is a structured, personalized plan of care developed with patient input and documented by you or someone from your care team. A care plan is more comprehensive than an after-visit summary, a hospital discharge plan, or a standard treatment/action plan for a single condition (such as diabetes or congestive heart failure). For about how many of your high-risk patients do you (or someone from your care team) develop a care plan, as defined above? 1 None 2 Some 3 Many 4 Most or all	2017 and 2018 CPC+ Practice Surveys PCMH-A	Yes	Care Management

Table 3.C.6 (continued)

Question number	CPC+ question text	Source	Modified from original source	Domain
D2a	How often are the following elements included in the care plans developed for your high-risk patients? [Never or rarely/Sometimes/Frequently/Usually or always/Don't know] a. Patient diagnoses b. Treatment goals identified by the care team c. Health goals identified collaboratively with the patient d. Patient concerns or barriers to meeting health goals e. Patient self-management action steps f. Advance directives	2017 and 2018 CPC+ Practice Surveys PCMH-A	Yes	Care Management Patient and Caregiver Engagement (f)
D2b	How often are the care plans that are developed for your high-risk patients used in the following ways? [Never or rarely/Sometimes/Frequently/Usually or always/Don't know] a. Used by you personally in ongoing care b. Documented in your practice's electronic health record (EHR) or other health information technology (IT) c. Shared with your patients d. Revised or redeveloped after major events, such as hospital discharge, exacerbation of a condition, or change in patient preferences	2016 CPC Clinician Survey 2018 CPC+ Practice Survey 2016 CPC Practice Survey	Yes	Care Management
E. Your compensation				
E1	What percentage of your total compensation for clinical activities is based on the following ways physicians can be paid? Please provide your best estimate. Enter "0" if a category does not apply. [The total percentage of your compensation should sum to 100%.] a. Guaranteed or "base" salary (not based on your productivity, the number of patients you manage, or clinical performance) b. Your own individual productivity (e.g., cash collection, billings, relative value units, visits) c. Number of patients you managed (regardless of amount or type of services provided) d. Performance on measures of the quality of care you provide to your patients (e.g., measures of adherence to guidelines, measures of control of chronic conditions) e. Performance on measures of your patients' satisfaction with the care you provide (e.g., results of patient satisfaction surveys) f. Your management of the health care services your patients use, as compared to other physicians (e.g., use of specialists) g. A share of your organization's profit or net revenue for the year h. Other payments (please describe)	2016 CPC Clinician Survey 2017 CPC+ Practice Survey NAMCS	Yes	Compensation for Clinical Activities
F. Health information technology (IT)				
F1	Did you or someone from your care team routinely use your practice's electronic health record (EHR) or other health IT to perform the following activities in the past six months? [YES: ROUTINELY USED FUNCTION IN EHR OR HEALTH IT /NO: FUNCTION NOT AVAILABLE IN EHR OR HEALTH IT, OR DID NOT ROUTINELY USE FUNCTION] a. Document patients' health-related social needs (e.g., for transportation, caregiver support, housing) b. Track referral and consultation communications with other providers c. Identify gaps in care (e.g., recommended screening tests) d. Identify and track patients with specific health conditions, risk states, or medications.	2016 CPC Clinician Survey	Yes	Comprehensiveness and Coordination (a, b) Planned Care for Chronic Conditions and Population Health (c, d) Health IT

Table 3.C.6 (continued)

Question number	CPC+ question text	Source	Modified from original source	Domain
F2	Please indicate how much you agree or disagree with the following statement: This practice's EHR (or other health IT) is a big help to me in providing quality care to my patients. 1 Strongly disagree 2 Disagree 3 Neither disagree nor agree 4 Agree 5 Strongly agree	2016 CPC Clinician Survey SNMHI	Yes	Health IT
G. Data feedback you received				
G1	In the past 12 months, have you received data feedback on quality of care for your patients? Examples of data feedback on quality of care include percentage of your patients with diabetes with a recent eye exam, or percentage of adults age 50–75 who had appropriate screening for colorectal cancer. [Y/N/DK]	2016 CPC Clinician Survey FQHC ACP 2018 CPC+ Practice Survey	Yes	Physician Use of Data Feedback
G1a	In response to this data feedback on quality of care, did you make any changes to how you deliver care? 1 No, you made no changes to how you deliver care 2 Yes, you made minor changes to how you deliver care 3 Yes, you made major changes to how you deliver care	2016 CPC Clinician Survey FQHC ACP 2018 CPC+ Practice Survey	Yes	Physician Use of Data Feedback
G2	In the past 12 months, have you received data feedback on health care service utilization for your patients? [Y/N/DK] Examples of data feedback on health care service utilization include number of hospitalizations or ED visits.	2016 CPC Clinician Survey 2018 CPC+ Practice Survey	Yes	Physician Use of Data Feedback
G2a	In response to this data feedback on health care service utilization, did you make any changes to how you deliver care? 1 No, you made no changes to how you deliver care 2 Yes, you made minor changes to how you deliver care 3 Yes, you made major changes to how you deliver care	2016 CPC Clinician Survey 2018 CPC+ Practice Survey	Yes	Physician Use of Data Feedback
G3	In the past 12 months, have you received data feedback on the total cost of health care (reimbursement by insurers to all providers who provide care) for any of your patients? [Y/N/DK]	2016 CPC Clinician Survey 2018 CPC+ Practice Survey	Yes	Physician Use of Data Feedback
G3a	In response to this data feedback on the total cost of health care, did you make any changes to how you deliver care? 1 No, you made no changes to how you deliver care 2 Yes, you made minor changes to how you deliver care 3 Yes, you made major changes to how you deliver care	2016 CPC Clinician Survey 2018 CPC+ Practice Survey	Yes	Physician Use of Data Feedback

Table 3.C.6 (continued)

Question number	CPC+ question text	Source	Modified from original source	Domain
G4	Some practices get data on their patients' costs (that is, reimbursement by insurers), presented separately for the individual specialists seen. For example, if the practice's patients have seen Dr. Smith and Dr. Jones for cardiology services, the data will present the costs for Dr. Smith and the costs for Dr. Jones. Do you receive any data on what insurers paid (reimbursed) for individual specialists for your practice's patients? Data can be presented as actual dollar costs or categories (low, medium, high cost). [Y/N]	2016 CPC Clinician Survey 2018 CPC+ Practice Survey	Yes	Physician Use of Data Feedback
G4a	When deciding which specialist to refer a patient to, how much do you consider these cost data? [A lot/Some/Not very much/Not at all]	2018 CPC+ Practice Survey	Yes	Physician Use of Data Feedback
H. Your impressions of CPC+¹				
H1	Overall, how much has participating in CPC+ changed the quality of care that you currently provide to your patients? [recent TWD use: Overall, how much did participating in CPC+ change the quality of care that you provided to your patients?] [Improved a lot/Improved somewhat/Did not change/Worsened somewhat/Worsened a lot/Don't know]	2016 CPC Clinician Survey 2018 CPC+ Practice Survey 2016 CPC Practice Survey	Yes	Experience with CPC+
H2	How much do you think participating in CPC+ reduced the overall costs of all the health care your patients received? [A lot/Some/Not very much/Not at all/Don't know]	Mathematica	New	Cost Orientation Experience with CPC+
H3	Overall, considering the amount of work required by CPC+, how adequate or inadequate do you think the CPC+ payments from all payers combined are [recent TWD use: were]? [More than adequate/Adequate/Less than adequate/Don't know – not familiar with CPC+ payments from all payers or costs of doing CPC+ work]	2016 CPC Clinician Survey 2018 CPC+ Practice Survey 2016 CPC Practice Survey	Yes	Experience with CPC+
H4	In answering this question, please consider: Improvements made to your practice site's care delivery CPC+ participation requirements (including care delivery, health IT, and reporting requirements) CPC+ supports (payments, learning activities, data feedback, and health IT vendor support) Given your practice's overall experience participating in CPC+, how likely is it that you would recommend that your practice participate in CPC+ if your practice could do it all over again? [Very likely/Somewhat likely/Not very likely/Not at all likely/Don't know]	2016 CPC Clinician Survey 2018 CPC+ Practice Survey 2016 CPC Practice Survey	Yes	Experience with CPC+
H5	Thinking about the individual(s) at your practice site who have made a substantive contribution of time or leadership to implement care delivery changes for CPC+, would you say that: 1 <u>Most or all of the practice site</u> was involved in the substantive work on CPC+ 2 A smaller group <u>that included at least one physician</u> did most of the substantive work on CPC+ 3 A smaller group <u>that did not include any physicians</u> did most of the substantive work on CPC+ 4 <u>One physician</u> did most of the substantive work on CPC+ 5 <u>One non-physician</u> did most of the substantive work on CPC+ 6 <u>No one at the practice site</u> did much substantive work on CPC+ d Don't know	2016 CPC Clinician Survey	Yes	Experience with CPC+

Table 3.C.6 (continued)

Question number	CPC+ question text	Source	Modified from original source	Domain
H6	Please indicate how much you agree or disagree with the following statement. You were better positioned to meet health care needs for your patients during the coronavirus pandemic because of your practice's participation in CPC+. [Strongly disagree/Disagree/Neither disagree nor agree/Strongly agree/Don't know]	2020 CPC+ Practice Survey	Yes	Experience with CPC+
H6a	Please describe how, if at all, participation in CPC+ affected your ability to meet health care needs for your patients during the coronavirus pandemic.	2020 CPC+ Practice Survey	Yes	Experience with CPC+
I. Background characteristics				
I1	What is your gender? [Male/Female]	2016 CPC Clinician Survey PACT SNMHI	No	Physician Characteristics
I2	What is your current age in years? 1 Less than 30 years 2 30–39 3 40–49 4 50–59 5 60–69 6 70 years or older	2016 CPC Clinician Survey PACT	Yes	Physician Characteristics
I3	Are you of Hispanic or Latino origin? [Y/N]	2016 CPC Clinician Survey PACT SNMHI	No	Physician Characteristics
I4	What is your race? [SELECT ALL THAT APPLY] 1 White/Caucasian 2 Black or African American 3 Asian 4 Native Hawaiian or other Pacific Islander 5 American Indian or Alaska Native 6 Other (specify)	2016 CPC Clinician Survey PACT SNMHI	No	Physician Characteristics
I5	Are you a part of the leadership that makes decisions about how physicians and staff at this practice site deliver care? [Y/N]	Mathematica	New	Physician Characteristics
I5a ¹	Are [recent TWD use: Were] you a lead or champion for the implementation of CPC+ at the practice site listed [on the cover of this questionnaire/at the top of this web page]? [Y/N]	Mathematica	New	Physician Characteristics
I6	How long have you worked at the practice site listed [on the cover of this questionnaire/at the top of this web page]? 1 Less than 2 years 2 2 years up to 5 years 3 More than 5 years up to 10 years 4 More than 10 years	2016 CPC Clinician Survey PACT SNMHI	Yes	Physician Characteristics

Table 3.C.6 (continued)

Question number	CPC+ question text	Source	Modified from original source	Domain
17	In a typical week, how many hours do you spend on patient care for the practice site listed [on the cover of this questionnaire/at the top of this webpage]? Patient care includes direct interactions with patients and tasks related to direct patient care, such as documenting care in your patients' health records and coordinating care with patients' other providers. 1 Less than 20 hours 2 20–39 hours 3 40–49 hours 4 50–59 hours 5 60 hours or more	2016 CPC Clinician Survey SNMHI	Yes	Physician Characteristics
18	In a typical day, how many patients do you see at the practice site listed [on the cover of this questionnaire/at the top of this web page]? If you work part time, please adjust your estimate to represent a full day. Number of patients seen in a typical day	Mathematica	New	Physician Characteristics
19	[CPC+] If you have more information about your experience with CPC+ or this survey that you think may be of interest to this study, please feel free to add it below. [Comparison] If you have more information about this survey that you think may be of interest to this study, please feel free to add it below.	2016 CPC Clinician Survey	Yes	Physician Characteristics

2019 CPC+ Physician Survey: Comprehensive Primary Care Plus (CPC+) 2019 Primary Care Physician Survey. Mathematica. “Evaluation of the Comprehensive Primary Care Plus (CPC+) Model 2019 Primary Care Physician Survey.” Princeton, NJ: Mathematica Policy Research, administered starting August 2019.

2016 CPC Clinician Survey: 2016 Comprehensive Primary Care Practice Survey. Mathematica Policy Research. “Evaluation of the Comprehensive Primary Care Initiative 2016 Clinician Survey.” Princeton, NJ: Mathematica Policy Research, administered starting June 2016.

Patient Aligned Care Team (PACT): 2013 PACT Personnel Survey. Helfrich C.D., E.D. Dolan, J. Simonetti, R. Reid, S. Joos, B. Wakefield, G. Schectman, R. Stark, S. Fihn, H. Harvey, and K. Nelson. “Elements of Team-Based Care in a Patient-Centered Medical Home Are Associated with Lower Burnout Among VA Primary Care Employees.” *Journal of General Internal Medicine*, vol. 29, suppl. 2, 2014, pp. 659–666. doi:10.1007/s11606-013-2702-z. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4070238/#MOESM1>.

Federally Qualified Health Center (FQHC) Advanced Primary Care (APCP): FQHC APCP Demonstration Clinician and Staff Experience Survey (Draft). Kahn, Katherine L., Justin W. Timbie, Mark W. Friedberg, Tara A. Lavelle, Peter Mendel, J. Scott Ashwood, Liisa Hiatt, Ian Brantley, Beverly A. Weidmer, Afshin Rastegar, Aaron Kofner, Rosalie Malsberger, Mallika Kommareddi, Denise D. Quigley, and Claude M. Setodji. “Evaluation of CMS FQHC APCP Demonstration: Second Annual Report.” July 2015. RR-886/1-CMS. Prepared for the Centers for Medicare & Medicaid Services. Santa Monica, CA: RAND Corporation. Available at <https://innovation.cms.gov/Files/reports/fqhc-scndevalrpt.pdf>.

Minimizing Error, Maximizing Outcome (MEMO): MEMO Survey. Linzer, Mark, Linda Baier Manwell, Marlon Mundt, Eric Williams, Ann Maguire, Julia McMurray, and Mary Beth Plane. “Organizational Climate, Stress, and Error in Primary Care: The MEMO Study.” In *Advances in Patient Safety: From Research to Implementation (Volume 1: Research Findings)*, edited by K. Henriksen, J.B. Battles, E.S. Marks, and D.I. Lewin. Rockville, MD: Agency for Healthcare Research and Quality, February 2005, pp. 65–77.

Schmoldt: Single-item measure of burnout. Schmoldt R.A., D.K. Freeborn, and H.D. Klevit. “Physician burnout: recommendations for HMO managers.” *HMO Practice*, vol. 8, no. 2, 1994, pp. 58–63. PMID: 10135263. Available at <https://pubmed.ncbi.nlm.nih.gov/10135263/>.

National Hospital Ambulatory Medical Care Survey (NAMCS): Physician Survey. DesRoches, C., and E. Rich. “Collecting Data on Physicians and Their Practices: Final Report to AHRQ.” Washington, DC: Mathematica Policy Research, 2014.

2018 CPC+ Practice Survey: 2018 Comprehensive Primary Care Plus Practice Survey. Mathematica Policy Research. “Evaluation of the Comprehensive Primary Care Plus (CPC+) Model 2018 Practice Survey – First Year Follow-up.” Princeton, NJ: Mathematica Policy Research, administered starting May 2018.

2017 CPC+ Practice Survey: 2017 Comprehensive Primary Care Plus Practice Survey. Mathematica Policy Research. “Evaluation of the Comprehensive Primary Care Plus (CPC+) Initiative 2017 Practice Survey.” Princeton, NJ: Mathematica Policy Research, administered starting March 2017.

2016 CPC Practice Survey: 2016 Comprehensive Primary Care Practice Survey. Mathematica Policy Research. “Evaluation of the Comprehensive Primary Care Initiative 2016 Practice Survey.” Princeton, NJ: Mathematica Policy Research, administered starting April 2016.

Table 3.C.6 (continued)

Patient-Centered Medical Home Assessment (PCMH-A): Safety Net Medical Home Initiative. "The Patient-Centered Medical Home Assessment Version 1.1." Seattle, WA: The MacColl Center for Health Care Innovation at Group Health Research Institute and Qualis Health, 2010.

Survey of Organizational Attributes for Primary Care (SOAPC): Ohman-Strickland, Pamela A., A. John Orzano, Paul A. Nutting, W. Perry Dickinson, Jill Scott-Cawiezell, Karissa Hahn, Michelle Gibel, and Benjamin F. Crabtree. "Measuring Organizational Attributes of Primary Care Practices: Development of a New Instrument." *Health Services Research*, vol. 42, no. 3, Part 1, June 2007, pp. 1257–1270.

Safety Net Medical Home Initiative (SNMHI): SNMHI Staff Experience Survey. Lewis, Sarah E., Robert S. Nocon, Hui Tang, Seo Young Park, Anusha M. Vable, Lawrence P. Casalino, Elbert S. Huang, Michael T. Quinn, Deborah L. Burnet, William Thomas Summerfelt, Jonathan M. Birnberg, and Marshall H. Chin. "Patient-Centered Medical Home Characteristics and Staff Morale in Safety Net Clinics." *Archives of Internal Medicine*, vol. 172, no. 1, 2012, pp. 23–31.

2020 CPC+ Practice Survey: 2020 Comprehensive Primary Care Plus Practice Survey. Mathematica. "Evaluation of the Comprehensive Primary Care Plus (CPC+) Initiative 2020 Practice Survey – Third Year Follow-up." Princeton, NJ: Mathematica, administered starting September 2020.

¹ These questions were included only in surveys provided to the CPC+ and recent TWD physicians (physicians in practices that recently withdrew from CPC+).

Y/N = response options were yes and no; Y/N/DK = response options were yes, no, and don't know.

CNS = clinical nurse specialist; DO = doctor of osteopathic medicine; ED = emergency department; EHR = electronic health record; IT = information technology; MD = medical doctor; NP = nurse practitioner; PA = physician assistant; PY = program year; TWD = treatment withdrawn.

3.C.4. Analytic methods

Analytic comparisons. For each survey question, except on ratings of CPC+, we compared survey responses between physicians in CPC+ and those in comparison practices. We conducted the analysis separately by track. Because we could not collect data before CPC+ began, differences might reflect existing differences between CPC+ and comparison practices. Another consideration when interpreting the differences is that the CPC+ physicians might have a better understanding than comparison physicians of the novel care delivery approaches the model promotes.

Statistical estimation. For each survey question, we calculated the weighted mean survey response or the weighted distribution of response options by study group (CPC+ or comparison) and by track (Tracks 1 and 2). We weighted estimates using the weights that accounted for sampling design and nonresponse and ensured CPC+ and comparison respondents had similar practice- and respondent-level characteristics. Given the similar characteristics of the CPC+ and comparison physicians after weighting adjustments, we did not regression-adjust survey responses. Furthermore, because most questions were answered by at least 95 percent of respondents, we did not adjust responses for question nonresponse; instead, we calculated results only among question respondents. We tested differences statistically between the responses from CPC+ and comparison physicians using two-tailed t-tests and chi-square tests. When responses to questions represented amounts, we used t-tests for mean differences between CPC+ and comparison physicians. When responses represented physicians distributed into multiple categories, we used chi-square tests to test whether distributions were independent of CPC+ or comparison status. To account for correlation in responses between physicians within practices, we used cluster-robust standard errors, clustering at the practice level.

Power. Using two-tailed tests at the 10 percent significance level, the analysis was designed to have 80 percent power to detect differences between CPC+ and comparison physician responses of 10 percentage points or larger, assuming a binary outcome with an overall mean of 70 percent.

Substantial importance. We must interpret results with caution. Because we performed 220 tests, this means that by chance alone, we would expect to find statistically significant differences in 22 tests using the 0.10 significance level. To reduce the risk of incorrectly concluding there were effects of CPC+, we considered responses between physicians in CPC+ and comparison practices to be statistically different and substantially important if the difference met two criteria: (1) the p-value was less than or equal to 0.10 and (2) the difference between the two groups was at least 10 percentage points.

Statistical software. We used SAS version 9.4 to clean and prepare the data for analysis and to construct the data tables. We performed the statistical tests using Stata version 17 and used Stata's survey commands to account for survey sampling design.

3.C.5. Data tables

This section presents three tables showing weighted data. Each table shows data for respondents in CPC+ and comparison practices separately, as follows:

- **Tables 3.C.7a–3.C.7e** present CPC+ and comparison physicians' responses to questions about their approaches to care delivery, organized by the Comprehensive Primary Care Functions which they align, by track, and by selected practice characteristics for selected questions.

- **Tables 3.C.8a –3.C.8e** present CPC+ and comparison physicians’ responses to other questions including physicians’ use of data feedback and health IT, perceived barriers to providing quality care, teamwork, job satisfaction, and burnout, by track, and by selected practice characteristics for selected questions.
- **Table 3.C.9** presents self-reported characteristics of the responding physicians in CPC+ and comparison practices, by track.

Table 3.C.7a. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Overall

Question	Overall (Track 1 and 2)		Overall Track 1			Overall Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Access and continuity									
B4	Portion of physician's patients offered a scheduled phone, video, or e-visit by physician or someone from care team.				0.033				0.227
	Most or all	31%	30%	25%	5	32%	26%	6	
	Many	32%	33%	25%	8	31%	28%	3	
	Some	34%	33%	47%	-14	34%	43%	-9	
	None	3%	4%	3%	1	3%	3%	-1	
	N	544	253	320		291	316		
B4a	Among patients offered a scheduled phone, video, or e-visit, how often these scheduled phone, video, or e-visits replace what would have been face-to-face office visits.				0.103				0.034
	Usually or always	7%	6%	13%	-7	9%	16%	-7	
	Frequently	25%	25%	23%	2	25%	21%	4	
	Sometimes	63%	62%	57%	5	63%	56%	6	
	Never or rarely	5%	7%	7%	0	3%	7%	-3	
	N	527	245	313		282	305		
B5	Portion of physician's frail or homebound patients offered home visits by physician or someone from care team.				0.910				0.011
	Most or all	4%	6%	5%	1	3%	4%	-1	
	Many	8%	5%	6%	-1	10%	5%	5	
	Some	33%	27%	28%	-1	38%	27%	11	
	None	55%	62%	61%	1	49%	63%	-14	
	N	543	250	314		293	312		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2)	Overall Track 1				Overall Track 2				
		CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
B6	Portion of physician's hospitalized patients visited in the hospital in a professional capacity by physician or someone from care team.					0.210				0.619
	Most or all	14%	14%	11%	3		15%	12%	2	
	Many	6%	5%	5%	0		7%	5%	2	
	Some	14%	16%	11%	5		13%	13%	-1	
	None	65%	65%	73%	-8		66%	70%	-4	
	N	543	251	320			292	317		
B7	Patients who come to practice for acute care see their physician...					0.032				0.299
	Usually or always.	44%	52%	43%	9		38%	35%	3	
	Frequently.	35%	30%	39%	-9		39%	42%	-2	
	Sometimes.	20%	17%	16%	1		22%	21%	1	
	Never or rarely.	0%	0%	2%	-2		1%	2%	-2	
	N	541	252	317			289	315		
B8	Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP/CNS, or answering service...					0.001				0.023
	is (1) always available, and (2) the practitioner on call regularly communicates problems and decisions back to the physician, and (3) does have real-time access to the practice's EHR system.	90%	91%	79%	12		89%	79%	10	
	is (1) always available, and (2) the practitioner on call regularly communicates problems and decisions back to the physician, but (3) does not have real-time access to the practice's electronic health record (EHR) system.	5%	4%	9%	-5		5%	7%	-3	
	is (1) always available, but (2) the practitioner on call does not regularly communicate problems and decisions back to the physician.	4%	5%	9%	-4		4%	10%	-6	
	is not available or is limited to an answering machine.	1%	0%	3%	-3		2%	3%	-2	
	N	544	252	320			292	316		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2) CPC+ Physicians	Overall Track 1				Overall Track 2			
		CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Care management									
B9	Follow-up by physician or physician's practice with their patients who had emergency department (ED) or hospital visits...				0.000				0.011
	is done routinely because physician or their practice has arrangements in place with the ED and hospital to track these patients and ensure that follow-up occurs within a few days.	71%	73%	53%	19	69%	57%	12	
	occurs because physician or their practice makes proactive efforts to identify these patients.	23%	22%	30%	-8	24%	29%	-5	
	occurs only if the ED or hospital alerts physician or their practice.	6%	5%	16%	-11	6%	13%	-7	
	generally does not occur.	0%	0%	1%	0	1%	0%	0	
	N	543	252	319		291	317		
C5 ¹	Percentage of physicians whose practices use designated care managers whose primary role is to help high-risk patients.				0.000				0.000
	%	91%	90%	67%	23	91%	74%	17	
	N	539	249	316		290	315		
C6 ¹	Among physicians whose practices use designated care managers, number of care managers who work on-site at the practice site at least once per week.				0.064				0.009
	0	28%	31%	43%	-12	25%	39%	-14	
	1	50%	50%	38%	11	50%	40%	10	
	2	13%	12%	11%	2	13%	14%	0	
	3	5%	5%	3%	2	6%	3%	3	
	4	3%	1%	3%	-2	5%	2%	3	
	5+	1%	1%	2%	0	1%	3%	-2	
	N	490	224	212		266	220		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2)		Overall Track 1			Overall Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
C7 ¹	Among physicians whose practices use designated care managers, percentage of physicians whose practice uses care managers who are always located off site.				0.003				0.152
	%	52%	49%	64%	-15	54%	61%	-7	
	N	487	222	212		265	219		
C8 ¹	Among physicians whose practices use designated care managers, how often designated care managers (on-site or off-site) engage in meetings, huddles, or conversations with the physician about high-risk patients whom they manage.				0.000				0.000
	Daily	21%	19%	9%	10	21%	13%	9	
	Weekly	37%	41%	24%	16	34%	23%	11	
	Monthly	17%	15%	27%	-12	19%	26%	-7	
	A few times per year	19%	17%	26%	-9	20%	22%	-2	
	Less than once per year or never	6%	8%	14%	-6	4%	16%	-11	
	N	487	222	211		265	218		
D1	Percentage of physicians whose practice or health system categorizes physician's patients into risk levels using a standard method, tool, or algorithm.				0.000				0.000
	%	78%	75%	37%	38	80%	41%	39	
	N	539	248	318		291	315		
D1a	Among those whose practice or health system categorizes their patients into risk levels using a standard method, tool, or algorithm, percentage of physicians (or care teams) who use the overall risk level to identify patients for care management.				0.070				0.000
	%	95%	91%	83%	8	97%	77%	21	
	N	415	188	126		227	127		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2)		Overall Track 1			Overall Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
D2 ²	Portion of physician's high-risk patients for whom the physician (or someone from their care team) develops a care plan (a structured, personalized plan of care).				0.011				0.000
	Most or all	22%	15%	10%	5	26%	9%	17	
	Many	24%	23%	14%	8	26%	16%	10	
	Some	34%	38%	42%	-4	31%	40%	-10	
	None	20%	24%	34%	-9	17%	34%	-17	
	N	540	251	315		289	312		
D2a.a ²	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often patient diagnoses are included in the care plans.				0.233				0.466
	Usually or always	86%	85%	82%	3	87%	84%	2	
	Frequently	10%	12%	10%	2	9%	9%	1	
	Sometimes	2%	2%	4%	-2	2%	4%	-1	
	Never or rarely	0%	0%	1%	-1	0%	1%	-1	
	Don't know	2%	2%	3%	-2	2%	2%	-1	
	N	421	191	212		230	207		
D2a.b ²	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often treatment goals identified by the care team are included in the care plans.				0.169				0.118
	Usually or always	61%	57%	58%	-1	63%	60%	4	
	Frequently	27%	34%	28%	6	23%	30%	-8	
	Sometimes	8%	7%	8%	-1	9%	6%	4	
	Never or rarely	0%	0%	2%	-2	0%	1%	-1	
	Don't know	4%	2%	5%	-3	5%	3%	2	
	N	421	189	213		232	206		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2)		Overall Track 1			Overall Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
D2a.c ²	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often health goals identified collaboratively with the patient are included in the care plans.				0.117				0.097
	Usually or always	49%	44%	43%	1	53%	43%	10	
	Frequently	31%	35%	38%	-3	28%	39%	-11	
	Sometimes	15%	18%	12%	7	13%	11%	2	
	Never or rarely	1%	1%	2%	-1	1%	2%	-1	
	Don't know	4%	2%	6%	-4	5%	5%	0	
	N	423	191	213		232	206		
D2a.d ²	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often patient concerns or barriers to meeting health goals are included in the care plans.				0.213				0.241
	Usually or always	50%	43%	40%	3	54%	42%	11	
	Frequently	31%	34%	36%	-2	28%	34%	-6	
	Sometimes	14%	19%	15%	4	12%	15%	-4	
	Never or rarely	1%	2%	2%	-1	1%	3%	-1	
	Don't know	4%	3%	7%	-5	5%	5%	0	
	N	422	191	213		231	206		
D2a.e ²	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often patient self-management action steps are included in the care plans.				0.075				0.218
	Usually or always	48%	43%	41%	2	51%	40%	11	
	Frequently	32%	32%	34%	-2	31%	36%	-5	
	Sometimes	16%	21%	15%	7	11%	15%	-3	
	Never or rarely	1%	1%	2%	-1	1%	3%	-2	
	Don't know	4%	3%	8%	-6	5%	6%	-1	
	N	423	191	213		232	206		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2)		Overall Track 1			Overall Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
D2b.a ²	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often care plans are used by the physician for ongoing care.				0.842				0.899
	Usually or always	26%	26%	22%	4	25%	27%	-1	
	Frequently	28%	28%	30%	-2	28%	30%	-2	
	Sometimes	36%	36%	39%	-3	36%	35%	1	
	Never or rarely	10%	9%	9%	0	10%	8%	2	
	N	417	187	211		230	205		
D2b.b ²	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often care plans are documented in the practice's electronic health record (EHR) or other health information technology (IT).				0.285				0.145
	Usually or always	64%	63%	52%	11	64%	53%	11	
	Frequently	17%	19%	25%	-6	16%	27%	-10	
	Sometimes	14%	13%	14%	-1	15%	16%	-1	
	Never or rarely	2%	2%	4%	-2	2%	2%	0	
	Don't know	3%	2%	4%	-2	3%	3%	0	
	N	423	191	212		232	205		
D2b.c ²	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often care plans are shared with patients.				0.985				0.749
	Usually or always	41%	41%	41%	0	41%	40%	1	
	Frequently	23%	25%	25%	0	21%	24%	-3	
	Sometimes	19%	20%	18%	2	18%	20%	-3	
	Never or rarely	4%	4%	3%	0	4%	3%	1	
	Don't know	14%	11%	13%	-2	16%	13%	3	
	N	423	191	213		232	206		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2)	Overall Track 1				Overall Track 2				
		CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
D2b.d ²	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often care plans are revised or redeveloped after major events such as hospital discharge, exacerbation of a condition, or a change in patient preferences.					0.818				0.538
	Usually or always	46%	44%	40%	5		47%	40%	6	
	Frequently	27%	26%	30%	-3		27%	26%	1	
	Sometimes	18%	22%	20%	1		15%	21%	-5	
	Never or rarely	2%	3%	3%	0		2%	3%	-2	
	Don't know	8%	6%	8%	-2		10%	9%	0	
	N	423	191	213			232	206		
Comprehensiveness and coordination										
B1	Percentage of physicians who report that counseling for behavioral or mental health problems is available to their patients on-site, at their office.					0.001				0.000
	%	50%	42%	27%	15		57%	30%	27	
	N	544	253	314			291	313		
B2.a	Portion of physician's adult patients (age 18 and older) screened at least once a year with a formal screening tool for depression (such as PHQ-2 or PHQ-9).					0.026				0.430
	Most or all	76%	81%	70%	11		72%	75%	-2	
	Many	17%	13%	20%	-7		20%	19%	1	
	Some	7%	6%	8%	-2		7%	5%	2	
	None	0%	0%	2%	-2		0%	1%	-1	
	N	546	253	320			293	318		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2)	Overall Track 1				Overall Track 2				
		CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
B2.b	Portion of physician's adult patients (age 18 and older) screened at least once a year with a formal screening tool for anxiety (such as GAD-7).					0.355				0.777
	Most or all	26%	22%	27%	-6		30%	32%	-2	
	Many	26%	24%	22%	3		27%	23%	4	
	Some	33%	35%	36%	-1		32%	33%	-1	
	None	15%	19%	15%	4		11%	12%	-1	
	N	545	252	318			293	318		
B2.c	Portion of physician's adult patients (age 18 and older) screened at least once a year with a formal screening tool for substance use (such as CAGE, AUDIT-C, or DAST).					0.608				0.774
	Most or all	20%	18%	19%	-1		22%	22%	0	
	Many	18%	16%	20%	-4		20%	21%	-1	
	Some	46%	49%	44%	5		44%	40%	4	
	None	15%	17%	17%	0		14%	16%	-2	
	N	545	253	318			292	318		
B2.d	Portion of physician's adult patients (age 18 and older) screened at least once a year with a formal screening tool for adult attention-deficit/hyperactivity disorder (such as Adult ADHD self-report tool).					0.140				0.421
	Most or all	1%	1%	3%	-2		1%	3%	-2	
	Many	7%	7%	8%	-2		7%	7%	0	
	Some	53%	50%	55%	-5		55%	55%	0	
	None	39%	43%	34%	8		37%	35%	2	
	N	543	252	318			291	318		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2) CPC+ Physicians	Overall Track 1				Overall Track 2			
		CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
B3	Portion of physician's patients age 65 and older screened for dementia at least once a year with a formal screening tool (such as Mini-Mental State Examination or Mini-Cog).				0.334				0.534
	Most or all	35%	31%	35%	-4	39%	32%	6	
	Many	30%	30%	28%	2	30%	31%	-1	
	Some	32%	37%	33%	4	29%	33%	-4	
	None	2%	2%	5%	-3	3%	3%	-1	
	N	544	252	319		292	318		
B10	Linking physician's patients to supportive community-based resources (e.g., transportation, caregiver support, housing)...				0.000				0.000
	is accomplished by a designated staff person who actively coordinates and follows up with the community service agencies and their patients.	33%	26%	15%	12	38%	18%	20	
	is accomplished by a designated staff person who is responsible for connecting their patients with community resources.	40%	42%	30%	12	39%	34%	5	
	is limited to providing their patients a list of identified community resources.	19%	22%	37%	-16	17%	33%	-15	
	is not done systematically by the physician or their practice.	7%	10%	18%	-8	5%	15%	-10	
	N	546	253	320		293	318		
B12	When physician refers a patient to a specialist, how often physician sends the specialist notification of the patient's history and reason for the consultation.				0.266				0.093
	Always or most of the time	76%	74%	74%	1	77%	70%	7	
	Sometimes	18%	19%	16%	3	17%	19%	-3	
	Seldom or never	5%	5%	10%	-4	5%	10%	-5	
	Not applicable	1%	2%	1%	1	1%	1%	0	
	N	544	253	320		291	317		

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2)		Overall Track 1			Overall Track 2				
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
B13	How often physician receives useful information about their referred patients from specialists.				0.464				0.492	
	Always or most of the time	59%	59%	61%	-1	58%	61%	-3		
	Sometimes	39%	39%	37%	2	39%	38%	1		
	Seldom or never	2%	1%	2%	-1	3%	1%	2		
	Not applicable	0%	1%	0%	0	0%	0%	0		
	N	542	250	319		292	317			
F1.a, F1.b	In the past six months, percentage of physicians (or someone from the care team) that routinely use practice's electronic health record (EHR) or other health IT to:									
	Document patients' health-related social needs (e.g., for transportation, caregiver support, housing)	61%	52%	48%	4	0.423	67%	53%	15	0.001
	Track referral and consultation communications with other providers	86%	86%	83%	3	0.374	86%	83%	3	0.360
	N	544	252	318		292	315			
Patient and caregiver engagement										
B11	Physician or someone from physician's care team documents advance care preferences (e.g., for end-of-life care and/or advance directives for when patients might become too sick to make their own decisions) in physician's electronic health record (EHR) for...				0.522				0.056	
	most or all of physician's high-risk patients.	36%	30%	31%	-1	41%	32%	9		
	many of physician's high-risk patients.	40%	40%	39%	0	40%	43%	-3		
	some of physician's high-risk patients.	23%	29%	27%	2	18%	22%	-4		
	none of physician's high-risk patients.	1%	1%	3%	-2	1%	3%	-2		
	N	545	253	320		292	318			

Table 3.C.7a. (continued)

Question	Overall (Track 1 and 2) CPC+ Physicians	Overall Track 1				Overall Track 2				
		CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
D2a.f	Among physicians who develops or someone from their care team develops care plans for high-risk patients, how often advance directives are included in the care plans.				0.595				0.928	
	Usually or always	35%	27%	35%	-7	40%	39%	1		
	Frequently	32%	35%	32%	4	30%	29%	1		
	Sometimes	21%	23%	22%	1	20%	19%	1		
	Never or rarely	5%	6%	3%	2	5%	5%	0		
	Don't know	7%	8%	8%	0	6%	8%	-2		
	N	423	191	213		232	206			
Planned care for chronic conditions and population health										
F1.c, F1.d	In the past six months, percentage of physicians (or someone from the care team) that routinely use practice's electronic health record (EHR) or other health IT to:									
	Identify gaps in care (e.g., recommended screening tests)	96%	95%	93%	3	0.227	96%	92%	4	0.049
	Identify and track patients with specific health conditions, risk states, or medications.	88%	85%	79%	6	0.103	90%	80%	10	0.002
	N	544	252	318			292	315		

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

¹ Designated care managers' primary role is to help high-risk patients (patients at highest risk for adverse and potentially preventable outcomes). Care managers provide ongoing support and education on chronic care management, and help coordinate care from other providers between and during visits. A designated care manager, which some practices call a care coordinator or patient navigator, can work on-site or off-site, and works to support the primary care provided by the physician.

² A care plan is a structured, personalized plan of care developed with patient input and documented by you or someone from your care team. A care plan is more comprehensive than an after-visit summary, a hospital discharge plan, or a standard treatment/action plan for a single condition (such as diabetes or congestive heart failure).

p.p. = percentage points; PA = physician assistant; NP = nurse practitioner; CNS = certified nurse specialist; EHR = electronic health record

Table 3.C.7b. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Practice Ownership¹

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Access and continuity																
B7	Patients who come to practice for acute care see their physician... Usually or always.			0.120				0.140				0.935				0.181
	42%	34%	8		68%	54%	14		34%	33%	1		44%	38%	6	
	35%	44%	-9		23%	33%	-10		40%	41%	-2		38%	42%	-4	
	23%	20%	3		9%	12%	-3		26%	24%	2		17%	16%	1	
	0%	3%	-2		0	1%	-1		1%	1%	-1		0%	4%	-4	
	N	149	176		103	141			159	185			130	130		
B8	Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP/CNS, or answering service... is (1) always available, and (2) the practitioner on call regularly communicates problems and decisions back to the physician, and (3) does have real-time access to the practice's EHR system.			0.008				0.117				0.089				0.148
	93%	81%	12		87%	77%	11		87%	77%	10		92%	82%	10	
	3%	5%	-2		6%	13%	-7		6%	6%	0		3%	9%	-7	
	4%	11%	-7		6%	7%	-1		4%	13%	-8		4%	7%	-3	
	0%	3%	-3		0%	3%	-3		2%	4%	-2		2%	2%	-1	
	N	148	178		104	142			160	184			132	132		

Table 3.C.7b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Care management																
B9	Follow-up by physician or physician's practice with their patients who had emergency department (ED) or hospital visits... is done routinely because physician or their practice has arrangements in place with the ED and hospital to track these patients and ensure that follow-up occurs within a few days.												0.001	0.007	0.002	0.732
	79%	58%	22		63%	48%	15		77%	58%	19		59%	56%	4	
	occurs because physician or their practice makes proactive efforts to identify these patients.															
	15%	32%	-16		31%	28%	3		18%	27%	-9		32%	33%	-1	
	occurs only if the ED or hospital alerts physician or their practice.															
	5%	10%	-6		6%	22%	-17		5%	15%	-10		8%	11%	-3	
	generally does not occur.															
	1%	0%	0		0%	1%	-1		1%	0%	0		0%	0%	0	
	N	148	177		104	142		158	184		133	133				
C5 ²	Percentage of physicians whose practices use designated care managers whose primary role is to help high-risk patients.												0.000	0.000	0.001	0.000
	92%	73%	19		87%	59%	28		91%	77%	15		92%	70%	21	
	N	146	176		103	140		158	184		132	131				
C7 ²	Among physicians whose practices use designated care managers, percentage of physicians whose practice uses care managers who are always located off site.												0.166	0.002	0.135	0.593
	53%	63%	-9		42%	66%	-25		51%	61%	-10		57%	62%	-4	
	N	137	130		85	82		145	134		120	85				
D1	Percentage of physicians whose practice or health system categorizes physician's patients into risk levels using a standard method, tool, or algorithm.												0.000	0.000	0.000	0.000
	74%	40%	34		76%	34%	42		80%	42%	38		80%	38%	41	
	N	148	176		100	142		159	183		132	132				

Table 3.C.7b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent										
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value							
Comprehensiveness and coordination																							
B1	Percentage of physicians who report that counseling for behavioral or mental health problems is available to their patients on-site, at their office.												0.352			0.000			0.000			0.000	
	%	44%	38%	6																			
	N	149	174		104	140	25		158	181	26		133	132	30								
B10	Linking physician's patients to supportive community-based resources (e.g., transportation, caregiver support, housing)...												0.002			0.000			0.000			0.000	
	is accomplished by a designated staff person who actively coordinates and follows up with the community service agencies and their patients.																						
		30%	14%	16	20%	15%	5		38%	17%	21		38%	18%	19								
	is accomplished by a designated staff person who is responsible for connecting their patients with community resources.																						
		40%	37%	3	44%	22%	22		38%	35%	3		40	33%	7								
	is limited to providing their patients a list of identified community resources.																						
		17%	34%	-17	28%	42%	-13		16%	31%	-15		19%	35%	-16								
	is not done systematically by the physician or their practice.																						
		12%	15%	-3	7%	21%	-14		7%	16%	-9		4%	14%	-10								
	N	149	178		104	142		160	185			133	133										
B12	When physician refers a patient to a specialist, how often physician sends the specialist notification of the patient's history and reason for the consultation.												0.236			0.563			0.294			0.242	
	Always or most of the time																						
		70%	71%	-1	81%	77%	4		73%	64%	9		82%	78%	4								
	Sometimes																						
		22%	18%	4	14%	13%	1		17%	23%	-5		16%	14%	2								
	Seldom or never																						
		6%	11%	-4	4%	8%	-5		7%	12%	-4		2%	8%	-6								
	Not applicable																						
		2%	0%	2	1%	2%	-1		2%	1%	1		0%	0%	0								
	N	149	178		104	142		159	185			132	132										

Table 3.C.7b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent				
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
B13	How often physician receives useful information about their referred patients from specialists.				0.772				0.291				0.924				0.385
	Always or most of the time	62%	62%	1	55%	60%	-5		64%	65%	-1		51%	55%	-4		
	Sometimes	36%	36%	0	45%	38%	7		34%	34%	0		45%	44%	1		
	Seldom or never	1%	2%	-1	0%	2%	-2		1%	1%	1		4%	1%	3		
	Not applicable	1%	0	1	0%	0%	0		1%	0	0		0%	0%	0		
	N	147	177		103	142			159	184			133	133			
F1.a, F1.b	In the past six months, percentage of physicians (or someone from the care team) that routinely use practice's electronic health record (EHR) or other health IT to:																
	Document patients' health-related social needs (e.g., for transportation, caregiver support, housing)	55%	53%	2	0.736	48%	43%	5	0.489	70%	52%	18	0.001	64%	55%	10	0.158
	Track referral and consultation communications with other providers	83%	83%	1	0.889	91%	84%	7	0.127	80%	82%	-1	0.817	92%	84%	8	0.063
	N	148	176		104	142			159	183			133	132			

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

¹ Practice ownership comes from the SK&A database, managed by IQVIA, a marketing organization that collects information directly from all health care practices in the United States. IQVIA updates this information on an ongoing basis; we obtained practice ownership information in November 2016.

² Designated care managers' primary role is to help high-risk patients (patients at highest risk for adverse and potentially preventable outcomes). Care managers provide ongoing support and education on chronic care management, and help coordinate care from other providers between and during visits. A designated care manager, which some practices call a care coordinator or patient navigator, can work on-site or off-site, and works to support the primary care provided by the physician.

p.p. = percentage points; PA = physician assistant; NP = nurse practitioner; CNS = certified nurse specialist; EHR = electronic health record

Table 3.C.7c. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Practice size¹

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Access and continuity																								
B7	Patients who come to practice for acute care see their physician... Usually or always.			0.573				0.037				0.246				0.502				0.413				0.671
	69%	66%	3		58%	45%	14		39%	32%	6		57%	47%	10		48%	40%	8		26%	28%	-2	
	27%	24%	3		24%	43%	-19		36%	42%	-6		35%	37%	-2		40%	46%	-5		39%	40%	-1	
	4%	10%	-6		18%	12%	6		24%	22%	2		7%	16%	-9		12%	12%	0		33%	29%	4	
	0%	0%			0%	1%	-1		1%	4%	-3		0%	0%			0%	3%	-3		1%	3%	-2	
	N	53	58		71	112		128	147			32	47		81	114		176	154					
Care management																								
C5 ²	Percentage of physicians whose practices use designated care managers whose primary role is to help high-risk patients.			0.001				0.001				0.000				0.004				0.031				0.000
	77%	46%	31		94%	75%	19		93%	69%	23		87%	59%	29		89%	77%	12		94%	77%	17	
	N	52	58		70	112		127	146			33	48		80	113		177	154					
Comprehensiveness and coordination																								
B1	Percentage of physicians who report that counseling for behavioral or mental health problems is available to their patients on-site, at their office.			0.084				0.045				0.015				0.302				0.000				0.000
	30%	15%	15		31%	17%	14		55%	38%	17		37%	25%	12		47%	17%	30		69%	40%	29	
	N	53	59		71	110		129	145			33	49		82	112		176	152					

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

¹ We calculated the number of primary care practitioners (PCPs) at the practice site using a November 2016 pull of SK&A data and the National Plan & Provider Enumeration System (NPPES). We counted a provider as a primary care practitioner if they met criteria in either the SK&A data or the NPPES data; we did not require them to be considered a primary care practitioner in both data sources. Using the SK&A data, we defined PCPs as a physician (MD or DO), nurse practitioner (NP), or physician's assistant (PA) who bill under their own National Provider Identifier (NPI) and have a specialty of general practitioner, family practitioner, internist, internal medicine/pediatrics, or geriatrician. In NPPES, we defined PCPs as physicians, NPs, PAs, or clinical nurse specialists with 1 of 56 primary care taxonomy codes.

Table 3.C.7c. (continued)

² Designated care managers' primary role is to help high-risk patients (patients at highest risk for adverse and potentially preventable outcomes). Care managers provide ongoing support and education on chronic care management, and help coordinate care from other providers between and during visits. A designated care manager, which some practices call a care coordinator or patient navigator, can work on-site or off-site, and works to support the primary care provided by the physician.

p.p. = percentage points

Table 3.C.7d. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Prior primary care practice transformation experience¹

Question	Track 1 – Prior primary care practice transformation experience				Track 1 – No previous experience				Track 2 – Prior primary care practice transformation experience				Track 2 – No previous experience						
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value			
Comprehensiveness and coordination																			
B1	Percentage of physicians who report that counseling for behavioral or mental health problems is available to their patients on-site, at their office.															0.126	0.001	0.000	0.002
	%	44%	35%	9	38%	16%	23	58%	32%	26	49%	17%	32						
	N	144	212		109	102		253	244		38	69							

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

¹We considered a practice to be a Multi-Payer Advanced Primary Care Practice participant if it participated in any year, 2011–2014 for 2017 Starters, as determined by a file from CMS. A practice was considered to have medical home recognition if it at least one of its primary care providers was listed as having recognition at some point 2014–2017 from the National Community for Quality Assurance (NCQA), a state, the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), or Utilization Review Accreditation Commission (URAC), as determined by the June 2016 (for 2017 Starters) NCQA PCMH file and data extracted from the websites of TJC, AAAHC, URAC, and state-specific sources from October 2016 to February 2017.

p.p. = percentage points

Table 3.C.7e. CPC+ and comparison physician responses, by care delivery function, by track, by selected practice characteristics (2017 starters), Medicare SSP Status¹

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Access and continuity																
B5	Portion of physician's frail or homebound patients offered home visits by physician or someone from care team.			0.520				0.917					0.005			0.371
	Most or all	5%	2%	3	7%	8%	-1		2%	1%	1		4%	7%	-3	
	Many	5%	4%	0	6%	8%	-2		9%	3%	7		10%	8%	3	
	Some	25%	30%	-5	29%	26%	3		41%	27%	14		35%	28%	8	
	None	66%	63%	2	58%	59%	-1		48%	70%	-22		50%	58%	-7	
	N	128	162		122	152			143	131			150	181		
B6	Portion of physician's hospitalized patients visited in the hospital in a professional capacity by physician or someone from care team.			0.249				0.224					0.533			0.101
	Most or all	16%	10%	6	11%	12%	0		16%	13%	4		13%	12%	1	
	Many	3%	6%	-3	7%	4%	4		3%	7%	-3		10%	3%	7	
	Some	16%	12%	4	17%	10%	7		12%	14%	-2		13%	12%	0	
	None	65%	72%	-7	65%	75%	-10		68%	66%	2		64%	73%	-9	
	N	130	167		121	153			143	136			149	181		
B7	Patients who come to practice for acute care see their physician...			0.454				0.029					0.258			0.571
	Usually or always.	51%	45%	6	53%	41%	13		34%	35%	-1		42%	35%	6	
	Frequently.	33%	36%	-2	27%	43%	-15		36%	39%	-3		42%	44%	-2	
	Sometimes.	16%	18%	-2	19%	14%	5		29%	22%	7		16%	19%	-4	
	Never or rarely.	0%	1%	-1	0%	3%	-2		1%	4%	-3		0%	1%	-1	
	N	131	165		121	152			140	136			149	179		

Table 3.C.7e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Care management																
B9	Follow-up by physician or physician's practice with their patients who had emergency department (ED) or hospital visits... is done routinely because physician or their practice has arrangements in place with the ED and hospital to track these patients and ensure that follow-up occurs within a few days.			0.003				0.005				0.460				0.012
	70%	0.51	19		0.76	0.55	20		0.66	0.58	8		0.71	0.56	15	
	occurs because physician or their practice makes proactive efforts to identify these patients.				0.19	0.3	-11		0.24	0.28	-4		0.24	0.3	-6	
	0.25	0.31	-6		0.06	0.15	-9		0.09	0.14	-4		0.04	0.13	-9	
	occurs only if the ED or hospital alerts physician or their practice. generally does not occur.				0	0	0		0	0	0		0.01	0	0	
	0.05	0.17	-13		0	0	0		0	0	0		0.01	0	0	
	0.01	0.01	0		0	0	0		0	0	0		0.01	0	0	
	N	130	167		122	152		141	136		150	181				
C5 ²	Percentage of physicians whose practices use designated care managers whose primary role is to help high-risk patients.			0.000				0.000				0.001				0.000
	91%	0.72	18		0.89	0.61	28		0.95	0.83	12		0.88	0.66	22	
	N	128	163		121	153		142	135		148	180				
C7 ²	Among physicians whose practices use designated care managers, percentage of physicians whose practice uses care managers who are always located off site.			0.000				0.990				0.260				0.424
	48%	0.75	-28		0.51	0.5	0		0.59	0.67	-8		0.49	0.55	-6	
	N	116	120		106	92		135	108		130	111				

Table 3.C.7e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
D1	Percentage of physicians whose practice or health system categorizes physician's patients into risk levels using a standard method, tool, or algorithm.															
	71%	35%	36	0.000	79%	40%	39	0.000	84%	41%	43	0.000	77%	40%	36	0.000
	N	127	166		121	152			142	136			149	179		
Comprehensiveness and coordination																
B1	Percentage of physicians who report that counseling for behavioral or mental health problems is available to their patients on-site, at their office.															
	40%	21%	19	0.002	44%	33%	11	0.109	63%	26%	37	0.000	51%	33%	18	0.003
	N	131	163		122	151			142	133			149	180		
B10	Linking physician's patients to supportive community-based resources (e.g., transportation, caregiver support, housing)...															
	24%	13%	11	0.004	29%	17%	12	0.003	39%	15%	23	0.000	37%	20%	17	0.000
	is accomplished by a designated staff person who actively coordinates and follows up with the community service agencies and their patients.															
	42%	30%	12		42%	30%	12		38%	38%	0		40%	32%	9	
	is accomplished by a designated staff person who is responsible for connecting their patients with community resources.															
	24%	36%	-13		19%	38%	-19		15%	31%	-16		19%	34%	-15	
	is limited to providing their patients a list of identified community resources.															
	11%	21%	-10		10%	15%	-5		8%	16%	-8		3%	14%	-11	
	is not done systematically by the physician or their practice.															
	N	131	167		122	153			143	136			150	182		

Table 3.C.7e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value				
	B12	When physician refers a patient to a specialist, how often physician sends the specialist notification of the patient's history and reason for the consultation.				0.910				0.005				0.807				0.003		
	Always or most of the time	69%	73%	-4	81%	75%	6		69%	69%	-1		84%	70%	14					
	Sometimes	20%	18%	3	17%	13%	3		22%	23%	-1		13%	17%	-4					
	Seldom or never	9%	8%	1	1%	11%	-10		08%	8%	0		2%	12%	-10					
	Not applicable	2%	1%	1	1%	0%	1		1%	0%	1		1%	1%	0					
	N	131	167		122	153			142	135			149	182						
B13	How often physician receives useful information about their referred patients from specialists.				0.321				0.171				0.318				0.884			
	Always or most of the time	52%	62%	-10	67%	59%	8		58%	62%	-4		58%	60%	-1					
	Sometimes	46%	37%	9	32%	37%	-5		4%	38%	2		37%	38%	0					
	Seldom or never	1%	1%	0	0%	3%	-3		2%	0%	2		3%	2%	1					
	Not applicable	1%	0%	1	0%	0%	0		0%	0%	0		1%	0%	0					
	N	128	167		122	152			143	136			149	181						
F1.a, F1.b	In the past six months, percentage of physicians (or someone from the care team) that routinely use practice's electronic health record (EHR) or other health IT to:				0.113				0.672				0.004				0.071			
	Document patients' health-related social needs (e.g., for transportation, caregiver support, housing)	52%	42%	10	53%	56%	-3		71%	52%	19		64%	53%	11					
	Track referral and consultation communications with other providers	--	--	--	--	--	--		--	--	--		--	--	--					
	N	130	165		122	153			143	135			149	180						

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

¹ Whether the physician's practice participated in a Medicare SSP accountable care organization at the start of CPC+ (January 1, 2017).

² Designated care managers' primary role is to help high-risk patients (patients at highest risk for adverse and potentially preventable outcomes). Care managers provide ongoing support and education on chronic care management, and help coordinate care from other providers between and during visits. A designated care manager, which some practices call a care coordinator or patient navigator, can work on-site or off-site, and works to support the primary care provided by the physician.

p.p. = percentage points; EHR = electronic health record

Table 3.C.8a. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Overall

Question	Overall (Track 1 and 2)		Overall – Track 1				Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
Physician use of data feedback										
G1	Physician received data feedback on quality of care for their patients in the past 12 months.						0.872			
	Yes	93%	91%	92%	-1	94%	90%	4		
	No	5%	6%	5%	1	5%	7%	-2		
	Don't know	2%	3%	3%	0	2%	3%	-1		
	N	541	252	317					289	314
G1a	Among physicians that received data feedback on quality of care for their patients, the extent to which physician made changes to how their deliver care in response to this feedback.						0.674			
	Physician made major changes to how they deliver care	13%	11%	8%	3	14%	10%	3		
	Physician made minor changes to how they deliver care	74%	76%	78%	-2	74%	77%	-4		
	Physician did not make changes to how they deliver care	13%	13%	14%	-1	13%	12%	0		
	N	496	228	290					268	279
G2	Physician received data feedback on health care service utilization for their patients in the past 12 months.						0.012			
	Yes	67%	66%	52%	13	69%	49%	20		
	No	26%	26%	37%	-12	26%	39%	-14		
	Don't know	7%	9%	11%	-2	6%	12%	-6		
	N	541	251	315					290	312

Table 3.C.8a. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
G2a	Among physicians that received data feedback on health care service utilization for their patients, the extent to which physician made changes to how their deliver care in response to this feedback.				0.451				0.161
	Physician made major changes to how they deliver care	7%	7%	7%	0	7%	9%	-2	
	Physician made minor changes to how they deliver care	66%	64%	58%	6	67%	56%	11	
	Physician did not make changes to how they deliver care	27%	29%	35%	-7	26%	35%	-9	
	N	359	164	166		195	153		
G3	Physician received data feedback on total cost of health care (reimbursed by insurers to all providers who provide care) for their patients in the past 12 months.				0.268				0.040
	Yes	31%	28%	25%	2	33%	23%	10	
	No	56%	58%	64%	-6	54%	64%	-10	
	Don't know	14%	14%	10%	4	13%	13%	0	
	N	539	249	317		290	313		
G3a	Among physicians that received data feedback on the total cost of care for their patients, the extent to which physician made changes to how their deliver care in response to this feedback.				0.795				0.239
	Physician made major changes to how they deliver care	7%	5%	7%	-2	8%	5%	3	
	Physician made minor changes to how they deliver care	57%	48%	52%	-4	62%	53%	9	
	Physician did not make changes to how they deliver care	36%	47%	41%	5	30%	42%	-13	
	N	151	66	82		85	71		

Table 3.C.8a. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
G4	Percentage of physicians who receive data on what insurers paid (reimbursed) for individual specialists for physician's practice's patients.				0.000				0.000
	16%	17%	7%	10		15%	6%	9	
	N	534	249	317		285	313		
G4a	Among physicians who received data on what insurers paid for individual specialists, extent to which the physician considers these cost data when deciding to which specialist to refer a patient.				0.015				0.757
	A lot	12%	5%	28%	-23	18%	14%	4	
	Some	42%	53%	19%	34	32%	34%	-1	
	Not very much	37%	29%	46%	-17	43%	38%	5	
	Not at all	9%	12%	7%	6	6%	14%	-8	
	N	74	36	24		38	22		
Teamwork									
C1.a	Extent to which physician agrees that "the group of staff and providers I work with the most at this practice site work well together as a team."				0.785				0.494
	Strongly disagree	1%	1%	1%	0	1%	1%	0	
	Disagree	2%	3%	2%	1	2%	2%	0	
	Neither disagree nor agree	6%	6%	7%	-1	6%	8%	-2	
	Agree	39%	39%	43%	-4	39%	45%	-6	
	Strongly agree	51%	51%	47%	4	52%	44%	8	
	N	545	253	319		292	317		
C1.b	Extent to which physician agrees that "we have a 'we are in it together' attitude at my practice site."				0.413				0.396
	Strongly disagree	2%	1%	1%	0	2%	1%	1	
	Disagree	5%	7%	4%	3	4%	5%	-1	
	Neither disagree nor agree	8%	7%	10%	-2	9%	13%	-4	
	Agree	46%	47%	41%	6	45%	42%	4	
	Strongly agree	39%	38%	43%	-5	39%	40%	0	
	N	545	253	319		292	317		

Table 3.C.8a. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2				
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
C1.c	Extent to which physician agrees that “my professional skills are used to the fullest at my practice site.”					0.348				0.369
	Strongly disagree	1%	0%	2%	-1	1%	3%	-2		
	Disagree	12%	12%	8%	4	12%	9%	3		
	Neither disagree nor agree	10%	10%	9%	1	10%	11%	-1		
	Agree	43%	43%	47%	-4	42%	46%	-4		
	Strongly agree	34%	34%	34%	0	34%	31%	4		
	N	545	253	319		292	317			
C1.d	Extent to which physician agrees that “it is hard to get things to change at my practice site.”					0.009				0.709
	Strongly disagree	9%	10%	8%	3	8%	7%	1		
	Disagree	32%	34%	28%	7	30%	31%	-1		
	Neither disagree nor agree	28%	21%	32%	-11	33%	30%	3		
	Agree	23%	26%	19%	7	21%	20%	1		
	Strongly agree	9%	9%	14%	-5	9%	12%	-4		
	N	545	253	319		292	317			
C1.e	Extent to which physician agrees that “I can rely on other people at my practice site to do their jobs well.”					0.012				0.213
	Strongly disagree	2%	1%	2%	0	2%	2%	0		
	Disagree	5%	5%	2%	4	4%	3%	1		
	Neither disagree nor agree	10%	11%	19%	-8	9%	16%	-7		
	Agree	54%	54%	45%	9	54%	51%	3		
	Strongly agree	30%	29%	33%	-4	31%	28%	3		
	N	545	253	318		292	317			
C1.f	Extent to which physician agrees that “we regularly take time to consider ways to improve how we do things at my practice site.”					0.466				0.120
	Strongly disagree	2%	3%	2%	1	2%	2%	0		
	Disagree	7%	9%	10%	-1	5%	11%	-6		
	Neither disagree nor agree	18%	17%	18%	0	19%	17%	2		
	Agree	45%	46%	51%	-5	45%	47%	-2		
	Strongly agree	28%	26%	20%	6	30%	23%	7		
	N	544	253	319		291	317			

Table 3.C.8a. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
C2	Way in which medical assistants are organized to work with physicians at the practice site.					0.904			
	Physician is paired with the same medical assistant(s) most days	80%	79%	77%	2	81%	82%	-1	
	Physician is not paired with the same medical assistant(s) most days	16%	16%	17%	-2	16%	15%	1	
	Physician does not work with medical assistants	4%	6%	6%	0	3%	4%	0	
	N	540	251	316		289	313		0.933
C3	Way in which nurses are organized to work with physicians at the practice site.					0.029			
	Physician is paired with the same nurse(s) most days	48%	49%	45%	4	47%	45%	2	
	Physician is not paired with the same nurse(s) most days	16%	13%	22%	-9	18%	23%	-5	
	Physician does not work with nurses	36%	38%	33%	5	35%	32%	2	
	N	540	252	317		288	317		0.469
C4	How often physician has huddles with their care team.					0.349			
	Every day	18%	16%	14%	2	19%	14%	5	
	On most days	23%	23%	18%	5	23%	19%	4	
	On some days	38%	37%	41%	-4	39%	41%	-2	
	Never	21%	23%	27%	-4	19%	26%	-7	
	N	543	252	316		291	316		0.126
Health information technology									
F2	Extent to which physician agrees that the practice's EHR (or other health IT) is a big help to them in providing quality care to their patients.					0.405			
	Strongly agree	19%	16%	23%	-7	20%	24%	-4	
	Agree	46%	46%	41%	5	47%	40%	6	
	Neither disagree nor agree	20%	22%	20%	2	18%	21%	-3	
	Disagree	8%	9%	10%	-1	7%	9%	-2	
	Strongly disagree	8%	7%	6%	1	8%	6%	3	
	N	543	251	317		292	315		0.381

Table 3.C.8a. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2					
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value		
Physician satisfaction, burnout, and likelihood to leave the practice											
A1	Extent to which physician agrees with the statement: "Overall, I am satisfied with my current job".					0.595					0.750
	Strongly agree	22%	20%	23%	-3	23%	23%	0			
	Agree	51%	52%	54%	-2	50%	55%	-5			
	Neither disagree nor agree	11%	11%	8%	3	12%	10%	2			
	Disagree	11%	13%	12%	1	10%	9%	1			
	Strongly disagree	4%	4%	2%	2	4%	3%	1			
	N	542	251	320			291	318			
A2	Using physician's own definition of "burnout," statement which best describes physician's situation at work.					0.120					0.139
	I enjoy my work. I have no symptoms of burnout.	9%	10%	11%	-1	9%	12%	-3			
	Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.	49%	50%	51%	-1	48%	50%	-2			
	I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.	31%	33%	29%	4	29%	31%	-1			
	The symptoms of burnout that I'm experiencing won't go away. I think about frustrations at work a lot.	8%	4%	8%	-4	11%	7%	4			
	I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	3%	3%	1%	2	3%	1%	2			
	N	543	252	320			291	318			

Table 3.C.8a. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
A3.a	Amount of stress physician experiences due to burdensome administrative tasks (such as paperwork related to insurance, pre-authorizations).				0.214				0.772
	None	3%	2%	3%	-1	3%	3%	1	
	A little	16%	18%	12%	6	15%	13%	2	
	Some	36%	39%	40%	-1	34%	38%	-4	
	A lot	45%	41%	46%	-4	47%	46%	2	
	N	546	253	318		293	317		
A3.b	Amount of stress physician experiences due to excessive time demands of using EHRs or other health IT.				0.895				0.614
	None	5%	6%	7%	-1	4%	6%	-1	
	A little	17%	17%	16%	2	16%	18%	-1	
	Some	31%	30%	33%	-3	31%	34%	-3	
	A lot	48%	47%	45%	2	48%	43%	6	
	N	546	253	319		293	317		
A3.c	Amount of stress physician experiences due to insufficient compensation and reimbursement.				0.086				0.038
	None	20%	15%	23%	-8	23%	25%	-2	
	A little	26%	32%	30%	2	22%	31%	-9	
	Some	31%	32%	24%	8	30%	28%	2	
	A lot	23%	20%	22%	-2	24%	16%	9	
	N	543	251	320		292	318		
A3.d	Amount of stress physician experiences due to lack of control or autonomy.				0.044				0.255
	None	14%	14%	20%	-6	14%	21%	-7	
	A little	39%	41%	30%	11	37%	33%	3	
	Some	32%	31%	32%	-1	32%	30%	3	
	A lot	15%	13%	17%	-4	17%	16%	1	
	N	546	253	319		293	318		

Table 3.C.8a. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
A3.e	Amount of stress physician experiences due to inadequate staff support.				0.351				0.615
	None	26%	26%	25%	1	27%	23%	4	
	A little	27%	24%	31%	-7	29%	27%	2	
	Some	29%	32%	28%	4	26%	31%	-5	
	A lot	18%	18%	16%	2	18%	19%	-1	
	N	546	253	319		293	318		
A4	Likelihood physician will leave current practice within two years.				0.259				0.692
	Not at all likely	37%	35%	35%	0	38%	34%	5	
	Not very likely	37%	39%	33%	5	36%	37%	-2	
	Somewhat likely	14%	15%	14%	1	13%	15%	-3	
	Very likely	12%	11%	17%	-6	13%	14%	0	
	N	545	253	319		292	317		
Experience with CPC+¹									
H1	Overall, extent to which participating in CPC+ changed the quality of care that the physician currently provides to patients.				n.a.				n.a.
	Improved a lot	18%	16%	n.a.	n.a.	19%	n.a.	n.a.	
	Improved somewhat	53%	55%	n.a.	n.a.	51%	n.a.	n.a.	
	Did not change	21%	19%	n.a.	n.a.	22%	n.a.	n.a.	
	Worsened somewhat	2%	3%	n.a.	n.a.	1%	n.a.	n.a.	
	Worsened a lot	0%	0%	n.a.	n.a.	1%	n.a.	n.a.	
	Don't know	6%	6%	n.a.	n.a.	6%	n.a.	n.a.	
	N	527	243	n.a.		284	n.a.		
H2	Extent to which physician thinks that participating in CPC+ reduced the overall costs of all the health care their patients received.				n.a.				n.a.
	A lot	6%	6%	n.a.	n.a.	6%	n.a.	n.a.	
	Some	38%	34%	n.a.	n.a.	41%	n.a.	n.a.	
	Not very much	26%	28%	n.a.	n.a.	24%	n.a.	n.a.	
	Not at all	9%	10%	n.a.	n.a.	8%	n.a.	n.a.	
	Don't know	21%	22%	n.a.	n.a.	21%	n.a.	n.a.	
	N	528	245	n.a.		283	n.a.		

Table 3.C.8a. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
H3	Overall, considering the amount of work required by CPC+, adequacy of the CPC+ payments from all payers combined.				n.a.				n.a.
	More than adequate	2%	1%	n.a.	n.a.	3%	n.a.	n.a.	
	Adequate	24%	29%	n.a.	n.a.	21%	n.a.	n.a.	
	Less than adequate	36%	29%	n.a.	n.a.	40%	n.a.	n.a.	
	Don't know - not familiar with CPC+ payments from all payers or costs of doing CPC+ work	38%	40%	n.a.	n.a.	36%	n.a.	n.a.	
	N	529	244	n.a.		285	n.a.		
H4	Given practice's overall experience participating in CPC+, likelihood physician would recommend that their practice participate in CPC+ if their practice could do it all over again.				n.a.				n.a.
	Very likely	31%	30%	n.a.	n.a.	31%	n.a.	n.a.	
	Somewhat likely	38%	38%	n.a.	n.a.	37%	n.a.	n.a.	
	Not very likely	11%	12%	n.a.	n.a.	11%	n.a.	n.a.	
	Not at all likely	5%	4%	n.a.	n.a.	6%	n.a.	n.a.	
	Don't know	15%	16%	n.a.	n.a.	14%	n.a.	n.a.	
	N	528	243	n.a.		285	n.a.		

Table 3.C.8a. (continued)

Question		Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
		CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
H5	Thinking about the individual(s) at their practice site who have made a substantive contribution of time or leadership to implement care delivery changes for CPC+, physician would say:									
	Most or all of the practice site was involved in the substantive work on CPC+	41%	35%	n.a.	n.a.	45%	n.a.	n.a.		n.a.
	A smaller group that included at least one physician did most of the substantive work on CPC+	36%	38%	n.a.	n.a.	34%	n.a.	n.a.		
	A smaller group that did not include any physicians did most of the substantive work on CPC+	5%	4%	n.a.	n.a.	5%	n.a.	n.a.		
	One physician did most of the substantive work on CPC+	1%	3%	n.a.	n.a.	1%	n.a.	n.a.		
	One non-physician did most of the substantive work on CPC+	4%	5%	n.a.	n.a.	4%	n.a.	n.a.		
	No one at the practice site did much substantive work on CPC+	2%	1%	n.a.	n.a.	2%	n.a.	n.a.		
	Don't know	12%	14%	n.a.	n.a.	11%	n.a.	n.a.		
	N	531	245	n.a.		286	n.a.			
H6	Extent to which physician agrees with the statement: "You were better positioned to meet health care needs for your patients during the coronavirus pandemic because of your practice's participation in CPC+."									
	Strongly disagree	8%	7%	n.a.	n.a.	8%	n.a.	n.a.		
	Disagree	11%	10%	n.a.	n.a.	11%	n.a.	n.a.		
	Neither disagree nor agree	35%	36%	n.a.	n.a.	34%	n.a.	n.a.		
	Agree	20%	20%	n.a.	n.a.	21%	n.a.	n.a.		
	Strongly agree	9%	7%	n.a.	n.a.	10%	n.a.	n.a.		
	Don't know	18%	19%	n.a.	n.a.	17%	n.a.	n.a.		
	N	530	244	n.a.		286	n.a.			

Table 3.C.8a. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Barriers to providing optimal patient care									
B14.a	Extent to which lack of available behavioral health specialists for consultations and/or referrals limits physician's ability to provide optimal care for their patients.				0.004				0.073
	Does not limit	12%	11%	8%	3	12%	8%	3	
	Limits somewhat	47%	48%	36%	12	46%	40%	7	
	Limits a great deal	42%	41%	56%	-15	42%	52%	-10	
	N	546	253	318		293	317		
B14.b	Extent to which lack of available medical or surgical specialists for consultations and/or referrals limits physician's ability to provide optimal care for their patients.				0.705				0.400
	Does not limit	63%	61%	63%	-2	64%	66%	-2	
	Limits somewhat	33%	36%	33%	3	31%	32%	-1	
	Limits a great deal	4%	3%	4%	-1	5%	3%	2	
	N	546	253	318		293	317		
B14.c	Extent to which inadequate reimbursement from insurers for primary care services limits physician's ability to provide optimal care for their patients.				0.772				0.252
	Does not limit	43%	46%	46%	-1	41%	47%	-6	
	Limits somewhat	40%	40%	37%	3	40%	39%	1	
	Limits a great deal	17%	14%	16%	-2	18%	14%	5	
	N	546	253	319		293	316		
B14.d	Extent to which inadequate time to spend with patients during visits limits physician's ability to provide optimal care for their patients.				0.254				0.592
	Does not limit	22%	22%	24%	-2	22%	25%	-3	
	Limits somewhat	52%	50%	54%	-4	54%	54%	0	
	Limits a great deal	26%	29%	22%	7	24%	21%	3	
	N	546	253	320		293	317		

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

¹ These questions were also asked to physicians whose practices withdrew from CPC+. For these physicians, the questions were asked in the past tense, to reflect their experiences participating in CPC+ in the past.

p.p. = percentage points; n.a. = not applicable because that group of physicians were not asked that question; EHR = electronic health record

Table 3.C.8b. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Practice ownership¹

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Physician use of data feedback																
G1	Physician received data feedback on quality of care for their patients in the past 12 months.			0.553				0.566				0.897				0.132
	Yes	92%	94%	-2	91%	91%	0	93%	92%	1	94%	87%	7			
	No	7%	4%	3	4%	6%	-2	5%	5%	0	4%	10%	-5			
	Don't know	1%	2%	0	6%	3%	2	2%	2%	-1	2%	4%	-2			
	N	148	175		104	142		156	182		133	132				
G1a	Among physicians that received data feedback on quality of care for their patients, the extent to which physician made changes to how their deliver care in response to this feedback.			0.816				0.634				0.293				0.964
	Physician made major changes to how they deliver care	10%	8%	2	13%	10%	3	15%	9%	6	13%	13%	0			
	Physician made minor changes to how they deliver care	73%	76%	-2	80%	80%	0	70%	76%	-6	78%	78%	-1			
	Physician did not make changes to how they deliver care	17%	17%	0	7%	10%	-3	15%	15%	0	9%	8%	1			
	N	135	163		93	127		144	166		124	113				
G2	Physician received data feedback on health care service utilization for their patients in the past 12 months.			0.041				0.107				0.000				0.144
	Yes	61%	45%	16	73%	60%	13	67%	41%	27	70%	61%	9			
	No	31%	43%	-13	18%	30%	-12	25%	47%	-21	26%	29%	-3			
	Don't know	9%	11%	-3	9%	10%	-1	7%	12%	-5	4%	11%	-7			
	N	149	173		102	142		157	180		133	132				
G2a	Among physicians that received data feedback on health care service utilization for their patients, the extent to which physician made changes to how their deliver care in response to this feedback.			0.776				0.344				0.127				0.652
	Physician made major changes to how they deliver care	4%	6%	-1	11%	8%	3	4%	8%	-4	11%	10%	1			
	Physician made minor changes to how they deliver care	63%	58%	5	66%	58%	8	67%	51%	15	66%	61%	6			
	Physician did not make changes to how they deliver care	32%	36%	-4	24%	34%	-11	29%	40%	-11	22%	29%	-7			
	N	92	77		72	89		98	72		97	81				

Table 3.C.8b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent				
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
G3	Physician received data feedback on total cost of health care (reimbursed by insurers to all providers who provide care) for their patients in the past 12 months.				0.146				0.614				0.025				0.819
	Yes	22%	15%	7	37%	38%	-1		28%	15%	13		39%	35%	4		
	No	65%	76%	-11	47%	51%	-4		58%	72%	-14		49%	52%	-3		
	Don't know	13%	10%	4	16%	11%	5		14%	13%	1		12%	13%	-1		
	N	145	175		104	142			157	182			133	131			
G3a	Among physicians that received data feedback on the total cost of care for their patients, the extent to which physician made changes to how their deliver care in response to this feedback.				0.036				0.295				0.394				0.164
	Physician made major changes to how they deliver care	0%	15%	-15	10%	3%	7		5%	9%	-3		11%	2%	9		
	Physician made minor changes to how they deliver care	34%	41%	-7	61%	57%	4		56%	39%	18		67%	62%	5		
	Physician did not make changes to how they deliver care	66%	44%	22	29%	40%	-11		39%	53%	-14		22%	35%	-13		
	N	29	28		37	54			35	28			50	43			
G4	Percentage of physicians who receive data on what insurers paid (reimbursed) for individual specialists for physician's practice's patients.				0.005				0.006				0.048				0.009
	%	12%	3%	9	24%	10%	14		8%	3%	5		24%	11%	13		
	N	146	175		103	142			156	181			129	132			
G4a	Among physicians who received data on what insurers paid for individual specialists, extent to which the physician considers these cost data when deciding to which specialist to refer a patient.				0.879				0.015				0.800				0.950
	A lot	0%	0%	0	9%	38%	-29		20%	8%	11		18%	17%	1		
	Some	46%	35%	11	58%	13%	46		44%	43%	1		28%	30%	-2		
	Not very much	38%	51%	-13	23%	45%	-22		27%	24%	3		50%	44%	5		
	Not at all	16%	14%	2	10%	4%	5		9%	25%	-15		5%	9%	-4		
	N	14	7		22	17			8	8			30	14			

Table 3.C.8b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Teamwork																
C1.a	Extent to which physician agrees that “the group of staff and providers I work with the most at this practice site work well together as a team.”			0.312				0.474				0.160				0.917
	Strongly disagree	1%	1%	0	1%	2%	0	1%	0%	0	1%	1%	0			
	Disagree	5%	4%	1	1%	0%	1	3%	3%	0	0%	1%	-1			
	Neither disagree nor agree	6%	11%	-5	8%	3%	5	6%	10%	-3	6%	4%	2			
	Agree	39%	46%	-7	39%	39%	0	39%	50%	-11	39%	37%	2			
	Strongly agree	50%	39%	11	52%	56%	-4	50%	36%	14	54%	57%	-3			
	N	149	177		104	142		159	185		133	132				
C1.b	Extent to which physician agrees that “we have a ‘we are in it together’ attitude at my practice site.”			0.831				0.23				0.184				0.343
	Strongly disagree	1%	1%	0	1%	2%	0	4%	1%	3	0%	1%	0			
	Disagree	8%	6%	2	5%	2%	3	4%	5%	-2	4%	4%	1			
	Neither disagree nor agree	8%	13%	-4	5%	6%	-1	10%	15%	-5	8%	10%	-2			
	Agree	46%	46%	0	49%	36%	12	43%	47%	-3	48%	34%	14			
	Strongly agree	36%	34%	2	40%	53%	-14	39%	32%	7	40%	52%	-12			
	N	149	177		104	142		159	185		133	132				
C1.c	Extent to which physician agrees that “my professional skills are used to the fullest at my practice site.”			0.275				0.719				0.740				0.135
	Strongly disagree	0%	2%	-2	1%	1%	0	1%	2%	-1	1%	4%	-3			
	Disagree	16%	10%	6	6%	6%	1	11%	12%	-1	13%	5%	8			
	Neither disagree nor agree	11%	13%	-2	9%	4%	4	13%	14%	-1	8%	7%	1			
	Agree	44%	46%	-2	42%	48%	-6	43%	48%	-5	41%	44%	-3			
	Strongly agree	28%	28%	0	42%	41%	2	32%	25%	7	38%	41%	-3			
	N	149	177		104	142		159	185		133	132				
C1.d	Extent to which physician agrees that “it is hard to get things to change at my practice site.”			0.003				0.091				0.487				0.857
	Strongly disagree	10%	2%	8	11%	15%	-3	6%	3%	3	10%	13%	-3			
	Disagree	28%	19%	9	44%	38%	6	24%	25%	0	37%	42%	-5			
	Neither disagree nor agree	25%	38%	-14	15%	25%	-10	33%	31%	2	32%	27%	5			
	Agree	26%	22%	3	25%	15%	11	25%	24%	1	16%	14%	2			
	Strongly agree	12%	18%	-7	4%	8%	-4	11%	17%	-6	5%	4%	1			
	N	149	177		104	142		159	185		133	132				

Table 3.C.8b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent				
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
C1.e	Extent to which physician agrees that “I can rely on other people at my practice site to do their jobs well.”				0.088				0.005				0.045				0.833
	Strongly disagree	1%	2%	-2	2%	1%	1		2%	2%	0		3%	2%	1		
	Disagree	6%	2%	3	5%	1%	4		7%	4%	3		1%	2%	-2		
	Neither disagree nor agree	13%	23%	-10	7%	14%	-7		7%	20%	-12		10%	10%	1		
	Agree	52%	50%	1	58%	39%	19		60%	52%	8		47%	49%	-2		
	Strongly agree	29%	22%	7	28%	45%	-17		25%	22%	2		39%	38%	2		
	N	149	176		104	142			159	185			133	132			
C1.f	Extent to which physician agrees that “we regularly take time to consider ways to improve how we do things at my practice site.”				0.188				0.218				0.038				0.558
	Strongly disagree	2%	3%	-1	4%	0%	4		2%	2%	0		1%	0%	1		
	Disagree	9%	12%	-3	8%	8%	1		6%	15%	-9		4%	5%	-1		
	Neither disagree nor agree	23%	21%	2	9%	14%	-5		17%	20%	-3		21%	12%	8		
	Agree	42%	50%	-8	52%	53%	-1		44%	45%	-2		45%	49%	-4		
	Strongly agree	25%	14%	11	27%	26%	1		31%	17%	13		29%	32%	-3		
	N	149	177		104	142			158	185			133	132			
Physician satisfaction, burnout, and likelihood to leave the practice																	
A1	Extent to which physician agrees with the statement: “Overall, I am satisfied with my current job”.				0.990				0.310				0.834				0.256
	Strongly agree	16%	16%	0	27%	32%	-5		23%	19%	4		24%	29%	-6		
	Agree	55%	57%	-2	47%	51%	-4		53%	56%	-3		48%	55%	-7		
	Neither disagree nor agree	12%	11%	0	10%	4%	6		12%	12%	-1		12%	6%	6		
	Disagree	13%	13%	0	13%	12%	1		8%	10%	-2		13%	8%	5		
	Strongly disagree	5%	3%	1	3%	1%	2		4%	3%	1		4%	3%	1		
	N	149	178		102	142			159	185			132	133			

Table 3.C.8b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
A2	Using physician's own definition of "burnout," statement which best describes physician's situation at work.															
	I enjoy my work. I have no symptoms of burnout.				0.626				0.147				0.408			
	8%	9%	-1		13%	12%	1		12%	13%	0		4%	11%	-7	
	Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.															
	50%	51%	-2		50%	50%	0		45%	50%	-4		51%	50%	1	
	I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.															
	33%	29%	4		32%	30%	3		29%	30%	-2		30%	31%	-1	
	The symptoms of burnout that I'm experiencing won't go away. I think about frustrations at work a lot.															
	5%	9%	-3		2%	8%	-6		13%	8%	6		8%	7%	2	
	I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.															
	4%	2%	2		3%	0%	3		1%	0%	1		7%	2%	4	
	N	149	178		103	142			158	185			133	133		
A3.a	Amount of stress physician experiences due to burdensome administrative tasks (such as paperwork related to insurance, pre-authorizations).															
	None				0.096				0.758				0.896			
	1%	3%	-2		3%	3%	0		2%	3%	0		5%	3%	2	
	A little															
	22%	12%	10		12%	12%	1		16%	15%	1		14%	11%	3	
	Some															
	38%	45%	-7		40%	34%	6		35%	39%	-4		34%	37%	-4	
	A lot															
	39%	41%	-1		44%	52%	-7		47%	44%	4		47%	49%	-2	
	N	149	177		104	141			160	185			133	132		
A3.b	Amount of stress physician experiences due to excessive time demands of using EHRs or other health IT.															
	None				0.957				0.464				0.724			
	8%	8%	0		3%	5%	-2		5%	7%	-2		4%	3%	1	
	A little															
	15%	17%	-2		21%	14%	7		19%	20%	-1		14%	14%	-1	
	Some															
	31%	32%	-1		29%	34%	-6		29%	31%	-2		33%	38%	-5	
	A lot															
	46%	43%	3		47%	46%	1		47%	41%	6		50%	45%	5	
	N	149	177		104	142			160	184			133	133		
A3.c	Amount of stress physician experiences due to insufficient compensation and reimbursement.															
	None				0.568				0.029				0.141			
	20%	25%	-5		8%	20%	-12		25%	26%	-1		21%	24%	-4	
	A little															
	31%	34%	-3		34%	26%	8		24%	35%	-10		20%	26%	-6	
	Some															
	32%	26%	6		32%	23%	10		32%	29%	4		28%	26%	1	
	A lot															
	17%	15%	2		25%	31%	-5		18%	11%	8		32%	24%	8	
	N	148	178		103	142			159	185			133	133		

Table 3.C.8b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent						
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value			
A3.d	Amount of stress physician experiences due to lack of control or autonomy.															0.179	0.330	0.427	0.431
	None	10%	14%	-4	20%	28%	-8	9%	16%	-6	20%	30%	-9						
	A little	41%	30%	11	42%	30%	11	35%	34%	1	39%	32%	7						
	Some	35%	35%	0	26%	29%	-3	34%	30%	3	30%	29%	2						
	A lot	14%	21%	-7	12%	13%	-1	22%	20%	2	10%	9%	1						
	N	149	178		104	141		160	185		133	133							
A3.e	Amount of stress physician experiences due to inadequate staff support.															0.211	0.912	0.982	0.280
	None	20%	16%	4	35%	36%	-1	17%	16%	1	39%	33%	6						
	A little	24%	35%	-11	25%	27%	-2	28%	30%	-2	30%	23%	7						
	Some	34%	28%	6	28%	27%	1	31%	31%	0	21%	31%	-10						
	A lot	21%	21%	1	13%	10%	3	24%	23%	1	11%	13%	-2						
	N	149	177		104	142		160	185		133	133							
A4	Likelihood physician will leave current practice within two years.															0.586	0.512	0.583	0.802
	Not at all likely	12%	18%	-6	9%	16%	-7	11%	14%	-3	16%	13%	4						
	Not very likely	17%	16%	1	13%	12%	1	14%	16%	-2	11%	14%	-3						
	Somewhat likely	43%	38%	6	32%	29%	3	39%	41%	-2	31%	31%	0						
	Very likely	28%	28%	0	46%	43%	3	36%	29%	7	41%	42%	0						
	N	149	177		104	142		160	184		132	133							
Experience with CPC+²																			
H1	Overall, extent to which participating in CPC+ changed the quality of care that the physician currently provides to patients.															n.a.	n.a.	n.a.	n.a.
	Improved a lot	11%	n.a.	n.a.	24%	n.a.	n.a.	19%	n.a.	n.a.	20%	n.a.	n.a.						
	Improved somewhat	57%	n.a.	n.a.	53%	n.a.	n.a.	49%	n.a.	n.a.	53%	n.a.	n.a.						
	Did not change	22%	n.a.	n.a.	15%	n.a.	n.a.	24%	n.a.	n.a.	20%	n.a.	n.a.						
	Worsened somewhat	4%	n.a.	n.a.	2%	n.a.	n.a.	1%	n.a.	n.a.	1%	n.a.	n.a.						
	Worsened a lot	0%	n.a.	n.a.	0%	n.a.	n.a.	1%	n.a.	n.a.	1%	n.a.	n.a.						
	Don't know	6%	n.a.	n.a.	6%	n.a.	n.a.	7%	n.a.	n.a.	5%	n.a.	n.a.						
	N	144	n.a.		99	n.a.		156	n.a.		128	n.a.							

Table 3.C.8b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent				
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
H2	Extent to which physician thinks that participating in CPC+ reduced the overall costs of all the health care their patients received.													n.a.	n.a.	n.a.	n.a.
	A lot	3%	n.a.	n.a.	10%	n.a.	n.a.	6%	n.a.	n.a.	7%	n.a.	n.a.				
	Some	27%	n.a.	n.a.	46%	n.a.	n.a.	37%	n.a.	n.a.	47%	n.a.	n.a.				
	Not very much	32%	n.a.	n.a.	23%	n.a.	n.a.	24%	n.a.	n.a.	23%	n.a.	n.a.				
	Not at all	11%	n.a.	n.a.	8%	n.a.	n.a.	6%	n.a.	n.a.	10%	n.a.	n.a.				
	Don't know	27%	n.a.	n.a.	14%	n.a.	n.a.	27%	n.a.	n.a.	13%	n.a.	n.a.				
	N	146	n.a.		99	n.a.		154	n.a.		129	n.a.					
H3	Overall, considering the amount of work required by CPC+, adequacy of the CPC+ payments from all payers combined.													n.a.	n.a.	n.a.	n.a.
	More than adequate	0%	n.a.	n.a.	3%	n.a.	n.a.	2%	n.a.	n.a.	3%	n.a.	n.a.				
	Adequate	21%	n.a.	n.a.	42%	n.a.	n.a.	16%	n.a.	n.a.	27%	n.a.	n.a.				
	Less than adequate	26%	n.a.	n.a.	35%	n.a.	n.a.	38%	n.a.	n.a.	43%	n.a.	n.a.				
	Don't know - not familiar with CPC+ payments from all payers or costs of doing CPC+ work	53%	n.a.	n.a.	19%	n.a.	n.a.	44%	n.a.	n.a.	27%	n.a.	n.a.				
	N	145	n.a.		99	n.a.		156	n.a.		129	n.a.					
H4	Given practice's overall experience participating in CPC+, likelihood physician would recommend that their practice participate in CPC+ if their practice could do it all over again.													n.a.	n.a.	n.a.	n.a.
	Very likely	23%	n.a.	n.a.	42%	n.a.	n.a.	28%	n.a.	n.a.	35%	n.a.	n.a.				
	Somewhat likely	40%	n.a.	n.a.	35%	n.a.	n.a.	36%	n.a.	n.a.	40%	n.a.	n.a.				
	Not very likely	13%	n.a.	n.a.	10%	n.a.	n.a.	14%	n.a.	n.a.	6%	n.a.	n.a.				
	Not at all likely	4%	n.a.	n.a.	3%	n.a.	n.a.	3%	n.a.	n.a.	10%	n.a.	n.a.				
	Don't know	20%	n.a.	n.a.	10%	n.a.	n.a.	19%	n.a.	n.a.	9%	n.a.	n.a.				
	N	144	n.a.		99	n.a.		156	n.a.		129	n.a.					

Table 3.C.8b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
H5	Thinking about the individual(s) at their practice site who have made a substantive contribution of time or leadership to implement care delivery changes for CPC+, physician would say:															
	Most or all of the practice site was involved in the substantive work on CPC+	30%	n.a.	n.a.	43%	n.a.	n.a.	n.a.	39%	n.a.	n.a.	n.a.	52%	n.a.	n.a.	
	A smaller group that included at least one physician did most of the substantive work on CPC+	40%	n.a.	n.a.	36%	n.a.	n.a.	n.a.	36%	n.a.	n.a.	n.a.	31%	n.a.	n.a.	
	A smaller group that did not include any physicians did most of the substantive work on CPC+	4%	n.a.	n.a.	5%	n.a.	n.a.	n.a.	5%	n.a.	n.a.	n.a.	4%	n.a.	n.a.	
	One physician did most of the substantive work on CPC+	2%	n.a.	n.a.	3%	n.a.	n.a.	n.a.	0%	n.a.	n.a.	n.a.	1%	n.a.	n.a.	
	One non-physician did most of the substantive work on CPC+	5%	n.a.	n.a.	5%	n.a.	n.a.	n.a.	4%	n.a.	n.a.	n.a.	4%	n.a.	n.a.	
	No one at the practice site did much substantive work on CPC+	1%	n.a.	n.a.	3%	n.a.	n.a.	n.a.	2%	n.a.	n.a.	n.a.	1%	n.a.	n.a.	
	Don't know	19%	n.a.	n.a.	6%	n.a.	n.a.	n.a.	15%	n.a.	n.a.	n.a.	6%	n.a.	n.a.	
	N	146	n.a.	n.a.	99	n.a.	n.a.	n.a.	157	n.a.	n.a.	n.a.	129	n.a.	n.a.	
H6	Extent to which physician agrees with the statement: "You were better positioned to meet health care needs for your patients during the coronavirus pandemic because of your practice's participation in CPC+."															
	Strongly disagree	6%	n.a.	n.a.	9%	n.a.	n.a.	n.a.	6%	n.a.	n.a.	n.a.	10%	n.a.	n.a.	
	Disagree	11%	n.a.	n.a.	9%	n.a.	n.a.	n.a.	11%	n.a.	n.a.	n.a.	11%	n.a.	n.a.	
	Neither disagree nor agree	35%	n.a.	n.a.	38%	n.a.	n.a.	n.a.	31%	n.a.	n.a.	n.a.	37%	n.a.	n.a.	
	Agree	19%	n.a.	n.a.	20%	n.a.	n.a.	n.a.	19%	n.a.	n.a.	n.a.	22%	n.a.	n.a.	
	Strongly agree	6%	n.a.	n.a.	10%	n.a.	n.a.	n.a.	9%	n.a.	n.a.	n.a.	11%	n.a.	n.a.	
	Don't know	23%	n.a.	n.a.	14%	n.a.	n.a.	n.a.	24%	n.a.	n.a.	n.a.	10%	n.a.	n.a.	
	N	146	n.a.	n.a.	98	n.a.	n.a.	n.a.	157	n.a.	n.a.	n.a.	129	n.a.	n.a.	
Barriers to providing optimal patient care																
B14.a	Extent to which lack of available behavioral health specialists for consultations and/or referrals limits physician's ability to provide optimal care for their patients.															
	Does not limit	11%	7%	4	0.12	10%	1		14%	7%	7		8%	10%	-2	
	Limits somewhat	48%	40%	8	0.47	30%	17		49%	40%	10		43%	39%	3	
	Limits a great deal	40%	53%	-13	0.42	60%	-18		37%	53%	-17		49%	50%	-2	
	N	149	178		104	140			160	185			133	132		

Table 3.C.8b. (continued)

Question	Track 1 – Health or hospital system owned				Track 1 – Independent				Track 2 – Health or hospital system owned				Track 2 – Independent			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
B14.b	Extent to which lack of available medical or surgical specialists for consultations and/or referrals limits physician's ability to provide optimal care for their patients.															
	0.800				0.522				0.768				0.267			
	Does not limit	64%	63%	1	56%	63%	-7		64%	68%	-4		64%	61%	3	
	Limits somewhat	33%	33%	0	42%	34%	8		33%	29%	3		29%	36%	-7	
	Limits a great deal	3%	4%	-2	2%	3%	0		3%	2%	1		7%	3%	4	
	N	149	178		104	140			160	185			133	132		
B14.c	Extent to which inadequate reimbursement from insurers for primary care services limits physician's ability to provide optimal care for their patients.															
	0.989				0.678				0.420				0.563			
	Does not limit	48%	49%	-1	42%	43%	-1		47%	51%	-4		34%	41%	-7	
	Limits somewhat	40%	40%	0	40%	35%	5		36%	38%	-1		45%	41%	4	
	Limits a great deal	12%	11%	0	18%	22%	-4		16%	11%	5		21%	18%	3	
	N	149	177		104	142			160	184			133	132		
B14.d	Extent to which inadequate time to spend with patients during visits limits physician's ability to provide optimal care for their patients.															
	0.382				0.730				0.151				0.181			
	Does not limit	19%	21%	-2	27%	28%	-2		21%	21%	0		23%	31%	-8	
	Limits somewhat	50%	56%	-6	49%	52%	-3		48%	58%	-10		61%	49%	13	
	Limits a great deal	31%	24%	7	25%	20%	5		31%	21%	10		16%	21%	-5	
	N	149	178		104	142			160	185			133	132		

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

¹ Practice ownership comes from the SK&A database, managed by IQVIA, a marketing organization that collects information directly from all health care practices in the United States. IQVIA updates this information on an ongoing basis; we obtained practice ownership information in November 2016.

² These questions were also asked to physicians whose practices withdrew from CPC+. For these physicians, the questions were asked in the past tense, to reflect their experiences participating in CPC+ in the past.

p.p. = percentage points; n.a. = not applicable because that group of physicians were not asked that question; PA = physician assistant; NP = nurse practitioner; CNS = certified nurse specialist; EHR = electronic health record

Table 3.C.8c. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Practice size¹

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison				
Teamwork																												
C1.a	Extent to which physician agrees that "the group of staff and providers I work with the most at this practice site work well together as a team."				0.456				0.648				0.451				0.185				0.996				0.497			
	Strongly disagree	2%	1%	1	1%	2%	-1	0%	1%	-1	0%	2%	-2	1%	1%	0	1%	1%	0	1%	0%	1	1%	0%	1			
	Disagree	7%	1%	6	5%	1%	3	0%	3%	-2	0%	0%	0	2%	2%	0	2%	2%	0	2%	3%	-1	2%	3%	-1			
	Neither disagree nor agree	4%	1%	2	7%	8%	-2	8%	9%	-1	3%	6%	-3	6%	6%	0	7%	6%	0	7%	10%	-3	7%	10%	-3			
	Agree	38%	42%	-4	33%	38%	-5	44%	46%	-2	44%	62%	-17	41%	44%	-3	36%	41%	-5	36%	41%	-5	36%	41%	-5			
	Strongly agree	50%	55%	-5	55%	50%	5	48%	41%	7	53%	31%	22	49%	47%	2	54%	47%	7	54%	47%	7	54%	47%	7			
	N	53	59		71	112		129	148		33	49		81	113		178	155		178	155		178	155				
C1.b	Extent to which physician agrees that "we have a 'we are in it together' attitude at my practice site."				0.332				0.561				0.586				0.082				0.726				0.51			
	Strongly disagree	3%	1%	2	1%	2%	-1	0%	1%	-1	3%	2%	1	3%	1%	2	1%	0%	1	1%	0%	1	1%	0%	1			
	Disagree	8%	0%	8	8%	4%	4	5%	6%	-1	0%	0%	0	5%	5%	0	5%	6%	-2	5%	6%	-2	5%	6%	-2			
	Neither disagree nor agree	6%	6%	0	8%	8%	0	8%	12%	-5	2%	20%	-18	11%	8%	2	10%	14%	-5	10%	14%	-5	10%	14%	-5			
	Agree	40%	43%	-3	46%	38%	8	51%	43%	8	50%	47%	3	45%	42%	3	44%	40%	5	44%	40%	5	44%	40%	5			
	Strongly agree	43%	50%	-7	37%	47%	-11	36%	37%	-2	45%	31%	14	36%	44%	-8	40%	40%	1	40%	40%	1	40%	40%	1			
	N	53	59		71	112		129	148		33	49		81	113		178	155		178	155		178	155				

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison				
C1.c	Extent to which physician agrees that "my professional skills are used to the fullest at my practice site."				0.207				0.656				0.650				0.869				0.789				0.426			
	Strongly disagree	0%	1%	-1	1%	2%	-1	0%	2%	-2	0%	2%	-2	1%	1%	0	1%	1%	0	1%	4%	-3						
	Disagree	15%	4%	12	11%	10%	1	12%	8%	3	10%	7%	3	14%	10%	5	11%	10%	5	11%	9%	2						
	Neither disagree nor agree	6%	11%	-5	13%	6%	7	10%	10%	0	15%	15%	0	11%	11%	0	8%	10%	0	8%	10%	-1						
	Agree	38%	38%	1	41%	48%	-6	47%	50%	-4	37%	43%	-6	37%	47%	-9	47%	47%	-9	47%	47%	0						
	Strongly agree	40%	47%	-6	33%	33%	-1	31%	29%	2	38%	34%	4	36%	32%	4	32%	29%	4	32%	29%	3						
	N	53	59		71	112		129	148		33	49		81	113		178	155		178	155							
C1.d	Extent to which physician agrees that "it is hard to get things to change at my practice site."				0.005				0.110				0.019				0.231				0.325				0.194			
	Strongly disagree	27%	11%	16	6%	3%	3	0.06	0.1	-4	5%	13%	-9	9%	3%	6	8%	7%	1	8%	7%	1						
	Disagree	23%	20%	3	41%	33%	7	0.35	0.27	8	40%	22%	17	29%	29%	-1	28%	36%	-8	28%	36%	-8						
	Neither disagree nor agree	14%	46%	-32	18%	37%	-19	0.27	0.24	3	30%	29%	1	31%	38%	-7	35%	24%	11	35%	24%	11						
	Agree	25%	17%	7	24%	17%	7	0.27	0.2	6	12%	28%	-15	25%	18%	7	21%	19%	1	21%	19%	1						
	Strongly agree	11%	5%	6	11%	10%	1	0.06	0.19	-13	13%	8%	6	7%	11%	-4	8%	14%	-6	8%	14%	-6						
	N	53	59		71	112		129	148		33	49		81	113		178	155		178	155							
C1.e	Extent to which physician agrees that "I can rely on other people at my practice site to do their jobs well."				0.243				0.563				0.025				0.134				0.493				0.552			
	Strongly disagree	2%	1%	1	3%	1%	2	0%	2%	-2	6%	2%	4	1%	2%	0	2%	2%	0	2%	2%	0						
	Disagree	14%	4%	10	2%	2%	1	3%	1%	2	2%	2%	1	6%	3%	2	4%	4%	-1	4%	4%	-1						
	Neither disagree nor agree	13%	16%	-3	10%	15%	-5	10%	23%	-13	5%	20%	-15	9%	13%	-5	10%	16%	-6	10%	16%	-6						
	Agree	42%	36%	6	59%	49%	10	56%	46%	11	49%	56%	-7	58%	46%	11	52%	52%	1	52%	52%	1						
	Strongly agree	29%	43%	-14	25%	32%	-7	30%	28%	2	38%	20%	17	27%	35%	-8	33%	26%	7	33%	26%	7						
	N	53	59		71	112		129	147		33	49		81	113		178	155		178	155							

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison				
C1.f	Extent to which physician agrees that "we regularly take time to consider ways to improve how we do things at my practice site."				0.896				0.037				0.302				0.264				0.687				0.056			
	Strongly disagree	2%	0%	2	3%	3%	0	3%	1%	1	0%	0%	0%	4%	3%	1	0%	1%	-1									
	Disagree	6%	9%	-3	17%	8%	8	5%	11%	-7	8%	9%	-1	5%	9%	-4	5%	13%	-9									
	Neither disagree nor agree	23%	22%	0	14%	12%	3	17%	20%	-3	12%	31%	-18	20%	14%	6	20%	15%	5									
	Agree	50%	49%	2	37%	61%	-24	50%	46%	4	55%	47%	8	46%	52%	-6	40%	43%	-3									
	Strongly agree	20%	20%	-1	29%	16%	12	26%	21%	5	25%	13%	11	25%	21%	4	35%	28%	7									
	N	53	59		71	112		129	148		33	49		81	113		177	155										
Physician satisfaction, burnout, and likelihood to leave the practice																												
A1	Extent to which physician agrees with the statement: "Overall, I am satisfied with my current job".				0.338				0.149				0.134				0.511				0.805				0.904			
	Strongly agree	24%	31%	-7	17%	23%	-6	21%	21%	0	33%	24%	9	18%	22%	-4	24%	24%	1									
	Agree	38%	49%	-11	57%	48%	10	55%	61%	-6	34%	54%	-19	54%	53%	0	53%	57%	-4									
	Neither disagree nor agree	10%	7%	3	4%	12%	-7	16%	6%	10	20%	12%	8	12%	13%	-1	9%	6%	3									
	Disagree	24%	12%	13	16%	17%	-2	5%	9%	-4	7%	8%	-1	14%	10%	3	8%	8%	0									
	Strongly disagree	3%	1%	2	6%	1%	5	3%	4%	-1	6%	3%	3	3%	1%	2	5%	5%	0									
	N	52	59		70	113		129	148		33	49		81	114		177	155										

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison				
A2	Using physician's own definition of "burnout," statement which best describes physician's situation at work.				0.402				0.009				0.759				0.462				0.048				0.871			
	I enjoy my work. I have no symptoms of burnout.	9%	8%	1	14%	12%	1	8%	11%	-3	5%	13%	-8	9%	10%	-1	10%	13%	-3									
	Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.	68%	64%	4	30%	47%	-17	55%	48%	6	50%	59%	-9	50%	51%	-1	46%	46%	0									
	I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.	14%	25%	-10	48%	28%	20	32%	32%	0	29%	23%	6	22%	34%	-12	34%	31%	4									
	The symptoms of burnout that I'm experiencing won't go away. I think about frustrations at work a lot.	4%	4%	1	4%	13%	-9	4%	7%	-3	7%	3%	4	16%	5%	10	9%	10%	-1									
	I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	5%	0%	5	4%	0%	4	2%	2%	0	9%	3%	6	4%	0%	4	1%	1%	1									
	N	53	59		71	113		128	148		33	49		81	114		177	155										

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison				
A3.a	Amount of stress physician experiences due to burdensome administrative tasks (such as paperwork related to insurance, pre-authorizations).				0.903				0.381				0.025				0.252				0.089				0.607			
	None	3%	2%	0	1%	2%	-1	2%	4%	-2	0%	4%	-4	6%	2%	4	2%	2%	0									
	A little	17%	13%	4	18%	13%	5	19%	10%	9	17%	6%	11	6%	15%	-9	20%	14%	6									
	Some	29%	34%	-5	31%	43%	-13	49%	40%	9	38%	37%	1	38%	44%	-6	31%	35%	-4									
	A lot	51%	51%	0	50%	41%	9	30%	46%	-16	45%	53%	-8	50%	39%	11	46%	49%	-2									
	N	53	57		71	113		129	148		33	48		82	114		178	155										
A3.b	Amount of stress physician experiences due to excessive time demands of using EHRs or other health IT.				0.686				0.983				0.933				0.308				0.465				0.508			
	None	7%	4%	3	7%	7%	-1	5%	7%	-2	13%	3%	10	2%	7%	-5	3%	5%	-2									
	A little	17%	15%	2	19%	17%	2	16%	15%	1	11%	20%	-9	21%	20%	0	15%	15%	0									
	Some	24%	34%	-9	29%	30%	-1	34%	35%	-1	34%	38%	-4	32%	30%	2	30%	36%	-7									
	A lot	51%	48%	4	45%	46%	-1	45%	43%	2	43%	40%	3	45%	42%	3	52%	44%	9									
	N	53	59		71	112		129	148		33	49		82	113		178	155										
A3.c	Amount of stress physician experiences due to insufficient compensation and reimbursement.				0.472				0.004				0.658				0.226				0.000				0.637			
	None	8%	10%	-2	11%	33%	-22	22%	21%	0	21%	20%	1	26%	27%	-1	21%	25%	-4									
	A little	25%	30%	-5	32%	32%	1	36%	30%	6	18%	25%	-7	17%	33%	-16	27%	31%	-4									
	Some	39%	24%	15	39%	24%	15	24%	25%	-1	45%	24%	21	21%	30%	-9	33%	27%	5									
	A lot	28%	36%	-8	18%	11%	7	18%	24%	-6	15%	31%	-16	36%	9%	27	19%	16%	3									
	N	52	59		70	113		129	148		32	49		82	114		178	155										

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison				
A3.d	Amount of stress physician experiences due to lack of control or autonomy.				0.327				0.658				0.001				0.515				0.318				0.031			
	None	9%	19%	-10	16%	18%	-2	15%	23%	-7	17%	22%	-5	16%	16%	0	12%	25%	-12	12%	25%	-12	12%	25%	-12			
	A little	34%	33%	1	34%	38%	-4	50%	24%	26	34%	24%	11	30%	43%	-13	42%	29%	13	42%	29%	13	42%	29%	13			
	Some	45%	32%	13	30%	32%	-2	25%	33%	-8	33%	26%	6	38%	30%	8	28%	30%	-2	28%	30%	-2	28%	30%	-2			
	A lot	12%	16%	-4	20%	13%	7	10%	21%	-11	16%	28%	-12	16%	11%	5	18%	16%	2	18%	16%	2	18%	16%	2			
	N	53	59		71	112		129	148		33	49		82	114		178	155		178	155		178	155				
A3.e	Amount of stress physician experiences due to inadequate staff support.				0.295				0.177				0.796				0.031				0.499				0.931			
	None	35%	28%	7	29%	27%	3	19%	23%	-4	32%	27%	5	27%	19%	8	25%	25%	1	25%	25%	1	25%	25%	1			
	A little	15%	29%	-14	18%	32%	-15	34%	32%	2	38%	22%	16	28%	35%	-6	26%	23%	3	26%	23%	3	26%	23%	3			
	Some	34%	34%	1	34%	29%	5	29%	25%	4	13%	43%	-30	31%	28%	3	27%	29%	-2	27%	29%	-2	27%	29%	-2			
	A lot	16%	9%	6	19%	13%	7	18%	21%	-2	18%	8%	10	13%	18%	-5	22%	23%	-2	22%	23%	-2	22%	23%	-2			
	N	53	59		71	112		129	148		33	49		82	114		178	155		178	155		178	155				
A4	Likelihood physician will leave current practice within two years.				0.455				0.093				0.576				0.498				0.407				0.420			
	Not at all likely	11%	12%	-1	10%	19%	-9	12%	18%	-6	19%	11%	8	16%	12%	4	9%	15%	-6	9%	15%	-6	9%	15%	-6			
	Not very likely	19%	13%	6	15%	20%	-5	14%	11%	2	10%	11%	-1	10%	19%	-9	15%	14%	2	15%	14%	2	15%	14%	2			
	Somewhat likely	27%	41%	-14	47%	28%	19	39%	34%	5	31%	46%	-16	38%	33%	4	36%	38%	-2	36%	38%	-2	36%	38%	-2			
	Very likely	43%	33%	10	28%	33%	-5	36%	37%	-1	41%	31%	9	36%	35%	1	40%	34%	6	40%	34%	6	40%	34%	6			
	N	53	58		71	113		129	148		33	48		82	114		177	155		177	155		177	155				

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison
	Experience with CPC+²																							
H1	Overall, extent to which participating in CPC+ changed the quality of care that the physician currently provides to patients.				n.a.				n.a.				n.a.				n.a.				n.a.			
	Improved a lot	17%	n.a.	n.a.	9%	n.a.	n.a.	21%	n.a.	n.a.	18%	n.a.	n.a.	22%	n.a.	n.a.	18%	n.a.	n.a.	18%	n.a.	n.a.		
	Improved somewhat	45%	n.a.	n.a.	62%	n.a.	n.a.	55%	n.a.	n.a.	59%	n.a.	n.a.	43%	n.a.	n.a.	54%	n.a.	n.a.	54%	n.a.	n.a.		
	Did not change	30%	n.a.	n.a.	18%	n.a.	n.a.	14%	n.a.	n.a.	15%	n.a.	n.a.	32%	n.a.	n.a.	17%	n.a.	n.a.	17%	n.a.	n.a.		
	Worsened somewhat	6%	n.a.	n.a.	6%	n.a.	n.a.	1%	n.a.	n.a.	3%	n.a.	n.a.	0%	n.a.	n.a.	1%	n.a.	n.a.	1%	n.a.	n.a.		
	Worsened a lot	0%	n.a.	n.a.	0%	n.a.	n.a.	0%	n.a.	n.a.	3%	n.a.	n.a.	0%	n.a.	n.a.	1%	n.a.	n.a.	1%	n.a.	n.a.		
	Don't know	2%	n.a.	n.a.	4%	n.a.	n.a.	10%	n.a.	n.a.	3%	n.a.	n.a.	3%	n.a.	n.a.	9%	n.a.	n.a.	9%	n.a.	n.a.		
	N	48	n.a.		68	n.a.		127	n.a.		33	n.a.		80	n.a.		171	n.a.		171	n.a.			
H2	Extent to which physician thinks that participating in CPC+ reduced the overall costs of all the health care their patients received.				n.a.				n.a.				n.a.				n.a.				n.a.			
	A lot	9%	n.a.	n.a.	1%	n.a.	n.a.	7%	n.a.	n.a.	9%	n.a.	n.a.	7%	n.a.	n.a.	4%	n.a.	n.a.	4%	n.a.	n.a.		
	Some	28%	n.a.	n.a.	36%	n.a.	n.a.	36%	n.a.	n.a.	40%	n.a.	n.a.	41%	n.a.	n.a.	42%	n.a.	n.a.	42%	n.a.	n.a.		
	Not very much	29%	n.a.	n.a.	28%	n.a.	n.a.	28%	n.a.	n.a.	22%	n.a.	n.a.	27%	n.a.	n.a.	21%	n.a.	n.a.	21%	n.a.	n.a.		
	Not at all	8%	n.a.	n.a.	16%	n.a.	n.a.	7%	n.a.	n.a.	16%	n.a.	n.a.	5%	n.a.	n.a.	7%	n.a.	n.a.	7%	n.a.	n.a.		
	Don't know	25%	n.a.	n.a.	19%	n.a.	n.a.	23%	n.a.	n.a.	13%	n.a.	n.a.	19%	n.a.	n.a.	25%	n.a.	n.a.	25%	n.a.	n.a.		
	N	48	n.a.		70	n.a.		127	n.a.		33	n.a.		79	n.a.		171	n.a.		171	n.a.			

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)				
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	
H3	Overall, considering the amount of work required by CPC+, adequacy of the CPC+ payments from all payers combined.				n.a.				n.a.				n.a.				n.a.				n.a.				
	More than adequate	4%	n.a.	n.a.	1%	n.a.	n.a.	1%	n.a.	n.a.	2%	n.a.	n.a.	4%	n.a.	n.a.	2%	n.a.	n.a.	2%	n.a.	n.a.	2%	n.a.	n.a.
	Adequate	26%	n.a.	n.a.	24%	n.a.	n.a.	34%	n.a.	n.a.	32%	n.a.	n.a.	19%	n.a.	n.a.	19%	n.a.	n.a.	19%	n.a.	n.a.	19%	n.a.	n.a.
	Less than adequate	33%	n.a.	n.a.	36%	n.a.	n.a.	23%	n.a.	n.a.	48%	n.a.	n.a.	41%	n.a.	n.a.	37%	n.a.	n.a.	37%	n.a.	n.a.	37%	n.a.	n.a.
	Don't know - not familiar with CPC+ payments from all payers or costs of doing CPC+ work	38%	n.a.	n.a.	39%	n.a.	n.a.	42%	n.a.	n.a.	18%	n.a.	n.a.	37%	n.a.	n.a.	42%	n.a.	n.a.	42%	n.a.	n.a.	42%	n.a.	n.a.
	N	47	n.a.	n.a.	70	n.a.	n.a.	127	n.a.	n.a.	33	n.a.	n.a.	80	n.a.	n.a.	172	n.a.	n.a.	172	n.a.	n.a.	172	n.a.	n.a.
H4	Given practice's overall experience participating in CPC+, likelihood physician would recommend that their practice participate in CPC+ if their practice could do it all over again.				n.a.				n.a.				n.a.				n.a.				n.a.				
	Very likely	28%	n.a.	n.a.	25%	n.a.	n.a.	35%	n.a.	n.a.	36%	n.a.	n.a.	29%	n.a.	n.a.	32%	n.a.	n.a.	32%	n.a.	n.a.	32%	n.a.	n.a.
	Somewhat likely	39%	n.a.	n.a.	41%	n.a.	n.a.	35%	n.a.	n.a.	32%	n.a.	n.a.	36%	n.a.	n.a.	41%	n.a.	n.a.	41%	n.a.	n.a.	41%	n.a.	n.a.
	Not very likely	10%	n.a.	n.a.	15%	n.a.	n.a.	11%	n.a.	n.a.	12%	n.a.	n.a.	12%	n.a.	n.a.	10%	n.a.	n.a.	10%	n.a.	n.a.	10%	n.a.	n.a.
	Not at all likely	8%	n.a.	n.a.	5%	n.a.	n.a.	1%	n.a.	n.a.	5%	n.a.	n.a.	11%	n.a.	n.a.	3%	n.a.	n.a.	3%	n.a.	n.a.	3%	n.a.	n.a.
	Don't know	16%	n.a.	n.a.	14%	n.a.	n.a.	17%	n.a.	n.a.	15%	n.a.	n.a.	12%	n.a.	n.a.	15%	n.a.	n.a.	15%	n.a.	n.a.	15%	n.a.	n.a.
	N	48	n.a.	n.a.	68	n.a.	n.a.	127	n.a.	n.a.	33	n.a.	n.a.	80	n.a.	n.a.	172	n.a.	n.a.	172	n.a.	n.a.	172	n.a.	n.a.

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)						
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison			
H5	Thinking about the individual(s) at their practice site who have made a substantive contribution of time or leadership to implement care delivery changes for CPC+, physician would say:				n.a.				n.a.				n.a.				n.a.				n.a.						
	Most or all of the practice site was involved in the substantive work on CPC+				38%	n.a.	n.a.		33%	n.a.	n.a.		34%	n.a.	n.a.		48%	n.a.	n.a.		48%	n.a.	n.a.		41%	n.a.	n.a.
	A smaller group that included at least one physician did most of the substantive work on CPC+				26%	n.a.	n.a.		37%	n.a.	n.a.		45%	n.a.	n.a.		32%	n.a.	n.a.		35%	n.a.	n.a.		34%	n.a.	n.a.
	A smaller group that did not include any physicians did most of the substantive work on CPC+				0%	n.a.	n.a.		6%	n.a.	n.a.		5%	n.a.	n.a.		5%	n.a.	n.a.		4%	n.a.	n.a.		5%	n.a.	n.a.
	One physician did most of the substantive work on CPC+				8%	n.a.	n.a.		1%	n.a.	n.a.		1%	n.a.	n.a.		3%	n.a.	n.a.		0%	n.a.	n.a.		0%	n.a.	n.a.
	One non-physician did most of the substantive work on CPC+				7%	n.a.	n.a.		7%	n.a.	n.a.		2%	n.a.	n.a.		0%	n.a.	n.a.		6%	n.a.	n.a.		3%	n.a.	n.a.
	No one at the practice site did much substantive work on CPC+				0%	n.a.	n.a.		4%	n.a.	n.a.		0%	n.a.	n.a.		2%	n.a.	n.a.		0%	n.a.	n.a.		2%	n.a.	n.a.
	Don't know				20%	n.a.	n.a.		11%	n.a.	n.a.		12%	n.a.	n.a.		9%	n.a.	n.a.		8%	n.a.	n.a.		14%	n.a.	n.a.
	N				48	n.a.			70	n.a.			127	n.a.			33	n.a.			80	n.a.			173	n.a.	

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison				
H6	Extent to which physician agrees with the statement: "You were better positioned to meet health care needs for your patients during the coronavirus pandemic because of your practice's participation in CPC+."				n.a.				n.a.				n.a.				n.a.				n.a.							
	Strongly disagree	12%	n.a.	n.a.	9%	n.a.	n.a.		4%	n.a.	n.a.		8%	n.a.	n.a.		11%	n.a.	n.a.		5%	n.a.	n.a.					
	Disagree	11%	n.a.	n.a.	15%	n.a.	n.a.		7%	n.a.	n.a.		15%	n.a.	n.a.		11%	n.a.	n.a.		9%	n.a.	n.a.					
	Neither disagree nor agree	32%	n.a.	n.a.	39%	n.a.	n.a.		35%	n.a.	n.a.		52%	n.a.	n.a.		32%	n.a.	n.a.		29%	n.a.	n.a.					
	Agree	18%	n.a.	n.a.	17%	n.a.	n.a.		22%	n.a.	n.a.		11%	n.a.	n.a.		22%	n.a.	n.a.		23%	n.a.	n.a.					
	Strongly agree	3%	n.a.	n.a.	8%	n.a.	n.a.		9%	n.a.	n.a.		7%	n.a.	n.a.		10%	n.a.	n.a.		11%	n.a.	n.a.					
	Don't know	23%	n.a.	n.a.	12%	n.a.	n.a.		23%	n.a.	n.a.		8%	n.a.	n.a.		14%	n.a.	n.a.		23%	n.a.	n.a.					
	N	48	n.a.		70	n.a.			126	n.a.			33	n.a.			80	n.a.			173	n.a.						
Barriers to providing optimal patient care																												
B14.a	Extent to which lack of available behavioral health specialists for consultations and/or referrals limits physician's ability to provide optimal care for their patients.				0.208				0.326				0.045				0.620				0.149				0.150			
	Does not limit	10%	6%	4	8%	6%	2		15%	11%	3		12%	6%	7		5%	7%	-2		16%	10%	6					
	Limits somewhat	51%	38%	13	40%	30%	10		52%	38%	13		45%	51%	-6		49%	34%	15		45%	40%	5					
	Limits a great deal	39%	56%	-17	52%	64%	-12		34%	50%	-17		42%	43%	-1		46%	60%	-13		39%	49%	-11					
	N	53	59		71	113			129	146			33	49			82	113			178	155						

Table 3.C.8c. (continued)

Question	Track 1 – Small (1-2 PCPs)				Track 1 – Medium (3-5 PCPs)				Track 1 – Large (6+ PCPs)				Track 2 – Small (1-2 PCPs)				Track 2 – Medium (3-5 PCPs)				Track 2 – Large (6+ PCPs)							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison				
B14.b	Extent to which lack of available medical or surgical specialists for consultations and/or referrals limits physician's ability to provide optimal care for their patients.				0.516				0.034				0.095				0.369				0.296				0.927			
	Does not limit	61%	59%	2	53%	69%	-15	67%	61%	6	51%	62%	-12	70%	67%	3	64%	65%	-2									
	Limits somewhat	29%	37%	-8	47%	29%	17	33%	35%	-2	39%	35%	4	24%	31%	-7	34%	32%	2									
	Limits a great deal	10%	5%	6	0%	2%	-2	0%	5%	-4	11%	3%	8	6%	2%	4	2%	3%	0									
	N	53	59		71	113		129	146		33	49		82	113		178	155										
B14.c	Extent to which inadequate reimbursement from insurers for primary care services limits physician's ability to provide optimal care for their patients.				0.491				0.015				0.254				0.571				0.045				0.600			
	Does not limit	45%	36%	10	34%	57%	-23	54%	43%	11	42%	31%	11	42%	55%	-14	41%	47%	-6									
	Limits somewhat	43%	46%	-3	48%	32%	16	33%	38%	-5	41%	53%	-12	36%	36%	0	43%	37%	6									
	Limits a great deal	12%	19%	-7	17%	11%	7	14%	19%	-6	17%	16%	1	22%	9%	13	16%	16%	0									
	N	53	59		71	112		129	148		33	49		82	112		178	155										
B14.d	Extent to which inadequate time to spend with patients during visits limits physician's ability to provide optimal care for their patients.				0.361				0.077				0.875				0.144				0.891				0.558			
	Does not limit	21%	22%	-1	19%	23%	-4	25%	25%	-1	31%	32%	0	23%	24%	-1	17%	23%	-5									
	Limits somewhat	48%	59%	-11	47%	58%	-11	52%	49%	3	39%	56%	-17	57%	54%	3	56%	54%	2									
	Limits a great deal	31%	18%	12	35%	19%	16	23%	26%	-2	30%	12%	18	19%	22%	-3	26%	23%	3									
	N	53	59		71	113		129	148		33	49		82	113		178	155										

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

Table 3.C.8c. (continued)

¹We calculated the number of primary care practitioners (PCPs) at the practice site using a November 2016 pull of SK&A data and the National Plan & Provider Enumeration System (NPPES). We counted a provider as a primary care practitioner if they met criteria in either the SK&A data or the NPPES data; we did not require them to be considered a primary care practitioner in both data sources. Using the SK&A data, we defined PCPs as a physician (MD or DO), nurse practitioner (NP), or physician's assistant (PA) who bill under their own National Provider Identifier (NPI) and have a specialty of general practitioner, family practitioner, internist, internal medicine/pediatrics, or geriatrician. In NPPES, we defined PCPs as physicians, NPs, PAs, or clinical nurse specialists with 1 of 56 primary care taxonomy codes.

²These questions were also asked to physicians whose practices withdrew from CPC+. For these physicians, the questions were asked in the past tense, to reflect their experiences participating in CPC+ in the past.

p.p. = percentage points; n.a. = not applicable because that group of physicians were not asked that question; EHR = electronic health record

Table 3.C.8d. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Prior primary care practice transformation experience¹

Question	Track 1 – Prior primary care practice transformation experience				Track 1 – No previous experience				Track 2 – Prior primary care practice transformation experience				Track 2 – No previous experience			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Teamwork																
C1.a	Extent to which physician agrees that “the group of staff and providers I work with the most at this practice site work well together as a team.”			0.894				0.278				0.349				0.774
	Strongly disagree	1%	1%	0	0%	1%	-1	1%	1%	0		0%	0%	0		
	Disagree	1%	3%	-2	6%	1%	5	2%	2%	0		0%	1%	-1		
	Neither disagree nor agree	7%	8%	0	5%	7%	-2	5%	8%	-3		11%	7%	4		
	Agree	40%	41%	-1	37%	45%	-8	38%	45%	-7		44%	48%	-4		
	Strongly agree	50%	48%	3	52%	46%	5	53%	44%	9		45%	45%	0		
	N	144	215		109	104		254	246			38	71			
C1.b	Extent to which physician agrees that “we have a ‘we are in it together’ attitude at my practice site.”			0.126				0.169				0.203				0.694
	Strongly disagree	1%	1%	1	1%	2%	-1	3%	1%	2		0%	1%	-1		
	Disagree	6%	7%	0	7%	1%	6	4%	5%	-1		3%	1%	2		
	Neither disagree nor agree	7%	10%	-4	8%	9%	-1	8%	14%	-6		13%	8%	6		
	Agree	53%	38%	15	39%	46%	-7	44%	40%	4		52%	50%	1		
	Strongly agree	32%	44%	-12	45%	42%	3	41%	40%	1		32%	40%	-8		
	N	144	215		109	104		254	246			38	71			
C1.c	Extent to which physician agrees that “my professional skills are used to the fullest at my practice site.”			0.854				0.158				0.599				0.295
	Strongly disagree	1%	1%	-1	0%	2%	-2	1%	3%	-2		0%	1%	-1		
	Disagree	11%	10%	1	14%	5%	9	12%	10%	3		12%	7%	5		
	Neither disagree nor agree	14%	10%	4	5%	7%	-2	11%	11%	0		7%	9%	-3		
	Agree	43%	46%	-4	43%	48%	-5	45%	47%	-2		28%	45%	-17		
	Strongly agree	31%	32%	0	37%	37%	0	31%	29%	1		53%	39%	15		
	N	144	215		109	104		254	246			38	71			

Table 3.C.8d. (continued)

Question	Track 1 – Prior primary care practice transformation experience				Track 1 – No previous experience				Track 2 – Prior primary care practice transformation experience				Track 2 – No previous experience							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value				
C1.d	Extent to which physician agrees that “it is hard to get things to change at my practice site.”				0.058				0.096				0.443				0.503			
	Strongly disagree	8%	7%	1	14%	9%	5		9%	7%	2		1%	5%	-4					
	Disagree	34%	30%	4	35%	25%	10		29%	31%	-1		33%	35%	-2					
	Neither disagree nor agree	26%	34%	-9	15%	30%	-15		33%	29%	5		29%	35%	-6					
	Agree	26%	16%	10	25%	22%	3		20%	21%	-1		23%	13%	10					
	Strongly agree	6%	13%	-6	12%	15%	-2		8%	12%	-5		14%	11%	3					
	N	144	215		109	104			254	246			38	71						
C1.e	Extent to which physician agrees that “I can rely on other people at my practice site to do their jobs well.”				0.302				0.002				0.16				0.436			
	Strongly disagree	2%	3%	-1	0%	0%	0		2%	2%	-1		6%	0%	6					
	Disagree	1%	3%	-2	11%	1%	10		4%	4%	0		5%	0%	5					
	Neither disagree nor agree	11%	18%	-7	10%	20%	-10		9%	17%	-8		7%	10%	-3					
	Agree	56%	48%	9	51%	41%	10		53%	49%	4		58%	57%	0					
	Strongly agree	29%	28%	1	28%	39%	-11		32%	28%	5		25%	33%	-7					
	N	144	215		109	103			254	246			38	71						
C1.f	Extent to which physician agrees that “we regularly take time to consider ways to improve how we do things at my practice site.”				0.656				0.399				0.202				0.256			
	Strongly disagree	2%	2%	0	3%	1%	2		1%	2%	-1		5%	1%	4					
	Disagree	7%	10%	-3	10%	10%	1		6%	12%	-6		2%	7%	-5					
	Neither disagree nor agree	19%	15%	4	14%	21%	-7		18%	16%	2		22%	21%	1					
	Agree	46%	52%	-6	46%	51%	-5		46%	46%	0		39%	52%	-13					
	Strongly agree	25%	21%	4	27%	17%	9		29%	24%	5		32%	19%	13					
	N	144	215		109	104			253	246			38	71						

Table 3.C.8d. (continued)

Question	Track 1 – Prior primary care practice transformation experience				Track 1 – No previous experience				Track 2 – Prior primary care practice transformation experience				Track 2 – No previous experience			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Physician satisfaction, burnout, and likelihood to leave the practice																
A1	Extent to which physician agrees with the statement: "Overall, I am satisfied with my current job".												0.559	0.776	0.645	0.944
	Strongly agree	19%	23%	-4	22%	23%	-1	22%	22%	0	30%	28%	2			
	Agree	52%	56%	-4	51%	52%	-1	49%	55%	-6	56%	55%	1			
	Neither disagree nor agree	12%	10%	2	9%	6%	4	13%	10%	4	5%	9%	-4			
	Disagree	12%	8%	4	13%	17%	-4	11%	10%	1	6%	5%	1			
	Strongly disagree	5%	3%	2	3%	2%	1	4%	3%	1	4%	3%	1			
	N	143	215		108	105		253	247		38	71				
A2	Using physician's own definition of "burnout," statement which best describes physician's situation at work.												0.110	0.522	0.091	0.402
	I enjoy my work. I have no symptoms of burnout.	10%	13%	-3	10%	8%	3	8%	13%	-5	13%	8%	5			
	Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.	46%	50%	-4	55%	52%	3	46%	49%	-3	56%	52%	4			
	I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.	36%	29%	7	28%	29%	-2	32%	31%	2	14%	30%	-16			
	The symptoms of burnout that I'm experiencing won't go away. I think about frustrations at work a lot.	4%	7%	-3	4%	10%	-6	11%	7%	4	11%	7%	4			
	I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	4%	0%	3	3%	2%	1	3%	1%	2	5%	3%	2			
	N	144	215		108	105		253	247		38	71				

Table 3.C.8d. (continued)

Question	Track 1 – Prior primary care practice transformation experience				Track 1 – No previous experience				Track 2 – Prior primary care practice transformation experience				Track 2 – No previous experience							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value				
A3.a	Amount of stress physician experiences due to burdensome administrative tasks (such as paperwork related to insurance, pre-authorizations).													0.319		0.331		0.570		0.690
	None	1%	3%	-2	4%	3%	1		4%	3%	1		0%	2%	-2					
	A little	17%	13%	4	20%	10%	9		15%	14%	2		13%	12%	1					
	Some	40%	38%	2	36%	42%	-6		32%	38%	-6		46%	40%	6					
	A lot	42%	46%	-4	40%	45%	-4		48%	46%	3		41%	46%	-5					
	N	144	214		109	104			255	247			38	70						
A3.b	Amount of stress physician experiences due to excessive time demands of using EHRs or other health IT.													0.970		0.730		0.304		0.347
	None	7%	7%	0	5%	7%	-1		3%	6%	-3		9%	4%	5					
	A little	15%	16%	-2	20%	15%	6		17%	17%	1		11%	22%	-11					
	Some	30%	32%	-1	29%	35%	-5		28%	34%	-6		45%	36%	9					
	A lot	48%	45%	2	45%	44%	1		51%	43%	8		35%	38%	-3					
	N	144	214		109	105			255	246			38	71						
A3.c	Amount of stress physician experiences due to insufficient compensation and reimbursement.													0.118		0.014		0.038		0.099
	None	16%	26%	-10	14%	18%	-4		22%	26%	-4		26%	20%	6					
	A little	36%	29%	7	27%	33%	-6		25%	32%	-7		8%	27%	-19					
	Some	28%	30%	-2	37%	17%	21		29%	29%	0		39%	23%	15					
	A lot	19%	14%	5	22%	33%	-10		24%	13%	11		27%	30%	-2					
	N	144	215		107	105			255	247			37	71						
A3.d	Amount of stress physician experiences due to lack of control or autonomy.													0.266		0.186		0.385		0.297
	None	14%	21%	-7	14%	19%	-5		15%	21%	-6		11%	21%	-10					
	A little	41%	32%	9	42%	27%	14		35%	34%	1		45%	31%	14					
	Some	31%	30%	1	32%	35%	-3		34%	29%	5		26%	35%	-9					
	A lot	14%	16%	-2	12%	18%	-6		17%	16%	0		18%	12%	6					
	N	144	215		109	104			255	247			38	71						

Table 3.C.8d. (continued)

Question	Track 1 – Prior primary care practice transformation experience				Track 1 – No previous experience				Track 2 – Prior primary care practice transformation experience				Track 2 – No previous experience							
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value				
A3.e	Amount of stress physician experiences due to inadequate staff support.				0.927				0.084				0.423				0.884			
	None	22%	23%	-1	32%	28%	4		29%	24%	5		16%	19%	-3					
	A little	29%	30%	-1	18%	33%	-16		28%	25%	3		33%	37%	-4					
	Some	33%	30%	4	30%	25%	5		26%	32%	-6		30%	28%	2					
	A lot	16%	17%	-1	21%	14%	7		17%	20%	-2		21%	15%	6					
	N	144	215		109	104			255	247			38	71						
A4	Likelihood physician will leave current practice within two years.				0.823				0.099				0.880				0.528			
	Not at all likely	13%	15%	-1	8%	21%	-13		13%	14%	-1		15%	13%	2					
	Not very likely	12%	12%	0	20%	18%	2		13%	14%	-1		11%	23%	-12					
	Somewhat likely	43%	38%	5	33%	28%	5		37%	39%	-2		31%	29%	2					
	Very likely	32%	36%	-4	39%	33%	6		38%	34%	4		43%	35%	8					
	N	144	214		109	105			254	246			38	71						
Experience with CPC+²																				
H1	Overall, extent to which participating in CPC+ changed the quality of care that the physician currently provides to patients.				n.a.				n.a.				n.a.				n.a.			
	Improved a lot	13%	n.a.	n.a.	20%	n.a.	n.a.		20%	n.a.	n.a.		18%	n.a.	n.a.					
	Improved somewhat	57%	n.a.	n.a.	52%	n.a.	n.a.		50%	n.a.	n.a.		55%	n.a.	n.a.					
	Did not change	19%	n.a.	n.a.	19%	n.a.	n.a.		23%	n.a.	n.a.		16%	n.a.	n.a.					
	Worsened somewhat	3%	n.a.	n.a.	4%	n.a.	n.a.		1%	n.a.	n.a.		0%	n.a.	n.a.					
	Worsened a lot	0%	n.a.	n.a.	0%	n.a.	n.a.		1%	n.a.	n.a.		0%	n.a.	n.a.					
	Don't know	8%	n.a.	n.a.	4%	n.a.	n.a.		5%	n.a.	n.a.		11%	n.a.	n.a.					
	N	140	n.a.		103	n.a.			248	n.a.			36	n.a.						

Table 3.C.8d. (continued)

Question	Track 1 – Prior primary care practice transformation experience				Track 1 – No previous experience				Track 2 – Prior primary care practice transformation experience				Track 2 – No previous experience			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
H2	Extent to which physician thinks that participating in CPC+ reduced the overall costs of all the health care their patients received.				n.a.				n.a.				n.a.			
	A lot	4%	n.a.	n.a.	8%	n.a.	n.a.	n.a.	7%	n.a.	n.a.	n.a.	3%	n.a.	n.a.	n.a.
	Some	35%	n.a.	n.a.	33%	n.a.	n.a.	n.a.	41%	n.a.	n.a.	n.a.	45%	n.a.	n.a.	n.a.
	Not very much	30%	n.a.	n.a.	26%	n.a.	n.a.	n.a.	23%	n.a.	n.a.	n.a.	26%	n.a.	n.a.	n.a.
	Not at all	9%	n.a.	n.a.	12%	n.a.	n.a.	n.a.	7%	n.a.	n.a.	n.a.	12%	n.a.	n.a.	n.a.
	Don't know	22%	n.a.	n.a.	22%	n.a.	n.a.	n.a.	22%	n.a.	n.a.	n.a.	16%	n.a.	n.a.	n.a.
	N	142	n.a.	n.a.	103	n.a.	n.a.	n.a.	247	n.a.	n.a.	n.a.	36	n.a.	n.a.	n.a.
H3	Overall, considering the amount of work required by CPC+, adequacy of the CPC+ payments from all payers combined.				n.a.				n.a.				n.a.			
	More than adequate	1%	n.a.	n.a.	2%	n.a.	n.a.	n.a.	3%	n.a.	n.a.	n.a.	3%	n.a.	n.a.	n.a.
	Adequate	25%	n.a.	n.a.	35%	n.a.	n.a.	n.a.	22%	n.a.	n.a.	n.a.	17%	n.a.	n.a.	n.a.
	Less than adequate	31%	n.a.	n.a.	27%	n.a.	n.a.	n.a.	38%	n.a.	n.a.	n.a.	50%	n.a.	n.a.	n.a.
	Don't know - not familiar with CPC+ payments from all payers or costs of doing CPC+ work	43%	n.a.	n.a.	35%	n.a.	n.a.	n.a.	38%	n.a.	n.a.	n.a.	30%	n.a.	n.a.	n.a.
	N	142	n.a.	n.a.	102	n.a.	n.a.	n.a.	249	n.a.	n.a.	n.a.	36	n.a.	n.a.	n.a.
H4	Given practice's overall experience participating in CPC+, likelihood physician would recommend that their practice participate in CPC+ if their practice could do it all over again.				n.a.				n.a.				n.a.			
	Very likely	27%	n.a.	n.a.	35%	n.a.	n.a.	n.a.	33%	n.a.	n.a.	n.a.	23%	n.a.	n.a.	n.a.
	Somewhat likely	41%	n.a.	n.a.	33%	n.a.	n.a.	n.a.	36%	n.a.	n.a.	n.a.	43%	n.a.	n.a.	n.a.
	Not very likely	13%	n.a.	n.a.	10%	n.a.	n.a.	n.a.	10%	n.a.	n.a.	n.a.	17%	n.a.	n.a.	n.a.
	Not at all likely	2%	n.a.	n.a.	6%	n.a.	n.a.	n.a.	6%	n.a.	n.a.	n.a.	7%	n.a.	n.a.	n.a.
	Don't know	17%	n.a.	n.a.	15%	n.a.	n.a.	n.a.	15%	n.a.	n.a.	n.a.	10%	n.a.	n.a.	n.a.
	N	140	n.a.	n.a.	103	n.a.	n.a.	n.a.	249	n.a.	n.a.	n.a.	36	n.a.	n.a.	n.a.

Table 3.C.8d. (continued)

Question	Track 1 – Prior primary care practice transformation experience				Track 1 – No previous experience				Track 2 – Prior primary care practice transformation experience				Track 2 – No previous experience			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
H5	Thinking about the individual(s) at their practice site who have made a substantive contribution of time or leadership to implement care delivery changes for CPC+, physician would say:				n.a.				n.a.				n.a.			
	Most or all of the practice site was involved in the substantive work on CPC+	31%	n.a.	n.a.	40%	n.a.	n.a.	46%	n.a.	n.a.	39%	n.a.	n.a.			
	A smaller group that included at least one physician did most of the substantive work on CPC+	43%	n.a.	n.a.	32%	n.a.	n.a.	34%	n.a.	n.a.	33%	n.a.	n.a.			
	A smaller group that did not include any physicians did most of the substantive work on CPC+	5%	n.a.	n.a.	4%	n.a.	n.a.	4%	n.a.	n.a.	9%	n.a.	n.a.			
	One physician did most of the substantive work on CPC+	2%	n.a.	n.a.	4%	n.a.	n.a.	1%	n.a.	n.a.	0%	n.a.	n.a.			
	One non-physician did most of the substantive work on CPC+	4%	n.a.	n.a.	7%	n.a.	n.a.	4%	n.a.	n.a.	0%	n.a.	n.a.			
	No one at the practice site did much substantive work on CPC+	2%	n.a.	n.a.	1%	n.a.	n.a.	1%	n.a.	n.a.	2%	n.a.	n.a.			
	Don't know	14%	n.a.	n.a.	13%	n.a.	n.a.	10%	n.a.	n.a.	16%	n.a.	n.a.			
	N	142	n.a.	n.a.	103	n.a.	n.a.	250	n.a.	n.a.	36	n.a.	n.a.			

Table 3.C.8d. (continued)

Question	Track 1 – Prior primary care practice transformation experience				Track 1 – No previous experience				Track 2 – Prior primary care practice transformation experience				Track 2 – No previous experience				
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
H6	Extent to which physician agrees with the statement: "You were better positioned to meet health care needs for your patients during the coronavirus pandemic because of your practice's participation in CPC+."													n.a.	n.a.	n.a.	n.a.
	Strongly disagree	7%	n.a.	n.a.	8%	n.a.	n.a.	8%	n.a.	n.a.	7%	n.a.	n.a.				
	Disagree	7%	n.a.	n.a.	16%	n.a.	n.a.	8%	n.a.	n.a.	24%	n.a.	n.a.				
	Neither disagree nor agree	41%	n.a.	n.a.	30%	n.a.	n.a.	33%	n.a.	n.a.	39%	n.a.	n.a.				
	Agree	19%	n.a.	n.a.	21%	n.a.	n.a.	23%	n.a.	n.a.	6%	n.a.	n.a.				
	Strongly agree	7%	n.a.	n.a.	8%	n.a.	n.a.	10%	n.a.	n.a.	10%	n.a.	n.a.				
	Don't know	21%	n.a.	n.a.	18%	n.a.	n.a.	18%	n.a.	n.a.	15%	n.a.	n.a.				
	N	141	n.a.		103	n.a.		250	n.a.		36	n.a.					
Barriers to providing optimal patient care																	
B14.c	Extent to which inadequate reimbursement from insurers for primary care services limits physician's ability to provide optimal care for their patients.													0.684	0.250	0.338	0.579
	Does not limit	47%	51%	-4	44%	40%	4	42%	49%	-7	37%	40%	-3				
	Limits somewhat	37%	37%	1	43%	38%	5	41%	39%	3	35%	42%	-6				
	Limits a great deal	16%	13%	3	13%	21%	-9	16%	13%	4	28%	18%	10				
	N	144	214		109	105		255	245		38	71					
B14.d	Extent to which inadequate time to spend with patients during visits limits physician's ability to provide optimal care for their patients.													0.104	0.990	0.432	0.045
	Does not limit	23%	26%	-3	21%	21%	-1	20%	25%	-5	29%	21%	9				
	Limits somewhat	46%	54%	-7	54%	54%	0	58%	53%	5	36%	62%	-26				
	Limits a great deal	31%	20%	11	25%	24%	1	22%	22%	1	34%	17%	17				
	N	144	215		109	105		255	246		38	71					

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

¹ We considered a practice to be a Multi-Payer Advanced Primary Care Practice participant if it participated in any year, 2011–2014 for 2017 Starters, as determined by a file from CMS. A practice was considered to have medical home recognition if it at least one of its primary care providers was listed as having recognition at some point 2014–2017 from the National Community for Quality Assurance (NCQA), a state, the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), or Utilization Review Accreditation Commission (URAC), as determined by the June 2016 (for 2017 Starters) NCQA PCMH file and data extracted from the websites of TJC, AAAHC, URAC, and state-specific sources from October 2016 to February 2017.

Table 3.C.8d. (continued)

² These questions were also asked to physicians whose practices withdrew from CPC+. For these physicians, the questions were asked in the past tense, to reflect their experiences participating in CPC+ in the past.

p.p. = percentage points; n.a. = not applicable because that group of physicians were not asked that question; EHR = electronic health record

Table 3.C.8e. CPC+ and comparison physician responses to other questions, by track, by selected practice characteristics (2017 starters), Medicare SSP Status¹

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Physician use of data feedback																
G1	Physician received data feedback on quality of care for their patients in the past 12 months.		0.087				0.332				0.123				0.935	
	Yes	89%	95%	-6	94%	90%	4	96%	89%	6	92%	91%	1			
	No	8%	3%	5	3%	7%	-4	4%	8%	-4	6%	6%	-1			
	Don't know	3%	3%	1	3%	3%	0	1%	3%	-2	2%	3%	0			
	N	130	165		122	152		142	135		147	179				
G1a	Among physicians that received data feedback on quality of care for their patients, the extent to which physician made changes to how their deliver care in response to this feedback.		0.293				0.843				0.775				0.605	
	Physician made major changes to how they deliver care	14%	7%	6	9%	10%	-1	12%	9%	3	16%	12%	4			
	Physician made minor changes to how they deliver care	71%	78%	-7	81%	78%	3	76%	79%	-2	71%	76%	-5			
	Physician did not make changes to how they deliver care	16%	15%	1	11%	13%	-2	11%	12%	-1	14%	12%	1			
	N	114	154		114	136		134	120		134	159				
G2	Physician received data feedback on health care service utilization for their patients in the past 12 months.		0.823				0.001				0.117				0.000	
	Yes	66%	62%	4	65%	41%	24	70%	57%	13	67%	41%	26			
	No	25%	28%	-3	26%	47%	-21	23%	33%	-10	28%	45%	-17			
	Don't know	9%	10%	-1	9%	12%	-3	7%	10%	-3	5%	14%	-9			
	N	130	166		121	149		142	136		148	176				

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant				
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
G2a	Among physicians that received data feedback on health care service utilization for their patients, the extent to which physician made changes to how they deliver care in response to this feedback.													0.520	0.369	0.157	0.417
	Physician made major changes to how they deliver care	8%	6%	3	6%	9%	-3		6%	7%	-1		8%	12%	-4		
	Physician made minor changes to how they deliver care	68%	64%	4	60%	48%	12		75%	63%	13		59%	48%	11		
	Physician did not make changes to how they deliver care	24%	30%	-7	34%	43%	-9		18%	31%	-12		33%	40%	-7		
	N	85	105		79	61			96	81			99	72			
G3	Physician received data feedback on total cost of health care (reimbursed by insurers to all providers who provide care) for their patients in the past 12 months.													0.616	0.402	0.127	0.122
	Yes	35%	32%	2	20%	18%	2		34%	25%	9		32%	21%	11		
	No	51%	57%	-6	65%	72%	-7		50%	64%	-13		57%	64%	-7		
	Don't know	14%	11%	3	15%	10%	5		15%	11%	4		11%	15%	-4		
	N	127	165		122	152			141	135			149	178			
G3a	Among physicians that received data feedback on the total cost of care for their patients, the extent to which physician made changes to how they deliver care in response to this feedback.													0.685	0.255	0.029	0.903
	Physician made major changes to how they deliver care	8%	5%	3	0%	10%	-10		14%	5%	9		3%	4%	-2		
	Physician made minor changes to how they deliver care	45%	52%	-8	55%	52%	3		71%	55%	17		53%	51%	3		
	Physician did not make changes to how they deliver care	47%	43%	5	45%	38%	7		15%	40%	-26		44%	45%	-1		
	N	41	54		25	28			41	35			44	36			

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
G4	Percentage of physicians who receive data on what insurers paid (reimbursed) for individual specialists for physician's practice's patients.															
	20%	9%	10	0.020	13%	4%	10	0.002	17%	8%	10	0.024	14%	5%	9	0.007
	N	127	166		122	151			141	136			144	177		
G4a	Among physicians who received data on what insurers paid for individual specialists, extent to which the physician considers these cost data when deciding to which specialist to refer a patient.															
	A lot	9%	33%	-24	0%	15%	-15	0.256	22%	8%	14	0.278	14%	23%	-9	0.661
	Some	58%	17%	41	45%	24%	21		24%	45%	-21		43%	19%	24	
	Not very much	21%	46%	-24	41%	47%	-6		53%	36%	16		32%	40%	-8	
	Not at all	11%	4%	7	14%	14%	0		2%	11%	-9		11%	18%	-7	
	N	20	17		16	7			21	11			17	11		
Teamwork																
C1.a	Extent to which physician agrees that "the group of staff and providers I work with the most at this practice site work well together as a team."															
	Strongly disagree	1%	2%	-1	1%	1%	0	0.216	1%	1%	1	0.678	1%	1%	0	0.771
	Disagree	5%	0%	4	2%	4%	-2		1%	1%	0		3%	3%	0	
	Neither disagree nor agree	6%	7%	0	7%	8%	-1		8%	9%	-1		4%	7%	-2	
	Agree	41%	43%	-2	37%	42%	-6		36%	44%	-7		42%	47%	-5	
	Strongly agree	47%	48%	0	54%	46%	8		53%	46%	7		51%	43%	8	
	N	131	166		122	153			142	136			150	181		

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
C1.b	Extent to which physician agrees that "we have a 'we are in it together' attitude at my practice site."															
				0.216				0.917				0.645				0.201
	Strongly disagree	2%	1%	0	1%	2%	-1		3%	1%	2		1%	1%	1	
	Disagree	7%	2%	5	7%	7%	0		2%	3%	-1		6%	6%	0	
	Neither disagree nor agree	8%	11%	-2	6%	9%	-3		13%	12%	1		5%	14%	-9	
	Agree	49%	43%	7	45%	40%	5		44%	43%	1		47%	41%	6	
	Strongly agree	34%	43%	-9	41%	43%	-2		38%	41%	-3		41%	39%	2	
	N	131	166		122	153			142	136			150	181		
C1.c	Extent to which physician agrees that "my professional skills are used to the fullest at my practice site."															
				0.300				0.615				0.574				0.692
	Strongly disagree	0%	1%	-1	1%	3%	-2		1%	3%	-2		1%	2%	-2	
	Disagree	11%	8%	3	14%	8%	6		11%	7%	4		13%	11%	2	
	Neither disagree nor agree	9%	5%	4	12%	13%	-2		10%	8%	2		11%	13%	-2	
	Agree	44%	53%	-9	42%	41%	1		46%	53%	-7		39%	41%	-2	
	Strongly agree	35%	33%	3	32%	35%	-3		32%	29%	3		36%	33%	4	
	N	131	166		122	153			142	136			150	181		
C1.d	Extent to which physician agrees that "it is hard to get things to change at my practice site."															
				0.017				0.071				0.871				0.817
	Strongly disagree	12%	8%	5	8%	8%	1		5%	5%	0		10%	8%	2	
	Disagree	29%	31%	-2	40%	24%	16		32%	34%	-2		29%	30%	-1	
	Neither disagree nor agree	18%	30%	-12	24%	35%	-11		34%	28%	6		32%	31%	0	
	Agree	29%	15%	14	21%	23%	-1		19%	20%	-1		22%	20%	3	
	Strongly agree	11%	16%	-5	6%	11%	-4		10%	13%	-3		7%	11%	-4	
	N	131	166		122	153			142	136			150	181		
C1.e	Extent to which physician agrees that "I can rely on other people at my practice site to do their jobs well."															
				0.247				0.018				0.724				0.348
	Strongly disagree	1%	2%	-1	2%	1%	1		3%	2%	1		1%	2%	0	
	Disagree	8%	3%	6	3%	1%	1		4%	3%	1		4%	4%	1	
	Neither disagree nor agree	13%	16%	-3	8%	22%	-14		11%	17%	-6		7%	14%	-8	
	Agree	52%	49%	3	57%	41%	16		52%	50%	2		55%	51%	4	
	Strongly agree	26%	31%	-5	31%	34%	-3		30%	27%	3		33%	30%	3	
	N	131	165		122	153			142	136			150	181		

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
C1.f	Extent to which physician agrees that "we regularly take time to consider ways to improve how we do things at my practice site."			0.567				0.328				0.004				0.282
	Strongly disagree	2%	0%	2	3%	3%	0	4%	0%	4	0%	3%	-3			
	Disagree	10%	13%	-3	8%	7%	0	2%	13%	-11	8%	9%	-2			
	Neither disagree nor agree	16%	16%	-1	19%	19%	0	16%	17%	-1	21%	17%	4			
	Agree	53%	53%	0	38%	49%	-11	43%	47%	-4	46%	47%	-1			
	Strongly agree	19%	18%	2	32%	21%	11	35%	23%	12	25%	24%	2			
	N	131	166		122	153		142	136		149	181				
Physician satisfaction, burnout, and likelihood to leave the practice																
A1	Extent to which physician agrees with the statement: "Overall, I am satisfied with my current job".			0.515				0.827				0.818				0.470
	Strongly agree	18%	24%	-6	23%	22%	1	24%	20%	4	23%	26%	-3			
	Agree	52%	54%	-2	52%	55%	-3	53%	58%	-5	48%	53%	-5			
	Neither disagree nor agree	10%	7%	2	12%	9%	3	10%	12%	-2	14%	7%	6			
	Disagree	17%	13%	4	8%	11%	-3	8%	7%	1	12%	11%	1			
	Strongly disagree	4%	2%	2	5%	3%	2	5%	3%	2	3%	3%	1			
	N	130	167		121	153		142	136		149	182				

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant				
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
	A2	Using physician's own definition of "burnout," statement which best describes physician's situation at work.				0.086				0.303				0.042			
	I enjoy my work. I have no symptoms of burnout.	8%	13%	-5	12%	8%	4		9%	14%	-4		8%	10%	-2		
	Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.	51%	54%	-3	49%	48%	1		40%	51%	-11		54%	48%	6		
	I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.	31%	26%	5	35%	32%	2		36%	30%	5		24%	31%	-7		
	The symptoms of burnout that I'm experiencing won't go away. I think about frustrations at work a lot.	5%	7%	-2	3%	10%	-7		10%	5%	5		12%	9%	3		
	I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	5%	1%	5	1%	2%	0		5%	0%	5		2%	2%	0		
	N	130	167		122	153			142	136			149	182			
A3.a	Amount of stress physician experiences due to burdensome administrative tasks (such as paperwork related to insurance, pre-authorizations).				0.935				0.032				0.881				0.663
	None	2%	3%	-1	2%	3%	-1		3%	4%	-1		4%	1%	2		
	A little	16%	15%	0	21%	8%	13		16%	14%	3		14%	13%	1		
	Some	39%	38%	1	38%	41%	-4		34%	39%	-4		35%	38%	-3		
	A lot	43%	43%	0	39%	48%	-9		46%	44%	2		48%	47%	1		
	N	131	165		122	153			143	135			150	182			

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
A3.b	Amount of stress physician experiences due to excessive time demands of using EHRs or other health IT.			0.656				0.577				0.254				0.967
	None	5%	9%	-4	7%	4%	3	4%	8%	-4	5%	4%	1			
	A little	16%	16%	-1	19%	15%	4	18%	19%	-2	15%	16%	-1			
	Some	30%	31%	-1	30%	35%	-5	26%	33%	-7	35%	35%	0			
	A lot	49%	44%	5	44%	46%	-2	52%	40%	12	45%	45%	0			
	N	131	167		122	152		143	136		150	181				
A3.c	Amount of stress physician experiences due to insufficient compensation and reimbursement.			0.189				0.488				0.253				0.150
	None	16%	24%	-8	14%	22%	-7	24%	26%	-2	22%	25%	-2			
	A little	31%	28%	2	34%	33%	1	23%	29%	-7	22%	33%	-11			
	Some	37%	27%	10	27%	22%	5	28%	30%	-2	32%	26%	6			
	A lot	17%	21%	-4	24%	23%	1	25%	15%	10	24%	17%	7			
	N	130	167		121	153		143	136		149	182				
A3.d	Amount of stress physician experiences due to lack of control or autonomy.			0.227				0.080				0.028				0.366
	None	15%	23%	-8	13%	18%	-5	10%	22%	-12	18%	21%	-3			
	A little	37%	27%	10	45%	33%	12	41%	32%	9	33%	34%	-2			
	Some	31%	35%	-4	32%	30%	2	30%	35%	-5	34%	25%	9			
	A lot	17%	15%	2	10%	20%	-10	19%	12%	8	15%	19%	-5			
	N	131	166		122	153		143	136		150	182				
A3.e	Amount of stress physician experiences due to inadequate staff support.			0.207				0.602				0.645				0.437
	None	24%	29%	-5	28%	21%	7	24%	26%	-1	29%	21%	9			
	A little	22%	30%	-8	27%	33%	-6	33%	25%	8	25%	29%	-4			
	Some	33%	25%	8	30%	31%	0	26%	31%	-5	27%	31%	-4			
	A lot	21%	16%	5	15%	16%	-1	17%	18%	-1	19%	20%	-1			
	N	131	166		122	153		143	136		150	182				

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
	A4	Likelihood physician will leave current practice within two years.			0.459				0.125				0.605			
	11%	14%	-3		11%	21%	-10		16%	11%	5		11%	16%	-5	
	19%	13%	6		12%	16%	-4		12%	16%	-4		13%	15%	-2	
	37%	33%	4		40%	34%	7		36%	34%	2		35%	40%	-5	
	33%	40%	-7		37%	30%	8		36%	39%	-3		41%	29%	11	
	N	131	166		122	153			143	135			149	182		
Experience with CPC+²																
H1	Overall, extent to which participating in CPC+ changed the quality of care that the physician currently provides to patients.			n.a.				n.a.				n.a.				n.a.
	20%	n.a.	n.a.		13%	n.a.	n.a.		17%	n.a.	n.a.		22%	n.a.	n.a.	
	47%	n.a.	n.a.		63%	n.a.	n.a.		51%	n.a.	n.a.		50%	n.a.	n.a.	
	25%	n.a.	n.a.		12%	n.a.	n.a.		22%	n.a.	n.a.		22%	n.a.	n.a.	
	3%	n.a.	n.a.		3%	n.a.	n.a.		1%	n.a.	n.a.		1%	n.a.	n.a.	
	0%	n.a.	n.a.		0%	n.a.	n.a.		1%	n.a.	n.a.		1%	n.a.	n.a.	
	4%	n.a.	n.a.		8%	n.a.	n.a.		8%	n.a.	n.a.		5%	n.a.	n.a.	
	N	125	n.a.		118	n.a.			137	n.a.			147	n.a.		
H2	Extent to which physician thinks that participating in CPC+ reduced the overall costs of all the health care their patients received.			n.a.				n.a.				n.a.				n.a.
	7%	n.a.	n.a.		4%	n.a.	n.a.		6%	n.a.	n.a.		6%	n.a.	n.a.	
	36%	n.a.	n.a.		32%	n.a.	n.a.		41%	n.a.	n.a.		41%	n.a.	n.a.	
	30%	n.a.	n.a.		26%	n.a.	n.a.		23%	n.a.	n.a.		24%	n.a.	n.a.	
	7%	n.a.	n.a.		14%	n.a.	n.a.		9%	n.a.	n.a.		7%	n.a.	n.a.	
	20%	n.a.	n.a.		24%	n.a.	n.a.		21%	n.a.	n.a.		21%	n.a.	n.a.	
	N	126	n.a.		119	n.a.			137	n.a.			146	n.a.		

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
H3	Overall, considering the amount of work required by CPC+, adequacy of the CPC+ payments from all payers combined.															
				n.a.				n.a.				n.a.				n.a.
	More than adequate	2%	n.a.	n.a.	1%	n.a.	n.a.		3%	n.a.	n.a.		2%	n.a.	n.a.	
	Adequate	25%	n.a.	n.a.	33%	n.a.	n.a.		20%	n.a.	n.a.		22%	n.a.	n.a.	
	Less than adequate	31%	n.a.	n.a.	28%	n.a.	n.a.		40%	n.a.	n.a.		40%	n.a.	n.a.	
	Don't know - not familiar with CPC+ payments from all payers or costs of doing CPC+ work	42%	n.a.	n.a.	38%	n.a.	n.a.		37%	n.a.	n.a.		36%	n.a.	n.a.	
	N	126	n.a.		118	n.a.			137	n.a.			148	n.a.		
H4	Given practice's overall experience participating in CPC+, likelihood physician would recommend that their practice participate in CPC+ if their practice could do it all over again.															
				n.a.				n.a.				n.a.				n.a.
	Very likely	34%	n.a.	n.a.	27%	n.a.	n.a.		32%	n.a.	n.a.		31%	n.a.	n.a.	
	Somewhat likely	35%	n.a.	n.a.	41%	n.a.	n.a.		34%	n.a.	n.a.		40%	n.a.	n.a.	
	Not very likely	10%	n.a.	n.a.	14%	n.a.	n.a.		12%	n.a.	n.a.		10%	n.a.	n.a.	
	Not at all likely	4%	n.a.	n.a.	3%	n.a.	n.a.		3%	n.a.	n.a.		9%	n.a.	n.a.	
	Don't know	17%	n.a.	n.a.	15%	n.a.	n.a.		19%	n.a.	n.a.		10%	n.a.	n.a.	
	N	125	n.a.		118	n.a.			137	n.a.			148	n.a.		

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
H5	Thinking about the individual(s) at their practice site who have made a substantive contribution of time or leadership to implement care delivery changes for CPC+, physician would say:				n.a.				n.a.				n.a.			
	Most or all of the practice site was involved in the substantive work on CPC+	33%	n.a.	n.a.	36%	n.a.	n.a.	n.a.	41%	n.a.	n.a.	n.a.	48%	n.a.	n.a.	n.a.
	A smaller group that included at least one physician did most of the substantive work on CPC+	37%	n.a.	n.a.	40%	n.a.	n.a.	n.a.	33%	n.a.	n.a.	n.a.	35%	n.a.	n.a.	n.a.
	A smaller group that did not include any physicians did most of the substantive work on CPC+	3%	n.a.	n.a.	5%	n.a.	n.a.	n.a.	8%	n.a.	n.a.	n.a.	2%	n.a.	n.a.	n.a.
	One physician did most of the substantive work on CPC+	3%	n.a.	n.a.	2%	n.a.	n.a.	n.a.	0%	n.a.	n.a.	n.a.	1%	n.a.	n.a.	n.a.
	One non-physician did most of the substantive work on CPC+	6%	n.a.	n.a.	5%	n.a.	n.a.	n.a.	4%	n.a.	n.a.	n.a.	3%	n.a.	n.a.	n.a.
	No one at the practice site did much substantive work on CPC+	1%	n.a.	n.a.	2%	n.a.	n.a.	n.a.	3%	n.a.	n.a.	n.a.	0%	n.a.	n.a.	n.a.
	Don't know	17%	n.a.	n.a.	10%	n.a.	n.a.	n.a.	11%	n.a.	n.a.	n.a.	11%	n.a.	n.a.	n.a.
	N	126	n.a.	n.a.	119	n.a.	n.a.	n.a.	137	n.a.	n.a.	n.a.	149	n.a.	n.a.	n.a.
H6	Extent to which physician agrees with the statement: "You were better positioned to meet health care needs for your patients during the coronavirus pandemic because of your practice's participation in CPC+."				n.a.				n.a.				n.a.			
	Strongly disagree	10%	n.a.	n.a.	5%	n.a.	n.a.	n.a.	6%	n.a.	n.a.	n.a.	9%	n.a.	n.a.	n.a.
	Disagree	7%	n.a.	n.a.	14%	n.a.	n.a.	n.a.	10%	n.a.	n.a.	n.a.	11%	n.a.	n.a.	n.a.
	Neither disagree nor agree	33%	n.a.	n.a.	39%	n.a.	n.a.	n.a.	34%	n.a.	n.a.	n.a.	33%	n.a.	n.a.	n.a.
	Agree	26%	n.a.	n.a.	12%	n.a.	n.a.	n.a.	20%	n.a.	n.a.	n.a.	21%	n.a.	n.a.	n.a.
	Strongly agree	4%	n.a.	n.a.	11%	n.a.	n.a.	n.a.	8%	n.a.	n.a.	n.a.	12%	n.a.	n.a.	n.a.
	Don't know	20%	n.a.	n.a.	19%	n.a.	n.a.	n.a.	21%	n.a.	n.a.	n.a.	14%	n.a.	n.a.	n.a.
	N	125	n.a.	n.a.	119	n.a.	n.a.	n.a.	137	n.a.	n.a.	n.a.	149	n.a.	n.a.	n.a.

Table 3.C.8e. (continued)

Question	Track 1 – Medicare SSP ACO Participant				Track 1 – Not a Medicare SSP ACO Participant				Track 2 – Medicare SSP ACO Participant				Track 2 – Not a Medicare SSP ACO Participant			
	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Barriers to providing optimal patient care																
B14.c	Extent to which inadequate reimbursement from insurers for primary care services limits physician's ability to provide optimal care for their patients.			0.728				0.670				0.267				0.665
	Does not limit	46%	51%	-5	45%	41%	4		39%	46%	-7		43%	49%	-5	
	Limits somewhat	42%	37%	5	38%	38%	0		42%	43%	-1		39%	36%	3	
	Limits a great deal	12%	12%	0	16%	21%	-4		19%	11%	8		18%	16%	2	
	N	131	167		122	152			143	136			150	180		
B14.d	Extent to which inadequate time to spend with patients during visits limits physician's ability to provide optimal care for their patients.			0.028				0.766				0.084				0.152
	Does not limit	17%	25%	-8	27%	23%	4		25%	23%	2		19%	26%	-7	
	Limits somewhat	51%	57%	-6	48%	51%	-3		44%	58%	-14		62%	51%	11	
	Limits a great deal	32%	18%	14	25%	26%	-1		31%	19%	12		19%	23%	-4	
	N	131	167		122	153			143	136			150	181		

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

¹ Whether the physician's practice participated in a Medicare SSP accountable care organization at the start of CPC+ (January 1, 2017).

² These questions were also asked to physicians whose practices withdrew from CPC+. For these physicians, the questions were asked in the past tense, to reflect their experiences participating in CPC+ in the past.

p.p. = percentage points; n.a. = not applicable because that group of physicians were not asked that question

Table 3.C.9. CPC+ and comparison physician characteristics and compensation, by track (2017 starters)

Question		Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
		CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Physician characteristics										
2	Percentage of respondents who are physicians (MD or DO).	100%	100%	100%	0		100%	100%	0	
	%	546	253	320			293	318		
	N									
3	Percentage of physicians who provide any primary care to patients at the practice site listed on the survey.	100%	100%	100%	0		100%	100%	0	
	%	545	253	320			292	318		
	N									
11	Distribution of physicians' gender.					0.932				0.975
	Male	54%	55%	55%	0		53%	53%	0	
	Female	46%	45%	45%	0		47%	47%	0	
	N	535	246	313			289	309		
12	Distribution of physicians' age, in years.					0.998				0.999
	Less than 30 years	0%	0%	0%	0		0%	0%	0	
	30-39	12%	11%	12%	-1		13%	13%	0	
	40-49	29%	28%	28%	0		30%	29%	1	
	50-59	29%	30%	30%	1		28%	29%	-1	
	60-69	26%	25%	25%	0		27%	27%	0	
	70 years or older	4%	6%	6%	0		2%	2%	0	
	N	542	250	317			292	313		
13	Percentage of physicians of Hispanic or Latino origin.					0.885				0.996
	%	3%	3%	4%	0		3%	3%	0	
	N	524	241	309			283	307		

Table 3.C.9. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2				
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
14	Distribution of physicians' race (select only one).					0.763				0.713
	White/Caucasian only	81%	82%	82%	0	81%	82%	-1		
	Black or African American only	1%	1%	1%	-1	0%	0%	0		
	Asian only	11%	10%	11%	-1	12%	13%	-1		
	Native Hawaiian or other Pacific Islander only	1%	--	--	--	1%	0%	1		
	American Indian or Alaska Native only	0%	0%	1%	0	0%	0%	0		
	Other	4%	4%	3%	1	4%	4%	0		
	Physician is more than one race	2%	2%	1%	1	2%	1%	1		
	N	531	243	316		288	311			
15	Percentage of physicians that are a part of the leadership that makes decisions about how physicians and staff at their practice site deliver care.					0.346				0.615
	%	53%	55%	51%	4	52%	49%	2		
	N	540	249	317		291	314			
15a ¹	Percentage of CPC+ physicians that are a lead or champion for the implementation of CPC+ at their practice site.					n.a				n.a.
	%	29%	27%	n.a.	n.a.	31%	n.a	n.a		
	N	530	244	n.a.	n.a.	286	n.a	n.a		
16	Percentage of physicians that have worked at the practice site for:					0.201				0.484
	Less than 2 years	6%	6%	3%	3	7%	5%	2		
	2 years up to 5 years	15%	13%	16%	-3	17%	14%	3		
	More than 5 years up to 10 years	20%	23%	19%	4	18%	20%	-2		
	More than 10 years	58%	58%	62%	-4	58%	61%	-3		
	N	539	250	317		289	314			

Table 3.C.9. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2				
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
17	Number of hours physician works at the practice site in a typical work week.					0.854				0.786
	Less than 20 hours	4%	4%	3%	1	5%	4%	0		
	20-39 hours	29%	25%	27%	-2	33%	30%	3		
	40-49 hours	32%	29%	32%	-3	34%	32%	2		
	50-59 hours	21%	26%	23%	4	17%	22%	-5		
	60 hours or more	13%	15%	15%	0	12%	12%	0		
	N	540	250	318		290	314			
18	Number of patients physician sees at the practice site in a typical day.					0.791				0.275
	Mean	19	19	19	0	19	19	-1		
	Median	18	18	19	-1	18	19	-1		
	N	543	251	317		292	313			
18, if 17 = 1	Average number of patients physicians see in a typical day at the practice site listed on the survey, if they work less than 20 hours per week.					0.673				0.903
	Mean	17	18	19	-1	17	17	0		
	Median	18	16	20	-4	18	20	-2		
	N	30	13	13		17	11			
18, if 17 = 2	Average number of patients physicians see in a typical day at the practice site listed on the survey, if they work 20-39 hours per week.					0.918				0.050
	Mean	17	18	18	0	17	18	-1		
	Median	16	18	18	0	16	18	-2		
	N	162	72	83		90	90			

Table 3.C.9. (continued)

Question	Overall (Track 1 and 2)	Overall – Track 1				Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
18, if 17 = 3 Average number of patients physicians see in a typical day at the practice site listed on the survey, if they work 40-49 hours per week.					0.023				0.867
Mean	20	21	19	2		19	19	0	
Median	18	20	18	2		18	18	0	
N	172	74	101			98	100		
18, if 17 = 4 Average number of patients physicians see in a typical day at the practice site listed on the survey, if they work 50-59 hours per week.					0.890				0.603
Mean	20	20	20	0		20	20	1	
Median	20	20	20	0		20	20	0	
N	108	59	71			49	72		
18, if 17 = 5 Average number of patients physicians see in a typical day at the practice site listed on the survey, if they work 60 hours or more hours per week.					0.056				0.143
Mean	19.00	18	21	-3		20	23	-3	
Median	18.00	18	21	-3		18	24	-6	
N	68	32	49			36	40		

Table 3.C.9. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2				
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
Compensation for clinical activities										
E1_a:h_any	Percentage of physicians reporting any compensation for clinical activities from the following categories:									
	Guaranteed or “base” salary (not based on physician’s productivity, the number of patients physician manages, or clinical performance)									
	51%	52%	46%	5	0.268	50%	46%	3	0.463	
	Physician’s own individual productivity (e.g., cash collection, billings, relative value units, visits)									
	76%	78%	83%	-5	0.209	74%	85%	-11	0.003	
	Number of patients physician managed (regardless of amount or type of services provided)									
	20%	18%	20%	-3	0.441	22%	23%	-2	0.622	
	Performance on measures of the quality of care physician provides to patients (e.g., measures of adherence to guidelines, measures of control of chronic conditions)									
	65%	64%	63%	1	0.832	65%	64%	2	0.722	
	Performance on measures of physician’s patients’ satisfaction with the care physician provide (e.g., results of patient satisfaction surveys)									
	28%	29%	40%	-11	0.015	28%	40%	-12	0.004	
	Physician’s management of the health care services physician’s patients use, as compared to other physicians (e.g., use of specialists)									
	9%	10%	11%	-1	0.727	8%	10%	-2	0.560	
	A share of physician’s organization’s profit or net revenue for the year									
	24%	20%	24%	-4	0.301	26%	24%	3	0.486	
	Other payments									
	10%	12%	8%	4	0.127	8%	10%	-2	0.531	
	N	528	241	310		287	306			

Table 3.C.9. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2				
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value	
E1_a:h_hun dred	Percentage of physicians reporting 100% compensation from the following categories:									
Guaranteed or "base" salary (not based on physician's productivity, the number of patients physician manages, or clinical performance)	12%	12%	7%	4	0.132	12%	7%	6	0.033	
Physician's own individual productivity (e.g., cash collection, billings, relative value units, visits)	8%	10%	12%	-2	0.470	7%	11%	-4	0.115	
Number of patients physician managed (regardless of amount or type of services provided)	0%	0%	0%	0	0.558	0%	1%	-1	0.199	
Performance on measures of the quality of care physician provides to patients (e.g., measures of adherence to guidelines, measures of control of chronic conditions)	0%	0%	0%	0	--	0%	0%	0	--	
Performance on measures of physician's patients' satisfaction with the care physician provide (e.g., results of patient satisfaction surveys)	0%	0%	0%	0	--	0%	0%	0	--	
Physician's management of the health care services physician's patients use, as compared to other physicians (e.g., use of specialists)	0%	0%	0%	0	--	0%	0%	0	--	
A share of physician's organization's profit or net revenue for the year	0%	0%	1%	-1	0.238	0%	1%	-1	0.350	
Other payments	1%	1%	1%	0	0.581	0%	1%	-1	0.278	
N	528	241	310			287	306			

Table 3.C.9. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
Among all physician respondents:									
E1_a	Guaranteed or "base" salary (not based on physician's productivity, the number of patients physician manages, or clinical performance)				0.179				0.135
	Mean %	39%	39%	34%	5	39%	33%	6	
	Min %	0%	0%	0%	0	0%	0%	0	
	Max %	100%	100%	100%	0	100%	100%	0	
	N	528	241	310		287	306		
E1_b	Physician's own individual productivity (e.g., cash collection, billings, relative value units, visits)				0.049				0.043
	Mean %	44%	44%	52%	-8	44%	51%	-7	
	Min %	0%	0%	0%	0	0%	0%	0	
	Max %	100%	100%	100%	0	100%	100%	0	
	N	528	241	310		287	306		
E1_c	Number of patients physician managed (regardless of amount or type of services provided)				0.731				0.704
	Mean %	3%	3%	3%	0	3%	4%	0	
	Min %	0%	0%	0%	0	0%	0%	0	
	Max %	100%	100%	100%	0	85%	85%	0	
	N	528	241	310		287	306		
E1_d	Performance on measures of the quality of care physician provides to patients (e.g., measures of adherence to guidelines, measures of control of chronic conditions)				0.081				0.023
	Mean %	7%	6%	5%	1	7%	5%	2	
	Min %	0%	0%	0%	0	0%	0%	0	
	Max %	50%	40%	40%	0	50%	50%	0	
	N	528	241	310		287	306		

Table 3.C.9. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
E1_e	Performance on measures of physician's patients' satisfaction with the care physician provide (e.g., results of patient satisfaction surveys)				0.981				0.010
	Mean %	2%	2%	2%	0	1%	2%	-1	
	Min %	0%	0%	0%	0	0%	0%	0	
	Max %	70%	70%	70%	0	20%	20%	0	
	N	528	241	310		287	306		
E1_f	Physician's management of the health care services physician's patients use, as compared to other physicians (e.g., use of specialists)				0.989				0.455
	Mean %	1%	1%	1%	0	0%	1%	0	
	Min %	0%	0%	0%	0	0%	0%	0	
	Max %	20%	20%	20%	0	20%	20%	0	
	N	528	241	310		287	306		
E1_g	A share of physician's organization's profit or net revenue for the year				0.661				0.619
	Mean %	3%	3%	3%	0	4%	3%	1	
	Min %	0%	0%	0%	0	0%	0%	0	
	Max %	100%	100%	100%	0	100%	100%	0	
	N	528	241	310		287	306		
E1_h	Other payments				0.544				0.410
	Mean %	2%	3%	2%	1	1%	2%	-1	
	Min %	0%	0%	0%	0	0%	0%	0	
	Max %	100%	100%	100%	0	100%	100%	0	
	N	528	241	310		287	306		

Table 3.C.9. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
E1_a:h_an y = 1	Among physician respondents with any compensation:								
E1_a	Guaranteed or “base” salary (not based on physician’s productivity, the number of patients physician manages, or clinical performance)								
	77%	76%	74%	1	0.634	78%	71%	7	0.014
	Mean percentage of their total compensation								
	Min %	5%	5%	5%	0	10%	5%	5	
	Max %	100%	100%	100%	0	100%	100%	0	
	N	272	124	148		148	147		
E1_b	Physician’s own individual productivity (e.g., cash collection, billings, relative value units, visits)								
	58%	56%	62%	-6	0.122	59%	60%	-1	0.772
	Mean percentage of their total compensation								
	Min %	1%	1%	2%	-1	1%	2%	-1	
	Max %	100%	100%	100%	0	100%	100%	0	
	N	402	187	254		215	255		
E1_c	Number of patients physician managed (regardless of amount or type of services provided)								
	17%	18%	15%	3	0.522	16%	16%	0	0.991
	Mean percentage of their total compensation								
	Min %	1%	1%	1%	0	1%	1%	0	
	Max %	100%	100%	100%	0	85%	100%	-15	
	N	109	41	59		68	68		

Table 3.C.9. (continued)

Question		Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
		CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
E1_d	Performance on measures of the quality of care physician provides to patients (e.g., measures of adherence to guidelines, measures of control of chronic conditions)					0.100				0.004
	Mean percentage of their total compensation	10%	10%	8%	1		10%	8%	2	
	Min %	1%	1%	1%	0		1%	1%	0	
	Max %	50%	40%	90%	-50		50%	90%	-40	
	N	340	153	196			187	195		
E1_e	Performance on measures of physician's patients' satisfaction with the care physician provide (e.g., results of patient satisfaction surveys)					0.275				0.659
	Mean percentage of their total compensation	5%	6%	5%	1		5%	5%	0	
	Min %	1%	1%	1%	0		1%	1%	0	
	Max %	70%	70%	30%	40		20%	30%	-10	
	N	158	71	124			87	123		
E1_f	Physician's management of the health care services physician's patients use, as compared to other physicians (e.g., use of specialists)					0.997				0.936
	Mean percentage of their total compensation	6%	7%	7%	0		6%	6%	0	
	Min %	1%	1%	1%	0		1%	1%	0	
	Max %	20%	20%	25%	5		20%	25%	5	
	N	47	23	33			24	31		
E1_g	A share of physician's organization's profit or net revenue for the year					0.299				0.817
	Mean percentage of their total compensation	14%	16%	12%	4		13%	13%	1	
	Min %	1%	1%	1%	0		1%	1%	0	
	Max %	100%	100%	100%	0		100%	100%	0	
	N	122	48	73			74	72		

Table 3.C.9. (continued)

Question	Overall (Track 1 and 2)		Overall – Track 1			Overall – Track 2			
	CPC+ Physicians	CPC+	Comparison	Difference (p.p.)	p-value	CPC+	Comparison	Difference (p.p.)	p-value
E1_h	Other payments								
	Mean percentage of their total compensation								
	19%	21%	25%	-3	0.731	17%	22%	-5	0.512
	1%	1%	2%	-1		1%	1%	0	
	100%	100%	100%	0		100%	100%	0	
	N	52	27	25		25	29		

Source: CPC+ Physician Survey administered to physicians at the 2017 Starter CPC+ and Comparison practices April through August 2021.

Abbreviations:

¹ This question was also asked to physicians whose practices withdrew from CPC+. For these physicians, the question was asked in the past tense, to reflect their experiences participating in CPC+ in the past.

p.p. = percentage points; n.a. = not applicable because that group of physicians were not asked that question; MD = doctor of medicine; DO = doctor of osteopathic medicine

3.C.6. Physician Survey Instrument



Comprehensive Primary Care Plus (CPC+)

2021 Primary Care Physician Survey

FINAL: APRIL 2021 (not for circulation)

SPONSORED BY

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

**[PRACTICENAME]
[PHYSICALADDRESS1], [PHYSICALADDRESS2]
[PHYSICALCITY], [PHYSICALSTATE] [PHYSICALZIP]**

Citation: Mathematica. "Evaluation of the Comprehensive Primary Care Plus (CPC+) Model – 2021 Primary Care Physician Survey." Princeton, NJ: Mathematica, April 2021.

[FOR TREATMENT ONLY]

The 2021 Comprehensive Primary Care Plus (CPC+) Physician Survey is a critical component of the study of the CPC+ initiative, sponsored by the Centers for Medicare & Medicaid Services (CMS).

We are collecting information from primary care physicians whose practices are participating in CPC+ in order to learn how CPC+ is affecting job satisfaction and burnout, and changing how physicians deliver care. You have been randomly selected to complete the survey to help us understand these important issues. Sharing your experiences can help shape future Medicare policies for primary care. This survey is being conducted by Mathematica, an independent research company hired by CMS.

We encourage you to respond candidly. Your responses to this survey are collected in a confidential manner and will be anonymous in all reports (i.e., will never be linked to your name or your practice in any reports to your practice, CMS, other payers, or the public). Our independent research team will use your data to study the effects of CPC+. Your responses will not have any consequences for payment or for your participation in CPC+. We are genuinely interested in your observations about how you currently deliver care. Your participation in the survey is voluntary but very important.

Please accept the \$100 check (enclosed in the FedEx invitation packet mailed to you in April) as a token of our appreciation for completing the questionnaire, which should take about 20 to 25 minutes.

Questions? Contact Mathematica's toll-free helpline at 1-833-359-9477 or email at CPCplus-PhysicianSurvey@mathematica-mpr.com.

[TREATMENT WITHDRAWN]

The 2021 Comprehensive Primary Care Plus (CPC+) Physician Survey is a critical component of the study of the CPC+ initiative, sponsored by the Centers for Medicare & Medicaid Services (CMS).

In order to understand the broader context in which CPC+ is operating, we are collecting information from primary care physicians whose practices are no longer participating in the CPC+ initiative. This information will help us learn how CPC+ is affecting job satisfaction and burnout, and changing how physicians deliver care. You have been randomly selected to complete the survey to help us understand these important issues. Sharing your experiences can help shape future Medicare policies for primary care. This survey is being conducted by Mathematica, an independent research company hired by CMS.

We encourage you to respond candidly. Your responses to this survey are collected in a confidential manner and will be anonymous in all reports (i.e., will never be linked to your name or your practice in any reports). Our independent research team will use your data to study the effects of CPC+. We are genuinely interested in your observations about how you currently deliver care. Your participation in the survey is voluntary but very important.

Please accept the \$100 check (enclosed in the FedEx invitation packet mailed to you April) as a token of our appreciation for completing the questionnaire, which should take about [*recent TWD*: 20 to 25 minutes/*older TWD*:15 to 20 minutes].

Questions? Contact Mathematica's toll-free helpline at 1-833-359-9477 or email at CPCplus-physiciansurvey@mathematica-mpr.com.

[FOR COMPARISON ONLY]

The 2021 Comprehensive Primary Care Plus (CPC+) Physician Survey is a critical component of the study of the CPC+ initiative, sponsored by the Centers for Medicare & Medicaid Services (CMS), which seeks to improve the quality of primary care (<https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>).

Even though your practice is not participating in CPC+, we must collect information from primary care physicians whose practices are not participating (as well as primary care physicians whose practices are participating). This information will help us learn how CPC+ is affecting job satisfaction and burnout, and changing how physicians deliver care. You have been randomly selected to complete the survey to help us understand these important issues. Sharing your experiences can help shape future Medicare policies for primary care. This survey is being conducted by Mathematica, an independent research company hired by CMS.

We encourage you to respond candidly. Your responses to this survey are collected in a confidential manner and will be anonymous in all reports (i.e., will never be linked to your name or your practice in any reports). Our independent research team will use your data to study the effects of CPC+. We are genuinely interested in your observations about how you currently deliver care. Your participation in the survey is voluntary but very important.

Please accept the \$100 check (enclosed in the FedEx invitation packet mailed to you in April) as a token of our appreciation for completing the questionnaire, which should take about 15 to 20 minutes.

Questions? Contact Mathematica's toll-free helpline at 1-833-359-9477 or email at CPCplus-PhysicianSurvey@mathematica-mpr.com.

IMPORTANT DEFINITIONS FOR THIS SURVEY

Practice site:

- Your practice site is identified on the cover of this questionnaire. If you work at multiple practice sites, please respond only about your work at this site.

Primary care:

- The first point of contact in the health care system. It refers to continuous and comprehensive care across a patient's needs and conditions, rather than focusing on just one body system. Primary care also includes coordination with specialists the patient may see.

Care team:

- You and the health professionals (physicians, nurse practitioners, physician assistants, nurses, medical assistants, clinical pharmacists, and other health care professionals) with whom you work to provide primary care to your patients.

INSTRUCTIONS FOR COMPLETING THE SURVEY [HARDCOPY VERSION]

- Answer all questions to the best of your ability and be as accurate as possible.
- For each item, please mark only one answer unless the instructions say to "MARK ALL THAT APPLY."
- Some answer options are followed by a directional arrow (→) and a "GO TO" instruction. After marking your response, please proceed to the appropriate question, as indicated by the arrow and "GO TO" instruction.
- If no instruction is provided, you should continue to the next question.
- You may use either pen or pencil.
- Mailing instructions for the completed questionnaire are provided after the last survey question.

PRACTICE SITE AND PHYSICIAN INFORMATION

Before we start the survey, we would like to quickly confirm information for the practice site you will be answering the survey questions about.

1. Please review the contact information below for your practice site. Is all of this information correct?

Practice Site Name

Physical Street Address 1

Physical Street Address 2

Physical City

Physical State

Physical ZIP Code

1 Yes → GO TO 2

0 No

- 1a. Please provide updated contact information for your practice site.

Practice Site Name:

Street Address 1:

Street Address 2:

City:

State:

Zip Code:

2. Are you a physician (MD or DO)?

1 Yes

0 No → At this time, we are only surveying MDs and DOs.
GO TO PAGE 23 FOR INSTRUCTIONS ON RETURNING THIS
QUESTIONNAIRE

3. Do you provide any primary care to patients at the practice site listed at 1 or 1a above?

1 Yes

0 No → **At this time, we are only surveying physicians who work at the practice site listed above. GO TO PAGE 23 FOR INSTRUCTIONS ON RETURNING THIS QUESTIONNAIRE**

4. What is your email address? (We will only use this information to follow-up with you about the survey, if needed.)

IMPORTANT REMINDER:

PLEASE COMPLETE THIS SURVEY FOR THE PRACTICE SITE LISTED AT 1 OR 1A ABOVE.

A. JOB SATISFACTION

A1. Please indicate how much you agree or disagree with the following statement:

Overall, I am satisfied with my current job.

1 Strongly disagree

2 Disagree

3 Neither disagree nor agree

4 Agree

5 Strongly agree

A2. Using your own definition of “burnout,” please indicate which statement best describes your situation at work.

1 I enjoy my work. I have no symptoms of burnout.

2 Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.

3 I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.

4 The symptoms of burnout that I'm experiencing won't go away. I think about frustrations at work a lot.

5 I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.

A3. How much stress, if any, do you experience due to each of the following factors?

MARK ONE RESPONSE PER ROW

	NONE	A LITTLE	SOME	A LOT
a. Burdensome administrative tasks (such as paperwork related to insurance, pre-authorizations)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Excessive time demands of using EHRs or other health IT	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Insufficient compensation and reimbursement	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Lack of control or autonomy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Inadequate staff support	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

A4. What is the likelihood that you will leave your current practice within two years?

- 1 Very likely
- 2 Somewhat likely
- 3 Not very likely
- 4 Not at all likely

B. APPROACHES TO PROVIDING PRIMARY CARE

B1. Is counseling for behavioral or mental health problems available to your patients on-site, at your office?

- 1 Yes
- 0 No

B2. How many of your adult patients (age 18 and older) are screened at least once a year with a formal screening tool for each of these conditions?

[MARK/SELECT] ONE RESPONSE PER ROW

<i>Condition (examples of formal screening tools)</i>	NONE	SOME	MANY	MOST OR ALL
a. Depression (such as PHQ-2 or PHQ-9)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Anxiety (such as GAD-7)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Substance use (such as CAGE, AUDIT-C, or DAST)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Adult attention-deficit/hyperactivity disorder (such as Adult ADHD self-report tool)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

B3. How many of your patients age 65 and older are screened for dementia at least once a year with a formal screening tool (such as Mini-Mental State Examination or Mini-Cog)?

- 1 None
- 2 Some
- 3 Many
- 4 Most or all

B4. For how many of your patients do you (or someone from your care team) offer scheduled phone, video, or e-visits?

- 1 None → **GO TO B5**
- 2 Some
- 3 Many
- 4 Most or all

B4a. How often do these scheduled phone, video, or e-visits replace what would have been face-to-face office visits for these patients?

- 1 Never or rarely
- 2 Sometimes
- 3 Frequently
- 4 Usually or always

B5. For how many of your frail or homebound patients do you (or someone from your care team) offer home visits?

- 1 None
- 2 Some
- 3 Many
- 4 Most or all

B6. How many of your hospitalized patients do you (or someone from your care team) visit in the hospital in a professional capacity?

- 1 None
- 2 Some
- 3 Many
- 4 Most or all

B. APPROACHES TO PROVIDING PRIMARY CARE (CONTINUED)

The four response boxes in each row below represent different approaches to providing a specific aspect of primary care. For each row, **please [mark/select] the box** that best describes the level of care you currently provide.

<p>B7. When your patients come to your practice for <u>acute care</u>, they see <u>you</u> ...</p>	<p>...never or rarely.</p> <p style="text-align: center;">1 <input type="checkbox"/></p>	<p>...sometimes.</p> <p style="text-align: center;">2 <input type="checkbox"/></p>	<p>...frequently.</p> <p style="text-align: center;">3 <input type="checkbox"/></p>	<p>...usually or always.</p> <p style="text-align: center;">4 <input type="checkbox"/></p>
<p>B8. Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP/CNS, or answering service ...</p>	<p>...is <u>not available</u> or is limited to an answering machine.</p> <p style="text-align: center;">1 <input type="checkbox"/></p>	<p>...is (1) <u>always available</u>, but (2) the practitioner on call <u>does not regularly</u> communicate problems and decisions back to you.</p> <p style="text-align: center;">2 <input type="checkbox"/></p>	<p>...is (1) always available, and (2) the practitioner on call <u>regularly</u> communicates problems and decisions back to you, but (3) <u>does not</u> have real-time access to the practice's electronic health record (EHR) system.</p> <p style="text-align: center;">3 <input type="checkbox"/></p>	<p>...is (1) always available, and (2) the practitioner on call <u>regularly</u> communicates problems and decisions back to you, and (3) <u>does</u> have real-time access to the practice's EHR system.</p> <p style="text-align: center;">4 <input type="checkbox"/></p>
<p>B9. Follow-up by you or your practice with your patients who had emergency department (ED) or hospital visits ...</p>	<p>...generally <u>does not</u> occur.</p> <p style="text-align: center;">1 <input type="checkbox"/></p>	<p>...occurs <u>only</u> if the ED or hospital alerts you or your practice.</p> <p style="text-align: center;">2 <input type="checkbox"/></p>	<p>...occurs because <u>you or your practice makes proactive efforts</u> to identify these patients.</p> <p style="text-align: center;">3 <input type="checkbox"/></p>	<p>...is done routinely because <u>you or your practice has arrangements in place</u> with the ED and hospital to track these patients and ensure that follow-up occurs within a few days.</p> <p style="text-align: center;">4 <input type="checkbox"/></p>
<p>B10. Linking your patients to supportive community-based resources (e.g., transportation, caregiver support, housing) ...</p>	<p>...is <u>not done systematically</u> by you or your practice.</p> <p style="text-align: center;">1 <input type="checkbox"/></p>	<p>...is limited to <u>providing your patients a list</u> of identified community resources.</p> <p style="text-align: center;">2 <input type="checkbox"/></p>	<p>...is accomplished by a <u>designated staff person</u> who is responsible for connecting your patients with community resources.</p> <p style="text-align: center;">3 <input type="checkbox"/></p>	<p>...is accomplished by a designated staff person who <u>actively coordinates</u> and follows up with the community service agencies and your patients.</p> <p style="text-align: center;">4 <input type="checkbox"/></p>

<p>B11. You (or someone from your care team) <u>document</u> advance care preferences (e.g., for end-of-life care and/or advance directives for when patients might become too sick to make their own decisions) in your electronic health record (EHR) for ...</p>	<p>...none of your high-risk patients.</p> <p style="text-align: center;">1 <input type="checkbox"/></p>	<p>...some of your high-risk patients.</p> <p style="text-align: center;">2 <input type="checkbox"/></p>	<p>...many of your high-risk patients.</p> <p style="text-align: center;">3 <input type="checkbox"/></p>	<p>...most or all of your high-risk patients.</p> <p style="text-align: center;">4 <input type="checkbox"/></p>
--	--	--	--	---

B12. When you refer a patient to a specialist, how often do you send the specialist notification of the patient’s history and reason for the consultation?

- 1 Always or most of the time
- 2 Sometimes
- 3 Seldom or never
- NA Not applicable

B13. How often do you receive useful information about your referred patients from specialists?

- 1 Always or most of the time
- 2 Sometimes
- 3 Seldom or never
- NA Not applicable

B14. How much does each of the following factors limit your ability to provide optimal care for your patients?

[MARK/SELECT] ONE RESPONSE PER ROW

	DOES NOT LIMIT	LIMITS SOMEWHAT	LIMITS A GREAT DEAL
a. Lack of available behavioral health specialists for consultations and/or referrals	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Lack of available medical or surgical specialists for consultations and/or referrals	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Inadequate reimbursement from insurers for primary care services	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Inadequate time to spend with patients during visits	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

C. TEAMWORK AND STAFFING AT YOUR PRACTICE SITE

C1. How much do you agree or disagree with each of the following statements related to teamwork at your practice site?

[MARK/SELECT] ONE RESPONSE PER ROW

	STRONGLY DISAGREE	DISAGREE	NEITHER DISAGREE NOR AGREE	AGREE	STRONGLY AGREE
a. The group of staff and providers I work with the most at this practice site work well together as a team	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. We have a “we are in it together” attitude at my practice site	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. My professional skills are used to the fullest at my practice site	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. It is hard to get things to change at my practice site	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e. I can rely on other people at my practice site to do their jobs well	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f. We regularly take time to consider ways to improve how we do things at my practice site	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

C2. At this practice site, how are medical assistants organized to work with you?

- 1 You are paired with the same medical assistant(s) most days
- 2 You are not paired with the same medical assistant(s) most days
- 3 You don't work with medical assistants

C3. At this practice site, how are nurses organized to work with you?

- 1 You are paired with the same nurse(s) most days
- 2 You are not paired with the same nurse(s) most days
- 3 You don't work with nurses

- C4. Care team huddles are brief meetings among physicians and staff such as nurses and medical assistants. They are typically held before morning or afternoon patient visits to discuss patient-specific issues and keep the core clinical team informed.**

How often do you have huddles with your care team?

- 1 Never
2 On some days
3 On most days
4 Every day

The next set of questions is about designated care managers whose primary role is to help high-risk patients (patients at highest risk for adverse and potentially preventable outcomes). Care managers provide ongoing support and education on chronic care management, and help coordinate care from other providers between and during visits. A designated care manager, which some practices call a care coordinator or patient navigator, can work on-site or off-site, and works to support the primary care provided by the physician.

- C5. Does your practice use designated care managers, as defined above?**

- 1 Yes
0 No → GO TO SECTION D

- C6. How many designated care managers work on-site, at the practice site listed [on the cover of this questionnaire/at the top of this web-page]? Please include only staff who are located on-site at least once per week, regardless of who employs them.**

Please enter “0” if you do not have any designated care managers who work on-site at least once per week.

____ Number of designated care managers who work on-site

- C7. Does your practice use any designated care managers who are always located off-site?**

- 1 Yes
0 No

- C8. On average, about how often do designated care managers engage in meetings, huddles, or conversations with you about your high-risk patients whom they manage? Please consider on-site and off-site designated care managers.**

- 1 Daily
2 Weekly
3 Monthly
4 A few times per year
5 Less than once per year or never

D. CARE MANAGEMENT AT YOUR PRACTICE SITE

D1. Some practices or health systems categorize their entire patient population into groups (such as high, medium, or low risk) based on the patient's overall risk level for adverse and potentially preventable outcomes, such as ED visits or hospitalizations.

Does your practice or health system categorize your patients into risk levels using a standard method, tool, or algorithm?

- 1 Yes
- 0 No → GO TO D2

D1a. Do you (or someone from your care team) use the overall risk level to identify patients for care management?

- 1 Yes
- 0 No

D2. A care plan is a structured, personalized plan of care developed with patient input and documented by you or someone from your care team. A care plan is more comprehensive than an after-visit summary, a hospital discharge plan, or a standard treatment/action plan for a single condition (such as diabetes or congestive heart failure).

For about how many of your high-risk patients do you (or someone from your care team) develop a care plan, as defined above?

- 1 None → GO TO E1
- 2 Some
- 3 Many
- 4 Most or all

D2a. How often are the following elements included in the care plans developed for your high-risk patients?

[MARK/SELECT] ONE RESPONSE PER ROW

	NEVER OR RARELY	SOMETIMES	FREQUENTLY	USUALLY OR ALWAYS	DON'T KNOW
a. Patient diagnoses	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
b. Treatment goals identified by the care team	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
c. Health goals identified collaboratively with the patient	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
d. Patient concerns or barriers to meeting health goals	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
e. Patient self-management action steps	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
f. Advance directives	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>

D2b. How often are the care plans that are developed for your high-risk patients used in the following ways?

[MARK/SELECT] ONE RESPONSE PER ROW

	NEVER OR RARELY	SOMETIMES	FREQUENTLY	USUALLY OR ALWAYS	DON'T KNOW
a. Used by you <u>personally</u> in ongoing care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
b. Documented in your practice's electronic health record (EHR) or other health information technology (IT)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
c. Shared with your patients	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>
d. Revised or redeveloped after major events, such as hospital discharge, exacerbation of a condition, or change in patient preferences	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	d <input type="checkbox"/>

E. YOUR COMPENSATION

E1. What percentage of your total compensation for clinical activities is based on the following ways physicians can be paid? Please provide your best estimate. Enter “0” if a category does not apply.

The total percentage of your compensation should sum to 100%.

	PERCENTAGE OF YOUR COMPENSATION
a. Guaranteed or “base” salary (not based on your productivity, the number of patients you manage, or clinical performance)	_ _ _ _ %
b. Your own individual productivity (e.g., cash collection, billings, relative value units, visits)	_ _ _ _ %
c. Number of patients you managed (regardless of amount or type of services provided)	_ _ _ _ %
d. Performance on measures of the quality of care you provide to your patients (e.g., measures of adherence to guidelines, measures of control of chronic conditions)	_ _ _ _ %
e. Performance on measures of your patients’ satisfaction with the care you provide (e.g., results of patient satisfaction surveys)	_ _ _ _ %
f. Your management of the health care services your patients use, as compared to other physicians (e.g., use of specialists)	_ _ _ _ %
g. A share of your organization’s profit or net revenue for the year	_ _ _ _ %
h. Other payments (<i>please describe</i>)	_ _ _ _ %

	SUM = 100%

F. HEALTH INFORMATION TECHNOLOGY (IT)

F1. Did you or someone from your care team routinely use your practice’s electronic health record (EHR) or other health IT to perform the following activities in the past six months?

[MARK/SELECT] ONE RESPONSE PER ROW

	YES: ROUTINELY USED FUNCTION IN EHR OR HEALTH IT	NO: FUNCTION NOT AVAILABLE IN EHR OR HEALTH IT, OR DID NOT ROUTINELY USE FUNCTION
a. Document patients’ health-related social needs (e.g., for transportation, caregiver support, housing)	1 <input type="checkbox"/>	0 <input type="checkbox"/>
b. Track referral and consultation communications with other providers	1 <input type="checkbox"/>	0 <input type="checkbox"/>
c. Identify gaps in care (e.g., recommended screening tests)	1 <input type="checkbox"/>	0 <input type="checkbox"/>
d. Identify and track patients with specific health conditions, risk states, or medications.	1 <input type="checkbox"/>	0 <input type="checkbox"/>

**F2. Please indicate how much you agree or disagree with the following statement:
This practice’s EHR (or other health IT) is a big help to me in providing quality care to my patients.**

- 1 Strongly disagree
- 2 Disagree
- 3 Neither disagree nor agree
- 4 Agree
- 5 Strongly agree

G. DATA FEEDBACK YOU RECEIVED

Physicians may receive data feedback on their performance, including feedback on quality, cost, or utilization. This data feedback may be internally generated by you, your practice, or the organization that owns your practice. It may also be provided by external sources, such as private health insurance plans, state health agencies, Medicaid, or Medicare. The questions in this section are about any feedback or performance data that you may have received in the past 12 months.

G1. In the past 12 months, have you received data feedback on quality of care for your patients?

Examples of data feedback on quality of care include percentage of your patients with diabetes with a recent eye exam, or percentage of adults age 50–75 who had appropriate screening for colorectal cancer.


- 1 Yes
 0 No
 d Don't know
- 

G1a. In response to this data feedback on quality of care, did you make any changes to how you deliver care?

- 1 No, you made no changes to how you deliver care
 2 Yes, you made minor changes to how you deliver care
 3 Yes, you made major changes to how you deliver care

G2. In the past 12 months, have you received data feedback on health care service utilization for your patients?


Examples of data feedback on health care service utilization include number of hospitalizations or ED visits.

- 1 Yes
 0 No
 d Don't know
- 

G2a. In response to this data feedback on health care service utilization, did you make any changes to how you deliver care?

- 1 No, you made no changes to how you deliver care
 2 Yes, you made minor changes to how you deliver care
 3 Yes, you made major changes to how you deliver care

G3. In the past 12 months, have you received data feedback on the total cost of health care (reimbursement by insurers to all providers who provide care) for any of your patients?

- 1 Yes
 - 0 No
 - d Don't know
- 

G3a. In response to this data feedback on the total cost of health care, did you make any changes to how you deliver care?

- 1 No, you made no changes to how you deliver care
- 2 Yes, you made minor changes to how you deliver care
- 3 Yes, you made major changes to how you deliver care

G4. Some practices get data on their patients' costs (that is, reimbursement by insurers), presented separately for the individual specialists seen. For example, if the practice's patients have seen Dr. Smith and Dr. Jones for cardiology services, the data will present the costs for Dr. Smith and the costs for Dr. Jones.

Do you receive any data on what insurers paid (reimbursed) for individual specialists for your practice's patients? Data can be presented as actual dollar costs or categories (low, medium, high cost).

- 1 Yes
- 0 No → GO TO SECTION H, PAGE 20

G4a. When deciding which specialist to refer a patient to, how much do you consider these cost data?

- 1 A lot
- 2 Some
- 3 Not very much
- 4 Not at all

H. YOUR IMPRESSIONS OF CPC+ [PARTICIPATING T AND RECENT TWD ONLY]

Your practice site [*T use*: participates; *recent TWD use*: recently participated] in CPC+, which supports specific care delivery approaches (for example, providing 24/7 access to a care team practitioner and risk stratifying patients). CPC+ provides participating practices with financial incentives, learning activities, and data feedback, and requires them to meet annual care delivery requirements and submit regular reports.

The next questions are about your practice site's [*recent TWD insert*: past] participation in CPC+. We encourage you to answer freely so that we can understand the strengths and weaknesses of CPC+. **As a reminder, your responses to this survey will never be linked to your name or practice in any reports to your practice, CMS or other payers, or the public.** Your responses will only be reported in aggregate (with all physicians combined).

- H1. [*T use*: Overall, how much has participating in CPC+ changed the quality of care that you currently provide to your patients?; *recent TWD use*: Overall, how much did participating in CPC+ change the quality of care that you provided to your patients?]
- 1 Improved a lot
 - 2 Improved somewhat
 - 3 Did not change
 - 4 Worsened somewhat
 - 5 Worsened a lot
 - d Don't know
- H2. How much do you think participating in CPC+ reduced the overall costs of all the health care your patients received?
- 1 A lot
 - 2 Some
 - 3 Not very much
 - 4 Not at all
 - d Don't know
- H3. Overall, considering the amount of work required by CPC+, how adequate or inadequate do you think the CPC+ payments from all payers combined [*T use*: are; *recent TWD use*: were]?
- 1 More than adequate
 - 2 Adequate
 - 3 Less than adequate
 - d Don't know – not familiar with CPC+ payments from all payers or costs of doing CPC+ work

H4. In answering this question, please consider:

- Improvements made to your practice site’s care delivery
- CPC+ participation requirements (including care delivery, health IT, and reporting requirements)
- CPC+ supports (payments, learning activities, data feedback, and health IT vendor support)

Given your practice’s overall experience participating in CPC+, how likely is it that you would recommend that your practice participate in CPC+ if your practice could do it all over again?

- 1 Very likely
- 2 Somewhat likely
- 3 Not very likely
- 4 Not at all likely
- d Don’t know

H5. Thinking about the individual(s) at your practice site who have made a substantive contribution of time or leadership to implement care delivery changes for CPC+, would you say that:

- 1 Most or all of the practice site was involved in the substantive work on CPC+
- 2 A smaller group that included at least one physician did most of the substantive work on CPC+
- 3 A smaller group that did not include any physicians did most of the substantive work on CPC+
- 4 One physician did most of the substantive work on CPC+
- 5 One non-physician did most of the substantive work on CPC+
- 6 No one at the practice site did much substantive work on CPC+
- d Don’t know

H6. Please indicate how much you agree or disagree with the following statement.

You were better positioned to meet health care needs for your patients during the coronavirus pandemic because of your practice’s participation in CPC+.

- 1 Strongly disagree
 - 2 Disagree
 - 3 Neither disagree nor agree
 - 4 Agree
 - 5 Strongly agree
 - d Don’t know
-

H6a. [If H6 = 1, 2, 3, 4, or 5] Please describe how, if at all, participation in CPC+ affected your ability to meet health care needs for your patients during the coronavirus pandemic.

I. BACKGROUND CHARACTERISTICS

This final section asks basic information about you and your work schedule. This information will be aggregated and used to generally describe survey participants.

I1. What is your gender?

- 1 Male
- 2 Female

I2. What is your current age in years?

- 1 Less than 30 years
- 2 30–39
- 3 40–49
- 4 50–59
- 5 60–69
- 6 70 years or older

I3. Are you of Hispanic or Latino origin?

- 1 Yes
- 0 No

I4. What is your race?

[MARK/SELECT] ALL THAT APPLY

- 1 White/Caucasian
 - 2 Black or African American
 - 3 Asian
 - 4 Native Hawaiian or other Pacific Islander
 - 5 American Indian or Alaska Native
 - 6 Other (*specify*)
-

I5. Are you a part of the leadership that makes decisions about how physicians and staff at this practice site deliver care?

- 1 Yes
- 0 No

15a. [T AND RECENT TWD ONLY] [T use: Are; recent TWD use: Were] you a lead or champion for the implementation of CPC+ at the practice site listed [on the cover of this questionnaire/at the top of this web page]?

1 Yes

0 No

16. How long have you worked at the practice site listed [on the cover of this questionnaire/at the top of this webpage]?

1 Less than 2 years

2 2 years up to 5 years

3 More than 5 years up to 10 years

4 More than 10 years

17. In a typical week, how many hours do you spend on patient care for the practice site listed [on the cover of this questionnaire/at the top of this webpage]? Patient care includes direct interactions with patients and tasks related to direct patient care, such as documenting care in your patients' health records and coordinating care with patients' other providers.

1 Less than 20 hours

2 20–39 hours

3 40–49 hours

4 50–59 hours

5 60 hours or more

18. In a typical day, how many patients do you see at the practice site listed [on the cover of this questionnaire/at the top of this webpage]? If you work part time, please adjust your estimate to represent a full day.

____|____|____| Number of patients seen in a typical day

Thank you for completing the questionnaire. [Hardcopy] Please return it in the enclosed postage paid envelope. If you have misplaced the envelope, please send your completed questionnaire to:

Karen Markowski
Mathematica Policy Research
P.O. Box 2393
Princeton, NJ 08543-2393

or Fax to 609-799-0005
Attention: Karen Markowski

[Treatment] If you have more information about your experience with CPC+ or this survey that you think may be of interest to this study, please feel free to add it below.

[Comparison] If you have more information about this survey that you think may be of interest to this study, please feel free to add it below.

Comments:

3.D. Background information about payments made by CMS and CPC+ payer partners

This Appendix presents information about various components of the payment approaches used by CMS and payer partners in paying CPC+ practices and practitioners. First, we cover three aspects of CMS payments: the Quality Payment Program, risk adjustment of CMS’s CPC+ care management fees, and the CPC+ comprehensiveness supplement. Then, we cover key elements of the memorandum of understanding (MOU) that CPC+ payer partners signed. Finally, we include a comparison of CPC+ care management fees paid by CMS versus payer partners.

3.D.1. CMS payments

A. The Quality Payment Program

In addition to the enhanced payments and alternative payments that CPC+ practices received from CMS, which we describe in the main report, practitioners (including those in CPC+ practices) also received payment adjustments as part of CMS’s Quality Payment Program (QPP). The QPP is a nationwide program that adjusts payments, based on performance, to all Medicare clinicians (not specifically to CPC+ practitioners).³⁰ Under QPP, both tracks of CPC+ qualified for Advanced Alternative Payment Model (APM) designation, which offered CPC+ practitioners greater rewards than the other QPP pathway, the Merit-Based Incentive Payment System (MIPS). Because CMS’s definition of clinicians eligible for MIPS (and QPP) is broader than its definition of CPC+ practitioners, some non-practitioner staff employed by some CPC+ practices (such as clinical nurse specialists and clinical social workers) were eligible to receive QPP adjustments under the APM pathway.

Table 3.D.1. Average PBPM QPP adjustments received by CPC+ practitioners, by track, PY 3 through PY 5

CPC+ track	PY 3	PY 4	PY 5
Track 1	\$2.20	\$2.10	\$2.70
Track 2	\$2.50	\$2.30	\$2.90

Note: CMS began making QPP adjustments to Medicare practitioners in 2019 (PY 3 of CPC+).

PBPM = per beneficiary per month; PY = Program Year; QPP = Quality Payment Program.

In our analysis of CPC+ impacts, we include these QPP payment adjustments in the CMS expenditures without enhanced payments analyzed in O’Malley (2023, Chapter 5).

B. Risk adjustment of CMS’s CPC+ care management fees

CMS risk adjusted its care management fees to CPC+ practices by assigning each Medicare fee-for-service (FFS) beneficiary to one of four risk tiers (for Track 1 practices) or five tiers (for Track 2 practices), with each tier corresponding to a monthly payment. The tiers reflected beneficiaries’ hierarchical condition category scores and, for Track 2 practices, whether patients had a diagnosis of

³⁰ According to CMS’s QPP eligibility guidelines, MIPS (and QPP) eligible clinicians include all the types of clinicians eligible for inclusion as CPC+ practitioners (physicians, nurse practitioners, and physician assistants), as well as many other types of health professionals (e.g., clinical nurse specialists, physical therapists, registered dietitians, and clinical social workers). See Quality Payment Program. “How MIPS Eligibility Is Determined.” May 11, 2022.

<https://qpp.cms.gov/mips/how-eligibility-is-determined#mips-eligible-clinician-types>.

dementia. The per-beneficiary-per-month (PBPM) payments corresponding to the four risk tiers in Track 1 were \$6, \$8, \$16, and \$30. The PBPM payments corresponding to the five risk tiers in Track 2 were \$9, \$11, \$19, \$33, and \$100.

C. Comprehensiveness supplement

The comprehensiveness supplement formed part of CMS’s payment approach in CPC+. Track 2 practices received a portion of their payments for services prospectively via the Comprehensive Primary Care Payment (CPCP), which we describe in the main report. In addition to the CPCP, Track 2 practices received the comprehensiveness supplement, which totaled 10 percent of the CPCP. Because this supplement was paid in addition to payments for services, we considered it an enhanced payment.

With the minimum CPCP percentage increasing over the first three program years (from 10 percent in PY 1 to 40 percent in PY 3), there was a corresponding increase in the average dollar amount of the comprehensiveness supplement during that time. From PY 3 through PY 5, the minimum CPCP percentage remained at 40 percent; as a result, the average comprehensiveness supplement also remained generally stable over the same time period.

3.D.2. Payer partners’ payments

Memorandum of understanding

All non-CMS payers signed MOUs with CMS as part of their agreement to partner in CPC+. The MOU detailed payers’ roles, how they would work together in CPC+, and the types of payment and data feedback supports they committed to providing to CPC+ practices. The payment supports described in the MOU closely mirrored CMS’s payment model. However, the MOU was not binding on payer partners.

Key elements of the MOUs CPC+ payer partners signed

The MOUs described payer partners’ commitments to:

1. Provide enhanced, non-visit-based financial support to practices, with larger amounts for Track 2 practices than for Track 1 practices (referred to in the evaluation as “payments for participation”).
2. Offer practices a Performance-based Incentive Payment using a methodology designed to assess the practices’ performance on measures of utilization, cost of care, and quality (referred to as “payments for performance”).
3. By PY 2, reimburse Track 2 practices for care provided using, at least partly, a reimbursement methodology (referred to as “alternative to FFS payments”) that differs from their current, visit-based, reimbursement methodology.
4. Share utilization or total cost-of-care data, or both, with practices at least quarterly (referred to as “data feedback”). This includes supporting a common regional approach to sharing data with practices (referred to as “data aggregation”).
5. Align quality measures with those of other payers in the region, to the extent possible.
6. Align their care delivery requirements for practices with CMS’s requirements, to the extent possible.

3.D.3. Comparison of CPC+ care management fees paid by CMS versus payer partners

Table 3.D.1. CPC+ payers’ average PBPM and median PMPM care management fees, by CPC+ track and line of business, PY 5

Consistent with patterns seen throughout CPC+, payer partners’ median payments continued to be far lower than CMS’s average payments and to vary widely across payers’ lines of business.

Line of business	Number of payers providing care management fees	Track 1		Track 2	
		Range	Median except where noted ^a	Range	Median except where noted ^a
Medicare FFS	1	\$6.00 - \$30.00	\$15.00 (average)	\$9.00 - \$100.00	\$28.00 (average)
Commercial, fully insured	27	\$1.25 - \$9.91	\$3.00	\$1.49 - \$9.00	\$4.00
Commercial, self-insured	24	\$2.00 - \$11.14	\$3.63	\$2.00 - \$9.00	\$4.00
Marketplace plan	11	\$1.25 - \$11.24	\$5.00	\$3.25 - \$9.00	\$9.00
Medicare Advantage	16	\$1.00 - \$16.24	\$5.00	\$1.00 - \$19.00	\$5.50
Medicaid/CHIP managed care	21	\$2.00 - \$12.18	\$3.54	\$2.00 - \$6.50	\$3.25
Medicaid/CHIP FFS	7	\$1.40 - \$8.00	\$5.88	\$1.40 - \$5.88	\$4.42

Source: Mathematica’s analysis of PY 5 CPC+ Payer Survey data.

Note: The 47 payer partners that completed the PY 5 Payer Survey are included in this analysis. Many of these payers included multiple lines of business in CPC+.

^a For payer partners, medians are presented to eliminate the effects of outliers.

CHIP = Children’s Health Insurance Program; FFS = fee-for-service; PBPM = per beneficiary per month; PMPM = per member per month; PY = Program Year.

3.E. Payment policy changes made by CPC+ payer partners in response to the COVID-19 pandemic

The PY (Program Year) 4 and PY 5 CPC+ Payer Surveys asked CPC+ payer partners how they modified their payment approaches in response to the COVID-19 pandemic, including patient cost-sharing policies, telehealth reimbursement, and temporary financial support to practices.³¹

In PYs 4 and 5, there were 57 payer partners in total. Forty-one of these payers responded to the CPC+ Payer Survey in both years, and 38 responded to the survey questions about COVID-19 in both years. The analytic sample for the findings presented in this Appendix consists of those 38 payer partners (which represent 67 percent of all payer partners in both years).

3.E.1. Patient cost-sharing policies

In PY 5, about one-third of payer partners (9 of 38, or 24 percent of those responding to the COVID-19 survey questions) either partially or fully reinstated cost-sharing requirements that they had waived in PY 4 (Table 3.E.1). Still, even after these PY 5 changes, about three-quarters of payer partners responding to the COVID-19 survey questions (27 payers) required no patient cost sharing for either primary care COVID-19 treatment (Table 3.E.1) or primary care telehealth services (Table 3.E.2).

Table 3.E.1. CPC+ payer partners' patient cost-sharing requirements for primary care COVID-19 treatment, PY 4 and PY 5

	PY 4 count (N = 38)	PY 4 percentage	PY 5 count (N = 38)	PY 5 percentage	PY 4 to PY 5 change (percentage points)
No cost sharing for COVID-19 treatment ^a	36	95%	27	71%	-24
No primary care cost sharing prior to COVID-19 ^b	11	29%	11	29%	None
Regular primary care cost sharing temporarily waived ^c	25	66%	16	42%	-24
Reduced cost sharing for COVID-19 treatment	1	3%	5	13%	+11
Regular cost sharing for COVID-19 treatment	1	3%	6	16%	+13

Note: Due to rounding, some percentages may not sum to 100.

^a The survey question specifies, "Please note this question is asking about COVID-19 treatment only, not COVID-19 testing."

^b This approach was common among Medicaid managed care and Medicaid fee-for-service payers.

^c This approach was common among commercial payers.

PY = Program Year.

³¹ In the tables in this Appendix, we note data patterns for specific lines of business only when these differ from overall patterns for all payer partners. Due to rounding, some percentages may not sum to 100.

Table 3.E.2. CPC+ payer partners' patient cost-sharing requirements for primary care telehealth visits, PY 4 and PY 5

	PY 4 count (N = 38)	PY 4 percentage	PY 5 count (N = 38)	PY 5 percentage	PY 4 to PY 5 change (percentage points)
No cost sharing for primary care telehealth	32	84%	27	71%	-13
No cost sharing prior to COVID-19 ^a	11	29%	11	29%	None
Regular cost sharing temporarily waived ^b	21	55%	16	42%	-13
Reduced cost sharing for primary care telehealth	4	11%	4	11%	None
Regular cost sharing for primary care telehealth	2	5%	7	18%	+13

^a This approach was common among Medicaid managed care and Medicaid fee-for-service payers.

^b This approach was common among commercial payers. PY = Program Year.

3.E.2. Coverage of and reimbursement for telehealth services

Among the 38 payer partners responding to the COVID-19 survey questions, there was no decline in PY 5 in the nearly universal telehealth coverage rates first seen in PY 4 (Table 3.E.3). Of the 38 payer partners, all reported providing coverage for telehealth for physical health visits, and all but one reported providing coverage for telehealth for behavioral health. In addition, in PY 5 one more payer partner reported that they expanded coverage for at least one type of telehealth visit due to COVID-19, compared to PY 4.

Table 3.E.3. CPC+ payer partners' coverage of telehealth visits, by type of visit, PY 4 and PY 5

	PY 4 count (N = 38)	PY 4 percentage	PY 5 count (N = 38)	PY 5 percentage	PY 4 to PY 5 change (percentage points)
Payer partner provided coverage for:					
Telehealth visits conducted by physicians (MDs and DOs)	38	100%	38	100%	None
Telehealth visits conducted by non-physician staff (NPs, PAs, or others)	38	100%	38	100%	None
Telehealth behavioral health visits conducted by physicians or non-physician staff	37	97%	37	97%	None
Did payer partner expand coverage due to COVID-19?^a					
Yes, expanded coverage for at least one type of telehealth visit due to COVID-19	17	46%	18	49%	+3
No, did not expand coverage due to COVID-19	20	54%	19	51%	-3

^a N = 37 for this measure.

DO = Doctor of Osteopathic Medicine; HIPAA = Health Insurance Portability and Accountability Act; MD = Doctor of Medicine; NP = Nurse Practitioner; PA = Physician Assistant; PY = Program Year.

In a similar vein, Table 3.E.4 shows that, in PY 5, payer partners did not pull back on covering telehealth visits conducted by non-HIPAA-compliant technology and by telephone. (Indeed, four of the 38 payer partners that had not covered non-HIPAA-compliant telehealth visits in PY 4 began doing so in PY 5.) One additional payer partner reported providing coverage for telehealth visits conducted via HIPAA-compliant technology as well as those conducted by telephone in PY 5 as opposed to PY 4.

Table 3.E.4. CPC+ payer partners' coverage of telehealth visits, by type of technology used, PY 4 and PY 5

	PY 4 count (N = 38)	PY 4 percentage	PY 5 count (N = 38)	PY 5 percentage	PY 4 to PY 5 change (percentage points)
Payer partner provides coverage for:					
Telehealth visits conducted via HIPAA-compliant technology	37	97%	38	100%	+3
Telehealth visits conducted via non-HIPAA compliant technology (for example, Skype, Zoom, Facetime, or comparable technologies)	35	92%	35	92%	None
Telehealth visits conducted via telephone	29	76%	30	79%	+3
Did payer partner expand coverage for HIPAA-compliant technology due to COVID-19? ^a					
Yes, expanded coverage due to COVID-19	4	11%	4	11%	None
No, did not expand coverage due to COVID-19	34	89%	34	89%	None
Did payer partner expand coverage for non-HIPAA-compliant technology due to COVID-19?					
Yes, expanded coverage due to COVID-19	29	76%	33	87%	+11
No, did not expand coverage due to COVID-19	9	24%	5	13%	-11
Did payer partner expand coverage to telephone visits due to COVID-19?					
Yes, expanded coverage due to COVID-19	13	34%	13	34%	None
No, did not expand coverage due to COVID-19	25	66%	25	66%	None

^a Payer partners may have expanded existing coverage due to COVID-19. For example, payer partners that had limited coverage for non-HIPAA-compliant technology in PY 4 may have expanded that coverage to more services or more patients in PY 5.

HIPAA = Health Insurance Portability and Accountability Act; PY = Program Year.

However, as shown in Table 3.E.5, a few payer partners reduced their reimbursement rates for some telehealth visits: four payer partners that had paid for *all* telehealth visits on par with in-person visits in PY 4 reported only doing so for *some* telehealth visits in PY 5.³² This reduced the proportion of payer partners providing payment parity for all telehealth visits from 84 percent in PY 4 to 74 percent in PY 5.

Table 3.E.5. CPC+ payer partners' reimbursement rates for telehealth visits, PY 4 and PY 5

	PY 4 count (N = 38)	PY 4 percentage	PY 5 count (N = 38)	PY 5 percentage	PY 4 to PY 5 change (percentage points)
Reimbursement rate relative to in-person visits:					
Payer partner reimbursed all telehealth visits on par with in-person visits	32	84%	28	74%	-11
Payer partner reimbursed some telehealth visits on par with in-person visits	5	13%	9	24%	+11
Payer partner reimbursed all telehealth visits less than on par with in-person visits	1	3%	1	3%	None
Did payer partner change telehealth reimbursement rate due to COVID-19?					
Yes, changed reimbursement rate due to COVID-19	18	47%	19	50%	+3
No, did not change reimbursement rate due to COVID-19	20	53%	19	50%	-3

PY = Program Year.

3.E.3. Temporary financial supports

Almost 90 percent of payers (33 payers) provided some type of temporary financial support in PY 4 (Table 3.E.6). Among these 33 payers, only 3 stopped providing any type of financial support in PY 5. The most common type of support in both years was providing accelerated payments of any kind to practices or providers (for example, providing care management fee payments ahead of schedule to help practices implement COVID-19 responses or ease cash flow problems); however, the percentage of payers who provided this type of support declined from 71 percent (20 payers) in PY 4 to 61 percent (17 payers) in PY 5.

³² The Payer Survey did not ask payers to provide further detail about their reimbursement rates for specific types of telehealth visits.

Table 3.E.6. CPC+ payer partners' temporary financial supports to practices, PY 4 and PY 5

	PY 4 count (N = 38)	PY 4 percentage	PY 5 count (N = 38)	PY 5 percentage	PY 4 to PY 5 change (percentage points)
Overall extent of support:					
Payer partner offered at least one type of temporary financial support	33	87%	30	79%	-8
Payer partner did not offer any type of temporary financial support	5	13%	8	21%	+8
Types of temporary financial supports payer partner offered:^a					
Increased fee-for-service payment rates	3	11%	4	14%	+4
Increased capitation payment rates	1	4%	1	4%	None
Increased care management fee payment rates	0	0%	0	0%	None
Providing accelerated payments of any kind to practices or providers (for example, providing care management fee payments ahead of schedule to help practices implement COVID-19 responses or ease cash flow problems)	20	71%	17	61%	-11
Postponing recoupment of funds owed by practices or providers	9	32%	10	36%	+4
Easing the requirements for practices or providers to earn performance-based payments (such as shared savings or bonus payments)	7	25%	5	18%	-7
Providing loans directly to practices or providers	4	14%	2	7%	-7
Providing loan guarantees, meaning loans that practices/providers receive from financial institutions that your organization is guaranteeing	0	0%	1	4%	+4
Providing grants directly to practices or providers	5	18%	5	18%	None
Other	6	21%	6	21%	None

Note: Due to rounding, some percentages may not sum to 100.

^a N = 28 payers for this measure. This is the number of payers that indicated they offer any temporary financial supports in both PY 4 and PY 5.

3.F. Trends in Performance-based Incentive Payment (PBIP) scores

This Appendix presents findings on CPC+ practices' performance on CMS's Performance-Based Incentive Payments (PBIPs) over the course of CPC+. The descriptive performance trends summarized in this appendix should not be interpreted as impacts of CPC+ on participating practices' quality and utilization outcomes. O'Malley et al. (2023, Chapter 5) and Laird et al. (2023, Chapter 5 appendices) contain detailed analyses of CPC+ impacts on key outcomes, including practices' performance on several dimensions.

PBIP design and structure. By design, only practices not participating in the Medicare Shared Savings Program (SSP) in a given program year were eligible to receive PBIPs for that year.³³ CMS structured PBIPs so each practice received its entire maximum annual PBIP amount prospectively at the beginning of each program year. (The maximum PBIP amounts were \$2.50 per beneficiary per month [PBPM] for Track 1 and \$4.00 PBPM for Track 2.) In the following year, CMS calculated the total PBIP score each practice earned for the prior year. This total score represented the portion of the maximum PBIP the practice was allowed to retain.³⁴

PBIP scoring methodology. The total PBIP score was equally composed of quality and utilization components.

The **quality score** consisted of two components: (1) *patient experience*, as measured by a summary score based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey in PYs 1 and 2, changing to the Patient Experience of Care (PEC) survey beginning in PY 3; and (2) *clinical quality*, as measured by electronic clinical quality measures (eCQMs). In PYs 1 and 2, patient experience accounted for 25 percent, and eCQMs accounted for the remaining 75 percent, of the quality score. From PY 3 through PY 5, the weight assigned to patient experience increased to 40 percent, while that assigned to eCQMs decreased to 60 percent, of the quality score. Also, in PYs 1 and 2, the eCQM component consisted of nine measures (weighted equally at 8.33 percent each); beginning in PY 3, the eCQMs were reduced to two equally weighted, mandatory measures: blood pressure control and HbA1c (blood glucose) control.

The **utilization score** consisted of two measures: inpatient hospital utilization (weighted at 67 percent) and emergency department (ED) utilization (weighted at 33 percent). Unlike its quality counterpart, the utilization scoring methodology remained unchanged throughout the five years of CPC+.

To be eligible to retain any PBIPs, practices needed to meet minimum reporting quality criteria: at least nine eCQMs and one CAHPS score in PYs 1 and 2; and two mandatory eCQMs and one PEC score for PYs 3 through 5.

³³ For a detailed description of PBIP eligibility and scoring methodologies, see Center for Medicare & Medicaid Innovation, "CPC+ Payment and Attribution Methodologies for Program Year 2021, version 2," March 23, 2021. <https://innovation.cms.gov/media/document/cpc-plus-payment-methodology-cy2021>.

³⁴ The dollar amount of total PBIPs a CPC+ practice retained equaled the practice's total PBIP score multiplied by the maximum PBIPs the practice was paid prospectively at the beginning of each program year.

In each program year, CMS recouped from each practice (that is, required each practice to repay) the proportion of the maximum PBIP that the practice was not eligible to retain.

Analytic sample. For this analysis of PBIP performance, we limited the sample to the 682 practices that (1) received PBIPs for all five program years, and (2) did not change their practice size or practice ownership status (e.g., through mergers or acquisitions) during those five years. We excluded practices that withdrew from CPC+, joined or left SSP, or changed their key practice characteristics because we did not consider those practices’ PBIP scores to be representative of actual PBIP performance trends over time.

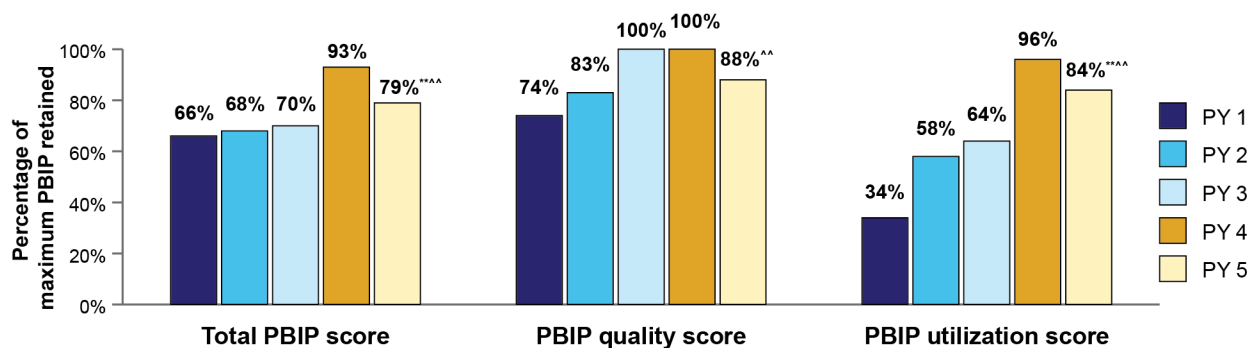
Key findings

Total PBIP scores improved over the course of CPC+, largely driven by improving scores on utilization measures. Over the five years of CPC+, practices increased their total PBIP scores (that is, the proportion of maximum PBIPs they were able to retain). In Program Year (PY) 5, the median PBIP score was 79 percent—13 percentage points higher than the baseline score of 66 percent in PY 1 (Figure 3.F.1). Median utilization scores—only 34 percent in PY 1—showed striking improvement over time, reaching 84 percent in PY 5. Median quality scores, which started from a much higher baseline of 74 percent in PY 1, reached 88 percent in PY 5.

Because the COVID-19 pandemic had both direct and indirect effects on raising PY 4 PBIP scores (as described in more detail below), it would be more analytically valid to view PY 4 scores as an exceptional case rather than part of the five-year performance trend.

Figure 3.F.1. Median PBIP scores, all years of CPC+

In the early years of CPC+, practices performed much better on quality than on utilization, but steep improvements in utilization helped drive overall increases in PBIP performance.



Source: Mathematica’s analysis of payment data provided by CMS.

Notes: For PY 4, the COVID-19 pandemic substantially reduced utilization, leading to higher utilization PBIP scores. In addition, CMS responded to the pandemic by making one-time changes to PBIP scoring to make it easier for practices to retain more of their PBIPs. As a result, comparing PY 4 scores to those for the other program years would be misleading.

N = 682 CPC+ practices that received PBIPs in PY 1 through PY 5 and did not change practice size or ownership status between PY 1 and PY 5.

The differences that were tested for statistical significance were (1) between PY 1 and PY 5 and (2) between PY 3 and PY 5.

^^ = The difference from PY 1 is significant at the $p = 0.01$ level.

** = The difference from PY 3 is significant at the $p = 0.01$ level.

PBIP = Performance-based Incentive Payment; PY = Program Year.

In deep-dive interviews about payments, CPC+ practices reported struggling more to identify actionable steps to improve performance on utilization than to improve their performance on quality measures. Yet, overall utilization scores showed steep, sustained improvement over the course of CPC+. One explanation for this seeming inconsistency is that, early in CPC+, a significant subset of practices had their entire PBIPs—including the utilization component—recouped because they failed to meet basic quality reporting criteria. Over time, as more practices met quality reporting requirements, they became eligible to retain some portion of their utilization PBIPs. (Indeed, in PY 1, 54 percent of practices in our sample had their entire utilization PBIPs recouped; this proportion fell over time and was only 9 percent by PY 5.)

Another factor that might have helped to improve utilization scores is that, beginning in PY 2, practice facilitators increasingly identified and prioritized ways to help practices boost their utilization performance, according to interviews. For example, most practice facilitators started providing group learning sessions to help practices review CPC+ utilization performance data; they also began offering quality improvement coaching sessions during which practices could review their utilization trends. These more targeted efforts may have contributed to the substantial and sustained boost in PBIP utilization scores after the first program year.

On quality, the median score reached 100 in PY 3, when exactly half of the sample achieved the maximum score. In PY 5, the median quality score fell to a still-high 88 percent, with 45 percent of practices achieving the maximum score of 100. However, the difference between the PY 3 and PY 5 median scores did not come close to attaining statistical significance ($p = 0.38$).

PBIP scores peaked in PY 4, but CMS made several pandemic-related PBIP changes that make it misleading to compare PY 4 scores with those for other program years. From PY 3 to PY 4, the median utilization score increased sharply from 64 percent to 96 percent, indicating that the coronavirus disease 2019 (COVID-19) pandemic (which began in early PY 4), substantially reduced hospitalizations and ED visits on a net basis. In addition to this direct impact of the pandemic on PBIP utilization performance, CMS responded to the pandemic by modifying the PY 4 PBIP scoring methodology and recoupment calculations to make it easier for practices to retain more of their PBIPs.

The key change that CMS made to the PY 4 PBIP methodology had the effect of boosting PBIP quality scores. Instead of fielding a patient experience survey in PY 4, CMS used PY 3 patient experience survey results to calculate PY 4 scores. For practices whose PY 3 patient experience survey scores were lower than the overall mean PY 3 scores, CMS used the mean PY 3 patient experience survey score to calculate the practice's PY 4 quality score. All other aspects of the PY 4 PBIP scoring methodology, including benchmarks, remained unchanged from previous years. Because the pandemic led to steep declines in hospital and ED utilization, retaining the earlier benchmarks benefited practices' utilization scores for PY 4.

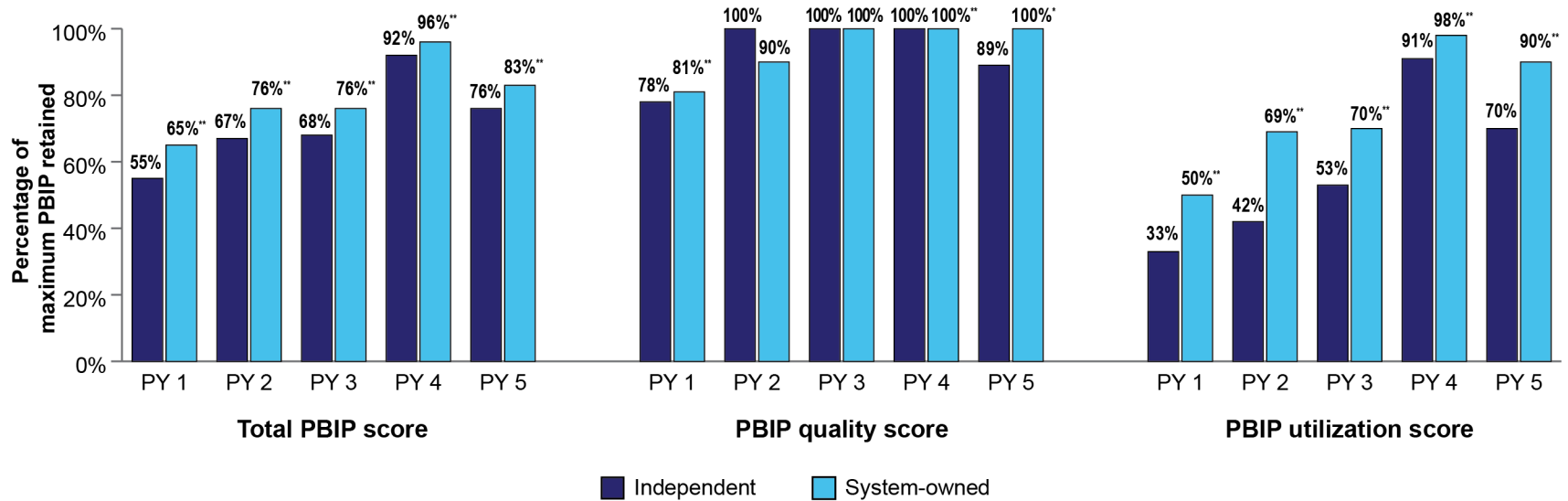
CMS also made a key change to its recoupment calculation for PY 4 to make it easier for practices to retain more of their PBIPs. Before the pandemic, CMS used a practice's overall PBIP score for a given year to determine how much of its PBIP the practice could retain for that year. However, for PY 4, CMS compared the practice's PY 3 and PY 4 overall PBIP scores, and used the higher of the two scores to determine the PBIP amount the practice could retain. Nineteen percent of practices had their PY 4 scores replaced by higher PY 3 scores.

Independent practices achieved higher PBIP scores than system-owned practices, driven by a substantial, persistent gap in utilization performance.³⁵ Both system-based and independent practices improved their overall PBIP scores over time, but a gap persisted between the two types of practices, with independent practices outperforming system-owned practices in every year of CPC+ (Figure 3.F.2).

On quality, the gap between system-owned and independent practices was often narrow and sometimes statistically indiscernible. In contrast, a much larger utilization gap persisted throughout the five program years (with independent practices outperforming system-owned practices by 17 percentage points in PY 1 and by 20 percentage points in PY 5), as both types of practices improved their utilization performance. In interviews, some practices, payer partners, and regional conveners noted two factors that might account for this performance gap. First, because systems continue to rely on hospital use to drive organizational earnings, practices owned by systems may be more likely than physician-owned practices to face weak or conflicting incentives to contain hospital utilization. Second, systems are more likely to have layers of internal bureaucracy that practices must navigate before implementing concrete steps to respond to payment incentives.

³⁵ We also examined differences in PBIP performance by other practice characteristics. Performance did not vary significantly by practice size. Practices with patient-centered medical home (PCMH) recognition outperformed those without PCMH recognition by 6 to 9 percentage points on overall PBIP scores. Track 2 practices performed slightly better than Track 1 practices on overall scores (by statistically significant but relatively small margins ranging from 3 to 5 percentage points).

Figure 3.F.2. Median PBIP scores stratified by practice ownership status, all years of CPC+



Source: Mathematica’s analysis of payment data provided by CMS.

Notes: N = 682 CPC+ practices that received PBIPs in PY 1 through PY 5 and did not change practice size or ownership status between PY 1 and PY 5.

* = The difference from system-owned practices is significant at the $p = 0.05$ level.

** = The difference from system-owned practices is significant at the $p = 0.01$ level.

PBIP = Performance-based Incentive Payment; PY = Program Year.

3.G. Incorporating Health Information Technology into Primary Care Transformation: Reflections on Vendor and Practice Experiences in CPC+

In this Appendix, we examine the role of health IT and health IT vendors in practices' primary care transformation. We provide context for this research in the introduction, describe our methods to collect and synthesize five years of qualitative and quantitative evaluation data, major themes, and the implications for these findings.

3.G.1. Introduction

Electronic health records (EHRs) and related health information technology (health IT) such as electronic patient registries can provide core information management functionality that allows practices to access patient data at the point of care and track patients' progress and needs over time. EHRs and other health IT can also provide communication functionality that supports information sharing with patients and coordination with team members inside and outside the practice ([Finkelstein et al. 2011](#); [Kellerman and Kirk 2007](#)). These activities are particularly important for primary care practices that have comprehensive, long-term responsibility for their patients and must manage the complex needs of their sickest patients as well as routine care for their overall panel. For example, physicians who reported using an EHR and participating in a patient-centered medical home were more likely to routinely engage in population management, quality measurement, and care coordination ([King et al. 2016](#)). However, many practices' experiences with health IT do not live up fully to this promise ([NASEM 2021](#)). For example, population health functionality that can help practices identify all patients with shared care needs (such as those with a particular illness or outstanding preventive care visit) may still require manual effort to define and generate reports ([NASEM 2021](#)). Further, practices participating in the Comprehensive Primary Care Initiative (CPC), a multipayer advanced primary care model developed by the Centers for Medicare & Medicaid Services (CMS), identified difficulties recording data in and extracting data from EHRs and gaps in health information exchange as barriers to primary care transformation ([Peikes et al. 2018](#)). CPC sought to leverage the EHR as a central support for care delivery changes, but found key functionalities missing ([Peikes et al. 2018](#)), partly because of the complex demands value-based care placed on the tools designed for billing in a fee-for-service environment ([Cimino 2013](#)).

To address these identified health IT barriers, CMS sought to strengthen relationships with health IT vendors and encourage development of new functionalities in a subsequent model, Comprehensive Primary Care Plus (CPC+). In addition to being the largest and most ambitious primary care payment and delivery reform effort ever tested in the United States, CPC+ was the first federal advanced primary care payment and delivery reform effort in which CMS formalized health IT vendors' roles in supporting health IT implementation and specified detailed health IT requirements for practices. To formalize vendors' roles, CMS encouraged vendors to provide participating practices with a Letter of Support and sign a Memorandum of Understanding with CMS describing their commitment to develop new or optimize existing advanced health IT capabilities ([CMS n.d.](#)). To support optimal development and use of health IT, CMS included requirements for health IT vendors and practices related to (1) information management within practices and (2) interoperability across practices ([CMS 2016](#)).

Our independent evaluation of CPC+ provides a unique opportunity to learn more about the roles of health IT vendors and health IT functionality in supporting advanced primary care. Examining lessons from CMS's approach to health IT improvement may help clarify the roles policymakers and payers can play in fostering technical improvements to support care delivery changes.

Using insights from practices and vendors involved in CPC+, we address the following research questions:

1. What were CPC+ practices' perspectives on, and experiences with, health IT to support care delivery changes?
2. In the context of a formal partnership with practices, what were health IT vendors' perspectives on, and experiences providing, functionalities to CPC+ practices?

3.G.2. Methods

A. Setting

CMS launched CPC+ in January 2017 in 14 regions and added 4 more regions in January 2018. Across these 18 regions, 68 health IT vendors at the start of CPC+ committed to support 3,070 primary care practices' efforts to improve the care they provide to more than 17 million patients. Along with payment reforms to support primary care through enhanced and alternative payments, CPC+ practices were required to meet care delivery requirements (CDRs) within five primary care functions hypothesized to improve patient health and reduce costs: (1) access and continuity, (2) care management, (3) comprehensiveness and coordination, (4) patient and caregiver engagement, and (5) planned care and population health. In our analysis for this Appendix, we focus primarily on the first three functions because they were most closely tied to required health IT functionalities.

Practices in CPC+ joined one of two tracks, with approximately the same number of practices in Track 1 and Track 2. Track 2 practices were required to meet more enhanced CDRs and more advanced health IT requirements. For example, while practices in both tracks were required to risk stratify their patients, Track 2 practices were required to do so using an established, health IT-enabled algorithm ([CMS 2019](#), [CMS 2018](#)). Practices and health IT vendors could choose how to design and use required health IT functionalities, though Track 2 practices were required to formally partner with at least one health IT vendor that supported these required functionalities.

CPC+ CDRs and health IT requirements were initially informed by gaps CMS identified during CPC, and then evolved throughout CPC+. For example, the care management requirement originally included a two-step risk-stratification process that included updating algorithm-based scores with the care team's perception, but later only required practices to ensure all empaneled patients were risk stratified ([CMS 2019](#)). Similarly, when the health IT requirements were introduced, some had a 6-12 month timeline and others had to be completed within 24 months of the January 2017 model kickoff ([CMS 2016](#)). In September 2018, CMS introduced changes that reworked or removed several required functionalities to reduce practice burden and to focus on functionalities that were higher priority or more straightforward to develop.

B. Data collection and analysis

The CPC+ evaluation team collected data from partnering health IT vendors and participating practices between 2017 and 2022 to better understand participation, available supports, and changes in care delivery. We do not analyze or report on the practices that joined CPC+ in 2018, as these practices account for only 5 percent of the total practices participating in CPC+, and their first-year implementation experiences were very similar to those that joined CPC+ in 2017 (Anglin et al. 2020). Below, we describe our data collection and analysis efforts, which are also summarized in annual reports to CMS (Peikes et al. 2019a; Anglin et al. 2020; Peikes et al. 2021; Swankoski et al. 2022; O'Malley et al. 2023). We identified cross-cutting themes related to health IT for both practices and vendors, comparing similarities and differences across participants and (when possible) over time.

C. Practice interviews

We conducted in-depth, semi-structured interviews with physicians and staff from 100 unique CPC+ practices (we interviewed 81 practices in-person in 2018, 59 practices by phone in 2019, 40 practices by phone in the first quarter of 2021, and 23 practices by phone in the last quarter of 2021). We asked practices about their experiences trying to implement care changes, probing about health IT among potential facilitators and barriers to their work for CPC+ (Anglin et al. 2019). Because health IT questions were open-ended and not asked in a standardized way in each interview round, we could not consistently analyze trends in experiences over time. Thus, we primarily assessed practices' common experiences throughout the four rounds of interviews--only noting clearly apparent trends. The evaluation team analyzed interview data by applying thematic codes related to CPC+ primary care functions and factors drawn from the Consolidated Framework for Implementation Research (see CPC+ annual reports and [Keith et al. 2017](#) for more detail).

D. Practice portal care delivery reporting data

CMS required participating practices to answer a series of questions about care delivery to understand how practices were approaching the five CPC+ functions. Some questions focused on specific CDRs and others asked about related care delivery processes. We calculated frequencies for CDRs and processes related to health IT.

E. Health IT vendor interviews

We conducted in-depth, semi-structured interviews with product development and policy experts at 13 health IT vendors in fall 2017, followed up with 10 of these vendors and interviewed 2 new vendors in winter 2019, and followed up with 10 of these vendors in winter 2021. We used structured data tables to summarize and synthesize details from professionally transcribed interview notes, identifying themes overall and by type of vendor.

3.G.3. Results

Practices reported some advancements and ongoing challenges with using health IT to support primary care functions

Across three rounds of interviews in 2018, 2019, and 2021, practices reported benefits as well as enduring challenges in developing and using advanced health IT in CPC+ to support primary care functions.

Primary care access and continuity. CPC+ required practices to improve patients' timely use of needed care ("access to care") from a care team that is cooperatively involved in a continuous relationship with the patients over the course of their health care management ("continuity of care"). Virtually all practices in our interviews provided patients with 24-hour access to a care team member with access to the EHR, and most practitioners in these practices reported that EHRs facilitated this availability through access to patient information when outside the office. Off-site EHR access also allowed for more consistent and comprehensive documentation of information in the patient's record. Most practices reported that EHRs facilitated care continuity by allowing clinicians to view patients assigned to them in their patient panel. Practices sometimes reported errors in these assignments, which may have been due to EHR functionality, data entry processes, or work-flow limitations. Several practices said EHRs also supported continuity by consolidating patient information in a single searchable location, allowing practitioners to know which clinician in the practice had treated the patient, and communicate with other relevant clinicians.

Care management. CPC+ practices were required to provide both shorter-term, episodic care management focused on acute care events such as ED visits, hospitalizations, and new diagnoses, and longitudinal approaches for higher-risk patients who would benefit from ongoing, proactive care management. Many practices reported that EHRs facilitated care management through registries and dashboards, allowing care team members to look up past care and health history and update information on patients. Many practices reported having established relationships with local hospitals, but several noted they experienced difficulties sharing information with at least some of the hospitals their patients visited. For example, several system-owned practices reported having formal relationships through which they received automated alerts in their EHR when a patient visited a system-affiliated hospital or ED, but several of these practices also reported challenges obtaining discharge information from non-affiliated hospitals due to interoperability issues.

Most practices risk stratified their patients for care management but several noted challenges using EHRs to do so. Early on, these challenges included identifying appropriate risk-stratification algorithms, incorporating necessary data sources, lacking adequate EHR functionality to automate risk stratification, and implementing workflows to support systematic risk stratification. Throughout CPC+, practitioners and staff were uncertain about how automated risk scores in the EHRs were calculated and perceived that their practice had insufficient EHR functionality to support the risk-stratification process or lacked a clear process for updating risk scores based on clinical intuition. These concerns affected practitioners' perceptions of the accuracy of risk scores, and thus their buy-in to the value of assigning risk scores and using risk scores to identify patients who need care management.

Comprehensiveness and coordination. CPC+ practices were also encouraged to provide comprehensive and coordinated care meeting most of their patient population's medical and behavioral health needs while playing a central role in helping patients and caregivers navigate a complex health care system. Many practices reported using their EHR to document and track their patients' social needs--a key element in providing more comprehensive care--though several others said their EHR lacked the functionality to support such tracking. Nearly all practices reported having access to inventories of social services resources, but most did not have this embedded in their EHR and kept these inventories on separate electronic or printed lists. Several practices also noted that their EHR supported behavioral health integration. These practices' embedded behavioral health specialists had access to their EHR and were able to document patient information, which facilitated communication with primary care practitioners.

Practices varied in the extent to which EHRs supported their referral management activities. Some reported that EHRs supported the ability to track and coordinate referrals--especially when there was robust interoperability across provider settings, but others noted this EHR functionality was limited. Many practices reported improvements in communication with hospitals and specialists in the first two years of CPC+ due to improved relationships with these providers and enhancements to their EHRs. Practices affiliated with systems or those where local hospitals had the same EHR tended to have better information sharing about care provided.

Despite some benefits from formalizing vendors as CPC+ partners, vendors did not substantially increase health IT support for practices during CPC+

Compared to vendors' historically limited role providing informal support in other CMS advanced primary care models, being formal partners with CMS and Track 2 practices in CPC+ introduced opportunities for collaboration as well as challenges managing expectations. In interviews, several vendors noted formalized partnerships helped strengthen their relationships with practices by more clearly identifying which practices were participating in CPC+, enabling them to provide more targeted outreach around new functionalities. In contrast, a few vendors were uncomfortable that formal partnerships committed them to supporting health IT requirements that they were not involved in designing and that CMS reserved the right to change throughout the model. For example, one vendor noted it had invested resources to meet the 2015 Edition CEHRT "electronic clinical quality measure (eCQM) filter" criterion, rather than investing in other product improvements, because it was originally a CPC+ requirement. When CMS removed the requirement, the vendor felt that investment had been wasted.

Health IT vendors reported primarily enhancing functionalities that were in place before CPC+, rather than creating new, CPC+ specific products. For example, vendors reported adding practice-site level eCQM reporting to their standard reporting templates and improving the usability of displays like care manager dashboards and health-related social needs assessments to better support CPC+ practices. Enhancing existing functionalities, rather than creating new ones, reflected several vendor considerations. First, vendors reported believing they had the functionalities necessary to support CPC+ practices and did not need to build new products. Second, vendors noted their development schedules were set more than a year in advance and the evolving nature of requirements was not conducive to broader investments. Third, CPC+ practices represented a small fraction of vendors' client base, and it was not strategic to invest in developing new functionality unless it was relevant to practices outside CPC+. Vendors particularly identified this challenge in the context of more novel CPC+ requirements, such as care plans, that lacked a corresponding clinical or industry standard at the outset of CPC+ and for which CMS did not provide examples that would meet requirements. Several vendors suggested it would have been beneficial for CMS to align the CPC+ health IT requirements more closely with other federal and private models to mitigate the tradeoffs they were asking vendors to make in partnering closely with CPC+ practices.

3.G.4. Discussion

This work highlights the first time CMS formally engaged health IT vendors in primary care transformation, including detailed requirements for their partnerships with practices. This is vendors' only formal engagement with federal primary care reform to date, as the successor to CPC+, Primary Care First, does not include vendor requirements. Our study identified several key benefits to this approach, with vendors and practices reporting advances in registries and dashboards for improved information management within the practice. Practices also reported increased support for health IT implementation through these partnerships. However, several challenges arose for developing and implementing more

transformative health IT change, particularly for interoperable health information exchange needed to support care management and care coordination.

CMS, payers, and regulators may be able to encourage needed investment to overcome these challenges through future model requirements, though competing demands from other requirements may constrain vendors' and practices' capacity for change. Greater consultation with vendors and practices when defining program requirements may make it more likely that they will undertake needed investment. For example, vendors partnering in CPC+ may have realized more progress with information management than information exchange functionalities because information management does not require as much buy-in from exchange partners at other health care delivery organizations and vendors. Moving forward, it is important for practices, vendors, regulators, and payers to build consensus about the highest-priority areas for improvement in health IT functionalities. This will allow health IT vendors to prioritize investments in these areas.

Given these potential benefits of increased collaboration, health systems, practices, and their relevant specialty societies (e.g., the American Academy of Family Physicians, the Society for General Internal Medicine, the American College of Physicians, and the American Board of Internal Medicine) can reflect on recent experiences with CPC+ and other advanced primary care programs to identify the most important primary care health IT functionalities. A recent National Academies of Sciences, Engineering, and Medicine report outlining key primary care digital health functions may also be a helpful input for this assessment ([NASEM 2021](#)). As part of their work setting model requirements, payers and regulators can consult with health IT vendors, individually or through a trade association like the HIMSS Electronic Health Record Association, to identify technical challenges in developing new functionalities, along with realistic timelines for working towards these goals. Finally, payers and regulators can align these requirements “across all applicable HHS funding programs, contracts, and policies” to maximize their impact, as specified in the new HHS Health IT Alignment Policy ([Tripathy and Posnack 2022](#)).

Limitations

This study offers several novel insights about the role of health IT vendors and functionality in supporting advanced primary care, but also has several limitations. First, we analyzed data that were originally collected to understand practices' implementation experiences that included, but did not primarily focus on, health IT. Rather, practice interview questions primarily focused on CDRs, and health IT topics emerged out of responses to these questions, rather than to questions about health IT. Second, by focusing on identified themes that explicitly related to health IT rather than re-analyzing original interview data, we may not have captured all the ways in which health IT facilitated or impeded practices' work on primary care transformation. Finally, our results are likely not generalizable to all primary care practices, as practices that applied to participate in CPC+ may have been uniquely motivated or positioned to make care delivery changes. However, these experiences could still be relevant to similarly motivated practices, including the 1,360 practices that applied to but were not selected for CPC+. These limitations suggest future research could identify additional knowledge around using health IT for advanced primary care, building on the experiences of practices and vendors working together in CPC+.

3.G.5. Conclusion

CPC+ reflects the next stage in the evolution of advanced primary care, building on findings from CPC Classic that health IT limitations challenged practices' success. CPC+ required more explicit partnership between practices and vendors, which facilitated vendors providing support that some practices found useful. Moreover, vendors and practices successfully developed and used some enhanced information management functionality. However, interoperable health information exchange proved more challenging, as vendors reported few changes and practices reported ongoing limitations related to care management and care coordination. These results indicate that continued collaboration among health IT vendors, practices, regulators, and payers could support continued technological improvements, particularly related to information exchange and communication.

Chapter 4 Appendix

4.A. Methods Used for the Deep-Dive Practice Study

In this Appendix, we describe changes to our data collection strategy and the number of practices interviewed over the course of the deep-dive practice study. First, we summarize the approach used in Program Years (PYs) 1, 2, and 4. Then we detail the interview guide, sample of practices, and analytic methods used in PY 5. As planned, we did not collect qualitative data for the deep-dive practice study in PY 3. More details on the deep-dive data collection methods used in PYs 1, 2, and 4 are in the Appendices to the evaluation's first, second, and fourth annual reports (Peikes et al. 2019b; Ghosh et al. 2020; and Laird et al. 2022).

In PYs 1, 2, 4, and 5, the sample of CPC+ practices chosen for the evaluation's deep-dive practice study were similar to all of the CPC+ practices that started in 2017, in five key characteristics: (1) CPC+ track, (2) participation in CPC Classic, (3) participation in the Medicare Shared Savings (SSP) program, (4) ownership status, and (5) size (the number of primary care practitioners at the practice site).

4.A.1. Overview of deep-dive data collection in PYs 1, 2, and 4

In PY 1, we identified 81 practices that joined CPC+ in 2017 to participate in the evaluation's deep-dive practice study. To collect data about practices' experiences with CPC+ in PY 1, we conducted in-person interviews with staff at the 81 deep-dive practices in spring 2018. We used one interview guide that included 10 topic-focused modules: one for each of the five CPC+ functions, and one each on payment, learning supports, health care systems' perspectives on CPC+, the use of specialists, and teamwork. (The use of specialists and teamwork were special topics.) Because of the length of the overall interview guide and to ensure that we collected comprehensive and in-depth data about practices' experiences with multiple aspects of CPC+, we administered 3 or 4 of the 10 modules to each deep-dive practice, enabling us to gather detailed information for each module from about 30 diverse practices.

To learn about practices' experiences with CPC+ in PY 2, we conducted telephone interviews in spring 2019 with staff from 59 of the 81 deep-dive practices interviewed in PY 1. We reduced the sample from 81 to 59 practices, because (1) in the analysis of the PY 1 interviews, we reached saturation and identified key findings before analyzing the full sample of 81 practices, (2) we wished to reduce data collection burden on practices when a smaller sample was sufficient, and (3) we wished to reduce evaluation costs and maximize efficiency. We used one interview guide that included eight topic-focused modules. The eight modules included one for each of the five CPC+ functions, and one each on payment, learning supports, and health care systems' perspectives on CPC+. Instead of creating additional special-topics modules, we added questions on two special topics to two of the eight modules. The special topics included in the PY 2 interview guide were practices' development and use of care plans and practices' experiences with continuous quality improvement. We administered two or three of the eight modules to each deep-dive practice, enabling us to gather detailed information for each module from about 22 diverse practices.

In PY 4, we interviewed fewer practices (40 of the 59 interviewed in PY 2), and we used the complete interview guide with all practices. These two changes were made possible by the fact that CMS reduced the number of care delivery requirements from 21 to 13 between PYs 2 and 3. This meant that we could cover all topics in the interview guide with each practice and reach data saturation with a smaller sample of practices. As in previous years, the 40 practices were chosen to be similar to all CPC+ practices in

terms of CPC+ track, CPC Classic participation, SSP participation, ownership, and size. Additionally, our interview guide in PY 4 focused on questions about the care delivery requirements we had observed to be particularly challenging for practices to implement in prior years. These topics included: alternatives to traditional office visits, risk stratification, longitudinal care management, episodic care management, coordination with specialty care, behavioral health integration, comprehensive medication management, health-related social needs, advance care planning, planned care and population health, the coronavirus disease 2019 pandemic, teamwork, CPC+ learning supports, and experiences with CPC+ overall.

4.A.2. Deep-dive data collection in PY 5

In PY 5, we made two key changes to the PY 4 deep-dive study. First, we focused our interview questions on the sustainability and spread of CPC+ activities (as opposed to implementation experiences). We changed the focus because practices were nearing the end of CPC+ funding and supports, and we wanted to hear about their plans for maintaining activities after CPC+ at their practice and learn about the extent to which they had spread CPC+ activities to other practices or providers. Second, we interviewed fewer practices. In PY 5, we interviewed 23 practices for the deep-dive study instead of 40. Based on our experiences in the previous rounds of the deep-dive study, and because we had fewer topics to cover during the interviews compared to previous years, we expected to reach saturation with this smaller sample size.

A. Interview guide for deep-dive telephone interviews

To learn about practices' plans to sustain and spread CPC+ activities, we used one interview guide with all of the practices. The interview guide included questions about which CPC+ activities the practices planned to continue after the model ended, their reasons for sustaining them, and how they made decisions to sustain activities. We also asked about the supports the practices expected to have and/or would need to sustain CPC+ activities. Additionally, we asked system-owned and multispecialty practices about the extent to which CPC+ activities spread to non-CPC+ practices (such as specialty practices or primary care practices that did not participate in CPC+), including the system's plans for continuing any of those activities after CPC+ ended.

B. Selection of deep-dive practices

As in previous years, the sample was selected through stratified random sampling to be similar to all the CPC+ practices on the following characteristics: track, CPC Classic participation, SSP participation, system ownership, and practice size (defined as the number of primary care practitioners) (Table 4.A.1). But unlike previous years, we chose to only select practices that had never been selected for the deep-dive or exemplar studies, since practices selected previously had already been interviewed within the past year and we did not want to further burden them. The sample of 23 practices came from 12 of the 14 regions that started in CPC+ in 2017.

Twelve practices either declined or did not respond to our requests to participate in deep-dive interviews, and were replaced with alternate practices with similar characteristics from the original sample.

Table 4.A.1. Characteristics of deep-dive practices and all CPC+ practices that started in 2017 and were interviewed about PY 5 experiences

Practice characteristic	Deep-dive practices interviewed about PY 5 experiences (N = 23)	All CPC+ practices participating at the end of PY 4 (N = 2,752)
Track 1	43%	47%
Track 2	57%	53%
Participated in CPC Classic	13%	15%
Participating in SSP	39%	48%
System or group affiliation ^a	64%	74%
Practice size (number of primary care practitioners)		
Small (1–2)	35%	26%
Medium (3–5)	22%	38%
Large (6+)	43%	35%

Source: We measured the time-varying practice characteristics of practice size and SSP participation status at the end of PY 4 to capture practices' characteristics at the start of PY 5. We measured practice system or group affiliation as reported in each practice's CPC+ application before CPC+ began. The data were derived from Mathematica's analysis of (1) data from CMS on CPC Classic participation, and (2) CMS's CPC+ practice tracking data for SSP participation status (as of January 2021), system or group affiliation (as of November 2016), and number of primary care practitioners (as of December 2020).

Notes: N = 2,752 CPC+ practices (1,293 Track 1 practices and 1,459 Track 2 practices) that were participating at the end of PY 4.

^aSystem or group affiliation includes practices that are part of *any* larger health care organization, including group practices. This differs from how system practice is defined elsewhere in this report, which only includes practices owned by a hospital or health system. System or group affiliation was missing for 4 percent of practices in this table.

PY = Program Year; SSP = Medicare Shared Savings program.

4.A.3. Analysis of deep-dive data interview data

With permission from interview respondents, we recorded interviews and transcribed the recordings. A team of trained researchers used the interview transcripts to code and analyze the interview data. To organize data for analysis, we used codes aligned with the topics covered in the interview guide. We also used the Consolidated Framework for Implementation Research to code factors that practices described as barriers or facilitators to CPC+ implementation, such as a practice's internal quality improvement resources or the presence of other primary care initiatives (Damschroder et al. 2009). We used NVivo software to code and organize the data for cross-practice analysis.

4.B. Care Delivery Requirement Data That CPC+ Practices Reported to CMS in 2021: CPC+ Practices That Started in 2017

This Appendix contains detailed information on practices' approaches to delivering care, based on Mathematica's analysis of the CPC+ Practice Portal data for practices that began CPC+ in 2017. CMS requires active CPC+ practices to submit responses online twice a year about care delivery requirements and related practice activities, using the CPC+ Practice Portal.³⁶ These data are used to track practices' progress on the CPC+ care delivery functions and may be used to judge compliance and to inform learning activities. Practices self-report the data to CMS.

Table 4.B.0 lists the number of practices active in CPC+ in each program year through the end of 2021, the fifth program year. Practices are listed overall and by track and Medicare Shared Savings Program (SSP) status. In this Appendix, we present CPC+ Practice Portal data from Quarter 4 of 2021 for practices that started CPC+ in 2017 and were still active as of December 31, 2021; the data reflect the experiences of practices at the end of Program Year (PY) 5.

Table 4.B.0. Participation in CPC+ for 2017 Starters, by track and SSP status

	Overall	Track 1		Track 2			
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Baseline (January 1, 2017)	2,905	1,385	738	647	1,520	616	904
End of Program Year 1 (December 30, 2017)	2,786	1,310	689	621	1,476	587	889
End of Program Year 2 (December 30, 2018)	2,716	1,271	724	547	1,445	622	823
End of Program Year 3 (December 30, 2019)	2,675	1,229	660	569	1,446	651	795
End of Program Year 4 (December 30, 2020)	2,599	1,185	606	579	1,414	657	757
End of Program Year 5 (December 30, 2021)	2,419	1,103	567	536	1,316	664	652

Source: Mathematica's analysis of 2017 CPC+ practice tracking data provided by CMS.

Note: Participation status in an SSP reflects status at the beginning of the year.

SSP = Medicare Shared Savings Program.

Although CPC+ requirements are based on track and starting year, every practice must answer the same CPC+ Practice Portal questions. However, some questions include skip patterns. Therefore, it is important to note denominators when interpreting the percentage of practices with a particular response.

We generally present the wording and organization of the questions and responses exactly as they appear in the CPC+ Practice Portal, recognizing that these factors could influence interpretation and practices' responses. To facilitate comparisons to the Care Delivery Reporting Guide, we have numbered our

³⁶ In 2017 and 2018, practices reported CPC+ Practice Portal data to CMS quarterly. From 2019 onwards, CMS changed these reporting requirements to twice a year, for Quarters 2 and 4. To reduce the reporting burden on practices, CMS also added the option for practices to indicate whether categories of care delivery had changed since the previous quarter and carried over the previous quarter's answers if practices selected "no."

Appendix tables to correspond with survey question numbers in the guide. (We do not include a table for every question.) Acronyms CMS used in the question stem or response options are defined in the acronyms list. Questions for which Mathematica did additional data manipulation (for example, combining items, applying thresholds, or conducting other data-cleaning steps) are indicated in the Notes section. Percentages may not sum to totals due to rounding.

Data for PYs 1, 2, 3 and 4 for practices that started CPC+ in 2017 are available in the Appendices for the first, second, third, and fourth annual CPC+ reports (Peikes et al. 2019b; Ghosh et al. 2020; Orzol et al. 2021; and Laird et al. 2022) and are not repeated here. Comparisons over time should be made with caution, for two reasons. First, the wording and response options for many CPC+ Practice Portal questions changed over time. Second, the sample changed over time. In this year's Appendix, we report responses to CPC+ Practice Portal questions based on the 2,396 CPC+ practices that submitted CPC+ Practice Portal data at the end of PY 5 (out of the 2,419 CPC+ practices active at the end of PY 5). In the Appendix to the previous report (Laird et al. 2022), we reported responses to CPC+ Practice Portal questions based on the 2,594 practices that submitted data at the end of PY 4 (out of the 2,599 practices that were active at the end of PY 4).

Table 4.B.1.1. Access and continuity: Empanelment, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1		Track 2			
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
What is your active patient lookback period?							
Less than one year	2%	1%	1%	2%	2%	<1%	2%
1-2 years	79%	82%	83%	82%	75%	73%	78%
More than two years	20%	16%	16%	16%	23%	27%	19%
N	2,396	1,089	559	530	1,307	660	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.
 SSP = Medicare Shared Savings Program.

Table 4.B.1.2. Access and continuity: 24/7 access, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1		Track 2			
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Does a clinician or care team member from your practice site usually provide 24/7 coverage?							
No, we do not provide 24/7 coverage	<1%	<1%	0%	<1%	<1%	<1%	0%
Yes	80%	81%	82%	79%	79%	79%	79%
No, we have a centralized call-center for our health system (after-hours coverage for all practices in the system)	16%	16%	14%	19%	17%	19%	14%
No, we have a formal coverage arrangement with another practice/organization	4%	3%	4%	2%	4%	2%	7%
N	2,404	1,094	564	530	1,310	663	647
Is 24/7 coverage provided with real-time access to your practice's EHR?							
Yes	100%	100%	100%	100%	100%	100%	100%
No	<1%	<1%	<1%	<1%	<1%	<1%	<1%
N	2,402	1,093	564	529	1,309	662	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

EHR = electronic health record; SSP = Medicare Shared Savings Program.

Table 4.B.1.3. Access and continuity: Continuity of care, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Do you track continuity of care (in terms of how often patients see the practitioner or care team to which they are empaneled) for your patients?							
Yes	100%	99%	99%	100%	100%	100%	100%
No	<1%	<1%	1%	<1%	<1%	<1%	<1%
N	2,404	1,094	564	530	1,310	663	647
What system(s) do you primarily use to track continuity of care? (Select all that apply)							
EHR	93%	93%	96%	91%	93%	96%	90%
Electronic practice management systems (e.g., appointment scheduling system)	27%	26%	25%	26%	28%	24%	33%
Other	10%	9%	7%	11%	11%	7%	16%
N	2,392	1,086	557	529	1,306	661	645

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.
 EHR = electronic health record; SSP = Medicare Shared Savings Program.

Table 4.B.1.4. Access and continuity: Enhanced access and communication, Program Year 5, 2017 Starters (percentages)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
When patients need it, my practice is able to provide same- or next-day appointments							
Never	0%	0%	0%	0%	0%	0%	0%
Rarely	<1%	0%	0%	0%	<1%	0%	<1%
Sometimes	2%	1%	<1%	2%	2%	1%	4%
Often	21%	21%	23%	19%	20%	18%	22%
Always	77%	78%	76%	79%	77%	81%	74%
N	2,403	1,093	564	529	1,310	663	647
When patients need it, my practice is able to provide office visits on the weekend, in the evening, or in the early morning							
Never	7%	9%	6%	12%	6%	4%	8%
Rarely	4%	5%	4%	5%	4%	4%	4%
Sometimes	12%	13%	12%	15%	11%	10%	13%
Often	27%	27%	29%	24%	27%	28%	25%
Always	50%	47%	50%	44%	52%	55%	50%
N	2,403	1,093	564	529	1,310	663	647
When patients need it, my practice is able to provide email or portal advice on clinical issues							
Never	2%	4%	4%	3%	<1%	<1%	<1%
Rarely	2%	2%	1%	3%	1%	1%	<1%
Sometimes	6%	8%	5%	10%	4%	4%	4%
Often	13%	11%	11%	12%	15%	13%	17%
Always	77%	75%	78%	73%	79%	81%	77%
N	2,403	1,093	564	529	1,310	663	647

Table 4.B.1.4. (continued)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
In the last two quarters, in which ways have you used the flexibility of CPC+ payments to deliver care in ways that you could not under FFS only? (Select all that apply)							
None	6%	13%	12%	13%	0%	0%	0%
Visits to hospitals, nursing facilities, or other locations by any staff as part of care management and coordination	32%	30%	31%	30%	33%	35%	31%
Visits in the home by designated staff for care management activities, home assessments, education, or self-management support	31%	23%	23%	22%	39%	46%	31%
Practice group visits for purposes of disease management, self-management, and other support	23%	17%	15%	19%	27%	25%	29%
Video-based conferencing for primary care visits (i.e., telehealth or telemedicine)	70%	58%	62%	54%	79%	78%	80%
Practitioner visit over an electronic exchange (i.e., phone or, e-visit, portal, e-mail)	78%	64%	65%	64%	89%	90%	88%
Patient outreach by community health worker, health coach, and/or caregiver support staff	65%	59%	61%	57%	70%	77%	63%
Other	22%	18%	17%	19%	26%	21%	31%
N	2,403	1,093	564	529	1,310	663	647
Are you delivering the care noted below - Visits to hospitals, nursing facilities, or other locations by any staff as part of care management and coordination?							
Potentially available to all patients	66%	68%	62%	73%	64%	64%	65%
Targeting high-risk patients only	34%	32%	38%	27%	36%	36%	35%
N	766	333	175	158	433	232	201
Are you delivering the care noted below - Visits in the home by designated staff for care management activities, home assessments, education, or self-management support?							
Potentially available to all patients	34%	40%	34%	46%	30%	29%	34%
Targeting high-risk patients only	66%	60%	66%	54%	70%	71%	67%
N	754	249	132	117	505	305	200
Are you delivering the care noted below - Practice group visits for purposes of disease management, self-management, and other support?							
Potentially available to all patients	68%	69%	59%	77%	67%	63%	70%
Targeting high-risk patients only	32%	31%	41%	23%	33%	37%	30%
N	543	187	85	102	356	167	189

Table 4.B.1.4. (continued)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
Are you delivering the care noted below - Video-based conferencing for primary care visits (i.e., telehealth or telemedicine)?							
Potentially available to all patients	99%	98%	99%	98%	99%	99%	99%
Targeting high-risk patients only	1%	2%	1%	2%	<1%	<1%	<1%
N	1,671	634	348	286	1,037	519	518
Are you delivering the care noted below - Practitioner visit over an electronic exchange (i.e., phone or, e-visit, portal, e-mail)?							
Potentially available to all patients	97%	96%	96%	95%	97%	98%	97%
Targeting high-risk patients only	3%	4%	4%	5%	3%	2%	3%
N	1,870	702	366	336	1,168	599	569
Are you delivering the care noted below - Patient outreach by community health worker, health coach, and/or caregiver support staff?							
Potentially available to all patients	63%	59%	60%	58%	66%	66%	67%
Targeting high-risk patients only	37%	41%	40%	42%	34%	34%	33%
N	1,565	644	344	300	921	512	409
On a scale of 1 to 5 (1=not considered; 3=fully considered; 5=fully implemented), rate the extent you have implemented these tactics to support care that is unconstrained by FFS billing - Adjusted care team schedules, workload, and workflow to accommodate care that is unconstrained by fee-for-service							
1	4%	7%	6%	8%	3%	2%	3%
2	4%	3%	3%	3%	5%	4%	7%
3	25%	26%	28%	25%	24%	24%	25%
4	15%	16%	15%	18%	15%	14%	15%
5	51%	47%	48%	47%	53%	56%	50%
N	2,264	954	494	460	1,310	663	647
On a scale of 1 to 5 (1=not considered; 3=fully considered; 5=fully implemented), rate the extent you have implemented these tactics to support care that is unconstrained by FFS billing - Determined new documentation approach that is necessary and sufficient for clinical care							
1	12%	14%	13%	14%	10%	5%	16%
2	6%	6%	7%	5%	5%	4%	7%
3	28%	24%	22%	25%	30%	41%	20%
4	14%	15%	17%	13%	13%	11%	15%
5	41%	42%	40%	43%	41%	39%	43%
N	2,264	954	494	460	1,310	663	647

Table 4.B.1.4. (continued)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
On a scale of 1 to 5 (1=not considered; 3=fully considered; 5=fully implemented), rate the extent you have implemented these tactics to support care that is unconstrained by FFS billing - Adjusted compensation formulas for your providers and/or care teams to recognize either the time spent on activities that don't generate relative value units (RVUs) or to recognize activities that result in an improvement in patient outcomes							
1	22%	25%	22%	29%	19%	13%	26%
2	10%	8%	9%	7%	11%	13%	9%
3	25%	29%	29%	28%	23%	24%	22%
4	15%	12%	13%	12%	16%	18%	14%
5	28%	25%	27%	24%	31%	33%	28%
N	2,264	954	494	460	1,310	663	647
On a scale of 1 to 5 (1=not considered; 3=fully considered; 5=fully implemented), rate the extent you have implemented these tactics to support care that is unconstrained by FFS billing - Identified set of metrics to assess and understand the impact							
1	10%	13%	13%	14%	7%	2%	13%
2	10%	8%	10%	7%	11%	9%	13%
3	29%	29%	27%	32%	29%	29%	28%
4	15%	17%	18%	17%	14%	19%	8%
5	36%	32%	33%	31%	39%	41%	37%
N	2,264	954	494	460	1,310	663	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

FFS = fee-for-service; SSP = Medicare Shared Savings Program.

Table 4.B.1.4.b. Access and continuity: Enhanced access and communication in Track 2 by SSP status, Program Years 3 and 4, 2017 Starters (percentages)

	Track 2, PY 3		Track 2, PY 4	
	SSP	SSP	Non-SSP	Non-SSP
In the last two quarters, in which ways have you used the flexibility of CPC+ payments to deliver care in ways that you could not under FFS only? (Select all that apply)				
Visits in the home by designated staff for care management activities, home assessments, education, or self-management support	48%	32%	48%	30%

Source: Mathematica's analysis of 2020 (Quarter 4) and 2019 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

FFS = fee-for-service; PY = Program Year; SSP = Medicare Shared Savings Program.

Table 4.B.2.1. Targeted care management: Risk stratification, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Do you risk stratify your empaneled patients?							
No	<1%	<1%	0%	<1%	<1%	<1%	<1%
Yes	100%	100%	100%	100%	100%	100%	100%
N	2,405	1,095	564	531	1,310	663	647
What factors are included in your data-driven algorithm for risk stratifying your patients? (Select all that apply)							
We do not use a data-driven algorithm as part of our risk stratification	1%	2%	<1%	3%	<1%	<1%	<1%
Claims variables	38%	34%	41%	26%	41%	55%	27%
Clinical variables from the EHR	90%	89%	92%	86%	92%	94%	89%
Computed risk scores (e.g., CMS-HCC scores or risk scores from other payers)	54%	54%	53%	55%	54%	62%	47%
Other	17%	12%	9%	15%	21%	22%	21%
N	2,402	1,094	564	530	1,308	662	646
What factors do you consider when using care team/clinical intuition to stratify your patients? Do not include factors included in your data-driven algorithm. (Select all that apply)							
We do not use the care team's perception as part of our risk stratification	<1%	1%	1%	<1%	<1%	<1%	<1%
Social needs	93%	90%	92%	88%	95%	98%	92%
Behavioral health needs	91%	91%	90%	92%	90%	88%	92%
Clinical factors	97%	96%	95%	97%	98%	99%	97%
Other	10%	7%	9%	4%	13%	14%	11%
N	2,402	1,094	564	530	1,308	662	646
What prompts reassessment of a patient's risk stratification assignment?							
We do not reassess the risk stratification of our patients	<1%	0%	0%	0%	<1%	0%	<1%
Only as needed, or we do not have a protocol in place	5%	5%	3%	7%	5%	5%	4%
Pre-specified clinical events (e.g., new diagnosis, hospitalization)	26%	31%	28%	34%	21%	15%	27%
Automatically updated when new information is in the health IT or EHR platform	37%	31%	34%	27%	43%	50%	36%
Schedule-driven protocol	18%	19%	21%	17%	18%	19%	16%
Other	14%	14%	13%	15%	13%	10%	16%
N	2,402	1,094	564	530	1,308	662	646

Table 4.B.2.1. (continued)

	Overall	Track 1		Track 2			
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
What prompts reassessment of a patient's risk stratification assignment? - Schedule-driven protocol							
Each patient visit	32%	36%	28%	46%	28%	31%	24%
Multiple times a year	25%	27%	28%	25%	24%	29%	18%
Annually	34%	32%	38%	25%	35%	24%	49%
Other	9%	5%	6%	4%	13%	16%	10%
N	442	210	121	89	232	127	105
Is risk stratification integrated within your EHR or health IT system?							
Yes	96%	94%	94%	93%	98%	98%	98%
No	4%	6%	6%	7%	2%	2%	2%
N	2,402	1,094	564	530	1,308	662	646

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

EHR = electronic health record; HCC = hierarchical condition category; SSP = Medicare Shared Savings Program.

Table 4.B.2.2. Targeted care management: Identifying patients for care management, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Indicate how you identify patients for episodic care management. This refers to short-term care management for patients who are not already in longitudinal care management. (Select all that apply)							
We do not identify patients for episodic care management	<1%	<1%	<1%	0%	<1%	<1%	0%
Practitioner or care team referral	87%	84%	83%	85%	90%	92%	88%
Hospital admission or discharge	99%	99%	99%	99%	99%	98%	100%
ED visit	96%	96%	98%	94%	95%	97%	94%
Skilled Nursing Facility (SNF) admission or discharge	72%	72%	82%	62%	71%	79%	63%
New health condition (e.g., cancer diagnosis, accident, chronic condition)	81%	80%	79%	81%	81%	83%	79%
New clinical instability in a chronic condition, including change in medications	76%	74%	73%	75%	77%	81%	73%
Life event (e.g., death of spouse, financial loss)	61%	57%	59%	56%	64%	62%	66%
Initiation or stabilization on a high-risk medication (e.g., anticoagulants)	55%	54%	56%	51%	56%	58%	54%
Other	12%	14%	12%	15%	11%	12%	10%
N	2,396	1,089	559	530	1,307	660	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

ED = emergency department; SSP = Medicare Shared Savings Program.

Table 4.B.2.2.b. Targeted care management: Identifying patients for care management, Program Year 5, 2017 Starters

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Tier 1 (Highest risk)							
Median percentage of empaneled patients in risk tier	2.7	2.8	3.1	2.5	2.4	3.2	1.9
Median percentage of patients in risk tier receiving longitudinal care management	27.0	27.0	28.3	26.3	27.1	26.7	27.8
N	2,329	1,048	544	504	1,281	644	637
Tier 2							
Median percentage of empaneled patients in risk tier	10.1	11.1	11.5	10.8	9.7	10.2	9.1
Median percentage of patients in risk tier receiving longitudinal care management	8.8	8.1	8.7	6.9	9.4	9.2	9.6
N	2,382	1,082	557	525	1,300	657	643
Tier 3							
Median percentage of empaneled patients in risk tier	45.0	45.9	54.1	36.3	44.2	55.9	36.2
Median percentage of patients in risk tier receiving longitudinal care management	1.4	1.2	0.9	2.0	1.6	1.3	1.8
N	2,332	1,079	552	527	1,253	626	627
Tier 4+							
Median percentage of empaneled patients in risk tier	59.5	58.5	53.2	66.7	60.9	56.2	65.0
Median percentage of patients in risk tier receiving longitudinal care management	0.5	0.5	0.1	0.7	0.6	1.0	0.4
N	1,325	584	276	308	741	337	404

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: Percentages are calculated within each practice, and medians are taken across all practices. Median percentages therefore will not sum to 100% across risk tiers. We combine all tiers below the three highest risk tiers and recalculate the percentage of empaneled patients and the percentage of patients receiving longitudinal care management for this group.

SSP = Medicare Shared Savings Program.

Table 4.B.2.3. Targeted care management: Care management staffing and activities, Program Year 5, 2017 Starters (percentages)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
What type of clinician and staff at your practice is/are primarily responsible for each of the following care management and coordination activities? - Assessing and reassessing patient risk status							
None	0%	0%	0%	0%	0%	0%	0%
Practitioner (i.e., MD, DO, NP, PA)	60%	57%	56%	58%	63%	65%	61%
Care manager/clinical staff (e.g., RN, LPN, social worker)	29%	33%	36%	30%	26%	26%	25%
Other clinical staff (e.g., MA/CMA, CNA)	3%	4%	1%	6%	3%	2%	3%
Non-clinical staff (e.g., admin, front desk)	<1%	<1%	<1%	2%	<1%	<1%	<1%
Other	7%	5%	6%	4%	9%	6%	11%
N	2,404	1,094	564	530	1,310	663	647
What type of clinician and staff at your practice is/are primarily responsible for each of the following care management and coordination activities? - Monitoring and management of care transitions (hospital, ED discharges)							
None	0%	0%	0%	0%	0%	0%	0%
Practitioner (i.e., MD, DO, NP, PA)	11%	11%	13%	9%	10%	13%	8%
Care manager/clinical staff (e.g., RN, LPN, social worker)	71%	69%	70%	68%	73%	74%	71%
Other clinical staff (e.g., MA/CMA, CNA)	11%	13%	9%	16%	11%	11%	11%
Non-clinical staff (e.g., admin, front desk)	1%	2%	2%	2%	<1%	0%	2%
Other	5%	5%	6%	4%	6%	3%	9%
N	2,404	1,094	564	530	1,310	663	647
What type of clinician and staff at your practice is/are primarily responsible for each of the following care management and coordination activities? - Medication reconciliation during transitions of care (hospital, ED discharges)							
None	<1%	<1%	<1%	0%	<1%	<1%	0%
Practitioner (i.e., MD, DO, NP, PA)	34%	39%	43%	35%	30%	27%	33%
Care manager/clinical staff (e.g., RN, LPN, social worker)	48%	43%	44%	41%	52%	55%	49%
Other clinical staff (e.g., MA/CMA, CNA)	11%	14%	9%	19%	8%	7%	10%
Non-clinical staff (e.g., admin, front desk)	<1%	0%	0%	0%	<1%	0%	<1%
Other	8%	5%	5%	5%	10%	12%	8%
N	2,404	1,094	564	530	1,310	663	647

Table 4.B.2.3. (continued)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
What type of clinician and staff at your practice is/are primarily responsible for each of the following care management and coordination activities? - Developing and monitoring care plans							
None	<1%	<1%	<1%	<1%	<1%	<1%	<1%
Practitioner (i.e., MD, DO, NP, PA)	31%	33%	40%	25%	30%	30%	30%
Care manager/clinical staff (e.g., RN, LPN, social worker)	63%	61%	54%	68%	65%	67%	64%
Other clinical staff (e.g., MA/CMA, CNA)	1%	2%	1%	2%	1%	<1%	1%
Non-clinical staff (e.g., admin, front desk)	<1%	0%	0%	0%	<1%	<1%	0%
Other	3%	4%	4%	4%	3%	2%	4%
N	2,404	1,094	564	530	1,310	663	647
What type of clinician and staff at your practice is/are primarily responsible for each of the following care management and coordination activities? - Providing condition-specific patient education and self-management support (e.g., motivational interviewing, 5 As., Teach Back, reflective listening)							
None	<1%	<1%	0%	<1%	<1%	0%	<1%
Practitioner (i.e., MD, DO, NP, PA)	27%	30%	26%	34%	25%	26%	24%
Care manager/clinical staff (e.g., RN, LPN, social worker)	60%	58%	65%	50%	61%	63%	59%
Other clinical staff (e.g., MA/CMA, CNA)	5%	7%	4%	10%	4%	3%	5%
Non-clinical staff (e.g., admin, front desk)	<1%	<1%	0%	<1%	<1%	0%	<1%
Other	8%	5%	5%	5%	10%	9%	11%
N	2,404	1,094	564	530	1,310	663	647
What type of clinician and staff at your practice is/are primarily responsible for each of the following care management and coordination activities? - Coordinating and communicating with specialty care							
None	<1%	<1%	<1%	0%	<1%	<1%	<1%
Practitioner (i.e., MD, DO, NP, PA)	29%	34%	32%	36%	25%	29%	21%
Care manager/clinical staff (e.g., RN, LPN, social worker)	23%	22%	24%	20%	23%	27%	19%
Other clinical staff (e.g., MA/CMA, CNA)	26%	25%	25%	26%	27%	25%	28%
Non-clinical staff (e.g., admin, front desk)	11%	12%	10%	13%	10%	6%	15%
Other	11%	7%	8%	5%	14%	13%	16%
N	2,404	1,094	564	530	1,310	663	647

Table 4.B.2.3. (continued)

	Overall	Track 1		Track 2			
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
What type of clinician and staff at your practice is/are primarily responsible for each of the following care management and coordination activities? - Navigating patients to community and social services							
None	<1%	<1%	0%	<1%	0%	0%	0%
Practitioner (i.e., MD, DO, NP, PA)	6%	5%	4%	6%	6%	7%	5%
Care manager/clinical staff (e.g., RN, LPN, social worker)	69%	69%	72%	65%	68%	69%	68%
Other clinical staff (e.g., MA/CMA, CNA)	12%	14%	10%	18%	10%	7%	13%
Non-clinical staff (e.g., admin, front desk)	5%	6%	8%	4%	3%	5%	2%
Other	9%	6%	5%	7%	12%	12%	12%
N	2,404	1,094	564	530	1,310	663	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.
 CMA = certified medical assistant; CNA = certified nursing assistant; ED = emergency department; DO = doctor of osteopathy; LPN = licensed practical nurse; MA = medical assistant; MD = medical doctor; NP = nurse practitioner; PA = physician's assistant; RN = registered nurse; SSP = Medicare Shared Savings Program.

Table 4.B.2.3.b. Targeted care management: Care plans, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1		Track 2			
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Among patients under longitudinal care management, how many have a care plan?							
None	<1%	<1%	<1%	1%	<1%	<1%	0%
Some	25%	28%	25%	31%	23%	14%	32%
Most	36%	35%	32%	38%	38%	42%	34%
All	38%	36%	43%	30%	39%	44%	34%
N	2,404	1,094	564	530	1,310	663	647
Do you document and store care plans?							
No	<1%	<1%	<1%	1%	<1%	<1%	0%
Yes, care plans are integrated with the EHR or other health IT	95%	91%	95%	86%	98%	98%	97%
Yes, care plans are documented and stored, but are not integrated with the EHR or other health IT	5%	8%	4%	13%	2%	2%	3%
N	2,394	1,085	561	524	1,309	662	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.
 EHR = electronic health record; SSP = Medicare Shared Savings Program.

Table 4.B.3.1. Comprehensiveness and coordination: Coordinated referral managements, Program Year 5, 2017 Starters (percentages)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
Over the past two quarters, we have ensured coordinated referral management with the following high-frequency referral and/or high-cost specialty care: (select all that apply)							
We do not ensure coordinated referral management with high-frequency referral and/or high-cost specialty care.	<1%	<1%	<1%	<1%	<1%	0%	<1%
Cardiology	74%	71%	68%	74%	77%	78%	75%
Endocrinology	48%	45%	45%	45%	52%	62%	41%
Gastroenterology	58%	57%	55%	58%	59%	67%	51%
Obstetrics/gynecology	44%	41%	39%	42%	47%	48%	45%
Oncology/hematology	40%	41%	45%	36%	40%	49%	30%
Ophthalmology	44%	44%	42%	46%	44%	45%	44%
Orthopedic surgery	47%	45%	43%	47%	49%	55%	43%
Surgery	44%	41%	42%	40%	47%	53%	41%
Other	60%	59%	53%	66%	61%	60%	61%
N	2,405	1,095	564	531	1,310	663	647
Cardiology - Tool(s) Used to Ensure Coordinated Referral Management with the Selected Specialty Category							
Collaborative agreement	73%	72%	77%	68%	73%	71%	76%
E-consult arrangement	20%	19%	21%	18%	21%	30%	12%
Other	18%	20%	17%	23%	17%	12%	21%
N	1,785	779	384	395	1,006	520	486
Endocrinology - Tool(s) Used to Ensure Coordinated Referral Management with the Selected Specialty Category							
Collaborative agreement	68%	64%	63%	64%	71%	72%	71%
E-consult arrangement	26%	28%	29%	27%	25%	26%	23%
Other	21%	23%	22%	24%	20%	18%	22%
N	1,165	488	251	237	677	410	267
Gastroenterology - Tool(s) Used to Ensure Coordinated Referral Management with the Selected Specialty Category							
Collaborative agreement	66%	65%	65%	66%	66%	69%	63%
E-consult arrangement	22%	19%	18%	20%	25%	28%	21%
Other	24%	26%	26%	25%	23%	14%	35%
N	1,396	620	311	309	776	444	332

	Overall	Track 1		Track 2			
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Obstetrics/gynecology - Tool(s) Used to Ensure Coordinated Referral Management with the Selected Specialty Category							
Collaborative agreement	64%	67%	66%	67%	62%	56%	68%
E-consult arrangement	25%	24%	25%	22%	26%	31%	19%
Other	20%	22%	19%	24%	19%	18%	21%
N	1,056	445	222	223	611	318	293
Oncology/hematology - Tool(s) Used to Ensure Coordinated Referral Management with the Selected Specialty Category							
Collaborative agreement	62%	61%	65%	55%	63%	64%	62%
E-consult arrangement	24%	21%	24%	19%	26%	26%	26%
Other	23%	28%	22%	36%	19%	14%	26%
N	968	447	255	192	521	327	194
Endocrinology - Tool(s) Used to Ensure Coordinated Referral Management with the Selected Specialty Category							
Collaborative agreement	68%	64%	63%	64%	71%	72%	71%
E-consult arrangement	26%	28%	29%	27%	25%	26%	23%
Other	21%	23%	22%	24%	20%	18%	22%
N	1,165	488	251	237	677	410	267
Gastroenterology - Tool(s) Used to Ensure Coordinated Referral Management with the Selected Specialty Category							
Collaborative agreement	66%	65%	65%	66%	66%	69%	63%
E-consult arrangement	22%	19%	18%	20%	25%	28%	21%
Other	24%	26%	26%	25%	23%	14%	35%
N	1,396	620	311	309	776	444	332
Obstetrics/gynecology - Tool(s) Used to Ensure Coordinated Referral Management with the Selected Specialty Category							
Collaborative agreement	64%	67%	66%	67%	62%	56%	68%
E-consult arrangement	25%	24%	25%	22%	26%	31%	19%
Other	20%	22%	19%	24%	19%	18%	21%
N	1,056	445	222	223	611	318	293
Oncology/hematology - Tool(s) Used to Ensure Coordinated Referral Management with the Selected Specialty Category							
Collaborative agreement	62%	61%	65%	55%	63%	64%	62%
E-consult arrangement	24%	21%	24%	19%	26%	26%	26%
Other	23%	28%	22%	36%	19%	14%	26%
N	968	447	255	192	521	327	194

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

SSP = Medicare Shared Savings Program.

Table 4.B.3.3. Comprehensiveness and coordination: Comprehensive medication management, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Which of the following steps has your practice achieved to implement comprehensive medication management (CMM)? (Select all that apply)							
We have not taken any of these steps yet	13%	28%	28%	27%	<1%	1%	<1%
Established a plan for identifying patients with CMM needs	74%	57%	60%	54%	88%	89%	87%
Identified or hired personnel for CMM	63%	43%	48%	39%	80%	81%	80%
Trained staff as necessary	71%	49%	48%	51%	88%	91%	85%
Developed workflows and processes	74%	53%	50%	56%	91%	94%	87%
Used measures to monitor and refine CMM	36%	23%	22%	24%	46%	47%	46%
N	2,405	1,095	564	531	1,310	663	647
In the last two quarters, how many patients who were under care management and/or in transitions of care received comprehensive medication management at your practice?							
None	3%	7%	9%	6%	<1%	0%	<1%
Some	61%	52%	56%	47%	67%	68%	67%
Most	29%	32%	28%	36%	27%	25%	29%
All	7%	9%	8%	11%	5%	7%	4%
N	2,091	793	405	388	1,298	655	643
How does your practice deliver comprehensive medication management?							
Coordination with an external pharmacist, program, or service NOT located at our practice	24%	18%	25%	11%	28%	25%	30%
Coordination with a pharmacist, program, or service located at our practice	35%	28%	26%	30%	40%	42%	38%
Primary care practitioners from our practice primarily deliver comprehensive medication management	41%	54%	49%	59%	32%	32%	33%
N	2,091	793	405	388	1,298	655	643

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

SSP = Medicare Shared Savings Program.

Table 4.B.3.4. Comprehensiveness and coordination: Behavioral health integration, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
What is your practice's strategy for addressing behavioral health needs? If you have or planned to integrate one or two of the behavioral health models listed below, please select the option(s) that apply.							
We are not integrating behavioral health needs at our practice	2%	3%	<1%	7%	<1%	<1%	1%
BHI with Care Management for Mental Illness only	35%	44%	46%	43%	28%	26%	30%
BHI with Primary Care Behaviorist model only	58%	48%	48%	49%	66%	67%	65%
BHI with CMMI and PCB Hybrid	5%	4%	6%	2%	5%	6%	4%
N	2,405	1,095	564	531	1,310	663	647
Which of the following steps has your practice achieved to integrate behavioral health using Care Management for Mental Illness? (Select all that apply)							
We have not taken any of these steps yet	<1%	<1%	1%	<1%	<1%	0%	<1%
Established a plan for identifying patients with behavioral health needs	90%	86%	91%	80%	94%	95%	92%
Identified and/or hired personnel	68%	64%	67%	61%	73%	76%	70%
Trained staff as necessary	85%	84%	84%	83%	87%	94%	81%
Developed workflows and processes	88%	86%	88%	84%	90%	94%	86%
Used measures to monitor and refine care management for patients with mental health disorders	39%	40%	43%	36%	39%	45%	33%
N	962	526	293	239	432	212	220
Which of the following steps has your practice achieved to integrate behavioral health using the Primary Care Behaviorist model? (Select all that apply)							
We have not taken any of these steps yet	<1%	<1%	0%	<1%	0%	0%	0%
Established a plan for identifying patients with behavioral health needs	95%	94%	96%	92%	96%	95%	96%
Identified and/or hired personnel	88%	78%	80%	76%	94%	93%	94%
Trained staff as necessary	89%	84%	83%	86%	93%	94%	92%
Developed workflows and processes	91%	91%	91%	91%	91%	87%	96%
Used measures to monitor and refine the Primary Care Behaviorist model	52%	44%	46%	41%	57%	60%	54%
N	1,502	571	303	268	931	484	447

Table 4.B.3.4. (continued)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
In the last two quarters, of your patients with identified behavioral health needs, estimate how many received behavioral health care management at your practice.							
None	1%	2%	1%	2%	<1%	0%	1%
Some	71%	73%	70%	77%	68%	58%	77%
Most	26%	24%	27%	20%	28%	38%	17%
All	2%	1%	1%	1%	4%	3%	5%
N	963	531	293	238	432	212	220
In the last two quarters, of your patients with identified behavioral health needs, estimate how many were seen by a primary care behaviorist at your practice.							
None	3%	6%	8%	3%	2%	3%	1%
Some	69%	65%	62%	68%	72%	71%	73%
Most	25%	27%	28%	26%	23%	25%	21%
All	3%	2%	2%	3%	3%	2%	4%
N	1,502	571	303	268	931	484	447
What mental health conditions are you targeting with your behavioral health strategy? (Select all that apply)							
We do not target specific mental health conditions	4%	6%	6%	6%	2%	2%	2%
Anxiety disorders	84%	83%	82%	84%	86%	90%	82%
Alzheimer's disease and related dementias	30%	28%	24%	31%	31%	40%	23%
Depressive disorders	90%	89%	90%	89%	91%	94%	88%
Chronic pain	37%	35%	30%	40%	39%	43%	34%
Co-existing mental health and physical chronic conditions	64%	58%	58%	59%	68%	75%	61%
High-risk behaviors (e.g., tobacco use, obesity, medication adherence)	62%	58%	56%	60%	65%	65%	66%
Insomnia	35%	27%	27%	28%	41%	55%	27%
Other	3%	2%	2%	2%	3%	5%	1%
Substance use disorders (Select all that apply)	43%	37%	29%	46%	48%	52%	44%
Opioid*	90%	90%	94%	88%	89%	87%	91%
Alcohol*	94%	92%	93%	92%	95%	93%	96%
Tobacco*	83%	79%	85%	74%	86%	90%	81%
Other substance use disorder type, please specify*	10%	10%	11%	10%	9%	9%	9%
N	2,355	1,058	562	496	1,297	658	639

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

* Percentages for opioid, alcohol, and tobacco substance use disorders are calculated only among practices that selected "substance use disorders."

BHI = Behavioral Health Integration; CMMI = care management for mental illness; PCB = Primary Care Behaviorist; SSP = Medicare Shared Savings Program.

Table 4.B.3.5. Comprehensiveness and coordination: Linkages with social services, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Do you routinely screen your patients for health-related social needs?							
We do not screen patients for health-related social needs	4%	8%	8%	8%	0%	0%	0%
We screen a targeted subpopulation of patients for health-related social needs	46%	45%	37%	53%	48%	48%	47%
We universally screen all patients for health-related social needs	50%	47%	54%	39%	52%	52%	53%
N	2,405	1,095	564	531	1,310	663	647
What type of screening tool(s) do you use or adopt to capture health-related social needs in your patient population? (Select all that apply)							
We do not use any screening tools	1%	2%	3%	2%	<1%	0%	<1%
Standardized screening tool (e.g., screening tools published by HealthLeads, IOM/NAM, Accountable Health Communities [AHCs])	45%	42%	48%	35%	48%	46%	50%
Tool developed by practice or system	59%	57%	58%	57%	61%	72%	50%
Other	14%	16%	15%	16%	12%	6%	17%
N	2,317	1,007	517	490	1,310	663	647
Are screening tools or questions integrated with your EHR or health IT system?							
Yes	89%	85%	86%	85%	92%	94%	91%
No	11%	15%	14%	15%	8%	6%	9%
N	2,290	983	503	480	1,307	663	644
What are the social needs your practice has prioritized to address in your patient population?							
We have not prioritized any social needs to address in our patient population	5%	10%	11%	10%	<1%	0%	<1%
Food insecurity	81%	73%	74%	72%	87%	92%	81%
Housing instability	65%	60%	51%	68%	70%	73%	67%
Utility needs	60%	55%	55%	56%	64%	66%	61%
Financial resource strain	65%	58%	60%	56%	71%	77%	65%
Transportation	85%	80%	77%	84%	89%	89%	89%
Employment	33%	33%	35%	30%	33%	35%	32%
Social isolation	56%	51%	56%	45%	60%	67%	53%
Safety	72%	64%	60%	68%	78%	79%	77%
Other	16%	12%	12%	12%	20%	16%	23%
N	2,405	1,095	564	531	1,310	663	647

Table 4.B.3.5. (continued)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
Do you have an established, ongoing relationship with social resources to address this need? - Food insecurity							
Yes	91%	86%	89%	83%	94%	97%	90%
No	9%	14%	11%	17%	6%	3%	10%
N	1,938	801	420	381	1,137	611	526
Do you have an established, ongoing relationship with social resources to address this need? - Housing instability							
Yes	85%	79%	84%	75%	90%	91%	88%
No	15%	21%	16%	25%	10%	9%	12%
N	1,569	652	290	362	917	485	432
Do you have an established, ongoing relationship with social resources to address this need? - Utility needs							
Yes	86%	82%	82%	82%	89%	93%	84%
No	14%	18%	18%	18%	11%	7%	16%
N	1,439	605	310	295	834	438	396
Do you have an established, ongoing relationship with social resources to address this need? - Financial resource strain							
Yes	84%	78%	78%	79%	87%	92%	82%
No	16%	22%	22%	21%	13%	8%	18%
N	1,564	634	338	296	930	512	418
Do you have an established, ongoing relationship with social resources to address this need? - Transportation							
Yes	89%	83%	84%	82%	94%	97%	90%
No	11%	17%	16%	18%	6%	3%	10%
N	2,045	881	436	445	1,164	589	575
Do you have an established, ongoing relationship with social resources to address this need? - Employment							
Yes	84%	78%	87%	67%	89%	90%	87%
No	16%	22%	13%	33%	11%	10%	13%
N	795	358	200	158	437	233	204
Do you have an established, ongoing relationship with social resources to address this need? - Social isolation							
Yes	85%	82%	85%	78%	86%	89%	82%
No	15%	18%	15%	22%	14%	11%	18%
N	1,344	558	317	241	786	441	345
Do you have an established, ongoing relationship with social resources to address this need? - Safety							
Yes	90%	85%	88%	83%	94%	97%	91%
No	10%	15%	12%	17%	6%	3%	9%
N	1,722	698	338	360	1,024	524	500

Table 4.B.3.5. (continued)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
Do you have an established, ongoing relationship with social resources to address this need? - Other, please specify							
Yes	87%	71%	65%	78%	95%	98%	93%
No	13%	29%	35%	22%	5%	2%	7%
N	388	132	68	64	256	109	147
Do you have an inventory of social service resources integrated with your EHR or health IT system?							
No, we do not maintain an inventory of social services resources	<1%	2%	<1%	3%	<1%	<1%	<1%
No, we have an inventory of social service resources, but it is not integrated with our EHR or health IT system	61%	68%	65%	71%	55%	54%	57%
Yes, we have an inventory integrated with our EHR or health IT system	38%	31%	34%	26%	44%	46%	43%
N	2,405	1,095	564	531	1,310	663	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For “select all that apply” questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

EHR = electronic health record; SSP = Medicare Shared Savings Program.

Table 4.B.3.6. Comprehensiveness and coordination: Comprehensiveness, Program Year 5, 2017 Starters (percentages)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
As part of your practice's work to increase comprehensiveness, what is/are the complex need(s) your practice is developing capabilities to address? (Select all that apply)							
We are not developing capabilities to increase comprehensiveness	4%	7%	6%	9%	<1%	<1%	<1%
End-of-life or palliative care	66%	59%	65%	53%	72%	76%	67%
Chronic pain	39%	40%	41%	39%	37%	42%	33%
Substance use disorders	36%	36%	32%	40%	37%	44%	29%
Co-existing chronic conditions	65%	65%	64%	66%	66%	73%	58%
High-acuity chronic conditions, please specify	44%	39%	43%	34%	49%	48%	49%
Alzheimer's disease and related dementias	27%	26%	29%	24%	28%	32%	23%
Frailty	24%	23%	24%	22%	25%	30%	20%
Other	15%	13%	14%	12%	16%	20%	12%
N	2,405	1,095	564	531	1,310	663	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

SSP = Medicare Shared Savings Program.

Table 4.B.4.1. Patient and caregiver engagement: Engaging patients and caregivers in your practice, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1		Track 2			
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Tell us how frequently your practice engages patients and caregivers in care improvement activities.							
Never	<1%	<1%	0%	<1%	<1%	<1%	<1%
Rarely	3%	4%	2%	6%	3%	1%	4%
Sometimes	43%	40%	41%	40%	46%	43%	49%
Often	40%	43%	40%	45%	38%	39%	38%
Always	13%	13%	17%	9%	13%	16%	10%
N	2,405	1,095	564	531	1,310	663	647
Which of the following steps has your practice achieved to implement and integrate the PFAC? (Select all that apply)							
We have not taken any of these steps	1%	1%	<1%	2%	<1%	1%	<1%
Identified staff participants	96%	96%	95%	96%	96%	96%	97%
Recruited patient participants	95%	93%	95%	91%	96%	95%	97%
Defined mission and vision of PFAC	94%	94%	96%	90%	94%	94%	95%
Determined structure of the PFAC (e.g., number of patients or family advisors, frequency of meetings, term lengths, and other meeting logistics)	94%	91%	95%	88%	96%	96%	96%
Incorporated PFAC recommendations into practice	89%	83%	85%	80%	93%	94%	93%
Communicated PFAC recommendations to patients and staff	85%	79%	81%	77%	89%	90%	89%
Developed a sustainability plan for the PFAC	65%	63%	67%	60%	67%	69%	65%
N	2,405	1,095	564	531	1,310	663	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For 'select all that apply' questions, practices may choose more than one option. Responses may therefore sum to greater than 100%

PFAC = Patient and Family Advisory Council; SSP = Medicare Shared Savings Program.

Table 4.B.4.2. Patient and caregiver engagement: Advance care planning, Program Year 5, 2017 Starters (percentages)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
Which of the following steps has your practice achieved to implement advance care planning (ACP)? (Select all that apply)							
We have not taken any of these steps yet	4%	9%	5%	13%	<1%	<1%	0%
Established a plan for identifying patients with ACP needs	85%	78%	82%	73%	92%	92%	92%
Identified personnel for ACP	77%	66%	72%	60%	86%	89%	82%
Trained staff as necessary	79%	70%	76%	64%	87%	85%	89%
Developed workflows and processes	77%	67%	77%	56%	85%	85%	86%
N	2,405	1,095	564	531	1,310	663	647
How does your practice identify patients for advance care planning? (Select all that apply)							
We do not systematically identify patients for advance care planning	1%	3%	3%	3%	<1%	<1%	0%
High-risk status (using the practice's two-step risk stratification methodology)	49%	48%	48%	47%	50%	53%	46%
Patients with serious illness and/or based on age (e.g., cancer diagnosis, end-stage kidney disease, heart failure, COPD)	74%	68%	70%	66%	78%	84%	71%
Clinician or care team referral/identification	79%	78%	79%	76%	80%	85%	75%
Other	29%	31%	31%	31%	28%	23%	33%
N	2,303	997	537	460	1,306	659	647
What system(s) do you use to document and store advance care planning conversations and decisions? (Select all that apply)							
We do not document and store advance care planning conversations and decisions	<1%	<1%	0%	<1%	<1%	0%	<1%
EHR or other health IT	99%	99%	99%	99%	99%	100%	99%
A local or regional Health Information Exchange	4%	3%	3%	4%	4%	3%	5%
Patient portal/patient health record	18%	19%	17%	22%	18%	15%	21%
Other	2%	2%	2%	2%	1%	1%	2%
N	2,303	997	537	460	1,306	659	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

COPD = chronic obstructive pulmonary disease; EHR = electronic health record; SSP = Medicare Shared Savings Program.

Table 4.B.5.1. Planned care and population health: Team-based care, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1		Track 2			
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
How often do care teams at your practice have structured huddles focused on patient care?							
Never	<1%	<1%	0%	<1%	<1%	<1%	0%
Only as needed or ad hoc	13%	18%	16%	20%	10%	7%	12%
At least daily	49%	50%	49%	50%	49%	44%	54%
At least weekly	29%	22%	24%	20%	34%	42%	26%
At least every 2 weeks	2%	2%	2%	2%	3%	2%	4%
At least monthly	6%	8%	9%	8%	4%	5%	4%
N	2,404	1,095	564	531	1,309	663	646
How often do care teams at your practice have scheduled care team meetings to discuss high-risk patients and planned care?							
Never	<1%	1%	<1%	2%	<1%	<1%	0%
Only as needed or ad hoc	27%	35%	26%	44%	21%	14%	29%
At least daily	13%	15%	19%	10%	12%	10%	13%
At least weekly	29%	22%	23%	21%	36%	43%	28%
At least every 2 weeks	4%	3%	3%	4%	5%	4%	6%
At least monthly	25%	24%	29%	19%	26%	29%	24%
N	2,404	1,095	564	531	1,309	663	646
How often do care teams at your practice meet and review quality improvement data (e.g., data on quality, cost, utilization, and patient experience of care)?							
Never	<1%	<1%	0%	<1%	<1%	<1%	0%
Only as needed or ad hoc	5%	7%	5%	9%	3%	3%	3%
At least weekly	15%	12%	6%	18%	18%	16%	20%
At least monthly	61%	57%	65%	49%	64%	68%	61%
At least quarterly	17%	21%	23%	18%	14%	13%	15%
At least annually	2%	3%	1%	4%	1%	<1%	2%
N	2,404	1,095	564	531	1,309	663	646

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.
 SSP = Medicare Shared Savings Program.

Table 4.B.5.2. Planned care and population health: Use of data to plan care, Program Year 5, 2017 Starters (percentages)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
Tell us what types of data on quality, utilization, patient experience, and other measures your practice regularly uses to improve delivery of care and achieve your CPC+ aims. (Select all that apply)							
We do not use data in quality improvement work at our practice	<1%	<1%	<1%	<1%	<1%	0%	<1%
Electronic clinical quality measures (eCQMs)	96%	95%	92%	98%	98%	98%	97%
Claims data feedback from CMS (CPC+ data feedback tool)	88%	85%	85%	86%	89%	94%	85%
Claims data feedback from other payers	76%	76%	79%	73%	77%	84%	70%
Multi-payer data from Health Information Exchange (HIE), all payer claims databases (APCDs), or other data aggregator	39%	43%	44%	42%	35%	37%	33%
Patient Reported Outcome Measures (PROMs)	29%	32%	39%	25%	25%	31%	19%
Patient experience data (e.g., CAHPS or other surveys)	93%	92%	93%	91%	94%	95%	93%
Performance-Based Incentive Payment (PBIP) Report	64%	59%	39%	80%	69%	52%	86%
ACO/IPA/System analytics	54%	57%	79%	33%	52%	78%	25%
N	2,405	1,095	564	531	1,310	663	647
How helpful is this data in quality improvement work at your practice? (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) - Electronic clinical quality measures (eCQMs)							
1	5%	4%	4%	4%	7%	10%	3%
2	2%	3%	4%	2%	1%	2%	<1%
3	12%	11%	9%	13%	12%	17%	7%
4	26%	30%	30%	31%	23%	18%	28%
5	55%	52%	53%	50%	57%	52%	61%
N	2,316	1,037	517	520	1,279	651	628
How helpful is this data in quality improvement work at your practice? (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) - Claims data feedback from CMS (CPC+ data feedback tool)							
1	4%	4%	3%	5%	5%	3%	7%
2	20%	15%	12%	17%	24%	27%	20%
3	32%	33%	27%	39%	31%	28%	35%
4	25%	24%	25%	24%	26%	26%	25%
5	19%	24%	33%	15%	15%	16%	14%
N	2,105	933	477	456	1,172	624	548

Table 4.B.5.2. (continued)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
How helpful is this data in quality improvement work at your practice? (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) - Claims data feedback from other payers							
1	3%	3%	2%	3%	3%	2%	4%
2	10%	9%	5%	14%	10%	6%	14%
3	30%	29%	29%	28%	31%	28%	35%
4	36%	34%	35%	34%	37%	41%	32%
5	22%	25%	29%	20%	19%	23%	14%
N	1,839	833	445	388	1,006	555	451
How helpful is this data in quality improvement work at your practice? (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) - Multi-payer data from Health Information Exchange (HIE)							
1	9%	11%	14%	8%	8%	7%	9%
2	9%	9%	12%	7%	8%	2%	14%
3	31%	36%	38%	34%	26%	26%	26%
4	25%	25%	18%	33%	24%	22%	27%
5	26%	18%	18%	19%	34%	43%	24%
N	928	467	246	221	461	246	215
How helpful is this data in quality improvement work at your practice? (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) - Patient Reported Outcome Measures (PROMs)							
1	8%	9%	10%	6%	7%	5%	9%
2	6%	7%	3%	14%	5%	3%	9%
3	33%	37%	41%	30%	29%	33%	21%
4	24%	21%	22%	21%	26%	22%	33%
5	29%	25%	23%	29%	33%	36%	29%
N	687	354	222	132	333	207	126
How helpful is this data in quality improvement work at your practice? (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) - Patient experience data (e.g., CAHPS or other surveys)							
1	2%	2%	2%	3%	2%	<1%	3%
2	4%	6%	3%	8%	3%	1%	6%
3	25%	28%	28%	28%	23%	21%	24%
4	29%	30%	26%	34%	29%	26%	31%
5	39%	35%	42%	27%	44%	51%	36%
N	2,235	1,008	526	482	1,227	628	599

Table 4.B.5.2. (continued)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
How helpful is this data in quality improvement work at your practice? (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) - Performance-Based Incentive Payment (PBIP) Report							
1	11%	6%	12%	3%	15%	18%	13%
2	7%	8%	6%	9%	7%	5%	8%
3	36%	33%	22%	39%	38%	37%	38%
4	28%	35%	39%	32%	23%	24%	23%
5	17%	19%	21%	17%	17%	15%	18%
N	1,549	644	218	426	905	348	557
How helpful is this data in quality improvement work at your practice? (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) - ACO/IPA/System analytics							
1	6%	5%	3%	11%	7%	7%	6%
2	5%	4%	3%	7%	5%	1%	19%
3	23%	26%	22%	36%	20%	22%	14%
4	32%	32%	38%	18%	32%	38%	14%
5	34%	32%	34%	28%	36%	32%	47%
N	1,297	620	445	175	677	515	162

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For “select all that apply” questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

SSP = Medicare Shared Savings Program; ACO = Accountable Care Organization; IPA = Independent Physician Association

Table 4.B.5.3. Planned care and population health: Continuous quality improvement, Program Year 5, 2017 Starters (percentages)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Identify the quality measures on which your practice focused its quality improvement efforts during the past two quarters. (Select all that apply)							
We have not focused quality improvement efforts on any of the quality measures below	0%	0%	0%	0%	0%	0%	0%
Electronic Clinical Quality Measures (eCQMs)							
Controlling High Blood Pressure	96%	95%	91%	98%	98%	99%	96%
Diabetes: Hemoglobin HbA1c Poor Control (>9%)	99%	99%	99%	99%	99%	100%	99%
Diabetes: Eye Exam	75%	73%	76%	69%	76%	82%	70%
Diabetes: Medical Attention for Nephropathy	61%	59%	58%	61%	63%	65%	61%
Dementia: Cognitive Assessment	24%	25%	22%	29%	24%	20%	27%
Depression Utilization of the PHQ-9 Tool	60%	64%	64%	64%	57%	59%	55%
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	59%	59%	60%	57%	59%	59%	59%
Preventive Care and Screening: Tobacco Use Screening and Cessation Intervention	60%	61%	64%	57%	59%	67%	52%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	12%	13%	10%	17%	11%	13%	9%
Falls: Screening for Future Falls Risk	62%	64%	70%	59%	61%	69%	53%
Breast Cancer Screening	85%	86%	90%	82%	84%	89%	78%
Cervical Cancer Screening	60%	59%	58%	60%	61%	66%	56%
Colorectal Cancer Screening	87%	87%	92%	82%	86%	92%	80%
Preventive Care and Screening: Influenza Immunization	63%	62%	64%	59%	64%	68%	59%
Pneumococcal Vaccination Status for Older Adults	53%	50%	53%	47%	56%	60%	51%
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	15%	18%	19%	17%	13%	16%	10%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	43%	47%	50%	44%	40%	43%	37%
Closing the Referral Loop: Receipt of Specialist Report	35%	38%	37%	39%	33%	32%	34%
Use of High-Risk Medications in the Elderly	20%	21%	18%	24%	18%	16%	21%
Other	10%	9%	11%	8%	10%	13%	6%

Table 4.B.5.3. (continued)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Utilization and cost measures							
ED	92%	91%	90%	92%	92%	93%	91%
Inpatient	86%	86%	86%	85%	86%	89%	83%
Specialty care	23%	26%	35%	17%	21%	28%	14%
Imaging/labs	21%	24%	31%	17%	19%	21%	16%
Post-acute care	29%	27%	37%	17%	30%	41%	18%
Observation stays	18%	21%	21%	21%	16%	18%	13%
Other	9%	6%	7%	5%	11%	16%	5%
Patient experience measures							
Getting timely appointments, care, and information	84%	80%	85%	75%	88%	90%	85%
How well practitioners communicate with patients	62%	59%	63%	55%	64%	67%	60%
Overall practitioner ratings	63%	65%	66%	63%	62%	67%	56%
Attention to care from other practitioners	29%	29%	31%	27%	29%	30%	28%
Practitioners support patients in taking care of own health	42%	42%	46%	37%	42%	41%	42%
Other	10%	7%	3%	10%	12%	9%	15%
N	2,405	1,095	564	531	1,310	663	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

Note: For "select all that apply" questions, practices may choose more than one option. Responses may therefore sum to greater than 100%.

ED = emergency department; SSP = Medicare Shared Savings Program.

Table 4.B.5.4. Planned care and population health: Culture of improvement at your practice, Program Year 5, 2017 Starters (percentages)

	Track 1				Track 2		
	Overall	Total	SSP	Non-SSP	Total	SSP	Non-SSP
Over the last two quarters, who in your practice primarily generated improvement ideas and opportunities?							
Did not occur	<1%	<1%	<1%	<1%	0%	0%	0%
Clinical and administrative leadership	91%	88%	95%	81%	93%	93%	92%
Designated quality improvement team	64%	63%	68%	57%	65%	72%	58%
Care teams and clinical staff	80%	76%	76%	76%	83%	88%	77%
Non-clinical staff	49%	50%	54%	46%	49%	46%	52%
Patients/caregivers	44%	46%	45%	47%	41%	44%	39%
N	2,405	1,095	564	531	1,310	663	647
Over the last two quarters, who in your practice implemented improvement projects or tests of change?							
Did not occur	<1%	1%	2%	1%	<1%	0%	<1%
Clinical and administrative leadership	83%	79%	85%	73%	86%	85%	86%
Designated quality improvement team	60%	59%	65%	53%	62%	66%	57%
Care teams and clinical staff	81%	79%	83%	74%	82%	87%	78%
Non-clinical staff	51%	49%	52%	45%	53%	56%	50%
Patients/caregivers	9%	10%	10%	9%	8%	7%	9%
N	2,405	1,095	564	531	1,310	663	647
Over the last two quarters, who in your practice had access to practice-level results?							
Did not occur	<1%	<1%	<1%	<1%	<1%	<1%	0%
Clinical and administrative leadership	96%	94%	96%	92%	97%	97%	97%
Designated quality improvement team	69%	65%	70%	60%	72%	82%	62%
Care teams and clinical staff	88%	85%	88%	82%	91%	94%	88%
Non-clinical staff	62%	58%	63%	53%	65%	68%	62%
Patients/caregivers	15%	16%	15%	18%	15%	12%	17%
N	2,405	1,095	564	531	1,310	663	647

Table 4.B.5.4. (continued)

	Overall	Track 1			Track 2		
		Total	SSP	Non-SSP	Total	SSP	Non-SSP
Over the last two quarters, who in your practice had access to results identified by the applicable practitioner or care team?							
Did not occur	<1%	1%	2%	<1%	<1%	<1%	<1%
Clinical and administrative leadership	95%	92%	95%	89%	97%	97%	96%
Designated quality improvement team	65%	61%	64%	57%	69%	79%	59%
Care teams and clinical staff	82%	81%	84%	78%	83%	86%	79%
Non-clinical staff	49%	47%	51%	44%	51%	54%	47%
Patients/caregivers	8%	9%	7%	11%	7%	6%	8%
N	2,405	1,095	564	531	1,310	663	647

Source: Mathematica's analysis of 2021 (Quarter 4) care delivery reporting data submitted by practices to CMS via the CPC+ Practice Portal.

SSP = Medicare Shared Savings Program.

4.C. How CPC+ Supported Patient Care During the COVID-19 Pandemic: Lessons for Alternative Payment Models

In this Appendix, we examine how practices and physicians perceive CPC+ affected their ability to meet patients' care needs during the coronavirus disease 2019 (COVID-19) pandemic. We describe the research objective, our methods to collect and analyze the quantitative and qualitative data, survey results, and the implications of the findings.

4.C.1. Research objective

The COVID-19 pandemic caused abrupt and unprecedented disruptions to primary care. Initially, primary care practices worked to manage short-term restrictions on in-person services. Eventually their efforts grew to adapt to varying rates of transmission (Mafi et al. 2022), screening protocols, changing involvement in vaccination rollout, and federal, state, and local public health policies (Koller 2021). A growing literature base documents how primary care practices adapted to the pandemic, including providing more telehealth services and using disease registries to support patient outreach (Albert et al. 2021; Lin et al. 2020). However, less is known about the role that payment reform played for practices operating outside a purely fee-for-service (FFS) framework, such as those practices in CPC+.

Because the pandemic undermined visit-based care, both by reducing demand for non-emergent care and by shifting care online (Landon and Landon 2021), the financial and other supports in CPC+ may have helped stabilize practices' finances and staffing. Previous analyses found some evidence that participating in Accountable Care Organizations (ACOs) was associated with better outreach to high-risk patients during the pandemic (Amon et al. 2022), but there is limited insight into practices' and physicians' perspectives on how AAPM participation affected their ability to provide care.

To better understand how practices and physicians perceive CPC+ affected their readiness to meet patients' care needs during the pandemic, we use mixed methods to examine:

1. What proportion of practices and physicians perceive that CPC+ better positioned them to meet patients' care needs during the pandemic?
2. How, if at all, do these perceptions vary by characteristics such as practice size, ownership, urbanicity, and participation in the Medicare Shared Savings Program (SSP)?
3. What components of CPC+ participation did practices and physicians identify as influencing their readiness to meet patients' care needs?

4.C.2. Methods

A. Setting

This study included nearly 2,300 primary care practices that were selected and participated in CPC+ in 14 regions across the U.S., beginning in 2017 and ending in 2021 (Swankoski et al. 2022).

B. Data sources

The study draws on data collected from two surveys: (1) a survey of practices that began participating in CPC+ in 2017 and (2) a survey of randomly selected primary care physicians from these practices. Both surveys were conducted in the final year of the CPC+ model. An online practice survey was administered to almost all of the participating CPC+ practices between July and October 2021.³⁷ The practice survey was sent to the CPC+ practice contact (typically the practice manager, but in some systems a system-level CPC+ project lead responded for all of their participating practices). The respondent was encouraged to review the survey with practice staff to arrive at a consensus on the responses. The physician survey was administered online and in paper form to randomly selected primary care physicians in practices participating in CPC+ from April through August 2021. See Appendix 3.B Practice Survey and Appendix 3.C Physician Survey for information on sampling, eligibility, weighting, and fielding methods.

The practice survey included a close-ended question that asked respondents whether they agreed or disagreed with the statement, “*Your practice was better positioned to meet patients’ care needs during the coronavirus pandemic because of your participation in CPC+.*” using a 5-point Likert scale. It also included an open-ended question that asked respondents to “*please describe how, if at all, participation in CPC+ affected your ability to meet patients’ care needs during the coronavirus pandemic.*” The physician survey questions were slightly modified to focus on how CPC+ participation affected the physician’s care during the coronavirus pandemic (“*Please describe how, if at all, participation in CPC+ affected your ability to meet health care needs for your patients during the coronavirus pandemic.*”) and included a “don’t know” response option as some physicians may not be aware of how CPC+ was implemented.

Of the 2,496 CPC+ practices that received the 2021 practice survey, 2,290 (92 percent) completed the survey, 2,282 of which responded to the Likert item discussed above and 1,316 (57 percent) of which responded to the open-ended item. A preliminary review of the practice survey open-ended responses revealed that some system-based practice managers, who were respondents for multiple practices, provided identical responses to both questions across their practices. For this reason, we deduplicated the open-ended responses to highlight unique practice experiences for the qualitative analysis.³⁸ After the deduplication process, there were 887 unique open-ended responses remaining for the analysis.

Among the 993 CPC+ physicians who were administered the physician survey, 55 percent completed the survey. Among these 546 physician respondents, 530 (97 percent) completed the Likert item and 385 (71 percent) completed the open-ended item.

³⁷ Four practices submitted paper surveys during the survey pretest, which were accepted as their final survey responses.

³⁸ We grouped responses by system to perform approximate string matching (fuzzy matching) to compare responses within the same system to each other, using the generalized Levenshtein edit distance with a maximum distance set to 0.3. The Levenshtein edit distance is the total number of insertions, deletions, and substitutions required to transform one response to the one it is being compared to. A max distance of 0.3 used on a response string of 100 characters allows a maximum of 30 changes (insertions/deletions/substitutions) to be considered a match. A string of 10 characters allows a maximum of 3 changes. We began with a maximum distance of 0.1 and through a process of trial and manual review settled on 0.3 as best for our dataset. Our program returned a flag indicating a list of IDs within the system response group were likely matches. This flag was then used to deduplicate responses that we identified as matches and to generate a count of duplicates (noting how many times a particular response appears). We supplemented this method with manual identification during subsequent analysis, and ultimately identified 429 (33 percent) duplicate responses in the practice survey.

C. Quantitative methods

We applied practice-level weights to practice survey data to account for differences in survey response rates between the evaluation’s key practice subgroups: region, track, and SSP participation in 2020 (see Appendix 3.B. Practice Survey). We weighted the physician survey results by the inverse of their probability of selection. First, we adjusted the weights for the probability of having a known eligibility status, and, second, we adjusted the weights to account for survey nonresponse (see Appendix 3.C. Physician Survey).

Using the weighted data, we calculated frequencies of practices’ and physicians’ responses to the Likert item, by track, practice size, system ownership/affiliation, urbanicity, and SSP participation.³⁹ At least 97 percent of the survey respondents answered the Likert question, so we did not adjust responses for question nonresponse and instead we calculated results only among respondents. Furthermore, when we reviewed the “neither agree nor disagree” responses to the Likert item in the physician survey, we saw that many of the follow-up open-ended responses indicated a lack of knowledge rather than a neutral response. Therefore, for the physician survey, we grouped the “don’t know” responses under the “neither agree nor disagree” response category. To reduce the risk of false positives from multiple comparisons, we did not statistically test differences between subgroups but instead we considered a difference of 10 percentage points or more to be meaningful.

D. Qualitative methods

We used qualitative coding to analyze the unique free responses to the prompt “*please describe how, if at all, participation in CPC+ affected your ability to meet [patients’ care needs/health care needs for your patients] during the coronavirus pandemic.*” A group of 10 coders (working in overlapping teams of 2), applied pre-determined codes to each qualitative response. They used these codes to map the responses to the five primary care functions defined in Chapter 1, as well as codes for formal CPC+ supports (payment, health IT, and learning) and codes for responses indicating CPC+ had no effect or a negative effect on practices’ positioning to meet patients’ care needs during the pandemic. Multiple codes could be assigned to each response (for example, a response describing the benefits of risk stratification and using telehealth as alternatives to traditional visits would be coded as both care management and access). After independently coding all unique responses, the teams of two coders met to resolve any areas of disagreement. Finally, individual coders developed and applied a second set of more granular codes to better support identification of themes (for example, secondary codes could distinguish between risk stratification or care manager support within the care management code). At least one additional member of the coding team (GC or ND) reviewed 10 percent of all secondary codes for quality and consistency.

³⁹ Practice size was based on the number of primary care practitioners (PCPs) reported by the CPC+ practices as of December 2020 (or December 2019 if we could not obtain the 2020 data). System ownership status as of October 2020 (or October 2019 if we could not obtain the 2020 data) was provided by IQVIA, a marketing organization that collects information directly from all health care practices and physicians in the United States. Urbanicity reflects the practice’s status as of 2013 based on the information from the 2015–2016 U.S. Department Health and Human Resources’ Area Health Resources File (AHRF). The practice’s SSP status was reported by CMS as of January 2021 (or January 2020 if we could not obtain the 2021 data). These subgroup results for practice size, system ownership, and SSP participation differ from those in Chapter 4 which use baseline values for these variables.

4.C.3. Results

A. Characteristics of practice and physician survey respondents

After weighting, the characteristics of respondents in the two surveys (including for the Likert item) did not differ by practice track, SSP status, ownership, or urbanicity (Table 4.C.1). Nearly two-thirds of the practice and physician survey respondents were in practices owned by a system and slightly over three-quarters were in practices located in urban areas. However, we did see a difference between the two groups of respondents in distribution across practice size. While the practice survey respondents were mostly from medium to large practices, the physicians were generally from large practices.

Table 4.C.1. Characteristics of practice and physician survey respondents

Practice characteristics	Practice Survey respondents (N = 2,282)		Physician Survey respondents (N = 530)	
	N	%	N	%
Track				
Track 1	1,054	46	244	46
Track 2	1,228	54	286	54
Practice size				
Small ^a (1-2 PCPs)	583	26	63	12
Medium (3-5 PCPs)	871	38	130	25
Large (6+ PCPs)	828	36	337	63
Ownership status				
System owned ^b	1,313	57	311	59
Not system owned	815	36	192	36
Urbanicity				
Rural ^c	200	9	42	8
Suburban	326	14	53	10
Urban	1,756	77	435	82
SSP participation status				
SSP ^d	1,155	51	253	48
Non-SSP	1,127	49	277	52

Source: Mathematica's analysis of data from the independent evaluation's PY 5 CPC+ Practice and Physician Surveys.

Note: For physician survey respondents, the table shows characteristics of the practice that physicians were associated with when they completed the survey.

^a We developed these three practice size categories based on the number of primary care practitioners (PCPs) reported by the CPC+ practices as of December 2020 (or December 2019 if we could not obtain the 2020 data).

^b The system ownership status as of October 2020 (or October 2019 if we could not obtain the 2020 data) was provided by IQVIA, a marketing organization that collects information directly from all health care practices and physicians in the United States. System ownership status was missing for 154 (7 percent) practice survey respondents and 27 (5 percent) of physician survey respondents.

Table 4.C.1. (continued)

^c Urbanicity reflects the practice’s status as of 2013 based on the information from the 2015–2016 U.S. Department Health and Human Resources’ Area Health Resources File (AHRF). The AHRF provides a 9-point rural-urban continuum code (RUCC) from the USDA Economic Research Service. From these codes, we defined urban as a county in a metro area of more than 250,000 people (RUCC = 1 or 2), suburban as a county in a metro area of less than 250,000 people or that has an urban population of 20,000 or more and is adjacent to a metro area (RUCC = 3 or 4), or rural if it does not meet the urban or suburban classifications (RUCC = 5–9).

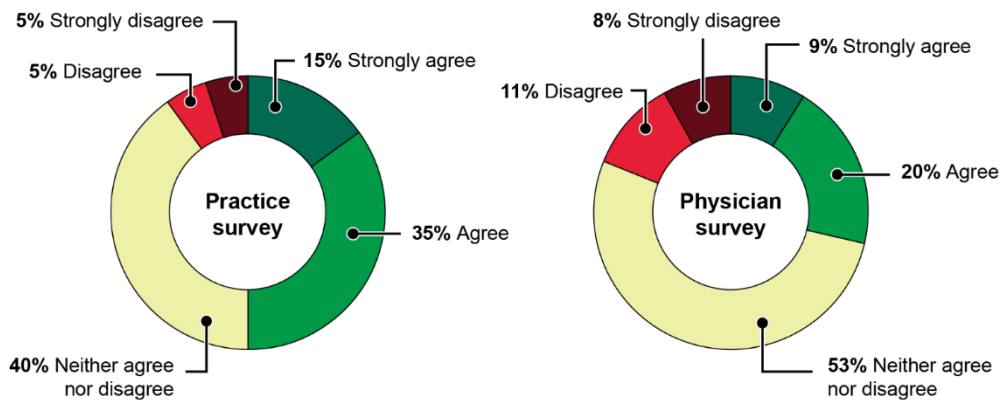
^d The practice’s SSP status was reported by CMS as of January 2021 (or January 2020 if we could not obtain the 2021 data).

PCP = primary care practitioner; SSP= Medicare Shared Savings Program.

B. Overall perceptions of CPC+

Half of practices and about one-third of physicians agreed or strongly agreed that participating in CPC+ better positioned them to meet patients’ care needs during the pandemic. One in 10 practices, and 2 in 10 physicians, disagreed or strongly disagreed with the statement. The remaining 4 in 10 practices and just over half of physicians neither agreed nor disagreed (or, for physicians, didn’t know) (see Figure 4.C.1).

Figure 4.C.1. Percentage of CPC+ practices and physicians that reported they were better positioned to meet patients’ care needs during the coronavirus pandemic because of CPC+



Source: Mathematica’s analysis of data from the independent evaluation’s 2021 CPC+ Practice and Physician Surveys.

Note: N = 2,282 practices and 530 physicians. Physicians’ “neither agree nor disagree” responses also include “don’t know” responses.

Practices’ and physicians’ responses did not differ by CPC+ track, health system ownership, or participation in SSP ACOs. We observed differences by practice size and urbanicity. First, more large practices (54 percent) than small practices (42 percent) agreed or strongly agreed that participating in CPC+ better positioned them to meet patients’ care needs during the pandemic. Similarly, more physicians from large practices than physicians from small practices (33 percent vs. 23 percent) agreed or strongly agreed with this statement (see Table 4.C.2).

Second, more rural practices than suburban practices agreed or strongly agreed that participating in CPC+ better positioned them to meet patients’ care needs during the pandemic (57 percent vs. 43 percent; 51 percent of urban practices agreed or strongly agreed). More rural physicians than suburban or urban physicians agreed or strongly agreed that participating in CPC+ better positioned them to meet patients’ care needs during the pandemic (41 percent vs. 20 percent and 29 percent, respectively) (see Table 4.C.2).

Table 4.C.2. Percentage of CPC+ practices and physicians that reported they were better positioned to meet patients' care needs during the coronavirus pandemic because of CPC+, by practice characteristics

Practice characteristics		Practice survey (N = 2,282)			Physician survey (N = 530)		
		Agree or strongly agree	Neither agree nor disagree	Disagree or strongly disagree	Agree or strongly agree	Neither agree nor disagree	Disagree or strongly disagree
Overall	N	1,145	914	223	155	289	86
	%	50%	40%	10%	29%	53%	18%
Track							
CPC+ Track 1	N	506	436	112	68	136	40
	%	48%	42%	11%	27%	55%	18%
CPC+ Track 2	N	639	478	111	87	153	46
	%	52%	39%	9%	31%	51%	18%
Practice size							
Small ^a (1–2 PCPs)	N	241	280	62	15	34	14
	%	42%	48%	10%	23%	53%	24%
Medium (3–5 PCPs)	N	449	334	88	34	70	26
	%	52%	38%	10%	24%	52%	24%
Large (6+ PCPs)	N	455	300	73	106	185	46
	%	54%	37%	9%	33%	53%	14%
Ownership status							
System owned ^b	N	701	499	113	85	181	45
	%	53%	38%	9%	27%	57%	16%
Not system owned	N	376	349	90	59	95	38
	%	46%	43%	11%	30%	48%	22%
Urbanicity							
Rural ^c	N	115	64	21	17	19	6
	%	57%	32%	10%	41%	38%	20%
Suburban	N	142	140	44	10	31	12
	%	43%	43%	14%	20%	53%	27%
Urban	N	888	710	158	128	239	68
	%	51%	41%	9%	29%	54%	17%
SSP participation status							
SSP ^d	N	598	442	115	72	142	39
	%	51%	38%	10%	29%	55%	15%
Non-SSP	N	547	472	108	83	147	47
	%	49%	42%	9%	29%	50%	21%

Source: Mathematica's analysis of data from the independent evaluation's PY 5 CPC+ Practice and Physician Surveys.

^a We developed these three practice size categories based on the number of primary care practitioners (PCPs) reported by the CPC+ practices as of December 2020 (or December 2019 if we could not obtain the 2020 data).

^b The system ownership status as of October 2020 (or October 2019 if we could not obtain the 2020 data) was provided by IQVIA, a marketing organization that collects information directly from all health care practices and physicians in the United States. System ownership status was missing for 154 (7 percent) of practice survey respondents and 27 (5 percent) of physician survey respondents

^c Urbanicity reflects the practice's status as of 2013 based on the information from the 2015–2016 U.S. Department Health and Human Resources' Area Health Resources File. The AHRF provides a 9-point rural-urban continuum code (RUCC) from the USDA Economic Research Service. From these codes, we defined urban as a county in a metro area of more than 250,000 people (RUCC = 1 or 2), suburban as a county in a metro area of less than 250,000 people or that has an urban population of 20,000 or more and is adjacent to a metro area (RUCC = 3 or 4), or rural if it does not meet the urban or suburban classifications (RUCC = 5–9).

^d The practice's SSP status was reported by CPC+ practices as of January 2021 (or January 2020 if we could not obtain the 2021 data).

PCP = primary care practitioner; PY = Program Year; SSP= Medicare Shared Savings Program.

C. Perceptions of CPC+ components

Although only half of the practices and two-thirds of the physicians that responded to the close-ended question provided an open-ended response, these responses shed light on the mechanisms through which CPC+ participation likely affected how well-positioned practices and physicians were to meet patients' care needs during the pandemic. Responses to the open-ended items generally focused on the benefits of participating in CPC+ during the pandemic. Among the 1,316 practices and 385 physicians who replied to the open-ended questions, the most commonly identified facilitating factors relate to care management, access, payment, and staffing. A small percentage of these practices and physicians said that CPC+ hindered their ability to meet patients' needs, mainly because they perceived CPC+ as burdensome.

C.1. Care management

Care management was the most common facilitating factor practices and physicians noted. Among practices and physicians that responded to the open-ended survey items, about one-third of practices and one-quarter of physicians reported that their work to implement care management for CPC+ helped them meet patients' needs during the pandemic. Both practices and physicians noted that care management processes helped ensure patients received necessary outreach and support. Longitudinal care management efforts helped ensure high-risk patients received education and monitoring to avoid the hospital, while episodic care management processes supported timely follow-up with patients who were discharged from the hospital or emergency department. Many of these practices and physicians noted they were able to adapt these care management workflows for patients who required additional support after testing positive for the pandemic. One practice noted:

As part of CPC+, our RN Care Coordinators on a daily basis were reaching out to high-risk patients and all patients discharged from the hospital/ED. This put them in a unique position to provide home monitoring to the COVID patients. Reaching out to COVID patients provided extra telephonic assessment and coordination of care that ultimately aided the patients to recover in a timelier manner.

Practices and physicians also noted that assigning risk scores to patients—which was required for CPC+—helped them understand patients' needs and prioritize outreach to patients who were not coming into the office for in-person visits.

C.2. Access

Another common facilitating factor that emerged from the open-ended survey questions was that efforts to improve patients' access to primary care, as required by CPC+, were helpful during the pandemic. About 15 percent of practices and physicians who responded to the open-ended survey items mentioned the importance of access, with almost all respondents focusing on telehealth.

Practices and physicians indicated that CPC+ helped them provide telehealth services, either because they had already implemented telehealth protocols due to the CPC+ requirement to offer alternatives to traditional office visits or because their work on CPC+ made them feel more prepared to adopt telehealth protocols (for example, because they had started to explore telehealth implementation before the pandemic).

C.3. Alternative payment

Among practices and physicians who responded to the open-ended survey items, one in 10 practices and 1 in 20 physicians noted that CPC+ payments supported practices' efforts to care for patients during the pandemic. Although practices and physicians did not identify which types of payments they perceived as being most helpful (e.g., care management fees, Performance-based Incentive Payments), they emphasized that additional funding from CPC+ helped them maintain operations during the pandemic when visit-based revenue was down. Additionally, CPC+ payments helped practices invest in telehealth, which (as noted earlier) was a central part of their pandemic response.

C.4. Staffing

Just under one in five practices and physicians who responded to the open-ended survey items highlighted how the staffing models CPC+ promoted, particularly for care management and behavioral health integration, were critical to addressing the specific patient needs that arose during the pandemic. Robust care teams including care managers, behavioral health specialists, pharmacists, or coaches were seen as helpful during the pandemic by providing practices with flexibility to address emergent issues. As one practice manager commented:

Behavioral health and care management were key with delivery assistance to patients who were struggling with multiple issues during the pandemic. We were able to offer support that many other practices did not have access to. We were able to truly help and make a difference with our patients.

Respondents mentioned that care managers assumed extended health care responsibilities because of the pandemic, such as scheduling vaccinations, staffing vaccine clinics, conducting COVID testing, following up with COVID-positive patients, and answering questions about ways to keep safe during the pandemic. Care managers also supported routine care by conducting outreach to the general patient population to encourage telehealth visits and answer questions when in-person visits were limited. In addition, several practices mentioned that their care managers also addressed the mental health needs of their patients. Practice and physicians acknowledged that having behavioral health staff on site or strong relationships with off-site staff allowed them to meet the escalating mental health needs.

Practices and physicians also noted CPC+ had strengthened their staff's capability to aid patients with health-related social needs and medication management, which were also more urgent during the pandemic.

C.5. Other helpful mechanisms

Although it was less common, practices and physicians also mentioned the helpfulness of the culture CPC+ fostered. They noted that participating in CPC+ had led to cultural changes in their workplace that allowed for creativity and nimbleness that benefited patient care during a time when the course of the pandemic was largely unknown and in flux. These practices discussed the mindset of adaptability, creativity, and flexibility that practices embraced throughout CPC+, which became essential in adjusting to the ever-changing pandemic.

Responses additionally mentioned the benefit of activities related to other primary care functions such as comprehensiveness, coordination, planned care and population health, patient and caregiver engagement, and supports from learning and health IT vendors. However, these primary care functions were cited less often than the primary care functions discussed in the sections above.

C.6. No effect

Among practices and physicians who responded to the open-ended survey items, about 15 percent of practices and one-third of physicians indicated participating in CPC+ had no effect on their ability to meet patients' care needs during the coronavirus pandemic. Several explained that factors other than CPC+ (such as reimbursement for telehealth visits under FFS or an existing practice culture focused on teamwork) had helped and many others expressed uncertainty about whether CPC+ had helped.

C.7. Negative

Fewer than 1 in 20 practices and physicians who responded to the open-ended survey items indicated CPC+ hindered their ability to meet patients' care needs during the coronavirus pandemic. Few responses elaborated on these mechanisms, but the most common explanation noted was that work required for CPC+, particularly reporting and meeting care delivery requirements, was burdensome, exacerbated staff burnout, or both. Respondents also noted it was stressful and challenging to meet CPC+ benchmarks when many patients were hesitant to be seen in person.

4.C.4. Discussion

Primary care practices have faced numerous, fluctuating challenges to traditional modes of care delivery due to the pandemic. Our study leveraged practice managers' and physicians' discrete and open-ended survey responses to provide a robust analysis of how, if at all, participating in CPC+ affected readiness to meet patients' care needs in the face of these challenges.

On close-ended survey questions, half of CPC+ practices and almost one-third of physicians perceived CPC+ participation positively in this context. The gap between positive practice and physician responses may reflect differing familiarity with how CPC+ supported the practice, staff, and daily operations. Physicians' experiences providing direct patient care may also have contributed to their feeling less readiness to meet patients' care needs during the pandemic, compared to other members of the practice with different responsibilities, like the practice managers who typically responded to the practice survey. Although CPC+ provided financial and other supports that some practices and physicians deemed helpful during the pandemic, this sentiment was not universal. On the close-ended survey questions, about 4 in 10 practices and just over half of physicians were neutral about whether their CPC+ participation helped them meet patients' care needs during the pandemic, and one-tenth of practices and two-tenths of physicians disagreed.

Navigating the pandemic remains an ongoing challenge for primary care as variants surge and wane, pandemic sequelae continue to emerge, and vaccine and booster recommendations evolve. Furthermore, primary practices will likely have to manage other shocks to their environment that could otherwise compound health or economic insecurity such as future disease outbreaks, natural disasters, and sudden changes to local or national economies. Open-ended responses reveal that investments in providing care management and improving access before the pandemic, funded at least in part by CPC+ payments, were particularly helpful in preparing to change health care delivery priorities and methods. However, these payments ended in 2021 with the conclusion of CPC+. While some of these changes may be possible to sustain after the model's end in 2021, the staffing supports that undergird much of the flexibility and proactivity practices described may be difficult to continue without ongoing funding. Larger and system-owned practices may be better positioned to use their shared resources to sustain supports like integrated behavioral health and non-billable staff like a care manager or care coordinator.

Our mixed-methods analysis has several limitations. First, our results may not be generalizable to other practices. Practices applied to be in CPC+ and may have been uniquely positioned to change care delivery relative to other primary care practices. However, responses could still generalize to other similarly motivated practices, such as the 1,360 practices that applied but were not selected for CPC+. Second, it was challenging to interpret and weight duplicate responses to the open-ended practice survey item, and focusing on unique responses likely underweights the system practice experience. Our choice to focus on unique responses prioritized identifying diverse ways CPC+ may have helped practices at the expense of precisely capturing the number of practices for which each answer applies. While removing duplicates risks minimizing factors that better positioned practices in systems to meet patients' care needs during the coronavirus pandemic, it also avoids overweighting factors described in a response that was repeated many times and may not accurately reflect individual practices' experiences within a health system. Finally, while we have identified several supports and requirements that practices and physicians most frequently mentioned as helping or hindering their experiences meeting patients' care needs, these elements of CPC+ were part of a cohesive and interrelated model. We did not systematically assess each of the model's component parts to determine if it was more protective or burdensome, and our results may not generalize to standalone interventions related to, for example, behavioral health support.

4.C.5. Conclusion

CPC+ provided many primary care practices with financial and structural support that helped buffer shocks related to the pandemic. Investing in care management, expanded access, and diverse staff, including care managers and behavioral health, enabled practices to build routines and relationships that supported patient care in the face of ongoing uncertainty and change.

4.D. Implementation of Comprehensive Medication Management in a National Primary Care Transformation Model

Comprehensive medication management (CMM) holds promise for improving health outcomes and reducing clinician workload. In this Appendix, we describe the implementation experiences of practices participating in Track 2 of CPC+ and their perceptions of CMM.

Key takeaways

1. By the final year of the CPC+ model, at least 80 percent of Track 2 practices reported they had taken key steps to implement CMM. Practices most commonly used a pharmacist to provide CMM.
2. Practice staff perceived CMM as beneficial, connecting it to improved medication adherence and patient outcomes (such as A1c levels for patients with poorly controlled diabetes). According to practice staff, improvements stemmed from identifying patients' barriers to medication adherence and helping to address them. Moreover, when pharmacists were integrated into primary care teams, physicians and nurse care managers found that they lightened their workloads.
3. Early in the model, pharmacists' effectiveness was impeded by confusion about CMM and low physician buy-in, but this dissipated as physicians recognized the value of collaborating with pharmacists. After CMM was implemented, practice staff rarely reported discontinuing it, and the most common CMM challenge they reported was the cost of a pharmacist.
4. Pharmacists, either embedded as practice team members or working as part of a larger population health approach to primary care, were central to the perceived benefits of CMM.

4.D.1. Introduction

Comprehensive medication management (CMM) holds promise for improving health outcomes and reducing clinicians' workload in the primary care setting. CMM is a patient-centered care approach designed to improve health outcomes of patients with complex medication needs, including those with chronic conditions (Prudencio and Kim 2020; McFarland et al. 2021; Chung et al. 2020; Funk et al. 2021; Kuo et al. 2021; Castelli et al. 2018; Patient-Centered Primary Care Collaborative 2012). To provide CMM, health care organizations often add clinical pharmacists to the care delivery team, which expands the care team's access to information about medication management and reduces clinician workload (American College of Clinical Pharmacy 2016; Funk et al. 2019; White 2020).

Two models of CMM implementation emerge in the literature: the expanded care team pharmacist model (ECT), and the population health team pharmacist model (PHT) (Mulrooney and Smith 2022). In ECT, a clinical pharmacist (pharmacist) is embedded in the practice as a care team member, communicating with practice clinicians and meeting directly with patients for chronic disease medication management. In PHT, the pharmacist is typically located centrally and does not meet directly with patients in the practice setting. PHT pharmacists take a population health approach to care delivery, identifying patients who may benefit from CMM, for example, by reviewing chronic disease registries for patients with multiple chronic illnesses. PHT pharmacists typically review patients' medications in the electronic health record

(EHR) and communicate with primary care providers to integrate recommendations into patients' care plans.

CMM and Comprehensive Primary Care Plus

This mixed-methods study describes the implementation of CMM in Comprehensive Primary Care Plus (CPC+). CMS required practices in Track 2 to plan for CMM implementation starting in 2018 and to provide CMM starting in 2019, specifically to patients receiving care management and/or undergoing a care transition (CMS 2021).

For CPC+, CMS defined CMM as a collaborative, patient-centered process between the primary care team and a CMM specialist, which incorporates but goes beyond the more common activities of medication review and reconciliation. The CMM specialist could be a pharmacist, but also could be a physician, nurse practitioner, or physician assistant. CMS suggested that CMM include the following activities: (1) identifying high-risk patients and referring them to a CMM specialist; (2) assessing the patient and evaluating medication therapy, including reviewing the patient's medical records and medication history to discuss with patients/caregivers the effectiveness, safety, affordability, and value of current medications; (3) developing and initiating an individualized action plan to address medication issues; and (4) following up with patients to monitor patients and share progress with primary care teams (CMS 2021). Although CMS encouraged inclusion of these CMM activities, which align with those described in the literature, it gave practices flexibility to select the model of CMM (that is, ECT, PHT, non-pharmacist CMM specialist) that best fit their practice.

We report findings on practices' experiences with and perceptions of CMM, including: (1) their approaches to CMM, (2) perceived benefits and drawbacks of CMM, and (3) factors that facilitated and impeded CMM implementation. The findings could inform future research, the design of CMM requirements and services in future primary care transformation models, and the development of other primary care policy and education and training approaches.

4.D.2. Methods

This mixed-methods study used quantitative program and survey data to examine the adoption of CMM in practices participating in Track 2 of CPC+. We also analyzed descriptive qualitative information on practices' experiences implementing CMM. We limited our analysis to practices participating in Track 2 of CPC+, because CMS required only those practices to implement CMM.⁴⁰

A. Quantitative analysis

Our quantitative analysis drew from two sources. The first data source comprises answers to questions about care delivery activities that CMS required all participating practices to self-report. For this study, we calculated the percentage of practices in Track 2 that reported to CMS whether they had taken key steps to implement CMM in the final quarter of CPC+ (2021; n = 1,310).

⁴⁰ Although CMS did not require Track 1 practices to implement CMM, at least 43 percent of Track 1 practices reported taking steps to implement CMM by the end of CPC+. These steps included identifying or hiring personnel for CMM (43 percent); training staff, as necessary (49 percent); and developing workflows and processes for CMM (53 percent).

The second data source was an annual survey of CPC+ practices. Because practice sites participating in CPC+ were expected to cooperate with the CMS evaluation (including responding to surveys), the response rate was over 94 percent. Practice managers, with input from practitioners and staff, answered questions about their experiences implementing CPC+, including their approaches to CMM. We report on survey data that practices in Track 2 provided in the final year of CPC+ (2021; n = 1,234), specifically the percentage of practices that reported having a clinical pharmacist on site. Details on the methods of analysis for the survey data and the data practices reported to CMS are in Appendixes 3B and 4B, respectively.

B. Qualitative analysis

In 2019, 2020, and 2021, we conducted semi-structured telephone interviews with a representative sample of 41 unique practices that began participating in CPC+ in 2017. In choosing practices for this qualitative study, we prioritized approximating the sample characteristics to the characteristics of all CPC+ practices, in terms of size, geographic location, ownership status, and participation in the Medicare Shared Savings Program (SSP) (Table 4.D.1). Our combined sample of practices from all three interview periods aligned with the broader set of Track 2 CPC+ practices' characteristics. Over 70 percent of interviewed practices were medium to large in size, located in urban areas, and just over half were owned by a health system or hospital.

Researchers collected qualitative data on CMM, as well as topics outside the scope of this study (for example, other CPC+ care delivery activities, payment, and learning supports) (Appendix 4A; Laird et al. 2022, Appendix 4B; Ghosh et al. 2020, Appendix 4D). In each practice, we interviewed three to four respondents, including at least one physician and one practice manager for 30 to 60 minutes each. In some practices, we interviewed care managers, medical assistants, or pharmacists who were involved or familiar with CMM in their practices. In system-owned practices, we also interviewed system-level staff, such as CPC+ coordinators or centralized care managers. Health service researchers conducted all interviews with practices. We obtained verbal consent and recorded and transcribed the interviews.

Table 4.D.1. Characteristics of all Track 2 practices that participated in all years of CPC+ and the sample that participated in the qualitative interviews

	All Track 2 practices participating in CPC+ at end of model	Track 2 practices interviewed in 2019, 2020, 2021
Number of practices	1,316	41
Participant in SSP ACO (%)	50%	44%
Owned by a hospital or health system (%)	57%	54%
Number of primary care practitioners per practice (%)		
6+ PCPs	40%	51%
3–5 PCPs	38%	24%
1–2 PCPs	21%	24%
Geographic location		
Rural	8%	7%
Urban	79%	73%
Suburban	12%	20%

Source: Data for practices that participated in CPC+ are derived from Mathematica's analysis of (1) CMS's CPC+ practice tracking data for time-varying characteristics of practice size, number of PCPs (as of December 2021), and SSP participation status (as of January 2021); (2) OneKey data for ownership status (as of October 2020); and (3) Area Health Resource File data for geographic location at baseline (2016).

Note: Table includes practices that started CPC+ in 2017 that were in Track 2. For detailed information on the approach to qualitative data collection, please see Appendix 4.A.

ACO = Accountable Care Organization; PCP = primary care practitioner; SSP = Medicare Shared Savings Program.

We used a grounded theory approach for our analysis, asking open-ended questions in each interview period to capture practices’ approach to CMM, their perceptions of CMM’s value, and the challenges and facilitators to implementing it (Table 4.D.2). Our within- and across-case analysis of these data proceeded in stages, using NVivo 12 (QSR International) and the Consolidated Framework for Implementation Research (CFIR) (Keith et al. 2017). A trained team of researchers coded interview transcripts using NVivo software. We organized data for analysis by tagging data about CMM with a CMM code, and adapted the CFIR to code factors that practices described as barriers to or facilitators of CMM implementation.

Three researchers analyzed data segments with combinations of the CMM code and CFIR codes for each practice to create analytic summaries that described the practice’s experience with CMM. The same three researchers entered these analytic summaries into matrices in Microsoft Excel and examined them for repeating patterns across practices to identify central themes connected to our research questions. We first examined themes within each interview period and then across the periods.

Four researchers met regularly to debrief, which allowed for modification and refinement of our analysis. For example, some practices reported providing CMM but their description of related activities did not meet CMS’s definition of CMM. Discussions helped the team establish criteria for determining CMM implementation. Practice descriptions needed to include (1) assessment of patient and evaluation of medication therapy for issues with effectiveness, safety, affordability; (2) development and initiation of a plan to address medication issues; and (3) communication about medication issues with care team members who could make medication changes, if this was not within the purview of the primary CMM provider.

Table 4.D.2. CMM qualitative interview topics

Topics and probes
<ul style="list-style-type: none"> • Changes practices implemented to provide comprehensive medication management because of CPC+ <ul style="list-style-type: none"> – For example, involvement of pharmacist, development and initiation of individualized action plan • Facilitators for providing comprehensive medication management • Challenges of providing comprehensive medication management • Plans to sustain comprehensive medication management beyond CPC+ <ul style="list-style-type: none"> – Reasons for continuing or not continuing • Benefits of providing comprehensive medication management <ul style="list-style-type: none"> – Benefits for patients and providers

4.D.3. Results

By the final year of CPC+ (2021), at least 80 percent of Track 2 practices reported to CMS that they had taken steps to implement CMM. These steps included identifying or hiring personnel for CMM (80 percent); training staff, as necessary (88 percent); and developing workflows and processes for CMM (91 percent). Slightly fewer practices we interviewed (about three-quarters) described full implementation of CMM, meaning their provided services were consistent with CMS’s definition of CMM (Table 4.D.3).

Practices we interviewed described providing CMM through a physician, nurse care manager, and/or pharmacist, depending on the patient’s needs and clinician’s availability and expertise. For example, a pharmacist at one practice reported specializing in patients with newly diagnosed or poorly controlled diabetes. At another practice, the physician conducted CMM for patients discharged from the hospital or a rehabilitation facility, referring patients to or consulting with the pharmacist as needed.

Table 4.D.3. Description of services provided by practices conducting CMM that aligned with CMS's definition

CMS's criteria for CMM	Assessment of patient and evaluation of medication therapy for issues	Development and initiation of a plan to address medication issues	Communication about medication issues with care team members who could make medication changes
Examples of practice activities that met CMS's criteria for CMM	<ul style="list-style-type: none"> • Reviewing the patient's medication list • Identifying drug interactions or redundancies in the patient's medication list • Discussing with patients/caregivers the effectiveness, safety, affordability, and value of current medications 	<ul style="list-style-type: none"> • Implementing changes to the medication regimen based on the patient's conditions, side effects, and challenges to adherence • Documenting the patient's barriers and next steps in a care plan • Counseling patients on their medications (especially when medications are new or have changed) • Discussing challenges to medication adherence with the patient 	<ul style="list-style-type: none"> • Updating care plan available in the EHR to all care team members to reflect changes to medication list, goals, and patient's health status • Communication via phone or messages in the EHR between CMM provider and other care team members about urgent and emergent issues not yet identified about the patient, before or after CMM

A. Identifying patients for CMM

Practices referred similar types of patients for CMM, most commonly high-risk patients and patients who experienced a new health episode. High-risk patients included those with polypharmacy, poorly controlled chronic illnesses (like diabetes, hypertension, or COPD), and social challenges to adhering to their medication regimen (such as being unable to afford their medications). Examples of new health episodes include discharge after an acute hospitalization, or a new diagnosis of diabetes, hypertension, or other chronic illness that requires medication. These patients were identified through clinical judgment by a care team member during a routine patient interaction, such as an annual visit or a checkup for a chronic condition like diabetes, or by population health staff (including pharmacists) from data reports and patient registries (such as a list of high-risk patients from an insurer, or a list of patients from the EHR who have laboratory values within a certain range).

B. Pharmacist collaboration

Most practices described collaborating with pharmacists to provide CMM, and very few described practice staff conducting CMM without any access to a pharmacist. More than half of practices we interviewed described employing an embedded pharmacist for at least part of the week. System-owned practices were more likely than independent practices to have access to a full- or part-time clinical pharmacist on site (62 versus 39 percent), according to the 2021 CPC+ Practice Survey. In interviews, independent practices typically described employing part-time embedded pharmacists, although one independent practice with seven doctors hired a full-time pharmacist. This practice did so using value-based payments from a commercial payer and its pharmacist saw any patient regardless of insurance type. In qualitative interviews, respondents described embedded pharmacists as fully integrated into the primary care teams, consistent with Mulrooney and Smith's (2022) definitions of the expanded care team model. These pharmacists functioned as additional providers who saw patients and communicated closely with care team members about patients.

A slightly smaller proportion of practices described providing CMM through processes consistent with the population health model. These pharmacists often worked on a centralized population health team and contributed to population health efforts by identifying patients who might benefit from CMM through patient registries and data reports. For example, a health system’s population health team may include a pharmacist who is available to all its primary care practices. Some centrally located pharmacists were available for two-way communication, where pharmacists provided practice clinicians with recommendations for patients identified through population health reports and the EHR, and practice clinicians could also communicate with pharmacists for patient referrals and consultations, according to practice staff we interviewed.

A few independently owned practices described loose relationships with pharmacists that did not fit either the embedded or population health model. For example, two practices described informal relationships with local pharmacists whom physicians were able to consult with about drug interactions and drug alternatives.

C. Perceived benefits of CMM

Practice staff perceived CMM to be beneficial and shared examples of how it improved medication adherence and patient outcomes. Conducting CMM allowed practice staff to learn about patients’ barriers to adherence so they could address them, and a few respondents described observing improvements in patients’ conditions, such as A1c levels for patients with poorly controlled diabetes. Pharmacists also reduced the burden of treatment on patients, who benefited from pharmacists’ developing easier-to-manage medication regimens and assisting with other barriers to adherence such as cost.

By the end of CPC+, nearly all the physicians we interviewed described valuing their collaborations with pharmacists, even though some were skeptical at first. Pharmacists had specialized knowledge (for example, of medications and programs for medication assistance) that helped clinicians make prescribing decisions and provide care that was tailored to the specific needs and circumstances of patients.

Physicians appreciated pharmacists’ knowledge of drug interactions and alternatives. One physician described finding the pharmacist particularly helpful

“when I find myself in over my head, or just stymied by patients who are seeing multiple sub-specialists and on multiple medications.” Moreover, when pharmacists were integrated into primary care teams physicians and nurse care managers found that they lightened their workloads, by adding an extra provider who could follow up with patients, handle prior authorizations, and develop and update care plans for high-risk patients.

“Pharmacists have much more knowledge of the medications, how they work, how they work together. Having that specialty knowledge, but also just that [expanded care team] gives the provider more time to address other things.”

–System-level coordinator

D. Challenges of implementing CMM

During the earlier years of CPC+ when pharmacist collaboration in primary care was beginning, some practices reported that a lack of physician buy-in impeded the effectiveness of the pharmacist. They described how physicians were reluctant to collaborate with available pharmacists because the workflows were new and difficult to remember or because physicians did not see the value of collaborating with pharmacists. The barrier dissipated as physicians had more opportunities to collaborate with pharmacists and see their value, and as pharmacists became more integrated into the practice’s care delivery workflows.

A small number of Track 2 practices we interviewed earlier in CPC+ seemed to conflate CMM with medication review or reconciliation. By the last two years of CPC+, however, we rarely detected this misunderstanding of CMM in respondents' descriptions of their practice's CMM activities.

After CMM was implemented, practice staff rarely reported discontinuing it, and the most common CMM challenge they reported was the cost of hiring and retaining a pharmacist. For example, one practice reported piloting a partnership with a pharmacy residency program that provided part-time pharmacists, but the practice could not afford to continue the partnership.

"[We] didn't know what we were going to do with the pharmacist when she first started...now we wouldn't know how to live without her."

– Program manager

4.D.4. Discussion

This study examined the implementation of CMM in practices in Track 2 of CPC+. In our in-depth qualitative study, we found that these practices were able to implement CMM, typically by involving pharmacists in CMM service delivery. Practices that implemented CMM found that it benefited their patients and providers, and that pharmacists were a valuable resource.

These findings build on previous work, primarily in the pharmacy literature, indicating that CMM can be an important component of comprehensive, patient-centered care that has the potential to improve outcomes such as medication adherence and clinical goal attainment, especially for patients with multiple chronic diseases (Brummel and Carlson 2016; Prudencio and Kim 2020). This large national study provides a primary care perspective on the implementation of CMM, indicating that it expands the delivery of services that are useful to patients and also reduces burden on clinicians. The involvement of pharmacists, either embedded in the primary care practice site or as part of a larger population health approach to primary care, was central to the perceived benefits of CMM.

Strengths and limitations

This mixed-methods study, conducted as part of a larger evaluation of CPC+, provides a unique look into the implementation of CMM in a large national sample of primary care practices of varying characteristics. Practices participating in Track 2 of CPC+ received payments from CMS and other payers to support the provision of care, and had access to coaching to support CMM implementation—such as practice coaches, webinars, and peer learning opportunities. Funding and learning supports of this type are not available to most primary care practices, which may limit the applicability of the findings. A further limitation is that we could not examine empirical associations between CMM service delivery and patient outcomes.

The study does, however, offer findings that can inform future research and policy on the provision of CMM services as a routine element of high quality, comprehensive, patient-centered primary care. First, additional research is needed in primary care settings on the contributions of CMM services to the health and well-being of patients. Research is needed on the effects of CMM on outcomes such as the burden of treatment in patients with complex conditions, and on patients' financial security and other social needs, in addition to other types of health outcomes that are more typically examined, such as diabetes A1c control (Ridgeway et al. 2014; Spencer-Bonilla et al. 2017). Second, additional research is needed on the specific costs of CMM in a variety of primary care settings, which could then inform the design of

payment policies that provide adequate and ongoing support for the provision of CMM by clinical pharmacists in primary care settings. Third, including pharmacists on the primary care team is not a new idea but we need to better understand how to integrate clinical pharmacists efficiently and fully into the comprehensive primary care team in both independent and system-owned practices, and the types of interprofessional education and training that will support that integration (Smith et al. 2013).

4.E. CPC+ Beneficiary Survey

This Appendix describes the CPC+ Beneficiary Survey used to assess patients' experience among Medicare fee-for-service (FFS) beneficiaries in practices that began participating in CPC+ in 2017 and their comparison practices. It details survey fielding (Section 1), sampling methods (Section 2), survey content and measures (Section 3), analytic methods (Section 4), and data tables (Section 5). Section 6 contains the Program Year (PY) 5 survey instrument.

4.E.1. Survey fielding

A. Timing of survey administration

Mathematica administered the first wave of the CPC+ Beneficiary Survey during PY 2,⁴¹ from May through December 2018, 17 to 24 months after CPC+ began (Table 4.E.1). We fielded the survey to three samples of Medicare FFS beneficiaries: (1) beneficiaries in CPC+ practices,⁴² (2) beneficiaries in a preliminary set of comparison practices, and (3) beneficiaries in the final set of comparison practices.⁴³

We administered the second wave of the CPC+ Beneficiary Survey during PY 3 from February through May 2019, 26 to 29 months after CPC+ began, to two samples of Medicare FFS beneficiaries: (1) beneficiaries in CPC+ practices and (2) beneficiaries in the final set of comparison practices.

We administered the third and final wave of the CPC+ Beneficiary Survey during PY 5, the final year of CPC+, from June through September 2021 to two samples of Medicare FFS beneficiaries: (1) beneficiaries in CPC+ practices and (2) beneficiaries in the final set of comparison practices.

⁴¹ Sections of this annual report refer to the Wave 1, Wave 2, and Wave 3 surveys as the PY 2, PY 3, and PY 5 surveys, respectively.

⁴² American Institutes for Research (AIR), a separate contractor, administered the PY 2 survey to the CPC+ Medicare FFS beneficiary sample using the same instrument and fielding plan as Mathematica did for the comparison samples. In the subsequent waves, Mathematica fielded the survey to the CPC+ and comparison samples.

⁴³ We drew the first sample of comparison beneficiaries—surveyed in June through September 2018—from a preliminary set of comparison practices for the 2017 Starters. After the first fielding, we selected the final set of comparison practices for the 2017 Starters for the evaluation. Thus, we drew an additional sample of beneficiaries that came from the practices in the evaluation's final comparison group but were not in the preliminary set of comparison practices, to ensure we surveyed beneficiaries from a sample drawn from all comparison practices. For more information about sampling, please refer to Section 4.E.2: Sampling methods.

Table 4.E.1. CPC+ Beneficiary Survey administration dates

Sample group	Wave 1 (PY 2)	Wave 2 (PY 3)	Wave 3 (PY 5)
CPC+ sample	May–August 2018	February–May 2019	June–September 2021
Preliminary comparison sample	June–September 2018	n.a.	n.a.
Final comparison sample	September–December 2018	February–May 2019	June–September 2021

n.a. = not applicable; PY = Program Year.

B. Survey mode, length, incentive, fielding procedures, and fielding plan

We administered the CPC+ Beneficiary Survey as a paper survey by mail. We identified mailing addresses for sampled CPC+ and comparison beneficiaries from the Medicare Enrollment Database. We sent all beneficiary mailing addresses through the National Change of Address database before mailing to ensure that addresses were current. The survey required 15 to 20 minutes to complete. We did not offer an incentive to complete the survey.

We followed the standard Clinician and Group—Consumer Assessment of Healthcare Providers and Systems (CAHPS) fielding procedures (Agency for Healthcare Research and Quality [AHRQ] 2016b). The recommended mail protocol for the CAHPS includes (1) setting up a toll-free number staffed by trained personnel, (2) sending a questionnaire mailing with a cover letter and postage-paid envelope, (3) sending a postcard reminder to nonrespondents 10 days after the initial questionnaire mailing, and (4) sending a second questionnaire with a reminder letter and a postage-paid envelope to nonrespondents three weeks after the initial mailing. We fielded the CPC+ Beneficiary Survey over a 13-week period, consistent with the CAHPS fielding procedures, which recommend a 10- to 14-week fielding period. Although we followed the CAHPS fielding procedures, we slightly modified the timing of the mailings (Table 4.E.2). Specifically, we accelerated the timing of the first postcard reminder to 7 rather than 10 days after the initial mailing, and we delayed the second questionnaire mailing by two weeks to provide more time for response.⁴⁴ We also added a step: we sent a third questionnaire four weeks after the second questionnaire to increase the response rate.

Table 4.E.2. Fielding procedures for CPC+ Beneficiary Survey

Week of field period	Fielding activity	Modification from CAHPS procedures
Week 1	Initial questionnaire mailing	No modification
Week 2	Mail reminder postcard	Accelerated by three days
Week 6	Second questionnaire mailing	Delayed by two weeks
Week 9	Third questionnaire mailing	Added; mailed four weeks after second questionnaire
End of Week 13	Data collection ended	No modification

CAHPS = Consumer Assessment of Healthcare Providers and Systems.

⁴⁴ We delayed this second mailing because our sample was so large that it took two weeks to print and mail surveys. Therefore, to send a reminder mailing three weeks after the first mailing, we would have needed the mailing file of nonrespondents only one week after the first mailing, which would not provide sufficient time for us to receive completed surveys.

4.E.2. Sampling and weighting methods

A. Sampling methods

Sample frames. We surveyed Medicare FFS beneficiaries from CPC+ and comparison practices. The sampling frames for the CPC+ and comparison practices consisted of Medicare FFS beneficiaries attributed to CPC+ or comparison practices using an algorithm applied to Medicare claims data. Medicare beneficiaries were attributed to the primary care practice from which they received their most recent visit for chronic care management or had received the largest share (plurality) of selected primary care services over the prior two years. (See Laird et al. 2023b, Appendix 5.B.2 for more information on patient attribution.)

For each of the surveys, we selected a single sample of patients attributed to the CPC+ practices. For the PY 2 survey, we selected patients attributed to the comparison practices from two different sampling frames in two stages. We drew the first sample from the preliminary set of comparison practices identified before we selected the final comparison group. The second sample was drawn from the practices that were included in the final comparison group but were not part of the preliminary group. To ensure that the sample of comparison patients ultimately drawn from the two combined samples was as similar as possible to the sample that would have been selected if we had the final set of comparison practices at the start, we took the following steps:

1. We combined the two samples of patients selected from each of the two sampling frames, and removed any patients drawn from preliminary comparison group practices that the final comparison group ultimately did not include.
2. We applied a weighting adjustment to the sample drawn from the preliminary comparison group to reflect the practice-level weights those practices have in the final comparison group.

For the PY 3 and PY 5 surveys, we selected a single sample of patients attributed to the comparison practices using the final comparison group determined during the PY 2 sampling.

Sampling CPC+ beneficiaries. We sampled Medicare FFS beneficiaries from all CPC+ practices that were still open at the time of sampling, regardless of whether the practice was still participating in CPC+ at the time. For each survey wave, we sought to have 4,000 CPC+ respondents per track to meet precision targets. For the PY 2 survey, we assumed a yield rate of 40 percent and aimed to release surveys to 10,000 patients per track, so we could achieve 4,000 completes. However, in PY 2 and PY 3 we selected an augmented sample of 12,000 patients per track in anticipation of needing to de-duplicate our sample against the samples of two other large Medicare beneficiary surveys being fielded during the same approximate time frame, to avoid beneficiaries receiving requests to complete multiple surveys.⁴⁵ The additional 2,000 patients selected per track were to replace any patients in our main sample who had already been sampled for these other surveys. This additional sample was not needed in PY 5 because no other Medicare beneficiary surveys were fielded around the same time frame, so we selected only slightly

⁴⁵ The two surveys we assessed for this sample overlap were the (1) CAHPS Survey for Accountable Care Organizations (ACOs), which ACOs participating in the Medicare SSP and Next Generation ACO Model use to meet their requirement to measure patient experience of care; and (2) CPC+ Patient Experience of Care Survey, a CAHPS-based survey fielded as part of the CPC+ model to a sample of all patients that is used to calculate recoupments of Performance-based Incentive Payments to CPC+ practices. AIR fielded the CPC+ Patient Experience of Care Survey in PY 1 and RTI fielded it in the subsequent years.

more than 10,000 patients per track. For the PY 3 and PY 5 surveys, we assumed a slightly lower yield rate of 39.5 percent given our experience with the PY 2 survey and sent surveys to slightly more than 10,000 patients per track.

For each survey wave, to select the sample of beneficiaries, we first split the sample frame by track and then stratified the sample frame within track by (1) whether the beneficiary's practice participated in the Medicare Shared Savings Plan (SSP) in 2016 (at baseline), and (2) whether the patient was considered high risk for needing medical services. Beneficiaries were considered high risk if they had a hierarchical condition category (HCC) score (Pope et al. 2004) in the top quartile of the HCC score distribution within their track. If beneficiaries' HCC scores were missing, we considered them to be high risk if they had end-stage renal disease (ESRD). We stratified in this way for two reasons: (1) because the analysis is stratified by the practice's track and Medicare SSP status; and (2) to increase the likelihood that survey respondents could answer questions about care received after visiting the emergency department or an in-hospital stay, we oversampled high-risk patients, selecting half of the sample from the high-risk group. We selected all patients within each stratum with equal probability.

After selecting the larger sample of about 24,000 CPC+ patients (24,000 patients in PY 2 and 24,300 patients in PY 3),⁴⁶ in each program year we randomly chose about 20,000 beneficiaries (10,000 beneficiaries per track)⁴⁷ for the main sample release. We then randomly assigned the remaining 4,000 patients into replicates of size 5 within stratum, resulting in about 100 replicate samples per track. In each program year, we used the replicate samples to randomly replace patients selected in the main sample release who were also selected for one of the other two Centers for Medicare & Medicaid Services (CMS) surveys. We matched patients selected for the CPC+ survey with those already selected for the other two surveys; we removed any patients also selected for one of the other surveys from the main sample release, and we drew from the replicate samples to replace them. After this de-duplication and replacement, there were 20,001 total selected patients for the PY 2 survey, (10,006 in CPC+ Track 1 and 9,995 in CPC+ Track 2)⁴⁸ and 20,247 total selected patients for the PY 3 survey (10,172 in CPC+ Track 1 and 10,163 in CPC+ Track 2).⁴⁹ As noted above, we did not need additional sample for PY 5 and we released all 20,250 sampled patients (10,180 in CPC+ Track 1 and Track 2, with 110 patients sampled from practices in both tracks).⁵⁰

Sampling comparison beneficiaries. The goal of the comparison patient sample was to select a sample of patients that looked as similar as possible to the CPC+ patient sample on a range of practice- and patient-level characteristics. Because the goal was to select a set of comparison practice patients that provided a good counterfactual to the CPC+ patients, rather than to select a set of comparison patients

⁴⁶ For the PY 2 survey, we selected 12,000 CPC+ patients per track. For the PY 3 survey, we selected 12,204 patients from Track 1 practices and 12,206 patients from Track 2 practices.

⁴⁷ For the PY 2 survey, we selected 20,000 beneficiaries, 10,000 per track. For the PY 3 survey we selected 20,250 beneficiaries, 10,125 per track.

⁴⁸ The final de-duplicated counts per track were not exactly 10,000 due to small differences in the number of patients de-duplicated and the size of the replicate samples.

⁴⁹ The total number of selected patients was less than the sum of the two track sample counts due to the small overlap from merged practices (that is, CPC+ practices that were first separate practices, but then combined into a single practice).

⁵⁰ A small number of CPC+ practices were considered as participating in both tracks due to cross-track merging of practices.

that represented all comparison patients, in PY2 and PY 3 we could conduct the de-duplication process described earlier for the other two CMS surveys before sample selection, thereby removing the need to select any backup sample. No such de-duplication was needed in PY 5. As with the CPC+ patients, we selected separate samples by track and stratified by SSP participation and patient-level high-risk status, again selecting half of the sample from the high-risk group. However, because the goal was to draw a sample similar to the CPC+ patients, we selected patients with probability proportional to their practice matching weight. We assigned selection probabilities to patients in direct proportion to their practice's matching weight, so we drew larger numbers of patients from practices with larger matching weights. Because the matching weights aim to maximize the weighted balance of comparison practices with CPC+ practices across a range of baseline practice-level characteristics, this method improved the balance, or similarity, of the comparison patient sample with the CPC+ patient sample.⁵¹ In the case of comparison practices matched to CPC+ practices in both Tracks 1 and 2, patients in those practices were eligible for selection in both the Track 1 and Track 2 samples. To reconcile these two independent samples into a single sample of patients, we used the larger of the two track-specific samples for those practices.

For the PY 2 survey, we used this sampling approach to draw the two comparison samples, one from a preliminary group of comparison practices and one from a final group of comparison practices. A total of 26,907 comparison patients were selected, 15,248 from the preliminary group and 11,659 from the final group of comparison practices. For the PY 3 survey, we selected 16,331 patients from the single sample—final comparison group—of comparison practices. For the PY 5 survey, we selected 16,265 patients from the final comparison group of practices.

B. Eligibility and weighting

Determining eligibility. The survey included 59 survey questions, which resulted in 68 analyzable items.⁵² After we received completed questionnaires, we used the following process to determine the eligibility status of all survey responses:

- We categorized a survey response as eligible if the respondent reported having received care from the selected primary care practice in the previous six months by having said yes to at least one of the following eligibility questions:
 - Whether the patient reported receiving any care at all from the selected practice
 - Whether the patient reported receiving any of the following types of care: scheduled appointment, same-day appointment, home or other location visit, video appointment, group medical appointment, hospital visit, or (PY 5 only) telephone visit not part of a video visit
 - Whether the patient reported contacting the doctor's office for immediate care
 - Whether the patient reported making an appointment for a check-up or routine care

⁵¹ Practice matching weights were calculated during comparison group selection. The weights ranged from 0.10 to 10.0, with higher values indicating the practice had a larger weight in the Medicare claims-based impact analysis; hence, they are more important in the evaluation. Appendix 6.C in the second annual report (Ghosh et al. 2020) provides more information on comparison group selection and the construction of the matching weights.

⁵² We have more items than survey questions because a “mark all that apply” survey question is considered one question, but each response option is considered a separate item or analyzable unit. Therefore, a mark all that apply question will have multiple items.

- Whether the patient reported contacting the doctor’s office with a health question during regular office hours
 - Whether the patient reported contacting the doctor’s office with a health question outside of regular office hours (for example, evenings, weekends, or holidays)
 - Whether the patient reported using email, a patient portal, or text messaging to ask the doctor’s office a health question
- We categorized a survey response as ineligible if the respondent (1) did not say yes to any of the questions listed above and (2) reported not receiving care from the selected primary care practice in the preceding six months by saying no to at least one of the eligibility questions. Survey responses were also considered ineligible if we received information during the field period that the respondent was deceased, if they no longer or never received care from the selected practice, or if all survey questions were missing except for the demographic questions at the end of the survey.
 - We categorized survey responses as having unknown eligibility if we did not have sufficient evidence to determine whether the respondent had or had not received care from the selected practice in the preceding six months. Surveys that were completed in reference to someone other than the selected respondent⁵³ or were completed in reference to care received from a different practice were also determined to have unknown eligibility.

Completed surveys. After determining eligibility, we reviewed the data to confirm completion status of the survey records. In total there are 59 questions in the PY 5 CPC+ Beneficiary Survey. Based on the CAHPS guidelines, we considered a survey to be complete if it had answers for at least 23 of 45 key questions and 1 of 40 reportable questions (AHRQ 2016b). Key questions are ones that all eligible respondents could have answered: that is, any eligible respondent would not have skipped the questions based on the survey logic. Questions confirming eligibility for the survey, the screeners for the questions included in the composite measures, the question about patients’ rating of the primary care doctors and staff, and demographic and other background items make up the key questions. Reportable questions are ones included in the composite and rating measures, and they overlap with some key questions (26 of the 40 reportable questions are also key questions). If a survey had responses to fewer than 23 of the key questions and 1 of the reportable questions (that is, the survey was not complete), or if we found the survey response to be ineligible or to have unknown eligibility, we excluded it from the analysis.

Calculating weights for CPC+ respondents. We assigned CPC+ patients sample weights equal to the inverse of their probability of selection within the sampling strata (that is, the practice’s track and SSP status) and to account for the oversampling of high-risk patients.

To reduce the potential of bias resulting from survey noncompletion, we adjusted the weights to account for patterns among noncompleters (those with known and unknown eligibility). In each program year, more than half of the total sample of patients did not return a survey, so we could not determine their eligibility. We adjusted for this nonresponse by estimating logistic regression models that predicted having a known eligibility status using a set of practice- and patient-level characteristics (Table 4.E.3). We selected practice- and patient-level characteristics to include in the regression models using a stepwise model selection procedure in SAS, where the p-value associated with a particular effect had to be less

⁵³ Surveys completed via proxy—that is, completed in reference to the selected respondent by someone else—could still be determined eligible.

than or equal to 0.15 to enter the model and had to remain less than or equal to 0.20 to stay in each subsequent fitted model. The stepwise model selection process ensured that the characteristic had at least a moderately strong relationship with the probability of having a known eligibility. The weighting adjustments did not include characteristics that did not meet either criterion. Because we estimated these models separately by track and program year, the set of characteristics that predicted known eligibility varied by track and program year. We then grouped patients with similar propensities for known eligibility status into classes and calculated adjustments within each class.

Very few beneficiaries returned a survey indicating they visited their primary care practice in the previous six months—and were therefore eligible—but did not answer enough survey items to be considered a complete response. As a result, we did not test the use of logistic modeling to adjust the weights for noncompletion among eligible beneficiaries, as any regression estimates would likely be unstable and could result in extreme adjustments, given the small number of eligible noncompletes. Instead, we used only weighting classes defined via a chi-square automatic interaction detection program, in which we can directly control minimum cell sizes to reduce the likelihood of extreme adjustments. We then post-stratified the weights to known population totals within strata.

Table 4.E.3. Characteristics used in adjusting for CPC+ Beneficiary Survey noncompletion

Characteristics	PY 2		PY 3		PY 5	
	Track 1	Track 2	Track 1	Track 2	Track 1	Track 2
Patients' characteristics						
Patient age	X	X	X	X	X	X
Patient gender		X			X	
Patient race	X	X	X	X	X	X
Patient dual eligibility status	X	X				
Original reason for Medicare eligibility was old age	X	X				
Whether patient received long-term institutionalized care	X	X	X		X	X
Indicators for patient county of residence	X	X		X	X	X
Indicators for patient state of residence	X	X		X	X	X
Patient considered at high risk			X	X	X	X
Patient diagnosed with end-stage renal disease					X	
Practice-level characteristics at baseline						
SSP status	X		X			
Health professionals shortage area—primary care		X				
Practice-level number of assigned beneficiaries	X	X				
County mean income		X				
CPC+ region	X	X			X	
Hospital ownership	X					X
County-level Medicare Advantage		X				
Rural–urban categorization	X			X	X	X
Mean beneficiary medical spending, quarter 5			X			
Mean beneficiary medical spending, quarter 8				X		X
Mean beneficiary medical spending, full baseline year				X		X
Assigned beneficiary count			X	X	X	
Outpatient ED visits				X	X	
Number of primary care providers at baseline						X

ED = emergency department; PY = Program Year; SSP = Medicare Shared Savings Plan.

Calculating weights for comparison respondents. As with the sampling, we used a different weighting approach for the comparison patients than we did for the CPC+ patients, as the goal of this sample was not to represent the population of comparison patients, but rather to serve as a valid counterfactual for the CPC+ respondents. Therefore, we calculated weights to align the CPC+ and comparison respondents on a range of practice- and patient-level characteristics, not simply to adjust for nonresponse among the comparison patient sample.

1. For the PY 2 survey, we calculated these weights in two stages. First, we applied an adjustment for the oversampling or undersampling of patients from practices that were part of the preliminary comparison group. This adjustment applied only to patients selected from the preliminary comparison group practices.
2. Second, we created weighting adjustments that, to the greatest extent possible, produced respondents from the comparison practices who had similar practice- and patient-level characteristics as the respondents from the CPC+ practices. The practice-level characteristics were the high-priority variables used in selecting the final comparison group for the evaluation (see Appendix 6.C in the second annual report [Ghosh et al. 2020] for full list of these variables), and the patient-level characteristics included age, race, sex, and the indicator for whether the patient was considered high risk. We calculated these balancing weights differently by track. For Track 1, we used inverse propensity score weights to balance the comparison respondents with the CPC+ respondents. We estimated these propensity scores via the *twang* package in R, which uses boosted regression to flexibly model the probability of being a CPC+ respondent (Ridgeway et al. 2017). After applying the inverse propensity score adjustments, we post-stratified the adjusted weights to the CPC+ population totals within strata. For Track 2, we post-stratified the comparison respondents to the CPC+ population totals within strata. We did not use inverse propensity score adjustments, because these provided little improvement in balance and substantially increased the variation in the weights, thereby reducing power. After post-stratification, we trimmed the adjusted weights for both tracks so no individual had undue influence on the results (specifically, so no weight was greater than 300). This trimming affected 1.5 percent of the respondents in Track 1 and 18.1 percent of the respondents in Track 2. We confirmed that this level of trimming made little difference to the balance achieved by the weights.

For the PY 3 and PY 5 surveys, we did not need to adjust the weights for over- or undersampling because we sampled only from the final set of comparison practices. As we did for the PY 2 survey, we calculated propensity score weights for Track 1 and post-stratified weights for Track 2. For PY 3, we trimmed the Track 1 weights to a maximum value of 300, which affected 0.6 percent of the respondents; no trimming was required in PY 5. We did not trim the weights for the Track 2 respondents because the maximum weight was about 316 in PY 3 and 350 in PY 5, not large enough to require trimming.

C. Sample sizes and response rates

In each program year, we invited about 20,000 of the roughly 1.8 million Medicare FFS beneficiaries attributed to CPC+ practices (about 10,000 per track) to respond to the survey. Among the roughly 3.5 million Medicare FFS beneficiaries attributed to comparison practices, we invited about 27,000

beneficiaries to respond to the PY 2 survey and about 16,000 beneficiaries to respond to the PY 3 and PY 5 surveys.⁵⁴

Using survey responses, we then identified respondents who reported having received care from the practice at least once in the six months before the start of the survey to include in the analytic sample. We obtained response rates⁵⁵ of about 41 percent for CPC+ beneficiaries and about 43 percent for comparison beneficiaries in PY 2 and PY 3, and about 40 percent in PY 5.

For the Track 1 analysis, our analytic sample includes: (1) 3,926 beneficiaries attributed to the CPC+ practices in PY 2, 3,921 in PY 3, and 3,392 in PY 5; and (2) 7,325 beneficiaries attributed to the comparison practices in PY 2, 4,582 in PY 3, and 3,894 in PY 5. These beneficiaries represent about 80 percent of CPC+ practices and 48 percent (PY 2), 42 percent (PY 3), and 38 percent (PY 5) of the comparison practices (Table 4.E.4).

For the Track 2 analysis, our analytic sample includes: (1) 3,989 beneficiaries attributed to the CPC+ practices in PY 2, 3,897 in PY 3, and 3,349 in PY 5; and (2) 7,059 beneficiaries attributed to the comparison practices in PY 2, 4,210 in PY 3, and 3,677 in PY 5. These beneficiaries represent about 79 percent of CPC+ practices and 54 percent (PY 2), 47 percent (PY 3), and 43 percent (PY 5) of the comparison practices (Table 4.E.4).

Among practices with at least one respondent in the analytic sample, each CPC+ practice had a median of three respondents (Track 1) and two respondents (Track 2) in PYs 2 and 3, and a median of two respondents in both tracks for PY 5. Each comparison practice, regardless of track, had a median of two respondents to the PY 2 survey and one respondent to the PY 3 and PY 5 surveys. Table 4.E.4 details the survey sample and response rates by research group, track, and program year.

⁵⁴ Comparison practices can be matched to CPC+ practices in both tracks. Therefore, we surveyed the beneficiaries in practices matched to CPC+ practices in both tracks once but counted them twice, once in Track 1 and once in Track 2. Of the 26,907 comparison beneficiaries in the PY 2 survey sample, we attributed 16,445 to comparison practices matched to both Track 1 and Track 2 CPC+ practices. Of the 16,331 comparison beneficiaries in the PY 3 survey sample, we attributed 7,622 to comparison practices matched to both Track 1 and Track 2 CPC+ practices.

⁵⁵ The response rate is the number of eligible and complete survey responses divided by the number of eligible sample members. The eligible sample includes a proportion of the sample with unknown eligibility that we estimate are eligible based on the rate of eligibility among those with known eligibility. This approach follows the guidelines of the American Association for Public Opinion Research (AAPOR 2016). This differs from the yield rate, which is just the number of completed surveys divided by the total sample regardless of eligibility.

Table 4.E.4. Attributed Medicare FFS CPC+ Beneficiary Survey sample and response rates, by treatment status and track

	CPC+			Comparison		
	Track 1	Track 2	Total ^a	Track 1	Track 2	Total ^a
PY 2						
Number of beneficiaries^b						
In sampling frame	811,775	986,220	1,797,995	2,582,796	2,205,969	3,580,360
Sent surveys	10,006	9,995	20,001	24,140	19,212	26,907
Returned surveys	4,633	4,647	9,280	10,435	8,232	11,516
Returned eligible survey response	3,935	3,999	7,934	8,973	7,065	9,879
Returned eligible and complete survey response	3,926	3,989	7,915	7,325	7,059	9,854
In analysis sample	3,926	3,989	7,915	7,325	7,059	9,854
In analysis sample per practice (minimum/median/maximum) ^c	1/3/31	1/2/26	1/2/31	1/2/95	1/2/95	1/2/95
Response rate (percentage, unweighted) ^d	41.2	41.9	41.5	42.9	42.8	42.6
Number of practices						
In sampling frame	1,373	1,515	2,888	5,209	3,754	6,874
With completed surveys	1,121	1,210	2,331	2,478	2,013	3,225
With completed surveys in our analysis sample (percentage)	1,121 (81.6)	1,210 (79.9)	2,331 (80.7)	2,478 (47.6)	2,013 (53.6)	3,225 (46.9)
PY 3						
Number of beneficiaries^b						
In sampling frame	794,317	971,092	1,757,433	2,491,311	2,115,142	3,421,114
Sent surveys	10,172	10,163	20,247	12,443	11,510	16,331
Returned surveys	4,610	4,559	9,141	5,422	5,000	7,098
Returned eligible survey response	3,954	3,930	7,865	4,617	4,239	6,030
Returned eligible and complete survey response	3,921	3,897	7,794	4,582	4,210	5,974
In analysis sample	3,921	3,897	7,794	4,582	4,210	5,974
In analysis sample per practice (minimum/median/maximum) ^c	1/3/30	1/2/32	1/2/32	1/1/28	1/1/29	1/2/29
Response rate (percentage, unweighted) ^d	41.6	41.0	41.3	43.3	43.2	43.1
Number of practices						
In sampling frame	1,364	1,514	2,859	5,161	3,743	6,787
With completed surveys	1,092	1,189	2,273	2,165	1,750	2,755
With completed surveys in our analysis sample (percentage)	1,092 (80.1)	1,189 (78.5)	2,273 (79.5)	2,165 (41.9)	1,750 (46.8)	2,755 (40.6)

Table 4.E.4 (continued)

	CPC+			Comparison		
	Track 1	Track 2	Total ^a	Track 1	Track 2	Total ^a
PY 5						
Number of beneficiaries^b						
In sampling frame	793,184	991,614	1,775,132	2,671,549	2,289,756	3,669,219
Sent surveys	10,180	10,180	20,250	12,288	11,550	16,265
Returned surveys	4,230	4,180	8,371	4,900	4,593	6,491
Returned eligible survey response	3,403	3,356	6,729	3,905	3,684	5,191
Returned eligible and complete survey response	3,392	3,349	6,711	3,894	3,677	5,174
In analysis sample	3,392	3,349	6,711	3,894	3,677	5,174
In analysis sample per practice (minimum/median/maximum) ^c	1/2/25	1/2/34	1/2/34	1/1/25	1/1/25	1/1/25
Response rate (percentage, unweighted) ^d	41.0	40.5	40.8	39.2	39.1	39.2
Number of practices						
In sampling frame	1,253	1,407	2,648	4,892	3,579	6,429
With completed surveys	1,010	1,128	2,128	1,869	1,535	2,414
With completed surveys in our analysis sample (percentage)	1,010 (80.6)	1,128 (80.2)	2,128 (80.4)	1,869 (38.2)	1,535 (42.9)	2,414 (37.5)

^a The total represents the number of unique beneficiaries or practices. Some beneficiaries and practices appear in both Tracks 1 and 2.

^b In all program years, comparison beneficiaries could be in practices matched to Track 1 and Track 2. In the PY 3 and PY 5 surveys, as a result of CPC+ practices merging with one another, CPC+ beneficiaries could also be in practices in both tracks; therefore, the counts in each track are not mutually exclusive and do not sum to the total. In the PY 3 survey, there were 7,976 patients attributed to 19 CPC+ practices in both tracks, and 1,185,339 patients attributed to 2,117 comparison practices matched to both tracks. In the PY 5 survey, there were 9,666 patients attributed to 12 CPC+ practices in both tracks, and 1,292,086 patients attributed to 2,042 comparison practices matched to both tracks.

^c Number of beneficiaries in analysis sample per practice reported for practices with at least one respondent in the analytic sample.

^d The response rate is the number of eligible and complete survey responses divided by the eligible sample. The eligible sample includes a proportion of the sample with unknown eligibility that we estimate are eligible following the guidelines of the American Association for Public Opinion Research (AAPOR 2016).

FFS = fee-for-service; PY = Program Year.

D. Assessing the potential impact of COVID-19 on respondent eligibility

Questions 52 and 53 on the PY 5 survey asked patients whether they delayed or avoided medical care due to concerns of getting coronavirus disease 2019 (COVID-19) or to office limitations related to the pandemic. Because patients were required to have received some type of medical care from the practice in the previous six months to be eligible for inclusion in our main analysis, some respondents who delayed or avoided care for more than six months due to COVID-19 would not be eligible for inclusion in the analysis (that is, had it not been for COVID-19-related factors, the respondent would have gotten care at the specified primary care practice and would have been included in the analysis).

To determine whether excluding respondents from our analysis that did not get care from their doctor's office in the past 6 months (but also said they avoided care due to COVID-19) could have impacted our

findings for these two questions, we conducted a separate analysis in which we included all patients who responded to these questions, regardless of their overall eligibility. To conduct this test, we calculated a separate weight to use in analyzing their responses. For the CPC+ practices, a total of 4,059 patients in Track 1 and 4,008 patients in Track 2 responded to these questions. For the comparison practices, 4,715 patients in Track 1 and 4,426 patients in Track 2 responded. The analytic weights for these two questions were calculated using the same methodology as the main analysis described earlier, and the weights had similar properties.

In the end, the results from this separate analysis were not meaningfully different from the results from the main analysis. Thus, we felt confident in using our standard eligibility criteria and weights for the analysis of these items as we do for the analysis of all other items and composite measure in the survey.

4.E.3. Survey content and measures

A. Survey content

The CPC+ Beneficiary Survey instrument primarily contains questions based on the core CAHPS survey version 3.0 (AHRQ 2015). Other items were based on the CAHPS versions 2.0 and 3.0 patient-centered medical home (PCMH) supplemental modules (AHRQ 2016a) and the CAHPS 2.0 Health Information Technology supplemental module (AHRQ 2012). The CAHPS survey gauges patients' experiences with the provider and the provider's office over the previous six months across five domains of primary care: (1) patients' ability to get timely appointments, care, and information; (2) providers' communication with patients; (3) providers' use of information to coordinate patients' care; (4) helpful, courteous, and respectful office staff; and (5) patients' overall rating of their primary care providers. In addition, the CPC+ survey includes questions on patients' demographics such as race, education, and physical and mental health status.

Although we based the survey design and many of the questions on the CAHPS survey, we also created new questions and modified existing survey items to better reflect innovative aspects of the CPC+ model, such as team-based care and alternative visit types. To develop our initial survey instrument, we considered the unique features of care under the CPC+ model and engaged experts on patients' experience within Mathematica, the CMS CPC+ program team, and the CAHPS consortium.⁵⁶ Then we conducted 34 cognitive pre-testing interviews across three rounds of testing. Four of these interviews included a full-survey administration test to determine administration time.

We made a few small changes to the PY 2 CPC+ Beneficiary Survey instrument for PY 3: we made minor wording changes to three items, major wording changes to two items, and removed one item from the instrument. We made these changes based on feedback from 39 cognitive pre-testing interviews across two rounds of testing.

⁵⁶ The CAHPS Consortium consists of AHRQ and other organizations that are responsible for conceiving, developing, testing, and refining CAHPS surveys and conducting research on the various uses of the CAHPS survey data. The survey instrument we developed was not reviewed or endorsed by AHRQ or the Consortium.

We made changes to the PY 3 CPC+ Beneficiary Survey instrument for PY 5: we modified 3 questions, removed 1 questions, and added 12 new questions about access to care, basic needs, safety, and whether care was delayed due to COVID-19. We made these changes based on feedback from 45 cognitive pre-testing interviews across two rounds of testing.

B. Measures

To help summarize patients' experiences, we created composite summary measures. First, we identified the 39 items included in the PY 2 survey that asked about patients' experiences and grouped them based on the care delivery functions described in the CPC+ implementation guide. We then conducted a confirmatory factor analysis (CFA) for the first wave of the survey using responses to the PY 2 survey from patients in CPC+ practices to confirm that the items fit well into the assigned domain. We conducted the CFA separately by track to ensure the composite measures had adequate reliability for both tracks. This resulted in 10 composite measures created from 37 questions that were both theoretically and statistically correlated. Two questions were excluded from the PY 2 composite measures because they were not statistically related to the other questions and did not map to a care delivery function.

Reflecting the combination of limited survey items and items needing to fit together both theoretically and statistically, four composite measures contain only one item. The remaining six composite measures were formed from the responses to multiple items. We calculated the internal consistency reliability of each of these six composite measures for the PY 2 survey, to assess how well its items produced consistent results. Each of the six composite measures with multiple items had adequate reliability with McDonald's omega values between 0.77 and 0.96 (Nunnally and Bernstein 1994; Lance et al. 2006).

Because only minor changes were made to the composite measures' makeup in PY 3 and PY 5,⁵⁷ additional CFA was not conducted after PY 2. Rather, we included in the analysis only the items that were in present in the PY 2, PY 3, and PY 5 surveys. For the PY 5 analysis, this resulted in 10 composite measures created from 34 items. These composite measures consisted of 1 to 9 items. Table 4.E.5a lists the PY 5 survey items included in each composite; Table 4.E.5b shows the full list of PY 5 survey questions along with their sources and domains.

⁵⁷ Changes to composite measures makeup from PY 2 to PY 5: Two questions were dropped from the access composite because they were dropped from subsequent survey waves, and two access composite questions were modified; two questions were modified in the continuity outside of the doctor's office composite; and one question was modified in each of the following composites: comprehensiveness, coordination, continuity within the primary care doctor's office, and patient and family caregiver engagement.

Table 4.E.5a. Experiences included in the PY 5 CPC+ Beneficiary Survey composite measures**Composite measure 1: Access (9 items)**

- How often the patient:
 - Got care as soon as needed when contacting the doctor's office for care needed right away
 - Got care as soon as needed when making an appointment for check-up or routine care
 - Received timely answers to health questions when contacting the doctor's office during regular office hours
 - Received timely answers to health questions when contacting the doctor's office outside of regular office hours
 - Received timely answers to health questions asked of the doctor's office via email, patient portal, or text messaging
 - Had appointments that started within 15 minutes of the scheduled appointment time
 - Whether the patient received care from the primary care doctors and their staff in the following ways:
 - Via phone, email, text messaging, or patient portal
 - Had a video appointment
- Whether someone from this doctor's office provided the patient with information about how to access care during evenings, weekends, or holidays

Composite measure 2: Continuity within the primary care office (1 item)

- How often the patient received care from his or her regular primary care doctor

Composite measure 3: Continuity across health care settings (2 items)

- Whether the patient's doctor or someone from the doctor's office came to see the patient^a
 - In the hospital
 - At another location (excluding the doctor's office or hospital) to provide health care

Composite measure 4: Care management (4 items)

- Whether someone from this doctor's office:
 - Asked about all of the patient's prescription medications
 - Asked the patient if there are things in life that make it hard for the patient to take care of his or her health
 - Provided timely follow-up care after an emergency department visit
 - Provided timely follow-up care after a hospital stay

Composite measure 5: Comprehensiveness (6 items)

- Whether someone in the provider's office:
 - Knew important information about the patient's medical history
 - Asked the patient if he or she had any problems with physical pain or discomfort
 - Asked the patient if he or she had experienced depression symptoms
 - Talked with the patient about things in his or her life that cause worry or stress
 - Asked the patient about non-medical problems such as housing insecurity, food insecurity, lack of reliable transportation, or trouble paying utility bills
 - Asked the patient if he or she had any problems with abuse or violence

Composite measure 6: Coordination (1 item)

- How often people from this doctor's office were informed and up to date on specialist care (PY 3 survey)
- How often people from this doctor's office coordinated well with specialists to care for the patient (PY 2 survey)

Composite measure 7: Patient and family caregiver engagement (7 items)

- How often the patient received his or her test results from this doctor's office
- How often people from this doctor's office:
 - Explained medical things in a way that was easy to understand
 - Listened carefully to the patient
 - Showed respect for what the patient had to say
 - Spent enough time with the patient
- Whether someone from this doctor's office asked the patient about his or her end-of-life care wishes
- Whether the patient currently has an end-of-life care plan

Table 4.E. (continued)**Composite measure 8: Helpful, courteous, and respectful office staff (2 items)**

- How often clerks and receptionists at this doctor's office:
 - Were helpful
 - Treated the patient with courtesy and respect

Composite measure 9: Teamwork (1 item)

- How often people from this doctor's office coordinated well among themselves to care for the patient

Composite measure 10: Patients' rating of the primary care doctors and staff (1 item)

- Patients' rating of care received from primary care doctors and staff from the doctor's office on a scale of 0 to 10, with 0 being the worst and 10 being the best

^a The two items in the continuity across health care settings composite measure also measure aspects of care management, such as visits to skilled nursing facilities or hospitals to support transitional care. However, these items were not statistically correlated with the items in the care management composite measure and are therefore a separate composite measure.

Table 4.E.5b. CPC+ Beneficiary Survey questions

Question number (PY 5)	PY 5 CPC+ question text ^a	Source	Modified from original source?	Modified from previous CPC+ wave?	Composite measure
n.a.	<p>Intro text: This is a survey about health care you received from primary care doctors and their staff. The person you got care from at this doctor’s office might be a physician (MD or DO), a nurse practitioner (NP), physician assistant (PA), or other staff that work with them. Primary care doctors treat preventive and wellness needs, common illnesses (such as a cold or the flu), and ongoing conditions (such as diabetes or high blood pressure). Primary care doctors do not do surgery and do not treat just one kind of health problem such as a heart condition.</p> <ul style="list-style-type: none"> - <i>PY 2 wording: This is a survey about health care you received from primary care doctors and their staff. Primary care doctors treat preventive and wellness needs, common illnesses (such as a cold or the flu), and ongoing conditions (such as diabetes or high blood pressure). Primary care doctors do not do surgery and do not treat just one kind of health problem such as a heart condition. Specialists are doctors like surgeons, heart doctors, eye doctors, skin doctors, and other doctors who specialize in one area of health care. Please do NOT include specialist care when answering questions about the primary care you received from this doctor’s office.</i> 	Mathematica: CPC+: PY 2 survey	Yes	Yes, in PY 3	n.a.
Q01	<p>In the last 6 months, did you get any kind of health care from primary care doctors or their staff who work at the primary care doctor’s office listed on the cover of this survey? You may know this doctor’s office by another name. [Y/N]</p> <ul style="list-style-type: none"> - <i>PY 3 wording: In the last 6 months, did you get any kind of health care from the primary care doctor’s office listed on the cover page? You may know this doctor’s office by another name.</i> - <i>PY 2 wording: In the last 6 months, did you get any kind of health care from the primary care doctors or their staff from the office listed on the cover page?</i> 	CAHPS v3.0	Yes	Yes, in PY 3 and in PY 5	n.a.

Table 4.E.5b. (continued)

Question number (PY 5)	PY 5 CPC+ question text ^a	Source	Modified from original source?	Modified from previous CPC+ wave?	Composite measure
Q02	<p>In the last 6 months, what kind of visits did you have with this primary care doctor's office? (Mark one or more.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> In-person visit at this doctor's office <input type="checkbox"/> Video visit <input type="checkbox"/> Telephone visit (not part of a video visit) <input type="checkbox"/> None of the above <ul style="list-style-type: none"> - <i>PY 3 wording: "Patients can get health care in different ways. How did you get care in the last 6 months from this primary care doctor's office? (Mark one or more.)"</i> <ul style="list-style-type: none"> <input type="checkbox"/> Had a scheduled appointment at this doctor's office <input type="checkbox"/> Had a same-day appointment or walk-in visit at this doctor's office <input type="checkbox"/> Received help from this doctor's office to fill prescriptions, set up medical tests, or schedule appointments <input type="checkbox"/> Had a video appointment with your doctor or someone from this doctor's office <input type="checkbox"/> Attended a group medical appointment arranged by this doctor's office with other patients who have similar medical issues <input type="checkbox"/> None of the above - <i>PY 2 wording: Patients can get health care in different ways. How did you get care in the last 6 months from primary care doctors and their staff who work at this doctor's office?</i> 	Mathematica: CPC+: PY 2 survey	Yes	Yes, in PY 3 and PY 5	Access <i>(subitem 2 is in the access domain; subitems 1, 3, and 4 are not in any domain)</i>
Q03	<p>In the last 6 months, did your doctor or someone from this doctor's office come to see you in the hospital? [Y/N]</p> <ul style="list-style-type: none"> - <i>PY 3 wording: Did you get any other kinds of care from this doctor's office in the last 6 months?</i> <ul style="list-style-type: none"> <input type="checkbox"/> Your doctor or someone from this doctor's office came to see you in the hospital 	Mathematica: CPC+: PY 2 survey	Yes	Yes, in PY 5	Continuity across health care settings
Q04	<p>In the last 6 months, did your doctor or someone from this doctor's office come to see you at another location besides this doctor's office or the hospital to provide health care (such as at your home or a senior center)?</p> <ul style="list-style-type: none"> - <i>PY 3 wording: Did you get any other kinds of care from this doctor's office in the last 6 months?</i> <ul style="list-style-type: none"> <input type="checkbox"/> Your doctor or someone from this doctor's office came to see you at another location besides this doctor's office or the hospital to provide health care (such as at your home or a senior center) 	Mathematica: CPC+: PY 2 survey	Yes	Yes, in PY 5	Continuity across health care settings
Q05	<p>In the last 6 months, other than visits, did you have any contact with this doctor's office to discuss your health or test results? Contact can be via phone, email, text messaging, or a patient portal. [Y/N]</p> <ul style="list-style-type: none"> - <i>PY 3 wording: "Patients can get health care in different ways. How did you get care in the last 6 months from this primary care doctor's office"</i> <ul style="list-style-type: none"> <input type="checkbox"/> Discussed your health with your doctor or someone from this doctor's office via phone, email, text messaging, or a patient portal 	Mathematica: CPC+: PY 2 survey	Yes	Yes, in PY 5	Access

Table 4.E.5b. (continued)

Question number (PY 5)	PY 5 CPC+ question text ^a	Source	Modified from original source?	Modified from previous CPC+ wave?	Composite measure
Q06	In the last 6 months, did you contact this doctor's office to get care for an illness, injury, or condition that needed care right away? [Y/N]	CAHPS v3.0	Yes	No	n.a.
Q07	In the last 6 months, when you contacted this doctor's office for care you needed right away, how often did you get care as soon as you needed? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Access
Q08	In the last 6 months, did you make any appointments for a check-up or routine care with this doctor's office? [Y/N]	CAHPS v3.0	Yes	No	n.a.
Q09	In the last 6 months, when you made an appointment for a check-up or routine care with this doctor's office, how often did you get care as soon as you needed? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Access
Q10	In the last 6 months, did you contact this doctor's office with a health question during regular office hours? [Y/N]	CAHPS v3.0	Yes	No	n.a.
Q11	In the last 6 months, when you contacted this doctor's office during regular office hours, how often did you get an answer to your health question that same day? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Access
Q12	Has this doctor's office given you information about what to do if you need care during evenings, weekends, or holidays? [Y/N]	CAHPS v3.0 Supplemental PCMH	Yes	No	Access
Q13	In the last 6 months, did you contact this doctor's office with a health question outside of regular office hours, for example, on evenings, weekends, or holidays? [Y/N]	CAHPS v3.0	Yes	No	n.a.
Q14	In the last 6 months, when you contacted this doctor's office outside of regular office hours, how often did you get an answer to your health question as soon as you needed? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Access
Q15	In the last 6 months, did you use email, a patient portal, or text messaging to contact this doctor's office with a health question? [Y/N]	CAHPS v2.0 Supplemental HIT	Yes	No	n.a.
Q16	In the last 6 months, when you used email, a patient portal, or text messaging to contact this doctor's office with a health question, how often did you get an answer to your health question as soon as you needed? [Never, Sometimes, Usually, Always]	CAHPS v2.0 Supplemental HIT	Yes	No	Access
Q17	In the last 6 months, how often did your appointment(s) with this doctor's office start within 15 minutes of your appointment time? [Never, Sometimes, Usually, Always, Not applicable, Did not have scheduled appointment(s) with this doctor's office in the last 6 months]	CAHPS v3.0	Yes	No	Access
Q18	In the last 6 months, did you take any prescription medicine? [Y/N]	CAHPS v3.0	No	No	n.a.
Q19	In the last 6 months, did your doctor or someone from this doctor's office ask you about all the prescription medicines you were taking? [Y/N]	CAHPS v3.0	Yes	No	Care management
Q20	In the last 6 months, did you have a blood test, x-ray, or other test that was ordered by your doctor or someone from this doctor's office? [Y/N]	CAHPS v3.0	Yes	No	n.a.

Table 4.E.5b. (continued)

Question number (PY 5)	PY 5 CPC+ question text ^a	Source	Modified from original source?	Modified from previous CPC+ wave?	Composite measure
Q21	In the last 6 months, when you had a blood test, x-ray, or other test that was ordered by your doctor or someone from this doctor's office, how often did you get your test results? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Patient and family caregiver engagement
Q22	In the last 6 months, how often did people from this doctor's office, including your doctor, explain medical things in a way that was easy to understand? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Patient and family caregiver engagement
Q23	In the last 6 months, how often did people from this doctor's office, including your doctor, listen carefully to you? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Patient and family caregiver engagement
Q24	In the last 6 months, how often did people from this doctor's office, including your doctor, seem to know the important information about your medical history? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Comprehensiveness
Q25	In the last 6 months, how often did people from this doctor's office, including your doctor, show respect for what you had to say? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Patient and family caregiver engagement
Q26	In the last 6 months, how often did people from this doctor's office, including your doctor, spend enough time with you? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Patient and family caregiver engagement
Q26_2 (in PY 2 only)	In the last 6 months, did your doctor or someone from this doctor's office talk with you about how to be healthy enough to do the things you like to do? [Y/N]	CAHPS v3.0 Supplemental PCMH	Yes	No	Patient and family caregiver engagement
Q27	In the last 6 months, did your doctor or someone from this doctor's office ask you if there are things that make it hard for you to take care of your health? [Y/N]	CAHPS v3.0 Supplemental PCMH	Yes	No	Care management
Q28	In the last 6 months, did your doctor or someone from this doctor's office ask you if you had any problems with physical pain or discomfort? [Y/N]	Mathematica: CPC+	Yes	No	Comprehensiveness
Q29	In the last 6 months, did your doctor or someone from this doctor's office ask you if there was a period of time when you felt sad, empty, or depressed? [Y/N]	CAHPS v2.0 Supplemental PCMH	Yes	No	Comprehensiveness
Q30	In the last 6 months, did your doctor or someone from this doctor's office talk with you about things in your life that worry you or cause you stress? [Y/N]	CAHPS v3.0 Supplemental PCMH	Yes	No	Comprehensiveness
Q31	An advance care plan describes a patient's wishes for end-of-life care in case the patient becomes too sick to make his or her own decisions. In an advance care plan, patients can choose family members or friends to make medical decisions for them, including health care that patients may not want. Advance care plans are often recorded in a document such as an advance directive, a do not resuscitate (DNR) order, health care power of attorney, or a living will. Do you have any kind of advance care plan? [Yes, No, I don't know]	Mathematica: CPC+: PY 2 survey	No	No	Patient and family caregiver engagement

Table 4.E.5b. (continued)

Question number (PY 5)	PY 5 CPC+ question text ^a	Source	Modified from original source?	Modified from previous CPC+ wave?	Composite measure
Q32	Has your doctor or someone from this doctor's office asked you about your end-of-life care wishes or creating an advance care plan? [Yes, No, I don't know]	Mathematica: CPC+: PY 2 survey	No	No	Patient and family caregiver engagement
Q33	In the last 6 months, did you have problems with any of the following basic needs? (Mark one or more.) <input type="checkbox"/> Getting enough food <input type="checkbox"/> Rent, housing, or homelessness <input type="checkbox"/> Transportation <input type="checkbox"/> Paying for utilities (such as heating, electric, or phone bills) <input type="checkbox"/> None of the above	Mathematica: CPC+: New for PY 5 survey	n.a.	n.a.	n.a.
Q34	Basic needs are food, housing, transportation, and utilities. In the last 6 months, did your doctor or someone from this doctor's office ask you if you had problems with any of these basic needs? [Y/N] - <i>PY 2 wording: In the last 6 months, did your doctor or someone from this doctor's office ask you about any non-medical problems you might need help with? These might include things like problems paying for or finding a place to live, not having enough food, lack of reliable transportation, or trouble paying utility bills.</i>	Mathematica: CPC+: PY 2 survey	Yes	Yes, in PY 3 ⁱ	Comprehensiveness
Q35	Did your doctor or someone from this doctor's office try to find a place or person to help you with any of these basic needs? [Y/N]	Mathematica: CPC+: New for PY 5 survey	n.a.	n.a.	n.a.
Q36	Did your doctor or someone from this doctor's office ask you if this place or person helped you with these basic needs? [Y/N]	Mathematica: CPC+: New for PY 5 survey	n.a.	n.a.	n.a.
Q37	In the last 6 months, did you have any problems with abuse or violence at home or in your neighborhood? [Y/N]	Mathematica: CPC+: New for PY 5 survey	n.a.	n.a.	n.a.
Q38	In the last 6 months, did your doctor or someone from this doctor's office ask you if you have any problems with abuse or violence at home or in your neighborhood? [Y/N]	Mathematica: CPC+: PY 2 survey	No	No	Comprehensiveness
Q39	Did your doctor or someone from this doctor's office try to find a place or person to help you with abuse or violence at home or in your neighborhood? [Y/N]	Mathematica: CPC+: New for PY 5 survey	n.a.	n.a.	n.a.
Q40	Did your doctor or someone from this doctor's office ask you if this place or person helped you with abuse or violence at home or in your neighborhood? [Y/N]	Mathematica: CPC+: New for PY 5 survey	n.a.	n.a.	n.a.
Q41	Specialists are doctors like surgeons, heart doctors, eye doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you get any health care from a specialist? [Y/N]	CAHPS v3.0 Supplemental PCMH	Yes	No	n.a.

Table 4.E.5b. (continued)

Question number (PY 5)	PY 5 CPC+ question text ^a	Source	Modified from original source?	Modified from previous CPC+ wave?	Composite measure
Q42	Remember, when we say “this doctor’s office,” we are referring to the primary care doctor’s office listed on the cover page. In the last 6 months, how often did the people from this doctor’s office, including your doctor, seem informed and up-to-date about the care you got from specialists? [Never, Sometimes, Usually, Always] - <i>PY 2 wording: In the last 6 months, how often did the primary care doctors and their staff from this doctor’s office and your specialist(s) seem to work well together to care for you?</i>	Mathematica: CPC+: PY 2 survey	Yes	Yes, in PY 3	Coordination
Q43	The questions below ask about health care you got from the primary care doctors and their staff from the doctor’s office listed on the cover page, after going to an emergency department or being in a hospital. In the last 6 months, have you gone to an emergency room or emergency department for care? Please do not include visits to an urgent care center. [Y/N]	Mathematica: CPC Classic	Yes	No	n.a.
Q44	Did your doctor or someone from this doctor’s office contact you to discuss your health needs within one week after your most recent emergency room or emergency department visit? [Y/N]	Mathematica: CPC Classic	Yes	No	Care management
Q45	In the last 6 months, have you been a patient in a hospital overnight or longer? [Y/N]	Mathematica: CPC Classic	Yes	No	n.a.
Q46	Did your doctor or someone from this doctor’s office contact you to discuss your health needs within 3 days after your most recent hospital stay? [Y/N]	Mathematica: CPC Classic	Yes	No	Care management
Q47	In the last 6 months, how often did the primary care doctors and their staff from this doctor’s office work well together to care for you? [Never, Sometimes, Usually, Always]	Mathematica: CPC+: PY 2 survey	No	No	Teamwork
Q48	In the last 6 months, when you got care from a primary care doctor from this doctor’s office, how often was this doctor the person you think of as your regular doctor in this office? By doctor, we mean a doctor, nurse practitioner (NP), or physician assistant (PA). [Never, Sometimes, Usually, Always] - <i>PY 2 wording: When you saw a primary care doctor from this office in the last 6 months, how often were these visits with your regular doctor? A primary care doctor might be a physician (MD or DP), nurse practitioner (NP), or physician assistant (PA).</i>	Mathematica: CPC+: PY 2 survey	Yes	Yes, in PY 3	Continuity within the primary care office
Q49	In the last 6 months, how often were clerks and receptionists at this doctor’s office as helpful as you thought they should be? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Patient experience: Helpful courteous, and respectful office staff
Q50	In the last 6 months, how often did clerks and receptionists at this doctor’s office treat you with courtesy and respect? [Never, Sometimes, Usually, Always]	CAHPS v3.0	Yes	No	Patient experience: Helpful courteous, and respectful office staff
Q51	Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate the care you have received from the primary care doctors and their staff from this doctor’s office? [0–10]	CAHPS v3.0	Yes	No	Patient experience: Patients’ rating of the primary care doctors and staff

Table 4.E.5b. (continued)

Question number (PY 5)	PY 5 CPC+ question text ^a	Source	Modified from original source?	Modified from previous CPC+ wave?	Composite measure
Q52	In the last 6 months, have you delayed or avoided getting medical care from this doctor's office due to concerns about getting or spreading COVID-19? (Mark one or more.) <input type="checkbox"/> No, I did not delay or avoid getting any medical care [due to concerns about getting or spreading COVID-19] <input type="checkbox"/> Yes, I delayed or avoided getting emergency or urgent medical care [due to concerns about getting or spreading COVID-19] <input type="checkbox"/> Yes, I delayed or avoided getting check-ups or routine medical care [due to concerns about getting or spreading COVID-19]	Mathematica: CPC+: New for PY 5 survey	n.a.	n.a.	
Q53	In the last 6 months, have you delayed or avoided getting medical care from this doctor's office because of office issues due to COVID-19 (such as closed office, shorter hours, or less staff)? (Mark one or more.) <input type="checkbox"/> No, I did not delay or avoid getting any medical care [because of office issues due to COVID-19 (such as closed office, shorter hours, or less staff)] <input type="checkbox"/> Yes, I delayed or avoided getting emergency or urgent medical care [because of office issues due to COVID-19 (such as closed office, shorter hours, or less staff)] <input type="checkbox"/> Yes, I delayed or avoided getting check-ups or routine medical care [because of office issues due to COVID-19 (such as closed office, shorter hours, or less staff)]	Mathematica: CPC+: New for PY 5 survey	n.a.	n.a.	
Q54	In general, how would you rate your overall health? [Excellent, Very good, Good, Fair, Poor]	CAHPS v3.0	No	No	n.a.
Q55	In general, how would you rate your overall mental or emotional health? [Excellent, Very good, Good, Fair, Poor]	CAHPS v3.0	No	No	n.a.
Q56	In the last 6 months, how often did you have friends or family to talk to about yourself or your problems? [Never, Sometimes, Usually, Always]	Mathematica: CPC+: New for PY 5 survey	n.a.	n.a.	
Q57	What is the highest grade or level of school that you have completed? [8th grade or less, Some high school, but did not graduate, High school graduate or GED, Some college or 2-year degree, 4-year college graduate, Advanced degree (master's, professional, or doctoral degree) (PY 2 version: <i>More than 4-year college degree</i>)]	CAHPS v3.0	No	Yes, in PY 3	n.a.
Q58	Are you of Hispanic or Latino origin or descent? [Y/N]	CAHPS v3.0	No	No	n.a.
Q59	What is your race? (Mark one or more.) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other	CAHPS v3.0	No	No	n.a.

Note: n.a. = not applicable; the question is not included in a domain because it either does not measure 1 of the 10 domains or is a screener question that allows respondents to skip questions if the situation does not apply to them.

Table 4.E.5b. (continued)

^a If question text changed between survey waves, the prior question text is listed below in blue, italic font.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; CPC+ = Comprehensive Primary Care Plus; GED = general educational development; HIT = health information technology; n.a. = not applicable; PCMH = patient-centered medical home; Q = question; Y/N = yes/no.

4.E.4. Analytic methods

Analytic comparisons. For each of the 34 items that measured patients' experience in the composites, 17 additional individual items not in the composites, and the 10 composite measures created using a subset of the items, we compared responses between patients in CPC+ practices and those in comparison practices to observe differences in patients' experience between the two groups at each point in time (PY 2, PY 3, and PY 5). Because we were not able to collect data before CPC+ began, observed differences in any of the years may reflect preexisting differences between CPC+ and comparison practices.

Estimation. For each of the 34 items that measure patients' experience in the composites, 17 additional individual items not in the composites, and the 10 composite measures, we calculated the proportion of Medicare FFS beneficiaries who gave the *best* (most favorable) responses (response scales varied from 2 points [yes/no] to 11 points [0 to 10 global rating scale]). We also calculated *average* responses on a standardized 0 to 1 scale. Examples of these responses are (1) the provider always explained things to the patient in a way that was easy to understand; (2) in the last 6 months, yes, the doctor's office gave the patient information about what to do if he or she needs care during the evenings, weekends, or holidays; and (3) the patient's rating of the care he or she received from the primary care doctors and their staff (where 0 is the worst level of care possible and 10 is the best level of care possible).

Best and average responses. We analyzed both the best and average responses because there are trade-offs to both methods of defining patients' experience. Reporting the proportion of beneficiaries who gave the *best* responses enables us to compare CPC+ and comparison practices in a way that is easier to understand and interpret. However, this analysis—which focuses only on shifting the proportion of beneficiaries who selected the best response category—ignores any shifts in the other response categories (for example, a shift in the proportion of responses from the third- to second-best response option). An analysis using *average* responses better reflects the range of beneficiaries' responses by averaging responses across all response options. However, this measure is also imperfect. Calculating average responses uses the survey's ordinal scale, which orders options from best to worst response, but counts the movement between each option as equivalent. For example, if there are five response options, it treats the movement from the fifth to the fourth option as equivalent to a movement from the second to first option. It does not take into account objective differences in the meaning of different response options. In addition, the sensitivity analysis increases the risk of finding statistically significant impacts due to chance alone—a result of multiple hypothesis testing (explained in more detail later).

Regression adjustment. We first calculated the likelihood (predicted probability) that beneficiaries would respond to an item with the best response using logistic regressions with recycled predictions. For each outcome, we estimated outcomes separately by track. All regressions controlled for baseline (before CPC+) beneficiary and practice characteristics; beneficiaries' self-reported education level, race, and health status at the time of the survey; and COVID-19-related region-level control variables to account for regional differences in the timing, severity, and effects of COVID-19 on health care use (Laird et al. 2023, Appendix 5.D details our strategy to account for the COVID-19 pandemic). Table 4.E.6 lists the control variables. The control variables used in this analysis are the same as those used in the claims-based impact analysis with the following exceptions: (1) the impact analysis uses practice fixed effects and therefore does not include practice-level control variables, and (2) this analysis also controls for the beneficiary's baseline Medicare FFS expenditures and service use, and self-reported education level, race, and health status at the time of survey response. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights as described in Section 4.E.2. To account for

correlation in responses of beneficiaries within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Table 4.E.6. Control variables used in regressions

Variable description	Source
Practice-level variables at baseline (2016)	
Number of practitioners (physicians, NPs, PAs) of all specialties	SK&A, 2016
Meaningful use status (whether physicians at practice are meaningful users of EHRs and earliest year that physician at practice attested to meaningful use)	CMS, 2016
Whether the practice is multispecialty	SK&A, 2016
Whether a hospital or health system owns the practice	SK&A, 2016
Whether the practice participated in an SSP accountable care organization	MDM, 2016
Prior experience in selected practice transformation activities: NCQA, TJC, AAAHC, URAC, or state medical-home recognition status (whether practice is in a medical home) or alumni of CPC Classic or MAPCP	NCQA, 2016; TJC, 2016; AAAHC, 2016; URAC, 2016; state-specific sources, 2016; CPC+ data; CMS, 2016
Modified U.S. Census region (Midwest, Northeast, South and Plains, West) ^a	SK&A, 2016
Median household income of the county	Area Resource File, 2015–2016
Whether there is a shortage of primary care health professionals in the practice's county	Area Resource File, 2015–2016
Medicare Advantage penetration rate in the practice's county	Area Resource File, 2015–2016
Whether in an urban, rural, or suburban area	Area Resource File, 2015–2016
Number of hospitals and/or hospital beds in the county	Area Resource File, 2015–2016
Percentage of county's population in poverty	Area Resource File, 2015–2016
Percentage of adults ages 25 or older in the county with a degree from a four-year college	Area Resource File, 2015–2016
Beneficiaries' characteristics at baseline (2016), unless otherwise noted	
Age	Medicare enrollment data, 2016
Gender	Medicare enrollment data, 2016
Self-reported race at time of survey response	CPC+ Beneficiary Surveys, 2018-2021
Reasons for Medicare eligibility	Medicare enrollment data, 2016
Dual eligibility status	Medicare enrollment data, 2016
Self-reported education level at time of survey response	CPC+ Beneficiary Surveys, 2018-2021
Risk score measured using the beneficiary's HCC score and indicator for whether the HCC score is missing	Medicare claims and enrollment data, 2016
Annualized Medicare expenditures at baseline (2016)	Medicare claims, 2016
Annualized number of hospitalizations at baseline (2016)	Medicare claims data, 2016
Annualized number of ED visits at baseline (2016)	Medicare claims data, 2016
Annualized number of primary care visits at baseline (2016)	Medicare claims data, 2016
Indicator for missing baseline Medicare FFS expenditures and service use for new-to-Medicare beneficiaries	Medicare claims data
Self-reported overall health status at time of survey response	CPC+ Beneficiary Surveys, 2018-2021

Table 4.E.6. (continued)

Variable description	Source
Presence of selected chronic conditions	Medicare claims data, 2016
HCC 8 – Metastatic Cancer and Acute Leukemia	
HCC 18 – Diabetes with Chronic Complications	
HCC 21 – Protein-Calorie Malnutrition	
HCC 22 – Morbid Obesity	
HCC 23 – Other Significant Endocrine and Metabolic Disorders	
HCC 85 – Congestive Heart Failure	
HCC 96 – Specified Heart Arrhythmias	
HCC 106 – Atherosclerosis of the Extremities with Ulceration or Gangrene	
HCC 111 – Chronic Obstructive Pulmonary Disease	
HCC 173 – Traumatic Amputations and Complications	
HCC 186 – Major Organ Transplant or Replacement Status	
HCC 40 or 47 – Rheumatoid Arthritis and Inflammatory Connective Tissue Disease or Disorders of Immunity	
HCC 46 or 48 – Severe Hematological Disorders, or Coagulation Defects and Other Specified Hematological Disorders	
HCC 54 or 55 – Drug/Alcohol Psychosis or Dependence	
HCC 57 or 58 – Schizophrenia or Major Depressive, Bipolar, and Paranoid Disorders	
HCC 70 or 71 – Quadriplegia or Paraplegia	
HCC 80 or 82 – Coma, Brain Compression/Anoxic Damage or Respirator Dependence/Tracheostomy Status	
HCC 86, 87, or 88 – Acute Myocardial Infarction, Unstable Angina and Other Acute Ischemic Heart Disease, or Angina Pectoris	
HCC 99 or 100 – Cerebral Hemorrhage, or Ischemic or Unspecified Stroke	
HCC 107 or 108 – Vascular Disease, with Complications	
HCC 157 or 158 – Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone; or of Skin with Full Thickness Skin Loss	
Chronic Conditions Warehouse indicator	
Alzheimer's Disease or Dementia	
Region-level COVID-19-related controls	
Social Vulnerability Index, county-level, 2018	CDC/ATSDR
Pandemic Vulnerability Index, 2021 county-level Q1 and Q2 means	National Institute of Environmental Health Sciences, North Carolina State University and Texas A&M University
Government Response Index, 2021 state-level mean	Oxford University

^a For the 2017 Starters, we grouped CPC+ regions into four market areas using the four U.S. Census regions as our starting point. We moved two CPC+ 2017 regions from their given Census region to a neighboring Census region. The Northern Kentucky–Ohio region spans two Census regions; therefore, we moved CPC+ practices in Northern Kentucky to the Midwest region. Because of its proximity to CPC+ regions in the South (Arkansas, Oklahoma, and Tennessee), we moved the Kansas City region from the Midwest region to the South. For face validity, we excluded several states from the external market areas from which we drew comparison practices. We also assigned three external states to a geographic region different from their Census region, to more closely mirror the CPC+ regions' market characteristics.

AAAHC = Accreditation Association for Ambulatory Health Care; ATSDR = Agency for Toxic Substances and Disease Registry; CDC = Centers for Disease Control and Prevention; CMS = Centers for Medicare & Medicaid Services; ED = emergency department; EHR = electronic health record; FFS = fee-for-service; HCC = hierarchical condition category; MAPCP = Multi-Payer Advanced Primary Care Practice; MDM = master data management system; NCQA = National Committee for Quality Assurance; NP = nurse practitioner; PA = physician assistant; SSP = Medicare Shared Savings Program; TJC = The Joint Commission; URAC = Utilization Review Accreditation Commission.

Missing data due to nonresponse or skips. We calculated predicted probabilities for each question among beneficiaries who responded to that question. Questions that asked respondents whether the next question applied to them preceded 10 of these questions. Fewer beneficiaries responded to these follow-up questions because of skip patterns in the survey. In those cases, we report responses among those who should have answered the question. For example, the survey asked all beneficiaries whether they had contacted the doctor's office with a health question during regular office hours. If respondents selected yes, the survey then asked a follow-up question about how often they received an answer to their medical question the same day. In the PY 2 survey, for example, 56 percent of respondents in both groups of practices answered that they had not phoned their provider's office with a medical question during regular office hours. Therefore, these beneficiaries were not asked the follow-up question and were not included

in the analysis for that question. Most questions that were not preceded by a screener question were answered by 95 percent or more of the survey respondents.

Creating and assessing composite measures. In addition to individual items, we created 10 composite measures using 34 of the 46 items about patients' experience (described above). We calculated composite measures by averaging nonmissing binary indicators for whether the beneficiary's response was the best option across each item in the composite. (That is, if the composite contained four items and the respondent answered all four and gave the best response for three of them, the patient's score for that composite measure was 0.75.) We then assessed differences in composite measures between beneficiaries in the CPC+ and comparison groups, using ordinary least squares regressions that controlled for the same characteristics as the regressions for individual items (described above).

Subgroups. For the composite measures, we also estimated the effects of CPC+ on key subgroups of beneficiaries based on practice or patient characteristics:

- Practice characteristics
 - Whether the beneficiary's practice participated in a Medicare SSP accountable care organization at the start of CPC+ (January 1, 2017, for practices that started CPC+ in 2017)
 - Whether the beneficiary's practice participated in prior practice transformation activities, defined as whether the practice was recognized as a medical home or participated in the Multi-Payer Advanced Primary Care Practice demonstration or CPC Classic⁵⁸
 - Whether a hospital or a health system owned the beneficiary's practice⁵⁹
 - The size of the beneficiary's practice site (measured by number of primary care practitioners: large [6 or more practitioners], medium [3 to 5 practitioners], or small [1 or 2 practitioners])⁶⁰

⁵⁸ We considered a practice to be a Multi-Payer Advanced Primary Care Practice participant if it participated in any year, 2011–2014 for 2017 Starters, as determined by a file from CMS. A practice was considered to have medical home recognition if at least one of its primary care providers was listed as having recognition at some point in 2014–2017 from the National Community for Quality Assurance (NCQA), a state, the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), or the Utilization Review Accreditation Commission (URAC), as determined by the June 2016 (for 2017 Starters) NCQA PCMH file and data extracted from the websites of TJC, AAAHC, URAC, and state-specific sources from October 2016 to February 2017.

⁵⁹ Practice ownership comes from the SK&A database, managed by IQVIA, a marketing organization that collects information directly from all health care practices in the United States. IQVIA updates this information on an ongoing basis; we pulled practice ownership information in November 2016.

⁶⁰ We calculated the number of primary care practitioners (PCPs) at the practice site using a November 2016 pull of SK&A data and the National Plan & Provider Enumeration System (NPPES). We counted a provider as a PCP if they met criteria in either the SK&A data or the NPPES data; we did not require them to be considered a PCP in both data sources. Using the SK&A data, we defined PCPs as a physician (MD or DO), nurse practitioner (NP), or physician's assistant (PA) who bills under their own National Provider Identifier (NPI) and has a specialty of general practitioner, family practitioner, internist, internal medicine/pediatrics, or geriatrician. In NPPES, we defined PCPs as physicians, NPs, PAs, or clinical nurse specialists with 1 of 56 primary care taxonomy codes.

- Whether the beneficiary’s practice was in a rural, suburban, or urban area⁶¹
- Patient characteristics
 - Race, as self-reported in the PY 5 survey
 - The beneficiary’s relative health status, measured in three different ways, by whether the beneficiary at baseline had:
 - A top quartile HCC risk score (Pope et al. 2004)
 - A top 10 percent HCC score or dementia
 - A serious mental illness (defined as having one of the following behavioral health conditions: schizophrenia or major depressive, bipolar, or paranoid disorder, or drug/alcohol psychosis or drug/alcohol dependence)

For these subgroup analyses, we included in the regressions interactions of variables denoting subgroup membership with the indicator for CPC+ versus comparison status and survey wave. Because there is likely to be significant correlation among practice or beneficiary characteristics, for example, between practice size and ownership, testing for differential effects for each characteristic separately might not unmask the real drivers of significant differences. Therefore, we included interactions with subgroup indicators for *all* practice (or beneficiary) characteristics in a single regression to disentangle characteristics that actually influence program impacts.

Power. Using two-tailed tests at the 10 percent significance level, the analysis had 80 percent power to detect differences between CPC+ and comparison patients of 1 to 4 percentage points for the composite measures and most individual items for PY 5. Exceptions were for seven items that applied to a small proportion of respondents, such as beneficiaries who had received a referral for help with a health-related social need, beneficiaries who had contacted the doctor’s office outside of regular office hours or via a patient portal or text messaging, as well as beneficiaries who in the last six months had gone to the ED for care or stayed overnight in the hospital; for these items we could detect differences of 6 to 10 percentage points. An additional three items with very small sample sizes (less than 300) had minimum detectable effects larger than 10 percentage points. Among subgroups, minimum detectable effects are larger due to smaller sample sizes.

Multiple comparisons and substantial importance. Because multiple comparisons can lead to false positives, we do not draw inferences about effects from tests of each hypothesis separately, but rather from the findings across the set of items and composites, relying most heavily on the summary composites. Nevertheless, we must interpret results with caution due to the number of tests performed. We tested for 122 primary impacts in PY 5 (51 survey items and 10 composite measures across the two tracks), not including the subgroup analyses and the sensitivity analysis on average response. The analyses for the eight subgroups in each track examined only the 10 composite measures, resulting in an additional 180 tests. The analysis of average responses added an additional 122 tests (51 survey items and

⁶¹ Geographic location is derived from the 2015–2016 U.S. Department of Health and Human Services’ Area Health Resource File (AHRF). The variable used reflects 2013 data. The AHRF provides a 9-point rural–urban continuum code (RUCC) from the U.S. Department of Agriculture Economic Research Service. From these codes, we defined urban as a county in a metropolitan area of more than 250,000 people (RUCC = 1 or 2), suburban as a county in a metropolitan area of fewer than 250,000 people or that has an urban population of 20,000 or more and is adjacent to a metropolitan area (RUCC=3 or 4), and rural as a county that does not meet the urban or suburban classifications (RUCC = 5 to 9).

10 composites across two tracks). This means that, by chance alone, we would expect to find statistically significant differences in 42 tests using the 0.10 significance level.

Thus, to reduce the risk of incorrectly concluding there were effects of CPC+, we considered responses between beneficiaries in CPC+ and comparison practices to be statistically different and substantially important if the difference met two criteria: (1) the p -value was less than or equal to 0.10 and (2) the difference between the two groups was larger than 5 percentage points.

Sensitivity tests using average response. To test the sensitivity of our findings, we examined CPC+–comparison differences in regression-adjusted average responses. Because the number of response options varies among items, we first standardized responses to a 0 to 1 scale, where 0 is the worst response and 1 is the best. To calculate average responses for the composite measures, we created beneficiary-level composite measures by averaging the nonmissing standardized responses across the items in the composite measure. We then used ordinary least squares regressions and controlled for the same practice and beneficiary characteristics used for the analysis of best responses.

Software. We conducted all analyses using SAS version 9.4 and Stata version 16, and statistical tests used survey commands to account for the survey sampling design.

4.E.5. Data tables

This section presents five sets of tables showing weighted and regression-adjusted data. Each table shows data for respondents in CPC+ and comparison practices separately, as follows:

- Tables 4.E.7a and 4.E.7b present the predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices who gave the best response to individual survey items and the 10 composite measures, by program year and track.
- Tables 4.E.8a and 4.E.8b present the predicted standardized average responses for composite measures and the individual survey items for Medicare FFS beneficiaries attributed to CPC+ and comparison practices, by program year and track.
- Tables 4.E.9a and 4.E.9b present the predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices who gave the best response to the 10 composite measures, by SSP status, by program year and track.
- Tables 4.E.10a–4.E.10d present the predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices who gave the best responses to the 10 composite measures, by various practice characteristics, by program year and track.
 - Tables 4.E.10a.1 and 4.E.10a.2: by practice ownership
 - Tables 4.E.10b.1 and 4.E.10b.2: by practice size
 - Tables 4.E.10c.1 and 4.E.10c.2: by practice’s geographic location
 - Tables 4.E.10d.1 and 4.E.10d.2: by practice’s prior primary care transformation experience
- Tables 4.E.11a–4.E.11d present the predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices who gave the best responses to the 10 composite measures, by various beneficiary characteristics, by program year and track.

- Tables 4.E.11a.1 and 4.E.11a.2: by beneficiary’s high-risk status defined by whether the beneficiary’s HCC score is in the top quartile of the sample
- Tables 4.E.11b.1 and 4.E.11b.1: by beneficiary’s high-risk status defined by whether the beneficiary has an HCC score in the top 10 percent or has dementia
- Tables 4.E.11c.1 and 4.E.11c.2: by beneficiary’s high-risk status defined by whether the beneficiary has a serious mental illness
- Tables 4.E.11d.1 and 4.E.11d.2: by beneficiary’s self-reported race at the time of the survey
- Tables 4.E.12a and 4.E.12b present the demographic characteristics of Medicare FFS beneficiaries attributed to CPC+ and comparison practices, by track

In each table, bolded text indicates a statistically significant ($p < 0.10$) difference between responses from beneficiaries in CPC+ and those from beneficiaries in comparison practices. Green shading with bolded text indicates a favorable finding that is both statistically significant ($p < 0.10$) and substantially significant (a difference of 5 percentage points or more); yellow shading with bold, italicized text indicates an unfavorable finding that is both statistically and substantially significant.

Table 4.E.7a. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to composites and individual items, PY 2, PY 3, and PY 5 (Track 1)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Composite measures (34 total items)															
Access (9 items)	37.6%	38.9%	-1.2%	0.095	3,542; 3,722	38.8%	38.0%	0.8%	0.120	3,818; 4,450	52.2%	52.4%	-0.2%	0.756	3,316; 3,823
Continuity in the doctor's office (1 item)	83.2%	84.6%	-1.3%	0.273	3,469; 3,643	81.0%	80.3%	0.7%	0.508	3,739; 4,359	80.8%	80.5%	0.3%	0.764	3,246; 3,747
Continuity across health care settings (2 items)	3.2%	3.7%	-0.5%	0.366	3,456; 3,659	2.2%	2.4%	-0.2%	0.413	3,721; 4,324	1.8%	2.1%	-0.3%	0.259	3,280; 3,790
Care management (4 items)	70.9%	71.5%	-0.6%	0.594	3,526; 3,702	70.5%	70.1%	0.3%	0.682	3,812; 4,442	69.6%	68.0%	1.6%	0.089	3,308; 3,815
Comprehensiveness (6 items)	50.5%	51.6%	-1.1%	0.238	3,529; 3,708	52.7%	51.3%	1.3%	0.069	3,801; 4,422	51.4%	50.0%	1.4%	0.056	3,315; 3,821
Coordination (1 item) ^a	66.3%	66.0%	0.3%	0.890	2,501; 2,687	60.2%	59.4%	0.8%	0.561	2,857; 3,247	57.8%	58.9%	-1.1%	0.492	2,512; 2,871
Patient and family caregiver engagement (7 items)	72.0%	73.8%	-1.8%	0.027	3,535; 3,714	75.2%	74.5%	0.7%	0.270	3,819; 4,449	74.6%	74.9%	-0.3%	0.718	3,298; 3,805
Helpful, courteous, and respectful office staff (2 items)	83.4%	85.5%	-2.1%	0.044	3,519; 3,709	84.8%	85.6%	-0.8%	0.320	3,802; 4,428	84.1%	86.0%	-1.9%	0.037	3,307; 3,813
Teamwork (1 item)	78.1%	78.5%	-0.5%	0.722	3,448; 3,664	80.8%	80.0%	0.8%	0.395	3,753; 4,357	79.2%	78.4%	0.8%	0.467	3,275; 3,759
Patients' rating of the primary care doctors and their staff (1 item)	83.8%	83.0%	0.8%	0.504	3,514; 3,684	85.8%	85.3%	0.5%	0.559	3,766; 4,393	85.2%	85.6%	-0.4%	0.648	3,284; 3,794
Individual items by domain (PY 5 item number unless otherwise noted)															
Access (9 items in composite, 6 other items, 15 total items)															
Q5 and Q2_2 Type of care received by patient from primary care doctors and their staff															
Q5 Discussed his/her health with doctor or someone from the doctor's office via phone, email, text messaging, or a patient portal ^b	34.2%	36.5%	-2.4%	0.125	3,456; 3,659	18.4%	19.6%	-1.2%	0.219	3,787; 4,423	55.4%	57.1%	-1.6%	0.221	3,286; 3,784
Q2_2 Had a video appointment with doctor or someone from doctor's office ^c	1.1%	1.6%	-0.5%	0.239	3,437; 3,646	0.4%	0.4%	0.0%	0.936	3,703; 4,300	8.1%	7.8%	0.3%	0.735	3,296; 3,796
Q7: Patient always got care as soon as needed when s/he contacted doctor's office for care needed right away	72.4%	74.2%	-1.8%	0.439	1,566; 1,623	75.8%	73.0%	2.7%	0.120	1,517; 1,747	71.4%	71.8%	-0.4%	0.839	1,106; 1,236

Table 4.E.7a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q9: Patient always got care as soon as needed when s/he made appointments for check-up or routine care	78.3%	81.0%	-2.8%	0.057	2,948; 3,075	81.4%	80.4%	1.1%	0.336	3,067; 3,604	78.1%	78.8%	-0.7%	0.557	2,626; 3,007
Q11: Patient always received an answer to his/her health question that same day when contacting doctor's office during regular office hours	61.1%	62.1%	-1.0%	0.696	1,520; 1,666	64.2%	59.6%	4.5%	0.020	1,606; 1,876	57.7%	58.3%	-0.5%	0.792	1,441; 1,652
Q12: Patient received information from doctor's office about what to do if she/he needed care during evenings, weekends, or holidays	71.8%	71.0%	0.8%	0.593	3,429; 3,552	73.7%	70.7%	3.0%	0.010	3,693; 4,314	68.1%	68.1%	0.1%	0.969	3,229; 3,722
Q14: Patient always received an answer to his/her health question as soon as needed when contacting doctor's office outside of regular office hours	60.4%	65.2%	-4.9%	0.405	268; 293	71.3%	66.4%	4.9%	0.228	289; 372	67.9%	63.9%	4.0%	0.369	273; 301
Q16: Patient always received an answer to his/her health question as soon as needed when contacting the doctor's office using email, a patient portal, or text messaging	76.3%	73.4%	2.9%	0.481	327; 433	75.7%	76.4%	-0.7%	0.806	451; 582	72.0%	73.9%	-1.9%	0.471	681; 789
Q17: Among individuals with scheduled appointments, appointments always started within 15 minutes of scheduled appointment time	41.2%	45.5%	-4.3%	0.020	3,438; 3,588	46.1%	45.3%	0.9%	0.520	3,704; 4,318	53.6%	52.7%	0.9%	0.529	3,195; 3,665
Other access items not included in composite measure															
Q2 Type of care received by patient from primary care doctor's office															
Q2_1 Had an in-person visit at this doctor's office	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	93.4%	93.7%	-0.3%	0.652	3,296; 3,796
Q2_3 Had a telephone visit (not part of a video visit)	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	9.7%	9.7%	0.0%	0.961	3,294; 3,799
(Wave 2 Q2_1) Had a scheduled appointment at doctor's office	94.4%	94.9%	-0.4%	0.583	3,456; 3,659	92.9%	92.7%	0.1%	0.843	3,787; 4,423	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.

Table 4.E.7a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
(Wave 2 Q2_2) Had a same-day appointment or walk-in visit	20.6%	20.2%	0.5%	0.733	3,456; 3,659	12.5%	13.0%	-0.5%	0.562	3,787; 4,423	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.
(Wave 2 Q2_3): Received help to fill prescriptions, set up medical tests, or schedule appointments from the primary care doctors and their staff	62.5%	63.1%	-0.6%	0.701	3,456; 3,659	36.4%	37.2%	-0.8%	0.508	3,787; 4,423	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.
(Wave 2 Q3_4) Attended a group medical appointment arranged by the doctor's office with patients with similar medical issues	1.3%	1.7%	-0.4%	0.271	3,435; 3,645	0.7%	0.6%	0.1%	0.775	3,696; 4,294	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.
Continuity in the doctor's office (1 item)															
Q48: Patient always received care from the primary care doctor she/he thought of as her/his regular doctor ^d	83.2%	84.7%	-1.5%	0.209	3,469; 3,643	81.0%	80.3%	0.7%	0.515	3,739; 4,359	80.8%	80.4%	0.4%	0.729	3,246; 3,747
Continuity across health care settings (2 items)															
Q3: Patient's doctor or someone from the doctor's office came to see patient in the hospital ^e	4.2%	4.7%	-0.5%	0.496	3,456; 3,659	3.1%	3.6%	-0.5%	0.273	3,721; 4,324	2.5%	2.6%	-0.1%	0.818	3,248; 3,757
Q4: Patient's doctor or someone from the doctor's office came to see patient at another location (excluding the doctor's office and hospital) to provide health care ^f	2.2%	2.7%	-0.5%	0.349	3,456; 3,659	1.3%	1.2%	0.1%	0.832	3,721; 4,324	1.2%	1.7%	-0.5%	0.107	3,272; 3,781
Care management (4 items)															
Q19: If patient took prescription medicine, someone from the doctor's office talked with patient about all the prescription medicines patient was taking	93.7%	93.2%	0.5%	0.574	3,392; 3,509	93.6%	93.9%	-0.3%	0.624	3,622; 4,221	91.0%	90.9%	0.1%	0.898	3,138; 3,606

Table 4.E.7a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q27: Patient's doctor or someone from the doctor's office asked patient if there are things that make it hard for him/her to take care of his/her health	52.9%	55.3%	-2.4%	0.173	3,430; 3,610	52.0%	51.6%	0.4%	0.761	3,723; 4,325	52.7%	50.1%	2.7%	0.067	3,226; 3,736
Q44: If patient visited the emergency room or emergency department for care, patient was contacted by doctor's office within one week	65.5%	58.0%	7.5%	0.033	811; 835	63.9%	58.8%	5.1%	0.055	856; 938	59.0%	59.0%	0.0%	1.000	629; 695
Q46: If patient stayed in a hospital overnight or longer, patient was contacted by doctor's office within 3 days	54.0%	56.9%	-2.9%	0.501	578; 598	55.9%	55.0%	0.9%	0.778	563; 660	51.1%	50.2%	0.9%	0.809	458; 544
Comprehensiveness (6 items in composite, 4 other items, 10 total items)															
Q24: People from the doctor's office, including the doctor, always seemed to know the important information about patient's medical history	75.5%	75.7%	-0.2%	0.877	3,503; 3,673	76.5%	75.2%	1.3%	0.237	3,770; 4,384	74.3%	74.9%	-0.6%	0.644	3,262; 3,776
Q28: Patient's doctor or someone from the doctor's office asked patient if she/he had any problems with physical pain or discomfort	85.4%	87.8%	-2.3%	0.029	3,484; 3,661	85.3%	85.5%	-0.2%	0.789	3,759; 4,375	83.0%	82.1%	0.9%	0.388	3,261; 3,769
Q29: Patient's doctor or someone from the doctor's office asked patient if there was a period of time when she/he felt sad, empty, or depressed	59.5%	59.8%	-0.3%	0.868	3,463; 3,630	64.6%	61.0%	3.5%	0.008	3,741; 4,361	68.1%	64.7%	3.4%	0.015	3,261; 3,765
Q30: Patient's doctor or someone from the doctor's office talked to patient about things in his/her life that cause worry or stress	52.0%	52.5%	-0.5%	0.762	3,448; 3,629	54.0%	51.6%	2.4%	0.080	3,725; 4,341	55.2%	52.6%	2.6%	0.074	3,250; 3,737
Q34: Patient's doctor or someone from the doctor's office asked her/him about basic needs she/he might need help with ^a	10.4%	10.1%	0.3%	0.802	3,439; 3,581	13.2%	12.4%	0.8%	0.386	3,744; 4,348	12.8%	10.7%	2.2%	0.024	3,198; 3,701

Table 4.E.7a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q38: Patient's doctor or someone from the doctor's office asked her/him if she/he had any problems with abuse or violence at home or in her/his neighborhood	17.4%	18.6%	-1.2%	0.413	3,443; 3,578	21.0%	20.3%	0.7%	0.569	3,736; 4,352	14.0%	13.2%	0.8%	0.415	3,195; 3,690
Other comprehensiveness items not included in composite measure															
Q35: Patient's doctor or someone from the doctor's office tried to find a place or person to help patient with basic needs	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	14.9%	19.9%	-4.9%	0.118	358; 369
Q36: Patient's doctor or someone from doctor's office asked if place or person helped with basic needs	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	92.5%	50.4%	42.1%	0.000	45; 68
Q39: Patient's doctor or someone from doctor's office tried to find patient a place or person to help with abuse or violence at home or in neighborhood	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	5.3%	5.9%	-0.6%	0.769	365; 379
Q40: Patient's doctor or someone from doctor's office asked patient if place or person helped them with abuse or violence at home or in neighborhood.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	75.7%	47.8%	27.8%	0.108	16; 25
Coordination (1 item)*															
Q42 If patient received care from specialist, primary care doctor's office was informed and up-to-date on specialist care	66.3%	66.0%	0.3%	0.884	2,501; 2,687	60.2%	59.4%	0.9%	0.554	2,857; 3,247	57.8%	58.9%	-1.1%	0.488	2,512; 2,871
Patient and family caregiver engagement (7 items in composite, 1 other item, 8 total items)															
Q21: Patient always received test results that were ordered by the doctor or someone at the doctor's office	82.7%	85.2%	-2.6%	0.039	2,924; 3,067	85.9%	84.5%	1.5%	0.130	3,139; 3,657	85.4%	85.5%	-0.1%	0.901	2,729; 3,153

Table 4.E.7a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q22: People from the doctor's office, including the doctor, always explained medical things to patient in a way that was easy to understand	78.4%	80.9%	-2.6%	0.044	3,506; 3,689	80.7%	80.4%	0.3%	0.781	3,778; 4,396	80.3%	80.0%	0.3%	0.783	3,267; 3,780
Q23: People from the doctor's office, including the doctor, always listened carefully to patient	82.3%	83.0%	-0.8%	0.562	3,504; 3,695	84.5%	83.9%	0.6%	0.513	3,780; 4,398	82.2%	83.0%	-0.8%	0.445	3,274; 3,783
Q25: People from the doctor's office, including the doctor, always showed respect for what patient had to say	87.2%	88.0%	-0.7%	0.522	3,517; 3,695	89.1%	87.8%	1.3%	0.102	3,782; 4,398	87.8%	88.4%	-0.6%	0.515	3,269; 3,789
Q26: People from the doctor's office, including the doctor, always spent enough time with patient	77.6%	78.0%	-0.4%	0.766	3,510; 3,692	79.2%	79.3%	-0.1%	0.928	3,784; 4,410	79.8%	80.5%	-0.8%	0.486	3,267; 3,785
Q31: Patient has an advanced care plan	61.9%	65.5%	-3.6%	0.018	3,474; 3,612	64.3%	65.7%	-1.4%	0.242	3,750; 4,360	64.4%	65.0%	-0.6%	0.642	3,271; 3,765
Q32: Patient's doctor or someone from the doctor's office asked patient about his/her end-of-life care wishes or creating an advance care plan	36.6%	37.3%	-0.8%	0.657	3,432; 3,586	45.3%	42.6%	2.6%	0.058	3,716; 4,321	46.0%	44.0%	1.9%	0.171	3,253; 3,758
Other patient and family caregiver engagement item not included in composite measure															
(Wave 1 Q26) Patient's doctor or someone from the doctor's office talked with patient about how to be healthy enough to do the things he/she likes to do	77.1%	79.8%	-2.7%	0.009	3,457; 6,374	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.
Helpful, courteous, and respectful office staff (2 items)															
Q49: Clerks and receptionists at the doctor's office were always as helpful as patient thought they should be	78.9%	81.6%	-2.7%	0.034	3,509; 3,694	79.8%	81.3%	-1.5%	0.153	3,789; 4,417	79.7%	81.0%	-1.3%	0.241	3,294; 3,803
Q50: Clerks and receptionists at the doctor's office always treated patient with courtesy and respect	88.0%	89.4%	-1.5%	0.151	3,512; 3,703	89.8%	90.0%	-0.2%	0.835	3,794; 4,417	88.6%	90.9%	-2.3%	0.008	3,295; 3,799

Table 4.E.7a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Teamwork (1 item)															
Q47: Primary care doctors and their staff always worked well together to care for patient	78.1%	78.5%	-0.5%	0.720	3,448; 3,664	80.8%	80.0%	0.8%	0.410	3,753; 4,357	79.2%	78.4%	0.8%	0.487	3,275; 3,759
Patients' rating of the primary care doctors and their staff (1 item)															
Q51: Patient's rating of care received from the primary care doctors and their staff as best level of care possible (9-10, out of a maximum of 10)	83.9%	82.9%	0.9%	0.466	3,514; 3,684	85.8%	85.3%	0.5%	0.563	3,766; 4,393	85.2%	85.6%	-0.4%	0.647	3,284; 3,794
Delayed care due to COVID (no composite measure, 6 items)															
Q52 Type of medical care patient delayed or avoided getting from doctor's office due to concerns about getting or spreading COVID-19															
Q52_1: Patient did not delay or avoid getting medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	87.8%	86.8%	1.0%	0.297	3,292; 3,787
Q52_2: Patient delayed or avoided getting emergency or urgent medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	1.5%	1.8%	-0.3%	0.404	3,243; 3,717
Q52_3: Patient delayed or avoided getting check-ups or routine medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	11.4%	12.0%	-0.5%	0.534	3,284; 3,779
Q53 Type of medical care patient delayed or avoided getting from doctor's office because of office issues due to COVID-19															
Q53_1: Patient did not delay or avoid getting medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	93.3%	92.3%	1.1%	0.128	3,270; 3,768
Q53_2: Patient delayed or avoided getting emergency or urgent medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	1.2%	1.3%	0.0%	0.965	3,208; 3,701
Q53_3: Patient delayed or avoided getting check-ups or routine medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	5.6%	6.8%	-1.2%	0.066	3,270; 3,768

Table 4.E.7a. (continued)

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Item numbers are from the PY 5 survey unless otherwise noted.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS – fee-for-service; n.a. = not applicable because the item was not asked in the wave; PY = Program Year.

^a This domain changed composition over time. While remaining a domain composed of one item, the wording changed substantially. In wave 1, we asked, “In the last 6 months, how often did the primary care doctors and their staff from this doctor’s office and your specialist(s) seem to work well together to care for you?” In wave 2 and wave 3, we asked, “In the last 6 months, how often did the people from this doctor’s office, including your doctor, seem informed and up-to-date about the care you got from specialists?” Given the substantial differences in the item wording, domain scores should not be compared over time.

^b The wording on this item changed from the wave 2 survey, in which we asked, “Patients can get health care in different ways. How did you get care in the last 6 months from this primary care doctor’s office? (Mark one or more.) 4-Discussed your health with your doctor or someone from this doctor’s office via phone, email, text messaging, or a patient portal.” In the wave 3 survey, we asked, “In the last 6 months, other than visits, did you have any contact with this doctor’s office to discuss your health or test results? Contact can be via phone, email, text messaging, or a patient portal.”

^c The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 3-Had a video appointment with your doctor or someone from this doctor’s office.” In the wave 3 survey, we asked, “In the last 6 months, what kind of visits did you have with this primary care doctor’s office? (Mark one or more.) 2-Video visit.”

^d The wording on this item changed from the wave 1 survey, in which we asked, “In the last 6 months, when you got care from a primary care doctor from this doctor’s office, how often was this doctor the person you think of as your regular doctor in this office? By doctor, we mean a doctor, nurse practitioner (NP), or physician assistant (PA).” In the wave 2 and wave 3 survey, we asked, “When you saw a primary care doctor from this office in the last 6 months, how often were these visits with your regular doctor? A primary care doctor might be a physician (MD or DO), nurse practitioner (NP), or physician assistant (PA).”

^e The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 1-Your doctor or someone from this doctor’s office came to see you in the hospital.” In the wave 3 survey, we asked, “In the last 6 months, did your doctor or someone from this doctor’s office come to see you in the hospital?”

^f The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 2-Your doctor or someone from this doctor’s office came to see you at another location besides this doctor’s office or the hospital to provide health care (such as at your home or a senior center).” In the wave 3 survey, we asked, “In the last 6 months, did your doctor or someone from this doctor’s office come to see you at another location besides this doctor’s office or the hospital to provide health care (such as at your home or a senior center)?”

^g The wording on this item changed from the wave 2 survey, in which we asked, “In the last 6 months, did your doctor or someone from this doctor’s office ask you about any non-medical problems you might need help with? These might include things like problems paying for or finding a place to live, not having enough food, lack of reliable transportation, or trouble paying utility bills.” In the wave 3 survey, we asked, “Basic needs are food, housing, transportation, and utilities. In the last 6 months, did your doctor or someone from this doctor’s office ask you if you had problems with any of these basic needs?”

Table 4.E.7b. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to composites and individual items, PY 2, PY 3, and PY 5 (Track 2)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Composite measures (34 total items)															
Access (9 items)	38.8%	38.9%	-0.1%	0.892	3,559; 3,731	38.6%	38.3%	0.3%	0.614	3,775; 4,081	53.6%	52.0%	1.6%	0.019	3,272; 3,610
Continuity in the doctor's office (1 item)	83.6%	83.8%	-0.2%	0.876	3,497; 3,650	78.6%	79.5%	-0.8%	0.430	3,679; 3,980	80.3%	79.6%	0.7%	0.556	3,199; 3,530
Continuity across health care settings (2 items)	3.5%	3.1%	0.4%	0.481	3,480; 3,663	2.2%	2.3%	-0.1%	0.741	3,684; 3,985	2.1%	2.1%	0.1%	0.788	3,246; 3,572
Care management (4 items)	71.1%	72.6%	-1.5%	0.137	3,548; 3,707	70.9%	70.0%	1.0%	0.253	3,769; 4,072	72.6%	68.2%	4.4%	0.000	3,263; 3,599
Comprehensiveness (6 items)	50.6%	53.2%	-2.6%	0.005	3,552; 3,711	52.8%	52.4%	0.4%	0.628	3,760; 4,058	52.9%	50.2%	2.7%	0.001	3,272; 3,608
Coordination (1 item) ^a	65.7%	66.6%	-0.9%	0.613	2,584; 2,708	59.1%	60.6%	-1.6%	0.266	2,863; 2,935	62.5%	58.4%	4.0%	0.010	2,427; 2,691
Patient and family caregiver engagement (7 items)	73.9%	74.8%	-1.0%	0.242	3,555; 3,719	75.5%	75.7%	-0.2%	0.793	3,776; 4,079	76.3%	75.3%	1.0%	0.132	3,256; 3,590
Helpful, courteous, and respectful office staff (2 items)	84.5%	85.9%	-1.4%	0.172	3,536; 3,708	85.0%	85.5%	-0.6%	0.513	3,760; 4,055	85.1%	85.7%	-0.6%	0.499	3,255; 3,592
Teamwork (1 item)	80.2%	78.5%	1.7%	0.200	3,488; 3,663	80.3%	80.8%	-0.5%	0.638	3,714; 3,971	80.6%	78.1%	2.5%	0.032	3,237; 3,552
Patients' rating of the primary care doctors and their staff (1 item)	85.1%	83.1%	2.0%	0.101	3,528; 3,695	85.8%	85.6%	0.2%	0.832	3,730; 4,026	85.9%	85.1%	0.8%	0.389	3,249; 3,574
Individual items by domain (PY 5 item number unless otherwise noted)															
Access (9 items in composite, 6 other items, 15 total items)															
Q5 and Q2_2 Type of care received by patient from primary care doctors and their staff															
Q5 Discussed his/her health with doctor or someone from the doctor's office via phone, email, text messaging, or a patient portal ^b	35.9%	34.9%	0.9%	0.535	3,480; 3,663	19.7%	19.7%	0.0%	0.982	3,748; 4,056	55.4%	56.1%	-0.6%	0.664	3,238; 3,566
Q2_2 Had a video appointment with doctor or someone from doctor's office ^c	1.3%	1.3%	0.0%	0.923	3,480; 3,663	0.2%	0.4%	-0.2%	0.120	3,684; 3,985	8.9%	7.9%	1.0%	0.197	3,256; 3,590
Q7: Patient always got care as soon as needed when s/he contacted doctor's office for care needed right away	74.9%	74.4%	0.5%	0.814	1,561; 1,580	75.3%	73.5%	1.8%	0.305	1,518; 1,607	73.9%	72.3%	1.6%	0.440	1,097; 1,147

Table 4.E.7b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q9: Patient always got care as soon as needed when s/he made appointments for check-up or routine care	80.2%	80.9%	-0.6%	0.666	2,933; 3,102	80.5%	79.8%	0.7%	0.545	3,056; 3,273	79.5%	77.3%	2.2%	0.074	2,613; 2,823
Q11: Patient always received an answer to his/her health question that same day when contacting doctor's office during regular office hours	59.3%	62.6%	-3.3%	0.165	1,517; 1,644	60.6%	60.3%	0.2%	0.911	1,535; 1,718	58.5%	57.3%	1.2%	0.548	1,415; 1,589
Q12: Patient received information from doctor's office about what to do if she/he needed care during evenings, weekends, or holidays	73.7%	71.9%	1.8%	0.234	3,443; 3,566	72.9%	70.9%	2.1%	0.079	3,668; 3,956	72.2%	67.6%	4.6%	0.000	3,183; 3,517
Q14: Patient always received an answer to his/her health question as soon as needed when contacting doctor's office outside of regular office hours	67.8%	66.7%	1.0%	0.855	264; 300	61.6%	63.7%	-2.1%	0.611	326; 341	62.7%	63.3%	-0.6%	0.889	287; 307
Q16: Patient always received an answer to his/her health question as soon as needed when contacting the doctor's office using email, a patient portal, or text messaging	75.7%	69.8%	5.9%	0.126	445; 436	78.1%	75.6%	2.5%	0.354	581; 583	75.6%	73.4%	2.2%	0.350	742; 819
Q17: Among individuals with scheduled appointments, appointments always started within 15 minutes of scheduled appointment time	44.1%	46.1%	-2.0%	0.293	3,447; 3,593	46.1%	47.2%	-1.1%	0.427	3,656; 3,940	53.7%	53.4%	0.3%	0.847	3,145; 3,457

Table 4.E.7b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Other access items not included in composite measure															
Q2 Type of care received by patient from primary care doctor's office															
Q2_1 Had an in-person visit at this doctor's office	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	93.5%	93.9%	-0.4%	0.590	3,248; 3,576
Q2_3 Had a telephone visit (not part of a video visit)	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	9.9%	9.6%	0.3%	0.679	3,240; 3,576
(Wave 2 Q2_1) Had a scheduled appointment at doctor's office	94.3%	95.6%	-1.4%	0.071	3,460; 3,645	92.5%	92.7%	-0.2%	0.746	3,732; 4,029	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.
(Wave 2 Q2_2) Had a same-day appointment or walk-in visit	19.1%	19.8%	-0.7%	0.591	3,480; 3,663	13.7%	13.3%	0.4%	0.623	3,748; 4,056	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.
(Wave 2 Q2_3): Received help to fill prescriptions, set up medical tests, or schedule appointments from the primary care doctors and their staff	62.2%	62.2%	0.0%	0.991	3,480; 3,663	35.6%	36.9%	-1.3%	0.283	3,748; 4,056	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.
(Wave 2 Q3_4) Attended a group medical appointment arranged by the doctor's office with patients with similar medical issues	1.7%	1.4%	0.3%	0.395	3,450; 3,638	0.7%	0.5%	0.2%	0.352	3,655; 3,950	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.
Continuity in the doctor's office (1 item)															
Q48: Patient always received care from the primary care doctor she/he thought of as her/his regular doctor ^d	83.5%	83.9%	-0.4%	0.770	3,497; 3,650	78.6%	79.5%	-0.9%	0.413	3,679; 3,980	80.3%	79.6%	0.6%	0.566	3,199; 3,530

Table 4.E.7b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Continuity across health care settings (2 items)															
Q3: Patient's doctor or someone from the doctor's office came to see patient in the hospital ^e	4.4%	3.7%	0.7%	0.214	3,480; 3,663	3.0%	3.4%	-0.4%	0.305	3,684; 3,985	2.8%	2.5%	0.3%	0.438	3,221; 3,541
Q4: Patient's doctor or someone from the doctor's office came to see patient at another location (excluding the doctor's office and hospital) to provide health care ^f	2.6%	2.5%	0.1%	0.875	3,480; 3,663	1.4%	1.2%	0.2%	0.401	3,684; 3,985	1.5%	1.6%	-0.1%	0.778	3,236; 3,562
Care management (4 items)															
Q19: If patient took prescription medicine, someone from the doctor's office talked with patient about all the prescription medicines patient was taking	93.5%	94.0%	-0.5%	0.533	3,394; 3,504	94.0%	94.0%	0.0%	0.947	3,597; 3,863	92.3%	91.0%	1.3%	0.096	3,114; 3,412
Q27: Patient's doctor or someone from the doctor's office asked patient if there are things that make it hard for him/her to take care of his/her health	53.4%	56.8%	-3.4%	0.040	3,446; 3,615	51.7%	51.2%	0.4%	0.767	3,681; 3,962	57.0%	50.5%	6.5%	0.000	3,193; 3,527
Q44: If patient visited the emergency room or emergency department for care, patient was contacted by doctor's office within one week	65.0%	60.2%	4.8%	0.144	836; 835	63.7%	60.7%	3.0%	0.280	796; 844	66.4%	56.7%	9.6%	0.002	589; 661
Q46: If patient stayed in a hospital overnight or longer, patient was contacted by doctor's office within 3 days	60.9%	54.5%	6.4%	0.118	594; 643	62.4%	51.9%	10.5%	0.002	571; 618	52.4%	50.4%	2.0%	0.582	424; 500

Table 4.E.7b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Comprehensiveness (6 items in composite, 4 other items, 10 total items)															
Q24: People from the doctor's office, including the doctor, always seemed to know the important information about patient's medical history	75.8%	75.6%	0.3%	0.843	3,514; 3,675	75.7%	76.0%	-0.4%	0.718	3,737; 4,019	75.3%	74.4%	0.9%	0.443	3,242; 3,563
Q28: Patient's doctor or someone from the doctor's office asked patient if she/he had any problems with physical pain or discomfort	84.2%	87.2%	-3.0%	0.011	3,485; 3,661	85.0%	85.2%	-0.2%	0.859	3,728; 4,004	84.1%	81.2%	2.9%	0.007	3,215; 3,561
Q29: Patient's doctor or someone from the doctor's office asked patient if there was a period of time when she/he felt sad, empty, or depressed	61.0%	63.5%	-2.5%	0.134	3,473; 3,647	65.1%	63.3%	1.8%	0.170	3,708; 3,998	69.1%	66.1%	2.9%	0.038	3,209; 3,552
Q30: Patient's doctor or someone from the doctor's office talked to patient about things in his/her life that cause worry or stress	51.9%	55.2%	-3.3%	0.046	3,455; 3,642	53.3%	53.4%	-0.2%	0.907	3,701; 3,979	57.7%	53.5%	4.3%	0.004	3,195; 3,529
Q34: Patient's doctor or someone from the doctor's office asked her/him about basic needs she/he might need help with ^a	10.8%	10.6%	0.2%	0.837	3,454; 3,578	14.8%	12.8%	2.0%	0.033	3,696; 3,989	14.9%	10.7%	4.3%	0.000	3,161; 3,485
Q38: Patient's doctor or someone from the doctor's office asked her/him if she/he had any problems with abuse or violence at home or in her/his neighborhood	17.6%	22.6%	-5.0%	0.001	3,453; 3,575	21.9%	21.6%	0.3%	0.801	3,710; 3,986	15.1%	14.1%	1.0%	0.377	3,160; 3,480

Table 4.E.7b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Other comprehensiveness items not included in composite measure															
Q35: Patient’s doctor or someone from the doctor’s office tried to find a place or person to help patient with basic needs	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	9.7%	16.2%	-6.5%	0.011	402; 331
Q36: Patient’s doctor or someone from doctor’s office asked if place or person helped with basic needs	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	86.5%	48.2%	38.3%	0.000	44; 48
Q39: Patient’s doctor or someone from doctor’s office tried to find patient a place or person to help with abuse or violence at home or in neighborhood	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	5.6%	4.2%	1.3%	0.402	384; 389
Q40: Patient’s doctor or someone from doctor’s office asked patient if place or person helped them with abuse or violence at home or in neighborhood.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	59.6%	53.2%	6.4%	0.709	28; 17
Coordination (1 item)^a															
Q42 If patient received care from specialist, primary care doctor’s office was informed and up-to-date on specialist care	65.7%	66.6%	-0.9%	0.620	2,584; 2,708	59.1%	60.6%	-1.6%	0.266	2,863; 2,935	62.5%	58.4%	4.0%	0.010	2,427; 2,691

Table 4.E.7b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Patient and family caregiver engagement (7 items in composite, 1 other item, 8 total items)															
Q21: Patient always received test results that were ordered by the doctor or someone at the doctor's office	84.7%	84.7%	0.0%	0.993	2,928; 3,144	86.1%	85.7%	0.4%	0.709	3,049; 3,341	86.6%	85.0%	1.5%	0.152	2,722; 2,977
Q22: People from the doctor's office, including the doctor, always explained medical things to patient in a way that was easy to understand	78.5%	82.1%	-3.6%	0.005	3,522; 3,690	81.7%	81.4%	0.2%	0.833	3,732; 4,031	79.7%	80.4%	-0.7%	0.544	3,233; 3,557
Q23: People from the doctor's office, including the doctor, always listened carefully to patient	83.7%	83.1%	0.7%	0.599	3,524; 3,697	84.3%	84.3%	-0.1%	0.944	3,737; 4,030	83.6%	83.3%	0.2%	0.829	3,245; 3,570
Q25: People from the doctor's office, including the doctor, always showed respect for what patient had to say	88.0%	87.4%	0.6%	0.601	3,521; 3,690	88.7%	88.6%	0.1%	0.884	3,737; 4,035	88.4%	88.8%	-0.4%	0.638	3,242; 3,573
Q26: People from the doctor's office, including the doctor, always spent enough time with patient	79.4%	76.8%	2.6%	0.058	3,533; 3,691	79.7%	80.3%	-0.6%	0.544	3,738; 4,042	80.2%	79.8%	0.4%	0.724	3,241; 3,566
Q31: Patient has an advanced care plan	64.5%	67.3%	-2.8%	0.065	3,491; 3,611	65.4%	67.1%	-1.7%	0.156	3,708; 3,991	67.4%	65.8%	1.5%	0.242	3,228; 3,563
Q32: Patient's doctor or someone from the doctor's office asked patient about his/her end-of-life care wishes or creating an advance care plan	40.7%	43.1%	-2.4%	0.201	3,467; 3,574	46.3%	45.2%	1.1%	0.429	3,679; 3,962	51.1%	46.6%	4.6%	0.002	3,198; 3,546

Table 4.E.7b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Other patient and family caregiver engagement item not included in composite measure															
(Wave 1 Q26) Patient's doctor or someone from the doctor's office talked with patient about how to be healthy enough to do the things he/she likes to do	77.4%	78.9%	-1.5%	0.173	3,459; 6,126	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.
Helpful, courteous, and respectful office staff (2 items)															
Q49: Clerks and receptionists at the doctor's office were always as helpful as patient thought they should be	79.9%	81.7%	-1.9%	0.157	3,532; 3,690	80.2%	81.6%	-1.4%	0.186	3,748; 4,046	80.5%	80.8%	-0.3%	0.790	3,250; 3,581
Q50: Clerks and receptionists at the doctor's office always treated patient with courtesy and respect	89.1%	90.1%	-1.0%	0.327	3,532; 3,703	89.7%	89.6%	0.1%	0.875	3,744; 4,042	89.7%	90.6%	-0.8%	0.333	3,243; 3,578
Teamwork (1 item)															
Q47: Primary care doctors and their staff always worked well together to care for patient	80.2%	78.5%	1.7%	0.205	3,488; 3,663	80.3%	80.8%	-0.5%	0.609	3,714; 3,971	80.5%	78.2%	2.4%	0.036	3,237; 3,552
Patients' rating of the primary care doctors and their staff (1 item)															
Q51: Patient's rating of care received from the primary care doctors and their staff as best level of care possible (9-10, out of a maximum of 10)	85.1%	83.1%	2.0%	0.100	3,528; 3,695	85.8%	85.6%	0.2%	0.861	3,730; 4,026	85.9%	85.1%	0.8%	0.406	3,249; 3,574

Table 4.E.7b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Delayed care due to COVID (no composite measure, 6 items)															
Q52 Type of medical care patient delayed or avoided getting from doctor's office <i>due to concerns about getting or spreading COVID-19</i>															
Q52_1: Patient did not delay or avoid getting medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	88.1%	86.4%	1.7%	0.061	3,249; 3,572
Q52_2: Patient delayed or avoided getting emergency or urgent medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	1.3%	1.8%	-0.5%	0.145	3,190; 3,497
Q52_3: Patient delayed or avoided getting check-ups or routine medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	11.4%	12.2%	-0.9%	0.323	3,249; 3,572
Q53 Type of medical care patient delayed or avoided getting from doctor's office <i>because of office issues due to COVID-19</i>															
Q53_1: Patient did not delay or avoid getting medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	93.5%	92.1%	1.5%	0.041	3,224; 3,554
Q53_2: Patient delayed or avoided getting emergency or urgent medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.7%	1.4%	-0.8%	0.004	3,161; 3,484
Q53_3: Patient delayed or avoided getting check-ups or routine medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	6.1%	6.8%	-0.7%	0.293	3,199; 3,524

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Item numbers are from the PY 5 survey unless otherwise noted.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS – fee-for-service; n.a. = not applicable because the item was not asked in the wave; PY = Program Year.

Table 4.E.7b. (continued)

^a This domain changed composition over time. While remaining a domain composed of one item, the wording changed substantially. In wave 1, we asked, “In the last 6 months, how often did the primary care doctors and their staff from this doctor’s office and your specialist(s) seem to work well together to care for you?” In wave 2 and wave 3, we asked, “In the last 6 months, how often did the people from this doctor’s office, including your doctor, seem informed and up-to-date about the care you got from specialists?” Given the substantial differences in the item wording, domain scores should not be compared over time.

^b The wording on this item changed from the wave 2 survey, in which we asked, “Patients can get health care in different ways. How did you get care in the last 6 months from this primary care doctor’s office? (Mark one or more.) 4-Discussed your health with your doctor or someone from this office via phone, email, text messaging, or a patient portal.” In the wave 3 survey, we asked, “In the last 6 months, other than visits, did you have any contact with this doctor’s office to discuss your health or test results? Contact can be via phone, email, text messaging, or a patient portal.

^c The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 3-Had a video appointment with your doctor or someone from this doctor’s office.” In the wave 3 survey, we asked, “In the last 6 months, what kind of visits did you have with this primary care doctor’s office? (Mark one or more.) 2-Video visit.”

^d The wording on this item changed from the wave 1 survey, in which we asked, “In the last 6 months, when you got care from a primary care doctor from this office, how often was this doctor the person you think of as your regular doctor in this office? By doctor, we mean a doctor, nurse practitioner (NP), or physician assistant (PA).” In the wave 2 and wave 3 survey, we asked, “When you saw a primary care doctor from this office in the last 6 months, how often were these visits with your regular doctor? A primary care doctor might be a physician (MD or DO), nurse practitioner (NP), or physician assistant (PA).”

^e The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 1-Your doctor or someone from this doctor’s office came to see you in the hospital.” In the wave 3 survey, we asked, “In the last 6 months, did your doctor or someone from this office come to see you in the hospital?”

^f The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 2-Your doctor or someone from this office came to see you at another location besides this doctor’s office or the hospital to provide health care (such as at your home or a senior center).” In the wave 3 survey, we asked, “In the last 6 months, did your doctor or someone from this office come to see you at another location besides this doctor’s office or the hospital to provide health care (such as at your home or a senior center)?

^g The wording on this item changed from the wave 2 survey, in which we asked, “In the last 6 months, did your doctor or someone from this office ask you about any non-medical problems you might need help with? These might include things like problems paying for or finding a place to live, not having enough food, lack of reliable transportation, or trouble paying utility bills.” In the wave 3 survey, we asked, “Basic needs are food, housing, transportation, and utilities. In the last 6 months, did your doctor or someone from this office ask you if you had problems with any of these basic needs?”

Table 4.E.8a. Predicted standardized average responses (0 to 1) for composite measures and individual items for Medicare FFS beneficiaries attributed to CPC+ and comparison practices, PY 2, PY 3, and PY 5 (Track 1)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Composite measures (34 total items)															
Access (9 items)	0.45	0.46	0.00	0.456	3,542; 3,722	0.46	0.45	0.01	0.185	3,818; 4,450	0.61	0.62	0.00	0.609	3,316; 3,823
Continuity in the doctor's office (1 item)	0.92	0.93	-0.01	0.184	3,469; 3,643	0.91	0.91	0.00	0.926	3,739; 4,359	0.91	0.90	0.00	0.931	3,246; 3,747
Continuity across health care settings (2 items)	0.03	0.04	0.00	0.366	3,456; 3,659	0.02	0.02	0.00	0.413	3,721; 4,324	0.02	0.02	0.00	0.259	3,280; 3,790
Care management (4 items)	0.71	0.72	-0.01	0.594	3,526; 3,702	0.70	0.70	0.00	0.682	3,812; 4,442	0.70	0.68	0.02	0.089	3,308; 3,815
Comprehensiveness (6 items)	0.53	0.54	-0.01	0.189	3,529; 3,708	0.55	0.54	0.01	0.094	3,801; 4,422	0.54	0.53	0.01	0.043	3,315; 3,821
Coordination (1 item) ^a	0.83	0.83	0.00	0.949	2,501; 2,687	0.81	0.81	0.00	0.589	2,857; 3,247	0.79	0.80	-0.01	0.183	2,512; 2,871
Patient and family caregiver engagement (7 items)	0.80	0.81	-0.01	0.027	3,535; 3,714	0.82	0.82	0.00	0.240	3,819; 4,449	0.81	0.82	0.00	0.555	3,298; 3,805
Helpful, courteous, and respectful office staff (2 items)	0.93	0.94	-0.01	0.119	3,519; 3,709	0.94	0.94	0.00	0.200	3,802; 4,428	0.93	0.94	-0.01	0.029	3,307; 3,813
Teamwork (1 item)	0.91	0.90	0.00	0.672	3,448; 3,664	0.92	0.92	0.01	0.165	3,753; 4,357	0.91	0.91	0.00	0.922	3,275; 3,759
Patients' rating of the primary care doctors and their staff (1 item)	0.93	0.93	0.00	0.913	3,514; 3,684	0.94	0.94	0.00	0.181	3,766; 4,393	0.94	0.94	0.00	0.218	3,284; 3,794
Individual items by domain (PY 5 item number unless otherwise noted)															
Access (9 items in composite, 6 other items, 15 total items)															
Q5 and Q2_2 Type of care received by patient from primary care doctors and their staff															
Q5 Discussed his/her health with doctor or someone from the doctor's office via phone, email, text messaging, or a patient portal ^b	0.34	0.37	-0.02	0.125	3,456; 3,659	0.18	0.20	-0.01	0.219	3,787; 4,423	0.55	0.57	-0.02	0.221	3,286; 3,784
Q2_2 Had a video appointment with doctor or someone from doctor's office ^c	0.01	0.02	0.00	0.239	3,437; 3,646	0.00	0.00	0.00	0.936	3,703; 4,300	0.08	0.08	0.00	0.735	3,296; 3,796

Table 4.E.8a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q7: Patient always got care as soon as needed when s/he contacted doctor's office for care needed right away	0.88	0.89	-0.01	0.371	1,566; 1,623	0.90	0.88	0.02	0.061	1,517; 1,747	0.87	0.87	0.00	0.878	1,106; 1,236
Q9: Patient always got care as soon as needed when s/he made appointments for check-up or routine care	0.91	0.93	-0.01	0.056	2,948; 3,075	0.93	0.92	0.01	0.165	3,067; 3,604	0.91	0.91	0.00	0.992	2,626; 3,007
Q11: Patient always received an answer to his/her health question that same day when contacting doctor's office during regular office hours	0.83	0.83	0.00	0.845	1,520; 1,666	0.84	0.82	0.03	0.007	1,606; 1,876	0.80	0.81	0.00	0.777	1,441; 1,652
Q12: Patient received information from doctor's office about what to do if she/he needed care during evenings, weekends, or holidays	0.72	0.71	0.01	0.593	3,429; 3,552	0.74	0.71	0.03	0.010	3,693; 4,314	0.68	0.68	0.00	0.969	3,229; 3,722
Q14: Patient always received an answer to his/her health question as soon as needed when contacting doctor's office outside of regular office hours	0.81	0.84	-0.03	0.310	269; 293	0.86	0.82	0.04	0.085	290; 373	0.83	0.84	-0.01	0.730	273; 302
Q16: Patient always received an answer to his/her health question as soon as needed when contacting the doctor's office using email, a patient portal, or text messaging	0.88	0.88	0.01	0.778	329; 433	0.89	0.88	0.01	0.698	451; 582	0.87	0.89	-0.02	0.189	681; 789
Q17: Among individuals with scheduled appointments, appointments always started within 15 minutes of scheduled appointment time	0.74	0.75	-0.01	0.293	3,438; 3,588	0.76	0.76	0.00	0.594	3,704; 4,318	0.80	0.80	0.00	0.737	3,195; 3,665

Table 4.E.8a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Other access items not included in composite measure															
Q2 Type of care received by patient from primary care doctor's office															
Q2_1 Had an in-person visit at this doctor's office	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.93	0.94	0.00	0.652	3,296; 3,796
Q2_3 Had a telephone visit (not part of a video visit)	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.10	0.10	0.00	0.961	3,294; 3,799
(Wave 2 Q2_1) Had a scheduled appointment at doctor's office	0.94	0.95	0.00	0.583	3,456; 3,659	0.93	0.93	0.00	0.843	3,787; 4,423	n.a.	n.a.	n.a.	n.a.	n.a.
(Wave 2 Q2_2) Had a same-day appointment or walk-in visit	0.21	0.20	0.00	0.733	3,456; 3,659	0.12	0.13	0.00	0.562	3,787; 4,423	n.a.	n.a.	n.a.	n.a.	n.a.
(Wave 2 Q2_3): Received help to fill prescriptions, set up medical tests, or schedule appointments from the primary care doctors and their staff	0.62	0.63	-0.01	0.701	3,456; 3,659	0.36	0.37	-0.01	0.508	3,787; 4,423	n.a.	n.a.	n.a.	n.a.	n.a.
(Wave 2 Q3_4) Attended a group medical appointment arranged by the doctor's office with patients with similar medical issues	0.01	0.02	0.00	0.271	3,435; 3,645	0.01	0.01	0.00	0.775	3,696; 4,294	n.a.	n.a.	n.a.	n.a.	n.a.
Continuity in the doctor's office (1 item)															
Q48: Patient always received care from the primary care doctor she/he thought of as her/his regular doctor ^a	0.92	0.93	-0.01	0.184	3,469; 3,643	0.91	0.91	0.00	0.926	3,739; 4,359	0.91	0.90	0.00	0.931	3,246; 3,747
Continuity across health care settings (2 items)															
Q3: Patient's doctor or someone from the doctor's office came to see patient in the hospital ^b	0.04	0.05	0.00	0.496	3,456; 3,659	0.03	0.04	0.00	0.273	3,721; 4,324	0.02	0.03	0.00	0.818	3,248; 3,757

Table 4.E.8a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q4: Patient's doctor or someone from the doctor's office came to see patient at another location (excluding the doctor's office and hospital) to provide health care ^f	0.02	0.03	0.00	0.349	3,456; 3,659	0.01	0.01	0.00	0.832	3,721; 4,324	0.01	0.02	0.00	0.107	3,272; 3,781
Care management (4 items)															
Q19: If patient took prescription medicine, someone from the doctor's office talked with patient about all the prescription medicines patient was taking	0.94	0.93	0.00	0.574	3,392; 3,509	0.94	0.94	0.00	0.624	3,622; 4,221	0.91	0.91	0.00	0.898	3,138; 3,606
Q27: Patient's doctor or someone from the doctor's office asked patient if there are things that make it hard for him/her to take care of his/her health	0.53	0.55	-0.02	0.173	3,430; 3,610	0.52	0.52	0.00	0.761	3,723; 4,325	0.53	0.50	0.03	0.067	3,226; 3,736
Q44: If patient visited the emergency room or emergency department for care, patient was contacted by doctor's office within one week	0.65	0.58	0.08	0.033	811; 835	0.64	0.59	0.05	0.055	856; 938	0.59	0.59	0.00	1.000	629; 695
Q46: If patient stayed in a hospital overnight or longer, patient was contacted by doctor's office within 3 days	0.54	0.57	-0.03	0.501	578; 598	0.56	0.55	0.01	0.778	563; 660	0.51	0.50	0.01	0.809	458; 544
Comprehensiveness (6 items in composite, 4 other items, 10 total items)															
Q24: People from the doctor's office, including the doctor, always seemed to know the important information about patient's medical history	0.90	0.90	0.00	0.844	3,503; 3,673	0.90	0.90	0.00	0.523	3,770; 4,384	0.89	0.90	-0.01	0.352	3,262; 3,776
Q28: Patient's doctor or someone from the doctor's office asked patient if she/he had any problems with physical pain or discomfort	0.85	0.88	-0.02	0.029	3,484; 3,661	0.85	0.86	0.00	0.789	3,759; 4,375	0.83	0.82	0.01	0.388	3,261; 3,769

Table 4.E.8a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q29: Patient's doctor or someone from the doctor's office asked patient if there was a period of time when she/he felt sad, empty, or depressed	0.60	0.60	0.00	0.868	3,463; 3,630	0.65	0.61	0.04	0.008	3,741; 4,361	0.68	0.65	0.03	0.015	3,261; 3,765
Q30: Patient's doctor or someone from the doctor's office talked to patient about things in his/her life that cause worry or stress	0.52	0.52	-0.01	0.762	3,448; 3,629	0.54	0.52	0.02	0.080	3,725; 4,341	0.55	0.53	0.03	0.074	3,250; 3,737
Q34: Patient's doctor or someone from the doctor's office asked her/him about basic needs she/he might need help with ^a	0.10	0.10	0.00	0.802	3,439; 3,581	0.13	0.12	0.01	0.386	3,744; 4,348	0.13	0.11	0.02	0.024	3,198; 3,701
Q38: Patient's doctor or someone from the doctor's office asked her/him if she/he had any problems with abuse or violence at home or in her/his neighborhood	0.17	0.19	-0.01	0.413	3,443; 3,578	0.21	0.20	0.01	0.569	3,736; 4,352	0.14	0.13	0.01	0.415	3,195; 3,690
Other comprehensiveness items not included in composite measure															
Q35: Patient's doctor or someone from the doctor's office tried to find a place or person to help patient with basic needs	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.15	0.20	-0.05	0.118	358; 369
Q36: Patient's doctor or someone from doctor's office asked if place or person helped with basic needs	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.92	0.50	0.42	0.000	45; 68
Q39: Patient's doctor or someone from doctor's office tried to find patient a place or person to help with abuse or violence at home or in neighborhood	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.05	0.06	-0.01	0.769	365; 379

Table 4.E.8a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q40: Patient’s doctor or someone from doctor’s office asked patient if place or person helped them with abuse or violence at home or in neighborhood.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.76	0.48	0.28	0.108	16; 25
Coordination (1 item)^a															
Q42 If patient received care from specialist, primary care doctor’s office was informed and up-to-date on specialist care	0.83	0.83	0.00	0.949	2,501; 2,687	0.81	0.81	0.00	0.589	2,857; 3,247	0.79	0.80	-0.01	0.183	2,512; 2,871
Patient and family caregiver engagement (7 items in composite, 1 other item, 8 total items)															
Q21: Patient always received test results that were ordered by the doctor or someone at the doctor’s office	0.92	0.93	-0.01	0.068	2,924; 3,067	0.94	0.93	0.01	0.184	3,139; 3,657	0.93	0.93	0.00	0.948	2,729; 3,153
Q22: People from the doctor’s office, including the doctor, always explained medical things to patient in a way that was easy to understand	0.91	0.92	-0.01	0.234	3,506; 3,689	0.92	0.92	0.00	0.408	3,778; 4,396	0.91	0.92	0.00	0.351	3,267; 3,780
Q23: People from the doctor’s office, including the doctor, always listened carefully to patient	0.93	0.93	0.00	0.992	3,504; 3,695	0.94	0.94	0.00	0.388	3,780; 4,398	0.92	0.93	-0.01	0.127	3,274; 3,783
Q25: People from the doctor’s office, including the doctor, always showed respect for what patient had to say	0.95	0.95	0.00	0.638	3,517; 3,695	0.96	0.95	0.01	0.122	3,782; 4,398	0.95	0.95	-0.01	0.115	3,269; 3,789
Q26: People from the doctor’s office, including the doctor, always spent enough time with patient	0.91	0.91	0.00	0.991	3,510; 3,692	0.92	0.92	0.00	0.751	3,784; 4,410	0.92	0.92	0.00	0.421	3,267; 3,785
Q31: Patient has an advanced care plan	0.62	0.66	-0.04	0.018	3,474; 3,612	0.64	0.66	-0.01	0.242	3,750; 4,360	0.64	0.65	-0.01	0.642	3,271; 3,765

Table 4.E.8a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q32: Patient's doctor or someone from the doctor's office asked patient about his/her end-of-life care wishes or creating an advance care plan	0.37	0.37	-0.01	0.657	3,432; 3,586	0.45	0.43	0.03	0.058	3,716; 4,321	0.46	0.44	0.02	0.171	3,253; 3,758
Other patient and family caregiver engagement item not included in composite measure															
(Wave 1 Q26) Patient's doctor or someone from the doctor's office talked with patient about how to be healthy enough to do the things he/she likes to do	0.77	0.80	-0.03	0.009	3,457; 6,374	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Helpful, courteous, and respectful office staff (2 items)															
Q49: Clerks and receptionists at the doctor's office were always as helpful as patient thought they should be	0.91	0.92	-0.01	0.077	3,509; 3,694	0.92	0.93	-0.01	0.108	3,789; 4,417	0.92	0.92	-0.01	0.150	3,294; 3,803
Q50: Clerks and receptionists at the doctor's office always treated patient with courtesy and respect	0.95	0.96	0.00	0.310	3,512; 3,703	0.96	0.96	0.00	0.563	3,794; 4,417	0.95	0.96	-0.01	0.012	3,295; 3,799
Teamwork (1 item)															
Q47: Primary care doctors and their staff always worked well together to care for patient	0.91	0.90	0.00	0.672	3,448; 3,664	0.92	0.92	0.01	0.165	3,753; 4,357	0.91	0.91	0.00	0.922	3,275; 3,759
Patients' rating of the primary care doctors and their staff (1 item)															
Q51: Patient's rating of care received from the primary care doctors and their staff as best level of care possible (9-10, out of a maximum of 10)	0.93	0.93	0.00	0.913	3,514; 3,684	0.94	0.94	0.00	0.181	3,766; 4,393	0.94	0.94	0.00	0.218	3,284; 3,794

Table 4.E.8a. (continued)

	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Delayed care due to COVID (no composite measure, 6 items)															
Q52 Type of medical care patient delayed or avoided getting from doctor's office <i>due to concerns about getting or spreading COVID-19</i>															
Q52_1: Patient did not delay or avoid getting medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.88	0.87	0.01	0.297	3,292; 3,787
Q52_2: Patient delayed or avoided getting emergency or urgent medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.01	0.02	0.00	0.404	3,243; 3,717
Q52_3: Patient delayed or avoided getting check-ups or routine medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.11	0.12	-0.01	0.534	3,284; 3,779
Q53 Type of medical care patient delayed or avoided getting from doctor's office <i>because of office issues due to COVID-19</i>															
Q53_1: Patient did not delay or avoid getting medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.93	0.92	0.01	0.128	3,270; 3,768
Q53_2: Patient delayed or avoided getting emergency or urgent medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.01	0.01	0.00	0.965	3,208; 3,701
Q53_3: Patient delayed or avoided getting check-ups or routine medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.06	0.07	-0.01	0.066	3,270; 3,768

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Item numbers are from the wave 3 survey unless otherwise noted.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS – fee-for-service; n.a. = not applicable because the item was not asked in the wave; PY = Program Year.

Table 4.E.8a. (continued)

^a This domain changed composition over time. While remaining a domain composed of one item, the wording changed substantially. In wave 1, we asked, “In the last 6 months, how often did the primary care doctors and their staff from this doctor’s office and your specialist(s) seem to work well together to care for you?” In wave 2 and wave 3, we asked, “In the last 6 months, how often did the people from this doctor’s office, including your doctor, seem informed and up-to-date about the care you got from specialists?” Given the substantial differences in the item wording, domain scores should not be compared over time.

^b The wording on this item changed from the wave 2 survey, in which we asked, “Patients can get health care in different ways. How did you get care in the last 6 months from this primary care doctor’s office? (Mark one or more.) 4-Discussed your health with your doctor or someone from this doctor’s office via phone, email, text messaging, or a patient portal.” In the wave 3 survey, we asked, “In the last 6 months, other than visits, did you have any contact with this doctor’s office to discuss your health or test results? Contact can be via phone, email, text messaging, or a patient portal.”

^c The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 3-Had a video appointment with your doctor or someone from this doctor’s office.” In the wave 3 survey, we asked, “In the last 6 months, what kind of visits did you have with this primary care doctor’s office? (Mark one or more.) 2-Video visit.”

^d The wording on this item changed from the wave 1 survey, in which we asked, “In the last 6 months, when you got care from a primary care doctor from this doctor’s office, how often was this doctor the person you think of as your regular doctor in this office? By doctor, we mean a doctor, nurse practitioner (NP), or physician assistant (PA).” In the wave 2 and wave 3 survey, we asked, “When you saw a primary care doctor from this office in the last 6 months, how often were these visits with your regular doctor? A primary care doctor might be a physician (MD or DO), nurse practitioner (NP), or physician assistant (PA).”

^e The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 1-Your doctor or someone from this doctor’s office came to see you in the hospital.” In the wave 3 survey, we asked, “In the last 6 months, did your doctor or someone from this doctor’s office come to see you in the hospital?”

^f The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 2-Your doctor or someone from this doctor’s office came to see you at another location besides this doctor’s office or the hospital to provide health care (such as at your home or a senior center).” In the wave 3 survey, we asked, “In the last 6 months, did your doctor or someone from this doctor’s office come to see you at another location besides this doctor’s office or the hospital to provide health care (such as at your home or a senior center)?”

^g The wording on this item changed from the wave 2 survey, in which we asked, “In the last 6 months, did your doctor or someone from this doctor’s office ask you about any non-medical problems you might need help with? These might include things like problems paying for or finding a place to live, not having enough food, lack of reliable transportation, or trouble paying utility bills.” In the wave 3 survey, we asked, “Basic needs are food, housing, transportation, and utilities. In the last 6 months, did your doctor or someone from this doctor’s office ask you if you had problems with any of these basic needs?”

Table 4.E.8b. Predicted standardized average responses (0 to 1) for composite measures and individual items for Medicare FFS beneficiaries attributed to CPC+ and comparison practices, PY 2, PY 3, and PY 5 (Track 2)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Composite measures (34 total items)															
Access (9 items)	0.46	0.46	0.00	0.768	3,559; 3,731	0.46	0.45	0.00	0.449	3,775; 4,081	0.63	0.61	0.02	0.009	3,272; 3,610
Continuity in the doctor's office (1 item)	0.93	0.93	0.00	0.549	3,497; 3,650	0.90	0.90	0.00	0.705	3,679; 3,980	0.91	0.90	0.01	0.178	3,199; 3,530
Continuity across health care settings (2 items)	0.03	0.03	0.00	0.481	3,480; 3,663	0.02	0.02	0.00	0.741	3,684; 3,985	0.02	0.02	0.00	0.788	3,246; 3,572
Care management (4 items)	0.71	0.73	-0.01	0.137	3,548; 3,707	0.71	0.70	0.01	0.253	3,769; 4,072	0.73	0.68	0.04	0.000	3,263; 3,599
Comprehensiveness (6 items)	0.53	0.56	-0.03	0.003	3,552; 3,711	0.55	0.55	0.00	0.527	3,760; 4,058	0.55	0.53	0.03	0.000	3,272; 3,608
Coordination (1 item) ^a	0.84	0.84	0.00	0.708	2,584; 2,708	0.81	0.82	-0.01	0.256	2,863; 2,935	0.82	0.80	0.02	0.029	2,427; 2,691
Patient and family caregiver engagement (7 items)	0.81	0.82	-0.01	0.049	3,555; 3,719	0.82	0.82	0.00	0.671	3,776; 4,079	0.83	0.82	0.01	0.032	3,256; 3,590
Helpful, courteous, and respectful office staff (2 items)	0.94	0.94	0.00	0.356	3,536; 3,708	0.94	0.94	0.00	0.659	3,760; 4,055	0.94	0.94	0.00	0.505	3,255; 3,592
Teamwork (1 item)	0.92	0.91	0.01	0.124	3,488; 3,663	0.92	0.92	0.00	0.947	3,714; 3,971	0.92	0.91	0.01	0.026	3,237; 3,552
Patients' rating of the primary care doctors and their staff (1 item)	0.94	0.93	0.00	0.547	3,528; 3,695	0.94	0.94	0.00	0.952	3,730; 4,026	0.94	0.94	0.00	0.670	3,249; 3,574
Individual items by domain (PY 5 item number unless otherwise noted)															
Access (9 items in composite, 6 other items, 15 total items)															
Q5 and Q2_2 Type of care received by patient from primary care doctors and their staff															
Q5 Discussed his/her health with doctor or someone from the doctor's office via phone, email, text messaging, or a patient portal ^b	0.36	0.35	0.01	0.535	3,480; 3,663	0.20	0.20	0.00	0.982	3,748; 4,056	0.55	0.56	-0.01	0.664	3,238; 3,566
Q2_2 Had a video appointment with doctor or someone from doctor's office ^c	0.01	0.01	0.00	0.923	3,480; 3,663	0.00	0.00	0.00	0.120	3,684; 3,985	0.09	0.08	0.01	0.197	3,256; 3,590
Q7: Patient always got care as soon as needed when s/he contacted doctor's office for care needed right away	0.89	0.88	0.01	0.502	1,561; 1,580	0.89	0.88	0.01	0.547	1,518; 1,607	0.88	0.87	0.01	0.276	1,097; 1,147

Table 4.E.8b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q9: Patient always got care as soon as needed when s/he made appointments for check-up or routine care	0.92	0.92	0.00	0.988	2,933; 3,102	0.92	0.92	0.00	0.332	3,056; 3,273	0.92	0.91	0.02	0.003	2,613; 2,823
Q11: Patient always received an answer to his/her health question that same day when contacting doctor's office during regular office hours	0.82	0.83	-0.01	0.560	1,517; 1,644	0.83	0.82	0.01	0.417	1,535; 1,718	0.82	0.80	0.02	0.151	1,415; 1,589
Q12: Patient received information from doctor's office about what to do if she/he needed care during evenings, weekends, or holidays	0.74	0.72	0.02	0.234	3,443; 3,566	0.73	0.71	0.02	0.079	3,668; 3,956	0.72	0.68	0.05	0.000	3,183; 3,517
Q14: Patient always received an answer to his/her health question as soon as needed when contacting doctor's office outside of regular office hours	0.84	0.85	-0.01	0.651	264; 300	0.83	0.82	0.01	0.673	326; 342	0.82	0.84	-0.02	0.300	287; 307
Q16: Patient always received an answer to his/her health question as soon as needed when contacting the doctor's office using email, a patient portal, or text messaging	0.89	0.86	0.02	0.274	445; 436	0.91	0.89	0.02	0.121	581; 583	0.89	0.89	0.00	0.756	742; 819
Q17: Among individuals with scheduled appointments, appointments always started within 15 minutes of scheduled appointment time	0.75	0.76	-0.01	0.489	3,447; 3,593	0.76	0.77	0.00	0.779	3,656; 3,940	0.80	0.80	0.00	0.722	3,145; 3,457
Other access items not included in composite measure															
Q2 Type of care received by patient from primary care doctor's office															
Q2_1 Had an in-person visit at this doctor's office	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.94	0.94	0.00	0.590	3,248; 3,576
Q2_3 Had a telephone visit (not part of a video visit)	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.10	0.10	0.00	0.679	3,240; 3,576
(Wave 2 Q2_1) Had a scheduled appointment at doctor's office	0.94	0.96	-0.01	0.071	3,460; 3,645	0.92	0.93	0.00	0.746	3,732; 4,029	n.a.	n.a.	n.a.	n.a.	n.a.

Table 4.E.8b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
(Wave 2 Q2_2) Had a same-day appointment or walk-in visit	0.19	0.20	-0.01	0.591	3,480; 3,663	0.14	0.13	0.00	0.623	3,748; 4,056	n.a.	n.a.	n.a.	n.a.	n.a.
(Wave 2 Q2_3): Received help to fill prescriptions, set up medical tests, or schedule appointments from the primary care doctors and their staff	0.62	0.62	0.00	0.991	3,480; 3,663	0.36	0.37	-0.01	0.283	3,748; 4,056	n.a.	n.a.	n.a.	n.a.	n.a.
(Wave 2 Q3_4) Attended a group medical appointment arranged by the doctor's office with patients with similar medical issues	0.02	0.01	0.00	0.395	3,450; 3,638	0.01	0.01	0.00	0.352	3,655; 3,950	n.a.	n.a.	n.a.	n.a.	n.a.
Continuity in the doctor's office (1 item)															
Q48: Patient always received care from the primary care doctor she/he thought of as her/his regular doctor ^d	0.93	0.93	0.00	0.549	3,497; 3,650	0.90	0.90	0.00	0.705	3,679; 3,980	0.91	0.90	0.01	0.178	3,199; 3,530
Continuity across health care settings (2 items)															
Q3: Patient's doctor or someone from the doctor's office came to see patient in the hospital ^e	0.04	0.04	0.01	0.214	3,480; 3,663	0.03	0.03	0.00	0.305	3,684; 3,985	0.03	0.03	0.00	0.438	3,221; 3,541
Q4: Patient's doctor or someone from the doctor's office came to see patient at another location (excluding the doctor's office and hospital) to provide health care ^f	0.03	0.03	0.00	0.875	3,480; 3,663	0.01	0.01	0.00	0.401	3,684; 3,985	0.01	0.02	0.00	0.778	3,236; 3,562
Care management (4 items)															
Q19: If patient took prescription medicine, someone from the doctor's office talked with patient about all the prescription medicines patient was taking	0.94	0.94	0.00	0.533	3,394; 3,504	0.94	0.94	0.00	0.947	3,597; 3,863	0.92	0.91	0.01	0.096	3,114; 3,412

Table 4.E.8b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q27: Patient's doctor or someone from the doctor's office asked patient if there are things that make it hard for him/her to take care of his/her health	0.53	0.57	-0.03	0.040	3,446; 3,615	0.52	0.51	0.00	0.767	3,681; 3,962	0.57	0.51	0.06	0.000	3,193; 3,527
Q44: If patient visited the emergency room or emergency department for care, patient was contacted by doctor's office within one week	0.65	0.60	0.05	0.144	836; 835	0.64	0.61	0.03	0.280	796; 844	0.66	0.57	0.10	0.002	589; 661
Q46: If patient stayed in a hospital overnight or longer, patient was contacted by doctor's office within 3 days	0.61	0.55	0.06	0.118	594; 643	0.62	0.52	0.11	0.002	571; 618	0.52	0.50	0.02	0.582	424; 500
Comprehensiveness (6 items in composite, 4 other items, 10 total items)															
Q24: People from the doctor's office, including the doctor, always seemed to know the important information about patient's medical history	0.91	0.90	0.00	0.454	3,514; 3,675	0.90	0.91	0.00	0.713	3,737; 4,019	0.90	0.90	0.00	0.377	3,242; 3,563
Q28: Patient's doctor or someone from the doctor's office asked patient if she/he had any problems with physical pain or discomfort	0.84	0.87	-0.03	0.011	3,485; 3,661	0.85	0.85	0.00	0.859	3,728; 4,004	0.84	0.81	0.03	0.007	3,215; 3,561
Q29: Patient's doctor or someone from the doctor's office asked patient if there was a period of time when she/he felt sad, empty, or depressed	0.61	0.63	-0.03	0.134	3,473; 3,647	0.65	0.63	0.02	0.170	3,708; 3,998	0.69	0.66	0.03	0.038	3,209; 3,552
Q30: Patient's doctor or someone from the doctor's office talked to patient about things in his/her life that cause worry or stress	0.52	0.55	-0.03	0.046	3,455; 3,642	0.53	0.53	0.00	0.907	3,701; 3,979	0.58	0.53	0.04	0.004	3,195; 3,529
Q34: Patient's doctor or someone from the doctor's office asked her/him about basic needs she/he might need help with ^a	0.11	0.11	0.00	0.837	3,454; 3,578	0.15	0.13	0.02	0.033	3,696; 3,989	0.15	0.11	0.04	0.000	3,161; 3,485

Table 4.E.8b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q38: Patient's doctor or someone from the doctor's office asked her/him if she/he had any problems with abuse or violence at home or in her/his neighborhood	0.18	0.23	-0.05	0.001	3,453; 3,575	0.22	0.22	0.00	0.801	3,710; 3,986	0.15	0.14	0.01	0.377	3,160; 3,480
Other comprehensiveness items not included in composite measure															
Q35: Patient's doctor or someone from the doctor's office tried to find a place or person to help patient with basic needs	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.10	0.16	-0.07	0.011	402; 331
Q36: Patient's doctor or someone from doctor's office asked if place or person helped with basic needs	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.87	0.48	0.38	0.000	44; 48
Q39: Patient's doctor or someone from doctor's office tried to find patient a place or person to help with abuse or violence at home or in neighborhood	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.06	0.04	0.01	0.402	384; 389
Q40: Patient's doctor or someone from doctor's office asked patient if place or person helped them with abuse or violence at home or in neighborhood.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.60	0.53	0.06	0.709	28; 17
Coordination (1 item)^a															
Q42 If patient received care from specialist, primary care doctor's office was informed and up-to-date on specialist care	0.84	0.84	0.00	0.708	2,584; 2,708	0.81	0.82	-0.01	0.256	2,863; 2,935	0.82	0.80	0.02	0.029	2,427; 2,691
Patient and family caregiver engagement (7 items in composite, 1 other item, 8 total items)															
Q21: Patient always received test results that were ordered by the doctor or someone at the doctor's office	0.93	0.93	0.00	0.983	2,928; 3,144	0.94	0.93	0.00	0.564	3,049; 3,341	0.94	0.93	0.01	0.076	2,722; 2,977

Table 4.E.8b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Q22: People from the doctor's office, including the doctor, always explained medical things to patient in a way that was easy to understand	0.92	0.93	-0.01	0.035	3,522; 3,690	0.92	0.92	0.00	0.951	3,732; 4,031	0.92	0.92	-0.01	0.259	3,233; 3,557
Q23: People from the doctor's office, including the doctor, always listened carefully to patient	0.93	0.93	0.00	0.604	3,524; 3,697	0.94	0.94	0.00	0.770	3,737; 4,030	0.93	0.93	0.00	0.592	3,245; 3,570
Q25: People from the doctor's office, including the doctor, always showed respect for what patient had to say	0.95	0.95	0.00	0.738	3,521; 3,690	0.95	0.95	0.00	0.967	3,737; 4,035	0.95	0.95	0.00	0.932	3,242; 3,573
Q26: People from the doctor's office, including the doctor, always spent enough time with patient	0.92	0.91	0.01	0.204	3,533; 3,691	0.92	0.92	0.00	0.619	3,738; 4,042	0.92	0.92	0.00	0.896	3,241; 3,566
Q31: Patient has an advanced care plan	0.65	0.67	-0.03	0.065	3,491; 3,611	0.65	0.67	-0.02	0.156	3,708; 3,991	0.67	0.66	0.02	0.242	3,228; 3,563
Q32: Patient's doctor or someone from the doctor's office asked patient about his/her end-of-life care wishes or creating an advance care plan	0.41	0.43	-0.02	0.201	3,467; 3,574	0.46	0.45	0.01	0.429	3,679; 3,962	0.51	0.47	0.05	0.002	3,198; 3,546
Other patient and family caregiver engagement item not included in composite measure															
(Wave 1 Q26) Patient's doctor or someone from the doctor's office talked with patient about how to be healthy enough to do the things he/she likes to do	0.77	0.79	-0.01	0.173	3,459; 6,126	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Helpful, courteous, and respectful office staff (2 items)															
Q49: Clerks and receptionists at the doctor's office were always as helpful as patient thought they should be	0.92	0.93	-0.01	0.320	3,532; 3,690	0.92	0.93	-0.01	0.256	3,748; 4,046	0.921	0.923	-0.002	0.654	3,250; 3,581
Q50: Clerks and receptionists at the doctor's office always treated patient with courtesy and respect	0.96	0.96	0.00	0.521	3,532; 3,703	0.96	0.96	0.00	0.612	3,744; 4,042	0.958	0.961	-0.003	0.479	3,243; 3,578

Table 4.E.8b. (continued)

	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Teamwork (1 item)															
Q47: Primary care doctors and their staff always worked well together to care for patient	0.92	0.91	0.01	0.124	3,488; 3,663	0.92	0.92	0.00	0.947	3,714; 3,971	0.918	0.906	0.012	0.026	3,237; 3,552
Patients' rating of the primary care doctors and their staff (1 item)															
Q51: Patient's rating of care received from the primary care doctors and their staff as best level of care possible (9-10, out of a maximum of 10)	0.94	0.93	0.00	0.547	3,528; 3,695	0.94	0.94	0.00	0.952	3,730; 4,026	0.940	0.939	0.001	0.670	3,249; 3,574
Delayed care due to COVID (no composite measure, 6 items)															
Q52 Type of medical care patient delayed or avoided getting from doctor's office due to concerns about getting or spreading COVID-19															
Q52_1: Patient did not delay or avoid getting medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.88	0.86	0.02	0.061	3,249; 3,572
Q52_2: Patient delayed or avoided getting emergency or urgent medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.01	0.02	0.00	0.145	3,190; 3,497
Q52_3: Patient delayed or avoided getting check-ups or routine medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.11	0.12	-0.01	0.323	3,249; 3,572
Q53 Type of medical care patient delayed or avoided getting from doctor's office because of office issues due to COVID-19															
Q53_1: Patient did not delay or avoid getting medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.94	0.92	0.01	0.041	3,224; 3,554
Q53_2: Patient delayed or avoided getting emergency or urgent medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.01	0.01	-0.01	0.004	3,161; 3,484
Q53_3: Patient delayed or avoided getting check-ups or routine medical care	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.06	0.07	-0.01	0.293	3,199; 3,524

Table 4.E.8b. (continued)

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Item numbers are from the wave 3 survey unless otherwise noted.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS – fee-for-service; n.a. = not applicable because the item was not asked in the wave; PY = Program Year.

^a This domain changed composition over time. While remaining a domain composed of one item, the wording changed substantially. In wave 1, we asked, “In the last 6 months, how often did the primary care doctors and their staff from this doctor’s office and your specialist(s) seem to work well together to care for you?” In wave 2 and wave 3, we asked, “In the last 6 months, how often did the people from this doctor’s office, including your doctor, seem informed and up-to-date about the care you got from specialists?” Given the substantial differences in the item wording, domain scores should not be compared over time.

^b The wording on this item changed from the wave 2 survey, in which we asked, “Patients can get health care in different ways. How did you get care in the last 6 months from this primary care doctor’s office? (Mark one or more.) 4-Discussed your health with your doctor or someone from this doctor’s office via phone, email, text messaging, or a patient portal.” In the wave 3 survey, we asked, “In the last 6 months, other than visits, did you have any contact with this doctor’s office to discuss your health or test results? Contact can be via phone, email, text messaging, or a patient portal.”

^c The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 3-Had a video appointment with your doctor or someone from this doctor’s office.” In the wave 3 survey, we asked, “In the last 6 months, what kind of visits did you have with this primary care doctor’s office? (Mark one or more.) 2-Video visit.

^d The wording on this item changed from the wave 1 survey, in which we asked, “In the last 6 months, when you got care from a primary care doctor from this doctor’s office, how often was this doctor the person you think of as your regular doctor in this office? By doctor, we mean a doctor, nurse practitioner (NP), or physician assistant (PA).” In the wave 2 and wave 3 survey, we asked, “When you saw a primary care doctor from this office in the last 6 months, how often were these visits with your regular doctor? A primary care doctor might be a physician (MD or DO), nurse practitioner (NP), or physician assistant (PA).”

^e The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 1-Your doctor or someone from this doctor’s office came to see you in the hospital.” In the wave 3 survey, we asked, “In the last 6 months, did your doctor or someone from this doctor’s office come to see you in the hospital?”

^f The wording on this item changed from the wave 2 survey, in which we asked, “Did you get any other kinds of care from this doctor’s office in the last 6 months? (Mark one or more.) 2-Your doctor or someone from this doctor’s office came to see you at another location besides this doctor’s office or the hospital to provide health care (such as at your home or a senior center).” In the wave 3 survey, we asked, “In the last 6 months, did your doctor or someone from this doctor’s office come to see you at another location besides this doctor’s office or the hospital to provide health care (such as at your home or a senior center)?”

^g The wording on this item changed from the wave 2 survey, in which we asked, “In the last 6 months, did your doctor or someone from this doctor’s office ask you about any non-medical problems you might need help with? These might include things like problems paying for or finding a place to live, not having enough food, lack of reliable transportation, or trouble paying utility bills.” In the wave 3 survey, we asked, “Basic needs are food, housing, transportation, and utilities. In the last 6 months, did your doctor or someone from this doctor’s office ask you if you had problems with any of these basic needs?”

FFS = fee-for-service; n.a. = not applicable because the item was not asked in the wave; PY = Program Year.

Table 4.E.9a. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): SSP status^a (Track 1)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
SSP															
Access (9 items)	37.1%	37.9%	-0.8%	0.275	1,838; 3,520	38.6%	37.3%	1.3%	0.079	2,009; 2,294	52.2%	51.5%	0.7%	0.435	1,629; 1,959
Continuity in the doctor's office (1 item)	82.4%	84.9%	-2.5%	0.065	1,797; 3,441	79.2%	80.1%	-0.9%	0.505	1,969; 2,243	82.2%	79.5%	2.7%	0.074	1,597; 1,930
Continuity across health care settings (2 items)	2.9%	3.1%	-0.1%	0.795	1,799; 3,456	2.1%	2.4%	-0.3%	0.409	1,963; 2,232	2.2%	2.6%	-0.4%	0.351	1,614; 1,934
Care management (4 items)	70.2%	71.9%	-1.6%	0.150	1,830; 3,504	70.1%	70.3%	-0.2%	0.852	2,006; 2,291	69.8%	68.7%	1.0%	0.409	1,624; 1,956
Comprehensiveness (6 items)	51.2%	52.3%	-1.2%	0.230	1,828; 3,511	52.9%	51.3%	1.6%	0.096	2,003; 2,280	51.4%	50.2%	1.2%	0.226	1,629; 1,958
Coordination (1 item)	64.6%	66.8%	-2.2%	0.275	1,281; 2,553	59.1%	59.1%	0.0%	0.995	1,528; 1,695	57.0%	58.1%	-1.1%	0.625	1,244; 1,487
Patient and family caregiver engagement (7 items)	72.0%	74.2%	-2.2%	0.014	1,833; 3,515	74.9%	73.8%	1.2%	0.178	2,010; 2,293	73.9%	74.5%	-0.7%	0.477	1,619; 1,948
Helpful, courteous, and respectful office staff (2 items)	82.3%	85.0%	-2.7%	0.024	1,823; 3,504	84.4%	84.4%	-0.1%	0.963	2,003; 2,279	83.0%	86.4%	-3.3%	0.012	1,628; 1,952
Teamwork (1 item)	76.8%	78.7%	-1.9%	0.211	1,782; 3,458	79.5%	79.3%	0.2%	0.890	1,979; 2,247	77.0%	78.0%	-1.0%	0.517	1,605; 1,925
Patients' rating of the primary care doctors and their staff (1 item)	83.4%	84.6%	-1.2%	0.374	1,818; 3,486	86.3%	85.2%	1.1%	0.374	1,986; 2,258	85.1%	85.0%	0.1%	0.935	1,617; 1,945
Non-SSP															
Access (9 items)	38.7%	39.8%	-1.0%	0.197	1,704; 3,029	39.2%	39.1%	0.2%	0.825	1,809; 2,156	51.6%	52.6%	-1.0%	0.332	1,687; 1,865
Continuity in the doctor's office (1 item)	84.5%	84.6%	-0.1%	0.957	1,672; 2,973	82.3%	80.4%	1.9%	0.218	1,770; 2,116	79.2%	81.0%	-1.8%	0.253	1,649; 1,818
Continuity across health care settings (2 items)	2.9%	2.6%	0.3%	0.633	1,657; 2,978	2.1%	2.3%	-0.2%	0.641	1,758; 2,092	2.0%	2.4%	-0.4%	0.245	1,666; 1,857
Care management (4 items)	72.0%	69.9%	2.1%	0.090	1,696; 3,019	70.8%	69.9%	0.9%	0.437	1,806; 2,151	69.1%	67.4%	1.7%	0.192	1,684; 1,860
Comprehensiveness (6 items)	50.8%	50.9%	-0.1%	0.934	1,701; 3,022	52.6%	51.4%	1.1%	0.312	1,798; 2,142	50.5%	48.8%	1.7%	0.128	1,686; 1,864
Coordination (1 item)	67.7%	68.4%	-0.7%	0.730	1,220; 2,197	61.3%	59.8%	1.4%	0.488	1,329; 1,552	59.0%	60.2%	-1.2%	0.579	1,268; 1,384
Patient and family caregiver engagement (7 items)	73.0%	74.3%	-1.2%	0.206	1,702; 3,025	75.5%	75.6%	-0.1%	0.940	1,809; 2,156	74.9%	74.8%	0.1%	0.957	1,679; 1,858
Helpful, courteous, and respectful office staff (2 items)	84.1%	85.1%	-0.9%	0.458	1,696; 3,023	85.1%	87.0%	-1.9%	0.118	1,799; 2,149	85.4%	86.3%	-0.9%	0.461	1,679; 1,862
Teamwork (1 item)	79.8%	79.9%	-0.1%	0.950	1,666; 2,990	82.1%	80.8%	1.4%	0.328	1,774; 2,110	80.8%	78.7%	2.1%	0.165	1,670; 1,835

Table 4.E.9a. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Patients' rating of the primary care doctors and their staff (1 item)	84.6%	83.4%	1.2%	0.402	1,696; 3,005	85.1%	85.3%	-0.2%	0.848	1,780; 2,135	85.3%	86.4%	-1.1%	0.431	1,667; 1,850

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate predicted probabilities for the composite measures, we first created beneficiary-level composite measures by averaging nonmissing binary indicators for whether the beneficiary's response was the best option across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately by SSP participation status at the start of CPC+ (January 1, 2017) within Track. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for-service; PY = Program Year; SSP = Medicare Shared Savings Program

^a Whether the physician's practice participated in a Medicare SSP accountable care organization at the start of CPC+ (January 1, 2017).

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.9b. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): SSP status^a (Track 2)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
SSP															
Access (9 items)	38.3%	37.7%	0.6%	0.451	1,590; 2,940	38.3%	37.5%	0.7%	0.346	1,717; 1,834	53.8%	50.8%	3.0%	0.007	1,449; 1,593
Continuity in the doctor's office (1 item)	82.6%	83.5%	-0.9%	0.551	1,556; 2,878	78.5%	79.2%	-0.7%	0.645	1,673; 1,780	78.6%	78.8%	-0.2%	0.902	1,417; 1,557
Continuity across health care settings (2 items)	3.2%	2.4%	0.7%	0.143	1,559; 2,882	2.5%	2.2%	0.3%	0.478	1,682; 1,790	2.6%	2.4%	0.2%	0.594	1,434; 1,569
Care management (4 items)	71.6%	72.0%	-0.4%	0.730	1,585; 2,924	72.3%	70.2%	2.2%	0.082	1,714; 1,831	73.7%	68.6%	5.1%	0.000	1,445; 1,589
Comprehensiveness (6 items)	51.4%	53.5%	-2.1%	0.070	1,586; 2,929	54.0%	52.7%	1.3%	0.227	1,711; 1,826	54.5%	50.8%	3.7%	0.001	1,449; 1,592
Coordination (1 item)	63.0%	66.8%	-3.7%	0.087	1,172; 2,165	59.6%	60.9%	-1.4%	0.511	1,324; 1,312	63.5%	56.7%	6.8%	0.003	1,084; 1,201
Patient and family caregiver engagement (7 items)	73.9%	74.5%	-0.5%	0.585	1,588; 2,935	76.2%	75.2%	1.0%	0.288	1,718; 1,833	76.4%	74.8%	1.5%	0.123	1,441; 1,582
Helpful, courteous, and respectful office staff (2 items)	83.9%	84.7%	-0.8%	0.532	1,581; 2,923	86.1%	85.0%	1.1%	0.337	1,711; 1,824	85.0%	85.9%	-0.9%	0.498	1,442; 1,586
Teamwork (1 item)	78.9%	78.1%	0.8%	0.627	1,555; 2,885	81.2%	80.0%	1.1%	0.438	1,684; 1,786	79.6%	77.0%	2.6%	0.136	1,434; 1,565
Patients' rating of the primary care doctors and their staff (1 item)	85.8%	84.4%	1.4%	0.315	1,578; 2,917	85.8%	85.8%	-0.1%	0.962	1,700; 1,806	85.7%	84.0%	1.7%	0.259	1,442; 1,583
Non-SSP															
Access (9 items)	39.6%	38.9%	0.7%	0.334	1,969; 3,365	38.9%	39.0%	-0.1%	0.904	2,058; 2,247	52.8%	52.0%	0.8%	0.389	1,823; 2,017
Continuity in the doctor's office (1 item)	84.8%	85.4%	-0.6%	0.637	1,941; 3,301	78.4%	79.4%	-1.0%	0.489	2,006; 2,200	81.4%	80.1%	1.4%	0.348	1,782; 1,973
Continuity across health care settings (2 items)	3.1%	2.4%	0.7%	0.181	1,921; 3,316	1.8%	2.3%	-0.5%	0.204	2,002; 2,195	2.3%	2.6%	-0.2%	0.553	1,812; 2,003
Care management (4 items)	71.0%	71.0%	0.1%	0.953	1,963; 3,349	69.8%	69.8%	0.0%	0.996	2,055; 2,241	70.7%	67.9%	2.8%	0.030	1,818; 2,010
Comprehensiveness (6 items)	50.7%	51.4%	-0.8%	0.424	1,966; 3,355	51.8%	52.2%	-0.3%	0.739	2,049; 2,232	50.4%	49.3%	1.1%	0.284	1,823; 2,016
Coordination (1 item)	68.5%	68.8%	-0.3%	0.895	1,412; 2,423	58.7%	60.4%	-1.7%	0.379	1,539; 1,623	61.4%	59.7%	1.7%	0.416	1,343; 1,490
Patient and family caregiver engagement (7 items)	74.5%	75.1%	-0.5%	0.546	1,967; 3,358	74.8%	75.9%	-1.1%	0.182	2,058; 2,246	75.9%	75.4%	0.5%	0.586	1,815; 2,008
Helpful, courteous, and respectful office staff (2 items)	85.0%	85.6%	-0.6%	0.625	1,955; 3,352	83.8%	85.7%	-1.8%	0.117	2,049; 2,231	85.4%	85.7%	-0.3%	0.795	1,813; 2,006
Teamwork (1 item)	81.8%	80.9%	0.9%	0.530	1,933; 3,310	79.4%	81.2%	-1.8%	0.180	2,030; 2,185	80.7%	78.9%	1.8%	0.219	1,803; 1,987

Table 4.E.9b. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Patients' rating of the primary care doctors and their staff (1 item)	85.2%	84.4%	0.7%	0.568	1,950; 3,336	85.6%	85.3%	0.3%	0.775	2,030; 2,220	85.7%	85.8%	-0.1%	0.942	1,807; 1,991

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate predicted probabilities for the composite measures, we first created beneficiary-level composite measures by averaging nonmissing binary indicators for whether the beneficiary's response was the best option across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately by SSP participation status at the start of CPC+ (January 1, 2017) within Track. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for-service; PY = Program Year; SSP = Medicare Shared Savings Program

^a Whether the physician's practice participated in a Medicare SSP accountable care organization at the start of CPC+ (January 1, 2017).

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.10a.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): practice ownership^a (Track 1)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
System															
Access (9 items)	36.9%	38.8%	-1.9%	0.008	1,931; 3,693	38.5%	38.0%	0.5%	0.435	2,142; 2,431	51.8%	51.9%	-0.1%	0.903	1,828; 2,154
Continuity in the doctor's office (1 item)	81.5%	84.4%	-2.9%	0.034	1,888; 3,622	80.6%	79.1%	1.4%	0.304	2,100; 2,381	79.9%	79.9%	0.1%	0.970	1,787; 2,108
Continuity across health care settings (2 items)	2.4%	2.5%	-0.1%	0.804	1,891; 3,626	1.8%	2.0%	-0.2%	0.663	2,080; 2,365	2.0%	2.5%	-0.4%	0.221	1,807; 2,138
Care management (4 items)	71.3%	71.6%	-0.2%	0.830	1,926; 3,677	71.8%	71.2%	0.7%	0.536	2,139; 2,428	69.9%	68.4%	1.6%	0.207	1,822; 2,149
Comprehensiveness (6 items)	51.9%	52.7%	-0.7%	0.457	1,926; 3,683	54.2%	52.2%	2.0%	0.053	2,132; 2,420	52.7%	50.4%	2.3%	0.018	1,828; 2,153
Coordination (1 item)	66.2%	69.7%	-3.6%	0.066	1,330; 2,686	60.7%	60.2%	0.4%	0.814	1,614; 1,779	57.4%	60.7%	-3.3%	0.112	1,387; 1,627
Patient and family caregiver engagement (7 items)	71.3%	75.0%	-3.7%	0.000	1,929; 3,688	75.6%	75.0%	0.5%	0.532	2,143; 2,430	75.1%	75.1%	0.0%	0.985	1,819; 2,141
Helpful, courteous, and respectful office staff (2 items)	82.2%	85.3%	-3.1%	0.007	1,921; 3,682	85.7%	85.9%	-0.2%	0.822	2,132; 2,418	85.1%	85.9%	-0.8%	0.457	1,823; 2,149
Teamwork (1 item)	76.7%	79.9%	-3.2%	0.026	1,876; 3,629	80.8%	80.2%	0.6%	0.643	2,101; 2,381	79.2%	77.7%	1.4%	0.315	1,804; 2,117
Patients' rating of the primary care doctors and their staff (1 item)	82.5%	85.2%	-2.7%	0.043	1,920; 3,650	85.7%	85.0%	0.7%	0.546	2,106; 2,404	86.3%	86.1%	0.2%	0.898	1,812; 2,137
Independent															
Access (9 items)	39.1%	38.8%	0.3%	0.720	1,611; 2,856	39.3%	38.4%	1.0%	0.201	1,676; 2,019	52.0%	52.2%	-0.1%	0.888	1,488; 1,670
Continuity in the doctor's office (1 item)	85.8%	85.2%	0.7%	0.640	1,581; 2,792	80.9%	81.7%	-0.8%	0.599	1,639; 1,978	81.7%	80.7%	1.0%	0.558	1,459; 1,640
Continuity across health care settings (2 items)	3.6%	3.3%	0.3%	0.639	1,565; 2,808	2.4%	2.8%	-0.4%	0.397	1,641; 1,959	2.2%	2.5%	-0.3%	0.412	1,473; 1,653
Care management (4 items)	70.9%	70.1%	0.8%	0.556	1,600; 2,846	68.7%	68.7%	0.0%	0.976	1,673; 2,014	68.9%	67.7%	1.2%	0.401	1,486; 1,667
Comprehensiveness (6 items)	49.8%	50.3%	-0.5%	0.621	1,603; 2,850	50.9%	50.3%	0.6%	0.564	1,669; 2,002	48.7%	48.4%	0.3%	0.791	1,487; 1,669
Coordination (1 item)	66.0%	64.8%	1.2%	0.577	1,171; 2,064	59.4%	58.4%	1.0%	0.643	1,243; 1,468	58.7%	57.1%	1.6%	0.520	1,125; 1,244
Patient and family caregiver engagement (7 items)	74.1%	73.2%	0.8%	0.387	1,606; 2,852	74.7%	74.2%	0.6%	0.537	1,676; 2,019	73.4%	74.2%	-0.8%	0.466	1,479; 1,665
Helpful, courteous, and respectful office staff (2 items)	84.5%	84.7%	-0.2%	0.898	1,598; 2,845	83.5%	85.4%	-1.8%	0.136	1,670; 2,010	83.1%	86.8%	-3.8%	0.007	1,484; 1,665
Teamwork (1 item)	80.2%	78.4%	1.8%	0.260	1,572; 2,819	80.7%	79.7%	1.0%	0.512	1,652; 1,976	78.5%	79.2%	-0.7%	0.663	1,471; 1,643

Table 4.E.10b.1. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)				Track 1 – PY 3 (Wave 2)				Track 1 – PY 5 (Wave 3)						
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Patients' rating of the primary care doctors and their staff (1 item)	85.9%	82.6%	3.3%	0.020	1,594; 2,841	85.7%	85.6%	0.1%	0.956	1,660; 1,989	83.9%	85.2%	-1.3%	0.390	1,472; 1,658

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for-service; PY = Program Year

^a Practice ownership comes from the SK&A database, managed by IQVIA, a marketing organization that collects information directly from all health care practices in the United States. IQVIA updates this information on an ongoing basis; we pulled practice ownership information November 2016.

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.10a.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): practice ownership^a (Track 2)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
System															
Access (9 items)	38.2%	37.7%	0.5%	0.487	1,989; 3,686	38.3%	37.9%	0.4%	0.565	2,095; 2,375	52.4%	50.9%	1.5%	0.118	1,792; 2,126
Continuity in the doctor's office (1 item)	83.5%	84.4%	-0.9%	0.485	1,950; 3,611	78.8%	79.3%	-0.5%	0.707	2,037; 2,315	79.1%	79.8%	-0.7%	0.637	1,748; 2,075
Continuity across health care settings (2 items)	2.7%	2.2%	0.5%	0.224	1,944; 3,626	2.1%	2.2%	-0.1%	0.801	2,042; 2,317	2.4%	2.5%	-0.1%	0.861	1,779; 2,104
Care management (4 items)	70.5%	70.9%	-0.4%	0.692	1,982; 3,665	70.9%	70.7%	0.2%	0.861	2,091; 2,370	72.0%	68.2%	3.8%	0.002	1,789; 2,121
Comprehensiveness (6 items)	50.7%	52.7%	-2.0%	0.045	1,984; 3,672	52.7%	53.2%	-0.5%	0.584	2,087; 2,364	52.0%	50.6%	1.4%	0.161	1,792; 2,125
Coordination (1 item)	66.1%	69.0%	-2.9%	0.119	1,437; 2,688	61.9%	62.4%	-0.6%	0.758	1,609; 1,705	63.9%	60.2%	3.7%	0.061	1,356; 1,592
Patient and family caregiver engagement (7 items)	73.6%	74.8%	-1.2%	0.177	1,987; 3,679	75.3%	75.3%	0.0%	0.984	2,096; 2,374	75.6%	75.3%	0.3%	0.709	1,783; 2,115
Helpful, courteous, and respectful office staff (2 items)	83.8%	85.1%	-1.3%	0.250	1,976; 3,670	85.1%	85.6%	-0.5%	0.661	2,088; 2,360	84.8%	85.9%	-1.1%	0.347	1,783; 2,118
Teamwork (1 item)	80.9%	79.3%	1.5%	0.266	1,944; 3,615	79.9%	80.0%	-0.1%	0.959	2,070; 2,310	79.3%	77.7%	1.6%	0.291	1,768; 2,092
Patients' rating of the primary care doctors and their staff (1 item)	84.8%	85.1%	-0.3%	0.809	1,976; 3,647	85.3%	85.0%	0.3%	0.823	2,064; 2,345	85.4%	85.5%	-0.1%	0.911	1,783; 2,103
Independent															
Access (9 items)	40.2%	39.3%	0.9%	0.274	1,570; 2,619	39.1%	39.0%	0.1%	0.861	1,680; 1,706	54.4%	52.2%	2.2%	0.039	1,480; 1,484
Continuity in the doctor's office (1 item)	84.3%	84.8%	-0.5%	0.735	1,547; 2,568	78.0%	79.3%	-1.3%	0.403	1,642; 1,665	81.6%	79.1%	2.5%	0.145	1,451; 1,455
Continuity across health care settings (2 items)	3.7%	2.8%	0.9%	0.115	1,536; 2,572	2.2%	2.3%	-0.2%	0.749	1,642; 1,668	2.5%	2.5%	0.0%	0.994	1,467; 1,468
Care management (4 items)	72.3%	72.1%	0.2%	0.867	1,566; 2,608	70.9%	68.9%	2.0%	0.107	1,678; 1,702	72.1%	68.2%	3.9%	0.009	1,474; 1,478
Comprehensiveness (6 items)	51.4%	51.9%	-0.5%	0.667	1,568; 2,612	53.0%	51.3%	1.7%	0.132	1,673; 1,694	52.5%	49.1%	3.4%	0.004	1,480; 1,483
Coordination (1 item)	65.9%	66.2%	-0.3%	0.900	1,147; 1,900	55.2%	58.1%	-2.9%	0.187	1,254; 1,230	60.2%	55.9%	4.4%	0.069	1,071; 1,099
Patient and family caregiver engagement (7 items)	75.2%	74.8%	0.3%	0.749	1,568; 2,614	75.5%	76.0%	-0.5%	0.632	1,680; 1,705	76.8%	74.9%	1.8%	0.078	1,473; 1,475
Helpful, courteous, and respectful office staff (2 items)	85.6%	85.4%	0.2%	0.879	1,560; 2,605	84.5%	85.1%	-0.5%	0.690	1,672; 1,695	85.8%	85.7%	0.2%	0.909	1,472; 1,474
Teamwork (1 item)	80.0%	80.1%	-0.1%	0.941	1,544; 2,580	80.6%	81.7%	-1.1%	0.453	1,644; 1,661	81.4%	78.5%	2.9%	0.077	1,469; 1,460

Table 4.E.10a.2. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Patients' rating of the primary care doctors and their staff (1 item)	86.3%	83.4%	2.9%	0.054	1,552; 2,606	86.3%	86.2%	0.0%	0.987	1,666; 1,681	86.1%	84.2%	1.9%	0.214	1,466; 1,471

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for-service; PY = Program Year

^a Practice ownership comes from the SK&A database, managed by IQVIA, a marketing organization that collects information directly from all health care practices in the United States. IQVIA updates this information on an ongoing basis; we pulled practice ownership information November 2016.

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.10b.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): practice size^a, Track 1

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
1–2 PCPs															
Access (9 items)	40.1%	40.6%	-0.5%	0.669	751; 1,343	37.8%	39.8%	-2.0%	0.078	798; 861	53.6%	52.6%	1.1%	0.473	693; 666
Continuity in the doctor's office (1 item)	86.8%	88.7%	-1.9%	0.333	733; 1,310	86.1%	85.1%	1.0%	0.602	769; 835	83.5%	82.2%	1.3%	0.587	682; 656
Continuity across health care settings (2 items)	4.5%	3.2%	1.3%	0.207	729; 1,317	3.4%	2.8%	0.6%	0.406	775; 825	2.3%	2.4%	-0.1%	0.868	686; 663
Care management (4 items)	72.0%	71.9%	0.1%	0.942	747; 1,339	68.3%	68.4%	-0.1%	0.960	795; 857	69.6%	68.3%	1.3%	0.530	693; 665
Comprehensiveness (6 items)	50.8%	51.3%	-0.5%	0.736	748; 1,338	52.2%	49.9%	2.4%	0.121	795; 854	50.9%	47.4%	3.5%	0.029	693; 666
Coordination (1 item)	65.4%	66.2%	-0.7%	0.820	528; 981	61.0%	55.1%	5.9%	0.060	591; 631	61.9%	57.9%	4.0%	0.236	519; 507
Patient and family caregiver engagement (7 items)	72.2%	72.5%	-0.3%	0.857	748; 1,341	74.6%	74.4%	0.2%	0.868	798; 861	75.0%	72.7%	2.3%	0.136	692; 663
Helpful, courteous, and respectful office staff (2 items)	85.0%	86.5%	-1.6%	0.412	748; 1,337	84.3%	87.4%	-3.1%	0.068	793; 855	87.0%	84.4%	2.7%	0.185	691; 665
Teamwork (1 item)	80.1%	79.9%	0.2%	0.917	732; 1,318	82.0%	82.1%	-0.1%	0.980	785; 845	81.0%	79.8%	1.2%	0.609	686; 659
Patients' rating of the primary care doctors and their staff (1 item)	87.3%	83.6%	3.7%	0.071	743; 1,331	85.9%	88.0%	-2.1%	0.245	786; 852	86.7%	85.9%	0.8%	0.706	685; 659
3–5 PCPs															
Access (9 items)	37.5%	38.8%	-1.3%	0.157	1,121; 2,378	39.3%	37.4%	1.9%	0.014	1,252; 1,635	51.8%	51.5%	0.3%	0.767	1,068; 1,444
Continuity in the doctor's office (1 item)	83.6%	85.6%	-2.0%	0.226	1,104; 2,321	80.0%	81.0%	-1.0%	0.583	1,234; 1,601	81.1%	82.2%	-1.2%	0.519	1,047; 1,420
Continuity across health care settings (2 items)	2.2%	2.9%	-0.7%	0.249	1,095; 2,335	1.6%	2.1%	-0.5%	0.321	1,227; 1,590	1.6%	2.5%	-0.8%	0.066	1,055; 1,433
Care management (4 items)	71.4%	72.1%	-0.7%	0.620	1,116; 2,366	70.5%	70.5%	0.0%	0.975	1,252; 1,634	70.2%	68.4%	1.8%	0.228	1,065; 1,440
Comprehensiveness (6 items)	51.5%	52.4%	-0.9%	0.448	1,115; 2,373	51.7%	51.1%	0.6%	0.587	1,248; 1,629	51.0%	51.2%	-0.3%	0.817	1,068; 1,444
Coordination (1 item)	66.1%	67.2%	-1.1%	0.659	794; 1,722	60.9%	60.3%	0.6%	0.811	943; 1,208	58.8%	59.6%	-0.7%	0.786	811; 1,063
Patient and family caregiver engagement (7 items)	72.3%	75.7%	-3.4%	0.002	1,118; 2,374	75.1%	73.7%	1.4%	0.173	1,252; 1,635	74.4%	75.3%	-0.9%	0.463	1,060; 1,438
Helpful, courteous, and respectful office staff (2 items)	82.3%	85.5%	-3.2%	0.027	1,113; 2,371	84.5%	84.4%	0.2%	0.914	1,249; 1,628	83.8%	86.2%	-2.4%	0.100	1,067; 1,440
Teamwork (1 item)	78.1%	80.0%	-1.8%	0.331	1,089; 2,340	80.7%	79.1%	1.6%	0.325	1,229; 1,603	79.8%	78.1%	1.7%	0.348	1,054; 1,421

Table 4.E.10b.1. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Patients' rating of the primary care doctors and their staff (1 item)	83.9%	85.7%	-1.8%	0.250	1,112; 2,357	87.4%	83.5%	3.8%	0.010	1,232; 1,616	84.5%	86.7%	-2.2%	0.160	1,057; 1,439
6+ PCPs															
Access (9 items)	37.2%	38.0%	-0.8%	0.323	1,670; 2,828	39.0%	38.0%	1.0%	0.210	1,768; 1,954	51.2%	52.2%	-1.0%	0.317	1,555; 1,714
Continuity in the doctor's office (1 item)	81.8%	82.3%	-0.5%	0.755	1,632; 2,783	78.8%	77.5%	1.3%	0.432	1,736; 1,923	79.2%	77.8%	1.4%	0.407	1,517; 1,672
Continuity across health care settings (2 items)	2.8%	2.6%	0.1%	0.807	1,632; 2,782	1.8%	2.3%	-0.5%	0.243	1,719; 1,909	2.4%	2.5%	-0.2%	0.655	1,539; 1,695
Care management (4 items)	70.5%	69.5%	0.9%	0.475	1,663; 2,818	71.4%	70.6%	0.8%	0.516	1,765; 1,951	68.9%	67.8%	1.1%	0.444	1,550; 1,711
Comprehensiveness (6 items)	50.7%	51.2%	-0.5%	0.670	1,666; 2,822	53.8%	52.2%	1.5%	0.197	1,758; 1,939	50.9%	49.1%	1.8%	0.117	1,554; 1,712
Coordination (1 item)	66.4%	68.5%	-2.1%	0.321	1,179; 2,047	59.2%	60.7%	-1.5%	0.485	1,323; 1,408	55.6%	59.3%	-3.8%	0.105	1,182; 1,301
Patient and family caregiver engagement (7 items)	72.8%	73.8%	-1.0%	0.294	1,669; 2,825	75.5%	75.5%	0.0%	0.971	1,769; 1,953	74.0%	75.1%	-1.1%	0.297	1,546; 1,705
Helpful, courteous, and respectful office staff (2 items)	83.1%	84.0%	-0.9%	0.510	1,658; 2,819	85.1%	85.9%	-0.8%	0.493	1,760; 1,945	83.2%	87.3%	-4.1%	0.003	1,549; 1,709
Teamwork (1 item)	77.5%	78.5%	-0.9%	0.554	1,627; 2,790	80.3%	79.8%	0.5%	0.755	1,739; 1,909	77.2%	78.0%	-0.8%	0.638	1,535; 1,680
Patients' rating of the primary care doctors and their staff (1 item)	82.6%	82.9%	-0.3%	0.837	1,659; 2,803	84.3%	85.4%	-1.1%	0.429	1,748; 1,925	85.1%	84.8%	0.3%	0.816	1,542; 1,697

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with bolded text indicates a favorable finding that is both statistically and substantially significant; **yellow shading with bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for-service; PY = Program Year; PCP = primary care practitioner

^a Practice ownership comes from the SK&A database, managed by IQVIA, a marketing organization that collects information directly from all health care practices in the United States. IQVIA updates this information on an ongoing basis; we pulled practice ownership information November 2016.

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.10b.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): practice size^a, Track 2

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
1–2 PCPs															
Access (9 items)	41.2%	38.3%	3.0%	0.036	442; 801	39.2%	40.2%	-1.0%	0.477	474; 550	55.6%	52.3%	3.3%	0.076	412; 441
Continuity in the doctor's office (1 item)	87.6%	87.4%	0.2%	0.925	431; 786	84.5%	85.1%	-0.6%	0.827	459; 530	84.3%	84.6%	-0.2%	0.932	401; 431
Continuity across health care settings (2 items)	4.2%	2.0%	2.2%	0.037	433; 787	2.1%	2.1%	0.0%	0.994	464; 531	3.3%	3.2%	0.1%	0.897	408; 438
Care management (4 items)	74.3%	72.8%	1.4%	0.522	442; 798	70.6%	68.3%	2.3%	0.287	472; 547	70.5%	69.3%	1.3%	0.650	410; 439
Comprehensiveness (6 items)	52.0%	52.8%	-0.7%	0.700	441; 796	53.1%	50.8%	2.3%	0.226	472; 548	52.9%	49.1%	3.8%	0.059	412; 441
Coordination (1 item)	72.6%	70.2%	2.4%	0.533	304; 591	58.3%	57.0%	1.3%	0.746	361; 385	60.0%	58.4%	1.6%	0.722	298; 338
Patient and family caregiver engagement (7 items)	75.9%	72.6%	3.3%	0.072	441; 799	76.7%	75.6%	1.2%	0.480	474; 549	76.6%	74.6%	2.0%	0.268	409; 439
Helpful, courteous, and respectful office staff (2 items)	87.9%	85.3%	2.7%	0.204	438; 794	86.5%	86.7%	-0.2%	0.943	471; 545	88.1%	85.5%	2.6%	0.271	409; 441
Teamwork (1 item)	80.5%	79.9%	0.6%	0.843	434; 785	81.4%	83.3%	-1.8%	0.503	468; 530	82.8%	80.0%	2.8%	0.354	407; 438
Patients' rating of the primary care doctors and their staff (1 item)	86.7%	83.3%	3.4%	0.183	438; 795	87.0%	88.5%	-1.5%	0.534	466; 545	86.0%	84.6%	1.3%	0.626	409; 436
3–5 PCPs															
Access (9 items)	38.8%	38.9%	-0.2%	0.844	1,160; 2,086	38.0%	38.2%	-0.2%	0.832	1,241; 1,374	51.9%	51.9%	0.0%	0.988	1,136; 1,252
Continuity in the doctor's office (1 item)	85.7%	85.7%	0.0%	0.993	1,143; 2,040	79.5%	80.2%	-0.7%	0.689	1,210; 1,343	83.5%	82.6%	0.9%	0.594	1,108; 1,230
Continuity across health care settings (2 items)	2.8%	2.3%	0.5%	0.411	1,135; 2,043	1.8%	2.2%	-0.3%	0.479	1,201; 1,347	1.6%	1.9%	-0.3%	0.419	1,124; 1,241
Care management (4 items)	70.1%	72.0%	-1.9%	0.192	1,155; 2,074	71.2%	71.2%	0.0%	0.974	1,241; 1,374	72.2%	68.7%	3.6%	0.016	1,131; 1,247
Comprehensiveness (6 items)	50.7%	52.6%	-1.9%	0.105	1,157; 2,082	51.7%	52.4%	-0.7%	0.597	1,235; 1,368	50.9%	50.8%	0.1%	0.963	1,136; 1,252
Coordination (1 item)	65.7%	66.7%	-1.0%	0.705	838; 1,516	59.5%	61.7%	-2.2%	0.372	939; 1,001	58.7%	58.4%	0.3%	0.907	825; 926
Patient and family caregiver engagement (7 items)	74.3%	75.6%	-1.4%	0.215	1,159; 2,083	75.0%	75.3%	-0.3%	0.751	1,241; 1,374	75.1%	75.6%	-0.5%	0.661	1,130; 1,247
Helpful, courteous, and respectful office staff (2 items)	84.1%	85.5%	-1.3%	0.378	1,154; 2,081	83.6%	84.9%	-1.4%	0.339	1,235; 1,368	83.6%	85.7%	-2.1%	0.177	1,130; 1,244

Table 4.E.10b.2. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Teamwork (1 item)	81.8%	81.8%	0.0%	0.985	1,135; 2,052	79.5%	80.1%	-0.6%	0.738	1,220; 1,339	78.8%	77.8%	1.0%	0.575	1,124; 1,229
Patients' rating of the primary care doctors and their staff (1 item)	86.0%	86.1%	0.0%	0.975	1,154; 2,069	84.7%	85.0%	-0.3%	0.851	1,229; 1,354	85.6%	85.9%	-0.3%	0.849	1,126; 1,245
6+ PCPs															
Access (9 items)	38.7%	38.0%	0.6%	0.389	1,957; 3,418	38.9%	38.0%	0.9%	0.200	2,060; 2,157	53.5%	51.0%	2.5%	0.013	1,724; 1,917
Continuity in the doctor's office (1 item)	81.8%	83.2%	-1.4%	0.310	1,923; 3,353	76.3%	77.3%	-1.0%	0.486	2,010; 2,107	77.1%	76.4%	0.7%	0.677	1,690; 1,869
Continuity across health care settings (2 items)	3.1%	2.6%	0.5%	0.325	1,912; 3,368	2.3%	2.4%	0.0%	0.970	2,019; 2,107	2.8%	2.7%	0.1%	0.844	1,714; 1,893
Care management (4 items)	71.3%	70.7%	0.5%	0.638	1,951; 3,401	70.8%	69.6%	1.2%	0.296	2,056; 2,151	72.3%	67.6%	4.6%	0.001	1,722; 1,913
Comprehensiveness (6 items)	51.0%	52.1%	-1.1%	0.287	1,954; 3,406	53.4%	52.8%	0.6%	0.560	2,053; 2,142	52.9%	49.6%	3.3%	0.004	1,724; 1,915
Coordination (1 item)	64.7%	68.0%	-3.4%	0.086	1,442; 2,481	59.0%	60.8%	-1.8%	0.344	1,563; 1,549	65.2%	58.4%	6.8%	0.001	1,304; 1,427
Patient and family caregiver engagement (7 items)	73.9%	74.8%	-1.0%	0.314	1,955; 3,411	75.3%	75.8%	-0.4%	0.626	2,061; 2,156	76.6%	75.0%	1.6%	0.077	1,717; 1,904
Helpful, courteous, and respectful office staff (2 items)	84.0%	85.0%	-1.1%	0.368	1,944; 3,400	85.3%	85.3%	0.0%	0.978	2,054; 2,142	85.5%	85.9%	-0.4%	0.739	1,716; 1,907
Teamwork (1 item)	79.7%	78.2%	1.5%	0.316	1,919; 3,358	80.3%	80.5%	-0.1%	0.913	2,026; 2,102	80.5%	77.8%	2.7%	0.093	1,706; 1,885
Patients' rating of the primary care doctors and their staff (1 item)	84.8%	83.6%	1.1%	0.397	1,936; 3,389	86.0%	85.1%	0.9%	0.482	2,035; 2,127	85.7%	84.5%	1.2%	0.373	1,714; 1,893

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for-service; PY = Program Year; PCP = primary care practitioner

^a Practice ownership comes from the SK&A database, managed by IQVIA, a marketing organization that collects information directly from all health care practices in the United States. IQVIA updates this information on an ongoing basis; we pulled practice ownership information November 2016.

Table 4.E.10b.2. (continued)

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.10c.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): geographic locations (Track 1)^a

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Rural															
Access (9 items)	38.4%	39.1%	-0.7%	0.697	333; 627	37.6%	36.7%	0.9%	0.585	359; 418	52.0%	53.5%	-1.5%	0.546	329; 318
Continuity in the doctor's office (1 item)	83.5%	86.0%	-2.5%	0.459	328; 615	77.9%	79.3%	-1.4%	0.667	350; 408	79.6%	78.0%	1.6%	0.653	320; 314
Continuity across health care settings (2 items)	1.7%	3.4%	-1.7%	0.135	317; 611	2.4%	3.3%	-0.9%	0.329	352; 405	3.1%	4.0%	-0.9%	0.426	325; 312
Care management (4 items)	70.4%	69.1%	1.3%	0.636	331; 623	68.8%	68.3%	0.5%	0.857	359; 418	67.9%	72.5%	-4.6%	0.109	329; 318
Comprehensiveness (6 items)	49.8%	50.3%	-0.5%	0.811	332; 623	51.9%	49.5%	2.4%	0.350	358; 413	50.8%	52.6%	-1.8%	0.445	329; 318
Coordination (1 item)	72.8%	69.1%	3.8%	0.421	211; 419	56.4%	60.3%	-3.9%	0.422	242; 260	57.2%	63.5%	-6.3%	0.203	219; 219
Patient and family caregiver engagement (7 items)	70.6%	71.7%	-1.1%	0.629	332; 624	75.0%	73.1%	1.9%	0.370	359; 419	72.7%	76.0%	-3.3%	0.173	327; 316
Helpful, courteous, and respectful office staff (2 items)	83.8%	82.8%	1.0%	0.712	331; 625	81.6%	87.3%	-5.7%	0.022	358; 417	82.8%	89.5%	-6.7%	0.021	327; 317
Teamwork (1 item)	81.4%	78.6%	2.8%	0.362	322; 618	80.7%	82.6%	-1.9%	0.535	353; 409	82.7%	83.3%	-0.6%	0.844	323; 315
Patients' rating of the primary care doctors and their staff (1 item)	82.4%	77.7%	4.8%	0.182	328; 625	84.4%	84.4%	0.0%	0.988	354; 416	82.5%	87.6%	-5.1%	0.096	324; 316
Suburban															
Access (9 items)	36.6%	38.8%	-2.2%	0.128	632; 1,027	39.1%	37.9%	1.3%	0.246	687; 790	50.6%	50.9%	-0.3%	0.865	596; 670
Continuity in the doctor's office (1 item)	81.6%	84.3%	-2.8%	0.238	620; 1,006	81.1%	79.3%	1.8%	0.473	678; 777	76.1%	79.2%	-3.0%	0.277	585; 654
Continuity across health care settings (2 items)	3.1%	2.5%	0.6%	0.541	617; 1,014	1.8%	1.6%	0.3%	0.649	674; 762	2.0%	3.1%	-1.2%	0.070	590; 666
Care management (4 items)	70.5%	71.1%	-0.7%	0.750	630; 1,024	72.9%	71.7%	1.2%	0.509	687; 788	68.1%	68.2%	-0.1%	0.956	596; 669
Comprehensiveness (6 items)	50.7%	51.6%	-1.0%	0.586	629; 1,024	53.8%	51.0%	2.8%	0.105	686; 786	50.5%	49.7%	0.9%	0.644	595; 670
Coordination (1 item)	65.8%	69.7%	-3.8%	0.301	445; 697	60.3%	61.4%	-1.1%	0.758	489; 544	58.5%	60.9%	-2.3%	0.573	435; 498
Patient and family caregiver engagement (7 items)	71.4%	74.7%	-3.3%	0.036	632; 1,025	75.6%	74.7%	0.8%	0.543	687; 789	71.1%	74.2%	-3.1%	0.097	594; 668
Helpful, courteous, and respectful office staff (2 items)	84.3%	87.3%	-3.0%	0.132	628; 1,025	85.8%	87.3%	-1.4%	0.440	685; 786	84.0%	87.5%	-3.5%	0.095	593; 669

Table 4.E.10c.1. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Teamwork (1 item)	78.7%	79.8%	-1.2%	0.637	617; 1,017	81.7%	80.7%	0.9%	0.680	678; 772	76.1%	79.7%	-3.6%	0.174	583; 658
Patients' rating of the primary care doctors and their staff (1 item)	84.4%	84.1%	0.3%	0.904	630; 1,012	87.1%	83.9%	3.2%	0.138	677; 780	84.3%	87.0%	-2.7%	0.237	589; 667
Urban															
Access (9 items)	38.1%	38.8%	-0.6%	0.297	2,577; 4,895	39.0%	38.4%	0.6%	0.351	2,772; 3,242	52.2%	52.1%	0.1%	0.900	2,391; 2,836
Continuity in the doctor's office (1 item)	83.9%	84.7%	-0.8%	0.483	2,521; 4,793	81.0%	80.6%	0.4%	0.767	2,711; 3,174	82.0%	80.8%	1.2%	0.342	2,341; 2,780
Continuity across health care settings (2 items)	3.0%	2.8%	0.2%	0.697	2,522; 4,809	2.1%	2.4%	-0.3%	0.381	2,695; 3,157	2.0%	2.1%	-0.1%	0.646	2,365; 2,813
Care management (4 items)	71.4%	71.1%	0.3%	0.792	2,565; 4,876	70.1%	69.9%	0.1%	0.892	2,766; 3,236	70.0%	67.5%	2.5%	0.019	2,383; 2,829
Comprehensiveness (6 items)	51.2%	51.8%	-0.6%	0.498	2,568; 4,886	52.6%	51.7%	0.9%	0.300	2,757; 3,223	51.0%	49.1%	2.0%	0.019	2,391; 2,834
Coordination (1 item)	65.4%	66.9%	-1.5%	0.355	1,845; 3,634	60.5%	58.9%	1.6%	0.323	2,126; 2,443	57.9%	58.2%	-0.3%	0.868	1,858; 2,154
Patient and family caregiver engagement (7 items)	73.0%	74.4%	-1.4%	0.063	2,571; 4,891	75.2%	74.8%	0.3%	0.681	2,773; 3,241	75.4%	74.6%	0.7%	0.343	2,377; 2,822
Helpful, courteous, and respectful office staff (2 items)	82.9%	84.8%	-1.9%	0.060	2,560; 4,877	84.9%	85.1%	-0.2%	0.831	2,759; 3,225	84.4%	85.6%	-1.2%	0.255	2,387; 2,828
Teamwork (1 item)	77.8%	79.2%	-1.5%	0.252	2,509; 4,813	80.6%	79.5%	1.1%	0.358	2,722; 3,176	79.0%	77.4%	1.7%	0.195	2,369; 2,787
Patients' rating of the primary care doctors and their staff (1 item)	84.1%	84.8%	-0.7%	0.508	2,556; 4,854	85.5%	85.7%	-0.2%	0.858	2,735; 3,197	85.8%	85.1%	0.7%	0.531	2,371; 2,812

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year

Table 4.E.10c.1. (continued)

^a Geographic location is derived from the 2015-2016 Department of Health and Human Services' Area Health Resource File (AHRF). The variable used reflects 2013 data. The AHRF provides a 9-point rural-urban continuum code (RUCC) from the USDA Economic Research Service. From these codes, we defined urban as a county in a metro area of more than 250,000 people (RUCC=1 or 2), suburban as a county in a metro area of less than 250,000 people or that has an urban population of 20,000 or more and is adjacent to a metro area (RUCC=3 or 4), or rural if it does not meet the urban or suburban classifications (RUCC=5-9).

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.10c.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): geographic locations (Track 2)^a

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Rural															
Access (9 items)	37.7%	37.9%	-0.2%	0.922	266; 537	36.0%	37.5%	-1.5%	0.429	282; 351	51.7%	51.3%	0.4%	0.865	242; 273
Continuity in the doctor's office (1 item)	84.2%	86.1%	-1.9%	0.614	261; 528	76.3%	77.5%	-1.2%	0.729	274; 338	81.1%	78.8%	2.3%	0.551	235; 269
Continuity across health care settings (2 items)	3.6%	1.9%	1.6%	0.208	263; 527	2.8%	2.3%	0.6%	0.566	273; 339	3.2%	4.6%	-1.3%	0.317	242; 270
Care management (4 items)	72.6%	69.8%	2.7%	0.359	265; 534	68.1%	70.6%	-2.5%	0.387	281; 351	68.4%	73.3%	-5.0%	0.134	240; 273
Comprehensiveness (6 items)	51.4%	51.5%	-0.1%	0.960	266; 535	51.7%	51.0%	0.7%	0.802	281; 348	50.6%	53.0%	-2.5%	0.361	242; 273
Coordination (1 item)	64.6%	70.4%	-5.8%	0.308	158; 367	49.6%	61.5%	-11.9%	0.031	189; 224	59.4%	59.6%	-0.1%	0.985	150; 184
Patient and family caregiver engagement (7 items)	75.3%	72.8%	2.6%	0.348	266; 536	73.2%	74.5%	-1.3%	0.574	282; 351	76.2%	74.7%	1.4%	0.556	241; 273
Helpful, courteous, and respectful office staff (2 items)	86.0%	84.5%	1.5%	0.639	265; 537	84.9%	87.3%	-2.3%	0.417	279; 348	88.4%	89.1%	-0.6%	0.809	241; 272
Teamwork (1 item)	78.0%	80.2%	-2.2%	0.613	262; 531	78.8%	83.1%	-4.3%	0.210	276; 340	81.4%	84.7%	-3.3%	0.368	242; 270
Patients' rating of the primary care doctors and their staff (1 item)	85.1%	80.4%	4.8%	0.201	263; 536	83.0%	85.0%	-2.0%	0.562	278; 348	87.8%	86.9%	0.9%	0.794	240; 272
Suburban															
Access (9 items)	39.0%	37.4%	1.6%	0.265	551; 1,016	37.9%	38.2%	-0.3%	0.798	587; 741	52.1%	50.3%	1.8%	0.316	514; 637
Continuity in the doctor's office (1 item)	85.1%	84.9%	0.2%	0.936	544; 995	74.8%	76.4%	-1.6%	0.549	577; 727	77.1%	79.6%	-2.5%	0.388	508; 620
Continuity across health care settings (2 items)	3.5%	2.2%	1.3%	0.165	540; 1,002	2.1%	2.3%	-0.2%	0.784	577; 719	3.0%	2.8%	0.2%	0.731	511; 630
Care management (4 items)	70.6%	72.2%	-1.6%	0.437	550; 1,011	70.4%	70.6%	-0.3%	0.888	586; 737	74.4%	69.1%	5.3%	0.020	513; 636
Comprehensiveness (6 items)	49.9%	52.9%	-3.1%	0.107	551; 1,012	51.4%	54.8%	-3.4%	0.052	584; 738	53.1%	51.1%	2.0%	0.283	514; 637
Coordination (1 item)	68.9%	68.8%	0.1%	0.975	377; 711	61.2%	62.4%	-1.2%	0.710	438; 498	67.2%	55.6%	11.6%	0.004	371; 472
Patient and family caregiver engagement (7 items)	72.7%	76.0%	-3.3%	0.063	551; 1,014	72.9%	74.6%	-1.7%	0.248	587; 741	76.1%	75.6%	0.6%	0.728	510; 634
Helpful, courteous, and respectful office staff (2 items)	84.0%	86.7%	-2.7%	0.236	547; 1,012	83.2%	86.5%	-3.3%	0.094	585; 737	86.4%	87.0%	-0.5%	0.802	512; 635

Table 4.E.10c.2. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Teamwork (1 item)	80.1%	80.8%	-0.7%	0.795	542; 1,001	77.5%	80.6%	-3.1%	0.226	577; 720	83.1%	79.4%	3.7%	0.188	505; 630
Patients' rating of the primary care doctors and their staff (1 item)	85.7%	85.1%	0.6%	0.805	544; 1,005	83.6%	83.7%	0.0%	0.992	576; 729	87.4%	83.8%	3.6%	0.125	512; 633
Urban															
Access (9 items)	39.2%	38.6%	0.6%	0.366	2,742; 4,752	39.1%	38.5%	0.6%	0.323	2,906; 2,989	53.6%	51.7%	1.9%	0.019	2,516; 2,700
Continuity in the doctor's office (1 item)	83.5%	84.4%	-0.8%	0.455	2,692; 4,656	79.4%	80.1%	-0.7%	0.578	2,828; 2,915	80.7%	79.6%	1.2%	0.369	2,456; 2,641
Continuity across health care settings (2 items)	3.0%	2.5%	0.5%	0.240	2,677; 4,669	2.1%	2.2%	-0.2%	0.609	2,834; 2,927	2.3%	2.2%	0.0%	0.887	2,493; 2,672
Care management (4 items)	71.3%	71.4%	-0.2%	0.867	2,733; 4,728	71.3%	69.7%	1.6%	0.099	2,902; 2,984	71.9%	67.4%	4.4%	0.000	2,510; 2,690
Comprehensiveness (6 items)	51.2%	52.3%	-1.1%	0.188	2,735; 4,737	53.2%	52.0%	1.2%	0.166	2,895; 2,972	52.2%	49.4%	2.8%	0.001	2,516; 2,698
Coordination (1 item)	65.6%	67.4%	-1.9%	0.262	2,049; 3,510	59.5%	60.2%	-0.7%	0.679	2,236; 2,213	61.6%	58.8%	2.8%	0.099	1,906; 2,035
Patient and family caregiver engagement (7 items)	74.5%	74.8%	-0.3%	0.708	2,738; 4,743	76.2%	75.9%	0.3%	0.703	2,907; 2,987	76.1%	75.1%	1.0%	0.197	2,505; 2,683
Helpful, courteous, and respectful office staff (2 items)	84.5%	85.0%	-0.5%	0.625	2,724; 4,726	85.2%	84.9%	0.3%	0.763	2,896; 2,970	84.6%	85.2%	-0.6%	0.574	2,502; 2,685
Teamwork (1 item)	80.9%	79.4%	1.5%	0.211	2,684; 4,663	80.9%	80.5%	0.4%	0.695	2,861; 2,911	79.5%	77.1%	2.4%	0.062	2,490; 2,652
Patients' rating of the primary care doctors and their staff (1 item)	85.4%	84.7%	0.7%	0.497	2,721; 4,712	86.4%	86.0%	0.4%	0.666	2,876; 2,949	85.1%	85.0%	0.1%	0.951	2,497; 2,669

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year

Table 4.E.10c.2. (continued)

^a Geographic location is derived from the 2015-2016 Department of Health and Human Services' Area Health Resource File (AHRF). The variable used reflects 2013 data. The AHRF provides a 9-point rural-urban continuum code (RUCC) from the USDA Economic Research Service. From these codes, we defined urban as a county in a metro area of more than 250,000 people (RUCC=1 or 2), suburban as a county in a metro area of less than 250,000 people or that has an urban population of 20,000 or more and is adjacent to a metro area (RUCC=3 or 4), or rural if it does not meet the urban or suburban classifications (RUCC=5-9).

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.10d.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): prior primary care transformation^a, Track 1

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Participant in CPC Classic, MAPCP, or has medical home recognition															
Access (9 items)	38.3%	38.4%	-0.1%	0.839	1,859; 4,094	39.4%	38.1%	1.3%	0.054	2,029; 2,635	51.8%	51.9%	-0.1%	0.923	1,826; 2,301
Continuity in the doctor's office (1 item)	83.1%	83.3%	-0.2%	0.887	1,820; 4,010	79.5%	79.3%	0.2%	0.876	1,986; 2,579	79.1%	79.6%	-0.5%	0.737	1,787; 2,255
Continuity across health care settings (2 items)	2.7%	2.5%	0.2%	0.612	1,817; 4,021	1.7%	2.3%	-0.6%	0.090	1,980; 2,565	2.2%	2.3%	-0.1%	0.879	1,808; 2,280
Care management (4 items)	71.2%	71.8%	-0.6%	0.623	1,848; 4,076	70.4%	70.5%	-0.1%	0.936	2,026; 2,632	69.1%	68.2%	0.9%	0.479	1,823; 2,297
Comprehensiveness (6 items)	51.4%	52.6%	-1.3%	0.203	1,853; 4,083	53.5%	52.7%	0.8%	0.455	2,020; 2,618	50.9%	50.2%	0.6%	0.520	1,826; 2,299
Coordination (1 item)	66.0%	68.5%	-2.5%	0.194	1,291; 2,978	59.9%	61.9%	-2.0%	0.294	1,531; 1,904	57.3%	59.5%	-2.3%	0.275	1,367; 1,721
Patient and family caregiver engagement (7 items)	72.7%	74.4%	-1.6%	0.066	1,854; 4,087	75.4%	75.8%	-0.4%	0.691	2,030; 2,634	74.5%	75.6%	-1.1%	0.256	1,814; 2,289
Helpful, courteous, and respectful office staff (2 items)	82.7%	85.1%	-2.4%	0.036	1,850; 4,078	85.4%	85.5%	-0.1%	0.936	2,019; 2,622	84.4%	86.5%	-2.2%	0.060	1,822; 2,295
Teamwork (1 item)	76.8%	78.9%	-2.1%	0.152	1,809; 4,031	80.7%	80.3%	0.4%	0.748	1,992; 2,574	77.8%	78.0%	-0.2%	0.870	1,808; 2,263
Patients' rating of the primary care doctors and their staff (1 item)	83.1%	84.5%	-1.4%	0.275	1,844; 4,057	85.0%	84.5%	0.5%	0.657	1,996; 2,601	84.3%	85.6%	-1.3%	0.312	1,808; 2,286

Table 4.E.10d.1. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Not a participant in CPC Classic, MAPCP, and does not have medical home recognition															
Access (9 items)	37.4%	39.3%	-1.9%	0.024	1,683; 2,455	38.2%	38.3%	0.0%	0.970	1,789; 1,815	51.9%	52.1%	-0.2%	0.867	1,490; 1,523
Continuity in the doctor's office (1 item)	83.8%	86.5%	-2.7%	0.060	1,649; 2,404	82.2%	81.4%	0.7%	0.639	1,753; 1,780	82.7%	81.0%	1.6%	0.310	1,459; 1,493
Continuity across health care settings (2 items)	3.1%	3.3%	-0.2%	0.771	1,639; 2,413	2.6%	2.4%	0.2%	0.695	1,741; 1,759	1.9%	2.7%	-0.8%	0.051	1,472; 1,511
Care management (4 items)	71.0%	69.9%	1.1%	0.379	1,678; 2,447	70.5%	69.6%	0.9%	0.433	1,786; 1,810	70.0%	68.0%	2.0%	0.142	1,485; 1,519
Comprehensiveness (6 items)	50.5%	50.4%	0.1%	0.885	1,676; 2,450	51.8%	49.7%	2.1%	0.043	1,781; 1,804	51.0%	48.6%	2.4%	0.027	1,489; 1,523
Coordination (1 item)	66.2%	66.5%	-0.3%	0.905	1,210; 1,772	60.5%	56.5%	4.0%	0.059	1,326; 1,343	58.8%	58.6%	0.2%	0.925	1,145; 1,150
Patient and family caregiver engagement (7 items)	72.2%	74.0%	-1.8%	0.061	1,681; 2,453	75.0%	73.3%	1.7%	0.068	1,789; 1,815	74.2%	73.6%	0.6%	0.563	1,484; 1,517
Helpful, courteous, and respectful office staff (2 items)	83.9%	85.0%	-1.1%	0.391	1,669; 2,449	83.9%	85.9%	-2.0%	0.089	1,783; 1,806	84.0%	86.0%	-2.1%	0.138	1,485; 1,519
Teamwork (1 item)	80.0%	79.7%	0.3%	0.851	1,639; 2,417	80.9%	79.7%	1.2%	0.415	1,761; 1,783	80.2%	78.8%	1.4%	0.405	1,467; 1,497
Patients' rating of the primary care doctors and their staff (1 item)	85.0%	83.4%	1.6%	0.276	1,670; 2,434	86.5%	86.2%	0.3%	0.816	1,770; 1,792	86.4%	85.8%	0.6%	0.680	1,476; 1,509

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year

^a We determined a practice to have prior transformation experience if it participated in CPC Classic, CMMI's Multi-payer Advanced Primary Care Practice (MAPCP) initiative or has medical home recognition. We considered a practice to be a MAPCP participant if it participated in any year, 2011-2014 for 2017 Starters, as determined by a file from CMS. A practice was considered to have medical home recognition if it at least one of its primary care providers was listed as having recognition at some point 2014-2017 from a state, the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), National Community for Quality Assurance (NCQA), or Utilization Review Accreditation Commission (URAC), as determined by the June 2016 (for 2017 Starters) NCQA PCMH file and data extracted from the websites of TJC, AAAHC, URAC and state-specific sources between October 2016 and February 2017.

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.10d.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by practice characteristics (PY 2, PY 3, and PY 5): prior primary care transformation^a, Track 2

Composite measures	Track 2 – PY 2 (Wave 1)				Track 2 – PY 3 (Wave 2)				Track 2 – PY 5 (Wave 3)						
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Participant in CPC Classic, MAPCP, or has medical home recognition															
Access (9 items)	39.1%	38.4%	0.7%	0.249	2,903; 4,756	38.8%	38.2%	0.6%	0.273	3,077; 3,013	53.0%	51.4%	1.6%	0.048	2,628; 2,724
Continuity in the doctor's office (1 item)	83.3%	84.7%	-1.4%	0.192	2,850; 4,659	77.6%	79.3%	-1.6%	0.163	3,003; 2,939	79.6%	79.1%	0.6%	0.656	2,572; 2,667
Continuity across health care settings (2 items)	3.0%	2.3%	0.7%	0.091	2,835; 4,669	2.0%	2.3%	-0.3%	0.327	3,005; 2,943	2.4%	2.4%	0.0%	0.982	2,609; 2,695
Care management (4 items)	71.3%	71.7%	-0.4%	0.645	2,893; 4,732	70.9%	70.4%	0.4%	0.636	3,072; 3,006	71.9%	68.5%	3.4%	0.001	2,622; 2,716
Comprehensiveness (6 items)	51.0%	52.8%	-1.8%	0.029	2,898; 4,739	52.9%	52.9%	0.0%	0.968	3,065; 2,996	52.4%	50.4%	2.0%	0.023	2,628; 2,722
Coordination (1 item)	65.4%	68.0%	-2.7%	0.100	2,112; 3,480	58.6%	61.6%	-3.0%	0.058	2,332; 2,159	62.6%	59.1%	3.6%	0.039	1,965; 2,031
Patient and family caregiver engagement (7 items)	74.1%	75.1%	-1.0%	0.184	2,899; 4,746	75.6%	75.9%	-0.3%	0.716	3,078; 3,011	76.3%	75.5%	0.7%	0.340	2,616; 2,709
Helpful, courteous, and respectful office staff (2 items)	84.1%	85.4%	-1.4%	0.167	2,886; 4,730	85.3%	85.4%	-0.1%	0.877	3,065; 2,995	85.3%	86.0%	-0.7%	0.480	2,618; 2,710
Teamwork (1 item)	80.3%	79.6%	0.8%	0.528	2,845; 4,672	80.9%	80.8%	0.1%	0.907	3,024; 2,933	80.3%	78.3%	1.9%	0.128	2,600; 2,683
Patients' rating of the primary care doctors and their staff (1 item)	85.4%	84.7%	0.7%	0.520	2,877; 4,716	86.0%	85.5%	0.6%	0.579	3,043; 2,970	86.2%	85.3%	1.0%	0.374	2,612; 2,699
Not a participant in CPC Classic, MAPCP, and does not have medical home recognition															
Access (9 items)	38.7%	38.2%	0.5%	0.673	656; 1,549	37.9%	39.2%	-1.3%	0.243	698; 1,068	54.1%	51.5%	2.5%	0.073	644; 886
Continuity in the doctor's office (1 item)	86.2%	84.0%	2.3%	0.268	647; 1,520	81.8%	79.3%	2.5%	0.285	676; 1,041	82.4%	81.4%	1.0%	0.662	627; 863
Continuity across health care settings (2 items)	3.5%	2.8%	0.8%	0.302	645; 1,529	2.7%	2.1%	0.7%	0.378	679; 1,042	2.5%	2.7%	-0.2%	0.729	637; 877
Care management (4 items)	71.3%	70.3%	1.0%	0.591	655; 1,541	71.1%	67.9%	3.2%	0.059	697; 1,066	72.5%	67.1%	5.5%	0.005	641; 883
Comprehensiveness (6 items)	51.0%	50.2%	0.8%	0.599	654; 1,545	52.3%	50.1%	2.2%	0.121	695; 1,062	51.5%	48.1%	3.4%	0.031	644; 886
Coordination (1 item)	69.0%	67.2%	1.8%	0.556	472; 1,108	61.2%	56.5%	4.7%	0.133	531; 776	61.1%	55.3%	5.8%	0.082	462; 660
Patient and family caregiver engagement (7 items)	74.9%	73.6%	1.4%	0.372	656; 1,547	74.4%	74.3%	0.1%	0.918	698; 1,068	75.4%	73.4%	2.0%	0.169	640; 881
Helpful, courteous, and respectful office staff (2 items)	86.5%	84.3%	2.2%	0.207	650; 1,545	83.1%	85.1%	-2.0%	0.262	695; 1,060	84.7%	84.7%	0.0%	0.988	637; 882

Table 4.E.10d.2. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Teamwork (1 item)	81.3%	80.1%	1.2%	0.608	643; 1,523	77.2%	80.5%	-3.3%	0.149	690; 1,038	79.9%	76.8%	3.1%	0.196	637; 869
Patients' rating of the primary care doctors and their staff (1 item)	85.8%	83.2%	2.6%	0.222	651; 1,537	84.3%	85.8%	-1.5%	0.443	687; 1,056	83.3%	83.7%	-0.4%	0.844	637; 875

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year

^a We determined a practice to have prior transformation experience if it participated in CPC Classic, CMMI's Multi-payer Advanced Primary Care Practice (MAPCP) initiative or has medical home recognition. We considered a practice to be a MAPCP participant if it participated in any year, 2011-2014 for 2017 Starters, as determined by a file from CMS. A practice was considered to have medical home recognition if it at least one of its primary care providers was listed as having recognition at some point 2014-2017 from a state, the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), National Community for Quality Assurance (NCQA), or Utilization Review Accreditation Commission (URAC), as determined by the June 2016 (for 2017 Starters) NCQA PCMH file and data extracted from the websites of TJC, AAAHC, URAC and state-specific sources between October 2016 and February 2017.

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.11a.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries (HCC score in top quartile), Track 1

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
High-risk															
Access (9 items)	38.8%	40.6%	-1.8%	0.061	2,325; 1,333	39.2%	39.4%	-0.2%	0.744	1,725; 1,516	50.0%	51.8%	-1.8%	0.192	866; 746
Continuity in the doctor's office (1 item)	82.6%	82.0%	0.6%	0.740	2,268; 1,299	79.3%	78.8%	0.5%	0.743	1,682; 1,473	79.0%	77.1%	1.9%	0.403	844; 734
Continuity across health care settings (2 items)	5.6%	5.6%	0.0%	0.998	2,280; 1,290	4.1%	4.7%	-0.6%	0.297	1,673; 1,480	3.0%	3.9%	-0.9%	0.170	862; 735
Care management (4 items)	73.0%	72.7%	0.2%	0.856	2,317; 1,327	72.7%	71.8%	0.9%	0.425	1,722; 1,515	68.9%	69.2%	-0.3%	0.841	864; 746
Comprehensiveness (6 items)	51.9%	52.3%	-0.4%	0.738	2,322; 1,330	54.2%	53.1%	1.1%	0.257	1,713; 1,508	50.4%	50.8%	-0.4%	0.764	866; 746
Coordination (1 item)	63.5%	69.6%	-6.1%	0.008	1,858; 1,053	59.6%	59.8%	-0.2%	0.904	1,342; 1,204	57.0%	58.5%	-1.5%	0.622	707; 602
Patient and family caregiver engagement (7 items)	71.9%	73.1%	-1.2%	0.283	2,323; 1,332	74.0%	74.5%	-0.6%	0.543	1,725; 1,516	70.7%	72.6%	-2.0%	0.193	863; 739
Helpful, courteous, and respectful office staff (2 items)	81.1%	84.4%	-3.3%	0.033	2,318; 1,325	83.8%	85.4%	-1.6%	0.187	1,714; 1,505	82.3%	83.6%	-1.3%	0.506	864; 744
Teamwork (1 item)	76.3%	78.3%	-2.1%	0.259	2,288; 1,292	79.6%	79.1%	0.4%	0.772	1,687; 1,487	74.4%	76.0%	-1.6%	0.527	854; 737
Patients' rating of the primary care doctors and their staff (1 item)	82.6%	82.5%	0.2%	0.916	2,308; 1,316	86.6%	86.3%	0.3%	0.819	1,699; 1,491	80.9%	82.8%	-1.9%	0.378	860; 740
Not high-risk															
Access (9 items)	37.6%	38.2%	-0.6%	0.348	4,224; 2,209	38.8%	37.7%	1.0%	0.081	2,725; 2,302	52.2%	52.0%	0.2%	0.743	2,958; 2,570
Continuity in the doctor's office (1 item)	83.5%	85.4%	-1.9%	0.101	4,146; 2,170	81.2%	80.6%	0.6%	0.643	2,677; 2,266	81.1%	81.0%	0.1%	0.921	2,904; 2,512
Continuity across health care settings (2 items)	2.2%	2.1%	0.1%	0.832	4,154; 2,166	1.6%	1.7%	-0.1%	0.722	2,651; 2,241	1.8%	2.1%	-0.3%	0.388	2,929; 2,545
Care management (4 items)	70.5%	70.5%	0.0%	0.979	4,206; 2,199	69.9%	69.7%	0.2%	0.840	2,720; 2,297	69.4%	67.7%	1.7%	0.084	2,952; 2,562
Comprehensiveness (6 items)	50.7%	51.5%	-0.8%	0.345	4,211; 2,199	52.4%	50.9%	1.5%	0.079	2,709; 2,293	51.0%	49.2%	1.7%	0.029	2,956; 2,569
Coordination (1 item)	67.2%	66.7%	0.6%	0.751	2,892; 1,448	60.4%	59.3%	1.0%	0.554	1,905; 1,653	58.1%	59.3%	-1.1%	0.524	2,164; 1,910
Patient and family caregiver engagement (7 items)	72.5%	74.4%	-1.9%	0.014	4,217; 2,203	75.5%	74.6%	1.0%	0.194	2,724; 2,303	75.1%	75.1%	0.0%	0.997	2,943; 2,559
Helpful, courteous, and respectful office staff (2 items)	83.9%	85.2%	-1.3%	0.217	4,209; 2,194	85.0%	85.6%	-0.6%	0.503	2,714; 2,297	84.7%	86.8%	-2.1%	0.029	2,950; 2,563

Table 4.E.11a.1. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
Teamwork (1 item)	78.8%	79.4%	-0.6%	0.622	4,160; 2,156	81.1%	80.1%	1.0%	0.415	2,670; 2,266	79.9%	78.9%	1.0%	0.395	2,906; 2,538
Patients' rating of the primary care doctors and their staff (1 item)	84.3%	84.5%	-0.1%	0.905	4,183; 2,198	85.4%	84.9%	0.6%	0.603	2,694; 2,275	86.2%	86.3%	-0.1%	0.905	2,935; 2,544

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices. HCC scores were derived from Medicare FFS claims. Details of our methodology for calculating HCC scores are in the CPC+ Annual Reports.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year; HCC = hierarchical condition category

^a The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.11a.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries (HCC score in top quartile), Track 2

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
High-risk															
Access (9 items)	39.9%	40.2%	-0.3%	0.703	2,282; 1,272	38.5%	38.9%	-0.4%	0.576	1,585; 1,510	52.9%	50.3%	2.7%	0.065	808; 749
Continuity in the doctor's office (1 item)	83.6%	81.2%	2.4%	0.147	2,233; 1,244	77.0%	77.4%	-0.4%	0.781	1,538; 1,464	73.7%	74.5%	-0.8%	0.758	786; 737
Continuity across health care settings (2 items)	7.3%	5.0%	2.3%	0.011	2,242; 1,241	4.5%	4.3%	0.2%	0.699	1,544; 1,473	4.8%	3.9%	0.8%	0.275	801; 738
Care management (4 items)	75.8%	73.8%	2.0%	0.120	2,273; 1,268	72.8%	70.7%	2.1%	0.079	1,582; 1,508	73.8%	70.2%	3.6%	0.031	804; 749
Comprehensiveness (6 items)	52.7%	53.5%	-0.8%	0.485	2,279; 1,271	53.9%	52.9%	1.0%	0.339	1,575; 1,504	52.9%	51.0%	2.0%	0.164	808; 749
Coordination (1 item)	65.8%	67.8%	-2.0%	0.370	1,842; 1,035	58.2%	59.5%	-1.3%	0.505	1,226; 1,247	60.3%	61.7%	-1.4%	0.638	648; 591
Patient and family caregiver engagement (7 items)	73.3%	74.5%	-1.2%	0.265	2,279; 1,272	74.2%	74.7%	-0.5%	0.606	1,585; 1,511	74.1%	73.3%	0.8%	0.567	803; 743
Helpful, courteous, and respectful office staff (2 items)	84.6%	84.4%	0.2%	0.881	2,272; 1,261	85.9%	84.5%	1.3%	0.259	1,574; 1,503	83.0%	83.8%	-0.9%	0.639	803; 744
Teamwork (1 item)	77.7%	78.6%	-0.8%	0.635	2,239; 1,237	80.0%	79.0%	0.9%	0.514	1,541; 1,487	76.8%	76.4%	0.4%	0.873	798; 742
Patients' rating of the primary care doctors and their staff (1 item)	85.3%	83.9%	1.5%	0.349	2,260; 1,254	85.1%	85.5%	-0.4%	0.767	1,561; 1,491	85.5%	82.8%	2.7%	0.185	801; 745
Not high-risk															
Access (9 items)	38.8%	37.8%	1.0%	0.103	4,023; 2,287	38.7%	38.2%	0.5%	0.456	2,496; 2,265	53.2%	51.6%	1.6%	0.040	2,802; 2,523
Continuity in the doctor's office (1 item)	83.7%	85.5%	-1.9%	0.108	3,946; 2,253	78.8%	79.7%	-1.0%	0.445	2,442; 2,215	81.6%	80.5%	1.0%	0.409	2,744; 2,462
Continuity across health care settings (2 items)	2.0%	1.7%	0.3%	0.446	3,956; 2,239	1.5%	1.7%	-0.2%	0.545	2,441; 2,211	1.9%	2.1%	-0.2%	0.500	2,771; 2,508
Care management (4 items)	70.0%	70.8%	-0.8%	0.440	4,000; 2,280	70.5%	69.8%	0.7%	0.474	2,490; 2,261	71.6%	67.7%	3.9%	0.000	2,795; 2,514
Comprehensiveness (6 items)	50.6%	52.0%	-1.5%	0.091	4,005; 2,281	52.6%	52.3%	0.3%	0.753	2,483; 2,256	52.0%	49.8%	2.2%	0.008	2,800; 2,523
Coordination (1 item)	66.0%	68.0%	-2.0%	0.272	2,746; 1,549	59.4%	61.0%	-1.6%	0.363	1,709; 1,616	62.7%	57.7%	5.0%	0.004	2,043; 1,836
Patient and family caregiver engagement (7 items)	74.5%	74.8%	-0.3%	0.712	4,014; 2,283	75.8%	75.8%	0.0%	0.980	2,494; 2,265	76.5%	75.6%	0.9%	0.208	2,787; 2,513
Helpful, courteous, and respectful office staff (2 items)	84.5%	85.4%	-0.9%	0.392	4,003; 2,275	84.6%	85.6%	-1.0%	0.332	2,481; 2,257	85.6%	86.2%	-0.6%	0.563	2,789; 2,511

Table 4.E.11a.2. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
Teamwork (1 item)	81.2%	79.8%	1.4%	0.265	3,956; 2,251	80.3%	81.1%	-0.8%	0.511	2,430; 2,227	80.9%	78.5%	2.5%	0.050	2,754; 2,495
Patients' rating of the primary care doctors and their staff (1 item)	85.4%	84.4%	1.0%	0.375	3,993; 2,274	85.9%	85.5%	0.4%	0.707	2,465; 2,239	85.7%	85.4%	0.3%	0.790	2,773; 2,504

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices. HCC scores were derived from Medicare FFS claims. Details of our methodology for calculating HCC scores are in the CPC+ Annual Reports.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year; HCC = hierarchical condition category

^a The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.11b.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries (HCC score in top 10 percent or has Dementia), Track 1

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
High-risk															
Access (9 items)	39.4%	41.0%	-1.6%	0.250	1,052; 643	38.9%	39.5%	-0.6%	0.619	711; 592	49.3%	50.9%	-1.6%	0.454	340; 298
Continuity in the doctor's office (1 item)	83.7%	80.9%	2.8%	0.276	1,025; 624	79.7%	77.6%	2.1%	0.391	696; 572	76.4%	74.4%	2.0%	0.584	335; 295
Continuity across health care settings (2 items)	6.6%	7.1%	-0.5%	0.746	1,034; 616	4.9%	6.6%	-1.6%	0.151	687; 579	3.9%	6.5%	-2.5%	0.069	338; 294
Care management (4 items)	73.7%	73.3%	0.4%	0.858	1,046; 639	71.7%	72.7%	-1.0%	0.585	710; 591	68.1%	68.5%	-0.4%	0.879	340; 298
Comprehensiveness (6 items)	54.5%	53.8%	0.7%	0.698	1,050; 642	52.9%	54.5%	-1.6%	0.331	705; 587	50.1%	51.8%	-1.8%	0.436	340; 298
Coordination (1 item)	61.9%	68.2%	-6.3%	0.065	833; 506	57.4%	60.3%	-2.9%	0.394	561; 466	55.3%	58.3%	-3.0%	0.542	267; 243
Patient and family caregiver engagement (7 items)	73.2%	74.3%	-1.1%	0.510	1,050; 642	74.4%	73.9%	0.5%	0.746	711; 592	71.5%	72.5%	-1.0%	0.686	337; 296
Helpful, courteous, and respectful office staff (2 items)	82.7%	85.7%	-2.9%	0.135	1,049; 638	82.7%	85.1%	-2.3%	0.227	705; 586	81.1%	81.4%	-0.3%	0.924	339; 298
Teamwork (1 item)	77.3%	75.9%	1.4%	0.610	1,036; 624	76.4%	79.4%	-3.0%	0.248	695; 579	73.6%	76.0%	-2.4%	0.524	336; 294
Patients' rating of the primary care doctors and their staff (1 item)	83.0%	83.2%	-0.2%	0.937	1,044; 639	85.8%	86.0%	-0.2%	0.939	698; 586	79.8%	80.3%	-0.5%	0.889	339; 297
Not high-risk															
Access (9 items)	37.7%	38.5%	-0.8%	0.170	5,497; 2,899	38.9%	37.9%	0.9%	0.089	3,739; 3,226	52.0%	52.0%	0.0%	0.960	3,484; 3,018
Continuity in the doctor's office (1 item)	83.2%	85.0%	-1.8%	0.077	5,389; 2,845	80.9%	80.5%	0.4%	0.711	3,663; 3,167	81.1%	80.8%	0.3%	0.807	3,413; 2,951
Continuity across health care settings (2 items)	2.5%	2.4%	0.1%	0.691	5,400; 2,840	1.8%	1.9%	-0.1%	0.820	3,637; 3,142	1.9%	2.1%	-0.2%	0.433	3,453; 2,986
Care management (4 items)	70.8%	70.8%	0.0%	0.998	5,477; 2,887	70.4%	69.8%	0.5%	0.561	3,732; 3,221	69.5%	67.9%	1.6%	0.105	3,476; 3,010
Comprehensiveness (6 items)	50.5%	51.4%	-0.9%	0.245	5,483; 2,887	52.8%	51.0%	1.8%	0.024	3,717; 3,214	50.9%	49.3%	1.6%	0.033	3,482; 3,017
Coordination (1 item)	66.8%	67.4%	-0.6%	0.713	3,917; 1,995	60.5%	59.3%	1.1%	0.463	2,686; 2,391	58.2%	59.2%	-1.1%	0.519	2,604; 2,269
Patient and family caregiver engagement (7 items)	72.3%	74.2%	-1.8%	0.009	5,490; 2,893	75.3%	74.6%	0.7%	0.318	3,738; 3,227	74.6%	74.8%	-0.2%	0.740	3,469; 3,002
Helpful, courteous, and respectful office staff (2 items)	83.3%	84.9%	-1.7%	0.077	5,478; 2,881	85.0%	85.7%	-0.7%	0.430	3,723; 3,216	84.5%	86.6%	-2.1%	0.024	3,475; 3,009

Table 4.E.11b.1. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)				Track 1 – PY 3 (Wave 2)				Track 1 – PY 5 (Wave 3)						
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
Teamwork (1 item)	78.3%	79.6%	-1.3%	0.257	5,412; 2,824	81.2%	80.0%	1.3%	0.225	3,662; 3,174	79.4%	78.5%	0.8%	0.468	3,424; 2,981
Patients' rating of the primary care doctors and their staff (1 item)	84.1%	84.1%	-0.1%	0.955	5,447; 2,875	85.7%	85.1%	0.6%	0.526	3,695; 3,180	85.7%	86.1%	-0.4%	0.696	3,456; 2,987

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year; HCC = hierarchical condition category

^a The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.11b.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries (HCC score in top 10 percent or has Dementia), Track 2

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
High-risk															
Access (9 items)	40.4%	40.3%	0.1%	0.960	1,042; 620	36.9%	38.7%	-1.8%	0.149	650; 581	51.4%	50.4%	1.0%	0.667	305; 276
Continuity in the doctor's office (1 item)	82.3%	80.9%	1.4%	0.574	1,018; 605	73.9%	75.0%	-1.2%	0.667	632; 563	72.3%	71.4%	0.9%	0.815	296; 271
Continuity across health care settings (2 items)	9.4%	7.1%	2.4%	0.132	1,025; 607	6.8%	5.5%	1.3%	0.358	634; 567	5.6%	6.6%	-1.0%	0.552	303; 274
Care management (4 items)	75.7%	74.5%	1.3%	0.495	1,037; 616	72.4%	70.8%	1.6%	0.417	649; 580	73.8%	70.2%	3.6%	0.214	305; 275
Comprehensiveness (6 items)	52.3%	56.2%	-3.9%	0.020	1,039; 620	52.5%	53.3%	-0.7%	0.674	644; 577	50.9%	52.2%	-1.3%	0.569	305; 276
Coordination (1 item)	65.3%	67.1%	-1.8%	0.564	840; 491	56.8%	58.2%	-1.4%	0.687	505; 466	59.3%	60.7%	-1.4%	0.782	234; 214
Patient and family caregiver engagement (7 items)	73.6%	76.0%	-2.4%	0.119	1,040; 620	73.1%	73.5%	-0.4%	0.825	650; 581	72.0%	73.2%	-1.2%	0.598	304; 273
Helpful, courteous, and respectful office staff (2 items)	85.1%	85.4%	-0.2%	0.912	1,037; 613	83.1%	83.3%	-0.1%	0.959	642; 576	81.2%	82.7%	-1.5%	0.623	303; 273
Teamwork (1 item)	75.6%	77.3%	-1.6%	0.533	1,015; 604	74.8%	79.3%	-4.4%	0.095	628; 568	75.1%	78.2%	-3.0%	0.429	300; 271
Patients' rating of the primary care doctors and their staff (1 item)	84.9%	84.6%	0.3%	0.898	1,030; 610	81.4%	83.8%	-2.3%	0.325	642; 569	84.6%	80.3%	4.3%	0.178	301; 275
Not high-risk															
Access (9 items)	38.9%	38.1%	0.8%	0.190	5,263; 2,939	38.8%	38.3%	0.5%	0.385	3,431; 3,194	53.3%	51.5%	1.8%	0.013	3,305; 2,996
Continuity in the doctor's office (1 item)	83.8%	85.0%	-1.1%	0.277	5,161; 2,892	78.9%	79.7%	-0.8%	0.465	3,348; 3,116	80.8%	80.1%	0.7%	0.521	3,234; 2,928
Continuity across health care settings (2 items)	2.5%	1.9%	0.5%	0.128	5,173; 2,873	1.7%	1.9%	-0.2%	0.384	3,351; 3,117	2.1%	2.1%	0.0%	0.993	3,269; 2,972
Care management (4 items)	70.8%	71.1%	-0.3%	0.725	5,236; 2,932	70.8%	69.9%	0.9%	0.293	3,423; 3,189	71.9%	68.0%	3.8%	0.000	3,294; 2,988
Comprehensiveness (6 items)	50.9%	51.9%	-1.0%	0.218	5,245; 2,932	52.9%	52.3%	0.5%	0.495	3,414; 3,183	52.2%	49.8%	2.4%	0.003	3,303; 2,996
Coordination (1 item)	66.0%	68.0%	-2.0%	0.205	3,748; 2,093	59.4%	60.9%	-1.6%	0.303	2,430; 2,397	62.6%	58.3%	4.3%	0.007	2,457; 2,213
Patient and family caregiver engagement (7 items)	74.3%	74.6%	-0.3%	0.697	5,253; 2,935	75.7%	75.8%	-0.1%	0.890	3,429; 3,195	76.4%	75.3%	1.0%	0.132	3,286; 2,983

Table 4.E.11b.2. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
Helpful, courteous, and respectful office staff (2 items)	84.4%	85.1%	-0.7%	0.473	5,238; 2,923	85.1%	85.6%	-0.5%	0.563	3,413; 3,184	85.5%	86.0%	-0.6%	0.539	3,289; 2,982
Teamwork (1 item)	81.0%	79.8%	1.2%	0.309	5,180; 2,884	80.8%	80.8%	0.0%	0.985	3,343; 3,146	80.6%	78.1%	2.5%	0.036	3,252; 2,966
Patients' rating of the primary care doctors and their staff (1 item)	85.4%	84.2%	1.2%	0.238	5,223; 2,918	86.2%	85.7%	0.5%	0.609	3,384; 3,161	85.8%	85.4%	0.4%	0.671	3,273; 2,974

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year; HCC = hierarchical condition category

^a The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.11c.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries based on having a serious mental illness^a (Track 1)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
High-risk															
Access (9 items)	32.4%	36.7%	-4.3%	0.609	1,048; 641	45.3%	39.8%	5.5%	0.418	709; 591	62.5%	56.4%	6.1%	0.565	337; 297
Continuity in the doctor's office (1 item)	88.9%	75.8%	13.1%	0.223	1,021; 622	77.7%	83.6%	-5.9%	0.657	694; 571	75.8%	91.4%	-15.6%	0.378	332; 294
Continuity across health care settings (2 items)	2.1%	5.1%	-3.0%	0.428	1,030; 614	5.3%	2.4%	2.9%	0.534	685; 578	0.8%	8.1%	-7.3%	0.228	335; 293
Care management (4 items)	66.3%	72.9%	-6.6%	0.483	1,042; 637	72.8%	66.6%	6.2%	0.461	708; 590	71.5%	78.3%	-6.8%	0.598	337; 297
Comprehensiveness (6 items)	55.0%	61.3%	-6.3%	0.504	1,046; 640	54.7%	53.0%	1.7%	0.842	703; 586	53.1%	52.0%	1.1%	0.936	337; 297
Coordination (1 item)	65.6%	71.0%	-5.4%	0.753	829; 504	55.9%	70.6%	-14.7%	0.391	559; 465	51.0%	29.8%	21.3%	0.386	265; 243
Patient and family caregiver engagement (7 items)	57.2%	58.4%	-1.2%	0.921	1,046; 640	74.3%	65.1%	9.2%	0.259	709; 591	73.4%	59.9%	13.4%	0.325	334; 295
Helpful, courteous, and respectful office staff (2 items)	75.9%	77.1%	-1.2%	0.907	1,045; 636	81.5%	89.2%	-7.7%	0.490	703; 585	94.1%	74.9%	19.2%	0.161	336; 297
Teamwork (1 item)	69.7%	60.4%	9.2%	0.619	1,032; 622	84.4%	77.0%	7.3%	0.625	693; 578	85.6%	50.7%	34.8%	0.150	333; 293
Patients' rating of the primary care doctors and their staff (1 item)	55.5%	60.8%	-5.3%	0.754	1,040; 637	77.1%	82.3%	-5.2%	0.731	697; 585	78.7%	63.0%	15.8%	0.550	336; 296
Not high-risk															
Access (9 items)	37.9%	38.8%	-0.8%	0.123	5,501; 2,901	38.8%	38.1%	0.8%	0.135	3,741; 3,227	51.8%	52.0%	-0.1%	0.882	3,487; 3,019
Continuity in the doctor's office (1 item)	83.4%	84.7%	-1.3%	0.170	5,393; 2,847	80.8%	80.2%	0.6%	0.564	3,665; 3,168	80.7%	80.3%	0.4%	0.721	3,416; 2,952
Continuity across health care settings (2 items)	2.9%	2.8%	0.1%	0.808	5,404; 2,842	2.1%	2.3%	-0.2%	0.433	3,639; 3,143	2.1%	2.5%	-0.3%	0.218	3,456; 2,987
Care management (4 items)	71.1%	71.0%	0.1%	0.925	5,481; 2,889	70.5%	70.1%	0.4%	0.666	3,734; 3,222	69.4%	68.0%	1.5%	0.116	3,479; 3,011
Comprehensiveness (6 items)	51.0%	51.6%	-0.7%	0.354	5,487; 2,889	52.8%	51.3%	1.5%	0.049	3,719; 3,215	50.9%	49.5%	1.4%	0.052	3,485; 3,018
Coordination (1 item)	66.2%	67.5%	-1.3%	0.354	3,921; 1,997	60.2%	59.4%	0.8%	0.583	2,688; 2,392	58.0%	59.2%	-1.2%	0.441	2,606; 2,269
Patient and family caregiver engagement (7 items)	72.5%	74.2%	-1.7%	0.009	5,494; 2,895	75.2%	74.6%	0.6%	0.325	3,740; 3,228	74.4%	74.7%	-0.3%	0.635	3,472; 3,003
Helpful, courteous, and respectful office staff (2 items)	83.3%	85.1%	-1.8%	0.040	5,482; 2,883	84.8%	85.6%	-0.8%	0.319	3,725; 3,217	84.2%	86.3%	-2.1%	0.021	3,478; 3,010

Table 4.E.11c.1. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Teamwork (1 item)	78.3%	79.3%	-1.0%	0.346	5,416; 2,826	80.8%	79.9%	0.9%	0.386	3,664; 3,175	78.9%	78.3%	0.5%	0.615	3,427; 2,982
Patients' rating of the primary care doctors and their staff (1 item)	84.1%	84.1%	0.0%	0.977	5,451; 2,877	85.7%	85.2%	0.5%	0.537	3,696; 3,181	85.3%	85.8%	-0.4%	0.638	3,459; 2,988

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year

^a Beneficiaries with behavioral health conditions (HCCs for schizophrenia or major depressive, bipolar, and paranoid disorders, or drug/alcohol psychosis or drug/alcohol dependence) at baseline (2016).

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The *p*-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The *p*-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.11c.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): high risk beneficiaries based on having a serious mental illness^a (Track 2)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
High-risk															
Access (9 items)	39.0%	36.2%	2.7%	0.659	1,042; 620	47.4%	38.3%	9.0%	0.102	650; 581	43.1%	54.2%	-11.1%	0.301	305; 276
Continuity in the doctor's office (1 item)	82.0%	70.4%	11.6%	0.403	1,018; 605	77.0%	83.1%	-6.1%	0.604	632; 563	58.2%	67.0%	-8.9%	0.648	296; 271
Continuity across health care settings (2 items)	0.2%	6.1%	-6.0%	0.035	1,025; 607	5.7%	4.5%	1.3%	0.766	634; 567	0.2%	8.7%	-8.6%	0.054	303; 274
Care management (4 items)	80.7%	79.7%	1.0%	0.909	1,037; 616	73.7%	68.5%	5.2%	0.517	649; 580	71.5%	75.3%	-3.8%	0.708	305; 275
Comprehensiveness (6 items)	55.2%	69.6%	-14.4%	0.076	1,039; 620	62.6%	55.8%	6.9%	0.295	644; 577	56.4%	51.5%	4.8%	0.627	305; 276
Coordination (1 item)	69.1%	69.2%	-0.1%	0.995	840; 491	65.9%	52.6%	13.3%	0.391	505; 466	57.3%	32.5%	24.8%	0.213	234; 214
Patient and family caregiver engagement (7 items)	74.7%	63.6%	11.1%	0.217	1,040; 620	73.1%	67.5%	5.6%	0.410	650; 581	58.7%	60.9%	-2.2%	0.840	304; 273
Helpful, courteous, and respectful office staff (2 items)	85.7%	68.3%	17.4%	0.249	1,037; 613	85.7%	89.3%	-3.6%	0.639	642; 576	62.8%	78.6%	-15.7%	0.329	303; 273
Teamwork (1 item)	96.7%	58.9%	37.8%	0.001	1,015; 604	82.7%	73.7%	9.0%	0.415	628; 568	48.0%	60.7%	-12.6%	0.539	300; 271
Patients' rating of the primary care doctors and their staff (1 item)	74.8%	60.8%	14.0%	0.359	1,030; 610	82.1%	80.2%	1.8%	0.861	642; 569	87.2%	64.1%	23.1%	0.213	301; 275
Not high-risk															
Access (9 items)	39.1%	38.4%	0.7%	0.217	5,263; 2,939	38.6%	38.4%	0.2%	0.675	3,431; 3,194	53.2%	51.4%	1.8%	0.010	3,305; 2,996
Continuity in the doctor's office (1 item)	83.8%	84.7%	-0.9%	0.349	5,161; 2,892	78.5%	79.3%	-0.8%	0.424	3,348; 3,116	80.3%	79.5%	0.8%	0.475	3,234; 2,928
Continuity across health care settings (2 items)	3.2%	2.4%	0.8%	0.033	5,173; 2,873	2.1%	2.2%	-0.1%	0.701	3,351; 3,117	2.5%	2.5%	0.0%	0.926	3,269; 2,972
Care management (4 items)	71.3%	71.4%	-0.2%	0.854	5,236; 2,932	70.9%	70.0%	1.0%	0.246	3,423; 3,189	72.0%	68.2%	3.9%	0.000	3,294; 2,988
Comprehensiveness (6 items)	51.0%	52.3%	-1.3%	0.085	5,245; 2,932	52.8%	52.4%	0.4%	0.604	3,414; 3,183	52.2%	50.0%	2.2%	0.005	3,303; 2,996
Coordination (1 item)	66.0%	68.0%	-2.0%	0.171	3,748; 2,093	59.1%	60.7%	-1.6%	0.253	2,430; 2,397	62.3%	58.4%	3.9%	0.011	2,457; 2,213
Patient and family caregiver engagement (7 items)	74.2%	74.8%	-0.6%	0.383	5,253; 2,935	75.5%	75.6%	-0.2%	0.797	3,429; 3,195	76.1%	75.2%	0.9%	0.162	3,286; 2,983
Helpful, courteous, and respectful office staff (2 items)	84.5%	85.3%	-0.7%	0.409	5,238; 2,923	84.9%	85.4%	-0.5%	0.580	3,413; 3,184	85.3%	85.8%	-0.5%	0.548	3,289; 2,982

Table 4.E.11c.2. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^b	N (CPC+; Comparison)
Teamwork (1 item)	80.4%	79.7%	0.7%	0.533	5,180; 2,884	80.3%	80.7%	-0.5%	0.639	3,343; 3,146	80.4%	78.1%	2.2%	0.047	3,252; 2,966
Patients' rating of the primary care doctors and their staff (1 item)	85.5%	84.4%	1.0%	0.265	5,223; 2,918	85.8%	85.5%	0.2%	0.807	3,384; 3,161	85.6%	85.1%	0.5%	0.570	3,273; 2,974

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year

^a Beneficiaries with behavioral health conditions (HCCs for schizophrenia or major depressive, bipolar, and paranoid disorders, or drug/alcohol psychosis or drug/alcohol dependence) at baseline (2016).

^b The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.11d.1. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): race (Track 1)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
White (non-Hispanic)															
Access (9 items)	37.8%	38.8%	-1.0%	0.073	5,785; 3,147	39.0%	38.3%	0.6%	0.224	3,972; 3,370	52.7%	52.1%	0.5%	0.464	3,393; 2,962
Continuity in the doctor's office (1 item)	84.3%	85.3%	-1.0%	0.318	5,669; 3,083	80.8%	80.9%	-0.1%	0.900	3,899; 3,310	80.9%	81.4%	-0.4%	0.696	3,307; 2,883
Continuity across health care settings (2 items)	2.7%	2.7%	0.1%	0.813	5,679; 3,068	1.9%	2.0%	-0.1%	0.708	3,863; 3,287	2.2%	2.4%	-0.2%	0.465	3,365; 2,931
Care management (4 items)	71.3%	71.0%	0.4%	0.673	5,755; 3,134	70.2%	70.4%	-0.3%	0.749	3,964; 3,366	69.6%	68.0%	1.6%	0.098	3,386; 2,956
Comprehensiveness (6 items)	50.8%	51.7%	-0.9%	0.229	5,767; 3,134	52.5%	51.2%	1.3%	0.095	3,948; 3,357	51.1%	49.7%	1.5%	0.051	3,391; 2,962
Coordination (1 item)	66.0%	67.7%	-1.7%	0.266	4,203; 2,246	60.1%	59.7%	0.4%	0.803	2,923; 2,547	58.1%	59.5%	-1.4%	0.393	2,554; 2,276
Patient and family caregiver engagement (7 items)	73.2%	75.1%	-1.8%	0.008	5,773; 3,141	75.3%	75.5%	-0.2%	0.750	3,971; 3,371	75.1%	75.3%	-0.3%	0.714	3,376; 2,945
Helpful, courteous, and respectful office staff (2 items)	83.9%	85.7%	-1.8%	0.043	5,760; 3,131	84.9%	86.4%	-1.5%	0.067	3,952; 3,357	84.7%	86.7%	-2.1%	0.022	3,363; 2,929
Teamwork (1 item)	79.7%	80.2%	-0.6%	0.617	5,684; 3,062	80.8%	80.8%	0.0%	0.993	3,891; 3,311	79.3%	79.2%	0.0%	0.969	3,316; 2,897
Patients' rating of the primary care doctors and their staff (1 item)	84.9%	85.0%	-0.1%	0.892	5,729; 3,121	85.6%	86.0%	-0.4%	0.655	3,920; 3,329	85.9%	86.2%	-0.3%	0.763	3,344; 2,910
Black or African American (non-Hispanic)															
Access (9 items)	41.2%	36.9%	4.3%	0.066	281; 120	39.8%	36.6%	3.2%	0.240	166; 138	46.2%	50.3%	-4.1%	0.219	158; 109
Continuity in the doctor's office (1 item)	78.8%	83.2%	-4.4%	0.423	271; 117	81.5%	77.5%	4.0%	0.437	160; 131	77.1%	69.4%	7.7%	0.213	154; 102
Continuity across health care settings (2 items)	5.0%	5.3%	-0.3%	0.887	275; 120	2.1%	4.5%	-2.5%	0.121	159; 133	3.0%	2.8%	0.2%	0.905	157; 106
Care management (4 items)	71.5%	68.7%	2.8%	0.510	281; 120	72.4%	74.1%	-1.7%	0.696	166; 137	66.4%	71.6%	-5.2%	0.283	158; 108
Comprehensiveness (6 items)	53.6%	52.1%	1.5%	0.662	281; 120	52.3%	56.5%	-4.2%	0.218	165; 137	51.8%	50.4%	1.3%	0.732	158; 109
Coordination (1 item)	78.2%	76.0%	2.2%	0.743	180; 79	62.3%	58.4%	3.9%	0.618	117; 92	63.0%	50.9%	12.0%	0.155	111; 72
Patient and family caregiver engagement (7 items)	66.2%	69.2%	-3.0%	0.369	281; 120	72.4%	70.1%	2.4%	0.480	166; 138	69.8%	65.7%	4.2%	0.277	158; 108
Helpful, courteous, and respectful office staff (2 items)	81.1%	82.3%	-1.2%	0.794	280; 120	87.2%	83.0%	4.2%	0.303	164; 136	87.0%	82.7%	4.3%	0.324	157; 105

Table 4.E.11d.1. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
Teamwork (1 item)	71.9%	79.0%	-7.2%	0.215	277; 116	80.3%	73.3%	7.0%	0.219	162; 135	80.8%	70.1%	10.7%	0.073	153; 104
Patients' rating of the primary care doctors and their staff (1 item)	81.5%	78.5%	3.0%	0.573	278; 120	86.2%	81.2%	5.0%	0.304	164; 134	80.4%	77.5%	2.8%	0.608	156; 103
All other races (non-Hispanic)															
Access (9 items)	35.5%	38.6%	-3.1%	0.208	282; 182	36.9%	37.5%	-0.6%	0.832	154; 215	46.5%	49.0%	-2.5%	0.459	152; 181
Continuity in the doctor's office (1 item)	79.2%	78.0%	1.2%	0.811	272; 173	79.3%	67.6%	11.7%	0.040	147; 209	77.5%	70.1%	7.4%	0.209	148; 172
Continuity across health care settings (2 items)	2.2%	3.3%	-1.1%	0.540	278; 177	3.9%	6.9%	-3.0%	0.228	150; 208	1.4%	2.1%	-0.7%	0.364	151; 180
Care management (4 items)	65.8%	69.6%	-3.8%	0.367	280; 180	73.5%	64.8%	8.7%	0.041	153; 212	68.6%	65.0%	3.6%	0.397	152; 181
Comprehensiveness (6 items)	50.0%	48.7%	1.3%	0.690	281; 181	57.1%	48.1%	9.0%	0.015	151; 213	48.6%	48.1%	0.5%	0.869	152; 181
Coordination (1 item)	67.3%	66.5%	0.7%	0.920	199; 120	57.4%	54.8%	2.6%	0.723	105; 149	49.6%	49.7%	-0.1%	0.988	115; 133
Patient and family caregiver engagement (7 items)	67.8%	66.9%	0.9%	0.799	281; 181	76.8%	65.1%	11.7%	0.001	154; 215	69.7%	68.6%	1.1%	0.750	151; 181
Helpful, courteous, and respectful office staff (2 items)	77.1%	78.1%	-1.0%	0.848	281; 178	80.0%	77.1%	3.0%	0.544	154; 215	77.1%	82.4%	-5.3%	0.270	149; 179
Teamwork (1 item)	67.6%	67.7%	-0.2%	0.979	277; 179	80.9%	72.6%	8.3%	0.153	147; 212	74.2%	70.5%	3.6%	0.520	148; 180
Patients' rating of the primary care doctors and their staff (1 item)	78.1%	77.1%	1.0%	0.843	279; 180	84.8%	76.3%	8.5%	0.105	150; 212	78.9%	81.3%	-2.4%	0.647	148; 178
Hispanic (any race)															
Access (9 items)	37.2%	40.2%	-2.9%	0.466	173; 71	39.0%	36.4%	2.6%	0.454	126; 74	51.3%	46.4%	4.8%	0.356	76; 62
Continuity in the doctor's office (1 item)	71.2%	78.9%	-7.7%	0.334	167; 69	79.8%	81.3%	-1.6%	0.813	120; 68	72.8%	68.0%	4.7%	0.597	73; 58
Continuity across health care settings (2 items)	8.9%	5.3%	3.6%	0.326	170; 69	7.7%	3.7%	4.0%	0.199	122; 71	2.7%	5.0%	-2.3%	0.342	75; 61
Care management (4 items)	77.8%	71.8%	5.9%	0.275	173; 70	67.7%	70.8%	-3.1%	0.609	125; 74	70.5%	68.0%	2.5%	0.704	76; 62
Comprehensiveness (6 items)	57.4%	54.2%	3.1%	0.495	173; 71	49.5%	57.4%	-7.9%	0.104	124; 74	51.6%	45.9%	5.7%	0.320	76; 61
Coordination (1 item)	49.0%	61.4%	-12.4%	0.245	133; 39	59.9%	67.1%	-7.2%	0.450	87; 58	57.7%	46.4%	11.3%	0.327	56; 41
Patient and family caregiver engagement (7 items)	67.2%	68.5%	-1.3%	0.764	173; 71	67.3%	70.3%	-3.0%	0.545	125; 74	66.7%	68.3%	-1.6%	0.745	75; 61

Table 4.E.11d.1. (continued)

Composite measures	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
Helpful, courteous, and respectful office staff (2 items)	78.2%	82.5%	-4.3%	0.491	171; 69	79.6%	84.3%	-4.8%	0.448	125; 72	75.0%	77.6%	-2.6%	0.709	75; 61
Teamwork (1 item)	65.3%	72.8%	-7.5%	0.357	173; 69	77.7%	76.2%	1.5%	0.830	123; 72	72.8%	64.1%	8.7%	0.308	73; 61
Patients' rating of the primary care doctors and their staff (1 item)	77.8%	84.5%	-6.7%	0.288	172; 70	79.7%	80.8%	-1.1%	0.870	123; 72	84.0%	75.2%	8.9%	0.266	74; 60

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year

^a The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.11d.2. Predicted percentage of Medicare FFS beneficiaries attributed to CPC+ and comparison practices giving the best response to items in the composites, by track, by patient characteristics (PY 2, PY 3, and PY 5): race (Track 2)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
White (non-Hispanic)															
Access (9 items)	39.0%	38.5%	0.5%	0.365	5,614; 3,157	39.0%	38.6%	0.3%	0.539	3,665; 3,347	53.6%	51.6%	2.0%	0.008	3,206; 2,904
Continuity in the doctor's office (1 item)	83.7%	85.6%	-1.9%	0.068	5,514; 3,097	78.2%	80.2%	-1.9%	0.084	3,587; 3,263	80.8%	80.7%	0.1%	0.918	3,114; 2,816
Continuity across health care settings (2 items)	3.0%	2.2%	0.8%	0.037	5,517; 3,086	2.0%	1.9%	0.1%	0.655	3,579; 3,261	2.6%	2.3%	0.3%	0.403	3,177; 2,880
Care management (4 items)	71.2%	71.3%	-0.1%	0.882	5,584; 3,146	71.2%	70.4%	0.9%	0.319	3,657; 3,341	72.4%	68.3%	4.1%	0.000	3,197; 2,895
Comprehensiveness (6 items)	51.0%	52.5%	-1.5%	0.050	5,595; 3,151	52.5%	52.4%	0.2%	0.823	3,647; 3,331	52.6%	50.2%	2.4%	0.003	3,204; 2,904
Coordination (1 item)	66.5%	68.5%	-2.0%	0.190	4,097; 2,316	59.5%	61.0%	-1.5%	0.309	2,653; 2,538	62.9%	58.9%	4.0%	0.015	2,397; 2,179
Patient and family caregiver engagement (7 items)	74.4%	75.9%	-1.4%	0.041	5,604; 3,155	76.0%	76.6%	-0.6%	0.340	3,664; 3,347	76.7%	76.1%	0.6%	0.432	3,184; 2,891
Helpful, courteous, and respectful office staff (2 items)	84.9%	86.2%	-1.3%	0.144	5,585; 3,132	85.3%	86.2%	-0.9%	0.288	3,643; 3,333	85.5%	86.5%	-0.9%	0.307	3,173; 2,864
Teamwork (1 item)	80.8%	80.6%	0.2%	0.853	5,508; 3,094	80.9%	81.5%	-0.6%	0.573	3,571; 3,294	80.6%	79.3%	1.3%	0.289	3,132; 2,848
Patients' rating of the primary care doctors and their staff (1 item)	85.8%	85.5%	0.3%	0.768	5,566; 3,128	86.3%	86.4%	-0.1%	0.917	3,617; 3,304	86.5%	85.9%	0.6%	0.553	3,148; 2,857
Black or African American (non-Hispanic)															
Access (9 items)	40.8%	37.6%	3.2%	0.275	291; 108	36.7%	35.8%	1.0%	0.742	160; 137	51.5%	48.3%	3.2%	0.384	146; 114
Continuity in the doctor's office (1 item)	81.1%	80.1%	0.9%	0.868	280; 103	77.1%	75.5%	1.6%	0.763	149; 131	75.9%	72.5%	3.4%	0.573	142; 109
Continuity across health care settings (2 items)	6.0%	5.3%	0.7%	0.803	285; 103	4.2%	4.5%	-0.4%	0.843	154; 135	4.1%	4.4%	-0.2%	0.913	145; 114
Care management (4 items)	75.9%	69.5%	6.4%	0.153	290; 108	67.8%	72.6%	-4.8%	0.301	160; 137	69.8%	67.7%	2.2%	0.665	146; 114
Comprehensiveness (6 items)	50.4%	52.3%	-1.9%	0.633	290; 107	61.9%	56.3%	5.7%	0.102	158; 137	49.1%	49.4%	-0.3%	0.934	146; 114
Coordination (1 item)	65.7%	71.1%	-5.4%	0.497	182; 71	56.4%	61.3%	-4.9%	0.501	114; 109	50.5%	48.7%	1.8%	0.841	94; 64
Patient and family caregiver engagement (7 items)	67.5%	69.5%	-2.0%	0.529	290; 107	69.6%	68.5%	1.0%	0.746	160; 137	68.5%	65.7%	2.8%	0.475	146; 112
Helpful, courteous, and respectful office staff (2 items)	83.1%	81.8%	1.2%	0.777	288; 108	85.5%	81.0%	4.4%	0.309	157; 135	83.3%	83.1%	0.2%	0.970	144; 113

Table 4.E.11d.2. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
Teamwork (1 item)	78.3%	78.3%	0.0%	0.999	286; 104	74.2%	74.0%	0.2%	0.974	154; 135	76.9%	70.3%	6.7%	0.291	142; 111
Patients' rating of the primary care doctors and their staff (1 item)	83.2%	80.1%	3.2%	0.529	287; 108	81.9%	80.7%	1.2%	0.818	156; 133	80.4%	78.2%	2.3%	0.697	144; 114
All other races (non-Hispanic)															
Access (9 items)	38.4%	37.8%	0.6%	0.796	250; 226	37.8%	38.5%	-0.7%	0.812	132; 208	49.6%	51.5%	-1.9%	0.567	144; 196
Continuity in the doctor's office (1 item)	81.0%	78.3%	2.7%	0.579	242; 221	80.7%	71.6%	9.1%	0.085	126; 203	75.6%	68.7%	6.9%	0.235	142; 187
Continuity across health care settings (2 items)	3.4%	2.8%	0.6%	0.717	248; 224	2.5%	7.6%	-5.1%	0.026	128; 204	1.4%	1.7%	-0.3%	0.715	142; 192
Care management (4 items)	71.1%	69.9%	1.3%	0.724	247; 226	67.6%	67.3%	0.3%	0.947	131; 208	66.7%	67.4%	-0.7%	0.875	144; 195
Comprehensiveness (6 items)	52.5%	50.0%	2.5%	0.402	249; 226	50.9%	49.5%	1.5%	0.669	129; 208	48.5%	50.5%	-2.0%	0.540	144; 195
Coordination (1 item)	58.7%	65.4%	-6.7%	0.313	188; 155	55.3%	54.7%	0.6%	0.938	87; 155	61.3%	53.7%	7.6%	0.263	112; 140
Patient and family caregiver engagement (7 items)	73.8%	66.6%	7.2%	0.037	249; 226	73.8%	68.7%	5.1%	0.129	131; 208	71.3%	69.2%	2.1%	0.528	144; 195
Helpful, courteous, and respectful office staff (2 items)	80.0%	73.7%	6.3%	0.158	249; 224	82.0%	78.6%	3.4%	0.458	131; 207	80.4%	83.9%	-3.5%	0.408	142; 192
Teamwork (1 item)	74.4%	69.5%	4.9%	0.363	245; 223	76.8%	75.7%	1.0%	0.855	125; 203	77.3%	76.6%	0.7%	0.889	141; 192
Patients' rating of the primary care doctors and their staff (1 item)	79.9%	75.5%	4.4%	0.372	246; 223	82.1%	80.2%	1.8%	0.717	128; 207	77.8%	81.9%	-4.1%	0.398	142; 190
Hispanic (any race)															
Access (9 items)	40.1%	35.5%	4.6%	0.231	132; 56	40.0%	37.1%	3.0%	0.388	108; 74	49.5%	41.1%	8.3%	0.094	75; 52
Continuity in the doctor's office (1 item)	83.2%	75.0%	8.1%	0.255	126; 55	79.9%	71.3%	8.6%	0.265	102; 71	67.2%	58.8%	8.4%	0.371	73; 51
Continuity across health care settings (2 items)	9.4%	3.9%	5.5%	0.200	127; 54	3.2%	2.5%	0.7%	0.698	103; 72	5.1%	5.9%	-0.9%	0.867	75; 52
Care management (4 items)	66.8%	72.0%	-5.3%	0.368	132; 56	80.5%	65.2%	15.3%	0.009	106; 74	73.5%	67.4%	6.1%	0.324	75; 52
Comprehensiveness (6 items)	43.9%	51.8%	-7.9%	0.092	131; 54	59.4%	53.1%	6.3%	0.199	106; 74	53.1%	43.1%	9.9%	0.088	75; 52
Coordination (1 item)	73.0%	58.3%	14.7%	0.179	93; 34	70.6%	60.4%	10.2%	0.265	74; 59	56.7%	49.8%	6.9%	0.551	57; 37
Patient and family caregiver engagement (7 items)	68.6%	64.8%	3.9%	0.380	131; 54	75.4%	65.2%	10.2%	0.021	107; 74	69.2%	64.2%	5.0%	0.389	74; 52

Table 4.E.11d.2. (continued)

Composite measures	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value ^a	N (CPC+; Comparison)
Helpful, courteous, and respectful office staff (2 items)	78.7%	73.9%	4.8%	0.467	130; 56	83.0%	81.9%	1.0%	0.865	108; 74	76.1%	70.5%	5.6%	0.487	74; 52
Teamwork (1 item)	82.0%	76.3%	5.7%	0.400	132; 53	80.0%	72.9%	7.1%	0.330	105; 72	69.5%	58.5%	11.0%	0.245	73; 52
Patients' rating of the primary care doctors and their staff (1 item)	86.3%	79.2%	7.0%	0.358	131; 55	86.6%	77.3%	9.3%	0.158	106; 74	79.6%	71.7%	7.9%	0.377	73; 51

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: Composite measures for the 10 domains of care were created from 34 survey items. To calculate the composite measures, we first calculated beneficiary-level composite measures by averaging the nonmissing standardized responses across each item in the composite. We then ran ordinary least squares regressions on beneficiary-level composite measures to create CPC+-wide composite scores.

We estimated outcomes separately for Track 1 and Track 2. All regressions controlled for baseline (pre-CPC+) beneficiary and practice characteristics, and beneficiaries' self-reported education level at the time of the survey. Appendix Table 5.6 lists the control variables. For all regressions, we weighted estimates using beneficiary-level nonresponse and matching weights. To account for correlation in responses within practices, our regression models used cluster-robust standard errors, clustering at the practice level.

Green shading with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year

^a The estimates in the difference column show subgroup-specific differences between CPC+ and comparison respondents separately for each practice characteristic listed in the table. The p-values represent results from testing for statistically significant differences in impact estimates between the subgroups, based on the same baseline practice characteristic. The p-values are from a t-test for subgroups with two categories and from an F-test for subgroups with more than two categories.

Table 4.E.12a. Descriptive characteristics of Medicare FFS beneficiaries attributed to CPC+ and comparison practices, by track (Track 1)

Characteristic	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Age^a															
% 0-64 years	13.4%	7.8%	5.5%	0.000	3,924; 7,320	14.6%	12.7%	1.8%	0.049	3,918; 4,579	23.5%	20.3%	3.2%	0.005	3,392; 3,894
% 65-74 years	47.0%	51.6%	-4.6%	0.000	3,924; 7,320	47.7%	48.0%	-0.3%	0.832	3,918; 4,579	47.5%	50.3%	-2.7%	0.040	3,392; 3,894
% 75-84 years	29.1%	30.7%	-1.5%	0.172	3,924; 7,320	28.0%	30.1%	-2.0%	0.069	3,918; 4,579	23.9%	24.1%	-0.2%	0.856	3,392; 3,894
% Older than 85 years	10.5%	9.9%	0.6%	0.364	3,924; 7,320	9.6%	9.2%	0.5%	0.479	3,918; 4,579	5.1%	5.4%	-0.3%	0.574	3,392; 3,894
Self-reported physical health															
% Excellent	8.4%	8.7%	-0.3%	0.572	165; 342	8.0%	8.0%	-0.1%	0.195	253; 284	9.4%	10.1%	-0.8%	0.305	261; 307
% Very good	32.5%	33.9%	-1.4%		835; 1,598	32.7%	31.4%	1.2%		1,092; 1,234	34.6%	32.4%	2.2%		1,003; 1,071
% Good	37.3%	36.7%	0.6%		1,462; 2,676	37.0%	39.6%	-2.6%		1,454; 1,774	35.9%	37.3%	-1.4%		1,223; 1,466
% Fair or Poor	21.8%	20.7%	1.0%		1,402; 2,600	22.3%	21.0%	1.4%		1,034; 1,179	20.2%	20.1%	0.0%		840; 989
Self-reported mental health															
% Excellent	25.5%	27.8%	-2.2%	0.018	968; 1,804	26.2%	26.7%	-0.4%	0.024	940; 1,100	26.9%	27.0%	-0.1%	0.222	840; 960
% Very good	34.8%	34.7%	0.1%		1,301; 2,415	33.3%	35.8%	-2.5%		1,248; 1,555	37.7%	35.8%	1.9%		1,197; 1,325
% Good	27.1%	27.2%	-0.1%		1,110; 2,074	28.1%	27.1%	0.9%		1,142; 1,269	24.4%	26.6%	-2.2%		870; 1,059
% Fair or Poor	12.6%	10.3%	2.3%		497; 924	12.4%	10.4%	2.0%		514; 557	11.0%	10.6%	0.4%		424; 498
Self-reported highest education level completed															
% 4-year college graduate or more	31.3%	33.9%	-2.6%	0.049	1,180; 2,215	34.2%	33.9%	0.3%	0.609	1,240; 1,412	36.6%	37.4%	-0.8%	0.816	1,192; 1,355
% High school graduate or some college	59.4%	58.1%	1.3%		2,279; 4,262	58.6%	58.2%	0.4%		2,272; 2,649	57.8%	57.0%	0.8%		1,937; 2,225
% Less than high school	9.3%	8.0%	1.3%		337; 685	7.2%	7.9%	-0.7%		304; 395	5.6%	5.6%	0.0%		207; 253
Self-reported race/ethnicity															
% White, non-Hispanic	85.0%	87.2%	-2.2%	0.045	3,926; 7,325	84.6%	87.9%	-3.3%	0.002	3,921; 4,582	85.5%	87.8%	-2.3%	0.041	3,392; 3,894
% Black, non-Hispanic	4.5%	4.0%	0.5%	0.467	3,926; 7,325	4.7%	3.5%	1.2%	0.080	3,921; 4,582	4.9%	3.8%	1.0%	0.187	3,392; 3,894
% Hispanic, any race	2.4%	2.5%	-0.1%	0.848	3,926; 7,325	1.9%	2.1%	-0.2%	0.662	3,921; 4,582	1.9%	2.0%	0.0%	0.925	3,392; 3,894
% All other	5.5%	3.9%	1.6%	0.027	3,926; 7,325	5.8%	3.1%	2.7%	0.000	3,921; 4,582	5.5%	3.6%	1.9%	0.008	3,392; 3,894
Self-reported basic needs (% that had problems with the following basic needs in the last 6 months)															
Had problems with the following basic needs in the last 6 months:															
% that had problems getting enough food	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	1.0%	0.5%	0.5%	0.032	3,392; 3,894
% that had problems with rent, housing, or homelessness	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.9%	0.5%	0.4%	0.042	3,392; 3,894
% that had problems with transportation	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	2.1%	2.0%	0.1%	0.773	3,392; 3,894
% that had problems paying for utilities (such as heating, electric, or phone bills)	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	2.1%	1.9%	0.1%	0.696	3,392; 3,894

Table 4.E.12a. (continued)

Characteristic	Track 1 – PY 2 (Wave 1)					Track 1 – PY 3 (Wave 2)					Track 1 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Abuse or violence in the last 6 months:															
% that had problems with abuse or violence at home or in neighborhood	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	1.0%	1.2%	-0.2%	0.410	3,330; 3,843
Had problems with one or more of these five basic needs															
% that had problems with one or more of these five basic needs	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	5.1%	4.8%	0.3%	0.625	3,354; 3,859
Self-reported impact of COVID-19 on seeking care in the last 6 months															
% that delayed or avoided any routine or urgent care due to COVID-19	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	13.5%	14.7%	-1.2%	0.215	3,392; 3,894
Self-reported social support: How often friends and family are available to talk about problems															
% Never	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	10.9%	10.2%	0.7%	0.843	347; 365
% Sometimes	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	16.7%	16.9%	-0.2%		576; 677
% Usually	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	19.2%	19.1%	0.1%		646; 751
% Always	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	53.2%	53.8%	-0.6%		1,741; 2,037
Presence of selected chronic conditions (high-risk beneficiaries)^b															
Mean HCC score	1.10	1.05	0.05	0.048	3,926; 7,320	1.04	1.03	0.00	0.826	3,921; 4,581	0.95	0.91	0.04	0.023	3,392; 3,894
% with HCC score in top quartile	24.1%	22.6%	1.5%	0.105	3,926; 7,325	21.7%	21.1%	0.6%	0.445	3,921; 4,582	14.9%	14.3%	0.6%	0.422	3,392; 3,894
% with HCC score in top 10 percent or has Dementia	11.9%	10.7%	1.2%	0.086	3,926; 7,325	9.5%	9.8%	-0.2%	0.697	3,921; 4,582	6.1%	5.7%	0.4%	0.431	3,392; 3,894
% that has a serious mental illness ^c	0.5%	0.4%	0.1%	0.460	3,924; 7,320	0.2%	0.4%	-0.2%	0.066	3,918; 4,579	0.4%	0.2%	0.2%	0.124	3,392; 3,894

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: **Green shading with bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading with bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year; HCC = hierarchical condition category

^a Beneficiary age comes from Medicare enrollment data (2016).

^b HCC scores were derived from Medicare FFS claims. Details of our methodology for calculating HCC scores are in the CPC+ Annual Reports.

^c Beneficiaries with behavioral health conditions (HCCs for schizophrenia or major depressive, bipolar, and paranoid disorders, or drug/alcohol psychosis or drug/alcohol dependence) at baseline (2016).

Table 4.E.12b. Descriptive characteristics of Medicare FFS beneficiaries attributed to CPC+ and comparison practices, by track (Track 2)

Characteristic	Track 2 – PY 2 (Wave 1)				Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)					
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Age^a															
% 0-64 years	13.7%	9.4%	4.4%	0.000	3,989; 7,056	13.0%	13.0%	0.0%	0.980	3,890; 4,206	22.1%	21.3%	0.8%	0.455	3,349; 3,677
% 65-74 years	49.1%	50.1%	-1.0%	0.398	3,989; 7,056	49.9%	49.6%	0.3%	0.804	3,890; 4,206	49.6%	49.2%	0.4%	0.759	3,349; 3,677
% 75-84 years	26.9%	31.2%	-4.4%	0.000	3,989; 7,056	27.9%	28.2%	-0.3%	0.800	3,890; 4,206	23.5%	24.1%	-0.6%	0.566	3,349; 3,677
% Older than 85 years	10.3%	9.3%	1.0%	0.102	3,989; 7,056	9.2%	9.3%	0.0%	0.987	3,890; 4,206	4.9%	5.5%	-0.6%	0.224	3,349; 3,677
Self-reported physical health															
% Excellent	8.3%	8.9%	-0.6%	0.052	279; 519	7.8%	9.0%	-1.2%	0.342	246; 296	8.5%	9.1%	-0.6%	0.271	224; 261
% Very good	31.2%	33.2%	-2.1%		1,084; 1,973	33.2%	31.8%	1.4%		1,106; 1,119	31.4%	33.3%	-2.0%		926; 1,043
% Good	37.3%	37.1%	0.1%		1,489; 2,605	38.2%	38.4%	-0.2%		1,468; 1,623	40.2%	38.0%	2.2%		1,357; 1,398
% Fair or Poor	23.2%	20.7%	2.5%		1,086; 1,844	20.8%	20.8%	0.0%		983; 1,069	20.0%	19.5%	0.4%		778; 916
Self-reported mental health															
% Excellent	26.3%	26.7%	-0.4%	0.010	975; 1,706	25.3%	27.4%	-2.1%	0.062	882; 1,025	24.8%	26.3%	-1.5%	0.535	750; 876
% Very good	33.3%	35.8%	-2.4%		1,314; 2,373	35.1%	35.9%	-0.8%		1,300; 1,404	37.4%	37.1%	0.4%		1,203; 1,290
% Good	27.2%	26.9%	0.4%		1,111; 1,985	28.7%	26.1%	2.7%		1,137; 1,158	27.0%	26.7%	0.3%		947; 1,020
% Fair or Poor	13.1%	10.7%	2.4%		536; 894	10.9%	10.6%	0.3%		485; 519	10.8%	10.0%	0.8%		388; 440
Self-reported highest education level completed															
% 4-year college graduate or more	32.7%	33.9%	-1.2%	0.639	1,227; 2,173	35.7%	35.1%	0.6%	0.300	1,285; 1,347	37.7%	38.0%	-0.2%	0.831	1,183; 1,294
% High school graduate or some college	59.7%	58.6%	1.1%		2,310; 4,120	57.6%	57.2%	0.5%		2,208; 2,385	57.3%	56.7%	0.6%		1,928; 2,096
% Less than high school	7.6%	7.5%	0.1%		321; 621	6.7%	7.7%	-1.1%		288; 352	5.0%	5.3%	-0.3%		179; 224
Self-reported race/ethnicity															
% White, non-Hispanic	85.7%	86.6%	-0.9%	0.411	3,989; 7,059	84.4%	87.8%	-3.4%	0.003	3,897; 4,210	84.9%	87.5%	-2.5%	0.035	3,349; 3,677
% Black, non-Hispanic	4.3%	4.4%	-0.1%	0.901	3,989; 7,059	4.5%	3.4%	1.0%	0.145	3,897; 4,210	4.9%	3.9%	1.0%	0.232	3,349; 3,677
% Hispanic, any race	2.0%	2.3%	-0.4%	0.416	3,989; 7,059	1.9%	2.4%	-0.5%	0.195	3,897; 4,210	1.6%	2.0%	-0.4%	0.283	3,349; 3,677
% All other	6.1%	4.2%	1.8%	0.009	3,989; 7,059	5.8%	3.2%	2.6%	0.000	3,897; 4,210	5.9%	3.9%	2.0%	0.004	3,349; 3,677
Self-reported basic needs (% that had problems with the following basic needs in the last 6 months)															
Had problems with the following basic needs in the last 6 months:															
% that had problems getting enough food	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	0.9%	0.6%	0.3%	0.169	3,349; 3,677
% that had problems with rent, housing, or homelessness	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	1.0%	0.6%	0.4%	0.077	3,349; 3,677
% that had problems with transportation	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	2.2%	2.1%	0.1%	0.860	3,349; 3,677
% that had problems paying for utilities (such as heating, electric, or phone bills)	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	1.7%	2.0%	-0.3%	0.473	3,349; 3,677

Table 4.E.12b. (continued)

Characteristic	Track 2 – PY 2 (Wave 1)					Track 2 – PY 3 (Wave 2)					Track 2 – PY 5 (Wave 3)				
	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)	CPC+ practices	Comparison practices	Difference	P-value	N (CPC+; Comparison)
Abuse or violence in the last 6 months:															
% that had problems with abuse or violence at home or in neighborhood	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	1.1%	1.1%	0.0%	0.997	3,303; 3,613
Had problems with one or more of these five basic needs															
% that had problems with one or more of these five basic needs	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	4.9%	4.8%	0.2%	0.761	3,320; 3,633
Self-reported impact of COVID-19 on seeking care in the last 6 months															
% that delayed or avoided any routine or urgent care due to COVID-19	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	13.4%	14.9%	-1.5%	0.116	3,349; 3,677
Self-reported social support: How often friends and family are available to talk about problems															
% Never	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	10.4%	10.3%	0.1%	0.104	326; 339
% Sometimes	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	16.7%	17.5%	-0.8%		545; 661
% Usually	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	18.1%	20.3%	-2.2%		610; 751
% Always	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	n.a.	n.a.	n.a.	n.a.	n.a.; n.a.	54.8%	51.9%	2.9%		1,799; 1,865
Presence of selected chronic conditions (high-risk beneficiaries)^b															
Mean HCC score	1.07	1.07	0.00	0.929	3,989; 7,057	1.01	1.02	-0.01	0.652	3,897; 4,208	0.93	0.92	0.01	0.673	3,349; 3,677
% with HCC score in top quartile	22.6%	23.3%	-0.7%	0.446	3,989; 7,059	21.4%	21.4%	0.0%	0.995	3,897; 4,210	14.5%	14.5%	0.1%	0.944	3,349; 3,677
% with HCC score in top 10 percent or has Dementia	11.0%	11.1%	-0.1%	0.840	3,989; 7,059	9.1%	9.7%	-0.6%	0.303	3,897; 4,210	5.5%	5.5%	0.0%	0.996	3,349; 3,677
% that has a serious mental illness ^c	0.6%	0.5%	0.1%	0.711	3,989; 7,056	0.5%	0.4%	0.1%	0.328	3,890; 4,206	0.5%	0.3%	0.2%	0.106	3,349; 3,677

Source: CPC+ Beneficiary Survey administered to Medicare FFS beneficiaries attributed to 2017 Starter CPC+ practices and comparison practices. Wave 1 survey was administered May through August 2018 to beneficiaries in CPC+ practices and June through December 2018 to Medicare FFS beneficiaries attributed to comparison practices. Wave 2 survey was administered February through May 2019 to beneficiaries in CPC+ and comparison practices. Wave 3 survey was administered June through September 2021 to beneficiaries in CPC+ and comparison practices.

Notes: **Green shading** with **bolded text** indicates a favorable finding that is both statistically and substantially significant; **yellow shading** with **bold, italicized text** indicates an unfavorable finding that is both statistically and substantially significant.

FFS = fee-for service; PY = Program Year; HCC = hierarchical condition category

^a Beneficiary age comes from Medicare enrollment data (2016).

^b HCC scores were derived from Medicare FFS claims. Details of our methodology for calculating HCC scores are in the CPC+ Annual Reports.

^c Beneficiaries with behavioral health conditions (HCCs for schizophrenia or major depressive, bipolar, and paranoid disorders, or drug/alcohol psychosis or drug/alcohol dependence) at baseline (2016).

4.E.6. The Medicare Health Care Opinion Survey

The Medicare Health Care Opinion Survey

This survey is sponsored by the Centers for Medicare & Medicaid Services (CMS). Mathematica is sending you this survey as part of an important national study. By completing this survey, you will help improve the quality of primary care nationwide. The survey should take you only about 15-20 minutes to complete.



Your Privacy Is Protected. All of your personal information will be kept private and confidential. Mathematica will not share your personal information or individual responses with anyone.



Your Participation Is Voluntary But Important. You may choose to answer this survey or not. Your choice will not affect the health care you get or your insurance coverage.



What To Do When You're Done. Once you finish the survey, please put it in the prepaid envelope that was sent with the survey, seal the envelope, and put the envelope in the mail.



What To Do If You Have Questions. If you have any questions, please call us toll-free at 1-833-278-3076 or send an email to MedicareSurvey@mathematica.org.

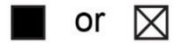


Si prefiere la encuesta en español, por favor póngase en contacto con Mathematica por teléfono (sin cargo) al 1-833-278-3076 o por correo electrónico a MedicareSurvey@mathematica.org.

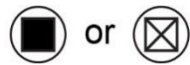
Primary Care Doctor's Office
[PRACTICENAME] [PRACTICEADDRESS1] [PRACTICEADDRESS2] [PRACTICECITY], [PRACTICESTATE] [PRACTICEZIP]

Survey Instructions

- Please use a black or blue ball point pen.
- Answer each question by completely filling in the box to the left of your answer or marking the box with an "X".



- If you want to change an answer, fill in the box for the correct answer completely or mark the box with an "X" and circle the correct answer as well.



- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

Yes → **If Yes, go to #7 on page 3**

No

This Primary Care Doctor's Office

This is a survey about health care you received from **primary care doctors and their staff**. The person you got care from at this doctor's office might be a physician (MD or DO), a nurse practitioner (NP), physician assistant (PA), or other staff that work with them.



Primary care doctors **treat preventive and wellness needs, common illnesses** (such as a cold or the flu), **and ongoing conditions** (such as diabetes or high blood pressure). Primary care doctors do not do surgery and do not treat just one kind of health problem such as a heart condition.

1. In the last 6 months, did you get **any kind of health care** from primary care doctors or their staff who work at the **primary care doctor's office listed on the cover of this survey**? You may know this doctor's office by another name.

¹ Yes

² No → **If No, go to #52 on page 11**

2. In the last 6 months, what **kind of visits** did you have with this primary care doctor's office?

Mark one or more.

- ¹ In-person visit at this doctor's office
² Video visit
³ Telephone visit (not part of a video visit)
⁴ None of the above

3. In the last 6 months, did your doctor or someone from this doctor's office come to **see you in the hospital**?

¹ Yes

² No

4. In the last 6 months, did your doctor or someone from this doctor's office come to **see you at another location besides this doctor's office or the hospital** to provide health care (such as at your home or a senior center)?

¹ Yes

² No

5. In the last 6 months, **other than visits**, did you have any contact with this doctor's office to discuss your health or test results?

Contact can be via phone, email, text messaging, or a patient portal.

¹ Yes

² No

As you answer the questions in this survey, please think about **all of the ways you got health care** in the last 6 months **from primary care doctors and their staff who work at this doctor's office.**

Contacting This Primary Care Doctor's Office

6. In the last 6 months, did you contact this doctor's office to get care for an illness, injury, or condition that **needed care right away**?

Yes
 No → **If No, go to #8**

7. In the last 6 months, when you contacted this doctor's office for **care you needed right away**, how often did you get care as soon as you needed?

Never
 Sometimes
 Usually
 Always

8. In the last 6 months, did you make any appointments for a **check-up or routine care** with this doctor's office?

Yes
 No → **If No, go to #10**

9. In the last 6 months, when you made an appointment for a **check-up or routine care** with this doctor's office, how often did you get care as soon as you needed?

Never
 Sometimes
 Usually
 Always

10. In the last 6 months, did you contact this doctor's office with a health question **during regular office hours**?

Yes
 No → **If No, go to #12**

11. In the last 6 months, when you contacted this doctor's office **during regular office hours**, how often did you get an answer to your health question that same day?

Never
 Sometimes
 Usually
 Always

12. Has this doctor's office given you information about **what to do if you need care during evenings, weekends, or holidays**?

Yes
 No

13. In the last 6 months, did you contact this doctor's office with a health question **outside of regular office hours**, for example, on evenings, weekends, or holidays?

Yes
 No → **If No, go to #15**

14. In the last 6 months, when you contacted this doctor's office **outside of regular office hours**, how often did you get an answer to your health question as soon as you needed?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

15. In the last 6 months, did you use **email, a patient portal, or text messaging** to contact this doctor's office with a health question?

- ¹ Yes
- ² No → **If No, go to #17**

16. In the last 6 months, when you used **email, a patient portal, or text messaging** to contact this doctor's office with a health question, how often did you get an answer to your health question as soon as you needed?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

Your Care From This Primary Care Doctor's Office

17. In the last 6 months, how often did your appointment(s) with this doctor's office start **within 15 minutes** of your appointment time?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always
- ⁵ Not applicable, did not have scheduled appointment(s) with this doctor's office in the last 6 months

18. In the last 6 months, did you **take any prescription medicine**?

- ¹ Yes
- ² No → **If No, go to #20**

19. In the last 6 months, did your doctor or someone from this doctor's office ask you about **all the prescription medicines you were taking**?

- ¹ Yes
- ² No

20. In the last 6 months, did you have a **blood test, x-ray, or other test** that was ordered by your doctor or someone from this doctor's office?

- ¹ Yes
- ² No → **If No, go to #22 on page 6**

21. In the last 6 months, when you had a blood test, x-ray, or other test that was ordered by your doctor or someone from this doctor's office, how often did you **get your test results**?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
22. In the last 6 months, how often did people from this doctor's office, including your doctor, explain medical things in a way that was **easy to understand**?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
23. In the last 6 months, how often did people from this doctor's office, including your doctor, **listen carefully to you**?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
24. In the last 6 months, how often did people from this doctor's office, including your doctor, seem to **know the important information about your medical history**?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always

25. In the last 6 months, how often did people from this doctor's office, including your doctor, **show respect for what you had to say**?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
26. In the last 6 months, how often did people from this doctor's office, including your doctor, **spend enough time with you**?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
27. In the last 6 months, did your doctor or someone from this doctor's office ask you if there are **things that make it hard for you to take care of your health**?
- 1 Yes
 - 2 No
28. In the last 6 months, did your doctor or someone from this doctor's office ask you if you had any **problems with physical pain or discomfort**?
- 1 Yes
 - 2 No

29. In the last 6 months, did your doctor or someone from this doctor's office ask you if there was a period of time when you felt **sad, empty, or depressed**?

¹ Yes

² No

30. In the last 6 months, did your doctor or someone from this doctor's office talk with you about **things in your life that worry you or cause you stress**?

¹ Yes

² No

31. An **advance care plan** describes a patient's wishes for end-of-life care in case the patient becomes too sick to make his or her own decisions. In an advance care plan, patients can choose family members or friends to make medical decisions for them, including health care that patients may not want.

Advance care plans are often recorded in a document such as an **advance directive, a do not resuscitate (DNR) order, health care power of attorney, or a living will**.

Do you have any kind of advance care plan?

¹ Yes

² No

³ I don't know

32. Has your doctor or someone from this doctor's office **asked you about your end-of-life care wishes or creating an advance care plan**?

¹ Yes

² No

³ I don't know

Basic Needs

33. In the last 6 months, **did you have** problems with any of the following **basic needs**?

Mark one or more.

- ¹ Getting enough food
² Rent, housing, or homelessness
³ Transportation
⁴ Paying for utilities (such as heating, electric, or phone bills)
⁵ None of the above

34. **Basic needs** are food, housing, transportation, and utilities.

In the last 6 months, did your doctor or someone from **this doctor's office ask you** if you had problems with any of these basic needs?

- ¹ Yes
² No → **If No, go to #37**

35. Did your doctor or someone from **this doctor's office try to find a place or person** to help you with any of these basic needs?

- ¹ Yes
² No → **If No, go to #37**

36. Did your doctor or someone from **this doctor's office ask you** if this place or person helped you with these **basic needs**?

- ¹ Yes
² No

Safety

37. In the last 6 months, **did you have** any problems with **abuse or violence** at home or in your neighborhood?

- ¹ Yes
² No

38. In the last 6 months, did your doctor or someone from **this doctor's office ask you** if you had any problems with **abuse or violence** at home or in your neighborhood?

- ¹ Yes
² No → **If No, go to #41 on page 9**

39. Did your doctor or someone from **this doctor's office try to find a place or person** to help you with **abuse or violence** at home or in your neighborhood?

- ¹ Yes
² No → **If No, go to #41 on page 9**

40. Did your doctor or someone from **this doctor's office ask you** if this place or person helped you with **abuse or violence** at home or in your neighborhood?

- ¹ Yes
² No

Your Health Care From Specialists

41. Specialists are doctors like surgeons, heart doctors, eye doctors, skin doctors, and other doctors who specialize in one area of health care.

In the last 6 months, did you get **any health care from a specialist**?

- ¹ Yes
² No → **If No, go to #43**

42. Remember, when we say “**this doctor’s office**”, we are referring to the primary care doctor’s office listed on the cover of this survey.

In the last 6 months, how often did people from this doctor’s office, including your doctor, seem **informed and up-to-date about the care you got from specialists**?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

Follow Up After Emergency Room And Hospital Care

The questions below ask about health care you got from the **primary care doctors and their staff** from the doctor’s office listed on the cover of this survey, after going to an emergency department or being in a hospital.

43. In the last 6 months, have you gone to an emergency room or emergency department for care? Please do not include visits to an urgent care center.

- ¹ Yes
² No → **If No, go to #45**

44. Did your doctor or someone from this doctor’s office contact you to discuss your health needs **within one week** after your most recent emergency room or emergency department visit?

- ¹ Yes
² No

45. In the last 6 months, have you been a patient in a hospital overnight or longer?

- ¹ Yes
² No → **If No, go to #47 on page 10**

46. Did your doctor or someone from this doctor’s office contact you to discuss your health needs **within 3 days** after your most recent hospital stay?

- ¹ Yes
² No

This Primary Care Doctor’s Office As A Whole

47. In the last 6 months, how often did the primary care doctors and their staff from this doctor’s office **work well together** to care for you?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

48. When you saw a primary care doctor from this office in the last 6 months, how often were these visits with **your regular doctor**? A primary care doctor might be a physician (MD or DO), nurse practitioner (NP), or physician assistant (PA).

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

49. In the last 6 months, how often were clerks and receptionists at this doctor's office as **helpful** as you thought they should be?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

50. In the last 6 months, how often did clerks and receptionists at this doctor's office **treat you with courtesy and respect**?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

51. Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate the care you have received **from the primary care doctors and their staff from this doctor's office**?

- 0 Worst level of care possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best level of care possible

Your Health Care During The Coronavirus Pandemic

52. In the last 6 months, have you **delayed or avoided getting medical care from this doctor's office** due to concerns about getting or spreading COVID-19?

Mark one or more.

- No, I did not delay or avoid getting any medical care
- Yes, I delayed or avoided getting **emergency or urgent** medical care
- Yes, I delayed or avoided getting **check-ups or routine** medical care

53. In the last 6 months, have you **delayed or avoided getting medical care from this doctor's office** because of office issues due to COVID-19 (such as closed office, shorter hours, or less staff)?

Mark one or more.

- ¹ No, I did not delay or avoid getting any medical care
- ² Yes, I delayed or avoided getting **emergency or urgent** medical care
- ³ Yes, I delayed or avoided getting **check-ups or routine** medical care

About You

54. In general, how would you rate your **overall** health?

- ¹ Excellent
- ² Very good
- ³ Good
- ⁴ Fair
- ⁵ Poor

55. In general, how would you rate your overall **mental or emotional** health?

- ¹ Excellent
- ² Very good
- ³ Good
- ⁴ Fair
- ⁵ Poor

56. In the last 6 months, how often did you have **friends or family to talk to** about yourself or your problems?

- ¹ Excellent
- ² Very good
- ³ Good
- ⁴ Fair
- ⁵ Poor

57. What is the **highest** grade or level of school that you have completed?

Mark one only.

- ¹ 8th grade or less
- ² Some high school, but did not graduate
- ³ High school graduate or GED
- ⁴ Some college or 2-year degree
- ⁵ 4-year college graduate
- ⁶ Advanced degree (master's, professional, or doctoral degree)

58. Are you of Hispanic or Latino origin or descent?

- ¹ Yes, Hispanic or Latino
- ² No, not Hispanic or Latino

59. What is your race?

Mark one or more.

- ¹ White
- ² Black or African American
- ³ Asian
- ⁴ Native Hawaiian or Other Pacific Islander
- ⁵ American Indian or Alaskan Native
- ⁶ Other

Thank you!!

Please return the completed survey in the prepaid envelope.

If you no longer have the envelope, you can mail your survey to:

Medicare Health Care Opinion Survey
5900 Baker Rd STE 100
Minnetonka, MN 55345-9893

If you have any questions or want to know more about this study, please call us toll-free at 1-833-278-3076 or send an email to MedicareSurvey@mathematica.org.

4.F. Pandemic-Related Physician and Practice Site Service Interruptions in CPC+ and Comparison Practice Sites

In this Appendix, we examine the impact of CPC+ on pandemic-related physician and practice site service interruptions in 2020 (Program Year 4 of CPC+)—the first year of the coronavirus disease 2019 (COVID-19) pandemic. In Section 4.F.1, we describe the motivation of this analysis, including an overview of how CPC+ could potentially affect pandemic-related physician and practice site service interruptions and how service interruptions might vary across physician, practice, and community characteristics. We next explain the study design, data and study cohort, measures, and the statistical analysis (Section 4.F.2). We describe the results in Section 4.F.3, and finally, discuss implications of our findings and limitations of this analysis in Section 4.F.4.

Key takeaways

1. CPC+ might have reduced physician service interruption during the COVID-19 pandemic, but the effect was limited to Track 2 practices. Relative to comparison physicians, Track 2 CPC+ physicians were 0.9 percentage points less likely to experience a service interruption in April 2020 relative to April 2019 (where service interruption in April is defined as the physician billing Medicare claims in March but not in April). However, CPC+ had no impact on the rates of physician service interruption in April 2020 in Track 1 and CPC+ had no impact on the rates of prolonged physician service interruption (i.e., the physician stopped billing Medicare in any month of a given year and did not resume billing within the next six months in that year) in either track.
2. The COVID-19 pandemic may have increased health inequality because physicians serving more disadvantaged patients had higher rates of prolonged physician service interruption. Among both Track 2 CPC+ and comparison practices, those in the highest quartile of dually eligible patients as a percentage of all attributed beneficiaries at baseline experienced higher rates of prolonged physician service interruption in 2020.
3. We did not find any clear evidence of variation in the impacts of CPC+ on physician service interruption by the practice's proportion of dually eligible beneficiaries served (or other practice site characteristics).

4.F.1. Introduction

The COVID-19 pandemic dramatically impacted access to health care for Medicare beneficiaries. Surveys of primary care physicians during the height of the public health emergency (PHE) documented numerous difficulties for practice organizations serving patients, including financial disruptions, staff availability, and the need to incorporate telehealth services (Primary Care Collaborative 2021; The Physician Foundation 2020). Most physicians practicing in outpatient settings experienced significant visit volume reductions in March 2020, and in response, many physicians reported substantive interruptions in their provision of outpatient services (Neprash and Chernew 2021). In their article, Neprash and Chernew (2021) used Medicare claims to investigate the rate of interruption in physician services to Medicare beneficiaries during the COVID-19 pandemic in 2020. Across all physicians serving Medicare beneficiaries, they investigated both physician service interruptions (defined as a physician who had billed Medicare in the previous month but did not bill any Medicare claims in the given month) and

prolonged physician service interruptions (defined as a physician who did not resume billing Medicare within six months of the last billing month). They found that, across all physicians serving Medicare fee-for-service (FFS) beneficiaries, the rates of service interruption spiked in April 2020 and the rates of prolonged service interruption were higher in April 2020 compared to April 2019. However, little is known about the extent of such service interruptions specifically among primary care physicians and practices.

The CPC+ evaluation is a useful lens through which we can examine how model supports for enhanced primary care delivery could potentially ameliorate pandemic-related service interruptions in primary care for patients. The CPC+ model provides participating practices with enhanced reimbursements relative to traditional Medicare FFS payments for primary care. Track 1 CPC+ practice sites receive modest per Medicare beneficiary per month payments in addition to visit-based FFS revenue; Track 2 practice sites receive more substantial per beneficiary per month care management fees (CMFs) as well as partially capitated payments for visits by attributed beneficiaries (and reduced FFS payments for Medicare visits), and thus may rely even less on visit-based Medicare FFS revenue. Track 1 and Track 2 comparison practice sites largely rely on traditional Medicare FFS payments to support their care of Medicare FFS beneficiaries.

The CPC+ evaluation also includes a large set of diverse practice sites, in terms of practice site size, affiliation with a health system, and community characteristics. Accordingly, the evaluation has assembled detailed information on the characteristics of the CPC+ and comparison practice sites as well as the constituent primary care physicians and the communities served. All this information can be employed to test policy-relevant questions related to the impact on pandemic-related service interruptions among physicians and practice sites. For example, some anecdotal reports suggested larger health care organizations (compared to smaller independent practices) found it easier to obtain resources, deploy telehealth services, and otherwise continue patient care during the pandemic. However, Chapter 3 of the CPC+ fourth annual report (Swankoski et al. 2022) noted that “with the pandemic causing months-long shutdowns of systems’ most lucrative services, such as elective surgeries and procedures, systems found a major revenue source for subsidizing their primary care practices temporarily cut off. Perhaps as a result, system-based practices in the deep-dive sample were more likely than independent practices to shut down completely in the first months of the pandemic, or to implement substantial staff layoffs or furloughs.” As such, it is an open question as to which practice site characteristics were more strongly correlated with a practice’s ability to continue operating during the pandemic.

In this Appendix, we examine three research questions:

1. Did rates of service interruption (lasting either one month or longer) differ between CPC+ and comparison physicians and practices during the 2020 COVID-19 pandemic (relative to 2019)?
2. What physician, practice, and community characteristics were associated with physician and practice site service interruptions during the pandemic?
 - Were CPC+ and comparison practices serving more socially disadvantaged patients more likely to experience service interruptions?
 - Were CPC+ and comparison practices with better access to resources or those that were more financially secure (e.g., practice sites that were health system-owned, multispecialty, and had more practitioners) more or less likely to experience service interruptions?

3. Did any effects of CPC+ on practice interruption differ across practice site subgroups defined by the select practice characteristics described above?

We tested several relevant hypotheses. First, CPC+ physicians and practices would have lower rates of service interruption in 2020 relative to 2019 compared to comparison physicians and practices. Second, CPC+ and comparison physicians and practices serving more socially disadvantaged patients were more likely to experience service interruption. We also explored whether other practice site characteristics (e.g., ownership by a health system, multispecialty composition, and the number of primary care practitioners) were associated with reduced risk of service interruption during the initial year of the PHE. Finally, we tested whether the effect of CPC+ on service interruptions differed across subgroups defined by select practice characteristics.

We found that:

- Although both CPC+ and comparison physicians experienced more service interruptions in April 2020 compared to April 2019, Track 2 CPC+ physicians were 0.9 percentage points less likely to experience increased service interruptions relative to comparison physicians. However, participation in Track 1 of CPC+ had no impact on the rates of service interruption in April 2020.
- Neither track of CPC+ affected prolonged physician service interruptions (i.e., the physician stopped billing Medicare in any month of a given year and did not resume billing within the next six months in that year).
- Among Track 2 CPC+ and comparison practices, those in the highest quartile of the percentage of dually eligible patients among their attributed beneficiaries at baseline experienced higher rates of prolonged physician service interruption in 2020.
- For the subgroup analyses based on select practice site characteristics, we did not find any clear evidence of variation in the impacts of CPC+ on physician service interruption by practice site characteristics.

Overall, our findings suggest that, although CPC+ reduced the likelihood of a physician experiencing a service interruption during the COVID-19 pandemic in April 2020, the effect was limited to Track 2 practices. Also, the COVID-19 pandemic may have increased health inequality because CPC+ and comparison physicians serving more disadvantaged patients had higher rates of prolonged service interruption.

4.F.2. Methods

A. Study design

We compared outcomes in 2019 and 2020 among physicians in practice sites that started CPC+ in 2017 with those in comparison practice sites, by track. We used the set of comparison practices selected for the main impact analysis of CPC+, with comparison selection based on propensity score matching of practice, market, and beneficiary characteristics. By design, comparison and CPC+ practices had very similar observable characteristics before CPC+, such as practice size and electronic health record use; attributed Medicare beneficiary demographics, spending, and service use; and county's median income and number of hospital beds, as well as whether there was a shortage of primary care practitioners.

B. Data and study cohort

To construct outcomes, we analyzed Medicare Part B professional claims from the CMS Virtual Research Data Center from 2018 to 2020. We counted the total number of unique claims billed by the physician in a month or year regardless of type of services. We restricted our analysis to primary care physicians with at least 1 claim in 2019 and at least 120 claims in 2018. Because physicians may bill Medicare intermittently for reasons other than service interruptions, including retirement, we wanted to restrict the analysis to physicians who actively billed Medicare in 2018. Our final sample consisted of 3,776 and 14,003 primary care physicians in Track 1 CPC+ and comparison practice sites, respectively, and 5,250 and 11,939 primary care physicians in Track 2 CPC+ and comparison practice sites, respectively.

C. Measures

C.1. Outcomes for physician and practice service interruption

With our focus on physician service interruption, we examined the rates of physician service interruption in April of each year and prolonged physician service interruption in each year for our main analysis. We focused on physician service interruption in April because disruptions to health care services due to COVID-19 peaked in the early months of the pandemic, especially in April 2020 (Neprash and Chernew 2021). Table 4.F.1 lists the outcome variables and definitions. Physician service interruption in a specific month (e.g., April) was identified as the physician billing claims in the previous month (i.e., March) but not billing any claims in the given month (i.e., April). This measure was adapted from the Neprash and Chernew (2021) measure “physician practice interruption.”

Prolonged physician service interruption was identified as a physician not billing claims in any month of a given year (through June) and not resuming billing within the next six months in that year (e.g., a physician stopped billing claims in April and continued billing no claims through October or after). This measure was adapted from the Neprash and Chernew (2021) measure “physician practice interruption without return.”

We also examined practice site-level service interruptions. We examined several practice site-level outcomes for primary care physicians:

- Whether any physician in the practice site had a service interruption in April.
- Complete practice site service interruption for all physicians in the practice site in April (i.e., at least one physician in the practice site billed any claims in the previous month [i.e., March] but none of the physicians billed any claims in the given month [i.e., April]).
- Prolonged complete practice site service interruption (i.e., for any month in a given year [through June] when all physicians in the practice billed zero claims, none of the physicians resumed billing within six months in that year).

In addition to examining these rates for primary care physicians at the practice sites, we also considered the addition of nurse practitioners and physician assistants. To do this, we separately examined complete practice site service interruption in April (as well as prolonged complete practice site service interruption) including all primary care practitioners in the practice site, not just physicians.

Table 4.F.1. Physician and practice service interruption outcomes

Outcome variables	Definition
Physician service interruption outcomes	
Physician service interruption in April of 2019 and 2020	The primary care physician billed ≥ 1 claim in the previous month (i.e., March) but 0 claims in the given month (i.e., April)
Prolonged physician service interruption in 2019 and 2020	The primary care physician did not bill claims in a month (through June) and did not resume billing in the next 6 months in the given year (e.g., a physician stopped billing claims in April and continued billing no claims through October or after)
Practice site service interruption outcomes focusing on all primary care physicians	
Practice site service interruption for any primary care physician in the practice site in April of 2019 and 2020	Any primary care physician in the practice site billed ≥ 1 claim in the previous month (i.e., March) but billed 0 claims in the given month (i.e., April)
Complete practice site service interruption for all primary care physicians in the practice site in April of 2019 and 2020	At least 1 primary care physician billed ≥ 1 claim in the previous month (i.e., March) but all primary care physicians billed 0 claims in the given month (i.e., April)
Prolonged complete practice site service interruption for all primary care physicians in the practice site in 2019 and 2020	None of the primary care physicians in the practice billed any claims in a month (through June) and did not resume billing in the next 6 months in the given year
Practice site service interruption outcomes focusing on all primary care practitioners	
Complete practice site service interruption for all primary care practitioners in the practice site in April of 2019 and 2020	At least 1 primary care practitioner in the practice site billed ≥ 1 claim in the previous month (i.e., March) but all primary care practitioners billed 0 claims in the given month (i.e., April)
Prolonged complete practice site service interruption for all primary care practitioners in the practice site in 2019 and 2020	None of the primary care practitioners in the practice site billed any claims in a month (through June) and did not resume billing in the next 6 months in the given year

C.2. Covariates

We controlled for a large set of physician, practice, and community characteristics to account for potential differences in these characteristics between CPC+ and comparison practices and to examine the heterogeneity of practice service interruption across these characteristics in our multivariate regression models. Supplemental Table 4.F.Supp.1 lists all the covariates. Physician-level control variables (defined in 2018) included sex, age, and specialty. We included practice site characteristics at baseline (in 2016), such as whether the practice is system-owned, multispecialty status, number of primary care practitioners, and participation in prior primary care transformation activities. We also included baseline beneficiary characteristics aggregated to the practice site level, such as percentages of beneficiaries who were dually eligible, male, in each age category, and in each race/ethnicity category, as well as each original reason for Medicare enrollment category, and average Hierarchical Condition Category (HCC) score. We included baseline market characteristics such as county-level Medicare Advantage penetration rate, median income, hospital referral region (HRR) price index, and percentage of people in poverty. Finally, we included COVID-19-related regional controls such as Social Vulnerability Index in the highest quartile in 2018, the wave-specific monthly excess deaths during 2020, and the wave-specific monthly Pandemic Vulnerability Index in 2020 (with COVID-19 waves defined as follows—Wave 1: March–May, Wave 2: June–September, Wave 3: October–December).

D. Statistical analysis

We used a difference-in-differences (DID) framework and compared the changes in the mean rate of service interruption among CPC+ physicians between 2019 and 2020 with changes among comparison physicians over the same period, adjusted for physician, practice, and community characteristics (Research Question 1). We estimated DID models separately by track, reflecting the differences in payment model (and related care delivery requirements). Among practice characteristics, we examined the association of social disadvantage characteristics with physician service interruption outcomes across both CPC+ and comparison practices, including whether the percentage of dually eligible patients among the practice's attributed beneficiaries was in the highest quartile and whether the Social Vulnerability Index in the practice's census tract was in the highest quartile. This allowed us to test whether practices serving more disadvantaged patients were more likely to experience service interruptions (Research Question 2). We also examined the association of whether the practice was system-owned, its multispecialty status, and whether it was large versus medium or small in size (based on the number of primary care practitioners) with service interruption outcomes across CPC+ and comparison practices to test whether practices with better access to resources or those that were more financially secure (e.g., practices that were system-owned, had multispecialty composition, and had more practitioners) were less likely to experience service interruptions. We used a linear probability model so that estimates could be interpreted as marginal effects. The p-values were two-sided and were considered statistically significant at $p < .05$. We did not adjust p-values for multiple comparisons but we did attempt to avoid false positives by examining the magnitude of the estimates, estimates for related outcomes, and robustness of findings in the sensitivity analyses.

We performed sensitivity analyses using an alternative definition of physician service interruption in April: total number of claims billed declining by at least 90 percent in the given month compared to the previous month. We performed a separate sensitivity analysis by including practice fixed effects in the regression instead of the various physician, practice, and community covariates. We also performed a sensitivity analysis by only accounting for the Wave 1-specific (March–May 2020) COVID-19-related regional controls (i.e., monthly excess deaths and monthly Pandemic Vulnerability Index) for the outcome of physician service interruption in April.

Research Question 2, as described earlier in this section, addressed whether select practice characteristics were associated with service interruption outcomes, regardless of the effect of CPC+. We also examined whether the effect of CPC+ on service interruption outcomes varied across subgroups defined by select practice site characteristics (Research Question 3). We performed subgroup analyses using social disadvantage characteristics like whether the percentage of dually eligible patients among the practice's attributed beneficiaries was in the highest quartile and whether the social disadvantage index for the practice's census tract was in the highest quartile, to examine whether the impact of CPC+ on physician service interruption outcomes varied by the extent to which practices served disadvantaged patients. We also performed subgroup analyses using practice site characteristics such as system ownership, multispecialty status, and number of primary care practitioners to examine whether the impact of CPC+ on physician service interruption outcomes varied across practices with different levels of access to resources and financial security. For these subgroup analyses, we included in the regressions the interactions of variables denoting subgroup membership with the indicator for CPC+ versus comparison status and the year indicator. To be consistent with the main CPC+ impact analysis for the practice subgroup analyses, we included interactions with subgroup indicators for all practice site characteristics in a single regression.

4.F.3. Results

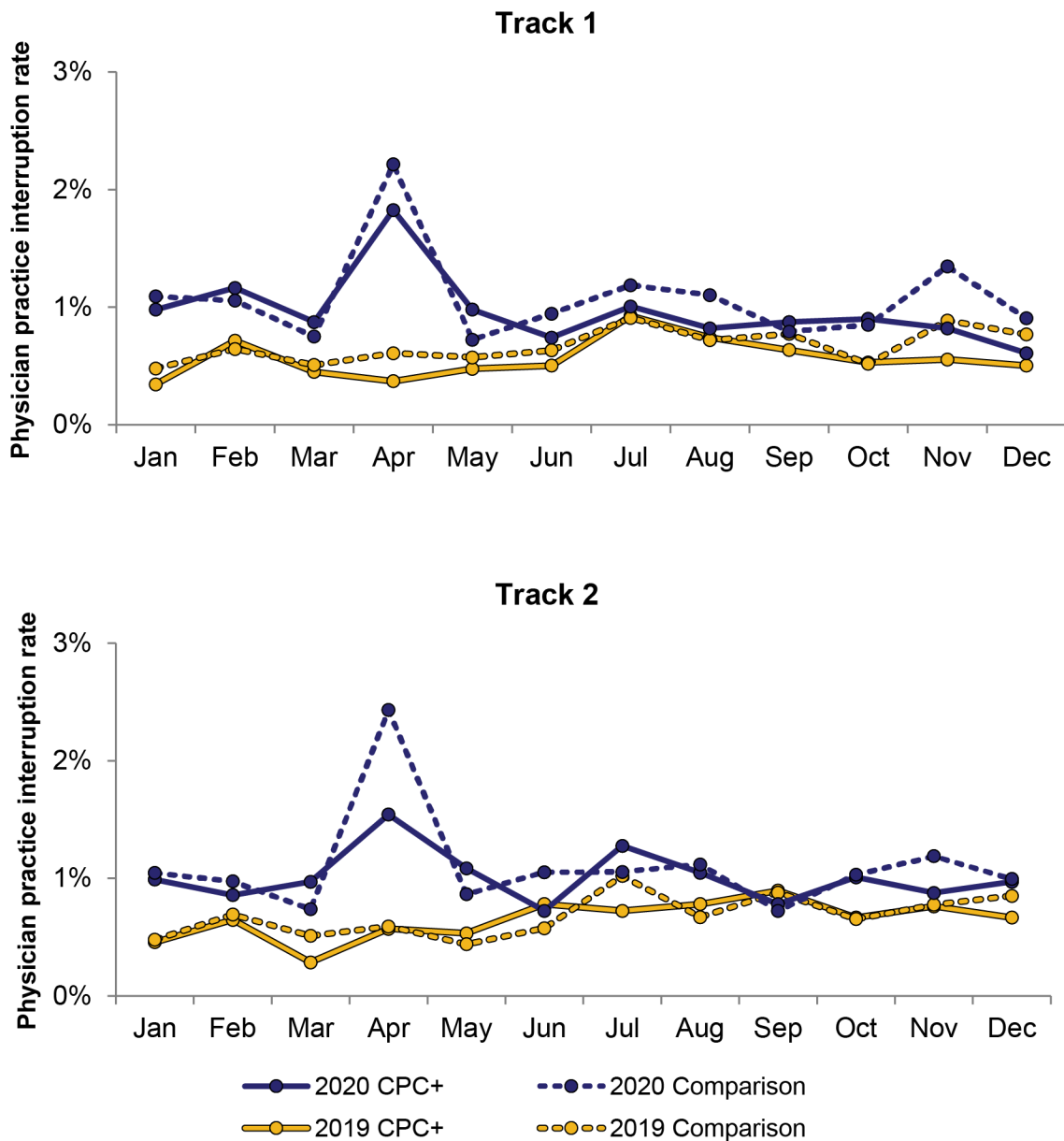
A. Trend in physician and practice service interruption rates over time

Figure 4.F.1 shows the trend by month in physician service interruption rates in 2019 and 2020, by CPC+ status and track. In 2019, rates of physician service interruption were relatively stable across all months for both CPC+ and comparison physicians in both tracks (0.3 to 1.0 percent). Rates of physician service interruption were much higher in April 2020 than in any other months in 2019 and 2020, and relatively lower among CPC+ physicians compared to comparison physicians. In Track 1, the average rate of physician service interruption in April 2020 was 1.8 percent among CPC+ physicians, compared to 2.2 percent among comparison physicians. In Track 2, the rate of physician service interruption in April 2020 was 1.5 percent among CPC+ physicians, compared to 2.4 percent among comparison physicians.

We also examined the trend by month in service interruption rates at the practice site level including practice site service interruption for any primary care physician in the practice site, complete practice site service interruption for all primary care physicians in the practice site, and complete practice site service interruption for all primary care practitioners in the practice site. Figure 4.F.2 shows the trend in monthly practice service interruption rates for any primary care physician in the practice site. Consistent with the trend in physician service interruption, rates of practice service interruption for any primary care physician in the practice site were much higher in April 2020 than in any other months in 2019 and 2020, and relatively lower among CPC+ physicians compared to comparison physicians. Rates of practice service interruption for any primary care physician in the practice site among CPC+ and comparison practices were 8.4 percent and 10.2 percent, respectively, in Track 1, and 10.0 percent and 13.6 percent, respectively, in Track 2.

Supplemental Figures 4.F.Supp.1 and 4.F.Supp.2 show the trend by month in complete practice site service interruption rates for all primary care physicians and all primary care practitioners, respectively. Rates of complete practice service interruption for all primary care physicians or all primary care practitioners were very low among both CPC+ and comparison practices in all months of 2019 and 2020 in both tracks (e.g., 0.0 to 0.6 percent for all primary care practitioners at a practice site).

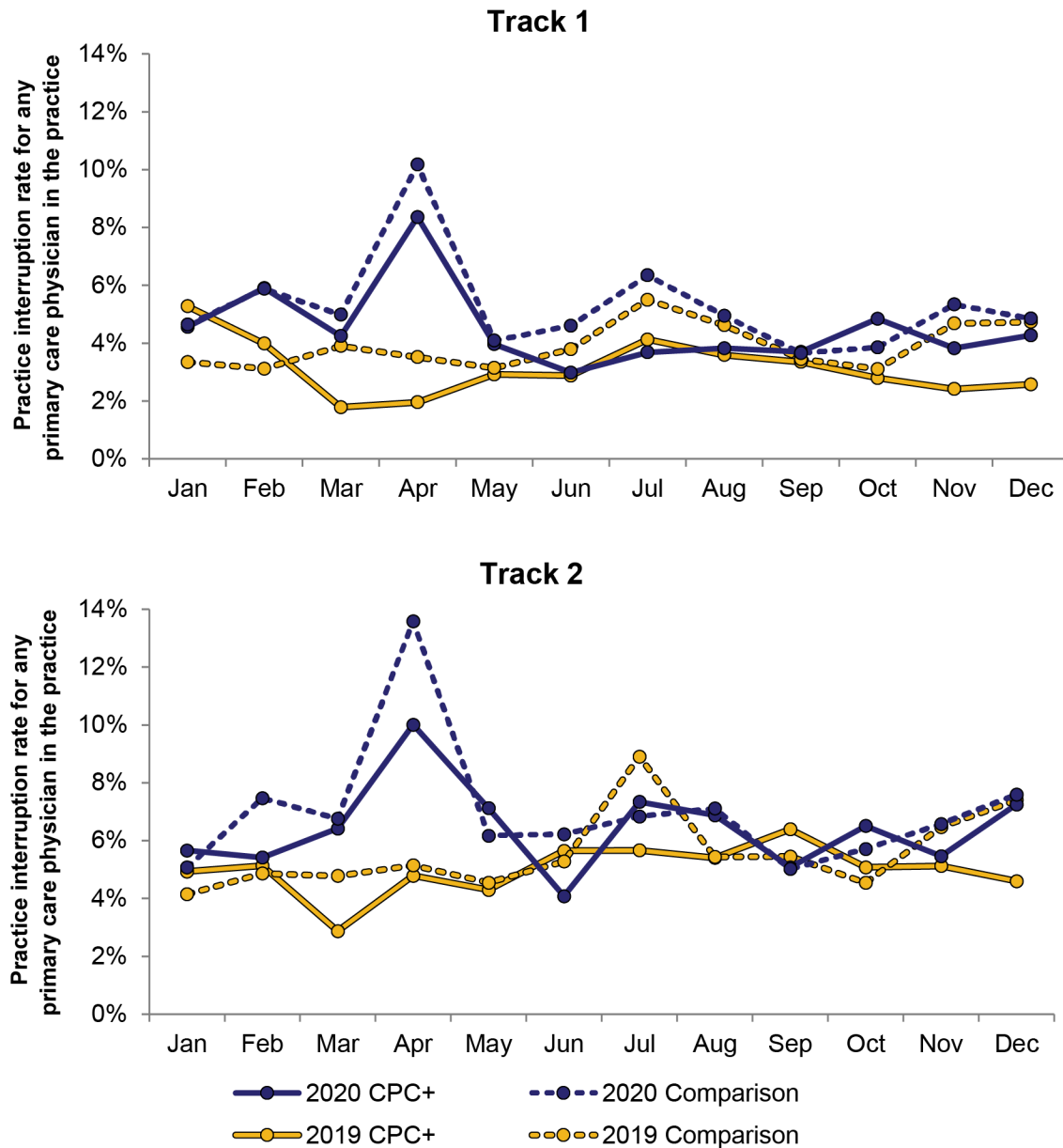
Figure 4.F.1. Monthly physician service interruption rate, by CPC+ status and track



Source: Mathematica’s analysis of Medicare Part B professional claims data from 2018 to 2020.

Note: Physician service interruption was defined as the primary care physician billing any Medicare claims in the previous month but billing zero Medicare claims in the given month (i.e., “new” service interruption). Data were weighted using the practice matching weights.

Figure 4.F.2. Monthly practice site service interruption rate for any primary care physician in the practice site, by CPC+ status and track



Source: Mathematica’s analysis of Medicare Part B professional claims data from 2018 to 2020.

Note: Practice site service interruption for any physician in the practice site was defined as any primary care physician in the practice site billing Medicare claims in the previous month but billing zero Medicare claims in the given month (i.e., “new” practice site service interruption for at least one primary care physician in the practice site). Data were weighted using weights that adjust for both practice-level matching and the number of beneficiaries in a practice for the practice-level outcomes.

B. Summary statistics for physician and practice site service interruption outcomes

Table 4.F.2 presents the summary statistics for physician and practice site service interruption outcomes (i.e., unadjusted rates). As shown in Figures 4.F.1 and 4.F.2, rates of service interruption in April at the physician level and at the practice level for any physician were much higher in 2020 compared to 2019, and the increased interruption was generally lower among CPC+ than among comparison physicians and practice sites. Rates of prolonged service interruption at the physician level and at the practice site level for all primary care physicians and primary care practitioners were also much higher in 2020 compared to 2019.

Our regression analysis focuses on physician service interruption outcomes, since the pattern of service interruption rates for any primary care physician at the practice site was similar to that of physician service interruption rates and very few practice sites experienced prolonged complete service interruptions.

Table 4.F.2. Rates of physician and practice site service interruption in CPC+ and comparison practices before and after COVID-19 (percentages)

Outcomes	Track 1, 2019		Track 1, 2020		Track 2, 2019		Track 2, 2020	
	CPC+	Comparison	CPC+	Comparison	CPC+	Comparison	CPC+	Comparison
Physician-level outcomes								
Physician service interruption in April	0.4	0.6	1.8	2.2	0.6	0.6	1.5	2.4
Prolonged physician service interruption	0.7	1.2	4.7	4.8	0.7	1.0	4.4	4.3
Practice-level outcomes								
Practice service interruption for any primary care physician in the practice site in April	2.0	3.5	8.4	10.2	4.8	5.1	10.0	13.6
Prolonged complete practice service interruption for all primary care physicians in the practice site	0.1	0.2	0.9	0.9	0.1	0.05	0.3	0.4
Prolonged complete practice service interruption for all primary care practitioners in the practice site	0.1	0.2	0.6	0.6	0.1	0.04	0.2	0.3

Source: Mathematica’s analysis of Medicare Part B professional claims data from 2018 to 2020.

Notes: Data were weighted using the practice matching weights for the physician-level outcomes and weights that adjust for both practice-level matching and the number of beneficiaries in a practice for the practice-level outcomes.

C. Impact of CPC+ on physician service interruption outcomes during the COVID-19 pandemic

Table 4.F.3 presents the estimated impact of CPC+ on physician service interruption outcomes during the COVID-19 pandemic using the DID models adjusted for all physician, practice, and community characteristics (for full regression results, see Supplemental Table 4.F.Supp.2). In Track 2, CPC+ physicians were 0.9 percentage points less likely to experience increased service interruptions in April 2020 relative to April 2019, compared to comparison physicians ($p < .01$). However, CPC+ had no impact on physician service interruption rates in April 2020 in Track 1 or on prolonged physician service interruption in either track.

Table 4.F.3 also lists the association of select practice site characteristics with physician service interruption outcomes, to examine the variation in service interruption across specific physician, practice site, and community characteristics after regression adjustment. Among Track 2 CPC+ and comparison practices overall, a practice site being in the highest quartile of the share of dually eligible patients among its attributed patients was associated with higher rates of prolonged physician service interruption (1.4 percentage points, $p < .01$). A practice site being in the highest quartile of the Social Vulnerability Index was not associated with physician service interruption outcomes.

Practice site ownership by a health system was associated with higher rates of prolonged physician service interruption in both tracks among CPC+ and comparison practices (0.7 and 0.8 percentage points in Track 1 and Track 2, respectively, $p < .05$ for both). Practice sites that had a multispecialty composition versus being composed of primary care practitioners only experienced higher rates of physician service interruption in April 2020 in both tracks by around 1 percentage point ($p < .01$). However, the number of primary care practitioners at the practice site had no independent association with rates of physician service interruption.

Table 4.F.3. Impact of CPC+ on physician service interruption outcomes during the COVID-19 pandemic in 2020: difference-in-differences analysis, coefficients in percentage points (SE)

Variables	Track 1		Track 2	
	Physician service interruption in April	Prolonged physician service interruption	Physician service interruption in April	Prolonged physician service interruption
Interaction of CPC+ and Year 2020	-0.15 (0.306)	0.46 (0.420)	-0.87** (0.304)	0.34 (0.378)
Practice site in the highest quartile of dually eligible patients as a percentage of all attributed beneficiaries	0.26 (0.336)	0.87 (0.490)	0.04 (0.328)	1.39** (0.484)
Practice site in the highest quartile of Social Vulnerability Index	0.07 (0.266)	-0.01 (0.421)	0.31 (0.267)	0.31 (0.330)
Practice site is health system owned	0.39 (0.203)	0.68* (0.343)	0.10 (0.207)	0.78* (0.324)
Multispecialty practice site	1.07* (0.507)	0.72 (0.746)	0.93* (0.420)	0.27 (0.542)
Number of primary care practitioners: 3–5	0.01 (0.254)	0.26 (0.426)	-0.01 (0.329)	0.25 (0.401)
Number of primary care practitioners: 6+	0.12 (0.284)	0.44 (0.477)	0.17 (0.337)	0.50 (0.439)

Source: Mathematica’s analysis of Medicare claims data from 2013 to 2020.

Notes: Difference-in-differences models were used to compare the changes in the mean rate of physician service interruption among CPC+ physicians between 2019 and 2020 with changes among comparison physicians over the same period. All models accounted for all other physician, practice, and community characteristics listed in Supplemental Table 4.F.Supp.1. Data were weighted using the practice matching weights. Standard errors (SEs) in parentheses were clustered at the practice site level.

*/**/** Significantly different from zero at the 0.05/0.01/0.001 level, two-tailed test.

D. Results from sensitivity tests and subgroup analysis

We conducted sensitivity analyses that defined physician service interruption in April as a decline in the number of claims by at least 90 percent compared to the previous month. These analyses showed results that were consistent with the main findings (Table 4.F.4). The increase in the rate of physician service interruption in April 2020 relative to April 2019 was 0.9 percentage points lower among CPC+ physicians compared to comparison physicians in Track 2 ($p < .01$). Additional sensitivity analyses that accounted for practice fixed effects instead of baseline practice site characteristics or that accounted for COVID-19 regional controls only during Wave 1 also showed results that were consistent with the main findings.

Table 4.F.4. Impact of CPC+ on physician service interruption outcomes during the COVID-19 pandemic in 2020: sensitivity analysis, coefficients in percentage points (SE)

Variables	Track 1		Track 2	
	Physician service interruption in April	Prolonged physician service interruption	Physician service interruption in April	Prolonged physician service interruption
Alternative definition of physician service interruption as the number of claims declining by at least 90 percent from prior month^a				
Interaction of CPC+ and Year 2020	-0.04 (0.321)	-	-0.88** (0.318)	-
Accounting for practice fixed effects^b				
Interaction of CPC+ and Year 2020	-0.15 (0.333)	0.46 (0.458)	-0.87** (0.327)	0.34 (0.406)
Accounting for only Wave 1 COVID-19 regional controls^c				
Interaction of CPC+ and Year 2020	-0.15 (0.306)	-	-0.87** (0.304)	-

Source: Mathematica’s analysis of Medicare claims data from 2013 to 2020.

Notes: Difference-in-differences models were used to compare the changes in the mean rate of physician service interruption among CPC+ physicians between 2019 and 2020 with changes among comparison physicians over the same period. Data were weighted using the practice matching weights. Standard errors (SEs) in parentheses were clustered at the practice site level.

^a All models accounted for all other physician, practice, and community characteristics listed in Supplemental Table 4.F.Supp.1.

^b All models accounted for practice fixed effects.

^c All models accounted for all physician, practice, and community characteristics listed in Supplemental Table 4.F.Supp.1 except monthly excess deaths and monthly Pandemic Vulnerability Index in Waves 2 and 3.

*/**/** Significantly different from zero at the 0.05/0.01/0.001 level, two-tailed test.

For the subgroup analyses based on select practice site characteristics, we did not find any clear evidence of variation in the impacts of CPC+ on physician service interruption by practice site characteristics. For instance, the joint F test of significance indicated that there was no evidence of variation in impacts across practice subgroups for any outcome, except for physician service interruption in April in Track 2 ($p = .03$; Table 4.F.5). However, for that outcome, none of the individual subgroup interaction terms were statistically significant. The impact of CPC+ on physician service interruption outcomes did not differ across practice site characteristics such as whether the percentage of dually eligible patients among the practice’s attributed beneficiaries was in the highest quartile, whether the Social Vulnerability Index in the practice site’s census tract was in the highest quartile, whether the practice site was system-owned, or the number of primary care practitioners.⁶²

62 Only one of the several subgroup interactions we tested was statistically significant—showing CPC+ reduced prolonged service interruption more (1.8 percentage points, $p < .05$) for multispecialty versus primary care-only practices in Track 2. However, since the joint F test of significance showed that there was no evidence of variation in impacts across practice sites for that outcome, this single statistically significant subgroup interaction could represent a chance finding.

Table 4.F.5. Impact of CPC+ on physician service interruption outcomes during COVID-19 pandemic: subgroup analysis, coefficients in percentage points (SE)

Variables	Track 1		Track 2	
	Physician service interruption in April	Prolonged physician service interruption	Physician service interruption in April	Prolonged physician service interruption
Interaction of CPC+ and Year 2020	-1.38 (0.749)	0.63 (1.006)	-0.66 (1.072)	1.03 (1.134)
Interaction of CPC+, Year 2020, and practice in the highest quartile of dually eligible patients as a percentage of all attributed beneficiaries	-0.05 (0.825)	-0.14 (1.091)	-0.92 (0.818)	-0.04 (1.044)
Interaction of CPC+, Year 2020, and practice in the highest quartile of Social Vulnerability Index	0.40 (0.749)	-1.68 (1.111)	-0.43 (0.786)	-0.62 (0.923)
Interaction of CPC+, Year 2020, and practice is health system-owned	0.34 (0.623)	-0.25 (0.886)	1.05 (0.613)	1.42 (0.747)
Interaction of CPC+, Year 2020, and multispecialty practice	0.91 (0.914)	-0.52 (1.259)	-1.17 (0.757)	-1.85* (0.912)
Interaction of CPC+, Year 2020, and number of primary care practitioners: 3–5	1.62 (0.899)	0.96 (1.191)	0.19 (1.069)	-0.79 (1.240)
Interaction of CPC+, Year 2020, and number of primary care practitioners: 6+	0.54 (0.830)	0.56 (1.166)	-0.52 (1.027)	-1.18 (1.224)
Joint F test of significance ^a	0.5139	0.5689	0.0281	0.1687

Source: Mathematica’s analysis of Medicare claims data from 2013 to 2020.

Notes. Difference-in-differences models were used to compare the changes in the mean rate of physician service interruption among CPC+ physicians between 2019 and 2020 with changes among comparison physicians over the same period. For these subgroup analyses, we included in the regressions the interactions of variables denoting subgroup membership with the indicator for CPC+ versus comparison status and the year indicator. All models accounted for all other physician, practice, and community characteristics listed in Supplemental Table 4.F.Supp.1. Data were weighted using the practice matching weights. Standard errors (SEs) in parentheses were clustered at the practice site level.

^a We conducted a joint test of significance across all practice subgroups in the regression to determine whether there was any evidence of variation in impacts across practice subgroups in general.

*/**/** Significantly different from zero at the 0.05/0.01/0.001 level, two-tailed test.

4.F.4. Discussion

We found that Track 2 CPC+ physicians were 0.9 percentage points less likely than comparison physicians to experience an increase in service interruption in April 2020 relative to April 2019. Given that the rate of service interruption in April 2020 among CPC+ physicians in Track 2 was 1.5 percent, the estimated effect translates to a 36 percent reduction in the rate of physician service interruption during the

COVID-19 pandemic.⁶³ However, our analyses showed that Track 1 of CPC+ had no impact on the rates of physician service interruption in April 2020. Furthermore, neither track of CPC+ had a significant effect on prolonged physician service interruption.

One potential explanation for our findings is that Tracks 1 and 2 of CPC+ differed meaningfully in payment models (and related care delivery requirements). Specifically, the Track 2 model involved a much greater shift of CPC+ practice revenue from traditional FFS toward population-based payment. On average, Track 1 CPC+ practices received 56.1 percent of payment for providing primary care to attributed Medicare beneficiaries as FFS payments and 43.9 percent as a quarterly CMF. In contrast, Track 2 practices received only 33.1 percent of payments for providing primary care to Medicare beneficiaries as FFS payments while 66.9 percent were from the quarterly CMFs or annual Comprehensive Primary Care Payments (CPCPs). Thus, this alternative payment model for Track 2 practices might have better protected CPC+ physicians and practice sites from financial shocks related to the COVID-19 pandemic. Some observers have speculated that such alternative payment models might make primary care practices more resilient during events like the 2020 PHE (Filippi et al. 2021). Greater telehealth expansion in Track 2 practices might have also contributed to reduced physician service interruption; in the fourth annual report for the CPC+ evaluation, we found that during 2020, non-face-to-face outpatient visits were 0.9 and 2.2 percentage points higher for CPC+ Track 1 and Track 2 beneficiaries, respectively, relative to comparison beneficiaries (Swankoski et al. 2022).

On the association between beneficiaries' social disadvantage and physician service interruption, we found that in Track 2 across CPC+ and comparison practices, practice sites' being in the highest quartile of the percentage of dually eligible patients was associated with higher rates of prolonged physician service interruption. This finding indicates that more disadvantaged patients might have suffered even more limited access to health care during the pandemic. Regarding the association between other practice site characteristics and physician service interruption across CPC+ and comparison practices, we found that practice sites owned by a health system or with multispecialty composition were more likely to experience physician service interruption. It is possible that, despite their generally greater financial resources, some system-owned organizations may have reduced staffing at primary care sites in response to the dramatic reductions in system revenue from lucrative specialist and hospital services, when elective procedures were curtailed during the early months of the COVID-19 pandemic. However, these differences did not appear to be affected by participation in CPC+.

Since the timing and magnitude of the COVID-19 pandemic in 2020 differed considerably by region, we controlled for several COVID-19-related regional controls, as in the main impact analysis for CPC+. Among the COVID-19 regional controls, only Wave 1 monthly excess deaths and the Pandemic Vulnerability Index were associated with the physician or practice service interruption outcomes. We conducted a sensitivity analysis where we only controlled for the monthly excess deaths and vulnerability index during Wave 1 of the pandemic. This showed consistent results with the main findings for physician service interruption in April, suggesting that our findings are unlikely to be confounded by differences in the timing of the pandemic across regions.

In addition to the risks imposed by multiple comparisons, our analyses have other limitations. First, the physician service interruption outcomes were measured in 2019 and 2020 but baseline practice site and

⁶³ We calculate percentage impacts relative to what the CPC+ mean would have been in the absence of the intervention—that is, the unadjusted CPC+ mean minus the impact estimate (i.e., $-0.87\% / (1.54\% - (-0.87\%)) = -36\%$).

community characteristics accounted for in the models were primarily measured in 2016. Therefore, we could not account for the effect of more recent pre-PHE changes in practice site characteristics such as practice specialty composition and system ownership. In addition, a small but not negligible proportion of CPC+ and comparison physicians practiced in multiple sites each year. Our analyses could not capture whether the physician service interruption experienced by a physician occurred specifically at the CPC+ or comparison practice site for which we observed specific practice site characteristics. This might lead to an underestimation of the effects of practice site characteristics on physician service interruption for physicians affiliated with multiple practice locations.

Nonetheless, our findings suggest that CPC+ might have reduced physician service interruption during the COVID-19 pandemic, but the effect was limited to Track 2 practices. In addition, the COVID-19 pandemic may have increased health inequality because physicians serving more disadvantaged patients had higher rates of prolonged physician service interruption.

4.F.5. Supplement. Additional Tables and Figures

Table 4.F.Supp.1. Physician, practice, and community characteristics included as control variables in regressions for physician service interruption outcomes

Variables	Categories
Physician characteristics (in 2018)	
Male	
Age	31–50 (reference) ≤ 30 51+
Specialty	Family practice (reference) General practice Internal medicine Geriatric medicine
Practice characteristics at baseline (2016)	
Practice is health system owned	
Participation in prior primary care transformation activities	
Meaningful use of electronic health records	None 2011–12 (reference) 2013–15
Multispecialty practice site	
Distribution of physician specialty: percentage of practitioners in the practice who are primary care	
Practice has one or more nursing practitioners or physician assistants	
Practice census region	Northeast (reference) Midwest South West
Practice urbanicity	Rural Suburban (reference) Urban
Practice has SSP status	
Number of primary care practitioners	1–2 (reference) 3–5 6+
Beneficiary characteristics (aggregated at practice site level in 2016)	
Mean beneficiary fragmentation of care at practice: Usual provider of care	
Mean beneficiary fragmentation of care at practice: Reversed Bice-Boxerman Index	
Age distribution of beneficiaries (percentages in each category)	≤ 49 50–64 65–74 (reference) 75–84 85+
Race/ethnicity distribution of beneficiaries (percentages in each category) ^a	White (reference) Black Other
Original reason for enrollment distribution of beneficiaries	Old age (reference) Disability End-stage renal disease
Percentage of dually eligible patients among the practice's attributed beneficiaries in the highest quartile	
HCC score (average)	

Variables	Categories
Percentage of beneficiaries in highest risk quartile: tier 4	
Percentage of beneficiaries in highest risk quartile: tier 5	
Percentage of beneficiaries with each chronic condition:	
HCC 8 – Metastatic Cancer and Acute Leukemia	
HCC 18 – Diabetes with Chronic Complications	
HCC 21 – Protein-Calorie Malnutrition	
HCC 22 – Morbid Obesity	
HCC 23 – Other Significant Endocrine and Metabolic Disorders	
HCC 85 – Congestive Heart Failure	
HCC 96 – Specified Heart Arrhythmias	
HCC 106 – Atherosclerosis of the Extremities with Ulceration or Gangrene	
HCC 111 – Chronic Obstructive Pulmonary Disease	
HCC 173 – Traumatic Amputations and Complications	
HCC 186 – Major Organ Transplant or Replacement Status	
HCC 40 or 47 – Rheumatoid Arthritis and Inflammatory Connective Tissue Disease or Disorders of Immunity	
HCC 46 or 48 – Severe Hematological Disorders, or Coagulation Defects and Other Specified Hematological Disorders	
HCC 54 or 55 – Drug/Alcohol Psychosis or Dependence	
HCC 57 or 58 – Schizophrenia or Major Depressive, Bipolar, and Paranoid Disorders	
HCC 70 or 71 – Quadriplegia or Paraplegia	
HCC 80 or 82 – Coma, Brain Compression/Anoxic Damage or Respirator Dependence/Tracheostomy Status	
HCC 86, 87, or 88 – Acute Myocardial Infarction, Unstable Angina and Other Acute Ischemic Heart Disease, or Angina Pectoris	
HCC 99 or 100 – Cerebral Hemorrhage, or Ischemic or Unspecified Stroke	
HCC 107 or 108 – Vascular Disease, with Complications	
HCC 157 or 158 – Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone; or of Skin with Full Thickness Skin Loss	
Percentage of beneficiaries with CCW indicator for Alzheimer’s or dementia	
Percentage of beneficiaries with HCC score assigned as a new enrollee HCC score	
Market characteristics (in 2016)	
Medicare Advantage penetration rate	
Median income	
Practice site in a county Health Professional Shortage Area	
HRR price index	
Percentage of people in poverty	
Percentage of people aged 25+ with 4 years of college education	
Ratio of PCPs to total physicians in the county	
Number of practitioners per 100,000 residents	
Number of hospital beds per 1000 residents	1st quartile (reference)
	2nd quartile
	3rd quartile
	4th quartile

Variables	Categories
COVID-19-related controls (in 2020 or 2018)	
Monthly excess deaths in the state-HRR averaged during each wave ^b of the pandemic in 2020	
Monthly Pandemic Vulnerability Index for each county averaged during each wave ^b of the pandemic in 2020	
Government Response Index in 2020	
Social Vulnerability Index ^c in the highest quartile in 2018	

Source: Mathematica’s analysis of Medicare claims data from 2013 to 2020.

^a Race/ethnicity distribution of beneficiaries is derived from the Medicare enrollment database.

^b We define three waves of the COVID-19 pandemic in 2020 based on trends in excess deaths: March–May (Wave 1), June–September (Wave 2), and October–December (Wave 3).

^c The Social Vulnerability Index (SVI), prepared by the Centers for Disease Control and Prevention, draws together 16 different measures of vulnerability in three themes: (1) socioeconomic (for example, poverty, unemployment), (2) demographic (for example, number of elderly and disabled), and (3) housing/transportation (for example, percentage of mobile homes, households with no vehicle). For every measure, census tracts above the 90th percentile, or the most vulnerable 10 percent of communities, are assigned a flag. The SVI is created by counting the total number of flags in each census tract. The higher the count, the more vulnerable the population.

CCW = Chronic Conditions Data Warehouse; HCC = Hierarchical Condition Category; HRR = hospital referral region; PCP = primary care practitioner; SSP = Shared Savings Program.

Table 4.F.Supp.2. Impact of CPC+ on physician service interruption outcomes during COVID-19 pandemic: full regression results from difference-in-differences analysis, coefficients (SE)

Variables	Track 1		Track 2	
	Physician service interruption in April, %	Prolonged physician service interruption, %	Physician service interruption in April, %	Prolonged physician service interruption, %
CPC+	-0.11 (0.170)	-0.40 (0.265)	-0.06 (0.168)	-0.11 (0.222)
Year 2020	1.61*** (0.195)	3.54*** (0.258)	1.84*** (0.228)	3.30*** (0.244)
Interaction of CPC+ and Year 2020	-0.15 (0.306)	0.46 (0.420)	-0.87** (0.304)	0.34 (0.378)
Practice in the highest quartile of dually eligible patients as a percentage of all attributed beneficiaries	0.26 (0.336)	0.87 (0.490)	0.04 (0.328)	1.39** (0.484)
Practice in the highest quartile of Social Vulnerability Index in 2018	0.07 (0.266)	-0.01 (0.421)	0.31 (0.267)	0.31 (0.330)
Practice is health system owned	0.39 (0.203)	0.68* (0.343)	0.10 (0.207)	0.78* (0.324)
Multispecialty practice site	1.07* (0.507)	0.72 (0.746)	0.93* (0.420)	0.27 (0.542)
Number of primary care practitioners (ref: 1–2):				
3–5	0.01 (0.254)	0.26 (0.426)	-0.01 (0.329)	0.25 (0.401)
6+	0.12 (0.284)	0.44 (0.477)	0.17 (0.337)	0.50 (0.439)
Physician is male	-0.35 (0.190)	-0.35 (0.286)	-0.28 (0.190)	-0.58* (0.264)
Physician age (ref: 31–50):				
≤30	0.48 (0.904)	0.04 (0.747)	-0.20 (0.677)	-0.89* (0.431)
51+	0.59** (0.187)	2.17*** (0.280)	0.42* (0.170)	1.98*** (0.270)

Variables	Track 1		Track 2	
	Physician service interruption in April, %	Prolonged physician service interruption, %	Physician service interruption in April, %	Prolonged physician service interruption, %
Specialty (ref: Family practice):				
General practice	-0.23 (0.968)	-3.54 (3.015)	-1.23 (1.734)	-0.58 (1.873)
Internal medicine	0.06 (0.976)	-3.33 (2.999)	-1.05 (1.753)	-0.51 (1.904)
Geriatric medicine	1.74 (1.603)	-4.37 (3.257)	-1.65 (1.937)	-0.25 (2.270)
Participation in prior primary care transformation activities	0.00 (0.166)	0.13 (0.308)	-0.24 (0.205)	-0.19 (0.302)
Meaningful use of electronic health records (ref: 2011–12)				
None	0.17 (0.429)	1.43* (0.663)	-0.38 (0.437)	0.00 (0.597)
2013–15	-0.05 (0.276)	0.14 (0.486)	0.07 (0.375)	0.20 (0.479)
Distribution of physician specialty: percentage of practitioners in the practice who are primary care	2.40 (1.274)	0.11 (1.950)	1.22 (1.207)	-0.99 (1.449)
Practice has one or more NPs/PAs	0.12 (0.193)	0.01 (0.327)	-0.26 (0.196)	-0.12 (0.298)
Practice census region (ref: Northeast region):				
Midwest region	-0.27 (0.401)	0.84 (0.623)	0.42 (0.352)	0.20 (0.505)
South region	0.34 (0.691)	1.65 (1.206)	0.91 (0.552)	2.03* (0.850)
West region	1.05 (0.583)	1.48 (0.976)	1.52** (0.508)	1.73* (0.757)
Practice urbanicity (ref: Suburban):				
Rural	-0.29 (0.517)	2.05 (1.070)	-0.25 (0.382)	1.64* (0.740)
Urban	-0.31 (0.328)	0.40 (0.536)	-0.28 (0.296)	0.28 (0.410)

Variables	Track 1		Track 2	
	Physician service interruption in April, %	Prolonged physician service interruption, %	Physician service interruption in April, %	Prolonged physician service interruption, %
Practice has SSP status	-0.12 (0.172)	-0.16 (0.282)	-0.09 (0.164)	-0.08 (0.262)
Mean beneficiary fragmentation of care at practice: UPC	2.95 (5.398)	1.18 (9.719)	2.53 (5.781)	4.92 (9.704)
Mean beneficiary fragmentation of care at practice: rBBI	1.61 (5.292)	-2.40 (9.570)	10.82* (5.198)	8.72 (7.951)
Percentage of beneficiaries male	1.32 (1.297)	-0.52 (2.192)	3.07* (1.370)	0.94 (2.312)
Age distribution of beneficiaries (ref: 65–74):				
≤ 49	-1.94 (6.911)	-9.08 (9.982)	2.74 (5.625)	1.01 (8.497)
50–64	-6.37 (5.649)	-5.50 (8.614)	0.21 (5.292)	-2.18 (7.436)
75–84	0.04 (2.793)	-0.34 (4.863)	-0.90 (3.087)	4.27 (4.116)
85+	2.98 (4.043)	-1.98 (5.896)	3.62 (3.527)	10.46 (5.526)
Race/ethnicity distribution of beneficiaries (ref: White):				
Black	-1.25 (0.802)	-1.18 (1.862)	1.04 (0.897)	-1.30 (1.438)
Other	0.48 (1.835)	-1.78 (1.744)	3.32 (2.054)	-3.85* (1.791)
Original reason for enrollment distribution of beneficiaries (ref: old age):				
Disability	7.35 (5.241)	5.70 (6.986)	-0.33 (4.172)	-0.59 (6.862)
ESRD	26.83 (23.309)	22.61 (45.553)	-35.25 (29.314)	-10.09 (37.241)
HCC score (average)	3.83 (3.222)	-3.24 (4.813)	4.05 (2.903)	-1.03 (3.743)
Percentage of beneficiaries in highest risk quartile: tier 4	-10.32 (5.609)	-9.24 (8.621)	-1.88 (5.304)	-1.72 (7.203)

Variables	Track 1		Track 2	
	Physician service interruption in April, %	Prolonged physician service interruption, %	Physician service interruption in April, %	Prolonged physician service interruption, %
Percentage of beneficiaries in highest risk quartile: tier 5	-25.40** (7.865)	12.89 (12.584)	-4.56 (8.039)	-17.98 (11.022)
Percentage of beneficiaries with each chronic condition:				
HCC 8 – Metastatic Cancer and Acute Leukemia	-6.42 (16.973)	0.88 (24.950)	-23.73 (18.284)	26.73 (24.093)
HCC 18 – Diabetes with Chronic Complications	0.99 (2.524)	1.90 (5.000)	0.83 (2.478)	5.95 (4.501)
HCC 21 – Protein-Calorie Malnutrition	4.36 (9.110)	-11.06 (16.522)	7.22 (13.973)	11.95 (17.487)
HCC 22 – Morbid Obesity	4.61 (4.655)	5.53 (7.291)	1.68 (5.079)	6.37 (7.512)
HCC 23 – Other Significant Endocrine and Metabolic Disorders	-4.04 (4.055)	-0.21 (8.587)	-13.22* (5.900)	8.97 (7.512)
HCC 85 – Congestive Heart Failure	-2.03 (3.248)	-9.71 (5.850)	-5.49 (3.743)	1.25 (5.451)
HCC 96 – Specified Heart Arrhythmias	5.25 (5.367)	9.14 (5.603)	-1.04 (4.136)	-5.35 (5.603)
HCC 106 – Atherosclerosis of the Extremities with Ulceration or Gangrene	9.40 (27.150)	-32.91 (35.802)	-54.95** (21.226)	-28.13 (33.122)
HCC 111 – Chronic Obstructive Pulmonary Disease	2.68 (3.667)	2.93 (8.337)	2.83 (3.857)	6.17 (5.099)
HCC 173 – Traumatic Amputations and Complications	-6.10 (28.739)	-13.76 (44.172)	52.34 (37.944)	-26.56 (42.121)
HCC 186 – Major Organ Transplant or Replacement Status	-16.66 (40.548)	-40.71 (44.847)	-49.70 (31.746)	-37.06 (38.593)
HCC 40 or 47 – Rheumatoid Arthritis and Inflammatory Connective Tissue Disease or Disorders of Immunity	5.87 (4.294)	1.82 (5.473)	-2.35 (4.407)	-5.65 (5.613)
HCC 46 or 48 – Severe Hematological Disorders, or Coagulation Defects and Other Specified Hematological Disorders	-3.48 (4.129)	3.14 (10.551)	-9.94 (5.735)	-7.38 (8.087)

Variables	Track 1		Track 2	
	Physician service interruption in April, %	Prolonged physician service interruption, %	Physician service interruption in April, %	Prolonged physician service interruption, %
HCC 54 or 55 – Drug/Alcohol Psychosis or Dependence	0.98 (5.547)	12.38 (8.734)	-1.11 (5.795)	22.92* (10.621)
HCC 57 or 58 – Schizophrenia or Major Depressive, Bipolar, and Paranoid Disorders	-1.38 (3.500)	-7.69 (5.463)	-0.99 (3.057)	-4.68 (4.751)
HCC 70 or 71 – Quadriplegia or Paraplegia	-12.82 (19.770)	5.75 (32.716)	-17.30 (25.985)	41.43 (37.832)
HCC 80 or 82 – Coma, Brain Compression/Anoxic Damage or Respirator Dependence / Tracheostomy Status	-29.09 (22.722)	70.28 (45.879)	17.74 (27.785)	37.43 (39.909)
HCC 86, 87, or 88 – Acute Myocardial Infarction, Unstable Angina and Other Acute Ischemic Heart Disease, or Angina Pectoris	0.87 (4.542)	-2.09 (6.918)	0.45 (7.429)	1.18 (7.393)
HCC 99 or 100 – Cerebral Hemorrhage, or Ischemic or Unspecified Stroke	-2.05 (6.306)	-12.19 (11.355)	-3.58 (7.640)	9.47 (10.415)
HCC 107 or 108 – Vascular Disease, with Complications	-2.63 (2.213)	8.56 (5.863)	-4.23 (2.264)	-2.90 (3.463)
HCC 157 or 158 – Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone; or of Skin with Full Thickness Skin Loss	-47.77 (25.349)	-36.05 (46.037)	-9.85 (27.296)	-23.11 (40.073)
Percentage of beneficiaries with CCW Alzheimer's or dementia	20.76** (6.986)	-1.89 (11.519)	0.45 (7.929)	9.48 (10.730)
Percentage of beneficiaries with HCC score assigned as a new enrollee HCC score	-0.18 (4.684)	6.35 (5.956)	-1.22 (2.847)	4.12 (4.142)
Medicare Advantage penetration rate	0.00 (0.011)	-0.0 (0.016)	0.01 (0.009)	0.00 (0.013)
Median income	0.00 (0.000)	0.00* (0.000)	0.00 (0.000)	0.00 (0.000)
Practice site in a county HPSA	-0.49 (0.575)	-1.30 (1.128)	-0.55 (0.600)	-0.28 (0.765)
HRR price index	2.65 (2.089)	8.99* (3.750)	-2.59 (1.974)	4.46 (3.266)
Percentage of people in poverty	-0.02 (0.059)	-0.16 (0.098)	-0.04 (0.055)	-0.15 (0.084)

Variables	Track 1		Track 2	
	Physician service interruption in April, %	Prolonged physician service interruption, %	Physician service interruption in April, %	Prolonged physician service interruption, %
Percentage of people aged 25+ with 4 years of college education	0.00 (0.019)	0.01 (0.031)	0.01 (0.019)	0.01 (0.030)
Ratio of PCPs to total physicians in the county	1.79 (1.265)	2.93 (2.751)	1.41 (1.483)	-5.11* (2.218)
Number of practitioners per 100,000 residents	0.00* (0.001)	0.00** (0.001)	0.00 (0.001)	0.00 (0.001)
Number of hospital beds per 1000 residents (ref: 1st quartile):				
2nd quartile	-0.13 (0.265)	-0.23 (0.422)	0.14 (0.276)	-0.04 (0.434)
3rd quartile	-0.52 (0.300)	-0.28 (0.476)	-0.22 (0.261)	-0.84* (0.411)
4th quartile	-0.54 (0.397)	-0.35 (0.686)	0.00 (0.327)	-0.55 (0.517)
Monthly excess deaths in the state-HRR in 2020:				
Wave 1	0.01 (0.020)	-0.02 (0.028)	0.06** (0.021)	0.01 (0.027)
Wave 2	-0.03 (0.062)	0.08 (0.111)	-0.09 (0.053)	0.08 (0.086)
Wave 3	0.02 (0.029)	0.04 (0.052)	0.00 (0.029)	-0.01 (0.040)
Monthly Pandemic Vulnerability Index for each county in 2020:				
Wave 1	1.35 (4.766)	15.58* (7.672)	-0.34 (4.289)	4.73 (6.023)
Wave 2	3.91 (6.983)	-2.55 (15.122)	6.71 (7.919)	0.38 (11.783)
Wave 3	2.66 (7.094)	-9.11 (14.641)	-2.19 (7.655)	1.31 (12.085)
Government Response Index in 2020	0.00 (0.031)	-0.02 (0.056)	0.02 (0.025)	0.04 (0.040)
Constant	-14.67 (7.887)	-0.77 (13.341)	-12.64 (8.066)	-13.01 (12.959)

Variables	Track 1		Track 2	
	Physician service interruption in April, %	Prolonged physician service interruption, %	Physician service interruption in April, %	Prolonged physician service interruption, %
Observations	35,558	35,558	34,378	34,378
R-square	0.0123	0.0246	0.0126	0.0221

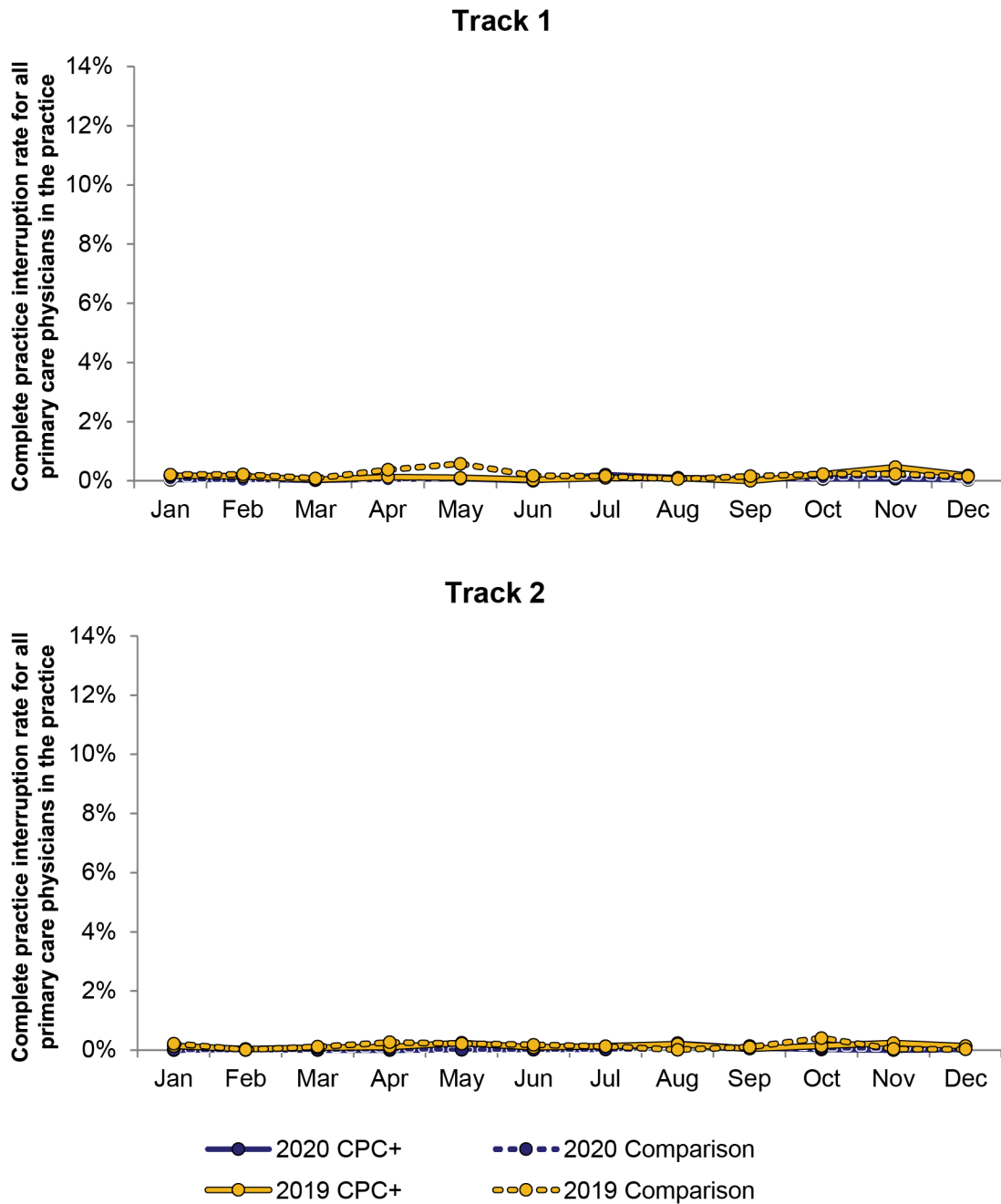
Source: Mathematica’s analysis of Medicare claims data from 2013 to 2020.

Note: Difference-in-differences models were used to compare the changes in the mean rate of physician service interruption among CPC+ physicians between 2019 and 2020 with changes among comparison physicians over the same period. Data were weighted using the practice matching weights. Standard errors in parentheses were clustered at the practice site level.

rBBI = Reversed Bice-Boxerman Continuity-of-Care Index; ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; HPSA = Health Professional Shortage Areas; HRR = hospital referral region; NP = nurse practitioner; PA = physician’s assistant; PCP = primary care practitioner; SE = standard error; UPC = usual provider of care.

*/**/** Significantly different from zero at the 0.05/0.01/0.001 level, two-tailed test.

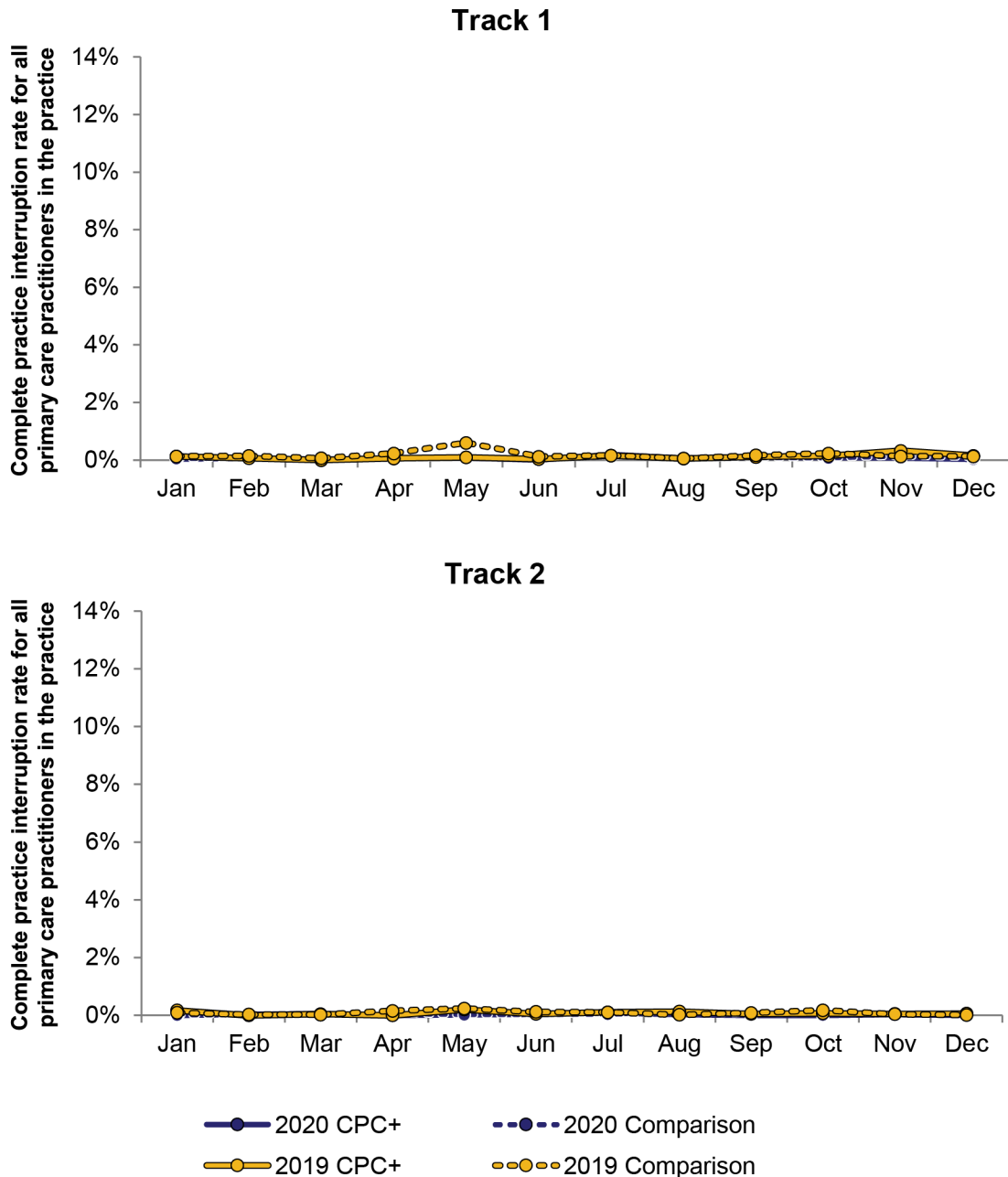
Figure 4.F.Supp.1. Monthly complete practice service interruption rate for all primary care physicians in the practice site, by treatment status and track



Source: Mathematica’s analysis of Medicare Part B professional claims data from 2018 to 2020.

Note: Complete practice service interruption for all primary care physicians in the practice site was defined as at least one primary care physician in the practice site billed any Medicare claims in the previous month but all physicians billed zero Medicare claims in the given month (i.e., “new” complete practice service interruption for all primary care physicians in the practice site). Data were weighted using the practice matching weights.

Figure 4.F.Supp.2. Monthly complete practice service interruption rate for all primary care practitioners in the practice site, by treatment status and track



Source: Mathematica’s analysis of Medicare Part B professional claims data from 2018 to 2020.

Note: Complete practice service interruption for all primary care practitioners in the practice site was defined as at least one primary care practitioner (primary care physicians, nursing practitioner, and physician assistant) in the practice billed any Medicare claims in the previous month but all practitioners billed zero Medicare claims in the given month (i.e., “new” complete practice service interruption for all practitioners in the practice site). Data were weighted using the practice matching weight.

References

- Albert, S., M. Paul, A. Nguyen, D. Shelley, and C. Berry “A Qualitative Study of High-Performing Primary Care Practices During the COVID-19 Pandemic.” *BMC Family Practice*, vol. 22, no. 237, 2021. <https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-021-01589-4>.
- American College of Clinical Pharmacy. “Comprehensive Medication Management in Team-Based Care.” 2016. <https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf>.
- Amon, C., J. King, J. Colclasure, K. Hodge, and C.A. DuBard “Leveraging Accountable Care Organization Infrastructure for Rapid Pandemic Response in Independent Primary Care Practices.” *Healthcare*, vol. 10, 2022. <https://doi.org/10.1016/j.hjdsi.2022.100623>.
- Anglin, G., D. Peikes, M. Harrington, A. Ghosh, K. Geonnotti, A. O’Malley, S. Dale, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report, Supplemental Volume.” Princeton, NJ: Mathematica, 2019.
- Anglin, G., D. Peikes, D. Petersen, A. O’Malley, K. Geonnotti, A. Ghosh, P. Singh, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Second Annual Report.” Princeton, NJ: Mathematica, 2020.
- Brummel, A., and A.M. Carlson. “Comprehensive Medication Management and Medication Adherence for Chronic Conditions.” *Journal of Managed Care & Specialty Pharmacy*, vol. 22, no. 1, 2016, pp. 56–62. doi: 10.18553/jmcp.2016.22.1.56. PMID: 27015052.
- Castelli, G., J.L. Bacci, S.K. Dombrowski, M. Osborne, A. Difilippo, P.M. Klatt, and M.S. McGivney. “Pharmacist-Delivered Comprehensive Medication Management Within Family Medicine Practices: An Evaluation of the SCRIPT Project.” *Family Medicine*, vol. 50, no. 8, 2018, pp. 605–612. doi: 10.22454/FamMed.2018.391124. PMID: 30215820.
- Center for Medicare & Medicaid Innovation. “CPC+ Payment and Attribution Methodologies for Program Year 2021, version 2.” March 23, 2021. <https://innovation.cms.gov/media/document/cpc-plus-payment-methodology-cy2021>.
- Centers for Medicare & Medicaid Services (CMS). “Information for Health IT Vendors.” n.d. <https://innovation.cms.gov/files/slides/cpcplus-healthvendoroverview-slides.pdf>
- Centers for Medicare & Medicaid Services (CMS). “CPC+ Certified Health IT Requirements (Revised).” 2016. <https://innovation.cms.gov/files/x/cpcplus-hit-track2reqs.pdf>
- Centers for Medicare & Medicaid Services (CMS). “Final 2019 CPC+ Health IT Requirements.” November 2018. <https://innovation.cms.gov/files/x/cpcplus-hit-py2019.pdf>
- Centers for Medicare & Medicaid Services (CMS). “CPC+ Care Delivery Requirements Crosswalk.” December 2019. <https://innovation.cms.gov/files/x/cpcplus-practicecaredlvreqs.pdf>.

- Centers for Medicare & Medicaid Services (CMS). “2021 CPC+ Implementation Guide: Guiding Principles and Reporting.” 2021.
- Chung, T.H., R.J. Hernandez, A. Libaud-Moal, et al. “The Evaluation of Comprehensive Medication Management for Chronic Diseases in Primary Care Clinics, a Texas Delivery System Reform Incentive Payment Program.” *BMC Health Services Research*, vol. 20, no. 671, 2020. <https://doi.org/10.1186/s12913-020-05537-3>.
- Cimino, J. “Improving the Electronic Health Record—Are Clinicians Getting What They Wished for?” *JAMA*, vol. 309, no. 10, 2013, pp. 991–992. doi:10.1001/jama.2013.890
- Damschroder, L.J., D.C. Aron, R.E. Keith, S.R. Kirsh, J.A. Alexander, and J.C. Lowery. “Fostering Implementation of Health Services Research Findings into Practice: A Consolidated Framework for Advancing Implementation Science.” *Implementation Science*, vol. 4, no. 50, 2009. <https://doi.org/10.1186/1748-5908-4-50>.
- Filippi, M.K., E. Callen, A. Wade, M. Coffman, J.M. Westfall, Y. Jabbarpour, C.M. Hester, and J. Carroll. “COVID-19’s Financial Impact on Primary Care Clinicians and Practices.” *Journal of the American Board of Family Medicine*, vol. 34, no. 3, 2021, pp. 489–497.
- Finkelstein, J., M.S. Barr, P.P. Kothari, D.K. Nace, and M. Quinn. “Patient-Centered Medical Home Cyberinfrastructure Current and Future Landscape.” *American Journal of Preventive Medicine*, vol. 40, no. 5, suppl 2, 2011, pp. S225–S233. doi: 10.1016/j.amepre.2011.01.003. PMID: 21521598.
- Funk, K.A., D.L. Pestka, M.T. Roth McClurg, J.K. Carroll, and T.D. Sorensen. “Primary Care Providers Believe That Comprehensive Medication Management Improves Their Work-Life.” *Journal of the American Board of Family Medicine*, vol. 32, no. 4, 2019, pp. 462–473. doi: 10.3122/jabfm.2019.04.180376. PMID: 31300566.
- Funk, K.A., L.A. Sorge, A.W. Bazemore, T.D. Sorensen, M.T.R. McClurg, and J.K. Carroll. “How Comprehensive Medication Management Contributes to Foundational Elements of Primary Care.” *Journal of the American Board of Family Medicine*, vol. 34, no. 2, 2021, pp. 420–423. doi: 10.3122/jabfm.2021.02.190318. PMID: 33833012.
- Ghosh, A., S. Orzol, S. Dale, J. Laird, N. Fu, P. Singh, M.-Y. Kim, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Second Annual Report, Appendices to the Supplemental Volume.” Princeton, NJ: Mathematica, 2020.
- Keith, R.E., J.C. Crosson, A.S. O’Malley, et al. “Using the Consolidated Framework for Implementation Research (CFIR) to Produce Actionable Findings: A Rapid-Cycle Evaluation Approach to Improving Implementation.” *Implementation Science*, vol. 12, no. 15, 2017. <https://doi.org/10.1186/s13012-017-0550-7>.
- Kellerman, R., and L. Kirk. “Principles of the Patient-Centered Medical Home.” *American Family Physician*, vol. 76, no. 6, 2007, pp. 774–775. PMID: 17910291.
- King, J., V. Patel, E. Jamoom, and C. DesRoches. “The Role of Health IT and Delivery System Reform in Facilitating Advanced Care Delivery.” *American Journal of Managed Care*, vol. 22, no. 4, 2016, pp. 258–265. PMID: 27143291; PMCID: PMC4878450.

- Koller, C.F. “Payer Actions and Primary Care in the Wake of COVID-19: Will Primary Care Be There When We Need It?” In *Primary Care in the COVID-19 Pandemic*, Milbank Memorial Fund, April 20, 2021. <https://www.milbank.org/publications/primary-care-in-the-covid-19-pandemic/>.
- Kuo, T., S. Chen, S.-M. Oh, N.C. Barragan, and the American Heart Association Western States Chronic Disease Prevention and Management Committee. “Comprehensive Medication Management as a Standard of Practice for Managing Uncontrolled Blood Pressure.” *Frontiers in Medicine*, vol. 8, 2021. doi: 10.3389/fmed.2021.693171.
- Laird, J., A. Markovitz, J. Zurovac, P. Singh, D. Petersen, P. Shanmugam, N. Morrison, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Appendices to the Fourth Annual Report.” Princeton, NJ: Mathematica, 2022.
- Laird, J., L. Timmins, N. Fu, J. Embry, B. Sullivan, P. Shanmugam, N. Morrison, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Appendices to the Final Report, Volume II (Chapter 5).” Princeton, NJ: Mathematica, 2023.
- Landon, B.E., and S.N. Landon “Financial Challenges for Primary Care Under COVID-19” In *Primary Care in the COVID-19 Pandemic*, Milbank Memorial Fund, April 20, 2021. <https://www.milbank.org/publications/primary-care-in-the-covid-19-pandemic/>
- Lin, S., A. Sattler, and M. Smith. “Retooling Primary Care in the COVID-19 Era.” *May Clinic Proceedings*, vol. 95, no. 9, 2020. <https://doi.org/10.1016/j.mayocp.2020.06.050>
- Mafi, J., M. Craff, S. Vangala, T. Pu, D. Skinner, C. Tabatabai-Yazdi, A. Nelson, et al. “Trends in US Ambulatory Care Patterns During the COVID-19 Pandemic, 2019-2021.” *Journal of the American Medical Association*, vol. 327, no. 3, 2022. doi:10.1001/jama.2021.24294.
- McFarland, M.S., M.L. Buck, E. Crannage, L.T. Armistead, H. Ourth, S.W. Finks, and M.R McClurg. “Assessing the Impact of Comprehensive Medication Management on Achievement of the Quadruple Aim.” *American Journal of Medicine*, vol. 134, no. 4, 2021, pp. 456–461. <https://doi.org/10.1016/j.amjmed.2020.12.008>.
- Mulrooney, M., and M. Smith. “Primary Care Pharmacist Practice Models Shape the Comprehensive Medication Management Process.” *Annals of Pharmacotherapy*, vol. 56, no. 5, 2022, pp. 620–625. doi:10.1177/10600280211042031.
- National Academies of Sciences, Engineering, and Medicine (NASEM). “Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.” Washington, DC: The National Academies Press, 2021. <https://doi.org/10.17226/25983>.
- Neprash, H.T., and M.E. Chernew. “Physician Practice Interruptions in the Treatment of Medicare Patients During the COVID-19 Pandemic.” *JAMA*, vol. 326, no. 13, 2021, pp. 1325–1328. <https://jamanetwork.com/journals/jama/fullarticle/2784484>.
- O’Malley, A., P. Singh, N. Fu, N. Duda, N. McCall, K. Geonnotti, D. Petersen, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Annual Report.” Princeton, NJ: Mathematica, 2023.

- Orzol, S., A. Ghosh, N. Fu, J. Laird, S. Dale, L. Timmins, K. Swankoski, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Appendices to the Third Annual Report.” Princeton, NJ: Mathematica, 2021.
- Patient-Centered Primary Care Collaborative (PCPCC). “The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes Resource Guide, 2nd ed.” Washington, DC: PCPCC, 2012.
www.pcpcc.org/sites/default/files/media/medmanagement.pdf.
- Peikes, D., G. Anglin, M. Harrington, A. Ghosh, K. Geonnotti, A. O’Malley, S. Dale, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report.” Princeton, NJ: Mathematica, 2019a.
- Peikes, D., G. Anglin, M. Harrington, A. Ghosh, K. Geonnotti, A. O’Malley, S. Dale, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report, Appendices to the Supplemental Volume.” Princeton, NJ: Mathematica, 2019b.
- Peikes, D., S. Dale, A. Ghosh, E.F. Taylor, K. Swankoski, A. O’Malley, T. Day, et al. “The Comprehensive Primary Care Initiative: Effects on Spending, Quality, Patients, and Physicians.” *Health Affairs (Millwood)*, vol. 37, no. 6, 2018, pp. 890–899. doi: 10.1377/hlthaff.2017.1678. Epub 2018 May 23. PMID: 29791190.
- Peikes, D., K. Swankoski, A. O’Malley, L. Timmins, D. Petersen, K. Geonnotti, H. Tu, et al. “Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Third Annual Report.” Princeton, NJ: Mathematica, 2021.
- Primary Care Collaborative. “Quick COVID-19 Primary Care Survey.” Larry A. Green Center, March 2021. <https://www.green-center.org/covid-survey>. Accessed July 29, 2021.
- Prudencio, J., and M. Kim. “Diabetes-Related Patient Outcomes through Comprehensive Medication Management Delivered by Clinical Pharmacists in a Rural Family Medicine Clinic.” *Pharmacy (Basel)*, vol. 8, no. 3, 2020, p.115. doi: 10.3390/pharmacy8030115. PMID: 32660091; PMCID: PMC7558112.
- Quality Payment Program. “How MIPS Eligibility Is Determined.” May 11, 2022.
<https://qpp.cms.gov/mips/how-eligibility-is-determined#mips-eligible-clinician-types>.
- Ridgeway, J.L., J.S. Egginton, K. Tiedje, M. Linzer, D. Boehm, S. Poplau, D.R. de Oliveira, L. Odell, V.M. Montori, and D.T. Eton. “Factors That Lessen the Burden of Treatment in Complex Patients with Chronic Conditions: A Qualitative Study.” *Patient Preference and Adherence*, vol. 8, 2014, pp. 339–351. doi: 10.2147/PPA.S58014. PMID: 24672228; PMCID: PMC3964167.
- Smith, M., D.W. Bates, and T.S. Bodenheimer. “Pharmacists Belong in Accountable Care Organizations and Integrated Care Teams.” *Health Affairs*, vol. 32, no. 11, 2013, pp. 1963–1970. doi: 10.1377/hlthaff.2013.0542. PMID: 24191087.
- Spencer-Bonilla, G., A.R. Quiñones, V.M. Montori, et al. “Assessing the Burden of Treatment.” *Journal of General Internal Medicine*, vol. 32, 2017, pp. 1141–1145. <https://doi.org/10.1007/s11606-017-4117-8>.

- Swankoski, K., A. O'Malley, H. Tu, D. Petersen, P. Singh, K. Geonnotti, R. Keith, et al. "Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Fourth Annual Report." Princeton, NJ: Mathematica, 2022.
- The Physicians Foundation. "2020 Survey of America's Physicians: COVID-19 Impact Edition." December 2020. https://physiciansfoundation.org/wp-content/uploads/2020/12/2020-Survey-of-Americas-Physicians_Exec-Summary.pdf. Accessed July 19, 2021.
- Tripathi, M., and S. Posnack. "E Pluribus Unum." Health IT Buzz. August 5, 2022. <https://www.healthit.gov/buzz-blog/interoperability/e-pluribus-unum>.
- White, N. "Reducing Primary Care Provider Burnout with Pharmacist-Delivered Comprehensive Medication Management." *American Journal of Lifestyle Medicine*, vol. 15, no. 2, 2020, pp. 133–135. doi: 10.1177/1559827620976539. PMID: 33790699; PMCID: PMC7958224.

□

Mathematica Inc.

Princeton, NJ • Ann Arbor, MI • Cambridge, MA
Chicago, IL • Oakland, CA • Seattle, WA
Woodlawn, MD • Washington, DC

EDI Global, a Mathematica Company

Operating in Tanzania, Uganda, Kenya, Mozambique, and the United Kingdom

Mathematica, Progress Together, and the “spotlight M” logo are registered trademarks of Mathematica Inc.



mathematica.org [website](#)