The following appendices are part of a Commonwealth Fund issue brief, Jennifer Podulka, Yamini Narayan, and Lynea Holmes, *Increasing Medicare's Investment in Primary Care* (Commonwealth Fund, Mar. 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/increasing-medicares-investment-primary-care.

APPENDIX A

Completed Primary Care–Focused CMMI Models

Program	Description	Multipayer?	Years in effect
Comprehensive Primary Care (CPC)	Multipayer initiative in seven U.S. regions that included population-based care management fees and the opportunity to receive shared savings for participating primary care practices	Yes	2012–2016
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice	Aimed to demonstrate how the patient-centered medical home model could improve quality of care, promote better health, and lower costs. Participating FQHCs were expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, and actively coordinate care for patients.*	No	2011–2014
Frontier Extended Stay Clinic (FESC)	Allowed remote clinics to treat patients for more extended periods, including overnight stays, than are entailed in routine physician visits	No	2010–2013
Graduate Nurse Education	Provided reimbursement to five hospitals for the reasonable cost of providing clinical training to additional advanced practice registered nursing (APRN) students	No	2012–2018
Medicare Coordinated Care	Tested whether providing coordinated care services to Medicare fee-for-service beneficiaries with complex chronic conditions could yield better patient outcomes without increasing program costs	No	2002–2014
Multipayer Advanced Primary Care Practice	Multipayer reform initiatives that were conducted by states to make advanced primary care practices more broadly available and test the extent to which they reduced unjustified utilization and expenditures and improved the safety, effectiveness, timeliness, and efficiency of health care	Yes	2011–2016
Transforming Clinical Practice	Supported clinician practices through nationwide, collaborative, and peer-based learning networks designed to help clinicians and practices achieve large-scale health care transformation; prepare practices to successfully participate in value-based payment arrangements, including alternative payment models (APMs); and improve the quality of care	Yes	2015–2019

* Level 3 is the highest level of recognition among patient-centered medical homes. To achieve this status, a patient-centered medical home generally has a comprehensive electronic health record (EHR) system and proficiency with data-driven analytics.

Notes: CMMI = Center for Medicare and Medicaid Innovation. Multipayer indicates whether the model includes only Medicare or additional payers. Some observers recommend the inclusion of multiple payers for more robust evaluation and increased chance of adoption. CMMI lists including multiple payers in more models as one of the goals in the new "strategy refresh" that signals the center's plans for the future. Models that began prior to 2010 were transferred to CMMI once it was established.

Data: Health Management Associates analysis of data from the Center for Medicare and Medicaid Innovation.

APPENDIX B

Current and Recently Completed Primary Care–Focused CMMI Models

	Comprehensive Primary Care Plus (CPC+)*	Global and Professional Direct Contracting (GPDC)**	Independence at Home (IAH)	Primary Care First
Description	National advanced primary care medical home model that tested the effects of multipayer payment reform, actionable data feedback, robust learning supports, and health IT vendor support on primary care practices	Model based on lessons learned from accountable care organizations and Medicare Advantage that allows various types of physician practices and other organizations to choose among voluntary risk-sharing options	Model delivering comprehensive primary care services at home to beneficiaries with multiple chronic conditions	Model of seamless continuum of care featuring various payment options, including financial-risk-based options and performance-based payments
Performance period	Jan. 2017–Dec. 2021	Apr. 2021–Dec. 2026	June 2012–Dec. 2023	Jan. 2021–Dec. 2026
States	18	40	8	27
Practices	2,610	53	9	822
Clinicians	>13,000	Not available	Not available	Not available
Patients	>17 million	Not available	6,388	Not available
Multipayer?	Yes	No	No	Yes
Some capitated payment?	Yes	Yes	No	Yes
Some physician fee schedule (FFS) payment?	Yes	Yes	Yes	No
Performance-based incentive payments?	Yes	Yes	Yes	Yes
Some prospective payment?	Yes	Yes	No	Yes
Two-sided risk for some cohorts/ tracks?	Yes	Yes	No	Yes
Expanded access to care requirement?	Yes	No	Yes	Yes

* Includes two practice tracks. Track 2 contains more advanced care delivery requirements and financial support and a greater shift from fee-for-service (FFS) toward population-based payment.

** GPDC will be rebranded as Accountable Care Organization Realizing Equity, Access, and Community Health Model, or ACO REACH, effective January 1, 2023.

Notes: CMMI = Center for Medicare and Medicaid Innovation. All data from available information about most recent performance year. Data for earlier performance years differ for some characteristics.

Data: Health Management Associates analysis of data from the Center for Medicare and Medicaid Innovation.

APPENDIX C

Payment Models Used by Current and Recently Completed Primary Care–Focused CMMI Models

	Comprehensive Primary Care Plus (CPC+)*	Global and Professional Direct Contracting (GPDC)**	Independence at Home (IAH)	Primary Care First
Performance-based incentive payment	Prospectively paid and retrospectively reconciled, based on performance on patient experience, clinical quality, and utilization measures **Track 1:** $15 per beneficiary per month (PBPM) average **Track 2:** $28 PBPM average	Shared-savings payments, funded by a 5% withhold, paid following each year to direct contract entities (DCEs) that meet quality thresholds	Opportunity to share in a maximum of 80% of any savings beyond the first 5%, paid following each year to practices that achieve standards on quality measures	Opportunity to be paid an additional 50% of model payments and a downside of –10% of model payments, assessed and paid quarterly, based on performance on quality and cost measures
Medicare Physician Fee Schedule payment	**Track 1:** Medicare FFS (fee-for-service) **Track 2:** Partly Medicare FFS + practices can elect to have either 40% or 65% of their payments paid prospectively via a comprehensive primary care payment (CPCP)	DCEs can choose Medicare FFS payment from the Centers for Medicare and Medicaid Services (CMS) only for non-primary care and have flexibility to tailor payment arrangements with providers	Medicare FFS	No
Capitated payment	CPCP paid quarterly and greater than the FFS payment amounts they replace to account for increased comprehensiveness of care (only for Track 2)	DCEs must choose monthly capitation from CMS for primary care or all care and have flexibility to tailor payment arrangements with providers	No	A population-based payment ranging from $28 to $175 per member per month (PMPM), adjusted for average risk for all patients attributed to the practice
Other payment	**Care management fee (CMF):** A non-visit-based PBPM CMF paid on a quarterly basis, risk-adjusted for each practice's population **Track 1:** $136,201 per practice (10% of total practice revenue) **Track 2:** $268,560 per practice (15% of total practice revenue)	No	No	**A flat payment:** National average primary care visit fee of $40.82, which can be billed regardless of whether the service is provided in-person or via telehealth
Most recent evaluation	Third year	Not available	Sixth year	Not available
Spending findings	"Total Medicare expenditures including enhanced payments increased."	Not available	"Insignificant reduction in total Medicare expenditures."	Not available
Quality findings	"Few, very small favorable impacts."	Not available	"Effect on performance was inconclusive."	Not available
Other key findings	"In [Year] 3, payers made no progress in shifting away from historically common fee-for-service payment for traditional services." "In Track 2 practices, small reductions in hospitalizations emerged in the third year. There were also small, persistent improvements in emergency department visits and some quality-of-care outcomes."	Not available	"In Year 5, the payment incentive lowered Medicare expenditures, but these results were driven by one site that later stopped providing home-based primary care." "The estimated effects on hospital admissions and ED [emergency department] visits were small and estimated imprecisely because of the small number of participating practices, providing no strong evidence that the payment incentive affected them."	Not available

* Includes two practice tracks. Track 2 contains more advanced care delivery requirements and financial support and a greater shift from fee-for-service (FFS) toward population-based payment.

** GPDC will be re-branded as Accountable Care Organization Realizing Equity, Access, and Community Health Model, or ACO REACH, effective January 1, 2023.

Data: Health Management Associates analysis of data from the Center for Medicare and Medicaid Innovation.