Medicare Delivery System Reform: The Evidence Link Side-by-Side Comparison: Medicare Medical Home Models					
	Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration (APCP)	**Multi-Payer Advanced Primary Care Practice (MAPCP)**	**Comprehensive Primary Care (CPC)**	**Independence at Home (IAH)**	**Comprehensive Primary Care Plus (CPC+)**
Model Basics					
Status	Ended (10/2014)	Ended (12/2016)	Ended (12/2016)	Active (through 9/2019)	Active (through 2021/2022)
Description of the Model	For the FQHC/APCP program, CMS paid FQHCs monthly per-beneficiary care management fees to support services and activities associated with requirements for becoming recognized as "Level 3" by the National Committee for Quality Assurance (NCQA) patient-centered medical homes.	For the MAPCP model, 8 participating state agencies were each responsible for aligning most aspects of their medical home program across multiple payers, including Medicare, Medicaid, and commercial insurers. These aspects included care management fees, medical home activity requirements, quality standards, and payment incentives.	For the CPC model, CMMI convened multiple payers—including Medicare, Medicaid, and commercial insurers—to provide care management fees to medical homes and align quality and efficiency incentives. CMS provided medical homes with technical assistance and data feedback on their patients' total cost and utilization.	The IAH model focuses on providing primary care services to chronically ill beneficiaries in their own homes. IAH practices are able to share in financial savings if they meet specified quality and spending targets. Unlike most other medical home models, IAH providers are not paid monthly care management fees.	The CPC+ model builds on the CPC framework, adding additional payment options with varying risk, care management fees, and advance payments as well as incentives for meeting quality and utilization benchmarks that, if not met, can be recouped by CMS. CPC+ also includes hybrid provider payments, which combine quarterly up-front payments with discounted per-visit payments.
Start Date	11/2011	7/2011	10/2012	6/2012	1/2017
Number of Medicare Beneficiaries	195,000 (2014)	900,000 (2014)	321,000 (2016)	10,000 annually (2017)	1,760,000 (2017)

Key Results					
Medicare Spending (savings/cost)	No net Medicare savings for FQHC/APCPs relative to a comparison group.	**Over 3.5 years (ending Dec 2014):** 2 of 8 states had statistically significant net Medicare savings among their MAPCP practices relative to a comparison group of beneficiaries in non-MAPCP medical homes; 1 state had non-statistically significant net savings; 4 states had net costs; and 1 state had net costs relative to beneficiaries not in a medical home.	**Over 4 years:** Relative to the overall benchmark, the CPC program had no net savings. CPC practices lowered Medicare expenditures on services, but care management fees exceeded savings. Although close to breaking even in the prior year, net Medicare spending on CPC practices totaled $51 million in 2016, excluding shared savings payments. An independent evaluation also found that relative to a matched comparison group, CPC practices had lower Medicare expenditures on services, but spending on care management fees exceeded these savings, resulting in net costs.	**First 2 years:** Modest net Medicare savings relative to benchmark each year; about half earned shared saving bonuses (7 of 15 in year 2).	Not yet available.
Quality of Care	FQHC/APCPs performed the same or better statistically on diabetes care compared to a control group, and the same or worse on hospital readmissions and emergency department use; mixed results in different years.	**First 4 years:** Considerable variation in performance on tests and screenings by state and by measure, as well as on patient satisfaction. Evaluation indicated that there was little evidence that MAPCP models provided beneficiaries with better access to care relative to a comparison group.	**Over 4 years:** Hospitalizations and emergency department visits significantly decreased for CPC beneficiaries relative to those in comparison groups.	**First 2 years:** IAH beneficiaries had, on average, fewer hospital readmissions than control group; 4 practices met benchmarks for all 6 quality measures used in determining shared savings (most of which specify standards or practice). Further details unavailable.	Not yet available.
Results in Detail: Medicare Spending (savings/cost)					
GROSS Medicare Spending on Services **(-) Reduced Spending (savings)** **(+) Increased Spending (cost)**	Relative to comparison group, no gross savings for FQHC/APCPs. *Results relative to benchmarks are not available.*	Relative to comparison group, gross Medicare spending over 3.5 years (ending Dec 2014) in MAPCP:[1] NY: +$3.9 million RI: +$12.4 million VT: -$82.3 million* NC: +$7.7 million ME: +$52.6 million	Relative to benchmark, gross Medicare spending in CPC: Year 4 (2016): -$5.2 million; -$1.38 per beneficiary per month (PBPM) Year 3 (2015): -$57.7 million; -14.88 PBPM Year 2 (2014): -$77.6 million; -$19.88 PBPM	Relative to benchmark, gross Medicare spending in IAH: Year 2: -$7.8 million Year 1: -$25 million *Results relative to comparison groups are not available.*	Not yet available.

		MI: -$294.7 million* PA: -$36.6 million* MN: +$85.5 million *(p < 0.10) *Results relative to benchmarks are not available.*	Relative to comparison practices, gross Medicare spending: Over 4 years: -$9 PBPM (increased 1% less than comparison practice spending); not statistically significant Year 4 (2016): 0% difference from comparison practices Year 3 (2015): -$2 PBPM (0% difference) Year 2 (2014): -$10 PBPM (-1% difference) Year 1 (2013): -$16 PBPM (-2% difference) *Note: Only Year 1 gross Medicare spending results were statistically significant relative to comparison practices.*		
NET Medicare Spending (after accounting for care management fees/shared savings payments in IAH) **(-) Reduced Spending (savings)** **(+) Increased Spending (cost)**	Relative to comparison group, no net savings in first 9 quarters. FQHCs participating in APCP model had the same or higher Medicare spending than FQHCs not participating in APCP model. *Results relative to benchmarks are not available.*	Relative to comparison group, net Medicare spending over 3.5 years (ending Dec 2014) in MAPCP[1]: NY: +$9.6 million RI: +$14.4 million VT: -$63.9 million* NC: +$14.2 million ME: +$64.9 million* MI: -$229.8 million* PA: -$24.2 million MN: +$87.9 million vs. *(p < 0.10) *Results relative to benchmarks are not available.*	Relative to benchmark, net Medicare spending in CPC: Year 4 (2016): +$51.3 million; +$13.54 PBPM, excluding shared savings payments made to CPC practices in Arkansas and Oklahoma Year 3 (2015): +0.2 million; +$0.06 PBPM, excluding shared savings payments Year 2 (2014): +$41.2 million; +$10.57 PBPM, excluding shared savings payments Relative to comparison practices, net Medicare spending in CPC: Over 4 years: +$6 PBPM (1% increase relative to comparison practices; not statistically significant) First 3 years (2013-2015): +$7 PBPM, excluding shared savings payments No difference in net Medicare spending in Year 1 (2013);	Relative to benchmark, net Medicare spending in IAH: Year 2: -$2.7 million2 Year 1: -$13.3 million *Results relative to comparison groups are not available.*	Not yet available.

			Years 2-4 (2014-2016) each had 1% increases in net Medicare spending relative to comparison practices, but none were statistically significant.		
Results in Detail: Quality of Care					
Hospital Readmission Rate	Most participating FQHCs performed the same as or worse than non-APCP FQHCs.	Across all states, there was a statistically significant reduction in 30-day readmission rates among MAPCP models compared to medical home comparison groups.	Small reductions in all years (not statistically significant).	Not reported.	Not yet available.
Emergency Department Use	Most participating FQHCs performed the same as or worse than non-APCP FQHCs.	No statistically significant difference between MAPCP models and medical home comparison groups across all states.	Total ED visits decreased over the initiative's four years relative to comparison practices (statistically significant).	Not reported.	Not yet available.
Mortality Rate	Not reported.	Not reported by state or across all states.	Not reported.	Not reported.	Not yet available.
Clinical Tests, Process Measures	Participating FQHCs performed the same as or better than the comparison FQHCs in diabetic and cholesterol testing.	Variation in MAPCP performance on tests and screenings by state and by measure. MI and MN had better scores for diabetes tests among Medicare beneficiaries with Medicaid coverage, relative to comparison groups.	Most process measures showed no statistical difference from control group; diabetes care (number of high-risk beneficiaries receiving all three relevant tests) was the only category with better performance among CPC practices (statistically significant).	Not reported; in years 1 & 2, four practices met benchmarks for all 6 quality measures (most of which specify standards of practice).	Not yet available.
Patient Satisfaction	No significant differences between FQHCs and control group on patient-reported satisfaction and access to care.	MAPCP models in 4 states (RI, ME, MN, NC) showed high patient satisfaction; one state (MI) had mixed satisfaction results. Patient satisfaction in other states was either unknown or not reported.	Patient-reported measures on satisfaction improved slightly more for CPC practices than for comparison groups.	Not reported.	Not yet available.
Provider Participation					
Number of Medical Homes/Providers Participating, by Year	Year 3: 500 FQHCs Year 2: 500 FQHCs Year 1: 500 FQHCs	2016: 5 states 2015: 5 states (chose to extend) 2014: 8 states 2013: 8 states 2012: 8 states	2016: 439 practices 2015: 445 practices 2014: 479 practices 2013: 492 practices 2012: 502 practices	2018: 16 practices 2017: 16 practices Year 2: 15 practices Year 1: 17 practices	2018: 2,982 practices 2017: 2,866 practices

Financial Arrangements					
Multi-Payer Alignment Multiple insurers (including Medicare, Medicaid, commercial insurers) agree to align financial arrangements and requirements for medical home activities.	✘	✓	✓	✘	✓
Prospective Payments for Primary Care Services Medicare makes quarterly, up-front payments to medical homes for their beneficiaries based on expected primary care service use.[3]	✘	✘	✘	✘	✘ (Track 1) ✓ (Track 2)
Care Management Fees					
Average care management fees (per beneficiary, per month)	$6	Up to $10; Varied by state.	$20 (Years 1 – 2) $15 (Years 3 – 4)	✘	Track 1: $15 Track 2: $28
Payer may risk-adjust care management fees based on patient health status.	✘	✓ Varied by state.	✓ 4 risk adjusted tiers; $8 - $40 in Years 1 and 2; $6 - $30 in Years 3 and 4	Not applicable.	✓ Track 1: 4 risk-adjusted tiers; $6 - $30. Track 2: 5 risk-adjusted tiers; $9 - $100
Financial Risk/Reward					
Upside Risk; Shared Savings Medical homes may share in savings with Medicare, if they meet specified requirements on patient experience, clinical quality, and expenditures.	✘	✓ (Pennsylvania only)	✓ Regionally aggregated.	✓	✘
Downside Risk; Shared Losses Medical homes may share in losses with Medicare if they exceed specified spending targets.	✘	✘	✘	✘	✘
Bonus Payments Medicare pays medical homes flat bonuses (per beneficiary, per month), which are recouped if quality and spending targets are not met.	✘	✘	✘	✘	✓ Track 1: $2.50 Track 2: $4
“Advanced APM” Bonus Physicians affiliated with medical homes are eligible for automatic 5% bonuses, starting in 2019, per MACRA.	✘	✘	✘	✘	✓

Beneficiary Involvement					
Informing Medicare Beneficiaries					
CMS mails notices to beneficiaries informing them of their medical home attribution, their continued rights to see any Medicare provider, and their option to decline having their health data shared with other providers.	✘	✓	✘	✓	✘
Medical homes inform beneficiaries via written or verbal notification and sign displayed in provider's office of their medical home attribution, their continued rights to see any Medicare provider, and their option to decline having their health data shared with other providers.	✘	✓	✓	✓	✓
Beneficiary Eligibility and Attribution					
Beneficiaries must have 2 or more chronic conditions, in addition to other high-need indicators.	✘	✘	✘	✓	✘
Option for beneficiaries to identify their own medical home by actively confirming that a specified clinician is/is not their primary care provider.[4]	✘	✘	✘	✘	✘
Benefit Enhancements/Enhanced Patient Experience					
Medical homes are required to provide patients with 24/7 access to physicians via office hours and telephone and electronic means.	Consistent with NCQA Level 3 recognition.	Varies by state.	✓	✘	✓
Medical homes are required to determine highest-risk patients and develop a proactive care plan for them, including self-management support and shared decision-making tools.	Consistent with NCQA Level 3 recognition.	Varies by state.	✓	✘	✓

Medical homes are required to seek patient or family feedback through surveys and/or family advisory council.	Consistent with NCQA Level 3 recognition.	Varies by state.	✓	✘	✓
Medical homes focus on providing home-based primary care to beneficiaries with multiple chronic conditions.	✘	Varies by state.	✘	✓	✘ Exception: Track 2 is required to offer alternative to office visits, such as home visits.
Independent Evaluations and Release Dates					
Evaluation Information	**RAND Corporation:** • September 2016: *Evaluation of CMS's Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration* • July 2015: *Evaluation of CMS FQHC APCP Demonstration: Second Annual Report* • February 2015: *Evaluation of CMS' FQHC APCP Demonstration: Final First Annual Report*	**RTI International:** • June 2017: *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Final Report* • April 2016: *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Third Annual Report* • April 2016: *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Second Annual Report* • January 2015: *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: First Annual Report*	**Mathematica Policy Research:** • May 2018: *Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report* • December 2016: *Evaluation of the Comprehensive Primary Care Initiative: Third Annual Report* • April 2016: *Evaluation of the Comprehensive Primary Care Initiative: Second Annual Report* • January 2015: *Evaluation of the Comprehensive Primary Care Initiative: First Annual Report*	No independent evaluation.	Evaluation not yet available.
Sources					
Sources Used	• **CMS overview page:** "FQHC Advanced Primary Care Practice Demonstration" (accessed June 26, 2017) • **CMS Fact Sheet:** "Federally Qualified Health Center Demonstration Fact Sheet" (updated February 12, 2014)	• **CMS overview page:** "Multi-Payer Advanced Primary Care Practice" (accessed June 26, 2017) • **RTI International:** *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Final Report* (June 26, 2017)	• **CMS overview page:** "Comprehensive Primary Care Initiative" (accessed June 26, 2017) • **CMS:** "Comprehensive Primary Care (CPC) Initiative 2016 Shared Savings & Quality Results" (September 2017)	• **CMS overview page:** "Independence at Home Demonstration" (accessed February 15, 2018) • **CMS Fact Sheet:** "Independence at Home Demonstration Corrected Performance Year 2 Results" (January 19, 2017)	• **CMS overview page:** "Comprehensive Primary Care Plus" (accessed February 15, 2018)

	• **RAND Corporation:** *Evaluation of CMS's Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration* (September 2016) • **RAND Corporation:** *Evaluation of CMS FQHC APCP Demonstration: Second Annual Report* (July 2015) • **RAND Corporation:** *Evaluation of CMS' FQHC APCP Demonstration: Final First Annual Report* (February 2015)		• **CMS:** "Comprehensive Primary Care (CPC) Initiative 2015 Shared Savings & Quality Results" (October 2016) • **CMS:** "Comprehensive Primary Care (CPC) Initiative 2014 Shared Savings & Quality Results" (updated October 2016) • **Mathematica Policy Research:** *Evaluation of the Comprehensive Primary Care Initiative: Third Annual Report* (December 2016) • **Mathematica Policy Research:** *Evaluation of the Comprehensive Primary Care Initiative: Second Annual Report* (April 2016)	• **CMS Press Release:** "Affordable Care Act Payment Model Continues to Improve Care, Lower Costs" (August 9, 2016) • **CMS Press Release:** "Affordable Care Act Payment Model Saves More Than $25 Million in First Performance Year" (June 18, 2015)	
Footnotes	[1] The comparison groups were beneficiaries in non-MAPCP medical homes, except in MN, for which the comparison group was beneficiaries not in medical homes. [2] These results for the IAH model reflect corrections released by CMS on 1/19/17. In a recent cost estimate for the CHRONIC Care Act of 2017, CBO estimated that a provision that extends the IAH model for two years would increase Medicare costs, rather than produce savings. [3] Different from care management fees, Medicare combines quarterly up-front payments, called Comprehensive Primary Care Payments (CPCPs), and claims-based payments in the CPC+ medical home model. The quarterly CPCPs are equal to a percentage of the medical home's expected Medicare payment for Evaluation and Management (E&M) services, and is combined with reduced payments on actual E&M actual claims. This "hybrid" approach is designed to provide financial incentives for medical homes to manage patient care without face-to-face visits, when possible. [4] In MAPCP, one state required medical homes to "self-attribute" each of their beneficiaries to their practice, but in general, beneficiary attribution to medical homes was based on beneficiary claims for primary care services.				

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