CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE AND MEDICAID INNOVATION

Findings at a Glance

Primary Care First Model

Evaluation of the Second Performance Year (2022)

Model Overview

The Centers for Medicare & Medicaid Services (CMS) launched the Primary Care First (PCF) Model in 2021 to improve quality of care, improve patients' experience of care, and reduce expenditures by increasing patients' access to advanced primary care services through a simplified payment structure designed to reduce administrative burden and reward performance. A second cohort of practices joined in 2022.

PCF emphasizes five comprehensive primary care functions: (1) access and continuity, (2) care management, (3) comprehensiveness and coordination, (4) patient and caregiver engagement, and (5) planned care and population health. Participants must meet a set of care delivery requirements within these five functions, but CMS is flexible on how practices meet these requirements.

CMS assigns practices to one of four risk groups based on the average health status of their attributed beneficiaries. Starting in the second year of participation, payments are adjusted based on performance on acute hospitalizations (risk groups 1 and 2) or total cost of care (risk groups 3 and 4) and quality metrics.

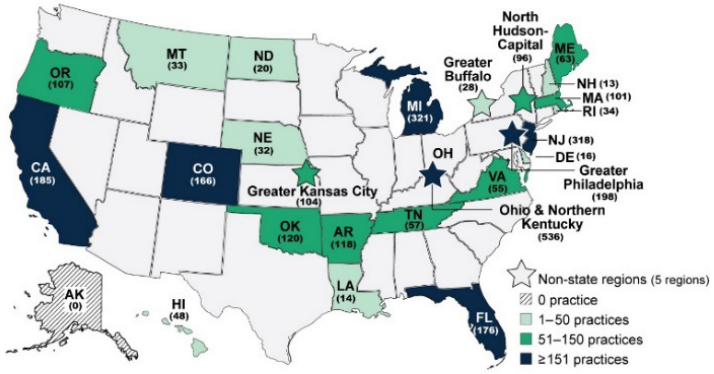
Model payment structure

- **Flat visit fee (FVF)** for face-to-face visits for primary care services
- **Population-based payment (PBP)** a prospective payment per beneficiary per month (paid quarterly), varies by risk group
- **Performance-based adjustment (PBA)** based on performance measures, ranging from 10 percent decrease to 50 percent increase
- **Performance-accuracy adjustment (PAA)** adjusts PBPs to account for qualifying primary care services furnished outside of the practice

Participants and Partners

At the start of 2022, nearly 3,000 participating practices were serving roughly two million Medicare FFS beneficiaries in PCF's 26 regions. There were 23 active payer partners at the start of 2022 that had varying degrees of alignment with PCF's payment model.

Participating practices serve a primarily White and affluent population, yet there were racial and socioeconomic disparities in acute care use within practices before PCF's launch.



Prior transformation experience	PCF participants	Non-PCF participants*
Medicare Shared Savings Program	51%	32%
Comprehensive Primary Care Plus (CPC+)	43%	4%
Advanced alternative payment model	86%	68%
Affiliation with a larger health care organization	**83%**	**46%**

* Non-participating participants are practices in PCF regions that either applied and did not join the model or did not apply.

PCF participants came with primary care transformation experience and were more likely to be affiliated with a larger health care organization.

About 15% of practices have left PCF since its launch. Common reasons for leaving were the opportunity to join the ACO REACH Model and concerns with the PAA.

Key Takeaways

In the first two years of PCF, practices used model funds to make care delivery changes, including continuing ones they started prior to joining the model, that they believe will ultimately reduce hospitalizations. Prior primary care transformation experience and affiliation with larger health care organizations facilitated these changes. As expected this early in the model, there have been minimal effects on hospitalizations and Medicare expenditures. Future reports will focus on the trajectory of practice transformation, deepen our understanding of practices' perception of the PCF payment model, and provide estimates for effects across a wider set of outcomes.

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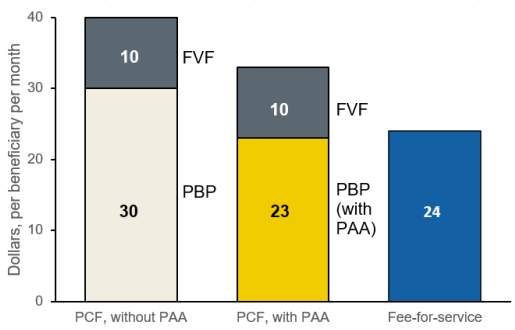
PCF payments were larger than Medicare FFS payments on average, but many practices felt payments were inadequate

Practices received on average $235,523 in population-based payments (PBPs) and about $100 in flat visit fees (FVFs) per beneficiary in 2022. The combination of the PBP and FVF was estimated to be greater than what participants would have received under Medicare FFS, even after adjusting for the PAA.

Model payments were estimated to be more generous than FFS



Note: FFS estimates based on 2019 claims.
FVF = flat visit fee; PBP = population-based payment;
PAA = payment accuracy adjustment.

Cohort 1 practices received their first PBA in 2022, with 62% of practices receiving a positive adjustment on average over the year, although not enough to offset decreases from the payment accuracy adjustment.

Practices—especially former CPC+ participants—said that model payments were inadequate to support transformation. Practices also expressed concern about the PAA because the lag in its application until the second performance year made it feel punitive and limited their ability to address the issue. Furthermore, practices were concerned about visits with nurse practitioners who might provide specialty care counting toward the PAA. Despite these concerns, however, practices by and large did not have plans to reduce the PAA.

This document summarizes the evaluation report prepared by an independent contractor. To learn more about PCF and to download the full evaluation report, visit [the Primary Care First Model webpage](#).

Risk group 1 and 2 practices focused on changes to care management strategies and practices in risk groups 3 and 4 took a broader approach to care delivery changes

Practices in risk groups 1 and 2 focused most on longitudinal and episodic care management strategies to reduce acute hospitalizations; they also made changes related to integrating behavioral health, addressing health-related social needs, and coordinating care with medical specialists. Practices in risk groups 3 and 4 built on existing strategies that spanned all five of the primary care functions to care for patients with complex needs.

Implementation facilitators and barriers

Facilitators

- Previous or ongoing participation in other public and private value-based payment arrangements
- Belonging to a larger hospital-based health care system or a network of group practices
- Robust interoperable electronic health records to coordinate care and identify patients for enhanced care
- Retention or expansion of previously hired care management or behavioral health staff
- Community connections to help link patients with needed services outside the practice

Barriers

- Reluctance of patients to engage in care delivery changes, especially care management
- Shortage of qualified staff in community or inability to offer competitive salary

PCF had minimal effects on hospitalizations and Medicare expenditures

Medicare expenditures, including model payments, grew by an estimated 1.5 percent over two years relative to a comparison group. There was no measurable reduction in acute hospitalizations.

Medicare FFS expenditures increased with no reductions in acute hospitalizations