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

Findings at a Glance

Primary Care First (PCF) Model
Evaluation of the First Year (2021)

Model Overview

The Centers for Medicare & Medicaid Services (CMS) launched the Primary Care First (PCF) model to improve quality, improve patient experience of care, and reduce expenditures by increasing patient access to advanced primary care services. Building on previous primary care models, PCF emphasizes five comprehensive primary care functions: access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and planned care and population health. Model participants must meet a limited set of care delivery requirements within these five functions; however, CMS is flexible on how practices meet these requirements. Participating practices are supported by CMS and 13 public and private payers, providing practices with enhanced and alternative payments, data feedback, and learning activities to support primary care transformation.

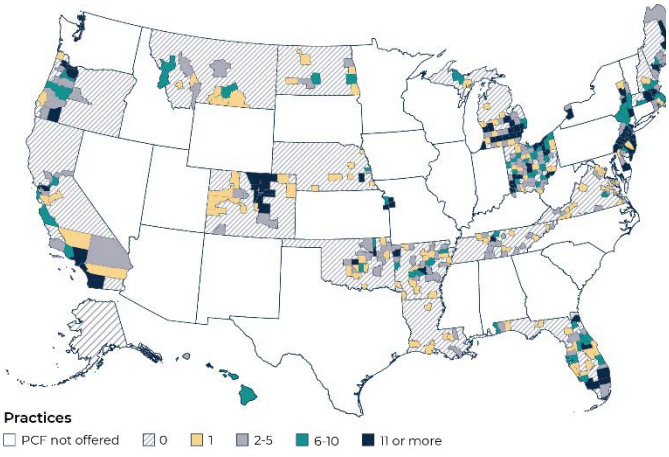
Participating practices take on upside and downside financial risk for the most common primary care services for their attributed Medicare fee-for-service (FFS) population. CMS assigns practices to one of four risk groups based on the average Hierarchical Condition Category (HCC) score among their Medicare FFS beneficiaries. Practices receive flat visit fees and a prospective population-based payment that varies by risk group. Starting in the second year of participation, practices' payments are adjusted based on performance on acute hospitalization use (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 office visits for primary care services
- **Population-based payment (PBP),** a prospective monthly payment per beneficiary per month, varies by risk group, ranging from $28 to $175
- **Performance-based adjustment (PBA)** based on performance measures, ranging from 10 percent decrease to 50 percent increase

Participants and partners

In 2021, CMS launched PCF in 26 regions; 846 practices joined Cohort 1. These practices, with more than 4,000 practitioners and over 500,000 Medicare beneficiaries, serve a primarily White and affluent population. Cohort 2 joined in 2022.



Most Cohort 1 practices were assigned to risk group 1 (lowest risk), meaning they treat a population with lower acuity patients compared with practices assigned to higher risk groups. More than 80 percent of practices were affiliated with at least one other PCF practice through health systems or medical groups.

Risk group	Practices
Risk group 1	760
Risk group 2	56
Risk group 3	21
Risk group 4	9

Payer partner participation was modest in PCF: 13 payers joined Cohort 1. Five of the 13 payers provided an alternative to FFS payments, falling short of CMS' goal for multipayer alignment. A challenge facing payer partners is the uneven practice participation across the 26 regions.

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Initial advanced care capabilities

Practices entered the model with advanced primary care capabilities, especially in the areas of access and continuity, care management, and patient and caregiver engagement.

Percent of practices providing advanced care delivery activities at baseline (n=827)

Access and continuity	Access to care informed by electronic health record	98
	Empanelment	94
Care management	Episodic care management	97
	Risk stratification	92
	Hospital follow-up within 72 hours	90
	Longitudinal care management	88
	Emergency department follow-up within 72 hours	48
	Personalized care planning	27
Patient engagement	Engage patients in improvement	94
	Advance care planning	92

CMS payments to PCF practices

Estimated PCF payments averaged about 20 percent higher than participating practices would have received under the Medicare physician fee schedule, after adjusting for primary care services provided outside the practice. Median annual PBPs to practices ranged from $143,412 to $766,781 across risk groups; median FVF payments to practices ranged from $40,820 to $114,994 across risk groups.

Median payments per participating practice by risk group

Risk group	Population-based payment	Flat visit fee
Risk group 1	$143,412	$40,820
Risk group 2	$172,443	$36,308
Risk group 3	$342,189	$72,271
Risk group 4	$766,781	$114,994

Planned care delivery changes

Participating practices added staff and built on existing capabilities to improve how they deliver care. Practices in risk groups 1 and 2 enhanced care management strategies, such as better follow up after a hospital discharge or expanding the chronic conditions eligible for services, emerged as practices' key strategies to reduce hospitalizations and lower total cost of care. Other strategies included enhanced access to care (such as through telehealth) and behavior health integration, underscoring how practices often planned to make changes across multiple primary care functions.

Participating practices in risk groups 3 and 4—which often treat homebound patients—reviewed advance care plans with patients and found ways to better use data and data analytics to identify patients who needed additional services.

Participating practices' areas of focus for care delivery improvement

Risk groups 1 and 2

- Expand care management
- Enhance access to care
- Integrate behavioral health

Risk groups 3 and 4

- Advance care planning
- Use data analytics to identify patient needs

Though CMS intended for PCF to be a practice-level intervention, PCF-funded interventions among practices affiliated with a larger health system were often planned and implemented by corporate staff. This raises questions about the extent to which practices in the model operate independently—as CMS had intended—and how health systems make decisions on behalf of their participating practices.

Key Takeaways

The PCF model offers participating practices the flexibility to select strategies to improve outcomes. Practices entered the model with advanced care capabilities; their care delivery changes in 2021 were largely enhancements of existing activities. Estimated PCF payments were generous, averaging about 20 percent higher than participating practices would have received under the Medicare physician fee schedule. Future reports will describe how practice activities result in improvements in quality of care and lower acute hospitalizations and total cost of care for Medicare beneficiaries and will explore how the model may affect health equity.

This document summarizes the evaluation report prepared by an independent contractor. To learn more about PCF and to download the full evaluation report, visit: Primary Care First Model Options | CMS Innovation Center.