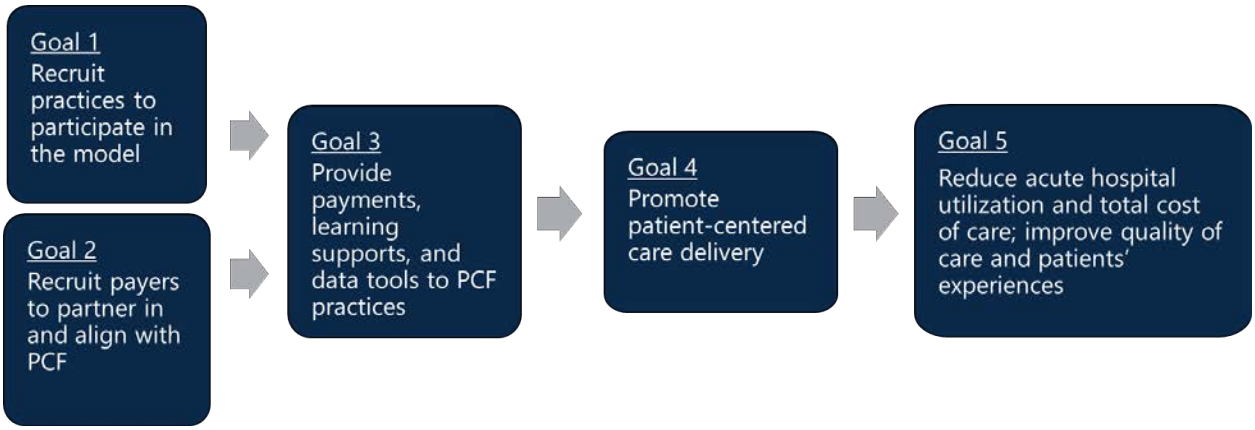
EXECUTIVE SUMMARY

Evaluation of Primary Care First: Third Annual Report

In 2021, the Center for Medicare & Medicaid Innovation, part of the Centers for Medicare & Medicaid Services (CMS), launched the Primary Care First (PCF) Model in 26 regions across the United States. PCF tests the impact of financial risk incentives and performance-based payments on advanced primary care practices, aiming to reduce acute hospitalizations, lower total Medicare fee-for-service (FFS) expenditures, and improve patient health outcomes. This third annual report covers the evaluation's findings through the end of 2023. Exhibit 1 provides an overview of PCF's goals.

Exhibit 1. Overview of PCF goals



CMS designed PCF as a multi-payer model in which Medicare Advantage plans, commercial health insurers, state Medicaid agencies, and Medicaid managed care plans commit to aligning with PCF's payment methodology for Medicare FFS beneficiaries to increase the reach of the model and help achieve a critical mass of aligned support to drive practice-level transformation. The PCF Model was meant to provide practices with the flexibility to leverage their self-reported advanced primary care capabilities, enabling them to transform and tailor their approach to meet the needs of their patient population. The model requires practices to have at least 125 attributed Medicare FFS beneficiaries and have primary care services comprise at least 50 percent of billing based on revenue. The PCF Model

defines a practice as a legal entity that furnishes patient care services at a particular "brick-and-mortar" physical location. Practices that met the eligibility criteria could join the model in 2021 as part of Cohort 1 or in 2022 as part of Cohort 2. Each cohort has a five-year period of performance. In 2021, 846 Cohort 1 practices began participating in the PCF Model, and another 2,228 practices joined in 2022 as Cohort 2, for a total of 3,074 practices.

Features of the PCF Model and model background

PCF represents a shift in the Innovation Center's primary care models away from detailed care delivery requirements and reliance on the FFS reimbursement structure. Instead, PCF emphasizes flexibility and outcomes—particularly reducing acute hospitalizations—with a greater level of reimbursement from population-based payments (PBPs) than FFS reimbursement. PCF's predecessor, the Comprehensive Primary Care Plus (CPC+) model, ended in 2021 as PCF launched. An independent evaluation estimated that CPC+ led to modest reductions in emergency department visits, hospitalizations, and acute inpatient expenditures and improvement on some claims-based quality-of-care measures (O'Malley et. al 2023). Just under half of CPC+ practices raised concerns, however, that payments across payers were insufficient for the work CPC+ required. Various stakeholders noted that CPC+ relied too much on traditional Medicare FFS billing and did too little to reduce the billing and quality reporting burdens on primary care practices or to shift clinicians' focus to outcomes of care. The PCF Model seeks to address these concerns by offering participating primary care practices a simplified payment structure designed to reduce administrative burden and reward performance.

The main components of the PCF payment model include a total primary care payment consisting of a PBP and a flat visit fee (FVF), paid FFS, for certain primary care services as well as a performance-based adjustment (PBA) tied to outcome measures. The PBP is subject to a payment accuracy adjustment (PAA).

The PBA took effect in April 2022 for Cohort 1 practices and April 2023 for Cohort 2 practices. The PBP was adjusted by the practice's quarterly PAA beginning in July 2022 for Cohort 1 practices and July 2023 for Cohort 2 practices.

PCF payment structure

- **Flat visit fee** for Medicare FFS beneficiaries' face-to-face and telehealth visits for primary care services
- **Population-based payment** to provide prospective payment per beneficiary per month (paid quarterly); practices are assigned to one of four risk groups based on the medical complexity of their Medicare patients, and PBP amounts vary by risk group
- **Performance-based adjustment** based on performance measures, ranging from 10 percent decrease to 50 percent increase of total primary care payment, based on performance on acute hospital utilization or total per-capita cost, depending on risk group, and a set of clinical quality and patient experience of care measures
- **Payment accuracy adjustment** to adjust population-based payment to account for qualifying primary care services furnished outside of the PCF practice

Key takeaways from the evaluation's third annual report

We summarize our key findings for the PCF evaluation through 2023 as they relate to each of the five goals of the PCF Model's goals:

- **Goal 1. Recruit practices to participate in the Model.** While the PCF Model initially recruited large numbers of practices, it had substantial practice attrition through 2023, primarily because of concerns related to financial aspects of the model.
- **Goal 2. Recruit payers to partner in and align with PCF.** Multi-payer participation and alignment continued to be limited through 2023.
- **Goal 3. Provide payments, learning supports, and data tools to PCF practices.** The PCF Model's payments were not the main motivating factor or funding source for many of the changes in care delivery that PCF practices reported under PCF; practices also were motivated by their involvement in other value-based contracting arrangements.
- **Goal 4. Promote patient-centered care delivery.** Practices continued to implement, and often modified, existing care delivery strategies, especially care management, and added new strategies, focused on comprehensiveness of and access to care.
- **Goal 5. Reduce acute hospital utilization and total cost of care and improve quality of care and patients' experiences.** PCF did not reduce acute hospitalization rates among Medicare FFS beneficiaries, and it increased Medicare expenditures (including model payments) by 1 percent.

A combination of three factors likely led to us not observing improvements in primary outcomes. First, PCF practices reported advanced care delivery capabilities when they applied to PCF and therefore started the model with high performance. Second, PCF participation was only one factor among many that influenced changes to practices' care delivery activities and strategies. Third, CMS anticipated detectable reductions in Medicare expenditures starting only in year four of the model.

Overview of the evaluation approach

The goal of the independent evaluation is to determine whether the PCF Model leads to better care for Medicare FFS beneficiaries and lower costs for CMS. We used mixed methods to analyze primary and secondary data, describe the participating practices and their experiences through 2023, and estimate impacts of the model on Medicare FFS expenditures and service use, including acute hospitalizations. We estimated the impacts of PCF on a range of primary and secondary outcomes for Medicare FFS beneficiaries served by PCF practices. We measured all outcomes using Medicare claims, which reflect health care services that clinicians provided to Medicare FFS beneficiaries and billed to the Medicare program. Our intervention group included all practices that started PCF, regardless of whether they later left the model, and we compared their outcomes with the outcomes of a matched comparison group of primary care practices in PCF regions that did not participate in PCF but had similar characteristics to PCF practices when the model began.

The third annual evaluation report examines the characteristics of practices (and payers) that continued to participate in PCF compared with those that left, the role that the PCF Model's incentives and supports played in the strategies and activities practices adopted to improve care delivery, and how the

trajectory of the care delivery strategies and activities practices implemented have transformed over time. The evaluation report includes six chapters. Primary data sources included data reported by PCF practices through the PCF Model portal (a CMS platform created for the model), interview data, and the evaluation's PCF practice survey (a new data source in 2023). Secondary data sources include Medicare FFS claims and model payments, clinical quality and patient experience of care measures that determine eligibility for a positive PBA, and practice and payer applications.

Road map to the third annual report of the PCF evaluation

- Chapter 1. Introduction
- Chapter 2. Changes in practice and payer participation
- Chapter 3. Practices' responses to the PCF Model's incentives and supports
- Chapter 4. Care delivery and the trajectories of change among PCF practices
- Chapter 5. Estimated impacts of PCF on outcomes during the first three years of the model
- Chapter 6. Conclusion

Summary of findings

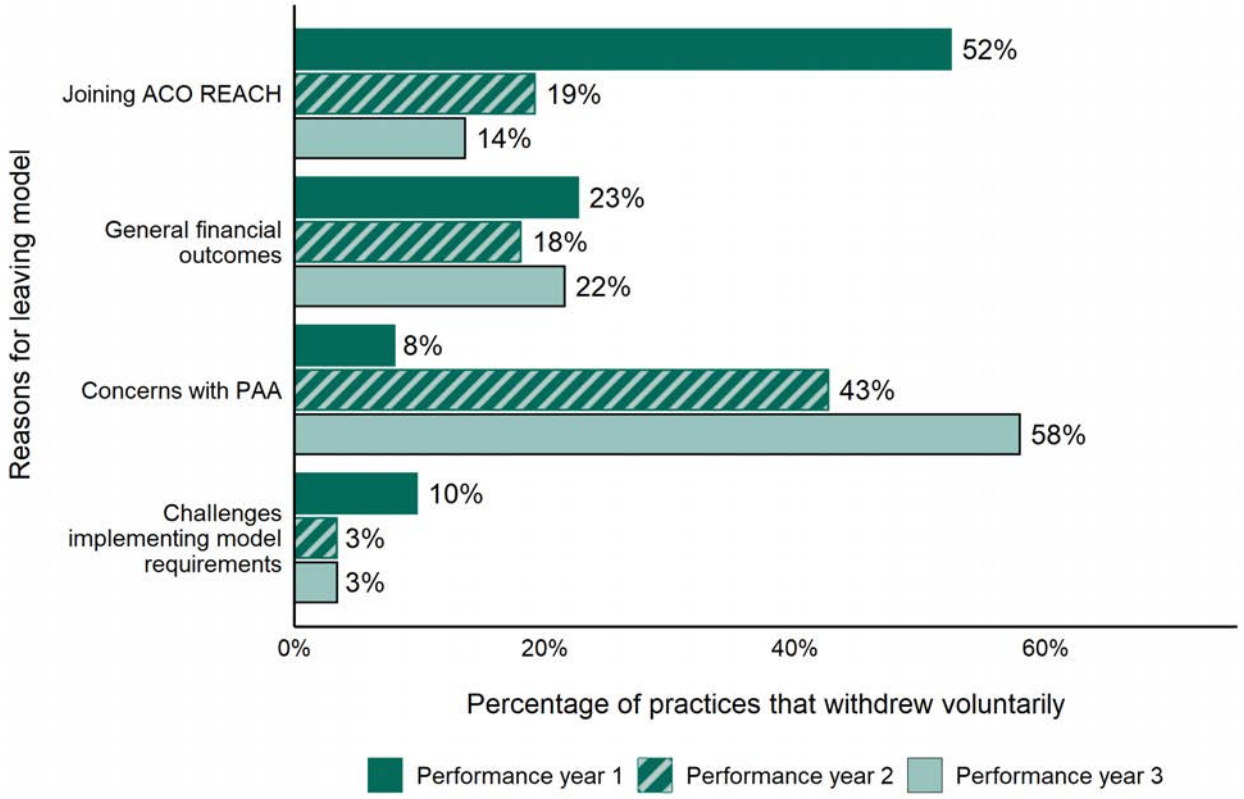
The PCF Model had substantial practice attrition through 2023, primarily because of concerns related to financial aspects of the model.

Attrition increased over time, with 27 percent of PCF practices leaving the PCF Model in the first three years since it launched. In comparison, 13 percent of practices in the Comprehensive Primary Care Initiative and 19 percent of practices in CPC+ withdrew over the lifetimes of those models. Attrition has not been evenly distributed across PCF regions.

Practices that voluntarily withdrew from the PCF Model differed from practices that remained in the model on important dimensions, and these differences in characteristics were consistent over time. Practices choosing to leave the model were more likely to be smaller, independent, or located in rural areas or areas with lower median household income. Practices that voluntarily withdrew from the model also had a less favorable impression of the PCF Model than practices that stayed, and those withdrawing practices reported in the evaluation's survey that their changes in care delivery were less likely to be motivated by PCF.

Reasons for voluntarily leaving the model changed over time. In the first performance year, about half of withdrawing practices voluntarily left to join another Innovation Center model, and 10 percent reported withdrawing because of challenges implementing the PCF Model requirements. Performance year 1 corresponds to calendar year 2021 for Cohort 1 and 2022 for Cohort 2. In the second and third performance years (Cohort 1 only), about half of practices that voluntarily withdrew reported leaving the model because of concerns with the PAA, which was introduced in performance year 2 (Exhibit 2). We did not, however, observe differences in model performance as measured by PBA (and PAA) applied to PCF payments between practices that withdrew from the model in 2023 and those that remained.

Exhibit 2. The top reason practices left the PCF Model differed in the first performance year and the second and third performance years



Source: Mathematica's analysis of PCF Model Practice Roster provided by the Payment, Operations, Monitoring, and Quality Contractor, January 2024.

Notes: This analysis included 667 practices from both cohorts that voluntarily withdrew from the PCF Model. The exhibit shows the top reasons for voluntarily withdrawing from the PCF Model. The performance year-specific percentages do not add up to 100 percent because practices reported a variety of other operational challenges, and concern with PECS as reasons for voluntarily withdrawing that are not included. Performance year 3 does not include Cohort 2 practices because they have only participated in the model for two performance years as of December 31, 2023.

ACO REACH = Accountable Care Organization Realizing Equity, Access, and Community Health; PAA = payment accuracy adjustment; PCF = Primary Care First; PECS = Patient Experience of Care Survey; PY = performance year.

Multi-payer participation and payer alignment was limited through 2023.

As reported in prior years, PCF payer partners' participation was limited because of the small number of participating national and regional payers. The number of payer partners in PCF has continued to be modest, especially compared with CPC+. Because PCF payer partners' reach is limited at the national and regional levels, we expect practices will have fewer resources and support to implement PCF-related changes for a larger proportion of their patients.

Payer partners were largely modifying payment models that predated PCF. Similar to previous years, PCF payer partners made minimal changes to their PCF approach in 2023, and the lack of more robust payer partner participation likely reduced the scale and scope of changes PCF practices could implement. Some modifications partners made include changing measure sets or improving data feedback. More than three-fourths of PCF practices reported that they did not observe any changes to payer partners' reimbursement approaches. Some practices noted that PCF payer partnership did not provide additional benefits or present any challenges because nothing about these payers' contracts had changed.

From 2021 to 2023, six of the starting 23 payer partners withdrew from the PCF Model, including a national payer that was in nearly every region. In addition, one payer paused its participation because of few participating PCF practices in its region. Payer partners that left the model reported that PCF was not a priority compared with their own initiatives. Although they saw collaboration and partnership with CMS and Innovation Center models as valuable, they preferred prioritizing their own programs and initiatives over PCF. They planned to continue to work on value-based payment methods in their own internal programs.

Payer partners also noted technological issues as a reason for withdrawing from the model. For example, payer partners reported difficulty paying out capitated payments for PCF using their current billing systems and said it was too expensive to resolve the issue to support their participation.

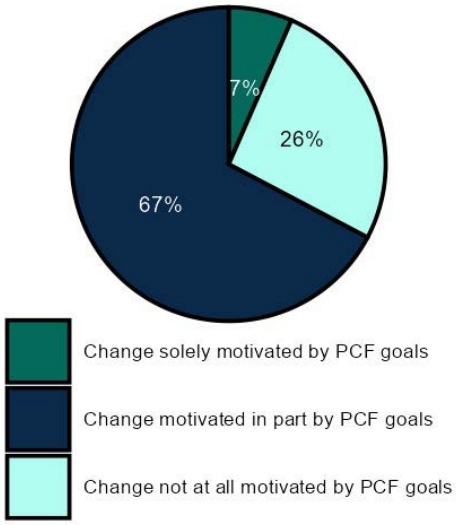
Payer partners cited limited internal capacity to support participation in the model as a reason for withdrawing. In one state, two payer partners reported they decided to leave the PCF Model after many practices in the region left PCF to join the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model. One payer partner described joining PCF to align with its community and improve quality of care in its community. Yet many of the practices in its region elected to participate in ACO REACH instead of PCF. Payer partners that remained in the model also reported similar technology and capacity challenges, such as managing data for the Model and working with other payers in the region.

$ The PCF Model's payments were not the main motivating factor or funding source for many of the changes in care delivery activities.

PCF practices typically reported that care delivery changes they made since joining PCF were only partially motivated by PCF's goals. On average, two-thirds of the care delivery changes PCF practices reported making between joining PCF and 2023 were motivated in part by PCF, according to responses to the PCF Practice Survey (Exhibit 3). Yet practices rarely reported that the changes they made were motivated solely or mostly by PCF's goals, and, occasionally, they reported that their changes were not at all motivated by PCF's goals. In interviews, most practices said that although they were making changes for PCF, they likely would have made similar changes to help them meet the requirements of other value-based contracting arrangements. These findings suggest that PCF motivation can be characterized as having a broad reach but limited influence. Although most practices reported that they were at least somewhat motivated by PCF, PCF was rarely the sole factor in practices' decisions to change care delivery. If the PCF Model is not a major motivational or financial factor for practice change, then we cannot conclude that PCF is driving changes in patient outcomes.

Together with PCF, the goals and incentives of other value-based contracting arrangements also motivated practices' decisions to change care delivery. Nearly all (92 percent) of PCF practices reported participating in at least one other value-based contracting arrangement such as accountable care organizations, commercial value-based care programs with shared savings or risk, or other Innovation Center models such as Bundled Payments for Care Improvement Advanced. Among practices participating in other value-based contracting arrangements, 91 percent reported that they were making care delivery changes to support PCF and other programs at the same time. In interviews, half of practices noted they made payer-agnostic resource allocation decisions for all patients rather than focusing solely on Medicare beneficiaries attributed to PCF. In other words, these practices noted that they would have made these changes even if they were not participating in PCF.

Exhibit 3. Most changes were motivated in part by PCF

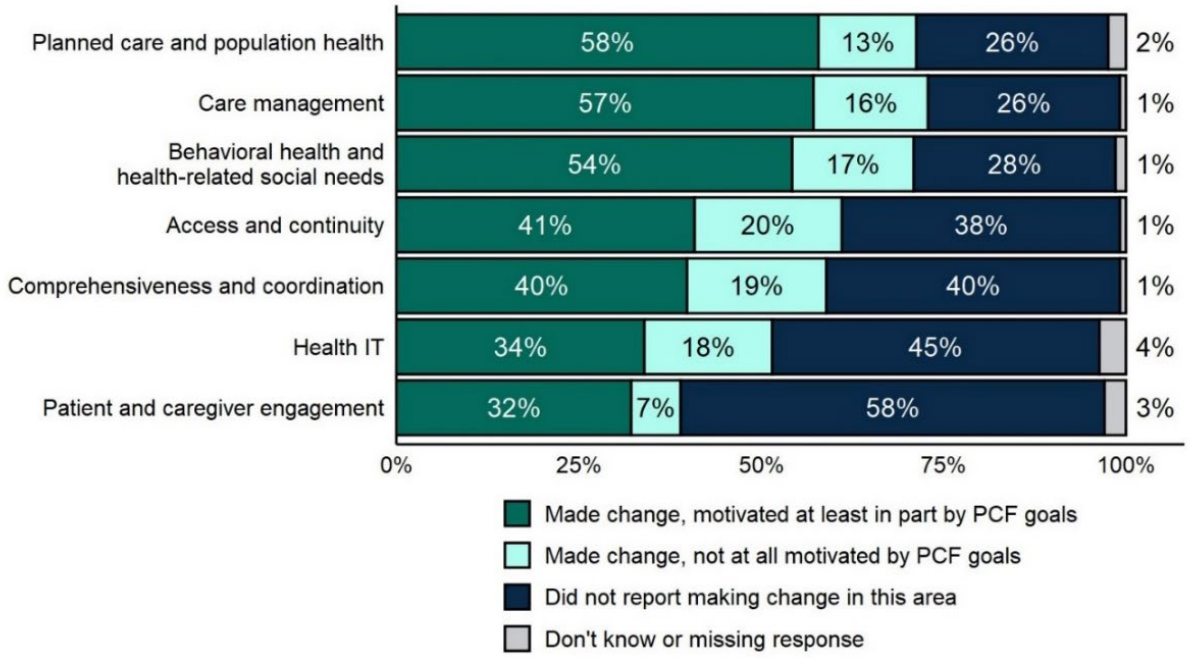


PCF = Primary Care First.

More than half of PCF practices were motivated by PCF's goals to make changes to care management (Exhibit 4). Since 2021, practices have consistently reported that longitudinal care management and episodic care management are their primary strategies for reducing acute hospitalizations, underscoring additional motivation for making these changes.

More than half of PCF practices were motivated by PCF's goals to make changes to planned care and population health as well as behavioral health and health-related social needs integration (Exhibit 4). In previous years, interviewed practices consistently reported making changes related to comprehensiveness and coordination, including to integrating behavioral health, addressing health-related social needs, and coordinating care with medical specialists, and practices anticipated these changes could help reduce acute hospitalizations and total cost of care.

Exhibit 4. Practices most commonly reported being motivated by PCF goals to make care delivery changes related to planned care and population health, care management, and behavioral health and health-related social needs



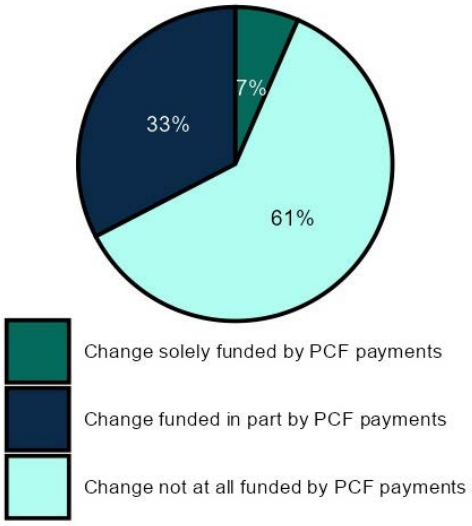
Source: Mathematica's analysis of PCF Practice Survey data (2023). Total N = 1,155 (both cohorts).

Note: This exhibit focuses on what motivated practices to make changes and not the actual changes that were the focus of the practice interviews. The exhibit shows a combined count of practices that responded yes to "Changes motivated solely or mostly by PCF's goals" or "Changes motivated in part by PCF's goals." If a practice reported that PCF's goals solely or in part motivated change to any care delivery activity in a domain, we count them in the "made change motivated by PCF's goals" bar for that domain. Some rows might not sum to 100 because of rounding.

IT = information technology. PCF = Primary Care First.

Most PCF practices reported that care delivery changes were not funded by PCF payments. On average, only around one-third of the care delivery changes PCF practices reported making since joining PCF were funded in part by PCF payments, and practices rarely reported the changes were funded solely by PCF payments (Exhibit 5). Although practices used PCF funds (along with other funding sources) to support care delivery changes, only about one-third of PCF practices indicated that PCF payments were adequate, considering the amount of work PCF required.

Exhibit 5. Most changes were not funded by PCF



PCF = Primary Care First.

In interviews, practices reported that the payments were unpredictable because of the PAA and PBA, making it challenging to plan for changes. Practices saw themselves as having little control over the PAA, and few practices reported trying to improve the PAA. Similarly, one-quarter of practices said they were not making efforts to improve their PBA because they had limited understanding of the PBA methodology or did not believe they could control the factors contributing to their performance adjustment. In addition, practices reported challenges leveraging CMS data sources to improve their financial performance, consistent with findings from prior years. Practices mentioned the need for additional supports from PCF, including more support from CMS to help them understand the data and make improvements, and more information on how to use the data feedback tool and claim and claim line feed. The perceived inadequacy of CMS' data supports deepened the sentiment that PCF payments are unpredictable.

We found that many practices' PAA increased and fewer practices earned positive PBAs over time. More practices saw their PAA increase across the four quarters of 2023 rather than decrease, which means that a greater proportion of revenue was lost because of patients receiving care from other practices. In addition, fewer practices earned positive PBAs because of the design of the incentive. About 60 percent of Cohort 1 practices earned a positive PBA from CMS in the second half of 2022. However, by the second half of 2023, less than a third of practices received a positive PBA and more than half of practices received a negative PBA. This decrease in the proportion of Cohort 1 practices receiving a positive PBA likely resulted from the automatic adjustments that went into effect in quarter 3 for practices failing the Quality Gateway (see text box), including the Patient Experience of Care Survey measure, which practices felt they had little control over.

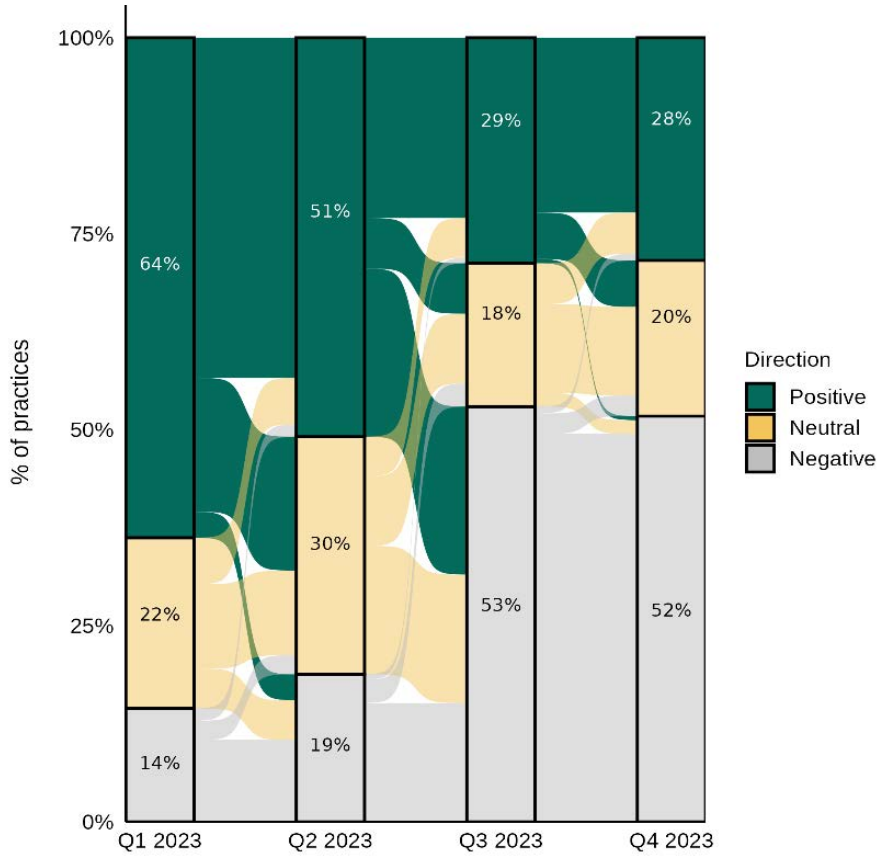
Quality Gateway

The Quality Gateway is a set of clinical quality and patient experience of care measures that determine eligibility for a positive PBA. Each performance year, practices must meet the benchmark for each of the measures to be eligible for an upward PBA. Practices received the PBA quarterly, starting in quarter 2 of performance year 2, based on their measured performance during a rolling 12-month period beforehand.

Starting in the third quarter of performance year 2, practices failing the Quality Gateway received a maximum PBA of 0 percent (a neutral adjustment). Starting in the third quarter of performance year 3, practices failing the Quality Gateway received an automatic PBA of negative 10 percent.

Exhibit 6 shows how the proportion of Cohort 1 practices that received a positive PBA decreased over time. In between the bars, flows show how each category feeds into the subsequent quarter, depicting the proportion of practices that (1) remained positive, (2) changed to neutral, and (3) changed to negative. Notably, the decrease in positive PBAs is observed alongside an increase in negative PBAs between quarters 2 and 3.

Exhibit 6. Cohort 1 PCF practices saw their PBA amounts decrease significantly in 2023



Source: Mathematica's analysis of 2023 PCF payment data to Cohort 1 practices.
PBA = performance-based adjustment; PCF = Primary Care First; Q = quarter.

Practices continued to implement, and often modified, existing care delivery strategies.

Nearly all participating practices the evaluation team interviewed continued efforts to improve care delivery after their first year in the PCF Model, modifying or sustaining their first-year strategies related to the model's five primary care functions. Practices most commonly modified and expanded many of the strategies and activities they implemented in their first year of model participation, which often predated the practices' participation in the model. Because many practices started PCF by building on existing care management strategies, interviewed practices frequently discussed continuing to modify these strategies. Practices also modified strategies under the planned care and population health function, with a focus on continuous quality improvement.

Five PCF primary care functions

- Access and continuity
- Care management
- Comprehensiveness and coordination
- Patient and caregiver experience
- Planned care and population health

Practices also improved care delivery by pursuing new strategies or reflecting on changes implemented during the first year of participation. More than half of interviewed practices reported adding at least one new strategy (and often more than one) after their first year of participation. Practices added strategies focused on improving comprehensiveness of care, such as addressing health-related social needs, integrating behavioral health, and improving coordination of referrals. Conversely, about half of interviewed practices said they had stopped making changes to at least one strategy or activity they implemented during their first year of participation (for example, stopped making changes related to advising practice improvements through patient and family advisory councils), often because these strategies were working well and did not need further changes. A couple of practices reported discontinuing strategies or activities that they implemented or planned in their first year of participation (behavioral health and podiatry services) due to financial constraints.

Care delivery changes focused on three areas of activities: workflows, staffing, and data and technology. Three factors—strengthening existing infrastructure, learning from experience with other initiatives, and creating community partnerships—helped practices remain engaged in practice transformation and to expand and improve care delivery. First, several practices identified electronic health record functionality and staff capacity as important drivers of ongoing changes in care delivery. Second, practices said lessons learned from their experiences participating in other value-based contracting arrangements and affiliation with hospital-based systems informed the activities they undertook to

> "[The social worker] just has a greater knowledge base to be able to get the patient or family exactly what they need. Whereas we can try to filter through resources and look stuff up online, help as much as we can…she'll just know something off the bat that would be helpful for them and can get the ball rolling way faster than we would be able to."
>
> — Care manager

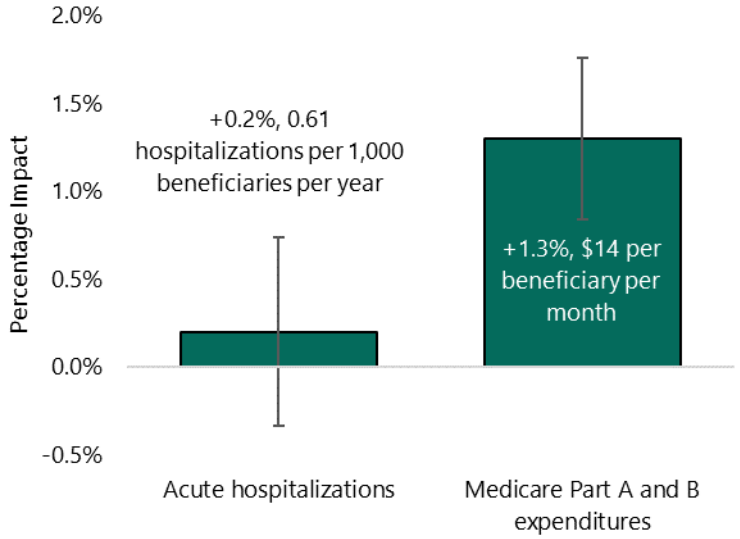
expand and improve care delivery. Third, several practices said establishing relationships with community resources to facilitate changes in care delivery, particularly related to addressing patients' health-related social needs, helped them expand the range of services they could offer their patients.

PCF did not reduce acute hospitalization rates among Medicare FFS beneficiaries, and it increased Medicare expenditures by 1 percent.

Acute hospitalization rates and Medicare Part A and B expenditures are the primary outcomes for this evaluation. We estimated the impact of PCF on these outcomes by comparing changes over time in PCF practices' outcomes to the changes in outcomes for a matched comparison group (a difference-in-differences regression model). The evaluation's comparison group is made up of primary care practices that did not participate in PCF, but are located in PCF regions and had similar practice and patient characteristics to the PCF practices when PCF began.

Our estimates show PCF did not reduce acute hospitalization rates among Medicare FFS beneficiaries, and counter to the model's goals, increased Medicare Part A and B expenditures including (non-claims-based) model payments. Exhibit 7 shows the average estimated impacts across performance years 1 and 2. The estimate for acute hospitalizations was not statistically significantly different from zero. The estimate for Medicare Part A and B expenditures was statistically significant. We estimate that PCF increased these expenditures by an average of $14 per beneficiary per month (1.3 percent) across performance years 1 and 2.

Exhibit 7. Estimated impacts of PCF on primary outcomes (performance years 1 and 2 average)



Source: Mathematica's analysis of Medicare claims data from January 2019 to December 2023.
Note: Black bars represent 90 percent confidence interval.
PCF = Primary Care First.

We also estimated the *probability* that PCF led to favorable impacts in acute hospitalizations and Medicare expenditures (using a Bayesian statistical technique). These findings indicated that PCF was just as likely to have reduced (49 percent) acute hospitalizations relative to the comparison group as it was to have increased them (51 percent). In addition, there was a high probability (72 percent) that PCF increased expenditures by at least 1 percent relative to the comparison group.

We find little evidence that PCF's impacts differed by practice and beneficiary characteristics. In general, results for the subgroups of practices and beneficiaries we examined resembled estimated impacts for the overall study population.

CMS hypothesized that PCF would not result in detectable cost savings to Medicare until performance year 4, so it is possible PCF could have impacts on these primary outcomes in later years of the model. Nevertheless, the lack of favorable findings for these primary outcomes is also consistent with findings that PCF participation led to little or no improvement in other measures like the proportion of eligible beneficiaries who adhere to medications prescribed for multiple chronic conditions or telehealth use that we would expect to see improve early in the model if PCF is to lower acute hospitalizations and Medicare spending. In addition, PCF did not meaningfully impact a range of secondary expenditure and service use outcomes such as inpatient expenditures and primary-care substitutable emergency department visits that we hypothesized could be affected through the same care delivery changes expected to influence primary outcomes.

Conclusion

Our findings indicate that changes PCF practices have implemented because of the model have not improved outcomes relative to a group of similar practices not participating in PCF. The findings for primary outcomes are consistent with findings that PCF participation led to little or no improvement in measures we would expect to see improve if the model is to lower acute hospitalizations and Medicare spending. These results do not necessarily imply that PCF practices' care delivery changes have no effects on outcomes but rather that their changes do not lead to substantively different effects than activities undertaken by a group of similar practices not participating in PCF.

A combination of three factors likely led to us not observing improvements in primary outcomes. First, PCF practices started the model with high performance in acute hospitalizations, potentially leaving little room for improvement. Second, PCF participation was only one factor among many influencing practices' changes to care delivery activities and strategies. Third, CMS anticipated detectable reductions in Medicare expenditures starting only in Year 4 of the model.

Looking ahead

Mathematica will continue collecting data to estimate model effects through the end of the model in 2026. We also will analyze new data to better understand practices' ability to use data to inform care delivery decisions and predict payments, as well as PCF's influence on staffing changes. In addition, we will identify factors and describe strategies that might contribute to practices' high performance in reducing acute hospitalizations.