



BRIEF

**PRIMARY CARE
STRATEGIES AND
OUTCOMES IN
MEDICARE
ADVANTAGE**



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Analysis by ATI Advisory for:

BETTER MEDICARE
ALLIANCE

BACKGROUND

In the ever-evolving landscape of health care delivery, the partnership between Medicare Advantage organizations and primary care provider organizations is a valuable strategy to improve quality health care services for Medicare beneficiaries. This brief defines primary care as health services that cover a range of prevention, wellness, and treatment for common illnesses either in-person or via telehealth. Providers of primary health care include doctors, nurses, nurse practitioners, and physician assistants who often maintain long-term relationships with patients, advise on and treat a range of health issues, and coordinate care with specialist providers. Primary care is associated with better health outcomes, increased access to services, and reduced hospital use, as well as mitigation of the socioeconomic drivers of poor health.¹ Given the positive outcomes associated with primary care, it is important to understand the primary care strategies that Medicare Advantage and primary care provider organizations employ.

This brief, commissioned by the [Better Medicare Alliance](#) and developed by [ATI Advisory](#), is informed by interviews with two Medicare Advantage organizations and three primary care provider organizations, an analysis of the 2020 Medicare Current Beneficiary Survey, and a policy review. The brief offers a guide to understanding the collaborative efforts between these two stakeholder groups, as well as a comparative analysis of how the Medicare Advantage and Fee-for-Service (FFS) Medicare programs perform on key primary care metrics and across demographics.



a. Throughout this brief, we refer to all individuals enrolled in the Medicare program, through both FFS Medicare and Medicare Advantage, as “beneficiaries.” When referring to individuals enrolled in a specific program (i.e., FFS Medicare or Medicare Advantage), we use the term “enrollee.”

OVERVIEW AND IMPLICATIONS

Connecting enrollees to primary care is a key approach that Medicare Advantage organizations employ to improve population health and promote patient-centered care.^a There are four key strategies Medicare Advantage organizations leverage to improve the quality of primary care and enrollee engagement:

- 1 Access and Enrollee Engagement:** Medicare Advantage organizations encourage enrollees to engage in primary care, and both Medicare Advantage and primary care provider organizations work together to support timely access to care.
- 2 Partnerships and Value-Based Care:** Medicare Advantage organizations offer a diverse array of value-based partnerships to incentivize quality care among primary care provider organizations. Both Medicare Advantage and provider organizations have distinct roles and strengths to bring to these partnerships.
- 3 Data and Data Sharing:** Medicare Advantage and primary care provider organizations participate in data exchange to meet care gaps, share risk stratification strategies, reduce administrative burdens, and enable value-based relationships.
- 4 Communication and Care Management:** Medicare Advantage and primary care provider organizations often collaborate through open communication to ensure enrollees receive the care they need and appropriately allocate care management responsibilities.

Analytic findings show that enrollees in Medicare Advantage report higher rates of having an annual wellness visit than enrollees in FFS Medicare (Figure 3). Among Black and Latino beneficiaries, those in Medicare Advantage were more likely than those in FFS Medicare to report having a usual source of care (Figure 1). For beneficiaries who spoke a language other than English at home, enrollees in Medicare Advantage were more likely to report having a usual source of care that spoke the same language (Figure 2).

In summary, this brief offers insights into the collaborative efforts between Medicare Advantage and primary care provider organizations, as well as strategies Medicare Advantage organizations employ on their own to improve primary care access, utilization, and experience of care for Medicare beneficiaries.

MEDICARE ADVANTAGE PRIMARY CARE PARTNERSHIPS AND STRATEGIES

Research informed by interviews with two Medicare Advantage organizations and three primary care provider organizations serves as a guide to understanding how Medicare Advantage organizations manage enrollees' health through primary care. Analyses of the 2020 Medicare Current Beneficiary Survey (MCBS)^b are interwoven to compare the primary care experiences of Medicare Advantage and FFS Medicare beneficiaries (see the Analytic Methods section for more detail). This quantitative and qualitative research highlights outcomes relevant to Medicare beneficiaries' receipt of primary care and the strategies Medicare Advantage organizations employ to strengthen primary care access and enrollee engagement, partnerships and value-based care, data and data sharing, as well as communication and care management.



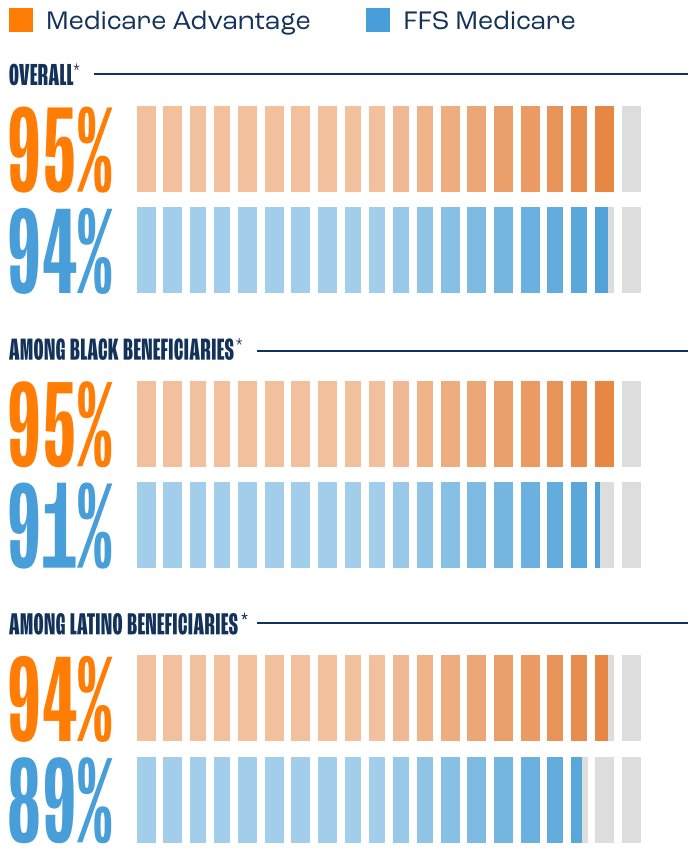
ACCESS AND ENROLLEE ENGAGEMENT

The first step to providing high-quality primary care is ensuring that enrollees are connected to a primary care provider. All enrollees in Medicare Advantage health maintenance organizations (HMOs) are required to have a primary care provider who serves as the first point of contact for most medical issues. Approximately six in ten Medicare Advantage enrollees are enrolled in an HMO, meaning the connection to primary care is a key part of the health care delivery experience for most Medicare Advantage enrollees.^{2,c} One Medicare Advantage organization reported encouraging brokers to list new enrollees' primary care providers to get them connected to care quickly during an insurance transition. If an enrollment form includes information on the primary care provider, the Medicare Advantage organization will contact the primary care provider about their enrollee's coverage so they can outreach appropriately, even before the enrollees' first appointment. For those without an existing primary care provider, Medicare Advantage organizations can facilitate beneficiaries' connection to primary care by sharing information about providers in their networks, including provider quality ratings.

The vast majority of Medicare beneficiaries report having a usual source of care, such as a particular doctor or clinic they go to when they are sick, and rates of having a usual source of care are similar across beneficiaries with Medicare Advantage and FFS Medicare. However, when disaggregating the likelihood of having a usual source of care by race and ethnicity, differences between the two programs become more apparent; Black Medicare Advantage beneficiaries are four percentage points more likely to report having a usual source of care than Black FFS Medicare beneficiaries. Similarly, Latino Medicare Advantage beneficiaries are five percentage points more likely to report having a usual source of care compared to Latino FFS Medicare beneficiaries (Figure 1).

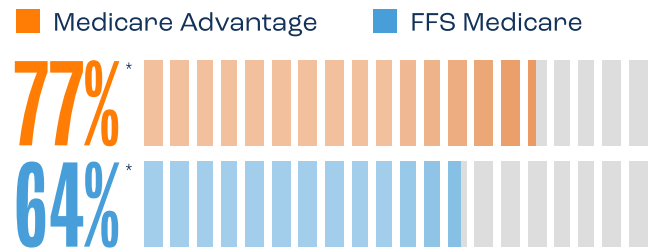
- b. Note, analyses leverage data from 2020 and should be considered in the context of the first year of the COVID-19 pandemic.
- c. Preferred provider organizations (PPOs) are another common type of Medicare Advantage plan. Enrollees in PPOs are not required to have a primary care provider and do not need referrals to see specialist providers.

FIGURE 1: ACCESS TO USUAL SOURCE OF CARE REPORTED BY MEDICARE BENEFICIARIES, BY RACE, ETHNICITY, AND PROGRAM ^{*,d}



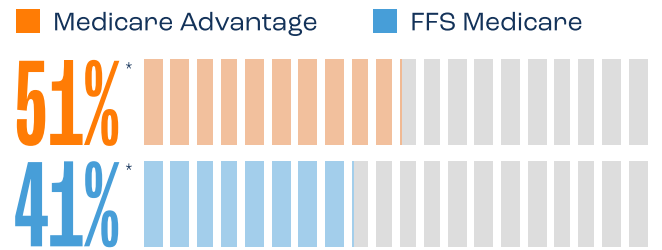
Language plays a central role in health care by facilitating communication, trust, understanding, and ultimately, the delivery of high-quality and patient-centered care. A provider who speaks the same language as the enrollee can enhance the health care experience and contribute to better health outcomes.^{3,4} Figure 2 demonstrates that among Medicare beneficiaries who speak a language other than English at home, approximately three in four Medicare Advantage beneficiaries report sharing their language with their usual care provider compared to two in three FFS Medicare beneficiaries.

FIGURE 2: AMONG MEDICARE BENEFICIARIES WHO SPEAK A LANGUAGE OTHER THAN ENGLISH AT HOME, PERCENT OF BENEFICIARIES WHO REPORTED SHARING A LANGUAGE WITH THEIR USUAL SOURCE OF CARE, BY PROGRAM ^{*}



Ensuring that beneficiaries have access to primary care within a reasonable timeframe is a key attribute of successful primary care.⁵ Medicare Advantage and primary care provider organizations can complement one another for this purpose. For example, if a beneficiary experiences a delay in seeing their primary care provider in person, a Medicare Advantage plan may offer telehealth, home visits, or late-night urgent care options. Medicare Advantage enrollees are more likely to use primary care than FFS Medicare enrollees. Medicare Advantage enrollees are ten percentage points more likely to receive an annual wellness visit within a year than beneficiaries in FFS Medicare (Figure 3).

FIGURE 3: ANNUAL WELLNESS VISIT IN PAST YEAR REPORTED BY MEDICARE BENEFICIARIES, BY PROGRAM



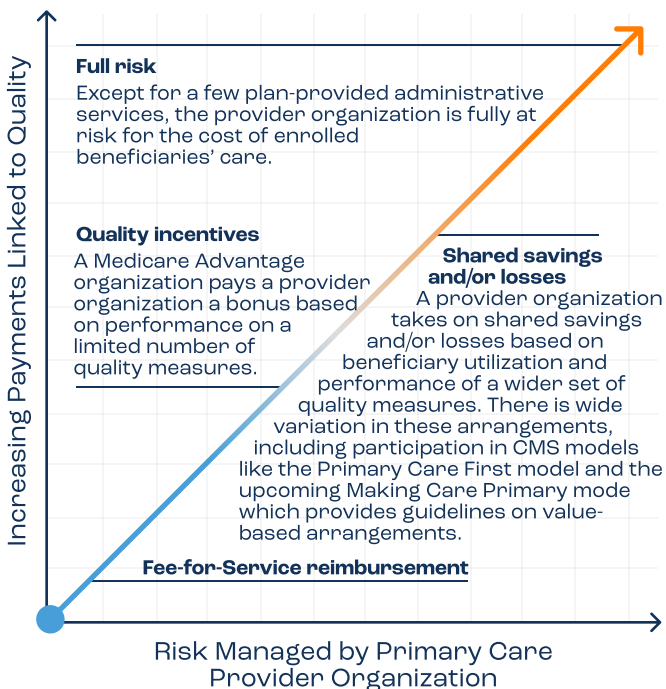
d. Throughout this report, differences between the Medicare Advantage and FFS Medicare programs that are statistically significant at a p-value of 0.05 using the Balanced Repeated Replication method are marked with an asterisk (*). All differences between the two programs described in prose are statistically significant.



PARTNERSHIPS AND VALUE-BASED ARRANGEMENTS

One of the key approaches that Medicare Advantage organizations use to improve care quality is partnering with primary care provider organizations in a value-based payment arrangement. There is variation in the level of risk that providers assume in value-based arrangements, including traditional FFS reimbursement, provider incentives, and accepting full financial and clinical risk (Figure 4). While some primary care provider organizations enter partnerships to accept full risk, other providers described a “sweet spot” of shared risk between the two entities.

FIGURE 4: CONTINUUM OF VALUE-BASED CARE ARRANGEMENTS BETWEEN PROVIDER ORGANIZATIONS AND MEDICARE ADVANTAGE ORGANIZATIONS



Medicare Advantage organizations report that the best outcomes, highest enrollee satisfaction ratings, and the greatest financial savings, often come from relationships with primary care provider organizations who take on financial risk. Therefore, though Medicare Advantage organizations may offer a range of value-based arrangements for primary care provider organizations, they encourage primary care provider organizations to take on more risk as they become more comfortable and experienced with value-based care. As one Medicare Advantage organization described, “The goal is to develop strategies that encourage and entice providers to focus on quality.” Another Medicare Advantage organization described a staff of “engagement

managers” who support primary care organization partners in setting up arrangements, tracking progress, and navigating challenges.

On a local level, Medicare Advantage and primary care provider organizations clearly enumerate roles and responsibilities to ensure enrollees receive the care they need without duplication of efforts. Even for primary care provider organizations taking on high levels of risk (e.g., shared losses in addition to savings), Medicare Advantage organizations still support provider organizations by retaining some responsibilities, for example, utilization management. To complement primary care service offerings, Medicare Advantage organizations may offer services for enrollees such as transportation to appointments using supplemental benefits. For example, in 2024, 49% of Medicare Advantage plans are offering non-emergency medical transportation.⁶ On the provider side, receiving capitated payments allows primary care provider organizations to be creative in how they serve enrollees and encourages them to test new models. Value-based arrangements allow primary care provider organizations to offer a variety of benefits they would not traditionally be able to bill to FFS Medicare, ranging from helping an enrollee complete a housing application to care management. For primary care provider organizations needing additional support in expanding capabilities, Medicare Advantage organizations can serve as a source of funding for infrastructure and education to improve providers’ ability to serve beneficiaries with complex needs. One Medicare Advantage organization reported that “the outcomes that we see in value-based care reflect better care management.”

Value-based arrangements can create aligned incentives between payers and providers that lead to “win-win-win” partnerships, with savings for Medicare Advantage organizations, increased reimbursement for primary care provider organizations, and effective incentives to increase access to high-quality care for enrollees. Higher spending on primary care is associated with both improved care quality and a reduction in overall health care spending.⁶ In particular, the greatest savings are associated with enrollees who have complex needs and who saw their primary care provider more often.⁷ Both primary care provider and Medicare Advantage organizations reported regularly receiving or paying between 150-200% of FFS Medicare rates. One Medicare Advantage

e. ATI Advisory analysis of CMS PY 2024 Plan Benefit Package files. Excludes EGHPs, PDPs, MMPs, Part B-only plans, and PACE. Analyses capture benefits that are filed under specific variables for the benefits above and do not capture benefits filed under “Other” categories.

organization reported tracking the success of a partnership as the ratio of primary care to specialty care spending, with a greater proportion of spending on primary care than specialty care being a marker of a successful partnership.

An additional benefit that primary care provider organizations reported was that the aligned incentives of value-based care strengthened relationships between primary care provider and Medicare Advantage organizations, as both work together toward a shared goal. A primary care provider organization reported: “When we went to full risk, we very quickly realized that our relationship with Medicare Advantage plans was improved. They want to be successful so they can grow, they want us to be successful to enable them to grow.”

Both Medicare Advantage and primary care provider organizations described attributes of a value-based arrangement that made the partnership easier and more likely to be successful. For example, interviewees reported that using already-collected measures as value-based metrics and keeping the value-based model consistent year-over-year reduced administrative burden. Medicare Advantage organizations draw from existing performance measures, notably those that influence Medicare Advantage Star Ratings, including the Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), or Medicare Health Outcomes Survey (HOS) in their value-based performance models.⁸

MEDICARE ADVANTAGE INVOLVEMENT IN CMS PRIMARY CARE MODELS

In addition to the value-based relationships that Medicare Advantage and primary care provider organizations develop independently, CMS offers structured models in which payers and providers can participate. Over the past decade, CMS has demonstrated interest in strengthening value-based primary care by piloting evolving models that build on one another:

- **Comprehensive Primary Care (CPC):** Launched in 2012 and became CPC+
- **Comprehensive Primary Care Plus (CPC+):** Launched in 2017, ended in 2021
- **Primary Care First:** Launched in 2021, five-year model
- **Making Care Primary:** Announced in June 2023, 10.5 year model

These models offer a value-based structure for Medicare Advantage and primary care provider organizations to use in their own partnerships. Medicare Advantage organizations noted CMS’ support for these models is helpful but recognize that many primary care organizations are not equipped to take on the level of risk these models involve.



DATA AND DATA SHARING

Data exchange between Medicare Advantage and primary care provider organizations can be one of the most important aspects of a value-based relationship seeking to improve access to care and outcomes. Many partnering organizations have bidirectional information exchange, where Medicare Advantage organizations take in data from primary care providers and share key actionable information that can lead to better care with primary care provider organizations. For example, one interviewee discussed exchanging data on twenty-nine care gaps or flags for enrollees whose conditions may be deteriorating, who are discharged from the hospital, and/or those who have not filled their prescriptions. Interviewees reported that bidirectional information exchange delivers the strongest value when it includes real-time data on value-based quality metrics and when data on care gaps are validated and actionable.

Both Medicare Advantage and primary care provider organizations have valuable information on enrollees' health, and sharing this information can improve coordination of care and the ability to meet enrollees' needs. Medicare Advantage organizations can share utilization information as well as beneficiary-reported information from a health risk assessment while primary care provider organizations often serve as an enrollee's primary point of contact to the health care system. One primary care provider organization described following up with an enrollee to understand why they received an MRI and if their care needs were met after learning from the Medicare Advantage organization that their enrollee had an MRI. Similarly, when a Medicare Advantage organization notifies a primary care provider organization that an enrollee has been discharged from the hospital, the primary care provider organization can work to set up an in-home visit with the enrollee. Both Medicare Advantage and primary care provider organizations may use risk stratification to ensure that enrollees receive the services they need. Because both organizations conduct risk stratification in different ways, they may compare their lists of identified enrollees with high medical or social complexity to ensure no enrollees' needs are missed.

There are a variety of tools that facilitate information exchange between Medicare Advantage and primary care provider organizations. Some payers will offer financial incentives to make electronic health records (EHRs) interoperable between the two organizations to reduce billing complexity as well as leverage data to reduce enrollees' care gaps. Medicare Advantage organizations may also offer an online platform that provides primary care provider organizations with population health management tools for the enrollees in their practice.

Looking to the future, data exchange can grow and further support primary care. EHRs and data exchange platforms can support primary care providers to practice at the top of their licenses through clinical decision support tools. As primary care is increasingly becoming team-based, where information must be shared between primary care providers, social workers, behavioral health providers, nurses, and pharmacists, the role of data exchange platforms will become more important.



COMMUNICATION AND CARE MANAGEMENT

A final strategy that Medicare Advantage and primary care provider organizations use to strengthen primary care is to coordinate care for their enrollees. The two organizations may form joint operating committees to discuss strategies to improve the care of their enrollees. Both parties may also collaborate on specific enrollees' care management in subcommittees, which can be made up of an enrollee's care team. These subcommittees may include a nurse navigator, care coordinator, and pharmacist from both organizations. The goal of the committee is to review enrollees' needs, identify care gaps, and develop action plans. This level of coordination is especially important for two key populations: new enrollees and enrollees with high-risk needs. In addition to enrollee-level conversations, one Medicare Advantage organization described reviewing utilization trends with primary care provider organizations and collaborating on how to solve challenges as they arise.

Both Medicare Advantage and primary care provider organizations deliver unique strengths and services, therefore, prioritizing communication between the organizations can ensure that enrollees access the best of both organizations. According to one interviewed primary care provider organization, "the door swings both ways": the primary care provider organization will educate plan care

coordinators on the services that they offer so that if an enrollee goes to the plan, they will connect the enrollee with the provider's services. Conversely, the primary care provider organization will learn about the plan's core and supplemental benefits and connect enrollees to those resources, like transportation or housing support. One primary care provider organization reported helping a Medicare Advantage organization design a supplemental benefit, based on the needs the primary care provider organization identified among enrollees.

Interviewees emphasized the importance of each partner playing to their strengths. For care management to be enrollee-centered, the right organization should take on the task, whether that is the Medicare Advantage organization, the primary care provider organization, or even a community-based organization. When Medicare Advantage organizations formally delegate care management responsibilities to another organization, they can ensure quality of care through required accreditation, audits, and performance reporting. At the same time, primary care provider organizations are often trusted members of the community and can serve as a connection point to enrollees. For example, one Medicare Advantage organization reported reaching out to an enrollee's primary care provider organization when the enrollee refused care management to see if the care management relationship could be established.



LOOKING AHEAD

The Medicare program serves individuals with some of the most complex medical and social needs, many of whom may benefit from effective and patient-centered primary care. Primary care can serve as an essential connection to help an individual navigate their health, prevent disease, and manage chronic illnesses to improve their quality of life. Given the Medicare Advantage program's flexibility to innovate and collaborate with primary care providers, Medicare Advantage organizations can continue to meet the needs of a growing number of Medicare beneficiaries.

Approximately half of the nearly 65 million Medicare beneficiaries are enrolled in the Medicare Advantage program, which employs multifaceted strategies to provide local primary care.⁹ Beneficiaries in the Medicare Advantage program report experiencing higher rates of annual wellness visit utilization and access than those in FFS Medicare (Figures 1 and 2). Ultimately, high-quality primary care relies on strong partnerships with primary care provider organizations, data sharing, access and enrollee engagement, as well as communication and care management. Examining the program's performance and strategies each year will allow policymakers to understand the strengths of the Medicare Advantage program, as well as opportunities to improve both the program and enrollees' health and experience.



ANALYTIC METHODS

Using the 2020 Medicare Current Beneficiary Survey (MCBS), ATI Advisory examined how Medicare Advantage and FFS Medicare enrollment is related to beneficiaries' demographics, utilization of, and experiences with primary care. All comparisons between Medicare Advantage and FFS Medicare are made using survey data from the same community-dwelling population. Statistical significance was measured at a p-value of 0.05 using a Chi-Squared test and the Balanced Repeated Replication method with a coefficient of 0.30. Beneficiaries who identify as both Latino and Black are classified as Latino. Analysis was conducted on MCBS data using the general sample, the usual source of care sample, and the patient activation sample. Some figures have smaller overall community sample sizes because certain question segments were asked to a subset of beneficiaries.

Sample sizes, 2020 Medicare Current Beneficiary Survey

	Overall Community-Dwelling Beneficiaries	Community-Dwelling Beneficiaries in Usual Source of Care Sample
Figures Using this Sample	Figure 3	Figures 1 & 2
MA Enrollees	6,373	5,252
FFS Enrollees	7,972	6,483
Total Medicare Beneficiaries	14,345	11,735

Full methods are available at:

<https://atiadvisory.com/resources/wp-content/uploads/2023/02/2020-MCBS-Research-Methods-2023.pdf>

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