Developing Primary Care Population-Based Payment Models in Medicaid: A Primer for States

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Center for Health Care Strategies

Contents

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

Introduction

Primary care — the basis of a strong health care system — is the only type of care where increased supply has been shown to promote health equity and population health.[1] State Medicaid programs are testing a variety of policies to strengthen primary care, including exploring new population-based payment models that can change how health care is delivered and, ideally, promote more flexible, tailored, and equitable health care that improves outcomes.

Primary care population-based payment (PBP) models are upfront, prospective, primary care value-based payment (VBP) models that include provider accountability both for quality and cost of care. Provider payments under these models are based on the number of empaneled patients a provider serves, as opposed to the number of services a provider performs. Models based on per-patient instead of per-service payment are often called capitated models, but in some instances capitated payment may not include a link to quality of care. In contrast, PBP models must hold providers accountable for quality. PBP models seek to move away from volume-based, fee-for-service (FFS) payments and toward predictable "budgets" that support population health management, flexible service delivery, and financial stability for participating providers and states implementing the model.[2] When designed with an explicit focus on addressing health equity, primary care PBP models can contribute to efforts that reduce health disparities.[3,4]

This primer can help state Medicaid programs as they design and refine primary care PBP models. Developed through support from The Commonwealth Fund and Arnold Ventures, it explores examples and implications of state and federal PBP model design choices, with an emphasis on the health equity impact for patients and providers. While each Medicaid program will make model design choices based on its specific goals, stakeholder preferences, and context, the primer outlines options for states to consider when making decisions about PBP model design in the following six key areas:

1. Model goals

4. Patient attribution

2. Model scope

5. Rate setting

3. Payment approach

6. Care delivery standards

The success of a primary care PBP model depends on engaging with stakeholders, designing models for primary care providers (PCPs) who face specific barriers to participation, and considering opportunities for alignment with other payers and models within the state. This resource explores these topics to support states in integrating these approaches into their model design.

Select PBP Models Discussed in this Primer

This primer for Medicaid programs draws from examples of implemented state and federal primary care PBP models, primary care PBP models currently in the design phase, and other primary care models that, although not PBP approaches, may be translated for PBP model design.

Exhibit 1 describes select primary care PBP models that state Medicaid agencies have already launched or are currently designing. Primary care models referenced in this resource that do not use a PBP approach are not included in the below table.

Exhibit 1. Select State and Federal Medicaid Primary Care PBP Models

Model	Overview
State Medicaid Models	
Colorado Alternative Payment Model (APM) 2[5] *(launched 2022)*	Hybrid primary care PBP *(for definition, see Exhibit 3, page 12)* that allows PCPs to choose the percentage of total revenue they receive from PBP or FFS payment. Includes an opportunity for PCPs to earn shared savings for controlling total cost of care (TCOC) for any of 12 common chronic conditions.
Maine Primary Care Plus[6] *(launched 2022)*	Developed in alignment with the Centers for Medicare & Medicaid Services' (CMS) Primary Care First model. Phase 1 of the model includes a new per member per month (PMPM) payment on top of the existing FFS payment (with no changes to FFS payment). In Phase 2, Maine plans to move toward a primary care PBP.[7]
Massachusetts Primary Care Sub-Capitation Model[8] *(launched 2023)*	Full primary care PBP *(for definition, see Exhibit 3, page 12)* that is part of MassHealth's broader Accountable Care Organization (ACO) model. The MassHealth ACO model is a TCOC model that is paid through a PBP, and the primary care sub-capitation model is designed to sit within the ACO model and ensure PCPs are also paid through a PBP.
New Mexico Primary Care Payment Reform[9] *(anticipated 2024)*	Flexible three-tiered model that allows PCPs to select their tier and will include the option for a full PBP. The model is designed in alignment with CMS' Making Care Primary model and will be run through the state's Medicaid managed care organizations.
Oregon Primary Care Value-Based Payment Model[10] *(in design)*	Voluntary multi-payer model designed in concert with the state's Medicaid program. The model will include a full PBP, along with: (1) infrastructure payments tied to the state's Patient-Centered Primary Care Home program and provision of other specified high-value services; and (2) performance-based incentive payments.
Washington State Primary Care Transformation Model[11] *(in design)*	Voluntary multi-payer model designed in concert with the state's Medicaid program and in alignment with CMS' Making Care Primary model. The model will include three provider levels: (1) FFS payment, plus a supplemental practice transformation payment; (2) a hybrid PBP/FFS payment, along with a supplemental practice transformation payment; and (3) a full PBP, along with a quality incentive payment.
CMS Models	
Primary Care First[12] *(launched 2021)*	Designed primarily for Medicare enrollees. The CMS Innovation Center sought state Medicaid program partners to design aligned primary care models. Hybrid primary care model, which is comprised of a combination of a flat per-visit fee and a PBP.
Making Care Primary[13] *(anticipated 2024)*	Designed primarily for Medicare enrollees. The CMS Innovation Center sought state Medicaid program partners to design aligned primary care models. Includes three tracks that participating providers are expected to move through over time. Track 1 includes FFS payment with additional financial support to build capacity; Track 2 is a 50/50 hybrid PBP and FFS payment with additional financial support; and Track 3 is a full PBP.

1. Model Goals

Clearly defined model goals are an essential component of any primary care PBP model.[14, 15] The goals can present a "north star" for the model — defining the state and stakeholders' **vision and purpose**, providing guiding **principles for model design choices**, and determining **how success and failure are measured**. These goals should be formulated in partnership with stakeholders, including PCPs and Medicaid enrollees, at the outset of the model design process. Because most model design choices are interconnected, the model's goals will ideally influence the design process itself — by determining which design choices the state starts with and how those choices will influence other aspects of the design.

While states should consider multiple options for goals, and may want their primary care model to achieve many things, two or three goals may be beneficial. States can also consider existing evidence on VBP model impact to help set ambitious but feasible goals. This narrowed focus and use of evidence increases the likelihood of success for the model, by allowing program participants to use their limited resources to concentrate on a more defined set of attainable objectives, rather than spreading time and resources across a larger number of goals or a set of unattainable goals.

Cost control is a common goal in TCOC programs, but few, if any, primary care PBP models look to control costs within primary care. In fact, it is widely accepted that primary care spending is too low, and many states are interested in using primary care PBP models to increase investment in primary care, in conjunction with statewide primary care spending targets.[16, 17]

The link between primary care and promoting health equity is strong.[18,19] Health equity can be a key element of primary care PBP model goals, and goals can reflect health disparities in the state and existing statewide priorities or opportunities.[20] Some states may choose an explicit goal related to health equity (e.g., decreasing a certain health disparity), while others might choose to approach health equity through goals related to priority populations (e.g., a focus on primary care in rural areas) or conditions (e.g., a focus on diabetes care, noting the disproportionate diagnosis of diabetes among Black, Native American, and Hispanic people in the U.S.[21]).

PBP goals can include processes, outcomes, or a combination of both. Following are some examples of each type of goal:

- ***Outcomes-based goals.*** Focused on an anticipated result of the model, such as:
  - → Achieving specific quality benchmarks (e.g., improve diabetes blood sugar control for 30% of patients within five years);
  - → Reducing specific health disparities (e.g., decrease racial, ethnic, and geographic disparities in childhood vaccination rates by 25% within five years); or
  - → Improving access to care (e.g., meet the recommended number of well visits for 75% of children ages three and under by year five of the program).

- ***Process-related goals.*** Focus on an anticipated care delivery change or other change that occurs as a result of the model, such as:
  - → Implementing specific interventions designed to advance health equity (e.g., within three years, use a medical interpreter for 80% of visits with non-English speaking patients and deaf/hard-of-hearing patients);
  - → Promoting team-based care (e.g., within three years, offer community health worker services at 50% of primary care practices); or
  - → Streamlining provider incentives (e.g., include the same three aligned quality measures in all VBP and quality improvement models across the state by the third year of the program).

Whatever goals are selected, they should be **measurable**, **accountable**, and **achievable**. For example, a goal to "reduce maternal mortality for Black people enrolled in Medicaid in the state by 25 percent in five years" is more specific and quantifiable than "reduce maternal mortality for Black people."

Stakeholder Engagement

A primary care PBP model, like any policy change, needs sufficient stakeholder buy-in to be successful.[22] Medicaid staff should think critically about the process of designing their primary care PBP models and who is involved, not just which decisions need to be made.

- ✓ **Providers and possibly health plans** will need to sign up to participate in voluntary models, and their input in model design will ensure their ability to meet requirements. Their input provides valuable insight into the structure of model components, helps avoid potential pitfalls, and creates a more palatable design that can smooth the transition to the new payment approach, as well as encourage enthusiastic participation in the model.
- ✓ **People enrolled in Medicaid** should also be part of stakeholder engagement. While program enrollees may have less to say about technical design choices, they can help identify model goals, opportunities to promote health equity, and care delivery priorities.[23]
- ✓ **Stakeholders should be engaged proactively**, before, during, and after the model design process. Long-term follow-up once the model is implemented can identify pain points or challenges in need of modification. States can use a variety of tools to engage stakeholders, including hosting multi-stakeholder work groups and focus groups and conducting surveys to collaborate and gather feedback.[24]

Using equitable processes that center diverse patient and provider voices will helps states design a PBP model that promotes health equity and achieves the model's goals.

2. Model Scope

The scope of a primary care PBP model includes: (1) **patients** who will be assigned to the model; (2) **provider types** eligible to participate in the model; and (3) **services covered** by the payment. Choices around patients, provider types, and services are related — the provider types and services included in the model should reflect the needs of assigned patients.

Additionally, states should also consider the health equity implications of these choices. Medicaid staff may ask themselves:

- ***How might decisions around inclusion and exclusion of patients and provider types disproportionately impact patients who are more likely to experience health inequities?***
- ***How might decisions around scope of services influence the services that PCPs participating in the PBP model elect to provide?***

Patient Assignment

One of the earliest choices in primary care model design is who the model will be designed to serve. Medicaid primary care PBP models might focus on Medicaid-covered adults, children and adolescents covered by Medicaid or CHIP, people dually enrolled in Medicare and Medicaid, or some combination or subset of these populations.

Each unique patient population may be best served by different primary care model designs, and states will need to decide if one primary care model can appropriately address the needs of Medicaid-eligible adults, children, and people who are dually eligible. To address tradeoffs between simplicity and specificity in a primary care PBP model, states might choose to create multiple primary care models for different populations — one overarching model with different "tracks" or requirements for different populations, or a primary care model designed to serve one population based both on assessing state bandwidth and patient and provider feedback. For example, the **Massachusetts** Primary Care Sub-Capitation model includes different clinical requirements for adult and pediatric primary care. While many design elements of the model are the same for all primary care practices, there are some differing care delivery standards and associated payment adjustments between adult and pediatric providers.[25]

Adults and children have different primary care needs, with care for adults focusing on control of common chronic conditions and pediatric care focusing on regular well visits, provision of immunizations, and age-appropriate screenings.[26] Pediatric primary care may also rely on higher levels of coordination (e.g., working with parents/families, schools, and state agencies). Primary care PBP models serving adults or children may be structured to account for these different population needs — for example, models might at a minimum include different care delivery requirements, quality measures, and risk adjustment methods. Some primary care models such as the **Massachusetts** Primary Care Sub-Capitation model[27] and **Ohio's** Comprehensive Primary Care for Kids model[28] also include increased reimbursement for pediatric providers.

A significant portion of people who are dually eligible for Medicare and Medicaid experience complex health needs — including living with disabilities, mental health conditions, or multiple chronic conditions.[29] This population benefits from well-coordinated, advanced primary care. However, because dually eligible people are covered primarily through Medicare — with Medicaid typically providing specific financial assistance and covering a smaller, defined set of long-term and home-based services[30] — many Medicaid programs do not include this population in their primary care models. States that have developed integrated Medicaid-Medicare programs, which create unified financing and care delivery systems for Medicaid and Medicare benefits, may be best suited to develop primary care PBP models that incorporate and address the needs of dually eligible enrollees.[31,32]

Provider Eligibility

States will need to decide which types of providers will be included in their primary care PBP model. States may consider their options by exploring a broad or narrow definition of a PCP as described in in Exhibit 2.[33,34]

Exhibit 2. Defining "Primary Care" in PBP Model Design

BROAD	Typically includes family medicine, internal medicine, pediatric medicine, general practice, nurse practitioner (NP), physician assistant (PA), geriatric medicine, adolescent medicine, and gynecology.
NARROW	Typically includes family medicine, internal medicine, pediatric medicine, and general practice.
COMBINATION	Might, for example, include all of the "narrow" specialties, along with geriatric and adolescent medicine, but not including PAs, NPs, or gynecology.

Categorizing Obstetricians and Gynecologists

A common decision point in defining provider eligibility is whether obstetricians (OB) and gynecologists (GYN) should be considered PCPs. While many practitioners operate as both an OB and GYN — providing both pregnancy and routine women's health care — some prioritize their work either as an OB or a GYN. States debating whether to include OBs and GYNs in their model may benefit from differentiating between providers who primarily focus on either type of care. OBs and GYNs can be a key entry point into the health care system, with about one fifth of women considering their OB/GYN as their PCP.[35] However, these providers may also offer services, such as labor and delivery, outside of the primary care setting and with significantly higher costs than typical primary care services. States can carve out these specific services from the primary care PBP and move them into other payment approaches (see the ***Model Scope*** and ***Care Delivery Standards*** sections). States should also engage directly with OBs and GYNs to gauge interest in participating in the primary care PBP model. There may be limited interest, however, as studies have found that a third to half of OB/GYNs do not think of themselves as PCPs.[36 37]

Specific state context may also play a role in defining who is a PCP under the state's primary care PBP model. In **Colorado**, the state had already defined the "Primary Care Medical Provider" through its Regional Accountable Entities structure.[38] Using a pre-existing PCP definition can help create clarity and program alignment and may decrease administrative complexity. However, pre-defined types could create challenges if the provider types do not cover the needs of all assigned patients or included services.

States can also consider the provider types that different groups of patients typically see for primary care. If there are notable patterns within the state, policymakers might consider whether excluding some provider types from the PBP model could disproportionately exclude specific patient groups. For example, researchers have found that nationally, about one-third of PCPs provide primary care for 80 percent of visits from patients of color.[39] While segregation in the provision of primary care may be unrelated to provider or practice type and patterns may vary across the country, states should consider if they are likely to unintentionally exclude communities of color or other marginalized populations from the primary care model by not including certain provider types — such as small providers, GYNs, or PCPs practicing in federally qualified health centers (FQHCs).[40] States can work to understand who seeks care where to help make these decisions with an equity lens.

To operationalize choices about who is considered a PCP, states can rely on a few factors:

- ***Taxonomy of provider.*** States may provide a taxonomy list, like **Colorado**, that specifically names each provider type that can participate in the model.[41]
- ***Site of care.*** Some models assess from where providers submit claims to determine if they are a PCP. **Maine's** Primary Care Plus model, for example, allows participation from FQHCs, rural health centers, or tribal health clinics and does not require PCPs to meet any other definition beyond practicing at these health centers to be eligible for model participation.[42]
- ***Types of claims.*** Models like **CMS' Primary Care First** and **Making Care Primary** require provider organizations to submit a certain percentage of claims as a primary care service to be eligible to participate in the model.[43,44] Common thresholds are 40 to 50 percent of claims meeting the model's definition of primary care. Additionally, PCPs who are the "right" provider type, but do not offer a sufficient number of "primary care services" are excluded from the model.

Provider Type Special Considerations

Federally Qualified Health Centers. One of the major decisions that states will need to make is whether to include FQHCs in their primary care PBP model, and if so, how to make the model accessible to them. FQHCs are traditionally paid per encounter via the federal Prospective Payment System (PPS) methodology,[45] no matter what services are provided at each encounter. There are federal rules that limit FQHCs' participation in payment models that involve downside risk and allow FQHC revenue to fall below what would have been paid under PPS.[46] To comply with these rules, models focused on FQHCs that include downside risk may pay FQHCs above the PPS rate, putting only payments in excess of PPS at risk, and typically undergo routine reconciliation between actual reimbursement and PPS to ensure adequate payment.[47] Further, FQHCs provide services, such as behavioral health and oral health services, which may not be covered under the primary care PBP model. Because FQHCs are significantly different from other PCPs, states have used multiple approaches, such as including FQHCs in the PBP model, creating a separate "track" or terms for FQHCs, or excluding them from the model altogether — creating either a wholly separate FQHC-specific model, or not creating a model for FQHCs at all. States should engage with their FQHCs and state primary care association during the model design process to discuss potential participation, and decide if FQHC participation in the primary care PBP model is desirable for FQHCs and the state.

Indian Health Care Providers. Health care programs operated by the Indian Health Service, a tribal government or tribal organization, or an urban Indian organization — known as Indian Health Care Providers (IHCPs) — receive significant third-party payments for their Medicaid-covered patients,[48] but are often not included in Medicaid VBP models. These providers, like FQHCs, are typically paid by Medicaid through an all-inclusive rate[49] and operate under specific laws and regulations that may make inclusion in a primary care PBP model more technically challenging. However, IHCPs often face shortfalls in funding[50] and may benefit from participation in models that focus explicitly on increasing overall investment in primary care and providing an opportunity to gain experience and confidence in PBP model participation. Models like **Arizona's** American Indian Medical Home (a primary care case management model)[51] and **CMS' Making Care Primary**[52] provide examples of how states can collaborate with IHCPs to support tribally led primary care initiatives and address health disparities experienced by Native American and Alaska Native people. States interested in including IHCPs in their primary care PBP should begin a consultation process with Native nations in their state and consider how they can meet and then build upon federal requirements to work with tribes on policies that will impact them.[53]

Primary Care Services

States will need to decide which specific primary care services to include in the PBP rate and which will remain in FFS payments. These choices should be clearly communicated to PCPs participating in the model. The different incentives inherent to each payment type (e.g., PBPs can cover services not typically reimbursed through claims-based payment; FFS payment incentivizes higher volume) may lead to choices to strategically include or exclude some primary care services from the PBP rate.

Policymakers and PCPs have explored this issue and have suggested similar principles that model designers can consider for determining a primary care PBP model scope of services. [54,55,56] The questions below, which have been synthesized from these sources by CHCS, can help states review these principles and identify services where the inherent volume-based incentives of FFS payment may be beneficial. This is not intended as a comprehensive list of services to exclude from a PBP model, rather model designers can use these questions to make choices in accordance with the state's context, model design decisions, and model goals.

- ***Are there services where a higher volume of delivery is encouraged because they improve equity, outcomes, access, or overall cost of care (e.g., immunizations, behavioral health screening)?***
- ***Are there services that should be delivered by a PCP as opposed to another provider to support systemwide cost savings (e.g., joint aspiration, insertion of long-acting reversible contraception)?***
- ***Are there services that may be under-counted in rate-setting methods?*** *For example:*
  - → *Services not commonly delivered through primary care (e.g., tobacco screening); or*
  - → *Services differentially delivered by type of provider (e.g., female PCPs are much more likely to provide pap tests than male PCPs).*
- ***Are there services that are costly for PCPs to provide (e.g., expensive injectable medications)?***

The bulk of a practice's primary care revenue should be paid through the PBP (assuming it is a full PBP model — hybrid models may operate differently as explored in the ***Payment Approach*** section), even if some services are intentionally paid for through FFS payment. This means that in most cases, the core services of primary care — outlined by the evaluation and management code set — should be paid for through the PBP, because evidence indicates that approximately two-thirds of practice revenue needs to be delivered through PBP to meaningfully change payment-based incentives.[57]

When determining the scope of services for the primary care PBP model, model designers should consider their plan for setting PBP rates, including if they hope to meaningfully change rate-setting processes over time. If PBP rates will be based on individual PCP history, as in **Colorado's** model[58] and **Massachusetts'** current model,[59] rates will naturally account for unique service delivery patterns or services that are costly to provide. If PBP rates are based on broader aggregate spending and utilization patterns, as some states are exploring, it may make sense for PBP rates to be calculated from a base set of primary care codes, with FFS payment used to fill in the gaps for the unique service delivery patterns of some individual PCPs. These rates may also be adjusted for member acuity to ensure PCPs receive the funding necessary to address the needs of their specific populations (see the ***Risk Adjustment*** section).

States should also incorporate their goals for primary care redesign into the model's scope of services. In addition to including traditional primary care activities in the PBP, many states require or incentivize PCPs to offer more advanced primary care services as part of the primary care PBP model.[60] The ***Care Delivery Standards*** section explores these delivery standards more fully, but states should consider how new services covered by PCPs will be incorporated into the model's scope of services.

3. Payment Approach

While primary care PBP models come in a variety of forms, they have several common characteristics. All primary care PBP models pay a prospective payment linked to quality to *primary care providers* for provision of *primary care services* to their *attributed patient population*. Such payments tend to be paid on a PMPM basis. However, payment structure — including whether any FFS payment is retained, how the prospective payment is linked to quality, and how quality is defined — may vary by model. This section explores the options states have to construct a payment approach within the primary care PBP.

Full vs. Hybrid PBP Models

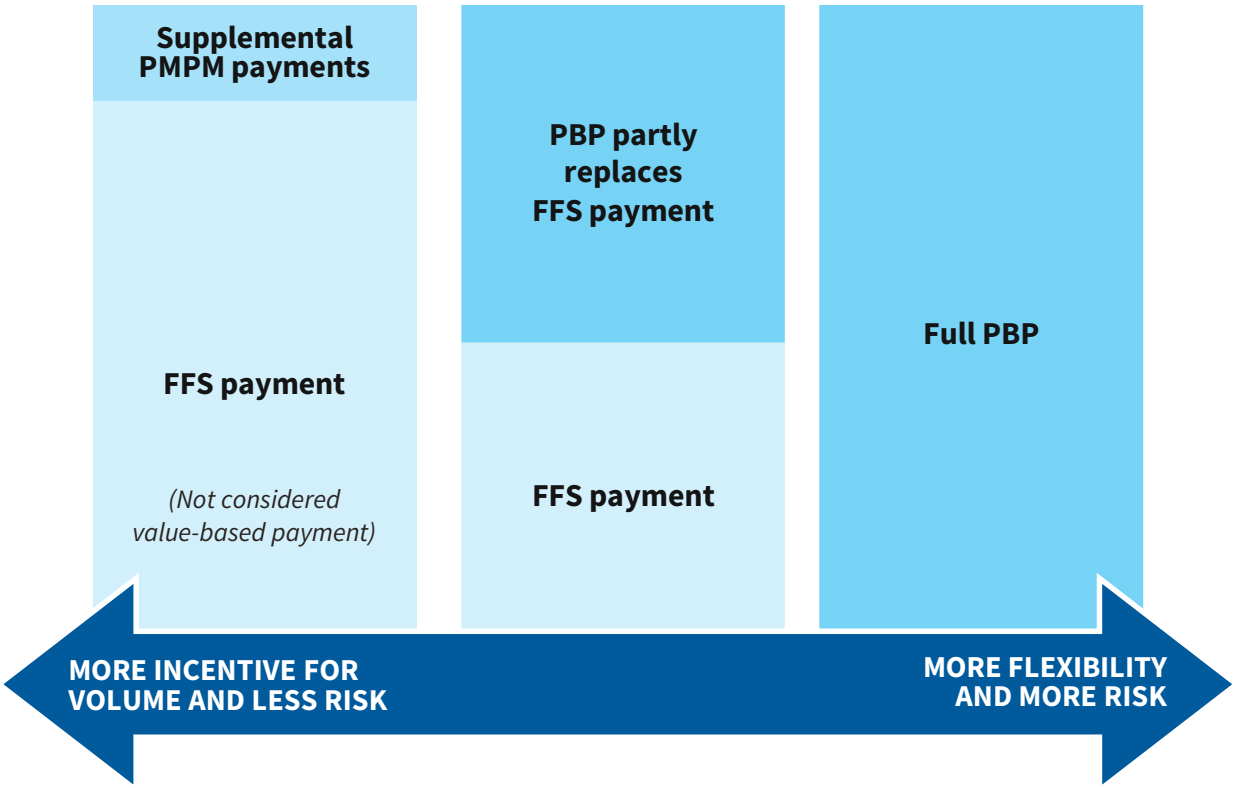
A foundational choice states need to make regarding a PBP structure is whether the model is a "full" or "hybrid" PBP. Exhibit 3 compares these approaches and offers an example of each.

Exhibit 3. Full vs. Hybrid PBP Models

	Full PBP	Hybrid PBP
Definition[61]	All or nearly all of the practice's scope of services is covered by an upfront population-based payment.	A portion of the provider's revenue is paid through an upfront PBP, and the rest is distributed through FFS rates proportionally reduced to account for the PBP.
Key Benefits	• Provides an immediate and pronounced move away from volume-based practice. • Allows PCPs more flexibility in treatment decisions.	• Can encourage increased uptake of the model, because it eases PCPs into the new payment approach. • May decrease incentives to withhold care.
Example	***Massachusetts Primary Care Sub-Capitation Model***: PCPs are paid through a PMPM rate that covers all services within the scope of the model for attributed patients.[62]	***Colorado APM 2***: PCPs can select the percentage of PBP they would like to receive (0-100%) for attributed patients and can adjust this percentage over time. The remaining revenue is paid through FFS.[63]

In some states, hybrid PBP models may be the desired endpoint for primary care model design. In others, policymakers might develop models designed to move PCPs into a full primary care PBP over time and employ a hybrid PBP model as an intermediary step (see Exhibit 4, next page). For instance, **CMS' Making Care Primary** and **New Mexico's** Primary Care Payment Reform models both include a full primary care PBP as the most advanced phase of the model and an intermediary hybrid PBP step. Making Care Primary, however, requires PCPs to move into more advanced payment approaches on a set schedule,[64] while New Mexico's model provides the option for PCPs to move toward a full PBP, but does not require it.[65] **Maine's** Primary Care Plus program takes a different approach by maintaining a FFS payment model, but including an upfront PMPM to familiarize PCPs with upfront payment and help them build capacity to support a PBP approach, with the goal of developing a statewide primary care PBP at a later phase in the state's primary care payment reform efforts.[66]

Exhibit 4. Percentage of Total Revenue Paid Through FFS, Hybrid, or Full PBP Payment



Broad Delivery System Reform: Ensuring Adequate Payment for Providers Participating in Primary Care PBP Models

Some primary care models sit within broader delivery system reform efforts, such as **Massachusetts'** Primary Care Sub-Capitation model, which is part of the state's Medicaid ACO program. In these cases, primary care payment may flow through the ACO or other umbrella organization, making it more difficult to ensure payment to individual primary care sites and PCPs is both adequate (especially if the primary care PBP model includes a rate bump or other investments in primary care) and uses a PBP, rather than FFS approach. This can be addressed through different oversight and reporting requirements. For instance, the Massachusetts model calculates the PBP rate for each participating primary care entity and requires that (1) 90 percent of the individual primary care entity's calculated PBP rate is paid by the ACO to that primary care entity; and (2) 100 percent of funding earmarked for primary care is paid out by the ACO to its affiliated primary care entities during the program year.[67] **CMS' Primary Care ACO Flex Model** will also include policies designed to ensure primary care PBP flow to PCPs. These policies include quarterly spending reports, public spend plan report to show how ACOs will use primary care funding, and development of defined categories of spending that will help ACOs understand what counts as primary care spending and what does not.[68]

Tying Payment to Quality

While some policymakers have previously implemented capitated payment without a tie to quality of care, all VBP models, including primary care PBP models, definitionally tie payment to quality performance. In a PBP model, such ties are usually made by a quality withhold or "clawback" of a portion of the capitated payment.[69] Many existing resources explore quality measurement for primary care performance, so selection of quality measures will not be discussed in this section.[70,71] Key things to consider when designing a quality measure set and tying it to payment include:

- ***Protect against withholding of needed care.*** One of the most important goals of a quality measure set for a full PBP is to guard against the incentive to deliver less care, since the payment level is fixed, at least in the short term. While a reduction in unnecessary or duplicative services or care delivered in high-cost settings is desirable, the goal of primary care PBP models is not to provide less primary care. Quality measures that encourage outcomes improvement and/or provision of especially needed services can be helpful to protect against perverse incentives. Hybrid PBP models may also disincentivize "skimping on care," as some portion of provider revenue is still tied to volume.

- ***Prioritize a few key quality measures that align with model goals.*** There is no shortage of quality measures available for primary care provision or health outcomes affected by primary care. States should focus on selecting a small set of measures that align closely with program goals to increase the likelihood of model success across the state. For example, **CMS' Primary Care First** includes up to five quality measures, depending on the complexity of patients the practice serves.[72]

- ***Align with other programs.*** If there are other VBP programs or quality improvement initiatives in the state, selecting relevant measures already used in those programs will ease provider burden and reinforce the importance of those measures.

- ***Accountability for equity.*** Stratifying quality measures by race, ethnicity, language, disability (RELD), or other factors or selecting equity-focused measures, can encourage provision of more equitable primary care. States should also understand the availability and quality of RELD data they have, and may want to consider initially incentivizing collection of this data as a path towards measuring stratified outcomes. For example, **Rhode Island** has incorporated a pay-for-reporting incentive into its ACO model to improve collection of RELD data and stratify quality measures by these data.[73] States can create these types of reporting requirements as a first step toward incentivizing disparities reduction.

- ***Quality may not be measured at the primary care level.*** There may be instances where quality is measured at a level other than primary care, even if the PBP operates at the PCP level. For example, the **Massachusetts** Primary Care Sub-Capitation model operates at the primary care level, but accountability for primary care measures lie at the ACO level, of which PCPs are a part. Under such a model, PCPs may be held to broader goals than just those that occur in the primary care office.

Financial Risk

Defining the level of financial risk associated with the primary care PBP model is an important design decision. While a "full" PBP model is considered a "full risk" model, there are mechanisms that can be used to ensure that PCPs are not at risk of bankruptcy due to the payment model. These mechanisms may be especially helpful in the early years of model participation, when PCPs have less experience managing a new payment approach. Hybrid models are the most obvious solution, as a PBP is supplemented by a volume-based FFS payment. States can also mitigate risk in a full PBP by using encounter data to calculate what the PCP would have earned under FFS, and then retrospectively or prospectively adjust the payment accordingly. Another approach is implementing a "risk corridor," where primary care organizations only bear full financial risk between a certain amount over or under the PMPM payments (such as five or ten percent). The state or health plan would absorb any excess variance. While states are required to collect FFS and utilization data to ensure actuarial soundness under a PBP,[74] an overzealous reconciliation process may decrease the model's ability to make a meaningful break with FFS, and limit the ease in administrative burden that breaking with FFS could provide.

4. Patient Attribution

Attribution methodology is one of the most important design choices in a primary care PBP model. Providers may be reluctant to participate in a model if they do not feel confident that their attributed patients (and therefore their rates and quality scores) reflect who they actually provide care to. While there may not be a perfect attribution method that will satisfy all stakeholders, states can work closely with providers to develop a widely acceptable attribution methodology. Creating room for PCP engagement in the attribution design process and being transparent about the method's benefits and potential limitations can make the difference between a model succeeding or failing. Simpler attribution methodologies may also help PCPs understand the process and can reduce the administrative burden of attributing patients. PCPs may appreciate being able to receive different levels of information about the attribution process and get information through different modalities — some may prefer a detailed explanation of the process and the opportunity to ask specific questions, while others might prefer a brief infographic or one-page overview.

To develop an attribution method, states commonly consider: (1) what level the patient is attributed to; (2) what steps are taken to attribute the patient; and (3) the frequency with which attribution is updated.[75] Prospective payment in a primary care PBP model typically requires prospective attribution, so considerations for retrospective attribution will not be considered in this section.

- ***Level of attribution.*** Some primary care models attribute patients to specific providers, while others attribute patients to practices or sites of care. States may reflect on existing primary care attribution methods or availability of data through claims or other sources to make this decision.
- ***Steps for attribution.*** Attribution methods in primary care ideally rely first upon patient selection of a PCP. To ensure patients with limited time, health literacy, and internet access are still able to select their preferred PCP, states can consider employing multiple, proactive opportunities for selection.[76] In the absence of clear patient selection, states rely on claims to indicate where the patient receives primary care. Different methods may weigh different types of claims more heavily. For example, the HCPLAN recommends prioritizing well visit codes over other primary care codes.[77] **CMS' Primary Care First** model uses this methodology — attributing patients who have not selected a PCP based on annual well visits or "Welcome to Medicare" visits.[78] Other methods consider all primary care claims, including **Colorado's** APM 2 model which attributes patients who have not selected a PCP based on the plurality of primary care visits in the lookback period.[79] When considering where care has historically been received, states will need to select a lookback period, often run from one to three years.[80] Patients who have not received primary care during the lookback period might not be attributed or factored into PBP model rates.

- ***Frequency of updates.*** As patients shift where they seek care, attribution can be updated. PBP models might update attribution on a quarterly, semiannual, or annual basis. Quarterly attribution is a common cadence for **CMS** primary care models, and is used in **Primary Care First**[81] and **Making Care Primary**.[82] More frequent updates to attribution may increase provider confidence in the accuracy of their panel at a moment in time, but can also create more revenue variability for providers, and it may be burdensome for the state to perform more frequent attribution calculations.

The selected attribution methodology and implementation details can have significant health equity implications. Patients who have not received primary care regularly in the past will not be attributed to the primary care PBP model — and those patients are disproportionately likely to be people from historically marginalized communities with limited access to care.[83] Attribution methods can examine a broad variety of claims to increase the likelihood that people who seek primary care in less traditional ways are still attributed to the model. For instance, **CMS' Medicare Shared Savings Program** now includes claims for evaluation and management services delivered via telehealth in its attribution method.[84]

When possible, attribution methods can also be used to assign patients to high-quality providers. If patients who do not meet requirements to be attributed to a specific provider are assigned to a PCP, for instance upon intake into a managed care entity, auto-assignment processes can account for provider quality and overall value of care, including capabilities around culturally and linguistically appropriate care.

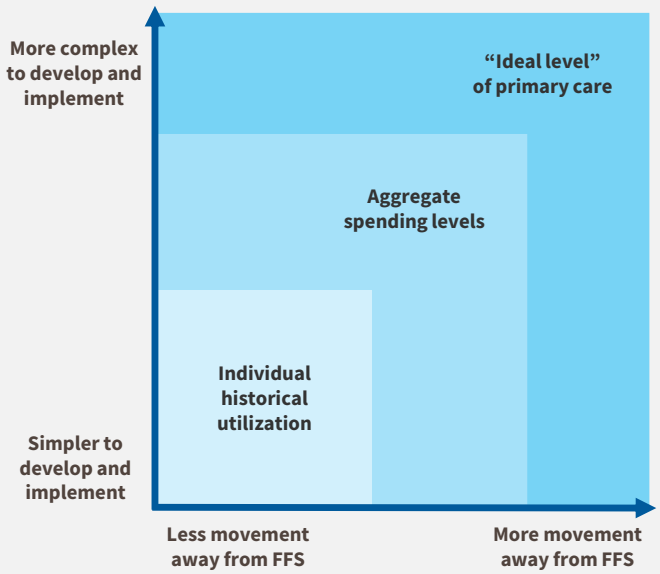
5. Rate Setting

States and their actuarial staff or partners will need to craft primary care PBP rates that are fair, equitable, and incentivize participating PCPs to provide the best possible care to the Medicaid patients they serve. There are several key components of rate development that states will need to determine, including what the rates are based on, risk adjustment, and the equity considerations within these components.

Basis for Rate-Setting

PBP model rates are typically based on historical utilization patterns, with a three-year lookback being most frequently used.[85] However, abnormalities in utilization related to the COVID-19 pandemic must be accounted for during the lookback period, as applicable.[86,87] Historical utilization, outside of COVID-19, has other potential limitations, including "locking in" the current level of primary care utilization — rather than the common goal of increased primary care utilization and decreasing other, more expensive care settings — and potentially reinforcing historical inequities.[88] To reduce these negative effects, some states have looked at alternatives to historical data for setting rates. These options may include rates that are based on aggregated utilization or spending across a region or state, a combination of aggregate and PCP-specific spending patterns, or expected or ideal levels of payment to PCPs (see Exhibit 5). No state has implemented this type of rate in their primary care PBP model as of 2024; however, **CMS' ACO Primary Care Flex** will test this concept through a primary care PBP that is based on the county's average primary care spending with adjustments for patient need and regional variation in spending.[89]

Exhibit 5. PBP Rate-Setting Mechanisms



Another way to increase primary care rates as part of the PBP model is to boost the underlying FFS payments for PCPs, which can also contribute to state goals to increase primary care investment.[90] When **Colorado** implemented its APM 2 model, it came with a 16 percent FFS rate increase available for model participants taking 25 percent or more of their payment as a PBP,[91] which in turn boosted participants' population-based payments. (PCPs in Colorado's model can earn a pro-rated rate increase if they elect to take less than 25 percent of their payment as a PBP). Such an approach creates a strong incentive to participate in the model and would help to prevent withholding of

needed care under a PBP model. Increased rates can also support safety net providers serving populations in historically marginalized communities, but would not necessarily close the gap between these practices and other practices operating in better-resourced environments that also receive the same percentage increase.

Risk Adjustment

Developing a sound risk adjustment methodology is also critical to set a fair rate. Risk adjustment is largely done to provide adequate payment for a patient's care needs, and to avoid incentivizing adverse selection or withholding of needed care.[92]

Medical risk adjustment in most VBP models is designed to predict a patient's TCOC, and is heavily influenced by a patient's risk of hospitalization and other costly utilization. Medical risk adjustment specifically designed for a primary care model is less common and might be calculated differently, for example, focused on predicting primary care-only spending or assessing ideal levels of primary care provision.[93,94,95] In primary care PBP models where rates are based on historical utilization, medical risk adjustment may be less necessary because utilization reflects patient acuity to some degree; however, primary care rates based on aggregate spending (as opposed to PCP-specific historical spending) will not adequately account for patient care needs without some form of risk adjustment.

In addition to exploring medical risk adjustment, many states are beginning to investigate social risk adjustment as a way to further enhance their risk adjustment process. Social risk adjustment is intended to acknowledge that health outcomes are largely driven by the social determinants of health, and additional adjustments to payment may be needed reflect the greater intensity of care required for people whose health is impacted by social needs.[96] The two pioneering states in social risk adjustment are **Massachusetts** and **Minnesota**, which both calculate social risk adjustment at the TCOC level within their Medicaid ACO models and incorporate this form of risk adjustment along with adjustments for medical complexity. Social risk adjustment has not yet been implemented at the primary care level in either state. The factors these states use are outlined in Exhibit 6.

Exhibit 6. Massachusetts and Minnesota Social Risk Adjustment Factors*

Massachusetts [97,98]	Minnesota[99]
• Housing insecurity/homelessness • Disability • Rural residency • Involvement with other state agencies (e.g., Department of Children and Families) In addition to including the above factors in the risk adjustment method, Massachusetts also adjusts non-medical rates for ACOs using the social vulnerability index.	**For adults** • Homelessness • Deep poverty *(income below 50% of the federal poverty level)* • Past incarceration **For children** • Parent experience of homelessness • Parent income at deep poverty • Parent with past incarceration • Involvement with child protective services

**Both Massachusetts and Minnesota additionally incorporate an adjustment for behavioral health diagnoses. Somes states and stakeholders might consider this an additional medical adjustment, while others might consider this a social risk adjustment.*

CMS has followed in these states' footsteps, requiring states participating in its **Making Care Primary** and **AHEAD** models to socially risk adjust payments over time, though a specific methodology is not specified.[100, 101] When developing a social risk adjustment methodology, it is important for states to understand their goals for the adjustment: Is it to predict costs as accurately as possible or increase investment in primary care? Could it be both? Or are there potentially other goals to consider?

Transparency in how rates are risk adjusted can be helpful to increase PCP confidence that risk adjustment accurately reflects the needs of their patients. Some providers may prefer more detail than others on the risk adjustment method, and sharing information frequently and through different modalities can support stronger engagement and buy-in from PCPs on the risk adjustment method.

6. Care Delivery Standards

Primary care PBP models often include specific requirements or incentives for improving and strengthening care delivery and promoting more equitable care. A common approach to care delivery redesign in VBP models is to create tiers of standards for providers to meet, with fewer standards associated with lower tiers and increasingly complex standards associated with higher tiers. Provider tiers are often, though not always, associated with increased payment levels or different payment approaches.

Changing how primary care is delivered may require new infrastructure (e.g., population health management technology) and may be best supported by additional members joining the primary care team (e.g., social workers, behavioral health professionals, community health workers(CHWs)). States can consider supporting these changes to primary care workflow through time-limited, upfront infrastructure building payments[102] or increased payments associated with higher provider tiers. Finally, states should note that any new services delivered by PCPs under the primary care PBP need to be paid for by incorporating new services into the PBP scope of service (see the ***Model Scope*** section) and accounting for service provision when setting rates (see the ***Rate Setting*** section).

Care delivery redesign is a key opportunity to promote health equity in a primary care PBP model by focusing on person-centered, culturally appropriate care.[103] States should refer to their PBP model goals and continue to engage with providers, people served by Medicaid, and other key stakeholders to determine what care delivery capabilities should be required or incentivized.

Priorities for improved primary care tend to be informed by approaches developed in primary care medical home models.[104] These priorities might include a focus on traditional primary care activities, such as increasing access to care and managing chronic conditions. **Washington State's** Primary Care Transformation Model, for example, will require PCPs to expand access through same-day appointments, 24/7 clinical advice, and telehealth services.[105] More advanced primary care activities,[106] such as integrating behavioral health care (including provision and management of medications for opioid use disorder), identifying and addressing health-related social needs (HRSN), providing contraceptives (including long-acting reversible contraceptives), and expanding the care team, may also be a focus. **Maine's** Primary Care Plus model requires advanced primary care capacities for its Tier 2 and 3 PCPs, including conducting screenings for HRSN, contracting with at least one behavioral health home organization, offering or having a referral relationship with a provider who can offer medication-assisted treatment services for substance use disorder, and employing CHWs or contracting with an organization that provides CHW services.[107]

States will have to balance setting attainable standards that still meaningfully change how care is delivered. While it may be tempting to include many ambitious changes to primary care within the model, there is a risk that too many requirements will cause PCPs to feel overwhelmed or unsure where to focus their efforts, or decline to participate in the model altogether. Additionally, without sufficient payment and practice transformation supports, PCPs may feel that primary care is a "catch all" for systemwide priorities. States can consider care delivery standards on a spectrum from more

flexible to more prescriptive (see state examples in Exhibit 7), in partnership with PCPs who provide feedback on the attainability of such standards.

Exhibit 7. Examples of Care Delivery Standards

MORE FLEXIBLE
Colorado's APM 2[108] This model does not include any specific care delivery requirements. The model includes two elements to incentivize improved primary care delivery: (1) a quality program; and (2) a shared savings or gainsharing element that focuses on managing and decreasing TCOC for chronic conditions. Participating PCPs can choose their area of focus based on their workflows and patient populations.
BALANCED
Oregon's Patient-Centered Primary Care Home (PCPCH) program[109] To be recognized as a PCPCH, PCPs meet 11 must-pass standards and earn another 30 out of a possible 430 points based on other practice capabilities. PCPs that earn more points are placed on a higher tier. This structure allows PCPs to select what care delivery standards make sense in their context. Oregon is currently designing an associated primary care PBP (the Oregon Primary Care Value-Based Payment Model) that will include infrastructure payments for PCPCHs based on their tier.[110]
MORE PRESCRIPTIVE
Massachusetts' Primary Care Sub-Capitation model[111] This model includes three tiers of clinical capabilities for PCPs, with increasing requirements for each tier — where Tier 1 is intended to set a foundation for primary care while being attainable for small, independent PCPs with limited capacity to transform care delivery, and Tier 3 is intended to be an ambitious set of care delivery requirements that focus on whole-person care and promote better, more equitable outcomes. PCPs receive increased payment in higher tiers as an incentive to move up and a recognition of the increased capacity this requires.

Finally, states should consider how they will hold PCPs accountable for implementing care delivery changes. States can link payment to specific capabilities through tiering or other methods. Alternatively, many primary care models do not directly link payment to care delivery standards and instead require a base set of capabilities that practices must commit to in order to participate in the model. A key constraint in holding practices accountable for meeting new care delivery standards in a primary care PBP is the state's bandwidth. While it might be ideal for states to conduct hands-on oversight activities to ensure care delivery is improved, many states will not have the capacity to do so. States might instead rely on self-attestation from practices and could supplement with random audits.

Model Alignment Efforts

Multi-Payer Alignment. To maximize model impact and minimize provider burden, Medicaid agencies can work with other payers to develop multi-payer primary care PBP models. Given state context and the need to customize models for the patient populations they serve, there may not always be opportunities to develop one single multi-payer model. States can still work with other payers to develop primary care models with directional alignment.[112] Identifying key areas for alignment, such as similar population health and health equity goals and a limited set of shared quality measures, and working towards alignment on other technical model details, may be a good starting point.

Many states that have successfully launched multi-payer models note that working with a neutral convener can help build trusting relationships and support long-term collaboration.[113] States may also capitalize on opportunities to align with existing models, whether those are CMS models or successful commercial models that might be expanded (e.g., the California Advanced Primary Care Initiative[114]). Working from an existing model can streamline decision-making and help states make choices based on what has worked well in other settings.

Statewide Model Alignment. States often have a portfolio of VBP models focused on different scopes of care. Ideally, states will design VBP models with goals that are aligned and move toward achievement of broad, statewide population health, health equity, and cost-related priorities. For instance, a primary care model might be focused on increasing investment in preventive care, while a hospital model might focus on controlling TCOC. These two models can work in concert to shift how health care is paid for across the state.

To align the practical elements of multiple VBP models, states may benefit from exploring what model participation looks like from the perspective of the provider and the patient. Activities such as journey mapping — focused on the member[115] or participating provider — can identify points of overlap or duplication of effort and may aid states in streamlining the model participation experience. As with multi-payer models, states might improve their ability to meet statewide goals and create better provider and patient experience if they can align technical model details, such as attribution methodology, quality measurement, methods for reporting and sharing data, or payment approach, across the portfolio of models.

Conclusion

Primary care PBP models show promise for improving how primary care is financed and delivered by reducing the negative incentives present in FFS payment and, when designed with an explicit focus on health equity, may be part of a broad strategy to promote equitable health care and outcomes for all Medicaid enrollees.

To design a successful model, states will need to consider what their goals are, the scope of the model, how the payment will be structured, how patients will be attributed, how rates will be constructed, and what care delivery standards will be part of the primary care model. States will also need to consider how to best engage with key stakeholders, involve a variety of PCPs in the model, focus on multi-payer alignment, and design models that contribute to the state's overall VBP portfolio. Examples from current primary care PBP models, those under development, and models developed by other payers or with other payment approaches provide lessons that can support states in making these critical choices as they design or refine their own primary care PBP models.

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