Center for Health Care Strategies

Implementing Primary Care Population-Based Payment in Medicaid

Massachusetts' Primary Care Sub-Capitation Model

State Context and Model Goals

The MassHealth Primary Care Sub-Capitation Program is part of ongoing delivery system reform efforts in Massachusetts Medicaid (MassHealth), which began in 2016 with the MassHealth Accountable Care Organization (ACO) Pilot Program[2] and continued with the 2018 launch of the statewide Medicaid ACO program.[3] The ACO program, designed using the Delivery System Reform Incentive Payment[4] program 1115 waiver authority, aims to move health system payment away from fee-for-service (FFS) reimbursement and into a value-based payment arrangement under which ACOs take on accountability for quality and cost of care and patient experience. There are currently 17 Medicaid ACOs in Massachusetts.[5] A large portion of MassHealth members are part of the ACO program, and most members who meet the following criteria are eligible to be in an ACO: (1) younger than age 65; (2) do not have other health insurance besides Medicaid; and (3) live in the community, rather than an institution.[6] The ACO program includes both adult and pediatric members.

AT-A-GLANCE

Overview: In April 2023, Massachusetts' Medicaid agency (MassHealth) launched its Primary Care Sub-Capitation Program, a population-based payment model.

Goal: Improve patient and provider experience, increase investment in primary care, and drive systems change toward improved population outcomes.

Context: Part of a broader accountable care organization (ACO) program; helps ensure alignment in payment and incentives from the ACO level to the primary care level in MassHealth.

Coverage: Over 75% of primary care practices that accept MassHealth participate in the program, which covers most primary care services and serves more than one million members.[1]

Impact: Early data show high provider participation, increased investment in primary care, and revenue stability for providers.

Case Study Series: Implementing Primary Care Population-Based Payment in Medicaid

This case study is part of a series highlighting innovative state approaches to primary care population-based payment in Medicaid. The series is a product of the ***Medicaid Primary Care Population-Based Payment Learning Collaborative***, a technical assistance and peer-learning initiative that is working with Medicaid agencies in six states to design, launch, and refine primary care population-based payment approaches. The initiative is led by the Center for Health Care Strategies (CHCS) through support from the Commonwealth Fund and Arnold Ventures. **LEARN MORE »**

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MassHealth's ACO program focuses on payment change and quality accountability at the health system level. While the state intended to have individual providers participate in value-based arrangements within ACOs, in the initial years of the ACO program there were minimal specific requirements governing what practice- or provider-level arrangements should look like.[7] As a result, changes in payment and incentives at the system level did not necessarily flow down to individual practices or providers.

To remedy this misalignment of incentives, in April 2023 MassHealth implemented its statewide Primary Care Sub-Capitation Program. The program works to harmonize payment and incentives at the primary care level with the ACO level by requiring ACOs to pay their primary care practices through a population-based payment (PBP)[8] — an upfront, per-member per-month (PMPM) payment to cover a defined set of primary care services. Through the Sub-Capitation Program, MassHealth aims to promote advanced and equitable primary care delivery, provide new investment for primary care practices, and promote multi-payer system change that will lead to improved population health outcomes.

Federally Qualified Health Center Participation

Federally qualified health centers (FQHCs) are eligible to participate in the Primary Care Sub-Capitation Program. In fact, all FQHCs in the state participate. Participation of safety net providers is one way program design promotes high-quality, equitable care for all MassHealth members. FQHCs are largely treated the same as other primary care providers, with a few exceptions to accommodate their unique needs, protections, and structure.

Like all types of participating primary care providers, FQHCs' sub-capitation program payments are based on their underlying provider rates. However, underlying provider rates for FQHCs are different than for non-FQHC primary care practices. Prior to the development of the Sub-Capitation Program, FQHCs were paid through an alternative payment methodology, which reimbursed at a set per-encounter rate. MassHealth made quarterly "wrap" payments to make sure final FQHC payment met prospective payment system (PPS) equivalency requirements. Under the Sub-Capitation Program, MassHealth uses the alternative payment methodology to develop the PBP rate for FQHCs. The quarterly PPS reconciliation process and wrap payments continue under this program.

Determining which care is considered primary care also looks different for FQHCs.[9] Because the FQHCs do not provide individual provider information on their claims, MassHealth is not able to carve out services delivered by specialists from the FQHC PBP. Therefore, the PBP rate for FQHCs is expected to cover more services than the PBP rate for non-FQHC primary care practices.

Finally, ACOs have less flexibility passing payment to FQHCs than to non-FQHC primary care practices. While ACOs are required to pay at least 90 percent of the PBP rate calculated by the state to each individual contracted non-FQHC primary care practice, they must pay 100 percent of the PBP rate calculated by the state to each individual FQHC.

Design Features

Following are design features of the Primary Care Sub-Capitation Program, including the program's payment structure and rate setting, quality measurement approach, model scope, and care delivery requirements. While this profile leads with a discussion of the program's payment structure, the care delivery requirements and decisions model scope informed design of the PBP; changes to delivery of primary care are key to the state's overall population health goals.

Payment Structure

Through the Sub-Capitation Program, practices (identified by their tax identification number, or TIN) are paid a PMPM payment designed to cover primary care provided to all attributed patients over the course of the month. This payment rate is currently based on historical primary care spending, which is in turn based on average member experience from a one-year historical period for in-scope services and patients. After historical spend is calculated, that amount is prospectively adjusted to account for anticipated changes in utilization. Finally, an additional payment based on the practice's clinical tier (see *Care Delivery Requirements*) is added. Together, these three components make the full PBP rate.[10]

In 2025, MassHealth updated its rate-setting methodology[11] to decouple primary care practices' PBP rate from their specific FFS expenditures. Instead of calculating a rate for each practice based on its own historical experience, rates are calculated at an aggregate, statewide level based on provider type (e.g., small practice, FQHC, part of a health system) and patient mix (accounting for age and disability status). These rates are adjusted by the state's newly developed "primary care effort model," a primary care-specific risk adjustment method designed to modify payment rates to reflect patient need.

Primary care payment flows through the ACOs. MassHealth requires that ACOs pay each individual primary care practice at least 90 percent of their individual rate as calculated by the state, seeking to pay practices enough to meet model expectations and increase primary care investment. The remaining 10 percent of the primary care PBP rate must still be paid directly to primary care, but can be paid out in different ways. For example, an ACO may use this funding to develop a performance-based payment for its in-network primary care providers, or target additional payments to practices that are struggling to stay open. MassHealth regularly reviews payment data to monitor ACO compliance with program expectations.

Quality Measurement

MassHealth holds ACOs accountable for quality performance[12] using a pay-for-performance program that also includes accountability for health equity.[13] The state does not directly hold individual primary care practices financially accountable for quality of care, though ACOs must ensure quality accountability for their contracted primary care practices. MassHealth hopes that setting quality accountability at the ACO level will reduce the burden on individual primary care practices and reduce the challenges associated with measuring quality of care at small practices. By focusing on achieving quality targets at the ACO level, the agency also aims to spur collaboration and investment in preventive care.

Model Scope

The scope of the Primary Care Sub-Capitation Program is defined by three components:

- **Eligible providers:** Included provider specialties are those focused on primary care (e.g., internal medicine, pediatrics, family practice, geriatrics), and excluded specialties are focused mainly on specialist care (e.g., dermatology, psychiatry, surgery).[14] Inclusion of obstetrician/gynecologists and nurse midwives has changed over the course of the model, based on stakeholder feedback — they were originally included under certain circumstances, but will be excluded in future years.
- **Eligible patients:** Members are attributed to specific primary care practices by selecting a primary care site or automatic assignment.[15] For a service to fall under the Primary Care Sub-Capitation scope, it must be rendered at the member's attributed primary care practice.
- **Services included in the PBP:** MassHealth maintains a set of CPT codes that the PBP rate is based on.[16] Rates are currently set using claims for these codes, and rates should cover provision of these services. Services not included in this code set are paid for on an FFS basis. To create the list of included services, MassHealth considered what services make up the bulk of primary care delivery (good candidates for inclusion) and which services have greater variability in volume or are outside the scope of primary care (good candidates for maintaining FFS payment).

Primary care practices must continue to submit claims to MassHealth for all delivered services under this model. Claims that fall within the scope of the model (an included service, performed by an included provider, for an attributed patient) will be received by MassHealth or the ACO but not paid out, since they are paid for via the PBP rate. Claims that do not fall within the scope of the model (e.g., a non-included service, a non-primary care provider, a non-attributed patient) will be paid through FFS.[17]

Care Delivery Requirements

MassHealth developed three tiers of care delivery requirements, ranging from less to more advanced provision of primary care. Each participating primary care practice selects their tier annually and attests to meeting the requirements. Tier payments, which are paid in addition to the rate that covers services, (and are therefore only a portion of the full PBP), varied from $5.20 – $13.52 PMPM for pediatric patients and $4.16 – $10.40 for adult patients in 2024 and 2025.[18]

MassHealth designed the tiered clinical requirements to support primary care practices in gradually undertaking practice transformation efforts to provide more advanced and equitable primary care.[19] Practices in higher tiers receive higher reimbursement in recognition of the increased effort and resources required to meet care delivery requirements. Requirements focus on:

- Coordinating between primary and specialty care;
- Integrating oral health, behavioral health, and contraceptive care into primary care practices;
- Building a team-based approach to primary care; and
- Addressing health-related social needs.

These requirements include specific practice capabilities and staffing specifications, and there is some variation between adult and pediatric practice requirements. MassHealth conducts an annual audit process to monitor compliance with clinical tier requirements.

Stakeholder Engagement

In developing the Primary Care Sub-Capitation Program, MassHealth worked primarily with ACOs, who work with their affiliated primary care practices, to understand primary care concerns and perspectives. This engagement approach helped to streamline communication between MassHealth and the individual practices. Recognizing the importance of including stakeholder perspectives in the model design, state staff met regularly with representatives from ACOs, primary care providers, and advocacy organizations while designing the Sub-Capitation Program.

ACOs provided an on-the-ground perspective that helped MassHealth with certain model design questions, notably developing provider inclusion and exclusion criteria and setting payment rates at the practice (i.e., TIN) level instead of the practice site or individual provider level.[20]

Now that the program has launched, most of the regular stakeholder workgroups have ended; however, MassHealth still meets on an ongoing basis with its ACOs to discuss

and seek feedback on rate setting for the ACO and Sub-Capitation Programs. MassHealth has also hosted several public meetings and provider discussions focused on elements of the Sub-Capitation Program.

Key Design Decisions

The major design choices MassHealth made for this program reflect the state's goal to fundamentally change how primary care is paid for — and as a result, how primary care is delivered — while giving practices time to adjust to these changes and succeed under the program.

- **Committing to a mandatory, full PBP for primary care practices in the ACO program.** MassHealth committed early on to implementing a model that would move most primary care revenue in Medicaid into an upfront PBP, and out of FFS. Making the new primary care model a requirement for MassHealth ACOs ensured wide uptake and helped align incentives across ACOs and primary care practices. Early engagement with stakeholders, including health plans, ACOs, providers, and members, demonstrated enthusiasm across the state for a major shift away from FFS payment for provision of primary care.
- **Shifting away from rates based on historical utilization.** Though technically difficult, MassHealth was committed to shifting to its new rate-setting methodology to continue to move primary care payment away from FFS payment. MassHealth hopes to promote more equitable payment by removing the link between historical care delivery, which may include under-provision of care for some marginalized populations, and payment level. MassHealth also hopes this method will: (1) prevent against rates declining in the future for practices that shift to more efficient care models that are less visit-based; (2) acknowledge the nonbillable care delivered by primary care practices; (3) simplify the rate-setting process; and (4) address concerns about significant variation in service delivery and payment between otherwise similar practices with similar patient panels.
- **Prioritizing practice stabilization in rate development and refinement.** Throughout implementation of the Sub-Capitation Program, the MassHealth team prioritized stability for primary care practices, with a particular focus on stabilizing rates and revenue year-over-year. The state team has had to balance actuarial soundness with the desire to not financially shock practices and has made compromises over time to do so. For instance, they have put temporary rate protections in place as the rate methodology shifts — creating a gradual transition for practices that might have seen a rate decrease under the updated methodology. This approach aims to ease practices into the new payment method and decrease the risk that practices will experience a sharp drop in rates that could disrupt their

business. The MassHealth team hopes their new rate-setting methodology will result in less variability in payments year-over-year, as shifts in volume of care delivered will be less influential on rates. One additional aspect of the state's work to stabilize practices was to increase the PBP rates for independent physicians and group practices starting in 2024. This policy came out of conversations with ACOs and other stakeholders, who had seen that independent practices were financially struggling more than other primary care providers.

Implementation Lessons

- **Changing payment requires changing mindsets.** The MassHealth team is using the first few years of Sub-Capitation Program implementation to focus on shifting perspectives among primary care practices and earning buy-in to a new way of paying for and providing primary care. The team created educational opportunities for ACOs and primary care practices to learn more about what is included in the PBP — i.e., how the program is designed to cover primary care service provision and allow greater flexibility in care delivery. The team also phased in some aspects of the program slowly to allow providers the opportunity to prepare for changes over time. For instance, while the shift from FFS payment to PBP happened at model launch, practices were given four months after model launch to meet tier requirements. Additionally, MassHealth paired protections with the implementation of the new rate-setting methodology, and new primary care risk adjustment methods are being tested over time.
- **Balance state goals with feasibility.** MassHealth worked with its ACOs and with advocacy organizations to find the right balance between feasibility and ambition. Frequently, MassHealth and patient advocates considered how model elements, such as care delivery requirements, would look to Medicaid members, while ACOs and primary care practices provided perspective on impact to workflow and resource management. For example, access to behavioral health clinicians integrated into primary care might ideally entail every primary care practice having on-site behavioral health staff, but given current behavioral health workforce shortages, the tier requirements allow for access to these staff to be more centralized and include virtual options. Finding the right balance between these perspectives is an ongoing effort.
- **Allow ample design time.** The state team reflected that the Sub-Capitation Program is a large and complex model, which took a long time to design. The design phase consisted of early ideation, seeking out and responding to stakeholder feedback, and addressing complex operational challenges before model launch. The MassHealth team spent about two years building their model, but believe even

more time might have been helpful — especially for rate development, which was one of the biggest challenges of model design.

- **Build on existing infrastructure to support provider success**. MassHealth built upon existing infrastructure from the statewide ACO program when launching the Sub-Capitation Program, but additional work was required to successfully implement the new program. In the lead up to program implementation, MassHealth hosted monthly technical assistance workgroups designed to prepare ACOs to pay primary care practices differently. Topics explored through the technical assistance workgroups included claims submission, attribution, model scope, and other technical details. Now that the model is up and running, technical assistance workgroups have ended, though MassHealth meets with ACOs and MCOs on an as-needed basis if issues arise. Because each of the state's seventeen ACOs are unique, the state team notes that individualized support is often necessary.

Impact

As part of their five-year 1115 waiver, the Massachusetts team has planned for an external evaluation of the Primary Care Sub-Capitation Program. The interim report will be submitted to the Centers for Medicare & Medicaid Services (CMS) at the end of 2026, and the final evaluation will be submitted in 2029. Both evaluation reports will be released to the public after CMS approval. Currently, the model has been in place for nearly two years, and it is too early for quantitative results around quality and cost of care. MassHealth anticipates it will take time to see meaningful changes in primary care provision and even longer, possibly up to five to 10 years, for these changes to result in improved health outcomes.

In the meantime, the program team is tracking early indicators, which look positive. The model is mandatory for primary care practices that are part of the state's ACO program, leading to high participation — over 75 percent of primary care practices that accept MassHealth participate.[21] Very few practices have dropped out of the model and, based on the MassHealth team's interactions with ACOs and primary care providers, trust that this new payment method will be sustainable for practices seems to be increasing. Of practices that continued in the program from 2023 to 2025, 23 percent increased their tier designation. MassHealth hopes this movement indicates that some practices are finding the higher payments to be appropriate support for developing new primary care capabilities. Early financial indicators also look promising. Overall, most primary care practices have seen stable or increased revenue under the new program, and MassHealth is meeting its goals for primary care investment, having invested an additional $350 million into primary care practices over the first two years of the model.

Next Steps

The MassHealth team is refining certain elements of the Primary Care Sub-Capitation Program. In addition to the major changes to rate setting currently being implemented, the team is also pursuing a multi-year plan to refine and update the program's clinical tier requirements. Changes will reflect feedback the MassHealth team has heard from ACOs and primary care practices about their experiences trying to meet requirements during the first two years of model participation. The team is committed to maintaining a tier that is achievable for smaller, less-resourced primary care practices.

A state's willingness to refine value-based payment models over time, especially in response to provider and patient experience, is critical to creating and managing a successful program that improves quality of care. The MassHealth team is excited about the Primary Care Sub-Capitation Program's early successes and looks forward to continued iteration and improvement.

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ENDNOTES

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[6] Seifert, R. (2023, October).

[7] Seifert, R. (2023, October).

[8] CHCS uses the term "population-based payment" to describe an upfront, prospective, value-based payment approach in which providers are accountable both for quality and cost of care. Payment is based on the number of patients a provider serves, as opposed to the number of services a provider performs. Population-based payment replaces some or all fee-for-service payment for providers. Sometimes this type of payment is also referred to as "capitated" or "prospective" payment.

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[11] MassHealth refers to this methodology as a "population-based rate setting methodology," reflecting the use of aggregated practice data, as opposed to individual practice data, to set payment rates. This term should not be confused with CHCS's use of the term "population-based payments," defined above.

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