



Advancing Primary Care Innovation in Medicaid Managed Care
**Using State Levers to Drive Uptake
and Spread**



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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. We support 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.

I. Introduction

Primarily care is a central component of a high-functioning health system and particularly important for enhancing health care access and quality for people who experience inequities.^{1,2,3,4} The U.S., however, underinvests in primary care^{5,6} and the fee-for-service payment system is frequently cited as a barrier to implementation of innovative, patient-centered care delivery models.^{7,8} Medicaid programs can play a key role in building a more robust primary care system, particularly given the health system challenges and pre-existing health inequities compounded by the COVID-19 pandemic.⁹

[Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States](#) is designed to help states leverage their managed care purchasing authority to advance primary care innovation. The first section of this toolkit, [Conceptualizing and Designing Core Functions](#), explores considerations for how states can define primary care priorities and advance targeted primary care delivery goals. This second section of the toolkit, [Using State Levers to Drive Uptake and Spread](#), outlines how states can incentivize and invest in advanced primary care through Medicaid managed care and consists of three modules:



[1. Promote accountability mechanisms for managed care organizations](#)



[2. Move to value-based payment in primary care](#)



[3. Monitor primary care spending and investment](#)

The strategies outlined here can be mutually reinforcing for providers and managed care organizations (MCOs). Directing more overall spending toward primary care can enable innovations incentivized at the MCO and provider levels. Similar to the first section of the toolkit, each module in this section outlines design considerations for Medicaid agencies, provides state examples, and highlights sample managed care contract language.



Advanced Primary Care Strategies in the Context of COVID-19

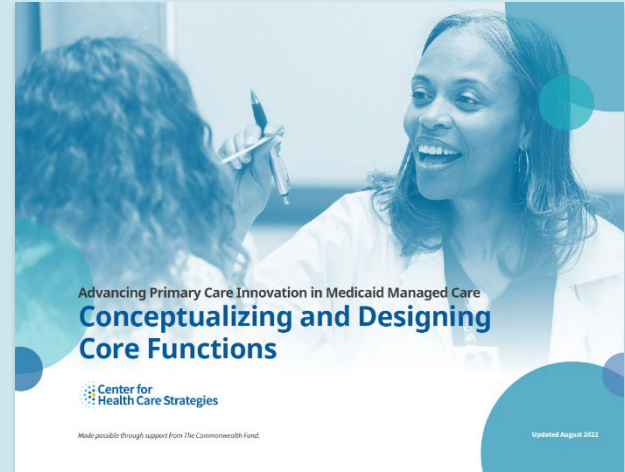
Prior to the COVID-19 pandemic, there was a strong case that the U.S. primary care system needed to be strengthened. Primary care is associated with better health outcomes, reduced mortality, lower costs, and decreased hospital and emergency department visits.^{10,11,12,13} Research further suggests that primary care access helps reduce socioeconomic disparities in health.^{14,15} Despite this, the U.S. has historically spent a far smaller proportion of health care expenditures on primary care compared to peer countries.¹⁶ Between 2008 and 2016, the U.S. has seen a decline in primary care visits^{17,18} and primary care workforce shortages are projected to grow.^{19,20}

COVID-19 compounded challenges in health care access and quality for communities that have been marginalized and further highlighting the need for a robust primary care system. Furthermore, primary care practices are under significant financial strain due to reduced visits, especially early in the pandemic. And while overall primary care visits rebounded as of October 2020, variation across providers remain²¹ and COVID-19 surges pose continued challenges. Many practices have experienced layoffs and furloughed staff and remain uncertain about ongoing financial viability.²² Primary care staff are also stretched thin, due to factors such as working unpaid hours and mental/emotional exhaustion.²³

At the same time, the COVID-19 pandemic has made the need for a high-quality primary care system even more critical. Primary care plays an important role in ongoing COVID-19 surveillance through means such as triaging symptomatic patients, coordinating testing, and managing care of at-risk patients and patients with mild symptoms.²⁴ Primary care is also well positioned to help coordinate and respond to the behavioral health and social service needs resulting from the pandemic.^{25,26} COVID-19's disproportionate impact on people of color and low-income communities,^{27,28} further underscores the need for more equitable access to high-quality primary care services.

This confluence of factors puts primary care at a crossroad: at a time when financial challenges and staff burnout threatens sustainability of the primary care system, the pandemic has also opened a path for rapid care delivery transformation. Many primary care practices have responded to COVID-19 by adopting innovations to meet the needs of the moment. For example, in face of a decline in in-person visits, telehealth has been rapidly adopted. According to one study of outpatient visits across a range of specialties, telehealth made up only 0.1 percent of visits in February 2019, peaked at 13.8 percent of visits in April 2020, and made up 6.3 percent of visits at the beginning of October 2020.²⁹ Primary care providers (PCPs) are also innovating in other ways in response to the pandemic, including accelerating adoption of or implementing new care

Advancing Primary Care Innovation in Medicaid Managed Care: Conceptualizing and Designing Core Functions



Using State Levers to Drive Uptake and Spread is the second section in a two-part toolkit. The first section of the toolkit, *Conceptualizing and Designing Core Functions*, explores considerations for how states can define primary care priorities and advance targeted primary care delivery goals to:

- **Address social needs;**
- **Integrate behavioral health into primary care;**
- **Promote health equity;**
- **Enhance team-based primary care approaches;** and
- **Use technology to improve access to care.**

The managed care levers of accountability mechanisms, value-based payment, and primary care investment outlined can be used to advance any of the above primary care goals. Learn more at: www.chcs.org/primary-care-innovation.

management and population health models.^{30,31} Going forward, there is an opportunity for adoption of new models of team-based care and deepened cross-sector partnerships, such as between primary care and social service providers and public health agencies.^{32,33,34}

Medicaid Managed Care’s Unique Role in Advancing Primary Care Innovation

State Medicaid programs collectively cover more than 80 million people in the U.S., enabling these programs to play a key role in both stabilizing primary care in the near-term, as well as supporting a transformed and more robust primary care system in the long-term. Moreover, Medicaid support is critical given its relationship with safety net providers and coverage of populations that are disproportionately impacted by COVID-19, including people of color and individuals with low-income.³⁵

Using State Levers to Drive Uptake and Spread — the second section of [***Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States***](#) — is designed to guide states in this role by describing how Medicaid agencies can leverage their managed care programs and contracts to invest in and pay providers for advanced primary care. The toolkit is a product of [***Advancing Primary Care Innovation in Medicaid Managed Care***](#), a national initiative made possible by The Commonwealth Fund and led by the Center for Health Care Strategies (CHCS). Through the initiative, CHCS assisted 12 states — **Delaware, Hawaii, Louisiana, Mississippi, Nevada, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, and Washington State** — in using their managed care purchasing authority to advance innovations in primary care. This second section of the toolkit summarizes strategies used by these states and others to invest in and pay for more comprehensive, coordinated, and patient-centered primary care services.

II. Strategies to Drive Uptake and Spread of Advanced Primary Care

While there are a number of managed care levers that states may consider to advance primary care priorities (see **Exhibit 1** on the next page), this section of *Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States* specifically focuses on strategies that impact primary care investment and MCO and primary care practice payment. It includes three modules:








- 1. Promote Accountability Mechanisms for Managed Care Organizations** outlines options for incentivizing Medicaid MCOs to work toward states' defined goals for investing in primary care. Specifically, it describes options for tying MCO payment to contract requirements or quality performance and directing MCO spending. This module also explores how states can provide guidance on classification of MCO expenditures, which can further encourage MCOs to invest in activities that support enrollees' health-related social needs (HRSN).
- 2. Move to Value-Based Payment in Primary Care** describes how states can leverage managed care programs to advance value-based payment (VBP) models for PCPs that reward value instead of volume of services. VBP models can support primary care goals by allowing practices more flexibility to implement services that may not be covered under traditional fee-for-service payment. States can also advance specific care delivery goals by tying payment to relevant quality measures or requiring certain care delivery capabilities for participation in VBP models.
- 3. Monitor Primary Care Spending and Investment** explores how states can track primary care spend and increase the portion of health spending devoted to primary care. Such policies can be an important foundation for ensuring providers receive sufficient funding to develop and sustain advanced primary care capabilities.

Used together, these strategies can be mutually reinforcing by directing more total spending toward primary care, while also creating incentives at both the MCO and provider levels to advance primary care. Each of the modules in this toolkit outline design considerations for Medicaid agencies, share state examples, and highlight sample managed care contract or request for proposal (RFP) language. This section of the toolkit also includes considerations for how states may adapt managed care levers as part of a broader Medicaid COVID-19 response and to support providers through and beyond the pandemic.



Exhibit 1. Opportunities within Managed Care to Advance Primary Care Innovation

Many traditional MCO functions can be used to advance primary care innovation. The modules here focus on MCO payment and VBP strategies.

 <p>Care Coordination/ Management</p> <ul style="list-style-type: none"> Partnerships with primary care teams, including data sharing Population health management Screening for social and behavioral health needs, in coordination with primary care teams and other providers 	 <p>MCO Payment</p> <ul style="list-style-type: none"> MCO incentives tied to performance on primary care quality measures and disparity reduction Clarification on how MCO expenditures may be classified <p>Focus of this toolkit</p>	 <p>Provider Network</p> <ul style="list-style-type: none"> Requiring provider training and incentives related to health equity, culturally and linguistically appropriate care, and advanced primary care Advancing certain models of care and primary care screening Time/distance standards for primary care providers Network makeup (e.g., inclusion of PCMHs, ACOs, etc.) 	 <p>Quality Assessment and Performance Improvement</p> <ul style="list-style-type: none"> Performance improvement projects that: advance certain models of care (e.g., advanced PCMH models); integrate behavioral health; or advance strategies to address social needs and promote health equity 	 <p>Services</p> <ul style="list-style-type: none"> Carving in a wider scope of services (e.g., integration of behavioral and physical health) Clarifying flexibility to provide value-added and in-lieu of services that may address social or behavioral health needs and health equity 	 <p>Utilization Management</p> <ul style="list-style-type: none"> Clarification on appropriate and inappropriate utilization management practices relating to telemedicine or models that integrate behavioral and physical health services 	 <p>Value-Based Payment</p> <ul style="list-style-type: none"> Requiring plans to integrate advanced primary care-related strategies into VBP initiatives for providers (e.g., models that support addressing social needs and advancing health equity) Alignment with non-Medicaid models (e.g., Primary Care First) or adoption of state models (e.g., Medicaid ACOs) <p>Focus of this toolkit</p>
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1. Promote Accountability Mechanisms for Managed Care Organizations

States have a variety of tools that can encourage, incentivize, or require MCOs to work toward the state's defined goals for advancing primary care innovation and promoting health equity, such as:

- Incentive arrangement;
- Rate adjustment;
- Withhold arrangement;
- Liquidated damages and penalties;
- Auto-assignment;
- State-directed payments;
- Community investment; and
- Strategic classification of MCO expenditures.

Broadly, these tools seek to: (1) direct targeted MCO efforts; (2) ensure that MCOs have the financial and administrative flexibility to creatively support network providers and members; and (3) reward MCOs for their performance.

This module provides a broad overview of these financial accountability mechanisms and highlights how they can be used to drive investments in equitable and comprehensive primary care. It also highlights ways that states have released funds associated with these tools, such as withhold arrangements to enable quick support of network providers during the COVID-19 pandemic.

Planning Considerations

✓ What are the state's budgetary constraints?

Certain managed care accountability mechanisms require more funds than others. Incentive arrangements, for example, can result in payment over and above a Medicaid MCO's capitation payment — capped at five percent of the capitation payment, per federal rules.³⁶ Other state initiatives may be funded by a corresponding rate adjustment, and may be closely

PROMOTE ACCOUNTABILITY MECHANISMS FOR MCOs: Design Considerations Summary

States seeking to further financially incentivize MCOs to invest in and support advanced primary care and health equity may consider:

Planning

- ✓ What are the state's budgetary constraints?
- ✓ How prescriptive does the state wish to be in its approach?
- ✓ How strong does the state want MCO incentives to be?
- ✓ Is the state prepared to enlist actuaries or other specialized staff to support the development of these mechanisms?
- ✓ How can the state advance explicit equity goals?

Implementation

- ✓ Will the state require MCOs to report on how they will distribute funds relating to withhold or incentive arrangements to support network providers and community-based strategies?
- ✓ Will the state offer alternatives to penalties and remittances to encourage additional investments in communities and network providers?
- ✓ If plans provide additional services to members and support advanced primary care capabilities, do plans know how to report associated expenses, as it relates to the medical loss ratio or rate-setting? Can the state improve guidance to the plans or adjust rates to counteract disincentives?
- ✓ How will the state monitor equity impacts?



monitored via contract requirements. For example, **Pennsylvania**'s community-based care management program is funded by a per-member-per-month rate and corresponding rate adjustment, and MCOs must submit plans that explain how they will spend those funds to support strategies relating to program goals, such as team-based care and social determinants of health (SDOH).^{37,38} States considering these options must have the budgetary flexibility to implement them. Other approaches — such as withhold arrangements tied to quality performance and liquidated damages, requiring MCOs to return funds to the state if certain conditions are not met — do not require additional funds.

Defining State Primary Care Goals

The MCO accountability mechanisms described in this module can be used to support a wide range of state primary care goals. Prior to exploring specific accountability mechanisms to include in MCO contracts, states may consider identifying specific primary care transformation priorities. For example, states may leverage these accountability mechanisms to advance primary care delivery goals such as: (a) enhancing team-based care; (b) integrating behavioral health care into primary care; (c) promoting health equity; (d) using technology to improve access to care; and (e) identifying and addressing social needs.

Additional considerations for identifying primary care priorities and advancing these specific care delivery components are available in the first section of this toolkit, [Conceptualizing and Designing Core Functions](#).



✓ How prescriptive does the state wish to be in its approach?

Some managed care accountability mechanisms generally allow MCOs more flexibility in implementing a primary care strategy while others are more prescriptive. Flexible approaches can allow innovation and MCOs to adapt primary care strategies to specific regional or provider needs. Prescriptive approaches can be useful in cases where states seek to implement consistent primary care strategies across payers. For example, withhold arrangements tied to VBP implementation often allow MCOs and providers a great deal of flexibility in designing and negotiating VBP arrangements. Alternatively, subject to Centers for Medicare & Medicaid Services (CMS) approval, states can require MCOs to pay PCPs a certain way, such as through specific, state-designed VBP models.³⁹

✓ How strong does the state want MCO incentives to be?

While strong incentives draw more attention to and can potentially allow states to achieve policy goals faster, they also have greater risk of unintended consequences, including for communities of color. States may consider factors such as strength of the evidence-base, payer/provider experience with a given approach, differences in member populations across MCOs, and potential equity-related impacts when determining what level and type of incentive is appropriate.

Strategies directly tied to MCO payment, such as rate adjustments or withhold arrangements, may be stronger incentives than those indirectly tied to payment, such as quality-based auto-assignment. Some accountability mechanisms, such as withholds and penalties or liquidated damages, also allow states flexibility to increase the financial incentive over time. The state can measure progress toward the state's primary care and health equity goals year over year, and MCOs can have time to roll out related programs and investments.

✓ **Is the state prepared to enlist actuaries or other specialized staff to support the development of these mechanisms?**

Certain approaches may require more thoughtful review by actuarial, financial, or legal staff. When states implement a withhold arrangement, for example, an actuary must determine that the “capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound.”⁴⁰ Similarly, states that use liquidated damages in their Medicaid managed care contracts ideally should structure those as “reasonable estimates” of an agency’s loss or damage,⁴¹ which may require more careful review by financial or legal staff.

✓ **How can the state advance explicit equity goals?**

Many accountability mechanisms include quality targets, and states should consider appropriately stratifying these quality targets using demographic data, such as race, ethnicity, language, and disability data. For example, states have begun including disparity reduction targets into their withhold and incentive arrangements, and may consider a glide path toward increased financial accountability for equity performance in the future (e.g., increased financial penalties for poor performance relating to equity, or increased weighting of health equity performance in quality composite scores).⁴²

Examples of States' Primary Care-Related COVID-19 Response Efforts

New Hampshire reallocated 1.5 percent of capitation dollars to fund provider rate enhancements in the form of managed care directed payments. The goal was to redirect funds to providers who are most stressed from reduced utilization amid the pandemic. Funding was distributed to the following provider types for the rating period covering September 1, 2019 through June 30, 2020 through a uniform percent increase: critical access hospitals, residential substance use disorder providers, home health care providers, private duty nursing providers, personal care providers, and federally qualified health centers and rural health centers.^{43,44}

Oregon released 60 percent of the 2019 Quality Pool Fund earlier than planned (in March 2020) “to support the needs across Oregon to prepare for the surge in patients needing care, maintain capacity, and ensure access to care across the delivery system.” The state also suspended the 2020 Quality Withhold during the COVID-19 emergency.⁴⁵

For more information on how states can modify their withhold arrangements, incentive arrangements, and penalties in response to the COVID-19 pandemic, see [COVID-19 Frequently Asked Questions \(FAQs\)](#) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies.⁴⁶



State Approaches: Accountability Mechanisms

Below is an overview of the different accountability mechanisms available to states, with specific examples relevant to primary care and core care delivery areas.

Summary of Strategy	Relevant State Examples
Approaches that May Require Additional State Funds	
<p>Incentive Arrangement. Implement an incentive payment program that provides MCOs with additional funds over and above the capitation payment for performance on selected quality measures or activities that relate to advanced primary care. Total payment may not exceed 105% of the capitation payment.</p>	<p>Arizona, under its Quality Measure Performance Incentive Program, enables MCOs to receive additional funds for performance on select quality measures related to primary care utilization, such as well-child, well-care, and annual dental visits.⁴⁷</p> <p>New York groups MCOs into five tiers based on performance on 41 measures, plus a bonus for telehealth innovation, and uses results to inform incentive payments and auto-assignment preference.⁴⁸</p> <p>As part of its Incentive Payment Program, focusing on capacity-building activities for enhanced care management (performed in partnership with network PCPs and health centers, among others), California must submit a narrative plan on how it will outreach to and engage "people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions," with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness.⁴⁹</p>
<p>Rate Adjustment. Direct MCOs to participate in a targeted initiative and embed additional funding into the monthly capitation payment. Alternatively, change the way rates are structured to reward strategic investments and programs, efficiency, and quality.</p>	<p>Pennsylvania makes per-member-per-month payments for MCOs' community-based care management (CBCM) programs as part of the monthly capitation process. Physical health MCOs submit a plan for their program, which can support face-to-face care coordination activities by PCPs and strategies to address HRSN.⁵⁰ For example, CBCM has supported co-location opportunities at federally qualified health centers and through community health workers.⁵¹</p> <p>New Mexico requires MCOs to pay for their share of administrative expenses for Project ECHO, a telementoring program designed to provide PCPs with knowledge and support to manage patients with complex conditions. The state appropriated \$850,000 to support this initiative, which is distributed to MCOs via capitation payments.</p> <p>In its new "Performance Based Reward Program," Oregon will reward plans with an increase in the non-medical load portion of rate, based on spending on voluntary services that can improve health care quality (i.e., "health-related services") and efficiency and quality metrics.⁵²</p>

Summary of Strategy	Relevant State Examples
Approaches that Do Not Require Additional State Funds	
<p>Withhold Arrangement. Withhold a percentage of MCOs’ monthly capitation payment. MCOs can gain or lose the entire amount withheld based on performance. Use to incentivize adoption of a wide range of activities that could impact adoption of advanced primary care: primary-care focused VBP, quality measures, and patient-centered medical home (PCMH) adoption.</p>	<p>Michigan, as part of its withhold arrangement, encourages its plans to implement targeted programs aimed at improving health outcomes, such as implementation of an evidence-based, integrated model that addresses low-birth weight through management of medical and social needs.⁵³ The withhold arrangement also includes a health equity component, which rewards statistically significant improvement on access to care measures and clinical care measures relating to maternity and primary care on disparities reduction targets (measuring Black/white and Latino/white disparities).⁵⁴</p> <p>Prior to 2020, Patient-Centered Primary Care Home program enrollment was one of Oregon’s 19 coordinated care organization (CCO) quality measures used to determine reward payments out of “quality pool” funds. The quality pool is funded through a withhold and is at least two percent of aggregate CCO payments made to all CCOs.^{55,56}</p> <p>Washington State ties a portion of its two percent capitation payment withhold to VBP thresholds and distributes “challenge pool” funds based on VBP achievement. For example, for 2020, Washington State requires that 85 percent of MCO health care payments to providers are within qualifying VBP arrangements, defined as level 2C (pay-for-performance) or higher on the Health Care Payment Learning & Action Network Alternative Payment Model Framework.⁵⁷</p> <p>In addition to general VBP targets, states could also consider tying withholds to primary care-specific VBP models or prioritizing primary care VBP models as part of general VBP requirements.</p>
<p>Liquidated Damages and Penalties.⁵⁸ Require MCOs that do not meet a certain primary-care related standard to return funds to the state.</p>	<p>Tennessee notes in its contract that “failure to achieve benchmarks of 37 percent PCMH membership” results in a damage of “\$500 per calendar day.”⁵⁹</p> <p>New Mexico ties performance on a series of “delivery system improvement performance targets” to a penalty of 1.5 percent of capitation payments. For example, achievement of each of the following targets is assigned 25 out of 100 possible points related to the penalty:⁶⁰</p> <p>“The contractor shall increase the number of unduplicated Medicaid Managed Care members receiving Behavioral Health services by a Non-Behavioral Health provider.”</p> <p>“The contractor shall increase the number of unique Members with a Telemedicine visit by twenty percent (20%) in Rural, Frontier, and Urban areas for Physical Health Specialists and Behavioral Health Specialists.”</p>
<p>Auto-Assignment. Award membership to plans based on primary care-related capabilities and/or performance, or other related state priorities (e.g., community investment), given that MCOs are often motivated by increasing their market share.</p>	<p>In 2018, Ohio based auto-assignment on three factors, including performance on women’s health measures; PCP and dental capacity; and prompt payment.⁶¹ In 2022, some of these women’s health quality-based auto-assignment measures will be stratified by race (e.g., prenatal and postpartum care).⁶²</p> <p>In addition to primary-care-related quality measures, California’s auto-assignment methodology includes the following “safety net measure:” “percentage of members assigned to PCPs who are safety net providers (based on rates provided by the MCPs that have been validated by DHCS and validation of a sample of screen prints verifying PCP assignments).’Safety net providers’ are defined as: FQHCs, Rural Health Centers, Indian or Tribal Clinics, non-profit community or free clinics licensed by the state as primary care clinics, or clinics affiliated with DSH facilities.”⁶³</p> <p>North Carolina may award an auto-assignment preference to PHPs that voluntarily contribute at least 0.1 percent of capitation to health-related resources in the region.⁶⁴</p>

Summary of Strategy	Relevant State Examples
<p>State-Directed Payments. Require MCOs to pay PCPs in a certain way (i.e., to implement a VBP model or to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative).⁶⁵</p>	<p>Tennessee’s Health Link program, which aims to enhance coordination between behavioral and physical health services for TennCare members with high behavioral health needs, is implemented through state-directed payment. Participating providers are eligible to receive practice transformation support, new activity payments, and outcome payments based on performance of quality and efficiency metrics.⁶⁶</p> <p>Pennsylvania directs MCOs to pay providers using a maternity care bundled payment, which includes a Health Equity score:</p> <ul style="list-style-type: none"> ■ 0.5 points for reaching NCQA 75th percentile for four out of seven HEDIS[®] measures within the Black/ African American community ■ 1 point for reaching NCQA 75th percentile for five out of seven HEDIS[®] measures within the Black/ African American community ■ 1.5 points for reaching NCQA 75th percentile for six out of seven HEDIS[®] measures within the Black/ African American community⁶⁷ <p>State Medicaid agencies have submitted statements of interest relating to the Primary Care First model. If states elect to align payment, quality measurement, and data sharing with CMS in support of Primary Care First practices, states can direct MCOs to adopt these standards via a contract amendment and CMS approval.</p>
<p>Community Reinvestment. Require MCOs to spend a portion of profits or reserves on local communities, including HRSN.</p>	<p>Arizona requires MCOs to contribute six percent of annual profits to community reinvestment. (See related reporting template.)⁶⁸</p> <p>Oregon, as part of its Supporting Health for All through Reinvestment Initiative (SHARE), will require MCOs to spend a portion of net income or reserves on SDOH and equity.^{69, 70} Oregon has proposed a structure where a portion of those funds will be community-managed, in partnership with Regional Community Investment Collaboratives.⁷¹</p>

Implementation Considerations

✓ Will the state require MCOs to report on how they will distribute funds relating to withhold or incentive arrangements to support network providers and community-based strategies?

MCO performance on quality measures can largely be attributed to the activities of the MCO’s network providers. Increasingly, states want to ensure that MCOs reward these network providers for their contributions. For example, **Oregon** requires its CCOs to submit a distribution plan for its Quality Pool and Challenge Pool earnings.⁷² The plan must include the process for evaluating the contributions of participating providers, including “SDOH and health equity partners,” and connecting those evaluations to the distribution of funds.

✓ Will the state offer alternatives to strict enforcement of penalties and remittances to encourage additional investments in communities and network providers?

Some states rely on a system of liquidated damages, penalties,⁷³ or remittances for contract enforcement, but offer MCOs alternatives to paying these funds back to the state. For example, **New Mexico** establishes several “delivery system improvement performance targets” relating broadly to primary care innovation, enforced by a penalty of 1.5 percent of the capitation payment. Instead of levying the penalty in every instance, however, the state allows plans to propose that the performance penalty amounts be spent on “system improvement activities for provider network development and

enhancement activities that will directly benefit members.”⁷⁴ Similarly, health plans in **North Carolina** that do not meet a minimum medical loss ratio can “contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the regions and communities it serves” in lieu of a rebate.⁷⁵

✓ **Do plans know how to report expenses associated with additional primary care services, as it relates to the medical loss ratio or rate-setting? Can the state improve guidance to the plans or adjust rates in an attempt to counteract MCO disincentives?**

MCOs may be reluctant to provide or reimburse for services outside of state plan benefits because they believe that expenditures will be deemed “administrative” and therefore not “count” toward medical loss ratio (MLR) calculations nor considered in rate-setting processes. This designation can make it more difficult to meet a minimum MLR, which often requires the plan to return funds back to the state. Similarly, plans may be worried about “premium slide,” where plans that implement effective interventions are rewarded with lower rates in future years because of reduced utilization of services. To combat this risk aversion, states may provide more guidance to plans on how to classify expenditures — especially those relating to HRSN. Alternatively, states can experiment with rate adjustments that reward plan performance.

✓ **How will the state monitor equity impacts?**

The state should ensure that it is using stratified quality measures, complaints and grievances, and community advisory councils, among other data sources, to monitor the effects of its policies on communities that have been marginalized. MCOs can also report on their own monitoring efforts relating to health equity — for example, in the context of required Health Equity Plans and VBP strategic plans. These monitoring efforts help ensure that accountability mechanisms are furthering the state’s goals (including equity goals) and not having unintended effects, and identify the need for more or different accountability mechanisms in the future.

State Approaches: Strategic Classification of MCO Expenditures

States implementing primary care approaches that address SDOH may consider how to classify MCO expenditures relating to SDOH and HRSN (see the [Identify and Address Social Needs](#) module in the first part of this toolkit for additional considerations and examples of how states may address HRSN). Current federal guidance is general, and states have taken a variety of approaches on classifying non-benefit expenditures relating to HRSN, with varying impacts on the calculation of a plan’s MLR and rates. For example, some states classify housing-related services as potential value-added services, while others have included the same types of services as an *in lieu of service*. Value-added services and *in lieu of services* both can be reported in the numerator of the MLR, but only *in lieu of services* can be considered for rate-setting purposes. And, in one new approach of note, **New York** allows specific SDOH-related expenditures embedded in advanced VBP arrangements to be included as a medical expense for the purpose of rate setting. Strategic classification of these expenditures can counteract commonly cited disincentives to invest in HRSN strategies. By classifying the expenditure as a medical versus administrative expense, the MCO may be less concerned about MLR-related remittances or, for some strategies, future rates.

The following table provides an overview of: (1) existing guidance in federal law, as it relates to MLR and rate-setting; (2) notable state examples relating to HRSN activities; and (3) a federal rule reference. States can use this table to consider how to provide additional clarification to MCOs on the classification of HRSN activities.

Classification	MLR and Rate Impact	State Example	Federal Rule
Value-Added Services	<p>MLR: Can include in the numerator of the MLR under “incurred claims.”</p> <p>Rate-setting: Cannot be considered when developing payment rates.</p>	<p>Massachusetts, in its guidance to Senior Care Options plans, includes a list of housing-related services that can be voluntarily provided to members as a value-added service (outside of the official Community Support Program). These services include: (1) assisting a member with housing search activities; (2) home modifications; and (3) paying for costs related to a member’s transition into housing from institutionalization or homelessness (e.g., first month’s rent or security deposit).⁷⁶</p>	<p>Value-Added Services provision: 42 C.F.R. § 438.3(e)(1)(i) (MCOs may voluntarily provide any service).</p> <p>MLR implications: 42 C.F.R. § 438.8(e)(1), (e)(2)(i)(A) (incurred claims and services under 42 C.F.R. § 438.3(e)). Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526 (value-added services may be considered as incurred claims in the numerator for the MLR calculation).</p>

Classification	MLR and Rate Impact	State Example	Federal Rule
In Lieu Of Services	<p>MLR: Can include in the numerator of the MLR under “incurred claims.”</p> <p>Rate-setting: Can be considered when developing payment rates.</p>	<p>Kansas, in its list of approved in lieu of services, includes services such as: (1) medical nutrition therapy; (2) assisted living rental; and (3) direct costs for transitions outside of institutional settings.⁷⁷</p> <p>California has approved <i>in lieu of services</i> that are provided as a substitute, or <i>to avoid</i>, other Medi-Cal covered services such as ER utilization, a hospital or skilled nursing facility admission, or a discharge delay. These services include medically supportive food and meals, asthma remediation, and housing-related services.⁷⁸ Federal guidance for states interested in this approach may be forthcoming.⁷⁹</p>	<p>In lieu of services provision: 42 C.F.R. § 438.3(e)(2) (listing approval criteria, including that the “alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan”).</p> <p>MLR implications: 42 C.F.R. § 438.8(e)(1), (e)(2)(i)(A)</p>
Activities that Improve Health Care Quality	<p>MLR: Can include in the numerator of the MLR under “activities that improve health care quality.”</p> <p>Rate-setting:</p> <p>Care Coordination/Case Management - The capitation payment must be adequate to support functions described in 42 C.F.R. § 438.208, including coordination of services with those provided by community and social support providers (see 42 C.F.R. § 438.4(b)(3)).</p> <p>Additional Services and Targeted Investments - In Oregon, health-related services (defined as activities that improve health care quality) are not used to develop the medical portion of the capitation payment; however, are reported in the “non-benefit load.”⁸⁰</p>	<p>States may evoke this provision through common contractual requirements, such as care coordination and case management, and voluntary services and initiatives.</p> <p>Care Coordination/Case Management</p> <p>New Mexico, in its contracts, notes that care coordination expenses relating to community health workers will be deemed “medical services.”⁸¹</p> <p>Additional Services and Targeted Investments</p> <p>Oregon CCOs can provide health-related services that address social needs at both an individual and a community level. For example, guidance documents include food-related interventions and housing-related services as a central part of a crisis intervention, stabilization and/or a transition for a patient with intention of a direct health benefit.⁸²</p> <p>North Carolina allows expenditures made for voluntary contributions to health-related resources that align with the department’s quality strategy to be included in the numerator of the medical loss ratio. Expenditures must:</p> <ul style="list-style-type: none"> ■ Represent “meaningful engagement with local communities and are non-discriminatory with respect to individual Members and North Carolina geographic regions, including rural areas.” ■ Be “spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.”⁸³ 	<p>Activities that Improve Health Care Quality provision: 45 C.F.R. § 158.150(b)</p> <p>MLR implications: 42 C.F.R. § 438.8(e)(1), (e)(3)(i)</p> <p><i>Relationship with care coordination/case management functions:</i></p> <p>45 C.F.R. § 158.150(b)(2)(i)(A)(1) (listing care coordination and management as an activity that improves health care quality).</p>
Value-Based Payment	<p>MLR: Most VBP models can be included as a medical expense under “incurred claims.”</p> <p>Rate-setting: VBP requirements are typically embedded in rate development, as noted in the CMS rate development guide.⁸⁴</p>	<p>New York, in its Value-Based Payment Roadmap,⁸⁵ has proposed to classify expenses relating to required SDOH interventions embedded into advanced VBP arrangements (“Level 2 and Level 3”) as a medical expense. (“The expenses for [SDOH] interventions being implemented within the VBP contract for which the MCO is making the investment, should be included in “Other Medical” on the MMCOR and MLTCRR. “)</p>	<p>Directed VBP and Delivery System Reform Initiatives Provision: 42 C.F.R. § 438.6(c)</p>

2. Move to Value-Based Payment in Primary Care

VBP arrangements are increasingly prevalent across payers, including Medicaid MCOs, as a means of improving quality and controlling cost of care.^{86,87} VBP arrangements change the way provider organizations are paid by shifting away from traditional fee-for-service (FFS) payments that reward volume to models that reward value. The Health Care Payment Learning & Action Network Alternative Payment Model Framework⁸⁸ provides VBP definitions that many states use to classify payment models. Payment innovation can support increased investment in primary care and help advance primary care capabilities such as integrating behavioral health with physical health services; addressing HRSN; enhancing team-based care; and, using technology to improve access.⁸⁹ VBP also has the potential to play a role in promoting health equity, such as through financially incentivizing reductions in health disparities, providing increased payment to providers that serve communities experiencing inequities, and allowing providers flexibility to deliver comprehensive care that is culturally and linguistically appropriate for populations served.^{90 91}

COVID-19 has further highlighted the need for payment models that move away from FFS. Decreases in primary care visits threatened the financial viability of many practices and VBP has the potential to play a central role in supporting the new normal of primary care delivery. For example, VBP models that include prospective payments, not tied to specific service codes, can allow more flexibility in how primary care is delivered and potentially provide more stable payments in a time when utilization is unpredictable. Moreover, VBP can complement states' primary care investment goals by incentivizing practices through increased payments above the FFS baseline. Going forward, states may consider how to leverage VBP models to support practices financially and to sustain practice innovations, such as telehealth, adopted in response to the pandemic.

MOVE TO VALUE-BASED PAYMENT IN PRIMARY CARE: Design Considerations Summary

States seeking to implement VBP models to support primary care may consider:

Planning

- ✓ What are the state's goals related to VBP for primary care?
- ✓ How will the state prioritize health equity as part of the VBP design and implementation process?
- ✓ How will VBP adoption be incentivized in Medicaid managed care?
- ✓ What elements of a primary care payment model will be standardized across MCOs?
- ✓ What is the state's PCP make-up (e.g., small vs. large practices, geography, etc.)? What types of providers does a state hope to engage through a primary care payment model?
- ✓ What care delivery requirements will be expected of participating PCPs?
- ✓ How will a Medicaid VBP model align with other payment models in the state?

Implementation

- ✓ How will the state track VBP model progress and impact on health equity and primary care?
- ✓ What data will the state or MCOs provide PCPs to support VBP implementation and reduction of health disparities?
- ✓ How will the state or MCOs support PCPs in developing capabilities needed to implement VBP?



This module focuses on considerations for developing VBP strategies and arrangements aimed at primary care practices, as opposed to models that seek to include and hold a wider range of providers (e.g., hospitals, health systems, etc.) accountable for care. Additionally, this module focuses on how VBP can be used to increase primary care practice capacity, improve quality of care, and potentially reduce health disparities, as opposed to lowering the cost of primary care expenditures (though such models may lower expenditure in other areas). VBP arrangements specifically focused on primary care can be implemented on their own or in addition to broader payment and care delivery reform strategies, such as accountable care organizations (ACOs).

Design Elements

VBP models, including primary care arrangements, can be defined through a set of discrete design elements. In determining a VBP strategy, states may consider whether and how to define elements such as populations of focus, scope of services covered under VBP, payment methodology, attribution methodology, quality measures, and risk adjustment.⁹⁷

Population Focus

Often, states design primary care VBP models to cover a broad population of adults and/or children. However, states may consider supplemental requirements and modified payments for certain sub-populations that are high-risk, are experiencing health disparities, have specific conditions, or for whom there is a particular need for quality improvement. For example, the **Ohio** Comprehensive Primary Care program launched a “CPC for Kids” component that includes a potential bonus payment and enhanced per-member, per-month payment for pediatric providers.⁹⁸ At the federal level, the Center for Medicare and Medicaid Innovation, has set the goal of increasing participation of Medicare and Medicaid beneficiaries from underserved communities and safety net providers in VBP models.⁹⁹ States may consider how they can advance this goal within Medicaid.

Request for Proposal & Contract Excerpts

Following is sample state managed care request for information and contract language related to VBP for primary care:

- **Tennessee (RFI):** “At least for some practices, should TennCare consider moving from its current rewards-only PCMH model to a total cost of care or two-way risk model, or some other form of advanced payment [APM] model that incentivizes quality and value, and includes more than nominal financial risk for monetary losses? If so, what are key factors that ensure success for PCPs in an advance payment model? Would you suggest the [APM] be designed for specific subgroups of the patient population? If so, which ones?”⁹²
- **Oregon (RFA):** “Describe the Applicant’s plan for mitigating any adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; lesbian, Gay, Bisexual, transgender and queer (LGBTQ) people; persons with disabilities; people with limited English proficiency; immigrants or refugees and Members with complex health care needs as well as populations at the intersections of these groups.”⁹³
- **Oregon:** “Contractor shall provide [per member, per month (PMPM)] payments to its PCPCH clinics as a supplement to any other payments made to PCPCHs, be they Fee-for-Service or VBPs. Contractor shall also vary the PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The PMPM payments must be in amounts that are material and increase each of the five Contract Years of this Contract.”⁹⁴
- **Pennsylvania:** “The PH-MCO must enter into arrangements with Providers that incorporate VBP strategies, all of which must comply with the Physician Incentive Plan (PIP) requirements. The Department will accept any of the following arrangements as VBP strategies: (I) Provider pay for performance programs (II) Patient-centered medical homes (III) Shared savings contractual arrangements (IV) Bundled or global payment arrangements (V) Full risk or [ACO] payment arrangements[.]”⁹⁵

“The financial goals for the VBP strategies for each calendar year are based on a percentage of the PH-MCO’s expenditures to the medical portion of the risk adjusted capitation and maternity revenue without consideration of risk sharing risk pools, P4P or other revenue or revenue adjustments...The PH-MCO must achieve the following percentages through VBP arrangements: Calendar year 2020 – 50% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP. At least 50% of the 50% must be from a combination of strategies iii through v.”

- **Colorado:** “The Contractor shall offer practice transformation support to Network Providers interested in improving performance as a Medical Home and participating in alternative payment models, including the Department’s APM. Practice transformation efforts may include activities such as: coaching practices in team-based care, improving business practices and workflow, increasing physical and behavioral health integration, and incorporation of lay health workers, such as promotores, peers, and patient navigators.”⁹⁶



For example, **Oregon** and **Washington State** have developed VBP models specifically for federally qualified health centers (FQHCs).¹⁰⁰

Attribution

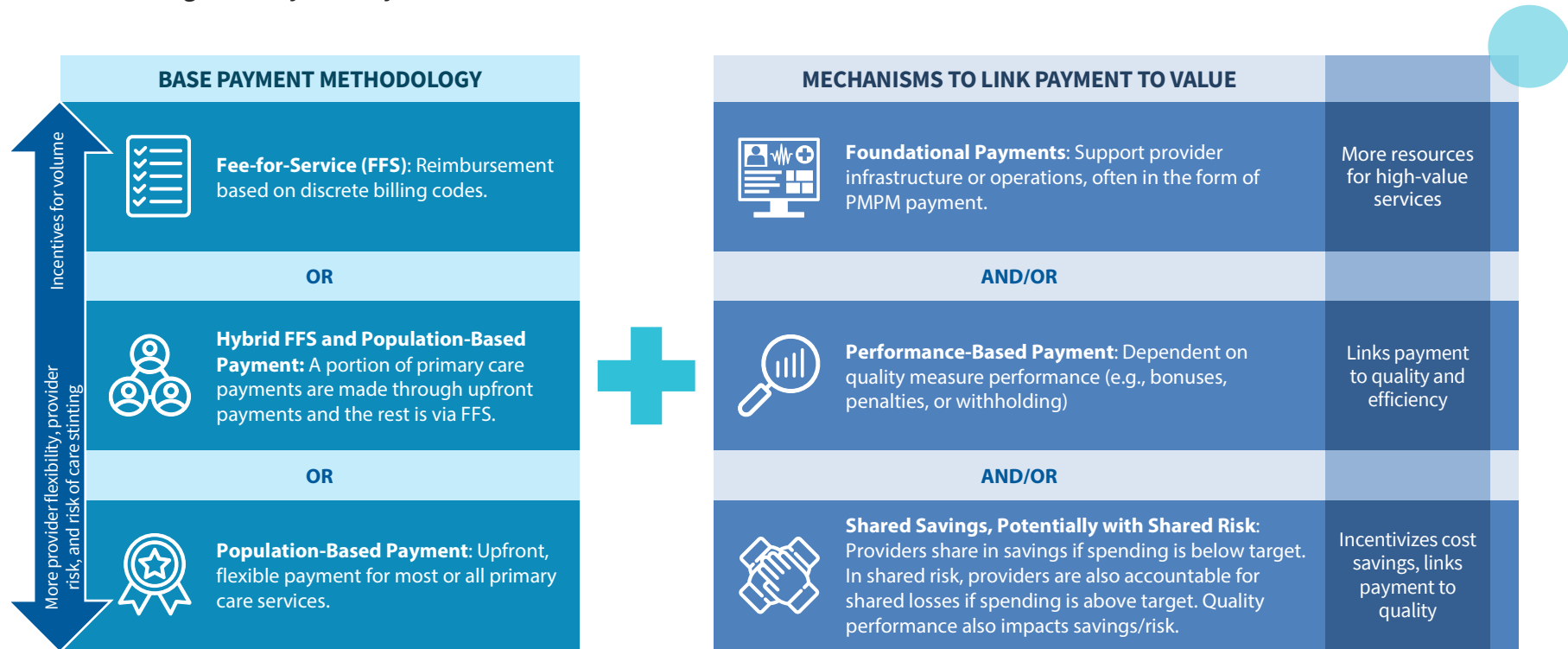
Attribution is the “method used to determine which provider group is responsible for a patient’s care and costs.”¹⁰¹ Primary care payment models generally attribute patients based on their PCPs. In defining an attribution methodology, states may consider how to define “primary care provider” and whether patients will be attributed prior to or after the model performance year (prospectively or retrospectively). States may also consider the extent to which such methodology will incorporate patient choice of PCP vs. assignment to a PCP based on factors such as historical utilization.

Payment Methodology/Level of Risk

The payment methodology defines how FFS payment is altered to better incentivize quality and value. In determining what payment methodology(s) to implement, states may consider whether the base payment will be structured around a FFS architecture or include a significant portion as upfront, flexible payments (e.g. capitation/population-based payment). States will also need to determine how to link value to quality through means, such as foundational payments, performance-based incentives, or shared savings/risk. In particular, states should consider how much risk is appropriate for PCPs to take on and the extent to which targeted participants have the capabilities to manage performance and population health under advanced VBP models. Level of risk in VBP models is determined both by the amount of payment that is made upfront versus FFS (see **Exhibit 2**, next page) and the services included in the model.

States may also consider developing additional payment supports for historically underfunded providers that serve populations experiencing numerous inequities in areas of high social vulnerability. For example, the Health Care Payment Learning & Action Network’s guidance for *Advancing Health Equity through APMs* recommends that payers provide additional, upfront payments to such providers to support capacity building, as well as develop a separate equity bonus pool that can be drawn from to reward these providers for improvement on health equity measures.¹⁰² The CMS ACO Realizing Equity, Access, and Community Health (ACO REACH) model includes a cost benchmark adjustment for provider organizations serving higher proportions of underserved beneficiaries to account for historically suppressed spending levels for these populations.¹⁰³

Exhibit 2. Building a Primary Care Payment Model^{104,105}



Included Services

VBP models that set cost targets or provide population-based payments must determine what services to cover through VBP. For example, primary care VBP models may focus on:

- Primary care services only:** Primary care models that include population-based payment frequently take this approach. The advantage of a focus on primary care services is that such models hold providers accountable for costs within their control. While there may be limited opportunity to save costs on primary care services specifically,¹⁰⁶ the scope of such models can indirectly be expanded by linking payment to broader efficiency metrics (e.g., emergency department utilization, acute hospital utilization).
- All costs for select conditions impactable by primary care (e.g., outpatient, inpatient, pharmacy):** This approach may require defining episodes of care, as was the case in the integrated primary care model **New York** developed under the Delivery System Reform Incentive Payment (DSRIP) program.¹⁰⁷ Such models can incentivize costs savings and limit risk to costs with provider control, but can be complex to implement.

- **Total cost of care (TCOC):** This is common for shared savings models intended to lower total costs while increasing investment in primary care. At a minimum, TCOC models generally include all physical health services, but may also include additional services, such as behavioral health, pharmacy, and dental. Such models may provide the strongest incentive for cost savings and significant opportunity to reward practices for managing care and reducing cost across the health system. However, it may not be financially feasible for practices, particularly small ones, to assume risk on such a wide breadth of services. For this reason, shared savings models based on TCOC may be more viable for many primary care practices than shared risk models.

Quality Measures

To link payment to quality, primary care models often utilize a mix of process and outcomes measures focusing on preventive care and management of chronic conditions. Increasingly, payers are emphasizing outcomes over process metrics to drive improvements in care. VBP models also often include patient experience measures and efficiency/utilization measures. Beyond typical primary care measures, states may consider quality measures that promote:

- **Integration of primary care with behavioral health:** While behavioral health screening measures are common in VBP models, states may consider further use of measures related to substance use disorders and behavioral health outcomes. For example, **New York's** 2021 Integrated Primary Care quality measure set included a variety of behavioral health measures for use or potential piloting in VBP models, such as *Depression Remission* and *Response for Adolescent and Initiation of Pharmacotherapy upon New Episode of Opioid Dependence*.¹⁰⁸ States may also consider implementing measures that directly incentivize coordination across behavioral health and physical health entities. For example, **Massachusetts'** ACO program includes a *Behavioral Health Community Partner Engagement* measure, which incentivizes ACO collaboration with community-based organizations responsible for managing patient behavioral health needs.¹⁰⁹
- **Integration of primary care with social services:** Some states are piloting the use of health-related social need (HRSN) measures in ACO programs. For example, ACO programs in **Rhode Island** and **Massachusetts** include HRSN screening measures. Such measures may be similarly appropriate for primary care-focused VBP models.¹¹⁰
- **Health equity:** States may also consider how to directly tie payment to metrics focused on advancing health equity.¹¹¹ There are a wide variety of approaches to health equity measurement, such as:
 - **Stratifying existing measures:** Stratifying existing process, outcomes, and/or patient experience measures on factors such as race and ethnicity can be a way to hold providers accountable for disparities reductions while not increasing the total number of quality measures.
 - **Health equity indices:** Health equity indices summarize equity performance across multiple quality measures.
 - **Area-level measures:** These types of measures summarize environmental, socioeconomic, and health indicators within communities and geographic areas.^{112,113}

- **Measuring evidence-based interventions for conditions in which there is evidence of disparities:** The National Quality Forum's *Roadmap for Promoting Health Equity and Eliminating Disparities* includes a compendium of measures that can be leveraged to assess implementation of effective interventions to reduce disparities and monitor care for conditions known to have health disparities¹¹⁴

For example, **Minnesota's** Integrated Health Partnership (IHP) program requires participating providers to implement an intervention to address social needs and holds them accountable for health equity measures related to the proposed intervention. Additionally, quality measures stratified by race and ethnicity are included in the IHP quality measure set tied to shared savings payments. In the first performance year, participating providers must develop interventions to reduce identified disparities. Thereafter, the quality score tied to shared savings payment is impacted by provider performance in reducing racial and ethnic health disparities.¹¹⁵

Risk Adjustment

Risk adjusting cost and quality measurement may be necessary to account for differences in patient complexity and avoid penalizing providers that care for more complex populations. States aiming to standardize risk adjustment approaches may consider whether to use an established methodology or develop a state-specific one. States may also consider including HRSN into risk-adjustment models as **Massachusetts'** ACO and **Minnesota's** Integrated Health Partnership programs have done.¹¹⁶ Including social risk adjustment in VBP models can potentially advance health equity by appropriately compensating providers and mitigating disincentives for serving patients with high social risk.^{117, 118} At the same time, states should carefully consider how to ensure social risk adjustment does not unintentionally exacerbate disparities by setting a lower quality standard for some populations.

Primary Care VBP in the Context of COVID-19

As Medicaid agencies, MCOs, and providers focused on implementing emergency responses to COVID-19, states needed to adapt VBP programs in the face of widespread care delivery disruptions. For example, states explored, and can continue to explore, how to:

- **Reduce provider administrative burden:** In some cases, this may include temporarily lifting VBP requirements or delaying implementation of new VBP programs. For example, at the federal level, the Centers for Medicare & Medicaid Services implemented a number of quality reporting exceptions and extensions in response to COVID-19 and have adjusted timelines for many VBP programs.^{119,120}
- **Sustain PCPs:** Primary care practices are under financial strain due to reduced visits, especially early in the pandemic,¹²¹ and COVID-19 surges introduce uncertainty about future trends. In response, states may consider implementing more upfront, flexible payments (prospective payments), that are not tied to in-person visits to sustain practices in the short-term.^{122,123} Such payment could be based on historical spending.¹²⁴ While it may not be feasible to tie such payment to quality measures during the pandemic, existing VBP models such as Comprehensive Primary Care Plus and Primary Care First may serve as templates for how additional prospective payment could be adopted. Over the longer term, states can consider transitioning emergency payment mechanisms into long-term payment models that are more flexible and sustainable than FFS. For example, **Washington State** recently proposed a primary care payment model with an upfront, monthly payment replacing FFS payments (see “Examples of State Approaches”).¹²⁵
- **Adjust policies related to performance incentives:** As utilization is disrupted, states will need to assess COVID-19’s impact to provider payments tied to quality, utilization, or cost of care to ensure that providers are not negatively impacted. For example, preventive care and access-related quality measurement may be negatively impacted as patients forgo usual services. In response, states may consider options such as holding providers harmless for 2020 performance, using 2019 performance, or omitting impacted measures from payment calculations.¹²⁶
- **Supporting patient behavioral health and HRSN:** Social distancing and the economic impact of COVID-19 may increase patient behavioral health needs and HRSN into the foreseeable future. States may consider how to support and guide PCPs in coordinating and integrating such services. In the near-term, more flexible, upfront payments can give providers more flexibility to manage and coordinate behavioral health and HRSN. In the long-term, once the acute pandemic has passed, states may consider tying payment to additional behavioral health or HRSN quality measures or care delivery requirements.
- **Sustaining innovation made during COVID-19:** Post-pandemic, states may consider how to incentivize primary care practices to sustain innovative practices implemented in response to COVID-19, such as expanded telehealth capabilities. For example, states may consider increased payment or flexibilities for telehealth over the long-term or shifting a portion of provider payments up-front — flexible payments not tied to in-person visits. States can also consider long-term quality or care delivery requirements related to sustaining telehealth capabilities.



Planning Considerations

✓ What are the state’s goals related to VBP for primary care?

VBP for primary care may be driven by a variety of goals such as increasing investment in primary care, allowing primary care practices more flexibility in care delivery, improving quality of care, promoting health equity, and controlling TCOC. See **Exhibit 3** for examples of how to connect payment reform goals to VBP requirements more explicitly.

Exhibit 3. Connecting Primary Care Goals to Provider Payment Reform

Goal	Possible Solution
Increase primary care resources/funding	<ul style="list-style-type: none"> Require VBP elements that increase total practice payment (e.g., supplemental care management payments, population-based payment larger than historic FFS payment). Pair VBP implementation with primary care spending targets to increase total percent of health care spending that is devoted to primary care.
Allow providers increased flexibility to implement innovative care delivery models	<ul style="list-style-type: none"> Shift some or all of FFS to upfront payment to de-couple payment from discrete service codes and face-to-face visits. Encourage telehealth/e-consults or new models of team-based care through payment model modifications (such as payment parity for telehealth), quality metrics, or care delivery requirements. See the Use Technology to Improve Access and Enhance Team-Based Care modules in this toolkit for specific examples.
Incentivize primary care integration with behavioral health and social services	<ul style="list-style-type: none"> Tie payment to quality measures incentivizing coordination across sectors and integrated behavioral health models. Require increased PMPM payments for advanced integration capabilities. Set care delivery requirements for VBP models that encourage integration/partnerships. For additional considerations and examples, see the Integrate Behavioral Health Care and Identify and Address Social Needs modules in the first section of this toolkit.
Advance health equity	<ul style="list-style-type: none"> Tie provider payment to reductions in health disparities Provide additional payments to providers that have been historically underfunded and serve communities experiencing numerous inequities. Ensure payment is sufficient to cover a comprehensive array of services.¹²⁷
Reduce provider administrative burden	<ul style="list-style-type: none"> Align elements of VBP models across MCOs and with non-Medicaid payers (e.g., quality measures, payment model).
Lower total cost of care	<ul style="list-style-type: none"> Link payment to utilization/efficiency metrics that drive cost of care. For large practices, payment could alternatively be linked to total cost of care. Provide PCPs with cost/quality data on specialists and hospitals to inform referral decisions.
Improve quality of care	<ul style="list-style-type: none"> Directly link payment to quality measures, including clinical process measures, outcomes measures, patient experience measures, and/or efficiency measures. Set care delivery requirements for VBP models that promote care transformation. See State Approaches to Patient-Centered Medical Homes in the first section of this toolkit for specific examples.

✓ How will the state prioritize health equity as part of the VBP design and implementation process?

VBP is one of the many policy levers that can help advance state health equity goals (see the [Promote Health Equity](#) module of this toolkit for further exploration of state levers to support health equity). To ensure VBP models are designed to support health equity, states may consider how to prioritize health equity as an explicit goal throughout the design and implementation process. This is important as some VBP models have unintentionally penalized providers serving populations with complex needs and communities of color, potentially widening health disparities.¹²⁸ Early in the design process, this entails identifying existing disparities within the state and setting goals for improvement that VBP can support. States should also consider how to partner with people enrolled in Medicaid and community-based organizations to help understand root causes of disparities and how VBP-supported interventions can help close gaps in care. These early planning activities can help states adapt VBP design elements to support health equity goals (as described under “payment model” and “quality measures” in the previous section). States should also develop an approach for monitoring the impact of the model on quality and access measures as well as potential unintended consequences, particularly for populations experiencing inequities, throughout implementation.

✓ How will value-based payment adoption be driven through Medicaid managed care?

States may consider a variety of strategies for incentivizing VBP through Medicaid managed care, such as:^{129,130}

- 1. VBP targets:** States that aim to maximize flexibility in VBP adoption may consider setting broad VBP targets or requirements in MCO contracts. For example, **Oregon** has VBP targets that increase over the lifespan of CCO contracts; by 2024, 70 percent of CCOs’ payments to providers must be through VBP models categorized as LAN Category 2C (Pay for Performance) or higher and 25 percent of payments to providers must be LAN Category 3B (Shared Savings and Downside Risk) or higher.¹³¹ To further incentivize VBP for primary care, states can consider pairing general targets with primary care-specific VBP requirements. For example, **Oregon** requires that CCOs pay state-recognized patient-centered medical home (PCMH) practices per-member per-month PMPM payments as a supplement to other FFS or VBP payments.
- 2. State-designed VBP models:** States can be prescriptive in VBP adoption by requiring MCOs to participate in specific value-based payment models. For example, **Tennessee** requires MCOs to participate in the TennCare Patient-Centered Medical Home (TennCare PCMH) program, which includes VBP and care delivery requirements. **Tennessee** requires that at least 37 percent of MCOs’ populations are attributed to a PCMH-participating organization.¹³² States that aim to be prescriptive in designing VBP models can standardize some or all of the VBP design elements described above.

3. High-level VBP model guidelines: States can take a middle path between flexibility and prescriptiveness, through means such as setting high-level value-based payment guidelines or allowing MCOs to select from a list of VBP options. For example, in addition to VBP targets, under DSRIIP **New York** provided a menu of priority VBP arrangements, one of which was an integrated primary care model.¹³³

Providing guidance on VBP design elements or standardizing specific elements can help align MCO VBP activity with state goals and provide guardrails for provider and MCO contract negotiations. Standardizing elements, such as payment methodology and quality measures, may also strengthen VBP financial incentives and reduce administrative burden for providers by aligning expectations and requirements across MCOs. On the other hand, more flexible state guidance allows MCOs and providers to innovate or customize models based on factors such as an organization's patient population or experience with VBP.

✓ **What is the state's PCP make-up? What types of providers does a state hope to engage through a primary care payment model?**

Characteristics of a state's primary care market, including size, geography, and VBP experience of primary care practices can be an important factor in determining which types of payment models are feasible. Shared savings models are generally not appropriate for small practices as a high volume of patients is required to accurately measure savings due to random cost variation. For example, rural and frontier clinics often do not have the patient volume to succeed in a shared savings model. However, to introduce more predictability and sustainability into the finances for rural practices while still pursuing payment reform, prospective payment models such as global budgets may be more desirable. As described under "Design Elements," states may also consider how to advance health equity goals by considering how to further support and enable VBP participation of safety net providers and providers that have historically been underfunded. Specific considerations for FQHC participation in VBP models are elaborated on in the following pages.

Level of provider experience with VBP may also impact a state's decision with regard to VBP models. Pay-for-performance models can serve as a steppingstone for providers new to VBP. On the other hand, providers with significant VBP experience may be better poised to transition away from FFS payments and adopt upfront population-based payments. States may consider assessing provider readiness for VBP through strategies such as requests for information or patient-centered medical home certification programs.

Considerations for Federally Qualified Health Center VBP Models

FQHCs are important PCPs for the Medicaid population and may have a particular opportunity to succeed under VBP as they are deeply embedded into communities. States seeking to implement VBP for FQHCs must consider how to implement new payment models within the requirements of the FQHC Prospective Payment System (PPS).

Federal law requires that FQHCs be reimbursed for all reasonable costs associated with the services they provide through a PPS or Alternative Payment Methodology (APM), based on a health center's historical costs of providing comprehensive care to Medicaid patients. If a state has chosen to reimburse health centers via an APM, two statutory requirements must be met: (1) that each health center agrees to the APM; and (2) that any payment be no less than what a health center would have received via the PPS rate. The latter provision has historically limited the types of VBP arrangements that states and plans can enter into with FQHCs, such as those involving downside risk, as direct payments to FQHCs cannot decrease under VBP arrangements. However, there are three ways that FQHCs can participate in VBP arrangements with downside risk:

- VBP programs involving services not covered under PPS rates;
- Programs that put a portion of the payment above the PPS rate at risk; and
- FQHCs could join in VBP arrangements with organizations that are capable of taking on risk.¹³⁴



✓ What care delivery requirements will be expected of participating providers?

States often set care delivery requirements that provider organizations must meet to be eligible to participate in a particular VBP model. Such requirements provide states with the opportunity to explicitly define goals and expectations for advanced primary care capabilities. For primary care, care delivery requirements typically draw from or build upon a PCMH framework. In defining care delivery standards, states can consider leveraging standards from existing accreditation organizations like NCQA or developing a state-specific program. For examples of state PCMH frameworks and standards, see [State Approaches to Patient-Centered Medical Homes](#) in the first section of this toolkit. States may also consider how to leverage PCMH or other primary care requirements to further health equity goals, such by setting standards related to improving data collection to measure disparities, implementing quality improvement activities aimed at reducing disparities, providing culturally and linguistically appropriate care, and enhancing patient and community engagement.¹³⁵ In setting care delivery expectations, state should also ensure that provider payment is adequate to cover costs of services and expected capabilities.

✓ How will a Medicaid primary care VBP model align with other payment models in the state?

Aligning Medicaid primary care VBP models, including design elements such as payment methodology, quality measures, and care delivery expectations, with those of other payers, can increase uptake by primary care practices. Alignment can serve to reduce administrative burden for providers as well as strengthen incentives for care delivery transformation and quality improvement. For example, going forward, states may consider aligning with CMS' Primary Care First program. The Primary Care First request for applications includes a table outlining guidelines for how Medicare Advantage, commercial insurers, and Medicaid can align with Primary Care First principles, such as “Move away from fee-for-service payment mechanism” and “Reward outcomes, not process.”

States may also consider how primary care VBP models align with other existing or planned VBP initiatives. States with multiple VBP models may consider whether providers can participate in multiple programs, how to align timelines of varying initiatives, how multiple payment methodologies would interact, whether quality measures would align across programs, and how care delivery expectations would vary by program. For example, **New York** provides guidance on how shared savings may be equitably distributed between professional-led contractors in primary care VBP arrangements and downstream hospitals in TCOC arrangements.¹³⁶ **Massachusetts** integrates primary care requirements into its TCOC ACO model, such as requiring that ACOs “develop, implement, and maintain value-based payments for Participating [Primary Care Clinicians].”¹³⁷

Implementation Considerations

✓ How will the state track VBP model progress and impact on primary care?

Tracking VBP model implementation and progress is particularly important for states that allow MCOs flexibility in designing VBP models. States may consider a standardized template or set of questions to enable comparison of VBP models across payers and ensure sufficient information is collected to assess progress toward statewide VBP goals. Reporting templates often contain detailed instructions for how MCOs should calculate VBP metrics and classify VBP models and may also collect more detailed information such as APM service area, provider/service type, and performance measures utilized. The **Texas** Value-Based Contracting Data Collection Tool is one example.¹³⁸ As part of such templates, states may also consider requiring MCOs to report on strategies for assessing and mitigating unintended consequences of VBP models. For example, **Oregon** requires Care Coordination Organizations to report on plans for mitigating adverse effects of VBP models.¹³⁹ Additionally, states may consider how to evaluate the impacts of Medicaid VBP models on quality and cost of care, such as through funding external evaluations or leveraging MCOs' self-reported impacts of VBP models. For example, **Virginia** requires that MCOs submit VBP status reports annually, including VBP goals and measurable results.¹⁴⁰

✓ **What data will the state or MCOs provide PCPs to support VBP implementation and reduction of health disparities?**

States may consider how to support practices with data sharing tools and analytic assistance to help them understand performance, coordinate care, outreach to members, and identify gaps in care. States can support practices by supplying or requiring MCOs to supply standardized performance data, including patient level claims data, or reports to practices. For example, **Tennessee** offers participants in its PCMH program access to a Care Coordination Tool that provides admission, discharge, or transfer data from hospitals and/or emergency departments, member panel information, and claims-based clinical data.¹⁴¹ To the extent available, states may also consider supplying, or requiring MCOs to supply, data on health disparities to inform health equity initiatives at the provider level.

✓ **How will the state or MCOs support PCPs in developing capabilities needed to implement VBP?**

Providers, especially small practices or practices without extensive VBP experience, may need technical assistance or infrastructure support to transition to VBP models. States may consider providing or directing MCOs to learning opportunities related to key topics such as specific VBP payment methods, care delivery transformation strategies, and/or developing analytic capabilities. For example, **Colorado** requires its Regional Accountable Entities to support practice participation in alternative payment models and achievement of medical home standards by offering practice coaching, trainings, learning collaborative, and/or other supports.¹⁴²

In terms of infrastructure, states may consider how to support small providers in extending capabilities related to care management, population health, and integration of behavioral health and social services. For example, **Vermont** implemented a community health team program to enhance primary care practice capacity and link patients to needed community services.¹⁴³

States may also consider whether there are opportunities to provide additional financial or non-financial supports to providers that have been historically underfunded and serve populations experiencing inequities. For example, **North Carolina** piloted an initiative that provided enhanced payments to primary care practices in areas with high poverty rates.¹⁴⁴ **California** has proposed allocating funds to support providers, including pediatric primary care practices, in developing capabilities to reduce racial and ethnic disparities in care.¹⁴⁵

Examples of State Approaches

State	Model Description
<p>Flexible, State Expectations and MCO Customization: States set general requirements for VBP and/or high-level guidelines for primary care VBP models. MCOs and providers have the flexibility to customize several aspects of VBP arrangements.</p>	
<p>New York</p>	<p>Under DSRIP New York required that MCOs enter into VBP arrangements with providers in alignment with goals and arrangements defined in the 2019 NYS VBP Roadmap. New York aimed to achieve “80-90% of managed care payments to providers using value based payment methodologies” by 2020.¹⁴⁶ To achieve these goals, the state defined a menu of VBP options, for MCOs and providers to select from. Possible VBP arrangements included:</p> <ul style="list-style-type: none"> ■ Total care for the general population; ■ Integrated primary care (IPC); ■ Maternity care; ■ Total care for subpopulations; and ■ New York also allows MCOs and providers to develop other models, as long as they are aligned with the goals of the VBP Roadmap. <p>The IPC arrangement included services related to three components of care: preventive care, chronic condition management, and sick care. Each of these components is defined by one or more underlying episodes of care; a total of 18 episodes make up the IPC arrangement. Potential levels of risk within the IP arrangement range from (each must tie payment to quality)</p> <ul style="list-style-type: none"> ■ Level 1: FFS with per-member per-month add-on and upside- only shared savings for a primary care bundle ■ Level 2: FFS with per-member per-month add-on and shared savings/losses for a primary care bundle ■ Level 3: per-member per-month capitated payment^{147,148,149,150}
<p>Oregon</p>	<p>Oregon’s CCOs contracts include VBP targets that increase over the course of the contract. Within this framework, Oregon requires CCOs to provide financial support to primary care practices recognized as Patient-Centered Primary Care Homes (PCPCHs).</p> <p>The PCPCH program is Oregon’s PCMH program and recognizes practice at five different tiers, depending on the criteria met. The CCOs must provide per-member per-month payments to PCPCHs as a supplement to any other FFS or VBP payment. CCOs must provide higher payments to higher-tier PCPCHs, increase per-member per-month payments each year over the five-year contract, and be sufficient to aid in the development of infrastructure and operations needed to maintain or advance PCPCH tier level.¹⁵¹</p>

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State	Model Description
Prescriptive, State Standardization and MCO Implementation: States design VBP models in which some or all elements are standardized across MCOs	
Ohio	<p>Ohio required MCOs to submit a strategy and track progress toward making “50% of aggregate net payments to providers value-oriented by 2020.”¹⁵² MCOs are also required to implement the state-sponsored VBP initiative, including Ohio’s PCMH program, Ohio Comprehensive Primary Care (Ohio CPC). Ohio CPC recognizes practices with advanced primary care capabilities and includes the following payment components:</p> <ul style="list-style-type: none"> ■ Prospective, quarterly, risk-adjusted per-member per-month payment to support care coordination activities; and ■ Retrospective shared savings payment based on TCOC (for practices with 60,000 member months only). <p>To receive any payments, primary care practices must:</p> <ul style="list-style-type: none"> ■ Meet all 10 Ohio CPC care delivery requirements. Ohio CPC includes care delivery requirements that are aligned with CMS’ Comprehensive Primary Care Plus program and include categories such as community service and supports, team-based care delivery, and population health management. ■ Meet at least half of applicable quality and efficiency measures. The Ohio CPC metrics set includes 20 clinical quality metrics and four efficiency metrics.^{153,154,155}
Tennessee	<p>Tennessee requires MCOs to implement state-designed VBP models including the TennCare PCMH program. To be eligible for the program, practices must maintain/work toward NCQA PCMH recognition. Providers are compensated for start-up activities, ongoing PCMH activities, and eligible for performance bonuses. Specific VBP components include:</p> <ul style="list-style-type: none"> ■ Practice transformation payment: \$1 per-member per-month, first year of PCMH participation only. ■ Activity payment: risk-adjusted per-member per-month payment, must average at least \$4 per-member per-month. ■ Outcomes payment: bonus based on efficiency and quality: (a) large panel providers [5,000+] may share in savings based on total cost of care; (b) small panel providers [500-5,000] may receive outcome payments for annual improvement on efficiency metrics; and (c) to be eligible for outcomes payments, organizations must meet a minimum level of quality performance. TennCare defines quality measure sets for adult [5 metrics], pediatric [5 metrics], and family practices [10 metrics]. <p>Tennessee required that at least 37 percent of MCOs’ populations are attributed to a PCMH-participating organization in 2020. MCOs face liquidated damages for failing to meet the PCMH benchmark.^{156,157}</p>
Washington State	<p>Washington State has proposed a Multi-payer Primary Care Transformation Model to strengthen primary care through multi-payer payment reform and care delivery transformation. The Washington Health Care Authority plans to collaborate with health plans to implement the model in state-financed programs. The model proposes the following payment components:</p> <ul style="list-style-type: none"> ■ Transformation of care fee: A payment aimed at supporting care transformation and paid to practices that commit to making progress on specified transformation measures. The payment will be provided for up to three years and then transition to the Performance Incentive Payment. ■ Comprehensive primary care payment: A fixed, monthly per-member per-month payment for comprehensive primary care services including “physical and behavioral health, evidence-based prevention and wellness, acute care, chronic care, and referral to specialty and community support.” ■ Performance incentive payment: A quarterly, tiered per-member per-month payment, based on performance on quality and utilization metrics. Full or partial payment may be recouped if performance thresholds are not met.¹⁵⁸

Examples of Medicare Approaches

In addition to state VBP model approaches, states may consider approaches from Medicare’s multi-payer primary care VBP models.

CMS Model	Description
<p>Primary Care First</p>	<p>Primary Care First is a five-year multi-payer program that is offered in 26 defined regions. The model is based on Medicare FFS and CMS encourages Medicare Advantage plans, commercial health insurers, Medicaid managed care plans, and state Medicaid agencies to align with the model. Components of the payment model include:</p> <ul style="list-style-type: none"> ■ Population-based payments with flat per-visit primary care fees; and, ■ Quarterly performance incentive payments, with an upside of up to 50 percent of revenue and downside of 10 percent of revenue. <p>Providers must meet quality standards and utilization measures to be eligible for performance-based adjustments to primary care revenue. Providers are also expected to be able to deliver five primary care functions. Through this initiative, CMS is promoting further alignment in terms of payment and data sharing across payers. For example, CMS is encouraging payers to align on the frequency, type, format, and level of data sent to providers and work toward providing multi-payer data in a single, regional platform.¹⁵⁹</p>
<p>Comprehensive Primary Care Plus</p>	<p>Comprehensive Primary Care Plus (CPC+) a predecessor program to Primary Care First. CPC+, was a multi-payer program that included Medicare FFS as well as Medicare Advantage, commercial, and/or Medicaid participants in each of 18 defined geographic regions. The model defined five Comprehensive Primary Care Functions, each with associated care delivery requirements. CPC+ had two program tracks with different practice eligibility criteria and performance-based payment models, with more requirements and higher payments to Track 2.</p> <p>Track 1 payment model included:</p> <ul style="list-style-type: none"> ■ Care management fee; ■ Prospective performance-based incentive payments; and ■ Medicare FFS payments. <p>Track 2 payment model included:</p> <ul style="list-style-type: none"> ■ Care management fee; ■ Prospective performance-based incentive payments; and ■ Reduced Medicare FFS payments plus lump sum Comprehensive Primary Care Payments larger than the FFS reduction.¹⁶⁰

3. Monitor Primary Care Spending and Investment

Primary care spending and investment is an important indicator of a health system's ability to achieve better health outcomes, more health equity, and lower costs.¹⁶¹ The U.S. has historically spent less than most developed countries on primary care in proportion to other services — between five and seven percent of health care spending — and, arguably experiences higher overall costs and worse health outcomes, including high levels of health disparities, as a result.¹⁶² By comparison, peer countries average 14 percent spending on primary care.¹⁶³

Challenges that emerged from the COVID-19 pandemic further highlighted gaps in current primary care investment. PCPs experienced financial strain due to reduced patient visits during the crisis and ongoing impact of COVID-19 surges remain uncertain.^{164,165} COVID-19 has also exacerbated long-standing racial and ethnic health disparities,^{166,167} underscoring the need for further investment and support for providers serving communities of color, in particular. Moreover, as individuals forgo short-term preventive and chronic care, there is the potential for a mounting backlog of primary care needs.^{168,169} In the aftermath of the immediate public health crisis, robust investment in primary care is necessary both to stabilize and potentially rebuild the primary care system. Primary care practices can also play an important role in addressing and coordinating growing behavioral health and social service needs emerging from COVID-19.

Recognizing the importance of primary care, state legislatures across the nation have recently passed bills to measure or increase health spending devoted to primary care, including in **Colorado, Delaware, Maine, Oregon, Vermont, and West Virginia. Connecticut, Rhode Island, and Washington State** have implemented similar policies through other regulation. State approaches vary in whether policies target spending among commercial payers, public payers, or both.¹⁷⁰

In concert with such strategies or in absence of other regulation, states can also consider using existing Medicaid managed care levers to increase health spending devoted to primary care. **This module outlines strategies and considerations for defining, measuring, and ultimately increasing primary care spend for states operating in a Medicaid managed care environment.**

MONITOR PRIMARY CARE SPENDING AND INVESTMENT: Design Considerations Summary

States interested in tracking and setting targets for primary care spending may consider:

- ✓ What are the state's goals related to primary care investment?
- ✓ How can primary care investment be leveraged to advance health equity?
- ✓ How will primary care be defined?
- ✓ What "counts" as improvement in primary care spending levels?
- ✓ Will the state set a specific benchmark for primary care investment, or begin by monitoring spending and/or improvement levels?
- ✓ Which organizations will be subject to the primary care spending requirements?
- ✓ How will the state monitor primary care spending, especially for any non-claims-based care or investments (e.g., bonus payments, shared savings payments, capitation)?
- ✓ How will states monitor primary care in conjunction with overall health care spend? Will the state include other accountability standards?



Design Considerations

✓ What are the state's goals related to primary care investment?

Consistent and growing evidence shows that primary care-oriented systems achieve better health outcomes, more health equity, and lower costs.¹⁷³ A report from the Patient-Centered Primary Care Collaborative and the Robert Graham Center found an association between increased primary care spend and fewer hospitalizations and emergency department visits.¹⁷⁴ **Rhode Island** increased its primary care spending from 5.7 percent in 2008 to 9.1 percent in 2012 while also implementing price controls for commercial insurers. Over this same period, total health care expenditures in the state fell by 14 percent. In 2014, an evaluation of **Rhode Island** identified a 7.2 percent reduction in hospital admissions.¹⁷⁵ A 2016 study in **Oregon** showed that for every additional dollar in primary care expenditures related to the state patient-centered medical home program, savings of \$13 were found in other services.¹⁷⁶

However, increasing primary care spend may not result in cost savings in the short term and, moreover, cost savings should not necessarily be the end goal of primary care improvement efforts. Rather, as described by a National Academies of Sciences, Engineering, and Medicine report, primary care investment and payment reforms should be motivated by “measures of population health, equitable outcomes, changing mortality and chronic disease prevalence trends, and overall increased health and well-being for individuals and families.”¹⁷⁷

Effectiveness of primary care investment may also depend on factors, such as baseline primary care access, care delivery patterns, and payment models. States may need to pair primary care investment policies with additional reforms, such as additional price regulations for other parts of the health systems and/or VBP to realize cost savings.¹⁷⁸ States should be realistic in their expectations about the timeframe of impact of new primary care spending requirements on overall cost and quality of care. For example, **Colorado**'s Payment Reform Collaborative explicitly noted plans to track identified metrics



Request for Proposal & Contract Excerpts

Following is sample state managed care request for proposal (RFP) and contract language related to monitoring primary care spending and investment:

- **Hawaii (RFP):** “To achieve DHS goals, the Health Plan shall support the vision of devoting resources to advancing primary care. To this end, the Health Plan must increase investment in, support of, and incentivization of, primary care in three concentric definitions.
 - a) In the narrowest sense, primary care is the provision of care in the outpatient setting by PCPs.
 - b) A broader definition includes the provision of preventive services, including behavioral health integration, in the primary care setting.
 - c) In the broadest definition, primary care additionally includes the wrap-around support services including team-based care and SDOH supports that augment and enhance the provider’s capacity to manage the patient’s care in the outpatient setting.

The Health Plan shall be responsible for tracking its primary care spend using measures corresponding the concentric definitions provided by DHS [...] For each definition of primary care spend, baseline spend will be used to set annual targets to enhance spending in primary care.”¹⁷¹

- **Washington State:** “HCA will develop the Primary Care Expenditure report utilizing input from HCA’s Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) program medical carriers, and Medicaid Managed Care Organizations. The Contractor shall complete HCA’s Primary Care Expenditure Report annually, by the last business day in July. The reporting period is January 1 through December 31.”¹⁷²

over time, with the expectation that short-term metrics (e.g., emergency department utilization) may show improvement in the first two years while long-term metrics (e.g., growth in total cost of care) may take up to a decade to improve.¹⁷⁹

✓ How can primary care investment be leveraged to advance health equity?

As a result of structural and interpersonal racism, people of color are more likely than white individuals to face barriers to accessing high quality primary care. For example, evidence shows that Black people can have more difficulty scheduling timely primary care appointments and have fewer primary care practices in their neighborhoods.^{180, 181, 182} Increasing overall levels of investment in primary care^{183, 184} and ensuring increased resources are directed to meet the needs of populations experiencing inequities can be an important part of advancing equity and complement other state health equity activities (See the [Promote Health Equity](#) module of this toolkit for further exploration of state levers to support health equity).^{185, 186} States seeking to increase overall investment in primary care may consider how to direct additional resources to providers serving populations experiencing disparities, quality improvement activities related to reducing disparities, and enhancing uptake of care models that hold promise for advancing equity. States should also consider how to monitor and evaluate the impact of increase primary care investment on health disparities.

✓ How will primary care be defined?

There is currently no national standard for how to define and measure primary care expenditures. However, in general, primary care can be defined by type of provider and/or type of service. Within those two categories — provider type and service type — primary care can be defined in both narrow and broad ways, sometimes including spending related to behavioral health and social needs supports (see [Exhibit 4](#), next page). For that reason, some states have chosen to define and measure primary care spending according to multiple definitions, rather than just one. For example, **Washington State**'s Primary Care Expenditure report provides a range of spending estimates, according to both a narrow and broad definition.¹⁸⁷ **Hawaii** is considering requiring managed care organizations to increase investment in primary care in “three concentric definitions,” the broadest of which includes services that address social care needs.”¹⁸⁸ To the extent that primary care practices begin adopting new capabilities to support COVID-19 surveillance, such as testing, contact tracing, or providing supports to high-risk individuals, states may consider including these activities in a primary care definition as well. States may also consider how to craft primary care definitions in a way that aligns with health equity initiatives. For example, broader primary care definitions including behavioral health and activities addressing HRSN may better incentivize investment in comprehensive, integrated, and team-based care models that show promise for advancing health equity.

Exhibit 4. Examples of Narrow and Broad Definitions of Primary Care

Provider Type

- Narrow definition: Physicians identified as family medicine, general practice, geriatrics, general internal medicine, and general pediatrics.
- Broad definition: The provider types in the narrow definition, as well as nurses/nurse practitioners, physician assistants, OB-GYNs, general psychiatrists, psychologists, and/or social workers.^{189,190}

Service Type

- Narrow definition: Evaluation and management and preventive services.
- Broad definition: Service types in the narrow definition, as well as: (a) other services performed by PCPs (minor surgical procedures and tests); (b) wraparound support services including behavioral health, team-based care, and social needs supports; and/or (c) primary care infrastructure/transformation payment (e.g., health information technology supports, and patient-centered medical home transformation payments).^{191, 192, 193}



✓ What “counts” as improvement in primary care spending levels?

In addition to providing an explicit definition (or definitions) of primary care, states have sometimes chosen to explicitly indicate the ideal source of increases in primary care spending over time. For example, some states have indicated that increases in primary care spend should not come solely from increases in payments to primary care physicians and other providers of primary care services. Rather, such states have provided examples of the specific kinds of activities and services they hope to see increased as a result of the primary care spend policy, including those aimed at broader infrastructure improvements. Such considerations may be particularly important as primary care delivery changes to adapt and respond to COVID-19.¹⁹⁴ States may consider how primary care investments can be directed to beneficial innovations such as telehealth or new team-based care models. (For additional information on specific care delivery priorities that may be supported by increased primary care investment see the first section of this toolkit, [Conceptualizing and Designing Core Functions](#).)

For example, **Delaware**'s Primary Care Collaborative noted: “*The increase in primary care spending should not be strictly an increase in fee-for-service rates. It should include an upfront investment of resources to build and sustain infrastructure and capacity, including use of health information technology, as well as support needed for a team-based model of primary care across the range of Delaware’s primary care settings. It also should include value-based incentive payments that reward for high-quality, cost-effective care.*”¹⁹⁵ Similarly, **Rhode Island** requires insurers, as a condition for rate approval, to raise their primary care spending rate by one percentage point per year using strategies other than increasing fee-for-service

payments. Insurers responded by spending more on PCMHs, ACOs, performance incentives, and “common good” services, such as information technology, practice transformation, and loan-repayment programs.¹⁹⁶ In **Massachusetts**, the Primary Care Investment Working Group developed a list of opportunities to increase primary care investment (see **Exhibit 5**).¹⁹⁷

States should also take steps to ensure increased investment in primary care services or capabilities to advance health equity. To do so, states may consider setting specific health equity goals and providing guidance on interventions that plans and providers may take to reduce disparities. There is no one-size-fits-all approach to such work; states should assess state-specific health disparities¹⁹⁸ and engage local stakeholders, including populations experiencing inequities, to develop contextually appropriate health equity strategies. The [National Quality Forum](#) and [Advancing Health Equity initiatives](#)^{199, 200} roadmaps for reducing disparities provide frameworks and tools states may leverage for this work. The Centers for Disease Control and Prevention’s [Strategies for Reducing Health Disparities](#) also provides examples of evidence-based interventions for reducing disparities.²⁰¹ States may also consider pairing primary care investment targets with additional health equity policies, such as requiring MCOs to implement and report on activities to reduce health disparities and/or exploring opportunities to direct additional funding to providers serving populations experiencing inequities.

Exhibit 5. Primary Care Investment Options in Massachusetts

Proposed legislation in Massachusetts is designed to promote access to behavioral health and primary care services.²⁰² For flexibility, the bill does not mandate how to achieve goals. The Massachusetts Primary Care Investment Working Group, however, developed the following potential options for increasing primary care investment:²⁰³

1. Group visits
2. Integrated behavioral health
3. Health coaches
4. Community health workers
5. Medical scribes
6. Addiction care (medication-assisted)
7. Care managers/social workers
8. Palliative care
9. Telehealth (video, email, and phone)
10. Additional time with patients
11. Walk in/urgent care availability
12. Early AM/evening/weekend hours
13. Elimination of copays in primary care
14. Home care
15. Patient advisory groups
16. Collaboration with pharmacists



✓ **Will the state set a specific benchmark for primary care investment, or begin by monitoring spending and/or improvement levels?**

States without a clear understanding of baseline primary care spending levels may consider beginning by monitoring primary care spend and/or incentivizing increased primary care spending as compared to a baseline. For example, to increase commercial payer investment in primary care, the **Colorado** Primary Care Payment Reform Collaborative recommended a baseline year to collect data and subsequently requiring a one percent annual increase in primary care spend. A more stringent strategy is setting a target benchmark for primary care spend as a percentage of total health care expenditure. To date, at least four states have set specific benchmarks, ranging from 10 to 12 percent, for primary care spending as part of their legislation or policies.^{204,205}

When setting primary care spend targets, states may also consider how to account for COVID-19 impacts of primary care utilization and spend. For example, 2020 may not be an appropriate baseline year for which to compare future primary care spend given reductions in outpatient utilization. States could alternatively consider using prior years or delaying implementation until the COVID-19 pandemic has passed. Additionally, states may consider whether revised methods or guidance is needed for measuring primary care spend, given the variety of new financing mechanisms being used to support primary care practices through the pandemic (e.g., new, non-claims-based payments, advanced payments).

✓ **Which organizations will be subject to the primary care spending requirements?**

By and large, the primary care spending requirements adopted by states to date have tended to apply solely to health insurers (e.g., Medicaid health plans, state employee health plans, Medicare Advantage plans, self-insured, and fully-insured). However, states may want to consider adopting primary care spending measures not just at the payer-level, but also within certain provider organizations, such as large health systems and/or ACOs. The reason for this is two-fold: (1) a strong primary care foundation has been shown to be a key contributor to successful ACOs;²⁰⁶ and (2) ACOs and large health systems can help drive spending and investments in primary care at the ground level, in part by ensuring that primary care physicians and other team members receive the compensation and infrastructure needed to support comprehensive primary care functions. In **Massachusetts**, a bill sponsored by Governor Charlie Baker would require insurers and *providers* to boost spending in primary care and behavioral health.²⁰⁷

✓ **How will the state monitor primary care spending, especially for any non-claims-based care or investments (e.g., bonus payments, shared savings payments, capitation)?**

Most states collect and monitor primary care spending based on two key data sources: (1) claims-based payments, including payments to PCPs or provider organizations for primary care services rendered to health plan members; and (2) non-claims-based payments, including payments to health care providers intended to motivate efficient care delivery, reward achievement of quality or cost-savings goals, and/or build primary care infrastructure and capacity.

States with all-payer claims databases (APCDs) tend to use those systems to collect the claims-based data from major health care payers. In some cases, states have passed legislation to enhance their APCDs to have more accurate and complete data for monitoring primary care spend. For example, in 2018, **Delaware** passed legislation requiring insurers to participate in the state's health care claims database and establishing a primary care reform collaborative.²⁰⁸

To capture non-claims-based primary care payments more consistently, states have provided additional guidance and/or reporting templates. For example, **Oregon** requires its prominent carriers and CCOs to report non-claims-based primary care spending and total medical spending. Such spending includes (but is not limited to): (a) capitation or salaried arrangements with PCPs; (b) prospective or retrospective incentives payments to PCPs aimed at decreasing costs, increasing value; and (c) payments for structural changes, such as adoption of health information technology or new workforce expenses (e.g., supplemental patient navigators or nurse care managers).²⁰⁹

States may also consider opportunities to stratify primary care investment data based on population characteristics. Many states stratify primary care spend by payer. States may further consider stratification by other population characteristics such as health status, geography, race, and gender identity. Such analysis may help states understand underlying patterns of primary care usage and further target policies to improve care and reduce health disparities.²¹⁰ For example, **California** is planning to require MCOs to report stratified primary care spend by race/ethnicity.²¹¹

✓ **How will the state monitor primary care spend in conjunction with other measures? Will the state include other accountability standards (e.g., hospital caps or total cost of care benchmarks, quality measures, and measures of health disparities)?**

In monitoring the success of primary care investment targets, states should consider what additional accountability measures are needed to understand downstream impact. States may consider what quality or patient measures are expected to be impacted by primary care investment and develop a process for tracking and reporting in conjunction with primary care investment reports. States should also consider developing capabilities to stratify performance measures by demographic variables to monitor progress on reducing health disparities. For example, **Delaware's** statewide Benchmark Trend Report includes both health care spending and quality data.²¹²

Additionally, as investing in primary care alone may not be sufficient to impact total health care costs,²¹³ states may consider monitoring primary care spending in conjunction with total health care spend or pairing primary care investment policies with additional health care spending regulations. For example, states such as **Massachusetts, Delaware, Rhode Island,** and **Oregon** have implemented statewide health care cost benchmarks.²¹⁴ Such benchmarks could potentially be targeted within Medicaid. For example, in 2012, **Oregon's** 1115 waiver established a 3.4 percent risk-adjusted, per-capita growth rate for CCO payment.²¹⁵ States could also consider price regulations for non-primary care spend. **Rhode Island's** 2010 affordability standards promoted such a strategy by implementing hospital price controls, such as annual price inflation caps, in addition to increasing primary care spend.²¹⁶

Select State Approaches to Primary Care Investment

The following table provides examples of select state approaches to incentivizing primary care investment including definitions of primary care spend and investment requirements. Note that estimates of primary care spending cannot be compared directly across states because of differences in data sets, methodologies, and definitions of primary care.

State	Approach and Current Primary Care Spend Levels	Definition	Investment Requirement	Additional Spending Requirements
Colorado ^{217,218}	<p>In 2019, CO passed legislation (HB19-1233) that set targets for investment in primary care and established a primary care payment reform collaborative in the division of insurance.</p> <p>Primary care spend levels:</p> <ul style="list-style-type: none"> ■ 1.3 - 13.5% (Colorado’s Primary Care Payment Reform Collaborative Report) ■ 5.0 - 10.6% (Patient Centered Primary Care Collaborative (PCC) Report) 	<p>The CO collaborative recommends a definition of primary care based largely, but not exclusively, on the type of provider, including family medicine physicians, internal medicine, pediatricians, OB-GYNs, nurse practitioners and physicians’ assistants, and behavioral health providers who support integrated services in a primary care setting.</p>	<p>The CO collaborative recommends a 1% point annual increase for commercial payers through 2022.</p>	<p>Increased investments in primary care should be offered largely through infrastructure investments and alternative payment models that provide prospective funding and incentives for improving quality.</p>
Delaware ^{219,220,221}	<p>In 2018, DE passed legislation requiring insurers to participate in the state’s health care claims database. The legislation also established a primary care reform collaborative.</p> <p>Primary care spend levels:</p> <ul style="list-style-type: none"> ■ DE’s PCC recommended that payers progressively increase primary care spending to eventually account for 12% of total health care spending. 	<p>“Primary care” means health care provided by a physician or an individual licensed under Title 24 to provide health care, with whom the patient has initial contact, and by whom the patient may be referred to a specialist and includes family practice, pediatrics, internal medicine, and geriatrics.</p>	<p>12% by 2024; 1% point annual increase.</p>	<p>The increase in primary care spending should not be strictly an increase in FFS rates. It should include an upfront investment of resources to build and sustain infrastructure and capacity, including use of health information technology, as well as support needed for a team-based model of primary care across the range of DE’s primary care settings. It also should include value-based incentive payments that reward high-quality, cost-effective care.</p>

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State	Approach and Current Primary Care Spend Levels	Definition	Investment Requirement	Additional Spending Requirements
Oregon ^{222, 223}	<p>In 2015, OR passed legislation to measure and annually report levels of primary care spend. In 2017, OR unanimously passed legislation setting a minimum primary care spend threshold for all payers, both commercial and public.</p> <p>Primary care spend levels:</p> <ul style="list-style-type: none"> ■ 5.6% - 10.9% (PCC Report) 	<p>The Primary Care Spending in Oregon report defines primary care based on the health care provider and what service is given.</p>	<p>12% by 2023; 1% point annual increase.</p>	<p>Not available.</p>
Rhode Island ^{224, 225}	<p>In 2010, RI's health insurance commissioner implemented affordability standards for all commercial insurers in the state.</p> <p>Primary care spend levels:</p> <ul style="list-style-type: none"> ■ Not available. 	<p>Primary care spending includes "Direct Primary Care Expenses," defined as payments to primary care practices for providing health care services, achieving quality or cost performance goals, and infrastructure development. Primary care spending may also include "Indirect Primary Care Expenses," defined as payments to support primary care capacity that does not fall within the definition of Direct Primary Care Expenses.</p>	<p>10.7% after 2014; 1% point annual increase between 2010 and 2014.</p>	<p>Insurers required to raise their primary care spending rate by 1 percentage point per year using strategies other than increasing FFS payments as a condition for rate approval. Insurers responded by spending more on PCMHs, ACOs, performance incentives, and "common good" services, such as health information technology, practice transformation, and loan-repayment programs. Includes hospital caps.</p>
Washington State ^{226, 227, 228}	<p>In 2019, WA appropriated \$110,000 for fiscal year 2020 to determine annual primary care expenditures by the state's insurance carriers. The state's first report was issued in December 2019.</p> <p>Primary care spend levels:</p> <ul style="list-style-type: none"> ■ 4.4% - 5.6% ■ 5.9% - 10.1% (PCC Report) 	<p>WA uses a narrow and broad definition:</p> <p>Narrow definition - providers who traditionally perform roles contained within strict definitions of primary care, and a specified list of primarily outpatient and preventive services.</p> <p>Broad definition - providers who perform roles not traditionally contained within a strict definition of primary care (e.g., obstetricians), and a broader range of services including psychiatric and hospice.</p>	<p>Not available.</p>	<p>Not available.</p>

III. Conclusion

Developing a robust primary care system is essential for improving health care access and outcomes for vulnerable populations. As COVID-19 continues to highlight and exacerbate health system challenges, supporting primary care will only become more important for stabilizing the health system and addressing health inequities.

Medicaid can play a central role in this effort.

This toolkit outlines how Medicaid agencies can leverage managed care programs to further invest in primary care services and incentivize primary care delivery improvement at the MCO and provider levels. The incentive and payment strategies described in this toolkit can be implemented separately or in tandem, depending on state bandwidth, context, and policy goals. These strategies can also be implemented alongside approaches defined in the first section of this toolkit, [*Conceptualizing and Designing Core Functions*](#), to incentivize specific primary care capabilities, such as integrating primary care with behavioral health and social services, promoting health equity, enhancing team-based care, and using technology to improve access to care. Investing in and financially supporting primary care can be an integral aspect of rebuilding the health system post-COVID-19, as well as developing a more comprehensive and equitable system for the long term.



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