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Move to Value-Based Payment in Primary Care:

Advancing Primary Care Innovation in Medicaid Managed Care

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Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit

This module is part of ***Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit***, which was created to help states leverage their managed care contracts and request for proposals to advance innovation in primary care.

The two-part toolkit outlines strategies to support states in: (1) defining primary care priorities and advancing core functions; and (2) achieving primary care innovation goals through managed care contractual levers.

To view the full toolkit, visit **www.chcs.org/primary-care-innovation**.

Value-based payment (VBP) arrangements are increasingly prevalent across payers, including Medicaid managed care organizations (MCOs), as a means of improving quality and controlling cost of care.[1,2] 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 Framework[3] 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 health-related social needs (HRSNs); enhancing team-based care; and, using technology to improve access.[4]

COVID-19 has further highlighted the need for payment models that move away from FFS. Decreases in primary care visits have 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 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 primary care provider 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 primary care providers?
- ✔ 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 primary care?
- ✔ What data will the state or MCOs provide primary care providers to support VBP implementation?
- ✔ How will the state or MCOs support primary care providers 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 and improve quality of care, 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. [10]

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, have specific conditions, or for whom there is a particular need for quality improvement. For example, Medicare's Primary Care First Model has a Seriously Ill Population component with a separate payment model providing additional financial resources to eligible practices.[11] Additionally, the Ohio Comprehensive Primary Care program launched a "CPC for Kids" component that includes a potential bonus payment and enhanced per-member, per-month for pediatric providers.[12]

Attribution

Attribution is the "method used to determine which provider group is responsible for a patient's care and costs."[13] Primary care payment models generally attribute patients based on their primary care providers (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

Request for Proposal & Contract Excerpts

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

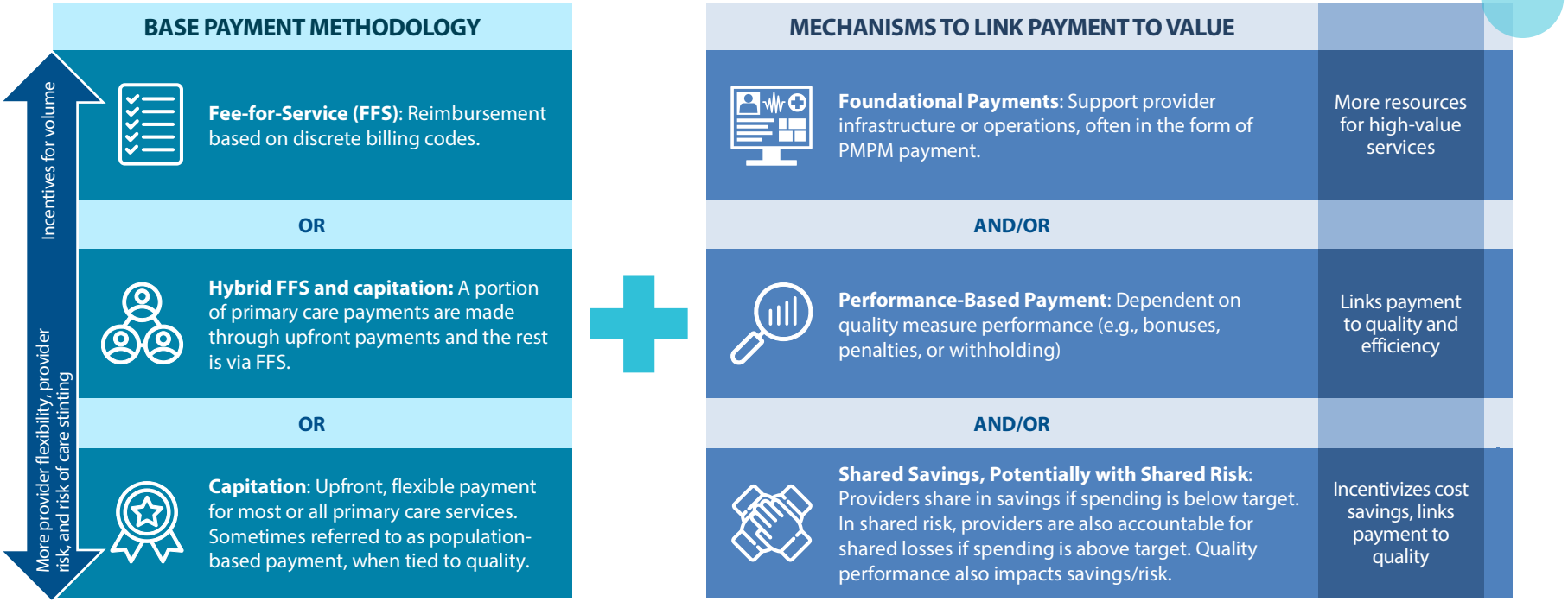
- **Tennessee (RFI)**: "At least for some practices, should TennCare consider moving from its current rewards-only PCMH model to a total cost of care or two-way risk model, or some other form of advanced payment [APM] model that incentivizes quality and value, and includes more than nominal financial risk for monetary losses? If so, what are key factors that ensure success for primary care providers in an advance payment model? Would you suggest the [APM] be designed for specific subgroups of the patient population? If so, which ones?"[5]
- **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."[6]

  Ohio: "The MCP shall play a key role in supporting the [Comprehensive Primary Care (CPC)] practice with achieving optimal population-level health outcomes. The MCP shall establish a relationship with each CPC practice and work collaboratively with the CPC to determine the initial and ongoing level of support to be provided by the MCP based on the CPC practice's infrastructure, capabilities, and preferences for MCP assistance[.] Reimburse CPC practices the agreed upon [PMPM] payment for attributed members and any shared savings for meeting model requirements in accordance with requirements set forth by ODM."[7]
- **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[.][8]

  "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."[9]

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 primary care providers 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 1**) and the services included in the model.

Exhibit 1. Building a Primary Care Payment Model [14,15]



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,[16] 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 is the case in New York's integrated primary care model.[17] 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 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 maybe 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 Integrated Primary Care quality measure set includes a variety of behavioral health measures for use or potential piloting in VBP models, such as *Depression Remission* and *Response for Adolescent* and *Pharmacotherapy for Opioid Use Disorder*,[18] 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. [19]

- **Integration of primary care with social services:** Some states are piloting the use of 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. [20]
- **Health equity:** States may also consider how to directly tie payment to metrics focused on advancing health equity.[21] For example, Minnesota's Integrated Health Partnership program holds providers accountable for agreed-upon health equity measures. [22] Additionally, the National Quality Forum identifies example health equity measures and sorts measures into two categories: (1) disparities-sensitive measures, which assess disparities in care; and (2) health equity performance measures, which incentivize interventions known to reduce disparities or test new interventions to reduce disparities.[23]

Risk Adjustment

Risk adjusting cost and quality measurement is 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 HRSNs into risk-adjustment models as Massachusetts' ACO and Minnesota's Integrated Health Partnership programs have done.[24]

Primary Care VBP in the Context of COVID-19

As Medicaid agencies, MCOs, and providers focus on implementing emergency responses to the COVID-19, states need to consider how to adapt VBP programs in the face of widespread care delivery disruptions. For example, states may consider 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.[25,26]

- **Sustain primary care providers:** Primary care practices are under financial strain due to reduced visits, especially early in the pandemic,[27] 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.[28,29] Such payment could be based on historical spending.[30] 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").[31]

- **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.[32]

- **Supporting patient behavioral health and HRSNs:** Social distancing and the economic impact of COVID-19 may increase patient behavioral health needs and HRSNs into the foreseeable future. States may consider how to support and guide primary care providers 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 HRSNs. In the long-term, once the acute pandemic has passed, states may consider tying payment to additional behavioral health or HRSNs 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, and controlling TCOC. See **Exhibit 2** for examples of how to connect payment reform goals to VBP requirements more explicitly.

Exhibit 2. Connecting Primary Care Goals to Provider Payment Reform

Goal	Possible Solution
Increase primary care resources/funding	■ 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	■ 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	■ 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.
Reduce provider administrative burden	■ Align elements of VBP models across MCOs and with non-Medicaid payers (e.g., quality measures, payment model).
Lower total cost of care	■ 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	■ 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 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:[33,34]

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. [35] 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. 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, New York provides a menu of priority VBP arrangements, one of which is an integrated primary care model.[36]

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 primary care provider 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.

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

Federally qualified health centers (FQHCs) are important primary care providers 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.[37]

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 patient-centered medical home (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.

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, which is expected to launch in January 2021. 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.[38] 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]."[39]

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.[40] States may also 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.[41]

✔ What data will the state or MCOs provide primary care providers to support VBP implementation?

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.[42]

✔ How will the state or MCOs support primary care providers 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.[43]

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.[44]

Examples of State Approaches

State	Model Description
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.	
New York	New York requires that MCOs enter into VBP arrangements with providers in alignment with goals and arrangements defined in the NYS VBP Roadmap. New York aims to achieve "80-90% of managed care payments to providers using value based payment methodologies" by 2020.[45] To achieve these goals, the state has defined a menu of VBP options, for MCOs and providers to select from. Possible VBP arrangements include: ■ 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. The IPC arrangement includes 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) ■ 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[46,47,48,49]
Oregon	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). 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.[50]

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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	Ohio requires MCOs to submit a strategy and track progress toward making "50% of aggregate net payments to providers value-oriented by 2020."[51] 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: ■ 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). To receive any payments, primary care practices must: ■ 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.[52,53,54]
Tennessee	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: ■ 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]. Tennessee requires 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.[55,56]
Washington State	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: ■ 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.[57]

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
Primary Care First	**Primary Care First** is a five-year multi-payer program that will be offered in 26 defined regions starting in January 2021. 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: ■ Population-based payments with flat per-visit primary care fees; and, ■ Quarterly performance incentive payments, with an upside of up to 50 percent of revenues and downside of 10 percent of revenues. Providers must meet quality standards and utilization measures in order to be eligible for performance-based adjustments to primary care revenues**.** Providers are also expected to be able to deliver five primary care functions. Primary Care First also includes a component focused on seriously ill populations, which is directed at providers who provide hospice and palliative care. 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. [58]
Comprehensive Primary Care Plus	**Comprehensive Primary Care Plus (CPC+)** is a predecessor program to Primary Care First. CPC+ is a multi-payer program that includes Medicare FFS and well as Medicare Advantage, commercial, and/or Medicaid participants in each of 18 defined geographic regions. The model defines five Comprehensive Primary Care Functions, each with associated care delivery requirements. CPC+ has two program tracks with different practice eligibility criteria and performance-based payment models, with more requirements and higher payments to Track 2. **Track 1 payment model includes:** ■ Care management fee; ■ Prospective performance-based incentive payments; and ■ Medicare FFS payments. **Track 2 payment model includes:** ■ 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. [59]

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