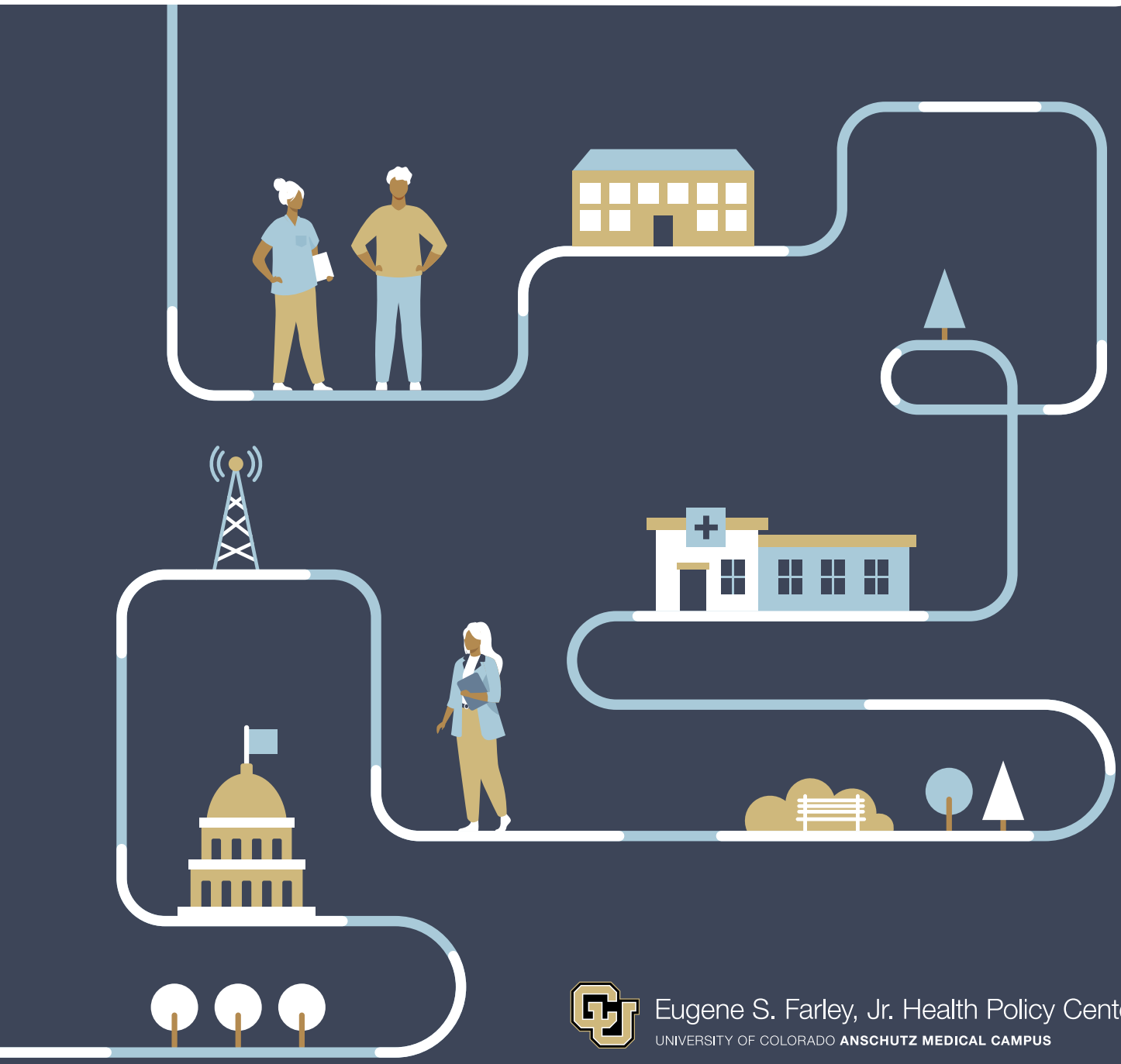
Advancing Primary Care Payment Reform in the Commercial Sector

A STATE POLICY PLAYBOOK



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About the Farley Health Policy Center

The Farley Health Policy Center develops and translates evidence to advance policies and integrate systems that improve health, equity, and wellbeing. With an interprofessional team of primary care and behavioral health providers, economists, and public health and policy professionals, the Farley Health Policy Center has expertise in finance and payment policy, workforce development, system transformation to integrate care, community-based prevention and wellbeing, and social policy to address disparities.

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SUGGESTED CITATION

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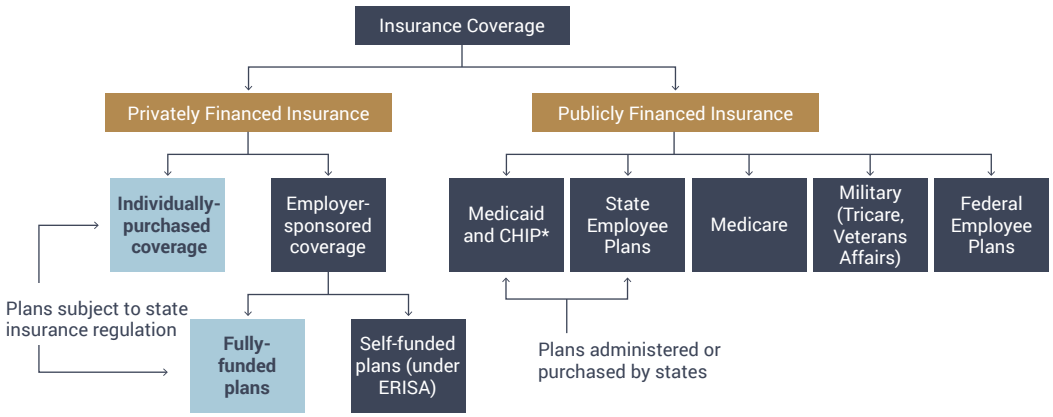
Introduction

Primary care improves health outcomes, lowers costs, and reduces disparities.[1-5] Experts have called for primary care to be considered a common good.[6] However, primary care is underfunded and largely paid on a fee-for-service (FFS) basis, which incentivizes greater volume of services and does not adequately support high-quality care. Inadequate payment is a major driver of primary care workforce shortages that make it difficult for people to access care.[7]

Shifting away from FFS to alternative payment models (APMs) is one approach to better support primary care and address poor health outcomes and rising health care costs in the United States. APMs are designed to improve care delivery, reward quality, and incentivize cost control.

State governments play a critical role in catalyzing primary care payment reform as the payers, purchasers, or regulators for Medicaid, state employee health plans, and fully-insured commercial plans in the individual and group markets (see Figure 1).

FIGURE 1. Overview of publicly and privately financed health insurance coverage denoting plans under state jurisdiction.



Plans highlighted in the light blue boxes are the focus of this report. Self-funded employer plans are exempt from state regulation under federal law (the Employee Retirement Income Security Act, or ERISA).

*Children's Health Insurance Program

This playbook is a guide for state policymakers and policy influencers looking to support high-quality primary care by transforming payment. The playbook focuses on policies advancing APMs for state-regulated commercial plans and also covers related areas of primary care payment reform found to be critical to their success: primary care investment and multi-payer alignment.

These recommendations are drawn from stakeholder interviews and review of policies in five pioneering states: Arkansas, Colorado, Delaware, Rhode Island, and Washington. A complete listing of findings and recommendations from the interviews are available in a companion report, State Policies to Advance Primary Care Payment Reform in the Commercial Sector.

These five states have taken different journeys to arrive where they are today, described in Table 1. While the journeys are varied, there are common lessons that other states beginning this work can learn from. These common lessons have been distilled into a stepwise approach spanning coalition building, policy development, legislation, regulation, and implementation.

Overview of Playbook Steps

STEP 1	Build your base. Find (or be) a champion.
STEP 2	Develop your vision for aligned primary care APM policy and situate this in a broader state primary care strategy.
STEP 3	Hold voluntary stakeholder convenings prior to drafting legislation, developing regulation, or participating in federal demonstrations.
STEP 4	Take advantage of federal demonstration opportunities when available.
STEP 5	Advance legislation that expands regulatory authority to develop affordability standards for primary care, drive multi-payer alignment, and create an infrastructure for continued improvement.
STEP 6	Set requirements for APM design in regulation that balance standardization and flexibility.
STEP 7	Scale and support APM adoption through regulatory targets, data monitoring requirements, and enforcement mechanisms.
STEP 8	Maintain regular communication in enforcement and implementation.

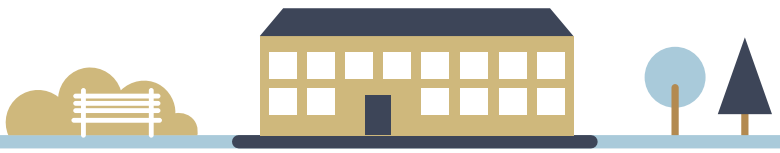
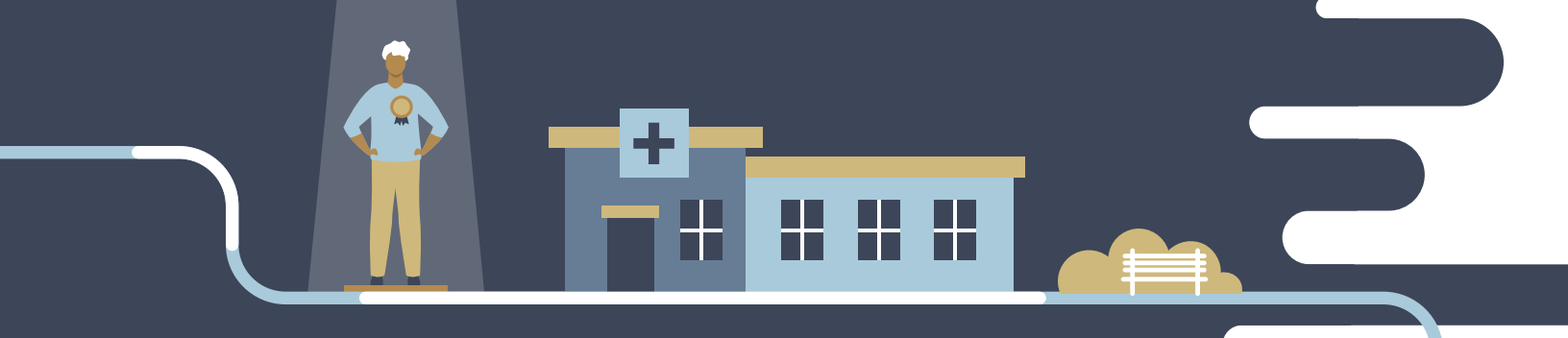


TABLE 1. Brief synopses of selected states' policy approaches to primary care payment reform and their unique features.

State snapshots with detailed timelines are available at the included hyperlinks.

STATE	POLICY APPROACH	UNIQUE FEATURES
AR	• Initially voluntary multi-payer effort that was expanded through federal demonstration programs, aligning major commercial payers, Medicaid, the state employee health plan, and Walmart on PCMH transformation with a PMPM payment • Legislation and regulation to require plans on the health insurance exchange to adopt the PCMH program	• Expanded Medicaid through a private option (plans on the health insurance exchange)
CO	• Legislation and regulation to increase investment in primary care through affordability standards, with advising by the Primary Care Payment Reform Collaborative • Legislation and regulation to align parameters of primary care APMs across payers	• Medicaid is primarily FFS rather than managed care
DE	• Stepwise legislation to create the Primary Care Reform Collaborative, increase investment in primary care, create the Office of Value-Based Health Care Delivery, and establish mandatory minimums for payment innovation • Regulation requiring carriers to offer primary care incentive programs with non-FFS payment	• Office of Value-Based Health Care Delivery focused on payment reform within the Department of Insurance
RI	• Legislation established the Office of the Health Insurance Commissioner • Regulation on affordability standards, with multiple updates that: increase investment in primary care, increase alignment, focus on prospective payment and integrated behavioral health	• Separate Office of the Health Insurance Commissioner
WA	• Voluntary multi-payer alignment work set the stage for participation in Making Care Primary (federal demonstration program, now scheduled to end early in 2025) • Legislation to set a goal for primary care investment	• Washington Health Authority oversees Medicaid as well as the state and public employee health plan

PCMH = patient-centered medical home PMPM = per-member-per-month



A Stepwise State Approach to Primary Care **Payment Reform in Commercial Plans**

STEP 1. Build your base. Find (or be) a champion.

WHY IT'S IMPORTANT: Successful policy change can often be linked back to a passionate individual or small group. In each of the five states studied, specific individuals (often multiple in a state) drove the work, demonstrating persistence throughout the process.

DETAILS: Champions bring together stakeholders to build a coalition and create a roadmap for change.

STATE EXAMPLES: In Colorado and Delaware, legislators championed policy change, taking the initiative to develop and advance legislation incorporating recommendations from primary care stakeholder groups. In Arkansas, commitment from the Governor's office, grounded in financial concerns about the growing costs of health care, created a foundation for policy work.

STEP 2. Develop your vision for aligned primary care APM policy and situate this in a broader state primary care strategy.

WHY IT'S IMPORTANT: The work to advance and align primary care APMs in the commercial sector is a necessary component of a broader state strategy, but not sufficient on its own to address the current primary care crisis.

DETAILS: In addition to payment policy, other supports for the primary care workforce are needed, including expansion of training programs, loan repayment, and efforts to decrease administrative burden. Any state strategy should be informed by past work within the state, lessons from other states, and ongoing data monitoring and evaluation.

Champions developing a vision for primary care create common understanding across a coalition of stakeholders and build on shared motivations, with improved care for patients as a central tenet. The vision may also include the role of primary care in addressing other state priorities, such as maternity and behavioral health care.

STATE EXAMPLE: The Rhode Island Affordability Standards address multiple aspects of primary care policy. In addition to primary care investment and APMs, a recent update establishes requirements for prior authorizations to decrease administrative burden. Health insurers are required to reduce the volume of prior authorization requests by 20% relative to baseline 2023 requests and prioritize services ordered by primary care for those reductions. Other requirements involve increasing transparency, streamlining processes, and submitting quarterly reports on prior authorizations.

STEP 3. Hold voluntary stakeholder convenings prior to drafting legislation, developing regulation, or participating in federal demonstrations.

WHY IT'S IMPORTANT: Voluntary efforts lay valuable groundwork for subsequent policy. However, voluntary efforts alone generally lead to little impact and must be followed by legislation, regulation, or participation in federal demonstrations.

DETAILS: Achieving consensus on an actionable level of detail increases the likelihood of successful policy passage and accelerates next steps. States may benefit from dedicated funding for external consultants to facilitate multi-stakeholder convenings.

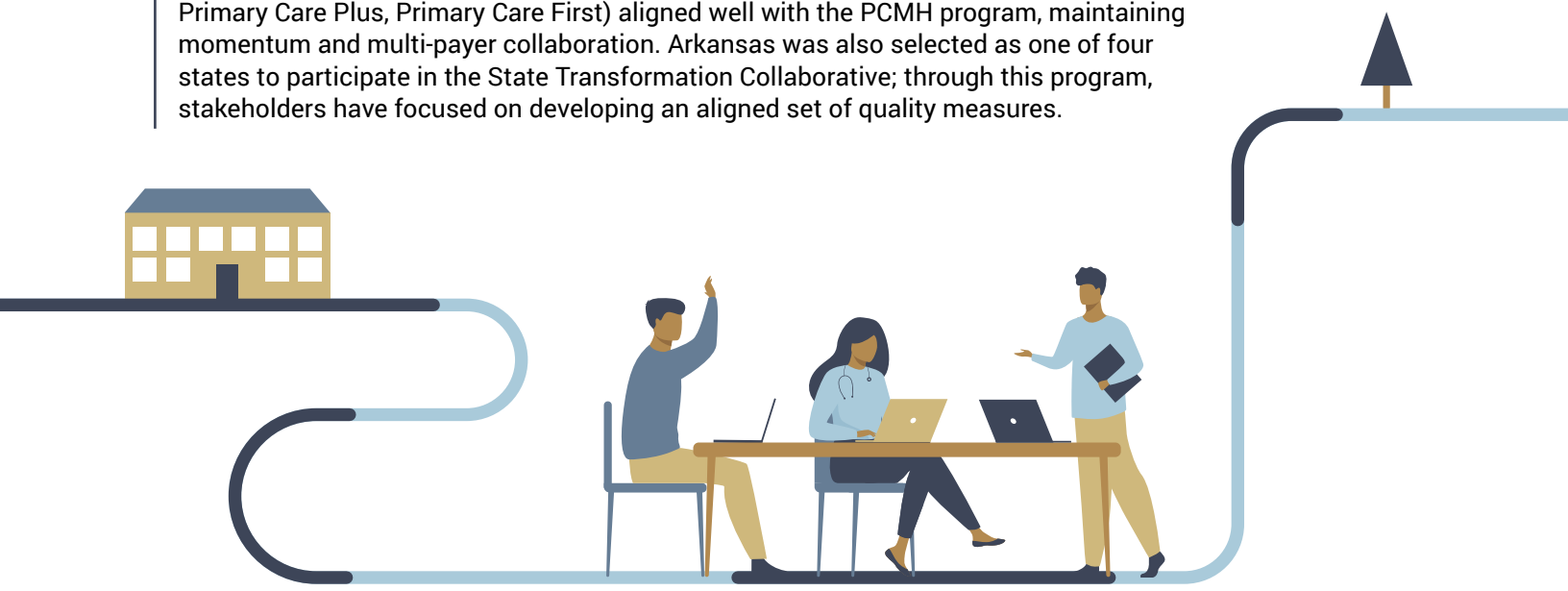
STATE EXAMPLE: The Washington Health Care Authority, which oversees Medicaid and the state and public employee health plans, co-designed its Primary Care Transformation Initiative with diverse primary care stakeholders. Voluntary memoranda of understanding (MOUs) resulting from the multi-stakeholder work did not lead to significant changes in payer contracts; however, the work positioned Washington well to apply and be selected for the federal Making Care Primary model. (On March 12, 2025, the CMS Innovation Center announced Making Care Primary will end early by December 31, 2025.)

STEP 4. Take advantage of federal demonstration opportunities when available.

WHY IT'S IMPORTANT: Participation in federal demonstrations provides an opportunity for dedicated funding, accountability, and multi-payer alignment, including with Medicare.

DETAILS: Federal demonstration programs for primary care have evolved over time to reflect lessons learned and have largely aligned with states' approaches to primary care APMs.

STATE EXAMPLE: In Arkansas, participation in the State Innovation Model was leveraged to scale their patient-centered medical home (PCMH) payment model for primary care. Participation in other federal demonstrations (Comprehensive Primary Care, Comprehensive Primary Care Plus, Primary Care First) aligned well with the PCMH program, maintaining momentum and multi-payer collaboration. Arkansas was also selected as one of four states to participate in the State Transformation Collaborative; through this program, stakeholders have focused on developing an aligned set of quality measures.



Step 5. Advance legislation that expands regulatory authority to develop affordability standards for primary care, drive multi-payer alignment, and create an infrastructure for continued improvement.

5A Create a multi-stakeholder primary care advisory group to make recommendations on payment reform in an ongoing manner.

WHY IT'S IMPORTANT: Primary care advisory groups provide an ongoing forum for multi-stakeholder input to inform strategy and policymaking to strengthen primary care.

DETAILS: Recommendations from the advisory group should broadly address primary care policy needs and be inclusive of all payers. Membership of a primary care advisory group should include, at a minimum, primary care providers, patients, payers, Medicaid, state employee health plans, federally qualified health centers, and the state insurance regulatory agency. Additional members to consider include legislators, self-funded employers, health systems, health insurance actuaries, nurses, the federal Health and Human Services regional director, and the state public health department.

STATE EXAMPLES: Colorado HB19-1233 created the Primary Care Payment Reform Collaborative (PCPRC), which was charged with several responsibilities, including advising in the development of affordability standards and targets for carrier investments in primary care. The PCPRC made recommendations on a definition of primary care and targets for investment which were adopted into regulation.

Alternatively, more focused, topic-specific committees can be created through regulation. Rhode Island's Office of the Health Insurance Commissioner established a Quality Measure Alignment Committee to advise on updates to a standardized set of quality measures.

5B Expand regulatory authority to state insurance regulators to develop and enforce affordability standards for primary care, tied to rate review.

WHY IT'S IMPORTANT: Legislation is needed to grant appropriate regulatory authority to state agencies. State insurance regulators conduct annual rate review of health plans' proposed premium changes. Rate review can be tied to affordability, enabling regulators to consider factors underlying premium increases. Affordability standards establish requirements related to these underlying factors, which may include investments in prioritized services.[8] These standards provide a vehicle for setting targets for primary care payment reform.

DETAILS: These standards should include establishing a definition of primary care in collaboration with stakeholders (i.e., a primary care advisory group), requirements for primary care investment and APM implementation, and data collection from carriers. Legislation can either specify a target percentage or require that insurance agencies specify the target in regulation.

STATE EXAMPLE: Delaware SB120 requires the establishment of mandatory minimums for payment innovations, including APMs and carrier investment in primary care.

5C Establish a state All Payer Claims Database (APCD), if not already in place, and require carrier reporting on both claims and non-claims payments.

WHY IT'S IMPORTANT: APCDs allow for tracking primary care payments over time and determination of whether the state is meeting payment reform goals. Non-claims payments are payments for something other than a FFS claim, such as a monthly care coordination or shared savings payment; FFS claims are tied to the delivery of specific billable services. Reporting on non-claims payments is necessary to monitor APMs.

DETAILS: APCD administrators should be required to provide public annual reports to the legislature on primary care APMs. These reports can be utilized by primary care advisory groups in developing recommendations.

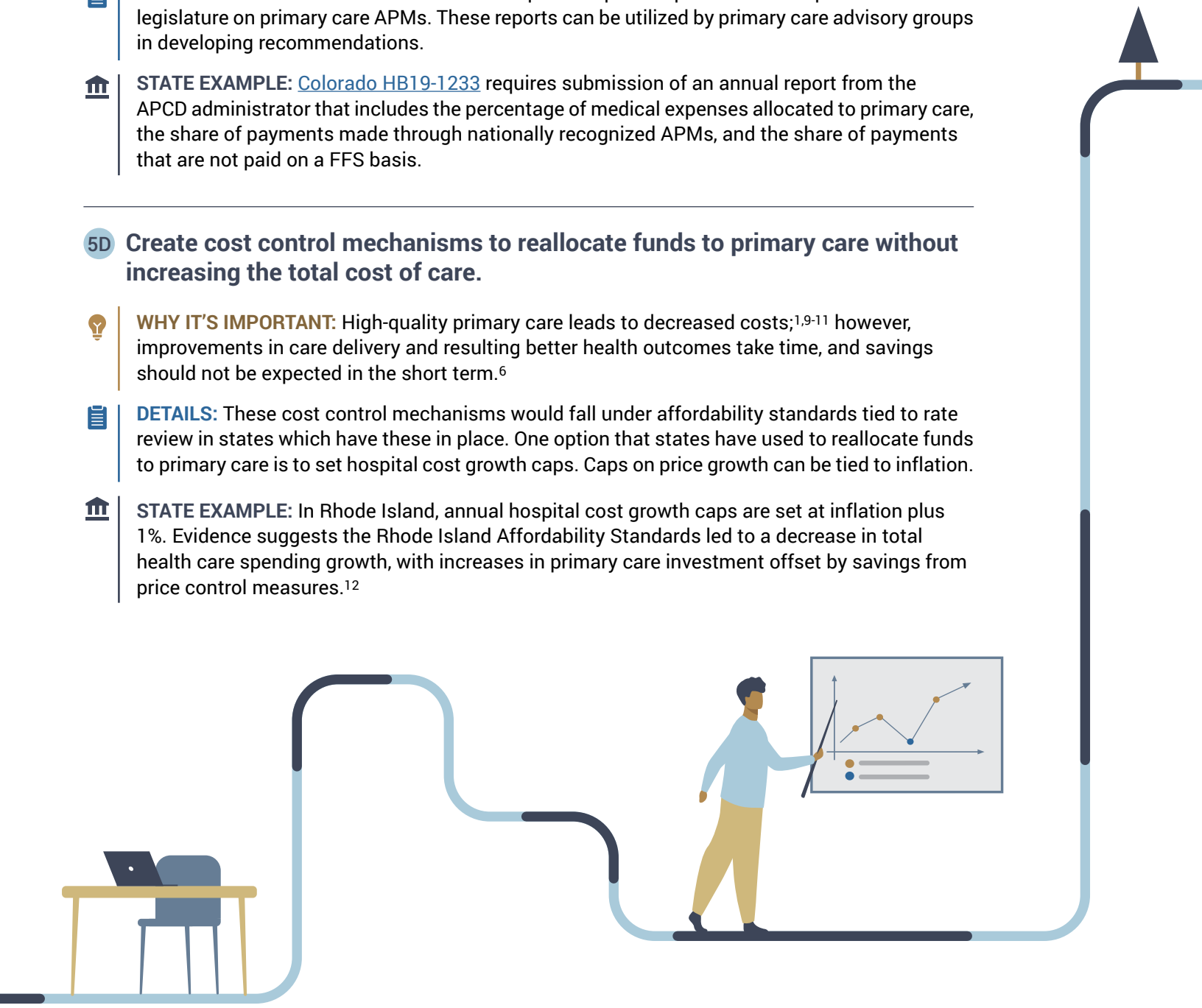
STATE EXAMPLE: Colorado HB19-1233 requires submission of an annual report from the APCD administrator that includes the percentage of medical expenses allocated to primary care, the share of payments made through nationally recognized APMs, and the share of payments that are not paid on a FFS basis.

5D Create cost control mechanisms to reallocate funds to primary care without increasing the total cost of care.

WHY IT'S IMPORTANT: High-quality primary care leads to decreased costs;[1,9-11] however, improvements in care delivery and resulting better health outcomes take time, and savings should not be expected in the short term.[6]

DETAILS: These cost control mechanisms would fall under affordability standards tied to rate review in states which have these in place. One option that states have used to reallocate funds to primary care is to set hospital cost growth caps. Caps on price growth can be tied to inflation.

STATE EXAMPLE: In Rhode Island, annual hospital cost growth caps are set at inflation plus 1%. Evidence suggests the Rhode Island Affordability Standards led to a decrease in total health care spending growth, with increases in primary care investment offset by savings from price control measures.[12]



5E Require alignment across all payers under state jurisdiction (all plans subject to state insurance regulation, Medicaid, and state employee health plans).

WHY IT'S IMPORTANT: Commercial plans under state jurisdiction comprise those in the individual and group markets, which only cover a minority of insured individuals. Approximately 6% of Americans are covered through individually purchased coverage, while 49% are covered through employer-sponsored insurance. Of those receiving employer-sponsored coverage, almost two-thirds are insured by self-funded plans,[13] which are exempt from state regulation under federal law (the Employee Retirement Income Security Act, or ERISA). The remaining 45% of Americans are covered through Medicare, Medicaid, the military, or are uninsured.[14] (These numbers are national averages; actual percentages vary across states.) This fragmentation limits the impact of state legislation and regulation. Incentives or investments that only apply to a small proportion of a primary care practice's patients are not enough to enable significant changes in care delivery. Primary care practices also face increased administrative burden from needing to comply with different requirements across payers.

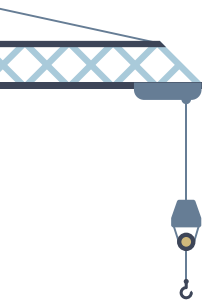
DETAILS: Alignment with state employee health plans and Medicaid (in states with Medicaid managed care) can be supported through contracting requirements. To the greatest extent possible, employers and third-party administrators of self-insured employer plans should be involved in efforts on a voluntary basis as well.

STATE EXAMPLE: The Arkansas Health Care Payment Improvement Initiative (AHCPII) includes Medicaid, the state employee health plan, the largest commercial insurers in the state (Arkansas Blue Cross and Blue Shield, QualChoice), and one of the state's largest self-funded employers (Walmart). Medicaid was expanded in Arkansas through a private option by providing patient cost-sharing support to purchase plans on the health insurance exchange. Legislation requires that all plans on the exchange participate in the AHCPII.

5F Consider creation of an office focused on health insurance regulation to increase capacity.

WHY IT'S IMPORTANT: State insurance regulators cover all types of insurance (e.g., home, auto). As a result, they often have limited capacity and sometimes expertise to implement programs specific to health insurance.

DETAILS: State offices focused on health insurance regulation can be established under the existing department and Insurance Commissioner, or as a separate office under a new Health Insurance Commissioner. Consider establishing a statutory obligation for the new office to direct insurers towards policies that advance the welfare of the public through improved efficiency, health care quality, and access.



STATE EXAMPLES: The Rhode Island Health Care Reform Act created an Office of the Health Insurance Commissioner separate from the Insurance Division managing other types of insurance with its own director. Delaware SB116 created an Office of Value-Based Health Care Delivery within the Department of Insurance under the insurance commissioner. These offices have served as the vehicle for advancing primary care APMs in commercial plans in these states.

Step 6. Set requirements for APM design in regulation that balance standardization and flexibility.

These regulatory changes require that adequate authorities have been granted in legislation, as detailed in step 5B, including the authority to set and enforce affordability standards related to primary care.

6A Ensure a meaningful amount of payment is delivered through non-FFS mechanisms, including prospective payment.

WHY IT'S IMPORTANT: Non-FFS payments need to both include a significant prospective component and be adequate in amount overall to enable improvements in care delivery. Without specific requirements related to the amount of payment delivered through non-FFS mechanisms, carriers can implement APMs that have a minimal care coordination fee or other small adjustments to FFS that do not meaningfully change how the practice is paid. Prospective payments provide greater revenue stability and flexibility over retrospective shared savings and performance-based payments.

DETAILS: There are multiple options for ensuring a meaningful amount of payment is delivered through non-FFS mechanisms, including in prospective payment:

- Define primary care APMs as relying on prospective payment for a specified set of services.
- Set a target for the proportion of overall primary care spend in non-claims payments or prospective payments specifically.
- Require offering the opportunity for practices to participate in APMs that include non-claims payments at least equivalent to Medicare demonstration programs.

STATE EXAMPLES: The Rhode Island Affordability Standards define primary care APMs as relying on prospective payment. Delaware regulation 1322 requires carriers to offer the opportunity for practices to participate in programs where non-FFS reimbursement is greater than or equal to primary care incentive programs offered by Medicare.

6B Standardize quality metrics and care delivery expectations.

WHY IT'S IMPORTANT: Primary care practices often participate in multiple APMs which have different requirements, increasing administrative burden. Aligning parameters of APMs helps to reduce this burden.

DETAILS: Quality metrics and care delivery expectations are common areas of focus for alignment. Care delivery expectations can be set in tracks for participation, tied to differential levels of payment, to meet practices where they are in terms of readiness for APM participation and current stage of advanced primary care delivery. Regulation can further decrease administrative burden by allowing other types of practice certification to qualify for meeting similar competency requirements.

STATE EXAMPLE: Colorado regulation 4-2-96 requires alignment on quality metrics and tracks of core competencies as well as transparency in attribution and risk adjustment methodology.

6C Set guardrails around downside risk.

WHY IT'S IMPORTANT: Downside risk refers to the risk of financial penalty if cost benchmarks or quality targets are not achieved. Downside risk in APMs can be implemented at the level of the primary care practice or an intermediary organization that the primary care practice participates in, such as an accountable care organization (ACO). The financial implications of downside risk at the level of an intermediary organization on the primary care practice may vary depending on their contractual arrangement. At the practice level, downside risk can create a significant barrier to APM participation, as many primary care practices operate without significant margins or reserves. This is particularly an issue during the initial period of APM adoption and for smaller, independent practices.

DETAILS: Guardrails on downside risk can be set through one or more of the following options:

- Require that health insurers assess whether provider organizations have the operational and financial capacity to enter into a risk-sharing contract.
- Prohibit carriers from requiring downside risk for an initial period of APM participation. This would not prevent including downside risk in a contract if mutually agreed upon with the primary care practice.
- Prohibit clawbacks (arrangements that place dollars at risk of needing to be returned to the insurance carrier) for prospective payments.
- Set risk-exposure caps and minimum loss rates.

STATE EXAMPLE: The Rhode Island Affordability Standards require that care management PMPM and infrastructure payments to primary care shall not be at-risk for total cost of care performance but may be at-risk for quality performance. Health insurers are prohibited from entering into a risk-sharing population-based contract with an ACO unless they have determined that the provider organization has the capacity to assume clinical and financial responsibility for provision of covered services. The Affordability Standards also establish risk-exposure caps and minimum loss rates to set boundaries for downside risk in population-based contracts with ACOs.

6D Establish requirements to support behavioral health integration.

WHY IT'S IMPORTANT: Integrated behavioral health services, including for mental health and substance use disorders, contribute to improved outcomes in advanced primary care models but lack sustainable funding.[15-19]

DETAILS: Higher tiers of advanced primary care delivery expectations should include behavioral health integration, tied to additional funding support. Other options for supporting behavioral health integration include prohibiting charging a second co-payment for integrated services if delivered on the same day and in the same location as primary care services.

STATE EXAMPLE: The Rhode Island Affordability Standards include behavioral health integration as part of their practice transformation expectations, prohibit same day co-payments for integrated services, open up Health Behavior Assessment and Intervention codes for behavioral health services delivered as part of the care for a physical health condition, and require adopting policies for behavioral health screenings that are no more restrictive than for other preventive services.

Step 7. Scale and support APM adoption through regulatory targets, data monitoring requirements, and enforcement mechanisms.

These regulatory changes require that adequate authorities have been granted in legislation, as detailed in step 5B, including the authority to set and enforce affordability standards related to primary care.

7A Set targets for APM implementation.

WHY IT'S IMPORTANT: These targets ensure that APMs are broadly scaled rather than only implemented in a small subset of practices.

DETAILS: Targets can be set for the percentage of providers or the percentage of covered lives in APM contracts.

STATE EXAMPLE: Delaware regulation 1322 requires that carriers report on progress toward achieving 75% of primary care providers and care team members with attributed patients participating in eligible care transformation activities.

7B Set targets for primary care investment, if not already done through legislation.

WHY IT'S IMPORTANT: Improvements or additions to care capacities in primary care are not feasible without additional investment.

DETAILS: Permissible categories for primary care investments can include spending on practice transformation support and upfront payments for infrastructure (such as for electronic health records and data analytics). State insurance regulators may allow for flexibility in how carriers meet investment targets, provided any alternative approaches are in line with regulatory aims. Regulation on primary care investment targets should include a provision that changes should not increase patient premiums or other cost-sharing mechanisms.

STATE EXAMPLE: Colorado regulation 4-2-72 sets targets for primary care spend, as a portion of total medical spending, to increase by 1% a year for 2 consecutive years. It also specifies that carriers shall not translate increased primary care spending into higher premiums.

7C Ensure payment intended for primary care ultimately benefits the primary care practice.

WHY IT'S IMPORTANT: Many primary care practices are part of large health systems and/or participate in an intermediary organization such as an ACO. In these structures, the insurer pays the intermediary organization or health system, which then has a separate payment arrangement with the primary care practice. There is a potential risk that incentive structures in APMs and additional investments intended for primary care paid to a health system or intermediary organization may not make it to the level of the practice.

DETAILS: It may be particularly challenging to determine and track the appropriate distribution of certain payment types to primary care, including infrastructure payments and shared savings distributions to health systems or ACOs.

STATE EXAMPLE: The Rhode Island Affordability Standards require insurers to provide a PMPM to primary care practices meeting criteria as patient-centered medical homes. Carriers may make the PMPM payments to an ACO only if there is a contractual obligation to use the funds to finance care management services at the primary care practice.

7D Create multiple mechanisms for data monitoring, including carrier reporting to state insurance regulators on APM contracts and the ability to carry out requests for additional data as needed.

WHY IT'S IMPORTANT: Data transparency helps to alleviate the need to use enforcement tools and monitor compliance with meeting targets. Reporting on APM contracts provides complementary details to APCD data.

DETAILS: Regulation should establish the authority to conduct data calls and market conduct exams as needed for additional information. Reporting requirements on APM contracts may include: selected APM approaches, timelines, the market(s) and line(s) of business involved, financial and quality measurement goals, and how the strategy aligns with other payers' APMs. States can consider a requirement for public-facing versions of carrier APM implementation plans for additional transparency.

STATE EXAMPLES: Delaware regulation 1322 authorizes market conduct exams as necessary, including review of carrier contracts with health care providers. Colorado regulation 4-2-72 includes detailed APM Implementation Plan reporting requirements.

7E Establish a menu of enforcement tools, ranging from corrective action plans to intermediate steps such as fines to denial of rates in rate review.

WHY IT'S IMPORTANT: Rate review is an important tool in the regulatory toolbox; however, it is viewed as a "large hammer" that will rarely be used.

DETAILS: If targets are not being met, a carrier could be placed on probationary status while addressing shortfalls in a corrective action plan. Failure to adhere to the corrective action plan could then lead to other enforcement mechanisms such as fines. Fines should include a penalty cap that is set high enough to dissuade further violations. States may allow waivers of certain requirements or deadlines if carriers are able to demonstrate progress and follow a reasonable adjusted timeline.

STATE EXAMPLE: Delaware regulation 1322 creates options for the insurance commissioner to take if carriers are non-compliant, including submitting a corrective action plan, setting daily fines for failure to submit documents, and imposing fines equal to the plan year's value of any deficiency in meeting payment or cost growth limit requirements.

Step 8. Maintain regular communication in enforcement and implementation.

8A Develop clear guidance on how to meet regulatory requirements, including processes for data reporting and validation.

WHY IT'S IMPORTANT: Designing and reporting on new APMs involves significant operational complexity for insurance carriers. Where standardization is required, carriers benefit from detailed guidance from the state. State agencies have also frequently encountered challenges in obtaining accurately categorized data.

DETAILS: Written guidance can be provided in data submission manuals or broader policy manuals. The guidance may include a summary of relevant regulations, reporting timelines, data specifications, and definitions. Processes for data reporting and validation should include use of standardized templates or forms, reviewing submitted data with carriers to confirm accuracy, and opportunity to request changes as needed.

STATE EXAMPLES: The Rhode Island Affordability Standards Policy Manual provides guidance for regulatory compliance related to primary care spend, APM contracting, use of aligned measure sets, and data specifications. It also includes a checklist to track compliance. The Delaware Office of Value-Based Health Care Delivery provides an Affordability Standards Data Submission Manual and Data Submission Template. The Office meets with carriers at minimum quarterly.

8B In the facilitation of primary care advisory groups, provide adequate level-setting, onboarding, and time for review of materials and iterative discussion.

WHY IT'S IMPORTANT: Primary care advisory groups review detailed, in-the-weeds policy information. Some stakeholders may face steeper learning curves than others and require more background. Facilitators of advisory groups can prevent conflict and improve engagement by naming and addressing common challenges up front.

DETAILS: Onboarding and level-setting should include establishing group rules, including what information is confidential, where antitrust applies, and standards for communication. Reviewing state-specific data, as well as information on other states' experiences, can help drive the conversation.

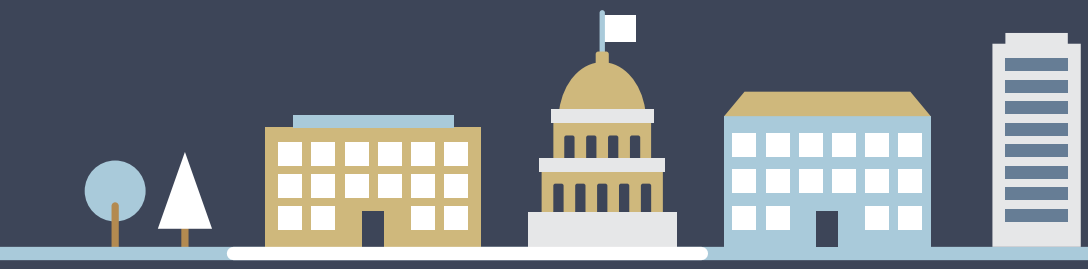
STATE EXAMPLE: The Colorado PCPRC Standard Operating Procedures and Rules of Order sets expectations regarding operational logistics, including communications around meeting materials and decision-making processes.

8C Create opportunities to gather public feedback broadly in addition to input from primary care advisory groups created through legislation or regulation.

WHY IT'S IMPORTANT: Multi-stakeholder primary care advisory groups bring together valuable diverse perspectives but may not be representative of all interested parties and opinions. Offering additional mechanisms for public feedback ensures that everyone has the opportunity to provide input.

DETAILS: Opportunities to obtain feedback beyond established primary care advisory groups include open calls for written public comment, town hall meetings, and having state insurance regulators attend existing meetings held by other stakeholder groups such as professional associations. Intentionally seeking input from patients, as well as primary care providers and practice managers, can yield valuable insights on the anticipated consequences of proposed policy changes on the frontlines.

STATE EXAMPLE: The Delaware Office of Value-Based Health Care Delivery published responses to public comments on their Health Care Affordability Standards report. State officials have leveraged joining existing meetings of professional associations as additional forums to obtain public comment.



Final Thoughts

Primary care payment reform, including through APMs, is a critical piece of the solution to better support primary care. Aligned primary care APMs will decrease administrative burden and enable transformation in care delivery that better supports the health of individuals, families, and communities. States have a key role to play in advancing primary care APMs for payers under their jurisdiction.

For state primary care APM policies to achieve their intended impact, they must:

1. Provide a meaningful amount of payment delivered through non-FFS mechanisms, including prospective payment.
2. Increase investment in primary care.
3. Ensure multi-payer alignment both within the commercial sector and across all sectors of payers.

Resources for additional reading are available in an appendix in the full project report.

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