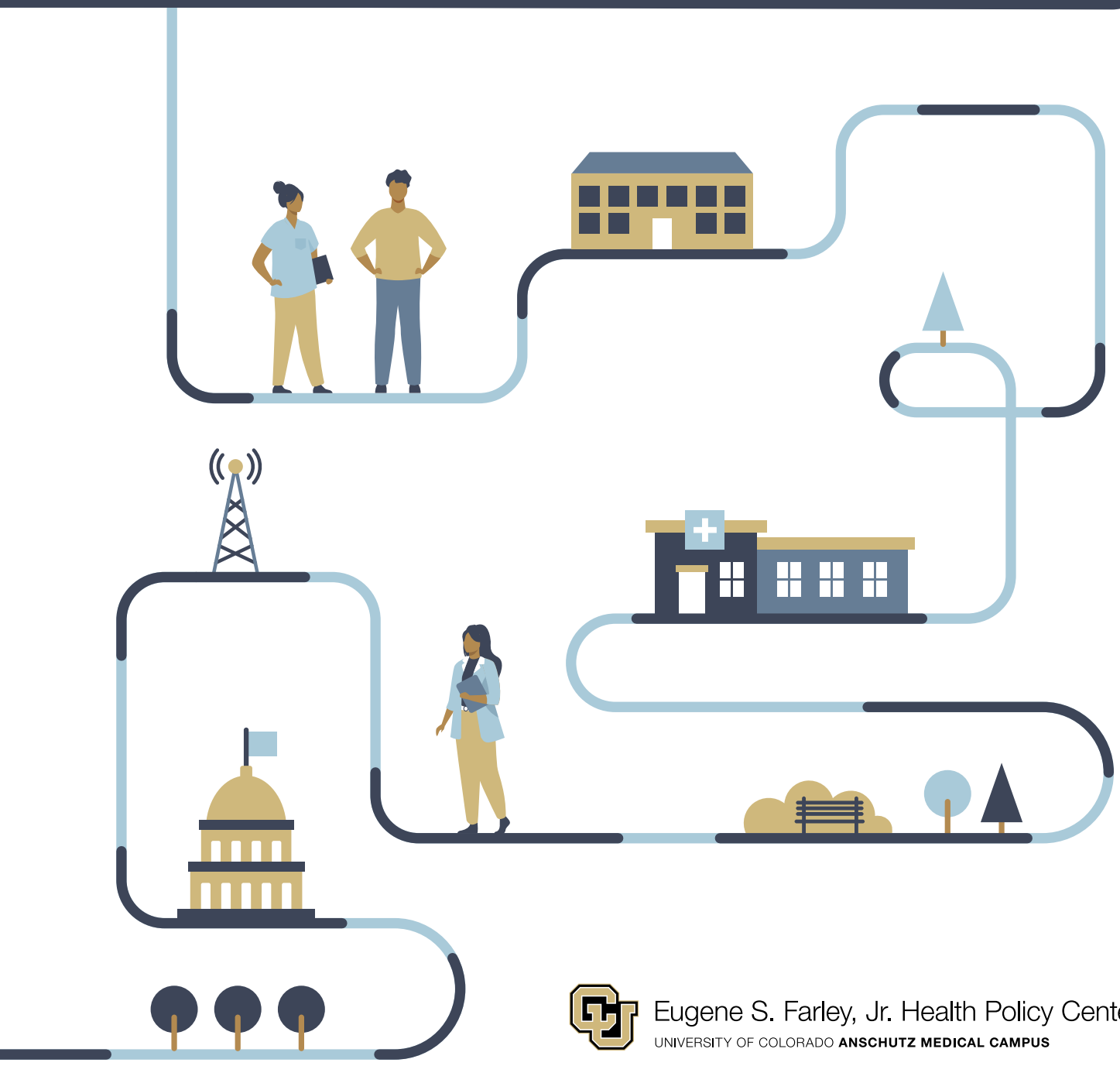
State Policies to Advance Primary Care Payment Reform in the Commercial Sector

APRIL 2025



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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.

About Arnold Ventures

Arnold Ventures is a philanthropy committed to improving the lives of American families, strengthening their communities, and promoting their economic opportunity by investing in research to understand the root causes of America's most persistent and pressing problems. Founded in 2010 by Laura and John Arnold as part of their Giving Pledge commitment to contribute their wealth to charitable causes during their lifetimes, the philanthropy's focus areas include higher education, criminal justice, health, infrastructure, and public finance, advocating for bipartisan policy reforms that will lead to lasting, scalable change.

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Interviewees

Arkansas

- Arkansas Blue Cross and Blue Shield: Alicia Berkemeyer
- Arkansas Center for Health Improvement: Joseph Thompson and Craig Wilson
- Arkansas Department of Human Services: John Selig
- Arkansas Foundation for Medical Care: Peggy Starling
- Arkansas Department of Human Services, Division of Medical Services: William Golden
- Arkansas Medical Society: David Wroten
- Embold Health: Matthew Resnick
- Walmart: Richard Harris

Colorado

- Center for Improving Value in Health Care: Dagmar Velez
- HealthONE Colorado Care Partners: Lisa Rothgery
- Colorado Consumer Health Initiative: Isabel Cruz
- Colorado Department of Health Care Policy and Financing: Trevor Abeyta
- Colorado Division of Insurance: Tara Smith
- Colorado State Legislature: Chris deGruy Kennedy
- Rocky Mountain Health Plans: Patrick Gordon
- University of Colorado, Department of Family Medicine: Venus Mann

Delaware

- Delaware Department of Health and Social Services: David Bentz (former Delaware State Legislator)
- Delaware Health Care Commission and Primary Care Reform Collaborative: Nancy Fan
- Freedman HealthCare: Mary Jo Condon and Vinayak Sinha
- Highmark Delaware: Kevin O'Hara
- Delaware Department of Insurance, Office of Value-Based Health Delivery: Cristine Vogel and Chris Haas
- Westside Family Healthcare: Maggie Norris Bent
- Christiana Care Health System: Rose Kakoza

Rhode Island

- Office of the Health Insurance Commissioner: Cory King
- Blue Cross and Blue Shield of Rhode Island: Nick Lefeber, Cathleen Newman, and Richard Glucksman
- Coastal Medical: Edward McGookin and Christopher Ferraro
- Executive Office of Health and Human Services: Amy Katzen
- HealthFacts Rhode Island: William Hendon
- Rhode Island Business Group on Health: Al Charbonneau
- Wood River Health Services: Alison Croke

Washington

- American Academy of Family Physicians: Karen Johnson (formerly with the Washington Health Alliance)
- Cascade Medical: Tony Butruille
- Foundation for Health Care Quality: Ginny Weir
- Northwest Health Law Advocates: Emily Brice
- Office of Washington State Governor Jay Inslee: Molly Voris
- Premera Blue Cross: Steve Jacobson
- Purchaser Business Group on Health: Raymond Tsai
- Washington Health Alliance: Drew Oliveira (formerly with Regence BlueShield)
- University of Washington Medicine: Michael Myint
- Washington State Health Care Authority: Judy Zerzan-Thul and JoEllen Colson
- Washington State Medical Association: Katina Rue
- Washington State Office of the Insurance Commissioner: Jane Beyer
- Washington State Legislature: June Robinson

Key informants

The following experts participated in initial project visioning calls:

- Agency for Healthcare Research and Quality: Arlene Bierman
- Bailit Health: Deepti Kanneganti
- Center for Health Care Strategies: Rob Houston
- Center for Medicare and Medicaid Innovation: Kate Davidson, Julia Murphy, and Nicholas Minter
- National Conference of State Legislatures: Kathryn Costanza
- Freedman HealthCare: Mary Jo Condon and Vinayak Sinha
- Milbank Memorial Fund: Rachel Block
- National Academy for State Health Policy: Maureen Hensley-Quinn
- National Association of Insurance Commissioners: Brian Webb and Joe Touschner
- Virginia Center for Health Innovation: Beth Bortz

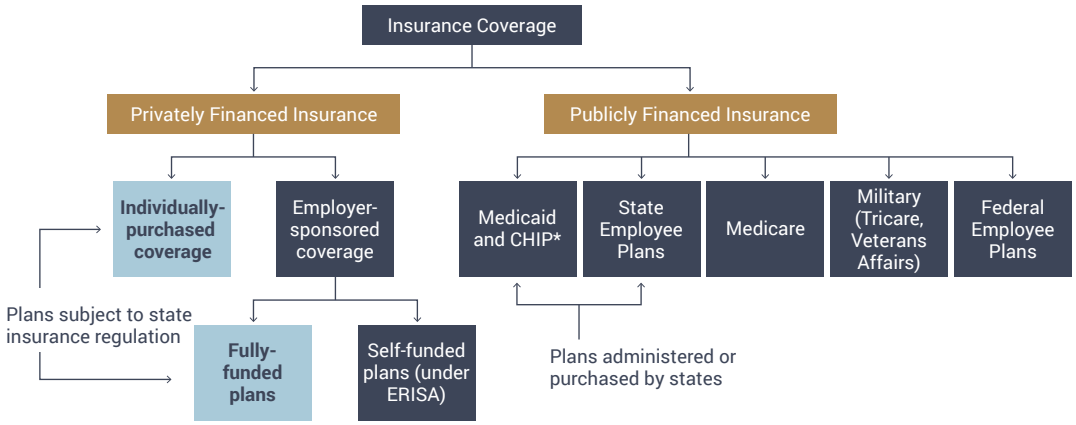
Executive Summary

Despite having the highest spending on health care in the world, many health outcomes in the United States lag behind peer nations.[1] High-quality primary care improves health outcomes, lowers costs over time, and reduces disparities;[2-6] yet this critical foundation of the health care system is crumbling. People across the country are struggling to access primary care,[7] and practices face challenges in recruiting and retaining providers. Workforce shortages are driven by large and pervasive issues plaguing primary care, including historic underfunding relative to other specialties, a reliance on fee-for-service (FFS) payment, and increasing administrative burdens and demands.[8,9] Payment reform is urgently needed to strengthen primary care.

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

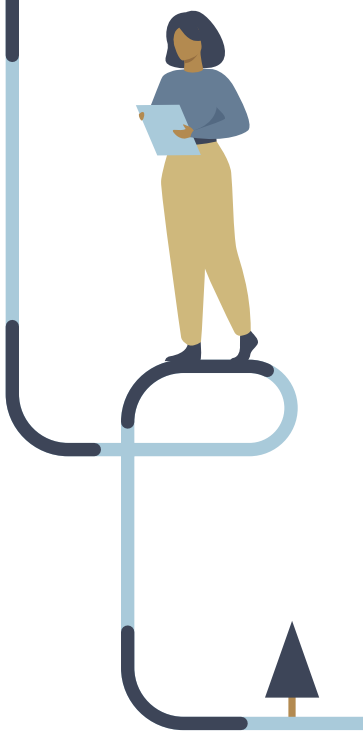
State governments play a critical role in catalyzing primary care payment reform. They act as the payers, purchasers, or regulators for Medicaid, state employee health plans, and fully insured commercial plans in the individual and group markets (See Figure 1). This report focuses on policies advancing APMs for **state-regulated commercial plans** and covers related areas of primary care payment reform found to be critical to their success: primary care investment and multi-payer alignment.

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



Several states have pioneered these policy changes to reform primary care payment and learned lessons that can inform other states' approaches. We detail those lessons learned from five states (Arkansas, Colorado, Delaware, Rhode Island, and Washington) that have taken varied approaches to policy but faced common challenges. These states were selected based on the diversity of their policy approach and state context.

Selected key findings and related recommendations are summarized in Table 1. These recommendations should be ideally situated within a comprehensive state primary care strategy, focused on improving care of patients as its north star and informed by ongoing data monitoring and evaluation. A comprehensive strategy would include aligned payment reform across all state payers and purchasers; workforce supports; and efforts to decrease administrative burden.

Table 1. Key report findings and related recommendations.

AREAS	KEY FINDINGS	RELATED RECOMMENDATIONS
General principles	Multistakeholder input, including from patients, should inform primary care payment reform.	Create a primary care advisory group to make ongoing recommendations on payment reform.
	Primary care alone cannot be expected to reduce the total cost of care in the short term.	Reallocate funds to primary care without increasing the total cost of care or cost-shifting to patients. Consider setting caps on hospital growth.
Roles of different policy levers	Voluntary efforts lay groundwork for subsequent policy but generally lead to little impact in isolation.	Convene stakeholders in advance of legislation, regulation, or participation in federal demonstrations. Involve all payers and purchasers, including employers.
	Legislation is needed to grant appropriate regulatory authority to state agencies.	Expand authority to state insurance regulators to develop and enforce affordability standards for primary care, tied to rate review. Affordability standards should include targets for APM implementation.
	Federal demonstrations create an ongoing structure to advance APMs and multi-payer alignment.	Apply for participation in primary care federal demonstration projects when available.
Payment reform principles	Increased primary care investment enables improvements in infrastructure and team-based care.	Set targets for primary care investment.
	Prospective payments support flexibility in care delivery and create revenue stability.	Ensure a meaningful amount of payment is delivered through non-FFS mechanisms, including prospective payment.
	If the amount of non-FFS payment in an APM is too small, it will not support changes in care delivery.	
	Multi-payer alignment is necessary to ensure meaningful impact and avoid increasing administrative burden or furthering complexity.	Require alignment across all payers under state jurisdiction (e.g., state-regulated commercial plans, Medicaid, state employee health plans).
		Standardize components of APM design, including quality metrics and care delivery expectations.
Monitoring & enforcement	State insurance regulators need tools to monitor and enforce primary care payment policy.	Create multiple mechanisms for data monitoring, including carrier reporting on APM contracts and the ability to hold data calls and market conduct exams.
		Establish a menu of enforcement tools, from corrective action plans to fines to rate review.

Table 11 in the Appendix includes the full list of report findings. The Policy Recommendations section details the complete list of recommendations for state voluntary efforts, legislation, regulation, and implementation with accompanying state examples. The recommendations from this report have also been organized into a streamlined, stepwise guide, Advancing Primary Care Payment Reform in the Commercial Sector: A State Policy Playbook.

For state primary care APM policies to have their intended impact without significant negative unintended consequences, they must:

1. Move towards "advanced" APMs that truly enable and incentivize change, particularly those with meaningful amounts of prospective payment.
2. Increase investment in primary care.
3. Improve multi-payer alignment in both of these efforts, not only within the commercial sector but also across sectors.

Success in the movement to advance aligned primary care APMs will decrease administrative burden and enable transformation in care delivery that better supports patients' health.

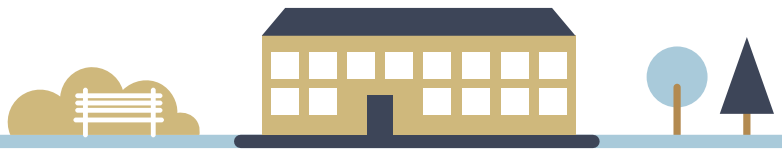
Definitions of terms

Alternative payment model (APM): approach to payment that incentivizes high-quality and cost-effective care.

High-quality primary care: provision of whole person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.[10]

Prospective payment: predetermined payment for all services in a defined period of time (e.g., a per-member, per-month [PMPM] amount) or for all services related to a given condition, paid independent of the volume of services delivered.

Multi-payer alignment: adoption of similar goals, payment models, and/or model features across payers.



Introduction

Background

Despite having the highest per capita spending on health care in the world, many health outcomes in the United States lag behind peer nations.[1] High-quality primary care improves health outcomes, lowers costs over time, and reduces disparities;[2-6] yet this critical foundation of the health care system is crumbling. People across the country are struggling to access primary care,[7] and practices face challenges in recruiting and retaining providers. Workforce shortages are driven by large and pervasive issues plaguing primary care, including historic underfunding relative to other specialties, a reliance on fee-for-service (FFS) payment, and increasing administrative burdens and demands.[8,9] Payment reform is urgently needed to strengthen primary care.

Shifting away from FFS to alternative payment models (APMs) is one approach to better support primary care and improve health outcomes and reduce health care costs in the United States. APMs are designed to improve care delivery, reward quality, and incentivize cost control. However, without alignment across all payers, including commercial and governmental payers, efforts to change care delivery through APMs will only apply to a subset of a practice's patient population and fall short on incentivizing change.

National experts have called for increasing investment in primary care, shifting FFS to hybrid models that include prospective funds, and aligning efforts across payers (see callout box for additional detail).

National Recommendations for Primary Care Payment Reform

In a landmark report, the National Academies of Sciences, Engineering, and Medicine (NASEM) laid out an implementation plan for high-quality primary care.[10] Related to payment, these recommended actions center on the objective of paying for primary care teams to care for people, not for doctors to deliver services.

Action 1.1: Payers (Medicaid, Medicare, commercial insurers, and self-insured employers) should evaluate and disseminate payment models based on the ability of those models to promote the delivery of high-quality primary care, as defined by the committee, and not on their ability to achieve short-term cost savings.

Action 1.2: Payers (Medicaid, Medicare, commercial insurers, and self-insured employers) using a fee-for-service (FFS) payment model for primary care should shift primary care payment toward hybrid (part FFS, part capitated) models, making them the default method for paying for primary care teams over time. For risk-bearing contracts with population-based health and cost accountabilities, such as those with accountable care organizations, payers should ensure that sufficient resources and incentives flow to primary care. Hybrid reimbursement models should:

- **A** Pay prospectively for interprofessional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations.
- **B** Be risk-adjusted for medical and social complexity.
- **C** Allow for investment in team development, practice transformation, and the infrastructure to design, use, and maintain necessary digital health technology.
- **D** Align with incentives for measuring and improving outcomes for attributed populations.

Action 1.3: The Centers for Medicare & Medicaid Services should increase the overall portion of spending going to primary care by:

- **A** Accelerating efforts to improve the accuracy of the Medicare physician fee schedule by developing better data collection and valuation tools to identify overpriced services, with the goal of increasing payment rates for primary care evaluation and management services by 50 percent and reducing other service rates to maintain budget neutrality.
- **B** Restoring the Relative Value Scale Update Committee to the advisory nature as originally intended by developing and relying on additional independent expert panels and evidence derived directly from practices.

Action 1.4: States should implement primary care payment reform by:

- **A** Using their authority to facilitate multi-payer collaboration on primary care payment and fee schedules.
- **B** Measuring and increasing the overall portion of health care spending in their state going to primary care.

The federal government has taken several key steps in line with these recommendations, including Center for Medicare and Medicaid Innovation (CMMI) primary care-focused demonstration models with hybrid payment such as Making Care Primary (now scheduled to end early) and the 2025 update to the Medicare physician fee schedule that creates a new Advanced Primary Care Management (APCM) payment, which practices can bill monthly to support additional care capacities. The previously introduced federal Pay PCPs Act of 2024 would authorize hybrid payments under Medicare, decrease patient cost-sharing for primary care services, and create a new advisory panel to improve the valuation of services in the Medicare physician fee schedule.

As the payers, purchasers, or regulators for Medicaid, state employee health plans, and commercial plans in the individual and group markets, state governments play a critical role in catalyzing primary care payment reform, as well as supporting multi-payer alignment. Several states are pioneering changes to address rising health care costs and improve access and quality, including through primary care payment reform. The federal government and state leaders can learn bidirectionally from one another as they pursue primary care reform.

While there are recent reports that lay out recommendations for primary care payment reform for state Medicaid agencies,[11] synthesized recommendations for state-level policy in the commercial space are lacking. In this report, we lay out policy considerations to advance payment reform for primary care in the commercial sector under state jurisdiction.

Project Aim and Approach

This project examines 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. Findings are synthesized in recommendations to inform future state policy work.

To select states to examine, we conducted an initial environmental scan of state documents and organizational reports and held informational calls with subject matter experts. Criteria for selection included diversity of geography, population size, political landscape, payer mix, history of participation in federal payment demonstrations, and policy levers used to advance APMs for primary care. We included states both with and without targets for primary care spend and total cost of care. Based on these criteria, we selected Arkansas, Colorado, Delaware, Rhode Island, and Washington. See Table 2 below for brief summaries of policy approaches and unique features.

We conducted 47 semi-structured interviews (7-13 per state) with interviewees identified by experts, state documents, and snowball sampling. Interviews were conducted from November 2023 through June 2024. Interviewee stakeholder types included representatives from health plans, primary care practices, patient/consumer advocacy organizations, state agencies responsible for health insurance regulation, state Medicaid agencies, managers of All Payer Claims Databases (APCDs), health systems, state legislators, purchasers, and other state-based health care stakeholder groups engaged in payment reform. Interviews were recorded, professionally transcribed, and uploaded to Atlas.ti for data management. Transcripts were analyzed for themes using an inductive approach, and themes were iteratively recategorized through discussions of the full research team. The summarized findings were supplemented with information from state documents and reports.

Table 2. Brief synopses of selected states' policy approaches to primary care payment reform and their unique features. The State Snapshots section includes timelines with additional detail.

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

Findings

The findings from the interviews are summarized below, supplemented with information from state policies and reports. We utilize the term interviewees to refer specifically to informants, and the term stakeholders to refer more broadly to groups interested or involved in primary care payment reform. Findings are organized by category and listed in bold. State examples are included throughout. For additional detail on the state examples, see the State Snapshots section.

Stakeholder Goals & Objectives

"Figuring out a way that primary care is independent, sustained, and well-funded seems to me like maybe the very biggest thing we can do to improve health care in America."

What drives stakeholder interest in primary care APMs?

There is broad consensus across stakeholders that FFS models are limiting and that implementing primary care APMs supports achieving higher quality, lower costs over time, and more equitable health outcomes.

Interviewees were in agreement that primary care is essential to a strong health care system and viewed primary care APMs as one component to address the total cost of care. At the same time, interviewees recognized that primary care is not a main driver of health care costs and the impact of primary care practice transformation on cost trends takes time. Significant decreases in costs should not be expected in the short term as a result of primary care payment reform alone.

Practice Experience Participating in APMs

What has been the experience of primary care practices with APMs?

Primary care providers have advocated for moving away from FFS and appreciate participating in APMs that provide funds upfront and in an ongoing, prospective fashion.

Primary care providers and professional associations have championed primary care payment reform in multiple states. Models that come with increased investment in the forms of prospective payments, such as federal demonstrations like Comprehensive Primary Care Plus (CPC+) and the Arkansas PCMH program adding per-member, per month payments (PMPMs) to FFS payments, have generally been well received by providers. The flexibility of prospective payments allows for care delivery to be more innovative, tailored to patient population needs, team-based, and focused on whole person care. Interviewees highlighted valuable examples of the use of flexible funds, such as use in distributing home blood pressure cuffs or addressing specific needs related to the social determinants of health like transportation. For one payer that transitioned to full primary care capitation, there was significant initial resistance but subsequently a lot of provider acceptance and appreciation.

Additional upfront funds to support infrastructure, data analytics, and administrative overhead have made the adoption of APMs possible. Some practices, especially smaller ones, have not found the amounts of prospective payments or upfront funds in current or past models to be sufficient for practice transformation. In Delaware, a grant program administered by the Delaware Medical Society supports infrastructure development funds for practices.

Not all APMs or features of APMs are well-received and some providers, even while seeing the faults in FFS, are hesitant to change the status quo.

> *"I think when it comes to it, you don't get that money until a year later. There's no upfront investment. The upfront investment is on the provider. For an organization like [us] that doesn't have a hefty margin or any type of margin to work with, that investment is really hard to swallow."*

Shared savings payments have been used to support building infrastructure. However, if a practice or system is relying on reinvesting shared savings or quality bonus payments to support population health, this can be challenging to plan for without having stability or predictability of payments year to year. Quality bonuses and shared savings payments may not be received until 18 months after the end of a performance period. It may also be more difficult for providers to achieve shared savings over time, as successful efforts to become more efficient lead to fewer subsequent opportunities to reduce costs. Similarly, tying PMPM payments to past performance or requiring "clawbacks," in which these payments are at risk of being returned to payers if performance targets are not achieved, also create hesitancy and instability and undermine the benefits of prospective payment.

One payer noted they built trust in provider participation in capitated models through reassurance that they would not change capitated rates solely based on metric performance. Instead, they met with practices to discuss any significant decreases in performance, for example reviewing change in emergency room utilization to understand if there was a valid reason such as changes in population acuity. They then worked with practices to identify underlying needs, such as expanding after hours care or member education. This payer noted that they had never had to terminate a provider contract because of performance because "we've always been able to sit down and just talk about issues and resolve them."

Some providers shared the view that value-based care is "a misnomer," questioning "who is the value to" and expressing concerns about payers being able to define what value means. Providers value autonomy and efforts that are clinically meaningful. Tensions arose between providers who felt that they should have autonomy to decide what constitutes good care and be paid more for having advanced primary care capabilities in place, and payers who felt that providers must demonstrate improvements in efficiency and quality metrics to justify higher payments.

> *"Power should go back to the providers to determine what their patients need and therefore what value should be measured. Ultimately, providers have to carry out the care, so they should be involved in defining value and quality metrics – you need their buy-in."*

Provider concerns related to current quality metrics incentivized in APMs include:

- Inflexibility for individual patient circumstances.
- Failure to recognize different approaches to care that are also clinically appropriate (e.g., measuring diabetes management by medication adherence has inadvertently penalized practices that were able to control patients' diabetes through lifestyle approaches).
- Emphasis on a narrow set of metrics with a lack of whole person or patient-centered metrics.
- Inadequate incorporation of input from stakeholders (especially in pediatrics).
- Being measured on total cost of care or otherwise having accountability for outcomes felt to be outside of providers' control.

Some providers were dissatisfied with the idea of tying increased investment to APM participation and suggested the first year of APM implementation should be investment-only while the second year could involve value-based contracting.

Practice leaders report significant administrative challenges with APM participation, including variability in model designs, requirements, and quality metric reporting; lack of data; coding burden; and inaccurate attribution.

Primary care practices face many sources of administrative burden at baseline, including obtaining prior authorizations, completing paperwork and documentation, and submitting claims to multiple payers. Those that elect to participate in APMs often encounter new and additional administrative challenges; engaging in advanced primary care requires committing resources to support data collection and analysis, quality improvement and reporting, and patient attribution.

Poor alignment of requirements and quality metrics across payers create competing or sometimes conflicting incentives, making it difficult for practices to integrate APM goals into clinical workflows. When APMs cover only a small pool of patients, there are not sufficient incentives or supports to invest in changes to care processes. For example, if a practice is getting resources to support change in care delivery (e.g., a care coordination fee) from only one payer, the dollars are not enough to "allow them to do anything." Practices strive to provide the same level of patient care across their entire patient population, agnostic to their payer source. This is both an ethical concern and a practical one: implementing one set of processes for one payer contract and different processes for another is "a road to insanity for any clinic."

Practices noted that access to data from payers on quality metrics was inconsistent, and when it was passed to practices it was often inaccurate, leading them to create their own data reports. Practices also noted a lack of access to additional data that would help with overall APM goals, such as quality and cost of specialist care to inform referrals. Regular and accurate feedback on practice quality performance, including through dashboards, supports provider engagement.

Finally, smaller practices did not have bandwidth, funding, or expertise to convert data to clinically actionable information. For example, larger practices were able to use data to inform patient outreach, care management initiatives, and accurately capture complexity of their patient populations through coding, but smaller practices lacked this capacity.

Practice ability to adopt APMs may be supported by participating in federal demonstration programs; being part of a large health system, ACO, or CIN; and receiving technical assistance and peer learning opportunities through state- or payer-led initiatives.

Participation in federal demonstration programs enhances practice readiness to participate in other APMs.

Federal demonstration projects spurred many practices to develop workflows and services that overlapped with other payers' APM requirements, such as proactive population outreach for chronic care management, and made them feel more ready to participate in additional models. However, it was noted that some of these demonstrations did not cover a high enough percentage of the practice's patient population, did not sufficiently influence or include commercial payers, were not sustainable when the funding period ended, or were limited in scope (i.e., limited to addressing social determinants of health).

Being part of a large health system provides useful infrastructure for practices to participate in APMs; however, this has led more practices to join large systems and contributed to practice consolidation.

Larger systems include specialist networks and dedicated staff for administration and data management that support APM participation. The need for greater infrastructure to participate in APMs has driven more independent practices to join health systems, furthering health care consolidation.

Accountable care organizations (ACOs) and clinically integrated networks (CINs) support APM participation through centralized support and aggregation of requirements, particularly for smaller independent practices.

Aligned APM design across payers would be the most effective way to address the current variability in requirements. However, within the existing system, participating in ACOs and CINs improves practices' ability to participate in APMs by taking on the administrative complexity of aligning highly variable APM designs, requirements, and metrics, including aggregating data across contracts. By consolidating smaller practices' patient pools, these organizations were able take actions that would have been cost prohibitive for a single practice, such as taking on downside risk and providing centralized behavioral health, care management, and coordination services as well as analytic support. Having an integrated network of specialty care providers through these organizations supports cost control efforts. ACOs have been particularly successful at achieving savings if they are physician-led (as opposed to hospital-led) and if a larger share of ACO physicians are primary care physicians.

Specific standards for an ACO can be useful to assist smaller practices in participating in APMs. Rhode Island issued clear standards to become an accountable entity with a minimum of 5,000 covered lives and provided a roadmap, after which five smaller practices came together to create a nonprofit with a greater number of pooled patients to more effectively participate in APMs.

State- or payer-led initiatives can support APM adoption by facilitating practice transformation through peer learning and technical assistance.

Interviewees cited having an organization dedicated to helping practices transition to APMs and convene diverse practices as a valuable tool for successful implementation. While ACOs or CINs may take on some of these roles, in some states a state agency (Medicaid in Washington), federal-state partnership (the Health Care Payment Learning and Action Network [HCPLAN] State Transformation Collaborative), payer (Blue Cross Blue Shield in Arkansas) or a third party (Care Transformation Collaborative in Rhode Island [CTC-RI]) have provided these supports. State-led initiatives can be funded through payer contributions as part of primary care investment requirements. CTC-RI was originally convened by the Office of the Health Insurance Commissioner (OHIC) and later incorporated as a 501c3 with funding from public and private payers as well as grant funding from government and non-governmental sources. These organizations facilitated APM participation through the creation of peer learning networks where practices could learn from one another, technical assistance with data analysis, addressing feedback from practices about implementation challenges, and providing ongoing updates about changes to requirements or metrics.

Results of APM Policy

How has primary care APM policy progressed in pioneering states?

Policy change to advance primary care APMs has been incremental and iterative.

Each of the five states examined has made advancements in primary care APM policy, over varying lengths of time and through different approaches. Across states, interviewees shared that work on primary care APMs and multi-payer alignment takes a lot of time and requires a willingness to continuously iterate. Delaware interviewees noted that early legislation grew awareness in the General Assembly around the need for further efforts supporting primary care but that if they had attempted to make all the changes at once "it probably would've been way too much." While interviewees shared benefits of an incremental approach, they also noted that it can take several years of preceding policy steps to arrive at regulation on primary care APMs.

Some regulations were recognized as only providing an initial step towards desired goals, but even these initial steps create a "backstop and a really powerful tool to be building from." In Colorado, voluntary multi-payer alignment work in 2021 led to legislation in 2022 and then regulation in 2023. This regulation was felt to be a "first iteration," particularly related to having requirements around attribution and risk adjustment be largely limited to transparency. Interviewees underscored the role of evaluation to see if regulation is achieving a dent in administrative burden and noted this should inform further iterations.

What have been the results of APM policy to date?

Overall, state policies on primary care APMs have led to positive changes in terms of some implementation and scaling of new models or improvements to existing models but have been disappointing to many stakeholders due to the small proportion of patients under these contracts and insufficient multi-payer alignment. The ultimate impact of these policies on costs and health outcomes will take more time to observe. In some cases of more recently enacted legislation and regulation, it is also too soon to determine the more intermediate impact on payers' APMs.

Regulation requiring primary care APMs has led to some improvements to models or implementation of new models by payers.

In Delaware, commercial payers have been meeting primary care investment and APM targets set out in regulation, including adoption by carriers that previously did not have any value-based programs in place. However, at the time of our interviews, it was unclear if all carriers would meet 2024 targets. In some cases, meeting these targets involves small changes or tweaks to existing programs, like adjusting quality metric programs to meet targets for non-claims primary care spend. However, regulation has also led to more transformative change, with some payers funneling increased investment into prospective care management fees. In Rhode Island, regulation has led to payers implementing primary care capitation, with interviewees noting early results of decreasing health care professional burnout and practice redesign for team-based care. One payer noted that they were already planning to move towards more APM implementation, but policy change accelerated the work.

Despite some movement on APM implementation, the overall impact of state APM policy efforts on primary care has been limited, due to (1) lack of multi-payer alignment, (2) the narrow scope of the market under state insurance regulation, (3) lack of mandated requirements, and (4) lack of granularity in policy around what qualifies as an APM.

> *"All of these things we talked about have had some impact, but it's been very narrow. I think that that's been a disappointment to a lot of people, but the good news is the framework's there to increase its scope."*

Across states, multiple interviewees lamented the limited impact of policy change specific to plans under state insurance regulator jurisdiction, sharing "on the ground I can't see much of a difference." Some interviewees cited estimates of their state-regulated commercial plans as being 10-15% of the overall health insurance market, "really a small sliver of who actually comes into primary care." (Employer self-funded insurance plans are exempt from state regulation under federal law [ERISA], and state employee health plans and Medicaid fall under other state agencies' jurisdiction.) When there isn't a significant increase in investment and shift away from FFS for a large enough proportion of a practice's patient population, there is not significant change in care delivery.

Policies that are voluntary or do not include a mandate have not led to significant results. Interviewees in Colorado noted they had not seen any change in provider contracts as a result of the target (without a mandated requirement) for 25% of primary care payments to be prospective. In Washington, interviewees reported they observed no significant changes in payer contracts as a result of the voluntary memorandum of understanding (MOU). One interviewee noted that additional details around model design and expectations in the MOU would have been helpful to support making changes.

Where there are vague requirements for what constitutes a primary care APM, particularly related to the proportion of payment that is not FFS, it is unlikely to lead to meaningful change for practices.

> *"One thing that we find in a lot of states is there is a lot of APM adoption and there's very little value-based payment. What you have is APMs in name only. I think it's really dangerous, honestly. Because what happens is, you have people saying, 'Well, APMs don't work.' It's like, well, nobody ever had any money to put value-based care in place, so that's why it's not working because nothing actually changed. You don't really know if it's working, because nothing changed. It just changed the name only."*

Compromises in policy (e.g., avoiding mandates) have decreased stakeholder opposition but constrained the intended impact.

Policy compromises across the states examined include targets or recommendations without mandates, exclusions for certain types of carriers, adjustments to hospital price cap methodology, and sunset provisions. Delaware SB120 set growth caps on hospitals to offset the increased investment in primary care; in order to mitigate stakeholder opposition, a sunset provision was added to the growth caps. Interviewees noted a concern that compliance with regulation may stop prematurely and speculated that non-compliance is unlikely to be penalized as the sunset approaches.

In Colorado, integrated carrier-provider networks are excluded from components of legislation apart from quality metric reporting. As a result, large carrier-provider networks in the state, such as Kaiser Permanente and Denver Health, have been excluded from many of the requirements of these laws. Interviewees noted that the portion of the insurance market under the jurisdiction of the Division of Insurance (DOI) is already small, and "having that pie get even smaller through some legislative and lobbying efforts was disappointing." Early conceptualizations of Colorado HB22-1325 would have required a single "gold standard" APM; while this was removed as a compromise in favor of aligning only on parameters of APMs, bill proponents declined compromising on making these aligned parameters voluntary rather than compulsory. Language that APMs should include prospective payment was also left in the bill, but this language was not included under the minimum parameters that had to be established by the DOI. The subsequent regulation 4-2-96 does not include requirements for prospective payment, though this may be considered in future iterations of the regulation.

What state, market, and other contextual factors have impacted the advancement and momentum of APM policy?

The COVID-19 pandemic highlighted the need for APMs but also created delays in progress.

The impact of the COVID-19 pandemic on APM advancement and adoption was both positive and negative. The drops in visit volume early in the pandemic led to significant strain on primary care practices receiving primarily FFS reimbursement, and there was widespread concern that primary care practices would face closures. Capitated payments allowed flexibility in care delivery and cash flow that allowed primary care practices to stay afloat. For example, interviewees in Arkansas reported PMPM payments were "life-saving" during this time.

However, the pandemic also caused significant slowing of momentum around APM policy as stakeholder attention was focused on the public health emergency. In Rhode Island, a planned working group to assess provider, insurer, and patient experience under APMs was not convened. In Colorado, regulation with mandates for increasing primary care investment and targets for prospective payments was delayed by a year. In Washington, work on a non-binding MOU was paused for about 6 months as providers and payers were too busy to engage in the work, even as they recognized there was a greater need for it.

The individual makeup of the insurance market in each state varies and can affect the ability of a state to implement APM reforms.

Where there are fewer commercial insurance plans in the state-regulated market, there is an opportunity to reach a greater proportion of the health insurance market through adoption by a smaller number of payers. In states where there is a higher proportion of self-funded employer plans, states are further limited in the proportion of the market they can impact.

The consolidation of health systems and hospitals limits competition and the negotiating power of insurance companies. In Delaware, consolidation has led to an "unusual market" where the carriers "need every hospital in their network."

The state political climate shapes the ability to advance primary care payment reform.

Changing political climate in a state can sometimes spur action. For example, in Arkansas, the state budget crisis created a window of opportunity for reform where there was previously not enough political will. In Colorado, having a Democratic "trifecta" across the Governor's office, House, and Senate supported the passage of legislation on multi-payer alignment.

Barriers to APM Policy

This section covers barriers to APM policy and multi-payer alignment; solutions to these barriers are covered in subsequent sections.

What barriers have states encountered while working with stakeholders to advance primary care APM policy?

Insurance carriers desire flexibility to design their programs without restrictions or mandates.

Insurance carriers generally want "to be left to their own devices to do this their own way" and be able to maintain APM work already underway that has been successful. Concerns from carriers regarding Colorado HB22-1325 on multi-payer alignment led to significant alterations in the policy, including moving away from the idea of having a "gold standard" APM, which would have created a standardized model for the state.

Some carriers expressed views that the burden of state regulation on primary care APMs has become too high, particularly when taking into account other concurrent health insurance regulatory changes. However, multiple payers also voiced commitment to working on primary care payment reform with the state, and in some cases shared a lack of concern around mandates because they were already compliant with requirements.

Some insurance carriers are hesitant to implement primary care APMs due to operational complexity.

Designing new payment models from scratch and ensuring successful implementation requires significant time and resources from carriers. Where standardization is required, carriers benefit from detailed guidance from the state.

Carriers often have a strong focus on provider accountability; some view prospective payment as "pay[ing] providers for work they haven't done yet." Many carriers also lack the infrastructure necessary to implement capitated payments, which can be particularly resource-intensive to build. Once this infrastructure is in place, close attention to detail is necessary to ensure successful implementation. In one example, a payer found success in piloting capitated payments first on a smaller scale to allow for manually fixing errors, with regular communication to the participating practices about payment calculations. Providers need this transparent sharing of data from payers to negotiate a capitated rate they feel is fair and equitable to them.

Carriers often have differences in their APM programs across lines of business because of differences in patient populations, however this adds to operational complexity and has led to some internal efforts to standardize measurement across a carrier organization. Carriers also report that increasing primary care investment without increasing premiums or the total cost of care in the short term presents an additional operational challenge.

While many insurance carriers have hesitation around implementing APMs, particularly those with prospective payment, there are payers that have developed successful innovations, including multiple examples of implementing full primary care capitation. Administering a fully capitated APM may be less complex than a blended capitated-FFS model, and if there are tools to monitor and ensure access if productivity falls, a FFS component may not provide a significant value-add.

Health systems may not recognize the value of participating in primary care payment reform or face significant challenges in doing so, including having one tax identification number for multiple specialties, receiving payments off-cycle from budgeting, and facing myriad requirements across APM contracts.

> *"Sometimes, from a hospital system, primary care is really just to prevent readmissions and decrease length of stay. If you're purely thinking about what serves the hospitals, and we have to articulate that primary care is that and more. Navigating that, I think it benefits from telling a more shared common story about our mission, vision, values and strategic plan."*

Primary care tends to be viewed as a loss leader that requires subsidization within health systems, where it makes up "a small fraction of the fee-for-service money that comes in." Health systems focus on more lucrative revenue-generating specialty care and see primary care's functions from a very narrow lens of specialty referrals and decreasing hospital costs and penalties.

Where all specialties are operating under one tax identification number (TIN) for a large health system in a unified contract, health systems may view having a separate program for primary care as overly complex. Health systems may also hesitate to innovate in their contracts if they have negotiated very favorable FFS rates. Even when there are programmatic opportunities for primary care, reaching consensus across specialties delivering primary care (family medicine, general internal medicine, geriatrics, pediatrics, and others such as obstetrics/gynecology when included in the definition of primary care providers) presents challenges given the differences in populations. Health systems benefit from having a unified voice representing primary care interests and a united governance structure across specialties and service lines to work on value-based care and participation in federal models. One health system reported that they were able to manage participation in primary care payment reform because they did have separate TINs.

Large health systems with specialized centers that receive outside referrals, such as cancer or transplant centers, may lead patients being seen there to be listed as attributed to primary care within the system, even if they are receiving primary care elsewhere. Such misattribution is particularly challenging since those patients tend to have very high healthcare costs.

Significant delays in receiving shared savings reconciliation payments mean that the receipt of those payments occurs off-cycle from budgeting, creating operational challenges. Prospective payments from programs like Making Care Primary were highlighted as valuable since it "pays us up front and gives us investment specific to primary care, which helps build capacity without waiting for – did we make money or lose money in [shared savings]?"

As with any other health care provider or facility, health systems participating in a large number of APM contracts with different payers face numerous reporting requirements unless these efforts are well aligned. One health system shared their attempts to consolidate value-based care efforts by creating "value levers," or the capacities and capabilities necessary to meet requirements across contracts, such as having panel navigators and processes for care gap closures. Developing workflows as part of value-based care for the patients covered under these APM contracts is further complicated when the payers covering the majority of patients are still operating in a mostly FFS system.

Multiple types of stakeholders share a concern that increasing investment in primary care and increased administrative costs of implementing APMs for carriers could lead to higher premiums for consumers without appropriate attention to other mechanisms to control costs.

Stakeholders generally recognize the value of investing in primary care to enhance access and quality, but desire to preserve affordability for consumers and understand that investments will likely lead to long term rather than short term savings. The challenge then becomes how much to reallocate to primary care to offset initial investments and from which source. Several of our interviewees alluded to the "pie" concept: the "health care pie" is only so big, and if the entire pie is not increasing in size, one must adjust the sizes of the individual pieces (e.g., primary care, specialty care, hospital services, pharmaceuticals).

Interest and engagement from the public in primary care APM policy has generally been low due to its technical, "in the weeds" nature; lack of awareness; and sometimes alienating messaging.

> *"I think until we can get out of this framework of cost savings first, how it impacts people next, we're A, not going to actually have the cost savings we want and B, it's going to I think continue to alienate people from this idea of changing how we pay for health care."*

The lack of patient or consumer engagement in the policymaking process may lead to policies that do not fully address their needs or concerns, further diminishing public interest. Many individuals may not see the connection between policy changes and their personal healthcare experiences. Moreover, concerns regarding the impact of cost-saving measures on care quality as well as skepticism around the need for higher provider reimbursement rates pose significant challenges. Patients also prefer broad networks without restriction on their choice of providers, which may conflict with utilization management approaches employed in some APMs.

What barriers do states face in achieving multi-payer alignment across sectors?

Given the small proportion of the market under the jurisdiction of state insurance regulators, multi-payer alignment is key not only among commercial payers but essential with other public and private payers as well.

Commercial, Medicare, and Medicaid populations vary significantly in terms of age distribution and care needs, creating challenges in model alignment, including around the adoption of the same metrics and identifying opportunities for reducing costs.

These population differences create challenges to standardizing APMs not only across payers but also across a given payer's lines of business. At the same time, at a practice level it can be problematic to have programs or interventions supported by an APM that only applies to a portion of the practice population.

With rare exceptions, stakeholders expressed that large national payers are generally not engaging in specific reforms at a state level, including lower levels of participation in federal demonstrations.

Large national payer capacity for local or regional innovation is limited due to having many competing priorities at the national level and the desire to avoid operational complexity from implementing a multitude of programs across markets. Decision-making authority for payment reform programs often sits at a plan's national headquarters. Blue Cross Blue Shield (BCBS) plans, as part of an association of health plans that are locally operated, have participated to a greater degree in state and regional payment reform, though there may still be barriers to local innovation where a regional BCBS plan operates in several different markets.

Under federal ERISA law, states do not have regulatory authority over employer self-insured plans, and these plans have had limited voluntary participation in state-based payment reform.

> *"The acknowledgement that I feel like a blind spot still in our work is the self-funded market, and really being able to engage them effectively in this conversation."*

As self-insured employer plans typically constitute a greater portion of the market than commercial fully insured individual and group plans (e.g., 35% vs 10% of the market in Delaware), the lack of self-insured employer plan participation creates significant barriers to reaching a tipping point of participating payers. Interviewees reported difficulties in finding the right person from the self-insured employer community to participate in multistakeholder workgroups. Even when self-insured employers agree that robust primary care is important, they often require education about what is needed to support changes in care delivery, including adjusting expectations on the length of time required for APM implementation and return on investment.

The aforementioned issue of large national health plans not wanting to create different programs in each market holds true for large national employers as well. Where there has been more successful engagement of self-funded plans in state-based payment reform, this typically has included local government employees and companies that have the majority or all of their employees in that state. While stakeholders more often lamented the lack of employer involvement, some highlighted standout exceptions, including the participation of Walmart in state-based payment reform in Arkansas. Some employers have desired leading change on primary care payment reform but encountered barriers from insurance carriers administering the plans and identified the need to go around their carriers to be able to innovate.

There is no unified regulatory authority across Medicaid, state employee, and commercial plans under state jurisdiction.

The lack of centralized regulatory authority makes it more difficult to advance aligned policies. There was significant variation across our five states in terms of views on the level of collaboration between Medicaid agencies and state insurance regulators. In a few of our states, stakeholders described the level of collaboration as keeping one another in the loop without actual coordination and noted that each has separate missions and siloed leadership structures.

In other states, state insurance regulators and state Medicaid agencies were described as key partners trying to maximize alignment within the constraints they face. In Colorado, there has been work to align quality metrics in Medicaid with an aligned set of quality metrics for commercial plans set forth in regulation. Washington is unique in that the Health Care Authority (HCA) manages both Medicaid and the state and public school employee health plan. Contracting for both the state and public school employees as well as Medicaid managed care organizations (MCOs) creates relationships between HCA and commercial plans. However, this work is still separate from individual and group plans regulated under the Department of Insurance.

State Medicaid agencies face several unique constraints to alignment, including limitations on implementing prospective payments.

State Medicaid agencies must follow rules and guidance from CMS, including requirements to report on core quality metrics. In the absence of a waiver providing additional payment flexibilities, Medicaid must reconcile payments back to FFS under the state plan, limiting prospective payments to the same amount as FFS payments and creating the potential for financial risk to practices. However, "any threat of reconciliation back to fee-for-service is kind of defeating the point of prospective payment." For states with Medicaid managed care, permission from CMS is necessary for including specific payment requirements in managed care organization contracting through a State Directed Payment plan, and then states must also monitor for compliance.

Medicaid agencies also face state-specific policy and political constraints. As rates cannot be raised without state legislative approval, any payment reform legislation that includes increases in rates must vie against many competing priorities in the state budget such as education, roads, or other needed infrastructure. In Arkansas, Medicaid was unable to participate in Primary Care First due to restrictions in state legislation around required downside risk.

Differences in Medicaid and commercial populations and scopes of services may also necessitate some variation in approach. For example, in states with primary care investment policies in place, different targets might be appropriate.

Key Provisions of APM Policy

When should different policy levers (e.g., voluntary, legislative, regulatory) be utilized?

MOUs and other voluntary agreements have limited ability to create change due to the lower priority of voluntary efforts compared to other policy initiatives, lack of shared accountability, and susceptibility to disruption if key policy champions leave their organization.

Multiple interviewees noted the limits of voluntary efforts, stating that "payers have been showing up for voluntary conversations. That's not the problem. It's that they show up to the voluntary conversation and then there's nothing that actually can drive change" and "if it's not mandated, it's not going to happen." In some instances, even when payers signed a voluntary agreement, they did not follow through and implement reforms.

Lack of participation or action from voluntary agreements did not necessarily denote a lack of interest; however, voluntary agreements are particularly fragile or susceptible to change in a few ways. First, voluntary programs such as MOUs are prioritized below other policy work such as following legal mandates or fulfilling existing contract requirements.

Second, if a key champion who signed the agreement leaves or changes positions within an organization, the level of commitment can change quickly. An example of this was when Rhode Island's OHIC subcommittee on APMs wanted to move forward with "advanced PC APMs" along with hospital global budgeting. There was initially strong buy-in from multiple stakeholders which led to the creation of the 2019 Compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island. Shortly after the compact was signed, the leadership of two large hospital systems changed and momentum on the compact stalled.

Third, payers have concerns about limited return on investment without assurance of broad payer participation and shared accountability. Absent shared accountability, payers may perceive that they are "paying for a benefit that then might carry over to other [carriers] who aren't paying" if someone switches insurance.

Despite limited effectiveness on their own, voluntary efforts can provide an avenue for advancing stakeholder consensus on APM policy in preparation for when legislation, regulation, or participation in federal demonstrations is feasible.

While stakeholder engagement through voluntary efforts generally did not lead to meaningful action in isolation, in some cases it laid the groundwork for future policy change. Washington's Health Care Authority (HCA) co-designed its Primary Care Transformation Initiative (PCTI) strategy in partnership with diverse payer, provider, and purchaser stakeholders. The voluntary stakeholder engagement helped prepare Washington for the opportunity to engage with the federal Making Care Primary demonstration project. Voluntary multistakeholder work on alignment in Colorado shaped the design of subsequent legislation and regulation. Recommendations from this group were developed in concert with input from the legislatively created Primary Care Payment Reform Collaborative.

Getting to an actionable level of detail with multistakeholder alignment work can increase the likelihood of adopting recommendations and accelerate next steps. While the multistakeholder work in Washington set the stage for participation in Making Care Primary, an earlier HCA request for state funding for their PCTI was not approved in part due to needing more details ironed out first. The standardized Delaware Primary Care Model was included as an option for payers in regulation; however, the stakeholder work needed to define the specifics of the model had not yet been done, delaying the potential start date for implementation.

Legislation is needed to grant appropriate regulatory authority to state agencies, including the authority to implement affordability standards.

Interviewees noted that there were sometimes reasons to utilize the legislative process even if there was existing executive or regulatory authority, primarily to avoid state agency actions being viewed as an overreach.

Both Colorado and Delaware passed legislation expanding the authority of state insurance regulators by requiring the development of affordability standards, modeled in part on Rhode Island. The initial versions of the Rhode Island Affordability Standards focused on primary care expenditure requirements and PCMH implementation; updated versions have focused on increasing the percent of covered lives through APMs, the use of prospective payments, and practice support payments.

Regulatory authority granted in legislation should match the scope of work required of state agencies.

Legislators and other stakeholders drafting bills should meet with their state insurance regulators to confirm the framework being created will grant sufficient authority for agencies to develop and enforce rules.

A specific example of matching regulatory authority to scope arose with Delaware SB120. During the original drafting of the bill, it was noted that the data collection was voluntary but there was mandated enforcement on outcomes related to the data collection. Ultimately, the bill was changed to include mandated data collection which appropriately scoped the regulatory authority to the enforcement. The regulation was written to intentionally ensure that the data collection authority would continue on despite sunsets for the hospital rate caps and specific spending targets.

Codifying particular targets or definitions in legislation may limit regulators' ability to make necessary future adjustments.

Limitations or potential pitfalls for legislation include being static and "lock[ing] things in" when APMs and value-based payment are constantly evolving. Specific codes utilized in definitions of primary care services may evolve as well. Instead of codifying definitions in statute, legislation should require state agencies to establish definitions in regulation. While the regulatory process can also be complex and lengthy, it is better structured for the ability to make adjustments over time and to enact some of the more detailed implementation requirements.

Participation in federal demonstrations creates an ongoing structure to advance primary care APM policy and multi-payer alignment.

Across states, participation in the State Innovation Model (SIM), Comprehensive Primary Care Initiative (CPC), CPC+, Primary Care First (PCF), and the State Transformation Collaborative all were cited as drivers of alignment and APM expansion, as was future participation in Making Care Primary or AHEAD. In Arkansas, SIM funding expanded their PCMH program and the number of episodes in their episode of care program. Participation in other federal demonstrations (CPC, CPC+, PCF) aligned well with the PCMH program, maintaining momentum and multi-payer collaboration. In Colorado, SIM created a common architecture and lexicon to approach practice transformation that endured through later state policy work. A multi-payer collaborative in Colorado was kept alive through CPC, SIM, and CPC+ but dissolved when there were fewer participating payers in PCF anchoring the work.

What targets should be set related to primary care payment reform?

Targets for primary care investment lay a crucial foundation for primary care payment reform that can be tied to APM implementation.

Interviewees, across states and stakeholder roles, stressed the importance of increasing investment in primary care. APMs fuel innovation in team-based care, population health management, and digital technologies; however, these care delivery transformations cannot be scaled without additional funds: "there seems to be too much focus on substitutive funding rather than additional funding or true innovation levels of funding." Leading with primary care investment has been important for provider buy-in and to recognize that additional care capacities are not feasible without additional investment.

> *"The primary care spend obligation has been the single greatest source of innovation funding in our health care delivery system transformation efforts. We have used the funding to hire nurse care managers, pharmacists, and community health workers. We then utilized these personnel and were able to demonstrate the cost avoidance associated with their efforts and estimate their contribution to shared savings revenues that allowed us to factor them into future budgets and maintain them as essential members of the clinical care team."*

Regulatory targets for primary care investment can serve as a "hook" for state insurance regulators to engage carriers in dialogue about implementing APMs. One interviewee also shared the idea that investments in primary care need to be tied to care delivery changes and APMs to show they are "worth the investment."

Four of the five states examined in our study have set primary care spend targets, and as of the time of this publication, it is under consideration in the fifth state (see Table 3).

Table 3. State Primary Care Investment Targets.

STATE	PRIMARY CARE INVESTMENT TARGET
AR	• No primary care investment target (at the time of this publication, a bill is under consideration that would lead to the creation of a target)
CO	• 1% increase as a proportion of total health care spending per year in 2022 and 2023 (Regulation 4-2-72)
DE	• Target of 8.5% of total health care spending in 2023, 10% in 2024, and 11.5% in 2025 (SB120)
RI	• 1% increase as a proportion of total health care spending per year 2010-2014 • Updated to 10.7% of total health care spending (2014 Affordability Standards) • Updated to 10% of total health care spending (2024 Affordability Standards). Note the definition of total medical expenditures was revised in this update; prior spend targets are not directly comparable.
WA	• Target of 12% of total health care spending (SB5589)

Prior to setting a primary care investment target in Delaware, legislation set a floor for primary care reimbursements at 100% of Medicare payments. Setting Medicare FFS payments as a floor for reimbursement was noted to be "shortsighted because as Medicare moves away from fee-for-service reimbursement and transitions dollars into non-fee-for-service reimbursement, the law has to keep up with that."

Targets for the percentage of primary care providers or covered lives in APMs can be set to scale implementation.

Rhode Island and Delaware have set different APM targets related to the proportion of covered lives or provider contracts in APMs (see Table 4). Targets related to the percentage of state residents under value-based contracts are more difficult to measure. In Delaware, legislative language requiring mandatory minimums for payment innovations set the stage for regulators to create APM requirements.

Table 4. APM targets for state-regulated commercial payers.

STATE	APM TARGETS
AR	• Carriers must provide care coordination payments to practices identified by Medicaid as participating in the PCMH program and may identify additional PCMH participants with at least 300 enrollees (Rule 108)
CO	• 50% of total medical expenditures in APMs and 25% of primary care expenditures in prospective payments; these are target percentages without a mandated requirement (Regulation 4-2-72)
DE	• 75% of primary care providers enrolled in an APM (Regulation 1322)
RI	• At least 10% of covered lives in a primary care APM by the end of 2021 and 60% by 2024 (2020 Affordability Standards) • Stepwise increases to 60% of covered lives in a primary care APM by 2027 (2023 Affordability Standards; timeline extended due to carriers not meeting targets) • 8% of total medical expenditures in primary care APMs inclusive of both non-FFS and FFS dollars (2024 Affordability Standards; also continued prior covered lives targets from 2023 Affordability Standards)
WA	• No APM target in regulation or legislation

Mechanisms to ensure primary care APMs meaningfully change how practices are paid include clearly defining what qualifies as a primary care APM or setting targets for the proportion of non-FFS dollars in APMs.

Multiple interviewees voiced concerns that there is a significant amount of APM adoption that does not truly support value-based care due to non-FFS funds being far lower than intended or ideal. They described examples of implementation with minimal payments for care coordination as merely "checking the box" in terms of APM design, with the great majority of their payments remaining in FFS. Targets on the specific amounts or proportions of non-FFS payments in addition to the proportion of providers or covered lives in APMs could help ensure that what is being implemented are not just "APMs in name only."

There was no definition of primary care APM in the Rhode Island 2020 Affordability Standards, and there was wide variability in what was submitted as an APM. This led to the addition of a primary care APM definition to the Affordability Standards in 2023.

Rhode Island Affordability Standards Definition of Primary Care APM

"'Primary care alternative payment model' means a payment model that relies on prospective payment to a primary care practice or a primary care provider for a defined set of primary care services (including office evaluation and management services) in addition to any amounts paid to support care management and infrastructure of the primary care practice. It may also include a model that includes additional services in the alternative payment methodology, such as integrated behavioral health."

Beyond targets, what other features of primary care payment reform policy are recommended by stakeholders?

When drafting legislation and regulation, policymakers should consider where there may be loopholes for stakeholders to interpret policy more narrowly or differently than intended.

Legislation and regulation should undergo legal review as part of the drafting process with a frame of "how would we reasonably actually do this, and what happens if it gets challenged by someone?" In Delaware, an administrative law attorney included language throughout regulation 1322 to reinforce the authorities granted in legislation, such as tying compliance to rate review, and ensure that the policy persists even if legislation sunsets or is repealed. However, there may be hesitation to utilize authority solely provided in regulation as this may create an opening for legal challenges. The Delaware Healthcare Association filed a suit related to the use of authority in regulation rather than strictly regulating based on what was specified in the law. This suit was ultimately withdrawn, but it left the state Department of Insurance (DOI) unable to comment on a separate bill the Healthcare Association concurrently ran to change their ability to increase hospital prices because it would have hurt the DOI in court. Ultimately, efforts by the Delaware Healthcare Association led to a modification to hospital cost growth caps to make them less stringent.

"I think one of the concerns is the ways in which ... hospitals will finagle their way out of the restraints [and] the way the insurance companies will finagle their way out of the increased payments and limit the scope of them. They have really good lawyers who will read the law and say, 'Based on our interpretation of what we're seeing, these payments only have to go for these services, to these physicians, through these contracts.'"

Additional concerns voiced by interviewees related to loopholes include applying requirements only to certain provider contracts in certain settings rather than across the board, decreasing potential incentive payments at the same time that prospective payments are increased so that the net result is a wash, and payers raising that they have multiyear contracts already set that cannot be modified. In Delaware, insurance regulators were able to clarify that the law did require opening up contracts and not delaying implementation until those contracts ended.

To allow for increased primary care investment, concurrent mechanisms are needed to control costs (e.g., hospital cost growth caps) and avoid cost-shifting (e.g., prohibiting investment from translating into premium increases for patients).

Delaware and Rhode Island implemented hospital cost growth caps to offset increased investment in primary care and contain the total cost of care. Hospitals, however, strongly oppose any rate-setting or caps on growth. Specialty care was highlighted as another valuable area for growth in payment reform efforts to control costs, with the need to expand APM innovations for specialists.

"We think—and there's evidence to support—that over time, spending more on primary care reduces healthcare expenditures, but that's not an immediate shift. It takes time to help people be healthier and to not need as much care, and the offset through the hospital price growth limit is what provides that bridge."

While the inclusion of hospital cost growth caps in Delaware faced opposition from hospital and health system stakeholders, one interviewee noted that this provision helped to address concerns from the governor's office about not "growing the pie" overall. Sharing data on how much hospitals are making, such as from sources like the National Academy for State Health Policy (NASHP) hospital cost tool, may help legislators feel more comfortable limiting hospital price growth despite the opposition. Regulation in Colorado on primary care investment as part of affordability standards for primary care includes a requirement to not shift costs to patients' premiums.

To maximize impact and reduce administrative burden, states could require alignment of primary care APM efforts across all payers under state jurisdiction (e.g., state insurance department-regulated plans, Medicaid, state employee health plans) to the greatest extent possible.

Across states and stakeholder roles, many interviewees expressed that a key solution to advancing change with the limited scope of state insurance departments is to align primary care payment reform across state agencies.

Alignment across state agencies requires taking into consideration the unique constraints each would face, including the federal CMS requirements for Medicaid described above.

For states with Medicaid managed care, managed care organization (MCO) contracts can be required to include a minimum dollar amount or percentage spend on APMs. Similarly, agencies regulating state employee health plans can make their requests for proposals (RFPs) contingent on support for primary care APMs or support for a certain kind of model.

Arkansas expanded Medicaid by offering premium assistance for commercial plans on the health insurance marketplace. Regulation requires that all qualified health plans on the health insurance marketplace participate in APMs as part of the Arkansas Health Care Payment Improvement Initiative, including carriers offering coverage to the Medicaid expansion population.

Primary care advisory groups created through legislation or regulation provide a valuable platform to obtain feedback from diverse groups of stakeholders to inform the development of APM policy.

Creating an advisory group through legislation or regulation establishes an ongoing entity to develop long-term strategy and inform subsequent policymaking to strengthen primary care in the state. These entities do not have their own regulatory authority but provide recommendations to state insurance regulators and/or other agencies. Interviewees shared that "multistakeholder engagement is critical to this work" but noted the public nature of meetings can create some limitations in what members are willing to share. Legislative or regulatory language requiring membership of certain groups can help encourage their participation.

Table 5. Membership of state primary care advisory groups created through legislation.

STATE PRIMARY CARE ADVISORY GROUP	MEMBERSHIP	NOTES
DE Primary Care Reform Collaborative (PCRC)	• The Chairperson of the Health Care Commission • The Chair of the Senate Health & Social Services Committee • The Chair of the House Health & Human Development Committee • One member from the Medical Society of Delaware • One member from the Delaware Nurses Association • One member from the Delaware Healthcare Association • Two members representing insurance carriers • The Secretary of the Department of Health and Human Services • The Director of the Division of Medicaid and Medical Assistance • The Insurance Commissioner • The Chair of the State Employee Benefits Committee • One member representing a Federally Qualified Health Center	• SB227 (2018) established the PCRC with initial members consisting of only the Commission Chairperson and Chairs of the relevant State and House health committees. • SB116 (2019) significantly expanded the PCRC membership, including adding a member representing self-insured employers which was later removed. • SB120 (2021) made additional minor adjustments to membership. • While the patient or consumer voice was not included in membership, it was recognized that elevating the patient voice to frame recommendations or share stories was impactful.
CO Primary Care Payment Reform Collaborative (PCPRC)	• Health care providers, including primary care providers • Health care consumers • Employers that purchase health insurance for employees and employers that offer self-insured health benefit plans • Health insurers, including Medicaid managed care entities • The Centers for Medicare and Medicaid Services • The Primary Care Office in the Department of Public Health and Environment • The state Medicaid agency • Experts in health insurance actuarial analysis	• The Division of Insurance (DOI), which hosts the PCPRC, has struggled to secure a seat for a large employer as a purchaser of a self-insured plan and to ensure the consumer voice is represented beyond a single organization. • Stakeholders have recognized the importance of inviting chief medical officers (CMOs) from commercial payers actively pursuing APMs, as well as clinicians from rural settings and small practices.

In Colorado, the Primary Care Payment Reform Collaborative (PCPRC) has been instrumental in informing primary care payment reform within the state, including through recommendations for a primary care definition and investment target that were adopted into regulation.

In Rhode Island, multiple committees created through regulation have informed updates to the Affordability Standards: the Care Transformation Advisory Committee, the Alternative Payment Methodology Committee, and the Quality Measure Alignment Committee. These committees, with a relatively narrower scope, have been able to develop detailed recommendations. For example, the Quality Measure Alignment Committee reviews each measure in the OHIC aligned measure sets annually. They may recommend specification changes to a measure, retiring or phasing out old measures, or elevating a measure from an optional menu measure to a core measure, which means it must be incorporated into a value-based contract.

State offices that regulate commercial health insurance separate from other insurance products (e.g., home, auto, life) increase focus and capacity on health policy priorities.

As state insurance regulators cover all types of insurance, they often have limited capacity and sometimes expertise to implement programs specific to health insurance. The Rhode Island Health Care Reform Act of 2004 created the Office of the Health Insurance Commissioner (OHIC), establishing a separate entity with its own insurance commissioner specific to health insurance products. The creation of OHIC has resulted in more health insurance-specific regulation and policy efforts, enabled by increased expertise in health insurance policy, dedicated staff and personnel, focused scope, and organizational structure outside of a broader state agency regulating all types of insurance. A large focus of OHIC has been the Affordability Standards, which have been updated several times.

In Delaware, SB116 created the Office of Value-Based Health Care Delivery (OVBHCD) within its Department of Insurance "to carve out a portion of that agency really focused on health." Interviewees cite the creation of the OVBHCD as a sustainable, valuable vehicle for ongoing payment reform. The OVBHCD performs data collection and analysis and works in collaboration with the Primary Care Reform Collaborative, which translates and interprets the data to form recommendations. There was some debate as to whether the OVBHCD should be placed under the Department of Health and Human Services rather than the Department of Insurance; however, it was ultimately felt that would lead to placing payers under a different regulator where there were not already existing relationships or capacities.

Equity considerations (e.g., risk adjustment for social factors) should be incorporated in primary care payment innovations from the beginning and throughout the process.

Interviewees highlighted the importance of ensuring APM policy improves equity in health care access and care delivery across patient groups, while acknowledging that there are limitations to existing evidence on the best ways to incorporate equity. Opportunities to include equity in primary care APMs include:

- Involving patients in model design planning, particularly those that represent marginalized or underserved populations.
- Risk adjustment for social factors (to enhance resources for patients with greater social risk factors).
- Disaggregating quality measure data by demographics including race and ethnicity.
- Supporting cultural responsiveness.

Additionally, policymakers should consider unintended consequences and ensure APMs do not worsen inequities. These unintended consequences include disproportionately less benefit from financial incentives of APM participation in areas with fewer economic resources, such as hospitals in underserved communities being more likely to receive penalties for not meeting cost or quality targets. Additionally, APM participation requirements contribute to consolidation trends that negatively impact healthcare affordability and ceding of provider autonomy to corporate interests. One interviewee also noted potential unintended consequences of quality measures on equity, including shifting attention away from patient-centered care, and in some instances dictating conversations that may bring up aspects of stigma, such as weight counseling.

> *"I worry that as we fund more money into primary care through these mechanisms, that that has and will continue to privilege some of these larger systems that are getting larger and eating up more and more practices and then pushing up the cost of care for patients on the end."*

Data and evaluation inform improvements to overall primary care APM efforts and require adequate funding.

In constrained state budgets with competing priorities, data collection and evaluation may be cut from proposed legislation but are key to understanding effectiveness of efforts and to inform future policy. Interviewees suggested that in addition to aiming for adequate dollars budgeted from the state, it can be helpful for organizations running APCDs to talk to one another about funding sources, explore grants, and pursue Implementation Advance Planning Document (IAPD) funding for enhanced federal matching of Medicaid dollars for use in health information exchange.

Payments intended for primary care should be paid directly to practices or enhance supports that benefit primary care practices.

> *"When you're measuring primary care investment, you need to understand [what happens when] payments that go to provider groups that might be multidisciplinary hospital-based provider groups. If there's a lump sum payment or if there's a shared saving distribution, how much of that actually works its way down to primary care versus how much gets taken elsewhere?"*

While some interviewees expressed concern that APM funds would not make it to the primary care practice for practices that are part of large health systems or ACOs, it was unclear to what extent this is occurring. Determining if this is occurring is more difficult to ascertain with certain types of APM payments. Infrastructure payments may go to a centralized ACO, but some ACO structures support primary care; shared savings distributions to multidisciplinary provider groups may be challenging to divide amongst providers. In Rhode Island, the Affordability Standards include an expectation that: "If the primary care practice is part of an Integrated System of Care, the health insurer may make the PMPM payment [for Patient-Centered Medical Homes] to the Integrated System of Care, provided the Integrated System of Care is contractually obligated to use the PMPM payment to finance care management services at the primary care practice earning the payment."

What are ideal principles of APM design?

APM design in this section refers to the types of payment structures and model requirements that states have specified in regulation or voluntary agreements.

States have varied in how prescriptive they are related to the type of APM required and balance of model standardization with flexibility.

Interviewees of multiple stakeholder types expressed the idea that there is not a one-size-fits-all primary care APM, though many also recommended greater standardization to ensure meaningful alignment. A single model may not be a reasonable end goal given differences in patient populations, practice types, and levels of readiness to participate in payment reform. Instead of a one-size-fits-all approach, policy can require directional alignment of payment model approach and alignment on parameters to balance decreasing administrative burden through standardization while still allowing for flexibility. In Colorado and Delaware, interviewees acknowledged that future policy iterations towards greater standardization would be beneficial. Some interviewees also mentioned the value of allowing payers to continue successful parts of their work without requiring changes.

In terms of overall model direction, states have generally encouraged prospective payment.

Several interviewees expressed that for a model to constitute an "advanced APM," prospective payment is required. Total cost of care models with retrospectively reconciled FFS and models of pay-for-performance in addition to FFS have been more commonly implemented but felt by many to not be particularly enabling of care transformation. Some of the interviewees highlighting the importance of prospective payment did also note the role of risk and quality targets as part of an overall model. One interviewee suggested that FFS may have a role for specific services that should be incentivized, such as vaccinations and well visits.

In addition to better supporting care transformation, prospective payments also help ensure that carriers meet regulatory targets and facilitate more timely monitoring by state insurance regulators. The lag in data on shared savings distributions and quality bonuses delays the ability of state insurance regulators to assess if insurers are meeting primary care spend and APM targets often until 18 months to two years after the performance year.

The five states in our study have all incentivized or required prospective payment, but with a varying degree of specificity (see Table 6).

Table 6. Specifics related to prospective payment in voluntary or regulatory state APM efforts.

STATE	REQUIREMENTS RELATED TO PROSPECTIVE PAYMENT
AR	• Regulatory minimum average risk-adjusted PMPM payment of $5 for the PCMH model (Rule 108)
CO	• Regulatory target (without a mandate) for 25% of primary care payments to be prospective (Regulation 4-2-72)
DE	• Regulatory requirement for carriers to offer: - Non-FFS payment greater than or equal to a primary care incentive program offered by Medicare (such as CPC+ track 1, which included a care management PMPM payment in addition to FFS), - A larger proportion of non-FFS payment similar to CPC+ track 2 (which shifted a portion of FFS payments to capitation), or - A carrier-designed program that transitions a portion of FFS payment to non-FFS payment (Regulation 1322)
RI	• Regulatory definition of primary care APMs as relying on prospective payment for a defined set of primary care services (Affordability Standards)
WA	• Voluntary Primary Care Transformation Model (PCTM) includes 3 provider certification levels: - Level 1 and 2 include transformation payments in addition to FFS - Level 3 replaces FFS payments with comprehensive care payments and quality incentive payments - The work on this model transitioned to the state's voluntary participation in Making Care Primary, which has three similar tracks for payment with Track 3 involving 100% prospective payment. (On March 12, 2025, the CMS Innovation Center announced Making Care Primary will end early by December 31, 2025.)

Quality metrics were highlighted as a common and high yield area of focus for multi-payer alignment to reduce administrative burden. Metrics should focus on what providers can impact and what matters to patients.

Multiple interviewees expressed there should be a single set of measures required across payers, and that these measures should be few in number, drawn from national standards (like National Committee for Quality Assurance [NCQA] measures, or CMS demonstration programs), reflective of patient priorities, and within primary care providers' control. While a single set of measures was viewed as desirable to the greatest extent possible, there may be some degree of variation necessary for different contract types and patient populations, such as pediatric and maternity measures. Flexibilities may also be appropriate for particularly high-performing practices to incentivize continued progress. Aligning quality measures with Medicaid requires considering CMS reporting requirements. In Rhode Island and Delaware, stakeholders have collaborated on a set of standard core metrics as well as additional 'menu measures' to balance these needs for standardization and flexibility.

Aligned care delivery requirements (e.g., on team-based care) standardize what is expected of a practice to participate in an APM and receive additional resources.

Tracks or tiers of care delivery standards present practices with multiple entry points for APM participation to match their level of readiness, capacity to shift financial systems, and current stage of advanced primary care delivery.

The tiers of care delivery create a glidepath towards more advanced aspects of care delivery and financing, which could include fully prospective payment. Models that "have a progressive approach where you are able to build capacity over time and increase risk over time are better because it is less intimidating and allows for some of that capacity building to happen at the practice level." Tiers should provide a framework for high performers to continue to make improvements and develop new areas of focus in innovations. Patient advocates called for embedding work on equity in all tiers.

Washington's Primary Care Transformation Model offers practices three participation tiers with a maximum of three years within a stated tier before requiring practices to advance tiers if they wish to continue receiving APM funds. This approach was found to be serendipitously similar to the tiers and timing parameters for Making Care Primary, allowing the streamlined adoption of the program for the state. Colorado regulation 4-2-96 includes three tracks of standardized care competencies as part of APM alignment parameters.

Acceptance of alternate forms of advanced care delivery certification can help reduce duplicative reporting requirements.

States should explore options to use existing certification processes and reduce duplicative requirements that contribute to administrative burden. Consideration should be given to accepting certification through bodies like NCQA to meet similar standards for APM participation. In Colorado regulation 4-2-96, participation in federal primary care demonstrations or PCMH certification must be accepted as "recognition that the practice is, at minimum, ready to participate in an APM in Track 1." In the Rhode Island Affordability Standards, practices meeting the requirements of a PCMH are eligible for practice support payments; the options for PCMH recognition include certification by a national accreditation body.

Common care delivery expectations as part of APM participation include enhanced access, care coordination, and expansion of team-based care, including integrated behavioral health for higher tier practices.

Enhanced access, including same day and after-hours visits as well as 24/7 access to a care team member, should be a foundational or base-tier requirement. Enhancing access by enabling primary care providers to have longer visits for patients with complex needs can also lead to decreasing specialty referrals that may otherwise result from having inadequate time to address multiple concerns.

Building out and supporting team-based care, including hiring adequate numbers of administrative staff, nurses, social workers, and others, is essential to the success of APMs — and to reducing provider burnout. Care coordination teams were acknowledged for improving patients' continuity of care in their medical home and reducing emergency room visits and hospitalizations.

Integrated behavioral health, including services for mental health and substance use disorders, was noted as an essential care delivery requirement that needs sustainable funding. One payer shared that enhanced non-FFS payments for behavioral health integration were their biggest draw for practices to participate in an APM. Behavioral health integration is incorporated in the tracks of standardized care delivery expectations in Colorado, with the third track requiring implementation of a behavioral health integration strategy and earlier tracks including more intermediate steps.

The Rhode Island Affordability Standards support behavioral health integration in several ways in addition to their inclusion in practice transformation expectations. Payers submit an annual care transformation report which includes data measuring the integration of behavioral health care and the impact of integration on quality and cost. Payments to support integrated behavioral health are considered an accepted spending category for infrastructure payments. Insurers are also required to (1) eliminate same day co-payments for behavioral health services if provided on the same day and in the same location as receipt of primary care services, (2) open up Health Behavior Assessment and Intervention codes, and (3) adopt policies for behavioral health screenings in primary care that are no more restrictive than for other preventive services.

In addition to quality metrics and care delivery expectations, states have aligned APM components related to practice transformation support, attribution, and risk adjustment.

To advance along tracks of care delivery requirements, many practices benefit from technical assistance or practice transformation support. In Arkansas, payers collaborate on alignment of their practice coach training programs to ensure these supports do not deliver mixed messages.

APMs necessitate accurate attribution of patients to providers. Where providers are accountable to quality metrics, inaccurate attribution could lead to being penalized based on another provider's care. In Colorado, regulation focused on having a process to correct errors in attribution and transparency around attribution methodology rather than actual alignment of methodology. In Arkansas, it took 2 years of discussions for stakeholders to arrive at a shared methodology. A patient advocate recommended having insurers help patients match with a PCP at enrollment; provider network directories are difficult to navigate, and patient choice should be the primary determinant of PCP assignment.

Where prospective payments are implemented, risk adjustment is a mechanism to match resources to patient need. However, interviewees lamented that the way the current system is structured is a set up for gaming the system without necessarily improving the level of supports available for patients with greater needs. Interviewees also shared goals for risk adjustment to drive funds to prevention, not only disease management, and to include social risk factors. Colorado regulation includes a requirement for transparency in risk adjustment methodology.

Where downside risk is included in APMs, appropriate guardrails should be included.

Some payers viewed having a level of risk as necessary to ensure providers and systems engage in APMs. Shared savings programs have incentivized shifting care to less expensive sites of care; moving services in house; and decreasing utilization by drawing more attention to care transitions, after hours care, and same day access. However, downside risk has spurred concerns from providers, particularly for smaller groups that lack large financial reserves to manage risk. In Arkansas, downside risk in the episodes of care model (which involved but was not specific to primary care) met with significant provider resistance. This resistance spurred legislation that made the episodes of care model upside-only and eventually contributed to discontinuing the program.

Suggestions to incorporate risk appropriately or place guardrails around risk include:

- Nest a primary care APM within a broader total cost of care payment model (such as an ACO).
- Delay incorporating downside risk for an initial period of APM participation.
- Require carriers to assess whether provider organizations have the organizational and financial capacity to enter into a risk-sharing contract.
- Prohibit clawbacks (arrangements that put dollars at risk of needing to be returned to the insurance carrier) of prospective payments.
- Specify risk exposure caps and minimum loss rates.

The Rhode Island Affordability Standards specify that care management PMPM and infrastructure payments shall not be at-risk for total cost of care performance but may be at-risk for quality performance.

Model requirements should allow sufficient time for practices to transform to advanced primary care.

Interviewees from all five states acknowledged that practice transformation took more time than initially expected or desired. Some interviewees suggested that while initial progress should be demonstrated within a year, a timeframe of three years is more realistic to achieve significant practice change. Understanding this timeframe from the outset facilitates multistakeholder collaboration and technical improvements and is important to maintain momentum and enthusiasm.

What data should be collected on primary care APMs?

Collecting both non-claims and claims data is key for accurately measuring primary care spend and primary care APMs.

Non-claims payments are payments for something other than a FFS claim; FFS claims are tied to the delivery of specific billable services. Without non-claims data, states cannot understand the full scope of both primary care spending as well as the types of primary care APMs being implemented.

> *"You can't capture all of primary care expenditures if you just look at claims. That's the thing that people really need to realize. There's got to be some direct payer reporting to whoever's trying to get a handle on that since there's such a significant percentage of primary care payments [that] come through non-claims-based methods."*

There is an important role for both APCD data collection and supplemental reporting from carriers to state insurance regulators.

APM data can be collected through both APCDs and supplemental data reporting to state insurance regulators. The types of data collected by state APCDs vary widely. States with primary care investment targets are collecting data on total cost of care and spending on primary care. Some states are starting to collect or incorporate data on equity (such as area deprivation index), quality measures, and categories or types of APMs. The type of data being collected on APMs may include contract ID, billing provider IDs, tax IDs, provider name, name of who is collecting the payment from the payer, entity type (e.g., facility, group, retail, e-site, ACO), line of business (e.g., Medicare, Medicare Advantage, Medicaid MCOs), HCPLAN categories for payment models, description of APM type, reporting year, period of performance, start/end date of contract, and percentage of population covered by the APM.

Insurance regulators in Colorado, Rhode Island, and Delaware collect supplemental data from insurers in addition to APCD reporting. The supplemental data reported to insurance regulators provides additional detail on APM contracts; for states where APCDs are not collecting non-claims-based data this is particularly crucial to understand non-FFS payments. State insurance regulators in Rhode Island and Colorado track how non-claims-based payments are being used by practices in care transformation, including integrated behavioral health, active use of data in population management, team-based care, and data infrastructure. Identified needs for further data in specific areas have led to iterative additions to policy, such as including a requirement for integrated behavioral health spending in the 2023 Rhode Island Affordability Standards update. In Delaware, carriers also provide data at a more granular level of detail, reporting non-claims payments at the provider organizational level.

Clear definitions and methodologies for data reporting on primary care are necessary for tracking and enforcing targets.

To understand the portion of total medical expenditures spent on primary care and the portion of primary care spending delivered through APMs, the question of "what counts as primary care?" must first be answered.

Existing conceptual definitions and characteristics, including the one for high-quality primary care put forth by the 2021 NASEM Implementing High-Quality Primary Care consensus study and the cumulative research and writing of Dr. Barbara Starfield, offer solid starting points. Definitions of primary care for the purposes of tracking payments require identification of both the appropriate types of providers and types of services; multiple states have refined these definitions over time, further specifying or adjusting the services and provider taxonomy codes included.

States in this study have built on national reports, work in other states, and prior multistakeholder work within their state to define primary care. In Washington, the Advisory Committee on Primary Care, a subcommittee of the Health Care Cost Transparency Board administered by the state Health Care Authority (HCA), recommended a definition based on the NASEM primary care report and prior work of the Bree Collaborative, a state volunteer group focused on identifying areas of significant variation in health care service delivery.

There was desire from multiple interviewees to be able to compare primary care spend across states. Some states have worked on a multi-state definition of primary care spend. New England States Consortium Systems Organization (NESCSO), a non-profit entity dedicated to improving the capacity and capability of health and human service agencies to respond to the needs of their constituents, has developed a standard definition of primary care spend that allows for comparable reporting across its member states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

Tracking and enforcing APM targets also requires defining categories of APMs for reporting.

The Health Care Payment Learning and Action Network (HCPLAN), a federally organized group of public and private health care leaders, created an APM framework that is commonly used to categorize APMs. However, this framework has some limitations in terms of understanding what dollars are non-claims and not the FFS component of a contract. For example, when a contract includes a FFS component and a non-FFS component, the national framework lumps dollars spent on both components together as APM payment. In APMs that include shared savings or quality bonuses in addition to FFS, if all of the dollars in the contract are counted as being part of an APM, this does not convey what portion of those payments are actually paid outside of FFS claims. A newer Expanded Non-Claims Payment Framework builds on the HCPLAN and other frameworks to increase specificity in reporting. This Expanded Framework serves as the basis for the National Association of Health Data Organizations (NAHDO)'s NCP (Non-Claims Payment) Data Layout.™

Accurate assessment of prospective spend data in particular is needed where states have set targets for percentage of primary care spend in prospective payments or otherwise have policies driving implementation of APMs with prospective payment. Colorado added a flag for prospective payments to APCD reporting to try to better capture this data. The 2023 Affordability Standards update in Rhode Island defined primary care APMs as involving prospective payment for a specified set of primary care services; data on primary care APMs reported to the Health Insurance Commissioner inherently reflects prospective payments. Delaware has a "non-claims: primary care capitation" category for reporting.

As Delaware has an APM target of 75% of primary care providers being enrolled in an APM, their process for APM data collection includes provider-level data in order to assess progress.

An interviewee noted hesitation around shifting frameworks or definitions for measurement once they have been set, particularly when there is still work being done to ensure accurate data collection on what is currently being utilized.

State insurance regulators and payers experience challenges to APM data collection and reporting related to navigating administrative burden and complexity.

Collecting and evaluating APM data is still fairly new and there is a steep learning curve in determining what data is actually being requested and what data is being reported. This process is further challenged if there is staff turnover among personnel involved in data collection and reporting.

> *"Sometimes they allocate money to one [HCP]LAN category one year, and then they allocate that same money amount to something else the next year because of staff turnover, because they misunderstand something."*

Claims based and non-claims-based data often exist within different departments (e.g., financial, accounting, or contracting departments) within a payer organization. State insurance regulators have long established relationships with the FFS reporting teams at carriers but may need to establish new relationships with the teams who can provide non-claims-based data.

State insurance agencies and carriers share concerns about the increased workload of APM data collection and reporting. Concurrent major state health care reform efforts can decrease capacity for monitoring and enforcement. In Colorado, some data reporting requirements were removed from initial drafts of regulation 4-2-96 on multi-payer alignment based on carrier concerns of creating too much administrative burden. Multiple interviewees mentioned striking a balance between flexibility and standardization in the data reporting forms and templates being used.

Successful data reporting involves an iterative process that includes collecting data multiple times per year and using standardized templates or forms.

The iterative process in Delaware and Rhode Island includes carriers meeting with state regulators after submission of data to walk through their filing and plans to meet APM goals. Interviewees recommended insurance regulators meet with carriers to ensure data accuracy and update data collection processes at minimum annually, but preferably on a more frequent quarterly basis. Having a standardized form or template for data collection was also an important factor in successful communication between insurance regulators and carriers. Building relationships between state insurance regulators and carriers and having shared goals regarding how the data will be used also support successful data collection and reporting.

Cross-state learning and using vendors and consultants can facilitate state APM data collection.

Some state insurance regulators and administrators of APCDs have employed vendors and consultants to facilitate work with data in four main areas: (1) creating and maintaining an APCD, (2) providing technical assistance to practices around their use and understanding of data, (3) helping state insurance regulators with their data collection process from carriers, and (4) helping states understand their APM data in comparison to other states. Vendors can augment or expand the capacity of state agencies, which may be overburdened. Vendors may have prior experience with the topic and can consult with subject matter experts and leverage work in other states. Disadvantages of utilizing vendors include cost and not being a known or trusted entity to stakeholders. In addition to learning from vendors and consultants, states also benefit from cross-state learning through the National Association of Health Data Organizations (NAHDO), a membership association for APCDs. Attending the national conference and participating in NAHDO working group or committees were recommended for APCD managers.

What monitoring and enforcement mechanisms should be included in regulation?

Data transparency and regular communications between state insurance regulators and payers drive compliance and limit the need to use enforcement mechanisms.

Transparency, including through public-facing reports and direct reporting to state insurance regulators, is often thought of as the first step in enforcement.

Publicly available data on primary care spend and APMs is vital in driving primary care APM policy, meeting APM targets, and holding all parties accountable. Examples of public-facing reports included those from All-Payer Claims Databases, Colorado's Primary Care Payment Reform Collaborative, insurance carriers in Colorado through APM implementation plans, Delaware's Primary Care Reform Collaborative, and Washington's Bree Collaborative.

In multiple cases, it was noted that increases in transparency helped to alleviate the need for rate review or other enforcement tools.

> *"I think in part because the transparency has been so strong and the conversations have been so, let's just say clear, there hasn't been the need yet to do any sort of regulatory enforcement."*

Data calls are an important tool to help understand primary care APMs at the carrier and provider organizational level.

Data calls are a standardized, non-public way to require carriers to submit information, including proprietary and confidential information, around a specific subset of their data to state insurance regulatory agencies. These data calls can also provide a mechanism to understand carrier attribution and risk adjustment methodology where there is regulation that pertains to those APM parameters.

Market conduct exams could provide a formalized process for determining if regulation or statute is being adhered to and mandate corrective action.

State insurance regulators use market conduct examinations to ensure regulatory compliance by insurers. As an interviewee described, "It's really just a way for the department to gain better information about whether or not a [regulation] or a piece of the statute has been violated, and if so, issue appropriate action." While interviewees mentioned an example of market conduct exams being used for mental health parity, they had not utilized it for primary care APM target monitoring to date.

Corrective action plans were viewed as an intermediate step towards more aggressive enforcement tools such as fines or rate review.

If an insurance carrier fails to meet its APM targets, it could be placed on probation with a corrective action plan. Requiring data submissions at regular intervals throughout the year also allows regulators the opportunity to identify carriers projected to fall short of their targets and devise a corrective action plan proactively. Failure to adhere to the corrective action plan would then lead to more aggressive enforcement such as fines.

Fines are a common tool for enforcement by state insurance regulators. It is key to clearly define what counts as a violation and ensure that the fine amount includes flexibility and an appropriate cap.

> *"If I could write the administrative penalty statute differently, I would. I would make it a lot clearer on what a violation is, so we don't have to … constantly debate with an insurance company on how you count violations, and I would make the penalty cap higher."*

Fines were mentioned as enforcement tools by multiple interviewees. Having a clear definition of what constitutes a violation is helpful for both state insurance regulators and carriers, and having a variable amount to choose from when levying a fine is helpful for insurance regulators. The fine cap should be a sufficiently large amount to dissuade further violations or non-adherence. Delaware regulation 1322 specifies that administrative penalties can include: (1) daily fines of up to $10,000 for failure to submit filing documents per established timelines or department instructions and (2) fines equal to each plan year's value of the deficiency in reimbursement, payment and cost growth limits.

Rate review and rate denial are seen as "big guns" that will rarely be utilized in APM enforcement.

Rate review enables state insurance regulators to review proposed premium increases by health insurers. Insurers are required to provide information explaining how they determine the amount they charge for base premiums and why a premium increase is needed. The type and scope of rate review vary by state; in states with prior approval rate review authority, insurance regulators can disapprove rates that they feel do not meet regulatory standards in advance of them going into effect.

Rhode Island, Delaware, and Colorado have laws that have expanded regulatory authority to state insurance regulators to include enforcement of affordability standards as part of the rate review process. Rate review gives state insurance regulators "the ability to be serious" and makes insurance carriers "come to the table." However, regulators are hesitant to utilize rate denial at least in part due to concerns around disrupting access to health care: "that we could deny your rates…. It's not action I see us taking." As multiple interviewees stated, state insurance regulators are committed to creating competitive insurance marketplaces and prohibiting a large insurance carrier from participating in the market threatens that goal.

Best practices for enforcement include state insurance regulators having the flexibility to use different tools for different situations and working with payers to support them in finding ways to meet regulatory targets and requirements.

Enforcement was described as an "art" in which the ultimate goal is to "get people to start working towards common goals with the expectation that maybe they won't get there on the schedule that you intend them to." Interviewees highlighted the value of state insurance regulators working with payers to meet requirements in alternative ways rather than seeking punitive action if they are not anticipating meeting targets. This includes flexibility around what is counted or credited in terms of meeting targets, for example for targets around attributed lives in care transformation, counting practices that are PCMH-recognized and practices participating in federal demonstrations. Related to targets for percentage spend on primary care, this includes helping to find alternative ways to invest money in primary care such as directing funds towards meeting community health needs. In Rhode Island, payers can request a waiver if they are not meeting targets but still have to show good faith efforts and their plans to meet requirements.

"Carrots" for health plan participation in APM advancement and alignment in addition to enforcement "sticks" can improve collaboration and engagement.

Interviewees suggested creating a floor in terms of expectations and then building incentives for efforts above this floor. Incentives could include creating relief from burdensome regulatory requirements (e.g., extending timeline to achieve other targets) or giving credit in purchasing (e.g., recognition placement in marketing on the health insurance exchange).

Lack of regulatory authority over providers creates some complications in enforcement, as the ultimate effectiveness of regulation requires participation by healthcare providers and health systems.

Scaling APM adoption requires providers to engage, but state insurance regulators do not have direct authority to regulate providers. Instead, state insurance regulators affect provider behavior indirectly through requirements on insurance carriers. Regulators are motivated to avoid overly negative incentives or ramifications for providers to protect the "health of the primary care system." State regulators have to consider, when providers say they do not have the bandwidth to participate in APMs, if they want to "really penalize the insurer in that instance? Or do I want to put so much pressure on the insurer that they put so much pressure on the provider that it might have harmful consequences for the provider in the short run?" Some interviewees, including state insurance regulators, felt that keeping APM participation voluntary for providers was the right choice while using carrots to "prod the providers along as well."

Primary Care Needs in Addition to Payment Policy

Outside of APM policy, what other reforms to support primary care are needed?

States should develop a comprehensive strategy to support primary care practices moving towards more advanced care delivery, inclusive of but not limited to payment reform.

A comprehensive state strategy would not only include aligning purchasing across all payers under state jurisdiction but also focus on decreasing administrative burden related to billing, claims, and prior authorizations; policies to address workforce shortages; and insurance reform. These additional strategic components would also support improvements in patient access and affordability.

The primary care workforce is distressed and navigating profound burnout because of chronic underinvestment and increasing burdens, leading to providers leaving traditional care models, early retirement, and students electing non-primary care careers.

Beyond payment reform, additional state solutions aimed at addressing workforce shortages include: widening the primary care pipeline through expanding primary care physician residency training, developing residency programs for nurse practitioners and other members of the primary care team, offering student loan forgiveness (including outside of federally designated shortage areas), licensing flexibility for high-need team members (e.g., behavioral health providers), and paying tuition and/or issuing stipends in exchange for primary care commitments. Efforts to decrease administrative burden beyond multi-payer alignment can also support primary care workforce recruitment and retention. In Arkansas, HB1271 mandates that there cannot be any prior authorizations required for services included in a value-based arrangement. The Rhode Island 2024 Affordability Standards update creates standards for prior authorizations to decrease administrative burden.

Interviewees also recommended insurance reforms to improve primary care access, including requiring carriers to assign their members to primary care providers, maintaining an up-to-date provider network directory, and minimizing the impact of insurance churn on patient-provider relationships.

State efforts to slow cost growth trends must look at health care system financing and delivery more broadly than primary care payment reform alone.

> *"You can say primary care is foundational and essential, but primary care can't fix the whole system."*

Interviewees noted that primary care constitutes a small proportion of total health care costs and is perhaps disproportionately addressed in comparison to other areas of health care, such as hospital care. Some states are more broadly targeting health care costs by instituting caps on hospital cost growth, setting targets to limit growth in the total cost of care, and requiring increased cost transparency. However, many payment reform efforts are focused on curbing utilization and quality improvement without addressing prices as a fundamental driver of uncontrolled healthcare costs. One interviewee expressed that "because of the fact there's so much trepidation towards doing real price regulation, we move into this bipartisan world where everyone's like, 'Okay, let's do payment reform.'" Primary care payment reform is critical for multiple reasons, including its contribution to bending the cost curve over time, but policymakers whose primary goal is to decrease cost growth should also target other health care sectors and consider the role of price controls.

"Payment reform is about aligning incentives to manage utilization. It doesn't really get at … the actual price specified on the fee schedule. It's a utilization management technique, and it's a quality improvement technique. Both of those have been draped on the shoulders of primary care as … the least paid of the physicians in the market, go out there and you'd be the quarterback for bending the cost curve and improving all the HEDIS metrics … frankly, I think we need to be [smarter] going forward about how much of the burden we place on primary care when there are other approaches to bending the cost curve that take money directly out of other people's pockets, like specialists and hospitals."

What do states need from the federal government to support primary care APM policy?

States benefit from collaboration, scaling, and flexibility in federal demonstration programs.

New federal demonstration models should continue to build on lessons learned.

Federal demonstration projects have tested various primary care models; newer models such as Making Care Primary (MCP) reflect many lessons learned over time with its prospective payments for primary care and a longer timeframe to support transformation. (MCP is now scheduled to end several years early, by December 31, 2025).

Colorado and Washington were selected as two of eight states to participate in the MCP federal demonstration model. In Colorado, MCP was seen as leverage to spur greater multi-payer alignment across commercial and government payers and to bring ERISA plans and large employers to the table. MCP was also viewed as a pathway to augment health equity efforts in the state and aligned with its ongoing Medicaid transformation efforts. In Washington, interviewees appreciated the alignment of MCP's parameters with their state Primary Care Transformation Model, with the additions of emphasizing specialist engagement and total cost of care measures.

Federal collaboration with states on demonstration projects should start early and provide strategic flexibilities to enable multi-payer participation.

Federal support for state-based innovation such as through the State Innovation Model and State Transformation Collaborative drives momentum. Collaboration with states in development phases of these models helps to ensure they are optimized for state participation. This collaboration, with some flexibility, is also important in other non-state-specific CMMI models such as MCP to enable better participation from state Medicaid agencies and commercial payers. While flexibility was noted to be valuable, some interviewees also noted that too much flexibility in CMMI models can lead to a lack of true alignment beyond a bare minimum of components.

Interviewees called out the opportunity to scale learnings from CMMI models, noting that the issues intending to be addressed are universal, and states that are not participating in these models are being left behind: "If you go back to the CPC Classic['s seven regions] ... and we're still just at Making Care Primary's eight states. It just feels like we're just really inching along on this whole voluntary approach. Until we put a... line in the sand about how important this is through some accountability mechanism with payers, it's going to happen in dribs and drabs." The need for scaling also applies across populations; Medicare-focused models may leave maternity care providers and pediatricians to feel ostracized from the value-based care movement.

Interviewees also recommended flexibility related to participation in multiple CMMI models at the same time.

States would benefit from federal guidance around standardization of quality measures and other APM design elements for multi-payer alignment, definition of primary care, and methods for measuring APM spending.

States have been working to establish standardized quality measures, define how to measure primary care, and develop approaches to measuring APMs, and a patchwork of approaches across states has resulted. For scalability and comparability, common measures and definitions would be helpful, and states look to the federal government to provide that direction. While some states still may want to tailor approaches to their own unique circumstances, stakeholders have called for a federal standard definition of primary care to provide a base definition for states to utilize and to support cross-state comparisons.

The growing proportion of Medicare beneficiaries in Medicare Advantage plans increases the importance of improving alignment with these plans in the federal movement on primary care APMs.

State participation in CMMI demonstration programs helps to get to a tipping point of impacting a majority of a practice's patient population. However, participation in these programs is optional for Medicare Advantage plans, which cover more than half of Medicare beneficiaries. Interviewees called for CMS to improve the participation of Medicare Advantage plans in the movement towards APMs and suggested contracts could be made contingent on multi-payer alignment.

Stakeholder Engagement

How can stakeholders be effectively engaged to drive change?

Policy champions, who can be state officials, payers, or providers, are essential to drive the design, implementation, and maintenance of momentum on primary care APMs.

In each state, specific individuals (often multiple in a state) were cited as leading the work, adeptly bringing together stakeholders, setting a vision, and demonstrating persistence. For example, a legislative champion in Colorado advanced recommendations from the Primary Care Payment Reform Collaborative and a multistakeholder alignment initiative into legislation. In Arkansas, commitment from the governor's office, grounded in financial concerns about the growing costs of health care, created a foundation for payment improvements. This commitment and the role of the governor's office were strengthened by having a lead health advisor to the governor who also served as part of the leadership team of the Arkansas Center for Health Improvement.

Engaged leaders prioritize building and maintaining authentic relationships with a wide array of stakeholders, leverage a crisis for good, act when the timing is right, and are willing to dig into the details. The downside, however, to one or two leaders who are essential to forward momentum is the leadership vacuum they create when they leave the organization. Changes in leadership at key agencies and organizations lead to a loss of institutional knowledge and disruption of ongoing policy efforts.

State agencies can serve as conveners for multistakeholder alignment work, often benefiting from external consultant support.

Each of the five states we explored hired an external consultant to facilitate and support multistakeholder convenings. Consultants are often very expensive but provide expertise that state governments and stakeholders may not have. External consultants have experience with other state work on payment reform and are well positioned to gather background research and present this to stakeholders, facilitate meetings, and navigate operational complexity where state agencies do not have sufficient capacity. Some states have been able to utilize Medicaid federal financial participation (FFP) funds to support hiring consultants where there are partnerships between state insurance regulators and state Medicaid agencies. One provider noted that while the work of external consultants moved the work forward, sometimes it "felt like you're just being fed the consultant's ideas," expressing the need for enough time for stakeholders to review information and provide meaningful input.

As a complement to standing primary care advisory groups, opportunities for public feedback improve the ability of state officials to hear from all voices.

One key informant offered, "It's really not appropriate to have certain stakeholders that tend to have louder voices, have a bigger say in reg development. What's more appropriate is to put it out for public comment, allow all people in the state to comment and then incorporate their comments as appropriate." Some state officials host town hall meetings for payers, providers, and hospital representatives. Others arrange Zoom meetings with providers early in the morning before their clinical duties begin. In Delaware, state officials make a point of attending key meetings with the Delaware Healthcare Association and the Medical Society, leveraging these as additional forums to obtain public comment. Some states intentionally seek diverse input from patients, including those from historically marginalized or underserved populations. Patients, clinicians, and practice managers can provide insight on the anticipated consequences of proposed policy changes.

In some cases, however, there are benefits to conducting closed door convenings for specific types of stakeholders, e.g., a payer-only group, to ensure their voices are heard and their concerns addressed.

Obtaining input from payers in a public forum tends to be particularly challenging, due to concerns about proprietary information or antitrust. One interviewee shared this reflection, "I think specifically for payers, there's a lot [at] stake for them. I think that there's a lot of different layers of how that conversation is hard for them to have in this public arena that don't elicit the most honest, not to say that they're being dishonest, but a lot of times they're silent. How do we actually have some of these conversations?" Another key informant raised the question whether to engage state insurance regulators in multi-payer or payer-specific groups and if doing so, how this might change the nature of the conversation.

In Rhode Island, local payers collaborated and pooled their money to create the all-payer Care Transformation Collaborative. In Colorado, attempts to restart a multi-payer collaborative met a lack of interest from payers. Interviewees suggested rewards for participation in multi-payer collaboration could help incentivize this.

Employers can be further engaged in driving payment reform for primary care.

Though employers have been difficult to engage in multi-payer alignment, there is a role for the business community to engage in health care reform as advocates for their employees and families when purchasing health care benefits. This role was elevated by the Consolidated Appropriations Act of 2021, which makes carriers under ERISA accountable to their employees as fiduciaries to ensure that their purchasing of health insurance is spent on high quality, cost-efficient care. Employers have also been motivated by employees' dissatisfaction with their benefits despite high costs for the company. One interviewee cited that Starbucks spends more on health care for their employees than on coffee beans. Further, cost-shifting from public to private payers may put further pressure on employers to engage as they may refuse to "subsidiz[e] everyone else."

Bright spot examples of employer engagement exist, including Walmart's participation in the Arkansas Health Care Payment Improvement Initiative and Boeing's efforts to participate in accountable care organizations. Some purchasers have also explored changes to benefit design through decreasing patient-cost sharing for advanced primary care services. The Purchaser Business Group on Health (PBGH), an organizing entity representing more than 40 different large private and public purchasers, has partnered with some state insurance regulators to bring employers to the table in stakeholder engagement efforts. Washington engaged PBGH to help convene employers interested in championing primary care. To address the barriers some of their members have faced in implementing innovations through third party administrators, PGBH developed requests for proposals to support direct contracting for advanced primary care services.

Effective multistakeholder meeting facilitation includes onboarding, level-setting, iterative discussion, and driving towards a shared vision.

Interviewees offered several suggestions for facilitating meetings well and building and maintaining strong relationships across stakeholder groups:

- Set meeting norms that stakeholders agree to at the outset and name potential challenges that could derail engagement, including clarification of what information is confidential and proprietary and how this will be respected, reviewing where anti-trust concerns do or do not play a role, establishing an open-door policy, discussing how to manage conflict, and communicating clearly and often, including providing pre-meeting work with ample time to review.
- Establish a clear and compelling shared vision for success and build on common problems or motivations.
- Use data, state-by-state comparisons, and examples to drive alignment on solving problems and correct misperceptions.
- Adjust expectations and prepare for deliberations to be slow and tedious at times, recognizing the value of iterative conversations to ensure understanding and arrive at consensus. For more contentious issues, host separate conversations with individuals or smaller interest groups and then compile and circulate an anonymized summary of all the input.
- Recognize that participation in a stakeholder engagement process may be a rather large request for volunteers, especially patients and family members. A law in Washington allows stakeholders who are low income or have lived experience participating in state work groups, boards, or committees to be paid for their service.
- Anticipate that some stakeholders may have steeper learning curves than others and provide sufficient background information (e.g., understanding where the state does and does not have jurisdiction, such as over ERISA plans).

How should the importance of primary care APM policy be messaged to stakeholders?

For effective messaging, ensure a baseline understanding about the value of primary care, unify communications about vision and planned changes, align with stakeholder goals, build on other state priorities, and share wins early and often.

In order to garner momentum and support for primary care APMs, policy champions may need to first ensure that legislators and others understand what primary care is, the importance of primary care, and how it plays into other priority areas.

> *"The average legislator probably would have a hard time even saying what primary care is. It's just something that folks who work in health care policy need to keep... pushing on."*

In Arkansas, Medicaid and private payers spoke at shared town hall meetings to providers and hospitals about being on the same page, enhancing understanding of a collective commitment.

Aligning with stakeholder goals in messaging will vary by audience but includes focusing on affordability and access for patients and making primary care more sustainable for primary care clinicians. Advancing APMs for primary care may also align with many other state priorities and initiatives such as maternity care deserts, behavioral health crises, health care costs and affordability targets. By actively including consumer voices, simplifying messaging and framing the impact of APMs in terms of patient and public priorities, policymakers can rebuild trust and generate interest in APMs.

Stakeholders appreciate hearing about early wins (e.g., practices achieving shared savings, intermediate process measures related to practice participation and covered lives in APMs), and this can maintain momentum for change.

Policy Recommendations

Recommendations for policy impacting commercial plans under state jurisdiction

Tables 7-10 outline recommendations for primary care payment reform in commercial plans under state jurisdiction, including through voluntary mechanisms, legislation, regulation, and implementation. Each of the five states in this study has had a unique pathway to achieve change, all involving multiple steps or iterations across these different types of policies. In some states, a stepwise policy approach has helped to build the political will necessary for larger subsequent changes.

Primary care payment reform in the commercial sector is necessary but not sufficient to address the current primary care crisis. These recommendations should be ideally situated within a comprehensive state primary care strategy, focused on improving care of patients as its north star and informed by ongoing data monitoring and evaluation.

A comprehensive strategy would include aligned payment approaches across all state payers and purchasers; workforce supports; and efforts to decrease administrative burden. A comprehensive strategy would also create a structure for shared accountability to primary care policy across agencies and other involved parties. Components of such a strategy were evident in states in this study; for example, the Rhode Island Affordability Standards have expanded to include efforts to decrease administrative burden through reductions and transparency in prior authorizations. However, no state in this study had a comprehensive state strategy, organized by a central coordinating body, with a broad scope both across payers and across all areas of necessary reforms.

Recommendations for state voluntary efforts

Voluntary efforts include stakeholder convenings not mandated by legislation or regulation, the creation of consensus recommendations or agreements (e.g., memoranda of understanding [MOUs]), and participation in federal demonstrations.

Table 7. Recommendations for state voluntary efforts.

RECOMMENDATIONS	STATE EXAMPLE(S)
V1.0 Convene stakeholders to lay the groundwork for subsequent legislation, regulation, or participation in federal demonstrations. Involve all payers, including employers as purchasers of self-insured plans.	The Washington Health Care Authority convened diverse stakeholders to design the Primary Care Transformation Initiative and resulting MOUs.
V2.0 Apply for participation in primary care federal demonstration projects when available.	Arkansas' participation in the State Innovation Model was leveraged to scale their PCMH program.

Recommendations for state legislation

In addition to the specific recommendations listed in table 8, the drafting process for legislation should include confirmation that appropriate regulatory authority has been granted for state agencies to develop and enforce rules.

Table 8. Recommendations for state legislation.

RECOMMENDATIONS	STATE EXAMPLE(S) (Note: Legal language has been shortened for conciseness.)
L1.0 Create a primary care advisory group to make recommendations on payment reform in an ongoing manner. Note: As an alternative (or adjunct), Rhode Island's OHIC has created more topic-specific committees through regulation.	CO HB19-1233 The Commissioner of Insurance shall convene the Primary Care Payment Reform Collaborative, with responsibilities that include: • Developing a recommendation to the commissioner on the definition of primary care • Advising in the development of the affordability standards and targets for carrier investments in primary care • Developing recommendations to increase the use of alternative payment models that are not paid on a fee-for-service or per-claim basis
L1.1 Require diverse membership. Membership should at a minimum include individuals representing: • Primary care providers • Patients or consumers • Payers • Medicaid • State employee health plan • Federally qualified health centers • State insurance regulatory agency Additional members to consider include individuals representing: • Legislators • Federal HHS regional director • Health insurance actuaries • Self-funded employers • State public health department • Nurses • Health systems	CO HB19-1233 The Primary Care Payment Reform Collaborative shall include: • Health care providers, including primary care providers • Health care consumers • Employers that purchase health insurance for employees and employers that offer self-insured health benefit plans • Health insurers, including Medicaid managed care entities • The Centers for Medicare and Medicaid Services • The Primary Care Office in the Department of Public Health and Environment • The state Medicaid agency • Experts in health insurance actuarial analysis
L1.2 Require annual reports from the advisory group with recommendations for primary care payment reform.	CO HB19-1233 The Primary Care Payment Reform Collaborative shall publish recommendations annually and make this report available to the public.

L2.0 Expand regulatory authority to state insurance regulators to develop and enforce affordability standards for primary care, tied to rate review.	CO HB19-1233 The insurance commissioner, in determining if rates are excessive, may consider whether the carrier's products are affordable and whether the carrier has implemented effective strategies to enhance the affordability of its products. The commissioner shall promulgate rules establishing affordability standards.
L2.1 Set targets for primary care investment or grant authority to the state insurance regulatory agency to set such targets.	CO HB19-1233 The Division of Insurance shall adopt appropriate targets for investments in primary care to support value-based health care delivery in alignment with affordability standards.
L2.2 Establish authority to develop targets related to APM implementation. Consider language requiring "mandatory minimums" for APMs.	DE SS1 for SB120 The Office of Value-Based Health Care Delivery shall establish mandatory minimums for payment innovations, including alternative payment models, provider price increases, carrier investment in primary care, and other activities deemed necessary to support a robust system of primary care.
L2.3 Require creation of a definition of primary care for the purposes of measuring and tracking targets. The definition should be created in collaboration with stakeholders (i.e., through a primary care advisory group). Consider a requirement that the definition be created in regulation rather than codifying in statute.	DE SS1 for SB116 "Primary care" means as defined by the Department of Insurance in regulations.
L2.4 Grant authority to collect data from carriers related to requirements.	DE SS1 for SB120 The Office of Value-Based Health Care Delivery shall collect data and develop reports regarding carrier investments in health care to monitor and evaluate: • The calculation of the amount of claims based and non-claims based primary care spending • Carrier compliance with required reimbursement rates for primary care • Health care spending data collected and reported through the state benchmarking process • The percentage of spending in primary care that is delegated to hospitals and related networks for care coordination through alternative payment models

L3.0 Include cost control mechanisms to reallocate funds to primary care without increasing the total cost of care. Consider setting caps on hospital growth.	DE SS1 for SB120 The Delaware Health Care Commission shall develop and monitor compliance with alternative payment models that promote value-based care, including reviewing the Office of Value-Based Health Care Delivery's analyses of affordability standards to achieve primary care targets without increasing costs to consumers or the total cost of care. Health plan rate filings for hospital other nonprofessional services must not exceed price growth by the greater of 2% or Core Consumer Price Index plus 1% by 2026.
L4.0 Create a state All Payer Claims Database (APCD), if not already in place.	AR SB956 Arkansas Healthcare Transparency Initiative Act The Arkansas Healthcare Transparency Initiative was established to create an all-payer claims database. The Initiative is governed by the State Insurance Department and advised by the Arkansas Healthcare Transparency Initiative Board.
L4.1 Require collection of both claims and non-claims payments. *L4.2 Require annual reports from the APCD on APMs to the legislature.*	CO HB19-1233 The administrator of the APCD is required to submit an annual report 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 fee-for-service basis.
L5.0 Ensure sufficient funding in the fiscal note for staffing in state agencies. The fiscal note should include adequate funds for monitoring and enforcement. Consider the potential need for external consultants as an additional expense.	DE SS1 for SB116 The fiscal note includes funding for three new positions to staff the Office of Value-Based Health Care Delivery, including a lead position and two insurance financial analysts. It also includes annual contractual services for an actuary.
L6.0 Require alignment across all payers under state jurisdiction (all plans subject to state insurance regulation, Medicaid, and state employee health plans).	AR Health Care Independence Act Carriers offering health care coverage for Medicaid expansion through the Health Insurance Marketplace are required to participate in Arkansas Health Care Payment Improvement Initiatives including support for patient-centered medical homes.
L7.0 Consider creation of an office focused on health insurance regulation to increase capacity and sustain work. 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.	RI Health Care Reform Act of 2004 The Office of the Health Insurance Commissioner is established within the Department of Business Regulation. It is tasked with several responsibilities, including (1) making recommendations to the governor and House and Senate Finance Committees regarding regulations and rates of health insurance carriers and (2) monitoring the transition from fee-for-service toward global and other alternative payment methodologies. DE SS1 for SB116 The Office of Value-Based Health Care Delivery is established within the Department of Insurance. Its responsibilities include establishing affordability standards based on recommendations from the Primary Care Reform Collaborative, establishing targets for carrier investment in primary care, and collecting data and developing reports on carrier investments in primary care.

Recommendations for state regulation

These recommendations require that adequate authorities have been granted in legislation as detailed above, including the authority to set and enforce affordability standards related to primary care. Several considerations apply across recommendations pertaining to regulatory targets:

- Language should be clear that regulatory targets apply to existing multi-year contracts.
- Targets can be set for stepwise increases over the years.
- Targets should be mandated rather than optional.

Table 9. Recommendations for state regulation.

RECOMMENDATIONS	STATE EXAMPLE(S) (Note: Legal language has been shortened for conciseness.)
R1.0 Ensure a meaningful amount of payment is delivered through non-FFS mechanisms, including prospective payment. Options include: • 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 to participate in APMs that include non-claims payments at least equivalent to Medicare demonstration programs.	RI Affordability Standards Primary care APMs rely on prospective payment for a specified set of services (including office evaluation and management services) in addition to any amounts paid to support care management and infrastructure. DE Regulation 1322 Carriers must offer the opportunity for practices to participate in programs that include: 1 Non-FFS reimbursement greater than or equal to primary care incentive programs offered by Medicare (such as CPC+ Track 1); 2 Non-FFS payments comprising a larger proportion of total provider reimbursement (such as CPC+ Track 2); or 3 A carrier designed program that transitions a portion of FFS to non-FFS payment.
R2.0 Require that payments intended to support primary care are paid directly to practices or ultimately benefit primary care.	RI Affordability Standards Insurers must provide a PMPM payment 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.
R3.0 Standardize components of APM design to improve multi-payer alignment.	CO Regulation 4-2-96 Carriers must follow aligned sets of care competencies and quality metrics. Carriers are also required to transparently report attribution and risk adjustment methodologies.
R3.1 Require alignment on quality metrics.	RI Affordability Standards Carriers must include all measures designated as core measures from an aligned measure set. "Menu" measures can be incorporated into contracts at the mutual agreement of the carrier and contracted provider.

R3.2 Require alignment on care delivery expectations; include tracks or tiers of increasing expectations and supports. Consider standards around access, care coordination, and team-based care, including integrated behavioral health for higher tier practices. Allow other forms of practice certification (e.g., PCMH certification) to qualify for meeting similar tier standards.	CO Regulation 4-2-96 Carriers must incorporate a set of aligned core competencies into expectations in primary care APMs. The aligned competencies include three participation tracks. Track 3 requires the practice to implement a behavioral health integration strategy. Carriers must accept federal demonstration participation and PCMH designation as recognition of Track 1 competencies at a minimum.
R3.3 Require alignment or transparency around attribution.	CO Regulation 4-2-96 Carriers must describe attribution methodologies used, provide and regularly review attribution lists quarterly at a minimum, and create a process for requests for reattribution.
R3.4 Consider requiring alignment or transparency on risk adjustment methodologies. Incorporate risk adjustment for social factors (requiring increased resources for patients or populations with higher levels of social risk factors).	CO Regulation 4-2-96 Carriers must describe the methodologies they use for risk adjustment and how this interacts with provider payments.
R4.0 Set guardrails around downside risk. Protections around downside risk can be established 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.	RI Affordability Standards 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.

R5.0 Establish requirements to support behavioral health integration in addition to its inclusion in aligned care delivery expectations. Options to support behavioral health integration include: • Prohibit charging a second co-payment for behavioral health services provided on the same day and in the same location as primary care services. • Require opening codes that support behavioral health services such as Health Behavior Assessment and Intervention codes. • Adopt policies that behavioral health screenings are no more restrictive than for other preventive services.	RI Affordability Standards In addition to the inclusion of behavioral health integration as part of practice transformation expectations, carriers are required to decrease barriers to access to integrated behavioral health services by adopting all three policies listed in the lefthand column.
R6.0 Set a target for the percentage of providers or percentage of covered lives in APMs.	DE Regulation 1322 Carriers must: 1 Offer primary care providers the opportunity to participate in primary care incentive programs. 2 Report progress on achieving the goal of 75% of primary care providers and team members in eligible care transformation activities.
R7.0 Set targets for primary care investment, if not already done through legislation.	CO Regulation 4-2-72 Carriers shall increase primary care investment by 1% of total medical expenditures per year in 2022 and 2023 without increasing premiums.
R7.1 Include in options for primary care investment spending on practice facilitation (technical assistance, peer learning) and upfront payments for infrastructure (such as for health information technology, 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.	RI Affordability Standards Primary care expenditures include payments to support population health management and infrastructure at the primary care site.
R7.2 Include a provision that changes should not increase patient premiums or other cost-sharing mechanisms.	CO Regulation 4-2-72 Carriers shall not translate increased primary care spending into higher premiums and should adopt strategies that improve value and quality of care without increasing total medical expenditures.
R8.0 Create multiple mechanisms for data monitoring.	

R8.1 Mandate reporting from carriers to state insurance regulators on APM contracts. Consider including a requirement for public-facing versions of carrier APM implementation plans.	CO Regulation 4-2-72 Carriers must submit an annual APM Implementation Plan describing which APM approaches the carrier intends to implement by market(s) and line(s) of business, including the timeframe, financial and quality measurement goals, and how the strategy aligns with other payers' APM strategies.
R8.2 Establish the authority to hold data calls and market conduct exams with carriers to gather additional information and formally evaluate compliance.	DE Regulation 1322 A market conduct exam may be conducted as necessary and include review of carrier contracts with health care providers.
R9.0 Establish a menu of enforcement tools. Clearly define what constitutes a violation requiring the use of enforcement tools.	
R9.1 Include APM targets as part of rate review.	DE Regulation 1322 The Insurance Commissioner may return a rate filing to the carrier for amendments and corrections of deficiencies.
R9.2 Set meaningful fines for failing to meet targets and requirements. Ensure the penalty cap is high enough to dissuade further violations. Consider daily fines for failure to submit documents per established timelines and annual fines equal to deficiencies in payments to practices.	DE Regulation 1322 The Insurance Commissioner may impose penalties including: 1 Daily fines of up to $10,000 per day for failure to submit filing documents on time 2 Fines equal to each plan year's value of deficiency in reimbursement, payment, and cost growth limits
R9.3 Create the option for corrective action plans. A carrier could be placed on probationary status while addressing shortfalls in the corrective action plan; failure to adhere to the corrective action plan could then lead to other enforcement mechanisms.	DE Regulation 1322 The Insurance Commissioner may require non-compliant carriers to submit a corrective action plan.
R9.4 Allow for waivers of certain requirements or deadlines for requirements if carriers are able to demonstrate progress and follow a reasonable adjusted timeline.	RI Affordability Standards A health insurer shall not be held accountable for a violation if they demonstrate that compliance was not possible notwithstanding good faith and reasonable efforts. The insurer shall notify the Commissioner and request a waiver as soon as such circumstances arise. Failure to establish that good faith and reasonable efforts were undertaken shall result in penalties.
R10.0 If an advisory group was not already established through legislation, create advisory committee(s) to inform future iterations of regulation. Advisory committees can be created to broadly make recommendations on changes to payment reform regulation, or to focus on a specific area such as aligned quality metrics.	RI Affordability Standards The Commissioner may convene: • Payment and Care Delivery Advisory Committee as needed to obtain input on policies related to the Affordability Standards • Statewide advisory committee on prior authorization as a subcommittee of the Administrative Simplification Task Force • Quality Measure Alignment and Review Committee

Recommendations for state implementation

The recommendations in Table 10 are intended for state insurance agencies implementing and updating regulation. These recommendations pertain to the provision of clear guidance to carriers, processes for data collection and validation, and obtaining multistakeholder feedback.

Table 10. Recommendations for state implementation.

RECOMMENDATIONS	STATE EXAMPLE(S)
I1.0 Establish clear processes and guidance on regulatory compliance, including for data reporting and validation. Written guidance may be provided in data submission manuals or broader policy manuals, including standardized forms or templates for data reporting. If a legislative sunset is approaching, consider communicating the intention to enforce compliance through the entire period that the policy is active.	RI Affordability Standards Policy Manual Developed by OHIC to provide guidance for regulatory compliance related to primary care spend, APM contracting, use of aligned measure sets, and data specifications. The Delaware Office of Value-Based Health Care Delivery provides an Affordability Standards Data Submission Manual and Data Submission Template.
I1.1 Review submitted data and meet with carriers to confirm accuracy and request changes as needed.	
I2.0 Utilize best practices to facilitate primary care advisory groups, including level-setting on group norms. Best practices to consider include: • Level-set regarding what information is confidential, where antitrust does or does not apply, and standards for communication. • Leverage consultants to provide background materials and facilitation. • Review state-specific data and other states' experiences. • Gather in-person as part of regular meetings where feasible. • Allow time for iterative conversations to ensure understanding, arrive at consensus, and reach actionable recommendations. • Ensure time for complete review of recommendations (with opportunity to make adjustments or express a dissenting opinion) prior to publication. • Compensate group members who are low income or have lived experience for their participation.	Colorado Primary Care Payment Reform Collaborative Standard Operating Procedures and Rules of Order Set expectations regarding operational logistics, including communications around meeting materials and decision-making processes. Revised Code of Washington 43.03.220 Subject to agency funding, stipends (not to exceed $200 per day) can be paid to low-income individuals or those with direct lived experience who serve on a board, commission, council, or committee.
I3.0 Create opportunities to gather public feedback broadly in addition to input from primary care advisory groups created through legislation or regulation. 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.	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.

Transparency in Coverage Rule

While it did not come up in our interviews, the federal Transparency in Coverage rule may provide a resource and tool to leverage for transparency and understanding what information is non-confidential related to rates. This rule requires that insurance carriers offering non-grandfathered coverage in the individual and group markets make public negotiated rates for all covered services from in-network providers and historical payments to, and billed charges from, out-of-network providers.[12]

Loopholes and Pitfalls to Avoid

Policymakers encountered several loopholes and unintended consequences in their primary care payment reform efforts. Other states may benefit from anticipating these issues and adjusting legislative and regulatory language accordingly.

Perceived lack of enforcement as legislative sunset approaches.

- In Delaware, stakeholders shared concerns that compliance with regulation could cease prematurely as a sunset deadline approaches and the perceived likelihood of enforcement decreases.

Excluding certain carrier types from requirements.

- In Colorado, integrated carrier-provider networks were excluded from some components of legislation. As commercial insurers under state insurance regulation are already a relatively small subset of the overall health insurance market, exclusions for specific carrier types within that group further constrain the potential impact of policy.

Not granting regulatory authority to carry out legislative mandates or goals.

- During the drafting of Delaware SB120, it was noted that data collection was voluntary but there was mandated enforcement on outcomes related to data collection; the bill was ultimately changed to include mandated data collection.
- Colorado HB22-1325 states that APMs must include prospective payments, however, this was not included in the minimum parameters for alignment that must be set by the Division of Insurance. Subsequent regulation 4-2-96 does not include specific requirements for prospective payment, though the authority has been set for future iterations of regulation to include this.

Lack of definition for what qualifies as a primary care APM.

- Significant variation in APM implementation was observed in Rhode Island following the 2020 update to the Affordability Standards which mandated increases in primary care APM adoption but did not define what would qualify as a primary care APM. The 2023 update to the Affordability Standards added a specific definition to reduce variation and ensure models were meaningfully different from FFS.

Codifying definitions or targets in statute.

- There may be adjustments to targets and definitions indicated over time, for example, codes included in a definition of primary care services based on lessons learned from implementation and evolving best practices. When definitions and targets are codified in statute, it creates barriers to adjustments. Notably, however, the process for updating regulatory targets and definitions can also be lengthy and face barriers.

Payer perception that new regulatory changes do not apply to existing multi-year contracts.

- In Delaware, the Office of Value-Based Health Care Delivery clarified that health insurers are required to reopen multi-year contracts in order to implement and comply with new regulation.

Basing parity on Medicare FFS payments.

- Delaware set Medicare reimbursements as a floor for commercial payer reimbursement. However, if this floor is based only on FFS then it will not reflect the growing shift of Medicare payment to non-FFS payments and then "parity is no longer parity."

Recommendations for other state agencies and the federal government

While our report is focused on the commercial market under state jurisdiction, multi-payer alignment necessitates action across private and public payers and purchasers. Our interviews also elevated policy recommendations for state Medicaid agencies, state employee health plans, and federal agencies. The Resources section in the Appendix includes reports with additional recommendations for these agencies.

STATE MEDICAID AGENCIES:

- Explore waivers for payment reform innovations including expanding the use of APMs with a focus on prospective payment.
- Utilize MCO contracting to advance multi-payer alignment and APMs with a focus on prospective payment.
  - Include requirement in contracts that payers participate in federal demonstrations that the state is engaged in.

STATE EMPLOYEE HEALTH PLANS:

- Utilize contracting to advance multi-payer alignment and APMs with a focus on prospective payment.
  - Include requirement in contracts that payers participate in federal demonstrations that the state is engaged in.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES:

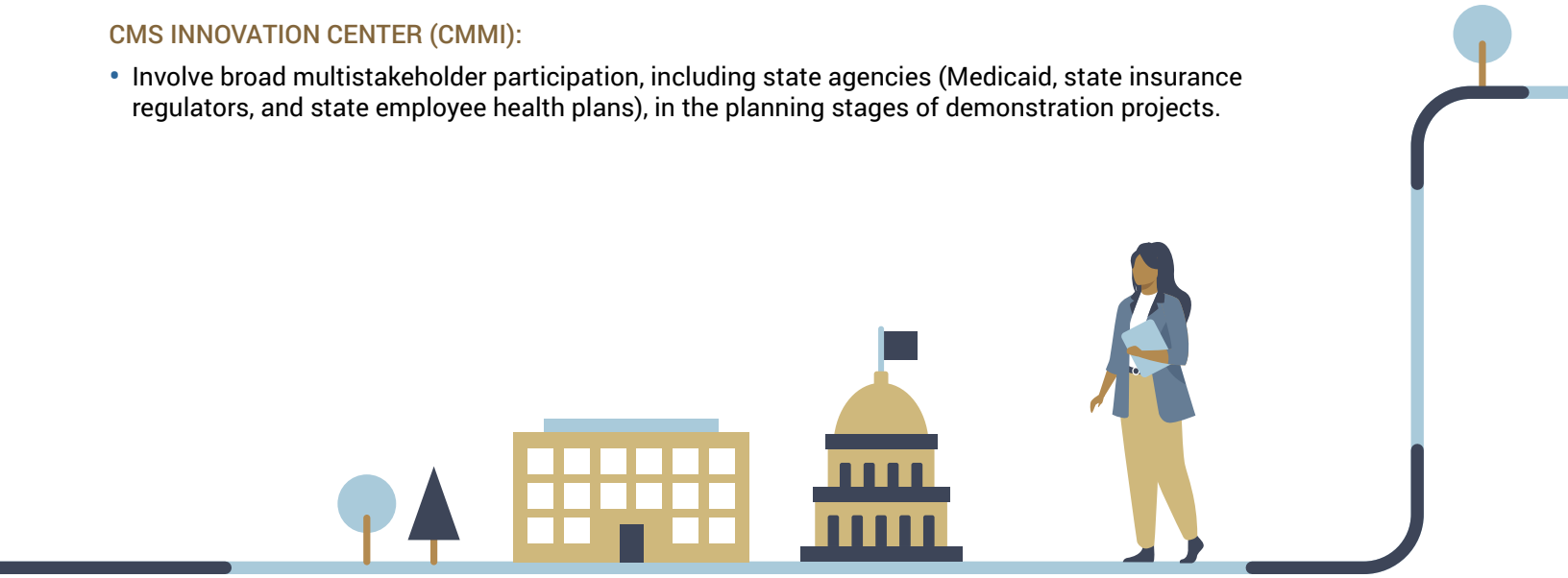
- Develop a national standard definition of primary care for the purposes of measuring investment.
- Establish federal standards on categorizing non-claims primary care payments.

CENTERS FOR MEDICARE & MEDICAID SERVICES:

- Create additional flexibilities and guidance for Medicaid to participate in multi-payer alignment on primary care payment reform.
  - Eliminate the requirement to reconcile payments back to FFS under state plans.
  - Facilitate the inclusion of APM requirements in managed care contracting.

CMS INNOVATION CENTER (CMMI):

- Involve broad multistakeholder participation, including state agencies (Medicaid, state insurance regulators, and state employee health plans), in the planning stages of demonstration projects.



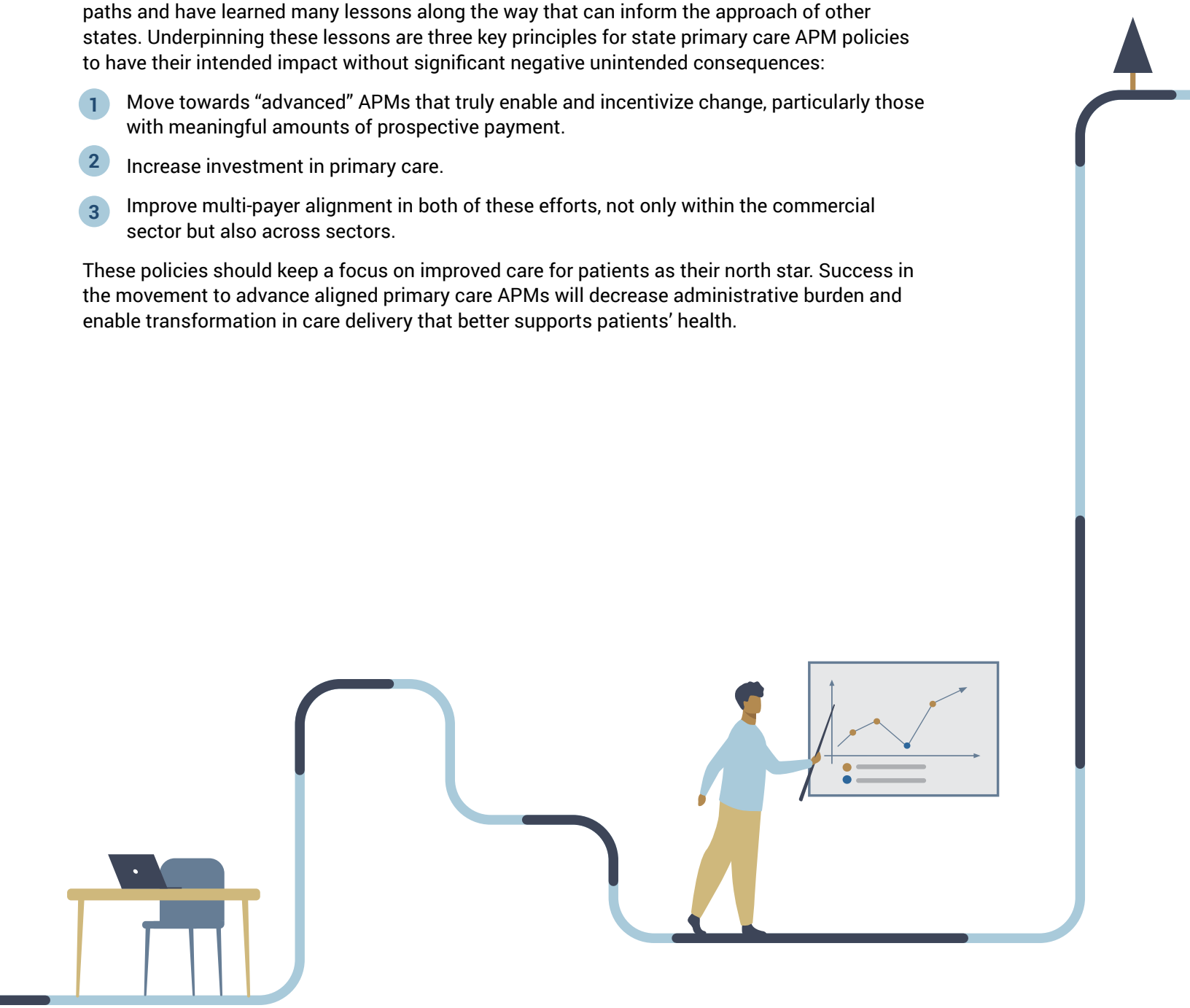
Conclusion

High-quality primary care improves outcomes for patients and supports control of total health care costs over time. However, underinvestment, increasing burdens, and other challenges are driving primary care workforce shortages and worsening access for patients. Primary care payment reform, including through APMs, is a critical piece of the solution to better support primary care. States have a key role to play in advancing primary care APMs for payers under their jurisdiction.

The five states studied in this report all advanced primary care APM policy through different paths and have learned many lessons along the way that can inform the approach of other states. Underpinning these lessons are three key principles for state primary care APM policies to have their intended impact without significant negative unintended consequences:

1. Move towards "advanced" APMs that truly enable and incentivize change, particularly those with meaningful amounts of prospective payment.
2. Increase investment in primary care.
3. Improve multi-payer alignment in both of these efforts, not only within the commercial sector but also across sectors.

These policies should keep a focus on improved care for patients as their north star. Success in the movement to advance aligned primary care APMs will decrease administrative burden and enable transformation in care delivery that better supports patients' health.



Arkansas Snapshot

At a glance

In 2012, a state budget crisis drove the Governor's office to support efforts to reduce health care costs through multi-payer adoption of alternative payment models (APMs) across major commercial payers, Medicaid, the state employee health plan, and a large self-funded employer. Stakeholders developed two APM programs, Episodes of Care and Patient-Centered Medical Home (PCMH), as part of the Arkansas Health Care Payment Improvement Initiative (AHCPII). Since the inception of these programs, Arkansas has advanced APMs by leveraging participation in federal demonstrations and passing legislation and regulation that require adoption of AHCPII by plans on the health insurance marketplace.

Provider resistance towards downside risk led to legislation that removed it from Episodes of Care; the program continued as upside-only until it ultimately ended in 2023. The PCMH program, however, has continued and is considered by stakeholders to be a success, introducing positive changes in care delivery while financially supporting practices.

Federal

State

2012

Comprehensive Primary Care Initiative (CPC)

Arkansas Health Care Payment Improvement Initiative (AHCPII)

- AHCPII is a multi-payer, voluntary initiative involving participation in PCMH and Episodes of Care APMs.
- PCMH program: provides a per-member, per-month payment (PMPM) to primary care practices for medical home care capabilities such as care coordination and efforts to increase patient access.
- Episodes of Care program: Principal accountable providers become eligible for shared savings for defined condition-based episodes if quality targets are achieved (and at financial risk if costs exceed an acceptable threshold).
- Led by the Department of Human Services' (DHS) Medicaid program and the Arkansas Center for Health Improvement (ACHI).
- Current participating payers include Medicaid, Blue Cross Blue Shield (BCBS), Arkansas State and Public School Employees Health Plan, Centene (previously QualChoice), HealthScope, and Walmart.

2013

State Innovation Model (SIM)

State Innovation Model

- Awarded $42 million to support AHCPII.
- Extended the PCMH and Episodes of Care programs to additional participating providers.
- Participating payers included Medicaid, BCBS, and QualChoice.

SB1020 to Create the Health Care Independence Act of 2013; and to Declare an Emergency

- Expands Medicaid through a private option by providing premium assistance and other cost-sharing supplemental payments to plans on the exchange.
- Requires qualified health plans (QHPs) on the health insurance marketplace to participate in AHCPII, including assignment of primary care clinicians, support for PCMH, and access to clinical performance data for providers.

Federal

State

2014

The Arkansas Insurance Department Rule 108

- Mandates QHPs on the health insurance marketplace follow the Arkansas PCMH model or a nationally accepted PCMH model.
- Requires payers to prospectively attribute every enrollee to a primary care practice.
- Sets the floor for payers to provide PCMH participating practices an average of five dollars PMPM, which may be risk stratified, for care coordination services.
- Carriers can terminate practice support for not meeting milestones or quality targets.
- Requires carriers to provide the state quarterly performance reports on practice transformation and quality metrics.

SB701 to Limit Financial Penalties on Physicians in Alternative Payment Systems

- Specifies that carriers, when determining gainsharing or risk-sharing amounts, shall not financially penalize physicians for costs that are a result of contracts with other persons or entities outside of the physician's practice.
- As a result of this legislation, carriers are no longer able to include downside risk in episodes of care.

2016

2017

HB1439 To Amend the Healthcare Quality and Payment Policy Advisory Committee

- Amends the membership of the Healthcare Quality and Payment Policy Advisory Committee to include two of each of the following: family physicians, pediatricians, internal medicine physicians, physicians of any specialty, and medical directors of an insurance company.
- Tasks the Committee with making recommendations and providing approval to DHS related to the development of AHCPII, PCMH, and episodes of care.

Comprehensive Primary Care Plus (CPC+)

2021

HB1271 To Amend the Prior Authorization Transparency Act; And To Exempt Certain Healthcare Providers That Provide Certain Healthcare Services From Prior Authorization Requirements

- Creates exemptions to prior authorizations for health care providers, including that insurers will not impose prior authorization requirements for any health care service that is included in a value-based reimbursement arrangement.

Primary Care First (PCF)

2023

Healthcare Payment Learning & Action Network State Transformation Collaborative

- Builds on groundwork of AHCPII and alignment efforts in CPC+ and PCF.
- Focused on all-payer alignment for quality metrics and increasing payer representation in quality measure discussions.

Health Care Payment Learning & Action Network State Transformation Collaborative (HCPLAN STC)

2025

Colorado Snapshot

Federal

2012

Comprehensive Primary Care Initiative (CPC)

2013

State Innovation Model pre-test award (SIM)

2015

2016

State Innovation Model test award (SIM)

2017

2019

Comprehensive Primary Care Plus (CPC+)

2020

At a glance

Two major pieces of legislation shaped how state-regulated commercial plans pay for primary care. A 2019 bill expanded the authority of the Division of Insurance (DOI) to set affordability standards related to primary care and created the multistakeholder Primary Care Payment Reform Collaborative (PCPRC) to advise the DOI on the development of these standards. Based on recommendations from the PCPRC, the DOI mandated increases in spending on primary care and recommended, but did not require, that 25% of primary care payments be made prospectively. The state convened another multistakeholder group to explore consensus on alternative payment model (APM) alignment; the group recommended core features of a primary care APM rather than a single standardized model. This work led to a 2022 bill requiring aligned parameters of primary care APMs. While legislation and regulation have promoted the use of prospective payments, they have not made them mandatory.

State

HB19-1233 Investments in Primary Care to Reduce Health Costs

- Expands authority of the DOI to set affordability standards related to primary care, including targets for primary care investments.
- Creates the PCPRC to advise in the creation of affordability standards, including recommendations on targets for primary care investment and increasing the use of APMs. The PCPRC is scheduled to sunset in 2025; however, a state agency responsible for sunset review processes recommended the PCPRC continue, and at the time of this report's publication, a bill to extend the PCPRC through 2032 is under consideration.
- Mandates an annual primary care spend report from the All-Payer Claims Database (APCD), including the portion of payments in APMs.

Regulation 4-2-72 Concerning Strategies to Enhance Health Insurance Affordability

- Mandates an increase in the amount of total medical expenditures allocated to primary care by 1% per year in 2022 and 2023 without increasing premiums. (A 2024 report showed this target was not achieved at the market level; the percentage of total medical spending on primary care for commercial plans was 9% in 2021 and 8% in 2023).
- Sets a target (not a mandate) of 25% of primary care expenditures in prospective payments by the end of 2023.
- Requires carriers to submit annually a Primary Care Implementation Plan describing strategies for increasing primary care investment, and an APM Implementation Plan describing strategies for APM adoption.

Federal

State

2021

Colorado Alternative Payment Model (APM) Alignment Initiative

- Multistakeholder work on APM alignment to increase standardization of approach across payers. The initiative was convened by the Lieutenant Governor's Office in collaboration with the DOI, the state's Medicaid agency, and the agency administering the state employee health plan.
- Recommends core features of an aligned APM in lieu of a single standardized APM to allow for flexibility in payment structures across payers and providers.

2022

HB22-1325 Primary Care Alternative Payment Models

- Builds on recommendations from the Colorado APM Alignment Initiative and the PCPRC.
- Directs the DOI to establish aligned parameters for primary care APMs in collaboration with the state Medicaid agency, state health department, state employee health plan, the PCPRC, and carriers and providers participating in APMs.
- APM parameters must include, at a minimum, quality measures, patient attribution, risk adjustment, and core competencies.
- Additional APM parameters include incorporating prospective payment, ensuring shared savings arrangements minimize financial risk to providers, preserving options for carriers and providers to negotiate appropriate levels of APMs suited to the practice, and incentivizing behavioral health integration.

Primary Care First (PCF)

2023

Regulation 4-2-96 Concerning Primary Care Alternative Payment Model Parameters

- Requires carriers to incorporate requirements into APMs related to the parameters mandated in HB22-1325 and report on their use in their APM Implementation Plans:
  - Risk adjustment: describe methodologies used.
  - Attribution: describe methodologies used, provide and regularly review attribution lists at minimum quarterly, and create a process for requests for reattribution.
  - Core competencies: utilize the DOI's set of aligned core competencies. The core competencies establish a common set of expectations for high-quality primary care delivery around domains such as care coordination and team-based care, including behavioral health integration. The competencies include three tracks for participation.
  - Quality measures: incorporate the aligned DOI adult and pediatric quality measure set in primary care APMs.

Health Care Payment Learning & Action Network State Transformation Collaborative (HCPLAN STC)

2024

Making Care Primary (MCP)

2025

Delaware Snapshot

At a glance

Primary care payment reform in Delaware has involved stepwise pieces of legislation to (1) create the Primary Care Reform Collaborative (PCRC) to develop recommendations to strengthen primary care, (2) increase primary care investment, (3) create the Office of Value-Based Health Care Delivery (OVBHCD) under the Department of Insurance (DOI), and (4) establish mandatory minimums for payment innovations including alternative payment models (APMs). Regulation 1322 implements the mandatory minimums including a target percentage of primary care providers engaged in APMs.

Federal

2013

State Innovation Model design award (SIM)

2015

2018

State Innovation Model test award (SIM)

State

SB227 Relating To Primary Care Services

- Creates the PCRC under the Delaware Health Care Commission (HCC) to develop annual recommendations that will strengthen primary care in Delaware.
  - The PCRC (as initially established) comprised the Health Care Commission Chairperson, the Chair of the Senate Health, Children, & Social Services Committee, and the Chair of the House Health & Human Development Committee.
- Requires all health insurance providers to participate in the Delaware Health Care Claims Database.
- Requires individual, group, and state employee insurance plans to reimburse primary care and chronic care management at no less than Medicare rates.

Executive Order 25 Establishing Delaware Health Care Spending and Quality Benchmarks

- Establishes Delaware Health Care Spend Benchmarks to set annual growth targets for total health care costs.
- Establishes the Delaware Economic and Financial Advisory Council Health Care Spending Benchmark Subcommittee to set the health care spending benchmark.

Federal

State

2019

[SS1 for SB116 Relating To The Primary Care Reform Collaborative And The Creation Of The Office Of Value-Based Health Care Delivery]

- Creates the OVBHCD within the DOI; responsibilities include:
  - Establish affordability standards based on recommendations from the PCRC.
  - Establish targets for carrier investment in primary care.
  - Collect data and develop reports on carrier investments in primary care.
- Expands membership of the PCRC significantly, adding members representing physicians, nurses, health systems, insurance carriers, large self-insured employers, federally qualified health centers, the state Medicaid agency, the DOI, the state employee health plan, and the state department of health and human services.

2021

[SS1 for SB120 Relating to Primary Care Services]

- Directs the HCC to:
  - In collaboration with the PCRC, monitor uptake of primary care providers with value-based care delivery models, including advising on a Delaware Primary Care Model.
  - Develop and monitor compliance with APMs that promote value-based care, including incorporating OVBHCD analyses and soliciting data from carriers.
- Mandates carrier primary care spend targets: at least 7% of the total cost of care in 2022, 8.5% in 2023, 10% in 2024, and 11.5% in 2025.
- Requires OVBHCD to establish mandatory minimums for payment innovation, including APMs.
- Specifies OVBHCD data collection and reporting on primary care includes claims and non-claims spending.
- Sets hospital rate caps that gradually reach the greater of 2% or Core Consumer Price Index (CPI) plus 1% by 2024.

2022

[Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance]

- Requires carriers to offer primary care providers the opportunity participate in primary care incentive programs, such as:
  - Non-fee-for-service (FFS) payment greater than or equal to Medicare incentive programs such as Comprehensive Primary Care Plus (CPC+) Track 1.
  - A larger proportion of non-FFS payments, such as in CPC+ Track 2.
  - A carrier-designed program that transitions a portion of FFS payment to non-FFS payment.
- Requires carriers to report progress on achieving a goal of 75% of primary care providers and team members in eligible care transformation activities, such as:
  - A carrier primary care incentive program as listed above.
  - The Delaware Primary Care Model established by the PCRC.
  - The National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home certification program.
  - Any other standards added by the DOI.

Rhode Island Snapshot

At a glance

Rhode Island has a unique regulatory structure for health insurance. In 2004, it created the Office of the Health Insurance Commissioner (OHIC), which has resulted in more health insurance specific regulations and policy efforts. A large focus has been the Affordability Standards, an expansion of the regulatory authority of OHIC to curb the cost of health care in Rhode Island, which apply to all commercial health insurers regulated by the state.

For primary care policy within the Affordability Standards, the focus has included increased primary care investment, practice transformation support for the adoption of the patient-centered medical home (PCMH) model, and increased use of primary care alternative payment models (APMs). Specifically, the primary care APM sections have increased the percent of covered lives through APMs and increased the use of prospective payments and practice support payments.

Federal

State

2004

The Rhode Island Health Care Reform Act of 2004

- Creates the OHIC, Rhode Island's commercial health insurance policy and regulatory agency.
- Authorizes OHIC to lead the creation and implementation of the Rhode Island Affordability Standards.

2009

Affordability Standards

- Requires commercial health insurers to:
  - Expand and improve primary care infrastructure by increasing the primary care spend by 1% per year 2010-2014.
  - Support the adoption of the PCMH model by directing payments to practices through OHIC's medical home transformation program (or an insurer may develop its own PCMH initiative).
  - Financially incentivize physicians to adopt electronic health records.
  - Engage in comprehensive payment reform efforts across the health care system including the primary care spend as mentioned above, and hospital rate caps.
- A 2013 evaluation of these standards found that the standards had "increased primary care infrastructure in the state, and accelerated PCMH transformation efforts."

2013

State Innovation Model design award (SIM)

2014

2014 Updated Affordability Standards

- Increases the primary care spend mandate to 10.7% of total health care spending.
- Requires 80% of contracted primary care practices to be functioning as PCMHs by the end of 2019.
- Requires insurers to provide practice support payments to adopt and maintain the PCMH model.
- Requires health insurers to increase their use of APMs and move away from fee-for-service (FFS).
- Creates the Alternative Payment Methodology Committee.

Federal

State

2015

State Innovation Model test award (SIM)

Alternative Payment Methodology Committee

- A state-convened advisory committee that provided recommendations for an APM target and how to achieve this target.
- Committee released multiple APM plans from 2015–2019, which helped inform continued updates to the Affordability Standards.

Measure alignment

- In 2015, the State Innovation Model (SIM) grant supported the creation of a Measure Alignment process through convening a work group of diverse stakeholders. This led to the creation of the first Aligned Measure Sets for use in primary care, ACO, and hospital contracts.
- In 2017, the Measure Alignment function transitioned to OHIC under the Affordability Standards to require that all commercial payers use the Aligned Measure Sets in any contract with a financial incentive tied to quality. OHIC is responsible for convening the work group annually to review quality measures and make changes to the Aligned Measure Sets as necessary.

2019

2020

2020 Updated Affordability Standards

- Requires health insurers to further increase use of primary care APMs by 2021, including development and implementation of a prospectively paid APM model that includes compensation for integrated behavioral health services.
- Set goals for primary care payments through these APMs to increase from 10% of covered lives in 2021 to 60% of covered lives by 2024; these targets were later extended and adjusted in the 2023 updates to the Affordability Standards.

2022

Compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island

- A voluntary compact between health insurers, providers, OHIC, and others to advance use of APMs beyond the scope and authority of what is possible through the Affordability Standards.
- Compact outlined both action steps and targets for primary care APMs in Rhode Island.
- No follow-up to date from this compact on the action steps or targets.

Rhode Island Affordability Standards Policy Manual

- Provides guidance for compliance with the Affordability Standards, including related to primary care spend, value-based contracting, use of aligned measure sets, and data specifications.

Primary Care First (PCF)

Federal

State

2023

[2023 Updated Affordability Standards]

- Creates a definition for Primary Care APM that includes prospective payment for a defined set of primary care services.
- Creates additional support for behavioral health integration through practice transformation and integration into primary care APMs.
- Extends the deadline for 60% of covered lives in primary care APMs from 2024 to 2027 and adjusted the interval year target percent of covered lives.

2024

[2024 Updates to Affordability Standards] (effective 3/20/25)

- Revises the definition of primary care expenditures as all claims and non-claims payments directly to a primary care practice for primary care services.
- Requires stepwise increases in the primary care spend target to at least 10% of total medical expenditures, with at least 8% of each insurer's total medical expenditure being through primary care APMs, by 2028 (the definition of total medical expenditures was revised to provide an updated denominator for the primary care spend target).

2025

- Amends that care management and infrastructure payments to primary care practices shall not be at risk for total cost of care performance but may be at risk for performance on quality measures.
- Annual budget development for total cost of care contracts shall be held harmless for mandated increases in primary care funding.
- Establishes requirements concerning prior authorizations to decrease administrative burden, including a reduction in the volume of prior authorization requests by 20% relative to baseline 2023 requests, with prioritization of services ordered by primary care for those reductions.

Washington State Snapshot

At a glance

Since 2019, Washington has advanced primary care payment and delivery reform largely through voluntary mechanisms. The state's Health Care Authority (HCA) co-designed its comprehensive Primary Care Transformation Initiative (PCTI), which now includes the Primary Care Transformation Model (PCTM) and participation in the federal demonstration Making Care Primary (MCP), in partnership with diverse payer, provider, purchaser, and health systems stakeholders.

Consistent voluntary efforts by the state and many stakeholders through the PCTI have sharpened their collective transformation focus, increased awareness about the needs and value of primary care and laid the groundwork for the state's selection for MCP in 2023. On March 12, 2025, the CMS Innovation Center (CMMI) announced that MCP, which started in 2024 and was originally planned for 10.5 years, will end early by December 31, 2025.

Federal

2013

State Innovation Model design award (SIM)

2015

State Innovation Model test award (SIM)

2019

State

2019

The Beginnings of the Primary Care Transformation Initiative (PCTI)

- HCA convened health systems, payers, and primary care clinicians to begin developing key elements of the Primary Care Transformation Model (PCTM) as part of the state's more comprehensive PCTI.

2020

Multi-payer MOU Among WA State Health Plans in Support of the PCTI

- Non-binding memorandum of understanding (MOU) signed by eight health plans within the WA multi-payer collaborative and the HCA to support aligned primary care reform efforts to advance integrated, whole person care.
- The PCTI includes seven components. The payer-specific components include:
  - Aligning payment and incentive approaches, tied to measurable metrics; payments may include transformation of care fees, per-member-per-month (PMPM) payments, and performance-based incentives.
  - Investing a defined and incremental percent spend on primary care. A specific percent spend was not established in the MOU.
  - Adopting a core set of process and outcome measures as well as using cost and utilization data in collaboration with providers to assess transformation initiatives.

Federal

State

2022

Finalized PCTM Framework

- Includes many elements from the 2020 non-binding multi-payer MOU.
- Payer accountabilities include:
  - Aligned practice supports, such as data sharing and common attribution principles.
  - Shared quality standards, determined by an ad hoc measures work group.
  - Aligned payment model by practice recognition level based on different provider accountabilities. Levels one and two involve transformation payments and fee-for-service (FFS) payments. Level three transitions to comprehensive care payments plus quality incentives.

Senate Bill 5589 Health Care–Primary Care Expenditures

- Directs the Health Care Cost Transparency Board (Board) to measure and provide annual reports on primary care expenditures and its progress towards increasing primary care spend to 12% of total health care expenditures.
- Authorizes the commissioner of insurance to include an assessment of primary care expenditures in its reviews of health plan forms or rate filings.

Health Care Cost Transparency Board Preliminary Report

- Introduced the new Board-established Advisory Committee on Primary Care and its initial responsibilities, including defining primary care for purposes of calculating spend, recommending how to measure claims and non-claims spending, and reporting on barriers to accessing data needed to perform the calculations.

2023

Making Care Primary

- WA was selected as one of eight states to participate in the federal model, Making Care Primary (MCP).
- State-run PCTM and federal MCP share similar elements, including capitated payments and infrastructure investments. MCP differs in that it additionally features total cost of care measurement and involves specialists in care coordination.
- WA primary care purchasers released a statement supporting multi-payer collaborative primary care reform efforts.

Annual Report of the Board re: Senate Bill 5589

- The Board shared approved actions of its Advisory Committee on Primary Care, including a state definition of primary care and a claims-based measurement methodology incorporating providers, facilities, and services.

Federal

2024

Making Care Primary (MCP)

2025

State

Updated Multi-payer MOU Among WA State Health Plans in Support of the PCTI

- Builds upon the 2020 multi-payer MOU and the 2022 final PCTM framework, connecting these efforts with MCP.
- Payers offer alternative payment to MCP participants based on level of advanced care capacities:
  - Level one: mostly FFS, potential upfront infrastructure investment, and quality incentives.
  - Level two: FFS or partial prospective payment, smaller potential upfront infrastructure investment, and quality incentives.
  - Level three: prospective payment and quality incentives.
- Quality: Payers will prioritize the use of the WA Primary Care Core Measure Set.

MOU for the WA PCTI

- CMMI and HCA commit to a collaborative relationship to support multi-payer primary care reform work through the state-led PCTI. CMMI will participate in WA multi-payer collaborative meetings to support PC reform initiatives and to align messaging and stakeholder engagement efforts across the PCTI and MCP.

Annual Report of the Board re: Senate Bill 5589

- The Board approved all seven recommendations made by the Advisory Committee on Primary Care, including two that would require legislative action:
  - "Increase primary care expenditures as a percentage of total health care spending annually by one percentage point until a 12 percent primary care expenditure ratio is achieved."
  - "Increase Medicaid reimbursement for primary care by no less than 100 percent of Medicare no later than 2028."

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Appendix

Resources

Resources in this list were highlighted by interviewees as informing policymaking in their states or identified as high yield during the project environmental scan.

Overall information on payment and payment models

- Evaluations from CMS Innovation demonstration projects, including Comprehensive Primary Care Plus' (CPC+) Fifth Annual Independent Evaluation report and reports from the State Innovation Models Initiative
- National Academies of Sciences, Engineering and Medicine's Implementing High Quality Primary Care report chapter on payment and related recommendations
- The Health of US Primary Care: 2025 Scorecard Report – The Cost of Neglect

Primary care investment

- Primary Care Collaborative State Investment Hub
- New England States Consortium Systems Organization's All-Payer Report on Primary Care Payments
- Investing in Primary Care: Lessons from State-Based Efforts

Nexus of primary care investment and cost growth targets

- Lessons learned from state efforts to slow and shift health care spending

Rate review and affordability standards

- Looking Under the Hood: "Enhanced" Health Insurance Rate Review to Improve Affordability
- Toolkit: Health Insurance Rate Review Authority to Control Health Care Costs, Including Model Legislation and Regulatory Language

Pricing and rate setting data

- Centers for Medicare & Medicaid Services' (CMS) aggregated Unified Rate Review templates – to understand how the individual and small group fully insured commercial markets are projected to change in terms of utilization and spending. Takeaways from 2024 are summarized in a report, ACA Market Insights Derived from 2024 Unified Rate Review Templates.
- CMS' Medicare Shared Savings Program – reference for risk corridors and minimum requirements related to shared savings
- National Academy for State Health Policy's (NASHP) Interactive Hospital Cost Tool and RAND Hospital Data web-based tool – if pursuing work on hospital price caps concurrently
- Center for Value-Based Insurance Design (V-BID) at the University of Michigan

Collecting non-claims data

- Expanded Non-Claims Payments Framework–this builds on the HCP-LAN's APM Framework and Milbank Memorial Fund-Bailit's Measuring Non-Claims-Based Primary Care Spending report

Payment reform in Medicaid

- Medicaid Population-Based Payment: The Current Landscape, Early Insights, and Considerations for Policymakers
- State Strategies to Promote Value-Based Payment through Medicaid Managed Care Final Report

Payment reform in state employee health plans

- Unleashing the giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability

General sources of information

- Milbank Memorial Fund's blogs and issue briefs
- Health Affairs' blogs and articles

Connections to other states through convening and networking

- NASHP for state health policy efforts overall
- National Association of Health Data Organizations (NAHDO) for health data organizations

Table of Summarized Findings

Table 11. Summarized report findings.

TOPIC	QUESTION	KEY FINDINGS
Stakeholder Goals and Objectives	*What drives stakeholder interest in primary care APMs?*	There is broad consensus across stakeholders that FFS models are limiting and that implementing primary care APMs supports achieving higher quality, lower costs over time, and more equitable health outcomes.
Practice Experience Participation in APMs	*What has been the experience of primary care practices with APMs?*	Primary care providers have advocated for moving away from FFS and appreciate participating in APMs that provide funds upfront and in an ongoing, prospective fashion.
		Not all APMs or features of APMs are well-received and some providers, even while seeing the faults in FFS, are hesitant to change the status quo.
		Practice leaders report significant administrative challenges with APM participation, including variability in model designs, requirements, and quality metric reporting; lack of data; coding burden; and inaccurate attribution.
		Practice ability to adopt APMs may be supported by participating in federal demonstration programs; being part of a large health system, ACO, or CIN; and receiving technical assistance and peer learning opportunities through state- or payer-led initiatives. *Participation in federal demonstration programs enhances practice readiness to participate in other APMs.* *Being part of a large health system provides useful infrastructure for practices to participate in APMs; however, this has led more practices to join large systems and contributed to practice consolidation.* *Accountable care organizations (ACOs) and clinically integrated networks (CINs) support APM participation through centralized support and aggregation of requirements, particularly for smaller independent practices.* *State- or payer-led initiatives can support APM adoption by facilitating practice transformation through peer learning and technical assistance.*
Results of APM Policy	*How has primary care APM policy progressed in pioneering states?*	Policy change to advance primary care APMs has been incremental and iterative.
	What have been the results of APM policy to date?	Regulation requiring primary care APMs has led to some improvements to models or implementation of new models by payers.
		Despite some movement on APM implementation, the overall impact of state APM policy efforts on primary care has been limited, due to (1) lack of multi-payer alignment, (2) the narrow scope of the market under state insurance regulation, (3) lack of mandated requirements, and (4) lack of granularity in policy around what qualifies as an APM.
		Compromises in policy (e.g., avoiding mandates) have decreased stakeholder opposition but constrained the intended impact.
	What state, market, and other contextual factors have impacted the advancement and momentum of APM policy?	The COVID-19 pandemic highlighted the need for APMs but also created delays in progress.
		The individual makeup of the insurance market in each state varies and can affect the ability of a state to implement APM reforms.
		The state political climate shapes the ability to advance primary care payment reform.

TOPIC	QUESTION	KEY FINDINGS
Barriers to APM Policy	*What barriers have states encountered while working with stakeholders to advance primary care APM policy?*	Insurance carriers desire flexibility to design their programs without restrictions or mandates.
		Some insurance carriers are hesitant to implement primary care APMs due to operational complexity.
		Health systems may not recognize the value of participating in primary care payment reform or face significant challenges in doing so, including having one tax identification number for multiple specialties, receiving payments off-cycle from budgeting, and facing myriad requirements across APM contracts.
		Multiple types of stakeholders share a concern that increasing investment in primary care and increased administrative costs of implementing APMs for carriers could lead to higher premiums for consumers without appropriate attention to other mechanisms to control costs.
		Interest and engagement from the public in primary care APM policy has generally been low due to its technical, "in the weeds" nature; lack of awareness; and sometimes alienating messaging.
	What barriers do states face in achieving multi-payer alignment?	Commercial, Medicare, and Medicaid populations vary significantly in terms of age distribution and care needs, creating challenges in model alignment, including around the adoption of the same metrics and identifying opportunities for reducing costs.
		With rare exceptions, stakeholders expressed that large national payers are generally not engaging in specific reforms at a state level, including lower levels of participation in federal demonstrations.
		Under federal ERISA law, states do not have regulatory authority over employer self-insured plans, and these plans have had limited voluntary participation in state-based payment reform.
		There is no unified regulatory authority across Medicaid, state employee, and commercial plans under state jurisdiction.
		State Medicaid agencies face several unique constraints to alignment, including limitations on implementing prospective payments.
Key Provisions of APM Policy	*When should different policy levers (e.g., voluntary, legislative, regulatory) be utilized?*	MOUs and other voluntary agreements have limited ability to create change due to the lower priority of voluntary efforts compared to other policy initiatives, lack of shared accountability, and susceptibility to disruption if key policy champions leave their organization.
		Despite limited effectiveness on their own, voluntary efforts can provide an avenue for advancing stakeholder consensus on APM policy in preparation for when legislation, regulation, or participation in federal demonstrations is feasible.
		Legislation is needed to grant appropriate regulatory authority to state agencies, including the authority to implement affordability standards. *Regulatory authority granted in legislation should match the scope of work required of state agencies.* *Codifying particular targets or definitions in legislation may limit regulators' ability to make necessary future adjustments.*
		Participation in federal demonstrations creates an ongoing structure to advance primary care APM policy and multi-payer alignment.

TOPIC	QUESTION	KEY FINDINGS
Key Provisions of APM Policy	*What targets should be set related to primary care payment reform?*	Targets for primary care investment lay a crucial foundation for primary care payment reform that can be tied to APM implementation.
		Targets for the percentage of primary care providers or covered lives in APMs can be set to scale implementation.
		Mechanisms to ensure primary care APMs meaningfully change how practices are paid include clearly defining what qualifies as a primary care APM or setting targets for the proportion of non-FFS dollars in APMs.
	Beyond targets, what other features of primary care payment reform policy are recommended by stakeholders?	When drafting legislation and regulation, policymakers should consider where there may be loopholes for stakeholders to interpret policy more narrowly or differently than intended.
		To allow for increased primary care investment, concurrent mechanisms are needed to control costs (e.g., hospital growth caps) and avoid cost-shifting (e.g., prohibiting investment from translating into premium increases for patients).
		To maximize impact and reduce administrative burden, states could require alignment of primary care APM efforts across all payers under state jurisdiction (e.g., state insurance department-regulated plans, Medicaid, and state employee health plans) to the greatest extent possible.
		Primary care advisory groups created through legislation or regulation provide a valuable platform to obtain feedback from diverse groups of stakeholders to inform the development of APM policy.
		State offices that regulate commercial health insurance separate from other insurance products (e.g., home, auto, life) increase focus and capacity on health policy priorities.
		Equity considerations (e.g., risk adjustment for social factors) should be incorporated in primary care payment innovations from the beginning and throughout the process.
		Data and evaluation inform improvements to overall primary care APM efforts and require adequate funding.
		Payments intended to support primary care should be paid directly to practices or enhance supports that benefit primary care practices.

TOPIC	QUESTION	KEY FINDINGS
Key Provisions of APM Policy	*What are ideal principles of APM design?*	States have varied in how prescriptive they are related to the type of APM required and balance of model standardization with flexibility.
		In terms of overall model direction, states have generally encouraged prospective payment.
		Quality metrics were highlighted as a common and high yield area of focus for multi-payer alignment to reduce administrative burden. Metrics should focus on what providers can impact and what matters to patients.
		Aligned care delivery requirements (e.g., on team-based care) standardize what is expected of a practice to participate in an APM and receive additional resources. *Tracks or tiers of care delivery standards allow practices with multiple entry points for APM participation to match their level of readiness, capacity shift financial systems, and current stage of advanced primary care delivery.* *Acceptance of alternate forms of advanced care delivery certification can help reduce duplicative reporting requirements.* *Common care delivery expectations as part of APM participation include enhanced access, care coordination, and expansion of team-based care, including integrated behavioral health for higher tier practices.*
		In addition to quality metrics and care delivery expectations, states have aligned APM components related to practice transformation support, attribution, and risk adjustment.
		Where downside risk is included in APMs, appropriate guardrails should be included.
		Model requirements should allow sufficient time for practices to transform to advanced primary care.
	What data should be collected on primary care APMs?	Collecting both non-claims and claims data is key for accurately measuring primary care spend and primary care APMs.
		There is an important role for both APCD data collection and supplemental reporting from carriers to state insurance regulators.
		Clear definitions and methodologies for data reporting on primary care are necessary for tracking and enforcing targets.
		Tracking and enforcing APM targets also requires defining categories of APMs for reporting.
		State insurance regulators and payers experience challenges to APM data collection and reporting related to navigating administrative burden and complexity.
		Successful data reporting involves an iterative process that includes collecting data multiple times per year and using standardized templates or forms.
		Cross-state learning and using vendors and consultants can facilitate APM data collection.

TOPIC	QUESTION	KEY FINDINGS
Key Provisions of APM Policy	*What monitoring and enforcement mechanisms should be included in regulation?*	Data transparency and regular communications between state insurance regulators and payers drive compliance and limit the need to use enforcement mechanisms.
		Data calls are an important tool to help understand primary care APMs at the carrier and provider organizational level.
		Market conduct exams could provide a formalized process for determining if regulation or statute is being adhered to and mandate corrective action.
		Corrective action plans were viewed as an intermediate step towards more aggressive enforcement tools such as fines or rate review.
		Fines are a common tool for enforcement by state insurance regulators. It is key to clearly define what counts as a violation and ensure that the fine amount includes flexibility and an appropriate cap.
		Rate review and rate denial are seen as "big guns" that will rarely be utilized in APM enforcement.
		Best practices for enforcement include state insurance regulators having the flexibility to use different tools for different situations and working with payers to support them in finding ways to meet regulatory targets and requirements.
		"Carrots" for health plan participation in APM advancement and alignment in addition to enforcement "sticks" can improve collaboration and engagement.
		Lack of regulatory authority over providers creates some complications in enforcement, as the ultimate effectiveness of regulation requires participation by healthcare providers and health systems.
Primary Care Needs in Addition to Payment Policy	*Outside of APM policy, what other reforms to support primary care are needed?*	States should develop a comprehensive strategy to support primary care practices moving towards more advanced care delivery, inclusive of but not limited to payment reform.
		State efforts to slow cost growth trends must look at healthcare system financing and delivery more broadly than primary care payment reform alone.
	What do states need from the federal government to support primary care APM policy?	States benefit from collaboration, scaling, and flexibility in federal demonstration programs. *New federal demonstration models should build on lessons learned.* *Federal collaboration with states on demonstration projects should start early and provide strategic flexibilities to enable multi-payer participation.*
		States would benefit from federal guidance around standardization of quality measures and other APM design elements for multi-payer alignment, definition of primary care, and methods for measuring APM spending.
		The growing proportion of Medicare beneficiaries in Medicare Advantage plans increases the importance of improving alignment with these plans in the federal movement on primary care APMs.

TOPIC	QUESTION	KEY FINDINGS
Stakeholder Engagement	*How can stakeholders be effectively engaged to drive change?*	Policy champions, who can be state officials, payers, or providers, are essential to drive the design, implementation, and maintenance of momentum on primary care APMs.
		State agencies can serve as conveners for multistakeholder alignment work, often benefiting from external consultant support.
		As a complement to standing primary care advisory groups, opportunities for public feedback improve the ability of state officials are hearing from all voices.
		In some cases, however, there are benefits to conducting closed door convenings for specific types of stakeholders, e.g., a payer-only group, to ensure their voices are heard and their concerns addressed.
		Employers can be further engaged in driving payment reform for primary care.
		Effective multistakeholder meeting facilitation includes onboarding, level-setting, iterative discussion, and driving towards a shared vision.
	How should the importance of primary care APM policy be messaged to stakeholders?	For effective messaging, ensure a baseline understanding about the value of primary care, unify communications about vision and planned changes, align with stakeholder goals, build on other state priorities, and share wins early and often.

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