

Putting Primary Care First: Factors Influencing State Medicaid Agency Participation in Federal Primary Care Models

By Greg Howe, Anne Smithey, and Rob Houston

Policy Points

- > Medicaid participation in federal multipayer primary care models has generally depended upon how well the model aligned with pre-existing state goals and initiatives
- > New federal primary care models should consider the unique needs and role of Medicaid payers, providers, and enrollees

ABSTRACT

The Centers for Medicare and Medicaid Services has recognized the importance of investing in primary care and has launched three models designed to strengthen it: Comprehensive Primary Care, Comprehensive Primary Care Plus (CPC+), and Primary Care First. All three models are designed to align multiple payers with Medicare. As the first or second largest payer in most markets and driver of a state's health policy priorities, Medicaid can be a very influential participant. To gain insights into state Medicaid agencies' decision-making around participating in these federal models, the Center for Health Care Strategies interviewed Medicaid leadership from nine states that considered participating in these models. These states included three Medicaid agencies that participated in CPC+, four agencies that had participating regions but did not join as a payer, and two agencies that opted to move forward with their own primary care models rather than participate in CPC+. State interviewees reflected on the value of stakeholder support, the importance of the primary care model aligning with existing state programs and goals related to advancing primary care, the need for financial and staffing investments to support the program, and challenges related to collecting, sharing, and using data. These insights informed key considerations and opportunities that could help shape future federal programs.

INTRODUCTION

For years, health care experts have stressed the importance of primary care for the health and well-being of patients.^{1,2,3} However, primary care is often under resourced and underutilized despite its well-established promise.⁴ The Comprehensive Primary Care (CPC) and Comprehensive Primary Care Plus (CPC+) programs were designed by the Centers for Medicare and Medicaid Services (CMS) to strengthen primary care across Medicare, Medicaid, and commercial payers. These models aim to use multipayer collaboration in value-based payment (VBP) methodologies to incentivize high-value primary care.⁵ Recently, CMS introduced Primary Care First (PCF) to build on CPC+ and give primary care practices the opportunity to enter a simpler, more risk-based arrangement.⁶

Multipayer VBP models help align payers' goals and allow providers to more effectively focus their time and resources on improving health outcomes for all patients, regardless of payer. These three models (referred to collectively in this brief as the Primary Care Models or PCMs) had a similar payer recruitment process. All three are voluntary, multipayer efforts that invite payers (including state Medicaid agencies, Medicare, and commercial managed care organizations [MCOs]) to apply to participate within defined regional geographies. Once payers are approved, primary care practices (PCPs) in the region are recruited and can voluntarily elect to participate. Ultimately, the spread of these PCMs has been determined by the willingness of a large number of payers to apply to the programs and PCPs to participate in these models. For state Medicaid agencies, Medicaid participation in PCMs can take different forms once the state is approved as a region or part of a region: (1) The Medicaid agency participates as a payer for its fee-for-service (FFS) population; (2) the Medicaid agency participates as a payer for its FFS population, and interested Medicaid MCOs participate for the managed care population; and (3) the Medicaid agency does not participate as a payer for its FFS population, but interested Medicaid MCOs participate for the managed care population. Throughout this brief, when we refer to Medicaid agencies "participating" in these models, we are specifically referring to the state Medicaid agencies participating as a payer, either through their FFS populations or, for

state Medicaid agencies with large or exclusively managed care populations, by encouraging Medicaid MCOs to participate as payers. Some of these state Medicaid agencies may also have encouraged their state leaders to apply to the PCMs. State Medicaid agencies that chose "not to participate" are ones that did not enroll their FFS populations and did not actively encourage Medicaid MCOs to participate as payers (though some of these MCOs may have elected to participate without encouragement). Similarly, these state Medicaid agencies may not have supported the state's application to be a PCM region, either actively or passively.

Though program evaluations of CPC and CPC+ have indicated mixed results to date,^{7,8} the number of regions participating in these PCMs has increased steadily over time, with seven regions participating in CPC,^{9,8} participating in CPC+,¹⁰ and 26 gearing up to participate in PCF.¹¹ Despite the consistent increases in the number of participating regions, there has not been a corresponding increase in the number of payers and practices participating in each region. (Additional information about these models can be found in Figure 1).

Medicaid agency participation in multipayer models, which may encourage other payers to participate and signals long-term state commitment to the program and primary care transformation, is likely to improve the chances of success for these PCMs. To gain insights into state Medicaid agencies' decisions about their participation in these PCMs, and potentially other voluntary federal payment models, the Center for Health Care Strategies (CHCS) interviewed Medicaid leadership from nine states that considered joining PCMs. The interviews sought to identify the factors that informed state decisions to participate in, or forgo, the CPC and CPC+ models, and whether or not they would be interested in participating in PCF. These states included three Medicaid agencies that participated in CPC+, four agencies that were located in participating regions but did not join as a payer, and two agencies that opted to move forward with their own primary care models rather than participate in CPC+. The interviewees and their states represented diverse viewpoints. CHCS spoke with interviewees in both urban and rural populations, Medicaid managed care and non-managed care states, and small and large states.

While state Medicaid agency interviewees agreed that CMS's efforts to improve primary care were worthwhile, opinions on particular PCM programs varied and largely depended on the state's primary care practice environment. In exploring state Medicaid agency leaders' perspectives on CPC and CPC+ models, this brief may provide useful feedback to CMS on program design changes that could increase Medicaid participation in future payment models.

CHOOSING TO PARTICIPATE IN PCMs

The interviewees from the nine state Medicaid agencies shared a variety of opinions related to agencies' decision-making on whether to participate in the PCMs, particularly CPC+. While specific themes clearly emerged on what issues were most salient, six factors surrounding the state's practice environment and health policy context determined whether the Medicaid agency decided to participate in the PCM. The following are six factors that emerged from these interviews. In the rest of this brief, the agencies' perspectives and actions should be understood to mean those stated or described by the interviewees.

Figure 1: Comparison of CMS Primary Care Models

Attribute	CPC	CPC+	PCF
Time Frame	2012–2016	2017–2022	2021–2026
Number of Participating Regions	7	18	26
Number of Participating Payers	38	52	37
Number of Participating Practices¹²	442	2,783	916
Payment Model	<p>A combination of three payment streams:</p> <ul style="list-style-type: none"> • Population-based care management fee (CMF) • Opportunity to earn shared savings if cost and quality metrics were met or exceeded • Standard fee-for-service (FFS) payments 	<p>Providers choose to participate in one of two tracks:</p> <ul style="list-style-type: none"> • Track 1 has FFS supplemented by a CMF and a performance-based incentive payment (PBIP) based on patient experience, clinical quality, and utilization metrics • Track 2 has similar CMF, PBIP, and FFS portions, but also adds quarterly lump-sum comprehensive primary care payments (CPCPs) that will reduce the FFS payments paid via claims 	<p>Payment structure broken into two components:</p> <ul style="list-style-type: none"> • Total primary care payment (TPCP) composed of a population-based payment and flat primary care visit fee • Performance-based adjustment based on key performance measures; the adjustment contains an upside to earn up to 50% of TPCP revenue, as well as a small downside of 10% of TPCP revenue¹³
Performance to Date	<p>An evaluation by Mathematica found CPC:</p> <ul style="list-style-type: none"> • Reduced hospitalizations and emergency department (ED) visits by 2% more when comparing Medicare FFS beneficiaries attributed to the CPC practices with beneficiaries attributed to comparison practices • Resulted in clinicians and staff having “largely favorable views of CPC” • Had little effect on clinical quality metrics and patient experience of care; while CPC generated some reduction in Medicare FFS expenditures, this was likely outpaced by the CMFs paid to practices¹⁴ 	<p>The latest evaluation of CPC+ by Mathematica, published in July 2020, found that CPC+:</p> <ul style="list-style-type: none"> • Drove small improvements in utilization, quality of care, and patient experience • Increased expenditures by 2%–3% when including enhanced payments provided to CPC+ practices¹⁵ 	N/A

1. Alignment between State Medicaid Primary Care Priorities and CPC+

While almost all Medicaid agencies mentioned primary care as an important priority for their states, how well CPC+ aligned with existing initiatives in the state was crucial. The Medicaid agency's judgment on how well CPC+ aligned with state priorities in primary care was a key factor in deciding whether to participate in the program and was mentioned by about half of the interviewed states. A few states that participated in CPC+ explicitly stated that they would not have participated if the program did not align as well with their priorities. For example, one state felt that CPC+ aligned well with existing multipayer primary care work, and another state appreciated that CPC+ expanded its focus on VBP and improving data capabilities at the provider level. Multiple states saw CPC+ as a good way to expand their focus on primary care to build on their efforts of implementing patient-centered medical homes (PCMHs).

State Medicaid agencies that did not participate¹⁶ in CPC+ and those that were not eligible to participate in CPC+ noted that their Medicaid agencies were already working on state-specific primary care programs when the PCMs were introduced and did not feel that the PCMs complemented their existing efforts and priorities. One Medicaid agency that decided not to participate mentioned that it felt its time and funding would be better used to support ongoing existing state projects, rather than implementing and supporting CPC+. Another state commented that the Center for Medicare & Medicaid Innovation (CMMI) designs models that offer substantial resources to providers, rather than using those resources to invest in customized state-led efforts that better align with the state's goals. Other interviewees also expressed interest in CMMI supporting state-led efforts.

2. Interest from the Governor's Office

Many state interviewees mentioned that interest from political leaders in PCM was a critical factor in deciding whether their Medicaid program would participate as a payer and whether the Medicaid agency would take an active role in encouraging other payers and providers in the state to participate. In a few states, governors did

not express interest in payment reform policies, leading these states to choose not to participate in CPC+. Other states that participated in CPC+ noted that encouragement from the governor's office was a significant part of their decision to participate. One state shared that commercial payers were behind initial efforts encouraging the governor to take interest in CPC+. Overall, about half of the interviewed states mentioned buy-in or lack of interest from the governor's office as a component of their decision-making process.

3. Interest from Payers and Providers

In general, the Medicaid agencies interfaced more often with payers than providers while deciding whether the state would apply to CPC+ and whether Medicaid would participate as a CPC+ payer. Even though Medicaid agencies did not need approval from commercial and Medicare payers to apply to participate in the program, more payer support made a stronger application, as well as broadening the potential impact on primary care in the region once selected.

Payers in various states had different levels of interest in the model. For instance, one state Medicaid agency agreed to support participation because other payers in the state were strongly interested in the program and wanted Medicaid to participate alongside them. In other states, governors or Medicaid agencies made the decision to participate unilaterally, without input from payers or providers, and then had to encourage reluctant MCOs to engage with the program once their state or region was selected. In these states, however, Medicaid agencies did not feel compelled to reach a critical mass of payer support before applying to participate in CPC+ because each individual payer in the state (Medicaid, Medicare, or commercial MCOs) could choose whether or not to participate in the region's model.

When considering both payer and provider response to CPC+, support for or against program participation may have influenced the state in participating but was rarely the deciding factor. States reported that providers tended to be less influential than payers during the decision-making process, given that the structure of the CPC+ application process required payers to apply and

be selected prior to allowing providers to apply to join the model. However, most states heard positive feedback from providers on the design of CPC+ once participation in the model began. In particular, state interviewees reported that providers had positive impressions of the multipayer aspect of the model, which enables consistent VBP processes and incentives across a large group of patients. Providers also appreciated the upfront care management payments, which help them invest in higher-value care during implementation rather than after achieving success.

4. State Insurance Market Concentration

The state insurance market environment (including commercial, Medicaid, and Medicare insurers) played a role in the Medicaid agency's choice about participating in CPC+. In interviews, Medicaid agencies in states with dominant commercial or Medicaid managed care payers indicated that they were less interested in participating in CPC+ because the multipayer aspect felt less valuable. In one state, for example, the majority of commercial and Medicaid members are covered by one payer, which provided little incentive for this payer to participate in a multipayer initiative.

In contrast, one state with a very competitive insurance market had significant interest from payers in CPC+ because providers had not invested heavily in meeting the requirements of any one payer's model. Payers and PCPs in this context both saw the value in developing a multipayer model that set consistent requirements for members in a variety of health plans and allowed providers to spend time and resources meeting one set of requirements. The Medicaid agency felt that this competitive insurance market contributed to the success in engaging payers and providers in CPC+ in their state.

5. Prior Experience with Multipayer Models

States that had previously attempted multipayer models in their health care systems said that these experiences played a role in their decision-making process for participating in PCMs. One state had a successful history implementing multipayer work while creating a PCMH model and saw CPC+ as the next step in evolving their approach. In two other states, unsuccessful prior attempts

to create a multipayer model influenced decisions to participate, albeit in different ways. In one state, payers were interested in CPC+ as a new way to make a multipayer model work and encouraged Medicaid and the governor's office to apply to participate in the program. In the other state, payers were unenthusiastic about the multipayer nature of CPC+ given their past challenges.

6. Financing CPC+

Many states that did not participate in CPC+ cited financing the model as a key concern. CPC and CPC+ require payers to include care management fees and performance-based incentive payments, in addition to standard FFS payments.¹⁷ CMS does not provide additional financial support to participating payers, meaning that payers would have to fund these payment model features in addition to FFS even if costs did not decrease.¹⁸ As a result, Medicaid agencies that pay relatively high rates to providers said that adding care management fees would likely have led them to reduce their FFS rates to balance the cost; this is precisely the reason that providers routinely push back against payment reform. In one state, hospitals opposed the adoption of CPC+ because they worried specialist rates would be lowered to increase primary care payments.

STATE MEDICAID AGENCY EXPERIENCES WITH CPC/CPC+

States with Medicaid agencies that chose to participate as a payer in PCMs generally discussed seven central themes they experienced when implementing and participating in the program. These reflections could help inform the design of future PCM models that will appeal to more states and potentially lead to widespread implementation.

1. Aligning Multiple Payers

Medicaid agencies that participated in CPC+ praised the multipayer model and multistakeholder requirements of the model. The state agencies enjoyed learning alongside other payers and participating in a program that would reach state residents enrolled in many types of insurance. One state talked about early challenges in creating trust between stakeholders but noted that consistent efforts to build relationships and the help of a skilled facilitator from CMHI improved this experience and

added value to the model. States discussed the role of Medicaid in multipayer convenings, noting that trust was built between Medicaid and the other payers by ensuring the Medicaid agency was one of many payers participating in the program, rather than driving the meetings and decision-making processes. Using the CMMI facilitator helped operationalize this role for Medicaid agencies. States also observed that they, like other payers and providers in the PCMs, benefited from the learning opportunities provided by multistakeholder convenings.

2. Expectations Were Met

States that participated in CPC+ felt that the model met their goals for primary care innovation, including building on existing PCMH programs, introducing non-FFS payments into primary care, informing state decisions about reimbursement rates, and creating a stronger relationship between Medicaid and commercial payers in the state. The program enabled some states to improve data collection in primary care and work with a broad range of payers to identify and begin to address gaps in care as well as sustain advancements in primary care. One state noted that some providers developed promising care delivery changes as a result of CPC+ participation.

3. Challenges with Data Activities

All states that participated in CPC+ noted that working with data was the most challenging aspect of the model. Multiple data-related challenges were mentioned by interviewees: (a) sharing data across different payer types; (b) sharing data among payers and providers; (c) dealing with the increased burden on providers to collect data; and (d) appropriately using patient data to track population health (e.g., importing health records into population health tools, stratifying data to guide patient outreach). Outdated data systems are common in government agencies, and many states reported that a lack of data capacity impeded their ability to effectively share data between Medicaid agencies and their partners. In particular, states noted that data collection and sharing platforms tend to be cumbersome, increasing the burden on all entities that have to work with data. Stakeholders

at every level of the CPC+ program found data-related activities challenging and could have benefited from greater state and federal financial and technical support in this area.

4. Voluntary Participation

Several states that were interested in CPC+ struggled to initially involve payers and providers in the PCMs, citing the voluntary nature of the models as a problem. In particular, some of these states noted that voluntary models are difficult when political leadership or the legislature is not fully invested in the model.

5. Regional Participation

Medicaid agencies that had only one region of the state involved in CPC+ did not choose to participate in the program. These interviewees instead preferred to focus on developing statewide payment and delivery system reform programs.

6. Flexibility

States had differing opinions on the prescriptiveness of PCMs. One state liked the structure of the models and found the explicit instructions and requirements very helpful in designing and implementing its approach. Other states noted that the model did not meet their particular needs because it didn't align with existing or planned state initiatives or priorities. These states would have preferred a more flexible model with access to tailored assistance and federal funding. Rural and small states noted that implementing models with many requirements can be too costly or resource-intensive for payers (including the Medicaid agency) and providers, and that models with more flexibility to meet specific state needs would be more likely to be successful in their states.

7. Using CPC+ to Prepare for the Future

One state felt that CPC+ prepared them for further efforts in primary care innovation, as the data collected for the program could be used to help identify gaps in care and drive future policies to improve primary care. This state also mentioned an interest in using data from CPC+ to better understand the state's primary care needs and inform future efforts to adjust Medicaid reimbursement rates to providers to bolster primary care and drive higher-value care.

REFLECTIONS ON PRIMARY CARE FIRST

PCF is CMMI's newest PCM and began on January 1, 2021. The model is designed to build on the principles of CPC+ while continuing to move away from FFS payment and focus on improving quality of care. The payment structure of PCF is different from CPC+. Providers are paid through (1) a population-based payment; (2) a flat fee for each primary care visit; and (3) performance-based adjustment that includes upside and downside risk, meaning that providers could be required to share losses with payers if they do not meet cost and quality targets.¹⁹

While all states interviewed conveyed a commitment to improving primary care in their states, states had mixed thoughts about PCF. Some states (including both participants and nonparticipants in CPC+) see PCF as an important next step toward improving primary care and expressed interest in participating in the model. Others were noncommittal, stating that they would consider participating in a future cycle but citing the timing of the program during the COVID-19 pandemic as a problem. Some said that they needed to first think through their primary care strategy and how PCF would fit into their plans. Other states indicated that they had no interest in the model, preferring their current primary care approaches and indicating that PCF increased financial risk for providers too quickly, as participating providers could lose up to 10% of revenue based on their quality and cost performance. A few states also were unclear about whether PCF is designed to be a "sequel" to CPC and CPC+ and were confused about whether CPC+ could continue beyond 2022.

Some states indicated that providers were not particularly interested in the model, or that they were more interested in participating in other primary care models, such as CMS's Community Health Access and Rural Transformation (CHART) model.²⁰ Others said they had not yet gauged provider interest. No state indicated that PCPs were excited about the model.

CONSIDERATIONS AND OPPORTUNITIES FOR FUTURE FEDERAL MODELS

As informed by interviews, the following key considerations and opportunities emerged for federal programs. While these considerations are for federal PCMs in particular, many of them could also inform other future federal efforts, particularly if those programs involve multiple payers.

- 1. Consult with states to understand state priorities and needs.** To maximize participation, CMS should consult with targeted states or survey all states to identify primary care and payment reform priorities before and during the model development process and design future models with this input in mind.
- 2. Allow flexibility for states to adapt to existing programs.** Interviewees indicated that a key factor for their participation in federal PCMs is whether the model aligns well with the technical requirements of existing programs (which vary from state to state). Therefore, federal programs that are designed to allow states to adapt them to their existing programs and efforts and appeal to health plans and primary care providers would likely increase states' interest.
- 3. Provide financial resources to help states cover additional costs.** Not surprisingly, states also mentioned financial support from CMS as a key factor in their decisions to participate in PCMs. CMS and CMMI should be mindful of state budgetary constraints when designing federal models of this nature. Even under the best of circumstances, models that require new financial investments from states, such as care management fees, performance-based incentive payments, and data investments, are less likely to be adopted than those that cover those costs. The financial impact of COVID-19 on state budgets will be felt for the foreseeable future, and states that are most impacted will be less likely to participate in new PCMs unless there is a financial incentive to do so. Implementing and administering new models also requires staff resources that may be stretched thin in the best of times, particularly in smaller states, but are clearly more strained in the current environment. It is reasonable to assume that many primary

care practices and other provider types would be similarly affected.²¹

- 4. Consider the unique needs and role of Medicaid payers, providers, and enrollees.** New PCMs should be designed with Medicaid payers in mind. Participation of Medicaid agencies and health plans brings a high volume of patients into new payment models and may encourage states to adopt more ambitious payment and delivery system reforms based on their experiences participating in PCMs. However, several interviewees noted that CMMI's approach to designing models may discourage participation by Medicaid agencies. One state commented that because CMMI models are designed primarily for Medicare, potential benefits of the models are limited to older and disabled adults, while neglecting pediatric and younger adult populations. This state also noted that CMMI staff have considerable Medicare expertise, but there are few staff that truly understand the Medicaid perspective and are capable of providing useful support to state Medicaid agencies to be successful in new models. Similarly, including primary care providers that serve a large volume of Medicaid patients, such as federally qualified health centers and community health centers, would also be beneficial and would involve coordination with the Health Resources and Services Administration.
- 5. Provide support for addressing data challenges.** As with any value-based payment model, collecting, using, and sharing data are critical elements of success for providers, health plans, and states. States struggled with all aspects of data in PCMs. While data challenges may not discourage states from participating in PCMs, future models that include greater financial and technical supports for developing user-friendly data platforms and opportunities for increasing the capacity of providers to use data effectively might be more appealing.
- 6. Look for opportunities to engage Medicaid providers that may have previously been uninterested.** The COVID-19 pandemic has cast a harsh spotlight on the shortcomings of the FFS payment system. Providers and provider organizations that were

previously reluctant to consider prospective payment models are recognizing the potential of these models to offer financial protection when the volume of services is reduced or unpredictable. States with providers and provider groups that are open to exploring new payment approaches may be more likely to push policymakers in their states to join PCMs.

CONCLUSION

While state interviewees agreed that federal efforts to improve primary care were worthwhile, their opinions related to the PCM programs—CPC, CPC+, and PCF—were varied and largely dependent on their state's current health policy environment. Though the details among states varied, state interviewees all agreed that stakeholder support, the way the PCM interfaced with existing state programs and goals, and the multipayer design were all important factors. For the agencies that chose to participate, implementation experience generally depended on how the PCM aligned with pre-existing state goals and initiatives. For states that chose not to participate, there were concerns related to the lack of alignment with their existing efforts, budgetary and staffing constraints, and minimal stakeholder interest. Ultimately, though, no matter what the PCM looks like, participation of state Medicaid agencies in federal PCMs requires flexibility among state Medicaid agencies and CMS. As CMS considers designing future PCMs, the insights from states and state Medicaid agencies may be useful in creating flexible models that will increase Medicaid participation and result in true multipayer models. Conversely, when considering whether to participate in these new PCMs, states and their Medicaid agencies may also need to be flexible, adapting existing efforts and programs to align with the PCM to reap the benefits of participating and to advance multipayer primary care in their states.

NOTES

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