Considerations for Statewide Advanced Primary Care Programs

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REPORT | March 2024

Milbank Memorial Fund

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ABSTRACT

As part of the movement to improve population health through investments in primary care, more than 20 states are measuring the percentage of overall health care expenditures on primary care.[1] The United States has over 10 years of experience with multipayer primary care models conducted in collaboration with the Center for Medicare and Medicaid Innovation (CMMI) that have helped to lay a foundation of advanced primary care. The energy around primary care investment targets, the impact of those investments, and lessons learned from CMMI's multipayer advanced primary care programs now present an opportunity for reflection on the role of states in advancing primary care.

In this report, we share insights gained from our experience working with CMMI on innovative state-led primary care programs in Vermont and Maryland, presenting key elements of approaches to invest new primary care dollars. Acknowledging that individual states will follow many different paths, this discussion is meant to be categorical rather than prescriptive. We hope that lessons learned from these state-led journeys can inform and assist other states working with Medicare and Medicaid to move toward increasing their own investments in advanced primary care.

HISTORY OF PRIMARY CARE INVESTMENT AND TRANSFORMATION

State-Led Programs

Over the last 15 to 20 years, several states have led an array of ongoing primary care transformation initiatives, often based on primary care practices implementing operations aligned with the National Committee for Quality Assurance's principles of the patient-centered medical home (PCMH) model.[2]

- Preceding a partnership with Medicare, Vermont passed guiding legislation that required all payers in the state to participate in an aligned payment model supporting qualified PCMHs and community health teams. This has been made possible by support through the Blueprint for Health[3] program for multistakeholder convening, centralized data aggregation, performance feedback, and a statewide shared learning network including practice coaches in each Health Service Area.[4]
- Oregon took a regional approach with its accountable Community Care Organizations,[5] which used Medicaid payments to support investments in advanced primary care and social support services. Oregon also provided state-level support for data feedback and shared learning through participation in CMMI models such as the Comprehensive Primary Care Initiative (CPC) and Comprehensive Primary Care Plus (CPC+).
- Rhode Island was one of the earliest states to require that Medicaid and commercial payers dedicate a specific percentage of their total expenditures to primary care investment, while also supporting shared learning and quality improvement along with other payers through the statewide Care Transformation Collaborative.
- Maryland, through its Total Cost of Care Model, built upon more than 40 years of experience with hospital rate setting by extending its program to include investments in advanced primary care[6] and engaging more than two-thirds of all eligible primary care practices. The state worked with the state health information exchange (HIE) to support data dissemination, align performance measures with the largest commercial insurer, establish a robust shared learning system, and develop a team of practice coaches under a Department of Health–based Program Management Office.

Common to these initiatives was each state's willingness to leverage its unique position and capabilities (e.g., convening or regulation) to advance participation and alignment in a primary care model, while building trust between payers and providers through investment in multipayer data sharing, convening, collaborative learning, organized quality improvement, and coaching.

- Now, an increasing number of states are making a commitment to setting statutory and regulatory spending targets at a level sufficient to support a strong primary care workforce capable of delivering whole-person, equity-focused, comprehensive primary care consistent with the recommendations made in the 2021 National Academies of Science, Engineering and Medicine (NASEM) report[7] on implementing high-quality primary

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care. The Primary Care Investment Workgroup, hosted by the Primary Care Collaborative, is facilitating discussions and providing resources to these states as they measure primary care spending and progress toward increasing investment in primary care. The Milbank Memorial Fund, together with the Commonwealth Fund and the Primary Care Development Corporation, has also established a network of state leaders engaged in setting primary care spending targets. As states engage in this work, they should consider how their state-supported programs will complement new and emerging CMMI models.[8]

The Role of States in Past CMMI Models

Since the passage of the Affordable Care Act, CMMI has been testing primary care transformation models. The first model, the Multi-Payer Advanced Primary Care Practice (MAPCP) model,[9] included eight states with varying approaches to PCMH payments and state-led transformation support. CMMI followed MAPCP with the CPC, CPC+, and Primary Care First models. Unlike MAPCP, these last three models incorporated a standard design for provider participation and took place in regions with or without state Medicaid agency participation, with variable participation by other payers, and without the commitment of sustainable state support. CMMI provided some level of transformation support, including sharing data and hosting model-specific learning forums. However, these CMMI-led programs started and stopped as part of each model's life cycle. One takeaway from the CMMI primary care model experience is the importance of Medicare participation to stimulate investments in primary care within markets, as well as the importance of state support and Medicaid managed care organization (MCO) participation to establish a more sustainable approach to transformation.

The Role of States in New CMMI Models

Based on its first 10 years of experience, CMMI published a report on its strategic refresh[10] in 2021, which continued to emphasize the importance of advanced primary care and, in particular, highlighted the findings in the NASEM report on strengthening primary care. The report identifies high-quality primary care as the foundation of a high-functioning health system.

CMMI is launching a new multipayer primary care model in 2024, Making Care Primary (MCP).[11] The model's mandatory Medicaid program participation, the inclusion of federally qualified health centers, and new requirements related to improving health equity will all contribute to strengthening primary care. MCP has a 10-year rather than a five-year life span to allow more time to realize the benefits of the payment and delivery changes.

CMMI recently announced an even more far-reaching state and regional program, the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model,[12] designed to allow states to take control of the total cost of care, health equity, and health priorities while encouraging hospitals to transition to global budgets and investing in a strong primary care infrastructure. This 11-year model provides a modest amount of funding for states to use for planning and implementation of essential capabilities to support transformation, including recruitment of providers into an advanced primary care program. Collectively, when aligned with payment and delivery models of a state's commercial payers and Medicaid, these advancements have the potential to support sustainable transformation.

CMMI's state-oriented approach in both models,[13,14] recognizes the strategic role that states must play in leading primary care transformation initiatives.

GUIDANCE FOR NEW INVESTMENTS IN PRIMARY CARE

The NASEM report provided evidence-based recommendations to increase funding for primary care. It suggested that a hybrid payment approach was the best vehicle to deliver the funding but fell short of indicating where investments should be made. Rhode Island, Oregon, and other states have primary care investment targets but do not specify how the extra dollars should be spent. By contrast, the Vermont Blueprint and the Maryland Primary Care Program have articulated transformation goals but have not identified targets for the investment dollar amount needed to attain the states' transformational goals.

Adding these missing ingredients will contribute to the success of new programs. States will need commitments from their commercial payers to make the required investment; define who is responsible for delivering the care; establish mechanisms for delivering the investments to the right health care organizations and/or primary care practices using the best hybrid payment methods; and ensure that all payers and providers are held accountable for effective use of the new investments to meet program goals such as access, quality, equity and population health.

States are well positioned to convene payers, providers, and other key stakeholders, including the Centers for Medicare & Medicaid Services, to leverage statewide contracts and statutory authority, and ultimately implement accountability measures to ensure that investments translate into a sustainable foundation of high-quality primary care. In Table 1, we present the statewide primary care program elements that are important for increased multipayer investment in primary care to be effective — and that can help primary care providers leverage new payment methodologies to deliver high-value primary care.

Table 1. Considerations for State-Led Multipayer Primary Care Investment Programs

Elements	Description
Leadership, Governance, and Policy	• Designate a leadership structure for policymaking • Secure governmental leadership • Require Medicaid and insurance regulatory policymakers to participate • Engage community-based health care, social support and advocacy groups, and provider stakeholders • Enshrine the program elements in statute
Business Case	• Payers see return on their investments • Purchasers see their investments improving desired health outcomes • Primary care providers gain revenue • State improves the health of the population • Consumers get greater access to high-value care

Infrastructure Costs and the Payment Model	• State government convenes and oversees the sources and uses of investments in infrastructure • Requirement of multipayer participation • Requirement of meaningful Medicaid participation • Integration of CMMI models where applicable • Primary care payments that are sufficient to attract and retain providers • State-provided financial support for data infrastructure and learning systems • Incentive payments focused on outcomes that primary care can substantially influence
Care Delivery Elements and Model Design	• Improved access for patients without primary care as well as 24/7 continuous access by patients to their primary care provider • Clear attribution methods at the provider and practice level that account for patient choice • Integration and coordination with behavioral health, mental health, and substance use disorder services • More complete health services based on patient needs including attention to social needs of patients and linkages to community-based resources • Use of available HIE to share data and improve coordination of health services • Provider reporting on care delivery elements, or use of aggregated data to reduce provider reporting burden • Aggregated data given to providers as available for use in improving care delivery
Data and Information	• Sustainable strategies for sharing and use of multipayer data including clinical, claims, and social needs • Collaboration of participating payers, health care providers, and community-based organizations with HIEs, health data utilities, and data aggregators to generate actionable insights • Use of aggregated data for monitoring of performance and for ongoing learning and improvement
Learning and Diffusion Systems	• Payers, providers, and community-based organizations participate in local and statewide learning and diffusion initiatives • Learning and diffusion activities are closely coordinated with program leadership priorities • Feedback loops inform leadership group decision-making • Multipayer multisource data (claims, clinical, other) are used to monitor comparative performance and generate actionable insights for improvement
Program Operations	• Operational elements to consider include program design, patient attribution to providers/ practices, marketing, application processing, information sharing, data and information management, incdentive program management, a system for learning, and claims and payment management • Level of support by the state depends on the roles assumed,which can range from oversight to a full complement of program management • The time and effort needed to build and sutstain program infrastructure is substantial • Effective operations and consistent state support are are key elements for the success of a primary care transformation programs
Sustainability	• Models provide sufficient time and investments for both onboarding and evaluation of results • Program leadership uses data-guided insights to adjust design elements • The program incorporates a combination of design elements that are applicable to multiple value based models to sustain provider and payer engagement • Political and financial support are maintained through multisector leadership • Guiding legislation helps to enable sustainable operations as leadership and priorities change

DISCUSSION

Leadership, Governance, and Policy

Leadership and support from the governor and the executive branch are essential in launching and maintaining a sustainable program, with a designated leadership group that has both authority and responsibility for achieving the objectives of advanced primary care.

The intersection between market forces, regulation, and the public interest highlight how state governments are well positioned to take a central role in the development and sustainability of a statewide primary care program. Leadership and support from the governor and the executive branch are essential in launching and maintaining a sustainable program, with a designated leadership group that has both authority and responsibility for achieving the objectives of advanced primary care; this is consistent with the requirement in the AHEAD model for an executive order to determine all-payer cost growth targets or at minimum to establish a process to determine the targets. Support from career state officials in the executive branch reduces the inevitable challenges of friction and inertia that programs face as leadership and budgetary changes occur.

In some states, levers for funding and use of funds are found in the regulatory authority of entities such as the insurance commissioners in Rhode Island[15] and Colorado,[16] or the Green Mountain Care Board in Vermont.[17] Other states use legislation: states that have established legislative mandates to measure and set targets for primary care spending are shown on the Primary Care Collaborative website.[18] In each of these states, including Rhode Island, Massachusetts, Maryland, Vermont, Oregon, and Colorado, there has been strong support from successive governors and ongoing support from legislative leaders.

The commitment and engagement of state Medicaid leadership is critical to a primary care program's success given Medicaid's size and the complexity of the population it serves. Medicaid explicitly includes both adult and pediatric providers in its coverage, offers broader benefits to address health-related social needs compared to other payers, and intentionally uses payments to stimulate better coordination between primary care and essential community support services. The inclusion of Medicaid coverage provides an opportunity for pediatrician participation and family practice providers caring for children, who have previously been left out of many models. Medicaid also allows an opportunity to coordinate with home- and community-based services. In addition, Medicaid can leverage contracts with MCOs to extend model requirements and payment strategies, supporting primary care providers with aligned incentives and performance priorities. The MCP and AHEAD programs wisely require the state Medicaid agency's commitment for participation, highlighting the importance of Medicare and Medicaid working together to effectively transform primary care within a market.

The governing body established by the state should be granted sufficient influence over payers and providers to implement an effective program. It should also establish a forum for meaningful input from key stakeholders, including payers, providers, professional associations, and citizen advocacy groups. Hospital systems and state hospital associations should be participants in governance forums.

Requirements for payer and provider participation is an important consideration, including the degree to which participation is voluntary or mandated. Some commercial payers, including Medicare Advantage payers and Medicaid MCOs,[19] have been slow to fully align on primary care payment and delivery models and must be provided mandates and/or incentives

to participate. Other states, like Tennessee[20] and Ohio,[21] have seen effective integration of advanced primary care into their Medicaid and MCO programs. MCP has been intentional in identifying opportunities for Medicaid alignment in eight willing states with engaged Medicaid leadership.

Business Case

A statewide primary care model must be attractive to providers, payers, consumers, employers, and state government from a business perspective.

Primary care providers

Payments to primary care providers must be sufficient to support the infrastructure and staffing necessary to achieve the requirements and goals of the program and allow for a stable financial margin. The providers' business case is enhanced by the addition of bonus structures that reward exemplary performance on measures that primary care providers can actually influence such as health, quality, coordinatiion, and equity. If primary care providers are required to take on financial risk, it is important to ensure that it does not put core operations at risk, and that reliable payments, both capitated and encounter-based, are sufficient for the practice to feel confident about investing in the new operating capabilities needed.

Specialists and hospitals

Strategies such as bundled payments, as in the Maryland Episode Quality Improvement Program (EQIP), can help with specialist buy-in. Bundled payment is most likely to be effective if performance incentives are aligned for both specialists and primary care providers. Hospitals may find the predictable population-based revenues under global budgets more attractive when combined with an advanced primary care program incentivized to reduce avoidable hospital utilization. Hospitals may also find opportunities to meet the goals of global budgets by shifting care to lower-cost ambulatory venues (primary and specialty care), with vertical revenue integration strategies. Providers of all types can benefit financially through the streamlining and reduction of administrative burden related to claims management and unaligned reporting requirements.

Payers

Enhanced primary care can have a meaningful impact on the capacity of providers to meet quality goals, reduce avoidable hospital utilization, improve safety and costs through medication management, and make longer-term improvements in the overall health of the population with proactive management of medical and social risk. Collectively, these factors can help control growth in health care expenditures, allow payers to negotiate payment rates that offer acceptable operating margins, and improve access for a payer's customers, which is a quality measure that many insurers use to bolster business.

States

High-quality primary care can contribute to a more effective and efficient Medicaid program linked to the state's social programs, which can impact the health of the state's population and its economy. Medicaid programs can incorporate payments and incentives that promote coordination between primary care and community-based organizations, which — along

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with investments in the capacity of community services — can better address health-related social needs. With the right data strategies, states can look holistically across their programs and budgets to demonstrate whether the investments are offset over time by reductions in avoidable health care expenditures related to improvements in control of chronic conditions, including mental health, behavioral health, and substance use disorders, as well as more sustained employment and reduced rates of incarceration. Ultimately, the business case for advanced primary care that coordinates with strong community support services rests on creating a healthier, more productive population, which makes the state more attractive for business growth and immigration.

It is important for states to incorporate an approach to monitoring that supports a common understanding of how their citizens view the effectiveness of their primary care services over time, such as the Person-Centered Primary Care measure being used in Making Care Primary.

Consumers

Consumers need to realize value from their health care payments, including the ability to get the right care at the right time, in a convenient location, and as part of a trusting long-term relationship. States participating in primary care models will need to educate consumers about the work being done to improve their access to high-quality care, and will need to help set expectations. It is important for states to incorporate an approach to monitoring that supports a common understanding of how their citizens view the effectiveness of their primary care services over time, such as the Person-Centered Primary Care Measure[22] being used in MCP.

Employers

Primary care offers long-term benefits, such as creating a healthier, more productive workforce, state markets that attract skilled workers, and, ultimately, reductions in the rate at which health insurance costs grow. Commercial insurers that act as third-party administrators for self-insured employers will need to work with the state to help convince their customers that investments in advanced primary care are cost-effective, including for employers that may have health and wellness programs.

Infrastructure Costs and the Payment Model

When planning a statewide primary care program, consideration should be given to the uses and sources of funds that go directly to providers for patient care support, along with funding for program staff and infrastructure support. Costs for building and maintaining infrastructure support will vary depending on the operational elements. Even minimal operational elements will incur significant staff costs, including those related to convening participants and implementing a meaningful decision-making process (e.g., governance).

Funding sources may vary by state, depending on participating payers and whether the state is involved in a CMMI model. Within the emerging MCP model, states will be encouraged to achieve multipayer alignment, with an emphasis on meaningful Medicaid participation. For states participating in the AHEAD model, CMMI is making modest upfront cooperative grant payments to the enrolled states for planning and to offset infrastructure costs. States may also seek Section 1115 waivers[23] for their Medicaid programs to support investments, as in Massachusetts[24] and Oregon,[25] among others.

States may develop statutory and/or regulatory authority over commercial insurers to require increased primary care funding, as has been done in Rhode Island, Delaware, and Colorado. Funding for infrastructure may ultimately need to be supported by executive budgets and/

or legislative actions. At the federal level, CMMI may elect to expand and make permanent current state-based primary care demonstration projects, such as the Maryland Primary Care Program[26] within the state's Total Cost of Care Model, or the Vermont Blueprint for Health.[27] Regardless of the source of funding, states will need to do considerable planning and gain stakeholder input to ensure that the funds are used efficiently and for the intended purposes. States should strongly consider making sufficient and sustainable investments in data infrastructure, learning networks, primary care workforce development, and administrative capacity to manage the model.

The most important element in building a statewide primary care program is ensuring that the payment model is sufficiently robust to accomplish the primary-care-dependent population health goals while strengthening the primary care delivery system. A sufficient overall level of investment, predictable annual revenue, and a hybrid payment methodology[28] will allow providers to deliver necessary face-to-face care while supporting population-based practice-level interventions. For voluntary primary care programs to gain the broad adoption necessary for statewide impact, the payment methodology must be sufficiently generous, and the administrative burdens must be equal to or less than the current fee-for-service reimbursement. Programs lacking sufficient payments will not be able to achieve the intended goals or attract a critical mass of providers. The Primary Care Collaborative's concordance statement[29] based on the NASEM report provides an excellent starting point and proposes a hybrid payment framework that includes risk-adjusted, equity-sensitive, population-based payments in conjunction with well-funded fee-for-service payments that incentivize necessary face-to-face visits.

As states make investments in primary care, they will need to monitor how those investments are used and the impact on program priorities. States should invest early on in the ability to aggregate reliable data for operations, evaluation, and sustainability. All payment models have some level of incentive payments linked to meeting predetermined process and/or outcome goals. When designing the incentive program, states should engage stakeholders to ensure that primary care providers can influence measured outcomes and that the measures are relevant to the population health goals, weighted according to their relative importance, and sensitive to demographic variations. Measures like controlling high blood pressure and attaining glycemic control, which are largely under the control of primary care providers, should carry heavier weight in an overall bundle of incentives.

Ideally, measure results can be generated using aggregated data captured as part of daily operations without additional provider reporting burden. Consideration should also be given to investing in a routine feedback mechanism and practice coaching to support ongoing quality improvement at the practice level.

Care Delivery Elements and Model Design

The enhancement of primary care payment is largely intended to address the gap between primary care and specialist incomes and, more importantly, to fund the staffing and infrastructure costs associated with the delivery of enhanced primary care services. The package of enhanced services desired may vary depending on the state's priorities and the available funding. However, a core group of care delivery elements are most likely to improve health outcomes and restrain cost growth. These elements are born of the Starfield 4Cs,[30] (1)

first contact, (2) coordination, (3) comprehensiveness, and (4) continuity, all four of which are supported by a legacy of scholarly studies.

"First contact" implies that the programs include efforts to expand access to primary care providers. The ability to connect with a primary care provider that has access to the patient's clinical record is a powerful tool in avoiding unnecessary emergency department, urgent care, and hospital utilization. First contact can be supported by expanding telehealth options, expanding office hours and investing in an adequate primary care workforce, including promoting the use of advanced practice providers.

The "coordination" element of the 4Cs describes the role of primary care in coordinating care with specialists, managing transitions of care, and having the tools and staffing to identify and address the care of high-needs patients. These functions will need to be carried out by appropriately trained staff and supported by advanced health information tools and interoperability across care settings.

"Comprehensiveness" can be achieved by building on the untapped capabilities of primary care to provide services that are in short supply in the community or have been relegated to specialists. The most pressing element is integrating behavioral health services. At a time when the nation is facing a mental health crisis,[31] primary care practices can screen and begin evidence-based treatments for behavioral health disorders, particularly when the primary care team is augmented with licensed counselors and therapists. Comprehensiveness of primary care also includes being able to screen for nonmedical patient needs and having the necessary staff, such as care managers, community health workers, and social workers, to help patients access community-based organizations and other resources to mitigate these issues.

The "continuity" element speaks to the role of primary care in developing and sustaining longitudinal care and building trusted relationships. The states will need to develop attribution methodologies to understand and support these relationships, and consider performance incentives based on patient experience.

Beyond the 4Cs, care elements should focus on the equitable delivery of care. The state will need to provide the technical assistance and data tools for practices to fully understand and respond to the diversity of their patient populations, including variation in care patterns associated with sociodemographic factors. Increasingly, CMMI models require participants to produce plans on how they will improve health equity and reduce disparities as part of model participation.

There should be a process for verifying that primary care investments translate into effective use of care delivery elements and a method for holding providers accountable for these services. In CMMI models this has been accomplished by self-reporting of care transformation requirements. Other methods of verification using external resources, such as monitoring for behavioral health integration in collaborative care claims and verifying log-ins to health information technology services, should also be developed. In particular, states and other payers that work closely with HIEs can leverage nearly real-time data on hospital encounters, ambulatory care patterns, recommended and preventive care services, procedures, and test results. Aggregated data from HIEs can reduce provider reporting burden if they are leveraged to monitor health service patterns, care continuity, and fragmentation and can help identify opportunities for improvement in care delivery.

Data and Information

Providing practices with actionable data-derived insights[32] is an important support for an effective primary care transformation model, and for accountable care models overall.[33] Payers frequently prioritize the use of data to support value-based care, and are willing to align with other payers on data strategies as long as it does not compromise their competitiveness within a market.[34] Because of their wide array of data sources, and their potential to serve as a neutral convenor for payers, providers, and data aggregators such as HIEs, states are well positioned to lead multipayer initiatives that incorporate different types of data to deliver useful information to practices. Aggregation of demographic, claims, clinical, attribution, vital statistics, and social needs data, along with other types of data, can be used to generate the types of focused insights that practices can use, including those with limited data capabilities such as smaller independent practices.

It is important that data initiatives provide practices with information that goes beyond what is available in their electronic health records, helps them prioritize patients for outreach and more proactive care, and offers a more holistic view of their patient population. Aggregation of claims, clinical, and sociodemographic data can support a number of important use cases, such as profiles that address medical risk due to poorly controlled health conditions, risk from health-related social needs, gaps in recommended and preventive care, and much more. As primary care models increasingly promote integration, state data from mental health/behavioral health, and substance use disorder programs can be used to promote coordination across the array of providers needed for effective services. Ultimately, it is essential for states and other payers to work closely with providers to prioritize use cases that align with primary care priorities, and to incorporate data delivery methods that can be easily adopted by practices as part of their routine workflows.

There are important considerations for states that choose to incorporate data initiatives as part of their primary care transformation models. First, consider sustained state leadership that prioritizes data sharing, including ensuring other state agencies are willing to overcome habitual resistance to data sharing and participate. State data from medical claims, public health registries, eligibility for safety net programs and support services, corrections, and labor are examples of data sets that, when shared, can improve strategic planning, coordination of services, and monitoring of model performance. For example, the impact of a primary care model that incorporates treatment for substance use, such as medication-assisted treatment for opioid use disorder, can best be understood with aggregated multisector data (health care, corrections, employment). Aggregation and reuse of these data must be done in ways that protect confidential information and are compliant with federal and state privacy and security rules, while still leveraging the power of data-derived insights on behalf of the state's population.

Second, avoid the tendency for states to treat these initiatives as technology or informatics projects led by technical teams. Instead, state-led data initiatives should be assigned leaders with health care expertise and experience using data for ongoing improvement. The needs of the health system should define its technical and infrastructure development, with data and informatics teams supporting the programmatic needs. Without the right state leadership, technical and informatics teams will define and control what is produced, resulting in a system that may be less useful to the intended end users.

Third, develop the infrastructure in a sustainable way, with capabilities that can be applied beyond the life span of any individual model or health care improvement program. Historically, many state-led data initiatives are conducted within specific agencies on a program-by-program basis, with tightly defined outputs for particular use cases. Primary care transformation is increasingly viewed in a much broader context that includes its coordinating role with specialty care, hospitalists, behavioral health care, long-term care, and community-based support services. This central "quarterbacking" role for primary care applies to populations covered by all payer types. Data-driven insights must be applied to improve prioritized services for all of these populations, with the flexibility to adapt to priorities that shift over time.

To accomplish this, states can work with other payers and regional data aggregators, such as HIEs, to establish the capacity to aggregate multipayer data (claims, clinical, other), along with the ability to provide extracts to support specific care management and quality priorities that may change with time. Approaching data initiatives as a sustainable core utility requires sustained leadership and commitment at the state level with the ability to convene and work in a meaningful way with other payers.

Learning and Diffusion Systems

States should establish an effective and sustainable learning and knowledge diffusion network, which is essential to transform and continually improve the delivery of primary care. Many providers, their staff, and virtually all members of the public have little knowledge of the elements of an advanced primary care model.

Creating a statewide, data-driven central learning system will help ensure that all parties can get information as part of a trusted, credible process that promotes peer-to-peer learning and an environment of "all teach, all learn."[35] It is helpful to extend this structure with regionally organized "natural" learning nodes that leverage local clinical leadership and utilize trusted practice coaches. In this way, a formalized statewide network approach (centralized and regional) can promote ongoing learning and diffusion in ways that are more likely to be adopted and to address local priorities.

An important companion to the learning system is a communication platform that provides a forum for practices to share documents, training, and notices, as well as hosting affinity groups and a calendar of program events. In addition, delivery of data-derived insights related to comparative performance and variation can provide motivation and engage providers in shared learning and ongoing improvement. The success of this platform depends heavily on sustained investment in data aggregation as described. Ultimately, the goal is to strengthen and expand a culture of data use, shared learning, and a willingness to change operations based on evidence.

Program Operations

Experience from a decade of CMMI primary care models [36] has highlighted the importance of infrastructure and support systems for effective primary care transformation programs. While states may vary in the levels of support they are willing and able to assume, it is important for them to work with stakeholders, and in particular primary care providers, to ensure that essential elements are addressed in the design and ongoing operations of

the model. The amount of time and effort required to build infrastructure should not be underestimated. Important operational elements to consider are:

- **Program Design.** A stakeholder team should design the program and ongoing modifications based on experience, performance, and emerging priorities to ensure sustained engagement and alignment across payers and providers.
- **Patient Attribution.** The process of attributing patients to providers and/or practices is essential for population-based payments, incentive payments, quality reporting, and accountability. This process requires at least annual and ideally quarterly updates. Providers must have a streamlined process for reconciliation where there are disagreements.
- **Marketing.** A team is needed to recruit providers and practices for annual enrollment by managing and presenting marketing materials and addressing provider questions
- **Application Processing.** Annual application processing requires the development and maintenance of a submission platform, establishment of a process for provider data confirmation, and a defined vetting process.
- **Information-Sharing Platform(s).** A hosted intranet platform will allow sharing of information, effective strategies, and important events.
- **Data and Information Management.** Management of data and information is a critical operational element, as previously discussed in more detail.
- **Incentive Program Management.** Central to all payment models is a fair and balanced incentive program with stakeholder input. Performance-based incentives ideally are driven by automated measurement that does not add to provider burden.
- **Learning System.** An effective learning system is critical for engagement and ongoing improvement.
- **Claims and Payment Management.** If states take on the role of managing claims and making payments, as proposed in the Massachusetts model,[37] it will require a significant infrastructure to be built or bought from an existing third-party administrator. If the decision is to outsource the claims and payments, a permanent state team will still be needed for coordination and accountability.

It is important for states to recognize the connection between operations and sustainability and to work closely with stakeholders. For example, primary care participation will be difficult to maintain if payments are not timely or accurate, do not reflect their attributed population, or are inadequate to support daily operations and the staffing that is needed to meet the model's objectives. Payer participation will be difficult to maintain if reliable data, performance monitoring, and objective evidence are insufficient to justify ongoing investment. Broader stakeholder engagement, including state programs outside of Medicaid and community-based organizations, will require convening the participants to provide meaningful input into operations.

Model performance may not be optimized without consistent state support for ongoing data-guided learning and improvement, which may be compromised by changes in administrations and leadership. Additionally, without reliable monitoring of consumer experience, it will be

difficult for states to maintain political support for primary care investment over time. While these dependencies may seem readily apparent, the focus on the full array of operational elements can diminish with time, highlighting the importance of effective leadership and broad support at the state level.

Sustainability

A statewide health care delivery and payment program that does not plan for sustainability is likely to fail and lead to an erosion of trust in the capacity of state government to lead large-scale reform initiatives. To be sustainable, programs must plan to adapt over time to meet the changing needs of the populations being served and their care providers. States like California[38] and New Mexico[39] serve as examples of planning for long-term transformation. As noted, states must make commitments to using data-guided insights to adjust design elements, including incentive design, as part of a learning health system approach.

Another essential element for sustainability is a reliable process for evaluating the program's impact on key outcomes such as patient experience, health outcomes, quality of services, equity, utilization, and expenditures. Both federal and state models often employ evaluation strategies with contractors. Delayed releases of these detailed reports can make it difficult to maintain long-term engagement and investment, particularly with payers who must negotiate with their ERISA purchasers to support the investments in primary care. States can leverage available data sources, including aggregated multipayer data from entities such as regional HIEs and all-payer claims databases, to report the program's impact in a timely fashion.

Convening and engaging payers and key stakeholders to design and oversee monitoring provides confidence in the results and ongoing investment in primary care. Likewise, reporting key performance indicators to stakeholders and the public in a timely, easily understood, and well-validated format lends support and credibility to the program. Ultimately, the results of monitoring should generate insights used to adapt model design, strategies, and operations as part of the overall learning system approach.

Multipayer programs will also be more likely to be sustained if the burden of financial support is equitably distributed among the participant payers, including the state. Statutory and regulatory safeguards should be in place to prevent "free riders." Similarly, providers will be more amenable to remaining in a multipayer program if the payers are closely aligned on attribution, payment, quality and care delivery requirements, monitoring, and benchmarking strategies.

The scope of operational issues that states manage directly influences the number of people and level of resources dedicated to the primary care transformation model. It is essential that state leadership commit to maintaining an adequate level of investment over a sufficient period of time to be successful. As noted, CMMI has incorporated longer timelines for the MCP model (10 years), and the AHEAD model (11 years), building on experience in previous five-year models. Given that changes in state leadership are likely to occur over a decade, it may be important to have guiding legislation and regulatory requirements that demonstrate the sustained commitment needed for providers to participate, particularly if the model incorporates increasing levels of provider responsibility for key outcomes. In addition, states will need a stable workforce with skill sets matched to the various complex operations, such as ensuring appropriate attribution and payment, implementing data systems that support operations, and convening participants for data-guided learning.

CONCLUSION

Statewide advanced primary care programs offer a path through which states and the federal government can take their fiduciary responsibility for the health of their citizens in a new and hopeful direction. After decades of experimenting with payment and delivery models that have failed to produce the desired financial and population health outcomes, we are beginning to invest in the foundation of health care: whole-person, longitudinal, relationship-based primary care, with a growing emphasis on working closely with social support service providers. As this next chapter begins, all stakeholders should prepare to ensure a successful and sustainable transformation to a health care system built on a strong foundation of advanced primary health care. As in the statement that is attributed to Winston Churchill, "You can always count on the Americans to do the right thing, after they have exhausted all the other possibilities." This investment may finally be the "right thing" for health care in the United States.

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