AAFP Primary Care Investment Toolkit

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

TABLE OF CONTENTS

PRIMARY CARE INVESTMENT TOOLKIT SECTIONS

Introduction

Primary care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs. A 2021 National Academies of Science, Engineering, and Medicine (NASEM) report made this point abundantly clear, stating, "Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes."[1]

Despite the strong evidence for action, primary care investment as a percentage of total health care spending lags significantly in the United States compared to most other high-income countries. Across public and private payers, primary care spending in the United States has trended downward from 6.2% of all health care spending in 2013 to 4.6% in 2020.[2] Contrast these figures with other high-income nations, which, on average, directed 7.8% of all health care spending toward primary care in 2016.[1] Countries with the highest-performing health care systems that produce better patient outcomes at a lower overall per capita cost have an important theme in common. A report from the Commonwealth Fund states that the highest-performing health care systems "invest in primary care systems to ensure that high-value services are equitably available in all communities to all people."[3]

While the exact percentages are difficult to ascertain given the varying approaches to defining and measuring "primary care," the highest-performing international systems are estimated to spend an average of 12-17% of overall health expenditures on primary care.[4] This investment translates to expanded care teams, more convenient and low-cost access to care, near-universal coverage that provides low or no-cost access to primary care, and strong public health and social resources.

In addition to providing the rationale for action, the NASEM report made clear that everyone has a stake in increasing primary care investment, stating, "primary care is a common good, making the strength and quality of the country's primary care services a public concern."[1]

The American Academy of Family Physicians (AAFP) joins others, such as The Milbank Memorial Fund and the Primary Care Collaborative, to champion the call for greater investment in primary care. To date, stakeholders in more than 20 states and regions nationwide are working together to close this investment gap and strengthen primary care systems.[5]
The rationale for action and the specific goals of state-led efforts may vary, but the overarching aim to strengthen primary care frequently includes:

- Increasing overall primary care investment.
- Transitioning primary care payment to well-designed value-based payment models that offer flexibility and financial stability, which practices can leverage to support primary care teams (e.g., social workers, behavioral health professionals) and provide advanced primary care services that are undervalued and require burdensome documentation in the fee-for-service (FFS) environment.
- Ensuring increased investment results in well-resourced primary care practices, including higher wages for primary care physicians and care teams to ensure a stable and sustainable workforce for the future.
- Improving patients' access to and connections with primary care teams for all people in all communities to address known disparities.
- Achieving the Quadruple Aim of better care for individuals, better population health, lower per capita cost of care over time, and returning the joy in practice and caregiving to primary care physicians and care teams.[6]

The AAFP's Role

The AAFP accelerated the work of increasing primary care investment by hosting the 2022-2023 Primary Care Policy and Investment Learning Community for AAFP state chapters. Physicians and staff leadership from more than 35 states learned from one another, identified best practices, and brainstormed solutions to common challenges. In addition, the learning community offered access to national experts in primary care policy and opportunities to develop deeper connections with colleagues across the nation.

How To...

The learning community's work informed the Primary Care Investment Toolkit, which was developed and designed by the AAFP in collaboration with consultants at Freedman HealthCare. The toolkit is organized around five key 'How To' steps in the process of driving state-level change. The 'Primary Care Investment Matrix' (also linked below under 'Advocacy Resources') is a quick introduction to learn more about our 'How To' strategies to advance primary care initiatives.

Click on the icons below for a deeper dive as you learn 'How To': define a shared vision, engage stakeholders, set targets for investment, measure primary care investment, and establish accountability..


Define a Shared Vision


Engage Stakeholders


Set Targets for Investment


Measure Primary Care Investment


Establish Accountability

States across the nation are at varying points on their journey to increase primary care investment, and they have lessons to share with other states and your chapters. Click on the 'Primary Care Investment Case Studies' icon below to learn more about six states' progress in their journeys along the AAFP's five key 'How To' steps to increase primary care investment.

Primary Care Investment Case Studies

AAFP state chapter leaders, staff, and members are driving conversations about primary care policy and increasing investment by leading or contributing to work in their state. This includes participating in multi-stakeholder workgroups and meeting with stakeholders outside of these groups to align understanding and elicit buy-in to advance primary care in the state. Click on the 'Primary Care Investment Workplan' icon below to learn the key tasks and activities for individuals and chapters centered around the AAFP's five key 'How To' steps to increase primary care investment.

Primary Care Investment Workplan

Advocacy Resources

A key driver to increase primary care investment in your state is leveraging human and financial resources to advocate for your goals. The AAFP has developed a number of additional resources to give you and your chapter the knowledge and understanding to present to stakeholders as you pursue the goals of increasing primary care investment. Resources include various state legislation on primary care investment and a PowerPoint template to use and modify as you present to stakeholders the rationale for increasing primary care investment in your state. Click on the bulleted items below to either take you to that section of the toolkit or to additional resources on the AAFP website.

- AAFP Primary Care Policy and Investment Glossary
- Frequently Asked Questions
- Making the Case for Primary Care (PowerPoint)
- Primary Care Data Collection Templates and Manuals
- Primary Care Investment Matrix
- Primary Care Legislation (Excel)

States across the nation are at varying points on their journeys to increase primary care investment. The examples below highlight six states' progress in engaging stakeholders, defining a shared vision, establishing accountability, measuring primary care investment, and setting targets for investment. The case studies section of this toolkit provides tools and lessons learned from six states (Colorado, Delaware, Massachusetts, Oklahoma, Oregon, and Rhode Island) and their work toward meaningful increases in primary care investment. The icons below appear at the beginning of each state's section to indicate that the state has achieved or is working toward these goals.

Colorado's Primary Care Payment Reform Collaborative

Background: In 2019, Colorado established the Primary Care Payment Reform Collaborative (PCPRC). The workgroup develops "strategies for increased primary care investments in primary care that deliver the right care in the right place at the right time and advise in the development of affordability standards and targets for carrier investments in primary care."[7] The workgroup also publishes annual primary care recommendations.

The Colorado Department of Insurance (DOI) convenes the group, which includes providers, consumers, actuaries, and representatives of insurance carriers, employers, state agencies, and the Centers for Medicare & Medicaid Services (CMS).[7]

Key Policies: In its initial report in 2019, the PCPRC recommended that a comprehensive definition of primary care, including both claims and non-claims primary care spending, be used to measure primary care investment. It also established an investment target to increase primary care investment by at least 1% annually through 2023 and recommended that investment support the provider adoption of advanced primary care models for whole-person care. The PCPRC preferred that additional investment occurs through FFS funding mechanisms, including infrastructure investments and alternative payment models (APMs) focused on prospective funding and incenting quality improvement to support the delivery of advanced primary care.[8]

In 2020, the PCPRC recommendations focused on aligning goals and expectations across payers to support care delivery transformation and increased use of non-claims payments. This focus included measuring performance consistently across APMs, incorporating equity in health reform, and collecting data to understand racial and ethnic disparities better.[9]

In 2021, the PCPRC recommendations reinforced investment in value-based and infrastructure payments in APMs centering around health equity. The PCPRC outlined key actions and actors to build a foundation of equity in APMs. They elaborated on recommendations for integrating and increasing access to behavioral health services within primary care.[7,10] Due to the impact of the COVID-19 pandemic, the PCPRC recommended a renewed focus on increasing collaboration between primary care and public health.[10]

In 2022, additional legislation was passed to direct the Colorado DOI to establish primary care APM adoption standards. To support the DOI in this work, the PCPRC serves as a convening group for discussions across stakeholders on quality measurement, patient attribution, risk adjustment, and core competencies.[7]

Takeaway: The Colorado PCPRC is an example of a multi-stakeholder group that works hand-in-hand with state agencies to support primary care transformation. Their involvement in the detailed aspects of care delivery, payment innovation, and improving health outcomes provides a path forward for the state to increase investments in primary care, improve the health of its citizens, and reduce care costs.

Delaware's Legislative and Regulatory Approach to Primary Care

Background: In 2018, the Delaware Health Care Commission established the Primary Care Reform Collaborative (PCRC) to develop recommendations to strengthen the state's primary care system. The PCRC's scope of topics includes payment reform, value-based care, workforce development and recruitment, directing resources to expand primary care access, increasing integrated care (including for women's and behavioral health), and evaluating system-wide investments into primary care using the state's all-payer claims database (APCD) to evaluate primary care investments. The PCRC comprises medical associations, public and private payers, and members of state agencies and the legislature.[11]

In 2019, the PCRC supported the establishment of the Office of Value Based Health Care Delivery (OVBCD) under the Delaware Department of Insurance (DOI) to establish affordability standards, mandatory minimums for payment innovation to support a robust system of primary care, and collect data and develop reports on carrier investment in health care.[11]

Key Policies: In 2021, the General Assembly passed legislation implementing affordability standards. The legislation was based on recommendations from the OVBCD in consultation with the PCRC. The legislation directed carriers to increase primary care investment by 1.5% annually until reaching 11.5% of the total cost of medical care, limit price growth for hospital and other non-professional services, and expand meaningful adoption of APMs.[5] The legislation tied approval of annual commercial fully insured rates by the DOI to compliance with the state affordability standards.[11] It also tasked the Delaware Health Care Commission with monitoring compliance with value-based care delivery models and developing a Delaware primary care model. The law tasks the OVBCD with developing regulations on topics, including APMs, provider price increases, carrier investment in primary care, and other activities to support a robust primary care system.[12]

The OVBCD developed regulations to support insurance carrier compliance with affordability standards, which are annually evaluated through the rate review process and supported by an annual public report. Insurance carriers that do not meet the requirements may have their rate filing denied, be required to submit a corrective action plan, be subject to additional reporting requirements, and/or pay administrative penalties for non-compliance.[13]

Takeaway: Delaware is one of two states with mandated primary care investment requirements tied to its annual rate review process,[5] which enables accountability at the carrier level. Requirements for increased investment, which are tied to accountability, can result in a defined process to foster a system change with specific requirements supported by the state government to comply with state laws. These types of opportunities provide an additional avenue for aligning the vision for primary care across payers.

Massachusetts' Stakeholder-designed Primary Care Model

Background: The Massachusetts insurance market has a variety of primary care-related APMs offered by private and public payers. In 2019 and 2022, then-Governor Charlie Baker introduced a bill to the legislature to increase primary care and behavioral health spending by 30% over three years.[14] While the act did not pass, it drew attention to the need for increased primary care investment in the state. Later that year, the Massachusetts Center for Health Information and Analysis (CHIA) published its mandated report on primary care spending in the state. They identified spending of 7.1% of the total cost of care dedicated to non-pediatric primary care services (excluding behavioral health prescriptions and obstetrics and gynecology [OB-GYN] services) across all payer types (commercial, Medicare, and Medicaid).[15]

Key Policies: In 2023, another bill was introduced in the House and Senate, which put forth the work of the Massachusetts Primary Care Alliance for Patients (MAPCAP). The bill requires commercial payers to offer an optional primary care payment model called Primary Care for You (PC4You). PC4You aims to decrease health inequities by doubling primary care investment and replacing the predominant payment model for primary care from an FFS model to monthly prospective payments.[16]

In this model, primary care clinicians and practices are incentivized to invest in a range of primary care capabilities and services that have proven effective at improving health outcomes, enhancing the patient and clinician experience, and decreasing total medical expenses. These primary care capabilities and services are not reimbursed by the fee schedule and are called "transformers." These include, but are not limited to[16]:

- Employ community health workers or health coaches as part of the primary care team
- Invest in the social determinants of health (SDoH)
- Collaborate with primary care-based clinical pharmacists
- Integrate behavioral health care with primary care
- Offer substance use disorder treatment, including medication-assisted treatment and telehealth services (including telehealth consultations with specialists, medical interpreter services, home care, patient advisory groups, and group visits)
- Use clinician optimization programs to reduce documentation burden, including, but not limited to, medical scribes and ambient voice technology
- Invest in care management, including employing social workers to help manage the care for patients with complicated health needs
- Establish systems to facilitate end-of-life care planning and palliative care
- Develop systems to evaluate patient population health to determine which preventive medicine interventions require patient outreach
- Offer walk-in or same-day care appointments or extended hours of availability
- Any other primary care service deemed relevant by a primary care board

PC4You also established a Primary Care Trust, administered by the Health Policy Commission, which would receive payments from commercial health insurance carriers and distribute the monthly prospective payments for commercial patients to primary care practices. These monthly payments would be based on historical spending, the degree of investment in the transformers' risk, and the quality of care.[16]

Takeaway: The MAPCAP PC4You effort exemplifies how extensive stakeholder discussions that seek to align primary care delivery and payment goals with evidence of advanced primary care can result in recommendations to transform primary care. While legislation for increased primary care investment has yet to pass in Massachusetts, the extensive work of stakeholder groups continues to guide the conversation in the state.

Oklahoma's Medicaid-led Primary Care Contracting

Background: The Oklahoma Health Care Authority (OHCA), which administers the state's Medicaid program, has spent three decades working towards improving the health outcomes of its citizens, regardless of their ability to pay. In 1996, the OHCA developed a managed care program centered around the principles of care coordination from the patient-centered medical home (PCMH) model. It provides per member per month (PMPM) and FFS payments to eligible primary care providers. Recently, the OHCA has focused on quality improvement initiatives to become a top 25 state in Medicaid member health outcomes by 2026.[17]

Key Policies: In 2022, the OCHA announced it would implement a new health care model, SoonerSelect, focused on comprehensive medical care with enhanced care coordination and assessments on the SDoH. The OHCA has requested proposals to implement this new model to leverage the resources of contracted entities. It includes cost containment by investing in preventive and primary care as one of its goals. This goal, coupled with the plan to move toward value-based payment, has spurred discussions in Oklahoma about primary care investment. The plan lays out a vision for a new care delivery model that centers on increased primary care investment as part of its contracting to achieve this goal.[18]

Oklahoma joins 40 other states in contracting with third-party organizations to administer certain Medicaid benefits. With SoonerSelect, Oklahoma is proposing ways to increase primary care investment. It will require the state to understand current levels of investment and account for the plans' vision for primary care.[18]

Takeaway: Oklahoma provides an example of how a state public payer can drive increases in primary care and kickstart conversations on a renewed vision, definition, and investment in primary care. A multi-stakeholder workgroup may align with OHCA's intent and learn from the details put forth through implementing the program in the state.

Oregon's Transparency Lessons

Background: In 2017, Oregon established its own Primary Care Payment Reform Collaborative (PCPRC) within the Oregon Health Authority (OHA) to support the implementation of its Primary Care Transformation Initiative. The initiative focuses on health care innovation and care improvement in primary care through increased investment. Goals of the initiative include[19]:

- Increase investment in primary care without increasing the total cost of care
- Improve reimbursement methods and invest in the SDoH
- Align primary care reimbursement by purchasers of care

The PCPRC provides focused support on using value-based payment, assists clinics and payers in implementing the initiative, aggregates data across payers and providers, aligns metrics in coordination with the Health Plan Quality Metric Committee, and facilitates the integration of behavioral health services into primary care. In addition, the PCPRC is charged with releasing an annual report with recommendations to achieve initiative goals by 2027.

The collaborative brings a multi-stakeholder perspective by including primary care providers, consumers, contracting and reimbursement experts, independent practice associations, behavioral health providers, employers, carriers and third-party administrators, the Department of Consumer and Business Services, CMS, and statewide organizations representing: mental health professionals who provide primary care, federally qualified health centers (FQHCs), physicians, family physicians, nurses, and hospitals and health systems.[19]

Key Policies: The OHA further supports primary care transformation by annually reporting on primary care investment by commercial health insurance carriers, public employee and educator plans, and Medicaid care coordination organizations (CCOs) through leveraging its APCD. Their annual report includes both claims and non-claims payments to understand whether carriers and CCOs will reach their required goal to allocate at least 12% of health care expenditures to primary care by 2023.[19]

Through its multiple efforts to transform primary care investment, delivery, and reimbursement, the OHA has published numerous recommendations and reports to inform the state of its health care system. With a half-decade of experience with this data and a commitment to transparency, Oregon highlights its findings with publicly accessible, interactive dashboards in *Figures 1, 2,* and *3*.[20]

Findings from Oregon's APCD highlight considerable variation within payer types. For example, within Medicaid CCOs, primary care investment ranged from 8.9% to 22.5% of health care expenditures, with a weighted average of 16.2%.[21]

They also show variation between payer types, with Medicare Advantage primary care spending at a weighted average of 10.8% and commercial carriers' primary care spending at 13.9%.[21]

Figure 1. Oregon's Medicaid Primary Care Spending

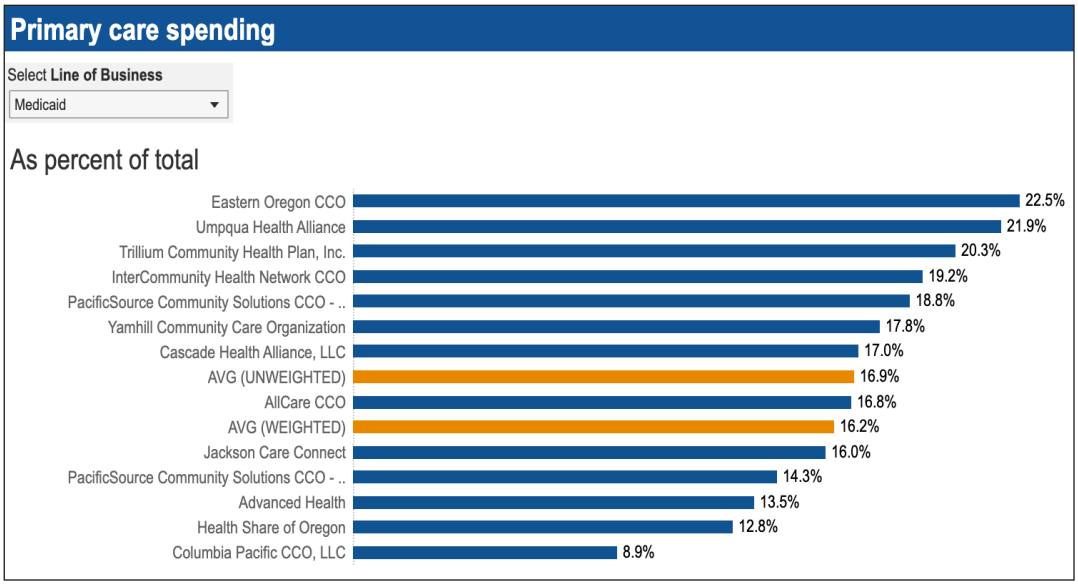


Figure 2. Oregon's Medicare Advantage Primary Care Spending

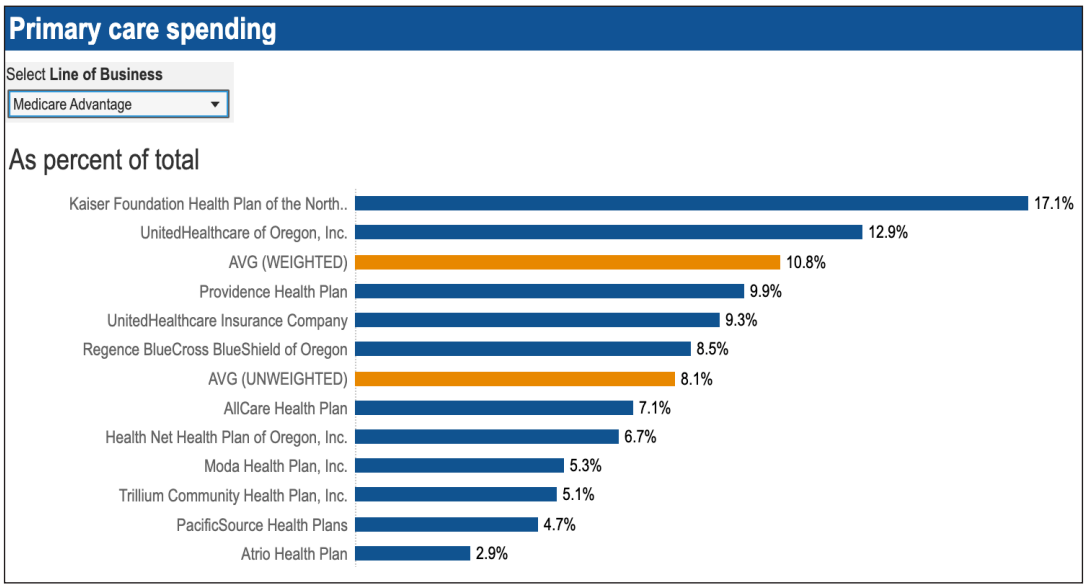
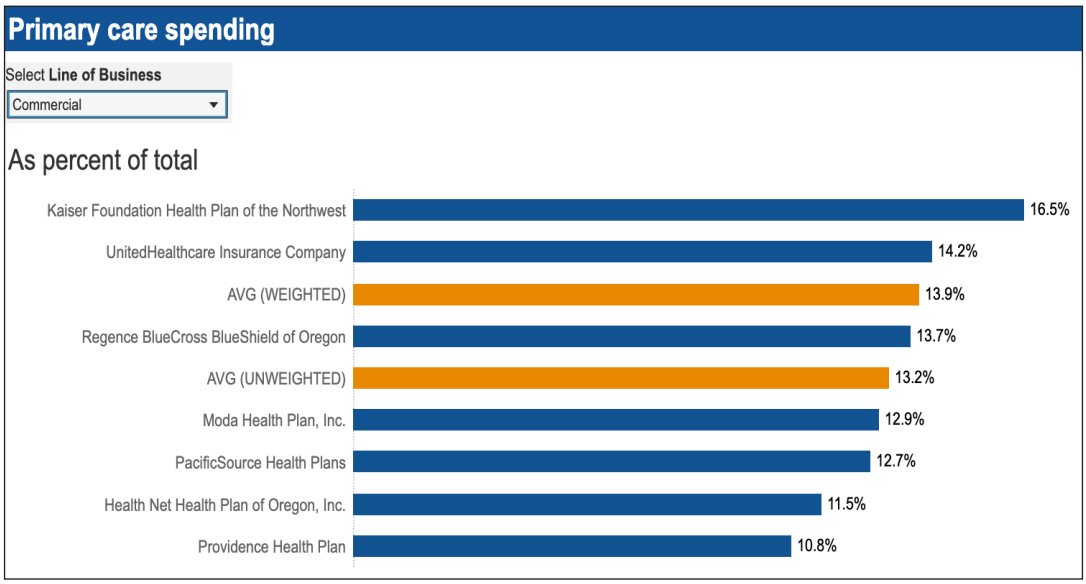


Figure 3. Oregon's Commercial Primary Care Spending



Takeaway: Oregon's early work on primary care investment and transformation provides an example of a multi-payer, absolute target requirement for primary care investment with frequent, transparent reporting on progress towards achieving this goal. In its most recent report, the OHA cautions readers not to compare their current findings to previous years' reports as a change in its APCD vendor resulted in a different approach to data processing. This teaches states to transparently inform the public about data and how to compare it across time or data source(s). It is also important to include multiple years of data to allow longitudinal comparisons with a consistent methodology whenever possible.

Rhode Island's Delivery-driven Investment

Background: Since 2009, Rhode Island's primary care transformation and investment efforts have been linked to the state's health care affordability standards. The Office of the Health Insurance Commissioner (OHIC) has monitored primary care investment for commercial carriers, focusing on how investments have been made and their impact on primary care delivery. These affordability standards have centered around transforming primary care to improve the quality of care and lower costs.[22] OHIC convened the Care Transformation Collaborative of Rhode Island (CTC-RI) in 2009 to align their work on affordability and care transformation.[22,23]

Since its creation, the CTC-RI has focused on the Quadruple Aim of enhancing patient experiences, improving population health, reducing the per capita cost of care, and improving the work life of health care providers[24] by supporting primary care practice sites that are transforming care. The CTC-RI provides a multi-stakeholder forum to advance primary care by supporting payer and provider contracting. The Common Contract, an agreement between payers and participating practices, provides a supplemental PMPM payment for driving practice transformation, team-based care, and a focus on quality improvement. These payments support practices in achieving PCMH recognition. Payments focus on care management and coordination for high-risk patients and enhanced data capabilities to improve population health.[23]

As the CTC-RI continued its efforts to foster care transformation funded by the increased primary care investment, it made strides in introducing additional primary care capabilities. Their initiatives on enhanced learning and services have included integrating behavioral health, supporting PCMH-Kids practices, and implementing community health teams to address the social, behavioral, and environmental needs of patients.[23,25]

Takeaway: Rhode Island's focus on care transformation has provided a pathway for increased primary care investment to become a reality. By enhancing efforts to transform primary care, the OHIC, in partnership with the CTC-RI and health care stakeholders, has consistently expanded the services provided by primary care practices in the state. In addition, the OHIC has driven accountability of increased investment in transformation by tying requirements to its rate review process.[22] Rhode Island provides an example of how continuous engagement in primary care transformation can empower stakeholders with the evidence needed to increase investment and a vision for how to do so.

HOW TO
Define a Shared Vision

The goal of this module is to prepare AAFP state chapter leaders to make impactful contributions to the visioning process that will result in meaningful and sustainable primary care investment within their state.

Ideally, stakeholders balance each other's perspectives and arrive at decisions all members can support. Even without reaching a full consensus, a shared vision can serve as a useful guidepost. By collaborating, stakeholders can share expectations for what an ideal primary care experience should look like and how to fund that experience.

The visioning process should include contributions from all stakeholders. It should prompt stakeholders to prioritize goals and embrace challenging conversations about trade-offs. Identifying the key stakeholders is the first step. In addition to patients, whose voices are paramount to building a shared vision, stakeholders might include purchasers (e.g., employers and/or union trusts who purchase health care on behalf of their workforce), payers (e.g., insurance companies and health plans), policymakers (e.g., lawmakers and regulators), physicians, and organizations that represent family and other primary care physicians and patients.

Bring stakeholders together to discuss and prioritize the following primary care delivery goals:

- Better patient access to preventive care
- More patient support in managing chronic conditions and serious health events
- Better patient connection to community support and services
- More patient access to integrated behavioral health services
- Better data and analytics to inform population health management

Align Primary Care Financing

If stakeholders collectively agree that primary care plays an essential role in achieving the patient goals described above, the primary care functions that contribute to these improvements should be included in the primary care definition. Further, any cost-benefit analysis should include the cost of performing those functions and any projected savings. Eventually, agreed-upon primary care investment targets or requirements should reflect services included in the shared vision of primary care and the cost of delivering those services. If the starting point for this work requires significant investment, stakeholders may agree to gradually increase targets and/or requirements to allow time for the system to absorb the cost growth needed to support the care transformations desired.

Bring stakeholders together to discuss and prioritize the following primary care financing improvements:

- Payers increase FFS reimbursement for primary care services without increasing the administrative burden.
- Payers shift an increasing share of primary care payments to predictable, prospective payments such as primary care capitation and care management fees.
- Payers offer the opportunity for primary care providers to earn incentives that reward improvement and sustain high performance over time.

Align Spending Measure Priorities

Understanding stakeholders' preferred payment mechanisms—in connection with their care delivery priorities—help to identify areas of alignment and those areas needing more discussion. For example, suppose care delivery priorities include care management, integrated behavioral health, and other services typically funded through flexible payments. In that case, it may be important to understand whether payers and purchasers would support flexible prospective payments to fund these services.

These questions also help inform the measurement strategy. For example, collecting information on non-FFS investment may be a lower priority if stakeholders predominantly focus on increasing FFS reimbursement. If increasing flexible, non-FFS payment to providers emerges as a shared goal, collecting information on these payments becomes a more immediate need. Stakeholders also may feel strongly about the percentage of total investment tied to performance and, in turn, may prioritize collecting these data. These discussions also surface the types of payments already occurring in the market, which can inform the non-FFS categories included in data collection.

Bring stakeholders together to discuss and prioritize the following spending measure improvements:

- Establish a baseline spending measure to identify the percent of health care investment currently allocated to services that stakeholders define as "primary care"
- Benchmark baseline spending against other states
- Inform a primary care investment target and/or roadmap to get where you want to go together
- Measure progress based on established targets and roadmap

Account for External Factors

Aligning around a shared vision and definition of primary care will help stakeholders when external factors impact spending and primary care goals.

Bring stakeholders together to discuss and prioritize the following external cost factors that impact measurement:

- Identify and discuss factors (e.g., pharmacy costs) that can negatively impact measurement efforts and detract from the shared vision for primary care investment
- Identify and prioritize the care delivery changes most important to key stakeholders for implementation. These may be based on meeting care needs, such as increasing access to behavioral health services through primary care and/or producing cost savings, such as reducing unnecessary emergency department visits with expanded access.
- Identify and prioritize ways to offset growth in spending, such as limits on hospital price growth and/or prescription drug prices

Increasing primary care investment remains challenging. States with the most success have recognized payers' and purchasers' reluctance to increase health care cost growth too quickly and are developing approaches that minimize their risk. These discussions are complex, but having them early in the process can result in a shared vision, aligned spending targets, and an accounting of external factors that produces a primary care system in which payers, purchasers, patients, and physicians can all thrive.

Modeling Cost and Impact

Information about the cost and impact of potential changes in care delivery can spark early conversations about primary care investment. This gives stakeholders a sense of the actual cost of delivering on the proposed primary care vision. Some findings show the timeline for return on new investments and the potential impact over the long term.[26,27] Data offers stakeholders a more informed starting point for developing a realistic target for sufficient and sustainable primary care investment.

Additional Considerations Depending on State-specific Characteristics

Policy Environment: If your state tends to lean more progressive, stakeholders may be more likely to endorse a broader vision for primary care that includes team-based care, integrated behavioral health, and connections to social support.

If working in a state with legislation, regulations, or executive orders related to primary care investment or health care cost growth, consider ways to leverage those policy initiatives to gain support for your work. States lacking an appetite for governmental action should focus on engaging the purchaser community, as discussed below.

Market Dynamics: States with concentrated health care provider and/or payer markets tend to be most successful when they can engage the purchaser community in the early visioning process. It allows employers, including private and public sector purchasers, to identify what they see as opportunities to strengthen primary care. Purchasers tend to recognize the value of a strong primary care system and can advocate for their specific priorities. Considering their priorities in the vision will make purchasers more likely to support increased investment when those conversations begin.

Existing Infrastructure: Employer or purchaser coalitions, often called business health coalitions, convene employers and can speak as a powerful voice on their behalf. If your state has a RHIC, it may be the organization that can bring together stakeholders to discuss and advance shared primary care goals.

States with APCDs have a ready data source to support early modeling as part of the visioning process. However, many APCDs do not include non-claims payments. Also, certain primary care services included in your future vision may not be occurring widely today. Other data sources, including quick surveys of payers and/or providers, can help supplement APCD data or offer another avenue for states without one.

Primary care providers and payers in many states have engaged in CMS programs, including Comprehensive Primary Care (CPC), Comprehensive Primary Care Plus (CPC+), and/or Primary Care First (PCF). In these states, the care delivery elements and other infrastructure established by these programs can serve as an important starting point for stakeholder brainstorming on the future vision for primary care. In several states, the convening of multiple payers around shared aims is a powerful mechanism for change.

HOW TO
Engage Stakeholders

The goal of this module is to equip AAFP state chapter leaders with the knowledge and resources to help them inform, guide, and participate in state-level multi-stakeholder workgroup initiatives targeting increased primary care investment.

States and regions with the most successful and sustained approaches to advancing and innovating primary care have key stakeholders representing a broad range of perspectives across the health care landscape. These stakeholders include purchasers (e.g., employers and/or union trusts who purchase health care on behalf of their workforce), payers (e.g., insurance companies and health plans), policymakers (e.g., federal and state lawmakers and regulators), physicians, and organizations that represent family and other primary care physicians and patients.

Frequently, stakeholders gather in a variety of formats, including listening sessions, educational forums, and/or workgroups. Convening stakeholders in workgroups can be particularly powerful as a shared, neutral space builds support and helps participants align around a shared vision for primary care with new approaches to primary care payment. The workgroup format allows stakeholders to share their hopes and concerns for their efforts at reform. They also provide a public forum to monitor progress against targets and goals.

Workgroup responsibilities frequently include the following:

- Identify ways increased investment will support a shared vision to improve the primary care delivery model and/or strengthen primary care capacity
- Oversee measurement of primary care investment, quality, and other analytic work
- Set goals for population health, affordability, and primary care investment
- Design a framework for care delivery and payment innovation to align payers around the vision

Efforts to maximize the family medicine impact in workgroups include the following:

- Join workgroups and volunteer to participate in a committee
- Learn how to get a family medicine representative appointed to the workgroup
- Contribute educational resources (the AAFP has numerous resources to get you started)
- Offer to present information to the workgroup
- Ask one or more of your state-level physician leaders to attend key discussions
- Seek opportunities to insert the family medicine perspective into the discussion
- Identify like-minded stakeholders and find opportunities to work with them to accomplish shared goals
- Be open to compromise, and do not let the perfect be the enemy of the good

Align Messaging Across the Family Medicine Community

Primary care and family medicine champions may differ in their priorities and/or preferred pace of change. Bring your constituents together to understand these differences. Then, articulate a shared position that reflects the nuance of members' perspectives.

Offer the Family Medicine Perspective

Chapter staff, contracted support staff, and AAFP members play a wide range of key roles in these multi-stakeholder workgroups. You may serve as a convener, champion, educator, and/or listener. Chapter staff or member representatives may sometimes serve in all these roles simultaneously. Engaging physician champions can lend credibility and amplify the message. Physician leaders are essential voices, offering their expertise and experience on the front lines of implementing care model redesign.

Collaborating and convening with other primary care physician perspectives outside the multi-stakeholder workgroup is another way to strengthen your collective voice.

Build Strong Partnerships

Influential workgroup participants build strong partnerships with other members of the group. They connect with key individuals, establish themselves as reliable sources of information, and become trusted partners in the work. Workgroup leaders appreciate participants who engage in the discussions as presenters and listeners. Multi-stakeholder workgroups recognize the need for compromise. Participants who remain open to new ideas and find opportunities for common ground gain the respect of others, which helps them influence key conversations.

Lessons Learned

Engage hospitals and health systems early to help them understand the benefits of strong primary care investment and a robust primary care system. Identify public and private purchasers—individual employers, public sector benefit plans, unions, and business coalitions—who can join with patient advocates to represent them.

Additional Considerations Depending on State-specific Characteristics

Policy Environment: Medicaid expansion and state actions (e.g., regulation, legislation, executive order) to increase primary care investment or limit cost growth can be an impetus to engage stakeholders in primary care initiatives.

If your state lacks the interest or resources to convene a workgroup, state chapters may need to identify a workgroup convener or convene the workgroup itself. This work may include the following:

- Identify state agencies and non-profit organizations that view primary care as a priority and meet with their leadership to assess interest in serving as a convener
- Identify potential workgroup participants (e.g., state chapter members, consumer advocates, leaders from health care-related state agencies, including representatives from insurance companies, employee benefit plans, health systems, health plans, employers, and employer coalitions)
- Reach out to these organizations to identify shared goals and recruit participants
- Convene an informal coalition to define a shared purpose and plan the next steps; this can help the AAFP chapter demonstrate the need for a workgroup
- Define resources needed to get started

Market Dynamics: States with concentrated health care delivery markets should ensure broad engagement across stakeholder groups. Purchaser representatives, including public and private sector employers, business health coalitions, and unions, will motivate payer participation. Health systems with a solid commitment to population health are well-positioned to succeed in value-based payment and are most likely to support it. State agency leaders bring a powerful voice and frequently participate even when legislation or regulation is not the goal. Consumer advocates help keep all stakeholders focused on the needs of patients and families.

Existing Infrastructure: Employer or purchaser coalitions, often called business health coalitions, convene employers and can speak as a powerful voice on their behalf. If you aren't sure where to start, visit the links below for more information about the following groups:

- National Alliance of Healthcare Purchaser Coalitions – State and regional business coalitions across the country
- Business Group on Health – Large employers working directly with each other to achieve their health care aims

- Purchaser Business Group on Health – Large employers working directly with each other to achieve their health care aims

States with APCDs have a data source to support early payment modeling and ongoing measurement. However, many APCDs do not include primary care payments made outside of traditional FFS payments, including care management/coordination fees, capitation payments, and other prospective, population-based payments. Other data sources, including surveys of payers and/or providers, can help supplement APCD data or offer another avenue for states without one.

To learn more about APCDs across the country, visit the APCD Council, which consists of leaders of state-based mandatory and voluntary APCDs.

HOW TO
Set Targets for Investment

The goal of this module is to prepare AAFP state chapter leaders to reach growth targets that are both achievable and agreeable to all stakeholders and meaningful to the shared goal of strengthening primary care delivery.

The initial target measurement process of primary care spending and/or investment provides a baseline for how much to spend (or a percentage of the total cost of health care) based on a common vision and definition of primary care spending. The next step is often setting an investment or growth target. Establishing targets will gain the most traction from key stakeholders when accompanied by goals impacting care delivery, along with fundamental changes in primary care payment that move away from FFS and toward more sustainable and flexible prospective, population-based payments. Stakeholders working together to increase investment, expand value-based payment, and improve primary care delivery will signal that the increased investment is one component of a broader approach that leads to a shared vision.

Targets can be "officially" set by state leaders or voluntarily agreed upon by key stakeholders. Primary care investment targets established by state leadership typically occur through an executive order, statute, or regulation. They can also occur through contracting efforts when states use their contracting authority on behalf of Medicaid, the Affordable Care Act Marketplace Exchange plan requirements, and/or benefit purchasing for state employees. For voluntary efforts led by others, coalitions of stakeholders typically demonstrate their commitment by signing a memorandum of understanding and/or co-authoring a publication. Voluntary targets do not guarantee the investment will increase. However, increased transparency and a shared vision can be powerful mechanisms to drive action.

Set a Target

The investment target should reflect an accurate and comprehensive assessment of the cost of achieving the vision for improved primary care delivery. This should include expenses related to additional staff, new technology, community-based infrastructure, and ongoing training and technical assistance. The starting point should ideally represent these expenses as a total cost or PMPM dollar amount. Primary care spending targets are frequently expressed as a percent of the total health care cost or spending. Primary care expense estimates can be easily converted into the percent of the total cost of care it represents when total health spending data is available. When calculating primary care spending as a percent of the total cost of health care, it is important to remember that high-cost states may fund primary care sufficiently with a lower percentage of the total cost of care than low-cost states.

Translate the Target into a Goal

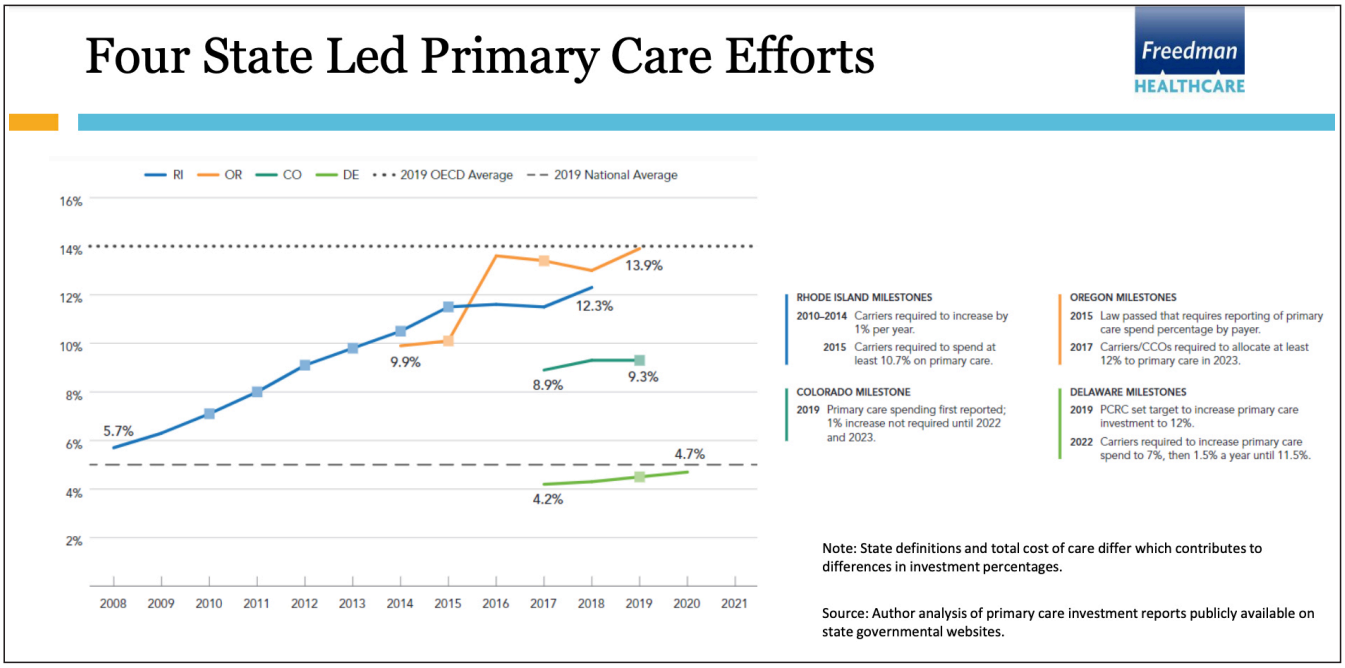
Goals can be established as absolute targets, incremental improvements, or a combination of the two, all presenting a vision for the future. Examples of each include:

- ***Absolute target*** – Establish a goal for primary care spending to represent 12% of the total health care spending by 2026
- ***Relative improvement targets*** – Establish annual goals, such as increasing the share of the total cost that is spent on primary care by one percentage point annually

- ***Long-term absolute target with short-term relative improvement targets*** – Establish a long-term goal to achieve 12% of the total health care spending by 2026 with annual targets embedded during the interim periods (e.g., primary care investment shall increase 1-1.5% per year until reaching 12% of the total cost of care by 2026)

Figure 4 below illustrates varying examples of how Rhode Island, Colorado, Oregon, and Delaware approached target goals to increase investments in primary care in their respective states.

Figure 4. Targeted Goals for Primary Care Investment[28]



Set Market-specific Targets

A single target is easier to communicate and creates a shared goal across stakeholders. However, payer-specific targets recognize that differences in a population's age, gender, health status, and benefit design lead to differences in primary care use and the total cost of care denominator. Calculating the difference in the cost of delivering the primary care vision to different populations can help determine whether different targets are needed.

Ensure Investment Targets Contribute to Care Delivery and Payment Innovation Changes

Primary care investment targets should always be realistic and tied to the shared vision of what key stakeholders want primary care to resemble. Some states also provide guidance about which payment methodologies best support care delivery goals. For example, this might include prospective care management payments to support care teams or shared savings risk arrangements to motivate reductions in the total cost of care or provide resources to invest in integrated behavioral health. Helping stakeholders translate investments into desired long-term outcomes (without creating unrealistic expectations of short-term savings) will help ensure key stakeholders understand and benefit from the transformations in terms of the amount (or percentage) and approach to primary care payment.

Additional Considerations Depending on State-specific Characteristics

Policy Environment: States with more conservative leadership may be less willing to set a target for increased primary care investment if they believe the risks will accelerate growth in the total cost of care. They also may be less inclined to recommend or require cost reductions elsewhere in the health care system. Setting a target based on a more gradual, relative increase—such as a 1% increase in total medical expenses per year—may be more palatable to those states. Conversely, states with more progressive leadership should resist the temptation to set targets requiring an overly aggressive increase in a single year. If stakeholders see it as too difficult to achieve, they may resist making any progress at all.

Market Dynamics: More consolidated markets may find it easier for a target to gain traction. With fewer participants in the market, it's easier to frequently engage with key stakeholders and gain a clear understanding of potential compromises. There will likely be more participants in less consolidated markets, making communication more challenging. Memorandums of understanding offer a valuable opportunity to publicly document the terms parties agree upon. Similar to their role in the measurement process, an engaged purchaser community can help facilitate reasonable agreements on a target.

Existing Infrastructure: A multi-stakeholder convener, often referred to as a RHIC, can be another helpful voice in reaching an agreement on a target. Organizations supporting APCDs can also serve in this capacity. For example, the Civitas Networks for Health is a national association RHICs and health information exchanges (HIEs), while the APCD Council is the national association for APCD organizations.

HOW TO
Measure Primary Care Investment

The goal of this module is to prepare AAFP state chapter leaders to contribute to this technical and important aspect of increasing investment in primary care once investment targets have been established.

Measuring and reporting on primary care investment builds trust among stakeholders and establishes a baseline to measure progress. Over time, reporting primary care investment consistently and transparently can motivate stakeholders to achieve their goals and guide future strategy planning (e.g., adjusting targets).

As described in the 'How To Set Targets for Investment' module, primary care spending or investment goals are often expressed as a percent of the total health care cost or spending. Measuring anything as a percentage requires two basic values—a numerator and a denominator. In this example, the numerator represents primary care spending, and the denominator represents the sum of all health care spending (including primary care), also referred to as the total cost of care. These values can be presented as total values but are more frequently expressed as PMPM values, allowing for better comparisons across populations or other states.

Measurement activities typically begin with calculating a baseline that establishes growth targets. If one exists, this can be based on data from the state's APCD. If not, the baseline can be derived from a survey or analysis that asks health plans and/or public purchasers, such as the state's Medicaid agency or state employee benefits entity, to provide information on current spending on primary care.

Most formal measurement efforts are led by states, often in collaboration with a multi-stakeholder workgroup. Their efforts span the range of activities described in this module, including the following:

- Identify data sources
  - Define the numerator – primary care spending
  - Define the denominator – total health care spending
- Adjust for differences in market segments/payer types

IDENTIFY DATA SOURCES

An APCD collects and aggregates health care claims from public and private-payer sources. Frequently, states rely on this data for measurement efforts. However, all-payer claims data has its drawbacks. Most APCDs hold limited data on individuals covered by self-insured plans and typically do not include large federal plans, such as the Federal Employees Health Benefits (FEHB) Program. Another challenge is the lack of non-claims data for payments outside the FFS system (see the definition of non-claims payment in the glossary). Obtaining non-claims payments requires an additional data collection mechanism—typically through a supplemental template completed by the payer and then submitted to the APCD or another entity responsible for data collection.

DEFINE THE NUMERATOR – PRIMARY CARE SPENDING

Ideally, primary care spending reflected in the numerator should include all spending considered payment for primary care services received by physicians and organizations providing the care. Most primary care payments continue to be made using FFS reimbursement tracked and reported as a claim payment. This is the most common form of primary care spending information, readily available as de-identified data within APCDs. The specific elements

of all-payer claims data include the date of service, type of service provided, diagnosis, type of provider delivering the service, place of service, as well as additional information regarding the patient, such as age, gender, zip code, and coverage type (commercial, Medicaid, or Medicare).

The AAFP strongly advocates for a shift away from FFS and toward prospective, population-based payments supporting comprehensive, team-based primary care. Including these payments in any measurement of primary care investment is vital for accurate measurement and for understanding the proportion of payments shifting to these new payment models.

An accurate calculation of primary care spending as the numerator would include FFS plus non-FFS payments. The technical considerations around the inclusion of these two important modes of primary care payment will now be examined.

Fee-for-Service Numerator: Primary care investment is typically spending for a primary care service, as denoted by an agreed-upon set of current procedural terminology (CPT) codes when the service is performed by a primary care physician or other providers, as specified by the provider's taxonomy code. Some definitions also specify the care delivery setting (e.g., outpatient clinic), defined by the place of service code. Tables comparing various states' definitions can be found in Investing in Primary Care: Lessons from State-Based Efforts in Appendix E on pages 28 and 29.

Organizations have a general agreement about the CPT codes representing primary care services. Minimal changes, such as including or omitting a single specific code, do not make a significant impact. However, spending increases as code sets expand to include broad categories of services, such as behavioral health or maternity services. Including maternity services tends to have less impact, as most of the cost of the service is attached to the infant rather than the mother. Hospital care for the infant is typically excluded. One state (Oregon) includes maternity services in its definitions, but it only includes 60% of the cost,[29] an estimate of the portion of the maternity bundle related to services provided in an office setting.

The impact is typically more significant for other service types, including behavioral health services. A Robert Graham Center and Patient-Centered Primary Care Collaborative analysis of Medical Expenditure Panel Survey (MEPS) data suggested that whether behavioral health services were excluded or included in the data could explain significant differences in spending levels between states who defined primary care using a narrow or broad definition. Those who used a narrow definition were more likely to exclude behavioral health services, while those who used a broad definition were more likely to include behavioral health services.[8]

Advisors on Vermont's primary care investment wanted to understand better the impact of including maternity and behavioral health services and asked the state to calculate the cost of these services separately so they could include or exclude the data. Maternity services increased primary care investment by only 0.2% for commercial payers, 0.1% for Medicaid, and no increase for Medicare. Using a subset of mental health and behavioral health services—mostly individual and group therapy sessions—increased primary care investment from 5.9% to 8.9%.[30]

The following table provides an overview of some common decision points and trade-offs when considering what is included and/or excluded as primary care spending in the numerator of the measurement calculation.

Table 1. The Primary Care Numerator – Common Decision Points and Trade-Offs

Topic	Decision Points	Argument Supporting Inclusion	Argument Supporting Exclusion
Women's Health	• Women's health providers (e.g., obstetricians-gynecologists (OB-GYN), women's health nurse practitioners) • Annual well-woman exam • Portion or all obstetrical care	Women's health is an important component of primary care. OB-GYNs and women's health nurse practitioners should be considered primary care providers. Well-woman exams and some portion of other services they provide also should be considered primary care.	OB-GYNs may provide some primary care services but are not primary care providers. Distinguishing if a service is a primary care service can be difficult. Therefore, it is more appropriate to exclude these providers and services.
Behavioral Health	• Behavioral health clinicians, therapists, and social workers • Psychiatrists and psychologists • All counseling services • Subset of counseling services and/or screenings/assessments • Only when integrated with primary care	Some behavioral health services are primary care services. Strong evidence suggests that integrating behavioral health into the primary care setting improves outcomes and reduces costs. Therefore, policymakers should take all opportunities to improve behavioral health access.	When measuring primary care investment, it is appropriate to include the time primary care providers associate with behavioral health integration. However, other expenses should be excluded.
Minor Procedures	Minor procedures (e.g., mole removal, certain injections, spirometry)	These services demonstrate the comprehensiveness of primary care and should be included.	Not all primary care providers feel comfortable providing many of these services. Therefore, they should be excluded.
Expanded Primary Care Providers *Note: Nurse practitioners and physician assistants with primary care-related taxonomies are typically considered primary care providers.*	• Age specific (e.g., geriatrics, adolescent medicine) • Other primary care provider-related physician subspecialties (e.g., developmental pediatrics) • Certified clinical nurse specialists, registered nurses	These providers offer primary care services, often to populations needing more comprehensive primary care. They should be included in the definition.	Physician subspecialties may function more as specialists than as primary care providers. However, it is difficult to determine when they are functioning in each capacity. Therefore, they should be excluded. Nurses and other care team members rarely bill FFS independently of another primary care provider. Explicitly including them in the definition is unnecessary.
Non-traditional Care Delivery Sites *Note: Telehealth is typically considered a primary care place of service.*	• Retail/convenience clinics • Urgent care clinics	The lack of primary care access is a problem. While these sites may not provide the full spectrum of primary care services, they are an important access point with significant spending. Therefore, they should be included.	Retail and convenience clinics and urgent care clinics do not meet the four primary care core functions (e.g., first contact, comprehensiveness, coordination, and continuity). Therefore, care delivered at these sites should be excluded.

Non-Fee-for-Service Numerator: A growing number of primary care investment definitions include care management payments, primary care incentive payments, and other non-FFS payments related to primary care delivery. These payments provide reimbursement outside the FFS structure and are, therefore, not tracked as claims payments. However, they are important to count as primary care investments since they offer primary care physicians and their teams with additional payment and flexibility to invest in expanded care teams, population health analytics, and other expenses to advance primary care delivery.

Non-claims payments can be made in various ways, each with its own measurement considerations. The two considerations to examine are whether the payment is made on a PMPM basis and can be identified as "earned" by a specific physician; or whether the payment is a lump-sum incentive or bonus payment that is earned based on the collective performance of a group of physicians, which can include primary care and other physician specialties. In the case of the latter, there is not a suitable mechanism for identifying which portion of the payment counts as primary care versus other types of health care spending.

Non-FFS payments made as a prospective PMPM amount to primary care practices on a monthly or quarterly basis are most easily tracked and should be included. However, if relying on APCD data, these payments may not be included, and separate reporting by the carriers of these payments may be required.

Including all or a portion of shared savings payments, also known as risk settlement payments, as primary care investment adds a layer of complexity. While some parts of these payments may support primary care, it is difficult to measure and document the portion for the above reasons. Payers typically reporting this data need insight into how provider organizations allocate shared savings or risk settlement payments. One mechanism is to allow the carriers to designate which portion of these payments should be considered primary care, with a cap or ceiling serving as a guardrail against overzealous estimates.

Delaware created a policy that allows carriers to classify a portion of risk settlement payments as primary care investments. However, after hitting a certain threshold, the carrier must submit an attestation from the provider organization that the dollars are spent on primary care.

Stakeholders typically categorize these payments using the Health Care Payment Learning and Action Network (HCP-LAN) framework or a "homegrown" approach. The HCP-LAN was established as a public-private partnership by CMS to establish improved and equitable health outcomes with multi-payer aligned APM implementation. The APM Framework is a standardized, national approach developed by the HCP-LAN stakeholders, including commercial health plans. While helpful for gauging overall progress, stakeholders may find its categories lacking sufficient specificity to be useful in measuring primary care spending. Layering both approaches—HCP-LAN as a broad framework with more specific "homegrown" subcategories inserted into each HCP-LAN category—may help balance the needs of those focused on primary care measurement. The AAFP is advocating that the HCP-LAN approach include primary care as a dimension of measurement in its annual survey.

When measurement efforts include a target to which payers are held accountable, they may request to have care management programs operated at their direction (frequently by a third-party vendor) and other internal expenses to be included as part of their primary care investment. Most states have adopted definitions that exclude the majority or all of these expenses that the health plan generates. Some states have adopted definitions that allow carriers to allocate a portion of their internal expenses related to primary care, such as care managers hired by the payer and investments in health information technology and analytics. The AAFP advocates that primary care measurement should be limited to payments made for services delivered directly to or on behalf of (in the case of capitation) patients.

DEFINE THE DENOMINATOR – TOTAL SPENDING (COST OF CARE)

While stakeholders often focus on the aspects of primary care included in the numerator, decisions regarding the denominator can have an equal or even more significant impact on the result. One of those factors that can be quite consequential and merits special consideration is spending on prescription drugs through the pharmacy benefit. Approximately half of primary care spending definitions include pharmacy in the denominator.

Key stakeholders often push back on including pharmacy in the denominator for a variety of the following reasons:

- Historically, pharmacy costs have increased rapidly based on factors and decisions outside the control of those prescribing.
- Accurately calculating pharmacy spending is difficult because the reported "costs" may be artificially inflated based on how these costs are reported and filtered through plans and their pharmacy benefit managers.
- A significant factor in pharmacy costs contributing to the inability to understand actual pharmacy cost is the payment of rebates. Pharmacy data collected by APCDs or through carrier templates designed for primary care spending data collection typically includes rebates. In two states (Colorado and Delaware), rebates represent approximately one-quarter of total pharmacy spending.[31,32]

Based on these factors, including pharmacy costs in the denominator may lead to unnecessarily high

increases in the spending on primary care when measured as a percentage of total spending without providing meaningful additional financial contributions to primary care spending.

Adjust for Differences in Market Segment/Payer Types

Commercial, Medicare, and Medicaid populations are fundamentally different. The respective coverage strategies also reflect essential differences. For example, Medicaid plans provide different benefits for long-term services and supports (LTSS) than commercial plans. Understanding and removing these differences from the denominator will facilitate a more accurate comparison across payer types.

Move Toward Standardization

Many primary care leaders are interested in a national definition of primary care investment, particularly one structured as a series of modular definitions that could be combined to support states' differing visions.

Additional Considerations Depending on State-specific Characteristics

Policy Environment: More progressive states with state agency initiatives may be tempted to define primary care investment as a purely technical exercise and, therefore, conduct minimal stakeholder engagement. Collaborative efforts that develop a shared understanding of the impact of measurement decisions tend to be the most successful over time.

States with a more conservative approach to health policy may lack the resources to conduct a thorough measurement process. Local foundations may be willing to fund this process. Leveraging the experience of other states, including numerator and denominator decisions, code sets, and analytic displays, may prove efficient.

Market Dynamics: Once stakeholders agree to proceed with measurement, states with more consolidated health care markets may benefit. An accurate measurement process relies, in part, on reliable information about care delivery and payment. As a result, fewer payers and care delivery organizations make it easy to understand critical payer-physician relationships and programs.

Less consolidated markets may want to use other means, such as a survey of care delivery organizations and payers, to understand better the most prevalent forms of primary care payment currently in place or planned. Survey results can inform the measurement approach, including the structure of the data collection tool and its instructions.

Organized purchasers can help ensure that payers cooperate with data collection requests. In some cases, it's helpful to have the request for data come from the purchaser community to the payer community.

Existing Infrastructure: An independent, neutral third party who serves as a multi-stakeholder convener can significantly contribute to progress. Their trusted voice in motivating all stakeholders, especially payers who must comply with data requests, can be the difference between forward progress or an impasse. These conveners are frequently found in RHICs. These organizations are almost always voluntarily supported by important health care stakeholders. Some RHICs also house voluntary APCDs, which can serve as the data source for measuring investment if an APCD is unavailable.

As stated above, some states measure primary care investment with claims data from an APCD—both mandated and voluntary in origin. However, states without APCDs and many with APCDs choose to use a separate data collection process to measure primary care investment to capture non-claims payments and/or include self-insured or other populations not typically included in an APCD.

Whenever possible, measurement efforts should capture non-FFS payments made through existing programs such as PCF or PCMH initiatives. These payments are not typically captured as claims payments within the mechanism that tracks these payments, including APCDs. Depending on the payment type, they are sometimes paid prospectively and sometimes retrospectively. Retrospective payments are typically paid six months or more after the year's end and may need to be estimated due to this lag. Capturing Medicare non-claims payments may be challenging and require data collection from those receiving these payments, in addition to the payer data collection process.

HOW TO
Establish Accountability

The goal of this module is to equip AAFP state chapter leaders with knowledge about three accountability mechanisms—transparency, contracting, and regulatory actions.

Efforts that successfully increase primary care investment will establish clear accountability for key stakeholders and deploy multiple tools to support this aim by working together over time.

Accountability Mechanisms

TRANSPARENCY

Most payment initiatives begin with transparency. A state or other measuring organization releases a report, typically with results in aggregate form or by payer type (e.g., commercial, Medicare, Medicaid). Individual data submitters—typically commercial insurers and other payers—may receive their results privately. This allows data submitters to build trust in the process and results before public reporting by the payer(s) begin.

Data: Data typically includes primary care investment presented as a PMPM amount and/or as a percentage of the total health care spending. The report may also show the impact of various decisions, such as whether to include non-claims payments. Displaying results by age, gender, and region can show important variation across populations. The methodology section typically includes the code set to define primary care.

Format: The report may be published in a static PDF format or through interactive, web-based dashboards using Tableau or a similar tool.

Voice: Some reports on primary care investment share the data without discussing or recommending potential policy options. Others use the report as an opportunity to recommend or announce the next steps, such as a primary care investment target.

CONTRACTING

Contracting can be a powerful mechanism used by public and private purchasers and multi-stakeholder entities. It offers more accountability than public reporting alone. These efforts typically factor into the procurement or contracting processes (described below). Many contracting initiatives emerge from purchaser coalition leadership and/or multi-stakeholder initiatives. Drivers of these initiatives view primary care investment as an important strategic step in broader efforts to improve value. Contract terms typically include increased investment, more innovative (non-FFS) primary care payments, and required advances in care delivery.

Example of Procurement Strategies:

- Include questions related to primary care investment, payment, and delivery in a request for proposal (RFP) to health plans
- Assign points to health plans that commit to a primary care target or participate in a care transformation/payment initiative, or penalize health plans that refuse

Example of Contracting Strategies:

- Require a certain level of investment as a condition of contracting
- Require participation in a care transformation/payment initiative that leads to an increase in non-FFS payment as a condition of contracting

Private and public employers and Medicaid agencies can use these procurement and contracting strategies when contracting with managed care organizations (MCOs) on behalf of their beneficiaries.

REGULATORY

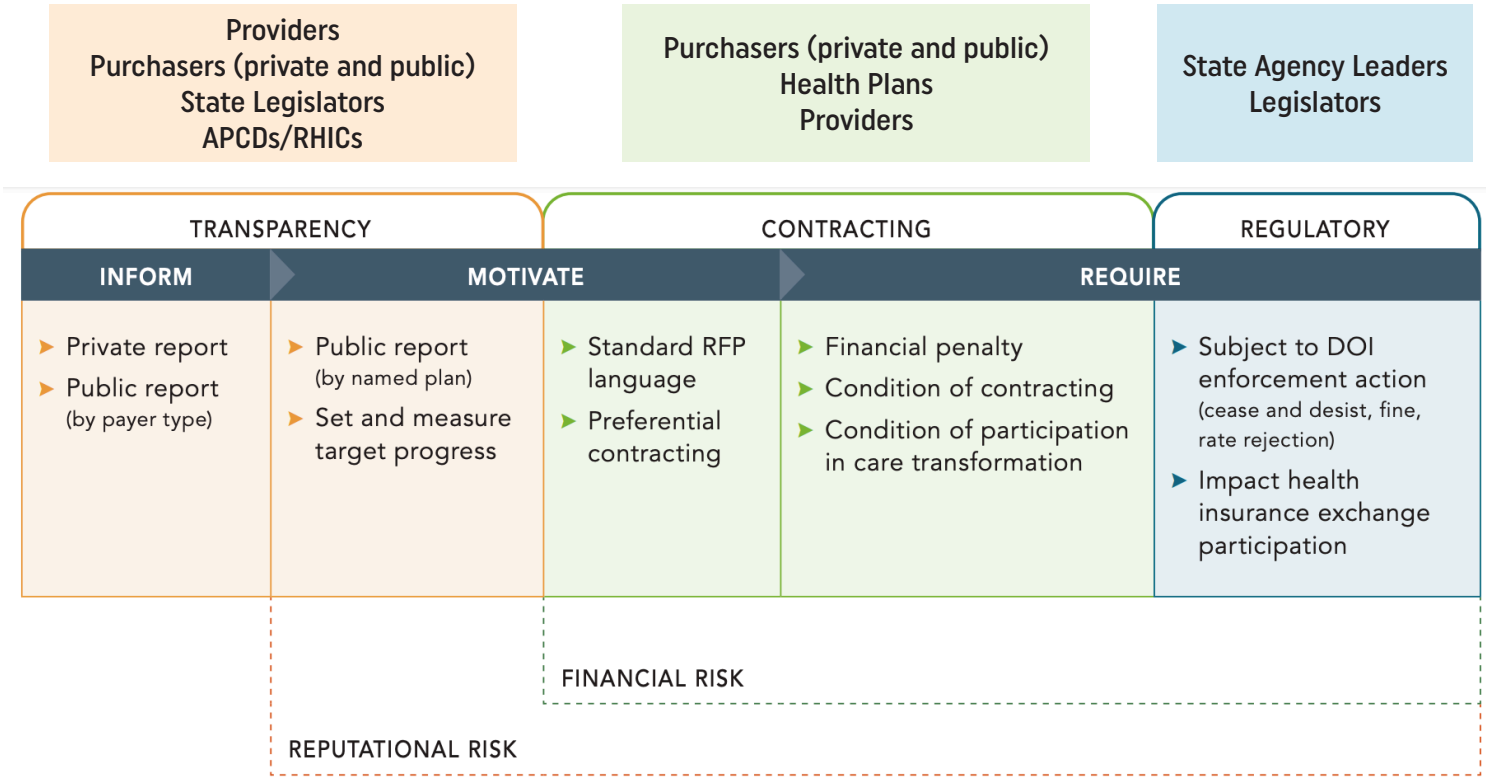
Regulatory efforts typically include passing legislation or enacting regulations to require the state's payers to achieve a defined level of primary care investment. The state already possesses the strongest regulatory authority, including over private payers who contract with the state as Medicaid MCOs or qualified health plans which offer coverage through the Affordable Care Act Marketplace Exchange. Additional regulatory authority over fully insured commercial health plans/insurers typically resides with states' department of insurance. The expanded regulatory authority can also be created through legislative action and/or executive order.

Regulatory requirements can be structured in much the same way as state targets—as an absolute requirement (e.g., primary care investment accounting for 10% of the total health care spending) or as a relative improvement target (e.g., primary care investment increasing 1% as a percent of the total health spending each year).

For commercial health plans, enforcement typically occurs through the rate review process. Legislation and regulation to increase primary care investment require intensive stakeholder engagement long past enactment and should be part of broader efforts to transform care delivery and payment. Four states—Colorado, Delaware, Oregon, and Rhode Island—require at least some payers to achieve a defined level of primary care investment. Enforcement of these requirements, however, varies by state.

Figure 5 summarizes the three accountability mechanisms and provides potential stakeholder groups who might influence those mechanisms.

Figure 5. Stakeholder Influence and Summary of Accountability Mechanisms[5,28]



Additional Considerations Depending on State-specific Characteristics

Policy Environment: More progressive states may be more likely to generate the support necessary to pass legislation or enact regulations to increase primary care investment. More conservative states may be more interested in establishing accountability through transparency and contracting. The most successful efforts include multiple accountability mechanisms and multiple requirements that span investment, payment innovation, and care delivery.

Market Dynamics: Achieving accountability in consolidated markets may be more difficult to achieve. While markets with a few large players could find it easier to achieve buy-in to a voluntary target, dominant health systems and health plans often use their power to block requirements. Less concentrated markets, particularly those that lack interest in regulatory action, could find more success with changes in contracting. A strong purchaser community can advocate for transparency and advance contracting efforts, regardless of other market dynamics.

Existing Infrastructure: Multi-stakeholder conveners, such as RHICs, can offer a home for transparency and reporting efforts. They also can define goals for contracting efforts, develop standard RFP and contract language, and help stakeholders measure performance compared to agreed-upon requirements.

Primary care delivery initiatives typically aim to be multi-payer and encompass investment, payment innovation, and care delivery requirements. Therefore, they provide an opportunity for broader alignment around an existing program or a foundation to build upon.

FREQUENTLY ASKED QUESTIONS

Stakeholder Engagement

What is a recommended, quick-read resource to learn lessons about engaging multiple stakeholders (e.g., policymakers, health plan representatives, and large purchasers of health care benefits, such as employers and union trusts, etc.) to advance primary care?
The Primary Care Collaborative's (PCC's) Lessons Learned from Multi-Stakeholder Advisory Groups is an excellent review of lessons learned from eight states measuring primary care spending.

Which stakeholder perspectives may be challenging to the workgroup but are essential to address early in the process?

- Primary care physicians' participation in workgroups can keep other group members focused on primary care investment and its importance to patient care.
- Health system champions who understand and appreciate the opportunities created through value-based care are compelling voices.
- Employers and other health care purchasers want healthy, productive workforces, and they can be persuaded about the value of primary care.

How often should workgroups meet?
Workgroups should convene at least quarterly, but ideally monthly or bi-monthly, depending on the scope of the workgroup's functions and responsibilities.

What are some tactics to encourage workgroup progress between meetings?

- Keep track of the next steps in an Excel spreadsheet or other planning document, and don't be afraid to follow up with group members about deliverables.
- Meet with individuals outside of workgroup meetings—especially those who need more convincing of the value of primary care investment.
- Consider meeting with stakeholder-specific groups outside the regular workgroup meetings to ensure alignment within stakeholder segments.
- Consider convening subgroups when appropriate, particularly to discuss measurement definitions and other more technical topics.
- Disseminate meeting information (e.g., schedules, agendas, minutes, presentations, progress tracking documents) and consider using a shared document system, such as Google Drive, Dropbox, or Microsoft Teams.

What are effective strategies for overcoming challenges or when the workgroup loses momentum?

- Listen and discuss differing opinions and perspectives. Multiple states are increasing primary care investment using different methodologies. Explore them all and your stakeholders' views about them.
- Identify and partner like-minded allies together, and encourage the quieter members of the group to speak up and offer their expertise.
- Don't let perfect be the enemy of good. Even an incremental increase in primary care investment is a step in the right direction. Use any 'wins' to build momentum.
- Consider meeting with workgroup members individually to identify and understand the factors that could be slowing the workgroup's progress.

Measurement

What is a recommended, quick-read resource to learn lessons about primary care investment measurement?
The California Health Care Foundation's (CHCF's) Investing in Primary Care: Lessons from State-Based Efforts is a review of primary care investment, payment innovation, and care delivery transformation strategies in 17 U.S. states and more than a dozen public and private payers. The CHCF highlights three lessons California should consider: establish a shared vision, conduct annual measurement and reporting under a common definition of primary care investment, and set investment targets.

What are some easy-to-use and/or customizable resources to help demonstrate the impact and need for increased primary care investment?
As part of the AAFP's Primary Care Investment Toolkit, we developed the PowerPoint presentation, 'Making the Case for Primary Care.' The presentation offers evidence to support the need and positive impact of increased investment in primary care. Users of the toolkit can download the presentation, customize it to their needs, and present it to stakeholders. There are even speaker notes to help presenters lead the discussion.

My state does not have an all-payer claims database (APCD). What are my options for measurement?
While APCDs can provide much value for primary care measurement, they are not essential nor the only option. Below are two alternative pathways to measurements:

- Request that health plans and/or public purchasers, such as the state's Medicaid agency or state employee

benefits entity, provide information using a survey tool or make a direct data request that facilitates state-level analysis of current spending on primary care.
- Publicly available data sources can offer high-level comparisons. For example, consider reviewing the analysis provided in the Milbank Memorial Fund's Health of US Primary Care Scorecard and The Commonwealth Fund's State Health Data Center.

What is the first question workgroups should ask when measuring primary care investment?
Ask the workgroup to consider the question, "What is the purpose of the measurement?" Three possibilities are listed below:
- *Core services:* Ask whether spending on core primary care services is sufficient and can be measured. You could help identify populations or geographic areas needing additional primary care access.
- *Tied to care delivery goals:* Define goals for primary care delivery and whether spending is adequate for the services envisioned. This may include services not currently provided on a routine basis and can help determine whether investments in those services are increasing.
- *All primary care spending:* Measure all spending on primary care services. Spending that is typically not captured includes individuals who are uninsured, individuals not using their health benefits, individuals using direct primary care services, third-party vendors, and worksite clinics.

What are the most important considerations when defining primary care spending for measurement purposes?
Services to include/exclude:
- *Narrow definition:* A narrow definition of primary care services typically includes a limited set of core primary care services (e.g., office visits, preventive care, vaccine administration).
- *Broad definition:* A broad definition of primary care services typically includes additional primary care services (e.g., minor procedures, screenings)
- *All services performed by primary care providers:* Some broad definitions of primary care services include all services performed by primary care providers.

Providers to include/exclude:
- *Narrow definition:* A narrow definition of a primary care provider typically includes a limited set of core primary care providers (e.g., family medicine, general practice, internal medicine, pediatrics, geriatrician, nurse practitioner [NP]/physician assistant [PA], Federally Qualified Health Center [FQHC]/Rural Health Clinic [RHC]).
- *Broad definition of a primary care provider:* A broad definition of a primary care provider typically includes additional primary care providers (e.g., clinical nurse specialists, behavioral health clinicians, obstetricians-gynecologists [OBs-GYNs], adolescent medicine specialists)

Include/exclude non-claims information: A growing number of primary care spending definitions include non-FFS spending as more dollars flow through value-based payments. These definitions allocate only a portion of certain non-FFS payments (e.g., risk settlements) to primary care.

Include/exclude pharmacy in the denominator: Primary care definitions may include or exclude pharmacy spending in the denominator. When definitions include pharmacy spending in the denominator, it is more accurate to have the pharmacy spend net of rebates, if available. If the rebate data is not available, pharmacy spending may be reported gross of rebates. However, that amount is higher than what is actually spent by payers.

Can measurements be different for different purposes?
Yes. Determine whether to include a single definition, multiple definitions, or a stackable definition from the descriptions below:
- *Single definition:* Single definitions are the easiest to communicate.
- *Multiple definitions:* Several states currently apply multiple definitions to support different use cases and successfully communicate these to stakeholders.
- *Stackable definition:* Many definitions include some ability to stack or include/exclude certain service categories. A stackable definition consisting of a core service component and the ability to "bolt on" additional service categories, such as behavioral health or non-claims, allows states to track spending on core services and progress towards funding emerging services aligned with care delivery goals.

Accountability

What is a recommended, quick-read resource about the current state of primary care in the United States?
The Milbank Memorial Fund's Health of US Primary Care Scorecard offers recommendations to advance high-quality primary care in the United States.

What are some tips to keep stakeholders energized while implementing accountability efforts?

- Focus on the reasons primary care measurement matters (e.g., patient care improvements, primary care workforce well-being, and better management of the per capita cost of care).
- Celebrate progress and even the small "wins." Share stories with stakeholders illustrating why primary care is essential to a high-quality health care system.
- Encourage stakeholders to meet (even when the agenda is light on content) and keep the momentum always progressing forward.
- Assign homework to stakeholders, follow up with reminders, and set expectations that tasks will be completed.
- Engage internal colleagues of the stakeholder while leveraging internal and external interests.

How can we achieve accountability if new legislation or regulations related to primary care are unlikely to pass?

- Report progress (or lack thereof), and publicize both the leaders working with you and those obstructing the movement toward increased investment in primary care.
- Collaborate with purchasers to drive meaningful changes in health plan/third-party administrator procurement and contracting.

What is the best way to gain a legislator's attention?

Publicize powerful human stories (ideally from their constituency) demonstrating the problem with lagging primary care investment.

What is the most important lesson learned from other states that have tried to increase primary care investment?

Enacting a law, regulation, or executive order represents the starting line and does not guarantee success. The hard work is changing the market through new care delivery and payment mechanisms, all of which must be codified in contracts between payers and providers and between payers and purchasers.

AAFP PRIMARY CARE POLICY AND INVESTMENT GLOSSARY

The AAFP Primary Care Policy and Investment Toolkit define the following terms to ensure a uniform understanding and alignment with definitions used in the California Health Care Foundation's report, Investing in Primary Care: Lessons from State-Based Efforts.

absolute primary care investment requirement: This requirement increases primary care investment to reach a specific set amount, such as 10%. The requirement typically stems from legislative action and has specific regulatory oversight from a state agency, such as a state department of insurance, with potential repercussions for failing to reach the required level of investment.

absolute primary care investment target: This target increases primary care investment to reach a specific set amount, such as 10%. The target typically involves public reporting, but there are no specific repercussions for failing to reach the investment target.

all-payer claims database (APCD): Databases that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from private and public payers are called APCDs. APCDs can be mandated and/or enabled by state legislation, while in other cases, APCDs rely on voluntary data submissions from public and private payers. The specific elements of APCDs include the date of service, type of service provided, diagnosis, type of provider delivering the service, place of service, as well as additional information regarding the patient, such as age, gender, zip code, and coverage type (i.e., commercial, Medicaid, or Medicare). Learn more about APCDs here.

alternative payment model (APM): An APM is a payment approach that provides financial incentives to reduce the total cost of care while improving quality. APMs can apply to a specific clinical condition, a care episode, or a population.

The Health Care Payment Learning & Action Network (HCP-LAN), a public-private partnership established with support from CMS, developed a framework that categorizes health care payment approaches from FFS (Category 1) to more advanced APM types—generally referred to as value-based payment. The most advanced value-based APM described by the framework is a population-based payment model that frequently includes acceptance of full risk by the care delivery organization (Category 4). The HCP-LAN framework consists of the following four categories:

- **Category 1:** FFS with no link to quality and value; payments are based on the volume of services and not linked to quality or efficiency
- **Category 2:** FFS with link to quality and value; at least a portion of the payments will vary based on the quality or efficiency of health care delivery
- **Category 3:** APMs built on FFs architecture; some payment is linked to the effective management of a segment of the population or an episode of care
- **Category 4:** Population-based payment in which the payment is not directly triggered by service delivery, so the payment is not linked to volume

Learn more about the AAFP's advocacy work on APMs here.

capitation: Capitation is a payment approach that provides a fixed amount of money per patient per unit of time paid in advance to the physician to deliver health care services. The amount of the capitated payment is determined by the range of services provided, the health status of patients involved, and the period of time during which the services are provided. The most common approach to making capitation payments is between health plans and care delivery organizations on a risk-adjusted PMPM basis. Learn more about the AAFP's position on primary care capitation for family physicians here.

care management: Activities performed by health care professionals to facilitate coordinated patient care across the health care system are called care management. Components of care management may include patient education, medication management and adherence support, risk stratification, population management, coordination of care transitions, and care planning. There are relatively new FFS billing codes that pay for these services with specific documentation requirements that are not widely used. Care management fees paid on a PMPM basis are more commonly used to pay for services not otherwise billable under FFS. Learn more about the AAFP's policy on care management fees here.

Comprehensive Primary Care Plus (CPC+): CPC+ is a national advanced primary care model that ended in 2022. This initiative represents the largest primary care innovation effort, involving more than 2,600 primary care practices caring for more than 17 million patients in 18 regions (states or metropolitan areas). Advanced primary care capabilities expected of model practices include:

- Access and continuity

- Planned care and population health
- Care management
- Patient and caregiver engagement
- Comprehensiveness and coordination

The goal of the model was to strengthen primary care through regionally based multi-payer payment reform and care delivery transformation. During the five-year model, more than 60 payers and 70 health information technology (IT) vendors participated in the CMS/Center for Medicare & Medicaid Innovation (CMMI) initiative. While the final evaluation is forthcoming, the results through the fourth year provide valuable insights from the qualitative aspects of the evaluation with mixed results in the quantitative outcomes. The full report with key highlights can be found here.

Current Procedural Terminology (CPT) code: A CPT code is a set of medical codes used by physicians, allied health professionals, non-physician practitioners, hospitals, outpatient facilities, and laboratories to describe the procedures and services they perform. Designed primarily for billing, CPT codes can be used to identify and analyze services provided by health care delivery organizations through claims data. Learn more about the AAFP's policy on coding and payment here.

fee-for-service (FFS): FFS is the current payment methodology in which physicians and other health care providers are retrospectively reimbursed for each service performed using CPT codes and other documentation requirements. CMS uses the Medicare Physician Fee Schedule (MPFS) to reimburse for physician services. The MPFS comprises costs associated with physician work, practice expenses, and professional liability insurance.

integrated behavioral health (IBH): IBH refers to the care for medical conditions and related behavioral health factors that affect health in one setting, typically in a primary care setting. Learn more about the AAFP's position on mental health care services here.

long-term services and supports (LTSS): Care for older adults and people with disabilities provided in the home, community-based settings, or facilities such as nursing homes are considered LTTS. Learn more about the AAFP's policy on long-term care here.

Medicaid: Medicaid is a joint federal and state health insurance program that provides health coverage and other supports to eligible low-income adults, children, pregnant people, elderly adults, and people with disabilities.

Medicare: Medicare is the federal health insurance program for people 65 years or older, people under 65 years with certain disabilities, and people of all ages with end-stage renal disease (ESRD).

non-claims payment: Non-claims payments are paid to health care providers outside of the FFS system that is often intended to motivate efficient care delivery, reward for quality or cost-savings goals, and build primary care infrastructure and capacity.

patient-centered medical home (PCMH): A PCMH model of primary care delivers the core functions of primary health care. The medical home encompasses the following five attributes: comprehensive care, patient-centered care, coordinated care, accessible services, and quality and safety. Learn more about the AAFP's policy on medical homes here.

payer: A payer is an entity that facilitates health insurance coverage and is responsible for negotiating health care prices with a provider network, managing the enrollment of its members, and payment for covered health care services. Payers can be public (federal or state health insurance programs) or private (commercial health plans) and can include employers or union trusts that self-insure and administer health insurance coverage directly on behalf of their employees or members.

performance incentive payments: Payments to providers for the quality of care they provide patients through a value-based alternative payment model (APM) are called performance incentive payments.

primary care: Primary care describes the integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community. Learn more about the AAFP's policies on primary care and comprehensive care here and here.

Primary Care First (PCF): PCF is a set of voluntary, alternative five-year payment options that seek to improve value and quality by offering an innovative payment structure to support the delivery of advanced primary care administered by the Center for Medicare & Medicaid Innovation (CMMI).

primary care investment: A measure of payments made to organizations that deliver primary care services is referred to as primary care investment. The services included in the measurement vary depending on the goals and the needs of the entity or entities conducting the measurement.

purchaser: A purchaser is an individual or organization (employer or union trust) responsible for paying for health services for a group of individuals (employees or members) either directly or through health insurance coverage.

Regional Health Improvement Collaborative (RHIC): A RHIC is a non-profit organization in a specific region governed by a multi-stakeholder board that helps stakeholders in its community identify opportunities for improving the health of the community and facilitates strategies to address those opportunities. RHICs sometimes facilitate or oversee data-driven efforts to measure quality and/or health care spending within their region.

regulatory action: Any substantive action by a governmental agency that promulgates or is expected to lead to the promulgation of a final rule or regulation is considered regulatory action. Learn more about the AAFP's policies on legislative activities and political action here and here.

relative improvement primary care investment requirement: This requirement increases primary care investment using incremental improvement compared to the current state, such as by 1% a year. Requirements typically stem from legislative action and have specific regulatory oversight from a state agency, such as the department of insurance, with potential repercussions for failing to reach the required level of relative improvement.

relative improvement primary care investment target: This target increases primary care investment using incremental improvement compared to the current state, such as by 1% a year. Targets typically involve public reporting, but there are no specific repercussions for failing to reach the relative improvement target.

risk settlement payments: Risk settlement payments are the amount a provider receives or penalty paid/accrued based on the level of achievement toward cost or quality performance targets, as set forth in a value-based contract arrangement.

taxonomy codes: Taxonomy codes are administrative codes for identifying the provider type and area of specialization for health care providers, including physicians and other clinicians. Each taxonomy code is a unique ten-character alphanumeric code that enables providers to identify their specialty. Taxonomy codes are assigned at both the individual provider and organizational provider levels. Taxonomy codes have three distinct levels: Level I is the provider type, Level II is Classification, and Level III is the Area of Specialization. A code that is "attached" to a National Provider Identifier (NPI) number that describes what type of health professional or entity that NPI represents. Taxonomy codes can be used for a variety of purposes, including billing for services. Thus, taxonomy codes become important data fields that aid in measuring primary care payment. Learn more about the AAFP's policy on coding and payment here.

team-based care: Team-based care is provided by a licensed physician with other health care personnel working as an integrated team to manage the care of an individual patient and a population of patients using a multidisciplinary, collaborative approach to health care. Learn more about the AAFP's policy on team-based care and primary care here and here.

total cost of care: The total dollars spent by health care purchasers for covered health care services is considered the total cost of care and is typically represented as a per capita cost to facilitate comparisons across populations and over time.

REFERENCES

1. National Academies of Sciences, Engineering, and Medicine. Implementing high-quality primary care. Rebuilding the foundation of health care. Accessed August 21, 2023. https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health
2. Jabbarpour Y, Petterson S, Jetty A, Byun H. The health of US primary care: a baseline scorecard tracking support for high-quality primary care. Robert Graham Center. The Physicians Foundation. Milbank Memorial Fund. Accessed August 21, 2023. www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf
3. Schneider EC, Shah, Doty MM, et al. Mirror, mirror 2021: reflecting poorly. Health care in the U.S. compared to other high-income countries. The Commonwealth Fund. Accessed August 21, 2023. www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly
4. Baillieu R, Kidd M, Phillips R, et al. The primary care spend model: a systems approach to measuring investment in primary care. *BMJ Glob Health.* 2019;4(4):e001601.
5 Condon MJ, Koonce E, Sinha V, et al. Investing in primary care: lessons from state-based efforts. California Health Care Foundation. Accessed August 21, 2023. www.chcf.org/wp-content/uploads/2022/03/InvestingPCLessonsStateBasedEfforts.pdf
6. Bodenheimer T, Sinsky C. From Triple to Quadruple Aim: care of the patient requires care of the provider. Ann Fam Med. 2014;12(6):573-576.
7. Colorado Department of Regulatory Agencies. Primary Care Payment Reform Collaborative. Accessed August 21, 2023. https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/primary-care-payment-reform
8. Jabbarpour Y, Greiner A, Jetty A, et al. Investing in primary care. A state-level analysis. Patient-Centered Primary Care Collaborative. Accessed August 21, 2023. www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf
9. Primary Care Payment Reform Collaborative. Oregon's Primary Care Transformation Initiative. 2022 progress report. Accessed August 21, 2023. www.oregon.gov/oha/HPA/dsi-tc/Documents/2022-PCPRC-Report.pdf
10. Colorado Department of Regulatory Agencies. Funding request for the FY 2022-23 budget cycle. Accessed August 21, 2023. https://spl.cde.state.co.us/artemis/regserials/reg19internet/2022-23/reg19202223014internet.pdf
11. Delaware General Assembly. Primary Care Reform Collaborative Report 2020. Accessed August 21, 2023. https://dhss.delaware.gov/dhss/dhcc/files/collabrptfinal2020_050820.pdf
12. Delaware General Assembly. Senate Substitute 1 for Senate Bill 120. 151st General Assembly (2021-2022). Accessed August 21, 2023. https://legis.delaware.gov/BillDetail/68714
13. Delaware Department of Insurance. Office of Value Based Health Care Delivery (OVBHCD). Accessed August 21, 2023. https://insurance.delaware.gov/divisions/consumerhp/ovbhcd/
14. The Commonwealth of Massachusetts. Office of the Governor. Senate docket, No. 3050. Senate No. 2774. Accessed August 21, 2023. https://malegislature.gov/Bills/192/S2774
15. Center for Health Information and Analysis. Primary care and behavioral health (PCBH) expenditures. Accessed August 21, 2023. www.chiamass.gov/primary-care-and-behavioral-health-care-pcbh-expenditures/
16. The 193rd General Court of The Commonwealth of Massachusetts. Bill SD.2233. An act relative to Primary Care For You. Accessed August 21, 2023. https://malegislature.gov/Bills/193/SD2233
17. Oklahoma Health Care Authority (OHCA). SoonerCare. Comprehensive quality strategy. Accessed August 21, 2023. https://oklahoma.gov/content/dam/ok/en/okhca/docs/about/qi/20220707%20-%20CQS%20Document.pdf
18. Oklahoma Health Care Authority (OHCA). Oklahoma Health Care Authority releases SoonerSelect medical and children's specialty plan request for proposals. Accessed August 21, 2023. https://oklahoma.gov/ohca/about/newsroom/2022/november/ohca-releases-soonerselect-medical-and-childrens-specialty-plan-rfps.html
19. Primary Care Payment Reform Collaborative. Oregon's Primary Care Transformation Initiative. 2019 progress report. Oregon Health Authority. Accessed August 21, 2023. www.oregon.gov/oha/HPA/dsi-tc/Documents/PCPRC%202019%20Progress%20Report.pdf
20. Oregon Health Authority. Primary care spending in Oregon 2021. Accessed August 21, 2023. https://visual-data.dhsohastate.or.us/t/OHA/views/PrimaryCareSpendinginOregon2021Aboutthisreport?%3Aembed=y&%3AisGuestRedirectFromVizportal=y
21. Oregon Health Authority. Primary care spending in Oregon 2021. Accessed August 21, 2023. https://visual-data.dhsoha.state.or.us/t/OHA/views/PrimaryCareSpendinginOregon2021/Primarycarespending?%3Aembed=y&%3AisGuestRedirectFromVizportal=y
22. Baum A, Song Z, Landon BE, et al. Health care spending slowed after Rhode Island applied affordability standards to commercial insurers. . 2019;38(2):237-245.
23. Care Transformation Collaborative of Rhode Island (CTC-RI). What is CTC-RI? Accessed August 21, 2023. www.ctc-ri.org/about-us/what-ctc-ri
24. Bodenheimer T, Sinsky C. From Triple to Quadruple Aim: care of the patient requires care of the provider. Ann Fam Med. 2014;12(6):573-576.
25. Primary Care Collaborative. Rhode Island. Accessed August 21, 2023. www.pcpcc.org/initiatives/rhode-island
26. Phillips RS. Investment in primary care is needed to achieve the Triple Aim. Health Affairs. Accessed August 21, 2023. www.healthaffairs.org/do/10.1377/forefront.20170510.060008/
27. Abrams MK, Nuzum R, Zezza MA, et al. The Affordable Care Act's payment and delivery system reforms: a progress report at five years. The Commonwealth Fund. Accessed August 21, 2023. www.commonwealthfund.org/publications/issue-briefs/2015/may/affordable-care-acts-payment-and-delivery-system-reforms
28. Condon MJ, Sinha V. Increasing primary care investment and orientation: experiences from other states. Maryland Primary Care Program Advisory Council. Freedman Healthcare. Accessed August 21, 2023. https://mhcc.maryland.gov/mhcc/pages/apc/apc/documents/Freedman_healthcare_091322.pdf
29. Oregon Health Authority. Primary care spending in Oregon. Department of Consumer and Business Services. Accessed August 21, 2023. www.oregon.gov/oha/HPA/ANALYTICS/PCSpendingDocs/2020-Oregon-Primary-Care-Spending-Methodology-and-Glossary.pdf
30. Vermont Green Mountain Care Board. Department of Vermont Health Access. Report to the Vermont Legislature. Defining primary care and determining primary care's proportion of health care spending in Vermont. Accessed August 21, 2023. https://legislature.vermont.gov/assets/Legislative-Reports/Act-17-Primary-Care-Spend-Report-15-January-2020_Final.pdf
31. Freedman Healthcare. Prescription drug spending and rebates in Delaware. Office of Value-Based Health Care Delivery. Delaware Department of Insurance. Accessed August 21, 2023. https://insurance.delaware.gov/wp-content/uploads/sites/15/2022/07/DelawarePBMSummary_FINAL_REPORT.pdf
32. Center for Improving Value in Healthcare. Drug rebates impact rising prescription drug spending and continue to increase for high cost drugs like brand and specialty. Accessed August 21, 2023. https://civhc.org/2021/08/13/prescription-drug-rebates/

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