



# Investing in Primary Care: Lessons from State-Based Efforts

APRIL 2022



## AUTHORS

Mary Jo Condon, Elizabeth Koonce, Vinayak Sinha, Emma Rourke,  
Maggie Adams-McBride, Linda Green, and John Freedman, with  
Freedman HealthCare LLC

# Contents

## About the Authors

Mary Jo Condon, MPPA, is a senior consultant at **Freedman HealthCare LLC** (FHC). Additional authors from FHC include Elizabeth Koonce, MPH, project manager; Vinayak Sinha, MPH, consultant; Emma Rourke, project associate; Maggie Adams-McBride, MPH, project manager; Linda Green, MPA, executive vice president; and John Freedman, MD, MBA, president and chief executive officer. Established in 2005, Freedman HealthCare is a national consulting firm that helps clients put health data to work to solve complex problems.

## Acknowledgments

The authors wish to acknowledge several organizations for their valuable insight and support in creating this technical brief. See Appendix B for a list of contributors.

## About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

## 3 Executive Summary

## 4 Introduction and Background

Methodology

National Momentum Builds

Levels of Engagement in Active States

The California Landscape

## 11 Mechanisms and Tools

Transparency Mechanism: Measurement and Reporting

Contracting Mechanism: Shaping Formal Agreements

Regulatory Mechanism: Statutes and Regulations

## 20 Steps Forward for California

## 21 Conclusion

## 22 Appendices

A. Glossary

B. Acknowledgments

C. Leadership and Partnerships, by State

D. Overview of Approaches to Non-Claims Payments

E. Overview of Primary Care Investment Definitions

F. Comparison of Primary Care Investment Definition Code Sets

G. Participation in PCMH and CMS Programs

H. Primary Care Investment Design and Measurement Considerations for California

## 33 Endnotes

### About the Primary Care Matters Series

The California Health Care Foundation engaged Freedman HealthCare to develop this technical report on primary care investment data collection, reporting, and enforcement mechanisms. The goal of this paper is to inform California stakeholders as they consider ways to share information on primary care investment and to develop accountability strategies to increase the proportion of the health care dollar directed toward primary care. This is the first in a series of three papers on primary care investment. To learn more, visit [www.chcf.org/primary-care-matters](http://www.chcf.org/primary-care-matters).

# Executive Summary

Primary care is the foundation of any high-performing health care system; decades of evidence show that robust, accessible primary care is the most effective means to keep populations healthier longer. Yet the US lags well behind peer countries in investing in these services. America, on average, spends only about five cents of every health care dollar on primary care, or about one-third of what other high-income countries spend. Not coincidentally, our peers boast longer life expectancy and lower rates of chronic disease — all with lower per capita health care spending.

The COVID-19 pandemic has pushed an already-strained primary care system to the brink. Low compensation for primary care providers (PCPs), amid other challenges, helped create a PCP shortage in California and nationally. Primary care spending has trended downward for several decades. Additional financial strain on PCPs associated with the pandemic means the PCP shortage could worsen, especially in areas that are already underserved, and exactly when primary care is most needed to combat the pandemic and rebuild the nation's health.<sup>1</sup>

Recognizing the urgent need to strengthen primary care and the need for collective action to achieve this goal, more than one-third of US states and several of the nation's largest public and private purchasers have prioritized shifting more of the health care dollar to primary care. They use **three types of mechanisms** and a range of specific tools, often in combination, to achieve this goal:

- ▶ **Transparency.** Measurement and reporting
- ▶ **Contracting.** Shaping formal agreements
- ▶ **Regulatory.** Statutes and regulations

The power of these approaches to shift health care investment rests on the engagement of multiple parties. The work is complex and takes time, yet leading states are showing measurable progress in the midst of multiyear journeys.

California, with its long history of public and private purchaser engagement and alignment, is well poised to take steps to strengthen primary care. While the state does not yet have regulation in place to increase investments in primary care statewide, individual purchasers and payers have enacted a number of transparency and contracting mechanisms (see *The California Landscape*, page 9). These purchasers and payers — as well as the state — can do more.

In planning for the next phases of work, California should consider lessons from the states profiled in this report, in the following areas:

**1. Establish a shared vision.** To bridge efforts already occurring, convene stakeholders to create a shared vision for primary care. Multi-stakeholder workgroups typically include primary care providers as well as representatives of health systems, commercial health plans, Medicaid, the state employee benefits plan, employers, and consumers. Ideally, stakeholders balance each other's perspectives and arrive at a fulcrum all can support. Even without reaching full consensus, a common vision can serve as a useful guidepost. By acting collectively, stakeholders offer providers, payers, and patients clear, aligned expectations for what should be included in the primary care experience and how primary care should be funded. Appendix C outlines the roles various state agencies play in moving this work forward.

## **2. Conduct annual measurement and reporting across markets based on a common definition of primary care investment.**

After developing a common vision, multi-stakeholder workgroups add detail by arriving at a common definition of primary care investment that can be applied across market segments to support annual measurement and reporting. The Department of Health Care Access and Information is a logical convener for this process as lead on California's Health Care Payments Data Program, the state's all-payer claims database, and the intended home for the proposed Office of Health Care Affordability. (See Appendix H for specific considerations for California.) Initially, measuring and reporting on primary care investment builds trust, serves as a call to action, and establishes a baseline by which to measure progress. Over time, public reporting can motivate stakeholders to achieve investment goals and also help guide future strategy (e.g., adjusting targets).

## **3. Set investment targets and encourage (or require) all purchasers to commit through contractual requirements.**

An investment target provides a clear and transparent goal. It should reflect the true cost of achieving the vision for improved care delivery, including expenses related to additional staff, new technology, and ongoing training and technical assistance. Options include an improvement target, such as increasing the share of total cost that is spent on primary care by one percentage point annually, or an absolute target, such as spending at least 10% of total costs on primary care. Targets can be set by purchasers and/or the state, and they can be voluntary or required and enforced through penalties. California should consider the trade-offs of such approaches and identify clear enforcement mechanisms for the approach it selects (lessons from other states are provided on page 18).

The ultimate goal of any effort to increase investment in primary care is a more robust primary care system that better serves patients through expanded care teams, integrated behavioral health, and connections to social care — achieving better and more equitable health outcomes for all.

## **Introduction and Background**

According to the National Academies of Sciences, Engineering, and Medicine (NASEM), primary care is the only component of the American health care system where increased supply is associated with improved population health and more equitable outcomes. For this reason, robust primary care is widely considered the foundation of any high-performing health care system. It is so important that NASEM has called for primary care to be considered a public good, which should be supported and strengthened by state and federal policymakers.

NASEM's call is urgent in the face of the US's historical underinvestment in primary care. The US spends only one-third of what other high-income countries do on primary care, yet we spend more than twice as much on health care per capita and experience worse outcomes on life expectancy, rates of chronic disease, and other critical measures.<sup>2</sup> Of concern, spending on primary care has trended downward in the past several decades, from an estimated 6.5% of total health care expenditures in 2002 to 4.7% in 2019 (for comparison, other high-income countries direct approximately 15% of health care spending to primary care services).

Directing more health care resources toward primary care is an important step in revitalizing US primary care, and the NASEM report specifically recommends that states take on this work. Research shows that increased primary care investment translates to

expanded care teams, more convenient, low-cost access to care, and strong connections to public health and social supports.<sup>3</sup> Although the data on direct cost savings is mixed, there is evidence that increased primary care investment reduces the need for emergency department visits and hospital stays and may have a moderating effect on total cost of care.<sup>4</sup>

Recognizing this opportunity, more than a dozen states — and many of the nation's largest public and private health care payers — have launched efforts to allocate a greater proportion of the health care dollar to primary care. At least five additional states are in the planning stages, and California is well positioned to join them.

The purpose of this report is to inform California policymakers and stakeholders about ways to bolster investment in primary care. It describes in detail the three mechanisms and associated tools that other states and payers use to increase primary care investment.

- ▶ **Transparency.** Tools include private and public reporting of primary care investment as well as public commitments to increase it.
- ▶ **Contracting.** Tools range from public and private purchasers asking questions about primary care investment in a request for proposal to requiring health plans and other partners to commit to a certain level of investment.
- ▶ **Regulatory.** Tools rely on state agencies to demand increased investment, and levy fines or deny rate filings when health plans fall short.

### A Public Good

“Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. For this reason, primary care is a common good, making the strength and quality of the country's primary care services a public concern,” according to a 2021 report from the National Academies of Sciences, Engineering, and Medicine (NASEM).

*Implementing High Quality Primary Care: Rebuilding the Foundation of Health Care* concludes that policymakers should strengthen primary care through government intervention at both the state and federal levels and through responsible public policy supported by private-sector action.

## Methodology

This report is based on detailed review of primary care investment, payment innovation, and care delivery transformation strategies in 17 US states and more than a dozen public and private payers. Research also included a scan of academic and other literature and interviews with a cross-section of stakeholders interested in and knowledgeable about primary care delivery and payment. Interviewees included primary care physicians, primary care advocates, researchers, and representatives of state governments, health plans, and public and private purchasers. The information in this report was collected during fall 2021.

## National Momentum Builds

Interest in increasing primary care investment has intensified in recent years as early adopters demonstrate progress and more states build all-payer claims databases (APCDs), allowing them to measure levels of primary care spending and utilization and track changes over time. In leading states, efforts to strengthen primary care have been underway for more than a decade, building on successes and opportunities identified through the patient-centered medical home (PCMH) movement.<sup>5</sup>

Common actions and patterns follow.

**Catalysts for action.** Several recent efforts to increase investment in primary care have launched with a call to action by a champion or group of champions; often these are from within government, such as a governor, several legislators, or agency leaders who declare a goal to increase the proportion of health care spending on primary care. Health plans and purchasers can also create a similar call to action.

These public statements frequently evolve into voluntary targets. While voluntary targets do not guarantee investment will increase, they are often a first step in a multiyear process of transparency (e.g., measurement, target development) and can galvanize stakeholders to take action. In some cases, these voluntary targets set the stage for a future contractual or regulatory requirement to allocate more dollars to primary care.

**Care transformation goals.** Efforts to increase primary care investment typically begin in the context of broader goals. These multi-payer efforts engage multiple state agencies and the private sector. The stakeholders see increasing primary care investment and payment innovation as fundamental to achieving care transformation and moderating growth in total cost of care.<sup>6</sup>

**Leadership and partnerships.** Successful initiatives recognize the need for multi-payer alignment and work to engage Medicaid agencies and state employee benefit plans.<sup>7</sup> Typically, among states that have created primary care investment requirements, one or two state agencies lead enforcement. They are often designated via executive, legislative, or regulatory action and sit within state agencies with the ability to enforce an allocation requirement for at least one payer type (e.g., private health plans or Medicaid).<sup>8</sup>

To ensure broad input, the lead agency convenes one or more multi-stakeholder workgroups to support the state in defining primary care, developing an approach to increase and measure investment, and prioritizing goals for care delivery transformation and payment innovation (see box on page 7).<sup>9</sup> Although multiple layers of governance add complexity, engaging stakeholders with differing viewpoints and leverage points is necessary to develop policies with enough support to be successful. State agencies and other stakeholders are more motivated to sail in the same direction when they have charted the course together. A table showing how states distribute responsibilities related to this work can be found in Appendix C.

## What Do We Want Most?

Developing a standard definition of primary care spending is typically a collaborative process among stakeholders. Working through key questions at the beginning of the process can provide clarity and accelerate alignment.

### 1. What is our vision for primary care delivery and payment innovation?

Some possibilities:

- ▶ Patients have better access to preventive care.
- ▶ Patients are better connected to community supports and services.
- ▶ More patients can access integrated behavioral health services.
- ▶ Health care providers and organizations have the necessary data/analytics to inform population health management.
- ▶ Payers provide health care providers with the flexible payments needed to achieve these goals, or payers contribute to shared infrastructure such as population health management technology or community-based care teams.

### 2. What do we hope to learn through the measurement process?

Some possibilities:

- ▶ Ascertain the portion of the health care dollar allocated to primary care providers.  
(This could involve broadening the definition.)
- ▶ Determine funding adequacy of the core primary care delivery system.  
(This could involve narrowing the definition.)
- ▶ Develop data collection and measurement systems to inform creation of a primary care investment target or requirement and measure progress.  
(This could involve creating a definition that aligns investment and care delivery goals.)

### 3. How can we accommodate concerns about a short-term rise in health care costs?

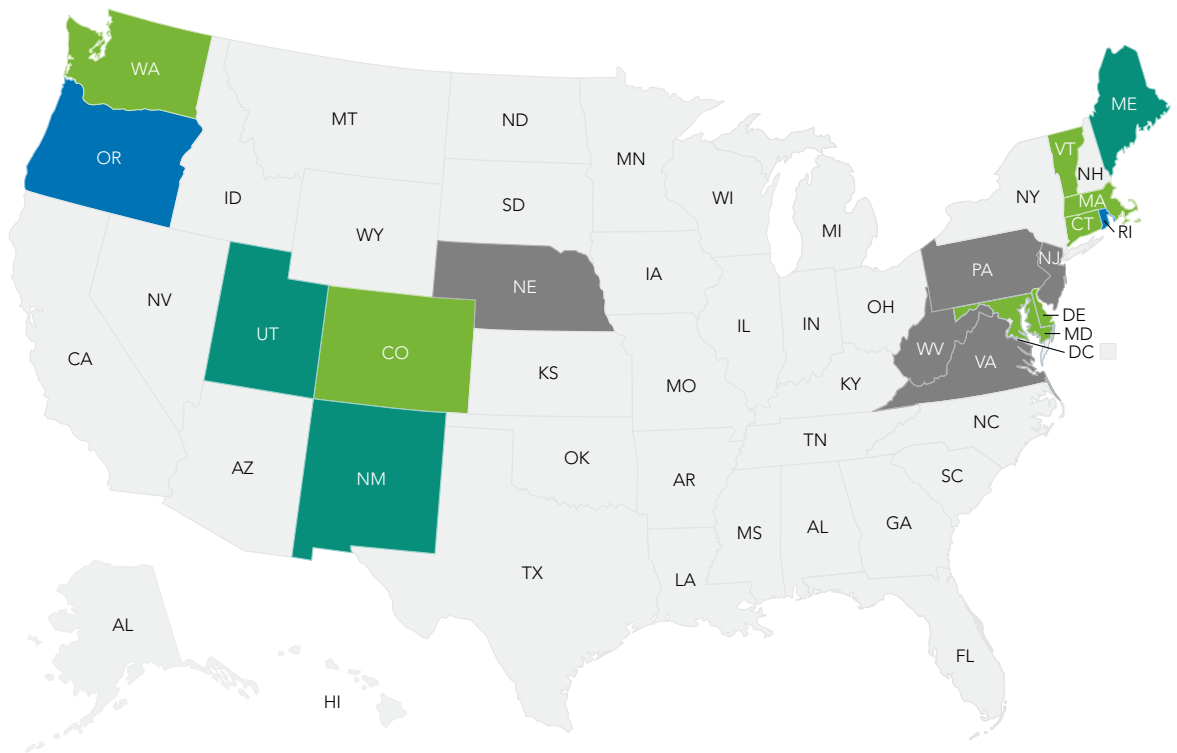
Some possibilities:

- ▶ Consider ways to remove factors that may be unnecessarily inflationary over time, such as pharmacy costs, in the definition of total cost of care.
- ▶ Consider ways to offset growth in spending. One strategy, used in Rhode Island and Delaware, is putting limits on hospital price growth.

## Levels of Engagement in Active States

A wide range of activities to increase both orientation to primary care and investment in primary care are occurring across the US. As displayed in Figure 1, states with a known interest in increasing primary care investment can be divided into categories based on their progress toward stimulating investment: Practicing, In Process, Getting Started, and Aspirational. The states and criteria defining each category are provided in the figure. Only states meeting all criteria are included in a category.

**Figure 1. States with Interest in Increasing Primary Care Investment**



**■ PRACTICING** (Oregon, Rhode Island)

- ▶ Measuring primary care investment regularly to understand progress
- ▶ Implementing care transformation and/or payment innovation vision
- ▶ Engaging multiple stakeholders
- ▶ Benefiting from meaningful, tested investment requirements/expectations for at least one payer (e.g., contract requirements, regulation, or via care delivery requirements and goals of Medicare demonstration)

**■ GETTING STARTED** (Maine, New Mexico, Utah)

- ▶ Communicating interest in increasing primary care investment and may be measuring it
- ▶ Developing care transformation and/or payment innovation vision
- ▶ Organizing stakeholders to develop target/requirement

**■ IN PROCESS** (Colorado, Connecticut, Delaware, Maryland, Massachusetts, Vermont, Washington)

- ▶ Measuring primary care investment
- ▶ Implementing or beginning to implement care transformation and/or payment innovation vision
- ▶ Engaging multiple stakeholders
- ▶ Implementing targets/requirements for at least one payer (e.g., legislation/regulation, executive order, payer memorandum of understanding, or MOU/commitment to commit); however, targets/requirements have not yet been tested

**■ ASPIRATIONAL** (Nebraska, New Jersey, Pennsylvania, Virginia, West Virginia)

- ▶ Stakeholders share interest in increasing primary care investment and may be measuring it



## The California Landscape

California is well positioned to increase investment in primary care. The state brings a strong stable of cross-sector partners already working to change how primary care services are paid for, delivered, and measured for quality and equity.<sup>10</sup> The state government and purchaser community are activated and aligned (see box on page 10).

Further, the vision for the proposed Office of Health Care Affordability (OHCA) includes many of the capabilities and powers (data analysis and reporting, multi-stakeholder convening, policy development and enforcement) that other states deployed to guide similar initiatives. The Health Care Payments Data Program (HPD), California's APCD, is expected to launch in 2023 and will include a method for collecting claims and non-claims payments. It could serve an important role as a trusted, neutral source of primary care investment information across payers and payer types.<sup>11</sup>

## California Efforts to Boost Primary Care

Stakeholders have engaged in multiple efforts to enhance primary care for Californians.

- ▶ **Blue Shield of California** adopted a **primary care pay-for-value hybrid payment model** in 2021, beginning with its preferred provider organization (PPO) products. The hybrid model includes four components: (1) population-based payment (per member per month, or PMPM) for primary care services; (2) population-based payment (PMPM) for “value services and performance outcomes”; (3) fee-for-service (FFS) payments for services not included in the PMPM rate; and (4) performance incentives for quality, utilization, and patient experience.<sup>12</sup>
- ▶ Focus on primary care and preventive services is a theme in the **2022 Comprehensive Quality Strategy** released by the **California Department of Health Care Services (DHCS)**, which manages Medi-Cal (California’s Medicaid program). Additionally, DHCS is planning to launch an alternative payment methodology for Federally Qualified Health Centers (FQHCs). If approved by the Centers for Medicare & Medicaid Services, **FQHC payment modernization** would provide FQHCs with prospective payment and greater flexibility to provide whole-person primary care services, including alternative workforce models, home visits, and virtual care.<sup>13</sup>
- ▶ The **California Quality Collaborative (CQC)**, a program of the Purchaser Business Group on Health (PBGH), and the Integrated Healthcare Association (IHA) have been working with system partners since 2019 to develop shared standards of advanced primary care, including common definitions of primary care practice **attributes**, a **performance measure set**, practice attribution methodology, and a value-based hybrid payment model.<sup>14</sup>
- ▶ In 2022, **Covered California** and the **California Public Employees’ Retirement System (CalPERS)** are requiring contracting health plans to participate in a pilot project conducted by CQC and IHA to **measure advanced primary care** based on the standard measure set. The results of the pilot will inform future contractual requirements related to primary care.<sup>15</sup>
- ▶ **Covered California’s 2023 contract with participating health plans** includes a requirement to measure and report on primary care payment (see Attachment 7, Article 4.01.3). Contracting plans must report on primary care clinicians and spend using the **Health Care Payment Learning & Action Network alternative payment model** (HCPLAN APM) categories.<sup>16</sup>
- ▶ **Medi-Cal’s CalAIM** is a multiyear initiative to move to a whole-person, population-health approach to care delivery. It includes key roles for primary care to help identify and address patients’ needs, including physical, behavioral, and social needs, and connect them to appropriate services.<sup>17</sup>
- ▶ The **Purchaser Business Group on Health (PBGH)**, whose members include Covered California (California’s marketplace) and CalPERS, created the **Health Value Index**, a set of key performance indicators that reflects the priorities of its large-employer and public-purchaser members in communicating with contracted health plans. The focused measure set includes primary care spending as a percentage of the total cost of care, with the goal of ensuring adequate investment in primary care to meet patient needs. Details are available in the September 2021 **Summary Findings**.<sup>18</sup>
- ▶ **PBGH** has incorporated the shared attributes and measure set into its **Employer Health Plan Common Purchasing Agreement for Advanced Primary Care**, outlining eight principles that purchasers can incorporate into their contracts with health plans.<sup>19</sup>

# Mechanisms and Tools

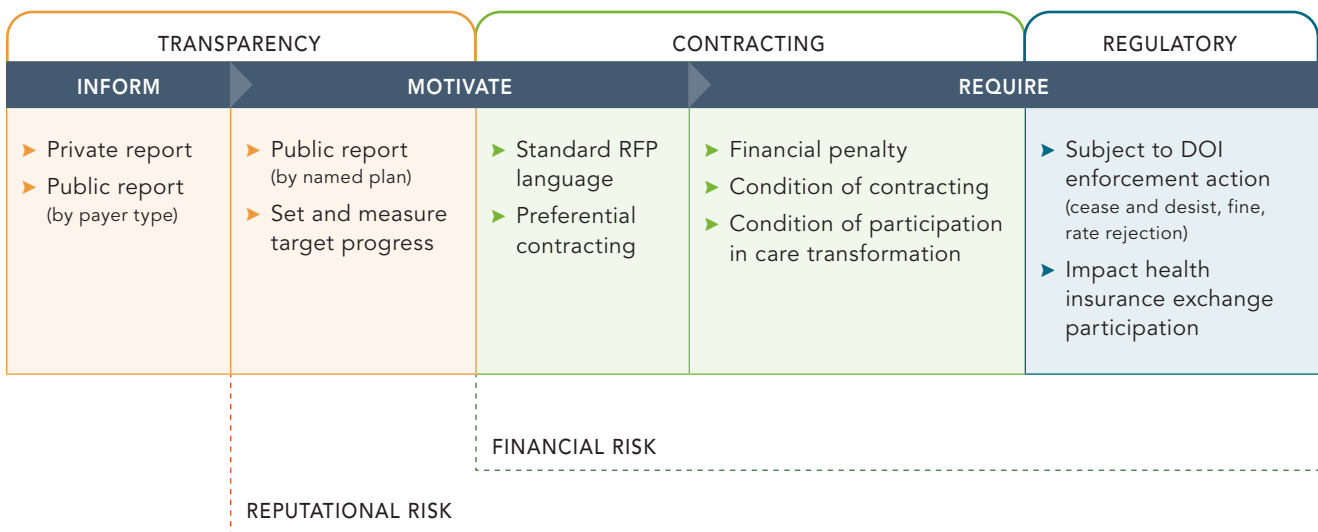
Public and private-sector efforts that successfully increase primary care investment deploy multiple tools that work together over time. These tools tend to fall into one of three mechanisms — transparency, contracting, or regulatory — as shown in Figure 2.

## Transparency Mechanism: Measurement and Reporting

Measuring and reporting primary care investment is a valuable early exercise that develops trust while building a common fact base. It can serve as a call to action for stakeholders and provide a baseline to inform investment targets. As efforts mature, the public reporting provides valuable information to guide ongoing strategy and motivate stakeholders to achieve investment goals.

Measurement activities may begin with an informal 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 investment in primary care. Most formal measurement efforts are led by states, often in collaboration with a multi-stakeholder workgroup. Public and private purchasers can build on these efforts by asking payers to measure and report primary care investment, putting additional pressure on payers to increase these allocations. Initially, measurement efforts may not have a standard definition of primary care or total cost of care. Such efforts typically evolve over time and may include revising definitions to better align with growing capabilities. See the section on definitions, below.

Figure 2. Increasing Investment in Primary Care: Mechanisms, Goals, Tools, and Risks



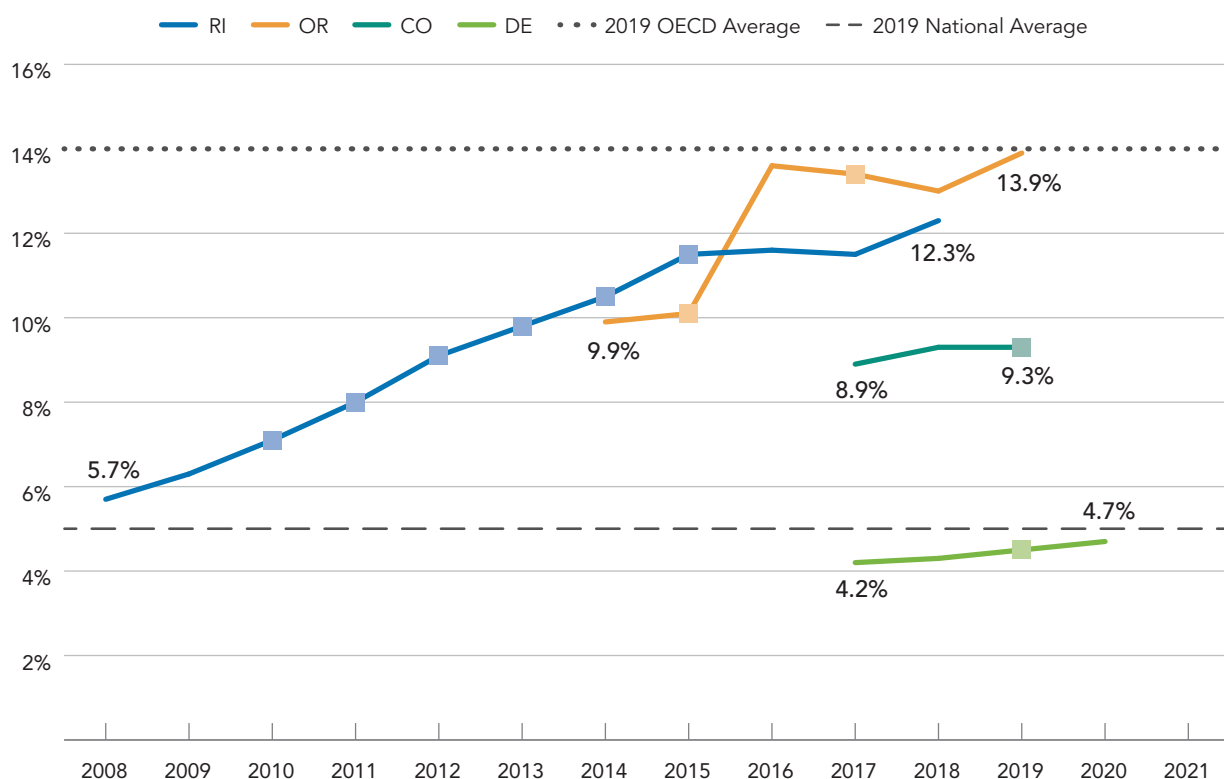
Notes: DOI is department of insurance; RFP is request for proposal.

Source: Author analysis of primary care investment reports, presentation materials, and other documentation publicly available on state government websites.

States saw increases in the proportion of their health spending dedicated to primary care after they drew attention to the topic, convened stakeholders, and began reporting.

Ten states have released reports on primary care investment, and two others are developing them. Four states — Rhode Island, Oregon, Colorado, and Delaware — have released multiple reports on primary care investment; all of them saw increases in the proportion of their health spending dedicated to primary care after the states drew attention to the topic, convened stakeholders, and began reporting, as shown in Figure 3.

Figure 3. Percentage of Health Care Dollars Invested in Primary Care, Selected States, 2008–2021



**RHODE ISLAND MILESTONES**

- 2010–2014** Carriers required to increase by 1% per year.
- 2015** Carriers required to spend at least 10.7% on primary care.

**COLORADO MILESTONE**

- 2019** Primary care spending first reported; 1% increase not required until 2022 and 2023.

**OREGON MILESTONES**

- 2015** Law passed that requires reporting of primary care spend percentage by payer.
- 2017** Carriers/CCOs required to allocate at least 12% to primary care in 2023.

**DELAWARE MILESTONES**

- 2019** PCRC set target to increase primary care investment to 12%.
- 2022** Carriers required to increase primary care spend to 7%, then 1.5% a year until 11.5%.

Notes: State definitions and total cost of care differ, which contributes to differences in investment percentages. CCOs are coordinated care organizations; OECD is Organisation for Economic Co-operation and Development; PCRC is Primary Care Research Consortium.

Source: Author analysis of primary care investment reports publicly available on state government websites.

The populations included in these reports vary (see Table 1). For example, Rhode Island measures primary care investment in the commercial population only and reports by health plan. Oregon measures primary care investment for “prominent carriers,” which the state defines as health insurance carriers with annual health premium income of \$200 million or more. These carriers may offer private health plans and/or Medicare Advantage plans. Oregon also measures primary care investment for Medicaid coordinated care organizations (CCOs) and health plans contracted by the Public Employees’ Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB). Colorado also reports by plan for private health plans, Medicaid plans, and Medicare Advantage plans. Delaware reports primary care investment for private health plans, Medicaid, Medicare, and Medicare Advantage by payer type. It plans to begin reporting private health plan primary care investment by health plan in 2023.

Oregon has been reporting primary care investment by health plan since 2016. The state’s first report, based on 2014 data, found that health plans spent an average of 9% of total cost of care on primary care compared to 13% for CCOs.<sup>20</sup> Oregon saw a large jump in investment from 2015 to 2016, after a law passed requiring reporting by health plan. The most recent comparable report, with 2018 data, found that health plans’ primary care

allocation increased to 13% and that of CCOs rose to more than 15%. Oregon’s 2021 report, based on 2019 data, pointed to another year of increases (but noted that the results cannot be compared to previous reports due to methodology changes and a new data vendor).<sup>21</sup> All of these increases occurred before implementation of Oregon’s primary care investment requirement, which does not go into effect until 2023.

**States use multiple mechanisms to encourage — and eventually require — increases.**

**Data sources.** Most states measure primary care investment with claims data from an APCD, which collects and aggregates health care claims from public and private-payer sources. However, APCDs hold limited data on individuals covered by self-insured plans and typically do not include certain national plans, such as the Federal Employees Health Benefits (FEHB) Program. Another challenge is the lack of non-claims data for payments outside the fee-for-service 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

**Table 1. Payer Types Included in State Primary Investment Reports**

STATE	COMMERCIAL	MEDICAID	MEDICARE ADVANTAGE	MEDICARE FEE-FOR-SERVICE
Colorado	✓	✓	✓	
Delaware	✓	✓	✓	✓
Oregon	✓	✓	✓	
Rhode Island	✓			

Source: Author analysis of primary care investment reports publicly available on state government websites.

for measurement and analysis. Information on the variation in non-claims data collected, the categories used, and the approaches to determining which dollars should be included as primary care investment can be found in Appendix D.

**Definitions of primary care investment.** Primary care investment is typically defined as spending for a primary care service, as denoted by a current procedural terminology (CPT) code, when it is performed by a primary care provider, as specified by the provider’s taxonomy code. Some definitions also restrict by place of service. A growing number of definitions now include care management payments, primary care incentive payments, and other non-fee-for-service payments related to primary care delivery. A high-level comparison of definitions reviewed for this report is provided in Appendix E. Code sets of the definitions reviewed for this report can be found in Appendix F. Primary care investment is typically shown as a percentage of total spending, as shown in Figure 4.

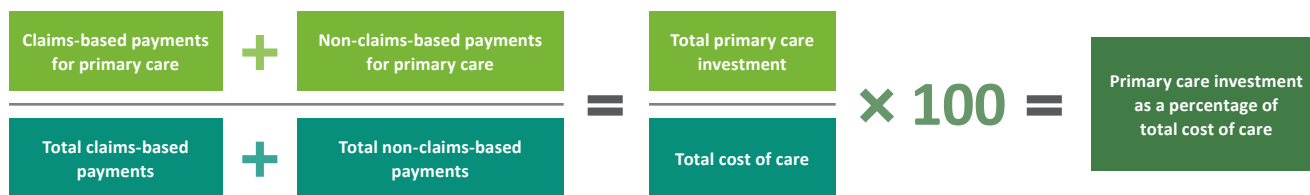
Interviewees for this report expressed strong interest in a national definition of primary care investment, particularly one structured as a series of modular definitions that could be combined as needed to support states’ differing visions. Previous research offers some guidance. In 2017, the publication *Standardizing the Measurement of Commercial Health Plan Primary Care Spending* tested four methodologies, each with different combinations of

services and providers. It provided a foundation for future measurement efforts and an early reference point for private health plans’ investment.<sup>22</sup> Three years later, the New England States Consortium Systems Organization (NESCSO) convened six New England states to develop a shared definition of primary care investment applied to standardized data from each state. The analysis included all payer types (Medicare, Medicaid, and private health plans) and offered more granular analyses on expected differences in spending by age, gender, and other factors.<sup>23</sup>

**Non-claims payments.** Non-claims payments provide reimbursement outside the fee-for-service structure. They offer primary care providers additional, flexible reimbursement to invest in the expanded care teams, population health analytics, and training necessary to move toward advanced models of primary care delivery. Non-claims payments include capitation payments and payments to support care management, health information technology, behavioral health integration, and other expenses not typically reimbursed via fee-for-service. Reimbursements under a value-based arrangement, including performance incentive payments and shared savings payments, also fall into this category.

Including non-claims payments makes a meaningful difference in the level of primary care investment reported. Four of the six states participating in the

**Figure 4. Primary Care Investment Equation**



Source: Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti, *Measuring Non-Claims-Based Primary Care Spending*, Milbank Memorial Fund, April 15, 2021.

NESCSO project contributed non-claims data. Using a standardized methodology, NESCSO found that including non-claims payments increased primary care investment between 0.2% (for Connecticut) and 4.5% (for Massachusetts). In Oregon and Colorado, the impact of including non-claims payments has been even greater. More than 40% of primary care investment in Oregon and nearly 60% of primary care investment in Colorado occur outside the fee-for-service or claims system. A comparison of state approaches to non-claims payments can be found in Appendix D.

However, there are challenges with including non-claims payments in measures of primary care investment. For example:

- ▶ There is little standardization of categories and definitions of non-claims payments across plans and across states. Non-claims payments typically support specific programs at the plan level or at the state level and therefore can vary widely. Examples of the variation across states are shown in Appendix D.
- ▶ There is minimal or no transparency into the portion of the non-claims payment dedicated to primary care. This is a particular challenge for risk-settlement payments paid to a large health system. Generally, the broader the purpose of the non-claims payment and the larger the organization receiving it, the more difficult it is to estimate the percentage of the payment allocated to primary care.
- ▶ It is difficult to verify whether data submissions are accurate or reflect the intention of the technical specifications.

To ease these problems, states are testing a variety of approaches to measure non-claims investment in primary care. See Appendix D.

**Voluntary investment targets.** After an initial process to measure primary care investment, the next step is often setting an allocation target. State-set voluntary targets typically occur through an executive order, statute, or regulation, or are published in a report by a multi-stakeholder workgroup. At this stage, the public nature of these workgroups can help inspire action and hold stakeholders accountable. Public and private purchasers may also set voluntary targets for primary care investment or offer support to state targets, as discussed in the contracting section below.

**While voluntary targets do not guarantee investment will increase, they are often a first step in a process of transparency that can galvanize stakeholders to take action.**

As displayed in Table 2, this report differentiates voluntary targets without defined accountability from contractual and regulatory targets and requirements, which are discussed in the following sections.

**Table 2. Setting a Primary Care Investment Goal**

DECISION POINT	GUIDANCE FOR SETTING	
	VOLUNTARY TARGET	CONTRACTUAL OR REGULATORY REQUIREMENT
<b>Aspirational goal or minimum floor</b>	<ul style="list-style-type: none"> <li>▶ Voluntary targets aim to engage stakeholders in a collaborative process and inspire shared commitment.</li> <li>▶ Aspirational goals will generate more stakeholder interest than minimum floors.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Requirements must be well-defined, achievable, and sustainable.</li> <li>▶ If a requirement is based on an aspirational goal, payers typically need several years to meet it.</li> <li>▶ Minimum floors can be met more quickly but should continue to increase over time.</li> </ul>
<b>Single target or target for each payer type</b>	<ul style="list-style-type: none"> <li>▶ A single target is easier to communicate and creates a shared goal across stakeholders.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Targets for each payer type recognize that differences in a population’s age, gender, and health status and in benefit design lead to differences in both primary care use and the total cost of care (the denominator in Figure 4).</li> </ul>
<b>Absolute improvement, relative improvement, or both</b>	<ul style="list-style-type: none"> <li>▶ An absolute target sets a vision for the future.</li> <li>▶ Though rarely met as quickly as hoped, absolute targets generate stakeholder interest and help approximate a budget for new primary care capabilities.</li> <li>▶ Relative improvement targets acknowledge that care delivery transformation takes time.</li> <li>▶ Combining them — e.g., “payers shall increase primary care investment 1% to 1.5% per year until reaching 12% of total cost of care” — allows all to succeed at a reasonable pace and defines an eventual ceiling.</li> </ul>	
<b>Percentage of total cost of care or per-member per-month amount</b>	<ul style="list-style-type: none"> <li>▶ Investment targets should reflect the cost of achieving primary care delivery goals sustainably and efficiently.</li> <li>▶ It is preferable to begin with a clear vision for primary care, estimate the cost, and translate the cost into a target.</li> <li>▶ Higher-cost states should consider whether primary care can be adequately funded with a lower percentage of total cost of care than lower-cost states.</li> </ul>	
<b>Defined offset for increased cost</b>	<ul style="list-style-type: none"> <li>▶ The risk of increased health care inflation is a common stakeholder concern.</li> <li>▶ Contractual and regulatory approaches that explicitly prioritize primary care may designate a specific approach to offset the increased investment, such as limiting increases in hospital prices.</li> </ul>	
<b>Measuring and ensuring accountability</b>	<ul style="list-style-type: none"> <li>▶ Public or private entities may measure and hold payers accountable for meeting voluntary targets or contractual or regulatory requirements.</li> <li>▶ Multi-stakeholder groups can also review performance and share progress and outcomes publicly. Such information can help inform decisions within participants’ own organizations. This type of review is critical for voluntary targets as it may be the only accountability mechanism available. It is also important for regulatory initiatives where risk to reputation may be more compelling than any enforcement action contemplated by regulators.</li> </ul>	



## Contracting Mechanism: Shaping Formal Agreements

Various tools related to contracting can be used by public and private purchasers as well as by multi-stakeholder entities. These tools range from simply inquiring about a payer's approach to strengthening primary care to requiring plans to commit to a certain spending target.

### Request for Proposals and Vendor Selection

A simple and low-risk way for public and private purchasers to show their interest in primary care investment is to include a question regarding primary care spending in a request for proposal. Answers are most comparable when a shared definition of primary care investment is in place, such as when a state or multi-stakeholder collaborative has already defined it. To further heighten health plans' motivation to increase their orientation toward primary care, purchasers can use preferential contracting or assign points to health plans with certain spending allocations. Going a step further, purchasers can impose a financial penalty on health plans that fail to achieve a target allocation or require a certain level of investment as a condition of contracting.

Because contracting tools that bring financial risk will likely generate some pushback from health plans, it is important to provide a clear definition and an accurate way to measure progress before enforcement is introduced. Beginning with minor penalties and providing multiple years of clearly communicated expectations can ease concerns.

### Condition of Participation

Requiring health plans to allocate a required level of primary care investment as a condition of participation in a care transformation effort is another way states and purchasers leverage the contracting tool. For example, national programs such as Primary Care First and state programs such as Oregon's

Patient-Centered Primary Care Home (PCPCH) program require plans to reimburse primary care providers' per-member per-month (PMPM) payment incentives, using a defined set of tiers. Plans that want to participate in these programs must agree to allocate a specific level of investment to support primary care. PCPCH is the state's program to recognize primary care providers that meet a defined set of standards for delivering patient-centered care. In some states and nationally, primary care practices demonstrating similar competencies may be referred to as primary care medical homes or patient-centered medical homes.

There are benefits and challenges to requiring a defined level of primary care investment to participate in care transformation. Benefits include the following:

- ▶ **Tie to value.** Linking increased investment to requirements for expanded primary care capabilities and improved quality helps purchasers and payers ensure they receive value. The effect is strengthened when primary care requirements are embedded in efforts to moderate growth in total cost of care. Without shared accountability for total cost of care, there is little financial incentive for provider organizations — particularly those reliant on expensive tests, emergency department visits, and hospitalizations — to make the necessary investments in primary care.
- ▶ **Multi-payer alignment.** A principal challenge of increasing investments in primary care is the difficulty of convincing private health plans to change their reimbursement model and business operations. Primary care providers cannot achieve care transformation goals for all patients if they are only paid sufficiently for a portion of them. Moreover, there is risk of a free-rider effect when only private health plans are contributing more for primary care services. Providers feel obligated to offer care management services to

patients who need them most, often Medicaid and Medicare beneficiaries. Multi-payer alignment is one important way to address these risks, and many states active in primary care investment efforts have sought such alignment. States' participation in these programs is shown in Appendix G. Primary Care First (PCF), a Center for Medicare & Medicaid Innovation (CMMI) program, is a basic example; five of the eight states identified as "Practicing" or "In Progress" in Figure 1 participate in PCF.

PCF offers Medicare a way to align with private health plans and Medicaid. However, in most states and regions, it has not generated enough participation to serve as a stand-alone approach. The Maryland CMS demonstration project and the Vermont All-Payer Model (VTAPM) have also struggled to attract sufficient participation from private health plans.

Washington state is trying to overcome the alignment challenge by fully engaging payers early in developing its primary care model. The state released its first report on primary care investment in 2019. As a next step, the Washington Health Care Authority (WA HCA) began convening stakeholders to develop a model for primary care delivery and payment. This effort, now called the WA Primary Care Transformation Initiative, aims to develop "a new whole-person, coordinated model of care for Washingtonians" and evaluate its impact.<sup>24</sup> Eight payers and the WA HCA signed a memorandum of understanding (MOU) documenting their commitments in a public, transparent fashion. Through the MOU, health plans agree to increase primary care investment to a yet-to-be-determined target. In this and other ways, plans are aligning payment and incentives to health care organizations so they have a greater cumulative effect on the overall health care market. Providers agree to improve capacity and access and measure progress toward a set of metrics.

## Regulatory Mechanism: Statutes and Regulations

Another approach to ensuring greater participation from health plans is to require it through state action. Four states now have a statute, regulation, or both that require health plans to reach a defined level of primary care investment. There are multiple ways to achieve state action.

### A State Structure for Insurance Enforcement

In Rhode Island and Colorado, state agencies that regulate the sale and operation of fully insured health plans require those plans to allocate a defined portion of the health care dollar to primary care. Oregon and Delaware will implement similar requirements on fully insured plans by 2023. For each state, enforcement of health plans occurs through the state's health insurance regulator. Colorado and Oregon also have primary care investment requirements for Medicaid plans. In each of these states, regulatory tools are layered with contracting and transparency tools to achieve the desired result. Oregon, Colorado, and Rhode Island have reported on primary care investment at the plan level. Delaware plans to begin doing so in 2022. Oregon and Rhode Island also require participation in payment and care delivery redesign initiatives, including mandating that CCOs serving Medicaid members receive additional payments to support medical home activities.

### In leading states, regulatory tools are layered with contracting and transparency tools to achieve the desired result.

Each state structures its requirement differently, but all recognize the importance of gradually increasing the target to give health plans time to identify ways to achieve cost savings in non-primary care spending categories. Gradually increasing targets also gives providers time to build new capabilities,

improve quality, and increase accountability for total cost. Specific work in four states includes the following:

- ▶ **Rhode Island** began with a relative improvement requirement for primary care investment at the plan level and transitioned to an absolute requirement. From 2010 to 2014, the Rhode Island Office of the Health Insurance Commissioner required health plans to increase primary care investment relative to non-primary care spending by one percentage point per year. Since 2015, health plans have been required to allocate at least 10.7% of total cost of care on primary care. Compliance is integrated into the rate review process.<sup>25</sup>
- ▶ **Oregon** has an absolute target of at least 12% for large private health plans, the state's employee benefit plans, and its Medicaid plans, called coordinated care organizations. It does not take effect until 2023, but Oregon payers have been increasing primary care investment for more than five years, with the state leveraging transparency and contractual tools.<sup>26</sup>
- ▶ **Colorado** imposes a relative improvement requirement for primary care spending by health plan. Health plans must increase the proportion of total medical expenditures allocated to primary care by 1% in 2022 and another 1% in 2023.<sup>27</sup> Noncompliance can result in "any of the sanctions made available in the Colorado statutes including fines, cease-and-desist orders, and revocation of the health plan's license."<sup>28</sup>
- ▶ **Delaware** law now includes a staircase approach, requiring health plans to reach 7% spending on primary care in 2022, 8.5% in 2023, 10% in 2024, and 11.5% in 2025. Similar to Rhode Island, enforcement occurs through the rate review process.<sup>29</sup>

## Health Insurance Exchange Participation

Denying plans the ability to sell products on the state's health insurance exchange or penalizing those that fail to meet primary care investment requirements is another approach. In certain states, such as Delaware, the department of insurance also oversees the health insurance exchange. Therefore, in those states, enforcement actions by the department equate to penalties for plans operating on the exchange.

There are benefits and challenges to employing regulatory tools. Benefits include the following:

- ▶ **Evidence of success.** As shown in Figure 3, regulatory requirements drive increases in primary care investment relative to higher-cost inpatient and outpatient specialty care. Health plans must comply or risk rate denials and fines. Rhode Island, which has required a specific allocation of primary care investment for more than a decade, finds that health plans comply.
- ▶ **Works alongside requirements to offset increased expenses.** For example, Rhode Island has limited hospital price growth for more than a decade, driving down the state's total cost of care while increasing the proportion of spending directed toward primary care.<sup>30</sup> Delaware included a similar provision in its statute.
- ▶ **Moving along laggards.** Oregon's primary care investment requirement, which goes into effect in 2023, is aimed at plans that have not achieved the 12% threshold with a voluntary approach. Private health plans' investment ranged from 10.8% to 16.5% in 2019, the most recent data available. The variation was even greater among Medicaid plans, with primary care investment ranging from 8.9% to 22.5% during the same period.<sup>31</sup>

Challenges to the use of regulatory tools include the following:

- ▶ **Stakeholder opposition.** While few stakeholders dispute the need to direct resources to primary care, payers and purchasers often raise concerns about the impact on total cost of care and the ability to generate a “return on investment.”<sup>32</sup> Strategies like directly offsetting increased investment and making providers more accountable for total cost raise concerns from hospitals and health systems that fear they will lose revenue under either scenario.
- ▶ **Balance between effectiveness and flexibility.** Regulatory tools should be drafted in ways that are specific enough to hold payers accountable, but flexible enough to adapt to changing market conditions and reimbursement strategies.

## Steps Forward for California

California, with its long history of public and private-purchaser engagement and alignment, is well poised to take steps to strengthen primary care. While the state does not yet have regulation in place to increase investments in primary care statewide, individual purchasers and payers have enacted a number of transparency and contracting mechanisms (see *The California Landscape*, page 9). These purchasers and payers — as well as the state — can do more.

**California, with its long history of public and private-purchaser engagement and alignment, is well poised to take steps to strengthen primary care.**

In planning for the next phases of work, California could consider lessons from the states profiled in this report, in the following areas:

- 1. Establish a shared vision.** To bridge efforts already occurring, convene stakeholders to create a shared vision for primary care. Multi-stakeholder workgroups typically include primary care providers as well as representatives of health systems, commercial health plans, Medicaid, the state employee benefits plan, employers, and consumers. Ideally, stakeholders balance each other’s perspectives and arrive at a fulcrum all can support. Even without reaching full consensus, a common vision can serve as a useful guidepost. By acting collectively, stakeholders offer providers, payers, and patients clear, aligned expectations for what should be included in the primary care experience and how primary care should be funded. Appendix C outlines the roles various state agencies play in moving this work forward.
- 2. Conduct annual measurement and reporting across markets based on a common definition of primary care investment.** After developing a common vision, multi-stakeholder workgroups add detail by arriving at a common definition of primary care investment that can be applied across market segments to support annual measurement and reporting. The Department of Health Care Access and Information is a logical convener for this process as lead on California’s Health Care Payments Data Program, the state’s all-payer claims database, and the intended home for the proposed Office of Health Care Affordability. (See Appendix H for specific considerations for California.) Initially, measuring and reporting on primary care investment builds trust, serves as a call to action, and establishes a baseline by which to measure progress. Over time, public reporting can motivate stakeholders to achieve investment goals and also help guide future strategy (e.g., adjusting targets).

**3. Set investment targets and encourage (or require) all purchasers to commit through contractual requirements.** An investment target provides a clear and transparent goal. It should reflect the true cost of achieving the vision for improved care delivery, including expenses related to additional staff, new technology, and ongoing training and technical assistance. Options include an improvement target, such as increasing the share of total cost that is spent on primary care by one percentage point annually, or an absolute target, such as spending at least 10% of total costs on primary care. Targets can be set by purchasers and/or the state, and they can be voluntary or required and enforced through penalties. California should consider the trade-offs of such approaches and identify clear enforcement mechanisms for the approach it selects (lessons from other states are provided on page 18).

The ultimate goal of any effort to increase investment in primary care is a more robust primary care system that better serves patients through expanded care teams, integrated behavioral health, and connections to social care — achieving better and more equitable health outcomes for all.

## Conclusion

Many states are taking action to increase investment in primary care, recognizing primary care's unique potential to improve population health and advance health equity. States that are making the most progress have found specific ways to increase utilization of primary care services, while simultaneously lowering growth in total health care spending. These states develop trust and collaboration, achieve alignment among payers to the degree possible, continually recalibrate their measurement processes to improve reliability, and find enforceable ways to drive change. The data collected and lessons learned from the 17 states profiled in this report provide California stakeholders, and others, with a rich playbook of options for increasing investment in primary care.

## Appendix A. Glossary

**Absolute primary care investment requirement.**

A requirement to increase primary care investment to reach a specific set amount, such as 12%.<sup>33</sup>

**Absolute primary care investment target.** A target that aims to increase primary care investment to reach a specific set amount, such as 12%.<sup>34</sup>

**All-payer claims database (APCD).** State databases that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from private and public payers.<sup>35</sup>

**Capitation.** A fixed amount of money per patient per unit of time, paid in advance to a health care provider for the delivery of health care services. The actual amount of money paid is determined by the range of services that are provided, the number of patients involved, and the period of time during which the services are provided.<sup>36</sup>

**Care management services.** Activities performed by health care professionals with the goal of facilitating coordinated patient care across the health care system. Components of care management may include patient education, medication management and adherence support, risk stratification, population management, coordination of care transitions, and care planning.<sup>37</sup>

**Comprehensive Primary Care Plus (CPC+).** A national advanced primary care medical home model developed by the Center for Medicare & Medicaid Innovation that aims to strengthen primary care through regionally based multi-payer payment reform and care delivery transformation.<sup>38</sup>

**Federal Employee Health Benefits (FEHB) Program.** A health benefits program for federal employees or employees of certain tribal organizations that provide consumer-driven and high-deductible plans or nationwide fee-for-service plans with preferred provider organizations or health maintenance organizations within service areas.<sup>39</sup>

**Fee-for-service.** A payment methodology in which doctors and other health care providers are paid for each service performed.<sup>40</sup>

**Medicaid.** A health insurance program that provides health coverage to eligible low-income adults, children, pregnant people, elderly adults, and people with disabilities.<sup>41</sup>

**Medicare.** A health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease.<sup>42</sup>

**Non-claims payment.** Payments that are made for something other than a fee-for-service claim. They include capitation payments and payments to support care management, health information technology, behavioral health integration, and other expenses not typically reimbursed via fee-for-service.

**Organisation for Economic Co-operation and Development (OECD).** An organization that works to build evidence-based policies and solutions to a range of social, economic, and environmental challenges.<sup>43</sup>

**Patient-centered medical home (PCMH).** A model in which the approach to delivering primary care is patient-centered, culturally appropriate, and team-based. The PCMH model coordinates patient care across the health system and has been associated with effective chronic disease management, increased patient and provider satisfaction, cost savings, improved quality of care, and increased preventive care.<sup>44</sup>

**Payer.** The organization that negotiates or sets rates for provider services, collects revenue through premium payments or tax dollars, processes provider claims for service, and pays provider claims using collected premiums or tax revenues.

**Primary care.** The provision of 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.<sup>45</sup>

**Primary Care First (PCF).** A voluntary, five-year alternative payment model program launched by the Center for Medicare & Medicaid Innovation that aims to reduce Medicare spending by preventing avoidable inpatient hospital admissions and improve quality and access to care for all beneficiaries, particularly those with complex chronic conditions and serious illness. The model specifically aims to reward value and quality by offering an innovative payment structure to support delivery of advanced primary care.<sup>46</sup>

**Primary care investment.** Payments to organizations that deliver primary care services or that contract with payers on behalf of providers of primary care services. These may include organizations that deliver services beyond primary care. The services included in the definition of primary care investment vary depending on the entity conducting the measurement.<sup>47</sup>

**Primary care investment mechanism.** An approach or strategy used by states, public and private purchasers, payers, and multi-stakeholder collaboratives to inform, encourage, or require increases in primary care investment. Three mechanisms — transparency, contracting, and regulatory — are profiled in this brief.<sup>48</sup>

**Primary care investment tool.** A specific tactic deployed by states, public and private purchasers, payers, and multi-stakeholder collaboratives to increase primary care investment. Tools profiled in this brief fall into one of three primary care investment mechanisms — transparency, contracting, and regulatory.<sup>49</sup>

**Quintuple aim.** The simultaneous pursuit of five aims, including improving quality, population health, and staff and provider experience as well as reducing costs and advancing equity.<sup>50</sup>

#### **Registration of Provider Organizations (RPO).**

A program that increases the transparency of provider structure and performance, tracks longitudinal changes in the health care market, and provides researchers, policymakers, market participants, and the public with access to the resulting data set.<sup>51</sup>

**Relative improvement primary care investment requirement.** A requirement to increase primary care investment using incremental improvement compared to the current state, such as by 1% a year.<sup>52</sup>

**Relative improvement primary care investment target.** A target that aims to increase primary care investment using incremental improvement compared to the current state, such as by 1% a year.<sup>53</sup>

**Taxonomy.** Taxonomy codes are administrative codes set for identifying the provider type and area of specialization for health care providers. Each taxonomy code is a unique 10-character alphanumeric code that enables providers to identify their specialty at the claim level. Taxonomy codes are assigned at both the individual provider and organizational provider level. Taxonomy codes have three distinct levels: Level I is the Provider Grouping, Level II is the Classification, and Level III is the Area of Specialization. A code that is “attached” to a National Provider Identifier (NPI) number describes what type of health professional or entity that NPI represents.<sup>54</sup>

**Total cost of care.** The total dollars spent by health care purchasers for health care services. Definitions of total cost of care may or may not include pharmacy, dental, certain behavioral health services, and long-term services and supports.<sup>55</sup>

## Appendix B. Acknowledgments

The authors wish to acknowledge the following organizations for their valuable insight and support in creating this technical brief:

- ▶ American Board of Family Medicine (ABFM)
- ▶ Blue Shield of California
- ▶ California Academy of Family Physicians (CAFP)
- ▶ California Health and Human Services Agency (CalHHS)
- ▶ California Public Employees' Retirement System (CalPERS)
- ▶ Covered California
- ▶ Integrated Healthcare Association (IHA)
- ▶ Milbank Memorial Fund
- ▶ Oregon Health Authority (OHA)
- ▶ CHCF's Primary Care Investment Coordinating Group (PICG)
- ▶ Purchaser Business Group on Health (PBGH)
- ▶ Rhode Island Office of the Health Insurance Commissioner (RI OHIC)



## Appendix C. Leadership and Partnerships, by State



Design/Develop



Measure/Monitor



Implement/Enforce

AGENCIES, ORGANIZATIONS, AND WORKGROUPS		CORE FUNCTIONS								
		INVESTMENT TARGET			CARE TRANSFORMATION			PAYMENT INNOVATION		
NAME	TYPE									
<b>CO Lead: Division of Insurance</b>	<b>OA</b>			✓						
Center for Improving Value in Health Care	APCD		✓			✓			✓	
Primary Care Payment Reform Collaborative	WG	✓			✓			✓		
<b>CT Lead: Office of Health Strategy (OHS)</b>	<b>OA</b>	✓				✓			✓	
Dept. of Public Health	OA				✓			✓		
Insurance Dept.	OA				✓			✓		
CT All-Payer Claims Database	APCD		✓							
OHS Stakeholder Workgroups	WG	✓			✓			✓		
Dept. of Social Services/Medicaid	P				✓	✓		✓		
Office of the State Comptroller	P	✓			✓	✓	✓	✓		
<b>DE Lead: Dept. of Insurance</b>	<b>OA</b>	✓	✓	✓				✓	✓	
<b>Lead: Health Care Commission</b>	<b>WG</b>				✓	✓	✓	✓	✓	
DE Health Information Network	APCD		✓							
Primary Care Reform Collaborative	WG				✓	✓	✓			
State Employee Benefits Committee*	P				✓	✓	✓	✓	✓	
Division of Medicaid and Medical Assistance*	P				✓	✓	✓	✓	✓	
<b>MA Lead: Center for Health Information and Analysis</b>	<b>APCD</b>	✓	✓	✓ <sup>†</sup>		✓			✓	
Health Policy Commission	WG			✓						
<b>MD Lead: Health Services Cost Review Commission</b>	<b>OA</b>	✓	✓	✓	✓	✓	✓	✓	✓	
MD Health Care Commission	OA/ APCD		✓		✓	✓				
MD Insurance Administration	OA			✓			✓		✓	
MD Primary Care Program	OA				✓		✓ <sup>‡</sup>	✓	✓ <sup>‡</sup>	
Care Transformation Organizations	Other						✓ <sup>‡</sup>		✓ <sup>‡</sup>	

\* Function only corresponds to organization's own population.

<sup>†</sup> Only for compliance of submission timelines.

<sup>‡</sup> Implementation only.

<sup>§</sup> Coordinates with the Primary Care Council to address primary care workforce shortages.

Notes: APCD is all-payer claims database; OA is oversight agency; P is purchaser; WG is appointed workgroup. Icon sources: The Noun Project (Wahyu Adam Pratama, Mahdaleny, and Lemon Liu).

## Appendix C. Leadership and Partnerships, by State, *continued*



Design/Develop



Measure/Monitor



Implement/Enforce

AGENCIES, ORGANIZATIONS, AND WORKGROUPS		CORE FUNCTIONS								
		INVESTMENT TARGET			CARE TRANSFORMATION			PAYMENT INNOVATION		
NAME	TYPE									
<b>ME Lead: Maine Quality Forum (MQF)</b>	OA	✓	✓							
Maine Health Data Organization	APCD			✓						
MQF Primary Care Spending Advisory Committee	WG	✓								
<b>NM Lead: Primary Care Council</b>	WG	✓	✓		✓			✓		
Graduate Medical Education Expansion Review Board	WG				✓ <sup>§</sup>					
<b>OR Lead: Dept. of Consumer and Business Services</b>	OA			✓						
<b>Lead: Oregon Health Authority</b>	OA/P/APCD	✓	✓	✓						
▶ OR Educators Benefit Board	P			✓			✓			✓
▶ Public Employees' Benefit Board	P			✓			✓			✓
▶ Medicaid Care Coordination Organizations	Other			✓ <sup>*</sup>			✓ <sup>†</sup>			✓ <sup>‡</sup>
Primary Care Payment Reform Collaborative	WG	✓	✓		✓	✓		✓	✓	
<b>RI Lead: Office of the Health Insurance Commissioner</b>	OA	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicaid	P			✓			✓			✓
Office of Employee Benefits	P			✓			✓			✓
Care Transformation Collaborative	Other				✓	✓	✓	✓		
<b>VT Lead: Green Mountain Care Board / Dept. of Health Access</b>	OA	✓	✓	✓	✓	✓	✓	✓	✓	✓
VT Health Care Uniform Reporting and Evaluation System	APCD		✓							
<b>WA Lead: Office of Financial Management</b>	OA	✓	✓							
WA All-Payer Claims Database	APCD		✓							
Primary Care Expenditures Stakeholder Group	WG	✓								
WA Health Care Authority	P		✓		✓	✓	✓	✓	✓	✓

\* Function only corresponds to organization's own population.

<sup>†</sup> Only for compliance of submission timelines.

<sup>‡</sup> Implementation only.

<sup>§</sup> Coordinates with the Primary Care Council to address primary care workforce shortages.

Notes: APCD is all-payer claims database; OA is oversight agency; P is purchaser; WG is appointed workgroup. Icon sources: The Noun Project (Wahyu Adam Pratama, Mahdaleny, and Lemon Liu).

## Appendix D. Overview of Approaches to Non-Claims Payments

	PRACTICING		IN PROCESS					GETTING STARTED	
	OR	RI	CO	CT	DE	MA	VT	ME	CA/IHA
<b>Framework</b>									
Health Care Payment Learning & Action Network	✓		✓		✓				
Homegrown					✓	✓	✓	✓	
Milbank Memorial Fund / Bailit Health		✓		✓				✓	✓
<b>Non-Claims Payment Collected</b>									
Capitation									
▶ All services						✓			
▶ All services, primary care separated	✓	✓	✓	✓	✓			✓	✓
Care management									
▶ All services						✓			
▶ All services, primary care separated	✓	✓	✓	✓	✓			✓	✓
Incentive programs									
▶ All services						✓			
▶ All services, primary care separated	✓	✓	✓	✓	✓			✓	✓
Population-based payment									
▶ Comprehensive	✓	✓	✓	✓	✓			✓	✓
▶ Condition-specific	✓	✓	✓	✓	✓			✓	
▶ Integrated finance / delivery system	✓	✓	✓	✓	✓			✓	✓
Payments for upside/downside risk programs									
▶ Shared savings/losses	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pay for									
▶ Reporting	✓	✓	✓	✓	✓			✓	✓
▶ Performance	✓	✓	✓	✓	✓			✓	✓

Notes: *IHA* is Integrated Healthcare Association. The **Oregon** All Payer All Claims Reporting Program (APAC) provides a public-facing non-claims payment arrangement dashboard at [visual-data.dhsoha.state.or.us](https://visual-data.dhsoha.state.or.us). **Rhode Island and Connecticut**: Payers and/or providers submit estimate of the percentage of non-claims payments allocated to primary care. **Colorado**: Non-claims payments made to providers with primary care taxonomy are classified as primary care investment. **Delaware** collects non-claims payments two ways: based on the Health Care Payment Learning & Action Network approach and using a homegrown approach. The homegrown approach designates certain categories of payments as part of primary care investment. **Massachusetts**: Each non-claims category is reported separately for primary care services, behavioral health services, and all other types of services. The MA definition includes pay for performance and reporting in a single "Incentive Payments" category. The MA definition includes all population-based payments under capitation. **Vermont** uses a homegrown approach and includes at least a portion of some categories of payments as primary care investment. Vermont's homegrown categories include Blueprint for Health PCMH, Comm. Health Team, Spoke, Women's Health Initiative, and Support & Services at Home. While these categories do not match those in the table, the dollars are used to support many of the same functions. **Maine**: Payers submit estimated non-claims payments, members, and member months for primary care and non-primary care providers in aggregate for each product. See **90-590 CMR Chapter 247: Uniform Reporting System for Non-Claims-Based Payments** (PDF), Maine Health Data Organization, December 12, 2021. **California/IHA**: Payers/providers submit estimate of the percentage of non-claims payments allocated to primary care.

## Appendix E. Overview of Primary Care Investment Definitions

PRIMARY CARE DEFINITION	PRACTICING		IN PROCESS							GETTING STARTED			MULTI-STATE REPORTS	
	OR	RI	CO	CT	DE	MA	MD	VT	WA	ME	UT	CA/IHA	MILBANK	NESCSO
Narrow (N), Broad (B), or No Distinction (ND)	ND	ND	ND	N, B	ND	ND	ND	ND	N, B	N, B	N, B	N, B	N, B	N, B
<b>Most Common Provider Specialties</b>														
▶ Family/general practice	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
▶ Internal medicine (no subspecialty)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
▶ Pediatrics (no subspecialty)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
▶ Nurse practitioner/physician assistant	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
<b>Expanded Provider Specialties</b>														
▶ Certified clinical nurse specialist	✓		✓			✓					✓			
▶ Nurse, nonpractitioner	✓		✓			✓	✓		✓	✓	✓			
▶ Internal medicine (geriatric specialty)	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
▶ Adolescent medicine	✓	✓	✓	✓		✓			✓	✓	✓	✓	✓	✓
▶ Obstetrician/gynecologist	✓		✓	✓		✓*		✓		✓†	✓		✓	✓
▶ Behavioral health practitioner	✓		✓			✓‡								
▶ Homeopath/naturopath	✓					✓	✓	✓	✓	✓	✓			
▶ FQHC/primary care clinic/rural health clinic practitioner	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
▶ Other			✓	✓		✓		✓	✓			✓		✓

\* In Massachusetts, services delivered by ob/gyn practitioners may be reported only for procedure codes listed in the Office Type, Preventive, and Obstetric measure categories.

† Maine only included specific primary care services/procedures provided by ob/gyn providers for both broad and narrow definitions.

‡ Massachusetts technical specifications allow for stand-alone calculations of behavioral health spend.

PRIMARY CARE DEFINITION	PRACTICING		IN PROCESS							GETTING STARTED			MULTI-STATE REPORTS	
	OR	RI	CO	CT	DE	MA	MD	VT	WA	ME	UT	CA/IHA	MILBANK	NESCSO
<b>Services and Expenses</b>														
▶ Office visits/preventive visits/vaccine administration	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
▶ Behavioral health	✓		✓			✓	✓	✓						
▶ Care coordination and/or management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
▶ Health information exchange/other infrastructure	✓	✓	✓	✓		✓		✓						✓
▶ Maternity	✓ <sup>§</sup>		✓ <sup>§</sup>					✓						
▶ Primary care incentive payments		✓	✓	✓	✓	✓		✓						✓
<b>Data Source</b>														
▶ All-payer claims database (APCD)	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓		
▶ Payer submits Excel template to state	✓	✓	✓	✓	✓	✓		✓				✓	✓	✓
▶ Non-claims-based payments included	✓	✓	✓	✓	✓	✓		✓				✓		✓
<b>Definition of Total Spending Includes</b>														
▶ Non-claims payments	✓	✓	✓	✓	✓	✓		✓				✓		✓
▶ Prescriptions (Rx)		✓		✓		✓	✓		✓			✓	✓	

<sup>§</sup> Colorado and Oregon include some delivery services at 60% of payment.

Notes: For states or reports that include narrow and broad service definitions, the narrow service definition is reflected in the table. As several definitions include multiple configurations of providers, the table includes all provider specialties. Table does not include New Mexico and Pennsylvania (no primary care investment measurements). Definitions in the table were taken from the state's report, which may differ from the New England States Consortium Systems Organization (NESCSO) report. *FQHC* is Federally Qualified Health Center; *IHA* is Integrated Healthcare Association. **Vermont** stakeholders requested that the data be shown with obstetrics and mental health services included and excluded. Vermont uses a set of homegrown non-claims payment categories that support primary care in the ways identified under "Services and Expenses." **Maine** excludes dental claims and applies a factor to Medicaid medical expenditure to exclude long-term services and support (LTSS). Maine also counts insurer paid amounts, not total paid amount. Non-claims payments voluntarily reported by insurers will be included in the February 2022 Maine Quality Forum (MQF) third annual spending report. **California/IHA**: Voluntary multi-payer claims database used for fee-for-service (FFS) amounts; the only non-claims payment included in the calculation is capitation. The **Milbank Memorial Fund** offered four definitions of primary care provider, including any specialty designated by an insurer as a PCP. See Michael H. Bailit, Mark W. Friedberg, and Margaret L. Houy, *Standardizing the Measurement of Commercial Health Plan Primary Care Spending*, Milbank Memorial Fund, July 25, 2017. **NESCSO**: *The New England States' All-Payer Report on Primary Care Payments* (PDF), NESCSO, December 22, 2020.

## Appendix F. Comparison of Primary Care Investment Definition Code Sets

Primary care investment is typically defined as spending for a primary care service, as denoted by a current procedural terminology (CPT) code, when it is performed by a primary care provider, as specified by the provider's taxonomy code. Some definitions also restrict by place of service or include non-claims payments for primary care services. A crosswalk of the CPT code sets used by 11 state and two national measures of primary care investment is available for download at [www.chcf.org/resource/primary-care-matters/lessons-from-other-states](http://www.chcf.org/resource/primary-care-matters/lessons-from-other-states).

Source: Author analysis of primary care investment reports publicly available on state government websites. Current as of December 2021.

## Appendix G. Participation in PCMH and CMS Programs

STATE	PCMH ACTIVITY	CPC	CPC+	PCF	HALF OR MORE MSSP ACOs IN TWO-SIDED RISK	CMS DEMONSTRATION
Colorado	✓	✓	✓	✓		
Connecticut	✓					
Delaware	✓			✓	✓	
Maine	✓			✓		
Maryland	✓					✓
Massachusetts	✓			✓	✓	
New Mexico	✓					
Oregon	✓	✓	✓	✓		
Pennsylvania	✓		✓	✓		
Rhode Island	✓		✓	✓	✓	
Utah	✓				✓	
Vermont	✓				✓	✓
Washington	✓					

Note: CMS is Center for Medicare & Medicaid Services; CPC is Comprehensive Primary Care; CPC+ is Comprehensive Primary Care Plus; MSSP ACOs are accountable care organizations participating in the Medicare Shared Savings Program; PCF is Primary Care First; PCMH is patient-centered medical home.

Sources: "Primary Care Innovations and PCMH Map by State," Primary Care Collaborative, accessed February 4, 2022; "Comprehensive Primary Care Plus," Centers for Medicare & Medicaid Services (CMS), updated January 3, 2022; "Primary Care First Model Cohort 2 CY 2021 Fact Sheet," CMS, updated April 12, 2021.

## Appendix H. Primary Care Investment Design and Measurement Considerations for California

**Generating fair comparisons.** Some California payers expressed concerns about having their primary care investment percentages compared to Kaiser due to its organizational structure and employment of providers. Kaiser Permanente and Denver Health are not subject to primary care investment requirements in Colorado due to their unique integrated payer-provider systems. Oregon, which also has a significant Kaiser presence, does not treat Kaiser differently.

**Measuring non-claims spending.** In California, a high percentage of primary care services are paid for outside of fee-for-service payments. If the Health Care Payments Data Program (HPD) is interested in providing data to support primary care investment design and monitoring, it will need to consider how its alternative payment model (APM) data collection tool will support this goal. Specifically, it will need to determine whether that data collection tool will identify the percentage of APM dollars that specifically support primary care services versus all other services. This may require a process (such as the provider survey approach) that the Integrated Healthcare Association (IHA) is testing to support its non-claims primary care measurement work.

**Provider organizational structure.** Understanding how primary investment flows within provider organizations is always challenging. Moreover, California primary care providers practice within a wide range of organizational affiliations. Perhaps most challenging are the layers of administrative arrangements that work to aggregate primary care providers and provide various types of administrative or clinical support. Since many of these arrangements — including managed services organizations, independent practice associations, and medical groups — receive a per-member per-month payment from a health plan and distribute it to primary care providers, it is difficult to generate meaningful data on the amount of primary care investment that each primary care practice receives. California stakeholders have expressed interest in very specific

and granular reporting, ideally at the practice level, on primary care investment and its impact on the state's ability to achieve the quintuple aim. Complicating matters, this type of granular data tends to be less available as value-based payments become more ubiquitous. In Massachusetts, the Registration of Provider Organizations (MA-RPO) program increases transparency of provider structure and performance; tracks changes in the health care market over time; and provides policymakers and the public with more accurate data on provider specialty, current practice focus, and organizational affiliations. With this goal in mind, California may want to consider Massachusetts' approach to developing the provider directory for its HPD.

**Shifting sources of care.** Some California employers have begun to contract directly or through their health plan partners for primary care services. These arrangements vary broadly from telehealth visits to treat acute needs after hours to more extensive care management and coordination services. For employers, these services offer necessary, convenient access to employees and their families. For primary care providers, they are competitors that risk disrupting the physician-patient relationship. For now, these arrangements are likely a small portion of primary care in California. However, if third-party vendors and other nontraditional primary care sites such as retail-based convenience clinics begin providing a significant portion of primary care, whether to include them in definitions of primary care investment will likely take on greater meaning.

**Retail pharmacy in the denominator.** IHA included prescriptions in the denominator (see Figure 4) for its evaluation of primary care investment in California. The decision was driven by the organization's definition for reporting its total cost of care. If California decides to develop a target or requirement based on the primary care definition, then it may decide to exclude prescriptions from the denominator to prevent unwarranted growth in the primary care investment goal.



## Endnotes

1. Celli Horstman, Corinne Lewis, and Melinda K. Abrams, *Strengthening Primary Health Care: The Importance of Payment Reform*, Commonwealth Fund, December 10, 2021.
2. Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?*, Commonwealth Fund, January 30, 2020.
3. *Realising the Full Potential of Primary Health Care* (PDF), OECD, 2019.
4. Yalda Jabbarpour et al., *Investing in Primary Care: A State-Level Analysis* (PDF), Patient-Centered Primary Care Collaborative, July 2019.
5. "Primary Care Innovations and PCMH Map by State," Primary Care Collaborative (PCC), accessed February 4, 2022.
6. *Investment in Comprehensive Primary Care: Unlocking Savings in Delaware* (PDF), Office of Value-Based Health Care Delivery, Delaware Department of Insurance, September 9, 2021.
7. *Colorado's Primary Care Payment Reform Collaborative Recommendations: First Annual Report* (PDF), Colorado Health Institute, December 15, 2019; *Memorandum of Understanding Among Washington State Health Plans in Support of Multi-Payer Collaborative Primary Care Reform Work* (PDF), Washington State Health Care Authority (HCA), accessed February 5, 2022; "Primary Care Payment Reform Collaborative," Oregon Health Authority (OHA), accessed February 15, 2022; *230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner* (PDF), Rhode Island Office of the Health Insurance Commissioner (OHIC), July 31, 2020; and *Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value* (PDF), Office of Value-Based Health Care Delivery (OVBHCD), Delaware Department of Insurance, December 18, 2020.
8. *Colorado's Primary Care Payment Reform*, Colorado Health Institute; *Memorandum of Understanding*, Washington State HCA; *Primary Care Payment Reform Collaborative*, OHA; *230-RICR-20-30-4*, Rhode Island OHIC; and *Delaware Health Care Affordability Standards*, OVBHCD.
9. *Colorado's Primary Care Payment Reform*, Colorado Health Institute; *Memorandum of Understanding*, Washington State HCA; *Primary Care Payment Reform Collaborative*, OHA; *230-RICR-20-30-4*, Rhode Island OHIC; and *Delaware Health Care Affordability Standards*, OVBHCD.
10. California Department of Health Care Access and Information (HCAI), "Get the Facts About the Proposed Office of Health Care Affordability at OSHPD," press release, February 24, 2021; and *AB-2817 Office of Health Care Quality and Affordability (2019-2020)*, California Legislative Information, March 2, 2020.
11. HCAI, "Get the Facts"; and *AB-2817*, California Legislative Information.
12. Edith Coakley Stowe, Megan Ingraham, and Sol Lee, *Supporting the Future of Primary Care in California Through Aligned Hybrid Payment Models: A Call to Action* (PDF), Blue Shield of California and Manatt Health, November 2021.
13. "DHCS Comprehensive Quality Strategy," California Department of Health Care Services (DHCS), modified December 28, 2021; and "Alternative Payment Methodology (APM) Initiative," California Primary Care Association (CPCA), accessed February 5, 2022.
14. *Advanced Primary Care: Defining a Shared Standard* (PDF), Pacific Business Group on Health (PBGH), accessed February 6, 2022; and *Advanced Primary Care Measure Set: Alignment with Attributes* (PDF), Purchaser Business Group on Health (PBGH), accessed February 6, 2022.
15. David Raths, "Covered California Health Plans Piloting Advanced Primary Care Measures," *Healthcare Innovation*, January 13, 2022.
16. *Attachment 7 to Covered California 2023-2025 Covered California for Small Business Qualified Health Plan Issuer Contract: Quality, Equity, and Delivery System Transformation Requirements and Improvement Strategy* (PDF), Covered California, accessed February 15, 2022; and *Alternative Payment Model (APM) Framework*, Health Care Payment Learning & Action Network, July 11, 2017.
17. "CalAIM: Our Journey to a Healthier California for All," California Department of Health Care Services (DHCS), accessed February 4, 2022.
18. *PBGH Health Value Index*, Purchaser Business Group on Health (PBGH), September 2021; and *PBGH Health Value Index for Successful and Collaborative Health Plan Management* (PDF), PBGH, September 2021.
19. *Employer Health Plan Common Purchasing Agreement for Advanced Primary Care* (PDF), Purchaser Business Group on Health (PBGH), accessed February 4, 2022.
20. *Primary Care Spending in Oregon* (PDF), Oregon Health Authority (OHA), February 2016.
21. "Primary Care Spending in Oregon 2021," Oregon Health Authority (OHA), accessed February 15, 2022.
22. Michael H. Bailit, Mark W. Friedberg, and Margaret L. Houy, *Standardizing the Measurement of Commercial Health Plan Primary Care Spending*, Milbank Memorial Fund, July 25, 2017.
23. *The New England States' All-Payer Report on Primary Care Payments* (PDF), New England States Consortium Systems Organization (NESCSO), December 22, 2020.
24. *Memorandum of Understanding*, Washington State HCA.

25. 230-RICR-20-30-4, Rhode Island OHIC.
26. "Primary Care Spending in Oregon 2021," OHA.
27. **3 CCR 702-4: Life, Accident and Health** (PDF), Department of Regulatory Agencies, Division of Insurance, accessed February 15, 2022.
28. 3 CCR 702-4, Department of Regulatory Agencies.
29. Tim Mastro, "**Carney Signs Bill to Increase Access to Primary Care in Delaware**," *Bay to Bay News*, October 1, 2021.
30. Aaron Baum et al., "**Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers**," *Health Affairs* 38, no. 2 (Feb. 2019).
31. **Primary Care Spending in Oregon** (PDF), Oregon Health Authority (OHA), February 2020.
32. Elizabeth Mitchell and Crystal Eubanks, interviewed by Mary Jo Condon via videoconference, October 2021; Catarina Reyes and Lisa Folberg, interviewed by Mary Jo Condon via videoconference, October 2021; Joe Castiglione, Angela Chen, Jas Nihalani, and Christopher Kiva, interviewed by Mary Jo Condon via videoconference, October 2021; Christopher Koller, Rachel Block, and Lisa Watkins, interviewed by Mary Jo Condon via videoconference, October 2021; Bob Phillips, interviewed by Mary Jo Condon via videoconference, October 2021.
33. "**Primary Care Investment**," Primary Care Collaborative (PCC), accessed February 4, 2022.
34. "Primary Care Investment," PCC.
35. "**All-Payer Claims Databases**," Agency for Healthcare Research and Quality (AHRQ), last reviewed February 2018.
36. Patrick C. Alguire, "**Understanding Capitation**," American College of Physicians (ACP), accessed February 4, 2022.
37. "**Key Functions of a Medical Home: Care Management**," American Academy of Family Physicians (AAFP), accessed February 4, 2022.
38. "**Comprehensive Primary Care Plus**," Centers for Medicare & Medicaid Services (CMS), updated January 3, 2022.
39. "**Federal Employees Health Benefits (FEHB) Program (FEDVIP)**," Benefits.gov, accessed February 6, 2022.
40. "**Fee for Service**," HealthCare.gov, accessed February 6, 2022.
41. "**Medicaid**," Medicaid.gov, accessed February 6, 2022.
42. "**Value-Based Programs**," Centers for Medicare & Medicaid Services (CMS), modified December 1, 2021.
43. "**Who We Are**," Organisation for Economic Co-operation and Development (OECD), accessed February 4, 2022.
44. "**Defining the PCMH**," Agency for Healthcare Research and Quality (AHRQ), September 2021.
45. The National Academies of Sciences, Engineering, and Medicine (NASEM), "**With Major Changes, Primary Care Can Form Base for Rebuilding Nation's Health Care System**," press release, March 12, 1996.
46. "**Primary Care First Model Options**," Centers for Medicare & Medicaid Services (CMS), updated January 13, 2022.
47. "Primary Care Investment," PCC.
48. "Primary Care Investment," PCC.
49. "Primary Care Investment," PCC.
50. K. Coleman et al., "**White Paper: Redefining Primary Care for the 21st Century**," Agency for Healthcare Research and Quality (AHRQ), November 2016.
51. "**Registration of Provider Organizations**," Massachusetts Health Policy Commission, Mass.gov, accessed February 6, 2022.
52. "Primary Care Investment," PCC.
53. "Primary Care Investment," PCC.
54. **Taxonomy Codes — Definition and Claims Use** (PDF), BlueCross BlueShield of New Mexico, December 2013.
55. "**Total Cost Estimate (for health coverage)**," HealthCare.gov, accessed February 6, 2021.