

# Supporting Social Service Delivery through Medicaid Accountable Care Organizations: Early State Efforts

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## IN BRIEF

Given the often overwhelming prevalence of social needs facing Medicaid populations, including housing, transportation, and nutrition, aligning social services and supports with health care delivery is critical. Many states recognize the connection between social determinants of health and health care utilization and outcomes, and are taking initial steps to provide essential non-medical supports through accountable care organization (ACO) programs. This brief, made possible by The Commonwealth Fund, outlines early efforts by state Medicaid agencies to incorporate social services into ACO models, including key themes and considerations for other states.

There is growing recognition that social determinants of health significantly influence health care outcomes and costs.<sup>1</sup> In Medicaid, which serves many of the most vulnerable Americans, the need to coordinate health care services with essential social supports including housing, nutrition assistance, and employment services is particularly critical.<sup>2</sup> Medicaid stakeholders are investigating how to link social services and supports with clinical care delivery models. Some states are positioning Medicaid accountable care organization (ACO) models as vehicles to support a continuum of physical and behavioral health, as well as social services.

When medical providers bear financial risk for health care quality and outcomes in ACO models, they have an incentive to use social services and supports to maximize the impact of their care interventions on patients. States recognize that ACOs need key infrastructure in place – team-based care, data sharing on clinical and social indicators, efficient referral networks, and a culture of collaboration among providers – to effectively integrate social services with clinical care. States are supporting the development of this infrastructure through program requirements, financial incentives, and data-sharing arrangements within ACO and related initiatives. States' efforts to incorporate mental health and substance use services in particular – already underway in many ACO programs – are providing lessons on how to include diverse, often community-based providers, and settings in care delivery.<sup>3</sup> This brief highlights early state efforts to build the foundation for social service integration in Medicaid ACO programs, and suggests strategies for other states to consider.

## "Social Services"

For this brief, **social services** are defined as non-medical services that may benefit a person's health, including housing, nutrition assistance, employment counseling, transportation, language and literacy training, legal and financial services, peer networks, and/or other supports that aid individuals with day-to-day living and optimal functioning.

EXHIBIT 1: Social Service Approaches of Select Medicaid ACO Programs

STATE	ACO ENTITY	DESCRIPTION	HIGHLIGHTED SOCIAL SERVICE ACTIVITIES
Colorado	Regional Care Collaborative Organizations (RCCOs)	Regional entities that receive care coordination payments and are eligible for performance incentives	<ul style="list-style-type: none"> <li>RCCOs provide care coordination across medical and non-medical services.</li> <li>The state’s Statewide Data Analytics Contractor works with RCCOs to profile demographics of high-risk members for referral to non-medical supports.</li> </ul>
Maine	Accountable Communities (ACs)	Provider-led organizations that participate in shared savings arrangements	<ul style="list-style-type: none"> <li>ACs are closely tied to the state’s existing health homes program, in which community care teams partner with primary care sites to provide wraparound support and community linkages to the highest-need patients.</li> <li>ACs are required to have contractual or informal relationships with at least one public health entity and at least one provider of certain targeted case management services.</li> </ul>
Minnesota	Integrated Health Partnerships (IHPs)	Provider-led organizations that participate in shared savings arrangements	<ul style="list-style-type: none"> <li>IHPs have the option to include social services and providers in shared savings arrangements.</li> <li>IHPs must demonstrate partnerships with community-based organizations, social service agencies, and public health resources.</li> </ul>
New York	Under development	Provider-led model closely tied to existing health home and Delivery System Reform Incentive Payment (DSRIP) programs	<ul style="list-style-type: none"> <li>Model includes linkages with criminal justice programs and housing, which are already supported through the state’s health homes program.</li> <li>DSRIP program supports development of community-based integrated care delivery by safety net providers.</li> </ul>
Oregon	Coordinated Care Organizations (CCOs)	Regional entities led by managed care organizations (MCOs) that operate under global budgets for services provided under the program	<ul style="list-style-type: none"> <li>CCOs must establish a community advisory council and develop a community health needs assessment.</li> <li>CCOs are encouraged to build partnerships with relevant social service and community entities, and collaborate with them flexibly under their global budget.</li> <li>CCOs use community health workers, peer wellness specialists, and personal navigators.</li> </ul>
Vermont	Accountable Care Organizations (ACOs)	Provider-led organizations that participate in shared savings arrangements	<ul style="list-style-type: none"> <li>ACOs have the option to include non-medical services beginning in the second year of the program.</li> <li>ACOs are encouraged to leverage the state’s existing health homes, Advanced Primary Care Demonstration, and Support and Services at Home (SASH) program.</li> </ul>
Washington	Under development	Developing program based on existing health home and patient-centered medical home (PCMH) models	<ul style="list-style-type: none"> <li>State is using cross-state agency database, and predictive modeling tool (PRISM) to target populations and support program development and implementation.</li> <li>State will include quality metrics for education, employment, and housing in its ACO quality strategy.</li> </ul>

Information contained in this table was drawn from a review of state materials and interviews with state officials.

This brief focuses on the approaches of seven states that participated in the Center for Health Care Strategies' (CHCS) *Medicaid ACO Learning Collaborative*: **Colorado, Maine, Minnesota, New York, Oregon, Vermont, and Washington**. With support from The Commonwealth Fund, CHCS worked with these states to accelerate Medicaid ACO implementation. Of these states, Medicaid ACOs are up and running in Colorado, Maine, Minnesota, Oregon, and Vermont, while programs in New York and Washington are still in development (see Exhibit 1).

## Building Blocks for Social Service Integration

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While these seven states have unique Medicaid ACO models,<sup>4</sup> all of them are leveraging existing program strengths to support collaboration among medical and social service providers. States are building capacity for ACO social service integration atop existing initiatives that can contribute necessary infrastructure and relationships, including referrals to community-based providers, cross-agency funding streams, and meaningful engagement with families. States are using a variety of existing programs to reinforce the foundation of ACOs:

### Health Homes

Several states are laying the groundwork for social service integration through a focus on complex patients via the Medicaid health home model. Health homes are required to provide referrals to community and social supports as one of their primary functions in serving patients with chronic physical or behavioral health conditions.<sup>5</sup> Health homes also have valuable experience in training care team members on standardized, comprehensive health assessments, which can help Medicaid ACOs identify high-risk patients who may require additional supports in the community, such as nutrition assistance or employment training. Maine, New York, Vermont, and Washington have leveraged health home strategies when designing their Medicaid ACO programs. For example, Maine attributes patients to ACOs through their existing affiliation with a health home. New York is using lessons learned from housing and criminal justice projects with its health homes to inform social service alignment of emerging ACOs and other state delivery reforms.

### Community Health Teams

Community health teams work closely with care managers to make connections with external social services and supports for patients in health homes and others with complex conditions. These teams often include lay health workers who have the cultural familiarity and expertise to meet patients' diverse social and linguistic needs and liaison effectively with the local, non-medical community. Maine's AC program uses its community care teams (Maine's term for community health teams) from health homes to provide wraparound support and community linkages to the highest-need patients. Per state requirements, ACs that include a health home must extend an invitation for participation to that health home's community care team.

### Behavioral Health Integration

State efforts across the nation to better coordinate physical health care with mental health and substance use services are building a foundation for incorporating social services. State strategies

to support behavioral health integration in ACOs, in particular, provide a useful blueprint.<sup>6</sup> These include: (1) shared savings to encourage collaboration between physical and behavioral health providers; (2) global payments to support case management and rehabilitation services for individuals with serious mental illness; (3) requirements to include behavioral health providers and consumers in governance structures; and (4) data reports to help providers identify high-risk patients (e.g., those with comorbid physical and behavioral diagnoses) for enhanced care management.

## Levers within State Medicaid ACO Programs

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States can use three main levers to support collaboration between ACO and social service providers: (1) program and governance requirements; (2) financial incentives; and (3) data-sharing infrastructure.

### Program and Governance Requirements

ACO program requirements offer a direct way to foster social service integration. States have included the following types of requirements for applying and/or participating ACOs to better incorporate social services into clinical models:

**Support care management and care coordination with local partnerships:** All Medicaid ACO programs require ACOs to form partnerships with external entities. In some cases, the entities are defined loosely to include public health authorities, community organizations, social service agencies, and/or local government. In other cases, specific partnerships are mandated. Oregon's CCOs must have Memorandums of Understanding with particular community emergency and mental health programs, including local Area Agencies on Aging or state Aging and Persons with Disabilities offices. In addition, Oregon encourages CCOs to develop "meaningful partnerships" with crisis management services, community prevention services, self-management programs, and state-based departments and programs. Maine requires that its ACOs develop contractual or informal relationships with at least one public health entity and at least one provider of targeted case management services, if there are such entities or providers serving members in the ACO's service area. During the application process, Minnesota's IHPs must demonstrate how formal partnerships with community-based organizations, public agencies, and social service agencies are incorporated into the care delivery model. Colorado requires each RCCO to link members, as needed, to non-medical, community-based services, such as child care, food assistance, services supporting elders, housing, and utilities assistance. The state specifies that "links" may range from providing members with the necessary contact information, to arranging the service and/or acting as a liaison among the member and involved providers. In addition, RCCOs must have a Transaction Access Program that coordinates with care managers and supports community recovery by:

- Providing access to needed community resources via provider web portal, email, fax, or phone;
- Managing non-hospital transitions through home visits by a care manager or health care provider who can address the member's medication, living skills, and behavioral needs;

- Arranging visits from the RCCO's mobile physician network; and
- Providing active transition management to prevent relapse for conditions such as alcohol withdrawal, tobacco cessation, and weight management.

**Utilize non-traditional providers:** The use of non-traditional providers, such as community health workers or peer specialists, may enable an ACO to more directly assist patients in accessing social supports (e.g., accompanying patients to employment counseling appointments or helping to complete federal nutrition assistance applications). Such workers often are culturally attuned to patients and have similar lived experience and/or familiarity with community resources, which can support attainment of patients' health care goals and build patients' trust in the health care system. Oregon encourages its CCOs to integrate community health workers and peer wellness specialists into care teams for broader outreach and preventive education functions. Colorado encourages its RCCOs to use community-based health educators to foster behavioral change through clinical, personal, and/or community-based strategies. Use of non-traditional providers by Minnesota's IHPs is facilitated through a state plan amendment that allows community health workers to bill Medicaid directly for some of their services.

**Create community governance or board structures:** Nearly all states require ACOs to develop formal structures for regular community input. These entities are expected to represent the individuals served by the ACOs, as well as the interests of the local community. ACOs must interface with these governance structures regularly for feedback on ACO service offerings and performance.

**Inventory local needs and make community resources available:** Oregon's CCOs are required to produce a community health needs assessment, which must identify any socio-economic, geographic, or racial/ethnic disparities in patient care and health status. CCOs are encouraged to develop these collaboratively with the local public health authorities, hospitals, mental health systems, and Area Agencies on Aging to avoid duplication with existing assessments. Oregon's Office of Health Equity and Inclusion helps CCOs identify data and required resources for these assessments. Colorado requires its RCCOs to create a library of community resources and a website that connects providers and patients with resources for child care, nutrition assistance, elder care, housing, utility assistance, and other non-medical supports. RCCOs are also required to develop a list of case management agencies and community-based service providers – including eligibility criteria and contacts to facilitate patient follow-up – that is updated every six months.

**Pay attention to the diverse cultural and linguistic needs of patients:** Understanding the role of patients' culture and language in their health care can help ACOs identify the most effective social services and supports. Most states loosely promote a focus on racial/ethnic equity, encouraging ACOs to be sensitive to members' cultural and linguistic needs, while other states are more prescriptive. Colorado's RCCOs, for example, must make health disparity and cultural competency training available to their provider networks on at least an annual basis (or within 60 days of their start date or any large program expansion). Oregon's CCOs are required to develop transformation plans describing how they will: (1) develop initiatives addressing members' cultural, health literacy, and linguistic needs; (2) enhance provider and administrative

staffing to better serve diverse community needs; and (3) establish quality improvement plans to eliminate racial, ethnic, and linguistic disparities.

## Financial Incentives

Financial incentives offer a powerful vehicle for fostering social service coordination. By instituting a shared savings or capitated payment for ACO programs, states can motivate closer collaboration between the health care delivery system and non-medical agencies and providers. State approaches range from integrated payment models connecting social services and providers, to one-time grants supporting provider capacity-building. Exhibit 2 presents payment options for states considering how to connect social services with care delivery models.

EXHIBIT 2: Payment Approaches to Connect Social Services with ACO Programs

PAYMENT METHODOLOGY	BENEFITS
Upfront Grants	<ul style="list-style-type: none"> <li>One-time investment</li> <li>More flexible funding than service-based payments</li> </ul>
Enhanced Per Member Per Month (PMPM) Payment	<ul style="list-style-type: none"> <li>Provides additional dollars for social services to aid care management</li> <li>Risk-adjusts for vulnerability of population</li> </ul>
Shared Savings	<ul style="list-style-type: none"> <li>Can tie savings/losses to social service quality metrics</li> <li>Encourages use of social service supports to bring down total cost of care</li> <li>Savings can be utilized to re-invest in the system</li> </ul>
Global Payments	<ul style="list-style-type: none"> <li>Ability to braid or blend Medicaid and non-Medicaid funds</li> <li>“Community” budget can be common source of funding for medical and non-medical collaborators</li> <li>Encourages use of social service supports to bring down total cost of care</li> <li>Savings can be utilized to re-invest in the system</li> </ul>

States with Medicaid ACO programs are employing some of the following financing approaches:

**Grants:** Oregon’s CCOs have access to financing through the state’s Health System Transformation Fund<sup>7</sup> to propose a range of projects to address social determinants of health. The state is also building capacity to address housing through State Innovation Model (SIM) funding.<sup>8</sup> Other states are also leveraging resources from existing federal initiatives, such as health homes and SIM, to help ACOs with start-up costs. Many states are using SIM resources for capacity building to support social service coordination, including: (1) provider training on care management and community engagement; (2) uniform data standards across state agencies; (3) data support for a statewide health information exchange; and (4) development of population health measures for performance-based contracts.

**Enhanced PMPM:** States can use an enhanced per member per month (PMPM) payment to cover care coordination costs for providers to link to social services. These fees are usually small (\$4-10), but cover a wide variety of care coordination responsibilities. Colorado’s RCCOs receive an enhanced PMPM for each attributed member.

**Shared savings:** Maine, Minnesota, and Vermont’s Medicaid ACO programs are operating under shared savings arrangements. Minnesota’s IHPs are allowed to include social services – or any other services outside the core set for the ACO program – within the total cost of care (TCOC) calculation for eligible patients. Providers whose services are included in the TCOC can also participate in the distribution of shared savings and loss payments. Minnesota awards bonus points for IHPs that include community organizations, local public health entities, and/or behavioral health and long-term care providers in distribution of shared savings and loss payments. Vermont has adopted an “encourage-incent-require” approach for calculating the TCOC over a three-year period. Starting in the second year of the program, in addition to receiving shared savings linked to core quality metrics, ACOs in Vermont can increase their shared savings rate from 50 to 60 percent by assuming accountability for additional services, such as non-emergency transportation. While tying shared savings to specific social service quality metrics (e.g., housing status) would be a direct way to encourage social service integration, Medicaid ACO programs have not included such metrics to date (although many states believe that ACO providers should leverage non-medical services and supports to improve performance rates for existing measures).<sup>9</sup>

**Global payments:** Oregon’s CCOs are regional entities – comprised of multiple payers, providers, and county public health departments – that accept a single global budget and are accountable for the cost and quality of Medicaid beneficiaries’ physical, behavioral, and dental health care. Through the global budget, CCOs can include Medicaid-covered services, such as non-emergent medical transportation, as well as services that are not traditionally covered, to support patients’ needs. The latter services can include health education (e.g., healthy meal preparation classes); peer support groups (e.g., post-partum depression programs); home and living environment improvements (e.g., air conditioners, athletic shoes); housing supports (e.g., shelter, utilities, critical repairs); and improvements to community health (e.g., farmer’s markets); among other social resources.<sup>10</sup> An increasing percentage of CCOs’ global budgets are withheld each year (two percent in 2013; three percent in 2014), which can be recouped by meeting quality targets. This strategy encourages CCO providers to coordinate with other sectors to meet cost and quality targets, even if the services provided by collaborators may not be directly included in the budget. A total spending cap further motivates CCOs to invest limited resources in services to spur improved health outcomes and reduced costs.

## Data-Sharing Infrastructure

Data sharing is one the most important aspects of social service integration. Shared patient data enables medical and non-medical collaborators to facilitate effective patient hand-offs, continuous follow-up, and/or long-term monitoring of outcomes. States are laying the groundwork for data exchanges to support the enhanced care coordination promised by ACOs, but this data sharing generally does not yet encompass social services. State strategies to expand data sharing include:

**State data reports for ACO providers:** Colorado’s State Data Analytics Contractor hosts a web portal giving providers access to a database that presents patient demographic information, utilization, and disease burden prevalence to identify complex patients by comorbidity and related costs. Colorado is also working to identify data on social determinants of health to link

Medicaid outcomes with those of other state agency programs and larger health/social systems. Minnesota provides its IHPs with monthly care management reports on high-need patients and is looking into including social risks in these reports.

**Cross-agency databases:** Washington developed an integrated social service client database that helps foster collaboration among state agencies (e.g., Medicaid, criminal justice, family services). It allows the state to identify patient risks, costs, and outcomes at the state or community level, as well as the individual or family level. The database includes a predictive modeling and decision support tool – Predictive Risk Intelligence System (PRISM) – to help providers and administrators implement care management interventions for high-risk patients. The state is using these data tools to identify high-utilizers of emergency and inpatient services, the jail-involved, and/or the homeless, and link them to programs that can meet their basic housing, substance use, and rehabilitation needs. As Washington develops its Medicaid ACO program, integrated client data and PRISM will be key assets to the state and ACO providers.

### CHALLENGES FACING SOCIAL SERVICE DATA/HEALTH INFORMATION INTEGRATION

While health information technology (HIT) offers many benefits to collaboration, successful efforts in the social service realm will require heightened attention to make data more broadly accessible and meaningful.

Social service providers, especially smaller community-based organizations, may not have access to advanced electronic infrastructure, including the capacity for data exchange, interoperability, and security/privacy, nor the staff familiarity to integrate HIT into workflow. Many clinical providers, especially community-based providers of mental health and substance use disorder services, are excluded from meaningful use and related incentive payment programs that would support opportunities to build HIT capacity.<sup>11</sup>

In order to facilitate seamless data exchange across these providers, additional fields – including housing status, incarceration, medication lists, employment, and social networks – should be included in electronic health records.<sup>12</sup> These key markers can be used to trigger referrals to non-medical services and supports and to help payers risk-adjust payments to providers. Trends in these data can also indicate the degree to which ACO care delivery impacts not only health care, but also social well-being. As social services become more integrated, it will be important for members of the care team beyond clinical care providers – e.g., community health workers, language interpreters, diabetes educators – to have access to this data.

## Considerations for Medicaid ACO Social Service Integration

While full social service integration may seem a distant prospect for state Medicaid agencies that are in the ACO planning stages, states should think early and creatively about key issues to guide implementation. Decisions around timing, scope, staff capacity, and the prescriptiveness of requirements can impact the long-term effectiveness of social service coordination efforts.

**Consider phased-in timing:** While some states may want to promote social service integration early in their Medicaid ACO programs, others may prefer to increase expectations of ACOs over time. Minnesota used initial ACO experiences to make changes to subsequent requests for participation (RFP), leading to its most recent RFP that rewards IHPs for inclusion of social services in the ACO and total cost of care. Vermont’s “encourage-incent-require” approach increases quality and cost requirements incrementally, allowing ACOs to build capacity to handle risk-based payments over three-years, without penalty. Maine, Minnesota, and Vermont do not



require downside risk during the first year of their shared savings model to provide ramp-up time for providers as they transform into the ACO model. In subsequent years, all three states offer options for ACOs to accept downside risk.

**Determine the ACO program’s scope:** There are many types of social services – e.g., weight counseling, smoking cessation, transportation, child care, and housing – that may yield positive health outcomes, but integrating all of them at once may be challenging. States may choose specific services to focus on initially to target the resources necessary for building collaborative agreements, referrals, and monitoring mechanisms. Initial efforts can serve as pilots, providing lessons that can be applied more broadly.

**Align care management programs and reduce duplication:** There are often multiple care management initiatives in a state that provide supports beyond medical care. These programs and/or services might include: (1) Area Agencies on Aging; (2) Assertive Community Treatment; (3) community-based mental health and substance use and treatment programs; (4) home- and community-based programs; (5) long-term services and supports; and/or (6) targeted case management for children with developmental disabilities or chronic health conditions, and adults with developmental disabilities or HIV. States should inventory, and foster connections with, these initiatives to facilitate ACO alignment, mitigate “turf issues,” and help ACOs adhere to federal or state regulations that minimize duplication. Maine requires ACs to leverage existing care management services before offering their own, recognizing the contribution of health homes to savings realized under an AC. Accordingly, state payments to health homes and community care teams that are part of an AC are deducted from shared savings payments made to ACs. Minnesota also has overlap in membership between its behavioral health-focused health homes and targeted case management efforts, and has developed policies to ensure services are not being duplicated.

**Build state agency capacity and seek external input:** Medicaid agencies are using subject matter experts to build institutional knowledge and develop strategies for social service integration. Seeking the input of key stakeholders – e.g., providers, patients, community organizations, and public health agencies – can also garner critical stakeholder buy-in and credibility, which is important for social service programs that may require new ways of working across silos within the state or across the health system. Vermont has used SIM funding to form several public-private workgroups charged with creating common definitions for “care management” and “population health.” Vermont’s Green Mountain Care Board has also been involved in developing quality measures that focus on non-medical services and supports. Oregon established a commission to create reimbursement policies, and training and certification standards, for a statewide workforce of community health workers, personal navigators, and peer wellness specialists. Washington is using a broad stakeholder process to develop a dashboard of 40-50 performance metrics, including social service-related measures.

**Determine the appropriate level of prescriptiveness:** States can take different approaches toward financial incentives and regulation in determining how to incorporate social services into ACOs. A more prescriptive strategy may require contracts with social service and community-based organizations. Some states may opt for more flexibility, making ACOs responsible for quality metrics that could be improved by connecting with social service entities. Overall,

choosing the right level of stringency will depend on provider capacity, existing intra-agency relationships, political factors, stakeholder input, and state goals for the Medicaid ACO program. Including the input of consumers, community-based organizations, public health entities, and social service providers in decision-making will be key to successful collaboration.

## Conclusion

States have taken important first steps toward fostering collaboration between medical and non-medical entities that impact patient health. Largely, these efforts have included cross-agency partnerships and workgroups at the state level, and ACO program regulations that institute connections at the ground level. Moving forward, states will likely pursue more integrated payment and quality strategies to create a more tenable link between the health care delivery system and social services and supports. By broadening the focus beyond medical care, ACOs can better address critical social determinants of health and ultimately be better positioned to improve outcomes and control costs for Medicaid populations.

### ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. This brief was developed through the *Medicaid Accountable Care Organization Learning Collaborative*, a CHCS initiative supported by The Commonwealth Fund. Through the collaborative, CHCS has assisted numerous states in developing and launching Medicaid ACO programs. For more information and resources, visit [www.chcs.org](http://www.chcs.org).

## ENDNOTES

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- <sup>5</sup> Center for Medicaid and CHIP Services (CMCS). State Medicaid Director Letter #10-024. Health Homes for Enrollees with Chronic Conditions. November 16, 2010. Available at: <http://downloads.cms.gov/cmmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>
- <sup>6</sup> D. Brown and T. McGinnis, op. cit.
- <sup>7</sup> See current projects here: <http://transformationcenter.org/transformation-funds/>
- <sup>8</sup> Center for Medicare and Medicaid Innovation. State Innovation Models Initiative: General Information. Available at: <http://innovation.cms.gov/initiatives/state-innovations/>
- <sup>9</sup> Technical Assistance Tool: *Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs*. Center for Health Care Strategies, September 2014. Available at: <http://www.chcs.org/resource/quality-measurement-approaches-medicaid-accountable-care-organizations/>
- <sup>10</sup> See Oregon Administrative Rules, 410-141-0000 (53) for the full list of "Other Non-Medical Services." Available at: [http://arcweb.sos.state.or.us/pages/rules/oars\\_400/oar\\_410/410\\_141.html](http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_141.html)
- <sup>11</sup> Centers for Medicare & Medicaid Services. EHR Incentive Programs. Meaningful Use Regulations. Available at: <http://www.healthit.gov/policy-researchers-implementers/meaningful-use-regulations>