



Advancing Primary Care Innovation in Medicaid Managed Care: Conceptualizing and Designing Core Functions

CHCS Center for
Health Care Strategies, Inc.

Made possible through support from The Commonwealth Fund.

Updated July 2021

Contents

I. Introduction	2
II. Identify Advanced Primary Care Priorities.....	4
1. Assess the Landscape	4
2. Articulate a Vision.....	5
3. Ask for Feedback and Fill in the Gaps.....	5
III. Design an Advanced Primary Care Strategy for Managed Care.....	9
1. Maximize State Procurement and Contracting Processes	9
2. Leverage MCO Functions	10
3. Consider Design Options	11
IV. Advance Targeted Care Delivery Goals	15
1. Identify and Address Social Needs	16
2. Integrate Behavioral Health Care	23
3. Promote Health Equity.....	32
4. Enhance Team-Based Care.....	44
5. Use Technology to Improve Access.....	54
V. Three State Approaches to Patient-Centered Medical Homes	58
VI. Conclusion	64

Authors

Diana Crumley, Rachael Matulis, Kelsey Brykman, Brittany Lee, Anne Smithey, Shilpa Patel and Michelle Conway

Acknowledgements

The authors would like to express their appreciation to J. Zoë Beckerman and Sara Rosenbaum, George Washington University's Milken Institute School of Public Health; Alice Lind, Washington Health Care Authority; and Ashley Wennerstrom, LSU School of Public Health and Medicine for their insights and feedback in the development of this toolkit. The authors would also like to thank Tricia McGinnis from the Center for Health Care Strategies for lending her subject matter expertise and guidance throughout this process.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs. To learn more, visit www.chcs.org.

I. Introduction

Primary care is the backbone of any high-functioning health care system, particularly for low-income populations. Greater use of primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality.¹

Traditionally, state Medicaid agencies have focused on enhancing primary care access — boosting Medicaid enrollment of providers, ensuring rates are sufficient to maintain access, and requiring managed care networks to have a sufficient number of primary care providers (PCPs) accepting patients within a given geography. However, that approach has limitations. Medicaid populations often have a broader range of complex health-related needs, requiring a primary care system that can fully respond to those needs.

In response, recently states have sought more advanced primary care models. These states ask not only *if* a patient has a relationship with a primary care provider, but also *how* the primary care team manages and addresses the diverse health-related needs of patients. Using technology and team-based care, these advanced primary care models seek to address not only physical health, but also behavioral health and social needs.

At the same time, states are becoming more sophisticated purchasers through their managed care programs. Yet, defining how managed care organizations (MCOs) can best support advanced primary care is a challenge. The state must define goals, roles, and responsibilities for all parties involved — states, plans, providers, and patients — through an agreement between the plan and the state.

[*Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States*](#) is designed to help states leverage their managed care purchasing authority to advance primary care innovation. This first section of the toolkit is designed to help states define primary care priorities and advance core primary care functions. A second section, *Using State Levers to Drive Uptake and Spread*, outlines how states can incentivize and invest in advanced primary care through Medicaid managed care. The toolkit is a product of [*Advancing Primary Care Innovation in Medicaid Managed Care*](#), a national learning collaborative made possible by The Commonwealth Fund and led by the Center for Health Care Strategies (CHCS). Under the first phase of the collaborative, CHCS assisted five states — **Louisiana, Hawaii, Pennsylvania, Rhode Island, and Washington State** — in using their managed care purchasing authority to advance primary care models.



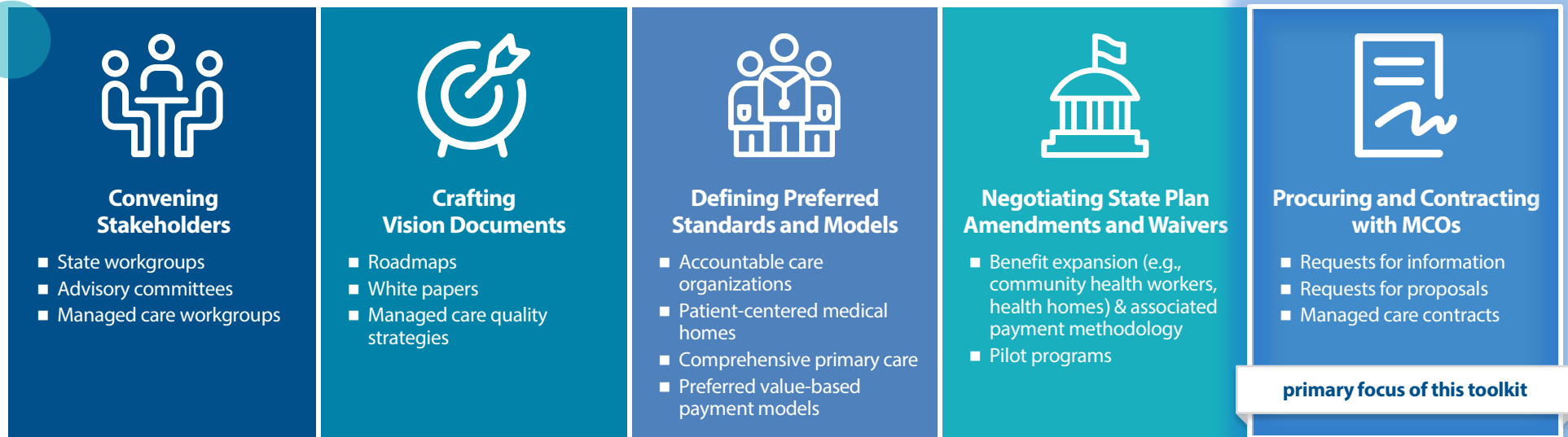
This first section of the toolkit details three steps for approaching advanced primary care work:

1. **Identify advanced primary care priorities.** Assess the landscape, articulate a vision, and ask for feedback from patients, plans, providers, and community-based organizations (CBOs).
2. **Design an advanced primary care strategy.** Maximize state procurement and contracting processes, leverage MCO functions, and chart a path to advance primary care innovation.
3. **Advance targeted care delivery goals.** Consider how to use managed care contracts to achieve goals, such as:
 - Identifying and addressing social needs;
 - Integrating behavioral health into primary care;
 - Promoting health equity;
 - Enhancing team-based primary care approaches to support the community's needs; and
 - Using technology to improve access to care.

In addition to outlining design considerations and state approaches relevant to these four care delivery areas, [State Approaches to Patient-Centered Medical Homes](#) summarizes how three states — New York, Ohio, and Oregon — promote enhanced care delivery transformation through their standards for patient-centered medical homes (PCMHs).

Although this toolkit addresses a range of common state activities that can promote primary care innovations, it primarily focuses on activities that relate to procuring and contracting with MCOs (**Exhibit 1**). It provides states with a range of potential options to support advanced primary care in Medicaid managed care.

Exhibit 1. State Activities to Advance Primary Care Innovation



II. Identify Advanced Primary Care Priorities

Advancing primary care innovation can help states improve care and outcomes, control costs, and build on the unique strengths of primary care teams. States can incorporate advanced primary care into a larger transformation strategy relating to, for example: advancing value-based payment (VBP); increasing the effectiveness of care management and coordination; or optimizing the use of scarce behavioral health or other specialty providers. For most states, a first step in designing an advanced primary care strategy involves identifying priorities for primary care specifically, and delivery system and payment reform more generally. Following are three key steps for identifying priorities:

1. **Assess the landscape;**
2. **Articulate a vision;** and
3. **Ask for feedback and fill in the gaps.**

1. Assess the Landscape

Understanding a state's existing primary care environment is a first step in determining how to best promote advanced primary care in Medicaid managed care. This includes: the size and capacity of the current primary care provider market; penetration of advanced primary care models; prevalence of integrated health care systems and small practices; utilization of primary care and common care gaps among Medicaid members; existing plan activities and quality performance; and population health trends across the state. To focus its advanced primary care efforts, the state Medicaid agency may first identify what data is needed to make key policy decisions and how to obtain such data. Some of this evaluative work may have already been performed through other efforts, including State Innovation Model (SIM) grants or projects driven by state public health departments, state agencies that regulate insurers, or external quality review organizations. For example, **Washington State** used data collected through SIM, such as expected savings associated with behavioral health integration and the number of advanced practice nurse practitioners providing primary care services, to help guide its advanced primary care efforts. Taking time upfront to analyze existing data and understand the primary care landscape can help facilitate policy and program decisions down the line.

In addition to understanding the state primary care landscape, it is also important to take stock of existing programs related to advanced primary care. This includes understanding other upcoming policy and program changes in the state and the impact they might have on advanced primary care, as well as past efforts to do similar work and what was successful or not successful and why. Agency silos can sometimes create barriers to gathering this internal information. Convening leadership or staff with



historical knowledge on this topic can be useful to help break down these silos and allow the agency to gain a more comprehensive understanding of the environment to support advanced primary care.

2. Articulate a Vision

States often find it useful to create a “roadmap,” vision document, or robust state Medicaid managed care quality strategy as they begin their advanced primary care planning process.² For example, **Hawaii** laid out a vision for investment in primary care within managed care as a part of its renewal application for its 1115 demonstrations. **Louisiana** developed a whitepaper outlining its vision for the future of its Medicaid managed care program, with investment in advanced primary care as the central focus. **Rhode Island** created a high-level policy document to explain how its “Next Generation” MCOs would interact with its Medicaid accountable care organizations (ACO). And, **Ohio**’s quality strategy discussed the role of PCMHs and Comprehensive Primary Care programs in its Medicaid managed care program.³

Articulating a clear vision for this work upfront can align all involved parties on goals and key priorities — though changes may still occur along the way. By laying out where the state currently is and where it would like to be, staff can engage with internal and external subject matter experts and stakeholders to identify what steps are needed to achieve goals and identify milestones. The vision document can build support with agency leadership, legislatures, managed care plans, and provider communities, among other important stakeholder communities.

For examples of state vision documents, see [Exhibit 2, Examples of Vision Documents: Louisiana and Hawaii](#), page 6.

3. Ask for Feedback and Fill in the Gaps

Stakeholder engagement helps states assess blind spots in their analysis and better understand the potential impact of these policies on providers, plans, consumers, and communities. This process is beneficial both in the initial stages of advanced primary care strategy development and during the implementation period. It can result in a more informed program or policy change, with broader external buy-in. It can also ensure that the state is apprised of successes and challenges as they arise, and can adjust its strategy accordingly.

In addition to traditional notice and comment processes, states can: (1) leverage existing groups that meet periodically through the agency or through the managed care plans, such as consumer advisory groups or quarterly stakeholder meetings; (2) form new groups dedicated to advanced primary care; (3) participate in cross-state “roadshows”; and (4) design approaches that directly engage consumers and communities. For example, **Pennsylvania**’s PCMH Advisory Council made recommendations to the state about its PCMH program that helped it take a more strategic approach to advanced primary care. The state’s Secretary of Human Services also embarked on a “Medicaid Innovation Tour” related to social determinants of health (SDOH), learning more about MCO partnerships and projects.⁴

Exhibit 2. Examples of Vision Documents: Louisiana and Hawaii

Louisiana's Department of Health “will partner with enrollees, providers, and high-performing health plans to build a Medicaid managed care delivery system that improves the health of populations (better health), enhances the experience of care for individuals (better care) and effectively manages Medicaid per capita care costs (lower costs). More specifically, the Department will hold health plans accountable for:

- Advancing evidence-based practices, high-value care, and service excellence;
- Supporting innovation and a culture of continuous quality improvement;
- Ensuring enrollees ready access to care, including through non-traditional means such as medical homes and telehealth;
- Improving enrollee health;
- Decreasing fragmentation and increasing integration across providers and care settings, particularly for enrollees with behavioral health needs;

Hawaii's Department of Human Services, Med-QUEST Division (MQD) “is committed to laying the foundation for innovative programs that support and create healthy families and healthy communities. To accomplish this goal, MQD is building the Hawai'i 'Ohana Nui Project Expansion (HOPE) program, a five-year initiative to develop and implement a roadmap to achieve this vision of healthy families and healthy communities.

MQD's vision is that the people of Hawai'i embrace health and wellness. MQD's mission is to empower Hawai'i residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha. The vision and mission will serve as the “North Star” and guide the work developed through HOPE.

The following guiding principles describe the overarching framework that will be used to develop a transformative healthcare system that focuses on healthy families and healthy communities:

- Assuring continued access to health insurance and health care;
- Emphasis on whole person and whole family care over their life course. Address the social determinants of health;

- Using a population health approach to maximize enrollee health, supported by health information technology, to advance health equity and address social determinants of health;
- Reducing complexity and administrative burden for providers and enrollees;
- Aligning financial incentives for plans and providers and building shared capacity to improve health care quality through data and collaboration; and
- Minimizing wasteful spending, abuse and fraud.”⁵

- Emphasis on health promotion, prevention, and primary care. Emphasis on investing in system-wide changes; and
- Leverage and support community initiatives.

In order to accomplish the vision and goals, HOPE activities are focused on four strategic areas:

- Invest in primary care, prevention, and health promotion;
- Improve outcomes for high-need, high-cost individuals;
- Payment reform and alignment; and
- Support community driven initiatives to improve population health.

In addition, HOPE activities are supported by initiatives that enhance three foundational building blocks:

- Health information technology that drives transformation;
- Increase workforce capacity and flexibility; and
- Performance measurement and evaluation.”⁶



States may engage stakeholders in their advanced primary care work at different times. Ideally, the state will have engaged communities, providers, and plans to inform its landscape analysis and vision development, but some states may prefer to give

stakeholders a plan to react to once the agency is aligned internally around priorities and options. Engaging stakeholders can also help states make important implementation decisions. For instance, **Washington State**'s fully integrated managed care (FIMC) contract required MCOs to promote behavioral health integration through a variety of approaches, including training and incentives. The successful implementation hinged on understanding what role the MCOs and Accountable Communities of Health (ACHs) — regional coalitions with representatives from multiple sectors — would each play. Early engagement about who is best suited to assume specific roles, and what resources and expectations exist can assist both the state and managed care entities in preparing for advanced primary care implementation.

States can also utilize requests for information (RFIs) or other equivalent processes to solicit input on their proposed or ongoing work in this space. RFIs often present opportunities for groups of stakeholders to come together to develop one unified set of recommendations, which can simplify the process for the state in addressing competing priorities across the stakeholder community. For example, **Hawaii** published an RFI on key delivery system reform goals to inform its managed care RFP, asking plans and providers the following open-ended question:⁷

MQD is interested in promoting greater utilization of primary care and greater integration of behavioral health with primary care. Please describe payment models that would support these initiatives. In addition to payment, what support would providers need in order to achieve increased primary care utilization and integrated care?

Similarly, **Pennsylvania** published a RFI specifically focused on tools that help providers identify and address social needs, such as “existing individual or family needs assessments, methods of connecting individuals and families to community resources, and models for providing whole-person or whole-family case management.”⁸ In particular, the RFI included several questions related to technology tools that can help providers identify and address social needs. Building upon the responses to this RFI and related presentations, the state plans on developing a “statewide online resource and referral tool that will allow providers to connect patients seamlessly to appropriate resources.”⁹

III. Design an Advanced Primary Care Strategy for Managed Care

After creating a vision for advanced primary care, state agencies usually embark on designing their advanced primary care strategy. Often, the bulk of this design work occurs in the context of managed care contracts and oversight mechanisms. The following are three steps related to designing an advanced primary care strategy for Medicaid managed care:

- 1. Maximize state procurement and contracting processes.** Integrate the state's vision for advanced primary care into RFPs and contract amendments;
- 2. Leverage MCO functions.** Consider how an MCO may promote advanced primary care through its traditional responsibilities; and
- 3. Consider Design Options.** Explore how to design an advanced primary care strategy in Medicaid managed care, balancing flexible versus prescriptive approaches and otherwise defining appropriate roles and responsibilities for the parties involved.

1. Maximize State Procurement and Contracting Processes

As part of the procurement process, state Medicaid agencies will issue RFPs for Medicaid MCOs. The RFP drafting process is an ideal time to define the next phase of a Medicaid managed care program and other large-scale reform efforts. A smart procurement strategy will identify the right partners for the state's various delivery system and payment reform initiatives. The state can craft questions and an evaluation process that rewards not only stability and sophistication, but also innovation. Examples of RFP questions are included in [Advance Targeted Care Delivery Goals](#).








Once a contract is awarded, states may also implement periodic contract amendments. The nature of state contracting processes often limits the extent to which states may expand a contractor's scope of work, but amendments can nonetheless significantly promote advanced primary care in a state. **Pennsylvania**, for example, recently published significant revisions to its contract relating to social determinants of health, modifying its community-based care management program and enhancing its requirements for PCMHs.¹⁰



2. Leverage MCO Functions

When designing a strategy, a state may first want to consider how traditional MCO functions can promote advanced primary care. Mapping out these functions can help the state craft a cohesive strategy and integrate advanced primary care priorities throughout a contract. **Exhibit 3** provides examples of potential advanced primary care-related MCO requirements and incentives, organized by common managed care contract sections.

Exhibit 3. Examples of Advanced Primary Care-Related Requirements and Incentives in Managed Care Contracts

 <p>Care Coordination/Management</p> <ul style="list-style-type: none"> ■ Partnerships with primary care teams, including data sharing ■ Population health management ■ Screening for social and behavioral health needs, in coordination with primary care teams and other providers 	 <p>MCO Payment</p> <ul style="list-style-type: none"> ■ MCO incentive and withhold arrangements tied to MCO performance on key advanced primary care-related quality measures ■ Clarification on what may be included in the numerator of the medical loss ratio (e.g., care coordination, value-added services) 	 <p>Provider Network</p> <ul style="list-style-type: none"> ■ Requiring provider training and incentives related to advanced primary care ■ Advancing certain models of care and primary care screening ■ Time/distance standards for primary care providers ■ Network makeup (e.g., inclusion of PCMHs, ACOs, etc.) 	 <p>Quality Assessment and Performance Improvement</p> <ul style="list-style-type: none"> ■ Performance improvement projects that: advance certain models of care (e.g., advanced PCMH models); integrate behavioral health; or advance strategies to address social needs 	 <p>Services</p> <ul style="list-style-type: none"> ■ Carving in a wider scope of services (e.g., integration of behavioral and physical health) ■ Clarifying flexibility to provide value-added and in-lieu of services that may address social or behavioral health needs 	 <p>Utilization Management</p> <ul style="list-style-type: none"> ■ Clarification on appropriate and inappropriate utilization management practices relating to telemedicine or models that integrate behavioral and physical health services 	 <p>Value-Based Payment</p> <ul style="list-style-type: none"> ■ Requiring plans to integrate advanced primary care-related strategies into VBP initiatives for providers (e.g., models that support addressing social needs) ■ Alignment with non-Medicaid models (e.g., CPC+) or adoption of state models (e.g., Medicaid ACOs)
--	---	--	--	---	--	---

[Advance Targeted Care Delivery Goals](#) discusses these potential requirements and incentives in the context of four advanced primary care priorities — addressing social needs, integrating behavioral health, enhancing team-based care, and using technology. The section uses options outlined in step three, [Consider Design Options](#) (next page), as an organizing framework.

3. Consider Design Options

To determine how MCOs should help the state achieve its advanced primary care priorities, a state can weigh several design considerations, which are organized in this toolkit around the following options:

- ✓ **Explore flexible versus prescriptive approaches;**
- ✓ **Define the roles and responsibilities of the state, primary care teams, and MCOs;**
- ✓ **Determine how to measure, monitor, and reward progress;**
- ✓ **Leverage payment reform to drive innovation; and**
- ✓ **Determine the need for additional investments.**

This section describes these options and outlines several high-level design considerations for states. [Advance Targeted Care Delivery Goals](#) details unique considerations related to four advanced primary care priorities — addressing social needs, integrating behavioral health, enhancing team-based care, and using technology — and uses these options as an organizing framework.

Explore Flexible Versus Prescriptive Approaches

When designing its advanced primary care strategy, a state can craft flexible or prescriptive contract language — sometimes referred to as “hard” or “soft” requirements — to promote advanced primary care in Medicaid managed care.¹¹ Flexible language allows MCOs to design and test a variety of approaches to advanced primary care, while prescriptive guidance is typically designed to reduce variation among managed care plans and encourage alignment. In selecting approaches, states may consider factors such as: (1) the degree to which MCOs have supported advanced primary care and worked with other MCOs to do so; (2) state capacity to define and monitor advanced primary care-related initiatives; (3) the number of contracted MCOs; and (4) the prevalence of a particular type of advanced care model in a state, such as through the Comprehensive Primary Care Initiative.¹²

Flexible approaches. In flexible approaches, states may define general expectations surrounding advanced primary care, allowing MCOs to customize their approaches.¹³ States may prefer to remain flexible when they would like MCOs to experiment in a particular area and negotiate with providers as they see fit, such as with provider incentive programs. For example, **Washington State** requires its MCOs to promote behavioral health integration through education, training, and financial and nonfinancial incentives. States may also insert language into contracts and RFPs that is primarily anticipatory — a reference to expected, but yet to be defined, initiatives.

Prescriptive approaches. Alternatively, the state may require a specific model or approach, expecting the MCO to implement or advance the uptake of a program within state specifications. For example, the state may want to: present a unique, standardized Medicaid model (e.g., Medicaid ACOs); advance a Centers for Medicare & Medicaid Services model, such as Primary Care First or Comprehensive Primary Care Plus; or implement a well-defined industry standard (e.g., NCQA's patient-centered medical homes).¹⁴ States may choose to be prescriptive when seeking to encourage alignment or to avoid fractured or duplicative efforts in a competitive managed care environment. A prescriptive approach may be less preferable when there is little evidence on effectiveness of a particular model or where there is a wide variation in primary care capacity throughout the state.

Define Roles and Responsibilities

Managed care contracts must accommodate the differing roles and responsibilities of the state, plans, and providers, as well as differing levels of oversight. When including provisions regarding primary care, the state can define how the MCO will influence primary care through MCO functions — network management, quality assurance and performance improvement, payment, utilization management, and care management, among others. In defining roles and responsibilities, the state may: (1) develop common processes and infrastructure, if needed; and (2) provide guidance or standards for coordination between primary care teams and MCOs.

Develop Common Processes and Infrastructure. States can define common standards or develop shared resources for their Medicaid managed care programs in order to reduce fragmentation in a competitive Medicaid managed care market. For example, **Louisiana, Kansas, North Carolina, and New Mexico** designed or will design standardized health risk assessments or other screening tools that integrate questions on social needs in the context of their managed care programs.^{15,16,17,18} In addition to a social needs screening tool, **North Carolina** introduced several tools to aid its comprehensive “healthy opportunities” strategy, which has a distinct focus on social needs: a GIS-mapping service and a common closed-loop referral system.¹⁹ **Tennessee** developed a centralized care coordination tool for providers participating in the state's PCMH program; this tool enables PCMHs to identify gaps in care and support care coordination by, among other things, providing admission, discharge, and transfer data from hospitals and emergency rooms, and allowing PCMHs to follow-up with patients and coordinate care post-discharge.²⁰

Provide Guidance or Standards for Coordination Between Primary Care Teams and MCOs. States may define how MCOs and primary care teams work together, especially on shared functions, such as care coordination and management. For example, Tier 3 Advanced Medical Homes will provide local care management as part of **North Carolina's** new managed care program.²¹ The state's RFP outlines how its new managed care plans must: (1) provide data to the medical homes; (2) calculate quality metrics; and (3) craft incentive payments.²² Similarly, individuals who are attributed to a Comprehensive Primary Care (CPC) Practice in **Ohio** receive all of their care management, including coordination of behavioral, physical, and social needs, from the CPC practice, and MCOs must support the CPCs with adequate data and reports.²³ In another example, **New Mexico's** MCOs may fully or partially delegate care coordination functions to primary care teams, such as administering a health risk

assessment or coordinating referrals to community service providers.²⁴ The state requires that full delegation occur in the context of a value-based payment, but allows MCOs and providers to craft other arrangements under a shared functions model. **Pennsylvania's** community-based care management program requires MCOs to explore partnerships with providers, CBOs, and community health workers, and to design more effective face-to-face care coordination programs, with a focus on: reducing preventable admissions and readmissions, addressing SDOH, and enhancing behavioral health and physical health coordination of services, among other categories.²⁵

Determine How to Monitor, Measure, and Reward Progress

As the mantra goes, what gets measured gets done. MCOs are likely to prioritize items for which they are held accountable. States can design ways to measure progress toward advanced primary care. States may consider both system-level measures, as well as more targeted quality measures. These measures can then be integrated into MCO incentive and withhold arrangements, VBP arrangements with providers, and overall quality assessment and performance improvement strategies. For a more detailed exploration of how to hold MCOs accountable for advanced primary care, leverage payment reform, and increase investment in primary care, see the second section of this toolkit, [*Using State Levers to Drive Uptake and Spread*](#).

Monitor Utilization of Primary Care Services. States may consider measures that gauge use of primary care services — for example, well-child visit measures included in the CMS Child Core Set.²⁶ In addition to these more standard quality measures, states have also implemented measures that seek to drive an increase in member enrollment with certain types of primary care teams, such as those affiliated with a PCMH or ACOs. For example, **Oregon** includes patient-centered primary care home enrollment as a coordinated care organization (CCO) incentive measure and ties that value to payment through the state's Quality Pool.²⁷

Measure Primary Care Spending in Relationship to Other Services. States may consider measures that track overall MCO investment in primary care, relative to health care spending as a whole. This system-level approach may help the state track gaps in the overall primary care system and the effect of large-scale rebalancing efforts and investments in preventive, primary care. For example, **Oregon** will require its Medicaid CCOs to spend 12 percent of total health expenditures on primary care.²⁸ The Patient-Centered Primary Care Collaborative, Milbank Memorial Fund, and the Robert Graham Center have been active thought partners in this field, designing methods by which primary care services are identified and included in primary care spending calculations, and promoting adoption of primary care spending measures by state legislatures and policymakers.²⁹ By measuring investment in primary care, the state can design benchmarks that drive further investment into primary care through both MCO- and state-defined infrastructure and incentive programs.

Incent Advanced Primary Care Strategies. States may consider their goals, such as the integration of behavioral health and social services into primary care settings, and design “catalytic” measures that nudge MCOs and network providers toward that goal. These catalytic measures can be integrated into MCO incentive and withhold arrangements that reward the MCO for performance on key quality measures. In order to perform well on the catalytic measure, the MCO, in conjunction with its

network providers, must promote advanced primary care efforts. For example, states may consider a depression screening measure to advance behavioral health integration. In order to perform well on this measure, the primary care teams in the MCO's network will likely need to improve processes for screening for and treating depression, perhaps with support and training from an MCO or coalition of MCOs.³⁰ Similarly, states interested in advancing SDOH strategies may include direct measures on social needs screening, or indirect measures such as avoidable readmissions after hospitalization.³¹ At the MCO contract level, and at the level of provider VBP, the incentive can drive advanced primary care efforts that advance whole-person care approaches. In the absence of catalytic measures such as these, an MCO may largely ignore general directives in a contract regarding behavioral health and social service integration.

Leverage Payment Reform to Drive Innovation

Many states are using managed care contracts to advance VBP and may consider reinforcing a primary care focus within these requirements. To the extent that a state imposes a VBP benchmark (i.e., a required percentage of payments tied to VBP arrangements), states can define what types of primary care payments count toward the benchmark and may even weigh those models more heavily in the calculation. For example, **Massachusetts** establishes a VBP benchmark based on percentage of enrollees. For every one percent of enrollees assigned to an ACO, the state deems that value two percent for the purpose of the VBP benchmark.

States may also ask the MCO to discuss primary care in the context of its VBP strategic plans.³² For example, **Louisiana** requires its MCOs to submit a VBP strategic plan that includes estimated primary care expenditures and related VBP payment methodologies.³³ Similarly, **North Carolina** requires its plans to integrate SDOH into their VBP plans.³⁴

States may also actively consider opportunities for alignment with other payment models, including Centers for Medicare and Medicaid Innovation models such as Comprehensive Primary Care Plus (CPC+) and its successor Primary Care First.^{35,36} Payer alignment may be particularly attractive to primary care teams, since they are likely affected by competing reporting requirements. **Ohio** requires MCOs to reimburse CPC+ the agreed upon per member per month (PMPM) payment for attributed members and any shared savings for meeting model requirements.³⁷

Determine the Need for Additional Investments

Given that advanced primary care models require PCPs to perform additional functions and develop supporting infrastructure, the state may assess the need for additional support. For example, the state may encourage the MCO to invest in PCMHs and other advanced primary care models. In this vein, **Oregon** will require MCOs to make infrastructure payments to its state-defined patient-centered primary care homes, and **Rhode Island** requires its MCOs to coordinate incentive payments for its accountable entities to enhance the system's capacity to address both social and behavioral health needs.^{38,39} Additional investments may also be needed to support state implementation of advanced primary care strategies. States will also need to test strategies to keep MCOs accountable for the advanced primary care goals in their contract — whether through reporting templates, contract enforcement, and/or continued convening and reporting.

IV. Advance Targeted Care Delivery Goals

After reflecting on its overall design strategy and broad-based goals relating to primary care, a state may want to consider how to use its managed care program to advance targeted care delivery goals. This part of the toolkit focuses on four advanced primary care priorities:

1. **Identify and address social needs;**
2. **Integrate behavioral health into primary care;**
3. **Promote health equity;**
4. **Enhance team-based primary care approaches that better meet the community's needs; and**
5. **Use technology to improve access to care.**

Each of the following modules include unique design considerations, organized by key options outlined earlier in the toolkit.

In addition to detailing design considerations, each advanced primary care priority includes **state approaches, sample contract and RFP language, and measurement and payment strategies**. While the modules in this section does not seek to define the right path, it can provide states with a range of potential approaches.



1. Identify and Address Social Needs

SDOH are conditions in the places where people live, learn, work, and play.⁴⁰ For individual patients, social needs, such as food or housing insecurity, can have a substantial effect on health.

This module focuses on how state Medicaid agencies can use managed care contracting levers to focus on both population-level SDOH and individual-level social needs. At the population level, states can advance targeted, coordinated investments in local communities, and encourage MCOs to design interventions to reduce health disparities by using and analyzing social needs data. At the individual patient level, states can consider defining how primary care teams (PCTs) and MCOs: (1) screen for health-related social needs; (2) address identified needs through referral and partnerships with CBOs, as well as direct investments; and (3) advance whole-person approaches to care coordination and management. Across this spectrum of activities, states may define appropriate coordination, collaboration, and integration goals for both PCTs and MCOs.⁴¹

Design Considerations

Both PCTs and MCOs have an important role to play in identifying and addressing social needs and broader SDOH.⁴² States may develop a comprehensive strategy that addresses SDOH throughout a managed care contract. For example, the state may integrate a focus on social needs into contract sections relating to: training programs for network providers; care coordination and management; quality assurance and performance improvement; VBP; additional services such as value-added and in lieu of services; and MCO payment incentives. The state may also consider ways to develop a common infrastructure and tools that can enable both PCTs and MCOs to better identify and address social needs. Following are considerations to inform state efforts in developing an SDOH strategy:

IDENTIFY AND ADDRESS SOCIAL NEEDS: Design Considerations Summary

Explore flexible versus prescriptive approaches.

- ✓ Will the state encourage, incent, or require PCTs or MCOs to screen for social needs? If so: (a) what social needs should be screened for; (b) what type of screening tool should be used; (c) who should be screened; and (d) how should social needs information be documented and reported?
- ✓ How should PCTs or MCOs connect beneficiaries to, or invest in, community resources? Will the state mandate a particular tool (e.g., community resource referral platform) or method (e.g., warm hand-off)? Will the state require a certain level of MCO investment, or particular focus area (e.g., housing, food insecurity)?

Define the roles/responsibilities of the state, primary care teams, and MCOs.

- ✓ Who should screen for social needs?
- ✓ Who will define priorities for SDOH-related work? How can they solicit input from local communities to determine priority interventions and investments?
- ✓ How can the state ensure that its planned approach will enhance, and not detract from, the capacity of the community to address SDOH?

Determine how to measure, monitor, and reward progress.

- ✓ How will the state measure progress and hold MCOs accountable for implementing a SDOH strategy?
- ✓ Will the state require or incent MCOs to partner with CBOs, or invest in certain interventions?

Leverage payment reform to drive innovation.

- ✓ Will the state require MCOs to integrate social needs partnerships and related metrics into VBP requirements?

Determine the need for additional investments.

- ✓ What infrastructure and investments are needed to support this work? How will payment models and state investment and leadership support this infrastructure and investment?



✓ Do PCTs and MCOs in the state already screen for social needs?

First, the state may want to access the degree to which: (1) PCTs participate in a particular model that includes social needs screening, such as Accountable Health Communities, Pathways Community HUB, or CPC+; and (2) MCOs integrate questions on social needs into their health risk assessments and other screeners.^{46,47,48} If PCTs and MCOs are already doing this work, states may prefer to be less prescriptive, outlining only general guidelines and avoiding potential conflicts with established systems and processes.

✓ Who should screen for social needs?

Both MCOs and PCTs can integrate social needs screening into their standard processes, and each approach has benefits. Individual MCOs are responsible for wider swaths of the Medicaid population and have the resources to systematize the collection of social needs data through health risk assessments and other screeners. However, many MCOs rely on telephonic care coordination processes that may not be as amendable to asking sensitive questions on social needs. By contrast, PCTs can likely develop a deeper, face-to-face connection with the patient, which can yield more complete and honest responses to social needs screening questions. The PCT, however, may not always have the resources to aggregate and analyze data. Building on these respective strengths, states can explore ways to encourage MCOs to partner with PCTs on, and pay PCTs for, care coordination functions that involve screening for social needs — avoiding unnecessary duplication where possible. In both MCOs and PCTs, community health workers can assist with these functions.



Managed Care Procurement

Following is sample state managed care request for proposal language related to social determinants of health:

Minnesota.⁴³ “Describe how the Responder will commit resources towards improving population health. Describe how Responder will proactively coordinate with counties and others to address social determinants of health for customers. Describe how providers will be encouraged / incentivized to reach preventative goals for cost saving outcomes.”

Oregon.⁴⁴ “Does Applicant currently have performance milestones and/or metrics in place related to social determinants of health and health equity? These milestones/metrics may be at the plan level or Provider level. If yes, please describe.”

Virginia.⁴⁵

- “How are social determinants assessed by your organization?”
- “What social determinants data elements are currently captured for your member population, and from what sources?”
- “What future data, data source(s), or technology enhancements are planned to capture more social determinants information?”
- “How does the Offeror partner with health care and social service providers to address social determinants? Describe any alternative payment arrangements that include social determinants reporting or intervention as a factor of payment.”
- “Describe your organizations ideas for best practices that should be included in [a] pilot program related to addressing nutritional insufficiency, including outreach and coordination with schools, community resources (including food resources), primary care physicians and/or other social services.”



✓ Who should be screened?

States may determine that only certain populations require a full social needs screening — for example, those who require more intensive care coordination because of complex needs or who have screened positively to a preliminary, shorter screen. However, given the prevalence of health-related social needs among Medicaid beneficiaries, gaps in screening practices may contribute to missed opportunities to determine appropriate diagnoses and approaches to care.

✓ What data does the state need, and what data does the state have?

The state may choose to allow an MCO to collect social needs information in the way it sees fit. At other times, the state may be interested in collecting standardized data from the plans to inform policy planning or a formal pilot evaluation. In either scenario, the state may assess what social needs information can be aggregated from other sources that can assist the state with its goals, and otherwise supplement MCO and PCT screening practices.

✓ What needs should be screened for, and what type of screening tool should be used?

Using current MCO/PCT screening practices and the state's data needs as starting points, states may consider whether it will require a standardized screening tool or provide general guidelines on an appropriate tool (e.g., a preference for validated questions or for priority social needs, such as housing and food insecurity).⁵²

✓ How will identified social needs be documented?

States may want to ensure that both MCOs and PCTs can access and supplement social needs screening information. States may defer to MCOs to define appropriate standards for social needs documentation, or encourage a particular approach, such as the use of Z Codes in the ICD-10 set.

Managed Care Contract Excerpts

Following is sample state managed care contract language related to social determinants of health:

Louisiana.⁴⁹ [The contractor shall]:

- "Offer evidence-based practices that have a demonstrated ability to address SDOH and reduce health disparities [...]"
- "Collaborate with its high-volume primary care practices to develop, promote and implement targeted evidence-based practice."
- "Measure and report semi-annually to LDH on the effectiveness of its evidence-based interventions to reduce health disparities. Minimum reporting requirements include data on self-reported race, ethnicity, language, housing, food, transportation, employment and safety needs, care management model utilized, risk stratification criteria highlighting priority populations, and targets for engagement and outcomes stratified by priority subgroup [...]"

Oregon.⁵⁰ [Contractor must, through its Community Advisory Council:]

- "Include SDOH and Health Equity partners and organizations, counties, traditional health workers, and tribes in development of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHP)."
- [Develop] "shared CHA and CHP priorities and strategies with local public health authorities, nonprofit hospitals, [...] other coordinated care organizations [...], and [...] federally recognized tribe[s...]"

Pennsylvania.⁵¹ The [MCO] will ensure the PCMH provider:

- "Will deploy a community-based care management team [...] that] connect[s] individuals as needed to community resources and social support services through 'warm hand off' referrals for assistance with problems such as food insecurity and housing instability."
- "Will [...] submit ICD-10 diagnostic codes for all patients"

✓ **How should PCTs and MCOs connect beneficiaries to community resources? Who should be responsible for creating the necessary infrastructure to support this work?**

Under federal rules, MCOs must coordinate the services they deliver with those available through community and social support providers.⁵³ States may build upon this general obligation to require the MCO to refer enrollees to community resources, or to advance particular types of referral in partnership with PCTs (e.g., “warm handoffs”). The state may also require the MCO to: (1) maintain an up-to-date list of community resources; (2) use specific referral pathways, such as 211; (3) implement closed-loop referral processes, whereby the MCO or PCP tracks whether a beneficiary actually received a service; or (4) facilitate formal partnerships among CBOs, MCOs, and providers. The state may also introduce a common resource for MCOs and PCTs that can facilitate this process, as **North Carolina** has done with its NCCARE360 community resource referral platform.⁵⁴

✓ **Who will define priorities for SDOH-related work?**

States may direct MCOs to: (1) collaborate with PCTs on evidence-based interventions relating to SDOH; (2) target those efforts to a particular state priority area, such as food or housing insecurity; or (3) identify interventions that are relevant to a particular community, as identified through data analysis or stakeholder engagement. Additionally, the state may present its specific SDOH requirements in the context of a particular health disparity, such as maternal mortality or low birth weight.

✓ **Will the state require or incent MCOs to partner with CBOs, or invest in certain interventions?**

To support care coordination and craft an effective SDOH strategy, MCOs can learn from, partner with, and sometimes fund CBOs that address the social needs of members. The state may direct MCOs to enter into formal partnerships with CBOs, and integrate PCTs into these partnerships and intervention programs, to the extent possible. The state may also encourage, incent, or require MCO investment in local communities, as in **Arizona**, **North Carolina**, and **Oregon**.^{55,56,57} The state may also define a priority area for investment, such as housing.

✓ **How will MCOs or PCTs solicit input from local communities to determine priority interventions and investments?**

States may define expectations around consumer and community perspectives, or require a specific structure or process to capture this input, such as **Oregon**’s community advisory councils and coordinated community health assessments.

✓ **How can the state ensure that its planned approach will enhance, and not detract from, the capacity of the community to address SDOH?**

States may consider how to advance MCO-CBO partnerships, and avoid unintended consequences arising from MCO contract requirements. For example, states may encourage MCOs to contract with and fund existing community health worker programs with strong connections to local communities, as opposed to merely strengthening and staffing in-house MCO activities. The state may also encourage MCOs to design programs that help CBOs build capacity to address an uptick

in referrals from MCOs, such as through upfront working capital or performance-based incentives (See [VBP requirements](#) in **New York** and **Oregon**).

✓ **How will the state measure progress and hold MCOs accountable for implementing an SDOH strategy?**

States may implement specific SDOH requirements in the context of: (1) a larger health equity initiative; (2) a targeted performance improvement project; (3) a VBP initiative; (4) a withhold or incentive arrangement; (5) an MCO care management requirements; or (6) a § 1115 demonstration project or pilot. Each of these approaches will have its own data and monitoring needs, as well as its own relationship to MCO or provider payment. The state may choose to focus on more clinical indicators, such as emergency department utilization or readmission rates. Alternatively, the state may choose to track social needs screening rates, or more subjective measures such as “healthy days” or self-rated health status.⁵⁸

State Approaches

States may take various approaches to identifying and addressing social needs in Medicaid programs. The approach may be flexible, defining state expectations and allowing space for MCO customization, or prescriptive, advancing state standardization and MCO implementation of a standardized model or tool. Following are specific state examples for identifying and addressing social needs for Medicaid populations.

Flexible	Prescriptive
Approaches to Identifying Social Needs	
Pennsylvania requires MCOs to ensure that its patient-centered medical homes complete an SDOH assessment using a “nationally recognized tool.” MCO case/disease and health management programs must “include collaboration with the Department to develop, adopt and disseminate a Social Determinants of Health assessment tool.” ⁵⁹	Kansas , ⁶⁰ Louisiana , ⁶¹ and North Carolina ⁶² require MCOs to use state-developed social needs screening questions.
Approaches to Addressing Social Needs	
Michigan ⁶³ and Louisiana ⁶⁴ require its MCOs to collaborate with its high-volume primary care practices to “develop, promote, and implement targeted evidence-based interventions” that can address SDOH and health disparities.	North Carolina requires MCOs to use a community resource referral platform called NCCARE 360. ⁶⁵ The system will enable health and human service providers to send and receive secure e-referrals, share client information, and track outcomes.
Pennsylvania requires MCOs to design a community-based care management program and team, which can include provider partners. MCOs must implement at least one rapid cycle quality improvement pilot program, implemented with CBOs and focused on improving health outcomes and addressing social determinants of health. ⁶⁶	Virginia requires MCOs to coordinate with the state on a pilot program addressing nutritional insufficiency, with a particular focus on children. ⁶⁷

Measurement and Payment

Measurement and payment approaches relating to SDOH are relatively nascent, but states are beginning to integrate SDOH measures and incentives into their Medicaid programs, such as through ACO quality measures, VBP initiatives, and MCO incentive and withhold arrangements. Following are examples of state measurement and payment strategies related to social needs.

State	Description
Accountable Care Organization Measures	
Massachusetts	Health-Related Social Needs Screening ⁶⁸ - Percentage of members who were screened for health-related social needs in the measurement year.
Minnesota	Health Equity Measure ⁶⁹ - During contract discussions, Minnesota's Integrated Health Partnership (IHP) attributed population will be examined to determine its predominant health disparities using DHS data as well as information provided by the IHP. The IHP will be required to propose an intervention and health equity measures tied to this intervention that are intended to reduce health disparities among the IHP's population.
Rhode Island	Social Determinants of Health Screening ⁷⁰ - The percentage of attributed patients who were screened for SDOH using a state-approved screening tool, where the Accountable Entity has documented the screening and results.
Rhode Island	Self-Reported Health Status - Adults ⁷¹ - The percentage of attributed patients who completed a Self-Reported Health Status screening, where the AE has documented the screening and the results.
Value-Based Payment Requirements	
New York ⁷²	New York requires certain advanced VBP arrangements to include at least one SDOH intervention and one partnership with a CBO. MCOs must provide a funding advance that assists the provider or CBO implement the intervention.
North Carolina ⁷³	North Carolina will require plans to "submit a written plan [...] that indicates how it will incorporate addressing Opportunities for Health [activities relating to health-related social needs] into its VBP strategy to align financial incentives and accountability around total cost of care and overall health outcomes."
Oregon ⁷⁴	Oregon requires CCOs to design payment arrangements that reward participating providers for their role in achieving MCO incentive metrics under the state's Quality Pool and Challenge pool. CCOs must: <ul style="list-style-type: none"> ■ "offer correlative arrangements with Participating Providers (including Social Determinants of Health & Health Equity (SDOH-HE) partners, public health partners, and other health-related services providers as appropriate), providing monetary incentive payment arrangements with Providers that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives." ■ "create a distribution plan for Quality Pool and Challenge Pool earnings. The plan should include [among other factors] [...] an overview of the methodology and/or strategy used to distribute quality pool earnings to participating providers, including SDOH-HE and public health partners, that provides information related to the contractor's process of evaluating the contributions of participating providers and connecting those evaluations to distribution of funds."

State	Description
MCO Withhold and Incentive Arrangements	
Michigan ⁷⁵	<p>Michigan has three MCO pay for performance (P4P) programs relating to SDOH; in each program, the MCO submits a baseline analysis, intervention proposal, and intervention report:</p> <p>Pay for Performance on Population Health and Health Equity. The state’s managed care contract defines a “population health management intervention” relating generally to social determinants of health and notes a particular state interest in housing.</p> <p>Low Birth Weight (LBW) Project. “For FY 2018, the goal is to involve the Medicaid Health Plans, existing home visiting programs, and community health worker programs to design and implement a meaningful P4P project. In order to improve infant health outcomes, the initiative will address documented health disparities and health inequities with particular focus on reducing the LBW-CH rate. The activities in FY18 will include identifying evidence-based, integrated models that address LBW through management of medical and social determinants of health. They will also incorporate parties who focus on maternity care to identify and implement models of choice through collaborative processes.</p> <p>The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: [a] Preconception, [b] Timeliness of prenatal care, [c] Post-partum care”</p> <p>Emergency Department Utilization. “Emergency Department (ED) utilization provides a snapshot about quality and access issues faced by Michigan Medicaid beneficiaries and their surrounding community. Health Plans will explore and develop innovative initiatives to improve the effectiveness and performance of ED utilization. Interventions should focus on the reduction and/or elimination of ED visits related to A) behavioral health, or B) substance use disorder treatment, or C) dental problems. They should also emphasize the clinical and non-clinical aspects of a member’s socio-logical system. Goals may include improvement in health outcomes; enhanced coordination of services and partnering with non-traditional healthcare providers; and increased cost-effectiveness with a major effort to lower inappropriate ED Utilization in the Michigan Medicaid Managed Care population. “</p>
Oregon ⁷⁶	<p>SDOH and Health Equity Bonus Fund. Oregon’s most recent RFP notes that the state “intends to establish a two-year incentive arrangement — the SDOH-HE Capacity-Building Bonus Fund (“SDOH-HE Bonus Fund”) — to offer monetary bonus payments above and beyond the capitation rate to contractors that meet SDOH-HE-related performance milestones and metrics.” These milestones and metrics have yet to be defined.⁷⁷ CCOs must submit a plan for how Contractor intends to direct its SDOH-HE spending for SDOH-HE that includes an evaluation plan and budget proposal. The CCO must also enter into formal written arrangements with SDOH-HE partners.</p>

2. Integrate Behavioral Health Care

Across the United States, behavioral health conditions — including mental illness and substance use disorders — are often underdiagnosed and treatment is delayed.⁷⁸ While behavioral health care is typically delivered separately from primary care, there is growing consensus that behavioral health should be integrated into primary care to help facilitate earlier diagnosis and treatment.^{79,80}

This module outlines strategies and considerations for integrating behavioral health into primary care for states operating in a Medicaid managed care environment, including a variety of activities and incentive arrangements.⁸¹

Design Considerations

✓ How will the state define “behavioral health integration” in primary care?

At the broadest level, behavioral health integration can describe any situation in which behavioral health and medical providers work together.⁸² Numerous overlapping terms have been used to describe behavioral health integration, which can create confusion and potentially inhibit implementation of effective interventions.⁸³ Increasingly, health care experts have supported the idea that integration occurs along a continuum. The Center for Integrated Health Solutions, jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA), developed a widely adopted framework ranging from minimal collaboration to co-located care to fully integrated care.⁸⁴ Likewise, some experts advocate for distinguishing between collaborative care, which involves behavioral health working *with* primary care, and integrated care, which involves behavioral health working *within* and as part of primary care.⁸⁵

INTEGRATE BEHAVIORAL HEALTH CARE: Design Considerations Summary

Explore flexible versus prescriptive approaches.

- ✓ How will behavioral health integration be defined in MCO contracts — in a specific way that promotes uniform care delivery approaches, or more broadly to allow flexibility?
- ✓ How, if at all, will the state define what types of behavioral health screenings should be integrated into primary care?
- ✓ Which existing care models could be used to advance behavioral health integration?

Define the roles/responsibilities of the state, primary care teams, and MCOs.

- ✓ How will the state minimize barriers to integrated care?
- ✓ Which providers are expected to participate in integration activities?
- ✓ To what extent will the state encourage or require MCOs to work together on integration activities?

Determine how to measure, monitor, and reward progress.

- ✓ What financial or non-financial incentives will the state use to encourage uptake of integration among MCOs and providers?
- ✓ How will progress toward integration be monitored, and by whom — centralized via the state, or delegated to health plans?

Leverage payment reform to drive innovation.

- ✓ How, if at all, will the state dictate how MCOs should pay providers for integrated care (recognizing that many activities related to integrated care, such as provider consultations, are not typically reimbursed under a fee-for-service (FFS) model)?
- ✓ To what extent can the state align payment approaches with other payment initiatives that incentivize behavioral health (e.g., CPC+)?

Determine the need for additional investments.

- ✓ What additional funding may be needed to ensure adequate reimbursement for new activities, staffing, or infrastructure deployed by MCOs and/or providers?
- ✓ To what extent might states either develop or require MCOs to provide shared supports for smaller primary care practices that are not independently able to undertake more sophisticated integration activities?





States may choose to define behavioral health integration in primary care differently based on their priorities and existing health plan and provider market, as well as population needs.⁸⁹ For example, patient populations at low risk for complex behavioral health conditions might best be served in coordinated primary care and mental health practices where collaboration is facilitated by a care manager.⁹⁰ Patients with serious mental illness or active substance use disorder (SUD) and multiple medical problems seen in traditional community mental health centers may need co-located care within partially or fully integrated provider practices to improve their outcomes.⁹¹

For example, **Oregon** requires its health plans to “understand and acknowledge” that integrated care spans a continuum ranging from communication to coordination to co-management to co-location to the fully integrated Patient-Centered Primary Care Home.”⁹² **Louisiana** defines behavioral health integration “activities” for its Medicaid MCOs, such as: incentivizing providers to co-locate physical and behavioral health services; providing support for PCPs who screen for behavioral health issues and treat mild to moderate cases; and ensuring collaboration and communication among physical and behavioral health providers.

✓ Which providers are expected to participate in behavioral health integration activities?

It is important to consider the providers to whom behavioral health integration expectations will apply. For example, will integration requirements apply only to particular providers or provider organizations, such as ACOs, PCMHs, or high-volume PCPs, or will they apply to PCPs in general? States with well-established PCMH programs may opt to define standards for behavioral health integration within those programs (see [Three State Approaches to Patient-Centered Medical Homes](#)), and then incent or require plans to contract with those providers.⁹³ Other states may outline expectations for MCOs to increase the level of integration activities occurring across the continuum for all primary care and behavioral health providers.

Managed Care Procurement

Following is sample state managed care RFP language related to integrated behavioral health services:

Arizona.⁸⁶ “To accelerate the focus on integration at the provider level, describe the Offeror’s specific and detailed value-based strategies that align incentives between providers and the Offeror in order to reduce fragmentation and improve member outcomes. The Offeror’s response must address value-based integration strategies for each of the following: [a.] integrated providers, [b.] behavioral health only providers, and [c.] physical health only providers.”

Kansas.⁸⁷ “Contractor(s) shall provide a detailed description in its proposal detailing [a.] what type of clinical support it will offer to Providers treating Behavioral Health conditions (including but not limited to depression, anxiety and addiction) in the Primary Care setting. [b.] How it will promote and support Primary Care based Behavioral Health in pediatric and adult populations; what best practices and recommended protocols it will use to support the integration of medical and Behavioral Health care; and what materials and tools it will utilize in order to engage Members and Providers to improve integration.”

Oregon.⁸⁸ “Applicant must identify and address billing system and policy barriers to integration that prevent Behavioral Health Provider billing from a physical health setting. Applicant will develop payment methodologies to reimburse for Warm Handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments.”



States interested in broadly scaling integrated care within a wide range of primary care practices may want to consider moving away from an emphasis on a particular care model to definitions of functions that are more broadly applicable to a range of providers (e.g., those that do not require hiring new staff).⁹⁷ Such states may choose to reference the eight common elements and minimum standards of integrated care developed by the Washington State Bree Collaborative.⁹⁸

✓ What are managed care organization requirements and responsibilities for integrated primary care?

States may take many different approaches to promote integration through Medicaid MCO contracts. Given that states have different populations, patient needs, and provider/health plan markets, there is no “right” way to do this work. States may choose to be firm in their expectations regarding a precise standard by which to measure performance, or instead express interest in achieving a particular outcome (e.g., co-located providers) accompanied by an incentive, such as a bonus or favorable auto-enrollment policies. **New Hampshire** requires MCOs to ensure that physical and behavioral health providers offer co-located or integrated care as defined in SAMHSA’s Six Levels of Collaboration/Integration or the Collaborative Care Model to the extent feasible, and to provide annual reports to the state on continued progression toward integration.⁹⁹ Alternatively, **Washington State** encourages “behavioral health-medical integration,” but provides MCOs with more flexibility to determine exactly what integration will look like. States might also choose to design and implement standardized statewide programs that advance behavioral health integration within primary care at the state-level, and then require or incentivize plans to participate in those.

States may also choose to define other expectations around specific MCO functions that support integrated care, such as data-sharing capabilities, provider network information, reporting requirements, or MCO workforce standards. For example, **Louisiana** requires MCO contractors to employ a full-time behavioral health medical director whom is charged with developing training for the MCO’s PCPs on specific behavioral health screening tools and collaborative care models, as well as provide all PCPs with a current list of referral providers, including behavioral health providers, on a quarterly basis.¹⁰⁰

Managed Care Contract Excerpts

Following is sample state managed care contract language related integrating behavioral health services:

New Hampshire.⁹⁴ “The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible.”

“[T]he MCO shall include in its Behavioral Health Strategy Plan and Report efforts towards continued progression of the SAMHSA Integration Framework at all contracted primary and behavioral health Providers.”

Louisiana.⁹⁵ “The PCP shall provide basic behavioral health services [defined term] and refer the enrollee(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services. The Contractor shall ensure that network PCPs fulfill their responsibilities including, but not limited to [...] conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, early detection, identification of developmental disorders/delays, social-emotional health, and SDOH to determine whether the enrollee needs behavioral health services.”

Washington State.⁹⁶ “The Contractor shall promote behavioral health-medical integration through education, training, financial, and nonfinancial incentives...including but not limited to [a.] increased screening, identification, and referral for behavioral health conditions that commonly occur in primary care settings [; and b.] development of collaborative care models and co-location of primary care and behavioral health providers.”

✓ **How, if at all, have states defined what types of screenings should be integrated into primary care?**

Many integrated care models involve systematic screening of a target population to proactively identify patients in need of care. Integrated primary care may involve different types of behavioral health screening, including screenings for mental health and/or SUD.¹⁰¹ Some states require MCOs to use a particular screening approach within primary care and/or train PCPs on implementation of that screening tool. **Minnesota**, for example, promotes Screening, Brief Intervention, and Referral to Treatment (SBIRT) for SUD, and allows plans and providers to choose among state-approved screening tools.¹⁰² In **Oregon**, SBIRT is a covered benefit for all Medicaid patients and for a wide range of provider types.¹⁰³ Depression screening is another common integration activity within primary care, with some states similarly allowing plans and providers to choose among validated screening tools and others requiring use of a particular tool, such as the Patient Health Questionnaire-9.¹⁰⁴ States may also explicitly require MCOs to reimburse PCPs for behavioral health screening activity, as **Michigan** has done. Additionally, states may wish to clarify appropriate screenings for children in the context of early, periodic, and diagnostic services. For example, in its 2019 RFP, **Oregon** asks potential respondents to describe how it will ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting.

✓ **How will the state minimize barriers to integrated care?**

In order to minimize barriers to integrated care, states can: (1) stipulate that MCOs assess and maintain billing approaches and other policies conducive to integrated care; and (2) assess their own policies, laws, and regulations to assess whether any may be unintentionally impeding progress toward integration. At the MCO-level, **Virginia** requires that its contracted health plans demonstrate the ability to cover specialty consultant services (e.g., telepsychiatry) to interested PCPs and contract with network behavioral health providers that can provide assessments and other services via telehealth, as needed. **Oregon** asks potential contractors to identify and address any billing and policy barriers to integration, and to develop payment approaches to reimburse for historically unpaid activities, such as care managers or provider consultations.¹⁰⁵

States can also solicit stakeholder feedback and conduct research on their own policies around billing to ensure they are conducive with the provision of collaborative and integrated care. For example, does the state have any same-day billing policies that impede integration? The 21st Century Cures Act recognizes this potential barrier to behavioral health integration, suggesting that Title XIX of the Social Security Act does not prohibit separate payment for a “mental health service furnished to the individual by a provider at a facility on the same day a primary care service is furnished to such individual by such provider (or another provider) at the facility.”¹⁰⁶

✓ **How, if at all, will the state dictate how MCOs should pay providers for integrated care?**

Integrating behavioral health into primary care has been widely demonstrated to improve quality and reduce costs, particularly for the Collaborative Care Model (see [Care Delivery Models](#) for more details on this model).¹⁰⁷ However, uncertainty about implementation and maintenance costs, and lack of a clear pathway for reimbursement, has hindered

more widespread adoption. A study of integrated team-based care approaches found that integrated practices generate \$115 per patient less annually, on average, under traditional FFS payment methods. This means that, from a business perspective, provider practices confront financial disincentives for integrating care unless the payment model is changed. In general, approaches that can be used to pay for integrated care include: (1) new fee-for-services billing codes (e.g., **Washington State's** Collaborative Care Model codes); (2) care management payments (e.g., **New York's** case rates for qualified Collaborative Care Model providers); (3) bundled payments (e.g., **Minnesota's** Diamond model); and (4) primary care capitation (e.g., **Rhode Island's** primary care capitation framework).

States may consider how, if at all, to dictate the way MCOs should pay for integrated care. A state may require MCOs to use a particular payment model or pay enhanced rates for providers demonstrating certain capabilities. Alternatively, a state may defer to the plan to develop payment methodologies to reimburse for historically unfunded services, such as provider consultations or integrated care management. States may be tempted to rely on broad VBP targets in Medicaid managed care contracts to spur new payment models for integrated care. Early evidence suggests, however, that use of broad VBP targets or benchmarks typically does not translate into widespread use of VBP for smaller or independent providers, including PCPs and behavioral health providers. Additionally, states may want to consider how and whether to align payment models for PCPs participating in related federal initiatives, such as CPC+ or Primary Care First. For example, CPC+ has explicit requirements for participating practices to integrate behavioral health services, selecting from one of two different care delivery options: *Care Management for Mental Illness* or *Primary Care Behaviorist* (see [Care Delivery Models](#) for more details).¹⁰⁸

✓ How do you measure and reward performance related to integration?

States may create financial incentives for health plans as well as providers that meet certain integration benchmarks and milestones, such as behavioral health services constituting a certain percentage of total claims for a primary care practice or demonstrating capacity to exchange information across providers through an electronic health record system. States might also require health plans to report on integrated care progress, similar to how **New Hampshire** requires its MCOs to report on continued progression of integration efforts for all contracted primary and behavioral health providers. States may also choose to assume some centralized responsibility for measuring and rewarding performance related to integration. For example, **Washington State** conducts an annual survey of providers related to value-based purchasing that includes questions about integration activities.¹⁰⁹ States can also rely on national accreditation bodies to help identify practices that have demonstrated the ability to provide integrated care, such as via the National Committee of Quality Assurance's PCMH Distinction in Behavioral Health Integration.¹¹⁰

✓ To what extent will you encourage or require MCO collaboration on behavioral health integration activities?

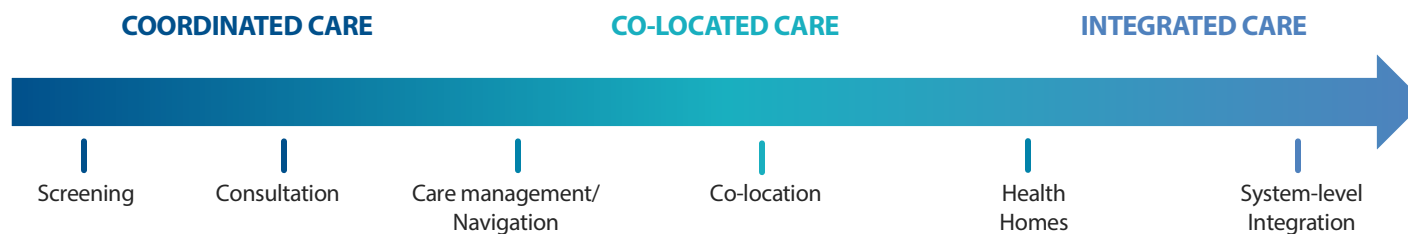
States operating in a Medicaid managed care environment may want to consider standardizing certain aspects of their integration efforts in order to reduce burden on providers and create seamless access to integrated care from the beneficiary's perspective. For example, **Pennsylvania's** Telephonic Psychiatric Consultation Service Program increases the

availability of peer-to-peer child psychiatry consultation teams to PCPs and other prescribers of psychotropic medications for children. The state's MCOs are required to contract with a telephonic psychiatric consultation team that provides real-time telephonic consultative services to PCPs and prescribers.¹¹¹ Pennsylvania required the physical and behavioral health MCOs to work together to collaboratively choose one psychiatric consultation team for each region. States might require MCOs to work together in a similar way to help fund or otherwise provide shared supports for smaller primary care practices that are not independently able to undertake more sophisticated integration activities.¹¹²

Care Delivery Models

For states contemplating how to incent integration of behavioral health in primary care via Medicaid managed care, knowledge of existing care models serves to provide examples of off-the-shelf approaches so that states, health plans, and providers do not have to “start from scratch” in developing approaches. Below is a list of selected behavioral health integration models, roughly organized along the SAMHSA-HRSA Continuum of Physical and Behavioral Health Integration (**Exhibit 5**):

Exhibit 5. Continuum of Physical and Behavioral Health Care Integration¹¹³



Care Delivery Model Examples

Screening

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. SBIRT enables PCPs to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues. States may cover SBIRT services as a Medicaid State Plan service.¹¹⁴

Consultation

- **Massachusetts Child Psychiatry Access Project** provides quick access to psychiatric consultation and facilitates referrals for accessing ongoing behavioral health care.¹¹⁵ It encourages and supports PCPs integrating behavioral health resources into their practices. Many states have implemented similar programs.¹¹⁶
- **Project ECHO**¹¹⁷ is a telehealth mentoring model that enhances workforce capacity in underserved areas by providing community-based primary care teams with the evidence-based knowledge to manage patients with complex conditions.

The Extension for Community Healthcare Outcomes (ECHO) model provides an opportunity to promote expansion of access to treatment for a broad range of mental health and substance use disorders, particularly in underserved areas.^{118,119}

- **Vermont's Hub and Spoke Model** is used to expand access to medication assisted treatment for substance use disorders.¹²⁰ Under the model, nine regional opioid treatment facility "hubs" offer daily support for complex addictions, while 75 "spokes" or primary care practices offer ongoing opioid use disorder treatment.

Navigation

- **Collaborative Care Model (CoCM)**,¹²¹ considered an advanced form of coordinated care, is an evidence-based approach for integrating physical and behavioral health services within PCMH or other primary-care settings.¹²² It enhances routine primary care by adding two key services: (1) care management support for patients receiving behavioral health treatment; and (2) regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.¹²³ CoCM is recognized as effective in treating a wide range of behavioral health disorders, including depression, anxiety, and SUD.
- **Care Management for Mental Illness** is one of the foundation behavioral health integration strategies under Comprehensive Primary Care Plus (CPC+). Selected CPC+ practices must develop capabilities using at least one foundational strategy. This strategy includes offering proactive, relationship-based care management, with specific attention to care management of the mental health condition (e.g., major depressive disorder/dysthymia, generalized anxiety disorder, and panic disorder).

Co-Location

- **Primary Care Behaviorist Model** is one of the foundational behavioral health integration strategies under CPC+. Selected CPC+ practices must develop capabilities using at least one foundational strategy. This strategy includes warm handoffs to a co-located behavioral health professional to address mental illness in the primary care setting and behavioral strategies for management of chronic general medical illnesses, and to facilitate specialty care engagement for serious mental illness.

Health Homes

- **Medicaid Health Homes**, made possible under Section 2703 of the Affordable Care Act, is designed to enhance coordination and continuity of care for Medicaid beneficiaries with complex chronic conditions across various care types and settings and to provide a "cost-effective, longitudinal 'home' to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions."¹²⁴ As noted in a Kaiser Family Foundation brief, "the comprehensive nature of health home services and the holistic approach to care place health homes further 'east' on the . . . integration continuum."¹²⁵

System-Level Integration

- **Oregon's "Fully Integrated" Patient-Centered Primary Care Home (PCPCH)**, integrated into Oregon Health Authority's broader CCO program, reaches the highest level of behavioral health integration. PCPCHs must provide integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.¹²⁶ Further, physical and behavioral health providers must also use the same medical record system and participate in collaborative treatment planning and co-management via case conferences, consults, pre-visit planning, and/or daily huddles.

State Approaches

States have a number of options to consider in determining how best to advance behavioral health integration in primary care within a Medicaid managed care environment. One option is to take a centralized approach at the state level, by, for example, stipulating behavioral health integration requirements as part of PCMH programs, and then requiring or encouraging health plans to contract with PCMH providers.

Another option is to implement requirements within Medicaid managed care contracts. States may opt to be prescriptive about what exactly behavioral health integration in primary care settings should look like (e.g., by requiring health plans to implement specific care models), or defer to Medicaid MCOs on how exactly to define, implement, fund, and monitor integration of behavioral health into primary care. States may also choose to be prescriptive about some elements (e.g., training or screening requirements) and flexible on others.

Centralized	Prescriptive	Flexible
Oregon developed a Patient-Centered Primary Care Home (PCPCH) model with tiered expectations for behavioral health integration. Oregon requires its CCOs to assist in advancing providers along the spectrum of the PCPCH model (from Tier 1 to Tier 5), and ties incentive funds to a PCPCH enrollment measure. ^{127,128}	Minnesota requires MCOs to provide SBIRT in primary care clinics, which must use a “valid and reliable” screening tool approved by the state. ¹²⁹	Washington State requires MCOs to increase screening, identification, and referral for behavioral health conditions that commonly occur in primary care settings, and to develop collaborative care models and co-location of primary care and behavioral health providers. ¹³⁰
New York developed the New York State Patient-Centered Medical Home (NYS-PCMH) which includes enhanced standards for behavioral health integration, among other areas. ¹³¹ New York also developed a program enabling PCPs who implement the Collaborative Care model (CoCM) to receive reimbursement for services provided. ¹³²	New Hampshire requires MCOs to ensure physical and behavioral health providers provide co-located or Integrated Care as defined in SAMHSA’s Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible. ¹³³	Michigan requires MCOs to provide primary care training on evidence-based behavioral health service models for PCPs, such as SBIRT, and to reimburse primary care practices for behavioral health screening services. ¹³⁴

Measurement and Payment

States have increasingly integrated behavioral health integration measures and incentives into their Medicaid programs, such as through PMCH models, VBP initiatives, and MCO incentive and withhold arrangements.

State	Description
Value-Based Payment and Other Provider Funding Arrangements for Behavioral Health Integration	
Arizona ¹³⁵	Arizona requires MCOs to enter into at least two alternative payment model contracts with integrated providers that offer physical and behavioral health clinical integration.
California ¹³⁶	California proposed four behavioral health integration measures as part of the value-based purchasing measure slated to be used by health plans with contracted providers: (1) screening for clinical depression; (2) management of depression medication; (3) screening for unhealthy alcohol use; and (4) co-location of primary care and behavioral health services. ¹³⁷
Colorado ¹³⁸	Colorado developed a primary care alternative payment model that offers enhanced rates for primary care services based on structural and performance measures. Primary care practices select 10 measures from a menu of 60+ options, including structural measures (e.g., screening and follow-up for at least three conditions, including behavioral health) and clinical measures (e.g., initiation and engagement of alcohol or other drug dependence treatment).
New York ¹³⁹	New York provides value-based monthly case-rate payments for eligible managed care beneficiaries enrolled in qualified collaborative care model programs. Enhanced PCMH payments are also distributed to providers designated as NY-PCMH through Medicaid MCOs for managed care members.
Washington State ¹⁴⁰	Building off Medicare's approach to payment for select behavioral health integration services, Washington's Medicaid program allows providers to bill for the collaborative care model, enhancing primary care by adding care management support and regular psychiatric consultation with a multidisciplinary care team. ¹⁴¹ Providers must attest they are providing care consistent with the state's guidelines.
MCO Withhold and Incentive Arrangements	
Oregon ^{142, 143}	Oregon has 19 quality measures used to determine reward payments for CCOs in 2019, including: (1) PCPCH enrollment; (2) Screening, Brief Intervention, and Referral to Treatment; and (3) depression screening and follow-up plan, with providers choosing a standardized screening tool.
North Carolina ¹⁴⁴	North Carolina has proposed measuring the percentage of individuals with a mental health disorder, substance use disorder, and intellectual/developmental disabilities who have a primary care visit.

3. Promote Health Equity

Health equity — the absence of unfair, avoidable, or remediable differences in health among social groups — can be understood as both a process and an outcome.¹⁴⁵ It is the process of sharing power among people to invest and distribute resources to those with greatest need, with the goal of creating just opportunities that result in the elimination of health disparities.¹⁴⁶ To achieve health equity, focus must be placed on communities historically excluded, exploited, and deprived of needed resources because of their race, ethnicity, language, gender identity, disability, sexual orientation, or location.¹⁴⁷

In particular, communities of color in the U.S. can have less access to primary care and worse health outcomes — inequities that often stem from structural and interpersonal racism.^{148,149} For example, Black people can have more difficulty scheduling timely primary care appointments, have fewer primary care practices in their neighborhoods, can spend more time seeking care, and are more likely to report unfair treatment and discrimination in medical settings.^{150, 151, 152, 153, 154} As a result of these inequities, life expectancy for Black people is substantially lower than that of white individuals — a gap that has widened during the COVID-19 pandemic.^{155,156}

Medicaid covers roughly one-third of Black individuals, Latinos, and American Indians and Alaskan Natives in the U.S., and 10 million people with disabilities.^{157,158} Therefore, Medicaid can serve as an important tool to advance health equity broadly, and improve primary care for marginalized communities, specifically. In the context of larger health reforms, it can help ensure that high-quality primary care is available to every person and family in all communities.¹⁵⁹

This module outlines how states can use their Medicaid managed care programs to strengthen primary care, reduce health disparities, and advance health equity. It primarily focuses on advancing equity for communities of color, and acknowledges the importance of achieving health equity for other marginalized communities, as well as the intersectionality of systems of oppression, such as ableism and sexism, that affect health and well-being.¹⁶⁰

States are in early stages of defining and working toward explicit health equity goals related to primary care and managed care, and few states have published outcomes for this work. The examples included in this toolkit are intended to serve as a starting point for states seeking to establish targeted health equity goals, with the aim of designing more advanced goals in the future.

PROMOTE HEALTH EQUITY: Design Considerations Summary

States interested in advancing health equity in primary care will want to consider opportunities to:

- ✓ Partner with communities to design a more equitable primary care system.
- ✓ Define the state's goals relating to health equity and primary care, within Medicaid and across state government.
- ✓ Monitor and enhance access to primary care.
- ✓ Promote the collection of race, ethnicity, and language data.
- ✓ Integrate health equity goals into existing and emerging primary care transformation efforts.
- ✓ Target social needs associated with health inequities.
- ✓ Address disparities in behavioral health treatment.
- ✓ Design value-based payment models to promote more comprehensive and equitable care.
- ✓ Hold managed care organizations accountable for progress toward the state's health equity and primary care goals.



Design Considerations

✓ Partner with communities to design a more equitable primary care system.

In their role as policymakers and conveners, states can best serve communities experiencing inequities by committing to the principle: “nothing about us without us.”¹⁶¹ By engaging communities and meaningfully connecting engagement work to decision-making, states can develop more effective policies, including those that advance more comprehensive and equitable primary care.¹⁶²

In approaching this work, states should seek to elevate people with lived expertise and earn trust. Because of logistic challenges and limited resources, it may be difficult for states to establish comprehensive community engagement strategies and compensate people for their contributions. States can consider alternative funding and partnership models to support this work. For example, **California**’s state Medicaid agency partners with foundations to secure additional funding for community engagement, which covers travel expenses and a per diem payment for community members.¹⁶³ Many states also call upon advocacy organizations, trusted local institutions like health centers, and accountable communities of health to inform primary care priorities.

State community engagement efforts should ideally include a variety of forums, strategies, and partners to capture community and consumer input on primary care and health equity initiatives. State Medicaid agencies can work with Medicaid members through their Medical Care Advisory Committees, and supplement this baseline requirement with other strategies, such as public forums, listening sessions, targeted workgroups, surveys, focus groups, online feedback tools, or a separate member advisory council (as in **Virginia** and **Colorado**).^{164,165,166}

For example, **Oregon** gathers community input and member perspectives at several levels. At the primary care policy level, a health care advocate participates on Oregon’s Primary Care Payment Reform Collaborative to offer a consumer perspective, and the Primary Care Office hosts a listening series to engage communities on health equity priorities relating to the behavioral health workforce and the Patient-Centered Primary Care Home (PCPCH) program.¹⁶⁷ At a broader state policy level, the Oregon Health Authority hosts public listening sessions to gather feedback on proposed equity-focused quality metrics and largescale Medicaid reform initiatives.¹⁶⁸ Through its managed care program, Oregon’s coordinated care organizations work with tribal liaisons and a tribal advisory council, and use a Community Advisory Council to set priorities for health equity and social needs investments and co-develop tools, including a community health assessment and community health improvement plan.^{169,170} At the regional level, regional health equity coalitions engage with communities to identify sustainable and long-term policy, system, and environmental solutions to increase health equity in Oregon.¹⁷¹

The Oregon Health Authority's community engagement strategies checklist helps to guide these activities, including questions such as:

1. Are community partners leading the direction of the work, or are we plugging them into our agenda?
2. Is there shared decision-making with all parties impacted?
3. Are community partners at the intersections (e.g., people of color with disabilities) who are most impacted by the topic or issue, present and fully participating?
4. Are there more accessible ways for information be conveyed (e.g., visuals, audio presentation, role-play)?¹⁷³

It is also important for states to consider how to accommodate the needs of communities in developing these engagement and partnership mechanisms. For instance, to engage non-English speaking communities, who are particularly likely to be left out of community engagement activities,¹⁷⁴ states can ensure that activities are conducted in multiple languages — as **New York** did when conducting focus groups to better understand community experiences seeking care.¹⁷⁵ Using multiple modalities and languages for engagement increases opportunities for different community members to give input and partner in decision-making processes to advance equity in primary care.

✓ **Define the state's goals relating to health equity and primary care, within Medicaid and across state government.**

To advance health equity, states should examine a wide variety of programs and structures, develop shared definitions of key terms (like "health equity" and "disparities"), and identify comprehensive short- and long-term goals and activities to move the work forward. For example, the **Pennsylvania** Department of Human Services developed a Racial Equity Report for 2021, which included not only an overview of Medicaid managed care initiatives, but also initiatives related to economic justice, early childhood education, and child welfare.¹⁷⁶

Within this broader context, states should assess existing primary care and managed care initiatives and how they can be strengthened and supported to improve care for people of color and other marginalized communities. This assessment can guide states in developing clear health equity goals related to primary care, the needs of communities, and ensuring accountability. Goals might be narrowly targeted toward specific activities or outcomes in primary care, such as improving maternal and infant outcomes for Black enrollees, or broader, like decreasing all racial/ethnic health disparities in primary

Request for Proposal Excerpts: Minnesota¹⁷²

Following is sample Minnesota managed care request for proposal (RFP) language related to health equity:

- "How does your organization address structural racism? What steps have you taken to become an antiracist organization? How do you plan to improve your systems and processes to be more antiracist?"
 - "Describe a specific initiative your organization has implemented to address racial disparities you see within populations you serve. Describe the selection of the initiative, the planning process, implementation, evaluation, and learnings from that initiative."
 - "Describe steps your organization has taken and/or will commit to taking to reduce implicit, explicit, and institutional bias experienced by Black and Indigenous people during pregnancy, delivery, and postpartum care. How are these actions monitored? How will these actions be sustained and/or adjusted in the future? How will these actions improve health outcomes and address disparities in health outcomes for Black and Indigenous people during and after pregnancy?"
 - "How has your organization approached disparities in well child visits? What have you learned from these efforts and how will you apply these learnings to future efforts? How are you connecting families to broader social supports?"
- "How does your organization use value-based purchasing or other incentive arrangements to improve racial equity in quality of care and health outcomes?"



care through improved access to high-quality, comprehensive primary care. These goals can be tracked at the state, Medicaid agency, and plan levels, and could use existing frameworks — such as quality measures embedded in MCO incentive and withhold arrangements or broader system-level measures like “the health of primary care” scorecard in a recent National Academies of Science, Engineering, and Medicine (NASEM) report.¹⁷⁷ As an example, **Oregon** set a goal to eliminate health inequities by 2030 and is exploring ways to support this goal through its PCPCH program, a diversified health care workforce, and telehealth that works better for those with limited English proficiency, among other broader strategies.^{178, 179}

States can also embed primary care health equity goals in the managed care state quality strategy, and set priorities related to targeted health disparities and populations.¹⁸⁰ For example, **Minnesota’s** quality strategy notes specific disparities in prematurity, low birth weight, and infant mortality among Black individuals and American Indians, and describes targeted goals relating to these inequities.¹⁸¹ A similar strategy could be applied to primary care goals. For example, a state might focus on access to and experience of care during well-child visits and establish objectives for managed care to reduce or close racial disparities. Recurring reports, like **Michigan’s** annual Health Equity Report, can help states consistently track progress on quality goals relating to health equity in a way that is transparent to all stakeholders.¹⁸² Using these reports to highlight metrics tied to provision of primary care — including immunization rates, well-child visit rates, and blood sugar control for diabetic patients — can reinforce a state’s primary care health equity goals.

Formal teams and offices can also empower state staff to work toward addressing these issues. In 2019, the **Louisiana** Department of Health established an Office of Community Partnerships & Health Equity and developed a Health Equity Framework and Action Plan, which authorized a series of Health Equity Action Teams (HEATs) throughout the Louisiana Department of Health.^{183, 184} The Medicaid-specific HEAT includes diverse members from multiple sections in the Medicaid agency, including the Quality Improvement and Innovations Section, which helps oversee Medicaid managed care and primary care initiatives. The state’s “barriers to health” fact sheet notes five state health priorities (maternal health, cancer, HIV, Hepatitis C, and behavioral health) and lists associated structural and social determinants of health.¹⁸⁵ To work toward these priorities, the state’s most recent RFP asks prospective MCOs to reflect on inequities relating to: low birth weight, postpartum care, colorectal and cervical cancer screening, and HIV viral load suppression, among other quality measures.¹⁸⁶

✓ **Monitor and enhance access to primary care.**

Many people, including communities of color, rural residents, and individuals with disabilities, have inequitable access to primary care, which can lead to disparities in health outcomes.¹⁸⁷ To respond to this challenge, states can monitor primary care access in Medicaid managed care programs (e.g., compliance with time and distance standards, among other quantitative network adequacy standards), with a specific focus on communities experiencing health disparities.¹⁸⁸ For example, states can use mystery or secret shopper programs, geospatial analysis, available claims data, and existing Federal Health Resources Services Administration data and tools to examine primary care access in communities of color.^{189, 190} The analysis can also occur in a variety of contexts, such as external quality review, contract monitoring and enforcement, or MCO reporting.

States can ensure that plans connect enrollees to a regular source of primary care, either through enrollee election of a primary care provider or auto-assignment, and consider ways to improve auto-assignment methodologies to direct enrollees to primary care providers that offer high-quality, equitable care.¹⁹² States can also ensure that, per federal rule, American Indian/Alaskan Native enrollees have timely access to primary care through health care programs operated by the Indian Health Service or by an American Indian Tribe, Tribal Organization, or Urban Indian Organization.¹⁹³

Once gaps are identified, states can also think holistically about opportunities to reduce disparities in primary care access. Potential options could include: Medicaid expansion, robust and responsive non-emergency medical transportation programs, and targeting enhanced payments to primary care practices in low-access areas — particularly in the aftermath of the COVID-19 pandemic.

Finally, state Medicaid agencies should communicate program needs to state legislatures. Clear communication about the needs of Medicaid programs — and the likely effect of inaction — can help states craft a cohesive approach to addressing longstanding health inequities, including primary care and behavioral health care provider shortages. For example, state legislatures can help craft cross-agency initiatives relating to workforce diversity and primary care investment, and authorize more funding for the Medicaid program to prevent or alleviate access to care obstacles.^{194, 195}

✓ **Promote the collection of race, ethnicity, and language data.**

Race, ethnicity, and language (REL) data enable states and health care organizations to identify racial and ethnic health disparities, and track progress in reducing these disparities. MCOs often collect and analyze REL data and can use this data to identify ways to improve care and reduce disparities in the context of quality and performance improvement and population health management. States can explicitly require these activities in their managed care contracts, or, like **Pennsylvania** (in its Medicaid program) and **California** (through its health insurance exchange), require that plans attain NCQA Distinction in Multicultural Health Care.¹⁹⁶

Request for Proposal Excerpts: Louisiana¹⁹¹

Following is sample Louisiana managed care request for proposal (RFP) language related to health equity:

- Describe the Proposer's organizational capacity to develop, administer, and monitor completion of training material for its staff, contractors and network providers, including if providers or Material Subcontractors are currently required to complete training topics on health equity, beyond CLAS standards.
- Describe the Proposer's demonstrated experience and capacity for engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care that exist among Enrollees.
- Describe how the Proposer will leverage data analysis and community input to address inequities in outcomes experienced by pregnant and postpartum Black Enrollees and their newborns related to pregnancy, childbirth, and the postpartum period.
- Describe how the Proposer will use feedback from enrollees and their family members to identify and execute program improvements. Include specific examples of experience that will enable the Proposer to be successful in this endeavor in LA, including but not limited to community engagement; home visiting programs; collaboration with community-based organizations, doulas, and/or community health workers; and provider training
- Specifically, which outcome measures does the Proposer propose to focus on to improve pregnancy and birth outcomes for Black populations enrolled in Louisiana Medicaid and what activities will the Proposer engage in to reduce disparities and improve outcomes for pregnant and postpartum Black Enrollees and their newborns during and after pregnancy? Please include specific actions and timelines. How does your organization use value-based purchasing or other incentive arrangements to improve racial equity in quality of care and health outcomes?



Strong data-sharing practices between MCOs and primary care teams can help reconcile REL data, standardize data collection practices, and verify data accuracy.¹⁹⁷ REL data collection may occur during multiple touchpoints, including by: (1) the state or its enrollment broker during Medicaid enrollment; (2) the MCO during health risk assessments or other contacts with members; and (3) primary care teams through patient intake. The routine contact and closer relationships between primary care teams and individuals makes primary care a natural setting in which to fill gaps and confirm accuracy of existing REL data. For example, MCOs may send REL data in member attribution files to primary care teams and provide incentives to these teams to supplement this data. Additionally, MCOs can send quarterly performance reports that include stratified performance data relating to state health equity and quality goals — such as for postpartum care or HbA1c testing quality measures.

Once REL data has been collected, states, MCOs, and primary care teams can use this data to stratify quality metrics to identify plan- or practice-specific health equity priorities. This data can also enhance practice-level quality improvement activities, such as equity-related patient-reported measures.¹⁹⁸

Finally, data limitations should not stop work relating to health equity. REL data collected at the state, plan, or provider level can be a powerful tool, but are not the only sources of data. Census-level data and qualitative data gleaned from community engagement activities can also help states identify primary care priorities for health equity and inform the design of health equity-focused interventions.¹⁹⁹

✓ **Integrate health equity goals into existing and emerging primary care transformation efforts.**

States often have patient-centered medical home programs and other primary care transformation efforts underway and can integrate explicit health equity goals into that work. For example, **Ohio** modified its longstanding comprehensive primary care program to include a specific patient experience requirement for 2021 relating to cultural competence and implicit bias training.²⁰⁰ States can also modify these programs to incorporate existing standards and certifications, like the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.²⁰¹

States can also direct MCOs to advance health equity goals through targeted primary care innovations. As an example, states could seek to scale and spread primary care models and services associated with reductions in health disparities in maternal and infant health outcomes, such as group prenatal care and community health worker models.

States can make it easier to provide these modes of care through payment and policy reform and set clear expectations for MCOs. States may consider: (1) adding relevant benefits and billing codes; (2) crafting payment models that allow for team-based, patient-centered modes of care, with a preference for multi-payer efforts whenever possible; and (3) directing MCOs to explore these models in the context of a performance improvement project (PIP), MCO incentive arrangement, value-based payment program, or network provider training. For example, **Michigan** requires its MCOs to work with primary care practices to develop evidence-based approaches to reduce disparities and to support the design and implementation of community health work interventions, which are “tailored to the needs of community members in terms of cultural and

linguistic competency and shared community residency and life experience.” Community health workers can accompany clients to, and participate in, office visits, advocate for clients with providers, and problem-solve barriers to care, among other activities.

Likewise, states could call on MCOs to adapt and codesign telehealth and digital health tools to improve primary care access for marginalized communities, embed interpreters into telehealth workflows, and connect members to low-cost internet and digital devices.^{202, 203}

For more, see the [team-based care](#), [behavioral health integration](#), and [technology](#) sections of this toolkit.

✓ Target social needs associated with health inequities.

Structural drivers of health inequity negatively impact social determinants of health for marginalized communities and produce health inequities.²⁰⁴ For example, structural racism negatively impacts Black people’s access to quality food, housing, and education, and is the root cause of social issues such as mass incarceration.^{205, 206, 207} Achieving health equity will require an examination of the social and structural drivers of health inequities, beyond broader social determinants of health.

Within this context, state Medicaid agencies can build cross-sector partnerships that seek to identify and address individual- and community-level social needs that impact health, as well as define a specific role for primary care teams and MCOs in the overall system. This process includes defining appropriate upstream, midstream, and downstream efforts related to social determinants of health, and assessing systems and structures that produce and perpetuate health inequities.²⁰⁸

States can embed social care integration activities into primary care initiatives and programs, and define how MCOs can support these goals to advance health equity and improve care.²⁰⁹ For example, **North Carolina** requires Advanced Medical Homes (AMHs) to assess the social needs of patients prioritized for care management, and develop care plans that address these social needs.²¹⁰ To support the primary care teams engaging in this work, MCOs must provide initial care needs screening results to AMHs, in addition to quality metrics and total cost of care data. MCOs then share consolidated care management data back to the state. In the future, the state will consider whether to require AMHs to screen for social needs more systematically and further encourage use of a statewide services referral system. Similarly, in the next phase of its managed care program, **Louisiana** will ask MCOs to describe, as part of its health equity plan, how they will partner with community-based organizations and reimburse network providers for screening for health-related social needs and submitting applicable diagnosis codes (“Z codes”) on claims.²¹¹

Building upon this multi-directional data sharing, states could require MCOs to provide primary care teams with actionable data on health disparities and associated social risk factors, and consider a suite of quality assessment and performance improvement strategies to close these gaps, including training, technical assistance, PIPs, and targeted investments. For example, **Oregon** expects coordinated care organizations to provide additional “health-related services” that include: (1)

flexible services, such as fresh food prescriptions for members and legal assistance for housing-related issues; and (2) community-benefit initiatives, which can include health information technology integration with social resource and referral systems in the primary care setting.²¹² And **Nevada** requires MCOs to choose two PIPs from a list of potential topics, including “social determinants of health and health equity” and “increased access and use to primary care,” in addition to a statewide PIP on Black maternal and infant mortality.²¹³

In addition, states can create structures that coordinate statewide and regional health planning efforts across health care and other organizations, in partnership with communities. These activities can be done broadly for the Medicaid population, but can also be tailored for the needs of specific populations experiencing health inequities, such as people involved in the justice system or Black people who are pregnant. For example, **Pennsylvania’s** Regional Accountable Health Councils collaborate on regional social determinants of health needs assessments and identify high-priority geographic areas impacted by disparities.²¹⁴ Council members include MCOs and health centers that provide primary care, in addition to trusted community institutions.

For more on identifying and addressing health-related social needs, see the [Identify and Address Social Needs](#) section of this toolkit.

✓ **Address disparities in behavioral health treatment.**

Behavioral health care — including mental health and substance use — is an integral component of overall health. Structural factors, such as differential insurance status, stigma surrounding mental illness, and a lack of diverse and culturally competent behavioral health care providers drive health disparities in access to behavioral health care for many communities, including for people of color.²¹⁵ The need for high-quality behavioral health treatment has only increased in the wake of the COVID-19 pandemic, which has led to widespread experiences of depression, toxic stress, and trauma.²¹⁶

Primary care teams and their MCO partners can work to address mental health disparities by tailoring behavioral health integration efforts to specific communities and patients, such as people with disabilities, Black individuals, Latinos, or LGBTQ+ youth experiencing homelessness.^{217,218,219,220} States may consider how to increase capacity and diversity in the behavioral health care workforce by identifying how to cover services from providers such as peer navigators,²²¹ who can use community connections and shared lived experience to promote health equity.²²² Trauma-informed primary care can further serve the behavioral health needs of populations who experience higher rates of trauma and the resulting negative impacts on mental and physical health.²²³

For more on integrating behavioral health and primary care, see the [Integrate Behavioral Health Care](#) section of this toolkit.

✓ **Design value-based payment models to promote more comprehensive and equitable care.**

As noted in a recent NASEM report, payers should seek to “pay for primary care teams to care for people, not doctors to deliver services.” This change in focus recognizes primary care’s impact on “measures of population health, equitable outcomes, changing mortality and chronic disease prevalence trends, and overall increased health and well-being.”²²⁴

To work toward this goal, state Medicaid agencies can design prospective and hybrid payment models that support comprehensive primary care and targeted health equity initiatives, as in **Washington State**.²²⁵ These new payment models can promote financial stability and flexibility, and can enable more advanced primary care delivery, such as screening for and addressing health-related social needs, increasing access to care through use of technology, providing team-based care, and integrating behavioral health care into primary care.²²⁶

States can also consider how to create new or modify existing primary care value-based payment models to explicitly incorporate health equity goals and monitor unintended effects of these models.²²⁷ Value-based payment models that are not intentionally designed to promote health equity can mask existing or growing health disparities in the patient population by averaging indicators and exacerbate disparities by penalizing providers who serve members with more complex needs. This risk is a particularly salient concern for primary care providers who serve underserved communities or patients with a diverse set of health needs. For example, **Minnesota** requires their integrated health partnerships to develop a health equity measure and considers performance on these measures when calculating the performance-based payments.²²⁸

States can also use value-based payment to support health centers, which have a long history of delivering culturally competent, comprehensive primary care and supportive services like translation.²²⁹ For example, Medicaid MCOs, like the Community Health Plan of Washington, have explored alternative payment model pilots that seek to support whole person care at federally qualified health centers and reward health centers for taking on health equity goals.²³⁰ Several states, including **Colorado**, **Oregon**, and **Washington State**, have also created state-led advanced payment models for health centers, which encourage investment in quality improvement and population health management strategies that could include health equity goals.²³¹

Primary care payment models sometimes experience a “chicken-egg conundrum,” where practices require flexible and enhanced financial support to enable care transformation, but cannot access that flexible funding without first demonstrating advanced capabilities.²³² To address these challenges, states may consider providing enhanced payments to primary care providers to begin care delivery transformation with a health equity focus, and enable multi-payer efforts to provide new, predictable, and sustainable revenue, tied to streamlined reporting requirements. This approach mirrors that of the Advanced Payment Accountable Care Organization model, which provided upfront payments for practice transformation and strengthened capacity to analyze population-level data used to analyze disparities in care.²³³ For example, **North Carolina**’s Health Equity Enhanced Payment Initiative offers an enhanced payment to primary care

practices serving individuals from parts of the state with high poverty rates. Participating practices commit to an initiative that advances health equity, such as recruitment of community health workers, health coaches, and doulas.²³⁴

✓ **Hold MCOs accountable for progress toward the state's health equity and primary care goals.**

Finally, states should hold MCOs accountable for progress toward the state's goals related to primary care and health equity. For example, states can embed disparity-related measures, goals, and activities into MCO incentive and withhold arrangements, and quality-based auto-assignment methodologies. **Michigan's** 2021 bonus program rewards statistically significant improvement in disparities for Black individuals and Latinos relating to several primary-care related measures, including access to preventive/ambulatory health services.²³⁵ This bonus program is in addition to a longstanding bonus program dedicated to strategies to address disparities in low birth weight,²³⁶ as well as a robust monitoring program that examines stratified quality measures by region and race, ethnicity, and language and reports progress in an annual Health Equity Report.²³⁷

For more information on MCO accountability, see the [Promote Accountability Mechanisms for Managed Care Organizations](#) module of this toolkit.

Promoting Health Equity through Primary Care: Examples of Medicaid Managed Care Requirements

Network Management and Training

The **District of Columbia** requires all managed care programs to have equal access to the District's major physician groups.²³⁸

California MCOs (according to the state's draft RFP) "must provide annual sensitivity, diversity, cultural competency and Health Equity training for its staff, Network Providers, and Subcontractors. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, and Subcontractors. Contractor must ensure Network Providers and Allied Health Personnel receive pertinent information regarding the [Population Needs Assessment] findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements:

- (1) Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and
- (2) Information about the Health Inequities and identified cultural groups in Contractor's Service Area which includes but is not limited to: the groups' beliefs about illness and health; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs."²³⁹

Required MCO Staff

In **Ohio**, MCOs must staff a Family Engagement Director and Youth Engagement Director, who are responsible for obtaining input from populations experiencing disparities in access to care and building practices that promote racial equity.²⁴⁰

Oklahoma MCOs must "maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Health Plan Enrollees and from Providers of direct services which are intended to reduce adverse health outcomes among Health Plan Enrollees, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts."²⁴¹

In its most recent RFPs, **California** (a draft version) and **Louisiana** plan to require MCOs to maintain a full-time Health Equity officer/administrator.^{242, 243}

Quality Assessment and Performance Improvement

Nevada requires MCOs to participate in a statewide PIP focusing on reduction in maternal and infant morbidity and mortality among Black individuals. MCO quality improvement teams must include staff with expertise in health equity.²⁴⁴

Washington State MCOs must "collaborate with peer MCOs and the [Department of Health] to form a Health Care Disparities Workgroup aimed at reducing disparities in one performance measure. The Health Care Disparities Workgroup shall consult with community experts and organizations as appropriate to disaggregate data on at least one performance measure and examine the data for racial/ethnic disparities. The Workgroup shall implement interventions aimed at reducing health care disparities in the selected measure."²⁴⁵

Population Health Management

Hawaii health plans must use “sophisticated IT infrastructure and data analytics to support DHS’ vision and goals for quality improvement, measurement and evaluation, including the capability to identify sub-populations by age, race, ethnicity, primary language, special populations, or other demographics experiencing disparities. The Health Plan shall also use predictive analytics to identify populations at risk for poor health outcomes and high cost, stratify and report metrics at the state and regional or service area level, and by sub-population, and be able to report data at the patient or provider level to DHS as required.”²⁴⁶

Utilization Management

Washington State MCOs must “have written policies for applying [Utilization Management Program] decision-making criteria based on individual Enrollee needs, such as age, comorbidities, complications and psychosocial and home environment characteristics, where applicable; the greater and particular needs of diverse populations, as reflected in Health Disparities, risk factors (such as [Adverse Childhood Events] for Enrollees of any age), Historical Trauma, and the need for Culturally Appropriate Care; and the availability of services in the local delivery system.”²⁴⁷

Value-Based Payment

Ohio includes a bonus payment for its Comprehensive Primary Care (CPC) for Kids program tied to foster care supports, school linkages, lead testing, and screening for adverse childhood experiences and health-related social needs. Each provider’s score is risk adjusted using data from the Ohio Opportunity Index, which includes domains like transportation, housing, and crime. The state requires MCOs to pay providers using state-defined criteria. In Fiscal Year 2021, Ohio requires CPC practices to conduct a cultural competency and implicit bias training.²⁴⁸

MCO Accountability

Oregon has developed a specific quality measure in its quality incentive program, entitled “Meaningful Access to Health Care Services for persons with limited English proficiency.”²⁴⁹

Rhode Island’s accountable entity and MCO incentive pool includes the following pay-for-reporting measure: “Percentage of AE attributed lives with a primary care visit for whom their attributed primary care provider possesses their race, ethnicity and language data.”²⁵⁰

4. Enhance Team-Based Care

Team-based care is a key aspect of providing high-quality, coordinated, and comprehensive primary care. In addition to clinical staff, primary care practices often incorporate non-clinical staff into care teams to support functions such as patient education, care management and coordination, and resource navigation. Innovative team-based care models often focus on employing staff with diverse expertise and backgrounds who can collaborate to work at the top of their licenses and provide high-quality care that meets their patients' needs.^{251,252,253} States may support team-based care through managed care in a variety of ways, such as encouraging, requiring, or incenting:

- Integration of specific types of staff — such as community health workers (CHWs), peer providers, pharmacists — into care teams;
- Implementation of primary care practice supports (e.g., community health teams); and
- Adoption of care delivery models that emphasize team-based care, such as PCMHs and multi-disciplinary care management.

States, MCOs, and primary care practices can develop team-based care approaches. MCOs in particular can integrate team-based care into their care coordination approaches, in addition to supporting team-based care through training opportunities and provider payment models.

This module outlines design considerations, provides examples of state approaches, and explores payment and measurement strategies for states and MCOs seeking opportunities to advance team-based care.

ENHANCE TEAM-BASED CARE: Design Considerations Summary

Explore flexible versus prescriptive approaches.

- ✓ Which existing care models could be used to help advance team-based care?
- ✓ How can the state align team-based care strategies or requirements with other state programs or priorities?
- ✓ Will the state require implementation of specific care delivery models supporting team-based care (including use of CHWs) or leave more flexibility for MCOs to develop customized approaches?
- ✓ Will the state align Medicaid requirements with existing CHW programs or standards?

Define the roles/responsibilities of the state, primary care teams, and MCOs.

- ✓ What aspects of a team-based care strategy can be implemented by MCOs versus PCPs?
- ✓ Do primary care practices have capacity to implement team-based care?
- ✓ How much administrative capacity does the state have to develop and oversee customized programs?

Determine how to measure, monitor, and reward progress.

- ✓ How can MCOs be held accountable for implementing team-based care strategies?
- ✓ How will the state ensure that MCOs enhance — and not detract from — local CHW programs?

Leverage payment reform to drive innovation.

- ✓ How can providers be compensated for team-based care (recognizing that providers may need higher rates or new reimbursement pathways to fund team-based care activities)?
- ✓ How will the state or MCOs fund CHWs?
- ✓ Should the state or MCOs define provider payment rates for team-based care?

Determine the need for additional investments.

- ✓ What additional funding may be needed to ensure adequate reimbursement for new activities, staffing, or infrastructure deployed by the state, MCOs, and/or providers?
- ✓ Will the state or MCOs need to develop new infrastructure to support team-based care in small or rural practices?



Design Considerations

Advancing Team-Based Care

✓ What aspects of a team-based care strategy can be implemented by MCOs versus PCPs?

Some care delivery models, such as PCMHs, are designed to be implemented at the primary care practice level. Other team-based care strategies, such as implementation of multi-disciplinary care management or use of CHWs, can be implemented at the primary care practice or MCO level. For example, MCOs can directly employ CHWs, or contract with organizations employing CHWs to support functions such as care management and coordination. In other cases, CHWs can be employed by provider organizations and more fully integrated into care teams. Additionally, while MCOs have traditionally implemented care management services themselves, often telephonically, some states allow MCOs to delegate care management to primary care practices.²⁵⁷ States may also consider requiring MCOs to support care management through community-based health teams.

✓ What role should MCOs play in defining team-based care models?

In establishing team-based care through managed care, states can require MCOs to implement, or support primary care practices in implementing specific care models, such as a state-defined community health team model or the National Committee for Quality Assurance (NCQA) PCMH model.²⁵⁸ Alternatively, states can set more general guidelines for team-based care, allowing individual MCOs more flexibility to customize programs.

A more prescriptive approach allows states to be more directive in how their goals are met and more standardization may reduce provider burden. Additionally, if there is a strong evidence-base for a particular model, implementing a prescriptive approach may be most effective. On the other hand, a more flexible approach may allow MCOs and primary care practices to develop innovative models and meet the specific needs of their patient populations.



Managed Care Procurement

Following is sample state managed care request for proposal language related to team-based care and community supports:

Hawaii (RFI). “MQD is exploring the development of Community Care Teams (CCTs) in collaboration with QI health plans that would provide a narrow set of supports for small and rural PCPs who treat HNHC Medicaid beneficiaries where the patients are located. Examples of services could include triage and referral, linkages to health-related social services, and outreach to populations that are difficult to reach.

23. What opportunities and considerations should MQD be aware of when considering CCTs? What services should CCTs provide and which populations should they target? What types of professionals should staff the teams?

24. What policies and best practices should the state consider in terms of delegation of care management responsibilities to CCTs?”²⁵⁴

Virginia (RFP). “In response to this RFP, Offerors shall describe the impacts of the social determinants of health within the five key domains as they relate to health risks, health outcomes, and quality of life. Offerors also shall describe its efforts to address the social determinants of health in the five key domains above.

Offeror’s response shall include, but is not limited to, the following elements…:

10. How has your organization engaged community health workers or other types of workers to improve care?”²⁵⁵

Minnesota (RFP). “Describe how the Responder uses non-traditional healthcare services (such as doulas, community EMTs, Community Paramedics, community health workers, etc.) to provide culturally competent care and/or improve health outcomes.”²⁵⁶



✓ **Do primary care practices have capacity to implement team-based care?**

Factors such as size, system affiliation, and geography of primary care practices may impact practice capacity to implement team-based care. For example, practices affiliated with large systems may have health system support for care management or PCMH implementation. States with more of these large-health system affiliated provider practices could consider incenting specific care delivery standards.

✓ **How will the state's approach accommodate small or rural practices?**

Small or rural practices may not have sufficient volume to support a multi-disciplinary team on their own. To support small independent or rural practices, states may consider building state or MCO infrastructure that can support and extend individual practice capabilities. For example, states may consider implementing local community care teams to support primary care practices in delivering PCMH functions such as care coordination or population health management.²⁶¹ States can also incentivize MCOs to employ or financially support CHWs or other types of staff to support primary care practices.

✓ **How much administrative capacity does the state have?**

More customized policies and programs to promote team-based care, such as state-defined PCMH standards or staff training/certification requirements (e.g., for CHWs) may require more state resources to design, implement, and oversee than adopting existing models or allowing MCOs flexibility. States may consider allowing MCOs flexibility in team-based care requirements or leveraging external models (e.g., CPC+ model standards, NQCA PCMH model, Individualized Management for Patient-Centered Targets (IMPACT) model for CHWs) if they do not have the resources to design or administer such programs.

Managed Care Contract Excerpts

Following is sample state managed care contract language related to team-based care and community supports:

Michigan. "Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by CBOs which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience..."²⁵⁹

Louisiana. "In addition to the case manager and the enrollee and their family or authorized representative, the care team shall include members based on an enrollee's specific care needs and goals identified in the individual care plan. The team may change over time as the enrollee's care needs change. Potential team members shall include, but are not limited to:

- Primary care provider;
- Behavioral health provider(s);
- Specialist(s);
- Pharmacist(s);
- Community health worker(s);
- Peer specialist(s);
- Housing specialist, if the enrollee is identified as homeless; and
- State staff, including transition coordinators."²⁶⁰

✓ **How can states align team-based care strategies with other state priorities?**

Advancing team-based care is often a key aspect of other state primary care priorities such as behavioral health integration, addressing health-related social needs, and improving care for patients with chronic conditions. A key way states can improve quality for certain services or populations is better integrating staff with expertise in these domains into care teams. As such, these broader policy goals may have implications for the types of staff or models that states choose to incent through MCO contracts. For example, peer providers can support patients in self-management of behavioral health conditions.²⁶² CHWs or other resource navigator roles can support referrals and coordination with community resources that can assist in addressing health-related social needs.²⁶³ Expanding the role of or better integrating pharmacists or pharmacy technicians into care teams can support better medication management for populations with chronic care needs.²⁶⁴

✓ **How can providers be compensated for team-based care?**

Providers may need higher rates or new reimbursement pathways to fund specific team-based care strategies. For examples, some states have chosen to reimburse practices recognized as PCMHs with higher FFS rates or additional PMPM payments. Others have developed new billing codes for specific payment models, such as the Collaborative Care Model or for new types of staff such as CHWs.^{265,266}

✓ **Should the state or MCOs define provider payment rates for team-based care?**

In some cases, states define specific FFS or PMPM rates for team-based care activities.²⁶⁷ In other cases, states may require MCOs to compensate providers for team-based care models, but not define specific rates.²⁶⁸ For example, states may consider defining standardized provider rates for specific models that will be implemented across different providers and MCOs. Alternatively, it may be appropriate for MCOs to have flexibility in determining rates for team-based care activities when they have the flexibility to implement more customized models.

In cases where states give MCOs responsibility for developing payment rates, states may provide guidance on the factors MCOs should consider in determining provider payment. For example, states may direct MCOs to base rates on factors such as patient population demographics, clinical complexity, cost, and care model.^{269,270}

Care Delivery Model Examples

Community Health Teams: Community health teams (CHTs), also known as Community Care Teams (CCTs) or care networks, are geographically assigned care coordination teams that manage patients' chronic conditions across different providers or health and social service systems, as opposed to being directly embedded in a practice. CHTs differ from other disease or care management models in their emphasis on in-person contact with patients and facilitating coordination with community resources. CHTs generally coordinate with primary care providers, and for small practices or rural providers, may provide functions such as care coordination or population health management. While specific staffing models are defined and vary by states, CCTs can potentially facilitate integration of new specialties (such as behavioral health or pharmacy) or non-clinical service providers (such as CHWs) into primary care.

Patient Centered Medical Homes: PCMHs and other care delivery models aimed at improving quality of care may incent or have specific requirements to utilize use multi-disciplinary care teams. For example, many states, as well as private accreditation organizations, have developed PCMH certification standards that encourage or require team-based care. For examples of how states are leveraging PCMH programs to promote advanced primary care, see [*Three State Approaches to Patient-Centered Medical Homes*](#).

✓ **How can MCOs be held accountable for implementing team-based care strategies?**

A common strategy for holding MCOs accountable for team-based care initiatives is through setting targets for member enrollment in PCMHs or members served by CHWs. States may tie these targets to MCO payment through withhold or incentive arrangements. Another strategy is incorporating team-based care elements into MCO care management requirements, such as encouraging use of multi-disciplinary care teams to support member needs.²⁷¹ States may also consider implementing team-based care requirements within performance improvement projects, VBP initiatives, or § 1115 demonstration projects or pilot programs.

Integrating CHWs into Care Teams

✓ **Will the state define goals for the use and uptake of CHWs?**

The specific definition and role of CHWs varies across states and organizations. A key aspect that may distinguish CHWs from other roles is that they are often hired, in part, based on their lived experience and connections to local communities.²⁷³ Common CHW roles include:

- Providing direct patient services such as health education, screenings, and self-management support;
- Providing health care and social service navigation and coordination;
- Advocating for individual and community needs; and
- Enhancing communication, understanding, and collaboration between individuals and communities, health, and social service systems.²⁷⁴

States may be prescriptive in defining the use of CHWs in managed care contracts. For example, the state may: (1) require CHW to enrollee ratios; (2) define the scope of CHW services; (3) define CHW training requirements; or (4) require pilot implementation of a particular type of CHW model, such as the ImPaCT model.^{275,276}

Alternatively, the state may leave more flexibility for MCOs to develop customized approaches. For example, states may craft a managed care request for proposals that asks respondents to present their approaches to integrating CHWs into their care management processes and into their provider networks, or design a contract requirement that allows MCOs to implement a community-based care management program that includes community health workers.

Who Are Community Health Workers?

CHWs are public health workers with close ties to local communities that serve to facilitate culturally competent care and build connections between health systems and community resources.²⁷² State are increasingly recognizing integration of CHWs into care teams as a key strategy in delivering high-quality, community-based care for Medicaid beneficiaries.



✓ **How will the state or MCOs fund CHWs?**

States may integrate CHW services into state plan benefits as either a standalone service (e.g., health education) or a component of another service, such as health homes. If CHWs are integrated into a state plan service, costs associated with CHWs can be included in managed care rate-setting processes as a portion of the medical premium. For example, **Minnesota** Medicaid reimburses for diagnosis-related health education services provided by CHWs who: (1) hold a CHW certificate from a school offering a standardized curriculum; and (2) are supervised by a variety of provider types such as physicians, dentists, public health nurses, and/or mental health professionals.²⁷⁷

States may also direct MCOs to use CHWs in the context of their contractual responsibilities to coordinate and manage care — for example, to coordinate medical services with services received from community and social support providers. States may consider whether the administrative or non-benefit portion of the MCO capitation rate is adequate to support these functions, and may clarify that CHW expenditures can be included in the numerator of the medical loss ratio (MLR) as an activity that improves health care quality.

To the extent that CHWs are not integrated into state plan benefits, states may also clarify that the MCO can voluntarily provide CHW services as a value-added service and also report that expenditure in the numerator of the MLR. Although value-added services cannot be used in the development of the capitation rate, inclusion in the numerator of the MLR may offset disincentives associated with MCO investment in this area.

✓ **Will the state align Medicaid requirements with existing CHW programs or standards?**

Some states, or state CHW associations, have developed frameworks, training curricula, or certification standards to support standardization of the CHW profession and ensure CHWs are proficient in core capabilities.²⁷⁸ States may choose to align CHW requirements or definitions with those certification standards, or defer to MCOs and their community-based partners to define appropriate standards for their staff.

✓ **How will the state ensure that MCOs enhance — and not detract from — local CHW programs?**

A potential consequence of MCO CHW targets or other utilization/integration requirements is that MCOs may hire CHWs away from providers or CBOs. To avoid disrupting local care delivery efforts, states may consider engaging with stakeholders or asking question on RFIs/RFPs to assess whether MCOs, CBOs, and providers are currently integrating CHWs into care teams. States could also consider encouraging their MCOs to use a “buy, not build” approach to support CBO or provider team-based care capacity, rather than hiring CHWs themselves. Finally, states may consider piloting new CHW programs in a specific locality before implementing new approaches statewide to limit disruptions.

State Approaches

States may take various approaches to supporting team-based care in Medicaid programs. Some approaches support team-based care more generally, while others support the addition of specific types of staff, such as CHWs, to care teams.

State	Description
Louisiana	Louisiana Medicaid and the Center for Healthcare Value and Equity at the Louisiana State University Health Sciences Center plan to pilot a CHW demonstration project, based on the IMPaCT model, serving high-risk Medicaid members in a target region in Louisiana. The goal for the pilot is to align MCO CHW use with evidence-based practice and build capacity to efficiently scale CHW programs across managed care. ²⁷⁹
Pennsylvania	Pennsylvania's Medicaid PCMH program includes a requirement that practices deploy a community-based care management team that consists of licensed professionals (e.g., nurses, pharmacists, or social workers) and unlicensed professionals (e.g., peer recovery specialists, peer specialists, CHWs, or medical assistants). The team collaborates with providers and MCOs to support individuals with complex care needs, develop care plans, and connect individuals to community resources. ²⁸⁰
Vermont	<p>Vermont has implemented CHTs to support PCMH capacity and link patients with community services. While Vermont has not implemented Medicaid managed care, aspects of this model and the state's contract with its all-payer ACO (OneCare) could be adapted to a managed care environment:</p> <ul style="list-style-type: none"> ■ Specific aspects of CHTs, including staffing, service configuration, and location (embedded within practices vs. offsite) are locally defined based on community needs.²⁸¹ ■ Medicare, Medicaid, and private payers share the costs of CHTs through PMPM payments; there is no cost to PCMHs or patients for CHT services.²⁸² ■ Vermont requires OneCare to use a portion of prepaid shared savings funds to support community health teams, in accordance with state guidelines.²⁸³

Measurement and Payment

Approaches for measuring and tracking team-based care implementation include CHW staffing, utilization targets, and targets for percent of members assigned to PCMHs. States may also incent provider adoption of team-based care models or CHWs through new payment mechanisms or increased rates.

State	Requirements
Provider Payment Requirement Examples	
New York ^{284,285}	The New York State Department of Health, in collaboration with NCQA, developed the New York State Patient-Centered Medical Home that is based on the NCQA PCMH model. Participating practices are eligible for enhanced reimbursement under the Medicaid PCMH Incentive Program, either through a Medicaid managed care PMPM payment or a FFS add-on for qualified evaluation and management codes.
Oregon ²⁸⁶	Oregon’s CCOs will be required to provide PMPM payments to the state’s Patient-Centered Primary Care Home (PCPCH) clinics, as a supplement to any other payments, in order to support development of infrastructure and operations for PCPCHs. PMPM rates must be set so that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs.
Pennsylvania ²⁸⁷	Physical health MCOs make monthly payments to PCMHs based on factors such as “clinical complexity, age, medical costs, and composition of the care management team” and reward PCMHs with quality-based enhanced payments.

State	Description	Tie to Payment
Patient Centered Medical Home Enrollment Target Examples		
New Mexico ²⁸⁸	<p>Legacy contractors must demonstrate:</p> <ul style="list-style-type: none"> ■ A minimum of a 5% increase of the contractor's members assigned to a PCP within a PCMH; or ■ Maintain a minimum of 50% of membership being served by PCMHs. <p>Non-legacy contractors must demonstrate:</p> <ul style="list-style-type: none"> ■ A minimum of 10% of the contractor's total membership assigned to a PCP within a PCMH. 	For the performance target program, 20 out of a total of 100 points are based on NM's MCO targets for contracting with providers meeting state PCMH requirements.
Oregon ^{289,290}	PCPCH enrollment is one of Oregon's 19 CCO quality measures used to determine CCO reward payments out of 'quality pool' funds. The PCPCH enrollment measure is based on percentage of membership enrolled in a PCPCH, with higher tier PCPCHs weighted more heavily (Oregon PCPCHs can be recognized at five different levels).	The quality pool is at least 2% of aggregate CCO payments made to all CCOs.
Pennsylvania ²⁹¹	<p>Physical health MCOs must contract with high-volume providers in their network who meet state PCMH requirements. For calendar year 2019:</p> <ul style="list-style-type: none"> ■ "PCMHs' must serve at least 20% of their total membership and at least 33% of members that fall within the top 5th percentile of medical costs." 	N/A
Rhode Island ²⁹²	<p>Rhode Island tracks:</p> <ul style="list-style-type: none"> ■ "percentage of members assigned to a primary care practice that functions as a patient centered medical home" as recognized by the state. <p>These PCMH assignment targets increase from 45% to 60% over the course of the contract period.</p>	Rhode Island ties a portion of its .5% withhold arrangement to the PCMH target.

State	Description	Tie to Payment
Community Health Worker Target Examples		
Louisiana ²⁹³	Louisiana requires that MCOs support the design and implementation of a CHW program, including maintaining a CHW caseload ratio of at least one full-time CHW per 100 enrollees enrolled in a CHW program.	N/A
New Mexico ²⁹⁴	“A minimum of three percent (3%) of the Contractor’s total enrollment shall be served by Community Health Workers (CHWs) who are either employed or contracted with the Contractor and/or Community Health Representatives (CHRs) through a shared functions model of care coordination delegation arrangement with Tribal providers.”	MCOs are subject to a 1.5% performance penalty on capitation rates tied to Delivery System Improvement Performance Targets. 20 out of a total of 100 performance target points are based on New Mexico’s CHW target.
Michigan ²⁹⁵	Michigan requires that MCOs support the design and implementation of CHW interventions delivered by CBOs, including maintaining a CHW to enrollee ratio of at least one full-time CHW per 15,000 enrollees.	N/A

5. Use Technology to Improve Access

Technology can enhance the capacity of PCPs to address a wider range of needs, such as behavioral health issues. “Telehealth” refers broadly to electronic and telecommunication technologies and services that support remote care delivery. It can be divided into two broad categories: provider-to-provider platforms and direct-to-consumer platforms. Reimbursement and regulation of telehealth in Medicaid vary from state to state. Almost all states (49 and D.C.) reimburse for live video services, but fewer reimburse for remote patient monitoring.²⁹⁶

Telementoring programs also have the potential to enhance primary care capacity and increase access to services. For example, Project ECHO is a provider-to-provider model that connects expert specialist teams to primary care clinicians via weekly videoconferences to help them treat patients with complex health needs, especially in rural and underserved communities.²⁹⁷ Through telementoring and guided practice, participating providers develop the competencies needed to effectively manage their complex patients independently and in their communities. Unlike teleconsultations, the goal of Project ECHO is to expand the capacity of PCPs to independently manage their patients with complex health care needs. A 2011 study found that patients receiving care from primary care providers who participated in ECHO received care that was either comparable or, in some circumstances, better than those who received care from specialists at the University of New Mexico Health Sciences Center.²⁹⁸

Similarly, telepsychiatry peer-to-peer models create opportunities for consultation between PCPs and psychiatric specialist providers to enhance primary care capacity. This type of model may be aimed at particular populations, such as children and new mothers as in the **Massachusetts** Child Psychiatry Access Program, or children prescribed psychotropic medications in the **Pennsylvania** Telephonic Psychiatric Consultation Service Program (TiPS). In one study, specialty-related eConsults at a Community Health Center in **Connecticut** resulted in costs of \$82 per patient per month less than for face-to-face visits for a Medicaid population.²⁹⁹

This module outlines design considerations, provides examples of state approaches, and sample procurement and contract language for states seeking to support telehealth services within Medicaid managed care programs.

USE TECHNOLOGY TO IMPROVE ACCESS: Design Considerations Summary

Explore flexible versus prescriptive approaches.

- ✓ Will the state encourage telehealth activities generally, or require buy-in to a particular centralized model?

Define the roles/responsibilities of the state, primary care teams, and MCOs.

- ✓ How will the state identify and address barriers to the uptake of telehealth or telemedicine services in their Medicaid managed care contract?

Determine how to measure, monitor, and reward progress.

- ✓ Will the state include measures relating to telemedicine or telehealth?

Leverage payment reform to drive innovation.

- ✓ How can VBP arrangements include telemedicine or telehealth services?

Determine the need for additional investments.

- ✓ How can the state and MCOs invest in common telehealth infrastructure and programs to support PCPs?





Design Considerations

✓ Will the state encourage telehealth activities generally, or require buy-in to a particular centralized model?

Some states may choose to promote use of technology among MCOs and providers more generally, or to encourage or require a specific approach to meet particular needs they have identified in their state. For example, physical health MCOs in

Pennsylvania must work with all other physical health and behavioral health MCOs in a health care region to collaboratively choose one psychiatric consultation team. This requirement sustains earlier efforts by MCOs to develop a centralized TiPS program. While this centralized approach allows for less variation at the community-level, the broad availability of the program, no matter the specific affiliation with a plan, may increase uptake of the service.

✓ How will the state identify and address barriers to the uptake of telehealth or telemedicine services?

States may consider identifying and addressing barriers to telehealth uptake. Common barriers include access to technology and broadband, licensure, privacy concerns, and state law and reimbursement policies.³⁰³ In Medicaid reimbursement, a common restriction is on the “originating site,” or where a patient is located. Many policies exclude a patient’s home as an originating site, but 13 states explicitly allow and reimburse service to a patient’s home.³⁰⁴ However, less restrictive policies alone may not incentivize the uptake of telehealth services.³⁰⁵

Managed Care Procurement

Following is sample state managed care request for proposals and request for information language related to telehealth:

Hawaii.³⁰⁰ “How can [...] health plans support initiatives like Project ECHO and expand the reach to all provider groups? What barriers do you see in providing this support and what solutions would help overcome these barriers?”

North Carolina.³⁰¹ “[Response shall include [...]]

Experience with innovative telemedicine modalities and pilot programs in other states/markets, and the proposed telemedicine approach to encourage use of telemedicine, including types of programs, and targeted providers, geographies (including rural), services, and members.”

Virginia.³⁰² “Offerors shall consider the following when establishing and maintaining its networks: [...]

The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

Offerors, in response to this RFP, also shall identify any deficiencies in its provider network that meets access to timely care for services and provide the plans to overcome such deficiencies.”



States may also assess how MCO prior authorization or utilization management processes have affected access to telemedicine services. The state may clarify expectations surrounding reimbursement for telemedicine services in its managed care contracts and note both appropriate and inappropriate limitations: for example, whether the plan may require providers to use certain platforms or require an in-person consultation for certain services. The state may also consider mechanisms by which PCPs can access information on telemedicine services, such as prescribed medications and exam findings.

✓ How can the state and MCOs invest in common telehealth infrastructure and programs to support PCPs?

States may fund telehealth programs in a variety of ways. Telemedicine services are often considered when developing capitation rates for Medicaid MCOs, and can be bundled into VBP contracts.

Telementoring and peer-to-peer consultation activities may not be in themselves a billable service, which sometimes requires more creative funding structures. In **New Mexico**, for example, the state embeds specific funding for its Project ECHO initiative in the MCO capitation rate, and in turn requires MCOs to pay for its “fair share of administrative costs” for Project ECHO. MCOs may also voluntarily fund common telehealth infrastructure. For example, in 2017, the **Oregon** Rural Practice-based Research Network developed a multi-payer infrastructure, called the Oregon ECHO Network, to support a coordinated network of ECHO hubs around the state and provide programming and support services. Eight of the 16 CCOs, covering 75 percent of the Medicaid population, subscribe to this service.³⁰⁸

Managed Care Contract Excerpts

Following is sample state managed care contract language related to telehealth services:

New Mexico.³⁰⁶ “The contractor shall participate in Project ECHO, in accordance with State prescribed requirements and standards including, but not limited to, paying its fair share of administrative costs as negotiated between the CONTRACTOR and Project ECHO and approved by HSD to support Project ECHO and shall”

“Work collaboratively with the University of New Mexico, HSD, and Providers on Project ECHO;”

“Identify high needs, high cost Members who may benefit from their providers participating in Project ECHO;”

“Identify PCPs who serve high needs, high cost Members to participate in Project ECHO;” ...

“Reimburse Primary Care clinics for participating in the Project ECHO model;”

“Provider Claims data to support evaluation of Project ECHO; ...”

“Track quality of care and outcome measures related to Project ECHO...”

Virginia.³⁰⁷ “The Contractor shall provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment services. Telemedicine may also include ‘store and forward’ technology, where digital information (such as an X-ray) is forwarded to a professional for interpretation and diagnosis.”

State Approaches

Flexible	Prescriptive
Virginia recognizes a wide variety of providers as “remote” providers for telemedicine and allows MCOs the ability to cover specialist consultative services like telepsychiatry as requested by a member’s PCP. ³⁰⁹	New Mexico requires its MCOs to participate in Project ECHO by contracting with the New Mexico Health Sciences Center, which operates Project ECHO programs in the state, and reimbursing primary care clinics for Project ECHO. The state embeds funding for Project ECHO into the MCO capitation rate and expects MCOs to pay its fair share of administrative costs for the program. The contract also requires MCOs to reimburse PCPs for participating in the program.
Arizona directs its MCOs to engage members through technology, including web-based applications and mobile device technologies, and to identify populations that can benefit from web- and mobile-based technology used to assist members with self-management of health care needs. ³¹⁰	Pennsylvania’s Telephonic Psychiatric Consultation Service Program increases the availability of peer-to-peer child psychiatry consultation teams to PCPs and other prescribers of psychotropic medications for children. The state’s MCOs are required to contract with a telephonic Psychiatric Consultation Team that provides real-time telephonic consultative services to PCPs and prescribers. ³¹¹ The team must include a child psychiatrist, behavioral health therapist, and a care coordinator.

Measurement and Payment

States may choose to define targets relating to the uptake of telehealth services. For example, **New Mexico** includes a telemedicine target as one of several “delivery system improvement performance targets.” The MCO must increase the number of unique members served through telemedicine visits with physical health and behavioral health specialists by 20 percent in rural, frontier, and underserved urban areas, as compared to the previous year. Twenty out of 100 points is allocated to a telemedicine target. The state imposes performance penalties of 1.5 percent of the capitation rate if the performance targets are not met.³¹²

Moving Forward

As the pace of telehealth accelerates, states may consider not only the ways that telehealth may increase access to care, but also the ways in which it may exacerbate disparities. For example, Medicaid recipients are less likely to use telehealth tools, such as patient portals and live video communication.^{313,314} In order for telehealth to realize its potential for Medicaid populations, states may look to its MCOs and providers to design creative engagement strategies for Medicaid populations.

V. Three State Approaches to Patient-Centered Medical Homes

One common state strategy for expanding primary care practice capabilities is supporting PCMH implementation. The medical home is a care delivery model aimed at providing patient-centered, accessible, coordinated, and comprehensive primary care with a commitment to quality improvement.³¹⁵ These foundational primary care elements can be opportune building blocks for states interested in incenting more advanced provider capabilities.

While many states have adopted PCMH models, CHCS collected information about three state PCMH programs that go beyond primary care basics and promote enhanced care delivery transformation. This PCMH analysis explores how **New York**, **Ohio**, and **Oregon's** PCMH requirements go beyond the NCQA's 2017 PCMH standards, one of the most widely adopted PCMH models, to address the following high-quality primary care attributes:³¹⁶

1. Integration of primary health care with public health, social services, and behavioral health;^{317, 318, 319}
2. Proactive patient and family engagement to address physical, social, and cultural barriers to care;^{320, 321, 322}
3. Mobile or digital health;^{323, 324, 325, 326, 327, 328}
4. Active use of data to manage and improve patient care and system performance;^{329, 330, 331}
5. Geographic empanelment, including appropriate risk stratification and targeting;^{332, 333}
6. Multidisciplinary teams with community health workers;^{334, 335, 336} and
7. Medical home capabilities as a foundation.^{337, 338, 339}

The following analysis also describes how states leverage Medicaid managed care for implementation, as well as specific payment methods used to reimburse PCMHs.

Overall, CHCS found that all three state programs have standards that go beyond NCQA PCMH behavioral health (BH) core requirements. For example, these three state programs include additional BH screening requirements, coordination standards, and quality metrics. These programs also include a number of advanced patient engagement capabilities such as training staff



on cultural competence, meeting patient language needs, and requiring care plan elements beyond baseline NCQA PCMH requirements. However, these programs have fewer advanced requirements related to mobile health, use of data, geographic empanelment, and multidisciplinary teams, suggesting areas for future development.

This table is a CHCS analysis of how state PCMH requirements compare to NCQA PCMH 2017 requirements, not a comprehensive description of state PCMH programs.³⁴⁰ State standards that are optional or similar to NCQA core requirements are not listed. The crosswalk does list standards that are required by state programs but optional (“elective”) under NCQA PCMH 2017.

New York	Oregon	Ohio
Overview of approach		
<p>The New York State Department of Health, in collaboration with NCQA, developed the New York State Patient-Centered Medical Home (NYS PCMH), which builds off the NCQA PCMH model.</p> <ul style="list-style-type: none"> ■ In 2017, NYS transitioned its model of advanced primary care from Advanced Primary Care (APC) to NYS PCMH.³⁴¹ ■ NYS PCMH converts 12 ‘Elective’ NCQA criteria into ‘core’ (required) criteria, in the areas of behavioral health, care coordination, Health IT, and VBP. NCQA reviews practice documentation and determines recognition status.³⁴² ■ The NY PCMH program covers initial provider costs for recognition and provides technical assistance through a SIM award.³⁴³ ■ Participating practices are eligible for enhanced reimbursement under the Medicaid PCMH Incentive Program.³⁴⁴ This program was created through 2009 legislation and CMS approved a related state plan amendment (SPA) in 2010.^{345, 346} ■ Selected practices are also eligible for enhanced reimbursement (typically via PMPM payments or pay-for-performance [P4P] arrangements) from commercial health plans participating in Regional Oversight Management Committees (ROMC).³⁴⁷ 	<p>Oregon Health Authority (OHA) administers the Patient-Centered Primary Care Home Program (PCPCH), which is integrated into its broader CCO program.</p> <ul style="list-style-type: none"> ■ The PCPCH program was created through 2009 legislation.³⁴⁸ ■ PCPCH requirements have some alignment with the NCQA PCMH model — in some cases, recognized NCQA PCMH clinics in Oregon may submit an abbreviated PCPCH application.³⁴⁹ ■ PCPCH clinics are recognized at five different tiers. All practices must meet the 11 must-pass standards and select optional standards. To be recognized at the highest tier (5-STAR), practices must also meet 11 out of 13 specified measures. OHA reviews practice applications and determines recognition status.³⁵⁰ ■ CCOs must include PCPCHs in their networks and PCPCH enrollment is a CCO quality measure.^{351, 352} 	<p>The Governor’s Office of Health Transformation and the Ohio Department of Medicaid developed the Comprehensive Primary Care (Ohio CPC) program, which closely aligns with Medicare’s CPC+ program.³⁵³</p> <ul style="list-style-type: none"> ■ Ohio CPC was developed through a SIM award and implemented under existing Medicaid authority. CMS approved a CPC SPA in 2018.^{354, 355, 356} ■ Ohio CPC practice requirements are similar to CPC+ requirements, though payment streams differ.³⁵⁷ To enroll in the program, practices submit application to Ohio Medicaid. Ohio Medicaid works with a vendor to conduct program monitoring.^{358, 359} ■ Practices are compensated for PCMH activities and cost and quality performance.³⁶⁰ ■ Previously, Ohio CPC eligibility criteria included national accreditation or CPC+ participation. OH removed these requirements in 2019.^{361, 362}

New York	Oregon	Ohio
Attribute 1: Integration of primary health care with public health, social services, and behavioral health		
<p>NYS PCMH requires that practices:</p> <ul style="list-style-type: none"> ■ Screen for alcohol use disorder and SUD. ■ Set expectations for information exchange for BH referrals.^{363, 364} 	<p>PCPCH requires that practices:</p> <ul style="list-style-type: none"> ■ Screen for BH conditions, including SUD. <p>PCPCH 5-STAR Criteria include:</p> <ul style="list-style-type: none"> ■ PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers. ■ PCPCH provides integrated BH services, including population-based, same-day consultations by behavioral health providers. ■ PCPCH tracks referrals and cooperates with community service providers outside the PCPCH.^{365, 366, 367} 	<p>Ohio CPC requires that practices:</p> <ul style="list-style-type: none"> ■ Employ care management strategies and plans that support integration of BH.^{368, 369} <p>Additionally, the CPC quality and efficiency measure set includes:</p> <ul style="list-style-type: none"> ■ Antidepressant medication management; ■ Follow up after hospitalization for mental illness; ■ Tobacco screening and cessation intervention; ■ Initiation of alcohol and other drug dependence treatment; and ■ Behavioral health-related inpatient admits per 1,000.^{370, 371}
Attribute 2: Proactive patient and family engagement to address physical, social, and cultural barriers to care		
<p>NYS PCMH requires that practices:</p> <ul style="list-style-type: none"> ■ Address disparities in care. ■ Educate staff on health literacy or cultural competence.^{372, 373} 	<p>PCPCH requires that practices:</p> <ul style="list-style-type: none"> ■ Offer providers who speak a patient/family's language or telephonic trained interpreters.³⁷⁴ <p>PCPCH 5-STAR Criteria include:</p> <ul style="list-style-type: none"> ■ PCPCH develops written care plan for patients with complex medical or social concerns. Plans should include at least self-management goals, goals of care, and action plan for exacerbations of chronic illness. ■ PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population. ■ Assess patient experience through CAHPS survey and use data in quality improvement process.^{375, 376, 377} 	<p>Ohio CPC requires that practices:</p> <ul style="list-style-type: none"> ■ Create and provide care plans to high-risk patients that include patient preferences, functional/lifestyle goals, potential barriers to meeting goals, and self-management plans.^{378, 379}
Attribute 3: Mobile or digital health		
<p>NYS PCMH requires that practices have a system for two-way electronic communication between the practice and patients.^{380, 381}</p>	<p>No requirements.</p>	<p>No requirements.</p>

New York	Oregon	Ohio
Attribute 4: Active use of data to manage and improve patient care and system performance		
<p>NYS PCMH requires that practices:</p> <ul style="list-style-type: none"> ■ Exchange data with the State Health Information Network for New York (SHIN-NY) that supports management of complex patients.³⁸² NYS provides funding through SIM for participating practices to connect to the SHIN-NY.^{383,384} ■ Use a certified electronic health record system.³⁸⁵ 	No requirements.	No requirements. Participating practices receive attribution, performance, and referral reports. The referral report provides provider performance and patient activity information for select episodes of care. ³⁸⁶
Attribute 5: Geographic empanelment, including appropriate risk stratification and targeting		
NYS PCMH requires that practices have a comprehensive risk stratification process. ^{387, 388}	No requirements.	<p>Ohio CPC requires that practices use risk stratification from payers and other available data to stratify patients and integrate risk status into health records and care plans.^{389, 390, 391}</p> <p>In cases where attribution cannot be determined based on patient choice or claims, geography may be a factor for determining attribution.³⁹²</p>
Attribute 6: Multidisciplinary teams with community health workers		
No requirements beyond NCQA PCMH Recognition.	No requirements.	No requirements.
Attribute 7: Medical home capabilities as a foundation		
NYS PCMH builds off the NYS APC and the NCQA PCMH model. NYS PCMH converts 12 ‘elective’ NCQA criteria into ‘core’ (required) criteria (as described in “Attribute 1–6” rows above, and “other required standards” row below). ³⁹³	Oregon includes required and optional standards similar to NCQA PCMH standards. Oregon’s PCPCH program organizes standards into the domains of access to care, accountability, comprehensive whole-person care, continuity, coordination and integration, and person and family centered care. ^{394, 395}	<p>Ohio CPC includes many requirements similar to NCQA PCMH and CPC+ standards. Ohio CPC organizes standards into the domains of access to care, risk stratification, population health management, team-based care, care management, follow up after hospital discharge, test and specialist referrals, and patient experience.^{396,397}</p> <p>Previously, participating practices were required to have either national accreditation or participate in CPC+. For 2019, OH has removed these requirements.^{398,399}</p>

New York	Oregon	Ohio
Other required standards beyond NCQA PCMH core criteria		
<p>NYS PCMH requires that practices:</p> <ul style="list-style-type: none"> ■ Provide continuity of medical record information when the office is closed; ■ Make care plans accessible across settings of care; ■ Obtain patient discharge summaries; ■ Set expectations for information exchange for specialist referrals; and ■ Engage in an up-side risk contract.^{400,401} 	<p>PCPCH requires practices to:</p> <ul style="list-style-type: none"> ■ Track at least one quality measure from the PCPCH quality measure set;⁴⁰² ■ Report they routinely offer comprehensive preventive and medical services; ■ Have a written agreement with hospital providers or provide routine hospital care;⁴⁰³ and ■ Coordinate hospice and palliative care, and counseling. <p>PCPCH 5-STAR criteria require practices to:</p> <ul style="list-style-type: none"> ■ Develop a clinic-wide improvement strategy;⁴⁰⁴ ■ Meet a benchmark for percent of patient visits with assigned clinician or team;⁴⁰⁵ ■ Define care coordination roles for care team members and tell patients/family the name of the team member responsible for their care coordination; and ■ Exchange information and coordinate care with specialized settings.^{406, 407, 408} 	<p>Ohio CPC requires that practices:</p> <ul style="list-style-type: none"> ■ Provide continuity of medical record information when office is closed;⁴⁰⁹ ■ Coordinate with managed care plans for population health and care management; ■ Ask about self-referrals and request reports from clinicians; and ■ Obtain patient discharge summaries.^{410, 411, 412}
Payment method		
<p>Practices with NCQA PCMH 2014 Level 3 Recognition, NCQA PCMH 2017 Recognition, or NYS PCMH Recognition (NCQA 2017 + 12 addition 'Core' requirements) are eligible to receive incentive payments through the Medicaid PCMH Incentive Program, effective July 1, 2018:</p> <ul style="list-style-type: none"> ■ Medicaid Managed Care \$6 PMPM. ■ FFS incentive payment add-on amounts of \$29.00 and \$25.25 for professional and institutional claims respectively, available for qualified evaluation and management codes.⁴¹³ <p>Select practices that are recognized as NYS PCMH can receive enhanced reimbursement through commercial payers that participate in three ROMCs. While the payment arrangements vary from ROMC to ROMC, they typically include either a PMPM or P4P.⁴¹⁴</p>	<p>CCOs are required to implement value-based payments and prioritize implementing alternative payments and incentives for PCPCHs.⁴¹⁵</p> <ul style="list-style-type: none"> ■ In 2016, all CCOs allocated at least 31% of primary care spending to non-claims-based payment, which include: payments to incent efficiency or quality, payments for patient-centered medical homes, or payments to improve provider capacity and infrastructure.⁴¹⁶ ■ Starting in 2020, CCOs will be required to provide PMPM payments to PCPCH clinics, as a supplement to any other payments, in order to support development of infrastructure and operations for PCPCHs.⁴¹⁷ 	<p>CPC practices may be eligible for two payment streams in addition to existing payment arrangements:</p> <ul style="list-style-type: none"> ■ PMPM payment, to support CPC activity requirements. PMPM amounts are based on risk tiers (Tier 1-\$1.80, Tier 2- \$8.50, Tier 3- \$22).⁴¹⁸ ■ Shared savings payment, based on achieving total cost of care savings (available to practices or practice partnerships with at least 60,000 member months over the performance period).^{419, 420} ■ To be eligible for PMPM and shared savings payments, practices must pass 50% of applicable quality and efficiency metrics.⁴²¹

New York	Oregon	Ohio
Managed care implementation		
<ul style="list-style-type: none"> Enhanced PCMH payments are distributed to providers through Medicaid MCOs for managed care members.⁴²² 	<ul style="list-style-type: none"> CCOs are required to enroll a significant percentage of members in PCPCHs. CCOs are required to have a plan to increase the number of enrollees served by PCPCHs and assist providers in achieving higher PCPCH tiers.⁴²³ State law requires CCOs to allocate at least 12% of health care expenditures to primary care by 2023.⁴²⁴ PCPCH enrollment is one of the 19 CCO quality measures used to determine reward payments out of 'quality pool' funds. The PCPCH enrollment measure is based on percentage of CCO membership enrolled in a PCPCH, with higher tier PCPCHs weighted more heavily.^{425,426} 	<ul style="list-style-type: none"> CPC PMPM and shared savings payments are distributed to practices through Medicaid managed care plans (MCPs) for managed care members.⁴²⁷ MCPs are required to coordinate with and support CPC practices in implementing CPC activities. This includes activities such as member outreach and data sharing.⁴²⁸

VI. Conclusion

Primary care is the backbone of any high-functioning health care system, particularly for low-income populations. Ongoing concern about the high cost and poor outcomes of health care in the U.S. continues to create an impetus for states to increase investments in primary care.

[Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States](#) seeks to help states use Medicaid's managed care purchasing levers to promote advanced primary care approaches and better serve low-income populations. This first section of the toolkit outlines the range of other state approaches to define primary care priorities and advance core primary care function, as well as key questions and considerations, but does not seek to identify the right approach. There is no one-size-fits-all approach to promoting advanced primary care approaches within Medicaid managed care, particularly given differences in states' populations, geographies, patient needs, and provider and health plan markets. A second section of this toolkit, *[Using State Levers to Drive Uptake and Spread](#)*, outlines how states can incentivize and invest in advanced primary care through Medicaid managed care.



ENDNOTES

- ¹ C. Koller. *Getting More Primary Care-Oriented: Measuring Primary Care Spending*. Milbank Memorial Fund, July 2017. Available at: <https://www.milbank.org/2017/07/getting-primary-care-oriented-measuring-primary-care-spending/>.
- ² 42 C.F.R. § 438.340; see also S. Rosenbaum, J.Z. Beckerman, M. Velasquez, A. Somodevilla, E. Gray, R. Morris, et. al. How Are States Addressing Primary Care Quality in Medicaid Managed Care? The Commonwealth Fund, March 19, 2019. Available at: <https://www.commonwealthfund.org/blog/2019/how-are-states-addressing-primary-care-quality-medicare-managed-care>.
- ³ The Ohio Department of Medicaid Managed Care Quality Strategy, p. 52. Ohio Department of Medicaid Office of Health Innovation and Quality, June 26, 2018. Available at: <https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/MCQ-Strategy2018.pdf>.
- ⁴ T. Miller. "How a State Advances Whole-Person Health Care." June 27, 2019. NEJM Catalyst. Available at: https://catalyst.nejm.org/state-advances-social-determinants-whole-person/?MessageRunDetailID=437391458&PostID=6439356&utm_medium=email&utm_source=rasa_io.
- ⁵ Bureau of Health Services Financing, Louisiana Department of Health. "Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care", pp. 3-4. March 1, 2018. Available at: http://www.ldh.la.gov/assets/HealthyLa/LDH_MCO_RFP_WP.pdf.
- ⁶ J.M. Peterson. "Hawaii Medicaid Ohana Nui Project Expansion (HOPE) Project." Med-QUEST Division, 2017. Available at: <http://www.hawaiipublichealth.org/resources/Documents/Hawaii-Medicaid-Ohana-Nui-Project-Expansion%2012.15.17%20.pdf>.
- ⁷ QUEST Integration, Request for Information No. RFI-MQD-2019-002, p. 6. Med-QUEST Division, Department of Human Services, September 20, 2018. Available at: <https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/RFP/REV-QI-RFI-MQD-2019-002-10-18-2018.pdf>.
- ⁸ Comprehensive Services and Information Resources, Request for Information, p. 1. Pennsylvania Department of Human Services, December 7, 2018. http://www.emarketplace.state.pa.us/FileDownload.aspx?file=0/Solicitation_0.pdf&OriginalFileName=RFI%20-%20Resource%20Coordination.pdf.
- ⁹ T. Miller. "How a State Advances Whole-Person Health Care." June 27, 2019. NEJM Catalyst. Available at: https://catalyst.nejm.org/state-advances-social-determinants-whole-person/?MessageRunDetailID=437391458&PostID=6439356&utm_medium=email&utm_source=rasa_io.
- ¹⁰ HealthChoices Agreement Exhibits, Exhibit B(5) and Exhibit DDD. Pennsylvania Department of Human Services, Effective January 1, 2019. Available at: <http://www.dhs.pa.gov/provider/healthcaremedicalassistance/managedcareinformation/>.
- ¹¹ See also S. Rosenbaum. "Inside the Trump Administration's Proposed Medicaid Managed Care Rule." Health Affairs Blog. December 5, 2018. Available at: <https://www.healthaffairs.org/do/10.1377/hblog20181204.187478/full/>. (referring to hard and soft power).
- ¹² Center for Medicare & Medicaid Innovation, U.S. Centers for Medicare & Medicaid Services. "Comprehensive Primary Care Initiative." Available at: <https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>.
- ¹³ See also S. Rosenbaum. "Inside the Trump Administration's Proposed Medicaid Managed Care Rule." Health Affairs Blog. December 5, 2018. Available at: <https://www.healthaffairs.org/do/10.1377/hblog20181204.187478/full/>. (referring to hard and soft power).
- ¹⁴ Center for Medicare & Medicaid Innovation, U.S. Centers for Medicare & Medicaid Services. "Primary Care First Model Options." Available at: <https://innovation.cms.gov/initiatives/primary-care-first-model-options/>.
- ¹⁵ See Section 2.7.2.5.1, p. 89. Appendix B: Louisiana Medicaid Managed Care Organizations Model Contract. Request for Proposals # 3000011953. Louisiana Department of Health Bureau of Health Services Financing, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf. (referring to a "common survey-based instrument," to be developed by the state)
- ¹⁶ Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0, BID Event Number EVT0005464, Attachment E and F. Kansas Department of Administration, October 27, 2017. Available at: <https://admin.ks.gov/offices/procurement-and-contracts/kancare-award>.
- ¹⁷ North Carolina Department of Health and Human Services. "Screening Questions." Available at: <https://www.ncdhhs.gov/about/departments-initiatives/healthy-opportunities/screening-questions>.
- ¹⁸ Centennial Care Letter of Direction #51, Human Services Department Standardized Health Risk Assessment, From Nancy Smith-Leslie, Director, Medical Assistance Division to Centennial Care Managed Care Organizations. New Mexico Human Services Department, March 8, 2016. Available at: https://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/LOD_%2351___HSD_Standardized_HRA_w_weighted_HRA.pdf.
- ¹⁹ North Carolina Department of Health and Human Services. "NCCARE360." Available at: <https://www.ncdhhs.gov/about/departments-initiatives/healthy-opportunities/nccare360>.
- ²⁰ Division of TennCare. "Care Coordination Tool." Available at: <https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/care-coordination-tool.html>.
- ²¹ North Carolina Department of Health and Human Services. "Medicaid Managed Care Proposed Concept Paper: North Carolina's Care Management Strategy under Managed Care." March 9, 2018. Available at: https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf.

- ²² Request for Proposal # 30-190029-DHB, Section V. Scope of Services, pp. 129-130. Division of Health Benefits, North Carolina Department of Health and Human Services. August 9, 2018. Available at: <https://files.nc.gov/ncdhhs/30-190029-DHB-1.pdf>.
- ²³ Medical Assistance Provider Agreement for Managed Care Plan, Appendix K. Ohio Department of Medicaid, July 2018. Available at: <https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/ManagedCare-PA-201807.pdf>.
- ²⁴ Amended Version (RFP A2) RFP Sample Contract, Centennial Care 2.0, Section 4.4.19. New Mexico Human Services Department. Available at: https://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/Amended_Version__RFP_A2__RFP_Sample_Contract.pdf.
- ²⁵ HealthChoices Agreement Exhibits, Exhibit B(5), op. cit.
- ²⁶ Centers for Medicare & Medicaid Services. "2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)." Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf>.
- ²⁷ Oregon Health Authority Office of Health Analytics. "CCO Metrics." Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx>.
- ²⁸ See ORS § 414.625(1)(c). Available at: https://www.oregonlegislature.gov/bills_laws/ors/ors414.html. ("Operating within a fixed global budget and, by January 1, 2023, spending on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care").
- ²⁹ M.H. Bailit, M.W. Friedberg, and M.L. Houy. *Standardizing the Measurement of Commercial Health Plan Primary Care Spending*. Milbank Memorial Fund, July 25, 2017. Available at: <https://www.milbank.org/publications/standardizing-measurement-commercial-health-plan-primary-care-spending/>.
- ³⁰ Center for Medicaid & CHIP Services, Centers for Medicare & Medicaid Services. "2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)." November 2018. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf>.
- ³¹ Manatt Health for Robert Wood Johnson Foundation. "Addressing Social Factors That Affect Health: Emerging Trends and Leading Edge Practices in Medicaid". April 2019. Available at: https://www.shvs.org/wp-content/uploads/2019/04/Social-Factors-That-Affect-Health_Final.pdf.
- ³² Page 249. Request for Responses from Managed Care Organizations, Bid # BD-17-1039-EHS01-EHS01-10209, Attachment A: Model MCO Contract. Executive Office of Health and Human Services, December 21, 2016. Available at: <https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-10209&external=true&parentUrl=bid>.
- ³³ Section 2.17.5.3.4. Request for Proposals for Louisiana Medicaid Managed Care Organizations, RFP #3000011953, Appendix B: Model Contract. Bureau of Health Services Financing, Louisiana Department of Health, February 25, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf.
- ³⁴ Page 141. Request for Proposal # 30-190029-DHB, Section V. Scope of Services, op. cit.
- ³⁵ Center for Medicare & Medicaid Innovation, U.S. Centers for Medicare & Medicaid Services. "Comprehensive Primary Care Initiative." Op. cit.
- ³⁶ Center for Medicare & Medicaid Innovation, U.S. Centers for Medicare & Medicaid Services. "Primary Care First Model Options." Op. cit.
- ³⁷ Medical Assistance Provider Agreement for Managed Care Plan, Appendix K. Ohio Department of Medicaid, op. cit.
- ³⁸ CCO 2.0 Request for Applications, RFA OHA-4690-19, Appendix B: Sample Contract, p. 149. Oregon Health Authority, January 25, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf>.
- ³⁹ Rhode Island Executive Office of Health and Human Services. "EOHHS Medicaid Infrastructure Incentive Program: Attachment L 2: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities". Program Year Two Requirements, June 1, 2019. Available at: [http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/Attachment%20L2%20\(Incentive%20Program%20Requirements\)_PY%202%20FINAL_Amended.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/Attachment%20L2%20(Incentive%20Program%20Requirements)_PY%202%20FINAL_Amended.pdf).
- ⁴⁰ Centers for Disease Control and Prevention. "Social Determinants of Health: Know What Affects Health." Available at: <https://www.cdc.gov/socialdeterminants/>.
- ⁴¹ "Levels of HRSN and SDH Integration Framework: A Practical Framework to Help Healthcare and Social Service Partners Address Health-Related Social Needs and Social Determinants of Health." HealthBegins, April 2019. Available at: https://www.healthbegins.org/uploads/2/2/0/4/22040328/levels_of_hrsn_and_sdh_integration_framework.pdf.
- ⁴² "Addressing Social Determinants of Health in Primary Care: Team-based Approach for Advancing Health Equity." American Academy of Family Physicians, 2018. Available at: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf.
- ⁴³ Request for Proposals for a Qualified Grantee to: Provide Health Care Services to Families and Children through Medical Assistance (Families and Children) and MinnesotaCare in 80 Greater Minnesota Counties, p. 60. Purchasing and Service Delivery Division, Minnesota Department of Human Services, February 25, 2019. Available at: https://mn.gov/dhs/assets/2019-fc-2020-rfp-amended-to-provide-prepaid-hc-to-greater-mns-eligible-fc-and-minnesotacare-individuals_tcm1053-385010.docx.
- ⁴⁴ RFA OHA-4690-19-0 – CCO 2.0. Attachment 10 — Social Determinants of Health and Health Equity. Oregon Health Authority, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/09-CCO-RFA-4690-0-Attachment-10-SDOH-HE-Questionnaire-Final.pdf>.
- ⁴⁵ Page 98. RFP 2017-03 – Medallion 4.0. Commonwealth of Virginia Department of Medical Assistance Services. Available at: <https://www.bidnet.com/bneattachments/459484772.pdf>.
- ⁴⁶ Centers for Medicare & Medicaid Services. "Accountable Health Communities Model." Available at: <https://innovation.cms.gov/initiatives/ahcm/>.

- ⁴⁷ Pathways Community HUB Institute. "Pathways Community HUB Model Overview." Available at: <https://pchi-hub.com/hubmodeloverview>.
- ⁴⁸ Centers for Medicare and Medicaid Services. "Comprehensive Primary Care Plus." Available at: <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>.
- ⁴⁹ Section 2.6.4.3, pp. 88-89. Appendix B: Louisiana Medicaid Managed Care Organizations Model Contract. Request for Proposals # 3000011953. Louisiana Department of Health Bureau of Health Services Financing, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf.
- ⁵⁰ OR: Exhibit N, Page 197. RFA OHA-4690-19-0 – CCO 2.0. Appendix B – Sample Contract. Oregon Health Authority, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf>.
- ⁵¹ PA: Exhibits DDD-2. HealthChoices Agreement Exhibits – Effective January 1, 2019. Pennsylvania Department of Human Services. Available at: http://dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf.
- ⁵² Kaiser Permanente. "Systematic Review of Social Risk Screening Tools." Available at: <https://sdh-tools-review.kp.washingtonresearch.org/>.
- ⁵³ 42 C.F.R. 438.208(b)(2)(iv).
- ⁵⁴ Y. Cartier, C. Fichtenberg, L. Gottlieb. "Community Resource Referral Platforms: A Guide for Health Care Organizations." Available at: <https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations>.
- ⁵⁵ Page 185. Contract No. YH19-0001. Amendment #1. Arizona Health Care Cost Containment System. October 1, 2018. Available at: https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_Contract_Amend_1.pdf. ("The Contractor shall demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing 6% of its annual profits to community reinvestment.")
- ⁵⁶ Page 143, 198-9. Attachment V. Scope of Services. RFP 30-190029-DHB. North Carolina Department of Health and Human Services. Available at: <https://files.nc.gov/ncdhhs/30-190029-DHB-1.pdf>. (encouraging plans to voluntarily contribute to health-related resources "that help to address Members' and communities' unmet health-related needs," and allowing plans to: count contributions in the numerator of the MLR; donate to health-related resources in lieu of a rebate; and earn a preference in auto-assignment for contributions).
- ⁵⁷ Page 199. Exhibit N. Appendix B – Sample Contract. RFA OHA-4690-19-0 tlh. Oregon Health Authority. Effective January 1, 2020. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf>. ("Contractor shall spend a portion of annual net income or reserves on services designed to address health disparities and the social determinants of health, according to requirements in Oregon Administrative Rule and ORS 414.625(1)(b)(C).")
- ⁵⁸ Humana News. "Humana's 2019 Bold Goal Progress Report Details A Focus On Social Determinants of Health and Improved Healthy Days in its Medicare Advantage Population." Available at: <https://humananews.com/2019/04/humanas-2019-bold-goal-progress-report-details-a-focus-on-social-determinants-of-health-and-improved-healthy-days-in-its-medicare-advantage-population/>.
- ⁵⁹ Exhibits DDD-2, M(1)-10. HealthChoices Agreement Exhibits – Effective January 1, 2019. Pennsylvania Department of Human Services. Available at: http://dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf.
- ⁶⁰ See Attachment E and Attachment F. KanCare 2.0 Request for Proposal and Attachments. Kansas Department of Administration. Available at: <https://admin.ks.gov/offices/procurement-and-contracts/kancare-award> (sample health screen and health risk assessment includes questions on social needs).
- ⁶¹ See Section 2.7.2.5.1, p. 89. Appendix B: Louisiana Medicaid Managed Care Organizations Model Contract. Request for Proposals # 3000011953. Louisiana Department of Health Bureau of Health Services Financing, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf. (referring to a "common survey-based instrument," to be developed by the state)
- ⁶² See Page 142. Section V: Scope of Services. Request for Proposals 30-190029-DHB. North Carolina Department of Health and Human Services, 2018. <https://files.nc.gov/ncdhhs/30-190029-DHB-1.pdf>. (referring to "standardized screening questions, to be developed by the Department, to identify Members with unmet health-related resource needs who require a Comprehensive Assessment for care management.")
- ⁶³ Page 69. State of Michigan Comprehensive Health Care Program Contract. Michigan Department of Health and Human Services, effective July 2, 2018. Available at: https://www.michigan.gov/documents/contract_7696_7.pdf.
- ⁶⁴ Section 2.6.4.3.2, page 88. Appendix B: Louisiana Medicaid Managed Care Organizations Model Contract. Request for Proposals # 3000011953. Louisiana Department of Health Bureau of Health Services Financing, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf.
- ⁶⁵ North Carolina Department of Health and Human Services. NCCARE 360. Available at: <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360>.
- ⁶⁶ Exhibit B(5). HealthChoices Agreement Exhibits – Effective January 1, 2019. Pennsylvania Department of Human Services. Available at: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf.
- ⁶⁷ Section 8.9A, page 233. Medallion 4.0 Managed Care Services Agreement. Commonwealth of Virginia Department of Medical Assistance Services, July 2018. Available at: [http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20\(07.26.2018\).pdf](http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20(07.26.2018).pdf).
- ⁶⁸ Appendix D. DSRIP Protocol. MassHealth (Project Number I I-W-00030/1). Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-appvd-dsrip-prtcl-20190408.pdf>.
- ⁶⁹ Page 18. "Request for Proposals for a Qualified Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration." Minnesota Department of Human Services Health Care Administration, June 11, 2018. Available at: https://mn.gov/dhs/assets/2019-ihp-rfp_tcm1053-294430.pdf.

- ⁷⁰ Accountable Entity Social Determinants of Health Measure. Rhode Island Executive Office of Health and Human Services, February 15, 2018. Available at: <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/SDOH%20Guidance%20Document%202018-02-15.pdf>.
- ⁷¹ Accountable Entity Self-Reported Health Measure. Rhode Island Executive Office of Health and Human Services, February 15, 2018. Available at: <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/Self%20Reported%20Health%20Measure%202018-02-15.pdf>.
- ⁷² Pages 44-47. "A Path toward Value Based Payment: Annual Update (June 2018: Year 4) New York State Roadmap for Medicaid Payment Reform," New York State Department of Health. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny-medicaid-redesign-team/ny-medicaid-rdsgn-vbp-roadmap-apprvl-20190501.pdf>; see also New York State Department of Health. "Social Determinants of Health and Community Based Organizations." Available at: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/.
- ⁷³ Section 8(d)(iii), p. 141. Section V: Scope of Services. Request for Proposals 30-190029-DHB. North Carolina Department of Health and Human Services, 2018. Available at: <https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf>.
- ⁷⁴ Page 103. RFA OHA-4690-19-0 – CCO 2.0. Appendix B – Sample Contract. Oregon Health Authority, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf>.
- ⁷⁵ State of Michigan. Contract No. Comprehensive Health Care Program for the Michigan Department of Health and Human Services. January 2021. Available at: https://www.michigan.gov/documents/contract_7696_7.pdf.
- ⁷⁶ Ibid., p. 201.
- ⁷⁷ RFA OHA-4690-19-0 – CCO 2.0. Attachment 10 — Social Determinants of Health and Health Equity. Oregon Health Authority, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/09-CCO-RFA-4690-0-Attachment-10-SDOH-HE-Questionnaire-Final.pdf>.
- ⁷⁸ Tennessee Primary Care Associate. "Appendix 4: PCMH Distinction in Behavioral Health Integration." September 2017. Available at: http://www.tnpscareducation.org/resource/clibrary/clinical/06.%20PCMH%20Recognition_Appendix%204_Distinction%20in%20Behavioral%20Health%20Integration_9.30.pdf.
- ⁷⁹ E. Woltmann, A. Kaylor-Grogan, B. Perron, H. Georges, AM. Kilbourne, and MS. Bauer. "Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: Systematic review and meta-analysis." *American Journal of Psychiatry*, 169, no. (2012): 790–804.
- ⁸⁰ Ramanuj, P., E. Ferencik, M. Docherty, B. Spaeth-Ruble, and H.A. Pincus. "Evolving Models of Integrated Behavioral Health and Primary Care." *Current Psychiatry Reports*, 21 (2019): 4.
- ⁸¹ Behavioral health integration can occur bi-directionally, whereby behavioral health services are integrated into primary care settings, and/or primary care services are integrated into behavioral health settings.
- ⁸² Agency for Healthcare Research and Quality. "What Is Integrated Behavioral Health Care (IBHC)?" Available at: <https://integrationacademy.ahrq.gov/products/ibhc-measures-atlas/what-integrated-behavioral-health-care-ibhc>.
- ⁸³ M. Gerrity. *Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015*. Milbank Memorial Fund, May 2016. Available at: <https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI.pdf>.
- ⁸⁴ SAMHSA-HRSA Center for Integrated Health Solutions. "A Standard Framework For Levels of Integrated Healthcare and Update Throughout the Document." March 2013. Available at: https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf.
- ⁸⁵ M. Gerrity. *Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015*. Milbank Memorial Fund, May 2016. Available at: <https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI.pdf>.
- ⁸⁶ Page 305. SOLICITATION # YH19-0001. AHHCS Complete Care Contracts. Arizona Health Care Cost Containment System Administration. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH19/ACC_RFP_11022017.pdf.
- ⁸⁷ Section E, P.34. Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0. Available at: <https://admin.ks.gov/offices/procurement-and-contracts/kancare-award>.
- ⁸⁸ Attachment 11. Behavioral Health Questionnaire. RFA OHA-4690-19 – CCO 2.0. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/10-CCO-RFA-4690-0-Attachment-11-BH-Questionnaire%20Final.pdf>.
- ⁸⁹ Ibid.
- ⁹⁰ Ibid.
- ⁹¹ Ibid.
- ⁹² Oregon developed a tiered Patient Centered Primary Care Home (PCPCH) model with three increasingly advanced standards: (1) a screening and referral strategy for mental health and substance abuse; (2) a cooperative referral process (or co-location) with specialty mental health and substance abuse; and (3) integrated behavioral health services, including same-day consultations by behavioral health providers.
- ⁹³ National Committee for Quality Assurance. "Distinction in Behavioral Health Integration." Available at: <https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/distinction-in-behavioral-health-integration/>.
- ⁹⁴ Section 4.11.1.6. P. 192. Appendix C. Medicaid Care Management Services. Model Contract. New Hampshire Department of Health and Human Services. Available at: <https://www.dhhs.nh.gov/business/rfp/documents/rfp-2019-oms-02-manag-appc.pdf>.

⁹⁵ Section 2.9.10.5.1.12, P. 120. Louisiana Medicaid Managed Care Organization Model Contract. Appendix B. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf.

⁹⁶ Section 14.5.1. Page 229. Washington Apple Health Fully Integrated Managed Care Contract. Amendment #5. Washington Health Care Authority. Effective July 1, 2019. Available at: https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf.

⁹⁷ Bree Collaborative. "Behavioral Health Integration Report and Recommendations." January 2017. Available at: <http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Draft-Recommendations-2017-01.pdf>.

⁹⁸ Ibid.

⁹⁹ SAMHSA-HRSA Center for Integrated Health Solutions. "A Standard Framework For Levels of Integrated Healthcare and Update Throughout the Document." March 2013. Available at: https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf.

¹⁰⁰ Section 2.3.3.4.4, page 51. Appendix B: Louisiana Medicaid Managed Care Organizations Model Contract. Request for Proposals # 3000011953. Louisiana Department of Health Bureau of Health Services Financing, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf.

¹⁰¹ Safety Net Medical Home Initiative. "Implementation Guide Supplement, Organized, Evidence-Based Care: Behavioral Health Integration." October 2014. Available at: <http://www.improvingprimarycare.org/sites/default/files/topics/BH-Intro3-SNMHI%20Implementation-Guide-Behavioral-Health-Integration.pdf>.

¹⁰² For more information on SBIRT, see the *Improving Access to Screening, Brief Intervention, and Referral to Treatment Services for Adolescents: A Resource Center* available at: <https://www.chcs.org/resource/improving-access-to-screening-brief-intervention-and-referral-to-treatment-in-primary-care-for-adolescents-a-resource-center/>.

¹⁰³ For more information on the Oregon Health Authority's approach to SBIRT, see: Oregon Health Authority. Available at: <https://www.oregon.gov/oha/HSD/AMH/Pages/SBIRT.aspx>.

¹⁰⁴ US Preventive Services Task Force. "Patient Health Questionnaire 9." Available at: <https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218>

¹⁰⁵ Oregon CCO RFA, Attachment 11 – Behavioral Health Questionnaire, Oregon Health Authority. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/10-CCO-RFA-4690-0-Attachment-11-BH-Questionnaire%20Final.pdf>

¹⁰⁶ 21st Century Cures Act of 2016, Pub. L. No. 114–255, § 12001, 130 STAT. 1272. Available at: <https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf>.

¹⁰⁷ M. Gerrity. *Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015*. Milbank Memorial Fund, May 2016. Available at: <https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI.pdf>.

¹⁰⁸ Center for Medicare and Medicaid Services. "CPC+ Behavioral Health Integration Menu of Options, 2017." Available at: <https://innovation.cms.gov/Files/x/cpcplus-bhinteg-options.pdf>

¹⁰⁹ J. Fischer. "Value-based purchasing survey results: Washington providers and health plans report 2017 VBP experiences." PowerPoint presentation, 2018. Available at: <https://www.hca.wa.gov/assets/program/2018-vbp-survey-analysis-public.pdf>

¹¹⁰ This is a set of optional standards available to NCQA-Recognized PCMHs, and includes 18 criteria across four competencies related to behavioral health: (1) behavioral health workforce (e.g., the practice incorporates behavioral health providers at the site); (2) integrated information sharing (e.g., the practice shares patient information within and outside the practice to support integrated/coordinated care); (3) evidence-based care (the practice uses evidence-based protocols to identify and address BH needs) and (4) measuring and monitoring (e.g., the practice uses quality measures to monitor care of patients with behavioral health needs).

¹¹¹ Exhibit A: Managed Care Regulatory Compliance Guidelines. Pennsylvania Department of Human Services, 2019. Available at: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf

¹¹² NYC Population Health Improvement Program. "The PHIP Small Practice Project." June 2018. Available at: https://uhfnyc.org/media/filer_public/24/47/2447edf3-c3e3-4688-8dcc-dd396ae88ef0/nyc-phil-small-practice-final-20180614_1.pdf

¹¹³ Adapted from Kaiser Family Foundation. "Integrating Physical and Behavioral Health Care: Promising Medicaid Models." February 2014. Available at: https://www.integration.samhsa.gov/integrated-care-models/kaiser_brief_on_integrated_health_2014.pdf

¹¹⁴ Center for Medicare and Medicaid Services. "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services, February 2019." Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT-Factsheet-ICN904084TextOnly.pdf>

¹¹⁵ For more information on the Massachusetts Child Psychiatry Access Program, see: MCPAP. Available at: <https://www.mcpap.com/>

¹¹⁶ Center for Health Care Strategies. "Psychiatric Consultations Programs by State." March 2018. Available at: https://www.chcs.org/media/Psychiatric-Consultation-Programs_FINAL-030818.pdf

¹¹⁷ For more information on Project ECHO, see: University of New Mexico School of Medicine, Project Echo. Available at: <https://echo.unm.edu/>

¹¹⁸ B. Hager, M. Hasselberg, E. Arzubi, J. Betlinski, M. Duncan, J. Richman, et al. "Leveraging Behavioral Health Expertise: Practices and Potential of the Project ECHO Approach to Virtually Integrating Care in Underserved Areas." *Psychiatric Services*, 69: 4 (2018): 366-369.

¹¹⁹ M. Komaromy, D. Duhigg, A. Metcalf, C. Carlson, S. Kalishman, L. Hayes, et al. "Project ECHO (Extension for Community Healthcare Outcomes): A new model for educating PCPs about treatment of substance use disorders." *Substance Abuse*, 37, no. 1 (2016): 20-24.

- ¹²⁰ For more information on Vermont's Blueprint for Health, Hub and Spoke Model, see: Blueprint for Health. Available at: <http://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke>
- ¹²¹ For more information on Collaborative Care, see: AIMS Center. Available at: <https://aims.uw.edu/collaborative-care>.
- ¹²² R. Rajesh, R. Tampi, and S. Balachandran. "The case for behavioral health integration into primary care." *The Journal of Family Practice*, 68, no. 5 (2019): 278-284.
- ¹²³ Center for Medicare and Medicaid Services. "Behavioral Health Integration Services, January 2018." Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>
- ¹²⁴ Mann, Cindy. 2010. "Health Homes for Enrollees with Chronic Conditions." CMS: State Medicaid Director Letter #10-024, ACA #12. Available at: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>
- ¹²⁵ Kaiser Family Foundation. "Integrating Physical and Behavioral Health Care: Promising Medicaid Models." February 2014. Available at: https://www.integration.samhsa.gov/integrated-care-models/kaiser_brief_on_integrated_health_2014.pdf.
- ¹²⁶ Oregon Health Authority Patient-Centered Primary Care Home Program: 2017 Recognition Criteria Technical Specifications and Reporting Guide, September 2018. Available at: <https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/TA-Guide.pdf>.
- ¹²⁷ CCO 2.0 Request for Applications, RFA OHA-4690-19, Appendix B: Sample Contract, p. 51. Oregon Health Authority, January 25, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf>
- ¹²⁸ Oregon Health Authority. Patient Centered Primary Care (PCPCH) Enrollment. 2019. Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-PCPCH-Enrollment.pdf>
- ¹²⁹ 2019 Families and Children MCO Model Contract. Minnesota Department of Human Services, December 2019. Available at: https://mn.gov/dhs/assets/2019-fc-model-contract_tcm1053-370132.pdf
- ¹³⁰ Section 14.5.1. Page 229. Washington Apple Health Fully Integrated Managed Care Contract. Amendment #5. Washington Health Care Authority. Effective July 1, 2019. Available at: https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf
- ¹³¹ New York State Patient-Centered Medical Home (NYS PCMH). New York State. https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/.
- ¹³² Collaborative Care Medicaid Program (CCMP). New York State. <http://aims.uw.edu/nyscc/programs/collaborative-care-medicaid-program-ccmp>
- ¹³³ Section 4.11.1.9. Page 200. Contract with Amerihealth Caritas. RFP-2019-OMS-02-MANAG-01. P. 200. State of New Hampshire Department of Health and Human Services. April 1, 2019. Available at: <https://www.dhhs.nh.gov/ombp/medicaid/mcm-procurement.htm>
- ¹³⁴ Sample Health Plan Contract, State of Michigan Contract No. Comprehensive Health Care Program for the Michigan Department of Health and Human Services. pp. 59-60. Michigan Department of Health & Human Services, July 2, 2018. Available at: https://www.michigan.gov/documents/contract_7696_7.pdf
- ¹³⁵ Alternative Payment Model Initiative – Strategies and Performance-Based Payments Incentive. Arizona Health Care Cost Containment System. October 2017. Available at: <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/307.pdf>
- ¹³⁶ Value Based Payment Performance Measures for Public Comment. Department of Health Care Services, California, March 2019. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/VBP_Proposal_for_Comment_March_2019.pdf
- ¹³⁷ Health plan to attest to co-location of the provider and the direct payments to those providers.
- ¹³⁸ "Primary Care Payment Reform." Available at: <https://www.colorado.gov/pacific/hcpf/primary-care-payment-reform-3>
- ¹³⁹ Medicaid Managed Care/Family Health Plus/HIV Special needs Plan/Health and Recovery Plan Model Contract. New York State Department of Health, Office of Health Insurance Programs, Division of Health Plan Contracting and Oversight, October 2015. Available at: https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
- ¹⁴⁰ Washington State Health Care Authority. "WAC 182-531-0425 Collaborative Care, March 2018." Available at: <https://www.hca.wa.gov/health-care-services-supports/collaborative-care>
- ¹⁴¹ Center for Medicare and Medicaid Services. "Behavioral Health Integration Services, January 2018." Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>.
- ¹⁴² Disparity Measures: Emergency Department Utilization for Individuals Experiencing Mental Illness. Oregon Health Authority, December 2018. Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-Disparity-Measures-ED-Utilization-Among-Members-Experiencing-Mental-Illness.pdf>.
- ¹⁴³ Screening for Depression and Follow-Up Plan. Oregon Health Authority, December 2018. Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-Depression-Screening.pdf>
- ¹⁴⁴ Medicaid Managed Care Proposed Concept Paper: North Carolina's Care Management Strategy under Managed Care. North Carolina Department of Health and Human Services, March 2018. Available at: https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf
- ¹⁴⁵ American Medical Association. Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity. 2021-2023. Available at: <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>.
- ¹⁴⁶ Ibid.
- ¹⁴⁷ Ibid.

- ¹⁴⁸ Zinzi D. Bailey, Justin M. Feldman, and Mary T. Bassett. How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities. February 25, 2021. N Engl J Med 2021; 384:768-773. DOI: 10.1056/NEJMms2025396. Available at: <https://www.nejm.org/doi/full/10.1056/NEJMms2025396>.
- ¹⁴⁹ R. Garfield, K. Orgera, and A. Damico. *The Coverage Gap: Uninsured Poor Adults in the States that Do Not Expand Medicaid*. Faiser Family Foundation, January 2021. Available at: <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.
- ¹⁵⁰ Wisniewski JM, Walker B. Association of Simulated Patient Race/Ethnicity With Scheduling of Primary Care Appointments. JAMA Netw Open. 2020;3(1):e1920010. doi:10.1001/jamanetworkopen.2019.20010. Available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2759761>.
- ¹⁵¹ Elizabeth J. Brown, Daniel Polsky, Corentin M. Barbu, Jane W. Seymour, and David Grande. Racial Disparities In Geographic Access To Primary Care In Philadelphia. Health Affairs 2016 35:8, 1374-1381. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1612>.
- ¹⁵² Daly, Michael R., and Jennifer M. Mellor. Racial and Ethnic Differences in Medicaid Acceptance by Primary Care Physicians: A Geospatial Analysis. Medical Care Research and Review 77, no. 1 (February 2020): 85–95. <https://doi.org/10.1177/1077558718772165>.
- ¹⁵³ Ray KN, Chari AV, Engberg J, Bertolet M, Mehrotra A. Disparities in Time Spent Seeking Medical Care in the United States. JAMA Intern Med. 2015;175(12):1983–1986. doi:10.1001/jamainternmed.2015.4468. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2451279>.
- ¹⁵⁴ Liz Hamel, Lunna Lopes, Cailey Muñana, Samantha Artiga, and Mollyann Brodie. KFF/The Undeclared Survey on Race and Health. October 13, 2020. Available at: <https://www.kff.org/report-section/kff-the-undeclared-survey-on-race-and-health-main-findings/#HealthCareSystem>.
- ¹⁵⁵ Leiyou Shi, James Macinko, Barbara Starfield, Robert Politzer, Jiahong Xu. Primary care, race, and mortality in US states. Social Science & Medicine, Volume 61, Issue 1, 2005, Pages 65-75, ISSN 0277-9536, <https://doi.org/10.1016/j.socscimed.2004.11.056>. Available at: <https://www.sciencedirect.com/science/article/pii/S0277953604006008>.
- ¹⁵⁶ Elizabeth Arias, Betzaida Tejada-Vera, and Farida Ahmad. Provisional Life Expectancy Estimates for January through June, 2020. February 2021. Available at: <https://www.cdc.gov/nchs/data/vsrr/VSRR10-508.pdf>.
- ¹⁵⁷ Medicaid Coverage Rates by Ethnicity. 2019. Available at: <https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- ¹⁵⁸ People with Disabilities. MACPAC. Available at: <https://www.macpac.gov/subtopic/people-with-disabilities/>.
- ¹⁵⁹ National Academies of Science, Engineering, & Medicine. Implementing High-Quality Primary Care Rebuilding the Foundation of Health Care: Ensure Access. Policy Brief. Available at: <https://www.nap.edu/resource/25983/High%20Quality%20Primary%20Care%20Policy%20Brief%202%20Access.pdf>.
- ¹⁶⁰ Crenshaw, Kimberle () "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," University of Chicago Legal Forum: Vol. 1989: Iss. 1, Article 8. Available at: <http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>.
- ¹⁶¹ J.M Zhu, R. Rowland, R. Gunn, S. Gollust, and D.T. Grande. "Engaging Consumers in Medicaid Program Design: Strategies from the States." *The Milbank Quarterly*, 99, no.1 (2020): 99-125. Available at: <https://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12492>.
- ¹⁶² See Community Engagement Framework, pg. 17. Louisiana Department of Health. "Phase I Health Equity Plan." Available at: https://ldh.la.gov/assets/cphe/Equity_Framework.pdf.
- ¹⁶³ J.M. Zhu and R. Rowland. *Increasing Consumer Engagement In Medicaid: Learnings from States*. Oregon Health & Science University, December 2020. Available at: <https://www.ohsu.edu/sites/default/files/2020-12/Increasing%20Consumer%20Engagement%20in%20Medicaid%20-%20Learnings%20from%20States%2012.14.20.pdf>.
- ¹⁶⁴ 42 C.F.R. § 431.12. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=a3521ae5c32f40fa3f4fc0680440d453&mc=true&node=se42.4.431_112&rgn=div8.
- ¹⁶⁵ Anne Smithey and Shilpa Patel. Building a Culture of Health Equity from Within: Spotlight on Virginia Medicaid. CHCS. Available at: <https://www.chcs.org/building-a-culture-of-health-equity-from-within-spotlight-on-virginia-medicaid/>.
- ¹⁶⁶ Member Experience Advisory Councils. Colorado Department of Health Care Policy & Financing. Available at: <https://hcpf.colorado.gov/meac>.
- ¹⁶⁷ Oregon Health Authority. "Primary Care Payment Reform Collaborative." Available at: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx>.
- ¹⁶⁸ Oregon Health Care Authority. "Health Equity Measure: Meaningful Access to Health Care Services." May 2019. Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/MeetingDocuments/2019-05-02-Health-Equity-Measure-Proposal.pdf>.
- ¹⁶⁹ Oregon Health Authority. "2019 Government to Government Report." Available at: [https://www.oregonlegislature.gov/cis/GovToGovReports/2019%20\(OHA\).pdf](https://www.oregonlegislature.gov/cis/GovToGovReports/2019%20(OHA).pdf).
- ¹⁷⁰ For more information on Oregon's Community Advisory Council requirements and responsibilities, see: Oregon Health Authority. "CCO Community Advisory Councils." Available at: <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Community-Advisory-Councils.aspx>.
- ¹⁷¹ Oregon Health Authority. "Regional Health Equity Coalitions (RHECs)." Available at: <https://www.oregon.gov/oha/oei/Pages/rhec.aspx>.
- ¹⁷² Minnesota Department of Human Services Purchasing and Service Delivery Division. Request for Proposals (RFP) for a Grantee to: Provide prepaid health care services to eligible individuals through the Families and Children Medical Assistance and MinnesotaCare contracts in the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. January 4, 2021.

- ¹⁷³ Oregon Health Authority, Office of Equity and Inclusion. "Community Engagement Strategies Checklist: Oregon Health Authority." Available at: https://www.oregon.gov/oha/OEI/Documents/Community%20Engagement%20Strategies%20Checklist_vOHA_FINAL.pdf.
- ¹⁷⁴ NORC at the University of Chicago, Medicaid MCO Learning Hub. "Key Findings from Medicaid MCO Learning Hub Discussion Group Series and Roundtable – Focus on Member Engagement and the Consumer Voice." January 2021. Available at: https://www.norc.org/PDFs/Medicaid%20Managed%20Care%20Organization%20Learning%20Hub/MMCQLearningHub_MemberEngagement.pdf.
- ¹⁷⁵ J.M. Zhu and R. Rowland. *Increasing Consumer Engagement In Medicaid: Learnings from States*. Oregon Health & Science University, December 2020. Available at: <https://www.ohsu.edu/sites/default/files/2020-12/Increasing%20Consumer%20Engagement%20in%20Medicaid%20-%20Learnings%20from%20States%2012.14.20.pdf>.
- ¹⁷⁶ Pennsylvania Department of Human Services. "Racial Equity Report 2021." Available at: <https://www.dhs.pa.gov/about/Documents/2021%20DHS%20Racial%20Equity%20Report%20final.pdf>.
- ¹⁷⁷ Appendix E. National Academy of Sciences, Engineering, and Medicine. "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care." 2021. Available at: <https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care#sectionPublications>.
- ¹⁷⁸ J. Bataille and C. Hodes. *Advancing Health Equity in Oregon: Building a Foundation*. State Health & Value Strategies, January 2021. Available at: <https://www.shvs.org/oregon-health-authority-health-equity-case-study/>.
- ¹⁷⁹ United States Department of Health and Human Services. "Telehealth for patients with limited English proficiency." Available at: <https://telehealth.hhs.gov/providers/increasing-telehealth-equity-and-access/improving-access-to-telehealth/#telehealth-for-patients-with-limited-english-proficiency>.
- ¹⁸⁰ See: 42 C.F.R. § 438.340 (state managed care quality strategy). Available at: <https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-sec438-340.pdf>.
- ¹⁸¹ Minnesota Department of Human Services. "Minnesota Managed Care Comprehensive Quality Strategy." Page 13. July 2020. Available at: <https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-4538C-ENG>.
- ¹⁸² Medicaid Health Equity Reports. MDHHS. https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-489167--00.html.
- ¹⁸³ Louisiana Department of Health. "Community Partnerships & Health Equity." Available at: <https://ldh.la.gov/index.cfm/subhome/63>.
- ¹⁸⁴ Louisiana Department of Health. "Phase I Health Equity Plan." Available at: https://ldh.la.gov/assets/cphe/Equity_Framework.pdf.
- ¹⁸⁵ Louisiana Department of Health. "Barriers to Health Fact Sheet." <https://ldh.la.gov/assets/cphe/resources/BTH-FACT-SHEET.pdf>.
- ¹⁸⁶ Louisiana Department of Health. Section 2.6.5.10. Request for Proposals for Louisiana Medicaid Managed Care Organizations. Issued June 23, 2021. Available at: <https://www.cfpd.doa.louisiana.gov/osp/lapac/agency/pdf/7660203-01.pdf>.
- ¹⁸⁷ Lei Yu Shi, James Macinko, Barbara Starfield, Robert Politzer, Jiahong Xu. Primary care, race, and mortality in US states. *Social Science & Medicine*, Volume 61, Issue 1, 2005, Pages 65-75, ISSN 0277-9536. <https://doi.org/10.1016/j.socscimed.2004.11.056>. Available at: <https://www.sciencedirect.com/science/article/pii/S0277953604006008>.
- ¹⁸⁸ See 42 C.F.R. 438.68 (noting that states must develop a State must develop a quantitative network adequacy standard for adult and pediatric primary care providers).
- ¹⁸⁹ Simon F. Haeder, David L. Weimer, and Dana B. Mukamel. Secret Shoppers Find Access To Providers And Network Accuracy Lacking For Those In Marketplace And Commercial Plans. *Health Affairs* 2016 35:7, 1160-1166. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1554>.
- ¹⁹⁰ Health Resources & Services Administration. "Find Shortage Areas." Available at: <https://data.hrsa.gov/tools/shortage-area>.
- ¹⁹¹ Louisiana Department of Health. Section 2.6.5.10. Request for Proposals for Louisiana Medicaid Managed Care Organizations, op cit.
- ¹⁹² National Academies of Science, Engineering, & Medicine. Implementing High-Quality Primary Care Rebuilding the Foundation of Health Care: Ensure Access. Policy Brief. Available at: <https://www.nap.edu/resource/25983/High%20Quality%20Primary%20Care%20Policy%20Brief%202%20Access.pdf>.
- ¹⁹³ 42 C.F.R. § 438.14. Available at: <https://www.govinfo.gov/content/pkg/CFR-2016-title42-vol4/pdf/CFR-2016-title42-vol4-sec438-14.pdf>.
- ¹⁹⁴ National Conference of State Legislatures. "Racial and Ethnic Health Disparities: Workforce Diversity." Available at: <https://www.ncsl.org/documents/health/Workforcediversity814.pdf>.
- ¹⁹⁵ Primary Care Collaborative. "Primary Care Investment." Available at: <https://www.pccpc.org/primary-care-investment>.
- ¹⁹⁶ National Committee for Quality Assurance. Multicultural Health Care Demonstrating a Commitment to Equity. <https://www.ncqa.org/wp-content/uploads/2020/11/MHC-Factsheet-Final.pdf>.
- ¹⁹⁷ Agency for Healthcare Research and Quality. "Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement." Available at: <https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldata3.html>.
- ¹⁹⁸ Karla Silverman and Tamara Dumanovsky. Assessing the Impact of Complex Care Models: Opportunities to Fill in the Gaps. Brief. May 2021. Available at: https://www.chcs.org/media/AIM-Measures-Brief_051721.pdf.
- ¹⁹⁹ R. DeMeester, R. Mahadevan, S. Cook, J. Martin, K. Tuck, S. Patel, E. Durkin. *Using Data to Reduce Disparities and Improve Quality*. Advancing Health Equity. 2021. Available at: https://www.chcs.org/media/Using-Data-to-Reduce-Disparities-2021_Final.pdf.
- ²⁰⁰ Ohio Comprehensive Primary Care: Cultural Competency and Implicit Bias Training in Fulfillment of the Patient Experience Requirement. January 15, 2021. Available at: <https://medicaid.ohio.gov/static/Providers/PaymentInnovation/CPC/CPC-Cultural-Competence-Requirements-2021.pdf>.
- ²⁰¹ United States Department of Health and Human Services. "National CLAS Standards." Available at: <https://thinkculturalhealth.hhs.gov/clas>.

- ²⁰² S. Basu, J. Alpert, R.S. Phillips, W. Applebaum. *Primary care in the COVID-19 pandemic*. Center for Primary Care, Harvard Medical School. 2021. Available at: <https://info.primarycare.hms.harvard.edu/primary-care-during-covid-0>.
- ²⁰³ J.A. Rodriguez, A. Saadi, L.H. Schwamm, and D.W. Bates. "Disparities In Telehealth Use Among California Patients With Limited English Proficiency." *Health Affairs*, 40, no. 3 (2021). Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00823>.
- ²⁰⁴ American Medical Association. Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity. 2021-2023. Available at: <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>.
- ²⁰⁵ National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States. "Communities in Action: Pathways to Health Equity." January 2017. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK425845/>.
- ²⁰⁶ Centers for Disease Control and Prevention. "Paving the Road to Health Equity." Available at: https://www.cdc.gov/minorityhealth/publications/health_equity/index.html.
- ²⁰⁷ S.H. Woolf. "Progress in Achieving Health Equity Requires Attention to Root Causes." *Health Affairs*, 36, no. 6. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0197>.
- ²⁰⁸ B.C. Castrucci and J. Auerbach. "Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health." *Health Affairs Blog*, January 16, 2019. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20190115.234942>.
- ²⁰⁹ National Academies of Sciences, Engineering, and Medicine. "Integrating social care into the delivery of health care: Moving upstream to improve the nation's health." 2019. Available at: <https://doi.org/10.17226/25467>.
- ²¹⁰ North Carolina Department of Health and Human Services. "Advanced Medical Home Manual 2.1." *Requirement 2: Provide care management to high-needs patients*. Pages 8-9. April 2021. Available at: <https://files.nc.gov/ncdha/AMH-Provider-Manual-2.1-Final.pdf>.
- ²¹¹ Section 2.6. Louisiana Model Contract. June 2021. Available at: <https://www.cfrd.louisiana.gov/osp/lapac/agency/pdf/7660203-02.pdf>.
- ²¹² Oregon Health Authority. "Addressing Social Determinants of Health & Equity Through Health-Related Services." March 2021. Available at: <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-SDOH-E-Guide.pdf>.
- ²¹³ Nevada Department of Health and Human Services "Bid Solicitation 40DHHS-S1457 MCO RFP." May 2021. Available at: <https://nevadaepro.com/bso/external/bidDetail.sdo?bidId=40DHHS-S1457&parentUrl=activeBids>.
- ²¹⁴ Pennsylvania Department of Human Services. "Regional Accountable Health Councils (RAHCs) Program Overview." December 2020. Available at: <https://www.dhs.pa.gov/HealthInnovation/Documents/RAHC%20Program%20Overview%201.11.2021.pdf>.
- ²¹⁵ American Psychiatric Association, Division of Diversity and Health Equity and Division of Communications. "Mental Health Disparities: Diverse Populations." 2017. Available at: <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Diverse-Populations.pdf>.
- ²¹⁶ J. Purtle. "COVID-19 and mental health equity in the United States." *Nature Public Health Emergency Collection*. No. 17 (2020): 1-3. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7298157/>.
- ²¹⁷ Centers for Disease Control and Prevention. "Disability and Health Promotion: Mental Health for All." 2020. Available at: <https://www.cdc.gov/ncbddd/disabilityandhealth/features/mental-health-for-all.html>.
- ²¹⁸ V. Agbafé, W.R. Boles, and R.E. Gee. "Bridging The Black Mental Health Access Gap," *Health Affairs Blog*, November 20, 2020. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20201113.817116/full/>.
- ²¹⁹ National Alliance on Mental Illness. "Hispanic/Latinx." Available at: <https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Hispanic-Latinx>.
- ²²⁰ National LGBTQIA+ Health Education Center. "Supportive Housing and Health Services for LGBTQIA+ Youth Experiencing Homelessness: Promising Practices." 2020. Available at: <https://www.lgbtqihealtheducation.org/wp-content/uploads/2020/07/Supportive-Housing-and-Health-Services-for-LGBTQIA-Youth-Experiencing-Homelessness.pdf>.
- ²²¹ United States Government Accountability Office. "Report to Congressional Committees: Substance Use Disorder Medicaid Coverage of Peer Support Services for Adults." August 2020. Available at: <https://www.gao.gov/assets/gao-20-616.pdf>.
- ²²² Association of State and Territorial Health Officials. "The Role of Peer Support in Federally Qualified Health Centers." August 2020. Available at: <https://www.astho.org/ASTHOBriefs/The-Role-of-Peer-Support-in-Federally-Qualified-Health-Centers/>.
- ²²³ National Council for Mental Wellbeing. "Fostering Resilience and Recovery: A Change Package for Advancing Trauma-Informed Care." Available at: https://www.thenationalcouncil.org/wp-content/uploads/2019/12/FosteringResilienceChangePackage_Final.pdf?dof=375ateTbd56.
- ²²⁴ National Academies of Sciences, Engineering, and Medicine. "Implementing high-quality primary care: Rebuilding the foundation of health care." 2021. Available at: <https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care>.
- ²²⁵ Washington Health Care Authority. "Multi-payer Primary Care Transformation Model." Available at: <https://www.hca.wa.gov/about-hca/value-based-purchasing/multi-payer-primary-care-transformation-model>.
- ²²⁶ State Health Value & Strategies. "Risk Adjustment Based on Social Factors: State Approaches to Filling Data Gaps." August 2020. Available at: https://www.shadac.org/sites/default/files/FINAL_SHVS-Risk-Adjustment-Brief.pdf.

- ²²⁷ S. Patel, A. Smithey, K. Tuck, & T. McGinnis. *Leveraging Value-Based Payment Approaches to Promote Health Equity: Key Strategies for Health Care Payers*. Advancing Health Equity. Available at: https://www.chcs.org/media/Leveraging-Value-Based-Payment-Approaches-to-Promote-Health-Equity-Key-Strategies-for-Health-Care-Payers_Final.pdf.
- ²²⁸ Minnesota Department of Human Services. "Request for Proposals for a Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through Track 1 of the Integrated Health Partnerships (IHP) Demonstration." *7.2 Quality and the Population-Based Payment*. Pages 19-20. August 2020. Available at: https://mn.gov/dhs/assets/2021-ihp-rfp_tcm1053-396900.pdf.
- ²²⁹ Health Resources & Services Administration. "What is a health center?" Available at: <https://bphc.hrsa.gov/about/what-is-a-health-center/index.html>.
- ²³⁰ Institute for Medicaid Innovation. "2020 Medicaid MCO Best Practices and Innovative Initiatives." Available at: https://www.medicaidinnovation.org/images/content/2020_Medicaid_MCO_Innovative_Programs.pdf.
- ²³¹ G. Howe, T. McGinnis, & R. Houston. *Accelerating Value-Based Payment in California's Federally Qualified Health Centers: Options for Medicaid Health Plans*. April 2019. Available at: https://www.chcs.org/media/CA-VBP-FQHC-Report_041619.pdf#page=9&zoom=100,73,129.
- ²³² Stephanie B. Gold, Larry A. Green, John M. Westfall. "Heeding the Call for Urgent Primary Care Payment Reform: What Do We Know about How to Get Started?" *The Journal of the American Board of Family Medicine* Mar 2021, 34 (2) 424-429. Available at: <https://www.jabfm.org/content/34/2/424>.
- ²³³ L&M Policy Research. "Evaluation of CMMI Accountable Care Organization Initiatives." November 2016. Available at: <https://innovation.cms.gov/files/reports/advpayaco-fnevalrpt.pdf>.
- ²³⁴ North Carolina Medicaid. "Fact Sheet Health Equity Enhanced Payment Initiative." March 2021. Available at: <https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Health-Equity-Payments-20210331.pdf>.
- ²³⁵ Michigan Department of Health and Human Services. "Comprehensive Health Care Program for the Michigan Department of Health and Human Services." *Appendix 5a: Performance Bonus Template*. Pages 183-184. FY2021 Contract. Available at: https://www.michigan.gov/documents/contract_7696_7.pdf.
- ²³⁶ Michigan Department of Health and Human Services. "Comprehensive Health Care Program for the Michigan Department of Health and Human Services." *Appendix 5b: Focus Bonus Low Birth Weight (LBW) Project*. Pages 185-186. FY2021 Contract. Available at: https://www.michigan.gov/documents/contract_7696_7.pdf.
- ²³⁷ Michigan Department of Health and Human Services. "Medicaid Health Equity Reports." Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-489167--,00.html.
- ²³⁸ Press Release: Mayor Bowser and the Department of Health Care Finance Announce New Policy to Advance Health Care Equity: Equal Access to Key Providers for All Medicaid and Alliance Enrollees. March 4, 2021. Available at: <https://thedcline.org/2021/03/04/press-release-mayor-bowser-and-the-department-of-health-care-finance-announce-new-policy-to-advance-health-care-equity-equal-access-to-key-providers-for-all-medicaid-and-alliance-enrollees/>.
- ²³⁹ California Department of Health Care Services. "Draft Request for Proposal #20-10029." *Exhibit A, Attachment III*. 2021. Available at: https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/CSBmcdmcpHOME.aspx.
- ²⁴⁰ Ohio Department of Medicaid. "Ohio Resilience through Integrated Systems and Excellence (OhioRISE) Program RFA Number: ODMR-2021-0025." Page 81. December 2020. Available at: <https://procure.ohio.gov/PDF/1028202082914ODMR20210025.pdf>.
- ²⁴¹ The Oklahoma Health Care Authority. "SoonerSelect RFP." *Section 1.10.7: Addressing Health Disparities*. November 2020. Available at: <https://oklahoma.gov/content/dam/ok/en/okhca/docs/about/procurement/soonerselect/documents/Solicitation%208070001240%20-%20SoonerSelect%20RFP.pdf>.
- ²⁴² California Department of Health Care Services. "Draft Request for Proposal #20-10029." *Exhibit A, Attachment III*. 2021. Available at: https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/CSBmcdmcpHOME.aspx.
- ²⁴³ Section 2.2.2.4.4.8. Louisiana Model Contract. June 2021. Available at: <https://www.cfprd.doa.louisiana.gov/osp/lapac/agency/pdf/7660203-02.pdf>.
- ²⁴⁴ Nevada Department of Health and Human Services "Bid Solicitation 40DHHS-S1457 MCO RFP." May 2021. Available at: <https://nevadaepro.com/bsa/external/bidDetail.sdo?bidId=40DHHS-S1457&parentUrl=activeBids>.
- ²⁴⁵ Washington State Health Care Authority. "Washington Apple Health Integrated Managed Care Contract." *Section 7.5.14*. Effective January 1, 2021. Available at: <https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf>.
- ²⁴⁶ State of Hawaii Department of Human Services Request for Proposals (RFP). QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals. RFP-MQD-2021-008. https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/RFP/quest-integration/QI_RFP-MQD-2021-008_Amendments_1-4.pdf.
- ²⁴⁷ Washington State Health Care Authority. "Washington Apple Health Integrated Managed Care Contract." *Section 7.5.14*. Effective January 1, 2021. Available at: <https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf>.
- ²⁴⁸ Ohio Department of Medicaid. Comprehensive Primary Care. <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/payment-innovation/comprehensive-primary-care/comprehensive-primary-care>.
- ²⁴⁹ Oregon Health Authority. Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency – MY2021 to MY2023. Available at: <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2021-2023%20Measure%20Spec%20Sheet-Meaningful%20Access-8July2020.pdf>.
- ²⁵⁰ ATTACHMENT K – INFRASTRUCTURE INCENTIVE PROGRAM: REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND CERTIFIED ACCOUNTABLE ENTITIES Program Year 4. Available at: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment_K_PY4_Incentive_Program_Requirements.pdf.

- ²⁵¹ L. Schottenfeld, D. Petersen, D. Peikes, R. Ricciardi, H. Burak, R. McNellis, et al. "Creating Patient-centered Team-based Primary Care." Mathematica Policy Research for Agency for Healthcare Research and Quality, March 2019. Available at: <https://pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-team-based-primary-care-white-paper.pdf>
- ²⁵² K. Coleman, E. Wagner, J. Schaefer, R. Reid, and L. LeRoy. "White Paper: Redefining Primary Care for the 21st Century". Prepared by Abt Associates, in partnership with the MacColl Center for Health Care Innovation and Bailit Health Purchasing, for the Agency for Healthcare Research and Quality, AHRQ Publication No. 16(17)-0022-EF, October 2016. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/workforce-financing/white_paper.pdf
- ²⁵³ D.N. Peikes, R.J. Reid, T.J. Day, D.D.F. Cornwell, S.B. Dale, R.J. Baron, et al. "Staffing patterns of primary care practices in the comprehensive primary care initiative." *Annals of Family Medicine*, 12 (2014):142–9. Available at: <http://www.annfammed.org/content/12/2/142.full>
- ²⁵⁴ QUEST Integration, Request for Information No. RFI-MQD-2019-002, pp. 8-9. Med-QUEST Division, Department of Human Services, September 20, 2018. Available at: <https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/RFP/REV-QI-RFI-MQD-2019-002-10-18-2018.pdf>
- ²⁵⁵ Request for Proposals for Medallion 4.0 Medicaid/Famis Managed Care, RFP 2017-03, pp. 98-99. Department of Medical Assistance Services, Commonwealth of Virginia, July 17, 2017. Available at: <https://www.bidnet.com/bneattachments/459484772.pdf>
- ²⁵⁶ Request for Proposals for a Qualified Grantee to: Provide Health Care Services to Families and Children through Medical Assistance (Families and Children) and MinnesotaCare in 80 Greater Minnesota Counties, p. 70. Purchasing and Service Delivery Division, Minnesota Department of Human Services, February 25, 2019. Available at: https://mn.gov/dhs/assets/2019-fc-2020-rfp-amended-to-provide-prepaid-hc-to-greater-mns-eligible-fc-and-minnesotacare-individuals_tcm1053-385010.docx
- ²⁵⁷ Amended Version (RFP A2) RFP Sample Contract, Centennial Care 2.0, Section 4.4.19. New Mexico Human Services Department. Available at: https://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/Amended_Version__RFP_A2__RFP_Sample_Contract.pdf
- ²⁵⁸ For more information on the NCQA Patient-Centered Medical Home Model, see: National Committee for Quality Assurance. "Patient-Centered Medical Home (PCMH)". Available at: <https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/>
- ²⁵⁹ Sample Health Plan Contract, State of Michigan Contract No. Comprehensive Health Care Program for the Michigan Department of Health and Human Services, Section X. Population Health Management, B.3. Michigan Department of Health & Human Services, July 2, 2018. Available at: https://www.michigan.gov/documents/contract_7696_7.pdf
- ²⁶⁰ Request for Proposals for Louisiana Medicaid Managed Care Organizations, RFP #3000011953, Appendix B: Model Contract, Section 2.7.11. Bureau of Health Services Financing, Louisiana Department of Health, February 25, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf
- ²⁶¹ Center for Health Care Strategies and State Health Access Data Assistance Center. "Community Care Teams: An Overview of State Approaches." March 2016. Available at: <https://www.chcs.org/media/Community-Care-Teams-An-Overview-of-State-Approaches-030316.pdf>
- ²⁶² SAMSHA-HRSA Center for Integrated Health Solutions. "Peer Providers." Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration. Available at: <https://www.integration.samhsa.gov/workforce/team-members/peer-providers#role%20of%20peer%20providers>
- ²⁶³ Association of State and Territorial Health Officials. "Community Health Worker Certification and Financing." 2016. Available at: <http://www.astho.org/Community-Health-Workers/CHW-Certification-Financing/>
- ²⁶⁴ C. Thomas-Henkel, S. Turner, and B. Freda. *Opportunities to Enhance Community-Based Medication Management Strategies for People with Complex Health and Social Needs*. Center for Health Care Strategies, June 2018. Available at: https://www.chcs.org/media/CMMC_Report_062918-1.pdf
- ²⁶⁵ Washington Health Care Authority. "WAC 182-531-0425 Collaborative Care." Available at: <https://www.hca.wa.gov/health-care-services-supports/collaborative-care>
- ²⁶⁶ Minnesota Department of Health. "Community Health Worker". Available at: <https://www.health.state.mn.us/facilities/ruralhealth/emerging/chw/index.html>
- ²⁶⁷ New York State Department of Health. "2018-2019 Enacted Budget Initiative: Patient Centered Medical Home Statewide Incentive Payment Program: Revised Incentive Payments and Updated Billing Guidance." New York State Medicaid Update, April 2018, Volume 34, Number 4. Available at: https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-04.htm#pcmh
- ²⁶⁸ HealthChoices Agreement Exhibits, Exhibit DDD. Pennsylvania Department of Human Services, Effective January 1, 2019. Available at: <http://www.dhs.pa.gov/provider/healthcaremedicalassistance/managedcareinformation/>
- ²⁶⁹ Ibid.
- ²⁷⁰ CCO 2.0 Request for Applications, RFA OHA-4690-19, Attachment 8 — Value-Based Payment Questionnaire. Oregon Health Authority, January 25, 2019. Available at: <https://www.oregon.gov/oha/OPHB/CCODocuments/07-CCO-RFA-4690-0-Attachment-8-VBP-Questionnaire-Final.pdf>
- ²⁷¹ Request for Proposals for Louisiana Medicaid Managed Care Organizations, RFP #3000011953, Appendix B: Model Contract, Section 2.7.11. Bureau of Health Services Financing, Louisiana Department of Health, February 25, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf
- ²⁷² Association of State and Territorial Health Officials. "Community Health Worker Certification and Financing". Op. cit.
- ²⁷³ C. Garfield and S. Kangovi. "Integrating Community Health Workers into Health Care Teams Without Coopting Them". *Health Affairs Blog*, May 10, 2019. Available at: <https://www.healthaffairs.org/do/10.1377/hblog20190507.746358/full/>

- ²⁷⁴ A. Spencer. *Integrating Community Health Workers into State and Local Chronic Disease Prevention Efforts: Program and Financing Considerations*. Center for Health Care Strategies for Nemours Children's Health System, AcademyHealth, and the Robert Wood Johnson Foundation. February 2018. Available at: <https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/integrating-community-health-workers-into-domain-3d-projects.pdf>
- ²⁷⁵ S. Kangovi, N. Mitra, D. Grande, M. L. White, S. McCollum, J. Sellman, et al. "Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes." *JAMA Internal Medicine*, 174, no. 4 (2014):535-543. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1828743>
- ²⁷⁶ S. Kangovi, N. Mitra, D. Grande, H. Huo, R.A. Smith, and J.A. Long. "Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial." *American Journal of Public Health*, 107, no. 10 (2017):1660-1667 Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28817334>
- ²⁷⁷ Minnesota Department of Health. "Community Health Worker." Op. cit.
- ²⁷⁸ Association of State and Territorial Health Officials. "Community Health Worker Certification and Financing". Op. cit.
- ²⁷⁹ Louisiana Department of Health. "Louisiana Demonstration Community Health Worker Program Overview." RFP Procurement Library. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/CHWPOverview.pdf
- ²⁸⁰ HealthChoices Agreement Exhibits, Exhibit DDD. Op. cit.
- ²⁸¹ Blueprint for Health, Department of Vermont Health Access. "Blueprint Community Health Teams." Available at: <https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-community-health-teams>
- ²⁸² Blueprint for Health, Department of Vermont Health Access. "Vermont Blueprint for Health Manual". September 2018. Available at: <https://blueprintforhealth.vermont.gov/sites/bfh/files/Blueprint-Manual-Oct1-2018.pdf>
- ²⁸³ State of Vermont, Contract for Services OneCare Vermont Accountable Care Organization, Contract #34070 Amendment #1, Attachment A1. 2017. Available at: <https://blueprintforhealth.vermont.gov/sites/bfh/files/OneCare%20Am1%2034070%20ForFinalExecution.pdf>
- ²⁸⁴ New York State Department of Health. "New York State Patient-Centered Medical Home (NYS PCMH)." Available at: https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/
- ²⁸⁵ New York State Department of Health. "2018-2019 Enacted Budget Initiative: Patient Centered Medical Home Statewide Incentive Payment Program: Revised Incentive Payments and Updated Billing Guidance." Op. cit.
- ²⁸⁶ CCO 2.0 Request for Applications, RFA OHA-4690-19, Attachment 8 — Value-Based Payment Questionnaire, op. cit.
- ²⁸⁷ HealthChoices Agreement Exhibits, Exhibit DDD. Op. cit.
- ²⁸⁸ Amended Version (RFP A2) RFP Sample Contract, Centennial Care 2.0, op. cit., Attachment 3.
- ²⁸⁹ Oregon Health Authority. "Patient Centered Primary Care Home (PCPCH) Enrollment." Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-PCPCH-Enrollment.pdf>
- ²⁹⁰ Page 126-129. Health Plan Services Contract, Coordinated Care Organization Contract # 143115-10 with Health Share of Oregon. Oregon Health Authority, effective January 1, 2018. Available at: <https://multco.us/file/69710/download>
- ²⁹¹ HealthChoices Agreement Exhibits, Exhibit DDD. Op. cit.
- ²⁹² Section 2.01.01.01.02, pp. 43-45. NHP-2017. Contract between State of Rhode Island and Providence Plantations Executive Office of Health and Human Services and Neighborhood Health Plan of Rhode Island for Medicaid Managed Care Services. Amended May 1, 2018.
- ²⁹³ Request for Proposals for Louisiana Medicaid Managed Care Organizations, RFP #:3000011953, op. cit, pp. 84-86
- ²⁹⁴ Amended Version (RFP A2) RFP Sample Contract, Centennial Care 2.0, op. cit., Attachment 3.
- ²⁹⁵ Sample Health Plan Contract, State of Michigan Contract No. Comprehensive Health Care Program for the Michigan Department of Health and Human Services, Section X. Population Health Management, B.3. Michigan Department of Health & Human Services, July 2, 2018. Available at: https://www.michigan.gov/documents/contract_7696_7.pdf
- ²⁹⁶ Center for Connected Health Policy. "State Telehealth Laws and Reimbursement Policies, At a Glance, Fall 2018." Available at: https://www.cchpca.org/sites/default/files/2018-10/Fall_2018_50_State_Infographic_FINAL.pdf.
- ²⁹⁷ For more information on Project ECHO, see: Project Echo and the University of New Mexico School of Medicine. Available at: <https://echo.unm.edu/>.
- ²⁹⁸ S. Arora, K. Thornton, G. Murata, P. Deming, et al. "Outcomes of Treatment for Hepatitis C Virus Infection by PCPs." *The New England Journal of Medicine*, 364 (2011): 2199-2207.
- ²⁹⁹ D. Anderson, V. Villagra, E. Coman, T. Ahmed, A. Porto, N. Jepeal, et al. "Reduced Cost Of Specialty Care Using Electronic Consultations for Medicaid Patients." *Health Affairs*, 37, no. 12 (2018): 2031-2036.
- ³⁰⁰ QUEST Integration (QI) Request for Information No. RFI-MQD-2019-002. Department of Human Services Med-QUEST Division. September 20, 2018. Available at: <https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/RFP/REV-QI-RFI-MQD-2019-002-10-18-2018.pdf>.
- ³⁰¹ RFP 30-190029-DHB. Section VII. Attachment O. North Carolina Department of Health and Human Services. Available at: <https://files.nc.gov/ncdhhs/30-19029-DHB-3.pdf>.
- ³⁰² Medallion 4.0 RFP. Commonwealth of Virginia Department of Medical Assistance Services. July 17, 2018. Available at: <https://www.bidnet.com/bneattachments?/459484772.pdf>.
- ³⁰³ MACPAC. "MACPAC Report to Congress on Medicaid and CHIP, Chapter 2: Telehealth in Medicaid." March 2018. Available at: <https://www.macpac.gov/wp-content/uploads/2018/03/Telehealth-in-Medicaid.pdf>.

- ³⁰⁴ Center for Connected Health Policy. "State Telehealth Laws and Reimbursement Policies, At a Glance, Fall 2018." Available at: https://www.cchpca.org/sites/default/files/2018-10/Fall_2018_50_State_Infographic_FINAL.pdf
- ³⁰⁵ J. Park, C. Erikson, X. Han, and P. Iyer. "Are State Telehealth Policies Associated With The Use of Telehealth Services Among Underserved Populations?" *Health Affairs*, 37, no. 12 (2018): 2060-2068.
- ³⁰⁶ <http://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx>.
- ³⁰⁷ [https://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20\(07.26.2018\).pdf](https://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20(07.26.2018).pdf).
- ³⁰⁸ G. Howe, "Project ECHO: Medicaid Financing," Presentation to Hepatitis C Medicaid Affinity Group, June 25, 2018. Available at: <https://www.hhs.gov/sites/default/files/HepCAffinityGroup-Project-ECHO-and-HCV-Treatment.pdf>
- ³⁰⁹ Contract to Provide Managed Care Services for the Medicaid and Family Access to Medical Insurance Security (FAMIS) Program, Commonwealth of Virginia, Department of Medical Assistance Services, July 2018. Available at: [https://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20\(07.26.2018\).pdf](https://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20(07.26.2018).pdf)
- ³¹⁰ Contract – RFP NO. YH19-0001. Arizona Health Care Cost Containment System, Arizona, April 2019. Available at: https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_Contract_Final_AMD4.pdf
- ³¹¹ Exhibit V. HealthChoices Agreement Exhibits – Effective January 1, 2019. Pennsylvania Department of Human Services. Available at: http://dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf.
- ³¹² Medicaid Managed Care services Agreement Among New Mexico Human Services Department, New Mexico Behavioral Health Purchasing Collaborative, and HCHC Insurance Services, operating as Blue Cross and Blue Shield of New Mexico, PSC 18-630-8000-0033 A1/CFDA 93.778, Department of Human Services, State of New Mexico, January 2019. Available at: <https://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Contracts/Medical%20Assistance%20Division/MCO's%20Centennial%20Care%202.0/BCBS%20Contract%20PS C%2018-630-8000-0033%20A1.pdf>
- ³¹³ D. Anthony, C. Campos-Castillo, and P. Lim. "Who Isn't Using Patient Portals And Why? Evidence And Implications From A National Sample Of US Adults." *Health Affairs*, 37, no. 12 (2018): 1948-1954. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05117>
- ³¹⁴ J. Park, C. Erikson, X. Han, and P. Iyer. "Are State Telehealth Policies Associated With The Use of Telehealth Services Among Underserved Populations?" *Health Affairs*, 37, no. 12 (2018): 2060-2068.
- ³¹⁵ Agency for Healthcare Research and Quality. "Defining the PCMH". Available at: <https://pcmh.ahrq.gov/page/defining-pcmh>
- ³¹⁶ NCQA's 2017 standards are categorized as either "core" or "elective"; practice must achieve all 40 core criteria and 25 credits in elective criteria (elective criteria are 1 or 2 credits each) to be PCMH Recognized. National Committee for Quality Assurance. "PCMH Standards and Guidelines". 2017 Edition, Version 4, July 24, 2018. Available at: <http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/>
- ³¹⁷ S. Artiga and E. Hinton. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*. Henry J. Kaiser Family Foundation, May 10, 2018. Available at: <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
- ³¹⁸ K. Kroenke and J. Unutzer. "Closing the False Divide: Sustainable Approaches to Integrating Mental Health Services into Primary Care Available". *Journal of General Internal Medicine*, 32, no. 4 (2017): 404–410. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5377893/>
- ³¹⁹ Institute of Medicine. "Primary Care and Public Health Exploring Integration to Improve Population Health". March 2012. http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2012/Primary-Care-and-Public-Health/Primary%20Care%20and%20Public%20Health_Revised%20RB_FINAL.pdf
- ³²⁰ J.H. Hibbard and J. Greene. "What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs." *Health Affairs*, 32, no. 2 (Feb 2013). Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1061>
- ³²¹ J.H. Hibbard, J. Stockard, E.R. Mahoney, and M. Tusler. "Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers". *Health Services Research*, 39, no. 4 (2004): 1005-1026. Available at: <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-6773.2004.00269.x>
- ³²² Julia James. *Health Policy Brief: Patient Engagement*. Health Affairs, Robert Wood Johnson Foundation. February 14, 2013. Available at: https://www.healthaffairs.org/doi/10.1377/hpb20130214.898775/full/healthpolicybrief_86.pdf
- ³²³ G. Guenther and J. Shearer. *Landscape Assessment: Bringing Health to Local Communities*. Global to Local, prepared by PATH. March 2016. Available at: https://www.globaltolocal.org/wp/wp-content/uploads/2017/02/G2L_LandscapeAssessment_FINAL.pdf
- ³²⁴ L. Fitzpatrick. *The Time Is Now: The Case for Digital Health Innovation for the Poor and Underserved*. The Commonwealth Fund. December 18, 2018. Available at: <https://www.commonwealthfund.org/blog/2018/time-now-case-digital-health-innovation-poor-and-underserved>
- ³²⁵ S. Seervai and L. Gustafsson. *Technology Could Transform Care for People on Medicaid*. The Commonwealth Fund. December 18, 2018. Available at: <https://www.commonwealthfund.org/publications/2018/dec/technology-could-transform-care-people-medicaid>
- ³²⁶ L. Uscher-Pines and A. Mehrotra. "Analysis Of Teladoc Use Seems To Indicate Expanded Access To Care For Patients Without Prior Connection To A Provider". *Health Affairs*. 33, no. 2 (2014): 258–264. Available at: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0989>

- ³²⁷ C.J. Peden and L.A. Saxon. *Digital Technology to Engage Patients: Ensuring Access for All*. NEJM Catalyst. October 12, 2017. Available at: <https://catalyst.nejm.org/digital-health-technology-access/>
- ³²⁸ V.G. Vimalananda, G. Gupte, S.M. Seraj, J. Orlander, D. Berlowitz, B.G. Fincke, and S.R. Simon. "Electronic consultations (e-consults) to improve access to specialty care: A systematic review and narrative synthesis". *Journal of Telemedicine and Telecare*, 21, no. 6 (2015): 323–330. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561452/pdf/10.1177_1357633X15582108.pdf
- ³²⁹ A. English, C. Lanzara, A. Awale, and L.Hatt. *Measuring What Matters: Case Studies on Data Innovations for Strengthening Primary Health Care*. Primary Health Care Performance Initiative. December 2018. Available at: https://improvingphc.org/sites/default/files/Measuring%20what%20matters_Innovation%20Cases_2018.pdf
- ³³⁰ A.W. Bazemore, E.K. Cottrell, R. Gold, L.S. Hughes, R.L. Phillips, H. Angier, et al. "'Community vital signs': incorporating geocoded social determinants into electronic records to promote patient and population health". *Journal of the American Medical Informatics Association*, 23, issue 2 (2016): 407–412. Available at: <https://academic.oup.com/jamia/article/23/2/407/2572403>
- ³³¹ Committee on the Recommended Social and Behavioral Domains and Measures for Electronic Health Records, Board on Population Health and Public Health Practice, and Institute of Medicine. *Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2*. Washington, DC: National Academies Press, 2015. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK269341/>
- ³³² M. Pesec et al. "Primary Health Care That Works: The Costa Rican Experience." *Health Affairs*, 36, no. 3 (March 2017). Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1319?siteid=healthaff&keytype=ref&ijkey=uG%2FhmzgKjtbo6>
- ³³³ Primary Health Care Performance Initiative. "Population Health Management: Empanelment." 2018. Available at: <https://improvingphc.org/improvement-strategies/population-health-management/empanelment>
- ³³⁴ J. Martinez, M. Ro, N.W. Villa, W. Powell, and J.R. Knickman. "Transforming the Delivery of Care in the Post-Health Reform Era: What Role Will Community Health Workers Play?". *American Journal of Public Health*, 101, no. 12 (2011): e1–e5. Available at: <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2011.300335>
- ³³⁵ H.B. Perry, R. Zulliger, and M.M. Rogers. "Community Health Workers in Low-, Middle-, and High-Income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness." *Annual Reviews Public Health*, 35 (Jan 2014): 399–421. Available at: <https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-032013-182354>
- ³³⁶ S. Kangovi, N. Mitra, L. Norton, R. Harte, X. Zhao, and T. Carter, et al. "Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities". *JAMA Internal Medicine*. 178, issue 12 (2018):1635–1643. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2707949>
- ³³⁷ Agency for Healthcare Research and Quality. "Defining the PCMH". Op. cit.
- ³³⁸ A.D. Sinaiko, M.B. Landrum, D.J. Meyers, S. Alidina, D.D. Maeng, M.W. Friedberg, et al. "Synthesis Of Research On Patient-Centered Medical Homes Brings Systematic Differences Into Relief". *Health Affairs*, 36, no. 3 (2017): 500–508. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1235>
- ³³⁹ M.W. Friedberg, K.L. Coltin, D.G. Safran, M. Dresser, and E.C. Schneider. "Medical Home Capabilities of Primary Care Practices That Serve Sociodemographically Vulnerable Neighborhoods". *Archives of Internal Medicine*, 170, no. 11 (2010): 938–944. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/775157>
- ³⁴⁰ National Committee for Quality Assurance. "PCMH Standards and Guidelines". 2017 Edition, Version 4, July 24, 2018. Available at: <http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/>
- ³⁴¹ New York State Department of Health. "APC Evidence Crosswalk to NYS PCMH". April 1, 2018. Available at: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/apc_to_pcmh_evidence_crosswalk.pdf
- ³⁴² National Committee for Quality Assurance. "New York State Patient-Centered Medical Home (NYS PCMH) Recognition Program." Available at: <https://www.ncqa.org/programs/health-care-providers-practices/state-and-government-recognition/nys-patient-centered-medical-home/>
- ³⁴³ M. Friedrich. "Notice of NYS PCMH Release". New York State Department of Health, Office of Quality and Patient Safety. April 9, 2018. Available at: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/pcmh_release_notice.pdf
- ³⁴⁴ New York State Department of Health. "New York State Patient-Centered Medical Home (NYS PCMH)." August 2018. Available at: https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/
- ³⁴⁵ New York State Department of Health. "Announcing New York Medicaid's Statewide Patient-Centered Medical Home Incentive Program." New York State Medicaid Update, December 2009, Volume 25, Number 16. Available at: https://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-12spec.htm
- ³⁴⁶ Approval document for New York State Plan Amendment (SPA) #09–49–A. Centers for Medicare and Medicaid Services. May 13, 2010. Available at: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NY/NY-09-49A.pdf>
- ³⁴⁷ Email exchange with New York State Department of Health staff, May 9, 2019
- ³⁴⁸ Oregon Health Authority. "Patient-Centered Primary Care Home Program: Policy Background and Program Development". Available at: <https://www.oregon.gov/oha/HPA/dsi-pcpc/Docs/Policy-Development-Program-Background.aspx>
- ³⁴⁹ Oregon Health Authority. "2017 PCPC Standards - NCQA PCMH 2017 Standards – Crosswalk". Available at: <https://www.oregon.gov/oha/HPA/CSI-PCPC/Docs/PCPC-2017-Crosswalk-with-NCQA.pdf>
- ³⁵⁰ Oregon Health Authority. "Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide". Version 3, pp. 4–5, September 2018. Available at: <https://www.oregon.gov/oha/HPA/dsi-pcpc/Docs/TA-Guide.pdf>
- ³⁵¹ Oregon Health Authority. "Patient-Centered Primary Care Home Program: Policy Background and Program Development". Op. cit.

- ³⁵² J. Vandehey and S. Jarem. "The future of coordinated care in Oregon: Introductory Webinar." Oregon Health Authority. March 15, 2018. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/Introductory%20Webinar%20slide%20deck.pdf>
- ³⁵³ Ohio Governor's Office of Health Transformation. "Ohio Comprehensive Primary Care (CPC) Program Frequently Asked Questions". December 2018. <https://www.medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/FAQ.pdf>
- ³⁵⁴ RTI International. "State Innovation Models (SIM) Round 2; Model Test Annual Report Two". Appendix H, 2018. Available at: <https://downloads.cms.gov/files/cmmti/sim-round2test-secondannrpt.pdf>
- ³⁵⁵ Ohio Governor's Office of Health Transformation. "State Innovation Models Round 2 Model Test: Ohio Operational Plan". December 16, 2015. Accessed February 2019.
- ³⁵⁶ Approval document for Ohio State Plan Amendment (SPA) #17 043. Centers for Medicare and Medicaid Services, March 8, 2018. Available at: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-17-043.pdf>
- ³⁵⁷ Ohio Governor's Office of Health Transformation. "Ohio Comprehensive Primary Care (CPC) Program Frequently Asked Questions." Op. cit.
- ³⁵⁸ Ohio Department of Medicaid. "Ohio CPC Enrollment Process". Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/enrollmentProcess.pdf>
- ³⁵⁹ Ohio Governor's Office of Health Transformation. "Ohio Comprehensive Primary Care (CPC) Practice Webinar #6: Ohio CPC Referral Reports". August 8, 2017. Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/Ohio-CPC-Practice-Webinar-08082017.pdf?ver=2017-08-08-170857-737>
- ³⁶⁰ Ohio Governor's Office of Health Transformation. "Ohio Comprehensive Primary Care (CPC) Program Frequently Asked Questions." Op. cit.
- ³⁶¹ Ohio Department of Medicaid. "2018 Ohio CPC Eligibility Requirements." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/Eligibility-Requirements-2018.pdf>
- ³⁶² Ibid.
- ³⁶³ These competencies are optional under NCQA PCMH.
- ³⁶⁴ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." 2017 Edition, Version 3, July 24, 2018. Available at: <http://store.ncqa.org/index.php/catalog/product/view/id/3100/s/2017-pcmh-standards-and-guidelines-for-new-york-state-practices-only-epub/>
- ³⁶⁵ NCQA PCMH has a similar, optional standards. NCQA standards do not mention same-day BH consultations.
- ³⁶⁶ Oregon Health Authority. "2017 PCPCH Standards - NCQA PCMH 2017 Standards – Crosswalk." Op. cit.
- ³⁶⁷ Oregon Health Authority. "Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide." Op. Cit.
- ³⁶⁸ Ohio Department of Medicaid. "Ohio 2019 CPC Activity Requirements." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/2019-ActivityRequirements.pdf>
- ³⁶⁹ Ohio Department of Medicaid. "Overview of CPC activity requirements". Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/ActivityRequirements.pdf>
- ³⁷⁰ Ohio Department of Medicaid. "Quality Metrics." Comprehensive Primary Care Program. Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/qualityMetricSpecs.pdf>
- ³⁷¹ Ohio Department of Medicaid. "Overview of CPC efficiency metrics." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/efficiencyMetricSpecs.pdf>
- ³⁷² These competencies are optional under NCQA PCMH.
- ³⁷³ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.
- ³⁷⁴ NCQA PCMH only requires practices to assess language needs of their population.
- ³⁷⁵ NCQA PCMH has less advanced requirement related to meeting language needs. NCQA PCMH requires practices to assess language needs of their population and has an optional standard related to tailoring patient materials to communication needs.
- NCQA has similar, but less extensive, requirements related to care plan development, and collection of patient experience data. NCQA PCMH standards require that practice develop care plans, but inclusion of a self-management plan is optional. NCQA requires similar collections and use of patient experience data but use of a standardized survey tool is optional.
- ³⁷⁶ Oregon Health Authority. "2017 PCPCH Standards - NCQA PCMH 2017 Standards – Crosswalk." Op. cit.
- ³⁷⁷ Oregon Health Authority. "Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide." Op. Cit.
- ³⁷⁸ Ohio Department of Medicaid. "Ohio 2019 CPC Activity Requirements." Op. cit.
- ³⁷⁹ Ohio Department of Medicaid. "Overview of CPC activity requirements". Op. cit.
- ³⁸⁰ These competencies are optional under NCQA PCMH.
- ³⁸¹ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.
- ³⁸² This competency is optional under NCQA PCMH.
- ³⁸³ This competency is optional under NCQA PCMH.
- ³⁸⁴ Email exchange with New York State Department of Health staff, May 9, 2019

³⁸⁵ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.

³⁸⁶ Ohio Governor's Office of Health Transformation. "How to Read Your Ohio CPC Referral Reports." August 2017. Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/How-to-Read-CPC-Referral-Reports.pdf?ver=2017-08-07-134242-633>

³⁸⁷ This competency is optional under NCQA PCMH.

³⁸⁸ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.

³⁸⁹ This requirement is similar to an optional NCQA PCMH criterion.

³⁹⁰ Ohio Department of Medicaid. "Ohio 2019 CPC Activity Requirements." Op. cit.

³⁹¹ Ohio Department of Medicaid. "Overview of CPC activity requirements". Op. cit.

³⁹² Ohio Governor's Office of Health Transformation. "Ohio Comprehensive Primary Care (CPC) Practice Webinar #1: Attribution and Payment". February 6, 2018. <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/PPW-AttPayment%20.pdf?ver=2018-02-06-143337-287>

³⁹³ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.

³⁹⁴ Oregon Health Authority. "2017 PCPCH Standards - NCQA PCMH 2017 Standards – Crosswalk." Op. cit.

³⁹⁵ Oregon Health Authority. "Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide." Op. Cit.

³⁹⁶ Ohio Department of Medicaid. "Ohio 2019 CPC Activity Requirements." Op. cit.

³⁹⁷ Ohio Department of Medicaid. "Overview of CPC activity requirements". Op. cit.

³⁹⁸ Ohio Department of Medicaid. "2019 Ohio CPC Eligibility Requirements." Op. cit.

³⁹⁹ Ohio Department of Medicaid. "Eligibility Requirements 2018." Op. cit.

⁴⁰⁰ These competencies are optional under NCQA PCMH.

⁴⁰¹ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.

⁴⁰² NCQA PCMH requires practices to track quality measures from certain categories, but does not require selection from a defined measure set.

⁴⁰³ NCQA PCMH requires coordination but not a written agreements with hospitals.

⁴⁰⁴ NCQA PCMH has quality improvement criteria but does not require a comprehensive strategy to guide multiple QI projects.

⁴⁰⁵ NCQA PCMH has a similar criteria but does not require practices to meet a benchmark.

⁴⁰⁶ This competency is optional under NCQA PCMH.

⁴⁰⁷ Oregon Health Authority. "2017 PCPCH Standards - NCQA PCMH 2017 Standards – Crosswalk." Op. cit.

⁴⁰⁸ Oregon Health Authority. "Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide." Op. Cit.

⁴⁰⁹ This competency is optional under NCQA PCMH.

⁴¹⁰ This competency is optional under NCQA PCMH.

⁴¹¹ Ohio Department of Medicaid. "Ohio 2019 CPC Activity Requirements." Op. cit.

⁴¹² Ohio Department of Medicaid. "Overview of CPC activity requirements". Op. cit.

⁴¹³ New York State Department of Health. "2018-2019 Enacted Budget Initiative: Patient Centered Medical Home Statewide Incentive Payment Program: Revised Incentive Payments and Updated Billing Guidance." New York State Medicaid Update, April 2018, Volume 34, Number 4. Available at: https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-04.htm#pcmh

⁴¹⁴ Email exchange with New York State Department of Health staff, May 9, 2019

⁴¹⁵ Health Plan Services Contract, Coordinated Care Organization Contract # 143115-10 with Health Share of Oregon, p.89. Oregon Health Authority, Effective January 1, 2018. Available at: <https://multco.us/file/69710/download>

⁴¹⁶ Oregon Health Authority and Department of Consumer and Business Services. "Primary Care Spending in Oregon: A Report to the Oregon State Legislature." February 2018. Available at: <https://www.oregon.gov/oha/HPA/CSI-PCPCH/Documents/SB-231-Report-2018-FINAL.PDF>

⁴¹⁷ CCO 2.0 Request for Applications, RFA OHA-4690-19, Attachment 8 — Value-Based Payment Questionnaire. Oregon Health Authority, January 25, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/07-CCO-RFA-4690-0-Attachment-8-VBP-Questionnaire-Final.pdf>

⁴¹⁸ Ohio Department of Medicaid. "Ohio Comprehensive Primary Care (CPC) Program Per-Member-Per-Month (PMPM) Payment Definition and Methodology." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/PMPM-definition.pdf>

⁴¹⁹ Ohio Department of Medicaid. "What is Ohio CPC?" Available at: <https://medicaid.ohio.gov/provider/PaymentInnovation/CPC#1657109-cpc-requirements>

-
- ⁴²⁰ Ohio Department of Medicaid. "Total cost of care definition and methodology." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/SharedSavingsMethodology.pdf?ver=2017-12-12-101215-823>
- ⁴²¹ Governor's Office of Health Transformation. "Thresholds for CPC quality and efficiency metrics." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/Thresholds.pdf?ver=2016-12-21-132914-243>
- ⁴²² Medicaid Managed Care/Family Health Plus/HIV Special needs Plan/Health and Recovery Plan Model Contract. Division of Health Plan Contracting and Oversight, Office of Health Insurance Programs, New York State Department of Health, effective March 1, 2014, as amended October 1, 2015. Available at: https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
- ⁴²³ Health Plan Services Contract, Coordinated Care Organization Contract # 143115-10 with Health Share of Oregon, op. cit, p. 76.
- ⁴²⁴ J. Vandehey and S. Jarem. "The future of coordinated care in Oregon: Introductory Webinar". Op. cit.
- ⁴²⁵ Oregon Health Authority. "2019 CCO Incentive Measure Set". July 2018. <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-Incentive-Measures.pdf>
- ⁴²⁶ Health Plan Services Contract, Coordinated Care Organization Contract # 143115-10 with Health Share of Oregon, op. cit, p. 126-129.
- ⁴²⁷ Ohio Department of Medicaid. "CPC Payments." Available at: <https://medicaid.ohio.gov/provider/PaymentInnovation/CPC#1657108-cpc-payments>.
- ⁴²⁸ Ohio Medical Assistance Provider Agreement for Managed Care Plan, pp.136-139. The Ohio Department of Medicaid, July 2018. Available at: <https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/ManagedCare-PA-201807.pdf>