

# Promote Accountability Mechanisms for Managed Care Organizations:

Advancing Primary Care Innovation in Medicaid Managed Care

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## Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit

This module is part of *Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit*, which was created to help states leverage their managed care contracts and request for proposals to advance innovation in primary care.

The two-part toolkit outlines strategies to support states in: (1) defining primary care priorities and advancing core functions; and (2) achieving primary care innovation goals through managed care contractual levers.

To view the full toolkit, visit [www.chcs.org/primary-care-innovation](http://www.chcs.org/primary-care-innovation).

States have a variety of tools that can encourage, incent, or require Medicaid managed care organizations (MCOs) to work toward the state’s defined goals for primary care innovation, such as:

- Incentive arrangement;
- Rate adjustment;
- Withhold arrangement;
- Liquidated damages and penalties;
- Auto-assignment;
- State-directed payments;
- Community investment; and
- Strategic classification of MCO expenditures.

Broadly, these tools seek to: (1) direct targeted MCO efforts; (2) ensure that MCOs have the financial and administrative flexibility to creatively support network providers and members; and (3) reward MCOs for their performance. **This module provides a broad overview of these financial accountability mechanisms and highlights how they can be used to drive investments in primary care. It also highlights ways that states have released funds associated with these tools, such as withhold arrangements to enable quick support of network providers during the COVID-19 pandemic.**

## Planning Considerations

### ✓ What are the state’s budgetary constraints?

Certain managed care accountability mechanisms require more funds than others. Incentive arrangements, for example, can result in payment over and above a Medicaid MCO’s capitation payment — capped at five percent of the capitation payment, per federal rules.<sup>1</sup> Other state initiatives may be funded by a corresponding rate adjustment, and may be closely monitored via contract requirements. For example, Pennsylvania’s community-based care management program is funded by a per-member-per-month rate and corresponding rate adjustment, and MCOs must submit plans that explain how they will spend those funds to support strategies relating to program goals, such as team-based care and social determinants of health.<sup>2,3</sup> States considering these options must have the budgetary flexibility to implement them.

## PROMOTE ACCOUNTABILITY MECHANISMS FOR MCOs: Design Considerations Summary

States seeking to further financially incentivize MCOs to invest in and support advanced primary care may consider:

### Planning

- ✓ What are the state’s budgetary constraints?
- ✓ How prescriptive does the state wish to be in its approach?
- ✓ How strong does the state want MCO incentives to be?
- ✓ Is the state prepared to enlist actuaries or other specialized staff to support the development of these mechanisms?

### Implementation

- ✓ Will the state require MCOs to report on how they will distribute funds relating to withhold or incentive arrangements to support network providers and community-based strategies?
- ✓ Will the state offer alternatives to penalties and remittances to encourage additional investments in communities and network providers?
- ✓ If plans provide additional services to members and support advanced primary care capabilities, do plans know how to report associated expenses, as it relates to the medical loss ratio or rate-setting? Can the state improve guidance to the plans or adjust rates to counteract disincentives?



Other approaches — such as withhold arrangements tied to quality performance and liquidated damages, requiring MCOs to return funds to the state if certain conditions are not met — do not require additional funds.

## Defining State Primary Care Goals

The MCO accountability mechanisms described in this module can be used to support a wide range of state primary care goals. Prior to exploring specific accountability mechanisms to include in MCO contracts, states may consider identifying specific primary care transformation priorities. For example, states may leverage these accountability mechanisms to advance primary care delivery goals such as: (1) enhancing team-based care; (2) integrating behavioral health into primary care; (3) using technology to improve access to care; and (4) identifying and addressing social needs.

Additional considerations for identifying primary care priorities and advancing these specific care delivery components are available in the first section of this toolkit, [Conceptualizing and Designing Core Functions](#).



### ✓ *How prescriptive does the state wish to be in its approach?*

Some managed care accountability mechanisms generally allow MCOs more flexibility in implementing a primary care strategy while others are more prescriptive. Flexible approaches can allow innovation and MCOs to adapt primary care strategies to specific regional or provider needs. Prescriptive approaches can be useful in cases where states seek to implement consistent primary care strategies across payers. For example, withhold arrangements tied to VBP implementation often allow MCOs and providers a great deal of flexibility in designing and negotiating VBP arrangements. Alternatively, subject to Centers for Medicare & Medicaid Services (CMS) approval, states can require MCOs to pay primary care providers a certain way, such as through specific, state-designed VBP models.<sup>4</sup>

### ✓ *How strong does the state want MCO incentives to be?*

While strong incentives draw more attention to and can potentially allow states to achieve policy goals faster, they also have greater risk of unintended consequences. States may consider factors such as strength of the evidence-base and payer/provider experience with a given approach when determining what level and type of incentive is appropriate.

Strategies directly tied to MCO payment, such as rate adjustments or withhold arrangements may be stronger incentives than those indirectly tied to payment, such as quality-based auto-assignment. Some accountability mechanisms, such as withholds and penalties or liquidated damages, also allow states flexibility in determining/adjusting the level of financial incentive.

✓ ***Is the state prepared to enlist actuaries or other specialized staff to support the development of these mechanisms?***

Certain approaches may require more thoughtful review by actuarial, financial, or legal staff. When states implement a withhold arrangement, for example, an actuary must determine that the “capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound.”<sup>5</sup> Similarly, states that use liquidated damages in their Medicaid managed care contracts ideally should structure those as “reasonable estimates” of an agency’s loss or damage,<sup>6</sup> which may require more careful review by financial or legal staff.

## Examples of States’ Primary Care-Related COVID-19 Response Efforts

**New Hampshire** reallocated 1.5 percent of capitation dollars to fund provider rate enhancements in the form of managed care directed payments. The goal was to redirect funds to providers who are most stressed from reduced utilization amid the pandemic. Funding was distributed to the following provider types for the rating period covering September 1, 2019 through June 30, 2020 through a uniform percent increase: critical access hospitals, residential substance use disorder providers, home health care providers, private duty nursing providers, personal care providers, and federally qualified health centers and rural health centers.<sup>7,8</sup>

**Oregon** released 60 percent of the 2019 Quality Pool Fund earlier than planned (in March 2020) “to support the needs across Oregon to prepare for the surge in patients needing care, maintain capacity, and ensure access to care across the delivery system.” The state also suspended the 2020 Quality Withhold during the COVID-19 emergency.<sup>9</sup>

For more information on how states can modify their withhold arrangements, incentive arrangements, and penalties in response to the COVID-19 pandemic, see [COVID-19 Frequently Asked Questions \(FAQs\)](#) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies.<sup>10</sup>



## State Approaches: Accountability Mechanisms

Below is an overview of the different accountability mechanisms available to states, with specific examples relevant to primary care and core care delivery areas.

Summary of Strategy	Relevant State Examples
<b>Approaches that May Require Additional State Funds</b>	
<p><b>Incentive Arrangement.</b> Implement an incentive payment program that provides MCOs with additional funds over and above the capitation payment for performance on selected quality measures or activities that relate to advanced primary care. Total payment may not exceed 105% of the capitation payment.</p>	<p><b>Arizona</b>, under its Quality Measure Performance Incentive Program, enables MCOs to receive additional funds for performance on select quality measures related to primary care utilization, such as well-child, well-care, and annual dental visits.<sup>11</sup></p> <p><b>New York</b> groups MCOs into five tiers based on performance on 41 measures, plus a bonus for telehealth innovation, and uses results to inform incentive payments and auto-assignment preference.<sup>12</sup></p>
<p><b>Rate Adjustment.</b> Direct MCOs to participate in a targeted initiative and embed additional funding into the monthly capitation payment. Alternatively, change the way rates are structured to reward strategic investments and programs, efficiency, and quality.</p>	<p><b>Pennsylvania</b> makes per-member-per-month payments for MCOs’ community-based care management (CBCM) programs as part of the monthly capitation process. Physical health MCOs submit a plan for their program, which can support face-to-face care coordination activities by primary care providers and strategies to address health-related social needs.<sup>13</sup> For example, CBCM has supported co-location opportunities at federally qualified health centers and through community health workers.<sup>14</sup></p> <p><b>New Mexico</b> requires MCOs to pay for their share of administrative expenses for Project ECHO, a telementoring program designed to provide primary care providers with knowledge and support to manage patients with complex conditions. The state appropriated \$850,000 to support this initiative, which is distributed to MCOs via capitation payments.</p> <p>In its new “Performance Based Reward Program,” <b>Oregon</b> will reward plans with an increase in the non-medical load portion of rate, based on spending on voluntary services that can improve health care quality (i.e., “health-related services”) and efficiency and quality metrics.<sup>15</sup></p>
<b>Approaches that Do Not Require Additional State Funds</b>	
<p><b>Withhold Arrangement.</b> Withhold a percentage of MCOs’ monthly capitation payment. MCOs can gain or lose the entire amount withheld based on performance. Use to incentivize adoption of a wide range of activities that could impact adoption of advanced primary care: primary-care focused VBP, quality measures, and patient-centered medical home (PCMH) adoption.</p>	<p><b>Michigan</b>, as part of its withhold arrangement, encourages its plans to implement targeted programs aimed at improving health outcomes, such as implementation of an evidence-based, integrated model that addresses low-birth weight through management of medical and social needs.<sup>16</sup></p> <p>Prior to 2020, Patient-Centered Primary Care Home program enrollment was one of <b>Oregon’s</b> 19 coordinated care organization (CCO) quality measures used to determine reward payments out of “quality pool” funds. The quality pool is funded through a withhold and is at least two percent of aggregate CCO payments made to all CCOs.<sup>17,18</sup></p> <p><b>Washington State</b> ties a portion of its two percent capitation payment withhold to VBP thresholds and distributes “challenge pool” funds based on VBP achievement. For example, for 2020, Washington State requires that 85 percent of MCO health care payments to providers are within qualifying VBP arrangements, defined as level 2C (pay-for-performance) or higher on the Health Care Payment Learning &amp; Action Network Alternative Payment Model Framework.<sup>19</sup></p> <p>In addition to general VBP targets, states could also consider tying withholds to primary care-specific VBP models or prioritizing primary care VBP models as part of general VBP requirements.</p>

Summary of Strategy	Relevant State Examples
<p><b>Liquidated Damages and Penalties.</b><sup>20</sup> Require MCOs that do not meet a certain primary-care related standard to return funds to the state.</p>	<p><b>Tennessee</b> notes in its contract that “failure to achieve benchmarks of 37 percent PCMH membership” results in a damage of “\$500 per calendar day.”<sup>21</sup></p> <p><b>New Mexico</b> ties performance on a series of “delivery system improvement performance targets” to a penalty of 1.5 percent of capitation payments. For example, achievement of each of the following targets is assigned 25 out of 100 possible points related to the penalty:<sup>22</sup></p> <p>“The contractor shall increase the number of unduplicated Medicaid Managed Care members receiving Behavioral Health services by a Non-Behavioral Health provider.”</p> <p>“The contractor shall increase the number of unique Members with a Telemedicine visit by twenty percent (20%) in Rural, Frontier, and Urban areas for Physical Health Specialists and Behavioral Health Specialists.”</p>
<p><b>Auto-Assignment.</b> Award membership to plans based on primary care-related capabilities and/or performance, or other related state priorities (e.g., community investment), given that MCOs are often motivated by increasing their market share.</p>	<p><b>Ohio</b> bases auto-assignment on three factors, including performance on women’s health measures; primary care provider (PCP) and dental capacity; and prompt payment.<sup>23</sup></p> <p>In addition to primary-care-related quality measures, <b>California’s</b> auto-assignment methodology includes the following “safety net measure:” “percentage of members assigned to PCPs who are safety net providers (based on rates provided by the MCPs that have been validated by DHCS and validation of a sample of screen prints verifying PCP assignments). ‘Safety net providers’ are defined as: FQHCs, Rural Health Centers, Indian or Tribal Clinics, non-profit community or free clinics licensed by the state as primary care clinics, or clinics affiliated with DSH facilities.”<sup>24</sup></p> <p><b>North Carolina</b> may award an auto-assignment preference to PHPs that voluntarily contribute at least 0.1 percent of capitation to health-related resources in the region.<sup>25</sup></p>
<p><b>State-Directed Payments.</b> Require MCOs to pay PCPs in a certain way (i.e., to implement a VBP model or to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative).<sup>26</sup></p>	<p><b>Tennessee’s</b> Health Link program, which aims to enhance coordination between behavioral and physical health services for TennCare members with high behavioral health needs, is implemented through state-directed payment. Participating providers are eligible to receive practice transformation support, new activity payments, and outcome payments based on performance of quality and efficiency metrics.<sup>27</sup></p> <p>State Medicaid agencies have submitted statements of interest relating to the Primary Care First model. If states elect to align payment, quality measurement, and data sharing with CMS in support of Primary Care First practices, states can direct MCOs to adopt these standards via a contract amendment and CMS approval.</p>
<p><b>Community Reinvestment.</b> Require MCOs to spend a portion of profits or reserves on local communities, including health-related social needs.</p>	<p><b>Arizona</b> requires MCOs to contribute six percent of annual profits to community reinvestment. (See related <a href="#">reporting template</a>.)<sup>28</sup></p> <p><b>Oregon</b>, as part of its Supporting Health for All through Reinvestment Initiative (SHARE), will require MCOs to spend a portion of net income or reserves on social determinants of health.<sup>29</sup></p>

## Implementation Considerations

### ✓ ***Will the state require MCOs to report on how they will distribute funds relating to withhold or incentive arrangements to support network providers and community-based strategies?***

MCO performance on quality measures can largely be attributed to the activities of the MCO's network providers. Increasingly, states want to ensure that MCOs reward these network providers for their contributions. For example, Oregon requires its CCOs to submit a distribution plan for its Quality Pool and Challenge Pool earnings.<sup>30</sup> The plan must include the process for evaluating the contributions of participating providers, including “social determinants of health and health equity partners,” and connecting those evaluations to the distribution of funds.

### ✓ ***Will the state offer alternatives to strict enforcement of penalties and remittances to encourage additional investments in communities and network providers?***

Some states rely on a system of liquidated damages, penalties,<sup>31</sup> or remittances for contract enforcement, but offer MCOs alternatives to paying these funds back to the state. For example, New Mexico establishes several “delivery system improvement performance targets” relating broadly to primary care innovation, enforced by a penalty of 1.5 percent of the capitation payment. Instead of levying the penalty in every instance, however, the state allows plans to propose that the performance penalty amounts be spent on “system improvement activities for provider network development and enhancement activities that will directly benefit members.”<sup>32</sup> Similarly, health plans in North Carolina that do not meet a minimum medical loss ratio can “contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the regions and communities it serves” in lieu of a rebate.<sup>33</sup>

### ✓ ***Do plans know how to report expenses associated with additional primary care services, as it relates to the medical loss ratio or rate-setting? Can the state improve guidance to the plans or adjust rates in an attempt to counteract MCO disincentives?***

MCOs may be reluctant to provide or reimburse for services outside of state plan benefits because they believe that expenditures will be deemed “administrative” and therefore not “count” toward medical loss ratio (MLR) calculations nor considered in rate-setting processes. This designation can make it more difficult to meet a minimum MLR, which often requires the plan to return funds back to the state. Similarly, plans may be worried about “premium slide,” where plans that implement effective interventions are rewarded with lower rates in future years because of reduced utilization of services. To combat this risk aversion, states may provide more guidance to plans on how to classify expenditures — especially those relating to health-related social needs. Alternatively, states can experiment with rate adjustments that reward plan performance.

## State Approaches: Strategic Classification of MCO Expenditures

States implementing primary care approaches that address social determinants of health (SDOH) may consider how to classify MCO expenditures relating to SDOH and health-related social needs (HRSNs) (see the [Identify and Address Social Needs](#) module for additional considerations and examples of how states may address HRSNs). Current federal guidance is general, and states have taken a variety of approaches on classifying non-benefit expenditures relating to HRSNs, with varying impacts on the calculation of a plan’s MLR and rates. For example, some states classify housing-related services as potential value-added services, while others have included the same types of services as an *in lieu of service*. Value-added services and *in lieu of services* both can be reported in the numerator of the MLR, but only *in lieu of services* can be considered for rate-setting purposes. And, in one new approach of note, New York allows specific SDOH-related expenditures embedded in advanced VBP arrangements to be included as a medical expense for the purpose of rate setting. Strategic classification of these expenditures can counteract commonly cited disincentives to invest in HRSN strategies. By classifying the expenditure as a medical versus administrative expense, the MCO may be less concerned about MLR-related remittances or, for some strategies, future rates.

The following table provides an overview of: (1) existing guidance in federal law, as it relates to MLR and rate-setting; (2) notable state examples relating to HRSN activities; and (3) a federal rule reference. States can use this table to consider how to provide additional clarification to MCOs on the classification of HRSN activities.

Classification	MLR and Rate Impact	State Example	Federal Rule
<b>Value-Added Services</b>	<p><b>MLR:</b> Can include in the numerator of the MLR under “incurred claims.”</p> <p><b>Rate-setting:</b> Cannot be considered when developing payment rates.</p>	<p><b>Massachusetts</b>, in its guidance to Senior Care Options plans, includes a list of housing-related services that can be voluntarily provided to members as a value-added service (outside of the official Community Support Program). These services include: (1) assisting a member with housing search activities; (2) home modifications; and (3) paying for costs related to a member’s transition into housing from institutionalization or homelessness (e.g., first month’s rent or security deposit).<sup>34</sup></p>	<p><b>Value-Added Services provision:</b> 42 C.F.R. § 438.3(e)(1)(i) (MCOs may voluntarily provide any service).</p> <p><b>MLR implications:</b> 42 C.F.R. § 438.8(e)(1), (e)(2)(i)(A) (incurred claims and services under 42 C.F.R. § 438.3(e)). Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526 (value-added services may be considered as incurred claims in the numerator for the MLR calculation).</p>
<b>In Lieu Of Services</b>	<p><b>MLR:</b> Can include in the numerator of the MLR under “incurred claims.”</p> <p><b>Rate-setting:</b> Can be considered when developing payment rates.</p>	<p><b>Kansas</b>, in its list of approved in lieu of services, includes services such as: (1) medical nutrition therapy; (2) assisted living rental; and (3) direct costs for transitions outside of institutional settings.<sup>35</sup></p> <p><b>California</b>, in its next phase of its managed care program, has proposed to formally incorporate <i>in lieu of services</i> that are provided as a substitute, or <i>to avoid</i>, other Medi-Cal covered services such as ER utilization, a hospital or skilled nursing facility admission, or a discharge delay. An initial proposed list includes: (1) housing transition and sustaining services; (2) recuperative care; (3) short-term non-medical respite; (4) home- and community-based wraparound services for beneficiaries to transition or reside safely in their home or community; and (5) sobering centers.<sup>36</sup></p>	<p><b>In lieu of services provision:</b> 42 C.F.R. § 438.3(e)(2) (listing approval criteria, including that the “alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan”).</p> <p><b>MLR implications:</b> 42 C.F.R. § 438.8(e)(1), (e)(2)(i)(A)</p>

Classification	MLR and Rate Impact	State Example	Federal Rule
<p><b>Activities that Improve Health Care Quality</b></p>	<p><b>MLR:</b> Can include in the numerator of the MLR under “activities that improve health care quality.”</p> <p><b>Rate-setting:</b></p> <p><b>Care coordination/Case management</b> - The capitation payment must be adequate to support functions described in 42 C.F.R. § 438.208, including coordination of services with those provided by community and social support providers (see 42 C.F.R. § 438.4(b)(3)).</p> <p><b>Additional Services and Targeted Investments</b> - In Oregon, health-related services (defined as activities that improve health care quality) are not used to develop the medical portion of the capitation payment; however, are reported in the “non-benefit load.”<sup>37</sup></p>	<p>States may evoke this provision through common contractual requirements, such as care coordination and case management, and voluntary services and initiatives.</p> <p><b>Care Coordination/Case Management</b></p> <p><b>New Mexico</b>, in its contracts, notes that care coordination expenses relating to community health workers will be deemed “medical services.”<sup>38</sup></p> <p><b>Additional Services and Targeted Investments</b></p> <p><b>Oregon</b> CCOs can provide health-related services that address social needs at both at an individual and a community level. For example, guidance documents include food-related interventions and housing-related services as a central part of a crisis intervention, stabilization and/or a transition for a patient with intention of a direct health benefit.<sup>39</sup></p> <p><b>North Carolina</b> allows expenditures made for voluntary contributions to health-related resources that align with the department’s quality strategy to be included in the numerator of the medical loss ratio. Expenditures must:</p> <ul style="list-style-type: none"> <li>■ Represent “meaningful engagement with local communities and are non-discriminatory with respect to individual Members and North Carolina geographic regions, including rural areas.”</li> <li>■ Be “spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.”<sup>40</sup></li> </ul>	<p><b>Activities that Improve Health Care Quality provision:</b> 45 C.F.R. § 158.150(b)</p> <p><b>MLR implications:</b> 42 C.F.R. § 438.8(e)(1), (e)(3)(i)</p> <p><i>Relationship with care coordination/case management functions:</i></p> <p>45 C.F.R. § 158.150(b)(2)(i)(A)(1) (listing care coordination and management as an activity that improves health care quality).</p>
<p><b>Value-Based Payment</b></p>	<p><b>MLR:</b> Most VBP models can be included as a medical expense under “incurred claims.”</p> <p><b>Rate-setting:</b> VBP requirements are typically embedded in rate development, as noted in the CMS rate development guide.<sup>41</sup></p>	<p><b>New York</b>, in its Value-Based Payment Roadmap,<sup>42</sup> has proposed to classify expenses relating to required SDOH interventions embedded into advanced VBP arrangements (“Level 2 and Level 3”) as a medical expense. (“The expenses for [SDOH] interventions being implemented within the VBP contract for which the MCO is making the investment, should be included in “Other Medical” on the MMCOR and MLTCRR.”)</p>	<p><b>Directed VBP and Delivery System Reform Initiatives Provision:</b> 42 C.F.R. § 438.6(c)</p>

## ENDNOTES

<sup>1</sup> 42 C.F.R. § 438.6(b)(2).

<sup>2</sup> Calendar Year 2021 HealthChoices Physical Health Databook, page 15. Pennsylvania Department of Human Services, March 2020. Available at: <https://www.dhs.pa.gov/providers/Providers/Documents/Managed%20Care%20Information/CY%202021%20HC%20PH%20Databook%20Narrative%20v20200312.pdf>.

<sup>3</sup> HealthChoices Agreement, Exhibit B(5)-3. Pennsylvania Department of Human Services, effective January 1, 2020. Available at: <https://www.dhs.pa.gov/providers/Providers/Documents/Managed%20Care%20Information/HC%20Agreement%202020.pdf>.

<sup>4</sup> 42 C.F.R. § 438.6(c); see also Centers for Medicare & Medicaid Services, State-Directed Payments. Available at: <https://www.medicare.gov/medicaid/managed-care/guidance/state-directed-payments/index.html>.

<sup>5</sup> 42 C.F.R. § 438.6(b)(3).

<sup>6</sup> See Florida Medicaid SMMC Compliance Actions Q3 FY16/17. Florida Agency for Health Care Administration. Available at: [https://ahca.myflorida.com/medicaid/statewide\\_mc/pdf/Q3\\_FY1617\\_Compliance\\_Actions.pdf](https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Q3_FY1617_Compliance_Actions.pdf) (providing a definition of liquidated damages).

<sup>7</sup> H. Howard, et al. "Targeted Options for Increasing Medicaid Payments to Providers During COVID-19 Crisis." State Health and Value Strategies webinar presentation, April 9, 2020. Available at: <https://vimeo.com/406238818>.

<sup>8</sup> J. Guyer and P. Boozang. "New Hampshire COVID-19 Directed Payment." State Health and Value Strategies. June 2020. Available at: <https://www.shvs.org/wp-content/uploads/2020/06/New-Hampshire-COVID-19-Directed-Payments-Preamble-Formatted.pdf>.

<sup>9</sup> Memorandum to the CCO Metrics Technical Advisory Group. Oregon Health Authority, April 8, 2020. Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020.04.08-COVID-19-CCO-metrics-TAG-update.pdf>.

<sup>10</sup> See COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, Centers for Medicare & Medicaid Services, Last updated June 30, 2020, p. 79 ("Should states consider adjustments to their managed care contract quality measurement requirements to account for the changes in clinical practice resulting from the COVID-19 public health emergency?"). Available at: <https://www.medicare.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

<sup>11</sup> For the acute care MCO contracts, the Quality Management Performance Measures associated with the incentive payment are: **Adults:** emergency department utilization and all-cause readmissions; **Children:** well-child visits (first 15 months and 3-6 years); adolescent well care visits; and annual dental visits; and a **Behavioral Health Measure:** 7-day follow-up after hospitalization for mental illness. AHCCCS Contractor Operations Manual, Policy 306, Attachment A - Alternative Payment Model (APM) Quality Management Performance Measure Standards. Arizona Health Care Cost Containment System. 2019. Available at: <https://www.azahcccs.gov/shared/ACOM/>.

<sup>12</sup> The quality incentive structure includes 30 quality measures (HEDIS and NYS-specific); 3 satisfaction measures (CAHPS); 2 "prevention" quality measures; 6 compliance measures; and a bonus for telehealth innovation.

2018 Quality Incentive Report: A Report on the Quality Incentive Program In New York State. New York State Department of Health. 2018. Available at: [https://www.health.ny.gov/health\\_care/managed\\_care/reports/docs/quality\\_incentive/quality\\_incentive\\_2018.pdf](https://www.health.ny.gov/health_care/managed_care/reports/docs/quality_incentive/quality_incentive_2018.pdf).

<sup>13</sup> HealthChoices Agreement, Exhibit B(5)-3, op. cit.

<sup>14</sup> Medical Assistance Quality Strategy for Pennsylvania. Pennsylvania Department of Human Services, April 2017. Available at: [http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c\\_260569.pdf](http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_260569.pdf).

<sup>15</sup> CCO 2.0 Procurement Rate Methodology: January 1, 2020 – December 31, 2020 Capitation Rates. Oregon Health Authority. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/Attachment-12-Oregon-CY20-Procurement-Rate-Methodology-2018.12.21.pdf>.

<sup>16</sup> State of Michigan Comprehensive Health Care Program FY 2020. Michigan Department of Health and Human Services, Appendix 5b. Available at: [https://www.michigan.gov/documents/contract\\_7696\\_7.pdf](https://www.michigan.gov/documents/contract_7696_7.pdf).

<sup>17</sup> Patient Centered Primary Care Home (PCPCH) Enrollment. Oregon Health Authority. Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-PCPCH-Enrollment.pdf>.

<sup>18</sup> 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>.

<sup>19</sup> Washington Apple Health- Integrated Managed Care Contract, Exhibit D-1. Washington State Health Care Authority. January 1, 2020. Available at: [https://www.hca.wa.gov/assets/billers-and-providers/ipbh\\_fullyintegratedcare\\_medicaid.pdf](https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf).

<sup>20</sup> Federal rules distinguish a penalty from a withhold arrangement, noting that "arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement."

42 C.F.R. § 438.6(a).

## Promote Accountability Mechanisms for Managed Care Organizations: Advancing Primary Care Innovation in Medicaid Managed Care

- <sup>21</sup> Tennessee MCO Statewide Contract with Amendment 11, Section E.29.2.2.7, C.10. Tennessee Department of Finance and Administration, Division of Health Care Finance and Administration, Division of TennCare, January 1, 2020. Available at: <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>.
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- <sup>30</sup> Oregon Health Plan Services Contract, Exhibit B – Statement of Work – Part 10 – Section 4. Oregon Health Authority, Effective October 1, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/Final-CCO-contract-terms-for-5-year-contract-awardees.pdf>.
- <sup>31</sup> Federal rules distinguish a penalty from a withhold arrangement, noting that “arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.”
- 42 C.F.R. § 438.6(a).
- <sup>32</sup> Medicaid Managed Care Services Agreement Among New Mexico Human Services Department, New Mexico Behavioral Health Purchasing Collaborative and HCSC Insurance Services Company, operating as Blue Cross and Blue Shield of New Mexico, Section 6.12.4, op. cit.
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