



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

 Center for
Health Care Strategies

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

I. Introduction

Primarily care is the backbone of any high-functioning, equitable health care system, particularly for populations with low-incomes. 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 sufficient primary care providers (PCPs) accepting patients within a given geography. However, this 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.

Recently, states have sought more advanced primary care models. These states ask not only *if* a patient has a relationship with a PCP, but also *how* the primary care team identifies and addresses health-related needs and disparities across its patient population. 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. They work toward making care more community- and patient-centered, and advancing explicit equity goals.

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 and promote health equity 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). Over three phases of the collaborative, CHCS assisted twelve states — **Delaware, Louisiana, Hawaii, Mississippi, Nevada, Oregon, Pennsylvania, Rhode Island, Tennessee,**

Advancing Primary Care Innovation in Medicaid Managed Care: Using State Levers to Drive Uptake and Spread



Conceptualizing and Designing Core Functions is the first section in a two-part toolkit. The second section of the toolkit, [Using State Levers to Drive Uptake and Spread](#), outlines how states can incentivize and invest in advanced primary care through Medicaid managed care and consists of three modules:

- **Promote accountability mechanisms for managed care organizations ;**
- **Move to value-based payment in primary care;** and
- **Monitor primary care spending and investment.**

Similar to this first section of the toolkit, each module outlines design considerations for Medicaid agencies, with state examples, and highlights sample contract language. Learn more at: www.chcs.org/primary-care-innovation.

Texas, Washington State, and Virginia — in using their managed care purchasing authority to advance comprehensive, equitable primary care models.

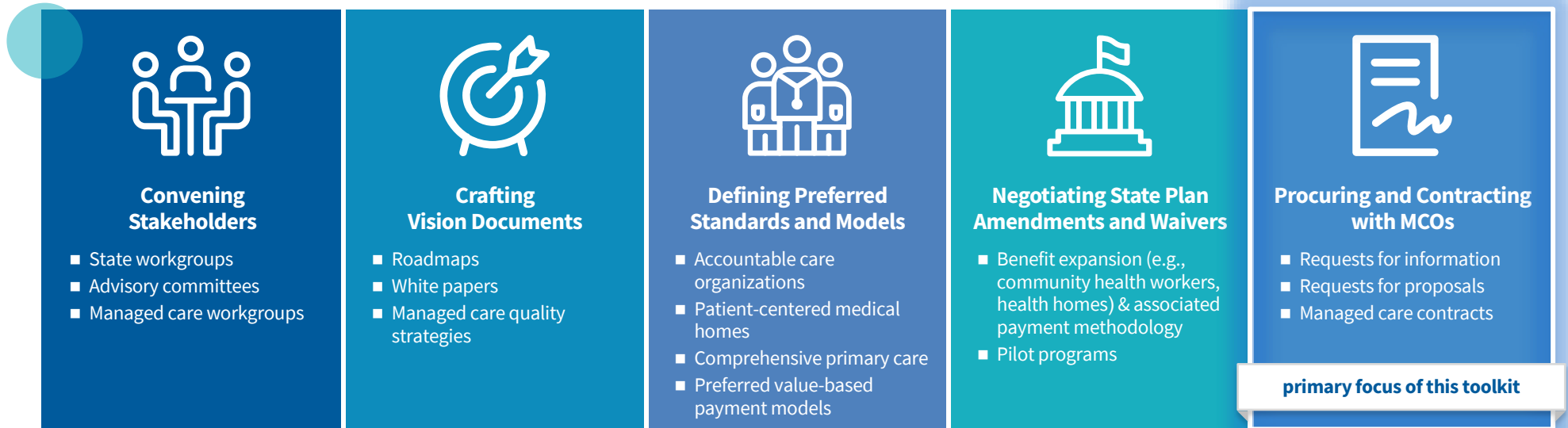
This first section of the toolkit details three steps for approaching advanced primary care work:

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 targeted care delivery goals, such as: (a) identifying and addressing social needs; (b) integrating behavioral health into primary care; (c) enhancing team-based primary care approaches to support the community's needs; (d) using technology to improve access to care; and (e) promoting health equity.

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 More Equitable, Advanced Primary Care



primary focus of this toolkit

II. Identify Advanced Primary Care and Health Equity 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 and health equity in Medicaid managed care. This includes: the size and capacity of the current PCP 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, including health disparities; 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 and health equity. 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.

Most importantly, the state should engage and partner with the communities they serve — particularly those experiencing health inequities — early and often to investigate experiences with primary care, and understand how health systems and primary care teams can earn trust and improve care. For example, **Oregon**'s Primary Care Office hosts a listening series to engage communities on health equity priorities relating to the behavioral health workforce and its Patient-Centered Primary Care Home (PCPCH) program.

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 and health equity as a 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** on the next page.

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;
- 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.”⁴



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's 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;

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

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.”⁵

3. Ask for Input 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, individuals, 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. 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.⁶

In addition to traditional notice and comment processes, states can: (a) leverage existing groups that meet periodically through the agency or through the managed care plans, such as consumer advisory groups or quarterly stakeholder meetings; (b) form new groups dedicated to advanced primary care; (c) participate in cross-state "roadshows"; and (d) design approaches that directly engage communities, such as hosting listening sessions across the state, requiring MCO community advisory councils, and supporting regional organizations, like accountable communities of health or health hubs. For more examples of community engagement strategies, see the [Promote Health Equity](#) module of this toolkit.

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 request for proposal (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 health-related social needs (HRSN), 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 developed 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 and health equity into RFPs and contract amendments;
2. **Leverage MCO functions.** Identify how an MCO may promote equitable, advanced primary care through its traditional responsibilities; and
3. **Consider design options.** Explore how to design an advanced primary care and health equity strategy in 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 the [Advance Targeted Care Delivery Goals](#) section.








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, published significant revisions to its contract relating to HRSN, 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 and health equity. Mapping out these functions can help the state craft a cohesive strategy and integrate advanced primary care priorities and health equity goals 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, and disparity reduction 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 related to health equity, culturally and linguistically appropriate care, and advanced primary care Advancing certain models of care and primary care screening Time/distance standards for PCPs 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 and promote health equity 	 <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 and health equity 	 <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 address social needs or promote health equity) Alignment with non-Medicaid models (e.g., CPC+) or adoption of state models (e.g., Medicaid ACOs)
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[Advance Targeted Care Delivery Goals](#) discusses these potential requirements and incentives in the context of five primary care priorities — addressing social needs, integrating behavioral health, promoting health equity, enhancing team-based care, and using technology. The section uses options outlined on the next page, [Consider Design Options](#), 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 progress toward primary care and health equity goals;**
- ✓ **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. The [Advance Targeted Care Delivery Goals](#) section details unique considerations related to five advanced primary care priorities — addressing social needs, integrating behavioral health, promoting health equity, enhancing team-based care, and using technology — and largely 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: (a) the degree to which MCOs have supported advanced primary care and promotion of health equity and worked with other MCOs to do so; (b) state capacity to define and monitor advanced primary care-related initiatives and reductions in health disparities; (c) the number of contracted MCOs; and (d) 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: (a) present a unique, standardized Medicaid model (e.g., Medicaid ACOs); (b) advance a Centers for Medicare & Medicaid Services model, such as Primary Care First or Comprehensive Primary Care Plus; or (c) 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 in a 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 and health equity 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: (a) develop common processes and infrastructure, if needed; and (b) 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 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 — enabling 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: (a) provide data to the medical homes; (b) calculate quality metrics; and (c) 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 (CHWs), and to design more effective face-to-face care coordination programs, with a focus on reducing preventable admissions and readmissions, addressing HRSN, and enhancing behavioral health and physical health coordination of services, among other categories.²⁵

Determine How to Measure Progress toward Primary Care and Health Equity Goals

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 goals and monitor impacts on specific communities. 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 process, outcome, and experience measures relating to primary care (e.g., well-child visit measures included in the CMS Child Core Set), stratified by demographic factors — such as race, ethnicity, language, gender identity, sexual orientation, geography, and disability status, as appropriate.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 ACO. 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.

Incentivize Equitable, Advanced Primary Care Strategies. States may consider their care delivery and health equity goals, such as the integration of behavioral health and social services into primary care settings, or the reduction of disparities, as well as 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, stratified as appropriate using demographic data. To perform well on the catalytic measure, the MCO, in conjunction with its network providers, must promote equitable, advanced primary care. For example, states may consider a depression screening measure, stratified by race/ethnicity, to advance behavioral health integration and monitor access to integrated care for people of color (e.g., postpartum depression screening). 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, including for providers that primarily serve people of color, 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 equitable, 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 preferred VBP arrangements, including those that support behavioral health and social care integration in patient-centered medical homes, and those designed to reduce health disparities and improve equity.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+ participating providers with 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} The state may also want to explicitly advance strategies that promote health equity and close health disparities for specific communities that have been marginalized. For example, **North Carolina** created a short-term Health Equity Payment initiative for practices with a minimum beneficiary poverty score, and **California's** 2022-2023 Budget included Equity and Practice Transformation Provider Payments to close health equity gaps in preventive, maternity, and behavioral health care.^{40,41} Primary care teams can use these funds to recruit physicians, nurses, CHWs, peer supports providers, midwives, and doulas from local communities, facilitating more culturally concordant and linguistically accessible care for patients.

Additional investments may also be needed to support state strategies to keep MCOs accountable for the advanced primary care and health equity 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 five advanced primary care priorities:

1. [Identify and address social needs;](#)
2. [Integrate behavioral health;](#)
3. [Promote health equity;](#)
4. [Enhance team-based care approaches;](#) 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 do not seek to define the right path, they 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.⁴² Factors, like structural racism, negatively impact the health of communities that have been marginalized and drive health inequities.⁴³ Comprehensive, high-quality, and equitable primary care models can help identify and address individual unmet HRSN, such as food or housing insecurity, and improve outcomes and patient experience of care.⁴⁴

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 and advance health equity, in partnership with communities that have been marginalized. At the individual patient or member level, states can consider defining how primary care teams (PCTs) and MCOs: (a) screen for social risk factors; (b) address identified unmet HRSN through referral and partnerships with CBOs; and (c) advance whole-person approaches to care coordination and management.⁴⁵ Across this spectrum of activities, states may define appropriate coordination, collaboration, and integration goals for both PCTs and MCOs.⁴⁶

Design Considerations

Both PCTs and MCOs have a role to play in identifying and addressing HRSN and broader SDOH.⁴⁷ States may develop a strategy that addresses HRSN throughout a managed care contract. For example, the state may integrate a focus on social needs into contract sections relating to: (a) training programs for network providers; (b) care coordination and management; (c) quality assurance and performance improvement; (d) VBP; (e) additional services such as value-added and in lieu of services; (f) MCO payment incentives; and (g) health equity plans or strategies.



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; (d) how should social needs information be documented and reported; and (e) how can that screening be more trauma-informed and person-centered?
- ✓ 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 risk factors, and navigate members to related services?
- ✓ What information should be shared across organizations?
- ✓ Who will define priorities for SDOH-related work? How can local communities 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 progress on primary care and health equity goals

- ✓ How will the state measure progress and hold MCOs accountable for implementing a SDOH strategy and related health equity goals?
- ✓ Will the state require or incentivize 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?

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:

✓ **Do PCTs and MCOs already screen for social needs?**

First, the state may want to assess the degree to which: (a) PCTs participate in a particular model that includes social needs screening, such as Accountable Health Communities, Pathways Community HUB, or CPC+; and (b) MCOs integrate questions on social needs into health risk assessments and other screeners.^{51,52,53} If PCTs and MCOs are already doing this work, states may be less prescriptive, outlining general guidelines and avoiding potential conflicts with established systems and processes.

✓ **Who should screen for social risk factors?**

Both MCOs and PCTs can integrate social risk factor 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 unmet HRSN through health risk assessments and other screening tools. However, many MCOs rely on telephonic care coordination processes that may not be as amenable to asking sensitive questions on HRSN. By contrast, PCTs can likely establish deeper, face-to-face connections with patients, and earn trust through trauma-informed and culturally appropriate care, which can yield more complete and honest responses to social risk factor screening questions.⁵⁴ PCTs can also experiment with other patient-centered ways to collect this information, such as through tablets in waiting rooms or post-appointment check-in calls in different languages.⁵⁵ 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 risk factors — avoiding duplicative, and potentially re-traumatizing, screening processes. In both MCOs and PCTs, CHWs and other resource navigators can assist with these functions.



Managed Care Procurement

Following is sample state managed care RFP language related to SDOH:

Minnesota.⁴⁸ “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.⁴⁹ “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.⁵⁰

- “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 risk factor screening — for example, those who require more intensive care coordination because of complex needs or who have screened positively to a preliminary, shorter screening. However, given the prevalence of HRSN 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 HRSN information in the way it sees fit. At other times, the state may be interested in having plans report standardized social data for key domains, such as food and housing insecurity, as well as self-identified race, ethnicity, language, and disability (RELD) data. This data can inform policy planning or a formal pilot evaluation, enable cross-sector partnerships, and strengthen quality assessment and performance improvement strategies and incentive programs with specific health equity goals. In either scenario, the state may assess what RELD and social needs information can be aggregated from other sources (like Medicaid eligibility files) and shared with MCOs and PCTs, to 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).⁵⁹

Managed Care Contract Excerpts

Following is sample state managed care contract language related to SDOH:

Louisiana (2019 RFP Model Contract, not implemented).⁵⁶ [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.⁵⁷ [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.⁵⁸ 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 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.

✓ **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.⁶⁰ States may build upon this general obligation to require the MCO to refer enrollees to community resources, or to advance particular types of referrals in partnership with PCTs (e.g., “warm handoffs”). The state may also require the MCO to: (a) maintain an up-to-date list of community resources; (b) use specific referral pathways, such as 211; (c) implement closed-loop referral processes, whereby the MCO or PCP tracks whether a beneficiary received a service; or (d) 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.⁶¹

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

States may direct MCOs to: (a) collaborate with PCTs on evidence-based interventions relating to HRSN; (b) target those efforts to a particular state priority area, such as food or housing insecurity; and (c) identify interventions that are relevant to a particular community, as identified through data analysis or community engagement. Additionally, the state may present its specific SDOH and HRSN requirements in the context of a particular health disparity, such as maternal mortality for Black birthing individuals or American Indians and Alaskan Natives.

✓ **Will the state require or incentivize 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 formal partnerships with CBOs, and integrate PCTs into these partnerships and intervention programs, to the extent possible. The state may also encourage, incentivize, or require MCO investment in local communities, as in **Arizona, North Carolina, and Oregon**.^{62,63,64} 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 community perspectives or require a specific structure or process to capture this input, such as **Oregon**'s community advisory councils, coordinated community health assessments, and its proposed Regional Community Investment Collaboratives.⁶⁵

✓ **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 CHW 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 invest in community-led solutions, and to design programs that help CBOs build capacity to engage in new types of financial relationships and manage upticks in referrals, such as through upfront working capital or performance-based incentives.⁶⁶ (See [VBP requirements](#) in **New York** and **Oregon**).

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

States may implement specific SDOH requirements in the context of: (a) a larger health equity initiative; (b) a targeted performance improvement project; (c) a VBP initiative; (d) a withhold or incentive arrangement; (e) an MCO care management requirement; or (f) 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, readmission rates, or low birth weight — stratified as appropriate by RELD data. Alternatively, the state may choose to track social needs screening rates, or more subjective measures such as “healthy days” or self-rated health status.⁶⁷

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 state examples for identifying and addressing social needs for Medicaid populations.

Flexible	Prescriptive
Approaches to Identifying Social Needs	
<p>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 SDOH assessment tool.”⁶⁸</p>	<p>Kansas,⁶⁹ Louisiana,⁷⁰ and North Carolina⁷¹ require MCOs to use state-developed social needs screening questions.</p>
Approaches to Addressing Social Needs	
<p>Michigan⁷² and Louisiana⁷³ require its MCOs to collaborate with its high-volume primary care practices to “develop, promote, and implement targeted evidence-based interventions” that can address social needs and health disparities.</p>	<p>North Carolina requires MCOs to use a community resource referral platform called NCCARE 360.⁷⁴ The system enables health care and human service providers to send and receive secure electronic referrals, share client information, and track outcomes.</p>
<p>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 SDOH.⁷⁵</p>	<p>Virginia requires MCOs to coordinate with the state on a pilot program addressing nutritional insufficiency, with a particular focus on children.⁷⁶</p>

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 related quality measures, VBP initiatives, and MCO incentive and withhold arrangements. Following are examples of measurement and payment strategies related to social needs.

State/Organization	Description
Measures	
Massachusetts	Health-Related Social Needs Screening ⁷⁷ - Percentage of members who were screened for HRSN in the measurement year.
Minnesota	Health Equity Measure ⁷⁸ - 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.
NCQA	Social Need Screening and Intervention (proposed 2022) ⁷⁹ - Assesses the percentage of members who were screened for unmet food, housing and transportation needs, and received a corresponding intervention if needed.
Oregon	Social Determinants of Health: Social Needs Screening and Referral Measure (March 2022 Draft Specifications) ⁸⁰ - The draft measure includes two components: (a) sample reporting using multiple data sources, including EHR, community information exchange, health information exchange, and other qualifying data sources, which may include screenings at the primary care practice level; and (b) CCO attestation on, among other activities, developing policies and practices that incorporate member voice, trauma-informed practices, empathic inquiry or motivational interviewing, culturally responsive and equitable practices, and clear protocols for referring members to available community resources.
Rhode Island	Social Determinants of Health Screening ⁸¹ - 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 ⁸² - The percentage of attributed patients who completed a Self-Reported Health Status screening, where the Accountable Entity has documented the screening and the results.

State/Organization	Description
Value-Based Payment Requirements	
New York ⁸³	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 ⁸⁴	North Carolina requires plans to “submit a written plan [...] that indicates how it will incorporate addressing Opportunities for Health [activities relating to HRSN] into its VBP strategy to align financial incentives and accountability around total cost of care and overall health outcomes.”
Oregon ⁸⁵	<p>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:</p> <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.”
CMS ⁸⁶	As part of the ACO Realizing Equity, Access, and Community Health (REACH) model, CMS is requiring all ACOs to collect and report beneficiary-reported demographic data (e.g., race, ethnicity, and language preference) and HRSN data. Collecting and reporting of this data will result in a bonus to the ACO quality score in the initial year of 2023, and may result in a downward adjustment in subsequent years.

State	Description
MCO Withhold and Incentive Arrangements	
California ⁸⁷	<p>In California, primary care teams can serve as providers of Enhanced Care Management (ECM), which includes coordination of and referral to community and social support services.⁸⁸ MCOs can receive incentive payments for ECM Provider Capacity Building, including points assigned to the following optional narrative measure:</p> <p>“Describe the strategy for closing identified health disparities with at least one strategy for each population of focus that will go live in the County in 2022, for a total of at least five identified health disparities.”</p>
Michigan ⁸⁹	<p>In FY 2018 and 2019, Michigan had 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 ⁹⁰	<p>SDOH and Health Equity Bonus Fund (not implemented). Oregon’s CCO 2.0 RFP included plans for 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.”</p>

2. Integrate Behavioral Health Care

Behavioral health conditions — including mental illness and substance use disorders (SUD) — are often underdiagnosed and treatment is delayed.⁹¹ Moreover, disparities in behavioral health condition prevalence, access to and use of behavioral health services, and behavioral health outcomes exist for many populations, such as Black and Spanish-speaking communities, people with disabilities, LGBTQ+ individuals, and people in rural areas.^{92, 93, 94, 95, 96} While behavioral health care is typically delivered separate from primary care, there is growing consensus that integrated care can facilitate earlier diagnosis and treatment, and reduce disparities.^{97, 98, 99, 100}

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.¹⁰¹

Design Considerations

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

Broadly, behavioral health integration can describe any situation in which behavioral health and medical providers work together.¹⁰² Numerous overlapping terms have been used to describe this integration, which can create confusion and inhibit implementation of effective interventions.¹⁰³ 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 framework ranging from minimal collaboration to co-located care to fully integrated care.¹⁰⁴ 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* primary care.¹⁰⁵



INTEGRATE BEHAVIORAL HEALTH CARE: Design Considerations Summary

Explore flexible versus prescriptive approaches.

- ✓ How will behavioral health integration be defined in MCO contracts in a way that promotes uniform care delivery approaches, or more broadly to allow flexibility?
- ✓ How will the state support culturally and linguistically appropriate behavioral health care?
- ✓ 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 identify and minimize barriers to integrated care?
- ✓ Which providers are expected to participate in integration activities?
- ✓ To what extent will MCOs be encouraged/required to work together on integration activities?

Determine how to measure progress on primary care and health equity goals?

- ✓ What financial or non-financial incentives will the state use to encourage uptake of integration among MCOs and providers?
- ✓ How will progress toward integration and health equity 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+) or health equity?

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?
- ✓ How can Medicaid agencies support state behavioral health workforce initiatives?



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.¹⁰⁹ 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.¹¹⁰ Patients with serious mental illness or active 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.¹¹¹

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.¹¹² **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.

Managed Care Procurement

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

Arizona.¹⁰⁶ “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.¹⁰⁷ “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.¹⁰⁸ “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.”

✓ How will the state support culturally and linguistically appropriate behavioral health care within primary care?

Regardless of which level or model(s) of behavioral health integration to support, states should consider how to incentivize and support culturally and linguistically appropriate behavioral health services, including how to tailor care to meet the needs of populations experiencing inequities. States may consider how to hold MCOs and providers accountable for implementing steps such as: (a) recruiting culturally and linguistically diverse staff and leadership; (b) providing cultural competency trainings for staff; (c) offering services in languages that meet the needs of their populations; and (d) regularly assessing and being responsive to community health needs. States can leverage the National Culturally and Linguistically Appropriate Services (CLAS) standards to guide this work, including for behavioral health services specifically.¹¹³ The U.S. Office of Minority Health has created a *Behavioral Health Implementation Guide for the [National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care](#)* that states can use.¹¹⁴



States may also consider how to incentivize or support implementation of specific care models that support culturally appropriate care. For example, a promising model is incorporating “peer providers”, health care staff with lived experience and close ties to the community being served, into health teams (e.g., CHWs, peer recovery coaches, peer navigators, etc.). Peer providers have the potential to advance health equity by helping build patient trust and overcoming stigma to help engage patients in behavioral health treatment.^{118, 119} For further information on how states incentivize and support peer provider models in Medicaid managed care, see the [Enhance Team-Based Care Approaches](#) module of this toolkit.

✓ **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 specific 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 incentivize or require plans to contract with those providers.¹²⁰ 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.

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).¹²¹ Such states may choose to reference the eight common elements and minimum standards of integrated care developed by the **Washington State Bree Collaborative**.¹²² States may also consider models that offer external supports or training to improve capabilities of under-resourced

Managed Care Contract Excerpts

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

New Hampshire.¹¹⁵ “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.¹¹⁶ “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.¹¹⁷ “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.”

practices. As examples, see descriptions of the **Massachusetts** Child Psychiatry Access Project and Project ECHO models described under [Care Delivery Model Examples](#).

✓ **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.¹²³ 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.¹²⁴ Additionally, as states increasingly build explicit health equity-related requirements into managed care contracts¹²⁵, they may consider requiring MCOs to measure and develop interventions to address disparities in access to integrated behavioral health services. For instance, states may consider asking plans to develop an approach for increasing access to integrated behavioral health services as part of MCO-developed health equity plans.

✓ **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.¹²⁶ 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.¹²⁷ In **Oregon**, SBIRT is a covered benefit for all Medicaid patients and for a wide range of provider types.¹²⁸ 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-9.¹²⁹ 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. States with prescriptive guidance related to behavioral health screening tools should also consider how to select screenings appropriate for diverse populations and how to implement screenings in a culturally appropriate way. For example, **Illinois** is reviewing whether its behavioral health screening tools have racial or ethnic bias.¹³⁰

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

In identifying barriers to integrated behavioral health care, states should consider how to seek input from a wide variety of stakeholders, including community-based organizations and people enrolled in Medicaid. Partnering with enrollees and communities, including populations that experience behavioral health disparities, is important for understanding barriers to care, root causes of disparities, and developing improved approaches to care delivery that build on existing community assets.¹³¹ See the [Promote Health Equity](#) module for specific examples of how states can partner with communities to advance equity in primary care.

States should also assess whether and how behavioral health capabilities of primary care practices varies by geography or population served by the practice, since a lack of availability of behavioral health services can be a driver of health disparities. As just one example, Black populations are less likely to have access to the full range of medication-assisted treatment services for opioid use disorder than white populations.¹³² In developing behavioral health integration requirements, states should consider how to support participation of providers that serve populations experiencing disparities.

States may also consider opportunities to minimize billing and regulatory barriers to integrated care. For example, states can: (a) stipulate that MCOs assess and maintain billing approaches and other policies conducive to integrated care; and (b) 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.¹³³

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.”¹³⁴ Additionally, states may consider how to adapt their long-term telehealth policies to expand access to tele-behavioral health services. In particular, the use and reimbursement of audio-only tele-behavioral health services helped increase access to behavioral health care during the COVID-19 pandemic. States may consider how to continue to reimburse for and support such services following the public health emergency.¹³⁵

✓ **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).¹³⁶ 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: (a) new fee-for-services billing codes (e.g., **Washington State**’s Collaborative Care Model codes); (b) care management payments (e.g., **New York**’s case rates for qualified Collaborative Care Model providers); (c) 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. For further considerations for how to develop VBP models to support primary care, including health equity goals, see the [Move to Value-Based Payment in Primary Care](#) module in the second part of this toolkit. 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).¹³⁷

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

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.¹³⁸ 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.¹³⁹ Finally, states may consider tying MCO payment to process or outcomes measures related to behavioral health integration. Stratifying such measure by demographic variables such as race, ethnicity, language, or disability (RELD) status can also help identify and track progress toward reducing health disparities. For example, **Louisiana** plans to require MCOs to stratify certain performance measures by race/ethnicity and urban/rural status, including behavioral health measures, such as follow up after emergency department visit for mental illness, after emergency department visit for alcohol and other drug abuse or dependence, and after hospitalization for mental illness.¹⁴⁰

✓ **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 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.¹⁴¹ 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 or practices in areas of high social vulnerability¹⁴² that are not independently able to undertake more sophisticated integration activities.¹⁴³

✓ **How can Medicaid agencies influence and support state behavioral health workforce initiatives?**

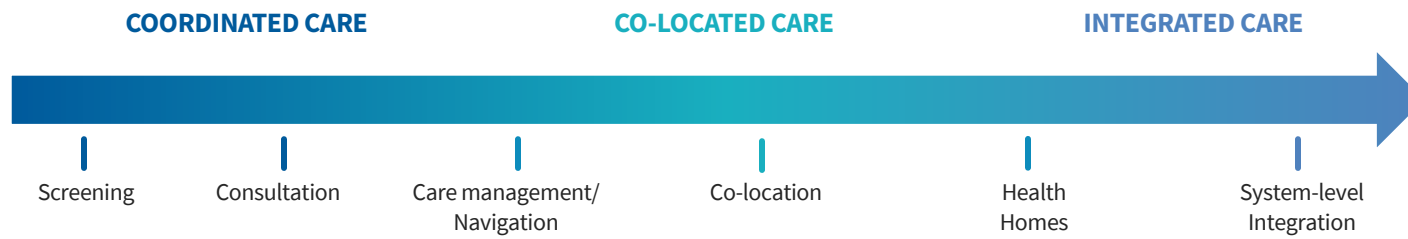
A key challenge to improving access to and quality of behavioral health services is a shortage of behavioral health providers.¹⁴⁴ While Medicaid agencies alone cannot solve this challenge, Medicaid staff may consider how to contribute to and align with broader state initiatives aimed at expanding the behavioral health workforce. For example, Medicaid agencies should consider how to collect and share data on workforce challenges to legislatures that may be developing and/or funding state-wide workforce initiatives.¹⁴⁵ Similarly, Medicaid agencies may consider whether there are opportunities to participate in cross-agency workgroups to help drive state-wide workforce development strategies.¹⁴⁶ Finally, Medicaid agencies may consider opportunities to alter their own policies, such as payment policies and services covered by state plans, to support a wider range of behavioral health provider types. For example, in 2019, **New York** expanded coverage of family peer services through their Children and Family Treatment and Support Services program.

Family peer support services provided by providers with state-recognized credentials for serving children and families with behavioral health needs is now available under the state plan.¹⁴⁷

Care Delivery Models

For states contemplating how to incentivize 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 select 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 Integration¹⁴⁸



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.¹⁴⁹

Consultation

- **Massachusetts Child Psychiatry Access Project** provides quick access to psychiatric consultation and facilitates referrals for accessing ongoing behavioral health care.¹⁵⁰ It encourages and supports PCPs integrating behavioral health resources into their practices. Many states have implemented similar programs.¹⁵¹
- **Project ECHO**¹⁵² 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 SUD, particularly in underserved areas.^{153,154}

- **Vermont’s Hub and Spoke Model** is used to expand access to medication assisted treatment for SUD.¹⁵⁵ 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)**,¹⁵⁶ 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.¹⁵⁷ It enhances routine primary care by adding two key services: (a) care management support for patients receiving behavioral health treatment; and (b) regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.¹⁵⁸ 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."¹⁵⁹ 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.”¹⁶⁰

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.¹⁶¹ 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
<p>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.^{162,163}</p>	<p>Minnesota requires MCOs to provide SBIRT in primary care clinics, which must use a “valid and reliable” screening tool approved by the state.¹⁶⁴</p>	<p>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.¹⁶⁵</p>
<p>New York developed the New York State Patient-Centered Medical Home (NYS-PCMH) which includes enhanced standards for behavioral health integration, among other areas.¹⁶⁶ New York also developed a program enabling PCPs who implement the CoCM to receive reimbursement for services provided.¹⁶⁷</p>	<p>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.¹⁶⁸</p>	<p>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.¹⁶⁹</p>

Measurement and Payment

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

State	Description
Value-Based Payment and Other Provider Funding Arrangements for Behavioral Health Integration	
Arizona ¹⁷⁰	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 ¹⁷¹	California includes four behavioral health integration measures as part of the value-based purchasing measures used by health plans with contracted providers: (a) screening for clinical depression; (b) management of depression medication; (c) screening for unhealthy alcohol use; and (d) co-location of primary care and behavioral health services. ¹⁷²
Colorado ¹⁷³	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 ¹⁷⁴	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 ¹⁷⁵	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. ¹⁷⁶ Providers must attest they are providing care consistent with the state’s guidelines.
MCO Withhold and Incentive Arrangements	
Oregon ^{177, 178}	Oregon had 19 quality measures used to determine reward payments for CCOs in 2019, including: (a) PCPCH enrollment; (b) SBIRT; and (c) depression screening and follow-up plan, with providers choosing a standardized screening tool.
Washington ¹⁷⁹	For 2022, Washington has a two percent MCO capitation withhold and MCOs can earn up to 75 percent of the withhold amount based on quality performance. The quality measure set includes measures related to behavioral health, such as antidepressant medication management and SUD treatment penetration.

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.¹⁸⁰ 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.¹⁸¹ 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.¹⁸²

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.^{183,184} 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.^{185, 186, 187, 188, 189} 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.^{190,191}

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.^{192,193} 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.¹⁹⁴

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.¹⁹⁵

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.”¹⁹⁶ 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.¹⁹⁷

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.¹⁹⁸ 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**).^{199,200,201}

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.²⁰² 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.²⁰³ 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.^{204,205} 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.²⁰⁶



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 to be conveyed (e.g., visuals, audio presentation, role-play)?²⁰⁸

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,²⁰⁹ 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.²¹⁰ 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.²¹¹

Within this broader context, states should assess existing primary care and managed care initiatives and how they can be strengthened 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

Request for Proposal Excerpts: Minnesota²⁰⁷

Following is sample Minnesota managed care 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?”

outcomes for Black enrollees, or broader, like decreasing all racial/ethnic health disparities in primary 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.²¹² 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.^{213, 214}

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.²¹⁵ 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.²¹⁶ 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.²¹⁷ 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.^{218, 219} 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.²²⁰ 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.²²¹

✓ **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.²²² To respond to this, 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.²²³ 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.^{224, 225} 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 PCP or auto-assignment, and consider ways to improve auto-assignment methodologies to direct enrollees to PCPs that offer high-quality, equitable care.²²⁷ 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.²²⁸

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.^{229, 230}

✓ **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.²³¹

Request for Proposal Excerpts: Louisiana²²⁶

Following is sample Louisiana managed care 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 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 CHWs; 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 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? 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 outcomes?

Strong data-sharing practices between MCOs and primary care teams can help reconcile REL data, standardize data collection practices, and verify data accuracy.²³² REL data collection may occur during multiple touchpoints, including by: (a) the state or its enrollment broker during Medicaid enrollment; (b) the MCO during health risk assessments or other contacts with members; and (c) 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.²³³

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.²³⁴

✓ **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.²³⁵ 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.²³⁶

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: (a) adding relevant benefits and billing codes; (b) crafting payment models that allow for team-based, patient-centered modes of care, with a preference for multi-payer efforts whenever possible; and (c) 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

CHW interventions, which are “tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience.” CHWs 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.^{237, 238}

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.²³⁹ 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.^{240, 241, 242} 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.²⁴³

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.²⁴⁴ 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.²⁴⁵ 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 HRSN and submitting applicable diagnosis codes (“Z codes”) on claims.²⁴⁶

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:

(a) flexible services, such as fresh food prescriptions for members and legal assistance for housing-related issues; and
(b) community-benefit initiatives, which can include health information technology integration with social resource and referral systems in the primary care setting.²⁴⁷ 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.²⁴⁸

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.²⁴⁹ Council members include MCOs and health centers that provide primary care, in addition to trusted community institutions.

For more on identifying and addressing HRSN, see the [Identify and Address Social Needs](#) module 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.²⁵⁰ 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.²⁵¹

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.^{252,253,254,255} 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,²⁵⁶ who can use community connections and shared lived experience to promote health equity.²⁵⁷ 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.²⁵⁸

For more on integrating behavioral health and primary care, see the [Integrate Behavioral Health Care](#) module 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.”²⁵⁹

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**.²⁶⁰ These new payment models can promote financial stability and flexibility, and can enable more advanced primary care delivery, such as screening for and addressing HRSN, increasing access to care through use of technology, providing team-based care, and integrating behavioral health care into primary care.²⁶¹

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.²⁶² 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 PCPs 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.²⁶³

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.²⁶⁴ 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.²⁶⁵ 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.²⁶⁶

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.²⁶⁷ To address these challenges, states may consider providing enhanced payments to PCPs 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.²⁶⁸ 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 CHWs, health coaches, and doulas.²⁶⁹

✓ **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.²⁷⁰ This bonus program is in addition to a longstanding bonus program dedicated to strategies to address disparities in low birth weight,²⁷¹ 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.²⁷²

For more information on MCO accountability, see the [Promote Accountability Mechanisms for Managed Care Organizations](#) module in the second part 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.²⁷³

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; need for gender affirming care; 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.”²⁷⁴

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.²⁷⁵

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.”²⁷⁶

In its most recent RFPs, **California** (a draft version) and **Louisiana** plan to require MCOs to maintain a full-time Health Equity officer/administrator.^{277, 278}

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.²⁷⁹

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.”²⁸⁰

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.”²⁸¹

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.”²⁸²

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 HRSN. 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.²⁸³

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.”²⁸⁴

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 PCP possesses their race, ethnicity and language data.”²⁸⁵

4. Enhance Team-Based Care Approaches

Team-based care is a key aspect of providing high-quality, coordinated, and comprehensive primary care. As noted in a National Academies of Sciences, Engineering, and Medicine report, the primary care team should include “a variety of clinical and nonclinical team members” who deliver “whole-person care” through supporting functions such as patient education, care management and coordination, and resource navigation.²⁸⁶ Innovative team-based care models often focus on: (a) employing staff with diverse expertise and backgrounds who can collaborate to work at the top of their licenses; (b) provide high-quality care that meets their patients’ needs; (c) support practices in providing culturally and linguistically appropriate care; and (d) promote more equitable care delivery and health outcomes.^{287,288,289, 290} States may support team-based care through managed care in a variety of ways, such as encouraging, requiring, or incentivizing:

- Integration of specific types of staff — such as 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. In particular, MCOs 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, including priorities to promote equitable care and outcomes?
- ✓ 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.

- ✓ Who will define priorities for adoption of team-based care? How will they partner with communities to co-develop these priorities?
- ✓ 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 capacity does the state have to develop and oversee custom programs?

Determine how to measure progress on primary care and health equity goals.

- ✓ How can MCOs be held accountable for implementing team-based care strategies?
- ✓ How can team-based care strategies be designed and monitored to ensure provision of culturally and linguistically appropriate care and promotion of health equity?
- ✓ How will the state ensure that MCOs enhance — and not detract from — programs run by local community-based organizations, such as 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 or other community-based workforce members?
- ✓ 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, safety net, 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.²⁹⁴ States may also consider requiring MCOs to support care management through community-based health teams who — due to shared backgrounds and experience with people in their communities who are enrolled in Medicaid — may be more successful at building trust and engaging patients in care.

✓ 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.²⁹⁵ Alternatively, states can set more general guidelines for team-based care, allowing individual MCOs more flexibility to customize programs.

Managed Care Procurement

Following is sample state managed care RFP 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?”²⁹¹

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 CHWs or other types of workers to improve care?”²⁹²

Minnesota (RFP). “Describe how the Responder uses non-traditional healthcare services (such as doulas, community EMTs, Community Paramedics, CHWs, etc.) to provide culturally competent care and/or improve health outcomes.”²⁹³

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.

Under both prescriptive and flexible approaches, states can signal their vision for how team-based care models support goals related to improved outcomes and decreased health disparities. States and MCOs can also consider how they will work with patients, families, and communities to co-develop team-based care models — ensuring that the primary care team is designed to support community needs and preferences.

✓ **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 incentivizing specific care delivery standards.

✓ **How will the state’s approach accommodate small, safety net, or rural practices?**

Small, safety net, or rural practices may not have sufficient volume or resources to support a multi-disciplinary team on their own. To support small independent or rural practices, or safety net providers, 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.²⁹⁸ States can also incentivize MCOs to employ or financially support CHWs or other types of staff to support primary care practices.



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...”²⁹⁶

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:

- PCP;
- 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.”²⁹⁷

✓ **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. Whether using customized or external models for team-based care, states may consider how requirements to address health equity are incorporated. For example, updating standards for team-based care models and primary care may be a useful way to ensure care teams engage with patients and community members and provide culturally and linguistically appropriate care. For more on this topic, see [Raising the Bar: Using Primary Care Practice Standards to Advance Health Equity in Medicaid](#).

✓ **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 HRSN, improving care for patients with chronic conditions, and promoting equitable care and outcomes. 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 incentivize through MCO contracts. For example, peer providers can support patients in self-management of behavioral health conditions.²⁹⁹ CHWs or other resource navigator roles can support referrals and coordination with community resources that can assist in addressing HRSN.³⁰⁰ 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.³⁰¹ Incorporating *promotores* into care management teams can better support the needs and engagement of primarily Spanish-speaking people.³⁰²

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 facilitate coordination with community resources. CHTs generally coordinate with PCPs, 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 incentivize 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 providers be compensated for team-based care?**

Providers may need higher rates or new reimbursement pathways to fund specific team-based care strategies. For example, 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.^{303,304}

✓ **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.³⁰⁵ In other cases, states may require MCOs to compensate providers for team-based care models, but not define specific rates.³⁰⁶ 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.^{307,308}

✓ **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.³⁰⁹ States may also consider implementing team-based care requirements within performance improvement projects, VBP initiatives, or § 1115 demonstration projects or pilot programs.

It is critical to ensure that people who experience inequities have equitable access to high-quality, team-based care. States can consider ways to monitor access, such as by stratifying enrollment in PCMHs by relevant demographic data (e.g., race, ethnicity, language, and disability status). They can develop strategies to promote equitable access to team-based care by engaging with safety net providers and identifying what barriers may exist to adopting these models.

Integrating CHWs into Care Teams

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

The specific definition and role of CHWs or other resource navigator roles 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, which improves their capacity to deliver culturally and linguistically appropriate care.³¹²

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, in particular needs related to identified health inequities; and
- Enhancing communication, understanding, and collaboration between individuals and communities, health, and social service systems.³¹³

States may be prescriptive in defining the use of CHWs in managed care contracts. For example, the state may: (a) require CHW to enrollee ratios; (b) define the scope of CHW services; (c) define CHW training requirements; or (d) require pilot implementation of a particular type of CHW model, such as the ImPaCT model.^{314,315}

Alternatively, the state may leave more flexibility for MCOs to develop customized approaches. For example, states may craft a managed care RFPs 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 CHWs.

✓ 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: (a) hold a CHW certificate from a school offering a standardized curriculum; and (b) are supervised by a variety of provider types such as physicians, dentists, public health nurses, and/or mental health professionals.³¹⁶ **Oregon's** Primary Care Payment Reform Collaborative has created principles to guide the development of payment arrangements for services provided by CHWs and other members of the community-connected health workforce. These principles note that payment approaches may be tailored to the specific context, but should include a focus on: (a) sustainability of funding; (b) supporting the ability of CHWs

Who Are Community Health Workers?

CHWs (also known as *promotores* or peer mentors) are part of the broader community-connected health workforce,³¹⁰ public health workers with close ties to local communities that serve to facilitate culturally appropriate care and build connections between health systems and community resources.³¹¹ States are increasingly recognizing integration of CHWs into care teams as a key strategy in delivering high-quality, equitable, community-based care for people enrolled in Medicaid.



to practice at the top of their certification; (c) identified community needs and health inequities; and (d) the ability of CHWs to provide person-centered care and improve outcomes in the long term.³¹⁷

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.³¹⁸ 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.

✓ **How can other members of the community-connected health workforce be integrated into care teams?**

In addition to CHWs, other members of the community-connected health workforce may be part of a successful team-based care strategy. For example, practices who offer integrated primary and behavioral health care may choose to employ peer support specialists who can draw on their lived expertise to support patients struggling with mental health or substance use conditions, especially for patients facing inequities related to race, ethnicity, spoken language, or income.³¹⁹ Practices serving large populations of immigrants or Native American people may be able to better serve patients by incorporating culturally concordant staff and services, such as **New Mexico**’s provision to cover traditional healing practices for Native American people.³²⁰ Provision of high-quality interpretation services can help mitigate health inequities experience by

people with limited English proficiency and deaf individuals. Finally, use of doulas has been shown to reduce maternal health disparities experienced by people of color³²¹ and can support primary care practices who work with pregnant and post-partum people.

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 (2019 RFP)	In its 2019 RFP, which was not implemented, Louisiana Medicaid and the Center for Healthcare Value and Equity at the Louisiana State University Health Sciences Center introduced a 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 was to align MCO CHW use with evidence-based practice and build capacity to efficiently scale CHW programs across managed care. ³²²
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. ³²³
Vermont	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: <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.³²⁴ ■ Medicare, Medicaid, and private payers share the costs of CHTs through PMPM payments; there is no cost to PCMHs or patients for CHT services.³²⁵ ■ Vermont requires OneCare to use a portion of prepaid shared savings funds to support community health teams, in accordance with state guidelines.³²⁶

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 incentivize provider adoption of team-based care models or CHWs through new payment mechanisms or increased rates.

State	Requirements
Provider Payment Requirement Examples	
New York ^{327,328}	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 ³²⁹	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 ³³⁰	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 ³³¹	<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 ^{332,333}	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 ³³⁴	Physical health MCOs must contract with high-volume providers in their network who meet state PCMH requirements. For calendar year 2019: <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 ³³⁵	<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 (2019 RFP) ³³⁶	In its 2019 RFP, which was not implemented, Louisiana proposed requirements 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 ³³⁷	“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 ³³⁸	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 primary care to address a wider range of needs, such as behavioral health issues, and help advance health equity, particularly through increased access to care. “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. In 2018, almost all states (49 and D.C.) reimburse for live video services, but fewer reimburse for remote patient monitoring.³³⁹

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.³⁴⁰ 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 PCPs 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.³⁴¹

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 specific 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.³⁴²

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 progress on primary care and health equity goals.

- ✓ 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?



Improving access through telehealth also has the potential to advance health equity. Many individuals enrolled in Medicaid experience access issues for in-person primary care visits due to transportation barriers, the potential for lost wages from taking time off from work, and other factors. These challenges are often exacerbated for people of color in underserved and rural communities. Telehealth solutions, including audio-only support, could help improve access to care for these individuals.³⁴³

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.

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 specific 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 among providers. Common barriers include access to technology and broadband, licensure, privacy concerns, and state law and reimbursement policies.³⁴⁷ In Medicaid reimbursement, a common restriction is on the “originating site,” or where a patient is located. As of 2018, many policies excluded a patient’s home as an originating site, but 13 states explicitly allowed and reimbursed service to a patient’s home.³⁴⁸ However, less restrictive policies alone may not incentivize the uptake of telehealth services.³⁴⁹

Managed Care Procurement

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

Hawaii.³⁴⁴ “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.³⁴⁵ “[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.³⁴⁶ “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. Further, states could obtain greater understanding of barriers to telehealth access by asking, or requiring MCOs to ask, patients and communities about their experiences.

✓ **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.³⁵²

Managed Care Contract Excerpts

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

New Mexico.³⁵⁰ “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.³⁵¹ “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
<p>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.³⁵³</p>	<p>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.</p>
<p>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.³⁵⁴</p>	<p>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.³⁵⁵ The team must include a child psychiatrist, behavioral health therapist, and a care coordinator.</p>

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.³⁵⁶

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 due to the digital divide. For example, Medicaid recipients are less likely to use telehealth tools, such as patient portals and live video communication,^{357,358} in part due to structural barriers within and outside the health care system. Therefore, it is important to evaluate the health equity impacts in any approach related to telehealth, including considering phone-based models as a more accessible option for underserved communities.³⁵⁹

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.³⁶⁰ These foundational primary care elements can be opportune building blocks for states interested in incentivizing more advanced provider capabilities, including capabilities that support more equitable primary care. This section focuses on how states can leverage the PCMH model to address the following high-quality primary care attributes:

1. Integration of primary health care with public health, social services, and behavioral health;^{361, 362, 363}
2. Proactive patient and family engagement to address physical, social, and cultural barriers to care;^{364, 365, 366}
3. Mobile or digital health;^{367, 368, 369, 370, 371, 372}
4. Active use of data to manage and improve patient care and system performance;^{373, 374, 375}
5. Geographic empanelment, including appropriate risk stratification and targeting;^{376, 377}
6. Multidisciplinary teams with CHWs;^{378, 379, 380} and
7. Medical home capabilities as a foundation.^{381, 382, 383}

In addition to supporting high-quality care, many of these attributes are important aspects of advancing more equitable primary care. For example, proactively engaging patient and families — including from communities experiencing inequities — is an important step in identifying root causes of and developing approaches to address health disparities.³⁸⁴ Similarly, integrating CHWs, or other non-traditional workers with close community ties, can be an important means of supporting a diverse health care workforce that reflects the community it serves and providing culturally appropriate care.³⁸⁵ Integration of primary care with public health, social services, and behavioral health care is important for supporting access to comprehensive and coordinated care, including for populations experiencing inequities. When developing PCMH program standards, states should consider how practice standards can be leveraged to support and align with broader state health equity goals. For further details



on how PCMH standards can be adapted to more explicitly focus on health equity, see [Raising the Bar: Using Primary Care Practice Standards to Advance Health Equity in Medicaid](#).

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.

³⁸⁶ 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 core requirements. For example, these three state programs include additional behavioral health 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.

There is also opportunity for states to develop additional PCMH requirements specifically focused on promoting health equity. In particular, states may consider setting standards related to: (a) enhancing demographic data collection to measure disparities; (b) quality improvement activities focused on health equity; and (c) enhancing requirements for practices to partner with patients and communities to inform care delivery. ³⁸⁷

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.³⁸⁸ 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.³⁸⁹ ■ 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.³⁹⁰ ■ The NY PCMH program covers initial provider costs for recognition and provides technical assistance through a SIM award.³⁹¹ ■ Participating practices are eligible for enhanced reimbursement under the Medicaid PCMH Incentive Program.³⁹² This program was created through 2009 legislation and CMS approved a related state plan amendment (SPA) in 2010.^{393, 394} ■ 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).³⁹⁵ 	<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.³⁹⁶ ■ 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.³⁹⁷ ■ 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.³⁹⁸ ■ CCOs must include PCPCHs in their networks and PCPCH enrollment is a CCO quality measure.^{399, 400} 	<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.⁴⁰¹</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.^{402, 403, 404} ■ Ohio CPC practice requirements are similar to CPC+ requirements, though payment streams differ.⁴⁰⁵ To enroll in the program, practices submit application to Ohio Medicaid. Ohio Medicaid works with a vendor to conduct program monitoring.^{406, 407} ■ Practices are compensated for PCMH activities and cost and quality performance.⁴⁰⁸ ■ Previously, Ohio CPC eligibility criteria included national accreditation or CPC+ participation. OH removed these requirements in 2019.^{409, 410}

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.^{411, 412} 	<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.^{413, 414, 415} 	<p>Ohio CPC requires that practices:</p> <ul style="list-style-type: none"> ■ Employ care management strategies and plans that support integration of BH.^{416, 417} <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.^{418, 419}
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.^{420, 421} 	<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.⁴²² <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.^{423, 424, 425} 	<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.^{426, 427}
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.^{428, 429}</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.⁴³⁰ NYS provides funding through SIM for participating practices to connect to the SHIN-NY^{431,432} Use a certified electronic health record system.⁴³³ 	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. ⁴³⁴
Attribute 5: Geographic empanelment, including appropriate risk stratification and targeting		
NYS PCMH requires that practices have a comprehensive risk stratification process. ^{435, 436}	No requirements.	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. ^{437, 438, 439} In cases where attribution cannot be determined based on patient choice or claims, geography may be a factor for determining attribution. ⁴⁴⁰
Attribute 6: Multidisciplinary teams with CHWs		
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). ⁴⁴¹	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. ^{442, 443}	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. ^{444, 445} Previously, participating practices were required to have either national accreditation or participate in CPC+. For 2019, OH has removed these requirements. ^{446, 447}

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.^{448,449} 	<p>PCPCH requires practices to:</p> <ul style="list-style-type: none"> ■ Track at least one quality measure from the PCPCH quality measure set;⁴⁵⁰ ■ Report they routinely offer comprehensive preventive and medical services; ■ Have a written agreement with hospital providers or provide routine hospital care;⁴⁵¹ 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;⁴⁵² ■ Meet a benchmark for percent of patient visits with assigned clinician or team;⁴⁵³ ■ 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.^{454, 455,456} 	<p>Ohio CPC requires that practices:</p> <ul style="list-style-type: none"> ■ Provide continuity of medical record information when office is closed;⁴⁵⁷ ■ 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.^{458,459, 460}
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.⁴⁶¹ <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.⁴⁶²</p>	<p>CCOs are required to implement value-based payments and prioritize implementing alternative payments and incentives for PCPCHs.⁴⁶³</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 incentivize efficiency or quality, payments for patient-centered medical homes, or payments to improve provider capacity and infrastructure.⁴⁶⁴ ■ Starting in 2020, CCOs will be required to provide PMPM payments to PCPCH clinics, as a supplement to any other payments, to support development of infrastructure and operations for PCPCHs.⁴⁶⁵ 	<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).⁴⁶⁶ ■ 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).^{467, 468} ■ To be eligible for PMPM and shared savings payments, practices must pass 50% of applicable quality and efficiency metrics.⁴⁶⁹

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.⁴⁷⁰ 	<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.⁴⁷¹ ■ State law requires CCOs to allocate at least 12% of health care expenditures to primary care by 2023.⁴⁷² ■ 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.^{473,474} 	<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.⁴⁷⁵ ■ MCPs are required to coordinate with and support CPC practices in implementing CPC activities. This includes activities such as member outreach and data sharing.⁴⁷⁶

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, poor outcomes, and persistent inequities 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 functions, 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 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 their Medicaid managed care programs.



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- ⁴¹⁴ Oregon Health Authority. "2017 PCPCH Standards - NCQA PCMH 2017 Standards – Crosswalk." Op. cit.
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- ⁴²² NCQA PCMH only requires practices to assess language needs of their population.
- ⁴²³ 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.
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- ⁴⁴⁶ Ohio Department of Medicaid. “2019 Ohio CPC Eligibility Requirements.” Op. cit.
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- ⁴⁴⁹ National Committee for Quality Assurance. “NYS PCMH Standards and Guidelines.” Op. cit.
- ⁴⁵⁰ NCQA PCMH requires practices to track quality measures from certain categories, but does not require selection from a defined measure set.
- ⁴⁵¹ NCQA PCMH requires coordination but not a written agreements with hospitals.
- ⁴⁵² NCQA PCMH has quality improvement criteria but does not require a comprehensive strategy to guide multiple QI projects.
- ⁴⁵³ NCQA PCMH has a similar criteria but does not require practices to meet a benchmark.
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