

# Enhance Team-Based Primary Care Approaches:

Advancing Primary Care Innovation in Medicaid Managed Care

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Health Care Strategies, Inc.

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

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

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

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

**T**eam-based care is a key aspect of providing high-quality, coordinated, and comprehensive primary care. In addition to clinical staff, primary care practices often incorporate non-clinical staff into care teams to support functions such as patient education, care management and coordination, and resource navigation. Innovative team-based care models often focus on employing staff with diverse expertise and backgrounds who can collaborate to work at the top of their licenses and provide high-quality care that meets their patients' needs.<sup>1,2,3</sup> States may support team-based care through managed care in a variety of ways, such as encouraging, requiring, or incenting:

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

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

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

## ENHANCE TEAM-BASED CARE: Design Considerations Summary

### Explore flexible versus prescriptive approaches.

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

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

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

### Determine how to measure, monitor, and reward progress.

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

### Leverage payment reform to drive innovation.

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

### Determine the need for additional investments.

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



## Design Considerations

### Advancing Team-Based Care

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

Some care delivery models, such as PCMHs, are designed to be implemented at the primary care practice level. Other team-based care strategies, such as implementation of multi-disciplinary care management or use of CHWs, can be implemented at the primary care practice or MCO level. For example, MCOs can directly employ CHWs, or contract with organizations employing CHWs to support functions such as care management and coordination. In other cases, CHWs can be employed by provider organizations and more fully integrated into care teams. Additionally, while MCOs have traditionally implemented care management services themselves, often telephonically, some states allow MCOs to delegate care management to primary care practices.<sup>7</sup> States may also consider requiring MCOs to support care management through community-based health teams.

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

In establishing team-based care through managed care, states can require MCOs to implement, or support primary care practices in implementing specific care models, such as a state-defined community health team model or the National Committee for Quality Assurance (NCQA) PCMH model.<sup>8</sup> Alternatively, states can set more general guidelines for team-based care, allowing individual MCOs more flexibility to customize programs.

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



## Managed Care Procurement

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

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

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

24. What policies and best practices should the state consider in terms of delegation of care management responsibilities to CCTs?”<sup>4</sup>

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

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

10. How has your organization engaged community health workers or other types of workers to improve care?”<sup>5</sup>

**Minnesota (RFP).** “Describe how the Responder uses non-traditional healthcare services (such as doulas, community EMTs, Community Paramedics, community health workers, etc.) to provide culturally competent care and/or improve health outcomes.”<sup>6</sup>



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

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

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

Small or rural practices may not have sufficient volume to support a multi-disciplinary team on their own. To support small independent or rural practices, states may consider building state or MCO infrastructure that can support and extend individual practice capabilities. For example, states may consider implementing local community care teams to support primary care practices in delivering PCMH functions such as care coordination or population health management.<sup>11</sup> States can also incentivize MCOs to employ or financially support CHWs or other types of staff to support primary care practices.

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

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

## Managed Care Contract Excerpts

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

**Michigan.** “Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by CBOs which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience...”<sup>9</sup>

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

- Primary care provider;
- Behavioral health provider(s);
- Specialist(s);
- Pharmacist(s);
- Community health worker(s);
- Peer specialist(s);
- Housing specialist, if the enrollee is identified as homeless; and
- State staff, including transition coordinators.”<sup>10</sup>



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

Advancing team-based care is often a key aspect of other state primary care priorities such as behavioral health integration, addressing health-related social needs, and improving care for patients with chronic conditions. A key way states can improve quality for certain services or populations is better integrating staff with expertise in these domains into care teams. As such, these broader policy goals may have implications for the types of staff or models that states choose to incent through MCO contracts. For example, peer providers can support patients in self-management of behavioral health conditions.<sup>12</sup> CHWs or other resource navigator roles can support referrals and coordination with community resources that can assist in addressing health-related social needs.<sup>13</sup> 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.<sup>14</sup>

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

Providers may need higher rates or new reimbursement pathways to fund specific team-based care strategies. For examples, some states have chosen to reimburse practices recognized as PCMHs with higher FFS rates or additional PMPM payments. Others have developed new billing codes for specific payment models, such as the Collaborative Care Model or for new types of staff such as CHWs.<sup>15,16</sup>

✓ ***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.<sup>17</sup> In other cases, states may require MCOs to compensate providers for team-based care models, but not define specific rates.<sup>18</sup> 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.<sup>19,20</sup>

## Care Delivery Model Examples

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

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

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

A common strategy for holding MCOs accountable for team-based care initiatives is through setting targets for member enrollment in PCMHs or members served by CHWs. States may tie these targets to MCO payment through withhold or incentive arrangements. Another strategy is incorporating team-based care elements into MCO care management requirements, such as encouraging use of multi-disciplinary care teams to support member needs.<sup>21</sup> States may also consider implementing team-based care requirements within performance improvement projects, VBP initiatives, or § 1115 demonstration projects or pilot programs.

**Integrating CHWs into Care Teams**

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

The specific definition and role of CHWs varies across states and organizations. A key aspect that may distinguish CHWs from other roles is that they are often hired, in part, based on their lived experience and connections to local communities.<sup>23</sup> Common CHW roles include:

- Providing direct patient services such as health education, screenings, and self-management support;
- Providing health care and social service navigation and coordination;
- Advocating for individual and community needs; and
- Enhancing communication, understanding, and collaboration between individuals and communities, health, and social service systems.<sup>24</sup>

States may be prescriptive in defining the use of CHWs in managed care contracts. For example, the state may: (1) require CHW to enrollee ratios; (2) define the scope of CHW services; (3) define CHW training requirements; or (4) require pilot implementation of a particular type of CHW model, such as the ImPaCT model.<sup>25,26</sup>

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

**Who Are Community Health Workers?**

CHWs are public health workers with close ties to local communities that serve to facilitate culturally competent care and build connections between health systems and community resources.<sup>22</sup> State are increasingly recognizing integration of CHWs into care teams as a key strategy in delivering high-quality, community-based care for Medicaid beneficiaries.



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

States may integrate CHW services into state plan benefits as either a standalone service (e.g., health education) or a component of another service, such as health homes. If CHWs are integrated into a state plan service, costs associated with CHWs can be included in managed care rate-setting processes as a portion of the medical premium. For example, **Minnesota** Medicaid reimburses for diagnosis-related health education services provided by CHWs who: (1) hold a CHW certificate from a school offering a standardized curriculum; and (2) are supervised by a variety of provider types such as physicians, dentists, public health nurses, and/or mental health professionals.<sup>27</sup>

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.<sup>28</sup> States may choose to align CHW requirements or definitions with those certification standards, or defer to MCOs and their community-based partners to define appropriate standards for their staff.

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

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

## State Approaches

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

State	Description
<b>Louisiana</b>	Louisiana Medicaid and the Center for Healthcare Value and Equity at the Louisiana State University Health Sciences Center plan to pilot a CHW demonstration project, based on the IMPaCT model, serving high-risk Medicaid members in a target region in Louisiana. The goal for the pilot is to align MCO CHW use with evidence-based practice and build capacity to efficiently scale CHW programs across managed care. <sup>29</sup>
<b>Pennsylvania</b>	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. <sup>30</sup>
<b>Vermont</b>	<p>Vermont has implemented CHTs to support PCMH capacity and link patients with community services. While Vermont has not implemented Medicaid managed care, aspects of this model and the state’s contract with its all-payer ACO (OneCare) could be adapted to a managed care environment:</p> <ul style="list-style-type: none"> <li>■ Specific aspects of CHTs, including staffing, service configuration, and location (embedded within practices vs. offsite) are locally defined based on community needs.<sup>31</sup></li> <li>■ Medicare, Medicaid, and private payers share the costs of CHTs through PMPM payments; there is no cost to PCMHs or patients for CHT services.<sup>32</sup></li> <li>■ Vermont requires OneCare to use a portion of prepaid shared savings funds to support community health teams, in accordance with state guidelines.<sup>33</sup></li> </ul>



## Measurement and Payment

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

State	Requirements
Provider Payment Requirement Examples	
<b>New York</b> <sup>34,35</sup>	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.
<b>Oregon</b> <sup>36</sup>	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.
<b>Pennsylvania</b> <sup>37</sup>	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
<b>Patient Centered Medical Home Enrollment Target Examples</b>		
<b>New Mexico</b> <sup>38</sup>	<p>Legacy contractors must demonstrate:</p> <ul style="list-style-type: none"> <li>■ A minimum of a 5% increase of the contractor's members assigned to a PCP within a PCMH; or</li> <li>■ Maintain a minimum of 50% of membership being served by PCMHs.</li> </ul> <p>Non-legacy contractors must demonstrate:</p> <ul style="list-style-type: none"> <li>■ A minimum of 10% of the contractor's total membership assigned to a PCP within a PCMH.</li> </ul>	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.
<b>Oregon</b> <sup>39,40</sup>	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.
<b>Pennsylvania</b> <sup>41</sup>	<p>Physical health MCOs must contract with high-volume providers in their network who meet state PCMH requirements. For calendar year 2019:</p> <ul style="list-style-type: none"> <li>■ "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."</li> </ul>	N/A
<b>Rhode Island</b> <sup>42</sup>	<p>Rhode Island tracks:</p> <ul style="list-style-type: none"> <li>■ "percentage of members assigned to a primary care practice that functions as a patient centered medical home" as recognized by the state.</li> </ul> <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
<b>Community Health Worker Target Examples</b>		
<b>Louisiana</b> <sup>43</sup>	Louisiana requires that MCOs support the design and implementation of a CHW program, including maintaining a CHW caseload ratio of at least one full-time CHW per 100 enrollees enrolled in a CHW program.	N/A
<b>New Mexico</b> <sup>44</sup>	“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.
<b>Michigan</b> <sup>45</sup>	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

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## About this Resource

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## About the Center for Health Care Strategies

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

## ENDNOTES

- <sup>11</sup> L. Schottenfeld, D. Petersen, D. Peikes, R. Ricciardi, H. Burak, R. McNellis, et al. "Creating Patient-centered Team-based Primary Care." Mathematica Policy Research for Agency for Healthcare Research and Quality, March 2019. Available at: <https://pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-team-based-primary-care-white-paper.pdf>
- <sup>2</sup> K. Coleman, E. Wagner, J. Schaefer, R. Reid, and L. LeRoy. "White Paper: Redefining Primary Care for the 21st Century". Prepared by Abt Associates, in partnership with the MacColl Center for Health Care Innovation and Bailit Health Purchasing, for the Agency for Healthcare Research and Quality, AHRQ Publication No. 16(17)-0022-EF, October 2016. Available at: [https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/workforce-financing/white\\_paper.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/workforce-financing/white_paper.pdf)
- <sup>3</sup> D.N. Peikes, R.J. Reid, T.J. Day, D.D.F. Cornwell, S.B. Dale, R.J. Baron, et al. "Staffing patterns of primary care practices in the comprehensive primary care initiative." *Annals of Family Medicine*, 12 (2014):142–9. Available at: <http://www.annfammed.org/content/12/2/142.full>
- <sup>4</sup> QUEST Integration, Request for Information No. RFI-MQD-2019-002, pp. 8-9. Med-QUEST Division, Department of Human Services, September 20, 2018. Available at: <https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/RFP/REV-QI-RFI-MQD-2019-002-10-18-2018.pdf>
- <sup>5</sup> Request for Proposals for Medallion 4.0 Medicaid/Famis Managed Care, RFP 2017-03, pp. 98-99. Department of Medical Assistance Services, Commonwealth of Virginia, July 17, 2017. Available at: <https://www.bidnet.com/bneattachments?/459484772.pdf>
- <sup>6</sup> Request for Proposals for a Qualified Grantee to: Provide Health Care Services to Families and Children through Medical Assistance (Families and Children) and MinnesotaCare in 80 Greater Minnesota Counties, p. 70. Purchasing and Service Delivery Division, Minnesota Department of Human Services, February 25, 2019. Available at: [https://mn.gov/dhs/assets/2019-fc-2020-rfp-amended-to-provide-prepaid-hc-to-greater-mns-eligible-fc-and-minnesotacare-individuals\\_tcm1053-385010.docx](https://mn.gov/dhs/assets/2019-fc-2020-rfp-amended-to-provide-prepaid-hc-to-greater-mns-eligible-fc-and-minnesotacare-individuals_tcm1053-385010.docx).
- <sup>7</sup> Amended Version (RFP A2) RFP Sample Contract, Centennial Care 2.0, Section 4.4.19. New Mexico Human Services Department. Available at: [https://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/Amended\\_Version\\_\\_RFP\\_A2\\_\\_RFP\\_Sample\\_Contract.pdf](https://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/Amended_Version__RFP_A2__RFP_Sample_Contract.pdf)
- <sup>8</sup> For more information on the NCQA Patient-Centered Medical Home Model, see: National Committee for Quality Assurance. "Patient-Centered Medical Home (PCMH)". Available at: <https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/>
- <sup>9</sup> Sample Health Plan Contract, State of Michigan Contract No. Comprehensive Health Care Program for the Michigan Department of Health and Human Services, Section X. Population Health Management, B.3. Michigan Department of Health & Human Services, July 2, 2018. Available at: [https://www.michigan.gov/documents/contract\\_7696\\_7.pdf](https://www.michigan.gov/documents/contract_7696_7.pdf)
- <sup>10</sup> Request for Proposals for Louisiana Medicaid Managed Care Organizations, RFP #3000011953, Appendix B: Model Contract, Section 2.7.11. Bureau of Health Services Financing, Louisiana Department of Health, February 25, 2019. Available at: [http://ldh.la.gov/assets/medicaid/RFP\\_Documents/RFP3/AppendixB.pdf](http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf)
- <sup>11</sup> Center for Health Care Strategies and State Health Access Data Assistance Center. "Community Care Teams: An Overview of State Approaches." March 2016. Available at: <https://www.chcs.org/media/Community-Care-Teams-An-Overview-of-State-Approaches-030316.pdf>
- <sup>12</sup> SAMSHA-HRSA Center for Integrated Health Solutions. "Peer Providers." Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration. Available at: <https://www.integration.samhsa.gov/workforce/team-members/peer-providers#role%20of%20peer%20providers>
- <sup>13</sup> Association of State and Territorial Health Officials. "Community Health Worker Certification and Financing." 2016. Available at: <http://www.astho.org/Community-Health-Workers/CHW-Certification-Financing/>
- <sup>14</sup> C. Thomas-Henkel, S. Turner, and B. Freda. *Opportunities to Enhance Community-Based Medication Management Strategies for People with Complex Health and Social Needs*. Center for Health Care Strategies, June 2018. Available at: [https://www.chcs.org/media/CMMC\\_Report\\_062918-1.pdf](https://www.chcs.org/media/CMMC_Report_062918-1.pdf)
- <sup>15</sup> Washington Health Care Authority. "WAC 182-531-0425 Collaborative Care." Available at: <https://www.hca.wa.gov/health-care-services-supports/collaborative-care>
- <sup>16</sup> Minnesota Department of Health. "Community Health Worker". Available at: <https://www.health.state.mn.us/facilities/ruralhealth/emerging/chw/index.html>
- <sup>17</sup> New York State Department of Health. "2018-2019 Enacted Budget Initiative: Patient Centered Medical Home Statewide Incentive Payment Program: Revised Incentive Payments and Updated Billing Guidance." New York State Medicaid Update, April 2018, Volume 34, Number 4. Available at: [https://www.health.ny.gov/health\\_care/medicaid/program/update/2018/2018-04.htm#pcmh](https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-04.htm#pcmh)
- <sup>18</sup> HealthChoices Agreement Exhibits, Exhibit DDD. Pennsylvania Department of Human Services, Effective January 1, 2019. Available at: <http://www.dhs.pa.gov/provider/healthcaremedicalassistance/managedcareinformation/>
- <sup>19</sup> Ibid.
- <sup>20</sup> CCO 2.0 Request for Applications, RFA OHA-4690-19, Attachment 8 — Value-Based Payment Questionnaire. Oregon Health Authority, January 25, 2019. Available at: <https://www.oregon.gov/oha/OPHB/CCODocuments/07-CCO-RFA-4690-0-Attachment-8-VBP-Questionnaire-Final.pdf>
- <sup>21</sup> Request for Proposals for Louisiana Medicaid Managed Care Organizations, RFP #3000011953, Appendix B: Model Contract, Section 2.7.11. Bureau of Health Services Financing, Louisiana Department of Health, February 25, 2019. Available at: [http://ldh.la.gov/assets/medicaid/RFP\\_Documents/RFP3/AppendixB.pdf](http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf)
- <sup>22</sup> Association of State and Territorial Health Officials. "Community Health Worker Certification and Financing". Op. cit.

- <sup>23</sup> C. Garfield and S. Kangovi. "Integrating Community Health Workers into Health Care Teams Without Coopting Them". *Health Affairs Blog*, May 10, 2019. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20190507.746358/full/>
- <sup>24</sup> A. Spencer. *Integrating Community Health Workers into State and Local Chronic Disease Prevention Efforts: Program and Financing Considerations*. Center for Health Care Strategies for Nemours Children's Health System, AcademyHealth, and the Robert Wood Johnson Foundation. February 2018. Available at: <https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/integrating-community-health-workers-into-domain-3d-projects.pdf>
- <sup>25</sup> S. Kangovi, N. Mitra, D. Grande, M. L. White, S. McCollum, J. Sellman, et al. "Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes." *JAMA Internal Medicine*, 174, no. 4 (2014):535-543. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1828743>
- <sup>26</sup> S. Kangovi, N. Mitra, D. Grande, H. Huo, R.A. Smith, and J.A. Long. "Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial." *American Journal of Public Health*, 107, no. 10 (2017):1660-1667 Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28817334>
- <sup>27</sup> Minnesota Department of Health. "Community Health Worker." Op. cit.
- <sup>28</sup> Association of State and Territorial Health Officials. "Community Health Worker Certification and Financing". Op. cit.
- <sup>29</sup> Louisiana Department of Health. "Louisiana Demonstration Community Health Worker Program Overview." RFP Procurement Library. Available at: [http://ldh.la.gov/assets/medicaid/RFP\\_Documents/RFP3/CHWPOverview.pdf](http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/CHWPOverview.pdf)
- <sup>30</sup> HealthChoices Agreement Exhibits, Exhibit DDD. Op. cit.
- <sup>31</sup> Blueprint for Health, Department of Vermont Health Access. "Blueprint Community Health Teams." Available at: <https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-community-health-teams>
- <sup>32</sup> Blueprint for Health, Department of Vermont Health Access. "Vermont Blueprint for Health Manual". September 2018. Available at: <https://blueprintforhealth.vermont.gov/sites/bfh/files/Blueprint-Manual-Oct1-2018.pdf>
- <sup>33</sup> State of Vermont, Contract for Services OneCare Vermont Accountable Care Organization, Contract #34070 Amendment #1, Attachment A1. 2017. Available at: <https://blueprintforhealth.vermont.gov/sites/bfh/files/OneCare%20Am1%2034070%20ForFinalExecution.pdf>
- <sup>34</sup> New York State Department of Health. "New York State Patient-Centered Medical Home (NYS PCMH)." Available at: [https://www.health.ny.gov/technology/innovation\\_plan\\_initiative/pcmh/](https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/)
- <sup>35</sup> New York State Department of Health. "2018-2019 Enacted Budget Initiative: Patient Centered Medical Home Statewide Incentive Payment Program: Revised Incentive Payments and Updated Billing Guidance." Op. cit.
- <sup>36</sup> CCO 2.0 Request for Applications, RFA OHA-4690-19, Attachment 8 — Value-Based Payment Questionnaire, op. cit.
- <sup>37</sup> HealthChoices Agreement Exhibits, Exhibit DDD. Op. cit.
- <sup>38</sup> Amended Version (RFP A2) RFP Sample Contract, Centennial Care 2.0, op. cit., Attachment 3.
- <sup>39</sup> Oregon Health Authority. "Patient Centered Primary Care Home (PCPCH) Enrollment." Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-PCPCH-Enrollment.pdf>
- <sup>40</sup> Page 126-129. Health Plan Services Contract, Coordinated Care Organization Contract # 143115-10 with Health Share of Oregon. Oregon Health Authority, effective January 1, 2018. Available at: <https://multco.us/file/69710/download>
- <sup>41</sup> HealthChoices Agreement Exhibits, Exhibit DDD. Op. cit.
- <sup>42</sup> Section 2.01.01.01.02, pp. 43-45. NHP-2017. Contract between State of Rhode Island and Providence Plantations Executive Office of Health and Human Services and Neighborhood Health Plan of Rhode Island for Medicaid Managed Care Services. Amended May 1, 2018.
- <sup>43</sup> Request for Proposals for Louisiana Medicaid Managed Care Organizations, RFP #:3000011953, op. cit, pp. 84-86
- <sup>44</sup> Amended Version (RFP A2) RFP Sample Contract, Centennial Care 2.0, op. cit., Attachment 3.
- <sup>45</sup> Sample Health Plan Contract, State of Michigan Contract No. Comprehensive Health Care Program for the Michigan Department of Health and Human Services, Section X. Population Health Management, B.3. Michigan Department of Health & Human Services, July 2, 2018. Available at: [https://www.michigan.gov/documents/contract\\_7696\\_7.pdf](https://www.michigan.gov/documents/contract_7696_7.pdf)