Primary Care Innovation in Medicaid Managed Care: Snapshot of State Activities

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Primary care is associated with better health outcomes, lower costs, and plays an important role in reducing socioeconomic disparities in health.[1,2,3,4] The COVID-19 pandemic underscores the need for robust investment in primary care to support ongoing COVID-19 testing and care, adapt care models to increase telehealth delivery, and address increasing behavioral health and health-related social needs.[5,6,7]

This resource explores how seven states — **Delaware**, **Hawaii**, **Nevada**, **Tennessee**, **Texas**, **Virginia**, and **Washington State** — are using their managed care purchasing authority to advance primary care models. The states were participants in ***Advancing Primary Care Innovation in Medicaid Managed Care***, a national initiative made possible by The Commonwealth Fund and led by the Center for Health Care Strategies. These examples can help inform other states that are considering the use of managed care levers to promote advanced primary care models.

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

These state snapshots are part of ***Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit***, which was created to help states use 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 innovation goals through managed care contractual levers.

To view the full toolkit, visit **www.chcs.org/primary-care-innovation**.

Advanced Primary Care Goals

Throughout *Advancing Primary Care Innovation in Medicaid Managed Care*, participating states explored opportunities to promote advanced primary care functions, such as addressing health-related social needs, integrating behavioral health, incorporating team-based care, and using technology to improve access to care. Goals of the states included:

- Developing state approaches to support primary care value-based payment (VBP), including moving away from fee-for-service and toward more predictable funding streams.
- Exploring managed care organization (MCO) accountability mechanisms, such as quality incentives, quality-based auto-assignment, and withhold arrangements.
- Identifying opportunities to address health-related social needs, including through quality strategies, VBP, and other MCO contractual requirements.
- Implementing and aligning social determinants of health (SDOH) screening approaches across MCOs.
- Exploring how to support behavioral health integration and implementation of care management models through managed care.

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Advanced Primary Care Strategies

The following table describes primary care-related initiatives and MCO contract strategies in the participating states.

Select Primary Care Initiatives	Sample Medicaid Managed Care Contract Language
DELAWARE	
▪ The Delaware Primary Care Reform Collaborative, within the Delaware Health Commission, convenes stakeholders and assists with the development of recommendations to strengthen the primary care system in the state.[8] ▪ The Delaware Department of Health and Social Services' Division of Medicaid and Medical Assistance authorized four health care provider groups to serve as Medicaid Accountable Care Organizations in September 2020.[9] Authorization requirements include supporting robust and high-quality primary care, cross-continuum care, and addressing social determinants of health.[10]	▪ **Team-based care**: Delaware encourages MCOs "to promote and support the establishment and use of patient-centered, multi-disciplinary, team-based approaches to care" such as patient-centered medical homes (PCMH), nurse-managed primary care clinics, integrated primary and behavioral health services, and use of non-traditional health workers. ▪ **Telemedicine**: Contracts require MCOs to "promote and employ broad-based utilization" of telemedicine. MCO telemedicine programs must align with state objectives, such as improved access to care, member compliance with treatment plans, improved health outcomes, and reduced costs of care. ▪ **VBP**: Delaware sets thresholds for value-based payment. In 2020, at least "40% of all medical/service expenditures for all populations" must be paid through VBP. One third of this percentage must be through bundled/episodic payment or models with downside risk.[11]
HAWAII	
▪ Most Medicaid beneficiaries receive medical, behavioral health, and long-term care services through the QUEST Integration managed care program, implemented in 2015. ▪ Med-QUEST Division is building the Hawai'I 'Ohana Nui Project Expansion (HOPE) program, a five-year initiative to develop and implement a roadmap to achieve a vision of healthy families and healthy communities. The HOPE program includes an emphasis on health promotion, prevention, and primary care.[12] ▪ Hawaii is currently exploring managed care approaches to implementing a stepped-care approach to behavioral health and promoting physical-behavioral health integration at the point of care.	▪ **PCMH:** Under Hawaii's 2013 QUEST Integration RFP/contract, primary care providers (PCPs) must use a medical home model "based on the domains of patient-centered, accessible, comprehensive, coordinated, evidence-based, and performance measurement." Medical home practices receive increased reimbursement, through two "tiers" of criteria with higher payment to the Tier 1 Medical Home compared to the Tier 2 Medical Home. ▪ **VBP**: The state imposes specific contract percentage targets for "Value-Driven Health Care" for the first three years of the contract for PCPs and hospitals. The targets are 50 percent of contracts for year one; 65 percent for year two; and 80 percent for year three.[13]

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NEVADA	
▪ Nevada is implementing a variety of approaches to support maternal health. For example, care management for pregnant women who are identified as high-risk for preterm birth or poor pregnancy outcomes includes services, such as patient education, nutritional services, personal care services or home health care, substance use disorder services, and care coordination services, in addition to maternity care. Pregnant women seeking help with substance use disorder also receive priority admission for treatment. ▪ Nevada is currently exploring additional managed care approaches to addressing SDOH, improving maternal health and birth outcomes, and promoting physical-behavioral health integration.	▪ **Team-based care/PCMH**: MCOs are "required to use existing patient-centered medical homes/health homes, when available and appropriate" and should "support the expansion of patient-centered medical homes/health homes." ▪ **Behavioral health and SDOH**: Initial comprehensive assessment of new members "must evaluate the member's physical health, behavioral health, comorbid conditions, and psychosocial, environmental, and community support needs."[14]
TENNESSEE	
▪ Tennessee Medicaid's (TennCare) PCMH program provides financial support and training to primary care practices that work toward or maintain NCQA PCMH Recognition. Providers are compensated for start-up activities, ongoing PCMH activities, and eligible for performance bonuses. TennCare PCMH is aligned with Comprehensive Primary Care Plus.[15] ▪ The Tennessee Health Link program supports integration of physical and behavioral health services for members with the highest behavioral health needs through provision of additional care coordination and patient engagement activities.[16] ▪ Tennessee offers PCMH and Health Link providers access to a care coordination tool that provides admission, discharge, or transfer data from hospitals and/or emergency departments, member panel information, and claims-based clinical data.[17]	▪ **PCMH/VBP**: In 2020, Tennessee requires at least 37 percent of MCOs' populations to be attributed to a PCMH-participating organization. MCOs face liquidated damages for failing to meet the PCMH benchmark. ▪ **Behavioral health**: MCOs are responsible for ensuring continuity and coordination between covered physical health, behavioral health, and long-term services and supports. For example, MCOs are required to encourage providers to adopt strategies, such as screening tools to "facilitate early identification of behavioral health needs." ▪ **Quality performance**: TennCare makes incentive payments to MCOs that meet benchmarks or significantly improve on quality measures, including measures related to primary care.[18]

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TEXAS	
■ To assist in the development of its DSRIP Transition Plan, Texas convened the SDOH Expert Advisory Panel to help identify factors associated with Texas Medicaid health outcomes, and proposed potential programs, policy changes, and strategies for quality improvement related to SDOH. ■ Texas is finalizing a revised VBP Roadmap and Quality Strategy that include an emphasis on addressing SDOH in managed care and rural health. ■ Texas' Value-Based Payment and Quality Improvement Advisory Committee is developing a report making recommendations to the 87th Texas Legislature.[19] The December 2020 report will include SDOH recommendations. ■ In partnership with Medicaid managed care and SDOH stakeholders, Texas developed a statewide MCO SDOH Learning Collaborative to explore the integration of SDOH in managed care through mechanisms, such as quality improvement costs and Accountable Health Communities.	■ **VBP**: MCOs must make progress transitioning from volume-based provider payment approaches to quality and value-based alternative payment models, such as models that improve access to primary care and support care coordination. Targets require achieving at least 50 percent of medical and pharmacy spend through alternative payment models by 2021. Texas also requires that at least 25% of spend be through risk-based models by 2021.[20] ■ **Behavioral health**: MCOs must require that PCPs have procedures to identify and refer their Medicaid members for behavioral health conditions. MCOs must also provide training on topics such as behavioral health screening, referral, and new models of interventions. The MCO must develop "policies regarding clinical coordination between Behavioral Health Service Providers and PCPs." ■ **Quality performance**: Texas creates incentives and disincentives for MCOs based on performance improvement. Under this system, recouped capitation dollars from low performing MCOs are redistributed to high performing MCOs. The state's risk and bonus quality measure set includes primary care metrics.[21, 22]
VIRGINIA	
■ In August 2020, Governor Ralph Northam launched a task force on primary care. The Governor's Task Force on Primary Care aims to address topics such as defining payment models and infrastructure needed to support primary care and promote innovation to adapt to the COVID-19 and post-COVID-19 environment.[23] ■ Virginia Medicaid is currently exploring opportunities to advance primary care goals, such as increased access to primary care and prevention services and improved chronic disease management, as well as support efforts to improve health equity and population health, and address health-related social needs. ■ Virginia Medicaid recently held a series of interviews with PCPs to explore opportunities to further support primary care, including delivery and payment models that would align with provider capabilities.	■ **SDOH**: MCOs are required to work with the state to develop a standard health risk assessment tool to identify members' physical and behavioral health status and risk factors as well as social needs. MCOs must develop programs to address health-related social needs, such as employment, food security, housing stability, education, and social cohesion. MCOs are encouraged to develop programs that focus on transitions of care, high-risk populations, and/or individuals with substance use disorders. ■ **Behavioral health**: The Addiction and Recovery Treatment Services Benefit provides the full continuum of evidence-based addiction treatment, including outpatient services. ■ **Telemedicine**: MCOs shall provide coverage for telemedicine to support goals, such as reducing unnecessary utilization, addressing disparities in care, and increasing access to care. Covered services include "Store and Forward Applications," "the ability to cover remote patient monitoring," and "the ability to cover specialty consultative services."[24]

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WASHINGTON STATE	
▪ Through Healthy Washington, which includes the State Innovation Model and the Medicaid Transformation Project, Washington is accelerating adoption of whole-person care across the state.[25] ▪ Washington procured Medicaid MCOs to operate in regional service areas that correspond with boundaries defined for Accountable Communities of Health (ACH). ACHs are: (1) assessing for service gaps and addressing those needs in their communities; (2) providing supports/funding to primary and behavioral health practices; and (3) addressing care coordination and care transitions.[26] ▪ In July 2020, Washington State proposed a Multi-payer Primary Care Transformation Model to strengthen primary care through multi-payer payment reform and care delivery transformation.[27]	▪ **Behavioral health**: Washington State recently transitioned to Integrated Managed Care (IMC) contracts, which includes all regional contracts covering both medical and behavioral health services. Contracts also require MCOs to promote bi-directional behavioral health integration through education, training, financial, and non-financial incentives.[28] ▪ **Primary care investment**: MCOs are required to report on primary care expenditures to support state measurement of the level of primary care investments in state-financed programs.[29] ▪ **VBP and quality performance**: IMC contracts use a two percent withhold from capitation payments that MCOs can earn back through value-based purchasing arrangements with providers and performance on quality-of-care measures, including primary care measures.[30]

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**.

ENDNOTES

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