State Medicaid Policy Options for Primary Care

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C. Landscape review of primary care policies and state Medicaid options, including assessment of primary care and behavioral health integration models and associated billing guidance.

2. Review of state Medicaid options to support high quality primary care, including differences in Medicaid authorities, highlighting key comparison states.

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Overview

Medicaid has several policy levers to support high quality primary care, ranging greatly in complexity and cost. This brief landscape review is aimed at describing key policy options and the various benefits or challenges associated with each. This review is not intended to describe all possible policy levers used by every state, but instead major strategies that could be leveraged. This report should not be seen as an endorsement of any specific policy option on behalf of the Virginia Task Force on Primary Care.

Authorities described in this report are generally ordered from ***most complex*** *to* ***least complex*** to execute from the perspective of the state Medicaid agency. Complexity also may be paired with additional flexibility to use federal funds for novel purposes.

Section 1115 Waivers

Multiple states have aimed to address critical primary care access and quality concerns through dedicated Section 1115 Waivers. Section 1115 Waivers are one of the main policy levers states can use to waive certain restrictions on the state program and establish creative eligibility, service, or payments structures. Section 1115 Waivers are also among the most complex authorities a state can use to design a new program.

New York[1]

In January 2024, New York received approval for "Medicaid Redesign Team" – the state's 1115 waiver, which includes a multitude of provisions, but many of which were directed at supporting primary care. The primary care policies include:

- Increase primary care, OB/GYN, and behavioral health payment rates to 80% of Medicare rates (was at 43%) or at least $199 million in rate increases. While a waiver is not required to increase rates, this increase is a condition of CMS approval for waivers that include coverage of health-related social needs, which the NY waiver does include.
- Receive $2.2 billion, from CMS, to support safety nets hospitals in transitioning to global budgets as a part of the CMMI AHEAD model. Hospital global budgets incentivize safety net health systems to prioritize investment in primary care, a lower cost setting of care.
- Participation in the CMMI AHEAD model, which in addition to hospital global budgets, includes a primary care spend target for all participating payers (i.e. commercial, Medicare and Medicaid). Medicare provides infrastructure funding to states that can also be used to support primary care.
- Authorizes Medicaid funding for two workforce development programs: (1) student loan repayment for primary care physicians and nurse practitioners who commit to 4 years in state with at least a 30% Medicaid/uninsured payer mix, with an emphasis on prioritizes providers that care for children; (2) Career Pathways training program for allied health to support career advancement for non-physician health professionals.
- Participation and alignment with CMMI Making Care Primary model. This model was eliminated by the Trump Administration but would have provided hybrid payments and

[1] New York State's Approved Health Equity 1115 Waiver Amendment: Summary of Key Provisions

infrastructure funds through Medicare to participating primary care providers that met certain comprehensiveness of care and quality standards.

Massachusetts

Approved in November 2022, Massachusetts' 1115 waiver restructures how primary care providers are paid in an effort to allow them to spend more time with patients and focus on supporting patients in navigating their care. Through the waiver, the Commonwealth leverages Primary Care Accountable Care Organizations (PC-ACOs) to serve as hubs for care coordination and general service support – including integrated behavioral health services and health-related social needs.

The model sets a per member per month (PMPM) payment for PC-ACOs, which increases based on the comprehensiveness of quality of care. The waiver is required because in addition to setting a PMPM, the model removes utilization incentives by replacing service-based payments with the PMPM. In addition to the PMPM, PC-ACOs receive an enhanced case management fee intended to directly support the care management and care coordination activities of the practice.

Summary of Section 1115 Benefits and Challenges

Key Benefits	Key Challenges
Enables greatest flexibility in terms of design and operations, including creating new payment models, leveraging non-Medicaid payers, and funding workforce development programs	Requires significant negotiations with CMS and multiple comment periods, which commonly take a year or more
Includes program evaluation to ensure policy effectiveness is assessed	Must be renewed every 5 years
	Policy must be determined to be budget neutral
	Federal administrations may vary on policy approvals
	Likely requires General Assembly approval

State Directed Payments (SDPs)

State directed payments (authorized via 42 CFR § 438.6(c)) allow the state to direct managed care organizations (MCOs) to pay a specific amount to providers under specific conditions. States have used this authority to direct MCOs to pass through payments to providers for many purposes. Key examples of SDPs used to support primary care are described below.

New York[2]

Most recently approved in April 2025, NY uses SDPs to direct MCOs to pay an enhanced monthly capitation payment to providers that are recognized as Patient Centered Medical Homes (PCMHs).

[2] NY State Directed Payment Approval Letter

Through this mechanism, an additional $237 million ($147 million federal share, $90 million state share) is invested into the state's PCMHs.

Massachusetts[3]

Massachusetts' "Primary Care Sub-Capitation Program" uses both a Section 1115 waiver and a state directed payment. The SDP is used to directly pay the PC-ACOs their tiered prospective PMPM. The MassHealth team determines the specific dollar amounts and then directs MCOs to pass through those amounts to the providers. Tiered payments range from $5.20- $13.52 for pediatric patients and $4.16-$10.40 for adult patients. The MA SDP also includes provisions that funds be distributed based on adherence to certain quality measures. The most recent SDP preprint was approved in March 2025.

Summary of State Directed Payments Benefits and Challenges

Key Benefits	Key Challenges
Does not require full section 1115 Waiver	Requires renewal annually
Does require some tying to quality metrics, but is generally flexible on how quality is measured	Recent executive order (June 6) suggests that future approval of state directed payments may be more limited, specifically limited to payments no higher than Medicare
Allows state to control some specific MCO payments for critical providers without impinging on managed care flexibility more broadly	

Health Home State Plan Amendment (SPA)

In general, state plan amendments are among the least administratively burdensome of the various approaches to modifying a state's Medicaid program. The Health Home state plan option (authorized via Section 2703/1945 SSA) allows states to create unique delivery systems and funding structures for the purposes of providing comprehensive care and care coordination for Medicaid members. Additionally, states that implement a Health Home SPA will receive an enhanced federal match rate of 90/10 for the first 2 years of implementation.

There are a few key requirements of the Health Home SPA, limiting its flexibility.

- To be eligible for a health home, a Medicaid member must have 2 or more chronic conditions OR have 1 chronic condition and be at risk for a second OR have a serious and persistent mental health condition – this may result in limited usefulness for children who are less likely to have chronic conditions. As a result payments per person may need to be higher to be sustainable for certain provider types.

[3] Massachusetts' Primary Care Sub-Capitation Model: Implementing Primary Care Population-Based Payment in Medicaid

- Health Home must provide: (1) comprehensive care management and coordination, health promotion activities, follow-up care, patient and family support, and referrals for community and social supports
- Health Home providers must report some quality measures to the state. The state must track utilization and spend as well as conduct an independent evaluation

The state has flexibility on defining providers that are eligible to be Health Home providers as well as payment mechanism and quality and utilization measures.

North Carolina[4]

The North Carolina Tailored Care Management program was implemented as a Health Home in 2023 for members with behavioral health needs or developmental disabilities. Providers could become certified as Health Homes for specific populations or certified to care for any qualifying patient. Both a primary care practice that directly collaborates with behavioral health or a behavioral health provider that directly collaborates with primary care could be eligible to be a Health Home provider. Health Home providers are eligible for an enhanced PMPM based on members assigned to them as their Health Home, so long as contact was made with the patient in that given month, whether via care management or other contact.

The current base PMPM rate is $343.97 with a high acuity add-on of $79.73 for particularly complex patients. As of July 1, 2025, the base PMPM rate will decrease to $294.86.

Summary of Health Home Benefits and Challenges

Key Benefits	Key Challenges
Relatively simple to execute and negotiate with CMS	Limitations on eligible patients
Receive 90/10 enhanced federal match for 2 years	
Allows for flexible payment models to create hybrid payments	

Managed Care Contract Language

While CMS has multiple authorities that can be used to request additional flexibility, a significant amount of support to primary care can be accomplished through contract language between the state and MCOs using the managed care authority.

[4] Updated details on the Underlying Assumptions Behind Tailored Care Management Payment Rates

North Carolina[5,6]

Advanced Medical Homes

Advanced Medical Homes (AMHs) are primary care providers that are certified as meeting specific state-determined criteria for comprehensive, coordination care. There are three tiers of AMHs/AMH+, each receiving an enhanced PMPM that varies by tier. Through their contracts, NC requires that MCOs pay the AMHs a PMPM and sets the floor rate; however, MCOs are free to negotiate above the floor. Because the specific rate can be negotiated this payment can be established through the managed care authority and included in state contracts.

	Base Rate (Non-ABD)	Base Rate (ABD)	Care Management Fee	Performance Incentive	Health Home Add-on
Tier 1- 3	$2.50	$5.00	Not eligible	Not eligible	$20
Tier 3/AMH+	$2.50	$5.00	Required, Rate Negotiated	Required, Rate Negotiated	$20

Capacity Building Funds for Health Home

In addition to including PMPMs for Advanced Medical Homes, North Carolina also included one-time capacity building funds for providers that became certified as for Tailored Care Management (Health Homes) through contract arrangements, using just the managed care authority. In their contracts with LME-MCOs (regional entities that managed the care of members with behavioral health or disability-related needs), North Carolina Medicaid required the payers to set aside $90 million for one-time infrastructure investments for these providers. While the state issued recommended guidance on how funds may be administered or used, the state could not direct specific amounts, processes or uses for funds. Instead, the state focused on issuing guidance, addressing provider complaints, and garnering LME-MCO support for collaborative processes. Directly designating amounts/details would have required SDP approval from CMS.

Summary of Managed Care Contract Language Benefits and Challenges

Key Benefits	Key Challenges
Does not require CMS approval for specific items	Limited oversight and enforcement mechanisms
Does not require state legislature action (VA Medicaid may have more limited authority due to state-specific restrictions)	Cannot standardize approaches or amounts across MCOs
Can set floors or ceilings for payments while allowing for additional negotiations	
Allows for great flexibility in design and payment models.	

[5] Advanced Medical Homes
[6] Tailored Care Management Capacity Building Program

Children's Health Insurance Program Health Services Initiatives (CHIP HSIs)

Unlike Medicaid, CHIP is administered as a block grant program to states. For states whose expenditures are below their allowed allotment, states may select to establish HSIs with remaining CHIP funds. An HSI is a public health program that aims to support the health and well-being for low-income children and allows for significant flexibility in how states choose to use these funds. States must submit programs through a CHIP state plan amendment to receive CMS approval. If approved, states will receive the higher administrative CHIP federal match rate for costs associated with the program (currently ~65/35 in Virginia compared to ~50/50 for general Medicaid).

Virginia currently has 2 CHIP HSI and continues to fall well below program allotment:

(1) FAMIS prenatal coverage for 60 says postpartum, and
(2) poison control centers.

Conceptually, CHIP HSIs could be used to support VMAP and fund some infrastructure investments for primary care, if the purpose is pre-specified and all clinics had clear criteria on the use of the funds. While unaware of states currently using funds for these purposes, programs could likely be designed to meet federal requirements.

More common state examples of HSIs include:

- Lead assessments and abatements
- Maternal health home visiting programs
- School-based vision and hearing exams and glasses
- School nursing
- Education campaigns
- Breast feeding hotlines

Summary of CHIP HSI Benefits and Challenges

Key Benefits	Key Challenges
Draw down enhanced federal match	Limited to programs aimed at child health
Covers public health initiatives not otherwise covered by Medicaid	Must remain below CHIP allotment
Can support children outside of the Medicaid program so long as there are key benefits for low-income children	Not intended to fund ongoing payments models, but could support some infrastructure development, training, and consult lines
Requires state plan amendment which is significantly less administratively burdensome than waivers	