kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey

Prepared by
Kathleen Gifford, Vernon K. Smith, and Dyke Snipes
Health Management Associates

and

Julia Paradise
Kaiser Commission on Medicaid and the Uninsured
Kaiser Family Foundation

September 2011

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/kcmu

kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Acknowledgments

Especially in this year, at a time of staffing shortages and increasing workloads, we thank the public servants who administer the nation's Medicaid programs in all 50 states and the District of Columbia, who completed the survey on which this study is based. Without the help of these Medicaid officials, this study would have been impossible, and we are truly grateful for their participation.

We also offer special thanks to Dennis Roberts at Health Management Associates, who developed and managed the database. His work is always excellent and his contributions were invaluable to our work on this survey. Finally, we owe many thanks to Rachel Arguello at the Kaiser Commission on Medicaid and the Uninsured, who provided expert and ready assistance in preparing this report for publication.

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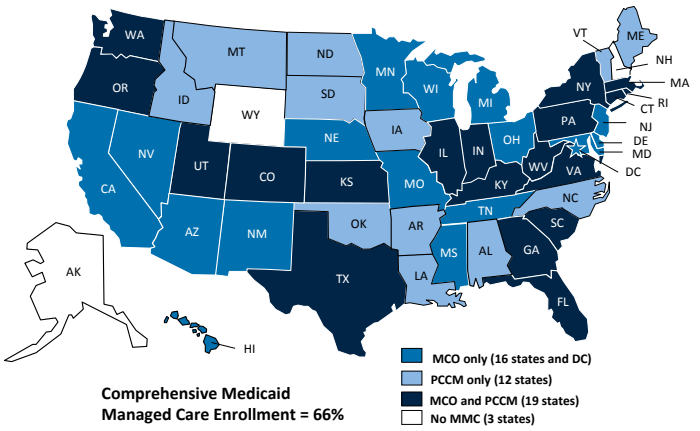
EXECUTIVE SUMMARY

Medicaid, the public insurance program for low-income Americans, is the single largest health care program in the United States. In calendar year 2011, average monthly Medicaid enrollment is projected to exceed 55 million, and a projected 70 million people, or roughly one in five Americans, will be covered by the program for one or more months during the year. Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) will expand Medicaid eligibility to cover nearly all non-elderly Americans with incomes below 133 percent of the federal poverty level ($14,404 for an individual), providing coverage to 16 million additional people – mostly, uninsured adults – by 2019.

A growing phenomenon since the early 1980's has been states' use of various models of managed care to deliver and finance care for Medicaid enrollees, with the goals of increasing access to care, improving quality, and, in some cases, reducing costs. Whereas in the traditional fee-for-service system, Medicaid beneficiaries must find providers willing to accept new (or any) Medicaid patients, states with managed care purchase or establish a network of providers for their Medicaid enrollees through contracts with health plans and/or providers who agree to accept Medicaid patients and to meet certain requirements to ensure timely access to care. These contracts give states a mechanism for holding plans or providers accountable for Medicaid enrollees' overall experience with the health care system, through performance standards related to access to care, quality of care, data reporting, and other patient care goals.

Comprehensive Medicaid Managed Care Models Operating in the States, 2010



SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

At the same time that managed care offers significant potential to improve access and care for Medicaid beneficiaries, it can fail as a strategy if capitation payment rates are not adequate, transitions from fee-for-service are not well-conceived, provider networks are not sufficient to meet the care needs of the enrolled population, or state oversight of managed care programs is lacking. The history of Medicaid managed care provides evidence of the promise of managed care, but also shows that the details of how it is structured and implemented are consequential for Medicaid beneficiaries.

The share of Medicaid beneficiaries enrolled in some form of managed care has increased every year except one for over two decades, reaching 71.7 percent as of June 30, 2009 according to CMS. This trend has heightened both policy interest and needs for information about Medicaid managed care, and three dynamics are focusing even more attention on how Medicaid managed care is developing. First, many state policymakers are eyeing managed care as a Medicaid cost containment tool and a means to address concerns about access and quality, particularly as states are facing severe budget pressures from the recession and the slow recovery. Second, many states are expanding managed care to more medically complex and fragile populations, for whom the stakes may be especially great. Third, states

are expected to rely heavily on managed care to serve the millions of adults who will become newly eligible for Medicaid in 2014.

In light of the large and growing role of managed care in Medicaid, and the implications for Medicaid beneficiaries, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a special survey of Medicaid programs to assess the state of Medicaid managed care, identify current issues, and gain perspectives on the directions Medicaid managed care may take in the coming years. This report presents data and findings based on that survey.

Key Findings

***Nearly all states operate comprehensive Medicaid managed care programs, covering about 66 percent of all Medicaid beneficiaries*.** Across all 50 states and DC, only three states (Alaska, New Hampshire and Wyoming) reported that they did not have any Medicaid managed care as of October 2010. Overall, 36 of the 48 states with comprehensive managed care programs reported contracting with risk-based managed care organizations (MCOs) and 31 reported operating a primary care case management (PCCM) program. Over 26 million Medicaid beneficiaries are enrolled in MCOs and 8.8 million are enrolled in PCCM programs; together, these beneficiaries in comprehensive managed care represent 65.9 percent of all Medicaid beneficiaries. When Medicaid beneficiaries who receive a limited set of services through a managed care plan (as discussed next) are also counted, the share of all beneficiaries who are enrolled in managed care is larger.

Half the states with MCOs and/or PCCM programs also contract with non-comprehensive prepaid health plans (PHP) to provide specific categories of services. The types of services most commonly provided by non-comprehensive PHPs, which are risk-based, limited-benefit plans, are inpatient and outpatient behavioral health services and substance abuse treatment. A number of states also contract with non-comprehensive PHPs to provide dental care, non-emergency transportation, or prescription drugs – all services that are frequently carved out of MCO contracts.

States are increasingly mandating managed care for previously exempt or excluded Medicaid beneficiaries. States have long mandated that most children, pregnant women, and parents and other caretaker adults in Medicaid enroll in managed care. A majority of states reported that, for at least one Medicaid managed care program and/or geographic area, they also mandate enrollment in managed care for children with disabilities receiving Supplemental Security Income (SSI), children with special health care needs, and seniors and people with disabilities who are not dually eligible for Medicare and Medicaid.

Risk-based comprehensive managed care

Almost two-thirds of Medicaid MCO enrollees are in health plans that primarily or exclusively serve Medicaid. In addition, for-profit plans account for a little over half of all Medicaid MCO enrollment. Roughly 60 percent of Medicaid MCO enrollees are in non-publicly traded plans. Medicaid MCO enrollment is distributed about evenly between local and national plans.

Auto-assignment rates appear to vary widely. Auto-assignment rates may provide a useful signal of how well Medicaid beneficiaries understand the managed care system and their choices within it. Across the 26 states that reported auto-assignment rates, half (13 states) reported rates of 20 percent or less; four states reported rates higher than 50 percent. More than two-thirds of states with MCOs use third-

party enrollment brokers to provide plan information to beneficiaries and assist them in choosing an MCO; a small number of vendors dominate the market. Most states allow MCOs to conduct outreach and marketing to Medicaid beneficiaries within federal rules.

Most states set MCO capitation rates administratively and risk-adjust their rates. Three-quarters of the states with MCOs reported that they used administrative rate-setting with actuaries to establish MCO rates. Other approaches states reported using are negotiation and competitive bidding, and some states combine multiple methods. Most states adjust their capitation rates for age and eligibility category, and about two-thirds adjust for health status. Risk-sharing arrangements with MCOs, such as stop-loss/reinsurance or risk corridors, are in place in half the states.

Over half the states with MCOs include a pay-for-performance (P4P) component in their payment to plans. Capitation withholds and bonus payments were reported most frequently. Examples of other approaches are shared savings, auto-assignment preference, and enhanced capitation.

A limited number of states have a minimum medical loss ratio (MLR) requirement for MCOs participating in Medicaid. Eleven states indicated that they have a minimum MLR requirement for plans, 21 states reported that they do not, and three states said they plan to establish one in the future. Minimum MLRs ranged from 80 percent in three states to 93 percent in one state for MCOs serving aged and disabled Medicaid beneficiaries.

All states but one "carve out" at least one acute-care benefit from their MCO contracts, but several states are carving some benefits back in. More often than not, dental care and outpatient and inpatient behavioral health care are carved out and provided either on a fee-for-service basis or by a non-comprehensive prepaid health plan (PHP) – a risk-based, limited-benefit plan. Other common carve-outs are outpatient substance abuse treatment, non-emergency transportation, and pharmacy services. Some states that previously carved out the pharmacy benefit or other Medicaid services are carving them back into their MCO contracts or plan to do so.

States use a variety of network adequacy standards. States typically use provider-to-population ratios and distance and travel-time maximums as standards to ensure that MCO networks are adequate. They generally apply different standards for primary and specialty care and frequently apply different standards for rural and urban areas. The standards states use vary widely. In most states, in addition to primary care physicians, providers such as ObGyns, nurse practitioners, federally qualified health centers, and physician groups/clinics are recognized as primary care providers (PCP) for MCO enrollees..

Many but not all states reported that Medicaid MCO enrollees sometimes face access problems. Over two-thirds of responding states with MCOs reported that Medicaid beneficiaries enrolled in MCOs sometimes experience access problems. Problems with access to dental care, pediatric specialists, psychiatrists and other behavioral health providers, and other specialists (e.g., dermatologists, ear-nose-throat doctors, orthopedists and other surgeons, neurologists, cancer and diabetes specialists) were all cited. At the same time, improved access to care – both primary and specialty care – was the most frequently cited perceived benefit of managed care relative to fee-for-service. Some states indicated that where an access problem existed, it usually paralleled a similar problem encountered by persons with other types of insurance, for example, due to provider shortages and other market factors. The survey, however, did not directly collect information on access problems in fee-for-service Medicaid.

Primary care case management (PCCM) programs

Nearly as many states have a PCCM program as have contracts with MCOs. Thirty-one states operate PCCM programs, in which PCPs, by contract with the state, agree to provide, manage, and monitor the primary care of Medicaid beneficiaries who select them, or, in some cases, are assigned to them. In addition to serving as a medical home for primary and preventive care, PCPs are contractually responsible for authorizing referrals when specialty care is needed. Most states pay PCPs a small monthly fee for case management in addition to regular fee-for-service payments. A quarter of states include a pay-for-performance element in their payments to PCPs.

Many states contract for PCCM administrative services. Over half the states with PCCM programs reported that they have PCCM administrative services contracts and, in a few cases, the administrative fees are at risk. The services provided under these contracts range from case or care management to enrollment broker services to claims administration.

Nine states operate Enhanced PCCM (EPCCM) programs. These programs incorporate strengthened quality assurance and care management and coordination. Enhancements include disease management services, coordination/integration of physical and mental health care, case management for high-cost/high-risk enrollees, and linkages between primary care and community-based services for targeted groups.

Non-comprehensive managed care

Half the states contract with non-comprehensive PHPs, separate from their MCO and PCCM programs, to provide some services. The services most commonly provided by these PHPs are inpatient and outpatient behavioral health care and substance abuse treatment, followed by dental care, non-emergency transportation, and prescription drugs – all services that are frequently carved out of MCO contracts.

Nearly all Medicaid beneficiaries receiving behavioral health care through a PHP were in plans that specialize in Medicaid. Not-for-profit, non-publicly traded, and local plans were strongly dominant. By comparison, Medicaid beneficiaries receiving dental care through a PHP were more likely to be in plans with mixed enrollment, for-profit plans, and plans affiliated with a national company.

Measuring, monitoring, and improving quality in Medicaid managed care

Sixteen of the 36 states with MCOs require plans to be accredited. All states with MCOs but one, and most states with PCCM programs, require HEDIS© and CAHPS© data or state-specific measures of performance and patient satisfaction. Required measures focus heavily on Medicaid priority areas such as prenatal and post-partum care, child health preventive care, management of chronic diseases, and access to care. A quarter of the states with MCOs and/or PCCM programs also assess quality in their fee-for-service delivery system.

Three-fourths of states with MCOs publish reports on MCO quality, and half the states with PCCM programs publish quality reports on their PCCM programs. A smaller number of states also publicly report on PHPs' performance, allowing a look at quality across all their managed care arrangements, and a few extend quality reporting to the non-managed fee-for-service component of their program. Fifteen states with MCOs and one PCCM-only state reported that they prepare a quality report card using

HEDIS©, CAHPS©, and state-specific measures, which Medicaid beneficiaries can use to compare and choose health plans. Two states publicly reported on quality performance for the first time in FY 2011.

Quality improvement activities in the states with MCOs reveal a breadth of state priorities. MCOs must conduct "performance improvement projects," and all states must contract with External Quality Review Organizations (EQRO) to provide an independent assessment of the quality of care provided by Medicaid MCOs. States reported wide-ranging quality improvement activities, including, for example, projects focused on improving birth outcomes, increasing access to pediatric subspecialists, identifying high-risk individuals for case management, and increasing coordination between behavioral health and medical providers. Four PCCM-only states reported contracting with EQROs.

Special initiatives to improve quality and care coordination

All but a small number of states have undertaken initiatives to reduce inappropriate use of ERs; many report initiatives to reduce obesity. States often include a focus on ER utilization in their Medicaid contracts with MCOs, and ER use is a factor in some pay-for-performance systems. MCOs may use data on ER use to target high-users for case management or care coordination, and to profile providers and work with medical directors to improve their utilization patterns. Systems that notify PCPs when their Medicaid patients use the ER and 24-hour nurse consultation lines are among the ER diversion strategies in PCCM programs. Initiatives to monitor and reduce obesity were also reported by most states, with Medicaid MCOs often playing a leading role.

About half the states reported current or planned initiatives in Medicaid to address racial and ethnic disparities, including participation in broader state efforts. Numerous states reported formal Medicaid performance improvement projects focused on reducing racial and ethnic disparities in certain measures (e.g., adolescents' use of well-child visits, breast or cervical cancer screening rates), or on cultural competency. Some states calculate or publish quality measures by race/ethnicity. Several states reported broader public health efforts to reduce disparities, with Medicaid participating in interagency and community task forces and statewide collaboratives.

States reported a broad spectrum of other, special managed care quality initiatives. Many states reported managed care quality initiatives in a host of additional areas, such as perinatal care and depression screening; improved care management for individuals with both behavioral health diagnoses and chronic conditions; identification of high-risk enrollees for intensive case management; dental utilization; and improving the data available to providers to benchmark their performance.

Many states have initiatives to improve primary care and to better coordinate care for Medicaid beneficiaries with more complex needs. Medical home initiatives are underway or in development in 39 states. The same number of states reported disease management or care management programs, which, in many instances, are integrated into their MCO or PCCM programs. Twenty-two states reported plans to elect the new "health home" option established by the ACA. Nine states reported that they have an Accountable Care Organization (ACO) initiative underway, planned, or under development.

Managed long-term care and managed care initiatives for dual eligibles

Over half the states operate PACE sites, and 11 states reported additional capitated managed long-term care (MLTC) programs. A total of 29 states operate PACE sites, which are paid on a risk basis to provide and coordinate the full range of medical and long-term services and supports for Medicaid enrollees; however, total PACE enrollment nationally is only about 20,000. Eleven states also reported

operating non-PACE, capitated MLTC programs as of October 2010, with aggregate enrollment of over 400,000. Some of these programs encompass only long-term services and supports, but others include acute medical care as well. Most include only Medicaid services, but programs in three states also include Medicare services. States highlighted numerous operational challenges associated with MLTC programs, such as contracting with Medicare Advantage Special Needs Plans, coordinating with physical health MCOs, slow enrollment growth, and plan difficulty contracting with Boarding Homes.

Half the states reported enrollment of dual eligibles in (non-PACE) Medicaid managed care arrangements, on either a voluntary or mandatory basis. Overall, 25 states reported that they enroll dual eligibles in some kind of non-PACE Medicaid managed care arrangement, on either a voluntary or a mandatory basis. In some states, dual eligibles are enrolled in comprehensive managed care; in others, dual eligibles may be enrolled in non-comprehensive PHPs for specific categories of services, but remain in fee-for-service or in other managed care arrangements for all other Medicaid-covered services.

In many states, broader efforts focused on dual eligibles are expanding or getting underway. Twenty-one states reported on plans to expand or modify current programs or initiate new programs focused on dual eligibles, including 15 states that received grant funding under the ACA initiative, "State Demonstrations to Integrate Care for Dual Eligible Individuals," administered by the new Medicare-Medicaid Coordination Office in CMS, to design new approaches to better coordinate care for dual eligibles and integrate Medicare and Medicaid financing. Twenty-one states reported that they contract with Medicare Advantage Special Needs Plans to provide care for dual eligibles.

Medicaid managed care and health reform

States expect to rely increasingly on managed care in the near term. Continued budget pressures and interest in improving service delivery and payment systems are fueling plans in many states to expand the use of managed care in Medicaid, including mandatory managed care for additional Medicaid populations and in new geographic areas.

Severe budget pressures remain a key challenge for states, and new demands associated with health reform also emerge as issues. The lingering effects of the recession – reduced tax revenues, high unemployment, and high demand for Medicaid and other human services – all continue to generate intense pressure on states already struggling to meet competing needs with limited resources. States cited additional challenges stemming from health reform, in particular, increased Medicaid enrollment, adequacy of provider networks, Exchange development, and development of systems for claiming the proper federal matching rate. Some states also cited a need for more flexibility to integrate care for dual eligibles. More general pressures, including required implementation of new procedure codes (ICD-10) and strains on state administrative capacity, were raised as well.

Key health reform implications for Medicaid managed care are yet to come into focus in many states. A little over half the states with MCOs (20) reported that their plans had or could develop sufficient network capacity to handle increased Medicaid enrollment expected under health reform, while one state said its plans could not. Nine states reported that they did not know whether or not their MCOs could develop the capacity, and six states did not respond to this question. Uncertainty was wider regarding Medicaid MCOs' interest in becoming Exchange plans, and especially concerning state intentions to require Medicaid MCOs to participate in the Exchanges or Exchange plans to participate in Medicaid. The widespread uncertainty may be an indication that more immediate issues and pressures still eclipse health reform in many Medicaid programs.

Conclusion

For over 30 years, state Medicaid programs have relied increasingly on managed care. The number and type of managed care arrangements used by states to deliver and finance care for Medicaid enrollees, as well as the number and share of Medicaid beneficiaries enrolled in these arrangements, have grown steadily. Growth in Medicaid managed care is expected to continue, driven by budget pressures to contain Medicaid spending and by the influx of millions of new adult Medicaid enrollees when the ACA takes full effect in 2014. As individual states look for new ways to improve health care quality, improve access, and achiever greater value for state dollars, there is much to be learned from the wide and evolving variety of Medicaid managed care program designs and experiences that can be found across the country.

This survey documents the diversity in current state Medicaid managed care approaches and activity, and state policymakers' perspectives on the value of managed care as a strategy to improve access, quality, and accountability, and to promote cost-effective care and better health outcomes. As such, it provides a baseline against which to measure and monitor what are likely to be important developments and trends in the coming years. However, an assessment of the impact of Medicaid managed care was beyond the scope of this project, which surveyed state policy officials alone and gathered largely descriptive information. Robust evaluations of Medicaid managed care will require extensive analyses that include investigations of beneficiary and provider experiences and perspectives, as well. Particularly as states expand managed care to Medicaid beneficiaries with more complex needs, and as they determine the delivery systems that will serve millions more low-income Americans, evaluative research is crucial, as are federal and state efforts to assess performance, to develop mechanisms to identify and resolve problems in meeting beneficiaries' needs, and to assure high quality care for all those served by Medicaid through managed care.

Introduction

Medicaid, the public insurance program for low-income Americans, is the single largest health care program in the United States. In calendar year 2011, average monthly Medicaid enrollment is projected to exceed 55 million,[1] and a projected 70 million people, or roughly one in five Americans, will be covered by the program for one or more months during the year.[2] Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) will expand Medicaid eligibility to cover nearly all non-elderly Americans with incomes below 133 percent of the federal poverty level ($14,404 for an individual), providing coverage to 16 million additional people – mostly, uninsured adults – by 2019.

Medicaid is structured as a federal-state partnership. Within federal guidelines, states design and administer their own Medicaid programs, which vary widely with respect to eligibility levels, benefits, provider payment methods and rates, delivery systems, and other characteristics. A growing phenomenon since the early 1980's has been states' use of various managed care models to deliver and finance care for Medicaid enrollees, with the goals of increasing access to care, improving quality, and, in some cases, reducing costs.

The traditional fee-for-service system, in which beneficiaries must find providers willing to accept new (or any) Medicaid patients, offers no explicit mechanism for measuring or ensuring access to care. With managed care, states establish or purchase a network of providers for their Medicaid beneficiaries through contracts with health plans and/or providers who agree to accept Medicaid patients and to meet certain requirements designed to ensure access to care, such as those relating to office hours, credentialing, or case management. These contracts give states a tool for holding plans and/or providers accountable for Medicaid enrollees' overall experience with the health care system; plans agree contractually to meet performance standards that may include structuring an adequate network of appropriate providers and ensuring timely access to care, demonstrating quality of care consistent with clinical and utilization benchmarks, improving quality in priority areas, and providing data sufficient to evaluate performance.

Still, at the same time that managed care offers significant potential to improve access and care for Medicaid beneficiaries, it can fail as a strategy if its design and implementation are not sound. If transitions from fee-for-service are not well-conceived, beneficiaries can face confusion and care disruptions. If provider networks are insufficient to meet the care needs of the enrolled Medicaid population, access problems can arise. If capitation payment rates are not adequate, volatility or declines in health plan participation can occur, leading to disruptions and gaps in care. And if state oversight of managed care programs is lacking, accountability has little traction. The history of Medicaid managed care provides evidence of the promise of managed care, but also shows that the details of how it is structured and implemented are consequential for Medicaid beneficiaries.

The share of Medicaid beneficiaries enrolled in some form of managed care has increased every year except one for over two decades, reaching 71.7 percent as of June 30, 2009 according to CMS. This trend has heightened both policy interest and needs for information about Medicaid managed care, and three dynamics are focusing even more attention on how Medicaid managed care is developing. First, many state policymakers are eyeing managed care as a Medicaid cost containment tool and a means to address concerns about access and quality, particularly as states are facing severe budget pressures

[1] CMS, Office of the Actuary, National Health Expenditure Projections, 2010-2020.
[2] HMA estimate based on Congressional Budget Office's Medicaid Baseline, March 2011.

from the recession and the slow recovery. Second, many states are expanding managed care to more medically complex and fragile populations, for whom the stakes may be especially great. Third, states are expected to rely heavily on managed care to serve the millions of adults who will become newly eligible for Medicaid in 2014.

In light of the large and growing role of managed care in Medicaid, and the implications for Medicaid beneficiaries, the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates conducted a special survey of Medicaid programs to assess the state of Medicaid managed care, identify current issues, and gain perspectives on the directions Medicaid managed care may take in the coming years. This report presents data and findings based on that survey.

About this survey

The Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) surveyed Medicaid directors in all 50 states and the District of Columbia (DC) to document state Medicaid managed care policies and programs as of October 1, 2010, and to collect information on likely policy directions in the near term and under health reform.

The KCMU/HMA survey was emailed to every state Medicaid director in late December 2010. The survey asked states to report on the Medicaid managed care arrangements that would be in operation in State Fiscal Year 2011, including comprehensive managed care through contracts with risk-based managed care organizations (MCOs) and primary care case management (PCCM) programs, as well as non-comprehensive prepaid health plans (PHPs). States were asked to complete only the sections relevant to their Medicaid managed care programs. For example, states that operate PCCM programs but do not contract with MCOs were instructed to complete the PCCM section, but not the MCO section. However, all states were asked to complete an overview section, and all states with any form of managed care were asked to respond to sections on quality, special initiatives, and health reform. Surveys were completed by state staff and responses were received from every state and DC. This report is based primarily on information as recorded by states on the survey instrument. It was not possible to independently validate all state responses. In addition, not all states responded to all questions relevant to their managed care programs.

In a few cases, at the request of a state Medicaid director, HMA staff partially completed the state's survey response based on publicly available information and then forwarded it to the state for verification and completion of remaining items, or completed a state survey response based on a telephone or in-person interview with state staff. Also, when necessary, HMA staff posed follow-up questions to state staff by telephone or email to clarify survey responses or obtain additional information. In some instances, HMA staff supplemented state responses based on web-based research and using enrollment data collected for KCMU.

The survey instrument is included as Appendix 14.

A note on Medicaid managed care terminology

In the private health insurance world, "managed care" usually refers to an arrangement in which a health maintenance organization (HMO) – a closed panel of physicians, hospitals, and other providers – provides a comprehensive set of contractually-defined covered services for an enrolled population, for which it is paid a per member per month premium, known as a capitation payment. The HMO is at financial risk for the full cost of services provided. In Medicaid, managed care encompasses more varied approaches to delivering and financing care, including risk-based arrangements with HMOs, but also contracts with other health plans for a non-comprehensive set of services, as well as non-risk or partial risk arrangements through state-administered primary care case management programs (described below). The KCMU/HMA survey collected information from states regarding the three basic models of Medicaid managed care recognized under federal law and regulations:

Risk-based managed care organizations (MCOs) or health plans. States contract with MCOs to provide a comprehensive package of benefits to enrolled Medicaid beneficiaries, primarily on a capitation basis (i.e., the state pays a per-member-per-month (PMPM) premium to the plan).* Medicaid MCOs may be commercial HMOs that also serve people with employer-sponsored insurance, or they may be Medicaid-only plans with no commercially insured members. States develop their own Medicaid standards of participation for MCOs, which usually include adherence to specified protocols for enrollment and member support, requirements to ensure adequate to access to care, achievement of set benchmarks for quality and quality improvement, and data collection and submission requirements. Medicaid MCOs may be licensed by the state, or they may operate under a contract with the Medicaid agency regardless of licensure.

Primary Care Case Management (PCCM) programs. PCCM programs are also considered a form of comprehensive Medicaid managed care. These state-administered programs build on the Medicaid fee-for-service system. States contract with Primary Care Providers (PCPs) who agree to provide case management services to Medicaid enrollees assigned to them, including the location, coordination, and monitoring of primary health services. States generally set specific requirements for PCPs, such as the ability to provide a set of primary care services, minimum hours of operation at each location, specific credentials or training, and responsibility for referrals to specialists. In addition to fee-for-service reimbursement for services delivered, PCPs are usually paid a nominal monthly case management fee. PCPs are usually physicians, physician group practices or clinics (such as federally qualified health centers), but a state may also recognize nurse practitioners, nurse midwives, and physician assistants as PCPs. State Medicaid staff carry out (or sometimes contract out) the administrative functions related to PCCM programs, from network development and credentialing to quality monitoring and improvement, and the state usually (though not always) assumes full financial risk.

Non-comprehensive prepaid health plans (PHPs). States contract with PHPs on a risk basis to provide either comprehensive or non-comprehensive benefits to enrolled Medicaid beneficiaries. Federal regulations that govern Medicaid managed care refer to MCOs as a comprehensive type of PHP, and identify two types of *non-comprehensive* PHPs. A prepaid inpatient health plan (PIHP) provides, arranges for, or otherwise has responsibility for a defined set of services that includes some type of inpatient hospital or institutional services, such as inpatient behavioral health care. A prepaid ambulatory health plan (PAHP) provides, arranges for, or otherwise has responsibility for some type of outpatient care only. Common types of non-comprehensive PHPs provide only behavioral health services or only dental services, which, in many instances, are "carved out" of the benefit package provided by MCOs. Like MCOs, non-comprehensive PHPs may be state-licensed or may operate under a contract with the Medicaid agency regardless of licensure.

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*"Comprehensive" is defined in federal regulations (at 42 CFR §438.2) as inpatient hospital services and any of the following services, or any three or more of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) FQHC services; (4) other laboratory and x-ray services; (5) nursing facility services; (6) early and periodic screening, diagnostic, and treatment (EPSDT) services; (7) family planning services; (8) physician services, and (9) home health services.

Overview of Medicaid managed care

Key Section Findings:

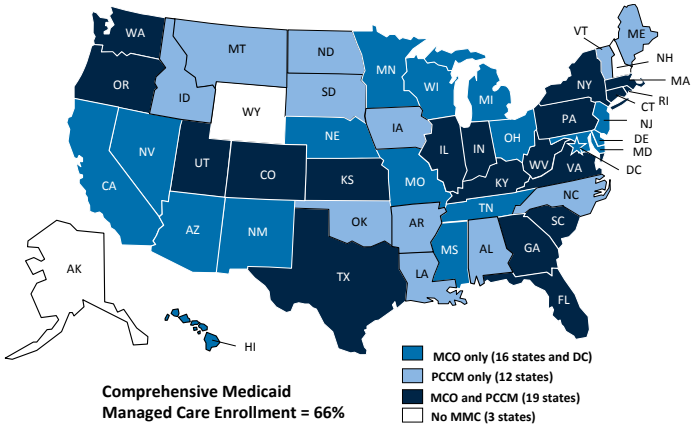
- Nearly all states operate comprehensive Medicaid managed care programs through contracts with MCOs or a state-administered PCCM program. Overall, 35.5 million Medicaid beneficiaries, or about 66 percent, are enrolled in comprehensive managed care.
- Thirty-six states contract with MCOs and 31 states operate a PCCM program. More states have both MCOs and a PCCM program than just one or the other. Half the states also contract with non-comprehensive PHPs to provide specific categories of services.
- The benefit that state officials most often attributed to managed care was improved beneficiary access to care. In addition, states cited improvements in quality and improved value for state dollars.

Nearly all states operate comprehensive Medicaid managed care programs. Across all 50 states and DC, only three states (Alaska, New Hampshire and Wyoming) reported that they did not have any Medicaid managed care as of October 2010 (Figure 1). Overall, 36 of the 48 states with comprehensive managed care programs reported contracting with MCOs and 31 reported operating a PCCM program.[3]

States were more likely to have both MCOs and a PCCM program than to have just one or the other. The 36 states contracting with MCOs include 17 states with MCOs alone and 19 states operating both MCO and PCCM programs (Table 1). The 31 states with a PCCM program include the 19 states with both a PCCM program and MCOs and 12 states operating only a PCCM program.

Figure 1

Comprehensive Medicaid Managed Care Models Operating in the States, 2010



SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

A total of 25 states operated non-comprehensive PHPs alongside their comprehensive managed care programs. States contracted with these plans to provide specific categories of services. Most frequently, states contracted with non-comprehensive PHPs to provide inpatient and outpatient behavioral health services and substance abuse treatment, dental care, non-emergency transportation, and pharmacy services.

Appendix 1 provides a state-by-state summary of managed care programs in operation as of October 2010. Appendix 2 provides a more detailed inventory of state managed care programs, the models under which they operate, and the Medicaid populations enrolled.

[3] For ease of presentation, DC is counted as a state in this report, including all tables and charts.

Table 1: Medicaid Managed Care Models Operated by States, October 2010		
Managed care model	**No. of states**	**States with this model**
Comprehensive managed care		
MCOs only	17	AZ, CA, DC, DE, HI, MD, MI, MO, MN, MS, NE, NJ, NM, NV, OH, TN, WI
PCCM only	12	AL, AR, IA, ID, LA, ME, MT, NC, ND, OK, SD, VT
MCOs and PCCM	19	CO, CT, FL, GA, IL, IN, KS, KY, MA, NY, OR, PA, RI, SC, TX, UT, VA, WA, WV
Non-comprehensive managed care		
PHPs	25	AL, AZ, CA, CO, DC, FL, GA, IA, ID, KS, MA, MD, MI, MS, NC, ND, NM, OR, PA, RI, TN, TX, UT, WA, WI
No managed care		
FFS only	3	AK, NH, WY
Source: KCMU/HMA Survey of Medicaid Managed Care, September 2011.		

About 66 percent of all Medicaid beneficiaries were enrolled in comprehensive managed care arrangements – either MCOs or PCCM programs – as of October 2010. States reported total Medicaid enrollment of 54 million in October 2010, including both fee-for-service and managed care. Of those 54 million, 35.5 million, or 65.9 percent, were enrolled in either MCOs or PCCM programs (Table 2). MCOs accounted for 26.7 million Medicaid beneficiaries, equivalent to three-quarters of comprehensive managed care enrollment and half (49.6 percent) of all Medicaid beneficiaries that month. PCCM programs accounted for 8.8 million beneficiaries, or one-quarter of those in comprehensive managed care and 16 percent of all Medicaid beneficiaries.

Compared with the most recent CMS data, these enrollment findings indicate a notably larger share of Medicaid beneficiaries in comprehensive managed care arrangements. CMS data show that, as of June 30, 2009, enrollment in MCOs and PCCM programs totaled 31.4 million, or 62.2 percent of all Medicaid enrollees. MCOs accounted for 24.1 million enrollees and PCCM programs accounted for 7.3 million, reflecting the same roughly 75/25 split between MCO and PCCM enrollment as indicated by this survey.

The share of Medicaid beneficiaries enrolled in comprehensive managed care was at least 50 percent in 42 states, including 13 states in which the share was greater than 75 percent. Table 3 provides state-by-state data on Medicaid MCO and PCCM enrollment.

Table 2: National Medicaid Enrollment in Comprehensive Managed Care: Comparison of KCMU/HMA Survey Data and CMS Data		
	KCMU/HMA Survey Data as of October 2010 (millions)	**CMS Enrollment Data as of June 2009 (millions)**
MCO Enrollment	26.7	24.1
PCCM Enrollment	8.8	7.3
Total Comprehensive Enrollment (MCO+PCCM)	35.5	31.4
Share of Total Enrollment	65.9%	62.2%
Sources: KCMU/HMA Survey of Medicaid Managed Care, September 2011; National Summary of Medicaid Managed Care Programs and Enrollment, CMS (data as of June 30, 2009).		

Table 3: Medicaid Enrollment in Comprehensive Managed Care, by State
As of October 2010 (unless otherwise indicated in Table Notes)

State	Total Medicaid Enrollment	Total MCO Enrollment	Total PCCM Enrollment	Total Comprehensive (MCO+PCCM)	As Share of Total Enrollment
AK	110,872	0	0	0	0.0%
AL	914,937	0	512,771	512,771	56.0%
AR	680,380	0	575,239	575,239	84.5%
AZ	1,355,598	1,209,559	0	1,209,559	89.2%
CA	7,422,206	4,079,334	0	4,079,334	55.0%
CO	546,301	45,182	25,893	71,075	13.0%
CT	673,826	391,377	517	391,894	58.2%
DC	228,440	168,706	0	168,706	73.9%
DE	192,057	142,483	7,264	149,747	78.0%
FL	2,844,337	1,286,884	594,409	1,881,293	66.1%
GA	1,660,109	1,133,405	135,558	1,268,963	76.4%
HI	262,290	262,290	0	262,290	100.0%
IA	498,805	0	182,718	182,718	36.6%
ID	218,691	0	185,958	185,958	85.0%
IL	2,572,257	187,734	1,653,807	1,841,541	71.6%
IN	1,017,533	721,146	33,846	754,992	74.2%
KS	321,735	135,088	22,893	157,981	49.1%
KY	786,566	168,638	361,565	530,203	67.4%
LA	1,191,772	0	752,977	752,977	63.2%
MA	1,307,930	512,814	319,830	832,644	63.7%
MD	926,668	685,420	0	685,420	74.0%
ME	279,700	0	197,312	197,312	70.5%
MI	1,837,389	1,251,434	70	1,251,504	68.1%
MN	720,000	477,000	0	477,000	66.3%
MO	899,828	427,060	0	427,060	47.5%
MS	610,339	56,758	0	56,758	9.3%
MT	101,829	0	77,267	77,267	75.9%
NC	1,621,799	0	978,579	978,579	60.3%
ND	65,875	0	42,553	42,553	64.6%
NE	204,581	84,815		84,815	41.5%
NH	131,750	0	0	0	0.0%
NJ	1,025,406	974,122	0	974,122	95.0%
NM	493,480	334,950	0	334,950	67.9%
NV	278,586	171,366	0	171,366	61.5%
NY	4,805,293	3,001,571	16,345	3,017,916	62.8%
OH	2,013,751	1,729,602	0	1,729,602	85.9%
OK	726,960	0	451,961	451,961	62.2%
OR	536,829	443,863	3,690	447,553	83.4%
PA	2,088,426	1,222,349	334,965	1,557,314	74.6%
RI	177,619	133,936	2,400	136,336	76.8%
SC	818,860	391,433	112,692	504,125	61.6%
SD	113,630	0	91,295	91,295	80.3%
TN	1,219,443	1,219,443	0	1,219,443	100.0%
TX	3,471,327	1,697,907	858,439	2,556,346	73.6%
UT	216,545	52,282	66,054	118,336	54.6%
VA	848,964	527,360	56,440	583,800	68.8%
VT	152,960	0	100,399	100,399	65.6%
WA	1,156,068	627,179	7,574	634,753	54.9%
WI	1,151,081	624,202	0	624,202	54.2%
WV	333,728	160,824	8,552	169,376	50.8%
WY	65,738	0	0	0	0.0%
Total	**53,901,094**	**26,739,516**	**8,771,832**	**35,511,348**	**65.9%**

Table 3 Notes:

Arkansas: Total Medicaid Enrollment from "Medicaid Enrollment: December 2010 Data Snapshot" (forthcoming from KCMU).
Colorado: Total Medicaid Enrollment accessed at http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251670562819&ssbinary=true.
Connecticut: Reflects January 2011 data for Total Medicaid Enrollment and February 2011 data for MCO and PCCM Enrollment.
Delaware: The state maintains a small "enhanced FFS" managed care program that was created to maintain client choice when the state only had one MCO. Per approval of CMS, enrollment may be limited. PCCM enrollment reflects enrollment in this program but the state is not otherwise counted as having a PCCM program for purposes of this report.
DC: Total Medicaid Enrollment accessed at http://dccouncil.us/media/fy12budgetresponses/health/april11/fy12budget_DHCF.pdf.
Georgia: Reflects June 2010 data.
Indiana: Reflects December 2010 data and includes Medicaid, CHIP and the Healthy Indiana Plan (1115 expansion).
Kansas: Total Medicaid Enrollment accessed at http://www.kdheks.gov/hcf/medicaid_reports/download/MARFY2011.pdf.
Kentucky: Total Medicaid Enrollment from "Medicaid Enrollment: December 2010 Data Snapshot" (forthcoming from KCMU).
Michigan: PCCM counts reflect enrollment in the state's Beneficiary Monitoring Program. The state does not have a formal PCCM program. Total MCO enrollment includes PACE.
Maine: Reflects August 2010 data.
Mississippi: Reflects January 2011 data.
New Hampshire: Total Medicaid Enrollment from "Medicaid Enrollment: December 2010 Data Snapshot" (forthcoming from KCMU).
New Mexico: Reflects July 2010 data.
New York: Total State Medicaid Enrollment from "Medicaid Enrollment: December 2010 Data Snapshot" (forthcoming from KCMU). Enrollment excludes Family Health Plus.
Nevada: Total Medicaid Enrollment reflects Projected FY 2011 Total Average Monthly enrollment. Source: State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy, "BIENNIAL BUDGET: PRE-SESSION BUDGET PRESENTATION, FY 12 FY 13," January 26, 2011, accessed at https://dhcfp.nv.gov/pdf%20forms/Pre-Session%20Budget%20Presentation%20ORIGINAL.pdf.
Oklahoma: Data from "SoonerCare Fast Facts, October 2010," accessed at http://www.okhca.org/research.aspx?id=2987.
Oregon: Enrollment includes OHP Plus and OHP Standard programs.
Rhode Island: Totals include clients who are eligible for RIte Care but are enrolled in the state's employer-sponsored insurance product, RIte Share.
Texas: Reflects November 2010 data.
Wisconsin: Total Medicaid Enrollment accessed at https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Member/caseloads/enrollment/enrollment.htm.spage.
Washington: PCCM enrollment accessed at http://hrsa.dshs.wa.gov/HealthyOptions/NewHO/Provider/HOEnrollmentdata.htm.

States are increasingly mandating managed care for previously exempt or excluded Medicaid beneficiaries. Although underlying federal Medicaid law generally ensures beneficiaries freedom of choice of providers, states have the option of requiring most beneficiaries to enroll in a managed care plan (either an MCO or a PCCM program) so long as the beneficiaries have a choice of at least two plans (except in rural areas). Certain categories of beneficiaries, including children with disabilities and Medicare beneficiaries, are exempt from mandatory enrollment.[4] The HHS Secretary has also granted waivers to some states under which certain populations are required to enroll in managed care.[5]

Nearly all states reported that enrollment in managed care is mandatory for at least some eligibility groups in some or all geographic areas of the state; mandatory managed care may refer to mandatory enrollment in non-comprehensive PHPs for specific types of care, such as inpatient or outpatient behavioral health services, or to enrollment in MCOs or PCCM programs. A large majority of states mandate managed care for most children (46 states), pregnant women (44 states), and parents and other caretaker adults (44 states). Enrollment may also be mandatory for other eligibility groups. Only two states (Colorado and Mississippi) reported that managed care enrollment was voluntary statewide for all Medicaid beneficiary groups eligible to enroll in managed care.

Historically, state Medicaid programs have offered managed care on a strictly voluntary basis to certain Medicaid populations or excluded them from managed care altogether. Examples of population groups sometimes exempt from mandatory managed care, or excluded, are persons with disabilities, foster children, nursing home residents, and those dually eligible for Medicare and Medicaid. However, as Table 4 shows, a majority of states reported that, for at least one managed care program and/or geographic area, they mandate managed care enrollment for children with disabilities receiving Supplemental Security Income, children with special health care needs, and seniors and people with disabilities who are not dually eligible for Medicare and Medicaid. Several states also indicated that they had undertaken initiatives or plan to mandate managed care for additional Medicaid populations.

Table 4: Mandatory and Voluntary Medicaid Managed Care Enrollment, by Eligibility Group

Eligibility Group	No. of states reporting that, for at least one program and/or geographic area, managed care enrollment is:		No. of states reporting that group is always excluded
	Mandatory	Voluntary	
SSI children	26	21	8
Foster children	21	21	14
Children with special health care needs	32	20	5
Medicaid-expansion CHIP children	34	8	0
All other children	46	12	0
Pregnant women	44	13	1
Parents/caretaker adults	44	12	2
Non-dual aged	29	15	10
Non-dual blind/disabled	33	14	8
Institutionalized beneficiaries	9	10	32
Home and community-based care beneficiaries	18	15	22

[4] Section 1932 of the Social Security Act, 42 U.S.C. 1396u-2.
[5] Section 1915(b) of the Social Security Act, 42 U.S.C. 1396n(b) and section 1115 of the Social Security Act, 42 U.S.C. 1315.

Many state Medicaid programs provide 12-month continuous eligibility for children; a much smaller number guarantee six-month eligibility for Medicaid managed care enrollees. Recognizing that stable coverage and contribute to continuity of care and the effectiveness of health care, a number of states have taken action to assure Medicaid eligibility for specific time periods, particularly for children, thereby reducing coverage disruptions that can occur when paperwork is late, family income fluctuates, or family composition changes. A total of 27 states reported that they provided 12-month continuous eligibility for children in FY 2011. Ten states indicated that they had elected the option to guarantee six-month Medicaid eligibility to managed care enrollees.[6]

Many states have a 12-month "lock-in" requirement for Medicaid managed care enrollees. Similar to the way that longer Medicaid eligibility periods support more continuous coverage and care for beneficiaries, "lock-in" policies, which require beneficiaries to remain enrolled in the same MCO or PCCM program for a specified period up to a year, give health plans and PCPs time to make appropriate investments in managing enrollees' care and potentially see some returns in terms of health and/or health spending. Typically, Medicaid enrollees are free to disenroll and re-enroll in another plan during the first 45 or 90 days following their initial enrollment, and the lock-in takes effect after that. In all, 31 states reported that they have a lock-in requirement, in most cases, for a 12-month period.

Perceived benefits of managed care are improved access and quality, primarily. Medicaid officials were asked to assess whether managed care in their state advanced a variety of goals ranging from improving quality, to increasing beneficiary and provider satisfaction, to generating cost savings. The benefit of managed care (relative to fee-for-service) cited most often across all three models of Medicaid managed care was improved access to care. The vast majority of states reported improved access to both primary and specialty care, and a substantial number indicated that the improvement was significant. Other benefits that state officials perceived were improved quality of care, reduced use of emergency rooms, and increased ability of Medicaid beneficiaries to navigate the health care system.

Over half the states attributed some or significant cost savings to each model of managed care, although very few quantified these savings. A small number of states cited no change or higher costs associated with their managed care programs, usually associated with a cash-flow issue due to the prepaid nature of risk-based managed care; however, state officials often indicated that managed care offered the state improved value related to access and quality, even if savings were modest or not realized.

[6] Arizona, DC, Delaware, Kansas, Kentucky, North Carolina, New Mexico, Nevada, New York, and Washington.

States with Medicaid MCOs

Key Section Findings:

- Almost two-thirds of Medicaid MCO enrollees are in health plans that primarily or exclusively serve Medicaid; for-profit plans account for a little over half of Medicaid MCO enrollment.
- A large majority of states set MCO capitation rates administratively using actuaries, and most risk-adjust their rates for health status. More than half incorporate pay-for-performance features in their MCO payments.
- Nearly all states "carve out" at least one acute care benefit, although some are considering or planning to carve some services back in. The most common carve-out is dental care, followed by inpatient and outpatient behavioral health care, non-emergency transportation, and pharmacy.
- Many states report that Medicaid MCO enrollees sometimes face access problems. Key areas of concern are dental care, pediatric and other specialty care, and mental health care.

Broad patterns in comprehensive risk-based Medicaid managed care

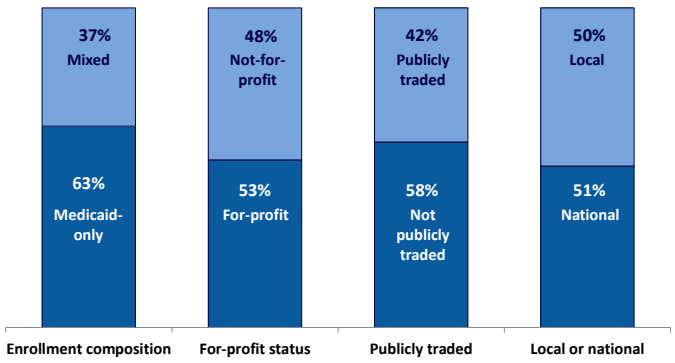
More than half of states with MCOs contract with four or more plans; a few large states have more than 20 contracts. Thirty-six states reported a total of 289 MCO contracts or plans covering over 26 million Medicaid enrollees. Of these 36 states, 15 had three or fewer MCO contracts, 13 states had four to seven contracts, and the others had a larger number. California reported the greatest number of contracts (42), followed by New York (30),[7] Florida (24) and Arizona (19).

A relatively small number of states with large population account for most Medicaid MCO enrollment. Three states – California, New York, and Texas – account for 34 percent of all Medicaid MCO enrollment nationally. Ten states account for over two-thirds of total MCO enrollment.

Almost two-thirds of Medicaid MCO enrollees are served by Medicaid-only plans, and for-profit plans account for a little over half of Medicaid MCO enrollment. The survey asked states to report MCO-specific enrollment as of October 2010 and to indicate, for each MCO, whether it exclusively or primarily serves Medicaid beneficiaries ("Medicaid-only") or serves both commercial and Medicaid populations ("mixed"), whether the plan is not-for-profit or for-profit, whether it is publicly

Figure 2

Distribution of Medicaid MCO Enrollment by Selected MCO Characteristics



Note: 36 states contract with MCOs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

[7] New York provided information on only seven (of 21 total) managed long-term care plans, describing them as representing the "vast majority" of managed long-term care enrollment.

traded, and whether it is a local or national (i.e., multi-state) company.

Overall, in FY 2011, 63 percent of Medicaid enrollees in MCOs were in plans that specialize in serving Medicaid. For-profit health plans accounted for a little over half of all Medicaid MCO enrollment (53 percent). Non-publicly traded plans accounted for 58 percent of enrollment. Medicaid MCO enrollment was distributed about equally between national and local plans (Figure 2).[8]

Appendix 3 provides state-by-state detail on MCO contracts, plan characteristics, and enrollment.

Most states require Medicaid MCOs to be licensed as HMOs. Federal regulations generally require that Medicaid MCOs meet state solvency standards established for private HMOs, or be licensed or certified by the state as a risk-bearing entity.[9] The vast majority of the 33 states responding (of 36 states with MCOs) reported that they require Medicaid MCOs to be licensed as HMOs or otherwise licensed by the state insurance regulatory body, with specified, limited exceptions. Two states (Arizona and Maryland) indicated that they have no insurance licensure requirements. Six states reported that they allow exemptions from state solvency requirements for Medicaid HMOs as permitted by federal law, or for Provider Service Networks or Provider-Sponsored Organizations (PSNs/PSOs), or Health Insuring Organizations (HIOs).

More than a third of states with MCOs provide for an external appeals process for MCO enrollees. Fourteen states with MCOs (of 34 responding) reported that, in addition to the state fair hearing process required by federal regulations, they provide for an external appeals process for MCO enrollees.[10]

Outreach, marketing, and health plan selection

Most states allow MCOs to conduct permissible outreach and marketing activities. A total of 28 states (of 34 responding) allow MCOs to conduct outreach and marketing to Medicaid beneficiaries within federal rules, while six states do not allow plans to conduct outreach or marketing.

A substantial majority of states with MCOs[11] use enrollment brokers. Twenty-five states (of 35 responding) reported that they contract with a third-party enrollment broker to provide plan information to beneficiaries and assist them in choosing an MCO. Vendors listed by more than one state include Maximus (11 states), Automated Health Systems (five states), ACS (three states), and HP Enterprise Services (two states).

States' auto-assignment algorithms typically reflect both beneficiary-based considerations and state policy objectives vis-à-vis MCOs. States prefer that beneficiaries make a choice from the health plans offered. However, Medicaid programs with any mandatory managed care must have a system for assigning Medicaid beneficiaries who do not select a plan within the required timeframe (although the states allow these beneficiaries an opportunity to opt out of the assigned MCO and into a different one).

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[8] MCO enrollment information was not reported for Kansas or Nebraska.

[9] See 42 CFR §438.116. Exceptions apply to federally qualified HMOs, public plans, plans that are (or are controlled by) one or more federally qualified health centers, and those whose solvency is guaranteed by the state.

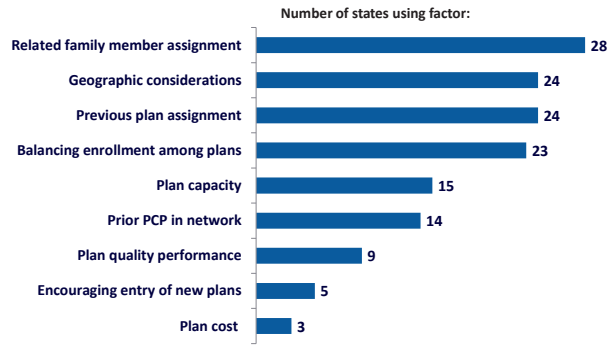
[10] The 14 states are California, Colorado, Delaware, DC, Florida, Hawaii, Illinois, Indiana, Michigan, New Jersey, Pennsylvania, Rhode Island, Washington, and West Virginia.

[11] Only states with MCOs were asked to report on enrollment broker arrangements.

States have "auto-assignment" algorithms for this purpose. The criteria in a state's auto-assignment algorithm provide some indication of that state's policy priorities. Two of the most common criteria – the MCO assignment of a related family member and geographic considerations – take into account what might be most practical and desirable from the beneficiary's perspective. However, states may also design their algorithms to support programmatic objectives, such as balancing enrollment among plans and incentivizing improved plan performance. Figure 3 shows selected criteria used in auto-assignment algorithms and in how many states they are used.

Figure 3

Auto-Assignment Algorithm Factors
(33 states responding)



Note: 36 states contract with MCOs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

Other auto-assignment criteria include plan quality performance measures, such as timely EPSDT check-ups, and measures of plan administrative performance, such as submission of encounter data.

Appendix 4 provides additional state-by-state detail on auto-assignment algorithm factors.

Pennsylvania reported using different auto-assignment algorithms in different areas of the state. In one area, auto-assignment is tied to plan quality performance measures. In two other areas with new MCO entrants, the state auto-assigns most new members to the new plans, but once their enrollment reaches state-defined thresholds, subsequent auto-assignment is based on the quality performance measures.

Auto-assignment rates appear to vary greatly. Auto-assignment rates may provide a useful signal of how well Medicaid beneficiaries understand the managed care system and what their choices are within it.

Twenty-six of the 36 states with MCOs provided information on their auto-assignment rates. These states reported widely different average monthly auto-assignment rates, ranging from a low of 3 percent to a high in two states of 80 percent. However, half (13 states) reported auto-assignment rates of 20 percent or less; four states reported rates exceeding 50 percent.[12]

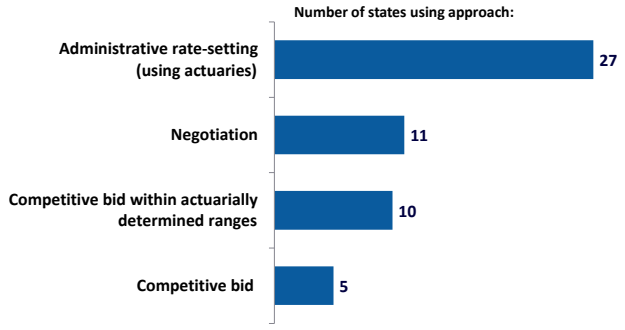
MCO payment methodologies and practices

Most states set MCO capitation rates administratively. To be in compliance with federal regulations, the capitation rates that states pay MCOs must be "actuarially sound."[13] Three-quarters of MCO states (27 of 35 responding) indicated that, for FY 2011, they set capitation rates administratively using actuaries (Figure 4). Smaller numbers of states reported setting capitation rates by negotiation (11 states), by competitive bid within actuarially determined ranges (10 states), and by simple competitive bid (five states).

[12] These are the auto-assignment rates reported for states' acute care programs only.
[13] 42 CFR 438.6(c)(1).

Figure 4

Capitation Rate-Setting Approaches
(35 states responding)



Note: 36 states contract with MCOs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

Most states (23) reported using only one methodology to set capitation rates, but several others combined multiple methods, including two states (Delaware and Nevada) that reported using all four approaches over time. Of the 11 states that reported negotiating rates, only Utah used this approach alone.

Most states risk-adjust their capitation rates for age and eligibility category, and about two-thirds adjust for health status. Capitation rates are intended to reflect the average monthly cost associated with providing a defined set of covered services to an enrolled population. Because monthly costs are known to vary significantly based on age, gender, and other variables, states generally adjust capitation rates by a number of factors so that the amount paid to an MCO more closely reflects the plan's actual average monthly cost to serve its actual enrollees. Among the 34 states that provided information on their rate-setting factors, the most commonly cited rate cell adjustment factors were age (31 states) and Medicaid eligibility category (28 states), followed by geography (27 states), gender (26 states), and health status (22 states) (Table 5).

States that risk-adjust MCO capitation rates for health status use various risk-adjustment and/or predictive modeling software systems. The 22 states that reported adjusting their MCO capitation rates for health status use a number of different programs that have been developed for this purpose. The systems used by more than one state are the Chronic Illness and Disability Payment System or CDPS (13 states), Medicaid Rx (four states), and Adjusted Clinical Groups or ACGs (three states).

Table 5: Rate-Setting Factors Used by States (34 states responding)

Factor	No. of states using
Age	31
Eligibility category	28
Geography	27
Gender	26
Health status	22

Most states with MCOs reported that they use encounter data in setting capitation rates. Twenty-eight states (of 34 responding) said that they use encounter data for rate-setting or related purposes, including some that use the data for risk-adjustment or risk-sharing reconciliations.

Half the states with MCOs have risk-sharing arrangements with their plans. Separate from the risk-adjustment methods that most states use in rate-setting, some also have one or more risk-sharing arrangements with health plans, primarily to encourage MCO participation in Medicaid by mitigating their downside financial exposure. Of the 36 states with MCOs, 18 reported that they have such arrangements; most prevalent are commercial or state-sponsored stop-loss/reinsurance, risk corridors, and condition-specific risk-sharing arrangements. Stop-loss/reinsurance limits an MCO's losses in

excess of a specified threshold for some or all enrollees. Risk corridors limit plans' aggregate profits and losses, with the state bearing a portion of plan losses and retaining a portion of plan profits that exceed the limits. Condition-specific risk arrangements apply to plan costs associated with specific health conditions. Table 6 shows how many states reported using each of these risk-sharing mechanisms.

Table 6: Risk-Sharing Arrangements between States and MCOs (18 states)

Risk-sharing arrangement	No. of states using
Required commercial stop-loss/reinsurance	7
Risk corridors	6
Required state-sponsored stop-loss/reinsurance	5
Condition-specific risk arrangement	5
Optional state-sponsored stop-loss/reinsurance	2
Optional commercial stop-loss/reinsurance	2
Risk pools	3
Experience rebate	1

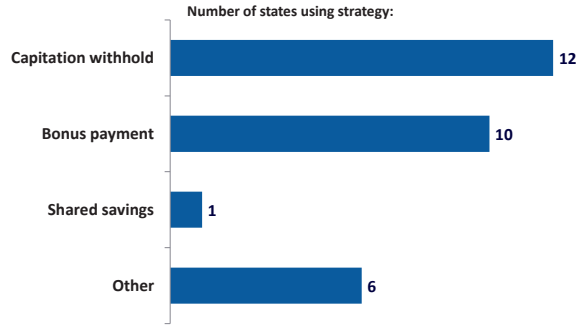
Arizona and **Rhode Island** both reported using three risk-sharing arrangements. Arizona requires state-sponsored stop-loss/ reinsurance, uses risk corridors, and also has condition-specific arrangements. Rhode Island underwrites stop-loss/reinsurance for TANF enrollees, but requires plans to purchase reinsurance for all products. The state also uses risk corridors.

Massachusetts requires stop-loss/reinsurance but permits plans to decide whether to buy it from the state or commercially. The state also uses risk corridors for its Children's Behavioral Health Initiative and its Special Kids/Special Care population.

More than half the states with MCOs report having a pay-for-performance (P4P) aspect to their payment methods. "Pay for performance" has been defined as a "quality improvement and reimbursement methodology which is aimed at moving towards payments that create much stronger financial support for patient focused, high value care."[14] Nineteen states with MCOs indicated that they incorporate at least one P4P component in their method for paying health plans. P4P can be implemented by withholding a portion of the capitation payment, which the MCO can earn back through high performance, or by offering a performance-based bonus in addition to the capitation amount, or through other approaches.

Figure 5

Pay-for-Performance Strategies in State Payment to MCOs (19 states)



Note: 36 states contract with MCOs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

Of the 19 states with a P4P component, over half (12) reported withholding a portion of the capitation payment (Figure 5). Ten states reported that they make bonus payments to MCOs. In addition to withholds or bonus payments, other P4P strategies identified by fewer states include: shared savings; auto-assignment preference; enhanced capitation; incentive for reporting encounter data; extra premium if MCO exceeds savings target for inpatient hospital costs; and one percent of premiums placed at risk in a pool for which plans can compete based on performance measures.

[14] https://www.cms.gov/MedicaidCHIPQualPrac/.

Under **Illinois**' Pay for Performance Bonus/Incentive program, MCOs may receive an additional compensation of up to.5 percent of its annual capitation payments for reaching the most recent 75th percentile for specified HEDIS measures. Each performance measure is eligible for one-eighth of the maximum additional compensation. MCOs may have no more than three measures with rates below the minimum performance level (MPL) in order to qualify for the additional P4P bonus.

Pennsylvania's P4P program includes 12 specific performance measures. MCOs can earn up to 1.5 percent of their total annual revenue (however, each measure also has a 25 percent offset if the MCO does not exceed the 50th percentile based on national HEDIS benchmarks).

Texas is increasing its withhold from one percent to five percent of the capitation amount in 2012. At the end of each rate period, MCO performance is evaluated. If an MCO does not meet targets, future monthly capitation payments are adjusted by the appropriate portion of the five percent at-risk amount. Texas' goal is for all MCOs to receive the full at-risk amount. However, if any MCOs do not receive the full 5 percent, the funds are reallocated through a "Quality Challenge Award" to other MCOs that demonstrate superior clinical quality, service delivery, access to care and member satisfaction. The number of MCOs that receive the Quality Challenge Award annually is based on the amount of funds to be reallocated.

Appendix 5 provides additional state-specific detail on MCO rate-setting methods and P4P strategies.

A limited number of states have a minimum medical loss ratio (MLR) requirement for MCOs participating in Medicaid. A medical loss ratio is the share of premium dollars an insurer or health plan spends on health services, as opposed to administration, executive salaries, marketing, and profits. The ACA places new limits on commercial insurer and plan profits and administrative spending by requiring that 80 to 85 percent of premium dollars be spent on medical care and health care quality improvement activities. Some Medicaid programs have a minimum MLR requirement for MCOs.

Of 33 states responding, only 11 reported minimum MLR requirements for Medicaid MCOs; 21 states reported no MLR. The 11 states with minimum MLR requirements are Arizona, California, DC, Hawaii, Illinois, Indiana, Maryland, New Jersey, New Mexico, Ohio, Virginia, and Washington. MLRs ranged from 80 percent in Illinois, New Jersey and Washington, to 91.5 percent for Hawaii's QUEST plans and 93 percent for plans in the Hawaii QUEST Expanded Access program for the aged and disabled population. Six of the 11 states (DC, Hawaii, Maryland, New Jersey, New Mexico and Virginia) indicated that they include direct care management as a medical cost in computing the MLR. Three states – California, Michigan, and Minnesota – reported that they plan to require a minimum MLR for MCOs in the future.

MCO acute-care benefit "carve-outs"

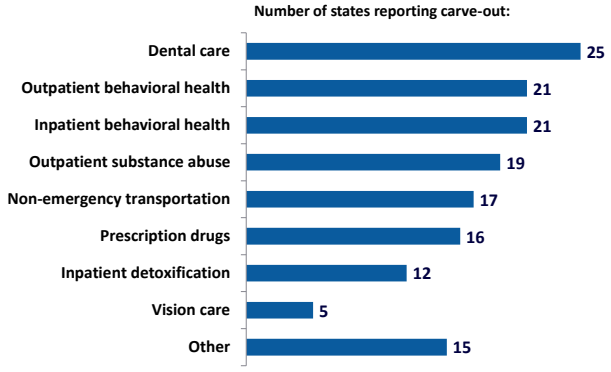
All states with MCOs except Minnesota reported that they carve out at least one acute-care benefit. Although MCOs are at risk for providing a comprehensive set of acute-care services, nearly all states elect to exclude or "carve out" certain services, which are provided and financed through another contractual arrangement (e.g., through a non-comprehensive prepaid health plan, or "PHP") or in the fee-for-service delivery system.[15]

[15] Because states largely provide and finance long-term care (both institutional and community-based services and supports) outside the MCO delivery system, only acute-care benefit carve-outs are discussed here.

Dental care and outpatient and inpatient behavioral health services are the Medicaid services most often carved out of MCO contracts. A substantial majority of the states with MCOs (25) reported that they carve dental services out of their MCO contracts (Figure 6). Five of these same states also reported that they have a dental PHP. Twenty-one states with MCOs reported that they carve out some or all outpatient and inpatient behavioral health services, respectively. Six of these states reported contracting with PHPs for these types of services. In MCO states that do not contract with PHPs to provide services that are carved out, these services are delivered and financed through the traditional fee-for-service system.

Figure 6

Acute-Care Benefit Carve-Outs in Medicaid MCOs



Note: 36 states contract with MCOs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

Non-emergency transportation and pharmacy services are also common carve-outs. Almost half the states with MCOs provide non-emergency transportation outside their MCO contracts, usually on a fee-for-service basis or through a brokerage arrangement. Nearly as many reported that they carve out prescription drugs partially or completely. For example, California carves out only antipsychotic medication and HIV/AIDS drugs and Kansas carves out only hemophilia factor drugs. Other services reported as carve-outs by a limited number of states include vision care, school-based health services, early intervention services, and abortion services. A variety of other carve-outs were also reported. For example, Nevada carves out orthodontia services, and Missouri carves out transplant services, child abuse-related exams and diagnostic studies, environmental lead assessments for children with elevated blood lead levels, and home birth services.

Appendix 6 provides state-specific detail on MCO acute-care benefit carve-outs.

Several states with pharmacy or other benefit carve-outs are carving these services back into their MCO contracts or plan to do so. Because the ACA now permits states to collect rebates on drugs purchased for Medicaid beneficiaries by MCOs, states have less of an incentive to carve out pharmacy services. Indeed, to improve coordination and integration of care, several states that previously had pharmacy carve-outs have carved the pharmacy benefit back in or are considering doing so. In 2011, states that plan to reverse a pharmacy carve-out include New York and Ohio. Texas plans to carve prescription drugs back in into MCO contracts in 2012. Some states reported that they were also considering carving back in other currently carved-out services. For example, West Virginia indicated that it was considering including behavioral health services and children's dental benefits in its MCO contracts. Similarly, South Carolina reported plans to carve in inpatient behavioral health services in April 2011 and outpatient behavioral health services beginning April 2012. New York, New Jersey, and Texas also reported plans to move additional services into their capitated plans.

MCO network adequacy and access to care

Federal regulations require states to ensure that covered services are available and accessible to all MCO (and PHP) enrollees through a requirement that each plan "maintains and monitors a network of

appropriate providers that is … sufficient to provide adequate access to all services covered under the contract."[16] In establishing networks, MCOs are required to consider a number of factors, including anticipated Medicaid enrollment, expected utilization, the geographic location of providers relative to enrollees, and physical accessibility for enrollees with disabilities. Female enrollees must have direct in-network access to a women's health specialist. The federal regulations also require plans to meet state standards for timely access to care and services and make services available 24/7 when medically necessary.

The survey asked states with MCOs to describe their network adequacy standards for primary care**,** obstetric care, specialty care, hospital care, and dental care.

States use a variety of network adequacy standards for primary care. States set network adequacy standards for MCOs in different ways, such as requiring minimum provider-to-population ratios, and distance and travel-time maximums. States reported a range of minimum primary care provider (PCP)-to-enrollee standards. For example, Maryland and Massachusetts require at least one PCP per 200 Medicaid enrollees; in contrast, in South Carolina, the required ratio is one PCP per 2,500 enrollees. Two states reported separate standards for pediatricians: Illinois requires one PCP per 1,200 enrollees, but one pediatrician per 2,000 child enrollees. Similarly, Virginia requires one PCP per 1,500 enrollees, but one PCP with pediatric training or experience for every 2,500 child enrollees.

States also reported a wide range of distance standards and frequently apply different standards for urban and rural areas. For example, Georgia requires two PCPs within eight miles of an MCO enrollee in urban areas and within 15 miles in rural areas, while New Mexico uses a 30-mile standard for urban areas, 45 miles for rural areas, and 60 miles for frontier areas. A few states also reported differing wait-time standards for routine care and urgent care appointments. For example, in New Mexico, routine, asymptomatic primary preventive care appointments must be scheduled within 30 days; routine, symptomatic, non-urgent primary care appointments within 14 days; and urgent care appointments within 24 hours.

Network adequacy standards for specialty care also vary. States' network adequacy standards for specialists may also be set in terms of provider-to-population ratios or time or distance thresholds, and vary for urban and rural areas and by other factors. For example, Indiana requires two providers within 60 miles of a member's residence for some specialties and one provider within 90 miles for others. In Massachusetts, the standard for the top five specialist types is 1 per 500 enrollees. For certain types of specialists, Pennsylvania requires a choice of two providers accepting new patients within 30 minutes in urban areas and 60 minutes in rural areas; for other types of specialists, one provider within those time/distance parameters is required.

Network adequacy standards for obstetric care vary widely as well. In many states, panel size and distance requirements for obstetric care mirror the requirements for primary care – with all their variation. Some network adequacy standards are not expressed in quantitative terms (e.g., "network must be adequate to serve members; otherwise MCO must approve out-of-network care" or "open access to OB services" or "sufficient to serve assigned population"), likely making them more difficult to monitor and enforce. Hawaii requires one obstetric provider on each island a plan serves. States also reported specific timeliness requirements for prenatal care. For example, Nevada requires plans to provide an appointment for prenatal care within seven days of the first request in the first trimester and

[16] 42 CFR §438.206.

the second trimester, and within three days of the first request in the third trimester. Appointments for high-risk pregnancies must be provided within three days of their identification as high-risk by the MCO or maternity care provider, or immediately if an emergency exists.

Appendix 7 provides additional state-specific detail on MCO network adequacy requirements.

States recognize a variety of providers as PCPs for MCO enrollees. In addition to primary care physicians, most states with MCOs allow ObGyns, nurse practitioners, and Federally Qualified Health Centers (FQHCs) to serve as PCPs. Table 7 shows the full list of PCP provider types that states reported. "Other" PCPs mentioned by states include endocrinologists, public health department clinics, and hospital outpatient primary care clinics.

Appendix 9 provides state-by-state detail on providers recognized as PCPs for MCO enrollees.

Table 7: Recognized Primary Care Provider (PCP) Types* in MCOs (35 states responding)

PCP provider type	No. of states recognizing
Ob/Gyn	31
Nurse practitioner	25
FQHC	25
Physician group/clinic	22
Physician specialist	21
Physician assistant	19
Nurse midwife	12
Rural health clinics	4
Geriatrician/gerontologist	2
Other	5

*In addition to general practitioners, family practice and internal medicine physicians, and pediatricians.

Most states require or encourage MCOs to contract with health centers, public health departments, and school-based clinics. To help ensure adequate access to care for Medicaid beneficiaries, Medicaid programs have historically relied on "safety-net" providers that, by mission or legal mandate, play a substantial role in serving low-income populations. The vast majority of the states (30 of 34 responding) reported that they include provisions in their MCO contracts to require or encourage plans to contract with federally qualified or other health centers, and over half include such provisions for local or county health departments (22 states) and school-based clinics as well (20 states).

Many but not all states reported that Medicaid MCO enrollees sometimes face access problems. Medicaid MCOs are required to have processes in place to assure access, including, for example, allowing enrollees to access out-of-network providers, and providing assistance in locating an appropriate provider. Still, notwithstanding federal as well as state and MCO access requirements, 25 states reported that Medicaid beneficiaries enrolled in MCOs sometimes experience access problems. Problems with access to dental care, pediatric specialists, psychiatrists and other behavioral health providers, and other specialists (e.g., dermatologists, ear-nose-throat doctors, orthopedists and other surgeons, neurologists, cancer and diabetes specialists) were all cited. At the same time, as mentioned earlier, improved access to care – both primary and specialty care – was the most frequently cited perceived benefit of managed care relative to fee-for-service. Some states indicated that where an access problem existed, it usually paralleled a similar problem encountered by persons with other types of insurance, for example, due to provider shortages in the area and other market factors. The survey, however, did not directly collect information on access problems in fee-for-service Medicaid.

States with PCCM programs

Key Section Findings:

- A total of 31 states operate PCCM programs. In most PCCM programs, states pay PCPs a small fee such as $3.00 per person per month for case management in addition to regular fee-for-service payments. A limited number of states incorporate a pay-for-performance feature in their PCCM program reimbursement.
- Many states have PCCM administrative services contracts for services ranging from case management and disease management to outreach and education, enrollment broker services, and claims administration.
- Nine states operate Enhanced PCCM (EPCCM) programs that incorporate strengthened quality assurance, case management, and care coordination.

PCCM is a Medicaid managed care alternative to MCOs in which the state itself administers a comprehensive health plan, establishing and contracting directly with its network of PCPs and performing many of the administrative and management functions that MCOs perform under contract to states. States operate PCCM programs for different reasons. A state may prefer to operate and have more direct control over its managed care arrangements, and have the administrative capacity to do so. A state may operate a PCCM managed care model in rural or other areas where the population is insufficient to attract MCOs, or as an alternative managed care model to provide a choice of plans. Or a state may adopt a PCCM because it may be more acceptable to some provider communities than traditional risk-based managed care.

Dimensions of PCCM programs

Nearly as many states have PCCM programs as have contracts with MCOs. Thirty-one states operate PCCM programs, compared with 36 that have MCO contracts. PCCM programs exist alongside MCOs in 19 states and are the sole managed care arrangement in 12 states. In PCCM programs, states contract with PCPs to provide, manage, and monitor the primary care of Medicaid beneficiaries who select them or, in some cases, are assigned to them. In addition to serving as a medical home for primary and preventive care, PCPs in most cases are also contractually responsible for authorizing referrals when specialty care is needed. PCPs typically receive a small monthly fee for this case management function, but they are generally not at financial risk and are paid fee-for-service for the care they provide.

Most states recognize certain providers in addition to primary care physicians as PCPs in their PCCM programs. The PCP is the backbone of a PCCM program. Having a sufficient number of participating PCPs is necessary to ensure both access to primary care and coordination of needed specialty care. To increase the availability of PCPs, many state Medicaid programs permit providers other than primary care physicians to participate as PCPs, such as ObGyns, nurse practitioners, and safety-net health centers. Table 8 shows the number of states recognizing specified types of providers as PCPs in PCCM programs.

Appendix 9 provides additional state-by-state detail on providers recognized PCPs.

Contracts with PCPs include extra requirements beyond those in regular Medicaid provider agreements, to ensure access to primary care for Medicaid beneficiaries. A large majority of the states with PCCM programs (27) reported that 24/7 coverage is a PCP requirement. About half (15 states)

reported that they limit PCP panel size, and slightly smaller numbers require PCPs to meet state reporting requirements (14 states) and to participate in state quality initiatives (13 states).

Appendix 10 provides state-by-state detail on PCP requirements and on PCP payment methods, discussed next.

Table 8: Recognized Primary Care Provider (PCP) Types* in PCCM Programs

PCP provider type	No. of states recognizing
Ob/Gyn	27
Nurse practitioner	23
FQHC	24
Physician group/clinic	22
Physician specialist	18
Physician assistant	14
Nurse midwife	12

*In addition to general practitioners, family and internal medicine physicians, and pediatricians.

PCCM program payment methods and practices

Most states pay PCPs a small case management fee. States provide some kind of compensation to PCPs in addition to regular fee-for-service reimbursement. A large majority of states (25 of 29 responding) pay PCPs a per member per month (PMPM) case management fee. A very small number reported that they pay a capitation amount to PCPs with gatekeeper responsibility for other services, have shared savings arrangements, or pay enhanced fee-for-service rates.

States often pay a PMPM case management fee of $2.00 to $4.00, with $3.00 being the most frequently cited amount. The lowest case management fee reported was $1.00 PMPM in North Carolina, where the state also pays an additional PMPM for networks in its Enhanced PCCM program (discussed later). The highest PMPM was $175.00 in Georgia, for case managers who coordinate the care of frail elders and individuals under the state's "Services Options Using Resources in a Community Environment" (SOURCE) program, which is classified as an Enhanced PCCM program.

One-fourth of states with PCCM programs include a P4P feature in their payment to PCPs. Eight of the 31 states with PCCM programs reported a P4P component to their PCCM payments. State P4P strategies focus on a variety of access- and patient care-related objectives. In some states, PCPs can earn extra payment if, for example, they have extended office hours, reduce emergency room use, or work toward gaining status as a NCQA-recognized Patient-Centered Medical Home. Other P4P policies reward PCPs based on clinical performance – for example, based on measures that indicate appropriate management of diabetes, hypertension, and other chronic conditions, timely prenatal care, cancer screening rates, and EPSDT screening rates.

Idaho is piloting management of persons with diabetes under a P4P arrangement with FQHCs only.

In 2011, **Louisiana** is paying PCPs on a per member per month basis: $.25 for doing their own EPSDT screenings; $.75 for having extended hours; $.50 for working to become an NCQA-recognized Patient Centered Medical Home by the end of CY 2011; and $.75 if the PCP is in the lowest quartile for certain ER visit procedure, $.50 if in second lowest quartile, and $.25 if in the third lowest quartile (phasing out after six months).

Maine reported that 40 percent of its PCCM P4P reimbursement is based on performance on an access measure, 30 percent on performance on an ER utilization measure, and 30 percent on performance on a quality measure.

Many states contract for PCCM administrative services. Over half the states with PCCM programs reported that they have PCCM administrative services contracts. Three of these 16 states (Illinois,

Pennsylvania and South Carolina) reported that the administrative fees are at risk. The services provided under administrative services contracts range from activities like case or care management and disease management to outreach/education, enrollment broker services, and claims administration.

Appendix 11 provides a state-by-state list of PCCM administrative services contracts.

Enhanced PCCM programs

A growing number of states operate Enhanced PCCM (EPCCM) programs. In recent years, in programs they characterize as "enhanced PCCM," a growing number of states have placed additional contractual requirements on PCPs to strengthen care coordination and management. The following nine states reported that they have an EPCCM program: Arkansas, Colorado, Georgia, Montana, North Carolina, Oklahoma, Pennsylvania, Rhode Island, and South Carolina. Included among the enhancements they have added within their PCCM programs are disease management services, coordination/integration of physical and mental health care, case management for high-cost/high-risk enrollees (e.g., medically complex children, individuals with disabilities), and linkages between primary care and community-based services for targeted groups. State EPCCM programs continue to evolve as states adopt new hybrid forms of care delivery and financing.

Georgia's EPCCM program, Service Options Using Resources in a Community Environment (SOURCE), serves the frail elderly and disabled with chronic health conditions. SOURCE was established to integrate primary, specialty, and home and community-based care, with the goal of eliminating care fragmentation, increasing treatment compliance, reducing emergency room, hospital, and nursing home admissions due to preventable medical complications, and reducing the need for long-term institutional care. Eligible individuals enroll in a SOURCE site as their primary care provider. A case manager works with the enrollee and his or her primary care provider to act as a link between medical care and home and community-based services. SOURCE operates on a fee-for-service model.

North Carolina's EPCCM, Community Care of North Carolina (CCNC) is built on the medical home model. Across the state, there are 14 Community Care Networks consisting of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organizations. These private non-profit networks are responsible for managing the care of Medicaid enrollees and use a variety of management tools to improve performance including: implementation of best practices, disease management, management of high-risk patients, and management of high-cost services. In addition to fee-for-service provider reimbursement and PCP management fees, each Community Care Network also receives a management fee based on the number of Medicaid enrollees in the network.

Pennsylvania's EPCCM program, ACCESS Plus, includes a Disease Management component in which telephonic and field-based disease case management services are provided. Other enhancements include a requirement that the ACCESS Plus vendor provide enhanced physical health/behavioral health coordination through letters of agreement established with behavioral health MCOs and behavioral health providers. The ACCESS Plus vendor is also financially responsible for meeting quality metrics and an agreed-upon, guaranteed percentage savings for members with the conditions subject to Disease Management.

States with non-comprehensive PHPs

Key Section Findings:

- Half the states contract with non-comprehensive PHPs, separate from their MCO and PCCM programs, to provide some services. The services most commonly provided by these PHPs are inpatient and outpatient behavioral health care and substance abuse treatment, followed by dental care, non-emergency transportation, and prescription drugs – all services that are frequently carved out of MCO contracts.
- The vast majority of Medicaid enrollees receiving behavioral health services through a non-comprehensive PHP were in plans that specialize in serving Medicaid. Not-for-profit, non-publicly traded, and local plans were also strongly dominant.
- Compared with Medicaid enrollees receiving behavioral health care through a PHP, those receiving dental care through a PHP were more likely to be in plans with mixed enrollment, for-profit plans, and plans affiliated with a national company.

Half the states (25) reported contracting with non-comprehensive PHPs to provide some Medicaid benefits in FY 2011. These states reported a total of 190 PHPs contracts. These contracts may be with Prepaid Inpatient Health Plans (PIHPs) responsible for some or all inpatient hospital services (including inpatient mental health services), or with Prepaid Ambulatory Health Plans (PAHPs) that provide a benefit package that includes no inpatient services. Payment to non-comprehensive PHPs is on a capitated, at-risk basis. The states that contract with non-comprehensive PHPs for one or more categories of service include states that rely largely on MCOs to deliver care to Medicaid beneficiaries but carve these services out, as well as states that operate largely on a fee-for-service basis.

Dimensions of non-comprehensive PHPs

Most non-comprehensive PHPs provide inpatient or outpatient behavioral health or substance abuse treatment services, but they may also provide other single categories of service. Fifteen states reported that they provide inpatient and outpatient behavioral health services, respectively, through non-comprehensive PHPs (Table 9); the next most commonly reported PHPs were those providing outpatient or inpatient treatment for substance abuse. The 11 states that reported enrollment data for non-comprehensive PHPs providing only behavioral health (and sometimes substance abuse treatment services) accounted for 7.9 million Medicaid enrollees in 87 plans, by far the largest number of enrollees in any type of non-comprehensive PHP. Other PHP contracts cover dental care, non-emergency transportation, prescription drugs, and vision care. In addition, at least one state reported providing each of the following types of care through a non-comprehensive PHP: maternity care; services for mentally retarded/ developmentally disabled beneficiaries; primary care, disease management, and chronic care.

Table 9: Medicaid Services Provided through Non-Comprehensive PHPs

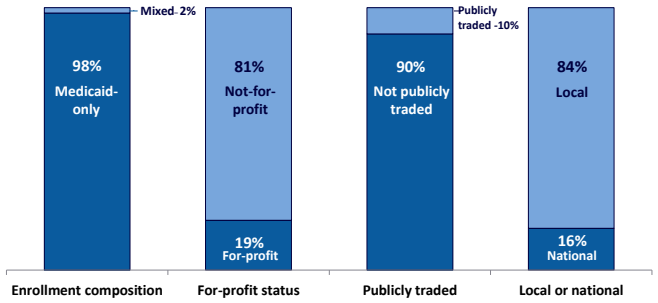
Type of service	No. of states providing service through PHP
Inpatient behavioral health	15
Outpatient behavioral health	15
Outpatient substance abuse treatment	11
Inpatient behavioral health detoxification	7
Dental care	7
Non-emergency transportation	7
Prescription drugs	6
Vision care	2

States were asked to indicate, for each non-comprehensive PHP, whether its enrollment was Medicaid-only or mixed Medicaid and commercial, and also whether it was not-for-profit or for-profit, publicly traded or not, and national or local. The profile of plans serving Medicaid beneficiaries varied by the type of service provided.

Nearly all Medicaid beneficiaries receiving inpatient or outpatient behavioral health services through a non-comprehensive PHP were in plans specializing in Medicaid, and not-for-profit, non-publicly traded, and local plans were strongly dominant. Almost all (98 percent) of the 7.9 million enrollees in PHPs providing behavioral health were in plans that primarily or exclusively serve Medicaid (Figure 7). Only one in five beneficiaries (19 percent) received their care in for-profit PHPs, and smaller shares were enrolled in plans affiliated with a publicly traded company (10 percent) or with a national company (16 percent).

Figure 7

Distribution of Medicaid Enrollees in Behavioral Health PHPs by Selected PHP Characteristics (11 states)

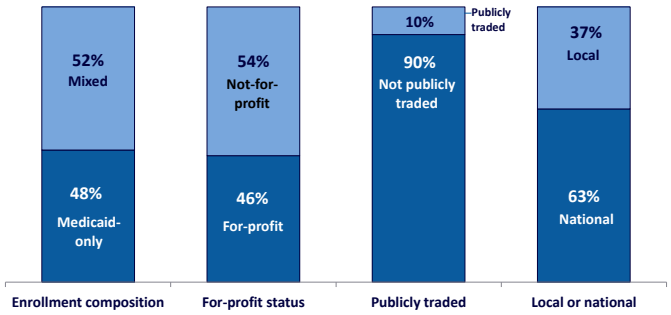


Note: 15 states contract with behavioral health PHPs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

By comparison, Medicaid enrollees receiving dental care through a non-comprehensive PHP were more likely to be in plans with mixed Medicaid and commercial enrollment, for-profit plans, and plans affiliated with a national company. Six states reported PHP contracts limited to dental services, with dental PHP enrollment of a little over 2 million in a total of 14 plans. Medicaid beneficiaries receiving care in these plans were relatively evenly distributed between dental PHPs with mixed enrollment (52 percent) and Medicaid-only plans (48 percent) (Table 8). For-profit plans accounted for close to half (46 percent) of Medicaid enrollment in dental PHPs. Almost two-thirds (63 percent) of dental PHP enrollees were enrolled in a plan affiliated with a national company.

Figure 8

Distribution of Medicaid Enrollees in Dental PHPs by Selected PHP Characteristics (6 states)



Note: Seven states contract with dental PHPs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

Measuring, monitoring, and improving quality in Medicaid managed care

Key Section Findings:

- All states with MCOs and most states with PCCM programs require HEDIS© or other measures of performance and CAHPS© or other surveys of patient experience. Required measures focus heavily on Medicaid priority areas such as prenatal and post-partum care, child health, preventive care, management of asthma, diabetes, and other chronic conditions, and access. Of the 48 states with MCOs and/or PCCM programs, over a quarter also measure and monitor quality in their fee-for-service delivery systems.
- Of the 36 states with MCOs, 16 require health plans to be accredited by a recognized national accrediting organization, such as NCQA, to participate in Medicaid.
- Over three-fourths of states with MCOs publicly report on the quality of their MCOs, and half of PCCM states publish quality reports on their PCCM programs. A smaller number of states also publicly report on PHP performance. Sixteen states with MCOs reported that they prepare a quality report card, using HEDIS©, CAHPS©, and state-specific measures, that Medicaid beneficiaries can use to compare and choose health plans.
- Quality improvement projects in the states with MCOs reveal the breadth of state priorities, including, among others, improved birth outcomes, increased access to pediatric subspecialists, identification of high-risk individuals for case management, and coordination between behavioral health and medical providers.

Managed care provides a platform for states to ensure the quality of care for Medicaid beneficiaries. Federal regulations define requirements that both states and health plans must meet to measure, monitor, ensure, and improve the quality of care provided to Medicaid beneficiaries enrolled in risk-based managed care, including both MCOs and non-comprehensive PHPs. Each state contracting with plans must have a written quality strategy that includes specified elements, including national performance measures, and must, through its contracts, ensure plan compliance with standards set by the state. Contracts with plans must require ongoing quality assessment and performance improvement projects (PIP), and submission of performance data to the state; states must also arrange for annual external reviews of the quality, appropriateness, and timeliness of services furnished to Medicaid enrollees. Similar requirements do not exist for fee-for-service.

With electronic data increasingly available on many aspects of utilization, clinical outcomes, and patient experience, states have growing opportunities to examine health plan and health system performance across a broad spectrum of quality-related measures. Managed care offers a structure in which performance can be measured and enforced. Through managed care contracts, states can specify benchmarks for acceptable performance and hold health plans accountable for their achievement, and structure payment to reward (or penalize) good (or poor) performance. The survey asked states a number of questions concerning the nature and breadth of current and planned activity aimed at measuring and improving quality in Medicaid.

Appendix 12 provides a summary of states' use of selected quality tools.

Of the 36 states with MCOs, 16 require that risk-based plans be accredited to participate in Medicaid. One means by which states can assure quality in risk-based plans is to require that, as a condition of participating in Medicaid, they obtain accreditation from a national accrediting body, such as the

National Committee on Quality Assurance (NCQA) or URAC. NCQA accreditation is widely considered to demonstrate that a health plan has in place the structure and processes necessary for high-quality care, including systems to measure performance and identify areas for improvement, and the processes needed to improve care. In addition, NCQA accreditation means that health plan performance data will be reported nationally and that the health plan will be ranked annually as part of a national process conducted in conjunction with Consumers Union.[17] [18]

Sixteen of the 36 states with MCOs reported that they require Medicaid MCOs to be accredited. All of them recognized NCQA accreditation, and six also recognized URAC and three recognized Accreditation Association for Ambulatory Health Care (AAAHC) accreditation. Some states do not mandate accreditation, but recognize or encourage it. For example, Pennsylvania does not require accreditation, but does require Medicaid plans to submit HEDIS© data to NCQA, and all health plans except two new ones are NCQA-accredited, with Excellent ratings. It is less common for states to require accreditation for non-comprehensive PHPs. Just four states (DC, Florida, Iowa, and North Carolina) reported that they require these plans to be accredited to participate in Medicaid.

Because NCQA requirements are at least as rigorous as federal standards, even states that do not require accreditation may deem NCQA-accredited plans to meet certain state and federal requirements. For example, California does not require accreditation but health plans with NCQA accreditation are deemed to meet state provider credentialing requirements. Ohio and Oregon deem health plans that are accredited to have met certain CMS requirements. Eight states deem federal external quality review requirements to be met for accredited MCOs.

Nearly all states collect, monitor, analyze, and report HEDIS©, CAHPS©, and similar state-specific performance or quality measures in their managed care programs. States can choose from a large inventory of performance measures developed by national bodies such as NCQA or the National Quality Forum, or create measures of their own. For cost reasons, most states do not require health plans and providers to report on all measures. Rather, they select or develop measures focused on priority issues or concerns. Only three states with any form of managed care indicated that they did not use performance measures to assess quality – Mississippi, which began contracting with MCOs in 2011, was selecting measures in 2011, and North Dakota and South Dakota (which do not have MCOs) reported that they do not use performance measures in their PCCM programs.

- ***MCO performance measurement.*** All states with MCOs (except Mississippi, with a newly implemented MCO program) indicated that, as of October 2010, they used performance measures to assess access and the clinical quality of care in their health plans. Most states selected measures from the HEDIS© data set developed by NCQA, often supplementing with measures developed by state staff to assess specific issues.

  The median number of measures that states require Medicaid MCOs to report is 32, consisting primarily of HEDIS© measures but also including state-specific measures. However, the number varied considerably by state. Of the measures used by NCQA for accreditation of Medicaid MCOs,

[17] The 2010-2011 NCQA national rankings of Medicaid health plans can be found at: http://www.ncqa.org/portals/0/health%20plan%20rankings/2010/HPR2010_NCQA_Plan_Ranking_Summary_Medicaid.pdf.

[18] The 2011-2012 NCQA rankings are published in September 2011 at http://www.ncqa.org/tabid/1329/Default.aspx.

seven states required 10 measures or fewer, while 11 states required 30 or more. Twenty-nine states with MCOs responded in detail regarding their use of HEDIS© measures (Table 10). The measures states require focus heavily on prenatal and postpartum care, access, child health, preventive care, and management of asthma, diabetes, and other chronic conditions.

Table 10: HEDIS© Measures Required for Medicaid MCOs, FY 2011 (29 states responding)

HEDIS© measure	No. of states requiring measure in 2011
Prenatal and Postpartum Care	28
Getting Needed Care	25
Childhood Immunization Status	25
Rating of Personal Doctor	24
Getting Care Quickly	24
Comprehensive Diabetes Care	24
Rating of Health Plan	23
Rating of All Health Care	23
How Well Doctors Communicate	23
Rating of Specialist Seen Most Often	22
Cervical Cancer Screening	22
Breast Cancer Screening	22
Use of Appropriate Medications for People With Asthma	22
Customer Service	21
Chlamydia Screening in Women	20
Comprehensive Diabetes Care - HbA1c Poorly Controlled	18
Controlling High Blood Pressure	15
Follow-Up After Hospitalization for Mental Illness	15
Appropriate Treatment for Children With Upper Respiratory Infection	14
Cholesterol Management for Patients With Cardiovascular Conditions	12
Antidepressant Medication Management	12
Use of Imaging Studies for Low Back Pain	11
Follow-Up for Children Prescribed ADHD Medication	11
Appropriate Testing for Children With Pharyngitis	10
Medical Assistance With Smoking Cessation	10
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	9
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	7

The most common examples of state-specific performance measures, which 21 states said they require, include: well-child visits for children and adolescents, by age group; hospital readmission rate; C-section rate; and infant low birth weight.

In addition to requiring HEDIS© and similar measures, all states with MCOs in 2011 (again, except Mississippi) reported that they conduct a survey of patient experience, using the CAHPS© survey or a state-developed variation that measures patient satisfaction and their experience with Medicaid providers. Almost all the states conduct surveys relating to both children and adults, and annual or biannual surveys are the norm.

Some states require Medicaid MCOs to submit HEDIS© and CAHPS© data to NCQA, which uses the data to create national rankings of plans. About half the states with MCOs (19) indicated that they require MCOs to submit HEDIS© data to NCQA, whether or not the plans are NCQA-accredited, and 16 states require them to submit CAHPS© data to NCQA. Some MCOs have submitted data to NCQA voluntarily in order to gain or keep NCQA accreditation, even though the state Medicaid

program does not require health plans to be accredited or reward them for this status. For example, of the 25 highest-ranked Medicaid plans in 2010-2011, seven are in Delaware, New York, or Pennsylvania, states that do not mandate accreditation.

- ***PCCM performance measurement.*** Eighteen of the 31 states operating a PCCM program indicated that they used HEDIS© measures to assess access and quality performance (Table 11); all but three of these states also use state-specific measures similar to those used for MCOs. The 18 states include nine states where PCCM is the only form of comprehensive Medicaid managed care, and nine states that operate both PCCM and MCO programs. In assessing the quality of a PCCM program, the state essentially treats the program as a health plan with an enrolled population.

  States typically use fewer performance measures for PCCM programs than for MCOs. The median number of required measures is 16, but again, considerable variation occurs across states, with four states requiring seven or fewer measures (Georgia, Louisiana, Massachusetts, and North Carolina), while five states use at least 25 measures (Kansas, Maine, Pennsylvania, South Carolina, and Texas); Pennsylvania indicated that it uses the entire HEDIS© data set. Required measures in PCCM programs tend to focus on access, rating of provider, preventive care, and management of chronic diseases.

  Seventeen states reported conducting CAHPS© surveys to assess patient experience within PCCM programs. The surveys are conducted annually in seven states, and every second or third year in the others. Some states alternate the child and adult

Table 11: HEDIS© Measures Used for PCCM Programs, FY 2011 (18 states responding)

HEDIS© measure	No. of states requiring measure in 2011
How Well Doctors Communicate	13
Getting Needed Care	13
Use of Appropriate Medications for People With Asthma	13
Rating of Personal Doctor	12
Rating of All Health Care	12
Getting Care Quickly	12
Breast Cancer Screening	12
Cervical Cancer Screening	12
Rating of Specialist Seen Most Often	11
Childhood Immunization Status	11
Comprehensive Diabetes Care	11
Customer Service	11
Prenatal and Postpartum Care	11
Rating of Health Plan	10
Comprehensive Diabetes Care - HbA1c Poorly Controlled	8
Chlamydia Screening in Women	7
Medical Assistance With Smoking Cessation	6
Cholesterol Management for Patients With Cardiovascular Conditions	6
Follow-Up for Children Prescribed ADHD Medication	5
Appropriate Testing for Children With Pharyngitis	5
Controlling High Blood Pressure	5
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	4
Antidepressant Medication Management	4
Appropriate Treatment for Children With Upper Respiratory Infection	4
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	4
Use of Imaging Studies for Low Back Pain	3
Follow-Up After Hospitalization for Mental Illness	3

CAHPS© surveys. North Carolina is the only state that indicated that it plans to submit the results of its upcoming CAHPS© survey for its PCCM program to NCQA.

- ***PHP performance measurement.*** Thirteen of the 25 states with non-comprehensive PHPs reported that they assess quality and performance in these plans using HEDIS© or similar state-specific measures. States tailor the measures they use to correspond to the limited benefits provided by these plans. Thus, because the most common PHPs are plans providing behavioral health services, typical performance measures relate to access to and timeliness of routine appointments for behavioral health care, coordination of behavioral and physical health services, and follow-up care after hospitalization for mental illness. Not surprisingly, most states use fewer measures for non-comprehensive PHPs than for either MCOs or PCCM programs. Only three states reported using CAHPS© for their PHPs (Arizona, Colorado, and DC).

Close to a third of states also measure quality in the FFS components of their Medicaid programs. Sixteen states reported using HEDIS© measures in FFS. The number of measures varies widely, from a low of 10 or fewer in three states (Ohio, Louisiana, and Wyoming), to a high of 25 or more in three states (Kansas, Maine, and South Carolina). In addition to providing states with information on access and quality in FFS, FFS data can also provide a useful benchmark for comparison to managed care performance in states that have MCOs and/or a PCCM program. In addition to HEDIS© measures, seven states reported using state-specific measures for FFS, usually the same ones added to assess managed care, or representing areas of high policy priority, such as access to well-child care and dental care. Eight states reported that they conduct the CAHPS© survey or a similar survey of patient experience in FFS at the same time they administer the survey among managed care enrollees (Colorado, Kansas, Maine, Michigan, Oregon, South Carolina, Virginia, and Washington).

Three-fourths of states with MCOs publicly report on the quality of their MCOs, and half of states with PCCM programs publish quality reports on those programs. The data collected by states and health plans provide rich information about how well Medicaid systems of care are performing, how providers and plans compare in their effectiveness, whether patients can access care when they need it, and areas where there is room for improvement. This information supports state value-based purchasing efforts and can help states structure payment to advance quality goals. Also, on the principle that transparency regarding performance will drive improvement in quality, states also provide data on performance to providers, plans, beneficiaries, the public, and policymakers.

Thirty-five states reported that they publicly release reports on MCO and/or PCCM quality performance, most often by posting the report on the Medicaid program's website. Most states also provide the reports back to providers and health plans that submitted the data, while others provide the reports to their legislature. Three states do not publish quality reports, but make the information available upon request. The total of 38 states that make quality information public includes 28 of the 36 states with MCOs, and 16 of the 31 states that operate PCCM programs. Two of the states reported that they first made quality reports public in FY 2011, an indication that public reporting of quality data may be growing. Nine states also publicly report on PHPs' performance, allowing a look at quality across all forms of managed care in those states. Further, six states extend quality performance reporting to the non-managed fee-for-service components of their Medicaid programs.

A number of states prepare quality "report cards." Fifteen states with MCOs and North Carolina, a PCCM-only state, reported that they prepare a quality report card, using HEDIS©, CAHPS©, and state-specific data, that Medicaid beneficiaries can use to compare and choose health plans. For example, the

"Guide to Michigan Medicaid Health Plans – Quality Checkup"[19] compares Medicaid MCOs on their performance on six measures: doctor's communication and service, getting care, keeping kids healthy, taking care of women, living with illness, and accreditation. California translates selected HEDIS© and CAHPS© results into ratings of "below average," "average," and "above average." The consumer guide containing these ratings is included in Medicaid enrollment packets to help beneficiaries choose a health plan and it is also available online. DC's guide rates plans based on two survey questions that ask patients how they rate their health care and their health plan. North Carolina is the only PCCM-only state that prepares a guide that compares its PCCM program with traditional fee-for-service.

Most states plan to report on some or all of the CHIPRA core child health quality measures. Thirty states indicated that they planned to report in Medicaid and CHIP on some or all of the children's health quality measures included in the core being developed by HHS. Five states indicated that they did not plan to use these measures, and 16 states did not know or did not respond to the question.

State "performance improvement projects" (PIPs) indicate the breadth of state priorities and activity. Federal regulations require all states with MCOs to contract with an External Quality Review Organization (EQRO) to provide an independent assessment of the quality performance of plans participating in Medicaid. All states reported contracting with an EQRO (except Mississippi, with its new managed care program, reported it did not have a contract as of October 2010.) Four PCCM-only states – Alabama, North Carolina, Oklahoma, and Vermont – also reported contracting with EQROs.

In addition to assessing plan compliance with standards for access to care and other requirements, EQROs conduct clinical studies and validate the required "Performance Improvement Projects" (PIPs). States reported a wide range of PIPs, reflecting many health priorities across the states, including among others: improving birth outcomes (DC and Virginia); access to pediatric subspecialists (South Carolina); emergency room use (Oklahoma); use of clinical risk groups to identify candidates for case management (New York); smoking cessation (Alabama); improving coordination between behavioral health and medical providers (Arizona); and improving outcomes for specified chronic diseases (several states.)

[19] http://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf

Special initiatives to improve quality and care coordination

Key Section Findings:

- Medicaid programs have undertaken a range of strategies to improve care, including initiatives to reduce inappropriate use of ERs. Most states also have initiatives to reduce obesity, with Medicaid MCOs often playing a leading role.
- About half the states have Medicaid initiatives designed to reduce racial and ethnic disparities in care and outcomes, including participation in broader state efforts.
- States report a broad spectrum of other special managed care quality initiatives.
- Large numbers of states report initiatives to improve primary care and to better coordinate care for Medicaid beneficiaries with more complex needs.

Managed care has raised expectations regarding the quality and appropriateness of care delivered to Medicaid beneficiaries, and it has provided state Medicaid programs with structural mechanisms for examining and potentially driving improvements in care. The survey asked states about their initiatives in three national priority areas – reducing inappropriate emergency room use, improving obesity rates, and reducing racial and ethnic disparities. It also asked about their adoption of strategies to promote more coordinated care. State responses indicate many kinds of activity on many fronts.

Initiatives to improve quality

All but a small number of states have initiatives to reduce the use of emergency rooms (ER) for non-emergent needs. Initiatives to reduce inappropriate use of ERs were reported by 43 states. States' focus on this issue was fueled by $50 million in CMS grants to states in 2008 for ER diversion projects. State approaches to reducing non-emergency use of ERs vary, depending in part on their managed care arrangements.

States with MCOs often include a focus on ER use in their contracts. For example, some state contracts specify that plans must monitor ER use as part of their broader monitoring of over- and under-utilization. Some states reported ER use as a factor in their P4P systems. States also reported that plans identify high ER users and target them for case management or care coordination, or use data on high ER users to profile providers and work with plan medical directors to improve utilization patterns.

Through its statewide collaborative, "Implement Medicaid Programs for the Reduction of Avoidable Visits to the Emergency Department (IMPROVE)," **Ohio** coordinated key stakeholders in five regions of high ED utilization. Regional participants include hospitals, community providers, managed care plans, advocacy organizations and their respective associations, and Medicaid consumers. The IMPROVE Collaborative adopted a rapid-cycle quality improvement approach, developed by the Institute for Healthcare Improvement, that is population-based and patient-centered. Five regional groups, including executive/clinical leaders of health care systems, partner with Ohio Medicaid and managed care plans to identify priority populations for the reduction of avoidable ED visits.

In states with PCCM programs, ER diversion can involve a data system that notifies primary care doctors when their patients use the ER. Also, ER use is often included among the data used to profile PCPs. Some states have established 24-hour nurse consultation lines and/or other approaches to educate beneficiaries on when it is appropriate to use the ER. States also have used information technology to identify high users of ERs and established case management programs for those with ER use exceeding a specified threshold, such as five or more visits in a 90-day period.

In some states, reducing avoidable ER use in Medicaid is part of a state-wide effort that may also involve other payers, statewide education efforts, establishment of nurse advice lines, and collaboration among hospitals, health plans, and primary care providers. These initiatives often include the development of diversion protocols that redirect people with non-emergent needs to appropriate sites for care, such as a nearby clinic or their primary care provider. Some ER-related efforts are part of a chronic care management initiative that focuses on individuals with specific diseases, such as asthma, diabetes, hypertension, or congestive heart failure. State medical home initiatives also include a focus on reducing inappropriate ER use and ensuring that care is provided in the appropriate setting. Most states are evaluating the effectiveness of their efforts to reduce ER use. Some states, but not all, reported reduced ER use resulting from state initiatives.

Most states report initiatives to address obesity, with Medicaid MCOs often playing a leading role. State Medicaid programs have a large stake in efforts to reduce obesity because many Medicaid beneficiaries suffer from chronic conditions related to obesity, such as diabetes. Initiatives to monitor and reduce obesity were reported by 34 states, with Medicaid MCOs often playing a key role. To illustrate, in Michigan, all Medicaid MCOs are required to conduct a performance improvement project (PIP) on childhood obesity, which must be evaluated by the EQRO. California and Tennessee require Medicaid MCOs to report scores annually for the HEDIS© measure "Weight Assessment & Counseling for Nutrition & Physical Activity for Children and Adolescents," and other states have added other HEDIS© measures relating to BMI. In some cases, MCOs have developed their own weight-reduction or disease management programs for obese adult and child enrollees. A number of Medicaid programs are participating in state-wide obesity initiatives that involve surveys, data collection, education, and health promotion.

All **TennCare** MCOs have implemented a disease management (DM) obesity program for children and adults with participants identified through self-referral, physician referral, and community referrals, and through other DM and care management (CM) program engagement, such as health risk assessments. Risk stratification, typically based on Body Mass Index and/or co-occurring conditions, determines the type and intensity of interventions, which can include educational material addressing nutrition, exercise and weight management, referrals to community partners that supply weight management programs, and individual care plans addressing weight loss. The DM obesity programs are evaluated annually based on both process and outcome measures.

About half the states report initiatives in Medicaid to address racial and ethnic disparities, including participation in broader state efforts. Because of Medicaid's large role in paying for births and covering communities of color, the program is instrumental to efforts to narrow racial and ethnic disparities in access, care, and outcomes related to major chronic diseases. Federal regulations require states to provide their contracted MCOs with data on the race and ethnicity of their Medicaid enrollees to allow health plans to measure, monitor, and address disparities.

Just under half of state Medicaid programs (24 states) reported that they had or would have quality initiatives in Medicaid specifically to address racial and ethnic disparities. Numerous states reported formal Medicaid PIPs focused on reducing racial and ethnic disparities in certain measures (e.g., adolescents' use of well-child visits, breast or cervical cancer screening rates), or on cultural competency. In one state, each MCO has a "disparity committee" that analyzes data by race and ethnicity and recommends interventions for the plan to implement. Several states analyze quality data by race and ethnicity, including one state that publishes the data. A number of states reported broader

public health efforts to reduce disparities, with Medicaid participating in interagency and community task forces and statewide collaboratives.

Wisconsin has implemented several efforts to reduce racial/ethnic disparities in poor birth outcomes. One includes a medical home pilot project in the southeast region of the state, and a financial penalty for health plans that fail to provide appropriate care for pregnant women who then have a poor birth outcome. **Washington** examines immunization data for racial/ethnic disparities. Having identified disparities in the Russian-speaking population, the state plans focus groups in 2011 to better understand the root causes of under-immunization of Russian-speaking children.

States reported a broad spectrum of other, special managed care quality initiatives. A total of 26 states reported managed care quality initiatives in a host of additional areas, reflecting diverse priorities and strategies. Among others, they mentioned quality initiatives focused on: perinatal care and depression screening; improved care management for individuals with both behavioral health diagnoses and chronic conditions; identification of high-risk enrollees for intensive case management; dental utilization; and improving the data available to providers to benchmark their performance. Many of the initiatives involve strategic use of HEDIS© and CAHPS© data by states and plans, to measure and monitor quality and drive improvement, sometimes via P4P approaches. In some states, the activity in Medicaid is part of a broader, statewide quality initiative.

Arizona AHCCCS has formed work groups with contracted health plans and community stakeholders to address issues such as low rates of breast and cervical cancer screening, childhood immunizations and well-child visits, and the need for better care management of members with behavioral health diagnoses who also have chronic conditions or development of toolkits for management by PCPs of some behavioral conditions such as anxiety, depression and ADHD. The work groups allow contractors, in conjunction with public agencies and other community providers, to identify barriers, collaborate on interventions and share promising practices.

Initiatives to improve primary care and care coordination

A large majority of Medicaid programs have a medical home initiative in place or under development. State Medicaid programs have long used the term "medical home" to capture the concept of firmly connecting the Medicaid enrollee with a particular primary care provider who has agreed to guarantee timely access when care is needed. In recent years, the term has also taken on a more specific and comprehensive meaning, associated with NCQA's "Physician Practice Connections® - Patient Centered Medical Home™" program, which recognizes providers who meet a set of specified benchmarks as medical home providers.[20]

Interest in medical homes spans public and private health insurers and payers, including Medicaid. In all, 39 states reported having a medical home initiative in place (27 states) or under development (12 states).

A large majority of states have disease and/or care management programs, which are often integrated into their managed care programs. Recognizing that a very small share of Medicaid beneficiaries with very high needs and costs account for a large share of Medicaid spending, states have increasingly turned to disease management (DM) and care management (CM) programs to improve care for people with specific chronic conditions. Early programs tended to focus narrowly on management of

[20] NCQA. See: http://www.ncqa.org/tabid/631/Default.aspx

the chronic condition (e.g., asthma, diabetes, congestive heart failure, etc.), but programs have evolved toward more comprehensive management of the individual's total health care needs.

Thirty-nine states reported that they operate DM and/or CM programs. Nineteen of these states indicated that their programs were integrated into or carried out by the states' MCOs; 12 indicated that the initiatives were part of a PCCM program.

Many states plan to elect the new "health home" option; most will claim the enhanced federal match for an existing program. The ACA established a new state plan option to provide "health homes" for Medicaid beneficiaries with chronic conditions. Under the option, designed to enhance coordination and integration of primary, acute, behavioral health, and long-term services and supports, a 90 percent federal match is provided for two years, for health home services, such as comprehensive care management, care coordination, and health promotion provided by a designated health home provider or team.

Twenty-two states said they plan to elect the new option. Another 19 states were uncertain whether they would elect the option; four plan not to do so.

A number of states report ACO initiatives in some stage of development. The ACA established the Medicare Shared Savings Program to facilitate coordinated care for Medicare beneficiaries through "Accountable Care Organizations" (ACO) comprising providers, hospitals and suppliers. ACOs are expected to create incentives for providers and insurers to work together to treat an individual patient across care settings, including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of patient care.

Practices participating in **Massachusetts**' Patient-Centered Medical Home initiative must implement and master 12 core competencies (e.g., patient/family centeredness, multi-disciplinary team-based approach to care), and must populate patient registries, attend Learning Collaboratives, meet regularly with Medical Home Facilitators, provide clinical CM services through a licensed nurse, achieve NCQA Level 1 Plus recognition, participate in a formal evaluation, and meet other milestones.

The **Texas** Medicaid Wellness Program (effective March 1, 2011) is a comprehensive CM program (with no disease exclusions) offered to high-cost and/or high-risk FFS clients. Benefits include diabetic education, nutritional counseling, and value-added services such as Weight Watchers for obese clients. Provider incentives include a comprehensive provider portal where providers can view patient summaries, claims data, care plans, and patient education materials and practice support facilitators, who provide practice improvement tools and training and assist with Patient-Centered Medical Home certification. MCOs also offer DM and CM services to clients with one or more of the five main chronic conditions.

Nine states reported having an ACO initiative underway, planned, or under development (California, Colorado, Connecticut, Indiana, Maine, Minnesota, Oklahoma, Vermont, and Washington). Three additional states (Massachusetts, New Jersey and Utah) indicated that legislation had been proposed in the 2011 legislative session to begin an ACO pilot or to require Medicaid reimbursement to ACOs.

Appendix 13 provides a state-by-state summary of initiatives to improved quality and care coordination.

Colorado is implementing a PCCM program that incorporates an Accountable Care Collaborative (ACC) design to improve the client/family experience and access to care, and establish accountability for cost management and health improvement. By integrating the principles of a Patient-Centered Medical Home, applying best practices in care coordination and medical management, and combining access to client and resource utilization data, Regional Care Collaborative Organizations (RCCOs) will become partners in the state's efforts to move toward an outcomes-based, efficient, health improvement model of care. Central to the ACC program is the interaction among three key roles: Primary Care Medical Providers are required to deliver accountable care; RCCOs are responsible for ensuring accountable care; and the Statewide Data and Analytics Contractor is responsible for bringing a new level of information and data analytics to Medicaid, providing insight into variations within and across RCCOs, benchmarking across key performance indicators, and facilitating health information exchange between the state and the RCCOs.

Medicaid managed long-term care and managed care initiatives for dual eligibles

Key Section Findings:

- Eleven states reported operating capitated managed long-term care programs other than PACE, including some that encompass acute medical care as well as long-term services and supports.
- Twenty-five states reported enrollment of dual eligibles in Medicaid managed care in 2010, on either a voluntary or a mandatory basis, and many other states are considering future managed care options for this population.
- Twenty-one states reported plans to expand or modify current programs or to initiate new programs focused on dual eligibles.

Medicaid managed long-term care

More than half the states have PACE sites and 11 states reported operating additional capitated managed long-term care (MLTC) programs. The Program of All-Inclusive Care for the Elderly (PACE) is a well-established model that permits states to provide comprehensive Medicare and Medicaid medical and social services to frail elders who would otherwise need nursing home care, using an interdisciplinary team approach in a PACE Center. The PACE Center operates as an Adult Day Health Care Center and is paid on a risk basis to provide and coordinate all preventive and primary care, acute medical care, pharmacy services, medical and assistive devices, mental and behavioral health services, and long-term services and supports. In all, 29 states reported operating a total of 124 PACE sites with aggregate enrollment of 20,585. California, New York, and Pennsylvania reported the largest numbers of PACE sites.

In addition to PACE, 11 states (of 50 responding) reported operating a capitated, non-PACE Medicaid MLTC program as of October 2010. Some of these programs encompass only long-term care, while others encompass acute medical care as well. In general, the programs include only Medicaid services (i.e., they do not include Medicare services). Exceptions are Massachusetts, New York, and Wisconsin, which also include Medicare services. The Medicaid MLTC programs are described in Table 12.

Table 12: Medicaid Capitated Managed Long-Term Care Programs

State	Enrollment 10/1/10	Payment Approach	Scope of services
Arizona	48,442	Monthly capitation.	Acute, behavioral health, in-home services, alternative residential settings.
Florida	20,928	Nursing Home Diversion (NHD) program rates based on program encounter data, adjusted for inflation and other legislatively required factors.	Acute care services (e.g., inpatient hospital and physician services) are covered by Medicare; long-term care services (personal care, assisted living, home-delivered meals, and adult day health care) covered by Medicaid.
Hawaii	(Not provided)	Risk-based capitation.	Institutional and HCBS services.

continued

Table 12 continued

State	Enrollment 10/1/10	Payment Approach	Scope of services
Massachusetts	16,321 (3/1/2011)	Monthly capitation.	Senior Care Options covers all Medicaid and Medicare benefits including primary, acute, pharmacy, behavioral health, community and facility-based services and supports and care coordination.
Minnesota	49,174	Capitation for health care with add-on capitation for nursing facility and home and community-based enrollees.	Integrated health and long-term care products for seniors include 180 days nursing facility liability for community-based enrollees and home and community-based services for community-based seniors. Integration with Medicare SNPs is an option through Minnesota Senior Health Options.
New Mexico	38,000	Global capitation.	Institutional and HCBS services.
New York	28,909	Medicaid Advantage Plus (MAP) fully integrates Medicare and Medicaid capitation and services. Partial cap plans receive monthly Medicaid capitation to cover benefit package; other services are fee-for-service.	MAP integrates Medicare Advantage, Medicare copayments, and a majority of traditional Medicaid services including long term care. Partial cap plans cover traditional HCBS services, custodial nursing home, DME, and ancillary services such as dental, podiatry and audiology.
Tennessee	28,793 (1/1/11)	Blended capitation payment encompassing all Medicaid-reimbursed long term care services (nursing facility and HCBS) as well as physical and behavioral health services.	Physical and behavioral health services, nursing facility, and HCBS including personal care visits, attendant care, homemaker, home-delivered meals, Personal Emergency Response System, respite (in-home and inpatient), adult day care, assistive technology, minor home modifications, pest control, and community-based residential alternatives (assisted living, adult care homes and companion care).
Texas	170,025	Capitated premium.	Home and community-based services.
Washington	4,231 (3/2011)	Full risk capitation - per member/per month.	The Washington Medicaid Integration Partnership is a fully integrated managed care program with one MCO in one county. Benefits include long-term care (HCBS and institutional), mental health, chemical dependency and medical care. State psychiatric hospitals are carved out as is inpatient residential chemical dependency treatment.
Wisconsin	34,598	Capitation.	Family Care provides HCBS and institutional services to frail elders and people with disabilities. The Family Care Partnership Program adds medical care (primary and acute) to the long term care services provided in Family Care.

States identified a number of challenges associated with operating non-PACE MLTC programs. States highlighted a wide range of operational issues, including: contracting with Medicare Advantage Special Needs Plans (SNP); coordination with physical health MCOs; challenges associated with slow enrollment growth; limited staff and administrative resources to accommodate expansion; plan difficulty contracting with Boarding Homes; added regulations when long-term care is administered by MCOs

(e.g., need to credential Adult Family Homes and Boarding Homes); lack of support from Area Agencies on Aging (AAAs); and difficulty contacting beneficiaries for potential enrollment.

Medicaid managed care initiatives for dual eligibles

Twenty-five states reported enrollment of dual eligibles in (non-PACE) Medicaid managed care arrangements, on either a voluntary or mandatory basis. Nearly nine million Medicaid beneficiaries are dual eligibles – low-income seniors and younger persons with disabilities who are enrolled in both Medicare and Medicaid. Dual eligibles are among the sickest and poorest Medicare beneficiaries, and they account for almost 40 percent of total Medicaid spending although they comprise just 15 percent of Medicaid enrollees. State policymakers are eager to find ways to better control costs and improve care for this population, including through managed care approaches that integrate medical and, in some cases, long-term services, and also through models that integrate Medicaid and Medicare service delivery and payment.

Overall, 25 states reported enrollment of dual eligibles in non-PACE Medicaid managed care arrangements, on either a voluntary or mandatory basis. In some of the 25 states, dual eligibles are enrolled in comprehensive managed care – MCOs or PCCM programs; in other states, dual eligibles are enrolled in non-comprehensive PHPs for specific categories of service, such as mental health care or long-term services and supports, but remain in fee-for-service or in other managed care arrangements for all other Medicaid-covered services. Table 13 summarizes Medicaid managed care enrollment arrangements for dual eligibles in the 25 states.

Table 13: Medicaid Managed Care Enrollment Arrangements for Dual Eligibles (non-PACE)

State	Description of Arrangement
Arizona	Dual eligibles must enroll in the ALTCS (long-term care managed care program). All ALTCS MCOs in Maricopa County must be a Medicare Advantage Plan or a Medicare Advantage SNP.
California	Enrollment of dual eligibles is mandatory in County-Organized Health Systems. Voluntary enrollment in Two-Plan and Geographic Managed Care counties under the following rules: 1) Medi-Cal beneficiary must be enrolled in a Medi-Cal MCO; 2) the Medicare Advantage/Special Needs Plan (MA/SNP) that the beneficiary chooses must be the Medi-Cal MCO in which the member is currently enrolled or its plan partner in the county; 3) the member will be disenrolled from the Medi-Cal MCO and placed into fee-for-service if the beneficiary chooses a MA/SNP that is not associated with the Medi-Cal MCO.
Colorado	Dual eligibles may voluntarily enroll in Denver Health (MCO), the Colorado Regional Integrated Care Collaborative (EPCCM), and Rocky Mountain Health Care (PHP).
DC	Dual eligibles are enrolled in the non-emergency transportation PHP on a mandatory basis.
Florida	Dual eligibles may voluntarily enroll in MCOs (including the Nursing Home Diversion Program plans) unless otherwise excluded.
Georgia	Dual eligibles may voluntarily participate in the Service Options Using Resources in a Community Environment (SOURCE) – an enhanced PCCM program serving certain frail elderly and disabled beneficiaries to improve the health outcomes of persons with chronic health conditions by linking primary medical care with home and community-based services. The program builds on the state's PCCM program, Georgia Better Health Care Program (GBHC).
Hawaii	Dual eligibles are enrolled in QExA (QUEST Expanded Access) on a mandatory basis.
Idaho	Dual eligibles may voluntarily enroll in the Medicare Medicaid Coordinated Plans (non-comprehensive PHPs) offered through Blue Cross and United Healthcare.
Iowa	Dual eligibles enroll in the state's behavioral health PHP.

continued

Table 13 continued

State	Description of Arrangement
Kentucky	Dual eligibles must enroll in the KY Partnership (MCO) to receive Medicaid-only benefits, such as pharmacy and transportation. They do not have to choose a primary care provider within the Partnership network and they retain their Medicare freedom-of-choice.
Massachusetts	Dual eligibles may voluntarily enroll in Senior Care Options, which covers all Medicaid and Medicare benefits including primary, acute, pharmacy, behavioral health, community and facility-based services and supports and care coordination.
Michigan	Dual eligibles must enroll in a behavioral health PHP.
Minnesota	Enrollment in managed care is mandatory for most seniors. Medicaid-only seniors must enroll in MSC+. Dually eligible seniors may enroll in MSC+ or in MSHO. MSHO is an integrated Medicaid/Medicare product that includes health services as well as home and community-based services and a certain amount of nursing facility services. The state contracts for Medicaid services with Medicare SNPs, so dual eligibles age 65 and older can receive all Medicaid and Medicare services through a single MCO. Dual eligibles who are blind or disabled and age 18 to 64 may voluntarily enroll in Special Needs Basic Care, an integrated Medicaid/Medicare product that includes a certain amount of nursing facility services; personal care and home and community-based services are available on a fee-for-service basis. Because the state contracts for Medicaid services with Medicare SNPs, blind and disabled duals aged 18 to 64 can receive Medicaid and Medicare services through a single MCO.
North Carolina	Dual eligibles may voluntarily enroll in the PCCM program and are enrolled statewide on an opt-out basis in addition to the voluntary enrollment. Also, the Community Care Networks have contracted directly with CMS for a Section 646 Demonstration.
New Jersey	Dual eligibles may voluntarily enroll in the New Jersey FamilyCare program.
New Mexico	Dual eligibles must enroll in the managed long-term care program.
New York	Dual eligibles may voluntarily enroll in Medicaid Advantage, which offers a uniform Medicare Advantage Product and a supplemental Medicaid product that covers cost-sharing associated with Medicare Advantage, as well as inpatient mental health exceeding Medicare limits, limited non-Medicare-covered home care, non-emergency transportation, and dental care plan options.
Oregon	Dual eligibles may voluntarily enroll in OHP Plus.
Pennsylvania	Dual eligibles must enroll in behavioral health PHP. Dual eligibles are not enrolled in MCOs or the PCCM program on either a voluntary or a mandatory basis.
South Carolina	Dual eligibles may voluntarily participate in the Medical Home Network (PCCM).
Tennessee	Dual eligibles receiving Medicaid-reimbursed long-term care (LTC) services are enrolled in the CHOICES program. Enrollment is voluntary, but it is required in order to receive Medicaid-reimbursed LTC services; thus, in effect, it is mandatory. In addition, all Medicaid-eligible individuals (excluding PACE participants) are enrolled in a MCO for physical and behavioral health services. Two of the state's three MCOs also offer SNPs. At this time, TennCare has a Coordination Agreement with existing SNPs, primarily for purposes of data exchange.
Texas	STAR+PLUS is a Texas Medicaid program offered in four service areas that integrates the delivery of acute care services and community-based long-term services and supports to aged, blind, and disabled (ABD) Medicaid recipients through a managed care system. STAR+PLUS operates under one 1915(b) and two 1915(c) waivers allowing the state to provide home and community-based services for Supplemental Security Income (SSI) eligible and SSI-related Medicaid clients, and to mandate managed care for clients aged 21 years and older. (Enrollment in STAR+PLUS is voluntary for clients aged 20 and younger.)
Utah	Dual eligibles living in geographic areas where mandatory MCO enrollment is in place are required to enroll in a health plan.
Washington	Full dual eligibles (QMB-Plus and SLMB-Plus) may voluntarily enroll in the Washington Medicaid Integration Partnership (which operates in one county). Clients can opt-in or opt-out at any time.
Wisconsin	Dual eligibles may voluntarily enroll in SSI managed care plans.
Note: Not all states provided data on their enrollment of dual eligibles in Medicaid managed care.	

In many states, broader efforts focused on dual eligibles are expanding or getting underway. Twenty-one states reported on plans to expand or modify current programs or initiate new programs focused on dual eligibles, including 15 states that received funding under an ACA initiative, "*State Demonstrations to Integrate Care for Dual Eligible Individuals".* Under this initiative, administered by the new Medicare-Medicaid Coordination Office in CMS, 15 states received up to $1 million each to design new approaches to better coordinate care for dual eligibles and integrate Medicare and Medicaid financing. Although the 15 states will not necessarily proceed to implementation, the goal of the design contracts is to identify and validate delivery system and payment coordination models that could be tested and replicated in other states.

More recently, CMS issued guidance to state Medicaid programs in July 2011 on new opportunities to align Medicare and Medicaid financing that CMS would like to test for full dual eligibles in the 15 states participating in the design contracts, as well as in other interested states. This letter has generated new interest in dual eligible initiatives in additional states.[21] In addition, CMS is making available Medicare Part A, B, and D data for dual eligibles to support states' care coordination efforts.[22]

Twenty-one states reported that they have contracts with Medicare Advantage Special Needs Plans (SNP). Many Medicare beneficiaries receive their care in Medicare managed care plans known as Medicare Advantage plans. Special Needs Plans (SNP) are Medicare Advantage plans that are available to Medicare beneficiaries who are institutionalized, suffer from a severe or disabling chronic condition, or are dually eligible for both Medicare and Medicaid. Twenty-one states (of 45 responding) reported that they contract with a dual eligible SNP to provide coverage to this population. The ACA reauthorized SNPs through 2013 and extended through 2012 the current moratorium on geographic expansion by dual eligible SNPs that do not also have Medicaid contracts. Beginning in 2013, all dual eligible SNPs operating in a state must have contracts with the state Medicaid agency.

Table 14 summarizes state activity related to Medicaid managed care for dual eligibles and broader initiatives for dual eligibles.

Table 14: Medicaid Managed Care Activity for Dual Eligibles

State	Enrolls dual eligibles	CMS design grant for duals initiative	Contracts with Medicare SNPs	Dual eligible initiative under development
AL			x	
AR			x	
AZ	x		x	
CA	x	x		x
CO	x	x	x	x
CT		x		x
DC	x			
DE				x

continued

[21] CMS Letter to State Medicaid Directors, July 8, 2011. See https://www.cms.gov/smdl/downloads/financial_models_supporting_integrated_care_smd.pdf.

[22] CMS Medicare-Medicaid Coordination Office - Center for Medicaid, CHIP and Survey & Certification Informational Bulletin, Access to Medicare Data to Coordinate Care for Dual Eligible Beneficiaries, May 11, 2011.

Table 14 continued

State	Enrolls dual eligibles	CMS design grant for duals initiative	Contracts with Medicare SNPs	Dual eligible initiative under development
FL	x		x	x
GA	x		x	
HI	x			
IA	x			
ID	x		x	
KY	x			x
MA	x	x	x	x
ME				x
MI	x	x		x
MN	x	x	x	x
MO			x	
NC	x	x		x
NE			x	
NJ	x		x	
NM	x			
NY	x	x	x	x
OH			x	
OK		x	x	x
OR	x	x		x
PA	x			x
RI			x	
SC	x	x	x	x
TN	x	x		x
TX	x		x	x
UT	x		x	
VT		x		x
WA	x	x	x	x
WI	x	x	x	x
Total	**25**	**15**	**21**	**21**

Looking ahead: Medicaid managed care expansion and health reform

Key Section Findings:

- States expect to rely increasingly on managed care to serve Medicaid beneficiaries.
- Severe budget pressures remain a key challenge for states, and new demands associated with health reform also emerge as issues.
- While some states see barriers to Medicaid MCOs becoming Exchange plans, others expect MCOs to seize the Exchange as a market opportunity.
- Key health reform implications for Medicaid managed care are yet to come into focus in many states.

Under the ACA, beginning in 2014, Medicaid eligibility will expand to reach nearly all Americans under age 65 with income below 133 percent of the federal poverty level, and others up to 400 percent of the poverty level will be eligible for subsidies to purchase coverage offered through new health insurance Exchanges. An estimated 16 million additional people – mostly, uninsured adults – are expected to gain Medicaid coverage by 2019, and a similar number will gain coverage through the Exchanges. The health reform law envisions seamless transitions and coordination between coverage programs when people move from one to the other due to changes in their income or other circumstances.

Although it is widely expected that managed care will play a growing role in Medicaid under health reform, until this survey, there has been no systematic assessment of states' plans in this regard, or of the capacity of their MCOs to absorb new Medicaid enrollment. To gauge how prepared states are for the Medicaid expansion and the coordination challenges ahead, the survey asked states that contract with MCOs several questions about the future of Medicaid managed care under health reform.

States expect to rely more on managed care in the near term. Continued budget pressures and interest in improving service delivery and payment systems are fueling states' plans to expand the use of managed care in Medicaid. In all, 27 states (of 45 responding) indicated that they expect to rely on Medicaid managed care to a greater extent. Of these 27 states, six specified that they have plans to mandate managed care enrollment for additional Medicaid populations (California, Kentucky, Louisiana, Michigan, New Jersey, and South Carolina), and four reported that they have plans to expand managed care to additional geographic areas (Florida, Kentucky, Texas, and Virginia).

States see significant issues, challenges, and opportunities in the next couple of years. State budget strains and enrollment increases are both challenges that states cited frequently. The lingering effects of the recession – reduced tax revenues, high unemployment, and high demand for health and human services programs (Medicaid, in particular) – all continue to generate intense pressure on states already struggling to meet competing needs with limited resources.

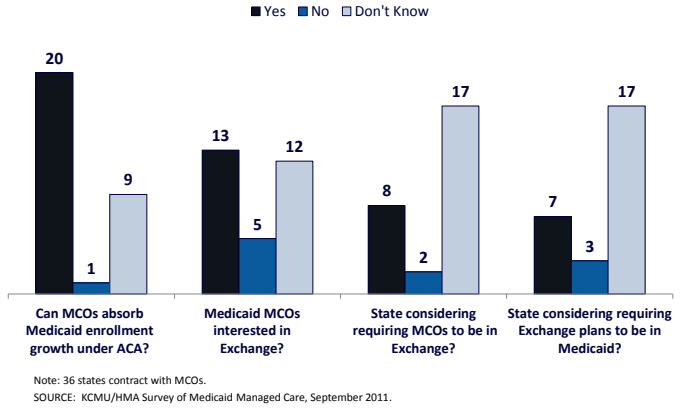
States also identified concerns about new demands on their capacity stemming from health reform, along with other issues. Increased Medicaid enrollment, adequacy of provider networks, Exchange development, and development of systems for claiming the proper federal matching rate were among the challenges states mentioned. States also cited a need for more flexibility to integrate care for dual eligibles. Individual states identified several other issues and pressures, including the need

for reliable encounter data, implementation of ICD-10, and state workload burden and administrative capacity.

While about half the states reported that their MCOs will be able to handle increased Medicaid enrollment under health reform, others were uncertain or did not respond. Of the 36 states with MCOs, 30 responded to a question about MCOs' capacity to accommodate increased Medicaid enrollment under the ACA. Of these 30 states, 20 said that they thought the MCOs serving Medicaid in their state had or could develop sufficient network capacity (Figure 9), while one state said its current MCOs could not. Nine states responded that they did not know whether or not their MCOs could develop the necessary capacity, and six states did not respond to this survey question.

Figure 9

Medicaid MCOs and Health Reform
(27-30 states responding)



Note: 36 states contract with MCOs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

Key health reform implications for Medicaid managed care are yet to come into focus in many states. Questions regarding the participation of MCOs in both Medicaid and the Exchange under health reform remain largely unanswered. Of the 36 states with MCOs, 30 responded to a question regarding Medicaid MCO interest in becoming Exchange plans. Of these states, 13 said that MCOs had expressed such an interest, five said they had not, and 12 states said they did not know. Medicaid officials were even more uncertain about whether their states might require one or more Medicaid MCOs to participate in the Exchange, or one or more Exchange plans to participate in Medicaid. A majority of the 27 states responding to this question said they did not know since these decisions were to be considered in the future in their state.

Several states identified barriers that might prevent or discourage Medicaid MCOs from becoming Exchange plans, but others were optimistic that MCOs could and would want to participate. While, again, there was substantial uncertainty among the states about MCOs' perspectives on participating in the Exchange, several states identified potential issues and barriers facing plans, including possible variance between Medicaid and Exchange regulatory requirements, separate rate-setting and underwriting issues for exchange plans, the challenge of building provider networks appropriate to serve both non-Medicaid and Medicaid enrollees efficiently and effectively, different rules for marketing and collection of premiums, and higher capital reserves needed before they could expand. Other states saw participation in the Exchange as doable for some plans or as a market opportunity that no plan would want to miss.

Conclusion

For over 30 years, state Medicaid programs have relied increasingly on managed care. The number and type of managed care arrangements used by states to deliver and finance care for Medicaid enrollees, as well as the number and share of Medicaid beneficiaries enrolled in these arrangements, have grown steadily. Growth in Medicaid managed care is expected to continue, driven by budget pressures to contain Medicaid spending and by the influx of millions of new adult Medicaid enrollees when the ACA takes full effect in 2014. As individual states look for new ways to improve health care quality, improve access, and achiever greater value for state dollars, there is much to be learned from the wide and evolving variety of Medicaid managed care program designs and experiences that can be found across the country.

This survey documents the diversity in current state Medicaid managed care approaches and activity, and state policymakers' perspectives on the value of managed care as a strategy to improve access, quality, and accountability, and to promote cost-effective care and better health outcomes. As such, it provides a baseline against which to measure and monitor what are likely to be important developments and trends in the coming years.

An assessment of the impact of Medicaid managed care was beyond the scope of this project, which surveyed state policy officials alone and gathered largely descriptive information. Robust evaluations of Medicaid managed care will require extensive analyses that include investigations of beneficiary and provider experiences and perspectives, as well. Particularly as states expand managed care to Medicaid beneficiaries with more complex needs, and as they determine the delivery systems that will serve millions more low-income Americans in the future, evaluative research is crucial, as are federal and state efforts to assess performance, to develop mechanisms to identify and resolve problems in meeting beneficiaries' needs, and to assure high quality care for all those served by Medicaid through managed care.

APPENDIX 1: Medicaid Managed Care Models in Operation, by State, October 2010

State	MCO	PCCM	PHP	No Managed Care
AK				X
AL		X	X	
AR		X		
AZ	X		X	
CA	X		X	
CO	X	X	X	
CT	X	X		
DC	X		X	
DE	X			
FL	X	X	X	
GA	X	X	X	
HI	X			
IA		X	X	
ID		X	X	
IL	X	X		
IN	X	X		
KS	X	X	X	
KY	X	X		
LA		X		
MA	X	X	X	
MD	X		X	
ME		X		
MI	X		X	
MN	X			
MO	X			
MS	X		X	
MT		X		
NC		X	X	
ND		X	X	
NE	X			
NH				X
NJ	X			
NM	X		X	
NV	X			
NY	X	X		
OH	X			
OK		X		
OR	X	X	X	
PA	X	X	X	
RI	X	X	X	
SC	X	X		
SD		X		
TN	X		X	
TX	X	X	X	
UT	X	X	X	
VA	X	X		
VT		X		
WA	X	X	X	
WI	X		X	
WV	X	X		
WY				X
Total	**36**	**31**	**25**	**3**

APPENDIX 2: Summary of Medicaid Managed Care Programs, by State

State	Program Name (e.g., Popular Name, 1915(b) or 1115 Waiver Name)	Statewide	Model			Eligibility Groups Enrolled										
			MCO	PCCM	PHP	SSI Children	Foster Children	Medicaid Expansion CHIP	All Other Children	Pregnant Women	Parents/ Caretakers	Non-Dual Aged	Non-Dual Blind/ Disabled	Childless Adults	Dual Eligibles	Other
AL	1915 (b) Patient First (PCCM)			X		X			X		X	X	X			
	1915 (b) Maternity Care Program				X					X						
AR	Connect Care -1115 (b) Waiver			X		X	X		X	X			X			
	TEFRA -1115 (a) Waiver	X		X		X										
	ARKids-1115(b) Waiver	X		X			X									
AZ	Arizona Health Care Cost Containment System (ACCESS)	X	X		X	X	X	X	X	X	X	X	X	X	X	X
CA	County Operated Heath System plans (1115)		X			X	X		X	X	X	X	X	X	X	
	2-plan & Geographic Managed Care plans (1115)		X			X	X		X	X	X	X	X	X	X	
	Senior Care Action Network (SCAN) (1115)		X												X	
	Family Mosaic (1115) (PIHP)				X	X	X									X
	Kaiser PHP (1115)		X		X	X	X		X	X	X	X	X	X	X	
CO	Denver Health		X			X	X		X	X	X	X	X		X	
	Primary Care Physician Program (PCPP)	X		X												
	Colorado Regional Integrated Care Collaborative			X		X	X		X	X	X	X	X	X	X	
	Rocky Mountain				X	X	X		X	X		X	X		X	
CT	Connecticut Healthcare for Uninsured Kids and Youth (HUSKY)	X	X	X		X	X		X	X	X					
DC	1915(b)	X	X		X	X		X	X	X	X			X		
DE[1]	Diamond State Health Plan	X	X	X		X	X	X	X	X			X	X		
FL[2]	Health Maintenance Organization		X			X	X	X		X	X	X	X		X	
	MediPass	X		X		X	X	X		X	X	X	X			
	Children's Medical Service Network	X		X		X	X	X					X			
	Provider Service Networks				X	X	X	X	X		X	X	X		X	
	Prepaid Mental Health Plan				X	X	X	X	X	X	X	X	X			
	Child Welfare Prepaid Mental Health Plan	X			X	X	X	X								X
	Prepaid Dental Health Plan				X	X	X	X	X				X			
	Disease Management	X			X	X	X	X		X		X	X		X	
	Nursing Home Diversion	X			X										X	X
GA	Georgia Families	X	X						X	X	X					X
	Georgia Better Health Care	X		X		X			X			X	X			
	Service Options Using Resources in Community Environment (SOURCE)	X		X								X	X		X	
	Non-Emergency Transportation	X			X	X	X		X	X	X	X	X		X	X
HI	1115 Waiver	X	X			X	X	X	X	X	X	X	X	X	X	
IA	MediPASS	X		X			X	X	X	X	X		X	X	X	
	Iowa Plan for Behavioral Health	X			X	X	X	X	X	X	X	X	X	X	X	
	Healthy Connections	X		X		X	X	X	X	X	X	X	X		X	

State	Program Name (e.g., Popular Name, 1915(b) or 1115 Waiver Name)	Statewide	Model			Eligibility Groups Enrolled										
			MCO	PCCM	PHP	SSI Children	Foster Children	Medicaid Expansion CHIP	All Other Children	Pregnant Women	Parents/ Caretakers	Non-Dual Aged	Non-Dual Blind/ Disabled	Childless Adults	Dual Eligibles	Other
ID[3]	Idaho Smiles				X	X	X	X	X	X	X	X	X	X		
	Medicare Medicaid Coordinated Plan				X										X	
IL[4]	Voluntary Managed Care		X					X	X	X	X					
	Illinois Health Connect	X		X				X	X	X	X	X	X			
IN[5]	Hoosier Healthwise	X	X					X	X	X	X					
	Healthy Indiana Plan	X	X								X			X		
	Care Select	X		X		X	X					X	X			X
KS	HealthWave, T19 and T21	X	X			X	X		X	X	X					
	HealthConnect Kansas			X		X	X		X	X	X					
	Cenpatico Behavioral Health	X	X							X						X
	Value Options	X			X						X					X
	Kansas Health Solutions				X	X	X		X	X						X
KY	KY Health Care Partnership		X			X	X	X	X	X	X	X	X		X	
	Kentucky Patient Access and Care (KenPAC)	X		X				X	X	X	X	X	X			
LA	CommunityCARE	X		X				X	X		X		X			
MA[6]	Mass Health 1115	X	X	X	X	X	X	X	X	X	X		X	X	X	
MD	HealthChoice Program	X	X			X	X	X	X	X	X		X			
	Primary Adult Care Program				X									X		
ME	Maine PrimeCare	X		X		X	X	X	X	X	X	X	X	X		X
MI	1915(b) Comprehensive Health Plan Program.	X	X			X	X	X	X	X	X	X	X			
	Michigan Managed Specialty Supports and Services	X			X	X	X	X	X	X	X	X	X		X	
	1915(b)(4) Health Kids Dental Waiver				X	X	X	X	X							
	1115 Adult Benefits Waiver	X			X								X	X		
MN[7]	Prepaid Medical Assistance Program (PMAP) Prepaid MinnesotaCare	X	X				X	X		X	X			X		
	Minnesota Senior Care Plus (MSC+)	X	X									X			X	
	Minnesota Senior Health Options (MSHO)														X	
	Minnesota Disability Health Options (MnDHO)	X				X							X		X	
	Special Needs Basic Care	X	X			X							X		X	
MO[8]	MO HealthNet Managed Care		X			X	X	X	X	X	X					X
MS	MississippiCAN	X	X			X	X						X			X
	Transportation PAHP	X			X	X	X		X	X	X	X	X			
MT	Passport to Health PCCM	X		X		X		X	X	X	X	X	X			
	Health Improvement Program EPCCM	X		X		X		X	X	X	X	X	X			
NC	Carolina Access	X		X		X	X	X	X	X	X	X	X		X	
	Community Care of North Carolina (Access II/III)	X		X		X	X	X	X	X	X	X	X		X	
	MH/DD/SAS Health Plan Waiver				X	X	X	X	X	X	X	X	X		X	

State	Program Name (e.g., Popular Name, 1915(b) or 1115 Waiver Name)	Statewide	Model			Eligibility Groups Enrolled										
			MCO	PCCM	PHP	SSI Children	Foster Children	Medicaid Expansion CHIP	All Other Children	Pregnant Women	Parents/ Caretakers	Non-Dual Aged	Non-Dual Blind/ Disabled	Childless Adults	Dual Eligibles	Other
ND	Primary Care Case Management Program	X		X					X	X	X					
	Experience HealthND Disease Mng.	X			X			X	X	X	X					
NE[9]	Nebraska Health Connection		X			X	X	X	X	X	X	X	X			
	Medical Home Pilot			X		X	X	X	X	X	X	X	X		X	
NJ[10]	NJ FamilyCare	X	X			X	X	X	X	X	X	X	X	X	X	X
NM	Salud	X	X		X	X	X	X	X	X	X	X				
	State Coverage Insurance (SCI)	X	X											X		
	Coordination of Long Term Services (CoLTS)	X	X										X		X	
NV	Nevada Managed Care Program		X					X	X	X	X			X		
NY	1115 Partnership Plan	X	X	X					X	X	X			X		
	1115 Federal State Health Reform Partnership (F-SHRP)	X	X	X		X			X	X	X	X	X	X		
	Family Health Plus	X	X													X
OH	Ohio's Full Risk Medicaid Managed Care Program	X	X			X	X	X	X	X	X	X	X			
OK[11]	SoonerCare Choice (1115)	X		X		X		X	X	X	X		X			X
OR	Oregon Health Program (OHP) Plus		X	X	X	X	X	X	X	X	X	X	X		X	
	Oregon Health Program Standard		X	X	X						X			X		
PA[12]	HealthChoices (PH)		X			X	X		X	X	X	X	X	X		
	HealthChoices (BH)	X			X	X	X		X	X	X	X	X	X	X	
	ACCESS Plus			X		X	X		X	X	X	X	X	X		
RI[13]	RIte Care	X	X			X	X	X	X	X	X					
	Rhody Health Partners	X	X									X	X			
	RIte Smiles	X			X	X	X		X							
	Connect Care Choice	X		X								X	X			
	RIte Share	X						X	X	X	X					
SC	Medicaid HMO Program	X	X			X	X		X	X			X			
	Medical Homes Network	X		X		X	X		X	X		X	X		X	
SD	Provider and Recipient in Medicaid Efficiency (PRIME)	X		X		X		X	X	X	X	X	X			
TN[14]	TennCare	X	X		X	X	X	X	X	X	X	X	X	X	X	X
TX[15]	Texas Medicaid Wellness Program				X	X			X				X			
	STAR+PLUS 1915(b)		X			X						X	X		X	
	1915(c) STAR+PLUS Waiver SSI		X									X	X		X	
	1915 (c) STAR+PLUS Waiver MAO		X									X	X		X	
	STARHealth	X	X				X									X
	State of Texas Access Reform (STAR) 1915(b)		X			X			X	X	X		X			X
	1915(b) Waiver (PCCM)			X		X		X	X	X	X	X		X		
UT	Select Access			X		X	X		X	X	X	X	X		X	
	Healthy U				X	X	X		X	X	X	X	X		X	
	Molina		X			X	X		X	X	X	X	X		X	
	Prepaid Mental Health Plan				X	X	X		X	X	X	X	X		X	

State	Program Name (e.g., Popular Name, 1915(b) or 1115 Waiver Name)	Statewide	Model			Eligibility Groups Enrolled										
			MCO	PCCM	PHP	SSI Children	Foster Children	Medicaid Expansion CHIP	All Other Children	Pregnant Women	Parents/ Caretakers	Non-Dual Aged	Non-Dual Blind/ Disabled	Childless Adults	Dual Eligibles	Other
VA	Medallion II		X	X		X		X	X	X	X	X	X			
	MEDALLION			X		X		X	X	X	X	X	X			
VT	Global Commitment: 1115	X		X		X	X		X	X	X	X	X	X		
WA	Healthy Options	X	X	X				X		X						
	Washington Medicaid Integration Partnership (WMIP)		X							X	X	X	X		X	
	Disability Lifeline	X	X										X			X
	King County Care Partners				X										X	
	Cowlitz County				X										X	
	Regional Support Networks	X			X	X	X	X	X	X		X	X			X
WI	1115 BadgerCare Plus	X	X						X	X	X			X	X	
	1915(a) Children Come First	X			X	X	X		X							
	Family Care		X									X	X		X	
	Family Care Partnership		X									X	X		X	
WV[16]	Mountain Health Trust/1915(b)	X	X	X						X	X					X
	Mountain Health Choices/Benchmark	X	X						X		X					X

Appendix 2 Notes

[1]**Delaware:** Maintains a small "enhanced FFS" managed care program (reflected as PCCM in the table above but not otherwise counted as a PCCM program in this report) that was created to maintain client choice when the state had only one MCO. Per approval of CMS, enrollment may be limited.

[2]**Florida:** MediPass: Adoption Subsidy children may also enroll. Women who are enrolled in Medicaid only due to pregnancy are excluded from MediPass. Prepaid Mental Health Plans: In all areas of the state except Baker, Broward, Clay, Duval, and Nassau counties (where 1115 Waiver operates). Medicaid managed care eligibles that voluntary select MediPass for their health care services are automatically enrolled in the prepaid mental health for their behavioral health services. Child Welfare Prepaid Mental Health Plans (CWPHPs): Foster care children mandatory enrolled. CWPHPs provide behavioral health services and operate statewide (except for Area 1, and Polk, Manatee, Hardee, and Highlands Counties only). Nursing Home Diversion: Includes elderly age 65 or older and disabled adults 55 or older. Plan members must: (1) live in county offering program services, (2) be age 65 or older, (3) be eligible for Medicare Part A and B and the Medicaid Institutional Care Program (ICP), (4) meet additional impairment criteria beyond nursing home level of care requirements, and (5) not be enrolled with the PACE program or any other Medicaid managed care program.

[3]**Idaho:** Idaho Smiles does not cover dual eligibles age 65 and over. Coordinated Care Plans cover Medicare Advantage dual eligibles.

[4]**Illinois**: During FY 2011, Illinois will implement a new Integrated Care Program (MCO) to serve approximately 40,000 seniors and adults with disabilities residing in Lake, Kane, DuPage, Will, Kankakee, and suburban Cook Counties.

[5]**Indiana**: On October 1, 2010, Care Select changed from a mandatory enhanced PCCM program to a voluntary disease management PCCM program for the populations checked above. However, the member must also have at least one of a specified list of disease conditions to be enrolled.

[6]**Massachusetts**: Dual eligibles are excluded from 1115 managed care enrollment. However, dual eligible children must enroll with the Massachusetts Behavioral Health Partnership.

[7]**Minnesota**: MNDHO contract terminated on December 31, 2010. In Special Needs Basic Care (SNBC), SSI children are 18 -21. SNBC no longer statewide effective January 1, 2011.

[8]**Missouri**: "Other" includes Refugees and children in a separate CHIP program.

[9]**Nebraska**: In February 2011, the state announced the implementation of a two-year patient centered medical home pilot in two medical practices utilizing a PCCM model that is included in the table above but not otherwise counted as s PCCM program in this report.

[10]**New Jersey**: "Other" is General Assistance, a state-only population.

[11]**Oklahoma:** Also includes TEFRA and women under treatment for breast or cervical cancer.

[12]**Pennsylvania:** For dual eligibles age 21 and older are not enrolled in Health Choices (PH) or ACCESS Plus.

[13]**Rhode Island:** RIte Share is the state's employer sponsored insurance program.

[14]**Tennessee:** TennCare includes one Prepaid Inpatient Health Plan (TennCare Select) and two Prepaid Ambulatory Health Plans (a DBM and a PBM). Persons in any of the populations named may be served in TennCare Select, depending upon their circumstances. The DBM serves only children under 21. The PBM serves all enrollees except dual eligibles.

[15]**Texas:** STAR: limited income families, pregnant women, children, SSI/SSI-related recipients without Medicare. STAR+PLUS: aged. blind, disabled SSI recipients. STAR: Federally recognized tribes. Exception: If any of the above are in waiver programs i.e. 1915 ⌐ they are excluded from PCCM.

[16]**West Virginia:** PCCM only applies when state is primary.

APPENDIX 3: MCO Contracts, Plan Characteristics, and Enrollment, by State

State (No. of contracts)	Name	Enrollment Composition*	Not-for-Profit or For-Profit	Publicly Traded	National or Local	Enrollment as of October 2010
AZ (19)	Arizona Physicians IPA, Inc. (United)	Mixed	For-Profit	X	National	249,236
	Bridgeway Health Solutions (Centene)	Mixed	For-Profit	X	National	17,588
	Care 1st Health Pl an	Mixed	For-Profit		National	50,343
	Comprehensive Medical & Dental (CMDP)	Medicaid only	Not-for-Profit		Local	9,616
	Health Choice Arizona	Mixed	For-Profit	X	National	194,095
	Mercy Care Plan-Acute	Mixed	Not-for-Profit		Local	304,422
	Phoenix Health Plan	Mixed	For-Profit	X	National	195,250
	Pima Health Plan	Medicaid only	Not-for-Profit		Local	1,803
	University Family Care	Mixed	Not-for-Profit		Local	71,105
	Maricopa Health Plan	Medicaid only	Not-for-Profit		Local	53,041
	Bridgeway Health Solutions (Centene)	Mixed	For-Profit	X	National	2,991
	Division of Developmental Disabilities	Medicaid only	Not-for-Profit		Local	22,908
	Cochise Health Systems	Medicaid only	Not-for-Profit		Local	881
	Evercare Select	Mixed	For-Profit	X	National	3,093
	Mercy Care Plan-ALTCS	Mixed	Not-for-Profit		Local	8,596
	Pima Health System	Medicaid only	Not-for-Profit		Local	4,353
	Pinal/Gila County LTC	Medicaid only	Not-for-Profit		Local	1,476
	Scan LTC	Mixed	Not-for-Profit		National	2,921
	Yavapai County LTC	Medicaid only	Not-for-Profit		Local	995
CA (42)	Alameda Alliance for Health	Medicaid only	Not-for-Profit		Local	101,109
	Anthem Blue Cross - Alameda	Mixed	For-Profit	X	National	28,381
	Contra Costa Health Plan	Medicaid only	Not-for-Profit		Local	61,357
	Anthem Blue Cross - Contra Costa	Mixed	For-Profit	X	National	11,576
	Health Net - Fresno	Mixed	For-Profit	X	Local	117,761
	Anthem Blue Cross - Fresno	Mixed	For-Profit	X	National	87,260
	Kern Health Systems	Medicaid only	Not-for-Profit		Local	107,566
	Health Net - Kern	Mixed	For-Profit	X	National	32,471
	LA Care	Medicaid only	Not-for-Profit		Local	846,303
	Health Net - LA	Mixed	For-Profit	X	National	441,359
	Inland Empire Health Plan - Riverside	Medicaid only	Not-for-Profit		Local	187,889
	Molina Health Care - Riverside	Mixed	For-Profit	X	National	40,969
	Inland Empire Health Plan - San Bernardino	Medicaid only	Not-for-Profit		Local	213,974
	Molina Health Care - San Bernardino	Mixed	For-Profit	X	National	57,317
	San Francisco Health Plan	Medicaid only	Not-for-Profit		Local	39,445
	Anthem Blue Cross - San Francisco	Mixed	For-Profit	X	National	11,756
	Health Plan of San Joaquin	Medicaid only	Not-for-Profit		Local	77,037
	Anthem Blue Cross - San Joaquin	Mixed	For-Profit	X	National	27,125
	Santa Clara Family Health	Medicaid only	Not-for-Profit		Local	102,146
	Anthem Blue Cross - Santa Clara	Mixed	For-Profit	X	National	33,875
	Anthem Blue Cross - Stanislaus	Mixed	For-Profit	X	National	50,001
	Health Net - Stanislaus	Mixed	For-Profit	X	National	23,015
	Anthem Blue Cross - Tulare	Mixed	For-Profit	X	National	75,585
	Health Net - Tulare	Mixed	For-Profit	X	National	31,158
	Partnership Health Plan of CA	Medicaid only	Not-for-Profit		Local	155,717
	Central California Alliance for Health	Medicaid only	Not-for-Profit		Local	179,588
	CenCal	Medicaid only	Not-for-Profit		Local	92,285
	CalOptima	Medicaid only	Not-for-Profit		Local	366,605
	Health Plan of San Mateo	Medicaid only	Not-for-Profit		Local	59,712
	Family Mosaic - San Francisco	Medicaid only	Not-for-Profit		Local	104
	Anthem Blue Cross - Sac	Mixed	For Profit	X	National	91,820
	Health Net - Sacramento	Mixed	For Profit	X	National	51,588
	Kaiser Foundation - Sac	Mixed	Not-for-Profit		National	27,058
	Molina Healthcare - Sac	Mixed	For Profit	X	National	28,045
	Care 1st Health Plan - SD	Mixed	For Profit		National	14,855
	Community Health Group - SD	Mixed	Not-for-Profit		Local	101,178
	Health Net – San Diego	Mixed	For Profit	X	National	31,373
	Kaiser – San Diego	Mixed	Not-for-Profit		National	13,521
	Molina Healthcare – San Diego	Mixed	For Profit	X	National	61,058
	KP Cal - Marin	Mixed	Not-for-Profit		National	933
	AIDS Healthcare Foundation - LA	Medicaid only	Not-for-Profit		National	778
	Senior Care Action Network	Mixed	Not-for-Profit		Local	2,500

State (No. of contracts)	Name	Enrollment Composition*	Not-for-Profit or For-Profit	Publicly Traded	National or Local	Enrollment as of October 2010
CO (1)	Denver Health	Mixed	Not-for-Profit		Local	43,432
CT	Aetna Better Health	Mixed	For-Profit	X	National	92,815
(3)	AmeriChoice by United Healthcare	Mixed	For-Profit	X	National	49,065
(as of 2/2011)	Community Health Network of CT	Medicaid only	Not-for-Profit		Local	249,498
DC	Chartered Health Plan	Medicaid only	For-Profit		Local	114,036
(2)	UnitedHealthCare Community Plan (Unison)	Medicaid only	For-Profit		Local	54,670
DE	Delaware Physicians Care (Aetna)	Mixed	For-Profit	X	National	98,636
(2)	Unison (now United HealthCare Community Plan)	Mixed	For-Profit	X	National	51,422
FL	Amerigroup	Mixed	For-Profit	X	Local	172,376
(24)	Coventry dba Buena Vista	Mixed	For-Profit	X	Local	22,666
	Coventry dba Vista	Mixed	For-Profit	X	Local	20,912
	Citrus	Mixed	For-Profit	X	Local	55,351
	Freedom	Mixed	For-Profit		Local	16,578
	HealthEase	Medicaid only	For-Profit	X	Local	157,079
	Personal Health Plan dba Healthy Palm Beaches	Medicaid only	For-Profit		Local	11,350
	Humana	Mixed	For-Profit	X	Local	51,468
	JMH Health Plan	Medicaid only	For-Profit		Local	15,176
	Medica	Mixed	For-Profit		Local	4,361
	Molina	Medicaid-only	For-Profit	X	Local	58,456
	AHF MCO dba Positive Healthcare	Medicaid only	Not-for-Profit		Local	58
	Preferred Medical Plan	Mixed	For-Profit		Local	15,960
	Simply Health Care	Medicaid only	For-Profit		Local	4,340
	Staywell	Medicaid only	For-Profit	X	Local	190,266
	Sunshine State Health Plan	Medicaid only	For-Profit	X	Local	116,201
	United	Mixed	For-Profit	X	Local	109,832
	Universal	Mixed	For-Profit		Local	54,137
	Better Health	Medicaid only	For-Profit		Local	31,375
	DOH Children's Medical Services	Medicaid only	Not-for-Profit		Local	6,805
	Shands Jax dba First Coast Advantage	Medicaid only	Not-for-Profit		Local	45,645
	South Florida Community Care Network	Medicaid only	Not-for-Profit		Local	40,297
	Integral	Medicaid only	Not-for-Profit	X	Local	10,065
	Prestige	Medicaid only	For-Profit		Local	46,672
GA	Amerigroup Georgia Managed Care Organization, Inc.	Medicaid only	For-Profit	X	National	266,942
(3)	Peach State Health Plan, Inc. (Centene)	Medicaid only	For-Profit	X	National	302,497
	WellCare of Georgia, Inc.	Medicaid only	For-Profit	X	National	555,225
HI	AlohaCare	Medicaid only	Not-for-Profit		Local	75,752
(5)	Hawaii Medical Service Association (HMSA)	Mixed	Not-for-Profit		Local	114,034
	Kaiser Permanente Hawaii	Mixed	Not-for-Profit		National	25,416
	Evercare (United)	Mixed	For-Profit	X	National	19,625
	Ohana Health Plan (WellCare)	Mixed	For-Profit	X	National	22,229
IL	Harmony Health Plan (WellCare)	Medicaid only	For-Profit	X	National	141,082
(3)	Meridian Health Plan	Medicaid only	For-Profit		Local	1,201
	Family Health Network	Medicaid only	Not-for-Profit		Local	52,749
IN	Anthem - Hoosier Healthwise	Mixed	For-Profit	X	National	171,572
(5)	Anthem - Healthy Indiana Plan	Mixed	For-Profit	X	National	29,190
	MDwise - Hoosier Healthwise	Medicaid only	Not-for-Profit		Local	292,331
	MDwise - Healthy Indiana Plan	Medicaid only	Not-for-Profit		Local	13,451
	Managed Health Services - Hoosier Healthwise (Centene)	Medicaid only	For-Profit	X	National	217,733
KS	Children's Mercy Family Health Partners	Medicaid only	Not-for-Profit		Local	(blank)
(2)	UniCare - Wellpoint	Medicaid only	For-Profit	X	National	(blank)
KY (1)	University Health Care, Inc. (d/b/a/ Passport Health Care Plan	Mixed	Not-for-Profit		National	168,638
MA	Boston Medical Center HealthNet Plan	Medicaid only	Not-for-Profit		Local	193,793
(9)	Fallon Community Health Plan	Mixed	Not-for-Profit		Local	13,190
	Neighborhood Health Plan	Mixed	Not-for-Profit		Local	144,975
	Network Health	Medicaid only	Not-for-Profit		Local	123,854
	Health New England	Mixed	Not-for-Profit		Local	5,049
	Commonwealth Care Alliance	Mixed	Not-for-Profit		Local	2,833
	EverCare	Mixed	For-Profit	X	National	5,131
	NaviCare	Mixed	Not-for-Profit		Local	549
	Senior Whole Health	Mixed	For-Profit		Local	6,778

State (No. of contracts)	Name	Enrollment Composition*	Not-for-Profit or For-Profit	Publicly Traded	National or Local	Enrollment as of October 2010
MD	Amerigroup Community Care	Medicaid only	For-Profit	X	National	194,496
(7)	Diamond Plan from Coventry Health Care	Mixed	For-Profit	X	National	11,244
	Jai Medical Systems	Medicaid only	For-Profit		Local	13,070
	Medstar Family Choice	Medicaid only	For-Profit		Local	27,470
	Maryland Physicians Care	Medicaid only	For-Profit		Local	130,507
	Priority Partners	Medicaid only	For-Profit		Local	183,400
	UnitedHealthcare	Mixed	For-Profit	X	National	125,233
MI	BlueCaid of Michigan	Mixed	Not-for-Profit		Local	20,363
(14)	CareSource of Michigan	Medicaid only	Not-for-Profit		Local	37,477
	Health Plan of Michigan	Medicaid only	For-Profit		Local	272,099
	HealthPlus Partners, Inc.	Medicaid only	Not-for-Profit		Local	70,330
	McLaren Health Plan	Mixed	Not-for-Profit		Local	78,550
	Midwest Health Plan	Medicaid only	For-Profit		Local	69,888
	Molina Healthcare of Michigan	Medicaid only	For-Profit	X	National	218,123
	OmniCare Health Plan, Inc. (Coventry)	Mixed	For-Profit	X	National	51,351
	PHP-MM Family Care	Medicaid only	Not-for-Profit		Local	18,400
	Priority Health Government Programs, Inc.	Medicaid only	Not-for-Profit		Local	61,541
	ProCare Health Plan, Inc.	Medicaid only	For-Profit		Local	1,687
	Total Health Care	Medicaid only	Not-for-Profit		Local	52,482
	United Healthcare of the Great Lakes Health Plan, Inc.	Mixed	For-Profit	X	National	229,732
	Upper Peninsula Health Plan	Medicaid only	Not-for-Profit		Local	29,269
MN	Blue Plus	Mixed	Not-for-Profit		Local	112,423
(8)	HealthPartners	Mixed	Not-for-Profit		Local	51,500
	Medica	Mixed	Not-for-Profit		Local	133,838
	IMCare	Medicaid only	Not-for-Profit		Local	5,158
	Metropolitan Health Care	Medicaid only	Not-for-Profit		Local	15,633
	PrimeWest Health	Medicaid only	Not-for-Profit		Local	19,651
	South Country Alliance	Medicaid only	Not-for-Profit		Local	30,062
	UCare Minnesota	Mixed	Not-for-Profit		Local	104,095
MO	Blue Advantage Plus of Kansas City	Mixed	For-Profit		Local	30,782
(6)	Children's Mercy Family Health Partners	Medicaid only	Not-for-Profit		Local	55,704
	Harmony Health Plan of Missouri (WellCare)	Medicaid only	For-Profit	X	National	16,304
	HealthCare USA (Coventry)	Medicaid only	For-Profit	X	National	195,253
	Missouri Care Health Plan (Aetna)	Mixed	For-Profit	X	National	97,372
	Molina Healthcare of Missouri	Mixed	For-Profit	X	National	31,645
MS	Magnolia Health Plan (Centene)	Medicaid only	For-Profit	X	National	0
(2)	United Healthcare	Mixed	For-Profit	X	National	0
NE	Coventry Nebraska	Mixed	For-Profit	X	National	
(2)	Share Advantage (United)	Mixed	For-Profit	X	National	
NJ	Amerigroup NJ	Medicaid only	For-Profit	X	National	133,574
(4)	Healthfirst NJ	Medicaid only	Not-for-Profit		National	21,363
	Horizon NJ Health	Mixed	Not-for-Profit		Local	467,463
	AmeriChoice of NJ	Mixed	For-Profit	X	National	351,722
NM	Presbyterian health plan	Mixed	Not-for-Profit		Local	157,400
(4)	Lovelace Health Plan	Mixed	For-Profit		National	82,000
	Molina Health Plan	Medicaid only	For-Profit	X	National	73,400
	Blue Cross Blue Shield	Mixed	Not-for-Profit		National	22,150
NV	Amerigroup	Medicaid only	For-Profit	X	National	75,913
(2)	Health Plan of Nevada (United Health)	Mixed	For-Profit	X	National	95,453
NY	Affinity Health Plan	Medicaid only	Not-for-Profit		Local	238,607
(30)	Amerigroup	Medicaid only	For-Profit	X	National	99,286
	Amida Care SN	Medicaid only	Not-for-Profit		Local	2,081
	Capital District Physicians Health Plan	Mixed	Not-for-Profit		Local	61,757
	Excellus Health Plan	Mixed	Not-for-Profit		Local	124,398
	GHI	Medicaid only	For-Profit		National	4,103
	Health Insurance Plan of Greater New York	Mixed	Not-for-Profit		National	250,141
	HealthFirst PHSP	Medicaid only	Not-for-Profit		Local	435,083
	HealthNow/BCBS-WNY/Community Blue	Mixed	Not-for-Profit		Local	41,088
	HealthPlus	Medicaid only	Not-for-Profit		Local	278,309
	Hudson Health Plan	Medicaid only	Not-for-Profit		Local	79,731
	Independent Health Association	Mixed	Not-for-Profit		Local	37,521
	MetroPlus Health Plan	Medicaid only	Not-for-Profit		Local	372,796
	MetroPlus Health Plan SN	Medicaid only	Not-for-Profit		Local	3,894

State (No. of contracts)	Name	Enrollment Composition*	Not-for-Profit or For-Profit	Publicly Traded	National or Local	Enrollment as of October 2010
NY cont.	MVP Health Plan	Mixed	Not-for-Profit		Local	35,024
	Neighborhood Health Providers	Medicaid only	Not-for-Profit		Local	193,480
	NYPS Select Health SN	Medicaid only	Not-for-Profit		Local	1,988
	NYS Catholic Health Plan	Medicaid only	Not-for-Profit		Local	543,726
	NYS Catholic Health Plan 1199	Medicaid only	Not-for-Profit		Local	3,662
	SCHC Total Care	Medicaid only	Not-for-Profit		Local	37,826
	United Healthcare Plan of NY	Mixed	For-Profit	X	National	243,034
	Univera Community Health	Medicaid only	Not-for-Profit		Local	39,115
	WellCare Of New York	Medicaid only	For-Profit	X	National	75,234
	VNS Choice	Medicaid only	Not-for-Profit		Local	8,487
	GuildNet	Medicaid only	Not-for-Profit		Local	6,295
	HomeFirst	Medicaid only	Not-for-Profit		Local	3,597
	Comprehensive Care Management	Medicaid only	Not-for-Profit		Local	2,537
	Senior Health Partners Inc	Medicaid only	Not-for-Profit		Local	2,393
	CCM Select	Medicaid only	Not-for-Profit		Local	1,764
	Independence Care Systems	Medicaid only	Not-for-Profit		Local	1,578
OH	Buckeye Community Health Plan (Centene)	Medicaid only	For-Profit		National	159,607
(7)	CareSource	Medicaid only	Not-for-Profit		National	812,503
	Molina Healthcare of Ohio	Medicaid only	For-Profit	X	National	241,153
	Paramount Advantage	Medicaid only	For-Profit		Local	88,559
	Unison Health Plan of Ohio	Mixed	For-Profit	X	National	122,351
	WellCare of Ohio	Medicaid only	For-Profit	X	National	102,014
	Amerigroup Community Care	Medicaid only	For-Profit	X	National	56,453
OR	Care Oregon	Medicaid-only	Not-for-Profit		Local	135113
(15)	Cascade Comprehensive	Medicaid-only	For-Profit		Local	9021
	Central Oregon Individual Health Solutions	Mixed	Not-for-Profit		National	31918
	Doctors of the Oregon Coast South	Medicaid-only	For-Profit		Local	10511
	DCIPA	Medicaid-only	For-Profit		Local	14518
	Family Care	Medicaid-only	For-Profit		Local	45508
	Inter Community Health Network	Mixed	Not-for-Profit		Local	26139
	Kaiser Permanente Oregon Plus	Mixed	Not-for-Profit		National	11651
	Lane IPA	Medicaid	For-Profit		Local	41899
	Marion/Polk Community Health Plan	Medicaid	For-Profit		Local	53683
	Mid Rogue IPA	Medicaid	For-Profit		Local	18970
	ODS Community Health	Medicaid	For-Profit		Local	9930
	Oregon Health Management Services	Medicaid	For-Profit		Local	4996
	Providence Health Plan	Mixed	Not-for-Profit		National	20858
	Tuality Health	Mixed	Not-for-Profit		Local	9658
PA	Aetna Better Health	Mixed	For-Profit	X	National	31,144
(9)	AmeriChoice of Pennsylvania	Mixed	For-Profit	X	National	76,900
	AmeriHealth Mercy Health Plan (AMHP)	Medicaid only	Not-for-Profit		National	107,067
	Coventry Cares	Mixed	For-Profit	X	National	9,249
	Gateway Health Plan	Medicaid only	For-Profit		Local	250,196
	Health Partners of Philadelphia	Medicaid only	Not-for-Profit		Local	165,191
	Keystone Mercy Health Plan	Medicaid only	Not-for-Profit		National	303,318
	Unison Health Plan	Mixed	For-Profit	X	National	151,985
	UPMC for You	Mixed	Not-for-Profit		Local	137,089
RI	Neighborhood Health Plan of Rhode Island	Medicaid only	Not-for-Profit		Local	85,444
(3)	UnitedHealthcare of New England	Mixed	For-Profit	X	National	38,336
	Blue Cross Blue Shield of Rhode Island	Mixed	Not-for-Profit		Local	10,156
SC	Absolute Total Care (Centene)	Medicaid only	For-Profit	X	National	88,998
(4)	BlueChoice Health Plan	Mixed	For-Profit		Local	30,620
	First Choice Health Plan	Medicaid only	Not-for-Profit		National	201,127
	Unison Health Plan of SC (United)	Mixed	For-Profit	X	National	70,688
TN	AmeriGroup Tennessee, Inc.	Mixed	For-Profit	X	National	200,204
(3)	UnitedHealthcare Plan of the River Valley, Inc.	Mixed	For-Profit	X	National	554,210
	Volunteer State Health Plan, Inc.	Medicaid only	For-Profit		Local	465,029
TX	Amerigroup	Medicaid only	For-Profit	X	National	455,105
(16)	Superior Health Plan & Bankers Reserve (Centene)	Medicaid only	For-Profit	X	National	307,557
	Texas Children's Health Plan	Medicaid only	Not-for-Profit		Local	198,081
	Community Health Choice	Medicaid only	Not-for-Profit		Local	125,916
	Evercare/United Health	Mixed	For-Profit	X	National	69,825
	Parkland Health Plan	Medicaid only	Not-for-Profit		Local	156,070

State (No. of contracts)	Name	Enrollment Composition*	Not-for-Profit or For-Profit	Publicly Traded	National or Local	Enrollment as of October 2010
TX cont.	Community First Health Plans	Medicaid only	Not-for-Profit		Local	83,775
	Aetna	Mixed	For-Profit	X	National	58,134
	Cook Children's Health Plan	Medicaid only	Not-for-Profit		Local	60,990
	Molina	Medicaid only	For-Profit	X	National	29,542
	Driscoll Children's Health Plan	Medicaid only	Not-for-Profit		Local	42,707
	El Paso First Health Plans	Medicaid only	Not-for-Profit		Local	48,441
	SHA dba FirstCare Health Plans	Mixed	Not-for-Profit		National	28,801
	UniCare (WellPoint)	Mixed	For-Profit	X	National	17,456
	Bravo (HealthSpring)	Mixed	For-Profit	X	National	0
UT (1)	Molina	Medicaid only	For-Profit	X	National	52,100
VA (5)	Anthem HealthKeepers	Mixed	For-Profit	X	National	193,529
	CareNet by Southern Health (Coventry)	Mixed	For-Profit	X	National	21,821
	Optima Family Care	Mixed	Not-for-Profit		Local	137,607
	Virginia Premier	Medicaid only	For-Profit		Local	139,801
	Amerigroup	Medicaid only	For-Profit	X	National	34,602
WA (6)	Molina Healthcare of Washington	Medicaid only	For-Profit	X	National	333,473
	Community Healthcare of Washington	Medicaid only	Not-for-Profit		Local	224,256
	Clark United Providers	Medicaid only	For-Profit		Local	41,954
	Asuris Northwest Health	Mixed	Not-for-Profit		Local	2,880
	Regence BlueShield	Mixed	Not-for-Profit		National	38,945
	Group Health Cooperative	Mixed	Not-for-Profit		National	21,088
WI (18)	Children's Community Health Plan	Medicaid only	Not-for-Profit		Local	37,062
	CommunityConnect Health Plan	Medicaid only	For-Profit		Local	8,241
	Compcare	Mixed	For-Profit		Local	29,434
	Dean Health Plan	Mixed	For-Profit		Local	41,027
	Dean Southeast	Mixed	For-Profit		Local	3,415
	Group Health Cooperative of Eau Claire	Mixed	Not-for-Profit		Local	40,020
	Group Health Cooperative of South Central	Mixed	Not-for-Profit		Local	4,132
	Gunderson Lutheran Health Plan	Mixed	Not-for-Profit		Local	16,465
	Health Tradition Health Plan	Mixed	For-Profit		Local	9,021
	Independent Care Health Plan	Medicaid only	For-Profit		Local	3,009
	Managed Health Services	Medicaid only	For-Profit	X	National	39,056
	MercyCare Insurance Company	Mixed	For-Profit		Local	15,071
	Molina	Medicaid only	For-Profit	X	National	30,538
	Network Health Plan	Mixed	For-Profit		Local	37,873
	Physicians Plus Insurance Company	Mixed	Not-for-Profit		Local	7,527
	Security Health Plan	Mixed	For-Profit		Local	52,250
	UnitedHealthcare	Mixed	For-Profit	X	National	237,874
	Unity Healthplans Insurance Co	Mixed	Not-for-Profit		Local	12,187
WV (3)	UniCare Health Plan of WV (WellPoint)	Mixed	For-Profit	X	National	79,563
	Carelink Health Plan (Coventry)	Mixed	For-Profit	X	National	53,726
	The Health Plan	Mixed	Not-for-Profit		National	27,559
Total Enrollment						**26,475,260**

* "Mixed" indicates mix of Medicaid and commercial enrollment.

APPENDIX 4: Factors Included in Auto-Assignment Algorithms, by State

State	Related Family Member Assignment	Geographic Considerations	Previous Plan Assignment	Balancing Plan Enrollment	Plan Capacity	Prior PCP in Network	Plan Quality Performance	Encouraging New Entrants	Other Performance Measures	Plan Cost	Other Factor
AZ	X	X		X			X		X	X	
CA							X		X		
CO											
CT			X	X	X						
DC	X	X	X	X		X					
DE	X		X	X							
FL	X	X	X		X						X
GA	X	X	X			X	X		X		
HI	X	X		X		X				X	
IL											
IN	X	X	X	X	X	X		X			X
KS	X	X	X	X	X	X					
KY	X	X	X								
MA	X	X	X	X		X		X			
MD		X									
MI	X	X			X		X				X
MN	X	X	X		X						
MO	X	X	X	X	X	X	X			X	
MS	X			X		X					
NE	X	X	X	X		X	X				
NJ	X	X		X	X						
NM	X	X		X	X						
NV	X		X	X							
NY	X		X		X		X				X
OH		X	X	X	X	X	X	X	X		
OR	X	X	X	X	X						
PA	X	X	X				X	X			
RI				X							
SC	X	X	X	X	X	X		X			
TN	X	X	X	X	X						
TX	X	X	X			X			X		X
UT	X	X	X	X		X					
VA	X		X	X							X
WA	X	X	X	X	X	X					
WI											
WV	X		X	X							
Total	**28**	**24**	**24**	**23**	**15**	**14**	**9**	**5**	**5**	**3**	**6**

Note: 36 states contract with MCOs. Not all states responded to this survey question.

APPENDIX 5: MCO Capitation Rate-Setting Methods and Pay-for-Performance Strategies, by State

	Rate-Setting Method				Rate Cell Factors						Pay-for-Performance Strategies			
State	Administrative Rate Setting Using Actuaries	Negotiation	Competitive Bid Within Rate Ranges	Competitive Bid	Age	Eligibility Category	Health Status	Gender	Geography	Other	Capitation Withhold	Bonus	Shared Savings	Other
AZ	X		X	X	X	X	X	X	X					
CA	X				X	X	X		X					
CO	X	X			X	X	X	X	X					
CT		X		X	X			X		X				
DC	X	X			X			X			X			
DE	X	X	X	X	X		X		X					
FL	X				X	X	X	X	X					
GA	X				X	X		X	X					
HI		X	X		X	X		X	X		X			
IL	X				X			X	X		X	X		
IN			X		X	X	X	X	X		X			
KS			X		X			X	X					
KY	X													
MA		X	X			X	X		X		X	X		
MD	X				X	X	X	X	X		X	X		
MI	X				X	X	X	X	X		X	X		
MN	X	X			X	X	X	X	X	X	X	X		
MO		X	X	X	X	X		X	X		X			X
MS	X					X			X					
NE	X				X	X		X						
NJ	X				X	X	X		X					
NM			X			X					X			
NV	X	X	X	X	X	X	X	X	X					
NY	X				X	X	X		X					X
OH	X				X	X	X	X	X			X		
OR	X				X	X	X	X	X					
PA	X	X			X	X	X	X	X			X		
RI	X				X	X		X				X		
SC	X				X	X	X	X						X
TN	X		X		X	X	X	X	X	X	X	X		
TX	X				X	X	X		X				X	X
UT		X			X	X	X	X		X				X
VA	X				X	X	X	X	X					
WA	X				X		X	X	X					
WI											X	X		X
WV	X				X	X		X	X					
Total	**27**	**11**	**10**	**5**	**31**	**28**	**22**	**26**	**27**	**4**	**12**	**10**	**1**	**6**

Note: 36 states contract with MCOs. Not all states responded to all survey questions.

APPENDIX 6: MCO Acute-Care Benefit Carve-Outs, by State

State	Dental	Outpatient Behavioral Health	Inpatient Behavioral Health	Outpatient Substance Abuse	Non-Emergency Transportation	Drugs	Inpatient Detox	Vision	Other
AZ		X	X	X			X		
CA	X	X	X	X		X	X		
CO	X	X	X	X	X		X	X	
CT	X	X	X	X		X			
DC									
DE	X	X	X	X	X	X	X		
FL	X	X	X		X				
GA					X				
HI	X	X							X
IL	X	X		X		X		X	
IN	X					X			X
KS	X								X
KY		X	X		X				
MA	X				X			X	X
MD	X	X	X		X				
MI	X		X	X			X		X
MN									X
MO		X	X	X		X	X	X	X
MS		X	X	X	X		X		X
NE	X	X	X	X		X	X		X
NJ		X	X	X		X	X		
NM	X							X	
NV									X
NY	X	X	X	X	X	X			X
OH		X	X	X		X	X		
OR	X					X			X
PA		X	X	X	X		X		
RI	X				X				
SC	X	X	X	X	X				
TN	X					X			
TX	X				X	X			X
UT	X	X	X	X	X	X			
VA	X	X	X	X					X
WA	X		X	X	X		X		
WI	X				X	X			X
WV	X	X	X	X	X	X			
Total	**25**	**21**	**21**	**19**	**17**	**16**	**12**	**5**	**15**

Note: 36 states contract with MCOs. Not all states responded to this question.

APPENDIX 7: MCO Network Adequacy Requirements by Type of Care, by State

State	Primary Care	Obstetric Care	Specialty Care	Hospital Care	Dental Care
AZ	All categories:				
	We require an annual Network and Development Plan, as required in the AHCCCS Contractor Operations Manual (ACOM) Policy 415 [42 CFR 438.207 (b)], Acute Care Contract, Section D, Par 27 & ALTCS Contract, Section D,				
CA	2000 Beneficiaries to 1 PCP.	Sufficient to serve assigned population.	Sufficient to serve assigned population.	Must meet requirements for time and distance - 10 miles and 30 minutes.	Not covered in Medi-Cal managed care.
CO	1 to 2,000 providers to clients.	Same as Primary Care.	Same as Primary Care.	Same as Primary Care.	TBD
CT	387 adult members per adult PCP and 301 children per child PCP; also PCP within 15 miles.	835 members per woman PCP including obstetrics and gynecology specialists, nurse midwives, and nurse practitioners of the appropriate specialty.	Network adequacy evaluations shall use ratios of Members to specific types of providers and shall not be less than the access ratio based on the Connecticut Medicaid fee-for-service delivery system for a similar population.	Network adequacy evaluations shall use ratios of Members to specific types of providers and shall not be less than the access ratio based on the Connecticut Medicaid fee-for-service delivery system for a similar population.	Carved out.
DC	MCO shall have at least 2 PCPs both geographically available and able to demonstrate can accept patients while maintaining their overall patient load within professional and industry norms and community standards.	In addition to a PCP, a female Enrollee may have a women's health specialist. MCO shall provide female Enrollees with direct access to a women's health specialist within the network for covered women's routine and preventive health care services.	MCO shall have a network including sufficient number and classes to furnish covered specialty services. The network shall include medical subspecialists and pediatric specialists and subspecialists. There is a list of specialists, at a minimum the MCO shall include within their network, but not limited to a list of Specialists as identified by DHCF.	Must demonstrate a hospital network in the District capable of furnishing a full range of tertiary services to enrollees. Enrollees shall have access to at least two general acute care hospitals located in the District. Additionally, there is a specific health system MCOs shall include within their network, or shall have hospital(s) providing comparable services offered by the health system, and at least one hospital that specializes in pediatric care.	MCOs shall maintain a sufficient network of dental providers, including dentists, pediatric dentists, orthodontists and oral surgeons to meet the needs of the enrollees.
DE	30 minutes/30 miles.		100 miles.		
FL	1 full-time PCP per 1500 enrollees (may increase by 750 for each ARNP or PA).			1 accredited hospital bed per 275 enrollees.	
GA	Urban Area: 2 within 8 miles: Rural: 2 within 15 miles.	For Obstetrics, Specialty, Hospital and Dental: Urban Area: 1 within 30 miles or 30 minutes; Rural Area: 1 within 45 miles or 45 minutes.			
HI	1 PCP for every 600 members.	Included on each island served.	Specialists available on each island served or bring to another island (or out of state) to provide.	Included on each island served.	N/A
IL	At least one FTE physician for each 1,200 enrollees.	At least one Women's Health Provider for each 2,000 female enrollees between ages 19 and 44; at least one physician specializing in obstetrics for each 300 pregnant female enrollees.	At least one pediatrician for each 2,000 enrollees under age 19.	Contractor must establish and maintain a network of affiliated providers, including hospitals, that is sufficient to provide adequate access to all services under the contract.	N/A
IN	Availability within 30 miles of member's residence.	30 miles.	Selected specialties must have 2 within 60 miles for member's residence, some are 1 within 90	no standard.	no standard.
KS					
KY	All categories: Delivery sites that are no more than 30 miles/30 minutes for members in urban areas, or 45 miles/45 minutes for members in rural areas.				
MA	PCP 1:200 per enrollees and 2 or more with open panels within 15 miles or 30 minutes of enrollee's residence.	OB 1:500 female enrollees.	Top 5 specialist 1:500 enrollees.	Within 20 miles or 40 minutes of enrollee's residence.	N/A - covered by the state.
MD	200:1 ratio; 1 provider in 10 mins/10 miles urban; 1 provider in 30 mins/30 miles rural.	Same as Primary Care.	Varies by specialty. Detailed in regulation COMAR 10.09.66.05-1.	None; all MCOs participate with all hospitals in Maryland.	1 provider in 10 mins/10 miles urban; 1 provider in 30 mins/30 miles rural.
MI	Michigan has a ratio standard of 1 PCP for every 750 members.	Open access to OB services.	Must have certain specialties within network if available.	Must have hospital contract if possible or must have the Michigan Hospital Access agreement available.	

State	Primary Care	Obstetric Care	Specialty Care	Hospital Care	Dental Care
MN	Access within 30 minutes and 30 miles , or state's accepted community standard, Appointment wait times: Not to exceed forty-five (45) days from the date of an Enrollee's request for routine and preventive care and twenty-four (24) hours for Urgent Care.	See Primary Care.	Access within 60 minutes or 60 miles or the state's generally accepted community standard. Appointments for a specialist are to be made in accordance with the time frame appropriate for the needs of the Enrollee, or the Generally Accepted Community Standards.	Transport time not to exceed 30 minutes or the state's generally accepted community standard.	Within 60 minutes or 60 miles or the state's generally accepted community standard. Appointment wait times: Not to exceed sixty (60) days for regular appointments and forty-eight (48) hours for Urgent Care. For the purposes of this section, regular appointments for dental care means preventive care and/or initial appointments for restorative visits.
MO	All Categories: Must comply with state DOI travel distance standards in 20 CSR 400-7.095. For providers not addressed under 20 CSR 400-7.095, MCO shall ensure members have access to those providers within 30 miles				
MS	All categories: 60 miles or 60 minutes for rural and 30 miles or 30 minutes for urban areas.				
NE	2 PCPs within 30 miles of residence.		1 high-volume specialist within 60 miles of	1 acute care hospital within 30 miles of	NA -- Dental carved out.
NJ	1 FTE PCP per 2000 enrollees, and 1 FTE PCP per 1000 DDD enrollees, minimum of 2 per county.	Same as Specialty Care.	Access to designated specialists within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county.	Minimum of 1 contracted hospital per county.	1 FTE primary care dentist per 2000 enrollees.
NM	Minimum one primary care provider per 1500 members/max of 1500 members per PCP. Also: (a) 90 percent of urban residents shall travel no farther than 30 miles; (b) 90 percent of rural residents shall travel no farther than 45 miles; and (c) 90 percent of frontier residents shall travel no farther than 60 miles. And: For routine asymptomatic appointments: w/in 30 days. For routine symptomatic appointments: w/in 14 days. Urgent care appointments: w/in 24 hours.	State guidelines.	For non-urgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time. Behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours. For specialty outpatient referral and consultation appointments, excluding behavioral health (addressed above) the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days.	State guidelines.	For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments. For routine, symptomatic, member-initiated, outpatient appointments for non-urgent dental care, the request-to-appointment time shall be no more than 14 days. Dental outpatient appointments for urgent conditions shall be available within 24 hours.
NV	At least one full-time equivalent (FTE) PCP, considering all lines of business for that provider, per 1,500 enrollees per service area. If PCP practices in conjunction with a health care professional, ratio increased to one FTE PCP per 1,800 recipients. Per geographic service area, at least 50% of all Network PCPs must contractually agree to accept eligible recipients and at least 50% must accept eligible recipients at all times. If the MCO contracts with an FQHC and/or the Univ. of Nevada Medical School, physicians from these two orgs can be counted to meet the 50% participation and acceptance requirements. PCP Appointments: Same-day, medically necessary, PCPs are available; Urgent care PCP appointments available within two calendar days; Routine care PCP appointments are within two weeks. Two week standard not applicable to regularly scheduled visits to monitor a chronic medical condition if schedule calls for less frequent visits.	Prenatal Care Appointments: Initial prenatal care appointments shall be provided for enrolled pregnant recipients as follows: First trimester within seven (7) calendar days of the first request; Second trimester within seven (7) calendar days of the first request; Third trimester within three (3) calendar days of the first request; and High-risk pregnancies within three (3) calendar days of identification of high risk by the Vendor or maternity care provider, or immediately if an emergency exists.	Must provide access to all types of physician specialists for PCP referrals, and must employ or contract with specialists, or arrange for access to out of network specialty care in sufficient numbers to ensure specialty services are available in a timely manner. Minimum ratio for non-PCP specialists is one specialist per one 1,500 recipients per service area. Ratios may be adjusted by DHCFP for under-served areas. Specialist Appointments. For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO must provide: Same day, medically necessary appointments within 24 hours of referral; Urgent care appointments within three calendar days of referral; and, Routine appointments within 30 calendar days of referral.	Must provide DHCFP with a quarterly report on the adequacy of contracted hospitals to the assigned recipient caseload. The report shall document the number and types of specialties covered by contracted hospitals. Reports must be submitted within 45 business days after close of the quarter to which they apply.	Dental Appointments: Dental care shall be provided immediately for dental emergencies, urgent care or referral appointments within three calendar days and routine appointments with dentists and dental specialists shall be provided within 30 calendar days or sooner if possible.

State	Primary Care	Obstetric Care	Specialty Care	Hospital Care	Dental Care
NY	Statute requires a minimum of 3. However, we review for geographic access which adds additional providers.	Minimum of 2 but geographic access requirement will bring additional providers.	Minimum of 2 but geographic access requirement will bring additional providers where available.	Minimum of 1 but counties that are larger and have more facilities require up to 4.	Minimum of 2 but geographic access requirement will bring additional providers where available.
OH	All categories: OHP specifies minimum number of providers required to be in each region.				
PA	A choice of 2 PCPs with open panels within the	A choice of 2 providers who are	General Surgery, Oncology, Physical Therapy,	At least 1 hospital within the travel times of	A choice of 2 providers who are
RI	1500 members per PCP, 30 days for non-emergent care, 24 hours for urgent care.	Direct access to OB/GYN.	30 days for non-emergent care. 5 days for non-urgent BH care.	Immediate.	30 days for appointment for non-urgent care
SC	At least one PCP per 2,500 members located within 30 miles of member residence.	Specialty care physicians must be located within 50 miles of member residence.	Specialty care physicians must be located within 50 miles of member residence.	Must be located within 50 miles of member residence.	NA
TN	PCP or Extender: (a) Distance/Time Rural: 30 miles or 30 minutes (b) Distance/Time Urban: 20 miles or 30 minutes (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender. (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.	Same as Primary Care plus: For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) calendar days of the day they are determined to be eligible.	Travel distance does not exceed 60 miles for at least 75% of non-dual members and Travel distance does not exceed 90 miles for ALL non-dual members Patient load varies by specialty.	Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.	Transport time to general dental providers will be the usual and customary, not to exceed thirty (30) minutes, except in rural areas where community standards, as defined by TennCare. Exceptions must be justified and documented to the State on the basis of community standards.
TX	All Members have access to an age-appropriate PCP in the Provider Network with an Open Panel within 30 miles of the Member's residence.	All female Members have access to an OB/GYN in the Provider Network within 75 miles of the Member's residence.	All Members have access to a Network specialist physician within 75 miles of the Member's residence for common medical specialties.	All Members have access to an Acute Care hospital in the Provider Network within 30 miles of the Member's residence.	
UT	Sufficient number for number of enrollees and geographic area.	Must allow women direct access.	Must provide out of network coverage if in network access insufficient.	Must provide access to hospitals equipped to handle high risk pregnancy.	NA
VA	At least one full time equivalent PCP regardless of specialty type for every 1,500	Network must be adequate to serve members; otherwise, MCO must	Same as obstetrics.	Same as obstetrics.	Same as obstetrics.
WA	Urban: 2 PCPs w/in 10 miles for 90% of enrollees; rural: 1 w/in 25 miles for 90%.	Same as primary care.	RB MCOs required to assess and provide measureable standards for Specialty providers in their network.	Same as specialty care.	Not included in the benefit.
WI	20 mile distance from members (however BadgerCare Plus HMOs in the SE region have more strict requirements in all provider areas).	Must provide access to a women's health specialist in addition to a PCP, and provide high risk prenatal care within 2 weeks of member's request or within 3 weeks if request is for a specific provider.	Mental health: 35 mile distance from any member (or equivalent to FFS).	Must provide access.	Within 35 miles.
WV	30 minutes and additional requirements to ensure beneficiary access is better than or equivalent to the fee-for-service program.	Same as Primary Care.	60 minutes and additional requirements to ensure beneficiary access is better than or equivalent to the fee-for-service program.	45 minutes and additional requirements to ensure beneficiary access is better than or equivalent to the fee-for-service program.	Additional requirements to ensure beneficiary access is better than or equivalent to the fee-for-service program.

Note: Narratives are as included in state survey response.

APPENDIX 8: Providers Recognized as PCPs in MCOs, by State

State	Ob/Gyn	Nurse Practitioner	FQHC	Physician Group/Clinic	Physician Specialist	Physician Assistant	Nurse Midwife	Other
AZ	X	X				X	X	
CA	X	X	X	X		X	X	
CO	X	X	X	X		X	X	X
CT	X	X				X		
DC	X	X	X	X	X			
DE	X		X		X			
FL	X	X	X	X	X	X		
GA	X	X	X	X	X			X
HI	X	X	X	X	X	X	X	
IL	X	X	X	X	X	X	X	
IN	X							X
KS								
KY	X		X	X	X			
MA	X	X			X			
MD	X	X	X	X	X		X	
MI	X	X	X		X	X		
MN	X	X	X	X	X	X		
MO	X	X	X	X	X	X		
MS	X		X	X	X			
NE	X							
NJ		X	X	X		X		X
NM	X	X			X	X	X	X
NV	X		X	X				
NY	X	X		X	X			
OH	X	X	X	X	X			X
OR		X	X			X	X	
PA		X	X	X		X		
RI	X	X	X	X		X	X	
SC	X		X					X
TN	X	X				X		
TX	X		X	X	X	X	X	X
UT	X							
VA	X		X	X	X			X
WA		X	X	X	X	X		
WI	X	X	X	X	X	X	X	
WV	X	X			X		X	
Total	**31**	**25**	**25**	**22**	**21**	**19**	**12**	**9**

Note: 36 states contract with MCOs. Not all states responded to this survey question.

APPENDIX 9: Providers Recognized as PCPs in PCCM Programs, by State

State	Ob/Gyn	Nurse Practitioner	FQHC	Physician Group/Clinic	Physician Specialist	Physician Assistant	Nurse Midwife	Other
AL	X		X	X	X			X
AR	X		X	X	X			
AZ								
CO	X	X	X	X		X	X	X
CT	X	X				X	X	
FL	X	X	X	X		X		X
GA		X		X	X			
IA	X	X	X		X		X	X
ID	X	X	X	X	X	X	X	X
IL	X	X	X	X	X		X	X
IN	X				X			
KS	X	X	X	X	X	X		X
KY	X	X				X		
LA	X	X	X	X	X			
MA	X	X	X		X			
ME	X	X	X	X	X	X		
MT	X	X	X	X	X	X	X	
NC	X	X	X	X	X	X	X	
ND	X	X	X	X			X	X
NY	X	X			X			
OK		X	X	X		X		X
OR		X	X	X		X	X	
PA	X	X	X	X	X	X	X	
RI								
SC	X		X	X				X
SD	X		X			X		X
TX	X	X	X	X	X		X	X
UT	X	X	X					
VA	X		X	X	X			X
VT	X		X	X				X
WA	X	X		X	X	X		
WV	X	X	X	X			X	
Total	**27**	**23**	**24**	**22**	**18**	**14**	**12**	**14**

Note: 31 states have PCCM programs. Not all states responded to this survey question.

APPENDIX 10: PCP Requirements and Payment Methodologies in PCCM Programs, by State

	PCP Requirements							Payment Methodology						
State	24 Hour/7 Day-a-Week Coverage	Meet State Reporting Requirements	Participation in State Quality Initiatives	Minimum Panel Size	Maximum Panel Size	Must provide Primary Care	Other	Fee-for-Service with Case Management	Case Management Fee	Fee-for-Service with Shared Savings Provision	Fee-for-Service with Enhanced Visit Rate	Capitated for Services Delivered by PCP with Gatekeeper Responsibility for Other Services	Other	Other Description
AL	X		X		X	X		X	$2.60 PMPM	X				
AR	X	X	X		X	X		X	$3.00 PMPM					
CO	X					X	X	X	$2.00-$1.50 PMPM				X	The PCPP is strictly Fee-for-Service
CT	X	X	X			X	X		$7.50 PMPM					
FL	X		X	X	X	X	X	X	$2.00 PMPM					
GA	X	X				X		X	$1.75 PMPM					
IA	X	X	X		X	X		X	$2.00 PMPM					
ID	X					X	X	X	$3.50 PMPM					
IL	X	X	X		X	X	X	X	$2.00 PMPM for children, $3.00 PMPM for parents and $4.00 PMPM for seniors and adults with disabilities.		X			
IN	X							X	$6.00 PMPM					
KS	X	X	X	X		X		X	$2.00 PMPM					
KY								X	$4.00 PMPM					
LA	X	X			X	X			$1.50 PMPM effective 1/1/11 (previously $3)					
MA	X										X			
ME	X	X			X	X		X	$3.50 PMPM for PCCM + $3.50 PMPM for PCMH					
MT	X				X	X	X	X	$3.00 PMPM PCCM				X	$3.75 PMPM EPCCM
NC	X	X	X		X	X	X	X	$1.00 to $5.00 PMPM			X	X	Additional PMPM for CCNC Networks
ND	X					X		X	$2.00 PMPM					
NY	X	X	X		X		X					X		
OK	X	X	X	X	X	X	X	X	Varies by type of medical home; avg is $4.50 PMPM					
OR								X						
PA	X	X	X		X	X	X						X	Fee-for-service for providers. PMPM for the administrative service contractor. Pay for performance opportunities for both providers and vendor.
RI						X		X	$4.00 or $8.00 PMPM					
SC	X	X	X		X	X		X	$10.00 PMPM				X	MCCW : Fee-for-service paid $230.96
SD	X				X	X		X	$3.00 PMPM					
TX	X	X	X			X	X	X	$4.90 PMPM effective September 1, 2010 and $4.85 PMPM as of February 1, 2011. RHCs & FQHCs are at $5.00 PMPM for except for title V, X and XX family planning services.					
UT								X						
VA	X					X	X	X	$3.00 PMPM					
VT	X						X	X	$5.00 PMPM					
WA	X					X			$3.00 PMPM					
WV	X				X	X		X	$3.00 PMPM					
Total	**27**	**14**	**13**	**3**	**15**	**24**	**13**	**25**		**1**	**2**	**2**	**5**	

Note: 31 states have PCCM programs.

APPENDIX 11: PCCM Administrative Services Contracts, by State

State	Contractor	Services Provided	Administrative Fees At Risk
AL	Alabama Department of Public Health	Care Management	
CA	AIDS Healthcare Foundation (AHF)	Medical Case Management	
CO	Colorado Regional Integrated Care Collaborative	EPCCM	
	Primary Care Physician Program	PCCM	
	Accountable Care Collaborative	PCCM	
	Colorado Alliance for Health and Independence	PCCM	
GA	Georgia Better Health Care	Case Management	
	SOURCE	Care Management	
IL	Automated Health Systems	Outreach, Education, Develop/Maintain PCP Network including PCP recruitment, Enrollment for PCCM program, Assisting enrollees in finding medical providers	X
IN	Advantage	Disease management	
	MDwise	Disease management	
KS	Health Connect	State Plan approved health services	
LA	Automated Health Systems (AHS)	Enrollment Broker, Outreach, Provider Recruitment, Provider Education, Call Center, 24/7 Nurse Hotline (via sub-contract with McKesson)	
MA	Massachusetts Behavioral Health Partnership	PCC Plan provider and member newsletters; quality forums; provider and member education material promotion, distribution, and inventory; PCC profiling and associated quality improvement site visits	
ME	Public Consulting Group	Member Services	
MT	Affiliated Computer Services (ACS)	Client & provider enrollment, outreach, education, disenrollment, reporting	
PA	ACCESS Plus/APS Healthcare	Care management, disease management, outreach, education, material development, behavioral health coordination, provider recruitment	X
SC	South Carolina Solutions	Medical Home Network	X
TX	Texas Medicaid and Healthcare Partnership (TMHP)	PCCM Claims administration, including operation, integration, and maintenance of the Texas Medicaid Management Information System (MMIS), PCCM network administration, PCCM program management, PCCM client services, PCCM provider relations and monitoring	
WA	Colville Indian Health Center	Care Management	
	Colville Indian health Clinic	Care Management	
	Spokane Tribe - David C. Wynecoop Memorial Clinic	Care Management	
	Inchelium Clinic	Care Management	
	Lower Elwha Health Clinic	Care Management	
	Lummi Tribal Health Center	Care Management	
	Native Health of Spokane	Care Management	
	Nooksack Community Clinic	Care Management	
WV	Molina	Fiscal Agent	
	IRG	Utilization Management	

APPENDIX 12: Use of Selected Quality Tools, by State

State	MCO Accreditation Required	Performance Measures (HEDIS© or Similar) Used for: MCOs	PCCM	PHPs	FFS	Patient Experience Measures (CAHPS© or Similar) Used for: MCOs	PCCM	PHPs	FFS	Publicly Releases MCO and/or PCCM Quality Reports	Prepares a Quality Report Card	Plans to Report on Some/All CHIPRA Measures
AK												
AL			X		X							
AR			X		X		X			X		X
AZ		X		X		X		X		X		X
CA		X				X				X	X	X
CO		X	X	X	X	X	X	X	X	X	X	X
CT		X			X	X				X		X
DC	X	X				X				X	X	
DE		X				X						X
FL	X	X		X		X	X			X	X	X
GA	X	X	X		X	X				X		
HI	X	X				X				X	X	
IA			X	X			X			X		
ID				X								
IL		X	X			X				X		X
IN	X	X				X						X
KS		X	X		X	X	X		X			
KY	X	X				X						
LA			X				X					X
MA	X	X	X	X						X		X
MD		X		X		X				X	X	X
ME			X				X		X	X		X
MI	X	X				X			X	X	X	X
MN		X			X	X				X	X	
MO	X	X				X				X	X	X
MS												
MT			X		X							
NC			X	X	X		X			X	X	X
ND												X
NE	X	X				X				X		X
NH												
NJ		X				X				X		X
NM	X	X										
NV		X				X				X	X	X
NY		X				X				X	X	X
OH		X			X	X				X		
OK			X				X			X		X
OR		X		X		X	X		X	X		
PA		X	X	X		X	X			X	X	X
RI	X	X		X		X				X		X
SC	X	X	X		X	X	X		X	X	X	X
SD												
TN	X	X				X				X		
TX		X	X	X	X	X	X			X		X
UT		X	X	X	X	X	X	X	X	X	X	
VA	X	X				X	X		X	X		X
VT			X				X			X		X
WA		X			X				X	X		X
WI		X				X				X	X	
WV	X	X	X		X	X	X			X		X
WY					X							
Total	**16**	**35**	**19**	**13**	**16**	**32**	**17**	**3**	**9**	**36**	**16**	**30**

APPENDIX 13: Initiatives to Improve Quality and Care Coordination, by State

State	Appropriate ER Use	Reduced Obesity	Racial and Ethnic Disparities	Other	Care or Disease Management	Medical Home	Health Home	ACO	Dual Eligibles Initiative
AK									
AL	x			x	x	x	x		
AR	x	x	x	x	x	UD	x		
AZ	x	x	x	x	x				
CA	x	x	x	x	x	UD	x	x	x
CO	x	x		x	x	x	x	x	x
CT	x	x	x		x	UD	x	x	x
DC	x	x	x	x	x				
DE	x	x	x		x	UD	x		x
FL	x		x	x	x				x
GA	x	x			x	UD			
HI	x	x				x			
IA	x				x	UD	x		
ID	x	x			x	x	x		
IL	x			x	x	x	x		
IN	x	x	x		x			x	
KS	x			x	x	x			
KY	x	x							x
LA	x			x		x			
MA	x		x		x	x	x	LP	x
MD	x	x	x		x	x			
ME	x	x	x	x	x	x	x	x	x
MI		x	x	x		x	x		x
MN	x	x	x	x	x	x		x	x
MO	x	x		x	x	UD	x		
MS					x				
MT	x				x	UD			
NC	x	x	x		x	x	x		x
ND					x				
NE		x				x			
NH									
NJ	x	x	x	x		x		LP	
NM	x	x	x		x	UD			
NV	x	x	x		x	x			
NY	x	x	x	x		x	x		x
OH	x	x		x	x	UD			
OK	x	x		x	x	x	x	x	x
OR	x	x	x	x	x	x	x		x
PA	x	x	x	x	x	x			x
RI	x	x		x		x	x		
SC				x	x				x
SD	x			x		UD			
TN	x	x	x		x	x			x
TX	x	x			x		x		x
UT	x	x	x		x	x		LP	
VA				x	x	UD			
VT	x			x	x	x	x	x	x
WA	x		x		x	x	x	x	x
WI	x	x		x		x			x
WV	x	x	x		x	x	x		
WY	x	x			x				
Total	**43**	**34**	**24**	**26**	**39**	**27/12**	**22**	**9/3**	**21**

UD = Under Development

LP = Legislation Proposed

APPENDIX 14

FY 2011 MEDICAID MANAGED CARE SURVEY

Return Completed Survey to: Vsmith@healthmanagement.com ***(email preferred)***

(Or mail or FAX to: Vernon K. Smith, Ph.D., Health Management Associates, 120 N. Washington Square, Suite 705, Lansing, MI 48933; FAX: (517) 482-0920)

If you have any questions, please call Vern Smith at (517) 318-4819.

State _____ **Name** _____

Phone _____ **Email** _____ **Date** _____

This survey of state Medicaid agencies is being conducted by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured to determine the nature and scope of state Medicaid managed care programs and related policies currently in place. The survey comprises the following seven sections; ***many states will not need to complete all sections***:

I. Managed Care Overview: All states should complete this section.

II. Comprehensive Risk-Based Managed Care: Only states contracting with comprehensive risk-based managed care organizations (RB-MCOs) should complete this section.

III. Primary Care Case Management (PCCM): Only states operating a Primary Care Case Management (PCCM) program should complete this section.

IV. Non-Comprehensive Prepaid Health Plans: Only states contracting with non-comprehensive prepaid health plans (PHPs) should complete this section.

> *A **Prepaid Health Plan (PHP)** refers to a type of managed care plan that provides less than comprehensive services on an at-risk or other-than-state-plan reimbursement basis. There are two PHP types. A **Prepaid Inpatient Health Plan** provides, arranges for or otherwise has responsibility for the provision of any inpatient hospital or institutional services. A **Prepaid Ambulatory Health Plan** does not provide any inpatient or institutional services. Common PHP examples include plans providing only behavioral health services or only dental services.*

V. Quality: All states contracting with comprehensive RB-MCOs or non-comprehensive PHPs, or operating a PCCM program should complete this section.

VI. Special Initiatives: All states should complete this section.

VII. Looking Ahead: All states should complete this section.

I. MANAGED CARE OVERVIEW

1. Total Managed Care Enrollment as of October 1, 2010. Please provide monthly enrollment numbers for October 2010. (If October 2010 data are not available, please provide data for the most recent month for which data are available, which is the month of _____.) Note: If data are not available for the indicated eligibility groups, please report readily available enrollment data and briefly describe differences under "Comments."

Eligibility Group		Total Medicaid enrollment: FFS + managed care	Number enrolled in:			Unduplicated count of managed care enrollees
			Comprehensive RB-MCOs	PCCM	PHPs	
a. All children						
If available:	b. SSI Children					
	c. Foster children					
	d. Medicaid expansion CHIP					
e. Pregnancy Medicaid						
f. Parents/ caretaker relatives						
g. All non-dual aged, blind and disabled						
If available:	h. Non-dual aged					
i. Childless adults						
j. Dual eligibles						
k. Other (Please describe in comments)						
l. Total						

Comments: _____

Instructions: Please check one of the two boxes below. If you check the first box, please complete the remaining questions in this section. If you check the second box, please skip to Section VI. SPECIAL INITIATIVES.

☐ *My state **does or will** operate a RB-MCO, PCCM or PHP managed care program in FY 2011.* → ***Continue to next question.***

☐ *My state **does not and will not** operate a RB-MCO, PCCM or PHP managed care program in FY 2011.* → ***Go to Section VI. SPECIAL INITIATIVES.***

2. Perceived Benefits of Managed Care.

a. If your state has calculated an estimated annual percentage cost savings associated with managed care, please provide that estimate here: _____%; or briefly describe: _____

b. Based on your state's managed care experience (compared to your state's experience without managed care), indicate to what extent each delivery system model has led to improvements towards the goals listed in the table below by choosing the most appropriate phrase in the drop-down box in each cell.

	Goal	*Comprehensive RB-MCO*	*PCCM*	*PHP*
i.	*Cost Savings*			
ii.	*Access to Primary Care*			
iii.	*Access to Specialty Care*			
iv.	*Reduced ER Use*			
v.	*Member ability to navigate health system*			
vi.	*Member satisfaction*			
vii.	*Provider satisfaction*			
viii.	*Improved quality/health outcomes*			
ix.	*Reduced fraud and abuse*			

Comments: _____

3. Medicaid Managed Care Program Names and Population Served.

Please list each of your state's managed care programs below and indicate whether it is statewide by checking the box, the managed care model used and the eligibility categories enrolled. If you check "Other" under Population Served, please briefly describe the population served under "Comments."

Program Name *(e.g., popular name, 1915(b) or 1115 waiver name or other state designation)*	Statewide? (Check if yes)	**Model** *(Check all that apply)*			**Populations Served** *(Check all that apply)*										
		Comp. RB-MCOs	PCCM	PHP	SSI Children	Foster Children	Medicaid Expansion CHIP	All Other Children	Pregnant women	Parents/ Caretakers	Non-Dual Aged	Non-Dual Blind/ Disabled	Childless Adults	Dual Eligibles	Other
a.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
d.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
e.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
f.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
g.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
h.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
i.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
j.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments: _____

4. Enrollment Requirements.

a. We are interested in learning about state enrollment policies for various eligibility groups. Please complete the table below to indicate whether each of the groups listed is *ever* subject to (1) mandatory or (2) voluntary managed care enrollment in any part of your state, or (3) whether the group is *always* excluded from managed care enrollment. Please note that it is possible to answer "yes" for both mandatory and voluntary if policies vary by geography or program or for some other reason. Also, if a particular group (e.g., childless adults) is not eligible for Medicaid in your state, please check "NA" in the drop-down box. You may provide additional explanatory detail under "Comments."

Eligibility Groups	**For *at least one* managed care program and/or geographic area, is enrollment:**		**(3) Population always excluded from managed care enrollment?** ***(Yes, No or NA)***
	(1) Mandatory? ***(Yes, No or NA)***	**(2) Voluntary?** ***(Yes, No or NA)***	
SSI children			
Foster children			
Children with special health care needs			
Medicaid expansion CHIP			
All other children			
Pregnant women			
Parents/caretaker relatives			
Non-dual aged			
Non-dual blind/disabled			
Childless adults			
Institutionalized recipients			
Home and Community Based recipients			
Hospice recipients			
Dual eligibles			
Medically needy/spend-down			
Native Americans			
Other: _____			
Other: _____			

Comments: _____

b. Continuous/Guaranteed Eligibility

   i. Does your state offer 12 months of continuous eligibility for children (as authorized by Section 4731 of the Balanced Budget Act of 1997)? ____

   ii. Does your state provide for 6-month guaranteed eligibility for any managed care enrollees (as authorized by Section 4709 of the Balanced Budget Act of 1997? ____

Comments: _____

c. Does your state impose a lock-in requirement limiting an enrollee's ability to change plans after initial enrollment? ____

   i. If "yes," please indicate the length of the lock-in period: _____

END OF MANAGED CARE OVERVIEW SECTION

II. COMPREHENSIVE RISK-BASED MANAGED CARE

Please check one of the two boxes below. If you check the first box, please complete the remaining questions in this section. If you check the second box, please skip to Section III. PRIMARY CARE CASE MANAGEMENT.

☐ *My state **does or will** contract with a comprehensive RB-MCO in FY 2011.* → ***Continue to next question .***

☐ *My state **does not and will not** contract with a comprehensive RB-MCO in FY 2011.* → ***Go to Section III. PRIMARY CARE CASE MANAGEMENT.***

1. RBMC Contractors

a. Please indicate in the table below, by contractor type, the number of comprehensive RB-MCOs and the estimated market share of total Medicaid managed care enrollment in October 2010. (Please note that a plan may fall within more than one of the listed categories.)

RB-MCO Type	*Number of MCOs*	*Market Share*
i. Medicaid-only (or predominantly Medicaid/CHIP)		%
ii. Mixed Medicaid/commercial enrollment		%
iii. Provider-owned		%
iv. Non-profit		%
v. For-profit		%
vi. Publicly traded		%
vii. Local (non-national)		%
viii. National		%

b. Please list in Appendix I, Table 1 the names of the comprehensive RB-MCOs in your state.

Comments: _____

2. Insurance Regulation

a. What are the insurance licensure requirements for comprehensive RB-MCOs in Medicaid in your state? ____

_____

b. Does the state exempt any of the following types of comprehensive RB-MCOs from the normal state insurance solvency requirements (as allowed under federal Medicaid law)?

HMOs? ____ PSNs/PSOs[1]? ____ HIOs[2]? ____

c. Is there an external appeals process for RB-MCO enrollees (other than the state fair hearing requirement)? ____

Comments: _____

3. Plan Selection

a. Does your state use an enrollment broker vendor to facilitate plan selection? ____

i. If "yes," name the enrollment broker vendor as of October 1, 2010: _____

b. Does your state use an auto-assignment process for enrollees who fail to select a plan? ____

i. If "yes," over the past year, approximately what percentage of enrollees is auto-assigned on an average monthly basis? _____% (If the percentage varies significantly by program and/or geographic area, please explain under "Comments.")

[1] Provider Service Networks or Provider Sponsored Organizations.
[2] Health Insuring Organization.

ii. Please indicate whether the factors listed in the table below are included in the state's auto-assignment algorithm. *(Check all that apply)*

A. ☐ Geographic considerations	G. ☐ Related family member assignment
B. ☐ Plan capacity	H. ☐ Plan quality performance
C. ☐ Balancing enrollment among plans	I. ☐ Plan cost
D. ☐ Encouraging new plan entrants	J. ☐ Other performance measures (*please specify*) _____
E. ☐ Previous plan assignment	_____
F. ☐ Prior PCP in network	K. ☐ Other factor (*please specify*) _____

Comments: _____

c. Subject to federal requirements, may RB-MCOs conduct outreach and marketing activities? ____

4. Payment

a. Please indicate which process(es) you use to set capitation rates. If different processes are used for different programs, please briefly describe under "Comments."

Capitation Rate-Setting Methodology *(Check all that apply)*		
i. ☐ Competitive bids	iii. ☐ Negotiation	v. ☐ Other :_____
ii. ☐ Competitive bids within actuarially determined ranges	iv. ☐ Administrative rate-setting (using actuaries)	_____

Comments: _____

b. Please indicate whether capitation rates vary by any of the factors listed below. *(Check all that apply)*

i. ☐ Age iii. ☐ Eligibility category v. ☐ Health Status
ii. ☐ Gender iv. ☐ Geography vi. ☐ Other: _____

c. If rates are risk-adjusted for health status, please indicate the system used (*Check all that apply*):

☐ CDPS ☐ MedicaidRx ☐ ACGs ☐ CRxGs ☐ DxCGs ☐ Other (*please specify*): _____

d. Please indicate in the table below any retrospective risk-sharing arrangement used by the state. If your state has different policies for different programs, please briefly describe under "Comments."

Risk Sharing Arrangements *(Check all that apply)*	
i. ☐ Optional state-sponsored stop-loss/reinsurance	v. ☐ Required state-sponsored stop-loss/reinsurance
ii. ☐ Optional commercial stop-loss/reinsurance	vii. ☐ Required commercial stop-loss/reinsurance
iii. ☐ Risk corridors (shared savings/loss)	viii. ☐ Risk pools
iv. ☐ Condition-specific risk arrangement	x.. ☐ Other: _____

Comments: _____

e. Is there a pay-for-performance aspect to reimbursement? ____ If "yes":

i. Indicate the type of incentive used (*Check all that apply*): ☐ Bonus payment ☐ Capitation withhold ☐ Shared savings ☐ Other (*please specify*): _____

ii. Please briefly describe on what basis an RB-MCO can earn a payment based on performance: _____

5. Benefits. Please indicate in the table below any benefit carve-outs. Under "Comments" please indicate if your state has different carve-out policies for different programs or regions, whether a particular benefit is only partially carved out or is a non-covered service for adults, and the nature of any planned change in carve-out status for any benefit.

Benefit Carve-Outs *(Check all that apply)*		
i. ☐ Outpatient behavioral health	v. ☐ Prescription drugs	ix. ☐ Nursing home
ii. ☐ Inpatient behavioral health	vi. ☐ Non-emergency transportation	x. ☐ Home & community-based services
iii. ☐ Outpatient substance abuse	vii. ☐ Dental	xi. ☐ Personal care services
iv. ☐ Inpatient detoxification	viii. ☐ Vision	xii. ☐ Other :_____

Comments: _____

6. Network Requirements and Access to Care

a. Network adequacy: Please briefly describe your state's network adequacy standards for:

i. Primary care: _____
ii. Obstetric care: _____
iii. Specialty care: _____
iv. Hospital care: _____
v. Dental care: _____

b. Primary Care Providers (PCPs): Please indicate in the table below which providers (other than Family/General Practitioners, Internists, and Pediatricians) may be primary care providers (PCPs) for enrollees of comprehensive RB-MCOs. If your state has different policies for different programs or regions, please briefly describe under "Comments."

Permitted PCP Types *(Check all that apply)*	
a. ☐ Ob/Gyn	e. ☐ Nurse practitioner
b. ☐ Physician specialist	f. ☐ Physician assistant
c. ☐ Physician group/clinic	g. ☐ FQHC
d. ☐ Nurse midwife	h. ☐ Other: _____

Comments: _____

c. Required Providers: We are interested in learning whether your state requires or encourages comprehensive RB-MCOs to contract with the provider types listed in the table below. For each provider type, please choose the appropriate response and, if applicable, briefly describe under "Comments" how plans are encouraged to contract.

Provider Type	*None operate in state / Contracts required / Contracts encouraged / Contracts neither required nor encouraged*
i. Federally Qualified Health Center (FQHC)	
ii. Community/migrant/rural health center (non-FQHC)	
iii. Academic Medical Center	
iv. Early Intervention & Special Education	
v. Family Planning Clinics (Title X)	
vi. Indian Health Service Providers	
vii. Local/county health department	
viii. Maternal and Child Health Clinics	
ix. Mental Health Center	
x. Public (DSH) Hospitals	
xi. HIV/AIDS Services Orgs. (Ryan White Providers)	
xii. School-Based Clinics	
xiii. Tribal Clinics	
xiv. Other	

Comments: _____

d. Access Issues: Do beneficiaries enrolled in a comprehensive RB-MCO sometimes experience access problems? _____

i. If "yes," please indicate which provider types are a particular concern (*Check all that apply*):

A. ☐ Primary care
B. ☐ Dental
C. ☐ Psychiatrists
D. ☐ Other behavioral health
E. ☐ Pediatric specialists
F. ☐ Obstetrics
G. ☐ Other specialists (specify) _____ _____

Comments on access to care: _____

7. Medical Loss Ratio. Does your state Medicaid agency set a minimum medical loss ratio (MLR) for Medicaid RB-MCOs? ____

a. If "yes,"

i. Please specify the MLR requirement: _____

ii. Does the MLR requirement include direct care management as a medical cost? ____

b. If "no," does your state plan to add this requirement in the future? ____

8. Encounter Data. Please briefly describe how your state uses encounter data and any current issues in your state relating to encounter data collection: _____

END OF COMPREHENSIVE RB-MCO SECTION

III. PRIMARY CARE CASE MANAGEMENT

Please check one of the two boxes below. If you check the first box, please complete the remaining questions in this section. If you check the second box, please skip to Section IV. NON-COMPREHENSIVE PREPAID HEALTH PLANS.

☐ *My state **does or will** operate a PCCM or EPCCM program in FY 2011.* → ***Continue to next question.***

☐ *My state **does not and will not** operate a PCCM or EPCCM program in FY 2011.* → ***Go to Section IV. NON-COMPREHENSIVE PREPAID HEALTH PLANS.***

1. Enhanced Primary Care Case Management (EPCCM). Does your state have a PCCM program that it considers to be an "enhanced" primary care case management program (EPCCM)? ____

a. If "yes," please briefly describe the enhanced features included in your state's EPCCM program: _____

2. Primary Care Providers (PCPs). Please indicate in the table below which providers may be PCPs (other than Family/General Practitioners, Internists, and Pediatricians.) If your state has different policies for different PCCM or EPCCM programs, please briefly describe under "Comments."

Permitted PCP Types *(Check all that apply)*	
a. ☐ Ob/Gyn	e. ☐ Nurse practitioner
b. ☐ Physician specialist	f. ☐ Physician assistant
c. ☐ Physician group/clinic	g. ☐ FQHC
d. ☐ Nurse midwife	h. ☐ Other:_____

Comments: _____

3. PCP Requirements. Please indicate in the table below other state PCP requirements. *(Check all that apply)*

a. ☐ 24 hour/7 day-a-week coverage	e. ☐ Maximum panel size
b. ☐ Meet state reporting requirements	f. ☐ Must provide primary care
c. ☐ Participation in State quality initiatives	g. ☐ Other (*specify*): _____
d. ☐ Minimum panel size	h. ☐ Other (*specify*): _____

4. Payment

a. Please indicate what payment method(s) you use for PCCM or EPCCM reimbursement. If your state has different policies for different PCCM programs, geographic areas or eligibility groups, please briefly describe under "Comments."

Methodology *(Check all that apply)*	
i. ☐ Fee-for-service with case management fee of $_____	iv. ☐ Capitated for services delivered by PCP with gatekeeper responsibility for other services
ii. ☐ Fee-for-service with shared savings provision	v. ☐ Other:_____
iii. ☐ Fee-for-service with enhanced visit rate	

Comments: _____

b. Is there a pay-for-performance aspect to reimbursement? ____

i. If "yes," please briefly describe:_____

5. PCCM Administrative Service Contracts. Please list on Appendix I, Table 2 your state's PCCM administrative service contracts, if any.

END OF PCCM SECTION

IV. NON-COMPREHENSIVE PREPAID HEALTH PLANS

Please check one of the two boxes below. If you check the first box, please complete the remaining questions in this section. If you check the second box, please skip to Section V. QUALITY.

☐ *My state **does or will** contract with a PHP in FY 2011.* → ***Continue to next question.***

☐ *My state **does not and will not** contract with a PHP in FY 2011.* → ***Go to Section V. QUALITY.***

1. Services Provided. Please indicate in the table below the services provided by PHP plans.

PHP Plan Services *(Check all that apply)*		
a ☐ Outpatient behavioral health	d. ☐ Inpatient detoxification	g. ☐ Dental
b. ☐ Inpatient behavioral health	e. ☐ Prescription drugs	h. ☐ Vision
c. ☐ Outpatient substance abuse	f. ☐ Non-emergency transportation	i. ☐ Other:_____

Comments: _____

2. PHP Contractors

a. Please indicate in the table below, by contractor type, the number of non-comprehensive PHPs as of October 1, 2010. (Please note that a plan may fall within more than one of the listed categories below.)

PHP Type	***Number***
i. Medicaid-only (or predominantly Medicaid/CHIP)	
ii. Mixed Medicaid/commercial	
iii. Provider-owned	
iv. Non-profit	
v. For-profit	
vi. Publicly traded	
vii. Local (non-national)	
viii. National	

c. Please list on Appendix I, Table 3 the names of the non-comprehensive PHPs in your state.

Comments: _____

END OF NON-COMPREHENSIVE PHP SECTION

V. QUALITY

All states with comprehensive RB-MCOs or PHPs or operating a PCCM program should complete this section.

1. Accreditation

a. Do you require RB-MCOs to be accredited? ____

i. If "yes," please indicate the type(s) of accreditation accepted (*Check all that apply*)

☐ NCQA, ☐ URAC ☐ AAAHC ☐ Other: _____

ii. If "no," indicate if accreditation is rewarded in one or more of the following ways. *(Check all that apply)*

A. ☐ Additional RFP technical points awarded if accredited
B. ☐ Auto-assignment algorithm favors accredited plans
C. ☐ Higher Medicaid payments available for accredited plans
D. ☐ Other: _____

b. Do you require PHPs to be accredited? ____

i. If "yes," please indicate the type(s) of accreditation accepted (*Check all that apply*)

☐ NCQA, ☐ URAC ☐ AAAHC ☐ Other: _____

ii. If "no," indicate if accreditation is rewarded in one or more of the following ways. *(Check all that apply)*

A. ☐ Additional RFP technical points awarded if accredited
B. ☐ Auto-assignment algorithm favors accredited plans
C. ☐ Higher Medicaid payments available for accredited plans
D. ☐ Other: _____

c. Is deeming of EQR requirements done for accredited RB-MCOs? ____

d. Is deeming of EQR requirements done for accredited PHPs? ____

2. Performance Measures

a. Does your state use performance measures (including HEDIS© or HEDIS©-like measures) to assess clinical quality or access? ____ If "yes":

i. Please indicate below in which delivery systems clinical quality or access performance measures are used and the number of measures used in FY 2011. If clinical quality or access performance measures are used in a PCCM delivery system, please indicate under "Comments" whether survey reports are available by PCP. (Enter "NA" if the delivery system model is not used in your state.)

	Fee-for-Service	PCCM	Comprehensive RB-MCO	Non-comprehensive PHP
A. *Performance measures Used?*				
B. *Number of Measures Used in 2011*				

ii. Are health plans required to submit HEDIS© or HEDIS-like measures to NCQA? ____

A. If "no," indicate whether one or more plans voluntarily submit HEDIS© or HEDIS-like measures to NCQA: _____

Comments: _____

iii. Does the state provide race and ethnicity data to plans for use in HEDIS© or other performance measure analysis? ____

iv. On Appendix II, please indicate the clinical quality or access performance measures that your state currently uses to measure plan performance.

b. Does your state use CAHPS© surveys to assess member satisfaction? ____ If "yes":

i. Does your state require the child, adult or both versions of CAHPS? ____

ii. Are health plans required to submit CAHPS© survey results to NCQA? ____

A. If "no," indicate whether one or more plans voluntarily submit CAHPS survey results to NCQA:

_____

iii. Please indicate below in which delivery systems CAHPS© surveys are used and how often they are performed (e.g., annually, every two years, etc.). If CAHPS surveys are used in a PCCM delivery system, please indicate under "Comments" whether survey reports are available by PCP. (Enter "NA" if the delivery system model is not used in your state.)

	Fee-for-Service	**PCCM**	**Comprehensive RBMC**	**Non-comprehensive PHP**
A.*CAHPS© Used?*				
B. *Frequency of Surveys*				

Comments: _____

3. External Quality Review

a. As of October 1, 2010, did your state have an EQRO contract? ____

b. If your state conducts quality focus studies, please briefly describe or name the most recent focus studies:

_____

4. Quality Reporting

a. Does your state publicly release quality performance reports for:

i. RB-MCOs? ____ ii. PCCM? ____ iii. PHPs? ____ iv. Fee-for-service delivery system? ____

Comments: _____

b. If you answered "yes" to any part of (a) above, are these reports available on the internet?:____

i. If "no," how can these reports be accessed? Please briefly describe: _____

_____

c. Does your state prepare a report card that enrollees can use to compare health plan performance when choosing a plan? ____

i. If "yes," please briefly describe the data reported: _____

_____

d. As required by the Children's Health Insurance Program Reauthorization Act, HHS has developed and posted for public comment an initial core set of children's health care quality measures for voluntary use by Medicaid and CHIP programs. Please indicate whether your state is planning to report on: _____

5. Quality Initiatives

a. Has your state undertaken any initiatives to monitor or improve emergency room use, misuse or overuse? ____

i. If "yes," please briefly describe including whether the initiative is/was viewed as successful:

_____

b. Has your state undertaken any initiatives to monitor or improve obesity rates? ____

i. If "yes," please briefly describe including whether the initiative is/was viewed as successful:

_____

c. Has your state undertaken any initiatives to monitor or improve racial/ethnic disparities? ____

i. If "yes," please briefly describe including whether the initiative is/was viewed as successful:

d. Please briefly describe any other special managed care quality initiatives or requirements:

6. Managed Care Issues. What are your state's top three priorities or strategies for improving quality and/or access in your Medicaid managed care program? Please list below.

a.	
b.	
c.	

Comments:

END OF QUALITY SECTION

VI. SPECIAL INITIATIVES

All states should complete this section.

1. **Care Management/Disease Management**. Please briefly describe any care management or disease management programs in place in your state or planned for implementation in FY 2011, including the population or condition/disease covered, a general description of the services provided, and whether the program is part of a comprehensive RB-MCO or PCCM program: _____

2. **Medical Home.** Does your state have a medical home initiative in place or under development? ____

a. If "yes," please briefly describe your state's:
   i. Medical home definition: _____
   ii. PCP requirements: _____
   iii. Payment method: _____

3. **Managed Long Term Care.**

a. Does your state operate a PACE (Program for All-Inclusive Care for the Elderly) program? ____ If "yes":
   i. How many PACE sites were in place as of October 1, 2010? _____
   ii. How many PACE enrollees were there in October 2010 (or the most recent month available): _____

b. Does your state operate one or more managed long term care (MLTC) programs (other than PACE) as of October 1, 2010? ____ If "yes":
   i. Enrollment. Please provide monthly enrollment numbers for October 2010, or the most recent month available for all MLTC programs (other than PACE): _____. (Please provide the month of the enrollment data if other than October 2010: _____)
   ii. Payment. Please briefly describe the payment methodology: _____
   iii. Benefits. Please briefly describe the benefits included (e.g., institutional services, home and community-based services, etc.): _____
   iv. Issues/Concerns: Please briefly describe any issues or concerns that have arisen in your state relating to MLTC over the past 12-18 months: _____

4. **Dual Eligibles**

a. Please briefly describe any managed care arrangements applicable to dual eligibles in your state currently in place or under development and whether enrollment is mandatory or voluntary: _____

b. Please briefly describe any other dual eligible initiative or program planned or under development in your state including the role, if any, that managed care organizations would play: _____

c. During FY 2011, will your Medicaid program contract with Medicare Advantage Special Needs Plans (SNPs)? ____

5. **Accountable Care Organizations.** Please briefly describe any accountable care organization initiative or program planned or under development in your state including the role, if any, that managed care organizations would play: _____

END OF SPECIAL INITIATIVES SECTION

VII. LOOKING AHEAD

All states should complete this section.

1. **Planned Changes.** Please briefly describe any planned changes or new initiatives in the state's managed care program(s), including enrollment of new populations, expansion to new geographic areas, change in managed care models, other plan changes, etc. _____

2. **Health Home Option.** Does your state plan to elect the new state plan option under section 2703 of the Affordable Care Act to establish Health Homes for enrollees with chronic conditions? ____

a. If "yes," will your state seek the enhanced FMAP available under Section 2703 for any program that already exists? ____

3. Outlook for Medicaid Managed Care in the Future

a. What is the expected future direction for managed care in your state (e.g., new, greater or lesser reliance on managed care or on the RB-MCO or PCCM delivery model)? _____

b. What do you believe are the most significant issues, challenges or opportunities that your state's Medicaid managed care program will face over the next year or two? _____

c. Please comment briefly on the implications for your state of the federal requirement that rates be actuarially sound: _____

d. What other federal regulatory requirements are issues for your program? _____

e. What do you currently envision will be the role of Medicaid managed care under health reform? _____

f. For states that currently have comprehensive RB-MCOs:
   i. Do your state's health plans have sufficient network capacity currently to add new enrollment? _____
   ii. Do you anticipate that your state's health plans collectively can develop or generate sufficient network capacity to accommodate the expected Medicaid enrollment growth under health reform? ____
   iii. Have any of your Medicaid health plans expressed interest in becoming Insurance Exchange plans? ____
   iv. Is your state considering requiring one or more health plans in the Exchange to participate with Medicaid? ____
   v. Is your state considering requiring one or more Medicaid health plans to participate in the Exchange? ____
   vi. Please briefly describe any issues or barriers to entry that would prevent or discourage your state's Medicaid health plans from becoming Insurance Exchange plans: _____

g. What do you envision the impact of health reform will be on Medicaid managed care? _____

Appendix I: Managed Care Contracts

1. Contracted Health Plans. Please list the names of your state's comprehensive RB-MCOs as of October 1, 2010 and the plan enrollments for that month. Indicate whether the RB-MCO exclusively or primarily serves Medicaid/CHIP populations, serves both commercial and Medicaid populations, is a nonprofit or for-profit company, is publicly traded and whether it is a local or national company. If new contracts have been awarded for implementation sometime in FY 2011 after October 1, 2010, please include those as well and include the planned implementation date under "Comments."

Health Plan Name	October 2010 Enrollment	Medicaid only / Mixed Commercial and Medicaid	Non-profit/ For- Profit	Publicly traded	National / Local
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28					
29.					
30.					

Comments: _____

2. PCCM Administrative Service Contracts. Please list any PCCM (or EPCCM) administrative service contracts your state has or will have in place in FY 2011. Indicate the services provided (e.g., outreach, education, credentialing, care management, etc.), and whether any fees are at risk.

Contract Name	Services Provided	Admin fees at risk?
1.		☐
2.		☐
3.		☐
4.		☐
5.		☐
6.		☐
7.		☐
8.		☐

3. Non-comprehensive Prepaid Health Plans. Please list the names of your state's non-comprehensive PHPs as of October 1, 2010 and the plan enrollments for that month. Indicate whether the PHP exclusively or primarily serves Medicaid/CHIP populations, serves both commercial and Medicaid populations, is a nonprofit or for-profit company, is publicly traded and whether it is a local or national company. If new contracts have been awarded for implementation sometime in FY 2011 after October 1, 2010, please include those as well and include the planned implementation date under "Comments."

Health Plan Name	October 2010 Enrollment	Medicaid only / Mixed Commercial and Medicaid	Non-profit/ For- Profit	Publicly traded	National / Local
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28					
29.					
30.					

Comments: _____

Appendix II: Clinical Quality Performance Measures

1. For each managed care model used in your state, please check the box next to each of the HEDIS measures listed below that your state uses or plans to use to measure health plan performance in FY 2011.

RBMC	PCCM	PHP	FFS	2010 HEDIS and CAHPS Measures Required as Part of the NCQA Accreditation Process for Medicaid Health Plans [3]
☐	☐	☐	☐	State does not have this care model
☐	☐	☐	☐	Antidepressant Medication Management
☐	☐	☐	☐	Appropriate Treatment for Children With Upper Respiratory Infection
☐	☐	☐	☐	Appropriate Testing for Children With Pharyngitis
☐	☐	☐	☐	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
☐	☐	☐	☐	Breast Cancer Screening
☐	☐	☐	☐	Cervical Cancer Screening
☐	☐	☐	☐	Childhood Immunization Status (Combination 2)*
☐	☐	☐	☐	Chlamydia Screening in Women (Total rate) **(new for 2010)**
☐	☐	☐	☐	Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening only)
☐	☐	☐	☐	Comprehensive Diabetes Care (Eye Examination, LDL-C Screening, HbA1c Testing, Medical Attention for Nephropathy)
☐	☐	☐	☐	Controlling High Blood Pressure (Overall rate only)
☐	☐	☐	☐	Follow-Up After Hospitalization for Mental Illness (7-Day rate only)
☐	☐	☐	☐	Follow-Up for Children Prescribed ADHD Medication (Initiation Phase and Continuation and Maintenance Phase) **(new for 2010)**
☐	☐	☐	☐	Comprehensive Diabetes Care - HbA1c Poorly Controlled (>9.0%)*
☐	☐	☐	☐	Medical Assistance With Smoking Cessation (Advising Smokers to Quit Only)
☐	☐	☐	☐	Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)*
☐	☐	☐	☐	Use of Appropriate Medications for People With Asthma (Total rate)
☐	☐	☐	☐	Use of Imaging Studies for Low Back Pain
☐	☐	☐	☐	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
☐	☐	☐	☐	Customer Service
☐	☐	☐	☐	Getting Care Quickly
☐	☐	☐	☐	Getting Needed Care
☐	☐	☐	☐	How Well Doctors Communicate
☐	☐	☐	☐	Rating of All Health Care
☐	☐	☐	☐	Rating of Health Plan
☐	☐	☐	☐	Rating of Personal Doctor
☐	☐	☐	☐	Rating of Specialist Seen Most Often

2. For each managed care model used in your state, please list below any other clinical quality or access performance measures that your state uses or plans to use to measure plan performance in FY 2011.

RBMC	PCCM	PHP	FFS	Name of Additional Performance Measures
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	

This completes the survey. Thank you very much.

[3] http://www.ncqa.org/tabid/689/Default.aspx.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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