Appendix A: Federal Medicaid Waivers

Waiver Type	Waiver Description	Section of the Social Security Act Waived
Managed Care/Freedom of Choice – 1915(b)	States may implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.	• Section 1902(a)(1) – Allows states to waive the statewideness requirements and operate the program in select regions of the state. • Section 1902(a)(10)(B) – Allows states to waive comparability of services requirements, which requires all services for categorically needy individuals to be equal in amount, duration, and scope. • Section 1902(a)(23) – Allows states to restrict free choice of providers. • Section 1902(a)(4) – Permits states to mandate consumers into a single managed care entity and restrict disenrollment.
Home- and Community-based Services – 1915 (c)	States may offer a combination of both traditional medical services (i.e. dental services, skilled nursing services) as well as non-medical services (i.e. respite, case management, environmental modifications). States have the discretion to choose the number of consumers to serve in a HCBS waiver program.[1]	• Section 1902(a)(1) – Allows states to target waivers to particular areas of the state. • Section 1902(a)(10)(B) – Allows states to make waiver services available to people at risk of institutionalization, without being required to make waiver services available to the Medicaid population at large. States use this authority to target services to particular groups, or people with certain conditions. • Section 1902(a)(10)(C)(i)(III) – allows states to provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent.
Combined 1915(b)/1915(c) waivers	States may opt to simultaneously utilized section 1915(b) and 1915(c) program authorities to provide a continuum of services to disabled and/or elderly populations. States use the 1915(b) authority to limit freedom of choice, and 1915(c) authority to target eligibility for the program and provide home and community-based services. By doing this, states can provide long-term care services in a managed care environment or use a limited pool of providers.[2]	See 1915(b) and 1915 (c)

[1] Center for Medicare and Medicaid Services. Available online: https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp

[2] Center for Medicare and Medicaid Services. Available online: https://www.cms.gov/MedicaidStWaivProgDemoPGI/06_Combined1915bc.asp

Waiver Type	Waiver Description	Section of the Social Security Act Waived
Research and Demonstration Projects – Section 1115	These projects are intended to demonstrate and evaluate a policy or approach has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. [3]	• Section 1115(a)(1) – Waives provisions of section 1902 to operate demonstration programs • Section 1115(a)(2) – Provides for federal financial participation for costs that otherwise cannot be matched under Section 1903.

[3] Centers for Medicare and Medicaid Services. Available online: https://www.cms.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp

Appendix B: Overview of States Interviewed

State	Rationale
Arizona	• Extensive history with Medicaid managed care • 1115 Waiver: asking federal government to exempt Arizona from federal mandate requiring states maintain existing health coverage until 2014 • Enrolls the aged, blind and disabled (ABD) population, including duals, in its acute care managed care programs and the Arizona Long Term Care System (ALTCS) • Maricopa County's behavioral health model
Florida	• 1115 Waiver: Medicaid reform increasing the use of managed care • Mandatory managed care program expansion will include dual eligibles, children with chronic conditions, foster care and adoption populations • Florida is seeking additional approval to implement cost sharing and premiums • 1915(b) and 1915(c) waivers expand managed care to long-term care for October 2013
Illinois	• Pilot project: Medicaid managed care: mandatory enrollment for 40,000 adults with disabilities • Experiencing provider resistance: major hospital networks indicating they will not participate
Indiana	• 1115 Waiver: Healthy Indiana: first state consumer-directed health plan aimed at low income individual; interested in obtaining federal approval to continue the plan and use it for the Medicaid expansion population • Behavioral health carved in to Hoosier Healthwise managed care program • Care Select - care management program for the ABD population in November 2007
Michigan	• Enrolls most consumers in managed care: dual eligibles and children with special health care needs are excluded • Pay for Performance (P4P): All Medicaid health plans must participate in a P4P program • Use Medicaid Prepaid Inpatient Health Plans to manage behavioral health services • Participating in the Center for Medicare and Medicaid Services (CMS') State Demonstrations to integrate care for dual eligible individuals
New Jersey	• Enrolls most consumers in managed care • FamilyCare provides coverage for uninsured children and some parents who are not eligible for traditional Medicaid; New Jersey is seeking a higher federal match for these programs • 1115 Waiver: waiting approval; expands managed care and seeks to place long term care and behavioral health in managed care
North Carolina	• Primary Care Case Management (PCCM)/ medical home model, Community Care of North Carolina (CCNC) • Enrolls ABD population and pursuing new chronic care initiatives for this population • Provides medical home services through 14 local physician led networks • Participating in CMS' State Demonstrations to integrate care for dual eligible individuals
Oklahoma	• Replaced managed care model with PCCM model, Sooner Care, for adults with children under 18, children under 19, pregnant women aged, blind or disabled population • "Medical home" initiative: strengthens provider incentives for care coordination • Participating in CMS' State Demonstrations to integrate care for dual eligible individuals

Appendix B: Overview of States Interviewed

State	Rationale
Pennsylvania	• Risk-based managed care and enhanced primary care case management (EPCCM) program; planning expansion of risk-based program so both programs will operate "side-by-side" • Dual eligibles originally enrolled, but now carved out; considering carving in again. • Includes pay-for-performance programs for managed care organizations (MCOs), EPCCM vendor and providers
Texas	• 1115 Waiver: waiting for approval: creating Regional Healthcare Partnerships that acquire and reroute $40 billion in federal funding for hospitals in their care for the poor • Expanding risk-based managed care statewide • Currently, has a variety of managed care programs, including programs for the ABD population, foster care children and individuals needing behavioral health services
Virginia	• Has a hybrid managed care/PCCM program including ABD population and foster care children (in some areas) • Directed by 2011 Session to expand Medicaid managed care and to implement a care coordination model for certain Medicaid populations
Wisconsin	• WrapAround Milwaukee: for children and adolescents who have serious emotional disorders • Family Care: capitated managed long-term care program • 1115 Waiver: seeking approval to make changes to Medicaid program designed to save the state money • Participating in CMS' State Demonstrations to integrate care for dual eligible individuals

***Interview: Beth Kohler Lazare, Kari Price, Shelli Silver**

November, 2011

Topic	Response
Medicaid Program Facts	**Number of Medicaid enrollees:** 1,368,844 (December 2011) **Annual Medicaid spending:** $8,665,269,493 (2009) **Medicaid Model:** Approximately 90 percent of Medicaid enrollees are in managed care. The remaining 10 percent includes Native Americans and emergency care for non-citizens. Acute Care Managed Care – provides services for most Medicaid enrollees, including aged, blind and disabled (ABD) populations and dual eligibles. Regional Behavioral Health Authorities (RHBAs) – behavioral health is carved out of acute care managed care and provided through health maintenance organizations (HMOs) –like RHBAs. Arizona Long Term Care System (ALTCS) – provides integrated acute (including behavioral health) and long-term care (LTC) services for those who meet the level of care criteria. Foster Care - separate managed care program overseen by the Arizona Health Care Cost Containment System (AHCCCS) but delivered by The Department of Economic Security (DES).
Arizona Economy and Medicaid Budget	In FY 2012, Arizona was in need of over $1 billion in additional funding to support AHCCCS. With the expiration of the American Recovery and Reinvestment Act of 2009 (ARRA), this has forced AHCCCS to make difficult program decisions.
Organizational Structure of Medicaid Agency	The AHCCCS is Arizona's Medicaid program. AHCCCS oversees contracted health plans in the delivery of health care to individuals and families who qualify for Medicaid and other medical assistance programs. ACCCHS oversees all of Medicaid in the state.
Program Structure and Monitoring	Because of the structure of the program, with separate vendors for acute, LTC, behavioral health and foster care, AHCCCS maintains 16 different contracts with vendors for its managed care programs. AHCCCS' monitoring is very extensive, involved and comprehensive. The state follows their contracts strictly, and all expectations of health plans are documented in the contract and regularly monitored. The contractor policy manual further lays out requirements. A dedicated division of 70 people all do contract monitoring. Additionally, AHCCCS receives operational and legal support from other departments (about 30 additional people). AHCCCS collects and analyzes over 100 deliverables from health plans. AHCCCS invests significantly in the infrastructure and monitoring required for health plans. If a health plan is not in compliance with a contract requirement, AHCCCS has a variety of administrative remedies such as corrective action plans, sanctions, capped enrollment, termination of contracts, etc. However, they have so much ongoing communication with

Topic	Response
	plans, that these corrective action plans are usually unnecessary.
Recent Program Changes	Arizona received approval for its 1115 Waiver in October 2011. The waiver permitted the State to continue to operate its mandatory managed care model but phased out enrollment for its spend down program, froze enrollment for childless adults and incorporated some efforts aimed at increasing personal responsibilities (penalties for missed appointments and above-nominal, mandatory cost sharing).
Long Term Care	On May 5, 2011, AHCCCS awarded 10 contracts to four successful managed care companies that will provide services to individuals enrolled in the ALTCS program. The contracts were awarded for up to five years, beginning on October 1, 2011. All contractors were incumbents. Some county operated plans lost contracts due to increased competition with national plans. ALTCS supports over 70 percent of its members with home or community-based services rather than placing members in more costly nursing home settings. ALTCS is divided into two separate program areas, which are administered differently: 1) Developmental Disabilities ALTCS is overseen by another state agency, not AHCCCS. Behavioral health services are carved out for this population. 2) ALTCS for non-developmentally disabled is overseen by AHCCCS and behavioral, physical and long-term care services are fully integrated.
Behavioral Health	Created in 1986, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) serves as the single state authority to provide coordination, planning, administration, regulation and monitoring of all facets of the state public behavioral health system. ADHS/DBHS contracts with community based organizations, known as Regional Behavioral Health Authorities (RBHAs), to administer Medicaid behavioral health services throughout the State. RBHAs function in a fashion similar to a health maintenance organization. The State is divided into six geographical service areas served by four RBHAs throughout the state. The Medicaid behavioral health program is structured this way because the public system for behavioral health services existed in AZ before Medicaid, so when Medicaid started, the program overlaid the existing structure. Arizona is pursuing a pilot in Maricopa County where they are trying to integrate care for populations with severe mental illness so that they receive their coverage for acute and behavioral health through one entity (the RHBA), rather than through two silo-ed entities. The population will be carved out of the acute care managed care program, and managed by the RHBA. There is an expectation that this would roll out to other counties. Arizona is not looking at this in terms of cost savings, but more to improve outcomes. They expect utilization may increase, but that they will achieve greater efficiencies and better care coordination for the needs of this population.

Topic	Response
Aged, Blind and Disabled Population	Included in both acute care and ALTCS programs.
Dual Eligibles	Included in both acute care and ALTCS programs.
Foster Care	Statutory requirement to have separate contract through Department of Economic Security, which also includes children in protective services (about 12,000 total). This agency is "high touch" and can dedicate staff and resources to this population. The agency is held to same monitoring/contract requirements as other contractors.

* This state was given the opportunity to review and edit the information contained in this case study, and has approved the final version.

***Interview: Medicaid Director Justin Senior, Gail Hanson, Phil Williams**

November, 2011

Topic	Response
Medicaid Program Facts	**Number of Medicaid Enrollees**: 3,021,300 (September 2011) **Annual Medicaid Spending:** total appropriation for state fiscal year 2011-12 - $21.2 billion **Medicaid Model:** Currently, Florida operates a mandatory managed care pilot program in 5 counties under an 1115 demonstration waiver. Outside of these counties, Florida covers services through a mix of fee-for-service (FFS) and through other contracted managed care entities. Individuals can receive care through 19 contracted managed care organizations (MCOs); the statewide PCCM system (MediPass) or a FFS or capitated Provider Service Network (PSN) outside the demonstration counties. In addition, the State maintains several carve-out programs for mental health services, dental care, and transportation outside the demonstration counties.
Anticipated Program Changes	The Florida Medicaid Agency is seeking an amendment to the current 1115 research and demonstration waiver to expand the waiver currently operating as a pilot in Broward, Duval, Baker, Clay and Nassau counties to the entire state (Statewide Managed Medical Assistance Program)with the following changes: • Expansion statewide • Include previously voluntary groups as mandatory (Medicaid, dual eligibles, children with chronic conditions, children in foster care and adoption subsidy) • Update programmatic operations and safeguards Florida has been filing 15 day extensions for the pilot project 1115 waiver ever since July, as CMS has not yet determined if the waiver amendment is approved. Florida also submitted a 1915(b)/(c) waiver to implement managed LTC statewide (the Long-Term Care Managed Care Program). Objectives for moving populations from a FFS system to managed care include: • Providing incentives to providers and recipients for efficient utilization of services by providing for coordination of health care in the most appropriate and cost-effective setting • Providing individuals a meaningful choice of plans and benefits • Reducing fraud, abuse and waste through managed utilization of health care services Florida also notes that although cost containment is an important consideration for these program changes, there will also be some benefit in simplifying the current Medicaid system. While Florida could not commit to cost savings that would result from the program, as the waivers are budget neutral, they do believe

Topic	Response
	that the efficiencies, accountabilities and coordination that will be realized, will result in cost savings. The University of Florida conducted a cost analysis of 2009-2010 program operations in the managed care demonstration counties, and found that Medicaid expenditures in Broward and Duval Counties were lower on a per member per month (PMPM) basis during the first two years post Reform than would have been the case in the absence of the demonstration project.
Florida Economy and Medicaid Budget	The state was hit hard by the recession, especially due to the significance of the real estate market in Florida, and Medicaid experienced increasing enrollment at the same time as budget cuts. Medicaid will represent approximately 29 percent of the State budget in state fiscal year (SFY) 2011-12. If trends continue, it is anticipated that by SFY 2014-15, the Medicaid expenditures will be over $23 billion.
Organizational Structure of Medicaid Agency	With the managed care statewide expansion, there will likely be a restructuring of the Medicaid agency. AHCA is conducting preliminary reviews of staffing implications.
Long Term Care	Upon approval of the waivers, the Florida Long-Term Care Managed Care Program will be available in all areas by October, 2013. Providers will provide LTC services only, such as home- and community-based services (HCBS) and nursing home care. All other care will be through the Florida Managed Medical Assistance Program.
Behavioral Health	Upon approval of the waivers, behavioral health will be carved in to the Statewide Managed Medical Assistance Program.
Aged, Blind and Disabled Population	Upon approval of the waivers, ABD populations will be carved in to the Statewide Managed Medical Assistance Program.
Dual Eligibles	Upon approval of the waivers, dual eligibles will be carved in to the Statewide Managed Medical Assistance Program and the Long-Term Care Managed Care Program.
Foster Care	Upon approval of the waivers, foster care will be carved in to the Statewide Managed Medical Assistance Program.
Transportation	Upon approval of the waivers, transportation will be carved in to the Statewide Managed Medical Assistance Program.
Health Reform: Initiatives to prepare for ACA provisions	In light of the ongoing legal challenges to the Affordable Care Act, Florida is not currently implementing it.

* This state was given the opportunity to review and edit the information contained in this case study, and has approved the final version.

***Interview – Medicaid Director Theresa Eagleson**

January 10, 2012

Topic	Response
Medicaid Program Facts	**Number of Medicaid Enrollees:** 2.8 million recipients • 28 percent of the population in Chicago is in the Medicaid program. 18 percent of the Chicago Suburbs/Collar Counties area are in Medicaid **Annual Medicaid Spending**: $15 billion per year **Medicaid Model:** Hybrid • In Illinois, recipients are covered through a FFS system or a managed care system. Illinois has several managed delivery systems, both operational and in development: o Integrated Care Program (ICP) is a managed care program for older adults and adults with disabilities (excludes dual eligibles). ICP is mandatory in the 6 counties where it operates. o Illinois Health Connect is a PCCM model. This is a statewide health plan available to most persons covered by the Department of Healthcare and Family Services' (HFS) medical program (excludes populations like Refugees, individuals in integrated community living arrangements, PACE recipients, etc.). o Voluntary Managed Care (VMC). Serving All Kids, Moms and Babies, and FamilyCare (for income eligible parents/guardians of children on Medicaid) in select geographic areas. o Care Coordination Innovations Program (CCIP) is currently being implemented as a result of legislation passed in January 2011. This is a care coordination program focused on seniors, adults with disabilities and dual eligibles .
Medicaid Budget	The FY2012 final Medicaid and Medical Assistance budget had a $1.7 billion unfunded budget gap that will result in a continued pattern of deferred payments for all Medicaid providers. In addition, for the period from July-December 2011, with limited resources to pay all outstanding FY2011 bills for the state, the Comptroller has notified HFS it will pay bills only up to certain dollar limits.
Organizational Structure of Medicaid Agency	HFS is responsible for providing healthcare coverage for adults and children who qualify for Medicaid, and for providing child support services to help ensure that Illinois children receive financial support from both parents. The agency is organized into two major divisions, Medical Programs and Child Support Services. In addition, all healthcare purchasing for the state of Illinois is consolidated in a new Office of Healthcare Purchasing within HFS. Director Eagleson noted that there are numerous separate divisions that oversee programs separately from HFS, such as mental health, disabilities, LTC and aging. This can create coordination issues with providers and agencies.

Topic	Response
Recent Program Changes	CCIP is the result of PA96-1501 (passed January 2011). This program requires that 50 percent of Medicaid clients be enrolled in coordinated care programs by 2015. The program seeks to build upon Illinois Health Connect. CCIP will bring together local primary care providers (PCPs), specialists, hospitals, nursing homes and other providers to organize care around a patient's needs. It is intended to keep enrollees healthy through more coordinated medical care, helping prevent unnecessary healthcare costs. RFPs will be released in January 2012 for provider organizations and hospital networks to organize into care coordination entities. The model allows providers to coordinate care for this population on their own. At a minimum, the network must serve 500 elderly patients. The geographic breadth of the program will depend upon the number of interested providers and hospital networks. HFS held a webinar in October 2011 to educate the public about the program. Providers and hospital networks seem to be excited to have the opportunity to manage their own care. HFS does not know how many proposals to expect in the coming weeks.
Long-term Care	The first phase of ICP covers only acute medical care; subsequent phases will carve in waiver and institutional services for the developmentally disabled population. The initiative will implement more home and community based services (HCBS) to aged and disabled persons as an alternative to institutional care.
Behavioral Health	Illinois Health Connect covers behavioral health, but prior authorization is required. Participants in the Voluntary Managed Care Program receive their behavioral health coverage through contracted MCOs. The ICP program contracts with two MCOs – Centene (IlliniCare) and Aetna. Behavioral health services are provided through these contracts. These MCOs, in turn, can subcontract with a behavioral/substance abuse provider network (e.g., Centene-IlliniCare contracts with sister company, Cenpatico for behavioral health services). For CCIP, the state is particularly interested in receiving proposals from providers and hospital networks that include individuals with mental illness and/or substance use disorders. The Department of Mental Health (separate division) operates 162 community mental health centers, more than 30 community hospitals with psychiatric units, and nine state-operated hospitals.
Aged, Blind and Disabled Population	CCIP proposals are currently being submitted, and will serve older adults and adults with disabilities including the dual eligible population. CCIP will not compete with ICP in the six counties where it is mandatory. As the state tries to implement more care management for the ABD population, as well as hospital rate reform, hospitals in the Chicago area are resistant to contracting with MCOs. Many have chosen not to participate in the ICP initiatives. Northwestern Memorial Hospital, Rush University Medical Center and the University of Chicago Medical Center have chosen not to participate. The University of Illinois at Chicago Medical Center has joined the program. Loyola University Health System said in a statement that it wasn't participating for now because "our expenses for Medicaid exceed our reimbursement."

Topic	Response
Dual Eligibles	Many in the dual eligible population are eligible for the CCIP program, except those that must enroll in ICP (Collar Counties: Suburban Cook, DuPage, Kane, Kankakee, Lake, Will). Part of the Medicaid Reform Initiative involves integrating care for Dual Eligibles through the development of Medicare Advantage HMOs. Requests for Proposals (RFPs) are expected to be released April 2012. This will involve a 3-way contract with state HMOs, and CMS. Dual Eligibles can also receive coverage through FFS. Those who have Medicare are excluded from IL Health Connect.
Foster Care	Children in foster care are carved in to Illinois Health Connect program and VMC
Pay for Performance	The state intends to experiment with numerous risk-based financial arrangements through their Medicaid Reform initiatives, as well as "pay-for-performance" plans. When the Medicaid Reform legislation was passed in January 2011, Governor Quinn stated that contracted managed care entities will be reimbursed using risk-based capitation methods creating incentives for plans to improve health care outcomes, disseminate evidence based practices, encourage meaningful use of electronic health record data, and promote innovative service models.

* This state was given the opportunity to review and edit the information contained in this case study, but did not respond in time for publication.

***Interview: Medicaid Director Pat Cassanova, Sarah Jagger**

November, 2011

Topic	Response
Medicaid Program Facts	**Number of Medicaid enrollees:** 1,081,900 (FY 2008) **Annual Medicaid spending:** $5,906490,283 (FY 2009) **Medicaid Model:** Since 2006, Hoosier Healthwise, the state's Medicaid managed care program for the Temporary Aid to Needy Families (TANF) population, has operated a statewide, risk based managed care arrangement. Additionally, the Care Select program provides medical home, utilization management, prior authorization and care management services for members of the ABD population with specified conditions. The state also operates the Healthy Indiana Plan (HIP) through an 1115 Waiver demonstration to low income childless adults and parents earning up to 200 percent of the federal poverty level. HIP includes high deductible coverage and Power Accounts covering the initial deductible and preventative care. Dual eligibles, ABD members not covered under the Care Select program, and children in foster care receive services through FFS. However, the state is currently developing two managed care pilot programs for duals.
Organizational Structure and Medicaid Agency	Hoosier Healthwise and the Healthy Indiana Plan are included under the Family and Social Services Administration. Both HIP and Hoosier Healthwise are in the Office of Medicaid Policy and Planning (OMPP). At the last procurement, Hoosier Healthwise and HIP combined their contracts so all three health plans are available in both programs. The goal was to get families together under one plan, which the state is still working toward.
Healthy Indiana Plan	The Healthy Indiana 1115 Waiver Demonstration allows the State to operate a public health savings account program, the Healthy Indiana Plan (HIP), for uninsured adults (childless adults and parents) not currently eligible for Medicaid. HIP is the first state consumer-directed health plan aimed at people earning Medicaid–level incomes. Childless adults and parents earning up to 200 percent of the federal poverty level qualify for coverage which includes free preventive care. The plan was originally marketed like a commercial health plan rather than a Medicaid plan to gain interest from those who may not be interested in a Medicaid plan. They were successful at gaining broad interest, quickly reached the capitation level, and currently have a waiting list of around 50,000 people. They have opened enrollment on a limited basis due to attrition. A main component of the program is the emphasis on personal responsibility. Each member makes a contribution, which is pro-rated based on income, to a POWER account. Most people, approximately 95 percent, value the coverage enough to diligently make the payment. The state makes the initial contribution and individuals must make up front payments. Pregnancy is not covered under HIP. If a member does become pregnant, they are moved to the Hoosier Healthwise Plan which has caused some difficulty in coordination. Unused POWER account funds rollover to the following year. Preventative care is at no cost to the member. A large portion of individuals make contributions to HIP which result in income being low enough that they do not need to make POWER

Topic	Response
	account contributions. This consequence was unintentional. The state is in the process of receiving legislative approval for a minimum contribution from all participants. Initially, there was an increase in usage; however, by the second year medical usage leveled off. Currently, HIP members are appropriately seeking out primary care providers and have less emergency department use compared to individuals not included in the HIP program. Providers must enroll in Medicaid and are paid the Medicare rates for services. The health plans collect payments from providers however, they have experienced some difficulty coordinating this process. Provider side - very positive because they pay Medicaid rates. It is a way to move uninsured off their lists. Indiana has submitted a State Plan Amendment to CMS to use HIP to provide services for the Medicaid expansion populations which will be eligible in 2014. The state plan amendment has been denied because CMS does not currently have the essential benefit package laid out. Indiana will submit their waiver renewal at the end of 2012. In the renewal they will ask for a three year waiver.
Monitoring	Conduct onsite reviews and reporting.
Long-term Care	LTC services are FFS. However, some LTC services will be included in the upcoming dual pilot projects.
Behavioral Health	Most behavioral health services are carved in to Hoosier Healthwise. Initially, health plans were concerned about the carve-in because they contracted with behavioral health plans, and providers were concerned with payments. The state worked closely with the plans and providers to resolve these issues. They formed a committee to work on this transition and partnered with an internal mental health agency. Currently, all stakeholders seem to be content with the carve-in.
Aged, Blind and Disabled Populations	Most of the ABD population is covered under Care Select. Prior to November 2010, all of the ABD population was covered. However, the program was too broad and needed cost efficiencies. In November of 2010, they updated the Care Select criteria to target those with chronic diseases who could benefit most from disease management. Those not included in this category receive services under FFS.
Dual Eligibles	Currently, all dual eligibles are included in fee-for-service. Two risk-based managed care pilot projects for duals in two geographic areas are currently being developed.
Foster Care	Children in foster care are currently in FFS; however, the state would like to transition this population to managed care. Some children in foster care are currently enrolled in Care Select due to mental illness.
Pay for Performance	Currently using pay-for-performance for some HEDIS® measures, including prenatal measures.
Health Reform: Initiatives to prepare for	Indiana has a Level I exchange planning grant which they are using to decide whether or not to pursue an exchange. They are currently assessing the rules, mapping out needed changes and submitting comments to the federal government regarding exchanges.

Topic	Response
ACA provisions	
Lessons Learned	It is a huge undertaking to do a redesign even for a small program. Eligibility issues cause problems. Eligibility processes were completely different in the beginning from where they needed to be for the redesign to be successful. They couldn't run the program as they wanted so they were more costly than they needed to be.

* This state was given the opportunity to review and edit the information contained in this case study, but did not respond in time for publication.

***Interview: Medicaid Director Stephen Fitton**

October, 2011

Topic	Response
Medicaid Program Facts	**Number of Medicaid enrollees:** 1,966,600 (FY 2008) **Annual Medicaid spending:** $10,583,215,243 (FY 2009) **Medicaid Model:** Since the late 90s, Michigan has operated mandatory managed care. Almost 90 percent of Medicaid enrollees are in some form of Medicaid managed care, and the state continues to make efforts to expand managed care enrollment. The ABD population has been in managed care since the late 90s. Foster care and pregnant women have only recently been placed into managed care. Certain populations are excluded from managed care. Dual eligibles, spend down, and children with special healthcare needs are carved out of managed care and receive services through FFS. Managed care is part of the state's effort to attain a more pro-active and organized system of care. Systems have developed and matured over time. They have 14 health plans available (they used to have 33). Takes years for MC programs to mature and develop into well-functioning programs.
Michigan Economy and Medicaid Budget	Michigan has been in a depressed economic state longer than other states. The economy has been on the decline for 10 years and is just now seeing an upturn. State revenues are below what they were in the 1990s, even accounting for inflation. This has had significant impact on Medicaid. In the 1990s, Michigan had 1.1 million Medicaid recipients, and now has 1.9 million recipients (growth was mostly children). Generally, the state has not cut eligibility. They have been more creative with funding, and have significantly relied upon ARRA federal funds. Additionally, Michigan has kept provider rates pretty flat.
Organizational Structure and Medicaid Agency	The Medicaid program is under a single state agency, the Public Health and Medicaid Division. The department is understaffed; they have lost 45 staff, and are now at about 300 people. This is the lowest number since the 80s. In the 90s, when Michigan operated a PCCM model, the department had 600 people. The Department is comprised of 3 Bureaus: 1. Medicaid Policy and Systems Innovation (policy process, state plan, Actuarial Division) 2. Medicaid Program Operations (handles HMO contracts, pharmacy, quality control) 3. Financial Services (this is a significant bureau, as MI does not contract out financial services and claims processing) In the past, MCOs bid on price. Michigan has changed this so that Michigan sets the price. Michigan considers this a less risky way to structure the program, in light of past bankruptcies.

Topic	Response
Monitoring	Michigan has a very robust quality and monitoring program for their managed care program. About 20 people work on monitoring the 14 MCO contracts. Monitoring and quality control is a high priority to Michigan Medicaid.
Long-term Care	Long-term care services are FFS.
Behavioral Health	Carved out. Carve out is primarily due to resistance from Community Mental Health (CMH) centers. There are 46 CMHs, almost entirely funded by Medicaid. For inpatient services, Michigan contracts with 18 Medicaid Prepaid Inpatient Health Plans.
Aged, Blind and Disabled Populations	Carved in to managed care.
Dual Eligibles	Dual eligibles were carved into managed care in the 1990s, but it became clear that they could not be managed well there. They have been in FFS since then. Current initiatives include participation in CMS' demonstration project for dual eligibles. Michigan is part of the CMS demonstration project to integrate Medicare/Medicaid financing. This will be a shared risk between contractor and state with full risk eventually shifting to the contractor. There will be phased implementation. Voluntary enrollment has started. There have been many challenges in designing and implementing this program. The project includes coordination of physical health, hospitals, Medicare, and mental health. Michigan is lacking Medicare claims data. Additionally, there are stakeholder challenges. About $2 billion of the combined $7.5 billion Medicare/Medicaid funding for duals is Medicaid funding for behavioral health. Therefore, stakeholders are very concerned about the demonstration project and protective of their funding. Nursing homes are also lobbying for carve-outs. It has very hard to combine these services for this population, and there is no current, scalable model that works.
Foster Care	Recently placed into managed care.
Pay for Performance	Michigan has a P4P program that uses HEDIS® and CAHPS measures. Michigan has seen significant improvement in outcomes over time for the P4P measures. These P4P initiatives are a low-cost way to get plans motivated. The pool used to be $3 million and is now $5 million. This is 0.19 percent of gross.
Health Reform: Initiatives to prepare for ACA provisions	The Medicaid Director feels MCOs are the best option to handle the capacity that will be needed under health reform. Michigan sees managed care as essential to being able to provide access given increased enrollment.

* This state was given the opportunity to review and edit the information contained in this case study, but did not respond in time for publication.

***Interview: Medicaid Director Valarie Harr**

October, 2011

Topic	Response
Medicaid Program Facts	**Number of Medicaid enrollees:** Division of Medical Assistance and Health Services Home, through Medicaid and NJ FamilyCare programs serves about 1.3 million New Jersey residents. **Annual Medicaid spending:** Division Budget - $11 billion (state funds and federal funds) **Medicaid Models:** Most NJ FamilyCare/Medicaid clients are enrolled in managed care, including TANF, long-term care (if 1115 Waiver is approved), ABD population (as of July, 2011), dual eligibles (as of fall, 2011), and foster care. Behavioral health is carved out currently and paid FFS. If 1115 Waiver is approved, behavioral health services will be managed by a non-risk-based contractor.
Anticipated Program Changes	New Jersey has submitted an 1115 waiver application to CMS that proposes delivery system changes, which is in the early stages of review. The waiver would consolidate all existing state plan services, five home and community-based services waiver programs, a "freedom of choice" waiver program, two earlier section 1115 waiver programs, and multiple contracts into a managed care delivery system. Though New Jersey is waiting for approval on the waiver, the state is still moving forward with many initiatives that move toward managed care. Starting July 1, 2011, the state moved ABD and dual eligibles into managed care and carved in personal care, assisted care, home health, pharmacy, adult and pediatric day care.
New Jersey Economy and Medicaid Budget	The state is going through tough economic challenges. They are faced with losing $1 billion in federal Medicaid stimulus money. Their Medicaid enrollment growth increased at 22 percent over 3 years
Organizational Structure of Medicaid Agency	Currently under a hiring freeze. In particular, there will be increased managed care monitoring duties as managed care is expanded, and New Jersey enhances efforts.

Topic	Response
1115 Waiver	New Jersey is currently awaiting CMS approval for their 1115 Waiver. 1115 Waiver was filed on September 9, 2011. The submitted 1115 Waiver was a revised from the initial concept paper from summer 2011. New Jersey received stakeholder feedback, which informed the changes to the waiver in September. There were three significant changes from the initial concept paper: 1. No enrollment freeze for adult parents in expansion population 2. No copayments for emergency room visits 3. Behavioral health not carved into managed care. Other stakeholder feedback has been generally positive. New Jersey is pursuing the waiver and managed care expansions because there is a need to address the budget issues and Medicaid expenditure and enrollment growth. New Jersey needs a more efficient program. New Jersey has had high managed care penetration since the 1990s. They are good at controlling cost, increasing access, etc. Now they want to expand their managed care programs even further and create more budget predictability. New Jersey did not want to commit to a specific cost savings estimate, and they are not willing to provide any data or cost studies until the waiver is approved. However, they strongly believe that the move to managed care, specifically, managed LTC, will result in significant savings.
Challenges of Waiver Process	1. Partnership with CMS. New Jersey desires shorter timeframes and expedited decision-making through 1115 waiver. 2. Stakeholder community. Changing delivery systems is challenging for stakeholders to accept. New Jersey needs to be willing to work with stakeholders, pursue performance based purchasing, and make stakeholders part of the process.
Long-term Care	If the 1115 Waiver is approved, LTC will move to managed care
Behavioral Health	Behavioral Health was a contentious topic area for managed care. Behavioral Health is not carved into managed care because of feedback and resistance from the provider and advocacy communities. The program will still be managed, but not risk-based at first. To improve coordination between physical health and behavioral health, New Jersey will amend their contracts with physical health services to include requirements for the sharing of information and care coordination.
Aged, Blind and Disabled Population	Starting July 1, 2011, the state moved the aged, blind and disabled into managed care and carved in personal care, assisted care, home health, pharmacy, adult and pediatric day care, and therapy. Managed care will be mandatory for all populations.
Dual Eligibles	Beginning in January, New Jersey will be contracting with a dual eligibles Special Needs Plan (SNP). As of fall 2011, Dual eligibles were carved into managed care.

Topic	Response
Foster Care	Foster care populations are carved in to managed care. Behavioral health is carved out.
Health Reform: Initiatives to prepare for ACA provisions	New Jersey Medicaid had a study performed that predicted they will receive 230,000 newly eligible Medicaid enrollees in 2014 due to health care reform. The state sees managed care as integral to being able to expand the program to serve additional 2014 enrollees. Ensuring access is a concern for these newly covered populations. New Jersey is negotiating (through the 1115 waiver) to receive a higher matching rate for additional populations that New Jersey already covered.

* This state was given the opportunity to review and edit the information contained in this case study, and has approved the final version.

***Interview: Medicaid Director Craigan Gray, Steve Owen**

December, 2011

Topic	Response
Medicaid Program Facts	**Number of Medicaid Enrollees:** 1,705,000 (2008) **Annual Medicaid Spending:** $11,506,119,180 (FY2009) **Medicaid Model:** PCCM/medical home. Community Care of North Carolina (CCNC) is a unique model that provides medical home services to Medicaid consumers through 14 local networks across the State. Local networks are physician led and provide care management and coordination to enrollees with the main goal of containing costs and improving quality of care.
Anticipated Program Changes	The state is interested in having CCNC pursue a more rational business model and more intensive care management efforts. The state wants CCNC to take more responsibility in program administration (for example, taking on some of the functions of an MCO), so the state can serve a monitoring role for CCNC. In efforts to manage more services, the state is implementing pay for performance initiatives such as a tiered per member, per month model. CCNC grew out of negative provider response to managed care. It is risk averse. CCNC's community network model started in the pediatric community. These were loose associations of quality initiatives, which gradually formalized. Now these groups have much more oversight and responsibility, but their models are not fully updated. North Carolina is trying to develop a structure that will allow them to develop into premier care management organizations.
North Carolina Economy and Medicaid Budget	North Carolina is experiencing an overall State budget shortfall. Enrollment is up, and the budget is down. Additionally, the state implemented a 6.3 percent rate reduction in 2010, and is pursuing numerous program modifications to try to meet need. North Carolina is averse to cutting benefits or eligibility.
Organizational Structure and Medicaid Agency	CCNC is not a government entity. It is a non-profit, provider owned organization that covers 1 out of 1.5 million Medicaid recipients in North Carolina.
Monitoring	Since program inception, CCNC has collected data and monitored financial, quality, and health outcomes. CCNC conducts both claims and chart audits to review outcomes and process data and measures. The CCNC program office assumes responsibility for collecting a range of outcome measures via claims analysis (e.g., inpatient admission rate) and performance and process measures via randomized chart audits. Each network has a medical committee consisting of participating PCPs that review evidence-based guidelines and Medicaid claims data to make recommendations to the clinical directors.
Long-term Care	Traditionally, CCNC has not managed these services, but it is now part of the vision for CCNC to engage this population better.

Topic	Response
Behavioral Health	In February 2010, the Division of Medical Assistance (DMA) approved the Behavioral Health Integration Initiative (BHI), a greater integration of behavioral health services into CCNC's approach. The plan supports the integration of behavioral health services, including mental health and substance abuse, into the 1,400 primary care practices in CCNC networks across North Carolina. CCNC hired a lead psychiatrist to focus and direct the implementation of this plan. The local networks have hired psychiatrists and behavioral health coordinators to implement the proposal at the network and local levels. Certain test sites are managing care of behavioral health within CCNCs. Behavioral health providers are being located in large family practices. Codes have been changed to allow charges to occur on the same day/same time. They also reversed co-locations of providers, and put physical health providers in psych settings. This has been very successful and has resulted in less churning on the part of the behavioral health provider.
Aged, Blind and Disabled Populations	Served through CCNC.
Dual Eligibles	Dual eligibles are served through CCNC. North Carolina is part of the CMS demonstration project to integrate Medicare/Medicaid financing. North Carolina's approach for integrating care for dual eligibles is to build on the CCNC program to improve the delivery of health care for vulnerable populations. The initiative aims to partner with LTC providers, home and community-based providers, area agencies on aging, and other stakeholders to design, in concert with dual-eligibles and their families, a health care delivery system for duals that can provide the right care at the right time and that will achieve the "Triple Aim".
Foster Care	Foster children can be enrolled in CCNC, but on a voluntary basis.
Health Reform: Initiatives to prepare for ACA provisions	NC does have an exchange planning grant. Medicaid providers in the state are pursing implementation of a pediatric Accountable Care Organization (ACO). The state has established work groups, which will release a final report soon, to discuss initiatives and programs to consider in preparation for ACA provisions.

* This state was given the opportunity to review and edit the information contained in this case study, but did not respond in time for publication.

***Interview: Medicaid Director Garth Splinter, Carrie Evans, Cindy Roberts**

November, 2011

Topic	Response
Medicaid Program Facts	**Number of Medicaid Enrollees:** 745,700 (2008) **Annual Medicaid Spending:** $3,937,604,747 (2009) **Medicaid Model:** SoonerCare Choice is a PCCM model, administered under an 1115 waiver, in which each member is linked to a primary care provider who serves as their "medical home." Overview of different programs operating under Oklahoma's SoonerCare Medicaid program: • SoonerCare Choice: patient centered Medical Home model, PCPs are paid monthly case management fee • SoonerCare Traditional: FFS program for members not qualified for SoonerCare Choice (institutionalized, foster care, tribal and HCBS waiver populations). • SoonerCare Supplemental: FFS program for dual eligibles • Opportunities for Living Life: Administrative office for LTC (HCBS waiver services, nursing home). Insure Oklahoma: for populations that are not eligible for Medicaid, but uninsured and under 200 percent of federal poverty level (FPL).
Oklahoma Economy and Medicaid Budget	Like other state agencies, OHCA's general appropriations for state fiscal year 2010 were cut by 7.5 percent, or almost $44 million in state funds. Those cuts involved reducing administrative costs, increasing various co-pay amounts, changes to durable medical equipment and prescription benefits, and changes in payments for certain services. Additionally, there was an across the board provider rate reduction of 3.25 percent. Due to budget concerns, a recent state plan amendment extended enrollment for children in Insure Oklahoma only up to 200 percent of FPL, rather than 300 percent of FPL.
Organizational Structure and Medicaid Agency	In total there are 460 employees in six divisions. Many key staff have been with the program since it was established in the early 1990s. OHCS contracts with the Oklahoma Department of Human Services to determine eligibility. OHCA is a stand-alone agency with its own governing board, which is an uncommon arrangement for a Medicaid administration. OHCA maintains its own hiring system, salary provisions, etc.

Topic	Response
Oklahoma's Unique PCCM Model	SoonerCare is a partially capitated, PCCM Medicaid program. SoonerCare provides health care to adults with children under age 19 and pregnant women and individuals who are aged, blind or disabled. The medical home provider receives a capitated rate, which includes medically necessary office visits, child screenings, injections, immunizations, limited lab services, basic family planning services and case management referrals. Other services are FFS. Health Access Networks (HANs) provide wraparound services which are not available in medical homes.
Managed Care History and PCCM developments	In 1995, the state operated the SoonerCare Plus Program. This was a risk-based managed care organization (MCO) model which operated in select regions of the state. In the early 2000s, there were only two MCOs operating in certain regions of the state (minimum federal requirement). In 2003, MCOs sought rate increases for 2004, but the state (under budget pressure) only offered a lower rate, which only two MCOs accepted. During this time of gridlock and stalled negotiation, OHCA developed analysis that indicated the state could operate the Choice program in the three urban areas of the state at lower cost and with fewer staff. OHCA convened an emergency meeting in November 2003, and the OHCA Board voted to end the Plus program, and replace it with the Choice program in all three urban areas. In 2003, the state discontinued SoonerCare Plus and switched to the SoonerCare Choice Program in all regions of the state. The state has continued to provide enhancements to the PCCM Model in 2004-2007, such as: • Nurse Care Management. Hired large amount of nurses who serve as coordinators for MCOs, and now are performing many of the care management and coordination functions the MCOs previously performed in rural areas. • Health Management Program. Focused on high cost, high need enrollees, launched in 2008. • Medical Home Model. Moved away from partial capitation reimbursement approach toward one that relies on FFS reimbursement.
Monitoring	Oklahoma has a Quality Assurance and Quality Improvement Division that is responsible for the following: • Monitoring of utilization for the various SoonerCare programs • On site provider audits for the evaluation of contract compliance • Investigation of member and provider complaints • Development and monitoring of quality improvement studies • Ongoing evaluation and maintenance of the integrity of the Oklahoma MMIS systems
Long-term Care	LTC services are paid through FFS. The Opportunities for Living Life (OLL) program coordinates additional benefits for SoonerCare Traditional and SoonerCare Supplemental available through HCBS waiver services.

Topic	Response
Behavioral Health	Behavioral health services are paid through FFS Medicaid. Medicaid also handles billing for the Department of Mental Health, so Medicaid has access to combined claims data. The agency meets regularly with behavioral health stakeholders as well as a behavioral advisory task force that meets every other month. The relationship with these groups can be contentious.
Aged, Blind and Disabled Populations	18 percent of Sooner Care enrollees are ABD, although this population makes up 53 percent of expenditures. More than half of the ABD population receives SoonerCare Traditional. Before switching to a PCCM model, the ABD population was in an MCO delivery system.
Dual Eligibles	Dual Eligibles are covered under Sooner Care Supplemental or Sooner Care Traditional, and their services are often coordinated through the OLL program. Oklahoma is in the very preliminary stage of implementing a program through CMS' dual eligible demonstration: 1. Involves creating ACOs with embedded medical education programs (Health Innovation Zone) with the University of Tulsa that specifically serves high cost patients that are eligible for both Medicare and Medicaid. This initiative is in the very preliminary stages as the University develops its model. 2. Explore feasibility of establishing benefit plan and network, administered and operated by the State. Oklahoma proposes combining the funding streams from Medicare and the OHCA and using these funds to purchase coverage through a plan and network developed and administered by OHCA. The federal government said Oklahoma could buy HMO products but not run their own. The state proposed instead that they use internal capabilities and sell it to a combined program, where the federal government would pay costs 3. Potential expansion of Oklahoma's Cherokee Elder Care PACE program statewide. Have had stakeholder meetings about expanding PACE and feedback has been supportive. Communities see value in PACE programs for participants and for local economies in general.
Dental Services	Except for children and pregnant women, routine dental services are not covered under SoonerCare.
Foster Care	Foster care populations are enrolled in SoonerCare Choice. Foster care population is paid for by Medicaid, but is managed by the Department of Human Services.

Topic	Response
Health Reform: Initiatives to prepare for ACA provisions	Oklahoma Temporary High Risk Pool serves as a bridge until 2014 brings in these new populations. Oklahoma believes their current PCCM model positions them well for health care reform. There are longstanding issues with provider capacity in rural areas, which will become more of a concern with the influx of new enrollees in 2014. The state has been recently talking to deans of medical schools to help address capacity issues Oklahoma is proud of their online enrollment and real-time eligibility capabilities. They feel that this also positions them for health reform provisions. OHCA implemented a web-based SoonerCare application to add newborns to existing SoonerCare cases. As a result of this system, newborns can now be enrolled in SoonerCare before they leave the hospital. A total of 23,908 babies were enrolled using electronic enrollment during SFY2010.

* This state was given the opportunity to review and edit the information contained in this case study, but did not respond in time for publication.

***Interview: Medicaid Director Scott Schalchlin, Eugenia Andrew, Gary Young**

November, 2011

Question	Response
Medicaid Program Facts	**Number of Medicaid enrollees:** 4,276,600 (2008) **Annual Medicaid spending:** $23,704,821,993 (2009) **Medicaid Model:** Texas Medicaid managed care is delivered through the following models: Managed Care Organizations (MCOs) and Primary Care Case Management (PCCM). PCCM currently serves unique populations and provides services in rural areas where managed care is not available. Managed Care: • STAR – risk-based managed care that serves non-disabled, low income families and pregnant women • STAR Health – risk-based managed care model for foster care kids providing acute care and behavioral health • NorthSTAR - provides behavioral health services in seven counties around Dallas • STAR PLUS – operates in select urban areas of the state and for the ABD population, including dual eligibles (PCP is through Medicare not STAR+PLUS)
Anticipated Program Changes	The Texas Health and Human Services Commission (HHSC) submitted a proposal to CMS in mid-July 2011 to create a Section 1115 Demonstration Waiver. This proposal would expand the STAR and STAR+PLUS Medicaid managed care programs to new counties on Sept. 1, 2011, and more counties on March 1, 2012. STAR will be statewide by March 2012, while STAR+PLUS will only be in specific counties. Additionally, this waiver brings dental services into managed care for the Medicaid population. Managed care expansion under the 1115 Waiver was brought in for cost containment purposes. CMS said in a September 14 letter, they had reached "agreement in principle" with the state on the 1115 waiver, which will reroute $40 billion over five years to public hospitals and new Regional Healthcare Partnerships, coalitions of public and private hospitals, to fund care for the uninsured and projects such as new clinics. Texas received final approval on the waiver on December 12, 2011. Medicaid had been moving forward as if the waiver would be approved, even though the legislature indicated that the managed care expansion could not proceed without approval of the waiver's hospital funding mechanism.
Texas Economy and Medicaid Budget	Texas did not balance the budget last session, and Medicaid was underfunded. Medicaid was able to use some funding from the "rainy day fund," but the legislature left Medicaid underfunded with the intention to encourage the agency to be more efficient.

Question	Response
Organizational Structure and Medicaid Agency	HHSC operates STAR, PCCM, STAR+PLUS, STAR Health and CHIP. Medicaid managed care and CHIP are administered under a single management structure at HHSC. NorthSTAR is administered by the Texas Dept of State Health Services (DSHS). Medicaid currently has a hiring freeze.
Monitoring	Monitoring: HHSC oversees two areas of monitoring: 1) Contract Managers, who oversee administrative items, and 2) Health Plan Management (HPM), which oversees complaints, reviews all HMO materials, tracks percentage of claims, manages timeliness, tracks claims indicators, etc. HPM has approximately 40 staff. Despite hiring freezes, managed care hiring is growing. In total, the managed care staff is around 95, including waiver oversight, HPM, contract managers, etc. These divisions and staff are very hands on with the MCOs.
Long-term Care	STAR+PLUS managed care operates in select urban areas of the state and covers the aged, blind and disabled population (ABDs), and dual eligibles (for duals, the PCP is through Medicare not STAR+PLUS) and is designed to provide health care, acute and long term services and support through a managed care system. Behavioral health is carved in. The legislature looks favorably on this program for its cost savings.
Behavioral Health	Behavioral health is carved in to STAR and STAR+Plus, except for the regions where the NorthSTAR program operates. NorthStar is a stand-alone, managed care program, providing behavioral health services in 7 counties around Dallas, which started as a pilot and expanded. It does well in the areas where it operates, but it will not likely be expanded further because the state perceives more benefit from having behavioral health carved in to the managed care programs. It is still a cost effective program, just a somewhat silo-ed approach. Behavioral health stakeholder concerns about managed care expansion are not significant compared to other states. Mental health advocates also perceive value in a more coordinated approach that managed care can offer.
Aged, Blind and Disabled Population	See LTC section above for more details.
Dual Eligibles	See LTC section above for more details.

Question	Response
Foster Care	STAR Health is the capitated managed care program for foster care populations, which provides acute care and behavioral health. The foster care population was previously FFS. Care coordination for this population is key, and is part of the reason for the move to managed care. The state maintains a separate contract because foster kids have specific service needs, including extensive behavioral health services, they have to move around, require other supports, etc. HHSC believes the population's specific needs are better met through this program design. The state acknowledges that cost control is not the primary focus of this managed care program, but rather provides the care coordination necessary for this population. There is only one MCO contractor for the program. HHSC considered expanding to include more MCOs, but the level of state coordination with other state agencies and MCOs is difficult.
Dental	Texas' 1115 Waiver incorporates dental managed care into the STAR program for the Medicaid population
Pay for Performance	Starting in March 2012, five percent of capitation premiums will be at risk for quality metrics (P4P). .
Health Reform: Initiatives to prepare for ACA provisions	State agency has five to six staff dedicated to health care reform. They communicate anticipated changes, etc. about information applicable to MCO contracts.

* This state was given the opportunity to review and edit the information contained in this case study, but did not respond in time for publication.

***Interview: Leesa Allen,**

November, 2011

Topic	Response
Medicaid Program Facts	**Number of Medicaid enrollees:** 2,197,600 (2009) **Annual Medicaid spending:** $17,231,560,151 (2009) **Medicaid Model:** Pennsylvania has had some form of Medicaid managed care since the 1970s. Currently, Pennsylvania uses the following delivery systems: • HealthChoices, a full risk-based mandatory managed care program, and consists of a physical health program and a behavioral health program. HealthChoices currently operates in three zones, or 25 counties. HealthChoices currently serves approximately 1.2 million Medicaid lives. • ACCESS Plus, an enhanced primary care case management (EPCCM) program, operates in 42 counties where HealthChoices does not currently operate. • Voluntary managed care program in 25 of the ACCESS Plus counties.
Anticipated Program Changes	On August 23, 2011, the Department of Public Welfare (DPW) announced plans for a statewide expansion of the HealthChoices program in a public discussion paper. DPW is planning to expand the program, alongside the existing ACCESS Plus program. The HealthChoices program has helped DPW to improve health care access, manage health care quality and control health care costs for its Medical Assistance consumers. DPW is interested in how consumers will react to ACCESS Plus and Health Choices running side by side and how care coordination will work with people who switch between programs.

Topic	Response
Organizational Structure of Medicaid Agency	The DPW is comprised of the following Offices, each of which is comprised of Bureaus and Divisions. • Office of Medical Assistance Programs: Serves as the single state agency responsible for oversight of the Medicaid program • Office of Mental Health and Substance Abuse Services: Operates HealthChoices for behavioral health services • Office of Developmental Programs: Administers some HCBS waiver programs • Office for Long-Term Living: Administers some HCBS waiver programs • Office of Administration • Office of Income Maintenance • Office of Child Development and Early Learning • Office of Children, Youth and Families
Pennsylvania Medicaid Budget	In the Commonwealth budget (2011-2012), DPW represents 43 percent of total budget. Of the DPW budget, Medical Assistance utilizes 52 percent (this does not include 16 percent for Long-Term Living programs and 4 percent for Mental Health). Pennsylvania is working to develop a long-term, multi-year strategy to reduce costs and change the mindset on public assistance to promote personal independence and individual empowerment. Past cost containment efforts include: • Increased efforts to deter fraud and abuse and recover costs - $46.6m in savings • Initiatives to encourage more home- and community-based care - $40.5m in savings
Long-term Care	Long-term care services are carved out of managed care and paid FFS.
Behavioral Health	Behavioral health is managed by separately contracted managed care entities (although behavioral health services are under the umbrella of the HealthChoices Program. There have been successes and challenges with this carve out. Managing the whole person is more difficult, and DPW has had continued challenges with controlling the drug spend. The Commonwealth has had success with pilot programs for individuals with serious mental illnesses (SMI). These SMI pilot programs include efforts by DPW and HealthChoices physical health and behavioral health MCOs to manage the whole person. They are focused on consumer engagement, medical homes (where community-based mental health centers are the medical home for many individuals) and information exchange. The programs include a pay for performance incentive program to encourage MCOs to meet performance measures.
Aged, Blind and Disabled Population	The ABD population is carved in to HealthChoices and ACCESS Plus.

Topic	Response
Dual Eligibles	Dual eligibles enrollment in HealthChoices was mandatory prior to 2005, but enrollment is now voluntary.
Foster Care	Enrollment in HealthChoices is voluntary.
Pay for Performance Initiatives	Pennsylvania has a well-developed P4P program and is considered an industry leader in this regard. The P4P program began by paying MCOs for meeting specific quality targets. The Department has since expanded to include HealthChoices Provider P4P and Quality-Based Auto-Assignment programs. The P4P program has allowed for concentrated quality improvement efforts in areas such as maternity care, dental access, childhood weight management and other areas primarily targeted by disease management program, where collection of quality data provides insights in the effectiveness and value of these services. The P4P program annually pulls from 27 high-priority areas and measures of healthcare quality, access and special needs. HealthChoices Performance Trending Report details MCO performance in these 27 areas and 11 are included in the P4P model. Of the 11 measures included in the 2009-2010 P4P program, HealthChoices has experienced: • Statistically significant improvements for 10 out of 11 measures between the baseline year and 2010 • No statistically significant declines between the baseline year and 2010 • Statistically significant improvements for 7 out of 11 measures between 2009 and 2010 • 9 of 11 HEDIS® measures meet or exceed the NCQA 50th percentile benchmark Pennsylvania is considering paying Medicaid recipients – in some cases as much as $200 – as an incentive to visit higher quality and lower cost hospitals and doctors. Experts say the strategy has never been tried by other states. The state's Secretary of the Department of Public Welfare, Gary Alexander, said his agency hopes to launch the plan by early next year in an effort to help control rising expenses in the $30 billion program. After sharing his ideas at a conference in Washington, he spoke with Kaiser Health News and said that his incentive plan would initially target the nearly 1 million Medicaid recipients still in the traditional FFS Medicaid program. Later, he said, it could be expanded to more than 1.2 million in private Medicaid managed care plans.

* This state was given the opportunity to review and edit the information contained in this case study, and has approved the final version.

***Interview: Rebecca Mendoza, Adrianne Fegans, Steve Ford, Karen Lawson, Tom Edicola**

November, 2011

Topic	Response
Medicaid Program Facts	**Number of Medicaid enrollees:** 929,463 (June, 2011) **Annual Medicaid spending:** $5,774,994,043 (FY 2009) **Medicaid Model:** In select geographic regions, Virginia operates risk-based managed care (the MEDALLION II program) with dental, behavioral health and long-term care services carved-out. Dual eligibles and foster care populations are carved-out. In regions where risk-based managed care is unavailable or voluntary due to lack of MCO choice, Virginia operates MEDALLION PCCM.
Anticipated Program Changes	In January 2012, 30,000 individuals will be moved into MCOs, including ABD populations. This is an expansion to the southwest region. Dental, long-term care and behavioral health services will be carved-out. Additionally, dual eligibles and some foster care populations in some geographic areas are excluded from managed care. Those receiving long-term care services will have their acute and primary care managed through MCOs. Virginia's managed care expansion was for a number of reasons: budgetary, preparation for ACA provisions and because statewide expansion of MCO has been the long term goal of the state. Statewide expansion had not been feasible in the past, until now, due to an inability to secure enough contracts for rural areas. Providers now have a better understanding of managed care concepts. It is still early in the expansion process for southwest Virginia, but so far they are educating providers on managed care, and the reception seems positive. Additionally, Virginia issued an RFP for a behavioral health care coordination program for those populations that do not get coverage through managed care. This care coordination model started July 2011 for all carved out populations. The contractor will serve as the Behavioral Health Services Administrator. These duties include strengthening behavioral health services in terms of increasing care coordination activities, authorizing, monitoring and encouraging appropriate behavioral health service utilization, effective program integrity activities, and paying claims.
Virginia Economy and Medicaid Budget	Virginia has seen significant enrollment increases. Enrollment is somewhat stabilized, but high rates still remain
Organizational Structure and Medicaid Agency	The Virginia Medicaid program is administered by the Department of Medicaid Assistance Services (DMAS). The Department of Medical Assistance Services is headed by the Agency Director. There are three Deputy Directors which oversee Maternal and Child Health, Appeals, Office of Communications and Legislative Affairs, Office of Behavioral Health, Policy and Research, Information Management, Fiscal and Purchases, Provider Reimbursement, Budget and Contract Management, Program

Topic	Response
	Operations, Health Care Services, Long Term Care and Program Integrity.
Monitoring	Virginia has contract monitoring process and requires NCQA accreditation of all MCO plans. The state monitors contractors and provides quality improvement feedback. VA has a Quality Collaborative for all MCOs, as well as a Program Integrity Collaborative which focuses on fraud, waste, and abuse among MCOs.
Long-term Care	MCO enrollment for HCBS waiver recipients is only available right now if they were enrolled in the MCO prior to HCBS waiver enrollment. They receive acute care services via the MCO and the LTC services are carved out.
Behavioral Health	Carved-out. In designing the program, the state decided that they did not have extensive experience with the SMI population and didn't want to take risks with that population. MCOs cover behavioral health through clinic services and outpatient psych. Behavioral health services carved out of the MCO include the state plan option services. The new RFP will not cover services covered by the MCO currently. Recipients in MCOs will have their carved out behavioral health services coordinated via the contractor. An RFP was recently released for this model. It is a 4 year contract; the contractor will have no risk in the first three years, and then will serve as a full risk behavioral health MCO in the 4th year.
Aged, Blind and Disabled Population	ABD population is covered through MCOs. For the Roanoke region that had the hybrid PCCM/MCO model, about 70 percent of ABD population are in MCOs, though they have the option to be in PCCM.
Dual Eligibles	Dual eligibles are carved out and receive services through FFS. Virginia plans to introduce a new optional pilot for the dual eligible population that fully integrates all services for the population – acute, primary, behavioral, etc.
Foster Care	Carved-out. Foster care populations were included originally in managed care, but the decision was made to ultimately carve them out because this population is unique, moves a lot, etc. Managed care was not statewide at the time, so it was difficult to manage when children moved out of the managed care areas. Currently, Virginia is piloting a project to move foster care populations in the Richmond area into managed care. Because managed care is now going to be statewide, it positions the state to expand the Richmond pilot to the rest of the state. Have not received any negative feedback from stakeholders about the pilot.
Health Reform: Initiatives to prepare for ACA provisions	The state's managed care expansion has been a goal for years, but the state believes it will facilitate the transition of new Medicaid-eligible populations in 2014. Virginia is also working on a new eligibility system due to concern about 2014 new populations. This next session will determine if the state initiates its own Exchange or not.

* This state was given the opportunity to review and edit the information contained in this case study, and has approved the final version.

***Interview: Marlia Mattke, Curtis Cunningham**

January, 2012

Topic	Response
Medicaid Program Facts	**Number of Medicaid Enrollees:** 1.1 million (2011) **Annual Medicaid Spending:** $6,684,081,412 (2009) **Medicaid Model:** Managed Care: • BadgerCare Plus (children, parents, pregnant women) o Statewide o Enrollment is mandatory for eligible members who reside in areas served by two or more BadgerCare Plus HMOs o Enrollment is voluntary for members who reside in areas served by only one BadgerCare Plus HMO • Family Care LTC, (FamilyCare and FamilyCare Partnership) o As of April 1, 2011, Family Care is available in 57 counties in Wisconsin. The state plans to expand enrollment in Family Care to more geographic regions of the state over time. o Voluntary enrollment for those who meet the requirements of a long-term care functional screen. • Supplemental Security Income (SSI) managed care program o Many SSI and SSI-related members are required to enroll in an SSI MCO. o In some counties, members are required to enroll for a trial period, but then may opt out and return to Medicaid FFS. o In other counties, enrollment is voluntary. o Voluntary enrollment for dual eligibles. Traditional fee-for-service (FFS) • FFS covers populations that are not in managed care service areas, or that have chosen to opt out of managed care, select individuals from the aged, blind and disabled (ABD) population, and select members from the dual eligible population.
Medicaid Budget	For the 2011-2013 biennium, state General Purpose Revenue expenditures are projected to be higher than assumed in the budget. The state budget directs the Department of Health Services to identify $444.6 million in Medicaid savings. Agency officials say they'll actually have to save $554.4 million to balance the program.

Topic	Response
Organizational Structure of Medicaid Agency	The Department of Health Services is one of the largest and most diverse state departments in Wisconsin with an annual budget of $7.8 billion and 5,500 employees. The Office of the Secretary of Health Services oversees the Division of Public Health, Division of Healthcare Access and Accountability, Division of Mental Health and Substance Abuse Services, Division of Quality Assurance, Division of Long Term Care and Division of Enterprise Services. Department activities include alcohol and other drug abuse prevention, mental health, public health, implementation of long-term care, disability determination, regulation of state nursing homes, and numerous other programs that aid and protect the citizens. The Department also oversees seven large institutions: three centers for the developmentally disabled, a facility for mentally ill inmates, two psychiatric hospitals, and a facility for treating sexually violent persons. The Division of Health Care Access and Accountability oversees Medicaid, which is the single largest program in the state budget, and other health and social service programs.
Recent Program Changes	Wisconsin initiated a number of Medicaid program changes, initiatives, cost containment efforts and reforms in 2011. A number of these reforms require committee review and approval, and/or CMS approval. Additionally, the state has a number of proposals pending (some requiring approval through the state Joint Committee on Finance, and some requiring federal approval via state plan amendments or waivers) related to payment reform, service delivery reform, benefit reform and eligibility reform. In the fall of 2011, WI submitted a maintenance of effort waiver request of eligibility restrictions established under the ACA. If not approved by year end, a statutory provision in the last budget provided that this would force the state to eliminate coverage for approximately 53,000 individuals. As of January 3, 2012, the state has not received approval, but is in conversations with CMS . The Governor has stated publicly that the provision to have to eliminate coverage for 53,000 members will not be enacted.

Topic	Response
Long-term Care	Wisconsin's Medicaid funded, LTC program for adults, administered by the WI Department of Health Services' Division of LTC are: • Family Care (managed care, voluntary) • Family Care Partnership (Partnership) (managed care, voluntary) • Program for All Inclusive Care for Elderly (PACE) (managed care) • Include, Respect, I Self-Direct (IRIS) (fee-for-service (FFS) self-directed option through community waiver) DHS contracts with MCOs to deliver the Family Care Program, the Family Care Partnership Program (Partnership) and PACE. These programs provide supports and services in the individual benefit package through a managed care service delivery model to enrollees in need of LTC. • Family Care is a capitated Medicaid managed care program for the delivery of all Medicaid long-term care services. Family Care provides *partial integration* (home and community based services (HCBS), institutional care, Medicaid personal care, home health and other services. Family Care does not pay for health care costs (acute/primary). Family Care participants use Medicare and Medicaid to purchase these health care services. • Partnership is a capitated integrated Medicaid and Medicare managed care program that, in addition to the Family Care long-term care benefits, provides managed health care benefits, and all applicable Medicare Advantage Special Needs Plans (SNP) and Medicare Part D prescription drug benefits. Partnership provides *full integration* (integrates a person's LTC services (primary and acute), and prescription medications. • PACE is a capitated integrated Medicaid and Medicare managed care program very similar to Partnership, but that conforms to some service delivery methods prescribed in federal regulations. The Department, per provisions enacted in the 2011-13 budget, effective July 1, 2011, capped enrollment in Family Care and its related programs (the Family Care Partnership Program, the Program for All-Inclusive Care for the Elderly (PACE), and the Include, Respect, I Self-Direct (IRIS) program, and stopped planned expansion into additional counties. However, on December 28, 2011, Gov. Scott Walker announced a plan to lift the enrollment cap on the state long-term care program . CMS has also indicated in recent correspondence that they believe that the state is not allowed to keep the cap in place. As of April 1, 2011, Family Care was offered in 57 counties in Wisconsin. The state aims to expand the program statewide over time.
Behavioral Health	Behavioral health is covered under Wisconsin's BadgerCare Plus Medicaid program for visits with a psychiatrist, though inpatient mental health services are carved out. The state has submitted proposals to CMS to integrate mental health services into health home models across the state. Additionally, the state is looking to incorporate the WrapAround Milwaukee Program (a managed care, mental health program for adolescents) into a health home model.
Aged, Blind and	If not eligible for LTC, the ABD population is covered through the SSI managed care program (only operates in certain geographies), or

Topic	Response
Disabled Population	through the Forward Health, FFS model. Those living in an institution or nursing home, or participating in a Home and Community Waivers program are not eligible for SSI managed care.
Dual Eligibles	Dual Eligibles receive coverage in a number of different ways: Family Care LTC (23,600 individuals), FFS (if not eligible for LTC), SSI managed care (if eligible and in select geographies), PACE (3,600 individuals), other waivers (7,000).
Foster Care	Foster care children are covered through BadgerCare Plus. Many of these children are also enrolled in Wrap Around Milwaukee. Additionally, there are proposals underway to achieve a health home model for this population.
Pay for Performance	Since 2009, the Department has operated a P4P program as part of its efforts to continue to improve quality outcomes. For 2011, the Department withholds 1 percent of the capitation rate of MCOs serving BadgerCare Plus and SSI members; MCOs can earn this back by attaining specific goals related to health care quality. For calendar year 2012, the Department will withhold 1.5 percent, amounting to approximately $10 million for BadgerCare Plus and SSI.

* This state was given the opportunity to review and edit the information contained in this case study, and has approved the final version.

kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

October 2011

EXAMINING MEDICAID MANAGED LONG-TERM SERVICE AND SUPPORT PROGRAMS: KEY ISSUES TO CONSIDER

EXECUTIVE SUMMARY

There is increased interest among states in operating Medicaid managed long-term services and support (MLTSS) programs rather than paying for long-term services and supports (LTSS) on a fee-for-service basis, as has been the general practice. This issue brief examines key issues for states to consider if they are contemplating a shift to covering new populations and LTSS benefits through capitated payments to traditional risk-based managed care organizations (MCOs). It draws on current literature as well as discussions conducted during the spring and summer of 2011 with a variety of respondents – federal and state officials, researchers, representatives from managed care organizations, service providers, and consumer advocates.

Experience with and evidence about the impact of Medicaid MLTSS is limited. Relatively few states currently use capitated models to manage care for the elderly or individuals with disabilities, the populations most likely to require LTSS. Research to date indicates that relative to fee-for-service programs, MLTSS programs reduce the use of institutional services and increase access to home and community-based services, but there is little definitive evidence about whether the model saves money or how it affects outcomes for consumers.

Program design is an important component of state MLTSS initiatives, and establishing high quality MLTSS programs is not a simple process. The extent to which MLTSS programs cover institutional services, medical care, or behavioral health services, in addition to community-based LTSS, affects MCOs' ability to coordinate services and manage costs effectively. Other significant program features to consider are whether enrollment in Medicaid MLTSS plans is mandatory or voluntary and whether the MCO is sponsored by a commercial, non-profit, or governmental entity. In light of budget shortfalls, and particularly if government downsizing is occurring, states may have diminished capacity to develop, implement, and monitor new MLTSS initiatives. It is important for planning and start-up periods to be long enough to allow state agencies to collaborate to make complex program design choices, to work with CMS to obtain the authority to operate new programs, and to consult with stakeholders, including consumers, providers, and MCOs.

Community-based organizations play a vital role in ensuring an adequate supply of LTSS, and it is important to consider their role in a managed long-term care system. These entities often have long-standing ties with consumers by making LTSS referrals or providing services. In a managed care environment, community-based organizations in some states function as MCOs or participate in MCO provider networks.

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Table 1: Design Features for 11 Capitated Medicaid MLTSS Programs

State	Program	Target Population	Mandatory or Voluntary Enrollment	Scope of Services in Addition to Community-Based LTSS	Integrated with Medicare
Arizona	ALTCS	Frail elderly; people of all ages with disabilities, except developmental disabilities	M	Institutional LTSS; medical	N
Florida	Nursing Home Diversion	Frail elderly	V	Institutional LTSS; medical	Y
Hawaii	QExA	Frail elderly; people of all ages with disabilities, except developmental disabilities	M	Institutional LTSS; medical	N
Massachusetts	Senior Care Options	Frail elderly	V	Institutional LTSS; medical	Y
Minnesota	Senior Health Options	Frail elderly	V	Limited institutional LTSS*; medical	Y
New Mexico	CoLTS	Frail elderly; people with disabilities, expect developmental disabilities	M	Institutional LTSS; medical	N
New York	Managed Long-Term Care	Primarily frail elderly; some younger adults with physical disabilities**	V	Institutional LTSS; limited medical**	Y
Tennessee	CHOICES	Frail elderly; younger adults with physical disabilities	M	Institutional LTSS; medical	N
Texas	STAR+PLUS	Frail elderly; younger adults with physical and mental disabilities	M	Limited institutional LTSS; limited medical***	N
Washington	Medicaid Integration Partnership	Frail elderly; younger adults with disabilities****	V	Institutional LTSS; medical	N
Wisconsin	Family Care	Frail elderly; younger adults with physical or developmental disabilities	V	Institutional LTSS*****	Y

* Medicaid pays for institutional LTSS beyond 180 days on a fee-for-service basis.
** Age of eligibility and scope of medical services may differ by plan. Medical services that are not covered by the plan are covered on a fee-for-service basis by Medicaid or, for dually eligible beneficiaries, by Medicare MA plans.
*** Medicaid pays for institutional LTSS beyond 120 days and for in-patient hospital services on a fee-for-service basis.
**** The program operates in only one county in Washington.
***** Medical services are covered on a fee-for-service basis by Medicaid or, for dually eligible beneficiaries, by Medicare.

Medicaid Reform Proposal Tracker (August 2011)©

	Coordination of Care							Payment Structure			Reductions				Efficiencies					Partnerships		HCBS Expansion			Request to Federal Govt	
	Primary Care Case Management	Medical Homes	Managed Care/Care Coordination	Chronic Care Case Management	Dual Eligibles	Integration of Medicare Medicaid	Accountable Care Organizations (ACOs) [1]	Payment for Performance	Authority for Care Coordination Payments	Managed Care/ Capitated Service Delivery	Reimbursement Rates	Eligibilty	Service Elimination	Service Reduction	Beneficiary Responsibility	Medicaid Program Integrity	Health Information Technology	Combining State Administrative Offices	Reducing Hospital Readmissions	Guiding Body for Reform Initiatives	Target Parnerships [2]	Money Follows the Person	Nursing Home Diversion	Medicaid Expanison Pre-2014	Request for Waiver of Maintenance of Effort	Governor support of Federal Medicaid Block Grant [3]
Alabama																										
Alaska																										
Arizona			X		X			X		X	X	X	X	X	X	X			X						X	X
Arkansas		X	X					X	X	X							X									
California		X	X	X	X			X	X	X	X	X	X	X			X						X	X		
Colorado																										
Connecticut		X	X		X	X			X	X	X	X					X					X	X	X		
Delaware			X		X				X	X	X							X		X		X	X			X
Florida	X	X	X						X	X				X		X							X			
Georgia																										
Hawaii		X	X						X		X	X		X												
Idaho																										
Illinois		X	X					X	X	X		X				X	X						X			
Indiana																										
Iowa																										
Kansas		X							X	X				X				X							X	X
Kentucky		X	X	X	X	X		X	X	X						X	X		X		X					
Louisiana																										
Maine								X																		X
Maryland			X					X												X	X					
Massachusetts		X	X		X	X	X	X	X	X	X					X	X		X							
Michigan					X																					
Minnesota					X						X					X								X		
Mississippi																										
Missouri																										
Montana																										
Nebraska																										
Nevada																										
New Hampshire	X	X	X				X	X			X						X			X						
New Jersey			X		X					X		X													X	
New Mexico			X							X		X			X											
New York		X	X		X				X	X	X			X						X						

	Coordination of Care							Payment Structure			Reductions				Efficiencies					Partnerships		HCBS Expansion			Request to Federal Govt	
	Primary Care Case Management	Medical Homes	Managed Care/Care Coordination	Chronic Care Case Management	Dual Eligibles	Integration of Medicare Medicaid	Accountable Care Organizations (ACOs)[1]	Payment for Performance	Authority for Care Coordination Payments	Managed Care/ Capitated Service Delivery	Reimbursement Rates	Eligibility	Service Elimination	Service Reduction	Beneficiary Responsibility	Medicaid Program Integrity	Health Information Technology	Combining State Administrative Offices	Reducing Hospital Readmissions	Guiding Body for Reform Initiatives	Target Partnerships [2]	Money Follows the Person	Nursing Home Diversion	Medicaid Expanison Pre-2014	Request for Waiver of Maintenance of Effort	Governor support of Federal Medicaid Block Grant [3]
North Carolina																										
North Dakota																										
Ohio		X	X		X	X	X	X	X	X	X			X					X	X				X		X
Oklahoma																										
Oregon			X		X				X	X	X								X							
Pennsylvania																										
Rhode Island																										
South Carolina		X	X		X				X	X	X		X	X	X					X			X			X
South Dakota											X			X				X								
Tennesee					X																					
Texas			X					X		X	X			X		X						X				X
Utah																										
Vermont					X	X					X									X						
Virginia	X		X		X	X				X	X									X						X
Washington		X	X	X	X	X		X	X	X	X			X	X		X	X	X		X					X
West Virginia																										
Wisconsin			X		X					X		X		X	X		X						X		X	X
Wyoming																										
District of Columbia																										
Total	**3**	**15**	**23**	**3**	**19**	**8**	**4**	**13**	**16**	**21**	**18**	**8**	**3**	**13**	**5**	**7**	**9**	**4**	**7**	**9**	**3**	**3**	**9**	**3**	**4**	**11**

[1]Accountable Care Organizations (ACOs) are a network of doctors and hospitals that shares responsibility for providing care to Medicare patients. In this chart states are listed as utilizing ACOs, if they are using ACOs as part of their Medicaid reform plan (i.e. developing plans for combined Medicare and Medicaid savings).
[2]Targeted Partnership is a partnership in which a particular group is targeted for participation in aiding Medicaid
[3]Though several governors have expressed support for federal Medicaid block grants, only Washington state and Texas have passed bills to establish Medicaid block grants.
Medicaid Reform Tracker is a monthly copy written publication of the National Association of States United for Aging and Disabilities.
Please email Sara Tribe at Stribe@nasuad.org if you would like to receive monthly updates

CHCS Center for Health Care Strategies, Inc.

States with Fully Integrated Care Programs for Dual Eligibles[1, 2]

Effective September 2010

State	Program Name	Population	Integration Model		Benefits				Geography		Medicaid Enrollment	
			Special Needs Plan (SNP)	Alternative	Medicare Acute	Medicaid Acute	LTC*	BH*	Pilot	Statewide	Mandatory	Voluntary
Arizona	**Arizona Long Term Care Services (ALTCS)**	Medicaid aged (65+), blind and disabled beneficiaries who need a nursing home level of care. Includes duals.	Currently contracts/ contractors not required to be SNPs		✓	✓	✓	✓		✓	✓	
California[§]	**In Development**	All duals.		Four pilots planned	IN DEVELOPMENT							✓
Colorado[‡]	**In Development**	All duals.	Contracts planned		IN DEVELOPMENT							✓
	In Development	All duals.		✓	IN DEVELOPMENT							✓
Maryland[‡]	**In Development**	Duals and Medicaid-only beneficiaries needing LTC services.	Contracts planned		✓	✓	✓		IN DEVELOPMENT			
Massachusetts[‡]	**Senior Care Options**	Duals and Medicaid-only beneficiaries age 65 and older.	Currently contracts/ contractors required to be SNPs		✓	✓	✓	✓		✓ Statewide procurement, but limited provider regions		✓
	In Development	Duals ages 22-64; may expand age range.		✓	✓	✓	✓	✓		✓	IN DEVELOPMENT	
Michigan[‡]	**In Development**	Duals and Medicaid-only beneficiaries with nursing home level of care.		✓	✓	✓	✓		✓		✓	
Minnesota[†]	**Minnesota Senior Health Options (MSHO)**	Duals and Medicaid-only beneficiaries age 65 and older.	Currently contracts/ contractors required to be SNPs		✓	✓	✓	✓		✓		✓
	Minnesota Disability Health Options (MnDHO)	Duals and Medicaid-only beneficiaries with physical disabilities, ages 18-65.	Currently contracts/ contractors required to be SNPs		✓	✓	✓	✓		✓ Limited regions		✓
	Special Needs Basic Care (SNBC)	Duals and Medicaid-only beneficiaries with disabilities.	Currently contracts/ contractors required to be SNPs		✓	✓		✓		✓ Limited regions *(may expand statewide)*		✓

[1] CHCS defines fully integrated care as programs that include the full range of Medicare and Medicaid primary, acute, and long-term supports and services.
[2] This matrix includes a selection of state activities for integrating care effective September 2010; it is not an exhaustive list.
[§] Indicates participation in CHCS' *California Technical Assistance* project (- present)
[‡] Indicates participation in CHCS' *Integrated Care Program* initiative (2005 – 2007).
[†] Indicates participation in CHCS' *Transforming Care for Dual Eligibles* initiative (2009 – present)

States with Fully Integrated Care Programs for Dual Eligibles *(continued)*

State	Program Name	Population	Integration Model		Benefits				Geography		Medicaid Enrollment	
			Special Needs Plan (SNP)	Alternative	Medicare Acute	Medicaid Acute	LTC*	BH*	Pilot	Statewide	Mandatory	Voluntary
New Mexico†	**Coordination of Long-Term Services (CoLTS)**	All duals; Medicaid-only beneficiaries who receive certain waiver services or reside in a nursing facility.	Currently contracts/ contractors required to be SNPs		✓	✓	✓			✓	✓	
New York†	**Medicaid Advantage**	Duals age 18 and older.	Currently contracts/ contractors required to be MA* or SNPs		✓	✓		✓		✓		✓
	Medicaid Advantage Plus	Duals age 18 and older who have a nursing home level of care.	Currently contracts/ contractors required to be MA or SNPs		✓	✓	✓	✓		✓		✓
Pennsylvania‡	**Integrated Care Option**	Duals age 60 and older.	Contracts planned/ contractors will be required to be SNPs		✓	✓	✓		✓			✓
Texas‡	**STAR+PLUS**	Medicaid beneficiaries who receive SSI* and/or qualify for certain waiver services. Includes duals.	Planning to mandate SNPs in new contracts		✓	✓	✓	✓ Limited		✓ Limited regions	✓	✓ Children receiving SSI
Vermont‡	**In Development**	All duals.		✓	✓	✓	✓	✓	✓			✓
Wisconsin	**Partnership Program**	All duals; Medicaid-only beneficiaries who receive a nursing home level of care.	Currently contracts/ contractors required to be SNPs		✓	✓	✓	✓ Mental Health		✓ Limited regions *(may expand statewide)*		✓
Washington†	**Washington Medicaid Integration Partnership (WMIP)**	Duals and Medicaid only beneficiaries ages 21 and older.	Currently contracts/ contractors not required to be SNPs		✓	✓	✓	✓	✓			✓

***Legend**

LTC	Long-Term Care Services
BH	Behavioral Health Services
MA	Medicare Advantage
SSI	Supplemental Security Income

Joint Principles of the Patient-centered Medical Home[1]

Personal physician – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision-making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

[1]Patient Centered Primary Care Collaborative. *Joint Principles of the Patient Centered Medical Home*. Available online: http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

- Practices complete a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.

- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers and community resources.

- It should support adoption and use of health information technology for quality improvement.

- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

- It should recognize case mix differences in the patient population being treated within the practice.

- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

- It should allow for additional payments for achieving measurable and continuous quality improvements.

National Committee on Quality Assurance Patient-centered Medical Home Standards[2]

The Standards: The PCMH 2011 program's six standards align with the core components of primary care.

- PCMH 1: Enhance Access and Continuity
- PCMH 2: Identify and Manage Patient Populations
- PCMH 3: Plan and Manage Care
- PCMH 4: Provide Self-Care and Community Support
- PCMH 5: Track and Coordinate Care
- PCMH 6: Measure and Improve Performance

The Must-Pass Elements: Six must-pass elements are considered essential to the patient-centered medical home, and are required for practices at all recognition levels. Practices must achieve a score of 50 percent or higher on must-pass elements:

- PCMH 1, Element A: Access During Office Hours
- PCMH 2, Element D: Use Data for Population Management
- PCMH 3, Element C: Care Management
- PCMH 4, Element A: Support Self-Care Process
- PCMH 5, Element B: Track Referrals and Follow-Up
- PCMH 6, Element C: Implement Continuous Quality Improvement

Optional Recognition for Use of Standardized Patient Experience Survey: Beginning in January 2012, NCQA will offer additional points based on reporting results from a standardized patient experience survey. This option will require practices to use the Medical Home version of the CAHPS Clinician and Group Survey (currently in development by the research team sponsored by the federal Agency for Healthcare Quality and Research [AHRQ], with collaboration from NCQA). Practices can earn NCQA Distinction for collecting data using the survey and methods

[2] National Committee for Quality Assurance. *Patient-Centered Medical Home (PCMH) 2011 Overview.* January 31, 2011. Available online at: http://www.ncqa.org/tabid/631/Default.aspx

and reporting the results to NCQA. Because there are no national data sources for benchmarking performance on patient-experience results using this new tool, results will not initially be publicly reported or used to score practices.

U.S. Department of Health & Human Services

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

2010 State Snapshots

Based on data collected for the *2010 National Healthcare Quality Report* (NHQR)

Executive Summary

Georgia

This document contains information available on the Web site of the Agency for Healthcare Research and Quality (http://statesnapshots.ahrq.gov/snaps10/).

This document is provided to facilitate information sharing when computers are not convenient, such as in group meetings. Included information is a high-level summary of the information available in the Web-based tool. Please visit the Web site for more in-depth detail on specific measures, different comparisons, and analytic methods.

Generated from the Web site:
May 23, 2011

Developed by Thomson Reuters and Social & Scientific Systems
under AHRQ Contract

Table of Contents

Guide to Contents

The 2010 State Snapshots provide State-specific health care quality information including strengths, weaknesses, and opportunities for improvement. The goal is to help State officials and their partners better understand health care quality and disparities in their State.

Select components from the 2010 State Snapshots for Georgia are incorporated into this Executive Summary, including:

Overall Health Care Quality: The overall health care quality for Georgia is shown on two meters as a composite of all 119 measures reported in the 2010 National Healthcare Quality Report for Georgia. The first meter shows the State's position relative to the quality of health care across all States reporting such data in the Nation. The second meter shows the same compared only to States in the same region of the country. (Most measures are reported by all States.) Following the meters are tables showing the meter score for your State and the best performing States.

State Dashboard: The dashboard is a summary of Georgia's performance, compared to all States reporting, on subsets of the measures related to types of care, settings of care, and clinical areas.

Strongest and Weakest Measures: Georgia's strongest and weakest measures are reported. Strongest measures are those in which the State performed above the all-State average and are strongest among their measures relative to all reporting States. Weakest measures are those in which the State performed below the all-State average and are weakest among their measures relative to all reporting States.

Focus on Payer and Disparities: Two special "Focus" sections from the 2010 NHQR State Snapshots are also featured. They include:

- **Focus on Payer** showing information for hospital care measures that refer to inpatient mortality and potentially avoidable complications by expected primary payer (privately insured, Medicare, Medicaid, and the uninsured), and

- **Focus on Disparities** showing information on disparities in quality of health care for potentially preventable admissions, inpatient mortality, and potentially avoidable complications by race/ethnicity and low-income communities.

Contextual Factors: A table shows Georgia's percent or rate for contextual factors related to demographics, health status, and resources compared to all States and the region. The contextual factors may aid in interpretation of the State performance meters.

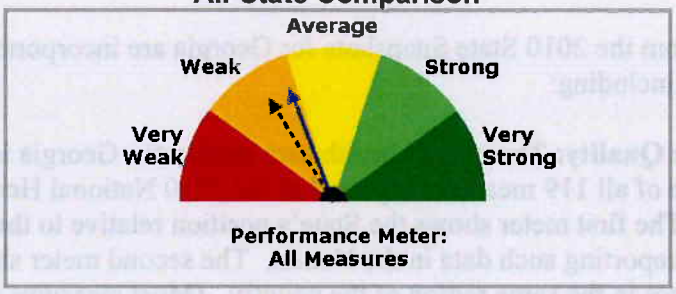
State Snapshots Web Site Summary: The final section of this report is a summary of all features available on the State Snapshots Web site: http://statesnapshots.ahrq.gov/snaps10/.

Executive Summary

Overall Health Care Quality for Georgia

Compared to all States, for the most recent data year, the performance for Georgia for all measures is in the weak range. For the baseline year, performance is in the weak range.

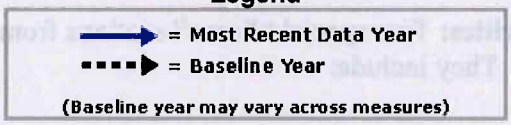
All-State Comparison



Compared to the South Atlantic States, for the most recent data year, the performance for Georgia for all measures is in the average range. For the baseline year, performance is in the weak range.

Regional Comparison

Legend



To see how close to best performance your State is, in the tables below find the rate for your State and compare to the rates for the best performing States.

Best Performing States Across All Measures in Overall Health Care

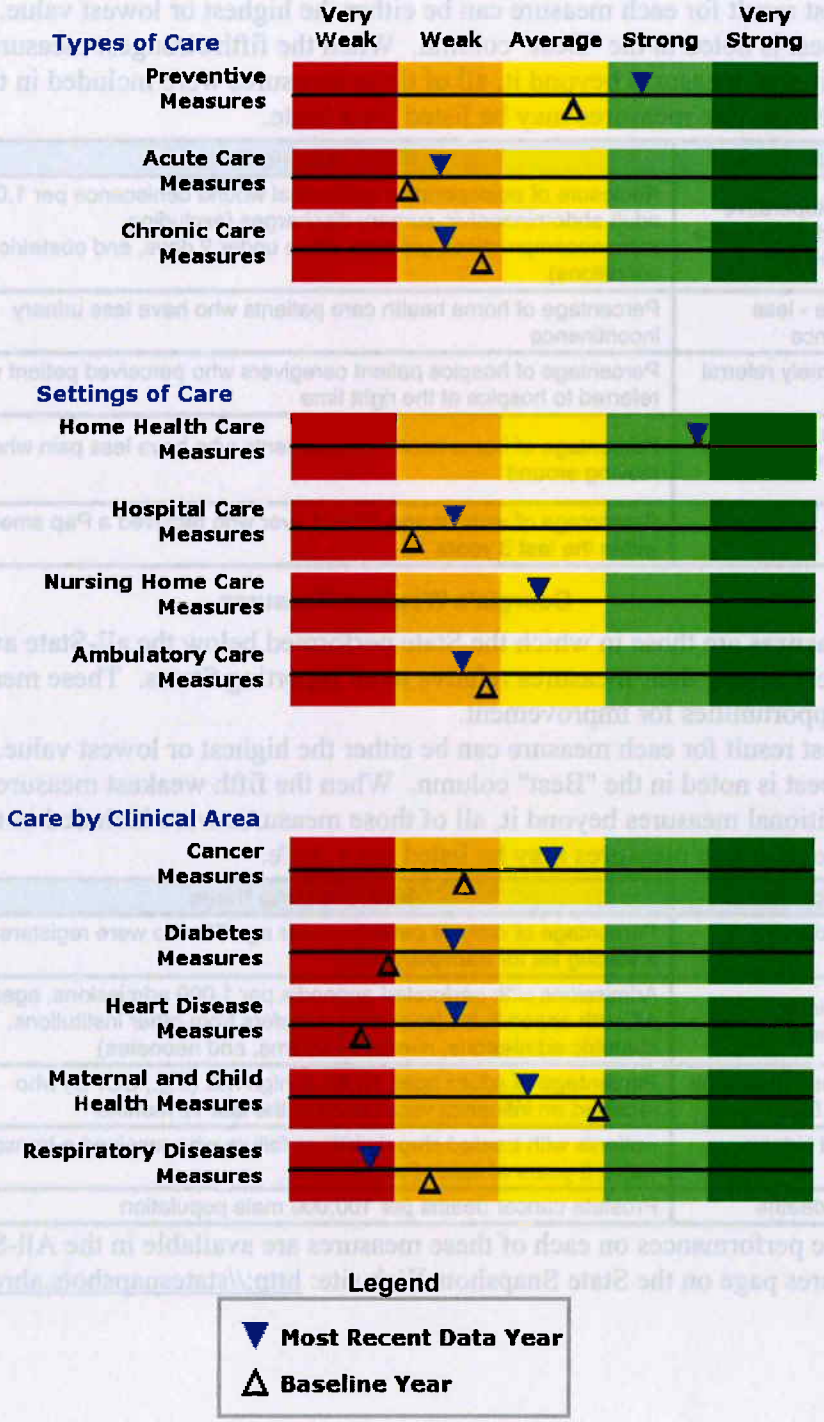
Your State	Meter Score for Overall Health Care
GA	38.24

Best Performing States	Meter Score for Overall Health Care
NH	65.49
MN	64.46
ME	62.61
MA	60.74
RI	59.57

Percentile Range Across States	Meter Score for Overall Health Care
75th Percentile	54.66
50th Percentile	46.43
25th Percentile	38.31

Georgia's Dashboard on Health Care Quality Compared to All States

The graphics below show a State's performance compared to the all-State average by different types of measures reported in the 2010 NHQR for the most recent and baseline data years. Information on the measures included in each type is provided in a separate Measures Appendix.



Five Strongest and Weakest Measures

Georgia's Strongest Measures

Strongest Measures are those in which the State performed above the all-State average and are the five strongest among their measures relative to all reporting States. This State may be leading the way in quality in these measures.

Notes: The best result for each measure can be either the highest or lowest value. The direction representing best is noted in the "Best" column. When the fifth strongest measure was tied in rank with additional measures beyond it, all of those measures were included in the strongest list; therefore more than five measures may be listed for a State.

Measure Short Name	Measure Long Name	Best
Reclosure of postoperative abdominal wound dehiscence per 1,000 discharges	Reclosure of postoperative abdominal wound dehiscence per 1,000 adult abdominopelvic-surgery discharges (excluding immunocompromised patients, stays under 2 days, and obstetric conditions)	Lowest
Home health care - less urinary incontinence	Percentage of home health care patients who have less urinary incontinence	Highest
Hospice care - timely referral to hospice	Percentage of hospice patient caregivers who perceived patient was referred to hospice at the right time	Highest
Home health care - improved pain management when mobile	Percentage of home health care patients who have less pain when moving around	Highest
Pap tests	Percentage of women age 18 and over who received a Pap smear within the last 3 years	Highest

Georgia's Weakest Measures

Weakest Measures are those in which the State performed below the all-State average and are the five weakest among their measures relative to all reporting States. These measures highlight some of the opportunities for improvement.

Notes: The best result for each measure can be either the highest or lowest value. The direction representing best is noted in the "Best" column. When the fifth weakest measure was tied in rank with additional measures beyond it, all of those measures were included in the weakest list; therefore more than five measures may be listed for a State.

Measure Short Name	Measure Long Name	Best
Dialysis and on kidney transplant list	Percentage of dialysis patients under age 70 who were registered on a waiting list for transplantation	Highest
Pediatric admissions - perforated appendix	Admissions with perforated appendix per 1,000 admissions, ages 1-17, with appendicitis (excluding transfers from other institutions, obstetric admissions, normal newborns, and neonates)	Lowest
Flu vaccine in past 12 months - high-risk, age 18-64	Percentage of adults ages 18-64 at high risk (e.g., COPD) who received an influenza vaccination in the last 12 months	Highest
Renal failure and kidney transplant	Patients with treated chronic kidney failure who received a transplant within 3 years of date of renal failure	Highest
Prostate cancer deaths	Prostate cancer deaths per 100,000 male population	Lowest

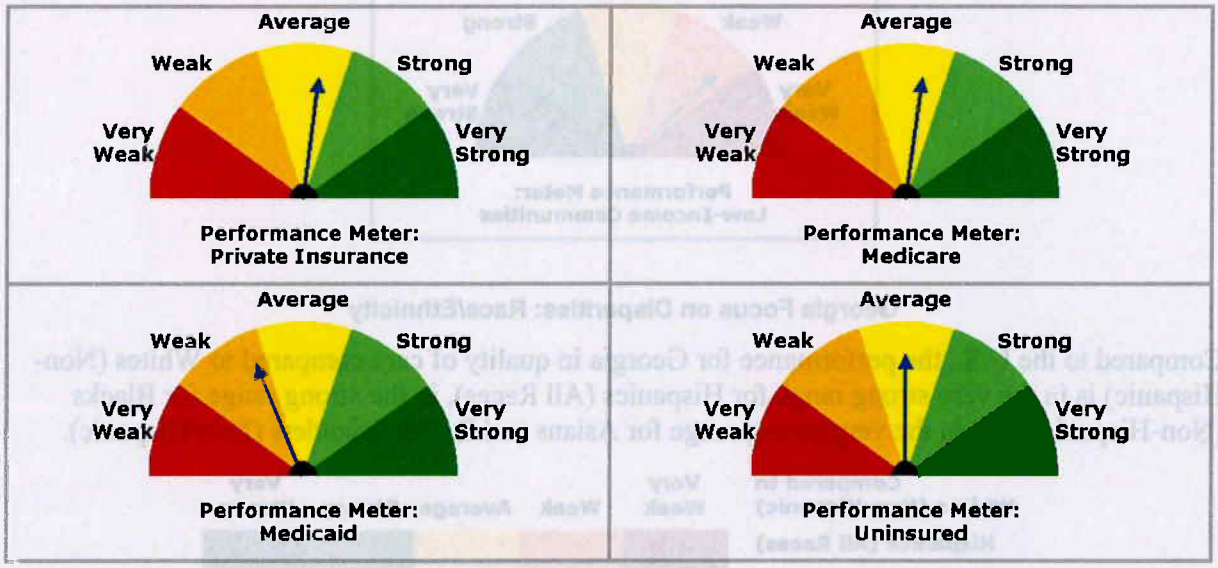
States' specific performances on each of these measures are available in the All-State Data Table for All Measures page on the State Snapshots Web site: http://statesnapshots.ahrq.gov/snaps10/.

Focus on Payer

Focus on Payer shows State-specific information by expected primary payer for hospital care measures that refer to:

- inpatient mortality and
- potentially avoidable complications.

The graphics below represent Georgia's balance of the number of those measures that are below average, average, and above average compared to the U.S. for Medicare, Medicaid, privately-insured and uninsured hospitalizations. The performance meter score is based on up to 15 measures of quality of care and is reported only if at least five measures are available. A State receives a stronger performance meter score as the number of measures for which the State is doing better than the U.S. increases. A State receives a weaker performance meter score as the number of measures for which the State is worse than the U.S increases.



Focus on Disparities

Focus on Disparities shows State-specific information on race/ethnicity and individuals living in low-income compared to high-income communities for health care disparities related to:

- potentially preventable admissions,
- inpatient mortality, and
- potentially avoidable complications.

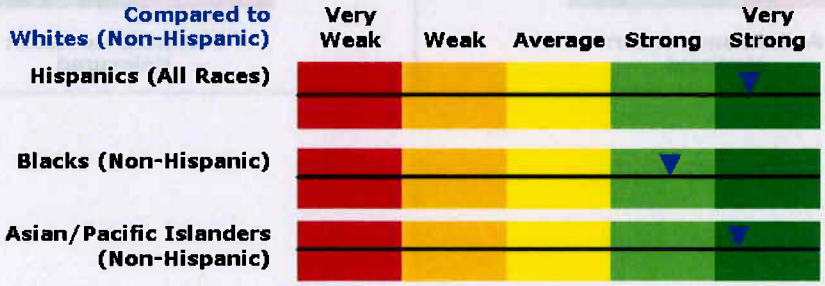
The graphics below show the Georgia-to-U.S. comparison for low-income communities compared to high-income communities and Hispanics (All Races), Blacks (Non-Hispanic), and Asians and Pacific Islanders (Non-Hispanic) compared to Whites (Non-Hispanic) for the most recent data year (2007).

Georgia Focus on Disparities: Low-Income Communities

Compared to the U.S., the performance for Georgia in quality of care of individuals living in low-income communities compared to persons in high-income communities is in the weak range.

Georgia Focus on Disparities: Race/Ethnicity

Compared to the U.S., the performance for Georgia in quality of care compared to Whites (Non-Hispanic) is in the very strong range for Hispanics (All Races), in the strong range for Blacks (Non-Hispanic), and in the very strong range for Asians and Pacific Islanders (Non-Hispanic).



A State receives a stronger score if the State is doing better than the U.S. (i.e., disparity in quality of care between the minority group and Whites (Non-Hispanic) or between the low-income and high-income communities is smaller) for a majority of the 29 possible measures. A State receives a weaker score if the State is doing worse than the U.S. (i.e., disparity in quality of care between the minority group and Whites (Non-Hispanic) or between the low-income and high-income communities is larger) for a majority of the 29 possible measures.

Contextual Factors Measures and Metrics
Compared to All States and South Atlantic States

The following table shows the State's percent or rate for each contextual factor compared to all States and the region. The contextual factors, categorized by demographics (seven factors), health status (three factors), and resources (three factors) may aid in interpretation of the State performance meters. The contextual factors might have a cause, effect, or other indirect association with the results in the performance meter.

Contextual Factor	State Percent or Rate	All-State		Regional	
		Minimum	Maximum	Minimum	Maximum
Demographics — Percent of State Population:					
Under poverty level (2008-2009)	21	11	28	15	23
Uninsured (2008-2009)	19	5	26	11	21
Under Medicaid (2008-2009)	13	8	22	10	21
Age 65 and over (2008-2009)	9	8	17	9	17
Black (2008-2009)	29	1	52	3	52
Hispanic (2008-2009)	9	1	42	1	20
Without Bachelor's degree (2008)	73	52	83	52	83
Health Status — Percent of State Population:					
Overweight/obese (2009)	62	50	68	50	65
At risk of heart disease and stroke (2003)	40	27	46	36	45
Reporting poor mental health (2007)	33	23	39	29	35
Resources:					
Specialist physicians per 100,000 population (2007)	165	116	570	165	570
Admissions per 1,000 population (2008)	99	83	233	99	233
HMO penetration rate (2009)	20	0	52	4	45