

Medicaid Managed Care Policies Affecting Safety-Net Providers and the People They Served

Volume I: Eligibility and Access Policies

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by

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EXECUTIVE SUMMARY: STATE ELIGIBILITY AND ACCESS POLICIES RELATED TO SAFETY-NET PROVIDERS

Over the last decade, safety-net providers¹ have become major players in the Medicaid managed care marketplace, in large part as a way to ensure consumer access. This report is the first of three in a series that uses findings from a literature review and an all-state survey conducted by the National Academy for State Health Policy (NASHP) in the fall of 2000 to examine Medicaid managed care policies related to safety-net providers and the people they serve. This first report examines state Medicaid policies regarding the inclusion of safety-net providers in Medicaid managed care and access for people served by these providers.

Safety-Net Providers are Major Players in Managed Care

- Thirty-eight of the 42 states with risk programs² (90 percent) reported that FQHCs participated in the managed care program and ten (24 percent) reported that an FQHC or community health center owned an MCO.
- Thirty-seven states (88 percent of those with risk programs) required and or encouraged plans to contract with at least one type of safety-net provider. Twenty-one states (42 percent) required plans to do so, and thirty-three (78 percent) encouraged them to do so.
- All 29 states that operate Primary Care Case Management³ programs allow primary care physicians, including those that work for safety-net providers, to serve as PCCM providers. In addition, 23 states (79 percent of those with PCCM programs) allow an FQHC, as an entity, to serve as a PCCM provider; and 22 states (76 percent) allow a rural health clinic to serve as a PCCM provider.

¹ These include Federally Qualified Health Centers (FQHCs), public hospitals, family planning clinics, community/migrant/rural health centers, maternal and child health clinics, local/county health departments, mental health centers, school-based clinics, academic medical centers, early intervention/ special education providers, Indian Health Service (IHS) facilities, tribal clinics, and AIDS service organizations.

² *Risk programs* are programs in which states contract with managed care organizations (MCOs) and/or Prepaid Health Plans (PHPs).

³ *Primary Care Case Management (PCCM)* programs are usually non-risk managed care programs involving the payment of a monthly care coordination fee to a PCCM provider in addition to fee-for-service payment for all services provided.

Safety-Net Providers Participate in Medicaid Managed Care Enrollment and Outreach

- Twenty-two of the 49 states with risk and/or PCCM programs (45 percent) reported that community-based organizations participated in informing beneficiaries about the managed care program, and 14 (28 percent) reported that providers, such as FQHCs, did so.
- Thirty-four states (69 percent) reported that FQHCs were used as a venue for informing beneficiaries about the managed care program.

Medicaid Agencies Have Policies in Place to Ensure Access to Care for Vulnerable Populations

- Thirty-six states of the 49 states with risk and/or PCCM programs (73 percent) exclude those with long-term care needs who live in the community from managed care, and 16 states (33 percent) either exclude children with special needs from the managed care program or allow them to choose to remain on fee-for-service.
- Ten of the 42 states with risk programs (24 percent) reported requiring contracted health plans to help some or all Medicaid enrollees access appropriate care (beyond the normal customer service function), and 17 states (40 percent) reported that at least one plan chose to provide such help without a state requirement to do so.
- Twenty-nine of the 42 states with risk programs (69 percent) reported requiring plans to allow beneficiaries to self-refer for some services, and 15 (36 percent) required plans to provide enrollees with special needs access to experienced providers.

INTRODUCTION

Safety-net providers⁴ are the healthcare providers of last resort for people, regardless of their ability to pay or any special health care needs. Many Medicaid beneficiaries also obtain care from safety-net providers, making Medicaid a major source of revenue for these providers. Therefore, how states structure their Medicaid programs significantly affects safety-net providers' ability to continue to meet their missions of caring for the underserved.

Managed care—the delivery system used by 49 states to serve Medicaid beneficiaries⁵—has evolved over the past decade. In 1990, most Medicaid managed care programs used primarily commercial MCOs to serve mostly women and children. In 2000, although most agencies continue to use commercial MCOs, a growing number are also using specialized MCOs that serve primarily Medicaid beneficiaries and often include safety-net providers. Agencies are also enrolling the full range of Medicaid beneficiaries, including those with complex needs, into managed care. Medicaid agencies have been challenged to be prudent purchasers, protect enrollee access to quality care, and find ways to compensate plans that better adjust for selection bias. Increasingly, they are, among other things, increasing their efforts to obtain stakeholder input, collecting and using performance measures in both risk and PCCM programs, and varying capitation payments based on enrollee health status.

The evolution of Medicaid managed care programs has an impact on the functioning of safety-net providers and therefore on the people they serve. State policies have a strong influence on the ability of safety-net providers to obtain and maintain contracts as providers within larger managed care entities and as managed care organizations directly contracted to Medicaid agencies. This report uses data collected from a literature review and a survey of all 50 states and the District of Columbia to examine Medicaid agencies' policies and efforts in the area of eligibility and access policies. It examines issues such as inclusion of safety-net providers, use of FQHCs for outreach and enrollment, populations excluded or exempted from managed care, access of managed care enrollees with special needs to appropriate providers, and the use of outreach workers to assist in accessing medical care. It is the first of a series of three reports; the other two reports examine Medicaid agencies' policies and efforts in the areas of:

- *Monitoring functions*—including the use of satisfaction surveys, efforts to gather input from safety-net related entities and consumers in developing managed care programs, strategies to

⁴ *Safety-net providers* may include Federally Qualified Health Centers (FQHCs), public hospitals, family planning clinics, community/migrant/rural health centers, maternal and child health clinics, local/county health departments, mental health centers, school-based clinics, academic medical centers, early intervention/special education providers, Indian Health Service (IHS) facilities, tribal clinics, and AIDS service organizations.

⁵ As of June 2000, this includes both risk-based and PCCM programs.

ensure the coordination of behavioral and physical health care, and efforts to work with other state agencies to coordinate services for enrollees with special needs; and

- *Financing issues*—including efforts to prevent MCO withdrawals and provide for continuity of care, use risk-adjustment, and include school-based health centers.

METHODOLOGY

Survey

Over the past decade, NASHP has conducted five surveys of state Medicaid managed care programs. The information presented in this report is drawn from these five surveys, conducted in 1990, 1994, 1996, 1998, and 2000. All 50 states and the District of Columbia responded to the five surveys.⁶ Each survey provides a snapshot of program policies as of June 30 of the survey year and was developed with extensive input from state officials.

In developing the 2000 survey, a focus group composed primarily of state officials reviewed the 1998 survey and suggested revisions to capture topics of new interest. A group of state officials then reviewed the draft 2000 survey, and further modifications were made based on the additional input. The revised draft was then piloted by four states in June 2000, resulting in further refinements. Finally, a focus group consisting primarily of state officials met in March 2000 to review the draft findings of the survey and to identify significant trends.

Every effort has been made to ensure that this data accurately reflects Medicaid managed care program policies. NASHP staff reviewed each survey for completeness and consistency with other sources of information, including previous surveys. All potential discrepancies were discussed with individual Medicaid agencies, and appropriate modifications were made to better reflect managed care program policies and to assure consistency in reporting.

All information reported is related to the two major types of managed care models: risk and PCCM.

- In a *risk program*, a Medicaid agency contracts with an entity or individual (the contractor) to provide or arrange for the provision of an agreed upon set of services in exchange for a set fee per person enrolled per month; the prepaid fee does not vary month-to-month based on services used by the individual enrollee. In other words, in risk-based managed care, the contractor assumes some level of financial risk for providing care to enrollees. There are two types of contractors that participate in risk programs:

Managed Care Organizations (MCOs) are entities that contract to provide a comprehensive set of benefits. Comprehensive is defined as inpatient hospitalization and at least one of the following services: (1) outpatient hospital and rural health clinic; (2) other laboratory and x-ray; (3) skilled nursing facility; (4) physician; or (5) home health. Contracts that exclude inpatient

⁶ To simplify the discussion, this analysis uses the term *state* to refer to the 50 states and the District of Columbia.

hospitalization but include three or more of the five groups of services are also considered comprehensive.⁷

Prepaid Health Plans (PHPs) are risk contractors that cover a less than comprehensive set of services, such as only behavioral health services.

- A *PCCM* program assigns responsibility for the care of a Medicaid beneficiary to a specific primary care provider who receives payment on a fee-for-service basis and who (typically) receives a small additional fee per enrollee per month to compensate for case management functions.⁸ PCCM providers do not generally assume any financial risk for providing care other than services within their scope of practice that they deliver directly to enrollees.

Literature Review

In addition to the survey, a literature review was conducted on managed care, health insurance status, the financial stability of safety-net providers, and the impact of managed care on safety-net providers. The findings of this review have been integrated throughout the paper, as appropriate.

⁷ 42 CFR 434.21(b)

⁸ The 1990, 1994, 1996, and 1998 surveys defined primary care case management (PCCM) programs to include only those programs in which the provider is not capitated. The Balanced Budget Act of 1997 (BBA), however, established a definition of PCCM that allows capitation in PCCM programs. The 2000 survey was updated to reflect this new definition.

STATE ELIGIBILITY AND ACCESS POLICIES RELATED TO SAFETY-NET PROVIDERS

Safety-net providers⁹ have become major players in the Medicaid managed care marketplace, in large part as a way to ensure consumer access. This volume deals with issues regarding the inclusion of safety net providers in Medicaid managed care and access to care by people served by safety net providers. These issues include Medicaid policies on:

- Inclusion, referral, and payment for safety-net providers;
- Use of FQHCs for outreach and enrollment;
- Populations excluded or exempted from managed care;
- Assured access of managed care enrollees with special needs to appropriate providers; and
- Use of outreach workers to assist in accessing medical care.

Medicaid Policies on the Inclusion of Safety-Net Providers and Use of FQHCs for Outreach/Enrollment

Policy issue

Managed care is the delivery system now used by 49 states to serve Medicaid beneficiaries.¹⁰ Some have raised concerns that this shift to managed care would have negative effects on safety-net providers and on the people who rely on them by reducing payments to these providers or creating barriers for Medicaid beneficiaries seeking care from them. Some fear that the viability of these providers is put in jeopardy in this new environment, or at least their ability to meet their mission of caring for the underserved. If managed care harmed traditional providers and then failed, access for Medicaid beneficiaries could be harmed.

⁹ These include Federally Qualified Health Centers (FQHCs), public hospitals, family planning clinics, community/migrant/rural health centers, maternal and child health clinics, local/county health departments, mental health centers, school-based clinics, academic medical centers, early intervention/ special education providers, Indian Health Service (IHS) facilities, tribal clinics, and AIDS service organizations.

¹⁰ As of June 2000, 20 states had risk-only programs; 7 had PCCM-only; and 22 had both risk and PCCM programs.

State responses

Safety-net providers remain significant players in the delivery of care to Medicaid beneficiaries, due to a number of factors:

- Safety-net providers are often conveniently located for Medicaid beneficiaries and have experience in meeting the needs of low-income managed care enrollees that other providers may not have. Location alone may make some safety-net providers essential in meeting state-established access requirements.
- Many safety-net providers made efforts to ensure they would not be left out of the new delivery system, either by pursuing MCO contracts or developing their own MCOs.
- FQHCs are eligible for cost-based reimbursement for services they provide to Medicaid beneficiaries. This may make them an attractive subcontractor.
- Many Medicaid agencies either encourage or require MCOs to subcontract with specific types of safety-net providers.

Safety-net provider participation in risk programs

In 2000, all 42 states with risk programs reported having developed a number of strategies for assuring access. These states examine the MCO's ability to provide access and either do not select an MCO that cannot provide adequate access or do not allow it to begin enrolling until the Medicaid agency judges that it will be able to provide access to care to enrollees.

Since many Medicaid beneficiaries have traditionally accessed care (and continue to do so) from safety-net providers, states often see it as being in their own interest to encourage these providers to participate in managed care programs.¹¹ In 2000, more than half the states reported efforts to increase participation of a wide variety of safety-net providers. As a result, in 2000:

- Ninety percent of the Medicaid agencies with risk programs reported that FQHCs participated in risk-based managed care.
- More than 75 percent reported that public hospitals and family planning clinics participated in risk-based managed care.
- More than half reported the participation of community/migrant/rural health centers, Maternal and Child Health (MCH) clinics, local/county health departments, and mental health centers.

¹¹ For example, in 2000, 27 agencies (64 percent of those with managed care programs) explicitly considered "include current providers" among the access factors considered during MCO selection.

- More than half reported that at least one safety-net provider participated as the owner or sponsor of a MCO (Table 1).

Table 1 Participation of safety-net providers in risk programs:¹² 1994-2000¹³

Provider Type	1994		1996		1998		2000	
FQHC	19	59%	30	79%	41	91%	38	90%
Public hospital	NR		NR		30	67%	36	86%
Family planning clinics	NR		NR		34	76%	33	79%
Community/migrant/rural health center	16	50%	22	58%	32	71%	30	71%
MCH clinics	NR		24	63%	28	62%	30	71%
Local/county health department	15	47%	25	66%	28	62%	25	60%
Mental health center	12	38%	24	63%	25	56%	24	57%
School-based clinic	11	34%	16	42%	20	44%	19	45%
Academic medical center	NR		NR		NR		17	40%
Early intervention/special education provider	NR		NR		15	33%	15	36%
Indian Health Service provider	NR		10	26%	12	27%	14	33%
Tribal clinic	NR		8	21%	6	13%	7	17%
AIDS services organizations (Ryan White)	NR		NR		NR		7	17%
# States with risk programs	32	100%	38	100%	45	100%	42	100%

In 2000, 26 of the 42 states with risk programs (62 percent) reported that a safety-net provider was either an owner or a sponsor¹⁴ of at least one MCO in the state. Eleven states reported public hospitals

¹² All tables in this report use the Medicaid agency as the unit of analysis. So, for example, the first line of this table indicates that, in 2000, 38 Medicaid agencies required MCO or PHPs to contract with one or more FQHCs. Further, these 38 agencies are 90 percent of the total number of Medicaid agencies that contract with at least one MCO or PHP.

¹³ This participation is detailed by state in Appendix A.

¹⁴ It is clear when a safety net provider owns an MCO. Sponsorship is less clearly defined, but it refers to the situation in which the MCO is generally perceived to be controlled by the safety-net provider, even

as an owner/sponsor, ten reported FQHCs or health centers, seven reported academic medical centers, three reported counties, and two reported local public health agencies.

For example, California Medicaid beneficiaries in 12 counties choose between a commercial MCO and a “Local Initiative” MCO that is developed by county governments and safety-net providers. These Local Initiatives are required to contract with safety-net providers. Rates paid to the Local Initiatives are higher to reflect cost-based payments made to FQHCs.¹⁵ The state has given preferential treatment to the Local Initiatives in assigning beneficiaries who do not select an MCO.

Between 1996 and 2000, the percentage of Medicaid agencies with risk programs that either required or encouraged MCOs to contract with each type of safety-net provider increased dramatically (Table 2). Such efforts were particularly likely to occur in states serving people with disabilities (SSI populations) through MCOs. Specific increases ranged from 62 percent for local/county health departments to 95 percent for MCH clinics. In 2000, states were most likely to *require* plans to contract with FQHCs and were most likely to *encourage* plans to contract with MCH clinics. In 2000, 37 of the 42 states with risk programs (88 percent) required and/or encouraged plans to contract with at least one type of safety-net provider (Table 3). Twenty-one states (42 percent) required plans to do so and thirty-three (78 percent) encouraged them to do so.¹⁶ The 33 states that encouraged plans to contract with safety-net providers reported encouraging them in many different ways, including the following:

- Awarding extra points during the contractor selection process (10 states—24 percent of the 42 states with risk programs);
- Favoring MCOs that include safety-net providers in their network in default assignment¹⁷ of Medicaid beneficiaries (seven states—17 percent);
- Requiring MCOs to make good faith efforts to contract (three states—seven percent); or

though the provider does not have an ownership interest in the MCO. For example, the safety net provider and the MCO may both be owned by the same company or the MCO network may consist solely of safety net providers.

¹⁵ Debra J Lipson, “Medicaid Managed Care and Community Providers: New Partnerships,” *Health Affairs* 16, no. 4 (July/Aug 1997):91-107.

¹⁶ There is duplication among these numbers. For example, if a Medicaid agency required MCOs to contract with FQHCs, but encouraged them to contract with public hospitals that agency would be counted as both requiring **and** encouraging safety net provider participation.

¹⁷ Although all Medicaid beneficiaries in mandatory risk programs are required to choose an MCO or PHP, not all do so. Those who do not choose are assigned.

- Facilitating meetings between the MCOs and providers (three states—seven percent).

Table 2 State requirement v. encouragement of MCO to contract with safety-net providers in risk programs: 2000

Provider Type	2000					
	Required		Encouraged		Either ¹⁸	
FQHC	14	40%	23	66%	35	100%
MCH clinics	3	10%	26	90%	29	100%
Family planning clinics	6	22%	21	78%	27	100%
Local/county health department	5	19%	24	89%	27	100%
School-based clinic	4	16%	22	88%	25	100%
Community/migrant/rural health center	4	16%	21	84%	25	100%
Public hospital	5	21%	21	88%	24	100%
Mental health center	4	17%	21	88%	24	100%
Early intervention/special education provider	5	26%	15	79%	19	100%
Tribal clinic	2	20%	9	90%	10	100%
Indian Health Service provider	1	10%	10	100%	10	100%
Academic medical center	1	17%	5	83%	6	100%
AIDS service organizations (Ryan White)	1	20%	4	80%	5	100%
At least one provider type	21	57%	33	89%	37	100%

¹⁸ Some states both require and encourage MCOs to contract with safety-net providers.

Table 3 Overview of state policies to increase participation of safety-net providers in risk programs: 1996-2000

Provider Type	1996		1998		2000	
	Required or Encouraged		Required or Encouraged		Required or Encouraged	
FQHC	7	18%	40	89%	35	83%
MCH clinics	1	3%	30	67%	29	69%
Family planning clinics	NR		32	71%	27	64%
Local/county health department	9	24%	28	62%	27	64%
School-based clinic	3	8%	26	58%	25	60%
Community/migrant/rural health center	4	11%	30	67%	25	60%
Public hospital	NR		23	51%	24	57%
Mental health center	3	8%	27	60%	24	57%
Early intervention/special education provider	NR		19	42%	19	45%
Tribal clinic	2	5%	11	24%	10	24%
Indian Health Service provider	2	5%	12	27%	10	24%
Academic medical center	NR		NR		6	14%
AIDS services organization (Ryan White)	NR		NR		5	12%
# States with risk programs	38	100%	45	100%	42	100%

Examples of safety-net providers' participation in MCO networks include:

- Nineteen of the states with managed behavior healthcare programs for Medicaid beneficiaries contract with public organizations, primarily county or local governments and community mental health centers.¹⁹
- In Connecticut, 69 percent of safety-net providers responding to a survey participate in the state's Medicaid managed care program; 54 percent of these providers had contracts signed when the program began, and 63 percent of those remaining had signed contracts by the time the program was fully implemented statewide (four months later). The vast majority of

¹⁹ The Lewin Group, *Substance Abuse and Mental Health Services Administration (SAMHSA) State Profiles, 1999, On Public Sector Managed Behavioral Health Care* (Washington, DC: US Department of Health and Human Services, 2000).

participating safety-net organizations have signed contracts with multiple MCOs, and all MCOs have contracts with at least some of the safety-net providers.²⁰

Other studies concur with the findings of the 2000 survey in the area of Medicaid efforts to facilitate the inclusion of safety-net providers in managed care networks. One study found that most states included provisions in their Medicaid managed care contracts that preserved the safety-net, such as adapting the managed care benefit package and promoting the participation of safety-net providers in managed care programs.²¹ Another study found that states typically use one or more of the following strategies to encourage partnerships between MCOs and safety-net providers: contract requirements, preference points for collaboration, preferential assignment to MCOs that include community providers, setting quality or access standards to encourage collaboration, or “transitional” payments and other enhanced reimbursement to community-based providers.²² A NASHP study found that states are taking significant action to assure that essential community providers are included in risk-based Medicaid programs, including:

- Working closely with state agencies, communities, providers, and clients to ensure that Medicaid clients are well served by new managed care initiatives.
- Developing standards and evaluation criteria for MCOs that encourage or compel MCOs to contract with essential community providers, such as provider/patient ratios, restrictions on wait times for appointments, and restrictions on client travel time and distance.
- Requiring MCOs to provide specific services (such as family planning, enabling services, or targeted case management) that have the potential to promote the use of essential community providers in risk-based contracts.
- Recognizing that enrollment policies can have a dramatic effect on Medicaid beneficiaries’ choices of MCOs.²³

²⁰ Colleen M Grogan and Michael K Gusmano, “How Are Safety-Net Providers Faring Under Medicaid Managed Care?” *Health Affairs* 18, no. 2 (Mar/Apr 1999):233-237.

²¹ Teresa A Coughlin, et al, “A Conflict of Strategies: Medicaid Managed Care and Medicaid Maximization,” *Health Serv. Res.* 34(1 Pt 2) (Apr 1999):281-93.

²² Debra J Lipson, “Medicaid Managed Care and Community Providers: New Partnerships,” *Health Affairs* 16 no. 4 (July/Aug 1997):91-107.

²³ Michele Solloway and Julie Darnell, *The Impact of Medicaid Managed Care on Essential Community Providers* (Portland, ME: National Academy for State Health Policy, 1998).

Safety-net provider participation in PCCM programs

The issue of access to safety-net providers in PCCM programs is different than in risk programs. PCCM enrollees are restricted to a specific provider for delivery of primary but not specialty care; in PCCM programs enrollees' access to family planning clinics and academic medical centers is not restricted. Therefore, the safety-net providers of concern in PCCM programs are those that provide primary care.

Twenty-three states (79 percent of those with PCCM programs) allow FQHCs to serve as PCCM providers; 22 states (76 percent) allow rural health clinics to serve as PCCM providers (Table 4). Caution, however, must be taken when interpreting this data. All states allow individual primary care physicians to serve as PCCM providers. Since the types of safety-net providers, such as FQHCs, that provide primary care, all have physicians on staff, it can be said that all states with PCCM programs allow safety-net providers to serve as PCCM providers. Twenty-two states also allow physician groups and clinics of any type (including safety-net providers) to serve as PCCM providers. The higher percentage of states that reported allowing safety-net providers to serve as PCCM providers in the 1996 and 1998 surveys may reflect state practices enabling the individual physicians that work for these providers to be certified as PCCM providers. In 2000, the survey was clarified to specify that states should only report those situations in which the safety-net provider was certified as a group or clinic (not an individual physician) as “allowing a safety-net provider to serve as a PCCM provider.”

Table 4 Safety-net providers that may serve as PCCM providers²⁴

Provider Type	1996		1998		2000	
	Count	Percentage	Count	Percentage	Count	Percentage
Federally qualified health center (not individual physician)	28	88%	24	83%	23	79%
Rural health clinic	21	66%	22	76%	22	76%
Community/migrant health center (not FQHC)	17	53%	16	55%	14	48%
Public health agency	11	34%	13	45%	13	45%
Indian Health Service clinic	13	41%	13	45%	12	41%
Tribal clinic	10	31%	10	34%	11	38%
Maternal and child health clinics	3	9%	6	21%	5	17%
School-based clinic (not individual physician)	NR		NR		2	7%
# States with PCCM programs	32	100%	29	100%	29	100%

²⁴ Year 2000 participation is detailed by state in Appendix B.

Safety-net provider responses to Medicaid managed care

In 2000, 26 states with risk contracts (62 percent) reported that they contracted with at least one plan that was either owned or sponsored by a safety-net provider. Among the 26 states, 11 reported public hospitals as owners/sponsors, ten reported FQHCs or health centers, seven reported academic medical centers, three reported counties, and two reported local public health agencies. Further, a previous NASHP report found that safety-net providers responded in numerous and diverse ways to Medicaid managed care, including:

- Developing hospital-based full-risk contracts;
- Developing or joining a horizontal network of providers in which they either:
 - S own an MCO** and contract with other providers on a fee-for-service or capitated basis;
 - or
 - S are part of a network** of primary care providers that contract with a larger MCO; and
- Developing or joining a vertically integrated system in which they partner with a hospital (and perhaps other entities) for either a full or partial risk-based contract.²⁵

A HRSA-sponsored study of Title V/Maternal and Child Health (MCH) and Ryan White medical providers found that these providers have been able to contract with MCOs for at least some services, in some cases as the result of Medicaid agency requirements and in others because they are key providers in their communities.²⁶ Another HRSA-sponsored study on Community/Migrant Health Centers (C/MHCs) found several key factors affecting C/MHC's success in a managed care environment:

- Developing appropriate risk relationships and managing risk;
- Establishing revenue replacement strategies;
- Mainstreaming infrastructure and operations;
- Building staff expertise in operations under managed care;
- Improving clinical case management and utilization management; and

²⁵ Michele Solloway and Julie Darnell, *The Impact of Medicaid Managed Care on Essential Community Providers* (Portland, ME: National Academy for State Health Policy, 1998).

²⁶ Nancy Fasciano, *New Rules, New Roles: How Title V/MCH and Ryan White Programs and Providers Are Adapting to Medicaid Managed Care* (Washington, DC: Mathematica Policy Research Inc. for Health Resources and Services Administration, 1999).

- Monitoring financial and clinical performance.²⁷

The authors of a study of safety-net providers in four cities with mandatory Medicaid managed care noted that provider organizations have shown remarkable resilience and resourcefulness in their adaptive behavior and have generally been able to compete effectively to retain patients and clients even when matched up against network providers who may not have been available to Medicaid beneficiaries prior to mandatory managed care.²⁸ A study of health activities in 13 states found that although the pressure on the safety-net is growing, safety-net systems appeared to be relatively secure. Individual safety-net providers may be in severe financial straits, and some have even shut down, but the systems that ensure access to care for the uninsured remain firmly in place. The authors suggested that these systems survived the building pressures for two reasons:

- States and localities have responded quickly and effectively to ensure that safety-net providers will survive; and
- The majority of providers have responded quickly and effectively to the pressures as they have arisen.²⁹

An Institute of Medicine report found that most safety-net providers have been able to adapt to the changing environment, including the implementation of mandatory Medicaid managed care. Responding to these changes, however, has stressed safety-net providers' finances and made it difficult for them to maintain their missions. Specific findings include:

- Almost all safety-net providers realize they must participate in Medicaid managed care;
- While, for the most part, the safety-net remains intact, many of the organizations are becoming increasingly fragile, due to the growing number of uninsured and reduced grants and revenues; and

²⁷ Terry Savelle, Lisa Chimento, and Nathan Stacy, *The Performance of C/MHCs Under Managed Care: Case Studies of Seven C/MHCs and Their Lessons Learned* (Fairfax, VA: The Lewin Group [HRSA Contract Number 240-94-0037], 1998).

²⁸ Robert E Hurley and John M Kuder, *Adapting to Medicaid Managed Care: A Tale of Four Cities* (Ithaca, NY: Cornell University, 2000).

²⁹ John Holahan, Joshua M Wiener, and Susan Wallin, *Health Policy for the Low-income Population: Major Findings from the Assessing the New Federalism Case Studies* (Washington, DC: The Urban Institute, 1999) <http://newfederalism.urban.org/html/occ19.html>.

- State and local policies that support vulnerable populations are critical to safety-net providers to ensure they remain viable while maintaining their mission to serve the uninsured.³⁰

Payment and referral of safety-net providers

Some states have implemented MCO contract language that goes beyond participation to address payment and referral to safety-net providers. As shown in table 5, contract language concerning FQHC referral/payment is most common, having been implemented by 15 states (36 percent of those with risk-based programs).

³⁰ Institute of Medicine. Marion Ein Lewin and Stuart Altman, editors. *America's Health Care Safety Net: Intact But Endangered*. (Washington, DC: National Academy Press, 2000).

Table 5 States with contract language addressing payment/referral: 2000

Provider Type	2000	
FQHC ³¹	15	36%
Local/county health department	7	17%
Family planning clinics	6	14%
School-based clinic	6	14%
Mental health center	6	14%
Community/migrant/rural health center	6	14%
Early intervention/special education provider	5	12%
AIDS services organizations (Ryan White)	5	12%
Indian Health Service provider	4	10%
Tribal clinic	4	10%
MCH clinics	3	7%
Academic medical center	2	5%
Public hospital	1	2%
# States with risk programs	42	100%

In a study of safety-net providers participating in Connecticut’s Medicaid managed care program, the vast majority are paid fee-for-service. Capitation is the next most popular method. Reimbursement varies by type of organizations. Although 65 percent of providers are paid by one reimbursement method, 35 percent are paid by two methods: capitation from some MCOs and fee-for-service rates from others.³²

Use of FQHCs for outreach/enrollment

Outreach, enrollment, and education are important factors in determining how well Medicaid managed care programs meet the needs of enrollees. These programs must work to ensure that enrollees are

³¹ Although the BBA had requirements regarding payment of FQHCs that participate in Medicaid managed care in place in 2000 not all states reported the existence of contract language addressing payment to FQHCs—possibly because states can fulfill these requirements by working directly with the FQHC, in which case the HMO contract would not need to address FQHC payment.

³² Colleen M Grogan and Michael K Gusmano, “How Are Safety-Net Providers Faring Under Medicaid Managed Care?” *Health Affairs* 18, no. 2 (Mar/Apr 1999):233-237.

enrolled with a Managed Care Entity (MCE)³³ that suits their needs and that enrollees understand how to access care within the program.

In 2000, 22 states (45 percent of the states with managed care) reported that community-based organizations were formally responsible for informing beneficiaries about managed care and their enrollment options, making this the fastest growing category between 1998 and 2000.³⁴ Since the survey sought information only about which states had formal arrangements with community-based organizations, it is likely that their use is even greater than that reported here.

Also, 14 states (29 percent of states with managed care) reported that providers held this responsibility; 13 reported that PCCM providers were responsible. Many safety-net providers would fall into these categories (Table 6).

³³ Managed Care Entity (MCE) is a term first used in the BBA which includes all three types of entities that may coordinate care in Medicaid managed care (MCO, PHP, and PCCM provider).

³⁴ This number includes Wisconsin, which reported that informing activities were conducted by “advocacy groups.”

Table 6 Who is responsible for informing beneficiaries about managed care and managed care enrollment options (selected entities): 1990-2000

	1990 ³⁵		1994 ³⁶		1996		1998		2000	
Community-based organizations	NR		NR		NR		16	33%	22	45%
Providers (e.g., clinic hospitals)	9	31%	12	27%	11	23%	15	31%	14	29%
PCCM providers	NR		NR		NR		NR		13	27%
# States with managed care	29	100%	45	100%	48	100%	49	100%	49	100%

Another significant part of enrollment and outreach is the location at which informing takes place. Obviously, the more convenient the location, the more people will participate in the process. In 2000, 17 states (35 percent of those with managed care programs) reported using FQHCs as venues in informing beneficiaries about managed care enrollment and policies. Thirty-four (69 percent) reported using medical provider offices other than FQHCs; these probably include other safety-net providers. Twelve (24 percent) reported using Tribal facilities.

Medicaid Policies on Populations Excluded or Exempted from Managed Care

Policy issue

Some of the people traditionally served by safety-net providers have complex needs or payment arrangements (such as having more than one source of healthcare coverage or living in an institution that already includes health services). Also, the Balanced Budget Act (BBA) identifies three categories of beneficiaries that cannot be mandatorily enrolled into managed care (risk and PCCM) without a waiver: Medicare/Medicaid dual eligibles, American Indians/Alaska Natives (AI/AN), and special needs children.

³⁵ In 1990, nine states responded that MCOs/providers only were responsible for enrollment and outreach. Fourteen other states reported that the MCOs and state shared responsibility. Therefore, this table assumes that nine states involved providers, and twenty-three (fourteen plus nine) involved MCOs.

³⁶ The 1994 survey did not ask separate questions about MCOs and providers. Therefore, the number of providers is equal to the number that reported “MCOs/providers,” and the number for MCOs is equal to the number of states that reported “MCOs/providers” or “MCOs and government shared responsibility.”

In addition to basic voluntary or mandatory enrollment policies, certain subgroups within otherwise eligible populations are either:

- Excluded—prohibited from enrolling in Medicaid managed care, or

- Exempted—allowed to disenroll from an otherwise *mandatory* program.

Collectively, these groups are often referred to as enrollment carve-outs. In general, carve-outs are designed to minimize administrative complexity, to avoid a situation of duplicate payments for services, to reduce MCO financial risk by disenrolling certain enrollees who experienced specific rare events that radically change the cost of caring for the individual (some transplant recipients, for example) or to acknowledge that the managed care system may not be adequate to meet the needs of certain groups (chronically ill children, for example).

State responses

The populations least likely to be enrolled in Medicaid managed care programs are people who receive long-term care (either in institutions or in the community), people who are dually eligible for both Medicaid and Medicare, and people with commercial managed care health insurance (Table 7).

Table 7 Selected subpopulations excluded from enrollment and exempted from mandatory enrollment in managed care programs: 2000

Population	Excluded		Exempted		Either	
Receiving long-term care in an institution	44	90%	1	2%	44	90%
Medicare dual eligibles	35	71%	5	11%	39	80%
Receiving long-term care in the community	36	73%	1	2%	37	76%
People with commercial managed care health insurance	29	59%	5	11%	33	67%
Foster care	19	39%	10	22%	29	59%
People with other non-managed care insurance	14	29%	2	4%	16	33%
Special needs children	8	16%	8	17%	16	33%
American Indians/Alaska Natives	4	8%	12	26%	16	33%
People with HIV/AIDS	3	6%	5	11%	8	16%
Children served by Title V agency	3	6%	3	7%	6	12%
Homeless	2	4%	3	7%	5	10%
# States with managed care	49	100%	46 ³⁷	100%	49	100%

³⁷ The number of states used for comparison in the exempted column is 46 because that is the number of states with mandatory programs (only in mandatory programs can beneficiaries be exempted from mandatory enrollment).

Excluded populations

The most frequently excluded subpopulations in 2000 were those receiving long-term care and dual eligibles:

- States may decide to exclude those receiving long-term care because the care of these beneficiaries is frequently already managed, either by an institution or under a Home and Community Based Services waiver (most states specified that they defined long-term care in the community to mean participation in a Home and Community Based Services waiver program).
- States may decide to exclude dual eligibles because of Medicare regulations that forbid states from limiting the providers from whom these beneficiaries can obtain Medicare services (unless the beneficiary voluntarily elects to join a Medicare HMO). This restriction severely reduces an MCO's ability to manage care. Other administrative issues may also hinder Medicaid agencies when enrolling this population.

Exempted populations

American Indians/Alaska Natives (AI/AN) and children in foster care are the most likely groups to be exempted from mandatory enrollment.

- AI/AN are likely to be exempted because many are already receiving care from the Indian Health Service or Tribal clinics. Medicaid agencies receive a 100 percent federal match for services provided to Indians through these specialized providers. This may encourage states to continue to provide a fee-for-service option for these beneficiaries. On the other hand, many AI/AN do not receive services from these providers and indeed have trouble accessing sufficient specialty and primary care. For these individuals, enrollment in managed care could prove beneficial. Exempting this group from mandatory enrollment allows individuals to choose the option that best suits their needs, at little cost to the state.³⁸
- The exemption for children in foster care is often due to the frequent placement changes (and resulting changes in residence) that many of these children experience. However, some children in foster care do receive care through either a Medicaid or commercial MCO before removal from the home. In these cases, it may be better to allow the child to remain in that MCO.

³⁸ For a more complete discussion of these issues, please refer to Neva Kaye and Joanne Rawlings-Sekunda, *Native Americans and Medicaid Managed Care, The Kaiser-HCFA State Symposia Series*, (Portland, ME: National Academy for State Health Policy, 1998).

Exempting this group allows the child welfare agency and others concerned with the care of the children to decide what option works best on an individual basis.³⁹

³⁹ For more information on these issues please refer to Neva Kaye, Jane Horvath, and Maureen Booth, *Monitoring the Quality of Health Care Provided to Children in Foster Care* (Portland, ME: National Academy for State Health Policy, 1998).

Medicaid Policies on Access of Enrollees with Special Needs to Providers

Policy issue

Most earlier Medicaid managed care programs served poor families. Over the last decade, however, states have begun enrolling populations with more complex needs. Some have argued that MCOs were not well equipped to adequately meet these individuals' needs. For example, proponents of having only physicians with HIV experience treat people living with HIV argue that the treatment possibilities have become so complex that only physicians with a significant number of HIV-infected patients will keep up with current knowledge.

State responses

These concerns have led to consideration of access policies regarding access to appropriate providers for managed care enrollees with special needs, such as specialists as primary care providers (PCPs), standing referrals, and requiring out-of-network referrals for services unavailable within an MCO's network.

Access strategies in risk programs

All but one Medicaid agency establish general measures/standards to ensure access that MCOs and PHPs must meet in their ongoing programs. All states that contract with comprehensive MCOs establish such standards. Also, many MCOs opt to use standards/measures to ensure access for Medicaid enrollees without a specific state requirement to do so.

In 2000, Medicaid agencies' most frequent requirements were for out-of-network access for services that were not provided within the network and for self-referral for specific types of specialists. MCOs were most likely to choose to allow standing referrals to specialists and specialists as primary care providers (PCPs).

Table 8 State requirement v. voluntary MCO adoption of access strategies: 2000

Strategy	State Requires		MCO Chooses ⁴⁰		Either	
Self-referral for specific type of specialist	29	83%	6	17%	35	100%
Out-of-network access if cannot provide in-network	31	94%	2	6%	33	100%
Allow standing referrals to specialist	11	35%	22	71%	31	100%
Allow specialist as PCP	16	53%	15	50%	30	100%
Continuity of provider after enrollment for period of time	14	54%	12	46%	26	100%
Experienced providers for enrollees with special needs	15	79%	4	21%	19	100%

As an example, in order to better serve children in foster care, Utah has MCOs make every effort to contract with providers identified by the child welfare agency. Upon enrollment, MCOs are to inform children or their caregivers which network providers have expertise in serving them. Contract language also requires MCOs to ensure that the child may see the provider of record.⁴¹

The largest reported increase between 1998 (the first year these items were reported) and 2000 among ongoing strategies (either mandated by states or chosen by MCOs) for assuring access was in allowing new enrollees to retain the provider they were using before enrollment for a predetermined period of time. This doubled, from 14 states (31 percent of those with managed care) reporting in 1996 to 26 states (62 percent of those with managed care) reporting in 2000 (Table 9).

⁴⁰ *MCO Chooses* means that at least one Medicaid contracted MCO uses the measure/standard to ensure access for Medicaid beneficiaries, even though the Medicaid agency does not require it to do so.

⁴¹ Joanne Rawlings-Sekunda, et al., *Efforts in Ensuring Health Care to Children in Foster Care: Case Studies of Nine States* (Portland ME: National Academy for State Health Policy, 1999).

Table 9 Ongoing strategies⁴² for assuring access by risk contractors: 1996-2000

Strategy	1998		2000	
Self-referral for specific type of specialists	38	84%	35	83%
Out-of-network access if cannot provide in-network	NR		33	79%
Allow standing referrals	32	71%	31	74%
Allow specialist as PCP	36	80%	30	71%
Continuity of provider after enrollment for period of time	14	31%	26	62%
Experienced providers for enrollees with special needs	NR		19	45%
# States with risk programs	45	100%	42	100%

Thirty-nine of the forty-two states with risk programs (93 percent) use multiple ongoing strategies for assuring access. Specifically:

- nine states use all six strategies;
- twenty-one use four or five strategies; and
- nine use two-three strategies

Access strategies in PCCM programs

In PCCM programs, between 1998 and 2000, states increased the use of four measures/standards of particular importance to beneficiaries served by safety-net providers—allowing specialists as PCPs in special circumstances, requiring providers to take special needs cases, allowing standing referrals to specialists, and allowing self-referral for specific types of service (Table 10). Among the 29 states with PCCM programs, 21 (72 percent) used more than one method to assure access in PCCM programs. Four of these twenty-one states used all four strategies and nineteen used two-three strategies.

⁴² In this table, a strategy is said to be in use if either the state requires the MCO to use the policy or at least one MCO has voluntarily chosen to do so.

Table 10 Strategies for assuring access in PCCM programs: 1996-2000

Strategy	1996		1998		2000	
	Allow specialist as PCP in special circumstances	NR		17	59%	20
Allow standing referrals to specialist	NR		13	45%	17	59%
Self-referral for specific type of service	NR		13	45%	17	59%
Providers take special needs cases	7	22%	7	24%	8	28%
# States with PCCM programs	32	100%	29	100%	29	100%

Medicaid Policies on the Use of Outreach Workers to Assist in Accessing Medical Care

Policy issue

In addition to general standards to ensure that enrollees can access care, some MCOs provide enabling services that help individual enrollees access appropriate health services. Although all Medicaid enrollees of health plans could benefit from enabling services, certain populations traditionally served by safety-net providers may be especially in need of these services because of the complexity of their health needs.

One strategy—using outreach workers (e.g., navigators) to assist in accessing care—is considered a service above the norm. All states expect plans to coordinate medical care. Care coordination refers to coordination of all care, including non-medical care, that effects medical care (i.e., working with a community-based organization to help a homeless person on anti-retro viral treatment to find a place to refrigerate prescription drugs or coordinating transportation to medical appointments). Similarly, all plans have member services staff to answer routine enrollee questions; some also hire staff to work directly with individuals who are experiencing difficulties navigating the managed care system.

State responses

In 2000, 26 states (62 percent of those with risk programs) reported that MCOs use outreach workers to assist in accessing medical care.

- In 10 states (38 percent of those with outreach workers), this use was required by the Medicaid agency.

- In 17 states (65 percent of those with outreach workers), at least one MCO chose to have its staff help individuals access care as “navigators” without state requirements to do so.

The 26 states reporting the use of navigators is a significant increase from 1996 when 11 states (29 percent of those with risk programs) reported such assistance, or 1998 when 22 states (49 percent of those with risk programs) reported such assistance.

States that enroll eligibility groups that include most Medicaid beneficiaries with complex medical needs are more likely to require MCOs to provide services that enable individuals with complex needs to obtain appropriate medical care. Although none of the states that only serve families through Medicaid managed care require navigator staff, 10 states that serve families *and* individuals with complex needs (the elderly and/or people with disabilities) have such requirements.

SUMMARY OF FINDINGS ON ELIGIBILITY AND ACCESS

Over the last decade, safety-net providers have become major players in Medicaid managed care, both as subcontracted providers and as owners of MCOs. For example, 90 percent of states that contract with MCOs and/or PHPs reported that FQHCs participated in the managed care program, and 10 reported that an FQHC or community health center owned an MCO. Also, 15 states went a step further than participation by developing MCO contract language regarding referral or payment to FQHCs.

In addition, many states consider access during the enrollment process. For example, 22 states reported that community-based organizations informed beneficiaries about the managed care program and 14 reported that providers, such as FQHCs, did so. Further, 34 states reported that informing activities took place at FQHCs (although the FQHC may not, itself, have conducted the informing). This heavy involvement in the enrollment process ensures that those who wish to receive their care from safety-net providers will continue to be able to do so under managed care.

States are also taking steps to ensure that those whose individual needs might not be best served by managed care are allowed to remain on fee-for-service and that those who enroll into managed care will be able to obtain the care they need. For example, 36 states exclude those with long-term care needs who live in the community from managed care, and 16 states either exclude children with special needs from the managed care program or allow them to choose to remain on fee-for-service. Also, ten states reported requiring contracted health plans to help some or all Medicaid enrollees access appropriate care (beyond the normal customer service function) and seventeen plans reported that at least one plan chose to provide such help without a state requirement to do so. Finally, states have also implemented policies to reduce potential barriers to care for those with special needs who are enrolled into managed care. For example, 29 of the 42 states that contract with PHPs or MCOs reported requiring plans to allow beneficiaries to self-refer for some services and 15 required plans to provide enrollees with special needs access to experienced providers.

Appendix B
National Academy for State Health Policy
Allowable PCCM Provider Types, Including Traditional Providers

Definition of Codes:		1=Family coverage; 2=Poverty level pregnant women; 3=Poverty level children; 4=Aged; 5=SSI children; 6=SSI adults; 7=1115 expansion; 8=CHIP expansion; 9=Other								
	Count	AL	AR	CA	CO	FL	GA	IA	ID(a)	IN
Description										
Individual physician	29	1, 2, 3, 4, 5, 6, 8	1, 2, 3, 5, 6, 7, 8	1, 2, 3, 4, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6, 8	1, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 4, 5, 6, 8, 9	1, 2, 3, 8(a)
1. Primary (Typically internist, family practitioner, etc.)	29	1, 2, 3, 4, 5, 6, 8	1, 2, 3, 5, 6, 7, 8	1, 2, 3, 4, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6, 8	1, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 4, 5, 6, 8, 9	1, 2, 3, 8
2. Ob/Gyn	25	1, 2, 3, 4, 5, 6, 8	1, 2, 3, 5, 6, 7, 8	1, 2, 3, 4, 5, 6, 8	1, 2, 6(r)	1, 2, 3, 4, 5, 6, 8	1, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 6, 9	1, 2, 3, 8
3 Specialist	21	1, 2, 3, 4, 5, 6, 8		1, 2, 3, 4, 5, 6, 8			1, 3, 4, 5, 6		1, 2, 3, 4, 5, 6, 8, 9	
Physician group/clinic	22	1, 2, 3, 4, 5, 6, 8	1, 2, 3, 5, 6, 7, 8(g)	1, 2, 3, 4, 5, 6, 8		1, 2, 3, 4, 5, 6, 8	1, 3, 4, 5, 6		1, 2, 3, 4, 5, 6, 8, 9	
Nurse midwives	7			1, 2, 3, 4, 5, 6, 8					1, 2, 6, 9	
Nurse practitioner	17			1, 2, 3, 4, 5, 6, 8		1, 2, 3, 4, 5, 6, 8	1, 3, 4, 5, 6		1, 2, 3, 4, 5, 6, 8, 9	
Physician's assistant center (not individual physician)	7					1, 2, 3, 4, 5, 6, 8			1, 2, 3, 4, 5, 6, 8, 9	
Community/migrant health center (not FQHC)	23	1, 2, 3, 4, 5, 6, 8	1, 2, 3, 5, 6, 7, 8	1, 2, 3, 4, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6, 8	1, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 4, 5, 6, 8, 9	
Public health agency	14				1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6, 8	1, 3, 4, 5, 6		1, 2, 3, 4, 5, 6, 8, 9	
Maternal and Child Health Clinics	13					1, 2, 3, 4, 5, 6, 8	1, 3, 4, 5, 6		1, 2, 3, 4, 5, 6, 8, 9	
School based clinic (not individual physician)	5						1, 3, 4, 5, 6		1, 2, 3, 4, 5, 6, 8, 9	
Rural health clinic	2									
Indian Health Service Clinic	22	1, 2, 3, 4, 5, 6, 8		1, 2, 3, 4, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6, 8	1, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 4, 5, 6, 8, 9	
Tribal Health Clinic	12			1, 2, 3, 4, 5, 6, 8	1, 2, 3, 4, 5, 6				1, 2, 3, 4, 5, 6, 8, 9	
Hospital	11			1, 2, 3, 4, 5, 6, 8	1, 2, 3, 4, 5, 6				1, 2, 3, 4, 5, 6, 8, 9	
Other (SPECIFY)	10		1, 2, 3, 5, 6, 7, 8(i)			1, 2, 3, 4, 5, 6, 8(j)	1, 3, 4, 5, 6(k)		1, 2, 3, 4, 5, 6, 8, 9(l)	

Appendix B
National Academy for State Health Policy
Allowable PCCM Provider Types, Including Traditional Providers

Definition of Codes:		1=Family coverage; 2=Poverty level pregnant women; 3=Poverty level children; 4=Aged; 5=SSI children; 6=SSI adults; 7=1115 expansion; 8=CHIP expansion; 9=Other										
	Count	KS	KY	LA	MA(b)	ME	MS	MT	NC	ND(c)	NE	NY
Description												
Individual physician	29	1, 2, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 7, 8, 9	1, 2, 3, 8	1, 2, 3, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8
1. Primary (Typically internist, family practitioner, etc.)	29	1, 2, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 7, 8, 9	1, 2, 3, 8	1, 2, 3, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8
2. Ob/Gyn	25	1, 2, 3, 5, 6	1, 2, 3, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 7, 8, 9	1, 2, 3, 8		1, 2, 6	1, 2, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8
3 Specialist	21	1, 2, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 5, 6, 8(c)	1, 2, 3, 5, 6, 7, 8, 9		1, 2, 3, 8(d)	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6		1, 2, 3, 5, 6, 8(e)	1, 2, 3, 5, 6, 8
Physician group/clinic	22	1, 2, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 7, 8, 9	1, 2, 3, 8	1, 2, 3, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			1, 2, 3, 5, 6, 8(h)
Nurse midwives	7						1, 2, 3, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			
Nurse practitioner	17	1, 2, 3, 4, 5, 6			1, 2, 3, 5, 6, 7, 8, 9	1, 2, 3, 8	1, 2, 3, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			1, 2, 3, 5, 6, 8
Physician's assistant center (not individual physician)	7					1, 2, 3, 8		1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			
Community/migrant health center (not FQHC)	23	1, 2, 3, 4, 5, 6		1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 7, 8, 9	1, 2, 3, 8	1, 2, 3, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6	1, 2, 3, 8		
Public health agency	14	1, 2, 3, 4, 5, 6			1, 2, 3, 5, 6, 7, 8, 9		1, 2, 3, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			
Maternal and Child Health Clinics	13	1, 2, 3, 4, 5, 6	1, 2, 3, 8				1, 2, 3, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			
School based clinic (not individual physician)	5								1, 2, 3, 4, 5, 6			
Rural health clinic	2				1, 2, 3, 5, 6, 7, 8, 9(i)							
Indian Health Service Clinic	22	1, 2, 3, 4, 5, 6	1, 2, 3, 8	1, 2, 3, 5, 6, 8		1, 2, 3, 8	1, 2, 3, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6	1, 2, 3, 8		
Tribal Health Clinic	12	1, 2, 3, 4, 5, 6						1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6	1, 2, 3, 8		
Hospital	11	1, 2, 3, 4, 5, 6				1, 2, 3, 8		1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			
Other (SPECIFY)	10			1, 2, 3, 5, 6, 8(m)	1, 2, 3, 5, 6, 7, 8, 9(n)							
	1											

Appendix B
National Academy for State Health Policy
Allowable PCCM Provider Types, Including Traditional Providers

Definition of Codes:		1=Family Coverage; 2=Poverty level pregnant women; 3=Poverty level children; 4=Aged; 5=SSI children; 6=SSI adults; 7=1115 expansion; 8=CHIP expansion; 9=Other								
	Count	OR	PA(d)	SD	TX(e)	UT	VA	VT	WA	WV
Description										
Individual physician	29	1, 2, 3, 4, 5, 6, 7	1, 2, 3, 4, 5, 6	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6, 7	1, 2, 3(b)	1, 2, 3, 5, 6
1. Primary (Typically internist, family practitioner, etc.)	29	1, 2, 3, 4, 5, 6, 7	1, 2, 3, 4, 5, 6	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6, 7	1, 2, 3	1, 2, 3, 5, 6
2. Ob/Gyn	25	1, 2, 3, 4, 5, 6, 7		1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 5, 6(s)			1, 2, 3, 5, 6
3 Specialist	21	1, 2, 3, 4, 5, 6, 7	1, 2, 3, 4, 5, 6	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6, 7(f)		1, 2, 3, 5, 6
Physician group/clinic	22	1, 2, 3, 4, 5, 6, 7	1, 2, 3, 4, 5, 6		1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6		1, 2, 3	1, 2, 3, 5, 6
Nurse midwives	7				1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6				
Nurse practitioner	17	1, 2, 3, 4, 5, 6, 7			1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6		1, 2, 3, 4, 5, 6, 7	1, 2, 3	1, 2, 3, 5, 6
Physician's assistant center (not individual physician)	7	1, 2, 3, 4, 5, 6, 7				1, 2, 3, 4, 5, 6				
center (not individual physician)	23	1, 2, 3, 4, 5, 6, 7	1, 2, 3, 4, 5, 6	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			1, 2, 3, 5, 6
Community/migrant health center (not FQHC)	14	1, 2, 3, 4, 5, 6, 7			1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			1, 2, 3, 5, 6
Public health agency	13	1, 2, 3, 4, 5, 6, 7			1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			1, 2, 3, 5, 6
Maternal and Child Health Clinics	5				1, 2, 3, 5, 6, 8		1, 2, 3, 4, 5, 6			
School based clinic (not individual physician)	2				1, 2, 3, 5, 6, 8					
Rural health clinic	22	1, 2, 3, 4, 5, 6, 7	1, 2, 3, 4, 5, 6	1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6	1, 2, 3, 4, 5, 6			1, 2, 3, 5, 6
Indian Health Service Clinic	12	1, 2, 3, 4, 5, 6, 7		1, 2, 3, 5, 6, 8	1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6			1, 2, 3	
Tribal Health Clinic	11	1, 2, 3, 4, 5, 6, 7			1, 2, 3, 5, 6, 8	1, 2, 3, 4, 5, 6			1, 2, 3	
Hospital	10	1, 2, 3, 4, 5, 6, 7	1, 2, 3, 4, 5, 6(o)		1, 2, 3, 5, 6, 8		1, 2, 3, 4, 5, 6(p)			
Other (SPECIFY)	1					1, 2, 3, 4, 5, 6(q)				

Appendix A
National Academy for State Health Policy
Traditional Provider Participation - Notes

Letter	Footnote
(a)	Must include, unless demonstrate provider not needed.
(b)	Voluntary MC.
(c)	Voluntary MC.
(d)	None in HMO County.
(e)	To contract w/University Hospital; enc w/others.
(f)	To contract w/University Hospital; enc w/others.
(g)	None in HMO County.
(h)	Carve out
(i)	Planned parenthood.
(j)	None in HMO County.
(k)	All MCOs have contracts w/hospital based clinics.
(l)	MCOs required to offer contract
(m)	Mental Health contractor.
(n)	None in HMO County.
(o)	Voluntary MC; Must have written agreement.
(p)	None in HMO County.
(q)	One plan contracts with Tribal clinics
(r)	Other family planning.
(s)	Non-FQHC Health Centers.
(t)	Other family planning.
State	Method(s) State Uses Encourage Plans to Contract with Traditional Providers
AZ	Encouraged in contract.
CA	Extra points in RFA; Continuity of care; Plans must reimburse for family planning and Indian Health Service out-of-plan visits.
CO	Will get points in competitive procurement. B. Will lose out in default assignment if don't enter into "good faith" contract talks.
DE	Plans need to contract w/these providers in order to meet access requirements for essential services.
DC	Contract language, extra points in RFP.
FL	Require good faith effort to contract w/FQHC, school districts and local public health agency; verbal encouragement for others; MH - consideration in RFP.
GA	Elements of contract application require contact.
HI	Verbal encouragement.
IA	MCO's encouraged in text of contract; no penalty for not contracting. Needed in order to deliver services in some areas. BHO must contract w/any provider who accepts standard contract terms
IL	MCO contract provides for linkages to other services, requires plans to use reasonable efforts to coordinate & communicate with these providers.
KS	Contract encourages contracting.
KY	Not specified
MA	Consider RFR evaluation scoring.
ME	Contract language
MI	Extra points in RFR review-which leads to additional assignments and findings in semi-annual site visits.
MN	Verbal encouragement.
MO	Preference in eval. process to MCOs that contract w/spec. BH providers & include school based services, considers Title X & V provider presence in plan networks.
NC	MCOs are encouraged to contract with the provider types through the inclusion of community resources in the contract language.
ND	MCO must make a reasonable effort to contract with all county public health clinics for these and other services.
NH	Verbal encouragement to submit a RFP
NJ	Identified providers; facilitated meetings; established workgroups.
NM	Facilitates dialogue between plans and providers.
NV	point system for default assignment--currently all MCOs are even balance
NY	Not Specified
OH	MCOs either contract with FQHCs or provide comparable services or the requirement is waived if an FQHC-based MCP is present in the service area.
OK	Preference in proposal evaluation to plans including relatively greatest number of ECPs in networks & who use these providers as PCPs to max extent possible, where appropriate.
PA	Encourages contracts w/identified providers during review of provider networks if not part of networks.
RI	Needed to meet general contract requirements.
SC	Voluntary Participation, State provides info on best practices for service delivery by traditional
TN	Facilitating meetings, verbal encouragement.
TX	Extra points on RFP and/or contract language.
UT	Informal suggestions.
VA	Language in contract. Part of access evaluation. Preference in pre-assignment.
WA	Part of network adequacy evaluation; extra points in RFP, preference in assignments.

Appendix A
National Academy for State Health Policy
Traditional Provider Participation - Notes

State	Method(s) State Uses Encourage Plans to Contract with Traditional Providers
WI	Contractual language which encourages HMOs to contract w/local health departments and community based health organizations. HMOs must sign an MOU w/all school based providers w/in their service area to promote continuity of care between HMO and SRS.
WV	Bonus Payment.