

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

Volume II: Monitoring Functions and Quality

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by

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EXECUTIVE SUMMARY: STATE MONITORING FUNCTIONS AND QUALITY ISSUES RELATED TO SAFETY-NET PROVIDERS

Over the last decade, safety-net providers¹ have become key stakeholders in the Medicaid managed care marketplace. This report is the second 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 second report examines state Medicaid policies regarding managed care monitoring functions and quality issues of particular concern to safety-net providers. This study found that:

Medicaid Agencies Have Structures in Place to Identify and Address Program Issues Based on Stakeholder Input

- All 42 states that contract with managed care organizations (MCOs) or Prepaid Health Plans (PHPs) either conduct an enrollee survey, hire a third party to conduct an enrollee survey, or require contract plans to conduct a survey and report the results to the state.
- Most states reported using enrollee survey data to assess plan performance. Specifically, 29 of the 42 states that operate a risk program (69 percent) use enrollee survey data to compare MCO performance; 27 (64 percent) use it to provide feedback to MCOs on their performance; 22 (52 percent) use it in state conducted quality studies; and 22 (52 percent) use it to identify issues that need investigation.
- Among the 29 states with Primary Care Case Management (PCCM) programs, 28 (97 percent) reported using enrollee surveys or focus groups to monitor activities.
- Among the 49 states that operate a PCCM or risk program, 47 (96 percent) solicit input on program operations from consumer advocacy agencies; and 21 (43 percent) reported soliciting input from AIDS services organizations (Ryan White providers).
- Most of the 49 states that operate a PCCM or risk program involve specific stakeholders in program operations by inviting them to participate in work or advisory groups (47 states—96 percent) or inviting stakeholders to comment on contracts and waivers (40 states—82 percent).

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.

Medicaid agencies coordinate with other agencies that serve vulnerable populations and ensure that plans do so as well

- In 2000, 38 of the 49 Medicaid agencies that operate PCCM or risk programs (78 percent) reported coordinating with the agency primarily responsible for serving children with special health care needs (usually the Title V agency); 38 (78 percent) reported coordinating with the state mental health agency.
- Medicaid agencies were most likely to coordinate through meetings (44 states—90 percent of 49 states), sharing information/data (38 states—78 percent), and by asking for written comments on program administrative material, such as requests for proposals (RFPs), waiver requests, and contracts (35 states—71 percent). They were least likely to use joint contracts (seven states—14 percent), joint RFPs (seven states), and coordinated funding (seven states).
- Among the 15 Medicaid agencies that use both MCOs and Behavioral Health Organizations (BHOs), 13 (87 percent) have a strategy in place to either require or encourage coordination between the two delivery systems.

INTRODUCTION

Safety-net providers² are the health care 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 beneficiaries³—has evolved over the past decade. In 1990, most Medicaid managed care programs used commercial MCOs to serve mostly women and children. In 2000, although most agencies continue to use these 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 to contract directly with Medicaid agencies as managed care organizations themselves. 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 monitoring managed care. It examines the use of satisfaction surveys, efforts to gather input from safety-net related entities and consumers in developing managed care programs, strategies to 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. It is the second of a series of three reports. The other two reports examine Medicaid agencies' policies and efforts in the areas of:

- *Eligibility and access*—including policies regarding inclusion of safety-net providers, use of FQHCs for outreach and enrollment, populations excluded or exempted from managed care,

² *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.

³ As of June 2000, this includes both risk-based and PCCM programs.

access of managed care enrollees with special needs to appropriate providers, and the use of outreach workers to assist in accessing medical care; 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.⁴ 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

⁴ 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.⁵

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

- 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.⁶ *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.

⁵ 42 CFR 434.21(b)

⁶ 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 MEDICAID MANAGED CARE MONITORING FUNCTIONS AND QUALITY

The 42 Medicaid agencies that reported operating risk programs in 2000 collect and use the types of data generally accepted to be key to assessing MCO performance in access, quality, and enrollee satisfaction. Of the 38 agencies that reported collecting performance measures to assess MCO/PHP performance in 2000, 34 (89 percent) reported collecting one or more Health Plan Employer Data and Information Set (HEDIS) measures; 27 (71 percent) reported collecting at least one state-developed measure; and 7 reported collecting at least one measure that was developed by another organization. Twenty-eight (74 percent) reported using more than one source for performance measures.

The 29 Medicaid agencies with PCCM programs also continued to increase their efforts to ensure quality in these programs. As discussed in other NASHP work,⁷ this increased emphasis on monitoring PCCM programs may have two causes. First, as Medicaid agencies become concerned about continued MCO participation, some are beginning to consider how they might manage care without MCOs; PCCM programs are often the obvious answer (as they were for the five states that have already dismantled their MCO programs). Second, many states have long considered their PCCM programs to be their “state-run MCO” and have worked to continually improve their program’s ability to deliver care to enrollees.

This section examines some of the monitoring and quality assurance practices that affect the care provided to consumers typically served by safety-net providers. These functions include:

- Collection and use of data from satisfaction surveys;
- Efforts to gather input from certain stakeholder groups;
- Strategies to ensure coordination of behavioral and physical health care; and
- Medicaid efforts to coordinate with other agencies to provide care for enrollees with special needs.

⁷ Joanne Rawlings-Sekunda , Deborah Curtis, and Neva Kaye, *Emerging Practices in Medicaid Primary Care Case Management Programs*, (Washington, DC: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2001), <http://aspe.os.dhhs.gov/health/reports/PCCM/index.htm>.

Medicaid Policies on Satisfaction Surveys

Policy issue

Consumer satisfaction is considered a very important measure of the quality of care received. In fact, one commercial MCO believes consumer satisfaction is so important that it is ending its system of awarding bonuses to doctors for controlling costs and beginning to link bonus payments directly to patient satisfaction.⁸

State responses

States with risk programs

In 2000, 41 of the 42 states with risk programs (all except South Dakota) reported that they collected and used enrollee survey data. This is the same proportion as in 1998 (98 percent or 44 states with risk programs), but a significant jump from 1996 (when 71 percent, or 27 agencies, reported such surveys).

Enrollee surveys can be conducted by the plan, the Medicaid agency, or another contractor, such as an External Quality Review Organization (EQRO). These surveys can be used to assess enrollee perceptions of MCO performance, enrollee health status, and how easily enrollees can access care, among other things. States can use an existing survey, develop their own, ask (or require) the MCO to develop one, or hire another organization to do so.

Of the 41 agencies that reported using enrollee survey information to assess MCO/PHP performance in 2000:

- Thirty-one reported that the agency (or a contractor other than the plans) conducted the survey. Twenty-three (74 percent) reported using the Consumer Assessment of Health Plans Survey (CAHPS), making it the most frequently mentioned nationally developed survey.
- Twenty-three reported that the MCO conducted the survey.
 - S Fifteen of these twenty-three (65 percent) reported that the MCO developed the survey.
 - S Eleven (48 percent) reported using CAHPS..

⁸ “Blue Cross of California Doctors to Get Bonuses for Patient Satisfaction, Not Cost Control,” *Kaiser Daily Health Policy Report*, July 10, 2001.

- Fourteen agencies reported that both the state and the MCOs conducted surveys.

Table 2 Types of enrollee surveys administered by MCOs and reported to states: 2000

Survey Type	2000	
MCO developed	15	65%
CAHPS	11	48%
State developed	2	9%
Developed by other organization	0	0%
# States requiring MCOs to administer enrollee surveys	23	100%
# States with risk programs	42	

Table 3 Types of enrollee surveys administered by states: 2000

Survey Type	2000	
CAHPS	23	74%
State developed	10	32%
Developed by other organization	6	19%
MCO developed	0	0%
# States administering enrollee surveys	31	100%
# States with risk programs	42	

The following table highlights how states use the data collected. The most common uses are to compare the performance of contracted MCOs, provide feedback to them on this performance, and to report this performance to the public. Among the 41 states that collect enrollee surveys, 36 (88 percent) use this data for more than one purpose. For example, a state might use enrollee survey data for both public reporting and to compare MCO performance. Similarly, seven of the ten states that collect provider focus group/survey information use that data for more than one purpose.

Table 4 Uses of survey information collected for risk programs: 2000

Use	Enrollee survey		Provider focus groups/surveys	
Compare MCO performance	29	71%	6	60%
Feedback on performance	27	66%	6	60%
Public reporting	27	66%	5	50%
State quality studies	22	54%	10	100%
Identify issues for investigation	22	54%	5	50%
Help beneficiaries select plan	14	34%	2	20%
Resolve individual enrollee problems	5	12%	2	20%
Contract renewal/contractor selection	5	12%	1	10%
Penalty payment determination	4	10%	0	0%
Incentive payment determination	1	2%	0	0%
Enrollment auto-assignment	1	2%	0	0%
Other	6	15%	4	40%
States that collect the data type	41	100%	10	100%

For example, in New Jersey, issues expressed in satisfaction surveys about appointment waiting times and referral processes resulted in tighter RFP standards.⁹ New Jersey also makes the results of satisfaction surveys available on publicly accessible computers in welfare and county offices throughout the state, as well as mailing copies to anyone requesting them.¹⁰

States with PCCM programs

⁹ Joanne Rawlings-Sekunda and Neva Kaye, *Emerging Practices and Policy in Medicaid Managed Care for People with HIV/AIDS: Case Studies of Six Programs* (Portland, ME: National Academy for State Health Policy, 1998).

¹⁰ Joanne Rawlings-Sekunda, *Consumer Involvement in Managed Care Programs Serving Persons Dually Eligible for Medicaid and Medicare* (Portland, ME: National Academy for State Health Policy, 1998).

In 2000, 28 states with PCCM programs (97 percent of those with such programs) reported using enrollee surveys or focus groups to monitor activities. This is significantly higher than in 1998, when 25 states (86 percent of those with PCCM programs) collected and used this data.

The type of surveys used in PCCM programs changed little between 1998 and 2000. The majority of PCCM programs still rely on state-developed surveys and have not switched to using standardized surveys, such as CAHPS. This may relate to two factors.

- In PCCM programs, the Medicaid agency acts in much the same capacity that an MCO does in risk programs. As a result, the agency may be concerned about specific operational issues that may not be captured by the national surveys.
- Since CAHPS was developed for use in assessing MCO performance, some have perceived it as being inappropriate for PCCM programs. That perception may change as more states gain experience using CAHPS in PCCM programs.

Table 5 Enrollee surveys used in PCCM programs: 1998-2000

Survey Type	1998		2000	
	State developed	16	64%	17
CAHPS	10	40%	12	43%
Developed by other organization	8	32%	8	29%
# States administering enrollee surveys	25	100%	28	100%
# States with PCCM programs	29		29	

Medicaid Efforts to Gather Input in Developing Managed Care Programs from HIV-related Stakeholders

Policy issue

Medicaid agencies need information from others in order to help them design and operate a managed care program that serves enrollees well. Consumers who have HIV and their advocates (including providers receiving Ryan White funds and state agency personnel directing Ryan White Care Act activities) can help identify areas in which beneficiaries are having difficulties accessing various types of care.

State responses

Stakeholders consulted

State Medicaid agencies use a number of different means to gather information from consumers, Ryan White providers, and state staff implementing Ryan White Care Act grants.

- Forty-eight states (98 percent of the states with risk programs) gather input from consumers. Fifteen of the 16 states that require consumers on MCO boards serve SSI populations (which may include people with HIV/AIDS) through comprehensive MCOs.
- Forty-seven states (97 percent) gather input from consumer advocacy groups, which may include HIV advocates.
- Twenty-one states (43 percent) gather input from AIDS service organizations, many of which receive Ryan White funds.

In a NASHP study of HIV-related efforts in six managed care programs,¹¹ Medicaid agencies often coordinated with public health departments (which usually staff Ryan White Care Act programs) regarding HIV-specific issues. Examples of this collaboration include:

- Tennessee created AIDS Centers of Excellence across the state. The team developing the model included the Medicaid agency, the Department of Health, the pharmacy benefits manager, doctors specializing in HIV treatment, the provider community, the advocacy community, and consumers.
- Massachusetts developed clinical guidelines for HIV drug therapy. The process included the Medicaid agency, the Department of Health, the New England AIDS Education Training Center, universities, teaching hospitals, and advocacy groups.

Table 6 HIV-related sectors of the public from which states gather input: 1996–2000

Public Sector	1996		1998		2000	
Consumers	32	67%	46	94%	48	98%
Consumer advocacy agencies	38	79%	46	94%	47	96%
Local public health agency (LPHA)	NR		41	84%	43	88%
AIDS services organizations (Ryan White providers)	NR		NR		21	43%

¹¹ See note 9.

# States with managed care	48	100%	49	100%	49	100%
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Methods for gaining input

States use a variety of means for seeking this input; all use more than one means. The most commonly used methods are meetings, advisory groups/commissions/workgroups, and open public meetings.

Table 7 Methods states use to gather public input: 1996–2000

Method	1996		1998		2000	
	Advisory groups/commissions/workgroups	34	71%	45	92%	47
Meetings	43	90%	44	90%	47	96%
Open public meeting	NR		37	76%	44	90%
Written comment on contract, RFP, etc.	30	63%	39	80%	40	82%
Focus groups	NR		28	57%	34	69%
Surveys	17	35%	29	59%	33	67%
Formal Requests for Information (RFI)	18	38%	26	53%	30	61%
Conferences	NR		20	41%	25	51%
# States with managed care	48	100%	49	100%	49	100%

Medicaid Efforts to Ensure Coordination of Behavioral and Physical Health Care

Policy issue

In 2000, 13 states (California, the District of Columbia, Colorado, Florida, Hawaii, Massachusetts, Minnesota, Missouri, Ohio, Oregon, Pennsylvania, Texas, and Washington) reported using multiple arrangements for behavioral health services.

Actions taken to promote physical health can have an effect on behavioral health and vice versa. For example, a medication prescribed by a mental health provider may interact with a medication prescribed by a primary care provider and harm a patient’s health. As a result, there is concern that physical and behavioral healthcare providers coordinate the services they provide when behavioral health is “carved out” from physical health programs. This concern can be particularly important for

people with complex physical and behavioral health needs, including those traditionally served by safety-net providers.

Physical and behavioral healthcare providers also need to protect patient confidentiality. The authors of a five-state study on care coordination write, “By far the single most problematic issue for states and MCOs is working through confidentiality issues between systems of care. For example, when an MCO is responsible for managing the physical health needs of a member, and a behavioral health organization (BHO) is responsible for addressing the mental health needs, the two organizations are often prevented from cooperating with each other because of confidentiality concerns. According to state officials [in the study], confidentiality concerns often can be dealt with during the early implementation phase by bringing all agencies—state and local—to the table to build trust and set realistic expectations. Legal issues can be addressed openly, and agencies can develop rules for sharing (or not sharing) information.”¹²

State responses

Most states that contract with MCOs for physical health care but deliver behavioral health services as fee-for-service or through a BHO reported taking steps to ensure coordination among physical and behavioral health providers. This may reflect a heightened concern for coordination under this type of arrangement or simply that under this arrangement an accountable entity exists for both types of services.

- Thirteen states (87 percent) that contract with an MCO for physical health and a BHO for behavioral health reported strategies that require/encourage coordination.
- Eleven states (61 percent) that contract with an MCO for physical health and fee-for-service providers for behavioral health reported using these strategies.

¹² Margo L. Rosenbach and Cheryl G Young, *Care Coordination in Medicaid Managed Care: A Primer for States, Managed Care Organizations, Providers, and Advocates*. (Washington, DC: Mathematica Policy Research Inc., 2000).

Table 8 Strategies to encourage coordination between physical and behavioral health providers where the comprehensive MCO is not responsible for behavioral health services: 2000

Strategy	2000			
	BHO/MCO ¹³		Fee-for-service/MCO	
Require coordination	10	67%	10	56%
Require BH provider/PCP exchange of information	6	40%	2	11%
Require agreements	4	27%	2	11%
Other	4	27%	3	17%
Use any of the four strategies	13	87%	11	61%
# States with arrangement	15	100%	18	100%

Examples of this coordination include:

- In two areas of Wisconsin, care is carved out for a small group of children with severe emotional disturbances. In the Children Come First (CCF) program, primary care is provided fee-for-service, while comprehensive mental health and support services are provided through managed care. The Medicaid capitation rate is paid to the counties, which combine it with their own capitation. The state capitation payment covers only Medicaid-covered services, including mental health and substance abuse services. The county capitation provides for non-Medicaid covered services such as respite and mentoring. CCF assigns a lead agency to provide case management based on a child’s presenting problems. The case manager is responsible for coordinating one plan—including all physical, mental, and ancillary health services—that has been developed by the treatment team. The treatment team includes the child and family, as well as professionals and non-professionals (informal supports). The case manager has full responsibility and authority to obtain mental health and support services and coordinates with the primary care provider. Health care other than behavioral health services are paid for through the fee-for-service system, but the case manager and treatment team can help in

¹³ Some states, such as Florida, reported that behavioral health services were provided both through BHOs and as fee-for-service. These states were reported here as BHO/MCO arrangements since they generally reported on policies for BHO/MCO coordination.

obtaining medical care. To further integrate care, the local agency heads meet monthly to work out problems.¹⁴

- Massachusetts requires MCOs to provide care coordination for certain at-risk populations, including people with AIDS and people who are homeless. Case managers are required to ensure that care plans are developed, implemented, and monitored. Implementation includes “ensuring timely and coordinated access to all Medicaid necessary MCO-covered services, including behavioral health services, and non MCO-covered services.” Case managers are to provide “linkage with staff in other agencies and/or community service organizations if the agency/organization is already involved in meeting the enrollee’s needs, or if the agency/organization is identified as helpful in meeting such needs.” MCOs report semiannually on case management activities.¹⁵

Medicaid Efforts to Work with Other State Agencies to Coordinate Services for Enrollees with Special Needs

Policy issue

People with special healthcare needs often obtain services from multiple state agencies, as well as from safety-net providers funded and regulated by these agencies. Medicaid managed care program implementors and managers will obtain a much fuller picture of serving people with complex needs if they work with other state agencies.

In a study of five states’ efforts in designing and implementing care coordination programs, Medicaid agencies emphasized the importance of involving other state agencies in design. MCO officials believed their organizations could not be expected to partner with state and local agencies if the Medicaid agency itself had not established collaborative relationships with these agencies. These agencies need to be involved during the design phase to address a variety of issues, such as:

- What resources exist in each community;
- What procedures should be used to coordinate services between the MCO and each agency;

¹⁴ Trish Riley, Joanne Rawlings-Sekunda, Cynthia Pernice, *The Kaiser-HCFA State Symposia Series—Transitioning to Managed Care: Medicaid Managed Care in Mental Health* (Portland, ME: National Academy for State Health Policy, 1997).

¹⁵ See note 9.

- What are the special needs of Medicaid managed care beneficiaries that were previously served by these agencies;
- What services will be included in the MCO benefit package and what services will be paid for by the state;
- How and by whom non-covered services will be ordered and authorized; and
- What and how information can be shared.¹⁶

State responses

Medicaid agencies have made concerted efforts to coordinate with other state agencies; these efforts have increased since 1998. In 2000, Medicaid agencies were most likely to coordinate with state public health departments, maternal and child health agencies, agencies serving children with special healthcare needs, people with mental illness or developmental disabilities, and children in protective custody/foster care.

¹⁶ See note 12.

Table 9 Selected agencies with which Medicaid agencies coordinate: 1998-2000

Agency	1998		2000	
Maternal and child health	32	65%	42	86%
State public health	31	63%	42	86%
Children with special health care needs	27	55%	38	78%
Mental health	32	65%	38	78%
Child protection/foster care	27	55%	34	69%
Developmental disabilities	29	59%	33	67%
Substance abuse	26	53%	32	65%
WIC	23	47%	32	65%
Early intervention/special education	27	55%	32	65%
Social services	18	37%	26	53%
Education	18	37%	25	51%
Aging	21	43%	24	49%
Juvenile justice	16	33%	19	39%
AIDS office/bureau	NR		16	33%
# States with managed care programs	49	100%	49	100%

Among the 49 Medicaid agencies operating a managed care program in 2000, all except one reported coordinating with at least one other state agency. Only South Dakota reported no coordination with other agencies. This state does not contract with comprehensive MCOs. It offers a PCCM program and contracts with a PHP that delivers only dental benefits. Medicaid agencies were most likely to coordinate with maternal and child health agencies and public health agencies. They were least likely to coordinate with vital statistics agencies.

Medicaid agencies coordinated with other agencies in a variety of ways. Medicaid agencies were most likely to coordinate through meetings (44 states), sharing information/data (38 states), and by asking for written comments on program administrative material, such as requests for proposal (RFPs), waiver requests, and contracts (35 states). They were least likely to use joint contracts (seven states), joint RFPs (seven states), and coordinated funding (seven states).

Further examples of coordination include:

- A NASHP study of nine states' efforts to ensure health care to children in foster care found that virtually every strategy implemented was the result of collaboration: between state agencies, between state and county/local agencies, between states and contracted MCOs, or between governmental and private sector players/providers. For example, in Utah, nurse case managers in each of the state's seven regions have caseloads of 100-300 children. Thirteen nurse case managers and nine support staff are employed by the agency which oversees Medicaid but are co-located with child welfare agency staff. These two agencies blend funding for these contracts. Primary functions include: working with child welfare caseworkers, training caseworkers to meet the healthcare needs of children with less complex needs, serving as medical case managers for the children with more complex needs, working with MCOs and healthcare providers to ensure coordination of services, and working with all players during placement changes to facilitate continuity.¹⁷
- In Massachusetts, approximately 42 percent of the contracted BHO's services are provided to children in state custody. Improvements in delivering services to these children have been undertaken by a collaboration of the Medicaid agency, the child welfare agency, the mental health agency and the BHO. All three agencies were involved in developing performance standards that include standards specific to foster children. Monthly team meetings—focusing both on policy and on individual cases—have resulted in many improvements.¹⁸
- In Michigan, a specialty managed care program—Children's Special Health Care Services—is a voluntary program for Title V beneficiaries, including those with Medicaid. It was developed by both the Medicaid and Title V agencies.¹⁹
- In Delaware, the Medicaid agency and the Department of Services for Children, Youth and Families (DSCYF) have an informal relationship, but the Medicaid program holds DSCYF accountable for serving the children involved. The Medicaid agency pays DSCYF a bundled rate for each child served in the previous month. If the Medicaid agency develops a question regarding the services provided, it retains the reimbursement until the issue is resolved.²⁰

¹⁷ 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).

¹⁸ *Ibid.*

¹⁹ Neva Kaye, Deb Curtis, and Maureen Booth, *Certain Children with Special Health Care Needs: An Assessment of State Activities and Their Relationship to HCFA's Interim Criteria* (Portland, ME: National Academy for State Health Policy, 2000).

²⁰ *Ibid.*

SUMMARY OF FINDINGS ON MONITORING FUNCTIONS AND QUALITY

Medicaid agencies have a responsibility to monitor their managed care programs and work with others, both in and out of state government, to improve their programs. States have structures in place to identify and address program issues; obtaining input from enrollees and others outside the managed care system is a major part of these efforts. All states that contract with MCOs or PHPs either conduct an enrollee survey, hire a third party to conduct an enrollee survey, or require contract plans to conduct a survey and report the results to the state. Also, 47 states solicit input on program operations from consumer advocacy agencies. Many states also make efforts to reach those that serve enrollees with special needs: 21 reported soliciting input from AIDS services organizations (Ryan White providers). Most states reported using enrollee survey data to assess plan performance, however, they involve specific stakeholders in program operations by inviting them to participate in work or advisory groups (47 states) or by inviting stakeholders to comment on contracts and waivers (40 states).

Medicaid agencies also realize that many enrollees are served by multiple agencies or delivery systems and that coordination among agencies and delivery systems is crucial to program success. For example, in 1998, 27 Medicaid agencies reported coordinating with the agency primarily responsible for serving children with special health care needs (usually the Title V agency). By 2000, this number had grown to 38. Similarly, in 1998, 32 Medicaid agencies reported coordinating with the state mental health agency, while in 2000, 38 did so. Finally, states found that coordinating behavioral and physical health is particularly difficult and important given that:

- States often establish behavioral health delivery systems (BHOs) that are separate from those used to deliver physical health (MCOs); and
- The lines between the services that are the responsibility of each system are not always totally clear; yet
- Services provided to an individual by one delivery system can impact the delivery of care by the other.

For example, among the 15 Medicaid agencies that use both MCOs and BHOs, 13 have a strategy in place to either require or encourage coordination between the two delivery systems.