The KAISER-HCFA State Symposia Series: Transitioning to Medicaid Managed Care

Medicaid-Only Managed Care Organizations

Prepared by

Alicia Fagan
Trish Riley

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NATIONAL ACADEMY
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50 Monument Square, Suite 502
Portland, Maine 04101
Phone [207]874-6524
Fax [207]874-6527
E-Mail info@nashp.org

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I. Introduction

The Henry J. Kaiser Family Foundation and the federal Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services, through the National Academy for State Health Policy, convened this symposium as fourth in the series entitled *The Kaiser-HCFA State Symposia Series: Transitioning to Medicaid Managed Care.* These symposia are designed to explore critical issues in building Medicaid managed care programs.

Held on May 12, 1998, "Transitioning to Medicaid Managed Care: Medicaid-Only MCOs" was attended by state and federal officials, consumer advocates, health plan representatives, managed care researchers and experts, and the Henry J. Kaiser Family Foundation and National Academy for State Health Policy staff.

The following states were represented: Colorado, Florida, Maine, Massachusetts, Minnesota, New Jersey, Oregon and Pennsylvania. Washington, D.C. participated as well.

The purpose of the roundtable was to examine the use of Medicaid-only MCOs in light of the provisions of the Balanced Budget Act which permit states increased flexibility to contract with Medicaid-only managed care organizations. The meeting sought to provide an open exchange to further examine state experiences with Medicaid-only plans, issues in the commercial marketplace, the concerns that Medicaid-only plans could lead to "Medicaid-mills" and strengths and weaknesses of these plans.

In April 1998, an earlier draft of this paper was reviewed by the participants. This paper is not intended to provide a detailed explanation of individual state approaches, but to present and summarize the key issues developed in the meeting and the lessons learned by states from their work and programs thus far.

II. Overview: The BBA 1997 and Market Context

The Balanced Budget Act of 1997 provides states with increased flexibility in designing and implementing Medicaid managed care programs by permitting states to contract with Medicaid-only MCO's without first obtaining a federal waiver. This expanded freedom to contract with Medicaid-only MCO's may provide options for states at a time when business decisions by some fully-licensed commercial HMOs may have begun to complicate the administration of both new and existing Medicaid managed care programs.

Even though commercial HMO participation in Medicaid grew sharply from 1992 to 1996, states

have begun to experience commercial plans' loss of interest in entering into new Medicaid contracts.[1] Some states report declines and even withdrawals in commercial plan participation from existing programs, with commercial plans citing rate reductions and volatility as prime motivations for departures. In some states, however, officials contend their programs remain unaffected by or have not experienced significant commercial plan withdrawal, and thus any new ability afforded by the Balanced Budget Aact to contract with additional types of plans will be exercised depending on their states' program needs, not in reaction to market phenomena.

Whether a state must contend with a greater or lesser degree of commercial managed care market tumult, all state officials are mindful of the need to structure Medicaid managed care programs in ways which both foster consumer choice and mitigate against challenging uncertainties of the market such as divestitures, mergers and buy-outs. States have and will continue to take varied approaches. Many states express a preference for contracting with Medicaid-only plans in addition to their commercial contractors, citing that a balance of contractor types is both desirable and essential to promote consumer choice of health plans and providers. For these states, Medicaid-only MCO's are and will remain an integral component of their programs. Other states for which Medicaid-only MCO's hold programmatic promise will gladly avail themselves of the additional flexibility afforded by BBA.

Some states and other stakeholders, however, caution against increased contracting with Medicaid-only plans, and have posed questions such as:

- does greater state reliance on these entities constitute a retreat to the days and difficulties of a "two-tier" healthcare delivery system (the ills of which Medicaid managed care was designed to cure) and
- are such organizations by definition more at risk for insolvency, and do they lack proper information systems and other key infrastructure elements to such a degree that service delivery is hobbled, and measurement of service delivery or member health outcomes is virtually impossible?

This paper briefly sets forth some of the considerations and reflections of state policy makers regarding use of Medicaid-only MCO's, such as:

- Is a plan's "Medicaid-only" status the main concern of state policy makers?
- Medicaid-only managed care organizations before the Balanced Budget Act of 1997;

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[1] Hurley R. and McCue, M., Medicaid and Commercial HMOs, at Risk Relationship, from a report funded by The Center for Health Care Strategies, February 1998.

- What we know about Medicaid-only MCO's;
- BBA provisions and Medicaid-only MCO's;
- Why state might seek to contract with Medicaid-only MCO's;
- What the potential problems are and why a state might not select to promote their use;
- How states can assure quality and sustainability of Medicaid-only MCO's; and
- Considerations for states.

III. A Plan's "Medicaid-only" Status Is Not Necessarily the Prime Concern of State Policy- Makers

At the outset of the roundtable, states clarified two contextual points:

1. The "Medicaid-only" plan distinction is essentially artificial, as Medicaid payer dominance does not appear to be the prime determinant of programmatic success or failure.

Instead, states reported, a more accurate attempt to describe certain participating plans might include a "mostly Medicaid" or "government only" designation, to reflect many such plans' active participation in other state programs such as Title XXI, the Children's Health Insurance Program (CHIP)."[2] While there is a very real recognition that these plans generally tend to serve vulnerable populations and that states will be permitted mandate enrollment of some populations into managed care plans, it is not the "Medicaid-only" or even "government-only" distinction which is particularly meaningful to states in anticipating or evaluating potential plan success or program utility. It is instead the underlying factors which are key: delivery structure, profit status, ownership/sponsorship, capitalization and management expertise all apparently impact as much or more on a plan's success than does a distinct payment source.

2. The ideal way to ensure a sound Medicaid managed care program is to have all participating plans and other, newer types of delivery systems meet the same, or at least comparable, quality, access and solvency standards.

Though states voice disagreement as to the significance of the "Medicaid-only" designation, it remains the case that the changes in the federal law do permit states to contract with these entities with greater ease and mandate enrollment, which may in turn mean that more low-income enrollees will

[2] Additionally, some plans separate Medicaid administration, making them de facto Medicaid only plans-within-larger plans with regard to systems, etc.

depend on states, through these plans, to deliver quality care.

IV. States' Use of Medicaid-Only Managed Care Organizations Pre-BBA

Prior to the passage of the Balanced Budget Amendment of 1997, a patchwork of administrative, regulatory and sometimes legislative exceptions provided states with pre-BBA flexibility mechanisms which fueled Medicaid-only MCO growth - particularly since 1993, when federal officials began in earnest to permit states to engage in Medicaid program restructuring efforts through the expanded use of Section 1115 demonstration projects. [3]

Federal law had limited Medicaid participation by managed care companies to entities which met a series of federal conditions of participation. Two key MCO conditions of participation for which states sought waivers to permit market entry by a greater number of Medicaid-only plans were: 1) the "75/25" HMO enrollment composition rule and 2) the entity was required be a "Federal/State Qualified HMO." [4]

The federal HMO enrollment composition limitation was also known as the "75/25" rule, which had prohibited states' use of Medicaid-only plans absent a Section 1115 waiver. The rule required at least 25% of a plan's membership to be in a non-Medicaid, non-Medicare line of business, and had been enacted to guard against fraud, quality shortcomings and enrollment abuses by Medicaid-only plans.[5] In the absence of other quality measures, "75/25" purported to ensure that Medicaid beneficiaries received quality services by relying on the presumption that the 75% of plan membership - Medicaid beneficiaries - would receive good care if the plan were able to attract at least a 25% critical mass of commercial members who had the choice to seek care elsewhere.

Even absent a waiver, some plans were exempted through specific federal legislation. New plans also had three years to meet the 75/25 requirement if they could demonstrate they were making "continuous efforts and progress" toward the desired ratio. Moreover, for some states the 25% "commercial" count was somewhat loosely construed, providing a less-than-ideal proxy for quality. That

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[3] Rosenbaum and Darnell, *Statewide Medicaid Managed Care Demonstrations Under Section 1115 of the Social Security Act: A Review of the Waiver Applications, Letters of Approval and Special Terms and Conditions,"* a Center for Health Policy Research/ GWU Medical Center report prepared for The Kaiser Commission on the Future of Medicaid (May 1997).

[4] Ibid.

[5] The original, more restrictive "50/50" version was enacted in 1976 in response to Medicaid plan abuses in California. The rule was amended to the less restrictive "75/25" ratio in 1981.

is, some states were permitted to count persons on general medical assistance in a plan's non-Medicaid/Medicare "commercial" count. New York plans, for example, were permitted to count those receiving Home Relief, the State's heretofore non-federally matched program, as members enrolled in a plan's "commercial" line of business. Even though technically non-Medicaid enrollees, these members were arguably as vulnerable as any Medicaid enrollee and were theoretically much less likely to "vote with their feet" if quality were found wanting than would their commercially-enrolled counterparts.

Also, HCFA granted all states' requests for waiver of this provision. As such, plans in states with federal 1115 waivers such as Arizona, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island and Vermont were exempted from the rule. Massachusetts, Kentucky, Florida, and Illinois applied for and received 1115 waivers which permitted a 75/25 exemption; these states have not yet implemented their waivers.

Most states also sought waivers from the federal requirement of Medicaid-participating plans operating on a full-risk capitated basis as having to be "Federal/ State Qualified HMOs." As of May 1997, HCFA had granted six of the twelve requests for waiver of this provision - in Hawaii, Minnesota, Ohio, Oregon, Rhode Island and Tennessee. However, HCFA had also clarified to states that it was actually unnecessary to waive this provision if the only intent was to avoid state licensure requirements because the "federally qualified rule"[6] did not require state licensure as a condition of participation under a Medicaid managed care contract.[7] Essentially the federal government's interpretation made the rules less restrictive so states could contract with Medicaid-only plans and not subject them to state licensure requirements.

As of June 30, 1996, the following states reported contracting with comprehensive risk Medicaid-only MCO's: Arizona, California, Colorado, Connecticut, Florida, Hawaii, Maryland, Massachusetts, Michigan, Minnesota, New York, Ohio, Oklahoma, Oregon and Pennsylvania.[8]

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[6] 1903(m)(2)(A)(i) of the Social Security Act.

[7] Rosenbaum and Darnell, *Statewide Medicaid Managed Care Demonstrations Under Section 1115 of the Social Security Act: A Review of the Waiver Applications, Letters of Approval and Special Terms and Conditions,"* a Center for Health Policy Research/GWU Medical Center report prepared for the Kaiser Commission on the Future of Medicaid (May 1997).

[8] Horvath, J. and Kaye, N., Editors, Medicaid Managed Care: A Guide for States, 3rd Edition, National Academy for State Health Policy, 1997.

V. What Do We Know About Medicaid-Only Plans?

A uniform characterization of Medicaid-only plans is difficult. Even though HCFA's pre-BBA 1115 waiver approvals permitting the existence of these plans became increasingly detailed from 1993-1997, the details of Terms and Conditions were found to vary from state to state, if only slightly, even on similar matters such as requisite structural and fiscal elements of Medicaid-only plans.[9] Historically, it's fair to say that Medicaid-only plans have been defined more by the requirements they were not required to meet, rather than those they were.

The variation in federal Terms and Conditions and state rules consequently makes both characterizing *and* counting those Medicaid-only plans operating under them more difficult. Suzanne Felt-Lisk and Sara Yang of Mathematica Policy Research, Inc. recently published their analysis of the growth in Medicaid-only plans from 1993-1996.[10] Generally, their analysis:

- included only those plans that were fully capitated for general medical services, including HMO-like organizations which carried similar responsibilities *but are not licensed as HMOs;* **(emphasis added)**
- excluded plans that only provided specialized services such as behavioral health and dental coverage and
- defined *Medicaid-dominant* plans as those with a Medicaid enrollment of 75 percent or more and *Medicaid-only* as those plans with a Medicaid enrollment of between 90 and 100 percent.

Given the above parameters, Felt-Lisk and Yang found that there were at least 144 full-risk Medicaid-only plans operating in 1996. Specific information about many of the plans, however, remained elusive. They write:

". . . of these [144 plans], at least sixteen are owned wholly or in part by federally funded community health centers; twenty-four plans nationally are owned or operated at least in part by community health centers. Others may be other types of provider-based plans, newly formed independent plans, subsidiaries of commercial based plans, or plans formed separately by companies focusing on Medicaid, but there was no information about the nature of 105 of the 144 plans in [the applicable] industry directories."

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[9] See, again, Rosenbaum and Darnell, *Statewide Medicaid Managed Care Demonstrations under Section 1115 of the Social Security Act.* (May 1997).

[10] Felt-Lisk and Yang, *Changes In Health Plans Serving Medicaid, 1993-1996*, Health Affairs, Volume 16, Number 5, September/October 1997.

Further, they found that a large number of beneficiaries are enrolled in these plans, and the number of plans grew significantly in recent years:

- In 1996, 7.7 million Medicaid beneficiaries received care under fully capitated Medicaid managed care programs in thirty-five states;
- nearly 3.6 million - virtually one-half - of all Medicaid beneficiaries were enrolled in plans in which Medicaid enrollees comprised between 75 and 100 percent of the total enrollment; of those, approximately 2 million beneficiaries are estimated to be enrolled in Medicaid-only MCO's[11]; and
- 157 newly-formed plans had entered the market between 1994 and 1996, and 127 of these - nearly 81 percent - were Medicaid-only plans.

The growth and variation of Medicaid-only plans is significant and very large numbers of new members are being enrolled into these plans. By virtue of enrollment numbers or other concerns, should state policy makers then treat managed care organizations that market to Medicaid as special or different from any other managed care organization? The National Association of Insurance Commissioners Model Act requires that the same standards, including those for structural issues such as network adequacy, be applicable to *all* risk-bearing entities. Colorado is one such state which requires licensure through its Insurance Department of all risk-bearing entities. Again, issues other than payer dominance loom much larger as areas of concern in many state insurance departments, such as whether a plan is sufficiently capitalized at its inception, and how best to monitor downstream risk[12] arrangements, independent of the "upstream" entity's status as Medicaid-only plan or not. Unfortunately, the very aspects of Medicaid-only plans which Felt-Lisk and Yang have reported are not readily available, such as subsidiary status, line of business, sponsorship, ownership or profit status, may prove to be among the most important factors for state regulatory agencies in determining a plan's potential for financial

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[11]Hurley R. and McCue, M., Medicaid and Commercial HMOs, An At Risk Relationship, from a report funded by The Center for Health Care Strategies, February 1998.

[12]"Downstream risk" refers to the risk borne by subcontractors of regulated managed care organizations, and includes those arrangements whereby a plan passes the risk of profit or loss "downstream" to network providers by paying providers a set capitation payment to provide many, most or all contracted-for services. Very generally, the more services paid for by the capitation payment, the more risk a provider has absorbed. Nationally, only four Insurance departments, one Public Health department, and three Medicaid agencies report regulating entities that subcontract with MCO's on a risk basis. See, Horvath & Snow, *Emerging Challenges in State Regulation of Managed Care*, NASHP (August 1996)

viability.

Precisely what aspects of plans do state agencies monitor in Medicaid-only plan oversight? While it is true that many states require Medicaid-only managed care organizations to be licensed as HMOs, some states also use many "Medicaid-only" *HMO-like* entities to deliver their Medicaid managed care programs. Though these plans bear the same responsibilities as commercially licensed plans, many are not subjected to the commercial licensure requirements. These entities must meet other types of standards, but they vary widely by state. Insurance, Public Health and Medicaid Departments all may many play a role in the oversight of these Medicaid-only plans, depending on state practice.[13] Felt-Lisk and Yang suggest further research about these plans is desirable and necessary to determine precisely what is similar and different about each states' requirements, and to help capture whether Medicaid-only plan enrollees are protected by states given different regulatory requirements.

VI. Balanced Budget Act Provisions and Medicaid-only MCO's[14]

The Balanced Budget Act of 1997 permits increased contracting activity between states and Medicaid-only MCO's, if only because its provisions repeal the "75/25" rule and eliminate the federal waiver requirement to contract with such entities. The Act sets forth some new conditions for participation and permits states to contract with more types of entities[15], but does not explicitly provide a definition or set of unique standards for Medicaid-only MCO's - rather, it simply eliminates the 75/25 requirement for managed care organizations participating in Medicaid.

BBA also adds a new Section 1932 to the Medicaid statute which sets forth federally mandated provisions and required managed care safeguards which a state must build into its programs if the state

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[13]Horvath & Snow, Ibid. at 38. This report found that it appeared more common for Medicaid to treat various prepaid managed care entities differently than do either Public Health or Insurance Departments. Thirteen, or almost one-half, of the state Medicaid agencies responding to the survey on which the report was based indicated that various pre-paid HMO like entities are regulated differently than commercially licensed HMOs. See also, Felt-Lisk and Yang, *Changes In Health Plans Serving Medicaid, 1993-1996*, Health Affairs, Volume 16, Number 5, September/October 1997.

[14]For a thorough review of impact of the BBA on Medicaid managed care, see, Schneider, Andy, "Overview of Medicaid Managed Care Provisions in the Balanced Budget Act of 1997" prepared for The Kaiser Commission on the Future of Medicaid (December 1997).

[15]Such as: FQHCs, Medicare+Choice organizations, provider sponsored organizations or "any other public or private organization" which meets federal advance directives policies, makes services accessible as they are for those not enrolled and has made adequate provisions against the risk of insolvency.

seeks federal funding. Section 1932 permits additional Medicaid managed care program design options beyond simply expanding states' contractor choice: states no longer need to seek a federal waiver if they choose to mandate enrollment of almost all groups of children and adult Medicaid beneficiaries into a managed care plan.[16] However, states must file an amendment to their Medicaid plans if they choose to mandate enrollment. States also now have the option impose an annual lock-in with a 90 day open enrollment period and can, if they choose, provide six months of coverage to any beneficiary and/or twelve months of guaranteed coverage for beneficiary up to age 19.

Each of these provisions can help states to stabilize enrollment rosters in all participating plans - particularly important for Medicaid-only MCO's which otherwise would be disproportionately subject to the short-cycle nature of their members' Medicaid eligibility. However, these new authorities provided to states could also restrict beneficiary choice and raise new concerns about the quality of plans into which they will enroll.

As a counterbalance, the BBA then raises the bar for states' Medicaid managed care quality management activities. States will be required to adopt quality assessment and improvement strategies which include the use of standardized performance measurement sets approved by HCFA; HCFA is directed to promulgate standards related to quality assessment and improvement strategies. States are also encouraged to eliminate duplicative review activities of private accrediting bodies.

To that end, HCFA has produced the Quality Improvement System in Managed Care, or QISMC, which HCFA is revising following public review. QISMC seeks to clarify the responsibilities of HCFA and State Medicaid agencies in promoting quality; it designs common standards and reviewer guidelines to reduce redundancy and conflicting efforts between these agencies and between private review and accrediting bodies. While QISMC will be optional for state programs, if states elect to use QISMC standards to assess plans, they are assured their programs will comply with the anticipated BBA regulations related to quality improvement.

States may very well set forth even more stringent quality standards for these plans than those in BBA and its companion regulations. All Medicaid MCO's must also comply with a state's applicable statutory, regulatory, licensing and managed care consumer protection provisions - and states are increasingly grappling with the need to standardize licensure and consumer protection provisions for all risk-bearing entities in their state, regardless of payer, profit status, designation or ownership.

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[16]States no longer need a waiver to require mandatory enrollment *except* for 1) dual eligibles, "special needs" children (primarily SSI or foster care kids) and 3) American Indians, unless the IHS or an Indian Health Program is participating in the plan in which the beneficiary must enroll.

VII. Why Might a State Seek to Contract with Medicaid-only MCOs?

As compared with many commercial managed care organizations, supporters contend, Medicaid-only MCO's may possess unique strengths and can be structured in ways purposefully designed to meet the often complex health care and psycho-social needs of Medicaid patients. Will states need to contract with these plans out of necessity due to commercial plans' exit from some markets? State officials have shared the following reasons as to why a state might seek to contract with Medicaid-only MCOs:

Mission

It is the experience of some Medicaid officials that these plans are, in fact, more mission driven, and that it is helpful to work across a singular shared mission to serve low-income persons. In many instances, these plans are reported to have a determination and focus, which may be more difficult to champion in a commercial plan serving the Medicaid population as a comparatively small line of business.

Governance

The governance and board of Medicaid-only plans is considered key, as Medicaid-only plans may be more finely attuned to issues such as the delivery of culturally competent care (which may get diluted in a commercial plan). If this approach is tempered with good business practice, Medicaid officials report this to be a winning combination.

Data Methods and Design

Although these plans have been faulted for having suboptimal data systems, states report some good experiences with how these plans design their data collection instruments and systems. Namely, Medicaid-only plans don't work back from the whole business system, but endeavor to design their systems specifically with the Medicaid requirements in mind.

Safety-Net and Essential Community Providers

Some states have encouraged participation by collaborating with so-called "safety-net" and essential community providers during the planning stages of Medicaid-managed care programs.[17] As

[17]Solloway & Darnell, *The Impact of Medicaid Managed Care on Essential Community Providers*, NASHP (April 1998)

confirmed by Felt-Lisk and Yang, many Medicaid-only MCOs are owned or sponsored by these providers. Often, these providers have organized as plans and obtained contracts with states in an effort maintain control over their Medicaid patient base and reimbursement levels during the transition to managed care. [18] With the advent of the Children's Health Insurance Program, however, these networks will also likely cease to be "Medicaid-only" and might better be described as "government program" provider-sponsored plans.[19]

Traditional provider- sponsored plans are operational in seventeen states. Examples include Community Health Plan of Washington, which is sponsored by nineteen community health centers, InterCommunity Health Network (IHN), an Oregon plan sponsored by three rural hospitals, and Community Health Network of Connecticut (CHN), another community health center sponsored plan.

The role of Federally Qualified Health Centers's is changing. As these health centers become health plans themselves, they are generally no longer available as providers to commercial plans. This may make it more challenging in some areas such as New York City for commercial plans to comply with elements of federal Terms and Conditions which require plans to demonstrate how they will provide the augmented services traditionally provided by entities such as FQHCs.

Some states may encourage these Medicaid-only safety-net provider sponsored plans because some states have experience with these plans as providing a high degree of expertise and experience, not only in diagnosing and treating conditions which disproportionately affect the Medicaid population,[20] but giving appropriate consideration to other factors which may contribute to health status such as social aspects, care giver concerns and unique medication compliance issues.

Commercial Plans Are Leaving Some Markets

Commercial plans have begun to withdraw from participation in state programs in increasing numbers. Managed Care Outlook (March 13, 1998) reports the Medicaid managed care industry's

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[18]See, Solloway & Darnell, *The Impact of Medicaid Managed Care on Essential Community Providers*, NASHP (April 1998), the PHSP Coalitions's *Safety Net Plans: The Role of Provider-Sponsored Health Plans in Maintaining the Safety net in a Managed Care Era* (1997) and The Alpha Center's *Medicaid Managed Care and Safety Net Providers* for The Center for Health Care Strategies, Inc (April 1998)

[19]Of the 37 states which have submitted state CHIP plans to the federal government, 20 of these plans are Medicaid expansions and seven are Medicaid expansions plus private plans. (Source: NASHP 6/5/98) Many of the Medicaid managed care contractors currently operating in these states will likely seek CHIP contracts.

[20]These conditions include, but are not limited to, HIV disease, substance abuse, mental health disorders, diabetes, asthma and hypertension.

growth rate has fallen approximately 12% since 1996 as for-profit managed care organizations have left the market, ostensibly because of "inadequate profitability." Beneficiary choice has suffered in the short run, but entire programs may be at risk absent state contracts with Medicaid-only MCO's to make up for health plan choice shortfall.

Representative examples of such withdrawals include:

- PacifiCare divested from the Medicaid markets in Utah, Florida, Illinois and New Mexico;
- United Healthcare exited markets in Missouri, Ohio and Florida;
- Oxford Health Plan, one of Connecticut's largest Medicaid managed care plans with 33,000 members, exited the Connecticut market in March 1998; the plan will leave New Jersey's Medicaid program as of July 1, 1998, affecting approximately 41,000 members,
- New York State received notification in February 1998 from AetnaUS Healthcare that the company would not seek renewal of its contract with New York City; this announcement precedes the implementation date for the City's mandatory program by just a few short months and will affect approximately 25,000 members.

Many states temper their recitation of Medicaid-only plan strengths, however, stating that an MCO's payer source doesn't absolutely guarantee either mission or efficacy in caring for more vulnerable enrollees any more than does any other single factor. Financial strength, administrative focus, sponsorship, network and medical delivery system structure all contribute substantially to a plan's competence. The impact of profit status is also unclear. One Section 1915(b) waiver state reported that among its best performing Medicaid-only plans are those which are not only for-profit, but run by venture capitalists. This state echoes the sentiment of other states when it indicates that successful plans have as their strengths, cultural competence, adequate networks, special services for Medicaid populations *and* good business practice.

As one state official succinctly put it, "Should you really use MCO profit status as a proxy for other important stuff you can't easily get to? After all, stereotyping hospitals by ownership or payer didn't work - why should this?"

VIII. What are the Potential Problems with Medicaid-only MCO's, and Why Might a State Not Elect to Promote Their Use?

While both the expansion and prevalence of Medicaid-only organizations may seem inevitable (at least in the near term), a variety of consumer groups and industry advocates, state and federal officials and legislators have raised a number of questions and concerns about states increasing reliance on these organizations, including:

Do they have sufficient operational infrastructure?

What about the goal of mainstreaming Medicaid?

Is the threat of insolvency more of a problem with Medicaid-only MCOs?

Is quality harder to assure with Medicaid-only MCOs?

1. Do Medicaid-only plans have sufficient operational infrastructure?

Some presume that commercial plans, usually due to sheer size and available financial reserves or capital, are more likely to have the ability to better and more efficiently perform the necessary administrative managed care functions such as claims payment and data collection.[21] It is thought that they achieve administrative efficiencies by spreading fixed costs over the larger membership base, resulting in savings to states. Medicaid-only plans tend to be smaller, often having fewer than 50,000 members[22], and do not enjoy this presumed advantage. Medicaid-only plans may also lack expertise built on long term experience, as many are comparatively new to the market.

Managed care information systems technology is expensive; smaller, Medicaid-only plans may not have adequate capital to fund these operations at the front end or as an improvement. This technology - and the staff who shepherd it - are obviously critical to a plan's success. If a plan cannot pay providers in a timely fashion, few providers will stay; if a plan cannot afford to collect and analyze data, it may find itself at a competitive disadvantage; if a plan simply does not collect data well or at all, it may also find itself out of compliance with both state and federal law. Medicaid-only plans' fiscal conditions are, of course, complicated by the fact they depend entirely on one revenue stream, and researchers have found that some states may be advancing rate policies which disproportionately disadvantage Medicaid-only MCO's, namely:

- "administering rates unilaterally;

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[21]Although New York's, New Jersey's and Connecticut's recent experiences with Oxford Health Plans' infrastructure difficulties help rebut this presumption.

[22]Felt-Lisk and Yang, *Changes In Health Plans Serving Medicaid, 1993-1996*, Health Affairs, Volume 16, Number 5, September/October 1997.

- imposing retroactive downward rate adjustments; and
- using actuarily unsound rates."[23]

2. What about the goal of mainstreaming Medicaid?

Increased reliance on Medicaid-only MCO's is seen by some to violate the spirit, if not the letter, of efforts by states to mainstream the care of their Medicaid beneficiaries. For the better part of two decades, policy makers have devoted time and energy devising strategies designed to remove access barriers to the health care delivery system so that the care of a state's poorest citizens would no longer be relegated to so-called "Medicaid mills."

Founded on the belief that this separate care for low-income patients could prove to be inherently unequal, some states sought to "mainstream" the care of the Medicaid beneficiaries using enrollment in a commercial managed care plan as a vehicle to provide access to physicians and hospitals which historically cared for commercially-insured patients. While Medicaid managed care has been shown generally to improve access to primary care services in underserved areas[24], enrollment of Medicaid beneficiaries into commercial plans did not assure full and equal access to all available providers. Some commercial HMOs maintained separate provider lists for each set of members according to payer status, effectively re-relegating poor members to Medicaid-only "sub-plans." [25]

Mainstreaming efforts were effected not by legislation or judicial decision, but by states' selecting to contract with large, commercial health plans seeking to enter the Medicaid market during the implementation of nascent Medicaid managed care demonstration projects, and imposing network access and other requirements on those plans as conditions of program participation.

States have attempted mainstreaming to varying degrees. In some instances, states have forbidden the use of the "two-list" system altogether by building provisions into their 1115 waiver applications, which were then reflected and restated in the resultant federal Terms and Conditions, state

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[23]Hurley & McCue, "Medicaid and Commercial HMOs: an At-Risk Relationship", Center for Health Care Strategies, May 1998.

[24]Felt-Lisk, Suzanne, et.al., *Medicaid Managed Care: Does It Increase Primary Care Services in Underserved Areas?* Mathematica Policy Research, Inc. November 1997.

[25]See, Rosenbaum, Sara et. al., *Civil Rights and Managed Care*, Health Affairs, Volume 16, Number 1 Jan/Feb 1997 citing " *Two Lists: Commercial and Medicaid Managed Care Providers*" (New York: Office of the Public Advocate of New York City, 1995)

RFPs and state-plan contracts.[26] Some states permitted the award of contracts to commercial plans which did not at the outset make their entire physician and hospital network available to their Medicaid members, as long as the plans continued to increase percentages of their network available to Medicaid members at state-mandated time intervals. A significant number of state Medicaid managed care contracts, however, do not contain any explicit mainstreaming provisions, reflecting divergent state opinion about the wisdom, feasibility or necessity of mainstreaming. States also point out that mainstreaming is not easily accomplished, independent of contractual requirements, and it occurs on two levels: both plan and provider. States articulate they have two discrete goals: 1) ensuring choice of a health plan, and 2) ensuring real access to a wider set of doctor which have undergone some sort of state-monitored credentialling process. State officials are attempting to balance different needs and articulate policies which both attempts to honor enrollees' desires to continue to see the providers who traditionally cared for families, and which ensures that providers who contract with Medicaid managed care plans deliver high quality care.

Enforcement of these mainstreaming provisions has proven problematic for state officials, given the technical complexity of assessing even basic network adequacy. Increased reliance upon Medicaid-only MCO's may represent an implicit policy shift and policy makers may wish to make this discussion explicit.

3. Is the threat of insolvency more of a problem with Medicaid-only MCOs?

A number of factors can be seen as contributing to potentially greater insolvency risks:

- Welfare reform efforts have in some states led to precipitous drops in the numbers of Medicaid eligibles. This phenomenon will likely disproportionately affect Medicaid-only plans' enrollment levels, making it more difficult for contractors to hit break even points and maintain solvent fiscal operations.[27]
- Enrollment of more members with disabilities will increase costs to plans and rate-setting for these populations is a complex task for states.
- States have reduced their Medicaid per-member per month premium rates by an average of 10-

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[26]Rosenbaum, Sara et al., *Negotiating the New Health Care System: A Nationwide Study of Medicaid Managed Care Contracts*, George Washington Center for Health Policy Research, February 1997.

[27]BNA's Managed Care Reporter, February 18,1998 and Medicine and Health, Faulkner & Gray, Vol. 52, March 1998.

20% over the past three years.[28]

- Some states do not impose the same rigorous solvency or other licensing requirements on Medicaid-only MCO's as are required of commercial HMO's, often to permit easier entry to medically underserved markets.

Some Medicaid-only plans and their providers are also beginning to experiment with global capitation and other more aggressive risk sharing arrangements. These contractual arrangements are designed to induce provider efficiencies and savings and promote flexibility of service delivery, but providers in Medicaid-only plans may be unprepared to manage such risks. "Downstream" risk in Medicaid-only plans may be completely outside the jurisdiction of state regulatory authority, leaving states without proper tools to assess and monitor these arrangements.[29]

Insolvency concerns may be alleviated by BBA's more rigorous rules requiring managed care organizations[30] to meet state-established solvency standards for private HMOs or be licensed or certified by the state as a risk bearing entity. On the other hand, many Medicaid-only MCO's, by virtue of their FQHC ownership or sponsorship, may be among the exempted organizations.

4. Is quality harder to assure with Medicaid-only plans?

Enrollment and solvency issues may adversely impact on a plan's quality.[31] Given some states' rate-setting policies, Robert Hurley's disconcerting conclusion may be true, namely: "you don't get what you don't pay for."[32] Smaller plans incur disproportionately high administrative costs, and

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[28] *American Healthline* (quoting *The Wall Street Journal*), April 7, 1998.

[29] States could simply prohibit aspects of downstream risk in their contracts with MCO's; contractual prohibitions of this sort could impact on the number and types of contractors which would participate in Medicaid managed care programs.

[30] BBA's solvency standards to not apply to organizations not responsible for providing inpatient hospital and physician services, organizations whose solvency is guaranteed by the state, public entities, or organizations controlled by FQHCs. Schneider, Andy, "Overview of Medicaid Managed Care Provisions in the Balanced Budget Act of 1997, prepared for The Kaiser Commission on the Future of Medicaid (December 1997).

[31] Gold, Aizer and Salganicoff, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Florida*, Kaiser/Commonwealth Low-Income Coverage and Access Project. January 1997. Gold, Aizer and Salganicoff's study found a greater risk of substandard Medicaid managed care in Florida, which contracted with "undercapitalized, inexperienced firms" and which did not require adherence to commercial licensure requirements until three years after entry into the Medicaid market.

[32] Harris Meyer, "Medicaid: States Serve Up a Real Turkey," Hospitals and Health Networks, November 1997.

therefore less money remains to attract, pay and retain good providers or maintain enabling services which are presumed to be a core competency of Medicaid-only MCOs.

Medicaid-only plans require the same performance from information systems as commercial plans. Again, because these plans cannot cross-subsidize as can the larger commercial plans to obtain necessary technology improvements, some detractors assert that Medicaid-only plans lack the rudiments of an adequate managed care information system. Weaknesses in an information system can impact on quality of service and a plan's or a state's ability to assess quality of care delivered by the plan and its providers. Simply put, it's unlikely a plan can deliver or enforce (at least to the satisfaction of attentive state quality officials) what it cannot validly measure, track and trend.

States are increasingly sophisticated purchasers, and, along with federal officials, are wrestling with the current inconsistent data collection and measurement tools for Medicaid-only plans. Certain measures, such as HEDIS, have proven useful to assess and preliminarily compare care delivered by plans. Newer, more refined measures which may provide comparable, valid data across Medicaid plans (such as QISMC) are still in development, however, which complicates a state's difficulties as it attempts to identify, compare and trend problems across Medicaid plans.[33] Even without measures such as QISMC, some states impose very strict quality requirements. Florida, for example requires all its HMO's to be accredited by an external accrediting body . Eighty-five percent of the state's 39 HMO's are NCQA accredited and the remainder are URAC and JCAHO accredited. Florida will soon require that all data collected by plans be audited data. For many Medicaid-only plans, not only would accreditation be technically difficult, it would simply be too expensive.

States are also increasingly turning to managed care to deliver services to their elderly and disabled populations.[34] State policies may permit or even mandate enrollment of persons with more complex needs into the traditional Medicaid-only plans simply because the plans have been operating for significant periods of time, have satisfactorily completed state reviews and appear to have adequate network and operational systems. Delivering, measuring and improving quality in managed care for people with disabilities is a critical endeavor, and some states have concerns that Medicaid-only plans

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[33]S. Felt-List and R. St. Peter, *The Quality Assurance Reform Initiative (QARI) Demonstration for Medicaid Managed Care: Final Evaluation Report* (Washington: The Henry J. Kaiser Family Foundation, November 1996) Felt-Lisk and St. Peter found that of the 23 plans studied, those with less-developed quality systems tended to be Medicaid-dominant plans.

[34]As is often noted, these groups constitute 27 percent of Medicaid enrollees but account for 59 percent of resource expenditures - hence states' interest in the "better value" promise of managed care.

may not be up to the task. Moreover, plan performance measurement for persons with disabilities is at best a fledgling science.

States may find that despite best efforts, plans which have real expertise in delivering care to mothers and children may not be prepared to deliver care to members who are disabled, elderly, or have developmental or disease-specific chronic needs. This unreadiness can potentially result in serious health and quality of life consequences for states' most vulnerable Medicaid consumers.

Some states have found that no useful generalization is possible about "Medicaid-only" plans' readiness to deliver quality services to people with disabilities. Commercial plans have demonstrated success in caring for persons with chronic illnesses, such as asthma. They have demonstrated less success and less experience in caring for persons, for example, with more complex conditions such as developmental disabilities. Critical factors to any plan's success include experience with the nature of the disability, provider network expertise and the ability to properly coordinate care, either in-house or in partnership with local governmental or community agencies. Some states see particular promise with "Medicaid-only" plans in the areas of substance abuse and mental health care delivery and coordination. The wise involves people with disabilities during the development of managed care programs and special health plan performance factors.

IX. What In Particular Should States Do to Assure Quality and Accountability of Medicaid-Only MCOs?

Much depends on a state's oversight structure and ability. States need to mitigate risk, but how much? As one state insurance regulator offered, states should "make the level of regulation commensurate with the level of risk assumed."

Medicaid, Public Health and Insurance officials grapple incessantly with how to best manage the changing delivery structures in their states. They are aware that conflicts can arise between the state's role as purchaser and its role as regulator. Contracting and regulatory functions may have the same goals - achieving quality, access and accountability, but serve different functions, and may well achieve a greater good working separately but in tandem. If, for example, only a very few plans operate in a state program, and those plans fail to meet quality or other regulatory standards, states can lose power to impose sanctions because the very imposition of sanctions may compromise aspects of an entire program. If enrollment is temporarily ordered closed the plans' fiscal soundness is compromised and the quality of services can weaken, and cancelling a plan's contract altogether may mean the end of a large share of a state's Medicaid managed care program and no available, accessible medical homes for the plan's recent

ex-members.

- **Some states advise, therefore, distinct separation of contracting and regulatory authority and activities.**
- **States need to set clear quality, consumer protection, service delivery and performance standards in the contractual specifications with Medicaid-only plans, and examine their regulatory schemes for oversight gaps.**

These "Medicaid-only" plans are increasingly publicly- (state-) funded plans. Can the state hold itself accountable? There may be a larger role for HCFA in Medicaid-only plan oversight.

- **States may also need to consider removing all unnecessary fiscal uncertainty and volatility from program participation.**

Obviously, Medicaid premium rates are the only source of income for Medicaid-only plans, and plans in some states contend they cannot afford to provide the benefits packages they have contracted to provide on the per-member, per month income received, particularly if the states impose rate cuts after the contracts are signed.[35]

States could also further develop their rate expertise, implement actuarily sound baseline rates and consider use of risk adjusters, particularly as they permit enrollment of more disabled and chronically ill persons into traditional Medicaid-only plans. Colorado, Maryland, Minnesota, Oregon, and Massachusetts are moving toward the use of such diagnosis-based risk adjusters. Maryland and Colorado will soon use diagnosis-based risk adjustment for both AFDC and SSI recipients in their Medicaid managed care programs, while other states, such as Michigan, are starting with SSI enrollees or other special populations first.[36]

States may need to consider use of risk corridors, particularly in Medicaid-only plans which have enrolled higher numbers of persons with costly special needs, such as those with HIV/AIDS or chronic mental illness.

- **States might consider advancement of policies which stabilize and bolster per-plan**

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[35]See, generally, *Safety Net Plans, The Role of Provider-Sponsored Health Plans in Maintaining the Safety Net in a Managed Care Era*, prepared by Kalkines, Arky, Zall & Bernstein, LLP, for The New York State Coalition of PHSPs, with support from the United Hospital Fund (February 1998). The PHSP Coalition's study found that the single most important factor in the success of all Medicaid managed care plans is the adequacy of premium rates; in states with "reasonable" premiums, the Coalition reports, "safety net plans are doing well." In states where "rates have plummeted, commercial HMOs are fleeing the market and safety net plans are running large deficits."

[36]"To Create the Right Incentives, States Move Ahead With Diagnosis-Based Risk Adjustment in Medicaid," *State Health Watch*, March 1997.

enrollment and resultant economies of scale.

Some direct marketing activities by contractors are prohibited by BBA, and it will likely be difficult for the smaller, Medicaid-only plans to overcome the brand name recognition enjoyed by large, commercial competitors. If states found compelling reasons to advantage Medicaid MCO enrollment,[37] it could be accomplished with mechanisms such auto-assignment algorithms as California has done and New York intends to do with their Medicaid-only plans sponsored by safety net providers. California's Department of Health Services has been implementing the Medi-Cal program since 1996, by contracting with one commercial plan and one "local initiative plan", a publically -sponsored health plan developed by the local government, clinics, hospitals and traditional Medicaid providers in each county. California gives preference to provider-sponsored plans (which can be Medicaid-only) and traditional Medi-Cal providers by initially assigning all beneficiaries to the local initiative plan. Once the enrollment of the local initiative plan reaches the same level as the commercial plan, the remaining auto-assignments are distributed equally between two plans. A provision of New York State's 1996 Medicaid Managed Care Act requires the first 25 percent of Medicaid beneficiaries who do not choose a plan to be assigned to the plans that have traditionally served the Medicaid population - many are Medicaid-only, all are Medicaid-dominant, and all are provider sponsored plans that are affiliated with, owned or sponsored by hospitals and health centers. The remaining 75 percent of enrollees will be distributed equally among all qualified plans.[38] Use of mechanisms such as these could serve to stabilize difficulties for the plans associated with episodic enrollment.

States may also want to decrease the numbers of plans participating in their Medicaid managed care programs. In an effort to improve the quality of its Medicaid managed care program, Massachusetts is pioneering an effort to enter into "longer, more intensive partnerships with fewer health plans."[39] In return, state officials are quoted as saying, "plans will get higher enrollments and rates adjusted

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[37]Auto-enrollment mechanisms can create risks for beneficiaries and states alike, and are considered by some stakeholders as giving rise to quality, access and program integrity concerns.

[38]From Currents, "Auto-Assignment in Medicaid Managed Care", Volume 3, Number 2, United Hospital Fund, Spring 1998.

[39]"Massachusetts Medicaid to Contract With Fewer Plans" from *State Health Watch*, January 1998. The contracts will take effect July 1, 1998. Bruce M. Bullen, Massachusetts Commissioner of Medical Assistance, indicates in the article that his state is in a better position to take this approach because it has 1) a high managed care penetration, 2) a longer history of managed care than other states and 3) several locally-controlled nonprofit HMOs that provide high quality services.

according to the needs of certain populations."[40] That state is seeking to strengthen its purchasing relationship with managed care organizations by soliciting proposals for five year contracts, which will replace the current three year contracts. State officials indicate they want to select plans with providers in their networks who are already caring for patients with special needs, because the number of disabled and special needs enrollees is growing. Massachusetts will risk adjust some capitation rates based on health status and case mix to attract fewer, more "appropriate" plans to the program.

- **States could continue to promote interagency cooperation to lessen unnecessary plan and state administrative burdens resulting from confusing or duplicative reporting and review requirements.**

Historically, different state agencies have had responsibility for different aspects of Medicaid managed care oversight, but many states have begun to employ newly collaborative oversight strategies.[41] To the extent possible, more states might heed BBA 97's explicit charge to do so.

X. Considerations for States

The number of Medicaid-only (or more precisely, "mostly Medicaid," or even "government payer-only") plans has grown significantly in the last few years, as has the proportion of Medicaid managed care beneficiaries enrolled in these plans. The plans are presumably as unique and varied as were the state and federal regulatory and administrative mechanisms which gave rise to them. Both the increased flexibility provided to states by the Balanced Budget Act and changes in commercial plans' willingness or ability to participate in Medicaid managed care programs could fuel this growth, as states seek to expand their programs and categorical enrollment rosters in managed care.

States hold different opinions about whether Medicaid-only plans have done or can continue to do the complex job for states that they have contracted to do. State policy makers continue the policy discussion as to whether Medicaid-only plans are the best means to a number of desired ends and, if so, how to best utilize these plans to assure plan solvency, quality and program integrity. Most states believe encouraging a mix of commercial, both investor-owned and not-for-profit, and "mostly Medicaid" plans

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[40]Ibid.

[41]For a comprehensive treatment of states' collaborative oversight efforts, see: Horvath, Jane *State Interagency Collaboration: Assuring Quality Care for Mothers and Children in Medicaid Risk-Based Managed Care* (1995) and *Quality Assurance in Practice-Report on a Two-State Demonstration: Interagency Collaboration for Quality Care in medicaid Managed Care for Low Income Mothers and Children* (1997) and Booth, Riley and Mitchell's *Building Quality in medicaid Managed Care: What Policymakers Need to Know (and Do!)* (1998). All reports were published the National Academy for State Health Policy.

is both best and most likely for a successful future of their Medicaid managed care programs. BBA and resultant regulations may assist states in this regard by providing for development of new, more uniform quality and other oversight standards.

The following summarizes factors which were considered key to successful Medicaid managed care programs, as developed by state symposium participants and identified in this paper:

- Carefully examine who your state's Medicaid managed care program serves - all low-income people enrolled in Medicaid managed care do not have the same needs.

- A "mostly Medicaid" or "Medicaid-only" designation is an inadequate proxy for either good or bad performance. To that end, the right question is "what is the best managed care organization *and* what are the best state requirements necessary to serve Medicaid patients."

- A mix of types of MCOs and networks in an state's Medicaid managed care program is generally good for the program and enrollees. "Medicaid-only", investor-owned, not-for-profit, Independent Practice Associations, specialty groups, Federally Qualified Health Centers, and academic medical centers - each brings with them a mix of skills and providers to serve a state's diverse needs.

- While a mix is good, care must be taken to avoid too much network and regulatory fragmentation.

- Understand where the risk really is, and regulate accordingly. Comparable licensure and solvency requirements for core functions of different types of networks - comprehensive and carve out, HMO and IPA - may help prevent or correct fiscal uncertainties. States continue to debate whether timelines for readiness should also be comparable.

- Uniform quality oversight mechanisms for all types of networks, regardless of payer or structure, are desirable to prevent or correct potential quality problems. States should consider dedicated investment in oversight, and technical assistance to plans.

- States should take care to make regulatory expectations *clear* - no matter what the plan design.

- In order to attract and maintain all varieties of plans, states should continue to minimize contracting uncertainty by 1) maintaining well-understood administrative requirements which survive the life of a contract, 2) setting and paying defensible rates and 3) seeking to engage as business partners for the long term.

- States may wish to continue to examine how they can best promote institutional cooperation among oversight agencies to reduce regulatory duplication and gaps, thereby both assuring better quality for enrollees and reducing burdens for both plans and program oversight officials.

PARTICIPANT LIST
Kaiser-HCFA State Symposia Series, Symposia IV
"Transitioning to Managed Care in Medicaid"
Medicaid-Only Managed Care Organizations: Potential & Pitfalls
May 12, 1998

Deborah Bachrach
Counsel, Prepaid Health Services Plans Coalition
Kalkines, Arky, Zall and Bernstein, LLP
1675 Broadway
New York NY 10019
Ph: 212-830-7223 Fax: 212-541-9250

Gordon Bonnyman
Attorney
Tennessee Justice Center
203 Second Avenue, North
Nashville TN 37201
Ph: 615-255-0331 Fax: 615-248-3230

Peg J. Dierkers
Director, Office of Policy Development
Commonwealth of PA, Dept. of Public Welfare
Rm. 323, Health & Welfare Bldg.
P.O. Box 2675
Harrisburg PA 17105-2675
Ph: 717-772-8318 Fax: 717-787-1229

Deirdre Duzor
Director, Division Quality System Management
Center for Medicaid and State Operations
7500 Security Blvd.C4-24-07
Baltimore, MD 21244
Ph: 410-786-4626 Fax: 410-786-3252

Alicia Fagan
Director of Special Initiatives
National Academy for State Health Policy
50 Monument Square - Suite 502
Portland ME 04101
Ph: 207-874-6524 Fax: 207-874-6527

Nancy J. Feldman
CEO
UCare Minnesota
2500 University Ave, W - Ste 201So
St. Paul MN 55114
Ph: 612-603-5368 Fax: 612-603-0650

Sue Felt-Lisk
Senior Health Researcher
Mathematica Policy Research
600 Maryland Ave., SW - Suite 550
Washington DC 20024
Ph: 202-484-4519 Fax: 202-863-1763

Cheryl Fish-Parcham
Associate Director Health Policy Department
Families USA
1334 G St. NW 3rd Floor
Washington, DC 20005
Ph: 202-628-3030 x 620 Fax: 202-347-2417

Mary Beth Fiske
Director, HMO Program
Commonwealth of MA
Division of Medical Assistance
600 Washington Street - 5th Floor
Boston MA 02111
Ph: 617-210-5426 Fax: 617-210-5003

Sandra Harmon-Weiss
Medical Director, Government Programs
Aetna US Healthcare
Mail Stop 22B
980 Jolly Road
Blue Bell PA 19422
Ph: 215-283-6596 Fax: 215-283-6614

Nancy Johnson
Deputy Superintendent
Bureau of Insurance
State House Station 34
Augusta ME 04333
Ph: 207-624-8403 Fax: 207-624-8599

Mary Kennedy
Assistant Commissioner & Medicaid Director
MN Dept of Human Services
444 Lafayette Road
St. Paul MN 55155-3852
Ph: 612-282-9921 Fax: 612-297-3230

Barbara Lyons
Deputy Director
Kaiser Commission on Medicaid and the Uninsured
1450 G Street, NW, Suite 250
Washington DC 20005
Ph: 202-347-5270 Fax: 202-347-5274

PARTICIPANT LIST
Kaiser-HCFA State Symposia Series, Symposia IV
"Transitioning to Managed Care in Medicaid"
Medicaid-Only Managed Care Organizations: Potential & Pitfalls
May 12, 1998

Patricia MacTaggart
Director of Quality & Performance Management
HCFA Quality & Performance Management Group
Center for Medicaid & State Operations
7500 Security Blvd. - C-3-18-26
Baltimore MD 21244-1850
Ph: 410-786-1285 Fax: 410-786-5515

Sherry Manetta
Executive Vice President/CFO
HealthRight, Inc.
134 State Street
Meriden CT 06450
Ph: 203-630-3356x4034 Fax: 203-238-4009

Kate Morgan
Chief, Medicaid Managed Health Care
Dept. of Health & Rehabilitive Services
P.O. Box 128900
2727 Mahan Dr - Bldg 1, Rm 311
Tallahassee FL 32317-2800
Ph: 850-922-6830 Fax: 850-414-5418

Trish Riley
Executive Director
National Academy for State Health Policy
50 Monument Square, Suite 502
Portland ME 04101
Ph: 207-874-6524 Fax: 207-874-6527

Alina Salganicoff
Program Officer
Henry J. Kaiser Family Foundation
1450 G Street, NW - Suite 250
Washington DC 20005
Ph: 202-347-5270 Fax: 202-347-5274

Andy Schneider
President
Health Policy Group
1850 M Street, NW
Washington DC 20036
Ph: 202-955-0021 Fax:

Karen Squarrell
Acting Director
Division of Medical Assistance
and Health Services
7 Quakerbridge Plaza CN 712
Trenton NJ 08625
Ph: 609-588-2601/00 Fax: 609-588-3583

Jane Thompson
Chief, Managed Care Unit
Commission on Health Care Finance
Dept of Human Services - Room 302
2100 Martin Luther King, Jr. Ave.
Washington DC 20020
Ph: 202-727-3688 Fax: 202-610-3209

Claire Witzleben
Senior Vice President
Keystone Mercy Health Plan
200 Stevens Drive - Suite 350
Philadelphia PA 19113
Ph: 215-937-8000 Fax: 215-937-5344

Barbara Yondorf
Director, Policy & Research
Colorado Div. of Insurance
1560 Broadway, Suite 850
Denver CO 80202
Ph: 303-894-7499 Fax: 303-894-7455

Joel Young
Office of Medical Assistance Programs
500 Summer Street NE
Salem OR 97310-1014
Ph: 503-945-6494 Fax: 503-373-7689