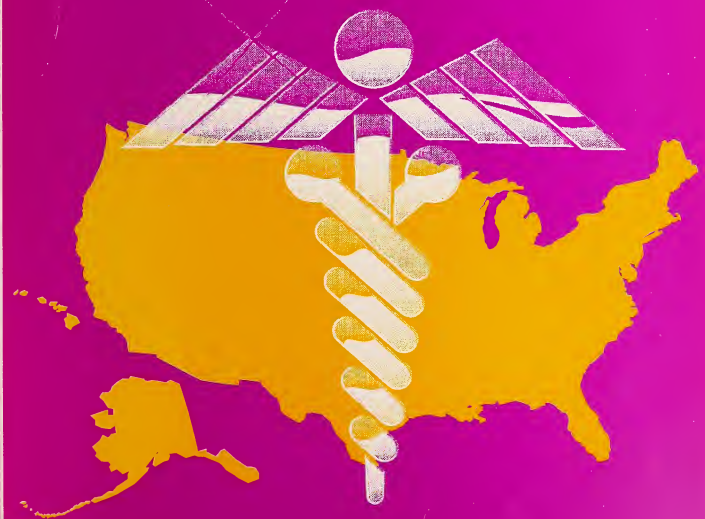
National Summary of State Medicaid Managed Care Programs

Program Descriptions as of June 30, 1994



U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Office of Managed Care

National Summary of State Medicaid Managed Care Programs

Program Descriptions as of June 30, 1994

The National Summary of State Medicaid Managed Care Programs is composed annually by the Medicaid Managed Care Office of the Health Care Financing Administration (HCFA) of the Department of Health and Human Services. The narrative descriptions of the states' Medicaid managed care programs as of June 30, 1994 were submitted to HCFA by the corresponding states and collected by the Medicaid Managed Care Team. Therefore, the information herewithin is found in or near its submitted form. The National Summary serves as a reference and informational guide to the public as well as other governmental agencies.

The Office of Managed Care wishes to extend special thanks to Christopher Eisenberg, Anna Meyers, Carolyn Lawson and Tammi Hessen of the Medicaid Managed Care Team for their assistance in developing this report. If there are any questions regarding the content of this document, please contact the Medicaid Managed Care Office at (410) 966-4464.

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Office of Managed Care

TABLE OF CONTENTS

ALABAMA

As of July 26, 1994 only 1 Health Maintenance Organization (HMO) has been approved by the Department of Public Health, Department of Insurance, and the Alabama Medicaid Agency as a Medicaid HMO.

Once Medicaid has at least 2 or more licensed Medicaid HMOs with an adequate provider network in Jefferson and Shelby counties and after Medicaid receives HCFA's approval, the Alabama Medicaid Agency plans to implement Managed Care's pilot program in Jefferson and Shelby counties.

CONTACT: Vicki Huff
Director
Managed Care Division
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624
(205) 242-5011
FAX: (205 242-0557

ALABAMA'S MEDICAID MATERNITY WAIVER PROGRAM

The Alabama Medicaid Maternity Waiver Program (Waiver) was implemented September 1, 1988, pursuant to 1915 (b)(1), (b)(3), and (b)(4) of the Social Security Act (the Act). Specific sections of the Act which were waived were Sections 1902 (a)(1) (Statewide effectiveness), 1902 (a)(10) (duration, amount, and scope of benefits), and 1902 (a)(23) (freedom of choice of providers). These specific waivers are necessary because the waiver program is being phased in on a statewide basis; consequently, additional services are offered to women affected by the waiver because the recipient's freedom of choice is restricted to a primary provider.

The waiver provider for a coordinated, comprehensive case managed system by which women receive all services necessary for a healthy pregnancy. High risk women are targeted early and referred to specialty physicians for care for their special needs. The waiver serves approximately 22,000 recipients each year in 44 counties. In addition to prenatal care, women receive information about nutritional services, (WIC), family planning services, EPSDT services, and post partum care. All care for the pregnant woman is coordinated through the primary provider. The primary provider for an area is responsible for establishing a network of subcontractors to provide a total system of obstetrical care.

The waiver has been judged to be successful in 3 areas: Access to Care and Quality of Services; Impact of the program; and Cost Effectiveness. Below is specific information about successes we have had.

A. PRENATAL VISITS/WEEKS GESTATION

The main objective of the Maternity Waiver Program is to get women into the care system early and to provide continuous and comprehensive prenatal care in an effort to produce better birth outcomes. Prior to the waiver, claims data indicated that women receive an average of 3 prenatal visits. Since 1988, women participating in the waiver utilized an average of 9 visits.

Though maternity services are available in non-waiver counties, they are fragmented. The difference in waiver counties is that there is a care coordinator who is responsible for coordinating all services through an established provider network ensuring that women make and keep all of their appointments for care.

B. VAGINAL VS C-SECTION BIRTH RATES

The costs associated with caesarean births are higher than vaginal birth costs. In waiver counties, the number of C-Section births per 100 deliveries is lower than in non-waiver counties. Since implementation of the waiver program, there has been a difference of approximately 7%. A reduction in C-Section births can also be indicative of adequate and quality prenatal care.

C. DIAGNOSTIC TESTINGS

Cost savings are being realized in the area of diagnostic testings. In non-waiver counties, prenatal care is fragmented and often times a woman will see numerous providers. Each time a woman visits a new physician, a variety of tests are performed, often repeating those already done. In the waiver, however, women are required to coordinate all phases of care through a care coordinator thereby eliminating duplication of services. Since inception of the program, recipients in non-waiver counties received an average of 203 tests per 100 deliveries compared to 117 tests per 100 deliveries for waiver recipients. The savings associated with reduced testings are substantial in that on average $2500 more per 100 deliveries is spent on testing in non-waiver counties as in waiver counties.

D. HOSPITAL READMISSIONS DURING THE FIRST YEAR OF LIFE

Our data indicates that the majority of NICU stays are for premature babies. If we can prevent just 1 birth complication which carries with it a lifetime of costly medical care, then the waiver program can be considered a success. On average, babies born to waiver recipients receive 10.5 NICU days compared to 11.7 days

for non-waiver babies.

Not only is medical care provided through the waiver, but this care is augmented with care coordination (case management) and home visitation. One key to the success of the waiver program is the care coordinator. The care coordinator will help to manage the care, ensuring that all appointments are kept, coordinating referrals to specialty physicians when appropriate, making arrangements for delivery (including availability of transportation), arranging for the home visit, and performing many other duties as enumerated in the care coordinator manual. An additional duty of the care coordinator is to educate the pregnant woman/new mother of the importance of medical care for the newborn. Enrollment into the EPSDT Program is encouraged and connection with pediatricians can be made if requested. The providers agree that the care coordinator approach has improved the pregnant woman's understanding of the importance of adequate prenatal care. According to the client evaluation survey conducted by the independent assessor, waiver program clients were significantly more likely to see care coordinators or social workers, to receive health education, counseling about social services and help with transportation than clients in non-waiver areas.

All of these services are paid for through an expanded global fee which is paid to the primary provider. The primary provider in turn reimburses its subcontractors a negotiated rate for the services performed. The expanded fee is set at 97% of the fee-for-service reimbursement which is an immediate cost savings. It is anticipated that, because the waiver is in place, the Agency will save approximately 10 million dollars in the coming years.

CONTACT: Kim B. Davis
Associate Director
Maternity Waiver Program
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624
(205) 242-5626
FAX: (205) 242-0533

ALASKA

Alaska currently has no managed care programs in operation although the possibilities are being discussed.

contact: Kimberly B. Busch, Director
Department of Health and Social Services
P.O. Box 110660
Juneau, Alaska 99801-0660
(907) 465-3355

ARIZONA

The Arizona Health Care Cost Containment System (AHCCCS) began operations on October 1, 1982 and is now in the 12th year of operation as a Medicaid 1115 Research and Demonstration project, under authority of 1115 of the Social Security Act. The program began October 1, 1982 and enrolled 160,000 persons in the first year of operation. As of August 1, 1994, AHCCCS is serving more than 490,000 persons: 436,000 Medicaid members; 34,000 persons who receive care funded with 100% state dollars; and, 19,000 persons who are eligible for the Arizona Long Term Care System (ALTCS), a program which provides Medicaid reimbursable institutional and home and community-based services for the elderly, physically disabled or persons with developmental disabilities.

Before 1982 Arizona was the only State which did not participate in Medicaid. In the Spring of 1982, AHCCCS was approved as a three-year demonstration project by the Health Care Financing Administration (HCFA). HCFA has given the program repeated extensions to continue operating while receiving Medicaid funds as a demonstration project. In November 1988, HCFA approved a 5-year extension of the program until 1993; in 1992 HCFA approved another extension until September 30, 1994. In August 1994, HCFA approved a 3-year extension of the existing program and is considering new waivers requested by AHCCCS.

The initial goal of the AHCCCS project was to develop and test a new delivery and payment system to provide managed care health care services, facilitate cost containment, improve member access to care and, at the same time, emphasize and deliver quality care.

The original program design called for a private contractor to serve as the day-to-day administrator. The administrator's responsibilities included: enrollment functions, health plan oversight, audit and compliance functions, claims processing, medical quality assurance, and grievance and appeals. The program was implemented with very little time for planning and development. Virtually every review of the early years of AHCCCS cites an inadequate amount of time for planning.

During its first 18 months, the program was beset with a number of administrative and budgetary problems, which resulted in the termination of the private administrator's contract less than halfway through the contracted term. There was a tremendous amount of negative press about the program, creating a lack of confidence among elected officials, the medical community and the public.

In March 1984, the State assumed the administration of the program appointing a task force to manage the transition from the private sector to State operations.

Within 30 days, the State successfully took over the operation. It hired 150 employees, transferred the private administrator's computer software system to State computers and brought on-line a new computer center.

The AHCCCS program was mobilized to assume a strong regulatory position. New challenges included:

- Financial and contractual compliance reviews of all contracted health plans;
- Quality control review of the county eligibility systems;
- Medical quality-of-care audits of the health plans, some of the most thorough medical reviews of any Medicaid program; and
- Increased staffing for the audits, compliance and utilization review functions.

After the State assumed administration of the program, 2 health plan contracts were terminated due to plan insolvency and another health plan under new management was successfully reorganized under the federal bankruptcy statutes.

Funding

AHCCCS is funded by a combination of State, county and federal contributions. One difference between AHCCCS and traditional Medicaid is that AHCCCS funds prepaid health plans on a capitated basis (fixed rates based on AHCCCS population numbers) rather than a traditional fee-for-service arrangement based on services rendered.

Eligibility Groups

AHCCCS provides services to several different groups of people. These include:

- Categorical individuals who enter AHCCCS through a mandatory Medicaid eligibility groups for which federal matching funds are available. Examples are persons who are receiving Aid to Families with Dependent Children (through the Department of Economic Security) or Supplemental Security Income (through the Social Security Administration);
- Optional Medicaid eligibility categories, such as AFDC Medical Assistance Only and 1902 R children up to the age of 14 with income

up to 100% of the federal poverty level.

- Sixth Omnibus Budget Reconciliation Act (SOBRA) mothers, infants and children (as of January 1, 1988);
- Persons with income up to 300 percent of the Supplemental Security Income who are eligible for ALTCS (as of December 19, 1988 and January 1, 1989);
- 100 percent state-funded population who have income and resource levels set by the Arizona legislature.

Covered Services

Services covered by AHCCCS include:

Acute Care

- Inpatient hospital services
- Outpatient Health services
- Laboratory and x-ray services
- Pharmacy services
- Medical supplies, medical equipment and prosthetic devices
- Emergency ambulance and medically necessary transportation
- Emergency dental care and extractions for adults
- Eyeglasses or contact lenses for adults if they are the sole prosthetic device after a cataract extraction
- Medically necessary dentures for adults
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under the age of 21
- Podiatry services
- Medically necessary transplants that include: kidney, cornea and bone transplants; heart transplants for categorical members only, liver transplants for categorically eligible children; autologous and allogenic bone marrow transplants for categorical members
- Family planning services
- Home health care services
- Nursing facility services, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year
- Private duty nursing services
- Rural health clinic services

- o Federally qualified health center services
- o Therapy services
- o Nurse-midwife services

- o Mental health services for acute care adults 21 years and older who are seriously mentally ill (SMI), all EPSDT children under the age of 21 and ALTCS eligible persons 65 years and older (The Legislature will consider adding the remaining mental health services for non-SMI adults and ALTCS eligible persons 21-64 in the 1995 legislative session).

ALTCS

- o All the above acute care services, nursing facility, Intermediate Care Facility for the Mentally Retarded, Hospice and comprehensive home and community-based services.

Delivery of Services

Services are provided to eligible members through health plans that are selected by competitive bidding. Bids are awarded on a county-by-county basis. Enrollment in a prepaid health plan is mandatory for all members except American Indians, who may choose either a health plan or the Indian Health Service as the provider of medical care. Beginning October 1, 1994, AHCCCS has contracts with 14 health plans statewide which are reimbursed on a prepaid capitated basis. Members have a choice of at least 2 health plans in the rural counties; in the 2 large urban counties, members have a choice of 5 health plans in Pina County (Tucson) and 10 health plans in Maricopa County (Pheonix).

AHCCCS was also able to award contracts to 2 large commercial health plans: Blue/Cross and Blue/Shield and CIGNA while actually experiencing a decrease in the capitation rates paid to all health plans. The reason for the decrease was the unprecedented level of competition for the 3 year contract award period beginning October 1, 1994 and a decrease in inpatient utilization.

AHCCCS also has a fee-for-service exposure which occurs under 2 conditions: (1) when a person has been found eligible but has not yet been enrolled with a health plan; or (2) in the prior quarter before eligibility for Medicaid. AHCCCS pays non-hospital providers directly based on a maximum allowable charge set by the AHCCCS Administration. Hospitals are reimbursed based on a per-diem, tiered system of reimbursement. The new system replaced the former adjusted billed charges method and is different because it is based on actual costs, not predetermined charges.

Quality Management

Documenting quality of care in a prepaid managed care setting has been a challenge for the states with managed care programs. Few quality of care measurements exist in the private sector; in Medicaid managed care, quality of care indicators are currently under development and interim guidelines are the only standards for the states.

Recognizing the importance of quality management in a managed care environment, AHCCCS is developing a health plan report card to measure quality of care provided through health plans based on guidelines set up by HCFA and the National Committee on Quality Assurance. This new quality management process will supplement quality assurance activities which each health plan must have in place contractually; AHCCCS performs annual operational reviews to assure the quality assurance programs are in place.

AHCCCS also plans to conduct a member survey to further gauge quality of care by health plan.

Medical quality of care audits have been conducted annually and ensure that care for AHCCCS members is being provided within generally accepted medical practice criteria. These audits also measure whether AHCCCS members are being mainstreamed into the general health care delivery system, evidenced by the fact that approximately 70 % of Arizona's licensed physicians (MDs and DOs) are registered with AHCCCS, either through its fee-for-service system or the managed care component.

AHCCCS has evolved from the first statewide managed care program in the nation meeting the challenges inherent in attempting a new approach into a mature managed care program. Elements of competition and risk-sharing have been introduced into the indigent health care delivery system and members have been mainstreamed into physician offices. Perhaps of equal importance, a program has been developed that can be used by other states to implement a prepaid, managed health care program and learn from the early lessons which AHCCCS learned in the early years of the program.

SRI International Evaluation of AHCCCS - January 1989

HCFA has contracted with 2 independent evaluators to assess the AHCCCS program.

A summary of their findings are as follows:

- **Cost:** In the first 9 years of the program, AHCCCS was able to constrain cost increases 44.1% below the cost of a traditional Medicaid program in Arizona

- **Utilization:** Hospital utilization under AHCCCS was lower than traditional Medicaid.

- **Quality of Care:** Care for children under AHCCCS was in greater conformance with generally accepted guidelines from the American Association of Pediatrics. In addition, AHCCCS "probably does more than any other state Medicaid program" in the area of quality assurance.

- **Access and Satisfaction:** Even though beneficiaries reported some problems with access to emergency care, access to routine care was better under AHCCCS and absolute satisfaction levels were high.

Arizona Long Term Care System

In December 1988, AHCCCS began offering long term care services through ALTCS. The program is based on a bundling concept which allows persons eligible for the program to receive all acute care and long term care services through a single Program Contractor. The emphasis in the program is community placement: AHCCCS has no cap on the number of slots for home and community based services for persons with developmental disabilities and a 35% cap based on population for home and community-based slots for the elderly or physically disabled population. AHCCCS has requested HCFA approval to raise the 35% cap to 45% beginning on October 1, 1994.

CONTACT: Lynn Dunton, Federal and State Policy Manager
Office of Policy and Coordination
AHCCCS - Mail Drop 42400
P.O. Box 25520
Phoenix, AZ 85034
(602)254-5522, extension 4319

ARKANSAS

The Arkansas Medicaid Primary Care Physician Managed Care Program is a statewide program. Under this program, Medicaid recipients must select a primary care physician (PCP) who will provide, through an ongoing recipient/physician relationship, primary care services and health education, monitor on an ongoing basis the recipient's condition, health care needs and service delivery, be responsible for locating, coordinating and monitoring medical and rehabilitation services on behalf of the recipient and refer the recipient for all medically necessary specialty services and other services. Recipients will be restricted to receive services from the PCP or from another provider to who the recipient was referred by the PCP.

Medicaid recipients participation in the program is mandatory except for certain recipients.

Recipients must select their PCP from any of the following types of physicians: family practitioner, general practitioner (including osteopaths),internal medicine, obstetrician/gynecologist or pediatrician.

The recipient must receive a referral from their PCP before receiving Medicaid services. There are numerous services a recipient can receive without first receiving a referral.

Each PCP is allowed to have up to 1000 Medicaid recipients on their PCP case load at one time. PCPs must meet a broad range of requirements in order to be a PCP.

PCPs are paid a per recipient, management fee per month, regardless of whether the recipient was actually seen that month by the PCP.

CONTACT: J.C. Kerr, 501-682-8360

CALIFORNIA

The Medi-Cal managed care program in California was created to improve access to medical care and save money by giving managed care plans financial incentives to provide preventive care and reduce unnecessary expenses. The system is based on capitation rates that are set by law at fee-for-service **(FFS)** cost equivalence or less. As Medi-Cal managed care expands and FFS Medi-Cal becomes more efficient the amount of savings realized via managed care is diminishing. While managed care programs continue to save money, the true dividend is the enhanced access to primary care and preventive services for Medi-Cal managed care members, and reduced administrative burden to Medi-Care providers imposed by the FFS Medi-Cal system.

Anticipated Program Expansion

The State of California is currently implementing a plan to expand Medi-Cal managed care. The goal of this plan is to assure access to medically necessary services in all areas of the State. The plan proposes fundamental changes in the Medi-Cal delivery system. They are:

- Expand capitated systems to include up to 50 % of the Medi-Cal population (approximately 2.5 million people) into managed care.
- Develop programs tailored to the needs of the State's elderly population.
- Create a FFS managed care program, in selected areas of the State where little or no managed care plans exist or are expected. FFS providers will be given incentives to control utilization and increase prevention.
- Stabilize Medi-Cal managed care enrollment through mandatory enrollment requirements and restricted disenrollment periods.

The managed care plan includes 3 key components. The most significant is the development of a 2-plan managed care model for 13 counties. The 2-plan model involves mandatory enrollment of most Medi-Cal beneficiaries within the 13 counties. Beneficiaries will have the choice of a commercial health maintenance organization (HMO) selected by the State through competitive bidding, or a "local initiative", a county government sponsored HMO. Full implementation of the two-plan model is projected for fiscal year 1995-96. The second component will be the expansion of the States' county organized health system (COHS) concept into 3

additional counties. Solano County is already operational, and expansion into Orange and Santa Cruz is expected in fiscal year 1995-96. The third component is the Geographic Managed Care (GMC) pilot project in Sacramento. The GMC model involves mandatory enrollment of most Medi-Cal beneficiaries in their choice of several fully capitated HMOs or Primary Care Case Management (PCCM) plans. PCCM plans are partially capitated clinic-based providers. The GMC pilot became operational in April 1994. Federal waivers are required for each of these programs; the waiver for the Solano County COHS and the Sacramento GMC pilot have been approved.

Current Programs

Prepaid Health Plans (PHPs)/HMOs. The California Department of Health Services (DHS), currently contracts with 14 PHPs that provide most Medi-Cal health care benefits. Enrollees agree to receive all contracted care through the plans and are entitled to access to a defined set of benefits and services guaranteed by the plan. In exchange for capitation fees, the PHP assumes the risk of the cost of covered services. Current enrollment in PHPs is approximately 522,713.

Primary Care Case Management (PCCM) Plans. The PCCM program, which includes 14 contractors, provides a means for Medi-Cal primary care providers to participate in a capitated program without having to qualify as a PHP/HMO. The primary differences between a PHP and a PCCM plan are the scope of capitated services, medical services authorization requirements, and the reimbursement mechanism for providers. PCCM plans are at-risk and receive payment for outpatient services only. Inpatient services and medical services not covered by the plan are covered under the FFS program with prior authorization from the PCCM plan. PCCM plans also participate in "Savings Sharing" whereby the State splits any savings with the plans on a 50-50 basis. The Savings Share is based on the difference between the actual FFS health care costs of noncapitated services authorized by the PCCM plan and an actuarial estimate of the costs that would have been incurred had the enrollees been covered by the FFS program. Since California is focusing its efforts on expanding service using PHP's current enrollment in PCCM plans has declined from 228,000 in 1993 to 155,000 in 1994.

County Organized Health Systems/Health Insuring Organizations (HIOs). California contracts with HIOs in 3 counties, Santa Barbara, San Mateo, and Solano. Contracts with Santa Cruz and Orange county are expected to be operational in FY 1995-96. Under these contracts, almost all Medi-Cal eligibles in each county either choose or are assigned to a primary care physician who case manages the enrollee. The HIO assumes the risk of covered medical services for a set capitation fee. Primary Care providers (PCPs) in HIO counties have an opportunity to share in program savings which are created by the efficient control of health care utilization. If the utilization of the assigned patients exceeds projections, no savings are shared

with the physicians. Cost overruns are not, however, passed on to the provider.

Enrollment in HIOs is mandatory for covered categories. Current enrollment is approximately 41,000 for Santa Barbara, 49,500 for San Mateo, and 39,000 for Solano County.

PHPs, PCCM plans, and HIOs also may elect a contractually determined risk ceiling, with costs beyond that ceiling being reimbursed by the State at FFS Medi-Cal rates.

Other Coordinated Care Programs. California also operates coordinated care programs for the elderly. On Lok Health Services is the prototype for the Program of All-Inclusive Care for the Elderly (PACE) which has an enrollment of about 450. On Lok's primary goal is to keep the frail elderly in their homes, living as independently as possible, for as long as appropriate. The State projects to have a total of 5 On Lok replications (PACE projects); 2 have been implemented. On Lok operates in San Francisco County; the 2 new projects operate in Sacramento and Alameda Counties with a combined enrollment of about 100.

Another program for the elderly is Senior Care Action Network (SCAN). SCAN is a participant in the Social Health Maintenance Organization (S/HMO) National Demonstration Project, which is to determine if the HMO concept can be effective in controlling health care expenditures of the elderly, particularly those with chronic impairments. SCAN operates in Los Angeles and Orange Counties with a total enrollment of about 400. SCAN's primary goal is the same as On Lok's, with the major difference being that the independent provider network in SCAN coordinates both social and health care services.

ON Lok and the 2 PACE projects cover lifetime long-term care, while SCAN does not. All of the coordinated programs for the elderly are demonstration projects under section 1115 of the Social Security Act.

In 1993, The State began implementation of the Case Management Assistance Project, a program of intensive medical case management, aimed at Medi-Cal Beneficiaries who are chronically or catastrophically ill. The program's goal is to identify and effectively treat the problems early and avoid preventable cost escalation.

The Family Mosaic Project provides case management and mental health services under capitation to severely and emotionally disturbed children at risk for out-of-home placement. The case manager comprehensively coordinates the care and treatment of the child to achieve the best overall outcomes. Such care may involve linkages with Social Services, probation officers, mental health workers, and case workers. The contract for this project is between the State and San Francisco City

and County. Current enrollment is approximately 122.

CONTACT: Joseph A. Kelly or Kenneth J. Wagstaff
State of California-Health and Welfare Agency
Department of Health Services
Medi-Cal Managed Care Division
714 P Street, Room 650
P.O. Box 942732
Sacramento, CA 94232-7320
(916) 654-8076

COLORADO

HMOs. The State of Colorado currently has 3 HMOs and 1 PHP actively providing services to Medicaid enrollees. Enrollment in HMOs account for 8.65% of the Medicaid population. Both Rocky Mountain HMOs and HMO COLORADO are Federally qualified. There are no HIOs. Colorado also has a PACE demonstration model which is a replication of the California "On Lok" program. The PACE demonstration model expanded to a second site August 1993.

Enrollment into Colorado's HMO program is mandatory for all categories of assistance except for Medicare/Medicaid and Foster Care recipients. Colorado has contracted with Rocky Mountain HMO on a prepaid capitated basis since 1974.

- Rocky Mountain HMO-Western Slope (RMHMO) based in Grand Junction, Colorado, has been a Medicaid HMO since 1974. RMHMO (Western Slope) serves Medicaid enrollees in Mesa, Montrose, Delta, Rio Blance, Archuleta, Dolores, La Plata, Ouray, San Juan and San Miguel counties on the Western Slope. RMHMO (Western Slope) enrollment was 11,000 as of June 1994 in those counties.

- Rocky Mountain HMO-Metro (RMHMO/Metro) is an expansion of the aforemention HMO in the Denver Metro area. RMHMO/Metro serves Medicaid enrollees in Denver, Adams, Arapahoe, Doughlas and Jefferson counties. RMHMO Metro Medicaid HMO enrollment was 2,661 as of June 1994 in those counties.

- Denver Health and Hospital (CHOICE CARE) is the only Prepaid Health Plan participating in the Medicaid at this time. CHOICE CARE serves Medicaid enrollees in Denver, Adams, Arapahoe, Douglas and Jefferson counties. CHOICE CARE enrollment was 7,784 as of June 1994 in those counties.

- HMO COLORADO is the newest HMO to provide services to Medicaid enrollees in Denver, Adams, Arapahoe, Douglas and Jefferson counties. HMO COLORADO enrollment was 1,567 as of June 1994 in those counties.

In 1988, Colorado developed its HMO Monitoring and Review program in an effort to assure that a contracting HMO provides quality care to all enrolled Medicaid clients.

There are 3 components of the monitoring and review process:

1) professional assessment covering quality assurance and peer review; 2)

technical assessment concentrating on contractual compliance and licensing review; and 3) client services assessment accomplished through client surveys.

The professional assessment review is conducted by the Colorado Peer Review Organization: the Colorado Foundation for Medical Care (CFMC). CFMC analyzes the internal quality assurance programs of the Medicaid HMOs. These are conducted yearly through Colorado's contract with CFMC. CFMC submits annual reports of their findings to the Department and to the HMOs.

CONTACT: Ms. Donna Marshall, Manager
Managed Care Section
Department of Health Care Policy & Financing
1575 Sherman Street
5th floor
Denver, CO 80203-1714
(303) 866-3163

Primary Care Physician Program (PCPP). Colorado's Medicaid PCPP was implemented statewide in 1983 as one of the first primary care case management programs operating under a §1915(b) freedom of choice waiver. Participation in the PCPP is mandatory for all Medicaid recipients unless a recipient resides in an HMO county, whereby the HMO would be an alternative to the PCPP. The other exception to participation in the PCPP is if the recipient is either a Medicare/Medicaid recipient or in the Colorado Foster Care program.

The PCPP is a physician-based program which focuses on the physician as the gatekeeper for Medicaid benefits. The primary care physician (PCP) is selected by eligible recipients. The physician has overall responsibility and accountability for the level, scope, and quality of care provided to the PCP's Medicaid patients. The PCP is responsible for providing primary care services, coordinating the provision of other necessary medical/health care, and monitoring utilization of Medicaid services by his/her patients. A referral is required from the PCP to other providers of care, except for the following exempted services:

- emergency care services
- community mental health services
- family planning services
- podiatry services
- dental/vision services under EPSDT program
- transportation services
- anesthesia services
- laboratory/radiology services
- pharmacy services
- child abuse victim related services

- pregnancy-related services

Independent program evaluations conducted in 1984, 1986, 1988 and 1991 have consistently concluded that the PCPP has been successful in reducing emergency room usage as a primary care setting, improving physician participation and patient access to care, and in realizing significant cost savings. Clients have reported satisfaction with the program in surveys conducted for each evaluation study. Physicians in Colorado continue to view this program as a joint initiative between them and the State, and continue their support by participating as PCPs. In June 1993, implementation of an automated telephone information system for both clients and providers was completed and provides general information to frequently asked questions and access to physician referral lists.

Current participation is approximately 112,659 recipients or 42.07% of the Medicaid population, with 1,931 participating providers and 38 participating Community Health Clinics.

CONTACT: Donna Allen, Coordinator
Primary Care Physician Program
Department of Health Care Policy & Financing
1575 Sherman Street
5th Floor
Denver, CO 80203-1714
(303) 866-2220

CONNECTICUT

Connecticut does not currently have a Medicaid managed care program; however, 1 is currently closing. Following is a brief description of the program:

Connecticut plans to implement a statewide mandatory enrollment Medicaid managed care program starting July 1, 1995. The program will ultimately serve upwards of 211,000 recipients in family and children coverage groups, with the majority of these in AFDC.

Comprehensive benefits and integrated services will be managed and provided through a variety of prepaid capitated risk plans. Eligible contractors will include traditional HMOs licensed by the Connecticut Department of Insurance, and Medicaid only plans certified by the Department of Social Services. These Medicaid only plans are likely to include a full risk entity organized by the state's FQHCs and partially capitated health plans owned by a provider or network of providers.

Plans will be encouraged, and in some instances required or given incentives, to include "safety net" providers in their networks. In each region, Designated Provider plans will be selected on the basis of price and specially targeted programs aimed at the Medicaid population.

The total number of Medicaid eligibles as of May 1994 was slightly under 300,000 recipients.

CONTACT: James Gaito
Health Program Planning Manager
25 Sigourney Street
Hartford, Connecticut 06106-5033
(203) 424-5137

DELAWARE

Delaware currently has one Managed Care contract under 1115 Demonstration Waiver. It is with the Nemours Foundation and is called the "Child Health Plan" which is operated by the A.I. duPont Institute. It is a capitated payment system with 2 sets of services. In 1 county the rate includes all primary care services, inpatient and outpatient care, lab, X-Ray, some durable medical equipment, eyeglasses, all EPSDT screen and referrals, immunizations, emergency room care at the Institute, some prescription drugs and case management. In the other 2 counties, the service package is essentially a Primary Care Case Management system with a capitated payment that also includes some prescription drugs and DME that is provided at the Institute.

Services not included in this contract are pregnancy and childbirth care, management of Family Planning, Long Term Care services, Mental Health services, Substance Abuse intervention and compensation to other providers. These services are provided on a fee-for-service basis to eligible recipients.

Presently, the enrollment into this plan is voluntary if the child has a "medical home." If not, the child's parent/guardian is asked to name a primary care physician within 30 days of eligibility determination. If they do not, the children are automatically enrolled in the Nemours Child Plan if there is a clinic site in the catchment area of their residence. These areas are determined by Zip Code.

This particular waiver has been approved through July 31, 1997.

DISTRICT OF COLUMBIA

The District of Columbia Medicaid Program began implementation of the D.C. Medicaid Managed Care program on April 1, 1994. This program is mandatory for most AFDC and AFDC-related recipients, and operates through a freedom of choice waiver. The D.C. Medicaid Managed Care program allows providers to participate on either a fee-for-service or capitated basis.

Under the D.C. Medicaid Managed Care program, each recipient selects or is assigned a primary care physician who provides all primary medical care and will refer or authorize specialty care services. All primary care physicians must provide recipients with 24-hour, 7-days-a-week access and provide management of most non-emergency care. Primary care physicians include general practitioners, family practitioners, internists, pediatricians and OB/GYNs. All Medicaid services are covered under the waiver program except dental services, optometry, nursing home and ICFs/MR, transportation, emergency services, psychiatric and/or mental health services, rehabilitational treatment, hospice services, family planning, and substance abuse. These included services are available to recipients without freedom of choice restrictions.

Managed Care recipients are locked into their primary care physician for a 6-month period. No administrative fee is paid to primary care physicians.

As of September 1, 1994, 310 primary care physicians participated in the fee-for-service program along with one prepaid health plan and one HMO. Approximately 53,000 of an estimated 77,000 eligible recipients have been converted to Managed Care as of September 1, 1994.

Fee-for-service physicians care for approximately 22,000 recipients, 17,000 are members of the prepaid health plan and 14,000 members of the HMO.

Prior to the mandatory Managed Care waiver program, D.C. had a voluntary coordinated care program for AFDC recipients. As the conversion of AFDC and AFDC-related recipients is completed, the voluntary program will be eliminated. As of September 1, 1994, approximately 7,000 recipients remain in the voluntary program.

CONTACT: Ms. A. Sue Brown
Commission on Health Care Finance
Dept. of Human Services.
2100 Martin Luther King, Jr. Avenue, S.E.
Suite 302
Washington, D.C. 20020
(202)727-0735

FLORIDA

PHPs/HMOs. For the past 13 years the managed care effort in Florida has been primarily focused on PHPs and HMOs. Today there are 28 contracts affecting nearly 350,000 Medicaid recipients in 39 of the 67 counties in the State. Thirty-five additional applications are under review to provide services to most counties in the State.

Thirteen of the 28 current prepaid contractors are State certified HMOs. The other 15 are PHPs, with 3 being governmental entities and the remaining 12 State defined HMOs operating with enrollment composition waivers.

Each of the current contractors provides a basic core of services including hospital, physician, prescribed drugs, lab, X-Ray, family planing, EPSDT, therapies, home health care and durable medical equipment. Optional services include transportation, adult denture and child dental, hearing, vision and nursing home services. The plans are capitated for all services.

The AFDC related eligible population is served by all contractors. All but 5 plans also serve the SSI population, both with and without Medicare. Only the SSI eligible group may receive nursing home services on a prepaid risk basis and 2 contractors have been authorized to cover that optional service to date.

Enrollment and disenrollment in all HMO/PHPs is voluntary from month to month. Internal monitoring is performed by Medicaid field staff. External peer review is performed under contract by a professional review organization (PRO). That review generally includes a statistically significant sample of each contractor's medical records, whether staff or IPA model.

PCCM. Florida also has a Primary Care Case Management program called "MediPass" (Medicaid Physician Access System), authorized under a § 1915(b) (1) waiver, which began providing services in 4 Florida counties in the Tampa/St. Petersburg area on October 1, 1991. Enrollment in MediPass or an HMO alternative is mandatory. As of July 1, 1994, 146,000 AFDC recipients have enrolled in MediPass, which has begun operating in 31 counties.

Primary Physicians (including general and family practitioners, internists, pediatricians, obstetricians, gynecologists, group practices, Federally Qualified Health Centers, rural health clinics and county public health units) receive a monthly $3 per capita case management fee. They are responsible for providing access to primary care services on a 24 hour, 7 days a week basis, and prior authorizing most specialty and hospital care.

Services managed by MediPass primary care physicians include hospital, physician,

prescribed drugs (when the Rx is written by the primary care physician), lab, x-ray, EPSDT, home health, podiatry, nurse practitioner, ambulatory surgical center and rural health center services. MediPass does not manage family planning, mental health, visual or maternity-related services. No prior authorization of true emergency services is required. Payment for services provided is on a fee-for-service basis. Primary Care providers are not at risk for any services. Continued participation in the program is dependent upon acceptable case management of services.

Evaluation of MediPass has been conducted under contract with the University of South Florida in Tampa. By means of satisfaction surveys, 100 percent of MediPass participating providers and 12 percent of MediPass clients were questioned concerning their access to care and satisfaction with the program. Over 80 percent of the MediPass clients rated MediPass highly on access to care and general satisfaction. The evaluation found an overall 25.3 percent reduction in the costs of services managed by MediPass physicians. While these savings are probably overstated because this initial evaluation was based on limited data, Medicaid expects MediPass to produce significant savings on a continuous basis.

Florida Medicaid has received federal approval to develop a prepaid mental health project. In addition, Florida is working cooperatively with the state's Title V agency to develop a coordinated system of care for SSI eligible physically disabled children. The capitated arrangement will be piloted in several areas and will test the blending of acute and LTC services for these medically complex kids.

CONTACT: Marilyn G. Reeves, Ph.D., Chief
Medicaid Managed Health Care
Department of Health and Rehabilitative Services
Post Office Box 12800
Tallahassee, FL 32317-2800
(904) 922-6830

GEORGIA

Georgia Better Health Care - Primary Care Case Management

Georgia pilot PCCM program began October 1, 1993, in 7 of Georgia's 159 counties. Additional counties will be phased into the program during the next year. As of June 30, 1994, 63,214 Medicaid recipients were enrolled in Georgia Better Health Care (GBHC). Enrollment in GBHC is mandatory for AFDC, AFDC related and SSI eligible recipients residing in the participating counties. Each of these recipients is linked to a primary care provider who is responsible for providing primary care services and authorizing specialty care and impatient admissions. The primary care case managers are paid a monthly fee for each Medicaid recipient enrolled with them as well as the fee-for-service reimbursement for actual services rendered.

Case Management Programs

* Children at Risk - Targeted Case Management
* Early Intervention Case Management
* Child Protective Service - Targeted Case Management
* Adults with aids - Targeted Case Management
* Perinatal Case Management
* Mental Health Case Management

Children at Risk - Targeted Case Management Programs

Through its involvement in the 19 Family Connection sites, the Department covers case management for children at risk of not completing a secondary education. The program links children and families with needed medical, social and educational services. These case management services were received by 10,817 children during state fiscal year 1994.

Early Intervention Case Management

Children's Intervention Services covered under this program are audiology, nursing, nutrition, occupational therapy, physical therapy, social work, speech-language pathology and developmental therapy instruction. Each of the covered services, except Developmental Therapy Instruction, is divided into 2 categories - assessment and services. Assessments are divided into initial and annual. The initial assessment must be completed within 45 days of the child's initial referral. The annual assessment reviews the services provided by the Children's Intervention Service provider to re-assess the current level of service and make any appropriate revisions. These case management services were received by 2,726 children during state fiscal year 1994.

Perinatal Case Management

To date, 42,053 women received perinatal case management services. In addition to linkage with medical services, Perinatal Case Management services provide coordination with providers of non-medical services, nutritional programs, such as Women, Infants, and Children (WIC) or educational agencies, when services are needed. A comprehensive set of interrelated activities are involved with the Perinatal Case Management Program, which include: needs assessment (including medical, nutritional, psychosocial, and health educational assessments) of clients eligible for Medicaid Case Management services; development and implementation of an individualized plan of services; as well as monitoring and follow-up to ensure that services are adequately delivered and recording the outcome of the pregnancy.

Child Protective Services - Targeted Case Management

The Child Protective Services Targeted Case Management program provides reimbursement for identifying, coordinating, monitoring and reviewing the delivery of appropriate medical, nutritional, social, educational, transportation, housing and other services as a means of assisting eligible recipients who are in Foster Care or are receiving Child Protective Services. This assessment and coordination of services helps to maintain a home environment free of maltreatment, neglect, abuse and threats to the safety and welfare of the children. These case management services were received by 12,498 children during state fiscal year 1994.

Mental Health Case Management

Mental Health Case Management services were provided to 3,390 people. This program provides for reimbursement for identifying, coordinating and reviewing the delivery of appropriate medical, nutritional, social, educational, transportation, housing and other services to eligible recipients. These recipients are either emotionally or mentally disturbed, drug or alcohol abusers, mentally retarded, or developmentally disabled.

Adults with Aids - Targeted Case Management

Under the Adults with Aids Case Management Program, enrolled providers receive reimbursement for identifying, coordinating, monitoring and reviewing the delivery of appropriate services for Medicaid eligible adults with Aids who need assistance with acute problem solving. This is accomplished through 3 activities -- comprehensive assessment, brief follow-up and extended follow-up. These case management services were received by 504 adults with AIDS.

CONTACT: Maria Greene Turk
State Plan Coordinator
State of Georgia
Department of Medical Assistance
2 Peachtree Street, N.W.
27th Floor
Atlanta, Georgia 30303-3159

HAWAII

Hawaii Health QUEST (Quality care, ensuring Universal access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided to public clients) is a statewide project which creates a public purchasing pool that will arrange for health care through capitated managed care plans. Under the program, the Medicaid eligibility income limits will be extended to 300 percent of the Medicaid Federal poverty level (FPL).

Hawaii's "seamless" program integrates the Medicaid program with State programs for the uninsured:

- Currently, the State-funded General Assistance (GA) program covers those who do not meet Medicaid categorical requirements but meet the financial criteria. The State Health Insurance Program (SHIP) covers the uninsured up to 300 percent FPL.

- Under the demonstration, the Federal and State public assistance programs will be combined with all individuals under 300 percent FPL eligible for Federal matching. With all participants in 1 group, individuals need not apply for different programs as their situations change.

- Aged, blind, and disabled will continue to receive Medicaid services under the current system.

Capitated Managed-Care Plans

- A standard benefit package will be provided under capitated contracts with health plans.

- To maintain a capitated rate within a reasonable range, the State will share equally in the risk with health plans for catastrophic costs between $30,000 and $50,000, and will bear 85 percent of the risk for costs between $50,000 and $100,000. The State will cover 100 percent of costs above $100,000.

- Dental coverage will be provided to beneficiaries through a capitated managed-care dental plan.

- Plans will cover acute mental health. The State will develop a fully capitated managed mental health program for the seriously mentally ill.

- Long-term care will continue to be provided on a fee-for-services basis and will not be part of this demonstration.

- Standard Benefit Package

- Currently, the GA population has the same Medicaid coverage as the Aid to Families with Dependent Children (AFDC) and AFDC-related population; whereas, SHIP participants have a more restrictive level of benefits.

- Under the demonstration, the standard benefit package will include all services covered by Medicaid.

Impact on Beneficiaries

- Eligibility

  + Financial Eligibility-all individuals with incomes up to 300 percent FPL are eligible. There is no maximum asset limit. Currently, 98 percent of Hawaiians are insured either through private or public programs.

  + The existing medically needy program for AFDC-related groups will be eliminated.

IDAHO

HEALTHY CONNECTIONS

Idaho is in its first year of introducing managed care to the Idaho Medicaid population. The State is using a Primary Care Case Management model for the program, which is called Healthy Connections. Only 14 of Idaho's 44 counties are targeted for implementation of the program. The remaining counties are either rural or frontier (6 persons/square mile) and are not targeted in the 2 year waiver period. The 2 year phase-in period for implementation in targeted counties began October 1993.

The goals of Healthy Connections are to:

- Ensure access to health care;
- Provide health education;
- Promote continuity of care;
- Strengthen the patient/physician relationship; and
- Achieve cost efficiencies.

Healthy Connections operates on a voluntary participation basis, by county, until enough primary care physicians have been recruited to serve the eligible Medicaid population in that county. Currently 2 of 7 participating counties operate on a mandatory basis.

Healthy Connections Representative

The Healthy Connections Representative functions as a liaison between the client and the provider regarding program delivery issues; conducts training sessions for clients, providers, and staff; resolves problems; and performs a variety of other program duties. Having a program representative at the local level has been an essential part of effective implementation.

Primary Care Providers

A Primary Care Provider (PCP) can be an individual doctor or an entire clinic. The PCP agrees to provide primary care, make referrals for most other medical services, to maintain a 24-hour/day, 7-day/week phone number for patients to call for medical advise after office hours, and to retain records for 5 years. The PCP may limit Healthy Connections patients and may withdraw from certain cases. The PCP is paid a case management fee of $3.50/month for each Medicaid eligible Healthy Connection client assigned to him/her.

Services

The services which do not require referral from the PCP are:

- Emergency services to prevent death or permanent damage;
- Family planning;
- Dental services;
- Podiatry services;
- Audiology services;
- Vision services;
- Pharmacy;
- Chiropractic care; and
- Immunizations from District Health Offices.

Client Participation

Healthy Connections encompasses most types of Medicaid eligibility. The following are exemptions from participation in mandatory counties:

- Residence in a nursing facility or ICF/MR;
- Travel of more than 30 miles or 30 minutes to the nearest participating PCP;
- An eligibility period of less than 3 months;
- An eligibility period that is only retroactive;
- Eligible as medically needy (if the State so chooses to implement a medically needy program);
- Eligible as a Qualified Medicare Beneficiary (QMB) only; or
- Eligible as a Specified Low-Income Medicare Beneficiary (SLMB) only.

A client may change his/her PCP or disenroll by contacting the Healthy Connections Representative.

Summary

Healthy Connections is a managed care approach to health care delivery. The program was designed to be very flexible in order to accommodate the diverse population of Idaho.

ILLINOIS

HEALTHY MOMS/HEALTHY KIDS

The Healthy Moms/Healthy kids program was implemented Statewide in April 1993 to improve the Health of low income families by expanding access to primary care and preventive services.

The goals of the Healthy Moms/Healthy Kids Program are to:

- Support infant mortality reduction efforts;
- Ensure pregnant women and children receive primary health care services;
- Expand quality primary care capacity through incentives;
- Reduce Medicaid expenditures for high-cost, preventable conditions;
- Comply with Federal Medicaid requirements of ensuring that 80 percent of Medicaid children receive appropriate screenings and vaccinations by 1995;
- Meet Federal Medicaid mandates to ensure access to care for pregnant women and children is at least equal to that available to the general population.

The key components include:

- Rate increases for participating physicians;
- Case management services for pregnant women and children;
- Managed Care for pregnant women and children (city of Chicago);

RATE INCREASES/PHYSICIAN QUALIFICATIONS

Physicians receive enhanced reimbursement for 1) EPSDT services for children through age 20; 2) risk assessments, and 3) delivery services provided to pregnant women. These rates are effective April 1, 1993 or with the date of the physician's enrollment into to HM/HK Program, whichever is later. In order for a physician to enroll in the HM/HK program and qualify for the enhance reimbursement rates, the physician is required to meet specific quality standards and agree to perform certain services, including:

- Hold hospital privileges;
- Provide 24-hour telephone coverage;

- Have arrangements for "sick" children and "at risk" pregnant women to be seen within 24 hours of the request, based on a triage of need;
- Provide periodic health assessment examination (EPSDT) and primary pediatric care, in accordance with the American Academy of Pediatrics or Academy of Family Physicians for providers serving children;
- Provide Obstetricians and Gynecologist or Academy of Family Physicians for providers serving pregnant women;
- Arrange for any specialty care required for the child or pregnant women;
- Coordinate with the case management entity (when applicable) to ensure that needed services are received;
- Perform risk assessment to assure that appropriate referrals are made when indicated to substance abuse programs, mental health providers, etc.

CITY OF CHICAGO-MANAGED CARE FOR PREGNANT WOMEN AND CHILDREN

Under the authority of a 1915 (b) waiver, Medicaid clients who are pregnant women and children (up to age 21) in the City of Chicago must select from one of the following primary health care options under the HM/HK program:

- An individual physician;
- A Federally qualified Health Center or other designated clinic; or
- A participating Health Maintenance Organization in the Chicago area.

Physicians providing services under the managed care program will receive a patient management fee for each enrolled client.

As a result of extensive recruitment efforts, the Department has successfully enrolled providers with capacity exceeding the pregnant women and children expected to be enrolled in the program. However, recruitment efforts will continue in an effort to add additional quality providers to the program to enhance and increase the client choice process.

NUMBER OF MEDICAID RECIPIENTS ENROLLED IN HEALTH MOMS/HEALTHY KIDS

Enrollment under the 1915(b) waiver.

The following data represents the actual number of Medicaid Clients assigned to a primary care physician as of May 26, 1994:

Total Individuals:	46,739*
Total Pregnant Women:	14,022
Total Children:	32,717

*This figure does not include HMO enrollees.
enrollment for the managed care portion of Healthy Moms/Healthy Kids was phased in slower than expected due to budgetary constraints.

Enrollment for Case management.

As of June 1994, there were a total of 44,592 Medicaid cases enrolled for case management in the Chicago managed care 1915(b) waiver areas: 8,098 pregnant women; 10,067 under age 1; and 26,427 over age 1.

As of June 1994, there were a total of 80,312 cases enrolled in case management in downstate Illinois (outside the Chicago managed care areas): 13,252 pregnant women cases; 22,797 under age 1 cases; and 44,263 over age 1 cases.

HMOs

Since 1974, the Department has contracted with HMOs to provide comprehensive prepaid care to **AFDC-MAG** recipients. The HMO Program was developed to:

- Alleviate the shortage of family practitioners serving Medicaid clients;
- Reduce client usage of emergency room for ambulatory services;
- Provide better access to preventive as well as episodic care; and
- Contain the rising costs of comprehensive care.

HMOs contract with employer groups, individuals and public health program agencies to provide care to members through a large panel of providers, including managing members' health care through primary care physicians, arranging support services and specialist treatment, and processing all related claims.

The Department's HMO Program contains the following characteristics:

- Only AFDC-MAG recipients in Cook County have been eligible to date;
- The Department will be accepting proposals for other service areas in FY 94-95;
- Voluntary and open member enrollment and disenrollment;
- All Medicaid Services except dental and optical are covered;
- Payment is made at the beginning of the month according to a capitation structure based on the age and sex of the recipient to remove the incentive for enrolling only low cost recipients, and to avoid paying the HMO any more than what the Department would pay in FFS costs;
- The enrolling recipient selects a clinic site within the chosen HMO, and also selects a physician from whom he or she will receive most ambulatory care, including periodic checkups;
- This physician orders all tests, makes all specialists referrals, and arranges hospital care if necessary;
- Requirements and features of the Healthy Moms/Healthy Kids Program have been incorporated.

About 105,000 recipients are enrolled in Medicaid HMOs.

Monitoring. Federal Medicaid regulations require annual evaluation of HMO quality of care by an independent Peer Review Organization (PRO). The Department contracted Cresent Counties, a PRO, to perform such an evaluation even before this was a Federal requirement. However, as this only allows periodic monitoring on a limited scope, the Department views the PRO review as only a supplement to its own internal monitoring activities, which allow the agency to identify and respond to issues proactively on an ongoing basis, rather than depend on outside, annual reviews.

The Department's Prepaid Health auditors perform annual contract compliance audits of the HMOs to verify that Department contractual requirements, as well as State and Federal Rules and Regulations, are met. The Department's Health Facility Surveillance Nurses perform onsite inspections and chart reviews and attend HMO Quality Assurance Committee meetings to monitor the quality of care provided by HMOs, evaluate the HMOs' internal Quality Assurance programs, and recommend action to correct deficiencies. Utilization data submitted to the Department on a monthly basis is profiled by provider, site, HMO, disease or procedure for use by the monitoring staff. Finally, the Prepaid Health Program staff monitors and investigates the field activities of HMO marketing representatives. All marketers are registered with the Prepaid Health Section, and violators are suspended from marketing to Medicaid recipients or appropriately reprimanded.

HMO financial stability is also reviewed annually by the Department's Internal Audits office, which contracts CPA firms to perform cost audits and report the net worth, assets and contingency reserves of each HMO.

Utilization data. The Department requires monthly submission of magnetic tapes containing records of all encounters and detailing recipient and provider identifiers, procedure codes, diagnosis codes and cost information. This data enhances the Department's capability to produce management reports on cost effectiveness as well as to assist the monitoring staff. Provisions exist to assess damages in the event of incomplete charts in the contract compliance audits.

Finally, the Department is in the process of developing a multi-year managed care implementation plan with the objective of including as many Medicaid eligibles as possible throughout the State. A variety of approaches is being considered.

CONTACT: Dawn Claborn, Manager
Maternal and Child Health/Managed Care
Illinois Department of Public Aid
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, IL 62763-0001
(217) 524-7478

INDIANA

In July, 1994, the State of Indiana's Office of Medicaid Policy and Planning (OMPP) implemented a mandatory managed care program called Hoosier Healthwise for eligible Medicaid recipients. A Section 1915(b)(1) waiver was approved by the Health Care Financing Administration in May 1994. The waiver applies to Section 1902(a)(23). The program is being phased in via county groupings over a 3 year period. Those eligible for Hoosier Healthwise include all parents and children receiving AFDC as well as non-AFDC pregnant women and children with incomes at or just above the poverty level (hereafter referred to as AFDC-related). Enrollment will be mandatory for all eligible recipients. Education about, and enrollment into Hoosier Healthwise will be facilitated by face-to-face contact with a benefits advocate (BA), along with informative brochures and videos. This enrollment facilitation will occur as part of the new enrollment or redetermination process.

The program has 2 components: Primary Care Case Management (PCCM) and Risk-Based Managed Care (RBMC). During the first year of the program, recipients eligible for Medicaid managed care in the initial group of counties will be mandated to enroll with a Primary Medical Provider (PMP) in 1 of the 2 components of Hoosier Healthwise. Recipients in the other counties will have the option of enrolling with a PMP in RBMC, but no PMPs in PCCM will be available until the second or third years. In other words, counties where PCCM is available, eligible recipients will be required to enroll with a PMP in 1 of the 2 components of Hoosier Healthwise. In all other counties, enrollment with a PMP in RBMC will be an option which recipients may choose as an alternative to the traditional Medicaid program.

During the Medicaid enrollment process, BAs ensure that all Hoosier Healthwise-eligible recipients who reside in mandatory counties receive a face-to-face interview during which they are educated on the usefulness of primary and preventive care; the differences between Hoosier Healthwise and the traditional Medicaid program; and the distinctions between the PCCM and RBMC components. During this interview, recipients will also receive brochures describing the program and watch a video on Hoosier Healthwise.

BAs will provide recipients with a list of their provider options and explain that they will have 30 days from the date they are eligible for Medicaid to choose a Primary Medical Provider (PMP). A PMP must be a physician in the field of general practice, family practice, general pediatrics, general internal medicine, or obstetrics/gynecology (OB/GYN). Primary care physicians in any setting are eligible to be PMPs.

Whether the recipient's choice leads to enrollment in PCCM or RBMC will depend on the PMP's enrollment status at the time of selection. Since the same Medicaid benefits are offered in the PCCM and RBMC components, the education provided by the BAs will focus on the choice of physician. If, within 30 days of the caseworker appointment, a recipient fails to make a selection, 1 will be made for him or her. Once a PMP is chosen, the recipient's Medicaid card will be updated to include the PMP's name and phone number.

PRIMARY CARE CASE MANAGEMENT (PCCM)

PCCM allows eligible Medicaid recipients to select a PMP who will provide, through an ongoing recipient/PMP relationship, preventive and primary medical care as well as authorization and referral for all medically necessary specialty services. The PMP will be available 24 hours a day, 7 days a week, and will assume total management of the Medicaid recipients mon-emergency medical needs. The Hoosier Healthwise Hotline is also available for recipients to call with any problems or questions they have about PCCM. Hotline staff will ensure that the question or problem is referred to the appropriate entity.

Physicians interested in becoming PCCM PMPs are educated about PCCM through face-to-face training sessions, brochures, and videos. When a physician decides to enroll as a PCCM PMP, he/she is required to sign a contract addendum to the Medicaid Provider Agreement. Once enrolled, each PMP receives a provider manual which outlines the PCCM contract and claims procedures as well as his/her responsibilities as a recipient's Primary Medical Provider.

As part of the case management function, PMPs will be expected to provide or authorize most primary and preventive services. If the service is authorized, the PMP must document the referral in the patient's medical record and the rendering provider must provide the PMP's authorization number on the claim form. Some medical services such as treatment for medical emergencies, substance abuse treatment, family planning, chiropractic, dental care, and mental health services will be implemented through self-referral, but PMPs will be free to suggest how to access these services if they wish.

PMPs will assume no financial risk through PCCM and they will receive a $3 monthly management fee for each eligible recipient under their care. Reimbursement for services will follow the existing fee-for-service methodology. PMPs may, with just cause, and following certain guidelines, choose to discontinue their relationship with a recipient.

Quality assurance measures will be conducted for all PMPs to ensure delivery of high quality care. The feedback the PMPs receive from these quarterly analyses will assist them in their ability to best understand the needs of their recipients. A

client tracking system containing service data related to each recipient will also be maintained by OMPP. This system will make available to state officials and the PMPs information such as appointments due, kept, or missed, PMP-recipient match-up, referrals made to specialists or other social service agencies, use of emergency room services, and historical data related to recent office visits and immunizations.

Risk-Based Managed Care (RBMC)

In February, 1994, OMPP released a Request for Proposals to solicit bids from Managed Care Organizations (MCOs) to provide Risk-Based Managed Care services to Hoosier Healthwise recipients. For purposes of RBMC, the state will be divided into 3 regions: Region I- Northern, Region II-Central, and Region III-Southern. In August, 1994, OMPP will finalize selections of the MCO proposals. OMPP intends to contract with up to 2 MCOs per region. Recipients will have the opportunity to begin enrolling with PMPs in the MCOs in the fall of 1994.

MCOs will be solely responsible for arranging or administering covered services to enrolled recipients. These services will be administered by or arranged for under the direction of a designated Primary Medical Provider. MCOs must ensure that this delivery system provides available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services. MCOs must ensure that emergency services are available 7 days a week, 24-hours per day. The MCO must maintain a delivery system of sufficient size and resources to offer quality care which can accommodate the needs of the enrolled recipients within each enrollment area. MCOs must assure that contracted PMPs are required to provide or arrange for coverage of services 24 hours a day, 7 days a week.

Successfully contracted MCOs will assume financial risk for developing and managing a health care delivery system that will arrange for or administer Medicaid covered services. The State will capitate the MCO with a monthly fixed, per enrolled recipient fee. Each MCO must demonstrate its ability to develop a provider network that will eventually cover the entire region. In situations where an insufficient number of managed care providers exists to treat Medicaid recipients, MCOs will be required to develop alliances with health care providers to maximize delivery of services for all Medicaid recipients within the region.

Comparison of PCCM and RBMC

Although the principles of managed care are consistent throughout the 2 components of Hoosier Healthwise, PCCM and RBMC can be distinguished in 6 important ways:

1) In July of 1994, the initial phase of PCCM began in 8 counties. Physicians in RBMC will be available for recipient enrollment beginning Fall, 1994, and will be available statewide on a regional basis.

2) Physicians wanting to participate in PCCM must sign an addendum to the Medicaid Provider Agreement with the State, while physicians wanting to participate in RBMC will sign an agreement with their respective MCO, which in turn will be under contract with the State.

3) Physicians will be permitted to act as PMPs in both PCCM and RBMC simultaneously, but the process of accepting new patients will be limited to 1 system of care at a time. In other words, a PMP participating in both PCCM and RBMC must designate which system of care is active to receive new patients, and this selection must be maintained for at least 1 calendar quarter.

4) PMPs participating in PCCM will not be at financial risk for service costs, namely those which will be reimbursed via the traditional fee-for-service mechanism. Under RBMC, the State will pay the MCO a monthly fixed fee per enrolled recipient to arrange or administer services.

5) While all eligible recipients will receive enrollment facilitation from BAs, recipients enrolled in PCCM will return to the BAs when subsequent problems arise, while recipients enrolled in RBMC will turn to the corresponding mechanism within the MCO.

6) The 2 systems of care will share quality assurance and utilization review goals. Data gathering and report-generating functions will be assumed by the State in PCCM, and by the MCO in RBMC. The MCO will then be required to generate quality control reports for the State. The State will monitor both PCCM and RBMC with its own comparative utilization reports.

For more information

CONTACT: Dr. Denise Ingram-Bradley
Medical Director (317)232-4707

Jane Baird
Policy Analyst (317)232-4971

Wendy Bokota
Policy Analyst (317)233-0237

IOWA

The State of Iowa Medicaid Program has two methods of providing coordinated or managed care to Medicaid recipients under Title XIX and is in the process of implementing a third.

HMOs. The State has contracts with several HMOs to provide Medicaid services to clients (AFDC and AFDC related groups) in 10 service areas. These contracts are for all services under the Medicaid Plan, with the exception of dental, chiropractic, pharmacy services, durable medical equipment, and nursing facility services. Services must be provided within the plan with the exception of emergency services and family planning.

Rates are based on actuarially sound principles developed under a contract with a firm selected from an RFP issued by the State. The rates are based on a percentage of the State FFS payments, established for specific groups of the Medicaid population (age, sex, etc.). Currently, the HMOs are receiving 95 percent of the FFS rate as their monthly capitated payment. Clients may request disenrollment from the HMO at anytime, effective at the end of the month.

The Medicaid Program is continuing the expansion of HMO coverage to other areas of the State. Current enrollment is 22,000. Eight HMOs have certificates of authority for various locations within the State.

CONTACT: Mary Roberts or Nan Foster Reilly
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319
(515)281-8747 or (515)281-6087

Waiver Services. The Iowa currently has a § 1915(b) waiver which allows the State to restrict recipients' freedom of choice of providers to permit managed care by physician patient managers.

The State hired a contractor April 1, 1993 to assist with ongoing maintenance of the program and to expand the Waiver Program and the HMO Program discussed above. The State has met their goal of enrolling 108,000 AFDC and AFDC-related Medicaid recipients in managed health care by June 30, 1994. The State utilized the Waiver Program as the basis for this expansion.

Clients are given a choice to enroll in either the MediPASS Program or a

participating Medicaid HMO. The client may choose the physician case manager of their choice as long as the physician has signed an agreement with the State to accept MediPASS clients.

Physician managers receive a $2 a month payment for each patient on their list and in turn are expected to act as a "gatekeeper" to services for the patient. Physician managers must maintain 24-hour "access and availability," and must refer for necessary specialty services. The manager's role is to control the utilization of the recipient who might tend to overutilize services and to serve as an advocate for the recipient who might underutilize services.

CONTACT: Nan Foster Reilly or Mary Roberts
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319
(515) 281-6087 or (515) 281-8747

Mental Health Access Plan (MHAP). The State currently has a §1915(b) waiver which allows a restriction on freedom of choice to permit managed mental health care on a statewide basis. This program meets federal regulations for a prepaid health plan. Procurement for this statewide program is currently underway.

All Medicaid eligible persons (approximately 190,000) will be enrolled in this plan except those being served by HMOs, medically needy with a cash spend-down, persons residing in ICF/MRs, involuntary patients in the state mental health institutes and persons 65 and over. Persons residing in a psychiatric medical institute for children (PMIC) are also currently excluded.

All mental health services including inpatient and outpatient treatment, case management and rehabilitation services as well are provided through this plan. A key aspect of the plan is to promote the flexible use of funding to provide increased prevention, early intervention and rehabilitation services to improve access and overall quality of life for covered persons. Increased use of these cost-effective services should also lead to reductions in the cost of inpatient as well as other services.

CONTACT: Candi Nardini or Mary Roberts
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319
(515)242-6021 or (515)281-8747

KANSAS

The Kansas Department of Social and Rehabilitation Services currently has one 1915(b) waiver in effect under the Medicaid program. The State is in the process of expanding Medicaid Managed Care programs statewide by July 1, 1997.

Waiver Services. The Kansas Primary Care Network (PCN) was established in February, 1984, as 1 of the first 1915(b) waivers to provide physician case management to recipients in the 7 most populous counties of Kansas. The program is currently operating in the following counties: Douglas (Lawrence), Johnson, Leeverworth, Saline (Salina), Shawnee (Topeka), Sedgwick (Wichita), and Wyandotte (Kansas City).

The populations covered under the waiver are AFDC and AFDC-related, SSI and GA/MediKan eligible recipients. Of the approximately 200,000 Medicaid eligibles in the state, 60,000 were enrolled in the PCN program as of June, 1994. Enrollment in the program is mandatory in the 7 counties where it is operational. Kansas is in the process of moving enrollment duties from the local level, namely where income Maintenance staff are responsible for enrolling recipients in the program, to hiring a contractor to perform most of the enrollment functions through the mail and a toll-free number. The State hopes to have the contractor, who will assist with other administrative duties in addition to enrollment, by December 1, 1994.

The State has renewed the waiver several times and HCFA Regional Office reviews have shown the program to be cost effective as well as providing access to services for the Medicaid populations included.

The recipient is allowed to select from a list of participating provider in choosing a physician case manager. The case manager is paid $2 per month for each recipient enrolled with him/her. For this reimbursement, the physician must maintain 24 hour access to service and must refer for specialty services. The concept is to reduce the over-utilization of services by having 1 physician contact who manages all the recipient's health care.

The State is in the process of making some needed changes to the program to reduce provider hassle, increase quality assurance efforts, increase provider recruitment, and increase the number of recipients assigned to primary care physicians. Once these changes are made, the program will be expanded statewide.

Capitated Services. Kansas is in the process of developing a capitated managed care program in the urban areas of the state. The estimated implementation date for the capitated programs is July 1, 1995.

CONTACT: Brenda Jackson, Manager, Managed Care Programs
or
Dorothy Hunt, Manager, PCN Program
Department of Social and Rehabilitation Services
Division of Medical Services
Docking State Office Building
Topeka, KS 66612
(913)296-3981

KENTUCKY

The Kentucky Department for Medicaid Services implemented the Kentucky Patient Access and Care Program (KenPAC), a PCCM program, in February, 1986. Under the KenPAC Program, Medicaid families with children are provided a primary care (KenPAC) physician who agrees to provide their primary medical care and will refer and authorize other specialty care services. Through a contractual arrangement with the Department, the KenPAC physician must be available 24 hours a day, 7 days a week and provide total management of the KenPAC recipients' non-emergency medical needs.

Eligible KenPAC Medicaid recipients include AFDC and AFDC-related, children in intact families, and poverty level children and pregnant women.

The KenPAC program is mandatory for eligible recipients and is operated under the authority of the Secretary of Health and Human Services through a freedom of choice waiver. For their services, KenPAC physicians receive a $3.00 per month per enrollee patient management fee in addition to the regular Medicaid FFS payments for medical services provided to their enrollees under the waiver:

- o physician services;
- o pharmacy services, when the prescription is issued by the primary physician or clinic;
- o hospital inpatient and outpatient services;
- o home health agency services;
- o laboratory services;
- o ambulatory surgical center services;
- o primary care center services;
- o rural health center services;
- o nurse practitioner services;
- o durable medical equipment and supplies;
- o nurse anesthetist services; and
- o laboratory and other x-ray services.

Excluded from management are any emergency medical needs.

In the above service elements KenPAC does not cover mental health/mental retardation services, psychiatric, ophthalmology, obstetrics, or routine newborn care billed under the mother's medical assistance identification number. Currently, 113 of Kentucky's 120 counties are covered by the KenPAC Program, covering approximately 305,000 Medicaid recipients through contract with 1,334 physicians.

Highlights of the most recent independent evaluation include: (a) a high degree of satisfaction with the KenPAC Program by KenPAC recipients and physicians; (b) a reduction of unnecessary referrals to medical specialists and inappropriate inpatient admissions; and (C) an estimated cost savings to the Medicaid Program of $545 million over 96 months of operation.

CONTACT: Karan Sullivan, Deputy Commissioner
Kentucky Department for Medicaid Services
Cabinet for Human Resources
Commonwealth of Kentucky
Frankfort, KY 40621-0001
(502) 564-4321
or
Larry McCarthy, Assistant Director
Division of Program Development and Budget
CHR Building
Third Floor East
275 East Main Street
Frankfort, KY 40621
(502) 564-8196

LOUISIANA

CommunityCARE is a Primary Care Case Management (PCCM) managed care program administered by Medicaid of Louisiana. The program provides Medicaid recipients in designated parishes with a physician, Federally Qualified Health Center (FQHC) or rural health clinic as the recipients' primary care physician (PCP). Medicaid of Louisiana operates CommunityCARE utilizing a freedom of choice waiver under the authority of section 1915(b)(1) of the Social Security Act. The Program is operational in 6 parishes and HCFA approval has been requested for additional parishes.

For their services, CommunityCARE providers receive a $5.00 per month per enrollee patient management fee in addition to the regular Medicaid fee-for-service payment. In addition to meeting Medicaid enrollment criteria, participating PCPs must have hospital admission privileges, give written referrals, provide 24-hour access and provide or arrange for EPSDT services.

As the care manager, the PCP bears total responsibility for managing all facets of the recipient's health care. This responsibility includes providing patient education, preventive care, maintenance and acute care, and referral to specialists when necessary. The population includes AFDC and SSI recipients.

CONTACT: Sondra K. Burns
Bureau of Health Services Financing
CommunityCARE Program
P.O. Box 91030
Baton Rouge, LA 70821-9030

MAINE

The Maine Department of Human Services received approval of its 1915(b) waiver in June 1994 for a primary care case management system. This managed care system, known as PrimeCare, requires mandatory participation on the part of AFDC and AFDC-related eligibles. Participating primary care providers receive a $3.00 per enrollee per month fee for the management of their panel of patients in addition to the fee-for-service reimbursement for medical services. The State has contracted with a community-based agency to perform outreach, enrollment, and education functions for the target populations. The State is implementing PrimeCare incrementally: initially in a 2 county area, with gradual expansion to other counties throughout the state.

Maine is also developing several risk-based contracting arrangements for Medicaid managed care. Over the next several years, the State anticipates incorporating the majority of its Medicaid eligibles, including those receiving long term care services, in a managed care delivery system. Initially, it will develop capitated arrangements for the AFDC populations, and then expand to the other categories of eligibility. Initial implementation of these risk-based contracts is slated for 1995.

CONTACT: Francis T. Finnegan, Director
Bureau of Medical Services
Department of Human Services
State House, Station #11
Augusta, ME 04333
(207) 287-2674
or
Deborah Curtis, Director
Division of Managed Care
Bureau of Medical Services
Department of Human Services
State House Station #11
Augusta, ME 04333
(207) 287-3835

MARYLAND

Maryland Kids Count Program

The Maryland Medical Assistance Program received federal approval of its 1115 waiver request to establish a Demonstration Project for Preventive and Primary Pediatric Care. This program, which is known as Maryland Kids Count, began on October 1, 1993. It provides a package of primary and preventive services for children who are not currently eligible for Medical Assistance because their family income is too high. The Department of Health and Mental Hygiene estimates that 15,000 uninsured children will be eligible for Maryland Kids Count.

The benefits offered under this Program include the following: well child visits, immunizations, screening for lead poisoning and other conditions, sick care in physician offices and clinics, diagnostic tests, vision care and eyeglasses, health-related special education services delivered in the schools, and prescription drugs with a co-payment of $5 per prescription. Dental services, as well as hospital inpatient, outpatient, and emergency room services are not covered.

Eligible for Maryland Kids Count are children who were born after September 30, 1993, are at least 1 year old, do not qualify for Medicaid, and their family income is less than 185% of the poverty as of June 30, 1994.

CONTACT: Susan Tucker
Chief, Division of Maternal and Child Health
Medical Care Policy Administration
201 West Preston Street
Baltimore, Maryland 21201
(410) 225-6538

Other Programs

Maryland Access to Care Programs (MAC). The Maryland Access to Care (MAC) Program links Medical Assistance recipients with primary medical providers (PMPs) who provide primary health care and serve as gatekeepers for the provision of specialty care. The included physicians engage in family practice, general practice, pediatrics, and internal medicine, as well as nurse practitioners. Under certain circumstances, another type of specialty physician may be designated as a MAC PMP when it is in the best interest of, and requested by, the recipient. PMPs must have regular office hours, 24 hour call and coverage arrangements, and participate in the EPSDT Program if they serve children. By stressing access to primary care, MAC seeks to promote quality, continuous care and provide recipients with a "medical home." Unlike other States with similar programs, Maryland does not pay a monthly per person management fee. Instead, concurrent with the start of the

MAC Program, office visit fees for primary care were raised by an average of 50%. The decision to raise fees rather than have a monthly per person payment was made after consulting with the leadership of the Maryland physician community.

The MAC Program began December 9, 1991. Currently, there are approximately 210,000 recipients enrolled. MAC is operational under a HCFA waiver and applies Statewide to designated categories of recipients. The MAC Program applies to most Medicaid recipients with 2 major exclusions: 1) Recipients enrolled in a Medicaid HMO and 2) Recipients for whom the State pays Medicare premiums. There are additional exclusions for those enrolled in other Medicaid managed care programs, those in State institutions and foster care, and subsidized adoption cases. A complete evaluation of the Program was conducted by Project Hope under a grant from the Health Care Financing Administration.

CONTACT: Dawn L. Grosshandler, Chief
MAC, Recipient & Provider Ser.
Program Systems & Operation Adm.
Department of Health and Mental Hygiene
201 West Preston Street, Room L-9
Baltimore, Maryland 21201
(410)225-5444

HMOs. The State of Maryland has offered HMO services to recipients since 1975. There are currently 5 HMOs on contract which serve recipients in Baltimore City and surrounding metropolitan counties. The State's most recent contract will open the service area to statewide participation in 1994. There were 88,995 Medicaid recipients enrolled ending fiscal year 1994.

All Maryland Medicaid Programs are regulated by the Department of Health and Mental Hygiene. All HMOs participating in the Medicaid Program must also operate under the regulations established by the Maryland Insurance Commissioner.

Enrollment in HMOs is voluntary. Providers are responsible for direct marketing with the State, providing assistance in the form of mailing and other administrative services. The Department also provides an "HMO Hotline" which functions as a patient advocate.

CAPITATION RATES

Rate setting methodology was developed by independent financial consultants and based on sound actuarial principles. Nineteen different rate categories are developed from fee-for-service equivalents based on eligibility, age and sex. Contracts are negotiated and are currently paid at 95.5% of fee-for-service, including a consideration for administration. There are several risk options

developed by the Department, consisting of catastrophic limits for combined inpatient hospitalization and psychiatric day care.

COMPLIANCE

The program carries out quality assurance activities through annual chart audits conducted by an independent contracted Peer Review Organization. Additionally, the Department performs its own chart audits to assure the HMOs' compliance issues are monitored through the Department's "Hotline."

HMOs are required to directly provide or arrange for all medically necessary services available to fee-for-service recipients under the State plan with the exception of long term institutional nursing care.

CONTACT: Katherine C. Tvaronas
Staff Specialist for the HMO Program
Division of Primary Care
Medical Care Policy Administration
Department of Health and Mental Hygiene
O'Conor Building, Room 120
201 West Preston Street
Baltimore, MD 21201
(410)225-1482

Corrective Managed Care Program. The Corrective Managed Care Program has been in existence since 1984. The purpose of the program is to promote coordination and continuity of health care, to assist recipients in their usage of the health care system appropriately and effectively, and to reduce program costs. Enrollment in Corrective Managed Care has as its basis the identification of recipients with behavioral patterns indicative of potential misutilization. A computer program with constantly refined exception parameters produces reports used to identify recipients whose payment histories suggest possible misuse of benefits. A detailed payment history of health care providers (who delivered the services contacted whenever necessary) is reviewed on each of these recipients by trained medical professionals to determine if a pattern of misuse actually exists. A recipient determined to have misused benefits will be enrolled with a managed care provider and a designated pharmacy for a period of 2 years. During the 2 years, the recipient must secure all health services not otherwise exempted by referral or by regulation directly from the Corrective Managed Care provider and must obtain prescriptions from only the designated pharmacy.

Primary care physicians and community health centers are enrolled as Corrective Managed Care providers upon agreeing to participate in the coordination of health

care for assigned recipients. Each provider must meet specific conditions of participation including 24 hour/seven day a week coverage and a minimum number of scheduled office hours. In addition to any customary FFS furnished to the Corrective Managed Care Provider for services to an enrolled recipient, the provider is also paid a retainer fee of $5 per month per assigned recipient regardless of whether the recipient utilizes services that month.

Currently, there are 2,000 recipients in Corrective Managed Care and 500 participating providers.

CONTACT: Rosalie, Koslof, Chief
Division of Utilization and Eligibility Review
Medical Care Compliance Administration
Department of Health and Mental Hygiene
2nd Floor- O'Conor Building
201 West Preston Street
Baltimore, MD 21201
(410) 225-5705

Diabetes Care Program (DCP). DCP is available to a recipient who has diabetes, has been discharged from a hospital inpatient stay for a diabetes-related diagnosis, and meets other specific requirements (e.g., is not a Medicare beneficiary, a nursing facility patient, or HMO enrollee). Enrollment is voluntary, but once enrolled in DCP the recipient must obtain health care from a single diabetes primary care provider (PMP) or upon referral from that provider to other providers. Unlike the Corrective Managed Care program described above, an enrollee is not restricted to a single pharmacy. The program is designed to operate statewide under a HCFA waiver and was implemented on June 1, 1991. Approximately 2,500 recipients are currently enrolled in the Program.

Enrollees may receive additional services which are not available to non-enrollees. These services include diabetes outpatient education, nutritional counseling, and therapeutic footwear, as well as items of disposable medical supplies and durable medical equipment usually available only to insulin-dependent diabetic recipients. Recipients enter the program by signing a voluntary enrollment form which may be obtained from the Program or from hospital discharge staff. Hospitals are required to notify the DCP of every recipient who is discharged after inpatient treatment of a diabetes-related condition. Recipients are enrolled for an indefinite period of time but may change their primary medical provider or terminate their participation at any time.

A diabetes primary medical provider (PMP) must meet special requirements in addition to meeting the basic Maryland Medicaid qualifications as a physician services provider in a private or group practice, a nurse practitioner, or a free-

standing clinic. PMP physicians and nurse practitioners are required to take a continuing medical education course on diabetes management within 12 months of beginning to provide services to recipients. Each primary medical provider must sign an agreement to provide coordination of health care for assigned recipients and to maintain a minimum number of scheduled office hours and 24 hour/seven day a week coverage. A monthly managed care fee of $20 per enrollee is paid to the PMP irrespective of service delivery during the month. Diabetes nutrition counseling must be rendered to program participants by licensed nutritionists or dieticians, and diabetes outpatient education must be furnished by a provider certified by the Office of Chronic Disease Prevention of the Maryland Department of Health and Mental Hygiene. There are 500 primary Care providers statewide participating in the Program.

CONTACT: Rosalie Kosloff
Division of Utilization and Eligibility Review
Medical Care Compliance Administration
Department of Health and Mental Hygiene
2nd Floor - O'Conor Building
201 West Preston Street
Baltimore, MD 21201
(410) 225-5705

MASSACHUSETTS

The Massachusetts Division of Medical Assistance is in its third year of implementing MassHealth Managed Care, a comprehensive program that affects over 460,000 of the state's 640,000 Medicaid recipients. The program has 4 principal components: the Primary Care Clinician Plan, the Mental Health and Substance Abuse Program, the HMO Program, and the Health Benefits Management Program. The first 2 components operate under a 1915 (b) Waiver. In Managed Care, recipients choose either an HMO or a Primary Care Clinician.

Primary Care Clinician Plan

The Primary Care Clinician (PCC) Plan is based on primary care case management. PCCs provide primary and preventive care and authorize most other medical services for patients enrolled with them. Over 2,800 physicians are now enrolled in the program. They represent capacity to serve twice the state's number of Medicaid recipients. As of July 1994, the total number of recipients enrolled with PCCs was 246,000.

The goals of the PCC Plans are to:

- o Increase access to preventive and primary care;
- o Improve quality, continuity and appropriateness of care; and
- o Improve program cost-effectiveness.

An independent assessment of the PCC Plan found that it saved significantly more money (7%) than originally estimated, while making significant progress toward improving access and quality.

The evaluation tools which the Division utilizes to measure the quality of the program include patient and PCC satisfaction surveys, service utilization reports, and clinical quality measures which highlight key program objectives and identify opportunities for improvement. Asthma treatment, preventive care for children, and use of hospital emergency rooms are some of the clinical areas currently being analyzed.

PCC compensation is not currently risk-based. There are financial and administrative incentives for participating providers. PCCs receive an additional reimbursement of $10 per enrollee visit for primary and preventive care.

Network management and development of risk-based reimbursement will be areas of special emphasis over the next year.

Mental Health/Substance Abuse Program

The Mental Health/Substance Abuse (MH/SA) Program seeks to ensure recipient access to medically necessary services in the most clinically appropriate, cost-effective settings. In its evaluation of the program, the Division focuses on the efficiency of treatment, in terms of recipient satisfaction, functioning and well-being.

Recipients participating in the MassHealth Managed Care initiative receive their MH/SA benefits in 1 of 2 ways. Those in an HMO receive MH/SA benefits through that HMO. Recipients enrolled with a medical provider receive their benefits through the Division's contractor, namely Mental Health Management of America, Inc. (MHMA). MHMA is reimbursed on a shared-risk, per capita basis. In July 1994, there were 383,000 recipients enrolled with MHMA. MHMA services can be obtained without a PCC's referral.

MHMA has established networks, through selective contracting, for outpatient and acute inpatient services. MHMA also does service authorization and utilization review for both inpatient and outpatient services, processes and pays claims, and procures diversionary services that were formerly non-reimbursable by Medicaid.

An independent evaluation of the MH/SA Program, conducted by Brandeis University, concluded that the program realized savings of 22% ($47 million) in fiscal 1993 while expanding access and preserving quality of care.

Three major initiatives are scheduled for implementation over the next year: 1) Quality Management Program - includes training of **MHMA** staff in the principles, tools, and techniques of **CQI**, and the formation of quality improvement teams to address issues of recidivism, linguistic barriers to services, and the needs of special populations, e.g. the dually diagnosed, children and adolescents, 2) Network Management - includes the development of data-based performance profiles for all service types, to be used as the basis for a goal/improvement-oriented management process. 3) Intensive Clinical Management Program-includes an internal treatment planning and tracking function combined with community-based support teams capable of delivering flexible services to identified high risk recipients.

HMO Program

The **HMO** Program contracts with 14 **HMO**s, and with 2 contractors for care of the severely physically disabled and to persons with end-stage **HIV/AIDS**. Recipient enrollment in the **HMO** program is voluntary and recipients may choose to transfer

enrollment to a different **HMO** or to a **PCC** at any time. As of July 1994, over

93,000 recipients were enrolled in **HMOs.** The **HMO** network includes Independent Practice Associations **(IPAs),** and staff, group and mixed model plans. The network comprehensively covers the entire state.

The **HMOs** function according to the principles of Total Quality Management/Continuous Quality Improvement. Furthering those principles, the HMO Program's standard agreement requires HMOs to: (1) meet pre-defined purchasing specifications regarding key aspects of health care delivery, and (2) develop and pursue quality improvement goals.

There are Purchasing Specifications for: Access, Quality, Mental Health Care, and Financial Stability. Improvement Goals focus on areas in which there are opportunities to improve the structure, process and/or outcome of providing care to enrollees. Goals are negotiated annually and may address clinical quality, cost-effectiveness, enrollee satisfaction or other areas. Improvement Goals have focused on issues of high priority to the Medicaid population such as **EPSDT,** prenatal care, asthma, HIV/AIDS, and well-child and adolescent services.

Health Benefits Management Program

The objective of the Health Benefits Management **(HBM)** Program is to meet the indicated health care needs of recipients by educating them about and assisting them in their selection of a health care provider from a range of Managed Care options. To accomplish this, the Division has contracted with Foundation Health Federal Services, Inc. The Foundation has placed trained HBMs in local offices and staffs a central site accessible via a toll-free telephone number.

HBMs conduct recipient health assessments, either in person or over the telephone, and then provide recipients with information about the HMOs and PCCs serving the recipients' areas. Locations, hours, special services, language capability and other information is made available. The recipients' questions are answered and they are encouraged to make a choice. Those who do not do so within 30 days are assigned to a PCC. Assignment protocols take into account each recipients' claims history, geography, language capabilities and age.

The conversion enrollment of the eligible population to Managed Care took over 2 years. Special outreach efforts were used to reach recipients in the disability aid categories.

In early 1995 a new HBM Program vendor contract will go into effect, which will add 2 new functions affecting all of the Division's beneficiaries: a customer service function and prior authorization of recipients' transportation to medical care.

Massachusetts has applied for an 1115 Waiver to implement a statewide health care reform initiative which includes subsidies for low-income workers' purchase of health insurance, partial reimbursement to their employers for contributing to the payment of that insurance, a streamlining and expansion of Medicaid eligibility, and special programs for low-income disabled and unemployed persons. Under that waiver, MassHealth Managed Care would be continued and expanded.

CONTACT: Michael Bailit, Assistant Commissioner
Managed Care Contracts and Development
Massachusetts Division of Medical Assistance
600 Washington Street
Boston, MA 02111
(617)348-5510

MICHIGAN

HMOs. The Medical Services Administration (MSA) of the Michigan Department of Social Services (MDSS) has contracted with HMOs to provide Medicaid (MA) covered health services since 1972. From the beginning, this program has been a successful means of containing Medicaid expenditures. Through 1986, the State has realized an estimated cost savings of $ 48,000,000 representing the difference in Medicaid expenditures of HMO enrollees as compared to expenditures for FFS recipients. Estimated savings for 1989 are $12,600,000 and for 1990 are $14,900,000. MDSS contracts with 8 State licensed and 7 Federally qualified HMOs in 12 Michigan counties with a current MA enrollment of 221,863 Medicaid recipients.

Contracting. MDSS actively seeks contracts with licensed HMOs in Michigan. Dialogues are initiated by MDSS and the HMOs; contract terms and capitation rates are shared.

MSA provides the HMOs with utilization and expenditure data. This enables the HMOs to compare service activity and costs of their enrollees with the Medicaid FFS market upon which the HMO payment rates are based.

Every other year MSA conducts onsite inspections for contract compliance. The HMOs are required to submit various articles for review (e.g., current approved Medicaid marketing material, updated listings of subcontractors). While onsite, MSA staff review the claims processing system, insurance policies, random samples of grievances filed and other pertinent items as needed. Upon completion of the onsite inspections the HMO receives a report of the findings.

From 1972 through 1979, HMOs were contracted on a cost basis since Federal regulations required that HMOs must be Federally qualified to be reimbursed under a risk contract. The cost settlement process was extremely cumbersome and continued well beyond the contract period involved. By 1980, contracts were established on a risk basis. Contracts are designed as a yearly document. Yearly changes are made as mandated by Federal and State laws; capitation rates are also updated each year. The contracts are standard and cover a calendar year.

Marketing. Marketing the HMO option to Medicaid recipients has been one of the most difficult problems. Initially, marketing was largely left to the contracted HMO. MDSS assisted only to the extent of providing names and addresses of Medicaid recipients within the area serviced by the HMO. HMO staff used a door-to-door approach in contacting these recipients. This approach was successful in enrolling a significant number of Medicaid recipients. However, it was discontinued when the Michigan Attorney General ruled that releasing recipient names and addresses breached confidentiality.

Through 1978 and 1979 several different marketing approaches were used. HMOs would market door-to-door in areas know to have a high concentration of Medicaid recipients. Efforts were made to enroll Medicaid recipients who were seen in an HMO clinic on a FFS basis. Also, former enrollees who had become ineligible for Medicaid were periodically recontracted to determine of they had regained eligibility.

Lately, MDSS has taken a more active role in marketing the HMO option. A brochure comparing HMO membership to FFS Medicaid was developed. This was provided to recipients at the time Medicaid eligibility was redetermined. A release form could be signed by the grantee to request additional information. The signature allowed MDSS to release the grantee's name, address and phone number to area HMOs for the purpose of providing this additional information. This "dual choice" project, however, did not prove to be successful in enrolling a significant number of recipients and has been discontinued.

Another pilot effort involved direct solicitation of Medicaid recipients at 2 MDSS local offices by an HMO/MDSS team. This effort also failed to result in significant numbers of new enrollees.

Mass mailings (at the HMO's expense) to Medicaid recipients for specific HMOs in an approach was used until recently. In this approach, the HMO provided MDSS with marketing materials to mail to eligible Medicaid recipients in a specified area. Interested recipients would then contact the HMO for future information.

The MDSS now mails a booklet with an enclosed enrollment form directly to the recipients offering the various Managed Care plan(s) to choose from. The recipient fills out the enclosed enrollment form and mails it back to MDSS for processing.

Enrollment. Most Medicaid recipients who live in an HMO service area have the option to voluntarily enroll in an HMO. However, a recipient cannot be enrolled in an HMO when the recipient is:

- o confined to an institutional setting (e.g., long term care facility of hospital);
- o active in the Crippled Children Program;
- o enrolled in another HMO; or
- o an active General Assistance client.

Michigan operated under a Federal waiver of §1903(m) permitting a lock-in for 6 months until December 31, 1983. As of January 1, 1984, HMO enrollees could elect to disenroll at any time.

The lock-in was reinstated effective July 1, 1987. This lock-in has 2 open window

periods (May and November) for disenrollment. If a recipient chooses not to disenroll during these time periods then he/she must wait until the next open window period to disenroll.

Services. The HMO must provide at a minimum the Medicaid covered services listed in the Medical Assistance Program Manuals. The HMO either directly renders or authorizes all contracted medical services. If the Medicaid recipient requires non-covered services (e.g., long term care), he/she is disenrolled from the HMO and receives the service in the FFS environment. The recipient can receive dental services from a FFS provider the remain an HMO member.

Services Covered by HMOs	Services not Covered by HMOs
Ambulance	Hospice
Family Planning	Long Term Care
Hearing Aid Dealers	Dental Services (with the exception of oral surgery)
Home Health	
Hospital	
Laboratory	
Medical Supplies	
Methadone Maintenance	
Pharmacy	
Physician (including chiropractor and Podiatric)	
vision	
Dental (oral surgery)	

Rate Setting. The MDSS capitation rates are based on the FFS costs of a like population for covered services for the contractor's service area. The MDSS rate-setting system provides recipient-based cost and eligibility data specific to county, program of assistance, age, and sex. The initial data base in capitation rate calculation is the most recent calendar year (date of service) cost and eligibility data. Any adjustments to the program effective with the new fiscal year will be reflected in the new contract year. Other adjustments to the rate-setting system consist of: gross adjustments, undifferentiated charges, administrative expenses, and copayments. Income investment and incurring factors are also included as adjustments to the data base. The final projected total is then dispersed into the age/sex/program rate categories, and the estimated average per capita cost is calculated by the MDSS. This reimbursement is from 90 percent to 98 percent of the FFS based on a comparison of the FFS costs in the rate-setting region to the highest rate-setting region.

Reimbursement. The individual enrollee capitation is paid through the Medicaid invoice processing system via submission and processing of paper invoices or magnetic tape for individual enrollees each month. The program's Remittance Advice services as a vehicle for payment and documentation of eligible enrollees.

Prior to February 1983, invoices were processed in the month prior to the month for which capitation was being paid. This prepayment resulted in reimbursement for enrollees subsequently determined ineligible. In February 1983, payments were changed to the month of capitation.

While the Remittance Advice still serves as the payment vehicle, a listing of HMO eligible enrollees had to be created. It is produced and mailed to the HMOs before the first of each month. Effective June 1, 1986, MSA agreed to force payment for all enrollees whose names appear on this list. Certain exceptions were made, i.e., admission to a LTC facility or State institution, eligibility for crippled children or General Assistance, death, or moving out of the service area.

Role of Other State Agencies. Under State law in Michigan, 2 State agencies have responsibility for HMOs, namely the Department of Public Health (MDPH) and the Insurance Bureau of the Department of Licensing and Regulation.

The MDPH is primarily responsible for monitoring the health care delivery system of HMOs. Such activities encompass medical record requirements, quality assurance programs, physical plant, provider staffing, delivery system (including required services and subcontracts for all referral services), service area, utilization reporting, and enrollment activity. The MDPH conducts periodic onsite inspections of medical records, physical plant, peer review activity, and quality assurance programs. HMOs are required to submit quarterly and annual reports to the MDPH providing aggregate utilization data and enrollment data. Further, the MDPH informs the MSA of HMO related matters. This encompasses notification of applications for intent and licensure, service area expansion, and physical plant expansion. Copies of aggregate utilization reporting and enrollment data are provided as well as copies of medical record reviews and quality assurance program reviews and, when necessary, deficiency reports, corrective action requirements, and follow-up reviews.

The insurance Bureau is primarily responsible for monitoring the financial condition of HMOs. The Insurance Bureau must approve all private market premiums (capitation rates) and is responsible for monitoring marketing practices and grievance programs and procedures. Further, the Insurance Bureau is responsible for monitoring reinsurance programs as well as general liability insurance, worker's compensation, and employee benefits programs. HMOs are required to file an annual report of grievance statistics as part of the annual financial report. The Insurance Bureau conducts periodic audits.

CONTACT: Mark Verleger, Manager
Provider Operations Section

Medical Services Administration
400 S. Pine Street
Lansing, MI 48909
(517) 335-5500

Medical Assistance/Clinic Plan Program. MSA implemented the Capitated Clinic Plans (CPs) in April of 1983 on a pilot basis. The clinic plan program operates under waivers of specific Federal regulations per requirements if §1915(b), 1902(a)(1),1902(a)(10), 1902(a)(23) and 1902(a)(30) of the Social Security Act.

On two separate occasions MSA solicited applications, once in 1982 and then again in 1986. An interdepartmental review committee reviewed the applications for various information and documentation, for example, prior experience in ambulatory health care, referral network, documentation of financial viability, etc. Those that met the criteria were accepted.

The program permits Medicaid recipients to select and enroll voluntarily in participating clinics and physician group practices to receive all their ambulatory and physician care. This program has been a successful means of containing Medicaid expenditures. The State has realized a 12% cost savings in Medicaid expenditures for CP enrollees compared to FFS recipients. MDSS contracts with 3 CPs in 4 Michigan counties with a current MA enrollment of 21,268 recipients.

Program Structure. A Clinic Plan is a program of partial capitation. Most ambulatory services are reimbursed through capitation while payments of inpatient hospital facility charges are the responsibility of the State. CPs authorize inpatient hospital admissions and services and share in any savings accrued as a result of the program. An incentive/bonus payment is paid the contractor if costs are less than 80 percent of what was expected if the recipient had been in FFS. The contractor's bonus is equal to 50 percent of the difference between actual cost and 80 percent of expected cost (there is no penalty if the CP inpatient costs are higher).

Contracting. MDSS contracts with CPs in Michigan on a periodic basis. Dialogues are initiated by MDSS and the CPs; contract terms and capitation rates are shared. Contracts are designed as a yearly document. Yearly changes are made as mandated by Federal and State laws; capitation rates are also updated each year. The contracts are standard and cover a calendar year.

Marketing. Marketing is primarily the responsibility of the CP. MDSS is responsible for determining the Medicaid eligibility of each enrollee and for notifying the CP of any changes in an enrollee's eligibility.

Each CP must conduct its marketing so that recipients are provided with adequate information to make an informed choice. The CP must assure that each recipient understands how to use the plan, including the restrictions on out-of-plan use. All marketing materials and procedures must be submitted to MDSS for approval prior to use.

The CP may offer additional services to the recipients as an incentive to enroll in the plan.

Enrollment. Most Medicaid recipients who live in a CP service area have the option to voluntarily enroll in the CP. However, a recipient cannot be enrolled in a CP when the recipient is:

- confined to an institutional setting (e.g., long term care facility or hospital);
- active in the Crippled Children Program;
- Enrolled in another managed care program; or
- an active General Assistance client.

Services. The CP must provide at a minimum the Medicaid covered services listed in the Medical Assistance Program Manuals. The CP either directly renders or authorizes all contracted medical services. If the Medicaid recipient requires non-covered services (e.g., long term care), he/she is disenrolled from the CP and receives the services in the FFS environment. The recipient can receive dental and inpatient hospital services from a FFS provider and remain a CP member.

Services Covered by CPs	Services Not Covered by CPs
Ambulance	Hospice
Family Planning	Long term care
Hearing Aids	Dental (except for oral surgery)
Hearing and Speech	Inpatient Hospital
Home Health	Community Mental Health
Hospital (outpatient) including emergency room services	
Laboratory	
Medical Supplies	
Methadone Maintenance	
Pharmacy	
Physician	
Vision	
Dental (oral surgery)	

Rate Setting. The MDSS capitation rates are based on the FFS costs and eligible

months of a like population receiving covered services in the contractor's rate setting area. The MDSS rate-setting system provides recipient-based cost and eligibility data specific to county, program of assistance, age, and sex. The initial base in capitation rate calculation is the most recent complete calendar year (date of service) cost and eligibility data. All program changes impacting CPS are incorporated into the rates. Other adjustments to the rate-setting system consist of gross adjustments, undifferentiated charges, administrative expenses, and copayments. Income investment and incurring factors are also included as adjustments to the data base. The final projected cost total is then dispersed into the age/sex/program rate cells, and the estimated average per capita cost is calculated by the MDSS. This reimbursement is 100 percent of FFS reimbursement. Inpatient target rates are set using the same methodology. Inpatient target rates are at 80 percent of FFS capitation rates and are also based on age/sex/program cells.

Reimbursement. The individual enrollee capitation is paid through the Medicaid Invoice Processing system via submission and processing of paper invoices or magnetic tape for individual enrollees each month. The program's Remittance Advice services as a vehicle for payment and indicates resolution of each claim.

While the Remittance Advice serves as the payment vehicle, a listing of eligible CP enrollees is sent to the CPs each month. It is produced prior to the first of the month and lists all enrollees having eligibility for the subsequent (report) month. Enrollees whose cases are in negative action (in review) at the time the report is produced do not appear on the report. Because case action is taken on an ongoing basis, the reports are not totally accurate on the first of the month. Effective June 1, 1986, MSA agreed to force payment for all ineligible enrollees whose names appear on this list. Certain payment exceptions were made, i.e., admission to LTC facility or State institution, eligibility for Crippled Children or General Assistance, death, or moving out of service area.

CONTACT: Mark Verleger, Manager
Provider Operations Section
Medical Services Administration
400 South Pine Street
Lansing, MI 48933
(517) 335-5500

Medicaid/Physician Sponsor Plan (PSP) Program. PSP was implemented July 1, 1982, in Wayne County, Michigan. The plan was devised by the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons in response to a legislative request for a proposal outlining an alternative

reimbursement approach. The costs of Medicaid were rising at a rate exceeding that of inflation. Physicians were paid on a FFS basis. Clients received a Medicaid card which could be used to access Medicaid covered services with very few limitations, such as normal copayments on some services and prior authorization needed on certain services such as dental and durable medical equipment.

The Plan. The PSP proposal submitted by the medical societies retained FFS reimbursement but differed significantly from the existing delivery system. Under the PSP, each client selects a primary care physician who becomes the client's physician sponsor. The sponsor either directly renders or authorizes most medical services. Some services do not require an authorization. These are: emergency services, chiropractic, podiatric, hearing, clinic, nurse midwife and dental. Radiology, pathology and pharmacy services to not require direct authorization but must be ordered by a physician who must have an authorization. The sponsor receives a case management fee of $3 per month per enrolled recipient (to a maximum of $3,000 per month). This fee is to offset the cost of maintaining a 24 hour access system, reviewing periodic utilization reports and establishing a referral mechanism. Continuation of the fee is contingent upon program savings. The selected sponsor's name will appear on the client's Medicaid card and remain there until either the sponsor or the recipient requests a change.

The Contract. All doctors in and around the Wayne County demonstration area were sent an application. Any doctor can be a sponsor but the doctor must have a primary care mode of practice or agree to render primary care to his/her enrollees. The contract is a 1 year, renewable document. It outlines the responsibilities of both the physician sponsor and the department. It also details contract sanctions.

Contract compliance is monitored in 2 ways. First, enrolled recipients and medical providers call in complaints. All complaints are investigated and may lead to contract sanction or termination. Second, an analyst does onsite reviews using protocols developed for PSP contract compliance. The visit is also used as a tool to educate physician sponsors about the concept of managed care.

Enrollment. Enrollment is mandated for all AFDC and AFDC-related Medicaid eligibles in Wayne County with the following exceptions:

- long term care patients;
- recipients active in the Cripple Children Program in foster care;
- recipients already enrolled in a medical care management program (HMO or Clinic Plan); or
- recipients in the Recipient Monitoring Program.

Recipients may change sponsors upon request. Except in unusual circumstances,

the change will take from 2 to 6 weeks to effect. Recipients may request an enrollment exception.

Marketing. The recipient marketing process has gone through several stages. Several methods have been found effective. Clients may enroll through their doctor's office. The sponsor has enrollment forms designed by the DSS and provided to the sponsor. AFDC clients must complete a form at eligibility determination and at redetermination. Periodic mailings include an enrollment form/mailer. Clients who do not respond to the mailer are assigned.

Requests for Proposal for the Managed Care Entry Plan (MCEP) have been mailed out to all participating HMOs, PSP doctors and Clinic Plans to submit proposals to become an entry plan provider. The MCEP providers will be assigned those recipients who fail to designate a choice within the prescribed time period. The providers are bidding on a geographic area; the price is not an issue. A maximum of 27 MCEP providers will be chosen. Once enrolled with the MCEP provider, the recipient continues to have the right to request a change or an exception. However, the MCEP enrollment will remain until the recipient takes a positive action.

Monitoring. To assess the impact of the PSP upon recipients, the DSS has contracted with an independent agency to monitor the implementation and the effect upon client access to care. Peat Marwick, the most recent contractor, would regularly survey recipients 6 weeks after enrollment and again 6 months after enrollment to ascertain the recipient's experience under the plan. The contractor also monitors the sponsor's 24 hour availability. Problems encountered are reported to a Monitoring committee and recommendations for resolution are given to the department. Individual problems are referred to the Sponsor Specialist Office for resolution. The Monitoring Contract is currently in the bid process.

Education. The PSP represents a shift in the way recipients receive care and also in the way physicians provide care. For this reason, educational information is supplied on a regular basis. Clients receive written booklets describing their options and how to use the system. A Tele-Med tape and video are also available.

Physicians receive program bulletins. There is also a provider Tele-Med tape. The Sponsor News is a publication produced periodically to provide educational material in an informal, interesting format.

The managed care staff is available to assist in the enrollment process and to intervene if problems arise. Phone access is available 9 hours per day.

Michigan appropriations bill annually directs the DSS to continue implementation of

the plan.

Evaluation. The PSP was initially evaluated under a 3 year HCFA grant. For 1983 and 1984, to study compared like populations of enrolled and non-enrolled recipients. Cost effective care was evident for enrolled recipients. A net savings of $108 per person per year was experienced. The savings were driven by AFDC clients aged 15 and above. There was a cost increase for AFDC children aged 14 and below. There was no significant change for SSI clients.

A second evaluation for 1986 used a different design approach. A per person rate was established for enrolled and non-enrolled recipients within the county using HMO rate setting age/sex/program cells. Considerable (12%) cost savings were apparent, but the study design was flawed because other variables, e.g., adverse selection, were not controlled. The study results confirmed cost effectiveness but the next evaluation design will address questions left unanswered with this study. A third evaluation looking at the 1988 and 1989 experience is now in progress.

Legal Base. The PSP is operating under waivers of the Social Security Act. Waiver of §1902(1) (1), (7), (10) and (23) were authorized under the authority of §1915(b) (1) of the Act. The Michigan appropriations bill annually directs the DSS to continue implementation of the plan.

CONTACT: Mark Verleger, Manager
Provider Operations Section
Medical Services Administration
400 S. Pine Street
Lansing, MI 48909
(517) 335-5500

MINNESOTA

Prepaid Managed Care Program

The Minnesota Prepaid Medicaid Assistance Program (PMAP) provides managed health care under the original mandatory demonstration design in 4 counties: Dakota, Hennepin, Ramsey, and Itasca. Approximately 123,000 recipients currently receive services through the PMAP, out of Minnesota's total Medicaid population of about 410,000. Implementation of the PMAP to Anoka, Carver, Scott, and Washington Counties is slated to begin in September 1994, and plans are in progress to expand the PMAP to several additional counties.

Medicaid (MA) recipients have a choice of health plans in all PMAP counties except Itasca. These health plans contract with the State to provide the full array of MA services in exchange for a capitated payment rate that is based on the State's experience in providing health care under the fee-for-service (FFS) program. In Itasca County, the program is somewhat different. The county acts as the health plan and is responsible for managing health care services provided to the county's MA recipients, who select a primary care provider from the county's network.

All PMAP enrollees are locked into the program for a period of 1 year. However, they are permitted to change health plans once during the initial year of enrollment. In addition, enrollees have the opportunity to change health plans during the open enrollment period in the fall of each year.

Besides the mandatory programs, a voluntary PMAP program is offered for MA recipients who live in the non-PMAP counties in the metropolitan area and in Lake County in northeastern Minnesota. Approximately 4,200 recipients are currently voluntarily enrolled in the PMAP. As the mandatory PMAP expands to the voluntary counties, the voluntary PMAP programs will be discontinued.

The PMAP and voluntary PMAP provides services for AFDC pregnant women, needy children, and elderly populations in Minnesota. At present, disabled populations under age 65 do not receive services through managed care contracts. Other specified groups who have complicating circumstances or special delivery needs are also excluded from the PMAP, such as foster children and new immigrants.

In certain counties, MA/Medicare elders can choose to enroll in Seniors Plus, the Social HMO demonstration project which is a cooperative venture between Group Health, Inc. (HealthPartners) and the Ebenezer Society. Seniors Plus provides for acute and long term care services for enrolled seniors, as well as social and supportive services.

Minnesota has a Robert Wood Johnson Foundation grant to develop an integrated service system for seniors. This project is referred to as the Long Term Care Options Project. Minnesota is also considering managed care models for persons with disabilities, is planning a dental managed care program for non-PMAP counties where dental access problems exist, and is preparing for expansion of managed care to the state-subsidized acute care Minnesota Care populations.

In a program similar to the PMAP, managed care services are provided to about 15,000 of Minnesota's approximately 55,000 state-funded General Assistance Medicaid Care recipients. This Prepaid General Assistance Medical Care (PGAMC) program is operational in Dakota, Hennepin, Ramsey, Lake, and Itasca Counties. The PGAMC will be expanded to include the same counties that are slated for PMAP expansion.

In terms of external reviews, Minnesota complies with the provisions of OBRA '86 which requires review of the States' managed care plans by independent accreditation organizations. This year the National Committee for Quality Assurance is conducting the quality assurance audit in conjunction with the Quality Assurance Reform Imitative (QARI). Minnesota is 1 of 3 states funded through the Kaiser Family Foundation to participate in the QARI project.

Managed Fee-for-Service Program

Through its Primary Care Utilization Review Program, the State identifies high users of medical services whom the State believes would be better serviced by having their health care managed. Such recipients are placed in a special recipient restriction program and their primary care providers case manage their use of medical services.

Minnesota uses a prior authorization system as one of its mechanisms for managing health care. Prior authorizations are required for specified expensive, unusual, high use, or high cost items and services.

To better manage its health care costs, Minnesota purchases many items in bulk. These volume-purchase items include eyeglasses, hearing aids, oxygen, and wheelchairs.

CONTACT: Kathleen Schuler, Acting Director
Managed Care Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155-3854
(612)297-4668

Patricia MacTaggart, Divisional Director
Health Care Delivery
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155-3854
(612)297-4113

MISSISSIPPI

In January 1993, the Mississippi Division of Medicaid received approval of a waiver to implement a primary care case management program named HealthMACS. Certain Medicaid recipients choose and enroll with, or are assigned to, a primary care provider (PCP) who manages their health care needs through provision of primary care, after-hours coverage, appropriate referrals for specialty services, and authorization of most Medicaid services. The PCP is paid a monthly case management fee of $3.00 for each recipient enrolled, and the usual fee for Medicaid services provided. The specified Medicaid recipients must participate in HealthMACS if they live in a county in which HealthMACS has been implemented, unless excluded in certain circumstances.

HealthMACS is being implemented on a pilot basis in 7 counties for about 32,000 Medicaid recipients prior to statewide implementation. Some recipients are enrolled by automated means based on historical usage of participating Medicaid providers. Enrollment of most other recipients occurs at regular or special redeterminations of eligibility during the next 6 months and at initial approval. Enrollment began in Washington County on August 23, 1993 and the first HealthMACS Medicaid cards were issued for October. Enrollment began May 23, 1994 in Covington, Jefferson Davis, and Lawrence counties with the first HealthMACS Medicaid cards being issued for June. As of July 1994, there are 7,356 recipients enrolled in HealthMACS. Implementation in Warren County will be effective for October 1994 Medicaid cards, and in Claiborne, and Jefferson Counties for December 1994 Medicaid cards. Expansion to other counties will begin in early 1995.

Specified categories of Medicaid recipients who currently must participate in HealthMACS are Aid to Families with Dependent children (AFDC) and 4 Medicaid-only programs that cover pregnant women and children. These recipients are enrolled at the county offices of the Mississippi Department of Human Services (MDHS) by Economic Assistance workers. Foster children and children for whom adoption assistance is provided will be phased-in later since eligibility is determined by state office staff of the Division of Social Services, MDHS. Recipients will be enrolled by staff of that Division either at the county or state office. When these populations are enrolled statewide, work will begin to include all other Medicaid recipients, such as those whose eligibility is determined by the Division of Medicaid and the Social Security Administration.

Recipients in the above categories of Medicaid eligibility are excluded from participation in HealthMACS if:

1) Medicaid eligibility is retroactive only; 2) recipient resides in a nursing or ICF/MR facility, or a mental hospital; 3) good cause exists because the recipient has a pre-existing relationship with a physician who is not a HealthMACS provider or

extensive travel time from the recipient's home/work to a HealthMACS provider.

HealthMACS enrollees have the same range and amount of services as other Medicaid recipients. There are some services that do not require the prior or post authorization of the PCP, but are obtained through the same procedure as used by other Medicaid recipients. These excluded services are dental, psychiatry, ophthalmology, optometry and eye glasses, podiatry, hearing aids, family planning, nursing home and ICF/MR, and general transportation and ambulance/wheelchair van. Although emergency services for a true emergency are covered by HealthMACS, emergency services do not require prior authorization by the PCP and may be authorized after the services are rendered.

PCPs may be physicians who are family or general practitioners, pediatricians, internists, obstetricians, or gynecologists; physician group practices, federally qualified health centers, rural health clinics, and Health Department Clinics; and pediatric, adult and family certified registered nurse practitioners. All PCPs must be Medicaid providers in good standing. Individual physician PCPs and HealthMACS physicians in a clinic/center must also have hospital admitting privileges. Certified registered nurse practitioners must be associated with a HealthMACS physician who has approved the protocol.

PCPs may specify the number of HealthMACS enrollees they will accept, as long as the number does not exceed the maximum number established by the Division of Medicaid. A physician provider may have no more than 500 enrollees; and a clinic/center may have no more than 1,500 times the number of full-time equivalent participating physicians plus 500 times the number of participating certified registered nurse practitioners. The Division of Medicaid may waive the upper limit on enrollees per PCP, if the PCP agrees, in order to secure adequate coverage or when other factors necessitate such action.

Prior to the beginning of each month, a PCP receives a report of enrollees for the coming month. The report lists current enrollees with new enrollees flagged, and enrollees from the previous month who are no longer enrolled. Following the end of each month, the PCP will receive a report of Medicaid services provided his/her enrollees by other providers. The PCP will be responsible for reviewing the report and notifying the Division of Medicaid of any errors and/or any services reported that were not authorized. Utilization reports generated at least quarterly will compare the PCP to others of his/her specialty and with all other PCPs. These reports will be used by the Division of Medicaid to determine whether medical audits/reviews are needed.

When HealthMACS is implemented in a location, the PCP is responsible for providing or referring for EPSDT services. However, in other counties a physician provider may enter into a written agreement with the Division of Medicaid to

provide continuing care services through the EPSDT program. The parent or other responsible party must agree in writing to participate in the continuing care arrangement that allows the physician to be the sole provider of EPSDT services. The designated screener is the only EPSDT provider to receive payment for well child services. It does not prevent on-call relief or any other physician from being paid for emergency or any other physician charges. A case management fee is paid annually for maintaining the child's medical records and any reports from specialists to whom the child was referred for services not usually provided by the continuing care physician.

CONTACT: Judith Michael
Director of Managed Care
Division of Medicaid
Suite 801, Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201-1399
(601) 359-6133

MISSOURI

Missouri currently has one 1915(b) waiver to provide managed care in Jackson County, Kansas City, Missouri, and has submitted an 1115 waiver to establish Managed Health Care statewide. Missouri's existing 1915(b) waiver provides a health care delivery system for recipients of Aid to Families with Dependent Children (AFDC) whereby primary care services are provided by 4 prepaid health plans and approximately 29 individual physicians, called physician sponsors.

History

The program originally began under a 4 year Federal demonstration grant approved in July 1982. Actual enrollment into the program began in January 1984, with full enrollment achieved in the first quarter of 1985.

Enrollment

Enrollment in the Managed Health Care Program is mandatory for all AFDC determined eligibles. As individuals apply to receive AFDC, they attend a presentation of the Managed Health Care Program. Employees of the Department of Social Services, Division of Medical Services (DSS/DMS) explain the program guidelines and available options in order that a well-informed choice of provider can be made by each individual. Choice counseling presentations are monitored to ensure the information given remains complete, accurate, and unbiased. Individuals are encouraged to select the health plan or physician sponsor which will best meet their needs. As of July 1, 1994, there were approximately 42,062 individuals enrolled.

Physician Sponsor Option

Physician sponsors are independent physicians who have chosen through the Managed Health Care Program to act as case managers for their enrollees. They provide primary care and refer enrollees for specialty care and hospitalization as necessary. Physician sponsors are reimbursed on a fee-for-service basis, though they also receive an additional $3.00 per enrollee per month for serving as the case manager. As of July 1, 1994, there were 8,923 recipients enrolled with 29 physician sponsors, or 21% of the total eligible Managed Health Care population residing in Jackson County.

Prepaid Health Plan Option

In the Managed Health Care Program, a prepaid health plan is a provider that offers health care of either 1 or several locations or at individual physicians' offices. The plan assumes contractual responsibility to provide or assure delivery of a stated

range of services for its enrollees.

Each health plan is then paid a monthly capitation rate per enrollee based on age, sex, and historical utilization data. This payment is received by the plan regardless of whether the cost of actual services provided to their enrollees is less than or exceeds the capitation amount, thus, presenting the plan with a degree of financial risk. Therefore, it is to the plan's financial advantage to initiate enrollees' education regarding preventive health care and proper utilization of health care resources. Any services covered under the plan, but not provided directly by the plan, are furnished on a referral or subcontractual basis to another provider who is then reimbursed directly by the plan. As of July 1, 1994, 4 prepaid health plans serve 33,139 recipients or 79% of the total eligible Managed Health Care population residing in Jackson County.

Quality Assurance

In order to sustain enhanced quality of care for the program's enrollees, the Managed Health Care Quality Assurance section employs a variety of methods, including monitoring contract compliance, review of grievances and transfer requests, audits of medical care, utilization reviews, and follow-up on satisfaction surveys administered to enrollees. Both the prepaid health plans and the physician sponsors are contractually required to furnish 24-hour-a-day 7-day-a-week availability to their enrollees. At a minimum, this must be a telephone answering service with access to a physician on call to provide medical advice.

In accordance with federal regulations, guidelines concerning transfer have been set forth in order to maximize continuity of care for the enrollee. For those individuals who elect to become enrolled with 3 of the prepaid health plans, a transfer to another provider may be requested during the first 30 days of each 6 month enrollment period. Should a transfer be requested after the initial 30 day period, an enrollee must first comply with the health plan's established grievance process. If, in so doing, the enrollee's problem is not satisfactorily resolved, a transfer will be permitted. For those individuals enrolled with a physician sponsor or with the remaining health plan, which operates as a locally supported public hospital, a transfer may be requested at any time. However, once an enrollee has transferred from a given provider, she/he may not re-enroll with that same provider for 6 months.

Since the program's inception, significant emphasis has been placed on enrollee education. The contracts contain language requiring that the health plans furnish documentation of their endeavors to educate their enrollees, thereby allowing the State a means of monitoring their efforts. This includes review and authorization by the State of all marketing materials and review of enrollee correspondence. On-site audits are also utilized as a direct contact with enrollees regarding the nature

of education provided by the plans. This education not only helps ensure compliance with the program's guidelines, it allows enrollees to make the most efficient use of the program's benefits.

Cost Effectiveness

Based upon cost effectiveness reviews conducted since its inception, the program has averaged $1.5 million in savings to the State each year. As a result of the success of the program, Missouri is expanding the program to include the Medicaid for Children eligibility category in Jackson County.

CONTACT: Gary Bailey
Medical Services
P.O. Box 6500
Jefferson City, Missouri 65102-6500
(314) 751-6922

MONTANA

Montana Medicaid has a 1915(b) waiver to operate a primary care case management program called PASSPORT TO HEALTH. It was implemented in January, 1993. The goal is to implement the program statewide or in as many areas as possible. Outlined below are the major components.

Recipients. Initially, existing AFDC recipients were enrolled by mail. Existing recipients in a new county are enrolled by mail. New AFDC and AFDC-related recipients are enrolled when they apply for benefits at the county office; new SSI recipients are enrolled by mail.

Exempted from participation are recipients who: are medically needy, have Medicare, are in a nursing home or ICF/MR, have eligibility period of less than 3 months, live in an area excluded from the waiver, are only retroactively eligible, have TPL in which they are already enrolled by a coordinated care program, cannot find a primary care provider (PCP) who will accept them, can prove it would be a hardship to participate, are in subsidized adoption, or are receiving home and community based waiver services.

Recipients who do not choose a PCP will be mandatorily assigned a provider. Recipients may request a change in their PCP once a month; they need not have good cause. Recipients requesting more than 2 changes in a 6 month period will be investigated. PCP information will appear on the Medicaid card.

Provider. Providers eligible to be PCPs are: physicians (family practitioner, ob/gyn, pediatrician, internist, and any other physician who agrees to provide primary care), certified nurse practitioners, certified nurse midwives, physician assistants, federally qualified health centers, rural health clinics, and Indian Health Services clinic on a reservation. County health departments would be eligible if they meet the criteria.

PCPs must agree to provide primary care (including EPSDT screens), refer for specialty care, and be accessible on a 24-hour a day, 7 days a week basis. They designate how many recipients they are willing to case manage. The upper limit is 1,500 for physicians and 1,200 for mid-level practitioners; there is no minimum. Providers may limit their PASSPORT enrollees to Medicaid recipients who are already part of their current caseload.

Services. The services that must be provided or authorized by the PCP are: inpatient and outpatient hospital, ambulatory surgical centers, physician, nurse specialist, EPSDT screens, federally qualified health center, rural health clinic, Indian Health Services clinic, EPSDT screens and chiropractic (an EPSDT service).

In the categories of service requiring authorization, exceptions are obstetrical care, vision, outpatient mental health, family planning procedures, anesthesiology, radiology, pathology, immunization, sexually transmitted diseases and blood level testing. All other categories of service may be obtained without the PCP's authorization.

Referrals may be made verbally or in writing. The PCP authorizes a service by giving his or her Medicaid ID, Medicare UPIN or a PASSPORT provider number to the provider to who the patient is referred. That provider must then put the PCP's number on the claim form in the appropriate field.

Reimbursement. PCPs will receive the regular fee-for-service or cost-based reimbursement for services delivered. In addition, they will receive a $3,000 per enrollee per month case management fee; that fee will be paid whether or not they saw each enrollee that month.

Program status. As of July 1994 the Primary Care Case Management program is operating in 20 out of 56 counties and has 27,000 Medicaid recipients enrolled in the program.

CONTACT: Sharon Donovan, Human Services Officer
Medicaid Services Division
Department of Social and Rehabilitation Services
P.O. Box 4210
Helena, MT 59604-4210
(406) 444-4540

NEBRASKA

Nebraska has neither a §1915(b) freedom of choice waiver program nor a contract with a prepaid health plan at this time.

The State is in the development phase of a statewide Primary Care Case Management (PCCM) managed care program. The dates for implementation are:

July 1, 1995 Omoha area
July 1, 1996 Lincoln area
July 1, 1997 Balance of the State.

CONTACT: Bob Seiffert
Medical Services Division
P.O. Box 95206
Lincoln, Nebraska 68509
(402) 471-9718

NEVADA

Nevada Medicaid has operated a Primary Care Case Management (PCCM) program since November 1983. The PCCM functioned under a §1915(b)(1) waiver from November 1, 1993 until May 25, 1988, when it was determined that the waiver was not required because enrollment was voluntary. Since May 1988, Medicaid has contracted to provide care and service under a Pre-paid Health Plan (PHP) pursuant to §1915(a)(1)(A).

The Nevada Legislature enacted Senate Bill (SB) 559 during the 1993 Legislative Session requiring the Legislative Committee on Health Care to evaluate and develop a mandatory managed care system for Nevada's Medicaid recipients. The Committee's recommendation to the Governor on July 1, 1994, mandates the Department of Human Resources to implement a mandatory enrollment managed care plan effective July 1, 1995, for the AFDC and AFDC-related population, and to phase in enrollment of the aged, blind and disabled (ABD) populations by the end of the second year of the program.

Nevada Medicaid is currently working with the Legislative Committee on Health Care to implement SB 559 by July 1, 1995. Nevada will submit a new §1915(b)(1) waiver to request a regional (northern and southern Nevada) mandatory choice enrollment program.

Currently there are 3 PCCM contractors. Nevada Medicaid has contracts with the following:

1) University of Nevada School of Medicine - which serves the AFDC, Aged, and Institutionalized Aged populations in Clark County (Las Vegas), North Las Vegas and Henderson), Washoe County (Reno and Sparks), and Carson City County.

2) NevadaCare, Inc. - which serves the AFDC, Aged, and Institutionalized Aged populations in Clark County (Las Vegas, North Las Vegas and Henderson), Washoe County (Reno and Sparks), and Carson City County.

3) Community Health Centers of Southern Nevada (an FQHC) - which serves the AFDC, Aged, and Institutionalized Aged populations in Clark County (Las Vegas, North Las Vegas and Henderson).

All contractors provide, either directly or through subcontract with appropriate parties, the following services:

- all physician services to include: office visits, emergency visits, clinic visits, family planning and inpatient care in both acute and nursing facilities;

- radiology and clinical pathology services (except those provided in an acute hospital); and

- prescribed drugs (except those provided in an acute hospital).

All other medical services are reimbursed by Nevada Medicaid and are subject to Medicaid service limitations.

Enrollment in the health plans is voluntary. Disenrollment may be requested at any time by the enrollee and is effective no later than the first of the second month following the request to disenroll. The contractor can request disenrollment of an enrollee under the $10,000 stop-loss provision of the contract.

Nevada Medicaid is primarily responsible for the marketing of the enrolled health plan. The program is marketed by welfare eligibility certification specialists in the Reno area, and by Medicaid marketing specialists in Las Vegas who conduct group marketing sessions at the welfare district offices.

As of July 1994, the health plans had 22,884 enrollees (4,059 in Reno/Carson City and 18,825 in Las Vegas/North Las Vegas and Henderson) from a total eligible population of 58,324. Approximately 38% of the eligible population is enrolled.

The medical professional staff conducts an annual monitor review at each program site. The monitors review for quality of care, access to care, follow-up, and evidence of the teaching of wellness concepts and Healthy Kids screening (EPSDT). There are quarterly studies to compare the cost and utilization of FFS Medicaid eligibles to the enrollees, by aid category, provider type, geographic area, age and sex. The pre-determined, monthly capitation payment to the contractor is reviewed annually for readjustment.

CONTACT: Joanne M. Grundmen, Program Specialist III
Nevada Medicaid
2527 North Carson Street
Carson City, NV 89710
(702) 687-4768

NEW HAMPSHIRE

The Division of Human Services currently contracts with 2 Health Maintenance Organizations (HMOs). Medicaid recipients who are categorically needy under the Aid to Families with Dependent Children (AFDC), Foster Care (FC) and Child Welfare Services (CWS) are eligible to enroll on a voluntary basis. As of June, 1994, there were 68,171 Medicaid eligibles and 7,802 are enrolled in managed care.

The 2 contracts are with:

1. Matthew Thornton Health Plan, Inc. (MTHP) and eligible recipients must reside in the Concord, Manchester, Nashua, (clinic based models) Portsmouth, Rochester, Dover or Salem (IPA model) service areas.

2. Healthsource New Hamphire, Inc. is available statewide and is an IPA model. This contract was effective April 5, 1994.

The Division of Human Services contracts with the New Hampshire Foundation for Medical Care, a professional review organization, to perform an external review of HMOs.

CONTACT: Diane M. Kemp, Program Specialist
Department of Health and Human Services
Division of Human Services
6 Hazen Drive
Concord, New Hampshire 03301-6521
603-271-4365

NEW JERSEY

The coordinated care programs for primary care in New Jersey include:

1. A State operated, public Health Maintenance Organization known as the Garden State Health Plan (GSHP);

2. Contracts with private HMOs; and

3. Inclusion of community health centers as participating providers in the regular Medicaid program as well as medical case managers under the GSHP.

The New Jersey Department of Human Services, Division of Medical Assistance and Health Services intends to implement a mandatory managed care program on county-by-county basis in early 1995. Within 2 years, the mandatory initiative using a phased-in approach and a voluntary enrollment strategy implemented simultaneously statewide, will require all AFDC populations to obtain health care through Health Maintenance Organizations (HMOs). A 1915(b) waiver is being finalized and will be submitted to HCFA.

In the mandatory managed care program there will be a standard benefit package that all HMOs must provide. The behavioral health care services, however, have been carved out and not all Medicaid services are part of the standard benefit package. There will be a standard contract that each HMO will sign in the mandatory managed care program. During the mandatory program, the State will use a Health Benefits Coordinator to provide health education to Medicaid clients needing assistance in choosing an HMO. The Health Benefits Coordinator will also take enrollment applications and assist Medicaid clients with disenrollment. The State expects to award a bid and hire a Health Benefits Coordinator firm by the fall of 1994. The Health Benefits Coordinator will also assist in preparing informational material for clients concerning mandatory managed care and HMOs.

GSHP. GSHP, a public HMO, is a subdivision of the single State agency, the New Jersey Department of Human Services and is administered by the Division of Medical Assistance and Health Services (DMAHS). DMAHS administers the Medicaid program and provides services as set out in 42 U.S.C. 1396b(n) (A) (1) and is organized pursuant to 42 U.S.C. 1396b(m) (6). The GSHP is organized primarily for the purpose of providing health care services through a medically case-managed system. Participation in the Plan is voluntary for Medicaid eligible members and physicians.

Administratively, the GSHP is organized as an HMO, with administrative, financial, marketing, medical, management information systems and plan relations staff. In

addition, the Plan has several outside advisory committees including 2 committees for Quality Assurance: Quality Assurance Advisory Committee (comprised of community providers), the Division's Medicaid Quality Assurance Committee and a Provider Advisory Council.

The Plan is currently open to Medicaid eligible individuals with the following categories of assistance: AFDC; other children under age 21, including Medicaid Special, and those in foster care and adoption assistance under the Division of Youth and Family Services supervision; SSI Aged, Blind and Disabled; Jobs Medicaid extensions through the sixth month of extension; Community Medicaid Only (non-institutionalized aged, blind, and disabled) and individuals in New Jersey Care...Special Medicaid Programs, except Medically Needy. Plan members may receive one 6 month period of guaranteed eligibility. The GSHP contracts directly with physicians in the community.

Any licensed physician, Medicaid participating physician, MD or DO, licensed to practice medicine and surgery, meeting the Plan credentialing requirement and providing service through a Free-standing, independent practice, may apply as a physician case manager. In general, pediatricians, family and general practitioners, internists, and obstetricians/gynecologists are the physicians who participate as case managers.

Participating physician case managers (PCM) are reimbursed on a capitation basis and must provide for primary care and coordinate all the health care needs of the members enrolled with them including referral to physician specialists and other health care practitioners, ancillary services, and inpatient care. The PCM must provide for Plan services 24 hours a day, 7 days a week.

Plan members are entitled to managed care package of medical services which include comprehensive preventive, diagnostic, rehabilitative, and therapeutic health care services in addition to all other Medicaid services.

The GSHP currently has a Certificate of Authority to operate in 14 of the 21 counties in New Jersey. The counties are: Atlantic, Bergen, Burlington, Camden, Essex, Gloucester, Hudson, Mercer, Middlesex, Morris, Passaic, Sussox, Union, and Warren. The GSHP will be expanded Statewide. The GSHP is in the process of Espanding its Certificate of Authority to operate Statewide.

Private HMO Coverage. Currently, the New Jersey Division of Medical Assistance and Health Services has a contact with 3 HMOs, 2 and federally qualified and 1 is a State defined HMO. The program is administered through the Office of Managed Health Care Programs. Staff are responsible for: negotiating contracts and capitation rates; arranging for the determination of eligibility; authorizing payments to the HMO; monitoring contract performance including quality assurance/utilization

review, financial status, and general contractual obligations; a liaison and advocate for the Medicaid enrollees; and providing technical support to the HMO.

Two HMO contracts are limited to the AFDC population, 1 contract includes AFDC and SSI, Blind and Disabled. HMOs are serving Medicaid members in a total of 10 New Jersey counties; Bergen, Burlington, Camden, Cumberland, Gloucester, Hudson, Mercer, Essex, Middlesex, and Union.

Categorically, the service package under the HMO contract is broad but does include several limitations to services in duration and scope. Medicaid enrollees are entitled to the managed care package of medical services which include comprehensive preventive, diagnostic, rehabilitative, and therapeutic health care services. In addition, Medicaid enrollees are entitled to all other Medicaid services not included under the HMO benefit package. A guarantee of Medicaid eligibility is made available to Medicaid enrollees in Federally qualified HMOs and the HMOs may utilize the lock-in provision if desired.

Interest in Medicaid participation by private HMOs has grown in the past year. The Division currently has 2 contracts under HCFA review and is providing assistance to at least 12 other HMOs regarding the contracting process.

The total number of Medicaid clients voluntarily enrolled in HMOs, including GSHP is 43,500 out of a total Medicaid population of approximately 699,000. This enrollment in growing steadily and is expected to increase dramatically with mandatory managed care.

Community Health Centers (CHCs)

Community Health Centers (CHCs). CHCs have participated as Medicaid providers for many years. Several CHCs also participated as physician case manager sites in the GSHP. CHCs provide services to all eligibility categories and participate in the special Medicaid programs in New Jersey such as HealthStart, EPSDT and New Jersey Special Medicaid Programs, including Medically Needy.

There are currently 3 active CHCs participating as physician case manager sites in the GSHP: CamCare CHC in Camden County, Eric B. Chandler CHC in Middlesex County, and CHC of Paterson in Passaic County.

As GSHP medical case mangers, the CHC physicians must provide for primary care and coordinate referrals for specialty, ancillary, and inpatient care included under the GSHP.

Under the GSHP, CHCs are subject to monitoring by the State and independent

quality assurance review by the State's outside contractor.

Other qualified CHCs will be outreached for participation as GSHP physician case manager sites as the Plan expands its provider network.

CONTACT: Beverly Blacher-Eide, Acting Chief Executive Officer
Garden State Health Plan
Division of Medical Assistance and Health Services
CN-712
Trenton, New Jersey 08625-0712
609-588-3580

Daniel Walsky, Executive Director
Office of Managed Health Care
Division of Medical Assistance and Health Services
CN-712
Trenton, New Jersey 08625-0712
609-588-2705

NEW MEXICO

The following is updated participation information for PCN:

- The program is operating in 26 of the state's 33 counties.

- While 60.2%, about 116,000 individuals of Medicaid eligible individuals reside in these counties, about 52% are currently locked into PCN. The Division is addressing the issues regarding reasons for non-lock in status. There are approximately 76,600 Medicaid eligible individuals residing in the remaining 7 counties. The Department has a goal of having the PCN operational statewide by July 1995.

- Due to implementation of a pharmacy point of sale system and retrospective drug utilization review within Medicaid, the Department is considering dropping the pharmacy lock-in.

- Based on changes in state law governing the scope of practice for certified nurse practitioners, the Department will be amending its PCN waiver to include qualifying nurse practitioners as primary care providers or gatekeepers within the PCN. As part of this change certified nurse practitioners will be allowed to accept up to 1,500 individuals.

- The program manager position for PCN is currently vacant. In addition, the program will be incorporated into the Office of Managed Care under development at present. The Office should be operational by the fall of 1994.

New Mexico will be applying for 1115 waivers during the current year. It is not clear if one will be in the managed care area. While New Mexico will be implementing capitated at risk contracts during 1995, we may use one of the state plan options as opposed to an 1115 waiver to establish this program.

If you need any additional information on these issues, please call Ramona Flores-Lopez at 505-827-3111.

NEW YORK

Legislation passed in 1991 focuses greater attention on the managed care effort by establishing statewide managed care program with specific enrollment goals for local district managed care programs. Enrollment goals for local district managed care programs are:

- 10% of the district's Medicaid population who are not exempt from participating in the managed care program within 1 year of the managed care plan approval;
- 25% of the district's Medicaid population who are not exempt from participating in the managed care program within 3 years of the managed care plan approval; and
- 50% of the district's Medicaid population who are not exempt from participating in the managed care program within 5 years of the managed care plan approval.

In 1991, the New York State Department of Social Services designated 20 local districts for submission of managed care plans to achieve the above enrollment goals. The second 20 districts were designated in 1992 for submission of managed care plans by May 1, 1993. The final round of districts were designated in 1993, with managed care plans due April 1, 1994. These plans contain a variety of service delivery systems and reimbursement models: health maintenance organizations (HMOs), prepaid health services plans (PHSPs), physician case management programs (PCMPs) and clinic-based models.

Currently, 26 local districts have exceeded year 1 (10%) enrollment goals, and 3 local districts have exceeded year 3 (25%) enrollment goals.

Regulations are being developed for the inclusion of the special care population (e.g. mental health, mental retardation and development disabilities, substance abuse) in managed care. A Memorandum of Agreement for Special Care was signed in January, 1994 by the Commissioners of the State Departments of Social Services, Health, Mental Health, Mental Retardation and Developmental Disabilities, and the Office of Alcohol and Substance Abuse Services. This agreement requires managed medical care providers and special care providers to adhere to a jointly developed linkage protocol to assure that managed care enrollees who need these services are able to receive them in a timely and coordinated fashion.

As of July 1994, there were 95 managed care contracts in New York State. These include 72 HMO contracts, 13 PHSPs, 9 partially capitated programs, and 1 case

management program. The HMOs and PHSPs are risk comprehensive full capitation reimbursement models and the partial capitation models are PCMPs with the primary care physicians at risk for delivery of primary care services and 1 partially capitated clinic model. Enrollment in these plans as of July 1994 is 361,376. As of July 1, 1994, there are 30 additional contracts in various stages of development.

A number of the partial capitation programs being developed are Article 28 comprehensive Clinic Model programs, which are expected to enroll approximately 16,000 MA recipients in all categories of assistance except Supplemental Security Income (SSI) and recipients eligible as a result of spend-down. A 1915(b) Federal waiver is in development to allow New York to share savings with these providers. One clinic model program, Staten Island University Hospital, is operational and began enrollment (without shared savings) on March 1, 1994. An alternative partial risk clinic model is being developed. This model will allow smaller or specialized clinics to receive enhanced fee-for-service rates for categories of bundled services and will allow these clinics to share in program savings.

While the population served varies by contract, all programs in New York State serve the Aid to Families with Dependent Children (AFDC) population. Thirty-six counties in New York State have operational programs. This represents a geographical catchment area of more than 1/2 of the State.

External review of the HMOs and PHSPs for quality assurance is performed by the Island Peer Review Organization (IPRO) which is overseen by the New York State Department of Health. The New York State Departments of Social Services and Health are currently working on protocols with the NYS Office of Quality Assessment and Audit for quality assurance reviews of partial capitation/partial risk programs.

In Broome County, a physician enhanced fee-for service (FFS) reimbursement model demonstration program (the case management program referred to above) was implemented in September 1991. Enrollment in this demonstration, as of July 1, 1994, is 3496. Under a Federal waiver, physicians in this program (primary care and specialists) receive enhanced fees for each visit. All referred services (e.g. pharmacy, lab) must be authorized by the enrollee's primary care physician. Utilization review and quality assurance will be conducted by a case management organization. In the Spring of 1994, HCFA approved a 1915(b) waiver to share program savings with recipients by adding dental services to the program's current benefit package. This waiver program includes 12 dentists an dental specialists, and allows the provision of dental services to approximately 1,200 enrollees, primarily children. Enrollment in the dental program began March 1, 1994, and as of July 776 people were enrolled.

New York's Southwest Brooklyn Managed Care Project is an approved 1915(b) waiver of freedom of choice, which began voluntary enrollment in October, 1991, and mandatory enrollment in October 1992. This waiver manages Medicaid recipients' health care through 7 HMOs and 1 PHSP. New York City anticipates an enrollment of approximately 52,000 AFDC recipients and current enrollment is approximately 38,000. The State projects savings of $580,182 in the first 2 years of operation. Savings projections are based on a capitation rate which equals 95% of the estimated FFS costs. In March, 1994, an independent assessment of the program (done by the NYS Office of Quality Assurance and Audit) demonstrated that more than 2/3 of the enrollees surveyed were satisfied with general access and the services and care received. The program was demonstrated to be cost effective, showing savings in every category of service except capitation. New York State is in the process of obtaining a waiver renewal to assure continuation of this project.

Other developments in New York City include implementation of a PCMP in Manhattan with a monthly capitation payment for primary care physician services and specialist office visits. Enrollment as of July, 1994, is 4,836. The program is sponsored by the county medical societies, which are currently developing similar programs for implementation in the Bronx, Queens and Brooklyn. These programs will play a significant role in the New York City plan to enroll 50% of its Medicaid population in managed care.

New York State is currently planning a budget initiative to fund a comprehensive planning evaluation, through an outside agency, of Medicaid Managed Care in the State.

Contact: James Wray
Department of Social Services
40 North Pearl Street
Albany, NY 12243
(518) 473-5600

NORTH CAROLINA

The Medicaid program in North Carolina presently has 2 alternative care programs: a comprehensive medical care plan with Kaiser Permanente Health Plan of North Carolina and Carolina ACCESS, a care coordination program.

Kaiser Permanente. The first managed care program was initiated in 1986 when we signed a prepaid contract with Kaiser Permanente (Kaiser). Kaiser is a Federally qualified HMO and the prepaid contract has been a part of our State Health Plan. The program is available in 4 counties and serves the AFDC category. The 4 counties that are participating in Kaiser are: Durham, Orange, Mecklenberg and Wake. Participation in Kaiser is voluntary and the present enrollment is 5,219.

For those recipients who elect HMO coverage, Medicaid pays their HMO premium. Kaiser offers all of the regular Medicaid benefits except dental care. The standard Medicaid service limitations do not apply to Medicaid recipients enrolled with Kaiser. There is a Kaiser Representative in the Department of Social Services for each county who is responsible for educating and enrolling the recipients in the program.

Overall, the Kaiser program is successful in these counties and we have encountered minimal problems. External annual reviews are conducted by the Peer Review Organization in North Carolina. In the past, other HMOs in our State have been unwilling to serve the Medicaid population. We continue to communicate with other prepaid plans who are now considering Medicaid clients as participants in their health care program. HMOs usually serve larger and more densely populated communities, and consequently much of our rural State remains without an HMO option.

CONTACT: Nancy O'Dowd
Division of Medical Assistance
P.O. Box 29529
1985 Umstead Drive
Raleigh, NC 27603
(919) 715-5417

Carolina Access. In April 1991, we began our managed care program cancelled Carolina ACCESS--North Carolina's Patient Access and Coordinated Care Program.

The program has been implemented in 24 counties so far and out intention is to expand statewide in the next 2 years. Approximately 134,000 recipients are enrolled in the program as of Carolina ACCESS encourages more efficient arrangements for delivering care by linking Medicaid recipients with primary care physicians. Eligible recipients enroll with the participating primary care physician or

clinic of their choice. This enrollment process is completed at the time of eligibility certification and recertification. Carolina ACCESS to contracts with primary care physicians in participating counties to coordinate their enrollees' health care needs by providing or arranging:

- o primary care services, including prevention, health maintenance, and treatment of illness and injuries;
- o referrals for specialty and for other covered services; and
- o after-hours coverage to needed primary care and referral services.

The Carolina ACCESS primary care physicians become the "gatekeepers" to their enrollees' health care services. Participating primary care physician receive, in addition to normal Medicaid payments, a monthly coordination fee of $3 per enrollee for the first 250 enrollees. For each addition enrollee over 250, the physician is paid a coordination fee of $2.50 per enrollee per month.

Primary care physician participation includes family physicians, pediatricians, obstetricians, general internists, and general practitioners. In addition, physician group practices, rural health centers, community health centers, health department primary care clinics and hospital outpatient clinics may also be enrolled as primary care clinics, and hospital outpatient clinics may also be enrolled as primary care providers. Participant physicians can set enrollment limits with a maximum limit of 1,200 enrollees per physician and 600 enrollees per physician's assistant or nurse practitioner.

This program is a mandatory program for certain categories of Medicaid recipients: AFDC; AFDC Related Groups; Medicaid Indigent Children (MIC); and Aged, Blind, and Disabled. Recipients who are also Medicare eligible have the option to enroll in Carolina ACCESS. Excluded from participation in Carolina ACCESS are individuals who are in mental hospitals, long term care facilities, personal care homes, foster care or subsidized adoption, domiciliary care facilities, and refugees.

The Department of Social Services in participating counties receive funds to establish a Carolina ACCESS Program Representative to coordinate the day-to-day operation of the program and to provide the necessary backup and training support within the county. We have focused on the need to change patterns of health care delivery through educating the recipients at every opportunity. Several different types of educational materials and brochures have been developed for this purpose.

Monthly and quarterly utilization reports are being monitored to assess the program's impact on access, quality of care, and cost savings. The initial response to this program has been very positive and participating counties are being selected based on their interest and commitment to the program and the willingness of primary care physicians to participate in Carolina ACCESS.

CONTACT: Nancy O'Dowd
Division of Medical Assistance
P.O. Box 29529
1985 Umstead Drive
Raleigh, NC 27626-0529
(919) 715-5417

NORTH DAKOTA

The North Dakota Department of Human Services, Medical Services Division implemented the North Dakota Access and Care Program under a 1915(b)(1) Freedom of Choice waiver January 24, 1994. Under NoDAC, Medicaid families with children must chose a primary care physician (PCP) to managed their health care needs and make referrals as needed.

Eligible Medicaid recipients include AFDC, Poverty Level and Medically Needy families with children. Excluded from the Freedom of Choice waiver are the aged, blind and disabled individuals, Medicare eligibles, those residing in nursing facilities or ICF/MRs, foster children, subsidized adoption children, those individuals receiving home and community based services and refugees.

There is no required enrollment for primary care physicians into this program. Physicians who have specialties of family practice, internal medicine, obstetrics, gynecology, general practice, pediatrics or osteopathy can be selected as primary care providers. Through enrollment in the North Dakota Medicaid Program, they automatically can be selected as a primary care physician.

There is no case management component to this Freedom of Choice Waiver. Physicians are paid fee-for-service.

Services with require authorization from the primary care physician are:

- Inpatient Hospital Services;
- Outpatient Hospital Services;
- Rural Health Clinic Services (includes Federally Qualified Health Centers);
- Physician Services;
- Private Duty Nursing Services;
- Physical Therapy;
- Occupational Therapy;
- Speech, Hearing and Language Services;
- Home Health Services;
- Durable Medical Equipment; and
- Hospice.

Family planning and emergency services are not restricted under this waiver.

Recipients who are required to enroll indicate their choice of a PCP to the local county social service office who in turn enters that information into the eligibility computer system. A letter is generated back to the recipient and the PCP indicating their selection. The recipients may change PCPs with good cause.

The eligibility computer system interfaces with MMIS to identify a specific PCP for a specific recipient. Claims with the correct provider number will be paid. Those recipients choosing to see someone other than their PCP will be responsible for those charges.

The Freedom of Choice Waiver was implemented statewide.

CONTACT: Darlene LeNoue, Administrator
Medicaid Policy for Families and Children
Medical Services Division
North Dakota Department of Human Services
600 East Boulevard Avenue
Bismarck, ND 58505-0261
(701) 224-4577

OHIO

The Ohio Department of Human Services (ODHS) is the single state agency with responsibility for the implementation and administration of the Ohio Medicaid program. In an effort to enhance the level of access, quality, and continuity of care as well as increase the predictability of Medicaid costs, ODHS has contracted with managed care plans (MCPs) since 1978 for the provision of managed care services to eligible persons under the Aid to Dependent Children (ADC) program. The Ohio Medicaid MCP program is administered by the Bureau of Medical Assistance, Managed Health Care Section in ODHS. The Section is responsible for the development and release of Requests For Proposals (RFPs), contract monitoring, the writing and implementation of policies and procedures, resolution of enrollment and payment discrepancies, fiscal activities, and quality assurance/utilization review.

The Ohio Medicaid MCP program is comprised of 2 components. The first component is a voluntary enrollment program with 10 participating MCPs serving 138,382 ADC Medicaid eligibles in 13 counties as of July, 1994. MCPs market directly to eligible individuals and families. Enrollment forms are completed and sent to the corresponding county department of human services (CDHS) for entry into the state computer system. This enrollment generates a monthly capitation payment to the MCP and has the regular Medicaid card the eligible person would normally receive.

Enrollment continues in the voluntary program until the eligible person elects to disenroll from MCP, changes MCPs, or loses his/her eligibility for Medicaid coverage. Disenrollments are effective at the end of each month, subject to monthly cut-off dates required in order to process recipient data and changes for the following month. All enrollments and disenrollments are effective at the beginning of the month.

The second component of the MCP program is a mandatory enrollment program currently operating in Montgomery County. This program covers 42,248 Medicaid ADC and related eligibles in 3 MCPs as of July, 1994. The current total ADC and Healthy Start[1] Medicaid population in Ohio is 911,496; MCP enrollment is approximately 20 percent of the total and 31 percent in the counties where Medicaid-MCP enrollment is available. Recipients select from 1 of the 3 MCPs when applying for benefits.

---

[1]Healthy Start is Ohio's name for the Medicaid program covering pregnant women and children up to age six with family incomes less than 133% of the federal poverty level, and children ages six through ten with family incomes of less than 100% of the federal poverty level.

In order to implement the mandatory program in Montgomery County, ODHS was required to apply to the Health Care Financing Administration (HCFA) for waivers of certain federal requirements governing the Medicaid program.

Specifically, Section 1915(b) waivers were required to permit ODHS to: (1) implement the mandatory program on less than a statewide basis; (2) require recipients to select an MCP for enrollment; (3) offer additional services such as primary case management and preventive care services on less than a statewide basis; and (4) pay subcontractors at a rate which exceeds projected fee-for-service (FFS) costs as long as total payments do not exceed equivalent total FFS costs. The Montgomery County mandatory enrollment program went into effect in May, 1989. The waiver was renewed in 1992, and an additional renewal application is pending.

In both the voluntary and mandatory programs, ODHS pays each MCP a pre-determined, monthly capitation payment for each Medicaid enrollee. The MCP is at financial risk for the entire range of medicaid-covered services (except long term care) including impatient hospital. However, ODHS limits the MCP's liability for inpatient hospital and related home health services through stop-loss coverage that is activated when an enrollee incurs single or aggregate inpatient hospital claims in excess of $30,000 for state fiscal year (SFY) 1994. ODHS covers 85% of the amount in excess of the deductible.

Quality Assurance

ODHS monitors the quality of care delivered to Medicaid recipients enrolled in MCPs through:

- An annual quality assurance (QA) survey performed by an independent external review contractor that includes a medical record audit, provider site facility reviews, and a corporate HMO review.
- A quarterly review of HMO operations and service provision.
- A quarterly review of service utilization statistics.

This process enhances ODHS' ability to oversee and assure the effectiveness of MCP activities and improve the quality of care delivered to Medicaid enrollees.

Utilization Review

Unlike the fee-for-service system, in which ODHS collects individual encounter data though claims submitted for payment,
aggregate encounter data is collected from the MCPs though service utilization

reports. MCPs submit data quarterly and annually based on their collection of encounter information from providers.

Quality Assurance Reform Initiative (QARI)

Ohio is 1 of 3 states participating in HCFA's 2-year QARI demonstration. QARI is testing medicaid managed care QA reforms which were developed by HCFA, state officials, MCPs, and consumer advocates.

Through QARI, committees of state agencies, MCPs, community and advocacy organizations, and enrollees are enhancing the health care quality improvement system (HCQIS) of the state's Medicaid managed care program.

Clinical care protocols have been developed so that MCPs and the state's external quality review contractor can measure quality of care in areas specific to the Medicaid population. In addition, QARI recommends standards for MCP quality assurance programs (QAPs), and MCPs receive technical assistance through the QARI project for implementing the QAP standards internally. Enrollee participation at all levels of the HCQIS is a primary goal of QARI.

Based on the experience of the 3 demonstration states, HCFA will modify its QARI guidelines and disseminate them to all 50 states so that other states can benefit from lessons learned in establishing an ongoing HCQIS for Medicaid managed care programs.

Medicaid Working Group (MWG) Project

ODHS is also a demonstration site for the Medicaid Working Group. This project, funded by the PEW Charitable Trusts and Robert Wood Johnson Foundation, will enroll disabled Medicaid recipients in MCPs.

Although disabled individuals represent only 11% of the state's Medicaid recipients, they consume 32% of total Medicaid expenditures each year. Four states (Ohio, Missouri, New York, and Wisconsin) are participating in the 2-year project to develop managed care arrangements to meet the needs of chronically ill and disabled Medicaid recipients. The project is administered by the Medicaid Working Group staff on Boston's University's School of Public Health. The Ohio project, called Accessing Better Care (ABC), is a voluntary enrollment program targeted to 95,000 chronically ill and disabled Medicaid recipients statewide. Based on the experience gained under this project, the state will phase in managed care enrollment for these individuals beginning the third year of the OhioCare waiver.

Future Program Directions/OhioCare

Ohio's biennial budget bill requires ODHS to expand the mandatory managed care program to 3 additional counties: Hamilton (Cincinnati), Lucas (Tolendo), and Franklin (Columbus). At least 1 of the counties must be mandatory by January 1, 1995, with all three mandatory programs implemented by July 1, 1996. Hamilton County is scheduled to begin mandatory enrollment, subject to federal approval, in January, 1995. All non-aged, blind, or disabled Medicaid recipients in these counties will be required to enroll in an MCP. At least 3 Medicaid-serving MCPs must be available in each county.

Through Amended Substitute House Bill 152, the General Assembly required that managed care entities be selected via a Request for Proposal process. Accordingly, ODHS issued an RFP in May 1994 to select MCPs to participate in both the voluntary and mandatory enrollment programs. The MCPs selected as a result of the process will enter into provider agreements with ODHS to be effective October 1, 1994.

Also, ODHS has submitted a comprehensive Medicaid reform proposal to HCFA. This 1115 research and demonstration waiver would replace the current Medicaid program with "OhioCare." Over the 5-year waiver period, OhioCare would provide health care coverage to all uninsured individuals with incomes under 100% of the federal poverty level in addition to current Medicaid eligibles. OhioCare proposes to phase-in enrollment of all eligibles in managed care plans, except for those recipients in long-term car facilities and those enrolled in home-and community-based waiver programs. Pending approval by HCFA, the target start date for waiver implementation with phased-in managed care enrollment is July, 1995.

Contact: Cynthia Burnell, Chief
Managed Health Care Section
Ohio Department of Human Services
30 East Broad Street
Columbus, Ohio 43266-0423
(614) 466-4693

OKLAHOMA

The Interim Task Force on Welfare and Medicaid Reform was established by the Oklahoma legislature in 1993 to address specific issues related to public assistance programs, including the Medicaid program. Working with the consulting group, KPMG Peat Marwick, the Task Force developed a plan for reform of the State's Medicaid system to create a statewide Medicaid managed care system. In addition, in the fall of 1992, a working group comprised of legislators and health policy experts developed a plan for creation of a health care authority to assume responsibility for the State's Medicaid program. Both concepts became the foundation for 2 pieces of legislation enacted during the 1993 legislative session. House Bill 1573 established the Oklahoma Health Care Authority, which will assume responsibility for the state's Medicaid program in January, 1995. Senate Bill 76 authorized conversion of the current fee-for-service program to a managed care system for Medicaid recipients, beginning July 1, 1995.

The Oklahoma Department of Human Services will remain the designated single state agency for the Title XIX Medicaid program until January 1, 1995. At that time, the Oklahoma Health Care Authority will become the designated state agency for Medicaid. The Authority will be responsible for administration of the Medicaid program, including all contracts with prepaid capitated health plans and contracts with primary care case managers and primary care networks in rural locations unable to support comprehensive, capitated services.

Senate Bill 76 mandated that managed care services be established incrementally for different populations of Medicaid recipients. The legislation provides that:

- By July 1, 1995, managed care plans will be developed for not less than 50% of the participants in AFDC and eligible recipients who are noninstitutionalized medically needy. By July 1, 1996, managed care plans must be developed for this entire population.

- By July 1, 1997, managed care plans must be developed for all eligible persons who are categorized as non-institutionalized aged, blind or disabled.

- By July 1, 1999, managed care plans must be developed for recipients who are institutionalized or seriously and persistently mentally ill. Prior to July 1, 1999, for purposes of managed care placement, any recipients previously integrated into managed care systems who become institutionalized will enter into the payment system in force for institutionalized recipients.

In order to ensure implementation of the Oklahoma managed care program in compliance with the timeline developed by the legislature, the State is currently developing a 1915(b) waiver to implement prepaid, fully-integrated health services

in urban areas. If the 1915(b) waiver is approved prior to the 1115(a) waiver, the urban program will operate under the 1915(b) waiver until approval of the proposed research and demonstration project, at which time the urban program will be subsumed under the demonstration waiver.

Oklahoma desires to integrate its urban program with rural project to ensure that services throughout the State are developed and delivered over time in a coordinated system. Appropriate expansion of fully-integrated health plans into rural areas of the State capable of supporting comprehensive, capitated health service delivery will occur most effectively through expansion of urban health plans into rural areas. This is 1 of the most important goals of the project.

In addition to its responsibilities for the Medicaid program, the Health Care Authority has responsibility for oversight of the purchase and administration of health-care-related benefits for State employees through the Employees Benefits Council. The Authority is also responsible for operation of the State's Health Care Information System.

CONTACT: Leigh Brown, J.D., M.P.H., Deputy Administrator for Health Policy
Oklahoma Health Care Authority
4545 N. Lincoln Blvd., Suite 177
Oklahoma City, Oklahoma 73105
405-530-3439

OREGON

KEY FEATURES

- Expands and Simplifies Eligibility

  Under the demonstration 180,000 Oregonians already covered by Medicaid will receive services through the Oregon Health Plan. Approximately 120,000 additional people living below the Federal poverty level (FPL)--$991 per month for a family of 3--will become Medicaid-eligible. Current income eligibility is at 67 percent FPL. Spend-down provisions of the Medically Needy program, with resulting off-again, on-again coverage, are eliminated. Retroactive eligibility is also eliminated, but under the demonstration, unlike the current Medicaid program, women can become eligible prior to becoming pregnant.

- Basic Benefits Defined by Prioritization Process

  Medicaid benefits are defined by a prioritization process.

- Prioritization Process - A Health Services Commission utilized a public prioritization process to rank a comprehensive set of primary and acute medical care services. The commission included health care providers and consumers who decided what kind of health services were most important and most likely to result in a healthier population. The final list included 696 conditions and treatments. The Legislature then authorized funding for items 1 through 565 on the list. These items comprise the Medicaid medical benefits. Additional preventive and patient education services were also added.

- Basic Benefits - The package covers virtually all current Medicaid mandates, including preventive and screening services. It also covers dental services, hospice care, prescription drugs, most transplants, and therapies, all of which are not currently required under Medicaid. The same basic benefits are to be the basis for the minimum benefit package required under the employer mandate scheduled to go into effect in 1997. Examples of services not included are aggressive cancer treatment where treatment will not result in a 5% probability of a 5-year survival; medical treatment for sore throat; diaper rash; and cosmetic services.

- Revision to List - The Department must approve any changes to the priority list and any changes in the Medicaid benefits that may result from budget changes.

In addition, Oregon will be required to adopt policies that ensure that before denying treatment for an unfunded condition for any individual, providers will be required to determine whether the individual has a funded condition that would entitle the individual to treatment. Oregon will provide through a telephone information line for the expeditious resolution of questions raised by providers and beneficiaries.

o Managed Care

Almost all care delivered will be managed care using fully capitated health plans (FCHPs); partial-service prepaid health plans, such as physician care organizations (PCOs); dental care organizations (DCOs) and primary care case managers (PCCMs). Oregon has contracted with 16 FCHPs, 4 PCOs, 5DCOs and several PCCMs. The FCHP model is the prevalent system throughout the State. Twenty-eight (78%) of the 36 counties have sufficient capacity to enroll beneficiaries exclusively into FCHPs, DCOs, and PCOs. The remaining 8 counties will rely on the PCCM model or fee-for-service.

PENNSYLVANIA

A. Health Maintenance Organizations (HMOs) and Federally Qualified Health Centers (FQHCs)

The Department of Public Welfare (DPW) is committed to expanding managed care throughout Pennsylvania. There are approximately 20 HMOs in Pennsylvania. Special efforts continue to be made to encourage HMOs to participate in Medicaid. We currently contract with 6 HMOs and 1 Community Health Center (CHC) to provide managed medical care to eligible medical assistance clients in Central, Southeast, and Western Pennsylvania.

Managed care plans contracting with DPW are required to provide, at a minimum, the same scope of services as the traditional Medical Assistance Fee-for-Service (FFS) Program. In most cases, the services and benefits provided by the managed care plans are more comprehensive than the FFS Program. These services include, but are not limited to hospitalization, inpatient physician care, outpatient services, mental health and drug and alcohol services, maternity, emergency, hospice, pharmacy, and optometry. Clients in managed care programs do not have copayment expenses.

We believe that managed care promotes continuity of care with emphasis on prevention and early detection, resulting in lower hospital utilization and subsequent lower costs for DPW. There are approximately 1.7 million eligible medical assistance clients in Pennsylvania, of which approximately 296,931 are enrolled in the HMOs. The number of enrollees in HMOs represents an increase of 61.3 percent from the 1993 National Summary. Enrollment in the HMO is on a voluntary basis. Our current HMO contracts are with:

- Aetna Health Plan of Western Pennsylvania, Inc., which provides services in Allegheny, Armstrong, Armstrong, Beaver, and Westmoreland Counties;

- Greater Atlantic Health Service, which provides services in Berks, Bucks, Delaware, and Philadelphia Counties;

- Keystone Health Plan East, which provides services in Bucks, Delaware, Montgomery, and Philadelphia Counties;

- Aetna Health Plans of Central and Eastern Pennsylvania (formerly FREEDOM), which provides services in Berks, Lehigh, and Lancaster Counties;

- Keystone Health Plan West, which provides services in Allegheny,

Beaver, and Westmoreland Counties; and

- OakTree Health Plan, which provides services in Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.

Federal regulations in 42 CFR 434.53, mandate the Commonwealth to have an independent organization conduct medical audits to ensure quality and accessible health care for medical assistance recipients enrolled in HMOs. An audit must be conducted at least once a year. The organization conducts an on-site review of medical files, interviews HMO medical staff, reviews the quality assurance system, evaluates the quality of care, and complies medical audit documents.

Pennsylvania has an agreement with a Federally funded CHC to provide capitated medical services to approximately 4,600 medical assistance recipients in Dauphin County. The program has been in effect since November 1988. The major difference between the HMO contracts and CHC contract is risk. The CHC cannot be at risk for inpatient hospital care. Providers must receive authorization for all non-emergency care and must verify the client's eligibility before services are given. The health center must be available to provide authorizations. One of the major benefits to the program is dental care. The CHC is the only provider of some of the major dental services in a tri-county area.

B. Health Insuring Organization (HIO)

On December 5, 1985, Pennsylvania received a waiver of specific provisions of Section 1902 of the Social Security Act to implement a primary care case management program. The program, known as HealthPASS, has been in continuous operation since March 1, 1986, in areas of South and West Philadelphia. HealthPASS is managed by Healthcare Management Alternatives, Inc. (HMA). HMA receives funds through a fixed rate prepaid capitation contract with DPW to pay for health services for medical assistance clients in the project area.

HealthPASS was created to reduce Medicaid expenditures while maintaining or improving the access to and quality of medical services. Unlike its FFS counterpart, in a managed care program such as HealthPASS, medical providers are paid for keeping their patients healthy. Clients select a primary care physician (PCP) to act as their personal physician. PCPs provide or locate, as well as coordinate and monitor, all primary care and other medical care and rehabilitation services on behalf of their patients. Clients have the freedom to choose their PCP, freedom to change their PCP at any time without cause, 24 hour telephone access to their PCP, access to a toll free 24 hour-a-day hotline maintained by the HealthPASS contractor, and freedom to enroll in an HMO serving the HealthPASS area. Clients have access to a structured complaint and grievance system, and

although not a waiver requirement, an extensive health education and outreach program assists and instructs recipients in accessing HealthPASS services.

All medical assistance clients residing in Vine, West, Snyder, Delancey, and Federal Districts of the Philadelphia County Assistance Office are covered by HealthPASS except monthly spend-downs, Planning Grants, state blind, clients enrolled in HMOs, clients of state mental hospitals, single point of contact clients, and residents of long term care facilities and extended acute psychiatric care facilities. The current enrollment in HealthPASS is approximately 73,000 clients.

HealthPASS clients are entitled to receive all services provided by Pennsylvania's Medicaid Program. Although HMO services, private and public, skilled or intermediate nursing facility services, funeral director services, transportation services other than by emergency ambulance to necessary medical care, outpatient drug and alcohol clinic services, outpatient psychiatric clinic and partial hospitalization services, and extended acute psychiatric care facility services are not the responsibility of HMA, clients have
access to these services through the traditional FFS Program.

External assessments of HealthPASS are conducted on an ongoing basis. Beginning in December 1986, Brich and Davis Associates, Inc. evaluated access to care and assessed the quality of that care and the program's cost effectiveness as compared to the FFS Program. On February 4, 1988, the final report detailing a medical review and evaluation of the quality of care delivered by HealthPASS was submitted by Health Assessment Associates. In March 1986, Chilton Research Services began a 3 phase study to assess medical assistance clients' perceptions about HealthPASS compared to the FFS program. Under a 3 year contract effective January 1, 1990, through December 31, 1992, the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) evaluated the quality assurance program and conducted on-site medical record reviews of providers. JCAHO described HMA's quality assurance program as "State of the Art." In January 1987, SOLON Consulting Group, Ltd. began assessing access to HealthPASS services, quality of care, cost effectiveness, and the effectiveness of the case management function. SOLON's reassessment, completed in September 1991, supports earlier findings showing that HealthPASS, through case management, has increased access to care, improvement quality of care, and maintained cost effectiveness. The current contract to conduct external assessment is with HealthPro.

On December 28, 1992, DPW submitted a request to the Health Care Financing Administration (HCFA) for approval of an amendment of the HealthPASS Program waiver. The approval to amend this waiver extended services covered by HealthPASS to include psychiatric clinic, partial psychiatric hospitalization, methadone maintenance clinic, and drug and alcohol clinic services currently

provided to HealthPASS enrollees through the FFS Program. The amendment also extended the geographic area serviced by HealthPASS to include the remainder of Philadelphia County as well as Berks, Bucks, Chester, Delaware, and Montgomery Counties. DPW's goal was to implement program changes effective July 1, 1994. In correspondence dated August 30, 1993, HCFA responded to DPW's request for a modification of the freedon of choice waiver granted under the authority in Section 1915(b) of the Social Security Act (the Act).

> "the modification to include mental health and substance abuse services can be approved. The determination was based on our findings that the modification would be cost effective and not substantially impair recipients' access to services of adequate quality. This action is effective as of January 1, 1994.
>
> HCFA did not grant approval to expand the HealthPASS Program to the remainder of Philadelphia and 5 surrounding counties. This modification was requested to extend the exception in the Consolidated Omnibus Budget Reconciliation Act of 1985 that was granted to Section 1915(b) waiver programs administered by HIOs."

C. The HealthChoices Program

A new 1915(b) waiver to implement mandatory managed care in Southeastern Pennsylvania through HMOs was submitted to HCFA in October 1993. On November 18, 1993, HCFA approved DPW's waiver request to expand managed care for medical assistance clients in Berks, Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.

The waiver program, known as HealthChoices, is authorized under Section 1915(b) of the United States Social Security Act. Sections of the Act relevant to this waiver request include:

- o Section 1902(a) (1) - Statewideness;
- o Section 1902(a) (10) (b)--Comparability of Services;
- o Section 1902(a) (23) -- Freedon of Choice; and
- o Section 1902(a) (30) -- Upper Payment Limits.

The objective of the waiver is to ensure access to quality health care for more than 650,000 Medicaid clients, to provide preventive health care, and to control costs by reducing unnecessary use of services.

The basic concept of the HealthChoices Program is simple. Clients will be enrolled in HMOs. The HMO will provide comprehensive health care services and will

approve all necessary specialty services. Clients will have full access to necessary emergency and family planning services under the waiver.

The HMOs will assist clients in using the health care system and will closely monitor their health care needs. The HMO will be responsible for coordinating their clients' primary health care as well as other medical and rehabilitation services.

Medical assistance clients enrolled in the health plans will be restricted to receiving medical care from the plan or from specialists to whom the clients are referred.

One out of 8 Pennsylvanians currently rely on the Commonwealth's Medical Assistance Program for their health care at an annual cost of more than $5.5 billion. The State's health care program for low-income residents consumes more than 20 percent of the state budget, and the program's cost has more than doubled in the last 4 years.

Much of the increase in the Medical Assistance Program can be attributed to the fact that many clients do not have a family doctor, resorting instead to costly hospital emergency room visits for health care.

The HealthChoices Program will be similar to the successful HealthPASS Program and other managed care plans currently serving medical assistance clients in the Southeastern Philadelphia area. The current programs in Southeastern Philadelphia provide quality comprehensive health care services to more than 303,959 Medicaid clients, many who have voluntarily chosen managed health care.

More than 40 percent of the Commonwealth's 1.7 million medical assistance clients will be covered under the HealthChoices Program.

The following information summarizes DPW's plans for managed care in Pennsylvania through its 1915(b) waiver program:

- The waiver allows DPW to begin the HealthChoices Program on December 1, 1994. The waiver will cover a period of 2 years, the maximum time allowed by federal law. DPW will seek a renewal of the waiver after the 2-year period.

- The waiver allows DPW to implement mandatory managed care for medical assistance clients in Berks, Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.

- All current Medicaid services will be covered under the waiver, with a few exceptions such as nursing home services. Mental health and drug and alcohol services will be included in the first year of the plan

for Philadelphia. These services will be included in the second year of the HealthChoices Program in the 5 remaining counties.

- Services in the HealthChoices Program include, but are not limited to: office visits; prescriptions; dentist; podiatrist; medical supplies; chiropractor; optometrist; ambulance; home health care; family planning; nurse midwife; hospice; EPSDT services; audiology/EPSDT; occupational therapy/EPSDT; psychological services; physical therapy; speech therapy; AIDS waiver services; case management; renal dialysis; and inpatient and outpatient hospitalization.

- Medical assistance clients in the 6 county region must enroll in a managed care program. Clients who do not select a plan will be assigned to the default contractor in their region. Clients, however, can initiate a plan change at any time.

DPW will competitively bid risk-comprehensive contracts for the 6 county region. DPW will procure the contracts under the Commonwealth's Occupational for Proposal (RFP) process.

Under the HealthChoices Program, the 6 county region will be divided into 3 geographic zones: Northeast; Northwest; and Southern. The City of Philadelphia will be equally divided among the 3 zones.

DPW will contract with a "default" contractor in each of the zones. Those contractors will manage the health care of clients who fail to choose their own managed care program. The contractors must be licensed by the Commonwealth of Pennsylvania's Department of Health and Insurance Department to operate as an HMO in that zone on the begin date of the contract.

DPW will contract with at least 1 additional HMO in each of the 3 zones to provide clients with a choice. Each client will have at least 2 plans from which to choose. As a result of the competitive procurement process, clients may have as many as 6 health care plans from which to choose.

Medicaid and Medicare clients can constitute no more than 75% of the total enrollment of the HMO's clientele. DPW can request federal waivers to allow the health care plans time this requirement.

The new waiver program will be phased into the current HealthPASS area.

CONTACT: Mr. Frank E. Lentz, Director
Bureau of Special Medical Assistance
Department of Public Welfare

P.O. Box 2675
Harrisburg, PA 17105-2675
(717)772-6300

D. Primary Care Case Management Programs

During 1994, Pennsylvania (PA) received approval of 2 Section 1915(b) (1) waivers from HCFA. These waivers permit the PA Department of Public Welfare, which administers medical assistance programs, to implement 2 mandatory primary care case management (PCCM) programs in 61 of the 67 counties in the state. Separate waivers were requested because 1 program covers the under age 21 MA population in 60 counties, while the other covers recipients of all ages in only 1 county.

1. Features of both PCCM Programs include the following:

- o Fee-for-service payment system for services provided by the primary care provider or specialists;

- o Case management fees of $3 per month per recipient to primary care providers:

- o Patient-load limits of $1,000 recipients per individual provider, and up to 5,000 clients per multi provider site;

- o Providers who enroll include those who are participating in the MA Program and who are:

    - physicians who provide comprehensive primary health care;
    - hospital outpatient clinics;
    - independent clinics;
    - rural health clinics; and
    - federally qualified health centers.

- o To enroll, providers must sign a supplemental provider agreement by which they agree to provide 24-hour access to care and to coordinate services with other medical providers as well as community-based service agencies;

- o Provider recruitment and enrollment is handled by the administrative contractor;

- o Unless they are excluded for one of the following reasons, recipient enrollment in the program is mandatory:

- opt to enroll in an MA HMO or enroll in a private HMO;
- reside in a nursing home or residential care facility;
- in a foster care placement or subsidized adoption arrangement;
- eligible for less than 90 days of MA coverage; or
- covered by Medicare.

o Recipient selection of, or assignment to a primary care provider is handled by the administrative contractor;

o Quality assurance activities are handled by the administrative contractor;

o Elimination of payment to emergency departments for non-emergency services provided to recipients linked with primary care providers;

o Elimination of payment for services provided to recipients without referral by the primary care provider; and

o Verification of a recipient's enrollment in the program available to all MA providers through the automated Eligibility Verification System.

2. **Objectives common to both PCCM programs include the following:**

o Improved access to primary and preventive care through linkage with primary care providers;

o Utilization of services from the most appropriate and cost-effective sources of care; and

o Assurance of quality of services.

3. The Family Care Network

o The Family Care Network PCCM Program focuses on the MA population under age 21, which is also covered by the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program.

o An additional objective of this program is to increase the rate of eligible recipients participating in the EPSDT Program, with the federal 80% mandate

as the goal. For this reason, physicians clinics and health centers must also be certified to provide EPSDT screening exams to enroll as primary care providers because of the population covered.

- The program is being phased-in; when it is fully operational, it will cover approximately 400,000 recipients in 60 counties. Implementation began in February 1994, and is expected to be completed by July 1, 1995. As of July 22, 1994, the program had been implemented in 11 counties and 64,488 recipients had been linked with primary care providers.

- Provider participation is critical to successful implementation of the program. Provider enrollment in each county must be sufficient to serve the recipient population before we mandate their enrollment. In the waiver, DPW agreed to reach a provider to recipient ratio of 1:1,000 before implementing mandatory recipient enrollment. The provider organizations have supported the program and encouraged their members to enroll. Provider recruitment has been so successful that in the counties implemented thus far, there is capacity to serve 2 and 3 times the number of recipients mandated to enroll. In Erie County, for example, providers have agreed to serve more than 94,000 recipients, far in excess of the 22,300 in the county who must enroll.

- As a direct result of the recruitment for the Family Care Network, the number of providers certified to participate in the EPSDT Program has increased significantly. In the 11 counties implemented thus far, the number has doubled. This increase will greatly influence our ability to achieve the goal regarding the EPSDT screening rate.

Of particular interest is the response of the hospitals to this program. Initial concerns centered on the loss of the emergency room fees for non-emergency services, resulting in the Hospital Association of PA requesting that DPW establish a triage fee. Despite their concerns, hospitals have found innovative ways to cut their losses and to be responsive to the needs of the recipients and providers in the community. Many hospitals are establishing new family practice or pediatric outpatient or independent clinics. These clinics may then become new sources of care for the recipients in the program under a variety of arrangements. The clinics may enroll as primary care provider sites and agree to serve a panel of recipients. Some hospitals are offering their clinics after-hours coverage for the other providers in the community, often enabling them to provide the required 24-hour coverage for recipients and participation in the program. Many hospitals are establishing these clinics adjacent to their emergency departments, so recipients who self-refer to the emergency room can be triaged and seen in the less costly clinic setting if they do not require emergency room care.

During the first 2 years of operation, the program is expected to achieve a net savings in MA program costs of $1.5 million. It will take at least 18 months before the program is fully operational. Once fully operational, savings are expected to increase. At the recommendation of HCFA, conservative estimates were used to project savings because there was no prior experience by other states with the population targeted by this program; thus there was no experience upon which to base the estimates. Additionally, the expected increases in the EPSDT screening rates and follow-up care are expected to offset the savings in other areas.

4. Lancaster Community Health Plan

The waiver for this PCCM Program was approved in February 1994. Contract negotiations are underway and implementation is tentatively scheduled for October 1994. This program will cover MA recipients of all ages, but only those who reside in Lancaster County. When fully operational, up to 20,000 recipients may be enrolled in this program. Lancaster County is included in the coverage area of an MA HMO and recipients may opt to enroll in that plan rather than the PCCM Program.

The Lancaster County Program differs from the Family Care Network in that it is an initiative sponsored by the physicians, hospitals, professional organizations that represent providers, medical insurers, private and public service agencies and consumers in the community, in response to the state of the local health care system. A Board consisting of representatives of all stakeholders was formed under the leadership of a local physician, Dr. Robert Doe, who is a past President of the local medical society, and an emergency room physician in one of the hospitals. Together, his consortium pursued the concept of a community health care system and over several years a program design evolved. Dr. Doe and the group obtained financial support and commitments from the hospitals, professional organizations and medical insurers and requested that DPW sponsor the program by obtaining HCFA's approval to use it for the MA Program.

The Program will establish a community patient information network (CPIN) which will be accessible to physicians, clinics and hospitals that enroll as primary care providers. The CPIN will eventually be used to store medical history for the patients, MA recipients and private, served by the providers in the community. Security for the system will preclude unauthorized individuals from accessing all or part of a patient's medical history. The establishment of this network will enable providers to immediately determine a patient's prior medical treatment and avoid duplication of services or

conflicting treatment. The data from this network will also be used for quality assurance/improvement and outcome-based evaluation of treatment.

Many of the costs associated with this program have been met by local hospitals, special legislative initiative grants, and vendors. CPIN software and hardware has been obtained at significantly discounted costs. The Pennsylvania Medical Society has donated staff and technical support for the program. This support from the community has made it possible for the program to be implemented.

During the first 2 years of operation, the program is expected to achieve a net savings in MA Program costs of $242,815. Conservative estimates of savings were used at the request of HCFA. It will take at least 6 months before the program is fully operational and at that point savings are expected to increase.

5. General Information

Both PCCM programs include quality assurance and quality improvement activities that will be conducted by DPW and its administrative contractors. These activities are intended to evaluate the success of the programs in achieving the objectives. Included in these activities are surveys of after-hours access, recipient satisfaction surveys, monitoring of paid claims to determine types and frequencies of services being provided, monitoring of referrals to other providers, monitoring of recipient and provider requests for new providers to be assigned, and monitoring of recipient and provider grievances.

Both PCCM Programs must have independent evaluations conducted prior to submitting a waiver renewal request. These evaluations will determine if the objectives regarding access, quality, and cost-effectiveness have been achieved.

Inquiries regarding the PCCM Programs may be directed to:

Office of Medical Assistance Programs
Bureau of Outpatient Programs
Division of Maternal and Child Health Programs
PCCM Unit
P.O. Box 8046
Harrisburg, PA 17105
Phone 717-772-6341

Should you have any questions or require additional information regarding the HMOs, please contact Ms. Margaret A. Williard, Director, Division of Capitation

Policy and Program Development, at 717-772-6292, and for the Primary Care Case Management Programs, please contact Ms. Dauvey Hoffman, at 717-772-6341.

RHODE ISLAND

Since 1972 the Rhode Island Department of Human Services has contracted with a Federally qualified HMO, the Harvard Community Health Plan (formerly RIGHA), to make prepaid medical care available on a voluntary basis to eligible recipients of the AFDC Program. Amendments have been made in subsequent years to allow medically needy family groups and foster children to enroll. The contract provides for payment of a monthly premium not to exceed the cost of the FFS alternative. Participants are provided with a Harvard identification card as well as a Medical Assistance eligibility card, the latter to be used for services outside of the scope of services covered by Harvard.

Starting in July of 1994, Rhode Island is implementing an ambitious initiative called RIte Care designed to expand Medicaid eligibility for pregnant women and children under the age of 6 and to enroll all AFDC-linked families in managed care during 1994. Each eligible person will be linked to a primary care provider responsible for coordinating all health care needs. The goals of RIte Care are to improve access and quality of care as well as to reduce the provision of unnecessary and duplicative services.

Clients will be enrolled into 1 of 5 HMO's participating in the program. Approximately 60% of the current Medicaid population will be transitioned into the mandatory managed care program. The program has been authorized as a statewide demonstration program under Section 1115 by the Secretary of Health and Human Services.

CONTACT: Robert J. Palumbo
Associate Director for Medical Services
Department of Human Services
600 New London Avenue
Cranston, RI 02920
(401) 464-3575

Lee D. Grossi
Interim Director
Office of Managed Care
Department of Human Services
600 New London Avenue
Cranston, RI 02920
(401) 464-3113

SOUTH CAROLINA

Introduction. The South Carolina Managed Care Program was implemented effective February 1, 1990. The Managed Care Program is a joint effort between the State Health and Human Services Finance Commission (SHHSFC) and the South Carolina Department of Mental Health (SCDMH). Eight community mental health centers provide managed care services for Medicaid eligible recipients with a diagnosis of schizophrenia or affective disorder. The waiver was renewed for an additional 2 years effective August 1, 1992- July 31, 1994. The State has decided not to request renewal of the waiver beyond July 31, 1994.

The goals of the program are to:

- o provide comprehensive medical and psychiatric care for the Medicaid population with sever mental illness;
- o improve access to quality, coordinated health care;
- o contain Medicaid costs for all health care by reducing inappropriate emergency room use, doctor shopping, inpatient admissions and duplication of services; and
- o prolong community tenure.

Provision of Services. The SHHSFC certifies providers (community mental health centers and primary care physicians) for participation in the managed care program. The SCDMH provides intensive case management and outpatient psychiatric services for a capitated rate through the community mental health centers.

The recruitment of primary care physicians/gatekeepers is a cooperative effort among SHHSFC, SCDMH and the community mental health centers. The appropriate staff explains the purpose of the program and the role of the gatekeeper, and addresses provider concerns about Medicaid participation, submission or claims, reimbursement and patient compliance. Any physician wishing to serve as a gatekeeper agrees to provide 24-hour coverage and inform the client's case manager when authorizing treatment to a specialist or hospital and of failed appointment or problems related to compliance with treatment. The mental health case manager links each recipient to a primary care physician/gatekeeper who will treat, refer or authorize provision of necessary medical services, including emergency room use, hospital admissions and specialty care. The recipient's Medicaid card indicates the name and telephone number of the primary care physician. It is marked "restricted" and providers are asked to contact the gatekeeper for prior authorization of specialty, emergency room and inpatient care.

Eligibility. Medicaid eligibles who meet all of the following criteria are eligible for participation: diagnosis of schizophrenia or affective disorder; not eligible for

Medicare; not institutionalized or living in a residential care facility; and not enrolled concurrently in another case management program. There is a maximum of 30 recipients permitted under the care of 1 case manager.

Program Evaluation. The Managed Care Program demonstrates the need for improved identification and coordination of total service needs for mentally ill patients among service providers, that intensive case management of the target population combined with smaller caseloads allows clinicians to effectively identify those medical and mental health needs which negatively affect the quality of life of the recipients, and that gatekeeper systems are most effective when States implement comprehensive utilization, monitoring and reporting system edits.

Preliminary evaluation results. We can conclude that the waiver has continued to result in increased access to health care for enrolled patients as compared to pre-enrollment. The SCMCP resulted in cost reductions per client for Medicaid claims in comparing waiver year 2 and 3. The reduction in the use of emergency room services observed in the 2 periods also represents a potential savings in Medicaid costs.

One of the most important benefits clients have received through this program is contact with a primary care physician. Interviews of the case managers reported that their clients were more likely to be compliant with medication, were more likely to receive preventive medical care and to have conditions diagnosed, less likely to use emergency room inappropriately and less likely to require psychiatric hospitalizations. A great deal has been learned by case managers, primary care physicians and the Medicaid agency about service delivery issues and effective strategies for operating intensive case management programs.

A final analysis of both mental health and medical care costs for the third and fourth waiver years will be performed later in 1994.

South Carolina Health Access Plan. The South Carolina Health Access Plan (SCHAP) was implemented effective February 1, 1993. This managed care national demonstration project is planned to operate for 3 years in a 2 county area of the State. The
project receives funding from the Federal Government (HCFA), the Duke Endowment, the AMA, and the State. As authorized by the enabling legislation and the program document, low income employees and their family members of qualifying small businesses are placed under primary care physicians for health maintenance supervision, with services being provided under the auspices of Medicaid.

The employer pays the State portion of Medicaid match for his/her eligible employees and family members in the form of a monthly premium. Where the

employee and his family have incomes between 100% and 150% of the Federal poverty level, the employer has the flexibility to request that the employee pay 1/4 of the State match as his/her premium.

The goals of the program are to:

- o increase the number of employers offering insurance coverage and the number of persons covered;
- o improve enrollee access to quality care, affect behavior by limiting use of emergency room services, necessary diagnostic testing, and inpatient hospitalization through the provision of managed care and more preventive services;
- o improve efficiency and cost effectiveness of medical care and to lower costs;
- o provide continuity of service to the demonstration participants;
- o reduce provider bad debt and resultant cost increases to other payers; and
- o provide information which may be used in other areas in South Carolina and the United States to assess the feasibility and cost-effectiveness of using Medicaid as a vehicle of providing insurance coverage to low income employed workers.

Provision of Services. Once entered into the program, the member (recipient) selects a Primary Care Coordinator (PCC) from a group of Medicaid enrolled physicians who are included in the network. All care is either provided by the PCC, or arranged and approved by the PCC, to include after-the-fact approval of emergency care if required. Non-authorized care becomes the financial responsibility of the patient.

Non-Covered Services. Where appropriate, patients will be moved into regular Medicaid programs when they become ineligible for the following non-covered services:

- o Pregnancy services, including prenatal care, delivery and post-partum services;
- o Neonatal, post-neonatal, and well child care for newborns;
- o Nursing home care and Community Long Term Care (CLTC) Services;
- o Organ transplantation and related services for adults;
- o End stage Renal Disease (ESRD) dialysis and related services;
- o Institutional care, including psychiatric hospital, mental retardation facility, and alcohol abuse/chemical dependency facility services;
- o Residential treatment facilities, such as boarding homes and group homes, and other residential mental health treatment programs for adults and

children;

- o Administrative days for members in acute care hospitals solely awaiting nursing home placement; and
- o Health care and services where coverage by other State and Federal programs exists and/or is required.

Other than these limitations, other Medicaid services will be provided subject to the availability of identified funding and continued approval of the demonstration. Participant premiums have been established on an annual basis, using average Medicaid costing data with the above non-covered service cost removed.

Criteria for Recipient Participation. To participate, a business must have less than 100 employees, at least 50% of the employees must have adjusted family incomes of less than 150% of the Federal poverty level, at least 3 employees must desire to participate, the business must have not offered health insurance to this population within the past year, and the business must be located within Horry or Marion counties. Employees must meet the 150% of poverty criteria, have no other health insurance, be under the age of 65, be full-time employees and be a resident of South Carolina. Their eligibility status is re-evaluated on an annual basis.

Program Evaluation. The managed care program demonstrates a partnership between the Federal Government, the State Government, and the private sector in meeting the health needs of a large segment of our population through the expansion of the State Medicaid program. HCFA has contracted with an independent evaluator to perform the evaluation of this project. Action is ongoing both by the State staff and the designated contractor to learn from this effort. This project might well provide valuable insight into proper methodologies of dealing with the uninsured of small businesses.

Current Status. The South Carolina Health Access Plan as of August 23, 1994, reports the following membership status:

Total active members	1,015
Total active employees	556
Total members enrolled during life of project	1,447
total active businesses	128
Total active Primary Care Coordinator Physicians	60

Membership growth has been steady and experiences with businesses, members and providers have been very positive during the life of the demonstration project.

Program Expansion. No expansion of the program is contemplated at this time.

Palmetto SeniorCare. Palmetto SeniorCare (PSC) is 1 of 10 operational replications of OnLok under Medicaid §1115 and Medicare §222 Demonstration waivers. PSC began operations under the waivers on October 1, 1990. OnLok is a risk-based, managed home care program in San Francisco for individuals with long term care needs. The program receives capitated Medicaid and Medicare payments. The OnLok/PACE demonstration waivers create joint Medicaid/Medicare capitated long term care programs for 10 projects that have been previously awarded grants by the Robert Wood Johnson Foundation pursuant to Section 9412 of P.L. 99-509. The goal of the demonstration is to consider the feasibility of risk based, long term care programs as viable options for Medicaid and Medicare.

The program serves individuals who are age 55 and older, live in Richland or Lexington county, meet the State long term care criteria, and are eligible for Medicaid and Medicare or willing to privately pay a premium equal to the combined Medicaid/Medicare capitated payment. Medicaid/Medicare eligible individuals who elect to participate in PSC waive traditional Medicaid/Medicare. Program participants who wish to return to the traditional Medicaid/Medicare system and who remain otherwise eligible, may do so with 30 days written notice. In return for the capitated payment, PSC assumes responsibility for the provision of all care. During the 3 year demonstration, the Medicaid and Medicare programs, through the State and Federal agencies, and PSC share in the financial risk through a complex risk sharing agreement. PSC assumes responsibility for the provision of all care. During the 3 year demonstration, the Medicaid and Medicare programs, through the State and Federal agencies, and PSC share in the financial risk through a complex risk sharing agreement. PSC completed year 3 of the demonstration September 30, 1993. Effective October 1, 1993, PSC assumed full risk and continues on yearly federal renewals. They manage care for over 200 clients through 3 day health centers.

Provision of Services. Eligible individuals who choose to participate in PSC waiver traditional Medicaid and Medicare Services and agree to receive all health care through PSC. A care plan is developed in cooperation with the participant and his family/caregiver and continually monitored by the PSC multi-disciplinary team. The services are oriented toward primary and preventive care provided in a special day health center. PSC provides care directly through PSC's medical staff of physicians, nurses, pharmacists, therapists, home care specialists and aides. Additional services are through staff social workers, nutritionist and transportation teams or through medical specialty contract.

Hospital and/or nursing home care, if needed, is provided and reimbursed by PSC through contracts negotiated by the program with local facilities. Even though this is a long term care program, individuals whose functional level may improve to a level above the State long term care criteria, remain eligible for the program.

Unlike traditional long term care programs, they are not disenrolled. Through constant monitoring of the participant in the day health and home setting, it is the goal of the program to minimize health care crises and maintain a more comfortable quality of life for persons in the final years of their lives.

Program Evaluation/Future Expansion. The Medicaid/Medicare waivers call for joint State/Federal monitoring visits to the program yearly. HCFA has also awarded the contract for the evaluation of the entire OnLok/PACE replication to ABT Associated, Inc. The evaluation design has been difficult to lock down. HCFA is currently reviewing the most recent design. The State completed a client satisfaction survey during the summer of 1993 and will explore other types of evaluations at the State level.

South Carolina High Risk Channeling Project (HRCP).

Introduction: The South Carolina High Risk Channeling Project (HRCP) was implemented in 1986 to address the problem of high infant mortality/morbidity rates which has plagued South Carolina.

The HRCP established the following goals:

- To reduce the South Carolina perinatal mortality and morbidity rates;
- To diminish the frequency and severity of handicaps associated with premature delivery and low birth weight and therefore reduce the need for long term care;
- To decrease overall expenditures for maternal and newborn care; and
- To promote other specialized care for high risk pregnant women and infants.

Criteria for Recipient Participation. Participants in the HRCP must be medical eligible pregnant women or newborns. The pregnant women must have a medical high risk factor such as hypertension, gestational diabetes, alcohol/drug addiction, documented by a physician on the SHHSFC's Pregnancy/Newborn Risk Assessment Form. The newborn must have a high risk factor (e.g. low birthweight) also documented on the Risk Assessment Form or be the newborn infant of a woman who was an HRCP participant.

Provision of Services. There are 3 essential elements of the HRCP: prenatal and intrapartum care furnished by an obstetrician, provision of ancillary services such as social work and nutrition services, and delivery in level II or level III hospitals. The predominant method of service delivery is described as follows:

- Prenatal care furnished in a HRCP clinic by an obstetrician working on a contractual basis or who is a direct employee of the clinic. Prenatal care may also be provided by a private HRCP physician;
- Provision of case management services by a registered nurse or a lay person who serves as an assistant case manager;
- Nutrition assessment/follow-up provided by a registered dietician;
- Social work assessment/follow-up provided by a master's level social worker;
- Delivery in a level II or level III hospital.

Evaluation. Extensive evaluation processes are used to measure the HRCP's success in getting Medicaid recipients into care and assuring that they receive all necessary services. An independent evaluation is performed to assess the HRCP's impact in the areas of: a) patient access to services; b) quality of HRCP services; c) increases in the number or pregnant women receiving prenatal care during the first trimester, and d) cost effectiveness of services.

The State has expanded its evaluation activities to include the following:

- Development of evaluation pilots in appropriate counties to compare different approaches to facilitating high risk care;
- Ongoing review of the Pregnancy/Newborn Risk Assessment tool to enhance its use as the point of entry to services for all Medicaid eligible women and infants.

The following outcome data is based upon FY 1993 evaluation activities:

Screenings:
- 1992 pregnancy screenings as percentage of pregnancy-ending hospitalizations: 82%
- Channeled pregnancies as percentage of hospitalizations: 18%
- Infant screenings as percentage of hospitalizations: 51%
- Channeled infants as percentage of newborns: 9%
- High risk Channelings:
  The percentage of Medicaid pregnancies channeled has risen from 11% in 1987-88, to 13% in 1990-01, to 18% in 1992.
- The percentage of infants channeled was 9% in 1991- 92, an increase over previous years that probably reflects the improvement in the percentage of infants screened.

- Place of Delivery:
  Throughout the 7 year waiver period, high risk women who live in counties with only Level I hospitals are more likely to deliver in Level II hospitals (27-36%) or Level III hospitals (43-51%) than in Level I hospitals.
- Outcomes:
  Percent of newborn claims with DRG 386 (extremely immature or respiratory distress) fell from 3.2% in the first year of the HRCP to 2.0% in 1990, to 1.5% in 1992.

Barriers identified that make outreach and enrollment difficult include:

- Inadequate transportation
- Inadequate number of Level II hospitals
- Access problems associated with rural counties, i.e. limited number of medicaid providers.

Strategies developed to overcome barriers include:

- Increased physician recruitment efforts;
- Upgrading Level I hospitals to allow Level II certification; and
- Increasing use of non-physician medical professionals (e.g. nurse practitioners) as services providers.

CONTACT: Robert A. Ehrlich, Department Head
Department of Delivery and Alternative Systems
1801 Main Street
Jefferson Square - 9th Floor
Columbia, SC 29201

SOUTH DAKOTA

South Dakota received waiver approval to implement a PCCM program to begin 7/1/93. The project began with full implementation on 9/1/93 in a pilot county (Codington) and has started to move incrementally throughout other counties. The project is expected to be state-wide by 11/1/95. The PCP includes mandating AFDC, AFDC low-income and SSI recipient to select a primary care provider, and this PCP will authorize/refer the following services:

> inpatient/outpatient hospital care
> general medical and surgery care
> mental health/community mental health center services
> specialty care i.e. ophthalmologist
> medical equipment/prosthetic
> prescription drugs
> home health
> residential/chemical dependency treatment
> EPSDT screenings

The program will continue the fee-for-service reimbursement that currently is used plus a case management fee of $3.00 per recipient per month. Specific provider requirements include 24-hour access, referral/authorization of care, peer review of utilization, and monitoring referral care in the plan.

We also have a managed care program which determines medical necessity of admissions, continued stays and discharges in exempt units of acute care hospitals which include neonatal, psychiatric, and rehabilitation. Field staff includes 2 care managers (RN'S) who will work closely with the facility staff in discharge planning as an essential part of monitoring.

Our managed care efforts also include working with the Department of Health, on the following 2 programs which are currently in operation:

1) High risk pregnant women. All pregnant women are referred to DOH for a risk assessment to determine whether case management activities should be provided. DOH provides case management activities for those clients that are determined high risk and prepare and maintain a case record for each that includes:

- prenatal risk assessment form;
- workers primary responsibility with the client;
- objectives of the management plan;
- progress notes; and
- pregnancy outcome report.

2) Children with special health needs. DOH provides case management activities for children (age 0-21) with special health care needs and their families and prepare and maintain a case record for each that includes:

- o a written comprehensive assessment of child/family strengths and needs;
- o objectives of the care plan;
- o worker with primary responsibility for the child and family; and
- o progress notes.

Another area of managed care consists of a program with Department of Human Services which includes managing individuals age 18 and older who are severely and persistently mentally ill. Services are to be Statewide and provided by, or supervised by, a qualified mental health professional and under the direction of a physician. The following case management services provided include:

- o client identification and outreach;
- o coordination of needs assessment;
- o development of a case management plan;
- o linking and monitoring with other agency services; and
- o referral and discharge planning.

CONTACT: Donna L.C. Keeler
Department of Social Services
Office of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
(605)773-3495

TENNESSEE

On January 1, 1994, Tennessee made history by implementing an innovative new health care reform plan called TennCare. TennCare required no new taxes and extended health coverage not only to the nearly 1 million Tennesseans in the Medicaid population, but also to an anticipated 500,000 uninsured or uninsurable persons using a system of managed care. TennCare will initially have an enrollment cap of 1.3 million people. The enrollment cap will grow to 1.5 million in future years.

Without radical change, the uncontrollable growth in the cost of Medicaid threatened financial stability of state government and the quality of Tennessee's health care delivery system. Simply maintaining the previous level of Medicaid services would have required annual tax increases and annual reductions in services that were unacceptable, while the working poor and other uninsured Tennesseans would have remained without coverage. It was determined that fundamental reform of the Medicaid program was the only acceptable alternative.

TennCare replaced the existing Medicaid program with a program of managed health care. Recipients now choose between Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs), and (in the HMO Model) choose a "gatekeeper" primary care provider to personally manage their health care.

TennCare services are offered through 5 PPOs and 7 HMOs, called managed care organizations (MCO's), under contract with the state. These MCOs, divided among 12 regions of Tennessee, are paid a fixed amount per recipient per month for the services. The managed care organization then negotiates payment rates with individual providers. Enrollees have a choice of managed care plans in their geographic area.

TennCare services, as determined medically necessary by the HMO or PPO, cover inpatient and outpatient hospital care, physician services, prescription drugs, lab and x-ray services, medical supplies, home health care, hospice care, and ambulance transportation. Excluded from TennCare are long-term care services and Medicare cross-over payments which will continue under the present Medicaid system.

TennCare is financed by pooling current federal, state and local expenditures for indigent health care which includes $2.11 billion the federal government would have given Tennessee for the Medicaid program. Pooled resources total $3.1 billion which is reduced by $939 million to continue the funding of long-term care programs and Medicare cross-covers through the Medicaid system. The remaining $2.2 billion will fund the first year of the TennCare program. Competition among

managed care networks, combined with the enrollment cap, should enable TennCare to grow at a predictable rate paralleling the annual growth in state spending.

As of June 30, 1994, there were 1,083,966 individuals enrolled in TennCare. Of the total enrollees, 762,121 are Medicaid eligibles and 321,845 are enrolled as the uninsured/uninsurable population.

The State of Tennessee was granted approval by the Health Care Financing Administration of the demonstration project under Section 1115 of the Social Security Act to implement TennCare. State rules were also promulgated to assist in administering the statewide program.

Administrative changes were necessary to make the transition from the Medicaid program to TennCare. These changes, consisting of (1) organizational (2) systems and (3) quality control/outcome of care changes, are important in insuring the success of TennCare in delivering comprehensive managed care in a planned and cost-effective manner to persons who are indigent and uninsured in the State of Tennessee.

Architects of this innovative health care reform plan are confident that the program developed can provide quality health care for all recipients at a substantially less cost than would be spent on the Medicaid program alone. TennCare could prove beneficial to efforts on a state and national level to reform existing health systems.

TEXAS

Texas implemented a Program of All-Inclusive Care for the Elderly (PACE) Waiver in February 1992. An 1115 Medicaid waiver and 222 Medicare waiver will enable Bienvivir Senior Health Services in El Paso to provide comprehensive health care services on a capitated basis to frail elderly individuals certifiable for nursing facility care. This program is part of a national demonstration project to replicate the On Lok model piloted in San Francisco.

This program is based on a comprehensive care approach, providing an array of medical, functional, and day activity services for a capitated monthly fee that is below the cost of institutional care. Clients must be over age 55, qualify for Medicaid in a nursing facility and choose PACE services. The Texas Department of Human Services conducts periodic utilization and post-payment review. The project is a pilot at 1 site in El Paso that will give information on the possible application of the program to other sites in the State.

Bienvivir transitioned into a fully capitated system over a 28 month period. While operating under the 1115 Medicaid waiver only, Bienvivir provided many health, social, and restorative services for a capitated Medicaid payment. On June 1, 1994, Bienvivir began operating under a 222 Medicare waiver. Bienvivir is not providing a comprehensive array of medical and social services for a monthly capitated fee form Medicaid and/or Medicare.

Bienvivir is currently serving 141 Medicaid eligible clients and 1 private pay client.

Although they are both capitated systems, PACE differs from a Social Health Maintenance Organization (S/HMO) because PACE concentrates on a high risk, frail population and uses an interdisciplinary team process to intensively manage risk at the individual client level. In contrast, an S/HMO manages risk actuarially by enrolling a range of well and frail individuals.

CONTACT: Anita Anderson
Medicaid Waiver Unit Manager
(512)450-3195

MEDICAID MANAGED CARE DEMONSTRATION PILOT

The Texas Department of Human Services is implementing an HMO model in Travis County on August 1, 1993. Texas has applied and received a 1915(b) waiver for this project which is called the LoneSTAR Health Initiative. The acronym STAR stands for the State of Texas Access Reform. Clients in Travis County will have a choice between a federally qualified HMO and a non-comprehensive PHP. Clients

will select a participating physician who will act as the gatekeeper for their medical services. The federally qualified HMO is contracting with the FQHC in this county to act as a PCP and to continue to provide EPSDT and family planning services. Clients will maintain freedom-of-choice for emergency services, family planning and EPSDT services. The 3 prescription limit for the traditional Medicaid program will be lifted to provide clients enrolled in this program with all medically necessary prescriptions. A new and extensive utilization management and quality assurance program will provide feedback to providers and tools for evaluating the project. The HMO model will be under total capitation. The PHP will be capitated for primary care services only.

A primary case management (PCCM) pilot implementation is planned for the late fall of 1993. Due to a reorganization of State government the project will transfer to the Texas Department of Health on September 1, 1993.

CONTACT: Linda K. Marstiller
Manager, Purchase Health Services
Texas Department of Human Services
P.O. Box 149030 y-927
Austin, TX 78714-9030

UTAH

Utah has operated a §1915(b) freedom of choice waiver since 1982. The program, called the Choice of Health Care Delivery (CHCD), is mandatory in the urban areas only, i.e., Weber, Davis, Salt Lake, and Utah Counties, and is optional in the remaining rural counties. In the urban areas, Medicaid clients are asked to choose between an HMO or a variety of primary care physicians to mange their care. (Current HMO options are FHP and Blue Cross Blue Shield/MedUtah; additional HMO choices beginning July 1, 1994 are United Healthcare of Utah, FHP-IPA and Intergroup of Utah). Once this choice is made, the provider's name is printed on the monthly medical care and the client must seek medical services though this "gatekeeper." If the services of a specialist are needed, written referrals to the specialist must be given by the primary care physician or the HMO must authorize the service before the service is rendered.

As part of Governor Leavitt's "Utah HealthPrint," a blueprint for market-oriented health care, Medicaid expansion in FY96 to provide medical coverage for aged, blind and disabled individuals below the federal poverty level will be funded by actual savings from increased form 20% to 65% in 1995 and to 100% in 1996. In addition to the 5 HMOs presently contracting with Medicaid, it is anticipated that 2 or 3 more HMOs will be serving medicaid clients by July 1995.

A unique feature of Utah's managed health care program is the employment of Health Program Representatives (HPRs) in the urban Human Services offices. The role of the HPRs is to explain the various health care options available and to assist the clients and their families in making a health care choice that is best for them. The HPRs also function as health educators and help to inform clients about the responsible use of the medical card. Furthermore, they function as client advocates in assisting individuals in getting the health and social services that they need.

Effective July 1, 1990, Utah initiated a program to encourage clients to utilize their primary care physicians instead of the emergency rooms. Clients that seek routing care through the emergency rooms are redirected back to their primary case physicians, as identified on their medical cards, for these services. Of course, urgent and emergent care are not effected by this policy. A payment of a $20 triage fee is made to the emergency room physicians for their assessment. In January 1994, to further reduce the inappropriate use of emergency room departments, a new method of reimbursing services provided in an emergency department was implemented. For diagnoses listed on a table of authorized emergency diagnoses, emergency room reimbursement is 98% of charges; for diagnosis not listed on the table, emergency room reimbursement is 40% of charges.

All Medicaid eligibles, with the exception of long term care and certain foster care clients are allowed to enroll in the CHCD program.

The Utah Peer Review Organization has a contract with the State Medicaid Agency to perform external reviews of the medical services provided by HMOs.

CONTACT: Ed Furia or Barbara Christensen
Utah Department of Health
Division of Health Care Financing
Bureau of Managed Health Care
288 North 1460 West
P.O. Box 16580
Salt Lake City, UT 81146-0580
(801) 538-6505 or 538-6456

Prepaid Mental Health Plan

Authority/Purpose

In July 1991, the Utah Medicaid agency implemented the Utah Prepaid Mental Health Plan in 3 different geographic areas of the state. The program is operated under the authority of §1915(b)(4) which restricts recipients to specific providers. Recipients in the areas served by the plan are required to obtain all mental health services (inpatient and outpatient) through the entity that has contracted with the State to provide a comprehensive array of mental health services.

The purpose of the waiver is threefold:

1. Control Inpatient Psychiatric Hospital Expenditures and Utilization - Control Medicaid expenditures for inpatient psychiatric care by promoting psychiatric care in the most appropriate and cost effective setting, including alternatives to inpatient hospital care.

2. Promote Access Through a Coordinated Mental Health Care Delivery System - Promote a coordinated mental health care delivery system that provides access to an appropriate array and mix of services for Medicaid recipients in need of such services.

3. Improve Outcome and Quality of Care - Improve the outcome and quality of care through periodic evaluations, holding contractors accountable, and providing financial and other incentives.

Covered Benefits

Covered benefits include inpatient hospital psychiatric and related physicians services. Medical detoxification is excluded. Under the outpatient benefit, all mental health clinic and related rehabilitative services providing in a clinic or other setting ar covered. The specific services include evaluation, psychological, treatment, skills development services, and targeted case management. Contractors may also provide a range of non-covered services such as residential treatment services with any savings from the risk-based contracts.

Enrollment/Contractors

All categorically and medically needy eligible groups in the counties served by the plan are automatically enrolled in the plan with the exception of Medicaid recipients who are at the State Hospital and the State Development Center. In 1992, approximately 57,000 Medicaid eligibles are enrolled in the plan, which represents about 52% of the total number of Medicaid eligibles.

Currently, 3 comprehensive community mental health centers have the exclusive contracts to serve the Medicaid recipients in their respective catchment areas. The largest contractor, Valley Mental Health, serves 2 urban counties that includes approximately 43% of all Medicaid eligibles; the other 2 contractors, Southwest Mental Health (5-county area) and Four Corners Mental Health (3-county area) serve rural areas and serve 5 and 3% respectively of the total Medicaid eligibles.

Payment Methodology

Contractors receive a combined premium each month for each enrolled Medicaid eligible in their catchment area. The premium is a combination of 2 rates: (1) inpatient psychiatric hospital and related physician services; and (2) all other outpatient mental health services. The premiums vary by eligibility category and age and are based on the historical cost adjusted for inflation of Medicaid expenditures for the groups served. When the plan was implemented there were 10 different rate cells. Beginning in January 1994 a new rate cell was added for children in custody.

During the first 2 years of the plan the contractors were at risk only for the inpatient psychiatric hospital services; they were not at risk for the outpatient services. This phase-in period gave them an opportunity to develop a range of alternative services and increase their ability to serve Medicaid recipients such as children who had traditionally been underserved.

First-Year Results

The first-year results have been promising from the perspective of the Medicaid agency, the contractors, and Medicaid recipients.

- Contractors successfully reduced the utilization of inpatient psychiatric services. In the areas served by the Prepaid Mental Health plan, the number of admissions was reduced by about 32% while in the areas that remained fee-for-service the number of admissions increased by about 31 percent.

- Medicaid agency and the group that conducted the independent evaluation of the waiver were able to demonstrate a savings of about $1 million to $1.5 million in the first year of the plan. This represents the difference between projected expenditures (upper payment limit) and what the Medicaid agency actually paid in premiums to the contractors for the risk portion of the contracts.

- Contractors increased the percentage of eligibles served in their catchment areas. In the year before the plan was implemented about 14% of Medicaid recipients received outpatient mental health services, while in the first year of the plan the percent served increased to about 19%.

- Based on survey of clients served in prepaid plan and fee-for-service areas, satisfaction with service varied slightly in favor of those in prepaid plan areas.

CONTACT: Zohreh Speckman or Ed Furia
Utah Department of Health
Division of Health Care Financing
Bureau of Managed Health Care
288 North 1460 West
Salt Lake City, UT 81146
(801) 538-6499 or 538-6505

Case Management Program for Pregnant Women. The presumptive eligibility/enhanced prenatal services program has been in operation in Utah since 1986. Increase emphasis from Federal legislation stimulated a planning effort with the initial goal of raising awareness and increasing the number of pregnant women receiving appropriate services at an early stage of pregnancy. The ultimate goal was to reduce infant mortality and morbidity. The COBRA legislation of 1985 which provided for case management and enhanced services was used, along with the SOBRA legislation of 1986 which provided for presumptive eligibility determination.

Case management was developed as a very essential part of the prenatal program. The case manager for this program is known as the Perinatal Care Coordinator (PCC). This coordination process requires the knowledge and skill of a registered nurse or a

certified social worker. The PCC serves as a liaison between clients and individuals or agencies involved in providing care, as a contract person for the client and family, and as a resource to prepare and counsel the client regarding essential services which are determined necessary and scheduled for the client.

The PCC is on the staff of the Qualified Provider (QP) of presumptive eligibility services or the private community physician who assumes care of the woman throughout her pregnancy. The intent is that the PCC becomes associated with the pregnant woman at the initial visit and begins at that point to assess her status and needs. The PCC plans and coordinates care and service to meet individual needs and to maximize access to necessary medical, social, nutritional, educational and other services for the pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

The perinatal care coordination process includes development of a comprehensive plan of service utilizing knowledge of alternative community resources to meet needs or resolve problems identified by provider assessments. Oversight tracking and monitoring of services by the PCC is essential to minimize fragmentation of care, reduce barriers, link clients with appropriate services and assure that services are provided consistent with optimal prenatal care standards.

We do not anticipate any expansion in the PCC program.

The services of a PCC are available to any woman with a medically verifiable pregnancy who is a Medicaid client or who meets the financial requirements for presumptive eligibility to receive ambulatory prenatal care services provided by a provider who is eligible for payment under the State plan.

Perinatal care coordination services are available statewide through qualified providers of presumptive eligibility services or private physicians.

There are no external review conducted in this program. Internal reviews are conducted from 2 different perspectives. First, the Utah Department of Health, Division of Family Health Services, manages this program operation. A program coordinator oversees activity by all qualified providers (including local health departments). Within the program operation there is a quality assurance audit and review. Second, Federally Qualified Community Health Centers are qualified providers in this program, and there is a quality assurance element within that organization.

The working relationship between Health Care Financing, Family Health Services and the Community Health Centers is such that we meet periodically to discuss issues, problems and proposed policy changes.

CONTACT: Urla Jeane Maxfield
Utah Department of Health
Division of Health Care Financing
P.O. Box 16580
Salt Lake City, Utah 84116-0580
(801) 538-6149

VIRGINIA

MEDALLION[SM]

In 1992, the Virginia Department of Medical Services (DMAS) implemented MEDALLION[SM], a primary care case management program (PCCM) for Aid to Families with Dependent Children (AFDC) in 4 pilot sites. By December, 1992, enrollment had reached 39,000 clients and more than 300 primary care physicians. With the successful completion of the pilot phase, the initiative was expanded statewide.

During 1993, the program expanded to include an additional 100,000 clients in 10 new localities within the State bringing total enrollment by December 1993 to nearly 140,000 with over 620 primary care physicians. By July 1994, a total of 30 localities within the Commonwealth were MEDALLION[SM] areas with more than 1100 primary care physicians and more than 226,000 clients.

The purpose of MEDALLION[SM] is to provide health care in a coordinated manner by enrolling clients with a primary care provider who is responsible for primary care and referral to specialty care. All services provided under Medicaid are available to MEDALLION[SM] clients. Emergency, obstetrical, dental, mental health, family planning and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) are excluded from referral requirements.

MEDALLION[SM] primary care providers are General and Family physicians, Pediatricians, Internal Medicine physicians, OB/Gyn physicians, and certain qualified specialists who agree to provide primary care services. Physicians who participate receive the standard fee-for-service payments plus a management fee of $3 per month for each MEDALLION[SM] client enrolled with them.

MEDALLION[SM] expansion beyond mid-1994 will focus on the non-institutionalized aged, blind, and disabled populations. Additionally, expansion into smaller communities is planned when the MEDALLION[SM] provider networks in those communities are deemed viable.

CONTACT: Thomas E. McGraw, Director
Division of Alternative Health Care
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Voice (804) 371-2451
FAX (804) 225-4512

WASHINGTON

The Department of Social and Health Services (DSHS), Medical Assistance Administration (MAA), currently has 220,000 clients enrolled in health care systems statewide, providing or arranging comprehensive medical services for eligible Medicaid clients under their Healthy Options program. A 3-county area has been operating a mandatory program, under the name Sound Care since 1986, with only 1 choice of health plans, while the rest of the State's enrollees are offered at least 2 choices. Current programs principally serve the Categorically Needy Children's and AFDC programs. The State's managed care programs require mandatory enrollment under federal waiver authority under 1915(b) of the Social Security Act. MAA contracts with managed care organizations through fully capitated, at-risk plans. In addition, MAA uses a primary care case management (PCCM) model, contracting directly with service providers and paying a monthly case management fee to provider care coordination. PCCM is used primarily in rural ares and with community and migrant health centers.

Program goals include: offering high quality, comprehensive care with an increased emphasis on prevention, increased access to appropriate medical services, increased efficiency through medical case management, enhanced health of clients through health education, increased continuity of care, reduction in the administrative burden of dealing with MAA, containment of long-term growth in medical care costs and more equitable reimbursement levels for participating primary care providers (PCPs) than under the current fee-for-service system.

Children with family incomes at or below 200% of the federal poverty level will be included in Health Options in counties being implemented on or after July 1, 1994, and will be added to existing counties on or after July 1, 1994. In some counties pregnant women, other than those who will eventually become eligible for AFDC in their third trimester of pregnancy, will also be included. By the end of 1994, there will be over 300,000 clients enrolled statewide in mandatory Medicaid managed care programs.

The Supplemental Security Income (SSI) eligible population will not be enrolled into a PCCM type of model beginning in July 1995. Eventually, most eligibility groups will be included in managed care. The implementation process will be driven by the unique needs of each eligibility group.

MAA is supporting Washington State's health care reform initiative and coordinating with the state's Basic Health Plan (BHP) to offer Medicaid benefits to children in families whose premiums are subsidized. There is a simplified eligibility process and joint marketing and promotion. The BHP premiums are more affordable for families who would otherwise remain uninsured.

In 1993, the Department of Social and Health Services was awarded a 2-year grant from the Henry J. Kaiser Family Foundation to implement the Health Care Financing Administration (HCFA) Medicaid Managed Care Quality Assurance Reform Initiative (QARI) Demonstration Project. The purpose of the project is to implement quality assurance guidelines for managed care, test whether the recommended guidelines are realistic, and suggest alternative approaches that may better meet the needs of providers, states, and the federal government to implement the final guidelines. The grant provides an opportunity for Washington State, managed health care providers, and External Quality Review Organizations (EQRO) to influence future federal mandates for managed care quality assurance programs.

CONTACT: MaryAnne Lindeblad, Chief
Office of Managed Care
DSHS- Medical Assistance Administration
P.O. Box 45506
Olympia, Washington 98504-5506
(206) 586-2583

The Mental Health Division (MHD) is implementing a waiver under section 1915(b) of the Act. Under the waiver the state Mental Health Program is administered through Prepaid Health Plans operated through individual Regional Support Networks. About half of the state is covered with the remaining part of the state expected to be covered by June 30, 1995. Enrollment in the PHPs is mandatory for all Medicaid eligibles in the state. During the initial phase of the waiver it will cover only outpatient mental health services. It is the intention of the MHD to phase in the Voluntary Inpatient Psychiatric program as soon as possible during the first 2 years of the waiver.

CONTACT: Dave Dula
Mental Health Division
DSHS-Health and Rehab. Services
P.O. Box 45320
Olympia, Washington 98504-5320
(206) 753-0911

WEST VIRGINIA

The State of WV has made no fundamental changes in our managed care program during the last year. We continue to operate a fee for service, primary care provider management program for AFDC and categorically related recipients and the like population eligible through OBRA expansions.

Currently a managed care proposal is being developed for mental health services. Also there is considerable activity in the provider and insurance communities directed to the development of HMOs, PPOs and other care management initiatives. As they become available, these options will be considered for inclusion in our Medicaid Managed Care offerings.

Program statistics as of August 1 are:

Total Medicaid Eligibles	303,615
PAAS Program Eligibles	188,435
PAAS Enrolled	91,769

The West Virginia Physician Assured Access System is a statewide managed care system operated by the Department of Health and Human Resources through its office of Medical Services with the goals of:

- o assuring needed access to health care;
- o providing for the continuity of care;
- o preventing unnecessary utilization and cost; and
- o strengthening the patient/physician relationship.

As an enhancement to the West Virginia Medicaid Program, the system provides recipients with a primary care provider who is responsible for providing or arranging the recipient's primary care and for referral for other medical services.

The following populations are enrolled in the program and are identified by the listing of the assigned provider on their medical card: Medicaid recipients receiving medical assistance under the AFDC or AFDC related categories; children in foster or subsidized adoption status; children eligible under Federal expansion programs and refugees. Excluded from participation are the following: aged, blind and disabled categories; SNF and ICF residents; and mental hospital patients.

Physicians who may participate include general and family practitioners, pediatricians, obstetricians and gynecologists,
internists, and physicians practicing in primary care centers or clinics. Other

physician specialists may participate under extraordinary circumstances with Departmental approval. Planning is currently under way to extend participation to certified, Medicaid enrolled Pediatric and Family Practice Nurse Practitioners.

Recipients may select any participating primary care physician or clinic. They are encouraged to select providers practicing in their county of residence or a contiguous county. Recipients not selecting a primary care provider will be assigned one based on claims history when possible and, if not, within a 30 mile radius of their home. Recipients are free to change providers if the assignment is incorrect, no longer appropriate or for cause. Likewise, a physician may choose to disenroll a particular recipient.

State of West Virginia has adopted a catchment area to include a 30 mile radius from participating providers. We have done this in lieu of constraining programs to county lines, because many of the counties within the State have few providers, while other have more than an adequate supply of primary care practitioners and many communities span county lines.

Primary physicians, in addition to their normal FFS reimbursements from Medicaid, are paid a monthly fee of $3 for each patient they manage.

Primary physicians must arrange for physician coverage 24 hours per day, 7 days per week. The primary physician should inform the recipient of his or her normal office hours and explain the procedures the recipient should follow when the office is closed. The recipient must be able to contact the primary physician, or other medical practitioner designated by the primary physician, to receive necessary medical care. A 24 hour access telephone number must be provided by the primary physician. This number is printed on the recipients's medical assistance identification card. Anyone unable to reach the primary physician or the designated representative should contact the program staff as soon as possible.

The following service categories must be either provided by the primary physician or referred by the primary physician in order to be reimbursed by Medicaid:

- Physicians, including EPSDT;
- Hospital inpatient;
- Hospital outpatient;
- Laboratory services;
- X-Ray services;
- Home health;
- Primary Care and rural health clinic services; and
- Ambulatory surgical centers.

Obstetrical care, including inpatient, family planning services, routine newborn care, routine eye care by ophthalmologists or optometrists, chiropractic and podiatric care, and outpatient mental health services may be provided for the recipient without referral from the primary physician or prior authorization. Referrals are made by the primary physician, in accordance with the accepted practices in the medical community, for specialty care or for primary care during his or her absence or non-availability. The primary physician must provide the specialist or other physician with the number necessary for billing for the service.

The PAAS physician's referral to a specialist may be for consultation, consultation and treatment, or ongoing treatment of a chronic problem and is construed to include routine diagnostic services. Time and other limitations may be imposed at the PAAS providers discretion. The specialist must keep the assigned provider apprised of the treatment plan and progress. After the primary physician's initial referral of a patient to a specialist for ongoing treatment, the specialist will not be required to receive further authorizations for the duration of the illness or, for the period of time specified by the primary physician. Referrals by the specialists to other providers for consultation and/or treatment require approval of the PAAS provider. For billing purposes the specialist and provider of any related services must obtain and enter the primary physician's authorization number on medical claim forms.

If a recipient is an established patient of a specified specialist, the referral to that specialist should be made whenever applicable to the recipient's condition as determined by the primary physician.

"Emergency care" is that care given when delay in treatment may result in death or permanent impairment of health and "urgent care" is that which should not wait for a normal scheduled office visit. Prior authorization from the primary physician is not required for this care. However, the primary physician should be contacted whenever practical to be advised that the care has been provided and to obtain the physician's authorization number for billing. If an authorization cannot be obtained from the primary physician, the provider may contact the PAAS Unit for assistance.

Routine care in the emergency room is not to be authorized by the primary physician and will not be payable under the program. If the recipient demands routine care in an emergency room he/she must be advised that it will be provided on a private pay basis.

The program will be monitored to insure that recipients are able to access care and that utilization patterns and costs fall within acceptable standards. Included in the measures reviewed will be numbers of emergency room visits, specialty referrals, inpatient hospital admissions, office visits, and laboratory procedures. Enrolled providers may receive printouts showing their utilization rates and the average rates

for their specialty to allow them to compare themselves on a statewide basis.

Program staff will use the review to identify program irregularities as a basis for targeted provider/recipient education and for investigation of possible system abuse and corrective action.

The PAAS Advisory Committee functions as a subcommittee of the Medical Services Fund Advisory Council and advises the PAAS Program relative to issues and problems of access, quality of care, recipient/physician relationships, policies, procedures and reporting. It has representation from recipient advocacy groups, medical provider groups and health-related State agencies.

WISCONSIN

The Wisconsin MA Program began contracting with Health Maintenance Organization's (HMOs) in the late 1970s. In 1982, Wisconsin received a waiver of federal freedom of choice regulations. This waiver permits Wisconsin to mandate Aid to Families with Dependent Children (AFDC) enrollment into HMOs.

In 1984, Wisconsin began mandatory enrollment of AFDC recipients residing in Dane and Milwaukee Counties HMOs. The program was expanded to Eau Claire County in 1986. Wisconsin has also received expanded waiver authority that permits mandated enrollment of Healthy Start recipients into HMOs. In 1994, Wisconsin plans to add Waukesha County to the HMO Program and is considering expanding to Kenosha County in 1995. Wisconsin, in fiscal year 1994, contracts with 9 HMOs in these 3 counties to service 120,000 Medical Assistance (MA)/AFDC recipients. Six of these HMOs are located in Milwaukee, 2 in Dane, and in Eau Claire. In May 1994, there were 118,345 HMO enrollees in Milwaukee County, 3,626 in Eau Claire County, and 2,711 in Dane County.

All AFDC recipients in Milwaukee County are mandatorily enrolled. In Dane and Eau Claire Counties, there is insufficient enrollment capacity to enroll all eligible recipients in Dane County, all AFDC recipients residing in the City of Madison are required to join an HMO, and in Eau Claire County all AFDC recipients are currently either enrolled in an HMO or placed on an HMO waiting list until space becomes available.

The HMOs receive a fixed payment for person per month in exchange for providing and managing MA services delivered to their MA enrollees. The MA enrollees receive all of their health care services from HMO providers, except that HMOs can elect not to cover dental services. Recipients who enroll in an HMO that does not cover dental receive dental services on a fee-for-service basis.

External review of the HMO Program is performed by Wisconsin's PRO contractor (currently the Wisconsin Peer Review Organization or WIPRO). WIPRO conducts annual medical chart reviews on 2% of all MA/HMO enrollees who use services.

Through these reviews, WIPRO identifies potential cases in which inappropriate care may have been delivered and the Department of Health and Social Services (DHSS) conducts follow-up on these cases. This process involves DHSS's review of documentation submitted by the HMO and provider and, in some instances, corrective action by the HMO and provider.

Since 1984, HMOs have saved over $100 million in Medicaid dollars and are projected to save at least $20 million during the next 2 years.

The attached chart summarizes current efforts and planned expansions of MA managed care in Wisconsin:

- Wisconsin FirstCare - Wisconsin will implement the Wisconsin FirstCare program in October 1994 in selected counties. AFDC and Health Start eligibles will be required to pick a primary physician to coordinate their care. Plans are to enroll at least 41,000 eligibles over 6 months.

- Community Care for The Elderly and Elder Care - Wisconsin is participating in the national On-Lok replication project. Under this project the frail (nursing home eligible) elderly are enrolled into a HMO-like program which provides intensive case management to contain costs and improve participants' quality of life. If this program proves successful as a pilot project, it could lead to large scale enrollment of the frail elderly into similar programs in Wisconsin.

- Targeted Managed Care (TMC) - This is a program designed to reduce and control costs while improving access to appropriate medical services and enhancing the effectiveness of those services. The TMC would target Medicaid recipients with diagnoses indicating long-term, chronic illness accompanied by periodic episodes of inpatient or other intensive care needs (e.g. AIDS patients, severe head injury). The Department is considering several payment models, including separate payment for case management services, or a risk-based capitation model for some of all services. Participating providers would coordinate appropriate care for these special needs cases.

- Independent Care - Wisconsin has implemented a prepaid research and demonstration program for providing coordinated medical and social services for disabled Medicaid recipients. The name of the project is Independent Care (I-Care). Work group members expect I-Care to have national significance as a prepaid program of care for the disabled and to provide the basis for large-scale enrollment of the disabled into HMOs in Wisconsin. Wisconsin received a Health Care Financing Administration grant to support this initiative. Additionally, Wisconsin was 1 of 4 states to be awarded the consulting services of the Medicaid Working Group. The Medicaid Working group is funded by the Robert Wood Johnson Foundation and Pew Charitable Trusts to work with Medicaid programs to develop new systems of care for people with disability and chronic illness.

- Children Come First - CCF is a program for severely emotionally disabled children in Dane County.

CONTACT: Neva J. Kaye

Department of Health and Social Services
Division of Health
One West Wilson Street
P.O. Box 309
Madison WI 53701-0309
(608) 266-7677

WYOMING

Wyoming currently does not have any managed care programs in operation. Wyoming is actively pursing primary care case management initiatives and a capitated arrangement with a hospital and physicians within a locale for primary case services.

Wyoming is exploring the feasibility of purchasing private health insurance for certain categories of Medicaid clients. The private health insurance would have to include a managed care element.

CONTACT: Kenneth C. Kamis
Administrator
Division of Health Care Financing
6101 Yellowstone Road, Room 259B
Cheyenne, WY 82002
(307) 777-7531

* U.S. G.P.O.:1995-386-897:23484