

medicaid  
and the uninsured

MEDICAID MANAGED  
CARE FOR PERSONS  
WITH DISABILITIES:  
CASE STUDIES OF PROGRAMS  
IN FLORIDA, KENTUCKY,  
MICHIGAN AND NEW MEXICO

*Prepared by*

Marsha Regenstein, Ph.D.

Christy Schroer, M.H.A.

Jack A. Meyer, P.h.D.

The Economic and Social Research Institute  
*for*

The Kaiser Commission on  
Medicaid and the Uninsured

**April 2000**

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of the Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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# MEDICAID MANAGED CARE FOR PERSONS WITH DISABILITIES: CASE STUDIES OF PROGRAMS IN FLORIDA, KENTUCKY, MICHIGAN AND NEW MEXICO

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Marsha Regenstein, Ph.D.<sup>1</sup>

Christy Schroer, M.H.A.

Jack A. Meyer, Ph.D.

The Economic and Social Research Institute

Preparation of this report was supported by a grant from the Kaiser Commission on Medicaid and the Uninsured. The views expressed in this report are those of the authors and do not necessarily reflect those of the Commission or The Henry J. Kaiser Family Foundation. A companion paper, *Medicaid Managed Care for Persons with Disabilities: A Closer Look* (publication #2179), provides an overview of the findings and summaries of the case studies. This work is part of a larger study on Medicaid managed care for individuals with disabilities that also includes a national survey of state practices and focus groups of low-income disabled individuals.

<sup>1</sup> Ms. Regenstein is currently director of the National Public Health and Hospital Institute.

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## About ESRI

**The Economic and Social Research Institute (ESRI)** is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

## About the Authors

**Marsha Regenstein, Ph.D.**, formerly vice president of ESRI, is the director of the National Public Health and Hospital Institute. Dr. Regenstein has analyzed how changes to the health care market affect vulnerable populations, especially persons with disabilities. She has written on safety-net hospitals, coverage policy within Medicare and Medicaid, long-term care, welfare reform, and models for financing early childhood education.

**Christy Schroer, M.H.A.** is a research associate at ESRI. Ms. Schroer has conducted research on Medicaid managed care, hospital outpatient services, laboratory safety and health regulations, and physician issues.

**Jack A. Meyer, Ph.D.** is the founder and president of ESRI. Dr. Meyer has conducted policy analysis and directed research on frontline issues in health care reform and social policy. He is the author of numerous books, monographs, and articles on topics including health care, labor market and demographic trends, and policies to reduce poverty.

## Acknowledgments

The authors would like to acknowledge the contribution of Medicaid staff, advocates, program beneficiaries, health plan administrators and medical directors and many others who were generous with their time during our site visits. We are particularly grateful to Charles Corley, Charles Kight, Wendy Smith and Jayne Parker in Florida; Jay Dowds, Dr. Richard Heine and Mary Walker in Kentucky; Richard Murdock and Jane Finn in Michigan; and Charles Milligan and Marise McFadden in New Mexico. The authors would also like to acknowledge Linda Cummings, Ph.D., for her assistance on this project. We gratefully acknowledge the support of the Kaiser Commission on Medicaid and the Uninsured.

# Overview

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Throughout the 1990s, states have been turning to managed care in an effort to improve access to care and control costs for Medicaid beneficiaries. At first, states were primarily moving young parents and their children enrolled in the Temporary Assistance to Needy Families (TANF, formerly AFDC) program into managed care. More recently, states have been attempting the more difficult task of finding managed care options for people with disabilities and chronic illnesses. This population includes children with special health care needs, non-elderly adults with physical impairments, functional limitations, and severe mental or emotional problems, and the frail elderly.

While approximately one in four non-elderly persons with disabilities in the Medicaid program is enrolled in managed care, there is not a lot known about how the disabled are faring in these programs. Proponents of managed care assert that such programs have considerable potential to improve the health and functional status of people with disabilities by improving access to primary and preventive care, coordinating and integrating health and social services, and encouraging the use of home and community-based alternatives to institutional care. Nevertheless, if not properly designed and monitored, managed care can pose serious threats to the health and well-being of people with disabilities. For example, managed care may sever patients' long-standing relationships with physicians who understand their special needs and problems. It may create incentives for providers to block access to specialty care and ancillary services that are required to meet the complex needs of children and adults with disabilities. It may also exacerbate the adverse risk selection in the health insurance market, furthering incentives facing health plans to sidestep enrolling people whose anticipated medical costs are high.

To further explore these issues, the Kaiser Commission on Medicaid and the Uninsured commissioned a three-part study of Medicaid managed care and individuals with disabilities with support from the Henry J. Kaiser Family Foundation. This study included a

national survey of state Medicaid programs and four in-depth case studies of managed care programs in Florida, Kentucky, Michigan, and New Mexico. In addition, Lake Snell Perry & Associates conducted seven focus groups of individuals with disabilities in Medicaid managed care in Florida and New Mexico.

This report presents the results of the case studies in Florida, Kentucky, Michigan, and New Mexico. The case studies are based on interviews conducted in the fall of 1998 with state officials, provider and plan representatives, and advocates. This report provides an overview of each state's Medicaid program, followed by an analysis of the structure and impact of various program features, such as whether capitated and/or PCCM programs are offered; whether the programs are mandatory or voluntary for people with disabilities; criteria for autoenrollment, if any; rate-setting criteria for capitated programs; whether disabled people are covered by "mainstream" managed care or by a separate specialized program; and whether the behavioral health is offered under a managed arrangement or an alternative approach. Additional findings from this project are available from the Kaiser Commission on Medicaid and the Uninsured.<sup>1</sup>

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<sup>1</sup> Marsha Regenstien and Christy Schroer. *Medicaid Managed Care for Persons with Disabilities: State Profiles*, prepared for the Kaiser Commission on Medicaid and the Uninsured, December 1998. Michael Perry and Neil Robertson. *Individuals with Disabilities and Their Experiences with Medicaid Managed Care: Results from Focus Group Research*, prepared for the Kaiser Commission on Medicaid and the Uninsured, July 1999. [www.kff.org](http://www.kff.org).

# Case Studies

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**Florida**

**Kentucky**

**Michigan**

**New Mexico**



# Florida

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## Introduction

Florida has a long history of enrolling its Medicaid population in managed care programs, beginning first with voluntary options in the early 1980s, moving to mandatory primary care case management in the early 1990s, and then operating mandatory capitated and PCCM managed care programs. Currently, Florida is one of four states that requires nearly all of its Medicaid population to enroll in managed care, but allows them to choose between a PCCM and a capitated program.

Florida's Agency for Health Care Administration (AHCA) conducts the operations of these two managed care programs – both of which enroll persons with disabilities: the Medicaid Provider Access System, known as MediPass, is the state's PCCM program; and the HMO Program, is a mainstream capitated program. Most children with disabilities or special health care needs receive services through the Children's Medical Services Network – a Maternal and Child Health (Title V) program that operates as part of the MediPass program for Medicaid beneficiaries. The majority of Medicaid beneficiaries in both programs receive behavioral health services on a fee-for-service basis; in five Tampa-area counties, however, MediPass beneficiaries receive mental health services through a capitated pilot project called the Prepaid Mental Health Program.

## Background

The Florida Medicaid program's initial experience with managed care began in the early 1980s with a voluntary capitated program. After several years of relatively modest enrollment, the state developed a mandatory PCCM program in the early 1990s, MediPass, and managed care enrollment swelled quickly.

Florida also has a long history of enrolling persons on SSI in capitated care. As early as 1984, only two years after the state entered its first full-risk contract, some SSI beneficiaries (not eligible for Medicare) enrolled in a voluntary capitated program. These early beneficiaries were attracted to the program because of additional services offered by participating health plans, such as enhanced dental or vision services. Still, enrollment in the voluntary HMO Program was relatively low in the 1980s and the early 1990s for the AFDC population, and was even lower for the SSI population.

Determined to make managed care the dominant mode of health care delivery for the Medicaid program, the state began in 1996 to require beneficiaries eligible for managed care<sup>2</sup> to enroll in either the MediPass program or in the state's capitated option, called the

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<sup>2</sup> Medicaid beneficiaries who are exempt from mandatory managed care include those who are dually eligible for Medicaid and Medicare, individuals in waiver programs and other special populations. Individuals who qualify for seven waiver programs are exempt from managed care. These seven programs are: the Aged/Disabled Adult Waiver; the Assisted Living for the Elderly Waiver; the Channeling Waiver; the Developmental Services Waiver; the Katie Beckett Waiver; the Project AIDS Care Waiver; and the Supported Living Waiver.

HMO Program. This requirement applies to adults with disabilities in Florida who do not qualify for one of the waiver programs and who are ineligible for Medicare. Children with disabilities are also required to participate in a managed care option; however, they are eligible for the MediPass option only. These children may choose to receive services through the Children's Medical Service Network (discussed below), or through other MediPass providers. They are not eligible for the HMO Program.

## **Autoassignment**

In 1996, when managed care became mandatory for individuals on SSI, beneficiaries began to be autoassigned according to the same proportions seen by those choosing plans. This represented a change from earlier autoassignment patterns, when beneficiaries who did not choose were assigned to the MediPass program. Not surprisingly, MediPass enrollment grew rapidly during those years. In part because of this "favoritism" toward MediPass, HMO representatives successfully lobbied the legislature to change the autoassignment criteria to mirror the ratio in which beneficiaries were voluntarily choosing between MediPass and health plans of the HMO Program. Even after this change, however, the MediPass program experienced the greatest gains in enrollment because beneficiaries continued to prefer MediPass over the HMO program. Thus, while the change in 1996 brought more beneficiaries into the HMO Program, it did not tilt the scales in favor of the HMO Program.

In September 1998, reflecting both pressure from the HMO industry and the state's desire to move more beneficiaries into capitated arrangements, the assignment process was changed a second time. Currently, all eligible beneficiaries who do not choose between the two programs within 30 days are autoassigned to a health plan in the HMO Program. This autoassignment procedure will remain in place until enrollment in the two programs reaches parity.

## **Medicaid Provider Access System (MediPass)**

The Medicaid Provider Access System (MediPass) was designed in the early 1990s to provide a medical home for beneficiaries, to reduce inappropriate utilization and to control Medicaid expenditures. The program was developed as a result of Medicaid beneficiaries' limited interest in the voluntary capitated program and the state's desire to move more individuals into managed care arrangements.

A MediPass pilot program was launched in four counties in the Tampa area in 1991. Persons receiving Aid to Families with Dependent Children (AFDC) and related individuals were required to participate in the pilot program. Ten months after the launch of the pilot, an independent evaluation by the University of South Florida noted positive findings in the review of the program, especially from the physicians' perspective. In 1993, the

program was expanded to include most of the state with the exception of the panhandle and the southern tip of the state, including Miami. In 1995, the program was expanded again to encompass the entire state.

In 1995, the statewide expansion of MediPass was accompanied by legislation that required mandatory participation in managed care for the majority of Medicaid beneficiaries in either the HMO Program or in MediPass. The legislation required SSI beneficiaries who were not receiving Medicare to be phased into managed care by spring 1996. Prior to the legislation, SSI beneficiaries were ineligible for MediPass and eligible for the HMO Program on a voluntary basis only. As a result of the program expansion that included the SSI population and the increased enrollment from the mandatory assignment, the MediPass program grew dramatically.

Because of this rapid growth over 1995 and 1996, Florida's Agency for Health Care Administration (AHCA), which runs the Medicaid program, found itself scrambling to sign up an ample number of primary care physicians to handle the influx of beneficiaries. Since the beginning of the MediPass program, the AHCA has required that a county have a network of physicians that is capable of serving all of the Medicaid beneficiaries in the area before it will certify it as MediPass eligible. Furthermore, the AHCA allows each provider a maximum of 1,500 MediPass beneficiaries on his or her panel. Due to these two requirements, AHCA personnel had to step up efforts to recruit providers and develop administrative mechanisms to support the program expansion.

# MediPass

## Features:

Waiver Authority	Program Model	Program Type	Participation	Program Operates	Ages Enrolled	Enrollment Broker
1915b	PCCM	Mainstream	Mandatory*	Statewide	All Ages	Yes

\*Enrollees can choose either MediPass or the Medicaid HMO Program.

**Per Member Per Month Case Management Fee:**  
\$3.00

### Enrollment:

Estimated Program Enrollment: 484,880

Estimated Enrollment of PWD: 135,000 (27.3%)

- ⇒ Autoassignment is based on geographic area, with children assigned to pediatricians or family physicians and women to obstetricians/gynecologists.
- ⇒ Beneficiaries who do not choose between the MediPass and Medicaid HMO Program are assigned to the HMO Program.

### Services Excluded from MediPass:

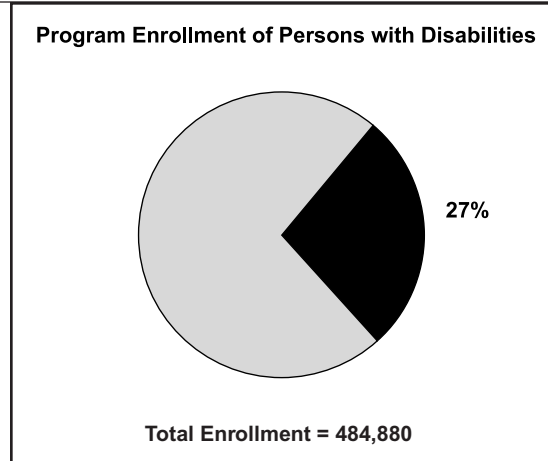
- Long-Term Care
- Home and community-based services
- Some Family Planning
- Ophthalmology related services
- Behavioral health services

### Behavioral Health Services:

- In the five county Tampa area, mental health services are provided by a single BHO through the pilot Prepaid Mental Health Program. In the remaining parts of the state, mental health services are provided on a fee-for-service basis. Substance abuse services are provided on a fee-for-service basis statewide.

### Special Features for Persons with Disabilities:

- Specialists can serve as PCPs for persons with disabilities.
- The Children's Medical Service Network, which functions as a subset of the MediPass program, serves children who meet certain medical eligibility criteria.
- The state requires all Medicaid beneficiaries to receive a health assessment, performed by the PCP, within 90 days of their enrollment.
- The state has also developed disease management programs for diabetes, hemophilia, and HIV/AIDS that will be incorporated into MediPass during 1999.



## Enrollment and Program Structure

The previous page provides a summary of enrollment and many key features of the MediPass program. In October 1998, there were roughly 232,000 SSI beneficiaries who did not receive Medicare in Florida. SSI beneficiaries are more likely to enroll in the MediPass program. Approximately 61 percent - or 143,000 - of these SSI beneficiaries were enrolled in MediPass. Persons on SSI continue to choose the MediPass program more frequently than those in the general Medicaid population.

MediPass is a traditional PCCM model, with participating MediPass physicians providing care or referring members for nearly all covered services, and creating a “medical home” for program beneficiaries.<sup>3</sup> MediPass members do not have to go through their PCP for ophthalmology-related services, behavioral health services, family planning, and emergency services. Primary care physicians receive a \$3.00 management fee per month for each MediPass enrollee they serve.

The program allows specialists to serve as PCPs, although the state reports that relatively few choose to participate, presumably because of the lower fees associated with primary versus specialty care. The AHCA requires the PCPs to perform a health assessment on all newly enrolled MediPass beneficiaries within 90 days of enrollment.<sup>4</sup>

State officials contend that PCPs in the program continue to refer beneficiaries to specialty services in the same numbers, but that duplication of services has been reduced. A Florida State University evaluation of the program<sup>5</sup> (performed prior to the enrollment of the SSI population in Medicaid managed care) supported the state’s assertion that all medically necessary referrals are being made under the program. The evaluation also found that the program resulted in cost savings, on average, of 13.5 percent compared with the fee-for-service program. These savings were seen in virtually all categories of services, except pharmaceuticals.

## Quality Assurance

Quality in the MediPass program is assessed, in part, by the MediPass Utilization Review System. The system monitors MediPass utilization in categories such as emergency room visits, outpatient visits, specialist referrals, inpatient hospital admissions, laboratory and x-ray procedures, PCP office visits, and the average cost per enrollee. Medicaid

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<sup>3</sup> In 1997, the legislature approved the operation of Provider Sponsored Networks (PSNs) to serve Medicaid beneficiaries. The PSNs, which are expected to become operational during spring 1999, will become a segment of the MediPass program and serve as an additional delivery system which beneficiaries can choose. If a MediPass provider joins a PSN, the provider’s entire MediPass panel will be rolled over into the PSN, although the recipient retains the option to change to a different MediPass physician or change to the HMO Program.

<sup>4</sup> This requirement applies to the HMO Program as well.

<sup>5</sup> Florida MediPass Evaluation Technical Report, Charles Barroilleauz, Susan Philips, Christopher Stream, December 1995.

beneficiaries who are outliers in any of these categories are investigated by the state according to specified guidelines. Physician performance under the MediPass program is reviewed by the state's Peer Review Organization. There are no additional quality assurance provisions that apply specifically to persons with disabilities.

## **Special Provisions for Persons with Disabilities**

When eligible SSI beneficiaries were being moved into managed care, the state held a number of forums to obtain input from disability advocates and consumers about how to structure the program. There were a series of meetings, mostly in Tallahassee, to which advocates were invited to attend and participate along with AHCA personnel and state legislators.

During the final MediPass expansion, the AHCA developed policies and provisions to accommodate the enrollment of persons on SSI. During the process, the AHCA worked closely with many advocacy groups that work on behalf of persons with disabilities. The agency developed information packets for PCPs to assist with the care of persons on SSI. The state trained Medicaid Area Offices personnel to help them conduct effective and informative sessions for local physicians serving the SSI population. The state also attempted to persuade specialists to become part of the MediPass network of PCPs for persons with disabilities. In this regard, the state aggressively pursued specialists who were already providing care to many SSI beneficiaries.<sup>6</sup>

The AHCA requires all Medicaid beneficiaries to receive a health assessment, performed by the PCP, within 90 days of their enrollment. While this requirement applies to all Medicaid beneficiaries, it is very helpful for identifying any immediate health care of persons with disabilities.

The AHCA has also developed disease management programs for diabetes, hemophilia, and AIDS that it will be incorporating into its Medicaid programs during 1999. The Agency has plans to launch disease management programs for conditions such as end stage renal disease, sickle-cell anemia, congestive heart failure, cancer, and hypertension.

## **Children's Medical Services (CMS) Network Program**

The MediPass program has an added feature for children with special health care needs. Interested parents can enroll eligible children in Florida's Children's Medical Services

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<sup>6</sup> It is not clear to what extent physicians participated in the educational activities offered by the state during the MediPass expansion. One physician who participated in the program since its inception in the Tampa area did not attend any meetings and was not even aware of their existence. On the other hand, a practice manager for a large group of physicians that serves many MediPass clients told us that she was aware of the education activities offered by the state.

(CMS) Network Program, a Title V/Maternal and Child Health Bureau program that specializes in the care of children with disabilities and other chronic conditions.

The CMS has been in existence in some form since 1929. The program originally provided orthopedic services and equipment to children with special health care needs. Over the years, the program evolved and its primary function was to provide specialty-related services to eligible children. During the early 1990s, however, the focus of the program shifted to incorporate primary care-related services. As a result, the CMS is currently a comprehensive health care program.

In 1996, when the Florida Agency for Health Care Administration required a majority of Medicaid beneficiaries to participate in a managed care program, the CMS was reorganized to function as a separate managed care choice that operates as a MediPass partnership. The CMS is authorized through an amendment to the 1915b waiver under which MediPass operates.

In order to be eligible for the CMS, children up to the age of 21 must receive Medicaid benefits and meet certain medical criteria.<sup>7</sup> The general medical requirements that determine eligibility for the CMS program include the following: a child must have a functional disability; have a condition that is expected to last at least twelve months; and require special medical care, therapies, supplies and equipment related to their primary diagnosis.

Enrollment in the CMS is initiated when a child or family becomes eligible for Medicaid. When the state's enrollment broker informs a family about its Medicaid managed care options, the CMS is discussed as one alternative.<sup>8</sup> Parents are encouraged to contact the local CMS office if it appears that their child is eligible for the program. When a family member contacts the local CMS office, the child's medical eligibility can be determined through a telephone survey or a medical examination, if necessary.

As of February 1999, approximately 26,000 children<sup>9</sup> were served by the CMS. About 80 percent of these children are Medicaid beneficiaries. The rest are ineligible for Medicaid but qualify for Title V/Maternal and Child Health Services.

The CMS network is attractive to many families as an alternative to the two mainstream Medicaid managed care programs because it provides a range of additional services to eligible children. These include early intervention services, respite care, genetic testing,

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<sup>7</sup> Despite the age restriction, the CMS program continues to treat certain beneficiaries even after they turn 21 because, according to CMS officials, there are no appropriate alternatives for their care. Legislation has been passed, however, that will not allow individuals over the age of 21 to be served by the CMSN after the year 2000.

<sup>8</sup> It is not clear to what extent families who choose their managed care plan understand their options.

<sup>9</sup> The CMS has recently begun enrolling children eligible under the Title XXI Program. As a consequence, enrollment is expected to increase substantially in the near future.



nutritional counseling and parental support. Moreover, the CMS provides services to eligible children in community settings, while retaining strong relationships with a specialty network that includes many pediatric centers of excellence and academic health centers.

The medical panel of the CMS network is comprised of a select group of MediPass physicians who are board certified in pediatrics or family practice and elect to participate in the program. While the CMS is a public program, it has a unique partnership with the Florida Pediatric Society and the Florida Medical Association, which lobby on behalf of the program. The efforts of these associations, combined with strong support from the legislature, have aided the program's development.

## **Case Management**

In an effort to ensure that children enrolled in CMS receive coordinated care, every child is assigned a case manager who is responsible for providing primary and specialty care case management. In addition, the case manager provides links with community resources and coordinates the flow of information among the PCP, the CMS network of physicians and other providers, other supporting programs, and the family.

The family works with the case manager to select a child's PCP, who is generally a pediatrician or a family practitioner. A specialist can serve as the PCP under some circumstances, if approved by the CMS Medical Director. Approval typically occurs only for children with AIDS or certain hereditary coagulation disorders.

## **Reimbursement**

The CMS network has operated as a component of the MediPass program since 1996.<sup>10</sup> As a result, network physicians are paid a \$3 case management fee, with services reimbursed on a fee-for-service basis. The physicians sign the MediPass participation agreement, and the program adheres to Medicaid's procedural standards pertaining to quality assurance and dispute resolution mechanisms. Additional quality measurement features, specific to children with special health care needs, are currently being incorporated into the program.

Reimbursement for the Medicaid portion of the CMS program is scheduled to be converted to a capitated arrangement some time in 1999. The rate will vary by age and geographic region; the state is also investigating the use of risk-adjusters, which it may implement some time in the future.

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<sup>10</sup> The CHIP portion of the program operates under a capitated arrangement that is adjusted for age and geographic region.

## Reactions to MediPass and the Children's Medical Service Network

It appears that physicians are generally favorable in their impressions of the MediPass and CMS programs. Those we interviewed for this study indicated that they do not treat the MediPass or CMS clients differently than their other patients, primarily because they are usually unaware of their patients' insurance status. One primary care physician mentioned, however, that he frequently has difficulty finding physicians to accept his referrals because many providers still do not accept MediPass patients.

For the most part, advocates who work on behalf of individuals with disabilities or chronic health care conditions view MediPass and the CMS favorably. One advocate mentioned that when the state implemented mandatory enrollment in managed care for SSI beneficiaries, the advocacy community expected the outcomes to be disastrous. Advocates were concerned that the program would limit services. But contrary to their original beliefs, they feel the program has worked surprisingly well for persons with disabilities. One advocate also credited the state's efforts to involve the advocacy community through hearings and informational sessions to voice their opinions prior to managed care's becoming mandatory for persons with disabilities.

Advocates remain concerned, however, about the recent change in autoassignment practices, which is increasing enrollment in the HMO Program. Advocates believe that persons with disabilities, especially individuals with more severe disabilities, fare better in the MediPass program than in capitated care arrangements. Advocates want assurances that the state is not going to discontinue the MediPass program and that it will remain a choice for Medicaid beneficiaries.

# Medicaid HMO Program

## Features:

Waiver Authority	Program Model	Program Type	Participation	Program Operates	Ages Enrolled	Number of MCOs	Enrollment Broker
1915b	Capitated	Mainstream	Mandatory*	Statewide**	All Ages	16	Yes

\*Enrollees can choose either MediPass or the Medicaid HMO Program.

\*\*Aside from a few rural counties.

## Capitation Rates Vary By:

Categorical eligibility for Medicaid, Age, Geographic Area

## Enrollment:

Estimated Program Enrollment: 372,300

Estimated Enrollment of PWD: 70,000 (18.8%)

- Beneficiaries who do not choose between the MediPass and Medicaid HMO Program are assigned to the HMO Program.

## Services Excluded from Medicaid HMO Program:

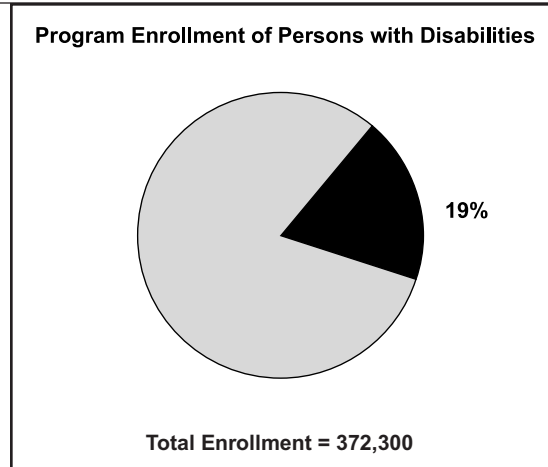
- Long-Term Care
- Home and community-based services
- Behavioral health services

## Behavioral Health Services:

- In the five county Tampa area, mental health services are provided by a single BHO through the pilot Prepaid Mental Health Program. In the remaining parts of the state, mental health services are provided on a fee-for-service basis. Substance abuse services are provided on a fee-for-service basis statewide.

## Special Features for Persons with Disabilities:

- Health plans must honor existing care plans for newly enrolled beneficiaries for 30 days until a new care plan can be developed.
- The state requires all Medicaid beneficiaries to receive a health assessment, performed by the PCP, within 90 days of their enrollment.
- The state has also developed disease management programs for diabetes, hemophilia, and HIV/AIDS that will be incorporated into MediPass during 1999.



## HMO Program

Florida has enrolled Medicaid beneficiaries in full-risk, capitated care since 1982. At that time, AFDC beneficiaries were given the option to enroll in a county public health department-run program. In the years that followed, the program grew slowly as the state contracted with a few additional health plans. In 1984, the state opened enrollment to non-Medicare SSI beneficiaries, although enrollment continued to grow at a very slow pace. Even a state-initiated RFP for the program in the mid-1980s drew a very limited response from interested health plans. As a result, the state decided to proceed with an “any willing provider” provision and the program continued to grow slowly.

By 1996, however, when the AHCA initiated a second bidding process (in response to the legislature’s concerns about the costs of the Medicaid program), there was a considerable amount of interest in bidding for contracts, as evidenced by the approximately 30 responses the state received. The increased interest may have reflected the perception that some of the established players in the Medicaid HMO Program were generating profits, or at least breaking even on this population. Instead of selecting only a few “winning” health plans, the state ultimately decided to continue to operate under its “any willing provider” clause, thereby allowing all health plans that meet the terms of the contract to participate in the Medicaid HMO Program. By September 1998, there were 14 participating health plans in the program.<sup>11</sup>

Since September 1998, all Medicaid beneficiaries who are eligible for managed care – and who do not select which program they wish to join – have been autoassigned to the HMO Program. This change in the autoassignment process is designed to bring HMO enrollment to MediPass levels. It reflects the state’s desire to move more beneficiaries into capitated arrangements, where they believe the cost savings will be more significant.

## Enrollment, Capitation Rates, and Covered Services

The previous page includes enrollment and program information about the HMO Program. Florida uses an enrollment broker to handle all functions associated with the enrollment process. Most interactions with clients – disabled or non-disabled – are through telephone contacts. No special enrollment provisions are available for clients with special needs in the Medicaid HMO Program, although there are special protocols for individuals who are eligible for waiver programs (and therefore ineligible for the HMO Program).

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<sup>11</sup> Since the state entered into its first risk-based contract in 1982, a considerable amount of legislation has been passed in Florida, which has regulated the HMO Program for Medicaid beneficiaries. In 1996, the requirement that the state could not contract with an entity that was not licensed by NCQA or JCAHO was added in response to political pressure generated by the HMO industry. Since 1982, the number of health plans with which the state contracts has ranged from three to approximately 28.

Once enrolled in a health plan, the state requires a health assessment for all members within 90 days by a primary care physician. The state also requires health plans to honor existing care plans for 30 days, allowing time for a new care plan to be developed. Currently, there is no lock-in period for any beneficiaries in the program.

In October 1998, there were approximately 64,000 persons with disabilities enrolled in the HMO Program. This figure represents approximately 28 percent of the total non-elderly SSI beneficiaries eligible for managed care in the state – fewer than the percentage of the general Medicaid population enrolled in the HMO Program.

As HMO Program enrollment has grown, Florida Medicaid has had difficulty maintaining adequate provider networks in certain parts of the state. This problem is particularly troubling in rural areas, where many of the provider networks are inadequate, causing concern that some beneficiaries may not be receiving all necessary services from the health plans. Also at issue is the use of Federally Qualified Health Centers (FQHCs), which health plans are required to include within their networks. The state contends that the health plans do not promote the use of these centers. As a result, the state is working with a coalition of FQHCs to assess their future role in the delivery of Medicaid services.<sup>12</sup>

The rates paid to participating HMO Program health plans vary according to three separate criteria – categorical eligibility for Medicaid, age and geographic region. The average rate is based on 92 percent of the average expected amount for coverage in the MediPass program. In 1999, the state will investigate ways to incorporate more sophisticated risk-adjusters into its payment methodology.

The health plans are responsible for providing a comprehensive range of services to beneficiaries, with a few important limitations. The plans are not responsible for most behavioral health services other than limited inpatient days in licensed facilities.<sup>13</sup> Most of the health plans that participate in the HMO Program try to attract beneficiaries by offering services that are not covered by the MediPass program. These services commonly include expanded dental coverage, enhanced vision services, and limited non-prescription medicines and first-aid supplies.

## Quality Assurance

The Professional Review Organization (PRO) with which the state contracts is charged with ensuring that appropriate care is rendered and that all appropriate referrals are made under the HMO Program. In addition, there are a few quality assurance features built into the contract of the HMO Program. The state has just begun collecting subsets

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<sup>12</sup> The state initially contracted with one of the FQHCs but had to discontinue the agreement in 1996 because of a requirement that the AHCA could only contract with licensed organizations.

<sup>13</sup> This excludes freestanding psychiatric service centers.

of the HEDIS indicators and plans to disseminate the collected information to beneficiaries some time in the future.

In November 1998, the first HMO report cards were available for the state, but they are not specific to Medicaid. The report cards include any health plan that voluntarily participates, including those that serve only commercial populations. The state requires health plans to conduct enrollee satisfaction surveys, but allows the plans to choose among a variety of survey instruments. The state is considering standardizing the surveys into one instrument in order to compare the health plans by consumer satisfaction categories.

The state requires health plans to provide written notifications to beneficiaries regarding denials of services. The state also requires health plans to publish a statewide hotline number on every member card that may be called by beneficiaries who experience problems or have concerns. Nurses staff the hotline, which is utilized frequently by Medicaid beneficiaries. The state tracks the calls and looks for trends or patterns of abuse within the system. Corrective action can be required by the state when problems are identified; the state has ample latitude within the contract to issue fines.

The AHCA has also created a statewide provider assistance panel that investigates selected unresolved complaints. The panel is composed of physicians who travel the state to review cases under their purview and make decisions about the appropriateness of a given decision or problem.

## **Special Features for Persons with Disabilities**

There are relatively few special features in the HMO Program designed specifically for persons with disabilities. Most of the features of the program are general in nature, although some may affect or benefit persons with disabilities to a greater degree. For instance, the state requires health assessments to be performed for all newly enrolled Medicaid beneficiaries within 90 days, and health plans must also honor existing care plans for newly enrolled beneficiaries for 30 days until a new care plan can be developed. While these provisions are not specific to people with disabilities, they do help to ensure continuity of care to a limited extent and guarantee that beneficiaries with health conditions will have an early interaction with their PCP.

The AHCA has also developed a set of disease management programs and is planning to expand them to include other conditions in the future. These special features are found in both the MediPass and HMO Programs and, while designed for the general Medicaid population, are likely to enhance quality of care for persons with certain chronic conditions and disabilities.

# Reactions to the HMO Program

## Advocates

Advocates who work on behalf of persons with disabilities have many concerns about the HMO Program. One of their major concerns is the difficulty some persons with disabilities face when trying to “work their way through the system.” This is particularly evident in the grievance and appeals processes. One advocate feared that persons with disabilities may “give up” due to the cumbersome administrative process associated with the health plans. He added that many persons with disabilities are apprehensive about initiating grievance procedures because they are fearful of repercussions from the health plans or the state. As a result, less knowledgeable or less aggressive people with disabilities may fare less well in the HMO Program.

Despite the perception that some people with disabilities fare poorly in the HMO Program, one advocate feared that many beneficiaries are enticed into the HMO Program because of the added benefits and extra services covered. The advocate did mention, however, that these additional services and benefits were advantageous to some disabled individuals, especially those with less severe disabilities.

Advocates have the opportunity to discuss issues and concerns during monthly meetings with the state. The meetings typically include mental health representatives, legal services personnel, community members and representatives of the American Association of Retired Persons.

## Health Plans

One of the major concerns expressed by the health plans that participate in the HMO program is the current reimbursement mechanism. Many of the health plans mentioned that they believe the rates are neither adequate nor equitable across the state. One rural health plan representative claimed that the plan was at a financial disadvantage since the state based the rates on historical usage. If health services were underutilized prior to the introduction of managed care – as this health plan representative claims – rates would be based on service utilization patterns that are sub-optimal. If health plans take steps to increase access to certain appropriate primary and preventive care services, the increase in utilization could threaten the financial viability of the plan. This could be especially troubling for persons with disabilities, whose rates would not cover their average costs of care. Under these circumstances, plans would be penalized financially for providing adequate care to persons with disabilities.

Health plan representatives also noted the considerable amount of regulation by the state. One health plan representative said he feels the HMO Program is one of the most regulated in the nation. The health plan representative, in response to a question about how to make the reimbursement more equitable, said he feared some form of risk-



adjustment because it would likely require even more oversight and regulation from the state. Another health plan representative also complained about reporting requirements, stating that they were overly burdensome and duplicative. The health plan would like to see a more streamlined reporting procedure for the HMO Program, one that ideally is not substantially different from the reports required for the other populations the plan serves, such as Medicare and commercial groups.

## Behavioral Health

Aside from the provision of behavioral health-related pharmaceuticals and limited inpatient stays under the HMO Program, behavioral health services are provided on a fee-for-service basis for the majority of Medicaid beneficiaries in MediPass and the HMO program. The AHCA contracts with a utilization management company, which employs case managers to coordinate care for individuals who utilize a substantial amount of behavioral health-related services.

Behavioral health services are handled differently in the Tampa area, where a pilot program is underway to compare three different delivery systems for mental health services. Substance abuse services are not covered under the pilot program.<sup>14</sup> In the Tampa area only, the health plans participating in the HMO Program are responsible for physical health services and mental health services; in this case, mental health services are essentially “carved-in” to the health plans’ total capitated payment. Medicaid beneficiaries in the MediPass program receive their mental health services from the Prepaid Mental Health Program; here, mental health services are “carved-out” of MediPass and provided by a single BHO. For comparison purposes during the pilot period, the Jacksonville metropolitan area serves as the “control,” with Medicaid beneficiaries in the HMO Program and MediPass receiving their behavioral health services on a fee-for-service basis with limited case management.

### Tampa Area Prepaid Mental Health Program

The Prepaid Mental Health program, which operates under a separate 1915b waiver from the HMO Program, was designed to improve access to services while controlling expenditures. The program was developed to respond to a number of competing factors. First, many of the private specialty psychiatric hospitals in the Tampa area wanted to serve the Medicaid population and encouraged the legislature to investigate waiver programs. Second, the rising cost of the Medicaid program was prompting the state to develop a managed behavioral health program. Third, the Tampa area Medicaid office, the Community Mental Health Centers and the local behavioral health providers were interested in a capitated option that would enable providers to have more freedom in the provision of behavioral health services.

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<sup>14</sup> At the time the Prepaid Mental Health program was developed, many of the substance abuse providers were not interested in participating.



As a result, the Prepaid Mental Health Pilot Program was born. The program includes mental health services only because, at the time it was developed, many of the substance abuse providers in the area did not wish to participate. The state's original RFP in 1993 led to a legal protest, with one of the bidders contending that the RFP gave an unfair advantage to a consortium of Community Mental Health Centers (CMHCs) in the region called the Florida Health Partnership (FHP). The RFP included requirements mandating the use of CMHCs and other providers that had historically served Medicaid beneficiaries. Although it was ultimately determined that the FHP, which won the bid, did not have an unfair advantage, implementation of the program was nevertheless delayed until March 1996.

Under the Prepaid Mental Health program, a single BHO serves all MediPass beneficiaries in the area. The BHO is a private-public partnership composed of a private for-profit administrative entity, Value Options, and public service organizations represented by FHP. FHP is a non-profit partnership among five Community Mental Health Centers in the Tampa area. FHP is responsible for the provision of mental health services while Value Options is responsible for contract negotiations, resolving problems and grievances, and performing utilization management for inpatient services.

Due to the non-competitive nature of the Prepaid Mental Health Program, the state established comprehensive service requirements and conducts extensive and ongoing monitoring of the program to ensure quality and compliance. FHP is held to high standards concerning access to mental health services. For example, an emergency must be seen immediately, an urgent situation must be seen within 23 hours, and a routine visit must occur within seven days. These requirements are mandated by the waiver and are a contractual requirement for the BHO.

As of October 1998, enrollment was approximately 27,000 in the Tampa area. About 34 percent of these beneficiaries were non-elderly individuals receiving SSI. As a result of the practice of placing all autoassignments in the HMO Program, enrollment in MediPass and corresponding enrollment in the Prepaid Mental Health Program is declining. Despite this fact, revenue and utilization of services under the Prepaid Mental Health program have remained relatively constant. Value Options personnel believe that these figures suggest that individuals who need a substantial amount of mental health services are choosing the MediPass option, in part so that they can enroll in the Prepaid Mental Health Program.

The capitation rate paid to the BHO is adjusted by categorical eligibility for Medicaid and age. In addition, there is a separate rate category for individuals with AIDS. The rates are based on 92 percent of the projected costs associated with mental health-related inpatient stays, outpatient services, physician services and targeted case management. The capitation rates are derived from costs for the same services in the Jacksonville area. Under the Prepaid Mental Health program, Value Options and the FHP assume all of the risk associated with providing care; there are no stop-loss provisions or risk-

sharing arrangements. The BHO signed a two-year contract and has the option of two one-year extensions.

## **Quality Assurance and Coordination of Care**

Value Options and the FHP are required to communicate with MediPass providers in order to coordinate physical and mental health services. Along the same lines, MediPass physicians have a contractual obligation to coordinate services with any behavioral health providers. The state monitors the communication from both entities.

In practice, Value Options mentioned that it is very difficult to communicate with MediPass PCPs because, although they are required to coordinate services, there are no financial incentives to do so. As a result, Value Options' primary method of eliminating the duplication of services is through the review of monthly pharmaceutical lists. If a patient is receiving the same prescription from different providers, such as from a PCP and from a Community Mental Health Center, Value Options contacts the PCP and together they work to eliminate the duplication. Value Options claims that this process has been relatively successful in eliminating duplicate prescriptions.

Value Options is obligated to provide a series of quality-related data to the state. The BHO submits provider reports, grievance reports, inpatient utilization reports, any critical incidents, patient satisfaction surveys, staffing reports and general finance reports. The grievance reports must include the number of complaints filed and the nature of the complaints. In addition, the state does a lot of "hands-on" monitoring in the form of chart reviews and interviews with patients in order to understand how the program is working. There are no special requirements regarding persons with serious and persistent mental illness or children with serious emotional disturbances.

The state contracted with the University of South Florida to study the delivery systems providing care to Medicaid beneficiaries: the Prepaid Mental Health Program; the services provided by the health plans of the HMO Program in the Tampa area; and the fee-for-service system in the Jacksonville area. The state plans to use the results to determine how to deliver mental health services in the most efficient manner throughout the state. Unfortunately, about 80 percent of the health plans that participate in the HMO Program in the Tampa area have subcontracted with a separate BHO that contracts with many of the CMHCs to provide mental health services. As a result, the pilot program has not led to a "pure" comparison of the three delivery systems because many of the CMHCs provide a substantial amount of the mental health services to beneficiaries in the Prepaid Mental Health program and beneficiaries of health plans from the HMO Program.

The state plans to incorporate substance abuse services into the Prepaid Mental Health Program in the future. These services will be added to the program in the Tampa area and will be included in any further expansions of the program in other areas of the state.

## Reactions to the Prepaid Mental Health Program

Advocates who work on behalf of consumers of mental health services generally feel that the program is working well. Advocates are encouraged by the increased emphasis the BHO is placing on individuals' needs, which has changed some beneficiaries' care patterns. For instance, one advocate mentioned that the program has led to a substantial decrease in the amount of day care for beneficiaries, which he claims is an improvement because day care was used excessively before the program. Advocates are also very encouraged by the service requirements, which enable beneficiaries to access care in a more timely manner.

Advocates are concerned about the coordination of activities between health plans and behavioral health providers. Advocates do not feel that the coordination is adequate, even under the Prepaid Mental Health program. Advocates are also concerned that Value Options and the FHP will implement a formulary that restricts access to some psychotropic drugs. The state is aware that mental health activists are concerned about formularies. At the time of this report, the state did not allow any formularies to assure that beneficiaries have access to the latest drugs as well as brand name pharmaceuticals.

Value Options representatives are very enthusiastic about the program and believe that it is working very well. Personnel at Value Options claim that the BHO has been able to achieve the stringent service requirements in part because the program focuses on results and individuals' needs. As a result of the individualized focus of the program, the BHO has been able to assess the appropriateness of care that many members were receiving. Value Options personnel also noted the decrease in day treatment for beneficiaries, stating that a considerable amount of the treatment was unnecessary. In addition, Medicaid staff mentioned that Value Options and the FHP had to hire additional counselors and nurses to meet the strict appointment schedule requirements and to perform health screens and assessments.

Value Options claims that it has incorporated the significant monitoring and recommendations from the state into its continuous quality improvement program. As a result, the input, suggestions and regulations that originate from the state have been well received by Value Options.

Even with the advocates' and providers regard for the program, it is not clear whether consumers of mental health services are satisfied with their new care arrangements. As part of this study, Lake Snell Perry & Associates conducted focus groups of Medicaid managed care beneficiaries in Florida and New Mexico and targeted individuals with chronic conditions and disabilities.<sup>15</sup> One of the focus groups addressed specifically the delivery of mental health services.

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<sup>15</sup> Perry, Michael, and Neil Robertson. *Individuals with Disabilities and Their Experiences with Medicaid Managed Care: Results from Focus Group Research*. Prepared for the Kaiser Commission on Medicaid and the Uninsured, July 1999.

There appear to be deep concerns and dissatisfaction on the part of individuals enrolled in the Tampa area pilot programs. They spoke of difficulties accessing care, getting the pharmaceuticals they need, and seeing the same mental health professional when they do access services. Several individuals in the group also said they feared that accessing the system during a mental health crisis would result in their being “locked up” – institutionalized against their will.

## Lessons Learned from Florida

The two Medicaid managed care programs in Florida, MediPass and the HMO Program, vary tremendously. The most fundamental differences between the two programs are their organizational structures and reimbursement mechanisms. MediPass is a mainstream PCCM program that provides limited case management to beneficiaries through their primary care physician. PCPs are paid a case management fee and services are reimbursed on a FFS basis. The HMO Program is a mainstream program that provides services to beneficiaries on a capitated basis.

Most of the “special features” of the Medicaid program in Florida apply to both MediPass and the HMO Program. While almost no special features in place today target people with disabilities exclusively, many of the provisions may favor or apply more frequently to this population. The special provisions include the requirement that all new enrollees receive a health assessment within 90 days, and the existence of innovative disease management programs for many conditions. The lessons learned from Florida include the following:

- **Consumers enjoy having choices.** Advocates contend that the fact that beneficiaries have a choice between MediPass and the HMO Program is the reason why moving so many individuals into managed care, including persons with disabilities, has occurred with only a limited amount of resistance. The choice between programs ensures that persons who are satisfied with their current treatment patterns are not forced to alter their care plans too dramatically.
- Including features to improve quality or safeguard care for the general Medicaid population can have a positive impact on delivery of care for persons with disabilities. Florida is one of just a few states to require health plans or providers to conduct health assessments and see new enrollees within a specified time period. This feature is extremely important for persons with chronic conditions and disabilities, assuring that persons in need of care will be assessed and seen by their new health care providers. Without such a provision, persons with disabilities might “fall through the cracks” and neglect primary or preventive services, or ongoing care for their chronic conditions.

- ***When states decide to offer a choice of programs, it is difficult to discontinue one of the options.*** Despite the fact that managed care, through either MediPass or the HMO Program, is a choice for beneficiaries, advocates feel that the state favors the HMO Program. This perception is reinforced by the current autoassignment protocol where all beneficiaries who do not make a choice are placed into the HMO Program. While the state did not indicate that the MediPass program would be phased out, the advocates fear for the program's future, especially since a larger proportion of SSI beneficiaries choose the MediPass option.
- ***A PCCM program is not the program of choice for all Medicaid beneficiaries, including some people with disabilities.*** Despite advocates' tendencies to favor the MediPass program, they do feel that many people with less severe disabilities can benefit from enrollment in the HMO Program, because of the added benefits. At the same time, advocates fear that many individuals, particularly those with more severe disabilities, who may be better served in the PCCM program, are lured into the HMO Program because of fancy brochures and the extra benefits that are covered.
- ***Adequate capitation rates must be paid in order to ensure that high quality health plans participate in the program.*** Many health plans that participate in the HMO Program, particularly ones that serve rural populations, feel that they are not paid adequately since the rates are based on historical usage, and beneficiaries in rural areas may have been underserved prior to managed care. In the current health care environment, where many health plans are limiting their participation in public programs, it is essential that the AHCA pay adequate and equitable rates for beneficiaries in the HMO Program in order to ensure that high quality health plans participate in the program.
- ***Carving out behavioral health services to a BHO may be one way to enhance the delivery of these services.*** The Prepaid Mental Health carve-out pilot program is a unique private-public partnership that has dramatically improved access to care in the Tampa area. It is a unique arrangement that may prove to be a delivery system that can adequately serve Medicaid beneficiaries' behavioral health care needs in a cost-effective manner. Despite the early accomplishments of the program, the state could face considerable challenges if it decides to expand the program. In order for the program to be successful, it takes enthusiastic providers, a strong Community Mental Health Board, and considerable state personnel to perform the oversight required to ensure quality in this type of non-competitive environment.

# Kentucky

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## Introduction

In Kentucky, the Cabinet for Health Services is responsible for operating the Medicaid program. Medicaid administers two separate managed care programs, one of which enrolls persons with disabilities. Kentucky Patient Access and Care (KenPAC), a primary care case management program that has been operating since 1986, enrolls TANF and related populations only. KenPAC is in the process of being phased out as the state implements the capitated Health Care Partnerships program.

Kentucky received approval from HCFA for an 1115 waiver in October 1995 to operate the Partnerships program. Most Medicaid beneficiaries, including persons with disabilities, are required to participate in regions where the Partnerships are operational (currently only two regions of the state). Medicaid officials anticipate that the program will be implemented in the remaining six regions of the state by 2000.<sup>16</sup> Behavioral health services are scheduled to be provided under Kentucky Access, a capitated program that will operate on a regional basis, similar to the Partnership program. The state expects to implement Kentucky Access some time in 1999.

## The Health Care Partnerships Program

In 1994, the Medicaid Administration, which is part of the Cabinet for Health Services, began to pursue ways to increase Medicaid's exposure to managed care. At the time, the state's PCCM program, KenPAC, was viewed as reasonably successful because it was popular with physicians and able to save modest amounts of money. The program, however, only served TANF and related individuals and had not been implemented in some of the rural areas of the state. Therefore, the administration decided to expand KenPAC into areas where it was not operational and incorporate other Medicaid populations – such as persons with disabilities – into the program.

The Cabinet for Health Service's decision to incorporate SSI beneficiaries into the KenPAC program was made without the input of consumers and advocacy groups; not surprisingly, there was considerable opposition to the expansion. Persons on SSI were apprehensive about managed care because they feared the "ratcheting down" of services and they did not want to be locked into one primary care physician. Physicians further complicated opposition of the proposed expansion, particularly by specialists who did not want to serve as PCPs for this population.

In part because of the considerable opposition to moving SSI beneficiaries into the KenPAC program, the state decided to investigate other options for expanding Medicaid managed care in the state, and the Governor's Office began circulating a host of

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<sup>16</sup> The two Partnerships operate in the two most populated, urban areas of the state. While Medicaid has divided the state into eight regions, it is possible that some of these regions will combine to form a Partnership (and thus resulting in fewer than eight Partnerships statewide).



alternative proposals. Most of these ideas were ultimately shot down by providers throughout the state who were skeptical about the introduction of Medicaid (and private sector) managed care.

As a result of this, the state challenged the providers to “put their money where their mouth was” by asking providers to develop their own regional managed care organizations (MCOs) that could serve as the sole source of care for the eligible Medicaid population in that area. All providers in a region would have to come to agreement on the specific structure of the MCO. The state developed a framework for the program requiring that regional Partnerships be developed among historical Medicaid providers. This challenge eventually resulted in what is known statewide as the Health Care Partnerships program.

The state established eight regions for Partnership development. These regions were designated using historical utilization patterns to ensure that each region has an actuarially sound number of Medicaid beneficiaries for the MCOs to accept capitation. By design, each regional MCO functions as a “Partnership” among local hospitals, physicians and health plans, including providers that have traditionally served the Medicaid population.

If more than one Partnership expresses interest in serving a region, the state encourages the entities to work together. If the organizations are unable to form a coalition, the state will accept applications and choose one Partnership to serve the region based on a number of selection criteria. After a certain period of time, if the regional providers are unable to form a Partnership, the state has the authority to solicit proposals from commercial MCOs to serve the particular regions.

Unlike many of their colleagues who serve privately insured individuals – and who are fairly apprehensive about managed care – Medicaid providers in parts of Kentucky seem relatively eager to develop regional MCOs to stave off the threat of commercial coverage. Even though providers are reluctant to embrace managed care, they prefer to develop their own MCOs over being forced to join a commercial plan.

From the state’s perspective, the Partnerships accomplish the following objectives: they increase the emphasis on primary and preventive services; improve access to health care services; improve the health and functional outcomes of beneficiaries; and hold the providers financially accountable, thereby creating a cost-effective system.

## **Passport and Kentucky Health Select**

As of January 1999, two Partnerships, Passport and Kentucky Health Select, were operational and serving clients. Passport, which began enrolling TANF and related populations from Louisville in November 1997, serves 16 counties in the Louisville area. Several months into enrollment, Passport began phasing in SSI and related beneficiaries in Louisville and all eligible Medicaid beneficiaries in the remaining counties of the region.



Kentucky Health Select (KHS) began enrolling TANF beneficiaries in November 1997 and phased in the SSI and related population several months later. KHS serves the 21 counties in the Lexington area.

Over time, Partnerships will be formed in the remaining regions of the state. The state anticipates that the program will be implemented across the state by the end of 1999. According to the provisions of the Partnership program, if Partnerships have not been formed by July 1999, the state has the authority to solicit proposals from commercial health plans to serve these areas. In practice, however, the state is likely to continue working with the regions to encourage them to form their own Partnerships.

The following page provides enrollment and program information on the Partnerships program. The program serves a majority of Medicaid beneficiaries, including persons on SSI and related groups. Foster care children, children in the Special Needs Adoption Program, children in a psychiatric residential treatment facility and medically fragile beneficiaries are also required to participate in the Partnerships.<sup>17</sup>

## **Carve-Outs**

The Partnerships are responsible for providing most but not all Medicaid covered services to beneficiaries. Behavioral health services are carved out of the Partnerships and have been provided on a fee-for-service basis. By the end of 1999, however, the state anticipates that the Kentucky Access program will be implemented, at least in one or two regions of the state. This program will ultimately consist of eight regional behavioral health organizations that will serve Medicaid beneficiaries in a similar manner to the Partnerships. Each Partnership will be linked with one BHO in the region to provide all covered mental health and substance abuse services.

Because of this carve-out, most behavioral health services are not provided by the Partnerships, although there is some overlap. For example, the carve-out is associated with the provider rendering service and not the service. This means that if an enrollee's primary care physician prescribes a medication or renders a service in the area of mental health, the Partnership is responsible for covering the cost. On the other hand, if a psychiatrist prescribes a drug or renders a service, the enrollee's BHO is responsible for the cost. The behavioral health program, Kentucky Access, will be discussed in detail in a later section.

Other services that are excluded from the Partnerships program include home and community-based waiver services, certain Medicare only services, school-based services and early intervention services for infants and toddlers with disabilities.

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<sup>17</sup> A few groups are ineligible for the program. These include Medicaid spend-down beneficiaries, nursing home residents, Support for Community Living Program participants, home- and community-based waiver beneficiaries, Qualified Medicare Only beneficiaries, Specified Low-Income Medicare beneficiaries, Qualified Disabled Working beneficiaries, residents of Intermediate Care Facilities for Mentally Retarded and beneficiaries in psychiatric facilities.

# Health Care Partnerships

**Features:**

Waiver Authority	Program Model	Program Type	Participation	Program Operates	Ages Enrolled	Number of MCOs	Enrollment Broker
1115	Capitated	Mainstream	Mandatory	Statewide*	All Ages	8**	Yes

\*The Partnership Program is still being implemented in 6 of 8 regions.

\*\*One partnership per region.

**Capitation Rates Vary By:**

Categorical eligibility for Medicaid.

**Enrollment:**

Estimated Program Enrollment: 175,280

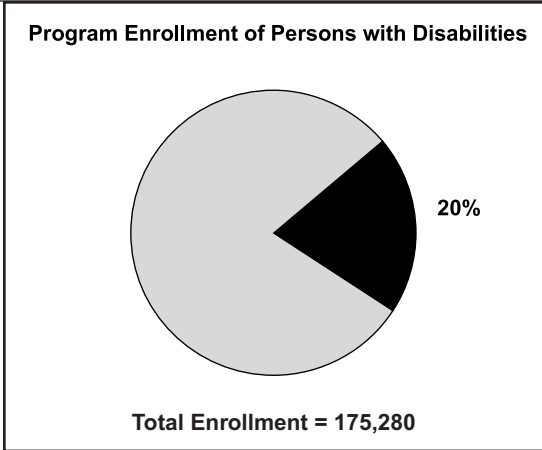
Estimated Enrollment of PWD: 35,000 (20.3%)

**Services Excluded from Health Care Partnerships:**

- Long-Term Care
- Home and community-based services
- Behavioral health services

**Behavioral Health Services:**

- Through the Kentucky Access program, regional BHOs will provide behavioral health services (implementation scheduled to begin in 1999).



**Special Features for Persons with Disabilities:**

- Health information surveys are sent out by the health plans. Responses may trigger case management.
- PCP has to contact new enrollees with a specific time period.
- The state identifies a "medically fragile" population. Health plans must develop care plans and contract with a certain number of providers that serve this population prior to enrolling this subgroup.
- Certain medical conditions require case management.
- SSI beneficiaries can not be assigned to a PCP.
- SSI beneficiaries can elect a specialist, or even a team of specialists to serve as their PCP.

## **Program Design**

In developing the Partnership program, the state wanted not only to improve the Medicaid program but also to demonstrate that managed care, if designed effectively, could create an efficient health care delivery system. Since managed care penetration rates are relatively low in Kentucky, the Partnership program was touted as a “litmus test” for whether managed care would work in the state.

From the very beginning, the program was designed and developed in a very open format to encourage discussion regarding the policies and procedures that would govern the program. Many program elements, including the development of the regulations, were constructed in front of consumers, advocates and providers. The state wanted input from all stakeholders in order to create a program that, when completed, would be embraced (or at least accepted) by all interested parties. When any of these parties disagreed about an issue, Medicaid staff encouraged the dissenting sides to debate and arrive upon a mutually acceptable resolution. In the same spirit, the first RFP was issued as a draft and was available to the public for comment; this draft was also available on the state’s website.

Once developed, public hearings were held on the regulations. At one hearing, many advocates and foster parents voiced concerns about how children in foster care arrangements would fare under managed care. As a result, the state encouraged the parents of foster children and some advocacy groups to work together to suggest ways to ensure that this population would receive the care they needed. The group’s efforts led to the addition of a provision that called for care plans to be developed for foster children who require substantial health care services.

## **Partnership Development**

Many of the providers that had historically served Medicaid patients were aware of the Partnership program from its inception. As stated earlier, provider opposition to the expansion of the KenPAC program and other ideas suggested by the Governor’s Office ultimately led to the creation of the Partnerships. As a result, communication between the state and providers regarding the formation of Partnerships was concurrent with planning for the program.

During their communications, state officials tried to keep providers abreast of all procedural and structural requirements that were being incorporated into the program. During this time, state officials encouraged all interested physicians, health plans, hospitals and other providers to work together to develop an MCO that would serve all eligible Medicaid beneficiaries in the region.

The state has a policy of providing each individual Partnership with considerable freedom to develop its own organizational structure, although the state has a number of requirements that each Partnership must fulfill. Partnerships must have an embedded HMO, be

provider driven, and be capable of taking risk as defined by the Kentucky Department of Insurance. Partnerships are able to meet the embedded HMO requirement in a few ways. The Partnership can create an HMO or partner with an existing HMO, including commercial plans. These HMOs must be capable of meeting the Department of Insurance requirements and have a presence in Kentucky.

Once formed, a Partnership must submit a formal letter to the state indicating its interest in serving the eligible Medicaid population in the region. If more than one Partnership expresses interest in serving a particular region, the state attempts to work with the entities to form a coalition among the interested applicants. If two or more Partnerships meet all of the qualifying conditions and each wants to serve the region, each must submit a request for application (RFA) to become the region's Partnership. The state then conducts a comprehensive evaluation of the RFAs and selects one as the region's Partnership. (In practice, multiple RFAs have not occurred.)

Commonly, however, only one Partnership is identified and it submits an RFA to allow it to serve as the sole provider of care for eligible Medicaid beneficiaries in the area. The state negotiates with each Partnership separately to arrive at the specific terms of the agreement. This includes negotiating capitation rates. As stated earlier, two Partnerships are currently operational and are serving Medicaid beneficiaries in two regions. Passport is the Partnership that serves the greater Louisville area, while Kentucky Health Select serves the greater Lexington area.

In the six remaining regions of the state, Partnerships are in different stages of development. State officials anticipate that these Partnerships will face considerable difficulties before securing a coalition of providers, in large part because of the absence of a major academic medical center in these regions. In the two regions where Partnerships have been implemented, the academic medical center serves as an anchor for the organization. In these regions, the University of Louisville and University of Kentucky Hospitals have played a pivotal role due to their historical relationships with the Medicaid program. The remaining regions are also very rural and tensions among providers and regional medical societies may further impede development of Partnerships.

Due to these obstacles, two different pairs of regions were considering consolidating at the time of this report. Providers in at least one region were also pursuing a relationship with one of the active Partnerships to expand its operations beyond one region. Providers in at least one region may also enter into an agreement with a commercial plan to serve as an administrative partner.

## **Enrollment Process**

To inform TANF and related Medicaid beneficiaries about the Partnership program, the state sends a "managed care is coming" letter 45 days prior to enrollment in their region. This letter explains the enrollment process and includes an enrollment packet from the

Partnership. The enrollment packet includes a brief survey to collect health information on the new enrollees. This survey can alert Partnership staff about any health conditions or special health needs among the AFDC population that should be monitored or addressed quickly.

## ***A Closer Look: Kentucky Health Select***

**Kentucky Health Select (KHS)** began serving the general Medicaid population in November 1997 and phased in persons on SSI in April 1998. It serves approximately 65,000 beneficiaries across 21 counties; about 15,000 of its beneficiaries are non-elderly disabled.

Preparation for Kentucky Health Select began during the Partnership's early planning stages. In 1995, representatives from the Fayette County (Lexington) Medical Society and the University of Kentucky Medical Center formed a steering committee to help "figure out" the Partnership program and monitor the state's activities during the planning process. Over the next months, the committee added urban and rural providers from the region, health department representatives, FQHCs representatives and consumers to its ranks.

In 1997, after the Partnership program was formally created, the committee officially became the Central Kentucky Regional Provider Entity (CKRPE) and entered into an agreement with CHA, a provider-based HMO owned in part by the University of Kentucky Hospital. CKRPE and CHA partnered to form the Region 5 Managed Care Organization, a limited liability company that contracts with the state as the regional Partnership. The Region 5 Partnership operates under the plan name of Kentucky Health Select (KHS).

**Enrollment:** Prior to the phase-in of the SSI population, the state conducted a "readiness review," which revealed that KHS needed to make some programmatic adjustments before expanding enrollment in the program. As a result, it chose to delay the phase-in of the SSI population by a few months. When enrollment eventually began, KHS took special care with persons on SSI and medically fragile individuals. Staff worked closely with these individuals to educate them about their options such as choosing a specialist or a team of specialists to serve as their PCP. The KHS staff was able to contact over 90 percent of the "medically fragile" population by telephone.

**Consumer Involvement:** KHS has made a tremendous effort to incorporate consumers into every aspect of their operations, including the planning stages of the Partnership. It educates and informs consumers in order to empower them and enhance their level of participation. The KHS board expanded its consumer representation from four to eight and now includes two members from each of the following categories: parents of children with special health care needs, TANF population, aged, and adult disabled. All board members have voting privileges. While some KHS staff were initially apprehensive about the heavy consumer presence, they now say the experience was invaluable. KHS personnel learned a great deal from consumers who helped in the formation of the Partnership. The consumers were particularly astute about areas for potential

cost-savings; their first-hand knowledge about the inefficiencies (and sometimes abuses) in the system was extremely valuable. Many other committees support and supplement the board's actions – each of which contain consumers as members (and in some cases as chair).

**Provider Education:** KHS conducted seminars and lectures to educate providers about how to accommodate persons with disabilities. KHS contracted with advocates and specialists to conduct many of these sessions.

**Case Management:** KHS takes a conservative approach towards the use of case management. While the Partnership feels that case management is beneficial for some beneficiaries, it is not intended to be a long-term service. Cases are reviewed periodically to determine whether case management should be discontinued. KHS contracts with organizations such as hospice, the Commission for Children with Special Health Care Needs and the local health department – groups that are experienced in serving persons with disabilities – to provide case management services. Case management is triggered when an enrollee's health care costs exceed a certain threshold within a given year; when someone is identified as medically fragile; during a contact with a PCP; or as a result of one of several diagnoses listed on a referral for specialty care.

**Behavioral Health:** KHS has one staff position dedicated to interfacing with the managed BHO that will provide all behavioral health related services to KHS beneficiaries.

**Communities:** KHS has organized its internal staff into "communities" that provide all services and support to three separate areas within their region. The communities contain member services representatives and case managers. The organizational structure allows each community to become familiar with the unique issues related to the particular area they serve.

**Reimbursement:** KHS pays physicians and hospitals on a modified FFS basis. It uses the Medicaid fee schedule but incorporates a 20 percent withhold. PCPs are organized into "Pools of Doctors" or PODs, which typically include five physicians and 1,000 or more members. Specialists and hospitals accept referrals from the PODs. All providers are encouraged to work together in an efficient manner to get a share of the total withhold. The withhold is returned to the providers and the hospitals in proportions that reflect the medical care utilization of their members. Quality assurance and review efforts help to ensure that services are provided on an appropriate level.

## A Closer Look: Passport

**Passport** began serving the general Medicaid population in November 1997 and phased-in persons on SSI and related populations in January 1998. By March 1998, all eligible individuals in the region's 16-county area were enrolled in the Partnership. Passport serves approximately 90,000 beneficiaries; about 20,000 of these are non-elderly disabled individuals.

Passport is a coalition of Louisville-based hospitals, including the University of Louisville Hospital, physicians and community health centers. The coalition secured a license as an HMO and contracted with an administrative partner, AmeriHealth Mercy, through a competitive bidding process. The group that became Passport was not the only one interested becoming the region's Partnership. The state selected Passport in part because its coalition represents many of the traditional Medicaid providers in the area.

Passport was granted the contract to serve the Louisville region during a difficult time for the HCPs program. Opposition from the sitting legislature and from dental and pharmaceutical groups threatened to disband the group. Passport was more vulnerable than Kentucky Health Select (KHS), because Passport was a start-up HMO. KHS tapped into an existing HMO through CHA, a provider-based HMO owned by the University of Kentucky Hospital and other regional hospitals.

**Enrollment:** Despite opposition, Passport began enrolling the general Medicaid population in the Louisville region. Passport delayed enrollment of persons on SSI to perform outreach and educational activities. Passport worked with state Medicaid officials to develop an action plan to bring persons with disabilities into the program. The plan includes four key steps:

Passport developed a "SWAT" team consisting of staff from the Health Services, Member Services and Utilization Management departments. The team assisted in the implementation plan for enrollment of persons with disabilities. The team was also involved in crisis management, training of Passport personnel and other outreach initiatives. While this process delayed enrollment, it enabled Passport to successfully incorporate persons on SSI into the program. Due to the outreach and educational activities, Passport did not receive a single complaint from advocates or SSI members during the enrollment process.

**Member Education:** Passport also offered welcome classes to all new enrollees. The welcome sessions were similar to the SSI outreach initiatives in that they were held in a variety of forums, including churches, community centers and physician offices. Passport personnel used the classes to explain the program to the

members and how to use the member handbook, which is available in several languages, as necessary.

**Consumer Involvement:** Passport involves consumers in many levels of governance of the organization. Consumers are voting members on Passport's Board of Directors and represented on committees that influence the day-to-day operation of the organization. Consumers were also involved in the planning process for the Partnership.

**Provider Education:** Passport conducted educational sessions for staff and providers in their network. Many of these sessions addressed issues that affect beneficiaries with special health care needs such as the provision and customization of durable medical equipment. Passport also conducted extensive education activities to stress the importance of EPSDT screens to providers. Educational activities, combined with higher reimbursement rates, have dramatically increased the number of EPSDT screens that are performed.

**Case Management:** Passport staff assess the health status of members and, if warranted, develop a care plan that may include case management. The plan is implemented and it is reviewed on a periodic basis. Passport employed only two case managers when persons on SSI began to enroll, causing delays in assigning these individuals to case managers. Passport hired more case managers and added specialty case managers to accommodate the diverse needs of the membership. Currently, in addition to the general case managers, a pediatric case manager specializes in neonates and a social worker performs case management functions.

**Care Coordination:** Passport is developing procedures to coordinate the provision of services with the BHO that will serve the greater Louisville area. A full-time liaison at Passport is developing procedures to facilitate communication between Passport and the BHO.

**Reimbursement:** Passport pays providers according to a mixed reimbursement model. PCPs are paid on a capitated basis for primary outpatient care. The capitated payment varies by Medicaid eligibility category and age. Pharmaceuticals are not included in the capitation rate. PCPs are eligible for a bonus based on the number of specialty referrals they generate and their members' utilization of certain services such as the emergency room. Specialists are paid on a fee-for-service basis and hospitals are paid on a per-diem basis. All fee-for-service payments are based on 105 percent of historical Medicaid costs and include a 10 percent withhold.



Thirty days prior to enrollment, the regional Partnership sends its own letter introducing the managed care organization as the provider for that area and outlining the process for selecting a PCP. The letter includes information about how members can communicate with the Partnership if they have questions or concerns.

This letter, from the Partnership to TANF beneficiaries – many of whom were previously enrolled in the KenPAC program – explains that if new enrollees do not choose a PCP, they will be automatically assigned to their KenPAC PCP. All new enrollees receive Medicaid cards that resemble commercial insurance cards.

The enrollment process for SSI and related populations is quite different from the enrollment process for the general Medicaid population and was designed to ease the transition for the SSI population into managed care. The Partnership program does not allow the MCOs to assign persons with disabilities to a PCP. Instead, Partnership staff continue to contact the enrollee until the individual makes a selection. In addition, specialists (and in some cases, teams of specialists) can serve as the PCP for persons with chronic conditions and disabilities. Thus, the Partnerships are required to exercise added caution when the assignment of a PCP is involved.

Approximately 45 days prior to enrollment, persons with disabilities receive the same “managed care is coming” letter that the state sends out to all new enrollees. About 30 days before enrollment begins, the Partnerships send out a packet of information to persons on SSI that includes a provider directory, a detailed list of specialty services that are covered by the health plan, and options for choosing a PCP.

The Partnerships must follow a more targeted enrollment protocol for a subset of the SSI population, classified as the medically fragile. The state assembled a team of clinicians to develop criteria to identify a population to be monitored more closely – individuals who are likely to require specialized, chronic or costly services. In order to determine the criteria, the clinicians considered utilization of services such as durable medical equipment, the emergency room, hospitalizations, and visits to specialists. The team ultimately decided that anyone who could be identified as falling under the category described by 29 groups of ICD-9 codes would be considered *medically fragile*. These diagnosis code groupings are shown in Table 7.

The Partnerships are required to perform additional outreach related activities before they are permitted to enroll the medically fragile population. For example, the Partnerships have to make a certain number of contacts with medically fragile individuals’ providers to develop continuity of care plans before they begin enrollment.

The Partnerships maintain that they have become very familiar with the group of beneficiaries classified as medically fragile. Nurse case managers have spoken with each of these beneficiaries to explain program benefits and make certain that they are “set up” with a PCP and with appropriate specialty care and services. This early contact is impor-



tant, because while the Partnerships are required to make significant attempts at the front end to identify persons who are medically fragile and to help them choose a primary care physician and get the services they need, they are not required to continue at the same level of case management over the long run. Once the enrollee is “set up” in the Partnership, it is unclear to what extent the MCOs will maintain communication with this vulnerable group of beneficiaries.

Judging from the outreach and energy the Partnerships have dedicated to this population early on, however, it is likely that they will continue to exercise extra care with them as they continue to participate in the Partnership program. Passport, for example, in the Louisville region, assembled “swat teams” to conduct extensive outreach with prospective beneficiaries in their own communities. They took an extremely aggressive approach to making their presence known in the community, and making certain that beneficiaries – and especially those with disabilities and other health conditions – understood how to contact their offices and access the services they required.

**Table 7: ICD-9 Diagnosis Code Groupings that Determine the *Medically Fragile* Population**

Diagnosis Description	ICD-9 Codes	Age Criteria
Tuberculosis	010-018	Ages 3 and greater
Viral Hepatitis	178.5	Ages birth and greater
Malignant neoplasm of lip, oral cavity and pharynx	140-149	Ages 21 and greater
Malignant neoplasm of digestive organs and peritoneum	150-159	Ages 21 and greater
Malignant neoplasm of respiratory and intrathoracic	160-165	Ages 3 and greater
Malignant neoplasm of bone, connective tissue, skin and breast	170-176	Ages birth and greater
Malignant neoplasms of genitourinary organs	179-189	Ages birth and greater
Malignant neoplasm of lymphatic and hematopoietic tissue	200-208	Ages birth and greater
Carcinoma in situ	230, 234	Ages 21 and greater
Diabetes Mellitus	250.4, 250.5	Ages 5 and greater
Cystic Fibrosis	277.0	Ages 2 and greater
Disorders involving immune system	279	Ages birth and greater
Sickle cell	282.5, 282.6	Ages 3 and greater
Meningitis	320	Ages birth and greater
Cerebral degeneration	330-337	Ages birth and greater
Other central nervous system	340-349	Ages birth and greater
Aortic valve	424.1	Ages 21 and greater
Hypertension severe	403, 404	Ages 30 and greater
Acute myocardial infarction	410	Ages 30 and greater
COPD	415-417	Ages 40 and greater
Heart failure	428, 428.1	Ages 40 and greater
CVA	430-438	Ages 40 and greater
Chronic obstructive asthma	493.2	Ages 10 and greater
Emphysema	494	Ages 40 and greater
Skull fractures	800-804	Ages birth and greater
Fracture of vertebral column and spinal cord injury	806	Ages birth and greater
Internal injuries	860-869	Ages birth and greater
Late effects of injuries	905-909	Ages 3 and greater
Burns	940-949	Ages birth and greater
Injuries to nerves and spinal cord	950-957	Ages birth and greater

Source: Kentucky Cabinet for Health Services

Both Partnerships appear to be extremely dedicated to serving their client populations, and understand that persons with disabilities may require additional monitoring, management, or assistance during their experiences with the MCO. This philosophy of service to the client populations begins at the state level. It may derive, in part, from the structural nature of the Partnership model and the fact that it does not compete with other MCOs in its region. But it also is likely to be a result of the strong role consumers play in Partnership activities and the extent to which Partnership “business” is monitored by Medicaid staff.

## **Programmatic Features**

The Partnerships are required to provide all services covered by Medicaid other than behavioral health-related services. The Partnerships can also cover additional services. For example, Passport covers some immunizations for adults that had not been covered by Medicaid prior to the program.

The Partnerships can also vary the ways that services are provided and can limit services to certain degrees. For example, they have looked closely at use of prescription drugs and are in the process of developing formularies to better manage drug costs. According to one of the Partnerships, medications were extremely overused under KenPAC, with clients sometimes filling multiple prescriptions for the same or similar medications over the same time period.

Likewise, at least one of the Partnerships – Passport – will limit the use of physical therapy that is provided for children with disabilities by physical therapists. Instead, the MCO will begin training parents and caregivers to provide physical therapy, with periodic assessments and monitoring from professional therapists. According to talks with representatives from this Partnership and anecdotal reports from participating providers, this policy change has not resulted in complaints from parents or concerns from advocacy groups.

Kentucky Medicaid also requires the Partnerships to include certain providers in their networks. The Partnerships have a contractual obligation to include teaching hospitals, FQHCs and rural health centers in their networks. Once all the Partnerships are operational, the state expects a certain level of cooperation among all of the Partnerships, especially among the more rural regions and the urban areas for the provision of some tertiary care services. For example, there are several infectious disease specialists in the state who specialize in treating HIV/AIDS cases. Most of these specialists live in the Louisville or Lexington area. As a result, the state expects the more rural Partnerships to contract with the Louisville or Lexington Partnership to provide certain HIV/AIDS related services.

The state requires Partnerships to allow beneficiaries to change PCPs somewhat liberally. Both Partnerships allow at least one PCP change without cause during the first

few months of enrollment. The Partnership, however, is required to monitor the extent to which individuals change PCPs. An enrollee who changes PCPs at least two times within a three-month period will automatically be assigned to case management to determine the reasons for the switching. Medicaid officials say they included this requirement to determine whether persons who changed PCPs with some frequency were not receiving services or were confused about the system.

While the Partnerships are encouraged to perform a health assessment on all new enrollees within 90 days, it is not a contractual requirement for Passport and Kentucky Health Select. Realizing the value of health assessments, Medicaid officials say they will build this requirement into future contracts with the remaining regions.

Early in the planning process, the state decided to incorporate the Department of Public Health (DPH) into the Partnerships. Medicaid officials wanted to ensure that the Health Department continued to play a significant role in the provision of services for the Medicaid population. Partnerships in the Lexington and Louisville regions use the Health Department in different ways. The Lexington Partnership (Kentucky Health Select) uses regional public health representatives to educate both beneficiaries and providers about managed care. Health Department personnel assist in conducting educational sessions for beneficiaries on managed care, the role of the PCP, ways to access services, and appropriate emergency room use. The Health Department staff also conduct sessions to educate providers about how to effectively communicate with the Partnership's client population. As a result of the public health department's efforts, less than 10 percent of the general Medicaid population were autoassigned to PCPs.

In the Louisville area, Passport utilizes the Department of Public Health in other ways. The DPH is a part owner of the HMO embedded in the Partnership. In addition, as part of a contract between DPH and Passport, DPH personnel are very active in performing EPSDT screens as well as other clinical services.

## **Case Management**

The state strongly recommends that Partnerships provide specialized case management to children and adults with certain conditions. These conditions are shown in Table 8. The state and the Partnerships, however, tend to view case management as a short-term service to stabilize clients or make sure that they have made the appropriate links with providers and services. This is consistent with the mechanisms in place to handle medically fragile individuals. The state and MCOs dedicate significant resources to identifying persons with chronic conditions and disabilities, making personal contact, assuring that these individuals understand the program and are comfortable with their PCP and access to care. Once these individuals are identified and linked with services, however, comparable resources are not devoted to ongoing monitoring or periodic updates of their conditions.

After initial case management is provided to these recommended groups, the Partnerships have the authority to move these clients out of case management as they see fit. The Partnerships may also develop internal criteria that may trigger case management. As stated earlier, Partnerships are also required by the state to assign members who frequently change PCPs to case management. Providers may also refer clients to case management and clients may also self-refer if they believe they are in need of services.

**Table 8: Conditions for Which Specialized Case Management is Recommended: Children and Adults**

Children	Adults
<ul style="list-style-type: none"> <li>• Craniofacial anomalies</li> <li>• Cleft lip and palate</li> <li>• Myelomeningocele</li> <li>• Cerebral palsy</li> <li>• Cystic fibrosis</li> <li>• Hemophilia</li> <li>• Scoliosis</li> <li>• Human immunodeficiency virus disease</li> <li>• Technology-dependent children</li> <li>• Autism</li> <li>• MR with related physical disabilities</li> <li>• Head injuries/brain trauma</li> <li>• Genetic conditions or congenital anomalies with complex treatment regimens</li> <li>• Neurological impairments</li> <li>• Seizures</li> <li>• Severe kidney disease</li> <li>• Severe health defects</li> <li>• Failure to thrive</li> <li>• Medically-fragile foster children</li> </ul>	<ul style="list-style-type: none"> <li>• Developmental disabilities</li> <li>• Mental retardation</li> <li>• Diabetes</li> <li>• Human immunodeficiency virus disease</li> <li>• Technology-dependent adults</li> <li>• Functional disabilities post CVA</li> <li>• Persons with chronic illnesses who live alone</li> <li>• Alzheimer’s disease and related disorders</li> <li>• Chronic heart disease</li> <li>• Chronic renal disease</li> <li>• Chronic lung disease</li> <li>• High risk pregnancy</li> <li>• Uncontrolled hypertension with complicated medication and/or treatment regimes</li> <li>• Severe visual impairment or blindness</li> <li>• Cerebral palsy</li> <li>• Cystic fibrosis</li> <li>• Hemophilia</li> </ul>

## Payment Mechanisms

One of the goals of the program is to hold the providers of care accountable under capitation. The state pays Partnerships on a capitated basis, and Partnerships in turn determine their own payment criteria. The Partnerships do not experience any adverse selection because the health plans serve all eligible Medicaid beneficiaries in their region. If Partnerships develop subcapitation payments, however, as at least one is considering, the issue of adverse selection could become quite relevant.

The state uses a relatively simple payment design to compensate the Partnerships. The capitation rates are adjusted by categorical eligibility for Medicaid only. For each Partnership, the state negotiates one rate for the following five categories: TANF, SOBRA, SSI without Medicare, SSI with Medicare, and foster children.

Both Partnerships are operating under three-year contracts with the state. Rates for both Partnerships are adjusted annually. The state did include a “look-back” provision in the

two contracts to assess the total expenditures related to the delivery of services for the AIDS population. The state will review each Partnership's total cost for treating this group, including hospitalizations and pharmaceuticals. If necessary, the state will adjust the payment accordingly.

## **Consumer Involvement**

One of the unique features of the program is the tremendous amount of consumer involvement seen not only during the planning process, but also in the ongoing management and operation of the program. The state spent time educating consumers prior to and during the development process, thereby empowering them to operate more effectively during the process.

Consumer involvement has occurred on two levels. On the state level, Medicaid officials held many conferences and forums to solicit consumer input and, prior to the launch of the first Partnership, hosted a large conference of advocates and consumers in Louisville and incorporated many of their ideas and suggestions into the program. At the Partnership level, consumers participate as part of the governance structure and in ongoing monitoring activities.

## **The Commission for Children with Special Health Care Needs**

The Commission for Children with Special Health Care Needs (the Commission) provides medical treatment to children with chronic conditions and disabilities. It is a Title V/Maternal and Child Health Bureau program that serves Medicaid and other children who qualify based on a combination of medical and financial criteria. The Commission operates fourteen clinics that assess and treat eligible children; a large percentage of the Commission's clients are Medicaid-eligible.

The role of the Commission has changed as a result of the Partnership program, with many children formerly served by the Commission now enrolled in one of the Partnerships. While the Commission continues to serve many of these children, its mission may be changing and is likely to result in a realignment of responsibilities between Partnership and Commission providers over the next several years.

The Commission serves any child under the age of 21 who is a resident of Kentucky and meets two criteria. A child must have a medical condition (shown in Table 9) that is treated by a Commission Clinic Program and the child's family must meet certain financial criteria. Persons who have hemophilia are eligible for Commission services regardless of age.

**Table 9: Commission for Children with Special Health Care Needs: Clinic Programs**

• Amputee	• Asthma	• Burn
• Cerebral Palsy	• Cleft Lip & Palate	• Craniofacial
• Cystic Fibrosis	• Hand	• Heart
• Pediatric Hemophilia	• Adult Hemophilia (Over 21)	• Rheumatology
• Neurology	• Ophthalmology	• Orthopedic
• Otology	• Plastics	• Scoliosis
• Seizure	• Sickle Cell	• Urology

The Commission's director envisions considerable change in the organization over the next several years as managed care and Title V services develop ways to work together to care for children with special health care needs. Although he is skeptical about the mainstream managed care model's ability to provide highly specialized care to children with complex needs, he recognizes that the "market" for children with special needs is changing. Most likely, the Commission will continue to play a direct role in the provision of services for children with craniofacial anomalies or cleft lip and palate anomalies, due to the specialized nature of the care. The Partnerships, on the other hand, may provide more preventive and primary services that may have been performed by the Commission in the past.

The Commission may also move into more of an oversight role in the future. It may be utilized by the state to ensure that children with special health care needs who are no longer served by the Commission continue to receive state-of-the-art treatments by the Partnerships. The Commission may also play a more substantial role in the regions where Partnerships are not yet active because these regions have less specialty care available than the Louisville and Lexington area.

## Quality Assurance

One of the major goals of the program is to improve quality of care in Medicaid by focusing on health outcomes. This goal, combined with the non-competitive nature of the program, led the state to establish a comprehensive quality improvement (QI) program that operates on both the state and Partnership level. The components of the QI program on the state level are evaluation of access to services, collection of utilization and encounter data for all members and sub-groups, administration of consumer and provider satisfaction surveys, review of all grievances and complaints and formation of a Quality Improvement Advisory Committee.

In order to assess the impact of the Partnerships on consumers, the state commissioned a baseline consumer satisfaction survey prior to implementation of the program.<sup>18</sup> The state plans to administer a similar consumer satisfaction survey in the near future and will compare the results of the two surveys. In addition, the Partnerships each conduct consumer and provider satisfaction surveys of their own enrolled populations and affiliated providers.

The state has also identified a set of health outcomes that, if achieved at certain benchmark levels, result in a financial reward of up to one percent of total capitation to a Partnership. The state lists twelve outcomes; each Partnership can choose four of these twelve to try to meet or exceed. For each health outcome that is attained at the benchmark level, the Partnership is rewarded .25 percent of the total capitation. These outcomes are shown in Table 10. The Partnerships are also contractually obligated to

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<sup>18</sup> Hager, Gregory and Jeffrey Talbert. 1998. *Baseline Satisfaction with Medicaid in Kentucky*, Martin School of Public Policy and Administration, University of Kentucky.



perform studies that pertain to the health of their regions. The Partnership that serves the Louisville region, for instance, is currently conducting a study related to asthma.

**Table 10: Fiscally Incented Health Care Outcomes**

Health Outcome	Indicator	Outcome Benchmark
Live, healthy birth <sup>a</sup>	Birth weight: -less than 1500 grams -less than 2500 grams	95% of Partnership's live births will be more than 2500 grams.
Pregnant female with normal	Prenatal visit during first trimester	90% of the Partnership's pregnant population will have a prenatal visit in the first trimester or within four weeks of enrollment; and
	11-13 prenatal visits during pregnancy	90% of the Partnership's pregnant women will have been screened for hepatitis B and other sexually transmitted diseases; and
	Postpartum visit within 42 days of delivery	90% of the Partnership's pregnant women will have documentation of history, assessment and counseling about the effects of nicotine, alcohol or other substance use in fetal development; and 80% of the Partnership's pregnant women will receive expected number of prenatal care visits; and 65% of the Partnership's pregnant women who had a live birth had a postpartum visit by the 42 <sup>nd</sup> day.
Reduced incidence of vaccine – preventable diseases <sup>a</sup>	Immunization: 4 DTP or DTaP; 4 Hib; 3 Polio; 1 MMR3; 3 Hepatitis B	90% child member of Partnership's by 35 months have received appropriate immunizations.
Well children and adolescents	Counseling	75% of children and adolescents ages 9-21 of Partnership will have received counseling related to the risk associate with the use of alcohol, drugs, sexual activity, and not using seat belts.
Well infants and children	Fluoride is <0.6 ppm in water supply	80% of children of the Partnership to age six whose water supply is <0.6 ppm. Fluoridated will have received fluoride supplementation.
Reduced mortality from breast cancer <sup>a</sup>	Mammogram and follow-up to abnormal finding	60% of women, ages 52-69 of the Partnerships' population have a mammogram every year.
Reduced mortality from cervical cancer <sup>a</sup>	Pap test and follow-up to abnormal findings	95% of women aged 21-64 of the Partnership's population (or younger if sexually active) have at least one Pap test.
Reduced incidence of unintended pregnancy	Counseling	75% of women of the Partnership's population at risk of pregnancy have received risk appropriate counseling.
Reduced mortality from heart disease <sup>a</sup>	Serum cholesterol screening	75% of adult, ages 21 and older, of the Partnership's population have serum cholesterol screening every five years.
	Beta Blocker after heart attack	75% of Partnership's population who were hospitalized and discharged alive received a prescription for beta blockers upon discharge.
Optimal nutrients/antibodies for infants up to age six months	Counseling for mothers about infant feeding, and breastfeeding first six months of life	25% of infants of the Partnership have human milk as their primary nutrition for the first six months.

<sup>a</sup> Health Plan Employer Data & Information Set measures

Source: Kentucky Cabinet for Health Services

The state formed a Quality & Access Recipient Advisory Committee (QARAC) and requires the Partnerships to form similar committees that report to their governing bodies. The QARAC on both the state and Partnership levels include consumers and advocates and addresses primarily member concerns. The committees also identify any potential problems in the program and develop action plans to combat the difficulties.

As part of the quality assurance program, an ombudsman is supposed to work on issues that support Medicaid beneficiaries' experiences in the Partnerships. At the time of our visit, the ombudsman position had not yet been filled.

## Grievance Procedures

The state views a grievance or complaint about the program or a Partnership as a piece of information and an opportunity for improvement. As a result, periodic review of all complaints and grievances is built into the QI program at both the state and Partnership levels.

Medicaid beneficiaries can report a problem or difficulty with the program to either the state or their Partnership. Members can call the state to discuss a problem directly through a toll-free number. The Partnerships also operate toll-free numbers that members can access if they have a complaint or grievance. All phone calls are logged, both at the Partnership and the state levels, using a common coding system. The state and the Partnerships review the calls and try to identify any trends or patterns. In addition, members have the right to request a fair hearing. At the time of this study, fourteen beneficiaries had requested such a hearing.<sup>19</sup>

The state plays an extensive role in monitoring the activities of the Partnerships. A Medicaid Managed Care Oversight Committee was formed at the state level to develop policies for the oversight activities. Prior to enrollment, the Partnerships work very closely with the state before they are permitted to begin enrolling beneficiaries. As stated earlier, the Partnerships are required to document a certain number of encounters with the medically fragile and the corresponding development of care plans before they can begin enrolling this sub-group of beneficiaries.

Once the Partnerships have enrolled their target populations, they must submit detailed information to the state. The plans submit, on an on-going basis, utilization and encounter data reports, narrative progress reports, and minutes of all QI and QARAC meetings. In addition, the state has to approve all brochures, information packets and other publications, before the Partnerships can distribute them to their members or providers.

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<sup>19</sup> In each of these cases, the beneficiaries were requesting that they be exempted from the program. None of these requests was granted. Instead, the hearing officer ruled that Partnership program could adequately meet their health care needs.

## **Coordination with Behavioral Health Services**

Once the Kentucky Access program becomes operational, the Partnerships will be required to exchange information with the BHO that serves the region. The Partnerships must employ a behavioral health liaison whose primary focus is coordinating efforts and communicating with the BHO.

An interface that outlines the coordination requirements is incorporated into the contract between the state and the Partnerships as well as the contract between the state and the BHOs. For instance, the BHOs must document that all persons using mental health or substance abuse services have a physical examination every year. This requirement encourages communication between the two entities, and also assures that persons with behavioral health needs are also receiving primary care services.

## **Special Provisions for Persons with Disabilities**

Due to the open environment in which the Partnership program was developed, many provisions that are designed to ensure quality for target populations, including people with disabilities, were built into the program. Medicaid officials designed some of the provisions, while consumers, advocates and providers suggested others.

It is important to note, however, that implementation of the Partnership program is a work in progress. The state has already identified additional requirements that will be incorporated into the remaining contracts with the Partnerships, such as the mandate that plans perform health assessments on all new enrollees. As a result of the tremendous amount of communication between the state and the Partnerships, the state has many opportunities to influence the actions of the Partnerships.

Four provisions are designed specifically to ensure quality for persons with disabilities:

- The state has identified medically fragile individuals and requires Partnerships to contact them and develop care plans before they can be enrolled.
- The state identified a group for case management services.
- The state does not allow Partnerships to assign persons on SSI to a PCP.
- Persons on SSI can elect to use a specialist, or even a team of specialists, as a PCP.

## Concerns about the Program: Comments from Medicaid Staff and Advocates

While Medicaid officials are very excited and enthusiastic about the program, they also have their concerns about its future. One fear voiced by Medicaid officials is that the Partnerships will eventually function as franchised entities, due to their non-competitive nature, that can lobby the legislature to alter the program to benefit their organization.

Advocates who work on behalf of persons with disabilities are cautiously optimistic about the Partnerships. Many of these same advocates strongly opposed the state's initial attempt to include persons on SSI in managed care, in part because the state did not consult advocacy or consumer groups on the proposed KenPAC expansion. While many advocates were initially reluctant to support the concept for the Partnerships program, the threat of the state entering into arrangements with commercial health plans prompted them to work closely with providers and consumers to develop the Partnerships.

Representatives of numerous advocacy organizations say that the development and implementation of the Partnership program was dramatically different from the proposed KenPAC expansion. Advocates said that the Partnerships were developed in a very open format and the state was very responsive to stakeholder input.

Two individuals who represented different advocacy organizations said they expected a lot of complaints from beneficiaries when the Partnerships went "live." They were both surprised when their organizations received relatively few calls, aside from a few DME-related questions and complaints. One advocate even said that the state had been "wonderful" communicating with advocacy organizations in an open and honest manner. Advocates are also excited that the program has directed the focus of Kentucky Medicaid away from the direct provision of services to emphasize members' needs and how to effectively meet them. Furthermore, advocates are encouraged by the consumer representation on governance boards at the state and Partnership levels.

Despite the substantial role that consumers and advocates have played in the development of the program, and continue to play in the on-going monitoring and improvement of activities, advocates have numerous concerns. Some feel that it is challenging to communicate with health plans in general, let alone interacting with those that have no history of serving Medicaid beneficiaries and persons with disabilities. Under the Partnerships, advocates essentially have to contend with a different MCO in each region. In addition, they contend that quality of care and availability of services varies across the two regions.

Other issues that are of particular concern to advocates include the provision of durable medical equipment (DME) and pharmaceuticals. Managed care has eliminated some of the flexibility that beneficiaries enjoyed under the fee-for-service system in obtaining

DME. One advocate mentioned that members have to go through more “hoops” now to obtain needed DME. The advocate also mentioned that more expensive DME, which may dramatically improve quality of life, is more difficult to acquire. The advocates also fear that the newest brand name pharmaceuticals, especially psychotropic drugs, will be harder to get under managed care.

Advocates are also concerned that the ombudsman office has yet to be created. Since the state has delayed creating the ombudsman’s office, advocates fear that the office will never be established.

Many of the concerns expressed by advocates, however, go beyond the program, and address issues related to health care delivery for people with disabilities. They mention their difficulties accessing to specialists, occupational and physical therapy, and the provision and customization of DME. While these concerns can be exacerbated by managed care arrangements, they are also common within Medicaid fee-for-service arrangements.

## **The Partnerships’ Impressions of the Program**

The Partnerships generally share the state’s enthusiasm and excitement for the program. The Partnerships enjoy the freedom to develop many policies and procedures that allow them to effectively care for the eligible Medicaid population in their regions. At the same time, the Partnerships did experience some problems during enrollment and generally share a few concerns about the program.

When the Partnerships began enrolling members, each experienced technical problems resulting from the exchange of data between the Partnerships and the state. The state’s information system is not completely compatible with the systems used by the Partnerships. Medicaid beneficiaries living outside of one Partnership’s region frequently receive information packets that claim they will be enrolled in the wrong Partnership. Conversely, Partnerships receive lists from the state listing all eligible Medicaid beneficiaries in their region. Some of the eligible individuals, however, do not reside in the Partnership’s region, and considerable confusion results regarding the responsibility for their care. Furthermore, certain data is sent to the state (sometimes from federal sources) and is delayed before it is sent to the Partnerships, resulting in considerable lags in processing information.

While the Partnerships are aware that the state has to perform considerable monitoring activities of their operations, they feel the oversight can be cumbersome. The Partnerships say they expend a tremendous amount of resources to meet all the state’s requirements. In addition, Partnership personnel must stay in constant contact with state officials because they need prior approval of all printed material. The Partnerships contend that the constant regulation by the state delays and sometime even impedes their activities.

The Partnership program, while unique and innovative in its design, expends a lot of resources on administrative activities. When the program has been implemented statewide, eight MCOs will serve all eligible Medicaid beneficiaries. There will be overhead and administrative activities at the MCO level as well as at the Medicaid office level. Some Partnership staff question the role of Medicaid staff in the future, suggesting that cost savings, borne by the plans, will be consumed by layers of state oversight.

## Behavioral Health Carve-Out Program: Kentucky Access

A majority of Medicaid beneficiaries will soon begin to receive behavioral health services through the Kentucky Access program. Implementation of Kentucky Access in the greater Louisville and greater Lexington regions is expected to begin some time in 1999. Until the program is operational, behavioral health services will continue to be provided on a fee-for-service basis.

Kentucky Access is a behavioral health carve-out program that will provide all mental health services to eligible Medicaid beneficiaries aside from any services provided by a PCP from a Partnership. It will also provide EPSDT related substance abuse services, which are the only substance abuse services Kentucky's Medicaid program has traditionally provided, other than inpatient medical detoxification, which is the responsibility of the Partnerships. Under Kentucky Access, the regional managed behavioral health organization will receive capitated payments from the state to serve all the eligible Medicaid beneficiaries in its area.

Behavioral health services were carved out of the Partnership program because of two main factors. First, expenditures for behavioral health-related services had been relatively low in Kentucky. State officials believed that a separate managed behavioral health program would allow the expenditures to remain relatively low. Second, the community mental health centers (CMHCs), which provide a majority of behavioral health-related services to the Medicaid population, were not interested in participating in the Partnership program.

The CMHCs are powerful organizations that receive considerable political support in the state. Opposed to managed care in the state, they banded together to successfully prevent inclusion in the program. Later, realizing that some form of managed care would be implemented for behavioral health services, the CMHCs took a proactive stance and designed a managed care program – one BHO that would serve the entire state. Medicaid officials were reluctant to accept this proposal because they wanted at least two BHOs to provide services in case one withdrew from the program.

Since Medicaid officials felt the plan offered by the CMHCs was not sufficient, the state held a major stakeholder forum to discuss what type of managed care program to adopt for behavioral health services. Advocates, consumers, providers and state officials attended the forum. The state eventually decided on Kentucky Access, a managed

behavioral health program that incorporates many of the same principles in the Partnership program.

Kentucky Access will operate on a regional basis, using the same divisions established by the Partnership program. In each region, Medicaid officials encourage the behavioral health providers to form a coalition that is similar to a Partnership. The state requires each coalition to partner or contract with a national administrative service organization (ASO) that has experience in managed behavioral health care. The coalition of providers and the ASO constitute the BHO for a region. While there are eight regions in the Partnership program, the state anticipates that there will be fewer BHOs because of less demand for these services. As a result, the state predicts that an individual BHO will serve more than one region. If a BHO meeting the state's requirements is not formed, Medicaid will solicit competitive applications from commercial BHOs.

Kentucky Access has three main goals: improve quality, enhance access to services and control expenditures. The state says that the quality assurance aspect of the program, which is still under development, will be outcomes driven. Service requirements established by Kentucky Access that will improve access to providers are very specific: any emergency condition must be seen immediately, urgent conditions must be seen within 24 hours, and routine visits must be scheduled within seven days. The BHOs will be paid capitation rates based only on categorical eligibility for Medicaid. State officials will negotiate rates with each individual BHO, which will then develop their own internal mechanisms to pay their network providers.

All Medicaid beneficiaries eligible for the Partnership program, aside from hospice patients, will be eligible for Kentucky Access. Children under 22 years of age who are eligible for Medicaid because they reside in a psychiatric facility will also be eligible for the program. These children are not eligible for the Partnership program.

Consumers will play a significant role in Kentucky Access. In addition to their participation in planning activities, consumers will be represented on the governing boards and advisory committees of each BHO.

Advocates who work on behalf of people with mental illness and substance abuse problems are approaching Kentucky Access quite cautiously. They are not convinced that the consumer involvement and focus of the Partnership program will continue in under Kentucky Access. Because advocates do not feel that many of the provider groups will be able to cooperate and work together, they are also skeptical that behavioral health providers will be able to form coalitions.



## Lessons Learned from Kentucky

In 1997, Kentucky's Medicaid administration began implementing a program that dramatically altered the health care delivery system for eligible beneficiaries. The organization of the program, in which one Partnership of providers serves all eligible Medicaid beneficiaries in a region, is unique. The amount of cooperation among all stakeholders during the planning process of the program also sets it apart from other Medicaid managed care programs. Suggestions from advocates, consumers and providers prompted the state to design the program to include many features to ensure that vulnerable populations, such as persons with disabilities, receive quality health care from the Partnerships.

There are several specific lessons that can be learned from the development and implementation of the Partnership program:

- ***Involving the opposition can result in enormous benefits, both programmatically and politically.*** The state's failed attempt to move SSI beneficiaries into managed care through the proposed KenPAC expansion demonstrated that many stakeholders are resistant or downright opposed to managed care for persons with special health care needs. At the same time, Medicaid officials realized that if they involved all of the relevant stakeholders in the planning of a managed care program, not only would the stakeholders be more supportive of managed care, but their ideas would lead to the development of a better delivery system.
- ***If the Medicaid office sets the tone of collaboration, inclusion and open debate, it is more likely that providers will follow suit.*** The state set the tone for the development of the program by its own internal actions. Many departments, including the Medicaid Administration and the Department of Mental Health and Mental Retardation Services, had to work together on issues that were often contentious in order to develop the policies that govern the Partnership program. The state then invited advocates, consumers and providers to work together in the same fashion to develop similar policies.
- ***Taking the time and effort to reach out to and educate prospective enrollees will eventually pay off.*** The two Partnerships that are operational were able to phase in the eligible Medicaid beneficiaries in their region with little problem. Aside from a few technical difficulties due to incompatible information systems, the Partnerships were able to enroll the TANF population and later the SSI population without causing significant disruption to existing care patterns. The success of this enrollment process was a result of the outreach activities that occurred on both the state and Partnership levels.
- ***Don't rush to include all populations or set all policies in stone: learn from each phase of implementation.*** The development and implementation of the program has been very gradual at both the state and Partnership level. The pace of the implementation of the program has enabled the state to identify a few features that it will



incorporate into the remaining Partnerships. Likewise, Passport and Kentucky Health Select both elected to delay the enrollment of persons on SSI to have more time for outreach activities. Implementing the program slowly allows for some of the “bugs” to be worked out of the system.

- ***Careful and consistent oversight on the part of Medicaid may be a nuisance to providers, but it is extremely important for beneficiaries with special health needs.*** The state conducts extensive oversight activities in order to ensure that Partnerships are in compliance with all regulations. The Partnerships and Medicaid officials are in constant communication about issues, concerns, and day-to-day operations. The Partnerships may feel that the state is “breathing down their necks,” but persons with disabilities have strong advocates within the Medicaid office who will exercise their influence – both contractual and informal – to make certain that plans are responsive to enrollee needs and concerns.

# Michigan

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## Introduction

Medicaid expenditures in the state rose dramatically in the 1990s. According to Michigan Department of Community Health (MDCH) figures, Medicaid expenditures in 1997 were four times greater than expenditures in 1980 and twice as high as in 1990. According to state reports, Medicaid costs have increased three times faster than the revenues that support the program. The MDCH began to investigate ways to control expenditures. Instead of restricting eligibility or reducing benefits to Medicaid beneficiaries, the MDCH decided to initiate managed care in the form of risk-based contracts that, state officials hoped, could make the delivery of health care more efficient. As a result, the MDCH developed the capitated Comprehensive Health Care Program (CHCP) for the general Medicaid population and later developed another capitated product for children with special health care needs. In addition, the MDCH reorganized the delivery of specialty behavioral health services and supports for person with developmental disabilities into another capitated program. In fall 1998, Medicaid also began serving persons with disabilities in two capitated carve-out programs that combine to form the Community Mental Health Services Program (CMHSP). The two tracks of the program consist of specialty behavioral health services and services and supports for persons with developmental disabilities. The MDCH is also in the process of developing a capitated program to serve the needs of persons requiring long-term custodial care.

The Medical Services Administration, which runs the state's Medicaid agency, is part of the Michigan Department of Community Health (MDCH), and Michigan's Medicaid program administers managed care programs that enroll persons with disabilities. (The programs include the Comprehensive Health Care Program (CHCP), a mainstream capitated program and the Children's Special Health Care Services (CSHCS), a specialized program serving children with disabilities that includes a recently launched capitated product). In a 1996 reorganization, several departments, including the Department of Public Health, the Department of Mental Health and the Medical Services Administration, were consolidated under the control of the MDCH. One of the goals of this reorganization was to bring together the policy, programs and resources related to the delivery of Medicaid services to enable the state to become a more efficient purchaser of health care services.

## The Comprehensive Health Care Program (CHCP)

One of the first objectives of the newly formed Michigan Department of Community Health (MDCH) was to initiate a competitive bidding process for health maintenance organizations, clinic plans and other providers to participate in the delivery of Medicaid services on a capitated basis. The resulting program is called the Comprehensive Health Care Program (CHCP).

The CHCP, which is mandatory for a large portion of Medicaid beneficiaries, was implemented in the five counties of the Detroit Metropolitan area during 1997. State officials predict that most of the target population will be enrolled by the end of 1999.

The CHCP is mandatory for the Temporary Aid for Needy Families (TANF) population, aged, blind, and disabled individuals who do not receive Medicare. In addition, individuals eligible for both Medicare and Medicaid and migrants may enroll in the program on a voluntary basis. Several groups are ineligible for the program. These include home- and community-based waiver participants, nursing facility residents, people in an intermediate care facility for the mentally retarded or in a state psychiatric hospital, and children enrolled in the Children's Special Health Care Services program.

In addition to these eligibility exclusions, an exemption from the program is possible if an individual is engaged in an episode of care with a physician who is not associated with one of the participating health plans of the CHCP at the time of enrollment. This "front-end" exemption, which is designed to promote continuity, allows an individual to remain in the fee-for-service program and be exempt from the CHCP until the qualifying episode of care is over. The enrollment broker explains the exception to Medicaid beneficiaries during the enrollment process if it is applicable to their current health care regimen.

There are approximately 30 qualified health plans that participate in the CHCP. While this number is in excess of the amount needed to adequately serve all of the Medicaid beneficiaries, the state decided to approve more health plans than necessary in order to provide security in case plans withdraw from the program. Ironically, the high number of plans increases the likelihood that some plans will have to drop out of the program.

# Comprehensive Health Care Program

## Features:

Waiver Authority	Program Model	Program Type	Participation	Program Operates	Ages Enrolled	Number of MCOs	Enrollment Broker
1915b	Capitated	Mainstream	Mandatory	Statewide	All Ages	30	Yes

## Capitation Rates Vary By:

Categorical eligibility for Medicaid, Age, and Gender.

## Enrollment:

Estimated Program Enrollment: 748,750

Estimated Enrollment of PWD: 140,600 (18.8%)

## Services Excluded from CHCP:

- Dental services
- Services provided by a school district
- Mental health services in excess of 20 outpatient visits per year
- Substance abuse services
- Services to persons eligible for the developmental disabilities carve-out
- Custodial care in a nursing home
- Home and community-based waiver program services
- Personal care or home help services
- Transportation for services not covered in the CHCP program
- Inpatient hospital psychiatric services
- Outpatient partial hospitalization psychiatric care

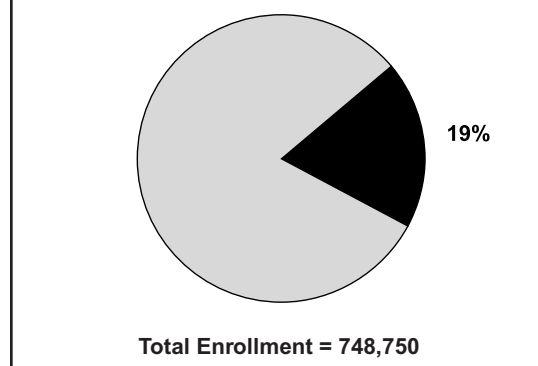
## Behavioral Health Services:

- BH services, in excess of 20 outpatient mental health visits, are provided through a statewide managed behavioral health program, the Managed Specialty Services Program. Community mental health service programs are the providers.

## Special Features for Persons with Disabilities:

- A “front-end” exception enables a person engaged in a health care regime with a provider not associated with a health plan to remain in the Medicaid fee-for-service program until the care episode is over.
- The enrollment broker employs a former disability advocate to train counselors to be cognizant of the needs of persons with disabilities during the enrollment process.

**Program Enrollment of Persons with Disabilities**



The qualified health plans are responsible for providing a comprehensive benefit package. They are not, however, required to provide the following services:

- dental services
- services provided by a school district
- mental health services in excess of 20 outpatient visits per year
- substance abuse services
- services to persons eligible for the developmental disabilities carve-out
- custodial care in a nursing home
- home and community-based waiver program services
- personal care or home help services
- transportation for services not covered in the CHCP
- inpatient hospital psychiatric services
- outpatient partial hospitalization psychiatric care.

Qualified health plans are required to collaborate and communicate with a wide range of public and community providers and organizations to help coordinate all health care services available to their members. The plans have a contractual obligation to communicate with the local health departments as well as the providers of care for the behavioral health and developmental disabilities carve-out. They are also expected to coordinate activities with public and community providers such as family independence agencies, school-based services and adolescent health centers. Health plans are also required to provide access to services from federally qualified health centers.

## **Enrollment Process**

An enrollment broker, Michigan Enrolls, is used by the MDCH to perform all enrollment duties for the state. The broker contacts and educates Medicaid beneficiaries about managed care and assists in processes of enrollment, disenrollment and changing health care plans, when applicable. Michigan Enrolls has hired a person to work specifically with issues pertaining to the enrollment of persons with disabilities or special needs.

Medicaid beneficiaries eligible for the CHCP will have full choice of contracting health plans within their county of residence. The beneficiary must choose a health plan within 30 days or the state will automatically assign the beneficiary to a health plan within the county of residence.

Beneficiaries will be automatically assigned to qualified health plans based on performance of the plan in areas specified by the Department of Community Health. Plans with higher performance rankings will be assigned a larger proportion of beneficiaries under

the automatic beneficiary enrollment process than plans with a lower performance ranking. The capacity of the plan to accept new enrollees and reasonable accessibility for the beneficiary also will be taken into consideration in automatic beneficiary enrollment. Enrollment of beneficiaries into a qualified health plan will be for a period of 12 months. The 12-month enrollment period will be in effect from July 1, 1999, through June 30, 2000. Michigan Enrolls monitors why beneficiaries change health plans, but the state claims the information has not been very useful because there are approximately 50 reasons why beneficiaries may change plans.

## **Payment Mechanism**

The capitation rates paid to qualified health plans that participate in the CHCP vary according to age, gender, categorical eligibility for Medicaid, and Medicare eligibility. In all, there are 25 different rates associated with the program. The state has contracted with actuaries and risk-adjustment experts to investigate ways to adjust payments for conditions such as HIV/AIDS, end stage renal disease, epilepsy, and transplants. State officials say they are committed to developing some type of case-based rate adjustments over the next year.

In addition to payment adjustments for certain conditions, state officials are considering incorporating some type of diagnosis-related component into the payment system in the next several years. The mechanism could be similar to the reimbursement system utilized for the newly implemented Children's Special Health Care Services managed care program (discussed later in this section).

The state has made a few adjustments in its payment mechanism in the last year to provide some monetary relief for the qualified health plans. The payment rate for dual eligibles, who may participate in the CHCP on a voluntarily basis, used to be a blended rate from both public sources. Since Medicare is the primary insurer, the state is now paying less from Medicaid funding sources. The state asserts that this change has resulted in approximately \$20 million per year in additional funds for the qualified health plans. The state has also made funds available for the plans for the provision of care associated with high-risk births. If a high-risk birth results in a newborn with a disability or a special health care need, the newborn is enrolled in the Children's Special Health Care Services program. Prior to their enrollment in the special children's program, however, the plan must provide for all of the newborn's health care needs. Approximately \$16 million has been made available to qualified health plans to compensate them for care provided to these newborns.

## **Quality Assurance**

During the implementation of the CHCP, advocates and consumers were invited to share their perspectives and input with the state and the plans. One of the main issues discussed was the provision and maintenance of durable medical equipment. In addition to

these preliminary meetings, consumers are involved on the Health Plans Advisory Council. This multidisciplinary council of consumers, advocates, health plan representatives and members of the community advises the MDCH and the qualified health plans on all aspects related to the delivery of health care to Medicaid beneficiaries.

The state requires health plans to send new enrollees a handbook explaining all of the services covered and the plan's internal procedures. The handbook must include information regarding the grievance and complaint resolution procedures. The state also outlines specific requirements with which the health plan must comply in terms of grievances and complaints. Michigan has already passed a patient's bill of rights that is in compliance with all requirements contained in the Balanced Budget Act, such as the use of appropriate notices when services are denied or terminated. Furthermore, the state Medicaid appeals process is available to beneficiaries in the event a client wants to bypass the health plan and appeal decisions directly to the state.

There are several ways that quality is being tracked and measured in the CHCP. The quality assurance (QA) program is comprised of four major components:

- The first component is the collection of aggregate utilization service reports and encounter data on a monthly basis. Historically, the Medicaid program in Michigan has collected only a limited amount of utilization data for its beneficiaries relative to the managed care program. As a result, the state is working with the plans to gradually increase efforts to collect the information. Since the HMO Program contracts with 30 health plans, some of which have only recently begun to enroll Medicaid beneficiaries, encounter data will be submitted and collected on a staggered basis. The plans will initially submit "test" tapes of encounter data. Once the "test" phase is over, the plans will be required to submit quarterly aggregate utilization service reports.
- The QA program requires that a complete set of HEDIS measures be collected on an annual basis from each qualified health plan. The state contracts with an independent organization to analyze and interpret the annual reports. It hopes to determine some sound quality measures from these reports that can be used to assess and measure quality in the plans.
- Consumer satisfaction with the program will be measured. To accomplish this task, the state plans to initiate an annual consumer satisfaction survey for Medicaid beneficiaries in the CHCP. The state will utilize the Consumer Assessment of Health Plans Study (CAHPS) as the survey instrument.
- External studies based on focused medical record reviews are another component of the QA program. Since 1995, Michigan has contracted with an organization to perform external studies of the Medicaid program. Every year, the studies look at three to four types of services; these always include well-child visits and the provision of prenatal care. The other areas of scrutiny have typically involved treatment for chronic diseases. In 1997, the two diseases studied were hypertension and diabetes. The state is in the process of rebidding its external review contract; the new contract will



include an area that concerns persons with disabilities, which will be identified by the state or the organization that is awarded the contract.

In order to evaluate the CHCP in its early stages, the legislation required the state to perform a study that investigated many factors including cost, quality, and access to services during the initial phase in of the CHCP in the southeastern portion of Michigan. The state is still in the process of evaluating the initial implementation of the program and expects the report to be completed some time in 1999.

In order to promote and assure quality as the program expands and matures, the state formed a Clinical Advisory Committee consisting of 15 representatives from the qualified health plans. The representatives, who are either medical directors or quality improvement directors, are nominated by the plans and selected by the state. The committee works to devise policy and identify quality improvement indicators. In addition, the committee develops ways for the plans to effectively coordinate activities with the behavioral health and developmental disabilities carve-out providers. Ultimately, the state envisions sharing encounter data with the committee to discuss issues and concerns. During implementation of the CHCP, however, the committee was tackling immediate concerns such as educating the plans and their providers about EPSDT and family planning, among other issues.

## **Special Provisions for Persons with Disabilities**

There are very few special provisions built into the Comprehensive Health Care Program for persons with disabilities or other special health care needs. One of the few structural features of the program that pertains to persons with disabilities in some instances is the “front-end” exception. As noted earlier, this provision enables a person engaged in an episode of care with a provider not associated with a health plan to remain in the Medicaid fee-for-service program until the episode of care is over. In addition, some of the more severely disabled Medicaid beneficiaries are not eligible for managed care in Michigan.

Recognizing the special needs of persons with disabilities, the MDCH is in the process of securing a grant that would fund technical support to the health plans to educate their more vulnerable populations about their benefits and rights within the health plan.

The enrollment broker, Michigan Enrolls, has also hired a former disability advocate to train counselors to be cognizant of the needs of people with disabilities during the enrollment process. They are trained to pick up on verbal clues that identify people with special needs, such as the amount of time an individual has been on Medicaid since people with special needs tend to be on Medicaid for longer periods of time. When working with special needs individuals during enrollment, the counselors also take into consideration additional features such as the adequacy of health plan’s network of specialists and the individual’s durable medical equipment needs.

In the state's contract with the qualified health plans, there is vague language about objectives for persons with special needs. The contract recognizes that some Medicaid beneficiaries with special health care needs require access to specialists and health plans should make arrangements for such individuals. Since the health plans are not obligated to provide behavioral health or developmental disability-related services, the contract also mentions that the plans should attempt to coordinate the services they provide with those from carve-out providers.

The CHCP does not require plans to perform an initial health assessment on new enrollees. If the program included this type of provision, it could help to identify individuals with special health care needs who may require immediate health care services. This type of provision also ensures that an individual is seen by the health plan.

## **Disability Advocates' Impressions of the CHCP**

Advocates that work on behalf of individuals with disabilities and special health care needs have many concerns about the CHCP. Advocates feel that many people with special health care needs should not be in the program but are included due to the limited enrollment exclusions. While the "front-end" exception enables some Medicaid beneficiaries to temporarily avoid participating in the CHCP, advocates have two concerns about the provision. The exception pertains only to an episode in which an individual is engaged with one provider. Since persons with special needs are frequently involved in episodes with a team of providers, they may or may not be eligible for the exception. Also, advocates do not believe that the exception is widely publicized by either the state or the enrollment broker.

While the advocates generally feel that the grievance procedures and dispute resolution features are sufficient under the CHCP, they do not feel that the information is adequately disseminated or clearly explained to the beneficiaries. Advocates also believe that the plans are not always knowledgeable about all aspects of the grievance process. The advocates mentioned that it is imperative for the plans to be informed about and held accountable for all grievance procedures.

Furthermore, disability advocates would like to see a definition of "medical need" added to the contract. The contract now says only that health plans must provide services that are medically needed by beneficiaries. Advocates feel that this wording is very vague and as a result, health plans are able to be overly conservative in the provision of some services. The state also recognizes this concern and mentioned that a definition would probably be added to the contract in the near future.

Advocates are also concerned about beneficiaries' access to durable medical equipment (DME) under the CHCP. Advocates' primary concern is not with the provision of the equipment, but with the inability to order equipment designed to meet the special needs of the beneficiary. Customization would allow DME to be tailored to the diverse needs of

people with disabilities. In addition, health plans may deal exclusively with one vendor in order to receive preferential pricing, but this arrangement may restrict an enrollee's ability to obtain DME with the special features that he or she is accustomed to using. While these "extra" features may cost a little more, they can make a major difference in the quality of life of a person with a disability.

## **Health Plans' Impressions about the CHCP**

One of the major concerns that participating health plans expressed about the CHCP involves insufficient reimbursement. Some qualified health plans that serve a large number of Medicaid beneficiaries are experiencing significant financial losses; some have frozen their Medicaid enrollment. Providers with reputations for excellent tertiary care feel that they are especially penalized because they attract patients with more complex medical conditions and are not provided any additional compensation. One of the plans mentioned that changing to case-rate payments for some conditions may provide some financial relief.

The state recognizes the need to adjust payments for some beneficiaries with conditions that require increased utilization of health services, and is pursuing ways to accomplish this. The state also concedes that the rates are relatively low; originally, the rates were bid very competitively and due to political pressure to contain Medicaid expenditures, raising the rates has proven difficult.

The health plans also feel that there should be a change in the provision of behavioral health-related prescription drugs. The health plans are responsible for all prescriptions, including psychotropic drugs. Since they are not responsible for behavioral health services – aside from 20 outpatient visits per year – they feel they are penalized because they pay for the pharmaceuticals, yet they are not responsible for managing the care. Furthermore, to promote access to the newest brand name drugs, the state does not allow the use of formularies or the mandatory use of generics. This creates a dilemma as open access to drugs improves health outcomes for people with severe mental illness but also raises costs. The state also recognizes this situation and is in the process of investigating ways to realign incentives to make the situation more equitable.

One health plan also mentioned that it used to employ a person to handle issues related to persons with special health care needs. The health plan said it enjoyed the freedom to develop such initiatives on its own. However, since reimbursement has been low and additional features are not a contractual requirement, the health plan has discontinued some of these extra features.

## Children's Special Health Care Services Program (CSHCS)

The Michigan Department of Community Health (MDCH) also administers the Children's Specialty Health Care Services (CSHCS) Program. The CSHCS program differs from the Comprehensive Health Care Program (CHCP) in two fundamental ways. First, the CSHCS is a specialized program caring for children with special health care needs only.<sup>20</sup> Second, CSHCS is not a Medicaid-only program – it provides specialty health care services to children who are covered by Medicaid or qualify for Maternal and Child Health Block Grant (Title V) program services or Michigan's CHIP program, MIChild.

The CSHCS program has existed for some time throughout the state as a fee-for-service option. In the fall of 1998, the state launched a new managed care product in southeastern Michigan, which is expected to go statewide in late 2000. Participation in the CSHCS managed care program is voluntary. The next page displays enrollment and program features for the Children's Special Health Care Services program.

The CSHCS program has a long history that spans over 50 years. For much of that period, the program was known as the Crippled Children's Program or the Title V program. The program's goal has always been to keep children with special health care needs as healthy as possible, to maximize functioning, and to prevent institutionalization.

### Enrollment in CSHCS

Children can be referred to the program in a number of ways. Frequently, a medical subspecialist will refer a child to the program by sending medical reports for the purpose of determination of medical eligibility. Local health departments also identify children who may be eligible for CSHCS services. Following referral to the program, a MDCH medical consultant reviews a child's medical records and assigns a primary diagnosis if the child is determined to be eligible. Families of eligible children decide whether they want their children to participate in the CSHCS program. If so, an application is completed by the family and the child is entered into the CSHCS system with authorized service providers.

Four factors about a child's medical condition are considered when determining eligibility: the primary disease or condition; how chronic the disease or condition is; the severity of the disease or condition; and the child's need to be seen by a subspecialist. Children up to the age of 21 are eligible for the program. Individuals with cystic fibrosis or certain hereditary coagulation disorders are eligible for the program for life. There are over 2,700 diagnoses that enable a child to become eligible for the program. Among these are cancer, cleft palate, liver disease, insulin-dependent diabetes, and neurological disorders.

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<sup>20</sup> The program serves children under the age of 21 and adults over the age of 21 with certain coagulation disorders or cystic fibrosis.

There are three separate tracks within the CSHCS managed care program that determine the coverage provided. The first track is for children who qualify for the program on the basis of their health condition but do not have Medicaid. For these children, the CSHCS program covers a full range of specialty care services required to treat their qualifying condition only; no primary care or preventive services are covered. The second track is for children who qualify on medical grounds for CSHCS and are eligible for Medicaid. For this track, the coverage is comprehensive, encompassing both primary and preventive care as well as the specialty care necessary to treat the qualifying medical condition. The third track is for children who qualify on medical grounds and are also eligible for Michigan's CHIP Program, MICHild. This track is a "look-alike" to the Medicaid track as it also provides comprehensive health care.

# Children's Special Health Care Services

## Features:

Waiver Authority	Program Model	Program Type	Participation	Program Operates	Ages Enrolled	Number of MCOs	Enrollment Broker
N/A	Capitated	Specialized	Voluntary*	Statewide**	0-21***	2	Yes

\*The Children's Special Health Care Services program is also available on a FFS basis.

\*\* The health plans of the CSHCS program are currently expanding their networks to be statewide.

\*\*\*Individuals with cystic fibrosis or certain hereditary coagulation disorders are eligible for the program for life.

### Capitation Rates Vary By:

Diagnosis Categories, Age, and Geographic Region. In addition, a separate rate was developed for children who need in-home nursing services.

### Enrollment:

Estimated Enrollment of PWD: 100%

The program began enrolling children in fall 1998.

### Services Excluded from CHCP:

- Behavioral health services in excess of 20 outpatient mental health visits.
- Custodial LTC
- Services provided by school districts

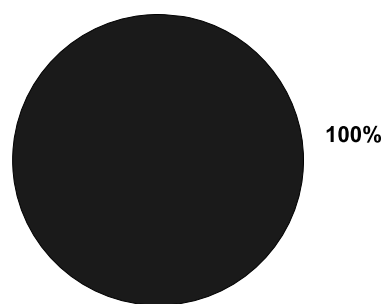
### Behavioral Health Services:

- BH services, in excess of 20 outpatient mental health visits, are provided through a statewide managed behavioral health program, the Managed Specialty Services Program. Community mental health service boards are the providers.

### Special Features for Persons with Disabilities:

- A Care Coordinator is assigned to each enrollee.
- A child's care coordinator and principal coordinating physician (who may be a primary care doctor or a subspecialist) work, in conjunction with the child's family, to develop an Individualized Health Care Plan which authorizes services and guides all providers during health care encounters.
- Quality assurance studies that will assess the quality of services provided in the program are specific to children with special health care needs.

### Program Enrollment of Persons with Disabilities



## **Capitated CSHCS Product**

While the traditional fee-for-service line of the program continues to be available throughout the state, a managed care product was launched in September 1998 in the Detroit metropolitan area that serves as an additional delivery system that families may choose for their eligible children. The capitated product was developed to initiate improvements in the program. According to Medicaid and program staff, the fee-for-service track is plagued by insufficient coordination between primary and secondary care, lack of adequate coordination among community services, inadequate focus on health and functional outcomes, and limited accountability for cost effectiveness at the provider level. Among the most concerned about the shortcomings of the program were participating families of children with special health care needs.

The state believes the CSHCS managed care product will enhance the coordination of care provided to children and improve the cost-effectiveness of the program. If the program is successful, it will enable the state to avoid reducing the benefit level or restricting the eligibility requirements for the program in order to control costs.

Planning for the managed care product of the CSHCS program began in 1994; it included the formation of a managed care subcommittee that was comprised of representatives from all of the relevant stakeholder groups such as state personnel, medical providers, family members of children in the program, children's advocates, and health plan personnel. The subcommittee developed comprehensive guidelines to follow during the planning process. Stakeholders wanted to take their time to develop a high-quality, comprehensive program because they knew they only had one opportunity to plan the program correctly.

The committee initially decided on a primary care case management model but abandoned the idea because a PCCM program would likely contain many of the deficiencies of the existing fee-for-service program. The decision to go with a stand-alone managed care program came at approximately the same time that risk-based programs were being pursued for the entire Medicaid population in the state.

The MDCH initiated a request for proposals (RFP) for the CSHCS managed care program in 1996. Three health care systems originally responded to the RFP, but two of the provider groups subsequently combined. The Henry Ford Health System and the University of Michigan formed a joint venture to create Kid's Care of Michigan. The Detroit Medical Center also participates in the CSHCS managed care program as Children's Choice of Michigan.

## **Outreach and Enrollment**

In order to educate families of children with special health care needs about the new managed care program, the state currently operates an aggressive information initiative



through consumer forums. The purpose of the forums is to explain the additional benefits of the program and to allay concerns about managed care. Representatives from a variety of organizations plan and attend the forums, including state personnel, medical providers and health plan personnel. As a result of the forums, interest in the program is beginning to build.

Once a child becomes medically eligible and joins the CSHCS program, the families in counties with a special health plan choice must contact the enrollment broker to discuss the child's health plan options. The family may choose a special health plan or the fee-for-service plan.

If a family chooses the managed care option, a nurse care coordinator who is employed by the health plan is notified. The care coordinator contacts the family and determines whether any immediate health care services need to be provided to the child. The care coordinator also assists the family in choosing a principal coordinating physician for the child. If current providers serving the child are not in the health plan, efforts are made to recruit the physician into the network.

The care coordinator, along with the principal coordinating physician, develops an Individualized Health Care Plan (IHCP) for a newly enrolled child. The IHCP is intended to be a comprehensive plan identifying all aspects of the child's needs, including medical, social, emotional, and school-based services. While the health plans are responsible only for the health care services, all of the child's needs must be identified.

In order for the IHCP to be in effect, it has to be approved by all the stakeholders, including the child's family. In addition to planning a health care treatment plan for the child, the IHCP also serves to authorize a number of services that are part of the care plan. The IHCP is also a coordinating tool because it helps to eliminate fragmentation and duplication of services. The IHCP is reviewed after six months to determine whether it is adequately and appropriately meeting the child's health care needs.

The two health plans are still in the process of developing their networks in an effort to expand statewide. The health plans generally feel that recruitment of providers is relatively easy for the CSHCS program because there are only a limited number of pediatric subspecialists; it is easy to identify these physicians because they constitute a relatively small number. Physicians are also generally eager to affiliate with at least one of the networks because they tend to support the mission of the program and they view the fees as fair. Recruitment of providers and access to services may prove to be more difficult in rural areas of the state. To help eliminate this problem and facilitate the expansion throughout the state, the health plans intend to utilize local nurses as care coordinators because they are more familiar with the regional services available.

The managed care CSHCS contract does require plans to contract with safety net providers, including pediatric "centers of excellence." Currently, there is no lock-in



provision; families may switch health plans or change to the fee-for-service option every thirty days.

Traditionally, the fee-for-service portion of the CSHCS program has used Children's Multidisciplinary Specialty (CMS) clinics to provide comprehensive plans of care to beneficiaries in the CSHCS program with the most complex health care needs. In the managed care track, the state requires the health plans to contract with pre-existing CMS clinics or to create their own multidisciplinary clinics to provide comprehensive services.

At least one of the participating health plans is working on developing practice guidelines to assist in the provision of care for the most expensive-to-treat diagnoses, which include cerebral palsy, asthma, diabetes, and hemophilia. The health plan is also in the process of developing quality indicators for these conditions.

## **Payment Mechanism**

One of the most interesting features of the CSHCS managed care program is its use of risk adjusters to determine capitation rates. In the ESRI survey, the CSHCS program was identified as one of only five Medicaid managed care programs that use some form of risk-adjustment (other than categorical eligibility, age, gender, or geographic area) to establish payment rates to health plans. In this regard, the reimbursement mechanism of the CSHCS program is very innovative and may prove to be a payment method that allows a managed care program serving a population such as children with special health care needs to succeed.

The state spent a considerable amount of time developing a comprehensive and equitable payment system. The state received research grants to accomplish the risk-adjustment planning and worked with numerous actuaries and a risk-adjustment specialist to develop their system. The payment mechanism is based on the premise that health care costs are actually more predictable over time for persons with disabilities than for other people.

The primary enrollment diagnosis serves as the major risk adjuster. The capitation rate is based on a matrix of four different disease rate cells, plus one for Medicaid patients who need in-home nursing services. These factors are further adjusted by age, whether a child is on Medicaid, whether a child has third party insurance, and by geographic area.

The capitation rates are based on 100 percent of the fee-for-service equivalent cost. In addition, there are numerous provisions written into the contract to ensure that health plans have financial security. For instance, the contract has risk-sharing provisions to protect plans from large losses and the state from undercutting the plans. The state has developed a series of risk corridors that define various levels of risk-sharing between the plans and the state. For example, if plans are able to provide care for their enrolled population at between 82 and 95 percent of the fee-for-service equivalent, the state and the

health plan split the savings evenly. If, on the other hand, the health plans expend more than 110 percent of the fee-for-service equivalent, the state is responsible for 90 percent of the losses. If plans expend less than 82 percent of the fee-for-service equivalent, which the state believes can only occur if the payment rates are set too high or adequate services are not provided, the state retains all of the saving.

A separate form of risk sharing, the establishment of a stop-loss provision, is also built into the program. The state will assume 90 percent of the cost exceeding a \$100,000 threshold for care associated with any individual case within a twelve-month period.

The health plans signed a four and a half-year contract with rates to be negotiated annually. The state will perform a study, 15 months into the program, to investigate whether the health plans are experiencing adverse selection.

There are cost restrictions built into the state's contract with the health plans that mandate that not more than 10 percent of the total amount paid to each health plan may go towards administrative costs, including up to 5 percent on care coordination, and thus, 85 percent must be utilized for providing health services. In order to assist the health plans with the expensive start-up costs, the state has given the health plans some seed money to help establish care coordination activities.

Additional funds are also available to the health plans if they utilize Locally Based Services for care coordination activities. Historically, Locally Based Services, a department of the local Health Department, have played a large role in determining eligibility and performing enrollment functions in the fee-for-service tract. The Locally Based Services have served as a place for "one-stop shopping" for families to access the CSHCS program. Due to the movement towards managed care, the role of the Locally Based Services office is changing. In order to ease the transition, the MDCH has made money available to the health plans if they utilize Locally Based Services to provide care coordination. If the plans choose this option, the MDCH will pay the local Health Department for their care activities for a limited time.

To ensure that the two MCO's continue to participate in CSHCS, Michigan has recently guaranteed the two systems participating in the program that they will not experience losses this year. Similarly, the health plans cannot earn a profit this year.

## **Quality Assurance**

The MDCH incorporated goals for preventive services for immunization and well-child visits into the CSHCS contract with the health plans. It also calls for 100 percent immunization rates for all infants up to age two, which is a statewide public health goal. The contract also ties some financial rewards and penalties to its quality of care goals for newly enrolled children, which are as follows: IHCPs must be developed within 60 days; care coordinators must be assigned within 60 days; and principal coordinating physicians

must be assigned within 60 days. Each of these goals triggers a reward equal to a one percent add-on to the capitation payment if the health plan achieves 100 percent compliance with the goals. Conversely, the health plans are charged a one percent penalty for each standard that falls to less than 90 percent of the target.

## **A Closer Look: Children's Special Health Care Services Reimbursement Mechanism**

The reimbursement mechanism used by the Children's Special Health Care Services (CSHCS) managed care product<sup>a</sup> is innovative and may prove to be a payment methodology that allows a managed care program, serving a population such as children with special health care needs, to succeed. One of its unique features is that capitation rates are adjusted to account for the severity of a child's chronic condition or disability.

**Rate Setting:** Capitation rates are adjusted by the following criteria: diagnosis category, age, and geographic region. The diagnosis category to which a child is assigned is based on the primary enrollment diagnosis, which is determined through an examination of a child's medical records by a Michigan Department of Community Health physician. In addition, a separate rate cell was developed for children who need in-home nursing services. The capitation rates are based on 100% of the fee-for-service equivalent cost.

The rates for CSHCS beneficiaries under one and over 20 are not risk-adjusted because there are only a small number of beneficiaries in each of these categories. The four categories that are used to adjust the payment rates are based on clusters of similar diseases. This arrangement is intended to eliminate *upcoding*, which is the potential for assigning children to different categories in order to receive higher payments.

**Stop Loss:** In order to protect the health plans from very high cost cases, a stop-loss provision was included in the payment mechanism. The state assumes 90 percent of the cost exceeding a \$100,000 threshold<sup>b</sup> for care associated with any individual case within a twelve-month period.

**Risk Corridors:** Risk corridors, which define various levels of risk-sharing between the plans and the state, were included in the payment system because of the state's lack of experience with risk-adjusted payments. For example, if plans provide care to beneficiaries for between 82 and 95 percent of the fee-for-service equivalent, the state and health plan split the savings evenly. The risk corridors allow the health plans partial protection in the case of financial loss, and partially reward the state if the CSHCS program is able to operate in a cost-effective manner.

### **Total Expenditure by the Health Plan Financial Profit/Loss Responsibility**

<85% of total capitation	State retains 100% of savings
Between 85-92% of total capitation	State retains 50% of savings. Health Plan retains 50% of savings
Between 92-103% of total capitation	Health Plan retains 100% of savings or is responsible for 100% of losses
Between 103-110% of total capitation	Health Plan responsible for 50% of losses. State is responsible for 50% of losses
>110% of total capitation	Health Plan responsible for 10% of losses. State responsible for 90% of losses

The total expenditure by each health plan is calculated based on a reconciliation of the reported allowable expenses of the plan, as compared with the total revenue received from the capitation rates. The expenses include all medical services and administration costs up to allowable limits.<sup>c</sup>

**Adverse Selection Studies:** The health plans signed a four and a half-year contract with the state. Rates will be negotiated annually. The state will perform a study, 15 months after the program's inception, to investigate whether the health plans are experiencing adverse selection.

**Financial Rewards/Penalties:** The contract also ties some financial rewards and penalties to some of the quality of care goals for newly enrolled children. Each of these goals triggers a reward equal to a 1 percent add-on to the capitation payment, if the health plan achieves 100 percent compliance with the goals. Conversely, the health plans are charged a one-percent penalty for each standard that falls to below 90 percent of the target.

<b>TASK/GOAL</b>	<b>STANDARD</b>	<b>REWARD/PENALTY</b>
IHCPs developed within 60 days	Achieved at 100%	1% of capitation reward
	Below 90%	1% of capitation penalty
Care Coordinators Assigned within 60 days	Achieved at 100%	1% of capitation reward
	Below 90%	1% of capitation penalty
Principal Coordinating Physicians assigned within 60 days	Achieved at 100%	1% of capitation reward
	Below 90%	1% of capitation penalty

<sup>a</sup> The Children's Special Health Care Services program is also available to eligible beneficiaries on a fee-for-service basis. Participation in the managed care product is entirely voluntary. For purposes of this profile, only the managed care product is discussed.

<sup>b</sup> Costs are based on Michigan's Medicaid fee schedule.

<sup>c</sup> The health plans are only allowed to expend up to 10 percent of the total capitation on administration costs, including up to 5 percent for care coordination activities.

Aside from the financially-based incentives, the quality assurance portion of the CSHCS managed care program is still under development. Currently, each health plan has a quality assurance committee that is performing some standard quality measurement features such as HEDIS reporting measures and developing clinical indicators for some specific illnesses. The health plans are already collecting encounter data, but the review process is still being developed. As mentioned in the CHCP quality assurance section, Michigan contracts for external review studies that investigate varying aspects of the Medicaid programs. Similar to the CHSP, the state will utilize a CAHPS customer satisfaction survey for this program that is tailored to children with special needs. The state expects to form a Clinical Advisory Committee for the CSHCS program that will identify special studies pertaining to children with special health care needs and advise the plans about the treatment regimens for certain conditions.

A formalized grievance process is used in the CSHCS program that is very similar to the general grievance procedures under the Medicaid program. The grievance process is designed to be equitable to health plans and members and outlines a specific timeline for the grievance and appeals process. Included in the grievance process is the provision that written notification of all appeals must be sent to members. If necessary, families can receive assistance with the grievance process. Furthermore, an emergency “fast-track” option is available for families who receive a denial or for families who request an appeal in order to resolve problems in a timely manner.

## **Family Involvement**

Another unique feature of the CSHCS program is the tremendous amount of family involvement that was incorporated into the planning of the program and will be used for its going monitoring and improvement. As one parent said, “... with all of the buzz over gatekeeping, the CSHCS program was designed to essentially give families a key to the gate.” With this thought in mind, the program was designed to enable families to be involved with the development and evolution of the program, as well as the child’s IHCP, in order to foster quality care. For instance, a family has to sign their child’s IHCP in order for it to be valid. Families also have the ability to guide the program by participating in the CSHCS Advisory Committee and within each health plan through governing boards and committees.

## **Disability Advocates’ Perceptions of the Program**

Advocates who work on behalf of children with special health care needs generally view the CSHCS managed care program favorably. One provision of the program which advocates worked very hard to ensure is the voluntary nature of enrollment in the managed care program. This provision allows families that are satisfied with the care their children receive in the fee-for-service program to avoid disruptions or alterations in that care. Since the program is in its infancy, however, advocates are watching the program very closely to ensure that it adequately meets the needs of its members.

One of the main problems with the program that advocates and family members mentioned concerns the enrollment broker. Family members complained about the phone lines, claiming that when they called, the lines were either busy or had very long queues. They also complained about the accuracy of the information given and the lack of consistency. Advocates echoed these sentiments and also noted that the fee-for-service option was not always mentioned to families as an alternative to managed care. It was noted that the enrollment broker is overwhelmed with the functions associated with enrollment in the CHIP program, MICHild, which contributes to the crowded phone lines.

## **Health Plans' Perceptions of the Program**

The two health plans are generally excited and optimistic about the CSHCS program. At the same time, the health plans, along with the state personnel, are finding it difficult to convince families about the value of the managed care program and the added benefits that are associated with it.

Once families decide to enroll their eligible children, the health plans must be able to manage the care while improving quality and decreasing, or at least stabilizing, costs. One provider mentioned that this task might prove to be very difficult because families can move their child from one health plan to the other or back into the fee-for-service track without restrictions. Since children are not locked into one program or health plan for a long period of time, health plans have less incentive to spend on preventive services and care coordination.

While health plan personnel concede that the voluntary nature of enrollment was very important to ensure that families who are content with their current mode of care are not forced to change, they also believe this feature may lead to low enrollment in managed care. The participating plans have invested a lot of money to create these programs and they need a sizeable enrollment to help recover the costs. At the time of the study, however, approximately 50 percent of the clients who were new to the program or had to renew their enrollment were choosing the managed care option.

## **The Community Mental Health Services Program**

Services and supports for eligible people with developmental disabilities are available through the Community Mental Health Services Program (CMHSP) carve-out. Behavioral health services for all Medicaid beneficiaries, aside from the provision of 20 outpatient mental health visits under the CHCP and the CSHCS programs, are also provided through (CMHSP).

Michigan's publicly financed behavioral health and developmental disabilities (DD) services have been moving towards community-based care for the last 20 years. During this time, the primary providers for these services have been the county sponsored CMHSPs.

Forty-nine CMHSPs, which are independent government entities, cover all 83 counties of the state. Each CMHSP provides all DD-related services to eligible Medicaid beneficiaries in its region. The CMHSPs are also responsible for specialty behavioral health services for all Medicaid beneficiaries in their region. The CMHSPs provide specialty mental health services and in most instances, subcontract for substance abuse services.

In 1974, the legislature required the responsibility for behavioral health and DD services to shift from the state to the community level when possible. About four years later, several pilot programs were launched to investigate delivery systems to facilitate the change. In the late 1970s and 1980s, Michigan began an aggressive initiative to move many institutionalized individuals back into the community. In order to accomplish this task, the state decided to reallocate funds used to care for formerly institutionalized people into the community for continued support and services. When this transition occurred, Medicaid programs were developed to serve these populations, which ultimately evolved into the CMHSP program.

The driving force to create the CMHSP program for specialty behavioral health and DD services was the development of managed care for physical health services in the form of the Comprehensive Health Care Program for a majority of Medicaid beneficiaries. The state believed that capitating other aspects of Medicaid beneficiaries' care, including behavioral health and DD services, was a logical progression. A second factor that contributed to the development of the CMHSP program was the state's desire to improve the health and functional outcomes of persons served while holding the providers accountable under capitation.

One factor that indirectly influenced the creation of managed care for behavioral health and DD services was the passage of the Mental Health Code in 1995 by the Michigan Legislature. The Mental Health Code stresses a patient-centered approach to delivering DD and behavioral health services. The patient-centered-approach lends itself to a managed care program, to give providers the freedom necessary to develop individualized care plans.

As a result of these factors, the CMHSP program was designed. The goal was not to necessarily save money on persons receiving DD and behavioral health services, but rather to reallocate the funds to use them more efficiently and to improve the health status and functional capacity of people being served. The state originally submitted two separate waivers to the Health Care Financing Administration: one for behavioral health and the other for DD services. Ultimately, the two services were combined into one program with separate capitation payments for behavioral health and DD services. One 1915b waiver was approved in June 1998 and implementation of the program began in October 1998.

All relevant stakeholders were involved in the planning process of the CMHSP program from the beginning. The stakeholders included consumers, parents of consumers,



advocates, providers and state personnel. The various interest groups were in on the original design team, and continue to be active in the implementation and ongoing monitoring of the program.

The traditional providers of specialty behavioral health and DD services, the CMHSPs, were awarded the contracts under the CMHSP program. As a result, the CMHSPs are transitioning themselves to function as prepaid health plans. Despite this reorganization, the state contends that implementation of the CMHSP program was not a transformational change for either the CMHSPs or the beneficiaries since individuals have been receiving all of their behavioral health and DD services from these providers for a number of years. The CMHSPs have experienced a dramatic change in their payment mechanism, which has changed from fee-for-service to capitation. In addition, the providers now enjoy more freedom to pursue alternative treatment plans under capitation.

A home and community-based waiver program for persons with developmental disabilities frequently serves beneficiaries under the DD portion of the CMHSP program. The state asserts that while the funding for these two programs is separate, the programs work together to serve these individuals in a seamless fashion.

Under the program, the CMHSPs are held to stringent service requirements: an emergency must be seen immediately, an urgent situation must be seen within 23 hours and a routine visit must occur within seven days. The state contends that the CMHSPs are able to achieve these service requirements in part because access was not a problem prior to the CMHSP program due to the long-standing focus on community based care.

A significant change is expected to affect the CMHSP program when the state introduces a competitive bidding process. The state is required under the waiver to develop the competitive process by the year 2000 and accept bids by 2002. The state may receive and accept bids from non-traditional Medicaid providers, especially in areas where performance in the CMHSPs has not met all of the contractual requirements.

## **Capitation Rates and Payments**

The capitation rates paid to the CMHSPs for DD-related services and support vary according to eligibility for Medicaid and age. These criteria combine to form four different capitation rates. The CMHSPs and the state share the risk associated with the delivery of care under and above established risk-corridors.

The payment for the behavioral health portion of the program mirrors the DD reimbursement. The program also operates on a partial-risk basis with risk-corridors. The CMHSP and the Michigan Department of Community Health share any savings below an established floor and share costs above an established threshold.



Substance abuse services are handled differently than behavioral health and DD services under the CMHSP program. In most instances, the CMHSPs do not provide substance abuse services. Instead, they subcontract with 15 regional Substance Abuse Coordinating Agencies, which have been the historic providers of substance services for the Medicaid population.

A portion of the capitation rate paid to the CMHSPs is earmarked for substance abuse services. While the amount of total funding for substance abuse services has not changed significantly, the CMHSP program has changed the funding stream as the money is now funneled through the CMHSPs. The state contends that this change has occurred relatively smoothly due to the historical ties and relationships that the CMHSPs and the Substance Abuse Coordinating Agencies have forged. Two of the CMHSPs also function as two of the Substance Abuse Coordinating Agencies.

## **Quality Assurance**

The MDCH has adopted a three-tiered approach to measure and assure quality in the CMHSP program. First, each CMHSP is required to administer a standardized consumer satisfaction instrument. Second, the state has formed teams, which include consumers, which perform on-site monitoring of the CMHSPs. The teams conduct chart review and interviews staff and consumers. Third, the state has contracted with an independent organization to conduct an evaluation of the program.

The CMHSPs are required to establish agreements with the qualified health plans of the Comprehensive Health Care Program and the Children's Special Health Care Services program in order to ensure that communication flows among the numerous providers to coordinate care appropriately. The state mentioned that this is a contentious issue, especially from the plans' perspective. The plans feel that they are penalized because they have to provide all pharmaceuticals, including psychotropic drugs, while they are not responsible for managing behavioral health care. As a result of the tension, communication does not flow among the plans and the CMHSPs as openly as the state would like.

## **Lessons Learned from Michigan**

The two Medicaid managed care programs in Michigan that enroll non-elderly persons with disabilities vary in design quite significantly. The Comprehensive Health Care Program is a mainstream managed care plan that enrolls the majority of Medicaid beneficiaries. This program contains relatively few special provisions for persons with disabilities. The Children's Special Health Care Services recently launched a capitated managed care product that is dramatically different from the CHCP. The children's program varies from the other programs because it contains many features to ensure quality for children with disabilities due to its specialized nature.

The CHCP has been successful in moving a large number of SSI and related individuals into managed care. It appears that the state designed the program with the philosophy that a program does not need to contain a lot of special features to ensure quality care for persons with disabilities. Instead, they adopted the approach that the program is sufficient to ensure quality care for all of the Medicaid beneficiaries enrolled. It is too early to tell whether persons with disabilities are receiving quality care and all the necessary services in the CHCP program.

The lessons learned from Michigan include the following:

- ***Splitting responsibility for payment of services can cause fragmentation in service delivery.*** The qualified health plans of the CHCP are very concerned about the fragmentation in the provision of behavioral health services, especially concerning the use of psychotropic drugs. The plans are required to cover all pharmaceuticals for the members, including behavioral health related prescriptions, yet they are not responsible for managing the care.
- ***In highly competitive markets, some plans are likely to exit the market – especially if they perceive rates to be too low.*** The qualified health plans of the CHCP are also very concerned about the current reimbursement mechanism. While health plans are paid a higher capitation rate for persons with disabilities on SSI, the payment is perceived as being too low. As a result of the perception that reimbursement is inadequate, a few of the health plans have frozen their Medicaid enrollment and are threatening to pull out of the program. The state claims that it purposely accepted contracts from more health plans than necessary in order to cover the Medicaid population in case some plans withdraw or limit their exposure to the program. The state also noted that Michigan is somewhat unique in that most of its health plans are “homegrown.” As a result, they are unlikely to leave the state as some national plans have done in response to low reimbursement in public programs. Some of these plans are, however, likely to withdraw from the CHCP, if the rates are not equitable.
- ***A system with many competing health plans is ripe for adverse selection.*** Qualified health plans in the CHCP that are known for treating complex cases feel that they are experiencing adverse selection by attracting individuals with more complicated health care needs. While the state may ultimately relieve providers that serve individuals with more complex health care needs through the use of case-rate payments for some conditions, these adjustments will be implemented in a budget neutral fashion. This will most likely create tension among the health plans, even if it is done well, because some plans will benefit while others will be hurt by the change.
- ***Even carefully designed specialty programs can attract very low enrollments if they are voluntary in nature and have a comparable fee-for-service alternative.*** The development and implementation of the CSHCS program illustrates the tremendous amount of care and attention that can accompany moving a vulnerable population into managed care. The entire process was a deliberate effort to get input from all stakeholders on issues, including financial planning and program structure. The

resulting program, however, still faces difficulties such as convincing families about the value of the managed care option. The program, although in its infancy, is also hampered by limited enrollment.

- ***Risk-adjustment is complicated, but programs will continue to be challenged to set rates that compensate plans for caring for more costly beneficiaries.*** The risk-adjusted feature of the payment mechanism in the CSHCS managed care program is very innovative. While the risk-adjustment may seem relatively crude, with only five diagnosis categories, it bears watching because it may prove to be a payment system that enables a Medicaid managed care program to work for a vulnerable population. This would be particularly true if the state incorporates aspects of the CSHCS risk-adjusted payment methodology into the CHCP.
- ***Managed care programs ultimately change the role of the state Medicaid administration.*** Since the inception of the CHCP and the CSHCS managed care programs, the role of the Michigan Department of Community Health is changing. The department is reorganizing to be less involved in the direct provision of health services and more involved in the administration, financial planning, oversight and quality monitoring of the two programs.
- ***Even after years of experience, it is not easy to determine how persons with disabilities are faring in managed care arrangements.*** State personnel recognize the need to determine and ensure quality for members with disabilities in the CHCP and the CSHCS. They also noted the difficulty in determining and measuring quality for this vulnerable population. Since Michigan has only begun to collect encounter data for the programs, the quality assurance activities will be modified and expanded over time.

# **New Mexico**

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## Introduction

In July 1997, New Mexico Medicaid launched Salud! – a fully capitated managed care program that requires most Medicaid beneficiaries to enroll in one of three managed care organizations to receive virtually all of their health services. By the fall of 1998, nearly 200,000 individuals, including approximately 35,000 non-elderly persons with disabilities, were part of the Salud! system.

The promise of a rapid move to mandatory capitated care created enormous concern for many Medicaid beneficiaries with disabilities and advocates in the state, even before the first person officially enrolled in the program. They feared that such a move could cause disruptions in service, could create barriers to care, and would be confusing and unduly onerous to persons in need of care. Now, with the program up and fully operational in all counties in the state, the Salud! program and the advocacy community appear to be making their peace with one another. In the words of one advocate, “Salud is not as bad as our worst fears, but not as good as our best hopes.”

The story in New Mexico is one of raised, dashed, and now more mature expectations. At one point in time, New Mexico Medicaid saw managed care as the solution to the state’s problems, while advocates saw it as the enemy to health care delivery and quality of care. Both sides appear to have settled on a middle ground. While they still do not agree completely on the value of managed care, both sides identify strengths and weaknesses in Salud! and are working together, with some bonds of trust, to try to build on the system’s successes and resolve its shortcomings.

What this means for persons with disabilities, however, remains uncertain. People with chronic conditions and disabilities are benefiting from what the program does well, but also suffering from what it does poorly. The state is still several stages away from empirical information about the delivery of services to persons with disabilities in Salud! and the ways that the structural and clinical components of the program affect their overall health and access to care. There are indications that at least some parts of the system have improved under the program, providing better access to primary care and certain other services throughout the state. But managed care’s gatekeeping features can also create access barriers. Without encounter data or “audits” of managed care organization beneficiaries and their access to services (which the state insists are forthcoming), it is quite difficult to determine the extent to which these features help or hinder access to and quality of care.

## Background

New Mexico is a large though sparsely populated state, inhabited by approximately 1.7 million residents in 1997. Its population is younger and more ethnically diverse than the U.S. as a whole. Over 32 percent of New Mexico residents are under 18 years of age;

approximately half of the population is Hispanic (39.8 percent), Indian (10.6 percent) or African American (1.1 percent).<sup>21</sup>

New Mexico is also a poor state, ranking 48th (in 1995) in personal income per person,<sup>22</sup> and first – with 25.3 percent of its residents – in persons living below the poverty line.<sup>23</sup> Nationally, approximately 13.8 percent of residents are below poverty. Many of these poor residents are children; in fact, 30 percent of children in the state live in families with household incomes below the poverty line.<sup>24</sup> Unemployment remains high (at 6.2 percent in 1997) relative to the low rates seen in other parts of the country. Over half of all employees work in the service industry or are local, state, or federal government employees.

One out of four persons in New Mexico is uninsured, compared to about one out of seven nationally.<sup>25</sup> Yet New Mexico operates a fairly generous Medicaid program, offering eligibility to children in families with incomes up to 185 percent of poverty. On March 1, 1999, the state's Children's Health Insurance Program (CHIP) extended eligibility even further to 235 percent of poverty – a sum that is more than the majority of two-worker families earn over the course of a year. This extension, however, is expected to bring an additional 6,000 or so children into the Medicaid program. Of much greater significance are the nearly 100,000 Medicaid-eligible unenrolled children throughout the state.<sup>26</sup>

## Medicaid in New Mexico

According to an October 1998 report from the state Human Services Department,<sup>27</sup> New Mexico's Medicaid expenditures have only recently begun to see single-digit growth from year to year. In 1986, New Mexico Medicaid served just over 40,000 beneficiaries each month – fewer than half of those eligible in the state. Average expenditures per recipient were \$344, and the total amount spent came to just under \$170 million. By 1996, the Medicaid program had ballooned to a nearly \$1 billion operation serving approximately 200,000 beneficiaries each month – a number that represented over 80 percent of those eligible for Medicaid.

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<sup>21</sup> Wallin S. *Health Policy for Low-Income People in New Mexico*. Washington, DC: Urban Institute. November 1998. Data come from 1995 and 1996 Census Bureau files, edited by Urban Institute's TRIM2 microsimulation model.

<sup>22</sup> In 1996, personal income per capita (in constant 1992 dollars) was \$17,088 in New Mexico and \$22,060 for the U.S.

<sup>23</sup> [www.census.gov/statab/www/states/nm.txt](http://www.census.gov/statab/www/states/nm.txt)

<sup>24</sup> [www.nmus.edu/~bho/bho/demograp.html](http://www.nmus.edu/~bho/bho/demograp.html).

<sup>25</sup> Wallin.

<sup>26</sup> New Mexico Medicaid has enrolled approximately 21,000 of these children since June 1999. Presumably, some of the state's CHIP outreach is also resulting in increased enrollment for Medicaid.

<sup>27</sup> State of New Mexico Human Services Department. Monthly Statistical Report. October 1998.

In 1994, the largely Democratic New Mexico legislature passed a bill that mandated managed care throughout the state by July of the following year. This move was driven largely by a desire to stem the tide of what was seen as almost uncontrollable growth in the Medicaid program. This growth was attributable to a number of factors, including expansions in Medicaid eligibility, benefit enhancements, and rapidly growing utilization. The addition of transportation services in rural parts of the state, for example, helped push utilization upward.

At the time, New Mexico operated a PCCM program that did not enroll persons with disabilities. The 1994 legislation, however, ultimately paved the way for a statewide, capitated program that includes nearly all Medicaid beneficiaries in the state. In 1996, a Republican governor – formerly unfamiliar with managed care or health care issues – embraced the conversion to a mandatory, capitated, all-inclusive program, and designated it among his highest priorities for his administration.

As the governor began to embrace managed care, the Legislature – which had set the events in motion just one year before – did an about-face and passed legislation against mandatory, capitated managed care, which the Governor vetoed. Even with this growing sentiment against managed care, and increasing fear and skepticism on the part of advocates, consumer groups, the press, and others, the Salud! program began to be implemented in 1997.

Salud!'s original design was released for public comment in the summer of 1996 and debated in a public Town Hall meeting that was attended by over 450 people, many of whom were very concerned about the advent of capitated care. Among those most in opposition to the plan were advocates for persons with chronic conditions and disabilities and consumers of mental health services. In addition, Native Americans, representatives of the Department of Children, Youth and Families, and many others opposed the move to mandatory capitated care.

The design that was eventually implemented reflected, in part, the concerns of these groups. For example, mental health was carved out of the managed care organization's primary set of responsibilities and instead was provided by subcontractor behavioral health organizations whose primary mission is the delivery of mental health services. Also, in response to concerns from the Indian Health Service (IHS), Native Americans were required to enroll but could opt out to remain under the care of the IHS.

## **SALUD!**

Salud! is a full-risk, capitated managed care program for the majority of Medicaid beneficiaries in New Mexico. The program is statewide, and each participating MCO must provide services to residents throughout the state. Because of the rural nature of the state and the associated shortages of health care professionals, providers are permitted and even encouraged to affiliate with all Salud! managed care organizations.



Three MCOs provide care to most Medicaid beneficiaries: Presbyterian Salud, Lovelace Community Health Plan, and Cimarron Salud. The program was rolled out in four phases, beginning with the Albuquerque area in July 1997 and completing implementation in more rural parts of the state in 1998.

The state held several provider forums with prospective MCOs and eventually received four proposals. All four were deemed acceptable on technical merits, based on what was described as an intensive review process conducted by Medicaid and outside reviewers. As part of the process, offerors had to demonstrate knowledge about special populations, with special emphasis placed on persons requiring behavioral health services. They also had to create consumer advisory boards and to list by name and organization all consumers and advocates who participated in the development of the offer. The MCO had to include explanations of how the consumers' comments and concerns were incorporated into their offer.

Three of the four proposals were offered contracts, with the fourth being rejected because of cost. After awarding the contracts, the state began an education program for physicians, pharmaceutical providers, home health agencies, and other providers.

New Mexico's urban, rural and frontier regions have different requirements with respect to access to services. In urban areas, for example, beneficiaries must be no more than 30 minutes away from at least one participating primary care physician; in rural and frontier areas, the requirements are 60 and 90 minutes, respectively. Beneficiaries must have access to other services in a reasonable time period, and are frequently provided transportation if they live too far from providers. Depending on the cost, MCOs are required either to transport an enrollee to the necessary services, or pay a local provider on a fee-for-service basis to deliver care.

It is important to repeat that each MCO is required to provide all Medicaid services (and its BHO is required to provide all Medicaid covered behavioral health services) to all beneficiaries, regardless of their location or particular set of needs. Consequently, many providers in New Mexico affiliate with all three MCOs. After the first phase of enrollment, for example, the three MCOs were required to include among their providers University of New Mexico (UNM) physicians and services – in part because UNM provides a significant amount of care to persons with special health care needs.

## **Populations Served**

Salud! provides health services for most, but not all, of New Mexico's Medicaid beneficiaries. Native Americans may choose to join one of the three Salud! MCOs. If they do not choose a plan, they are automatically enrolled in a plan and have 30 days to "opt out" of Salud! Native Americans who enroll in Salud! retain the option to receive services directly from the Indian Health Service, although their choice of health plan has, until recently, been constrained. Though the other two MCOs will shortly sign contracts with the Indian



Health Services to provide Salud! services, Cimarron has been the only MCO that contracts with the IHS as an in-network provider.<sup>28</sup>

According to Medicaid officials, Native Americans are enrolled in Salud!, and then permitted to disenroll, because of difficulties identifying Native Americans from Medicaid enrollment information alone. Once enrolled, Native Americans can self-identify and determine whether to remain with Salud! or receive care under fee-for-service Medicaid.

Approximately 35,000 Native Americans have been identified as being part of Medicaid. About one in five have opted out of Salud! Many of these are members of the Navajo Nation, which was a forceful opponent of the move to managed care.

New Mexico estimates that approximately 100,000 children were uninsured in October 1997 – a startling figure for a state with generous Medicaid eligibility rates and fewer than 2,000,000 residents.<sup>29</sup> About 95 percent of these children are eligible under current Medicaid eligibility; the state's CHIP program should expand eligibility to only about 5,000 to 10,000 children. Medicaid officials have stepped up efforts to reach out to eligible children and enroll them in the Salud! program.

## **Enrollment Process**

Medicaid's Client Services Bureau was created when Salud! was first developed to help beneficiaries understand, access, interact with and complain about the new health care system. The Bureau's initial mission was to train a cadre of state employees, advocates and community partners to educate prospective enrollees about the program and their plan options. They also trained state income support staff and had two Salud! representatives stationed at welfare offices throughout the state so that individuals understood and retained access to Medicaid during changes to the welfare system.

New Mexico does not use an enrollment broker, although the state's fiscal agent acts as a de facto enrollment broker. The state set up an enrollment hot-line that was available 12 hours a day so that people could enroll over the telephone, ask questions about the program, or set up a time for a consultation. In addition, the Client Services Bureau ran a series of Enrollment Fairs that were well-attended by community residents and advocates. The Bureau also ran advertisements about Salud! in local radio markets, newspapers, newsletters, and flyers.

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<sup>28</sup> The Indian Health Service and Salud! have several overlapping delivery systems for Native Americans in New Mexico. Native Americans who either choose or are assigned to Salud! plans can receive IHS services without a referral. If a member of Cimarron, they could receive services from the IHS as an in-network provider but if enrolled in the other plans could also receive services from the IHS – in this case under a fee schedule set for the IHS by OMB. Likewise, if they decided to opt out of Salud!, Native Americans could receive services on a fee-for-service basis from the IHS.

<sup>29</sup> This date coincides with the passage of the Balanced Budget Act, which included the Children's Health Insurance Program (CHIP) legislation. As of June 1999, this figure has been reduced to approximately 80,000.

# Salud!

## Features:

Waiver Authority	Program Model	Program Type	Participation	Program Operates	Ages Enrolled	Number of MCOs	Enrollment Broker
1915b	Capitated	Mainstream	Mandatory	Statewide	All Ages	30	Yes

### Capitation Rates Vary By:

Categorical eligibility for Medicaid, Age, and Gender.

Estimated Program Enrollment: 191,600

Estimated Enrollment of PWD: 35,000 (18.3%)

⇒ Autoassignment is based on previous provider and MCO's rating in the RFP process.

### Services Excluded from CHCP:

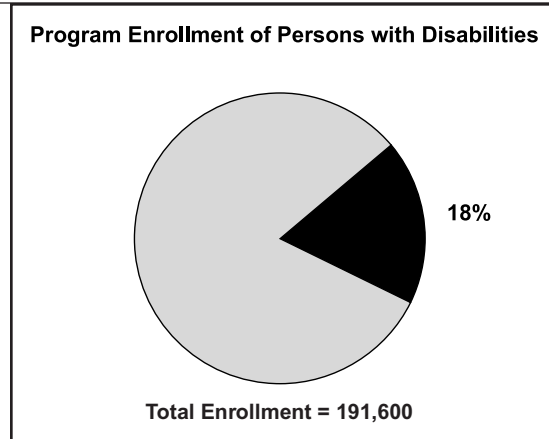
- Long-Term Care
- Home and community-based services
- Some Family Planning
- Respite Care

### Behavioral Health Services:

- Provided on a capitated basis. The MCOs subcontract with one behavioral health organization, which then subcontracts with multiple behavioral health providers.

### Special Features for Persons with Disabilities:

- Enrollment personnel receive special training in working with persons with special health care needs.
- Enrollment process includes outreach program.
- Salud contracts with six consumer organizations (representing HIV/AIDS, mental health, etc.) for community education and outreach.
- State monitors complaints and grievances for persons with disabilities in MCOs.
- Although not required to do so, MCOs routinely assign case managers to persons with disabilities.



All prospective Salud! enrollees received “welcome” letters from Medicaid (shown on next page, Figure 5) that included information about the new program and details about how individuals could choose a managed care organization. The letters were quite brief, with relatively little information about the new program, and no information about the various MCO options.

During the period July 1, 1997 through June 1, 1998, Salud! rolled through all four phases of enrollment, beginning with the most populated urban areas, and moving throughout the state through rural and then to frontier areas. By the end of the fourth phase, just over half of Salud! beneficiaries (51.5 percent) chose an MCO, and the remainder were autoassigned to one of the three options. A lower percentage of Native Americans chose plans (about 43 percent), and nearly two-thirds of residents of urban areas (62 percent) selected one of the MCOs. According to Medicaid officials, people with disabilities chose an MCO at a rate exceeding 65 percent.

New Mexico officials believe that the enrollment process worked as smoothly as it did because the state offered targeted outreach for persons with certain disabilities and other special populations. Medicaid contracted with six organizations to assist with outreach and education efforts. These included: ARC of New Mexico; the HIV Coordinating Council; the Indian Pueblo Council; Parents Reaching Out; Family Voices; and the Alliance for the Mentally Ill. According to Medicaid officials, these organizations were extremely helpful in allaying some of the fears of prospective beneficiaries about their access to specific health services.

Once enrolled, clients receive a member handbook that lists covered services, program rules and procedures, and physicians and other health providers affiliated with the network. Interestingly, despite not having information about provider networks when initially asked to select a plan, the majority of persons with disabilities in New Mexico did select plans and therefore did not require autoassignment to one of the three MCOs.

Originally, if an enrollee selected a plan or was autoassigned to one, he or she had 25 days to switch to another option. After that, if the enrollee was a member of Presbyterian of Lovelace, he or she would be locked in for a period of five months. Cimarron members were permitted to switch out every thirty days.

In response to provisions of the Balanced Budget Act, beneficiaries will have three months to switch out of their original plan; after that, they will be locked into a choice for nine months. Beneficiaries can switch plans for cause at any time, although these requests must be approved by Medicaid staff.

## **Autoassignment Process**

During the first year of Salud!, if beneficiaries did not select a plan option, they were automatically assigned to one of the three MCOs based on rankings from the RFP process, which rated quality and access as 80 percent of the score and cost as 20 percent. These rankings led to autoassignments in the following proportions: Presbyterian, 55 percent; Lovelace, 30 percent; and Cimarron, 15 percent. Consequently, these proportions remained constant even after autoassignments had been made.

Since the first rounds of autoassignment, the process has changed, and people are assigned based on the following criteria:

- Has the person been in Medicaid managed care over the past six months? If so, that person will be assigned to the same MCO.
- Is there a family member in one of the MCOs? If so, the person will be assigned to the family member's MCO.

If none of these situations existed during the first year, the person was autoassigned based on an algorithm that derived from the point value assigned through the RFP process, and the number of beneficiaries the MCO indicated that it wanted. In years two and beyond, the autoassignment process incorporates quality indicators in the algorithm. For the year beginning July 1, 1999, for example, it is based in part on EPSDT screens and immunization rates. Under this new system, Presbyterian receives about the same proportion of new beneficiaries, but Lovelace and Cimarron have switched proportions, with Lovelace indicating that it wanted fewer Salud! beneficiaries, and Cimarron asking for more.

## **Payment Rates and Adverse Selection**

Salud! pays MCOs on the basis on 29 rate cohorts that correspond to categorical eligibility, age and gender. The rates for the first two years of the program were set in the RFP; rates for year three of Salud! were being negotiated during the time of the site visit.

The rates vary across MCOs, and are negotiated separately by Medicaid staff. Several of these rates apply to blind or disabled persons on SSI. For example, infants (up to one year of age) on SSI have the highest payment rate; rates are adjusted downward as age increases, although MCOs continue to receive higher rates for persons on SSI than for other Salud! beneficiaries. There are no further payment adjustments based on severity of condition or prior use of health services.

Not surprisingly, there are differences of opinion as to whether one or two of the MCOs is enrolling a disproportionate share of high-cost Salud! beneficiaries. When the Salud! program began, Cimarron was the only MCO that contracted with the University of New

Mexico. This caused accusations of adverse selection, since UNM traditionally cares for individuals who require complex and costly care. After the first phase of enrollment, however, all three MCOs were required to contract with UNM, making adverse selection a less likely outcome, at least with phase two through four enrollees.

Medicaid staff conducted an in-house analysis of the distribution of high-cost cases across MCOs, and concluded that no one MCO suffered from adverse selection. Acknowledging that one MCO may attract more persons with a chronic condition such as AIDS, Medicaid staff contend that another MCO attracts more patients with heart disease, and the third attracts more patients with disabilities. The MCOs, however, do not necessarily agree with the state's analysis.

## **Provider Participation and Development of Networks**

Persons with disabilities generally were able to access specialty care in New Mexico prior to the creation of the Salud! program, although there are reports that primary care could be especially difficult to find. Pediatricians often were unwilling to take Medicaid patients, in large part because of low reimbursement rates.

Most individuals interviewed in the site visit believe that access to primary and specialty care has improved under Salud!, primarily because traditionally “private” physicians are part of the network of providers.

Each of the MCOs must provide all required Medicaid services and a package of enhanced services (such as transportation). They are not required to provide case management services, although some provide case management services to persons with disabilities. Each MCO has its own formulary – in practice, each has contracted with a pharmacy benefits manager to closely monitor pharmaceutical use.

## **Coordination of Services**

With MCOs encouraged to develop their own approaches to managing the health care needs of disabled and other special needs populations, it is difficult to identify specific mechanisms for coordinating services. Each MCO has its own case management program, although all three contract with the Medically Fragile Case Management program for services for technology-dependent children. All MCOs have a designated EPSDT coordinator who, presumably, makes certain that children get their screenings and required referrals.

Other than the Medically Fragile Case Management Program, there do not appear to be formal mechanisms to coordinate care for persons with disabilities. Each of the MCOs may provide case management on a case by case basis, but it is not clear whether the case managers are appropriately trained to handle the complex needs of many disabled individuals.

Some of the care coordination that previously existed for persons with disabilities may actually have been disrupted by Salud!. For example, several individuals spoke of the efforts of local leaders who worked informally on behalf of children and adults in rural and frontier settings to help access needed services. These care arrangements – though highly informal, localized, and individual – seemed to work well in these settings. Under Salud!, choice of physician, other providers, home health workers, pharmacy, and durable medical equipment companies are often limited, and can disrupt a system of care that previously depended on a delicate system of balance.

At the same time, there are reports that primary care is much better coordinated under Salud!, which perhaps reflects better access and outreach on the part of MCOs in encouraging beneficiaries to seek primary care and follow through with medical protocols. It also reflects the MCOs' attempts to promote healthier behaviors and educate members about benefits and services.

## **Quality Assurance**

The philosophy of New Mexico's quality assurance program is to allow MCOs to develop their own individual programs and allow them to address problems and concerns as they best see fit. Medicaid officials were clearly trying to strike a balance between allowing MCOs maximum flexibility in responding to the needs of their enrollee populations and meeting the goals and requirements of the Salud! program. Medicaid officials tried not to be prescriptive in their quality assurance approach, but instead monitored MCO activity to make certain that problems were being addressed. Medicaid officials report that this approach is working well, and that MCOs appear to be working to resolve complaints and concerns from their beneficiaries.

As clients enrolled in Salud!, Medicaid officials ran searches through the new enrollees' claims histories to identify persons with disabilities, persons who had used case management services in the past, and persons with chronic conditions such as asthma and diabetes. They also identified beneficiaries who had used durable medical equipment within the recent past. Medicaid staff would pass this information along to the MCOs to help them identify persons in need of chronic care or special services, presumably so that they could intervene more quickly to manage their care. This identification process does not apply to newer enrollees.

Despite this process, representatives from the MCOs stated that they "struggled" to get lists of persons with special needs from Medicaid staff, but found that these lists were not always readily available. Since the lists applied to early enrollment phases, there was no opportunity to improve the reporting system as Salud! became more experienced operationally. For this reason, it is difficult to assess whether health plans actually were aware of a person's health status upon enrollment.

Each of the plans conducts a health assessment on every enrollee, although it is not clear how aggressive the plans are in reaching out to individuals who indicate that they have

a health problem. Lovelace representatives stated that they categorize individuals as low, medium and high risk, based on their health assessment responses. Persons with low risk do not receive additional services, those with medium risk are called to discuss their health care needs, and individuals in the high-risk category are referred for case management. In addition, Lovelace says that it tries to identify potential mental health needs and refer individuals to its BHO for care. None of the MCOs had assessment or outreach activities targeted specifically to persons with disabilities.

Each of the MCOs has a toll free number that beneficiaries can call with complaints. The MCO logs the complaints into a database which is reviewed weekly by Medicaid staff and each MCO's "grievance coordinator." According to Medicaid staff, of over 25,000 calls received by the MCOs through the fall of 1998, approximately 4 percent, or 1,000 calls, were complaints.

While there are no quality assurance features that formally apply to persons with disabilities, Medicaid staff report that they monitor closely the care of persons on SSI in the Salud! program. For example, beneficiaries who use durable medical equipment and who have been identified as also using case management services have their cases reviewed to determine which primary care physicians they are using. This is also true for certain beneficiaries with diabetes, to make certain that they are cared for by persons who are familiar with diabetes management.

There are plans to conduct a large consumer survey, during which persons with disabilities will be oversampled to identify their satisfaction with the Salud! program. Also, at least one of the external quality reviews will address depression in adults. During the site visit, Medicaid staff also discussed plans for a special study of beneficiaries with developmental disabilities.

Still, with no discrete quality assurance program for persons with disabilities, it is difficult to say whether the Salud! program is meeting its goals vis-à-vis the SSI population. With encounter data beginning to become available for physical health care (there are still difficulties with encounter data for behavioral health services) there may be opportunities in the future to better assess the quality of care received by persons with disabilities in Salud!

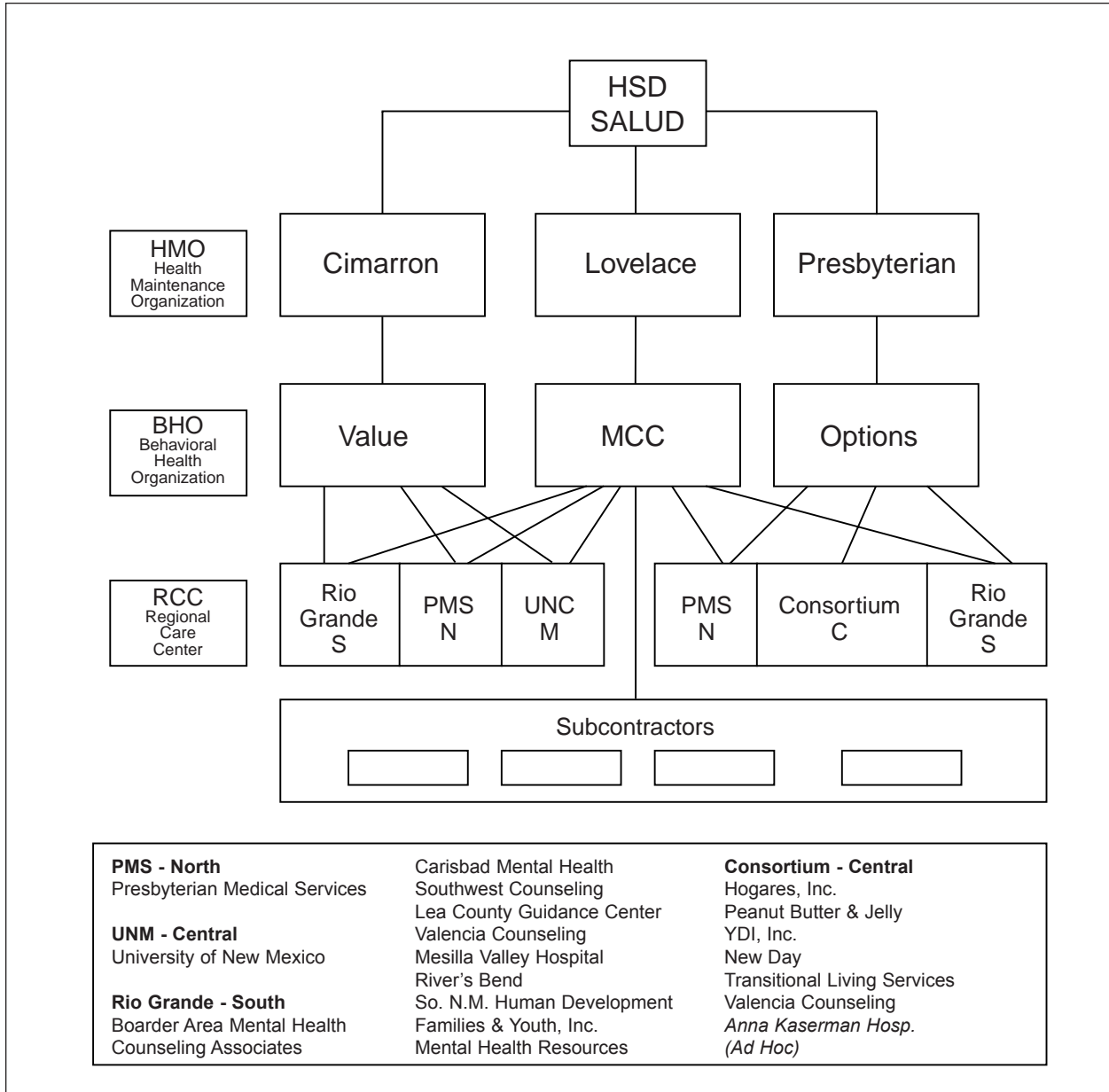
## Behavioral Health

When Salud! began operating, consumers received behavioral health services from one of three BHOs, each of which was linked to one of the MCOs. These organizational relationships are displayed in Figure 6. Medicaid officials contend that this design, which was debated heatedly during the planning phase, is an attempt to blend a need to separately pay for mental health and substance abuse services, with a desire to have one MCO manage all physical and mental health services. While each MCO is technically responsible for the delivery of all covered managed behavioral and physical health services,



consumers have direct access to the BHO, which has its own set of quality assurance standards.

**Figure 6: SALUD! Organizational Structure - Behavioral Health Managed Care**



Medicaid officials shared with us their own hopes and concerns for the behavioral health component of the Salud! program. Behavioral health seems to play a surprisingly important role in Salud!, and is tracked and watched carefully by Medicaid officials and advocates alike to make certain that appropriate care is available when needed. The delivery model for behavioral health care, however, sets off certain warning bells since it shifts risk increasingly closer to the community providers and away from the parent BHO and MCO.



Each of the MCOs partners with a BHO for all of its beneficiaries' mental health and substance abuse needs.<sup>30</sup> Presbyterian, the largest Salud! MCO, has partnered with Options and Cimarron's BHO is Value. Lovelace's BHO is MCC.<sup>31</sup>

The BHOs then subcontracts with "Regional Care Centers" that act as intermediaries between the BHOs and community-based organizations. The Regional Care Centers (RCC) contract with multiple BHOs, providing access to a fairly broad range of community-based mental health and substance abuse providers. They also are responsible for credentialing providers and developing service contracts.

Within this structure, the BHOs receive one of 29 capitated rates for each enrollee, regardless of whether the person uses behavioral health services. The rates correspond to the physical health capitation rates, which vary according to an individual's age, gender, and categorical eligibility. The BHOs can pass the risk on to the RCCs, which in turn can pass risk on to the community-based organizations. Options, for example, receives all of its compensation from a fixed percentage of administrative overhead "off the top," and works with the RCCs and providers to set policy, help coordinate care, and set standards for financial and care delivery outcomes. This structure, according to Options leadership, removes any incentive to stint on care, but also creates a system in which valuable resources are siphoned off at several levels for administrative and other overhead functions.

From several accounts, access to many behavioral health services has improved since the beginning of the Salud! program. Beneficiaries access behavioral health services directly; they are not required to go through their PCP or seek a referral for the services. Beneficiaries are guaranteed access to various services within specified time periods, and the structure helps to match beneficiaries in need of care with the most appropriate and least intrusive service for the situation. Medicaid staff report that once long-waiting lists for behavioral health services have been eliminated.

During our site visit, Options management estimated that the BHO provided behavioral health services to approximately 6 percent of Presbyterian's beneficiaries – far fewer than the 10-12 percent commonly seen in the Medicaid population. According to Medicaid officials, however, the BHO reports that they are serving 9 to 11 percent of Presbyterian's beneficiaries. If Options is serving fewer numbers of Medicaid beneficiaries than is generally expected, this could reflect more appropriate use of services; on the other hand, it could also signal problems with obtaining necessary care. It will be important to monitor behavioral health service utilization to make certain that beneficiaries have easy access to services under Salud!

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<sup>30</sup> Medicaid covers substance abuse for children and for adults with dual diagnoses (mental health and substance abuse) only.

<sup>31</sup> Since the time of our site visit, two BHOs – Value and Options – merged to form ValueOptions.

Some of the most contentious resistance to managed care has centered around the behavioral health component of Salud! In fact, a class action suit<sup>32</sup> was filed by a local attorney on behalf of eight children with “serious, chronic medical and/or mental health conditions.” The suit contends that the state failed to establish a “proper Medicaid managed care system which provides the plaintiff class with needed medical and mental health care...”.

The lawsuit is a response, in part, to changes in the mental health system and refusals by Medicaid to pay for some children with serious emotional disturbances to be maintained in residential treatment centers (RTC). Prior to the introduction of Salud!, New Mexico had built up a system of RTCs that frequently admitted children with less severe mental health diagnoses than would normally be warranted for an RTC stay. At its height, there were about 1,200 RTC beds in the state, with few options for less intensive mental health services. Thus, RTCs became the default option for a group of children with emotional disorders.

In an abrupt about-face, the Medicaid/Salud! program refused to cover RTC stays for children whose behavioral health diagnosis did not warrant institutionalization, regardless of whether the overall situation could be improved by removing the child from the home or placing the child in a temporary living situation. The result of this policy change, according to some advocates, was that children with serious emotional disturbance were “kicked out” of institutions and left with no appropriate, alternative setting for treatment of their mental health needs. Almost overnight, nearly half of the RTCs closed amid angry opposition from mental health advocates, and with some of the children being transferred into the juvenile justice system. Medicaid officials, however, respond that they can only legally cover institutional costs in cases when a child’s physical or mental health condition is critical enough to warrant institutionalization.

Several of the advocates appear to be siding, at least informally, with the state on the debate. While acknowledging the problems of caring for these children, many advocates for children’s mental health services also realize that the mental health system – at least as defined by the Salud! program – may not be the appropriate vehicle for addressing a broader set of social service needs. In the words of one of the advocates, “The system has gone through difficult times.” Even those who believe in the intent of the policy direction remained concerned, however, that children with serious emotional disturbances may have difficulty finding the care that they need.

There are, not surprisingly, other difficulties in providing high quality behavioral health services to Salud! beneficiaries. There is a significant shortage of board-certified child psychiatrists in New Mexico – a situation that is fairly common in rural states. Some of

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<sup>32</sup> Taylor v. Johnson, CIV No. 98-1382, U.S. District Court of New Mexico (1998). As of October 1999, Taylor is in the discovery stage of the legal proceedings. According to the New Mexico Medicaid, this suit follows another lawsuit against Salud! a year earlier from the same attorney seeking an injunction against Salud’s handling of RTCs. That suit was dismissed in November 1998.

these physicians do not participate in the Salud! program or have limited program involvement. As a result, doctoral-trained psychologists and mid-level practitioners are used frequently to address both routine and severe behavioral health needs. While this practice can certainly provide excellent care to beneficiaries, it does create concerns for those children who need more intensive psychiatric treatments.

Also mentioned is the need for a better-developed community-based mental health system that will replace the RTC/institutionalized model of care. Despite indications that many of these community-based services exist on the physical health side, there appear to be deficiencies on the behavioral health side that will take years and targeted efforts to resolve.

## Waiver Programs

There is an enormous amount of political support in New Mexico for home and community-based services. According to several people we interviewed, the idea of children with disabilities living in institutions, when they could be supported through intensive long-term services and case management in their homes, is completely foreign to residents throughout the state.

New Mexico Medicaid runs four waiver programs:

- one for persons with developmental disabilities, which has enrollment of about 1,650;
- one for disabled and elderly, with about 1,300 persons;
- a medically fragile program with approximately 130 beneficiaries, which targets children who are severely disabled and who are generally technology dependent; and
- an HIV/AIDS waiver, with about 50 beneficiaries.

The HIV/AIDS waiver program is the only one without a waiting list. The reason, according to Medicaid officials, is that New Mexico has a relatively low prevalence of HIV/AIDS, coupled with the availability of Ryan White funding.

All four programs provide case management, homemaking, and personal care services. Waiver beneficiaries receive non-waiver services from Salud! and are therefore considered part of the Salud! program. Like other Salud! beneficiaries, waiver participants can choose their primary care providers and specialists, and have access to the same range of services as other non-waiver beneficiaries.

## Program for Medically Fragile Children

The Medically Fragile Case Management Program is part of the Center on Development and Disability at the University of New Mexico Health Sciences Center. The program is a model for nurse case management and service coordination for children who have both

a developmental disability and a medically fragile condition. Based at UNM in Albuquerque, the program provides statewide case management coverage through case managers in satellite offices in eight locations throughout the state.

The program uses registered nurses to provide case management services to support the in-home care of medically fragile children. While the services across programs differ little, the program offers two entry points for care: the Medically Fragile Medicaid Waiver Program, and the EPSDT Enhancement of Services Program. Several of the features for these programs are listed in Table 11.

In order to qualify for the waiver program, individuals must be diagnosed with a medically fragile condition prior to their 22nd birthday as well as be developmentally disabled. The services offered are designed to enable children to remain at home or in community-based residences and include case management, physical therapy, occupational therapy, speech/language therapy, counseling, private duty nursing, home health aides, and nutritional counseling. To qualify for the EPSDT Enhancement program, a child must be on Medicaid and/or SSI; services provided include case management and home private duty nursing to individuals from birth through age 21 who are medically fragile and require skilled care.

Skilled and targeted case management forms the core of both of the medically fragile programs. The goals of case management are to address the needs of families of individuals who are medically fragile within their community settings, to access resources that would assist in stabilizing the individual's health as well as to support the dynamic relationship of the family.

**Table 11: Comparison Chart of the Medically Fragile Waiver and EPSDT Enhancement of Services for Medically Fragile Individuals**

MEDICALLY FRAGILE WAIVER	EPSDT ENHANCEMENT OF SERVICES
Client receives Medicaid as a result of qualifying for the Medically Fragile Waiver (30 days after ISP is approved). Application is made at local ISD office for category 95.	Client must qualify for Medicaid before being eligible for EPSDT Services.
Must meet eligibility criteria for medical fragility and development disability. Must have qualifying condition (diagnosis) before the age of 22 years.	Must meet eligibility criteria for medical fragility. The same forms for the MFW are used for EPSDT, this includes the medically fragile criteria.
Must require skilled nursing care. Eligibility determination through NMMUR.	Must require skilled nursing care. Eligibility determination through NMMUR/Salud.
After qualifying, client is eligible for RN/LPN, PT, OT, ST, counseling, nutritional counseling, Home Health Aide and institutional respite, as appropriate. All of these services must be provided through the MF Waiver budgetary parameters.	After eligibility approval, client is eligible for RN/LPN services only. The child's Medicaid card purchases other services, such as therapies, separately.
As long as client continues to meet eligibility requirements, services continue throughout the client's life span.	As long as client continues to meet eligibility requirements for medical fragility, services will continue until the child turns 21 years old.
Reassessment for continued eligibility every 12 months.	Reassessment done every 6 (or 12) months based on Medicaid HMO.
The client's private health insurance benefits must be used, if available, before Medicaid will pay for services.	The client's private health insurance benefits must be used, if available, before Medicaid will pay for services.
RN/Case Management by an approved State provider is mandatory in order to receive MF Waiver services.	RN/Case Management by an approved State provider is mandatory in order to receive EPSDT Enhancement of Services.
Medically Fragile Case Management Program UAP/UNM Health Sciences Center 7/95	

## Special Provisions for Persons with Disabilities

It is difficult to identify any special features that apply specifically to persons with disabilities or chronic conditions. Nevertheless, Medicaid officials insist that they monitor carefully and closely the care of persons with special needs and therefore have a targeted effort in place. In fact, the three MCOs must have policies and procedures in place to care for persons with disabilities; in practice, however, this means that they include persons with disabilities among their many quality assurance provisions, but have not identified additional or tailored provisions for their care.

Although a mandatory program, Salud! includes mechanisms for persons with disabilities to disenroll from the program and receive care in a modified fee-for-service plan. Beneficiaries or their guardians may request such a change, although according to Medicaid officials, fewer than 50 such requests have been made so far. These low numbers could reflect an awareness of the low likelihood of the request being approved. Since the beginning of Salud!, only three of these requests have been approved – two of

them, on a temporary basis (to allow the individuals to finish an episode of care with a current provider). Several of these requests are referred to the medically fragile program.

## Advocates' Reactions to Salud!

At some point along the way, as managed care began to roll into their state, many disability and consumer advocates acknowledged the inevitability of the situation and began to work with Medicaid officials and MCOs to try to shape the program to meet the needs of persons with disabilities and other vulnerable groups. Advocates for persons with developmental disabilities were particularly concerned about the inclusion of long-term care services in the Salud! program. Their opposition was instrumental in keeping these services out of Salud! and in waiver programs targeted to persons with disabilities and chronic conditions.

According to many interviewed, some of the most effective opponents to managed care were Native Americans, who eventually were successful in creating an exit door from Salud! back to the fee-for-service system. Other groups for persons with physical disabilities and consumers of mental health services could not persuade the state that persons with disabilities could not be cared for appropriately in the current Salud! model. While they did not win their war against mandatory managed care in the state, they have been waging battles with the state on how the program is implemented and access to services for persons with special needs.

They also point to unfulfilled promises from the state – for improved access to dental services, for example – and suggest that the state still has much to do to provide quality health care to all Medicaid beneficiaries. According to several discussions with advocates, the state tried to force dental providers to accept low fees, causing many dentists who previously took Medicaid patients to exit the program. With no dental school in the state and relatively few dentists statewide, Salud! has not been able to provide the dental care that was originally included in its design. Thus, despite being one of the few states that includes dental benefits in its managed care program for both adults and children, Salud! is finding it extremely difficult to identify dental providers who can make that care a reality.<sup>33</sup>

Several advocates disagree with the state's contention that there is no adverse selection across the three MCOs, and state that Cimarron receives a disproportionate share of persons with disabilities and chronic conditions. This occurs, in part, because of Cimarron's longer relationship with the University of New Mexico, which provides much of the specialty care for persons with complex conditions. To date, however, advocates (and Cimarron) have been unsuccessful at convincing the state that this problem even exists.

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<sup>33</sup> According to state Medicaid officials, this led the state to seek a major appropriation from the legislature to increase dental fees; the appropriation was approved and will go into effect in October 1999.



On balance, however, many advocates are “giving Salud! a chance,” citing examples of improved access to primary care, developing relationships with providers, and increasing numbers of providers who are involved in providing care to Medicaid beneficiaries. After so much rancorous debate about the advent of managed care, many advocates are resigned to its existence and are instead turning their efforts to shaping a fair and appropriate system of care for people with special needs.

While any managed care program may require time to adjust to the demands of its enrolled population, difficulties in providing services can result in a disproportionate burden to persons with disabilities. For example, advocates mentioned that Cimarron beneficiaries had difficulties early on accessing pharmaceuticals, in large measure because the MCO relied on an out-of-date formulary that did not include many commonly prescribed medications. And while this problem was reportedly resolved quickly – within months after the program’s implementation – it did result in serious access problems for many beneficiaries with chronic conditions and disabilities who use a disproportionate share of outpatient prescriptions.

Likewise, advocates pointed out that beneficiaries were having significant difficulties accessing durable medical equipment. Apparently, when Salud! began signing up Medicaid beneficiaries, DME contractors were not yet lined up and there was insufficient capacity to handle beneficiaries’ needs. Though this problem has since been resolved, as was the case above with Cimarron’s formulary, these examples illustrate how glitches in the system can affect persons with disabilities and their ability to gain access to necessary services.

## **How the Program is Working**

Most of the individuals we talked with spoke of a fragmented system of care for Medicaid beneficiaries that has been improved, to various degrees, since the beginning of Salud! Clearly, there is better and more stable access to primary care services, but individuals with disabilities are still experiencing problems accessing specialized physical and mental health care. At the time of our site visit, more than one year after the first phases of implementation, consumers and providers alike have a better understanding of the system and are beginning to work collaboratively to improve care.

Many of the people we interviewed stated that they have new trust in Medicaid leadership and believe that the state wants to run a high-quality managed care program. Although advocates continue to point to deficiencies in the system, they are more likely also to highlight milestones and successes that they, in some cases, have helped to accomplish. In fact, because some of the advocacy groups have forged close working relationships with Medicaid staff, some others have accused these groups of “selling out” to the system and turning their backs on the people they represent.

Advocates in New Mexico walk a fine line between supporting the Salud! program and trying to maximize its benefits and potential for persons with disabilities, and fighting its

structure, design and policies. Most advocates were resigned to the “inevitability” of managed care in the state and wanted to turn their attention to making the most of what it had to offer for their respective constituencies.

Salud! did suffer from a rocky start, in part because the Medicaid program was unaccustomed to capitated managed care. As far as care for persons with disabilities, several MCOs stated that there were difficulties getting durable medical equipment (DME) and home care services to people in need of care. Some people went without necessary services and many others were forced to change vendors mid-stream, despite having developed long-standing relationships with DME and home care companies and pharmacies throughout the years.

## Lessons Learned from Salud!

New Mexico moved quickly from a state that had only a PCCM program that did not enroll persons with disabilities – even on a voluntary basis – to a state with nearly all of its Medicaid population with disabilities in mandatory capitated care. The move was painful and contentious for nearly all parties involved. But as the dust is settling, the different parties are learning to live with managed care and try to make it a strong program. Several lessons emerge from the experiences in New Mexico:

- ***Rapid movement to managed care can create apprehension and confusion that takes months or years to resolve.*** Many of the individuals we spoke with were still angry about the way mandatory managed care bulldozed into their state. While the general consensus of many of the people we spoke with is that Medicaid staff are sincere in their efforts to put out a quality product, the manner in which the program was introduced and pushed through was too fast for many involved. This was especially true for persons with disabilities and their advocacy organizations.
- ***Involving consumer groups in the enrollment process can help alleviate some of the fear of managed care.*** Salud!’s use of six community-based organizations for outreach and enrollment counseling was helpful to the community and helped build a bridge between the users of the services and the architects of the program.
- ***Rural states face enormous challenges in bringing health services to beneficiaries.*** Managed care can create hardships for individuals in rural areas because of a lack of access to providers. New Mexico is experienced with rural health care delivery, but it remains a challenge nevertheless. Salud! MCOs must develop networks statewide, including primary care physicians, specialists, durable medical equipment and home health companies, pharmacies, therapists, and other services. Enrolling in one of the three MCOs can result in an enrollee retaining his or her principal specialist but having to establish new relationships with a host of service providers. Some rural residents, however – in part because of the nature of living in a rural community – may have built up strong relationships with these providers that are stronger than the ones with their physicians. As the Salud! program matures, Medicaid staff should



look closely at these arrangements to ensure that the new managed care arrangements are not creating excessive burdens or disruptions in care for its rural or frontier residents.

- ***A strong interest in the behavioral health component of the managed care plan can result in a better product.*** There is a surprising and even unique concern about the delivery of behavioral health services in New Mexico. Unlike the situation in other states, behavioral health is a valued component of the managed care program and is likely to receive considerable attention from critics and supporters alike. This attention appears to help the delivery of services in the state. Despite an administrative structure that could become problematic over time (with risk passed down several levels to community providers), New Mexico has elevated the importance of behavioral health services with consumers and others.
- ***In the absence of special features for persons with disabilities, strong waiver programs can fill certain service gaps and safeguard care of very vulnerable individuals.*** Without the medically fragile case management program, it would be hard to imagine how Salud! could appropriately care for individuals with truly complex medical needs. The waiver program for children helps shore up gaps in care and draws on a professional and highly trained staff of nurse case managers to work with Salud! plans and Medicaid officials on behalf of children with special health care needs.
- ***Without special program or quality assurance provisions, and in the absence of useful encounter data early in an implementation, it is difficult to determine how well persons with disabilities are faring in Salud!*** One provider who is experienced in caring for persons with chronic conditions and disabilities in Salud! said: “I worry about the adults with physical and developmental disabilities. Lots of people worry about the kids, but fewer people worry about the adults.” In its current form, it is extremely difficult to judge how well Salud! is serving adults with special health care needs. This is especially true if these individuals do not lodge complaints and do not try to change health plans with some frequency.



1450 G STREET NW, SUITE 250, WASHINGTON, DC 20005  
PHONE: 202-347-5270, FAX: 202-347-5274,  
WEB SITE: WWW.KFF.ORG

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