Medicaid Managed Care for Persons with Disabilities: State Profiles

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1. Ms. Regenstein is currently director of the National Public Health and Hospital Institute.

Executive Summary

Over the past several years, almost all of the states have turned to managed care as a means to control costs and/or increase access to care for many of their Medicaid enrollees. All but two states - Alaska and Wyoming - enroll some or all of their Medicaid recipients in managed care arrangements, and the Health Care Financing Administration (HCFA) estimates that about half of all Medicaid enrollees are now in managed care.

Most of these managed care programs were developed for the majority of the Medicaid population who do *not* have chronic conditions and disabilities. With early goals to transfer large numbers of people from fee-for-service to managed care plans and systems, states decided to leave the more complex needs of disabled persons to "later phases" of managed care enrollment.

These later phases are now upon us, with the majority of states including persons with disabilities in their managed care programs. *Approximately one in four non-elderly persons with disabilities in the Medicaid program is enrolled in managed care, and it is likely that these numbers will grow over the next several years.* The majority of these individuals are in capitated managed care arrangements, typically a prepaid health plan that is paid a monthly lump sum to provide and coordinate all of an individual's health care needs. Only about one-third of persons with disabilities in Medicaid managed care arrangements are in Primary Care Case Management (PCCM) programs, which match an individual with a primary care provider (PCP) to coordinate primary and specialty care on a fee-for-service basis, with the PCP receiving a monthly management fee. These facts shatter the common perceptions that relatively few persons with disabilities are in Medicaid managed care, and that most of these individuals essentially are in managed fee-for-service programs.

Making the decision to include persons with disabilities in a managed care program is a complicated one that requires the state to consider a number of different program and enrollment options. Some of these options are:

- Developing a capitated program, a PCCM program, or both;
- Deciding whether each of the options is mandatory or voluntary for persons with disabilities;
- Developing an enrollment process and criteria for autoenrollment;
- Developing rate-setting criteria for capitated programs;

- Creating a separate managed care program for persons with disabilities or mainstreaming them with other Medicaid enrollees;

- Including behavioral health in the managed care option, or developing an alternative approach.

Using a comprehensive interview guide and numerous follow-up telephone calls, the Economic and Social Research Institute (ESRI) collected information on 50 states and the District of Columbia to develop profiles of state Medicaid managed care programs that enroll non-elderly persons with disabilities. ESRI surveyed state program administrators on the policy issues outlined above that are essential in effectively enrolling persons with disabilities into Medicaid managed care programs.

Key Findings from the State Surveys

- Thirty-six states operate one or more Medicaid managed care programs that enroll non-elderly persons with disabilities. In total, these states operate 58 such programs. The states are listed below, with the number of programs in states with more than one program noted in parentheses.

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Georgia (2)	New Jersey	Vermont
Idaho	New Mexico	Virginia (3)
Indiana	New York (2)	West Virginia
Kansas	North Carolina (2)	Wisconsin

- In total, roughly 1.6 million persons with disabilities are enrolled in the 58 programs. This represents 26.9 percent of the 5.9 million non-elderly Medicaid beneficiaries with disabilities. Florida has the highest *number* of persons with disabilities enrolled, with 205,000 individuals – or 66.4 percent of this population in the state – in its capitated and PCCM programs. Indiana has the lowest number enrolled, with 70 individuals – or 0.1 percent of the state's population of persons with disabilities – enrolled in a voluntary capitated program. When ranking the states by the *percent* of

disabled persons enrolled in managed care, Tennessee heads the list, with 100 percent enrolled in a mandatory capitated program.

- Of the 58 programs that enroll persons with disabilities, 36 are capitated and 22 are PCCM programs. Roughly two-thirds of all persons with disabilities enrolled in Medicaid managed care programs are in capitated programs, with the remaining one-third in PCCM programs.

- Five states (the District of Columbia, Indiana, Michigan, Ohio, and Wisconsin) operate Medicaid managed care programs exclusively for persons with disabilities. All of these programs are capitated and voluntary.

- Of the 58 programs that enroll persons with disabilities, 34 utilize an enrollment broker to facilitate the enrollment process for this population. Of these, 23 are capitated and 11 are PCCM programs.

- Most of the mandatory programs have developed a process to automatically assign enrollees to a managed care organization (MCO) when they have not enrolled in a plan of their own choosing. This process is referred to as autoassignment. Mandatory PCCM programs also rely on autoassignment to link individuals with a provider.

- Ten programs limit eligibility to certain age groups: three programs enroll only children, six enroll only those under age 65, and one excludes children under age 16. In the other programs, all age groups are eligible.

- Some state Medicaid managed care programs do not cover all Medicaid-mandated benefits in the capitation rate that is paid to MCOs. Certain services, such as behavioral health, pharmacy, dental, hospice, and long-term care, often are provided through a separate program or on a fee-for-service basis.

- Most of the capitated programs vary rates paid to MCOs based on SSI eligibility. Many other programs also vary rates by age and gender. Eleven states use additional factors to "risk adjust" payments for persons with disabilities. These include special rates for HIV/AIDS (California, Utah); adjustments based on resource use (Colorado, Ohio); diagnostic categories (Indiana, Maryland, Massachusetts, Michigan, Wisconsin); and adverse selection adjustments (Nebraska, Tennessee).

- Some of these programs have developed special enrollment or program features for persons with disabilities. For example, some programs are voluntary for persons with disabilities, but mandatory for other populations; some provide a special hotline

number to address specific concerns related to persons with disabilities; and/or some use special care coordinators or ombudsmen to help broker services for persons with chronic conditions and disabilities.

- More than half of the programs do not require their participating MCOs or providers to see persons with disabilities within any specified time period. Fourteen of the 36 capitated programs require plans to assign case managers to persons with disabilities; only one of the PCCM programs assigns case managers (although presumably, the primary care physician would assume certain case management functions). About one-quarter of the plans require health plans or providers to conduct a health assessment or ask enrollees to complete a health questionnaire, although several of the programs appear to conduct such assessments voluntarily.

- All of the capitated Medicaid managed care programs include a quality assurance (QA) component in their contractual arrangements with MCOs. Few programs, however, currently include QA provisions that pertain specifically to persons with disabilities.

- Most of the states indicate that while they are beginning to receive encounter data from the MCOs, it is not yet in an accurate or complete enough format to provide useful and comparative information about the types and amounts of services that persons with disabilities are receiving in capitated managed care arrangements.

- Despite being paid different rates for persons with disabilities than the general Medicaid population, most health plans and providers probably do not know whether a new enrollee has a chronic condition or disability. Fewer than half of the programs are required to contact a new enrollee (with or without a disability) within a given time period.

- States have very different ways of providing behavioral health services for program enrollees. Behavioral health services can be provided through an MCO directly or by the MCO subcontracting with a behavioral health organization (BHO) for all or part of the care; behavioral health services can also be provided by a BHO that is paid a per-member, per-month capitated fee from the state. As an alternative, these services can be provided on a fee-for-service basis.

A copy of the full report is available by calling the Foundation's publication request line at (800) 656-4533. Ask for # 2114.

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.

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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, M.C.P., formerly vice president of ESRI, is the director of the National Public Health and Hospital Institute. Ms. Regenstein has analyzed how changes to the health care market affect vulnerable populations, especially persons with disabilities. She has written on early education, long-term care, welfare reform, and coverage policy within Medicare and Medicaid.

Christy Schroer, M.H.A., is a research assistant at ESRI. A recent graduate of Indiana University's masters' program in health administration, Ms. Schroer has conducted research on hospital outpatient services, laboratory safety and health regulations, and physician issues.

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These later phases are now upon us, with the majority of states including persons with disabilities in their managed care programs. *Approximately one in four non-elderly persons with disabilities in the Medicaid program is enrolled in managed care, and it is likely that these numbers will grow over the next several years.* The majority of these individuals are in capitated managed care arrangements, typically a prepaid health plan that is paid a monthly lump sum to provide and coordinate all of an individual's health care needs. Only about one-third of persons with disabilities in Medicaid managed care arrangements are in Primary Care Case Management (PCCM) programs, which match an individual with a primary care provider (PCP) to coordinate primary and specialty care on a fee-for-service basis, with the PCP receiving a monthly management fee. These facts shatter the common perceptions that relatively few persons with disabilities are in Medicaid managed care, and that most of these individuals essentially are in managed fee-for-service programs.

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Introduction

Over the past several years, almost all of the states[1] have turned to managed care as a means to control costs and/or increase access to care for many of their Medicaid enrollees. All but two states – Alaska and Wyoming – enroll some or all of their Medicaid recipients in managed care arrangements, and the Health Care Financing Administration estimates that about half of all Medicaid enrollees are now in managed care.[2] Most of these individuals are in one of two common managed care arrangements. They may be in a capitated or prepaid plan that is paid a monthly lump sum to provide and coordinate all of their health care needs.[3] As an alternative, they may be part of a primary care case management (PCCM) system, which matches them with a primary care provider (PCP) to coordinate primary and specialty care on a fee-for-service basis, with the PCP receiving a monthly management fee.

Most of these managed care programs were developed for the majority of the Medicaid population who do *not* have chronic conditions and disabilities. In fact, almost all Medicaid managed care arrangements originally excluded persons with disabilities from enrollment. With early goals to transfer large numbers of people from fee-for-service to managed care plans and systems, states decided to leave the more complex needs of disabled persons to "later phases" of managed care enrollment.

As is evident from the findings of this report, these later phases are now upon us, with the majority of states including persons with disabilities in their managed care programs. Approximately one in four non-elderly persons with disabilities in the Medicaid program is enrolled in managed care, and it is likely that these numbers will grow over the next several years. Furthermore, the majority of these people are in capitated arrangements – only about one-third of persons with disabilities in Medicaid managed care

[1] The term "states" refers to the 50 states, plus the District of Columbia. While there are other Medicaid programs in American territories, they are not included in this report.
[2] Health Care Financing Administration. Managed Care Enrollment, July 1997. From the HCFA Website, www.hcfa.gov/medicaid/mcsten97.htm.
[3] Medicaid capitated arrangements frequently do not include certain types of services, such as pharmaceuticals, dental care, behavioral health, etc. Therefore, the statement that they handle all of the enrollee's needs is an overstatement. These "carved out" benefits are generally provided on a fee-for-service basis, or are capitated under separate arrangements.

arrangements are in PCCM programs. These two facts shatter the common perception that relatively few persons with disabilities are in Medicaid managed care, with most of these in essentially managed fee-for-service programs.

This report documents Medicaid managed care for non-elderly persons with disabilities in all of the states. Because many state programs exclude persons who are dually eligible for Medicaid and Medicare from capitated arrangements (or enroll them on a voluntary basis only), this report concentrates on children and adults under 65 years of age. It describes state programs that enroll non-elderly persons with disabilities in managed care, either on a voluntary or mandatory basis, their key enrollment and quality assurance features, and the "special program features" that are designed to facilitate the enrollment of persons with disabilities or support their health care needs. It also provides estimates of state-by-state enrollment of non-elderly persons with disabilities in Medicaid managed care.

Our findings indicate enormous variation across state Medicaid managed care programs that include persons with disabilities. Persons with disabilities are in capitated and PCCM programs, voluntary and mandatory programs, large and small programs – with even more variation in the way they receive behavioral health services. The reasons behind a state's decision to implement a program at all, or to implement one with particular characteristics, are as varied as the program configurations themselves. Surely, they are the result of some combination of political, historical, fiscal, and administrative factors that are unique to each one of the states. The political dimension alone often involves Medicaid officials, the governor, the legislature, other state agencies (most notably, the Departments of Public Health and Mental Health), physicians and other provider groups, and advocacy organizations. There are also important considerations of provider capacity and availability of interested managed care organizations, especially in rural and underserved areas of the country.

This report describes and discusses the issues that states need to address in establishing Medicaid managed care programs for persons with disabilities. The information reported on state policies and practices reflects the view of state officials. This report is not an analysis of the programs and does not evaluate the advantages or disadvantages of any one approach. In addition, the report does not address the motivations behind the development of any of the programs included in this report. A subsequent report by the Economic and Social Research Institute will look closely at Medicaid managed care

programs in four states, and will include an analysis of the genesis, implementation and effectiveness of the programs for persons with disabilities.

Including Persons with Disabilities in a Medicaid Managed Care Program

With the passage of the Balanced Budget Amendments (BBA) of 1997, states were given considerably more latitude in putting together managed care programs for the general Medicaid population and persons with disabilities. Prior to the BBA, states were required to apply to the Health Care Financing Administration for waivers that were designed to modify some of the requirements for operating state Medicaid programs. There are two types of waivers that states generally use to enroll Medicaid beneficiaries in managed care: research and demonstration waivers (1115 waivers) and freedom of choice waivers (1915 (b) waivers).[4]

Research and demonstration waivers give the states substantial flexibility in experimenting with their Medicaid programs. Although there are some restrictions, 1115 waivers are broad in scope and allow states to deviate from many Medicaid requirements in order to test new policy ideas. They can be used for a range of activities, including covering benefits beyond Medicaid's mandated benefit package; implementing different financing mechanisms; or a major restructuring of a state's Medicaid program.

Freedom of choice waivers are much more limited in scope than research and demonstration waivers. In contrast to 1115 waivers, 1915(b) waivers can be used to waive only certain provisions of Medicaid law, including beneficiaries' right to select their own providers; comparability of service requirements; and the requirement to make any service provided available statewide.

The BBA allows states to implement mandatory Medicaid managed care programs without first obtaining a waiver from HCFA.[5] Under this new rule, it is not necessary for state Medicaid managed care programs to operate on a statewide basis; benefits can differ across the state and within eligibility groups; and administrators can restrict

[4] The number in parentheses refers to the relevant sections of Medicaid law (Title XIX of the Social Security Act) that would be waived.
[5] 42 U.S.C. Section 1396v

enrollees' choice of providers. States must still obtain a waiver, however, to expand eligibility to different groups or to waive other provisions of the Medicaid law.

Even with the flexibility inherent in the new legislation, making the decision to include persons with disabilities in a managed care program is a complicated one that requires the state to consider a number of different program and enrollment options. The first, perhaps, is whether to include all persons with disabilities in the program, or to limit eligibility to some subset of the population. This is an important decision for state Medicaid agencies, in part because the disabled as a group are more costly than the general Medicaid population, and in part because they are an extremely heterogeneous population.

Persons with disabilities include those with physical disabilities, mental retardation / developmental disabilities, and / or mental illness; they generally qualify for Medicaid in one of two ways. Persons with disabilities can meet the disability and income criteria of the Supplemental Security Income (SSI) program. These include federal income and asset tests and a national standard for disability. They also can qualify through a state's medically needy program if they do not meet SSI standards. Individuals qualify for this program if their medical expenses cause them to "spend down" to a state's medically needy standard (which can be as high as 133 percent of a state's old AFDC level).[6] In addition, severely disabled persons in institutions qualify for Medicaid if their income is no greater than 300 percent of the SSI cash payment (or roughly 200 percent of poverty).

Some states limit eligibility of persons with disabilities in managed care programs to persons on SSI; many states exclude persons in intermediate care facilities for the mentally retarded (ICF / MR) or nursing homes, persons in home and community based waiver programs, or some combination of these groups, presumably because of their high costs and the difficulties associated with developing capitated programs for their care.

Once the decision is made to include at least some persons with disabilities in a managed care arrangement, states must address several key program options. Some of these options are:

[6] Thirty-four states have medically needy programs.

- Developing a capitated program, a PCCM program, or both;
- Deciding whether each of the options is mandatory or voluntary for persons with disabilities;
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- Including behavioral health in the managed care option, or developing an alternative approach.

Each of these options is described below.

Capitated versus Primary Care Case Management (PCCM) Program

States rely on two options for Medicaid managed care: the capitated or the PCCM option. Capitated programs tend to be considered "real" managed care, since managed care organizations (MCOs) assume some level of risk for the care of enrollees, and therefore have an interest (at least theoretically) in providing an array of services in an efficient manner that will maintain health. PCCM programs can be described as managed fee-for-service, since most PCCM care is paid on a fee-for-service basis. And while a PCP in a PCCM program is paid a monthly management fee to coordinate care, it is unclear to what extent the PCP actually "manages" health care delivery for the PCCM enrollee.

Most states appear to be moving toward a capitated care model, with some discontinuing their PCCM programs and transferring enrollees into capitated arrangements. The clear trend among states is to move toward greater enrollment of their Medicaid population – and in many cases, their Medicaid enrollees with disabilities – in capitated plans. Nevertheless, some of the states have found the PCCM option a very useful and important transitional tool to bridge the distance between traditional Medicaid fee-for-service and fully capitated arrangements. Like capitated programs, PCCM plans have improved access to care and are serving a significant portion of enrollees with disabilities

quite well.[7] Several of the states with PCCM programs have no plans to discontinue them or move some of their enrollees into capitated plans.

Mandatory versus Voluntary Enrollment

Once the decision is made to set up a capitated or PCCM program that includes persons with disabilities (either from the outset or as an added population), states must determine whether to *require* persons with disabilities to enroll. If the state chooses to make enrollment mandatory, at least for certain segments of the disabled population, it must develop an enrollment process and designate criteria for autoassignment – that is, the process by which persons are assigned to a managed care plan or primary care provider if one is not chosen by the enrollee.

Voluntary managed care programs do not require such autoassignment procedures, because individuals who enroll choose to do so and presumably will also designate their preferred plan or provider. Voluntary programs, however, are likely to experience favorable selection.[8] When given the option, persons with less serious or less resource-intensive chronic conditions and disabilities are likely to opt for the managed care plan, and persons with more complex and costly conditions tend to remain within the fee-for-

[7] PCCM programs do not carry with them the threat of discontinuity of care that can commonly occur in capitated arrangements. After selecting (or being assigned) a PCP, enrollees in a PCCM program can see a variety of specialists and, once approved by the PCP, are restricted in access to providers only to the extent that those providers refuse to accept Medicaid payments. In capitated arrangements, however, persons with disabilities – who often see many different health care providers over long periods of time – are likely to have to choose which of these providers to retain when they enroll in a capitated plan. (Ironically, this becomes all the more problematic in states with liberal choice of plans, where all providers are not likely to belong to all plans. In states with only one managed care organization in the state or in a region, providers are sometimes encouraged to affiliate with the plan to continue seeing the enrollee.)

[8] This has been documented in early studies of Medicare managed care. See Brown RS, Bergeron JW, Clement DB, Hill JW, Retchin SM. *The Medicare Risk Program for HMOs.* Final Version. 1993. Princeton, NJ: Mathematica Policy Research, Inc.

service system.[9] Making a managed care program mandatory can mitigate this problem, especially when eligibility for the managed care program is quite broad.[10]

Making managed care programs mandatory for persons with disabilities, though, is a huge leap from the current fee-for-service system, where people can select among participating physicians and change providers if they are dissatisfied with their care. This feature is extremely important for persons with disabilities, and it is the reason why several states have included "exit doors" to their managed care programs. Some states require persons with disabilities to enroll in managed care plans, but will allow them to disenroll and opt into the fee-for-service system if they are dissatisfied with their care. Other states require persons with disabilities to be in a managed care arrangement, but allow them to choose between capitated and PCCM options.

Regardless of these features, if a state requires persons with disabilities to enroll in managed care, it must develop criteria to facilitate automatic assignment to a plan or provider. These autoassignment criteria vary considerably from state to state, but generally are based on an enrollee's geographic location, current provider relationships, condition, or some formula for random assignment among participating plans.

States must also determine whether they will use an enrollment broker to handle the process, or will assign enrollees using state Medicaid staff or marketing representatives from the plans. Enrollment brokers facilitate the enrollment process by serving as a neutral third party that does not market any one provider or plan to the enrollee. Brokers describe the full range of plan and provider choices to new enrollees and facilitate the enrollment process. Brokers can also assist enrollees with their applications and undertake any necessary outreach. (In some states, enrollment brokers assume additional responsibilities such as collecting information on service utilization and scheduling appointments for enrollees).

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[9] There are a number of explanations why less healthy persons would choose to remain in fee-for-service arrangements. Capitated plans employ gatekeeping mechanisms to control access to care, including specialists; individuals who know that they require such services might choose to stay in a system that allows them to control their own access to care. In addition, capitated plans manage supportive services (therapeutic services, home care, etc.) quite closely. Persons with disabilities might stay within the fee-for-service system to avoid risking loss of these important services. In addition, since their conditions are often complex and require multiple specialists, it is quite likely that persons with disabilities will need to change providers if they move to managed care.

[10] Most states that enroll persons with disabilities in managed care exclude persons in institutions and some other groups from eligibility. To the extent that the more complex conditions are

Mainstream or Specialized Programs

States must determine whether they want to integrate persons with disabilities into "mainstream" managed care arrangements that serve the general Medicaid population, or create special programs designed exclusively for persons with chronic conditions and disabilities. Mainstream programs combine all enrollees into one administrative structure, and may be administratively less complex. They also may reduce discrimination against persons with disabilities.[11]

Specialized programs have the advantage of serving a specific population whose needs differ from those of the general Medicaid population. Specialized programs tend to recruit providers who are experienced in caring for persons with chronic conditions and disabilities, and include the types of supportive services, therapies and equipment that are extremely important to the health and functional well-being of this population.

The debate between specialized and mainstream programs is an important one, but in practice, it has largely been decided in favor of mainstream care. The vast majority of non-elderly persons with disabilities enrolled in Medicaid managed care programs are currently enrolled in mainstream arrangements. Five states (the District of Columbia, Indiana, Michigan, Ohio and Wisconsin) have developed specialized programs that enroll persons with chronic conditions and disabilities only; however, these five programs together represent only about one-half of one percent of total enrollment of non-elderly persons with disabilities in Medicaid managed care.[12]

Rate Setting and Risk Adjustment for Capitated Programs

Persons with disabilities are a costly group for the Medicaid program by almost any measure available. For example, in 1995, the 16.6 percent of Medicaid beneficiaries who were classified as blind and disabled accounted for about 33.7 percent of total Medicaid

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excluded from care, favorable selection is pre-determined to some degree even prior to voluntary enrollment.

[11] Hurley RE, Draper DA. "Special Plans for Special Persons: The Elusive Pursuit of Customized Managed Care." In: Remaking Medicaid: Managed Care for the Public Good. S. Somers, S. Davidson (eds.). Jossey-Bass, Inc., Forthcoming.

[12] Michigan's program, the Special Health Care Kids Program, began enrolling children on September 1, 1998. Up to 12,000 children are expected to enroll in that program, which would bring national enrollment of persons with disabilities in specialized programs to about 1.7 percent.

expenditures.[13] On a per capita basis, Medicaid spent more than twice as much – $8,784 – on persons with disabilities than the $3,789 that was spent on the average beneficiary.[14] And while costs for average and disabled beneficiaries vary enormously across the states, persons with disabilities are more costly to care for regardless of where they reside in the country.

States that decide to include persons with disabilities in their managed care plans must address the issue of setting monthly capitation rates for different categories of enrollees. This process is referred to as risk-adjustment. States can adjust payments according to *categorical eligibility* – in other words, they can set different capitation rates for persons who qualify for Medicaid on the basis of income[15] than for persons who qualify on the basis of disability status.[16] They can also vary rates by age and/or gender.

States can also undertake a more complex risk-adjustment process that attempts to vary payments based on the likely health costs that the particular enrollee – by virtue of prior use of the health system, chronic condition or some other set of variables – is likely to incur in the coming year. The ultimate goal is to develop an adjusted payment that prospectively provides just enough money for the health plan to appropriately and efficiently care for the enrollee, regardless of that enrollee's health condition.

This is another important issue for persons with disabilities who are enrolled in capitated arrangements. Persons with disabilities who enroll in managed care plans carry with them a monthly payment that may or may not reflect their actual health care needs. If the payment falls short of meeting such needs, health plans that enroll persons with disabilities are likely either to provide uncompensated care or to "stint" on necessary services.[17]

Risk-adjustment obviates the need for such stinting, and there are indications that this is a feasible alternative for persons with disabilities in Medicaid managed care. In a study

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[13] Liska D, Bruen B, Salganicoff A, Long P, Kessler B. *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends*, 1990-1995, Third Edition. Kaiser Commission on the Future of Medicaid. 1997.
[14] Liska, et al.

[15] Most of these would include adults and children in the Temporary Assistance for Needy Families (TANF) program.
[16] Most of these would include adults and children in the Supplemental Security Income (SSI) program.

of Medicaid beneficiaries in four states, researchers found that the health expenditures of disabled beneficiaries were actually more predictable than those of the general population.[18] Despite these encouraging findings, risk-adjustment methods are still in their infancy, and present considerable implementation and administrative challenges for states that wish to embark on this course of action.

Behavioral Health

Behavioral health services – namely, mental health and substance abuse care – do not necessarily follow the same path to managed care that somatic services do.[19] In determining the type of managed care program to implement and the requirements or features relating to persons with disabilities, states must also decide how to provide and pay for behavioral health services. In the case of capitated programs, states can include behavioral health within the capitated payment and expect MCOs to provide the full range of services to all enrollees. As an alternative, states can separately contract with behavioral health organizations (BHOs) that have expertise in mental health, substance abuse, or both, for the needs of the Medicaid population. States can also decide to keep behavioral health as a fee-for-service benefit.

In each of these cases, states must weigh the benefits of keeping all services under the same "roof," which could result in improved continuity of care, against the downside of such an arrangement. For example, the need for specialized provider expertise could argue for keeping the program fee-for-service or contracting with an experienced behavioral health firm in order to broaden the availability of providers. States must also decide whether to develop a behavioral health benefit for all of their enrollees, or segment care by severity of need. For instance, states can include behavioral health services within their capitated rate (paid either to the MCO or the BHO), while referring persons with serious and persistent mental illness out of these care arrangements and into state mental health agencies, community mental health clinics, or traditional fee-for-service arrangements.

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[17] Newhouse JP, Buntin MB, Chapman JD. Risk Adjustment and Medicare: Taking a Closer Look. *Health Affairs*, 1997;16:26-43.

[18] Kronick R, Zhou Z, Dreyfus T. Making Risk Adjustment Work for Everyone. *Inquiry*, 1995;32:41-44.

[19] The term "somatic" is used to differentiate care for the "body" from care for the "mind." Somatic services are sometimes referred to as the "medical/surgical" component of managed care, in contrast to its mental health component.

Summary

Even for states that have wrestled with these very same issues for the general Medicaid population, applying managed care program and enrollment criteria to persons with disabilities requires a careful and thoughtful planning approach. Some of the states are still struggling with these issues and have yet to begin enrolling persons with disabilities into their managed care programs. Other states have discontinued enrollment of persons with disabilities because of various program difficulties and are going back to the drawing board to create a more financially or programmatically sound managed care option. Washington and Minnesota, for example, enrolled persons with disabilities in their Medicaid managed care programs at one point, but moved this population back into the fee-for-service system. Washington discontinued enrollment for this population when utilization of services and costs to health plans increased well beyond reimbursement rates, and plans became reluctant to participate in the program. Minnesota discontinued enrollment when the health plan that attracted the majority of disabled enrollees (because of its broad provider network) pulled out of the Medicaid managed care market in the state.

This report describes programs in the 36 states with managed care programs that enroll at least some non-elderly persons with disabilities. Section I of the report provides national enrollment information and state program descriptions as they relate to non-elderly persons with disabilities in managed care. It is organized to allow the reader to make comparisons across the states with respect to enrollments and various program features. Section II includes state program descriptions that pull together the key features of the individual programs in one location. These descriptions highlight the special enrollment or program features that relate to persons with disabilities.

Section I. State Medicaid Managed Care Programs that Enroll Non-elderly Persons with Disabilities

The Economic and Social Research Institute (ESRI) collected information on 50 states and the District of Columbia to develop profiles of state Medicaid managed care programs that enroll persons with disabilities. Medicaid directors initially received letters from the Kaiser Commission on Medicaid and the Uninsured explaining the goals of the study and requesting participation by appropriate staff. ESRI contacted each of the Medicaid offices to identify staff members who were familiar with their state's managed care programs and the different program features that were relevant to the study. For example, in most states, we talked to more than one person about the general program details, but followed up with calls to other Medicaid staff who were familiar with specific program features such as quality assurance, the enrollment process, contracting, and rate-setting. We often talked to additional staff to get estimates of program enrollment.

This study includes estimates of the enrollment of non-elderly persons with disabilities in 58 managed care programs. The estimates come primarily from state Medicaid offices. In a few cases, the estimates were developed by state Medicaid and ESRI staff using our "best judgment" by taking into account the enrollment requirements (mandatory or voluntary), territory covered (county only, statewide, etc.) and the number of non-elderly disabled in the state.[20]

In cases where states could not identify the non-elderly component of their enrolled population, we discounted enrollment to "back out" elderly enrollees from our estimates.

[20] For example, in the case of Michigan's mainstream program, enrollment of persons with disabilities was unavailable; however, total enrollment was available, and the percent of the Medicaid population that is disabled was known. Using these numbers, we arrived at an estimate of enrollment that the Medicaid staff in Michigan thought accurately reflected the enrollment of persons with disabilities. Likewise, an estimate of the number of children with disabilities in Pennsylvania's Family Care Network was not available. The enrollment number in the report comes from the state's estimate that approximately 10 percent of the program's enrollees have a disability.

We used a very conservative discount factor equal to 20 percent of the elderly Medicaid population in the state.[21]

We conducted telephone interviews with one or more Medicaid staff in each state, using a lengthy interview guide. Some state representatives requested that they fill out the interview guide in writing, but in each of those cases we followed up with shorter telephone interviews. Finally, we condensed the findings from the longer interview guides into a shorter (three-page) form for each of the programs and sent these to the states for verification. In all, 73 forms were sent to Medicaid staff for verification, and 68 were reviewed and verified by the appropriate Medicaid staff.[22]

When we interviewed Medicaid staff, we asked for information about program features and enrollment figures for non-elderly persons with disabilities. We defined "persons with disabilities" as individuals who were eligible for Medicaid by virtue of their disability status. We included in the broader definition of disabilities individuals in the Supplemental Security Income (SSI) program, SSI-related groups, and medically needy individuals. Because definitions of disability can vary across states, and because some states do not have medically needy programs (or define medically needy differently), we used SSI eligibility as a way to gauge whether a state enrolls persons with disabilities in managed care. For example, some states enroll persons on SSI, medically needy individuals, residents of ICF/MRs or nursing homes, persons in home and community-based waiver programs, or some combination of these groups. Other states exclude all but non-institutionalized persons on SSI.

We included all of the states that enroll some non-elderly SSI recipients in their managed care program, irrespective of their Temporary Assistance for Needy Families (TANF) eligibility. Two states – Connecticut and Missouri – enroll persons on SSI in their managed care plans only if they also qualify as part of the TANF program. In these states, all other persons on SSI are ineligible for the program. Thus, while Connecticut and Missouri have small numbers of SSI recipients in their managed care plans, they did

[21] Additional information on the estimation methodology and the specific state discounts is available from the authors.
[22] The 73 forms were sent to the 58 programs that enroll persons with disabilities and the 15 states that do not.

not meet our study criteria and therefore appear on the list of states that do not enroll persons with disabilities in managed care.[23]

This discussion applies to the medical/surgical, or somatic, component of health care delivery only. Behavioral health programs are discussed later in this report, and apply to those states that enroll persons with disabilities in their somatic managed care programs. In addition, because of its concentration on the non-elderly population, this study does not track managed long-term care programs.

Enrollment of Non-elderly Persons with Disabilities in Medicaid Managed Care

There are 36 states that operate one or more Medicaid managed care programs that enroll non-elderly persons with disabilities, either on a mandatory or voluntary basis. Sixteen of these states have both PCCM and capitated options (noted with an asterisk). These states are listed below.

Alabama*	Kentucky	Ohio
Arizona	Louisiana	Oregon*
Arkansas	Maryland	Pennsylvania*
California*	Massachusetts*	South Carolina*
Colorado*	Michigan	South Dakota
Delaware	Mississippi	Tennessee
District of Columbia	Montana*	Texas*
Florida*	Nebraska*	Utah*
Georgia*	New Jersey	Vermont
Idaho	New Mexico	Virginia*
Indiana	New York*	West Virginia
Kansas	North Carolina*	Wisconsin

[23] We suspect that there are other states that will allow some children on SSI to remain with their family and enroll in a capitated arrangement, despite the state policy of excluding disabled persons from managed care.

Fifteen states do not enroll non-elderly persons with disabilities in managed care programs.[24] These states are:

Alaska	Maine	North Dakota
Connecticut	Minnesota	Oklahoma
Hawaii	Missouri	Rhode Island
Illinois	Nevada	Washington
Iowa[25]	New Hampshire	Wyoming

Table 1 includes information about enrollment of persons with disabilities in Medicaid managed care programs. It identifies the type of program (PCCM or capitated), and illustrates whether enrollment in these programs is mandatory or voluntary for persons with disabilities. Figure 1 highlights the states that have PCCM programs, capitated programs, or both, that enroll persons with disabilities.

[24] These states either do not enroll any persons with disabilities in managed care, or do not fit our study criteria for inclusion. There may be some individuals with disabilities enrolled in managed care in several of these states. As was stated above, Connecticut and Missouri enroll persons with disabilities if they also meet TANF participation eligibility standards. Washington also may have some individuals who remained in managed care after their program for persons with disabilities was discontinued.

[25] Iowa has mandatory managed mental health and substance abuse programs, but does not enroll persons with disabilities in its somatic managed care program.

Table 1: State Medicaid Managed Care Programs for Persons with Disabilities (PWD)

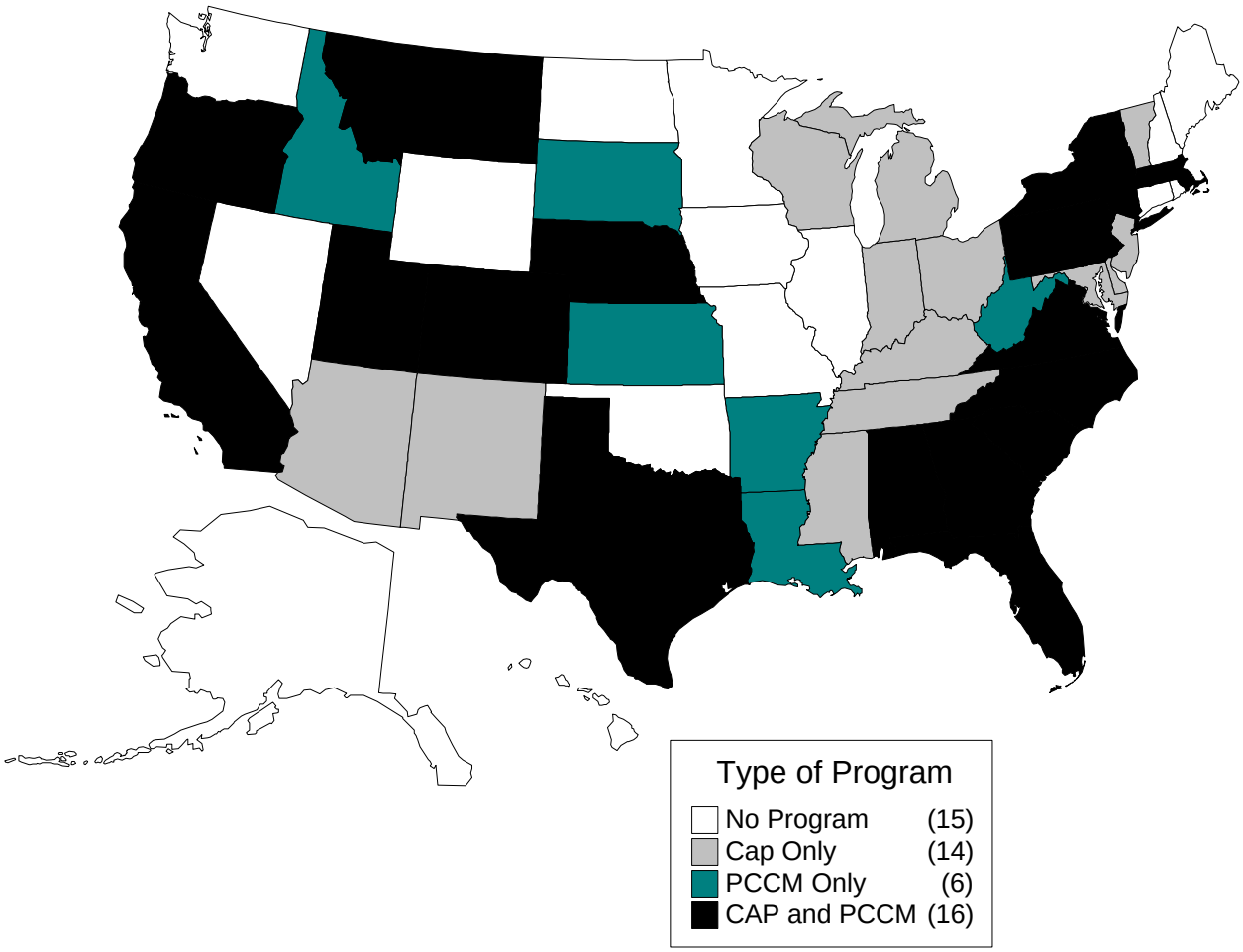
State	Are PWD enrolled in some form of managed care?	PCCM		Capitated		Are any of the programs exclusively for PWD?
		Are PWD enrolled in the program?	Is this program mandatory (M) or voluntary (V) for PWD?	Are PWD enrolled in the program(s)?	Is this program mandatory (M) or voluntary (V) for PWD?	
Total	36 Yes	22 Yes	16 M**	30 Yes	19 M**	5 Yes
Alabama	Yes	Yes	M	Yes	M	No
Alaska	No	---	---	---	---	---
Arizona	Yes	No	---	Yes	M	No
Arkansas	Yes	Yes	M	No	---	No
California	Yes	Yes	V	Yes	M,V	No
Colorado	Yes	Yes	M *	Yes	M *	No
Connecticut	No	---	---	---	---	---
Delaware	Yes	No	---	Yes	M	No
District of Columbia	Yes	No	---	Yes	V	Yes
Florida	Yes	Yes	M *	Yes	M *	No
Georgia	Yes	Yes	M	Yes	V	No
Hawaii	No	---	---	---	---	---
Idaho	Yes	Yes	M/V	No	---	No
Illinois	No	---	---	---	---	---
Indiana	Yes	No	---	Yes	V	Yes
Iowa	No	---	---	---	---	---
Kansas	Yes	Yes	M	No	---	No
Kentucky	Yes	No	----	Yes	M	No
Louisiana	Yes	Yes	M	No	---	No
Maine	No	---	---	---	---	---
Maryland	Yes	No	---	Yes	M	No
Massachusetts	Yes	Yes	M *	Yes	M *	No
Michigan	Yes	No	---	Yes	M,V	Yes
Minnesota	No	---	---	---	---	---
Mississippi	Yes	No	---	Yes	V	No
Missouri	No	---	---	---	---	---
Montana	Yes	Yes	M	Yes	V	No
Nebraska	Yes	Yes	M *	Yes	M *	No
Nevada	No	---	---	---	---	---
New Hampshire	No	---	---	---	---	---
New Jersey	Yes	No	---	Yes	V	No
New Mexico	Yes	No	---	Yes	M	No
New York	Yes	Yes	V	Yes	V	No
North Carolina	Yes	Yes	M *	Yes	M *	No
North Dakota	No	---	---	---	---	---
Ohio	Yes	No	---	Yes	V	Yes
Oklahoma	No	---	---	---	---	---
Oregon	Yes	Yes	M	Yes	M	No
Pennsylvania	Yes	Yes	M	Yes	M/V	No
Rhode Island	No	---	---	---	---	---

State	Are PWD enrolled in some form of managed care?	Are PWD enrolled in the program?	Is this program mandatory (M) or voluntary (V) for PWD?	Are PWD enrolled in the program(s)?	Is this program mandatory (M) or voluntary (V) for PWD?	Are any of the programs exclusively for PWD?
South Carolina	Yes	Yes	V	Yes	V	No
South Dakota	Yes	Yes	M	No	---	No
Tennessee	Yes	No	---	Yes	M	No
Texas	Yes	Yes	V	Yes	V	No
Utah	Yes	Yes	V	Yes	M	No
Vermont	Yes	No	---	Yes	M	No
Virginia	Yes	Yes	M	Yes	M/V	No
Washington	No	---	---	---	---	---
West Virginia	Yes	Yes	V	No	---	No
Wisconsin	Yes	No	---	Yes	V	Yes
Wyoming	No	---	---	---	---	---

Mandatory or Voluntary refers to program requirements for persons with disabilities only.
M/V = Mandatory in some programs or regions of programs and voluntary in others.
For California, three of the four capitated programs are voluntary and one is mandatory.
For Michigan, Pennsylvania and Virginia, one of the capitated programs is mandatory and the other is voluntary.
For Idaho, enrollment is mandatory in some counties and voluntary in others.
M* = Enrollment is mandatory, but enrollee can choose between the PCCM and capitated options.
** This list may include states whose capitated programs are voluntary for segments of the population.

Source: ESRI Survey of Medicaid staff, Summer 1998.

Figure 1: States that Have Capitated and/or PCCM Programs that Enroll Persons with Disabilities



Source: ESRI Survey of Medicaid staff, Summer 1998.

PCCM Programs

Twenty-two of the states that enroll persons with disabilities in managed care programs have PCCM programs (either in addition to or instead of capitated programs).[26] In sixteen of the PCCM programs, enrollment is mandatory for persons with disabilities. This means either that states require persons with disabilities to enroll in the PCCM option, or require them to enroll in the PCCM option or the capitated option. (The states with the requirement to enroll in one or the other of the state's managed care options are listed with an asterisk.) In Idaho, enrollment is mandatory in some of the larger counties and voluntary in others. Idaho is included in the mandatory category, since the program is likely to become mandatory across the state over the next year or so.

Mandatory	**Voluntary**
Alabama	California[27]
Arkansas	New York[28]
Colorado*	South Carolina[29]
Florida*	Texas
Georgia	Utah[30]
Idaho	West Virginia
Kansas	
Louisiana	
Massachusetts*	
Montana	
Nebraska*	
North Carolina*	
Oregon	
Pennsylvania	
South Dakota	
Virginia	

26 Several other states had PCCM options as late as last year, but discontinued PCCM enrollment and began moving enrollees into capitated plans.

27 Some of California's PCCM programs are partially capitated.

28 New York has one true PCCM program, and many other partially capitated programs. The program capitates only a small portion of primary care and ambulatory care services, and has limited risk for the provider. For the purposes of this discussion, these programs are included in the PCCM category.

29 South Carolina's PCCM program can be more accurately described as a partially capitated program. Like the New York program, a small portion of primary and ambulatory care services are provided on a capitated basis, with limited risk to the provider. Because most of the costs fall outside of the capitation rate, however, it is included in the category of PCCM programs.

30 Utah's PCCM program provides managed care in rural areas that are not served by capitated arrangements. About 15 percent of the total managed care enrollment falls in this category.

Capitated Programs

Thirty states that enroll persons with disabilities in their managed care programs operate one or more capitated programs (either in addition to or instead of PCCM programs). Fifteen states require persons with disabilities to enroll in these capitated programs. (The states with an asterisk require persons with disabilities to enroll either in the PCCM or capitated program.) Eleven states offer enrollment to persons with disabilities on a voluntary basis.

Four states with more than one capitated option mandate enrollment in one or more of the programs, but have voluntary enrollment in the other (or others). For example, California has four different capitated managed care programs covering different counties or regions of the state. Three of these programs have voluntary enrollment (noted by the number in parentheses) and one has mandatory enrollment. Likewise, Pennsylvania has two capitated programs, one of which is mandatory (in the eastern part of the state) and one of which is voluntary (in the western part).[31]

Mandatory	**Voluntary**
Alabama	District of Columbia
Arizona	California (3)
California	Georgia
Colorado*	Indiana
Delaware	Michigan
Florida*	Mississippi
Kentucky	Montana
Maryland	New Jersey
Massachusetts*	New York
Michigan	Ohio
Nebraska*	Pennsylvania
New Mexico	South Carolina
North Carolina*	Texas
Oregon	Virginia
Pennsylvania	Wisconsin
Tennessee	
Utah	
Vermont	
Virginia	

[31] Pennsylvania will soon convert the voluntary program in the western part of the state to a mandatory program, but will continue to have some voluntary HMOs in the middle of the state.

Special Managed Care Programs for Persons with Disabilities

Five states operate managed care programs exclusively for persons with disabilities.[32] Each is a capitated program that enrolls persons with chronic conditions and disabilities on a voluntary basis. These states are:

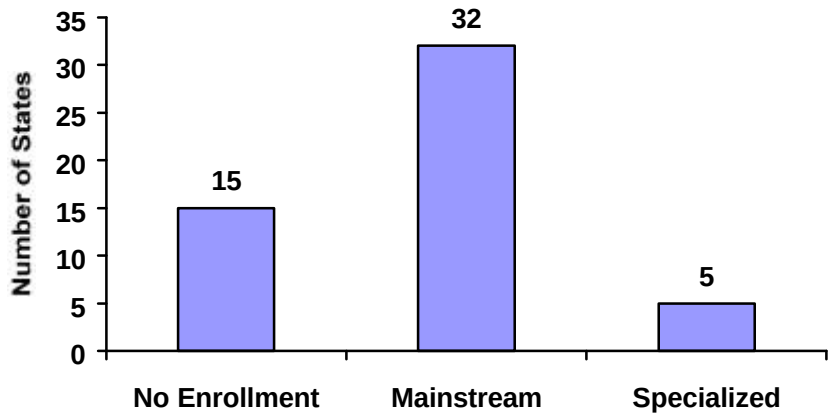
District of Columbia	Ohio
Indiana	Wisconsin
Michigan	

Summary of State Enrollments

Figure 2 illustrates the number of states that enroll persons with disabilities in managed care programs, distinguishing between those that operate specialized programs and those that run mainstream programs. Clearly, states have shown a strong preference for enrolling persons with disabilities in programs that are designed to accommodate the needs of both the general Medicaid population as well as the specialized and often unique requirements of persons with disabilities.

[32] Massachusetts had a quasi-specialized program for several years. Many of the state's more severely disabled persons (including persons with AIDS) routinely enrolled with CMA, an HMO that specialized in the care of complex cases. In July 1998, this arrangement was altered after CMA merged with another provider. Currently, all MCOs are expected to care for all types of conditions.

Figure 2: Distribution of States By Enrollment of Non-elderly Persons with Disabilities in Medicaid Managed Care Programs.



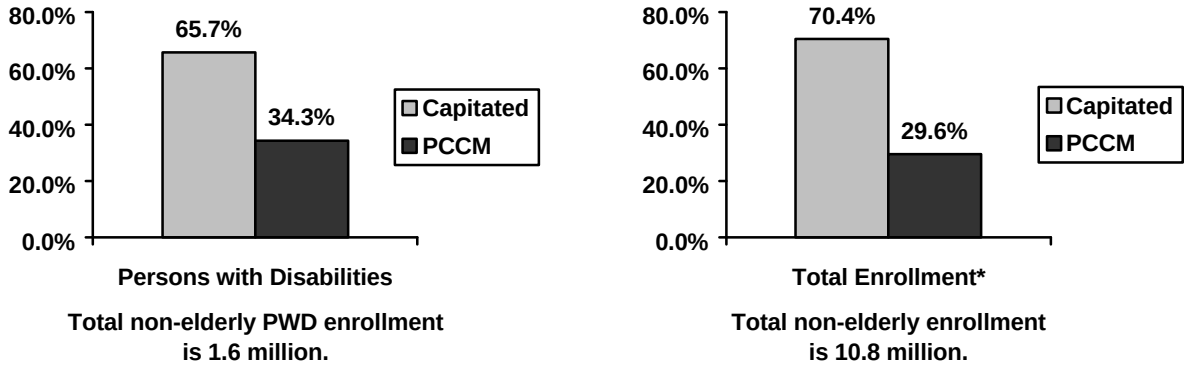
Source: ESRI Survey of Medicaid staff, Summer 1998. Number adds to 52 because Michigan has both a mainstream and a specialized program.

Estimates of Enrollment by Program and by State

Table 2 provides estimates of the total program enrollment of each of the state managed care programs that enroll non-elderly persons with disabilities. The estimates of PCCM and capitated enrollments are for non-elderly persons with disabilities only. There are 58 programs that enroll persons with disabilities in Medicaid managed care programs; 36 are capitated programs and 22 are PCCM programs.[33] Together, they enroll 1,594,260 persons with disabilities. As Figure 3 illustrates, approximately two-thirds of these persons are enrolled in capitated arrangements. This percentage is similar to the distribution between capitated and PCCM programs for persons without disabilities enrolled in these Medicaid managed care programs.

[33] Some of the states operate capitated and PCCM options within one program structure. For the purpose of this analysis, we counted these as two separate programs.

Figure 3: Comparison of Enrollment of PWDs and the Non-disabled Population in PCCM and Capitated Medicaid Programs



* This does not include persons with disabilities enrolled in these programs.
Note: This applies only to the programs in the 36 states that enroll persons with disabilities. Some of the states (e.g., the District of Columbia, Kentucky and Mississippi) operate additional programs that are not open to persons on SSI.

Source: ESRI Survey of Medicaid staff, Summer 1998

Table 2: Enrollment* of Non-elderly Persons with Disabilities (PWD) in State Medicaid PCCM and Capitated Programs

State	Name of Program (M=Mandatory, V=Voluntary)	Type of Program	PCCM Enrollment of Non-Elderly PWD	Capitated Enrollment of Non-Elderly PWD	Total State Enrollment of Non-Elderly PWD
Total Enrolled			546,800	1,047,460	1,594,260
Percent Enrolled			34.3%	65.7%	100%
Alabama	Better Access for You (M)	CAP		9,000	24,000
	Patients 1st (M)	PCCM	15,000		
Arizona	Arizona Health Care Cost Containment (M)	CAP		56,200	56,200
Arkansas	Connect Care (M)	PCCM	25,470		25,470
California	County Operated Health System (M)	CAP		112,600	168,000
	Geographic Managed Care (V)	CAP		7,200	
	PCCM Program (V)	PCCM	1,000		
	Prepaid Health Plans (V)	CAP		16,200	
	Two Plan Model (V)	CAP		31,000	
Colorado	Medicaid HMO Program (M)	CAP		8,500	13,500
	Primary Care Physician Program (M)	PCCM	5,000		
Delaware	Diamond State Health Plan (M)	CAP		4,000	4,000
District of Columbia	Health Services for Children with Special Needs (V)	CAP		2,000	2,000
Florida	Medicaid HMO Program (M*)	CAP		70,000	205,000
	Medipass (M*)	PCCM	135,000		
Georgia	Georgia Better Healthcare (M)	PCCM	87,000		92,000
	HMO Program (V)	CAP		5,000	
Idaho	Healthy Connections (M,V)	PCCM	6,680		6,680
Indiana	Voluntary Risk-Based Managed Care for Persons with Disabilities (V)	CAP		70	70
Kansas	Health Connect Kansas (M)	PCCM	15,000		15,000
Kentucky	Health Care Partnerships (M)	CAP		35,000	35,000
Louisiana	Community Care (M)	PCCM	12,550		12,550
Maryland	Health Choice (M)	CAP		67,400	67,400
Massachusetts	HMO Program (M*)	CAP		15,600	87,970
	Primary Care Clinician Program (M*)	PCCM	72,370		
Michigan	Children's Special Health Care Services (V)	CAP		130	140,730
	Comprehensive Health Plan Initiative (M)	CAP		140,600	
Mississippi	Capitated Managed Care Pilot (V)	CAP		800	800
Montana	Medicaid HMO (V)	CAP		70	6,070
	Passport to Health (M)	PCCM	6,000		
Nebraska	Nebraska Health Connection - Capitated (M*)	CAP		1,600	2,890
	Nebraska Health Connection - PCCM (M*)	PCCM	1,290		
New Jersey	New Jersey Care 2000 (V)	CAP		7,500	7,500
New Mexico	Salud! (M)	CAP		35,000	35,000
New York	CAP programs (V)	CAP		23,000	29,000
	PCCM / Partial Cap programs (V)	Partial CAP	6,000		

* Additional information about the methods used to estimate enrollment is available from the authors

State	Name of Program (M=Mandatory, V=Voluntary)	Type of Program	PCCM Enrollment of Non-Elderly PWD	Capitated Enrollment of Non-Elderly PWD	Total State Enrollment of Non-Elderly PWD
North Carolina	Carolina Access (M*)	PCCM	70,000		72,100
	Health Care Connection (M*)	CAP		2,100	
Ohio	Accessing Better Care (V)	CAP		130	130
Oregon	Oregon Health Plan: HMO (M)	CAP		35,120	36,630
	Oregon Health Plan: PCCM (M)	PCCM	1,510		
Pennsylvania	Family Care Network (M)	PCCM	22,000		146,400
	Health Choices (M)	CAP		89,400	
	Voluntary HMOs (V)	CAP		35,000	
South Carolina	Medicaid HMO (V)	CAP		50	550
	Physician Enhanced Program (V)	Partial CAP	500		
South Dakota	Provider & Recipient in Medicaid Efficiency (PRIME) (M)	PCCM	11,000		11,000
Tennessee	TennCare (M)	CAP		200,000	200,000
Texas	Star-HMO (V)	CAP		5,420	8,880
	Star-PCCM (V)	PCCM	3,460		
Utah	Choice of Health Care Delivery Program: Cap (M)	CAP		9,000	12,000
	Choice of Health Care Delivery Program: PCCM (V)	PCCM	3,000		
Vermont	Vermont Health Access Program (M)	CAP		300	300
Virginia	Medallion (M)	PCCM	43,970		63,240
	Medallion II (M)	CAP		15,770	
	Options (V)	CAP		3,500	
West Virginia	Physician Assured Access System (V)	PCCM	3,000		3,000
Wisconsin	Independent Care (I-Care) (V)	CAP		3,200	3,200

Source: ESRI Survey of Medicaid staff, Summer 1998.

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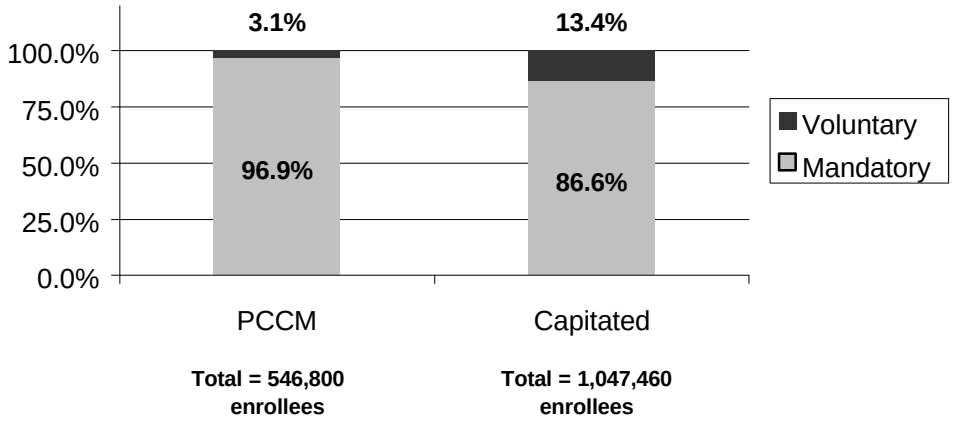
Figure 4 shows the ratio of voluntary and mandatory enrollment in each of these models. Of the 1,047,460 non-elderly persons with disabilities enrolled in capitated programs, 86.6 percent are enrolled on a mandatory basis. Approximately 96.9 percent of the 546,800 persons with disabilities in PCCM programs are enrolled on a mandatory basis.

Figure 4: Percentages of Non-elderly Medicaid Enrollees who are in Voluntary or Mandatory Medicaid Programs[34]



Source: ESRI Survey of Medicaid staff, Summer 1998.

As is clear from these figures, most of the persons with disabilities in managed care programs are enrolled on a mandatory basis. In contrast, 100 percent of enrollment in specialized programs for persons with chronic conditions and disabilities is on a voluntary basis. Still, the total enrollment for these five programs is less than one percent of all managed care enrollment for persons with disabilities.

Table 3 provides information on the total enrollment for state Medicaid managed care programs.[35] It provides the percentage of non-elderly persons with disabilities in managed care in the state, as well as the percentage of total managed care enrollment that is made up of non-elderly persons with disabilities. Table 4 includes these figures only for those states that enroll persons with disabilities in managed care programs, and ranks the states by the percentage of non-elderly persons enrolled.

[34] In states that require the enrollee to be in a managed care arrangement but allow the enrollee to choose between the capitated or PCCM option, all enrollment is considered to be mandatory.
[35] This includes the general Medicaid non-elderly population plus non-elderly persons with disabilities.

Table 3: Enrollment of Non-elderly Persons with Disabilities (PWD) in Medicaid Managed Care, by State

State	*Total Enrollment in Medicaid Managed Care*	*Total Enrollment of PWD in Medicaid Managed Care*	*Total Number of PWD in Medicaid (1996)*	*Estimated Percent of PWD in Medicaid Managed Care*	*Percent Medicaid Managed Care Enrollment that is PWD*
Total	13,685,260	1,594,260	5,919,074	26.9%	11.6%
Alabama	245,670	24,000	129,381	18.5%	9.8%
Alaska	0	0	7,962	0.0%	0.0%
Arizona	407,760	56,200	71,411	78.7%	13.8%
Arkansas	179,630	25,470	84,410	30.2%	14.2%
California	1,807,170	168,000	730,317	23.0%	9.3%
Colorado	117,180	13,500	60,738	22.2%	11.5%
Connecticut	220,000	0	51,297	0.0%	0.0%
Delaware	63,040	4,000	13,824	28.9%	6.3%
District of Columbia	80,030	2,000	24,276	8.2%	2.5%
Florida	857,180	205,000	308,804	66.4%	23.9%
Georgia	661,180	92,000	165,152	55.7%	13.9%
Hawaii	86,680	0	14,915	0.0%	0.0%
Idaho	29,530	6,680	19,551	34.2%	22.6%
Illinois	183,980	0	264,389	0.0%	0.0%
Indiana	222,860	70	72,436	0.1%	0.0%
Iowa	87,370	0	49,455	0.0%	0.0%
Kansas	92,490	15,000	44,405	33.8%	16.2%
Kentucky	337,430	35,000	159,400	22.0%	10.4%
Louisiana	52,410	12,550	163,280	7.7%	23.9%
Maine	12,200	0	34,827	0.0%	0.0%
Maryland	330,000	67,400	90,294	74.6%	20.4%
Massachusetts	463,990	87,970	162,840	54.0%	19.0%
Michigan	748,750	140,730	238,970	58.9%	18.8%
Minnesota	165,780	0	75,970	0.0%	0.0%
Mississippi	82,470	800	119,229	0.7%	1.0%
Missouri	247,960	0	103,253	0.0%	0.0%
Montana	46,340	6,070	16,269	37.3%	13.1%
Nebraska	34,100	2,890	24,769	11.7%	8.5%
Nevada	25,830	0	20,805	0.0%	0.0%
New Hampshire	8,800	0	11,218	0.0%	0.0%
New Jersey	375,720	7,500	133,136	5.6%	2.0%
New Mexico	191,600	35,000	38,267	91.5%	18.3%
New York	610,150	29,000	543,094	5.3%	4.8%
North Carolina	431,280	72,100	186,229	38.7%	16.7%
North Dakota	23,420	0	9,118	0.0%	0.0%
Ohio	344,480	130	231,426	0.1%	0.0%
Oklahoma	144,250	0	61,313	0.0%	0.0%
Oregon	307,450	36,630	46,900	78.1%	11.9%
Pennsylvania	922,230	146,400	346,605	42.2%	15.9%
Rhode Island	68,860	0	25,425	0.0%	0.0%
South Carolina	10,650	550	104,762	0.5%	5.2%
South Dakota	40,740	11,000	13,650	80.6%	27.0%
Tennessee	827,220	200,000	200,000	100.0%	24.2%
Texas	275,780	8,880	308,500	2.9%	3.2%
Utah	86,030	12,000	22,118	54.3%	13.9%

State	*Total Enrollment of in Medicaid Managed Care*	*Total Enrollment of PWD in Medicaid Managed Care*	*Total Number of PWD in Medicaid (1996)*	*Estimated Percent of PWD in Medicaid Managed Care*	*Percent Medicaid Managed Care Enrollment that is PWD*
Vermont	51,080	300	14,508	2.1%	0.6%
Virginia	299,130	63,240	114,998	55.0%	21.1%
Washington	448,180	0	111,605	0.0%	0.0%
West Virginia	129,400	3,000	92,732	3.2%	2.3%
Wisconsin	199,810	3,200	102,938	3.1%	1.6%
Wyoming	0	0	7,289	0.0%	0.0%

Source: Numbers of disabled in states come from Urban Institute preliminary 1996 estimates. Other estimates are from Medicaid staff and HCFA data. Enrollments are rounded to the nearest 10.

Table 4: Ranking of States by Percent Non-elderly Persons with Disabilities (PWD) Enrolled in Medicaid Managed Care

State	*Total Enrollment in Medicaid Managed Care*	*Total Enrollment of PWD in Medicaid Managed Care*	*Total Number of PWD in Medicaid (1996)*	*Estimated Percent of PWD in Medicaid Managed Care*	*Percent Medicaid Managed Care Enrollment that is PWD*
Tennessee	827,220	200,000	200,000	100.0%	24.2%
New Mexico	191,600	35,000	38,267	91.5%	18.3%
South Dakota	40,740	11,000	13,650	80.6%	27.0%
Arizona	407,760	56,200	71,411	78.7%	13.8%
Oregon	307,450	36,630	46,900	78.1%	11.9%
Maryland	330,000	67,400	90,294	74.6%	20.4%
Florida	857,180	205,000	308,804	66.4%	23.9%
Michigan	748,750	140,730	238,970	58.9%	18.8%
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Pennsylvania	922,230	146,400	346,605	42.2%	15.9%
North Carolina	431,280	72,100	186,229	38.7%	16.7%
Montana	46,340	6,070	16,269	37.3%	13.1%
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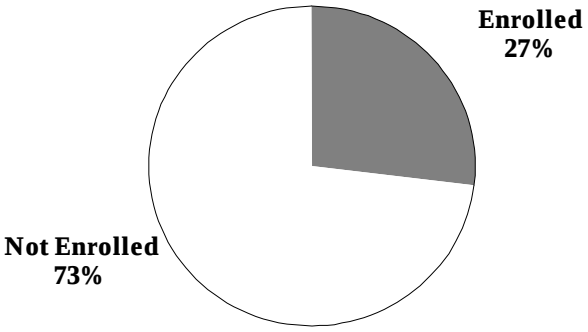
Delaware	63,040	4,000	13,824	28.9%	6.3%
California	1,807,170	168,000	730,317	23.0%	9.3%
Colorado	117,180	13,500	60,738	22.2%	11.5%
Kentucky	337,430	35,000	159,400	22.0%	10.4%
Alabama	245,670	24,000	129,381	18.5%	9.8%
Nebraska	34,100	2,890	24,769	11.7%	8.5%
District of Columbia	80,030	2,000	24,276	8.2%	2.5%
Louisiana	52,410	12,550	163,280	7.7%	23.9%
New Jersey	375,720	7,500	133,136	5.6%	2.0%
New York	610,150	29,000	543,094	5.3%	4.8%
West Virginia	129,400	3,000	92,732	3.2%	2.3%
Wisconsin	199,810	3,200	102,938	3.1%	1.6%
Texas	275,780	8,880	308,500	2.9%	3.2%
Vermont	51,080	300	14,508	2.1%	0.6%
Mississippi	82,470	800	119,229	0.7%	1.0%
South Carolina	10,650	550	104,762	0.5%	5.2%
Indiana	222,860	70	72,436	0.1%	0.0%
Ohio	344,480	130	231,426	0.1%	0.0%

Source: ESRI Survey of Medicaid staff, Summer 1998.

Nearly 6 million Medicaid beneficiaries can be classified as non-elderly disabled persons.[36] More than one-quarter of these individuals, or roughly 1.6 million, are enrolled in Medicaid managed care arrangements (see Figure 5). About two-thirds are enrolled in capitated plans and one-third in PCCM programs. Together, they represent nearly 12 percent of total Medicaid managed care enrollment.

Figure 5: Medicaid Managed Care Enrollment of Persons with Disabilities



Total = 5.9 million non-elderly persons with disabilities

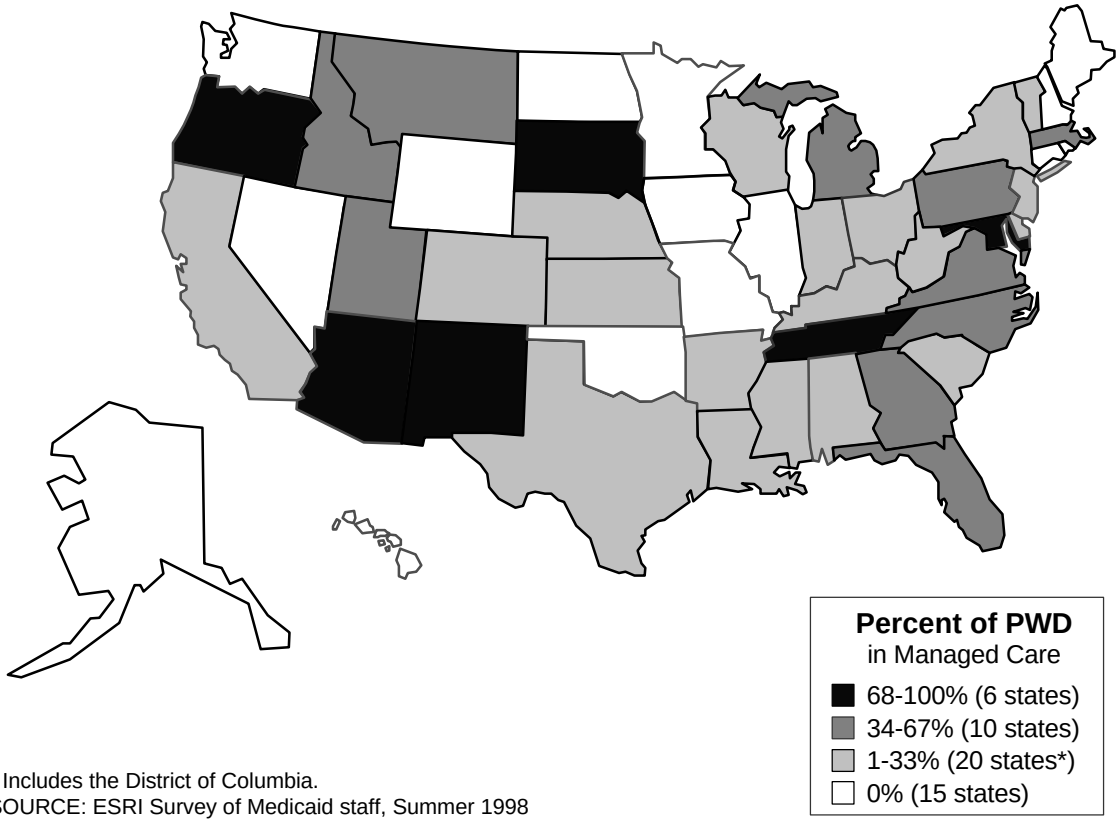
Source: ESRI estimates, Summer 1998.

We used a number of sources to estimate total non-elderly enrollment in Medicaid managed care. Several states provided current enrollment figures; when these figures included elderly enrollees that the state could not specifically identify, we used a discount factor (which was one-fifth of the percentage of elderly Medicaid enrollees in that particular state) to estimate the number of elderly enrollees. We also used HCFA enrollment data to estimate total enrollments.

As can be seen in Table 4, Tennessee leads the states with 100 percent enrollment of non-elderly persons with disabilities in managed care, but several states are close on Tennessee's heels. New Mexico enrolls over 90 percent of its non-elderly disabled population, and South Dakota includes over 80 percent in its program. These enrollments are also summarized on the map in Figure 5, which shows enrollment of persons with disabilities across the states. Clearly, enrollment is not clustered in any one part of the country.

[36] Bruen, Urban Institute. Preliminary estimates.

Figure 6: Percent of Non-elderly Persons with Disabilities (PWD) in Medicaid Managed Care



* Includes the District of Columbia.
SOURCE: ESRI Survey of Medicaid staff, Summer 1998

Enrollment and Program Features[37]

Use of an Enrollment Broker

We asked state Medicaid staff whether they use an enrollment broker to handle the enrollment process for persons with disabilities. Thirty-four of the 58 programs use an enrollment broker. Of the 23 capitated programs that use a broker to assign an enrollee to an MCO (and in some cases a PCP), 12 are mandatory programs and 11 are voluntary.[38] Of the 11 PCCM programs that use a broker to assign a PCP, nine are mandatory programs and two are voluntary. Twenty-four programs do not use an enrollment broker. For example, Alabama and Kentucky automatically assign all enrollees to the one MCO that serves their entire region. New York and Utah do not contract with a broker, but instead use Medicaid staff to assign enrollees to plans either on a mandatory (Utah) or voluntary (New York) basis.[39]

[37] See Section II for separate descriptions of the managed care programs.
[38] This means that the programs are voluntary for persons with disabilities. They may or may not be voluntary for the general Medicaid population.
[39] New York plans to begin using a broker in certain counties.

Guaranteed Eligibility and Lock-in Provisions

Because the Medicaid population moves on and off Medicaid coverage with some frequency, several states have instituted guaranteed eligibility provisions to develop a more stable enrollment base for MCOs, and assist with continuity of care for enrollees. States with guaranteed eligibility provisions agree to "cover" enrollees for a predetermined period of time, whether or not they continue to be eligible for the Medicaid program. Only about one-quarter of the programs have a guaranteed eligibility provision. Commonly, these are for one-, six-, or 12-month periods.

A few more programs – 21 in all – have "lock-in" provisions that require enrollees to remain with a particular plan or PCP. Again, these lock-provisions typically last one, six or 12 months. During the period, enrollees are not permitted to change plans or PCPs, or are allowed to change for cause only. Many of the programs that do not have lock-in provisions allow enrollees to enroll and disenroll, or to switch from one plan or PCP to another, as often as they wish. Others allow more limited plan or provider switching within a one-year period.

Table 5 provides information on whether a program uses an enrollment broker and information on guaranteed eligibility and lock-in periods.

Table 5: Use of Enrollment Broker, Guaranteed Eligibility, and Lock-in Periods

State	Name of Program	Enrollment broker	Guaranteed eligibility	Lock-in
Total Programs		34 Yes	15 Yes	21 Yes
Alabama	Better Access for You (BAY)	No	Yes	Yes
	Patients 1st	No	No	Yes
Arizona	Arizona Health Care Cost Containment System	No	Yes	Yes
Arkansas	Connect Care	No	Yes	Yes
California	County Organized Health System	No	No	No
	Geographic Managed Care	Yes	No	No
	PCCM Program	No	No	No
	Prepaid Health Plans	No	No	No
	Two Plan Model	Yes	No	No
Colorado	Medicaid HMO Program	Yes	Yes	Yes
	Primary Care Physician Program	Yes	No	Yes
Delaware	Diamond State Health Plan	Yes	Yes	Yes
District of Columbia	Health Services for Children with Special Needs	No	No	No
Florida	Medicaid HMO Program	Yes	No	No
	Medipass	Yes	No	No
Georgia	Georgia Better Healthcare	Yes	No	No
	HMO Program	Yes	No	No
Idaho	Healthy Connections	No	No	No
Indiana	Voluntary Risk-Based Managed Care for Persons with Disabilities	Yes	Yes	No
Kansas	Health Connect Kansas	Yes	No	Yes
Kentucky	Health Care Partnerships	No	Yes	Yes
Louisiana	Community Care	Yes	No	Yes
Maryland	Health Choices	Yes	Yes	No
Massachusetts	HMO Program	Yes	No	No
	Primary Care Clinician Program	Yes	No	No
Michigan	Comprehensive Health Plan Initiative	Yes	No	Yes
	Children's Special Health Care Services	Yes	Yes	No
Mississippi	Capitated Managed Care Pilot	Yes	No	No
Montana	Medicaid HMO	Yes	No	No
	Passport to Health	Yes	No	No
Nebraska	Nebraska Health Connection: CAP	Yes	Yes	Yes
	Nebraska Health Connection: PCCM	Yes	Yes	Yes
New Jersey	New Jersey Care 2000	Yes	No	No
New Mexico	Salud!	Yes	No	Yes
New York	Cap Programs	No	No	No
	PCCM/Partial Cap Programs	No	Yes	No
North Carolina	Carolina Access	No	No	No
	Health Care Connections	Yes	No	No
Ohio	Accessing Better Care	No	No	No

State	Name of Program	Enrollment broker	Guaranteed eligibility	Lock-in
Oregon	Oregon Health Plan: HMO	No	No	Yes
	Oregon Health Plan: PCCM	No	No	Yes
Pennsylvania	Family Care Network	Yes	No	No
	Health Choices	Yes	Yes	No
	Voluntary HMOs	No	Yes	No
South Carolina	Medicaid HMO	No	No	No
	Physician Enhanced Program	No	No	No
South Dakota	Provider & Recipient in Medicaid Efficiency (PRIME)	No	No	No
Tennessee	TennCare	No	No	No
Texas	Star – HMO	Yes	No	No
	Star – PCCM	Yes	No	No
Utah	Choice of Health Care Delivery: CAP	No	No	No
	Choice of Health Care Delivery: PCCM	No	No	No
Vermont	Vermont Health Access Program	Yes	Yes	Yes
Virginia	Medallion	Yes	No	Yes
	Medallion II	Yes	No	Yes
	Options	Yes	No	Yes
West Virginia	Physician Assured Access System	No	No	Yes
Wisconsin	Independent Care (I-Care)	Yes	No	No

Source: ESRI Survey of Medicaid staff, Summer 1998.

Choice or Autoassignment of Health Plan or Provider

Most of the capitated programs that have more than one participating MCO per area (29 of 36 programs) first give enrollees an opportunity to enroll in a plan of their own choosing. When individuals do not choose a plan or provider, however, programs that are mandatory autoassign prospective enrollees to one of the participating MCOs. Mandatory PCCM programs also rely on autoassignment for individuals who do not select a PCP. Tennessee autoassigns all persons with disabilities to the plan closest to their place of residence; if they want to change plans, they have 45 days to switch to a different plan.[40] After this, individuals who want to change plans must wait for the state's annual open season.

In the case of PCCM programs, persons with disabilities are most commonly autoassigned to PCPs who are current or former providers. In capitated programs, they are most frequently assigned to MCOs that are affiliated with one of their providers. The second most frequently cited criterion is geographic location for both PCCM and capitated programs.

Some of the states randomly assign persons with disabilities to plans or providers. Other methods include: autoassigning in the same proportions as individuals who voluntarily enroll;[41] dividing up the autoenrollees according to an MCO's "score" in the contracting process; the capacity of the MCO or provider panel; and defaulting to the MCO with the most generous benefit package within the region.

Massachusetts will not autoassign persons with disabilities to its capitated option. Although managed care is mandatory in the state, persons with disabilities who do not choose an option will always be autoassigned to the PCCM program. Oregon's PCCM option also does not autoassign persons with disabilities; Medicaid staff follow a lengthy procedure to work with enrollees to help them select a provider.

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[40] According to Tennessee Medicaid officials, during 1997, only 3 percent of new TennCare enrollees switched plans. The state says it will try to determine why these individuals were dissatisfied with their original assignments.

[41] There are usually large numbers of people who choose plans or providers, and therefore do not need to be autoassigned. Some states will follow the choice patterns of this group – for example, if two-thirds of these enrollees choose Plan 1 and one-third choose Plan 2, the state will autoassign in these same proportions.

Most of the PCCM programs allow specialists (such as neurologists, endocrinologists and orthopedists) to serve as a PCP for a person with a disability, but it is not clear how prevalent this practice is.[42] Several state Medicaid staff indicated that they would classify specialists as PCPs; however, it appears that few specialists are willing either to offer the full range of PCP services or to accept PCP fees in lieu of their (commonly) higher specialty fees. South Dakota's *PRIME* program does not allow specialists to serve as PCPs, but will move a person with a disability into the fee-for-service system with a specialist as gatekeeper, if that person's physician recommends such action to the state Medicaid office. Six of these "transfer" requests have been made over the course of the program, and all six requests have been approved.

All but two of the PCCM programs pay participating PCPs a per-member, per-month management fee; in most cases, this fee is $3.00. Utah's *Choice of Health Care Delivery* does not pay a monthly fee, and the *Primary Care Clinician Program* in Massachusetts provides enhanced (by $10) primary care visit fees.

Eligibility by Age

Only ten of the 58 programs that enroll non-elderly persons with disabilities limit enrollment to certain age groups. Three programs enroll children only: the District of Columbia's *Health Services for Children with Special Needs*, Michigan's *Children's Special Health Care Plan*, and Pennsylvania's *Family Care Network*; and one program, Wisconsin's *I-Care*, specifically excludes children under age 16. Six other programs exclude persons over age 65: Louisiana's *Community Care*; Massachusetts' *Primary Care Clinician* and *HMO Programs*; Ohio's *Accessing Better Care*; South Carolina's *Medicaid HMOs*; and West Virginia's *Physician Assured Access System*.

Services Not Provided Through the MCO Capitation Rate

While some of the capitated programs require participating MCOs to provide all Medicaid mandated benefits through the capitation rate, many of the programs either create separate programs for certain types of services, or cover them through fee-for-service Medicaid. Services such as behavioral health care, pharmacy, dental, hospice,

long-term care, and chiropractic services often are made available to enrollees through separate capitated or fee-for-service arrangements. These arrangements are sometimes referred to as "carve-outs," because the services are provided to the enrollee outside the capitated or fee-for-service benefit package. Several PCCM programs also set up different arrangements for behavioral health services – for example, either contracting on a capitated basis with a behavioral health firm, or allowing the enrollee to bypass the PCCM's PCP structure and seek mental health or substance abuse services directly from specialist providers.[43]

Of the 36 capitated programs that enroll persons with disabilities, 31 provide at least some of their benefits outside of the basic capitation rate paid to MCOs. Most often – in 22 programs – these were some or all of the behavioral health services covered by the state Medicaid program. Eight programs cover pharmaceuticals outside of the capitation rate, five make separate arrangements for dental care, and others carve out services such as long-term and hospice care, chiropractic services, non-emergency transportation, specific drugs and therapies, vision care, or social service case management. In Maryland's *Health Choices* program, drug therapy for AIDS is the only Medicaid service that is moved out of the capitated payment and covered by the fee-for-service system. Five programs (Oregon's *Health Plan*, the District of Columbia's *Health Services for Children with Special Needs*, Arizona's *Health Care Cost Containment System*, and Virginia's *Medallion II* and *Options* programs) cover all Medicaid services within their capitated rate.

Rate-Setting

Most of the capitated programs set different rates for persons with disabilities, by virtue of their categorical (e.g., SSI, medically needy) status. In other words, these programs pay MCOs more for persons on SSI than for persons in the general Medicaid population. As can be seen in Table 6, of the 36 capitated programs that enroll persons with disabilities, 31 vary rates based on SSI eligibility. Several states also take age, gender, and geographic area into account when setting rates. For example, 23 states have different payment rates based on age and 17 vary rates based on gender. Only 12 programs vary rates by geographic area of the enrollee.

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[42] Most of the programs allow pediatricians, obstetricians and gynecologists to serve as PCPs. The question about specialists as PCPs refers to medical and surgical specialties that are not generally associated with the delivery of primary care.

[43] These issues will be discussed in greater detail in the section on behavioral health.

Eleven programs use additional factors to set payment rates for persons enrolled in managed care. For example, California's *County Operated Health System* and Utah's *Choice of Health Care Delivery* base rates on SSI eligibility, but pay an additional amount for persons with AIDS. Colorado and Ohio have developed mechanisms to adjust rates based on prior resource use, and five states (Indiana, Maryland, Massachusetts, Michigan[44] and Wisconsin) set rates based on pre-determined diagnostic groupings. Nebraska and Tennessee have developed mechanisms that retrospectively adjust payments to provide additional funds to MCOs that have experienced adverse selection (Nebraska has yet to use this mechanism).

Four of the five specialized programs that enroll persons with chronic conditions and disabilities vary rates by diagnostic category or prior use of health services. Michigan's *Special Health Care Kids Program* has set five rate categories, based on ICD-9 diagnosis groups, for children who enroll in the program. These rates correspond to the severity of chronic condition or disability, and the type or amount of resources that are likely to be needed by the child. The exception in this category is the District of Columbia's *Health Services for Children with Special Needs,* which has one payment rate for all enrollees.[45]

[44] This applies to the Children's Special Health Care Kids Program.
[45] This program enrolls children only, up to the age of 23.

Table 6: Rate-Setting Criteria

State	Program Name	Categorical eligibility	Age	Gender	Geography	Other risk-adjustment+
Total Programs		31 Yes	23 Yes	17 Yes	12 Yes	11 Yes
Alabama	Better Access for You (BAY)	Yes	Yes	No	No	No
Arizona	Arizona Health Care Cost Containment System	Yes	Yes	Yes	No	No
California	County Organized Health System	Yes	Yes	Yes	No	Yes
	Geographic Managed Care	Yes	No	No	No	No
	Prepaid Health Plans	Yes	No	No	No	No
	Two Plan Model	Yes	No	No	No	No
Colorado	Medicaid HMO Program	Yes	Yes	Yes	Yes	Yes
Delaware	Diamond State Health Plan	Yes	Yes	Yes	No	No
District of Columbia	Health Services for Children with Special Needs	No◆	No	No	No	No
Florida	Medicaid HMO Program	Yes	Yes	No	Yes	No
Georgia	HMO Program	Yes	Yes	Yes	Yes	No
Indiana	Voluntary Risk-Based Managed Care for Persons with Disabilities	No◆	No	No	No	Yes
Kentucky	Health Care Partnerships	Yes	No	No	No	No
Maryland	Health Choices	Yes	Yes	Yes	Yes	Yes
Massachusetts	HMO Program	Yes	No	No	Yes	Yes
Michigan	Children's Special Health Care Plan	Yes	Yes	No	Yes	Yes
	Comprehensive Health Plan Initiative	Yes	Yes	Yes	Yes	No
Mississippi	Capitated Managed Care Pilot	Yes	Yes	Yes	Yes	No
Montana	Medicaid HMO	Yes	Yes	No	No	No
Nebraska	Nebraska Health Connection: CAP	Yes	Yes	Yes	No	Yes
New Jersey	New Jersey Care 2000	Yes	Yes	Yes	Yes	No
New Mexico	Salud!	Yes	Yes	Yes	No	No
New York	NY State Voluntary Managed Care Program	Yes	Yes	Yes	No	No
North Carolina	Health Care Connections / HMO Program	Yes	Yes	Yes	No	No
Ohio	Accessing Better Care (ABC)	No◆	No	No	No	Yes
Oregon	Oregon Health Plan: Cap Plan	Yes	No	No	Yes	No
Pennsylvania	Health Choices	Yes	No	No	No	No
	Voluntary HMOs	Yes	Yes	Yes	Yes	No
South Carolina	Medicaid HMO	Yes	Yes	Yes	No	No
Tennessee	TennCare	Yes	No	No	No	Yes
Texas	Star -- HMO	Yes	No	No	Yes	No
Utah	The Choice of Health Care Delivery: CAP Program	Yes	Yes	Yes	No	Yes
Vermont	Vermont Health Access Program	Yes	Yes	Yes	No	No
Virginia	Medallion II	No	Yes	No	No	No
	Options	No	Yes	No	No	No
Wisconsin	Independent Care (I-Care)	Yes	No	No	No	Yes

◆ In these programs, the rates apply to persons with disabilities only.
+ Other risk adjustment includes special rates for HIV / AIDS (California, Utah); adjustments based on resource use (Colorado, Ohio); diagnostic categories (Indiana, Maryland, Massachusetts, Michigan, Wisconsin); and adverse selection adjustments (Nebraska, Tennessee).
Source: ESRI Survey of Medicaid staff, Summer 1998.

Issues of Quality for Persons with Disabilities in Medicaid Managed Care

Quality Assurance Programs

All of the capitated managed care programs include a quality assurance component in their contractual arrangements with MCOs; this component, however, rarely addresses the unique needs of persons with disabilities (see Table 7). Commonly, MCO contracts contain requirements to develop a quality assurance program that will specify the policies and procedures to assure that enrollees receive appropriate services in a fair, responsible and timely manner. Typically, they also include grievance and appeals procedures if enrollees believe that they are not receiving the services they need or have other concerns about their care. They may also specify various reporting requirements and the types of data that the plans must provide to the state Medicaid office.

Some of the programs indicate that they have quality assurance provisions that pertain specifically to persons with disabilities.[46] For example, Vermont's *Health Access* program has designated a state "managed care ombudsman" to address issues of concern to persons with disabilities in managed care. The Robert Wood Johnson Foundation is helping to fund a three-year study of persons with disabilities in Nebraska's *Health Connections* programs that will look at access to care for that group. In Texas' *Star* programs, all quality assurance studies must include some persons with disabilities. Utah is in the process of surveying persons with disabilities in managed care to see whether the programs are meeting their needs.

[46] These programs are ones that also enroll the general Medicaid population. By definition, all of the quality assurance provisions in specialized programs pertain to persons with disabilities.

Table 7: Quality Assurance

State Name	Program Name	Does your QA program include any additional provisions for PWDs?	Are there any QA external studies that pertain to PWDs?	Notes
Total Programs		15 Yes	15 Yes	
Alabama	Better Access for You (BAY)	No	Yes	External review of ambulatory follow-up after hospitalization for selected mental illnesses.
	Patients 1st	No	No	
Arizona	Arizona Health Care Cost Containment System	No	No	
Arkansas	Connect Care	No	No	
California	County Organized Health System	No	Yes	External study of care received by SSI population.
	Geographic Managed Care	No	No	
	PCCM Program	No	No	
	Prepaid Health Plans	No	No	
	Two Plan Model	No	No	
Colorado	Medicaid HMO Program	Yes	Yes	External study on discharge planning.
	Primary Care Physician Program	No	No	
Delaware	Diamond State Health Plan	No	Yes	External studies on mental health, children with special health care needs.
District of Columbia	Health Services for Children with Special Needs	Yes	No	
Florida	Medicaid HMO Program	No	No	
	Medipass	No	No	
Georgia	Georgia Better Healthcare	No	No	
	HMO Program	No	No	
Idaho	Healthy Connections	No	No	
Indiana	Voluntary Risk-Based Managed Care for Persons with Disabilities	Yes	No	Plan conducts surveys of enrollees after 1, 3, 6 months.
Kansas	Health Connect Kansas	No	No	
Kentucky	Health Care Partnerships	Yes	Yes	
Louisiana	Community Care	No	No	
Maryland	Health Choices	No	No	
Massachusetts	HMO Program	No	Yes	External reviews include clinical topics for PWDs.
	Primary Care Clinician Program	No	No	
Michigan	Children's Special Health Care Plan	Yes	No	
	Comprehensive Health Plan Initiative	No		
Mississippi	Capitated Managed Care Pilot	No	No	

State Name	Program Name	Does your QA program include any additional provisions for PWDs?	Are there any QA external studies that pertain to PWDs?	Notes
Montana	Medicaid HMO	No	Yes	Clinical focus studies on cerebral palsy and pediatric asthma.
	Passport to Health	No	Yes	Clinical focus studies on cerebral palsy and pediatric asthma.
Nebraska	Nebraska Health Connection: CAP	Yes	No	Three-year study on access issues for PWD.
	Nebraska Health Connection: PCCM	Yes	No	Three-year study on access issues for PWD.
New Jersey	New Jersey Care 2000	No	No	
New Mexico	Salud!	No	No	
New York	NY Partial Cap Program	No	No	
	NY State Voluntary Managed Care Program	No	No	
North Carolina	Carolina Access	No	No	
	Health Care Connections / HMO Program	No	No	
Ohio	Accessing Better Care (ABC)	No	Yes	External study on case management.
Oregon	Oregon Health Plan: Cap Plan	Yes	Yes	QA program includes special toll-free number for complaints / concerns for elderly and disabled only. External studies on asthma, diabetes and depression.
	Oregon Health Plan: PCCM Model	Yes	Yes	QA program includes special toll-free number for complaints / concerns for elderly and disabled only. External studies on asthma, diabetes and depression.
Pennsylvania	Family Care Network	No	No	
	Health Choices	No	No	
	Voluntary HMOs	No	No	
South Carolina	Medicaid HMO	No	No	
	Physician Enhanced Program	No	No	
South Dakota	Provider and Recipient in Medicaid Efficiency (PRIME)	No	No	
Tennessee	TennCare	Yes	Yes	QA program includes consumer advocacy / assistance specifically for PWDs. External studies on diabetes care and pediatric asthma inpatient admissions.
Texas	Star -- HMO	Yes	No	QA studies, focus groups, etc. must include some PWDs.
	Star -- PCCM	Yes	No	QA studies, focus groups, etc. must include some PWDs.

State Name	Program Name	Does your QA program include any additional provisions for PWDs?	Are there any QA external studies that pertain to PWDs?	Notes
Utah	The Choice of Health Care Delivery: CAP Program	Yes	No	Special survey for persons with special health care needs.
	The Choice of Health Care Delivery: PCCM Model	No	No	
Vermont	Vermont Health Access Program	Yes	Yes	State managed care ombudsman part of QA program. External study on diabetes. Internal QA committee reviews LTC issues.
Virginia	Medallion	No	No	
	Medallion II	No	No	
	Options	No	No	
West Virginia	Physician Assured Access System	No	Yes	External study on adults with breathing problems
Wisconsin	Independent Care (I-Care)	Yes	Yes	

Source: ESRI Survey of Medicaid staff, Summer 1998.

Oregon's quality assurance program requires that all MCOs have "exceptional needs care coordinators" on site to address the needs of persons with disabilities.[47] Also, persons with disabilities (and the elderly) have access to a toll-free telephone number that they can call to get advice about available services from the managed care ombudsman, or air their complaints about their managed care experiences.

Oregon's ombudsman program has been an important feature in creating a mainstream program that nevertheless targets the special needs of persons with chronic conditions and disabilities. The following list includes examples of hot-line callers' common complaints:

1. An enrollee receives a bill for services that have not been pre-approved. In this case, the ombudsman explains the requirements under managed care to get pre-approval for use of certain types of services.

2. An enrollee's prescription has been changed – the specific medication is either off the MCO's formulary, or the generic brand is required.

3. An enrollee has difficulty accessing durable medical equipment.

[47] Exceptional needs care coordinators, commonly nurses or social workers, assist individuals with chronic illnesses, disabilities or other special health needs by providing individualized care coordination.

In each of these cases, the ombudsman works with the enrollee and the plan to resolve the problem, bringing the exceptional needs care coordinator into the discussion when appropriate. In some of these cases, the ombudsman spends time on the telephone with the enrollee explaining the way that managed care works, and how the system differs from fee-for-service. This often averts problems in the future. But the ombudsman also attempts to resolve the problem at hand. For example, in the case of a changed prescription, after speaking to the MCO's exceptional needs care coordinator and the enrollee, the ombudsman may encourage the MCO to approve the original drug for the enrollee, even though it is off the formulary. This might occur if the parties suspect that changing the medication would do more harm than good – in other words, if changing the prescription would cause the enrollee to stop taking the medication. According to the ombudsman, MCOs have been very cooperative in trying to address the concerns of persons with disabilities.

State Medicaid managed care programs are required by the Health Care Financing Administration to conduct "external studies" of service delivery to certain populations – states have considerable latitude in determining the topics of these studies. Most of the states have not used the external study mechanism to evaluate health care delivery or access issues for persons with disabilities.[48] In many of these cases, the programs are relatively young, or persons with disabilities have only recently begun to enroll, and so studies would not have been feasible. The *TennCare* program, however, has already conducted studies on pediatric asthma and diabetes-related inpatient admissions. Several other states have one or more disability-related topics on their agendas for future external studies. Some of these topics are case management services, ambulatory care following hospitalization for selected mental illnesses, and targeted studies of the SSI population.

What Plans Know about New Enrollees

We asked Medicaid staff if the health plans or providers know whether an enrollee has a disability or chronic condition, and what requirements plans and providers face with respect to contacting, seeing, or collecting health information on new enrollees. While it may be in the enrollee's best interest to maintain confidentiality prior to making an enrollment selection, it could help the plan's providers better address the needs of the enrollee if they knew the types of health services the enrollee would be likely to require. It also could expedite treatment for conditions that require chronic or more immediate care.

Interestingly, many health plans or providers do not know whether a new enrollee has a chronic condition or disability, or is part of the general Medicaid population. While it is true that most capitated

[48] Many of the external studies that have been conducted address issues that pertain to maternal and child health.

programs receive higher payments for persons on SSI (and therefore must have knowledge of someone's categorical eligibility), it is not clear that this information filters down to the provider.

According to state Medicaid staff, more than half of the managed care programs that enroll persons with disabilities are not aware of the health or functional status of new enrollees. Several states indicated that this information should be available by virtue of the enrollee's categorical eligibility status; again, it is unclear whether this information is made available to providers.

Some programs have provisions that would assist plans and providers in identifying persons with disabilities. Oregon, for example, provides plans with monthly enrollment lists that identify persons with disabilities. Pennsylvania's enrollment broker for the *Health Choices* program notifies the MCO's "special needs unit" if an enrollee has a disability. Five programs also say that they receive "continuity of care" forms on new enrollees that help them identify special needs for persons with chronic conditions and disabilities. Also, some programs require MCOs or providers to contact new enrollees within a specified period of time. Presumably, they could become familiar with their health and functional status at that time.

Maryland has had some difficulties identifying children with disabilities, who are sometimes eligible for a managed fee-for-service alternative called the *Rare and Expensive Case Management (REM)* program.[49] All children in the state are enrolled in *Health Choices* until such time that they are "flagged" for the REM program. Reportedly, delays in identifying children who qualify for the REM program have resulted in delays in their treatment.

Program Requirements Related to Persons with Disabilities

We asked Medicaid staff whether they required their managed care programs to see new enrollees within any specified period of time (and whether this requirement differed for persons with disabilities), or to request that new enrollees complete a health questionnaire or assessment. We also asked them if persons with disabilities were required to have a case manager. Table 8 displays the results of these questions.

More than half of the programs do not require their participating MCOs or providers to see persons with disabilities within any specified time period. The ones that do have requirements to see new enrollees generally require plans or providers to see *all* new enrollees, and do not distinguish between persons with disabilities and the general Medicaid population. Ohio's *Accessing Better Care* program, targeted to persons with disabilities only, requires providers to see new enrollees within 30 days, and Nebraska's

[49] The REM program currently enrolls about 1,200 persons with "expensive" chronic conditions and disabilities that are expected to cost in excess of $10,000 per year. Most of the program's enrollees are children.

Health Connections programs require persons to be seen within 45 days. Several other state Medicaid managed care programs require new enrollees to be seen or contacted within 60, 90 or 120 days.

Fourteen of the 36 capitated programs require plans to assign case managers to persons with disabilities; only one of the PCCM programs assigns case managers (although presumably, the primary care physician would assume certain case management functions). About one-quarter of the plans require health plans or providers to conduct a health assessment or ask enrollees to complete a health questionnaire, although several of the programs appear to conduct such assessments voluntarily.

Table 8: Requirements to See Enrollees within Specific Time Period, Use of Case Managers, and Health Questionnaire or Assessment

State	Program Name	Specific time requirement to see PWD	Case Manager Requirement*	Health Questionnaire or Assessment Requirement
Total Programs		26 Yes	14 Yes	17 Yes
Alabama	Better Access for You (BAY)	9 months	No	Yes
	Patients 1st	No	No	No
Arizona	Arizona Health Care Cost Containment System	No	Yes	Not required, but some do
Arkansas	Connect Care	No	No	No
California	County Organized Health System	120 days	Not required, but some do	Not required, but some do
	Geographic Managed Care	120 days	No	
	PCCM Program	120 days	No	
	Prepaid Health Plans	120 days		
	Two Plan Model	120 days	No	
Colorado	Medicaid HMO Program	Yes	No	Yes
	Primary Care Physician Program	No		
Delaware	Diamond State Health Plan	No	Yes	Yes
District of Columbia	Health Services for Children with Special Needs	Yes	Yes	Yes
Florida	Medicaid HMO Program	Must contact twice within first 90 days to schedule health assessment	Not required, but must monitor care of PWD	Yes
	Medipass	Screen within 90 days		Not required, but some do
Georgia	Georgia Better Healthcare	No	No	
	HMO Program	Initial assessment within 90 days	No	Yes
Idaho	Healthy Connections	No		
Indiana	Voluntary Risk-Based Managed Care for Persons with Disabilities	Yes	Yes	Yes
Kansas	Health Connections	No	No	
Kentucky	Health Care Partnerships	Yes		
Louisiana	Community Care	No		No
Maryland	Health Choices	Within 90 days	Yes	Yes
Massachusetts	HMO Program	No	Yes	Yes, from enrollment broker
	Primary Care Physician Program	Within 90 days	No	No
Michigan	Children's Special Health Care Plan	Within 60 days	Yes	No
	Comprehensive Health Plan Initiative	No		
Mississippi	Capitated Managed Care Pilot	No	No	No
Montana	Medicaid HMO	No	No	No
	Passport to Health	No	No	
Nebraska	Nebraska Health Connection: CAP	Within 45 days	No	Yes
	Nebraska Health Connection: PCCM	Within 45 days	No	Yes
New Jersey	New Jersey Care 2000	Yes	Yes	Yes
New Mexico	Salud!	No	Not required, but most have case manager	No
New York	NY Partial Cap Program	Within 90 days		Not required, but some do
	NY State Voluntary Managed Care Program	Within 90 days	No	No

* This applies to capitated programs.
Blanks are non-responses.

State	Program Name	Specific time requirement to see PWD	Case Manager Requirement*	Health Questionnaire or Assessment Requirement
North Carolina	Carolina Access	No		No
	Health Care Connections / HMO Program	Within 90 days	Not required, but most have case manager	No
Ohio	Accessing Better Care (ABC)	Within 30 days	Yes	Yes
Oregon	Oregon Health Plan: Cap Plan	No	Not required, but most have case manager	No
	Oregon Health Plan: PCCM Model	No		No
Pennsylvania	Family Care Network	No		No
	Health Choices	Within 45 days	Yes	Yes
	Voluntary HMOs	No	No	Yes
South Carolina	Medicaid HMO	No		No
	Physician Enhanced Program	No		No
South Dakota	Provider and Recipient in Medicaid Efficiency (PRIME)	No		No
Tennessee	TennCare	No	Yes	No
Texas	Star -- HMO	No	Yes	No
	Star -- PCCM	No	No	No
Utah	The Choice of Health Care Delivery: CAP Program	Yes	Not required, but most have case manager	Yes
	The Choice of Health Care Delivery: PCCM Program	No		No
Vermont	Vermont Health Access Program	No	Yes	Yes
Virginia	Medallion	No		
	Medallion II	No		
	Options	No		
West Virginia	Physician Assured Access System	No		No
Wisconsin	Independent Care (I-Care)	Yes	Yes	No

Source: ESRI Survey of Medicaid staff, Summer 1998.

In all, only three state Medicaid offices (other than those that operate specialized programs only) indicate that they monitor disenrollments by disability status. Two of these states, Nebraska and Oregon, believe that persons with disabilities disenroll at somewhat higher rates than those of the general population; the Massachusetts *Primary Care Clinician Program*, however, appears to have lower-than-average rates of disenrollment among persons with disabilities.

Special Enrollment or Program Features for Persons with Disabilities

We asked Medicaid staff to describe any special features that are in place for enrolling persons with disabilities in managed care programs. We also asked them about special program features that pertain

* This applies to capitated programs.
Blank spaces represent non-responses.

specifically to this population. Most of the PCCM and capitated programs use one enrollment process for all enrollees, regardless of whether the person is on SSI or is part of the general Medicaid population. Some of these programs, however, modify this process in some way to serve persons with disabilities. These modifications are described in Table 9.

Two states – New Jersey and Texas – operate programs that are mandatory for the general Medicaid population, but voluntary for persons with disabilities. Persons with special health care needs in Alabama, Maryland, and Nebraska can enroll through home visits by Medicaid staff or enrollment personnel. Other states devote more time to enrolling persons with disabilities, run outreach programs, and/or train staff specifically for this purpose. New Mexico, for example, has contracted with six special needs groups to help facilitate enrollment of various populations, including those with HIV/AIDS and mental illness.

Table 9: Special Enrollment Features for Persons with Disabilities (PWD)

State	*Program*	*Special Enrollment Features*
Alabama	Better Access for You (BAY)	Medicaid will conduct home visits to enroll persons with special health care needs.
Kentucky	Health Care Partnerships	MCOs (Partnerships) must have protocols in place for enrolling PWD.
Maryland	Health Choices	Medicaid will conduct home visits to enroll persons with special health care needs.
Massachusetts	HMO Program and Primary Care Clinician Program	All autoassignments are made to the PCCM program. The program will not autoassign to a PCP, but will continue to work with the enrollee to select a provider.
Montana	HMO Program and Passport to Health	Enrollment materials and information packets are targeted directly to persons with disabilities.
Nebraska	Nebraska Health Connections: capitated and PCCM options	The enrollment process for persons with disabilities includes home visits, special transportation if necessary, and outreach.
New Jersey	New Jersey Care 2000	Enrollment is voluntary for persons with disabilities, but mandatory for the general Medicaid population.
New Mexico	Salud!	Enrollment personnel receive special training to assist them in working with persons with special health care needs. State contracted with six special needs groups for community-level outreach.
North Carolina	HMO Program and Health Care Connections	Persons with disabilities have a longer period of time to choose a plan or provider than enrollees in general Medicaid.
Ohio	Accessing Better Care	MCOs have outreach staff who are trained to work with people who are disabled.
Oregon	Oregon Health Plan: capitated and PCCM options	The PCCM program does not autoassign persons with disabilities. In the capitated program, specially trained caseworkers work closely with enrollees to help them select a health plan and provider.
Pennsylvania	Family Care Network	If a person with special health care needs has a current provider he or she wishes to continue seeing (either as a PCP or a specialist), the program will attempt to bring that provider into the network.
Texas	Texas Star HMO Program and Star PCCM	Enrollment is voluntary for persons with disabilities, but mandatory for the general Medicaid population.
Utah	Choice of Health Care Delivery: capitated and PCCM options	Enrollment personnel spend more time with persons with disabilities, trying to link them with the most appropriate plan or provider for their particular health care needs.
Vermont	Vermont Health Access Program	Enrollment personnel receive special training to assist them in working with persons with special health care needs; outreach program targets community health centers.
West Virginia	Physician Assured Access System	Volunteers assist persons with special needs in the enrollment process.
Wisconsin	I-Care	Care coordinator assigned to each new enrollee. Outreach programs.

Source: ESRI Survey of Medicaid staff, Summer 1998.

Some of the states also have special program features for persons with disabilities in managed care, as is seen in Table 10. Some of these states run programs exclusively for persons with chronic conditions and disabilities; consequently, all of the program features are geared toward caring for persons with special health care needs. An example of such a program is the *I-Care* program in Wisconsin, which provides enrollees with a care coordinator who helps arrange for necessary services from both PCPs and social services agencies. In addition, the *I-Care* program helps members choose a PCP, assists with transportation to and from appointments, and provides a number of prevention classes.[50]

Some states with mainstream programs also include special features for their disabled enrollees. As was mentioned previously, Oregon's capitated program requires MCOs to have an exceptional needs care coordinator on staff, and also provides elderly individuals and persons with disabilities access to an 800-number "hot line" that handles complaints and concerns about the managed care program. With few exceptions, however, most of the programs have limited special enrollment or program features for persons with disabilities. As a rule, they tend to follow the same enrollment process as the general Medicaid population. Some plans identify individuals on staff who can work with persons with disabilities as care coordinators; otherwise, they follow the same policies and procedures as other enrollees in the program.

[50] Medicaid Managed Care News from the Department of Health and Family Services and the Division of Health. "Wisconsin Plans Expansion of Managed Care Option for Recipients with Disabilities." *Forward.* Wisconsin Medicaid: January 1998.

Table 10: Special Program Features for Person with Disabilities (PWD)

State	*Program*	*Special Program Features*
Alabama	Better Access for You (BAY)	Persons with special needs or AIDS can continue to see providers outside of the BAY network.
Arizona	Arizona Health Care Cost Containment Commission	MCOs must include on list of network providers some who are recognized in the community as AIDS / HIV experts.
Delaware	Diamond State Health Plan	Children with disabilities are assigned case manager by MCO. MCOs cannot change care plans without first conducting home visit. Persons with HIV / AIDS can opt out of the program and receive care on a fee-for-service basis under an AIDS waiver.
District of Columbia	Health Services for Children with Special Needs	All services are targeted to children with special needs. Emphasis on supportive and wrap-around services in the home and community.
Florida	Medipass	MCOs are required to monitor conditions of persons with disabilities on an ongoing basis. Will soon begin disease management initiative for persons with HIV / AIDS.
Kentucky	Health Care Partnerships	MCOs (Partnerships) must have care plan for medically fragile enrollees. Generally provide additional benefits to enrollees with AIDS / HIV.
Indiana	Voluntary Risk-Based Managed Care for Persons with Disabilities	Specialists can serve as primary medical providers.
Maryland	Health Choices	MCOs must assign a special needs coordinator to persons with disabilities.
Massachusetts	HMO Program	Additional care management services are provided for persons with chronic conditions and disabilities.
Michigan	Children's Special Health Care Plan	All services are targeted to children with special needs. Emphasis on supportive and wrap-around services in the home and community.
Montana	HMO Program and Passport to Health	Enrollment materials and information packets are targeted directly to persons with disabilities.
New Mexico	Salud!	State monitors complaints and grievances by persons with disabilities in MCOs.
North Carolina	Health Care Connections	HIV case management services do not require PCP referral.
Ohio	Accessing Better Care	Includes special services for enrollees. Strong emphasis on team approach to clinical care and case management. Contractor networks must have demonstrated experience serving target population.
Oregon	Oregon Health Plan (capitated option)	Hot line for complaints to ombudsman's office, exceptional needs care coordinator position required in each of the health plans.
Pennsylvania	Health Choices	All persons with disabilities are required to be seen by a provider within 45 days of enrollment.
Tennessee	TennCare	Consumer advocacy program assists persons with disabilities in negotiating social services. Children's special services program provides care coordination by nurses and social workers for children with special health care needs. State designated AIDS Center of Excellence provides comprehensive approach to AIDS / HIV care.
Vermont	Vermont Health Access Program	One of the MCOs targets a staff member to work with enrollees on SSI, and the other MCO conducts outreach.
Wisconsin	Independent Care	MCO conducts assessment on all enrollees and develops care plan. Very broad provider network allows many enrollees to retain providers.

Source: ESRI Survey of Medicaid staff, Summer 1998.

Behavioral Health

States have very different ways of approaching the delivery of behavioral health services – both for persons with disabilities and for the general Medicaid population. Table 11 describes the behavioral health arrangements that apply to each of the managed care programs that enroll non-elderly persons with disabilities. The table shows the program (capitated versus PCCM is shown in brackets), the type of financing arrangements, and key program features.[51]

There are three basic models for the delivery of behavioral health services: [52]

1. Persons in capitated arrangements can receive mental health and substance abuse services through their MCO. In this model, the MCO either provides the services directly, or subcontracts with a behavioral health organization (BHO) for all or part of the care.
2. Persons in capitated or PCCM arrangements can receive mental health and substance abuse services on a fee-for-service basis.
3. Persons in capitated or PCCM arrangements can receive mental health and substance abuse services from a BHO, which is paid a per-member, per-month capitated fee.

[51] Table 11 illustrates the way that behavioral health is delivered and financed for persons enrolled in the managed care plan. In many of the states, however, there is no program relationship between the medical/surgical managed care program and the behavioral health program.

[52] Depending on the state, persons not in managed care, who receive their health care on a fee-for-service basis, either receive behavioral health services on a fee-for-service basis as well, or participate in managed behavioral health plans. Iowa has mandatory mental health and substance abuse managed care programs for all Medicaid enrollees, including persons with disabilities, who are ineligible for the state's somatic managed care program.

Table 11: Behavioral Health Services for Persons with Disabilities (PWD) in Managed Care[♦]

State	Programs	Model	Key Features
Alabama	BAY Program [C]	Capitated	MCO subcontracts with one BHO.
	Patients 1st [P]	Fee-for-service	
Arizona	Arizona Health Care Cost Containment System [C]	Mostly capitated	MCO subcontracts with several regional BH agencies. Indians in tribes receive services on FFS basis.
Arkansas	Connect Care [P]	Fee-for-service	
California	All programs [C,P]	Mixed	Each of 56 counties has capped "budget" for Medicaid eligibles. Counties provide some MH services directly. Other MH and all SA services are referred to providers for care on FFS basis. MCOs provide very limited MH services.
Colorado	Medicaid HMO Program and Primary Care Physician Program [C,P]	Mixed	Eight regional Mental Health Assessment Service Agencies (MHASAs) receive capitated rates for assessments and direct services for certain covered MH services. Other MH and all SA services are referred to providers outside MHASAs, who are paid on FFS basis.
Delaware	Diamond State Health Plan [C]	Mixed	MCOs provide short-term outpatient benefits for children only. State handles chronic inpatient and outpatient care at bundled FFS rate.
District of Columbia	Health Services for Children with Special Needs [C]	Capitated	MCO provides all BH services.
Florida	Medicaid HMO Program [C]	Mixed	In five counties, MCOs subcontract with BHOs for all MH except community services, which are FFS. In rest of state, MH is FFS. SA services in entire state are FFS.
	Medipass [P]	Mixed	In five counties, enrollees receive BH from single BHO. Other counties are FFS.
Georgia	HMO program and Georgia Better Health Care [C, P]	Fee-for-service	
Idaho	Healthy Connections[P]	Fee-for-service	
Indiana	Voluntary Risk-Based Managed Care for Persons with Disabilities [C]	Capitated	MCO provides all BH services. Persons with SPMI are not eligible for program.
Kansas	Healthy Connect [P]	Fee-for-service	
Kentucky	Health Care Partnerships [C]	Capitated	Regional BHOs provide all BH services.
Louisiana	Community Care [P]	Fee-for-service	
Maryland	Health Choices [C]	Mixed	Primary care BH services included in MCO capitation rate. All other services are FFS and provided by state MH system.

♦ This table includes only those states that enroll persons with disabilities in Medicaid managed care programs.

State	Programs	Model	Key Features
Massachusetts	HMO Program [C]	Capitated	MCOs provide all BH services.
	Primary Care Clinician Program [P]	Capitated	One BHO provides all BH services.
Michigan	Children's Special Health Care Services and Comprehensive Health Plan [C]	Fee-for-service	
Mississippi	Capitated Managed Care Pilot [C]	Fee-for-service	
Montana	Medicaid HMO and Passport to Health [C,P]	Capitated	One BHO provides all BH services to enrollees in both programs.
Nebraska	Nebraska Health Connection HMO and PCCM programs [C,P]	Capitated	One BHO provides all BH services. SA services covered for children up to age 18 only.
New Jersey	New Jersey Care 2000 [C]	Fee-for-service	
New Mexico	Salud! [C]	Capitated	MCOs subcontract with multiple BH providers.
New York	Voluntary Managed Care Program [C]	Mixed	
	Partial Capitation Program [P]	Fee-for-service	MCOs provide limited inpatient and outpatient services. Persons with SPMI mostly in FFS.
North Carolina	Health Care Connection / Voluntary HMO Program [C]	Capitated	One BHO provides all BH services.
	Carolina Access [P]	Mixed	One BHO provides all BH services in participating counties only. Other counties are FFS.
Ohio	Accessing Better Care [C]	Mixed	MCO provides limited BH services. Other services provided on FFS basis. Persons with SPMI are ineligible for program.
Oregon	Oregon Health Plan: HMO Model [C]	Mixed	MCOs subcontract with MH organizations for most MH services. SA services provided by MCO, except for inpatient stays after detox, which are paid FFS.
	Oregon Health Plan: PCCM Model [P]	Mixed	MH services provided on capitated basis through MH organizations. SA services provided via PCP referrals, paid FFS.
Pennsylvania	Healthy Choices [C]	Capitated	Counties, acting as BHOs, provide all services.
	Voluntary HMOs [C]	Mixed	In certain counties, MCO provides all services. In other counties, services are FFS.
	Family Care Network [P]	Fee-for-service	
South Carolina	Medicaid HMOs [C]	Mixed.	MCO covers first $1,000 in BH service costs. Additional services covered FFS.
	Physician Enhanced Program [P]	Fee-for-service.	
South Dakota	PRIME [P]	Fee-for-service.	
Tennessee	TennCare [C]	Capitated.	Two BHOs provide all BH services.

State	Programs	Model	Key Features
Texas	Star HMO Program [C]	Mixed	MCOs subcontract with BHOs to provide all SA and limited MH services. Other MH services are FFS.
	Star PCCM Program [P]	Fee-for-service.	
Utah	Choice of Health Care Delivery Program, HMO and PCCM programs [C,P]	Mixed.	MH MCO provides MH services. SA services are FFS.
Vermont	Vermont Health Access Program [C]	Mixed	MCOs subcontract with BHOs for services. Services other than inpatient stays are under separate FFS arrangement for persons with SPMI.
Virginia	Options [C]	Capitated.	MCOs provide all services.
	Medallion II [C]	Fee-for-service.	Until recently, MCOs provided services through capitated rate. Services are now provided FFS by community service boards.
	Medallion [P]	Fee-for-service.	
West Virginia	Physician Assured Access System [P]	Fee-for-service.	
Wisconsin	Independent Care (I-Care) [C]	Capitated.	MCO provides all BH services.

[C] or [P] designates whether program is capitated [C] or primary care case management [P] model.
MH = Mental Health.
SA = Substance Abuse
MCO = Managed Care Organization
BHO = Behavioral Health Organization
FFS = Fee-for-service
SPMI = Serious and Persistent Mental Illness

Source: ESRI Survey of Medicaid staff, Summer 1998.

As can be seen from Table 11, some states create hybrids of these models and provide only certain services on a capitated basis. Some states also differentiate between persons with serious and persistent mental illness (SPMI), who have one set of benefits, and other persons with less complex mental health needs. And a few states exclude persons with SPMI from their capitated behavioral health arrangements. For example, persons with SPMI are ineligible for the managed mental health program in Delaware and are instead cared for on a fee-for-service basis. Indiana's *Voluntary Risk-Based Managed Care Plan for Persons with Disabilities* covers behavioral health within its capitated rate, but excludes persons with SPMI from the program. A few states also separate coverage of mental health and substance abuse services, either by services or populations covered.

Most of the PCCM programs do not use capitated arrangements for behavioral health services. Massachusetts, however, requires all managed care enrollees to be in a capitated behavioral health program. Persons in the HMO program receive all services from their MCO, and PCCM enrollees receive all services from one BHO that serves the entire state. In Utah, all enrollees in the PCCM and capitated options receive mental health services from one MCO, with substance abuse services provided on a fee-for-service basis.

Conclusion

At the time of our survey, there were approximately 1.6 million persons with disabilities in Medicaid managed care arrangements, about two-thirds of whom were in capitated programs. These numbers are likely to grow over the next several years, as states that currently have programs expand them geographically, add new segments of the disabled population, and change the programs' enrollment requirements from voluntary to mandatory. Additionally, some of the 15 states that do not now enroll persons with disabilities are likely to change that policy over the next few years.

Perhaps surprisingly, the vast majority of persons with disabilities in Medicaid programs have been mainstreamed into managed care arrangements with the general population, with very few special enrollment or program features to support their considerable needs for health care services. While it is not possible, in this study, to evaluate how well these programs are serving the needs of persons with disabilities, we can report that Medicaid officials across the country believe that many of these programs are vast improvements over previous fee-for-service arrangements. Most of these programs include traditional safety net providers in the MCO or PCCM networks, both to maintain quality of care and minimize the disruption and discontinuity that can occur with plan and provider switching.

This is not to say that enrolling persons with disabilities into Medicaid managed care has been an easy undertaking, or that the states have resolved all of the enrollment, service delivery, or quality issues that are vital to the safe and appropriate care of persons with disabilities. Several of the programs have run into difficulties with their managed care programs for persons with disabilities; Minnesota and Washington, for example, do not currently enroll persons with disabilities into Medicaid managed care arrangements, despite having done so in the past. Medicaid officials in Washington decided to discontinue enrollment when health plans became reluctant to participate in the state's program because their costs in serving this population often greatly exceeded their reimbursement rates. Minnesota discontinued enrollment for persons with disabilities when the health plan that attracted the majority of these individuals pulled out of the state's Medicaid managed care market. Other states are aware of problems with certain

aspects of their programs, but will try to resolve them administratively or by adding new features in their next round of contracts with MCOs and providers.

Also, as these programs mature, state Medicaid offices will receive encounter data that will allow them to assess whether persons with disabilities are receiving the types of services that they require. Currently, all of the capitated programs require participating MCOs to submit encounter data, but all of the states say that the data does not yet provide useful information for evaluating health service delivery.[53] Improved encounter data, coupled with targeted external quality assurance studies conducted by the states, could yield valuable information about how well persons with disabilities are cared for by Medicaid managed care arrangements.

[53] While states report that certain MCOs are providing at least some useful data, they are constrained in their ability to compare among program options until all MCOs provide such data. No state indicated that they have this data at this point.

Section II. State Profiles: Descriptions of Medicaid Managed Care Programs that Enroll Non-elderly Persons with Disabilities

This section provides brief profiles of the Medicaid managed care programs that enroll at least some non-elderly persons with disabilities. They appear in alphabetical order by state; in states with both capitated and PCCM options, the capitated program precedes the PCCM program.

Each profile includes information about enrollment, rate-setting, autoassignment, and various enrollment or program features as they relate to persons with disabilities. In some cases, however, these features also apply to the general Medicaid population as well. For example, some states require MCOs to contact new enrollees within a certain time period; in most cases, these requirements apply to the general Medicaid population as well as enrollees with disabilities or other special health care needs. We have made an attempt to identify those cases that apply to persons with disabilities only.

A brief note about the enrollment figures: Both the estimated program enrollment and the estimated enrollment of persons with disabilities (PWD) include non-elderly enrollees only. In cases where these estimates were not available from the state (that is, in cases where the state was unable to estimate the number of elderly individuals in the program), we used a discount formula to estimate the number of non-elderly enrollees in the program.[54]

[54] We used a very conservative discount (equal to about 20 percent of the state's elderly Medicaid population) that probably understates the number of elderly enrollees in the programs.

ALABAMA: Better Access for You (BAY)

Waiver Authority: **1115** **Model:** **CAP**

Estimated Program Enrollment: **37,320**

Estimated Enrollment of PWD: **9,000**

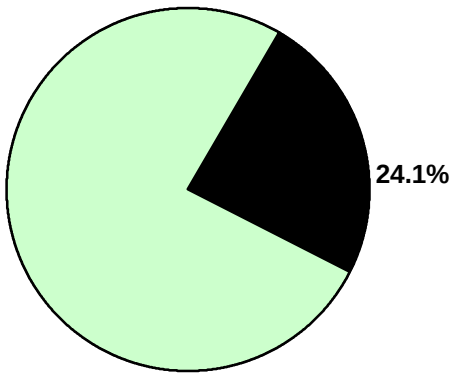
Enrollment is **mandatory.**

Program operates **in Mobile County only**.

Ages enrolled: **all ages**

Number of Managed Care Organizations: **1**

Program Enrollment of PWD



Autoassignment is based on **previous provider and geographic area.**

Capitation rates vary by **SSI eligibility and age.**

Services carved out of the capitated rate: **Eyeglasses, long-term care facility fee, most transplants, non-emergency transportation, home- and community-based waiver services and targeted case management.**

This program:

- **does not have** an enrollment broker.
- **has** a guaranteed eligibility period of **6 months.**
- **has** a lock-in period.
- **requires** PCP to see the new enrollee within **9 months**.
- **does not require** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health services are **included in the BAY program capitation rate. The MCO subcontracts with one BHO for mental health and substance abuse services.**

Special enrollment, program or quality assurance features:

BAY personnel will conduct home visits to enroll persons with special needs. Persons with AIDS/other special needs can continue to see some providers outside of the BAY network. Program has external review of ambulatory follow-up after hospitalization for selected mental illnesses.

ALABAMA: Patients 1st

Waiver Authority: 1915b Model: PCCM

Estimated Program Enrollment: **208,350**

Estimated Enrollment of PWD: **15,000**

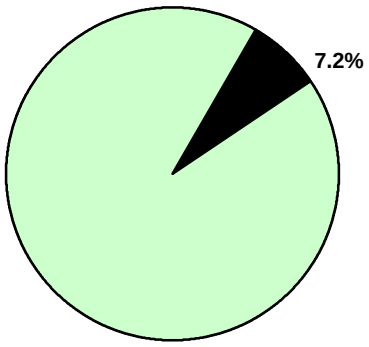
Enrollment is **mandatory.**

Program operates **in 50 of 66 counties.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



Autoassignment is based on **previous provider.**

This program:

- **allows** specialists to serve as PCP.
- **does not have** an enrollment broker.
- **has** a lock-in period of **1 month**.
- **does not require** PCP to see the new enrollee within a specific time.
- **does not require** an initial health assessment.

Behavioral health services are **provided on a fee-for-service basis. Services from community mental health centers are not included in the PCCM program.**

Special enrollment, program or quality assurance features:
None.

ARIZONA: Arizona Health Care Cost Containment System

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **407,760**

Estimated Enrollment of PWD: **56,200**

Enrollment is **mandatory.**

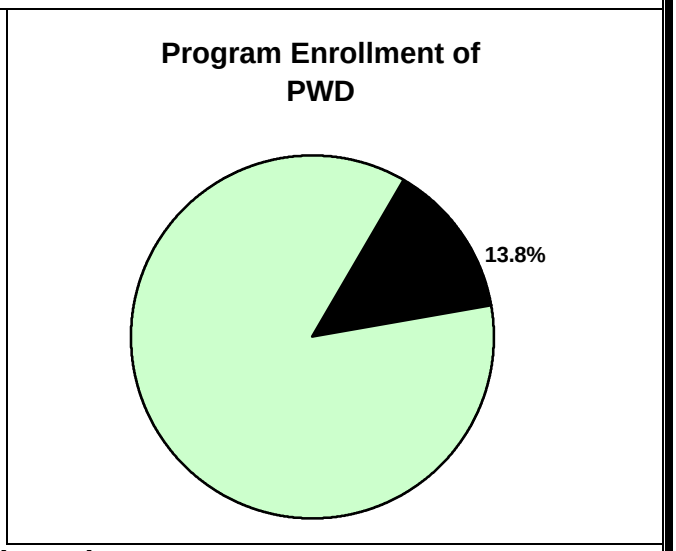
Program operates **statewide.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **12**

Autoassignment is based on **geographic area.**

Capitation rates vary by **SSI eligibility, age and gender.**



Services carved out of the capitated rate: **none.**

This program:

- **does not have** an enrollment broker.
- **has** a guaranteed eligibility period.
- **has** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **does not require** an initial health assessment.

Behavioral health services are **mostly capitated. MCOs subcontract with several behavioral health agencies. Indians in tribes receive services on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

About half of the MCOs conduct a health assessment. MCOs must include recognized experts in HIV/AIDS among their network providers.

ARKANSAS: Connect Care

Waiver Authority: 1115 Model: PCCM

Estimated Program Enrollment: **179,630**

Estimated Enrollment of PWD: **25,470**

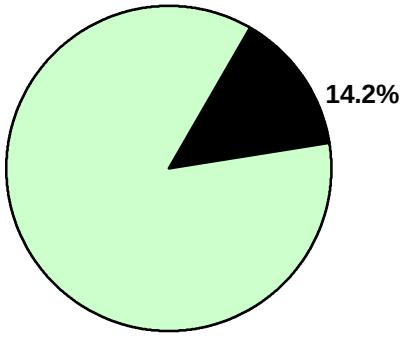
Enrollment is **mandatory.**

Program operates **statewide.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



Autoassignment is based on **geographic area.**

This program:

- **does not allow** specialists to serve as PCP.
- **does not have** an enrollment broker.
- **has** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health services are **provided on a fee-for-services basis.**

Special enrollment, program or quality assurance features:
None.

CALIFORNIA: County Organized Health System

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **387,470**

Estimated Enrollment of PWD: **112,600**

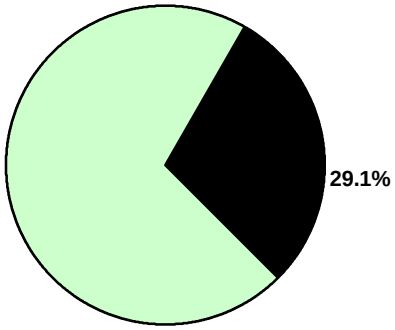
Enrollment is **mandatory.**

Program operates in **6 counties.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **5**
(Each of these subcontracts with a variety of providers, including many HMOs.)

Program Enrollment of PWD



Autoassignment is based on **previous provider, geographic area and language.**

Capitation rates vary by **SSI eligibility, age and gender. Rates are adjusted to reflect AIDS diagnosis.**

Services carved out of the capitated rate: **Behavioral health and long-term care (in some counties).**

This program:

- **does not have** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **120 days**.
- **does not require** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health services are **provided on a mixed basis. Each of 56 counties has a capped "budget" for Medicaid eligibles. Counties provide some mental health services directly. Other mental health and all substance abuse services are referred to providers for care on a fee-for-service basis. MCOs provide very limited mental health services.**

Special enrollment, program or quality assurance features:

Enhanced SSI/AIDS capitation rate. Program has external study of care received by SSI population.

CALIFORNIA: Geographic Managed Care

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **136,770**

Estimated Enrollment of PWD: **7,200**

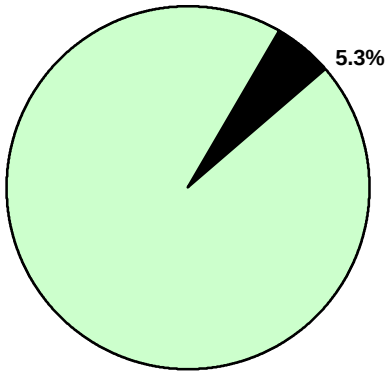
Enrollment is **voluntary.**

Program operates **in Sacramento and San Diego Counties.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **5**

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility.**

Services carved out of the capitated rate: **Behavioral health and some pharmaceuticals.**

This program:

- **Has** an enrollment broker.
- **Does not have** a guaranteed eligibility period.
- **Does not have** a lock-in period.
- **Requires** PCP to see the new enrollee within **120 days**.
- **Does not require** the MCO to assign a case manager to PWD.
- **Does not require** an initial health assessment.

Behavioral health services are **provided on a mixed basis. Each of 56 counties has a capped "budget" for Medicaid eligibles. Counties provide some mental health services directly. Other mental health and all substance abuse services are referred to providers for care on a fee-for-service basis. MCOs provide very limited mental health services.**

Special enrollment, program or quality assurance features:

None.

CALIFORNIA: Prepaid Health Plans

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **395,160**

Estimated Enrollment of PWD: **16,200**

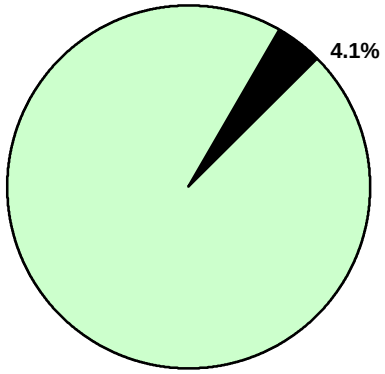
Enrollment is **voluntary.**

Program operates in **two counties. This program is being phased out of San Diego County but is still operating in Sacramento County.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **1**

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility.**

Services carved out of the capitated rate: **Behavioral health.**

This program:

- **does not have** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **120 days**.

Behavioral health services are **provided on a mixed basis. Each of 56 counties has a capped "budget" for Medicaid eligibles. Counties provide some mental health services directly. Other mental health and all substance abuse services are referred to providers for care on a fee-for-service basis. MCOs provide very limited mental health services.**

Special enrollment, program or quality assurance features:
None.

CALIFORNIA: Two Plan Model

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **876,010**

Estimated Enrollment of PWD: **31,000**

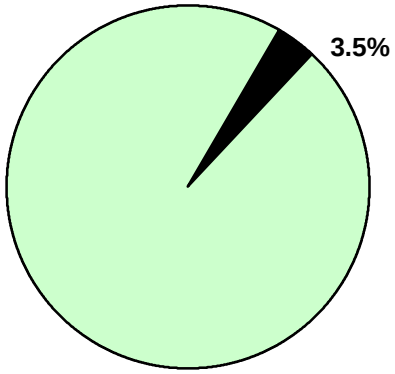
Enrollment is **voluntary.**

Program operates in **12 counties.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **2**
per participating county
Capitation rates vary by **SSI eligibility.**

Program Enrollment of PWD



Services carved out of the capitated rate: **Behavioral health, some pharmaceuticals, chiropractic, adult day care and some services for children with special needs.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **120 days**.
- **does not require** the MCO to assign a case manager to PWD.

Behavioral health services are **provided on a mixed basis. Each of 56 counties has a capped "budget" for Medicaid eligibles. Counties provide some mental health services directly. Other mental health and all substance abuse services are referred to providers for care on a fee-for-service basis. MCOs provide very limited mental health services.**

Special enrollment, program or quality assurance features:
None.

CALIFORNIA: PCCM Program

Waiver Authority: 1915b Model: PCCM

Estimated Program Enrollment: **11,770**

Estimated Enrollment of PWD: **1,000**

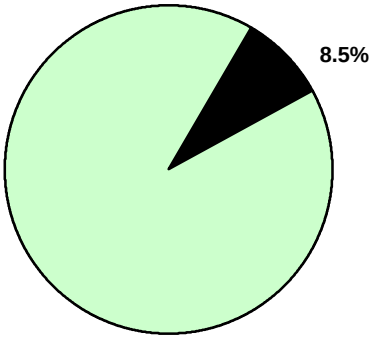
Enrollment is **voluntary.**

Program operates in **counties/regions.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **varies by county/region**

Program Enrollment of PWD



This program:

- **does not allow** specialists to serve as PCP.
- **does not have** an enrollment broker.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **120 days**.

Behavioral health services are **provided on a mixed basis. Each of 56 counties has a capped "budget" for Medicaid eligibles. Counties provide some mental health services directly. Other mental health and all substance abuse services are referred to providers for care on a fee-for-service basis. MCOs provide very limited mental health services.**

Special enrollment, program or quality assurance features:
None.

COLORADO: Medicaid HMO Program

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **70,030**

Estimated Enrollment of PWD: **8,500**

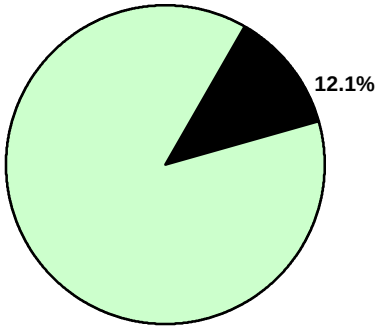
Enrollment is **mandatory (although enrollees can choose either the PCCM or capitated option).**

Program operates **statewide (although some counties are not yet participating).**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **6**

Program Enrollment of PWD



Autoassignment is based on **previous provider, enrollment of family member, geographic area, and condition or disability.**

Capitation rates vary by **SSI eligibility, age, gender and geographic area. Rates are also adjusted based on prior resource use.**

Services carved out of the capitated rate: **Most behavioral health services.**

This program:

- **has** an enrollment broker.
- **has** a guaranteed eligibility period.
- **has** a lock-in period of **6 months**.
- **requires** PCP to see the new enrollee within a specific time period.
- **does not require** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a mixed basis. Eight regional Mental Health Assessment Service Agencies (MHASA) receive capitated rates for all Medicaid enrollees. This covers assessments for all persons needing mental health or substance abuse services, as well as direct care for certain covered mental health services. Other mental health services and all substance abuse services are referred to providers outside of MHASAs, who are paid on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

Persons with disabilities go through an expedited screening process that includes a health assessment at the time of enrollment or shortly after enrollment. QA program includes additional provisions for persons with disabilities. Program has an external study on discharge planning.

COLORADO: Primary Care Physician Program

Waiver Authority: 1915b Model: PCCM

Estimated Program Enrollment: **47,150**

Estimated Enrollment of PWD: **5,000**

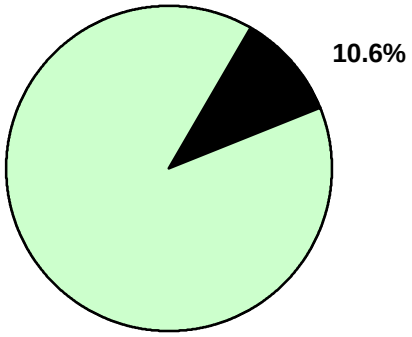
Enrollment is **mandatory (although enrollees can choose either the PCCM or capitated option).**

Program operates **statewide, except for two counties.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



This program:

- **allows** specialists to serve as PCP.
- **has** an enrollment broker.
- **has** a lock-in period of **12 months.**
- **does not require** PCP to see the new enrollee within a specific time period.

Behavioral health is **provided on a mixed basis. Eight regional Mental Health Assessment Service Agencies (MHASA) receive capitated rates for all Medicaid enrollees. This covers assessments for all persons needing mental health or substance abuse services, as well as direct care for certain covered mental health services. Other mental health services and all substance abuse services are referred to providers outside of MHASAs, who are paid on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

None.

DELAWARE: Diamond State Health Plan

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **63,040**

Estimated Enrollment of PWD: **4,000**

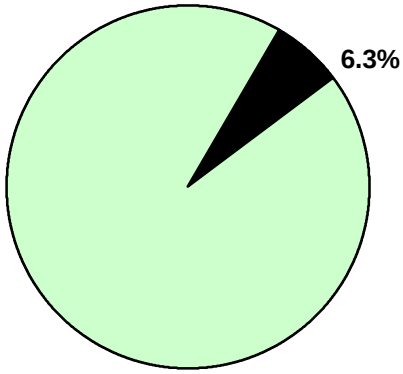
Enrollment is **mandatory.**

Program operates **statewide.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **3**

Program Enrollment of PWD



Autoassignment is based on **random assignment.**

Capitation rates vary **by SSI eligibility, age and gender.**

Services carved out of the capitated rate: **Pharmaceuticals.**

This program:

- **has** an enrollment broker.
- **has** a guaranteed eligibility period of **1 month.**
- **has** a lock-in period of **12 months.**
- **does not require** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a mixed basis. MCOs provide short-term outpatient benefits for children only. State handles chronic inpatient and outpatient care at bundled fee-for-service rate.**

Special enrollment, program or quality assurance features:

HIV/AIDS patients can opt out of managed care and receive care on a fee-for-service basis under an AIDS waiver. An MCO must conduct a home visit prior to changing a new enrollee's care plan. Program has external studies on mental health and children with special health needs.

DISTRICT OF COLUMBIA: Health Services for Children with Special Needs

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **2,000**

Estimated Enrollment of PWD: **2,000**

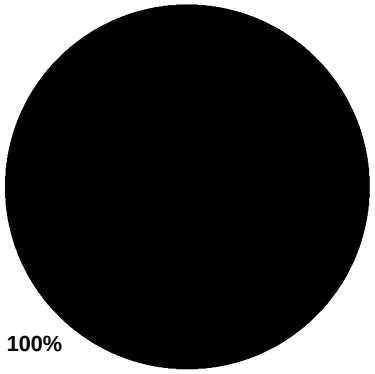
Enrollment is **voluntary.**

Program operates **district-wide.**

Ages enrolled: **0-22**

Number of Managed Care Organizations: **1**

Program Enrollment of PWD



Capitation rates **do not vary. The MCO and state share the risk for enrollees. If total costs exceed total capitation rates by 10 percent, the state and the MCO evenly share these excess costs. If total costs are less than 90 percent of total capitation rates, the MCO returns half of this amount to the state. The MCO has returned money to the state during these reconciliation periods.**

Services carved out of the capitated rate: **None.**

This program:

- **does not have** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a capitated basis, with the MCO providing all covered services.**

Special enrollment, program or quality assurance features:

All services are targeted to children with special needs. Emphasis on supportive and wrap-around services in the community. QA program includes provisions for person with disabilities.

FLORIDA: Medicaid HMO Program

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **372,300**

Estimated Enrollment of PWD: **70,000**

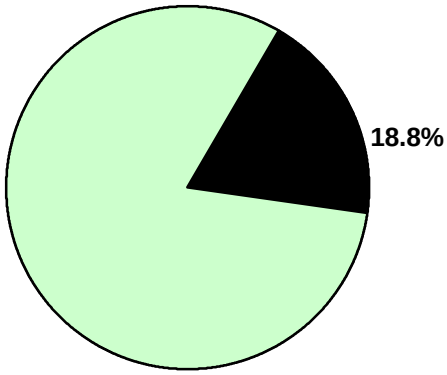
Enrollment is **mandatory (although enrollees can choose either the PCCM or capitated option).**

Program operates **statewide, aside from a few rural counties.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **16**

Program Enrollment of PWD



Autoassignment is based on **proportions chosen by those not requiring autoassignment.**

Capitation rates vary by **SSI eligibility, age and geographic area.**

Services carved out of the capitated rate: **Behavioral health.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **Requires** PCP to see the new enrollee within **90 days.**
- **does not require** the MCO to assign a case manager to PWD.
- **Requires** an initial health assessment.

Behavioral health is **provided on a mixed basis. In five counties, MCOs subcontract with BHOs for all mental health except community services, which are on a fee-for-service basis. In the rest of the state, mental health services are fee-for-service. All substance abuse services are fee-for-service.**

Special enrollment, program or quality assurance features:

MCOs are required to monitor the conditions of persons with disabilities on an ongoing basis. The state encourages community outreach and AIDS education programs.

FLORIDA: MediPass

Waiver Authority: 1915b Model: PCCM

Estimated Program Enrollment: **484,880**

Estimated Enrollment of PWD: **135,000**

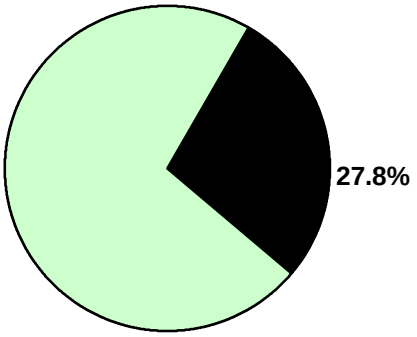
Enrollment is **mandatory (although enrollees can choose either the PCCM or capitated option).**

Program operates **statewide.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



Autoassignment is based on **geographic area, with children assigned to pediatricians or family physicians, and women to obstetricians/gynecologists**.

This program:

- **Allows** specialists to serve as PCP.
- **Has** an enrollment broker.
- **Does not have** a lock-in period.
- **Requires** PCP to contact the new enrollee within **90 days for a health screening.**
- **Requires** an initial health assessment.

Behavioral health is **provided on a mixed basis. In five counties, enrollees receive behavioral health services from a single BHO. Other counties are fee-for-service.**

Special enrollment, program or quality assurance features:

A disease management initiative is being developed for persons with HIV/AIDS.

GEORGIA: HMO Program

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **49,090**

Estimated Enrollment of PWD: **5,000**

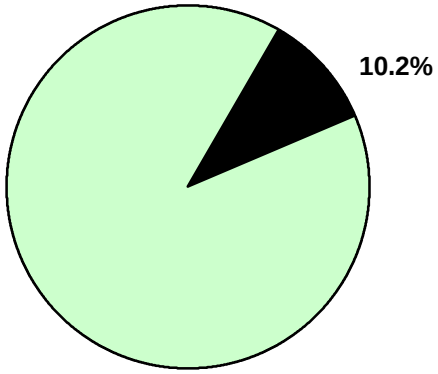
Enrollment is **voluntary.**

Program operates in **Metro Atlanta, Augusta, Savannah, and Macon.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **3**

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility, age, gender and geographic area.**

Services carved out of the capitated rate: **Behavioral health, dental and non-emergency transportation.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to contact the new enrollee within **90 days.**
- **does not require** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:
None.

GEORGIA: Georgia Better Healthcare

Waiver Authority: 1915b Model: PCCM

Estimated Program Enrollment: **612,090**

Estimated Enrollment of PWD: **87,000**

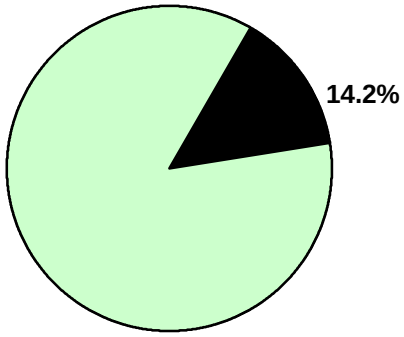
Enrollment is **mandatory.**

Program operates **statewide.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



Autoassignment is based on **previous provider and geographic area.**

This program:

- **allows** specialists to serve as PCP.
- **has** an enrollment broker.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

None.

IDAHO: Healthy Connections

Waiver Authority: 1915b Model: PCCM

Estimated Program Enrollment: **29,530**

Estimated Enrollment of PWD: **6,680**

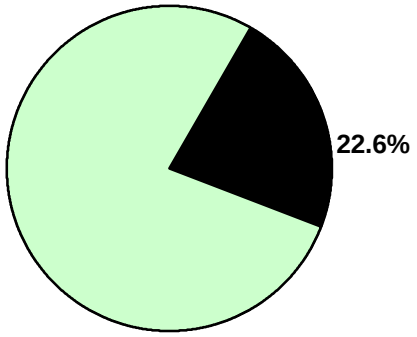
Enrollment is **mandatory in 2 counties and voluntary in other counties.**

Program operates **statewide (currently serving 38 of 44 counties).**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3.50**

Program Enrollment of PWD



This program:

- **allows** specialists to serve as PCP.
- **does not have** an enrollment broker.
- **does not have** a lock-in period.
- **does not require** PCPs to see the new enrollee within a specific time period.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:
None.

INDIANA: Voluntary Risk-Based Managed Care for Persons with Disabilities

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **70**

Estimated Enrollment of PWD: **70**

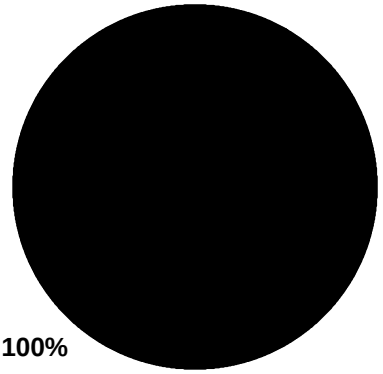
Enrollment is **voluntary.**

Program operates in **Marion County.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **1**

Program Enrollment of PWD



Capitation rates vary by **diagnostic categories**.

Services carved out of the capitated rate: **Hospice and long-term care.**

This program:

- **has** an enrollment broker.
- **has** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health services are **provided on a capitated basis by the MCO. Persons with the primary diagnosis of serious and persistent mental illness are not eligible for this program.**

Special enrollment, program or quality assurance features:

Program conducts surveys of enrollees after 1, 3, and 6 months as part of its QA.

KANSAS: Health Connect Kansas

Waiver Authority: 1915b Model: PCCM

Estimated Program Enrollment: **92,490**

Estimated Enrollment of PWD: **15,000**

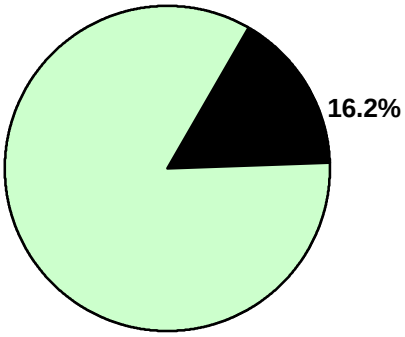
Enrollment is **mandatory.**

Program operates **statewide.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$2**

Program Enrollment of PWD



Autoassignment is based on **previous provider.**

This program:

- **does not allow** specialists to serve as PCP.
- **has** an enrollment broker.
- **has** a lock-in period of **6 months.**
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health services are **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:
None.

KENTUCKY: Health Care Partnerships

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **175,280**

Estimated Enrollment of PWD: **35,000**

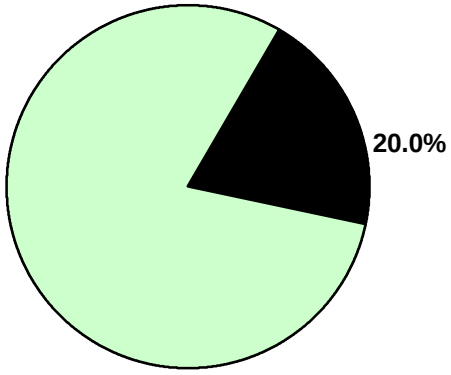
Enrollment is **mandatory.**

Program operates **statewide (still phasing in 6 of 8 regions in state)**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **8**
(1 "partnership" per region)

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility.**

Services carved out of the capitated rate: **Behavioral health.**

This program:

- **does not have** an enrollment broker.
- **has** a guaranteed eligibility period.
- **has** a lock-in period.
- **requires** PCP to contact the new enrollee within a specific time period.

Behavioral health is **provided on a capitated basis. Regional BHOs provide all mental health and substance abuse services.**

Special enrollment, program or quality assurance features:

MCOs must have care plan for medically fragile enrollees. Must have protocols in place for enrolling persons with disabilities. MCOs generally provide additional benefits to enrollees with HIV/AIDS. Program has QA external studies that pertain to persons with disabilities.

LOUISIANA: Community Care

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **52,410**

Estimated Enrollment of PWD: **12,550**

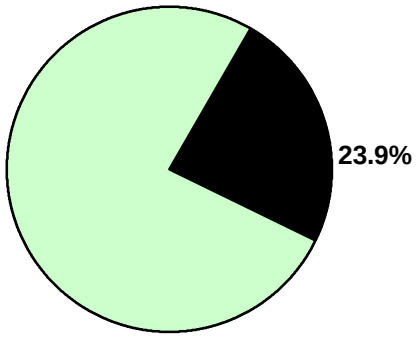
Enrollment is **mandatory.**

Program operates **in 20 of 64 parishes.**

Ages enrolled: **0-64**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



Autoassignment is based on **previous provider and geographic area.**

This program:

- **allows** specialists to serve as PCP.
- **has** an enrollment broker.
- **has** a lock-in period of **6 months**.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:
None.

MARYLAND: Health Choices

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **330,000**

Estimated Enrollment of PWD: **67,400**

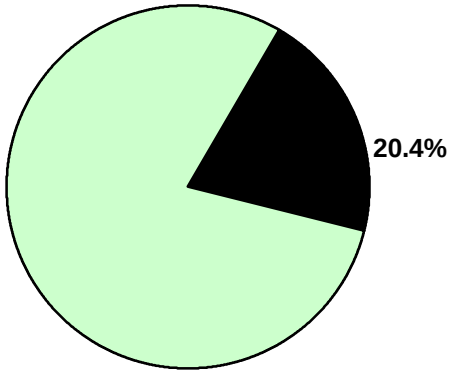
Enrollment is **mandatory.**

Program operates **statewide.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **9**

Program Enrollment of PWD



Autoassignment is based on **previous provider and availability of dental plan.**

Capitation rates vary by **SSI eligibility, age, gender and geographic area. Rates are also adjusted based on ambulatory care groups.**

Services carved out of the capitated rate: **AIDS drugs.**

This program:

- **has** an enrollment broker.
- **has** an **initial** guaranteed eligibility period of **6 months.**
- **does not have** a lock-in period **for the first year.**
- **requires** PCP to see the new enrollee within **90 days**.
- **requires** the MCO to assign a **special needs coordinator** to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a mixed basis. Primary care behavioral health services are included in the MCO's capitated rate. All other services are fee-for-service and provided by the State Mental Health System, which is run by the Mental Hygiene Administration.**

Special enrollment, program or quality assurance features:

Program conducts home visits to enroll persons with special health care needs.

MASSACHUSETTS: HMO Program

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **136,410**

Estimated Enrollment of PWD: **15,600**

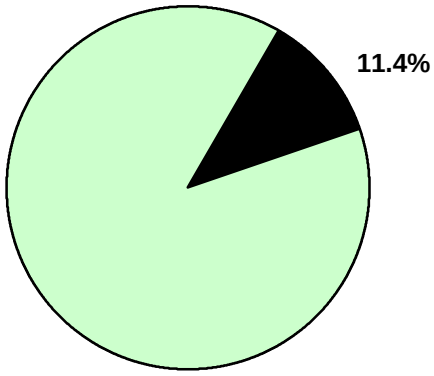
Enrollment is **mandatory (although enrollees can choose either the PCCM or capitated option).**

Program operates **statewide.**

Ages enrolled: **0-64**

Number of Managed Care Organizations: **6**

Program Enrollment of PWD



No Autoassignment for PWDs.

Capitation rates vary by **SSI eligibility, geographic area and risk-rating categories.**

Services carved out of the capitated rate: **Pharmaceuticals, institutional care, adult day care, day habilitation, vision, personal care attendant, private duty nursing, non-emergency dental and transportation.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment **from the enrollment broker**.

Behavioral health is **provided on a capitated basis by the MCO.**

Special enrollment, program or quality assurance features:

Program includes targeted care management for persons with HIV/AIDS and other chronic conditions and disabilities. Program conducts external reviews on clinical topics for persons with disabilities.

MASSACHUSETTS: Primary Care Clinician Program

Waiver Authority: **1115** **Model**: **PCCM**

Estimated Program Enrollment: **327,580**

Estimated Enrollment of PWD: **72,370**

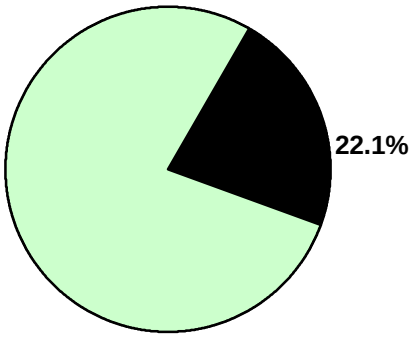
Enrollment is **mandatory (although enrollees can choose either the PCCM or capitated option).**

Program operates **statewide.**

Ages enrolled: **0-64**

Per Member Per Month fee to PCP: **None.**
PCPs receive enhanced (by $10) primary care visit payments.

Program Enrollment of PWD



No Autoassignment for PWDs.

This program:

- **allows** specialists to serve as PCP.
- **has** an enrollment broker.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **3 months**.
- **does not require** an initial health assessment.

Behavioral health is **provided on a capitated basis, with one BHO providing all services for Primary Care Clinician Program enrollees.**

Special enrollment, program or quality assurance features:

Persons with disabilities who do not choose a managed care option are placed in the PCCM option. There is a lengthy enrollment process that attempts to match persons with disabilities with current providers or another provider with expertise in a particular chronic illness or condition category.

MICHIGAN: Children's Special Health Care Services

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **130**
Enrollment began September 1, 1998 and will be phased in over 24 months.

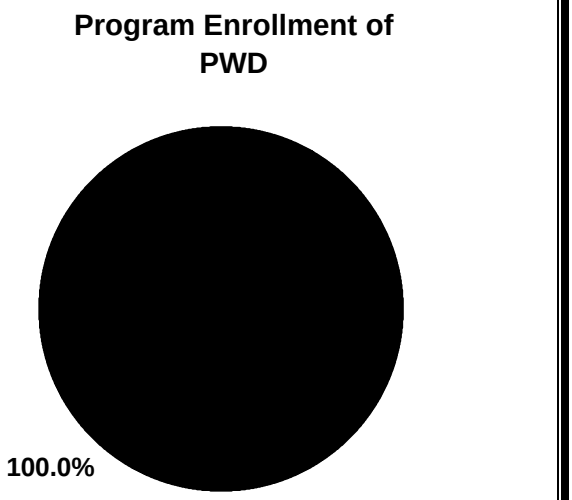
Estimated Enrollment of PWD: **130**

Enrollment is **voluntary.**

Program will operate **statewide.**

Ages enrolled: **0-21**

Number of Managed Care Organizations: **2**



Capitation rates vary by **SSI eligibility, age and geographic area. Rates are also adjusted by diagnostic categories.**

Services carved out of the capitated rate: **Behavioral health and dental.**

This program:

- **has** an enrollment broker.
- **has** a guaranteed eligibility period of **12 months**.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **60 days.**
- **requires** the MCO to assign a **care coordinator** to PWD.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

Within 60 days, a full care plan must be developed and accepted by both the provider and the child's parents. A protocol has been established for children with special health care needs. QA program includes additional provisions for persons with disabilities.

MICHIGAN: Comprehensive Health Plan Initiative

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **748,750**

Estimated Enrollment of PWD: **140,600 (Some of these are transitioning from the former PCCM option.)**

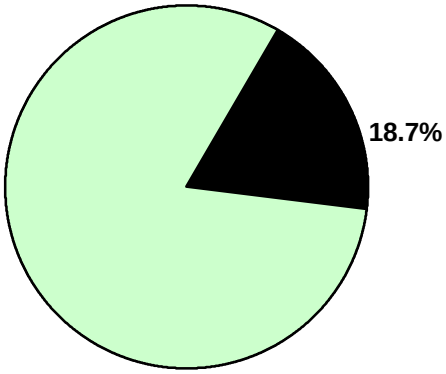
Enrollment is **mandatory.**

Program operates **in 5 counties in the Detroit metro area.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **30**

Program Enrollment of PWD



Autoassignment is based on the **MCO's rating in RFP process.**

Capitation rates vary by **SSI eligibility, age, gender and geographic area.**

Services carved out of the capitated rate: **Behavioral health.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **has** a lock-in period of **6 months**.
- **does not require** PCP to see the new enrollee within a specific time period.

Behavioral health is **provided on a fee-for-service basis through community mental health boards.**

Special enrollment, program or quality assurance features:
None.

MISSISSIPPI: Capitated Managed Care Pilot

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **9,140**

Estimated Enrollment of PWD: **800**

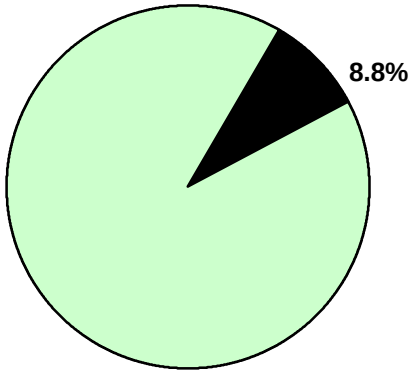
Enrollment is **voluntary.**

Program operates **in 6 counties.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **4**

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility, age, gender and geographic area.**

Services carved out of the capitated rate: **Behavioral health.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** the MCO to assign a case manager to PWD.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:
None.

MONTANA: Medicaid HMO

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **2,170**

Estimated Enrollment of PWD: **70**

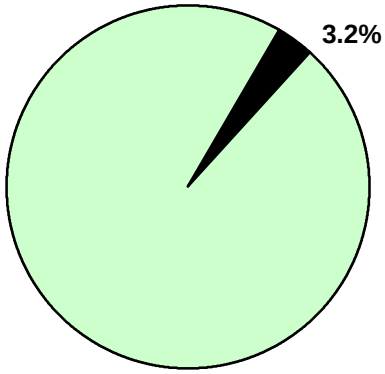
Enrollment is **voluntary.**

Program operates **in 2 counties.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **2**

Program Enrollment of PWD



Autoassignment is based on **previous provider.**

Capitation rates vary by **SSI eligibility and age.**

Services carved out of the capitated rate: **Behavioral health, dental, vision, personal care attendants and durable medical equipment.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** the MCO to assign a case manager to PWD.
- **does not require** an initial health assessment.

Behavioral health is **provided on a capitated basis. One BHO provides all services to enrollees in the capitated plan and in Montana's PCCM program, Passport to Health.**

Special enrollment, program or quality assurance features:

The HMO program is voluntary for the SSI population but mandatory for TANF and related individuals. External quality assurance studies have focused on cerebral palsy and pediatric asthma.

MONTANA: Passport to Health

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **44,170**

Estimated Enrollment of PWD: **6,000**

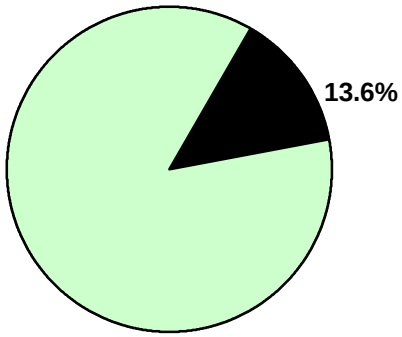
Enrollment is **mandatory.**

Program operates **in 52 of 56 counties**.

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



Autoassignment is based on **previous provider.**

This program:

- **allows** specialists to serve as PCP.
- **has** an enrollment broker.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a capitated basis. One BHO provides all services to enrollees in the PCCM program and in Montana's capitated Medicaid HMO program.**

Special enrollment, program or quality assurance features:

External quality assurance studies have focused on cerebral palsy and pediatric asthma.

NEBRASKA: Nebraska Health Connection: CAP

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **17,540**

Estimated Enrollment of PWD: **1,600**

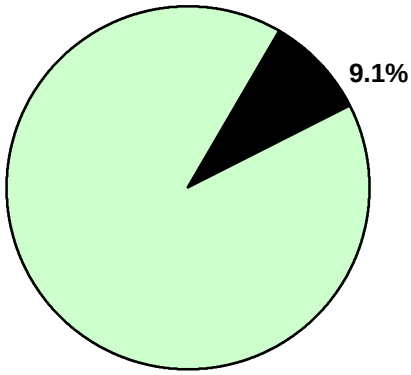
Enrollment is **mandatory (although enrollees can choose either the PCCM or capitated option).**

Program operates **in 3 counties in the Lincoln/Omaha area.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **2**

Program Enrollment of PWD



Autoassignment is based on **previous provider and geographic area.**

Capitation rates vary by **SSI, age and gender. Nebraska has also developed a mechanism to retrospectively adjust payments to MCOs experiencing adverse selection. To date, the state has not used this mechanism.**

Services carved out of the capitated rate: **Behavioral health.**

This program:

- **has** an enrollment broker.
- **has** a guaranteed eligibility period **for children up to age 18**.
- **has** a lock-in period for **1 month.**
- **requires** PCP to see the new enrollee within **45 days**.
- **does not require** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a capitated basis. One BHO provides all mental health services and substance abuse services for children up to age 18 in Nebraska's capitated or PCCM options.**

Special enrollment, program or quality assurance features:

The enrollment process includes home visits and/or transportation services for persons with disabilities. The state is conducting a three-year study on access to care for persons with disabilities in Medicaid managed care.

NEBRASKA: Nebraska Health Connection: PCCM

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **16,560**

Estimated Enrollment of PWD: **1,290**

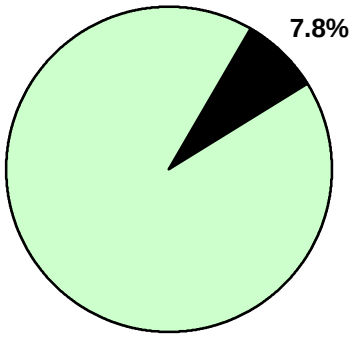
Enrollment is **mandatory (although enrollees can choose either the PCCM or capitated option).**

Program operates **in 3 counties in the Lincoln/Omaha region.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3.50 - $4.00**

Program Enrollment of PWD



Autoassignment is based on **previous provider, geographic area and provider capacity.**

This program:

- **allows** specialists to serve as PCP.
- **has** an enrollment broker.
- **has** a lock-in period of **1 month.**
- **requires** PCP to see the new enrollee within **45 days**.
- **requires** an initial health assessment.

Behavioral health is **provided on a capitated basis. One BHO provides all mental health services and substance abuse services for children up to age 18 in Nebraska's capitated or PCCM options.**

Special enrollment, program or quality assurance features:

The enrollment process includes home visits and/or transportation services for persons with disabilities. The state is conducting a three-year study on access to care for persons with disabilities in Medicaid managed care.

NEW JERSEY: New Jersey Care 2000

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **375,720**

Estimated Enrollment of PWD: **7,500**

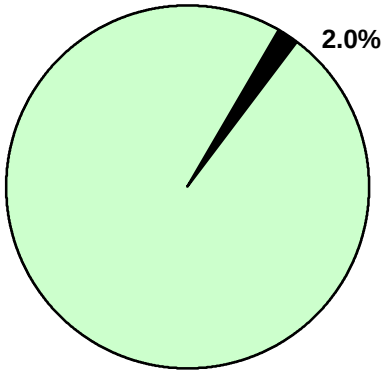
Enrollment is **voluntary.**

Program operates **statewide.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **10**

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility, age, gender and geographic area.**

Services carved out of the capitated rate: **Behavioral health.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

Program is voluntary for persons with disabilities, but mandatory for TANF and related populations.

NEW MEXICO: Salud!

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **191,600**

Estimated Enrollment of PWD: **35,000**

Enrollment is **mandatory.**

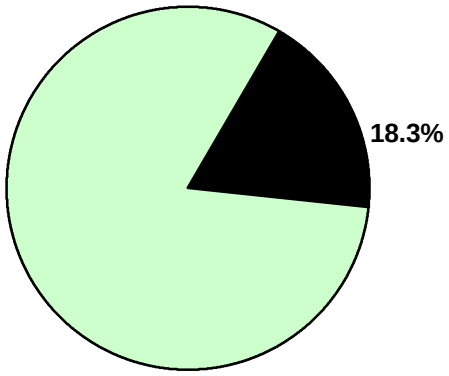
Program operates **statewide.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **3**

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

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility, age and gender.**

Services carved out of the capitated rate: **Home and community-based services, some family planning and respite care.**

This program:

- **Has** an enrollment broker.
- **Does not have** a guaranteed eligibility period.
- **Has** a lock-in period.
- **Does not require** PCP to see the new enrollee within a specific time period.
- **Does not require** the MCO to assign a case manager to PWD.
- **Does not require** an initial health assessment.

Behavioral health is **provided on a capitated basis, with the MCOs subcontracting with one behavioral health organization, which then subcontracts with multiple behavioral health providers.**

Special enrollment, program or quality assurance features:

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 by persons with disabilities in MCOs. Although not required to do so, MCOs routinely assign case managers to persons with disabilities.

NEW YORK: New York State Voluntary Managed Care Program

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **589,290**

Estimated Enrollment of PWD: **23,000**

Enrollment is **voluntary.**

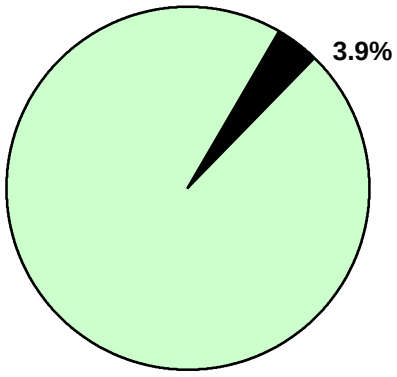
Program operates **by county/region.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **50+**

Capitation rates vary by **SSI eligibility, age and gender.**

Program Enrollment of PWD



Services carved out of the capitated rate: **Varies by county, but commonly includes pharmaceuticals, chiropractic services and extended nursing home care.**

This program:

- **does not have** an enrollment broker.
- **has** a guaranteed eligibility period **in some counties.**
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **90 days**.
- **does not require** the MCO to assign a case manager to PWD.
- **does not require** an initial health assessment.

Behavioral health is **provided on a mixed basis. MCOs provide limited inpatient and outpatient services. Persons with serious and persistent mental illness are mostly in fee-for-service.**

Special enrollment, program or quality assurance features:

None*. Note:* Program has low SSI enrollment because MCOs have included only those SSI recipients who became eligible for SSI after already being enrolled. New York has recently developed an SSI capitation rate and expects enrollment to increase over the next year.

NEW YORK: New York Partial Cap Program

Waiver Authority: **Voluntary Model**: **PCCM (Partial CAP)**

Estimated Program Enrollment: **20,860**

Estimated Enrollment of PWD: **6,000**

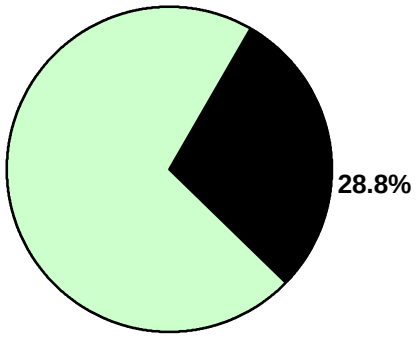
Enrollment is **voluntary.**

Program operates **statewide.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **varies by county. Some counties use traditional PCCM fees while others use a partial cap for ambulatory services or enhanced monthly fees.**

Program Enrollment of PWD



This program:

- **allows** specialists to serve as PCP.
- **does not have** an enrollment broker.
- **has** a guaranteed eligibility period **in some counties.**
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **90 days**.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:
None.

NORTH CAROLINA: Health Care Connections/HMO Program

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **32,380**

Estimated Enrollment of PWD: **2,100**

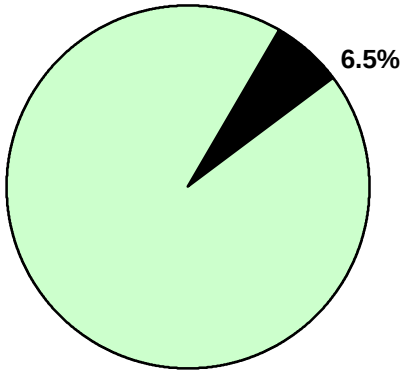
Enrollment is **mandatory in Mecklenburg County only. Enrollees in 8 other counties must choose either the PCCM or capitated option.**

Program operates **in 9 counties.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **5**

Program Enrollment of PWD



Autoassignment is based on **previous provider and medical history.**

Capitation rates vary by **SSI eligibility, age and gender.**

Services carved out of the capitated rate: **Behavioral health, pharmaceuticals, child service coordination and social service case management.**

This program:

- **Has** an enrollment broker.
- **Does not have** a guaranteed eligibility period.
- **Does not have** a lock-in period.
- **Requires** PCP to see the new enrollee within **90 days**.
- **Does not require** the MCO to assign a case manager to PWD.
- **Does not require** an initial health assessment.

Behavioral health is **provided on a capitated basis, with one BHO providing all services.**

Special enrollment, program or quality assurance features:

Persons with disabilities have more time to choose a health plan prior to autoassignment. Program encourages MCOs to assign case managers to persons with disabilities. HIV case management services do not require a referral from a PCP.

NORTH CAROLINA: Carolina Access

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **398,900**

Estimated Enrollment of PWD: **70,000**

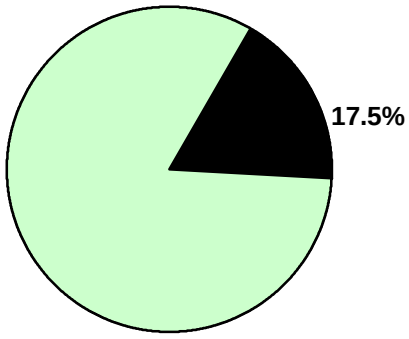
Enrollment is **mandatory (although enrollees can choose either the PCCM or capitated option, if both are available in the county).**

Program operates **in 71 of 100 counties.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$2.50**

Program Enrollment of PWD



Autoassignment is based on **previous provider and medical history.**

This program:

- **allows** specialists to serve as PCP.
- **does not have** an enrollment broker.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a mixed basis. One BHO provides all services in participating counties only; enrollees in counties not covered by the BHO receive services on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

None.

OHIO: Accessing Better Care (ABC)

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **130**

Estimated Enrollment of PWD: **130**

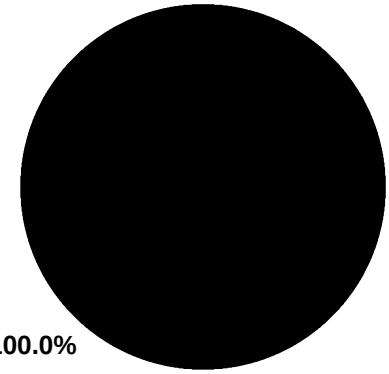
Enrollment is **voluntary.**

Program operates **in 2 counties.**

Ages enrolled: **0-64**

Number of Managed Care Organizations: **1**

Program Enrollment of PWD



100.0%

Capitation rates are **adjusted based on prior utilization.**

Services carved out of the capitated rate: **Behavioral health.**

This program:

- **does not have** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **30 days**.
- **requires** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a mixed basis. The MCO provides limited mental health and substance abuse services. Other services are provided on a fee-for-service basis. Persons with serious and persistent mental illness are ineligible for the program.**

Special enrollment, program or quality assurance features:

MCOs have outreach staff who are trained to work with people who are disabled. Program includes special services for enrollees. Strong emphasis on team approach to clinical care and case management. Contractor networks must have demonstrated experience serving target population. External quality assurance study on case management.

OREGON: Oregon Health Plan: Cap Plan

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **299,030**

Estimated Enrollment of PWD: **35,120**

Enrollment is **mandatory.**

Program operates **statewide, except for three counties.**

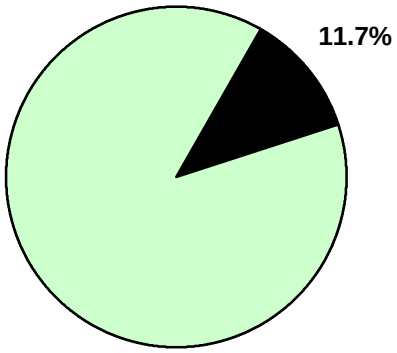
Ages enrolled: **all ages**

Number of Managed Care Organizations: **14**

Autoassignment is based on a **combination**

of patient-focused factors.

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility and geographic area.**

Services carved out of the capitated rate: **Residential treatment after detox.**

This program:

- **Does not have** an enrollment broker.
- **Does not have** a guaranteed eligibility period.
- **Has** a lock-in period of **6 months.**
- **Does not require** PCP to see the new enrollee within a specific time period.
- **Does not require** the MCO to assign a case manager to PWD.
- **Does not require** an initial health assessment.

Behavioral health is **provided on a mixed basis. MCOs subcontract with mental health organizations for most mental health services. Substance abuse services are provided by the MCO, except for inpatient stays after detox, which are paid fee-for-service.**

Special enrollment, program or quality assurance features:

Persons with disabilities generally receive more individualized counseling about plan options from caseworkers. Case management assignment is based on specific needs of each member. All MCOs must have exceptional needs care coordinator to assist enrollees with special health care needs. Quality assurance hot-line for persons with disabilities (and elderly) responds to questions, concerns and complaints about the program. External quality assurance studies on asthma, diabetes and depression.

OREGON: Oregon Health Plan: PCCM Model

Waiver Authority: **1115** **Model**: **PCCM**

Estimated Program Enrollment: **8,420**

Estimated Enrollment of PWD: **1,510**

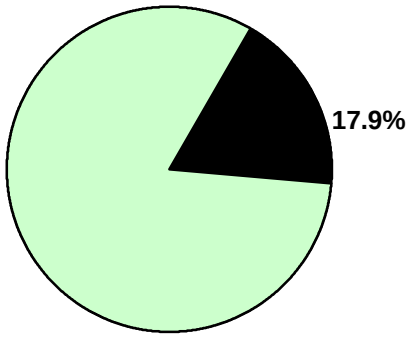
Enrollment is **mandatory**.

Program operates in **3 counties.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



No Autoassignment of PWDs.

This program:

- **Allows** specialists to serve as PCP.
- **Does not have** an enrollment broker.
- **Has** a lock-in period of **6 months.**
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a mixed basis. Mental health services are provided on a capitated basis through mental health organizations. Substance abuse services require a referral from the PCP and are paid fee-for-service.**

Special enrollment, program or quality assurance features:

Quality assurance hot-line for persons with disabilities (and elderly) responds to questions, concerns and complaints about the program. External quality assurance studies on asthma, diabetes and depression.

PENNSYLVANIA: Health Choices

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **456,030**

Estimated Enrollment of PWD: **89,400**

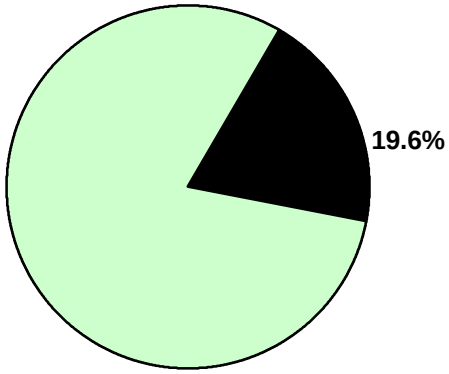
Enrollment is **mandatory.**

Program operates in **5 counties (including Philadelphia County) in eastern Pennsylvania.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **4**

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility.**

Services carved out of the capitated rate: **Behavioral health.**

This program:

- **has** an enrollment broker.
- **has** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within **45 days**.
- **requires** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a capitated basis. Counties, acting as BHOs, provide all services.**

Special enrollment, program or quality assurance features:

Special needs unit handles enrollment of persons with disabilities and acts as case manager for each enrollee with identified special needs.

PENNSYLVANIA: Voluntary HMOs

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **246,200**

Estimated Enrollment of PWD: **35,000**

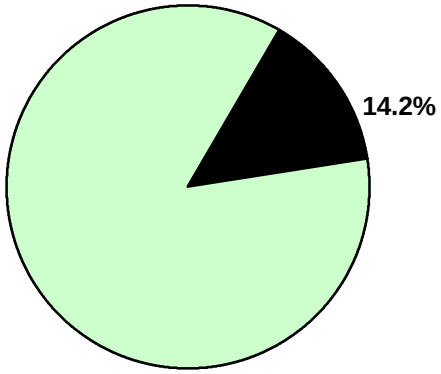
Enrollment is **voluntary.**

Program operates in **28 of 67 counties (including the Pittsburgh area and the middle of the state).**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **6**

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility, age, gender and geographic area.**

Services carved out of the capitated rate: **Behavioral health in some counties.**

This program:

- **does not have** an enrollment broker.
- **has** a guaranteed eligibility period.
- **does not have** a lock-in period **in most counties**.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment **from the MCO**.

Behavioral health is **provided on a mixed basis. In certain counties, the MCO provides all services; in others, services are on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

None. *Note:* This program will be replaced in the western part of the state by a mandatory, capitated program over the next year.

PENNSYLVANIA: Family Care Network

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **220,000**

Estimated Enrollment of PWD: **22,000**

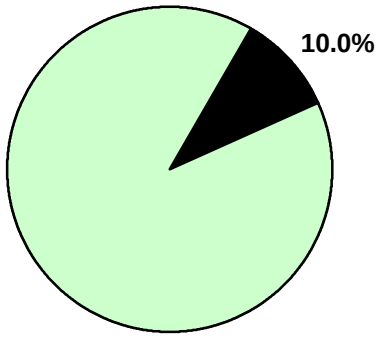
Enrollment is **mandatory.**

Program operates **statewide except in Health Choices counties.**

Ages enrolled: **0-21**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



Autoassignment is based on **previous provider.**

This program:

- **allows** specialists to serve as PCP.
- **has** an enrollment broker.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

Program tries to recruit current physicians of persons with disabilities into the Family Care Network.

SOUTH CAROLINA: Medicaid HMO

Waiver Authority: Voluntary Model: CAP

Estimated Program Enrollment: **4,960**

Estimated Enrollment of PWD: **50**

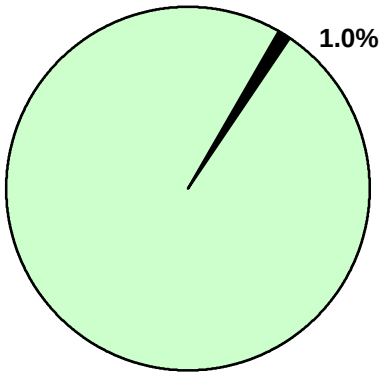
Enrollment is **voluntary.**

Program operates **statewide (although the program is currently only in 12 counties.)**

Ages enrolled: **0-64**

Number of Managed Care Organizations: **3**

Program Enrollment of PWD



Capitation rates vary by **SSI eligibility, age and gender.**

Services carved out of the capitated rate: **Behavioral health, dental, vision, non-emergency transportation, therapies for children with special needs, targeted case management, family planning, home and community-based waiver services and long-term care.**

This program:

- **does not have** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a mixed basis. The MCOs cover the first $1,000 in behavioral health service costs. Additional services are provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:
None.

SOUTH CAROLINA: Physician Enhanced Program

Waiver Authority: **Voluntary Model**: **PCCM (Partial CAP)**

Estimated Program Enrollment: **5,690**

Estimated Enrollment of PWD: **500**

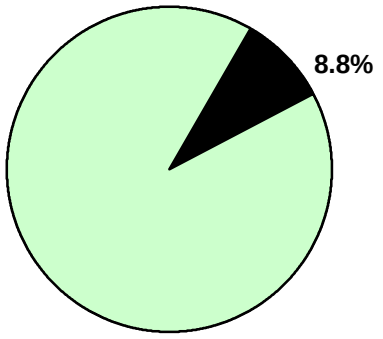
Enrollment is **voluntary.**

Program operates in **5 counties.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **None.**
Office visits and limited x-ray and lab services are paid on a capitated basis.

Program Enrollment of PWD



This program:

- **does not have** an enrollment broker.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:
None.

SOUTH DAKOTA: Provider and Recipient in Medicaid Efficiency (PRIME)

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **40,740**

Estimated Enrollment of PWD: **11,000**

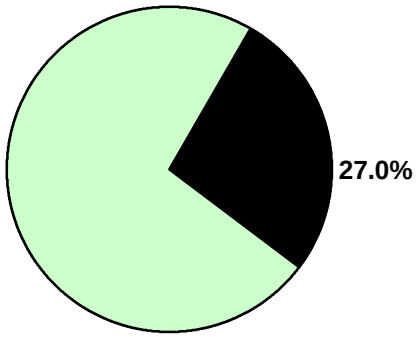
Enrollment is **mandatory.**

Program operates **statewide.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



Autoassignment is based on **geographic area (with children assigned to pediatricians or family practice physicians).**

This program:

- **does not allow** specialists to serve as PCP.
- **does not have** an enrollment broker.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-services basis.**

Special enrollment, program or quality assurance features:

Physicians can petition PRIME to move person with special needs into managed fee-for-service (gatekeeping) arrangement.

TENNESSEE: TennCare

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **827,220**

Estimated Enrollment of PWD: **200,000**

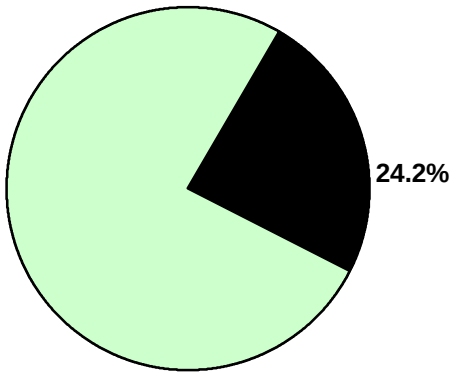
Enrollment is **mandatory.**

Program operates **statewide.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **9**

Program Enrollment of PWD



Autoassignment is based on **geographic area.**

Capitation rates vary by **SSI eligibility. Additional end-of-year payments, known as adverse selection payments, reflect greater enrollment of high cost participants.**

Services carved out of the capitated rate: **Behavioral health and long-term care.**

This program:

- **does not have** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **does not require** an initial health assessment.

Behavioral health is **provided on a capitated basis. Two BHOs provide all TennCare services covered.**

Special enrollment, program or quality assurance features:

QA program includes consumer advocacy program that assists persons with disabilities in negotiating the social service system. External studies on diabetes and pediatric asthma inpatient admissions. A children's special services program provides care coordination by nurses and social workers for children with special health care needs. State designated AIDS Center of Excellence provides a comprehensive approach to AIDS/HIV care.

TEXAS: Star- HMO

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **153,650**

Estimated Enrollment of PWD: **5,420**

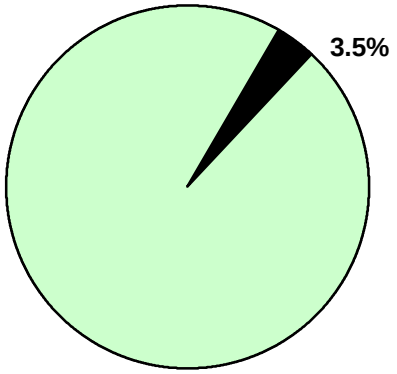
Enrollment is **voluntary.**

Program operates in **41 counties.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **11**

Program Enrollment of PWD



Autoassignment is based on **previous provider, geographic area, enrollment of family member and provider capacity.**

Capitation rates vary by **SSI eligibility and geographic area.**

Services carved out of the capitated rate: **Pharmaceuticals.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **does not require** an initial health assessment.

Behavioral health is **provided on a mixed basis. The MCOs subcontract with BHOs to provide all substance abuse and limited mental health services. Other mental health services are provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

The program is voluntary for persons with disabilities and mandatory for TANF and related populations. QA studies, focus groups, etc. must include some persons with disabilities.

TEXAS: Star- PCCM

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **122,130**

Estimated Enrollment of PWD: **3,460**

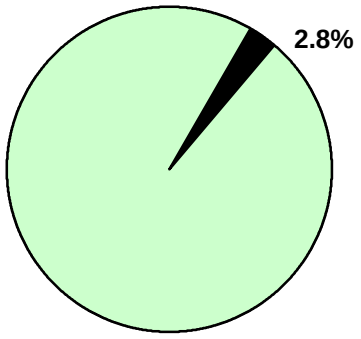
Enrollment is **voluntary.**

Program operates by **county/region.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



Autoassignment is based on **previous provider, geographic area, enrollment of family member and provider capacity.**

This program:

- **allows** specialists to serve as PCP.
- **has** an enrollment broker.
- **does not have** a lock-in period.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

The program is voluntary for persons with disabilities and mandatory for TANF and related populations. QA studies, focus groups, etc. must include some persons with disabilities.

UTAH: The Choice of Health Care Delivery: CAP Program

Waiver Authority: 1915b Model: CAP

Estimated Program Enrollment: **73,130**

Estimated Enrollment of PWD: **9,000**

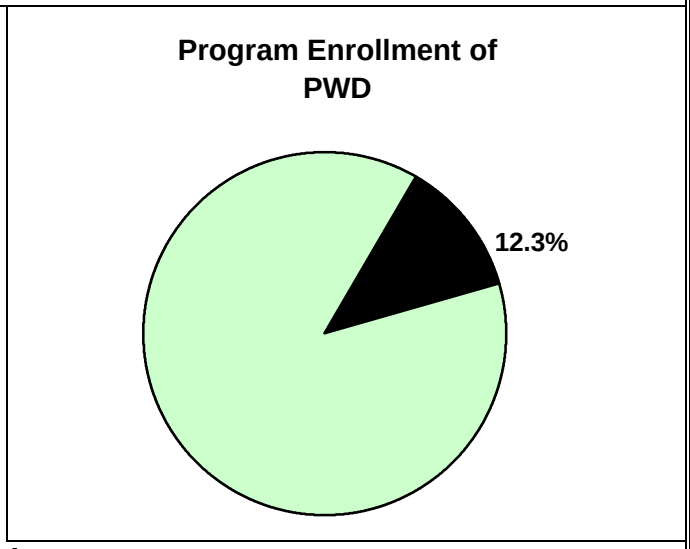
Enrollment is **mandatory.**

Program operates in **4 urban counties.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **5**

Autoassignment is based on **previous provider if possible; otherwise, random assignment.**



Capitation rates vary by **SSI eligibility, age and gender. Rates are adjusted to reflect the diagnosis of AIDS.**

Services carved out of the capitated rate: **Behavioral health, pharmaceuticals, wrap-around services and chiropractic services.**

This program:

- **does not have** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within a specific time period.
- **does not require** the MCO to assign a case manager to PWD.
- **requires** an initial health assessment.

Behavioral health is **provided on a mixed basis. A mental health MCO provides mental health services for enrollees in Utah's capitated and PCCM programs. Substance abuse services are provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

Enrollment personnel spend more time with persons with disabilities and try to link them with the most appropriate plan or provider for their particular health needs. QA program includes special survey for persons with special health care needs.

UTAH: The Choice of Health Care Delivery: PCCM Program

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **12,900**

Estimated Enrollment of PWD: **3,000**

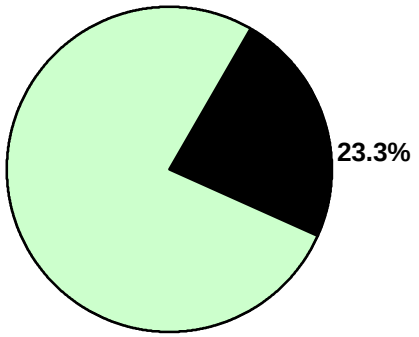
Enrollment is **voluntary.**

Program operates **statewide.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **None**

Program Enrollment of PWD



This program:

- **Allows** specialists to serve as PCP.
- **Does not have** an enrollment broker.
- **Does not have** a lock-in period.
- **Does not require** PCP to see the new enrollee within a specific time period.
- **Does not require** an initial health assessment.

Behavioral health is **provided on a mixed basis. A mental health MCO provides mental health services for enrollees in Utah's capitated and PCCM programs. Substance abuse services are provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

Enrollment personnel spend more time with persons with disabilities and try to link them with the most appropriate plan or provider for their particular health needs.

VERMONT: Vermont Health Access Program

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **51,080**

Estimated Enrollment of PWD: **300**

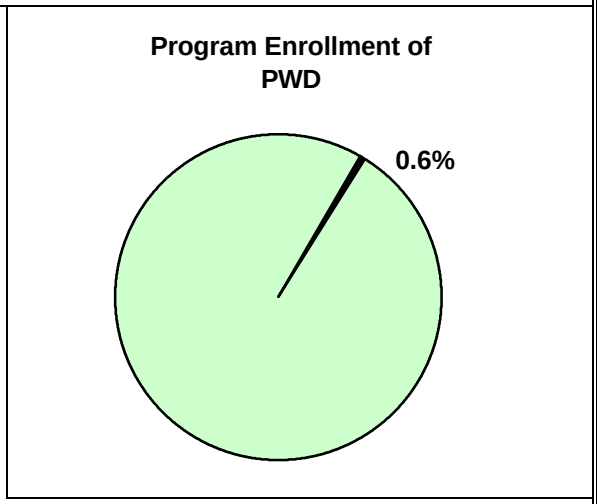
Enrollment is **mandatory.**

Program operates **statewide.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **2**

Autoassignment is based on **random assignment.**



Capitation rates vary by **SSI eligibility, age and gender.**

Services carved out of the capitated rate: **Dental, chiropractic, vision and family planning services.**

This program:

- **has** an enrollment broker.
- **has** a guaranteed eligibility period of **6 months**.
- **has** a lock-in period of **6 months**.
- **does not require** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **does not require** an initial health assessment.

Behavioral health is **provided on a mixed basis. The MCOs subcontract with BHOs for most services. For persons with serious and persistent mental illness, services other than inpatient stays are provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

A health risk assessment that is tailored to persons on SSI is sent by plans to new enrollees. Enrollment brokers receive special training to assist them in enrolling persons with disabilities. One of the MCOs targets a staff member to work with enrollees on SSI, and the other MCO conducts outreach, which targets community health centers. State managed care ombudsman part of QA program. External study on diabetes.

VIRGINIA: Medallion II

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **84,050**

Estimated Enrollment of PWD: **15,771**

Enrollment is **mandatory.**

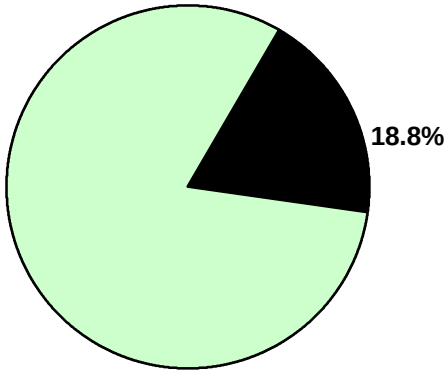
Program operates in **Tidewater region.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **N/A**

Capitation rates vary by **age.**

Program Enrollment of PWD



Services carved out of the capitated rate: **None.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **has** a lock-in period of **12 months**.
- **does not require** PCP to see the new enrollee within a specific time period.

Behavioral health is **provided on a fee-for-service basis by community services boards.**

Special enrollment, program or quality assurance features:

Persons diagnosed with full blown AIDS can opt for managed fee-for-service care under an AIDS waiver.

VIRGINIA: Options

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **28,000**

Estimated Enrollment of PWD: **3,500**

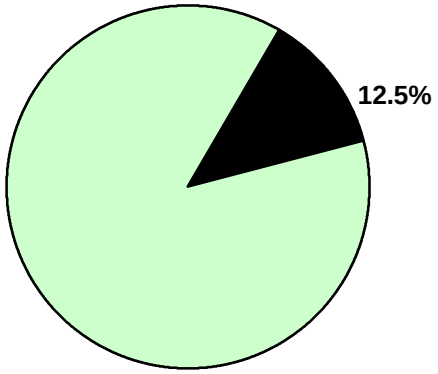
Enrollment is **voluntary.**

Program operates **in the Metro Richmond area.**

Ages enrolled: **all ages**

Number of Managed Care Organizations: **3**

Program Enrollment of PWD



Autoassignment is based on **enrollment of family member, claims history and geographic area.**

Capitation rates vary by **age.**

Services carved out of the capitated rate: **None.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **has** a lock-in period of **12 months**.
- **does not require** PCP to see the new enrollee within a specific time period.

Behavioral health is **provided on a capitated basis, with the MCOs providing all covered services.**

Special enrollment, program or quality assurance features:

Persons diagnosed with full blown AIDS can opt for managed fee-for-service care under an AIDS waiver.

VIRGINIA: Medallion

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **187,080**

Estimated Enrollment of PWD: **43,970**

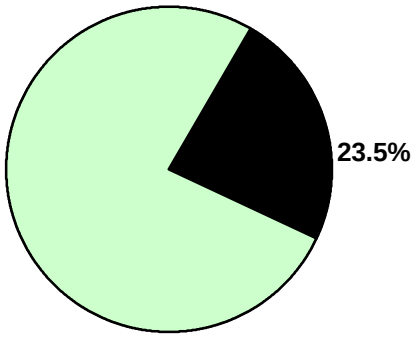
Enrollment is **mandatory.**

Program operates **statewide.**

Ages enrolled: **all ages**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



This program:

- **allows** specialists to serve as PCP.
- **has** an enrollment broker.
- **has** a lock-in period of **12 months**.
- **does not require** PCP to see the new enrollee within a specific time period.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

Persons diagnosed with full blown AIDS can opt for managed fee-for-service care under an AIDS waiver.

WEST VIRGINIA: Physician Assured Access System

Waiver Authority: **1915b** **Model**: **PCCM**

Estimated Program Enrollment: **85,410**

Estimated Enrollment of PWD: **3,000**

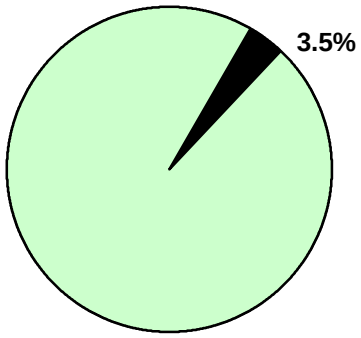
Enrollment is **voluntary.**

Program operates **statewide.**

Ages enrolled: **0-64**

Per Member Per Month fee to PCP: **$3**

Program Enrollment of PWD



This program:

- **allows** specialists to serve as PCP.
- **does not have** an enrollment broker.
- **has** a lock-in period of **1 month**.
- **does not require** PCP to see the new enrollee within a specific time period.
- **does not require** an initial health assessment.

Behavioral health is **provided on a fee-for-service basis.**

Special enrollment, program or quality assurance features:

Volunteers assist persons with special needs in the enrollment process. External quality assurance study on adults with breathing problems.

WISCONSIN: Independent Care (I-Care)

Waiver Authority: 1115 Model: CAP

Estimated Program Enrollment: **3,200**

Estimated Enrollment of PWD: **3,200**

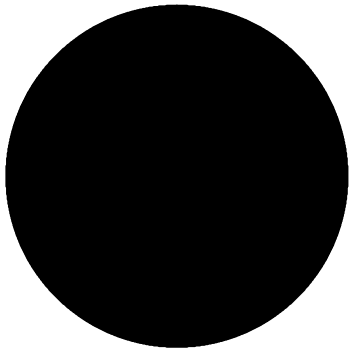
Enrollment is **voluntary.**

Program operates **in Milwaukee County.**

Ages enrolled: **15 and older**

Number of Managed Care Organizations: **1**

Program Enrollment of PWD



100.0%

Capitation rates vary by **diagnostic categories.**

Services carved out of the capitated rate: C**hiropractic and family planning services.**

This program:

- **has** an enrollment broker.
- **does not have** a guaranteed eligibility period.
- **does not have** a lock-in period.
- **requires** PCP to see the new enrollee within a specific time period.
- **requires** the MCO to assign a case manager to PWD.
- **does not require** an initial health assessment.

Behavioral health is **provided on a capitated basis, with the MCO providing all covered services.**

Special enrollment, program or quality assurance features:

A care coordinator is assigned to each new enrollee. Program conducts outreach. The program's very broad network allows many enrollees to retain previous providers. QA program includes provisions for persons with disabilities. Program has external studies that pertain to persons with disabilities.