THE UNIVERSITY OF IOWA

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Review of Medicaid Activities and Evaluative Results in States that Have Transitioned to Managed Care

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3/10/17

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EXECUTIVE SUMMARY

On April 1, 2016, the Medicaid program in Iowa converted from a State-managed and State-run program to a program known as Iowa Health Link, which is administered by the State through contracts with managed care organizations (MCOs). Under the contracts, the MCOs manage the process of providing Medicaid program health care services to enrolled Medicaid beneficiaries and paying health care providers.

Many states use MCOs to manage components of their Medicaid programs, but Iowa's Medicaid MCO program is distinguished in that *nearly all* Iowa Medicaid beneficiaries now access services by joining one of three MCOs. Medicaid managed care contracts in most other states do not include special needs populations such as disabled, behavioral health, or Medicare dual eligible enrollees.

In short, the Iowa Medicaid program has undergone a fundamental shift in how beneficiaries and providers interface with entities administering the program. While reporting systems are in place to monitor activities of the MCOs and assess numeric results (e.g., total enrollment and payment), analysis regarding beneficiaries' access to services and timely use of services is an important evaluation component. This study was conducted to better understand the metrics and methods that other states have used to evaluate their MCO program model.

This report summarizes the findings associated with Medicaid MCO implementation in seven states whose programs closely resemble the Iowa Health Link program. Delaware, Florida, Hawaii, Kansas, New Hampshire, Rhode Island, and Tennessee were selected because in 2016, 90% or more of their Medicaid population was covered under MCO contracts, all (or nearly all) of the states' special populations are mandatorily enrolled, and all (or nearly all) behavioral health services are always "carved in."

Findings indicate that the types of evaluations completed for each state vary in number, scope, and type. The evaluations range from technical reports of the program to full multiyear independent evaluations. Each evaluation uses different measures and different data collection methods. All plans rely at least partially on existing reporting systems and the use of nonplan surveys (e.g., Consumer Assessment of Healthcare Providers & Systems) for evaluation. In addition, all states collect and monitor encounter data, data regarding complaints and grievances, enrollment and disenrollment data, and consumer satisfaction.

This report reviews each state's MCO implementation highlights as well as program evaluation metrics and methods. In addition, keys and barriers to success are noted.

SUMMARY OF FINDINGS BY STATE

Overview

More than half of all Medicaid beneficiaries nationally receive most or all of their care from risk-based managed care organizations (MCOs) that contract with State Medicaid programs to deliver comprehensive Medicaid services to enrollees. Although not all State Medicaid programs contract with MCOs, a large and growing majority do. In addition, states are rapidly expanding their use of MCOs to reach larger geographic areas, serve more medically complex beneficiaries, and deliver long-term services and supports (LTSS).[1] This report summarizes the findings of a study of Medicaid MCO implementation and resulting evaluations in states whose programs closely resemble the Iowa Health Link program.

States were selected for review based on the level of their MCO service penetration in 2016. In Iowa, 96.0% of the Medicaid population is covered under MCOs, all "special populations" are under mandatory enrollment, and all behavioral health services are always "carved in." Special populations include:

- pregnant women
- foster children
- persons with intellectual and development disabilities
- children with special health care needs
- adults with serious mental illness
- adults with physical disabilities

Behavioral health services include:

- specialty outpatient mental health
- inpatient mental health
- outpatient substance use disorder
- inpatient substance use disorder

Four states closely approximate Iowa's program on those criteria: Hawaii (5 MCOs), Kansas (3 MCOs), New Hampshire (2 MCOs), and Tennessee (4 MCOs). Three additional states meet nearly the same criteria: Delaware (2 MCOs), Florida (17 MCOs), and Rhode Island (2 MCOs).[1]

State Medicaid MCO Service Penetration

	MCO Enrollment ≥ 90%[a] <KFF Table 5>	Mandatory Special Population Enrollment[b] <KFF Table 6>	Behav Health Services Always Carved In[c] <KFF Table 7>
Delaware	>90%	Nearly all	Nearly all
Florida	93.0%	Nearly all	All
Hawaii	99.9%	All	All
Iowa	96.0%	All	All
Kansas	95.0%	All	All
New Hampshire	95.7%	All	All
Rhode Island	90.0%	Nearly all	All
Tennessee	100.0%	All	All

Source: Smith VK, Gifford K, Ellis E, et al, Kaiser Family Foundation. *Implementing coverage and payment initiatives: Results from a 50-state Medicaid budget survey for state fiscal years 2016 and 2017*. http://kff.org/medicaid/report/implementing-coverage-and-payment-initiatives-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2016-and-2017/. October 13, 2016. Accessed January 12, 2017.

[a]**MCO Enrollment >90%** – Share of the Medicaid population covered under Managed Care Organizations.

[b]**Mandatory Special Population Enrollment** – Enrollment of special populations under Medicaid Managed Care contracts. Includes (1) pregnant women, (2) foster children, (3) persons with intellectual and development disabilities, (4) children with special health care needs, (5) adults with serious mental illness, and (6) adults with physical disabilities.

[c]**Behav Health Services Always Carved In** – Behavioral health services covered under acute care MCO contracts. Includes (1) specialty outpatient mental health, (2) inpatient mental health, (3) outpatient substance use disorder, and (4) inpatient substance use disorder.

Broadly, states identify specific areas to measure and evaluate within each program or plan. The standards selected for review are often based on contract requirements and federal Medicaid managed care regulations. They include the following categories:

- Member services
- Medical home/preventive care
- Women's health
- Chronic care
- Behavioral health
- Children with special health care needs
- Children in substitute care
- Children's preventive care
- Resource maximization
- Access to care
- Cost control/effectiveness
- Member satisfaction
- Credentialing
- Continuity of care
- Case management
- Coding and billing
- Denials and appeals
- Utilization
- Effectiveness of care
- Quality

The types of evaluations completed for each state vary in number and type and range from technical reports of the program to full multiyear independent evaluations. Each state's evaluations use different measures and different data collection methods. All plans rely at least partially on existing reporting systems and the use of nonplan surveys (e.g., Consumer Assessment of Healthcare Providers & Systems [CAHPS]) for evaluation.

In all states except Rhode Island, measures are collected at the individual MCO level. All states collect performance data using Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance and use the results for evaluative purposes. All states collect and monitor the following:

- Encounter data
- Data on complaints and grievances
- Enrollment and disenrollment data
- Consumer satisfaction (measured using CAHPS health plan survey)

Some states (Delaware, Tennessee, Hawaii, Florida, and New Hampshire) use additional surveys to collect data such as provider participation and beneficiary satisfaction. In addition, Tennessee and Hawaii use member surveys to collect data on the experience of the beneficiary.

The following evaluation documents were reviewed for the State Medicaid programs contained in this report.

- The Centers for Medicare & Medicaid Services' (CMS) review to determine the extent of program integrity oversight of the managed care program in Delaware; Internal quality reports for 2014 and 2015[2]
- Medicaid's comprehensive review of the Florida program in 2011, and an independent organization's review of the LTSS program in 2016[3]
- Evaluations completed for Hawaii, including two different technical reports for years 2013 and 2014 conducted by the Health Services Advisory Group[4]
- Leavitt Partners report on the Kansas program in November 2016[5]
- New Hampshire's independent three-year evaluation of the statewide implementation of risk-based managed care in New Hampshire's Medicaid program, and a quality update conducted in late 2016[6]
- Mathematica's review of the Rhode Island program in 2004, and an annual external quality review technical report, "Improving Health Care for the Common Good," completed in 2011 (the most recent results); strategy documents for assessing and improving the quality of care released in 2012, and an evaluation design plan developed by the University of Southern Maine and RTI International released in 2016[7]
- Tennessee's internal annual update report on quality assessment/quality improvement activities (QA/QI) in 2015; the 2015 evaluation of LTSS services by the National Association of States United for Aging and Disabilities in 2015[8]

Additional State Evaluation Activities

In some states, such as Delaware, Hawaii, and Tennessee, part of the evaluation process relies on performance improvement projects (PIPs). These projects are ongoing assessments designed to achieve results through rapid interventions and measurements. The key concepts of the PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions, testing and refining interventions, and spreading successful changes. Plans are expected to show significant improvement, sustained over time, in clinical and nonclinical areas, and are rated according to the following rubric:

- *High confidence* = The PIP was methodologically sound, achieved meaningful improvement for the SMART (specific, measureable, achievable, relevant, and time-bound) Aim measure, and the demonstrated improvement was clearly linked to the QI processes conducted.

- *Confidence* = The PIP was methodologically sound; achieved meaningful improvement for the SMART Aim measure; and some of the QI processes were clearly linked to the demonstrated improvement, but there was not a clear link between all QI processes and the demonstrated improvement.
- *Low confidence* = The PIP was methodologically sound, but (1) improvement was not achieved for the SMART Aim measure or (2) improvement was achieved for the SMART Aim measure, but the QI processes and interventions were poorly executed and could not be linked to the improvement.

The following pages briefly summarize the MCO implementation history for each of the identified states (Delaware, Florida, Hawaii, Kansas, New Hampshire, Rhode Island, Tennessee, and Iowa). Each state approaches evaluation differently, so this report provides an overview of key metrics, evaluation methodology, and QI projects specific to each state. Some states do not have a clear published evaluation plan.

DELAWARE

Delaware MCOs
Diamond State Health Plan (DSHP)
Diamond State Health Plan-Plus (DSHP-Plus)

Delaware MCO Implementation Highlights[9]

- **1994**: The Delaware Health Care Commission recommends conversion of the State's Medicaid program to a managed care program.
- **1996**: Delaware Health and Social Services first implements DSHP in January for a three-year term. DSHP covers acute, primary, and behavioral health care services for low-income children, families, and adults; children and adults with disabilities; and foster care children.
- **2001, 2004, 2007, and 2010**: Subsequent three-year renewals are implemented, Medicaid health coverage is expanded to additional low-income adults in Delaware, and family planning services to women are expanded.
- **2002**: Delaware creates a small fee-for-service primary care case management program called Diamond State Partners to maintain client choice when the State had only one MCO. The State transitioned all beneficiaries enrolled in this plan to an MCO in 2014.
- **2012**: Delaware expands managed care to additional populations and adds LTSS to the benefit package with the implementation of the DSHP-Plus program. The new program mandates enrollment of dual eligible beneficiaries, individuals enrolled in the elderly and disabled and AIDS home and community-based service (HCBS) waivers, and nursing facility residents, and provides LTSS, acute, primary, and behavioral health care services to eligible individuals. DSHP and DSHP-Plus cover a limited number of outpatient and inpatient behavioral health and substance abuse services, and any services in excess of the limits on visits are provided as a fee-for-service wraparound.
- **January 2014**: Delaware adopts Medicaid expansion through the Affordable Care Act, and total enrollment in Delaware's Medicaid/CHIP program grows by nearly 17,000 people from 2013 to June 2015.
- **June 2016**: Medicaid beneficiary enrollment totals 235,967.[10]

Types of Measures Collected and How Evaluation Is Conducted

In Delaware, a provider satisfaction survey is conducted annually by each MCO, and the results are reviewed by the State during the annual compliance review. Areas for monitoring include availability of services, timely access to care, primary care and coordination/continuity of services, and coverage and authorization of services.[2] Examples of questions from the Delaware survey of program recipients include the following:

- How helpful was the person you spoke with when enrolling in your Health Plan?
- Did the person you spoke with talk about a primary care doctor, specialist referrals, emergency room use, and insurance cards?
- Did the person you spoke with answer all your questions/concerns regarding your health plan?
- Did you find the enrollment materials easy to read?

The State also utilizes surveys to assess member satisfaction for both HCBS and institutional enrollees.

Results of MCO Evaluation Activities

The annual evaluation in Delaware is overseen by the Center for Medicaid and CHIP services. The report lists achievements by plans and areas for improvement.[2] Achievements include the following:

- Fulfilling the contract requirement for MCOs to suspend or terminate providers who have been suspended or terminated by the State Medicaid agency, and to terminate any providers who have been terminated from Medicare or any State Medicaid or CHIP program.
- Fulfilling the contract requirement for MCOs to notify the State within two business days of taking any action against a provider for program integrity reasons.
- Providing clear directions on recoupment of overpayments, providing evidence of the collection of overpayments, and determining which party is eligible to retain the recoupment.
- Enforcing requirements for disclosure of criminal action for dishonesty or breach of trust by contractor's staff.
- Providing clear directions on reporting of investigations and time frames.

The Delaware State Medicaid agency receives encounter data from the MCOs, but does not analyze the data due to limitations with their legacy system and the Medicaid Management Information System (MMIS). The State is in the process of developing a new MMIS, which is being designed to address many of the areas related to fraud, waste, and abuse. The State's limited ability to analyze encounter data hinders it in identifying aberrant provider billing patterns in the managed care sector. As the state is predominantly managed care, this further hinders the State in its ability to monitor the MCOs' program integrity activities and to determine whether plans are adequately identifying fraud, waste, and abuse in the program.

Keys and Barriers to Success

The following requirements, division of responsibilities, collaboration, and ongoing communication have played a significant role in the program's achievements.[2]

- Requiring MCOs to suspend or terminate providers who have been suspended or terminated by the State Medicaid agency, and to terminate any providers who have been terminated from Medicare or any State Medicaid or CHIP program.
- Requiring MCOs to notify the State within two business days of taking any action against a provider for program integrity reasons.
- Providing clear directions on recoupment of overpayments, reporting of collection of overpayments, and which party is eligible to retain the recoupment.
- Requiring disclosure of criminal action for dishonesty or breach of trust by contractor's staff.
- Providing clear directions on reporting of investigations and time frames.
- Providing clear direction on payment suspensions.
- Enhancing provisions for a Fraud, Waste, and Abuse Compliance Plan.
- The Medical Management Managed Care team developed and refined the Quality and Care Management Measurement Reporting (QCMMR) and QCMMR Plus templates. The QCMMR reports on the DHSP and CHIP Medicaid Populations, while the QCMMR Plus reports on the DSHP Plus population. The Medical Management Managed Care team works in conjunction

with Mercer (the External Quality Review Organization [EQRO] contractor) and the MCOs in developing the guidelines and reporting templates.

- Monthly reports are reviewed by the Medical Management team, and an agenda is developed for a monthly meeting with each MCO to discuss the findings from the reports. The Medical Management team's goal is to establish a partnership with the MCOs to improve quality of care for members.

FLORIDA

MCOs (17 Total)	MCO Enrollment as of September 2016[11]
Better Health	100,590
Children's Medical Services Network	51,310
Coventry Health Care of Florida	59,761
Freedom Health, Inc.	115
Humana Medical Plan	340,893
Magellan Complete Care, LLC	58,645
Molina Healthcare of Florida	332,104
Prestige Health Choice	314,273
Simply DBA Clear Health Alliance	9,282
Simply Healthcare Plans, Inc.	84,195
AHF / Positive Healthcare	1,909
Staywell Health Plan of Florida	678,799
Sunshine State Health Plan, Inc.	472,175
Sunshine State Health Plan, Inc. (Foster Care)	31,494
UnitedHealthcare of Florida	279,432
Amerigroup Florida, Inc.	349,336
South Florida Community Care Network (SFCCN)	44,632
Total	3,208,945

Florida MCO Implementation Highlights[12,13]

- **1990**: Florida creates primary care case management program, called Medicaid Provider Access System, or MediPass.
- **1996**: MediPass expands statewide. Approximately 5,000 MediPass primary care providers served about 600,000 beneficiaries.
- **2006**: Florida initiates the Florida Medicaid Pilot in two counties, enrolling low-income children, pregnant women and parents, and aged and disabled individuals (with some exceptions).
- **2007**: The pilot expands to three more counties.
- **December 2011**: The pilot expands to all counties and is renamed Statewide Medicaid Managed Care (SMMC). Participants can choose between a capitated MCO or alternative provider-sponsored networks. The plans cover all mandatory acute, primary, and specialty services. Enrollment is mandatory for most populations receiving full Medicaid benefits, including aged adults, disabled adults and children, low-income adults and children, full dual eligibles, and children in foster care.
- **June 2013**: Florida's request to transition nearly all Medicaid beneficiaries and services into managed care is approved by the Federal government, beginning in 2014. The new program has two separate components that mandate statewide managed care enrollment. One new component is the Managed Medical Assistance program, which expanded the five-county pilot program to statewide managed care.
- **May 2014:** The first phase of the Managed Medical Assistance program is implemented.

- **August 2014**: The final phase of the Managed Medical Assistance program is implemented. Beneficiaries enrolled in MediPass transition to the Managed Medical Assistance program. The Managed Medical Assistance program provides comprehensive Medicaid services to beneficiaries, with the exception of women eligible only for family planning services, women eligible through the breast and cervical cancer services program, people eligible for emergency Medicaid for aliens, and children receiving services in a prescribed pediatric extended care center. Effective August 2014.

Types of Measures Collected and How Evaluation Is Conducted

A team of researchers from the University of Florida determined five areas for evaluation. They pursued these areas of inquiry in a coordinated fashion that allowed focus in each area, but integration within a single project. The main subdivisions were studies that examined the following:

- The experience of participating organizations, participating MCOs, consultants, contractors, and others
- Enrollees and their experiences
- Fiscal consequences (particularly Florida's expenditures for care in the demonstration)
- The Low Income Program and its implementation
- The demonstration's impact on mental health services

In Florida, the Experience of Care and Health Outcomes survey assesses the impact of the demonstration program on the mental health care experiences of individuals with mental illness.

- In 2009, the survey was conducted in Broward, Duval, Baker, Clay, and Nassau counties (demonstration counties). The survey was also conducted in a nondemonstration (control) county.
- Domains assessed included health plan rating, access, benefit use, and willingness to recommend the program.

In addition, Florida MCOs are required to have the following components as part of the evaluation process:

- Utilization of data sources outside the health plan (e.g., public health data, including birth records, to measure the impact of its managed care program on prenatal care and intervals between births)
- Interviews and/or focus groups
- Record reviews completed by the State annually or semiannually based on the performance measure associated with each review

Results of MCO Evaluation Activities

Florida is a high achieving plan, according to an evaluation commissioned by CMS and prepared by an independent evaluation team at the University of Florida led by R. Paul Duncan, Ph.D.[3]

- Florida Medicaid health plans' HEDIS scores under MMA have trended upward, with 65% of all measures at or above the national average.
- Medicaid health plans outperformed commercial plans on quality, customer satisfaction, preventive care, and treatment.
- CAHPS survey scores were high.

- LTSS service and quality ratings were high.
- Florida Medicaid is serving the greatest number of people it has ever served, more efficiently than ever, with the highest quality services offered at the lowest cost: the cost per person of the program has dropped steadily and consistently over the last several years.
- Consumers found it easy to find a personal doctor. The independent researchers found significant increases between the year prior to the program and program year 1 in the percentage of enrollees reporting that they have a personal doctor and that they did not have a problem finding a personal doctor with whom they were happy. The level achieved in program year 1 was maintained in years 2 and 3.
- Consumer satisfaction with their personal doctor went up significantly. The independent research team found a significant increase over time in the percentage of program enrollees reporting satisfaction with their personal doctor at the highest level.
- Consumer satisfaction with communication with their personal doctor improved. The independent research team found statistically significant improvements between the year prior to the program and program years 1, 2, and 3 in enrollees' ratings of communication with their personal doctor.

Keys and Barriers to Success

Several factors have contributed to the success of the Florida plan.[3]

- The demonstration was implemented very quickly, although the mandated start date of July 1, 2006, was extremely ambitious by any standard. The Florida Agency for Health Care Administration (AHCA) was nevertheless committed to meeting its legislated timeline.
- The use of a disciplined project management approach was a critical element in achieving the start time.
- From the beginning and throughout the pilot, AHCA organized key participants into teams that included staff from various AHCA bureaus; content experts; and trained, experienced project managers.
- Strong leadership at all levels played an integral role in the development and implementation of the demonstration. Effective internal communication and external communication were critical success factors.
- The State's dedication of significant resources (including funding, vendors, human resources, information, and time) to the demonstration's development and implementation was critical to the initiative's success.

HAWAII

MCOs (5 Total)	MCO Enrollment as of September 2016[14]
Hawaii Medical Service Association	158,796
AlohaCare	67,458
Ohana Health Plan	42,977
UnitedHealthcare Community Plan	42,779
Kaiser Foundation Health Plan	31,091
Total	343,101

Hawaii MCO Implementation Highlights[15]

- **1994**: Hawaii implements a managed care program, QUEST, which covers acute, primary, and behavioral health care services for low-income children, families, pregnant women, and childless adults.
- **2009**: Hawaii expands QUEST to include aged, blind, and disabled children and adults, and dual eligibles, through QUEST Expanded Access (QExA), which also includes institutional, home, and community-based LTSS. QUEST and QExA are statewide programs with mandatory enrollment for all population groups.
- **March 2013**: Hawaii begins transitioning all adults with serious mental illness and persistent mental illness into the Community Care Services (CCS) program for their behavioral health services, phasing out most of the fee-for-service benefits that the Department of Health had previously provided. CCS was also converted to a risk-based, limited benefit plan (Ohana Health Care) at this time.
- **September 2013**: Hawaii renews the QUEST demonstration. Under this renewal, the State consolidated the programs within the demonstration into a single "QUEST Integration" program. The renewal also made changes to align QUEST with the requirements of the Affordable Care Act, including adding to the State plan a childless adults group and implementing the modified adjusted gross income methodology.

Types of Measures Collected and How Evaluation is Conducted

The State reviews selected standards for the program to measure member satisfaction, using monitoring tools to assess and document compliance with a set of federal and State requirements while ensuring all standards are reviewed within a three-year period for all health plans. Hawaii requires both provider and member surveys. Specific evaluation methods include the following:

- Hawaii uses an additional version of the CAHPS survey—the Child Medicaid Health Plan Survey—which is sent to Medicaid members of the QI health plans, including CHIP-eligible enrollees, via a statewide sampling methodology.
- Examples of measures collected for members include rating of health plan, all health care, personal doctor, and specialist seen most often, and rating of five composite measures—getting needed care, getting care quickly, how well doctors communicate, customer service, and shared decision making. In addition, two individual items are assessed, coordination of care and health promotion and education.

- A pre-on-site desk review and an on-site review with interview sessions and record reviews is conducted for compliance purposes. Follow-up monitoring of the health plans is required for those that are supposed to take corrective actions.

In addition to the above annual activities, a sample of Medicaid providers (primary care practitioners and specialists) is surveyed to assess satisfaction. Providers have the option of responding to the survey via the mailed hard copy or completing an online version.

Results of MCO Evaluation Activities

The program has had mixed results.[4]

- The individual MCOs have been diverse in their performance. The Kaiser Foundation Health Plan reported 58% of its indicators at or above the HEDIS 2014 national Medicaid 90th percentile, the Hawaii Medical Service Association reported 22 of 80 rates above the 50th percentile, and the remaining three MCOs reported 55% or more measures below the 25th percentile.
- Improvements have been made in quality initiatives and transparent public reporting: compliance monitoring and corrective action follow-up evaluation, validated PIPs, addition of the child CAHPS surveys and an additional child CHIP survey, and a provider survey. Health plan report cards and dashboards were rolled out in 2015.
- Non-HEDIS quality measures, such as STD screening and immunization rates, improved in some areas and declined in others.
- Survey response has improved over time. The overall response rate for the 2015 member survey of 19.6% exceeded the 2013 response rate (5.8 percentage points higher). The response rate of Kaiser providers was higher than that of non-Kaiser providers (26.4% and 17.1%, respectively). In all, 260 providers responded to the survey. Approximately one-third of the respondents were primary care providers, with the other two-thirds identifying themselves as specialists.

Keys and Barriers to Success

Evaluation materials for Hawaii did not describe keys or barriers to success.

KANSAS

MCOs (3 Total)	MCO Enrollment as of December 2015[16]
Amerigroup of Kansas, Inc. (Amerigroup)	23,205
Sunflower State Health Plan (Sunflower)	134,793
UnitedHealthcare Community Plan of Kansas (United)	17,232
Total	175,230

Kansas MCO Implementation Highlights[17]

- **1985**: Kansas introduces managed care through HealthConnect, a primary care case management program available statewide on a mandatory basis for all Medicaid beneficiaries except dual eligibles and foster children. Enrollees can receive a variety of services coordinated through a designated primary care provider, including acute, primary, and specialty care, plus behavioral health, pharmacy, dental, and transportation services.
- **1995**: Kansas expands State managed care through HealthWave 19, a comprehensive risk-based program, which primarily enrolls low-income children and parents and covers acute, primary, and specialty care, plus pharmacy and transportation services.
- **2006**: Kansas contracts with separate MCOs to provide prepaid mental health and substance abuse services to most Medicaid eligibility groups.
- **2013**: Kansas begins to significantly restructure its Medicaid system by enrolling virtually the entire Medicaid population—including those formerly served in the primary care case management program and the Health Wave 19 program, as well as older adults and people with disabilities formerly served in the fee-for-service system—into a comprehensive managed care program called KanCare.
- **February 2014**: Kansas includes the Intellectual/Developmental Disability (1915(c)) waiver in managed care. This HCBS waiver was originally carved out of KanCare for the first year of implementation.

Types of Measures Collected and How Evaluation Is Conducted

In Kansas, an independent evaluation was conducted by Leavitt Partners measuring the program's performance against its original stated goals. These goals included the following:

- Implement long-lasting reforms that improve the quality of health and wellness for Kansans.
- Measurably improve health care outcomes for members in the following areas: diabetes, coronary heart disease, prenatal care, and behavioral health.
- Reduce overall costs.

Results of MCO Evaluation Activities

The Leavitt Partners evaluation found KanCare to be a low performing plan.[5]

- There has been little to no improvement in the MCOs' HEDIS scores.
- Providers feel there is very little activity related to the integration of physical health, behavioral health, and LTSS.
- Results from interviews and a survey show that an overwhelming number of respondents do not feel KanCare has met its goals and commitments (e.g., it has not helped preserve the safety net,

and access to care is being sustained by the providers in the system rather than being improved by the MCOs).
    - In general, interviewees do not believe that moving to a managed care system has led to improvements in the quality of care provided to Kansas Medicaid beneficiaries.
    - 66% of survey respondents indicated the program had not met the goal of preserving and stabilizing the safety net.
    - 45% do not believe KanCare has improved integration of services.
- While the data indicate the State has achieved savings in relation to the established benchmark, there are concerns regarding how MCOs are spending KanCare funding. Medical loss ratio (MLR) has fallen each year.
- While the KanCare MCOs experienced significant financial losses in the first two years, reflected in a negative underwriting ratio, the underwriting ratio reversed in 2015, resulting in overall financial gains more than double the national mean (5.9% v. 2.6%).

Federal officials have rejected Kansas' request to extend its privatized Medicaid program, saying it has failed to meet federal standards and risked the health and safety of enrollees.[18] According to a January 13, 2017, letter to the State from CMS, KanCare is "substantively out of compliance with Federal statutes and regulations," based on a review by federal investigators in October 2016. The State's failure to ensure effective oversight of the program put the lives of enrollees at risk and made it difficult for them to navigate their benefits, the investigators found. Concerns about the program's transparency and effectiveness were cited.

Keys and Barriers to Success

Significant barriers to KanCare's success include the following:[5]

- There is a lack of standardization across MCOs, including appeals processes, prior authorization processes, encounter data provision processes, credentialing processes, and clear guidelines on approval and payment of emergency services.
- Both data and interviewees suggest that KanCare is underfunded. For example, the MCOs' low administrative costs (ALR) in CY2015 could have resulted in higher profits for the MCOs compared to the national average. The low ALR may also be a reflection of interviewee's comments about MCOs' poor customer service, general unresponsiveness, and potentially using payment delays to reduce both the MLR and ALR.
- The State is not sufficiently involved in monitoring MCOs and sharing results with providers. Increased oversight could help resolve many of problems, including reducing the lag time between State policy changes (both programmatic and rate changes) and MCOs making system adjustments.

NEW HAMPSHIRE

MCOs (2 Total)[19]	MCO Enrollment as of June 2015
New Hampshire Healthy Families	64,178[20]
Well Sense Health Plan	85,000[21]
Total	149, 178

New Hampshire MCO Implementation Highlights[22]

- **1999-2003**: New Hampshire operates a voluntary, capitated, risk-based program for children and low-income women.
- **2005-2009**: New Hampshire operates a disease management program for beneficiaries with chronic illness.
- **June 2011**: New Hampshire enacts legislation requiring mandatory enrollment in risk-based managed care for all Medicaid beneficiaries in the state.
- **December 2013**: The Medicaid Care Management program begins enrolling all Medicaid beneficiaries in MCOs, except individuals needing LTSS. The program initially covers acute medical services, primary care, behavioral health services, and pharmacy.
- **2014**: New Hampshire expands services, including LTSS, to the benefits provided by the MCOs and enrolls individuals newly eligible for Medicaid under the Affordable Care Act.

Types of Measures Collected and How Evaluation Is Conducted

In New Hampshire, the State itself set the areas of focus for evaluation. They include the following:

- State oversight
- Plan selection
- Credentialing
- Contracting
- Prior authorization
- Coding and billing
- Denials and appeals
- Education and enrollment
- Provider networks
- Continuity of care
- Quality and access
- Case management

New Hampshire surveys patients to gather information on patient perceptions of their health care. The survey is a household sample, and the interview is conducted with the head of the household. This design allows comparison between responses from all households and households in the MCO.

Results of MCO Evaluation Activities

The New Hampshire program has experienced mixed results.[6]

- Initial implementation of managed care in New Hampshire's Medicaid program went relatively smoothly.
- The enrollment process resulted in few reports of problems and a relatively high rate of self-selection of a managed care plan by beneficiaries, which likely reflects the State's extensive efforts to educate beneficiaries and providers about the transition.
- There was little evidence of provider networks diminishing because of managed care, and focus group participants noted they found it easy to make an appointment for primary or specialty care.
- Providers reported a smooth transition when it came to implementation issues such as credentialing, claims submission, and payment procedures.
- Communication among the key stakeholders was good, and when problems arose, efforts were made to address them and track the issue.
- Both providers and Medicaid beneficiaries reported significant problems with prior authorization processes, particularly for pharmacy services.
- The provider community was clear in its dissatisfaction with the new prior authorization requirements imposed by the managed care plans. Across types and locations, providers agreed the requirements had added considerable administrative burden to their practice and in some cases had jeopardized beneficiary care. Focus group participants confirmed delays in care caused by the prior authorization process and noted particular difficulty receiving needed prescriptions.

Keys and Barriers to Success

Careful planning, education, and communication contribute to this program's success.[6]

- The State undertook extensive efforts to educate beneficiaries and providers about the transition, and as a result, initial implementation of managed care in New Hampshire's Medicaid program went relatively smoothly.
- By most accounts, communication among key stakeholders was good, and when problems arose, efforts were made to address them and track the issue.
- The State developed an ambitious quality strategy and sophisticated data collection and analysis plans for the program. These measures led to the effective monitoring of over 400 quality indicators on the NH Medicaid Quality Indicators web site, annual QI projects, PIPs, and EQRO activities, including all optional activities outlined in Federal regulations.
- The State has recognized that prior authorization processes are the biggest issue in New Hampshire Medicaid managed care and has been meeting with the MCOs to address these issues.

RHODE ISLAND

MCOs (2 Total)	MCO Enrollment State Fiscal Year 2015[23]
RIte Care	132,702
Rhody Health Partners	13,893
Total	146,595

Rhode Island MCO Implementation Highlights[24]

- **1994**: Rhode Island introduces comprehensive, risk-based managed care through the Rite Care program, which originally covered low-income children and families and has expanded over time to include low-income working families and children with special health care needs. Rite Care covers acute, primary, and specialty care; pharmacy; and behavioral health services on a mandatory basis across the state (except for foster care children, who may enroll on a voluntary basis). Older adults and individuals with disabilities (excluding dual eligibles) are generally required to enroll in one of the State's other managed care programs, Connect Care Choice and Rhody Health Partners.
- **2008:** Rhode Island introduces Rhody Health Partners, a comprehensive, risk-based program that provides acute and primary care services to older adults and individuals with disabilities who are not enrolled in Connect Care Choice.
- **2013:** Rhode Island integrates LTSS into its Rhody Health Partners program; LTSS for adults with developmental disabilities and behavioral health services for individuals with serious and persistent mental illnesses are not yet covered.

Types of Measures Collected and How Evaluation Is Conducted

In Rhode Island, the University of Southern Maine determined the following areas for evaluation:

- Monitor demonstration implementation
- Evaluate the impact of the demonstration on beneficiary experience
- Monitor unintended consequences
- Monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with mental illness and/or substance use disorders and LTSS recipients)

Results of MCO Evaluation Activities

Rhode Island has a highly rated program, according to an external evaluation by an EQRO, mandated by CMS to conduct an annual review of the services provided by contracted Medicaid MCOs.[7]

- While maintaining efficiency and cost effectiveness, the Rhode Island plan has improved over time.
- There have been fewer emergency hospital admissions for children and adults.
- The program has provided better access to primary care (seeing a doctor throughout childhood and getting immunizations) and resulted in fewer preventable hospitalizations (asthma, hypertension, chronic obstructive pulmonary disease, congestive heart failure angina).
- More expectant mothers receive prenatal care in the first trimester of pregnancy.

- The program has low rates of receiving no prenatal care or care only in the last trimester, fewer mothers smoke, and there are longer intervals between births.
- Infant deaths have decreased and birth weights have increased.

Keys and Barriers to Success

Rhode Island has made the most extensive and creative use of both internal and external analytic resources among our case study states. They have created a "culture of evaluation"[7] using a combination of internal staff, long-standing external contractors, other State agencies, foundation grants, and local university researchers. Together, they have produced an extensive series of evaluations and reports stretching over the last decade. Specific highlights of this culture include the following:

- From the outset, key managers in the program fostered a culture of evaluation in which program managers, staff, and consultants continually examined the program to identify problems and areas for improvement. The resulting reports are aimed at both internal and external audiences. Consumer advocates are heavily involved in these evaluations.
- The Rhode Island Medicaid program has a small in-house staff of State employees. However, it has supplemented that staff with highly experienced consultants and evaluators who work in the same offices as the State staff and perform extensive program monitoring, reporting, and evaluation work.
- Focus groups are used to provide a human dimension to the data and analysis, and the information may be more timely and actionable than that obtained from claims and survey data. In addition, information from focus groups may sometimes prove more persuasive to legislators, reporters, and others who want to know what "real people" think about the program.
- The legislative staff interviewed said that the "most remarkable thing" about the officials and staff running the Rite Care program is that they report problems promptly to the legislature and propose fixes.

TENNESSEE

MCOs (4 Total)	MCO Enrollment as of September 2016[25]
Amerigroup	452,836
TennCare Select	70,422
UnitedHealthcare Community Plan	484,288
BlueCare	544,128
Total	1,551,674

Tennesee MCO Implementation Highlights[26]

- **1994**: Tennessee introduces its Medicaid managed care program, TennCare. Its managed care program is statewide and mandatory for all coverage groups. The program has evolved over time to include or exclude various services from MCO contracts.
- **1996**: Tennessee begins offering behavioral health services to managed care enrollees through a prepaid limited benefit plan.
- **2007**: Tennessee reintegrates behavioral health under the medical MCO contracts.
- **2010**: MCOs begin to cover LTSS for older adults and individuals with physical disabilities via the TennCare CHOICES program (services had previously been paid for on a fee-for-service basis by the State). With the inclusion of CHOICES, TennCare MCOs now cover medical, behavioral health, and long-term care services.
- **July 2013**: CMS reapproves the demonstration authority used to operate TennCare. Under the renewed demonstration, beneficiaries will face small increases in cost sharing for prescription drugs.

Types of Measures Collected and How Evaluation Is Conducted

Tennessee uses the National Quality Strategy and CMS requirements as a guideline for developing goals. For example, one of the States' five main goals is to improve health care; this aligns with the aim of the National Quality Strategy to improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher quality care.

Tennessee requires both provider and member surveys as part of their MCO evaluation process.

- Each MCO is required to submit an annual Provider Satisfaction Survey Report that encompasses both physical and behavioral health. The report must summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement.
- TennCare also contracts with the nine Area Agencies on Aging and Disability—the program's points of entry for the aging and disabled populations —to conduct a face-to-face customer satisfaction survey and survey a sample of 5,000 recipients to gather information on their perceptions of their health care. The sample survey is conducted at the household level and compared to results from non-MCO beneficiaries from Tennessee.

The State of Tennessee developed a successful continuous QI process regularly used in assessment. QI processes include the following:

- The MCOs are contractually required to submit a variety of reports to various divisions within the Bureau of TennCare. The reports cover PIPs, population health, Early and Periodic Screening, Diagnostic, and Treatment services, dental services, CHOICES care coordination, annual QI/utilization management descriptions, evaluations and work plans, provider satisfaction surveys, dual eligible care coordination, etc.
- These reports are reviewed either quarterly or annually, depending on the report, and an annual analysis is completed.

Results of MCO Evaluation Activities

Tennessee has succeeded in managing the dual eligible population.

- In May 2013, a coordination of care program was established for an estimated 30,000 dual eligible TennCare enrollees. These include both frail elderly members and young people with physical and/or mental disabilities.
- During 2014, over 14,350 hospital admission notices were exchanged between hospitals, Medicare Dual Special Needs Populations (D-SNPs), and Medicaid MCOs.
    - Many of these notices led to requests for assistance with discharge planning and HCBS assessments, skilled nursing facility diversions, coordination of services through coordination of the authorization process, and other means of coordinating care between MCOs and D-SNPs.
    - Coordination of services upon hospital discharge occurred for over 10,000 of these admissions.
    - Over 1,100 care coordination touches were provided for these dual members, ranging from requests for assistance with assessment and care planning to referrals for service coordination.

Keys and Barriers to Success

TennCare addresses disparities as part of its strategy for success[8] through tracking rates of illness and chronic conditions in relation to key demographic factors, and is directly working to reduce health care disparities through contractually requiring its MCOs to provide essential networks and services required to address disparity issues. Examples of these requirements include the following:

- Ensuring an adequate medical provider network of appropriately credentialed providers increasingly committed to evidence-based practices to improve access to care and higher quality outcomes.
- Proactively promoting health screenings and preventive health care services to all TennCare members.
- Providing care coordination and direct support services for HCBS enrollees.

IOWA

MCOs (3 Total)	MCO Enrollment as of September 2016[27]
Amerigroup Iowa Inc.	185,833
AmeriHealth Caritas, Iowa Inc.	212,367
UnitedHealthcare Plan of the River Valley, Inc.	170,254
Total	568,454

Iowa MCO Implementation Highlights[28] [29]

- **December 1986**: Iowa introduces managed care through a pilot program that contracts with an MCO in one county.
- **1990**: Pilot program evolves into a primary care case management program, called MediPASS, and begins serving seven counties.
- **1999**: Iowa's Plan for Behavioral Health begins providing all inpatient and outpatient behavioral health and substance abuse services through a single prepaid inpatient health plan to all Medicaid eligibles, including dual eligibles and nondual age groups, not covered under MediPASS.
- **July 2011**: Greater than 90% of Medicaid beneficiaries in Iowa become enrolled in some form of managed care.
- **March 2012**: Iowa begins offering eligible beneficiaries the option of enrolling in a single MCO instead of MediPASS to cover all primary, all acute, and some specialty services.
- **June 2012**: Iowa announces a statewide health homes initiative to coordinate care for adults and children with at least two chronic conditions or one existing chronic condition but at risk of another (behavioral health is included as a chronic condition).
- MediPASS members who qualify for a health home and agree to participate are removed from MediPASS when they enroll in the health home.
- **June 2013**: A statewide health home initiative becomes available in 25 counties. A statewide, Integrated Health Home program begins in six counties for children and adults with chronic mental illness.
- **August 2013**: An MCO alternative to MediPASS becomes available in 19 counties.
- **2014**: MediPASS expands to 93 counties and MCOs expand to 43 counties. The Integrated Health Home program expands to 99 counties.
- **March 2016:** Statewide MCO contracts begin implementation.

The Iowa MCO implementation plan was delayed from January 1, 2016, to March 1, 2016, by CMS following a site visit to the state in December 2015. CMS indicated that although Iowa had worked hard to transition from a fee-for-service environment to managed care, the State had failed to meet some key implementing goals. The most significant was that MCO provider networks were not fully developed and lacked key providers.

The State began MCO implementation on March 1, 2016, and member enrollment began April 1, 2016. As of February 2017, there were 568,454 members enrolled in the Iowa Health Link program.

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