

Medicaid Managed Care: How States' Experience Can Inform Exchange Qualified Health Plan Standards

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State Affordable Insurance Exchanges (exchanges) are at the core of the coverage reform in the Patient Protection and Affordable Care Act (ACA), establishing a marketplace in which individuals and small employers can compare and select among affordable, quality health insurance options. The ACA charges exchanges with making Qualified Health Plans (QHPs) available to consumers and small businesses within the parameters of proposed ACA implementation guidance released on July 15, 2011.¹ State exchanges may go beyond these federal minimums and require QHP issuers to meet additional criteria to drive higher-value insurance coverage and advance broader state priorities.

As state exchanges embark on the task of certifying QHPs, they would do well to look to their experience with Medicaid managed care (MMC). In the past 20 years, states have learned an enormous amount from both their mistakes and their successes in purchasing MMC services. Today, states vary in their approaches to MMC purchasing, which range from highly regulated models to free market models intended to drive value through competition, though all states have minimum standards that MMC plans must meet in order to secure a contract with the state. This diversity in approach is likely to be mirrored as state exchanges develop more or less prescriptive approaches to QHP selection, and states can learn from and perhaps in some cases adopt the purchasing levers and requirements used in MMC programs at both ends of the spectrum.

Not all MMC requirements can or should be operationalized in state exchanges; some may even have become arcane in the context of MMC. Federal rules -- and, in some cases, state rules as well -- were adopted in the 1990s, when there was far less experience with managed care models. MMC has evolved considerably since then; some of the initial rules were prescient and assured successful managed care programs for consumers and states alike, while others proved unnecessary, adding costs or imposing barriers to effective managed care programs. However, whether the focus is on network adequacy and

IN BRIEF

A key responsibility of Affordable Insurance Exchanges is certification of Qualified Health Plans (QHPs), based on criteria including network adequacy, marketing requirements, clinical quality measures, and consumer information. State Medicaid managed care (MMC) contracts, expertise, and experience offer a wealth of information that can inform QHP certification policies and protocols. State MMC purchasing strategies range from more to less regulated; exchanges are likely to have a similar range of strategies.

This paper looks at MMC contracts in six states, noting the opportunities for exchanges to "borrow" from and align QHP standards with MMC, as well as areas in which MMC requirements are ill suited for adoption in exchanges.

marketing strategies or quality initiatives, whether implementation failed or succeeded, the experience of state MMC programs offers a foundation for exchanges as they operationalize QHP certification and selection protocols. In addition, by aligning standards across Medicaid and QHPs, exchanges maximize their influence on health care delivery models and facilitate continuity of coverage for individuals and families.

The MMC Experience

Mature MMC programs provide a wealth of experience in procuring and establishing contracting criteria for health plans. In Medicaid programs throughout the country, states have built upon federal MMC statutory and regulatory requirements² to develop robust criteria and systems for health plan certification, procurement, and oversight of key requirements related to quality, network adequacy, and marketing. Based on a nationwide survey of Medicaid directors conducted by the Kaiser Commission on Medicaid

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and the Uninsured, as of October 2010, 36 states (including Washington D.C.) were contracting with risk-based managed care organizations (MCOs) to provide health care services to Medicaid beneficiaries. Forty-one states and DC had enrolled more than 50 percent of their Medicaid population in some form of a comprehensive managed care arrangement (such as a Medicaid MCO or a primary care case management (PCCM) program).³

While Medicaid managed care differs from commercial health insurance with respect to population served, consumer cost-sharing, benefit design, and, to some degree, provider networks,⁴ the two sectors share many goals regarding quality and access. Forty percent of Medicaid enrollees are in plans that also serve the commercial and/or Medicare markets;⁵ alignment of these standards and criteria across Medicaid plans and QHPs provides an opportunity to promote delivery system reform. Examples of such opportunities are evident in MMC programs today, where states are driving system-wide initiatives to influence provider behavior and care delivery. Among these are New York's medical home initiatives, implemented in 2009, and Oregon's coordinated care organizations, authorized in 2011. The number of states pursuing delivery system reform initiatives is considerable and expanding – 39 states had a medical home initiative in place or under development as of October 2010, while 22 states were planning to exercise the new ACA-created “health homes” option for beneficiaries with chronic conditions and nine had an Accountable Care Organization (ACO) effort in some stage of development.⁶ State exchanges and Medicaid agencies would do well to collaborate in implementing similar initiatives across QHPs and Medicaid plans.

Mature MMC programs may also provide in-house expertise and infrastructure that state exchanges can leverage in their aggressive implementation timeframe to support QHP procurement and oversight. In

addition to being administratively efficient, this approach would allow Medicaid programs and exchanges to leverage purchasing power across multiple federally-subsidized and state-subsidized health insurance plans.

This paper examines MMC contracts in six states – Arizona, Minnesota, New York, Tennessee, Washington and Wisconsin⁷ – where a significant percentage of Medicaid beneficiaries are enrolled in comprehensive risk-based plans.⁸ We examine the decisions these states have made with respect to:

- Provider networks;
- Quality;
- Accreditation;
- Marketing;
- Information and data disclosure; and
- Plan selection.

For each area, we review relevant ACA provisions and the draft regulations, outline the requirements of the federal MMC law, and describe the mechanisms that these states use to implement these standards in their MMC contracts with insurance plans. We note the opportunities for exchanges to “borrow” from and align QHP standards with MMC, as well as areas in which MMC requirements are ill suited for adoption in exchanges. While it is beyond the scope of this paper, the federal and state governments may want to seize the opportunity presented by ACA implementation to rethink MMC policies and rules.

Provider Networks: Adequacy, Enrollee Access, Essential Community Providers

Federal MMC Requirements

Federal regulations are detailed, requiring state Medicaid programs to ensure that all covered services are available and accessible to MMC enrollees, with availability and access defined in the federal statute to include both: (1) sufficiency of the delivery

network, including range of services and number, mix and geographic distribution of providers;⁹ and (2) timely access to providers, with covered services “available within reasonable timeframes and in a manner that ensures continuity of care.”¹⁰ Federal regulations expand on these requirements so that MMC plans must meet state-specified standards for timely access to care and services taking into account the urgency of the need for care, and make services available 24 hours a day, seven days a week when medically necessary. States are required to establish mechanisms to regularly monitor provider compliance with these standards.¹¹

States must also ensure that MMC plans promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.¹²

State MMC Requirements

While their standards differ, state Medicaid programs include specific access requirements in their MMC contracts related to distance or travel time and distance maximums, appointment availability standards, and specific enrollee-to-provider ratios. States often apply different standards for primary and specialty care, as well as for urban and rural areas.¹³

Network Adequacy

State MMC contracts contain network adequacy provisions to ensure the sufficiency of plan provider networks. While some states, like Washington, incorporate only high-level requirements that generally align with federal MMC mandates, other states include specific requirements for primary and specialty care networks. Tennessee, for example, specifies certain types of hospital services and Centers of Excellence that must be included in MMC plan networks.¹⁴

To ensure adequate capacity, states mandate provider-to-enrollee ratios. New York’s contract specifies that no more than 1,500

enrollees can be assigned to each physician, or 2,400 enrollees for a physician practicing in combination with a registered physician assistant or certified nurse practitioner.¹⁵ Tennessee and Wisconsin’s contracts establish ratios for a wider range of specialty providers as well, including behavioral health, dental, and others.¹⁶

By comparison, Arizona’s MMC contract does not specify a provider-to-enrollee ratio, but specifies that the state will notify contracted plans on a quarterly basis if a PCP’s patient panel totals more than 1,800 Medicaid enrollees (assigned by a single plan or multiple plans), to enable plans to potentially modify the size of a given PCP’s panel.¹⁷ Washington requires MMC plans to establish their own provider-to-enrollee ratios for PCPs and specialty providers and then monitor compliance with those metrics.¹⁸

Timely Access to Care

All state MMC contracts articulate distance and travel time standards on plan provider networks, differentiating between rural and urban areas. Tennessee requires that travel time/distance for primary care sites not exceed 30 miles or 30 minutes in rural areas and 20 miles or 30 minutes in urban areas, while distance standards for specified specialty providers must not exceed 60 miles.¹⁹ Many contracts allow that distance/travel time standards may be waived or modified for rural areas if the closest provider is beyond the applicable distance standards.²⁰

Appointment availability standards are fairly consistent across state contracts. Most states require that plans be able to provide enrollees with emergency appointments on a same-day basis, urgent care appointments within 2-3 days of the request, and routine care appointments within 3-6 weeks of the request, depending on type of provider. Some states also include requirements for in-office waiting times. Arizona requires plans to ensure that an enrollee’s waiting time for a scheduled appointment is no

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more than 45 minutes.²¹ New York's contract prohibits plans from allowing enrollees to routinely wait longer than one hour to see a provider for a scheduled appointment.²²

All state contracts require plans to monitor provider compliance with access standards through such means as appointment schedule reviews and secret shopper phone calls, and to develop corrective action plans for providers that do not meet plan standards. States likely vary in their oversight of these compliance requirements.

Inclusion of Essential Community Providers

Several states require, and a number encourage, MMC plans to include in their networks providers who serve predominantly low-income, medically underserved individuals. Minnesota requires that an MMC plan offer to contract with all state-designated Essential Community Providers within its service area.²³ The state also requires plans to contract with nonprofit community health centers (CHCs), including all federally qualified health centers (FQHCs), rural health centers (RHCs), community mental health centers, and community health services agencies.²⁴ New York requires that plans contract with FQHCs in counties where enrollment in the MMC program is mandatory.²⁵ Tennessee and Arizona encourage plans to contract with FQHCs or other safety net providers,²⁶ and Arizona requires plans operating in specific counties to contract with homeless clinics for primary care services.²⁷

ACA Requirements for QHPs

Draft implementing regulations for state exchanges require that a QHP must comply with network adequacy standards,²⁸ and that such standards should be responsive to a state's particular geography, demographics and market conditions.²⁹ The Department of Health and Human Services (HHS) solicits comments as to whether additional, specific federal quantitative or qualitative standards would be appropriate in evaluating QHP

network sufficiency, including standards to assure access for enrollees residing in medically underserved and isolated areas.³⁰

The ACA and implementing guidance establish provider network adequacy requirements as a condition of QHP certification, including ensuring that enrollees have a sufficient choice of providers and information regarding the availability of both in-network and out-of-network providers.³¹ In establishing such standards for QHPs, the law acknowledges that in addition to providing access to comprehensive insurance coverage, exchanges, through their participating QHPs, are charged with ensuring that such coverage leads to timely access to health care. Proposed implementing regulations also require that QHPs include in their networks "sufficient" numbers of essential community providers that serve predominantly low-income, medically-underserved individuals, an area of deep Medicaid experience.³² Recognizing that primary care access may be a challenge, HHS encourages exchanges to consider broadly defining the types of providers that furnish primary care services.³³

Discussion

Vast experience in MMC demonstrates that it is critical for the purchaser – whether the state Medicaid agency or the exchange – to influence access to care through specific access requirements, and to monitor plans and providers for compliance with those requirements. MMC standards related to network adequacy and access provide a valuable foundation for state exchanges as they consider development of similar access standards for QHPs. In particular, MMC standards and requirements geared toward ensuring access in medically underserved areas will be instructive to QHP criteria development. MMC is a natural and robust source of intelligence on these issues.

Quality Requirements

The ACA includes several provisions and significant funding for improving quality of

and access to health care at the community, health plan, delivery system, and point-of-care levels. As required by the law, HHS recently released a National Strategy for Quality Improvement in Health Care that sets priorities to “promote quality health care in which the needs of patients, families, and communities guide the actions of all those who deliver and pay for care.”³⁴ Consistent with this overarching quality focus, the ACA and subsequent guidance requires that state exchanges ensure that QHP issuers implement a quality improvement strategy.

Federal MMC Requirements

State MMC contracts operate under extensive federal quality requirements, including development of a quality assessment and improvement strategy that encompasses: (1) standards for access to care and other measures to assess care and quality; (2) procedures for monitoring, evaluating and reporting on the quality of

care provided by MMC plans to enrollees;^{35,36} and (3) quality assessment/performance improvement (QA/PI) programs.³⁷ Plans must also meet requirements related to care coordination for all enrollees, including those with special needs,³⁸ and the establishment and dissemination of clinical practice guidelines.³⁹

State MMC Requirements

All states require that MMC plans engage in quality assessment and improvement activities. State contracts include minimum plan performance level benchmarks, performance improvement goals, and initiatives aimed at improving the quality of care provided to enrollees with chronic conditions or special care needs. Several states provide financial or other incentives (such as auto-assignment of enrollees) to plans that demonstrate high performance on defined quality measures and, conversely, impose financial penalties and sanctions on

TABLE 1: Medicaid Managed Care State Network Adequacy and Enrollee Access Requirement

	AZ	MN	NY	TN	WA	WI
Network Adequacy						
Provider-to-enrollee ratios specified	--	--	✓	✓	--	✓
Detailed requirements for specialty networks	✓	--	✓	✓	--	--
Timely Access to Covered Services						
Appointment availability standards	✓	✓	✓	✓	✓	✓
Appointment waiting time standards	✓	--	✓	✓	--	✓
Travel time/distance standards	✓	✓	✓	✓	✓	✓
Transportation wait time standards	✓	--	✓	✓	--	--
Compliance monitoring specified	✓	--	✓	✓	--	✓
Enrollee Information						
Information to enrollees regarding contracted providers required	✓	✓	✓	✓	✓	✓
Inclusion of Essential Community Providers						
Requirements related to contracting with providers for the medically underserved	✓	✓	✓	--	--	--

plan contractors that fail to meet quality benchmarks or continually improve performance. Indeed, more than half of the MMC states that contract with MCOs have a pay-for-performance (P4P) element in their payment to plans, such as bonus payments, or withholding a portion of the capitation that can be earned back through improved or high performance.⁴⁰

Quality Assessment/Performance Improvement Programs

All states require that MMC plans implement QA/PI programs, submit written plans detailing program structure and processes, and periodically evaluate the effectiveness of QA/PI activities. Some states, like Washington, specify only baseline requirements for written QA/PI program plans, while others detail the substance of those plans. Arizona, for example, requires that contractors submit a “Quality Management Plan Checklist” that indicates their compliance with almost 100 state requirements.⁴¹

- *Performance Improvement Projects (PIPs)* – All states require that plans establish and maintain PIPs, but requirements vary considerably.⁴² New York requires that plans “conduct at least one PIP each year in a priority topic area of its choosing with the mutual agreement of the SDOH [State Department of Health]” in compliance with SDOH guidelines regarding study structure and reporting format.⁴³ Wisconsin requires that plans conduct at least two PIPs selected from a diverse list of state-identified clinical and non-clinical priority areas (e.g., tobacco cessation, childhood immunizations, blood lead testing, diabetes management, access and availability of services, member satisfaction, etc).⁴⁴
- *Performance Measures* – All states require MMC plans to measure and report their performance on key measures.⁴⁵ The majority of states rely on Healthcare Effectiveness Data and Information Set (HEDIS) performance measures to assess the quality and

accessibility of care provided to enrollees, as well as Consumer Assessment Healthcare Providers and Systems (CAHPS) survey results to gauge member satisfaction with MMC arrangements.⁴⁶ All states require that performance measurement data be validated by External Quality Review Organizations (EQROs) in compliance with federal requirements.

In several states, plans that fail to meet minimum performance benchmarks may be subject to sanctions. Arizona plans that do not achieve specified minimal levels of performance are required to submit a corrective action plan and may be subject to a sanction of up to \$100,000 for each deficient measure.⁴⁷ In Washington, plans that fail to meet benchmarks for any of several specified performance measures must implement PIPs designed to increase rates for those measures.⁴⁸

Care Coordination and Disease Management

States also require that plans undertake efforts to improve the quality of care for enrollees with special health care needs or particular medical conditions. All states require that plans identify enrollees with special needs and implement case management/care coordination services or some type of treatment plan for them. Some states also require care coordination for particular types of services; for example, Wisconsin requires that contracted plans identify women at high risk for poor birth outcomes and provide for their coordinated and continuous care.⁴⁹ A number of states also require that MMC plans implement disease management (DM) programs.⁵⁰ Minnesota requires that plans make DM programs available to enrollees with diabetes, asthma, and heart disease.⁵¹ Tennessee’s requirements, which are considerably more stringent, require that plans operate DM programs for 10 specified conditions.⁵²

Clinical Practice Guidelines

All state MMC contracts include provisions that require plans to develop and/or adopt existing practice guidelines that are based on reliable clinical evidence and to disseminate them to providers. Some MMC contracts, such as New York's, specify the organizations from which plans are permitted to adopt established clinical guidelines (e.g., American Academy of Pediatrics, American Academy of Family Physicians, etc.).⁵³ Some states also require plans to monitor or assess provider compliance with disseminated guidelines. Minnesota requires that plans audit a "reasonable sample of providers" to determine compliance with practice guidelines that the plan considers a high priority for audit.⁵⁴ New York requires that plans annually select at least two practice guidelines and assess the performance of appropriate providers (or a sample of providers) against them, as well as develop and implement procedures for identifying and improving the compliance of providers who do not adhere to guidelines.⁵⁵

Pay for Performance

As mentioned above, a number of states offer plans financial and other incentives to encourage their provision of high-quality, accessible, and cost-effective care. Minnesota's MMC contract offers plans incentive payments for meeting performance measurement goals related to the accessibility of well-child primary care, certain types of preventive health services (such as mammograms or Chlamydia screenings), and developmental and mental health screenings for children.⁵⁶ Minnesota also requires that MMC plans implement a pay-for-performance model that rewards its network providers for furnishing high-quality care for diabetes and/or coronary/vascular disease.⁵⁷ In 2003, New York launched a program to incentivize Medicaid health plans to improve quality outcomes and care for their members. The program awards incentives to plans that excel in quality outcomes, report high consumer satisfaction, avoid preventable hospital admissions, and meet state

compliance standards. Recently, the program has awarded a one, two, or three percentage adjustment to plan premiums depending on the recognition level achieved by the plan. Plans that do not receive the quality incentive are not allowed to participate in the auto-assignment algorithm for new members who do not choose a plan. Notably, funding for both the Minnesota and New York performance incentive programs has been reduced in state Medicaid budget cuts over the past two years.⁵⁸

Wisconsin offers financial incentive payments to MMC plans that meet or exceed minimum performance standards.⁵⁹ In some states with mandatory Medicaid managed care programs, plan contracts provide for preferential auto-assignment of beneficiaries who do not otherwise select a plan to plans with higher quality rankings.⁶⁰

ACA Requirements for QHPs

In order to be certified as a QHP, a health plan must implement a quality improvement strategy,⁶¹ including a payment structure that provides increased reimbursement or other incentives for:⁶²

- Improving health outcomes through activities such as quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, and use of the medical home model.
- Preventing hospital readmissions through hospital discharge programs providing patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional.⁶³
- Improving patient safety and reducing medical errors through the use of best clinical practices, evidence-based medicine, and health information technology.
- Implementation of wellness and health promotion activities.

Mature MMC programs provide in-house expertise and infrastructure that state exchanges can leverage to support QHP procurement and oversight within an aggressive implementation timeframe.

- Implementation of activities to reduce health and health care disparities, including the use of language services, community outreach, and cultural competency training.

Proposed implementing regulations require QHP issuers to implement and report on their quality improvement strategies and enrollee satisfaction surveys, but defer specific quality standards to future regulation.⁶⁴

Discussion

State MMC programs provide a wealth of policy and operating experience from which exchanges should draw as they develop QHP criteria with regard to quality

improvement. Some standards, specifically DM and care coordination requirements, may provide a useful foundation from which to build QHP criteria, but do not necessarily merit wholesale adoption or full alignment. This is largely because of the inherent differences between Medicaid populations and higher-income QHP populations. Differences in health status, socioeconomic status and clinical acuity may drive unique DM and care coordination services in Medicaid that need not be replicated in QHPs. The use of pay-for-performance strategies for MMC plans in New York and Minnesota has been hit hard from a budgetary perspective, making their ability to influence quality questionable in the near term. Nevertheless, the need for quality

TABLE 2: Medicaid Managed Care State Quality Requirements

	AZ	MN	NY	TN	WA	WI
Quality Assessment/Improvement						
QA/PI program and written plan required	✓	✓	✓	✓	✓	✓
Performance measure reporting	✓	✓	✓	✓	✓	✓
Minimum performance standards for required measures	✓	--	✓	✓	✓	✓
Performance goals / ongoing improvement required	✓	--	--	--	--	✓
PIP(s) required	✓	✓	✓	✓	✓	✓
PIP topics specified to align with state's public health goals	✓	--	--	✓	--	✓
Care Coordination and Disease/Chronic Care Management						
PCPs as care coordinators	✓	✓	✓	✓	✓	✓
Case management/ treatment plans for enrollees with special care needs	✓	✓	✓	✓	✓	✓
Disease/chronic condition management program	✓	✓	--	✓	--	--
Clinical Guidelines						
Practice guidelines required	✓	✓	✓	✓	✓	✓
Assessment of provider compliance with guidelines	--	✓	✓	--	--	✓
Pay-for-Performance						
Financial incentives available to plans for high performance	--	✓	✓	✓	-- ⁶⁵	✓

improvement, reporting, measurement, and quality-driven payment arrangements is common across the continuum of health insurance and systems of care delivery, and these requirements lend themselves to standardization in Medicaid and the exchanges. Indeed, the Secretary's National Quality Strategy identifies these requirements as four of the 10 principles implicit in designing a quality program consistent with the aims of the national strategy.

Accreditation Requirements

Central to the value that exchanges bring to states' insurance markets is transparency and comparability of information regarding QHP options. The ACA and implementing guidance articulate substantial requirements of exchanges with regard to presenting information about QHP offerings on the exchange in plain language and in a standardized fashion, to enable consumers to easily understand and compare their options for purchasing coverage. One aspect of standardization is the requirement that QHP issuers be accredited by an HHS-recognized entity, indicating that an issuer meets minimum standards of quality and consumer protection.⁶⁶

Federal MMC Requirements

Federal law does not require that plans be accredited in order to participate in MMC, but does recognize overlap in private accreditation processes and federally-required External Quality Review (EQR) activities. The federal Medicaid statute and regulations require states to ensure through MMC contracts that plans participate in an EQR process, while allowing for the non-duplication of EQR activities and private accreditation processes.⁶⁷

State MMC Requirements

A number of states surveyed require or otherwise recognize third-party accreditation for contracted MMC plans. According to the Kaiser Commission's survey of Medicaid directors, as of October 2010, 16 states require plans to be

accredited in order to participate in Medicaid, while a number of other states recognize or encourage accreditation, often by deeming accredited plans to meet certain state and federal requirements.⁶⁸ Indeed, several of the states under review include requirements in their MMC contracts related to third-party accreditation:

- *Tennessee:* Tennessee's MMC contract requires that all plans contracting with TennCare be National Committee for Quality Assurance (NCQA) accredited.⁶⁹ Plans that are NCQA accredited at the contract start date must maintain accreditation throughout the contractual period; those plans that are not NCQA accredited at the contract start date must obtain accreditation on a specified timeline and maintain accreditation for the duration of the contract.⁷⁰ The contract also requires plans to use the "NCQA Guidelines for the Accreditation of MCOs" for a number of activities, including the credentialing and re-credentialing of contract providers,⁷¹ the development of certain sections of its member handbooks,⁷² and the development and implementation of its Quality Management/Quality Improvement (QM/QI) Program.⁷³
- *Wisconsin:* Wisconsin's MMC contract "encourages" plans to "actively pursue accreditation by the NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), Utilization Review Accreditation Commission (URAC), or other recognized accrediting bodies approved by the Department."⁷⁴ Moreover, Wisconsin offers an "accreditation incentive" for a plan's achievement of full accreditation by an approved body.⁷⁵ The Accreditation Incentive Program allows plans to submit evidence of accreditation in lieu of undergoing required onsite external quality reviews and providing certain documentation related to performance improvement projects.⁷⁶

The need for quality improvement, reporting, measurement, and quality-driven payment arrangements is common across the continuum of health insurance and systems of care delivery.

- Minnesota:** Minnesota’s MMC contract recognizes private accreditation standards in a number of areas. Like Tennessee, Minnesota requires that MMC plans use NCQA accreditation standards for a number of activities such as development of a utilization management structure,⁷⁷ a uniform provider credentialing and re-credentialing process,⁷⁸ an annual Quality Assurance Work Plan and QA/PI program evaluation, and required disease management programs.⁷⁹ The contract also specifies that the state may rely on information collected from private accreditation reviews in place of information collected by an EQRO, provided that such activity is in compliance with specified requirements.⁸⁰

ACA Requirements for QHPs

Draft ACA implementing regulations interpret the ACA’s accreditation requirement as applying to issuers, not QHPs, and specifically require states to establish an accreditation timeline.⁸¹ HHS encourages states to provide a sufficiently long grace period to accommodate issuers that may be seeking accreditation for the first time.⁸² The distinction between QHPs and QHP issuers will allow state exchanges to certify a QHP while the QHP issuer is still seeking accreditation.

Discussion

MMC programs appear to increasingly rely on accreditation as a requirement of program participation or as a proxy demonstrating that plans meet program quality, service, and access requirements. Standards for accreditation, at least those for NCQA accreditation, are uniform for Medicaid health plans and commercial carriers, supporting the notion of alignment in purchasing across Medicaid and QHPs. Additional alignment considerations for states relate to Medicaid agency and exchange policies and procedures with regard to treatment of plans or issuers who have their accreditation suspended.

Table 3 compares the accreditation provisions of the six state contracts.⁸³

Marketing Requirements

The ACA and implementing guidance require exchanges to establish marketing regulations for QHPs, but leave much to the discretion of states with respect to the substance of such requirements. Federal and State statute and regulation impose significant marketing requirements on MMC health plans. These requirements, which in some states are highly prescriptive, are an outgrowth of marketing abuses in the early days of MMC implementation nationally. While such MMC marketing

	AZ	MN	NY	TN	WA	WI
Accreditation as condition of contract	--	--	--	✓	--	--
Incentives for accreditation (e.g., use of accreditation information in lieu of specific EQRO activities or other required documentation)	--	✓	--	--	--	✓
Required use of private accreditation standards for specific activities (e.g., creation of provider credentialing process, DM programs)	--	✓	--	✓	--	--

experience may provide insight to state exchanges, the breadth and depth of marketing restrictions in some state MMC programs may not be applicable or necessary in the context of exchanges.

Federal MMC Requirements

MMC plans are subject to an array of federal marketing requirements. Specifically, MMC entities are prohibited from distributing marketing materials without prior approval of the state.⁸⁴ Marketing materials may not contain false or materially misleading information.⁸⁵ MMC plans are required to distribute marketing materials throughout their contractually-specified service area.⁸⁶ MMC plans are prohibited from directly or indirectly engaging in door-to-door, telephone or other types of “cold-call” marketing activities⁸⁷ (defined as any unsolicited personal contact by the plan for the purposes of marketing⁸⁸). Finally, plans must ensure that prior to enrollment individuals receive sufficient information, in a language and format that is easily understood, to make an informed decision regarding whether to enroll in a particular MMC plan.⁸⁹

State MMC Requirements

States have incorporated a range of marketing requirements into their MMC plan contracts, defining how and to whom plans may market their MMC product offerings. Though varied in specificity and stringency, state MMC contract marketing provisions are intended to protect consumers from aggressive marketing tactics, provide them with accurate information on plans and the MMC program, and prevent discrimination. Permitted marketing activities vary from state to state. Most states allow MCOs to conduct outreach and marketing activities within federal parameters, but six states explicitly prohibit such activity.⁹⁰ Additionally, a majority of states that contract with Medicaid MCOs use a third-party enrollment broker to provide plan information to beneficiaries and assist them with plan selection.⁹¹ Of the states under review, Tennessee bars

MMC plans from engaging in any type of marketing to potential or current enrollees, allowing plans to engage only in communication that promotes the contractor but does not specifically seek to influence an individual’s enrollment decision.⁹² However, other states, like New York and Arizona, permit plans to market MMC offerings to prospective enrollees in compliance with a specified set of guidelines.⁹³

State Prior Approval of Marketing Materials and Activities

All states require approval of marketing materials prior to distribution, and several specify how frequently materials must be reapproved. Arizona, for example, requires that materials be resubmitted for approval every two years, as well as after any modification.⁹⁴ In addition, Arizona and New York require plans to seek approval before engaging in specific types of permissible marketing activity.⁹⁵ New York goes further still by mandating that plans submit for approval a detailed Marketing Plan that specifies all of the proposed activities that the plan intends to undertake during the contract period.⁹⁶

Marketing Materials

Each state’s MMC contract also specifies content that is either required or prohibited in MMC plan marketing materials. All states prohibit the inclusion of false or misleading content; additionally, states often use MMC contracts to dictate the format that marketing materials must take, including accessibility standards. Minnesota’s contract, for example, is among the most specific, mandating that all written materials pass a “readability test” in which they prove to be understandable to a person who reads at a seventh-grade level and be printed in at least 10-point type.⁹⁷

Marketing Activities

Contracts specify rules related to the distribution of marketing materials, with most reiterating the federal requirement that materials be distributed throughout a contractor’s entire service area and, in a number of cases, specifying that distribution

MMC marketing experience and requirements can provide exchanges with a base of expertise in developing materials that are linguistically and culturally accessible to all consumers.

be equitable and “without bias toward or against any group.”⁹⁸ Some states limit the frequency with which materials can be distributed, and contracts often list particular locations where written materials can be made available. Wisconsin’s contract specifies that plans may make brochures and posters available at provider offices and clinics to inform patients that the provider is part of their network, as long as all plans with which the provider contracts are allowed to participate.⁹⁹ New York includes considerably more detail in this regard, providing an extensive list of locations where approved marketing materials may be distributed (e.g., community centers, markets, pharmacies, schools, etc.) as well as where they may not be (e.g., hospital emergency rooms and patient rooms or treatment areas).¹⁰⁰

Contracts also govern the types of events that plans can attend to engage in marketing activities. A common theme across contracts is that these events must be health-related and open to the public.¹⁰¹ Finally, many states include provisions in MMC contracts that specify whether plans are permitted to offer gifts or incentives to potential enrollees or current members. Wisconsin permits plans to offer nominal gifts as an incentive to meet a health goal.¹⁰² Minnesota forbids any compensation or reward as an inducement to enrollment.¹⁰³

Marketing Representatives

Only a small number of contracts include provisions setting guidelines related to MMC plans’ marketing representatives. However, these contracts seem worthy of mention in light of the ACA’s requirement that state exchanges establish Navigator programs to similarly facilitate individuals’ enrollment in a QHP. Tennessee’s MMC contract addresses the issue by placing restrictions on “compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled.”¹⁰⁴ New York imposes a similar restriction, but is considerably more

specific and stringent. The contract includes restrictions on plans’ reducing representatives’ base salary for failure to meet productivity targets, paying a commission or fixed amount per enrollment, and awarding particular types of bonuses.¹⁰⁵

ACA Requirements for QHPs

The ACA requires the Secretary to establish marketing requirements.¹⁰⁶ Proposed implementing regulations require QHP issuers to comply with state marketing rules and bars use of practices that discourage enrollment of individuals with significant health needs.¹⁰⁷ HHS seeks comment on the best means to monitor QHP issuers’ marketing practices, and on whether a broad prohibition against unfair or deceptive marketing practices is warranted.¹⁰⁸ HHS urges that exchanges work closely with state insurance departments to ensure that issuers in and out of the exchange are subject to the same minimum marketing standards in order to create a level playing field with equal consumer protections.¹⁰⁹

Discussion

MMC marketing experience and requirements can provide exchanges with a base of expertise, particularly in the area of developing consumer materials that are linguistically and culturally accessible to all consumers. MMC programs also have deep experience in monitoring plan compliance with marketing rules, and such experience may well be relevant to exchanges. Other marketing restrictions that are typical in MMC programs, such as prior approval of all marketing materials, and prohibitions with regard to marketing material distribution points, may be both onerous and costly to administer in an exchange setting. Such requirements may have the effect of driving up exchange and QHP administrative costs, and, ultimately, consumer premiums. Additionally, overly restrictive marketing rules for exchange products as compared to products outside of the exchange may impact consumer purchasing behavior.

In draft implementing regulations, HHS encourages states to maintain similar marketing standards inside and outside of the exchange. In establishing marketing and other requirements of QHPs, it will be essential for state exchanges to balance consumer protection and adverse selection concerns against the goal of maximizing carrier and consumer participation in the exchange.

Table 4 compares the marketing provisions of the six state contracts.

Information and Data Disclosure Requirements

To further the goal of providing standard, transparent and accessible information to consumers to facilitate their health insurance purchasing decisions, the ACA

requires QHP issuers to provide extensive information and data to exchanges. State MMC programs, pursuant to federal MMC requirements, also impose significant reporting requirements on contracted plans. A principle difference between QHP and MMC plan reporting requirements is that QHP data will be public-facing on exchange websites, while MMC plan reporting has historically been prepared for regulatory consumption and in many states is not made public to consumers. However, some MMC programs may be moving toward making this information more readily available and actionable for consumers. For example, 15 states that contract with MCOs in their MMC programs currently prepare and make available quality “report cards” for beneficiaries to use when choosing a plan or a provider.¹¹⁰

TABLE 4: Medicaid Managed Care State Marketing Requirements						
	AZ	MN	NY	TN	WA	WI
State Prior Approval						
Marketing/member outreach plan	--	--	✓	--	--	✓
Pre-approval of marketing materials	✓	✓	✓	✓	✓	✓
Pre-approval of marketing activities/events	✓	--	✓	--	--	--
Re-approval of marketing materials (periodic or due to revision)	✓	--	✓	--	--	✓
Marketing Materials						
Specific content required/prohibited	✓	✓	✓	✓	✓	✓
Specific format required	--	✓	✓	--	✓	✓
Marketing Activities						
Distribution rules specified	✓	✓	✓	--	✓	✓
Acceptable sites for marketing materials/activities specified	✓	✓	✓	--	--	✓
Acceptable marketing mediums specified (e.g., radio, TV)	✓	✓	✓	--	--	--
Prohibition on cold-call marketing	✓	✓	✓	✓	✓	✓
Limits on gifts/incentives specified	✓	✓	✓	✓	✓	✓
Explicit prohibition against discrimination in marketing	✓	--	✓	--	✓	✓
Marketing Representatives						
Rules for plans’ marketing representatives	--	--	✓	✓	--	--

Federal MMC Requirements

Federal law imposes several requirements regarding plans' collection and reporting of information to states to verify plan compliance with federal MMC standards, including requirements related to financial disclosure and quality reporting. The federal Medicaid statute requires that MMC plans disclose financial information related to company ownership and certain financial transactions.¹¹¹ They must also report encounter data¹¹² and quality assurance data¹¹³ to the state.

Federal regulations also mandate that MMC plans report a considerable amount of information to the state related to required quality assessment and improvement programs, such as the outcomes of PIPs, and plan performance on specified quality measures.¹¹⁴ Pursuant to federal law, plans must maintain an information system that collects, analyzes, integrates, and reports: (1) information on utilization, grievances, and disenrollment; and (2) encounter data on enrollee and provider characteristics, and services furnished to enrollees.¹¹⁵

With regard to public reporting of collected information, federal law requires that plans make financial disclosures available to enrollees upon request.¹¹⁶ Federal law also mandates that the results of required EQR activities be made available to the public¹¹⁷ and that, in states which utilize enrollment brokers, information on benefits, cost-sharing and plan quality and performance be made available in comparative, chart-like form.¹¹⁸

State MMC Requirements

States impose considerable data reporting requirements on MMC plans. All require that plans submit financial reports to the state, including disclosure of ownership information, as well as encounter data and quality measurement performance data. Contracts also specify the required format for reports and deadlines for submission. Additional types of reporting requirements that are common across state MMC contracts include:

- Financial statements
- Conflict of interest and business transaction disclosures
- Enrollment and disenrollment data/reports
- Network adequacy and access reports
- Provider payment reports
- Utilization management reports
- Quality assessment/improvement reports
- Marketing reports
- Grievance system summaries/reports
- Claims management reports
- Fraud and abuse activities reports
- HIPAA reports

Quality Reports

All states require that MMC plans report their performance on a set of standardized performance measures. All state MMC contracts also mandate that plans submit reports on their required Quality Assessment/Performance Improvement Programs, as well as on plan PIPs.

Financial Reports

All contracts require that plans submit a range of financial reports, as well as disclose ownership and business transaction information, to state Medicaid agencies. For example, Tennessee requires that MMC plans submit quarterly and annual financial reports, audited financial statements, medical loss ratio reports, and ownership and financial disclosures reports.¹¹⁹ Arizona provides contractors with a Financial Reporting Guide that details the required components of financial reports and instructs contractors regarding report creation and submission.¹²⁰

Public Reporting

States generally make information on plan performance and plan financial information available to the public. New York, for example, makes a considerable amount of information available on the NYSDOH's website regarding contracted MMC plans,¹²¹ including consumer-friendly charts that compare plan performance on required Quality Assurance Reporting Requirements (QARR) measures across plans.¹²²

Wisconsin and Minnesota similarly make MMC plan “report cards” or comparison charts available online that compare health plan performance on quality and consumer satisfaction metrics.¹²³ Minnesota also makes available financial reports submitted to the state by MMC plans.¹²⁴ In fact, Governor Dayton of Minnesota issued an Executive Order in March 2011 requiring that the state establish a managed care website for “all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts and other information for state public programs.”¹²⁵ Finally, as part of its “value driven decision support initiative,” Arizona is in the process of developing a score card that will compare plan performance on cost management, consumer satisfaction, and quality requirements and will be made available to the public on the AHCCCS web site.¹²⁶

ACA Requirements for QHPs

The ACA and the proposed regulations require that QHP issuers provide exchanges, states, HHS, and consumers with a range of information on plan operations, including: quality performance metrics, enrollee satisfaction, enrollment and disenrollment rates, enrollee cost-sharing, claims payment practices, justification for rate increases and enrollee rights, and any other information required by the Secretary.¹²⁷ Much of this information must be provided on an exchange website in a way that enables consumers to compare QHPs.¹²⁸ All public information must be presented in plain language and be accessible to individuals with limited English proficiency and to people with disabilities.¹²⁹ Proposed regulations codify the ACA’s requirement that transparency is a condition for certification of QHPs.¹³⁰

Discussion

MMC reporting experience provides a solid basis of expertise from which exchanges should draw, particularly those states that have developed consumer-facing plan comparison tools on quality and consumer

satisfaction metrics. Because MMC products are fundamentally different from QHP products in that MMC benefits and consumer out-of-pocket costs are generally standardized across all contracted plans, there is little in MMC from which to draw in terms of consumer information on comparing benefits and costs of plans. Perhaps the most significant opportunity, as exchanges develop reporting and data sharing requirements for QHPs, is that state MMC programs can collaborate with exchanges in developing aligned and standardized reporting across programs. This may include investing in and leveraging all payer claims database development in states, which will be designed to meet new risk adjustment requirements in the ACA. These tools will also meet MMC encounter and claims data reporting requirements. Ideally, such coordination could be informed by and aligned with private sector quality and performance reporting efforts, such as the Robert Wood Johnson Foundation’s Aligning Forces for Quality (AF4Q) initiative.

Plan Selection Requirements

The ACA requires state exchanges to certify QHPs to the extent that their participation in the exchange is in the interest of businesses and consumers. Provided that exchanges have standard and consistent criteria for QHP selection, the ACA provides states with broad discretion in procuring and selecting QHPs. Federal statute similarly leaves much flexibility to states in terms of how they select and contract with MMC plans, and as a result, MMC procurement practices vary across states, ranging from states contracting with all plans that meet state price and contracting requirements, to competitive bidding in which a limited number of plans are selected based on price and value.

Federal MMC Requirements

Federal law and regulations impose numerous requirements on states and the MMC plans with which they contract.

Perhaps the most significant opportunity, as exchanges develop reporting and data sharing requirements for QHPs, is that state MMC programs can collaborate with exchanges in developing aligned and standardized reporting across programs.

With respect to plan selection, the regulations forbid states from contracting with MMC plans that fail to meet federal statutory and regulatory requirements. Additionally, states must monitor plan compliance with contract requirements¹³¹ and establish “intermediate sanctions” to be imposed on plans that are not in compliance.¹³² States also have the authority to terminate contracts with MMC plans that do not carry out the substantive terms of their contract.¹³³ Beyond requiring that MMC plans meet the standards articulated in law and regulations, HHS does not dictate the process by which state Medicaid agencies should select the health plans with which it contracts.

State MMC Requirements

States employ a range of strategies for selecting health plans with which to contract for MMC services. Some states, such as New York, accept all plans that meet contractual requirements and agree to the price established by the state; other states, such as Minnesota, use a competitive procurement process and select plans based on parameters including price and quality. States have also gained experience with these processes through their setting of capitation rates – while a number of states set capitation rates administratively using actuaries, other states set rates by negotiation (11 states), by competitive bid within actuarially determined ranges (10 states), by simple competitive bid (five states) or by some combination thereof.¹³⁴

Limit on Number of MMC Plans

Among those states that use an RFP process, some exercise the state’s purchasing power by limiting the number of plans with which the state will contract for MMC services. Tennessee, for example, contracts with only two plans in each of three geographical regions in the state.¹³⁵ Arizona similarly limits the number of plans with which it will contract by geographical service area (GSA); the state awards a maximum of two contracts in the majority of GSAs and a limited number of additional contracts in its

two most populous GSAs (a maximum of five and six contracts, respectively).¹³⁶

States that do not limit the number of plans that may participate – such as Washington and Wisconsin – reserve the right to act in the state’s best interest in accepting or rejecting plan proposals. Wisconsin’s RFP specifies that the state will select the three highest-scoring proposals to be eligible for a contract but indicates that, if deemed to be within the best interest of the state, additional contracts “may be awarded to one or more Proposals” that fall within close range of the third-highest-scoring proposal.¹³⁷ Likewise, Washington’s draft RFP states that it will award contracts to “multiple bidders” based on proposal evaluation scores, but that the final decision regarding the number of and which bidders are awarded contracts will be made by the Health Care Authority (HCA). Further, the decision will be “guided, but not bound, by the scores awarded by the evaluators” and will ultimately be based on a determination of which proposals “best meet the needs” of the state.¹³⁸

Right to Negotiate Contract Terms / Best and Final Offers

Due to reforms put into effect in March 2011 by Governor Mark Dayton, Minnesota now requires that all state contracts be subject to a competitive bidding process.¹³⁹ Accordingly, MMC plans must submit bids that are scored on a point system which assesses a plan’s ability to provide quality services while keeping costs low.¹⁴⁰ Several states also reserve the right to negotiate prices with or request best and final offers from bidders. Wisconsin, for example, explicitly states that they “may negotiate the terms of the contract, including award amount, with the selected Proposer(s) prior to entering into a contract.”¹⁴¹ Additionally, the Wisconsin RFP indicates that the state may ask the highest-scoring bidders to submit best and final offers. Final offers are then scored against the stated evaluation criteria and awards are granted to the highest scoring final offers.¹⁴² Arizona also reserves the right to issue a written request

to submit a best and final offer in a particular GSA if considered in the best interests of the state.¹⁴³

Evaluation Criteria

Finally, states seek to shape bidders' responses to meeting state contracting priorities by weighting the proposal criteria. For example, Arizona weights its evaluation factors in the following order: capitation bids (cost); program (the policies and procedures supporting the provision of covered services); organization (ability to perform necessary administrative tasks); and network (capacity to develop and manage an adequate provider network).¹⁴⁴

Comparatively, Tennessee awards the most possible points for a bidder's proposed technical approach; the next highest weighted evaluation criterion is cost, followed by qualifications and experience.¹⁴⁵ Wisconsin weights its evaluation criteria between technical requirements and cost equally so that each is worth 50 percent of the proposal's final score. However, components of the technical requirements section are weighted so that 60 percent of the points awarded are based on a bidder's previous MMC experience, 32 percent on proposed quality performance strategy, and eight percent on medical home pilot strategy.¹⁴⁶

ACA Requirements for QHPs

The ACA and the proposed implementing rule establish certification requirements to ensure that QHPs in all exchanges meet consistent minimum standards of quality and value, while allowing states to impose additional requirements tailored to local market conditions.¹⁴⁷ Tracking the language of the ACA,¹⁴⁸ proposed exchange regulations provide that an exchange may only certify a QHP upon determining that the QHP's participation in the exchange is in the interest of consumers and small employers.¹⁴⁹ An exchange could decide to certify all plans that meet minimum certification requirements that align with or expand upon federal minimums. Alternatively, an exchange could undertake

a competitive procurement or selective contracting process, achieving additional value and quality objectives by limiting plan participation.¹⁵⁰ Notably, the preamble to the draft regulations specifically references the experience of many state Medicaid agencies in using selective contracting models.¹⁵¹

The preamble suggests additional criteria beyond federal minimums that state exchanges may want to consider in determining whether a QHP serves the interests of individuals and employers, including: (1) past performance of the QHP issuer; (2) reasonableness of plan cost-sharing requirements; (3) quality improvement activities; (4) network capacity; and (5) service area.¹⁵²

The ACA and the proposed rules require exchanges to monitor QHP compliance with certification standards and to establish recertification and decertification processes for QHPs.¹⁵³

Discussion

Procurement of commercial market products such as exchange QHPs is significantly different from procurement in MMC, where plans are bidding on or required to meet a set price point to provide a standard, uniform benefit. Nevertheless, state MMC procurement strategies may inform exchanges as they determine whether the state will "actively purchase" QHPs or certify all QHPs that meet minimum criteria for participation in the exchange. Additionally, MMC programs have staff with experience in running a procurement process that may prove useful to state exchanges. Some states may consider aligning or integrating MMC and QHP procurement functions to gain administrative efficiencies and perhaps to leverage purchasing across state-sponsored programs and the exchange.

By aligning standards across Medicaid and QHPs, exchanges maximize their influence on health care delivery models and facilitate continuity of coverage for individuals and families.

Conclusion

As state exchanges consider strategies to align quality, certification, and purchasing requirements across the full continuum of health insurance coverage options, including Medicaid, CHIP, Basic Health Plan, and QHPs, state MMC programs provide a starting point on which to base “all payer” standards in the re-organized insurance markets of 2014.

Medicaid agencies in more than 36 states have experience with risk-based Medicaid managed care and have developed standards, reporting, and compliance mechanisms in a host of areas that mirror QHP criteria in the ACA and implementing regulations, including network adequacy and access, marketing, accreditation, and quality standards. MMC criteria have evolved over time as states identified where additional consumer protections were warranted and where plans could drive access, quality and efficiency.

The most mature MMC programs have progressed beyond basic standards for participation to value-based procurement linked to quality and performance measurement. This experience and infrastructure will be invaluable as state exchanges develop rules and strategies for QHP certification. States seeking to develop a system of coverage that includes Medicaid, a Basic Health Plan, and QHPs will be well-served to align standards where possible for ease of procurement.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

About the State Health Reform Assistance Network

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.rwjf.org/coverage.

Endnotes

- ¹ The proposed regulation was published in the Federal Register on July 15, 2011. *Patient Protection and Affordable Care Act: Establishment of exchanges and Qualified Health Plans Proposed Rule*, 76 Fed. Reg. 41866, (July 15, 2011). Available at: <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>.
- ² Social Security Act §§ 1903(m), 1915(a), 1915(b), 1932; 42 C.F.R. Part 438.
- ³ Kaiser Commission on Medicaid and the Uninsured and Health Management Associates. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." September 2011. Available at: <http://www.kff.org/medicaid/upload/8220.pdf>
- ⁴ MACPAC. "Report to the Congress: The Evolution of Managed Care in Medicaid," June 2011. Available at: <http://www.macpac.gov/reports>.
- ⁵ McCue, Michael, and Michael Bailit. "Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide," Commonwealth Fund, June 2011.
- ⁶ Kaiser Commission on Medicaid and the Uninsured, September 2011.
- ⁷ This paper assesses only Wisconsin's contract to provide BadgerCare Plus managed care services for approximately 240,000 members in six southeastern Wisconsin counties (Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties); it does not include an assessment of Wisconsin's separate contract for the provision of statewide Medicaid SSI managed care services and BadgerCare Plus services in the state's remaining counties.
- ⁸ Enrollment in comprehensive, risk-based Medicaid managed care plans is 90 percent in Arizona; 63 percent in Minnesota; 65 percent in New York; 94 percent in Tennessee; 52 percent in Washington; and, 46 percent in Wisconsin (MACPAC at Table 9, June 2011).
- ⁹ Social Security Act § 1932(b)(5).
- ¹⁰ Social Security Act § 1932(c)(1)(A)(i).
- ¹¹ 42 CFR § 438.206(c)(1)
- ¹² 42 C.F.R. § 438.206(c)(2).
- ¹³ The Kaiser Commission on Medicaid and the Uninsured, September 2011.
- ¹⁴ "Contractor Risk Agreement Between the State of Tennessee d.b.a. TennCare and (Name of Contractor) – East/West CRA – May 19, 2008 – With Amendment 4 (Effective January 1, 2011)," Section 2.11.3. Available at: <http://www.tn.gov/tenncare/forms/eastwestmcocontract.pdf>.
- ¹⁵ "Contractor Risk Agreement Between the State of Tennessee d.b.a. TennCare and (Name of Contractor) – Middle Tennessee CRA – August 15, 2006 – Includes General Amendment 8 (Updated July 1, 2011)," Section 2.11.3. Available at: <http://www.tn.gov/tenncare/forms/middletnmco.pdf>.
- ¹⁶ "New York State Medicaid Managed Care and Family Health Plus Model Contract," March 2, 2011, Section 21.12. Available at: http://www.health.state.ny.us/health_care/managed_care/docs/medicaid_managed_care_and_family_health_plus_model_contract.pdf.
- ¹⁷ Tennessee Contracts, Attachment IV; "Contract for BadgerCare Plus HMO Services Between the HMO and The Wisconsin Department of Health Services, September 1, 2010 through December 31, 2013", Article III, Section H, No. 7. Available at: <http://www.badgercareplus.org/HMO/2010-2013.pdf>.
- ¹⁸ "Arizona Health Care Cost Containment System Administration (AHCCCS) Division of Business and Finance CYE'11 Acute Care Contract", Section D, Paragraph 30. Available at: <http://www.azahcccs.gov/commercial/Downloads/ContractAmendments/AcuteCare/YH09-0001/YH09-0001CYE11AcuteCareRenewal.pdf>.
- ¹⁹ "Washington State Department of Social and Health Services 2008-2011 Contract Amendment 8 for Healthy Options", Section 7.11. Available at: <http://hrsa.dshs.wa.gov/HealthyOptions/NewHO/Provider/HOContractthruAmendment8.pdf>.
- ²⁰ Tennessee Contracts, Attachment III and Attachment IV.
- ²¹ Washington Contract, Section 7.9.2.
- ²² Arizona Contract, Section D, Paragraph 33.
- ²³ New York Contract, Section 15.4.
- ²⁴ "Minnesota Department of Human Services Contract for Medical Assistance and MinnesotaCare," 2011, Section 9.3.10. Available at: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_156514.pdf.
- ²⁵ Minnesota Contract, Section 9.3.9.
- ²⁶ New York Contract, Section 21.21.
- ²⁷ Arizona Contract, Section D, Paragraph 34; Tennessee Contracts, Section 2.11.7.
- ²⁸ Arizona Contract, Section D, Paragraph 29.
- ²⁹ Proposed § 156.230, 76 Fed. Reg. at 41923-4.
- ³⁰ 76 Fed. Reg. at 41893.
- ³¹ 76 Fed. Reg. at 41894.
- ³² ACA § 1311(c)(1)(B).
- ³³ ACA § 1311(c)(1)(C).
- ³⁴ 76 Fed. Reg. at 41894.
- ³⁵ National Strategy for Quality Improvement in Healthcare, March 2011. <http://www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf>
- ³⁶ Social Security Act § 1932(c)(1).
- ³⁷ The statute also requires that state contracts provide for an annual "external independent review conducted by a qualified independent entity" to assess access to, and the quality outcomes of, contracted services (Social Security Act § 1932(c)(2)). Federal MMC regulations further define the external quality review process (42 C.F.R. Part 438, Subpart E).
- ³⁸ 42 C.F.R. § 438.240.
- ³⁹ 42 C.F.R. § 438.208.
- ⁴⁰ 42 C.F.R. § 438.236.
- ⁴¹ Kaiser Commission on Medicaid and the Uninsured, September 2011.
- ⁴² "AHCCCS Medical Policy Manual," Chapter 900, Section 910 and Exhibit 910-1. Available at: <http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx>
- ⁴³ Kaiser Commission on Medicaid and the Uninsured, September 2011.
- ⁴⁴ New York Contract, Section 18.5(x).
- ⁴⁵ Wisconsin Contract, Article IV, Section J.
- ⁴⁶ Kaiser Commission on Medicaid and the Uninsured, September 2011.
- ⁴⁷ New York's MMC contract requires plans to submit information on a state-specific set of Quality Assurance Reporting Requirements (QARR) measures. QARR measures are based on the HEDIS measure set but include a number of additional measures developed by the state that are focused on the state's priority areas for quality improvement (New York Contract, Section 18.5(v)).
- ⁴⁸ Arizona Contract, Section D, Paragraphs 23(B)(l).
- ⁴⁹ Washington Contract, Section 8.2.5 – Section 8.2.8.
- ⁵⁰ Wisconsin Contract, Article IV, Section K.
- ⁵¹ Kaiser Commission on Medicaid and the Uninsured, September 2011.
- ⁵² Minnesota Contract, Section 7.3.
- ⁵³ Tennessee Contracts, Section 2.8.1.
- ⁵⁴ New York Contract, Section 16.2(a).
- ⁵⁵ Minnesota Contract, Section 7.1.5 (D).
- ⁵⁶ New York Contract, Section 16.2(d) and Section 16.2(e).
- ⁵⁷ Minnesota Contract, Section 7.10.6 – Section 7.10.9.
- ⁵⁸ Minnesota Contract, Section 7.10.10.
- ⁵⁹ <http://www.house.leg.state.mn.us/ss2011/11-3678.htm>,
- ⁶⁰ Wisconsin Contract, Addendum VI.
- ⁶¹ Wisconsin Contract, Addendum VI(A)(1)(f)(2).
- ⁶² ACA § 1311(c)(1)(E).
- ⁶³ ACA § 1311(g)(1).
- ⁶⁴ Additionally, beginning January 1, 2015, a QHP may contract with a hospital with greater than 50 beds only if the hospital uses a patient safety evaluation system and implements a comprehensive hospital discharge program that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement/follow-up (ACA § 1311(h)).
- ⁶⁵ Proposed § 156.200, 76 Fed. Reg. at 41923; 76 Fed. Reg. at 41897.

⁶⁵ Washington made available a quality incentive to plans based on HEDIS measures for childhood immunizations and well child visits for 2008 and 2009 but did not offer a quality incentive in 2010 and 2011 (Washington Contract, Section 6.1.9).

⁶⁶ ACA § 1311(c)(1)(D); Proposed § 156.275, 76 Fed. Reg. at 41925.

⁶⁷ Social Security Act § 1932(c)(2); 42 C.F.R. § 438.360.

⁶⁸ Kaiser Commission on Medicaid and the Uninsured, September 2011.

⁶⁹ Tennessee Contracts, Section 2.15.5.

⁷⁰ Tennessee Contracts, Section 2.15.5.1.

⁷¹ Tennessee Contracts, Section 2.11.8.1 and Section 2.11.8.2.

⁷² Tennessee Contracts, Section 2.17.4.7.25.

⁷³ Tennessee Contracts, Section 2.15.1.1.

⁷⁴ Wisconsin Contract, Article IV, Section I(1).

⁷⁵ Wisconsin Contract, Article IV, Section I(2). **Note:** The Wisconsin contract mentions, but does not define or give specifics, regarding the Accreditation Incentive Program. Accordingly, information on Wisconsin's Accreditation Incentive Program is taken from secondary sources as cited.

⁷⁶ NCQA, April 2010; Center for Health Care Transformation. "Wisconsin Medicaid HMO Accreditation Incentive." Available at: http://www.healthtransformation.net/cs/wisconsin_medicaid_hmo_accreditation_incentive

⁷⁷ Minnesota Contract, Section 7.1.3.

⁷⁸ Minnesota Contract, Section 7.1.6.

⁷⁹ Minnesota Contract, Section 7.1.7 and Section 7.1.8; Minnesota Contract, Section 7.3(A).

⁸⁰ Minnesota Contract, Section 7.5.1.

⁸¹ Proposed § 156.275, 76 Fed. Reg. at 41925; 76 Fed. Reg. at 41903.

⁸² 76 Fed. Reg. at 41903.

⁸³ As described in a preceding footnote, information on some states' accreditation requirements, such as related incentive programs, was gleaned from sources outside the state MMC contract.

⁸⁴ Social Security Act § 1932(d)(2)(A)(i)(I); 42 C.F.R. § 438.104(b)(1)(i).

⁸⁵ Social Security Act § 1932(d)(2)(A)(i)(II); 42 C.F.R. § 438.104(b)(2).

⁸⁶ Social Security Act § 1932(d)(2)(B); 42 C.F.R. § 438.104(b)(1)(ii).

⁸⁷ Social Security Act § 1932(d)(2)(E); 42 C.F.R. § 438.104(b)(1)(iv).

⁸⁸ 42 C.F.R. § 438.104(a).

⁸⁹ Social Security Act § 1932(d)(2)(D); 42 C.F.R. § 438.104(b)(1)(iii); 42 C.F.R. § 438.10.

⁹⁰ Kaiser Commission on Medicaid and the Uninsured, September 2011.

⁹¹ *Ibid.*

⁹² Tennessee Contracts, Section 2.16.

⁹³ New York Contract, Appendix D.3; "AHCCCS Contractor Operations Manual (ACOM)," Section 101(IV)(A)(1). Available at: http://www.azahcccs.gov/shared/Downloads/ACOM/6_24_11ACOM.pdf.

⁹⁴ AHCCCS Contractor Operations Manual, Section 101(IV)(A)(1).

⁹⁵ New York Contract, Appendix D.3; and Arizona Contractor Operations Manual, Section 101(IV)(A)(2).

⁹⁶ New York Contract, Appendix D.1.

⁹⁷ Minnesota Contract, Section 3.2.3(C).

⁹⁸ New York Contract, Appendix D.2(2)(b).

⁹⁹ Wisconsin Contract, Article III, Section L(3)(a).

¹⁰⁰ New York Contract, Appendix D.3(2)(d).

¹⁰¹ AHCCCS Contractor Operations Manual, Section 101(IV)(2); Wisconsin Contract, Article III, Section L(3)(c); New York Contract, Appendix D.3(1)(b).

¹⁰² Wisconsin Contract, Article III, Section L(3)(d) and Section L(3)(e).

¹⁰³ Minnesota Contract, Section 3.2.4(A).

¹⁰⁴ Tennessee Contracts, Section 2.16.1.4.

¹⁰⁵ New York Contract, Appendix D.3(3)(c).

¹⁰⁶ ACA § 1311(c)(1)(A).

¹⁰⁷ Proposed §156.225, 76 Fed. Reg. at 41923.

¹⁰⁸ 76 Fed. Reg. at 41898.

¹⁰⁹ *Ibid.*

¹¹⁰ Kaiser Commission on Medicaid and the Uninsured, September 2011.

¹¹¹ Social Security Act §§ 1903(m)(2)(A)(viii), 1903(m)(4)(A).

¹¹² Social Security Act § 1903(m)(2)(A)(xi).

¹¹³ Social Security Act § 1932(c)(1)(A)(iii).

¹¹⁴ 42 C.F.R. § 438.240.

¹¹⁵ 42 C.F.R. § 438.242.

¹¹⁶ Social Security Act § 1903(m)(4)(B).

¹¹⁷ Social Security Act § 1932(c)(2)(A)(iv); 42 C.F.R. § 438.364(b).

¹¹⁸ Social Security Act § 1932(a)(5)(C); 42 C.F.R. § 438.10(i).

¹¹⁹ Tennessee Contracts, Section 2.30.15.

¹²⁰ "AHCCCS Financial Reporting Guide for Acute Health Care Contractors." Available at: http://www.azahcccs.gov/commercial/Downloads/FinancialReporting/FinancialReportingGuide_AcuteCare.pdf.

¹²¹ "Managed Care Reports," New York State Department of Health Website. Available at: http://www.health.state.ny.us/health_care/managed_care/reports/.

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¹²⁴ "Managed Care Reporting: Financial Information and Data," Minnesota Department of Human Services Website. Available at: <http://tinyurl.com/637dktj>.

¹²⁵ Minnesota Executive Order 11-06, March 23, 2011.

¹²⁶ Arizona Contract, Section D, Paragraph 42.

¹²⁷ ACA § 1311(c)(1)(H); ACA § 1311(c)(1)(I); ACA § 1311(e)(3).

¹²⁸ Proposed § 155.205(b)(1) – (6), 76 Fed. Reg. at 41915.

¹²⁹ Proposed § 155.205(b)(2), 76 Fed. Reg. at 41915.

¹³⁰ ACA § 1311(e)(3)(a); Proposed § 156.220(a) and (b), 76 Fed. Reg. at 41923.

¹³¹ 42 C.F.R. § 438.66.

¹³² 42 C.F.R. § 438.700.

¹³³ 42 C.F.R. § 438.708.

¹³⁴ Kaiser Commission on Medicaid and the Uninsured, September 2011.

¹³⁵ "Tennessee Request for Proposals for Managed Care Organizations for East and West Tennessee," Section 1.1. Available at: http://www.state.tn.us/tenncare/forms/RFP_percent20318.66-053.pdf

¹³⁶ "AHCCCS Notice of Request for Proposal, CYE '09 Acute Care RFP, February 1, 2008," Section I. Available at: <http://www.azahcccs.gov/commercial/Downloads/Solicitations/Closed/YH09-0001/YH09-0001.pdf>

¹³⁷ "Southeast Wisconsin Medicaid Managed Care Organization Request for Proposals," October 30, 2009, Section 4.5 (p. 21). Available at: http://www.dhs.wisconsin.gov/rfp/DHCF/pdf/Southeast_percent20Wisconsin_percent20Medicaid_percent20Managed_percent20Care_percent20Organizations_percent20RFP.pdf

¹³⁸ "Draft Request for Proposal: Washington Health Care Authority Procurement for Managed Care Services," Section E (p. 25). Available at: http://www.hca.wa.gov/documents/joint_procurement_rfp_draft.pdf.

¹³⁹ "Dayton Administration Takes on Health Care to Better Serve Taxpayers." Press Release. March 23, 2011. Available at: <http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=10288>

¹⁴⁰ Minnesota Department of Human Services Managed Care and Policy Division Request for Proposals," May 9, 2011. Available at: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_160241.pdf

¹⁴¹ Southeast Wisconsin MMC RFP, Section 4.4 (p. 21).

¹⁴² Southeast Wisconsin MMC RFP, Section 4.5 (p. 21).

¹⁴³ AHCCCS Notice of RFP, Section I.

¹⁴⁴ AHCCCS Notice of RFP, Section H.

¹⁴⁵ Tennessee RFP, Section 5.1.

¹⁴⁶ Southeast Wisconsin MMC RFP, Section 4.3.

¹⁴⁷ ACA § 1311(d)(4)(A); Proposed § 155.1000, 76 Fed. Reg. at 41921.

¹⁴⁸ ACA § 1311(e)(1)(B).

¹⁴⁹ Proposed § 155.1000, 76 Fed. Reg. at 41921.

¹⁵⁰ 76 Fed. Reg. at 41891.

¹⁵¹ Ibid.

¹⁵² 76 Fed. Reg. at 41891-2.

¹⁵³ Proposed §§ 155.1075 and 155. 1080, 76 Fed. Reg. at 41922