CHCS Center for
Health Care Strategies, Inc.

Seeking Higher Value in Medicaid:

A National Scan of State Purchasers

By
Melanie Bella, Claudia Williams,
Lindsay Palmer, Stephen A. Somers

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) works to improve the value of publicly financed care for people with chronic illnesses and disabilities, the elderly, and racially and ethnically diverse populations. We work with the federal government, state Medicaid agencies, health plans, providers, and consumers to design and test strategies for delivering care that is effective, equitable, and efficient.

About the Authors

Melanie Bella is a senior vice president at CHCS; Claudia Williams is a principal with AZA Consulting; Lindsay Palmer is a program associate at CHCS; and Stephen A. Somers, PhD, is the president of CHCS.

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Acknowledgements

Introduction

Medicaid managed care has come a long way since it took its first baby steps in many states in the mid-1990s. From what was often a harried scramble to implement quickly crafted procurements, states now have deliberate and well-tested strategies for embarking on managed care expansions — derived both from their own experiences and other states' examples. In approaching these expansions, states clearly recognize that all health care — like politics — is local, and variations in managed care approaches, especially in rural areas and for more complex populations, must be made to accommodate state-specific conditions. States also recognize that there is more to do to assure that health plan and primary care case management (PCCM) arrangements provide accountable medical homes, access to needed specialty services, care management, consumer engagement, and incentives for improving performance.

This report presents key findings from interviews with Medicaid directors and staff in 14 states to provide a nationwide scan of the current state of Medicaid managed care.[1] The states — California, Colorado, Florida, Georgia, Hawaii, Kentucky, Maryland, Michigan, Ohio, Oregon, Pennsylvania, Texas, Washington, and Wisconsin — represent a variety of purchasing strategies, geographies, and managed care experiences past and present. Because this scan reflects only a subset of state purchasers and was designed to limit focus to a number of key areas, there is a risk that it may only scratch the surface of issues critical to other states; however, we feel that the perspectives of the states interviewed provide a rich snapshot of Medicaid managed care today.

During our interviews, Medicaid purchasers shared perspectives about managed care and its potential to address the most significant challenges facing Medicaid: providing value through improved quality, controlling expenditures, and developing effective and efficient approaches to care for those with multiple chronic conditions and the highest costs. Our interviews particularly focused on state plans for managed care expansions, trends in the Medicaid managed care marketplace, and promising state practices for improving quality.[2] Three cross-cutting themes emerged:

1. States are generally happy with and continue to pursue full-risk managed care, and are also using managed care alternatives as a way to provide accountable medical homes and expand care management.

2. States want to expand and extend mechanisms for accountable medical homes and managed care into new areas (rural) and populations (aged, blind, and disabled and dual eligibles).

3. States now realize that they can do much more with their purchasing power than merely secure financial predictability, and they are acting accordingly. Increasing quality, efficiency, and accountability are all important goals.

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1 For the purposes of this report, "managed care" includes full-risk (capitated) managed care as well as primary care case management programs (PCCM), enhanced PCCM programs, and disease and/or care management programs.

2 While we did not specifically focus on the states' ability to achieve cost savings through managed care, it is important to note that a number of states, several of which are included in this scan, have sought independent evaluation of these savings. Examples include: *Medicaid Capitation Expansion's Potential Cost Savings*. The Lewin Group. April 2006; *Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-For-Service Program*. The Lewin Group. May 2005; and *Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems*. Center for Health Program Development and Management, University of Maryland Baltimore County. April 2005.

These three themes form the backbone of this report. Overall, we found that states are expanding the boundaries of traditional full-risk managed care and are using innovative models, including enhanced primary care case management and comprehensive care management, to find the best value in delivering care to Medicaid beneficiaries. The findings within this report outline future priorities, barriers, and opportunities for managed care expansion or enhancements, in the eyes of leading state purchasers. We hope that the lessons herein offer valuable insights and direction to help all Medicaid stakeholders — not only state purchasers, but also managed care organizations, consumer organizations, providers, and legislators — pursue innovative strategies for improving the lives of the 55 million Americans receiving publicly financed care under Medicaid and related State Children's Health Insurance Programs.

Characteristics of States Interviewed

The 14 states interviewed for this report were chosen to represent the variation in Medicaid delivery across the country. The Medicaid programs included in the scan range in size from small (e.g., Hawaii, with approximately 200,000 total enrollees) to very large (e.g., California, with more than six million enrollees). Children account for the majority of Medicaid enrollees in 10 of the 14 states, while the aged, blind and disabled (ABD) population makes up between 19% and 40% of Medicaid enrollees depend-

ing on the state. Each of the 14 states operates full-risk Medicaid managed care programs and more than half administer a primary care case management program (PCCM). The states vary in whether these managed care programs operate statewide or on a more limited, geographic basis. As a result, the level of Medicaid managed care also varies from state to state, with the overall Medicaid managed care penetration rate (including PCCM and full-risk) ranging from 30% to 85%. All 14 states include the Temporary Assistance for Needy Families and related populations in their Medicaid managed care programs and the majority of states serve or plan to serve the ABD population as well (although the Medicaid managed care penetration rate for this group is much lower on average). Dual eligibles (those eligible for both Medicare and Medicaid), on the other hand, are included in less than half of the Medicaid managed care programs, although this could change in the near future as states become more familiar with the potential for contracting with Medicare Special Needs Plans (SNPs) to integrate their care. Additional information on the characteristics of the state Medicaid programs that were surveyed can be found in the Appendices.

Study Findings

Theme 1: **States are generally happy with and continue to pursue full-risk managed care and are also using managed care alternatives as a way to provide accountable medical homes and expand care management.**

In many states the growth and development of large, multi-state, for-profit health plans, especially those focusing exclusively on Medicaid, has made managed care more feasible by increasing access and participation. Publicly traded firms are exerting increasing influence on Medicaid managed care with four firms (Amerigroup, Centene, Molina, and Wellcare) now operating 30 plans with 3.8 million members in 18 states. Another five publicly traded managed care companies (United Healthcare, Wellpoint, Coventry, HealthNet, Humana) have separate Medicaid lines of business with four million Medicaid members in 30 plans in more than 16 states.[3] The so-called Medicaid "pure plays," which only operate a Medicaid line of business, have experienced some financial "right-sizing" of late, but continue to expand market position.

In order to better understand the current dynamics of Medicaid managed care, this scan incudes states actively pursuing a variety of Medicaid managed care models. Not only are all of the states using traditional full-risk managed care, but the penetration rate for both full-risk and PCCM models is at least one-half (and in some cases as much as two-thirds) in the majority of states we selected (Figure 1). Regardless of this high managed care penetration rate, all of the states interviewed recognize that full-risk capitation is not the only vehicle for managed care expansion.

Figure 1: Medicaid Managed Care in Scan States
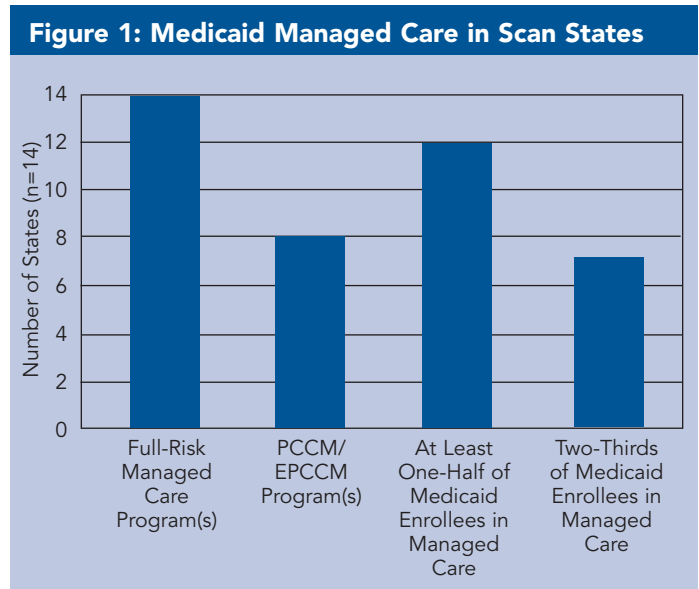
Source: State interviews and websites, Kaiser State Health Facts. Note: Figures are not unduplicated counts.

The prospect of more extensive enrollment of the ABD population offers potential appeal to many of the pure play plans, which already have invested in a data and care management infrastructure that is well equipped to serve these members. Some states, however, continue to be cautious about these plans — either because of stakeholder resistance or because these plans may not be willing and/or able to develop the more tailored approaches that states are seeking. Moreover, in some rural and frontier areas there simply are not enough potential members or interested providers to make full-risk managed care work.

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[3]   R. Hurley. *Understanding the Influence of Publicly Traded Health Plans on Medicaid Managed Care*. Center for Health Care Strategies, Inc. November 2006.

When capitated managed care is not feasible, states are experimenting with alternatives to introduce medical homes and care management to more Medicaid consumers. Enhanced primary care case management (EPCCM), disease management, and comprehensive care management are seen as potential strategies to manage the care of populations not historically enrolled in full-risk managed care (Figure 2).

Figure 2: State Alternatives to Full-Risk Managed Care

Model	Description
Enhanced Primary Care Case Management (EPCCM)	EPCCM programs use primary medical providers to coordinate primary care and approve specialty referrals for Medicaid beneficiaries, and also incorporate features originally developed for capitated managed care programs, such as care coordination and quality improvement efforts.
Disease Management	Disease management is a strategy of delivering health care services to improve the health outcomes of patients with specific diseases. It often uses telephone interventions, interdisciplinary clinical teams, and patient self-management education.
Comprehensive Care Management	Comprehensive care management is designed to ensure continuity and accessibility of services to overcome rigidity, fragmented services, and the misutilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's changing needs over time.

Pennsylvania, for example, is piloting an EPCCM program in rural areas that do not yet have Medicaid managed care. The state may also introduce this approach in urban areas as an alternative to capitated managed care, thereby creating opportunities to test how the models can function in the same region. The program, called ACCESS PLUS, was implemented in 2005 and offers disease management for asthma, diabetes, chronic obstructive pulmonary disease,

coronary artery disease, and congestive heart failure. ACCESS PLUS links members with these conditions with a primary care physician (PCP) who provides or coordinates the members' care. Introducing EPCCM is a departure from Pennsylvania's former plan of deliberate progression toward statewide full-risk managed care. Two issues drove this change: the challenge of developing plan networks in rural areas and questions about whether the tighter capitation rates being imposed by the state's fiscal realities might be undermining the plans' incentives to improve care management. ACCESS PLUS will rely on the state Medicaid agency's capacity and infrastructure for managing care developed over years of running managed care programs. For example, the state has created a fee-for-service special needs unit to work with medically complex ACCESS PLUS consumers that is modeled after Medicaid plans' special needs units. In addition, pharmacy management for the program is based on a managed care best-practices report prepared by the state's actuarial consultants.

Pennsylvania is also taking a proactive approach to chronic care management by developing health initiatives for smoking and obesity that aim to prevent the onset of disease. To increase the low numbers of consumers using smoking cessation benefits, the state is reaching out to providers to share information about the positive return on investment for smoking cessation and to encourage more patient referrals to smoking cessation programs. In addition, the state is developing a childhood obesity benefit and a program for kids at risk for obesity that includes nutritional counseling. A positive return on investment is predicted for the childhood obesity program, with initial analysis indicating that it will pay for itself in two years. The state is consider-

ing requiring the adoption of these benefits by plans in the 2007-2008 contracts.

Like Pennsylvania, several other states are experimenting with care and disease management programs as alternatives to full-risk managed care. Much of the impetus for these experiments comes from trying to overcome political resistance to capitated managed care for populations with chronic conditions and disabilities. In addition, some states are beginning to question the wisdom of paying for three or four care management infrastructures in three or four health plans, when the state can potentially develop one program on its own or with a single contractor acting as its administrator. Washington recently issued a new request for proposals for care management of its high-risk Medicaid population that takes "a consumer rather than a disease-focused approach." The new approach will include predictive modeling to identify at-risk populations and contracts with regional community-based organizations (in addition to a statewide entity) that will work with consumers and PCPs to manage chronic care needs. The local care management entity will not only provide the traditional care management activities of assessment and disease-specific education and support, but will also ensure that the client has a medical home by entering into contractual relationships with providers who agree to serve aged, blind and disabled clients. In areas of the state without a local care management entity, a statewide care management contractor will provide care management that takes a holistic view of client needs, as opposed to a single-disease focus. Another state is developing a disease management program that would contract with a single entity to manage the care of the state's highest-risk, highest-cost members. The program, still in the early conceptual stage and tentatively set for a 2008 launch, would link medical services with behavioral health and social supports.

Georgia, building on its existing care management infrastructure, is launching a new disease management program as a wrap-around to its EPCCM for the ABD population. All EPCCM enrollees except dual eligibles will be automatically enrolled in the disease management initiative with an opt-out option. The disease management vendor will be responsible for analyzing data to produce provider profiles and will be at risk for performance, but all care management activities will be the responsibility of the primary care provider. A similar program will be implemented for dual-eligible beneficiaries using an administrative services organization, rather than a risk-based contract.

Theme 2: States want to expand and extend mechanisms for accountable medical homes and managed care into new areas (rural) and new populations (aged, blind, and disabled and dual eligibles).

States are striving to create "medical homes" for all Medicaid beneficiaries. Although there is not a universally accepted definition of "medical home," the term generally represents an ongoing connection between a beneficiary and the health care system that results in the coordination and management of that person's total health care needs. In practice, a medical home often refers to a primary care provider who directly or through care managers coordinates and facilitates an individual's health care needs by making referrals, conducting home assessments, providing care management, and helping the consumer navigate the health care system. The American Academy of Pediatrics describes the medical home as being "accessible, continuous, comprehensive, family-centered, coordinated and culturally effective."[4] This definition does not restrict medical home to a particular type of provider, location, or payment structure; rather, it defines the concept broadly as long as it "provides the services that constitute comprehensive care." A medical home ideally replaces the traditionally fragmented, uncoordinated care received under the fee-for-service system that tends to be more costly and less effective, particularly for people with complex or chronic conditions. Challenges to establishing medical homes range from the more straightforward issues of provider availability and access in rural areas to selecting from among multiple providers for beneficiaries with more complex conditions.

By definition, managed care organizations should provide members with a medical home, as should EPCCM and specialty disease or care management programs. As indicated in Figure 3, a number of states are interested in increasing access to medical homes by extending some type of managed care delivery system to include additional populations (ABD), benefits (long-term care), and regions of the state (rural areas). Furthermore, while states acknowledge the benefits of mandatory enrollment (higher enrollee participation, ability to reward high-performing plans with default enrollment, and less potential for adverse selection), they recognize that mandatory enrollment may not always be feasible, at least not initially, due to the lack of plan capacity in rural areas, as well as resistance from state legislators, providers, and ABD beneficiaries. In those circumstances, state leaders are also considering mechanisms to increase participation in voluntary programs.

Figure 3: Managed Care Expansions in Scan States
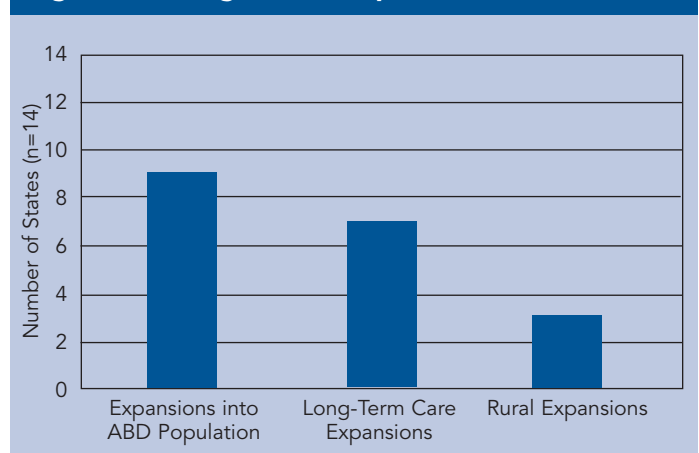
Source: State interviews. Note: Figures are not unduplicated counts.

As noted earlier, states are exploring a variety of managed care delivery models to achieve their expansions, including traditional full-risk managed care; alternative

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4   *The National Center for Medical Home Initiatives for Children with Special Health Care Needs.* The American Academy of Pediatrics. Available at: http://www.medicalhomeinfo.org/ Accessed July 11, 2006.

methods such as EPCCM, disease/care management; and contractual relationships with Medicare Advantage SNPs to coordinate care for dual-eligible beneficiaries (Figure 4).

Figure 4: Type of Managed Care Delivery System Targeted for Expansions in Scan States

Source: State interviews. Note: Figures are not unduplicated counts.

Managed care choices are more limited in rural areas.

States with large rural populations face common challenges getting plans to participate and building provider networks in these areas. Believing rural populations could be better served by some form of managed care, a number of states are intervening to build rural managed care capacity or experimenting with alternative managed care models such as EPCCM. As discussed previously, Pennsylvania hopes its new EPCCM program will be an effective and efficient way to extend care management resources to rural areas. Maryland, meanwhile, anticipates that planned physician fee increases will increase provider access in rural areas.

States are considering a variety of models for introducing medical homes and expanding managed care to the aged, blind, and disabled population.

After years of experience implementing managed care for relatively healthy families, states are increasingly realizing that they need to obtain the same level of increased access, quality, and financial predictability for their most complex and costly populations — ABD beneficiaries. These adults with specialized needs constitute roughly 25% of members yet account for nearly 70% of Medicaid costs nationally.[5] As a result, several states are interested in implementing programs that better manage the care of the ABD population. The ABD population itself is quite diverse and includes not only the elderly but also persons with physical disabilities and the developmentally disabled, many of whom may also be dually-eligible for Medicare and Medicaid and all of whom may require a range of medical and supportive/social services from multiple providers and in a variety of settings. The complex care needs of many ABD beneficiaries often require additional services that may not typically be included in traditional managed care programs. For example, adults with chronic conditions are also more likely to report poor mental health; however, behavioral health services are often carved out of full-risk managed care programs. Although a number of states expressed interest in programs that combine behavioral and physical health, few had concrete plans for integrating these services in the near future. In part, this may be because, in many states, behavioral health services are provided through other state or community programs and agencies that are often reluctant to cede those services to a Medicaid agency or managed care plan, making behavioral and physical health integration difficult. Instead, most states seemed to

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5 *Medicaid Program at a Glance.* Kaiser Family Foundation. May 2006. http://www.kff.org/medicaid/upload/7235.pdf

focus more on achieving better coordination between current acute care and behavioral health programs and/or other carve-outs. States developing managed care programs for ABD beneficiaries must also determine whether to include the entire ABD population or to design programs that address the needs of individual subsets of the population (e.g., a program for the elderly and a separate program for persons with developmental disabilities).

Ohio is developing a full-risk managed care program for select ABD beneficiaries to more cost-effectively manage health care services. In designing its ABD program, Ohio made critical departures from its current managed care program for families and children. Specifically, the care management requirements for the ABD health plans will be increased to focus not only on a single condition but also on the complexities of multiple comorbid conditions. Further, the state's performance measurement set was expanded to better represent the unique needs of the population. The state will also use plan-specific enrollment data to risk adjust the health plan capitation rates to ensure an equitable payment structure for plans serving beneficiaries with more complex needs.

In Colorado, while many stakeholders still oppose major managed care expansions for the ABD population due to an unsatisfactory experience with an earlier mandatory managed care enrollment initiative, the legislature recently approved a small pilot managed care program for people with special needs. It is fashioned after the Massachusetts Commonwealth Care Alliance program. In keeping with the state's preference for local and nonprofit solutions, the authorizing legislation stipulates that the program be developed by a local nonprofit organization with experience in the disability arena.

Creating medical homes is also the intent of Washington, which plans to transition the ABD population into managed care over the next three to five years. The state defines managed care to include PCCM and aggressive chronic care management models. The focus of the effort will be to establish medical homes, actively manage the care of this population, and increase consumer engagement. There is considerable interest from current Medicaid plans as well as several new plans entering the market. Implementation challenges anticipated by the state include: building adequate networks (particularly for specialty care); risk adjustment; and incorporating structured case management into PCCM.

Wisconsin operates a mandatory Medicaid managed care program for ABD recipients. The program is currently operational in five counties, but the state plans to expand the program into 37 additional counties over the next year and a half. Wisconsin attributes the success of its ABD Medicaid managed care initiative to:

• Integrated care teams, which provide holistic, patient-centered and high-quality care;
• An automatic enrollment approach (discussed later in this document); and
• The requirement that plans assess members and develop a care plan in the first 60 days of enrollment.

However, not all states have been as successful in implementing managed care strategies for the ABD population. For the last two years, California has attempted to implement mandatory enrollment of the ABD population in Medi-Cal managed care, including a scaled-down pilot program, but the state was not able to secure legislative approval or the support of key advocacy organizations. The state is currently seeking other options to enroll ABD beneficiaries in managed care (page 14).

There is considerable state interest in managed long-term care, but a number of barriers are slowing the rate of adoption.

While the pursuit of managed care for all or part of the ABD population, including dual eligibles, is in full swing in a number of states, the "tipping point" for capitating Medicaid long-term care (LTC) services for any of these beneficiaries is still far off on the horizon. Aside from Arizona, with its long-established Arizona Long Term Care System (ALTCS) program of capitated long-term care, and now Wisconsin, Texas, and New York, few states are aggressively moving forward with the implementation of statewide programs.

Texas, in particular, is poised for growth in its managed long-term care efforts, extending integrated managed acute and long-term care into several new areas of the state. As part of this effort the state is expanding its current mandatory capitated program, STAR+PLUS, to four new metropolitan areas and will extend its non-capitated Integrated Care Management program to one new area. Managed care plans are responsible for the first four months of nursing home care, but after that the member receives services through the fee-for-service system. This approach (modeled after the Minnesota Senior Health Options program) is designed to encourage home- and community-based alternatives. Texas is just one example of a state that is experimenting with payments and incentives that promote care in the community and decrease institutional placements, a major challenge for states pursuing managed LTC programs.

Wisconsin offers several innovative programs that provide managed long-term care for ABD beneficiaries, including dual eligibles. The four sites in the Wisconsin Partnership Program integrate care across the full spectrum of Medicaid and Medicare services, including long-term care. The state's Family Care program provides capitated Medicaid long-term care services to 10,000 Medicaid beneficiaries through county-based managed care organizations. The state is preparing to launch a statewide expansion of Family Care to encourage the development of multi-county consortia and public-private partnerships. While Family Care is a voluntary program, the state may implement an "automatic enrollment with opt-out" option paralleling the enrollment design for its ABD managed care program. By contrast, expansion of the Wisconsin Partnership Program is stymied by a high degree of stakeholder skepticism about Medicare managed care.

A number of other states are also interested in developing managed care programs that integrate the full range of services for the ABD population, including dual eligibles. Florida recently received waiver approval from the Centers for Medicare and Medicaid Services (CMS) to create an integrated, managed long-term care delivery system for Medicaid beneficiaries age 60 and older. The proposed program, Florida Senior Care, will provide all Medicaid services, including long-term care, using managed care organizations to build integrated service delivery models under fixed payment financing. The state believes that the coordination of all Medicaid services under one organization will establish accountability for the delivery of high-quality comprehensive health and long-term care services to its seniors.

Hawaii is also planning a substantial managed care expansion for its ABD population (including dual-eligible beneficiaries) that will include long-term care, carving in nursing facility and home- and community-based services. The state will begin a phased-in implementation in 2008, beginning with the elderly and persons with physical disabilities and ending with enrollment of the

developmentally disabled/ mentally retarded population.

As in Florida, Maryland's proposed CommunityChoice program will cover primary, acute, and long-term care services. The program will be mandatory for dual-eligible members, adult Medicaid-only consumers who meet a nursing facility level of care, and any other Medicaid consumers age 65 and over. Under CommunityChoice, the state will make capitation payments to Community Care Organizations (CCOs) that will be responsible for providing primary, acute, and long-term care services, including many of the services that are currently available only through a 1915(c) waiver. Behavioral health services will be carved out. In addition, participating CCOs must be licensed as Medicare Advantage plans to facilitate the integration of Medicare services and funding for the dual eligibles. These organizations will be required to provide care coordination and offer a consumer-directed model for the delivery of personal care services. By including primary, acute, and long-term care services under one capitation payment, Maryland believes that it will create an environment for integrated care and improved outcomes.

Meanwhile, Georgia is expanding SOURCE, a modified Program of All Inclusive Care for the Elderly (PACE). SOURCE uses case managers to integrate Medicare acute care and Medicaid home- and community-based services for frail elderly and persons with disabilities. The program, which was recently approved to operate statewide, is expected to expand from serving 7,000 to approximately 10,000 voluntary enrollees.

In some states Medicare Advantage Special Needs Plans are generating considerable interest from plans and Medicaid; other states are not yet prepared to partner.

The Medicare Modernization Act's Special Needs Plan provision, which creates an opportunity for integration of Medicaid and Medicare services for dual eligibles including long-term care, is creating substantial interest in some states. Integrating Medicare and Medicaid via SNPs provides states with an opportunity to improve the quality, coordination, and cost-effectiveness of care for the duals. Some states also view SNPs as a way to gain access to information on prescription drug utilization by dual eligibles that was lost with the creation of Medicare Part D.

In Oregon, about 60% of duals are already enrolled in Medicaid managed care. Ten of the state's 13 Medicaid plans serving duals have Medicare SNP status, which greatly facilitated the Part D transition process. State officials noted that dual-eligible beneficiaries in these plans had a much easier transition than those in other plans. They also discussed the possibility of developing a pilot program that would combine Medicare, Medicaid acute and long-term care, and mental and dental health funding into one program. Furthermore, the state also believes that a number of the 10 Medicaid plans with SNP status are interested in and capable of managing long-term care services. Oregon will be developing potential mechanisms for contracting with these plans in the near future.

Despite the significant administrative and operational challenges to integrating Medicare and Medicaid, several states are actively pursuing capitated contracts with SNPs. Although there is no specific requirement for Florida Senior Care con-

tractors to be SNPs, the state anticipates that some SNPs will apply, and is open to contracting with them. In addition, Florida recently approved a policy shift that will allow dual-eligible beneficiaries to enroll in Medicaid managed care. This shift was made to facilitate a state strategy to contract with SNPs to integrate care for the duals. Florida anticipates implementing the program in the next year. Washington currently contracts with two SNPs that provide managed, integrated acute and long-term care for dual-eligible members and Medicaid-only consumers in two areas of the state. To better support these plans in meeting consumer needs, the state is working to set rates that more accurately reflect the cost of long-term care, particularly home- and community-based services.

In Texas, there are nine SNPs, including two that were approved by CMS to automatically enroll dual eligibles who were plan members prior to receiving SNP approval (called passive enrollment). In addition to the current nine, at least two of the plans participating in the STAR+PLUS program are planning to establish SNPs, and will then jointly manage the full spectrum of Medicare and Medicaid services (except Medicaid inpatient care, which is currently carved out). Outside of the STAR+PLUS program, the state has not pursued paying SNPs or other Medicare Advantage plans a capitated rate for long-term care, as officials are unsure how Medicaid will share in any savings resulting from better care management. Initial savings, most likely through reduced hospital utilization, will accrue only to Medicare. Unless Medicaid can share in Medicare savings, the fiscal advantages to the state of integrating Medicaid and Medicare through SNPs are potentially modest. This concern is shared by all states interested in integrating Medicare and Medicaid for duals.

In Michigan, two Medicaid plans, including one of the largest in the state, have received approval to operate as Medicare SNPs. The state is considering developing managed long-term care pilots with these plans. However, state implementation efforts would be hampered by the state's enrollment system, which currently excludes all dual eligibles from enrollment in managed care plans.

Several other states are in a "watchful waiting" mode vis-à-vis SNPs. Colorado, California, Georgia, Hawaii, Ohio, Pennsylvania, and Kentucky are potentially interested in partnering with SNPs, but are not yet ready to do so. Colorado faces several barriers, including a state law that, in essence, prohibits Medicaid managed long-term care except through a PACE program. Several of these other states, although interested in working with SNPs, are in the midst of multiple Medicaid reforms and feel that the time is not right for entering into new arrangements with additional plans.

States are making concerted efforts to build support for ABD managed care models from advocates and legislators.

The emergence and growth of alternative managed care models for the ABD population is driven by several factors, including concerns from stakeholder groups regarding provider networks, access to services, and consumer choice. State Medicaid leaders have invested considerable time and effort in building the case for managed care with legislatures and forging partnerships with interested stakeholders.

Wisconsin cites the involvement of consumers in contract development as one key to the success of its managed care initiative for the ABD population. Medicaid consumers were included in the negotiation teams for each of the ABD managed care contracts. This helped strengthen consumer

buy-in, and led to the negotiation of several important contract requirements to assure quality, including the in-depth evaluation of a plan's provider network as a condition of certification. Having consumers at the table enabled the state to proceed with its "automatic enrollment" approach, in which all beneficiaries are enrolled in managed care but have the ability to opt out under certain circumstances.

The support or opposition of legislators often determines how states proceed with managed care plans for the ABD population. In Ohio, for example, legislative support tempered opposition from some groups, and state officials are now working collaboratively with stakeholders to ensure a smooth transition. Provider opposition, which has been limited and mainly emanates from hospitals, is based on solvency and reimbursement issues.

Michigan is one of a number of states where term limits have required a renewed effort to educate legislators on the potential benefits of managed care every four to six years. In some states, such as Colorado, the legislature has strongly influenced the direction of Medicaid managed care. In Pennsylvania and Georgia, by contrast, legislative pressure is not as significant because less of the Medicaid program is contained in statute in these states, giving the Medicaid agency more flexibility.

As in Colorado, the California legislature has played a major role in determining the future of managed care. Although the governor's office has strongly backed managed care expansions, the California legislature has been reluctant to approve all proposals. The legislature recently approved a geographic expansion of full-risk managed care in 13 of 58 counties (in addition to the 22 counties already in managed care), but it would not approve mandatory enrollment of the ABD population in all managed care counties. (California currently enrolls ABD beneficiaries on a mandatory basis in its county organized health systems [COHS] in eight counties.) The legislature has encouraged increased efforts to voluntarily enroll the ABD population in non-COHS counties and has approved funding for the development of performance standards and a state-financed consumer education effort encouraging people with disabilities to explore the benefits of full-risk managed care.

Theme 3: States now realize that they can do much more with their purchasing power than merely secure financial predictability, and they are acting accordingly. Increasing quality, efficiency, and accountability are all important goals.

Generally, there has been growing continuity and stability among the plans participating in Medicaid managed care. Mergers have become less disruptive because they often pair an existing local plan with a larger national entity. The overall stability has produced many positive effects, including improved state-plan communication and collaboration and continuity of enrollment for consumers. But some state Medicaid leaders wonder if the stability could have a cost. Will stable markets translate into less aggressive or innovative efforts by plans to improve quality and increase efficiencies?

While states agree on the need to increase quality and efficiency in Medicaid managed care, opinions vary about how to do this. Some states have focused primarily on developing and strengthening quality partnerships with a stable group of at-risk plans. Other states, seeing healthy competition among plans as key to higher performance, are encouraging new market entrants. Still others hope that new managed care models, including EPCCM and care management, might increase innovation and competition between divergent models, if not among plans. Regardless of the method, most states agree that they want more from managed care, and they are using their purchasing power to ensure that medical homes are accountable in terms of both quality and cost. To that end, states are employing a number of tools — including improved data infrastructure, pay for performance programs, health information technology (HIT), consumer engagement, and chronic care management — to get more from managed care programs (Figure 5).

Figure 5: Tools Scan States Are Pursuing to Enhance Managed Care
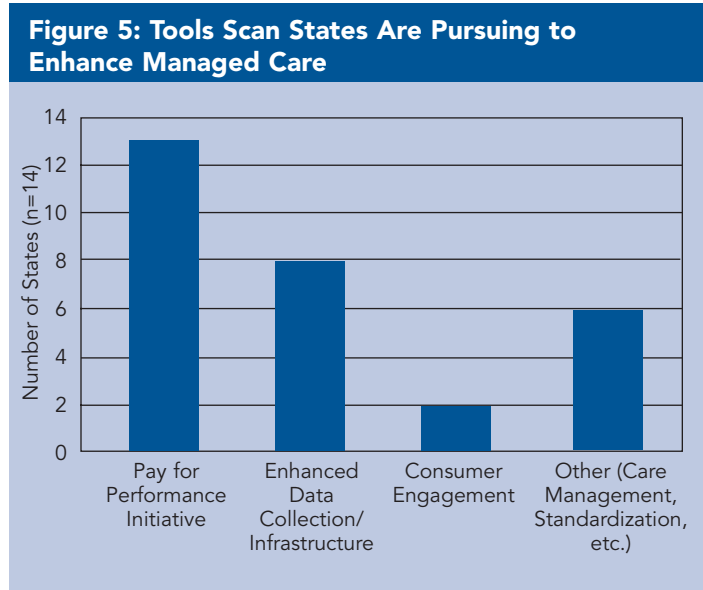
Source: State interviews. Note: Figures are not unduplicated counts.

States are strengthening data-related infrastructure both to maximize their purchasing power and to support care management initiatives.

States are becoming increasingly sophisticated in their use of data to improve purchasing strategies. Whether expanding capitated managed programs or developing new care management approaches, states realize they need better data from their plans and providers, a more advanced data infrastructure, and stronger in-house expertise than was required in the past. New state tasks may include: using claims data to identify and stratify target populations for disease management; analyzing claims to examine disease prevalence, predict recurrences, and design interventions; acquiring and validating encounter data to measure and reward quality; and developing performance measurement approaches (e.g., HEDIS-like measures) for EPCCM and care

management programs. States increasingly view data and systems improvements as key to achieving quality and efficiency gains, a stance that is bolstered by broad support for health information technology coming from national, political, and health care leadership.

To support better chronic care and care management, two states have implemented or are considering initiatives to provide consumer-level data to plans and providers. Recently, Michigan offered plans 12 months of historical encounter data for their new members, although so far just two plans have requested the data. Similarly, Pennsylvania is considering reinstating its former practice of providing historical utilization data to plans for their new members.

States are also harnessing the power of encounter data submitted by health plans. States can use encounter data to monitor health plan performance and patient utilization patterns, implement provider profiling, and identify high-risk beneficiaries for care management. With less access to fee-for-service utilization data in states transitioning to managed care, perhaps the most important use of health plan encounter data for states is in rate setting and risk adjustment for plan payments. Florida, which historically has not focused on encounter data collection, used its recent managed care reform initiative to require encounter data submission. Florida will begin to use the data immediately to risk adjust and set appropriate plan-specific capitation rates. Florida plans to use encounter data to better monitor quality measures from its health plans and report that information publicly on an ongoing basis.

More advanced data analysis examining the size of primary care provider practices and their performance on chronic care measures

has given Michigan new insights into where beneficiaries receive care. In a study of Wayne County (Detroit), Michigan found that approximately half of the Medicaid beneficiaries receive primary care from small one- and two-physician practices. This will require the state to work with its health plans to determine how to improve quality in smaller practices that often lack the infrastructure found in larger entities.

States are looking for ways to align payment and quality. The leading strategy is pay for performance.

Incentive programs are emerging in Medicaid as a way to improve health care services and outcomes. Whereas reimbursement in health care has traditionally focused on volume — the more patients a physician sees, the more he or she gets paid — pay-for-performance (P4P) programs attempt to better align payment and quality with the goal of improving the efficiency, timeliness, and quality of care.[6] Not surprisingly, many states are using P4P to pursue quality improvement and performance goals. These efforts are increasingly specialized and tailored to the states' needs, whether that is improving quality, promoting prevention, strengthening care management, or increasing managed care participation in quality improvement activities.

Ohio has invested considerable resources in P4P initiatives, holding 1% of the premium at risk for graduated performance-based payments. Tiered incentives are paid based on plan performance. The highest payments go to plans achieving Superior Performance (for satisfactory performance on 21 measures) while somewhat lower payments are made to plans achieving Excellent Performance (for satisfactory performance on three measures). Although

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6   N. Highsmith and J. Reller Rothstein. *Rewarding Performance in Medicaid Managed Care*. Center for Health Care Strategies, Inc. March 2006. http://www.chcs.org/usr_doc/MedicaidP4PBrief.pdf

strategies may vary by health plan and /or geographic area, many plans also provide incentives at the physician level to secure provider panels, improve quality of care, and enhance consumer access to preventive care outside regular office hours. Some plans partner with providers on profit/risk sharing to help address systems issues such as e-billing. Incentives to promote health care compliance at the consumer level are also quite common. Leveraging the success of its P4P effort with managed care plans, Ohio would like to extend performance-based payment to its fee-for-service program.

Likewise, Michigan has established a with-hold pool to fund for its P4P initiative. The $3 million P4P capitation bonus pool is used to pay managed care organizations based on their performance on five clusters of measures. Some Michigan plans have incorporated these performance-based payments into capitated provider contracts. Others have reverted to fee-for-service provider payment as a way to more easily generate the encounter data needed to demonstrate performance for the state P4P initiative. Both Hawaii and Wisconsin are also developing P4P efforts. Wisconsin's P4P initiative will focus on dental care, lead testing, birth outcomes and tobacco use cessation. Future efforts will focus on chronic care. Washington has incentives for EPSDT screening and childhood immunizations and would also like to adopt an "outcomes focus" to encourage care management. Under pressure from providers to give more generous rate increases (above the usual 2 to 4% increases), Washington is considering increasing rates through pay-for-performance initiatives rather than across the board.

Maryland has initiated sanctions, but not rewards, for plan performance on 11 measures, including HEDIS and locally developed indicators, such as lead screening for children. The state is planning to institute performance awards in addition to penalties in 2007.

Pennsylvania is focusing its P4P efforts on encouraging better chronic care management. As part of ACCESS PLUS, the state contracts with a disease management vendor to coordinate care for several chronic diseases, including asthma, diabetes, chronic heart failure, chronic obstructive pulmonary disorder and coronary artery disease. The program's vendor has 5% of its per member per month fee for the PCCM portion of its contract tied to incentives/penalties based on five measures related to better screening and prevention. In addition, ACCESS PLUS operates a P4P program to encourage primary care physicians to participate and play an active, collaborative role with the disease management program. Pennsylvania is also developing a quality measurement and performance system for the EPCCM program, which would potentially produce HEDIS-like measures from fee-for-service data, as well as instituting P4P programs within its full-risk managed care program, HealthChoices. The managed care plans can earn bonuses of up to half a percent of premium, based on improvement on 10 HEDIS measures. Pennsylvania also encourages managed care plans to reduce unnecessary emergency room visits and inpatient stays by building incentives directly into the rate-setting process.

Other states (Colorado, Florida, Georgia, and Oregon) are interested in developing P4P efforts, but face barriers including concerns about the sources of funding for P4P initiatives and lack of plan and data capacity to make it work. Oregon is interested in developing P4P efforts, although it would like to do so with new money, instead of withholds from current plan payments. While interested in P4P, Colorado feels that this strategy would not be effective

without more robust competition among plans — the state has voluntary enrollment and a very limited number of full-risk plans (two at the time of the interviews, since then reduced to one). Florida is similarly interested in P4P initiatives, but needs to strengthen its encounter-data system to create the baseline and measure progress.

Another form of incentives for health plans is default enrollment, or auto-assignment of new members to those plans with the highest performance. California has implemented an auto-assignment algorithm in 14 counties that rewards higher quality plans with more default assignments of members who do not actively choose a plan for themselves. California bases the algorithm on five HEDIS measures and two measures of plan participation with safety-net providers. The state believes this will help motivate the plans to improve their performance, resulting in higher quality care for the approximately 2.7 million managed care enrollees that reside in the participating counties.

To increase participation in its managed care programs, Wisconsin recently implemented automatic Medicaid managed care enrollment with an opt-out provision for the Milwaukee ABD population, resulting in a 92% retention rate. Yet plan-imposed enrollment caps and a lack of provider networks in rural areas of the state still limit statewide participation. The state is considering establishing incentives — dubbed "enrollment P4P" — to reward plans for increasing enrollment by expanding their

service areas or relaxing their enrollment caps.

Beyond P4P, states are trying new approaches to hold plans accountable.

Pay-for-performance approaches are not the only strategies states are using to improve performance and care management. Oregon has required all plans to have exceptional-needs coordinators, and feels that this is a good model for helping consumers navigate both medical and social services. Having seen positive results from its disease management programs serving the fee-for-service population, the state is also considering including specific disease management requirements in its managed care contracts.

Several states are grappling with how to create more standardization across plans for quality improvement. Georgia joins a number of other states in having standard quality improvement requirements, and has also implemented uniform disease measurement requirements across plans. Ohio is interested in standardizing performance measures across plans and measuring performance at the provider level, rather than just at the plan level. The state is researching options that will enhance its current P4P structures and will be viable in its expanded full-risk managed care environment. Through its new Medicaid Management Information System (MMIS) procurement, the state plans to give providers patient registries and daily access to patient health status. The state's commitment to value-based

Figure 6: Ohio ABD Procurement Scoring System

Mandatory Application Requirements Review	Pass/Fail
Experience & Compliance History	200
Delegation	100
Performance Improvement and Clinical Management	250
Information Systems	100
HIPAA	50
Provider Panel (region-specific)	300
Total	**1,000**

purchasing can also be seen in the scoring system used for its recent procurement of plans to serve the ABD population (Figure 6). Of the 1,000 available points, over half were allocated for quality improvement tools that plans could use to improve patient outcomes and cost-effectiveness such as performance improvement/clinical management systems, information systems, and a robust provider panel.[7]

Some states are implementing reforms that vary benefits by eligibility group and ask consumers to choose among coverage options.

Both Florida and Kentucky have proposed new reform initiatives that will vary benefit packages by eligibility group and offer consumers a choice of coverage options, including a health savings account-like option. Enrollees in Florida may earn credits toward their "Enhanced Benefits Accounts" if they pursue identified healthy behaviors. While a great deal of policy debate has focused on the potential benefits and risks of this approach, its significance in the short term is not clear. The consumer-direction elements will only be implemented in two Florida counties, and will allow health plans to create customized benefit packages tailored to a target population. As of October 2006, Florida had contracted with 14 plans. The plans have offered creative packages by targeting co-payments, limiting

select services, and offering additional services. Examples of additional services include preventive adult dental services, home-delivered meals post-surgical care, respite care, and acupuncture services. The state is implementing "choice counselors" to help consumers select among plans, and is also grappling with how best to provide quality data on available plans and providers to Medicaid consumers. Developing better approaches to monitoring plan quality remains an issue. Although Florida is joined by a number of other states — most notably South Carolina, West Virginia, and Kentucky — in exploring ways of enhancing the consumer role in choosing care and health healthy behaviors, the concepts are too new and untested in Medicaid to say much more than "stay tuned" and wait for results from early evaluations of these experiments.

Reimbursement rates continue to be a key issue for states.

Whether attempting to increase reimbursement rates to build provider or plan participation, or managing the effects of stagnant rates, states remain concerned with reimbursement issues. In an effort to enhance provider participation, especially in rural areas, Maryland hopes to increase provider rates until they are at least comparable to Medicare rates. After a gubernatorially-initiated review of all Medicaid plans, California obtained rate increases from the legislature for several plans. Meanwhile, the state has engaged a consulting firm to make recommendations on its rate methodology that will allow development of rates that are more predictive of plan costs.

In states with low or declining rates, plan complaints, as opposed to outright withdrawal from the market, have been the norm. Having experienced a 12% rate decrease in the last year, some Oregon plans

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7 "Industry Overview: MOH, CNC, & WLP Win Big on OH Awards." Lehman Brothers Equity Research. October 9, 2006. p.5.

may now be operating in the red, but so far none have dropped Medicaid. In a departure from this trend, Colorado's largest plan, and one of only two full-risk entities, announced it would withdraw from Medicaid managed care in response to the state's announcement of a significant rate decrease that resulted from a legislatively mandated rate methodology. Even before the plan left the market, Medicaid officials in Colorado were interested in attracting new plans, and had been approached by two national Medicaid managed care entities. State officials are not optimistic, however, about their success in contracting with these plans, given that the state legislature has typically resisted entry by out-of-state plans. In Georgia, state officials have attempted to avoid plan complaints in their new full-risk managed care program by requiring the plans to bid their rates as part of the proposal, rather than having the state set rates in the more traditional manner. While this method may not eliminate plan dissatisfaction with rates altogether,

the state hopes it will reduce the number of complaints in the short term, since the plans bid their own rates.

Because of the burden of annual rate negotiations, Medicaid leaders in Pennsylvania say it is difficult to establish a meaningful, ongoing quality partnership with plans. Medicaid officials are exploring adopting a two-year rate period, which might allow more breathing room for state-plan collaboration on quality and other issues beyond rates.

The actuarial soundness of rates may present an additional challenge to states. While the states included in this scan did not have much to say about the issues they are facing regarding actuarial soundness requirements overall, it seems likely that as they go forward with managed care expansions, actuarial soundness may particularly impact their ability to include non-traditional, supplemental support services as part of their managed care programs.

Conclusion

Medicaid and managed care have come a long way together, proving that they indeed have a lasting relationship.[8] Together they have successfully evolved, adapting to continuing changes in the managed care marketplace and responding to state budget priorities. Today's definition of Medicaid managed care goes far beyond the traditional full-risk model. States are using a variety of innovative mechanisms, including enhanced primary care case management, disease management, and comprehensive care management to effectively manage high-quality and cost-effective care for Medicaid beneficiaries.

Satisfied with the opportunities for increased quality and efficiency that Medicaid managed care, in all its forms, is able to provide, many states are now looking to it to develop accountable medical homes not only for children and families, but for adults with chronic conditions and seniors as well. Elderly adults and those with complex health needs represent only one-quarter of the 55 million people served by Medicaid, yet they consume nearly 70% of the program's resources.[9] By shifting the focus from managing the costs to managing the care of this population, states see an opportunity to reap long-term value in improved health outcomes and reduced costs.

Overall, the subset of states interviewed for this scan have become more sophisticated purchasers both in reaction to external budget pressures and due to internal recognition that they can use their purchasing leverage to obtain better value. States are adopting new tools to achieve quality and efficiency improvements, including new approaches for managing care; incentives for improving performance; standardized process and outcome measures; consumer engagement strategies; and methods to systematically collect encounter data. Indeed, a recent 50-state survey by the Kaiser Commission on Medicaid and the Uninsured confirmed that progressively more states are focusing on quality improvement and disease management to curb long-term costs and improve quality, particularly for high-cost beneficiaries.[10]

Medicaid managed care's first 20 years have shown that as the program continues to evolve, states will expect managed care to evolve with it. This is already being tested as some states try out the flexibility provided by the Deficit Reduction Act of 2005 (DRA). While some of the states included in the scan have used or are considering using DRA authority to implement new cost sharing or expand home-and community-based services, others appear to be taking more of a wait and see approach when it comes to integrating the DRA into their Medicaid managed care strategies in the near term.

Medicaid is challenged to provide health care services for a rapidly expanding and vastly diverse group of Americans, including adults with complex chronic conditions and disabilities, the low-income elderly, and a disproportionate number of consumers in racial and ethnic minority populations. Through increasingly sophisticated and varied models, state purchasers are demanding more value for public expenditures and are effectively targeting investments to deliver high-quality health care services and, ultimately, improved health outcomes, for Medicaid beneficiaries.

8   R. Hurley and S. Somers. "Medicaid and Managed Care: A Lasting Relationship?" *Health Affairs* 22.1 (2003): 77-88.

9   *Medicaid Program at a Glance*, op. cit.

10 V. Smith, et al. *Low Medicaid Spending Growth Amid Bounding State Revenues: Results from a 50 State Medicaid Budget Survey State Fiscal Years 2006 and 2007*. Kaiser Family Foundation. October 2006. http://www.kff.org/medicaid/upload/7569.pdf

APPENDIX 1: MEDICAID OVERVIEW IN SCAN STATES[11]					
State	**Total Medicaid Enrollment (June 2005)**	**Distribution of Medicaid Population by Eligibility Group**	**% of Medicaid Population with Dual Eligibility Status**	**Overall Managed Care Penetration**	**% Aged, Blind & Disabled in Managed Care**
California	6,552,553	Children, 50% Adults, 27% Elderly, 12% Blind and Disabled, 11%	15%	50%	19%
Colorado	410,445	Children, 59% Adults, 17% Elderly, 10% Blind and Disabled, 12%	14%	30%	19%
Florida	2,247,559	Children, 53% Adults, 7% Elderly, 17% Blind and Disabled, 13%	17%	67%	11%
Georgia	1,377,746	Children, 60% Adults, 17% Elderly, 9% Blind and Disabled, 14%	9%	57%	0%
Hawaii[12]	200,534	Children, 47% Adults, 32% Elderly, 10% Blind and Disabled, 11%	10%	80%	0%
Kentucky	692,053	Children, 51% Adults, 13% Elderly, 12% Blind and Disabled, 24%	17%	69%	36%
Maryland	701,601	Children, 60% Adults, 14% Elderly, 7% Blind and Disabled, 18%	12%	70%	0%
Michigan	1,435,236	Children, 55% Adults, 19% Elderly, 9% Blind and Disabled, 17%	14%	66%	41%
Ohio	1,711,152	Children, 55% Adults, 21% Elderly, 8% Blind and Disabled, 16%	11%	57%	0%[13]
Oregon	411,478	Children, 41% Adults, 41% Elderly, 7% Blind and Disabled, 11%	13%	80%	65%
Pennsylvania	1,697,693	Children, 48% Adults, 17% Elderly, 23% Blind and Disabled, 12%	17%	62%	55%
Texas	2,767,261	Children, 59% Adults, 17% Elderly, 12% Blind and Disabled, 12%	24%	71%	20%
Washington	963,057	Children, 56% Adults, 24% Elderly, 13% Blind and Disabled, 7%	10%	49%	3%
Wisconsin	862,426	Children, 40% Adults, 27% Elderly, 16% Blind and Disabled, 17%	19%	54%	35%

[11] Information presented in both Appendix 1 and Appendix 2 was taken from each state's Medicaid website, the CMS website, and Kaiser State Health Facts and validated by the states.

[12] Data presented for Hawaii have not been validated by the state.

[13] The ABD population is currently excluded from Ohio Medicaid managed care; however, the state will begin enrolling approximately 125,000 SSI consumers in December 2006.

APPENDIX 2: MEDICAID MANAGED CARE PROGRAMS OVERVIEW IN SCAN STATES

STATE	Populations Served by Medicaid Managed Care Programs			Type of Managed Care Delivery System		Geography		Enrollment		Benefits Included in MCO or PCCM Program			Relationship with Special Needs Plans (SNPs)	
	TANF	ABD	Duals	PCCM	MCO	Limited	State-wide	Mandatory	Voluntary	Acute	LTC	BH	Currently Contract	Interest in Contract
California	✓	In certain counties	In certain counties		✓	✓		For certain aid codes in all counties; for all aid codes in COHS	For certain aid codes in non-COHS counties	✓	Limited coverage in certain plans and fully covered in 4 plans in 7 COHS counties			✓
Colorado	✓	✓		✓	✓	✓			✓	✓				✓
Florida	✓	✓	Currently included in HCBS managed care waiver program and will be included in future LTC program	✓	✓	Reform in two pilot counties	✓	✓Currently choice between PCCM and MCOs excluding reform counties	Reform initiative will be voluntary for certain populations	✓	Will be included in Florida Senior Care only			✓
Georgia	✓			✓	✓	✓	✓	(Except SOURCE)	✓	✓	In SOURCE only	✓		✓
Hawaii[14]	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Kentucky	✓	✓	✓	✓	✓		(Not Passport Health Plan)	✓(Except Passport Health Plan)	✓	✓	✓(Except Passport Health Plan)	✓(Except Passport Health Plan)	✓	✓
Maryland	✓	✓			✓		✓	✓		✓	Plans to include in future program	✓		✓

14 Data presented for Hawaii have not been validated by the state.

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STATE	Populations Served by Medicaid Managed Care Programs			Type of Managed Care Delivery System		Geography		Enrollment		Benefits Included in MCO or PCCM Program			Relationship with Special Needs Plans (SNPs)	
	TANF	ABD	Duals	PCCM	MCO	Limited	State-wide	Mandatory	Voluntary	Acute	LTC	BH	Currently Contract	Interest in Contract
Michigan	✓	✓			✓	✓	✓	✓	✓	✓		✓(Not substance abuse)		✓
Ohio	✓	A portion will be included in expansion			✓	✓	Will be statewide by 12/06	In certain counties by 12/06	In certain counties	✓	✓	✓		✓
Oregon	✓	✓	✓	✓	✓	✓		In certain counties	In certain counties	✓	Limited to PACE and 20 days SNF	✓		
Pennsylvania	✓	✓	✓	✓	✓		✓	In certain counties	In certain counties	✓	✓	✓		✓
Texas	✓	✓	✓	✓	✓		✓	For TANF populations in STAR HMOs; ABD in STAR +PLUS; for TANF and ABD in PCCM	For ABD in STAR HMOs	✓	In STAR +PLUS service areas	✓Carved out of North-STAR (Dallas area)	✓	✓
Washington	✓	Pilot integrated programs	Pilot integrated programs		✓	✓		✓ (Except for the two pilot integrated programs)		✓	In pilot integrated programs	In pilot integrated programs	✓	✓
Wisconsin	✓	✓	✓	✓	✓	✓		For TANF populations where 2+ HMOs; duals	ABD may opt-out	✓Not in Family Care	Only in Family Care and Partnership Program	✓	✓	