



THE GEORGE
WASHINGTON
UNIVERSITY
MEDICAL CENTER
WASHINGTON, D.C.

SCHOOL OF PUBLIC HEALTH
& HEALTH SERVICES

DEPARTMENT OF HEALTH POLICY

Managed Care and Medi-Cal Beneficiaries with Disabilities: Assessing Current State Practice in a Changing Federal Policy Environment

**Sara Rosenbaum^a
Sara Wilensky^b
Peter Shin^c
Ramona Whittington^d**

June 2006

Funded by:



^a Hirsh Professor and Chair, Department of Health Policy, The George Washington University School of Public Health and Health Services

^b Assistant Research Professor, Health Policy

^c Assistant Research Professor, Health Policy

^d Research Assistant, Department of Health Policy

Executive Summary

This analysis, prepared for The California Endowment, is a follow-on report to our earlier work that raised issues to be considered before moving persons with disabilities into compulsory Medicaid managed care plans and reviewed the extent to which California's legal framework addressed the concerns identified. In this report, the George Washington University School of Public Health and Health Services examines how other states have addressed issues that arise in designing, implementing and overseeing compulsory managed care systems for persons with disabilities and serious and chronic health conditions. The experiences of other states that have developed these types of arrangements offer an important learning opportunity for any state that is beginning the process of evaluating possible reforms. In addition, we evaluate how the changes in the Deficit Reduction Act of 2005 relate to decisions regarding the use of mandatory managed care enrollment for disabled beneficiaries.

Our previous report for The California Endowment focused on a series of issues central to the development of contractual arrangements with managed care organizations:

- The process of enrolling and disenrolling from health plan arrangements, including the extent and design of the auto-enrollment process;
- Accountability standards governing contractor performance in the areas of access and the experience and quality of the provider network with respect to both primary and specialty care;
- Benefit design with respect to both contractual and extra-contractual coverage for both children and adults, with particular attention paid to the allocation of coverage responsibilities between the state program and its contractors in the case of Early and Periodic Screening Diagnostic and Treatment (EPSDT) services;
- Contractor payment levels and terms and the down streaming of financial risk to network providers, including safety-net providers; and
- The ability to measure the quality of plan performance.

This report focuses on these issues in the context of other state experiences while also identifying key challenges in other areas that were identified by the state officials with whom we spoke. The five states whose plans were the focus of this study were Arizona, Maryland, Massachusetts, Minnesota and Wisconsin because of their extensive use of managed care systems for beneficiaries with disabilities. Our research methods entailed review of relevant documents and interviews with officials charged with program management.

Findings in Brief

Although we were able to gather extensive information from state officials and through our document review, we were struck by the very limited extent of state experience with compulsory managed care for persons with disabilities, a fact that we attribute to the complexity of implementing complex systems of care for persons who experience both extensive medical and health care needs and very low income as well as the lack of adequate performance assessment standards despite notable work on the part of numerous organizations in recent years, particularly the Center for Health Care Strategies. The complex nature of the purchasing task, coupled with uncertainty around performance measurement, may account for the slow rate with which these systems appear to have developed. Our research also yielded a series of specific findings related to the following matters:

- *The extent to which sufficient time is allocated to pre-implementation planning on the part of both agencies and contractors, as well as the degree to which additional resources are allocated to staffing and readiness activities.* Managed care for low-income persons with disabilities involves the development of customized health care systems requiring special knowledge and capabilities on the part of both purchasers and contractors that go well beyond the standardized activities associated with managed care purchasing for a Medicaid population without serious disabilities.
- *Delegation of oversight.* Careful consideration is needed regarding the extent to which basic decisions over program design and oversight should be delegated to sub-state administration authorities;
- *Particular attention to coverage design.* Managed care enrollees with disabilities typically need access to the full scope of acute and long-term care services covered under their state Medicaid plan. Many managed care contracts cover less than the full range of state plan services, and failure to carefully juxtapose and integrate multiple sources of coverage can create serious coverage gaps for enrollees. Contractual development requires careful attention to the integration of coverage and service design with respect to the written standards that frame coverage operations and program performance;
- *Training.* The extent to which those charged with purchasing and overseeing care at the state and local level are sufficiently trained and supported to carry out oversight activities;
- *Measurable standards.* The ability to conduct oversight through performance measurement utilizing a combination of standard reporting measures, specialized measures tailored to members with critical but low-prevalence health needs that are not reflected in standard performance measures, and “real-time measurement” that utilizes data sources such as complaints, appeals and grievances.

Agency officials reported that for reasons of clear accountability, their contract documents represent the primary source of written standards governing their managed care systems. At the same time, more elaborate guidance related to performance and performance measurement typically is found in supplementary materials furnished to all contractors, such as transmittals and operational instructions, which may or may not create enforceable expectations. The task of determining when expectations should be advisory as opposed to enforceable is a complex one and entails weighing factors related to cost, quality and safety, and the ability to develop clear standards capable of enforcement.

Finally, the Deficit Reduction Act of 2005 includes far-reaching changes with respect to state flexibility to introduce new types of benefit designs in to Medicaid coverage; these arrangements can be offered on an optional basis in the case of persons with disabilities. At the same time, new limitations on Medicaid payment for case management services may create new challenges for states that seek to create integrated systems of care for persons with disabilities that span multiple public programs beyond Medicaid, such as specialized public systems for children with special health care needs and adults with mental and developmental disabilities.

Introduction

This analysis, prepared for The California Endowment, examines issues that arise in designing, implementing and overseeing compulsory managed care systems for persons with disabilities and serious and chronic health conditions. In recent years there has been a growing interest in using managed care tools to create compulsory systems of care for children and adults with disabilities. The experiences of other states that have developed these types of arrangements offer an important learning opportunity for any state that is beginning the process of evaluating possible reforms. Of course, positive actions taken by other states should be viewed as opportunities, not limitations, and California's policymakers should not feel confined by the decisions made in other states. This paper focuses on experiences outside of California because our prior report¹ for The Endowment reviewed California's legal framework, including boilerplate County Operated Health Systems contracts, and other researchers working during this same time frame are evaluating California's experiences with managed care and contract language use by California managed care organizations.

The George Washington University School of Public Health and Health Services ("GWU") conducted a preliminary analysis of this issue for The Endowment in August, 2005. This second-phase analysis represents a follow-on to our earlier work. **Part 2** provides a background and context, summarizing both the key findings in our earlier report as well as important developments subsequent to our initial work that bear directly on the establishment of compulsory managed care systems for Medi-Cal beneficiaries, including policy developments at the state level and the enactment of the Deficit Reduction Act of 2005 (DRA). **Part 3** describes the results of our analysis of state experiences with compulsory managed care arrangements, including both a description of various state contractual approaches to key design questions as well as findings from a series of interviews with state officials involved in managed care administration and oversight. **Part 4** discusses important federal policy considerations arising from the DRA.

In this report, certain acronyms appear in **Parts 3 and 4**. **Appendix A** contains a list of these acronyms and their definitions. **Appendix B** contains a list of the clinical indicators that Massachusetts' Senior Care Options Program requires providers to report.

¹ Sara Rosenbaum, Sara Wilensky, and Peter Shin. Achieving "Readiness" in Medi-Cal's Managed Care Expansion for Persons with Disabilities: Issues and Process. Prepared for The California Endowment (August 2005). Available at http://www.calendow.org/reference/publications/pdf/npolicy/TCE0930-2005_Achieving_Read.pdf. (Accessed June 19, 2006).

2. Background and Context

A. Summary of Key Findings from GWU's Initial Analysis for The California Endowment

In August 2005, GWU conducted an analysis for The Endowment regarding the major challenges that arise in transitioning Medi-Cal beneficiaries with disabilities to managed care systems utilizing a compulsory enrollment model.² This analysis occurred at a time when this type of transitional plan appeared to be proceeding in California at a rapid pace. Based on an examination of federal legal requirements for Medicaid managed care, as well as a body of previous research into Medicaid managed care arrangements, the analysis identified a series of important issues that could be expected to arise in designing and overseeing mandatory managed care systems for children and adults with serious disabilities. These issues can be summarized as follows:

- *The process of enrolling and disenrolling from health plan arrangements, including the extent and design of the auto-enrollment process.* Autoenrollment – the process of automatically assigning to some or all health plans eligible individuals who fail to select a plan -- is essential in any compulsory system, but it also can result in a significant disruption in health care access and established provider/patient relationships. Furthermore, in the case of individuals at heightened risk of institutionalization, or whose disability may be associated with behavior considered disruptive or that is complex to manage, deciding when -- if ever -- plans will be permitted to disenroll such members becomes an important question for resolution.
- *Accountability for access and provider network experience, availability and competency.* Organized health care systems specializing in the treatment and management of persons with disabilities merit heightened attention to issues related to physical, geographic, and language and communication access, as well as the qualifications, experience levels and competency of provider networks. Also important is the extent to which certain types of health care providers offering unique services remain accessible regardless of plan enrollment. Finally, health systems for persons with significant disabilities may raise important questions related to the extent to which patients are permitted to remain in previously established and valued provider relationships.
- *Benefit design and extra-contractual coverage, especially in the case of children with disabilities for whom access to enhanced coverage under Early and Periodic Screening Diagnostic and Treatment services (EPSDT) remains a basic requirement.* Benefit design in managed care systems for persons with disabilities is complex because of the range of coverage needed and the standards that need to be applied when making individualized determinations regarding the medical

² Id.

necessity of care. Standard treatment guidelines may be irrelevant to patients with multiple, serious and chronic conditions whose need for health care intervention is not simply to “improve” but also to maintain functioning or avert a loss of functioning. For children, additional considerations that arise under EPSDT become particularly important, because of the need to intervene at the earliest possible point in order to maximize healthy growth and development.

In this regard, five challenges emerge as key:

- The first key challenge is to identify contractual coverage versus extra-contractual coverage so that the state agency and plans are in clear agreement regarding which services to which beneficiaries are a managed care plan obligation and which remain directly covered under the state’s Medicaid plan.
- The second key challenge is the extent to which plans will be permitted to apply across-the-board coverage limitations and exclusions.
- The third challenge is the development and application of appropriate standards of medical necessity in individualized coverage decision-making to promote functional attainment and healthy child development and to avert the loss of functional capability.
- The fourth challenge is the use of a decision-making process that is patient-centered, focusing on the particularized facts in individual cases and allowing for a broad range of evidence to be considered beyond standardized treatment guidelines. In this regard the grievance and appeals process becomes critical, as well as the relationship between plan appeals procedures and special regulatory safeguards applicable to Medicaid beneficiaries that ensure that ongoing health services are not reduced or terminated prior to a thorough evidentiary hearing.
- The fifth challenge is ensuring appropriate coordination to ensure that plan treatment decisions take into account the health supports that members will need to be able to take full advantage of other community services. These include supports such as between plan coverage and service activities, health and supportive services available through other programs such as special education and child development programs, job-training and supported work opportunities, and community living and socialization opportunities.
- *Payment levels and terms and the “downstreaming” of financial risk.* Persons with disabilities present a much greater potential for financial loss, especially if managed care contracts include a wide array of services and management obligations. As a result, payment levels and stop-loss provisions are key features to consider. Whether states provide a limit to managed care plan’s financial obligations instead of placing more financial risk on plans and providers is a central aspect of planning. Essential planning questions include: How much risk is

transferred from the purchaser to the plan and, in turn, “downstreamed” to health professionals and practice groups? Are the terms of payment adequate to avert serious treatment disincentives that can harm patients? Are payment levels sufficient to avoid financially damaging health care practices?

- *Measuring the quality of plan performance.* There is heightened interest in linking payment to the achievement of quality performance benchmarks. In systems that emphasize care and treatment for relatively small numbers of persons, many of whom have multiple diagnoses and relatively unique health needs, what measures are to be used? Will measures take into account the extent to which plans succeed in maximizing the functional status of patients, minimizing the potential for deterioration, and ensuring that their health services and supports make it possible for patients to fully benefit from the broader array of community services? How can payers ensure safeguards against under-service in relation to need, particularly where some of the most important signals of quality may involve events that are limited in number and do not lend themselves easily to standardization or mass measurement techniques?

While this paper focuses on how these and other issues affect access to care for persons with disabilities in managed care plans, it is worth noting that many of the hurdles we describe here are also present in fee-for-service settings. For example, the need for consumer-focused decision-making, improved care coordination to obtain Medi-Cal covered services or a mix of Medi-Cal covered and uncovered services, and issues relating to medical necessity standards are also concerns in fee-for-service settings. While managed care may not have created many of these problems, managed care organizations are in a position to make decisions that either exacerbate the concerns raised above or improve the accessibility and quality of care received by persons with disabilities.

B. Subsequent State Policy Developments

Following a decision to delay plans to aggressively move forward with compulsory managed care under §1115 federal demonstration authority, Gov. Arnold Schwarzenegger, in his FY 2007 Budget submission to the California Legislature, proposed to take a “more cautious and deliberate” approach to the transformation to managed care for persons with disabilities on order to “further develop the infrastructure, policies, procedures, and performance standards” necessary for managed care to appropriately serve persons with disabilities.³ The Governor instead proposed to develop pilot health care coordination programs for persons with serious mental illness, as well as persons with chronic conditions who are seriously ill and may be approaching the end of their lives.

³ The Governor’s Budget Summary 2006-07, Health and Human Services, p. 131.

C. Federal Policy Developments

In February 2006, President George W. Bush signed into law the Deficit Reduction Act of 2005 (DRA).⁴ Arguably the most far-reaching set of Medicaid coverage reforms since Medicaid's 1965 enactment, the DRA creates a series of new flexibility options for state Medicaid programs that have direct relevance to decisions regarding the use of compulsory managed care arrangements for persons with disabilities. The flexibility measures for persons with disabilities that have garnered the most immediate attention are those related to the provision of long-term care services; at the same time, early implementation rulings by the United States Department of Health and Human Services clarify that new flexibility options related to benefit-redesign of states' general Medicaid programs may, under certain circumstances, be extended to persons with disabilities. These DRA provisions, whose relationship to existing coverage and managed care requirements are only in their early implementation stage, will be discussed at length in **Part 4**.

Part 3: Managed Care and Persons with Disabilities: State Experiences and Contract Documents

During the 2005-2006 time period, GWU researchers examined experiences of other states with compulsory systems of managed care. Based on our research, we have identified a series of issues considered by state officials as essential to consider when developing compulsory managed care programs for beneficiaries with disabilities and serious and chronic health care needs. These issues were reflected both in our discussions with state officials as well as in our review of the purchasing documents that govern the health care arrangements in these states. Many of the issues have been identified in other reports examining compulsory managed care Medicaid beneficiaries with disabilities and chronic conditions.⁵

A. Methodology

Researchers worked with The Endowment and experts in the field to identify states with experience in the use of mandatory managed care systems for Medicaid beneficiaries with disabilities. A relatively small number of states possess such experience; those included in this study are Arizona, Maryland, Massachusetts, Minnesota and Wisconsin. Some states have more than one relevant program, and some voluntary programs are included in the analysis because the decision-making and experience of Medicaid officials proved helpful when considering the issues relating to mandatory managed care programs.

Once the states were identified, we collected and reviewed available state contractual documents using review techniques developed a decade ago for the

⁴ P.L. 109-362.

⁵ *Performance Standards for Medi-Cal Managed Care Organizations, op. cit.*

Department's ongoing studies of Medicaid managed care contracts,⁶ but with a focus on provisions specifically aimed at services and protections for beneficiaries with disabilities. In addition, we were able to interview Medicaid officials in most of the selected states about their experiences implementing and operating their systems.⁷

Our analysis covers managed care systems found in the five states and specifically considers the following systems:

- **Arizona's** Health Care Cost Containment System (AHCCCS), a compulsory system enrolling most Medicaid beneficiaries, but excluding Qualified Medicare Beneficiaries (QMB);
- **Maryland's** HealthChoice program, a compulsory system enrolling most Medicaid beneficiaries including many with disabilities, but excludes "full benefit" Medicare/Medicaid dual enrollees, institutionalized beneficiaries; and beneficiaries in Home Care for Disabled Children;
- **Maryland's** CommunityChoice Program, an 1115 demonstration program currently pending before the Centers for Medicare and Medicaid Services (CMS). If approved, CommunityChoice would mandate enrollment of "full benefit" dual enrollees who receive full Medicaid benefits on the basis of age, blindness or disability, who are 65 or receiving Medicare, or who need a nursing home or chronic hospital level of care;
- **Massachusetts'** MassHealth Senior Care Options Program (SCOP) a voluntary program for dual enrollee elderly.
- **Minnesota's** Senior Care (MSC)⁸ which is a mandatory program for most Medicaid beneficiaries, but excludes blind and disabled beneficiaries under 65, QMBs and Specified Low-Income Medicare Beneficiaries not otherwise receiving Medicaid, and institutionalized beneficiaries (unless approved by the MCO);
- **Minnesota's** Senior Health Options (MSHO), which is a voluntary program for beneficiaries who are 65 and older and either dual enrollees or Medicaid only. Enrollees may be residents of nursing facilities and hospices;

⁶ Sara Rosenbaum, et. al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (GWUMC, 1997-2000). The results of these studies and the methodology used can be viewed at the Department's Web site, www.gwhealthpolicy.org.

⁷ We were unable to speak directly with a Maryland HealthChoice official. However, the official from Maryland's CommunityChoice Program was familiar with the HealthChoice program and provided important background information. Since we interviewed public officials in their official capacity, the GWU Institutional Review Board ruled our study was IRB Exempt. IRB #110534, A Multi-state Analysis of Medicaid Managed Care Systems for the Elderly and Disabled.

⁸ The tables also refer to Minnesota Senior Care Plus (MSC+) which is for beneficiaries who require nursing home level of care because there is one model contract that covers MSC, MSC+, and MSHO.

- **Minnesota's** Disabled Health Options (MDHO), a voluntary program for enrollees between 18-64 years who are certified as disabled and eligible for Medicaid. Enrollees may be dual enrollees or hospice residents;
- **Wisconsin's** Supplemental Security Income Managed Care (SSI MC), which is a mandatory program in Milwaukee for Medicaid only beneficiaries who are 19 years and older, living in Milwaukee County, who meet SSI disability criteria and are not living in a nursing home, institution, or participating in a Home and Community Based waiver program. Dual enrollees may choose to enroll on a voluntary basis; and
- **Wisconsin's** Partnership Program (WPP), a voluntary program for Medicaid or waiver eligible individuals who are residents of designated counties. Persons eligible for enrollment are individuals who are 65 and older, 18-55 years of age with a disability determination, or residents of nursing facilities. Full benefit dual enrollees may choose to enroll as well.

B. Findings in Brief

Our research suggests that a series of key issues arise in the development of compulsory managed care systems for persons with disabilities and chronic conditions are designed, as beneficiaries are transitioned into such systems, and as systems become fully operational:

- Pre-implementation planning, staffing needs and challenges: the extent to which sufficient time is allocated to the development of a specialized health system market and agency personnel charged with development and implementation are accorded sufficient time to develop the system, particularly in states such as California, in which localities – and thus, their readiness -- play a major role in the process;
- Careful consideration regarding the extent to which basic decisions over program design and oversight can be – and in fact will be -- delegated to sub-state administration authorities;
- Contractual development and careful attention to coverage and service design in the preparation of written documents and standards that will frame program operations and performance;
- The extent to which those charged with purchasing and overseeing care at the state and local level are sufficiently trained and supported to carry out oversight activities;
- The ability to conduct thorough performance measurement consisting of three critical elements:

- standardized reporting through reliable and valid data and evidence-based performance measures;
- specialized and more comprehensive performance measurement around special conditions and populations whose management is not the subject of standard measurement; and
- real-time performance measurement through well-designed grievance and appeals systems.

States tend to capture many of these key issues in their contracts, although contract documents contain limited provisions related to the scope of plans' performance improvement and measurement duties as well as submission of information and data. More elaborate standards may be contained in supplementary materials furnished to all contractors such as transmittals and operational instructions, which may or may not create enforceable expectations.

The following sections report on our interviews with state officials and present tables that describe relevant contract language used to address specific issues that arise in design and implementation.⁹

C. Findings from Interviews with State Officials

(1) Pre-Implementation Planning

State officials emphasized the need to allocate sufficient time to develop and implement mandatory managed care for persons with disabilities. Time is needed to work with key stakeholders in developing the program. In the view of officials, program development encompasses:

- accurate assessment of beneficiary needs;
- accurate assessment of provider capacity to meet needs across sub-populations, the range of disabilities and conditions and functional limitations, and management of persons with co-occurring conditions;
- development of new contractual service and coverage requirements including minimum information needs;
- development of data collection tools, and
- development of partnerships with key sub-state level players such as county or city governments that will have a central role in implementing and administering the program.

Officials emphasized that as a result of the range and uniqueness of the needs of the population, it is frequently not sufficient to simply attempt to modify the structure and tools of managed care systems for persons without disabilities for use in new systems.

⁹ These contracts are maintained by GWU, and interested persons can request additional searches of relevant information.

Instead, time, staff, and resources must be dedicated to designing and implementing this new program.

Although there was significant variation among the states, most Medicaid officials stressed the value of a needs assessment that involved beneficiaries and very specific data in order to help guide program requirements.

- In Massachusetts, the state funded focus groups of elderly beneficiaries to discover what problems currently existed and what it would take for a managed care program to succeed. The results not only helped officials understand what changes to make, but made it easier to implement changes to the current system because the recommendations were coming from patients, not state staff who might also be concerned about the impact of changes on their own operations.
- Wisconsin officials focused on creating and evaluating detailed data reports before starting their managed care program for SSI beneficiaries. These reports included identification of which services were used by potential enrollees on a county-by-county basis, identification of the most important providers in each county in order to clarify network expectations for MCOs for purposes of quality and continuity of care, and predictive risk reports that evaluated prior authorizations and FFS use of enrollees to help stratify beneficiaries by risk and assist MCOs in conducting post-enrollment risk assessments. In addition, Wisconsin was able to build on its experience from *iCare*, an HMO dedicated to serving special needs populations. Even so, they indicated they would have conducted additional preparatory work if time had permitted, particularly with respect to the evaluation of service area, beneficiary, and MCO readiness. Finally, Wisconsin also created an advisory committee that was extensively involved in the development of the program, including identification of beneficiary needs.
- Although Minnesota officials indicated that they did not conduct a needs assessment specifically tailored to program implementation, they also indicated that they were able to avoid a specialized assessment because they conducted ongoing needs assessments for other state programming and operational purposes. Furthermore, officials indicated that expansion counties are responsible for supplying the state with a comprehensive analysis of potential problems and shortages in the relevant service area. Because Minnesota is a state with considerable local involvement in Medicaid plan administration, its experiences may be particularly relevant.
- Maryland spent a year and a half planning its Community Choice program and used both focus groups and data analysis during this time. The state concentrated on examining patient utilization patterns from financial and claims data and in developing predictions regarding how program implementation would alter service use.

(2) Staffing Needs and Challenges

Given the need for extensive planning and restructuring in order to prepare for implementation of managed care for persons with disabilities and chronic conditions, all state officials interviewed indicated the need for considerable additional staffing. Interviewees identified key staffing needs in certain specified areas:

- Expertise in rate setting;
- Expertise in contract design and drafting as well as general contract law;
- The addition of specific staff skilled in the needs of elderly persons and persons with disabilities;
- The development of appeal and grievance procedures modified to competently manage grievances and appeals involving complex cases and capable of speedy and professionally competent reviews of cases potentially far more complex than the norm and requiring extensive review of individualized facts;¹⁰
- Individuals with expertise in the design and management of health information technology systems design and management, and analysis of health information data covering enrollees, services, providers and claims.

While all of these issues arise in any managed care arrangement, respondents stressed that the need to adapt current standards, technologies and operating approaches to the population of persons with disabilities required new knowledge and understanding of key differences between and among populations. For example, states all experienced a need to create new rate-setting methodologies that could appropriately account for the high-risk, high-use patients. And, as will be discussed in more detail below, state officials also found that standard data measurements were not adequate for health care quality measurement.

State officials reported using a mix of in-house staff, both within and without their respective managed care division. Officials also reported using outside management and other experts. Still other states reported that they had to “beg, borrow, and steal” staff from other parts of the state agency. When state staff from outside a particular managed care division was involved, as was often the case with data management, quality assurance and rate-setting, additional time was needed in order to ensure that the

¹⁰ In this regard, it is especially important to consider the experience of Medi-Cal beneficiaries with extensive health care needs with Medicare Part D enrollment into standardized drug benefit plans whose benefit design may omit significantly used prescribed drugs. Where standardized design rules are maintained but the enrollee population is complex, enrollees have a disproportionate dependence on an appeals and exceptions process. Under this circumstance, the imperative for a fast and competent exceptions process is particularly great. See Avalere Health, Inc. *The Medicare Drug Benefit: How Good are the Options?* California HealthCare Foundation, 2006. Available at <http://www.chcf.org/topics/view.cfm?itemid=119451>.

additional staff members and the core managed care staff could fully understand each group's respective needs and integrate their own expertise.

- For example, in Maryland, the long-term care staff had to learn about managed care specifics and vice versa;
- In Minnesota, most of the quality assurance staff did not possess initial managed care expertise. State officials noted that training was necessary even though the state conducted much of the work in-house and in fact had hired staff with expertise in managed care, elder health and disability issues.
- Wisconsin staff relied heavily on the Mental Health Division because the managed care staff did not have knowledge about these issues, which are often relevant to persons with disabilities.

Officials also noted that added staffing needs did not end once their programs were operational and that ongoing expertise was essential for purposes of program oversight. Many states that used outside consultants indicated that they expected to remain in a consulting mode rather than transition to permanent staff and thus noted the importance of ongoing consultation budgeting. Officials noted the added challenge in these situations of having to oversee the work of consultants who possessed specialized knowledge that surpassed those of the state officials. These officials facing this particular situation urged the importance of considering whether, at least over time, a certain amount of expertise in-house.

State officials were particularly emphatic about adequately assessing resource and expertise needs in states in which the intention was to delegate ongoing oversight to sub-state governmental entities. Interviewees indicated that in many cases counties or cities would face even greater challenges understanding their needs and securing the proper staffing and resources. Massachusetts officials emphasized the need for states to be in a position to give ongoing financial and technical support to county and city governments faced with managed care implementation responsibilities and that it was not sufficient to assume that other funding sources would be made available to local officials charged with program implementation.

(3) Delegation of Operational Authority to Local Units of Government

In many states, including, of course, California, local governments play a central role in Medicaid administration, as well as in the operation of specialized systems of care for children and adults with disabilities. The experiences of other states with decentralized administration all point to careful consideration of how such a system will operate:

- Although its program is much smaller (3,500 enrollees after one year) than might be the case in California, Massachusetts offers a useful model because of the state's reliance on a county delegation system. In Massachusetts, state officials

charged with program operation work closely with the Area Agencies on Aging (AAAs) which in Massachusetts hold relatively great importance. The state managed care system requires participating MCOs to contract with AAAs for social work services, and many MCOs contract with them for additional services as well. The Massachusetts Medicaid official emphasized the importance of the role played by the AAA in ongoing oversight and reporting back to the state.

- Minnesota officials noted that counties could no longer maintain specific managed care units. As a result, the state's largest county experienced difficulty in conducting eligibility re-determinations and enrollment (initial enrollment is a state function), which in turn, of course, led to potential problems with service failure and lags. The state faced situations in which delays at the county level led to the loss of coverage and health care access among beneficiaries. In other words, the state experienced a problem not unlike those that have arisen in the transition of dual Medicare/Medicaid enrollees into compulsory prescription drug plans, namely, the loss of access to coverage as beneficiaries fell outside of health care systems as a result of flaws in the eligibility process.
- Wisconsin's SSI managed care program carves out mental health services, which receive additional financial support from counties. In Wisconsin, counties are not central to delivery structure, but officials noted that were mental health services to be incorporated into the contracts (a decision pending with the state as of winter 2006), then an enormous amount of collaboration would be required in order to ensure coordination between county and state financing policy and operations. Wisconsin officials noted that such integration would work only if both parties were mutually interested in collaboration, particularly since the county would assume contractual obligations to the state and thereby assume the position of a vendor rather than a political subdivision.

(4) Program Oversight

All of the Medicaid officials stressed the need for stringent oversight of MCOs. Officials pointed to a number of oversight techniques:

- Automated reporting requirements using standard measures of performance and data that could be validated for accuracy through audit procedures;
- Monthly meetings with MCOs to address issues in ongoing administration;
- Ongoing training sessions for both oversight and MCO staff; and
- Extensive state review of all materials and documents used by the MCOS.

Minnesota, whose managed care system integrates Medicare and Medicaid, has found that its MCOs often exceed the minimum state requirements in terms of the data they report (the Minnesota reporting system, like others, includes a preprinted data

template, which may be instructive in California). As the Minnesota Medicaid official put it, the state keeps a “strong finger on the pulse” of its managed care program. Minnesota’s experience in Medicare/Medicaid integration mirrors those of other states, whose officials report that the funding, staffing, resources and requirements associated with Medicare integration have significantly increased their ability to provide strong oversight functions.

(5) Medicare Integration

Several of the Medicaid officials stressed the benefits of integrating Medicaid and Medicare managed care programs. They felt that the integration allowed seniors to receive more comprehensive and coordinated care because a single plan could furnish beneficiaries with all of their services, thereby making navigation easier. Officials also noted the benefits derived from Medicare’s requirements and support in the area of monitoring, resources, and financing and voiced support for the development of Special Needs Plans under the Medicare Modernization Act. These state officials believed that integration helped avert provider cost-shifting because there were fewer financial incentives to shift costs from one program to another within the state. In addition, cost-shifting incentives could be lowered by carving out fewer services from the program. Officials stressed that such an integrated approach could not occur on the basis of compulsory enrollment.

(6) The Use of Compulsory Enrollment

As of winter 2006, compulsory enrollment is a rarity given the small number of states using such systems. While Arizona, Maryland, and Wisconsin all have auto-enrollment procedures, only Wisconsin used a process designed to provide beneficiaries with a safety-valve to disenroll from managed care. The other states allow beneficiaries to switch plans, but not to exit from managed care entirely.

- Wisconsin, a state with extensive managed care experience in both public and private markets, uses an innovative enrollment approach that according to state officials satisfies both their desire to achieve widespread enrollment as well as advocates’ desire for flexibility. Known as “all-in/opt out” enrollment, the state system automatically enrolls all eligible beneficiaries. Enrollees are required to remain with the MCO for a minimum of 60 days and may choose to disenroll between 60 and 120 days. After 120 days of enrollment they are locked-in for the year. Over the 12-month period following implementation of the “all-in/opt out” approach, voluntary disenrollments stand at fewer than 10 percent of total enrollment.

(7) Performance Measurement

State officials viewed data collection and performance measurement as essential features of a managed care program focusing on disabled beneficiaries. Given their frequent and complex health care needs, officials viewed quality measurement as an

imperative, with common, relevant, timely, reliable and valid measures of health care quality that are publicly reported in a timely manner.

To varying degrees, the individuals with whom we spoke were attempting to develop measures consistent with the needs of the population, but their lack of a comprehensive approach is consistent with the fact that there exists no tool comparable to the HEDIS[®] standardized reporting system. States appear to use various approaches and several have developed their own data tools in addition to relying on standard data measures such as HEDIS[®].

- Minnesota has evaluated a range of benchmarking systems and has extracted measures it considers relevant and useful, combining these measures with specialty measures created by their own analysis of treatment and outcomes.
- Wisconsin relied on its experience from *iCare*, an MCO that serves special needs beneficiaries, and worked with a physician group to establish specialty indicators.
- Maryland established a quality measurement subcommittee to consider appropriate performance measure.

D. Review of Contractual Documents Pertaining to Managed Care System Design for Persons with Disabilities and Chronic Conditions

Because of the variety of needs and often extensive use of services among persons with disabilities and chronic conditions, it is necessary to develop new models of managed care. In Massachusetts, for example, the state worked closely with geriatric experts to develop a geriatric specific model of care that emphasized a small, physician-directed team approach. The Wisconsin Partnership Program also centers on a small, collaborative, interdisciplinary patient-centered team approach that is considered essential to program success. In both models the critical goal is to alter the manner in which care is delivered and structured. Accordingly, contracts used for a population without disabilities need to be rethought, particularly with respect to patient protections, network structure, benefit design, and integration of care services. This section presents selections from the contract documents in states that have elected to use a managed care systems approach coverage and service delivery in the case of persons with disabilities and chronic conditions.

(1) Network and Service Protocols. Several states have moved beyond the generic network adequacy and clinical protocol language commonly found in a standard managed care contract and now specify service standards tailored to an enrollee population with extensive and multiple health care needs. Maryland has the most extensive requirements, mandating the MCOs show that it has a network of providers with experience and capacity to serve special needs patients as well as the adoption of protocols that have been tailored to treating special need patients. Minnesota's disability program also has specific requirements for access to out-of-network specialists, centers of excellence and other experts.

Table 1. Network and Protocol Requirements	
AZ-AHCCCS	Contractor must have a procedure for identifying providers willing to provide medical home services and make reasonable efforts to offer access to these providers. Contract refers to AAP medical home care description. (D11).
MD-Health Choice	MCO must provide documentation to show its preparedness to work with specialty mental health system and access for waiver-eligible individuals with physical, mental, or developmental disabilities, and for deaf individuals.(10.09.94.06; 10.09.65.04; 10.09.70), MCO application must show the clinical expertise and experience of its network in serving patients with special needs and written evidence including treatment protocols demonstrating the range of clinical and support services it offers to special needs populations. MCO must have referral arrangements for children with special health care needs to be referred to specialty services. Contract includes extensive requirements showing capacity to provide care to special needs populations, including specifically children with special health care needs. (10.09.64.10; 10.09.65.04; 10.09.65.05). The MCO shall demonstrate that its pediatric and adult PCP's are clinically qualified to provide or arrange for the provision of arrangements for the special needs population. (10.09.65.04)
MA-SCOP	The Contractor must provide or arrange for the delivery of scheduled and unscheduled services in the Enrollee's place of residence (2.6.F). The presence of Complex Care needs must trigger a comprehensive evaluation process. The Primary Care Team must consult with and advise acute, specialty, long term care and behavioral health providers about care plans and clinical interventions (2.4.B.2). The Contractor must maintain a Provider network sufficient to provide enrollees with specialty services (2.5.A).
MN-MS/MSHO	No information in contract.
MN-MDHO	MCO shall have a process to review request for access to out-of-network specialists, centers of excellence and experts, and approve such access if medically necessary and meets MCO's service authorization guidelines (6.1.34.C). MCO shall have guidelines to review referrals to specialists for rare and low prevalence conditions (6.1.34.E). MCO shall contract with non-profit community health clinics, community mental health centers, community health services agencies if they accept competitive rates (9.3.10-11). MCOs shall offer to contract with any essential community providers (9.3.12).
WI-SSI	No information in contract.
WI-WPP	No information in contract.

(2) Auto-Enrollment-Related Safeguards. A mandatory managed care program must have an auto-enrollment process for beneficiaries who do not select a plan. In theory, if a state has adopted sufficiently comprehensive network and service protocol requirements for treating patients with special health care needs, as well as a requirement to assess enrollee health status, any participating MCO might be able to adequately serve the enrolled population. However, it is likely that some plans are going to be better equipped to treat patients with certain diagnoses than others, or that beneficiaries are going to be able to access certain plans more readily than others because of provider locations. Accordingly, it would be desirable to have an auto-enrollment procedure that takes into account provider history, geographic location, translation needs and other factors that enhance a beneficiary’s ability to access care.

It is important to recognize that auto-enrollment can disrupt ongoing provider-patient relationships and treatment regimens (a fact that has been in evidence in the Medicare Part D auto-enrollment process in the case of dual enrollees). In order to guard against service interruption, a state might require plans to make rapid contact with auto-enrolled patients and their representatives and to provide a minimum transitional period during which treatment regimens currently in place are continued. Another safeguard would be a post-enrollment opportunity to switch plans or primary care providers. In this

review, the majority of states eschew compulsory enrollment for the selected population and thus the contract reviews provide limited examples upon which state officials can draw. In this regard, post-enrollment selection, rapid contact and transitional time periods during which pre-existing treatment regimens are continued are all options, and examples can be found in both Medicare Part D and in compulsory systems for the non-disabled population. In addition, contracts provide for immediate assessment of member needs upon enrollment.

Table 2. Auto-Enrollment	
AZ-AHCCCS	Almost all members have a choice of available contractors. If there is only one contractor in the member's geographic service area, no choice is offered as long as the contractor offers a choice of PCPs (D3). Members who do not choose a contractor are automatically assigned to one based on family continuity or the auto-assignment algorithm which favors contractors with lower capitation rates and higher performance measures. Members have 16 days to choose a different contractor after assignment. There are exceptions for members who were recently enrolled in AHCCCSA and other limited groups. (D3; D6).
MD-Health Choice	Beneficiaries have 21 days from when Dept. mails eligibility notification to select an MCO. If no selection is made, Dept. will assign beneficiaries based on availability in local access area. Dept. will assign all members of family who share a household to same MCO (10.09.63.02).
MA-SCOP	No auto enrollment because no mandatory enrollment.
MN-MS/MSHO	The MCO will accept all eligible Recipients who select the MCO for MSHO or who select or are assigned to the MCO for MSC/MS+. (3.1.2.A)
MN-MDHO	No auto-enrollment because no mandatory enrollment.
WI-SSI	All eligible are placed in an MCO and may opt-out (Art.7B1). The Dept. has the right to assign an MCO when the individual does not make a choice during the required enrollment period (Art. 7B1).
WI-WPP	No auto-enrollment because no mandatory enrollment.

Table 3. Identifying Members with Special Needs	
AZ-AHCCCS	Contractor must have a mechanism in place to identify and assess members with SHCN. The assessment must use appropriate health care professionals. The results of the assessment must be shared with other entities providing services to avoid duplication (D11).
MD-Health Choice	Dept. will attempt to administer a health assessment at time of enrollment. If not, it will administer a health assessment within 5 days of enrollment, unless beneficiary is uncooperative or unreachable. The Dept. will transmit assessment information to MCO within 5 days. Upon receipt and review, MCO will take appropriate action so enrollees with special or immediate health care needs receive them in a timely manner. If beneficiary is unreachable or uncooperative, MCO does not have an obligation to provide expedited service. (10.09.63.03) MCO must conduct one diagnostic and evaluation service annually for enrollees with HIV/AIDS (10.09.67.28).
MA-SCOP	Contractor will administer Initial and Ongoing Assessments, using an assessment tool approved by DMA, in order to identify all of the Enrollee's needs and the presence of Complex Care Needs (2.4.A.4). The Contractor must then record assessment results in a Centralized Enrollee Record and report results to the Enrollee's Provider Network in a timely manner. Assessments should be performed at least once every 6 months or for Complex Care Enrollees, once every quarter. (2.4.A.11)
MN-MS/MSHO	The MCO must have effective mechanisms that assess the quality and appropriateness of care furnished to Enrollees with special health care needs (7.1.4).
MN-MDHO	The MCO shall conduct an initial assessment of enrollee health care needs, including medical, social, environmental, and mental health factors (6.1.3.C). MCO shall develop a comprehensive care plan based on available evidence and incorporate an interdisciplinary/holistic and preventive focus, and include advance directives and enrollee participation (6.1.3.D). The MCO shall conduct a Long Term Care Consultation for each new enrollee (6.1.11). MCO shall assess enrollee needs for assistive technology (6.1.19.B).
WI-SSI	MCO must have procedures for a comprehensive assessment for each enrollee as soon as possible after receiving the enrollment report. The assessment should include, but is not limited to an evaluation of mental or physical impairments or disorders, activities of daily living,

	substance abuse, communication and cognition (Art.3E2,3).
WI-WPP	No information in contract.

(3) Involuntary Disenrollment. When a population with disabilities is enrolled on a mandatory basis, two possible involuntary disenrollment concerns arise, in addition to disenrollment because of loss of underlying eligibility: disenrollment for cause based on disruptive or uncooperative behavior; and disenrollment following institutionalization in extra-contractual institutional care (e.g., a state mental hospital).

- With respect to disenrollment for disruptive behavior, Arizona appears to have the most protective standard in its prohibition of MCO-requested disenrollment because of uncooperative or disruptive behavior resulting from special health care needs. In essence, patient abandonment, even with notice to the patient, is prohibited.
- In Minnesota’s Senior Care program, MCOs may not request disenrollment of beneficiaries for any reason. However, Minnesota’s voluntary elderly and disabled programs and Wisconsin’s SSI MC program both allow involuntary disenrollment for disruptive, uncooperative, or non-compliant behavior.
- With regard to re-enrollment after disenrollment as a result of institutionalization, Arizona, Maryland, Minnesota and Wisconsin maintain general re-enrollment requirements with the same MCO for individuals who regain eligibility within a specified period of time.

Table 4. Involuntary Disenrollment	
AZ-AHCCCS	Contractor will not disenroll member for any reason unless directed by AHCCCSA; Contractor may request disenrollment per ACOM Change of Plan Policy; Contractor may not request disenrollment due to adverse change in health status, utilization of services, diminished mental capacity, uncooperative or disruptive behavior resulting from special needs. AHCCCSA will disenroll member who loses eligibility, moves out of Contractor's service areas, changes Contractor (Health Plan) during open enrollment, if Contractor does not provide needed services due to religious or moral objections, or when a Contractor change is approved (D3).
MD-Health Choice	Dept. may disenroll from MCO if enrollee is institutionalized for 30 consecutive days in LTC facility or 30 consecutive days (60 days total in one year) in an IMD facility, admitted to ICF/MR facility, enrollee has rare and expensive case management, or enrollee loses Medicaid eligibility or become ineligible for enrollment in HealthChoice. (10.09.63.06). MCO may request disenrollment if enrollee moves out service area or is ineligible. (10.09.63.06).
MA-SCOP	A Contractor may request that an Enrollee be disenrolled only if there is a loss of MassHealth eligibility, they have remained out of the Service Area or more than six consecutive months; and if approved in advance by CMS and DMA, or when the Contractor's ability to furnish services to the Enrollee or to other Enrollees is seriously impaired (2.4.E.3)
MN-MS/MSHO	MSHO Enrollees may not be involuntarily disenrolled unless they become ineligible Medicaid, Medicare, move out of the service area, or have deemed to engage in disruptive behavior as determined by the CMS process. If the enrollee loses eligibility for both Parts A and B but remains eligible for MA, the Enrollee remains eligible for MSHO (3.4.2.; 3.4.4.). MSC/MSC+ MCOs may not request disenrollment of beneficiaries for any reason (3.4.5).
MN-MDHO	Enrollees may not be involuntarily disenrolled unless they become ineligible Medicaid, Medicare, move out of the service area, do not meet enrollment criteria, or engage in disruptive behavior (3.5.2; 3.5.4). MCOs may not request disenrollment of enrollees unless they are no longer eligible or engage in disruptive behavior. (3.5.5). An enrollee that loses Medicaid eligibility for not more than three months may be re-enrolled in same MCO without filling out

Table 4. Involuntary Disenrollment	
	a new enrollment form (3.4.8.).
WI-SSI	MCO may request an involuntary disenrollment when enrollment would be harmful to the beneficiary or when the MCO cannot provide medically necessary services for reasons beyond its control (Art.7C1). MCOs may request involuntary disenrollment for just cause - enrollee is not compliant, unable to maintain a good working relationship with providers, or unreachable for assessment and care planning within the first 60 days of enrollment despite a good faith effort by MCO. (Art.7C1b). MCO may request disenrollment if it is unable to establish and maintain contact with enrollee for an 18 month period (Art.7C1c). Enrollees will be disenrolled if they become ineligible for Medicaid, move out of the service area, participate in one of the named community programs (Art.7C2). Enrollees are involuntarily disenrolled if they are in a nursing home for 90 days or longer (Art.7C1a)
WI-WPP	MCO may request disenrollment if the member has a demonstrated history of ongoing, willful non-compliance with an essential treatment plan that results in a physical risk to the individual, the cognitively impaired member's informal support system fails to protect the member from abuse and/or neglect in the home setting, and there is a risk to the person and the family or guardian refuses an alternate living setting, the program no longer has a contract with the member's physician and the member refuses to change physicians, and the member has committed acts of physical or verbal abuse that pose a threat to MCO staff, subcontractors or other members of the MCO (Art. 7.E.1). Involuntary disenrollment requires Department's approval and may also be requested for absence from service area for more than 30 consecutive days and Contract termination or loss of HMO Licensure (Art. 7.E.2). MCO may request non-enrollment if the potential member has a primary diagnosis of mental retardation, a major mental illness in which the individual is a risk to themselves or others, and people with traumatic head injuries where cognitive and behavioral symptoms are evident (Art. 7.C.6)

(4) Enhanced Case Management. While all managed care programs include some type of care coordination requirement, states with managed care experience mandate that extensive care coordination occur. State officials with enhanced case management programs stressed the value of intensive and personalized services for both the patient and the state. Superior case management allows beneficiaries to obtain needed care more quickly and efficiently, helping to improve their health outcomes. In addition, the state benefits from having care provided in the most efficient and cost-effective manner to deal with current problems and help stave off more expensive conditions down the line. Minnesota and Maryland provide for the assignment of a care manager/case coordinator to each enrollee, who is responsible for creating and implementing a care plan and coordinating with local resources. The Minnesota official noted that it would have been very difficult to fund their enhanced case management program if they had not integrated Medicaid and Medicare. Wisconsin's Partnership Program reports an average 12 diagnoses and 13 medications per person, and the state thus considered high quality care coordination to be essential. Similar requirements are found in Massachusetts.

Table 5. Enhanced Case Management	
AZ-AHCCCS	No information in contract.
MD-Health Choice	MCO must have, document, and update annual a comprehensive care plan for enrollees with special needs that includes coordinated and continuous case management. MCO must have the capacity to conduct home visits as part of case management, that case managers are assigned upon enrollment when necessary. MCO must be familiar with community based resources for special needs population and collaborate with inpatient facilities and home and community based resources. MCO must designate a special needs coordinator as a contact point for enrollees with special needs. This coordinator must have experience with special needs populations. (10.09.65.04). Additional care coordination requirements in place specifically for children with special health care needs (10.09.65.05), individuals with developmental disabilities (10.09.65.07), individuals with HIV/AIDS (10.09.65.10.09.67.22). MCO must have case management services targeted to enrollees with rare and expensive conditions. (10.09.69).

Table 5. Enhanced Case Management	
MA-SCOP	The Contractor must contract with at least one Aging Service Access Point to coordinate all the Geriatric Support Services Coordinator (GSSC) work in the Contractor's Service Area. The GSSC is responsible for arranging, coordinating and authorizing the provision of appropriate community long-term care and social support services and authorizing a range and amount of community based services (2.4.A.5). The Contractor must ensure effective linkages of clinical and management information systems among all providers in the Provider Network including clinical subcontractors. The integrated and coordinated services include (not limited to) Individualized Plan of Care, written protocols for referrals, in or out of network second options, management of medications, specialty service provisions, the tracking and coordination of Enrollee transfers and the obtaining and sharing of individual medical and care planning between caregivers (2.4.A.6).
MN-MS/MSHO	The MCO must provide Care Coordination services that are designed to ensure access to and to integrate the delivery of preventive, primary, acute, post acute, rehabilitation and long-term care services including state plan Home Care Services and Elderly Waiver Services (6.1.3). MSHO The Care Coordination system should provide each enrollee with a primary contact person who will assist the enrollee in simplifying access to services and information. The system must incorporate the following elements for all enrollees: Comprehensive Assessment (includes ADLs), Comprehensive Care Plan Development (including: Interdisciplinary/Holistic Focus, Preventative Focus, Advance Directive Planning, Enrollee Participation), Care Plan Implementation, Care Plan Evaluation (for nursing home enrollees) and Care Coordinator Caseload Ratios. (6.1.3.A) MSHO and MSC/MS+ The MCO shall provide: rehabilitative services for MSHO only, range of choices in Elderly Waiver and Nursing Facility Services, Coordination with Social Service Needs, Coordination with VA, Specialist Referral, and identify Special Needs. (6.1.3.C; 6.1.4)
MN-MDHO	MCO must coordinate care for enrollees and designate a care coordinator with lead responsibility for creating and implementing the care plan (6.1.3; 6.1.3.K). The care should be coordinated with Local Agencies and other community resources (6.1.3.K).
WI-SSI	MCO will provide care coordination and case management (Art.3E). MCO must conduct patient status and plan reviews at least annually (Art.3E5). MCO will develop a working relationship with community mental health and substance abuse providers (Add. II 9).
WI-WPP	MVO shall provide services through a comprehensive, interdisciplinary health and social services delivery system which integrates acute and long-term services pursuant to regulations and Partnership protocol (Art. 4B). MCO shall develop a working relationship with community agencies which are involved in the provision of non-medical services to enrollees. (Add. 2)

(5) Direct Access to Specialists. As noted, persons with disabilities who are enrolled in managed care plans experience multiple diagnoses and complex care management needs. State contracts provide for direct access to specialists, standing specialty referral provisions, and the use of specialists to manage primary care.

Table 6. Direct Access to Specialists	
AZ-AHCCCS	Members with SHCN who need a specialized course of treatment or regular care monitoring must have direct access to specialists (D11).
MD-Health Choice	PCP may also be a specialist. (10.09.65.04; 10.09.66.05)
MA-SCOP	No information in contract.
MN-MS/MSHO	If the enrollee assessment determines the need for a course of treatment or regular care monitoring the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs (7.1.4.C).
MN-MDHO	MCO shall establish guidelines allowing an enrollee to request standing referral to a specialist (6.1.34.B).
WI-SSI	No information in contract.
WI-WPP	No information in contract.

Special Needs Services. State contracts provide for special member support services to help enrollees avoid problems in the receipt of care or to ensure rapid access to resolution of questions regarding coverage and payment for services. Maryland's and Minnesota's contract documents provide for extensive coverage of patient support

services and require MCOs to provide items such as assistive technology, incontinency pants or pads, substance abuse services, and HIV/AIDS treatment. Massachusetts’ contract includes a category of services for “Complex Care Needs.”

Table 7. Special Needs Services	
AZ-AHCCCS	The Contractor shall provide audiology services to members under the age of 21 including the identification and evaluation of hearing loss and rehabilitation of the hearing loss through medical or surgical means (i.e. hearing aids). Only the identification and evaluation of hearing loss are covered for members 21 years of age and older unless the hearing loss is due to an accident or injury-related emergent condition (D.10).
MD-Health Choice	Requirements regarding services that must be available for enrollees with special health care needs such as DME, assistive technology coordination, with EPSDT for children with special needs, incontinency pants and disposable underpads (10.09.65.05, .06; 10.09.67.13). MCO will have specialists for individuals with HIV/AIDS (10.09.65.10), and individuals needing substance abuse treatment (10.09.65.11).
MA-SCOP	The Contractor must establish qualifications for a Geriatric Support Services Coordinator (GSSC). The GSSC must determine the appropriateness of institutional long-term care services, developing community-based care plans and with the agreement of the Primary Care Team, authorize social support services (including ADLs, IADLs, housing, home-delivered meals, and transportation). (2.4.A.5) The Contractor must provide appropriate services as listed for those identified with Complex Care needs (2.4.B.1-2). Physical and telephone access must be available for individuals with disabilities, and access to home and community based services must exist (2.6.E). Physical and telephone access to services must be made available for individuals with disabilities. The Contractor must reasonably accommodate persons with disabilities and ensure that physical and communication barriers do not inhibit individuals with disabilities for obtaining services from the Contractor (2.6.E). The Contractor must demonstrate the capacity to deliver or arrange for the delivery of scheduled and unscheduled services in the Enrollee's place of residence when office visits are unsafe or inappropriate for the Enrollee's clinical status (2.6.F).
MN-MSC/MSHO	The MCO shall have the capacity to implement and coordinate with when indicated, other Care Management and risk assessment functions conducted by appropriate professionals, including Long-Term Care Consultation and other screenings to identify special needs such as common geriatric medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long-term care risks due to lack of social supports, mental and or chemical dependency problems, mental retardation, high risk health conditions, and language or comprehension barriers (6.1.3.C.7). The MCO must offer appropriate services for the following special needs groups: seriously and persistently mentally ill, physically handicapped and chronically ill elderly, abused adults, abusive individuals, enrollees with language barriers, cultural and racial minorities, enrollees in need of gender specific mental health and/or chemical dependency, lesbians, gay men, bisexual and transgender persons, and the hearing impaired (6.13.1-8).
MN-MDHO	Home and Community Based waiver services, including but not limited to assisted living, consumer directed community support services, home health, homemaker, independent living skills, home modifications and adaptations, personal care assistance (6.1.12). Additional TBI waiver services including but not limited to behavioral programming, cognitive therapy, mental health, transportation. (6.1.12). Assistive technology to enable independent living (6.1.19). Medical transportation services (6.1.22). Medically necessary services that would otherwise be covered under the contract but are in the child's IEP or IFSP and provided by the school district are excluded from this contract (6.8.9). MCOs must provide appropriate services to visually impaired and hearing impaired (6.15).
WI-SSI	Handbook information is available through TDD/TYY services (Add. IV). MCO covers transportation for individuals in wheelchairs. (Add. IV).
WI-WPP	No contract information available.

(6) Patient Safeguards. State contracts provide for various additional safeguards such as prohibition against enrollment discrimination based on health status or need for services, employee training to improve communication with patients with developmental

disabilities, and providing all information in a manner and format that accommodates patient needs.

Table 8. Patient Safeguards	
AZ-AHCCCS	With the goal of mainstreaming members, the Contractor will take affirmative action to provide services without regard to genetic information or physical or mental handicap, except where medically indicated. A Contractor will be in default of its contract if it knowingly executes a subcontract with the intent of allowing or permitting the subcontractor to implement barriers to care. If a Contractor identifies a problem involving discrimination by one of its providers, the Contractor must intervene and implement a corrective action plan, or otherwise be in default of the contract (D8).
MD-Health Choice	MCO may not discriminate on the basis of health status or need for health services, including presence of a physical or mental handicap. (10.09.65.02). MCO will provide training for its employees about special communication requirements for individuals with developmental disabilities. (10.09.65.07). MCO will provide access to services in compliance with ADA (10.09.66.01).
MA-SCOP	For Enrollee's for whom written materials are not suitable, non-written orientation information in the form of video, phone, home visit or group presentations will be provided. (2.3.D) Upon enrollment, the Contractor must conduct initial and ongoing assessments to identify Enrollee needs and the presence of Complex Care Needs. (2.4.A.4)
MN-MS/MSHO	MCO will accept all eligible recipients who select or are assigned to it regardless of physical or mental health condition, health status, or need for health services (3.1.2. A). All communications with the enrollee must comply with the ADA and have information available in alternative formats and in a manner that takes into consideration the enrollee's special needs (3.2.2). All written information must include a notice that the information is available to persons with disabilities in other forms, such as voice, TDD, and other services (3.2.2. C).
MN-MDHO	MCO will accept all eligible recipients who select it regardless of physical or mental health condition, health status, or need for health services (3.2.2. A). All communications with the enrollee must comply with the ADA and have information available in alternative formats and in a manner that takes into consideration the enrollee's special needs (3.3.2). All written information must include a notice that the information is available to persons with disabilities in other forms, such as voice, TDD and other services (3.3.2.C).
WI-SSI	MCO may not discriminate on the basis of health status or need for health services, including an enrollee with diminished mental capacity who is disruptive and uncooperative as a result of the enrollee's special needs (Art.7F). MCO must have a system in place that utilizes opportunities for SSI-Medicaid enrollees in Milwaukee public schools (Art.3Z4).
WI-WPP	The MCO does not discriminate in enrollment and disenrollment activities between individuals on the basis of current medical condition (except mental illness) (Art. 7A2).

(7) Performance measurement and provision of information. In conducting this phase of the analysis, we examined two additional contracts targeting populations with disabilities:

- Arizona’s Long Term Care contract (Arizona LTC). The Arizona Long Term Care System is a program under AHCCCSA that delivers long-term, acute, behavioral health care and case management services to eligible members.
- Wisconsin’s Wraparound Milwaukee (Wisconsin Wraparound) managed care program which was created to provide mental health services to severely and emotionally disturbed children who are covered under Medicaid or BadgerCare (the state’s supplemental insurance program for low-income children ineligible for Medicaid).

Our review of contract specifications sought answers to the following questions:

- Do contracts specify an approach to the measurement of quality or quality performance standards?
- Do the contracts specify performance measurement with respect to certain patient safeguards such as involuntary disenrollment, patient selection of providers, or specialty care access?
- Do contracts require medical errors reporting?
- Do contracts specify patient satisfaction/health care experience studies?
- Do states collect grievance and appeals data?

Performance reviews. Our review found very limited contractual specifications regarding performance reviews. In other words, the standards and procedures to be used to measure contractor performance with contractual specifications or performance measures were not themselves contractual, although self-assessment was required in several places. In general, these specifications called for contractor self-review and maintenance of continuous improvement activities.

Table 9. General Quality Management	
MD-HealthChoice	MCOs must have a continuous, systematic program designed to monitor, measure, evaluate, and improve the quality of health care services delivered to enrollees including individuals with special health care needs. (COMAR 10.09.65.03)
MA-SCOP	Contractors must assess the quality and appropriateness of care furnished to Enrollees with special health care needs. (2.10.A-C)
MN-MDHO	MCOs must annually conduct at least one quality of care study that examines clinical or support services issues pertinent to people with physical disabilities. (7.2)

Disenrollment data. Massachusetts specifically requires MCOs to track disenrollment data in relation to disenrollments based on health care quality or provider lack of availability.

Provider network data. Arizona and Massachusetts specify that enrollees must have access to information about providers’ areas of expertise, including treatment of enrollees with disabilities; Massachusetts requires submission of such data as part of its quality of care requirements.

Table 10. Provider Network	
MA-SCOP	The Contractor shall develop, maintain and update the following additional data regarding Providers, including but not limited to, PCPs and BH Providers, and make available to Enrollees, CMS and DMA information regarding providers with areas of special experience, skills and training. (2.5.D)
AZ – LTC	The MCO’s plan, at a minimum, shall include a description of network design by GSA for the general population, including details regarding special populations. (Amendment to YH04-0001, page 45-46, October 1, 2005)

Data on enrollee treatment and management. The availability of electronic health records can significantly improve the quality and timeliness of information, as well as its availability to patients, providers and the state. Massachusetts and Minnesota specify data access requirements that provide for expanded access to health information. The Massachusetts contract specifies that MCOs must identify and report special needs population data to the state and must make such data available to all network providers. The system also plays a role in ensuring that enrollees receive timely access to care. Wisconsin also provides for the reporting of data on SSI-related enrollees to the state.

Table 11. Care Management	
MA-SCOP	The Centralized Enrollee Record must be available and accessible to specialty, long-term care, and mental health and substance abuse providers. (MassHealth Senior Care Options Program, page 12-19, 2003)
MN-MDHO	Upon notification from the State, the MCO must enter all required screening documents into MMIS for the purpose of determining rate cell and payment. (3.2.2 and
WI-Wraparound	The MCO shall submit a monthly detailed report of assessments to the Department. (Art. 3E.3)

Medical error reporting. Minnesota’s contract provides for the voluntary reporting of medical errors and specifies that MCOs must “encourage” its providers to “develop and implement patient safety policies to systematically reduce medical errors.”¹¹

Patient surveys. All states require MCOs to have consumer satisfaction surveys or another type of patient feedback mechanism as part of their quality of care assessment. However, they do not appear to use a standard approach to surveying patient experiences.

- Massachusetts specifies the use of the Consumer Assessment of Health Plans Survey (CAHPS), although the instrument is not specifically designed to assess an adequate sample of dual enrollees.
- Maryland requires MCOs to use the Health Care Quality Improvement System Standards.
- Minnesota refers to use of Program of All-Inclusive Care for the Elderly (PACE) surveys, which is designed specifically for evaluation of care for the frail elderly.

Table 12. Patient surveys	
MD-HealthChoice	MCOs must conduct an annual enrollee satisfaction survey using the latest version of the Consumer Assessment of Health Plans Survey (CAHPS) conducted by NCQA certified CAHPS vendor. (COMAR 10.09.65.03)
MA-SCOP	The Contractor must administer an annual survey to all enrollees and report the results to CMS and DMA. One survey must be conducted with each of the following groups: non-English speaking members, persons with physical disabilities, minority enrollees and family members of enrollees (2.10.F).

¹¹2005 MDHO Model Contract, page 50, 12/16/04.

Table 12. Patient surveys	
MN-MDHO	The MCO shall include enrollees in an annual satisfaction survey and it must provide the state with a copy of the survey results. Results must also be reported to the enrollees (7.4). In order to determine the ‘frailty factor of the risk portion of the Medicare rate’ the MCO will conduct community health surveys in a manner to be determined by CMS and the State (4.2.1).

*Performance standards.*¹² The states surveyed use HEDIS® or QA/PI performance standards, although only in the case of Maryland and Massachusetts does submission of HEDIS data appear to be a contractual specification. See **Appendix B** for a complete list of the Massachusetts SCOP reporting requirements.

Table 13. Performance Standards	
MD-HealthChoice	The MCO must annually collect, validate, and evaluate the latest approved version of the Health Employer Data and Information Set (HEDIS), including performance measures targeting ambulatory care for SSI adults and children. (COMAR 10.09.65.03)
MA-SCOP	The Contractor must report clinical indicator data including certain HEDIS 3.0 reporting set measures that are appropriate for the enrolled the population. (MassHealth Senior Care Options Program, page 64-73, 2003)

Encounter data. Contractual documents maintained by Massachusetts, Maryland and Minnesota appear to require the collection and reporting of specific data elements.

Table 14. Encounter Data	
MD-HealthChoice	An MCO shall submit encounter data monthly, reflecting 100 percent of provider-enrollee encounters, in HCFA 1500 and UB92 format or an alternative format previously approved by the Department. (COMAR 10.09.65.15)
MA-SCOP	The Contractor must report clinical indicator data including certain HEDIS 3.0 reporting set measures that are appropriate for the enrolled population, including Institutional Utilization Data, Community Health Service Utilization, Enrollees Medically Eligible for Nursing Facility Services, Behavioral Health Utilization Data, Functional Data and Mortality Data. (MassHealth Senior Care Options Program, page 64-73, 2003)
MN-MSHO	INDEX OF MSHO VALUE EQUATION MEASURES, December 2003 include: Clinical Measures, Utilization Measures. Satisfaction Measure, Quality of Life Measures, Nursing Home Only Measures...” (Correspondence from Minnesota Senior Health Options and the Minnesota Department of Human Services consensus measures, December 15, 2003)
MN-MDHO	The MCO shall provide the following information: individual enrollee specific, claim-level encounter data for services provided by the MCO to MDHO Enrollees detailing all medical and dental diagnostic and treatment encounters, supplies and medical equipment dispensed to Enrollees, Nursing Facility services, Home Care Services and Home Community-Based services for which the MCO is financially responsible.” (3.6.1)

Grievances and appeals. State contracts tend to address issues related to expedited appeals, and the continuation of coverage during an appeal involving a

¹² Persons interested in this subject may wish to examine an excellent report, *Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions*. Prepared by the Center for Health Care Strategies and the Lewin Group for the California HealthCare Foundation (November, 2005). Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=323343. (Accessed June 19, 2006).

reduction or termination of a Medicaid benefit. This latter provision is a direct result of federal requirements applicable to Medicaid managed care enrollees, which in turn is based on Constitutional requirements related to the termination or reduction of covered benefits and services for individual enrollees.¹³ The contracts provide for continuation of benefits for the duration of an appeal as long as appropriate procedures are followed, including a request for continuation of services by an enrollee. In addition, Minnesota and Wisconsin Medicaid officials stressed during the interview process the role of an Ombudsman as a figure that is able to reduce the need for appeals by intervening in a problem before it reaches a critical stage.

Table 15 provides reviews the contract language from Minnesota’s MSC/MSHO contract to illustrate typical grievance and appeals requirements. Arizona’s LTC contract is the only one that requires plans to identify trends and correction action plans.

Table 15. Grievance and Appeals – MN MSC/MSHO	
Appeals Overview	The MCO must have a Grievance system in place that includes a Grievance process, an Appeal process and access to the State Fair Hearing system (8.1.1).
Expedited Appeal	The MCO must resolve and provide written notice of resolution for both oral and written Appeals as expeditiously as the Enrollee's health condition required, but no later than 72 hours after receipt of appeal (8.4.3.A).
Grievance Information	Within 15 days of the availability of readable enrollment data from the State, the MCO shall present information about the Grievance System to all enrollees (3.2.6.B.7).
Cultural/LEP Competency	In order to avoid discrimination against LEP persons, the MCO must take adequate steps to provide the language assistance necessary, free of charge. The MCO shall comply with the OCR recommendations (3.2.1). The MCO must provide the Potential Enrollee or Enrollee information in his/her primary language either through oral interpretation or other means (3.2.3 A).
Grievance Reports	The MCO must submit to the State a quarterly DTR compilation report (8.2.4). The MCO shall send a quarterly electronic report of all written Grievances and oral and written Appeals in a format determined by the State, due on or before the 15th day of the month following the end of the quarter for all written Grievances and all oral and written Appeals resolved in the previous quarter (8.6.1).
Benefit Continuation	Benefits will continue until a decision is reached if an Enrollee files an Appeal with the MCO before the date of the Action proposed on a DTR, the appeal involves the termination, suspension or reduction of service, the services were ordered by an authorized provider, and the enrollee requests continuation of the services. The MCO may not reduce or remove the service until 10 days after a written decision is issued in response to the Appeal (8.2.3).
Denial Information	DTR must be written, understandable at a 7 th grade reading level, comply with the ADA, be approved by the State, maintain confidentiality for Family Planning Services and sent solely by the MCO unless previously approved by the State. (8.2.1.A) Notice must state the type of service, reason for DTR, a description of Enrollee rights, the intended Action of the MCO and the regulations that allow such Action. Enrollee must be notified of the right to file an Appeal, request a Fair Hearing Trial and the continuation of benefits. The DTR must include the right to an expert medical opinion at the State’s expense, in times of medical necessity, for review during the State Fair Hearing. DTR must provide a language block in the languages specified by MN Statutes and must include a phone number where a translation of the DTR may be obtained in Spanish, Hmong, Laotian, Russian, Somali, Vietnamese or Cambodian. (8.2.1.B)

¹³ See 42 C.F.R. §438.1 et. seq; In *Goldberg v Kelly* 397 U.S. 254 (1970), the United State Supreme Court held that the “brutal need” experienced by recipients of need-based public assistance created so great a property interest in the continued receipt of assistance that Constitutional due process considerations prohibited the termination or reduction of benefits without timely, adequate, and advance notice and the opportunity for a pre-termination factual hearing.

Part 4. The Deficit Reduction Act of 2005 (DRA): Implications for Managed Care Systems for Persons with Disabilities and Chronic Conditions

The DRA contains more than \$28 billion in federal Medicaid spending reductions. Although a complete review of the Act is beyond the scope of this analysis, several provisions are of particular relevance when considering managed care system reform for persons with disabilities. In general, the Act contains a series of changes specifically aimed at broadening state options in the area of long-term care. At the same time however, the DRA makes a number of changes in benefits and cost-sharing as well as in the availability of federal financial participation for case management services.

At this point it is unclear how the DRA will affect the development of managed care systems for persons with disabilities, or the extent to which federal funding for case management services will continue to be available for certain types of managed care arrangements involving contracts with public entities. The ambiguity of these changes suggests that states should proceed with caution in the development of managed care systems that are predicated on the continued availability of federal funding for extensive case management services for persons enrolled in publicly operated managed care entities. How the DRA will affect CMS' approach to approving federal contributions toward case management services in the case of states operating under §1115 demonstration authority is not known at this point.

A. Changes in Benefit and Managed Care Design

The DRA creates a new state option with respect to the coverage rules that have governed Medicaid for four decades. Under this option, states may revise the definition of "medical assistance" previously required for categorically needy persons¹⁴ and substitute "enrollment in coverage" that provides "benchmark coverage" or "benchmark equivalent coverage."¹⁵ The terms "benchmark" and "benchmark equivalent" coverage are defined in a manner identical to the definitions used under the State Children's Health Insurance Plan (SCHIP).¹⁶ Benchmark or benchmark equivalent coverage can be substituted on a mandatory basis for certain categorically persons including low-income children and their parents. Children under 19 who are enrolled in benchmark coverage must continue to receive all services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, whether covered as part of benchmark enrollment or otherwise (e.g., on a "wraparound" basis). States may supplement benchmark coverage for adults at their option. Individuals enrolled in benchmark coverage must continue to have access to federally qualified health center and rural

¹⁴ §1937(a) as added by §6044 of Pub. L. 109-362. For a complete description of categorically needy persons, who comprise the vast majority of program beneficiaries of all ages and regardless of health status, see Andy Schneider et. al, *The Medicaid Resource Book* (Kaiser Commission on Medicaid and the Uninsured, Washington D.C. 2003)

¹⁵ SSA §1937(a)

¹⁶ SSA §1937(b)

health clinic services, and these clinics must continue to be paid in accordance with a federally required rate methodology.¹⁷

As **Figure A** illustrates, benchmark coverage is more limited than the federal definition of medical assistance that previously governed coverage of categorically needy persons.

Figure A. Benchmark Coverage Under the DRA

<p><u>BENCHMARKS</u></p> <ul style="list-style-type: none">• Federal employee health benefits plan• State employee plan• Largest selling federally qualified HMO <p><u>BENCHMARK EQUIVALENCY</u></p> <p><i>REQUIRED (FULL ACTUARIAL VALUE TO A BENCHMARK)</i></p> <ul style="list-style-type: none">• Inpatient and outpatient hospital services• Physician surgical and medical services• Laboratory and X-ray services• Well-baby and well-child care, including age appropriate immunizations• Other appropriate preventive services, as designated by the secretary <p><i>OPTIONAL (75% OF ACTUARIAL VALUE)</i></p> <ul style="list-style-type: none">• Prescription drugs• Mental health services• Vision services• Hearing services
--

A State Medicaid Director Letter issued by CMS on March 31 2006¹⁸ clarifies that states may offer voluntary enrollment in benchmark coverage to other categorically needy groups, for whom benchmark coverage cannot be substituted on a required basis. The SMD letter appears to make two points clear:

- *First*, CMS will permit the *voluntary enrollment* into benchmark coverage of categorically needy persons other than low-income children and adults and furthermore, that the agency will permit the use of voluntary opt-out systems similar to those used in Wisconsin, as noted above. Most children and adults with disabilities, regardless of age, receive Medicaid as categorically needy persons. Thus, CMS appears willing to permit the enrollment into alternative benchmark plans of all Medicaid beneficiaries, as long as voluntary opt out safeguards are in place for protected classes.

¹⁷ Sara Rosenbaum and Peter Shin, *Health Centers: Opportunities and Challenges in Reauthorization* (Kaiser Commission on Medicaid and the Uninsured, March, 2006). Available at www.kff.org/pubs.

¹⁸ Available at <http://www.cms.hhs.gov/smdl/downloads/SMD06008.pdf> (Accessed April 15, 2006)

- *Second*, it also appears that CMS may be prepared to treat the concept of “enrollment in” . . . “benchmark coverage” *not only* as an option for states to use as an alternative definition of “medical assistance,” but as authorizing the use of entities known as “benchmark plans.” It is unclear at this point whether standards applicable to Medicaid-participating managed care arrangements under §1932 of the Social Security Act would continue to apply to these alternative plans. Indeed, the letter notes that the benchmark provision of law allows states to supercede “certain other traditional Medicaid requirements” and the State Plan Preprint that accompanies the letter makes no mention of §1932 compliance with respect to benchmark enrollment.¹⁹

In sum, §1937 as added by the DRA may permit states to utilize contractual service arrangements that cover all persons with disabilities so long as such individuals are permitted to opt out of such arrangements and return to “traditional” Medicaid coverage. States may but are not required to supplement coverage for benchmark enrollees. The extent of state response to this new flexibility is unclear at this point; although both West Virginia and Kentucky have elected to reconfigure benefit design under the new state flexibility authority, other states appear to be moving more slowly.²⁰ Indeed, in a managed care context, states that have used flexibility to create systems of care for persons with disabilities have tended to emphasize more, not less, coverage and greater service integration.

B. Changes in Beneficiary Cost-Sharing and Premiums

The DRA also permits states to make greater use of premiums and cost sharing,²¹ with only limited exceptions for high health care users. These changes permit the imposition of higher copayments and the use of coinsurance, and application of emergency department “diversionary” copayments²² in the case of near-poor beneficiaries with family incomes between the federal poverty level and 150 percent of the federal poverty level. In the case of beneficiaries with family incomes in excess of 150 percent of the federal poverty level, states may combine these charges with premiums. The DRA is silent on treatment of persons with family incomes below 100 percent of the federal poverty level. While the amendments contain certain exemptions, state flexibility is considerable, and in addition, the Act permits “provider enforceability” generally, that is, the denial of treatment to individuals unable to pay required copayments and coinsurance.²³

¹⁹ The Preprint can be found at

<http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS061241>. (Accessed April 15, 2006)

²⁰ For an analysis of the West Virginia and Kentucky reforms see, Judith Solomon, West Virginia’s State Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries’ Health (Center on Budget and Policy Priorities, Washington D.C., May 31, 2006). Available at <http://www.cbpp.org/5-31-06health.htm>.

²¹ §1916A as added by §6041 of the DRA.

²² §1916A as added by §6043 of the DRA

²³ For a detailed overview of the cost sharing provisions of the DRA, see *Deficit Reduction Act of 2005: Implications for Medicaid* (Kaiser Commission on Medicaid and the Uninsured, Washington D.C.) Available at <http://www.kff.org/medicaid/reconciliation.cfm> (Accessed April 15, 2006)

Premium and cost sharing exemptions under the DRA reach preventive pediatric care, services for pregnant women, and services for residents of long-term care institutions and hospice recipients. No exemption exists for persons with serious disabilities receiving services in community settings, although states have the flexibility to create such exemptions in either fee-for-service or managed care arrangements. Thus, for example, a state could apply significant cost sharing rules to Medicaid beneficiaries with disabilities who remain in fee for service coverage arrangements while exempting beneficiaries who enroll in managed care systems. How states use cost sharing flexibility to incentivize certain types of service utilization among Medicaid enrollees is not yet known.

C. Changes in Federal Funding for Targeted Case Management

From the vantage point of expanded managed care for persons with disabilities, one of the more significant changes under the DRA may be provisions related to federal Medicaid coverage of and payment for case management services. Every state interviewed in this study stressed the importance of case management. In many states, specialized health care service delivery systems financed with public grant funds (e.g., county-operated mental health systems, school-based health services for children with education-related disabilities) may be active managed care participants, furnishing case management along with other covered medical and health care services.

Table B, set forth below, summarizes the changes in targeted case management made by the DRA.²⁴ As of mid-June 2006, CMS had not issued comprehensive implementation guidelines, but it is important to note that the amendments appear to make broad changes in federal Medicaid funding for targeted case management services when these services are furnished by providers that also participate in other publicly funded programs. The DRA achieves this change by effectively re-defining the meaning of *third party liability* to extend “first-dollar-payer” payment obligations to other public programs that also recognize case management as an allowable activity. The only public programs exempted from this broadened scope of “third party liability” appear to be the Ryan White Care Act and the Indian Health Service. How this shift affects efforts to integrate Medicaid financing into publicly operated health care systems serving individuals with extensive health care needs is unclear. Also unclear is the extent to which other public programs will be treated as a source of third party liability if their recognition of case management costs is only in the context of public program *administration* rather than as an allowable medical care cost. A recent decision by the United States Supreme Court clarifies that Medicaid third party liability law is intended to reach third parties liable for the cost of *medical care*; as a result, it is unclear how the amendments would treat payments made in furtherance of program administration in the case of separate and distinct public programs operated by school systems, mental health or substance abuse agencies or public hospital authorities.²⁵ Because case management and public program involvement both are integral to the growth of managed care for

²⁴ Table prepared for the Commonwealth Fund as part of an analysis by Sara Rosenbaum and Anne Markus of the DRA and its implications for child development services.

²⁵ *Arkansas Department of Health and Human Services v Ahlborn* 126 S. Ct. 1752 (2006)

children and adults with disabilities, how CMS resolves this issue may have a significant impact on the advancement of managed care for persons with disabilities. Table B summarizes the case management changes made under the DRA.

Table B. Targeted Case Management

PRE-DRA	DEFICIT REDUCTION ACT (§6052)
Case management defined	
<p>Medical assistance case management (targeted case management). Medical assistance case management: services that assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services (42 U.S.C. §1396n(g) (2)). All federal requirements applicable to medical assistance access, coverage, claims and payment would apply.</p> <p>Case management billed as an administrative service. Federal policy recognizes that case management also can be billed as an administrative service under certain situations related to EPSDT program administration, utilization review, and preadmission screening for inpatient care. Separate FFP rates and claims payment and billing procedures apply.</p>	<p>DRA impact. The DRA revises the definition of targeted case management to include specific enumerated activities that will be considered related to “assisting individuals” in gaining access to needed medical, educational, social, educational, and other services.” The more particularized definition applies to case management services furnished to all populations.</p> <p>DRA impact. The expanded definition of case management appears to incorporate services and activities that previously might have been treated as an administrative expenditure. The expanded definition of what will be recognized as allowable case management costs encompasses:</p> <ul style="list-style-type: none"> • assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social or other services. Such assessment activities include the following: taking client history; identifying the needs of the individual and completing related documentation; • gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual. • development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual’s authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual. • referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers, or other programs and

PRE-DRA	DEFICIT REDUCTION ACT (§6052)
	<p>services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.</p> <ul style="list-style-type: none"> • monitoring and follow-up activities including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as whether services are being furnished in accordance with an individual’s care plan; whether the services in the care plan are adequate; whether there are changes in the needs or status of the eligible individual and if so, making necessary adjustments in the care plan and service arrangements with providers. <p>Specifically excludes from the definition: “the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including with respect to the direct delivery of foster care services, services such as (but not limited to) the following: (I) research gathering and completion of documentation required by the foster care program. (II) assessing adoption placements. (III) recruiting or interviewing potential foster care parents. (IV) serving legal papers. (V) home investigations. (VI) administering foster care subsidies. (VII) making placement arrangements.</p> <p>Clarifies that case management services need not comply with comparability or statewide-ness requirements.</p>
Types of Case Management and Conditions for FFP	
<p>Payment and federal financial participation. Medical assistance case management services (FFP at the state medical assistance rate) may be targeted to particular subgroups. Medical assistance case management services require provider compliance with claims payment procedures. (SMM §4302)</p> <p>Case management also may be furnished as an integral part of another billable service, in which case it is not separately reimbursable (SMM §4302)</p> <p>Case management may be furnished as an administrative service (paid at the federal</p>	<p>CRA impact. Unclear whether prior differentiation between medical assistance and administrative services continues to apply in terms of both FFP and payment procedures to which states must adhere in order to qualify for FFP. In the case of case management services that are reimbursable under another federally funded program as third party liability, state cost allocation systems must adhere to OMB Circular 87 or successor circulars</p>

PRE-DRA	DEFICIT REDUCTION ACT (§6052)
<p>matching rate for administrative services). Case management services must be directly related to state plan administration. When case management is furnished as an administrative service, federal requirements regarding administration costs must be followed (use of time studies, allocation of costs among programs, related to administration of state Medicaid plan). (SMM §4302)</p> <p>Case management may be furnished as an integral part of EPSDT medical assistance services or as an EPSDT administrative service.</p>	
<p>Third party liability recovery for case management services</p>	
<p>General third party liability recovery principles apply to “care and services available under the plan” 42 U.S.C. §1396a(a)(25)(A). Where [third party] legal liability is found to exist, states must make recovery efforts “after medical assistance has been made available” 42 U.S.C. §1396a(a)(25)(B). States must have in place subrogation laws that apply “to the extent that payment has been made under the state plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance.” 42 U.S.C. §1396a(a)(25)(H).</p>	<p>Specifies that “in accordance with 42 U.S.C. §1396a(a)(25), federal financial participation only is available under this title for case management services or targeted case management services if there are no other third parties liable to pay for such services, <i>including as reimbursement under a medical, social, educational, or other program.</i>”</p> <p>Exempts activities carried out under the Indian Health Service and the Ryan White Care Act from the meaning of federal programs.</p>

Source: GW Analysis of the Deficit Reduction Act of 2005

D. Changes in Long Term Care Coverage Flexibility

The DRA permits states to pursue new flexibility where long-term care services are concerned, offering home and community services without regard to whether or not they are required as a substitute for institutional care. In its *Road Map to Long Term Care Reform* under the DRA,²⁶ the United States Department of Health and Human Services identifies certain coverage expansion options for children with serious disabilities in moderate income working families, new state flexibility to cover patient self-directed personal care without a waiver, and state flexibility to offer home and community care services to individuals who experience serious functional limitations but are not at risk for institutional care. This ability on the part of states to extend community services to persons with serious and chronic conditions but not yet on the verge of institutional care represents a potentially important advance both generally and in particular in the context of developing managed care systems. States that have moved ahead with managed care for persons with disabilities emphasize the importance of using managed care systems as

²⁶ Available at <http://www.cms.hhs.gov/smdl/downloads/Rvltcneeds.pdf> (Accessed April 15, 2006)

an integrated service strategy for maintaining individuals in the community, and this new option appears to be an important addition to the armament of strategies for improving services for populations with heightened health needs.

Conclusion

The evidence presented here points to several important conclusions. First, each of the areas discussed in our prior report were areas of concern for other states as they moved disabled beneficiaries into managed care programs. While the prior report concluded that California's legal framework inadequately addressed many of the concerns mentioned above, this report provides examples, where available, of how other states have addressed each issue. However, despite the high level of interest in compulsory managed care for beneficiaries whose Medicaid eligibility is linked to disability, the total level of multistate experience on which to draw on is actually limited. We encountered considerable challenges in locating state Medicaid purchasers with relevant experience. Indeed, we had to expand our review to several voluntary enrollment systems in order to find sufficient examples on which to draw. The very voluntary nature of these sites raises questions of relevance, since by definition, compulsory systems have a potential impact quite distinct from other arrangements and raise issues that are unique to compulsory environments.

The Wisconsin "opt out" system offers an interesting example of an attempt to straddle the two concepts, and it may be that this approach is worth pursuing. Notably, the voluntary disenrollment rate remains at 10 percent, a not-inconsiderable number. Furthermore, the incentives to participating plans created by a voluntary environment may be considerably different; it is unclear for example, if the voluntary leavers in the opt-out system were in fact the very highest cost patients. The lack of widespread compulsory managed care for beneficiaries with disabilities is notable in our opinion, given the extent to which managed care has become a norm for non-disabled populations. We believe that this low rate of managed care systems use suggests the sheer complexity of the undertaking and underscores the need to proceed with caution.

Second, we were struck by the extent to which states struggled with the challenge of performance assessment. Even states with considerable track records in Medicaid managed care and performance measurement have found that arriving at a satisfactory approach for persons with disabilities is difficult. States appreciate the need for layering in the range of tools used, just as they layer their tools for the non-disabled populations: standardized measures reported on the basis of audited data; special performance studies; and special reporting on certain measures such as network design, grievance and appeals, and disenrollments. States clearly are struggling, and they report that even as they oversee plans, they do not have a comprehensive approach yet to quality measurement. Whether compulsory enrollment can safely be undertaken in an environment in which no one appears sure how to measure quality raises important questions, although recent

efforts by the Center for Health Care Strategies to develop performance measurement standards for the California HealthCare Foundation may offer promising directions.²⁷

Third, the DRA opens new options relevant to managed care for persons with disabilities who need both acute services and home and community care to avoid institutional care at the earliest possible point. But these options are new and further experience in their application to a population with disabilities would appear to be advisable prior to moving into compulsory managed care. In addition, changes in federal payments for targeted case management may bear particularly careful scrutiny, since case management services offered through publicly funded health systems appear to be integral to a successful transition into managed care among persons with severe disabilities.

Finally, our interviews with state officials make clear that managed care for persons with disabilities requires a considerable investment in staffing, expert assistance and other resources. According to the state officials with whom we spoke, planning will take time, the transition should be predicated on data and needs assessment, and beneficiary involvement will be key not only prior to the decision to convert to managed care, but as part of the ongoing process of transformation and oversight. Whether the state wants to make this type of investment at the moment is an issue that must be decided as part of a broader discussion that weighs all of these issues and considerations. An additional and essential matter in the view of the state officials with whom we spoke is the precise nature of the relationship between a state and its local governments, especially in systems in which oversight is a shared responsibility. In managed care for persons with disabilities, the state must anticipate that its local governments will need extensive support.

A final observation from our discussions with state officials is that the most important area of future development may be voluntary arrangements created for the dual enrollee population, which utilize specialized Medicare managed care plans authorized under the Medicare Modernization Act supplemented with wrap-around Medicaid long-term care benefits.

²⁷ California HealthCare Foundation, *Medi-Cal Performance Standards Recommendations* (Nov. 2005). Available at <http://www.chcf.org/topics/medi-cal/perfstandards/index.cfm?itemID=116096>.

Appendix A. Acronyms and Definitions Contained in State Contracts

AAA – Area Agencies on Aging
AAP – American Academy of Pediatrics
ABD – Aged, Blind and Disabled
ACOM – AHCCCS Contractor Operations Manual
ADA – American with Disabilities Act
ADL – Activities of Daily Living
AHCCCS – Arizona Health Care Cost Containment System
AHCCCSA – Arizona Health Care Cost Containment System Administration
BH – Behavioral Health
BOH – Bureau of Health
CAHPS – Consumer Assessment of Health Plans Survey
CMS – Centers for Medicare and Medicaid Services
DMA – Division of Medical Assistance
DME – Durable Medical Equipment
EOHHS – Executive Office of Health and Human Services
EPD – Elderly and Physically Disabled
EPSDT – Early and Periodic Screening, Diagnostic and Treatment
EQRO – External Quality Review Organization
FFS – Fee For Service
GSSC – Geriatric Support Services Coordinator
GWU – George Washington University
HCFA – Health Care Financing Administration
HEDIS – Health Plan Employer Data and Information Set
HMO – Health Maintenance Organization
IADL – Instrumental Activities of Daily Living
ICF/MR – Immediate Care Facility for the Mentally Retarded
IEP – Individual Education Plan
IFSP – Individual Family Service Plan
IMD – Institutions for Mental Disease
LEP – Limited English Proficiency
LTC – Long-Term Care
MA – Medical Assistance MSC – Minnesota Senior Care
MCO – Managed Care Organization
MDHO – Minnesota Disabled Health Options
MSC – Minnesota Senior Care
MSC+ – Minnesota Senior Care Plus
MSHO – Minnesota Senior Health Options
MMIS – Medicaid Management Information Services
NCQA – National Committee for Quality Assurance
PACE – Program of All-Inclusive Care for the Elderly
PCP – Primary Care Physician
QA/PI – Quality Assessment and Performance Improvement
QMB – Qualified Medicare Beneficiary

SCOP – Senior Care Options Program

SHCN – Special Health Care Needs

SSI – Supplemental Security Income

SSI MC - Supplemental Security Income Managed Care

TBI – Traumatic Brain Injury

TDD/TYY – Telecommunications Device for the Deaf / Teletype

VA – Veteran’s Administration

WPP – Wisconsin Partnership Program

Appendix B. MassHealth Senior Care Options Program Data and Reporting Requirements

2.13 Data Submissions, Reporting Requirements, and Surveys

A. General Requirements for Data

The Contractor must provide and require its subcontractors to provide:

1. all information CMS and DMA require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation; and
2. any information CMS and DMA require to comply with all applicable federal or state laws and regulations.

B. General Reporting Requirements

The Contractor must:

1. be responsible for all administrative costs associated with the development, production, mailing and delivery of all reports required under the Contract;
2. submit to CMS and DMA all required reports in accordance with the specifications, templates and time frames described in this Contract and **Appendix E**, unless otherwise directed or agreed to by CMS and DMA. The Contractor must submit all proposed modifications, revisions, or enhancements to any reports to CMS and DMA for approval prior to making such changes;
3. if CMS and DMA do not approve any report the Contractor submits, correct or modify the report as directed by CMS and DMA and resubmit it to CMS and DMA for final acceptance and approval within agreed-upon time frames;
4. at request of CMS or DMA provide additional ad hoc or periodic reports or analyses of data related to the Contract, according to a schedule and format specified or agreed to by CMS and DMA;
5. have the capacity to display data graphically, in tables, and in charts, as directed by CMS and DMA;
6. apply generally accepted principles of statistical analysis and tests for statistical significance, as appropriate, to data contained in reports;

7. ensure that all reports are identified with a cover page that includes at least the following information:
 - a. title of the report;
 - b. production date of the report;
 - c. contact person for questions regarding the report;
 - d. data sources for the report;
 - e. reporting interval;
 - f. date range covered by the report; and
 - g. methodology employed to develop the information for the report;
8. provide with each report a narrative summary of the findings contained in the report, analyses, and actions taken or planned next steps related to those findings;
9. submit one printed original and two printed copies of each report and, upon the request of CMS or DMA, also make each report available electronically in a format and media compatible with CMS and DMA software and hardware requirements. The original and printed copies must:
 - a. be in a loose-leaf binder;
 - b. be clearly labeled with the titles of the reports it contains; and
 - c. have clear separations between reports when more than one report is contained in one binder;
10. provide CMS and DMA with reports and necessary data to meet all applicable federal and State reporting requirements within the legally required time frames; and
11. provide reports to CMS and DMA according to the following timetable, unless otherwise specified or approved by CMS and DMA. All references to “annual” or “year-to-date” reports or data refer to the contract year, unless otherwise specified. CMS and DMA may at their sole discretion assess financial penalties as described in **Subsection 5.3(P)** for failure to perform any reporting requirements.

- a. Incident Reports – deliver incident reports to CMS and DMA by 5:00 p.m. (Eastern Time) on the next business day after the Contractor receives incident notification, in accordance with the established protocol.
- b. Weekly Reports – no later than 5:00 p.m. the next business day following the week reported.
- c. Biweekly Reports – according to a schedule agreed to by CMS and DMA for the specific reports in question.
- d. Monthly Reports – no later than 5:00 p.m. on the 20th day of the month immediately following the month reported, if the 20th of the month falls on a non-business day, the next business day; except for October, January, April, and July, when monthly reports may be submitted with quarterly reports.
- e. Quarterly Reports – no later than 5:00 p.m. on the 30th day of the month following the end of the quarter reported, that is, October 30, January 30, April 30, and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Quarterly reports due January 30 and July 30 may be submitted with semiannual reports.
- f. Semiannual Reports – no later than 5:00 p.m. on the 30th day following the end of the semiannual period reported, that is, January 30 and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Semiannual reports due July 30 may be submitted with annual reports.
- g. Annual Reports – no later than the 45th day after the end of the Contract year, or, if the 45th day falls on a non-business day, the next business day.
- h. One-time, Periodic, and Ad Hoc Reports – no later than the time stated, or as directed by CMS and DMA.

C. Participation in Surveys

The Contractor agrees to participate in surveys required by CMS and DMA and to submit to CMS and DMA all information that is necessary for CMS and DMA to administer and evaluate the program. CMS and DMA will provide this information to current and prospective Enrollees. This survey information regarding the Contractor must include but not be limited to:

1. plan quality and performance indicators, including:

- a. information on Enrollee satisfaction;
 - b. the availability, accessibility and acceptability of services;
 - c. information on health outcomes and other performance measures required by CMS and DMA;
 - d. compliance with survey requirements determined by CMS and DMA; and
 - e. other information determined by CMS and DMA to be necessary to assist current or prospective Enrollees in making an informed choice among SCO Contractors, M+C plans, and traditional Medicare and Medicaid;
2. information about Enrollee Appeals and their disposition; and
 3. information regarding all formal actions, reviews, findings, or other similar actions by any governmental body, or any certifying or accrediting organization.

2.14 Required Program Reports

A. Clinical Indicator Data

The Contractor must report clinical indicator data including certain HEDIS 3.0 reporting set measures that are appropriate for the enrolled population. The Contractor must analyze clinical indicator data to identify opportunities for improvement and initiate quality management activities.

The following clinical indicator data, which relate to the program initiatives in **Subsection 2.10(D)**, must be reported annually. The technical definitions of such indicators and the reporting format will be provided jointly by CMS and DMA.

1. Preventive Medicine

- a. Influenza immunization rates: percentage of Enrollees who have received an influenza vaccination in the past year.
- b. Pneumococcal vaccination rate: percentage of Enrollees who have received the pneumococcal vaccination at any time.
- c. Fecal occult blood testing: percentage of Enrollees who received a fecal occult blood test during the past year.

- d. Mammography screening: percentage of female Enrollees age 65-69 who received a mammogram during the past year, and percentage of female Enrollees age 70-79 who received a mammogram during the past year.
- e. Eye examination every two years: percentage of Enrollees receiving vision screening in the past two years.
- f. Hearing examination every two years: percentage of Enrollees receiving hearing screening in the past two years.
- g. Screening for alcohol abuse: percentage of Enrollees reporting alcohol utilization in the CAGE risk areas, and percentage of those referred for counseling.

2. Acute and Chronic Disease

a. Enrollees Diagnosed with Diabetics Mellitus (DM)

- (1) Number of Enrollees diagnosed with DM.
- (2) Percentage on insulin.
- (3) Percentage who received a glycosylated hemoglobin test in the past year.
- (4) Percentage who received a blood test for cholesterol or LDL in the past year.
- (5) Percentage who received an ophthalmologic dilated fundoscopic examination in the past year.

b. Enrollees Diagnosed with Chronic Obstructive Pulmonary Disease (COPD)

- (1) Number of Enrollees diagnosed with COPD.
- (2) Percentage who received pneumococcal vaccine at any time.
- (3) Percentage who received influenza immunization within the past year.
- (4) Number hospitalized for COPD and average lengths of stay.
- (5) Of those hospitalized, percentage who received corticosteroid treatment prior to admission.

- (6) COPD readmission rate (the number of Enrollees admitted more than once for COPD during the past year);
- (7) COPD readmission rate ratio (the ratio of Enrollees admitted more than once for COPD compared to Enrollees admitted only once for COPD).

c. Enrollees Diagnosed with Congestive Heart Failure (CHF)

- (1) Number of Enrollees diagnosed with CHF.
- (2) Number of Enrollees hospitalized for CHF and average lengths of stay during the past year.
- (3) Percentage for whom angiotensin converting enzyme (ace) inhibitors were prescribed.
- (4) CHF readmission rate (the number of Enrollees admitted more than once for CHF during the past year).
- (5) CHF readmission rate ratio (the ratio of Enrollees admitted more than once for CHF compared to Enrollees admitted only once).

d. Enrollees Diagnosed with Depression

- (1) Number of Enrollees diagnosed with depression.
- (2) Percentage receiving antidepressants.
- (3) Percentage with inpatient psychiatric admissions with average length of stay during the past year.
- (4) Percentage with psychiatric readmissions within 30 calendar days.
- (5) Percentage with outpatient visits with a mental health provider.
- (6) Percentage of these Enrollees who received an ambulatory follow-up visit within one month of hospital discharge.

e. Enrollees Diagnosed with Dementia

- (1) Number of Enrollees diagnosed with dementia.
- (2) Percentage who are receiving geriatric support services.

- (3) Percentage with severe behavioral symptoms (such as wandering or assaultiveness).
- (4) Percentage residing in nursing facilities.
- (5) Percentage receiving community long-term care services.

B. Encounter Reporting

The Contractor must meet any diagnosis or encounter reporting requirements that are in place for Medicare+Choice plans and Medicaid managed care organizations. CMS and DMA will provide the Contractor with a nine-month advance notice of such a requirement. During the nine-month period, CMS or DMA will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements by the end of the nine-month period.

C. Enrollee Orientation Performance

The Contractor must evaluate the effectiveness of Enrollee orientation activities and report the results to CMS and DMA on each anniversary of the start date of the Contract, specifying the costs and benefits of implementation and the lessons learned. The Contractor must also implement improvements based on the evaluation, including, as appropriate, continuing education programs for providers and administrative staff.

D. Complaints and Appeals

1. On a monthly basis, the Contractor must report the number and types of Complaints filed by Enrollees and received by the Contractor, specifying how and in what time frames they were resolved (see **Subsections 2.8 and 2.9**). The Contractor must cooperate with CMS and DMA to implement improvements based on the findings of these reports.
2. The Contractor must report the number, types and resolutions of Appeals filed, including, for external Appeals, whether the external review was by the CMS Independent Review Entity or by the DMA Board of Hearings.

E. Disenrollment Rate

The Contractor must report annually voluntary disenrollment rates and reasons (see **Subsection 2.3(E)(5)**). The Contractor must track such information and develop interventions to address opportunities for improvement identified through the analysis of voluntary disenrollments.

F. Institutional Utilization Data

The Contractor must report institutional utilization data annually for Enrollees, including, but not limited to the following, by gender categories and age groups as defined by and in the format provided by CMS and DMA.

1. Rate of Acute Hospital Admissions

- a. Admissions per 1,000 Enrollees.
- b. Average length of stay.
- c. Readmission rate within seven calendar days.
- d. Readmission rate within 30 calendar days.

2. Rate of Preventable Hospital Admissions (for example, Pneumonia, COPD, CHF, Dehydration and Urinary Tract Infection)

- a. Admissions per 1,000 Enrollees for each condition and in total.
- b. Average length of stay.
- c. Readmission rate within seven calendar days.
- d. Readmission rate within 30 calendar days.

3. Rate of Nursing Facility Admissions

- a. Admissions per 1,000 Enrollees for short-term rehabilitation or recovery (90 calendar days or less).
- b. Admissions per 1,000 Enrollees for long-term or permanent placement.
- c. Readmission rate to nursing facilities within 60 calendar days of nursing facility discharge.

4. Enrollees Discharged from a Nursing Facility

Percentage of Enrollees with the following length of stay at date of discharge and the disposition after discharge, whether home, another institution, or death.

- a. Less than 30 calendar days

- b. 30 - 90 calendar days
- c. 90 calendar days to one year
- d. One year to three years
- e. Longer than three years

5. Enrollees Residing in Nursing Facilities

- a. The number of Enrollees with diagnoses of dementia and the percentages of those with the following lengths of stay.
 - (1) Less than 30 calendar days
 - (2) 30-90 calendar days
 - (3) 90 calendar days to one year
 - (4) One year to three years
 - (5) Longer than three years
- b. The number of Enrollees with urinary incontinence and the number of Enrollees with urinary catheters, as well as the percentages of those with the following lengths of stay.
 - (1) Less than 30 calendar days
 - (2) 30-90 calendar days
 - (3) 90 calendar days to one year
 - (4) One year to three years
 - (5) Longer than three years

6. Rate of Chronic Hospital Admission

- a. Admissions per 1,000 Enrollees for short-term rehabilitation or recovery (90 calendar days or less) with average length of stay.
- b. Admissions per 1,000 Enrollees for long-term or permanent placement with average length of stay.

- c. Readmission rate to chronic hospitals within 60 calendar days of chronic hospital discharge.

G. Community Health Service Utilization

The Contractor must report community health service utilization data for Enrollees, including number of units and units per 1,000 Enrollees by age group and gender categories. Units means days unless otherwise noted. The data must be reported in the following summary categories.

1. Adult day health
2. Home health (units = visits)
3. Group adult foster care
4. Family adult foster care
5. Hospice
6. Homemaker, chore, respite and other non-medical residential support services (units = hours)
7. Personal care attendant (units = hours)

H. Enrollees Medically Eligible for Nursing Facility Services

The Contractor must report quarterly on Enrollees who are medically eligible for nursing facility services, by age group and gender, in the following categories.

- 1. Number in Nursing Facilities at the End of the Quarter**
 - a. Total days hospitalized
 - b. Total days in nursing facility
- 2. Number Living in the Community at the End of the Quarter**
 - a. Total days hospitalized
 - b. Total days in nursing facility
- 3. Number Who Died during the Quarter**
 - a. Those who died in nursing facility

- b. Those who died in hospital
- c. Those who died in community

I. Behavioral Health Utilization Data

The Contractor must report behavioral health utilization data annually for Enrollees as specified by CMS and DMA, including but not limited to the following, by age group and gender categories.

1. Inpatient Admission for Mental Health Treatment

- a. Number of admissions/1000 Enrollees
- b. Average length of stay
- c. Number of days/1,000 Enrollees
- d. Re-admission rate within seven calendar days
- e. Re-admission rate within 30 calendar days

2. Inpatient Admission for Substance Abuse Treatment

- a. Number of admissions/1,000 Enrollees
- b. Average length of stay
- c. Number of days/1,000 Enrollees
- d. Re-admission rate within seven calendar days
- e. Re-admission rate within 30 calendar days

3. For Enrollees with a Diagnosis of Alcohol Abuse

- a. Number of inpatient admissions/1,000 Enrollees
- b. Average length of inpatient stay
- c. Number of inpatient days/1,000 Enrollees
- d. Number of outpatient visits with a substance abuse provider/1,000 Enrollees

J. Functional Data

The Contractor must report the need for assistance with Activities of Daily Living (ADLs) annually for all Enrollees by age and gender. This data will be collected in accordance with the Minimum Data Set (MDS), and will include the number of Enrollees per 1000 needing limited assistance and number of Enrollees per 1000 needing extensive or total assistance with:

1. mobility;
2. transfer;
3. dressing;
4. eating;
5. toilet use;
6. personal hygiene;
7. bathing.

K. Mortality Data

The Contractor must report mortality data annually, by age and gender, in the following categories:

1. the number of Enrollees who died during the past year;
2. percentage who died in hospitals;
3. percentage who died in nursing facilities;
4. percentage who died in non-institutional settings; and
5. cause of death.

L. Medications

The Contractor must report Enrollee-specific prescription data through the MDS 2.0 for nursing facility residents and the MDS-HC for home care.

(MassHealth Senior Care Options Program, page 64-73, 2003)