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White Paper:

The Value of Medicaid Managed Care

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Executive Summary

In this paper, we review the literature describing the evolving Medicaid delivery system, focusing specifically on the growth of Medicaid managed care in the form of comprehensive risk-based managed care (RBMC) organizations. We explore the role of Medicaid RBMC relative to the fee for service (FFS) delivery system and draw comparisons of the experience of these delivery systems from the perspective of the Medicaid beneficiary, the provider, and the state. We conclude the paper with lessons learned from the last decade of Medicaid managed care expansion for states that may be considering additional delivery system reform.

From the member perspective, RBMC offers several advantages over the FFS Medicaid delivery system. Many of these advantages are derived from a comprehensive set of regulations that govern Medicaid RBMC around continuity of care, care coordination, and performance monitoring and quality oversight. However, the academic literature offers few concrete examples where RBMC produces measureable and significantly better outcomes on selected quality and access metrics relative to FFS. Much of the research that examines the delivery systems is dated and given the rapid expansion of RBMC in recent years, there are fewer opportunities to conduct systematic head-to-head analyses of outcomes in RBMC and FFS.

From the provider perspective, reimbursement is frequently the most critical factor associated with a provider's decision to participate in Medicaid. States are challenged to encourage provider participation in Medicaid, which is directly connected to the way states fund their Medicaid programs – this is a universal issue regardless of the delivery system in which a provider serves. States have several opportunities to increase participation in Medicaid and improve quality of care through RBMC.

- Performance incentives through value-based payment methodologies create the opportunity for RBMC plans to encourage provider participation in their networks and improve quality of care to Medicaid beneficiaries. Pay for performance, delegation of risk and other quality incentives must be designed in such a way that there are alignments in approach across plans with leadership provided by the state in order to avoid the challenges that may arise from different types of incentives and reporting requirements from multiple plans.
- In order to meet their contractual obligations regarding network adequacy, RBMC plans may develop different strategies to recruit and retain providers. States and RBMC plans also have implemented a variety of initiatives to improve provider retention and experience including:
    - Reductions in administrative burden by streamlining credentialing requirements;
    - Establishing provider relations representatives that can assist providers in local communities as they need support with patient outreach or receiving training to enhance their ability to meet the needs of their Medicaid beneficiaries;
    - Offer opportunities for providers to participate in local no-cost Continuing Medical Education (CME);
    - Payment of claims promptly;
    - Adjusting requirements for prior authorizations; and
    - Providing other innovations in service delivery that can help providers manage their patient panel such as Community Health Workers, practice coaches, and data tools.

Medicaid is the largest state expense in most state budgets and the costs of delivering care in the FFS system have grown over time, with few tools available to states to control growth. Medicaid RBMC offers a number of opportunities for states to improve upon the FFS delivery system including the following:

- Budget stability: Can provide budget stability over time and assists in predicting costs;
- Limits financial risk: Assists in limiting states' financial risk by passing part or all of it on to contractors through payment arrangements that provide a fixed, predictable fee per enrollee;
- Accountability: Allows states to hold MCOs accountable for controlling service use and providing quality care and support rather than trying to manage such activities for thousands of individual providers;
- Cost savings: Creates the potential to provide services to more people as a result of cost savings;
- Encourages innovation: Provides flexibility in service provision and encourages innovation among competing MCOs; and
- Market-based solution: MCOs (and not the state) are accountable for administering program, including managing networks, paying claims, utilization management, etc.

Several themes arose from the literature that may inform state considerations for RBMC implementation. These include considerations for:

- Planning and implementation: States should thoughtfully plan RBMC implementations, allowing time to build state infrastructure, define state contracting requirements and priorities, and ensure plan readiness.
- Stakeholder engagement: A key element of thoughtful planning is the engagement of a broad range of stakeholders who can provide feedback and help shape the implementation of RBMC. This process can be lengthy, especially as states consider expanding RBMC to vulnerable populations such as dual eligibles and individuals with disabilities, and should be factored into planning and implementation.
- Procurement approaches: States need to consider the implications of their approach to RBMC plan procurement. Generally, states pursue either a competitive procurement or take an "any willing plan" approach to contracting with RBMCs. Further, with a competitive procurement, states may limit the number of plan contracts they will pursue. These decisions around procurement approach can have implications for beneficiary choice of health plans as well as ongoing program stability.
- Outreach and enrollment: Experiences of states with different outreach approaches to support enrollment of new populations into RBMC programs demonstrate that strategies typically used for beneficiary enrollment (i.e., use of written materials) may not be sufficient to maximize beneficiary understanding and engagement. Selected states offer examples of approaches to ensuring adequate outreach, particularly for vulnerable populations, to ensure they understand the changes in Medicaid that will impact them as well as understand the choices they must make.
- Contract monitoring: States that administer RBMC programs must set clear goals for their program, in addition to ensuring that their RBMC contractors meet a number of federal requirements. This requires developing contract requirements that connect to state goals as well as sufficient state resources to conduct the oversight and enforcement activities.

Background

Medicaid, the public health insurance program for low-income individuals, is the largest payer of health care in every state. Nearly one in five Americans are covered by the Medicaid program.[1] The traditional Medicaid payment and delivery model is a 'fee-for-service' (FFS) approach in which providers are paid on a fee schedule for each service provided. The FFS Medicaid system is often viewed as a barrier to access and high quality care for Medicaid beneficiaries. Fragmentation in the FFS system is significant because there is no entity coordinating care for the eligible population.[2] To address these issues,

improve quality and improve financial sustainability, states have increasingly looked to risk-based managed care (RBMC) for their Medicaid programs.

Comprehensive RBMC plans are organizations that receive a capitated global payment for the provision of all acute and primary medical services for a specified population. Some comprehensive RBMC plans also cover behavioral health and long-term services and supports (LTSS).[3] The Medicaid delivery system continues to evolve and is being dominated by efforts to improve coordination of care and pay for value. This evolution is described in detail throughout the report, but key trends are identified below (see Appendix A for more detail):

- Non-risk bearing models like Primary Care Case Management (PCCM) are waning in popularity, with RBMC growing in prevalence and in some states, replacing FFS or PCCM entirely.
- States are pursuing both contract level and delivery system reforms to enhance care coordination and value-based purchasing. States with RBMC and those operating PCCM or FFS programs are also leveraging delivery system reforms that include Health Homes, Patient Centered Medical Homes (PCMHs), and Accountable Care Organizations (ACOs) (see Appendix A for definitions).
- Increasingly states are looking to RBMC for a comprehensive solution for their Medicaid program – designing contracts that integrate all State Plan and waiver benefits for a particular population or across the Medicaid program.

Although there has been significant growth in other delivery system innovations including ACOs, PCMHs, and Health Homes, for the remainder of this paper, we will narrow our focus to examine trends and outcomes for traditional FFS, PCCM, and RBMC in Medicaid. The intention in the decision to focus on these models and not the other delivery system innovations is, in part, due to the uneven distribution of these innovations across states. In addition, the implementation of these other delivery models is more recent and thus the evidence of their value is still relatively unexplored. FFS, PCCM, and RBMC have a longer history in states as models for the delivery of Medicaid benefits and thus offer more opportunities to evaluate and examine their value.

A National View of the Medicaid Delivery System: 2005 to 2015

Both the number and the share of Medicaid beneficiaries enrolled in Medicaid managed care have grown in the past decade. In 2005, total Medicaid enrollment was 45.4 million, with 28.6 million (62.9%) enrolled in some form of managed care.[4]

Table 1. Medicaid Enrollment in Managed Care

Year	# of Medicaid Beneficiaries	% in managed care	# of Medicaid Beneficiaries in managed care (all types)	% of Medicaid in RBMC	% Change in RBMC
2010	54.6 million	71.5%	39.0 million	47.4%	-
2013	62.2 million	71.7%	44.5 million	56.3%	18.8%

Source: HMA analysis of CMS enrollment data.[5, 6]

Table 1 shows the increase in the number and percentage of Medicaid beneficiaries enrolled in managed care from 2010 to 2013. By the time the ACA was passed in 2010, there were 54.6 million Medicaid beneficiaries in the United States; 39.0 million, or 71.5%, of those were enrolled in some form

of managed care, including PCCM and/or RBMC. When one examines further, 25.9 million of the 39 million enrolled in managed care (or about 47.4% of all Medicaid beneficiaries) were enrolled in comprehensive RBMCs.[7] The most current enrollment data publicly available on Medicaid enrollment from July 2013 indicate that there were about 62.2 million Medicaid beneficiaries nationwide, with 44.5 million (71.7%) in some form of managed care and of these, 35 million (56.3%) in comprehensive RBMC.

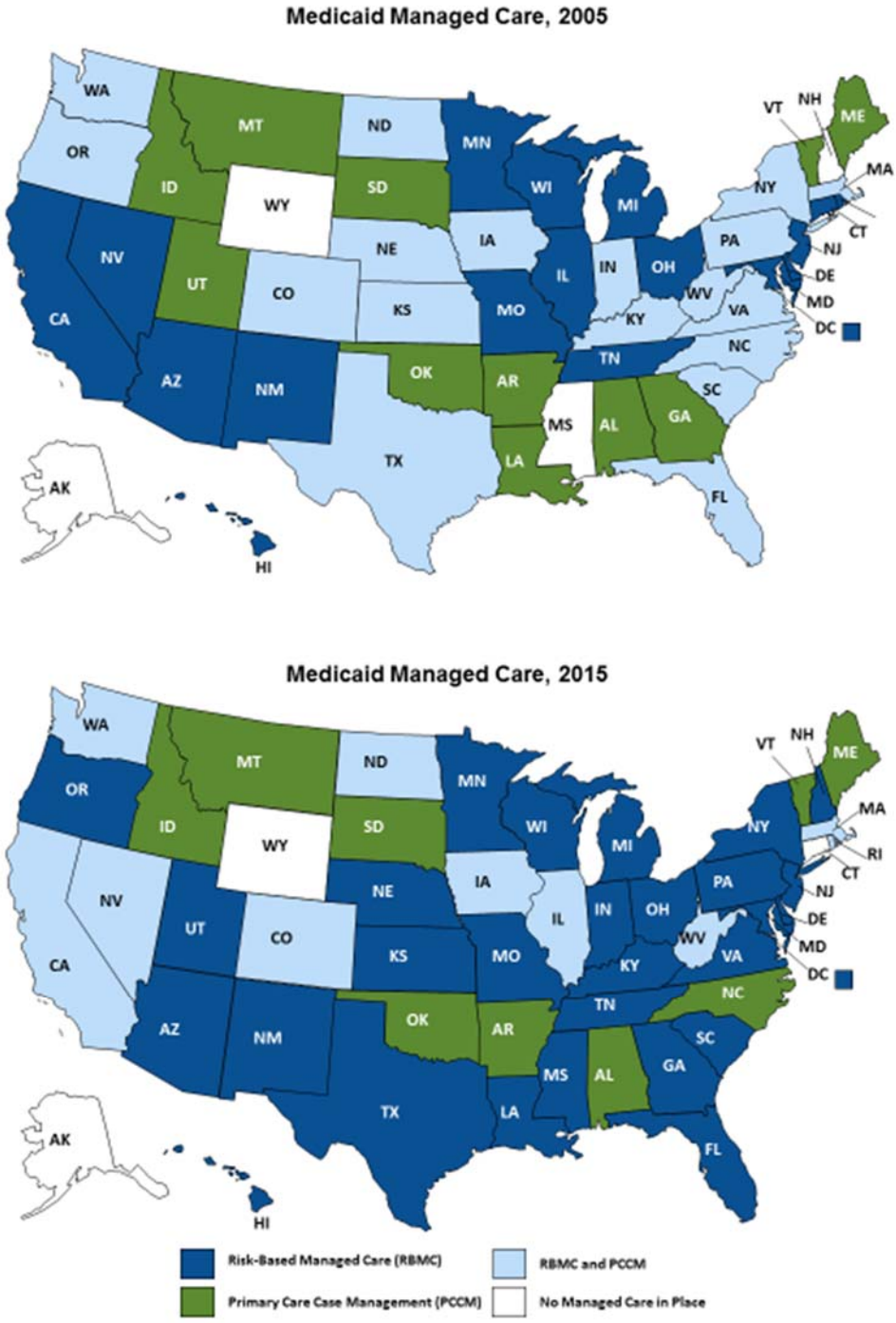
Table 2 describes the shift in the Medicaid delivery system between 2005 and 2015 by exploring states who use only FFS, those who use a PCCM or a RBMC model, or both. In 2005, 36 states operated a RBMC program and 29 states operated a PCCM program. Of these, 11 states operated only a PCCM program and 18 operated a PCCM program along with an RBMC program, typically in more rural areas of states. Another four states (AK, MS, NH, and WY) had no managed care program at all in 2005, thus relying on the traditional FFS model of care delivery. By 2015, another three states had added RBMC for the Medicaid population. Although currently operating both PCCM and RBMC, the North Carolina legislature passed legislation in September 2015 to eliminate its PCCM program and retain RBMC alone with three statewide plans. What is most notable from this time period is the decline in the use of PCCM. Between 2005 and 2015, there has been a 34% decrease in the number of states operating PCCM programs and at the same time, a 61% increase in the number of states operating *only* RBMC programs. Figure 1 presents two maps to graphically depict the change in the Medicaid delivery system.

Table 2. Change in Medicaid Delivery System between 2005 and 2015

Type of Managed care	2005		2015		% change 2005-2015
	# of States	% of total	# of States	% of total	
RBMC	18	35%	29	56%	61%
PCCM	11	22%	9	18%	-18%
Both (RBMC and PCCM)	18	35%	10	20%	-44%
Traditional FFS only	4	8%	3	6%	-25%
Total	51	100%	51	100%	
RBMC total (RBMC or both)	36	71%	39	76%	8%
PCCM total (PCCM or both)	29	57%	19	37%	-34%

Source: HMA analysis of data from the Kaiser Family Foundation.[8,9]
Note: FFS – Fee for Service; RBMC – Risk Based Managed Care; PCCM – Primary Care Case Management.

Figure 1. Medicaid Managed Care Models in the States, 2005 and 2015



Source: Kaiser Family Foundation[10,11]

Early Adopter States. Medicaid managed care is now the most common vehicle for delivering Medicaid benefits, but there is no single common approach – although there are national standards and requirements, no two state programs look alike and outcomes will vary based on program design. Here we highlight two states, Arizona and Tennessee, with longstanding risk-based Medicaid managed care programs and unique program designs.

ARIZONA - Arizona's Medicaid managed care program is notable for a number of reasons. The state did not begin participating in Medicaid until 1982 (the last state to adopt Medicaid). When it did, it established the Arizona Health Care Cost Containment System (AHCCCS), the state Medicaid agency, and rolled out the first statewide mandatory managed care program. Arizona operates two major Medicaid managed care programs under the AHCCCS – the Acute Care program and the Arizona Long Term Care System. Both programs are mandatory and statewide, and operate under section 1115 waiver authority covering more than one million lives (about 84% of the full Medicaid population). Arizona also operates a behavioral health managed care plan in Maricopa County. In addition, a statewide behavioral health program (excluding Maricopa County) is scheduled to launch in Fall 2015.[12] [13]

TENNESSEE – Tennessee Medicaid (TennCare) transitioned to RBMC in 1994 with a dual purpose to: 1) cover the uninsured and those with pre-existing conditions who could not get coverage elsewhere; and 2) lower Medicaid costs and stave off a budget crisis in the face of rising state expenditures for FFS Medicaid beneficiaries and the uninsured. The state initially aimed to save money that it could then reinvest into expanding services. TennCare split into two programs in July 2002: TennCare Medicaid for those eligible for Medicaid and TennCare Standard for those who didn't qualify for Medicaid but met the state's criteria for being "uninsured" or "uninsurable." The benefits between the two programs were approximately the same except TennCare Standard beneficiaries were required to pay premiums and copays.[14] Although it has changed dramatically since its inception, today TennCare Standard remains a mandatory managed care program for children while the Medicaid program includes all eligible groups, covering medical, behavioral health, and LTSS, with certain service carve-outs. As of 2013, there were about 1.2 million Medicaid beneficiaries in Tennessee; it is the only state with 100% of Medicaid beneficiaries enrolled in comprehensive RBMC.[15,16]

Currently, there are three states who do not operate any managed care program (Arkansas, Connecticut and Wyoming). Two states, Mississippi and New Hampshire, had no managed care engagement in 2005, but added RBMC in 2011 and 2013 respectively. Mississippi launched MississippiCAN in 2011, a statewide "care coordination program" using RBMCs to cover most Medicaid services for most populations except dual-eligibles, those enrolled in waiver programs, and institutionalized beneficiaries. This program was designed to enhance care access and quality and achieve program efficiencies and cost-effectiveness.[17] New Hampshire established a RBMC program in 2013 for most of its eligible Medicaid populations, with the Medicaid expansion population enrolled in RBMC in 2014.[18] Interestingly, Connecticut, a state that had operated both PCCM and RBMC programs for many years, decided in 2012 to dissolve both programs and return to a traditional FFS delivery system, using contracts with Administrative Service Organizations (ASO) for medical, behavioral health, dental, and non-emergency transportation. The ASO contracts withhold a percentage of the annual administrative fee based on the ASO's ability to achieve benchmarks on health outcomes, quality measures, and member and provider satisfaction.

RBMC Expansion and Trends. As noted earlier, some states are making the transition to comprehensive risk-based managed care (RBMC) from PCCM or FFS. As an example, Kansas operated both PCCM and RBMC but in 2013, the state launched KanCare, a RBMC program that covers virtually all Medicaid populations and services, including physical health, behavioral health, and LTSS (nursing facilities and home and community-based services). KanCare replaced the state's PCCM program and expanded on its earlier RBMC model. Others are expanding their existing RBMC programs to include new services or populations. Just in Calendar Year 2015, we have observed significant changes and new initiatives being planned in several states:

- **Illinois increased RBMC enrollment**. Illinois has undergone one of the largest Medicaid RBMC expansions in the last few years. Medicaid RBMC enrollment neared 2.1 million as of June 2015, nearly five times what it was the previous year.[19]
- **Iowa is transitioning from mostly PCCM to statewide managed care**: In August 2015, Iowa announced four winners of its statewide Medicaid managed care RFP seeking RBMC plans to cover nearly all of the state's 570,000 Medicaid beneficiaries beginning January 2016.[20] In conjunction with this RFP, the state is also carving behavioral health services into the RBMC contracts, which were previously provided through two separate behavioral health contracts.
- **Virginia is considering Medicaid managed LTSS implementation statewide:** Virginia has proposed transitioning about 107,000 beneficiaries to Medicaid managed LTSS (MLTSS), using a phased approach that begins in 2016. This would include the mandatory enrollment of dual eligibles with full Medicaid benefits as well as individuals residing in an institutional setting or one of the state's home- and community based (HCBS) waiver programs.[21]
- **Pennsylvania is moving forward with statewide MLTSS beginning in 2017**: Pennsylvania has developed plans to implement Medicaid MLTSS and will be issuing an RFP in early 2016 to establish a statewide MLTSS program, starting with its rollout in Southwest Pennsylvania in 2017. This program will integrate physical health and LTSS coverage for the eligible population, including dual eligibles and Medicaid-only populations who meet clinical eligibility for LTSS based on a new level of care assessment to be developed by the state.[22]
- **North Carolina is moving toward RBMC and use of provider-led entities**: As noted earlier, in September 2015, the North Carolina General Assembly passed H.B. 72, which requires the state to make changes to its Medicaid program, including discontinuing its long-standing PCCM program and replacing it with three statewide RBMC contracts and up to ten regional provider-led entities, like ACOs, for most Medicaid beneficiaries except dual eligibles.
- **Arkansas is exploring the possibility of issuing an RFP for MLTSS with potential for integration with medical and behavioral health:** The Arkansas Department of Human Services issued a Request for Information (RFI) in 2015 to explore contracting with RBMC for MLTSS for the behavioral health population (109,850 beneficiaries), individuals with developmental disabilities (20,261 beneficiaries), and the aged, frail, and physically disabled population (31,700 LTSS users).
- **Oklahoma's potential adoption of care coordination for ABD population:** The Oklahoma Health Care Authority (OHCA) in 2015 solicited input via RFI on a care coordination model, or combination of models, to serve its Medicaid aged, blind, and disabled (ABD) population (approximately 137,000 individuals), and is expected to issue an RFP for ABD care coordination in 2016. It is not clear at this time that the state will adopt RBMC but it is exploring its options. Oklahoma currently has a PCCM program called SoonerCare Choice and does not have comprehensive RBMC.

Medicaid Program Design Trends

Federal statute establishes the basis for state Medicaid programs as part of amendments to the Social Security Act passed in 1965.[23] States however have great flexibility in determining eligibility criteria, benefits covered, provider payment policy, and the approach to administering and financing the program. In this section, we discuss recent trends regarding changes to population and benefit carve-ins and carve-outs. See Appendix B for background on the Medicaid program more generally.

Medicaid Population or Benefit Carve Outs

States may choose to exempt one or more populations from Medicaid RBMC and instead offer benefits for those populations through the traditional FFS system. The decision to carve out benefits or populations from Medicaid RBMC may be driven by a number of factors, including stakeholder concerns regarding the ability to assume responsibility and risk for selected populations, or whether services have historically been administered or paid for separately, such as behavioral health or LTSS described below.

Benefit Carve Outs: States are trending toward carving some of the historically carved-out benefits back into RBMC. In this section below, we describe the benefits that are most commonly considered carve outs from RBMC, with a discussion of where those benefits are beginning to be carved in.

- **Long-term services and supports (LTSS).** LTSS in a nursing facility or in a home or community-based setting, as well the populations who need these services, have typically been carved out of Medicaid managed care and instead paid FFS directly by states. Over the past decade, however, a growing number of states have carved them in to their Medicaid managed care plans, including Medicaid-only plans and plans for dual-eligibles.[24] As of 2015, 22 states provide at least some LTSS under RBMC contracts for at least some of the population that is eligible for these benefits; another five states plan to implement new MLTSs programs in 2016.[25]
- **Behavioral health care.** Historically, Medicaid physical and behavioral health services have been kept separate, managed by different state agencies and subject to different purchasing strategies. This structure did not reflect the importance of providing integrated care or the more recent recognition of how interrelated behavioral and physical health are, and created problems with information sharing and care coordination for beneficiaries who have comorbid physical and behavioral health conditions. Under a bifurcated system, these beneficiaries may have no single provider that serves as a point of contact to help them manage potentially complex health needs.[26] This fragmentation still exists in most states, but some are taking steps to integrate the two, or to "carve in" behavioral health care services to their Medicaid managed care program. In 2014, nine states included all behavioral health services as part of an integrated Medicaid managed care benefit package, and one state had plans to do so.[27] As of 2015, 16 states included at least outpatient mental health services through RBMC contracts; 15 states also cover inpatient mental health and substance use services through RBMC, these numbers include both states that have developed integrated programs and those that continue to cover behavioral health services separately but provide them through RBMC plans. By 2016, another six states are anticipated to carve behavioral health services into RBMC for at least some of their contracts.[28]
- **Dental care.** Federal law requires that state Medicaid programs include dental care for children and most children (under age 21) enrolled in Medicaid managed care have access to a limited dental benefit through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Dental coverage for adults is an optional state plan benefit and not available in all states; 15 states have nearly comprehensive coverage, 16 states offer limited coverage, and another 14 states cover only emergency dental care. Five states offer no adult dental coverage at all.[29,30,31] More than half of states (21 out of 38) with RBMC that covers children carve in

children's dental services to those plans. Just over half of the states with RBMC programs that cover adult dental services have also carved in this benefit.[32]

- **Prescription drugs.** Prior to 2010, many states opted to carve out pharmacy benefits from RBMC in order to collect manufacturers' rebates, because manufacturers were not required to pay these rebates if the RBMC plan paid for prescriptions.[33] However, effective March 2010, the ACA required that these discounts also be applied to prescriptions paid for by Medicaid RBMC plans on behalf of their clients.[34] As a result, between FY 2011 and FY 2014, 6 states moved to a carve-in model for prescriptions.[35] Even among those that carve in pharmacy benefits, some states still retain carve outs for certain drugs or drug classes (e.g., medications for HIV, hepatitis C, behavioral health, etc.). There are still six states that carve out pharmacy benefits from their RBMC programs.[36] There are arguments for and against carving in prescriptions, however one study conducted at the request of America's Health Insurance Plans (AHIP) found that states carving in prescriptions in FY 2014 realized 14.6% lower net cost per prescription than states with a carve-out model (after accounting for rebates and other costs).[37]

Population Carve Outs: States may choose to exempt selected Medicaid-eligible beneficiaries from enrollment in Medicaid RBMC. These individuals either remain in FFS Medicaid or are enrolled in a specialized Medicaid RBMC plan targeted to their specific condition or needs.[38] Populations most commonly considered to be exempt from mandatory Medicaid RBMC enrollment include:

- **People with physical disabilities:** Per capita Medicaid spending on acute and long-term care services is the highest for this eligibility group due to their complex health care needs. In 2008, the roughly 15% of Medicaid beneficiaries with disabilities made up about 42% of total Medicaid spending for services. More states are including individuals with disabilities in RBMC on a mandatory or voluntary basis, due in large part to state budget pressures as well as initiatives to improve quality and coordinate care for these beneficiaries.[39]
- **Dual eligibles:** In FY 2011, those individuals dually eligible for Medicaid and Medicare comprised 15% of U.S. Medicaid enrollees.[40] About 985,179 were enrolled in a Medicaid RBMC in 2011 and 131,317 were enrolled in PCCM. Most states still carve out or allow voluntary enrollment of dual eligibles into RBMC. However, many states are pursuing delivery models that integrate Medicare and Medicaid (see below for more detail). States mandatorily enrolling dual eligibles into Medicaid RBMC FY 2014 or FY 2015 include California, Florida, Illinois, New York, Ohio, Rhode Island, South Carolina and Virginia.[41]
- **Children with special needs:** In a 2010 survey, 20 states said that they had at least one geographic area and/or program for which Medicaid RBMC enrollment was voluntary for children with special health care needs. Five states reported that this population was always excluded.[42] As with other populations, some states have recently carved in children with special needs to RBMCs, or are in the process of doing so. These states include Ohio, California, Massachusetts and Michigan.[43,44]
- **Foster children:** Almost all children in foster care or adoptive placements are eligible for Medicaid, and many of them have developmental or chronic mental or physical health conditions.[45,46] In FY 2011, 865,000 children in foster care accounted for $5.3 billion in Medicaid expenditures.[47] In 2010, 14 states responding to a Kaiser Family Foundation survey said that foster care children are always excluded from Medicaid managed care. Since then, states such as Florida, Georgia, Nebraska, Texas, Washington and Virginia have moved to add these children and other high-risk children into RBMC, with the states selecting one RBMC to develop a statewide program tailored to the specific needs of the population.[48]
- **People with Intellectual and Developmental Disabilities (I/DD):** There are approximately 4.5 million people in the U.S. with intellectual and developmental disabilities (I/DD).[49] The I/DD

population has historically been carved out of Medicaid RBMC in part due to concerns about the complex care needs of the population and the challenges of establishing an appropriate provider network to serve the population needs.[50] In most states, the I/DD population is carved out of Medicaid RBMC. As of 2012, six states had carved the I/DD population into RBMC for MLTSS (AZ, HI, MI, NC, PA [for adults with autism], WA, and WI).[51] Other states also include the I/DD population in managed care for primary/acute care Medicaid benefits (e.g., KS, MI, NJ, RI, and TX) and several states stand poised to launch Medicaid managed care programs for their I/DD population in the near future (IA, NH, NY, and TN).[52] Louisiana allows voluntary enrollment into Bayou Health for the I/DD population. Kansas is currently the only state that includes I/DD waiver benefits in RBMC; New York, Iowa, Tennessee, and Texas are moving to do the same.

In FY 2014 and FY 2015, 25 states and 19 states, respectively chose to expand voluntary or mandatory enrollment in RBMC to additional eligibility groups.[53]

Carve-In and Integration Models and Trends: In addition to state Medicaid RBMC programs assuming risk for populations and benefits that were historically carved out, many states are currently testing out efforts to integrate medical and supportive services within RBMC models of care delivery. In particular, state efforts to integrate physical and behavioral health care are growing. A small number of states shifted most or all benefits and populations into the Medicaid RBMC delivery system.

Some of the models that states are adopting to integrate services and benefits include:

- **Financial Alignment Demonstration.** Individuals dually eligible for Medicaid and Medicare ("dual eligibles") are among the most costly and complex beneficiaries and face the challenge of navigating two forms of health care coverage with different benefits and participating providers. To help address this issue, the ACA established the Medicare-Medicaid Coordination Office within the Centers for Medicare and Medicaid Services (CMS), which implemented the Financial Alignment Demonstration in states, aimed at improving and coordinating care and lowering costs for duals. States were given the option to implement a capitated model or a managed FFS model, and nine of the twelve states participating in the demonstration currently opted for a capitated model; Rhode Island will implement its demonstration in February 2016 as a capitated model as well.[54] In most states that chose to implement a demonstration, duals are either actively or passively enrolled into a RBMC plan that receives capitated payments to cover both their Medicare and Medicaid benefits.
- **Behavioral Health and Physical Health Integration.** Several strategies and approaches can be used to integrate physical and behavioral health benefits. Integrating payment and coverage of behavioral and physical health under Medicaid RBMC (a purchasing strategy) may be combined with administrative integration (combining or reorganizing the state agencies that provide oversight) and/or regulatory strategies that address the state regulations for licensure, certification, billing, and health information exchange to facilitate improved integration.[55]
- **Comprehensive Integration of All Benefits.** Some states take a comprehensive approach that integrates all (or nearly all) benefits and services into their MMC programs. Kansas (discussed below) and Tennessee (previously discussed) are both examples of states that made the decision to carve most or all Medicaid benefits into a single RBMC program.

Below are descriptions of selected states that have recently established integrated models of RBMC or expanded the benefit offerings to existing programs.

- **New York.** New York has amended its 1115 Medicaid waiver with CMS to carve in behavioral health to its RBMC program. Mainstream Medicaid RBMC will begin covering behavioral health services and Health and Recovery Plans will be established and operated by the mainstream

RBMC plans for eligible adults with Serious Mental Illness and Substance Use Disorders. The transition begins in New York City in 2015 and expands to the rest of the state in 2016.[56] In addition, as of July 2015, CMS approved New York State's transition to mandatory managed long term care for all dual eligible beneficiaries requiring more than 120 days of community-based long-term care, which began in certain counties in August, 2012.

- **Kansas**. Kansas launched a RBMC program in 2013 called KanCare, which covers virtually all Medicaid populations and services, including physical health, behavioral health, and LTSS (nursing facilities and home and community-based services) via RBMC.[57]
- **California.** Children and youth with special health care needs (CYSHCN) have been mandatorily enrolled in Medi-Cal (California's Medicaid program) RBMC for their primary care services since 2012, but services related to their eligible health condition that qualifies them for specialty services under California's Children's Services (CCS - the Title V program for CYSHCN) remain carved out of managed care. The state's Section 1115 waiver, approved in 2010, gave the opportunity to carve in specialty CCS services via county-level pilots.[58] As of 2014, implementation of the CCS pilot had occurred in one county. Additionally, the state has launched a Financial Alignment Demonstration to integrate Medicare and Medi-Cal benefits in 7 counties for dual eligibles, called Cal MediConnect; the state has also mandatory Medi-Cal RBMC enrollment for dual eligibles in the 7 counties. The state also established MLTSS in these same 7 counties; all Medi-Cal beneficiaries including dual eligibles receive their MLTSS benefits through their Medicaid RBMC plan.[59]
- **Michigan.** In 2012, Michigan Medicaid began mandatory enrollment of the CYSHCN population into Medicaid RBMC from FFS Medicaid. To ease the transition, the state added plan contract provisions specifically to address the needs of these children such as requirements to provide continuity of care with the Primary Care Physicians (PCPs) and specialists they were using upon enrollment in the plan.[60] Michigan has also implemented a Duals Demonstration called MI Health Link, which integrates all Medicare and Medicaid benefits within one RBMC plan.[61]
- **Washington.** Washington's Health Care Authority (HCA), in partnership with the Department of Social and Health Services (DSHS), released a request for proposals (RFP) on July 31, 2014 for eligible bidders to develop and implement a managed care program for children and youth who are in foster care, in adoption support programs, or are alumni of the foster care system. HCA and DSHS accept joint responsibility for the physical and mental health of children and youth in foster care or receiving adoption support. Historically, this population has been served through a fragmented system composed of the Medicaid fee-for-service system, charity care, and care authorized by Children's Administration Social Workers to expedite access to needed services. HCA awarded a single contract to provide a comprehensive and coordinated medical benefit, including primary care, ancillary services, pharmacy, and an outpatient mental health benefit. This is an example of a state expanding RBMC to a new population, however, the foster care RBMC program is separately administered from RBMC for other populations.

The Regulatory Environment for Medicaid Risk-Based Managed Care

As the Medicaid delivery system has evolved, so too has the regulatory environment. The Balanced Budget Act (BBA) of 1997 was the first comprehensive revision to federal statutes governing the Medicaid program since the early 1980s. These regulations established a comprehensive set of consumer protections, including the following:

- Enrollee rights: Managed Care Organizations (MCOs) must provide information about their health plan to enrollees, treat enrollees with respect and with due consideration for their dignity and privacy, and allow provider counseling on all available treatment options;
- Provider-enrollee communications: prohibits MCOs from restricting health professionals from advising or advocating on behalf of his/her patient about care or treatment options;
- Marketing activities: defines allowed or prohibited (e.g., cold-calling) MCO marketing activities and requires states to review all marketing materials prior to MCO use;
- Liability for payment: MCOs cannot hold enrollees liable under certain circumstances such as insolvency or if the MCO doesn't get paid by the state for the service for whatever reason;
- Emergency and post-stabilization services: defines what is considered an emergency and requires MCOs to cover emergency and post-stabilization services provided by non-network providers; and
- Solvency standards: requires MCOs to meet certain insolvency standards.

In addition, the regulations established a number of core requirements for states and MCOs around quality monitoring, provider network adequacy, coordination of care, and service authorizations. Highlights of these additional requirements include:

- States must develop a quality oversight strategy that is reported to CMS and conduct external quality reviews of MCOs.
- MCOs must develop an adequate network to meet the needs of enrollees and routinely monitor their network for timely access to care and services, and cover out-of-network services if they are unable to provide timely access using network providers.
- MCOs must ensure that all enrollees have an ongoing source of primary care to coordinate all medically necessary services, while protecting enrollee privacy.
- MCOs must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services and for all enrollees, provide a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.
- MCOs must identify, assess and develop treatment plans for enrollees with special health care needs.
- States must define the scope of coverage for each service covered by the MCO, which has to be no less than the amount, duration and score for the same service provided to Medicaid beneficiaries on a fee-for-service basis.
- Allows MCOs to place appropriate limits on services based on defined criteria such as medical necessity, while restricting arbitrary denials or reductions of services. The definition of what constitutes a "medically necessary" service cannot be more restrictive than the criteria defined by the Medicaid State Plan or state policies.
- MCOs must have written policies and procedures and mechanisms to ensure consistent review criteria for service authorization decisions, use appropriate health care professionals to make service denial decisions, and make timely written notifications to the provider and enrollee in the case of decisions to deny or reduce the amount of a service requested for an enrollee.

These regulations took effect in 2002 and at the time were notable by: 1) allowing states to mandate enrollment of certain eligibility groups into managed care without first seeking a waiver; 2) establishing consumer protections to Medicaid managed care commonly available in the private sector; and 3) applying quality improvement approaches also commonly used in the private sector to the Medicaid program.[62]

Since 2002, other key legislation has been passed that altered the way Medicaid operates, such that the regulatory framework was no longer sufficient. On June 1, 2015, CMS released the Medicaid Managed Care proposed rule, the first major revision of the regulations since 2002.[63] Key elements of the proposed rule include:

- Requiring clearer and more consistent definitions of provider network adequacy, including for MLTSS;
- Strengthening state capacity to promote value based purchasing, establishing performance targets, and promoting innovative and efficient models of care delivery;
- Aligning Medicaid managed care with the Health Exchanges and Medicare;
- Enhancing beneficiary protections; and
- Requiring states to develop a state plan for quality improvement in managed care and establishing a quality rating system for Medicaid managed care that will be publicly reported.

Additional discussion of the Medicaid Managed Care proposed rule can be found in the sections below.

Medicaid RBMC: The Member Perspective

This section discusses Medicaid RBMC from the member perspective and highlights differences between the member experience in RBMC, PCCM, and FFS Medicaid delivery systems. Table 3 summarizes key issues related to the member perspective in ten different domains. We further discuss below issues around care coordination, continuity of care, and provider access.

Care Coordination

Care coordination has emerged as a central component of health care delivery and a core feature of the definition of quality: right care, right place, right time. In 2003, the Institute of Medicine recommended care coordination within and between organizations to ensure that patients receive high-quality, seamless, and safe care.[64] The ACA built on this guidance by establishing both federal agencies and care delivery models, directed at improving care coordination across various settings.[65] The need for care coordination is high, especially among high-needs populations (e.g., those with chronic conditions and functional limitations and those with high levels of service utilization) given the complexity of their care and the many transitions across providers and care settings they experience.

Despite an increasing importance among policymakers, advocates, and providers, the term “care coordination” still lacks a clear and consistent definition. Care coordination, in its most general terms, is a broad-based endeavor to integrate multiple systems and providers of care. This may focus solely on providers in the physical health realm or may be more inclusive of physical health, LTSS, and behavioral health that include an emphasis on non-medical interventions (e.g., “supportive services”) that directly or indirectly impact health outcomes. Some organizations use the terms “care coordination” and “case management” interchangeably. Care coordination is typically defined as ongoing and not confined to one episode of care. In contrast, case management is generally defined as a subset of care coordination – working to organize care in the medical system exclusively within one setting or a specific episode.[66] In practice, these types of services exist along a spectrum and the line between the two is all but clear.[67]

Table 3. A Comparative View of Key Medicaid Program Features in Traditional FFS, PCCM, and RBMC

	Fee-For-Service	Primary Care Case Management[a]	Risk-Based Managed Care
Care Coordination[68]	Typically, enrollees may receive care from any participating provider but no single provider is responsible for coordinating care across providers, settings, or services.	Care coordination generally limited to services that can be performed in primary care offices. Without responsibility for the broader service package such as hospital care, savings on such services due to effective coordination may not be used to finance more robust care coordination.	Health plans are required to perform care coordination services and activities tend to be more robust due to expected savings from reductions in hospitalizations and other services. Care coordination activities may include care coordinator participation on multidisciplinary teams. Many plans are utilizing Information Technology to facilitate care coordination with the goal of developing a comprehensive picture of the member, their care plan, and service utilization.
Continuity of Care[69]	No guarantee of continuity of care for beneficiaries who transition into Medicaid unless their provider will agree to accept Medicaid rates.	No guarantee of continuity of care for beneficiaries who transition into Medicaid unless their provider will agree to accept Medicaid rates.	States generally require plans to allow a newly enrolled beneficiary to continue seeing a provider not in network for a set period of time to complete a course of treatment or until another provider can be identified. The provider must be willing to accept the plan's rates.
Member Services[70,71]	Beneficiaries may receive little or no guidance on their benefits and coverage.	Beneficiaries may receive little or no guidance on their benefits and coverage.	Member services requirements for Medicaid RBMC plans are laid out in their contracts with the state. Plans are generally contractually required to ensure that enrollees get the information they need to access services. Toll-free call centers and phone lines, and ombudsman programs are commonly used to address enrollee questions and concerns.

	Fee-For-Service	Primary Care Case Management[a]	Risk-Based Managed Care
Benefit Design[72]	Beneficiaries get all their covered Medicaid benefits through individual providers. There is no guarantee that a provider in their area will accept Medicaid rates, which effectively curtails access to some benefits.	Beneficiaries get all their covered Medicaid benefits through individual providers. There is no guarantee that a provider in their area will accept Medicaid rates, which effectively curtails access to some benefits.	Beneficiaries get most or all their Medicaid benefits through the plan.
Choice[73]	Beneficiaries have full choice of participating providers in their state.	States that mandate PCCM must offer beneficiaries at least two choices of provider entities.	States that mandate RBMC must offer beneficiaries at least two plan options to choose from.
Value Added Services	Beneficiaries are eligible for only those benefits covered by the Medicaid State Plan.	Beneficiaries are eligible for only those benefits covered by the Medicaid State Plan with the addition of limited care coordination.	Medicaid RBMC plans may offer additional benefits beyond those required, in order to attract beneficiaries to enroll in their plan. These benefits often include limited vision, hearing, or dental benefits where not required under the state plan or where the state benefit is limited. Plans may also offer healthy lifestyle programs, health coaching, incentives for completing preventive care, etc., if approved by the state.
Provider Access[74]	Difficult to identify providers willing to accept Medicaid, especially specialty care providers.	Difficult to identify providers willing to accept Medicaid, especially specialty care providers. Contracts with primary care providers include additional requirements beyond those in traditional FFS Medicaid provider agreements to ensure access to primary care for beneficiaries. Most states require 24/7 coverage.	Providers must contractually agree to participate in the plan's network. Federal regulation requires states to have a written strategy for assessing and improving quality of care offered within RBMC, including standards for access to care. Many plans operate 24-hour nurse advice lines.

	Fee-For-Service	Primary Care Case Management[a]	Risk-Based Managed Care
Provider Participation Requirements[75,76]	Any willing provider licensed by the state who agrees to accept Medicaid rates as payment in full can participate.	PCCM programs may be required to meet additional state requirements and agree to certain service policies.	Federal regulations require states to detail network adequacy standards for RBMC plans. Plans must ensure that their network contains sufficient numbers of providers to ensure adequate access to Medicaid services under contract. Plans generally must credential providers before accepting them into the network. Plans may be permitted to selectively contract based on quality.
Beneficiary Protections[77]	Beneficiaries have the right to a state hearing for grievances and appeals.	Beneficiaries have the right to a state hearing for grievances and appeals.	Federal regulations establish clear roles and responsibilities for states and plans with regard to beneficiary protections.[b]
Performance Monitoring and Quality Oversight[78]	Limited performance monitoring and quality oversight. Few states use HEDIS or other measure sets to measure FFS performance.	Several states use HEDIS or other measures sets to measure PCCM performance.	State contracts may include financial withholds for plans for specific quality measures. Some states conduct auto-assignment to plans based on quality parameters. A small number of states publicly report quality metrics for plans or publish plan ratings. Plans are required to perform consumer satisfaction surveys.

[a] States may contract with a PCCM entity to provide additional services, as defined in the Medicaid Managed Care proposed rule (section §438.2).
[b] Please refer to the discussion of the Medicaid Managed Care regulatory environment for additional detail.

Care coordination is directly linked to quality of care. Poor coordination of care can result in prescribing errors (multiple providers prescribing medications that may be contraindicated if taken together), duplicative diagnostic tests, preventable hospitalizations, and high or unnecessary emergency room use, all of which lead to poor quality of care and poor health outcomes. The ideal care coordination model has a lead provider, generally the primary care provider (PCP) in a PCCM model or the case manager and/or PCP in RBMC, that evaluates the beneficiary's needs and preferences for care, develops a care plan, and brings together the resources and providers necessary to achieve the goals of the care plan. Key features of the care coordination model are the provision of assistance to navigate the myriad providers and services needed by the beneficiary as well as an ability to assess and treat the needs of an individual in a more holistic way. Care coordination is enhanced by information technology such as electronic health records that can transmit timely information about an individual to other providers on the individual's "team".[79]

Care Coordination in PCCM: Under PCCM, beneficiaries are connected to PCPs who are paid a per member per month (PMPM) fee to provide limited care coordination activities, such as authorization for ER and specialist visits. Care coordination in PCCM programs is somewhat limited because the services provided are generally limited to what can be performed in the PCP's office; however PCCM programs in some states have enhanced the coordination role through contracts with entities to support PCP care management, payment enhancements, a greater orientation to complex care coordination and associated quality measurement, and the adoption of some of the elements of a medical home.[80] While providers may have some portion of their compensation tied to performance incentives, the payment for care is still FFS, with the financial incentive to coordinate care not as strong as within a health plan that assumes full risk.

- Illinois established a statewide PCCM program in 2006 called "Illinois Health Connect" for non-dually eligible Medicaid beneficiaries. Providers are paid a PMPM for care coordination and additional bonuses for achieving specific quality targets. Eligibility for bonus payments is determined by meeting or exceeding HEDIS benchmarks. An evaluation of the program revealed quality improvements for participating beneficiaries, a 30.3% decrease in inpatient costs, a 15.6% decrease in hospital bed days, and a 5% decline in emergency room visits in Illinois Health Connect relative to projected outcomes.[81]

Care Coordination in RBMC: In comprehensive RBMC, Medicaid plans are required by their state contracts to provide care coordination and/or case management to patients. Furthermore, plans are incentivized to provide care coordination since they are at financial risk for the cost of health care utilization and better coordination can lead to better outcomes and a more coordinated and efficient use of resources. The care coordination level and type of care coordination plans provide vary by state and by plan. In addition, some plans have developed their own special care coordination programs geared toward certain beneficiary groups such as pregnant women or complex patients with multiple chronic conditions, without being specifically required to do so by their contracted states.

Continuity of Care

Medicaid beneficiaries experience continuity of care issues as they move in and out of eligibility and as provider networks change. Continuity of care for Medicaid beneficiaries is a critical issue and one of the most pervasive challenges in the Medicaid program, especially in recent years with the growth of RBMC and expansion of managed care to new populations. The risk of a disruption in care is especially problematic for individuals with chronic conditions and/or disabilities. Often those provider relationships are with specialty providers and are long-standing.

Medicaid beneficiaries transitioning between FFS and RBMC or PCCM either voluntarily or due to mandatory enrollment or changes in eligibility, could lose access to their providers if the provider does not participate in Medicaid PCCM or is not contracted with a RBMC plan's network, which can result in potential interruptions to current treatment plans.[82]

Continuity of Care in FFS and PCCM: Traditionally, the FFS system offers few guarantees for continuity of care for those gaining Medicaid eligibility. If a provider is unwilling to participate in the Medicaid program, the beneficiary must change providers, which can result in gaps in care. As PCCM is an extension of the FFS system, the same continuity of care challenges may apply.

Continuity of Care in RBMC: State Medicaid programs often require RBMC plans to allow new members access to out-of-network providers for a specified period of time, often 90 to 180 days, to allow for a current course of treatment to be completed or to afford the plan and beneficiary time to develop a transition plan and identify a new provider. These policies are designed to minimize disruption for the beneficiary during these transitions.[83]

The Future of Continuity of Care Protections: The proposed rule for Medicaid managed care released by CMS in May 2015 strengthens the continuity of care provisions for all Medicaid beneficiaries across delivery systems, including Medicaid RBMC plans and PCCM entities, thus leveling the field for these two models of managed care relative to their historical requirements.[84] The proposed regulations require states to ensure timely services are provided to beneficiaries who are dis-enrolled when state contracts with RBMCs or PCCM entities are terminated or for any other disenrollment reason other than loss of eligibility. Furthermore, the state must develop a transition of care policy to ensure continuity of access to services during transitions among FFS, RBMC, or PCCM programs in order to avoid hospitalization or institutionalization.

Under the proposed rule, the state's transition of care policy would be required to include: 1) consistent service access and allowance for retaining a beneficiary's current provider for a period of time if they are not in the network; 2) referral of beneficiaries to appropriate in-network service providers; 3) the state (for FFS or PCCM) or the RBMC that previously served the beneficiary complies with requests for historical utilization data; and 4) the new provider or plan can obtain copies of the beneficiary's medical records, as appropriate. In addition, the state would contractually require its RBMCs to implement compliant transition of care policies and implement a monitoring system for all managed care programs to ensure compliance.[85]

Assurance of Provider Access

Encouraging Medicaid provider participation, particularly for certain specialties, is often challenging. Provider access can be measured by the availability of providers within a certain geographic distance from a beneficiary (e.g., within a specified mile radius) or the travel time between the provider and beneficiary. Additionally, provider access can be measured as a ratio of providers to beneficiaries (e.g., one PCP per 500 beneficiaries) or in the length of time it takes to get an appointment with a provider.[86]

Provider Access in FFS and PCCM: As is discussed later in the section on the provider perspective, state policy on Medicaid reimbursement is perhaps the greatest barrier to provider participation in Medicaid, regardless of the type of delivery system. In FFS Medicaid and PCCM programs, providers are paid following the Medicaid fee schedule, which pays a standard fee for services provided. If providers will not accept the fee schedule, the state will face challenges to have a sufficient supply of providers to meet the needs of the eligible population. PCCM offers an advantage over FFS in that PCPs are offered an enhancement to the fee schedule in the form of a PMPM payment to provide care coordination, which supplements their income. The literature is mixed on whether this payment enhancement results

in better provider access in PCCM relative to FFS.[87] The state has few policy levers aside from its reimbursement policy to attract a sufficient provider network within the FFS system.

Provider Access in RBMC: Unlike with FFS and PCCM, the federal and state governments have the ability to define provider network standards and enforce those requirements with RBMC plans to ensure provider access.[88] Federal regulation requires states to have a written strategy for assessing and improving the quality of care offered within RBMC, including standards for access to care. States have a fair amount of discretion in how they define network adequacy.[89] A recent review of state standards for provider access in RBMC revealed that 32 states have specific standards limiting time or distance a beneficiary must travel to see a provider; 31 states require that a beneficiary be able to get an appointment within a set timeframe; and 20 states establish provider/enrollee ratios. A small number of states have also established other network access standards such as in-office wait times, access to multilingual care, and 24-hour telephone access.[90] RBMC plans must also demonstrate they have the capacity to serve expected enrollment and maintain the necessary amount, geographic distribution, and mix of providers and services. In addition, if the provider network is unable to provide contracted necessary services to a particular beneficiary using its existing network, the RBMC plan must cover these services out of network for as long as the provider network is unable to provide them in-network.

In the proposed Medicaid Managed Care Rule, CMS further refines the expectations for states and RBMC plans regarding network adequacy.[91] In particular, the proposed rule would require states to establish time and distance standards for selected providers,[92] which may vary by urban versus rural geographic regions. CMS further specifies a set of factors states should consider when developing their network adequacy standards including: 1) anticipated Medicaid enrollment; 2) expected utilization of services; 3) taking into account the characteristics and health needs of the covered populations; 4) number and types of providers needed to provide covered services; 5) the number of providers that are not accepting new Medicaid beneficiaries; and 6) the geographic location and accessibility of the providers and beneficiaries. New to the proposed rule is the requirement for states to establish time and distance standards specifically for MLTSS providers. The proposed rule also has a provision that would allow a beneficiary to disenroll from a MLTSS plan and either change plans or return to FFS if access to services is impacted by providers leaving a network.[93]

Medicaid RBMC: The Provider Perspective

Review of the provider experience within a FFS delivery system compared to a system where states contract with RBMC plans yields several potential themes, including opportunities to improve provider participation, development of provider incentives to improve quality of care, “value added” benefits for providers who participate in Medicaid RBMC, and issues around the provider transition from FFS to RBMC. Each of these topics will be addressed, in turn, below.

Provider Participation

Beneficiary access to providers is one the biggest challenges that states face and access is directly connected to the way states fund their Medicaid programs – this is a universal issue regardless of the delivery system in which a provider serves. Provider reimbursement is the most critical factor associated with the decision to participate in Medicaid.[94] In FFS delivery systems, providers are paid the rates defined by the state’s Medicaid fee schedule. States have significant flexibility for establishing Medicaid fee schedules and there is substantial variability across states in the rates they pay providers in order to attract the type of provider network they desire. For Medicaid RBMC, federal regulation requires that Medicaid RBMC plans are paid by the state based on an actuarially sound rate, but states determine the actual reimbursement policy for their own program. In many states, the RBMC plans are able to

determine reimbursement policy for their provider networks, following state guidelines.[95] Therefore, RBMC plans have the flexibility to negotiate rates for providers, which means they could be higher than the FFS fee schedule; however, the rates could also be lower. The flexibility to establish provider rates is important to attracting certain providers that may be scarce in a particular region.

In addition, stigma associated with Medicaid is another factor that may impact provider willingness to participate, with providers concerned about perception of other providers if they choose to join the program.[96] Providers who might be reluctant to associate directly with FFS Medicaid may be more willing to participate in a network for a RBMC, which ultimately increases access for Medicaid beneficiaries to a broader set of Medicaid providers.

Provider Incentives and Quality Improvement

Performance incentives through value-based payment methodologies are another potential opportunity for RBMC plans to encourage provider participation in their networks and improve quality of care to Medicaid beneficiaries; this may be an attractive option for some providers such as large physician groups or hospitals that may create flexibility for care delivery and provide opportunities to achieve additional financial benefits from providing high quality care. The ACA includes several provisions to encourage value based purchasing, most targeted to the Medicare program. However, states are now increasingly pursuing similar value based purchasing initiatives themselves, requiring RBMC plans to increase their use with their provider network, and/or participate in multi-payer processes aligning incentives for providers across the states.

RBMC plans are experimenting with different approaches to encourage better quality. They have the infrastructure and expertise to offer an array of value-based options to providers, allowing collaboration between providers and plans to determine readiness for participating in different value-based arrangements with variable risk levels. Examples may include pay for performance (P4P) programs that generally provide a bonus to providers if they meet or exceed selected performance or quality targets.[97] Similarly, P4P programs may also provide financial penalties if a provider does not achieve performance or quality targets. Or, in California and in some other states, a common model of RBMC plans is to delegate risk to providers, paying them a PMPM for their services rather than paying them on a negotiated FFS basis.

One of the challenges that arises from the varied approaches to quality improvement and value based purchasing in RBMC is that the same provider may be subject to multiple and different types of incentives and reporting requirements from multiple plans. This lack of consistency across plans can act as a disincentive for providers to participate.[98] States are increasingly recognizing the challenges faced by providers and in pursuit of better care for beneficiaries, are developing efforts that streamline and standardize provider incentives across delivery system approaches. For example, Medicaid and commercial purchasers and plans in Minnesota are adopting common program goals and performance measures, combining incentive dollars for provider payment.[99]

"Value Added" Benefits for Providers

In order to meet their contractual obligations regarding network adequacy, RBMC plans may develop different strategies to recruit and retain providers. RBMC plans also have implemented a variety of initiatives to improve provider retention and experience. Numerous best practices have been identified that support provider retention including:[100]

- **Reducing administrative burdens:** Generally, health plans set their own policies around provider credentialing requirements that may differ from plan to plan, creating a barrier to provider participation. Georgia is an example of a state that has initiated a centralized

credentialing process for providers to standardize the process across FFS and RBMC; Medicaid plans in New York City all use a centralized uniform credentialing system; and New Jersey is in the process of developing its own standardized approach as well. In states where there is no centralized credentialing process, many plans have established electronic submission processes, reduced the information requirements for credentialing, and extended the timeframe before re-credentialing is necessary.

- **Plan communications, training, outreach:** Plans often have provider relations representatives that can assist providers in local communities as they need support with patient outreach or receiving training to enhance their ability to meet the needs of their Medicaid beneficiaries. Additional training opportunities may include RBMC plans offering local Continuing Medical Education (CME) to providers for free. This benefits both the provider who must complete a certain number of CMEs to maintain a license and the plan who wants to ensure its provider network is knowledgeable about clinical and system innovations.
- **Payment practices:** States may not dictate reimbursement policy entirely for plans but they may establish a floor for reimbursement in plan contracts to ensure that providers receive at least a minimum standard payment. States require plans to pay provider claims promptly and while there are federal standards for payment of claims in FFS,[101] states can also require plans to pay claims even sooner than what is required in federal regulation.
- **Authorization processes:** The authorization process can be a source of frustration and delay for both providers and their patients. Some plans have eliminated prior authorizations for certain types of in-network services or made available utilization management staff at the plan available after hours to support provider practices.
- **RBMC plan and provider partnerships to improve care outcomes:** There are many examples across states of partnerships between plans and providers in which community health workers (CHWs), practice coaches, and data tools can help providers better manage their patient panel. As an example, in New Mexico, an innovative partnership between the University of New Mexico's Health Sciences Center and Medicaid RBMC plans in the state has formed to create the CHW model. CHWs serve as patient navigators for the highest-risk beneficiaries, particularly in rural areas of the state. Thus far, this initiative has resulted in better use of primary care and improved quality metrics for the high-needs population, with a significant return on investment.[102] Not only does this program result in positive outcomes for the beneficiary but providers benefit also by beneficiaries coming in to get care in a timely fashion.

Provider Challenges

There are also potential challenges for providers related to use of RBMC plans for Medicaid beneficiaries, which may vary from state to state depending on state requirements or processes. A recent report on provider experiences with RBMC plans in four communities with high concentrations of Medicaid beneficiaries identified several challenges to providers, including inadequate plan support for care management, limitations due to service carve-outs, and the impact of volatility in participation of RBMCs due to state procurement decisions or RBMC voluntary withdrawals. These issues are summarized here:[103]

- Providers identified the need for more support from plans with more effective care management that involved face-to-face engagement and less telephonic case management, using additional data beyond claims to monitor progress and need for services.
- Enhanced care transitions support was also identified as a need. Providers indicated that although RBMC plans may send reports to providers when their patients are discharged from hospitals in order to support discharge management, the data are not always timely or comprehensive, and additional discharge management support by plans is not always provided.

- State decisions around benefit carve-outs may also lead to provider challenges, where providers must coordinate with the plan for some services and other organizations for other services for the same patients; this was particularly problematic in the context of physical and behavioral health integration efforts.
- In addition, changes in plan options as a result of plan withdrawals or new procurements can also be disruptive to providers who may need to manage patient transitions due to the changes and must develop relationships and processes with new RBMC plans.

There are also specific challenges to providers who serve populations newly added to RBMC responsibility or in states with new RBMC implementation. Providers who have only worked in traditional FFS often find it challenging to transition from contracting with and billing one entity (the state) to contracting with potentially many RBMC plans. The burden that is placed on providers is minimized in states that limit plan contracts (e.g., Tennessee contracts with three plans statewide) relative to states that allow a larger number of plan contracts (e.g., New York where the state allows any plan that meets their requirements to participate for most of their programs, resulting in 6-8 plans per region). The burden of the transition may be especially felt by non-traditional providers such as HCBS providers in MLTSS programs. Many traditional medical providers who may be new to Medicaid RBMC may have experience with managed care through commercial or Medicare contracts. However, for HCBS providers, RBMC is an entirely new environment for them and many find they are challenged to negotiate contracts, price their services, and remain in compliance with reporting requirements when the information technology infrastructure may be lacking.

Some of these challenges may be addressed by state decisions that require RBMC plans to contract with certain providers for a limited period of time. For example, states may require Medicaid RBMC plans to contract with all nursing facilities in their market area to ensure residents do not need to be relocated. Some states have required that plans contract with Area Agencies on Aging (AAAs) to be part of the provider network in MLTSS. In Massachusetts, plans participating in the Senior Care Options program, the integrated Medicare/Medicaid RBMC program for dual eligibles age 65 and older, are required to contract with Aging Services Access Points (most of which are AAAs) to provide HCBS service coordination for the plans' enrollees. In some states, RBMC plans may be required to contract with any willing provider of a certain type but for a limited period of time, after which the plan can selectively choose providers to include in their network as long as they meet specified criteria for participation. These types of policies allow providers time to work with RBMC plans to establish relationships and processes and also demonstrate their value.

Medicaid RBMC: The State Perspective

State risk-based Medicaid managed care programs are a major part of the health care delivery system for Medicaid beneficiaries and as noted earlier, their role will continue to expand in the coming years. In the sections below, we explore state motivations to shift the Medicaid delivery system to RBMC, the implications of the shift to Medicaid RBMC on state roles, and the responsibilities of states in program development and implementation. Appendix C provides a discussion of how states and CMS engage around delivery system reform.

State Goals in Shifting to RBMC

States have pursued Medicaid RBMC arrangements to achieve several important goals for the state and Medicaid-eligible populations including improving care coordination and quality of care, ensuring provider access for enrollees, improving program accountability, and making state budgets more predictable and potentially achieving administrative savings.[104] A review of state-issued press releases,

fact sheets, and other materials describing recent risk-based Medicaid managed care implementations/expansions illuminates the reasons that states pursue RBMC:

- The State of Iowa issued a Request for Proposals (RFP) in February 2015 emphasizing the state's interest to "modernize" Medicaid through RBMC. The key goals of the Medicaid Modernization program are: 1) improving quality and access, 2) achieving greater accountability for outcomes, and 3) creating a more predictable and sustainable Medicaid budget.[105]
- As Kansas was preparing to implement KanCare, it identified as a key challenge to the state the annual growth rate for Medicaid costs. Its vision for KanCare was: "To serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility".[106]
- When Tennessee decided to implement its managed LTSS program in 2010, the state's explicit goals for pursuing the program were: "1) Better experience through coordination of services and integration with primary, acute, and behavioral health; 2) Better outcomes for health, functioning and quality of life; 3) Flexibility through the ability to tailor unique services/supports; 4) Predictable, managed costs through budget stability and trend management; 5) Alignment of financial incentives through paying for quality and value; 6) Expanded access to HCBS with the potential to provide services to more people and for increased flexibility in service provision; and 7) System balancing by increasing the use of community services and decreasing inappropriate use of institutional services".[107]
- As part of New York's overarching Medicaid Redesign initiative, New York announced that implementation of MLTSS was part of "Governor Andrew Cuomo's program to redesign New York's Medicaid system in ways that will decrease costs while improving the quality of care provided."[108] Similarly, a July 2015 announcement about upcoming programmatic changes that will affect the delivery of Behavioral Health services to adults when the services are transitioned to Medicaid Managed Care, indicates that the initiative is "…intended to improve clinical and recovery outcomes for individuals with Serious Mental Illness (SMI) and Substance Use Disorders (SUD); reduce the growth in costs through a reduction in unnecessary emergency and inpatient care; and increase network capacity to deliver community-based recovery-oriented services and supports".[109]
- Kentucky implemented risk-based Medicaid managed care in 2011, primarily motivated by the need to close a $142.4 million shortfall in the biennial Medicaid budget. Two years after a challenging implementation, Governor Beshear reflected on why he opted to implement managed care: "…A focused managed care program provides better health outcomes for patients, because it emphasizes wellness, disease prevention and consistent health management, instead of high-cost care for conditions that have been allowed to worsen without treatment. Managed care is also a better use of taxpayer dollars. In both health outcomes and financial savings, Medicaid managed care is succeeding in Kentucky".[110]

As indicated in the announcements cited above, a consistent element of states' expectations for implementation of risk-based managed care is the opportunity to control state health care spending. Medicaid is the largest state expense in most states and the costs of delivering care in the FFS system have grown over time, with few tools available to states to control growth. Primary tools used by states to control costs historically have been provider rate setting and premium rate negotiations with health plans. These tools may offer savings to state budgets when programs are first implemented, but there is mixed evidence documenting continued savings over time. Downward pressure on rates based on state rate decreases to RBMC plans can impact provider network development and ultimately beneficiary

access to care. In addition, although RBMC plans are paid a capitated rate for each member enrolled, many providers are still paid on a FFS basis by the RBMC plan.

This is not to say that savings are not possible with RBMC implementation. The evidence that managed care can save states money is mixed,[111] but with some emerging studies showing state savings can be achieved. The Pennsylvania HealthChoices program achieved a savings of $5.0 to $5.9 billion over the period 2000 to 2010 and was projected to save another $2.9 to $3.3 billion over the period 2011 to 2015 as compared to projected FFS expenditures over the same time period.[112] Early evaluation of Medicaid expansion efforts afforded by the ACA have revealed significant savings in several states, including Arkansas, Kentucky, Michigan, New Mexico, Washington, and West Virginia who enrolled their expansion populations in risk-based managed care. In Arkansas and Kentucky specifically, analyses suggest that savings and revenue gains attributed to Medicaid expansion will continue to be achieved at least through FY 2021.[113] A recent report examining state savings to the Medicaid program estimated that RBMC programs produced $2.4 billion in savings nationally for the year 2011; in part due to the ACA and other efforts to increase the population covered by Medicaid RBMC plans. The authors of that report estimate that states will see a combined $6.4 billion in savings for 2016.[114]

The challenge to states in establishing RBMC is in the need to be patient to allow the transition to RBMC to occur and make necessary modifications along the way. Greater budget predictability and even cost savings may be realized, but the timeline to seeing these outcomes can be very long. Because of its 23-year history in MMC, its immediate adoption of a RBMC model, and its unique program design, Arizona is often studied for its successes and lessons learned. One study compared Arizona Medicaid costs to other states that were similar to Arizona in their Medicaid requirements. It estimated that from FY 1983 to FY 1993, Arizona saw savings of $197 million and the average annual cost increase for its acute care program was smaller than in the traditional Medicaid programs (9.1% vs 10.3%, respectively).[115]

Oversight and Quality Monitoring

Establishing contracts with RBMC plans will shift the roles of state staff from administering a FFS system to the responsibility for implementing managed care contracts and focusing on contract oversight and monitoring. According to Tennessee, “it takes a village” with significant state Medicaid program organization and resources to “manage” managed care.[116] Staff skill sets necessarily will need to evolve to meet the changing state roles.

State Medicaid RBMC programs have historically been more highly regulated than FFS delivery systems with state requirements to monitor plan operations in specific areas, including beneficiary enrollment and disenrollment as well as appeals and grievances. With the May 2015 Medicaid Managed Care proposed rule, CMS further expands the responsibilities of states to monitor Medicaid RBMC plans to include the following:

- Claims management systems,
- Medical Loss Ratio (MLR) reporting,
- Encounter data reporting,
- Enrollment/marketing materials,
- Program integrity,
- Provider network management,
- Delivery of Long-Term Services and Supports (LTSS), if applicable, and
- Complaint and appeal logs.[117]

To ensure plans meet their contractual obligations, states may develop corrective action plans for RBMC plans with identified deficiencies; if those deficiencies are not corrected according to the requirements laid out by the state and in state/federal law, health plans may be subject to sanctions, including

financial penalties. To further the transparency of state monitoring activities, the proposed rule would also require an annual report to CMS assessing the RBMC program with the inclusion of information on financial performance, encounter data reporting, enrollment, performance on quality measures, and sanctions.

States would also be responsible for expanding their quality strategy to all delivery systems including FFS and PCCM under the proposed rule. Longstanding federal regulations dictate that states contract with external quality review organizations (EQROs) to monitor health plans. As part of the proposed rule, CMS would require EQROs to play a larger role in supporting states to monitor health plans, including assessing plans on their compliance with network adequacy requirements in addition to their current responsibilities.[118] Further, the proposed rule would require that states publicly release the findings of the EQRO to facilitate transparency in each state's program.

Increasingly, states are making quality metrics and other information about Medicaid RBMC plans publicly available to support beneficiaries making informed choices about which plan will best suit their needs. Many states have adopted plan rating systems and publicly report this information on the Internet to educate Medicaid beneficiaries and increase transparency in quality of care in the Medicaid delivery system.[119] The proposed rule includes a provision to establish a quality-rating system for Medicaid RBMC plans that would be implemented by states. This and other quality-related provisions in the proposed rule are designed to further the goal of transparency in Medicaid RBMC, to support stakeholder engagement, and to improve consumer engagement in his/her care. These new state quality rating requirements only apply to states that contract with comprehensive RBMC plans, Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plan (PAHPs), and do not apply to state PCCM programs.

If implemented as proposed, state monitoring requirements from the rule will be extensive and will require significant internal and external resources. States can use various approaches to monitor plan performance, including reviews of reports and data, site visits to review processes, and conducting audits. States may also need to engage multiple contractors to support their programs and meet federal obligations, including actuary, EQRO, member services call center, medical appeals vendor, MMIS vendor, third party liability vendor, and a vendor to conduct member satisfaction surveys.

State Responsibilities in Program Development and Implementation

As states shift their FFS Medicaid system toward RBMC, their responsibility for engaging stakeholders and integrating them into the development and implementation process increases. Federal regulations require the establishment of a Medical Care Advisory Committee in each state to advise the state Medicaid director on proposed rules that involve Medicaid policy or affect Medicaid-funded programs. Beyond this traditional role, stakeholder engagement is increasingly a critical feature of delivery system reform from program development stages, through implementation, and beyond to program monitoring. Some of the common strategies used by states to engage stakeholders, including consumers, are public meetings, focus groups, and advisory and quality committees.[120] Through stakeholder engagement, states and CMS can ensure that the program meets the needs and goals of the community. Further, stakeholders can be enlisted to serve in the "watchdog" role of early identification of issues that need correction.

RBMC and FFS: Medicaid Performance in Comparison

In this section, we present published data on the quality and performance of the Medicaid program, comparing metrics for FFS, PCCM, and RBMC, where available. Quality and performance measurement

helps to strengthen accountability and support performance improvement. The dominant measurement sets used to evaluate quality of care in Medicaid are the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) developed by the Agency for Health Research and Quality (AHRQ). The ACA required the US Department of Health and Human Services to establish a quality measurement program to standardize the way health care quality is measured across states. A product of this requirement was the identification of a core set of quality measures for adult Medicaid beneficiaries. States voluntarily participate in reporting these measures back to CMS, and the first report summarizing the status of measurement and reporting efforts was recently released, although no actual performance data were reported.[121]

This section is not designed to be exhaustive but designed to highlight trends in performance by delivery system design. One of the key challenges in a discussion such as this is the limited availability of data in comparative form. There are numerous studies that evaluate Medicaid RBMC and PCCM, but few put these two types of delivery systems head to head. In addition, most of the existing literature is based on older datasets, limiting comparability to the existing RBMC environment, which has seen enormous change in the last decade as previously noted. Many of the new initiatives established by the ACA are still in their infancy and comprehensive evaluations are not yet available. Further, as states increasingly shift populations into RBMC, the ability to conduct comparative analyses will become even more limited.

Access

A 2012 research synthesis published by the Robert Wood Johnson Foundation[122] revealed little evidence that managed care leads to improvements in access to care. Of the 24 studies reviewed, only four examined RBMC and FFS in the same study but in each case, with additional comparisons between FFS and PCCM (no studies were identified that compared RBMC and PCCM head to head). In one national study, urban-residing disabled Medicaid beneficiaries in RBMC were more likely to have a usual source of preventive care relative to FFS but there was no evidence that PCCM improved access to care relative to FFS.[123] Another study examining access to care for children enrolled in Medicaid revealed that RBMC resulted in fewer emergency room visits and hospitalizations but also delays in access to care and lower overall satisfaction relative to FFS. In this same study, children enrolled in PCCM programs had higher rates of unmet needs relative to FFS.[124] A study by Garrett et al. revealed that enrollment of children in PCCM programs had a minimal, but positive, impact on children's usual source of care relative to FFS and enrollment in RBMC plans decreased children's use of emergency rooms and expanded access to specialists relative to FFS.[125] In aggregating numerous studies, the report concludes that Medicaid RBMC can enhance access, but the results are mixed and state-specific.[126] Among other findings, the authors suggest that:

- The mixed effect on access to different types of services (e.g., outpatient vs inpatient care) is in fact derived from the program design, since managed care is intended to enhance access to primary care while reducing hospital utilization.
- Different models and payment methodologies yield different results.
- Narrow provider networks in Medicaid RBMC plans sometimes result in limited patient access to specialists, but at the same time, these plans may offer more robust specialist access than found in FFS Medicaid.

Access measures, where available, tell a mixed story about the performance of Medicaid RBMC relative to FFS Medicaid. In a study from New York State, RBMCs performed better on access to prenatal care in the first trimester as well as measures of well-child and preventive health visits for children age 3 to 6

and for adolescent well care and preventive care visits relative to FFS, but performed worse on a measure of well-child and preventive health visits for infants.[127]

Quality and Quality Improvement

Historically, the federal government played a limited role in measuring quality in the Medicaid program. The Medicaid managed care regulations promulgated in 2002 established the federal expectations for states to establish quality standards for RBMC plans and to monitor compliance with those standards. In 2003, CMS issued a final rule requiring external quality review of Medicaid RBMC programs, which involves the validation of plan performance measures. This review may be conducted by the state or by a separate External Quality Review Organization (EQRO) however, because the EQROs in each state may use different measures, there is no nationally standardized information about the quality of care in Medicaid health plans.**[128]** Further, not all states use the results of the EQRO reviews in the same way; some use the reviews to share information across participating plans as well as share best practices; some states use the results to make changes to their contractual relationships with plans or set new performance standards.[129]

As the footprint of Medicaid RBMC expands, so too do new quality improvement (QI) initiatives in the program. In FY 2014-2015, 34 states implemented new QI initiatives, including use of new quality metrics, the addition or strengthening of pay-for-performance (P4P), and/or public reporting of quality metrics.[130] However, the existing literature on the large-scale impact of Medicaid managed care on quality is thin. A small number of states collects HEDIS data and/or other measures on the Medicaid population in FFS Medicaid that can allow comparison with RBMC.[131] In the published literature, few studies use HEDIS data to compare quality of care provided in Medicaid. In the research synthesis conducted by the Robert Wood Johnson Foundation, the authors identified 14 studies that evaluated quality in RBMC but only four of them compared RBMC plans to FFS; none found significant evidence of better quality in RBMC.[132]

Despite a lack of widespread evidence, there are specific state studies that evaluate quality of care and outcomes in RBMC relative to FFS, with mixed results:

- A California study found that from 1994 to 2002, CalWORKS beneficiaries' annual preventable hospitalization rates were more than one-third lower in RBMC than in FFS Medicaid. Disabled beneficiaries in RBMC had about a 25% lower rate.[133] A different California study from 1993 to 2001 found that RBMC enrollment had no effect on infant mortality or the prevalence of low birthweight babies, compared with FFS Medicaid.[134]
- A Virginia study of pregnant women enrolled in RBMC found that low birthweight rates were most favorable in RBMC compared to FFS, PCCM and the national benchmark.[135]
- A recent analysis of quality of care in Missouri comparing FFS and RBMC Medicaid found that the population enrolled in RBMC performed better on one performance measure (breast cancer screening) but worse on six others as compared to the FFS population.[136]
- A study of Minnesota RBMC plans in 1998 concluded that moving from FFS to RBMC resulted in only a minimal impact on quality of care.[137]

Much of the research described above is dated, reflecting delays in public access to relevant data, challenges in identifying data sources that allow comparisons of RBMC and FFS populations using similar metrics, and other issues. As we move forward, new challenges will arise in conducting comparative analyses of populations in RBMC and FFS delivery systems given the rapid growth in adoption of RBMC for many, if not most, sub-populations eligible for Medicaid. As a result, fewer populations will remain in FFS Medicaid that are comparable to those enrolled in RBMC.

In looking at states' standards for quality measurement and reporting, a 2004 study suggests that state Medicaid agencies put more emphasis on monitoring quality for RBMCs than for PCCM programs. States were more likely to collect performance data on Medicaid RBMC programs than PCCM programs; PCCM programs often did not report performance results for the public or providers; and PCCM programs tended to look more at utilization over quality.[138] Additionally, RBMC plans must implement performance improvement projects that focus on initiatives such as improving birth outcomes or increasing coordination between behavioral health and medical care.[139]

Member Satisfaction

Given the differences from state to state in the way managed care programs are constructed, and the variation in how member satisfaction is measured and reported in each state, it is difficult to draw generalizable conclusions regarding member satisfaction for beneficiaries in Medicaid RBMC plans compared to beneficiaries in FFS Medicaid. From the member perspective, there are characteristics of Medicaid RBMC that may seem less favorable than FFS – such as utilization management and prior authorization requirements – but there are also stronger beneficiary protections in Medicaid RBMC and frequently there are value-added benefits and enhanced care coordination services that some members prefer.

States and plans monitor member satisfaction and other access and quality measures as part of the oversight of their RBMC programs. HEDIS and CAHPS data are used to gauge satisfaction and evaluate members' experiences with health care.[140] These surveys measure members' satisfaction with the plan as well as satisfaction with their health care providers in the plan's network.

A 1996 study that evaluated member satisfaction in five New York City Medicaid RBMC plans found that, compared with FFS Medicaid, managed care enrollees had significantly greater odds of being "extremely satisfied" although there were fewer statistically significant differences between RBMC and FFS when comparing the proportion of the population that was "extremely dissatisfied" on various measures.[141] Similarly, a 2012 Consumer Satisfaction Report of Utah RBMC plans indicates that a slightly larger percentage of plan members gave an overall high rating of their plan (83.6% - 86.0%) versus FFS (83.4%).[142] Under the Medicaid Managed Care proposed rule, Medicaid plans would have even more of an incentive to strengthen their member satisfaction efforts, as they would be scored on a five-star quality rating system (similar to the Medicare Advantage star ratings) that beneficiaries would be able use to compare plans.[143]

Lessons Learned from Medicaid Risk-Based Managed Care

Although every state Medicaid program has its own unique attributes because of the populations covered, their political environment, geography, and other factors, there is still much to learn from the states who have implemented Medicaid RBMC programs previously, including how programs can and should continuously improve over time and how states and RBMC plans can work together to improve the success of the program. In this final section of this paper, we review some of the themes that have surfaced from past evaluations of Medicaid RBMC implementation. It is important to note that most state RBMC programs are still in their infancy and it will take more time to fully understand whether the changes to the delivery system had an impact on state goals.

The state programs that are more mature offer opportunities for newer states to learn from their experiences, so their efforts may be more likely to have success "out of the gate." Tennessee, one of the older RBMC state programs in the country, serves as an exemplar of how a program evolves over time and how state decisions and approaches drive the quality of the program. In 1994, Tennessee

established "TennCare" as part of a newly restructured and expanded Medicaid program. The program was built on the assumption that cost-savings from implementing managed care would pay for the expanded coverage. These ultimately unrealistic assumptions led to the program's rough start and substantial overhaul. The program has now achieved stability and high levels of satisfaction with stakeholders, including the state, beneficiaries, and providers.[144] An overview of key elements of its program design evolution is provided in Table 4 below.

Table 4. The Evolution of the TennCare Program

	Program Year		
Key Program Elements	**1994**	**2006**	**2013**
# of Plans, Service Areas, Level of Risk, Enrollment	▪ 12 plans, 12 community service areas, only 2 statewide plans ▪ Risk Model: Full risk ▪ Membership: 1.1 million	▪ 7 plans – all HMOs ▪ Risk Model – ASOs (no risk) and RFPs were made for at-risk plans in 1 of the 3 regions. ▪ Membership: 1.2 million **Note:** State recognized expansion assumptions were not viable; cut coverage and some benefits.	▪ 3 plans – all HMOs ▪ Risk Model: Full risk ▪ Membership: 1.2 million ▪ Extended contracts to maintain stability through health reform planning. ▪ CHOICES program fully implemented in August of 2010
Benefits	▪ Physical ▪ Dental ▪ Pharmacy ▪ Routine Mental Health Services	▪ Physical	▪ Physical ▪ Behavioral Health ▪ LTSS (for elderly/ disabled)
Quality Monitoring Elements	▪ Basic contract requirements ▪ Contracted with EQRO ▪ Network monitoring: Geo-access and MCO self-report ▪ Data quality was poor (encounter data) ▪ Appeals managed by plans ▪ **Satisfaction Survey – 61%**	▪ 1st Medicaid agency in U.S. to require NCQA HMO accreditation ▪ Began annual HEDIS reporting ▪ EQRO focus on Tennessee specific concerns and annual on-site monitoring. ▪ Network monitoring: validated MCO reports and confirmation of time to appointment. ▪ **Satisfaction Survey – 87%**	▪ Plans rate above the national Medicaid average in many quality measures and continue to improve. ▪ New focus on CHOICES program quality. ▪ New requirements to use hybrid measures for HEDIS reporting where hybrid or administrative is acceptable to NCQA. ▪ **Satisfaction Survey – 95%**

Source: Gordon, 2013[145]

The following are key lessons and insights from Tennessee's experience as detailed by the state's Medicaid director:[146]

1. **State contracts should be detailed and reviewed and amended routinely**. Contracts with MCOs must be detailed, with carefully-defined requirements, and strong reporting/monitoring processes for contract compliance. As state priorities change or as performance levels are achieved, requirements should also change as part of continuous quality improvement.
2. **Incentives should be strong and take different forms**. Tennessee effectively implemented pay for performance incentives to target the states' priorities. In other states that may be simultaneously pursuing other delivery system reforms (e.g., health homes, PCMHs, bundled payments), the state should be aligning incentives at all different levels of the program to achieve state priorities.
3. **States should have clear authority to enforce sanctions and promote compliance**, with flexible tools that allow states to match the level of sanction to the gravity of the non-compliance. Having a variety of sanctions to choose from can be important for states that must demonstrate their authority and enforce compliance by applying appropriate sanctions when warranted.
4. **Medicaid RBMC is a partnership.** As the TennCare program evolved, the number of plans selected by the state decreased from 12 to three. Tennessee purposefully limited the number of plan contracts in part to establish a partnership with the selected plans. Fewer plans reduce complexity of program administration and allow the state and plans to identify and resolve issues in a collaborative fashion.
5. **Access to reliable data is critical**. States need to be able to perform timely performance monitoring, using encounter data or grievances and appeals reports. Strong data analytic resources to develop tailored dashboards can be critical for state-level monitoring.
6. **Performance measures should be evidence-based and standardized.** Use of these measures will allow tracking of trends over time and comparison to national benchmarks.
7. **Quality requirements should be clearly defined.** Requirements about external accreditation and reporting requirements should be laid out clearly so that the plans have clear expectations.
8. **Savings estimates must be realistic.** Tennessee's initial assumptions about savings were flawed, leading to the rocky foundation for the program.

In addition to the lessons from Tennessee, additional themes emerge from the literature to inform state considerations for RBMC implementation. These include considerations for planning and implementation, stakeholder engagement, procurement approaches, outreach and enrollment, and contract monitoring.

Planning and Implementation

States should thoughtfully plan RBMC implementations, allowing time to build state infrastructure, define state contracting requirements and priorities, and ensure plan readiness. Most states that pursued RBMC for their Medicaid programs started small – either in a small geographic region or with less complex beneficiary populations (e.g., children and families). Only two states (Arizona and Tennessee) pursued statewide and mandatory RBMC for Medicaid beneficiaries at the outset of their programs. Arizona's experience, described in other sections of this paper, is the longest running program of this kind, sustaining the same program structure since its inception in 1982.[147] In contrast, Tennessee's RBMC program (TennCare) went through a tumultuous time, as described above. Despite its bumpy past, the current TennCare program has been in place since 2009 and continues to remain stable. According to interviews with some state officials, in hindsight, they would have been better off to implement the program with a slower pace than they did.[148]

A phasing approach to implementation has been used effectively by some states. When Florida launched its Managed Long Term Care program in 2013, a mandatory program for Floridians with LTSS needs, they used a phased implementation approach, allowing learning from regions that went first and

making changes in later stages of implementation as mid-course corrections. In Florida's RBMC program, the terms and conditions include a "pause" provision that required problems arising from implementation in one region be resolved before implementation could continue in other regions.[149] In California, based on the experience of the Coordinated Care Initiative, which includes the state's Financial Alignment Demonstration, in the six counties already operational, CalOptima in Orange County (the final county to implement the demonstration) made the decision jointly with the state's Medicaid agency and CMS to delay enrollment of beneficiaries residing in nursing facilities to ensure that they received additional support during the enrollment process.[150]

It is also important for states to build in time to develop comprehensive contracts and allow for sufficient time to negotiate the contracts with plans, once the plans have been selected. Lengthy contracting processes and limited time for contract negotiations resulted in uncertainty about plan capacity to launch when the Florida Managed Long Term Care program went live as provider networks were not complete at the time that beneficiaries started the enrollment process. [151]

Stakeholder Engagement

A key element of thoughtful planning is the engagement of a broad range of stakeholders who can provide feedback and help shape the implementation of RBMC. This process can be lengthy, especially when RBMC is being extended to cover vulnerable populations such as older adults and people with disabilities.

California's Medicaid program (called Medi-Cal) engaged in large-scale enrollment of vulnerable populations in RBMC since 2011, following approval of its "Bridge to Reform" 1115 waiver. This included the transition of Medi-Cal-only seniors and people with disabilities (SPDs) into RBMC beginning in 2011, the transition of the Adult Day Health Care benefit into a RBMC benefit (now called Community-Based Adult Services) in 2012, and the implementation of the Coordinated Care Initiative (CCI) in seven counties: 1) mandatory enrollment of dual eligibles into RBMC, 2) implementation of MLTSS, and 3) implementation of Cal MediConnect (the state's Financial Alignment Demonstration) beginning in 2014. In addition to these initiatives, the state also expanded RBMC to 28 rural counties in 2013. A key lesson learned from the efforts to transition SPDs into RBMC was related to stakeholder engagement. The California Department of Health Care Services underestimated the amount of engagement that would be needed to support a smooth transition for SPDs, which led to confusion and great concern among beneficiaries and their advocates. As a result of this experience, the Department initiated an extensive and multi-faceted stakeholder engagement effort for the CCI that included community forums, webinars, an extensive media and communications plan, e-mail updates, and a dedicated website (www.calduals.org), which documented the progress of developing the policy and posted meetings and updates.[152] The website continues to be a resource, both of the historical efforts to develop the program as well as a venue for current updates including quarterly stakeholder meetings, enrollment statistics and other related information.[153]

As part of Arizona's lesson learned about their program, they highlight the need to consider all stakeholders in the engagement process, including the governor, legislature and their staffs along with beneficiaries, consumer advocates, and providers. Developing strong relationships with the governor and the legislature is important to ensure program needs are met and funding issues get resolved. Further, regularly briefing the media to discuss what the state is trying to accomplish is important to foster transparency and to get ahead of challenges and negative stories that might show up in the press.[154]

Procurement Approaches

There are lessons learned from states around the decision to pursue a competitive procurement that limits the number of plans selected to serve the covered population versus an "any willing plan" approach to contracting with RBMCs, where a state develops specific criteria for plans and any plan that demonstrates that they meet the criteria is allowed to participate. The decision has implications for beneficiary choice of health plans as well as ongoing program stability. Too few plans could lead to instability if one or more plans leave the market. However, too many plans can be unwieldy for effective state management and oversight, as well as overwhelming for beneficiaries when trying to choose the best plan option. A large number of plans competing for the same set of beneficiaries may also lead to plans enrolling an insufficient number of beneficiaries to be financially stable, causing them to drop out of the program. While there may still be plan choice even as the plan exits the market, this type of plan exit can be disruptive and create continuity of care challenges for the beneficiary and providers.

In the case of Oklahoma, its SoonerCare program was forced to shut down when the state canceled one of the plan contracts due to an excessive rate increase request. Because there had only been two plans selected in the market, the exit of one of the plans left beneficiaries without choice of plan and the program had to end.[155]

Table 5. Advantages and Disadvantages of Procurement Approaches

Contracting approach	Advantages	Disadvantages
Competitive procurement	▪ Ability to achieve better (lower) capitation rates, if rates are competitively bid ▪ Ability to control the number, quality, and geographic distribution of plans ▪ Requires innovation in plan proposals to be competitive including quality improvement, value added benefits, etc.	▪ Initially administratively burdensome to implement a competitive procurement ▪ May lead to more turnover in plans and instability for program enrollees if the number of plans is limited ▪ Depending on number of plans selected, could be a disincentive for provider participation as the management of multiple contracts by a provider practice can be burdensome
Any willing plan	▪ Not as administratively burdensome initially ▪ May result in more plans, with more beneficiary choices and back-up if plans drop out	▪ Little ability to control the number and geographic distribution of plans ▪ No guaranteed market share for health plans, which can create instability ▪ The level of beneficiary choices may be overwhelming ▪ Administratively burdensome for state to monitor ▪ Could be a disincentive for provider participation as the management of multiple contracts by a provider practice can be burdensome

Source: Howell et al.[156]

Tennessee provides an example of how this decision can evolve over time, as state priorities change and lessons are gained. During the initial implementation phase of the RBMC program in Tennessee, the

state used an "any willing plan" approach, resulting in 12 plans with no requirements around geographic participation. By its second procurement in 2003, the number of plans decreased to 9, then 6 by 2006, followed by a selective procurement in 2009 that selected three statewide plans. Tennessee also decided in 2013 to simply extend its contracts rather than conduct a re-procurement, given its satisfaction with the participating plans and to maintain stability. The current approach ensures beneficiary choice and because of the small number of plans, the state and the plan leadership have a close working relationship and good communication, which enables them to address challenges quickly and partner on various initiatives as a collective.[157]

Table 5 above outlines the advantages and disadvantages of states using a competitive procurement approach versus an "any willing plan" approach to contracting with RBMCs.

Outreach/Enrollment

Experiences of states with different outreach approaches to support enrollment of new populations into RBMC programs demonstrate that strategies typically used for beneficiary enrollment (i.e., use of written materials) may not be sufficient to maximize beneficiary understanding and engagement. For example, with the SPD transition in California, mailings and written materials were not effective communications, but in-person counseling and phone support were found to be more effective in engaging beneficiaries during enrollment.[158] Similarly, during the enrollment period for MLTSS in New York City, staff at the Human Resources Administration (HRA) made calls to beneficiaries who had not selected a plan and who would be subject to auto-assignment to a plan if they did not proactively select a plan. HRA administered three-way calls with the state's enrollment broker and the beneficiary, which resulted in an auto-assignment rate of two percent.[159] These types of additional multi-pronged and personal approaches to outreach are particularly important with the most complex populations, and may be worthwhile investments to ensure a smooth implementation.

Contract Management/Monitoring

As discussed earlier in this paper, states that administer RBMC programs must set clear goals for their program, in addition to ensuring that their RBMC contractors meet a number of federal requirements. The way to meet these requirements will involve developing relevant contract requirements, including establishing performance incentives, and providing the state with sufficient authority and flexibility to monitor performance and enforce compliance, where necessary. Sufficient state resources to conduct the oversight and enforcement activities is critical. Arizona has articulated the need for strong leadership in three key areas that do not always exist in traditional FFS Medicaid: 1) a Chief Information Officer who understands the value of data for shaping policy, 2) a Chief Financial Officer who understands RBMC operations and can lead efforts to monitor plans, and 3) a Chief Medical Officer who can lead quality assurance and quality monitoring efforts.[160]

Ultimately, a state's RMBC program is only as good as its contract and how it is enforced, with the contract serving as the primary vehicle to define state priorities and enable compliance.

Glossary of Managed Care Delivery System and Payment Models

Managed Care Delivery System Models[161]

- Primary Care Case Management (PCCM)
  - Medicaid agencies contract with primary care providers to provide, coordinate and monitor primary care services. Providers serve as the medical home for primary and preventive care. States pay monthly case management fees in addition to regular FFS payments. Unlike risk based managed care, providers do not assume financial risk.
- Risk-Based Managed Care (RBMC)/ Managed Care Organization (MCO)
  - Private managed care organizations (MCOs) contract with states to provide comprehensive benefits to Medicaid enrollees for a pre-set per-member-per-month (PMPM) premium, or capitation payment. MCOs are financially responsible for providing the services specified in their contracts. States may "carve out" certain services from the contract, such as behavioral health care or prescription drugs.
- Accountable Care Organization (ACO)
  - A group of health care providers or a regional entity that contracts with providers and/or health plans that agree to share responsibility for the health care delivery and outcomes for a defined population. Usually includes primary and specialty care and at least one hospital. CMS model has focused primarily on Medicare rather than Medicaid.
- Prepaid Health Plan
  - PHP can be either a Prepaid Inpatient Health Plan (PIHP) or a Prepaid Ambulatory Health Plan (PAHP). A PIHP is a non-comprehensive prepaid health plan that covers primarily inpatient services including those in acute and psychiatric hospitals. A PAHP is a non-comprehensive prepaid health plan that provides only certain outpatient services such as dental or behavioral health care.
- Managed Long-Term Services and Supports (MLTSS)
  - Risk-based arrangement for the delivery of Medicaid long-term services and supports, which may include institutional and home and community-based serves (HCBS) such as adult day care.
- Patient Centered Medical Home (PCMH)
  - A personal physician leads a team responsible for the patient's ongoing care; physicians' coordinate care and payment is designed to recognize enhanced care and certain administrative costs associated with PCMH care.

Managed Care Payment Models[162]

- Capitation
  - Refers to the fixed per-member-per-month amount that a state Medicaid agency pays a managed care organization (MCO) to provide or arrange for delivery of services to Medicaid members enrolled in the MCO's plan. Rates are pre-set, MCOs are at financial risk for the cost of the services they provide.
- Fee-for-Service (FFS)
  - In a FFS system, the Medicaid agency establishes the fee levels for covered services and pays participating providers directly for each service they provide. Providers do not bear any financial risk
- Care Management Fee
  - FFS Providers or provider organizations operating as patient-centered medical homes/health homes are paid a supplemental per-member-per-month care

management fee for Medicaid patients assigned to them. Fees may be adjusted based on patient demographics or health status.

- Pay-for-Performance (P4P)
  - Payment model that rewards providers or MCOs financially for achieving or exceeding specified quality benchmarks or goals. Some states contracting with MCOs incorporate a P4P component into their payment methods, such as requiring an MCO to earn a portion of the capitation payment by meeting certain performance targets.
- Shared Savings/Gain Sharing Arrangements
  - Provider organizations or ACOs have an opportunity to share in any net savings that accrue for a defined group of patients if the providers meet specific performance requirements while reducing costs. Arrangements are usually used by ACOs and some PCMHs.
- Shared Risk Arrangements
  - Organizations that participate in shared savings arrangements may also agree to share in losses as well as savings. Risk sharing may be added to shared savings arrangements after the providers have developed some experience serving a defined population.
- Episode of Care Payment
  - Providers receive a single, pre-established amount for a specific set of services for treating a patient's health event (such as a knee replacement) or a particular health condition (such as Attention Deficit Hyperactivity Disorder) over a specified period of time.

Appendix A. Background on Medicaid Delivery Systems

The FFS Medicaid system is often viewed as a barrier to access and high quality care for Medicaid beneficiaries. Fragmentation in the FFS system is significant because there is no entity coordinating care for the eligible population.[163] Medical errors may occur as beneficiaries transition from one setting to another or from provider to provider.[164] Further, financial incentives for providers in the FFS system place a priority on volume rather than on receiving the right care at the right time in the right place, which may lead to over-utilization of some services and under-utilization of others.

From the beneficiary perspective, this fragmentation results in challenges to accessing providers and certain health care benefits and can have significant impacts on health and quality of life. This may be especially true for those with chronic conditions for whom timely access to both primary and specialty providers and benefits is necessary to manage their symptoms. When appropriate and timely services in the community are unavailable, individuals often turn to the emergency room to obtain care and conditions are rarely stabilized without connections back to the community.

From the state perspective, the fragmentation existing in the FFS system leads to substantial costs and poor quality for the population. Further, state budgets are less predictable in FFS and strained by the duplication of efforts and the emergent needs when someone has fallen through the cracks.

Over the last three decades, but especially in the last decade, we have observed an evolution in the delivery of Medicaid benefits to models that are more centrally focused on care coordination and the alignment of incentives to achieve specific health outcomes and value. In 2001, the Institute of Medicine (IOM) released the report *Crossing the Quality Chasm: A New Health System for the 21st Century* in which the IOM called for major changes to the health care delivery system to make it more safe, effective, person-centered, timely, efficient, and equitable.[165] The authors of this report identified the challenges in the FFS system and called for significant redesign, including better efforts to coordinate care across an individual's conditions, services/providers, and sites of care.

Prior to the release of this report by the IOM, Primary Care Case Management (PCCM), a model of care delivery built on the FFS delivery system, became an attractive alternative to risk-based managed care for many states, with substantial growth observed between the late 1990s and early 2000s. PCCM programs would pay a small per-member per-month (PMPM) fee (usually $2 to $4 PMPM) to primary care providers to provide case management for their Medicaid enrollees.[166] About one-third of states with PCCM programs operate what is called "Enhanced" PCCM in which the state has added a more intensive care coordination function to their PCCM programs, often through contracts with so-called PCCM entitities (as defined in the proposed Medicaid Managed Care regulations) including regional networks or organizations that oversee the case management/care coordination activities performed by the primary care case managers and administer provider financial incentives, provider profiling, and performance and quality reporting.[167]

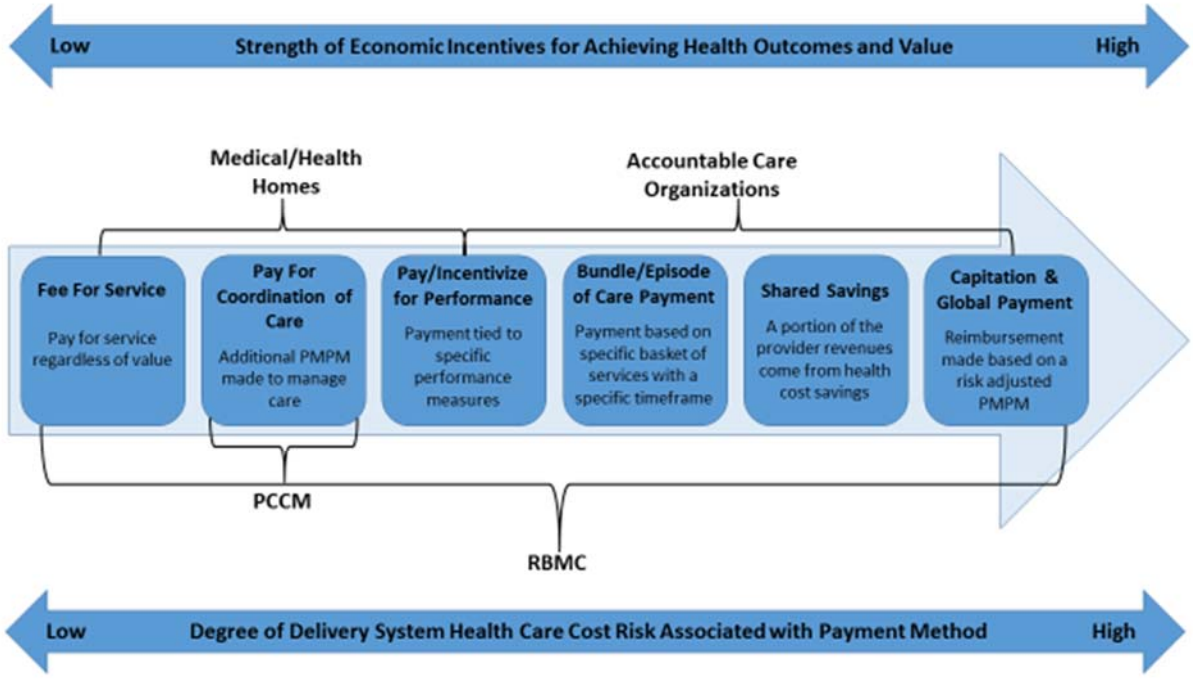
The Medicaid delivery system continues to evolve and is being dominated by risk-based managed care (RBMC). RBMC plans are organizations that receive a capitated global payment for a set of services and providers covering a specified population. As is described in detail in the body of the report, PCCM trends indicate that this model of service delivery is beginning to wane in popularity, with risk-based managed care (RBMC) growing in prevalence and in some cases, replacing FFS or PCCM entirely.

Significant delivery system reform has occurred in the last few years as a result of the Patient Protection and Affordable Care Act (ACA). The ACA created several opportunities for states to expand coverage for their residents through their Medicaid programs and managed care has evolved. New models are evolving to support coordinated care delivery at the provider level, through different types of financial incentives such as Accountable Care Organizations (ACOs) in which providers are organized through

contractual relationships to coordinate care using a range of payment models. Health Homes are another model promulgated through the ACA that offer states additional funding for targeted Medicaid populations. Central to the Health Home design is the focus on populations with multiple comorbidities and the integration of medical care with other benefits including behavioral health as well as community and social supports.[168] The Patient Centered Medical Home (PCMH), another model of care delivery that pre-dates the ACA, focuses on care coordination and takes a "whole person" approach. The PCMH is not a new concept but it has taken on a new life and expanded rapidly in most states. PCMHs share some of the same features of Health Homes but both are distinct from PCCM programs in that the provider team has responsibilities extending beyond coordination of medical services, including the adoption of health information technology and greater engagement of the individual in their own care.[169] Although PCCM, ACOs, PCMHs, and Health Homes are delivery system models that "manage" care to different degrees, these are models that are still currently primarily driven by the FFS paradigm (although they can operate within a managed care framework as well).

Figure A.1 depicts health system and aligned payment methods for the Medicaid program on a continuum that graphically describes the different health service delivery models. On one end of the continuum is the traditional FFS model with little to no financial incentive for providers to achieve specific health outcomes or value and where providers assume little to no risk. On the other end of the continuum is capitation and global payment, in which an organization assumes full risk through a capitated amount per member per month (PMPM) to cover all benefits and ties financial incentives to outcomes of care.

Figure A.1. Medicaid Delivery System Models and Aligned Payment Methods



Source: HMA

PCCM programs pay a PMPM to providers specifically for coordination of care, a relatively low risk activity from the provider perspective. Thus, in the figure above, PCCM is present in a limited way on the continuum. In contrast to the narrow relationship to risk that PCCM has, RBMC plans cover the full span

of risk in the various ways they can pay providers. RBMC engages in different payment approaches based on the provider's readiness to assume risk. States also have influence over the level of risk associated with RBMC plan payments to providers, although much of the discretion over how providers are paid is left to plans. The trend of RBMC plans paying network providers on a FFS basis is shifting as more states explore alternative payment methodologies that move them away from FFS.[170] As an example, in Massachusetts, there continues to be an increase in the percentage of providers serving MassHealth beneficiaries through a value-based payment (i.e., payments for value rather than FFS volume) through either RBMCs or the state's PCCM program.[171]

While PCCM and RBMC are contracting mechanisms that engage providers, PCMH/Health Homes are initiatives that can function within either contracting structure. PCMHs and Health Homes fall close to the FFS side of the continuum and are characterized by a fairly low strength of economic incentives to achieve health outcomes and produce value and with little risk to the providers. ACOs trend toward the other end of the continuum and while some ACO models assume full risk, most do not. Some Next Generation ACOs may receive full capitation but the general model is still centered on the FFS system.[172] All states engage in one or more of these contracting vehicles and delivery system initiatives, layering provider-level and contracting-level initiatives to achieve the best outcomes. Decisions about the type of geographic spread of these initiatives depend on the populations included, the provider community, and other unique circumstances of the state.

The dominant model for Medicaid managed care is comprehensive RBMC, where states contract with RBMC plans that provide a comprehensive set of medical benefits to Medicaid beneficiaries required under a state plan in exchange for a monthly premium, or capitated rate for each enrolled member of the RBMC plan. These are called "risk-based" managed care plans, because the financial risk for serving enrolled Medicaid beneficiaries is transferred from the state to the RBMC plan. Other forms of managed care include Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). These plans are also operated by organizations that assume risk for a set of services but are less than the comprehensive set of services that RBMC's typically cover. For example, a PIHP may assume risk for inpatient or other institutional services; for example a behavioral health PIHP could include inpatient and outpatient mental health services. Similarly, PAHPs may assume risk for benefits in the ambulatory care setting that are not comprehensive; for example, a dental PAHP that only covers dental benefits.

Appendix B. Medicaid Program Design

Federal statute establishes the basis for state Medicaid programs as part of amendments to the Social Security Act passed in 1965.[173] States however have great flexibility in determining eligibility criteria, benefits covered, provider payment policy, and the approach to administering and financing the program. In this section, we describe the general structure of Medicaid as defined in federal statute as well as the variation across states in terms of benefits and populations covered.

Table B.1. Mandatory and Optional Medicaid Benefits

Mandatory Medicaid Benefits	Optional Benefits	
▪ Inpatient hospital services ▪ Outpatient hospital services ▪ Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) ▪ Nursing facility services ▪ Home health services ▪ Physician services ▪ Rural health clinic services ▪ Federally qualified health center services ▪ Laboratory and X-ray services ▪ Family planning services ▪ Nurse Midwife services ▪ Certified Pediatric and Family Nurse Practitioner services ▪ Freestanding Birth Center services (when licensed or otherwise recognized by the state) ▪ Transportation to medical care ▪ Tobacco cessation counseling for pregnant women	▪ Prescription drugs ▪ Clinic services ▪ Physical therapy ▪ Occupational therapy ▪ Speech, hearing and language disorder services ▪ Respiratory care services ▪ Other diagnostic, screening, preventive, and rehabilitative services ▪ Podiatry services ▪ Optometry services ▪ Dental services ▪ Dentures ▪ Prosthetics ▪ Eyeglasses ▪ Chiropractic services ▪ Other practitioner services ▪ Private duty nursing services ▪ Personal Care ▪ Hospice ▪ Case management	▪ Services for individuals age 65 and older in an Institution for Mental Disease (IMD) ▪ Services in an Intermediate Care Facility for individuals with an intellectual disability ▪ 1915(i) State Plan home- and community-based services ▪ 1915(j) self-directed personal assistance services ▪ 1915(k) Community First Choice Option ▪ Tuberculosis-related services ▪ Inpatient psychiatric services for individuals under age 21 ▪ Health Homes for enrollees with chronic conditions ▪ Other services approved by the Secretary*

Source: CMS[174]

*Includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).

Medicaid-Covered Benefits. The benefits covered under Medicaid managed care plans, and how they are covered, vary from state to state. Federal statute and regulations define mandatory benefits that states must cover in their Medicaid programs as well as optional benefits they may choose to cover (see Table B.1 above). States also have some flexibility regarding the type, amount, duration, and scope of covered services, as long as they adhere to the broad federal guidelines. In addition, federal statute establishes three key features of Medicaid programs within a state:

1. Comparability: Medicaid benefits must be equally available for all beneficiaries;
2. Statewideness Rule: Benefits must be the same throughout the state; and
3. Freedom of Choice: Beneficiaries must have freedom of choice among health care providers and/or managed care plans participating in Medicaid.[175]

As noted in the section on the state perspective in the body of in this paper, states may apply to CMS for a waiver of these statutory requirements of the Medicaid program.

States can decide whether and how to limit their Medicaid benefits, again leading to great variation in coverage across states. For example, states may require prior authorization for certain services, including mandatory services. States have even greater flexibility in the coverage of optional benefits. For example, most states cover adult dental services but some limit this coverage to trauma and emergency treatment while others cover routine annual dental exams. Similarly, states may limit the frequency of optional services (such as hearing aids, eyeglasses and dentures), limit the number of services that can be received without authorization (such as a cap on the number of prescriptions per month), or impose a monetary cap on the total amount of a particular type of optional service covered in a year.[176]

Medicaid Population or Benefit Carve Outs

In states with managed care, key elements of the program design include making decisions about which populations will have access to services through RBMC, either on a voluntary or mandatory basis, and which benefits they will receive. The state contracts with RBMC plans to provide all or most of the state's Medicaid-covered benefits via the plan's network of participating providers. States make a PMPM payment to the plans to provide these benefits, thereby transferring financial risk to the plans. States may choose to "carve out" one or more benefits from the managed care delivery system and instead opt to provide those services separately via FFS or a limited benefit plan (e.g., a PIHP or PAHP).[177] Further, states may choose to exempt one or more populations from Medicaid RBMC and instead offer benefits for those populations through the traditional FFS system. The decision to carve out benefits or populations from Medicaid RBMC may be driven by a number of factors, including stakeholder concerns regarding the ability to assume responsibility and risk for selected populations, or whether services have historically been administered or paid for separately, such as behavioral health care or LTSS described below.

Appendix C. State Engagement with CMS

State Medicaid programs have substantial flexibility within which to develop their delivery systems. Still, their plans to proceed with a new direction for Medicaid service delivery require CMS approval. State Medicaid benefits are guided by federal and state law, which establishes a minimum set of benefits each state must cover and these benefits become part of the State Plan. States can opt to provide additional services beyond those mandated by federal law with eligible federal match to state funds, upon request in the form of a State Plan Amendment and approval from CMS. Further, states can pursue Medicaid delivery reform via managed care through three primary statutory authorities, which are summarized in Table C.1.

The decision to pursue a waiver to operate a Medicaid RBMC program rather than submit a State Plan Amendment is based on several considerations. Among these is a determination of the target populations to be included, what services the state wants to include, and issues about budget neutrality. For example, states that may be interested in pursuing RBMC for dual eligibles will need to consider whether they want dual eligibles to be mandatorily or voluntarily enrolled into RBMC. If the state's choice is to mandatorily enroll dual eligibles, an 1115 waiver may be most optimal. If a state wants to offer services not required by the State Plan and receive federal match to state dollars for those benefits (e.g., home- and community-based services), the 1915(b)/(c) waiver or the 1115 waiver would be most appropriate. Waivers require that states provide evidence that the program is either cost effective or budget neutral relative to what would be the costs in the FFS system. This can be a challenging effort and the decision to pursue managed care through the 1932(a) State Plan option must be weighed against other goals of the program.

CMS approval of a modification to a state's Medicaid program is a lengthy process and requires significant stakeholder engagement. The process to transition to RBMC can take as much as two to three years from concept development to actual implementation. The process begins with the state developing its own conceptual program design and regulatory framework. At the same time or shortly after, stakeholder engagement is generally initiated to share the conceptual approach and receive feedback. Legislative and budget discussions will need to happen early on as well to ensure the state has the state statutory authority to make the shift to RBMC. The waiver application process (if a waiver is pursued) can take a year or more from initial application development. To encourage transparency, states will post the application to obtain stakeholder comment, incorporate any necessary changes, and then submit the application to CMS. At the same time, states will generally issue a Request for Proposals (RFP) for RBMC plans to apply to hold a managed care contract with the state. States will determine the number of plans they will develop contracts with and select plans based on a competitive review process or determine if they want to use a non-competitive "certification" approach, where plans that meet a specified set of criteria can be certified to hold a contract with the state. Each approach has its advantages and disadvantages: competitive procurement through an RFP is necessary if a state wants to limit the number of plans selected but is more administratively complex than the certification (or "any willing plan provider") approach during the procurement process.[178] CMS will review a state's waiver application and often submit requests for additional information and then the state and CMS will negotiate the Special Terms and Conditions. CMS will issue a decision regarding the waiver application and assuming it is approved, the state and CMS will work together to ensure plans are ready to implement the program.

Table C.1. Medicaid Statutory Authorities – Comparison of Major Characteristics

Characteristics	Sec. 1932(a) State Plan	Sec. 1915(b/c) Waiver Combo	Sec. 1115 Demo Waiver
General Authority	Exempts state from state wideness, comparability and freedom of choice (can restrict freedom of choice to managed care providers)	Same as 1932(a), but also allows state to provide "other" services, limit number/types of providers, and permits reimbursement for non-Medicaid services needed to permit people to live in home/community settings	Supports 1915b/c combo waivers. Also permits federal matching for non-Medicaid funded services. Enables major redesign of Medicaid program to permit integration of acute, behavioral and LTSS, and can be used to expand Medicaid eligibility.
Mandatory Enrollment Target Populations	Allowed for all state plan populations *except* children with special needs, American Indians, and Medicare members. Duals can be enrolled in managed care, but must have an opt-out option.	All state plan populations. Can cap enrollment and establish waiting lists. State can require ABD and dual eligible populations be mandatorily enrolled. (Dual eligibles can still opt out of the managed care plan for Medicaid services.)	All state plan populations *plus* designated groups not otherwise eligible for Medicaid benefits. State can require ABD and dual eligible populations be mandatorily enrolled.
Approval Period and Process	Indefinite (this is a State Plan Amendment (SPA)). Review by CMS Region and Central Offices. Review follows standard SPA time frame.	3-year period + opportunity for 5-year renewal periods. Review by CMS Region and Central Offices. Review takes up to two 90-day periods + time taken to respond to CMS questions.	5-year period + opportunity for renewal periods. Review by CMS Region, Central and other HHS divisions and OMB. Review has no set timeframe. Can be 12 months or longer.
Budget/Cost Neutrality	No budget/cost analysis required	Must demonstrate cost effectiveness	Must demonstrate budget neutrality
Program Evaluation	State must evaluate the managed care organizations.	State must evaluate the managed care organizations.	Special terms and conditions (STCs) are negotiated between CMS and state. External evaluations required.

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