The Development of Capitation Rates under Medicaid Managed Care Programs: A Pilot Study

Volume 2: State Summaries

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ARIZONA

I. Overview

When Arizona began its Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), in 1982, it was the last state to implement a Medicaid program, but the first to use managed care arrangements on a statewide level for Medicaid service delivery. It is, therefore, the only state to have no fee-for-service Medicaid experience. In establishing a state-organized health care system, the prepaid, capitated managed care environment was embraced as the setting most effective for mainstreaming recipients into private physician care, increasing the use of preventive and primary care, reducing the use of hospital and emergency room care, and ensuring high-quality care, while controlling costs and preventing fraud and system abuse.

AHCCCS operates under the authority of an 1115(a) waiver, the most recent renewal of which extends authority until 1 October 1997. The state has recently applied to Health Care Financing Agency (HCFA) for extension of the waiver until 1 October 2000. Since its inception, AHCCCS has expanded its acute care benefits package to include long-term care (covered under the Arizona Long Term Care System) beginning in 1989, and behavioral health services (provided mostly by Regional Behavioral Health Agencies, under contract with Arizona's Department of Health Services), which was fully phased in by 1 October 1995.

According to the waiver, plan qualification is determined by AHCCCS discretion, rather than by state health maintenance organization laws. AHCCCS requires that contracting plans enroll only Medicaid recipients, though the providers themselves generally provide services to the commercially insured population as well, through affiliated entities. Participating plans

include physician-owned plans, hospital-owned plans, local county plans, and the subsidiary plans of several managed care organizations. Through these contractors, AHCCCS recipients currently have access to approximately 80 percent of the state's private physicians. In addition, plans are encouraged to use the 11 Federally Qualified Health Centers (FQHCs) located in Arizona, which provide for greater access to care in underserved areas. Given that there is no fee-for-service alternative in AHCCCS, enrollment in one of these plans is mandatory for all Medicaid eligibles.

The rates paid to AHCCCS plans are developed based on the offerors' bids, which are compared to rate ranges developed by the state and its independent actuaries. Rate ranges for

the program's initial year were developed using fee-for-service experience provided by the counties and an actuarial database, while those for subsequent years have been based on past AHCCCS experience trended to the current year.

II. Development of Capitation Rates

A. Benefits

AHCCCS plans are responsible for providing comprehensive benefits packages to their enrollees. Notable benefits include necessary medical supplies, emergency dental care, case management, private duty nursing, rehabilitation services for children who are not eligible for the Children's Rehabilitative Services (CRS) program, EPSDT services, organ transplants (though with limitations), and family planning services. Plans are also required to provide services to members enrolled in the Family Planning Services Extension Program, a program that provides only family planning services for a maximum of 24 months to women whose SOBRA eligibility has terminated.

Certain services are carved out of the capitation rates, and are, therefore, not covered by the plans. These include behavioral health for all but 18- to 20-year old members who are not eligible for the Seriously Mentally Ill (SMI) program, nonemergency adult dental care, and specialty services for children covered under the CRS program.

Beginning in 1990, behavioral health services were added to the AHCCCS benefits package. These services are carved out of the AHCCCS plan rates for most eligibles and are provided by Regional Behavioral Health Agencies, under a separate contract with Arizona's Department of Health. AHCCCS plans are responsible, however, for providing behavioral health services to non-SMI-eligible members ages 18 to 20 and for up to 72 hours of emergency behavioral health services for all other members.

Plans are responsible for the collection of legislated copayments ($1 to $5 per visit, depending on the service) from enrollees, but cannot deny services to those who cannot afford these copayments. Each plan must also coordinate benefits with other insurers so that it is the provider/payer of last resort. Third-party liability claims are recovered by a private firm contracted with AHCCCS for this purpose.

B. Rate Development

Though AHCCCS capitation rates are determined through a bid and negotiation process, the state contracts with outside actuaries to develop a set of rate ranges as a frame of reference for the process. The rate ranges are developed by geographic service area (i.e., county groupings) and specific eligibility category. There are ten eligibility rate code classifications, as follows:

- Temporary Assistance to Needy Families (TANF) and the Children's Care Program (which includes SOBRA children):
  - Females and males less than one year of age,
  - Females and males between 1 and 13 years of age,
  - Females between 14 and 44 years of age (including SOBRA pregnant women),
  - Males between 14 and 44 years of age, and
  - Females and males 45 years of age and over.
- SSI:
  - With Medicare, and
  - Without Medicare.
- All Medically Needy/Medically Indigent (MN/MI)
- SOBRA:
  - Family Planning Services Extension Program, and
  - Supplemental payment for birth-related costs.

The rate ranges in the program's initial year of operation (1982) were calculated using a combination of fee-for-service information from the counties and information available through an actuarial database. During each bid year since, rate ranges have been developed using AHCCCS expenditure and utilization data from the previous two and a half years, and various trending factors that include changes in utilization and service cost, and programmatic or legislated changes. The state then works with the actuaries to convert each rate into a rate range.

At no time are either the values or the breadths of these ranges public information, although the ranges are referenced by the state for the evaluation of bids, as described in the next section. In order to further evaluate offerors' bids, AHCCCS offerors are required to fill out Capitation Rate Calculation Sheets (CRCS) that show how they arrived at their bidding rates. In addition to their internal expenditure and utilization data, historical AHCCCS utilization data are made available to the offerors to use in their calculation of geographic service area- and rate code-specific capitation rates. According to the CRCS, each capitation rate is calculated in three steps:

- First, per-member-per-month costs for each of seven service types are calculated as the product of annual units per 1000 members and the cost per unit. Legislated copayments are subtracted from each of the service rates where applicable, and then these rates are summed.

- Added to this subtotal is a separate set of average per-member-per-month costs for various additional services, including laboratory services, family planning, physical therapy, medically necessary transportation, dental care, and mental health services (for non-SMI eligibles ages 18 to 20), yielding a gross capitation rate.

- Finally, this gross rate is adjusted downward by separate amounts representing expected reinsurance and third party recoveries (for which plans are responsible), and then upward by an amount that accounts for administrative costs, and an amount representing expected profits and other contingencies.

In addition to the capitation rates, plans are paid a one-time supplemental premium to cover births to SOBRA-eligible women. Contractors receive monthly capitation payments for SOBRA-eligible women in addition to a supplemental payment upon the birth of a child to a SOBRA-eligible woman enrolled with that contractor. This supplement is paid to offset costs related to the certain risk of birth for SOBRA women. Plans are asked to calculate this supplement by estimating the number and cost of SOBRA births and deducting six months (the average number of months of capitation typically paid to a plan for a SOBRA woman) of capitation for TANF women aged 14 to 44 to arrive at a net cost per birth.

Between bid years, rates are adjusted annually for inflation (approximately 2.5 percent of contract year 1996-1997) and any programmatic or legislated changes.

C. Negotiating and Contracting

Prior to the start of each contract year, AHCCCS issues a Request For Proposals (RFP) to potential offerors, which includes an estimate of how many contracts are expected to be awarded in each geographic service area. Offerors are evaluated based on their strengths in four areas and ranked with the following weights placed on each area: 35 percent for Provider Network (quality, size, comprehensiveness, development); 30 percent for the proposed Capitation Rate; 20 percent for Program (including executive management, services, and grievance processes); and 15 percent for Organization (expectation of ability to perform administrative functions). Within the Capitation Rate area and the development portion of the Provider Network area, offerors are scored separately for each geographic service area. For the remaining categories, offerors are scored according to their statewide rankings. Preference is given to offerors who propose full-county plans.

The final set of contract rates must fall within the actuarial rate range for each rate code. If a plan bids a rate that falls above the range for any particular rate code, AHCCCS may allow the

plan to adjust and resubmit its bid in one or more Best and Final Offer (BFO) rounds. AHCCCS has initiated BFO rounds on a limited basis, where it appears to be in the state's "best interest." The decision to initiate a BFO round is made separately for each county, and this negotiation step is generally pursued when AHCCCS feels that too few attractive plans have made acceptable bids.

In the BFO round, AHCCCS indicates to each offeror which of its rates lies below the upper limit for the relevant rate code and which falls above this upper limit. The bidder can then use this information to adjust its rate schedule and submit a new offer. Rates can be adjusted upward only in the first BFO round, and only under the condition that the weighted amount (using population figures supplied by AHCCCS) of these rate increases does not exceed the weighted amount of other rate reductions (i.e., the total bid amount cannot be increased). The BFO will be rejected if it does not conform to these conditions, in which case the bid offered before the BFO round is considered to be the final offer for that round.

After the last bid is offered (which may or may not involve a BFO round) AHCCCS will make counteroffers to each plan that proposes rates that do not fall within the allowable range. For all rates below their relevant range, the counteroffer will equal the range's lower limit, and for all rates above the relevant range, the counteroffer will fall somewhere in the bottom half of the range. (The same counteroffers will be made to all plans in a given geographic service area.) In this way, offerors have a strong incentive to propose more conservative rates, since they are aware that final rates above the range will elicit relatively low counteroffers, and since they are not informed where they stand on other evaluation factors during the negotiation process.

The final capitation bids are ranked from lowest to highest. Each plan is then scored on a 100-point scale based on the proximity of its rates to the lower limits of the ranges. Rates equal to the lower limits will be given a score of 100; however, rates equal to the upper limits of the ranges will be given scores greater than zero. A plan's rate scores are then averaged to yield final cost scores. To determine the overall ranking of an offeror, AHCCCS multiplies the points awarded to the offeror in each area by that area's relative weight. The weighted amounts for each of the four evaluation areas are then combined to determine the composite score.

Currently, AHCCCS has contracts with ten plans in Maricopa County, six plans in Pima County and two plans each in all remaining counties; the number of contracts to be granted in the upcoming bid year is being re-evaluated. The duration of each contract is one year, and contracts can currently be renewed up to four times at AHCCCS's discretion. When a contract expires, the contracted plan must re-bid with all other offerors.

If an existing plan loses its contract, AHCCCS may present it with the option to continue serving its current enrollees (according to the capitation amount arrived at in the failed bidding process), but it may not enroll any new members. When larger plans lose their AHCCCS contracts, the decision whether to cap a plan's enrollment or eliminate the plan entirely is complicated. AHCCCS reviews each case on an individual basis and in the past has considered two key opposing factors in making this decision:

- First, it is concerned with maintaining continuity of care for AHCCCS members. While transferring the members of a plan with only a small portion of the area's members to a new contractor does not present a large problem, for larger plans this transfer is much more complicated, and may be unmanageable in a short period of time and disrupt the continuity of enrollees' coverage. Therefore, as long as it has an acceptable history, a larger plan will tend to be capped, rather than simply eliminated.

- The second concern regards how many plans a county's population base can reasonably support. This issue becomes relevant most often in rural areas, which usually have a small base of members, making it potentially difficult for a new contractor to enroll enough members to support itself if the existing plan (which has lost its contract) is allowed to continue serving members in the county. When it is determined that the member base is not large enough to support the new contractors with the incumbent maintaining its share of the market, the incumbent plan will probably be eliminated, rather than capped.

D. Enrollment

As part of the contracting process, a target enrollment percentage is calculated for each plan. For all rate codes except MN/MI, the target percentages used in the algorithm are based upon three equally weighted factors: the plan's final submitted capitation rate bid, the plan's final awarded capitation rate bid, and the plan's score on the Program component of its proposal. For each of the first two factors, plans are ranked from lowest to highest bid, and a total of 100 points for each factor are then allocated among offerors to reflect these rankings. The third factor is ranked from highest Program score to lowest, with another 100 points allocated among offerors to reflect this Program score ranking. The points awarded for the three factors are then averaged to develop the target percentage for each offeror by geographic service area and by rate code.

The target percentages for the MN/MI rate code are based solely on the rankings of plans according to their final awarded capitation rates (from lowest to highest bid). 100 points are allocated among plans, reflecting this ranking.

There is an open enrollment period prior to the start of each contract year during which all non-MN/MI eligible members can choose the plan through which they will receive their care. All MN/MI eligibles, along with those who do not choose a plan by the time the AHCCCS administration is notified of their eligibility, are automatically assigned to a plan, either according to family continuity or according to an algorithm that identifies the contractor currently farthest away from its target percentage. The algorithm identifies this contractor by calculating the difference between each contractor's current share of the county's AHCCCS recipients for the relevant rate code category and the contractor's target percentage for that category. By recalculating this algorithm for each auto-assignment case, officials ensure that the assignment process is accurate at the margin.

Categorically eligible members, as well as Eligible Assistance Child members enrolled under the Children's Care Program, are guaranteed enrollment for at least five months. Except under limited circumstances, members are locked in to their chosen plan until the next round of open enrollment.

E. Sharing of Risk

All participating plans are required to participate in the state-funded reinsurance program. AHCCCS is self insured for this reinsurance program, which offers two types of reinsurance: regular and catastrophic. The deductible level for regular reinsurance varies from $20,000 to $50,000 per member, depending on the plan's statewide enrollment, except for the MN/MI rate code's regular deductible, which is equal to $15,000 for all plans. Plans are reimbursed at 75 percent of service costs in excess of the deductible for all rate codes. The catastrophic insurance policy is the same for all plans, regardless of size: AHCCCS pays a coinsurance reimbursement rate of 85 percent for services provided to hemophilia patients, and for heart, bone marrow, and other covered organ and tissue transplants. There is no deductible for catastrophic reinsurance.

AHCCCS has no other risk-sharing arrangements with participating plans.

F. Quality Assurance

Quality assurance has, especially recently, become a key focus of the AHCCCS program. The program is currently working with HCFA on an intensive quality management initiative that is an important piece of the new waiver extension request. AHCCCS has instituted various processes to monitor the quality of care, and has also required plans to establish internal quality assurance mechanisms. AHCCCS officials conduct operational and financial reviews of AHCCCS plans at least once a year, during which they identify areas in which plans could improve, monitor how closely plans have conformed with mandatory programs and policies, provide technical assistance to plans when needed, and assess the financial viability of plans based on a variety of criteria. AHCCCS also conducts periodic member surveys in which members are asked to assess accessibility, availability (plans are required to maintain certain appointment availability standards), continuity of care with their primary care provider, communication between members and their plan, and overall satisfaction.

In addition to instituting internal mechanisms to assess areas for need of improvement, and to plan, implement, and evaluate quality improvement activities, plans are required to submit a variety of quantitative and qualitative reports, including reports of encounter data; quarterly and annual financial reports, quarterly grievance reports, quality management and utilization management plans, and clinical outcome indicator assessments (which have been developed with reference to HEDIS). Plans must continue submitting encounter data after contract termination for a period that accounts for the lag time in encounter data submission, and must maintain all their report files for at least five years after contract termination.

Plans are also required to take steps to achieve at least an 80 percent EPSDT screening rate. Target rates (ranging between 70 and 90 percent) for several EPSDT immunization requirements are also indicated. Plans that achieve screening and immunization levels below corresponding target rates but above the corresponding statewide average rates may be required to submit corrective action plans; those that fail to at least match the statewide average participation rates must submit corrective action plans and may be subject to sanctions. Finally, plans are encouraged to perform their own member satisfaction surveys.

III. Future of AHCCCS

State officials report that the bid and negotiation process has encouraged desirable competition; therefore, future design efforts will most probably focus on monitoring and improving the quality of service utilization management and service delivery. As previously mentioned, AHCCCS is applying to HCFA for a three-year extension of its waiver authority, during which time it intends to complete its quality management initiative.

The RFP and the rate ranges will continue to be updated annually to account for inflation, legislative changes, and other program changes. Pending legislative issues include:

- AHCCCS is awaiting approval from HCFA for expanding Medicaid eligibility to adults with household incomes up to 100 percent of the Federal Poverty Level (FPL). The Arizona legislature may also enact a premium-sharing program for persons with household incomes up to 300 percent of the FPL in late 1997. Persons eligible under either of these potential expansion programs would be absorbed into AHCCCS plans.

- Currently, inpatient hospital rates paid by AHCCCS are increased to account for the funding of Graduate Medical Education. There is legislative interest in making direct payments to hospitals with GME programs, in place of this indirect method of funding. Should this legislation be approved, inpatient hospital rates will be appropriately decreased.

- According to federal legislation effective 1 January 1998, women and their newborns must receive a minimum 48 hours of inpatient maternity care following a normal vaginal delivery and up to 96 hours following a cesarean delivery. Plans will be compensated through future program and contract amendments, if necessary, for additional costs incurred as a result of this policy.

Rate ranges will continue to be developed specific to each eligibility category and geographic service area.

CALIFORNIA

I. Overview

California began using managed care arrangements for the delivery of health care services to enrollees in Medi-Cal (California's Medicaid program) in 1972. As of December 1996, 25 of the state's 58 counties have Medi-Cal recipients enrolled in some form of managed care program. California is unique in the wide variety of managed care initiatives it has implemented for Medi-Cal service delivery. Under these various initiatives, Medi-Cal has contracts with Health Insuring Organizations (HIOs), Health Maintenance Organizations (HMOs), Pre-Paid Health Plans (which, in California, meet the federal definition of HMOs), and/or Primary Case Care Management plans (PCCMs). With the exception of PCCMs, which are not responsible for providing inpatient hospital care, most participating plans assume full risk for the health care needs of their enrollees. California has implemented its Medi-Cal managed care initiatives primarily on the county level under a series of 1915(b) waivers. These initiatives include the following:

- ***Pre-Paid Health Plan (PHP) Program.*** In any county, one or more PHPs (i.e., HMOs) may contract to provide fully capitated services to Medi-Cal recipients who enroll voluntarily. This program is currently in operation in 15 counties.

- ***Primary Case Care Management (PCCM) Program.*** In 1983, the state began contracting with qualified primary care providers (e.g., individual physicians, physician groups, and clinics) under partially capitated arrangements to provide case-managed care to Medi-Cal beneficiaries. In those counties that have implemented the program, Aid to Families with Dependent Children (AFDC) and AFDC-related eligibles may voluntarily enroll in a PCCM. Currently, this initiative is operating in six counties; however, these arrangements are expected to be phased out by the Two-Plan Model program, described below.

- ***County Organized Health System (COHS) Program.*** Begun in 1984, this program provides fully capitated arrangements administered by local commissions, comprising representatives from providers, recipients, local government, and other concerned parties. Each local commission is responsible for establishing a comprehensive, case-managed provider network in its county.

Medi-Cal recipients have substantial choice among managed care providers, but cannot receive services from fee-for-service providers unless approved by the local commission. The COHS program is currently operating in five counties.

- ***Geographic Managed Care (GMC) Program.*** This pilot project has been operating in Sacramento County since 1994, and is expected to expand to San Diego County in 1997. The state contracts with a variety of managed care organizations to provide partially or fully capitated health care services to the county's Medi-Cal population. Beneficiaries choose among the competing plans, but enrollment in one of the plans is mandatory for all AFDC and AFDC-related eligibles.

- ***Two-Plan Model Program.*** In 1996, the state began implementing this program in 12 counties. In each county, two plans are established to provide fully capitated services to the county's Medi-Cal recipients: one Local Initiative (LI) plan—a quasi-public agency, which is usually inclusive of public-sector hospitals, clinics, and community health centers—and one commercial plan. Enrollment in one of the two plans is mandatory for AFDC and AFDC-related eligibles. In contrast to the state's other managed care initiatives, this program was designed not to reduce Medi-Cal expenditures, but to afford Medi-Cal beneficiaries access to the same type and level of care as privately insured Californians; thus, the capitation rates of the Two-Plan Model were set slightly differently from those of the other initiatives.

Under most of these initiatives, including the PCCM program, the PHP program, and the Two-Plan Model program, participating plans accept rates developed by the Department of Health Services (DHS). Under the COHS and GMC programs, plans' cost proposals are compared to an upper payment limit developed by DHS, and the final rates are negotiated between the plans and the state. These processes are detailed below.

II. Development of Capitation Rates

A. Benefits

Contracted managed care organizations in the Two-Plan Model are required to provide the comprehensive Medicaid benefits package to their Medi-Cal enrollees. The capitation rate includes physician services, outpatient and inpatient hospital care, outpatient and inpatient substance abuse services, family planning, enhanced support services for pregnant women, high-risk infants and at-risk children, Long Term Care (LTC) services for the first two consecutive months, and transportation services. Though not included in the capitation rate, plans are also required to provide case management and translation services.

Some services, on the other hand, are not paid for using Medi-Cal funds. These services include all mental health services (these are covered by the Department of Mental Health, which is in the process of implementing its own managed care system); specialty services for children with special health care needs (financed through California Children's Services [CCS], the state's Title V Children with Special Health Care Needs program); and Part H Early Intervention Services. Finally, certain services are part of the Medi-Cal benefits package, but are not provided by Two-Plan Model managed care organizations, and are excluded from the capitation rate (i.e., are either excluded from the database or excluded through factor adjustments), and are. The three notable services in this category are major organ transplants (covered through fee-for-service arrangements); the provision of ophthalmic lenses (which are supplied through a Medi-Cal contract with Prison Industry Associates); and LTC services (after the first two consecutive months).

Participating plans in the Two-Plan Model are responsible for providing all medically necessary treatment to Medi-Cal enrollees without limitation and without enrollee copayments. In competing for enrollees, the LI and commercial plans in a county may offer additional benefits to supplement the required services indicated above.

B. Rate Development

1. Methodology for Development of Medi-Cal Managed Care Rates

Under the COHS, GMC, PCCM, and PHP initiatives, capitation rates are based on historic Medi-Cal fee-for-service expenditure and utilization experience. For each county in which one of these programs is implemented, a separate rate is set for each of five eligibility categories. (Participants are grouped by aid code into Family, Aged, Disabled, Child [non-AFDC], and Adult [non-AFDC] eligibility categories.) To develop each rate, a service-specific rate is developed for each of six service types (Physician, Pharmacy, Hospital Inpatient, Hospital Outpatient, Long Term Care, and Other Services), and these service-specific rates are then summed to yield a total rate; this total rate is then subjected to a series of adjustments to yield a final, eligibility category-specific rate.

Within each of the 30 eligibility category/service type cells, a per-member, per-month base rate is calculated, using Medi-Cal expenditure and utilization data from 1993. Each base rate takes into account all expenditures relevant to the particular rate cell, including the estimated amount of claims incurred but not paid at the time of the calculation, but excluding expenditures on the two categories of service explicitly carved out of all managed care plans benefits packages (specialty services for children enrolled in CCS and for major organ transplants). The following adjustments were then made to these base rates:

- An adjustment is made to account for the differences in demographic makeup of Medi-Cal enrollees across counties. To generate the factors for this adjustment, statewide ratios were first developed for each of 18 age/sex categories within each eligibility category/service type cell by comparing the average statewide

expenditure for the specific age/sex category to the average statewide expenditure for the entire eligibility category/service type cell. Based on the distribution of age/sex characteristics in a county's Medi-Cal population, the ratios in each rate cell were converted into a weighted average age/sex adjustment factor for that cell.

- A similar adjustment is made to account for county-specific variations in the distribution of specific aid codes within each of the five eligibility categories. Again, after statewide ratios were calculated by comparing the average expenditure for a specific aid code to that for its entire eligibility category, a weighted average factor was developed for each of a county's 30 rate cells based on the aid code distribution within the county's Medi-Cal population.

- While much of the difference between the average statewide per-member per-month expenditure and the expenditure in an individual county is accounted for with the age/sex and aid code adjustments, a further adjustment is made to account for residual area-specific expenditure differences. This set of adjustment factors represents the relative costliness of services in the individual county, with age/sex and eligibility characteristics held constant.

- Three adjustment factors are then used to account for the exclusion of three more services from the managed care benefit package: mental health services, LTC services after two months, and ophthalmic lenses. Since some managed care programs may include one or more of these services, state officials chose to account for these exclusions using factor adjustments, rather than simply excluding them from the actuarial database (as was done with the earlier exclusions). In this way, the initial base cost calculations could be used universally, across all of the programs. These adjustment factors are calculated as the percentage of total claims in the appropriate service categories that are attributable to the excluded services.

- Under the fee-for-service Medicaid system, the state earns interest on its Medicaid funds in the period between utilization of and payment for services. Under prepaid capitated systems, the state forgoes this interest revenue. Therefore, a reduction of between .04 and .1 percent is made in the rate for each service category to account for this interest loss to the state. These adjustment factors, which are calculated individually for each eligibility category/service type cell, are based on a 4.5 percent interest rate, using 1992 data on the average lag time for reimbursement of fee-for-service claims.

- An adjustment is made in each rate cell to account for legislative changes to the Medi-Cal program made in each fiscal year. The cost implications of these changes are estimated each year by the state Fiscal Forecasting office.

- A trend factor is applied to the base expenditures to account for changes in the number of expected users, number of units of service used, and the payment per unit in each of the 30 cells between 1993 (the base year for all program rates) and the current fiscal year. It is important to note that, while this is the step in which price inflation is taken into account, these factors do not always result in an increase in the capitation rates; for most eligibility categories, for example, the rates for inpatient hospital care decrease due to this adjustment.

After summing the six adjusted service type cells for each eligibility category, the resulting five eligibility category-specific rates are then subjected to the following adjustments to calculate the final capitation rates:

- A deduction is taken to account for the estimated amount that may be collected from third-party insurers who cover Medi-Cal beneficiaries. For enrollees in the Family aid code, this amounts to $.04 of a total per-member, per-month rate of $70.83.

- An amount is added to the calculated rate to account for the cost of the Child Health and Disability Prevention program (California's EPSDT program). Because these services are recorded using a separate data system, these services are not included in the base rates. The expenditures for this program are then increased by 19 percent, to account for the estimated cost of EPSDT treatment services that were not previously covered by the program, but for which plans are heretofore responsible.

- Finally, an administrative allowance of 1 percent of service costs is added to the adjusted rates.

The resulting rates represent the expected per-member monthly expenditures for each eligibility category based on fee-for-service experience. In the PCCM and PHP programs, a discount is then taken to represent the savings to be realized from managed care. This discount varies across the different managed care programs: PCCMs are paid at 95.5 percent of calculated rates, and PHP contract rates are set at 99 percent of the calculated rates (the PHP rate is higher due to the additional risk involved in covering inpatient care). The COHS and GMC rates are arrived at through a bid and negotiation process in which the calculated rates define an upper payment limit. Since Medi-Cal reimbursement rates have not been adjusted for several years, this upper payment limit has become more constricting over time, with the result that capitation payments to COHS and GMC plans have in recent years amounted to 99.9 percent of this limit.

2. Current Methodology for Developing Rates Under the Two-Plan Model

Under the Two-Plan Model, capitation rates are set using a two-step process. First, an overall limit on program expenditures is calculated in order to comply with the requirement of the 1915(b) waiver that expenditures not exceed expected fee-for-service expenditures for the

enrolled population. For this step, the methodology described above is used, using the entire 12-county region rather than a single county to produce an overall upper payment limit for the program.

Next, capitation rates are developed for each county included in the pilot. These rates were based not on fee-for-service expenditures, but on Medi-Cal managed care experience in one county, Santa Barbara, which has a particularly well-established, -managed and -documented County Organized Health System (COHS). State officials chose this approach so as to create rates that accurately reflect utilization rates and costs under a managed care system, rather than continuing to rely on fee-for-service expenditures (and thus on utilization patterns found under fee-for-service) to develop capitation rates. However, as the rates were developed, the actuaries were required to rely on fee-for-service data to develop certain adjustment factors, as county-specific managed care data are not yet available. As the state's experience with managed care grows, these factors will be based on appropriate managed care data. The steps involved in developing this rate are the following:

- Using the Santa Barbara COHS utilization data from 1993, the average annual expected units of service are calculated for each of the six service categories and five eligibility categories. These base utilization rates are then adjusted for each county based on factors related to the age, sex, and aid code distribution for the Medi-Cal eligibles in each of the 12 counties.

- Base costs for each service category and aid code are calculated based on the average payment per unit in the Santa Barbara COHS. For all service categories except Hospital Inpatient, this calculation is straightforward. For Hospital Inpatient, two steps are involved:

    - First, base rates are calculated based on the actual expenditure per inpatient day in each of the 12 counties.

    - These rates are then adjusted for the two types of plans involved in the two-plan model. Local Initiatives are required to contract with disproportionate share hospitals in their counties, which usually receive a higher daily rate than other hospitals. LI plans' capitation rates are therefore calculated using the disproportionate-share rate, while commercial plans' rates are based on the nondisproportionate share hospital rates. An adjustment is then made to account for the expected level of use of each type of hospital by each plan; for example, if a large proportion of hospital days in a given county is attributable to disproportionate-share hospitals, it is assumed that the mainstream plan will use these hospitals to a greater extent, and its rate will be increased.

A further adjustment was made to the cost estimates for Physician Services to account for differences in the cost of these services in each of the 12 counties, based on county-specific data on the average salaries of physicians.

- The estimated utilization rates are then multiplied by the estimated service expenditures and a series of adjustments made to the resulting rates. These adjustments, which were made using the methodologies described above, included factors reflecting the interest lost to the state on prospective capitation payments; legislative changes in the Medi-Cal program; trend factors between 1993 and 1996-97; and 0contract limits on mental health, long-term care, and lenses. As mentioned above, these adjustments were made using fee-for-service data; as managed care data become available, they will be recalculated.

The adjusted, service-specific rates for each eligibility category are then summed to calculate a preliminary monthly rate. To this preliminary rate, a further adjustment was made to account for the additional cost of the CHDP program, as in the methodology described above. Finally, the total estimated cost of the program using this method was compared to the upper payment limit described above. The rates developed for both 1995-96 and 1996-97 exceeded this limit, so the rates were reduced by an appropriate percentage to meet the overall limit (2 percent in 1996 and 1 percent for 1997).

Pursuant to 1995 legislation, a further, two-step adjustment is made to the LI rates to account for the additional costs involved in the LI's inclusion of Federally Qualified Health Centers (FQHCs) in their networks. These added costs account for the portion of FQHC payments attributable to cost-based reimbursement—estimated at 56 percent of FQHC payments, based on analysis of FQHC reimbursement experience. The purpose of this adjustment is to more accurately determine the rate at which LIs will be reimbursed for this incremental portion of FQHC costs. First, 56 percent of FQHC reimbursement estimates (based on the previous year's figures) are subtracted from both the upper payment limit (calculated based on fee-for-service experience) and the Santa Barbara-derived base costs. Then, new, more empirically sound estimates LI costs attributable to cost-based reimbursement of FQHCs are developed. These new estimates are added to both the upper payment limit and the capitation rate developed for the LI. The new estimates are based on actual estimates of FQHC cost and utilization experience per 1000 enrollees in each county and are developed using the assumption that 75 percent of a county's FQHC visits will be paid for through the county's LI, and that 50 percent of eligibles in each county will enroll in the LI.

Since the adjusted LI rates projections are based on FQHC utilization and reasonable cost experience from the previous year and the indicated assumptions, the potential inaccuracy of these rates for the current year is recognized. Therefore, they are understood to be interim rates, and under- or over-estimations are resolved through the reconciliation process described below.

C. Negotiating and Contracting

There is no formal Request for Applications (RFA) or Request for Proposals (RFP) issued by the state to contract with managed care organizations for the PHP and PCCM programs; rather, for counties in which these programs are operating, plans may at any point submit an application to the DHS to serve as a PHP or PCCM provider. Applications submitted by plans are evaluated by the DHS and ranked in areas including quality, licensing, capacity, and financial solvency. Neither the PHP program nor the PCCM program imposes limits on the number of plans which may be chosen to serve in a particular county.

The California Medical Assistance Commission (an administrative entity external to the DHS) is responsible for contracting with managed care plans for the COHS and GMC programs. Counties that decide to initiate a COHS or GMC program submit their proposals to the Commission, which then evaluates these plans based on a bid and negotiation process, with concern to quality, financial solvency, cost (the bid must be below the fee-for-service upper payment limit), and the ability to meet contract requirements. Only one plan can win the COHS bid for a particular county, while several plans can win GMC contracts within a specific geographic area.

To contract with plans under the Two-Plan Model, the state issued an RFA for commercial plans in each of the 12 pilot counties. Plans are evaluated and ranked in areas of quality, financial solvency, and capacity, and one plan is chosen for each county. A commercial plan could gain bonus points by including safety net providers in its provider network or by offering additional benefits, but cost is not a factor in the selection process. LI plans must satisfy similar financial, quality, and capacity standards, and include safety net providers in their provider networks in order to gain state approval for participation in the program.

In this way, one commercial plan and one LI are enrolled in each county, which then compete for the county's Medi-Cal recipients. (The only exception is Fresno County, in which the LI was deemed unqualified, so two commercial plans were contracted to compete within the county.) For the first year of this program, managed care organizations are contracted from 1 June 1996 through September 1997. Each year, rates will be completely recalculated using current data, based increasingly on managed care experience as the managed care data accumulate and fee-for-service data become less available.

D. Enrollment

Two-Plan Model recipients choose to receive their services through either their county's LI or the local commercial plan. Enrollees are not locked in to the plan they choose. When the plan is fully implemented in all 12 counties, participation will be mandatory for AFDC, AFDC-related, medically needy, and indigent child eligibles, and voluntary for SSI and SSI-related eligibles. As of December 1996, however, only two counties have both plans in place, and mandatory enrollment has not yet begun.

Each managed care organization contract outlines the plan's enrollment limit. Consideration is given to the extent of the plan's provider network, particularly the number of primary care providers and hospitals available to enrollees, and the estimated proportion of a county's enrollees which would allow the realization of economies of scale and critical mass. The intention is for half of the county's eligible population to enroll in each plan while maintaining disproportionate sharing.

Normally, recipients who do not voluntarily choose a plan will be assigned randomly to one. Once one of the two managed care organizations reaches its enrollment capacity, however, nonchoosers will be assigned to the other.

E. Sharing of Risk

Unless the participating managed care organizations can prove their ability to self-insure, they are required to purchase some form of reinsurance. Although the state offers various stop-loss insurance options, most plans have preferred to either purchase commercial insurance or self-insure.

In order to further protect LI plans and encourage their use of FQHCs, the state goes through a FQHC-payment reconciliation process (mentioned above) with the LIs at the end of the contract year. For this reconciliation, the state set up a risk corridor from 90 to 110 percent of the portion of the capitation payment attributed to FQHC costs, to limit LI gains or losses from the use of FQHCs for the contract period. Should a LI's FQHC expenses for the contract period amount to less than 90 percent of its total payment, these additional savings will be recovered by the state. Should FQHC expenses exceed 110 percent of the payment, the state will reimburse the LI for these additional losses.

F. Quality Assurance

Both LI and commercial plans are required to institute internal quality assurance mechanisms. Plans must collect a variety of relevant information, including encounter, cost, and outcomes data, and member satisfaction surveys, which are used to prepare monthly, quarterly, and annual financial reports, and to inform each plan's Quality Improvement Plan (QIP). The QIP program uses the compiled information to monitor, evaluate, and improve the quality of a plan's performance. Through this program, a plan must assess its compliance with various contractual standards (including standards of service, accessibility, and provider/member ratios); track its outcomes performance; conduct quality of care studies in 11 different service areas; assess utilization management; and develop, implement, and evaluate improvement strategies.

Plans must also submit an annual QIP report to DHS, which summarizes the results of QIP studies and activities, provides utilization and quality of care data, and assesses the QIP for effectiveness and potential modifications. In addition, plans are required to conduct periodic

facility reviews, and to maintain a management information system that allows the information exchange necessary for administrators and providers to meet contract requirements.

Further, the state has established a quality assurance unit within DHS devoted to monitoring the Two-Plan Model. This unit reviews the various data, summary, and assessment reports that plans are required to submit, using relevant HEDIS indicators and outcome measures, and occasionally conducts independent audits and assessment studies. Plan solvency is monitored by the state's Department of Corporations, with some relevant information provided by DHS.

III. Future of Medi-Cal Managed Care

State officials believe that the future direction of the Medi-Cal managed care program will be towards mandatory enrollment programs, such as the COHS and GMC programs and the Two-Plan Model. Although California intends to continue operating COHS and GMC programs in addition to the Two-Plan Model, however, the future of rate development for Medi-Cal managed care programs appears to lie with the Two-Plan Model methodology, using data from managed care plans to develop capitation rates.

While state officials feel that internal rate-development makes the selection of a commercial plan simpler than under a bid and negotiation process, the addition of a cost proposal may help to assure that the state's rates are realistic. In addition, adjustments may continue to be made to the rate-development methodology, including additions to the rate to finance uncompensated care, or to enhance access.

Connecticut

I. Overview

In 1995, the Connecticut Department of Social Services (DSS) received a 1915(b) waiver to begin its Medicaid managed care initiative, Connecticut Access. The program began voluntary enrollment in two counties in August 1995; the 1915(b) waiver went into effect in October 1995, allowing for statewide mandatory enrollment of AFDC and AFDC-related eligibles, as well as pregnant women, children, and foster children. SSI, Medically Needy, and General Assistance populations are excluded from enrollment in Connecticut Access. As of December 1996, the program has reached almost full penetration, enrolling 92 percent of eligible Medicaid recipients. The 1915(b) waiver is effective until September 1997.

Connecticut has established two processes for selecting managed care plans to serve its Medicaid eligible population. DSS first uses an RFA process to contract with all plans that meet the state's quality standards and are willing to accept the state's rates. The RFA process is employed to ensure that Medicaid eligibles have sufficient choice among health plans, and to assure that historic Medicaid providers such as Federally Qualified Health Centers (FQHCs) may participate in the program. DSS then uses an RFP process, based on both price and quality standards, to select "Designated Plans" to which those who have not chosen a plan will be assigned. Because state officials anticipated that as many as one-third of eligibles would not choose a plan, they established this process to assure the quality of the Designated Plans. Connecticut Access currently contracts with two Designated Plans; the bidding process used to choose these plans will be discussed in more detail below.

Connecticut Access' capitation rates are developed by DSS based on 95 percent of historical fee-for-service per capita expenditures. Connecticut Access currently has contracts with nine fully capitated health plans and two Partially Capitated Health Plans (PCHPs), which are responsible for providing all services except inpatient hospital and skilled nursing facility services. DSS has encouraged the formation of PCHPs in order to offer providers who have experience serving the Medicaid population a way to participate in the managed care initiative and to directly benefit from the cost savings of their efforts. Licensed HMOs are not allowed to participate directly or indirectly as PCHPs.

II. Development of Capitation Rates

A. Benefits

The capitation rates developed for Connecticut Access encompass all of the federally required benefits, including primary and preventive care, specialty care, inpatient and outpatient hospital care, and EPSDT services, as well as such optional benefits as prescription drug coverage, dental services, and physical therapy. Plans are also asked to identify in their applications any special initiatives they provide for pregnant women and children with respect to access, utilization, comprehensiveness, continuity, and quality of care.

Plans are mandated to contract with Medicaid-reimbursed, school-based clinics and to refer emotionally disturbed children to child guidance centers or alternative providers of psychiatric/mental health and substance abuse services if the plans do not provide these services themselves. Neither school-based child health services for children with special health care needs nor Part H early intervention services are included in the capitation rate.

B. Rate Development

The Connecticut Department of Social Services hired an outside actuary to develop the capitation rates for calendar year (CY) 1996. The actuary calculated the rates using Connecticut's CY 1994 claims database, making adjustments to more accurately reflect expenditures under managed care. These adjustments are listed below:

- Expenditures for school-based health services for children with special health care needs are not the responsibility of the health plans and were therefore removed from the database.

- Pharmacy expenditures in the database were reduced by 17.97 percent to account for the savings that DSS had received under the Federal Drug Rebate Program. Under the fee-for-service system, this program allowed state Medicaid agencies to receive discounted drug prices in the form of rebates. This discount was taken from the gross pharmacy expenditures in the claims database to assure that the state would pay the same net amount for pharmacy services under managed care.

- Inpatient expenditures were increased by about 3 percent to account for retrospective hospital cost adjustments. The increase reflected each hospital's retrospectively identified expenditure differences between their anticipated and actual length of stay for Medicaid admissions.

- The costs and eligible months associated with retrospective eligibility periods were eliminated from the database. Although retrospective eligibility is often

awarded to applicants for Medicaid coverage, health plans are not expected to provide coverage until the state has determined eligibility. In this step, expenditures for pregnant women during the presumptive eligibility period were removed, as were expenditures for infants born before their mothers' eligibility had been determined.

- The cost and eligible months of a small number of people who were covered by Connecticut Medicaid but who reside outside the state were removed from the database.

The net effect of these adjustments was a decrease in the average per-member, per-month expenditure of $3.78 per eligible per month.

The actuary used the CY 1994 adjusted data to establish rates for six age/sex categories (0-1, 1-14, 15-39 Female, 15-39 Male, 40+ Female, and 40+ Male). Several adjustments were made to these initial rates, as described below.

- The rates were increased to compensate plans for serving five new coverage groups made up of pregnant women and foster children. These groups had not previously been enrolled in Connecticut Access, and state officials felt that they were likely to have higher costs than the original target population. Although the state does not develop rates for specific eligibility categories, rates in all affected cells were adjusted to account for the addition of these new, higher-cost groups. While the new groups were phased in beginning in April 1996, a single set of capitation rates was developed for the 1996 calendar year. These rates were determined by calculating a weighted average based on 1994 PMPM expenditures and the estimated number of 1996 enrollee months for both the original and new coverage groups. The rate cells most affected by this adjustment were the 1-14 age group, whose rates increased by 4.9 percent, and females age 15-39, whose rates increased by 4.4 percent.

- The claims database used by the actuaries was estimated to be 98.33 percent complete for fully capitated plans; that is, 1.67 percent of the CY 1994 claims had not been paid at the time the database was developed. Therefore, all expenditures in the database for fully capitated plans were increased by 1.69 percent to account for incurred but unpaid claims. Expenditures for partially capitated plans were increased by 1.47 percent, as the data used to develop this rate were determined to be 98.55 percent complete.

- Two methodologies were employed to develop the inflation factors used to project rates forward to 1995 and 1996. The results of the two methodologies were averaged, giving each equal weight. The two methodologies are presented below:

- The first approach took into consideration recent inflation rates experienced in Medicaid expenditures for the target population, accounting for changes in intensity, price, and eligibility. Using this approach, the per capita increase for rates paid to fully capitated plans was 8.71 percent for both periods, 1994-95 and 1995-96. For partially capitated plans, the increase amounted to 10 percent for both periods, 1994-95 and 1995-96.

- The second trending methodology took into account only changes in Medicaid reimbursement rates. For fully capitated plans, this methodology produced an inflation factor of 6.67 percent for 1994-95 and 4.46 percent for 1995-96. For partially capitated plans, this methodology produced an inflation factor of 5.56 percent for 1994-95 and 3.21 percent for 1995-96.

After averaging the results of these two methodologies, the rates for fully capitated plans for 1995 were adjusted using an inflation factor of 7.69 percent and the rates for 1996 using a factor of 6.58 percent. The rates for partially capitated plans were adjusted using an inflation factor of 7.79 percent for 1994-95 and 6.62 percent for 1995-96.

- The 1996 rates were then multiplied by 95 percent in order for the state to experience a 5 percent managed care savings.

- Finally, county-specific factors were developed to adjust the rates paid in each county for the expected level of cost in the county. For each county, a total expected expenditure level was derived by multiplying each age/sex cohort's actual eligible months by the cohort's statewide average PMPM rate (using the baseline 1994 rate before adjustments) and then summing the results. Then the actual 1994 expenditure in the county was divided by the total expected expenditure to derive the county factor. County factors were developed separately for fully and partially capitated plans.

Final rates to be paid in each county for fully and partially capitated plans were created by multiplying the final discounted rate by the county factor.

C. Negotiation and Contracting

In 1995, DSS developed three RFAs: one for partially capitated plans, one for licensed HMOs, and one for full risk plans operating under the auspices of FQHCs, which receive the same full-risk rate as HMOs but have different financial reserve requirements. As part of the solicitation, plans were provided with a document describing how the capitation rates were set and were offered claims data on tape so as to analyze the adequacy of the rates offered.

Plans submitted applications and were judged on their ability to meet 137 noncost criteria. These criteria were related to financial solvency, access to care and provider networks, internal quality review mechanisms, utilization management programs, ability to provide EPSDT services, outreach mechanisms, language translation services, marketing techniques, and the delineation of internal grievance procedures. All of these factors were specifically addressed in the RFA and plans were asked to give detailed responses to questions addressing each component. DSS then conducted site visits to the plans' facilities to verify the information presented in the applications and to provide assistance if plans needed help meeting any technical criteria. Connecticut Access contracted with 11 of the 14 plans who presented applications; the remaining three withdrew their applications.

Plans that had successfully passed through this RFA process could choose to submit a proposal in response to the RFP for Designated Plan status. This bidding process was employed to select plans to which to assign enrollees who have not voluntarily chosen a plan. DSS aimed to choose one Designated Plan (DP) for each of the two regions of the state, although the state had the leeway to award as many as four DPs statewide or as few as one. The initial DP contracts were signed for two years with two optional one-year extension periods. They began in July 1995 and will end in June 1997.

In designing the RFP for Designated Plans (DPs), state officials felt that those Connecticut Access enrollees who do not choose a managed care plan would have a particular need for outreach and education services from the plan to which they are assigned. Therefore, bidders were evaluated based on their responses in the following four areas:

- The health plan's overall managed care experience and expertise including solvency and organizational stability (20 percent);
- The breadth of their provider networks and experience in serving the Medicaid population (30 percent);
- The health plan's ability to coordinate Medicaid enrollees' overall health needs, and quantity and quality of special initiatives to improve access to health care services (30 percent); and
- Their cost proposals (20 percent).

Plans submitting proposals for DP status had to achieve a minimum score on the RFP's technical criteria in order for the cost proposal to be reviewed. In the cost proposal, plans presented a per capita rate as a percentage of historical fee-for-service expenditures; plans are allowed to bid no more than 95 percent of fee-for-service costs, and DSS gives an incentive for plans to offer a lower rate by awarding points for percentages under 95 percent. The points are calculated based on a formula that evaluates each bidder's rates as a fraction of the highest bidder's rates. The discounted rates paid to the Designated Plans are applied to all enrollees, not just the assigned population.

In the 1995 RFP process, six plans presented bids. In the Western region of the state, the winning plan offered a rate of 90 percent of fee-for-service costs. In the Eastern region, only one plan met the RFP's technical criteria; this plan offered a bid of 95 percent. At present, approximately 10 percent of Connecticut Access eligibles are assigned to the Designated Plans.

D. Enrollment

Connecticut has developed overall plan capacity standards based on ratios that were established under the fee-for-service system. After making adjustments for providers with small claims volume, DSS established standard ratios for the number of Connecticut Access enrollees per primary care provider, dentist, and mental health provider; these ratios are used to develop each plan's enrollment limit based on the size of each plan's provider network. DSS has also established a maximum practice size of 1200 Medicaid recipients per primary care provider.

After initial enrollment in a chosen health plan or Designated Plan, an enrollee may disenroll without cause during the first month. In the next five months, the enrollee may disenroll after demonstrating a need to change plans.

F. Sharing of Risk

DSS initially offered optional stop-loss coverage to plans; if a plan chose to purchase this coverage, its capitation rate would be reduced. Stop-loss coverage for fully capitated plans was offered for expenditures over $75,000 and for partially capitated plans for expenditures over $35,000 for the full calendar year. DSS would reimburse the plan for 80 percent of costs above this threshold and the plan would be responsible for the remaining 20 percent. However, plans did not show an interest in purchasing stop-loss coverage from the state, so it has been withdrawn. Plans are required to purchase private reinsurance in order to pass through the RFA process.

G. Quality Assurance

HMOs participating in Connecticut Access are licensed by the Connecticut Department of Insurance, while PCHPs are approved by DSS. DSS has begun to collect encounter data to monitor the quality of care provided by both types of health plan, basing the indicators monitored on HEDIS. To further ensure quality of care, DSS is about to sign a contract with an external quality review organization that will collect and analyze encounter data collected by plans and do focused studies in the areas of pediatric asthma, behavioral health, and maternal and child health. DSS also has a requirement that encounter data be submitted not only to the Department but also to the Children's Health Council (CHC), which is an independent body that monitors the plan's compliance with the requirements of the EPSDT program. The CHC provides DSS with ongoing reports on plans' progress toward immunization and EPSDT screening goals.

DSS collects quarterly financial statements and audited annual reports from plans to assess the adequacy of the capitation rates. In addition, DSS has established budget targets for the two partially capitated plans. Even though these plans are not financially liable for inpatient care, they are expected to manage the use of hospital care. If inpatient costs under these plans come in under budgeted targets, the state shares 50 percent of the savings with the plan.

III. The Future of Connecticut Access

Connecticut's plan for the immediate future is to renew the 1915(b) waiver and to expand coverage to incorporate the General Assistance population. DSS officials hope that Connecticut Access will eventually operate under an 1115(a) waiver that would allow development of a program for the dually eligible. The 1115(a) waiver application will not be ready for submission until the fall of 1997. It is likely that Connecticut will use a competitive bidding process under this 1115(a) waiver, due to both legislative pressure to reduce Medicaid expenditures and the administrative burden of monitoring a large number of participating plans.

Delaware

I. Overview

On 1 January 1996, the State of Delaware implemented the Diamond State Health Plan (DSHP), the state's fully capitated, mandatory managed care program initiated under an 1115(a) waiver. Through DSHP, three statewide plans and one regional plan are contracted to provide services to the state's AFDC, AFDC-related, and SSI (except those requiring long-term care) Medicaid eligibles. In addition, the DSHP program expands Medicaid eligibility to include adults with household incomes up to 100 percent of the Federal Poverty Level. DSHP absorbed the state's statewide, voluntary Nemours CHILD Plan, which was initiated in 1992 under an 1115(a) waiver for coverage of Medicaid eligible children under the age of 18. The Nemours Foundation—the sole managed care organization contracted with for this program—provided services under fully capitated arrangements in New Castle County, and under partially capitated arrangements in Sussex and Kent Counties.

Delaware contracts with independent actuaries to develop contract rates for DSHP; plans do not make cost proposals, but are evaluated based on their technical proposals according to the state's quality standards. Contract rates are statewide, but are specific to 12 eligibility categories and are based on the state's previous fee-for-service Medicaid experience, trended to the rate year and adjusted for the expected effects of managed care on utilization and expenditures.

II. Development of Capitation Rates

A. Benefits

Participating plans are required to provide DSHP recipients with a comprehensive benefit package. The services included in the benefit package include physician services, outpatient and inpatient hospital care, family planning, EPSDT services, case management, durable medical equipment, emergency transportation, and some enhanced services (such as diabetes, asthma, and parenting education classes). Also included in this required benefit package are Smart Start services for pregnant women who, due to a variety of possible medical, nutritional, or social problems, are at risk for having a low birth weight or premature baby. Through this

program, eligible women must be case managed for receipt of assessment, education, and counseling (including referrals) in areas of nutrition, nursing, and social services.

In addition, certain services must be provided by plans up to a limit. Plans are responsible for providing behavioral health services to limits of 30 days for adult inpatient care, 20 visits for adult outpatient care, 9 days for adult involuntary psychiatric care (up to 3 days per episode), 5 days for adult detoxification services, and 30 days for child outpatient care. Plans must also provide up to 90 days of pre-/postnatal care, 28 hours per week of private duty nursing, and 30 days of skilled nursing facility services. Detailed descriptions of EPSDT, Smart Start, behavioral health, and other required services are included in the Request For Proposals (RFP) issued to plans.

Some services are completely excluded from the capitation rate and are therefore not within the package of benefits provided by the plans:

- Prescription and nonprescription drugs (currently provided through the state's Drug Utilization Program, though they may eventually be included in the capitated package);
- Inpatient behavioral health services for children under the age of 18 (paid by Medicaid but provided through the state's Department of Services for Children, Youth, and Their Families);
- All dental services (child dental care is covered under out-of-plan fee-for-service arrangements);
- Nonemergency transportation (covered under out-of-plan fee-for-service arrangements); and
- Part H Intervention Services for high-risk infants and children (covered under out-of-plan fee-for-service arrangements).

Plans are prohibited from imposing any cost-sharing provisions on their DSHP members.

B. Rate Development

As previously mentioned, Delaware contracts with independent actuaries to develop rates for the DSHP program. The most recent rate development was completed in the summer of 1995, for the 1996 contract year, using state fee-for-service incurred claims data collected between 1 July 1991 and 30 June 1994. Due to differences in the utilization and expenditure patterns observed for different groups of eligibles, program recipients are assigned into the following 12 rate categories:

- AFDC and expansion group:

- Females and males under the age of 1.
- Females and males between the ages of 1 and 10,
- Females between the ages of 11 and 17,
- Males between the ages of 11 and 17,
- Females between the ages of 18 and 44,
- Males between the ages of 18 and 44, and
- Females and males over the age of 45.

■ SOBRA women:

- Supplemental payment for delivery-related inpatient and physician expenses, and
- Monthly capitation rate for all other medical expenses.

■ SSI:

- Males and females under the age of 18, and
- Males and females over the age of 18.

■ All those eligible under the state's Health First general assistance program.

Statewide rates are then developed separately for each of these rate categories. Following a three-step rate development process, the fee-for-service database is first adjusted to match program specifications; the adjusted database is then used to develop projected fee-for-service equivalent per-member, per-month (PMPM) rates; and the fee-for-service equivalent rates are then adjusted for the effects of managed care, to yield final contract rates. These processes are described in more detail below.

In the first step of this process, data for excluded populations and services are removed from the database. Populations excluded from the database include those in long-term care institutions, those covered under community-based long-term care waivers (such as the AIDS or mental retardation waivers), those dually eligible for both Medicare and Medicaid, and those covered through other managed care plans, for whom Medicaid is the secondary payor. Services excluded from the program's benefit package include dental services for children, behavioral health services beyond program limits, prescribed pediatric extended care, pharmacy, school district services reimbursed directly by Medicaid, skilled nursing facility

service beyond program limits, and nonemergency transportation. In addition, payments for disproportionate share hospitals are removed from the database, although expenditures for hospital medical education and capital costs are retained.

Using this adjusted database, actuaries then develop rate category-specific fee-for-service equivalent rates according to the following methodology:

- First, rate category-specific utilization and unit cost data are used to calculate base PMPM rates for each of five categories of service (Inpatient, Outpatient, Physician, Mental Health, and Other services).

- These service category-specific rates are then trended forward for inflation, using the Medicaid Producer Price Index for the Inpatient and Outpatient categories, and the Medical Consumer Price Index for all other categories. With the exception of those used for the Mental Health category, the factors are compounded over the 3.5 years between the midpoint of the base years (1 January 1993) and the midpoint of the contract year (1 July 1996), and are identical across all AFDC/expansion group rate categories:

  - For Inpatient and Outpatient services, this factor is 1.143 (an annual rate of 3.9 percent, compounded);

  - For Physician services, this factor is 1.17 (with an annual rate of 4.6 percent, compounded); and

  - For Other services, the inflation factor is 1.12 (with an annual rate of 4.9 percent, compounded).

  The Mental Health rates were developed using data from 1 July 1994 to 30 June 1995; thus, the inflation period for this service category is only 1.5 years (1 January 1995 to 1 July 1996). Inflation factors for Mental Health services range from 1.061 to 1.099 (with annual rates between 4.0 to 6.5 percent, compounded) across all AFDC and related rate categories.

- Next, the Inpatient rates are decreased by 1 percent across all rate categories, to account for retrospective settlements with hospitals during the base years that are not accounted for in the database. These settlement payments were paid retrospectively by hospitals to the state, indicating that the incurred claims expenditure data in the database are slightly overstated. The state also adopted a new inpatient hospital reimbursement methodology in July 1994; however, since the net effect of the change is zero, no adjustment is made for this new methodology.

- To account for incurred but not reported (IBNR) claims in the last base year (1994), IBNR adjustment factors are applied to the service category-specific rates. These factors are service-specific, but are identical across all AFDC rate categories. They range from 1.018 (for Outpatient services) to 1.058 (for Other services). All incurred claims from the previous base years are assumed to be reported and paid.

- In the period between eligibility determination and enrollment into a health plan, recipients are covered through fee-for-service Medicaid providers. Plan enrollment occurs on the first day of the month after eligibility determination. Since expenditures for this retroactive eligibility period appear in the fee-for-service database, but do not fall under plan responsibilities, a retroactive eligibility adjustment factor is applied to the service category-specific rates. This factor is identical across all service categories and all AFDC rate categories, reducing all rates by 2.5 percent.

- Finally, all rates are reduced by a factor of 3 percent to account for third party liability recoveries. This factor is based on the state's historical recovery rate for its Medicaid program. The state intends to ensure these expenditure savings; plans are expected to make their own recoveries.

The resulting service category-specific rates are projected fee-for-service equivalent rates, which, when summed, define the fee-for-service equivalent upper payment limit for each rate category. To convert these fee-for-service equivalent rates into contract rates, a service category-specific adjustment is made to the rates to account for historical utilization trends and for expected changes in utilization patterns associated with the use of managed care. For Inpatient, Outpatient (including emergency room), and Mental Health services, utilization is expected to decrease with the use of managed care. The decrease in Inpatient rates ranges from 18 percent to 25 percent across rate categories; Outpatient rates are reduced by 4 to 20 percent across rate categories; and Mental Health service rates are decreased by 5 percent for all AFDC recipients under 18 years of age, and 35 to 38 percent for AFDC recipients 18 years of age or older. To substitute for these services, physician services are expected to increase, with an increase of 10 percent expected for all AFDC and AFDC-related rate categories. No change is expected in the use of Other services for AFDC and related eligibles. These fully adjusted service category-specific rates are then summed to yield a final managed care contract PMPM rate for each rate category. For the AFDC rate categories, these managed care rates equal between 83.9 and 91.8 percent of their corresponding fee-for-service equivalent rates. There is no adjustment made for the administrative expenses incurred by plans, since the fee-for-service database implicitly includes the Medicaid program's administrative costs.

The rates are all paid on a prospective monthly basis to participating plans, with the exception of the supplemental delivery-related rate for SOBRA women, which is a one-time, lump sum payment made upon enrollment of a SOBRA woman into a plan.

Contract rates for the second year of the program (State Fiscal Year 1997 [SFY97]) were identical to those in the first year (described above). All participating plans accepted these rates despite the fact that they were not increased for inflation. For Year Three of the program, however, the state may recalculate contract rates using more recent data.

C. Negotiation and Contracting

Prior to the start of each bid year, Delaware issues an RFP to managed care organizations throughout the state, for the purposes of contracting with plans for the DSHP. Included in the RFP are the contract rates developed by state-contracted independent actuaries. The state provides plans with a databook including historical utilization, expenditures, and enrollment levels, as well as final contract rates. Plans are also given the opportunity to purchase these data in electronic form. Responding plans accept these contract rates, and are evaluated based on their technical proposals. The technical evaluation committee, comprising staff from several state departments and community representatives, evaluates proposals in five technical areas. Points are assigned in the five areas as follows:

- A maximum of 30 points can be assigned for a plan's network management. Within this area, the committee evaluates the plans on a variety of provider network and accessibility issues, including provider credentials, provider access standards, the inclusion or exclusion of Federally Qualified Health Centers (FQHCs) and/or Nemours CHILD providers, the maximum number of clients assigned to each primary care provider, and the plan's strategy for expanding access in the more sparsely populated southern regions of the state. Another set of issues examined in this area are those relating to a plan's quality assurance and utilization management mechanisms. This evaluation includes how and how often reviews are conducted, how reviews are documented and review information shared with providers, the level of provider participation in the review process, the plan's credentialling and recredentialling standards and protocols, how clients with chronic and/or complex conditions are identified and managed, the extent of plan efforts to encourage prenatal care and child immunizations, and the types of outcomes measures used in the review process.

- A maximum of 30 points can be awarded for a plan's client services. This area includes the quality and client-friendliness of delivery and coordination systems for in-plan services (including the referral process and the timeliness of appointments), client health education, the plan's grievance and appeals processes, and the plan's enrollment and disenrollment processes.

- A maximum of 20 points may be awarded for a plan's financial viability and stability, as assessed through a variety of required financial data reports.

- A maximum of 10 points may be assigned for a plan's data reporting and data systems capacity (described in the Quality Assurance section below).

- Finally, a maximum of 10 points may be awarded for the plan's administrative strengths. Of interest in this area are the number and credentials of the plan's key personnel, the plan's corporate background, its prior experience and track record with the Medicaid population, and its strategy and implementation plans (for instance, its understanding of program goals and strategy for reaching them).

In addition, the state may also award bonus points to bidders that emphasize client sensitivity (by developing creative outreach efforts, demonstrating concern about health outcomes, and increasing PCP-to-member ratios, especially in areas with a shortage of PCPs), include community providers (besides FQHCs) in their networks, or offer additional services beyond those required by the RFP (for instance, smoking cessation classes). These bonus points are considered separately, after the basic points have been determined.

Plans are evaluated and scored individually compared to DSHP's minimum program standards, not to each other. Plans are selected based on their point totals and on the number of contracts that the state decides to award. Though the state does not predetermine the number of plans it intends to contract with, this number is determined during the evaluation process, with concern for enhancing freedom of choice and competition (especially in sparsely populated areas) without overestimating the number of plans that can be supported by the state's relatively small Medicaid-eligible population.

During the evaluation process, plans may be contacted by the committee to clarify certain points in their proposals. In order to maintain equality of opportunity amongst the bidders, whenever a question is posed to one plan, it is also posed to all competing plans. Once plans are selected, the state then works with them individually to address any remaining concerns or areas for improvement prior to formally offering each plan a contract. This negotiation is not, however, considered part of the selection process.

In the most recent bid year (SFY96), the state contracted with four of the eight bidding plans. As noted above, three of these plans operate statewide, while one serves only in New Castle county. The program's contract period extends for one year, though the state reserves the option to renew contracts for up to two additional one-year periods.

D. Enrollment

Upon determination of eligibility, each recipient is assigned a Health Benefits Manager, who, in an unbiased manner, provides the recipient with information regarding DSHP and each of the participating plans with PCPs in the recipient's geographic area and assists the recipient in selecting a plan. Recipients who do not express a preference within 30 days of the date on their enrollment form are automatically assigned into a plan based on a random assignment algorithm. This auto-assignment algorithm only includes plans with PCPs in the recipient's geographic area, and weighs plans differently, based on their technical evaluation scores, the

degree to which their provider networks include community and Nemours CHILD Plan providers, and their success at reaching EPSDT goals.

Once enrolled in a plan, recipients may transfer to a different plan at any point during the contract year, provided that the Department of Social Services finds (through standard enrollee grievance procedures) the transfer request to be motivated by "good cause." Otherwise, recipients are locked into their plans until the next annual open enrollment month, during which they are free to switch plans at will.

No explicit enrollment limits are determined for each plan, although the number of contracts awarded in a service area implicitly limits enrollment. Currently, one plan has a somewhat larger (approximately 30 percent) share of the market than the remaining three plans (which each enroll approximately 20 percent of program eligibles).

E. Sharing of Risk

Plans are required to be reinsured to protect against the risk of insolvency. They must either demonstrate an ability to self insure or purchase private reinsurance; however, the state does not enter into any risk-sharing arrangements with participating plans through stop-loss provisions or risk corridors.

F. Quality Assurance

Quality assurance is maintained through mechanisms both internal and external to participating plans. As mentioned above, plans must establish internal quality assurance and utilization management (QA/UM) programs geared toward monitoring, evaluating, assuring, and improving the timeliness, appropriateness, quality, and accessibility of the care they provide. The programs must include practice guidelines and clinical indicators addressing adult preventive care, child and adolescent developmental and preventive care (including EPSDT services), obstetrical/ maternity care, child and adult behavioral health services, family planning services, and selected diagnoses relevant to the Medicaid population.

In addition, plans must track and seek to improve health outcomes based on EPSDT guidelines, guidelines developed by the U.S. Preventive Services Task Force, and other scientifically/clinically validated criteria; they must also collect encounter and utilization data, and validate these data periodically through provider audits. Using these utilization data, plans must prepare quarterly profile reports on areas of under- and over-utilization and observed utilization trends, as well as quarterly profiles comparing the average utilization rates for clients of individual PCPs to the average utilization rates of all plan members (specifically for PCP services, specialty services, inpatient stays, emergency room services, and behavioral health services). Additionally, plans are required to conduct annual client satisfaction surveys. All of the above data must be analyzed and results disseminated to providers. Wherever these mechanisms reveal areas of deficiency, plans must implement and monitor corrective activities.

Plans must also submit data to the Division of Social Services (DSS) for its monitoring efforts. Plans must submit monthly encounter data, quarterly grievance and resolution reports, semi-annual reports detailing quality assurance activities and results (including HEDIS and other clinical outcomes measures), and periodic data reports on behavioral health service utilization, expenditures, enrollment, and access, annual client satisfaction surveys.

Using these reports, along with biannual on-site reviews of plan quality assurance programs, on-site facility inspections, and staff and enrollee interviews, the DSS monitors, evaluates, and works with plans to assure compliance with quality assurance guidelines. Contracted review organizations review the above reports and conduct independent on-site visits to evaluate plans in areas of access, quality and cost-effectiveness of care, along with the effectiveness of the plans' case management efforts and quality assurance procedures and implementation.

Plans are also required to submit various quarterly and annual financial reports, intended to parallel those submitted to the state's Insurance Department for monitoring of plan solvency. Plans in unstable financial situations may be required to submit financial reports on a more frequent basis.

III. Future of the Diamond State Health Plan

State officials report that they decided to develop rates internally rather than through a bid and negotiation process in order to ensure savings and work within the state budget, while encouraging the participation of qualified plans in the initial years of the program. Officials felt that the best way to ensure savings was to predetermine rates; and they have been pleased with the interest shown by plans despite the small size of the state's Medicaid population. State and plan officials have also been very willing to work together to resolve the minor contract concerns that have arisen.

State officials indicated that program rates will continue to be developed internally, given the positive response of plans that has been observed to this point. They expect to eventually base these rates on encounter data collected from participating plans; however, due to the unreliability of the data collected thus far, rates for the next contract year will probably be based primarily on the fee-for-service experience for the enrolled population before the program began (this includes data from SFY95 and through April 1996, when the program became fully operational). Plans will be penalized for any further unreliable data submitted, in an effort to ensure the reliability of collected managed care data.

State officials are also considering including more services in the plans' required benefit package, such as pharmacy services and nonemergency transportation. Since the increased substitution of managed care for fee-for-service has resulted in a loss of economies of scale in the state's Medicaid agency, officials feel that it may be more cost-effective to capitate as many services as possible, and thus minimize the amount of benefit coordination and claims processing required of the Medicaid agency.

Officials are hopeful that plan interest in program participation will grow with the increasing size of the state's Medicaid population, thus increasing the level of competition and quality among plans.

Florida

I. Overview

In 1982, Florida first began contracting with HMOs for coverage of its Medicaid population. Since then, the Florida Agency for Health Care Administration (AHCA) has gradually expanded the program into new areas of the state; the HMO option is now available in 49 of the state's 67 counties. AFDC eligibles, SOBRA children, foster children, and SSI eligibles must choose between Florida's fully capitated program and MediPass, the state's PCCM model. AHCA excludes pregnant women in the SOBRA eligibility category from both the fully capitated program and the PCCM program. (However, women whose eligibility category changes to the SOBRA group after enrolling in a plan remain eligible for enrollment with their current HMO plan or MediPass provider). Individuals who are institutionalized and SSI eligibles who are enrolled in a Medicare HMO are also excluded from Florida's Medicaid managed care programs. Other groups excluded from the HMO program include individuals receiving services through other waiver programs, children enrolled in Children's Medical Services (the State Title V Children with Special Health Care Needs program), Medicaid eligibles who reside in residential group care facilities through the Department of Juvenile Justice, and those who reside in group treatment for alcohol, drug abuse, or mental health services purchased by HRS.

Since 1982, AHCA has used a noncompetitive contracting process, allowing all plans meeting the state's quality standards and accepting the capitation rates developed by AHCA to participate in the capitated program. In September 1996, midway through the 1996-97 contract year, AHCA issued a new RFP in an attempt to contain costs and to improve the quality of care. In this RFP, the state shared its technical and cost criteria with the plans and asked them to submit bids to be scored on both quality and price. The contracts developed based on the September 1996 RFP were never implemented, however, because of various legal challenges. Therefore, when the current contracts expire in July 1997, the state will return to its previous contracting process. However, the process begun in September 1996 includes a number of unique and noteworthy features; it is therefore the focus of this summary.

II. Development of Capitation Rates

A. Benefits

The benefit package provided under Florida's HMO program includes all of the federally required benefits, including primary and preventive care, specialty care, inpatient and outpatient hospital care, inpatient and outpatient mental health care, and EPSDT services, as well as optional benefits such as prescription drugs, community mental health services, school health services and vision and hearing services. Inpatient care up to 45 days is included in the capitation rate; after the first 45 days, this service is reimbursed on a fee-for-service basis. In the September 1996 RFP, AHCA encouraged plans to offer additional benefits such as health and wellness programs, smoking cessation classes, fitness and exercise programs, parenting classes, first aid programs, and STD awareness programs, by offering additional points on the technical proposal for providing these services. While plans will not be offered an incentive for providing enhanced benefits in the July 1997 RFP, they will still be encouraged to offer them at their own discretion.

Plans may choose to offer child and adult dental benefits and transportation services for a standard supplemental capitation rate that is determined by the state. If plans choose not to cover dental and transportation services, they must refer EPSDT eligibles to the area Medicaid Program office to obtain assistance in scheduling these services. Institutional long-term care services for people with developmental disabilities are not covered by the HMO program. For enrollees requiring this care, the plan must consult the Children and Family Services Office to identify appropriate methods of assessment and referral.

B. Rate Development

For its 1996-1997 contracts, Florida set its capitation rates by age category and geographic region based on the previous year's fee-for-service claims data, most of which reflected experience under the state's PCCM program. The claims data were first separated into six age categories (0-1, 1-5, 6-13, 14-20, 21-54, 55+); 10 geographic areas; and 15-25 service categories (depending on age group). A separate category for the 14-20-year-olds was added in July 1996 at the request of plans, to differentiate between the costs of care for children and those for adolescents.

Service-category-specific rates were calculated for each age category and geographic area by multiplying the unit cost for each service by the utilization rate. The only adjustment made to this base rate was for an inflation factor that was calculated separately for each service category. This adjustment allows the state to account for any changes in either the unit cost of specific services or legislative appropriations for the Medicaid program. Thus, the "inflation factors" do not always result in an increase in the base rate; the factors used in 1996 ranged from .54 to 1.45. The service-category-specific rates were then summed to produce the total capitation rate paid to plans in each age group and region. The resulting upper payment limits

were then multiplied by 95 percent, in order for the state to achieve 5 percent savings from the use of managed care.

The new RFP issued in September 1996 attempted to respond to a legislative mandate that the HMO program begin saving an additional 3 percent over the previous year's expenditures. In this RFP, AHCA developed upper and lower payment limits using the same rate calculation process described above. The upper payment limit was set at 92 percent of adjusted fee-for-service payments, in an attempt to save an additional 3 percentage points over the previous year's rates. The lower payment limit was set at 87 percent of the FFSE, the lowest the state felt it could pay and still be able to expect high-quality services. Plans were offered standard supplemental capitation payments if they chose to provide dental and/or transportation services.

C. Negotiating and Contracting

The state contracts with all plans that meet its technical standards and accept its calculated rates. Plans are asked to bid to serve counties within each of the state's 10 areas, according to where the plans hold licensure.

In the September 1996 RFP, AHCA had asked plans to submit bids to be scored on both technical and price criteria. Bids were scored on a scale of 1000 points, with technical factors worth 800 points and price 200 points. On the cost proposal, HMOs had been given a score of 200 points for rates equal to 87 percent of the upper payment limit and 150 points for rates equal to 92 percent of the upper payment limit; rates in the middle of this range had received scores between 150 and 200. The 800 technical points had been distributed to plans based on their answers to a series of questions regarding the size of their provider networks, their management information systems, their corporate structure, and their ability to provide the requested data to AHCA. AHCA had also awarded points to plans for contracting with County Public Health Units and for providing the enhanced benefits mentioned above.

If a plan had met the minimum score criteria of 300 points on the technical proposal and submitted a cost proposal within the allowable range, they would have been awarded contracts; no limit was placed on the number of plans that would have been chosen to operate in any county. (If plans' total cost proposals had amounted to more than 92 percent or less than 87 percent of the aggregate FFSE, they would have been automatically eliminated from consideration). Plans' total scores would not have been used to select between plans; instead, they would have been used to determine their enrollment limits, as described below.

As mentioned above, the contracts were not implemented due to various legal challenges presented by plans. Because AHCA was still required to achieve an additional 3 percent savings, program officials changed the rates paid to existing contractors to 92 percent of fee-for-service expenditures in April 1997. The state was able to do this because it had stipulated in the contract that it be allowed to adjust the capitation rates at any time to reflect budgetary

changes in the Medicaid HMO program. The state will continue to offer 92 percent of fee-for-service equivalent rates to all plans who sign contracts in July 1997.

D. Enrollment

If the September 1996 contracts had been implemented, each plan's total score on quality and price would have been used to determine the enrollment capacity in each plan for each county. This limit would have been calculated in such a way that plans with the highest total score would have received the largest share of the county's enrollees. The total points awarded to all contracted plans in each county were to be summed, and each plan would receive a share of total enrollment equal to its share of total points awarded.

Upon enrollment in Medicaid, recipients are asked to choose between the HMO Program and the PCCM program. Those who choose the HMO program are asked to select one of the available plans in the county. Those who do not choose between the HMO and the PCCM options are assigned to these programs according to the distribution of those who make a voluntary choice; that is, the percent of the assigned population enrolled in HMOs will equal the percent of choosers who join HMOs. (Prior to February 1997, nonchoosers were automatically enrolled in the PCCM program; under the 1915b waiver, those who do not choose a plan may be enrolled in an HMO). Eligibles who are assigned to the HMO program are randomly enrolled in a plan that has not yet reached its enrollment capacity.

E. Sharing of Risk

Plans are not required to purchase reinsurance from the state nor on the private market. The state's only mechanism of sharing risk with plans is the 45-day limit on inpatient hospital care.

F. Quality Assurance

AHCA is collecting utilization and cost data from plans to determine the adequacy of their rates. AHCA also requires plans to report HEDIS 2.5 indicators; AHCA is currently modifying this requirement to include items from HEDIS 3.0.

Plans are required to have an internal quality assurance process to identify problems, design strategies for change, implement improvement activities and measure success. The plan's quality assurance program must have a peer review component with the authority to review practice patterns of individual physicians and to evaluate the appropriateness of care. The plans must conduct an annual survey of enrollee satisfaction and submit the results to AHCA.

Solvency is monitored by the Department of Insurance. Plans are required to establish a restricted insolvency protection account with a federally guaranteed financial institution. Plans must deposit 5 percent of the capitation payments received each month into this account until a maximum total of 2 percent of the total current contract amount is reached.

III. The Future of the Florida HMO Program

AHCA was not able to implement its September 1996 contracts because of legal challenges concerning the enrollment capacities awarded to the plans. The state will therefore return to its previous contracting process in July 1997, when the 1996-97 contracts expire. All plans that had contracts previously will be able to renew their contracts and any plans wishing to enter the process will be encouraged to submit a proposal at this time.

Georgia

I. Overview

Georgia first began using managed care arrangements for delivery of health care services to its Medicaid population in 1993, when the Georgia Better Health Care Program was implemented. This program continues to operate as a primary case care management (PCCM) model under authority of a 1915(b) waiver. Currently, the program operates in 47 counties, and enrollment in the program is mandatory for all AFDC eligibles, AFDC-related children, and SSI eligibles. The program is scheduled to expand statewide by December 1997.

In January 1996, the state also initiated a voluntary, fully capitated program called the Georgia Medicaid Health Maintenance Organization (HMO) Program. The program is currently establishing itself in the central Atlanta and suburban Atlanta regions, although it is also expected to eventually become a statewide program. It extends eligibility to AFDC, Right From the Start Medicaid (RSM) children (SOBRA children), and SSI Medicaid eligibles, who may enroll on a voluntary basis; those who do not enroll in a capitated HMO are enrolled in the PCCM program. Pregnant women eligible for Medicaid under the SOBRA expansion may not enroll in HMOs; state officials feel that, since SOBRA women often enroll only at the time of delivery, their lengths of eligibility are too unpredictable to effectively spread costs through the development of a capitation rate.

Under the Georgia Medicaid HMO Program, the state contracts with outside actuaries to calculate aid category-, age/sex-, and area-specific capitation rates which are the basis for HMO contracts. State officials chose to develop rates internally rather than through a bid and negotiation process in order to ensure managed care savings to the state and to use a continuous contracting process to facilitate program participation for qualified HMOs. This rate development process may be refined to form a benchmark for a future bid and negotiation process.

II. Development of Capitation Rates

A. Benefits

Plans participating in Georgia's Medicaid HMO Program must provide their Medicaid enrollees with a comprehensive benefit package, which includes family planning services, Children's Intervention Services (including physical/speech therapy and EPSDT services), a Childbirth Education Program, and emergency transportation. Contracted plans may also offer enrollees additional services (such as health promotion and expanded health services) as a marketing tool, but compensation for these services is not included in the capitation rate.

Certain services are excluded from the capitation rates; these services are reimbursed on a fee-for-service basis. Among these are all dental services and behavioral health services and nonemergency transportation, which are currently all covered under fee-for-service arrangements with other Medicaid providers. The state encourages plans to provide case management services, although it does not reimburse the costs of these services. The state also has an 1115(a) waiver application currently pending to provide behavioral health services under an independent capitated system.

Further, certain services are completely excluded from the Medicaid benefits package. The notable exclusions are long-term care, Part H Early Intervention (except for those included under other service categories), and chiropractic services.

Medicaid enrollees are entitled to receive all their services without any copayments or other costsharing provisions; however, those who use the emergency room for nonemergency care must pay the cost of these services in full.

B. Rate Development

The state contracts with outside actuaries to develop a rate structure on which to base HMO contracts. The rates are recalculated every 1 July, using the most current actuarial fee-for-service data available from within and without Georgia's Medicaid program, and are intended to represent fee-for-service equivalents adjusted for the impact of managed care on utilization and expenditures. The actuaries' databook, which documents the development of these rates and includes demographic, geographic, cost, and utilization data, is made available to prospective applicants. The per-member per-month (PMPM) rates are calculated based on three demographic characteristics:

- Four categories of aid (AFDC, Right from the Start Medicaid [RSM] children [SOBRA children], SSI with Medicare, or SSI without Medicare);
- Seven age/sex cells (males and females 1 to 2 months old, males and females 3 to 12 months old, males and females 1 to 6 years old, males and females 7 to 13

years old, males 14 to 44 years old, females 14 to 44 years old, and males and females over the age of 44); and

- Two geographic regions (central Atlanta and suburban Atlanta). The most recent calculation of rates was conducted in 1996, using fee-for-service data from January 1993 to October 1995, for contracts effective for the 1996/97 state fiscal year.

Actuaries follow a two-step process in developing these rates. In the first step of the process, the aggregate fee-for-service database is adjusted to match the specifications of the HMO program. This first step involves the following adjustments:

- First, the actuaries remove from the database all expenditure and utilization data regarding services for which contractors are not responsible, including dental, mental health, and long-term care services. In addition, although Medicaid is responsible for covering an eligible's health care costs in the time period beginning 90 days before application and ending upon enrollment into a plan, plans are not responsible for these expenses; therefore, such expenditures are excluded.

- All grant payments made by Medicaid toward disproportionate share hospitals and graduate medical education facilities are removed.

- In order to adjust for incurred but unpaid claims, claims and units are increased according to actuarial completion factors.

- In the fee-for-service system, some newborn birth charges are billed to the mother's Medicaid number. In order to shift these expenditures to the newborn's rate, 35 percent of the inpatient hospital delivery claims included in the mothers' records are transferred to those of AFDC newborns.

- Finally, in order to preserve the savings received through the Federal Drug Rebate Program, the following percentages were subtracted from pharmacy claims: 15 percent for AFDC, 14 percent for RSM, and 19.342 percent for SSI eligibles.

Once the database has been adjusted, the data are analyzed by category of service (Inpatient hospital, Emergency Room, Outpatient hospital, Primary Care Physician [PCP], Other Physician, Pharmacy, and Other Services) to develop PMPM rates specific to each aid category, age/sex category, and geographic region. First, an average monthly enrollment size is calculated for each region. Then, for each combination of the aid, age/sex, and region variables, a PMPM Upper Payment limit (UPL) rate and a PMPM managed care rate are calculated. The UPL rate is, essentially, a fee-for-service equivalent that serves as the upper limit for the corresponding contract rate. The managed care rate derived from the UPL rate is

the actual contract rate, reflecting utilization, price, and administrative costs under managed care. These two rates are developed as follows:

- A base PMPM rate is calculated for each service category, as the product of annual utilization per 1000 eligibles and the unit cost of that service, divided by 12,000. The use of annual, per-1000 member utilization rates minimizes the unwanted capture of short-term trends within the base year, and allows for a comparison across rate cells. By comparing across rate cells, outliers can be noted, and incomplete and/or inaccurate data can be identified.

- Two adjustments to these service-specific rates are then made in order to assure that the rates are appropriate for the contract period. The first adjusts both utilization and unit cost figures to account for changes in the health care industry between the base year and the contract year. These trend factors, which include changes in population, technology, costs and utilization levels, were calculated separately for each service type within each eligibility category (though they are identical for all age/sex groups). For the group of AFDC eligibles, trends in service costs ranged from an 8.70 percent increase for emergency room care to a decrease of 2.26 percent for outpatient care, while trend factors in utilization levels ranged from a 4.17 percent increase in outpatient care to a 5 percent decrease in emergency room care.

  The second adjustment accounts for any legislated programmatic changes occurring between the base period (January 1993 to October 1995) and the contract year (state fiscal year 1996/1997) that have not been previously accounted for. This adjustment is service specific, but is identical across all demographic categories. As a result of this adjustment, unit cost figures for all service types were reduced by between 7 and 8 percent. At this point, the adjusted, service-specific rates are summed, yielding a base PMPM UPL rate for the rate cell.

- The adjusted (but unsummed) service-specific rates are then further adjusted to develop service-specific PMPM managed care rates. These adjustments account for the changes in unit cost and utilization anticipated with the use of managed care. The adjustment to the unit cost figure is identical across all rate cells, reducing the unit cost for Inpatient services by 10 percent and the unit costs for Other Physician, Pharmacy, and Other Services by 5 percent. No effect is assumed on the unit costs for Emergency Room, Outpatient, and PCP services.

  An additional adjustment is made for predicted changes in utilization of services due to managed care. Actuaries assume that managed care will lead to some substitution of Outpatient and PCP utilization for the other service types, particularly for Inpatient and Emergency Room services. To reflect this substitution, utilization rates for Outpatient and PCP services are increased by 5

percent and those for Inpatient and Emergency Room services are decreased by 15 percent and 20 percent, respectively. Those for the other three service types are reduced by between 5 and 10 percent. These fully adjusted service-specific rates are then summed to yield the base PMPM managed care rate.

- Both the UPL and the managed care base rates are then subjected to five more adjustments before arriving at the final UPL and managed care rates.

  - In anticipation of third party liability recoveries, the base rates are reduced by a standard percentage. For the AFDC and RSM rates, this reduction factor is 2 percent.

  - Next, all base rates are increased by .425 percent, to account for the state tax on HMOs that serve the Medicaid population.

  - Actuaries then allow a 3.078 percent increase in the UPL rate and a 10 percent increase in the final managed care rate to account for administrative costs.

  - A further adjustment, applied only to the rates for certain categories of AFDC, RSM, and SSI children, is intended to supply plans with sufficient resources to meet EPSDT screening goals. This adjustment involves a PMPM $1.34 increase in the rates for all AFDC children below the age of six, and all RSM and SSI children below the age of one, and a $0.41 increase in the rates for all eligible children between the ages of 7 and 13.

  - Finally, since state officials expect that the enrollees in a voluntary, capitated program can be expected to be a relatively healthy population, this lower risk is accounted for by a reduction (3 percent for AFDC and RSM eligibles) in the UPL and managed care rates. With this adjustment, a final UPL and a final managed care rate are calculated for each rate cell.

As more managed care data become available, they will be incorporated into the actuarial calculations. In the future, the actuarial rates will be converted into rate ranges, based on the state's past experience with rate adequacy, to guide a bid and negotiation contracting process. The methodology for this conversion is yet to be developed; however, state officials indicate that the upper limits of these ranges will fall below fee-for-service equivalent upper payment limits.

C. Negotiation and Contracting

To contract with managed care organizations for the Medicaid HMO Program, the state issues a Request for Applications (RFA) to plans in the relevant geographic areas, continuously accepting applications from state-licensed HMOs that meet the RFA's solvency, network, and quality standards. Responding plans are assessed by officials with HMO expertise for their ability to meet these standards. If an applicant does not succeed in meeting these criteria, state officials identify the areas that are in need of improvement. The plan may then either withdraw its application or ask for a reassessment when it feels that it has made the necessary improvements. (Officials may conduct site visits to assist the plan in making these improvements.)

When the RFA was issued to plans in the Atlanta metro area, only two of the region's 13 commercial HMOs responded; neither of these two plans finalized a contractual agreement with the state. The primary complaint expressed by these HMOs was that the state's proposed capitation rates were inadequate to support the program requirements. Two for-profit HMOs did respond to the RFA, and are currently under contract with the state to provide services to program participants, though only one is presently in operation (the other is expected to begin serving program members on 1 April 1997). Both of these contractors are located in the immediate Atlanta region, though they are both expected to expand incrementally to the statewide level as the program expands. The state is also currently reviewing four contract applications, and state officials estimate that two or three more HMOs will submit applications in 1997.

D. Enrollment

Participation in Georgia's Medicaid HMO Program is voluntary for all eligibles; eligibles who do not choose to enroll in the HMO Program are auto-assigned to Georgia's PCCM program. Upon entering the HMO program, members are free to choose their plan from among their region's participating HMOs. Those who enroll in a federally qualified HMO may change plans during the first month of each six-month enrollment period, after which they are locked in to their present HMO for the remainder of the period. Those enrolled in a nonfederally qualified HMO are never locked in to their plan. Approximately one-third of those eligible to enroll in HMOs are currently doing so. Referencing Florida's experience with a similar program, state officials reported that this participation rate is consistent with their expectations.

During contract negotiations, the state sets an enrollment limit for each participating plan. Each plan is required to maintain a certain provider-to-enrollee ratio (one Full Time Equivalent [FTE] primary care physician per 1,500 members in an Independent Practice Association and per 2,500 enrollees in a group or staff model plan), along with other organization and staffing levels related to accessibility (such as the proximity of primary care physician services, full time emergency facilities, and licensed pharmacies to enrollees; the availability of appropriate foreign language interpreters; and sufficient support staff), which serve as the bases for

enrollment limit calculation. Further, no more than 75 percent of a plan's enrollees may be Medicaid or Medicare recipients.

E. Sharing of Risk

The state did not establish risk corridors, stop-loss reinsurance, or any other type of risk-sharing provisions as part of its Medicaid HMO Program. Federal regulations, however, require HMOs to demonstrate the ability to protect themselves against insolvency; most applicants (including both current contractors) are privately reinsured.

F. Quality Assurance

Participating plans are required to maintain internal mechanisms for the purposes of quality assurance. They must review the process and outcome of their care; collect and maintain encounter data; provide utilization management; inform and monitor providers on quality standards; conduct annual member satisfaction surveys; and develop, implement, and monitor improvement strategies. All collected information must be made available to the state.

In addition, plans must submit a variety of reports to the state, including an annual financial report; quarterly HEDIS utilization reviews, and reports of quality of care measures (outcomes). Submitted data must be in compliance with HEDIS reporting requirements and standard HCFA claim forms (e.g., HCFA-1500, UB-92, and the Universal Drug Claim form). The state's Department of Medical Assistance has established a quality assurance unit, which reviews the aforementioned reports, and monitors quality-related contract compliance; a separate HMO management unit monitors administrative-related contract compliance. The state's Insurance Commissioner is responsible for licensing plans and monitoring them for solvency.

Georgia's Medicaid HMO Program has an elaborate mechanism for promoting compliance with federal EPSDT standards, which was developed in part to strengthen and broaden support for the program by demonstrating its ability to address a key quality of health care problem faced by state. (In January 1996, the state's EPSDT screening rate was only 26 percent, although it is currently reported at approximately 50 percent—still well below the federally required 80 percent compliance level.) Plans must achieve EPSDT screening rates of 80 percent and immunization rates of 90 percent to be fully compliant with contract standards. To promote these goals, the state requires plans to refund a portion of their capitated payment if their EPSDT screening or immunization rates fall below 80 percent. The schedule of refunds required for rates below these standards is shown in Table 1, below.

Table 1. Required Rebates for EPSDT Screening and Immunization Rates Below the Minimum Compliance Level	
Screening and Immunization Rate	**Refund**
Above 60 percent but less than 80 percent	$10 per member under 21 times the average length of enrollment in years for members under 21
Above 50 percent but less than 60 percent	$20 per member under 21 times the average length of enrollment in years for members under 21
Above 40 percent but less than 50 percent	$30 per member under 21 times the average length of enrollment in years for members under 21
Above the state average but less than 40 percent	$50 per member under 21 times the average length of enrollment in years for members under 21
Any rate lower than the state average in the fee-for-service population (including those in the PCCM program), regardless of the four categories above	$100 per member under 21 times the average length of enrollment in years for members under 21

Plans' screening rates will also be made public, and new enrollees will be informed of plans' rates by the marketing and enrollment contractor. Since plans are exempted from paying the rebate for the first year of their contract, the results of this mechanism are not yet available.

III. The Future of the Georgia Medicaid HMO Program

The HMO Program is still in the process of establishing itself in Georgia's Atlanta metro area. Therefore, state officials are primarily concerned with increasing support for the program and developing an adequate, stable network of plans, which will allow members access to quality care with some degree of choice. Officials felt that a continuous contracting process, which bases the contracting on qualification rather than competition, would be more successful in encouraging plan participation than would an annual round of competitive bidding. The continuous, noncompetitive contracting process is seen as more welcoming for new plans, particularly since the process will not lock out new plans for the duration of an existing plan's contract (which, with renewals, can last up to four years).

One of the key strategies for building program support is to ensure that the program produces savings for the state through the use of managed care. The development of a consistent set of rates in the early years of the program helps to assure that savings are achieved, and provides a benchmark against which to compare future bids. Officials felt that an internal rate development approach would be more successful than a bid and negotiation process for establishing a consistent set of rates.

Once plan participation and program support have become better established, and once the program has enough experience on which to base a stable set of rates, program officials intend to develop and adopt a bid and negotiation process for HMO contracting. In a more stable environment, officials believe that a competitive bidding process will promote managed care savings without threatening the quality or accessibility of health care to the enrolled Medicaid population. Further, since more sparsely populated rural areas often cannot support more than one or two plans, officials prefer to limit the number of plans serving in these areas, and feel that a bidding process will allow them to select those which are most competitive.

The program is also expected to expand incrementally to the statewide level, and state officials hope to draw in a larger percentage of the Medicaid population.

Massachusetts

I. Overview

In 1992, Massachusetts obtained a Section 1915(b) waiver from the Health Care Financing Agency (HCFA) to initiate the MassHealth Managed Care program for the coverage of its Medicaid recipients. The program has three statewide components: the Primary Care Clinician Program (PCCP); the fully capitated HMO Program; and the Mental Health Substance Abuse Program (MHSAP), which is a fully capitated program for mental health and substance abuse services. AFDC, AFDC-related, SSI, SSI-related, and medically needy eligibles may participate in the PCCP and HMO programs. Prior to August 1996, both of these programs enrolled members on a voluntary basis, with the traditional fee-for-service program serving all remaining eligibles. Beginning in August 1996, enrollment in these two programs became mandatory for all except medically needy eligibles, although only AFDC and AFDC-related eligibles may be involuntarily assigned into the HMO Program. Enrollment in MHSAP is mandatory for all Medicaid eligibles receiving mental health/substance abuse services who are not enrolled in the HMO Program.

Massachusetts has recently obtained approval for a Section 1115(a) waiver, giving it the authority to roll its state-funded CommonHealth and Medical Security Plan programs into the state's Medicaid program, and to create the New State Benefit Plan for the Unemployed (NSBP), which will also fall under the Medicaid umbrella. CommonHealth provides supplemental health coverage to disabled children and working disabled adults, while the Medical Security Plan covers individuals and families who have household incomes below 400 percent of the Federal Poverty Level (FPL) and those who are receiving federal unemployment benefits. NSBP extends Medicaid eligibility to unemployed persons whose household income is below 133 percent of the FPL. When the waiver is fully implemented, state officials anticipate approximately 125,000 new Medicaid eligibles; with the exception of those residing in long-term care institutions and those with other public or private health insurance coverage, all Medicaid recipients will be eligible for the HMO and PCCP Programs.

For the purposes of contracting with plans for the HMO Program, the state develops fee-for-service equivalent rates for each of five rate categories, which then serve as upper payment limits (UPLs) for a bid and negotiation process. In the Program's experience, proposed bids have significantly exceeded the upper payment limits; as a result, contract rates tend to be

determined through state counterproposals rather than through an intensive negotiation process. The state intends to redesign the current rate development and contracting processes with more emphasis on competitive bidding for the next round of contracting, so as to make program participation more attractive to potential contractors and to limit the Medicaid agency's administrative burden in the expanding program.

II. Development of Capitation Rates

A. Benefits

Plans in the HMO Program are responsible for providing their Medicaid enrollees with a comprehensive benefit package. The Program's capitation rate includes coverage of physician services, outpatient and inpatient hospital care, family planning services, physical/occupational/ speech therapy, emergency dental care, durable medical equipment (with a $1,500 limit), mental health and substance abuse services, EPSDT services, Early Intervention Program services, long-term institutional services (with a limit of 100 days for skilled nursing facilities), and emergency transportation. Though not explicitly accounted for in the rate, plans must also provide case management and certain enhanced services to Program enrollees. In addition, upon state approval, plans may elect to provide pharmacy services to their enrollees; these services would then be reflected in the rates. The Request For Proposals (RFP) issued by the state provides detailed descriptions of particular service requirements, such as EPSDT services, mental health /substance abuse services, and the Early Intervention Program.

Certain services are covered by MassHealth through fee-for-service arrangements outside of the HMO Program, such as dental care, skilled nursing facility services beyond the 100-day limit, durable medical equipment exceeding the $1,500 limit, pharmacy services (when not provided by an enrollee's HMO), chronic care hospitalization, and nonemergency transportation. In addition, due to federal open-access requirements, enrollees may self refer to out-of-plan Medicaid providers for family planning services. In such cases, the out-of-plan provider is compensated by the state on a fee-for-service basis, and the enrollee's HMO must refund the state appropriately through an annual reconciliation process.

Plans are permitted to offer additional benefits to their enrollees as a means of competition; they are prohibited, however, from requiring enrollees to share in the cost of care through copayments or deductibles.

B. Rate Development

Capitation rates for the HMO Program are developed through a bid and negotiation process in which final contract rates may not exceed UPLs based on fee-for-service equivalents. The state contracts with outside actuaries to develop separate UPLs for five defined rate categories: AFDC and AFDC-related eligibles (Rate Category I), SSI and SSI-related eligibles (Rate

Category II), eligibles with end-stage AIDS (Rate Category III), eligibles with severe physical disabilities (Rate Category IV), and eligibles who are dually enrolled in Medicare risk programs (Rate Category V). Given the variation in cost and demographics across the state, actuaries develop region-specific UPLs (one for each of the state's Western, Central, and Eastern regions) for each Rate Category, which are then used to calculate a customized UPL for each plan, reflecting the projected geographic and demographic composition of the plan's enrolled population.

Regional UPLs are calculated based on region- and Rate Category-specific incurred claims data from the traditional fee-for-service program, as well as from the PCCP Program. Since fee-for-service expenditures in the PCCP Program have been estimated to be approximately 2 percent lower than those of the unmanaged fee-for-service system, PCCP expenditures are inflated by this percentage so that they can be used to develop the fee-for-service equivalent UPLs. These incurred claims data are obtained from the most recent complete 12 months prior to the rate year; thus, data from State Fiscal Year 1995 were used to develop rates for Rate Year 1997.

In order to match contract specifications regarding included and excluded services, certain incurred claims data are removed from the database. In particular, data on dental services, long-term care services, whole blood and blood derivatives, and durable medical equipment costs and skilled nursing facility days in excess of contract limits are eliminated. In developing rates for plans that will not provide pharmacy services, pharmacy data are also excluded from the rate calculations. The adjusted region- and Rate Category-specific database is then used to develop three regional PMPM UPLs per Rate Category, according to the following methodology:

- To adjust for the actuarial differences between the HMO-enrolled population and the populations from which the base data are taken, an actuarial adjustment is made to the data, based on the demographic differences between the two populations. Historically, this adjustment has been a decrease of between 0 to 4 percent for AFDC and related eligibles.

- Using service-specific utilization and unit cost data from the adjusted database, three base regional PMPM UPLs are then calculated for each Rate Category.

- Each UPL is then increased by a factor of less than 1 percent to account for incurred but not reported (IBNR) claims. This adjustment is minor due to the fact that the data are close to complete by the time they are analyzed.

- Next, trend factors are applied to the base UPLs, accounting for inflation, programmatic changes, and changes in utilization patterns between the base year and the rate year (1 January to 31 December). For instance, the state has experienced an overall increase in fee-for-service costs of approximately 3 to 4

percent between the 1995 base year and the 1997 rate year; trend factors for 1997 generally reflect this increase.

- A discount[1] is then taken from each UPL to account for expected third-party liability recoveries. For plans that purchase reinsurance from the state, a PMPM reinsurance premium is also removed from each UPL.

- Finally, to account for the administrative cost of delivering services to the HMO-enrolled population, actuaries use fee-for-service experience to calculate the state's average PMPM administrative cost associated with Medicaid fee-for-service coverage of an actuarially equivalent population, and then add this PMPM number to the adjusted base UPLs. For AFDC and AFDC-related eligibles, this increase has historically been equal to about 3 percent of the base UPLs.

Once a Rate Category's regional UPLs have been developed, the regional UPLs are weighted based on each plan's enrollment experience from the previous 24 months and projected future enrollment to calculate a plan-specific weighted average UPL for each Rate Category. This plan-specific UPL weighting involves the following two steps:

- First, since most of the Program's plans serve in more than one of the state's regions, a weighted average of the three regional UPLs is calculated, based on the geographic distribution of each plan's expected future enrolled population.

- Next, an adjustment is made to account for differences in demographic composition between each plan's projected enrolled population and the Medicaid HMO enrollee population in general. This plan-specific adjustment takes into account the relative distribution of age and sex characteristics and specific category of aid[2] characteristics in each plan's projected enrolled population when compared to the distribution of these characteristics in the general Medicaid HMO population. Thus, the plan-specific UPLs resulting from this adjustment are adjusted for each plan's relative risk, as determined by its enrolled population. These plan-specific demographic adjustments are zero-sum, in that the sum of UPL increases across plans is, essentially, canceled by the sum of the UPL decreases.

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1 In order to maintain the integrity of the bidding process, most of the specific adjustment factors used to develop the UPLs are not public information.

2 Each Rate Category comprises eligibles from a number of categories of aid, based on similarities in health risk observed in the fee-for-service data, in order to limit the number of rates while maintaining actuarial logic. There are, however, remaining actuarial differences between the categories of aid within a Rate Category.

The methodology above yields plan-specific UPLs for each Rate Category; however, these are not shared with the plans. In making its counterproposal to a plan, the state will offer a certain percentage of the relevant UPL, which takes into account, among other things, the state's desired savings and a profit margin for the plan. This negotiation process is discussed further in the next section.

In addition to developing plan-specific UPLs that serve to meet the federally required budget limits and serve as references for the state's counterproposals, the state also guides plans in the development of their rate proposals. Included in the RFP are capitation rate proposal worksheets, with instructions as to the assumptions and considerations that must be made when completing them. Plans are required to follow a methodology similar to that used in the UPL development; however, they must base their Rate Category-specific rates on their own relevant encounter data.

Thus, for each Rate Category, a plan must use its own experience to develop a rate proposal as follows:

- First, the plan must use its utilization and unit cost experience to calculate PMPM total costs for each of ten service subgroups, which are categorized into four major service groups:

  - Under the Physician Services major group, a PMPM rate must be calculated each for Primary Care and Referral Care subgroups;

  - Within the Mental Health/Substance Abuse major group, both Outpatient and Inpatient rates must be calculated;

  - Under Facility, PMPM rates must be calculated for Inpatient services (separate rates are required for General Hospital/Acute Inpatient Care, Births, and Other Inpatient service), Emergency Room services, and Surgical Day Care;

  - Finally, under the Other Medical service group, a Pharmacy rate must be calculated (for plans offering these services), along with Ancillary rates (one each for Laboratory and Radiology services), and an Other Outpatient Services rate.

  Plans must also break these rates out by provider reimbursement arrangement type (capitation, fee-for-service, or salaried) where applicable.

  As subtotal PMPM costs are calculated for each major service group, the plan must apply service-group-specific utilization and unit cost IBNR factors to each

subtotal. The four IBNR-adjusted subtotals are then summed to yield a total medical PMPM rate for each Rate Category.

- The plan must then adjust these Rate Category-specific PMPM rates, as was done in the UPL development methodology. Specifically, the rates must make adjustments to the rates for the following factors:

  - Administrative costs,
  - Third-party liability recovery experience,
  - Reinsurance premiums (where applicable),
  - Risk reserve for the commercial and Medicaid-specific populations,
  - Medicaid-specific interest income,
  - Year-end adjustments for risk settlements with providers, and
  - Profit (which may not exceed 2 percent of gross operating profit).

  Any other adjustments must be explained and justified with accompanying documentation.

Using this methodology for each Rate Category, plans can then propose either a separate rate for each region included in its service area, or one rate for its entire service area, which is calculated as a weighted average across all included regions. For plans with no previous experience serving eligibles in a particular Rate Category, the rate calculation for this Rate Category should be based on the distribution of eligibles in the plan's service area, and the plan's experience with other populations.

C. Negotiation and Contracting

As previously mentioned, the state uses a bid and negotiation process, guided by plan-specific, Rate Category-specific UPLs, to contract with plans for the HMO Program. Prior to the start of each contract period, the state issues an RFP to plans across the state. Responding plans are evaluated based on their technical and business proposals. The technical evaluation is used to identify the plans that appear capable of meeting the minimum standards of provider network, quality improvement program, accessibility, and guideline compliance outlined in the contract. Plans that qualify according to this technical evaluation are then evaluated based on their bid proposals.

Historically, all initial bids have substantially exceeded their corresponding UPLs. In response, the state offers counterproposals that, essentially, are discounted plan-specific UPLs.

The size of the discount taken is determined separately for each plan, based on the state's budget constraint, the estimated minimum number of plans that the state intends to contract with, an allowance for plan profitability, and the plan's performance experience with regard to quality, access, and utilization patterns. The counterproposals are then negotiated until there is either an agreement on a final set of contract rates, or the bids are rejected by the state or withdrawn by the plan.

Currently, the state contracts with nine HMOs, only one of which operates statewide. The contract period is for two years (most recently, 1997-1999), with no option for renewal. State officials do not set an upper limit on the number of plans to which it will award contracts.

Should a rebidding plan fail to successfully negotiate a new contract, its enrollees must be disenrolled and transferred to a plan that has secured a new contract within six months of the disqualified plan's termination date. In the interim period, the disqualified plan must continue to serve its enrollees at the previous contract rates. In the Program's experience, a few contracts have been terminated due to disagreement on an acceptable cost proposal; however, most of the disqualified plans have lost their contracts because they failed to meet contract performance standards.

D. Enrollment

Upon enrollment into MassHealth Managed Care, recipients meet with a contracted enrollment broker, who informs them about the participating HMOs and PCCP providers and, in an unbiased manner, helps them choose a plan. Recipients who fail to select a plan or PCC within 33 days of eligibility notification (approximately 50 percent of the eligible population) are auto-assigned to the plans/PCCs in their region in accordance with the preferences of those who expressed a choice. Thus, the percentage of nonchoosers assigned to a particular plan/PCC reflects the portion of choosers that selected the same plan/PCC. Only AFDC and AFDC-related eligibles, however, may be auto-assigned into the HMO Program; other recipients may only be auto-assigned to the PCCP Program in the region. Since approximately 20 percent of the eligible population selects an HMO, about 20 percent of nonchoosers in AFDC and related categories are assigned to the HMO Program. Once enrolled in a plan, recipients may, with good cause, transfer to another plan at any point, with no lock-in period restrictions.

As yet, the state has not found it necessary to impose enrollment limits on participating plans, since the number of plans has been sufficient so as not to cause capacity problems in any particular plan.

E. Sharing of Risk

Contracted plans must have reinsurance for high-cost cases. For those without private reinsurance, the state may offer stop-loss reinsurance to cover their Rate Category II, III, and IV populations; however, the state does not offer reinsurance for AFDC and AFDC-related

enrollees. The capitation rates for the one plan that currently purchases this stop-loss coverage are reduced by a factor that accounts for the reinsurance premium.

The state does not provide risk corridors for the coverage of AFDC and related eligibles; it only provides such corridors for Rate Categories II, III, and IV, by which it shares in the annual profits and losses experienced by plans covering these enrollees.

F. Quality Assurance

Contracted HMOs are required to maintain internal Quality Management programs to track and improve their clinical and nonclinical performance. Through these programs, plans must monitor and assess their performance in areas of accessibility, utilization, outcomes, and guideline compliance, and must then develop, implement, and evaluate strategies for improving performance in these areas. Plans are also responsible for submitting various descriptive and analytical reports to the state documenting their quality management activities.

With regard to accessibility, each plan must report the percentage of counties in which it does not meet certain standards of provider availability for its Medicaid population, as compared to its commercial population. Each plan must also submit a number of reports related to utilization of services, including an annual report with HEDIS membership information, HEDIS utilization tables, enrollment/disenrollment tables, and a descriptive and analytical report on Medicaid-specific versus commercial patterns of enrollee utilization across services (including a list of the five most common and five most costly treatments per major diagnosis group).

Plans are further required to conduct an annual member satisfaction survey and to collect voluntary disenrollment data and annual HEDIS clinical indicator measures (including outcomes measures of asthma, low birth weight, and prenatal care in first trimester). These data are then to be the subjects of analytical outcomes reports. Finally, each plan must have processes to measure, report, and assure compliance with clinical practice guidelines, EPSDT screening goals, asthma management guidelines, the Early Intervention Program, and standards for coordination with school-based providers.

In semi-annual contract status meetings, the Program's quality improvement unit reviews and evaluates these reports. Based on its assessment of the reports, the unit annually negotiates with plans regarding quality goals, which are intended to move the plans from minimum contract standards to "best practice" standards.

Plans are also responsible for collecting financial data, in order to monitor and assess financial stability and to direct internal and state corrective actions. Each quarter, plans must submit financial experience reviews and profit/loss reports to the state. They must also submit annual reports on a variety of financial ratios (revealing liquidity, capitalization, profitability, and composition), and on a series of financial indicators (such as enrollment, net income, net worth, and utilization trends). In addition, each plan must maintain reinsurance and liability

protection, and must track its record of incurred but unreported claims and incurred but unpaid claims. In addition to reviewing and evaluating these reports, the Division of Medical Assistance may conduct independent audits of each plan. Plan solvency is monitored by the state's Division of Insurance.

III. Future of MassHealth Managed Care

While the current rate development and contracting processes have proven successful in establishing the HMO Program, the state intends to redesign these processes for the upcoming contract period (1997 to 1999). This effort is driven by the desire of state officials to increase competition in the contracting process, expand the number of HMO Program contracts, and decrease the administrative burden on the state's Medicaid agency. State officials feel that the recent move toward mandatory enrollment for the AFDC and AFDC-related populations and the imminent implementation of the 1115(a) waiver will require a larger number of participating HMOs and greater administrative simplicity.

The discrepancy between the UPLs and the plans' rate proposals has been a key point of negotiation between the state and HMO offerors. According to state officials, the issue of concern is that, while UPLs are based on Medicaid provider reimbursement rates, plans base their rate proposals on their commercial provider reimbursement rates. Officials hope that the expansion of the HMO-eligible population will make HMO Program contract more attractive to hesitant plans, encouraging them to accept lower rates; however, they are also concerned about the stringency of the UPL methodology, and hope to move away from this methodology to the extent possible. Some preliminary thought has been given to how the process can be made more competitive; however, no clear direction has emerged. One idea mentioned in this context was to include target rates (as a certain percentage of the UPLs) within the RFP, in order to give plans a better frame of reference for their rate proposals.

Another area that state officials felt should be particularly targeted in the redesign effort is the scope of benefits included in the capitation rate. As the HMO Program undergoes significant expansion, the administrative burden on the state's Medicaid agency is expected to greatly increase, though the agency will not be expanded accordingly. Therefore, state officials feel that an effort should be made to capitate as much of the Medicaid benefit package as possible, in order to relieve the agency of claims processing and benefit coordination responsibilities.

In addition, the state may attempt to streamline the number of rate categories, since it is felt that the rate structure is overly fragmented. Should the state pursue this reform, it would then also make retrospective risk adjustments to enrollee rates based on enrollee health status. Further, state officials have considered adjusting the UPLs for the frequency with which a plan's enrollees use outside Medicaid providers for family planning services. Such an adjustment would account for the double-payment caused by this out-of-plan utilization through a prospective PMPM mechanism, rather than through the more costly retrospective reconciliation process currently used.

While no specific direction for the redesign has been reached, the rate development and contracting processes for the HMO Program can be expected to undergo significant changes from the methodologies described above.

Minnesota

I. Overview

In 1985, the Minnesota Department of Human Services (DHS) received an 1115(a) waiver to begin its Medicaid managed care initiative, the Prepaid Medical Assistance Program (PMAP), in two counties. In 1990, this initiative was expanded to two additional counties in the Twin Cities metropolitan area (the metro area) to include Hennepin county. In 1995, the state received an 1115(a) waiver to expand the PMAP program statewide, and as of 1996, PMAP is mandatory for AFDC and AFDC-related eligibles, as well as the SSI elderly, pregnant women, and medically needy children in more than 16 counties. Minnesota does not include SSI eligibles under age 65, foster children, or severely disabled children covered by the Tax Equity and Fiscal Responsibility Act option in its capitated system.

Minnesota contracts with all managed care plans that meet the state's quality standards and are willing to accept the capitation rates offered by the state. DHS developed PMAP's capitation rates based on actuarial evaluation of fee-for-service utilization and expenditure data; this approach has been used since the PMAP program began because of the accessibility of the historical fee-for-service database. Separate rates are established for each of three geographic areas: Hennepin county (Minneapolis), which contains 25 percent of the program's enrollees; the six other counties in the Twin Cities metro area; and the remaining counties covered by PMAP. Plans that are willing to accept PMAP's rates may contract with the state to serve the Medicaid population in counties in which they are licensed to operate.

II. Development of Capitation Rates

A. Benefits

The capitation rates established for PMAP include all of the federally required benefits including primary and preventive care, specialty care, inpatient and outpatient hospital care, inpatient and outpatient mental health care, and EPSDT services, as well as optional benefits such as prescription drug coverage, dental services, physical therapy, and nurse-midwife services. In addition, DHS has instituted a special prenatal care program designed to identify women who are at risk of having poor birth outcomes, to assure increased access to care, and to

provide additional enhanced services for high-risk pregnant women. Transportation services are provided to all PMAP enrollees, but are only included in the capitation rate for metro area plans. In the nonmetro area, plans receive 95 percent fee-for-service reimbursement for transportation services; once sufficient experience is established, the cost of these services will be added to the capitation rate.

Each health plan is required to contract with public health agencies, due to these providers' extensive experience serving the Medicaid population. It is recommended that plans make use of the expertise of public health agencies by making arrangements for direct access or referral to these agencies for specific services. The Minnesota Department of Health also mandates that the plans work with public health agencies to reach the state's immunization objective of 90 percent of two-year-olds immunized by the year 2000.

B. Rate Development

The Minnesota DHS last did extensive research to develop new rates for its 1996 contracts. The base capitation rates for 1996 were developed by an outside actuary using fee-for-service expenditure and utilization data from the four-year period of 1990-1993.

To develop these rates, a single base rate was initially established using females ages 16-49 in the metro area as a reference group. The average per-member, per-month (PMPM) expenditure for this group was calculated and adjusted for the other two geographic regions. The adjustment factor used for Hennepin County was 1.06 and the factor for the nonmetro area was 0.83.

A number of actuarial adjustments were made to these base rates in order to develop preliminary CY 1996 rates. These adjustments are listed below:

- The base rates were increased by $2.95 per member per month (PMPM) for all rate groups to encourage increased access to dental services.

- A trend factor developed by the outside actuary was applied to increase the FY 1993 rates to CY 1996 based on changes in both expenditures and utilization. This involved trending the FY 1993 rates first through FY 1996, an overall increase of 18.5 percent. Because the state's fiscal year ends June 30, an additional 2.6 percent increase was applied to make the rates applicable through December 1996.

- The base rates in each area were then adjusted for the other age and sex categories. Eight rate cells were used, one for each sex in four age groups (0-1 , 2-15, 16-49, and 50+). This adjustment was made using a set of ratios that compared the average expenditure for each age/sex group to that of the reference groups of females ages 16-49. These ratios were applied to the base rates to develop a set of age- and sex-specific rates.

- The base rates were adjusted by a hospital rebasing factor that was created to more equitably reimburse nonmetro hospitals for inpatient care. This resulted in no change in the rate for Hennepin County, a reduction of 2.7 percent in the rate for the metro area plans, and an increase of 1.2 percent for plans in the nonmetro area.

Additional adjustments were made to the preliminary CY 1996 age-, sex-, and area-specific rates to create the final CY 1996 PMPM plan rates. These adjustments are described below:

- The benefit package was changed to comply with changes made in the 1995 legislative session. Two exclusions, fertility drugs and gender reassignment services, resulted in no change to the capitation rates because the per capita cost of these services was negligible. The addition of a chicken pox vaccine resulted in a rate increase of $2.21 PMPM for children under age 2, and $1.77 PMPM for children ages 2-5. In future years, when children can be expected to receive the vaccine in infancy, this cost will not be included in the capitation rates for children 12-24 months of age.

- Rates were increased by $.072 PMPM for the cost of interpreter services and $.071 PMPM for the cost of nonemergency medical transportation services for plans in the metro area. Both of these services were reimbursed but not included in the 1996 preliminary rates.

- Per legislative directive, a portion of Disproportionate Population Adjustment (DPA) dollars—additional funding for disproportionate share hospitals—was exempt from discounting. These DPA funds were estimated to represent 0.8 percent of the FY 93 base rate; this amount was removed from PMPM rates in all geographic areas until rate adjustments had been completed.

- Plan-specific adjustments were made to the rates paid to plans serving Hennepin County to compensate them for utilization of graduate medical education facilities (ME) and disproportionate-share hospitals (DPA). To make this adjustment, the estimated amount of PMPM rates in Hennepin County attributable to ME/DPA expenditures in 1996 was first subtracted from the rates; this amount was calculated to be $5.96. Then plan-specific PMPM adjustments, calculated on the relative proportions of each plan's enrollees using ME/DPA hospitals, were added back into the rates less 20.9 percent (the percentage attributable to nondiscountable DPA funds). This amount was to be added back into the rate after discounts and adjustments had been made.

- Per a 1995 legislative decision, an access adjustment was developed to assure access to services in the nonmetro area. To this end, the legislature required that nonmetro area rates be equal to at least 85 percent of metro area rates. In 1996,

this requirement was met, so no adjustment was necessary; in 1997, however, this adjustment was necessary.

- A discount was taken to represent the savings to be realized from managed care. This discount was legislated to be 10 percent for AFDC and AFDC-related populations and 5 percent for the elderly. However, in 1996, plans serving Hennepin County negotiated an increase in overall rates of about 4.5 percent. This reduced the state's managed care discount to approximately 5.5 percent for AFDC and related populations and 0.5 percent for the elderly.

- Finally, the statewide DPA fund amount (trended forward to 1996) was added back to the capitation rate. In addition, for plans serving Hennepin County, the portion of the plan-specific DPA subtracted earlier was added back to the rate.

This methodology produced the capitation rates for CY 1996. To adjust the 1996 rates for 1997, the capitation rates were increased by an inflation factor of 4.2 percent. Of this total increase, 3 percentage points represented inflation in hospital costs, per legislative directive. The other 1.2 percentage points were based on published data on inflation in the cost of medical care. In addition, DHS agreed to raise each plan's capitation rates by 0.5 percent in response to plans' concerns about the adequacy of DHS's rates in the areas of translation and interpretation services.

C. Negotiation and Contracting

The RFP issued to plans was not competitive; plans were simply required to agree to meet the RFP's requirements in the areas of county service development and access, plan design, network capabilities, and administration and reporting. DHS representatives consulted with and made site visits to each of the plans to help them through this contracting process. One point of discussion between the state and the plans was that, while the state requires the plans to cover all PMAP-eligible populations in each county served, some plans preferred to serve only certain subpopulations within those areas. State officials reported that the state will insist that plans enroll all categories of PMAP eligibles, although negotiations are not yet completed.

There are presently eight health plans that serve the Medicaid population in Minnesota, most of which serve in more than one of the three geographical areas. However, one of the plans currently serves only the Twin Cities metro area and three serve only the nonmetro area. The state does not limit the number of plans with which it will contract in each county. However, DHS feels that the four plans currently serving Hennepin County have saturated the market. In contrast, some of the rural counties to which PMAP will expand in the future have only one plan; DHS is interested in increasing plans' participation in these counties.

D. Enrollment

New PMAP enrollees have a one-time option to change plans at any time during the first year of enrollment. After the first year, an open enrollment period is held once a year. Minnesota has a low assignment rate of 4-5 percent, which state officials feel may reflect the population's familiarity with managed care and the available plans. Medicaid eligibles who do not choose a plan are assigned randomly by DHS to one of the plans contracted in the enrollee's region.

No formal enrollment limits are set by the state for each participating plan. Because most of the plans have large commercially insured populations, state officials feel that their enrollment capacity for the PMAP population need not be limited. While some plans would like to set limits on the number of Medicaid eligibles they enroll, state policy will not allow them to do this.

E. Sharing of Risk

The state offers plans stop-loss insurance, which would pay 80 percent of inpatient costs over $15,000; however, none of the plans is currently purchasing it. The PMAP contract does not require plans to have reinsurance, though HMO regulations administered by the Minnesota Department of Health may require the plans to have commercial reinsurance, if they do not choose to purchase it from the state. If the plans do purchase stop-loss insurance from the state, the state would reduce the capitation rates by the actuarial equivalent of the benefit.

F. Quality Assurance

DHS, in cooperation with the Minnesota Department of Health, requires health plans to employ a number of measures to monitor their quality improvement efforts. The items collected by DHS include the following:

- HEDIS 3.0 measures;
- Data on utilization of services to ensure that no barriers to utilization of services are experienced by any segment of the population;
- Two annual reports, one detailing progress toward meeting EPSDT goals, and another that outlines the results of plans' efforts to improve enrollees' health status in one area of chronic disease management and in one area of Maternal and Child Health;
- Semiannual reports providing records of the number, nature, and disposition of all written complaints filed with the health plan;

- Independent quality improvement reviews and evidence of corrective action to remedy any deficiencies identified in this review process; and

- The results of consumer satisfaction surveys developed by the Minnesota Health Data Institute.

Plans must maintain specific encounter databases, but as of December 1996, DHS has never requested these data. In order to monitor solvency, the state Department of Health also collects financial data and information on the number of people enrolled in and served by the plans.

III. The Future of PMAP

As mentioned above, state officials report that the major advantage of using fee-for-service data to develop capitation rates has been the accessibility of these data. However, as PMAP expands into more of Minnesota's counties, the fee-for-service data are becoming outdated; in addition, state officials are concerned that the historical fee-for-service data do not adequately represent the utilization patterns found under managed care. In fact, use of fee-for-service data to set capitation rates may preserve the inefficiencies of the fee-for-service system, such as the overuse of services in urban areas with an oversupply of providers and reduced access to care in underserved rural areas.

Therefore, DHS hopes to begin setting rates based on encounter data collected from managed care plans by 1998. This process will be complicated by two factors. First, DHS has never requested such data from PMAP plans, so it is unclear whether plans have adequate encounter databases. Second, a methodology will be needed to assign prices to the encounters, something the state and its actuaries have not yet developed.

DHS is also in the process of developing, in partnership with the Minnesota Department of Health, a risk adjustment mechanism based on diagnosis. The risk adjustment methodology has not yet been developed and would not be implemented until 1998 or 1999.

When the contracts come up for rebid in 1998, Minnesota may consider implementing a competitive bid approach in which plans would be given minimum requirements and be asked to present cost proposals, if DHS receives legislative approval to do so.

Missouri

I. Overview

In 1995, Missouri implemented its fully capitated Managed Care Plus program to serve Medicaid recipients in five counties (including St. Louis) in the Eastern region of the state. Originally a voluntary program, Managed Care Plus has since been expanded to three other regions of the state (Central, Western, and Northwestern) and become mandatory for AFDC, AFDC- related, and Foster Care eligibles in these four regions, under authority of a 1915(b) waiver. SSI eligibles may participate in the program on a voluntary basis.

In its expansion, Managed Care Plus absorbed the mandatory, fully capitated program that had been operating in Jackson County under a 1915(b) waiver since 1982. Managed Care Plus is expected to continue expanding into the Southwestern region of the state; however, officials foresee difficulty in expanding the program into the remaining sparsely populated portions of the state.

Plans interested in participating in the Managed Care Plus program submit rate proposals to the state, which are evaluated with reference to bids submitted by competing plans and to rate ranges that have been developed by state-contracted independent actuaries. To arrive at each region- and rate category-specific rate range, relevant historical data from Missouri's fee-for-service program are used to forecast a fee-for-service equivalent upper payment limit, which is adjusted for the expenditure and utilization savings expected from managed care, and then converted into a range.

II. Development of Capitation Rates

A. Benefits

Participating plans are required to provide their Medicaid enrollees with a comprehensive benefit package, including primary and preventive care, inpatient and outpatient hospital services, family planning, case management, pharmacy services, dental services, EPSDT services, behavioral health services for all except foster children (to a 30-day inpatient and 20-visit outpatient limit), emergency and nonemergency transportation, durable medical equipment, private duty nursing, vision care, and physical, occupational, and speech therapy. The only notable services excluded from the capitated package are behavioral health services for foster care children and all organ transplant services. A recently established, separate network of fee-for-service providers has proven effective for delivering behavioral health

services to foster care children, and state officials are hesitant to dismantle this new network by incorporating these services into the managed care program. Transplant services are also provided through separate fee-for-service arrangements, as are behavioral health services beyond the limits mentioned above for non-Foster Care eligibles.

Plans are prohibited from requiring their Medicaid enrollees to share in the cost of their care.

B. Rate Development

Missouri contracts with independent actuaries to develop the rate ranges that are used to evaluate plans' proposals. The actuaries use Missouri's fee-for-service claims database as their primary data source for developing region- and rate category-specific fee-for-service equivalent rates, which are then trended forward to the contract year, adjusted for the impact of managed care on utilization and cost, and converted into ranges of acceptable rates. The rates for the most recent contract period (1997-1999) were based on the database from State Fiscal Years 1993, 1994, and 1995.

The state's rates are developed in three steps, before being converted into rate ranges. Initially, the fee-for-service database is adjusted to reflect the portion of eligibles, services, and expenditures for which participating plans will bear responsibility. Next, the adjusted database is used to calculate base per-member per-month (PMPM) rates, and these base rates are subjected to a series of adjustments to develop fee-for-service equivalent upper payment limits. Finally, the state's final rate ranges are calculated by adjusting the fee-for-service equivalents for, among other things, changes in unit cost and utilization rates, which are expected to accompany managed care. The three steps of this methodology are described in greater detail below.

1. Adjusting the Database

Prior to customizing the database, the fee-for-service data are identified and sorted by age and eligibility category into 11 rate categories and one lump-sum maternity care payment:

- AFDC and related (including SOBRA children):
  - Males and females under 1 year of age,
  - Males and females 1 to 6 years of age,
  - Males and females 7 years to 13 years of age,
  - Females 14 to 20 years of age,
  - Males 14 to 20 years of age,

- Females 21 to 44 years of age,
- Males 21 to 44 years of age, and
- Males and females 45 years of age and older.

■ Foster Care children:

- Males and females under 6 years of age, and
- Males and females 6 to 20 years of age.

■ Medicaid Pregnant Women (SOBRA women):

- Monthly capitation rate (equal to that developed for females 14 to 20 years of age), and
- One-time maternity care payment upon delivery.

Next, a series of adjustments is made to the database to yield a database that reflects the expenditures for which plans will be contractually responsible:

■ The data are first adjusted to ensure that they reflect expenditures for services that are covered by the capitation rate. To this end, the following adjustments are made:

- Expenditures for all behavioral health services for Foster Care children and for behavioral health services in excess of the limits for non-Foster Care eligibles are removed from the database.
- Expenditure data for services directly related to organ transplants are removed.
- Next, expenditures for prescription and nonprescription medications, which were refunded to the state through the Federal Drug Rebate Program, are removed from the database, in order to preserve these savings. The rebate reduction factors that are applied to the pharmacy expenditures data from the base years vary by year, but are identical across all rate categories. The 1993 and 1995 pharmacy data are reduced by 17 percent, while the factor applied to the 1994 pharmacy data is equal to 16 percent.
- Finally, expenditures for Graduate Medical Education (GME) are removed from the inpatient, outpatient, and emergency room

expenditure data. The GME deduction factors are equal to 2.62 percent for base year 1993, 4.05 percent for base year 1994, and 3.70 percent for base year 1995.

Since all incurred claims are assumed to be reported and paid, there is no need to apply completion factors to the data.

- Claims for Medicaid-eligible populations that are excluded from the Managed Care Plus program are also removed from the database. Notable populations in these categories include Medicaid recipients who are dually eligible for Medicare benefits, recipients in long-term care institutions, and permanently and totally disabled recipients.

2. Upper Payment Limit Development

After the database has been appropriately adjusted, the claims database is analyzed to calculate region- and rate category-specific PMPM rates for each of 20 service types. The following two adjustments are then made to these service-specific rates:

- First, the rates are adjusted to account for any programmatic changes occurring during the base period (1993-1995) or between the base period and the targeted contract year.

- The service-specific rates are then trended forward to the targeted contract year based on historical inflation in Missouri's fee-for-service costs for each service type. Some trend information from other states may also be used in this adjustment.

The adjusted, service-specific rates are then summed to yield region- and rate category-specific fee-for-service equivalent PMPM base rates. These base rates are then adjusted as follows to develop upper payment limits:

- The PMPM costs of nonemergency transportation services are calculated separately and then added to the base rates. For the most recent contract year, these costs were estimated at $1.50 for all rate categories, with the exception of the maternity care payment, for which these costs were estimated to be $9 per birth.

- The administrative costs to the state associated with administering the fee-for-service Medicaid program are then added to the PMPM rates. This increase was equal to 2.5 percent for the most recent contract year.

- Although Medicaid is responsible for covering an eligible's health care costs in the time period before the eligibility determination date and ending upon

enrollment into a plan, plans are not responsible for these expenses; therefore, such expenditures are removed.

- Finally, since the state will make and keep third party liability recoveries (participating plans are not required to make these recoveries), an upward adjustment of 1.9 percent is made to the rates to account for the third party liability payments made in the base period, which are absent from the fee-for-service database. This adjustment is eliminated when calculating the rates for plans that opt to make third party liability recoveries themselves.

The resulting adjusted PMPM rates represent the fee-for-service equivalent upper payment limits.

3. Final Ranges

In the final step of the methodology, the fee-for-service equivalents are subjected to several additional adjustments to arrive at the state's final rate ranges:

- First, the fee-for-service equivalents are adjusted to account for the changes in utilization and unit cost anticipated with the use of managed care. These adjustments are intended to reflect typical changes, such as the substitution of primary and preventive services for inpatient and emergency room services. The specific factors used for this adjustment are not public.

- Next, a rate category-specific deduction is taken from the fee-for-service equivalents to finance the state's reinsurance program. For AFDC and related newborns under the age of 1 this reinsurance offset is 5.1 percent; for all other rate categories, this offset ranges between 0.1 and 1.5 percent.

- Last, the fee-for-service equivalents are adjusted to allow for plans' administrative expenses in excess of Medicaid's historical administrative costs under its fee-for-service program. This adjustment is accomplished by replacing the Medicaid administrative allowance amount (included in the fee-for-service-equivalents) with an administrative allowance estimate for plans. This adjustment includes an allowance for plans' profits and contingency expenses.

The resulting final rates are then converted to region- and rate-category-specific rate ranges, which are used to guide the bid and negotiation process for the state's Managed Care Plus program. The final rates serve as midpoints for this conversion. Neither the limits nor the breadths of the ranges are public information.

In addition to developing these rate ranges, the state provides guidance to plans in the development of their rate proposals. Plans are required to complete a pricing page for each rate category in each region for which a plan is bidding. On the pricing page, plans are asked to

present region- and premium group-specific utilization rates, unit costs, and total PMPM rates for 22 service categories. The following five adjustments must then be made to the sum of these service-specific rates:

- Rates must be decreased to reflect a reinsurance offset.
- Rates must then be increased by a percentage of net medical costs according to a plan's PMPM estimate of its administrative expenses.
- Next, the plan must add an estimate of its margin of profit.
- An addition is also made to allow for contingency and risk charges.
- Finally, plans that do not choose to make their own third party liability recoveries are asked to increase their rates to account for these payments.

The resulting rates represent a plan's bid for each rate category.

The pricing for SOBRA-eligible women is calculated separately, as a one-time payment that covers the delivery-related costs of a SOBRA birth. Using the same 22 service categories and the same five adjustments as for the other pricing pages, plans must detail the development of a total, lump-sum price for coverage of a SOBRA-eligible pregnant woman whose pregnancy ends in a vaginal birth and a separate lump-sum price for coverage of a SOBRA pregnancy ending in a cesarean birth. A weighted average of these two amounts is then calculated based on the relative distribution of vaginal and cesarean SOBRA births in each region. In order to arrive at the net supplemental maternity payment for a SOBRA birth, plans must then deduct six times the capitation bid for the AFDC female ages 14-20 subgroup from this weighted average amount, the state estimates that SOBRA women are enrolled in a plan for an average of six months. This deduction is intended to exclude nondelivery-related costs from the supplemental payment.

Contract rates are inflated in between years of the multi-year contract according to a legislatively approved factor. Historically, the state's Department of Social Services has recommended that this inflation rate equal the medical CPI (approximately 4.5 percent); however, the state legislature has generally approved a factor somewhat below this index. For example, the factor used for inflating the rates in St. Louis from 1995 to 1996 was equal to 3 percent.

Fee-for-service claims data, adjusted for excluded populations and services, are made available to bidders in the contract Databook and on disk for use in developing rates; however, plans are encouraged to use their own encounter data wherever possible.

C. Negotiation and Contracting

Prior to the start of a bid year for a particular region, the state issues a Request For Proposals (RFP) to the fully capitated plans in that region for the purposes of contracting for the Managed Care Plus program. After an initial screening process, responding plans are evaluated and ranked according to their strengths in the following four areas:

- Experience and Reliability. Bidding plans are evaluated and scored based on their previous experience and reliability related to the provision of required medical and behavioral health services to Medicaid recipients and other low-income or uninsured families. Services of particular interest are EPSDT, family planning, prenatal, dental, and mental health and substance abuse services. Also of interest in this area is the financial stability of bidding plans, particularly as forecasted into the contract period. ***15 percent***

- Expertise of Personnel. In the area of personnel expertise, the state evaluates the experience and qualifications of key personnel with relation to the Medicaid population. In addition, the state evaluates the plans' provider credentialing and recredentialing processes, as well as provider accessibility and availability. ***10 percent***

- Proposed Method of Performance. The evaluation of each plan's proposed method of performance involves an examination of the plan's enrollment and disenrollment procedures, proposed approach to providing required services, coordination with out-of-plan services, provider network, access standards, member and provider services, proposed quality assurance and utilization management efforts, and data reporting. ***35 percent***

- Cost Proposal. Finally, a plan is evaluated based on how each of its rate bids compares to the bids of competing plans and to the state's rate range for the corresponding rate cell. A plan's total cost score is derived through the following, multi-step process:

  - First, for each rate cell, plans are ranked from highest to lowest based on their bids in that cell. (Thus, in a competition between two plans, the plan with the higher bid receives a ranking of 1 while the plan with the lower bid receives a ranking of 2.) Each plan then receives a number of points calculated according to the following equation:

$$\text{Bid points} = \frac{\text{Plan's ranking for the rate cell}}{\text{Number of offering plans}} \times 100 \text{ points}$$

    For example, the lowest (number one) ranked plan (the plan with the highest bid) of three receives 33, or 1/3 times 100, points.

- Next, a comparison is made between the plan's rate bid and the state's rate range for that rate cell to determine inoto which quartile of the range th plan's bid falls. A plan whose bid falls in the lowest quartile of the range is then awarded 100 points; a plan whose bid falls in the second lowest quartile is awarded 75 points; and so forth.

- The two bid scores for each rate bid are averaged. This average score is then multiplied by the estimated population within the rate category for the plan's service area, to arrive at the total points for each rate category. A plan's total bid point score is calculated as the sum of its point scores within each rate category.

- Finally, this total bid point score is then divided by the total number of points possible (had each rate bid submitted by the plan fallen below all competing bids and within the lowest quartile of its corresponding rate range) to arrive at a percentage representing the plan's total cost score. ***40 percent***

The points awarded to a plan in each area are then weighted appropriately and summed to yield the plan's total evaluation score. Plans are ranked and selected based on these total evaluation scores. If in its best interest, the state may elect to conduct one or more rounds of best and final offer (BFO). Should it so choose, state officials will meet with the officers of each plan to discuss the strengths and weaknesses of the plan's proposal. In these discussions, plans are told which of their rates fall below and which fall above the state-developed rate ranges, and are then given the opportunity to adjust their rates and the other areas of their proposal. Plans are warned, however, that the negotiation process will be terminated as soon as the state successfully negotiates contracts with a sufficient number of plans. In this way, bidders are encouraged to treat each offer they make as their best and final offer. Further, any plan that, by the end of the negotiation process, still has a rate bid in any cell which falls either below or above the state's rate ranges is considering unqualified to be awarded a contract. At the close of the contracting process, all final contract rates are made public.

Contracts are awarded for a one-year period, with one additional one-year period renewal option. Since Managed Care Plus was expanded incrementally to the four regions in which it is currently implemented, each region is at a different point in its contract period. On 1 September 1997, the Eastern region will begin its third year. Program operation began on 1 January 1996 in the state's Central region, and on 1 January 1997 in the Western and Northwestern regions. When the program was initiated in the Eastern region, seven of the nine offering plans were awarded program contracts, one of which lost its contract during the first contract period. Based on the early experience of the program in the Eastern region, state officials decided that the population of a region could not adequately support more than three or four plans. Therefore, of the four plans competing to serve in the Central region, three were awarded contracts, while four of the seven plans bidding in the Western region were selected to serve this region's Medicaid population.

D. Enrollment

From the point of eligibility determination notification, AFDC, AFDC-related, and Foster Care eligibles residing in the Managed Care Plus program's four regions are given 15 calendar days to select a plan. Family members are encouraged to enroll in the same plan. Those Managed Care Plus eligibles who do not make a selection by the 16th day after eligibility notification are automatically assigned into one of their region's geographically accessible plans according to either family continuity or an auto-assignment algorithm. The algorithm is designed to weigh plans according to their total evaluation scores. The relative distribution of auto-assigned enrollees among a region's plans is intended to reflect not only the absolute rankings of plans by total evaluation score, but also the relative spread between their scores. As of March 1997, the rate of auto-assignment was 14 percent in the Eastern region, 16 percent in the Central region, 26 percent in the Northwestern region, and 31 percent in the Western region.

Once enrolled in a plan, recipients are never locked in to the plan, and thus may, at any point, switch plans for "good cause." Although no explicit enrollment limit is determined for each plan, plans are required to maintain certain quality assurance and accessibility standards that may place rough, implicit limits on the enrollment of each plan. In addition, usually a plan's enrollment may not be composed of more than 75 percent Medicaid or Medicare recipients, although some plans are exempted from this limit, such as FQHCs.

Contract language establishes that when an incumbent plan loses its contract, it must continue to serve its current Medicaid enrollees until the enrollees are transferred to another plan. In bid years, state officials expect that this transfer will be more smooth, in that enrollees will be given advanced notice of their plan's failure to renegotiate a contract with the state, and will thus have ample time to switch or be auto-assigned to a new plan. Should a plan lose its contract in between bid years, the transition process may be more pressed for time.

E. Risk Sharing

The state requires that participating plans be insured against financial insolvency. To this end, the state has established a reinsurance program that it requires plans to purchase through an appropriate reduction in their capitation rate payments; however, this program is limited to inpatient hospital expenses. According to program, plans must cover the first $50,000 of an enrollee's inpatient hospital medical expenses. Expenses in excess of this deductible will be shared by the state at a rate of 80 percent. For the purposes of this program, expense levels are always assessed according to the lesser of Medicaid's current per diem inpatient hospital rate or the plan's negotiated rate with the hospital.

The state does not offer any other reinsurance policies, nor does it establish any risk corridors for the sharing of profits or losses.

F. Quality Assurance

Participating planning must comply with quality assurance and improvement requirements that included both internal and external mechanisms. Plans must maintain an internal mechanism for monitoring, analyzing, evaluating, and improving the quality of the care they provide, with an emphasis on maternity, pediatric, and adolescent development; family planning and well women care; and key access and other issues of priority for Medicaid recipients. In addition to enforcing provider compliance with the plan's written standards, practice guidelines, and protocols of care and utilization management, plans must monitor and improve their credentialing and recredentialing activities and conduct analytical studies of their outcomes data.

Plans must periodically document and submit reports on their monitoring, evaluation, and improvement activities. They must also submit utilization, member satisfaction, and complaint data to the state on a regular basis. Plans have begun submitting encounter data as well; however, the state's quality assurance unit has placed greater priority on the submission of key performance and outcomes measures, such as immunization levels.

Based on these reports and annual independent reviews, the state or its outside reviewers externally assure the quality of care provided by plans. External quality assurance activities include on-site facility inspections, staff and enrollee interviews, reviews of complaint and grievance procedures and resolutions, review of encounter data, analysis of outcomes data using HEDIS measures and indicators, and review of the internal quality assurance mechanisms.

Although the state's Department of Insurance monitors the financial solvency of participating plans, the state's Department of Social Services also requires plans to submit a variety of financial reports for its own monitoring purposes, and in order to have advanced notice when plans are headed toward insolvency.

III. Future of Missouri Managed Care Plus

Missouri state officials report that the decision to develop rates through a bid and negotiation process rather than internally was based on the desire to increase the level of competition between high-quality plans by allowing greater flexibility in the pricing of contracts. State officials have reportedly been pleased with the results of the rate development and contracting process invoked. The selection process has been competitive, and contracts have been awarded to prominent, high-quality plans. In addition, the state's experience with pricing has been satisfactory, and officials see no need to implement an internal rate development methodology for cost-saving purposes.

For the most part, therefore, the Managed Care Plus program's rate development process is not expected to change significantly in the near future. The only notable change to the rate development process will be the inclusion of SOBRA women into the AFDC and related rate categories. Rather than cover SOBRA women separately from other recipients through a one-time supplemental payment made to plans at the time of a SOBRA birth, the state intends to

cover these women through a monthly capitation rate, and make a supplemental maternity payment to plans for all births. In this way, plans can receive payments for SOBRA women without having to distinguish them from other pregnant women at the time of delivery.

Otherwise, officials hope to eventually incorporate encounter data reported by the plans in the development of rate ranges; however, the effort to enforce submission of such data has been in competition with a currently more forceful effort to collect quality assurance-related data.

Officials hope to further expand the program into the Southern portion of the state, and potentially to the remaining scarcely-populated portions as well. Future expansion may also include an expansion of the income eligibility criteria for children and the inclusion of certain SSI-disabled eligibles.

New York

I. Overview

New York began using managed care arrangements to provide health care services to its Medicaid recipients in 1976, with the Medicaid Managed Care Program. In the past, this program has included a voluntary, fully capitated component and a Primary Case Care Management (PCCM) component. On 1 April 1996, the state initiated the Partnership Plan—a new voluntary, fully capitated managed care program for AFDC, AFDC-related, and Home Relief (New York's state-funded program for low-income, Medicaid-ineligible persons), differing from the old in terms of its contracting process and particular emphasis on quality assurance. The state also operates two mandatory, fully capitated programs in Southwest Brooklyn and Westchester County, each operating under its own 1915(b) waiver.

The voluntary Partnership Plan was introduced as the first phase in an effort to implement a statewide, mandatory, fully capitated program under 1115(a) waiver authority. In March 1997, New York received HCFA approval for a 1915(b) waiver that gives the state authority to make enrollment mandatory in all of the Partnership Plan's current 32 operational counties. Additionally, in the summer of 1997, the Partnership Plan is expected to expand to all but 12 of the state's remaining counties, as a result of recent HCFA approval of New York's 1115(a) waiver request. The 12 counties excluded from this expansion are sparsely populated rural counties that may have difficulty supporting a fully capitated program. Given this exclusion, however, state officials will permit the introduction of new PCCM programs in these 12 counties; these programs will be phased out with the Partnership Plan in the state's remaining counties.

Prior to the Partnership Plan, the state developed fee-for-service equivalent upper payment limits, which were the basis of its contracts with managed care organizations under the original voluntary, fully capitated program. Currently, the state contracts with outside actuaries to develop region- and premium group-specific rate ranges, which are used to guide the Partnership Plan's competitive bid and negotiation contracting process. These ranges are based on historical fee-for-service data, trended forward and adjusted for the expected effects of managed care on utilization and unit costs. This current methodology, with some minor changes, will be the basis for the development of rates under the mandatory program as well.

II. Development of Capitation Rates

A. Benefits

Participating plans in the voluntary Partnership Plan are responsible for providing their Medicaid enrollees with a comprehensive benefit package, including physician services, inpatient and outpatient hospital care, case management, enhanced services (including general health, parenting, and childbirth education classes, smoking cessation classes, and nutrition counseling), Child/Teen Health Plan (C/THP) services (including EPSDT services), prescription and nonprescription drugs, mental health and substance abuse treatment services (with limits of 20 outpatient mental health visits, 60 outpatient substance abuse visits, and 30 total days of inpatient mental health and substance abuse services combined), organ transplants, vision care, emergency transportation, and durable medical equipment. In the voluntary program, plans may choose either to receive capitated payments for dental services or to be reimbursed for these services through fee-for-service arrangements. Upon the start of mandatory enrollment, reimbursement for dental services for children under the age of 21 will be capitated for all plans. At a plan's option, it may also provide family planning services and nonemergency transportation to its enrollees, for which its capitation rates will be enhanced. Otherwise, these services are covered on a fee-for-service basis through out-of-plan providers.

In selecting among plans for the next procurement in 1998, the state will take into account plan performance in certain benefit areas. For instance, plan performance regarding C/THP services will be taken into consideration, as will the number of contracts it has with traditional Medicaid providers, such as school-based health centers. In the Request For Proposals (RFP) for the 1996 bid period, the state emphasizes its interest in preventive services, and declares the C/THP program to be "one of the highest priorities of the Medicaid program." Starting in the second year of the contract, plans will be required to contract with school-based providers for the provision of medical and behavioral health services to their enrollees.

Plans are prohibited from requiring any enrollee cost sharing; otherwise, plans must treat Medicaid enrollees as they do their commercially enrolled populations.

B. Rate Development

Prior to the Partnership Plan, fully capitated contract rates were developed by state officials based on fee-for-service equivalent upper payment limits. In contrast, New York uses a bid and negotiation process for the purposes of contracting with plans under the new Partnership Plan. Through this process, the final contract rates negotiated must fall within rate ranges developed by actuaries who are under contract with the state. The actuaries use New York's fee-for-service Medicaid claims database as their primary data source for developing fee-for-service equivalent rates, which are then trended forward to the contract year, adjusted for the impact of managed care on utilization and cost, and converted into ranges of acceptable rates. These ranges are not shared with bidding plans; however, final contract rates are public

information. The rate ranges for the most recent, 1996-1997 contract year were based on the database from Fiscal Year 1994.

The contract rates are developed according to a three-step methodology. In the first step, the fee-for-service database is customized with certain adjustments to reflect the portion of eligibles, services, and expenditures for which plans will be responsible. During the second step of the process, the customized database is used to calculate per-member per-month (PMPM) rates; it is in this step that the rates are trended forward to the contract year and adjusted for the impact of managed care. Finally, in the third step of the methodology, the rates are converted into rate ranges and subjected to several additional contractual adjustments. The three steps of this methodology are detailed below.

1. Customizing the Database

The fee-for-service claims data are identified and sorted by age and eligibility category into eight premium groups to yield ten distinct datasets:

- AFDC and Home Relief [HR] males and females under 6 months of age,
- AFDC and HR males 6 months to 20 years of age,
- AFDC and HR females 6 months to 14 years of age,
- AFDC and HR females 15 to 20 years of age,
- AFDC males and females 21 to 64 years of age,
- HR males and females 21 to 29 years of age,
- HR males and females 30 to 64 years of age,
- SSI-Seriously Persistent Mental Illness/Serious Emotional Disability (SPMI/SED) males and females (1 to 64 years of age),
- SSI males and females 1 to 20 years of age, and
- SSI males and females 21 to 64 years of age.

All inpatient delivery-related expenditures identified in these datasets are separated into a distinct dataset used to develop a one-time supplemental maternity payment paid to plans to cover the inpatient birth costs of each pregnant Medicaid newborn. Next, a series of adjustments are made to the database to reflect the expenditures for which plans will be contractually responsible:

- The claims for various Medicaid-eligible populations were retained or excluded in accordance with expected participation in the Managed Care Program. Portions of the data for the symptomatic AIDS, asymptomatic HIV-positive, SPMI/SED, and Foster Care Children populations are eliminated to reflect the anticipated participation rates of these populations. Since dually eligible Medicare recipients are not eligible for the program, their claims are completely eliminated.

  In addition, to ensure that the base data included in the datasets reflect fee-for-service utilization and expenditures, the data for recipients enrolled in PCCM or other managed care programs in the base year (ranging regionally between 13.8 to 52.9 percent of the entire AFDC/Home Relief population) are eliminated, since these data do not represent pure fee-for-service expenditures.

- The data are then adjusted to ensure that they reflect expenditures for services that are covered by the capitation rate. Expenditures for adult mental health and substance abuse services in excess of the limits described above are removed from the database. Also, expenditures for prescription and nonprescription medications that were refunded to the state through pharmacy rebates were removed from the database, in order to preserve these savings. The rebate reduction factors vary by geographic region (defined below), ranging between 18.1 and 19.8 percent of total pharmacy expenditures.

  While catastrophic claims over $50,000 are included in the database, factors are developed by which the fee-for-service equivalent rates can be reduced for those plans that purchase reinsurance from the state, protecting them partially from expenditures above $50,000 and fully from expenditures exceeding $250,000.

- Several services may be provided at managed care plans' option. The expenditures for these three services—dental care, family planning, and nonemergency transportation—are retained in the datasets. For plans that opt not to offer these services, expenditures for these services will be removed from contract rates as follows:

  - For plans that opt not to provide dental care, the per-member per-month (PMPM) cost of dental services are deducted from the rates.

  - For plans not offering family planning services, adjustment amounts are subtracted from contract rates. These amounts are calculated specifically for each region and premium group, and are based on family planning-related expenditures in seven service types (inpatient, outpatient, primary care physician, other physician, C/THP, medication, and laboratory services). On average, the amounts subtracted were $5.77 for AFDC males and females 21-64 years of age and $5.07 for

AFDC females 15 to 20 years of age, and are negligible (between $0.00 and $0.07) for remaining AFDC eligibles.

For plans that choose not to provide nonemergency transportation, adjustment factors are developed, which carve out the nonemergency portion of historical transportation expenditures. The factors represent the portion of transportation expenditures that are retained in the rates for emergency transportation, which all plans must provide. They vary across geographic regions (defined below), ranging from 3.7 percent to 26.6 percent of transportation expenditures.

- Next, two other categories of expenditures are removed from the database. Although Medicaid is responsible for covering an eligible's health care costs in the time period beginning 90 days prior to application and ending upon enrollment into a plan, plans are not responsible for these expenses; therefore, such expenditures are removed. For the 1996-97 rate year, these exclusions combined to result in a 5 percent reduction in all expenditures. Also removed were the expenditures for graduate medical education payments.

- In order to adjust for incurred but unpaid claims, expenditures and units are increased according to actuarial completion factors. These completion factors are service specific, and a separate set of factors is used for the New York City Metro region than is used for the remaining regions (identified below). Each factor is applied as a divisor less than one to the relevant utilization and expenditure data, and represents the portion of incurred claims that is represented in the fee-for-service database. Completion factors mostly fall in the range of 91.41 to 100 percent (though the non-Metro factors for inpatient mental health and inpatient substance abuse services are both 86.95 percent), and are generally higher in the Metro region.

- Actuaries remove data for claims that were recovered due to third party liability, since the plans are responsible for making such recoveries themselves. Also, total expenditures slightly underestimate the cost of caring for Medicaid eligibles, due to charity care and bad debt payments; however, the data are not inflated to reverse this effect, since the state intends to preserve these savings and revenues.

- Two further adjustments decrease the fee-for-service expenditures included in the rates. First, since state officials expect that those who voluntarily enroll in the capitated program will be a relatively healthy population, this lower risk is accounted for by a reduction (approximately 5 percent for the AFDC and Home Relief populations) in fee-for-service expenditures. Since inpatient and outpatient hospital payments experienced decreases in 1995 of 7.28 percent and

2.6 percent respectively, the base data were also adjusted to reflect these changes for the contract year.

- Finally, the costs to the state associated with administering the fee-for-service Medicaid program are then added to the claims data. In New York City, these costs amounted to 1.7 percent of fee-for-service costs for the base year, while in the remainder of the state they were calculated at 2.4 percent of the 1994 fee-for-service costs.

2. Developing Preliminary Contract Rates

In the second step, the adjusted utilization and unit cost data are analyzed and used to calculate premium group-specific fee-for-service equivalent PMPM base rates for each of 31 service types. Adjustments are then made to these base service type-specific rates as follows:

- First, the rates are adjusted to account for any programmatic changes that have occurred between the base year and the targeted contract year. Sources of such changes include changes to the list of included services, incentive or reimbursement programs newly established under the capitated program, and any other program changes that may have a significant impact on the expenditures, utilization patterns, or demographic composition of the Medicaid program.

- After the programmatic adjustments are made, the rates are adjusted for regional variation across the state. In the development of rates for the 1996-97 rate year, the state's counties were grouped into nine regions (Metro, Long Island, North Metro, Mid-Hudson, Northeast, Utica-Adirondack, Central, Finger Lakes, and Western) according to regional differences in demographics and patterns of service use. Thus, the adjusted PMPM service-specific rates were recalculated separately for the nine regions.

- The region- and service-specific rates are then trended forward, based on changes in population, technology, plan design, service delivery, service costs, and service utilization identified between the base year and the rate year. The specific inflation factors used are not public information.

- In the second step's final adjustment, the service-specific rates are adjusted to account for the changes in utilization and unit cost anticipated with the use of managed care. While the specific adjustment factors used in the most recent rate development are not public, actuaries indicate that utilization rates for inpatient hospitalization and emergency room services were expected to decrease as the use of these services became more appropriate under managed care; they also indicated that the utilization of outpatient and primary care physician services were expected to increase, due to managed care's emphasis on ambulatory, primary, and preventive care.

3. Final Capitation Rate Adjustments

In the concluding step of the rate development methodology, the fully adjusted service-specific rates are summed to yield gross PMPM medical expense rates, which are then converted into rate ranges specific to each region and premium group. The rates represent midpoints for the ranges, with the upper and lower limits of the ranges defined in a range around the midpoint. These gross rate ranges are, finally, subjected to the five further adjustments listed below. The specific magnitudes of these adjustments are not public.

- An additional administrative charge is added to the gross rate ranges to account for the fact that managed care plans will have higher administrative costs than the state's Medicaid program.

- Another increase in the ranges allows for the plans' margin of profit.

- The ranges are also enhanced to allow plans some protection against the risk they assume.

- Should analysis of the fee-for-service data in previous steps reveal random variations in these data, the ranges may be subjected to zero-sum relational modeling. Relational modeling accounts for such random variation by smoothing the relative costs of the rate ranges across categories of aid and across regions, to yield rate ranges that more accurately reflect the relative risks across program enrollees.

- Last, for plans that choose to purchase stop-loss reinsurance from the state, reinsurance percentages are applied to the rate ranges to reflect their reduced risk and their reinsurance premium payments. These percentages are premium group-specific, and those for the Metro region are developed separately from those for all remaining regions. All of the Metro percentages are higher than their non-Metro counterparts. The percentages for children under six months of age were the highest—in the Metro region, they were 8.93 percent for the birth month and 3.85 percent for all other months, and in the non-Metro regions they were 6.99 percent for the birth month and 1.98 percent for all other months. Otherwise, the percentages range from 0.7 to 1.8 percent in the Metro region, and from 0.17 to 0.79 in the non-Metro regions.

The resulting rate ranges guide the bid and negotiation process for the state's Managed Care Program.

In addition to developing these rate ranges, the state provides guidance to plans in the development of their rate proposals. Plans are required to complete a Capitation Rate Calculation Sheet (CRCS) for each premium group in each region for which a plan is bidding. On the CRCS, plans are asked to present region- and premium group-specific utilization rates, unit costs, and total PMPM rates for 17 service categories. The sum of these rates are then

adjusted for administrative charges, plan profitability, risk and contingencies, and reinsurance (for plans purchasing state reinsurance).

Costs related to deliveries are not included in the CRCS calculation. Rather, separate supplemental case rates are developed for births to eligible women, by calculating a birth-related inpatient hospital PMPM rate based on utilization and unit costs, specific to each premium group and region. This rate is then adjusted to account for administrative charges, plan profitability, risk and contingencies, and reinsurance (for plans making this purchase) to produce net rates for deliveries.

Base data, adjusted for excluded populations and services, are made available to bidders in the contract Databook and on disk for use in developing rates; however, plans are encouraged to use their own encounter data wherever possible.

C. Negotiation and Contracting

Prior to the start of the contract period, the state issued a Request for Proposals to HMOs and PHPs in the relevant regions for the purposes of contracting for the Medicaid Managed Care voluntary program. Responding plans were evaluated based on the strengths of their technical and business proposals. In order to be considered "qualified" to enroll Partnership Plan members, a plan's technical proposal and rate proposal both had to meet standards of acceptability, and the plan had to receive a favorable readiness review. In the technical evaluation, the state assessed and ranked plans within each region by a point system based on their strengths in areas including their provider network's quality, depth, and capacity; use of traditional Medicaid providers (such as school-based health centers); record regarding service and provider accessibility; quality assurance mechanisms; data and reporting systems; complaint resolution process; and timeliness of provider payments. The plan that received the highest technical score then served as a benchmark for the other plans. Plans that did not receive scores within 75 percent of the benchmark score were informed of the areas in which their proposals were deficient and given the opportunity to make the improvements necessary to achieve acceptable technical scores. Those that failed to improve their scores were removed from consideration

Plans that are deemed "qualified" through this technical evaluation are then evaluated based on their rate proposals. The RFP indicates that all final contract rates (for each rate cell) must fall within the state's rate ranges; however, at no point are these ranges or certain factors used to develop them made public.

At the end of the rate review process, the state makes its final counteroffer to each plan that proposed rates that do not fall within the allowable ranges. For all rates below their relevant range, the counteroffer will equal to the range's lower limit, and for all rates above the relevant range, the counteroffer will fall somewhere below the range's top quartile. In this way, offerors have a strong incentive to propose more conservative rates, since they are aware that

final rates above the range will elicit relatively low counteroffers. For rate bids that fall within the appropriate rate range, this rate is accepted.

Plans that accept the state's counteroffer and have qualified through the technical evaluation are then considered qualified for a contract award. The state then distributes to individual counties a list of plans qualified for contracts in their region, from which county officials then determine the number of contracts to be awarded in their county. This decision is made with consideration for balancing several important factors. On one hand, the number of contracts will be limited by the size of the enrollee population in the county and by each plan's capacity. On the other hand, officials will be interested in awarding a greater number of contracts in order to enhance enrollees' freedom of choice and begin establishing an adequate infrastructure of plans prior to implementation of the mandatory program. In presenting the list of qualified plans to county officials, the state may order the plans in accordance with their technical proposal rankings. The final negotiated rates, however, are not a consideration in determining this rank ordering—the rate proposal evaluation is only meant to negotiate rates within the rate ranges. Plans that are awarded contracts must then receive readiness approval from the state before they will be permitted to begin enrolling Partnership Plan members.

The state currently has approximately 40 county-specific contracts with an estimated 28 separate plans. Contracts extend for two years, and the first contract period is from 1 April 1996 to 31 March 1998.

D. Enrollment

During the contracting process, the state determines an enrollment limit for each plan through an assessment of the plan's capacity. Capacity is determined based on financial capacity and certain minimum provider-to-member ratios: each physician cannot be assigned more than 1500 Medicaid members, each physician/physician assistant combination cannot be assigned more than 2400 Medicaid members, and each nurse practitioner cannot be assigned more than 1,000 Medicaid members. In addition, no more than 75 percent of a plan's membership may be Medicaid or Medicare recipients.

While there is no need to auto-assign nonchoosers under the voluntary program, an auto-assignment algorithm has been developed for nonchoosing members in the Southwest Brooklyn and Westchester mandatory programs and for the mandatory Partnership Plan. Only plans with available capacity that are geographically accessible to the auto-assigned enrollee will be entered into the algorithm. The algorithm gives highest priority to provider-sponsored, nonprofit plans—in the 1996/97 contract year, these plans received over 25 percent of the auto-assigned members. The remaining nonchoosers are then distributed among all the region's plans (including the provider-sponsored plans), with relative weights reflecting each plan's performance regarding C/THP periodicity schedules and other quality measures and contribution to expanding service capacity in underserved areas. Members who have not chosen a plan within two weeks of receiving their letters of eligibility will be automatically assigned according to this algorithm. The algorithm will yield a different percentage of the

auto-assigned population for each plan; however, no single plan will receive all the assignments in a geographic area.

Enrollees of federally qualified plans are given a one-month window of opportunity for switching plans, after which they are locked in to their plans for the subsequent five months or until the next round of open enrollment (whichever comes first); enrollees of nonfederally qualified plans may switch plans at any time.

E. Sharing of Risk

Plans are required to be reinsured against insolvency. For those without private reinsurance or the ability to self-insure, the state offers a stop-loss reinsurance plan. Under this plan, expenditures above $50,000 for an individual enrollee are reimbursed at 85 percent by the state during Year One of the contract period, and at 80 percent during Year Two. Further, the state covers 100 percent of an enrollee's expenditures that exceed a $250,000 threshold. (These reinsurance thresholds are calculated based on the lesser of the Medicaid reimbursement rate and the plan's negotiated reimbursement rate with the enrollee's providers.) Plans pay reinsurance premiums as direct deductions from their capitation rates.

Finally, the state makes risk adjustments to the monthly capitation payments for plans that enroll a greater than expected proportion of certain high-risk populations. Any plan whose enrollee population consists of more than 0.1 percent symptomatic AIDS patients will receive enhanced rates based on this AIDS enrollment percentage. For each percentage point by which the expected enrollment is surpassed, th plan's capitation rates will be increased by a certain, predetermined percentage. A plan enrolling between 20 and 40 percent of this population will have each premium group's capitation rate increased by 1.16 percent; a plan enrolling between 40 and 60 percent of this population will receive a 2.32 percent rate enhancement; a plan enrolling 60 to 80 percent of this population will receive a 3.48 percent rate increase; and a plan enrolling over 80 percent of this population will have its rates increased by 4.64 percent.

F. Quality Assurance

Plans are required to maintain internal quality assurance and improvement mechanisms, guided by written quality improvement plans. These mechanisms include the following plan requirements:

- Perform quality reviews of their providers;
- Follow standard of care guidelines (such as those established by the C/THP program, the state's Quality Assurance Reporting Requirements [QARR], American Academy of Pediatrics, the U.S. Public Health Service Task Force on Preventive Care, the U.S. Department of Health and Human Services Center for Substance Abuse Treatment, the New York State Prenatal Care Standards for

Managed Care Plans, and the AIDS Clinical Standards for Adult and Pediatric Care);

- Conduct utilization reviews, including reviews of the protocols used for approval and denial of services, and identification and correction of enrollee (especially child) over- and under-utilization patterns; and

- Conduct at least one internal clinical study per year, focusing on an area of choice from a list established by the State Department of Health.

Plan performance and provider networks are also monitored externally by the state. State quality assurance activities include assessments of quality, appropriateness, and timeliness of services; focused clinical studies of acute and chronic health conditions; periodic medical audits; and an annual collection of management data. The state also collects operational data to monitor program access and outcomes performance. Plans must submit a variety of reports including semi-annual and annual statements of operations, encounter data, quality of care performance measures according to QARR specifications, quarterly complaint reports, quarterly provider network reports, reports evaluating provider and service availability, an annual member satisfaction survey, and additional reports as deemed important by the state.

In addition, plans are required to report financial data relating to capitation payments, third party liability recoveries, sources and application of funds, and the plan's capacity to bear financial risk. The state uses these reports to monitor and assess the financial status and solvency of participating plans.

III. Future of New York Medicaid Managed Care

New York received approval of its 1115(a) waiver in July 1997 to convert the primarily voluntary managed care program into the mandatory Partnership Plan. Upon implementation of the 1115(a) waiver, certain adjustments to the voluntary program rates will be required to account for differences in the design and population characteristics of the mandatory Partnership Plan. The following adjustments will be made directly to the rate ranges:

- Under the voluntary program, plans are responsible for a combined limit of 30 days of inpatient mental health or substance abuse services. Under the mandatory program, the limit is to be expanded to 30 days for each type of service; thus, the rate ranges will be increased accordingly. In addition, the outpatient substance abuse service limit will be reduced under the Partnership Plan from 60 visits to 20 visits; the rate ranges will therefore be decreased to reflect this change.

- Though the enrolled population under the Partnership Plan is expected to be somewhat healthier on average than the Medicaid population as a whole (since the program will remain voluntary for some populations, and since some higher-

cost populations will be ineligible for the program), the average expenditure per capita is likely to be higher than in the voluntary program. Thus, the voluntary selection factor applied in the methodology above will be reduced using an adjustment factor that increases the rates appropriately.

Upon completion of the current contract, the state will establish procedures for awarding contracts in the next contracting cycles. Also, as with any new methodology, minor changes may be made to the current rate development process in accordance with contracting experience.

OREGON

I. Overview

In 1993, the Oregon Department of Human Resources (DHR) Office of Medical Assistance Programs (OMAP) received an 1115(a) waiver to begin its Medicaid managed care initiative, the Oregon Health Plan (OHP). Since 1 February 1994, the OHP program has been mandatory for all AFDC and AFDC-related eligibles, including pregnant women and children under age six with household incomes below 133 percent of the Federal Poverty Level (FPL). Since 1 January 1995, OHP has also been mandatory for foster children, and SSI eligibles. In addition to enrolling these Medicaid eligibles in managed care, the OHP program expanded eligibility to uninsured individuals, including families, childless adults, and couples with incomes below 100 percent of the FPL. Oregon does not include Qualified Medicare Beneficiaries (QMBs) or undocumented aliens in the OHP program.

The distinguishing feature of Oregon's research and demonstration waiver program is the use of a prioritized list of 744 diagnosis and treatment pairs to define the OHP benefit package. Every two years, with HCFA's approval, the Oregon Health Services Commission revises the prioritized list. The state legislature determines the amount of funding allotted to the program, which determines how far down the prioritized list coverage can be extended. Rates paid to managed care plans are based on the number of services covered.

OMAP contracts with all managed care plans that meet the state's standards for care and are willing to accept the capitation rates offered by the state to cover the services in the benefit package. Until 1996, OMAP contracted with both Fully Capitated Health Plans (FCHPs) and partially capitated Physician Care Organizations, in order to assure that traditional Medicaid providers would be able to participate in the program, but OMAP now contracts only with FCHPs. Currently, OMAP contracts with 15 plans across the state. Oregon is a sparsely populated state with a corresponding dearth of plans. For that reason, OMAP officials feel that their noncompetitive bidding process, in which OHP representatives regularly meet with representatives of the 15 plans to assess the quality of care and the adequacy of the capitation rates, has been more effective than price competition.

II. Development of Capitation Rates

A. Benefits

The capitation rates developed for OHP are for all services included in the Basic Health Care Package which are above the cutoff line drawn on the prioritized list each year. Beginning in October 1995, only services through line 606 were covered. In January 1996, reduced funding lowered the number of covered services to line 581, and in February 1997, the Legislative Emergency Board moved the line again to 578; at this point, some services on the list between lines 578 and 581 were reprioritized in order that they would continue to be included in OHP. HCFA has required that there be no more changes in the benefit package before 1999, the year the 1115(a) waiver expires.

The benefits covered by the OHP include primary and preventive care, obstetrical care, prescription drugs, hospice care, home health care, most organ transplants, and chemical dependency services. Benefits below line 606 on the prioritized list, which have been excluded since 1 February 1994, include treatments for acute viral hepatitis, hypotension, infertility, and peripheral nerve disorders. Items between lines 581 and 606, excluded since January 1996, include treatments for chronic bronchitis, operations to correct deformities of the upper body and limbs, and treatments for sexual disfunction. As of February 1997, treatments for anal fissures were also excluded. Mental health benefits on the "Prioritized List" are included in the OHP Basic Health Care Package only for 20 counties. Abortion and maternity case management services are provided by plans and included in the capitation rate at the plans' option. Dental services are provided under a separate capitation rate by dental care organizations.

B. Rate Development

From the start of OHP, OMAP used outside actuaries to develop the capitation rates. For OMAP's 1995-96 and 1996-97 contracts, the actuaries used 1992 and 1993 fee-for-service expenditure and utilization data to calculate the expected per capita cost of all 744 health care services on the prioritized list. Sources of these data included the state's Medicaid Management Information System, Blue Cross Blue Shield of Oregon (BCBSO), ODS Health Plan (for dental services), Good Health Plan (for mental health and chemical dependency services), and Oregon Mental Health and Developmental Disability Services Division (for mental health services). Per capita costs were estimated separately for each of the following 13 eligibility categories:

- AFDC Eligibles;
- General Assistance Eligibles (GA)—adults with an income below 47 percent of the FPL who do not qualify for any other programs and are unable to work due to medical disability for at least 60 days;

- Poverty Level Medical (PLM) Adults and Pregnant Women with a family income less than 100 percent of the FPL;
- Poverty Level Medical Adults and Pregnant Women with a family income between 100 percent and 133 percent of the FPL;
- Poverty Level Medical Children under age 10 with a family income less than 100 percent of the FPL;
- Poverty Level Medical Children under age 6 with a family income between 100 percent and 133 percent of the FPL;
- Oregon Health Plan (OHP) Families—families with household income below 100 percent of the FPL with demographic characteristics similar to those required to qualify for Medicaid under the AFDC program, but with an income above the current income limit for AFDC;
- OHP Adults and Couples—individuals or couples with household income below 100 percent of the FPL, but with demographic characteristics that would not allow them to qualify for Medicaid coverage;
- Aid to the Blind and Disabled with Medicare;
- Aid to the Blind and Disabled without Medicare;
- Old Age Assistance with Medicare;
- Old Assistance without Medicare; and
- Foster Children.

For each of these eligibility categories, a base per capita rate was developed using a three-step process. First, per-capita utilization estimates were calculated for each of approximately 90 general categories of service. For these estimates, historical Medicaid data were used to estimate utilization by those groups who were traditionally eligible for Medicaid, as well as those who are demographically similar to Medicaid eligibles but have higher family income levels. For OHP Adults and Couples, whose characteristics and utilization levels are expected to differ from traditional Medicaid eligibles, BCBSO and Good Health Plan data were used to estimate utilization rates. (Some adjustments were made to the BCBSO data to reflect the higher use of services, particularly outpatient services, by newly insured populations.) Data from ODS Dental Plan were used to estimate dental utilization for all eligibility groups, because the 1992 and 1993 Medicaid claims data for dental care did not include adults.

The second step in the cost estimation process involves the estimation of total allowable *charges* to be applied to the utilization estimates. Medicaid claims data were used as the primary source of data for average allowed charges estimates per unit of service. Finally, these charges were converted to estimates of the expected *cost* of services under managed care, based on assumptions regarding expected cost-to-charge ratios for hospital services under managed care, and the discounts from commercial reimbursement rates that managed care organizations are able to negotiate with participating physicians. (Based on discussions with managed care organizations, the discount was determined to be about 20 percent of standard allowable charges.) For services related to prescription drugs, supplies, and case management, Medicaid payment amounts were used to estimate the costs directly, as Medicaid reimbursement rates were determined to closely approximate provider costs.

These calculations produce a base per-capita rate for each eligibility category. A number of adjustments are then made to this base, as described below:

- The rates were adjusted to account for differences in the severity of illness across eligibility categories. For those service categories in which there was a difference in the average charge per unit of service of more than 10 percent, and for which at least 500 units of service were provided, an adjustment factor was calculated based on the ratios of the average charges per unit across eligibility categories.

- An inflation factor was applied to adjust the 1992-93 rates for fiscal year (FY) 95 and FY 95. These inflation factors, which were calculated separately for six categories of service, including inpatient and outpatient hospital, physician, prescription drug, dental, and mental health, were based on both changes in medical costs (as calculated by HCFA) and expected changes in utilization (based on estimates developed by the Congressional Budget Office). To increase the rates for FY 1995, the inflation factors ranged from 4.1 percent for inpatient hospital services to 9.5 percent for prescription drugs. To increase these rates to apply to FY 1996, additional factors were applied, ranging from 3.6 percent for inpatient hospital to 7.0 percent for prescription drugs. (These inflation factors were applied to non-dual-eligible rate categories only; separate factors were calculated for the dual-eligible rate categories).

- An administrative cost factor was added to the rates. This factor, which is intended to compensate plans both for usual administrative functions as well as for the provision of data to OMAP, was set at 6 percent.

- A set of factors was calculated to account for the savings expected from managed care in each service category. These factors were based on a series of assumptions regarding the savings that could be expected in specific service categories, as listed below:

- A 30 percent reduction in inpatient medical/surgical services and outpatient hospital services for most population groups;

- An increase of 10 percent in utilization and cost of physician services, to substitute for hospital care;

- A decrease in maternity costs of 10 percent as the rate of cesarean sections is reduced; and

- An increase of 5 percent in prescription drug costs, as a substitute for inpatient and outpatient treatments.

- For the newly eligible OHP population, an additional adjustment was made to account for differences between the demographic distribution of this population and the privately insured BCBSO population on which the rates were based. Because many pregnant women and children will be eligible for the OHP under other eligibility categories, men and nonpregnant women will be disproportionately represented in the newly eligible population. Thus, an age/sex adjustment was applied to this group's rate based on the expectation that this population's costs will represent 89 percent of those of an average commercial population.

Once these adjustments had been made, the capitation rates were adjusted to account for the proportion of the total benefit package to be covered for the contract period. As mentioned above, OMAP has received approval to cover all services through line 606 of the prioritized list for the period of 1 October 1995 through 1 December 1995, through line 581 for the period of 1 January 1996 through 31 January 1997, and through line 578 from 1 February 1997 until the end of the waiver period.

To make this adjustment, the actuaries first distributed the costs included in the per capita rates across the diagnosis/treatment pairs included in the prioritized list; claims dollars were assigned using ICD9 codes for diagnoses and matching them with CPT4 procedure codes for treatment expenditures. Actuaries then calculated the percentage of the total cost represented by the services included in the covered benefit package for each eligibility category and each of 25 required services and five optional services. (For the purpose of calculating these total rates, 9 capitation rate categories were created from the 13 listed above. Five categories—AFDC, PLM Adults under 100 percent FPL, PLM Children under 100 percent FPL, OHP Families, and OHP Adults and Couples—were combined into a single capitation rate group, the OHP "Basic.") The resulting percentages were then applied to the total per capita cost for each service type for each eligibility category; the resulting rates are added to produce a capitation rate for each eligibility category.

Several additional adjustments were made to the resulting rates, which are described below.

- An adjustment is made for newly enrolled OHP eligibles (those for whom eligibility is expanded) and enrollees in the General Assistance category due to high fee-for-service expenditures before these groups are enrolled in managed care plans. Many previously uninsured people in the OHP Adults and Couples category are enrolled in OHP upon admission to a hospital or emergency room. Services used by these enrollees are reimbursed on a fee-for-service basis until they are enrolled in a managed care plan. Thus, it was calculated that capitation payments make up an average of only 39 percent of the total annual cost of services for this group. The unadjusted per capita cost developed for these categories included the total expenditures for these enrollees; thus, a factor of .39 was applied to the original rates for this group to remove the cost of those services that are reimbursed on a fee-for-service basis before enrollment in a capitated plan, leaving a pure capitation rate for payment to plans.

- Geographic adjustment factors are applied to the capitation rates to reflect differences in cost in five regions of the state. Separate adjustment factors were calculated for each of four service types: hospital services, professional services, chemical dependency services, and other services, such as prescription drugs. The adjustment factors for hospital and professional services were based on data developed by HCFA: Those for hospital services were based on hospital-specific cost data used in developing payment rates based on diagnosis-related groups, and those for professional services were based on the geographic weighting factors used in the development of the Resource Based Relative Value Scale. Geographic factors for chemical dependency treatment services were based on historic differences in the use of methadone treatment in the five regions. No significant differences were found across regions in the cost of prescription drugs and other services, so no adjustment factor was developed for this service category.

- An adjustment was made to account for the variation in expenditures across plans for maternity services. Because maternity and newborn care are high-cost services, and because there are known differences in the prevalence of maternity cases across health plans, plans are compensated for providing these services through a payment made to each plan every six months, based on the relative number of deliveries provided in the previous six-month period. Funds for these payments are drawn from a "maternity and newborn withhold pool" funded by a contribution of 25 percent of the capitation rate for maternity and newborn services paid to each plan for the OHP Basic and PLM Children between 100 percent and 133 percent of FPL rate cells.

- Finally, an adjustment is made to account for expenditures for family planning services provided outside of managed care plans' networks. Out-of-plan family planning services are reimbursed by OMAP on a fee-for-service basis, and are thus not included in the capitation rate. State officials have calculated that 6.8

percent of family planning services for enrollees in capitated plans are provided outside of plans' networks; thus, the capitation rates are reduced by this amount.

C. Negotiating and Contracting

OMAP presented plans with the capitation rates, as well as the summary level Medicaid claims data and summary level claims data from ODS Dental and BCBSO to support the rates that the actuary had developed. The RFA issued to plans was not competitive; plans were required to meet the RFA's requirements in the areas of provision of health care services, emergency and urgent care medical services, continuity of care, medical record keeping, quality assurance, accessibility, complaint procedures, informational requirements, member education, member rights and responsibilities, financial solvency, exceptional needs care coordination, and chemical dependency.

Each plan was asked to submit only one application for all of the counties they wanted to serve. Oregon contracts with 15 health plans, between one and eight in each county. Many rural counties do not have enough providers to support more than one plan; thus, state officials do not anticipate contracting with more than one plan in several counties. Contracts with plans are renewed on an annual basis.

D. Enrollment

OMAP performs a capacity analysis of potential Medicaid eligibles by county to determine the minimum and maximum number of enrollees that they will allow per plan. The maximum number of OHP enrollees in a plan is determined by the number of primary care physicians (PCPs) in the plan's network and the size of the PCPs' practices. Medicaid eligibles may represent no more than 25 percent of each primary care physician's caseload, unless approved by OMAP.

New OHP enrollees are locked into a plan for six months. Clients who also receive Medicare, however, can change plans every 30 days. OHP eligibles who do not choose a plan are assigned randomly by county and ZIP code and are then given 30 days to change plans.

E. Sharing of Risk

Oregon requires plans to obtain stop-loss insurance on the private market. OMAP officials also describe such provisions as paying for deliveries through the maternity and newborn withhold pool, and fee-for-service reimbursement for hospital costs for uninsured individuals who become eligible for OHP while in the hospital, as mechanisms for sharing risk with plans.

F. Quality Assurance

Plans contracting with OMAP are required to monitor the quality of their care in the categories of utilization of care, adequacy of medical record keeping, operation and outcome of referral procedures, medication reviews, the appointment system, the after-hours-call-in system, out-of-plan utilization, and access to services. Plans are not required to submit information on HEDIS indicators, but they are required to establish internal monitoring procedures, such as written protocols and criteria for conducting review activities, to assess the quality of care service that they are providing. Plans are also required to submit encounter data that are validated by an external review organization. In addition, plans are required to submit fiscal data to OMAP.

III. The Future of the Oregon Health Plan

For the 1997-98 contracts, OMAP will develop separate rates for each of the 13 capitation rate categories, as OMAP and plans have found that the 5 capitation rate groups that were combined were not similar enough to be covered by one rate. The state has also proposed to increase the administrative adjustment paid to plans to 8 percent based on analysis by the actuaries.

In the future, OMAP would like to begin using encounter data submitted by plans to help set and validate rates. OMAP would also like to begin using HEDIS to monitor the quality of their plans. Although OMAP has thought about giving plans the opportunity to submit price bids, OMAP feels that Oregon has more to gain by staying with its current contracting process.

Rhode Island

I. Overview

In 1993, the Rhode Island Department of Human Services (DHS) received an 1115(a) waiver to begin its Medicaid managed care initiative, RIte Care; the waiver will be in force from the first quarter of SFY 1995 until the first quarter of SFY 2000. Since its inception, the program has been mandatory for the state's AFDC and AFDC-related populations, including pregnant women and children under age six in families with incomes under 185 percent of the FPL. DHS categorically excludes SSI eligibles from RIte Care's capitated system.

In addition, as part of the 1115(a) waiver, the RIte Care program allowed for the expansion of Medicaid eligibility to include uninsured pregnant women and children under age six in households with incomes under 250 percent of the FPL. In 1996, the RIte Care program was expanded further to include children ages six and seven in households with incomes below 250 percent of FPL. However, beneficiaries with a family income over 185 percent of the poverty level must participate in their health care costs either (a) by paying a portion of the premium (totaling 3 percent of the capitation rate each month) and a $35 copay for nonemergency use of emergency transportation services, or (b) by paying no premium share and being subject to copayments for outpatient surgical procedures, prescriptions, inpatient hospital admissions, nonemergency use of emergency transportation services, and all outpatient office visits except for prenatal and preventive care.

Rhode Island established its capitation rates for this program based on a competitive procurement process in which price is a factor. DHS and its actuaries developed a range of acceptable capitation rates, consisting of an upper payment limit and a price floor, within which plans were expected to bid. Three of the four licensed commercial HMOs in Rhode Island presented bids within the state's range of acceptable rates. These three HMOs, as well as Neighborhood Health Plan of Rhode Island (another HMO organized by the state's Community Health Centers), are under contract with the state to serve the Medicaid population.

II. Development of Capitation Rates

A. Benefits

The capitation rates developed for RIte Care include all of the federally required benefits, including primary and preventive care, specialty care, inpatient and outpatient hospital care, inpatient and outpatient mental health and substance abuse treatment, and EPSDT services, as well as optional benefits such as prescription drug coverage, enhanced support services for women and children, and a centralized nonemergency transportation service. Managed care plans that contract with RIte Care are also required to provide parenting skills education, smoking cessation and nutrition education classes, childbirth education classes, and general tracking, outreach, and follow-up services. RIte Care also provides extended family planning benefits and enhanced case management services. DHS provides dental benefits for both adults and children on a fee-for-service basis.

There are several additional services that health plans are required to provide, but for which the state continues to pay on a fee-for-service basis, as described below:

- RIte Care does not include obstetrical delivery fees in its base capitation rate. The state provides a case rate for each delivery as a reimbursement.

- DHS pays fee-for-service for 90 percent of the costs incurred by anyone receiving mental health or substance abuse treatment in excess of 30 days. Mental health benefits for children who are seriously emotionally disturbed (SED) and adults who are seriously and persistently mentally ill (SPMI) are provided entirely on a fee-for-service basis.

- The state pays fee-for-service for any early intervention services exceeding $3000 for the year.

- The state pays fee-for-service for organ transplants.

The state also supports various special service programs that are not covered by RIte Care. While plans are not obligated to provide or pay for these noncapitated services, the state expects that plans will promote and coordinate such services in order to promote the health of RIte Care members. Some of these special services include coordinating care with ongoing special education services, making available tools for assessment and identification of SED children and SPMI adults, providing information and referrals to early intervention and youth services, providing lead screening and education, and providing referrals to the Adolescent Pregnancy and Parenting network and the WIC program.

B. Rate Development

1. Development of Rate Ranges

Rates are developed through a process of bidding and negotiating with plans. Plans must first submit technical proposals that include information about their provider networks, patient education plans, enhanced case management plans, quality of service, and any enrollment limits. After plans' technical proposals have been approved, their cost proposals are compared to a range of acceptable rates developed by the state and its outside actuaries. For the contracts in effect from April 1996 through June 1997, the ranges had been shared with the plans. These ranges were based on the ranges developed for the first contract, which was in effect from August 1994 through March 1996; the ranges for this contract had been kept confidential. The initial range development process is described in the following paragraphs.

The 1994-96 ranges were calculated by an outside actuary using a data book produced by the state. The data book, which was provided to both the actuaries and the plans, contained Medicaid claims and eligibility data from SFY92, data from studies on the health status of Rhode Island's population, and reports on the demographic characteristics of the AFDC population from the U.S. Department of Health and Human Services. From this data book and their own internal data sets, the actuaries produced estimates of expenditures both per eligible and in total for SFY92. Per capita expenditures were estimated for eight categories:

- Males/Females under age 1,
- Males/Females age 1-5,
- Males/Females age 6-14,
- Males age 15-44,
- Females age 15-44,
- Males/Females age 45 years and over,
- A supplemental payment to be made following delivery or termination of pregnancy, and
- An Extended Family Planning and Women's Reproductive Health group. (Women who lose their Medicaid eligibility after pregnancy are entitled to 24 months of family planning benefits including one gynecological exam per year and family planning education.)

These rates were then projected forward to 1994-96, accounting for the actual and expected health care inflation rate (8 percent per year for the periods of 1992-93 and 1993-94, and 6

percent per year for the periods of 1994-95 and 1995-96) and the higher medical costs that were to be incurred by eligibles coming into the program as a result of pregnancy (due to RIte Care's expansion to cover pregnant women between 185 percent and 250 percent of FPL). The actuaries made additional adjustments based on their experience with Medicaid managed care programs in states in the northeast, as well as in other parts of the country.

Before the rate ranges were developed from the rates, the dollar amount allocated for reinsurance and transportation was subtracted from the rate in each capitation rate category. The rates were then multiplied by 1.075 to create the state's upper payment limit and 92.50 to create the lower limit of the range, the lowest that state officials felt they could pay and still receive quality services. After these ranges had been developed, the costs of reinsurance and transportation were added back to the upper and lower limits of the range.

In 1996, for the second RFP, the actuary and the plans were presented with an updated data book containing encounter data and financial reports from the health plans participating in RIte Care, enrollment data, updated bid specifications, and fee-for-service data for formerly excluded services that were to be covered by plans in the 1996-97 contracts, including mental health, substance abuse, and early intervention services. Using the rate ranges developed for the 1994-96 contracts as a base, the actuaries incorporated the new data into the 1996-97 rates. Additional adjustments were made for eligibility, benefit, or policy changes that would have an impact on the cost of providing health care:

The actuaries first adjusted the rate ranges to reflect the following benefit changes:

- The annual limit on days of outpatient mental health and substance abuse services was raised from 20 to 30.
- The annual limit on days of inpatient mental health and substance abuse services was raised from 15 to 30.
- Coverage for nursing facility care was extended beyond 30 days, with plans to be reimbursed on a fee-for-service basis (at 90 percent of cost) for services provided beyond 30 days.
- Nonemergency services provided in the emergency room were removed from the capitated benefit package. However, plans continue to be responsible for assessing whether a condition should be treated in the emergency room. Thus, the expected emergency room utilization rate was increased, and the unit cost decreased slightly to allow for this medical screening provision.
- EPSDT behavioral health services, which had not previously been covered, were added to the RIte Care benefit package.

The actuaries then adjusted the rates to reflect the following policy decisions:

- The state withdrew its offer of reinsurance to plans, so the adjustment for the cost of reinsurance was removed from the capitation rate.

- Copayments for nonemergency use of emergency rooms were removed, as plans are no longer responsible for these services. This adjustment was incorporated into the rate in the area of hospital outpatient care.

- At the State's request, the actuary increased the unit cost used for hospital inpatient services and relied more heavily on the plans' reported hospital inpatient expenditures. This adjustment was made after plans presented evidence that they had not been able to contract with hospitals at a unit cost as low as that used by the actuaries in developing the rate ranges for the 1994-96 contracts.

Relational modeling was performed in order to more accurately account for the risk of each population. In particular, the rates paid for newborns, who present a relatively higher risk to plans, were increased, while rate cells with lower risk were decreased. The aggregate change in the rates was zero. Finally, the rates were increased for health care inflation by service category for a total of about 3 percent for the period of 1996-97; the rates will continue to be increased by up to 4 percent each year (the budget neutrality indicator) until the waiver expires in 1999.

2. Bid Requirements

Plans were asked to present bids for the eight rate categories described above. For these eight rate categories, plans were asked to submit utilization estimates, cost estimates, and any adjustments, along with a rationale for their calculations, as described below.

- ***Utilization.*** Plans were asked to submit utilization estimates for the first six rate categories for nine categories of service, including hospital inpatient, diagnostic tests and lab, emergency room, primary care provider, specialty physician, ambulatory surgery, pharmacy, emergency transportation, and nonemergency transportation. Services related to pregnancy were not to be included in any of the above categories. Utilization rates for prenatal, delivery, and postpartum services were estimated separately and placed in the supplemental delivery payment. Health plans also prepared utilization estimates for the Extended Family Planning benefit for specific outpatient services, including physician services, diagnostic tests, and pharmacy costs.

- ***Cost Estimates.*** Plans were asked to submit cost estimates, on a per-unit basis, for each rate group and category of service based on the actual reimbursement method negotiated with providers in their networks. Plans made adjustments to account for the effect of expected inflation within the bid year. All cost estimates were net of copayments.

- ***Rate Calculation.*** Health plans then completed a Capitation Rate Calculation Sheet (CRCS) for each of the eight rate categories. For each rate category, the anticipated monthly utilization rate for each category of service was multiplied by the unit cost for each category of service. The resulting amount was divided by 12 to arrive at a per-member per-month (PMPM) rate. The individual PMPM rates for each category of service were then summed to develop the Gross Capitation Rate.

  For the supplemental pregnancy payment, plans were instructed to calculate separate Gross Capitation Rates for vaginal and cesarean deliveries; a weighted average of these two amounts was then calculated based on the expected distribution of delivery methods within the plan. Finally, an amount equal to five times the PMPM rate for females in the 15-44 category was subtracted from this average. The last step was required by the state to eliminate double payment for services not related to pregnancy.

- ***Adjustments.*** After calculating the gross capitation rates, the health plans were instructed to make adjustments to arrive at the net capitation rates in each rate category, as described below.

  - Plans were expected to subtract 3 percent from each rate category to account for expected third party liability recoveries.

  - Plans were expected to account for the fact that the state intends to withhold 3 percent of the capitation payment to health plans for each enrollee with an income over 185 percent of the FPL. These RIte Care eligibles are required to share in their costs by making copayments or sharing in premiums. Because of limited historical data available for plans to make their own adjustments, the state mandated a uniform 3 percent adjustment.

  - Plans were asked to identify any profit they expect to achieve.

  - Plans were asked to identify any risk and contingency charges.

  - Plans were asked to make adjustments for administrative costs not to exceed 6 percent.

  - Plans were asked to make adjustments to account for the cost of purchasing reinsurance on the private market.

C. Negotiating and Contracting

In the 1994-96 contract period, DHS asked plans to present bids without knowledge of the actuarial rate range. After the plans presented their bids, the state and the plans negotiated rates and mutually decided to limit the mental health services and transplant services covered by the capitation rate. In the 1996-97 contract period, DHS decided to publish the ranges of rates within which the plans were expected to bid, in order to simplify and expedite the negotiation process. Plans were only allowed to submit one statewide capitation proposal for each rate category.

In the 1996-97 contract period, all of the plans' initial bids were higher than the upper limit of the range of rates that DHS had presented. The plans presented evidence for the elevated rates, with the following arguments:

- Because the state has only one hospital with a Level III neonatal intensive care unit, it had been difficult to contract for discounted hospital rates for maternity and newborn services;
- Utilization of neonatal intensive care units had been higher than projected; and
- Plans had not been able to collect enough money under Medicaid's third party liability requirements to make up for the 3 percent discount that RIte Care had included in the rate ranges.

After reviewing the evidence presented by plans, DHS agreed to raise the rate range that had been presented in the RFP by an amount acceptable to both the state and plans. The resulting negotiated rates were approximately 11 percent higher than the previous contract's negotiated rates; this was as high as state officials felt they could go and remain within the budget neutrality standard required by the 1115 waiver. Most of this overall increase was attributable to an increase in the rate for the 0-1 age group because of the first two factors listed above. The rates ultimately agreed upon in negotiation fell at the high end of this revised range; two plans signed contracts at the upper limit of this range and two accepted slightly lower rates. Because only three licensed HMOs and Neighborhood Health Plan of Rhode Island (NHPRI) presented bids, all plans were needed to serve the Medicaid population.

D. Enrollment

Open enrollment occurs once a year on the same date. However, health plans are guaranteed a six-month minimum capitation payment even if an enrollee loses Medicaid eligibility after less than six months. Health plans have enrollment limits determined by the number of primary care physicians (PCPs) in their network; health plans may assign no more than 1,500 RIte Care enrollees to PCPs in individual practices and no more than 1,000 RIte Care enrollees to a single PCP within a team or site. Plans are closed to new enrollees when the enrollment limit is reached.

While 88 percent of Rhode Island's Medicaid recipients elected to choose their health plan in 1994-96 and 96 percent did so in 1996-97, those who did not select a plan were disproportionately assigned to available plans with the lowest rates based on an algorithm devised by the state. If there were only two contracting plans, 60 percent of the assignments would be awarded to the lowest bidder and 40 percent to the second lowest bidder. If there were three contracting plans, 50 percent of assignments would be awarded to the lowest bidder, 30 percent to the second lowest bidder and 20 percent to the third lowest bidder. If there were four plans, the proportions would be 40, 30, 20, and 10 percent, and if there were five plans, the proportions would be 40, 30, 15, 10 and 5 percent.

E. Sharing of Risk

In order to assure that community health centers would be able to provide accessible, high-quality care in a managed care environment, DHS established a risk-and-profit-sharing agreement with Neighborhood Health Plan of Rhode Island (NHPRI). Under the risk-sharing part of the agreement, NHPRI bears full risk for only the first 1 percent of medical expenses greater than 88 percent of the premium when enrollment is less than 25,000 members, the first 2 percent when enrollment is 25,000-30,000 members, and 3 percent when enrollment is over 30,000 members. Beyond these risk corridors, DHS will share risk with NHPRI for the remaining medical expenses on a quarterly basis. For the first three quarters of the 1996-97 contract, DHS will pay 90 percent of excess medical expenses; for the last quarter of the contract, DHS will pay 80 percent; and for the 1997-98 year, DHS will pay 60 percent of medical expenses.

Profit will be shared on an annual basis depending on the net profit achieved by NHPRI. The first 1 percent of net profit will be retained by NHPRI; the distribution of net profit between 1 and 3 percent will be discussed by NHPRI and DHS; and if net profit exceeds 3 percent, the state and NHPRI will split the profit equally. In addition, NHPRI is only expected to recover 1 percent of the premium through third party liability recoveries.

Under the first RIte Care contract, the state offered reinsurance to participating plans. However, state officials feel that the plans now have had experience serving the Medicaid population, and required them to purchase reinsurance on the private market under the second contract. As a result, DHS was able to more accurately project its expenses for the 1996-97 contract year.

F. Quality Assurance

To monitor the utilization of services by its enrollees and assure quality and accessibility of care, plans are required to adhere to the guidelines contained within HCFA's, Health Care Quality Improvement Survey for Medicaid managed care (HCQIS). In addition, DHS requires that plans have Utilization and Review and Quality Assurance committees that meet on a regular schedule and report to the state. Plans' quality improvement provisions must include assurances of confidentiality of medical records/client information, adequate provider

credentialing, and grievance and appeals procedures. Plans must also collect member satisfaction data through an annual survey of a representative sample of RIte Care enrollees. In addition, DHS has hired an outside organization to monitor quality in areas such as grievances and access to care.

Plans are required to collect person-level and aggregate encounter data in accordance with the data elements stipulated in *Encounter Data Business Design.* Plans must submit the data in an electronic or tape format on a quarterly basis. The plans must then assist the state in its validation of the data by making available medical records as well as claims data.

The Insurance Commissioner in the Department of Business Regulations monitors all of the health plans for solvency, while the Health Department oversees the quality of medical care.

III. The Future of RIte Care

DHS presently incorporates encounter data and financial data from plans into the fee-for-service data used to build their rates. As the fee-for-service data becomes outdated, the encounter and expenditure data that are being collected from plans will serve an even more important role in developing the rates. However, to establish rates for the 1997-98 contract year, DHS is considering simply inflating the negotiated 1996-97 rates. Rhode Island plans to continue to publish the ranges of rates within which they expect plans to bid.

DHS would like in the future for more HMOs to participate in RIte Care, especially because several of the current plans have enrollment caps.

Tennessee

I. Overview

In 1994, the Tennessee Department of Health received an 1115(a) waiver to begin its Medicaid managed care initiative, TennCare. Under TennCare, enrollment in managed care is mandatory for all Medicaid eligibles, including AFDC and AFDC-related pregnant women and children, SSI eligibles, and Medically Needy eligibles. In addition to enrolling these Medicaid eligibles in managed care, the TennCare program expanded eligibility to include uninsurable individuals who meet the criteria for Tennessee's Comprehensive Health Insurance Pool (TCHIP), and other individuals in the state who did not have access to health insurance through their place of employment. However, uninsured and uninsurable individuals with a family income over 100 percent of the federal poverty level (FPL) must share in a percentage of their health care costs each month, which consist of premiums, deductibles, and/or copayments based on a sliding scale according to income; these enrollees are also subject to a $25 copayment for nonemergency use of emergency rooms. TennCare health plans are also responsible for children enrolled in the Children's Plan, an insurance program for children who are in state custody, including foster children and children in the juvenile court system.

TennCare contracts with all managed care plans that meet the state's quality standards and are willing to accept the capitation rates offered by the state. TennCare now contracts with 11 plans across the state; however, some serve only select geographic regions. In some regions, an enrollee may be able to choose among as many as four to five plans.

II. Development of Capitation Rates

A. Benefits

The capitation rates developed for TennCare include all of the federally required benefits, including primary and preventive care, specialty care, inpatient and outpatient hospital care, and EPSDT services, as well as such optional benefits as prescription drug coverage, physical therapy, and transportation. Tennessee provides long-term care services, 1915(b) waiver services, Medicare premiums, and cost-sharing for dual eligibles on a fee-for-service basis.

Enhanced benefits, such as case management for children enrolled in the Children's Plan, are also reimbursed on a fee-for-service basis.

TennCare enrollees are limited to 45 outpatient mental health visits per year and two outpatient substance abuse treatment programs in their lifetime, with a maximum fee per program of $3000. (These limits do not apply to the Seriously and Persistently Mentally Ill [SPMI] population.) Since July 1996 these services have been covered by a separate capitation rate paid to Behavioral Health Organizations (BHOs). Enhanced mental health services for the SPMI population must also be provided by the BHOs.

Plans are encouraged to contract with FQHCs and other safety net providers. If FQHCs are not included in a plan's network, the plan must show its ability to provide services for vulnerable populations.

B. Rate Development

The Tennessee Department of Health set its capitation rates for the five-year duration of the TennCare 1115(a) waiver in January 1994. The rates were developed using 1992 Medicaid claims data. The following costs were excluded from this database:

- Expenditures for long-term care, 1915(b) waiver services, and Medicare coinsurance and premium payments were deducted from the claims data because they remain outside the capitation rate.

- Expenditures for enhanced services for Children's Plan eligibles and people with chronic mental illness were subtracted from the claims data, because those services are paid for on a fee-for-service basis.

- Expenditures for disproportionate share hospitals were subtracted from the claims data.

Statewide per-member per-month (PMPM) rates were calculated in six age/sex categories (0-1, 1-13, 14-44 M, 14-44 F, 45-64, 65+); separate rates were developed for Medicaid/Medicare dual eligibles and those in the Blind and Disabled categories. The rates were based on 1992 paid claims, and were inflated by 5.5 percent per year to January 1994 based on historical patterns of growth in Medicaid expenditures.

Reductions to the base rates were then made to reflect the following adjustments.

- The capitation rates were reduced by 22 percent to account for charity care contributions. Because TennCare has expanded to cover previously uninsured enrollees, this adjustment was made to assure that providers did not receive a windfall once TennCare was available to previously uninsured patients.

- The capitation rates are reduced by an average of 3 to 4 percent to account for revenues from copayments and deductibles that health plans may collect from individuals who meet the criteria for patient cost-sharing (those who are uninsured or uninsurable with family incomes greater than 100 percent of FPL). The state subtracts a predetermined portion of the capitation rate before paying the rates to the plans, and the health plan or its providers are expected to collect the difference from the patient. However, some health plans have chosen not to collect copayments at all.

- The Medicaid-funded capitation rates were reduced by 1.8 percent because of the availability of local government funding for care of the uninsured.

The capitation rates as developed above were to be increased as determined necessary and as funding is available. For the period of July 1995 through June 1996, the rates were increased by 9.5 percent. For July 1996 through June 1997, the rates were increased by 5 percent, 1 percent of which was diverted to the adverse selection pool discussed below. The rates for July 1997 through June 1998 will be increased by 3 percent.

C. Negotiating and Contracting

The state signed contracts with all plans that met the state's technical criteria and were willing to accept the rates developed by the Department of Health. In order to meet the state's technical standards, plans had to have the following approved:

- Their provider networks,

- Any additional benefits and services they wished to provide,

- Their grievance procedures,

- Their quality monitoring procedures,

- Their subcontracts, and

- Their insurance bonding plans.

The state of Tennessee has been divided into 12 geographic regions, each consisting of one or more counties; health plans are contracted to enroll eligibles by geographic region. However, The Department of Health contracts with health plans based on statewide average capitation rates.

Beginning in 1994, incentive payments were made to all health plans that turned in a signed contract by 27 September 1995 and could demonstrate that the stipulations within the contract

were being met; this payment increased the capitation payments by 4.5 percent. Since 1994, contracts with plans have simply been renewed each year with an increase for cost inflation.

D. Enrollment

The Department of Health would like to enroll as many eligible persons as possible in TennCare, as funding is available. There is no limit to the number of Medicaid or uninsurable (TCHIP) eligibles that are allowed to enroll in TennCare. However, while Medicaid and TCHIP eligibles may enroll at any time, the uninsured may only enroll at designated open enrollment periods. Enrollment was closed to the uninsured in January 1995; however, enrollment was re-opened to uninsured children under the age of 18 effective April 1, 1997.

Plans are allowed to accept new enrollees in the order in which their applications are approved. Each health plan is required to put together a marketing package to be mailed to enrollees to help them chose a plan; those enrollees who do not choose a plan are randomly assigned to a plan that serves their geographic region. However, plans may not enroll more people than they can serve, given the size of their provider networks.

E. Sharing of Risk

TennCare has established an adverse selection pool to use in compensating plans for the care of high-cost or high-risk enrollees. The amount that plans receive is based on the number of enrollees that meet adverse selection criteria, defined by TennCare as a "health care factor such as age, race, sex, pre-existing medical condition, or episodic medical event which has been demonstrated statistically to increase both the utilization and the cost of services provided to a defined subpopulation of enrollees." Plans are paid a share of the adverse selection pool based on the number of enrollees that meet the risk criteria with an equal payment given for each high-risk enrollee. AIDS, organ transplants, kidney or heart disease, and pregnancy are all considered criteria for the supplemental capitation payment. TennCare has set aside between $40 and $55 million for this program annually, depending on policy decisions within the state. Currently, a study is being conducted to review the adverse selection process to ensure the most beneficial use of the funds designated for this purpose.

Plans are not required to purchase stop-loss insurance on the private market; however, if they choose to do so, they must use their own administrative funds.

F. Quality Assurance

TennCare plans are required to develop Quality Monitoring Programs to measure the quality of their health plans. The guidelines for these programs were derived from HCFA's Health Care Quality Improvement System for Medicaid Coordinated Care (HCQIS). The Quality Monitoring Program addresses quality of clinical care and nonclinical care, including availability, accessibility, coordination, continuity of care, and use of preventive services. In

their programs, each health plan is required to provide the Department of Health with detailed information on provider and recipient activity, including encounter data, types of care provided, levels of care provided, and the outcome of care. Plans must also establish grievance and appeals procedures. In addition, the Department of Health contracts with an external review organization to monitor MCO quality assurance initiatives and to assist the state in the analysis of encounter data using models that allow the identification of areas of concern.

A monthly 10 percent reserve is withheld from all capitation rates to minimize contract deficiencies and encourage quality improvement. If a plan meets quality standards and other TennCare contract requirements, the reserve will be returned the next month. However, if there are any deficiencies within the plan, the money will be withheld each month until the deficiencies have been corrected. If a deficiency is found in any month, the plan must correct it within six months or forfeit the amount withheld for that month.

Health plans are also required to conduct quality of care studies targeting specific clinical conditions and/or specific service delivery issues. In addition, plans are required to use clinical care standards and practice guidelines to objectively evaluate the care delivered for the targeted conditions, and use quality indicators derived from the standards and guidelines to monitor the services delivered.

Patient satisfaction surveys are conducted by TennCare independently of the health plans to obtain information about access to care. The Commerce and Insurance Department, in conjunction with the Controllers office, audits the health plans to assure that they meet the financial solvency requirements.

III. Future of TennCare

Tennessee's 1115(a) research and demonstration waiver will be in effect until 1999. Until then, rates will be inflated each year based on inflation of health care costs and legislative directives. State officials see the main advantage of developing one rate for each age/sex category to be the simplicity of this process. State officials also believe that the fact that a sufficient number of plans have signed contracts with TennCare supports the adequacy of the state's rates.

Texas

I. Overview

Under a 1915(b) waiver, the Texas Department of Health (TDH) is incrementally implementing its Medicaid managed care initiative—the State of Texas Access Reform (STAR) Program—in localized pilot programs across the state. The program expands two pilot projects begun in 1993 in Travis County and the tri-county area of Jefferson, Galveston, and Chambers Counties into a number of County Service Areas, each typically encompassing five to seven contiguous counties. The STAR Program was implemented in the Lubbock, Tarrant, and Bexar County Service Areas in the fall of 1996, and will be expanded into an additional Service Area—the Harris County Service Area—beginning 1 October 1997. As of April 1997, the STAR Program served 35 counties in Texas and approximately 15 percent of the state's eligible Medicaid recipients.

Texas's 1915(b) waiver allows mandatory enrollment of the following six AFDC and AFDC-related populations into the STAR Program:

- ***AFDC Adults.*** Individuals age 21 and over, who are eligible for the AFDC program.
- ***AFDC Children.*** Individuals under age 21, who are eligible for the AFDC program.
- ***Pregnant Women*** (Medicaid Assistance Only). Pregnant women whose family income is below 185 percent of the Federal Poverty Level (FPL).
- ***Newborns*** (Medical Assistance Only). Children under age one born to Medicaid-eligible mothers.
- ***Federal Mandate Children*** (Medical Assistance Only). Children under age 19, born on or after 1 October 1983, whose family income is below 100 percent of FPL.

- ***Expansion Children*** (Medical Assistance Only): Texas includes four distinct populations within this category:

  - Children under age 18, who are ineligible for AFDC because of the applied income of their stepparents or grandparents;

  - Children under age one with a family income below 185 percent of FPL;

  - Children age one through five, whose family income is at or below 133 percent of FPL; and

  - Children under age 19 born before 1 October 1983, whose family income is below the AFDC income limit.

In two of the Service Areas—Lubbock and Bexar—clients may choose to enroll in either an HMO or a PCCM model. All other clients enrolled in the STAR Program are served exclusively through an HMO model. The state is simultaneously implementing the STAR+Program, a managed care initiative that provides acute and long-term care services to the elderly and people with disabilities. The STAR+Program will be introduced in Harris County beginning in October 1997.

Texas uses a competitive RFA process to contract with plans that meet the state's quality standards and are willing to submit a bid at or below the state's maximum capitation amounts. Texas officials reported that, because of the relatively low upper payment limits set by the state, they did not anticipate or significantly favor lower bids by plans.

II. Development of Capitation Rates

A. Benefits

The capitation rates developed for the STAR Program encompass all of the federally required benefits covered under the Medicaid program, including primary and preventive care, specialty care, inpatient and outpatient hospital services, family planning, Part H Early Childhood Intervention (ECI) services except case management, and EPSDT/Texas Health Steps services (known as *THSteps*). TDH also includes optional benefits such as durable medical equipment for children, physical/occupational/speech therapy and support services for pregnant women in the rate. In addition, HMOs are responsible for providing a basic behavioral health benefits package that includes inpatient and outpatient mental health and substance abuse services. The capitation rates do not cover prescription drug coverage, EPSDT dental care, and mental health rehabilitation services.

Under the state's standard Medicaid program, recipients are subject to a 30-day limit on inpatient hospital per spell of illness and a limit of three prescriptions per month; these limits

are waived for individuals enrolled in HMOs under the STAR Program. EPSDT dental care is paid on a fee-for-service basis. Services provided by Federally Qualified Health Centers (FQHCs) are paid by the HMO at the standard rates paid to other primary care providers. Differences between these rates and the FQHC's actual costs are then cost settled by the state.

Plans may set their own limits on the use of particular services in their proposals. HMOs and PCPs also have the prerogative to determine medical necessity and duration of need in serving their STAR Program clients.

B. Rate Development

As described above, Texas uses a competitive RFA process to contract with plans that meet the state's quality standards and are willing to submit a bid at or below the state's upper payment limits. The state develops maximum capitation rates for each county and for each of the six risk groups covered by the STAR Program—AFDC adults, AFDC children, pregnant women, newborns, federal mandate children, and expansion children—as defined above. For the first two years of the program, the state used adjusted Medicaid fee-for-service experience data to determine these maximum amounts.

Using fee-for-service data for the period of September 1992 through May 1996, state actuaries calculated base per-member, per-month (PMPM) expenditures for each risk group and county. The following adjustments were then made to the base rates:

- ***Trend Factors.*** The base PMPM rates were trended forward to the first year of the contract in each County Service Area. For the Service Area contracts that began in 1996, TDH trended historical rates from data collected between 1992 and mid-1995. A baseline trend of 2 percent was used, then adjusted to reflect the observed area trend. TDH officials report that the trend rate, which combines both price and utilization factors, typically remains about 3.5 percent per year.

- ***Completion Factors.*** To account for incurred but unreported and/or unpaid claims, a claims completion factor was applied to the data.

- ***Retroactive Eligibility.*** This amount was then discounted to reflect the estimated impact of retroactive eligibility, i.e., new enrollees who remain in traditional Medicaid for a period of several weeks before STAR enrollment becomes effective. Managed care plans are not responsible for retroactive claims; therefore, a discount is taken from the total PMPM rate to reflect the exclusion of these expenses. The discount varies between 10 and 20 percent and is determined by actuarial analysis of information from the pilot counties.

- ***Managed Care Discount.*** The PMPM rates are also discounted to reflect the anticipated savings due to managed care for each risk group and county. Again,

this discount is based on actuarial data from the pilot projects. The specific discount is not shared by the state.

Discounted factors were applied to all services except family planning, genetics, EPSDT medical screens, and services provided by FQHCs. TDH officials estimate that the total reduction from FFS rates varies between 15 and 30 percent, depending on county and risk group. No further risk adjustments (such as for the age, sex, or health status of enrollees) are done.

The state's upper payment limits are shared with the plans. In addition, HMOs are provided with detailed information outlining how the state's payment limits were set, including information on member months by county and risk group, incurred cost by type of service, and forecasts of future trends. This data is available from the TDH on computer disk or may be accessed on the Internet. The TDH does not share trend factors, completion factors, or discount factors with plans. There is no limit (or minimum) to the number of plans the state may contract with; the number of contracted plans is based on need and final scores of applicants responses, as described in the following section.

Within each Service Area, HMOs submit separate rates for each county and risk group to be served by the STAR Program within a defined Service Area. They are not required to present specific information (other than overall proof of financial solvency) to support their proposed rates. TDH only considers proposals that fall at or below the state's upper payment limit.

C. Negotiation and Contracting

HMOs that submit applications are judged on their ability to meet to meet 24 broad criteria, including financial solvency, adequate and appropriate staff, access to care, quality monitoring and improvement, data systems and collection, culturally and linguistically appropriate services, and linkages with other health care providers, including significant traditional providers. In meeting these criteria, applications are evaluated according to the point scale listed below in Table 2. The TDH determined the relevance of each section and weighed it accordingly. Within each category, points are further broken down according to a series of specific guidelines. Each of the 24 categories is specifically described in the RFA.

Texas's RFA clearly states that these values are intended only as a guide for evaluation and not as a strict scoring system; that is, each category is important regardless of its weighted value. For example, a plan that does not present an adequate quality improvement system could be disqualified on that basis alone, regardless of the plan's overall score.

Applications are given special consideration for including "value-added services" to their proposed scope of work, including the provision of a continuum of care for Medicaid clients at least 12 months after the clients lose Medicaid eligibility, medical education, coordination with

Table 2. Point Scale for Evaluation		
RFA Section	**Weight**	**Percentage of Total**
Proposed Capitation Amounts	50	8.3%
Organization	10	1.6%
Administration/Staffing	25	4.2%
Financial Information	50	8.3%
Management Information System	50	8.3%
Quality Improvement System	80	13.3%
Provider Network/Significant Traditional Providers/Geographic Access/Value-Added Services	100	16.7%
Scope of Services/Medical Standards/Health Education	60	10%
Marketing/Enrollment	30	5%
Membership Services/Complaints	25	4.2%
Cultural/Linguistic Requirements	20	3.3%
Behavioral Health	100	16.7%
TOTAL	**600**	**99.9%**

such other traditional providers as local/regional public health clinics, and provision of essential public health services. In addition, special considerations of merit on the part of the plan may be a factor in the state's evaluation process.

Most HMOs that successfully bid on the RFA propose (and are paid) a rate that is equal to or slightly below the maximum capitation amount. Once an HMO's bid is accepted, the capitation rate is not negotiated with the plan.

D. Enrollment

As noted above, in the Lubbock and Bexar County Service Areas, clients may choose to enroll in either an HMO or a PCCM model. All STAR Program clients in other Service Areas are served exclusively through an HMO model. Within the two Service Areas that offer the PCCM option, approximately 50 percent of clients select the PCCM model.

Clients are encouraged to select an HMO and primary care provider (PCP) and are offered a number of enrollment mechanisms, including calling a toll-free telephone number, mailing in

an enrollment form, or completing an enrollment form at an enrollment fair. STAR clients are given at least 30 days to select and enroll in an HMO. Clients who do not select an HMO are assigned to plans through a three-tiered default process, summarized below. The goal of the default process is to match the percentage of clients defaulted to each plan with the percentage of all STAR eligibles that voluntarily enroll in each plan.

- First, those clients who have been enrolled in the STAR Program in the past are enrolled with the PCP with whom they have been enrolled most recently. If this PCP is contracted with an HMO, the client will be enrolled in that HMO. If the PCP is under contract with more than one HMO, the client will be enrolled in the plan with the greatest shortfall between the percentage of elective enrollment and the percentage of default enrollment.

- Those clients who do not have any experience with a provider involved in the STAR Program are assigned based on Medicaid claims history, attempting to assign clients to PCPs with whom they have had three or more encounters in the past six months. If this PCP is contracted with an HMO, the client will be enrolled in the HMO, as described below. Within a family, the state will attempt to assign clients without a history with a PCP to the PCP of the oldest family member.

- Remaining clients are assigned to the HMOs closest to their home, then assigned a PCP within the HMO. Specifically, clients are assigned to the HMOs that have the largest shortfall between the elective enrollment percentage in the client's service delivery area and the actual default percentage in that area. The client is then assigned to a PCP within the HMO's PCP network, who is located within the client's ZIP code and has the greatest unfilled capacity with the HMO network. To the greatest extent possible, all family members enrolled in the STAR Program are assigned to the same HMO and the same PCP.

These is no lock-in period for enrollees, although clients are guaranteed enrollment in Medicaid managed care for at least 30 days.

E. Sharing of Risk

During the first two years of each Service Area contract, the Texas Department of Health and each HMO share equally in the plan's profit from the STAR Program before taxes. TDH does not share any losses with the plan, and does not provide stop-loss mechanisms or reinsurance. This policy was developed to prevent excessive profit incentives to plans.

F. Quality Assurance

As detailed in the RFA, the state will provide financial incentives to HMOs that meet or exceed 13 specific preventive health performance objectives related to *THSteps* screens,

immunizations, adult annual exams, pregnancy visits, and health education. Specifically, the TDH will retain a capitation amount of $2 per member month for minimum performance objectives, to be paid to the plan after the end of each contract year and after appropriate encounter data is reviewed and confirmed by TDH. The objectives include the following

- 90 percent of children under 12 months and 90 percent of children age 12 to 24 months will receive at least one comprehensive EPSDT screen;
- 70 percent of children age 25 months through 20 years will receive at least one comprehensive EPSDT screen;
- The average number of screens for children under 12 months will be 3.8;
- 90 percent of children age 12 months, and 90 percent of children age 24 months, will be fully immunized as appropriate for age;
- 16 percent of adults, age 21 and older, will receive an adult annual health examination;
- 60 percent of women pregnant at the time of STAR enrollment will receive an initial prenatal exam within two weeks of initial plan enrollment;
- 60 percent of pregnant women will receive a minimum of ten prenatal visits, scheduled as appropriate for gestation age; and
- 50 percent of pregnant women will complete a perinatal education program.

Within the quality improvement program (QIP), TDH requires that plans demonstrate their knowledge of and response to the unique health care needs of STAR populations. Quality requirements for HMOs are derived from HCFA's *A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States* (July 1993) and *Medicaid HEDIS: An Adaptation of the HMO Employer Data and Information Set 2.0/2.5* (December 1995).

HMOs are mandated to conduct focused quality of care studies in several health areas. Specifically, plans are required to report semi-annually on the detailed information in these areas (report includes an analysis of the data): the HCFA-recommended clinical indicators for pregnancy; THSteps, including childhood immunizations; asthma or other chronic conditions defined by TDH; and behavioral health care. Other HEDIS areas of concern—preventive services for women and acute and chronic care—may be mandatory study topics in the future. On a quarterly basis, HMOs must also submit utilization management data that conform to data elements developed by TDH and based on HEDIS 3.0.

Additional quality requirements include the following:

- The development and use of clinical care standards/practice guidelines focusing on the process and outcomes of health care delivery and access to care;
- An annual QIP report that addresses QI studies, trending of clinical and service indicators and other performance data, and areas of improvement and deficiency;
- The development of standards for access (e.g., to routine, urgent and emergency care; telephone appointments; and member service lines) with which to compare plan performance;
- A written utilization management program description; and
- The demonstration of systems in place to ensure coordinated patient care.

III. The Future of the STAR Program

As directed by the Texas Legislature, TDH is in the process of implementing a managed care model that integrates preventive, primary, acute care, and long-term care into a single program. The STAR Program currently provides acute care services to designated Medicaid-eligible clients. Beginning in Harris County, the pilot STAR+Program will provide acute care services and long-term care services to SSI- and Medicaid-only clients on a mandatory basis; the STAR Program will continue to provide acute care services to eligible AFDC and AFDC-related populations. The STAR and STAR+Programs will begin in Harris County in October 1997. The STAR Program will expand in March 1998 to include Brazoria, Fort Bend, Montgomery, and Waller Counties.

In September 1996, the State submitted an 1115(a) waiver application to HCFA for review. This waiver would allow the state to implement capitated managed care for Medicaid enrollees statewide, and would use local indigent care funds to expand eligibility for the program to children ages 6 through 18 with family incomes below 133 percent of the FPL, who are not already eligible for Medicaid. These children would be served through managed care networks developed by the local hospital districts. Under the waiver program, capitation rates would be developed using the same method used under the STAR program; for the expansion population, rates paid to the hospital districts would be set based on fee-for-service equivalents for children in the population's age group.

Washington

I. Overview

In October 1993, the Washington Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA) received a 1915(b) waiver to begin its Medicaid managed care initiative, Healthy Options. This program is mandatory for AFDC and AFDC-related eligibles, as well as for pregnant women with family incomes below 185 percent of Federal Poverty Level (FPL) and children with family incomes below 200 percent of FPL. SSI eligibles are not included in the Healthy Options program.

Washington State contracts with managed care plans on a capitated basis using a bidding process in which price, quality, and access are factors. Plans submit technical proposals, which are scored based on quantifiable quality criteria, and cost proposals, which are compared to upper payment limits set by MAA. MAA contracts with at least three plans in each of the state's eight regions.

II. Development of Capitation Rates

A. Benefits

The capitation rates developed for Healthy Options encompass all of the federally required Medicaid benefits, including primary and preventive care, inpatient and outpatient hospital care, and EPSDT services, as well as optional benefits such as prescription drug coverage and physical therapy. Emergency transportation services are included in the capitation rate, while nonemergency transportation services are reimbursed on a fee-for-service basis. Translation requirements are also included in the rate and are stipulated by county, depending on the languages most common in each county. Adult dental benefits are excluded from the benefit package entirely.

Mental health and substance abuse treatment services are covered by a separate capitated program housed in the Division of Mental Health Abuse, which operates under a 1915(b) waiver and a fee-for-service program in the Division of Alcohol and Substance. Healthy Options plans refer their clients to these programs for these services. Medicaid has historically

provided a small amount of funding for mental health services, which is included in the capitation rate. These funds are estimated to cover one visit per client per month.

B. Rate Development

MAA used fee-for-service expenditure and utilization data to set upper payment limits for its capitation rates in 1996. In 1997, the upper payment limits were developed based on the actual capitation payments to health plans in 1996 and were adjusted to account for changes in the capitated benefit package.

MAA developed upper payment limits for plans' capitation rates for contract year (CY) 1996 based on state fiscal year (SFY) 1993 fee-for-service expenditure and utilization data (in Spokane County, 1992 baseline data were used, as this was the last full year for which fee-for-service data were available). Rates were developed separately for each county in each of four eligibility categories.

- AFDC-R (AFDC eligibles), and GA-S (pregnant women receiving general assistance);
- AFDC-E (children and their parents when both parents are in the home and employable but working less than 100 hours a month);
- S-Women (pregnant women with family incomes below 185 percent of FPL); and
- H-Kids (Infants up to one year of age whose mothers received medical benefits at the time of their birth, and children under age 19 with family incomes under 200 percent of FPL).

Three deductions were made directly from the 1993 fee-for-service baseline expenditure database, as described below:

- The dollar amount equal to 18.44 percent of 1993 total drug expenditures was deducted from the expenditure data. This amount represents an estimate of the anticipated savings from discounted drug prices that MAA had received under the Federal Drug Rebate Program. The discount was taken from gross pharmacy expenditures to assure that the state would pay the same net amount for pharmacy services under managed care.
- A legislative directive required MAA to achieve a 5 percent decrease in prescription drug expenditures by the end of 1997, beginning in May 1996. Prorating this deduction for 1996, a deduction of 2.5 percent was taken from the 1993 base outpatient prescription drug expenditures.
- Graduate Medical Education expenses paid to the University of Washington and

Harborview Medical Center for their medical training programs were subtracted from the 1993 fee-for-service base data, as funds are paid directly to the medical centers rather than through the managed care plans.

Preliminary per-member, per-month (PMPM) rates were then calculated for each county and eligibility category. In doing this, all expenditures made on behalf of infants born to S-Women were identified and transferred to the rates for H-Kids. Under the fee-for-service system, infant services were often charged to the mother's Medicaid number; this adjustment assures that the cost of these services is included in the infants' capitation rate. In addition, the 1993 PMPM rates for each county were adjusted to reduce the amount of variation between counties in the same region. This helped to assure that plans would not choose which counties to serve based on the rates paid for eligibles in those counties.

The SFY 93 PMPM rates were then trended forward to CY 96 by an overall inflation factor of 26.8 percent. This factor accounted for both increases in utilization and increases in reimbursement rates over the three-year period. Estimates of utilization increases were based on the trends that were developed by DSHS to build the 1995-97 MAA budget. Reimbursement rate increases reflected the actual increases resulting from state-legislated budget appropriations.

A series of adjustments were then made to the newly developed CY 96 capitation upper payment limits (UPLs):

- All abortion expenses were removed. Abortion services are financed using state-only funds; these services will continue to be reimbursed on a fee-for-service basis.

- State officials have found that many Medicaid eligibles, upon initially enrolling in the program, postpone seeking needed services, as they know they will soon be enrolled in a managed care plan. Thus, expenditures in the first month of enrollment in a plan may be higher than those for the succeeding months. To account for this pent-up demand, PMPM rates were increased 15.97 percent or $ 4.38 PMPM.

- Rates were reduced in the AFDC-R/GA-S eligibility category by .476 percent, in the AFDC-E category by .424 percent, and in the H-Kids category by .941 percent to account for the cost of care for clients who are exempted from the Healthy Options program for medical reasons. These adjustments were determined by calculating the percent change in the average PMPM expenditure that results from the exclusion of those with ongoing medical conditions

- Similarly, the rates were reduced to account for the costs eliminated for pregnant women who are exempt from the Healthy Options program. Pregnant women may

be exempted from the Healthy Options program to maintain continuity of care if they have begun receiving prenatal care from a provider, such as a nurse midwife, who is not in a managed care plan network.

- The rates were increased by 2.7 percent to compensate plans for administrative expenses.

- The rates were reduced by 2.5 percent in order for the Healthy Options program to achieve savings through the use of managed care.

- A 2 percent premium tax was added to the upper payment limits.

MAA developed the 1997 upper payment limits based on actual expenditures for 1996, including several additional adjustments. To simplify the billing and payment process, MAA calculated a single upper payment limit for each of the state's eight rate regions, instead of establishing separate upper payment limits for each county and each eligibility category. The upper payment limit for each rate region was developed using a weighted average of the rates paid for the counties in that rate region. Nine age/sex factors (0-1 M&F, 1-5 M&F, 6-18 M, 6-18 F, 19-34 M, 19-34 F, 35-64 M, 35-64 F, and 65+ M&F) were then calculated by comparing the average expenditure for each age/sex group to that of Healthy Options enrollees statewide. Rates are paid to plans for each enrollee by multiplying the regional rate by the age/sex factor for that individual and the bid factor particular to each plan.

The development of the 1997 upper payment limits included a number of changes to the 1996 rates paid to plans. These include the following:

- Federally Qualified Health Centers (FQHCs) are paid by the managed care plans with which they contract, with an enhanced payment made to these providers, outside the capitation rate. These payments were deducted from the 1997 UPLs. The FQHC rate enhancement is paid by the state as a supplement to the capitation rate on a clinic-specific basis to ensure that FQHCs are paid at 100 percent reasonable cost for the services they provide under the Healthy Options program. The amount of the enhancement is based on the capitation rate paid to plans to cover the set of services provided by the FQHC. The capitated amount is then adjusted by the difference between the fee-for-service payment and the clinic's costs.

- The upper payment limits were adjusted to include expanded service coverage for organ transplants and treatment for eating disorders in the Healthy Options benefit package.

- The upper payment limits were increased to account for the cost of payments to the Basic Health Plan (BHP) for the care of women who become pregnant when enrolled in the BHP. (BHP is a state-funded insurance program for low-income

individuals not eligible for Medicaid.) Healthy Options allows these women to remain enrolled in BHP health plans in order to maintain continuity of care, but Healthy Options is responsible for paying BHP plans for services included in the Healthy Options benefit package, which are provided to these enrollees until two months postpartum. BHP plans that also contract with Healthy Options receive the same capitation rate they would for their Healthy Options enrollees; for BHP plans that do not contract with Healthy Options, the state pays an average of the three lowest rates paid to plans in the region and applies that amount to the UPL.

- The upper payment limits paid for S-Women were increased by 22 percent in May 1996. This adjustment was made because it was discovered that the average length of enrollment for pregnant women in Healthy Options was only six months, not the seven months previously anticipated. Therefore, the rate paid for pregnant women was spread across a shorter timeframe, raising the monthly rate, although the total amount budgeted per individual remained the same.

- In May 1996, plan enrollment was used to project the capitation payments that would have been made to the plans if no change were made to the existing payment methodology; these projected payments were then compared to actual enrollment trends. It was discovered that the number of S-Women enrolled in the Healthy Options program had been increasing, due to stricter exemption policies for this group. Since each of these women can be expected to give birth to an infant who will be a member of the H-Kids <1 age category, the expected enrollment in this category was adjusted correspondingly.

- The analysis of enrollment patterns also revealed that pregnant women often changed plans near the end of their pregnancy. Thus, to adequately compensate plans for delivery services, the payment methodology for these services was changed to a case rate beginning in 1997. The expenditure for deliveries was estimated by applying the historical birth rate in each eligibility category and age group to the adjusted 1996 enrollment estimate. The resulting estimate was then multiplied by the rate to be paid per delivery. The upper payment limits were in turn reduced by $13.23 PMPM to exclude these costs.

The resulting 1997 upper payment limits were not further adjusted for inflation, as the Washington State legislature had required that the Healthy Options Program show savings of $19.3 million dollars, or 3 percent of 1996 expenditures. Plans were informed of this savings target when they were presented with the UPLs and asked to submit cost proposals.

C. Evaluation of Proposals

MAA presented plans with regional upper payment limits and supporting documents, and asked them to respond with both cost and technical proposals. A series of selection criteria were developed with a specified number of points associated with each. The overall

distribution of points allocated 60 percent (60 points) to the cost proposal and 40 percent (40 points) to the technical proposal. The process used to evaluate the two proposals is described below.

1. Cost Proposal

To assist plans in developing their cost proposals, MAA provided plans with the upper payment limits (UPLs) for each region, along with such supporting documentation as the 1996 upper payment limits and descriptions of the adjustments made to them. In addition, plans were advised that MAA had been directed to achieve a real reduction of $19.3 million from 1996 expenditures, or an average of 3 percent statewide. Plans submitted separate proposals for each region in which they bid.

While the rates were set on a regional basis, plans did not have to bid to serve all counties in a region; as long as a plan agreed to cover more than 15 percent of the population in a given region, the plan still received the regional rate for all of the counties it proposed to serve. Though the counties had been grouped into regions for the simplicity of developing only eight rates, most plans continued to bid only in counties where they had operated in previous years.

Plans' cost proposals were scored based on a maximum score of 60 points. Each plan's score was developed using the following formula:

60 - [(bid percent - 90 percent) x 300] = points to subtract from maximum score

This calculation is described in detail below.

- First, the plan's proposed rate for the region is divided by the state-defined upper payment limit for the region to produce the plan's "bid percent."
- The lowest acceptable bid percent, 90 percent, is subtracted from the plan's bid percent; this was the lowest rate for which the state thought plans could provide high quality care.
- The difference, expressed in percentage terms, is multiplied by 300.
- The product represents the number of points that are to be subtracted from the maximum score of 60.

Under this formula, a plan bidding 90 percent of the UPL (the amount the state and its actuaries determined to be the minimum that a plan would need to deliver high-quality, comprehensive services) would receive the maximum score of 60 points; a plan bidding the full UPL would receive the minimum score of 30 points. The formula was developed by the actuary per the state's request that a plan receiving the minimum quality score and bidding the lowest price would score higher than a plan receiving the highest quality score and bidding the highest price. This calculation was done for each rate region.

2. Technical Proposal

The RFP set out minimum qualifications in the form of pass/fail questions that plans had to pass in order to be considered for Healthy Options. In addition to enforcing these minimum qualifications, MAA adopted a point system for the 1997 contracts to use in evaluating the proposals. The point system was developed as an incentive for plans to be of high quality and as an attempt to make standards as objective and quantifiable as possible.

The 40 available points for access and quality addressed four fundamental issues:

- Geographic access to health services;
- Managed care delivery systems, including access to appropriate emergency services; access to medical advice from a licensed health professional on a 24 hour basis; and access to services provided by essential community providers such as rural health clinics, FQHCs, local public health departments, and family planning providers;
- Continuing and strengthening ongoing government initiatives, including the ability to retain improvements in infant mortality and low birthweight rates under managed care and the ability to ensure that women have access to a full range of family planning services; and
- Commitment to exceed minimum requirements related to internal quality improvement systems, production of accurate and timely encounter data, and access to interpreters.

Additional points were awarded to plans willing to participate in Healthy Options for SSI eligibles.

The minimum acceptable score on the quality and access measures was 17 of the total 40 points. No plan with a score of fewer than 17 points was accepted, unless the plan was needed for clients in a particular county to have a choice of plans. Plans needed for this reason were required to develop an approved plan to improve their quality and access ratings; no plans were required to do this in the 1997 contracting process.

3. Overall Evaluation and Contracting

Each plan's score on the cost proposal was added to its score on the technical proposal to obtain the plan's total score for the region. After the proposals had been evaluated and scored, a regional evaluation was conducted to determine the number of plans needed to provide sufficient access to services in all areas of each region. In 1997, this assessment led MAA to contract with three to ten plans in each region. Although bidders were permitted to submit proposals for more than one of the eight regions, a successful bid in one region did not guarantee that the plan would be awarded a contract in another region.

Although MAA would have liked to award contracts only to plans that bid lower than 100 percent of the UPL, in some cases they did not have that option. During their 1996 reenrollment experience, MAA discovered that they did not have the administrative capacity to effect a large enrollment turnover in a timely manner. In addition, MAA wanted to limit the level of disruption to clients. Therefore, in 1997, MAA required that no more than one-third of Healthy Options eligibles in any county could be forced to change plans in a given year because their plan had lost its contract. In their evaluation process, state officials were required to include an assessment of the number of individuals who would be forced to change plans if MAA awarded contracts based strictly on the formula. Because some plans had enrolled more than one-third of eligibles in a county in 1996, these plans were guaranteed a contract even if they bid the upper payment limit; nonetheless, some still presented lower bids.

Ultimately, the rates paid to plans fell between 90 and 100 percent of the UPL, with a cluster in the 95-97 percent range, evidence of the 3 percent savings attempt. If MAA had determined that the bids received would not enable the agency to achieve the desired amount of savings, they could have requested Best and Final Offer bids from plans. State officials surmised that some plans had bid 100 percent of the UPL on the assumption that they would have an opportunity to revise their initial bids. However, MAA did not use its option to request Best and Final Offers in 1997. Therefore, some of these plans were not awarded contracts for the 1997 contract year.

MAA had the discretion to ask high-scoring bidders to expand to rural areas. Bidders in this case would have been allowed to modify their proposals to accommodate the expansion. MAA could have then rejected this modified proposal and have moved on to the next highest ranking bidder if they had wished. If none of the plans were willing to expand, MAA might have been forced to contract with a bidder who did not meet all of the requirements. In 1997, MAA did not exercise this option.

D. Enrollment

Healthy Options enrollees who do not voluntarily choose a plan are assigned to plans based on the plans' total point scores. The contracted plans are ranked in descending order based on their total scores; each enrollee who does not choose a plan is assigned to the highest ranking plan that has an available provider. In 1997, the majority of assignments went to plans who bid the lowest rates, most often 90 percent. Because it has been shown in Washington State that the assigned population (about 10 percent of Healthy Options enrollees) use fewer services than those who choose a plan, plans have an incentive to offer competitive rates in the hope of winning the enrollment of these clients.

Enrollees are currently allowed to change plans every 30 days. However, MAA is pursuing federal approval of a waiver that would limit the ability of clients to switch plans except during the first 30 days of enrollment and during an annual open enrollment period.

E. Sharing of Risk

MAA does not require plans to have stop-loss insurance but does permit them to purchase it. Most plans participating in the Healthy Options program either self-insure or purchase reinsurance on the private market, because they feel this benefit gives them an advantage in negotiating with providers.

F. Quality Assurance

Plans are encouraged to maintain quality improvement programs consistent with HCFA's Health Care Quality Improvement System for Medicaid Managed Care (HQUIS), and NCQA's 1995 Standards for Accreditation of Managed Care Organizations. More specifically, plans are required to maintain quality improvement efforts in the areas of program structure, coordination with other management activities, and access to care and services. Plans are required to collect utilization data, provider-specific encounter data, and annual maternity and pediatric provider data. In addition, each month, plans must provide the Office of Managed Care with a list of members who died during the month, including the cause of death.

Plans are expected to measure the effects of their quality improvement initiatives and use the results to improve their clinical care services. MAA keeps records of plans' quality improvement activities and is required to evaluate plans' quality improvement efforts on a frequent basis.

III. The Future of Healthy Options

The state of Washington came very close to achieving its 3 percent savings goal for 1997. However, the state has not received federal approval of its waiver application to require that Healthy Options enrollees remain in their chosen plan for a full year. To compensate plans for the additional risk involved in potentially brief periods of enrollment, the capitation rate paid to plans was increased by 1 percent. Washington will continue to pursue federal approval of this waiver.

MAA will continue to make adjustments to the 1996 rates paid to plans when developing its 1998 upper payment limits. If the state could change their contracting process in the future, it may choose to develop minimum quality standards and have plans compete solely on price. However, the state legislature in Washington has become closely involved in the competitive procurement process, and may choose to continue to set savings targets and mandate competitive procurement based on quality as well as price.

MAA is currently working to coordinate the Healthy Options program with the Basic Health Plan. MAA has also begun to enroll all SSI clients, except dual-eligibles, in the Healthy Options program and intends to complete this enrollment by 1998.

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