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Enabling Services: A Profile of Medicaid Managed Care Organizations

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for

The Kaiser Commission on Medicaid and the Uninsured

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THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of the Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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This paper was prepared for the Kaiser Commission on Medicaid and the Uninsured. The views represented in this report are those of the authors and do not necessarily represent the views of the Kaiser Commission on Medicaid and the Uninsured.

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EXECUTIVE SUMMARY

A range of studies have concluded that greater attention should be given to redressing nonfinancial (cultural, socioeconomic, attitudinal) barriers and providing enabling, or nonmedical support services to the Medicaid population (Lipson et al., 1995; Rymer, et al., 1995). The presence of Medicaid managed care has grown substantially over the past few years, with enrollment rising nearly sevenfold from 1991 to 1999 (2.7 million to 17.8 million). According to the Health Care Financing Administration, 55.6 percent of Medicaid beneficiaries were enrolled in managed care as of June 1999. As managed care participation in Medicaid continues to escalate, enrollment of low-income, minority, ethnically diverse, and medically high-risk populations will rise commensurately. There is considerable concern about the ability of Medicaid enrollees to navigate Medicaid managed care systems which may be more bureaucratic or may contract with more limited provider networks than were available under fee-for-service Medicaid programs. Vulnerable populations, such as chronically ill or non-English speaking populations, may be especially reluctant to switch providers or usual sources of care, which may be required under new managed care initiatives. In addition, concerns have been voiced about potential negative financial incentives inherent in capitation—a feature of most Medicaid managed care initiatives—to underserve enrollees.

In this environment, enabling services—defined as non-medical services that facilitate access to timely and appropriate medical care, such as transportation, interpretation, translation, targeted case-management, community outreach, or educational programs—could broaden access to care among Medicaid beneficiaries enrolled in managed care. In order to help document the extent to which different Medicaid managed care organizations provide these important services, this report presents results of a survey of enabling services provided by risk-based Medicaid managed care organizations (MCOs) in operation during the Spring of 1998. This represents approximately 55 percent of all Medicaid MCOs (n=197).

This study was designed to obtain baseline statistics on:

- the extent to which Medicaid managed care organizations (MCOs) were providing such enabling services as transportation, language, education, and case management services;
- the scope and type of these Medicaid MCO enabling services; and
- related MCO and service characteristics.

In 1998, a fairly sizeable proportion of the Medicaid MCOs report providing one or more forms of enabling services. Almost every MCO in the study provided either some interpretation or translation services or enrollees had access to such services through their state Medicaid department, 97 percent of MCOs provided at least some targeted case management services and 87 percent provided common educational programs. Over half of Medicaid MCOs provided all four enabling services examined in this study. There is, however, considerable variation in the mix and scope of enabling services across MCOs, and more important, considerable variation in the manner in which MCOs organize and provide enabling services.

More specifically:

Transportation Services. Sixty-three percent of MCOs offered non-emergency transportation assistance, and another 20 percent relied on the state to provide transportation assistance to Medicaid enrollees. The most common method offered was providing reimbursement for public transportation (44 percent). Many Medicaid MCOs also provided cab fare (41 percent). Twenty-one percent used their own vehicles to transport enrollees, and 7 percent used volunteers. Forty-four percent of plans offered more than one form of transportation assistance.

Language Services. Almost all of the MCOs supported various interpretation and/or translation services. Most (70 percent) provided access to bilingual MCO network doctors. Eighty-two percent of MCOs reported using an AT&T or other telephone interpretation service, and very few relied exclusively on this form of third-party communication assistance (3 percent). The vast majority of MCOs (70 percent) offered bilingual primary care providers within their Medicaid networks. Over half of the MCOs reported having bilingual medical staff and/or bilingual non-medical staff. Forty-two percent of MCOs retained professional interpreters, although less than half reported that their professional interpreters were specially trained in medical terminology.

A substantial percentage translated marketing materials such as plan handbooks or enrollment information, with a smaller percentage translating patient care materials such as informed consent forms or information about prescribed medicines. Nearly three-quarters (73 percent) of Medicaid MCOs assessed the language ability of their enrollees. Most plans used their own staff to assess the language ability of new enrollees (35 percent); about 17 percent relied on state Medicaid staff and another 18 percent relied on enrollment brokers to make these linguistic assessments.

Health Education and Outreach Activities. Eighty-seven percent of Medicaid MCOs provided at least one health education class, with smoking cessation, perinatal education, asthma management, diabetes management, and nutrition classes being the most commonly offered. Nineteen percent of MCOs offered classes on ten or more topics. Information, referrals, and reminders were the dominant forms of health promotion educational activities. About 87 percent of Medicaid MCOs provided fact sheets or brochures. More than three-quarters offered referrals to community-based agencies for health education classes, seminars, and support groups, and provided reminders for screenings and preventive services (e.g., immunizations).

Targeted Case Management. Ninety-six percent of the Medicaid MCOs had at least one of the targeted case management programs listed in our survey. Seventy-eight percent used pregnancy as a target condition, 73 percent targeted HIV/AIDS patients, and 72 percent targeted asthma. Behavioral problems also ranked moderately high as targeted conditions; 47 percent of the MCOs case managed care of those with substance additions. Forty-three percent targeted the mentally ill and 42 percent targeted the developmentally disabled.

Associations With Safety Net Providers. Seventy-four percent of Medicaid MCOs had established contracts, agreements, or letters of understanding with local health departments, and 78 percent had such agreements with home health agencies or visiting nurse agencies (VNAs). Almost as many MCOs had referral arrangements with local substance abuse treatment programs (68 percent) and children's social service programs (70 percent), including

school-based health centers and Head Start programs. More than one-third of Medicaid MCOs had established some form of referral relationship with education and welfare agencies that are vital for persons facing financial, housing, or welfare-to-work challenges.

Training for Providers and Staff. Approximately half of the Medicaid MCOs offered provider training programs to assist network staff to better understand the special circumstances of Medicaid enrollees, including, for example, socioeconomic characteristics, disease prevalence, and implications of cultural diversity for care experiences and care patterns.

State Contracts, Requirements, and Payment Issues. Payment for non-emergency transportation services was included in the capitation rate received from the state Medicaid agency by roughly 40 percent of the Medicaid MCOs in this study. About half of MCOs reported that the state requires their contracts with network Medicaid providers to cover non-emergency transportation services. Eighty-seven percent of the MCOs indicated that state regulations require that providers contracting with Medicaid MCOs must cover interpretation or translation services. While virtually all responding MCOs provided language services, only 31 percent reported receiving a defined capitation payment for interpretation/translation services. Eighty-three percent of MCOs reported state requirements for case management, and 62 percent of the MCOs were in states covering this service within their capitation rate.

Evaluation of Enabling Services. At most, about half of those MCOs that offered an enabling service assessed patient/client satisfaction. Twenty-six percent of MCOs assessed the effectiveness of at least one of the following enabling services (given that they provided the service): transportation, language services, educational services, or case-management. Most MCOs reported collecting data on the enabling services that they provide to Medicaid enrollees. Nearly all (62 percent) MCOs who provided any transportation services collect some data on the transportation services provided to Medicaid enrollees, and 53 percent collect data of some sort on their education and health promotion initiatives. Only about one-fourth of the MCOs, reported collecting any information on their interpretation/translation services.

During the 1990s, Medicaid represented a new market in an increasingly market-driven health care environment. For more mature HMOs, Medicaid offered new market share opportunities while presenting the challenge of serving enrollees who are culturally diverse, less attuned to managed care rules than the privately insured population, and more likely to present with comorbidities and psychosocial problems. These formative years can be viewed as a time for MCO innovation and natural experiments to develop, organize, and provide enabling services to Medicaid enrollees who require special assistance. This report documents the substantial presence of enabling services, and demonstrates that some Medicaid MCOs have begun to collect data necessary for assessing the implications and impact of enabling services on access, continuity of care, medication compliance, ER visits or hospitalizations, or overall care costs.

INTRODUCTION

The presence of Medicaid managed care has grown substantially over the past few years, with enrollment rising nearly sevenfold from 1991 to 1999 (2.7 million to 17.8 million). According to the Health Care Financing Administration, 55.6 percent of Medicaid beneficiaries were enrolled in managed care as of June 1999. As managed care participation in Medicaid continues to escalate, enrollment of low-income, minority, ethnically diverse, and medically high-risk populations will rise commensurately.

There is considerable concern about the ability of Medicaid enrollees to navigate complex managed care systems. The negative implications of the financial incentives that are inherent in most capitation arrangements also have raised major concerns. The potential for underservice is a frequently voiced concern for Medicaid's largely disadvantaged and medically vulnerable populations. All managed care plans, including Medicaid managed care plans, can restrict enrollees' choice of primary care doctors or require advance authorizations for making an appointment for specialists and other services. Similarly, an emergency room visit for urgent care—a pattern common to many vulnerable populations—is likely to require a phone call to obtain permission from the managed care plan. Newly enrolled Medicaid vulnerable populations, such as the chronically ill or those who do not speak English, may be especially reluctant to switch to a new doctor who may be unfamiliar with their course of treatment, unable to converse in their native language, or unable to adapt to more bureaucratic practices such as prior authorization for specific types of referrals or visits.

Over and above basic concerns about the ability to deal with managed care bureaucracies, vulnerable populations may have special needs and concerns about dealing with managed care organizations. Concerns about the implications of various managed care rules and financial incentives for Medicaid populations have focused interest on enabling services—defined as non-medical services, such as translation or transportation services—that facilitate access to timely and appropriate medical care. Enabling services are viewed as a possible means for promoting access and counterbalancing the challenges that the new Medicaid managed care rules pose for Medicaid enrollees. Many safety-net providers view enabling services—such as translation, transportation and case management—as important for facilitating access and coordinating care among high-risk, multi-risk, and hard-to-reach populations.

Focusing on the Potential Value of Enabling Services

Several concurrent trends underscore the rising interest in enabling services and the potential value of enabling services as provided by Medicaid managed care organizations (hereafter referred to as MCOs), especially Medicaid MCOs.

Changing rules and incentives. Federal and state policies are encouraging if not mandating enrollment in managed care systems, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), primary care case management programs, and other arrangements, for specific low-income and publicly subsidized populations. Most notably, federal and state policies are reshaping the rules, incentives, and care strategies for Medicaid programs, providers, and populations. As noted above, Medicaid enrollment in managed care

plans is rising nationwide, although the percentage varies widely by state. The entire Medicaid population in Tennessee, for example, is enrolled in one of the managed care plans, while Alaska does not have a Medicaid managed care program. Most of the state Medicaid programs, however, have already implemented or are moving toward mandatory Medicaid managed care programs.

New players to serve Medicaid populations. A growing number of managed care organizations, including the mainstream HMOs with established reputations in the commercial markets, are gearing up to enroll and serve Medicaid populations (Felt-Lisk and Yang, 1997). Various MCOs are moving more aggressively into the Medicaid and Medicare markets as they view new markets as potentially valuable. New organizational configurations are contracting with state Medicaid departments to accept capitated payments to provide "managed care," including HIOs (health insuring organizations) or PHPs (prepaid health plans) that may or may not be licensed as HMOs.

Potential of enabling services to address non-financial barriers. Mounting evidence indicates that neither financing alone nor managed care enrollment guarantee access, assure appropriate care-seeking patterns, or achieve desirable health status outcomes (Katz and Hofer, 1994; Ginsberg, 1994; Millman, 1993; Baumgartner, Grossman and Fuddy, 1993; La Veist, Keith and Gutierrez, 1995; Rice, 1991). Similarly, studies that examine the impact of Medicaid eligibility expansions on prenatal care and birth outcomes conclude that greater attention should be given to redressing non-financial barriers to care (i.e., cultural, socio-economic, attitudinal) and to providing "non-medical support services" or enabling services to both motivate timely care and achieve coordinated care (Lipson et al., 1995; Rymer, et al., 1995).

Initial studies explored the potential value of home health and other enabling services for high-risk pregnant women (Brown, 1989). Over time, enabling services have become integral features of health care delivery systems that serve hard-to-reach, vulnerable, and high-risk populations. Safety-net providers, such as federally qualified health centers, provide a variety of these services, including transportation, translation, targeted case management, and health promotion and disease management education (Lewis-Idema, et al., 1997; Lewis-Idema, et al., 1998).

As HMOs and other MCOs seek to expand their markets and Medicaid enrollments, they will seek to build capacity to manage care for populations with special needs. Compared with commercially insured enrollees, both Medicaid and Medicare populations are at higher risk and use more services. Medicaid enrollees are more likely to be female, women of childbearing age, and children. Both Aid to Families with Dependent Children (AFDC), the program now replaced by Temporary Assistance to Needy Families (TANF), and Supplemental Security Income (SSI) enrollees will require care for various chronic, disabling conditions, and perhaps more attention is needed to more prevalent medical concerns such as high-risk pregnancy, drug abuse, mental illness, and HIV/AIDS. Medicaid is comprised of disadvantaged populations including institutionalized aged and mentally retarded, blind, and disabled populations. Case mix and care experiences of Medicaid populations are thus different from those of higher-income commercially insured workers and their families who are now the dominant HMO enrollees. Many Medicaid beneficiaries also face non-financial barriers to care such as language and lack of transportation (HCFA, 1999; Arndt and Bradbury, 1995; Kronick, Zhou and Dreyfus, 1995).

Recent studies also indicate ways in which Medicaid enrollees' utilization patterns differ from other HMO enrollees. For example, Medicaid enrollees had higher use of hospital emergency rooms, fewer preventive care visits (e.g., immunizations, well-baby), a higher likelihood of missing scheduled appointments, and had higher walk-in rates than other HMO enrollees (Felt, Frazer & Gold, 1995). There is also some evidence that Medicaid populations under fee-for-service arrangements are more likely to use hospital emergency rooms as their usual source of medical care and that this pattern is difficult to break for new Medicaid MCO enrollees (Gibson et al., 1998; McCauley et al., 1998).

To survive in increasingly competitive markets and attract enrollees, Medicaid MCOs are likely to consider ways to tailor or customize services for a more medically complex, culturally heterogeneous population. Customization requires knowing the demographics and special needs of the target populations, and identifying the demographic differences that make a difference in promoting appropriate access to MCO services. Many Medicaid beneficiaries also need assistance with childcare and transportation.

Documenting the Presence of Enabling Services

There is a growing body of literature on enabling services that are provided to at-risk and vulnerable populations who are not HMO enrollees. These populations often lack insurance coverage. This literature focuses primarily on specific enabling or health-related services as provided to a specific target (categorical) population, often by a single provider or a small group of providers, such as those who contract with or are employed by a federally qualified health center (FQHC). Literature reviews present crosscutting assessments of specific services such as case management for specific high-risk populations (Falik et. al., 1992). Other studies explore costs associated with the delivery of selected enabling services as provided by community health centers (Lewis-Idema, 1994), or value or impact of various enabling services for specific, targeted populations (Blumenthal, Mort and Edwards, 1995; Lipson et al., 1995; Schauffler and Rodriquez, 1994; Jonas and Lewis-Idema, 1994; John Snow, Inc., 1993; Brown, 1988).

Recent studies also support anecdotal evidence that MCOs offer various enabling services to assist vulnerable, special needs, and hard-to-reach populations (Felt et al., 1995; Hilderbrant, Beery & Pearson, 1993; Delgiudice & Schaak, 1993; Mark et al., 1995). For example, several first-wave Medicaid MCOs offered a variety of special services (or enabling services) such as outreach, prevention education, case management, bilingual/translation services, and transportation (Felt et al., 1995). MCOs may view these non-medical services as a means for improving care-seeking behavior (e.g., reducing emergency room visits) and motivating timely care (e.g., prenatal or well-baby visits, and scheduled age-appropriate immunizations). To the extent that appropriate, timely care can be viewed as cost-effective care, enabling services can promote efficiency as well as access.

While our focus is on Medicaid managed care enrollees, it should be noted that enabling services are not restricted to Medicaid enrollees. Most HMOs offer some form of member services that encompass various health promotion and disease-specific education activities that target enrollees by age (e.g., immunizations), by age and gender (e.g., mammography), or by chronic condition, such as diabetes and asthma.

Study Approach

Our study was designed to examine and document the extent to which Medicaid MCOs were providing enabling services to Medicaid enrollees in 1998. Data were collected through a mail survey, fielded in the Summer/Fall of 1998.

Survey Content. The survey instrument was designed to obtain baseline statistics on the

- extent to which Medicaid MCOs were providing enabling services;
- scope and type of these enabling services; and
- related MCO and service characteristics.

Four clusters of enabling services were defined after considerable consultation with Medicaid MCO staff and nationally recognized Medicaid and managed care researchers:

- Transportation assistance, an established optional service under state Medicaid plans. Considerable variability exists across states in the scope and methods for providing transportation assistance;
- Language services, via translation, interpretation and/or bilingual staff, which are increasingly recognized as valuable, if not essential, for communicating with and providing care to recent immigrants and to non-English speaking patients;
- Education and health promotion activities, encompassing various forms of: (1) health promotion activities, for example, seeking timely prenatal care, acquiring parenting skills, or participating in stress reduction or smoking cessation programs; (2) disease prevention and disease detection efforts through scheduled immunizations or timely screenings for specific cancers or cardiovascular diseases; or (3) disease management counseling for chronic conditions such as diabetes, asthma or hypertension; and
- Case management, including both targeted case management for specific populations (e.g., pregnant women) or specific conditions (e.g., diabetes) and collaborative efforts to facilitate enrollee access to other community-based health, behavioral, and social services such as home health, Women, Infant and Children (WIC), or literacy programs.

The survey also sought information about the MCO, its Medicaid program, enrollee characteristics, and delivery system features relevant to serving special populations, for example, whether the MCO offered staff training on how to address the needs of vulnerable or non-English speaking populations.

Sample Frame. The survey-sampling frame was the universe of MCOs that met three criteria:

- located in a state that had enacted some form of Medicaid managed care, mandatory or voluntary, statewide or limited number of communities;
- negotiated a risk-based capitation contract with a Medicaid agency for enrollment of Medicaid eligibles; and
- achieved enrollment of at least 100 Medicaid eligibles by spring 1998.

Methodology. The survey was mailed during the Spring of 1998 to 370 managed care organizations, across 43 states that we identified as offering some form of capitated managed care to Medicaid eligibles. During the phone follow-up stage, we were able to refine our valid sample of MCOs. For example, we were able to determine that several MCOs no longer had a Medicaid contract while other MCOs were no longer doing business in the state. If a MCO was operating as a Medicaid MCO in more than one state, we requested a completed survey for each of these states.

Taking into account phone follow-up information to establish a valid number for the universe of operational Medicaid MCOs, the survey response rate was 55 percent and the final sample was 197 MCOs. Our hard refusal rate was 28 percent.

Presentation of findings. This report profiles the type, mix, and ways in which Medicaid MCOs provided enabling services to Medicaid enrollees in 1998. We also profile related MCO attributes and enrollee characteristics. These data establish a baseline for future studies and monitoring changes in the ways in which MCOs provide enabling services to Medicaid enrollees. We anticipate that reported descriptive statistics and findings will be sufficiently suggestive to assist in generating hypotheses and foster more in-depth study of enabling services.

Section II presents data describing the scope and mix of enabling services, by type of service, as provided by Medicaid MCOs in 1998. Section III raises some hypotheses and the data to examine them about which types of MCOs might be more or less likely to offer specific enabling services, and then summarizes major findings and their implications. Several factors that might influence the extent to which MCOs provide enabling services and the ways in which MCOs organize and make these enabling services available to Medicaid enrollees are described in Appendix A, and a more detailed description of the survey methodology is provided in Appendix B.

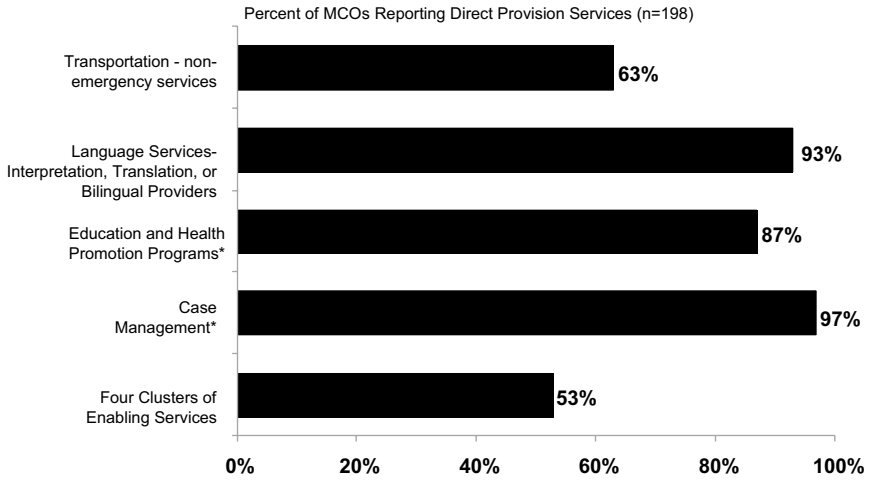
PROFILE OF ENABLING SERVICES

Most Medicaid MCOs were providing a variety of enabling services during 1998. Nearly every respondent Medicaid MCO either provided some interpretation or translation services or reported that enrollees had access to such services through their state Medicaid department (that is, the state provided the service directly to all Medicaid beneficiaries regardless of the type of plan or program in which they were enrolled). Ninety-seven percent of MCOs provided some form of targeted case management and 87 percent supported various education and health promotion activities. Sixty-three percent provided non-emergency transportation services. Overall, more than half of Medicaid MCOs provided a broad spectrum of enabling services (see Figure 1).

There is, however, considerable variation in the mix and complement of enabling services across Medicaid MCOs, and more significantly, considerable variation in the manner in which MCOs organize and provide specific enabling services. Understanding the organization of and ways in which enabling services are provided can often be more informative than simply documenting that a particular service is being made available to Medicaid enrollees.

The following discussion describes the scope and selected aspects of the way in which specific enabling services are being provided by Medicaid MCOs.

Figure 1



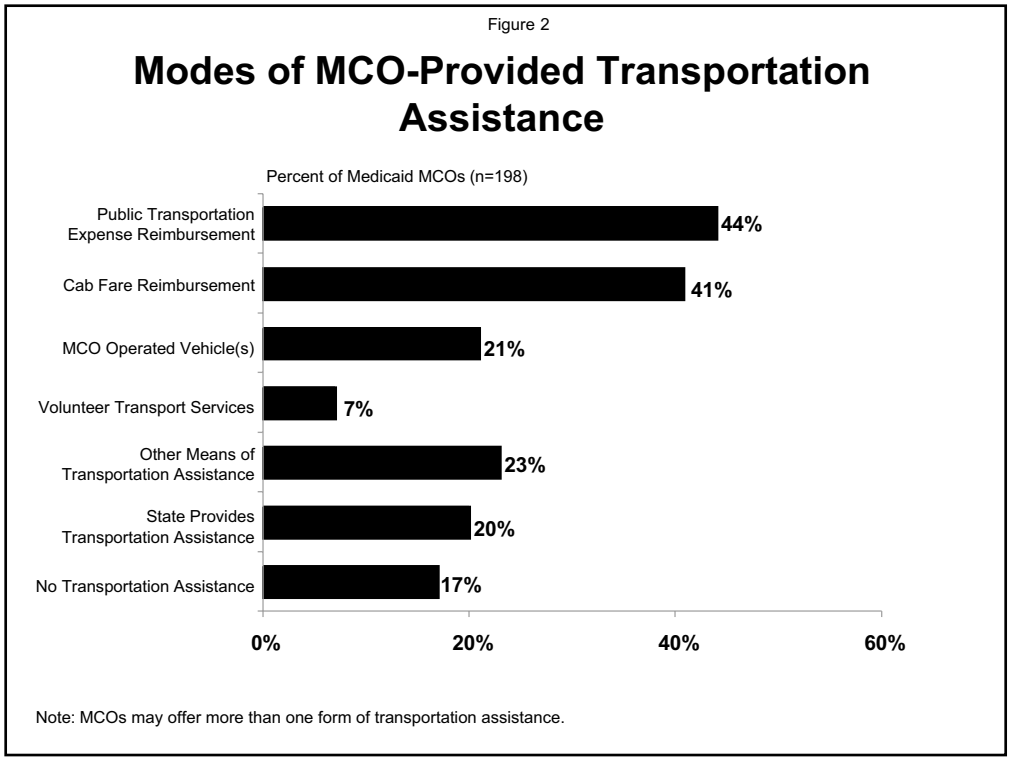
*The survey instrument presented a list of health promotion education programs and conditions often designated for case management.

Transportation Assistance for Non-Emergency Care

Survey results indicate that most Medicaid managed care enrollees had access to some form of transportation assistance for non-emergency care, provided by the Medicaid MCO or by a state agency. As shown in Figure 1 above, 63 percent of the MCOs reported providing transportation services for Medicaid enrollees. Figure 2 on the following page shows that another 20 percent of the MCOs reported that the state organizes and provides transportation services to Medicaid enrollees. Seventeen percent of plans reported that their enrollees did not have access to either plan- or state-sponsored transportation services. The MCO-provided transportation services were more likely to be centralized than decentralized, with transportation services being organized and managed at the plan level (43 percent), rather than being the responsibility of the individual providers (12 percent). Thirty-five percent of the MCOs delegated responsibility by subcontracting operations for their transportation services to another firm that specialized in managing and providing transportation services. Forty-four percent of the MCOs offered more than one form of transportation assistance.

As Figure 2 shows, the most common methods were to provide reimbursements—for public transportation expenses (44 percent) or for cab fare (41 percent). Twenty-one percent of MCOs had their own vehicles for transporting enrollees. MCOs were least likely to rely on volunteer strategies (7 percent) to provide or augment transportation services. Most of the responding MCOs did not report the number of trips made by Medicaid enrollees over the past year.

Figure 2



Note: MCOs may offer more than one form of transportation assistance.

Language Services

Some form of language service is vital to serving and providing care to limited and non-English speaking patients. Medical encounters, for example, require an exchange of information, beginning with medical history, recounting symptoms, and explaining care regime, including referrals and prescriptions. Effective communication between provider and patient requires some degree of trust between the parties. Some recent immigrants may fear or lack confidence in western medicine. Providers, on the other hand, might not be aware of or might be insensitive to a patient's preferences for traditional forms of care.

A recent study of the content of Medicaid MCO contracts, however, observed that requirements pertaining to "cultural competence" appear in about two-thirds of Medicaid MCO contracts, few states define what is meant by "cultural competence" or proscribe what MCOs or providers should do to assure or demonstrate cultural competency (Rosenbaum, 1998). Language services to mediate linguistic barriers can be viewed as an essential aspect of promoting cultural competency.

The percentage of Medicaid enrollees who speak English as a second language (ESL) varies widely across MCOs. However, English as a second language is a potential barrier to care for a relatively large proportion of Medicaid enrollees. Research shows that language is a significant barrier to medical care, especially for low-income populations (Flores et. al., 1998; Schur and

Albers, 1996; Harlan, Bernstein and Kessler, 1991). As shown in Table 1 below, of the 175 MCOs responding to this question, 4 out of 10 reported that more than 10 percent of their enrollees did not speak English as a first language.

Table 1. Percentage of Medicaid MCO Enrollees Speaking English as a Second Language

Percent of Medicaid Enrollees—English as Second Language	Number of MCOs	Percent of MCOs
Total	**175**	**100%**
Less than 1 percent	30	17%
1 to 5 percent	46	26%
5 to 10 percent	28	16%
More than 10 percent	71	41%
10 to 25 percent	*33*	*19%*
25 to 50 percent	*31*	*18%*
More than 50 percent	*7*	*4%*

While 17 percent of the Medicaid MCOs reported virtually no non-English speaking enrollees, 22 percent reported greater than 25 percent as speaking English as a second language or as unable to speak any English. An additional 19 percent of MCOs reported between 10 and 25 percent ESL enrollment.

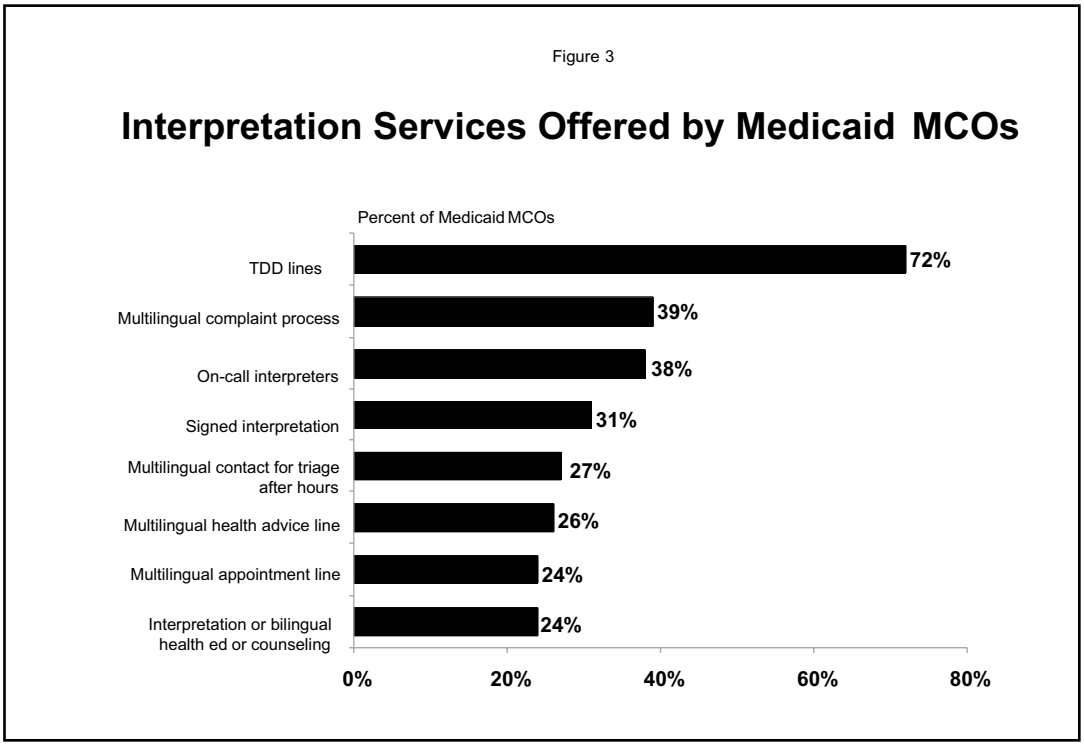
Our survey indicates that nearly three-quarters (73 percent) of MCOs assessed the language ability of their Medicaid enrollees. Over one-third (35 percent) of the MCOs reported that they rely on their own staff to assess English competency and language preference(s) of new enrollees; about 17 percent relied on state Medicaid staff and another 18 percent relied on Medicaid enrollment brokers to assess linguistic competencies.

Nearly all of the responding Medicaid MCOs reported that their enrollees have access to some form of translation and/or interpretation services. Ninety-three percent of MCOs reported that they provide language services; only four percent of the MCOs reported relying on some form of state-provided language services for Medicaid enrollees. Among respondents, only five MCOs reported not offering any services designed to meet the needs of non-English speaking enrollees.

Interpretation services. Guidelines or thresholds for when it is necessary to make interpreters or bilingual staff available can be developed by a state, an MCO, or other managed care regulatory organization. Sixty-eight percent of the responding MCOs reported that their respective states set the language threshold for mandatory language services (usually in terms of a percentage of ESL enrollees, by foreign language). Another seven percent of the MCOs established their own threshold for when to provide interpretation or bilingual services. In contrast, one-quarter of MCOs relied on other mechanisms to determine whether and when to offer specific language services, including voluntary standards promulgated by accreditation organizations such as the National Committee for Quality Assurance (NCQA).

Looking across MCOs, we find that mechanized methods, such as AT&T language lines and TDD lines, are much more commonly used than any of the more individual, professional, or volunteer interpreters. The TDD lines for hearing-impaired enrollees, for example, are available at 72 percent of the Medicaid MCOs; signed interpretation is available only at 31 percent of the Medicaid MCOs (Figure 3).

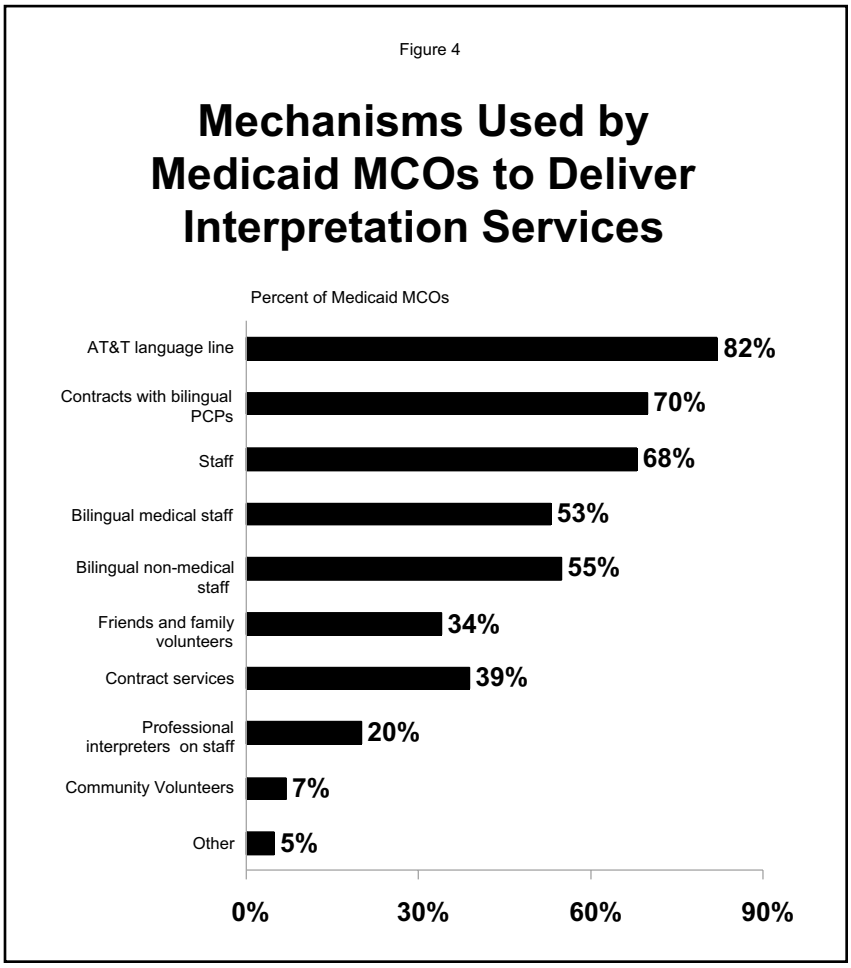
Figure 3



Eighty two percent of MCOs reported that they can access interpretation services via the AT&T or other telephone service language lines (Figure 4 on the following page). With AT&T language lines, no specific threshold exists and even a comparatively small number of Medicaid enrollees can be accommodated on a requested or as necessary basis. On the other hand, AT&T language lines might be viewed as a less than optimal strategy for building cultural competency and establishing physician-patient rapport. Very few (3 percent) of MCOs, however, relied exclusively on this form of third-party communication assistance (data not shown).

Telephone interpretation services can be awkward and inadequate for both patients and providers. Such services can entail passing a telephone back and forth, or relying on a speakerphone. Especially problematic are times when a phone service interpreter is not conversant with medical terminology. If volume is high, a telephone service strategy can be quite expensive. As demand for interpretation rises, MCO staff capacity can be significantly less expensive (and more professional and sensitive to patients) than extensive use of the phone services (National Health Law Program, 1998). The third-party telephone services can, however, be cost-effective for relatively rare languages or for a small number of ESL enrollees.

Figure 4



As shown in Figure 4 above, the vast majority of MCOs (70 percent) offer bilingual primary care providers within their Medicaid networks. Over half of the MCOs report having bilingual medical and/or non-medical staff. As a caveat, however, it should be noted that we are unable to assess whether these MCOs have a sufficient number of bilingual providers to meet the interpretation needs of all of their ESL enrollees, either by number of languages or by number of Medicaid enrollees who would require bilingual providers.

Beyond basic linguistic and translation skills, trained medical interpreters are more familiar with medical terminology and clinical issues than are untrained interpreters. Among the 42 percent of MCOs who retained professional interpreters (either on staff or through contract), less than half reported that their contract interpreters were specially trained in medical terminology or conversant with clinical issues (data not shown). When asked if the competence of interpreters was assessed, most MCOs failed to respond. Among the responding MCOs, about half reported that they assessed competency of their interpreters. Information on competency assessments, training, or certification requirements was not collected.

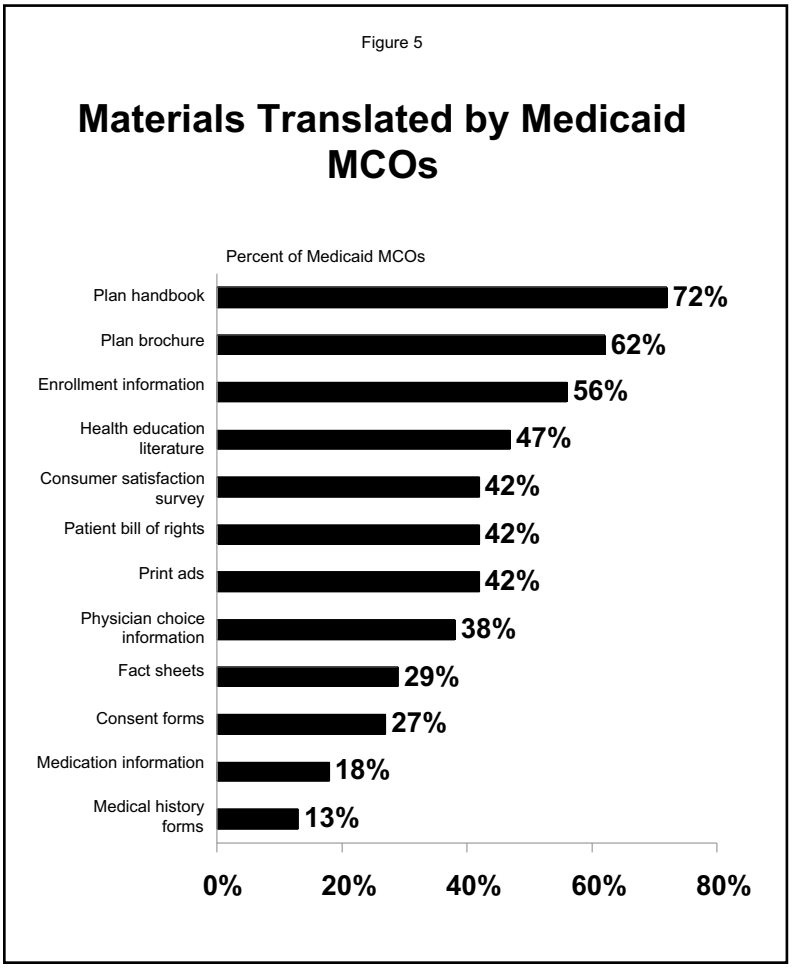
Following use of the AT&T language line, the second most common mechanism reported by MCOs was contracting with bilingual primary care providers (70 percent). This assumes,

however, that non-ESL enrollees will somehow be linked up with a PCP who speaks their language. This mechanism also does not guarantee that there are a sufficient number of PCPs available to serve all necessary languages or enrollees. Some MCOs rely on friends and family of enrollees to interpret for them when necessary (34 percent), and are less likely to rely on volunteers from the community (7 percent).

As noted above, Medicaid enrollees for whom English is a second language make up more than 10 percent of enrollees for 4 out of 10 MCOs responding to this survey. These results suggest that an unmet need for language services may exist. With the exception of TDD lines, less than 40 percent of the responding MCOs offered any of the more basic information and member services in a language other than English. As shown previously in Figure 3, 39 percent offered multi-lingual complaint or grievance services; 27 percent provided multilingual contacts for after-hour triage services; 26 percent offer a multi-lingual medical advice hotline; and barely one-quarter of the MCOs offer a multilingual appointments staff. Only 24 percent of the MCOs routinely offered bilingual or interpretation staff for health education or counseling sessions.

Translation services. Similar to interpretation services, MCOs vary in the extent to which they translate marketing, administrative, or clinical information—policies, procedures, and fact sheets. MCOs appear to focus on enrollee and access rules in their translation efforts. As shown in Figure 5, 72 percent of MCOs translated their plan handbook into at least one non-English language.

Figure 5



Essential enrollee materials such as how to select a primary care physician or consumer satisfaction surveys are less likely to appear as non-English versions. Sixty-two percent of the MCOs translated their plan brochure and slightly more than half of the MCOs (56 percent) translated enrollment information. Only forty-two percent conducted consumer satisfaction surveys in languages other than English. Even fewer MCOs translated physician choice information (38 percent).

Marketing and outreach to ESL populations does not appear to be a priority, as only 42 percent of the MCOs reported bilingual or multilingual print advertisements. Bilingual marketing materials, including print advertisements, are highly visible invitations for ESL and minority groups to open the MCO door. Limited multilingual marketing efforts can reduce effective choices available to ESL and minorities who have less than adequate English capabilities. Lacking accessible information, auto-enrollments are more likely to take place.

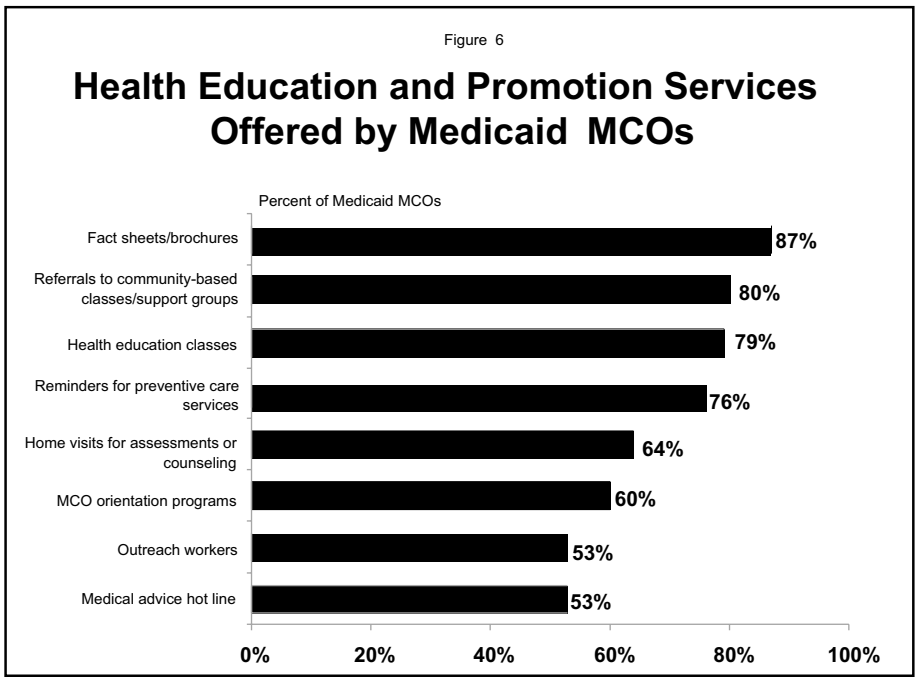
Once enrolled, ESL members are even less likely to be able to obtain needed information in their native language. Comparatively few MCOs translated clinical forms and materials, such as the patient bill of rights (42 percent), consent forms (27 percent), and medication information (18 percent). Only 38 percent translated information critical for selecting a PCP. While 47 percent of the MCOs translated health education literature, less than one-third translated fact sheets on specific diseases or different types of preventive screening. Only 13 percent of the MCOs offered non-English versions of the medical history form.

Education and Health Promotion Services

Over the past decade, patient education and health promotion activities have become a more integral aspect of health care services. Historically, health maintenance organizations (HMOs) have emphasized patient education, scheduled screenings, prevention and education activities, and disease management for patients with chronic conditions like diabetes or hypertension (Brooks-Gunn et al., 1989; Hilderbrandt, Beery and Pearson, 1993; Schauffler and Rodriquez, 1994). Similarly, Federally supported health centers (FQHCs) and Rural Health Centers (RHCs) emphasize health promotion activities, ranging from environmental campaigns (e.g., improve water supply and sanitation) to disease prevention (e.g., immunizations, cancer screenings) and disease management for high incidence chronic conditions such as asthma, diabetes, and hypertension (Dievler and Giovannini 1998; Davis, Schoen, 1978).

Health promotion activities for Medicaid's low-income populations might also target groups with specialized care needs, for example, pregnant and high-risk pregnant women, or target at-risk populations for prevention strategies to reduce incidence of substance abuse, anxiety and depression, sexually transmitted diseases and HIV/AIDS, or establish focused screening initiatives. Medicaid MCOs could build on these two reinforcing models. Medicaid MCOs might provide health education and health promotion services through a variety of venues—individual counseling or group sessions at MCO clinics, broadening the reach via community forums or cultural centers, and coordinated referrals, for example—with women's shelters, addiction treatment facilities, and support groups.

Figure 6



As shown in Figure 6 above, about 80 percent of responding Medicaid MCOs provided health education classes and reminders to obtain scheduled preventive services such as immunizations and cancer screening. A similar percentage (79 percent) made referrals to community-based organizations and support groups (Figure 6). Outreach efforts are supported by fewer Medicaid MCOs; 64 percent conduct home visits, and about half employed outreach workers or staffed medical advice hot lines (53 percent for both activities).

Medicaid MCOs offered health promotion classes, seminars, and group counseling sessions that focus on disease prevention as well as disease management. As shown in Figure 7 on the following page, more than half of the Medicaid MCOs (56 percent) offered between two and ten topic-specific health promotion classes or group counseling sessions. Nearly one-fifth of MCOs (19 percent) reported offering more than ten topic-specific health promotion classes. Only 13 percent of the responding MCOs reported not offering any health education or health promotion programs.

The roster of health promotion classes most likely to be available reflects several of the health risks most common among Medicaid patients: smoking, pregnancy/parenting, asthma, and diabetes (Table 2 below). The smoking cessation and perinatal care classes were the two most available health promotion programs (64 percent and 63 percent, respectively). Over 50 percent offered diabetes and asthma management classes (57 percent and 56 percent respectively), health promotion via nutrition/diet classes (54 percent), and parenting skills classes (50 percent). Somewhat less common were educational programs that focus on comparatively high-incidence conditions, including how to care for high-risk infants (37 percent), hypertension (29 percent), stress and anxiety reduction (29 percent), and cancer screening (29 percent). Over one-fourth of MCOs targeted complex behavioral issues, including STD and HIV/AIDS prevention, substance abuse, and depression. Barely one-quarter of MCOs targeted domestic violence for special sessions or educational forums.

Figure 7

Percent of Responding MCOs Offering the Following Numbers of Health Promotion Classes or Group Counseling Sessions

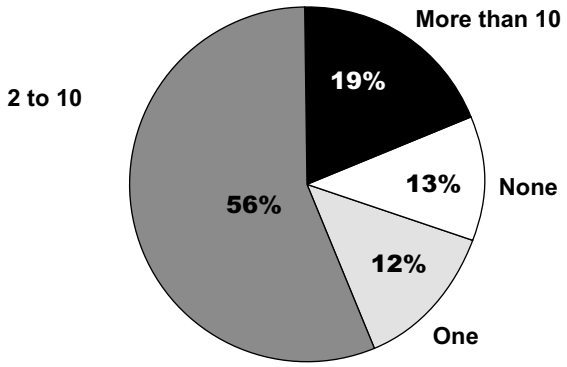


Table 2. Health Education Classes/Sessions Offered by Medicaid MCOs

Health Education Classes/Sessions	Percent of MCOs
Smoking cessation	64%
Perinatal education	63%
Asthma management	57%
Diabetes management	56%
Nutrition/diet	54%
Parenting skills	50%
High-risk infants	37%
Hypertension management	29%
Stress and anxiety reduction	29%
Breast cancer screening	29%
STD prevention	28%
Substance abuse counseling	27%
HIV/AIDS prevention	27%
Lead poisoning screening	24%
Depression management	23%
Cervical cancer screening	20%
Domestic violence	19%
Arthritis management	14%
Other	18%

Given that many Medicaid MCOs are relatively new, many of the MCOs and providers within their networks may have little or no experience with low-income and minority families. While this survey on enabling services was not designed to examine MCO provider education policies or issues, we did ask if MCOs offered their providers training opportunities that focused on understanding the special needs of low-income, minority, and Medicaid populations. Almost half of the Medicaid MCOs reported that they offered provider training programs to assist network staff to better understand the special circumstances of Medicaid enrollees, including, for example, socio-economic characteristics, disease prevalence, and implications of cultural diversity for care experiences and care patterns.

Case Management Services

Case management can take various forms, such as intensive one-on-one counseling, care coordination, treatment plan monitoring and referrals for specialized or social services. MCO case managers are drawn from many different fields, for example, social work, nursing, and psychology. Case managers work closely with clinicians, often assisting with care coordination, care referrals, and care follow-up. Case management has become more common in recent years, with hospital-based case managers engaged in discharge planning and follow-up, and MCO-based case managers engaged in targeted case management, for example with high-risk pregnant women or disabled persons, disease management programs and one-on-one counseling to facilitate timely care and compliance with treatment regimes (Falik, 1993).

Case management, as part of disease management, seeks to educate the patient to assume a positive role in his/her treatment, and to motivate health-promoting behaviors. Nearly all (97 percent) of Medicaid MCOs reported sponsoring at least one targeted case management program. As Table 3 on the following page indicates, targeted case management focuses on populations that share common circumstances, for example, pregnant women or high-risk infants, or medical conditions such as asthma or diabetes.

About two-thirds of the Medicaid MCOs focused on more than three different populations, defined as sharing risk circumstances and/or medical conditions.

It is not surprising to find that case management for pregnant women is most common across MCOs (78 percent) given the prominence of women of childbearing age and comparatively high pregnancy rates. Approximately 15 percent of pregnant women and 40 percent of all births were covered by Medicaid in 1997 (Thorpe, 1999; National Governor's Association, 1997, http://www.nga.org/pubs/issueBriefs/1997/970930MCHUpdate.asp). HIV/AIDS ranks second (73 percent), followed by asthma (72 percent). Both are high-cost conditions of near epidemic proportions, especially among Medicaid's minority and urban populations. Both require clinical monitoring and medical interventions to reduce acute episodes, for example, among asthmatic children to prevent avoidable hospitalizations. Behavioral problems rank moderately high as targeted conditions for case management, as does substance abuse (47 percent), mental illness (43 percent), and developmental disability (43 percent). Hypertension and arthritis are the only chronic conditions that fewer than one-third of the MCOs targeted for case management. MCOs are less likely to target psycho-social problems such as domestic abuse for case management initiatives.

Table 3. Conditions Targeted for Case Management

Condition	Percent of MCOs
Pregnancy	78%
HIV/AIDS	73%
Asthma	72%
High-risk infants	69%
Diabetes	66%
Cancer	48%
Substance abuse	47%
Mental illness	43%
Developmental disability	43%
High-risk youth	40%
Stroke	34%
Coronary disease	33%
Hypertension	27%
Victims of violence	22%
Eating disorders	18%
Arthritis	12%
Other	20%

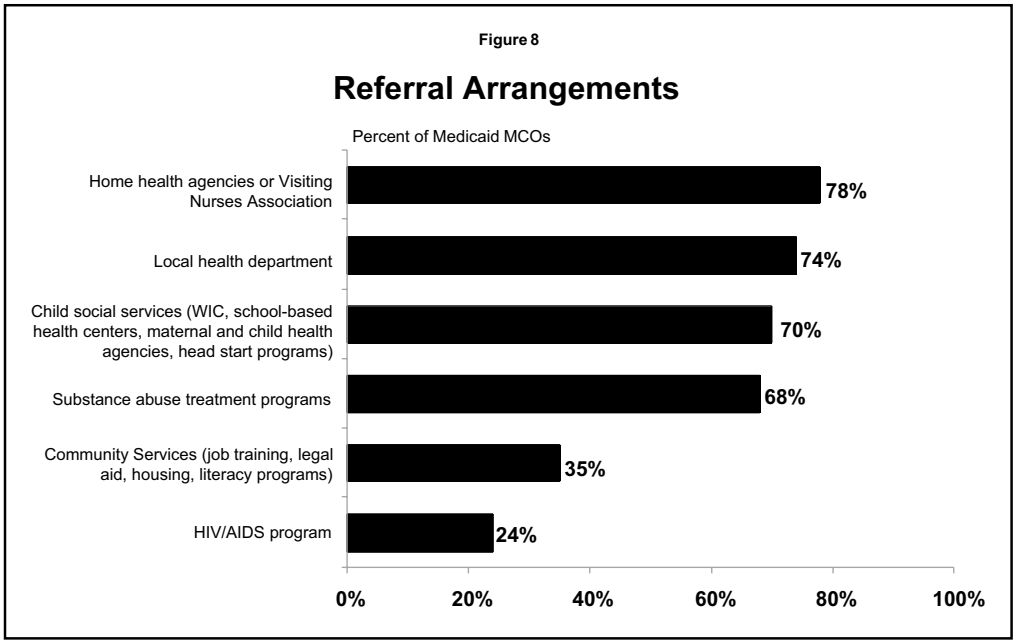
Targeted case management (or its close relative, disease management) can be viewed as a means for identifying problems and promoting positive behaviors, and in turn, achieving more cost-effective care. In the current fiscal environment, and as length of Medicaid enrollment decreases, Medicaid MCOs might be more oriented towards short-term acute and basic chronic care regimes rather than disease prevention initiatives, which require a longer time horizon for realizing and observing results. High turnover among Medicaid enrollees might well militate against the broader-based health promotion activities. Targeted case management, with an emphasis on disease management, may be viewed as more cost-effective, or at least more expedient, than case management for more complex lifestyle circumstances. It may be easier to target and treat avoidable hospitalizations for asthma than more complex lifestyle circumstances like violence or behaviors like eating disorders.

Medicaid enrollee characteristics can influence case management priorities. MCOs that serve AFDC/TANF as well as other Medicaid populations, for example, the SSI (low income disabled) were more likely to provide targeted case management for at least one major chronic condition than MCOs that served only the AFDC/TANF population. Ninety percent of MCOs serving populations other than AFDC/TANF provided targeted case management for diabetes, hypertension, stroke, coronary heart disease, hypertension or arthritis compared to 77 percent of Medicaid MCOs serving the more traditional AFDC/TANF populations.

Case-management and health promotion programs seem to be targeting many of the same conditions or populations—pregnant women and high incidence conditions, including asthma, diabetes, HIV/AIDS and hypertension/coronary diseases. This emphasis indicates that many of the MCOs appear to be designing health promotion and case-management programs to meet the special circumstances and special needs of their enrollees.

Referrals to Community-Based Organizations

Referrals to community-based agencies can supplement MCO capacity to serve at-risk and special needs Medicaid enrollees. Many Medicaid MCOs appear to be taking the initiative and leveraging local resources to assist enrollees who require additional, often uncovered, services (Figure 8). Seventy-four percent of Medicaid MCOs reported having established contracts, agreements, or letters of understanding with local health departments, and 78 percent had such agreements with home health agencies or visiting nurse agencies (VNAs). Almost as many MCOs had referral arrangements with local substance abuse treatment programs (68 percent) and children's social services (70 percent), including school-based health centers and Head Start programs.



More than one-third of Medicaid MCOs had established some form of referral relationship with education and welfare agencies that are vital for persons facing financial, housing, or welfare-to-work challenges. The impact of referrals, however, would be very difficult to assess because only about 28 percent of the MCOs have a system in place for following up on whether referrals to community-based organizations were carried out by enrollees.

It is difficult to evaluate how MCOs conduct outreach activities without also noting that there is often not a clear distinction between when an MCO "refers" an enrollee to another organization and when the MCO "contracts" directly with that organization. As shown in Table 4, the vast majority of study MCOs reported having established relationships or contracts with at least one safety net provider.

Eighty-four percent of Medicaid HMOs reported a relationship with at least one FQHC or RHC, and 63 percent reported having a local health department within their network. To a somewhat lesser extent, other safety net providers are part of the Medicaid MCO delivery systems. One quarter of Medicaid MCOs involve reproductive health centers, such as Planned Parenthood

Table 4. Safety Net Providers Within Medicaid MCO Networks

Type of Providers Included in MCO Network	Number of MCOs	Percent of MCOs
FQHC or RHC	166	84%
Local Health Department	124	63%
Reproductive Health Center	51	26%
HIV/Ryan White Clinic	40	20%

(26 percent), and one-fifth of MCOs involve community-based agencies specializing in HIV/AIDS services, such as those funded by the Ryan White Care Act.

Only 10 percent of Medicaid MCOs reported that they had no safety net providers in their networks. Fourteen percent contracted with only one type of safety net provider; one third contracted with two types of safety net providers; 28 percent with three types, 10 percent with four types, and 6 percent with all five types of safety net providers.

Simply having a contract or referral relationship with a safety net provider, however, does not say much about how much the safety net provider is actually used by the Medicaid MCO. Little data exist on the extent to which Medicaid MCOs refer patients to the safety net providers with whom they contract. A recent study, however, concluded that several of the Medicaid MCOs examined had contracts with FQHCs but referred very few patients to them (Families USA, 1998).

Training for Providers and Staff

The ability of health professionals to be sensitive to and understand socio-cultural preferences, concerns, and expectations of their patients has been shown to influence physician-patient communications, care regime compliance, and outcomes of these clinical encounters (Lavizzo-Mourey, 1997). Our survey indicates that being able to address language barriers is necessary for a majority of Medicaid MCOs, as nearly 80 percent reported serving limited- and non-English-speaking patients. Only 26 percent of these MCOs, however, offered ESL (English as

Table 5. Training for Providers and Staff on Medicaid, Special Needs, and Circumstances of Low-Income and Vulnerable Populations

Type of MCO	MCOs offer training sessions	MCOs do not offer training sessions
Mainstream MCOs–Require providers to serve Medicaid enrollees	41%	20%
Mainstream MCOs–No requirement that providers serve Medicaid enrollees	36%	43%
Medicaid-only MCOs	22%	36%

Significance: *chi-quare p<0.01*

Table 6. Provider Training on Serving Vulnerable Populations by Percent of ESL Enrollees

Percent of Enrollees with English as a Second Language (ESL)	Training on serving ESL populations	Training on serving vulnerable populations
No ESL enrollees	11%	12%
1-10 percent ESL enrollees	32%	45%
More than 10 percent ESL enrollees	57%	43%
Chi-square p value	0.03	0.12*

* Not Significant

a second language) training to assist clinicians and other staff to communicate with enrollees, and appreciate and reconcile cultural differences.

MCOs that require providers to enroll Medicaid eligibles were the most likely to offer special training sessions on how to serve vulnerable populations, and Medicaid-only MCOs were less likely to offer these training sessions (Table 5).

The presence of ESL enrollees has implications for MCO training. MCOs were more likely to provide training sessions for providers on serving vulnerable populations when ESL enrollees comprise a comparatively high proportion of their Medicaid enrollments (Table 6). Some MCOs that report not having any ESL enrollees also offer these training sessions for providers.

State Contracts, Requirements, and Payment Issues

States seeking to promote access to enabling services can choose to contractually require that specific benefits be provided, explicitly include payment for these services within the capitation rate, or both. As shown on Table 7 on the following page, states appear to be more inclined to require that MCOs provide specific enabling services than to pay explicitly for these services. About 40 percent of the MCOs report that payment for non-emergency transportation services was included in the capitation rate received from the state Medicaid agency. We did not seek to validate, by state and MCO, whether the responding MCOs were correct in their statements about what is or is not covered by an explicit or negotiated component of the capitation payment. About half of MCOs reported that the state requires their contracts with network Medicaid providers to cover non-emergency transportation services.*

*These estimates are consistent with a recent work by the National Academy for State Health Policy, which found that Medicaid agencies are most likely to require plans to provide care coordinators and translation, and less likely to require non-emergency transportation, outreach, and home visits. The National Academy of State Health Policy shows that 58 percent of states require Medicaid plans to provide on-site interpretation and 90 percent of states require off-site interpretation; 98 percent require translation of written materials (unspecified); 63 percent require non-emergency transportation; and 64 percent require care coordinators (Kaye, Pernice and Pelletier, 1999.) The National Academy estimates, however, ask about whether the enabling services are required for any Medicaid populations, or whether they know of any plan that provides the service voluntarily. In addition, the estimates presented here refer to the percentage of Medicaid plans that respond that they have a requirement to provide the service, while the estimates for the National Academy refer to the percentage of states that require that the service must be provided.

Table 7. State Requirements and Payments for Enabling Services

Type of Mandate or Payment	Non-emergency Transportation	Language Services	Education/Health Promotion	Language Services
MCO provides service	63%	93%	87%	97%
State requires that MCO must provide service in some form	49%	87%	62%	83%
State provides payment for service in capitation rate	40%	31%	44%	62%
MCO provides service, there is state requirement and payment is included	40%	30%	26%	57%
MCO provides service, no requirement	15%	8%	32%	15%
MCO provides service, state has requirement, and state does not include payment	8%	55%	29%	24%

Eighty-seven percent of the MCOs indicated that state regulations require that providers contracting with Medicaid MCOs must cover interpretation or translation services. While virtually all responding MCOs provided language services, only 31 percent reported receiving a defined capitation payment for interpretation/translation services. States are most inclined to cover case management within their capitation rates (62 percent); 83 percent of the MCOs reported state requirements for case management.

Many MCOs covered these enabling services even when they report that capitation dollars are not designated for specific enabling services, or that their state did not require the service (Table 7). Eight percent of MCOs provided language services even though they did not believe their state required them to do so; fifty-five percent of MCOs reported that they were providing language services even though their state did not include payment for this service in its capitation rate. Thirty-two percent of MCOs provided education/health promotion services without a state requirement.

Requirements, especially from the state perspective, are relatively simple to implement. Establishing equitable rates for specific services, however, can be very complicated and methods for cost finding vary by type of service and staffing or delivery design. For example, tracking resources and costs for enabling services can be difficult if resource costs are imbedded in the costs for staff, as an MCO relies on bilingual physicians and staff. Transportation services, on the other hand, are far more distinctive and separable for cost-finding and cost-recovery purposes. Evaluations of alternative methods of service delivery and associated costs and implications for target populations would assist states and MCOs in negotiating payments for enabling services.

MCO Assessment of Enabling Services

There is limited information about the costs or the effectiveness of different enabling services, and virtually no data for assessing the cost-effectiveness of specific enabling services. MCOs require data for assessing costs and/or benefits, especially when considering whether to implement, continue, or drop a particular service or benefit. Survey results suggest that MCOs are likely to be guided more by requirements than by information borne of experience. Some MCOs are taking the lead and beginning to collect data on use and costs, and to some extent, beginning to assess the effect and effectiveness of specific enabling services.

At most, about half of those MCOs that offered an enabling service devoted the resources to assess patient/client satisfaction. Twenty-six percent of MCOs reported assessing the effectiveness of at least one of the following enabling services (given that they provided the service): transportation, language services, educational services, or case-management. Substantially fewer than half of the responding MCOs collect utilization or cost data and with the exception of case management, even fewer have assessed the effectiveness of enabling services (Table 8 below).

Table 8. Analysis of Enabling Services by Medicaid MCOs Providing Specific Enabling Services

Percent of MCOs Reporting Direct Provision of Enabling Service	Transportation 63%	Interpretation 93%	Education 87%	Case Management 87%
Percent of MCOs Assessing Patient Satisfaction*	52%	25%	54%	38%
Percent of MCOs Collecting Utilization Data*	62%	26%	47%	62%
Percent of MCOs Collecting Cost Data*	61%	28%	53%	46%
Percent of MCOs Assessing Value, Effectiveness, or Outcomes*	29%	11%	16%	73%

*Of those MCOs providing the service directly

Most MCOs reported collecting data on the enabling services they provide to Medicaid enrollees. Most MCOs (62 percent) who provided any transportation services collect some data on the transportation services provided to Medicaid enrollees. Sixty two percent of the MCOs also collected data on their case-management programs, and 53 percent collected data of some sort on their education and health promotion initiatives. Only about one-fourth of the MCOs, however, reported collecting any information on their interpretation/translation services.

Table 8 shows the percentage of those Medicaid MCOs that conduct evaluations or assess the effectiveness of specific enabling services given that they offer the service.

Of these specific enabling services, case-management programs were most likely to be evaluated by MCOs. Seventy-three percent of MCOs conducted some sort of evaluation of their case management services. MCOs were much less likely to evaluate other enabling services.

While nearly a third (29 percent) of MCOs evaluated their transportation programs, only 16 percent evaluated their education and health promotion programs and a mere 11 percent evaluated their interpretation or translation services.

Given the limited resources and the complexity of determining the incremental costs and associated benefits of specific services, the fact that even one-quarter of these MCOs conducted some sort of evaluation is certainly worth noting. It is appears that for services where there is a greater likelihood of a capitation payment, such as case management, there is greater number of MCOs devoting resources to data collection and evaluation.

CONCLUSIONS

The 1990s bear witness to an avalanche of health care innovations, new entrants into virtually every health care market, and major shifts in key relationships—between insurers and providers, providers and other providers, and between providers and patients. Medicaid is a new market in an increasingly market-driven environment. For more mature HMOs, Medicaid may offer new market share opportunities and present the challenge of serving enrollees who are culturally diverse, less attuned to managed care rules than the privately insured population, and more likely to present with comorbidities and psychosocial problems. For traditional safety-net providers, such as FQHCs, health department clinics and public hospitals, who may be more familiar with the special needs of Medicaid patients, the challenge may be to learn to partner with managed care networks and adapt to new payment incentives and administrative requirements.

A constellation of forces—characteristics and needs of the populations served, state contract requirements and local market forces among them—are likely to influence whether MCOs offer enabling services and how MCOs choose to make such services available to Medicaid enrollees. Medicaid managed care remains in its formative years. Most of the state Medicaid managed care programs, their markets, and their networks, are less than five years old. Medicaid rules, guidelines and standards are evolving, and states are increasingly involved in mandating what enabling services Medicaid providers must offer, and how they should be offered.

These formative years can be viewed as a time for MCO innovation and natural experiments to develop, organize, and provide enabling services to Medicaid enrollees who require special assistance. The survey results indicate a substantial presence of different configurations of enabling services. Some Medicaid MCOs have begun to collect data necessary for assessing the implications and impact of enabling services on access, continuity of care, medication compliance, ER visits or hospitalizations, and overall care costs.

As Medicaid managed care evolves, debate ensues about whether some Medicaid MCOs are more able, and perhaps more willing, to provide enabling services than others. Characteristics of MCOs might influence the provision of care to Medicaid beneficiaries. MCO experience (i.e., years with a Medicaid MCO contract), licensure and structure (e.g., HMO, IPA, HIO, hybrid), safety-net relationships or whether a MCO only serves Medicaid enrollees are all factors that might affect Medicaid MCOs' provision of enabling services. Future multivariate analyses should examine these, as well as other factors that might influence the provision of specific enabling services in more depth. Cluster or service-specific studies are logical next steps for

examining alternative ways that MCOs are providing enabling services and for identifying “best practices” and more attention should be given to examining enrollee perspectives on enabling services, their availability, and their value.

Certainly, we should also be somewhat circumspect in suggesting that most Medicaid MCOs are providing enabling services. We do not have any information to assess whether available enabling services are accessible or satisfactory to meet the needs of the target populations. We have no data to begin to describe the structure or staffing of specific enabling services. We do not have requisite information to compare different approaches to providing specific enabling services.

The impact of enabling services will be difficult to determine, but as Medicaid managed care grows it will be increasingly important to identify services, including enabling services, that increase access to and quality of care for Medicaid beneficiaries. Anecdotal evidence suggests that at least some enabling services are well received by beneficiaries, help them obtain needed services in a more timely manner, and improve the ultimate quality of their care. Illuminating which enabling services are most helpful for specific populations will benefit all managed care enrollees, not just Medicaid enrollees. Some MCOs have begun these evaluations and hopefully results of their internal evaluations will be shared with other MCOs and policymakers. This study serves as a starting point for identifying enabling services and populations that should be examined in more depth if we are to understand how to deliver managed health care in the most effective manner.

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APPENDIX A: MEDICAID MANAGED CARE ATTRIBUTES AND DISTINCTIVE FEATURES

The extent, scope, and types of enabling services provided by MCOs that enroll Medicaid eligibles are likely to reflect the somewhat varying needs of the populations being served by the Medicaid MCOs. State regulatory requirements can also influence the availability of enabling services. The organization or configuration of these MCOs could influence the extent, type, and manner in which enabling services are made available. For example, some MCOs may favor centralization of enabling services; others might be more likely to subcontract or rely on community-based providers to provide enabling services. Before examining whether organizational or regulatory factors influence the provision of enabling services, we begin with a baseline profile of the Medicaid MCOs—as reported by the MCOs in Spring of 1998.

Years Serving Medicaid Populations

Managed care is a relatively recent innovation for Medicaid; four out of 10 respondent plans (42 percent) reported having more than four years Medicaid experience (i.e., they were enrolling Medicaid recipients prior to 1995). Thirty-eight percent of our sample commenced Medicaid enrollment in 1995 or 1996, and 20 percent began serving Medicaid enrollees in 1997 or 1998. These statistics reflect HCFA's recent approvals of Medicaid managed care waivers, further powers granted to the states to implement Medicaid managed care enacted with the Balanced Budget Act of 1997, and states' rapid implementation activities across regions and within nearly every state.

Geographic Location

By Spring 1998, MCOs were enrolling Medicaid populations in the vast majority of states. Medicaid MCOs were in place in all but seven states. New York state had the largest number of contracts with Medicaid MCOs (37) and 10 states had only one or two contracts. We obtained responses of at least 50 percent from all geographic regions of the U.S. with the exception of the East North Central region (Ohio, Indiana, Illinois, Michigan, and Wisconsin). This is primarily due to a poor response rate in Michigan, where we received responses from only 31 percent of the 26 plans we identified. Other states with a response rate of less than 45 percent include Hawaii, Maryland, Massachusetts, Minnesota, New Mexico, Oklahoma, and Tennessee.[†]

Sixty three percent of MCOs reported that they served both urban and rural Medicaid populations. Thirty percent served only urban Medicaid populations, and only 7 percent (13 plans) served only rural populations.

[†]To preserve plan confidentiality, we do not present any state-level estimates in this report.

Table A1.
Plan Distribution by Geographic Region and Response Rates by Geographic Region

Region	Number of Responding Medicaid	Percentage of all U.S. Medicaid MCOs	Universe of Medicaid MCOs	Response Rates by U.S. Region*
New England	16	8.1%	25	64%
Middle Atlantic	30	15.2%	54	56%
South Atlantic	31	15.7%	57	54%
East North Central	33	16.7%	74	44%
East South Central	8	4.0%	16	50%
West North Central	16	8.1%	27	59%
West South Central	11	5.6%	16	69%
Mountain	21	10.6%	31	68%
Pacific	32	16.2%	58	55%
Total US	**198**	**100%**	**358**	**55%**

**Percentage of plans within that region that responded to the survey*

Configuration of the Delivery System

Prior to the 1990s, plan type and configuration—for example, sponsorship or organizational structure—were viewed as important factors in understanding plan incentives or explaining differences across plans. (Kongstvedt, 1996, p.40). Medicaid MCOs come in a variety of managed care models. Some are conventional managed care models such as staff models or Independent Practice Associations (IPAs); others are framed by Federal or state rules. For example, HCFA's HIOs (health insuring organizations), Comprehensive Managed Care Organizations, or PHPs (prepaid health plans) are managed care models that may or may not be licensed as HMOs.

Increasingly, however, model type is becoming a less useful method of classifying managed care organizations. "Managed care is on a continuum, with a number of plan types offering an array of features that vary in their abilities to balance access to care, cost, quality control, benefit design, and flexibility" (Kongstvedt, 1996 p. 44). MCOs can operate more than one model (the so-called "mixed model"), and the traditional categories of MCO models (group, staff, IPA, and network) do not offer concrete information about managed care strategies that influence plan incentives and behaviors, such as type and extent of gatekeeping, scope of utilization review, or provider payment arrangements or carve-outs.

Our survey documents a shift from staff and group models to IPAs and networks (see Table A2). Only seven of our respondent MCOs identified themselves as group-only or staff-only model organizations. Forty-seven percent were network-only plans, and 21 percent identified themselves as having IPA configurations. The other MCOs were mixed-models; six percent had network and group or staff model organizations, and 14 percent had both an IPA and a network. Only three percent of the MCOs were sponsored by a local health department, a community health center, or other provider organization.

About three-quarters of the respondent sample classified themselves as licensed HMOs (with no other Medicaid certified organizations such as HIOs or PHPs). The remaining quarter indicated that they had some other type of special Medicaid designation, either in conjunction with a more formal HMO or as a separate entity, for example, an MCO sponsored by a group of community health centers or a health department.

Table A2.
Medicaid MCOs—Configuration of the Delivery Systems

MCO Model Types Offered	Number of Plans	Percentage of plans
Group or staff only	7	4%
Network only	92	47%
IPA only	42	21%
IPA plus network	28	14%
Group/Staff plus Network	12	6%
Group/Staff plus IPA	2	1%
Group/Staff plus IPA plus Network	12	6%
Other (health department, CHC)	3	2%

Provider Requirements to Serve Medicaid Enrollees

Plans also differ with regard to whether distinct and separate provider panels are available to different groups of enrollees or different "products lines." Commercial plans, for example, can organize their managed care products differently for privately insured or Medicaid enrollees by maintaining separate panels of providers for each product or group of enrollees. Alternatively, MCOs can require providers with whom they contract to accept both privately insured and Medicaid enrollees within their panels.

Most MCOs that enroll Medicaid populations also serve non-Medicaid populations—primarily enrollees with private employment or individual insurance. There has been some speculation that MCOs that serve only Medicaid populations may organize and operate differently than MCOs that serve both Medicaid and privately insured or Medicare populations. For example, a study of the American Medical Association's Socioeconomic Monitoring System survey for 1992 and 1993 showed that physicians who specialize in serving Medicaid patients differ significantly from physicians who accept capitation, with respect to training, specialty and practice size, and location, and that physicians who have significant private insurance earnings are less likely to participate in Medicaid (Simon, 1997).

Plans licensed only as HMOs were far less likely to serve exclusively Medicaid enrollees (16 percent compared with 63 percent of the other types of plans). Of plans that require providers to include Medicaid enrollees on their panels, 83 percent were HMO-only; 89 percent of plans that do not require Medicaid contracting are Medicaid-only. Looking at these plans in another way, Table A3 shows that while HMO-only plans are more likely to include commercial enrollees than are other plans, plans that include other types of Medicaid MCOs are more likely to serve

Table A3.
MCO Providers Serving Medicaid Enrollee—HMO-Only MCOs Compared with Other MCOs

Medicaid CO Certification	Plan serves Medicaid and non-Medicaid enrollees; may maintain separate provider panels	Plan serves Medicaid and non-Medicaid enrollees; all providers must serve Medicaid enrollees	Medicaid-only plan
HMO-only	49%	35%	16%
Other managed care organization (may also include HMO)	16%	20%	63%

Table A4.
MCO Providers Serving Medicaid Enrollees, by Age of Medicaid Contract

MCO Medicaid Contracting Requirements	Percentage of plans with Medicaid contract prior to 1995	Percentage of plans that began began Medicaid MCO in 1995 or 1996	Percentage of plans that began Medicaid MCO after 1996
Plan serves Medicaid and non-Medicaid enrollees; may maintain separate provider panels	40%	35%	25%
Plan serves Medicaid and non-Medicaid enrollees; all providers must serve Medicaid enrollees	49%	42%	9%
Medicaid-only plans	35%	37%	28%

only Medicaid enrollees. Table A4 shows that the newest plans B those acquiring contracts with Medicaid departments after 1996 B are more likely to be either commercial plans with separate panels or Medicaid-only plans, and less likely to require providers who have private panels to serve Medicaid enrollees.

Medicaid Populations by Medicaid Program Eligibility

Because people may receive Medicaid through eligibility in a variety of state programs, MCOs which serve predominantly pregnant women and children (eligible through the past Aid to Families with Dependent Children or AFDC, now called Temporary Assistance to Needy

Families or TANF, may find different enabling services to be more useful than MCOs that also serve disabled, blind, or other categorically eligible populations. Our Medicaid MCOs reported serving both AFDC/TANF recipients, predominately women and children, and other Medicaid eligibles such as the SSI and disabled populations. Sixty-five percent of MCOs reported enrolling disabled, SSI, or other non-TANF Medicaid-eligible populations. Not surprisingly, MCOs report that women of childbearing age were a rather large part of their clientele. Twenty-five percent of the MCOs reported that more than half of their Medicaid enrollment are women of childbearing age; 46 percent reported that between 25 and 50 percent of their enrollments were women of childbearing age.

Turnover appears to be quite high as Medicaid enrollees tend to remain enrolled in a given Medicaid MCO for relatively short periods of time. Half of the MCOs report that the average length of Medicaid enrollment is less than one year; an additional 30 percent estimate an average length of Medicaid enrollment of less than two years. These enrollment statistics, combined with the comparatively new MCOs serving Medicaid markets, suggest that MCOs must serve successive groups of potentially underserved and potentially increasingly medically complex enrollees. The high turnover rates may persist as the welfare-to-work reforms move AFDC/TANF non-pregnant women off of Medicaid.

APPENDIX B: METHODOLOGY

We attempted to contact all Medicaid managed care organizations existing in the spring of 1998. To define our Medicaid MCO sample, we started with a 1998 list of state Medicaid Directors with contact information. We also cross-referenced these state Medicaid MCO lists with lists available from the Health Care Financing Administration (HCFA) and the *Interstudy Competitive Edge* database to compile a reasonably comprehensive list of plans with Medicaid enrollees.

In each of the state Medicaid offices, there are either administrative units or designated staff responsible for MCO contracts and related information. Through screening calls to the state Medicaid Directors we confirmed that the state had Medicaid MCO contracts with one or more managed care plans. We requested and obtained lists of plans that had a current capitation contract with the state Medicaid program and were enrolling Medicaid eligibles. The requested Medicaid MCO information included the plan name, mailing address, plan contact and phone number.

Based on available information (combining the Medicaid Directors, HCFA, and InterStudy lists), our preliminary survey list sought to include MCOs that had a full-capitation contract with a state Medicaid program. We excluded from the sampled plans with (1) Primary Care Case Management (PCCM) contracts, limited risk health arrangements (e.g., only primary care or PCPs) and specialty risk arrangements (e.g., dental only or behavioral services plans). With available information (from state, HCFA or plans), we attempted to eliminate plans that were serving fewer than 100 Medicaid enrollees.

At least two phone follow-up calls were made to each of the MCO contacts, and for many plans we made as many as six follow-up calls. Second, and occasionally third, mailings were made to those MCOs that were unable to locate the questionnaire.

It is important to observe that it is difficult to identify the universe of Medicaid MCOs for several reasons:

- There is no up-to-date national list of Medicaid MCOs. Both HCFA's list and the *InterStudy Directory* were dated and incomplete, and did not provide contact information necessary for a mail survey;

- State lists of Medicaid MCOs were somewhat out-of-date. Annually updated state Medicaid plan lists failed to incorporate mid-year changes such as plan mergers, cease participation in Medicaid, bankruptcy or inability to commence Medicaid enrollment as initially planned;

- Markets are very volatile. Some plans dropped out of the Medicaid program or ceased enrollment during the time between our calls to obtain status and mailing information and fielding of the questionnaire;

- Complex and different contracting arrangements made it difficult to obtain an accurate, up-to-date count of the Medicaid MCOs within the state—some MCOs are managed by a central Medicaid umbrella plan that has a single contract with a state Medicaid

program but multiple service plans within the state (e.g., California where the one umbrella organization managed multiple Medicaid MCOs); in other cases, a MCO had contracts with several states; and in a few instances, we found a state plan administered by an out-of-state MCO (e.g., some Pennsylvania MCOs managed MCOs in Delaware or New Jersey).

Based on our final list of Medicaid plans, our final response rate was 55% and our hard refusal rate was 28%.

APPENDIX C: SURVEY INSTRUMENT

SURVEY OF MEDICAID MANAGED CARE ORGANIZATIONS

This survey of Medicaid managed care organizations (MCOs) has been commissioned by the Henry J. Kaiser Family Foundation. We are interested in learning about the extent to which Medicaid MCOs offer health-related support or enabling services to Medicaid enrollees. Health-related support or enabling services include, for example, transportation, interpretation/translation, case management, and various health promotion education or support services.

Confidentiality is guaranteed. We assure you that the analysis will present only aggregate statistics to profile the overall Medicaid managed care experience. Each responding managed care organization will receive a copy of the survey results. Thank you for your time and valuable assistance.

If you have any questions please call Rachel Ermann at 202-296-1818

Medicaid Managed Care Organization (MCO)

Name _____

MCO State _____

Q1. ***Does your Medicaid contract cover (check all that apply):***

☐ AFDC/TANF ☐ SSI ☐ Other _____
Please specify

Q2. ***Your Medicaid MCO is (check all that apply):***

☐ Independent Practice Association (IPA)

☐ Network

☐ Staff or group model

Q3. ***Is your Medicaid MCO any of the following:***

☐ Health Maintenance Organization (HMO)

☐ Prepaid Health Plan (PHP)

☐ Provider Sponsored Organization (PSO)

☐ Community Health Center-sponsored HMO

☐ Health Insuring Organization (HIO)

☐ Other _____
Please specify

Q4. ***Are any of the following organizations in your Medicaid MCO network (check all that apply):***

☐ Federally Qualified Health Center (FQHC)

☐ Local Health Department

☐ Rural Health Clinic (RHC)

☐ Ryan White or HIV/AIDS Clinic

☐ Reproductive Health Center

TRANSPORTATION SERVICES (NON-EMERGENCY)

T1. ***Does your Medicaid MCO offer non-emergency transportation services?***

☐ Yes, provided directly by MCO

☐ Yes, provided directly by state's Medicaid department/program ▶ (Skip to **Interpretation, Bilingual and Translation Services**, page 3)

☐ No ▶ (Skip to **Interpretation, Bilingual and Translation Services**, page 3)

T2. ***What transportation services does your MCO provide for Medicaid enrollees (check all that apply):***

☐ MCO vehicles—limo/van/bus/car

☐ Public transportation reimbursement (bus/subway/other public transportation)

☐ Cab fare

☐ Volunteers from community

☐ Other _____

Please specify

T3. ***How are your Medicaid MCO's transportation services organized?***

☐ Centralized at plan level

☐ Decentralized at site/provider level

☐ Subcontracted to an agency that specializes in transportation services

☐ Other _____

Please specify

T4.***Who authorizes use of transportation services (check all that apply):***

☐ No one

☐ Appointment scheduler/receptionist

☐ Transportation coordinator

☐ Case manager

☐ Primary care physician

☐ Other _____

Please specify

T5. ***Must the Medicaid enrollee document that other transportation was not available?***

☐ Yes ☐ No

T6. ***Approximately how many trips does your Medicaid MCO provide annually?***
_____ ***Trips/year***

T7. ***Is MCO payment for transportation services for non-emergency care or routine office visits:***

☐ Included in state Medicaid capitation rate

☐ Not included in state Medicaid capitation rate

T8. ***How are transportation expenses covered (check all that apply):***

☐ Advance payment to enrollee

☐ Reimbursement to enrollee

☐ MCO Vehicles

☐ Included in subcapitation rate to transportation service

☐ Other _____

Please specify

T9. ***Does your state Medicaid MCO contract require that you provide transportation services?***

☐ Yes ☐ No

INTERPRETATION, BILINGUAL AND TRANSLATION SERVICES

I&T1. ***Does your Medicaid MCO offer interpretation/bilingual/translation services?***

☐ Yes, provided directly by MCO

☐ Yes, provided directly by state's Medicaid department/program ▶ (Skip to **Education Services**, page 5)

☐ No ▶ (Skip to **Education Services**, page 5)

I&T2. ***Estimated percentage of your Medicaid enrollment for whom English is a second language:***

☐ Less than one percent ☐ Ten to twenty-five percent

☐ One to five percent ☐ Twenty-five to fifty percent

☐ Five to ten percent ☐ More than 50 percent

I&T3. ***Among your Medicaid MCO enrollees, what are the three (3) most common languages other than English?***

Language _____ _____% of Medicaid enrollees

Language _____ _____% of Medicaid enrollees

Language _____ _____% of Medicaid enrollees

I&T4. ***For how many languages does your Medicaid MCO provide interpretation or bilingual services:***

I&T5. ***What is the basis for your decision to provide interpretation or bilingual services for a specific language?***

☐ State-specified threshold _____
Please specify threshold

☐ Plan-specified threshold _____
Please specify threshold

☐ Other _____
Please specify

I&T6. ***Do your interpretation or bilingual services include any of the following (check all that apply):***

☐ Contracts with bilingual primary care physicians

☐ Multilingual appointment line

☐ Multilingual contact for triaging after hours care

☐ Multilingual health advice line

☐ Multilingual complaint process

☐ AT&T language line or other telephone service

☐ On-call interpreters for primary care or specialist appointments

☐ Interpretation or bilingual services for health education classes or counseling

☐ TDD lines (for hearing-impaired)

☐ Signed interpretation

☐ Other _____
Please specify

I&T7. ***What approaches do you use to provide interpretation or bilingual services (check all that apply):***

☐ Staff:

☐ Bilingual medical staff: ▶ Is bilingual competency assessed? ☐ Yes ☐ No

☐ Bilingual non-medical staff (e.g. receptionist)

▶ Is bilingual competency assessed? ☐ Yes ☐ No

☐ Professional interpreters assigned only to interpretation duties?

☐ Contract services:

☐ Interpreters trained in medical terminology

☐ Interpreters with no specific medical terminology training

☐ AT&T language line or other telephone service

☐ Volunteers:

☐ Community volunteers ▶ is bilingual competency assessed? ☐ Yes ☐ No

☐ Friends and family

☐ Other _____

Please specify

I&T8. ***Does your Medicaid MCO contract require you to include bilingual PCPs in your network?***

☐ Yes ☐ No

I&T9. ***Do any of your contracts with providers require interpretation or bilingual services:***

☐ Yes, all providers in the network

☐ Yes, selected providers in the network

☐ No

I&T10. ***Do you translate any of the following (check all that apply):***

☐ Plan brochure

☐ Plan handbook

☐ Enrollment information

☐ Physician choice information

☐ Print advertisements

☐ Radio/TV advertisements

☐ Consumer satisfaction survey

☐ Patient bill of rights

☐ Consent forms

☐ Health education literature/videos

☐ Medication/Rx information

☐ Medical history forms

☐ Fact sheets

☐ Other _____

Please specify

I&T11. ***Is language preference and/or ability assessed at enrollment?***

☐ No ☐ Yes ▶ ☐ by plan staff

☐ by state staff

☐ by enrollment brokers

☐ Other _____

Please specify

I&T12. ***Do you offer training/orientation for participating providers to help them understand the special care needs of non- or limited-English speaking enrollees?***

☐ Yes ☐ No

I&T13. ***Do you offer training/orientation for participating providers to help them understand the special care needs of vulnerable/low income enrollees?***

☐ Yes ☐ No

I&T14. ***Is MCO payment for interpretation and/or translation services:***

☐ Included in state capitation rate

☐ Not included in state capitation rate

I&T15. ***Does the state Medicaid MCO contract require that you provide interpretation, bilingual or translation services?***

☐ Yes ☐ No

EDUCATION SERVICES/HEALTH PROMOTION

ED1. ***Does your Medicaid MCO provide any of the following <u>health promotion services</u> (check all that apply):***

☐ MCO orientation programs

☐ Health education classes

☐ Fact sheets/informational literature/brochures

☐ Referrals to community-based classes/support groups

☐ Home visits for assessments and counseling

☐ One-on-one health counseling during routine visits

☐ Medical advice hot-line

☐ Informational campaigns (media, health fairs)

☐ Health promotion videos

☐ Reminders for appointments

☐ Reminders for preventive care services (e.g. immunizations, mammography)

☐ Peer counselors, peer group leaders

☐ Outreach workers

☐ Other _____

Please specify

ED2. ***Do you offer <u>education classes/support groups</u> that target (check all that apply):***

☐ Perinatal	☐ Cervical cancer screening	☐ Asthma management
☐ Parenting skills	☐ Breast cancer screening	☐ Diabetes management
☐ High-risk infants	☐ Substance abuse counseling	☐ Arthritis management
☐ Stress and anxiety	☐ Lead poisoning screening	☐ Hypertension reduction management
☐ Smoking cessation	☐ STD prevention	☐ Depression
☐ Nutrition/diet	☐ HIV/AIDS prevention	☐ Domestic violence

☐ Other _____

Please specify

ED3. ***Does your Medicaid MCO provide any <u>monetary incentives</u> to encourage Medicaid enrollees to (check all that apply):***

☐ Reduce inappropriate emergency room use	☐ Obtain mammograms
☐ Attend perinatal classes	☐ Obtain Pap tests
☐ Keep appointments	

☐ Other _____

Please specify

ED4. ***Have you implemented any <u>other incentives</u> to promote appropriate health-related behaviors (e.g. keeping appointments, reducing inappropriate use of the emergency room, or encouraging preventive care)?***

☐ No ☐ Yes _____

Please briefly describe these incentives, or attach information on the initiative

ED5. ***Does your Medicaid MCO provide any health promotion equipment (check all that apply):***

☐ Telephones

☐ Helmets

☐ Car seats

☐ Baby supplies (e.g. diapers/formula)

☐ Beepers/pagers

☐ Other _____

Please specify

ED6. ***Is payment for health promotion or prevention education service(s):***

☐ Included in state capitation rate ☐ Not included in state capitation rate

ED7. ***Does your state Medicaid MCO contract require that you provide specific education services?***

☐ No ☐ Yes ☐ Other _____

Please specify

CASE MANAGEMENT SERVICES

CM1. ***What methods do you use to identify candidates for case management (check all that apply):***

☐ Assessed during routine primary care visit

☐ Assessed during emergency/urgent care encounter

☐ Case finding through population-based screening

☐ Risk assessment/medical history

☐ Other _____

Please specify

CM2. ***Does a Medicaid enrollee qualify for targeted case management if he/she has any of the following conditions or characteristics (check all that apply):***

☐ Pregnancy	☐ HIV/AIDS	☐ Eating disorder
☐ Substance Abuse	☐ Diabetes	☐ Victims of violence
☐ Coronary Disease	☐ Arthritis	☐ Developmental disability
☐ Stroke	☐ High-risk infant	☐ Mental illness
☐ Cancer	☐ High-risk youth	☐ Hypertension
☐ Asthma		

☐ Other _____

Please specify

CM3. ***Please estimate the number or percentage of your Medicaid MCO's enrollees that receive targeted case management in a recent 12 month period for each of the following conditions (or NA for none):***

Asthma	▶ _____	Medicaid enrollees	**Or** _____	% of Medicaid enrollees
Diabetes	▶ _____	Medicaid enrollees	**Or** _____	% of Medicaid enrollees
Hypertension	▶ _____	Medicaid enrollees	**Or** _____	% of Medicaid enrollees
Pregnant women	▶ _____	Medicaid enrollees	**Or** _____	% of Medicaid enrollees

CM4. ***How have you organized your case management services for Medicaid enrollees (check all that apply):***

☐ Centralized at plan level

☐ Decentralized at site/provider level

☐ Subcontracted to an agency that specialized in case management services

☐ Other _____

Please specify

CM5. ***Does your Medicaid MCO have contracts, agreements or letters of understanding with any of the following community-based organizations or programs (check all that apply):***

☐ WIC

☐ Legal aide agencies

☐ Housing authorities

☐ HIV/AIDs (e.g. Ryan White agencies)

☐ Meals on Wheels

☐ School-based health clinics/centers

☐ Maternal and Child Health agencies

☐ Head Start programs

☐ Local Health Departments

☐ Social service agencies

☐ Substance abuse treatment programs

☐ Community mental health centers

☐ Visiting Nurse Association

☐ Job training agencies

☐ Home health agencies

☐ Literacy programs

☐ Early intervention programs (Parts B and H of the Individuals with Disabilities Act)

☐ Other _____

Please specify

CM6. ***Do you have a formal process for confirming that the Medicaid enrollee contacted the community-based organization subsequent to referral for services?***

☐ Yes ☐ No

CM7. ***Is payment for case management services:***

☐ Included in state capitation rate

☐ Not included in state capitation rate

CM8. ***Does your state Medicaid MCO contract require that you provide case management services?***

☐ Yes ☐ No

SATISFACTION AND EVALUATION

S1. ***Do you assess consumer satisfaction with enabling services (check all that apply):***

☐ Transportation

☐ Interpretation and translation

☐ Education/health promotion

☐ Case management

☐ Other _____

Please specify

S2. ***How do you assess satisfaction with these enabling services (check all that apply):***

☐ Consumer satisfaction surveys
☐ Complaint boxes
☐ Informal interviews with Medicaid enrollees
☐ Tallies from consumer hotlines
☐ Focus groups
☐ Other _____
Please specify

S3. ***Does your plan collect data on the use of enabling services (check all that apply):***

☐ Transportation
☐ Education/health promotion
☐ Interpretation and Translation
☐ Case management
☐ Other enabling services _____
Please specify

S4. ***Does your plan collect data on the costs of enabling services (check all that apply):***

☐ Transportation
☐ Education/health promotion
☐ Interpretation and Translation
☐ Case management
☐ Other enabling services _____
Please specify

S5. ***Have you assessed the <u>value or effectiveness</u> of enabling services for Medicaid enrollees (check all that apply):***

☐ Transportation
☐ Education/health promotion
☐ Interpretation and Translation
☐ Case management
☐ Other enabling services _____
Please specify

S6. ***Do your Medicaid enrollees have access to (check all that apply):***

☐ Medicaid member services unit
☐ Grievance/support hotline
☐ Medicaid ombudsman/consumer representative

S7. ***Does your plan offer childcare for Medicaid enrollees who bring young children to appointments?***

☐ Yes ☐ No

BACKGROUND

B1. ***First year of your plan's Medicaid MCO contract?***

From _____(month) _____(year)

B2. ***Estimated current Medicaid enrollment*** [__ __, __ __ __, __ __ __] as of (date)_____

B3. ***Estimated current total enrollment*** [__ __, __ __ __, __ __ __] as of (date)_____

B4. ***Based on your experience, what is the average length of enrollment of Medicaid MCO enrollees?***

☐ Less than one year ☐ More than two years

☐ One to two years ☐ NA/plan is too new to evaluate

B5. ***Estimated percentage of Medicaid MCO enrollees that are females of childbearing age:***

☐ One to ten percent ☐ Fifty to seventy-five percent

☐ Ten to twenty-five percent ☐ More than seventy-five percent

☐ Twenty-five to fifty percent

B6. ***Is your Medicaid population urban (MSA and suburbs), rural or both?***

☐ Urban ☐ Rural ☐ Both Urban and Rural

B7. ***Do your contracts with providers who serve commercial plan enrollees require them to accept Medicaid enrollees onto their panels?***

☐ Yes, all provider contracts

☐ Yes, some provider contracts

☐ No

☐ Not applicable, Medicaid-only MCO

B8. ***For group, staff and network models: Estimated number of MCO locations that serve Medicaid enrollees?***

[__ __ __] sites (clinics or groups)

B9. ***Estimated number of primary care physicians in your MCO who treat Medicaid enrollees (all sites):***

[__ __, __ __ __] primary care physicians

(Primary care physicians include general practitioners, general internists, OB/GYNs and pediatricians)

Please attach other relevant information about enabling services that your Medicaid MCO offers.

☐ See information enclosed

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