



A Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care

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March 2015**

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Acknowledgements

Our sincere thanks to Jane Perkins, Legal Director of the National Health Law Program, for her thoughtful comments and edits; Sheldon V. Toubman, Staff Attorney at New Haven Legal Assistance Association, for his insights and assistance; and Gretchen Gaskill, NHeLP Office Manager, and Derek Carr, Legal Intern for checking cites, links, and making the document ready for publication.

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1. Introduction

The National Health Law Program has studied and monitored Medicaid managed care at the federal, state, and local levels since the 1980s. Over that time, we have supported advocates, beneficiaries, and others as they work to obtain information about and improve Medicaid managed care systems that serve low-income people. We have drawn upon our decades of experience to create this Guide to support stakeholders as they embark on, or continue to engage in, Medicaid managed care work.

When Congress first introduced managed care into the Medicaid program, it primarily served children and their caretaker relatives. But as of 2011, nearly 75% of Medicaid beneficiaries received services through some type of managed care arrangement – and that proportion is surely higher today.¹ Most Medicaid beneficiaries are now enrolled in capitated managed care plans, including Managed Care Organizations (MCOs), which receive a fixed per-member, per-month “capitated” fee, regardless of how many services an enrollee may actually need. MCOs assume the risk that the services they provide will cost more than the capitated payments they receive. Medicaid managed care programs are different from traditional fee-for-service systems, in which providers are paid for each service rendered. The key to successful managed care is ensuring that financial incentives do not result in under service because, in contrast to fee-for-service, the less care provided, the more payments are retained by the MCO. Thus, accountability protections and quality performance metrics are vital tools to ensure that MCOs and other types of capitated plans provide services when they are needed. This is particularly true as plans more frequently enroll vulnerable populations with disabling and chronic conditions who require more frequent care and, often, more specialty services.²

This Guide describes federal Medicaid managed care monitoring and oversight requirements. It provides a robust set of tools, tips and techniques to obtain information about Medicaid managed care programs. Finally, it explains how to use this information to ensure that managed care companies and state Medicaid agencies are fulfilling their obligations to enrollees and to taxpayers. The National Health Law Program’s managed care team is available to work with you as you use this Guide.

Where to Start

The Centers for Medicare & Medicaid Services (CMS) recently posted [Managed Care State Profiles](#), which provide an overview of states' managed care. The profiles include information on most state’s Medicaid managed care companies, what populations are enrolled, services provided, and quality activities.

What Is In This Guide?

NHeLP's *Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care*:

- Describes federal laws, regulations, and guidance that require managed care plans and state Medicaid agencies to ensure access to and quality of care;
- Identifies key data collection and reporting requirements in federal law;
- Directs advocates where and how to obtain data and other information; and
- Explains how to use data and information to assess the performance of managed care plans and the state's oversight efforts.

Who Should Use This Guide?

- Advocates, Medicaid beneficiaries, policy makers, researchers, journalists, and other interested parties.

2. Overview

2.1 *Pre-paid, Risk-based Managed Care*

There are four models of Medicaid managed care entities (MCEs):

- **Managed Care Organizations (MCOs):** entities that provide a comprehensive package of services in exchange for a payment for each enrollee, called a "capitation payment." MCOs enter into "comprehensive risk contracts," through which they agree to provide certain services and incur a loss if the cost of providing services exceeds the capitated payment. They are typically required to offer only a limited number and type of services, but may offer more.³
- **Prepaid Inpatient Health Plans (PIHPs):** entities receiving capitated payments that have the responsibility to provide inpatient hospital or institutional services but do not have comprehensive risk contracts. That is, unlike MCOs, they do not offer a comprehensive package of services.⁴
- **Prepaid Ambulatory Health Plans (PAHPs):** entities that receive capitated payments but do *not* provide inpatient or institutional services and do not have comprehensive risk contracts. Many states use this model to cover non-emergency medical transportation, and several states use it for other limited services such as dental or maternity care.⁵

- **Primary Care Case Managers (PCCMs):** Primary care providers that receive a monthly per person fee to coordinate care for beneficiaries. Services rendered by the provider are reimbursed on a fee-for-service basis.⁶

In risk-based, capitated managed care systems, plans receive a fixed, per-member per-month payment to provide Medicaid benefits and services to enrollees. MCOs incur a loss if the cost of providing services exceeds the capitated payment. But if enrollees use fewer services, the plan keeps the excess payment. Managed care promises savings by reducing unnecessary treatments and services. However, it is important that stakeholders monitor capitated systems be monitored to ensure that enrollees are receiving necessary care.

A Note on Terminology

Much of the discussion in this Guide focuses on MCOs, which are the predominant form of managed care in the Medicaid program. PIHPs are almost universally subject to the same managed care requirements as MCOs. However, PAHPs are not subject to all the same rules, including most notably the performance measurement, external quality review and grievance and appeals requirements. When the Guide discusses issues or rules related to all types of Medicaid managed care entities, it will refer to “managed care entities” or “managed care plans.” When it is focusing on a particular type of entity – MCO, PHP, or PCCM – that will be clearly indicated in the text.

Because PCCMs do not receive capitated payments, the Guide does not devote significant discussion to them.

2.2 Legislative Background

In 1976, in response to Medicaid managed care scandals in California and Illinois, Congress established standards for managed care organizations and other prepaid entities wishing to participate in Medicaid.⁷ That legislation prohibits federal funding to states unless managed care plans comply with specified accountability and stewardship requirements.⁸ Among other things, the contracts between the state and each managed care entity must assure that it does not discriminate on the basis of health status or need, that beneficiaries have right to disenroll consistent with federal requirements, that the state can audit and inspect the managed care entity’s books and records, and that the plan will maintain adequate patient encounter data to identify the providers who deliver the services to patients.⁹

In the early 1980s, Congress and the Administration enacted legislation to encourage increased enrollment in Medicaid managed care. Under traditional Medicaid rules, enrollees have the freedom to obtain services from any qualified, Medicaid-participating provider that will accept them.¹⁰ States may, however, obtain permission from the U.S.

Department of Health and Human Services (HHS) to waive this Medicaid provision so that beneficiaries can be required to enroll in managed care plans and obtain services through the plan's provider network.¹¹

To protect enrollees and ensure that the state and federal governments are getting value for taxpayer dollars, Medicaid managed care regulations require states and health plans to engage in monitoring, quality measurement, and improvement activities.

Mandatory Enrollment in Medicaid Managed Care

States can implement mandatory managed care for most Medicaid populations through a simple state plan amendment.¹² However, certain populations can only be enrolled in mandatory managed care when states obtain special permission from the federal government using waiver authority or demonstration projects.¹³ These protected populations are: (1) individuals eligible for both Medicare and Medicaid (dual eligible), (2) children under age 19 with special needs, and (3) most Native Americans.¹⁴ States are increasingly seeking to enroll these traditionally exempt populations in managed care.

2.3 Consumer choice of managed care plan

States that require beneficiaries to enroll in Medicaid managed care must, with limited exceptions, provide each enrollee a choice between at least two managed care plans.¹⁵ In theory, consumer choice provides plans with the incentive to provide high quality services and care to attract enrollees, while poorly performing plans are effectively penalized with fewer enrollees. However, in practice, consumers may be unaware of their healthcare options, as well as protections and rights for obtaining care. They also may not know whether a particular plan is performing well.

2.4 Information to help consumers make informed choices

Federal law requires states and managed care entities to make certain information available to enrollees and potential enrollees to help them make informed choices. Each state, enrollment broker, and managed care plan must provide "all informational materials ... relating to enrollees and potential enrollees in a manner and in a format that may be easily understood."¹⁶ Written materials must be available in alternative formats and in a manner that accounts for the needs of persons who are, for example, visually limited or have limited reading proficiency.¹⁷

2.5 Managed care contracting

Federal and state laws establish the rules that govern states' Medicaid managed care programs. However, many significant requirements, including crucial consumer protections are established through the contracts between the managed care plans and

state agencies. These contracts describe the rights and responsibilities of the state and the plan. The contract, therefore, offers an additional and significant means to ensure consumer inclusion and enforcement of consumer protections.

States use different approaches to Medicaid contracting. Some states use a competitive bidding process; while other states have any-willing-provider contracting in which the state sets rates and terms, and any health plan that meets those requirements is allowed to participate.¹⁸ A [2012 report from ASPE](#) notes that two states, Florida and Arizona, have a notably transparent bidding process, including opportunities for stakeholder involvement.¹⁹

Managed Care Contracting Resources

There are a number of Medicaid managed care contracting resources available. The National Senior Citizens Law Center provides a [Library of Managed Long Term Services and Supports Contract Provisions](#) from a dozen states.

NHeLP has been collecting actual contracts or RFPs from every state's capitated managed care plan. Please contact [NHeLP's North Carolina office](#) for further information.

NHeLP [released model contract provisions](#) for demonstration managed care programs for persons dually eligible for Medicaid and Medicare.

States may refuse to provide the actual signed contracts with managed care entities, citing exemptions from public records laws for proprietary information. Advocates can generally, however, obtain the Request for Proposals (RFPs) or Request for Applications (RFAs) issued by the state. The RFPs or RFAs are public solicitations in the competitive bidding process that describe, in detail, the requirements under the contract. Generally, RFPs and RFAs are posted in the state's official register. Some states have public notice requirements, such as publishing notices in newspapers. Advocates should also be aware that some states have a dedicated state office or agency for contracting and procurement, so managed care contracting may not necessarily be conducted by the state's Medicaid agency.

TIP: Advocates who need help negotiating their state's budget and contracting activities should check out the [State Priorities Partnership](#) coordinated by the Center on Budget & Policy Priorities. This network of more than 40 independent, nonprofit research and policy organizations focuses on budgeting and finance issues for low income populations. The centers focus on transparency and public engagement in state budget processes.

3. Information on Plan Design and Performance

Federal regulations require states to provide Medicaid beneficiaries information about plan design to help enrollees and potential enrollees understand their available options.²⁰ When states implement mandatory Medicaid managed care and require enrollment in MCOs or PCCMs, agencies must provide enrollees and potential enrollees, annually and upon request, a side-by-side chart comparing:

- managed care plan benefits;
- cost sharing (if any); and
- quality and performance indicators.²¹

While some states post the side-by-side chart on their agency websites, federal law does not require them to do so.

3.1 *Why information about plan design is important*

The side-by-side chart comparing plans and benefits will help consumers understand and select the managed care plan that best suits their needs. Advocates and others should obtain and review their state's plan comparison charts to see if the descriptions are uniform so that people can readily make side-by-side comparisons. Accordingly, stakeholders should press agencies to make such charts widely available, keep them updated, inform people of their options, rights, and responsibilities in easy-to-understand language, and to make consumer education an on-going priority.

3.2 *How to obtain plan design information*

In managed care programs with required managed care enrollment, the chart with side-by-side comparisons of MCO and PCCM plans and benefits must be available to Medicaid enrollees upon request. You can review which of your state's programs have mandatory enrollment on CMS's [Managed Care Profiles](#) web page. Check to see if the state Medicaid agency posts the chart on its website. Advocates who are not Medicaid enrollees may need to submit a public records or FOIA request to obtain these documents from the state Medicaid agency.

TIP: Check to see when the state Medicaid agency last updated the comparison chart and review it to see if it contains all required information, including performance indicators for the plans. Also, ask the agency to request stakeholder input when it next updates the chart.

4. Information on Network Access Standards

States must ensure that all services covered under the state plan are available and accessible to managed care enrollees.²² States have, however, significant flexibility in establishing and enforcing network access standards.²³

Medicaid MCOs, PIHPs, and PAHPs must assure and document for the state their capacity to serve the health care needs of the anticipated number of enrollees.²⁴ This includes demonstrating that the participating plans offer the necessary range of primary, preventive, and specialty services.²⁵ Specifically, plans need to maintain a provider network sufficient in number, type and geographic distribution to meet the needs of its enrollees.²⁶ Proper geographic distribution includes consideration of distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees.²⁷ Plans must also provide female enrollees with direct access to women's health specialists for routine and preventive services.²⁸

Types of Network Access Standards

- Limits on the travel time or distance for enrollees to see a provider
- Limits for wait times for appointments for urgent care, primary care, and specialty care
- Limits on office wait times
- Patient-to-provider ratios for primary and specialty care

See also NHeLP's [Medicaid Managed Care Model Provisions: Network Adequacy](#)

Federal law requires states to review and certify that all managed care networks comply with federal requirements.³¹ States also have the responsibility to monitor plans to ensure that they meet the network adequacy requirements.³² Yet the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) has found that many states simply accept managed care plans' assurances that their provider networks meet the states' minimum standards for access.³³ The OIG found that 22 of the 33 states examined had not found a single violation of network adequacy standards over a five-year period from 2008-2013.³⁴

4.1 Why network access standards are important

Medicaid managed care enrollees cannot receive the services they need unless they have access to adequate provider networks; however, federal regulations do not currently prescribe specific standards governing, for example, the types of providers who

Examples of Contract Provisions for Network Access

- Virginia requires plans to include certain specialty types, like adolescent medicine and nephrology.²⁹
- Wisconsin's contracts for its BadgerCare program require participating plans to meet specific provider ratios, including a 1:100 ratio for primary care providers, a 1:1600 ratio for dentists, and a 1:900 ratio for psychiatrists.³⁰

must be included or maximum travel times and distances. Thus, it is up to the states to establish such standards – or not. Moreover, active monitoring and enforcement of those standards is frequently lacking, as noted by the OIG.³⁵ Accordingly, it often falls to stakeholders to advocate for specific network standards and to identify problems with networks that may be failing to meet enrollees' needs.

4.2 How to obtain network access standards and compliance data

Some states, such as California, establish specific and detailed network access standards through state laws and regulations.³⁶ However, in most states, network access standards and compliance requirements are established through the managed care contracts.³⁷ Many contracts have provisions that require monthly or quarterly reports from MCOs, PIHPs, and PAHPs on their provider networks. Advocates should therefore check their own state law and managed care contracts.

States also contract with External Quality Review Organizations (EQROs) and enrollment brokers. (See Sections 8 & 11, below). Stakeholders should work to obtain and review these contracts and monitor the extent to which states, plans, and brokers consider network access and adequacy when enrolling Medicaid beneficiaries and assessing plan performance.

Mapping Travel Time and Distance

States may also contract with outside consultants to evaluate network access. For example, this study by ABT Associates examines [Travel Time Analysis of Medicaid Managed Care Plans in the District of Columbia](#).

Such analyses typically estimate travel times for enrollees to reach primary care and other providers by measuring distances for walking, driving, and access through public transportation.

In addition, federal law requires states to provide transportation and appointment scheduling assistance to children and their families as part of the Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT) for children and adolescents.³⁸ States must also make available necessary transportation services to assist enrollees get to and from providers;³⁹ and can contract these services to a transportation broker.⁴⁰ Advocates can request non-emergency transportation utilization data from their state Medicaid agencies to get another perspective on provider access and possible barriers to care.

5. Information on Provider Availability

Federal law requires states to monitor all Medicaid MCO and PIHP networks to ensure that enrollees have access to a network of appropriate providers, including adequate numbers and types of geographically accessible providers who are actually accepting Medicaid patients.⁴¹

All Medicaid managed care plans must provide potential and current enrollees the names, locations, qualifications, and availability of health care providers that participate in the specific managed care plan, including non-English languages spoken by current contracted providers and information on providers who are not accepting new Medicaid patients.⁴² Potential enrollees must be given this information when first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among available plans.⁴³ MCOs, PIHPs, and, when appropriate, PAHPs, must send timely written notice to enrollees when one of their regular providers terminates participation in the plan.⁴⁴

5.1 Why is provider availability important?

Availability of providers is at the heart of network adequacy. If enrollees are unable to find a doctor who provides needed services or accepts Medicaid, they will not obtain the services to which they are entitled, regardless of what the state Medicaid plan or managed care contract requires. Moreover, being able to see the same primary care provider and specialists promotes continuity of care, improved coordination of care. Thus, for many enrollees, having access to the right providers represents a key factor in selecting a managed care plan.

EXAMPLE: In December 2014, the HHS OIG published a report – [Access to Care: Provider Availability in Medicaid Managed Care](#). The report found that 51% of providers on Medicaid managed care provider lists were either not longer in business, were not longer participating in Medicaid or the managed care plan, or were not accepting Medicaid enrollees.⁴⁵ The OIG also faulted state Medicaid agencies and CMS for poor oversight of managed care companies.

However, enrollees and advocates often discover that plan provider lists are out of date, and including providers who are no longer part of the network, no longer accepting Medicaid patients, or even no longer in business.⁴⁶ Therefore, enrollees and advocates should not only obtain a plan provider list, but should also verify that providers are actually participating in a managed care network.

5.2 How to obtain network provider lists and monitoring reports

Provider lists – Federal law does not require managed care plans or state agencies to publicly post their provider networks. However, state Medicaid agencies or managed care plans must provide such information to individuals once they have been found

eligible for Medicaid, or at the time of renewal, to help enrollees select a plan.⁴⁷ Advocates and others who are not enrolled in Medicaid may need to file a public records request with the state Medicaid agency to obtain the provider list.

Monitoring reports – Advocates should request and, if necessary, file public records requests with state Medicaid agencies to obtain periodic provider network reports filed by plans, if such reports are required by the contract. The contracts between MCOs or PHPs and Medicaid agencies usually include the requirements governing the sufficiency of provider networks on which plans must report including, for example:

- the number of network providers not accepting new patients;
- wait times to schedule initial and follow up appointments;
- in-office wait times; and
- public transportation travel time between providers and enrollees.

EXAMPLE: The District of Columbia’s Behavioral Health Subcommittee of the Medical Care Advisory Committee (MCAC) [reviewed managed care performance for behavioral health services](#) in 2011. The review found that MCOs complied with contract requirements to provide quarterly network adequacy reports. However, according to the MCAC review, the state Medicaid agency failed to analyze those reports or conduct necessary oversight to ensure that MCO provider networks met the needs of enrollees.⁴⁸

5.3 How to verify a managed care plan provider list

Advocates may want to conduct their own survey of providers to independently validate a managed care plan’s network. Sometimes called “secret shopper” surveys, these can also serve as an effective tool to determine whether providers are accepting new Medicaid patients as well as other metrics such as wait times for an appointment and customer care. Secret shopper surveys have advantages over self-reported data by providing powerful insights into the real-life experience of Medicaid enrollees and the quality of care they receive from managed care plans and providers. Surveys can target access to primary care and specialty care for managed care enrollees or sub-populations such as children or persons with disabilities.

In November 2006, the Connecticut Department of Social Services released results of a secret shopper survey that found that just 26% of calls to pediatricians, dentists, dermatologists, neurologists, and orthopedists resulted in timely appointments for newly enrolled children in the state’s Medicaid managed care plans. The state ultimately ended capitated managed care in its Medicaid program, partly due to concerns raised by the secret shopper survey.⁴⁹

In another recent secret shopper survey, callers using prepared scripts used plan provider directory listings to set appointments with dermatologists in the largest

Medicare Advantage (MA) plans in 12 major metropolitan areas.⁵⁰ More than 45% of the 4,754 provider listings were duplicates. Of the remaining unique listed providers, 18% could not be reached due to incorrect contact information, 8.5% had moved or were no longer working, 8.5% were not accepting new patients, 6.1% claimed to not accept the plan, and over 10% claimed to be subspecialists who would not see a patient with an itchy rash (as stated in the script). Across all MA plans, callers successfully set appointments with only 49% of providers in the directory. Success rates for individual plans ranged from 0 to 78%. Appointment wait time averaged 45 days.⁵¹

Tips for Designing Secret Shopper Surveys

Advocates can design their own secret shopper surveys to measure provider access in Medicaid managed care networks. Here are some issues to consider:

- Make sure you have the most recent provider lists.
- Identify a patient population (e.g., adults, children, persons with disabilities).
- Target provider types (e.g., primary care providers, pediatricians, specialists).
- Develop a fair and replicable method for selecting a sample of providers to call if you do not have the resources to call all providers on the list.
- Develop a standard script when cold calling for appointment.
- Document performance on measures such as whether the provider is accepting Medicaid enrollees and wait times for appointments.
- Publish the results.

Partnering with academic institutions or *pro bono* law firms can provide added resources to conduct secret shopper surveys and boost the profile and reach of published results.

6. Information on Services

States must ensure that managed care enrollees have access to all Medicaid state plan services.⁵² States must also provide that enrollees receive information on managed care plans' responsibilities to coordinate care, including any cost sharing – as well as Medicaid benefits not covered under the managed care contract, including how and where the enrollee can obtain such services.⁵³

States must inform children and families enrolled in Medicaid managed care about coverage of immunizations, the benefits of preventive care, and their choice of providers.⁵⁴ Federal law also requires states to conduct aggressive outreach to children and their families as a part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements.⁵⁵ (See Section 12, below).

State Medicaid agencies must make emergency services available to applicants and beneficiaries whenever needed.⁵⁶ To the extent that such services are included in a managed care contract, either the state or the managed care entity must notify enrollees about:

- the processes and procedures for obtaining emergency care;
- the definition of an emergency condition, which is based on what a “prudent layperson” with average health knowledge would perceive as an emergency;⁵⁷
- locations of hospitals and providers that perform emergency services covered under the contract; and
- the enrollee’s right to obtain emergency care without prior authorization.⁵⁸

States may carve out certain types of services from the managed care contract. The most common types of carve-outs include pharmacy benefits, behavioral services, and dental services.⁵⁹ These services may be provided to managed care enrollees on a fee for service (FFS) basis, or through other types of contracts with prepaid ambulatory health plans (PAHPs) or prepaid inpatient health plans (PIHPs).

Some states have entered into Medicaid managed care contracts that allow religiously controlled plans to carve out the Medicaid-covered reproductive health services to which they object.⁶⁰ The state must inform beneficiaries which services are carved out and how and where they may obtain that care outside the plan’s network.⁶¹

Family Planning Services

Under federal law, enrollment in a managed care plan cannot restrict the choice of family planning services providers.⁶² Federal regulations require states to provide information to enrollees on how to obtain services outside the managed care network, including family planning services.⁶³ For more information, see NHeLP’s [*Medicaid Managed Care and Women’s Health*](#).

6.1 How to obtain information on services

Information on managed care services, cost sharing, and carve-outs may be obtained from state Medicaid agencies and managed care companies. Managed care plans provide enrollees with member handbooks, which detail managed care services, cost sharing, and participating providers. If plans are reluctant to provide their handbooks, stakeholders should request them from the state Medicaid agency.

Stakeholders should pay special attention to carve outs and plans with religious affiliations that may refuse to provide certain Medicaid services, such as contraception, based on religious objections. Enrollees in these plans must be adequately informed of how to obtain these services by reviewing member handbooks, managed care plans’

websites, and requesting copies of introductory enrollment materials from the state Medicaid agency.

EXAMPLE: Fidelis Care is a Catholic-sponsored plan that serves over a million Medicaid enrollees in New York.⁶⁴ The plan's [Member Handbook](#) contains the following disclosure:

Fidelis Care does not cover certain family planning and reproductive health services, such as abortion, sterilization, and prescription birth control. New York State requires us to inform you that you can use your Medicaid card to get these services from any doctor or clinic that accepts Medicaid. You do not need a referral from your PCP to get these services. If you have any questions or need information about these non-covered services, you can call Fidelis Care's Member Services Department at 1-888-FIDELIS (1-888-343-3547). You can also call the New York State Growing Up Healthy Hotline at 1-800-522-5006 to get assistance to obtain a list of Medicaid Family Planning Providers.⁶⁵

7. Consumer Rights and Engagement

Federal law establishes standards and rights to protect enrollees in Medicaid managed care plans. MCOs, PAHPs, and PIHPs must inform enrollees of their rights and protections, including the right to:⁶⁶

- Be treated with respect and dignity;⁶⁷
- Participate in health care decisions;⁶⁸
- Obtain a second opinion;⁶⁹
- Disenroll due to poor quality or lack of access;⁷⁰
- Have timely access to services, including specialists;⁷¹
- Receive information on grievance, appeal, and fair hearing procedures;⁷² and
- Have adequate provider networks.⁷³

Federal non-discrimination provisions, including prohibitions of discrimination on the basis of health status and disability, apply to all Medicaid managed care plans.

- All Medicaid managed care contracts must prohibit discrimination in enrollment, disenrollment, and re-enrollment on the basis of health status or requirements for health services. States may sanction MCOs or PCCMs that engage in such discrimination.⁷⁴
- All managed care plans must comply with the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and other civil rights laws.⁷⁵

- States must consider the extent to which locations where health care services are provided are physically accessible.⁷⁶

Additional provisions require states contracting with MCOs and PIHPs to engage consumers in quality assessment:

- States must obtain input from managed care enrollees and other stakeholders for a written quality improvement strategy and make the strategy available for public comment before adopting it in final.⁷⁷
- MCOs with physician incentive programs (such as an MCO that pays bonuses to certain providers in its network) must survey current and previous managed care enrollees to determine the degree of access and satisfaction with services.⁷⁸

Get Involved! Medical Care Advisory Committees

Federal law requires states to have a Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services, help develop Medicaid policies, and give ideas about how the program should be run.⁷⁹ MCAC members are appointed by Medicaid agency director and must include state officials, physicians and providers who work with low income people, consumer groups, and Medicaid recipients.⁸⁰

MCACs must have the authority to:

- Participate in policy development and program administration, including furthering the participation of recipient members in the agency program;⁸¹
- Review managed care marketing materials in consultation with the state Medicaid agency;⁸²
- Conduct hearings to solicit public comments on §1115 demonstration projects.⁸³

Although MCAC's role is advisory, "the scope of [MCAC's] advisory authority is intended to cover the entire field of state decision-making with respect to the Medicaid program, and is not limited to discrete areas of concern."⁸⁴ MCACs ask for information from the state agency and participating plans.

Advocates should search the web or contact their state Medicaid agency to find out their MCAC membership and meeting times. In addition, ask for a copy of the MCAC's by-laws, meeting procedures, conflict-of-interest rules, as well as meeting agenda and minutes. See NHeLP's [*Your State Too Can Have an Effective MCAC*](#) for best practices and advocacy strategies.

7.1 Why consumer rights and engagement are important

Medicaid enrollees many not know that federal law provides them with certain rights and protections, and may be unlikely to challenge poorly performing programs. Yet, Medicaid enrollees are the real experts when it comes to evaluating what is working and what is not in Medicaid managed care. However, consumer engagement in Medicaid policy and managed care plan performance reviews does not come without effort on the part of state agencies, plans, advocates, and other stakeholders.

7.2 How to obtain information on consumer rights and engagement

Stakeholders should review managed care plan materials that are provided to beneficiaries, such as member handbooks, to assess whether the plans are properly informing enrollees of their rights. Also, they should ask their state Medicaid agencies for documentation showing monitoring and compliance with these requirements. If information is difficult to obtain or indicates problems with compliance, outside assistance should be enlisted, such as the Medical Care Advisory Committee (MCAC) or policymakers.

8. Enrollment

Medicaid beneficiaries may select a managed care plan within 30 days of their eligibility determination or renewal. If they do not choose a plan within that time period, the state Medicaid agency can automatically enroll (auto-enroll) beneficiaries into a plan.⁸⁵ Those who have been auto-enrolled have 90-day window during which they can change plans.⁸⁶ Beneficiaries also can voluntarily disenroll from a plan for cause at any time. Federal law prohibits managed care entities from disenrolling or otherwise discriminating against individuals on the basis of health status.⁸⁷

In general, states must allow beneficiaries to choose from at least two managed care entities.⁸⁸ However, in rural areas, state can require enrollment in a single managed care entity as long as the individual has a choice of not less than two physicians or case managers, to the extent they are available.⁸⁹

8.1 Why it is important to protect enrollment and disenrollment rights

Discrimination, other unfair practices, or technical problems with enrollment can deprive enrollees of the care they need, harming them and wasting taxpayer dollars by paying capitated rates to plans that are not providing services. Information on enrollment practices and data can provide important insights on both plan and state agency performance in this area. Stakeholders should watch for discriminatory outreach and enrollment practices designed to discourage individuals with significant health needs from enrolling in certain plans. Plans may also improperly disenroll members who develop serious health needs or may create administrative barriers to prevent healthier individuals from disenrolling. For example, states with managed long term services and supports (LTSS) programs that carve out nursing home services may create a financial

incentive for plans to deny coverage of home and community-based services, forcing people into nursing homes – and therefore out of the plan.

Extremely high auto-enrollment rates suggest that Medicaid beneficiaries may not be adequately informed about their health care choices and show the need for greater consumer education. Moreover, auto-assignment can result in separating individuals from their providers and family members into different managed care plans.

In addition, voluntary disenrollment from health plans could indicate persistent or widespread deficiencies in plan performance and quality of care.

Marketing Practices

Before Congress imposed greater consumer protections, some Medicaid managed care plans routinely engaged in deceptive or heavy-handed marketing practices, such as falsely telling Medicaid beneficiaries that they would lose coverage if they failed to enroll in a specific MCO, harassing beneficiaries at home, or offering gifts like hair products or smoke detectors.

Federal law now prohibits Medicaid managed care companies from engaging in deceptive, inaccurate, and fraudulent marketing practices.⁹⁰ Plans may not conduct door-to-door or cold-call marketing.⁹¹ Companies may not distribute marketing materials until they have been approved by the state Medicaid agency.⁹² In addition, Medicaid managed care marketing materials must be reviewed by the state's Medical Care Advisory Committee (MCAC).⁹³ For more on MCACs, see Section 7 above.

8.2 How to obtain enrollment information

Federal law requires states to monitor managed care enrollment practices.⁹⁴ States must track how many Medicaid beneficiaries are auto-enrolled in managed care plans.⁹⁵ States must also monitor voluntary disenrollment rates and the reasons beneficiaries have disenrolled themselves, or been disenrolled from, from managed care plans.⁹⁶

States may publicly post managed care plan enrollment but, even if they do not, such data should be obtainable through a public records request or through the MCAC. The data may be found in separate enrollment reports, broker reports, or External Quality Review (EQR) annual reports. Advocates may also request data on auto-enrollment rates, state monitoring activities, or voluntary disenrollment data and reasons from state Medicaid agencies through public records requests.

EXAMPLE: The New York Department of Health posts [monthly enrollment reports](#) which include data on eligibility categories and enrollment for each MCO. These reports also include data on enrollment in the state's Medicaid Managed Long Term Care Program (MLTCP) and other programs.

The District of Columbia's Department of Healthcare Finance also provides a [monthly enrollment report](#) to the MCAC showing the total number of enrollees in managed care, as well as fee-for-service and waiver programs. The reports do not break down enrollment in each MCO, however, and are not regularly posted to the agency's website.

9. Information on Quality Assessment: HEDIS® and Performance Measurement

The predominant set of performance measures in managed care today is the Healthcare Effectiveness Data and Information Set (HEDIS®), published by the National Committee for Quality Assurance (NCQA), a private non-profit organization. Medicare, Medicaid, and many commercial ventures use HEDIS measures as part of their quality assessment programs.⁹⁷ Currently, there are 83 HEDIS measures related to 5 health care domains, including effectiveness of care, access/availability of care, and use of services.⁹⁸ Measures address: (1) asthma medication use; (2) breast and cervical cancer screening; (3) childhood and adolescent immunization status; (4) various aspects of diabetes care; and (6) antidepressant medication management.⁹⁹

HEDIS does allow better comparison across plans and states than many non-standardized performance measures, particularly in the area of acute medical care. But, states or plans may vary data collection methods or choose different measures from other entities, making comparison challenging.¹⁰⁰ In addition, HEDIS measures generally focus on clinical care and on process rather than outcomes. This is problematic because more states are enrolling more people with disabilities and older people in capitated managed care. Many of the long term services and supports that this population needs are not clinical services, or even medical in nature, thus have fallen outside the scope of traditional quality measurement. Thus, HEDIS results can be a useful tool, but use of HEDIS alone does not satisfy all Medicaid quality requirements or address all types of services and subpopulations.

HEDIS® Strengths and Limitations

HEDIS measures often form the baseline for quality assessment of Medicaid MCOs. They provide a useful snapshot of plan performance, and allow some comparison between plans and against national standards, including commercial insurance.

There are inherent limitations to any single performance measure, HEDIS or otherwise. Managed care plans enter and leave the Medicaid program, making long term tracking difficult. Also, HEDIS tends to include only Medicaid beneficiaries with at least a year of continuous eligibility, while the typical Medicaid beneficiary is enrolled for only [nine out of 12 months](#). This renders a portion of the Medicaid population invisible to evaluation.

Finally, much of NCQA's HEDIS performance measure data, member satisfaction surveys and technical measure specifications are only available for purchase from NCQA, often at prohibitive sums. For example, access to a single user license for [NCQA's "Quality Compass" data tool](#) starts at three thousand dollars.

The quality measurement industry is only recently seriously engaged in developing and endorsing new measures of long term services and supports, particularly those provided in the community.

For example, NCQA and other groups are working to expand the number of available validated measures for use to evaluate quality. One important initiative in this area is the National Quality Forum's (NQF) Measure Applications Partnership (MAP), which includes a working group dedicated to identifying key validated measures for beneficiaries dually eligible for Medicaid and Medicare (dual eligible). NQF is a private non-profit that convenes multiple stakeholders to evaluate and endorse performance measures. NQF includes consumer representation in its work groups. The MAP initiative has endorsed an initial core set of measures for individuals who are eligible for Medicare and Medicaid, including several relevant to LTSS, and more importantly has identified key gaps where more LTSS measure development and research is needed.¹⁰¹

FACT: The number of NQF-endorsed measures has climbed sharply in the last ten years to [over 630 in 2014](#).

In December 2014, NQF also launched a new work group to identify and endorse core quality measures for home and community-based services over the next two years.¹⁰² NQF reports are regularly posted for public comment. Also, the National Association of States United for Aging and Disabilities, in collaboration with the Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services, has launched an effort to expand its National Core Indicators survey instrument to cover aging adults and people with physical disabilities as well. That project was piloted in three states in 2014 and will expand to as many as 15 in 2015.¹⁰³

Another source for quality measures are the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) patient surveys developed by the Agency for Healthcare Research and Quality (AHRQ).¹⁰⁴ CAHPS evaluates patient satisfaction with providers or health plans as well as other aspects of the care experience. Plans are not required to conduct these surveys, but a requirement to do so can be included in managed care contracts.

Managed care plans often participate in both the Medicaid and Medicare markets. The Medicare program also provides information useful for Medicaid quality research. CMS rates the performance of Medicare Advantage (Part C) and prescription drug (Part D) plan quality. Known as 5-Star ratings, these ratings are based on administrative data and survey information, including CAHPS and HEDIS measures.¹⁰⁵ These ratings reflect various aspects of plans, including quality of chronic condition management, responsiveness and customer services, the number of complaints and appeals filed, drug pricing and safety, and coverage of preventive services.¹⁰⁶ One star indicates poor and five stars excellent performance.¹⁰⁷ CMS targets “consistent poor performers” that receive an overall rating of less than three stars for at least three years, sending a notice to plan enrollees of the plan’s rating and encouraging them to enroll in other plans.¹⁰⁸

Nearly all dually eligible Medicare and Medicaid beneficiaries are automatically enrolled in Medicare Part D. Moreover, information about Medicare Advantage plans can also be illuminating because several large managed care plans serve Medicaid as well as Medicare Advantage enrollees. Plan ratings can be found on [CMS’ website](#).¹⁰⁹

Finally, CMS is attempting to impose more consistency and comparability through the introduction of core measure sets for [adults](#) and for [children](#).¹¹⁰ While currently voluntary, CMS actively promotes the adoption and standardization of these measures. The [2014 Annual Report](#) shows the state-by-state implementation of the children’s core measures, established in 2011.¹¹¹ Participation has increased substantially each year.

9.1 Why performance measurement is important

Capitated managed care establishes a payment system that is designed to reward plans that avoid providing unnecessary services. This delivery system needs robust mechanisms to monitor and evaluate care quality; otherwise, the structure of capitated managed care could encourage plans to deny or delay even medically necessary care simply to save money. Performance measurement is the principal mechanism for evaluating quality of care.

The federal government has recognized the importance of this information. Regulations require that managed care plans make available to enrollees and others all information related to quality and performance, which may include HEDIS data.¹¹² Finally, as performance measurement becomes more standardized, it allows more meaningful

comparisons between health plans, which may help guide consumers' enrollment and disenrollment decisions, as well as states' decisions regarding contracting.

Health Disparities and Quality Measures

Quality measurement in Medicaid managed care has until recently barely addressed the issue of health disparities.¹¹³ Most performance data is reported in aggregate for each health plan and is not broken down by key demographic factors, like race, gender or socioeconomic status. Stratifying quality data by these key factors could sharpen quality improvement interventions, identify groups that continue to be left behind, and provide a status report on whether managed care is helping resolve the longstanding inequities in our health care system.

The Affordable Care Act requires "any federally conducted or supported health care or public health programs, activities or surveys" to collect and report data stratified by race, ethnicity, sex, primary language, geography and disability status.¹¹⁴ HHS has moved to implement this mandate for national Medicaid population health surveys and to incorporate it into Medicaid claims database upgrades. In a November 2014 [progress report](#) to Congress, HHS specifically calls for more complete health disparities data collection in Medicaid managed care as a next step. A 2011 HHS report, [Approaches for Identifying, Collecting, and Evaluating Data on Health Care Disparities in Medicaid and CHIP](#), laid out strategies that states can adopt to improve health disparities data collection from their contracted managed care plans, such as requiring plans to report encounter data with demographic information or develop performance improvement projects that specifically address health disparities.

In 2012, CMS launched the [Adult Medicaid Quality Grants Program](#) to help states build their capacity to collect and report data stratified by key demographic categories. Participating states agree to stratify at least three of four selected measures by at least two key demographic categories. You can find the twenty-six states selected to participate on CMS's website, along with descriptions of some states efforts to improve maternal health through these programs. For example, California will use the funds to enhance its maternal health quality data collection to allow the state to tailor appropriate performance targets by plan, demographic group, or geographic area. More information on CMS's efforts to measure and address health disparities is available on the agency's [website](#).

9.2 How to obtain data on performance measures

State Medicaid agencies and MCOs and PIHPs, must make performance measure information available upon request.¹¹⁵ In addition, though public posting is not required, many states provide information on HEDIS performance on their website or in their External Quality Review annual reports.¹¹⁶ Some of these links are available in the chart provided in Appendix B.

NCQA publishes a free annual report, [The State of Health Care Quality](#), which discusses the organization's latest findings on quality, focusing on selected HEDIS results.¹¹⁷ It reports national results on selected HEDIS measures for Medicaid, Medicare, and commercial plans, which provides national benchmarks for performance. NCQA also [annually ranks](#) hundreds of health plans based on performance and member satisfaction results and provides [basic accreditation report cards](#) for plans in every state.

For its part, CMS produces [annual reports](#) on both the [adult](#) and [child](#) core measure sets that summarize how completely states are implementing the recommended measures. These reports are available on CMS's Medicaid website.¹¹⁸

Finally, several examples of state "MCO report cards" using HEDIS measures are linked in Appendix B (See, e.g., [Maryland](#) and [South Carolina](#)).

10. Information on Quality Assessment: Performance Improvement Projects (PIPs)

Performance Improvement Projects (PIPs) are interventions designed to enhance care quality in selected clinical or nonclinical focus areas. Each Medicaid MCO or PIHP must implement an ongoing program of PIPs as part of its overall efforts to achieve ongoing quality improvement.¹¹⁹ Typical PIPs focus on a given service, condition or population, such as reducing non-emergency use of the emergency department, improving blood sugar control for plan members with chronic diabetes, or increasing the use of preventive colorectal cancer screening for older adults. The MCO or PIHP develops a series of practical interventions intended to improve performance using a quantifiable measure or measures related to the PIP topic. Success of the intervention is gauged by the degree and sustainability of improvement in the measure(s) over the course of the progress.

States may stipulate specific topics for PIPs in their managed care contracts or permit MCOs to select focus areas.¹²⁰ CMS may also mandate topics for PIPs, but as yet has not gone beyond recommending that states and MCOs consider PIPs that align with national health priorities.¹²¹ Finally, states may contract with independent organizations to conduct system-wide PIPs through the External Quality Review (EQR) process (See Section 11, below).

10.1 Why PIPs are important

PIPs can effectively direct attention and resources to priority focus areas. Because MCOs and PIHPs may utilize different methods to accomplish the expected improvements, PIPs can also be a mechanism to test the efficacy of a variety of interventions. For example, Florida’s annual report on PIP implementation identifies specific best practices for plans, such as conducting an annual analysis of “barriers” to quality care. The report also highlights practices implemented by particular managed care plans that appeared to lead to substantial improvement in specific measures.¹²²

Advocates and others should push for a stakeholder process to identify PIP priorities, This will enable them to help set priorities and draw attention to underperforming or neglected aspects of the managed care system. While federal regulations do not mandate detailed public reporting of these projects, some states make useful data publicly available. For example, Georgia reports and [posts substantial data](#) on the specific interventions MCOs undertake to improve performance in PIP focus areas, and provides documentation of the success or failure of intervention strategies with recommendations for improvement.¹²³

10.2 How to obtain information about PIPs

MCOs and PIHPs must report to the State on the status and success of their ongoing PIPs at least annually as part of the State’s year review of managed care quality.¹²⁴ Some states post summary reports of PIPs with outcome data.¹²⁵

All states must include validation of PIPs as part of their External Quality Review (See Section 11, below). This involves an analysis of the appropriateness of the PIP methodology, interventions, and measurement data. The annual EQR technical report must include the top-line results of the PIPs, and these reports must be made available upon request. Many are also posted on-line. A chart in Appendix B provides state-by-state links to state’s EQR reports and other quality-related resources, including some PIP summaries.

Finally, CMS strongly encourages states to submit data on their PIPs’ trends and outcomes for CMS’s annual [Secretary’s Report on the Quality of Care for Children in Medicaid and CHIP](#) or the [Secretary’s Report on the Quality of Care for Adults in Medicaid](#).

11. Information on Quality Assessment: External Quality Review

Part of the overall Medicaid managed care quality strategy mandated by federal law requires annual independent external quality reviews (EQRs) in all managed care contracts with MCOs and PIHPs.¹²⁶ Contracts typically require plans to engage an independent organization to evaluate the performance of Medicaid managed care plans.¹²⁷ States also have considerable flexibility to choose the reviewer (or to conduct

the review themselves), identify required activities, and select applicable quality measures. States that contract with a recognized EQR Organization (EQRO), receive enhanced federal matching funds for the costs of performing the EQR.¹²⁸

EQRs must, at a minimum, validate MCO and PIHP performance measures and PIPs annually. Validation means “the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.”¹²⁹ At least every three years, each MCO and PIHP must also undergo a more extensive external review of its compliance with standards for access to care, structure and operations, and quality measurement and improvement.¹³⁰

The annual technical report compares and evaluates the health plans subject to review based on these and any other EQR activities specified by the state.¹³¹

The report must include the following components:

- evaluation of quality, timeliness, and access to care under the plan;
- assessment of each plan’s strengths and weaknesses as well as recommendations for each plan to improve its quality performance; and
- appraisal of how well each plan responded to recommendations for quality improvement in the prior year’s report.¹³³

Compliance with the EQR requirements has been uneven. A 2008 report from the U.S. Department of Health & Human Services’ Office of Inspector General (OIG) found that over half the states contracting with EQROs received annual reports missing either required elements or information on the three mandatory EQR activities.¹³⁴

Minnesota’s EQR: A Model

Minnesota centralizes its managed care quality data, including EQR reports, in a single website.¹³² The EQR report compares the strongest and weakest performance measures from each MCO against national standards for both Medicaid and commercial insurance, which puts the numbers in some context. The evaluation tracks measures that indicate a three year negative trend and notes whether the MCO met quality goals. The report includes additional information that provides important insight on plan performance, such as voluntary disenrollment rates in excess of 5% or shortcomings in the grievance process. The report includes an entire chapter dedicated to each MCO’s detailed response to the two prior years’ recommendations. Finally, it offers recommendations for statewide changes, which, for example, included a recommendation to increase the number of measures relevant to seniors and persons with disabilities.

11.1 Why EQR is important

EQR can provide meaningful independent oversight of managed care plan compliance with Medicaid requirements and quality control. The best EQRs standardize the reporting of quality metrics to allow comparisons between plans, and take an active role in testing plan compliance. In addition, states may take advantage of the enhanced federal match and considerably expand the scope of their independent oversight to include other EQR-related activities.¹³⁵ For example, states can opt to have their EQRO conduct separate PIPs, consumer surveys, or assess other performance measures. Several states, like Texas and Pennsylvania, also use EQR to validate managed care plan encounter data. Because encounter data forms the basis of most quality metrics as well as the data used to determine capitation rates, independent oversight of the accuracy of plan-reported encounter claims is critical.

Another good example of effective use of optional EQR activities involves network adequacy. Ohio and New York have contracted with EQROs to conduct direct tests (such as secret shopper surveys) of plans' compliance with network adequacy standards. A recent OIG report commended these states for their active oversight and enforcement of provider directory standards. These two states alone accounted for nearly 60% of *all* the network adequacy violations reported by 33 states with Medicaid managed care programs from 2008 to 2013. This is not because Ohio and New York had the poorest managed care networks, but rather because those states went to greater lengths to identify problems, largely through the "secret shopper" findings.¹³⁶ Other states also use EQR to assess plan performance, including developing and piloting new PIPs and quality metrics, such as experience surveys for long-term services and supports. Significantly, results from these EQR activities must be made publicly available through the annual EQR report.

Even in states that only apply the minimum EQR requirements, annual reports often include useful data on plan performance. Stakeholders should look for information on how plans respond to recommendations over time. If a state's EQR appears to be a rubber stamp instead of a tool to ensure the state is getting value for its managed care investment, stakeholders could push to address some of the most common EQR deficiencies. For example, many EQRs rely on self-reported data from managed care plans, which rarely reveal major problems. Another common criticism revolves around the significant delays between data collection and publication. Reports sometimes cover results from 18 or even 24 months prior to the release date. CMS has encouraged states to push for shorter turnaround times, but has not required action to this end.¹³⁷

Stakeholders can, however, press their state Medicaid agencies to include contract provisions that mandate a shorter turnaround time for EQRO reports, require results to be posted on line, or even charge EQROs to conduct direct tests to independently verify self-reported MCO data. Such tests might include conducting enrollee experience evaluations, developing secret shopper surveys (See Section 5.3, above), or verifying the reliability of MCO encounter data.

See NHeLP's [External Quality Review: An Overview](#) for more information on EQROs, reporting requirements, and ways to improve plan oversight.

11.2 How to obtain EQR reports

A chart in Appendix B provides state-by-state links to state's EQR reports and other quality-related resources.

Regulations require states to make reports available on request to interested parties, but do not require states to post the reports online.¹³⁸ Many states do, however, post reports on their Medicaid websites. CMS also posts some EQR reports on its [website](#), but the collection as of now is far from comprehensive and is not regularly updated. You can identify your state's EQRO, as of October 2014, on CMS's Medicaid [Managed Care Profiles](#) webpage.

If your state still does not post its annual EQR report on-line, you can obtain it by sending a request to the state Medicaid agency.

12. EPSDT and Child Health Reporting

Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive health care and support services for low-income children under age 21. EPSDT is intended to provide children and adolescents with a full range of medical, dental, vision, and hearing services. The CMS Form 416 gathers information from each state about this legally mandated benefit.¹³⁹

States must report, by age groups, information including:

- the number of children provided at least one child health screening;
- the number of children under age 5 who received a lead blood test;
- the number of children referred for corrective treatment;
- the number of children who receive any dental or oral health service, including service by a non-dentist provider;
- the number of children in the 6-14-year-old age grouping who have received a protective sealant on at least one permanent molar tooth;
- EPSDT participation rates in relation to goals set for the State by HHS; and
- the number of children enrolled in Medicaid managed care.¹⁴⁰

HHS has specified an 80 percent participation goal for children to receive timely EPSDT screenings.¹⁴¹

TIP: See NHeLP's [Thirty Questions to Ask About Managed Care and EPSDT](#) for elements that should be included in contracts and Requests for Proposals (RFPs) between the state Medicaid agency and managed care plans.

12.1 Why child health information is important

Children have unique healthcare needs that change as they grow and develop. Research shows that children from lower income families are more likely to encounter health problems, including vision, hearing, speech and dental problems, elevated blood lead levels, sickle cell disease, behavioral problems, anemia, asthma, and pneumonia. If undetected and left untreated, even minor health issues in children can turn into major concerns, possibly with lifelong consequences.

Tracking state performance on EPSDT and information about other child health measures is essential to ensure that children in low-income families receive the health check-ups and treatments they need.

12.2 How to obtain child health information

CMS posts national and state-based data on responses to Form 416, which is available on the [EPSDT section of its website](#).

Each state Medicaid program must also submit annual reports to the Secretary on specific child health quality measures applied by the states and information on the quality of health care furnished to children, including the information collected through EQRs of managed care organizations.¹⁴² This information, nationally and state-based, is summarized by the Department of Health and Human Services in an Annual Report on the Quality of Care of Children in Medicaid and CHIP.¹⁴³

In addition to the federally required Medicaid reporting, there are a number of other resources in the federal statistical system that track the well-being of children and youth and, thus, provide helpful background when monitoring managed care programs. The federal Centers for Disease Control offer on-line access to many of the databases supported by the federal government.¹⁴⁴ These resources include the results of health surveys and important research. For example, the State and Local Area Integrated Telephone Survey (SLAITS) examines the physical and emotional health of children aged 0-17; past surveys have placed special emphasis on factors such as medical homes and parents' awareness of, experience with, and interest in enrolling in Medicaid and CHIP.¹⁴⁵ There are also reliable sources of information from non-government sources. For example, since 1990, the Annie E. Casey Foundation's Kids Count has annually ranked states' overall child health and well-being using an index of key indicators.¹⁴⁶

13. Waivers and Demonstration Projects

While states may require Medicaid beneficiaries to enroll in managed care through a state plan, there are limits to the state's authority, including prohibitions on enrolling certain populations into managed care. Therefore, many states choose to implement managed care programs through a "waiver" or "demonstration" program.¹⁴⁷ These programs allow states to ignore certain requirements of the Medicaid program.¹⁴⁸ Waivers and demonstrations require CMS approval and must be periodically reviewed. CMS maintains a comprehensive list of pending and approved waiver and demonstration programs on its website.¹⁴⁹

Managed Care Waivers: The Medicaid Act permits states to waive many Medicaid provisions prescribing the contents of a state plan, but only insofar as is necessary to achieve one of four specific purposes:

1. Most commonly, to restrict beneficiaries' access to a limited network of Medicaid providers, provided that the network meets standards "consistent with access, quality, and efficient and economic provision of covered care and services;"¹⁵⁰
2. To restrict access to providers necessary to implement a Primary Care Case Management (PCCM) program;
3. To allow a locality to serve as a central broker to help beneficiaries choose among competing plans; or
4. To use savings from a more cost-effective delivery model to provide additional services to beneficiaries.

These managed care waivers are commonly used to operate programs dedicated to a specific type of service or population, such as non-emergency medical transportation, behavioral health demonstrations, or managed long term supports and services (MLTSS). They may be coupled with a Home- and Community-Based Services (HCBS) waiver or other state plan HCBS options.¹⁵¹ Florida and Illinois both use this waiver authority for their MLTSS programs. A few other states, including Michigan, Washington and North Dakota, use this authority to implement standard capitated managed care for specified eligibility groups, such as the adult expansion group authorized by the Affordable Care Act.

Before approving a waiver, CMS must evaluate proposals to ensure they are cost-effective and consistent with the objectives of the Medicaid program.¹⁵²

Demonstration Authority: Demonstration programs authorized by § 1115 of the Social Security Act can be used for a broader range of purposes than operating managed care systems. Section 1115 demonstrations were intended for pilot projects to test new innovations. Several states, including Arizona, Tennessee, and Rhode Island, run their entire Medicaid programs under a single comprehensive managed care 1115

demonstration. Other states offer HCBS programs, family planning, or other limited scope demonstrations to specific populations through § 1115 authority.

Under § 1115, states may only waive specified provisions of the Medicaid Act, must show the demonstration is likely to assist in promoting the objectives of the Medicaid program, and must develop and describe an experimental, pilot purpose for their demonstration, including a methodology to test and evaluate the project. Demonstrations must also show budget neutrality. That is, the demonstration may not cost more than it would cost to serve the target population under the current Medicaid coverage system. The methodology CMS uses calculating budget neutrality has generated some controversy and criticism.¹⁵³

Over the years, NHeLP has produced many issue briefs and analysis related to § 1115 Medicaid demonstrations, including related litigation.¹⁵⁴ For specific resources, see Appendix A or NHeLP's [website](#).

13.1 Why information about waivers and demonstrations is important

Managed care waivers and demonstration projects warrant close attention because states use them to waive key benefits and protections written into the Medicaid statute, including requirements for statewide operation, free choice of willing provider, coverage of nonemergency transportation, and prohibitions on premiums and limitations on cost sharing.

13.2 How to obtain and comment on demonstration proposals

Section 1115 Demonstrations

Demonstrations On-line

CMS's [waiver website](#) is a searchable resource for active and pending § 1115 and 1915(b) programs. The database includes proposals, approval documents, evaluation designs, and other formal communications between the State and CMS.¹⁵⁵

Until recently the design and approval process happened largely behind closed doors. In 2012, HHS approved revised § 1115 demonstration regulations that add more transparency and require stakeholder input in both the design and evaluation process.¹⁵⁶ For example, each new or renewing demonstration proposal must undergo two 30-day public comment periods, one at the state level and one after submission to CMS, and at least two public hearings to receive feedback.¹⁵⁷ Tribal consultation is also required, and CMS has already refused to accept several proposals due to insufficient

tribal input.¹⁵⁸ For the state level comment period, states typically post new § 1115 proposals or significant amendments to existing demonstrations on their Medicaid website along with notices for public hearings.

In its final proposal to CMS, the state must include a record of comments received during the State level comment period and how the State responded to those

comments. CMS maintains a comprehensive database of pending and approved § 1115 demonstrations. Advocates can submit feedback for the federal level 30-day public comment period through CMS's waiver website (see box, above).

Final approval letters and the approval – or “terms and conditions”- are also posted on CMS's waiver website, but advocates need to check the site regularly as CMS does not announce or maintain a list of recently approved waivers and demonstrations. Quick summaries of each states current managed care waiver and demonstration programs are also available on CMS's state Medicaid [managed care profile page](#).

13.3 How to obtain demonstration and waiver evaluations

Managed Care Waivers

CMS requires states with managed care waivers to maintain data on the cost effectiveness of managed care as well as its impact on quality of care and beneficiary access.¹⁵⁹ All managed care waiver programs must undergo independent assessments for at least the first two waiver cycles.¹⁶⁰ Moreover, the statutory and regulatory provisions that generally govern Medicaid managed care apply fully to managed care waiver programs unless they are explicitly waived.¹⁶¹ Therefore, such managed care programs with comprehensive risk contracts must generally undergo External Quality Review (EQR) as well as complying with the other performance and quality reporting requirements.

Advocates can thus obtain evaluation data on § 1915(b) waivers through the state's annual external quality review reports (See Appendix B). EQR annual reports must be made available on request even if they are not posted on-line.

Section 1115 Demonstrations

Section 1115 demonstrations are subject to several reporting and oversight mandates. While the initial demonstration must include some description of the hypotheses, test populations, and evaluation methodology, states are supposed to submit a full evaluation design plan separately to CMS. States must post the evaluation design on their Medicaid website within 30 days of approval. Oversight and evaluation must include periodic state reviews of implementation submitted to CMS, and CMS may conduct its own evaluation or select an independent evaluator to analyze any component of the demonstration.¹⁶²

A major element of the demonstration evaluation and oversight is the annual report to CMS.¹⁶³ Regulations require that these reports include, at minimum, data on:

- enrollments and disenrollment;
- progress toward reaching the goals and hypotheses of the demonstration;
- quality of care, access to care and participant outcome metrics;
- any beneficiary satisfaction surveys conducted;
- grievances, complaints and appeals;
- financial performance data; and
- reports on any audits, investigations or lawsuits that affect the demonstration.¹⁶⁴

Special Terms and Conditions

While § 1115 regulations set out a baseline for public participation in design, monitoring and oversight, nothing prohibits stricter requirements for a given demonstration. Many demonstrations require quarterly progress reports, especially during implementation, and advocates may also push for a meaningful stakeholder advisory committee with significant consumer representation.

States submit draft demonstration annual reports for CMS approval within the first quarter after each demonstration year. Both the draft and the final reports must be posted on the State's public website within 30 days of submission/approval.

States must also solicit public response to implementation of the demonstration.¹⁶⁵ For example, within six months of beginning implementation, the state must hold a public forum that solicits public comments on the demonstration's progress. Thereafter, states must also hold annual public forums to solicit public comments on the demonstration. Summaries of both the initial and annual public forums must appear in annual demonstration reports to CMS.¹⁶⁶ These reports must be posted on the state's website and can often be found on CMS' [waiver website](#).¹⁶⁷

14. Managed Care Corporate Filings and Financial Information

Medicaid managed care plans can be organized as for-profit entities, often as affiliates of large insurance companies that also offer health plans for the private market. Plans may also be organized as non-profit organizations.¹⁶⁸

Regardless, federal law requires most Medicaid managed care plans to meet minimum solvency standards and to be licensed and certified by the state as a risk-bearing entity.¹⁶⁹

14.1 Information Available in Annual Statements

Health insurance companies and managed care companies must file financial reports with the state's office of insurance regulation. The year-end report, the Annual Statement, must be filed with the NAIC and state insurance regulators in March, with interim reports filed on a quarterly basis.

Annual Statements contain a wealth of information on managed care companies, including corporate officers, affiliated organizations including for-profit subsidiaries, annual income, expenses, reserves, surplus, and pending litigation.

TIP: To find out what managed care plans are operating in your state, and whether those plans are for-profit or non-profit, visit CMS' [Managed Care State Profiles](#).

The Kaiser Family Foundation's [Medicaid Managed Care Market Tracker](#) provides information on Medicaid managed care, including state-level sanctions, and identifies the parent companies of state MCOs.

When Solvency Is an Issue

State regulators assess financial stability of all risk-based entities such as insurers and HMOs using a standard established by the National Association of Insurance Commissioners (NAIC) called Risk Based Capital (RBC). RBC represents the minimum amount of capital an insurer needs to operate given its size, revenue, and obligations.¹⁷⁰ All states have adopted a version of the NAIC model legislation establishing regulatory standards for insurers.¹⁷¹ A managed care company's RBC may trigger specific regulatory actions, ranging from enhanced monitoring to receivership, when its RBC falls below acceptable levels.¹⁷²

Risk Based Capital (RBC)	Regulatory Level	Intervention
Above 200%	None	None
150% - 200%	Company Action Level	Insurer files financial and business plan
100% - 150%	Regulatory Action Level	Regulator must examine and require corrective action
70% - 100%	Authorized Control Level	Regulator may take control of insurer
Less than 70%	Mandatory Control Level	Regulator required to take control unless corrected within 90 days

Advocates can calculate RBC by checking page “Five Year Historical Data” of the Annual Statement. Take the number on Line 14 (Total Adjusted Capital) and divide it by the number on Line 15 (Authorized Control Level) and multiply the quotient by 100.

$$\text{Line 14} \div \text{Line 15} \times 100 = \text{RBC}$$

EQROs also may report on a capitated managed care plans' RBC and general financial profile.

In 2012, DC regulators placed Chartered Health Systems, one of the largest managed care companies serving 110,000 Medicaid enrollees in the District, into receivership based on the RBC.¹⁷³ Hundreds of providers sought payments for claims for services already rendered.¹⁷⁴ Tens of thousands of enrollees were eventually transferred to other plans.

14.2 How to obtain Annual Statements

Many state insurance regulators publicly post information on insurance companies operating within the state, including Annual Statements, as well as investigations, examinations, and regulatory actions. Insurers and managed care companies also file Annual Statements with the National Association of Insurance Commissioners (NAIC).

TIP: To obtain Annual Statements and other insurance company filings from the NAIC, go to the NAIC [website](#) for Insurance Data. The NAIC provides up to five Annual Statements of the public without charge. You need to set up an account and obtain a validation code.

Insurance companies and managed care companies often operate in multiple states, can have affiliates with similar-sounding names, and offer different products for the private insurance market and public programs such as Medicaid. Therefore, advocates should make sure they identify, request, and review the Annual Statement from the right entity.

The NAIC assigns a unique NAIC company code to every managed care company, HMO, and insurance company, which appears at the top of the Annual Statement and other filings. Once you identify the NAIC code for your state's Medicaid managed care companies, you should cite that reference number every time you request a financial document or review company filings.

14.3 Information available in IRS Form 990

Non-profit, 501(c)(3) organizations must file an IRS Form 990 with the Internal Revenue Service (IRS).¹⁷⁵ 990s contain a wealth of information, including an organization's annual income, expenditures, special projects, affiliations, and executive compensation.

In addition to MCOs, some EQROs are organized as 501(c)(3) organizations and therefore must file an IRS Form 990.

14.4 How to obtain a company's IRS Form 990

Federal law requires that organizations make their IRS Form 990s available for public inspection.¹⁷⁶ The IRS Form 990's for the preceding tax year are generally available in April, however some non-profits obtain extensions and delay annual filing until October.

Advocates can obtain forms from www.Guidestar.org - a website that collects and posts financial information, including IRS Form 990s, for thousands of non-profit 501(c)(3) organizations. Registration and access to IRS Form 990s on GuideStar are free. However, additional services are available for charge.

14.5 How to obtain SEC filings for commercial plans

Commercial, publicly-traded health plans are required to report financial and business information on Securities and Exchange Commission (SEC) forms. Copies of SEC forms can be obtained through the [SEC website](#). Once on the site, you will be prompted to enter the company name. The SEC site may return a list of companies matching the name you entered, so identify which company or state affiliate you want to review. Alternatively, you can click the “more options” button and search for “6324” in the box “Standard Industry Classification” (SIC).¹⁷⁷ This will list all the companies classified as “Hospital or Medical Service Plans.” Clicking on the company’s Central Index Key number will bring you to the company’s filings page, which lists forms by filing date and provides direct links via the “document” button. You can designate the particular form you want to review by entering it into the “Filing Type” box and clicking “search.” The following reports may be of special interest:

The screenshot shows the U.S. Securities and Exchange Commission's Edgar search interface. At the top, there is a search bar for SEC documents and a navigation menu with links for ABOUT, DIVISIONS, ENFORCEMENT, REGULATION, EDUCATION, FILINGS, and NEWS. The main content area is titled "EDGAR | Company Filings" and includes a sidebar with various search tools like "Latest Filings", "Company Filings", "Mutual Funds", etc. The central search form has fields for "Company Name", "File Number", "State", "Country", and "Standard Industry Classification". It also includes radio buttons for "Starts with" or "Contains" and "Ownership Forms 3, 4, and 5" (Include, Exclude, Only). A "Fast Search" box is available for ticker or CIK symbols. A "Company Filing Search Tips" box provides advice on search results. At the bottom, there are sections for "Guides" (How to Research Public Companies, Filing Types) and "Search Tools" (CIK Lookup Tool, Save Your Search).

Screenshot of <http://www.sec.gov/edgar/searchedgar/companysearch.html>, last visited January 26, 2015.

- Form 10-K. This form provides a comprehensive analysis of the company's financial position. It must be filed annually with the SEC, within 60 days after the end of the company's fiscal year. The filing includes information about the company's Medical Loss Ratio (MLR) as well as the Medicaid, Medicare, and military enrollment. The "selected financial data" portion of the report is particularly descriptive. Exhibits attached to the report may include the Medicaid managed care contract between the company and the state Medicaid agency.
- Form 10-Q. This form is filed with the SEC each quarter. It includes unaudited financial statements and provides a picture of the company's ongoing financial situation.
- Form 8-K. This form is filed with the SEC each quarter and is used to report events and information that was not previously contained in the Form 10-K or Form 10-Q. For example, the information could describe a recent acquisition or major litigation involving the company.
- Form DEF 14a. This form includes the company's proxy statements, which will show executive compensation and board of director membership.

14.6 Medical Loss Ratio Reports

Medical Loss Ratio (MLR) is a measure of how much health insurers spend on administration, marketing, and overhead compared with the amount spent providing medical services.¹⁷⁸ This service spending amount is known as the Medical Loss Ratio. The ACA requires most individual, large, and small group plans to spend at least 80% or 85% of premium dollars on medical care.¹⁷⁹ However, the ACA's MLR provision does not apply to Medicaid managed care plans.¹⁸⁰ Nonetheless, some states set MLR limits and/or require reporting on MLR from their Medicaid managed care plans. A 2011 study by the Kaiser Commission on Medicaid and the Uninsured found that 10 states and the District of Columbia had MLR requirements for Medicaid MCOs.¹⁸¹ Recently, Florida established an 85% MLR limit for Medicaid managed care plans operating pursuant to a § 1115 demonstration project.¹⁸²

Even in states with no Medicaid MLR limit, advocates seeking additional information should check whether their state has such a reporting requirement, which may be in the state's contracts with MCOs, in an § 1115 demonstration, or established by statute. The Kaiser Family Foundation's [Medicaid Managed Care Tracker](#) computes an average MLR across all Medicaid MCOs in a given state. If no current reporting requirement exists, advocates should push to include such provisions in future contracting, as MLR data is a useful tool for the state to evaluate an MCO's cost effectiveness.¹⁸³

15. Grievances and Appeals

Medicaid enrollees, including those enrolled in Medicaid managed care, have due process rights that stem from the Fourteenth Amendment of the U.S. Constitution, which prohibits governmental deprivations of "life, liberty, or property, without due process of law."¹⁸⁴

Grievances vs. Appeals

Appeal means a request for review of an action, which is a denial, limited authorization, reduction, termination, or suspension of a service; a denial of payment for a service; a failure to provide services in a timely manner; or failure of an MCO or PIHP to act within required timeframes.

Grievance means an expression of dissatisfaction about any matter other than an action. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights).

The essential elements of due process in Medicaid are an adequate written notice and the opportunity to challenge an adverse state action in a pre-termination hearing before an impartial decision maker.¹⁸⁵ Beneficiaries and applicants are also entitled to present a case without interference, cross examine witnesses, and have access to their case file. These due process rights are what make Medicaid an entitlement and a source of dependable insurance for the vulnerable population that needs it.¹⁸⁶

In addition to a state fair hearing, individuals enrolled in MCOs and PIHPs must have access to plan-level procedures to file grievances and to appeal actions by the plan to an impartial decision maker.¹⁸⁷

The state can require exhaustion of the internal MCO and PIHP appeal process before obtaining a state fair hearing. The state must permit the enrollee to request a state fair hearing within a reasonable time, from 20 to 90 days, from whichever of the following dates applies--the date of the plan's notice of resolution if exhaustion is required or from the date on the plan's notice of action if exhaustion is not required.¹⁸⁸ MCOs and PIHPs must maintain records of grievances and appeals, which the state Medicaid agency must review as part of its quality strategy.¹⁸⁹

Notably, "the public" is entitled to access to all agency hearing decisions, including those in managed care systems, after safeguards are made to protect confidential information.¹⁹⁰

15.1 Why information on grievance and appeals is important

While EQR reports or annual reporting of HEDIS measures can take a year or more to be compiled and released, grievances and appeals provide real time information on how well a managed care plan is meeting the needs of enrollees. Advocates and others should, however, note that plans reporting a large number of grievance and appeals are not necessarily poorly performing plans. Those plans could instead be doing a good job in informing enrollees of their rights. Conversely, an absence of grievances may mean a lack of information about how to use the system.

When looking at grievances and appeals data, advocates should be on the lookout for patterns of abuse or deficiencies. By conducting a qualitative analysis, advocates can identify program shortcomings and areas for improvement.

15.2 How to obtain information on grievances and appeals

“The public” must have access to all agency hearing decisions, subject to protections for confidential information.¹⁹¹ State Medicaid agencies are also required to monitor managed care grievances and appeals and to use that information in developing the state’s quality improvement strategy.¹⁹² There is, however, no specific requirement that this information be made publicly available. Some states may do so, however; for example, Minnesota publishes an annual report of the numbers of grievances and appeals filed in each Medicaid managed care plan.¹⁹³

Due process and MCOs

“Because of the pecuniary incentives that MCOs have for denying, suspending, or terminating care under the [managed care] system . . . enrollees need strong due process protections to protect themselves from inappropriate denials of health care.”

Daniels v. Wadley, 926 F. Supp. 1305 (M.D. Tenn. 1996)

Advocates can request information from the state Medicaid agency on grievances and appeals, as well as how such information is used in developing the state’s quality improvement strategy. This information can be requested through a public records request.

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TIP: Raw numbers of grievances and appeals filed are of limited value in assessing plan performance. New Jersey’s Health Quality Act requires annual reports listing the number and type of appeals filed against private market managed care companies operating in the state, as well as the incidences whereby coverage denials were later overturned upon external review.¹⁹⁴ Stakeholders can push for a similar system for the Medicaid grievances and appeals in their state.

16. Public records and data requests

Transparency and public access to documents and data vary widely among states. Some make Medicaid managed care and other information publicly available and easily accessible by posting to agency websites, while others may not meet minimum federal public reporting requirements.

Moreover, federal Medicaid managed care regulations need to be modernized. For example, federal regulations require that the results of the annual External Quality Review (EQR) must be provided, upon request, to enrollees, potential enrollees, participating health care providers, recipient advocacy groups, and other interested parties.¹⁹⁶ However, they do not require states to post EQR or other reports to agency websites.

16.1 State public records law

Most Medicaid managed care data and information should be obtainable at the state level using state public records or freedom of information acts (FOIA). Advocates should familiarize themselves with their state's laws, since the legal requirements and procedures vary widely.

Some states provide public record access to state residents only.¹⁹⁷ In 2013, the Supreme Court upheld a state's authority to deny public records requests submitted by anyone not a state resident.¹⁹⁸ Thus, advocates seeking data and information on Medicaid managed care in other states may need to partner with advocates from that state.

MCOs and FOIA

In Connecticut, three individuals requested information about Medicaid managed care plans through the state's freedom of information act requiring disclosure of records by public agencies. They asked for information about reimbursement rates, fees, and preferred drug lists and formularies. Their requests were denied on the grounds that the MCOs were not performing a government function. The MCOs also claimed that the information sought included "trade secrets" and forcing them to disclose the information would be an unconstitutional taking.

The Connecticut Superior Court held that the MCOs were public agencies under FOIA because their conduct was regulated to a significant degree by a public agency (the Department of Social Services), they were operating part of a public program (Medicaid), and they were making significant governmental decisions (whether to cover a service, what rate to pay providers). Accordingly, the court held that the information was subject to disclosure and the records were released.¹⁹⁵

16.2 Federal FOIA

Some information on a state's Medicaid managed care program may be obtainable from the federal government, such as State Plan Amendments (SPAs), correspondence between CMS and state Medicaid agencies, documents related to the development of § 1115

demonstrations and waivers, or federal monitoring and oversight activities. Some of these documents are available on the CMS website. However, if documents are not posted or otherwise available, the federal FOIA requires records and information to be released to the public upon request.¹⁹⁹

Records and information include documents on file with the agency in any format, including electronic formats, and also include any information that is maintained for an agency by an entity under government contract for purposes of records management.²⁰⁰

Except in unusual circumstances, the agency must determine whether to comply with a request within 20 working days after its receipt. The agency must immediately notify the requester of the decision and of the right to appeal any adverse determination to the head of agency, who must decide the appeal within 10 working days.²⁰¹

16.3 Where to file a federal FOIA request

You can submit an FOIA request to DHHS through a letter. Mark both the envelope and its contents: "Freedom of Information Act Request" and mail to:

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Freedom of Information Group
Room N2-20-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

State Public Records Laws

The Reporters Committee for Freedom of the Press, a non-profit organization providing legal assistance to journalists, has compiled the [Open Government Guide](#) -- a complete compendium of information on every state's open records and open meetings laws, including citations. This useful and easy to read guide is available without charge.

TIP: Advocates can also file FOIA requests online using HHS' web portal at:
<http://wcdapps.hhs.gov/FoiaRequest/>

16.4 FOIA fee waivers

In most cases, federal agencies can charge a fee for providing the documents under FOIA.²⁰² The agency must publish the fees schedule, including guidelines for waiving or reducing fees.²⁰³ Notably, the FOIA requires documents to be furnished without charge or at a reduced charge “if disclosure of the information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester.”²⁰⁴

Endnotes

¹ Ctrs. for Medicare & Medicaid Servs. (CMS), *Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011*, 1 (2013), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf>.

² See, e.g., Margaret E. Burns, *Medicaid Managed Care and Cost Containment in the Adult Disabled Population*, 47 MED. CARE 1069 (Oct. 2009); KAISER COMM'N ON MEDICAID & THE UNINSURED, PEOPLE WITH DISABILITIES & MANAGED CARE: KEY ISSUES TO CONSIDER, 3 (Feb. 2012).

³ 42 U.S.C. § 1396b(m)(1)(A), 42 C.F.R. § 438.2.

⁴ 42 C.F.R. § 438.2.

⁵ *Id.*

⁶ *Id.*

⁷ S. Rep. No. 95-749, 95th Cong., 2d Sess. (1978) (investigative report); H. Rep. No. 94-1513, 94th Cong., 2d Sess. (1976) (Conference Committee Reporting to accompany H.R. 9019), as reprinted in 1976 U.S.C.C.A.N. 4371. See also Andreas Schneider & Joanne Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW.U.L.REV. 90, 126-38 (1975).

⁸ See 42 U.S.C. § 1396b(m).

⁹ *Id.*

¹⁰ *Id.* § 1396a(a)(23).

¹¹ *Id.* § 1396n(b).

¹² See *id.* § 1396u-2.

¹³ *Id.* § 1396n(b), which allow them to waive many Medicaid requirements. They may also require them to enroll through 42 U.S.C. § 1315 (also known as Section 1115 of the Social Security Act) by proposing demonstration programs to test alternative service delivery methods.

¹⁴ *Id.* § 1396u-2(a)(2).

¹⁵ *Id.* § 1396u-2(a)(3)(A); 42 C.F.R. § 438.52(a). In rural areas, states can require enrollment in just a single managed care entity; however, that plan must provide consumers a choice of more than one physician or case manager. 42 U.S.C. § 1396u-2(a)(3)(B); 42 C.F.R. § 438.52(b). Certain county-operated plans, such as those operated under the MediCal program in California, also do not have to offer a choice in MCOs. See 42 U.S.C. § 1396u-2(a)(3)(C); 42 C.F.R. § 438.52(c).

¹⁶ 42 C.F.R. § 438.10(b)(1).

¹⁷ *Id.* § 438.10(d)(1).

¹⁸ See ASPE, MEDICAID AND CHIP RISK-BASED MANAGED CARE IN 20 STATES - EXPERIENCES OVER THE PAST DECADE AND LESSONS FOR THE FUTURE, Appendix Table 3: Contracting Approaches for Medicaid and CHIP Managed Care Programs in Study States, 2001–2010 (Jul. 2012) available at <http://aspe.hhs.gov/health/reports/2012/riskbasedmanagedcare/rpt.pdf>.

¹⁹ *Id.* at 24.

²⁰ 42 C.F.R. § 438.10(b)(2).

²¹ 42 U.S.C. § 1396u-2(a)(5)(C); 42 C.F.R. § 438.10(i).

²² *Id.* § 1396u-2(b)(5); 42 C.F.R. § 438.206(a) (requiring states to ensure that services are available to enrollees in Medicaid managed care organizations (“MCOs”), Prepaid Inpatient Health Plans (“PIHPs”) and Prepaid Ambulatory Health Plans (“PAHPs”)); *id.* § 438.207(b) (requiring State to ensure adequate network adequacy in Medicaid managed care plan contracts).

²³ CTRS. FOR MEDICARE AND MEDICAID SERVICES, *MA Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance*, 7 (2012), available at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf.

²⁴ 42 C.F.R. § 438.207(a).

²⁵ *Id.* § 438.207(b)(1).

²⁶ 42 C.F.R. § 438.207(b)(2).

²⁷ *Id.* § 438.206(b)(1)(v).

²⁸ 42 C.F.R. § 438.206(b)(2); see also Jina Dhillon, *Medicaid Managed Care and Women’s Health*, 16 HEALTH ADVOCATE 1 (2013), available at <http://www.healthlaw.org/component/jfssubmit/showAttachment?tmpl=raw&id=00Pd0000008M1GGEA0>; Jina Dhillon, Nat’l Health Law Program (NHeLP), *Medicaid Managed Care and Women’s Health* (2013), <http://www.healthlaw.org/component/jfssubmit/showAttachment?tmpl=raw&id=00Pd0000009ZZ5UEAW>

²⁹ Commonwealth of Virginia, *Medallion II Managed Care Contract*, 245 (Jul. 1, 2013), available at http://www.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_cntrct710.pdf. Virginia does require plans to provide one primary care provider per 1500 members, and one pediatric primary care provider per 2500 members under age 18. *Id.* at 39.

³⁰ WISCONSIN MEDICAID STANDARDS, CONTRACT FOR BADGERCARE PLUS § III(H)(7), Jan. 1, 2014 – Dec. 31, 2015, 75, available at <https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/Providers/providerContracts.htm.space>.

³¹ 42 C.F.R. § 438.207(d).

³² *Id.* § 438.206(b).

³³ U.S. DEP’T OF HEALTH AND HUMAN SERVS., OFFICE INSPECTOR GEN. (“OIG”), STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE, NO. 09-25-2014, (Sept. 29, 2014), available at <https://oig.hhs.gov/oei/reports/oei-02-11-00320.asp>.

³⁴ *Id.* at 15.

³⁵ *Id.* at 19.

³⁶ CAL. WELF. & INST. CODE § 14182(c)(7); CAL. CODE REGS., tit. 22, § 53800(b)(2)(C)(1). (For more information, see NHeLP’s [Network Adequacy Laws in Medi-Cal Managed Care Plans](#) (Aug. 2014)).

³⁷ 42 C.F.R. § 438.207(a).

³⁸ *Id.* § 441.62.

³⁹ *Id.* § 431.53.

⁴⁰ *Id.* § 440.170

⁴¹ *Id.* § 438.206(b).

⁴² 42 U.S.C. §§ 1396u-2(5)(B), (C); 42 C.F.R. §§ 438.10(e), (f).

⁴³ 42 C.F.R. § 438.10(e).

⁴⁴ *Id.* § 438.10(f)(5).

⁴⁵ OIG, *Access to Care: Provider Availability in Medicaid Managed Care*, OEI-02-13-00670 (Dec. 2014), available at <http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>.

⁴⁶ For example, a 2011 survey conducted by the DC Behavioral Health Association found that more than 50% of identified mental health practitioner listed in each of the District of Columbia Medicaid MCOs' provider directories were no longer employed or in business. See Medical Care Advisory Committee, Behavioral Health Subcommittee, *FY 2011 Year-end Report and Recommendations* (Apr. 12, 2012), available at <https://docs.google.com/a/healthlaw.org/file/d/0BwhX1B9WJhhVLUZ6RINKdXdKUFEdit?pli=1>

⁴⁷ 42 C.F.R. §§ 438.10(e)(2)(iii)(D), 438.10(f)(6)(i).

⁴⁸ District of Columbia Medical Care Advisory Committee, Behavioral Health Subcommittee, *FY 2011 Year End Report and Recommendations* (April 18, 2012) at 5, available at <https://docs.google.com/file/d/0BwhX1B9WJhhVLUZ6RINKdXdKUFEdit?pli=1>.

⁴⁹ Kaiser Health News, *Connecticut Drops Insurers from Medicaid*, (Dec. 29, 2011), <http://www.kaiserhealthnews.org/Stories/2011/December/29/Connecticut-Drops-Insurers-From-Medicaid.aspx>.

⁵⁰ Jack S. Resneck, Jr. et al., *The Accuracy of Dermatology Network Physician Directories Posted by Medicare Advantage Health Plans in an Era of Narrow Networks*, *JAMA DERMATOLOGY*, E1 (published on-line Oct. 29, 2014).

⁵¹ *Id.* at E4-E5.

⁵² 42 C.F.R. § 438.206(a).

⁵³ *Id.* §§ 438.10(e)(2)(i)(C), 438.206(b).

⁵⁴ 42 U.S.C. § 1396a(a)(43); 42 C.F.R. § 441.56.

⁵⁵ *Id.* § 1396a(a)(43); 42 C.F.R. § 441.56.

⁵⁶ 42 C.F.R. § 435.930(c).

⁵⁷ *Id.* § 438.114.

⁵⁸ *Id.* § 438.10(f)(6)(viii).

⁵⁹ See e.g., THE COMMONWEALTH FUND, *STATE STRATEGIES FOR INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH SERVICES IN A CHANGING MEDICAID ENVIRONMENT* (Aug.2014), available at <http://www.commonwealthfund.org/publications/fund-reports/2014/aug/state-strategies-behavioral-health> (last visited Mar. 4, 2015); THE LEWIN GROUP, *PROJECTED IMPACTS OF ADOPTING A PHARMACY CARVE-IN APPROACH WITHIN MEDICAID CAPITATION PROGRAMS* (Feb. 2011), available at http://www.lewin.com/~media/lewin/site_sections/publications/mhpapaperpharmacycarve-in.pdf.

⁶⁰ See PATRICIA MILLER & CELINA CHELALA, CATHOLICS FOR A FREE CHOICE: CATHOLIC HMOs AND REPRODUCTIVE HEALTH CARE (2000) *available at* www.catholicsforchoice.org/topics/healthcare/documents/2000catholichmos.pdf.

⁶¹ 42 C.F.R. § 438.10(f)(6)(vii).

⁶² 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(b)(2).

⁶³ 42 C.F.R. § 438.10(f)(6)(vii).

⁶⁴ New York, Dept. of Health, Medicaid Managed Care Enrollment Reports, Jan. 2015, *available at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

⁶⁵ FIDELIS CARE, NEW YORK STATE MEDICAID MANAGED CARE MODEL MEMBER HANDBOOK at 8 (Revised April 2014), *available at* <http://www.fideliscare.org/Portals/0/DocumentLibrary/Products/Medicaid%20Managed%20Care/NYMHandbook.pdf> (last visited Mar. 4, 2015).

⁶⁶ 42 C.F.R. § 438.10(f)(6)(iii).

⁶⁷ *Id.* § 438.100(b)(2)(iii)

⁶⁸ *Id.* § 438.100(b)(2)(iv).

⁶⁹ *Id.* § 438.206(b)(3).

⁷⁰ *Id.* § 438.56(d)(2)(iv).

⁷¹ *Id.* §§ 438.206, 438.208.

⁷² *Id.* § 438.10(g), (h).

⁷³ *Id.* § 438.207.

⁷⁴ *Id.* § 1396b(m)(2)(A)(v); 42 C.F.R. § 438.700(b)(3).

⁷⁵ *Id.* § 438.100(d).

⁷⁶ *Id.* § 438.206(b)(1)(v).

⁷⁷ 42 C.F.R. § 438.202.

⁷⁸ 42 U.S.C. § 1396b(m)(2)(A)(x); § 1395mm(i)(8).

⁷⁹ *Id.* § 1396a(a)(4); 42 CFR § 431.12.

⁸⁰ *Id.* § 431.12(d).

⁸¹ *Id.* § 431.12(e).

⁸² *Id.* § 438.104(c).

⁸³ *Id.* § 431.408.

⁸⁴ *Morabito v. Blum*, 528 F. Supp. 252, 263-67 (S.D.N.Y. 1981).

⁸⁵ 42 C.F.R. § 438.50(f).

⁸⁶ *Id.* § 438.56(c).

⁸⁷ *Id.* § 1396u-2(e)(1)(A)(iii); 42 C.F.R. § 438.6(d).

⁸⁸ *Id.* § 1396u-2(a)(3)(A); 42 C.F.R. § 438.52(a), (b).

⁸⁹ *Id.* § 1396u-2(a)(3)(B). Certain county-operated plans do not have to offer enrollees a choice of plans. See 42 U.S.C. § 1396u-2(a)(3)(C); 42 C.F.R. § 438.52(b).

⁹⁰ 42 C.F.R. § 438.104(b)(2).

⁹¹ *Id.* § 438.104(b)(1)(v).

⁹² *Id.* § 438.104(b)(1)(i).

⁹³ *Id.* § 438.104(b)(2)(c).

⁹⁴ *Id.* § 438.66.

⁹⁵ *Id.* § 438.50(f)(1).

⁹⁶ *Id.* § 438.56(c).

⁹⁷ NCQA is also a key player in accrediting health plans for health marketplaces.

⁹⁸ NCQA, *HEDIS 2015*, <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2015.aspx>, (last visited Jan. 12, 2015).

⁹⁹ NCQA, *What is HEDIS?*, *Id.*

¹⁰⁰ EMBRY M. HOWELL ET. AL., URBAN INSTITUTE, MEDICAID AND CHIP RISK-BASED MANAGED CARE IN 20 STATES, 45 (July 2012), <http://www.urban.org/publications/412617.html>.

¹⁰¹ NAT. QUALITY FORUM, MEASUREMENT APPLICATION PARTNERSHIP: MEASURING HEALTHCARE QUALITY FOR THE DUAL ELIGIBLE BENEFICIARY POPULATION FINAL REPORT TO HHS, 21-28 (June 2012), <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71218>.

¹⁰² DISABILITY RIGHTS EDUC. & DEF. FUND AND NAT'L SENIOR CITIZENS LAW CTR., IDENTIFYING AND SELECTING LONG-TERM SERVICES AND SUPPORTS OUTCOME MEASURES (Jan. 2013), <http://dredf.org/2013-documents/Guide-LTSS-Outcome-Measures.pdf>. NHeLP is currently a member of the NQF board and participates in the MAP dual eligibles work group.

¹⁰³ *National Core Indicators - Aging and Disabilities*, Nat. Ass'n of States United for Aging & Disabilities, <http://nasuad.org/initiatives/national-core-indicators-aging-and-disabilities> (last visited May 25, 2014).

¹⁰⁴ U.S. Dep't of Health & Human Servs., *CAHPS: Surveys and Tools to Advance Patient Centered Care*, <https://cahps.ahrq.gov/>.

¹⁰⁵ HENRY J. KAISER FAMILY FOUNDATION: MEDICARE ADVANTAGE PLAN STAR RATINGS AND BONUS PAYMENTS IN 2012 (Nov. 2011), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8257.pdf>.

¹⁰⁶ *Id.*

¹⁰⁷ CMS, *Five Star Plan Ratings*, <https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2013-5-Star-Enrollment-Period-Job-Aid.pdf>.

¹⁰⁸ CMS, *Introduction to the Consistent Poor Performer Notice*, <http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/Downloads/PoorPerformingSEPFall2013.pdf>.

¹⁰⁹ CMS, *Part C and D Performance Data*, <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>.

¹¹⁰ CMS, *Quality of Care Performance Measurement*, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-%E2%80%93-performance-measurement.html> (last visited Jan. 12, 2015.)

¹¹¹ HHS, *2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP*, 40 (Nov. 2014), <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf>.

¹¹² 42 C.F.R. §§ 438.236-.242.

¹¹³ As of 2011, only South Carolina required MCOs to require the collection, analysis and reporting on data related to race of Medicaid managed care enrollees. HHS, *Report to Congress: Approaches for Identifying, Collecting, and Evaluating Data on Health Care Disparities in Medicaid and CHIP*, 16 (Sept. 2011), <http://medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/4302b-rtc.pdf>.

¹¹⁴ 42 U.S.C. § 300kk.

¹¹⁵ 42 C.F.R. § 438.10(i)(3)(iv).

¹¹⁶ See Appendix B.

¹¹⁷ NCQA, *THE STATE OF HEALTH CARE QUALITY REPORT 2014* (Oct. 2014), <http://www.ncqa.org/Portals/0/Newsroom/2014/SOHC-web.pdf>.

¹¹⁸ Ctrs. for Medicare and Medicaid Services, *CHIPRA Initial Core Set of Children's Health Care Quality Measures*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html> (last visited Jan. 12, 2015).

¹¹⁹ 42 C.F.R. § 438.240(a)(1).

¹²⁰ CTRS. FOR MEDICARE AND MEDICAID SERVICES, *EQR PROTOCOL 3: VALIDATING PERFORMANCE IMPROVEMENT PROJECTS (PIPS)*, 3 (Sept. 2012.)

¹²¹ *Id.* at 4. See also 42 C.F.R. § 438.240(a)(2).

¹²² FLA. AGENCY FOR HEALTH CARE ADMINISTRATION, *SFY 2012–2013 ANNUAL TECHNICAL REPORT OF EXTERNAL QUALITY REVIEW RESULTS*, 42-44 (Apr. 2014), http://myfloridaeqro.com/Resources/FL2012-13_EQR_TR_Report_F2.pdf.

¹²³ Ga. Dep't of Community Health, *Medicaid Quality Reporting*, <http://dch.georgia.gov/medicaid-quality-reporting> (last visited Jan. 12, 2015).

¹²⁴ 42 C.F.R. § 438.240(d)(2), (e).

¹²⁵ MINN. DEPT. HUMAN SERVS., *PERFORMANCE IMPROVEMENT PROJECTS SUMMARY REPORT FOR 2012* (July 2012), <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6646A-ENG>.

¹²⁶ Federal regulations require EQRs for Managed Care Organizations (MCOs), Prepaid Inpatient Hospital Plans (PIHPs), and certain Health Insurance Organizations (HIOs), as defined in 42 C.F.R. §§ 438.2 and 438.310. See also 42 U.S.C. § 1396u-2.

¹²⁷ States may enlist a state department other than the Medicaid agency to conduct EQR, but do not receive enhanced federal match if the reviewing department does not qualify as an EQRO.

¹²⁸ The federal government reimburses states for at least half of their Medicaid costs for services and at 50% for most administrative costs. A Federal Medical Assistance Percentage (FMAP) is calculated individually for each state for their expenditures for covered services and can vary from 50 to 83 percent. 42 U.S.C. §§ 1396b(a), 1396d(b). The enhanced match for

EQR-related expenditures conducted by an EQRO is 75 percent, compared to 50 percent for EQR activities conducted by another entity. 42 U.S.C. § 1396b(a)(3)(C)(ii); 42 C.F.R. § 438.370.

¹²⁹ CMS, *External Quality Review Protocols: Introduction*, 7 (Sept. 2012).

¹³⁰ 42 C.F.R. § 438.358(b).

¹³¹ 42 C.F.R. § 438.358(c). Reports must also include detailed explanation of the methodology for data collection, aggregation and analysis for each required EQR activity and validation of quality measures and may include other optional activities.

¹³² *Managed Care Reporting: Quality, Outcome and Performance Measures*, Minn. Dept. Human Servs., (last visited Dec. 18, 2014), http://www.dhs.state.mn.us/main/idcplg?ldcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_160043.

¹³³ 42 C.F.R. § 438.364(a).

¹³⁴ U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE INSPECTOR GEN. ("OIG"), EXTERNAL QUALITY REVIEWS IN MEDICAID MANAGED CARE, 11 (Jun. 2008), <http://oig.hhs.gov/oei/reports/oei-01-06-00510.pdf>.

¹³⁵ 42 C.F.R. § 438.358.

¹³⁶ OIG, STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE, *supra* note 33, at 15.

¹³⁷ Ctrs. for Medicare and Medicaid Services, *supra* note 129, at 4.

¹³⁸ 42 C.F.R. § 438.364(b).

¹³⁹ 42 U.S.C. § 1396a(a)(43).

¹⁴⁰ *Id.* § 1396a(a)(43)(D); 42 U.S.C. §§ 1397hh(e)(1), (2). Ctrs. for Medicare and Medicaid Services (CMS) Form 416, *available at* <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>. Information about managed care enrollment is provided on Form 416, line 13.

¹⁴¹ CTRS. FOR MEDICARE AND MEDICAID SERVICES, STATE MEDICAID MANUAL, § 5360.

¹⁴² 42 U.S.C. § 1320b-9a(c).

¹⁴³ For the 2014 report, see <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf>.

¹⁴⁴ Ctrs. for Disease Control and Prevention, *Surveys and Data Collection Systems*, <http://www.cdc.gov/nchs/surveys.htm> (last visited Mar. 4, 2015).

¹⁴⁵ Ctrs. for Disease Control and Prevention, "State and Local Integrated Telephone Survey: Nat'l Survey of Children's Health," <http://www.cdc.gov/nchs/slits/nsch.htm> (last visited Mar. 4, 2015).

¹⁴⁶ ANNIE E. CASEY FOUNDATION, KIDSCOUNT DATABOOK 2014, Status of Children, <http://www.aecf.org/m/resourcedoc/aecf-2014kidscountdatabook-2014.pdf#page=18> (last visited Mar. 4, 2015).

¹⁴⁷ See 42 U.S.C. §§ 1315, 1396n(b).

¹⁴⁸ The standards for cost-effectiveness and consistency with Medicaid objectives differ somewhat for 1915(b) and 1115 waivers. See 42 U.S.C. §§ 1315(a), 1396n(b).

¹⁴⁹ CMS, *Waivers*, (last visited Mar. 4, 2015), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html.

¹⁵⁰ Section 1915(b) expressly prohibits the restriction of access to providers of family planning services and supplies and Federally Qualified Health Centers (FQHCs). 42 U.S.C. § 1396n(b).

¹⁵¹ See 42 U.S.C. §§ 1396n(c), 1396n(i), 1396n(k).

¹⁵² 42 U.S.C. § 1396n(b). 42 C.F.R. § 431.55.

¹⁵³ U.S. GOV'T ACCOUNTABILITY OFFICE, *MEDICAID DEMONSTRATIONS: HHS'S APPROVAL PROCESS FOR ARKANSAS'S MEDICAID EXPANSION WAIVER RAISES COST CONCERNS* (Aug. 8, 2014), <http://www.gao.gov/products/GAO-14-689R>.

¹⁵⁴ See Jane Perkins, NHeLP, *Q&A: Medicaid 'Reform' Waivers the Administrative Procedures Act* (Mar. 1, 2013), <http://www.healthlaw.org/publications/browse-all-publications/qa-medicaid-reform-waivers-and-the-administrative-procedures-act#.VFf0U8mq76o>.

¹⁵⁵ CMS, "Waivers," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html (last visited Mar. 4, 2015).

¹⁵⁶ 42 C.F.R. §§ 431.400-438.428.

¹⁵⁷ *Id.* §§ 431.408, 431.412.

¹⁵⁸ Most recently, Indiana was required to resubmit its Healthy Indiana Plan 2.0 proposal for this reason. Tom LoBianco, *Feds Return Indiana Waiver Request*, INDY STAR, Aug. 5, 2014.

¹⁵⁹ 42 C.F.R. § 431.55(b)(2).

¹⁶⁰ HHS, *Section 1915(b) Waiver Program Independent Assessments: Guidance to States*, 1 (Dec. 22, 1998); See also CTRS. FOR MEDICARE AND MEDICAID SERVICES, STATE MEDICAID MANUAL § 2111.

¹⁶¹ 42 U.S.C. 1396u-2 42 C.F.R. pt 438.

¹⁶² 42 C.F.R. § 431.420(f).

¹⁶³ *Id.* § 431.428.

¹⁶⁴ *Id.* § 431.428.

¹⁶⁵ *Id.* § 431.420(c).

¹⁶⁶ *Id.* §§ 431.420(c), 428(a)(11)

¹⁶⁷ CMS, *Waivers*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html (last visited Jan 12, 2015).

¹⁶⁸ See generally ACAP: The Association for Community Affiliated Health Plans, <http://www.communityplans.net/AboutUs.aspx;Mission/tabid/68/Default.aspx> (last visited Mar. 4, 2015).

¹⁶⁹ 42 C.F.R. § 438.116

¹⁷⁰ See generally Nat'l Ass'n of Ins. Comm'rs, "Risk Based Capital," http://www.naic.org/cipr_topics/topic_risk_based_capital.htm (last visited Mar. 4, 2015).

¹⁷¹ Nat'l Ass'n of Ins. Comm'rs, *Risk-Based Capital (RBC) For Insurers Model Act* (updated July 2014), available at <http://www.naic.org/store/free/MDL-312.pdf>.

¹⁷² *Id.*

¹⁷³ Press Release, DC DISB, Department of Insurance, Securities and Banking Puts Chartered Health Plan in Receivership (Oct. 19, 2012) *available at* <http://disb.dc.gov/node/344692>.

¹⁷⁴ Mike DeBonis, *Chartered Could Owe D.C. Health Providers \$85 Million*, WASH. POST (April 19, 2013).

¹⁷⁵ 26 U.S.C. § 6033.

¹⁷⁶ 26 U.S.C. § 6104(d).

¹⁷⁷ A list of all SIC categories is available by clicking the “?” next to the search box. Other potentially useful SIC numbers include 6321 – Accident and Health Insurance, 8050 – Services: Nursing and Personal Care Facilities, 8051 – Services-Skilled Nursing Care Facilities, 8060 – Services: Hospitals, and 8062 – Services: General Medical & Surgical Hospitals, NEC.

¹⁷⁸ See generally CMS, *Fact Sheet - Medical Loss Ratio: Getting Your Money's Worth on Health Insurance* (Nov. 22, 2010), *available at* <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/medical-loss-ratio.html>; HENRY J. KAISER FAMILY FDN: EXPLAINING HEALTH CARE REFORM: MEDICAL LOSS RATIO (MLR), Feb. 29 2012, *available at* <http://kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/>.

¹⁷⁹ 42 U.S.C. § 300gg–18; 45 C.F.R. pt. 158.

¹⁸⁰ 42 U.S.C. § 300gg–18.

¹⁸¹ KAISER COMM’N ON MEDICAID AND THE UNINSURED, A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2010: FINDINGS FROM A 50-STATE SURVEY (Sept. 2011), 3, *available at* <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8220.pdf>.

¹⁸² Letter from Cindy Mann, Director, Center for Medicaid & CHIP Services, to Justin Senior, Deputy Secretary for Medicaid Florida Agency for Health Care Administration (Jul. 31, 2014), *available at* <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-ca.pdf>.

¹⁸³ Sheldon Toubman, New Haven Legal Assistance, MEDICAID ADVOCATES’ GUIDE FOR HOLDING CAPITATED MANAGED CARE ENTITIES ACCOUNTABLE TO MEDICAID ENROLLEES AND STATE TAXPAYERS (Sept. 2013) (Available from NHeLP).

¹⁸⁴ *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970). See also 42 U.S.C. § 1396a(a)(3) (providing for a hearing for individuals whose claims for medical assistance under the plan are denied or not acted upon with reasonable promptness).

¹⁸⁵ *Goldberg*, 397 U.S. at 267; 42 C.F.R. §§ 431.210-431.240.

¹⁸⁶ See Jane Perkins, NHeLP, *Appeal Rights and Medicaid Benefit Reductions* (Jan. 2010) *available at* <http://www.healthlaw.org/publications/issue-brief-appeal-rights-and-medicaid-benefit-reductions#.VK7c63uULhw>.

¹⁸⁷ 42 U.S.C. § 1396u-2(a)(1)(A)(i), (b)(4); 42 C.F.R. §§ 438.400-.424.

¹⁸⁸ 42 C.F.R. § 438.408(f).

¹⁸⁹ *Id.* § 438.416.

¹⁹⁰ *Id.* § 431.244(g).

¹⁹¹ *Id.* § 431.244(g).

¹⁹² *Id.* § 438.416.

¹⁹³ Minn. Dept. of Human Servs., *Managed Care Grievance System Information Summary Calendar Years 2010-2012*, available at <https://edocs.dhs.state.mn.us/lfsrserver/public/DHS-6178A-ENG>.

¹⁹⁴ See N.J. DEPT. OF BANKING AND INSURANCE, INDEPENDENT HEALTH CARE APPEALS REPORTS, available at http://www.state.nj.us/dobi/division_insurance/managedcare/ihcareports.htm (last visited Mar. 4, 2015).

¹⁹⁵ *HealthNet of Conn. v. Freedom of Information Act Comm'n*, No. CV064010428S, 2006 WL 3691796 (Conn. Super. Ct. Nov. 29, 2006).

¹⁹⁶ See 42 U.S.C. § 1396u-2(c)(2)(A); 42 C.F.R. § 438.364(b).

¹⁹⁷ For example, the Virginia Freedom of Information Act provides that “all public records shall be open to inspection and copying by any citizens of the Commonwealth,” but it grants no such right to non-Virginians. Va. Code Ann. §2.2–3704(A).

¹⁹⁸ *McBurney v. Young*, 133 S. Ct. 1709 (2013).

¹⁹⁹ 5 U.S.C. § 552; see also 45 C.F.R. pt. 5 (HHS regulations implementing the FOIA).

²⁰⁰ *Id.* at § 552(f) (as amended by OPEN Government Act, Pub. L. No. 110-175, § 9).

²⁰¹ *Id.* at § 552(a)(6)(A).

²⁰² See Jane Perkins, NHeLP, Q&A - *Fee Waivers for Freedom of Information Act Processing*, (Sept., 24, 2008), available at <http://www.healthlaw.org/about/staff/jane-perkins/all-publications/qa-fee-waivers-for-freedom-of-information-act-processing#.VFFHcMntiyl>.

²⁰³ 5 U.S.C. § 552(a)(4); see 45 C.F.R. §§ 5.41-5.45 (DHHS fee procedures).

²⁰⁴ 5 U.S.C. § 552(a)(4)(A)(iii).

Appendix A. Medicaid Managed Care Resources and Reports

NHeLP Resources and Publications on Managed Care

NHeLP Resources (by Subject)

- General and Managed Care Series
- Accessibility & Language Access
- Due Process
- Enrollment & Disenrollment
- Financing and Contracting
- Managed Long Term Services and Supports (MLTSS)
- Network Adequacy
- Quality
- Reproductive Health
- Section 1115 & 1915 Waivers & Demonstrations
- Services
- Sunshine Project/Accountability

General Managed Care & NHeLP Series

- Medicaid Managed Care Model Provisions:
 - [Model Modernized Medicaid Managed Care Regulations](#) (Aug. 2014)
 - [Letter to Centers for Medicare and Medicaid Services re: Modernization of Medicaid Managed Care Regulations](#) (Aug. 2014)
 - [Sarah Somers, Medicaid Managed Care: Modernized Federal Regulations are Long Overdue](#), 29 HEALTH ADVOCATE 1, (Sept. 2014)
 - [Grievances and Appeals, Issue 1](#) (Sept. 2014)
 - [Enrollment and Disenrollment, Issue 2](#) (Sept. 2014)
 - [Network Adequacy, Issue 3](#) (Sept. 2014)
 - [Accessibility & Language Access, Issue 4](#) (Sept. 2014)
 - [Access to Reproductive Health Services, Issue 5](#) (Jan. 2015)
- Managed Care & Older Adults Series:
 - [Due Process in Duals Demonstrations: A Closer Look at New York](#) (Nov. 2014)
 - [Health Status, Care Management and Low-Income Seniors of Color](#) (Aug. 2014)
 - [Medicaid Managed Care Regulations and Older Adults](#) (Aug. 2014)
- Managed Care in California Series:
 - [County Organized Health System Medi-Cal Plans](#) (Sept. 2014)
 - [Network Adequacy Laws in Medi-Cal Managed Care Plans](#) (Aug. 2014)
 - [Sarah Somers, Beyond the HMO: Managing Care through Integrated Care Models in Medicaid](#), 10 HEALTH ADVOCATE 1 (Feb. 2013)
 - [Sarah Somers, Medicaid Managed Care](#), 5 HEALTH ADVOCATE 1 (Sept. 2012)
- [Medicaid Managed Care: 20 Questions to Ask Your State](#) (Apr. 2012)
- Getting the Best Out of Managed Care Fact Sheets:
 - Sheet 1: Introduction (July 2008) ([English](#) & [Spanish](#))
 - Sheet 2: Understanding Quality Measures (July 2008) ([English](#) & [Spanish](#))
 - Sheet 3: Figuring Out Which Health Care Plan Meets Your Needs (July 2008) ([English](#) & [Spanish](#))
 - Sheet 4: Report Cards (July 2009) ([English](#) & [Spanish](#))
 - Sheet 5: Consumer Surveys (July 2008) ([English](#) & [Spanish](#))

Appendix A. Medicaid Managed Care Resources and Reports

Accessibility & Language Access

- [Medicaid Managed Care Model Provisions: Accessibility & Language Access, Issue 4](#) (Sept. 2014)
- [Q & A: Medicaid Managed Care and Disability Protections](#) (May 2012)
- Getting the Best Out of Managed Care Fact Sheets:
 - [Sheet 1: Introducción](#) (July 2008)
 - [Sheet 2: Comprenda las Medidas de Evaluación de la Calidad](#) (July 2008)
 - [Sheet 3: Determine qué Plan de Atención de Salud Responde a sus Necesidades](#) (July 2008)
 - [Sheet 4: Boletas de Calificaciones](#) (July 2009)
 - [Sheet 5: Encuestas de Consumidores](#) (July 2009)
- [51-State Survey of Assessment of State Laws, Regulations and Practices Affecting the Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Plans](#) (July 2001)
- [Medicaid Managed Care Contracts: An Advocacy Checklist for People with Disabilities](#) (Sept. 1997)

Due Process

- [Medicaid Managed Care Model Provisions: Grievances and Appeals, Issue 1](#) (Sept. 2014)
- [Due Process in Duals Demonstrations: A Closer Look at New York, Managed Care and Older Adults Series, Issue No. 4](#) (Nov. 2014)
- [Medicaid Managed Care: Grievances and Appeals](#) (Apr. 2012)
- [Managed Care: Dealing with Problems](#) (Jan. 2005)
- [Model Medicaid Managed Care Contract Provisions – Complaint and Grievance Procedures](#) (May 1999)

Enrollment & Disenrollment

- [Medicaid Managed Care Model Provisions: Enrollment and Disenrollment, Issue 2](#) (Sept. 2014)
- [Medicaid Managed Care Model Provisions: Accessibility & Language Access, Issue 4](#) (Sept. 2014)
- [Continuity of Care in the Transition from the Low Income Health Program to Medi-Cal](#) (Dec. 2013)
- [Continuity of Care in Medi-Cal](#) (Sept. 2013)
- [Five Key Standards for Dual Eligible MOUs](#) (Oct. 2012)
- [Medicaid Managed Care: Enrollment and Education](#) (Apr. 2012)

Financing and Contracting

- [Sarah Somers, *Beyond the HMO: Managing Care through Integrated Care Models in Medicaid*, 10 HEALTH ADVOCATE 1](#) (Feb. 2013)
- [Medicaid Managed Care: Financing](#) (Apr. 2012)

Appendix A. Medicaid Managed Care Resources and Reports

- [Model Medicaid Managed Care Contract Provisions -- A Primer on Medicaid Managed Care Contracting](#) (Apr. 1998)

Managed Long Term Services and Supports (MLTSS)

- [Five Key Standards for Dual Eligible MOUs](#) (Oct. 2012)
- [Q & A: Medicaid Managed Care and Disability Protections](#) (May 2012)
- [NHeLP Guide for Evaluating State Duals Integration Demonstration Proposals](#) (May 2012)
- [A Guide to Medi-Cal Managed Care for People with Developmental Disabilities, their Families and Professionals](#) (May 1999)
- [Medicaid Managed Care Contracts: An Advocacy Checklist for People with Disabilities](#) (Sept. 1997)

Network Adequacy

- [NHeLP Comments on NAIC's Managed Care Plan Network Adequacy Model Act](#) (Jan. 2015)
- [Medicaid Managed Care Model Provisions: Network Adequacy, Issue 3](#) (Sept. 2014)
- [Managed Care in California Series, Issue 1: Network Adequacy Laws in Medi-Cal Managed Care Plans](#) (Aug. 2014)
- [Network Adequacy in Medicaid Managed Care: Recommendations for Advocates](#) (Sept. 2013)
- [Five Key Standards for Dual Eligible MOUs](#) (Oct. 2012)

Quality

- [External Quality Review: An Overview](#) (June 2014)
- [Health Advocate: Quality and Accountability – An Introduction for Advocates](#) (July 2013)
- [NHeLP Comments to Agency for Healthcare Research and Quality Regarding Priority Setting for CHIPRA Pediatric Quality Measures Program](#) (Jan. 2011)
- [Report: The Pursuit of Medicaid Managed Care Quality Information in Six States](#) (Jan. 2010)
- [Medicaid Managed Care Quality: HEDIS Measure Comparisons for Five States](#) (Jan. 2010)
- Getting the Best Out of Managed Care Fact Sheets:
 - Sheet 1: Introduction (July 2008) ([English](#) & [Spanish](#))
 - Sheet 2: Understanding Quality Measures (July 2008) ([English](#) & [Spanish](#))
 - Sheet 3: Figuring Out Which Health Care Plan Meets Your Needs (July 2008) ([English](#) & [Spanish](#))
 - Sheet 4: Report Cards (July 2009) ([English](#) & [Spanish](#))
 - Sheet 5: Consumer Surveys (July 2008) ([English](#) & [Spanish](#))
- [External Quality Reviews in Medicaid Managed Care](#) (July 2008)
- [Medicaid Managed Care Monitoring Tool 1: Client Questionnaire](#) (July 1997)

Appendix A. Medicaid Managed Care Resources and Reports

Reproductive Health

- [Medicaid Managed Care Model Provisions: Access to Reproductive Health Services, Issue 5](#) (Jan. 2015)
- [Medicaid Managed Care and Women's Health](#) (Aug. 2013)
- [Health Advocate: Medicaid Managed Care and Women's Health](#) (Sept. 2013)

Section 1115 & 1915 Waivers & Demonstrations

- [NHeLP Comments to Arkansas 1115 Demonstration Application](#) (Sept. 2013)
- [Q & A: Medicaid "Reform" Waivers and the Administrative Procedures Act](#) (Mar. 2013)

Services

- [Lessons from CA: Ensuring Medi-Cal Plans Provide Services to Children](#) (Dec. 2014)
- [Behavioral Health: Medicaid, Managed Care and Children More Questions to Ask](#) (2012)
- [Medicaid Managed Care: Services](#) (Apr. 2012)
- [Thirty Questions to Ask About Managed Care and EPSDT](#) (Apr. 2012)
- [Medicaid Managed Care and Children with Special Needs: An EPSDT Checklist](#) (Sept. 1997)

Sunshine Project/Accountability

- [Fact Sheet: Medicaid Managed Care Litigation](#) (June 2013)
- [Q & A: Managed Care Informing and Disclosure Requirements](#) (Sept. 2012)
- [Medicaid Sunshine and Accountability: Listing of Requirements for Information](#) (Jan. 2010)
- [Q & A: Publicly Available Data in Medicaid Managed Care](#) (June 2007)
- [Q & A: Assuring Accountability and Stewardship in Medicaid Managed Care: Public Reporting Requirements for States and MCOs](#) (June 2007)

Medicaid Managed Care: External Resources

- **General and Managed Care Series**
- **Accessibility & Language Access**
- **Due Process**
- **Enrollment & Disenrollment**
- **Financing and Contracting**
- **Key Medicaid Managed Care Guidance**
- **Managed Long Term Services and Supports (MLTSS)**
- **Network Adequacy**
- **Oversight, Transparency & Accountability**
- **Quality**
- **Reproductive Health**
- **Section 1115 & 1915 Waivers & Demonstrations**
- **Services**

General Managed Care

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Appendix B. EQROs and Web-Accessible Quality and EQR Data, by State

This chart links to the active EQROs in each state with a Medicaid or CHIP managed care contract that triggers the EQR requirement. While not comprehensive, it provides an overview of transparency and variability between states and makes it easier to compare across Medicaid programs.

State	EQRO	Website for Annual EQR Reports & Related Quality Data
Alabama	No current MCO or PIHP contracts, so EQR not required. Alabama recently proposed an ACO-like managed care demonstration, but has not received CMS approval as of this writing.	
Alaska	No current MCO or PIHP contracts, so EQR not required.	

Arizona	Health Care Excel (HCE) Quality Quest, Inc. Health Services Advisory Group (HSAG)²⁰⁵	EQR reports for behavioral health plans, acute care plans, and long-term care: http://www.azahcccs.gov/reporting/reports/EQR.aspx
Arkansas	Managed care is delivered through an § 1115 Marketplace premium assistance demonstration. Independent review is required, but not necessarily by an EQRO. The evaluation strategy was approved by CMS in March 2014. Other data on the state's waiver demonstration are available from the Arkansas Center for Health Improvement and on the Division of Medical Services website .	
California	HSAG APS Healthcare, Inc.	Medi-Cal Managed Care EQR reports: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx Mental Health Plans EQR reports: http://caegro.com/webx/Reports%20and%20Presentations/
Colorado	HSAG	Behavioral & physical health plan EQR reports: http://www.colorado.gov/cs/Satellite?c=Page&childpagename=HCPF%2FHCPFLayout&cid=1251580848959&pagename=HCPFWrapper
Connecticut	Mercer Government Human Services Consulting (Mercer) (Through 2011)	As of January 2012, CT no longer contracts with MCOs. The current primary care case management program does not require EQR. 2011 EQR powerpoint: http://www.cga.ct.gov/med/council/2011/0311/20110311ATTACH_External%20Quality%20Review.pdf

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Delaware	Mercer	Quality strategy: http://www.dhss.delaware.gov/dhss/dmma/dshpplus.html EQR reports not readily available online.
District of Columbia	Delmarva Foundation	2011-12 EQR report (also available on CMS EQRO website): http://dhcf.dc.gov/release/dhcf-cy-2011-2012-managed-care-organization-technical-report
Florida	HSAG Institute for Child Health Policy at the University of Florida (ICHP)	Medicaid managed care reports, PIP plans and quality measures data since 2006 (conducted by HSAG): http://www.myfloridaeqro.com/Resources.aspx CHIP EQR reports (conducted by ICHP): https://www.healthykids.org/resources/research/institute/
Georgia	HSAG	EQR annual reports and other quality measurement data: http://dch.georgia.gov/medicaid-quality-reporting
Hawaii	HSAG	EQR reports: http://www.med-quest.us/ManagedCare/consumerguides.html
Idaho	Qualis Health	Applies to Idaho's managed care program for dual eligible beneficiaries. EQR reports not readily available online.
Illinois	HSAG	EQR reports through 2011: http://www2.illinois.gov/hfs/ManagedCare/Pages/EQRTR.aspx Evaluation of Illinois' Integrated Care Program managed care § 1115 demonstration (conducted by the Institute on Disability and Human Development at University of Illinois at Chicago): Year 1: http://www.ahs.uic.edu/media/uicedu/ahs/documents/dhd/publications/An,Independent,Evaluation,of,the,Integrated,Care,Program,(full).pdf
Indiana	Burns & Associates, Inc.	CHIP & Medicaid (Only most recent year available online): http://www.burnshealthpolicy.com/publications/

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Iowa	Iowa Foundation for Medical Care (IFMC), now Telligen	Iowa EQR includes its CHIP program, known as hawk-I, and its mental health and substance abuse MCO, Magellan Health. Recent quality and EQR reports are not readily available on the Medicaid or hawk-i website. It is unclear how EQR regulations will apply to Iowa's new premium assistance Medicaid Expansion. 2008 EQR report for Magellan Health (mental health and substance abuse MCO): http://www.ime.state.ia.us/docs/EQR-2006-07.doc
Kansas	Kansas Foundation for Medical Care, Inc.	Kancare § 1115 demonstration evaluation quarterly reports: http://www.kancare.ks.gov/reports.htm
Kentucky	Island Peer Review Organization (IPRO)	IPRO 2012-13 <i>Managed Care Program Progress Report</i> (EQR technical report not available online): http://chfs.ky.gov/nr/ronlyres/82c340a5-d0bf-4852-8300-93e98a8dfe5d/0/2managedcareprogramprogressreport_20122013final21114.pdf IPRO has created an MCO performance dashboard based on HEDIS measures: http://ky.mco.ipro.org/ Urban Institute has also evaluated Kentucky's managed care § 1115 demonstration: 2012: Urban Institute Year 1 Evaluation 2013: Urban Institute Year 2 Evaluation
Louisiana	IPRO	EQR reports (Summary only): http://new.dhh.louisiana.gov/index.cfm/subhome/6 Grievance, appeals and other quality measures by plan: http://new.dhh.louisiana.gov/index.cfm/page/1750
Maine	No MCO or PIHP contracts, so EQR not required.	
Maryland	Delmarva Foundation	EQR & PIP reports: https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/CY%202012.aspx MCO Report Card: https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/HealthChoice%20Quality%20Assurance%20Activities.aspx
Massachusetts	APS Healthcare, Inc.	HEDIS results, CHIP annual reports: http://www.mass.gov/eohhs/researcher/insurance/masshealth-annual-reports.html Details of 2013 EQRO activities: http://www.mass.gov/eohhs/docs/masshealth/research/qualitystrategy-05.pdf
Michigan	HSAG	Medicaid health plans: https://www.michigan.gov/mdch/0,4612,7-132-2943_4860-28384--,00.html

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Minnesota	Michigan Peer Review Organization (MPRO)	EQR and other Quality Data Site: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_159905#
Mississippi	The Carolinas Center for Medical Excellence (CCME)	EQR and other quality data for Mississippi Coordinated Access Network not readily available on the website.
Missouri	Behavioral Health Concepts, Inc. (BHC)	EQR Protocols: http://www.dss.mo.gov/mhd/mc/pages/eqr-protocols.htm EQR and other Quality Evaluations: http://www.dss.mo.gov/mhd/mc/pages/reports.htm
Montana	No MCO or PIHP contracts, so EQR not required.	
Nebraska	IPRO	EQR and other quality data for physical health managed care not readily available online. Nebraska's behavioral health managed care program, which began in September 2013, has not yet compiled its first EQRO report.
Nevada	HSAG	EQR report and quality strategy: https://dhcfp.nv.gov/ManagedCare/EQRO.htm
New Hampshire	HSAG	New Hampshire implemented its managed care program in December 2013. It has posted a Medicaid Care Management Quality Performance Report and its first EQR annual report on the state's Medicaid quality webpage .
New Jersey	MPRO (2008-2010) IPRO (2011-present)	Managed Care Performance Reports: http://www.state.nj.us/humanservices/dmahs/news/
New Mexico	HealthInsight New Mexico	EQR reports: http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx
New York	IPRO Burns & Associates, Inc.	2011 report summary available on CMS' EQRO website . Healthy NY Program (2009-2010): http://www.burnshealthpolicy.com/report/healthy-ny/
North Carolina	Formerly CCME , currently none	HEDIS results & other performance data for the Division of Medical Assistance: http://www.ncdhhs.gov/dma/quality/
North Dakota	Delmarva Foundation	Draft Quality Strategy Plan 2014: http://www.nd.gov/dhs/info/pubs/docs/medicaid/draft-quality-strategy-plan.pdf EQR reports pending initiation of managed care program.

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Ohio	HSAG	EQR activities website: www.myohioeqro.com Member satisfaction reports and other managed care data for Covered Families and Children program: http://medicaid.ohio.gov/RESOURCES/Research/MedicaidManagedHealthCareReports.aspx#1202500-2012 Aged, Blind, Disabled: http://medicaid.ohio.gov/RESOURCES/Research/MedicaidManagedCareReports.aspx#1199505-2008-combined-abd-and-cfc-reports
Oklahoma	Burns & Associates, Inc. (2008) Telligen	InsureOK program (2008 only): http://www.burnshealthpolicy.com/publications/ Pacific Health Policy Group conducts independent quality reviews of the Soonercare Health Management Program (2011-2013): http://www.telligen.com/state-government-medicaid/program-success
Oregon	Acumentra Health	Oregon Coordinated Care Organizations & Mental Health Plans evaluations: http://www.acumentra.org/publications/external-quality-review-reports/
Pennsylvania	IPRO	HEDIS & EQR reports: http://www.dpw.state.pa.us/publications/healthchoicespublications/index.htm
Rhode Island	IPRO	Summary of EQR and other quality measures: http://www.eohhs.ri.gov/ReferenceCenter/ResearchAnalysis.aspx 2012 EQR report: http://www.ohhs.ri.gov/documents/documents13/Aggregate_EQR_Report.pdf 2011 Lewin Group evaluation of RI § 1115 demonstration: http://www.ohhs.ri.gov/documents/documents13/
South Carolina	CCME	2009 EQR process & contact info: http://www.thecarolinascenter.org/documents/SCEQR_EQRProcessPresentation.ppt 2009 EQR report for Medical Homes Network: https://www.thecarolinascenter.org/documents/SCEQR_PIPOverview200910.doc Health Plan report cards: http://www.schealthviz.sc.edu/health-plan-performance-report-card Other EQR reports not readily available online.
South Dakota	No MCO or PIHP contracts, so EQR not required.	

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Tennessee	Qsource HSAG	HEDIS reports: http://www.tn.gov/tenncare/pro-hedis.shtml Quality Assessment and Improvement Strategy reports: http://www.tn.gov/tenncare/news-reports.shtml EQR reports not readily available online.
Texas	ICHP	EQRO survey reports: Contract year 2012: http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf Contract year 2011: http://www.hhsc.state.tx.us/reports/2012/2011-EQRO-Summary-Activities.pdf Other: http://www.hhsc.state.tx.us/about_hhsc/reports/search/Search_Reports.asp (Search by report type “Medicaid.” Additional results under report type “EQRO”) MCO performance profiles: http://www.hhsc.state.tx.us/medicaid/managed-care/mco-profiles.shtml
Utah	HCE Quality Quest, Inc. (to 2012) Utah Department of Health, Office of Health Care Statistics (Since 2013)	2013 CAHPS survey results and MCO performance reports available at: http://health.utah.gov/hda/
Vermont	HSAG	http://humanservices.vermont.gov/news-info/whats-new
Virginia	Delmarva Foundation	Virginia’s EQR and MCO performance reports: 2013: EQR and performance report 2012: EQR and performance report Other quality data, including 2014 Managed Care Annual Report , available on DMAS Managed care page under Studies and Reports tab.
Washington	Acumentra Health HSAG (Subcontractor)	Sort by EQR in: http://www.hca.wa.gov/medicaid/healthyoptions/documents/ For EQR updates see: https://www.acumentra.org/assets/WA-EQR-Update-2013-12-31.pdf
West Virginia	Delmarva Foundation	2009-2011 EQR reports: http://www.dhhr.wv.gov/bms/mco/Pages/Reports.aspx

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Wisconsin	Metastar	<p>Badgercare (only 2007 report available online): https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/reportsData.htm.spage</p> <p>Long-term Care: http://www.dhs.wisconsin.gov/ltcare/statefedregs/EQRO.htm</p> <p>LTSS Outcomes Survey 2012 Report (PEONIES—conducted by Metastar): http://www.chsra.wisc.edu/peonies/documents/PEONIES%20Final%20Report%20SFY2012%20-%20rev%2011-9-2012.pdf</p>
Wyoming	No MCO or PIHP contracts, so EQR not required.	

²⁰⁵ Federal regulations permit states to contract with more than one EQRO to conduct EQR and EQR-related activities. Subcontracting is also permitted. 42 C.F.R. § 438.356.

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This chart links to the active EQROs in each state with a Medicaid or CHIP managed care contract that triggers the EQR requirement. While not comprehensive, it provides an overview of transparency and variability between states and makes it easier to compare across Medicaid programs.

State	EQRO	Website for Annual EQR Reports & Related Quality Data
Alabama	No current MCO or PIHP contracts, so EQR not required. Alabama recently proposed an ACO-like managed care demonstration, but has not received CMS approval as of this writing.	
Alaska	No current MCO or PIHP contracts, so EQR not required.	

Arizona	Health Care Excel (HCE) Quality Quest, Inc. Health Services Advisory Group (HSAG)²⁰⁵	EQR reports for behavioral health plans, acute care plans, and long-term care: http://www.azahcccs.gov/reporting/reports/EQR.aspx
Arkansas	Managed care is delivered through an § 1115 Marketplace premium assistance demonstration. Independent review is required, but not necessarily by an EQRO. The evaluation strategy was approved by CMS in March 2014. Other data on the state's waiver demonstration are available from the Arkansas Center for Health Improvement and on the Division of Medical Services website .	
California	HSAG APS Healthcare, Inc.	Medi-Cal Managed Care EQR reports: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx Mental Health Plans EQR reports: http://caegro.com/webx/Reports%20and%20Presentations/
Colorado	HSAG	Behavioral & physical health plan EQR reports: http://www.colorado.gov/cs/Satellite?c=Page&childpagename=HCPF%2FHCPFLayout&cid=1251580848959&pagename=HCPFWrapper
Connecticut	Mercer Government Human Services Consulting (Mercer) (Through 2011)	As of January 2012, CT no longer contracts with MCOs. The current primary care case management program does not require EQR. 2011 EQR powerpoint: http://www.cga.ct.gov/med/council/2011/0311/20110311ATTACH_External%20Quality%20Review.pdf

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Delaware	Mercer	Quality strategy: http://www.dhss.delaware.gov/dhss/dmma/dshpplus.html EQR reports not readily available online.
District of Columbia	Delmarva Foundation	2011-12 EQR report (also available on CMS EQRO website): http://dhcf.dc.gov/release/dhcf-cy-2011-2012-managed-care-organization-technical-report
Florida	HSAG Institute for Child Health Policy at the University of Florida (ICHP)	Medicaid managed care reports, PIP plans and quality measures data since 2006 (conducted by HSAG): http://www.myfloridaeqro.com/Resources.aspx CHIP EQR reports (conducted by ICHP): https://www.healthykids.org/resources/research/institute/
Georgia	HSAG	EQR annual reports and other quality measurement data: http://dch.georgia.gov/medicaid-quality-reporting
Hawaii	HSAG	EQR reports: http://www.med-quest.us/ManagedCare/consumerguides.html
Idaho	Qualis Health	Applies to Idaho's managed care program for dual eligible beneficiaries. EQR reports not readily available online.
Illinois	HSAG	EQR reports through 2011: http://www2.illinois.gov/hfs/ManagedCare/Pages/EQRTR.aspx Evaluation of Illinois' Integrated Care Program managed care § 1115 demonstration (conducted by the Institute on Disability and Human Development at University of Illinois at Chicago): Year 1: http://www.ahs.uic.edu/media/uicedu/ahs/documents/dhd/publications/An,Independent,Evaluation,of,the,Integrated,Care,Program,(full).pdf
Indiana	Burns & Associates, Inc.	CHIP & Medicaid (Only most recent year available online): http://www.burnshealthpolicy.com/publications/

Appendix B. EQROs and Web-Accessible Quality and EQR Data, by State

Iowa	Iowa Foundation for Medical Care (IFMC), now Telligen	Iowa EQR includes its CHIP program, known as hawk-I, and its mental health and substance abuse MCO, Magellan Health. Recent quality and EQR reports are not readily available on the Medicaid or hawk-i website. It is unclear how EQR regulations will apply to Iowa's new premium assistance Medicaid Expansion. 2008 EQR report for Magellan Health (mental health and substance abuse MCO): http://www.ime.state.ia.us/docs/EQR-2006-07.doc
Kansas	Kansas Foundation for Medical Care, Inc.	Kancare § 1115 demonstration evaluation quarterly reports: http://www.kancare.ks.gov/reports.htm
Kentucky	Island Peer Review Organization (IPRO)	IPRO 2012-13 <i>Managed Care Program Progress Report</i> (EQR technical report not available online): http://chfs.ky.gov/nr/ronlyres/82c340a5-d0bf-4852-8300-93e98a8dfe5d/0/2managedcareprogramprogressreport_20122013final21114.pdf IPRO has created an MCO performance dashboard based on HEDIS measures: http://ky.mco.ipro.org/ Urban Institute has also evaluated Kentucky's managed care § 1115 demonstration: 2012: Urban Institute Year 1 Evaluation 2013: Urban Institute Year 2 Evaluation
Louisiana	IPRO	EQR reports (Summary only): http://new.dhh.louisiana.gov/index.cfm/subhome/6 Grievance, appeals and other quality measures by plan: http://new.dhh.louisiana.gov/index.cfm/page/1750
Maine	No MCO or PIHP contracts, so EQR not required.	
Maryland	Delmarva Foundation	EQR & PIP reports: https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/CY%202012.aspx MCO Report Card: https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/HealthChoice%20Quality%20Assurance%20Activities.aspx
Massachusetts	APS Healthcare, Inc.	HEDIS results, CHIP annual reports: http://www.mass.gov/eohhs/researcher/insurance/masshealth-annual-reports.html Details of 2013 EQRO activities: http://www.mass.gov/eohhs/docs/masshealth/research/qualitystrategy-05.pdf
Michigan	HSAG	Medicaid health plans: https://www.michigan.gov/mdch/0,4612,7-132-2943_4860-28384--,00.html

Appendix B. EQROs and Web-Accessible Quality and EQR Data, by State

Minnesota	Michigan Peer Review Organization (MPRO)	EQR and other Quality Data Site: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_159905#
Mississippi	The Carolinas Center for Medical Excellence (CCME)	EQR and other quality data for Mississippi Coordinated Access Network not readily available on the website.
Missouri	Behavioral Health Concepts, Inc. (BHC)	EQR Protocols: http://www.dss.mo.gov/mhd/mc/pages/eqr-protocols.htm EQR and other Quality Evaluations: http://www.dss.mo.gov/mhd/mc/pages/reports.htm
Montana	No MCO or PIHP contracts, so EQR not required.	
Nebraska	IPRO	EQR and other quality data for physical health managed care not readily available online. Nebraska's behavioral health managed care program, which began in September 2013, has not yet compiled its first EQRO report.
Nevada	HSAG	EQR report and quality strategy: https://dhcfp.nv.gov/ManagedCare/EQRO.htm
New Hampshire	HSAG	New Hampshire implemented its managed care program in December 2013. It has posted a Medicaid Care Management Quality Performance Report and its first EQR annual report on the state's Medicaid quality webpage .
New Jersey	MPRO (2008-2010) IPRO (2011-present)	Managed Care Performance Reports: http://www.state.nj.us/humanservices/dmahs/news/
New Mexico	HealthInsight New Mexico	EQR reports: http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx
New York	IPRO Burns & Associates, Inc.	2011 report summary available on CMS' EQRO website . Healthy NY Program (2009-2010): http://www.burnshealthpolicy.com/report/healthy-ny/
North Carolina	Formerly CCME , currently none	HEDIS results & other performance data for the Division of Medical Assistance: http://www.ncdhhs.gov/dma/quality/
North Dakota	Delmarva Foundation	Draft Quality Strategy Plan 2014: http://www.nd.gov/dhs/info/pubs/docs/medicaid/draft-quality-strategy-plan.pdf EQR reports pending initiation of managed care program.

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Ohio	HSAG	EQR activities website: www.myohioeqro.com Member satisfaction reports and other managed care data for Covered Families and Children program: http://medicaid.ohio.gov/RESOURCES/Research/MedicaidManagedHealthCareReports.aspx#1202500-2012 Aged, Blind, Disabled: http://medicaid.ohio.gov/RESOURCES/Research/MedicaidManagedCareReports.aspx#1199505-2008-combined-abd-and-cfc-reports
Oklahoma	Burns & Associates, Inc. (2008) Telligen	InsureOK program (2008 only): http://www.burnshealthpolicy.com/publications/ Pacific Health Policy Group conducts independent quality reviews of the Soonercare Health Management Program (2011-2013): http://www.telligen.com/state-government-medicaid/program-success
Oregon	Acumentra Health	Oregon Coordinated Care Organizations & Mental Health Plans evaluations: http://www.acumentra.org/publications/external-quality-review-reports/
Pennsylvania	IPRO	HEDIS & EQR reports: http://www.dpw.state.pa.us/publications/healthchoicespublications/index.htm
Rhode Island	IPRO	Summary of EQR and other quality measures: http://www.eohhs.ri.gov/ReferenceCenter/ResearchAnalysis.aspx 2012 EQR report: http://www.ohhs.ri.gov/documents/documents13/Aggregate_EQR_Report.pdf 2011 Lewin Group evaluation of RI § 1115 demonstration: http://www.ohhs.ri.gov/documents/documents13/
South Carolina	CCME	2009 EQR process & contact info: http://www.thecarolinascenter.org/documents/SCEQR_EQRProcessPresentation.ppt 2009 EQR report for Medical Homes Network: https://www.thecarolinascenter.org/documents/SCEQR_PIPOverview200910.doc Health Plan report cards: http://www.schealthviz.sc.edu/health-plan-performance-report-card Other EQR reports not readily available online.
South Dakota	No MCO or PIHP contracts, so EQR not required.	

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Tennessee	Qsource HSAG	HEDIS reports: http://www.tn.gov/tenncare/pro-hedis.shtml Quality Assessment and Improvement Strategy reports: http://www.tn.gov/tenncare/news-reports.shtml EQR reports not readily available online.
Texas	ICHP	EQRO survey reports: Contract year 2012: http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf Contract year 2011: http://www.hhsc.state.tx.us/reports/2012/2011-EQRO-Summary-Activities.pdf Other: http://www.hhsc.state.tx.us/about_hhsc/reports/search/Search_Reports.asp (Search by report type “Medicaid.” Additional results under report type “EQRO”) MCO performance profiles: http://www.hhsc.state.tx.us/medicaid/managed-care/mco-profiles.shtml
Utah	HCE Quality Quest, Inc. (to 2012) Utah Department of Health, Office of Health Care Statistics (Since 2013)	2013 CAHPS survey results and MCO performance reports available at: http://health.utah.gov/hda/
Vermont	HSAG	http://humanservices.vermont.gov/news-info/whats-new
Virginia	Delmarva Foundation	Virginia’s EQR and MCO performance reports: 2013: EQR and performance report 2012: EQR and performance report Other quality data, including 2014 Managed Care Annual Report , available on DMAS Managed care page under Studies and Reports tab.
Washington	Acumentra Health HSAG (Subcontractor)	Sort by EQR in: http://www.hca.wa.gov/medicaid/healthyoptions/documents/ For EQR updates see: https://www.acumentra.org/assets/WA-EQR-Update-2013-12-31.pdf
West Virginia	Delmarva Foundation	2009-2011 EQR reports: http://www.dhhr.wv.gov/bms/mco/Pages/Reports.aspx

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Wisconsin	Metastar	<p>Badgercare (only 2007 report available online): https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/reportsData.htm.spage</p> <p>Long-term Care: http://www.dhs.wisconsin.gov/ltcare/statefedregs/EQRO.htm</p> <p>LTSS Outcomes Survey 2012 Report (PEONIES—conducted by Metastar): http://www.chsra.wisc.edu/peonies/documents/PEONIES%20Final%20Report%20SFY2012%20-%20rev%2011-9-2012.pdf</p>
Wyoming	No MCO or PIHP contracts, so EQR not required.	

²⁰⁵ Federal regulations permit states to contract with more than one EQRO to conduct EQR and EQR-related activities. Subcontracting is also permitted. 42 C.F.R. § 438.356.