ASTHO Report
In-depth coverage of leading state and territorial public health issues.
May 2019

Leveraging Public Health Assets in Medicaid Managed Care

State and territorial health agencies (S/THAs) and Medicaid agencies each serve at-risk populations and may seek to align their resources to efficiently meet their goals. However, the two types of agencies have differences in terminology, tools, and orientation that can present barriers to alignment and collaboration.

This three-part guide maps the public health capacities, assets, and resources onto the obligations and direction of Medicaid agencies and their managed care health plans.

- **Part I describes the current Medicaid and managed care context**. This background section provides a summary of Medicaid mandatory and optional benefits and populations. This segment of the report is intended to be used for introductory learning and as a resource for references.

- **Part II describes the Medicaid managed care life cycle.** This summary section is intended to assist state and territorial health officials (S/THOs) in strategically and effectively timing outreach and partnership with Medicaid with respect to influencing managed care by describing the different phases of Medicaid managed care.

- **Part III describes Medicaid managed care key obligations and goals and identifies public health assets that can assist Medicaid in meeting these obligations.** This final and critical section of the guide equips S/THOs to lead strategic coordination efforts between S/THAs and state Medicaid agencies by elevating the public health assets that can inform network adequacy, quality oversight and monitoring, quality and care delivery improvement, and consumer supports. This section provides the content and public health expertise that would be most attractive to Medicaid managed care and could serve as the basis for ongoing partnership.

Medicaid managed care is by no means the only context for a collaboration between state public health and Medicaid agencies, but because of the prevalence of managed care arrangements in Medicaid, it warrants a specific discussion. While this guide is intended for state and territorial health officials, it may also be used by other members of a health department team.

Table of Contents

Part I: Medicaid Managed Care Context

Medicaid is a federal-state partnership that provides jointly-funded health insurance coverage to approximately 73 million low-income people in the United States.[i] Medicaid primarily serves low-income people who meet specific criteria in the following categories: children, senior citizens, people living with disabilities, and pregnant women.[ii] Each state can elect to have a Medicaid program, but no state is required to do so.[iii] If a state chooses to have a Medicaid program, it must provide certain services, known as mandatory services, to certain groups of people, known as mandatory populations. Appendix C describes mandatory and optional services provided to Medicaid participants, as well as mandatory and optional populations who may be eligible for Medicaid coverage. In return for meeting these baseline requirements, the federal government pays a fixed percentage (never less than 50%) of the cost of the provided services; states must pay the remaining proportion of costs. States can tailor their programs with respect to how they deliver services, what range of services they offer, and who is eligible for services by electing to cover optional services and optional populations.

Medicaid programs across the nation are increasingly contracting with managed care organizations (MCOs) to provide healthcare services to Medicaid participants. In fact, more than 75 percent of the 73 million Medicaid enrollees receive some or all of their Medicaid services through managed care arrangements.[iv] Understanding the relationship between a Medicaid agency and managed care health plans can help S/THOs collaborate effectively with Medicaid leadership to strategically deploy public health interventions within a Medicaid program.

Medicaid managed care generally describes a healthcare payment and delivery system in which a state Medicaid program pays a fixed, per-person rate (referred to as a capitated or per member per month rate) to an MCO for the delivery of Medicaid services.

An MCO usually refers to a health plan that manages the risk of coverage, contracts with providers for provision of services, processes provider claims or bills, and is paid by the purchaser of coverage. The purchaser in this instance is a state Medicaid program.

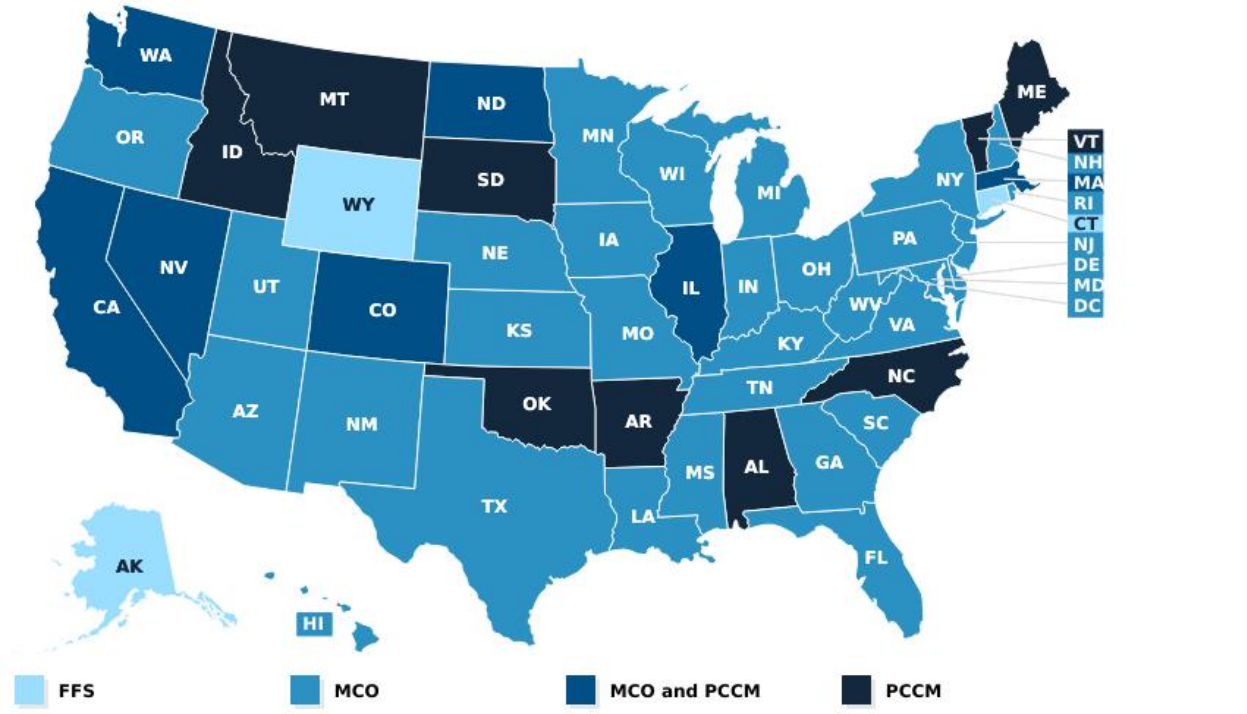
Many different payment and delivery arrangements are commonly included under the umbrella term of Medicaid managed care.[1,2] In addition to the MCO model noted above, there are two common prepaid, limited benefit plans that can be thought of as managed care for a specific subset of services (e.g., dental care or inpatient psychiatric care). These limited capitated arrangements are referred to as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs).

Primary care case management (PCCM) is another reimbursement arrangement under Medicaid managed care. This model is focused at the primary care level and includes a per-person fee paid directly to providers for the provision of a set of support services such as case management, disease management, and/or patient navigation. States may use a combination of all these arrangements for

[i] Medicaid only enrollment is 65.9 million. The 73 million figure includes Children Health Insurance Program (CHIP) enrollment. Accessed from: https://www.medicaid.gov/medicaid/index.html.
[ii] The subgroups described here are general categories, and often differ by each individual state.
[iii] At date of publication, all 50 states and the District of Columbia have elected to have a Medicaid program.
[iv] In a handful of states, the entire Medicaid benefit package—from physician services to long-term care to behavioral health—is provided by managed care health plans.

different populations and/or service sets.[3] This guide focuses on MCOs, PIHPs, and PAHPs.[v] Appendix B outlines the number of MCOs in each state.

Figure 1: Share of Medicaid Population Covered Under Different Delivery Systems: Types of Managed Care in Place (as of July 1, 2017)[4]



Medicaid managed care has grown in prevalence and reach for several decades. Figure 1 illustrates the breadth of Medicaid managed care across states, but there are major differences in levels of managed care saturation and involvement among the states. Some states use managed care arrangements to provide most of their Medicaid services, including community-based long-term care and dental and behavioral health. In other states, only hospital and physician services are completely provided through managed care, while other specialty services remain in the fee-for-service (FFS) environment. Likewise, some states enroll all Medicaid-eligible populations in managed care, while other states keep specific populations in fee-for-service care.

[v] PIHP and PAHP arrangements are included under the "MCO" designation in Figure 1 and throughout the remainder of the document.

Part II: Medicaid Managed Care Life Cycle

In general, Medicaid programs that use MCOs to administer benefits follow a similar procurement process across states. To initiate a Medicaid managed care program, a Medicaid agency develops and publishes a request for proposals (RFP) that lays out the general structure of the program, including performance expectations, quality measures, coverage rules, and reporting requirements for health plans. Health plans develop and submit applications in response to the RFP and, based on their competitive scores, are selected to enter into contracts with the state for the provision of the corresponding services. In most instances, states must offer a minimum of two plans to meet federal obligations.[vi]

Once the state executes the contract, each health plan can develop its own approach to meeting the requirements of the contract in a manner that is consistent with federal and state requirements.[5,6] As a result, there are as many ways of delivering Medicaid managed care as there are health plans. While the state may be prescriptive in a specific area or treatment protocol, it generally dictates the framework and coverage requirements, leaving it to health plans to decide specific elements, such as whether they should use alternative providers such as community health workers (CHW), offer telephonic or in-person disease management, or contract with S/THAs for specialized services, such as sexually transmitted disease (STD) identification and treatment.

Although Medicaid serves only a portion of the lives within a jurisdiction for which a State Health Official is responsible for all the lives, Medicaid population are frequently complex, underserved, and fragile subpopulations who experience disparities in health status and health outcomes. S/THAs can provide valuable direction to Medicaid programs about how to address those complexities and mitigate disparities through evidence-based practices to improve population health, strategies to engage consumers and connect them to clinical and community services, and robust data to inform decision-making. Many state Medicaid agencies utilize MCOs to manage and deliver clinical care services; consequently, it is critical that S/THAs engage with Medicaid agencies in the development and implementation of MCO contracts as a primary component of their Medicaid partnership activities.

Checklist for Engaging with Medicaid about Managed Care in Your State

Medicaid MCO coverage and contracting processes vary by state and may require thoroughly examining a state's Medicaid website and publicly available information. S/THA staff may also wish to engage Medicaid contacts in the state, if known, or build a relationship with appropriate Medicaid staff. The federal Medicaid website lists contact information for each state Medicaid agency.

[vi] 42 C.F.R. 438.52 2016. Available at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed 06-12-18. Managed care works under a set of federal rules that were revised in 2016 and again in 2018. This rule (CMS-2390-F) touches many aspects of managed care arrangements, and serves as the basis for state programs. State Medicaid agencies must submit managed care RFPs, contract templates, and rate structures to CMS for review.

Appendix A lists links to the rule and materials explaining key aspects of the rules. Some elements of these rules have yet to be fully implemented, and others are still evolving.

Use the following steps to engage with Medicaid about managed care.

At a Glance:
Checklist for Engaging with Medicaid About Managed Care in Your State

- ☐ Know who is in and who is out.
- ☐ Know what is included in your state's managed care arrangements.
- ☐ Identify your state's phase of managed care.
- ☐ Assemble the S/THA team and develop a targeted, focused plan of approach.

Know who is in and who is out of managed care.

The first recommended step in approaching a state Medicaid agency is to assess which Medicaid populations are enrolled in managed care in your state. This will help determine how to most effectively target specific public health tools and programs to Medicaid. For example, public health efforts to prevent prediabetic adults under 65 from progressing to fully developed diabetes will have less relevance in a state where Medicaid primarily covers older, disabled adults. Likewise, a state that excludes dental services from its managed care plans may have less motivation to tackle that issue than a state where health plans bear risk for their performance on preventive dental care quality measures. See Appendices 3 and 4 for more information about each state's Medicaid enrollment in managed care. S/THA staff can also find state-by-state information about which Medicaid populations are enrolled in managed care in the 2016 Medicaid Managed Care Enrollment Report.

Know what is included in your state's managed care arrangements.

The second step is to assess which services are provided through your state's managed care delivery system. For example, some states contract with a single group of health plans for all services. However, frequently there are also different health plans for different service lines. For example, a state may contract with three health plans for traditional clinical services but may contract with two others for long-term care services, and still another health plan entirely for behavioral health services. Some states also carve out prescription drug coverage, meaning those services may be delivered through different payment and delivery system entities.[vii]

Identify your state's phase of managed care.

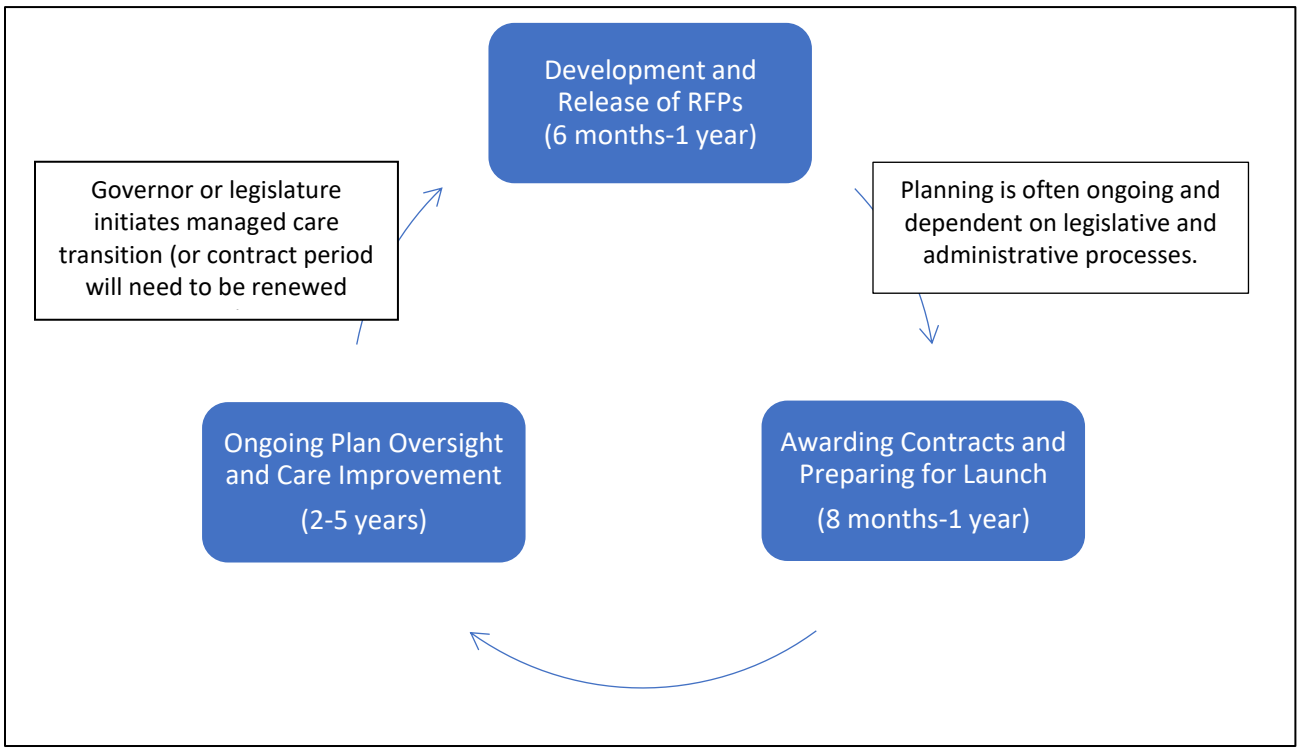
The third step in engaging your state Medicaid agency is to identify which phase of the managed care life cycle your state is in. Each state program is different, and even within a state, the current phase of managed care may differ for different service lines. Regardless, managed care contracting generally follows a standard process (see Figure 2).[viii] Depending on where a state stands with respect to its current phase of Medicaid managed care, certain activities will have more relevance and impact than others. States may also vary regarding how publicly accessible their MCO RFPs and contracts are. S/THA staff should examine state Medicaid websites and engage the Medicaid office for this information.

States may also seek Section 1115 research and demonstration waivers for certain aspects of their delivery system, which would likely occur prior to the life cycle described in this document. For more information on the Section 1115 Demonstration waiver process, see the Medicaid About Section 1115 Demonstrations web page.

[vii] Please note that health plans may not have direct control over drug utilization in a state where the Medicaid program uses a pharmacy benefits manager.

[viii] Managed care contracts vary in length but are generally issued in intervals of two to five years.

Figure 2: Life Cycle of Managed Care Programs and Contracting Process



Assemble the state or territorial health agency (S/THA) team and develop a targeted, focused plan of approach.

The fourth step in the checklist is to identify potential areas for collaboration with your state Medicaid agency based on current statewide health trends. Medicaid and S/THAs share many common pressures and demands, and often serve different cross-sections of the same populations. As a result, identifying three to five overarching common goals—such as introducing Medicaid to the state health improvement plan (SHIP) and its top priorities or reducing the prevalence and incidence of diabetes across the state—is helpful before focusing in on a more targeted set of objectives specific to the Medicaid population.

S/THOs can target a few areas of mutual priority and help ensure that the business case for partnership is oriented toward meeting Medicaid's obligations as well as public health goals. One example of this type of collaboration is CDC's 6|18 Initiative: Accelerating Evidence into Action.[7] Through this program, CDC provides technical assistance to state teams led by Medicaid and S/THAs to target six common and costly health conditions through 18 evidence-based interventions to prevent and reduce the impact of those conditions. Many states have implemented this framework to create effective collaborations between Medicaid agencies and S/THAs to address shared areas of focus. ASTHO's Guide on Getting Started with the CDC's 6|18 Initiative provides more information on how interested states can pursue the 6|18 framework.

The four Medicaid managed care life cycle phases described below highlight the key elements present during the managed care procurement life cycle process and include identified areas of potential collaboration.

Phase 1: Developing and Releasing the Request for Proposals

S/THAs can be especially instrumental during three components of the first phase of the managed care life cycle: educating Medicaid about valuable public health priorities and resources, incorporating public health priorities as managed care contract goals and metrics, and improving rate setting and risk adjustment with population-level data.

Educating Medicaid about Valuable Public Health Priorities and Resources

Depending on a state's legislative and administrative procedures, the managed care planning process may begin prior to the RFP release. However, much of the planning often occurs simultaneously to developing and releasing the RFP. ***The RFP is the basis of the future contract that will be executed between the state and the health plans. Subsequently, S/THAs can have the biggest influence on a Medicaid managed care program by engaging with state Medicaid agencies while they are still developing their RFPs, either when they are initiating the programs or amending or renewing existing contracts.*** Engaging early in the process will provide S/THAs with the best opportunity to advocate for including population health interventions in the managed care delivery system, especially in managed care contracts.

During the managed care planning process, state Medicaid agencies often use data from a variety of sources outside of health insurance claims to inform their RFPs. S/THAs can identify and present relevant data (e.g., vital statistics, health opportunity indices, and disease surveillance statistics) and can also analyze specific populations' health needs and report their results toe Medicaid leadership. Sharing such data can shape Medicaid contracting decisions that ultimately support specific public health initiatives or at-risk populations.

S/THAs can also identify effective interventions and services that are relevant to Medicaid programs and are already provided through public health programs and/or community-based public health service providers.

A S/THA should prepare the following information in anticipation of meeting with the state Medicaid agency about managed care procurement:

- The three most prevalent disease states or health conditions in the state.
- Evidence-based public health services and interventions that are already deployed in the state to address the above priorities.
- The relative efficacy of the intervention(s) in preventing or mitigating the specific health condition and any cost reductions associated with that efficacy.
- Where and how those services or interventions are currently available for the at-risk population.
- Information about how residents (especially existing Medicaid members, if known) currently utilize those services.

Table C below discusses further how S/THAs can support strategic planning efforts in these early stages. By providing this information, S/THAs can encourage Medicaid agencies to include performance requirements in their RFPs and contract directing MCOs to target existing state health improvement priorities and to use existing public health assets and providers to meet contract goals and targets. For

example, Michigan's 2015 Medicaid managed care RFP required MCOs to offer CHW services to enrollees with significant behavioral health issues and complex comorbidities. Michigan also required MCOs to maintain a CHW-to-enrollee ratio of at least one CHW for every 20,000 Medicaid enrollees.[8]

Incorporating Public Health Priorities as Managed Care Goals and Metrics

The next opportunity for incorporating public health priorities into the Medicaid managed care space is for S/THAs to work with state Medicaid agencies to isolate a finite number of shared priorities (briefly explored above) and incorporate them as goals and with metrics into RFPs. After laying out the business case for public health interventions, S/THOs can work with Medicaid agencies to review different measure sets (described in greater detail later in this document) to choose appropriate metrics that both align with population health needs and would be feasible for health plans to collect. These metrics can be used to measure health plans' progress toward meeting its stated goals and requirements**.**

Improving Rate Setting and Risk Adjustment with Population-Level Data

At some stage of developing the RFP, states will offer proposed capitated rates to be paid to the health plan for each member (a per person per month flat payment). These rates may be based on categories as broad as services to be provided together with the Medicaid members' gender, age, or eligibility group. Population-level data about health outcomes and social determinants of health (SDoH), which Medicaid normally doesn't collect, may help Medicaid agencies set those rates and perform risk adjustment.[9,10] Such data include vital records (i.e., births, deaths, and infant mortality); registry data (e.g., from cancer registries); data regarding reportable diseases and conditions (e.g., STDs and HIV/AIDS); immunization data; data from WIC offices, family planning clinics, and reproductive health clinics; newborn screening data; environmental health data; electronic reportable laboratory results; and population-based surveys.

Social indices like the Social Vulnerability Index, the Health Opportunity Index, or other informatics tools that compile data on income, education, housing, and other SDoH may be better aligned with Medicaid members' depth of need than traditional capitation rates based on broad demographic categories. For more information on using population-level data to adjust payment, the report, Medicaid and Social Determinants of Health: Adjusting Payment and Measuring Health Outcomes, includes best practices and state examples of SDoH data collection and risk adjustment in Medicaid programs. S/THAs can help to identify any assets that exist in this space and can collect the disparate data sets to help inform the risk adjustment process.

Table C: Engagement During the RFP Development Phase

State Medicaid Agency Engagement Ideas
Identify and provide data on: • The top 3-5 areas identified for improvement in SHIP. • Statewide disease surveillance data and registries. • Statewide natality, morbidity, and mortality. • Provider shortage designation areas. • SDoH and the health indices of communities Medicaid serves.
Identify evidence-based chronic and infectious disease programs that target needs identified in the SHIP.
Identify existing public health services and providers that Medicaid should require MCOs to contract with to serve Medicaid participants, such as:[11] • CHWs • Ryan White HIV/AIDS providers

• Immunization clinics • Housing assistance and home modification programs • Lead poisoning prevention and abatement programs • Tobacco cessation and prevention programs • Diabetes participation prevention programs • Hypertension prevention programs. • Unintended pregnancy prevention programs • Telehealth programs
Identify areas for Medicaid cost savings and/or outcome improvements. Possible activities include: • Identifying opportunities to utilize CHWs and other community-based health and social service providers. • Identifying low-cost, high-impact health interventions, such as the 6|18 interventions. • Using information from disease surveillance data to help identify and target health interventions for Medicaid-serving populations. • Working with local stakeholders to identify key community health needs and successful community health intervention strategies. • Providing data highlighting provider shortage areas. • Identifying evidence-based care coordination programs, outreach language, and materials that promote positive healthy behaviors.
Propose goals and metrics to be in the contract that require the health plans to address: • Reducing and preventing the 3-5 top priority conditions in the state health improvement plan. • Emerging health issues, such as STD outbreaks and cancer clusters. • SDoH. • Requiring public health providers to be in all MCO networks.
Provide Medicaid with population-level data on SDoH to refine rate setting and risk adjustment.

Phase 2: Selecting Plans and Preparing for Launch

Once state Medicaid agencies selects their health plans, they enter into contracts and begin preparing to launch the programs. For health plans that are new to the state Medicaid program, this process may include readiness reviews of health plans' procedures and operations. Sometimes these reviews find gaps in the current plan capacity (e.g., no preparedness plan or insufficient consumer support capacities). At this juncture, S/THAs can share best practices and respond to the identified gaps in care using the suggestions listed in Table D.

Table D: Engagement During the Review and Launch Phase

State Medicaid Agency Engagement Ideas
• Review health plan RFPs for service gaps and/or quality improvement strategy gaps. • Help health plans draft their own disaster preparedness plan or emergency communications tools to meet disaster preparedness and response requirements. • Evaluate health plan proposals to address top state health improvement priorities, address SDoH, care for vulnerable/at-risk populations, establish cultural competency, and account for language needs. Verify sufficient data collection, monitoring, and quality improvement plans. • Help health plans develop a needs assessment that includes SDoH.

Phase 3: Ongoing Plan Oversight and Care Improvement

Contracts with managed care plans typically last two to five years. Each year, the state may identify new quality improvement initiatives (e.g., performance improvement plans [PIPs]), quality metrics, or other modifications that health plans need to be address. They may also adjust reimbursement rates, which

may change during ongoing plan operations due to delivery system reforms, quality performance, and cost controls.

Many states are developing dashboards and other tools for hot-spotting problems and identifying areas needing focus or improvement. Often, Medicaid agencies will identify an area of concern and pull plans together to address and ameliorate the problems. For example, Medicaid agencies may assess claims data to identify opioid over-prescribing or high-cost populations' service utilization patterns indicating a lack of meaningful coordination or access to support services.

Collaboration opportunities during this period vary widely. Some S/THAs can work with health plans and Medicaid agency leadership to identify performance or quality improvement opportunities. Other public health programs work with Medicaid agencies to survey MCOs on how they reimburse for and deliver evidence-based interventions—such as long-acting reversible contraception or asthma medications or devices—in order to better understand barriers to uptake and opportunities for improvement. For example, for people living with HIV, the Ryan White HIV/AIDS Program can help Medicaid create viral load suppression performance measures and set benchmarks for performance improvement projects. (Table E demonstrates opportunities to engage with state Medicaid agencies during the contract management phase.)

Table E: Engagement During the Contract Management Phase

State Medicaid Agency Engagement Ideas
Monitor and support health plan progress in reaching contract goals and targets focusing on: • SDoH metrics. • Network adequacy. • Access to and outcomes of preventive services. • Performance of chronic disease management programs.

Part III: Medicaid Obligations and Public Health Supports

Four Medicaid managed care program obligations offer the most appropriate and fertile ground for collaboration with public health:

1. **Network Adequacy:** Medicaid must ensure that health plans have provider networks sufficient to provide access to all covered services for Medicaid enrollees. Under recent rules, states must establish a set of expectations relative to the time and distance that enrollees must travel to access care as part of this access definition. (States can use other metrics by which to assess adequacy.) Plans must provide documentation of their network enrollment for all provider types, and usually provide a network plan to address any gaps in the network.

2. **Quality Oversight and Monitoring:** States must establish a quality rating system for plans and have several transparency requirements for reporting quality data and performance assessment for managed care plans. Typically, states establish a set of quality metrics that all plans must report on that states use to evaluate plan performance and inform future contracting decisions. Health plans must report on quality and are expected to improve over time.

3. **Quality and Care Delivery Improvement:** Medicaid programs are expected to be able to demonstrate that they are good stewards of the large public investment required of any state with a Medicaid program. Many states have a variety of healthcare delivery reforms and expect their plans to participate. These reforms may include initiatives such as accountable care organizations, Medicaid health homes, or payment reform. Medicaid also requires performance improvement plans (PIPs) in its managed care contracts, which often target medical issues that have a significant impact on costs and outcomes (e.g., reducing C-section rates and reducing hospital readmissions). Plans are typically expected to participate in one to three such initiatives each year and report data to demonstrate improvement.

4. **Consumer Supports:** Medicaid is required to help its members access the program and is expected to enable members to participate in their own healthcare. This support takes many forms, from eligibility and enrollment assistance to providing consumer support materials in multiple languages. For special populations, like senior citizens, adults with disabilities, low-income expectant women, or children with special health needs, these requirements are considerably more demanding.

For most of these topics, state Medicaid agencies must meet federal requirements and receive federal approval for all potential program modifications. The amount of federal flexibility given to states in implementing new activities differs by Medicaid population and/or scope of services. The federal government also has strict rules for how states can use Medicaid funds, which may make it more difficult to implement innovative approaches.

The following tables identify high-value opportunities for S/THAs to collaborate with state Medicaid agencies, categorized by the Medicaid obligation to which they best contribute. (See Appendix D for

more information regarding S/THA opportunities to support Medicaid managed care obligations by section.)

Obligation: Network Adequacy

Public Health Capacity or Skill	Program or Funding Stream	Data Source
• Data analysis, interpretation, and visualization. • Population health needs by geography. • Provider geographic availability. • Best practices in network maximization (rural health and alternative providers). • Public health service providers, school health clinics, and Title X Family Planning Clinics. • Credentialing and "top of license/training" practice, including CHWs in team-based care. • Provider shortage area programs, e.g., The Physician Shortage Area Program. • Supports for Medicaid medication assisted treatment.[12] • Telehealth, telemedicine, and alternative visit types.	• Title X clinics and funding resources. • Community-based public health clinics and programs. • Immunization programs and tuberculosis clinics. • School health clinics. • Ryan White HIV/AIDS Program.[13] • Enabling services (e.g., environmental home assessments and other supports for health management).	• Licensure requirements and the distribution of licensed professionals. • Population health tools, including state data sets and statewide health planning tools. • Global information system tools and mapping for provider clusters, including Health Professional Shortage Areas. • CMS access rules compliance for guidelines and benchmarking for Medicaid managed care programs and plans. • Health informatics: managing and using patients' healthcare information.

The Medicaid managed care regulations require states to set standards for network adequacy based on time and distance metrics. It also allows states to use other measures of access and adequacy. Nationwide, states use multiple strategies to address network adequacy in the public health landscape. Three examples supporting network adequacy from a public health perspective include utilizing state primary care office efforts for workforce development, increasing healthcare worker availability and 'top of practice' utilization, and promoting Title X clinic connections to MCOs.[14]

The following offers promising ideas to support network adequacy requirements:

Support Network Providers

In many states and territories, the S/THA includes a primary care office (PCO), a program that HRSA funds to support comprehensive healthcare service delivery in areas that lack adequate health professionals or access to care and provide technical and non-financial assistance to community-based providers. S/THAs and their PCOs can support providers through scholarship and loan repayment programs, coordinating National Health Service Corps program sites, training opportunities, and other partnerships. S/THAs can use information from the primary care needs assessment and shortage designations to inform network adequacy.

Best Practices in Network Maximization

CHWs may be able to effectively engage traditionally hard-to-reach patient populations to improve

communication gaps, reduce cultural barriers to appropriate care, promote health equity, increase health literacy, and promote wellness. Integrating the CHW workforce into models of care delivery can maximize the limited resources of community health centers or chronic disease state programming to retain patient engagement and participation in care. Medicaid programs may include CHW services through defined reimbursement through Section 1115 Demonstration waivers, state legislation and state plan amendments for defined preventive services or broader Medicaid reimbursement, or reimbursement through managed care contracts.[15,16] For example, Massachusetts received approval of a Section 1115 Demonstration waiver that includes funding for specific CHW services, while Michigan required MCOs to contract with CHWs through a state plan amendment approved in 2016.[17] In addition, certain state Medicaid programs require MCOs to contract CHWs. For example, New Mexico requires its MCOs to make CHWs available to offer certain services, including healthcare system navigation, informal counseling, and translation services.[18] Louisiana is the latest state to include CHWs in their request for proposals for MCOs.

Louisiana Request for Proposals: Managed Care Organization Model Contract[19]

The Contractor shall, to the extent applicable, support the design and implementation of an evidence-based Community Health Worker (CHW) program which addresses SDOH, promotes prevention and health education, and is tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. Examples of CHW services include, but are not limited to:

- *Pilot a CHW demonstration project serving high-risk enrollees in a target region in Louisiana, if selected by [the Louisiana Department of Health (LDH)];*
- *Conduct in-person holistic assessments to understand enrollee needs, preferences and socioeconomic barriers;*
- *Assess barriers to healthy living and accessing health care, including conducting home visits;*
- *Schedule medical and behavioral health office visits;*
- *Address barriers to attending visits;*
- *Remind clients of scheduled visits multiple times;*
- *Accompany clients to office visits, as necessary;*
- *Participate in office visits, as necessary;*
- *Advocate for clients with providers;*
- *Arrange for social services (such as housing and heating assistance) and surrounding support services;*
- *Locate clients when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care;*
- *Provide social support to help boost clients' morale and sense of self-worth;*
- *Provide clients with training in self-management skills;*
- *Provide clients with someone they can trust by being reliable, nonjudgmental, consistent, open, and accepting; and*
- *Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives.*

Many states and regions throughout the nation have CHW associations and training programs to prepare CHWs for delivering specialty care services.[20] CHWs' abilities to navigate community resources and build trust among underserved populations can help strengthen network adequacy to ensure that

patients seeking services are connected to care. However, there can be challenges in developing and integrating a CHW workforce. Without a contractual requirement by the Medicaid agency for the MCOs to contract with CHWs, it will be up to individual health plans to decide whether and how much to use CHWs, and what services may be best suited for these providers.

During phase one of the Medicaid managed care life cycle, S/THAs can provide guidance and best practices to health plans and state agencies regarding how to maximize this community resource. During the procurement process, S/THAs can conduct learning sessions with plans and CHW forums or agencies. After the contract award, S/THAs can continue to facilitate interactions among the stakeholders about the benefits of using CHWs, including studying the quality and cost impacts.

Promoting Rural Health Network Adequacy

State offices of rural health may also be able to share best practices in network maximization for rural areas. Beyond just sharing information on access barriers such as location, rural health offices can provide subject matter expertise on ensuring that states meet network adequacy standards in rural areas and can help Medicaid programs apply a rural health lens when developing policies. In 2018, CMS launched the first ever Rural Health Strategy, which encourages state Medicaid agencies to adopt a rural health lens in policies, programs, and initiatives related to network adequacy and beyond.

Promoting Title X Clinic Connections to Managed Care Organizations

Access to reproductive health services relies on strong primary care systems and includes providers like Title X-funded clinics. Many individuals seen in Title X clinics are enrolled in Medicaid, but despite receiving Medicaid reimbursement for services, these clinics often remain reliant on public health funding. In managed care states, Medicaid reimbursement requires contracts with the plans serving enrolled populations, as well as any direct fee-for-service payments for any carved-out populations.

Many Title X-funded sites struggle with operational and data systems, which can have a dramatic effect on their financial sustainability. S/THAs can assist these clinics with data matching tools, privacy protections, billing acumen, and support during MCO plan negotiations. These activities can take place during any phase of the MCO life cycle, but they may be more necessary when a state is undergoing changes to a family planning waiver. In addition, partnering with Title X programs for children and youth with special health care needs can be an effective way for state Medicaid agencies to improve quality of care measurements and care coordination.[21]

Obligation: Quality Oversight and Monitoring

Public Health Capacity or Skill	Program or Funding Stream	Data Source
• Setting quality standards, including for long-term care, and supporting recipients living in the community. • Data tracking (comparison and baseline data).	• Healthy People 2020 and quality report cards. • Chronic disease surveillance programs.	• Disease surveillance systems and public health lab reports. • Dashboard monitoring. • Immunization and other case reporting registries.

• Disease-specific knowledge to inform evidence-based interventions. • Supporting health plans' PIPs. • Hospital quality and surveillance and monitoring data (e.g., data related to readmissions hospital acquired infections). • Provider education and profiling (e.g., regarding issues like over-prescribing antibiotics). • Data analytics, including hot-spotting and trending from population-level statistics. • Survey and study design.	• Prescription drug monitoring programs. • Public health laboratory services (e.g., for specialized testing like viral loads). • Disease reporting and monitoring through publicly-available reports. • CDC's 6|18 Initiative.	• Epidemiological analyses. • Healthcare Effectiveness Data and Information Set measure comparison.[22] • Consumer Assessment of Healthcare Providers and Systems measures. • Health information exchanges (HIE) and electronic medical records (EMR) data warehouses. • HIE meaningful use compliance across the state.[23]

S/THA priorities, tools, and evidence-based initiatives could serve as a strong foundation for state Medicaid agency efforts to track and improve their program quality and performance transparency. The most important element of this partnership will be matching up S/THA interventions with Medicaid priorities. S/THA demographic modeling, performance improvement, and quality monitoring can be directed toward Medicaid's quality agenda. Two possible avenues in this arena are HHS' Healthy People 2020 (HP2020) initiative and prioritizing quality metrics. S/THAs can review regulations and the 2017 MACPAC report *Program Integrity in Medicaid Managed Care* to understand Medicaid's obligation to provide oversight for MCOs to avoid fraud and abuse ensure quality service delivery.[24,25]

The following offers promising ideas to support quality oversight and monitoring requirements:

Healthy People 2020

For the past 30 years, HHS has used the HP2020 initiative to track 1,200 health objectives across 42 topic areas. These objectives and targets which can be tailored and focused at a state-specific level, provide goals ranging from preventive care to disease surveillance that inform quality monitoring and oversight for Medicaid agencies and MCOs.

Quality benchmarks, baseline data, and trending analyses are an important activity in all MCO life cycle phases and can be informed by HP2020. S/THAs can provide recommendations on goal setting during contract oversight and can provide comparative analytics across plans or state regions where health plans operate.

Setting Quality Standards

The 2016 Medicaid managed care "mega-rule" requires states to develop and publish an annual quality report.[26] States can shape this report and implement new quality measurement strategies that will support sound Medicaid policy and managed care practice. Working with Medicaid, S/THAs can help identify a quality infrastructure that aligns with state health goals and incorporates best practices in population health assessment and measurement.

Many state agencies are looking to develop MCO "dashboards" that track quality indicators, plan performance, financial data, and health outcomes. States must also develop a quality rating system for

their health plans under the 2016 Medicaid managed care "mega-rule." To assist in these efforts, S/THAs could propose a list of indicators and provide support in measurement activities around selected quality indicators.

Support the Quality and Performance Improvement Strategy

State Medicaid agencies require health plans to conduct PIPs. These plans may include efforts to reduce the frequency of C-sections or preterm delivery; control a specific chronic disease like asthma or hypertension; or address the needs of high-cost, complex populations like homeless individuals, racial or ethnic groups with high rates of health disparities, or people living with HIV. Typically, the state will set metrics and review plan progress on these efforts. Plans may work on developing quality and performance improvement activities by using different planning models, such as a Plan-Do-Study-Act cycle.[27] However, plans are encouraged to innovate and implement best practices that will improve outcomes.

S/THAs can offer a wide range of supports, including identifying priority health needs for PIPs, helping Medicaid agencies define and track performance metrics, and working with health plans to maximize supportive tools and evidence-based interventions. Where plans have discretion as to the topics and orientation for a performance improvement agenda, S/THAs can work directly with the plans to identify local resources, evidence-based initiatives, and provider-based opportunities to improve care.

Obligation: Quality and Care Delivery Improvement

Public Health Capacity or Skill	Program or Funding Stream	Data Source
• Epidemiologists and tracking disease state analyses. Data can inform policy and programs. • Population health management. • Population-specific targeting. • Provider supports for health reform, like health homes and community resource referrals. • CDC's Community Guide, which summarizes evidence-based findings of the Community Preventive Services Task Force. • Antibiotic stewardship. • Supporting the state's managed care PIP with best practices and evidence-based strategies. • Risk stratification and modeling for clinical management and payment reform. • Drafting specific, measurable, achievable, relevant, and time limited objectives (a protocol for objective setting) for plans.	• Lead poisoning prevention and abatement. • Maternal and child health programs, including maternity care improvement programs, newborn screening, and supports for children with special healthcare needs. • Behavioral health programs and community supports. • HIV programs and resources, such as the Ryan White HIV/AIDS Program. • Wellness programs, including programs for obesity prevention, older adults, and disease management. • Chronic disease interventions (e.g., CDC's National Asthma Control Grants).	• GIS data visualization tools. • Linkages to public health data systems for quality improvement projects. • Disaster preparedness plans and resources. • Data sharing platforms (e.g., HIEs and EMR data warehouses).

The following areas offer promising ideas to support quality and care delivery requirements:

Addressing the Social Determinants of Health

S/THAs can help Medicaid agencies identify and understanding SDoH and their impact on population health outcomes among Medicaid beneficiaries. S/THAs provide or link to support services relevant to these non-clinical needs and can connect Medicaid agencies with local health liaisons, community health offices, and health promotion offices to enhance care coordination efforts. Using S/THA data resources and GIS capabilities, S/THAs can help state Medicaid agencies identify and classify critical SDoH and solutions to these disparities; work with Medicaid agencies to develop needs assessments that include social needs; help the Medicaid agencies set RFP expectations for SDoH; coach health plans in assessing non-clinical needs and addressing SDoH; and work with providers to improve their capacity to engage with entities that can help patients on their SDoH needs.

Identifying Evidence-Based Practices for Priority Conditions

The Guide to Community Preventive Services (the Community Guide) is a collection of evidence-based findings of the Community Preventive Services Task Force.[28] This resource aims to help policymakers and researchers select interventions to improve health and prevent disease at a state, community or population level. The Community Guide provides evidence-based recommendations on interventions across a wide range of health topics, including: injury prevention, SDoH, infectious and chronic diseases and health promotion. The interventions identified include quality and care improvement strategies that can be applied statewide or directly with a state Medicaid agency or MCO.

Where the Community Guide interventions reflect a state Medicaid agency's priorities, public health can recommend appropriate ways to include these in the state's managed care RFP during Phase 2 of the managed care life cycle. During plan oversight, S/THAs can publicize these best practices and work with plans on adopting these evidence-based programs to tackle important challenges.

Advising Medicaid Agencies on Innovation Approaches

CMS has provided two rounds of State Innovation Model grants to allow states to implement and test strategies for health system transformation that meet their residents' specific needs.[29] Many states have also applied for waivers, such as Section 1115 waivers, to test innovative healthcare delivery approaches. New MCO configurations may be central to these approaches. For example, Oregon's Coordinated Care Organizations were created by a Section 1115 waiver that focuses on collaboration between public health, healthcare, and community service providers to improve primary care and prevention.[30] S/THAs can provide information to MCOs on public health interventions for chronic disease or other promising practices from their grant-funded work to inform payment and delivery reform initiatives.

Obligation: Consumer Supports

Public Health Capacity or Skill	Program or Funding Stream	Data Source
• Local health department and engagement with local entities in disease prevention. • Cultural competency and communications skills for minority populations and disadvantaged communities. • Identifying populations experiencing SDoH-related barriers to care and health disparities. • Emergency response planning regarding essential medicines and durable medical equipment for seniors and persons with disabilities. • Data support (e.g., connecting consumer populations to care). • Co-locating public housing and public health programs and initiatives. • Patient self-management and care management referrals.	• Aging disease management programs. • Food access programs (e.g., Feeding America). • Minority HIV/AIDS Fund from HRSA to improve access to care for disproportionately affected minority populations. • Community-based health promotion programs and enabling services for hard-to-reach populations. • Environmental health programs. • Public health campaigns, including harm reduction and mitigation strategies.	• Mobile communication and health-tracking technologies. • Databases of community resources. • Data on population demographics and language preference to inform culturally and linguistically appropriate service standards.

There is considerable overlap between Medicaid member populations and the populations targeted for state public health initiatives, and the strategies outlined below support outreach to both groups. The following offers promising ideas to support consumer supports:

Patient Self-Management

Medical self-management is the provision of education and supportive interventions to increase patients' skills and confidence in managing their health. Management skills include regularly assessing progress and problems, goalsetting, and problem-solving support. An effective way to directly engage Medicaid members is to create informed programs using patient activation measures. Like self-management protocols, these programs have been well received in targeted communities, especially when they include materials prepared at an appropriate level of health literacy. S/THAs have experience in behavior change, such as utilizing techniques for motivational interviewing, curriculum for patient self-management programs, and identifying evidence-based programs.

One specific type of patient self-management, diabetes self-management and education (DSME), is a prime example of how S/THAs and Medicaid agencies can help members access programs and participate in healthcare.[31] The education provided through DSME establishes a foundation to help people with diabetes navigate the decisions and activities of daily living. DSME is cost-effective and is correlated with positive effects on clinical, psycho-social, and behavioral health outcomes of diabetes

care.[32,33] (Applying best practices from the Diabetes Prevention Program (DPP) to the DSME education modules has also proven highly effective.[34]) For a population of members with diabetes, DSME, informed by DPP best practices, can serve as a cost-effective tool to incorporate into members' support services. DPP is also one of the evidence-based strategies promoted by the CDC's 6|18 Initiative. DSME and DPP are behavior change programs offered at many local health departments, with support from S/THAs.

Telehealth Efforts

Technology innovations have created many opportunities to optimize mobile communications in the Medicaid environment, as most low-income individuals own mobile devices.[35] S/THAs' knowledge of healthy behaviors and culturally competent communications could be an advantage for Medicaid MCOs and Medicaid agencies, and could improve health outcomes. For example, the Text4Baby mobile application demonstrates the potential benefits of using telehealth to improve a specific public health challenge of poor birth outcomes.[36] Natural next steps include home monitoring, community supports, and mechanisms that use mobile communications to keep people healthy outside of the clinic setting.

S/THAs can work with Medicaid regarding quality oversight to optimize telehealth and home monitoring. As state Medicaid agencies develop their RFPs, S/THA input can be important in helping understand shortage areas and working through licensure issues and provider oversight concerns that may arise as telehealth becomes more prevalent.

Conclusion

The concepts shared in this report are intended to initiate or support coordinated initiatives to improve alignment between Medicaid and public health. There is no shortage of potential areas for strategic coordination between S/THAs and state Medicaid agencies. However, strong leadership, clarity of purpose and diligence are required to realize their full potential. By identifying and leveraging public health assets within four state Medicaid obligation areas and across the life cycle of MCO contracting, this guide promotes collaboration opportunities and shared agenda-making moving forward.

Acknowledgements

This report was developed by the Association of State and Territorial Health Officials in partnership with Health Management Associates. This resource was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UD3OA22890 National Organizations for State and Local Officials. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Appendix A: Additional Resources

Topic	Source and Resource Description	Accessing the Resource
Regulations and Guidance on Medicaid Managed Care	CMS – Medicaid and CHIP Managed Care Final Rule guidance	https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html
	CMS – "Medicaid and CHIP Managed Care Final Rule" webinar presentation	https://www.medicaid.gov/medicaid/managed-care/downloads/final-rule-overview.pdf
	Kaiser Family Foundation – "CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions"	https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/
	CMS – "State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval"	https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf
	National Health Law Program – "Medicaid Managed Care Final Regulations and Health Equity" issue brief	http://www.healthlaw.org/publications/browse-all-publications/Brief-1-MMC-Final-Reg
	National Health Law Program – "Medicaid Managed Care Final Regulations Grievance & Appeals System"	http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg
	National Health Law Program – "Model Medicaid Managed Care Contract Provisions – A Primer on Medicaid Managed Care"	https://healthlaw.org/resource/model-medicaid-managed-care-contract-provisions-a-primer-on-medicaid-managed/
Network Adequacy	National Health Law Program – "Medicaid Managed Care Regulations: Network Adequacy & Access" issue brief	https://healthlaw.org/resource/issue-brief-3-medicaid-managed-care-regulations-network-adequacy-access/
	CMS – "Promoting Access in Medicaid and CHIP in Managed Care: A Toolkit for Ensuring Network Adequacy and Service Availability"	https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf
Quality Oversight and Monitoring	National Health Law Program – "Medicaid Managed Care Final Regulations: Quality and Transparency" issue brief	http://www.healthlaw.org/publications/browse-all-publications/Brief-4-MMC-Final-Reg#.V2wLnvkrKM9
	National Health Law Program and Georgetown University Health Policy Institute – "Medicaid/Managed Care Rules: Assuring Quality" presentation	http://ccf.georgetown.edu/wp-content/uploads/2016/09/MC-Quality-Webinar-Final-9-8-16.pdf

	CMS – "Adult Health Care Quality Measures"	https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html
	CMS – "Children's Health Care Quality Measures"	https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html
	National Committee for Quality Assurance – "HEDIS and Performance Measurement" page on the Healthcare Effectiveness Data and Information Set	http://www.ncqa.org/hedis-quality-measurement
	Agency for Healthcare Research and Quality – "About CAHPS" (Consumer Assessment of Healthcare Providers and Systems Measures)	https://www.ahrq.gov/cahps/about-cahps/index.html
Quality and Care Delivery Improvement	CMS – "Medicaid and CHIP Managed Care Final Rule: Strengthening States' Delivery System Reform Efforts"	https://www.medicaid.gov/medicaid/managed-care/downloads/strengthening-states-delivery-system-reform-efforts-fact-sheet-final-rule.pdf
	CMS – "Rate Setting, Medical Loss Ratio, and Delivery System Reform" presentation	https://www.medicaid.gov/medicaid/managed-care/downloads/managed-care-final-rule-rate-setting.pdf
	Medicaid and Children's Health Insurance Program Payment and Access Commission– "Delivery System Reform Incentive Payment Programs"	https://www.macpac.gov/wp-content/uploads/2018/03/Delivery-System-Reform-Incentive-Payment-Programs.pdf
	Commonwealth Fund – "The Role of Medicaid Managed Care in Health Delivery System Innovation"	http://www.commonwealthfund.org/publications/fund-reports/2014/apr/role-of-medicaid-managed-care-in-health-delivery-system-innovation
	National Academy for State Health Policy – "How State Medicaid and Title V Partnerships Improve Care for Children with Special Health Care Needs in Medicaid Managed Care"	https://nashp.org/how-state-medicaid-and-title-v-partnerships-improve-care-for-children-with-special-health-care-needs-in-medicaid-managed-care/
Consumer Support	National Health Law Program – "Medicaid Managed Care Final Regulations: Beneficiary Support Systems" issue brief	http://www.healthlaw.org/publications/browse-all-publications/Brief-7-BSS-Final-Reg#.WAEHs-ArKUk
	National Health Law Program – "Medicaid Managed Care Final Regulations: Older Adults" issue brief	http://www.healthlaw.org/publications/search-publications/Brief-6-MMC-Final-Reg-Older-Adults#.V_-knugrKUk

	Families USA – "Medicaid Managed Care Rule: Improving the Enrollment Experience" short analysis	http://familiesusa.org/product/medicaid-managed-care-rule-improving-enrollment-experience
	CMS – "Medicaid and CHIP Managed Care Final Rule: Strengthening the Consumer Experience"	https://www.medicaid.gov/medicaid/managed-care/downloads/strengthening-the-consumer-experience-fact-sheet.pdf
Information Sources for Managed Care Demographics and National Context	Kaiser Family Foundation – "Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018"	https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/
	Kaiser Family Foundation – "Medicaid Managed Care Market Tracker"	https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/
	Health Management Associates – "Weekly Roundup"	https://www.healthmanagement.com/knowledge-share/weekly-roundup/
Federal and National Stakeholders	CMS	www.cms.gov
	Medicaid and Chip Payment and Access Commission was established by Congress in 2010, and provides Medicaid updates to Congress, HHS, and other stakeholders across the country.	www.macpac.gov https://www.macpac.gov/topics/managed-care/
	Medicaid Health Plans of America, an MCO association	http://www.medicaidplans.org/
Other Resources	ASTHO – "Medicaid and Public Health Partnerships" web page with resources and examples of Medicaid and S/THA coordination	http://www.astho.org/Health-Systems-Transformation/Medicaid-and-Public-Health-Partnerships/
	ASTHO – Resources about cross-sector partnerships	http://www.astho.org/Clinical-to-Community-Connections/Cross-Sector-Partnerships-to-Address-Social-Determinants-of-Health/
	ASTHO – Resources about community health workers	http://www.astho.org/Community-Health-Workers/
	ASTHO – Resources about telehealth	http://www.astho.org/Telehealth/
	ASTHO – "Guide on Getting Started with the CDC's 6|18 Initiative"	http://www.astho.org/Form/618-Tool/
	Center for Health Care Strategies – "A Resource Center for Implementing CDC's 6|18 Initiative"	http://www.618resources.chcs.org/

Appendix B: State Medicaid Managed Care Enrollment Data Summary and Share of Medicaid Enrollees in Managed Care

As of July 1, 2016, from the Centers for Medicare & Medicaid Services[37]

State or Territory	Total Medicaid Enrollees	Total Medicaid Enrollment in Any Type of Managed Care: Number of Individuals	Total Medicaid Enrollment in Any Type of Managed Care: Percent of all Medicaid enrollees	Medicaid Enrollment in Comprehensive Managed Care: Number of Individuals	Medicaid Enrollment in Comprehensive Managed Care: Percentage of all Medicaid enrollees	Medicaid Enrollment in Comprehensive MCOs Under ACA Section VIII Expansion
Totals	80,184,501	65,005,748	81.1%	54,627,180	68.1%	12,572,147
Alabama	1,037,037	664,687	64.1%	175	0.0%	0
Alaska	155,865	0	0.0%	0	0.0%	0
American Samoa	n/a	n/a	n/a	n/a	n/a	n/a
Arizona	1,849,166	1,560,972	84.4%	1,560,972	84.4%	387,382
Arkansas	799,488	554,108	69.3%	167	0.0%	0
California	13,739,388	10,574,784	77.0%	10,571,742	76.9%	3,699,069
Colorado	1,344,548	1,291,043	96.0%	134,792	10.0%	37,943
Connecticut	860,758	0	0.0%	0	0.0%	0
Delaware	221,229	196,102	88.6%	196,102	88.6%	53,352
District of Columbia	251,791	180,942	71.9%	180,942	71.9%	63,350
Florida	3,900,380	3,280,187	84.1%	3,187,837	81.7%	0
Georgia	1,973,586	1,352,087	68.%%	1,341,597	68.0%	0
Guam	n/a	n/a	n/a	n/a	n/a	n/a
Hawaii	358,302	354,289	98.9%	354,289	98.9%	113,737
Idaho	295,267	280,527	95.0%	2,326	0.8%	0
Illinois	3,230,870	1,967,569	60.9%	1,967,553	60.9%	434,953
Indiana	1,421,696	1,078,625	75.9%	1,078,625	75.0%	318,450
Iowa	624,973	562,382	90.0%	562,382	90.0%	144,383
Kansas	435,850	390,829	89.7%	390,829	89.7%	0
Kentucky	1,361,722	1,284,134	94.3%	1,262,610	92.7%	457,746
Louisiana	1,504,333	1,381,116	91.8%	1,263,562	84.0%	282,115
Maine	277,697	239,953	86.4%	0	0.0%	0
Maryland	1,324,796	1,080,085	81.5%	1,080,085	81.5%	247,085
Massachusetts	1,889,306	1,268,120	67.1%	874,367	46.3%	289,891
Michigan	4,448,582	4,370,138	98.2%	2,220,029	49.9%	484,937
Minnesota	1,088,610	817,463	75.1%	814,947	74.9%	162,747
Mississippi	726,473	499,365	68.7%	499,365	68.7%	0
Missouri	982,776	961,682	97.9%	494,392	50.3%	0
Montana	207,340	121,277	58.5%	0	0.0%	0
Nebraska	244,355	242,836	99.4%	191,479	78.4%	0
Nevada	629,265	557,497	88.6%	401,434	63.8%	175,686
New Hampshire	206,997	136,985	66.2%	136,985	66.2%	5,929
New Jersey	1,679,572	1,557,081	92.7%	1,557,081	92.7%	516,336
New Mexico	884,368	684,488	77.4%	684,488	77.4%	222,110
New York	6,139,403	4,669,344	76.1%	4,512,115	73.5%	1,887,296

North Carolina	2,028,935	1,581,301	77.9%	1,636	0.1%	0
North Dakota	93,422	48,621	52.0%	21,347	22.9%	21,232
Northern Mariana Islands	n/a	n/a	n/a	n/a	n/a	n/a
Ohio	3,022,121	2,413,500	79.9%	2,413,500	79.9%	643,312
Oklahoma	792,387	532,213	67.2%	310	0.0%	0
Oregon	1,109,321	894,543	80.6%	894,543	80.6%	422,316
Pennsylvania	2,753,618	2,521,421	91.6%	2,233,115	81.1%	701,225
Puerto Rico	1,617,501	1,617,501	100.0%	1,617,501	100.0%	0
Rhode Island	325,177	237,863	73.1%	230,439	70.9%	64,065
South Carolina	1,235,361	1,235,361	100.0%	742,528	60.1%	0
South Dakota	125,395	94,295	75.2%	0	0.0%	0
Tennessee	1,684,268	1,556,269	92.4%	1,556,369	92.4%	0
Texas	4,051,664	3,922,822	96.8%	3,582,604	88.4%	0
Utah	294,707	291,426	98.9%	244,763	83.1%	0
Vermont	200,481	124,299	62.1%	124,399	62.1%	46,107
Virgin Islands	n/a	n/a	n/a	n/a	n/a	n/a
Virginia	1,111,999	761,019	68.4%	761,019	68.4%	0
Washington	1,820,084	1,820,084	100.0%	1,535,441	84.4%	525,700
West Virginia	553,318	390,083	70.5%	390,083	70.5%	163,694
Wisconsin	1,204,511	801,939	66.6%	754,202	62.6%	0
Wyoming	64,442	391	0.6%	112	0.2%	0

As of September 2018, Medicaid Managed Care Organizations in Each State [ix,x,38]

Location	Total Medicaid MCOs*	Location	Total Medicaid MCOs*
United States	**275**	**Missouri**	3
Alabama	N/A	**Montana**	N/A
Alaska	N/A	**Nebraska**	3
Arizona	11	**Nevada**	3
Arkansas	N/A	**New Hampshire**	2
California	24	**New Jersey**	5
Colorado	2	**New Mexico**	4
Connecticut	N/A	**New York**	24
Delaware	2	**North Carolina**	N/A
District of Columbia	4	**North Dakota**	1
Florida	17	**Ohio**	5
Georgia	4	**Oklahoma**	N/A
Hawaii	5	**Oregon**	15
Idaho	N/A	**Pennsylvania**	9
Illinois	7	**Rhode Island**	3
Indiana	4	**South Carolina**	5
Iowa	2	**South Dakota**	N/A
Kansas	3	**Tennessee**	4
Kentucky	5	**Texas**	19
Louisiana	5	**Utah**	4
Maine	N/A	**Vermont**	N/A
Maryland	9	**Virginia**	6
Massachusetts	6	**Washington**	5
Michigan	11	**West Virginia**	4
Minnesota	8	**Wisconsin**	16
Mississippi	2	**Wyoming**	N/A

[ix] Medicaid programs in U.S. territories are mainly fee-for-service programs. Puerto Rico is the only U.S. territory with a Medicaid managed care program. Therefore, the document focuses primarily on states. For more information on Medicaid in U.S. territories, please see: https://www.kff.org/medicaid/issue-brief/medicaid-in-the-territories-program-features-challenges-and-changes/.

[x] Data are current as of September 2018. Data reflect only capitated MCOs providing comprehensive services to Medicaid participants.

Appendix C: Medicaid Mandatory and Optional Benefits and Covered Populations

Table A: Mandatory and Optional Medicaid Benefits[39]

Mandatory Benefits	Optional Benefits
• Inpatient hospital services • Outpatient hospital services • EPSDT: Early and periodic screening, diagnostic, and treatment services • Nursing facility services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and x-ray services • Family planning services • Nurse midwife services • Certified pediatric and family nurse practitioner services • Freestanding birth center services (when licensed or otherwise recognized by the state) • Transportation to medical care • Tobacco cessation counseling for pregnant women • Medication assisted treatment* *The SUPPORT for Patient and Communities Act temporarily makes medication assisted treatment mandatory.	• Prescription drugs • Mental health and substance use disorder services • Physical therapy • Occupational therapy • Speech, hearing, and language disorder services • Respiratory care services • Other diagnostic, screening, preventive, and rehabilitative services • Podiatry services • Optometry services • Dental services • Dentures • Prosthetics • Eyeglasses • Chiropractic services • Other practitioner services • Private duty nursing services • Personal care • Hospice • Case management • Services for individuals age 65 or older in an institution for mental disease • Services in an intermediate care facility for individuals with intellectual disability • State plan home and community-based services- 1915(i) • Self-directed personal assistance Services- 1915(j) • Community First Choice Option- 1915(k) • Tuberculosis-related services • Inpatient psychiatric services for individuals under age 21 • Other services approved by the Secretary* • Health Homes for enrollees with chronic conditions – Section 1945 *This includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).

Table B: Mandatory and Optional Medicaid Populations[40]

Mandatory Populations	Optional Populations
• Low-income families • Transitional Medical Assistance • Extended Medicaid due to child or spousal support collections • Children with Title IV-E adoption assistance, foster care, or • guardianship care • Qualified pregnant women and children • Mandatory poverty level related pregnant women • Mandatory poverty level related infants • Mandatory poverty level related children aged 1-5 • Mandatory poverty level related children aged 6-18 • Deemed newborns • Individuals receiving Supplemental Security Income (SSI) • Aged, Blind and Disabled individuals in 209(b) states • Individuals receiving mandatory state supplements • Individuals who are essential spouses • Institutionalized individuals continuously eligible since 1973 • Blind or disabled individuals who were eligible in 1973 • Individuals who lost eligibility for Supplemental Security Income/State Supplementary Payment (SSI/SSP) due to an increase in old age, survivors, and disability insurance (OASDI) benefits in 1972 • Individuals who would be eligible for SSI/SSP but for old age and survivors insurance trust fund (OASI) cost-of-living adjustment (COLA) increases since April 1977 • Disabled widows and widowers ineligible for SSI due to early receipt of social security • Working disabled individuals under 1619(b) • Disabled adult children • Qualified Medicaid beneficiaries • Qualified disabled and working individuals • Specified low income Medicare beneficiaries • Qualifying individuals	• Children with Non-Title IV-E adoption assistance • Independent foster care adolescents • Optional targeted low-income children • Children under 21 not receiving cash assistance[xi] • Families who would qualify for cash if requirements were more broad • Individuals eligible for cash except for child care subsidy • Optional poverty level related pregnant women and infants • Presumptively eligible pregnant women • Presumptively eligible children • Individuals electing COBRA continuation coverage • Individuals eligible for but not receiving cash • Individuals eligible for cash except for institutionalization • Individuals in HMOs guaranteed eligibility • Individuals receiving home and community-based services under Institutional rules • Individuals participating in a Program of All-Inclusive Care for the Elderly (PACE) program under institutional rules • Individuals receiving hospice care • Optional state supplement recipients: 1634 states, and SSI criteria states with 1616 agreements • Optional state supplement recipients: 209(b) states, and SSI criteria states without 1616 agreements • Qualified disabled children under 19 • Institutionalized individuals eligible under a special income level • Poverty level aged or disabled individuals • Individuals with tuberculosis • Certain women needing treatment for breast or cervical cancer • Presumptively eligible women with breast or cervical cancer • Work Incentives Eligibility Group • Ticket to Work Basic Group • Ticket to Work Medical Improvements Group • Family Opportunity Act children with disabilities • Individuals eligible for family planning services • Individuals eligible for home and community-based services and those special income level individuals • Individuals at or below 133 percent of the federal poverty line ages 19 through 64

[xi] Medicaid traditionally automatically linked program eligibility to cash assistance programs. However, eligibility requirements have changed over time and this category permits a state Medicaid program to allow eligibility for individuals who higher incomes made them ineligible for cash assistance but may be medically needy or meet other program eligibility criteria. For more information, please see: https://www.macpac.gov/wp-content/uploads/2017/06/Mandatory-and-Optional-Enrollees-and-Services-in-Medicaid.pdf.

Appendix D: Index of Public Health Assets Mapped to Medicaid Managed Care Organization Obligations

Obligations	Public Health Asset	Description
Network Adequacy	*Develop Baseline Metrics for Access and Population Visualization*	State and territorial health agencies (S/THAs) can assist with or perform initial provider network assessments at the state, regional, or local level as the state Medicaid agency sets access requirements and policies. S/THAs can work with state Medicaid agencies to develop baseline access metrics and expectations for managed care organization (MCO) contracts, utilizing data visualization and geographic information system (GIS) mapping of provider locations. State primary care offices and rural health offices can provide support, given their access to provider data and shortage designation areas. GIS/data visualization techniques can be used for network management, access improvement projects, or to identify service gaps.
	Support Top of License/Training Practice	Given the shortage of physicians and other providers in some areas, encouraging health providers to work at the top of their licenses and training can increase access to care. Some S/THAs support boards that oversee state healthcare professional licensing. S/THAs can also help support the use of alternative providers such as nurse practitioners and physician assistants as appropriate. Further, S/THAs can support top of license practice by identifying opportunities to better utilize community health workers (CHWs) and other community-based providers who can improve Medicaid outcomes and cost-effectiveness.
	Support Public Health Participation	S/THAs can encourage public health service providers participation in Medicaid managed care by educating the state Medicaid agency about the business case for using public health services providers like local health departments and Title X Family Planning Clinics. S/THAs can support public health providers in the Medicaid managed care delivery system by advocating for Medicaid to require public health providers' participation in MCO contracts.
	Support Community-Based Providers Participation	S/THAs and public health partners can encourage the Medicaid agency direct MCOs in their contract to utilize federally qualified health centers and other community health centers, rural health clinics, clinics servicing people living with HIV, school-based clinics, EMS services, CHWs and other community providers. They can also monitor progress and provide a CHW oversight framework.
	Support Network Providers	Many regions may lack adequate providers for primary care, behavioral health, or other specialties. Workforce

		development (both recruiting new providers and identifying resources to support current providers) can help address workforce shortages. Primary care offices (either within the S/THA or elsewhere) support providers by coordinating the National Health Service Corps program, helping with provider recruitment and retention, collaborating on health center planning and development, and partnering with other organizations (e.g., primary care associations and state offices of rural health) to expand access to care. S/THAs can also provide resources related to care coordination and working with a multidisciplinary team.
Quality Oversight and Monitoring	*Establish Reporting and Dashboard Monitoring*	Core public health functions include maintaining epidemiologic data and vital records, performing statistical analyses, and targeting health needs. S/THAs can support state Medicaid agencies as they develop benchmarks, report cards and other quality parameters by helping create performance monitoring dashboards that include important quality or epidemiologic data.
	Establish Disease Surveillance, Epidemiologic Analysis, and Case Reports	S/THAs can support state Medicaid agencies by reporting their state vital statistics, infectious disease surveillance, and immunization registries to Medicaid. S/THAs can also support specific epidemiology analyses and utilize population health offices and relevant disease and population programs to support Medicaid participants' needs. For example, S/THAs can analyze public health data to identify pressing and emerging health challenges (e.g., overprescribing, overdoses, or infections), including GIS and hot-spotting for at-risk population groups. S/THAs can then help Medicaid agencies create strategies for MCOs to implement localized, targeted initiatives that address specific health challenges through contracting or other opportunities.
	Share Data	S/THAs can share data with Medicaid agencies by establishing data centers and programs and provider-facing divisions, and via policy and department leadership. To this end, S/THAs can: Identify important data sources relevant to state Medicaid agency projects and issues; develop tools and approaches for sharing this data and helping to analyze it; establish ongoing data sharing agreements with the state Medicaid agency for quality oversight and tracking; offer relevant statewide data to help craft request for proposal (RFP) expectations; provide data analysis as needed to support plan proposal review; and work with providers as they engage in quality improvement to ensure access to key data, including contributing data to health information exchanges.
	Identify Benchmarks	S/THAs can help state Medicaid agencies develop benchmarks, report cards and other quality parameters. Medicaid agencies mostly use Healthcare Effectiveness Data and Information Set (HEDIS) measures, but they may consider alternative measures around a high-priority topic (e.g., opioid abuse or pre-term births). S/THAs can participate in quality

		improvement activities and working groups with a focus on the most challenging and costly Medicaid issues; serve as a clearinghouse or otherwise contribute to assessing plan and provider quality as a neutral party; provide evidence and data-based metrics and quality assessment; and connect delivery system entities and health plans to best practices in prevention and disease management when improvement is needed.
	Utilize Cost Management Techniques	S/THAs can provide expertise regarding evidence-based practices that are identified as cost-effective or cost-saving to inform payment incentives developed by Medicaid and managed care plans. Payment incentives are becoming more frequent and include goals like reducing readmissions and improving patient outcomes.
	Inform Performance Improvement Project Development	S/THAs can provide insight or information on evidence-based practices related to the performance improvement projects that plans are required to conduct each year. (These projects are often a collaborative approach and can be focused population health goals such as reducing hemoglobin A1c levels or new HIV infections in a specific population.)
	Develop a Preparedness Response	S/THAs can work with state Medicaid agencies to develop requirements for preparedness plans, particularly in states with frequent weather emergencies. To this end, S/THAs can connect MCOs with preparedness offices and local public health liaisons and agency leadership. S/THAs can also participate in tabletop and planning exercises that focus on the unique needs of vulnerable populations that Medicaid serves.
Quality Care and Delivery Improvement	*Identify Social Determinants of Health and Establish Linkages to Community Resources*	S/THAs can help identify and explain social determinants of health and their impacts on population health outcomes. S/THAs can provide or link to support services relevant to these non-clinical needs or can connect local providers serving Medicaid enrollees to health liaisons, community health offices, and health promotion offices to enhance care coordination efforts. Using S/THA data resources and GIS capabilities, S/THAs can help state Medicaid agencies identify and classify critical social determinants and solutions to these disparities; work with state Medicaid agencies to develop needs assessments that include social needs; help state Medicaid agencies set RFP expectations around social determinants; coach plans in assessing non-clinical needs and addressing social determinants; and work with providers to improve their capacity to engage with patients on their social determinant needs. Further, S/THAs can connect state Medicaid agencies with disease management programs and improve the capacity of these community programs to engage with Medicaid managed care plans and share information.

	Incorporate Critical Health Improvement Opportunities and Share Innovative Solutions	S/THAs can incorporate critical health improvement opportunities and related metrics into the comprehensive quality plan that CMS requires for all states who contract with managed care organizations. S/THAs can provide quality improvement expertise, as well as clinical and policy leadership and subject matter expertise in prevention and health promotion, chronic disease programs, maternal and child health, disease surveillance, and epidemiology. S/THAs can provide input on quality strategy during RFP development, but they can also provide feedback during ongoing quality planning. Specifically, S/THAs can help the state Medicaid agency explore new quality metrics and reporting requirements in the RFP; review quality improvement plans for their impact on critical public health issues; provide validating data for quality metrics reported by MCO plans; and work with plans to improve quality management and opportunities for quality improvement. Furthermore, S/THAs can work with state Medicaid agencies and MCO plans to identify important targets and approaches for quality improvement efforts that will bring down costs and improve health outcomes. Beyond sharing strategies on quality improvement and evidence-based practices, S/THAs can also provide information to MCOs on innovative solutions to chronic disease or other promising practices from their grant funded work. (For example, a state can call for innovative approaches in their RFP on improving asthma control in children.)
Consumer Supports	*Advise on Care Management Referrals*	S/THAs can work with MCO plans on care management referrals to community resources in a number of arenas (e.g., family planning, immunizations, and disease management programs). This funding is flexible, but there are limits and restrictions. Example funding streams include the Ryan White CARE Act, Title V, and Title X community partners and contractors.
	Encourage Patient Self-Management	S/THAs and the public health community can collaborate to provide patient education on self-management, prevention and compliance with treatment; align messaging campaigns and materials with state Medicaid agency goals and Medicaid populations; help state Medicaid agencies meet cultural competency and language requirements; evaluate plan efforts to engage consumers in their care and in disease management structures and processes; help MCO plans' work on social determinants of health and removing barriers to compliance and provide plans with tools to engage consumers in self-management; assist state Medicaid agencies with monitoring prevention opportunities and identifying compliance barriers (e.g., prior authorization or drug limits).

	Develop Enrollee Support for Emergency Risks	S/THAs can partner with epidemiology offices and relevant preparedness programs, including immunizations, environmental health divisions, and communications programs, to support enrollees for emergency risk management. S/THAs can support enrollees and communities in times of emergency or increased risk; ensure that preparedness plans address Medicaid recipients' needs and that community preparedness resources are informed of supports; work with state Medicaid agencies on emergency communications tools with health plans; work with plans on disaster preparedness, epidemic, and immunization efforts; prepare materials that can be tailored by health plans; and include health plans in communications circles, as requested by state Medicaid agencies.

References

[1] Medicaid and CHIP Payment and Access Commission. "Types of Managed Care Arrangements." Available at www.macpac.gov/subtopic/types-of-managed-care-arrangements/. Accessed 6-12-2018.
[2] Kaiser Family Foundation. "Share of Medicaid Population Covered under Different Delivery Systems". Available at www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems. Accessed 6-12-2018.
[3] Medicaid and CHIP Payment and Access Commission. "Types of Managed Care Arrangements." Available at www.macpac.gov/subtopic/types-of-managed-care-arrangements/. Accessed 6-12-2018.
[4] Kaiser Family Foundation: State Health Facts. Share of Medicaid Population Covered under Different Delivery System. Available at https://www.kff.org/medicaid/state-indicator/.
[5] Centers for Medicare & Medicaid Services.. "Medicaid and CHIP Managed Care Final Rule." 2016. Available at https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html. Accessed on 6-12-2018.
[6] Kaiser Family Foundation. Kaiser Commission on Medicaid and the Uninsured. "CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions." Available at http://files.kff.org/attachment/CMSs-Final-Rule-on-Medicaid-Managed-Care. Accessed 6-12-2018.
[7] Centers for Disease Control and Prevention. "6|18 Initiative." Available at https://www.cdc.gov/sixeighteen/. Accessed 6-12-2018.
[8] Health Management Associates. "HMA Weekly Roundup." Available at https://www.healthmanagement.com/wp-content/uploads/051315-HMA-Roundup.pdf. Accessed 6-12-2018.
[9] Center for Health Care Strategies. "Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons." Available at https://www.chcs.org/media/CHCS-SDOH-Measures-Brief_120716_FINAL.pdf. Accessed 6-12-2018.
[10] Centers for Disease Control and Prevention. "Social Determinants of Health." 2018. Available at: https://www.cdc.gov/socialdeterminants/. Accessed 6-12-2018.
[11] National Technical Assistance Center and Positive Outcomes. "Expanding & Implementing: Contracting with Medicaid & Marketplace Insurance Plans." Available at: https://targethiv.org/sites/default/files/file-upload/resources/8%20Essential%20Actions_01_2016.pdf. Accessed 12-06-2018.
[12] Substance Abuse and Mental Health Services Administration. "Medication-Assisted Treatment (MAT)." Available at https://www.samhsa.gov/medication-assisted-treatment. Accessed 6-12-2018.
[13] Health Services and Resources Administration. "About the Ryan White HIV/AIDS Program." Available at: https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program. Accessed 6-12-2018.
[14] Health and Human Services Office of Population Affairs. "About Title X Grants." Available at https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/index.html. Accessed 6-12-2018.
[15] Families USA. "How States Can Fund Community Health Workers to Improve People's Health, Decrease Costs, and Reduce Disparities." Available at http://familiesusa.org/sites/default/files/product_documents/HE_HST_Community_Health_Workers_Brief_v4.pdf. Accessed 6-13-2018.
[16] Association of State and Territorial Health Officials. "Community Health Worker Successes and Opportunities for States." Available at http://www.astho.org/Prevention/Heart-Disease-and-Stroke/Tools-for-Change/Community-Health-Worker-Issue-Brief/. Accessed 6-13-2018.
[17] National Association of State Health Policy. State Community Health Worker Map. Available at https://nashp.org/state-community-health-worker-models/. Accessed 12-07-2018.
[18] Families USA. How States Can Use Medicaid Managed Care Contracts to Support Community Health Workers. 2018. Available at: https://familiesusa.org/sites/default/files/product_documents/How-States-Can-Use-Medicaid-Managed-Care-Contracts-to-Support-CHWs_1.pdf. Accessed 12-07-2018.
[19] Louisiana Department of Health. "Louisiana Medicaid Managed Care Organization Model Contract." 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf. Accessed 3-20-2019.
[20] Association of State and Territorial Health Officials. "Community Health Worker Certification and Financing." Available at http://www.astho.org/Community-Health-Workers/CHW-Certification-Financing/. Accessed 6-12-2018.
[21] National Academy for State Health Policy. "How State Medicaid and Title V Partnerships Improve Care for Children with Special Health Care Needs in Medicaid Managed Care." Available at https://nashp.org/how-state-medicaid-and-title-v-partnerships-improve-care-for-children-with-special-health-care-needs-in-medicaid-managed-care/. Accessed 7-11-2018.

[22] National Committee for Quality Assurance. "HEDIS and Quality Compass." Available at http://www.ncqa.org/hedis-quality-measurement/what-is-hedis. Accessed -12-2018.
[23] HealthIT. "Meaningful Use Definition and Objectives." Available at https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives. Accessed 6-12-2018.
[24] Health Care Financing Administration National Medicaid Fraud and Abuse Initiative. "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care." Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/GuidelinesAddressingfraudabuseMedMngdCare.pdf. Accessed 6-12-2018.
[25] Medicaid and CHIP Payment and Access Commission. "Report to Congress, Chapter 3: Program Integrity in Medicaid Managed Care." Available at https://www.macpac.gov/wp-content/uploads/2017/06/Program-Integrity-in-Medicaid-Managed-Care.pdf. Accessed 6-13-2018.
[26] Centers for Medicare & Medicaid Services. "Medicaid and CHIP Managed Care Final Rule: Improving the Quality of Care for Medicaid Beneficiaries." Available at https://www.medicaid.gov/medicaid/managed-care/downloads/improving-quality-of-care.pdf. Accessed 6-12-2018.
[27] Institute for Healthcare Improvement. "Plan-Do-Study-Act (PDS) Worksheet." Available at http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx. Accessed 6-12-2018.
[28] Community Preventive Services Task Force. "About the Community Guide." Available at https://www.thecommunityguide.org/about/about-community-guide. Accessed 6-12-2018.
[29] Centers for Medicare & Medicaid Services. "State Innovation Models Initiative." Available at https://innovation.cms.gov/initiatives/state-innovations/. Accessed 6-12-2018.
[30] Oregon Health Authority. "Coordinated Care: the Oregon Difference." Available at https://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx. Accessed 6-11-2018.
[31] Powers M, Bardsley J, Cypress M, et al. "Diabetes Self-Management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics." *Clin Diabetes.* 2016. 34(2):7-80. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833481/. Accessed 6-12-2018.
[32] Haas L, Maryniuk M, Beck J, et al. "National standards for diabetes self-management education and support." *The Diabetes Educator*. 38(5): 619-629. 2017. Available at: https://www.diabeteseducator.org/docs/default-source/practice/deap/standards/nationalstandards_2017.pdf?sfvrsn=2.
[33] Piatt GA, Anderson RM, Brooks MM, et al. "3-year follow-up of clinical and behavioral improvements following a multifaceted diabetes care intervention." *The Diabetes Educator*. 2010. 36(2): 301-309. Available at https://www.ncbi.nlm.nih.gov/pubmed/20200284.
[34] National Institutes of Health. "Diabetes Prevention Program." Available at https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/Pages/default.aspx. Accessed 6-12-2018.
[35] Pew Research Center. "Mobile Fact Sheet." Available at http://www.pewinternet.org/fact-sheet/mobile/. Accessed 6-11-2018.
[36] Whittaker R, Matoff-Stepp S, Meehan J, et al. Text4baby: Development and Implementation of a National Text Messaging Health Information Service. *American Journal of Public Health*. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3519339/. Accessed 6-12-2018.
[37] The Centers for Medicare & Medicaid Services. Medicaid Managed Care Enrollment and Program Characteristics, 2016. Available at: https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf. Accessed 06-12-18.
[38] Kaiser Family Foundation. Total Medicaid MCOs. September 2018. Available at: https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/. Accessed on 2-28-2019.
[39] Centers for Medicare & Medicaid Services. List of Medicaid Benefits. Available at: https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html.. Accessed 11-28-2018.
[40] Centers for Medicare & Medicaid Services. List of Medicaid Eligibility Groups. Available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/list-of-eligibility-groups.pdf. Accessed on 11-28.2018.