

California Department of Health Services Medi-Cal Managed Care Transition

Today, California provides Medi-Cal benefits via a managed care delivery system in 22 counties to 3.2 million beneficiaries including families, children, seniors and persons living with disabilities. Of the 3.2 million individuals currently enrolled in Medi-Cal managed care, approximately 280,000 are seniors and persons living with disabilities.

In enrolling an additional 800,000 individuals into managed care, the Medi-Cal Redesign proposes to build upon the state's current managed care experiences. Successful managed care expansion and implementation requires careful and deliberate planning. Central to the success of the proposed Medi-Cal managed care expansion is the demonstration of plan readiness to meet the care needs of new enrollees. Plan readiness can help facilitate a smooth transition from FFS system to managed care thus minimizing negative impacts on the newly enrolling beneficiaries.

The intent of this document is to outline the current processes by which Medi-Cal reviews managed care plan readiness and to outline some of the plan readiness issues to be considered in transitioning seniors and persons living with disabilities from FFS to managed care.

MEDI-CAL MANAGED CARE PLAN READINESS

The assessment of a contracting health plan's readiness to provide health care to Medi-Cal health plan members is performed both prior to the start of actual operations and on an ongoing basis to monitor health plan performance. The ongoing aspects are timed to reflect the critical nature of the item subject to review (e.g., Policy and Procedures are reviewed as they are updated, whereas, Provider Network is reviewed on a quarterly basis). Review and evaluation of a managed care health plan's readiness to begin operations serving Medi-Cal beneficiaries includes the following major steps:

1. Coordination with Department of Managed Health Care (DMHC)
 - DMHC is the State licensing and enforcement agency. Medi-Cal Managed Care Division (MMCD) verifies if the health plan has submitted all filings necessary for a Knox Keene license or material modification. The two agencies coordinate reviews in areas that overlap such as the provider network, Evidence of Coverage, financial review and some quality improvement system areas.

2. Contract deliverable schedule

- A “deliverable” is a written policy, procedure or other document the health plan submits to MMCD for demonstration of understanding and ability to comply with program requirements. Deliverables are intended to bore down to the detail of health plan operations. For instance, in the area of Member Services health plans must submit for approval policies and procedures related to protection of members’ rights to confidentiality; advance directives; member service staff training; the development, content and distribution of member materials; member selection of a primary care physician (PCP); assignment of a PCP; notifying Members for denial, deferral, or modification of requests for prior authorization; as well as a Member Services Guide and Member Identification Card. Deliverables are submitted under the following categories:
 - Organization and Administration;
 - Financial Information;
 - Management Information System;
 - Quality Improvement System;
 - Utilization Management;
 - Provider Network;
 - Provider Relations;
 - Provider Compensation Arrangements;
 - Access and Availability;
 - Scope of Services;
 - Case Management and Coordination of Care;
 - Local Health Department Coordination;
 - Member Services;
 - Member Grievance System;
 - Marketing; and
 - Enrollments and Disenrollments.

- Various professionals within MMCD review the “deliverables.” For instance, nurses and/or medical consultants review all clinical areas. Staff trained and responsible for that specific area of the managed care program review member services areas. MMCD auditors review financial documents. A Health Educator reviews health education materials. The core components of the administration, organization and the provider network are the responsibility of an Associate Government Program Analyst that acts as a Contract Manager with ongoing responsibility for the health plan contract.

- All deliverables must be approved by MMCD prior to the start of providing services to Medi-Cal members. The deliverables are reviewed to ensure consistency with Federal and State law, the

Department of Health Services (DHS) managed care contract and MMCD policy letters. Discussions, edits and adjustments are made to the policies and procedures until the health plans are compliant.

- As with any major or complex system of operations, contracting health plans frequently delegate responsibility for meeting access and availability standards or quality assurance activities to subcontracting medical groups or Independent Physician Associations. In these cases, the contracting health plans must demonstrate that they have appropriate systems in place to fulfill their responsibility and that accountability systems are sufficient to assure that contract requirements are fulfilled at all levels of the health care delivery system. DHS contract requirements must be fulfilled at all levels of care all the way to the actual provider of service. Expectations include collection of data, establishment of reporting systems, regular provider site reviews, monitoring and follow-up of complaints, and analysis of encounter data.

3. Provider Network

- The provider network is a “deliverable” but warrants special attention. The review is overseen by the Contract Manager but in practical terms involves a variety of staff. Data is requested electronically and used with a Geographic Information System to produce visual reports that identify the locations of primary care physicians, specialists, pharmacies and hospitals. Reports are used to ensure compliance with time and distance standards and member to physician ratios established by the Knox Keene Act and are included in the DHS contracts. The list of specialists by type is compared to the DMHC list of required specialists. Clinical staff review the number of each type of specialist. There are no standards in this area but a subjective determination is made based on the population makeup and particular geographic needs. For instance, with the current health plans there is a great deal of focus given to obstetricians, pediatricians and pediatric specialists because health plan membership is comprised mostly of women and children. In the Central Valley, allergists and lung specialists are given special focus because there are high incidence of allergies and lung diseases in that region of the state.
- The provider network is also a California Code of Regulations (CCR), Title 28, requirement, enforced by DMHC. The review of the provider network is coordinated between DMHC and MMCD to ensure that the health plans do not receive conflicting information.
- Once the provider network is determined to be adequate, MMCD verifies the provider network by reviewing the actual subcontracts and

signature pages. The health plans submit a Provider Directory that is used to inform health plan members of available network physicians, including location, office hours and language capabilities. The provider directory is compared to the provider network listing for consistency and random telephoning of physicians is done as an additional verification step.

4. Evidence of Coverage (EOC) review

- The EOC or member services guide is the health plan's compilation of its members' entitlements, instructions on how to access services, and member's rights and responsibilities. Law and regulation dictate much of what is included in an EOC. The EOC is reviewed by MMCD to ensure the accuracy of its information, its conformance with statute and regulation, and that Medi-Cal beneficiaries can easily understand it. The EOC must be written at a 5th grade reading level and translated into languages other than English as determined by DHS.
- The EOC is also a CCR, Title 28, requirement. The review of an EOC is coordinated between DMHC and MMCD to ensure that the health plans do not receive conflicting information.

5. Primary Care Physician, Facility Site Reviews

- MMCD, in conjunction with the health plan Medical Director and quality assurance specialists have developed a comprehensive assessment tool to review and evaluate physician offices. Health Plans are required to conduct a facility site review and evaluate all primary care sites using the assessment tool prior to beginning operations. MMCD nurses take a sample of the sites reviewed by the health plan and conduct a separate follow-up review of the facility as part of MMCD's on-going monitoring process.

6. Community stakeholder meetings

- In counties converting from fee-for-service to managed care, regardless of model, a community stakeholder meeting is advertised and facilitated in the county seat. MMCD and each of the health plans are represented. This is an opportunity for providers, beneficiaries, advocates and other stakeholders to discuss and ask questions about the health plans, their delivery systems, operations, etc.

7. Onsite health plan visit

- A team, comprised of MMCD staff conducts an onsite visit to the health plan's administrative offices to meet with the various departments responsible for quality improvement activities, member services, provider relations, financial reporting and marketing. This visit allows MMCD staff to confirm the information reported in the health plan's "deliverables". Particular focus is given to the member services departments ensuring mechanisms to respond and track member calls and requests are physically present.
- The larger commercial health plans typically have a central administrative office. However, many times a county or regional office is established to maintain a local presence in the community. If a local office is present, MMCD staff will also go onsite to review the services and activities that are conducted from that location.

8. Federal Centers for Medicare & Medicaid Services (CMS)

- CMS conducts a review of MMCD's processes of evaluating a health plans' compliance with rules and readiness to commence operations. In the past CMS has brought a team to MMCD to examine a sample of the "deliverables" MMCD has approved. Close attention is always given to MMCD's assessment of the health plans' provider network. CMS will request a meeting or accompany staff to the on-site visit in order to hear a health plan presentation about their organization and operation features.

**Transition of Seniors and Persons Living with Disabilities
from Fee-for-Service to Managed Care**

The transition of people from Medi-Cal FFS into managed care requires the exploration of many considerations for individuals with chronic illness and disabilities to ensure that health care delivery through Medi-Cal managed care will improve upon rather than compromise access to high quality health care services. Beginning with this basic premise, this section outlines several examples of innovative managed care programs in California that address the unique health care needs of seniors and persons with disabilities and identifies elements of managed care health plan readiness that must be considered to facilitate the transition from a FFS health care delivery system to a managed care delivery system.

Many states require people living with disabilities who receive Medicaid benefits to enroll in managed care programs. Many states and health plans have found that some form of managed care is the best path to take in meeting the needs of seniors and persons living with disabilities. Consumers, while less sure, also agree that managed care offers the potential for better access and increased quality.ⁱ Research findings reveal that individuals enrolled in managed care organizations were more likely to be highly satisfied in three domains—global quality, access to care, and technical skills—compared with individuals in the local and national FFS study groups but fewer were highly satisfied with the interpersonal manner of their providers.ⁱⁱ Managed care offers many potential benefits over the traditional FFS delivery system (**See Table One**).

Table One
Potential Benefits of Managed Care for People with Disabilities

Managed Care	Traditional FFS
<ul style="list-style-type: none"> ▪ Assigned Primary Care Provider ▪ Access to defined network of providers 	<ul style="list-style-type: none"> ▪ Search for doctor who accepts Medi-Cal
<ul style="list-style-type: none"> ▪ Plan responsible for providing appropriate specialist(s) 	<ul style="list-style-type: none"> ▪ Individuals are on their own in finding specialists
<ul style="list-style-type: none"> ▪ Member services and 24-hour help-lines 	<ul style="list-style-type: none"> ▪ No 24-hour help-lines
<ul style="list-style-type: none"> ▪ Initial health assessment and care planning 	<ul style="list-style-type: none"> ▪ No initial health assessment required
<ul style="list-style-type: none"> ▪ Increased access/help with referrals and special services (e.g. transportation) 	<ul style="list-style-type: none"> ▪ No/limited help to obtain referrals, special services
<ul style="list-style-type: none"> ▪ Access to interpreter services in MD offices 	<ul style="list-style-type: none"> ▪ No/limited help with interpreter services
<ul style="list-style-type: none"> ▪ Case management and care coordination services 	<ul style="list-style-type: none"> ▪ Limited case management; No care coordination assistance
<ul style="list-style-type: none"> ▪ Quality measurement routine 	<ul style="list-style-type: none"> ▪ Quality measurements not required
<ul style="list-style-type: none"> ▪ On-going formal quality improvement efforts 	<ul style="list-style-type: none"> ▪ Quality improvement programs not required

Consumer Experience

California will be building on lessons learned through experiences gained in Medi-Cal managed care health plans that currently provide health care services to seniors and persons living with disabilities. In addition to this, California will

also build on lessons learned in other states and on input from stakeholders and potential consumers to ensure that enrollment of persons living with disabilities into managed care will not have an adverse impact on access, satisfaction, and quality of care.

Considerations and Best Practices

The best practices that are highlighted in this section illustrate some of the efforts that have been undertaken by current Medi-Cal managed care plans in response to meeting the health care needs of their enrollees who have chronic and/or disabling medical conditions. These highlighted references are not intended to represent a standard or minimum practice that has been established for plans in caring for seniors and persons living with disabilities.

Assessment and Reassessment of Need

Because of the diversity of needs among individuals with disabilities, assessment and re-assessment of need is a necessary first step to ensure that conditions and emerging problems can be assessed and addressed accurately and efficiently. Health plans use new member outreach activities to explain how the managed care plan works and the importance of selecting and establishing a relationship with a primary care physician. Medi-Cal managed care plans are required to proactively contact new members to schedule an Initial Health Assessment (IHA), to determine the past history and current needs of new enrollees and to offer appropriate referrals or supplemental services. The IHA has been a significant tool in health care management for families and children. The tool and process will be re-examined for improvements that can facilitate assessment and re-assessment of complex and changing needs of enrolled seniors and persons living with disabilities. In this way, specific disease groups and chronic conditions can be identified quickly in order to anticipate greater need for intervention and services.

For Example,

Identifying Children with Complex Needs: A First Step to a Medical Home



HealthNet, with 625,000 Medi-Cal members in 7 counties, implemented a quality improvement program to improve access and reduce unmet needs in Children with Special Health Care Needs. HealthNet also wanted to improve access and reduce unmet needs for children needing services in other systems of care. All new child members received welcome calls, which included a formal screen for unmet health care needs and identification of use of other agency services (e.g. Regional Center, Mental Health). The number of children identified as having special needs increased from 1 to 18 percent. Nurse Health Assessment Coordinators follow up to ensure each child has a medical home.

Customer Service and Information About Care

Persons living with disabilities face unique challenges in accessing information. Individuals living with certain disabilities may need information in media and formats beyond that typically provided. Health plans will need to ensure that information is available in alternative formats (e.g. Braille, large print, audio cassette), including in threshold languages. Health plans may want to explore having their plan website information be “Bobby Approved” which is a free internet service that can identify accessibility barriers to web sites.

Obtaining information from others who do not understand unique needs of persons living with disabilities may be especially frustrating for the affected population. To improve this situation, health plans may need to augment the training provided to health plan customer service or member service representatives to ensure they are knowledgeable about the needs of those living with a disability. Member information and materials can be re-examined with an eye toward demonstrating greater sensitivity to disabled individuals. For example, health plan directories can identify providers with particular experience/expertise with complex health problems.

For Example,

Informing Enrollees about Access to Provider Offices			
Inland Empire Health Plan (IEHP) enrolls 285,000 enrollees in Riverside and San Bernardino counties. IEHP surveyed its primary care providers to determine which provider sites are fully accessible. The IEHP provider directory notes which providers office sites are accessible with an easy-to-see icon so that members know which offices have accessible parking, access from parking to building, and adjustable exam tables.			
Provider:	DR. RIGHT	Gender:	FEMALE
Address:	1111 1 st St. POMONA, CA 91767	Type:	PEDIATRICS
Phone:	(909) 123-4567	Age	UP TO AGE 21
AfterHours:	(888) 123-4567	Limits:	CARE FOR U MEDICAL
Access:	 <u>HLIMITED</u> <u>ACCESSH</u>	IPA:	GROUP
		Hospital:	UNIV HOSPITAL
		Bus:	

Access to Primary Care, Specialists and Other Services

Managed care plans offer an advantage to plan members through guaranteed access to primary care providers and specialists. With the transition from FFS to managed care, individuals will discover certain enhancements to their health care experience, such as:

- Greater emphasis on identification of a primary care provider and an effort to find the best provider match.
- Wider access to specialists as primary care providers in order to ensure the best level of care for persons with chronic and complex conditions.
- In less populated areas, or areas with shortages of specialty care, primary care providers have access to specialist consultation to help appropriately to meet specific needs.

In areas where there is a general shortage of primary care physicians and/or specialists, there will be increased opportunity for state agencies and stakeholders to develop partnerships and to cultivate greater expertise in the health care needs in certain specialty areas; for example, developmental disabilities, and mental illness.

There is anecdotal evidence that individuals with complex needs and chronic conditions have problems arranging timely access to specialist care. Managed care beneficiaries in some other states have been shown to have access to larger numbers of providers than in FFS, and improved access to evening or weekend appointments.ⁱⁱⁱ

Individuals living with disabilities sometimes have a “thinner” margin of health. It is especially important that there not be delays in getting appointments for urgent care or prescription medications. Managed health care plans may want to consider incorporating “maintaining the highest level of independent function” as a component of their “medical necessity “ definition.

For Example,

<p>Wheelchairs That Work</p> <p>CalOptima serves over 275,000 enrollees in Orange County, including members with disabilities. In order to avoid delays and access to needed equipment, CalOptima established multi-disciplinary Seating Clinics at St. Jude and Tustin Rehabilitation Hospital. Each Seating Clinic team includes a physical therapist that specializes in rehabilitation equipment. Vendors are required to meet quality standards and timelines; a CalOptima Benefits Coordinator works closely with the clinics and vendors. The seating clinics have served over 1,000 members. Turnaround time to receipt of custom wheelchairs has been reduced from 120 to 52 calendar days. 100 percent of the seating clinic clients report high satisfaction levels.</p>
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Coordination of Care

An effective care system for people living with disabilities or chronic illness includes care that is person-centered, integrated across a full and flexible array

of services, pro-active support for self-management, and the use of interdisciplinary care teams. ^{iv} Primary care providers who serve as the “medical home” for people with disabilities must spend time on care coordination and communication with other providers; including specialists.

For Example,

Partnership Health Plan: Providing Medical Homes to Disabled Children

Partnership Health Plan serves over 80,000 members in Solano and adjacent counties. The plan used a model developed by the Center for Medical Home Improvement to work with providers to ensure that children receiving California Children Services also receive primary care in a true medical home – care that is family-centered, coordinated, comprehensive, and culturally effective. Partnership developed a coalition with other local agencies serving children with complex needs; together they developed a parent notebook, improved coordination among agencies, and worked with providers to improve assessment and care planning.

Adequacy of Network and Continuity of Care:

For individuals with established relationships with a FFS provider, changing providers may disrupt a complex therapeutic regimen. Providing good chronic care often requires more attention be paid to long-term provider-patient relationships, with more focus on maintaining function and independence. Special attention must be paid to continuity issues during transitions from FFS to managed care. Prior to the transition period, each currently operating plan will be expected to assess its provider network to ensure that providers are appropriately included in the plan network based on the specific needs of the enrolled population. For existing Medi-Cal beneficiaries transitioning from the FFS to managed care environment, consideration should be given to the inclusion of the provider in the managed care provider network or a suitable transition plan be developed in consultation with that enrollee and provider.

To assist health plans in developing appropriate provider networks, the Department has initiated a data analysis of provider claims to identify physicians, specialists and hospitals that currently provide care to the Medi-Cal FFS population. This data will be provided to health plans for the development/enhancement of their provider networks.

Managed Care Plan Rates

A significant area that must be considered is health plan reimbursement rates. Rates must be developed that address plan capacity to adequately manage the needs of any expansion population. Rates will need to factor in a consideration

regarding the medical care needs of seniors and persons living with disabilities and their service utilization patterns.

Circles of Support:

Circles of social support play a very important role in the healthcare of individuals living with disabilities, providing support, advocacy, and often daily care and care coordination. Some individuals who are not in a position to represent themselves often have appointed surrogate decision-makers who express their preferences and desires about health care. Whether there is a circle of support or a formal surrogate decision-maker, health plans and providers will need to take into account whom, along with the beneficiary him/herself, can work with the care-planning team to arrange for or even provide services. It is important that there be opportunities for consumers' own circles of support to be considered during the design and operation of systems of care.

Quality Measurement and Quality Improvement

Measuring quality of care is a current state and federal requirement for all Medi-Cal managed care plans. Medi-Cal managed care plans are required to routinely assess quality of care, and to implement quality improvement projects focused on areas with performance gaps; there is no comparable process in FFS Medi-Cal. Some states (Wisconsin, New Jersey) with larger numbers of enrolled Supplemental Security Income (SSI) beneficiaries have begun to report information on the enrollees' assessment of their care.

This year the Medi-Cal Managed Care Division (MMCD) is evaluating the care experience of children with complex needs, using the Children with Chronic Needs supplemental module in the Consumer Assessment of Health Plans survey. MMCD has implemented a number of collaborative quality improvement projects (e.g. diabetes), which could be augmented to address additional issues of interest to other populations with chronic conditions and complex needs. The collaboratives facilitate sharing of best practices and resources among plans. Quality measurements will need to include measures relevant to the needs of individuals with complex and chronic care needs. Surveys that measure patient care experiences need to allow reporting on quality of life measures and indicators specifically pertinent to living with disabilities in order to improve services to the enrolled population.

For Example,

Quality Improvement for Older Individuals with Complex or Chronic Care Needs

Medi-Cal managed care plans are currently conducting a variety of quality improvement projects that focus on individuals living with complex and/or chronic care needs:

- 13 plans are working to improve care for people with diabetes (10 in the Medi-Cal Managed Care Division diabetes collaborative).
- 11 plans are working with the Center for Health Care Strategies to improve care for people with asthma.
- 3 plans have projects to improve breast and cervical cancer screening.
- 3 plans have instituted programs to improve medication management in enrollees with several diseases and multiple prescriptions.
- 3 plans are collaborating to improve the quality of hospital care.
- 4 plans have implemented projects to improve care for children with special health care needs.

Health Plan Readiness for Seniors and Persons with Disabilities:

In preparation of ensuring health plan readiness for the transition of seniors and persons living with disabilities into managed care, two processes will be undertaken: 1) the convening of stakeholders; and 2) conducting a formal health plan readiness review, as previously described in this document.

The DHS will begin with the convening of stakeholders to actively engage interested parties to identify areas of consideration to ensure plan readiness in order to meet the diverse health care needs of this population. The process will begin with an exploration of the lessons learned from prior implementations of Medi-Cal managed care. The stakeholder process will be used to examine current managed care program standards and determine what augmentations are necessary to both protect and ensure quality improvement for seniors and persons living with disabilities. The stakeholder process will be a 9 to 10 month process beginning in July 2005 with the goal of developing recommendations in early 2006. Identified program changes can then be adopted, implemented, and included in health plan contracts as appropriate.

Determining if a health plan is prepared to meet the determined standards for delivery of services to all individuals covered under the plan, including seniors and persons living with disabilities, is conducted in a systematic manner. Readiness reviews consist of both documentation reviews as well as on-site visits to both health plan headquarters and provider offices. The current Medi-Cal Managed Care Health Plan Readiness Review, as previously described,

provides the steps that are performed prior to any enrollment of beneficiaries in a health plan.

In 1993, the DHS released its plan entitled Expanding Medi-Cal Managed Care; Reforming the Health System; Protecting Vulnerable Populations. Following the release of the plan, several workgroups were formed to examine the various implementation and policy areas. The workgroups were composed of individuals representing stakeholders and experts including: beneficiary advocacy organizations; county government; health care associations; hospitals; universities; state departments; clinicians; public health professionals, etc. Each workgroup was assigned a subject matter area of responsibility such as management information systems; data reporting; cultural and linguistics; quality assurance; scope of services; health education; public health; member services; provider networks. Each workgroup met for a number of months culminating in the development of policy recommendations for the new managed care program.

The program was well served by acknowledging that the “managed care delivery system” expertise was not within the confines of the State and that the participation of external resources and other interested parties was essential to implementation success. This process was recently emulated in the Medi-Cal Managed Care Division’s convening of a Task Force on Children with Special Health Care Needs. The Task Force was created in response to new federal requirements specific to this population, in the Balanced Budget Act of 1997. Over 50 individuals met for several months to deliberate on approaches to improving the quality of care for children with special health care needs who are enrolled in Medi-Cal Managed Care health plans. Strategies as well as recommendations from the workgroup have been incorporated into the managed care program.

The strategies employed above, the lessons learned and experiences gained from these processes will set the stage for the stakeholder engagement in examining the needs of seniors and persons living with disabilities transitioning into managed care. The inclusion of seniors and persons living with disabilities in mandatory managed care introduces into the managed care program, in greater numbers, Medi-Cal’s most vulnerable population. As the Department has already heard in the Medi-Cal Redesign public forums, there are many experts and interested parties willing to help guide the transition of these populations to a managed care environment. Establishing a similar process of stakeholder participation would bring the knowledge, experience and expertise to the development of a managed care system design that could respond to the unique needs of these groups.

The areas of discussion will include those previously identified in this document and the following:

- Analysis of service utilization and cost data;
- Beneficiary enrollment and consumer engagement;
- Linkages with non-Medi-Cal services: (e.g. Regional Centers, In-Home Supportive Services, county mental health, independent living);
- Accessibility and availability of new treatment modalities;
- Health Plan and provider compliance with Americans with Disabilities Act of 1990;
- Roles, responsibilities and participation of non-Department of Health Services entities (e.g. Department of Development Services, Department of Mental Health, Department of Alcohol and Drug Program, Department of Aging, Department of Rehabilitation, Department of Social Services, State Independent Living Council); and
- Information sharing to ensure coordination of services and to prevent duplication.

It is envisioned that workgroups would be established to address these areas and other identified issues. The sense of an impending transition of seniors and persons living with disabilities into mandatory managed care has fortunately instigated new research on many of these issues. The Department also has actual experience in the County Organized Health Systems, which are already caring for this population. Additionally, unlike the initial expansion of Medi-Cal managed care, California will not be the pioneer in serving the population of seniors and persons living with disabilities on a mandatory enrollment basis and can take advantage of lessons learned from other state experiences. These workgroups would therefore have the advantage of completed research, analysis, evaluations and experience.

Endnotes

ⁱ Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States, Nicki Highsmith and Stephen Somers, Center for Health Care Strategies, 2003

ⁱⁱ Health Care Finance Rev. 2001 Summer; 22(4):175-8 Burton LC, Weiner JP, et al. Health Services Research and Development Center, John Hopkins University School of Hygiene and Public Health, Dept of Health Policy and Management, USA. H**burton@jhsph.edu**H

ⁱⁱⁱ Haslanger K. Medicaid Managed Care in New York: A Work in Progress H**http://www.cmf.org/programs/newyork/haslanger_medicaidmancareny_bn_673.asp**H

^{iv} Ireys H, Thornton C, McKay H. Medicaid Managed Care and Working-Age Beneficiaries with Disabilities and Chronic Illnesses. Health Care Financing Review (2002): 24:27-42