MHPA's 2008-2009 Best Practices Compendium

A compilation of Best Practices within the Medicaid health plan community

www.mhpa.org

About MHPA and this Compendium

Medicaid Health Plans of America (MHPA) is the leading trade association solely focused on representing Medicaid health plans. MHPA is a nonprofit, tax-exempt organization formed in 1993 and incorporated in 1995. The Association provides advocacy, research, analysis and organized forums that support the development of effective policy solutions to promote and enhance the delivery of quality health care.

MHPA's 2008-2009 Best Practices Compendium is a compilation of the best practices put forward by the Medicaid health plan community. This booklet, published annually, is provided as a valuable reference tool.

The comprndium also features Centers for Medicare and Medicaid Services (CMS) statistical data on the state of the managed care industry as well as a listing of the current state Medicaid directors and an MHPA-member health plan resource directory.

Introduction

A Special Message from Thomas L. Johnson, MHPA Executive Director

Welcome to the second issue of the Medicaid Health Plans of America's *Best Practices Compendium*. The *Compendium* continues to highlight the best that Medicaid health plans offered Medicaid recipients in terms of their health coverage.

Medicaid Health Plans have made significant contributions to improving the physical and mental health of Medicaid recipients. The partnership that the industry enjoys with states offers a classic example of how the public and private sectors can work together to achieve significant measurable results.

The Medicaid industry has grown each year over the past 10 years, and more than 63 percent of those eligible for Medicaid are now members of a Medicaid Health Plan. Medicaid is the largest health insurer in the country now, serving more than 44 million individuals. The industry remains committed to offering quality care while controlling rising costs.

In this *Compendium*, we have included excellent examples of the most effective best practices in use today. Also included in this *Compendium* is statisical data about the industry from the 2006 Centers for Medicare and Medicaid Services (CMS) National Summary of the Medicaid Managed Care Program and Enrollment. We hope you find the information in this report helpful, and we look forward to continuing our mission to improve the health and quality of life of our members.

Sincerely,

Thomas L. Johnson
Executive Director
Medicaid Health Plans of America

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Part I: Best Practices Compendium

Centene

17P Program

DESCRIPTION: Preterm delivery, defined as a delivery before 37 weeks, and the resulting large NICU claims, are a large portion of a managed Medicaid company's expenses and result in poor quality outcomes. The history of prior spontaneous preterm delivery is one of the strongest risk factors for preterm birth in subsequent pregnancies.

ACTION TAKEN: An increase of utilization of 17P injections for pregnant mothers with previous preterm births in order to decrease NICU admissions and premature births. This program offers the following:

- 17P as a benefit
- Educational program on 17P for physician providers including free Continuing Medical Education credit
- Enhanced pregnancy notification system identifying potential candidates for 17P and case management
- Increased interaction with health plan case managers/providers to discuss patients who may benefit from 17P
- New educational materials for patients which prepare at risk mothers for their next pregnancy (podcasts, website, and "NICU packet")

OUTCOMES: 17P and an aggressive case management program may reduce by 30% the number of NICU babies/premature births. Patients who received at least five 17P injections have the same outcomes for reduced NICU admissions and preterm births before 32 weeks and 37 weeks as patients who received a full course of 17P initiated in the recommended timeframe.

**Body mass index for obesity is 30 or greater.*

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Keystone Mercy Health Plan

40-Day Journey

DESCRIPTION: African-Americans suffer disproportionately from every major disease. Most health authorities agree that the United States' medical system which has all but institutionalized these health disparities. The medical community is challenged in eliminating health disparities even with increased awareness and technology.

ACTION TAKEN: The 40 Day Journey is a faith-based wellness program for African American women that is 40 days in length. There are pre- and post-physical assessments to establish participants' baseline and outcomes. The group meets weekly for six weeks receiving education on nutrition, exercise, water intake, and medication compliance. Each session also has a cooking class demonstrating alternatives to high-cholesterol and fried foods. The Journey includes daily opportunities for varied activities such as walking clubs, nutrition/cooking classes, and Gospel aerobics. Over the years, the program has grown to include men as well.

OUTCOME: Of the participants who followed the three-pillared program (a plant-based diet where possible, intermittent training and cognitive behavior change), preliminary data found the following health improvements among participants with diabetes:

- Nearly a 20 percent drop in triglycerides
- 22 percent decrease in LDL ("bad") cholesterol (31 percent for those with Type-1 diabetes)
- 17 percent reduction in fasting blood sugar
- 4.6 percent weight reduction (3 percent for Type-1 patients)
- 5 percent reduction in resting heart rate
- Nearly a 6 percent drop in systolic blood pressure
- 4 percent decline in diastolic blood pressure

In a post-program survey, participants reported, on average, a 73 percent improvement in pain and an 81 percent improvement in mobility and flexibility. They also reported, on average, an 84.5 percent improvement in their attitude and hope for the future.

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Great Lakes Health Plan

Affecting Positive Health Outcomes with Relational Databases

DESCRIPTION: Estimates are that by 2030 chronic disease will affect nearly 150 million Americans. Twenty-eight percent of those affected by chronic diseases will be so impacted by the disease process they will not be able to fully function. Where chronic disease costs the United States $470 billion annually today, left unchecked, the costs can only spiral upward.

Disease Management promotes optimal patient health status through an active, integrated model involving all healthcare professionals in a patient centered approach to improve the consistency, quality and effectiveness of health care thus achieving optimal health status.

ACTION TAKEN: Great Lakes Health Plan (GLHP) created relational databases/registries to support the use of health outcomes data in multiple ways. GLHP disease management registries are disease specific based on nationally accepted clinical practice guidelines. Registries facilitate:

- Stratifying members to create a system that focuses on members who are in the greatest need for intervention,
- Identifying gaps in care and services to initiate healthcare practitioner and member reminders,
- Employing high-impact interventions,
- Tracking of member and practitioner education, hospitalizations, ER visits and primary care visits, lab tests and results, pulmonary tests, vaccines etc, pharmaceuticals, and patient compliance.

OUTCOME:
Increased the rate at which:

- Members with chronic obstructive pulmonary disease receive appropriate pulmonary testing to determine degree of severity by 10 percentage points. This is the first step to getting members on appropriate pharmaceutical therapy.
- Doctors are testing diabetic members' A1c (blood sugar) by eight percentage points.

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AmeriHealth Mercy Health Plan

Asthma Beta-Agonist/Controller Medication Initiative

DESCRIPTION: AmeriHealth Mercy Health Plan implemented an aggressive campaign to help members with asthma in the fall of 2007. Through an analysis of pharmacy claims, this program identified members who were using their beta-agonist (i.e., rescue) inhaler more than twice a week without being on concomitant therapy with a controller inhaler. According to the National Heart Lung and Blood Institute's (NHLBI) asthma guidelines, these patients are classified as having mild, persistent asthma, and the recommended therapy for this group is an inhaled corticosteroid in addition to a rescue inhaler.

ACTION TAKEN: AmeriHealth Mercy Health Plan sent letters to pre-selected members explaining why they were selected and how to know if they had poor control of their asthma. The letter also urged them to speak to their physician to receive a controller medication. Four educational handouts were included to help patients learn more about their disease. Primary Care Providers (PCPs) were sent detailed member reports that included: 1) utilization rates of both metered-dose inhalers and nebulized rescue medications for all selected members, and 2) highlights of the NHLBIs recommendations for use of controller medications. Information about covered, formulary, inhaled corticosteroids was also included in these mailings.

OUTCOME: More than 800 asthmatic members who were overusing beta-agonist inhalers and not using any controller medications were identified and included in the program. Five months later, 20 percent ($p<.000001$) had been prescribed a controller medication, while the percent of the asthmatic population utilizing high levels of beta-agonist medication without receiving controller medication dropped from 7 percent to 1 percent ($p<.000001$).

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Passport Health Plan

Asthma Program

DESCRIPTION: According to the National Institute of Health and the National Heart, Lung, and Blood Institute, from 1980 to 1996 the number of Americans diagnosed with asthma more than doubled to almost 15 million. In 1999, asthma was responsible for 2 million emergency department visits, 478,000 hospitalizations with asthma as the primary diagnosis, and 4,426 deaths nationwide. Healthy Kentuckians 2010 reports over 220,000 Kentuckians are affected by asthma with 72% in persons under age 45 with increasing prevalence in all ages, especially children. PHP has an average of 5,931 eligible members per quarter in 2007.

ACTION TAKEN: Based on claims data as well as hospital and prescription drug use, the plan stratifies members based on the severity of their illness and the types of services they have used, such as inpatient admissions and emergency room visits. Disease managers contact members by phone to evaluate the severity of their asthma, identify their needs, and determine their level of knowledge about asthma. Based on this information, they work with members and their physicians to develop an asthma action plan that includes goals for improved health and arrange for home visits as needed. Members receive educational materials and services tailored to their specific needs. All newly identified members with asthma receive a welcome packet with educational materials about the physiology of asthma, signs and symptoms, environmental factors that exacerbate asthma, and effective medications.

OUTCOME: From 2001 to 2006, the percentage of members taking controller medications has risen from 75.68% to 91.51%. In recognition of the program's success, the Robert Wood Johnson Foundation's Center for Health Care Strategies chose PHP's Asthma Disease Management for its Best Clinical and Administrative Practices award in 2002.

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MDwise

BLUEBELLEbeginnings

DESCRIPTION: The MDwise BLUEBELLEbeginnings program is an outreach program focused on member accountability for their health and wellness. This program was launched in 2004 to improve access and care for pregnant women and to improve the likelihood of a healthy baby.

ACTION TAKEN: BLUEBELLEbeginnings includes a wide range of interventions including health education materials, community referrals, access to health education classes, telephonic outreach, high-risk case management, and a member incentive. The program:

- Identifies high risk factors and provides support and resources to reduce risks and complications during pregnancy
- Links member with additional resources, such as childbirth and parenting classes, ensures member enrollment in other beneficial programs, and if necessary, behavioral healthcare
- Educates members on the importance of prenatal care and encourages them to access it, including keeping scheduled appointments and arranging transportation
- Educates the pregnant member regarding signs and symptoms that warrant immediate care
- Encourages and rewards members who obtain appropriate prenatal and post-partum care.

OUTCOME: Frequency of Ongoing Prenatal Care

ROQ Results (Administrative Data Only)					
Measure	2002	2003	2004	2005	2006
Frequency of Ongoing Prenatal Care*	-	-	54.0%	54.9%	62.6%
Timeliness of Prenatal Care	59.3%	63.4%	62.6%	73.8%	71.2%
Timeliness of Postpartum Care	15.7%	44.2%	50.3%	54.9%	62.6%

MDwise is currently experiencing an approximate 30% success rate in reaching pregnant members to conduct a pre-natal assessment. Of those members, 10% follow through to collect their incentive after the post-partum exam and birth of their child.

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Passport Health Plan
Childhood Obesity Program

DESCRIPTION: The Heuser Clinic reports “Kentucky has the highest rates of obese, smoking, and diabetic teens in the nation.” In order to improve health outcomes for morbidly obese members, Passport Health Plan partnered with the Heuser Clinic on their Childhood Obesity Program. The Heuser Clinic is a scientific-based 12-week fitness program for young children, adults, athletes, and corporate employees. Passport Health Plan (PHP), is enrolling morbidly obese children in this 12-week program aimed at helping these children get started on the road to a healthier lifestyle. The children are followed by a personal trainer and medical staff. In addition, participants and their caregivers attend nutritional counseling on-site at the Heuser Clinic’s training and exercise facility.

ACTION TAKEN: All of the participants in the Childhood Obesity Program come to the clinic with co-morbidities directly related to their weight. Many of these comorbidities resolve with participation in the program. The Plan encourages primary care providers to refer children with obesity to the Heuser Program for evaluation and participation. Through the program, children and their caregivers are taught how to improve their health by making better food choices. They are also paired with personal trainers to create customized exercise programs. In addition, members are given transportation stipends to attend sessions which are usually held three times per week after school hours. Participants in the program range in age from 6 to 18 years old.

OUTCOMES: All The Plan’s obesity program is helping improve the quality of life of our most at risk children. Along with improved medical status, reduction in overall weight and body mass index, all participants report improvements in self-esteem and increased socialization. Members have shown measurable improvements. Johnny, a nine-year old member and pioneer to the program, has shown significant improvement since the inception in February 2005. In February 2005, he weighted in at 334 lbs, had a resting heart rate of 100, and a body mass index of 59.2.* To date, Johnny has lowered his overall weight to 157 lbs, his resting heart rate is now 92, and his body mass index has been lowered to 27.2* which now removes him from the obese category. In addition, Johnny’s weight loss has lowered the number of medications he is taking from 12 to seven. Johnny’s improved outlook on life and his ability to interact socially has reduced stress-releated symptoms including anxiety, heartburn and migraines. To date, 24 members have participated in the program and the Plan’s goal is to enroll 15 new members each quarter.

**Body mass index for obesity is 30 or greater.*

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Great Lakes Health Plan
A Collaborative Initiative for Early ID of Chronic Kidney Disease

DESCRIPTION: Chronic kidney disease (CKD) is a public health problem in the United States. It affects 20 million Americans. CKD increases risk for cardiovascular disease, complications of decreased kidney function, and progression to kidney failure, eventually necessitating dialysis or a kidney transplant for survival.

Key is early identification of the disease, timely and appropriate medical management to delay the progression of kidney disease and its complications. As CKD is a silent disease, most people who develop CKD don’t even know they have it, and primary care practitioners (PCPs) may overlook the potential for the disease.

ACTIONS TAKEN: Studies by the National Kidney Foundation (NKF) clearly demonstrate that physician education is necessary for successful implementation of an early CKD reporting system. GLHP worked with two other HMOs and the NKF of Michigan to educate:

- PCPs about early identification of CKD using. estimated Glomerular Filtration Rate (eGFR) from a simple blood test for creatinine.
- At-risk members about the potential for CKD and to see their doctors to be tested.

GLHP sent its doctors a letter explaining the initiative and educational material on early identification and management of CKD along with a list of at risk members for testing.

OUTCOME: The culmination of this effort resulted in earlier detection of CKD members, initiation of appropriate medications and care, and a referral to nephrology. By identifying and treating of those at risk, the prevention of the devastating effects of CKD including dialysis and renal transplant is effected.

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Select Health of South Carolina
Community Education and Outreach

DESCRIPTION: In a rapidly changing Medicaid environment, Select Health of South Carolina recognized the need for increased education, awareness and advocacy in the community. To better serve our membership, we needed to create linkages to resources and programs in the community. In addition to benefiting our membership, such linkages would allow for additional opportunities to provide outreach and education to both the staff and clientele of these community organizations.

ACTION TAKEN: In 2006, Select Health created the Community Liaison Department. With a team positioned in communities across the state, this department plays a key role in improving health outcomes and assuring availability of services to all members by building positive relationships with organizations that share our mission. Specifically, this department:

- Educates the community about Medicaid Managed Care and Select Health
- Creates a stronger presence in communities across the state by establishing relationships with state, federal, community and faith-based organizations
- Affects positive health outcomes through collaboration with community partners
- Increases our membership’s awareness of resources in their communities

OUTCOMES:

- Increased our support of organizations serving our membership
- Increased visibility of Select Health in the communities across the state
- Educated 1,000+ South Carolinians about the state’s Medicaid Managed Care auto-enrollment process
- Active service on 50+ community coalitions and boards throughout the state

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Centene

CONNECTION PLUS

DESCRIPTION: Pregnant and high-risk members with limited or unreliable phone access often experience greater difficulty contacting their health plan case manager, primary care physician or other significant provider. Communication with these members is difficult to establish since no constant or reliable means of contact is available between the provider and the member. Due to the greater likelihood of these members requiring serious and/or immediate medical attention, a constant and reliable means of communication is necessary between the providers and members to facilitate proper care

ACTION TAKEN: Provides member a free preprogrammed, limited use cell phone to call their health plan case manager, primary care physician or other significant provider, NurseWise® (Centene's nurse triage line) and 911. These free cell phones include a walkie-talkie feature that allows a health plan case manager to call the member if they miss an appointment or the member to contact the health plan for some reason. This is done by having the case managers keep phones that only have the walkie-talkie feature. Representatives in each of our health plans are available to connect members to community social services.

OUTCOMES: CONNECTIONS PLUS allows members without phone access to telephonic case and disease management programs that can positively impact health outcomes, provide a new venue to educate members, and allow customization to meet the member's needs while providing an economical way to eliminate the communication barrier with high-risk Medicaid patients.

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Passport Health Plan

Coronary Artery Disease Program

DESCRIPTION: Coronary Artery Disease (CAD) is the leading cause of death in Kentucky accounting for 15,000 deaths, 38% of all deaths in Kentucky in 2001. Kentucky is ranked the fourth highest cardiovascular mortality state in the nation. Studies show that certain modifiable risk factors such as high blood pressure, high blood lipid levels, cigarette smoking, lack of physical activity and obesity increase the risk of CAD.

ACTION TAKEN: The CAD program provides education regarding risk factors prior to a cardiac episode. All participants in the CAD program receive educational mailings promoting a healthy lifestyle including smoking cessation, weight management, physical activity, nutrition, routing practitioner office visits, screenings and treatment, and contact information for the program. High-risk members are evaluated via telephone outreach and a disease specific assessment. Interventions are based on the severity of the disease. High-risk members receive self-management counseling, resources, arrangements for home health visit(s) for CAD education and/or CAD education classes, assistance with appointments, transportation, other coordination of care needs, CAD specific educational mailings, and one-on-one phone contact. Practitioners are informed when members are enrolled in the program and they are given detailed information regarding member's status of LDL screening, medication utilization including lipid lowering medication, ACE inhibitor or Beta Blocker, and identified co-morbidities

OUTCOMES: In 2006, 91.53% of membership received Beta Blocker treatment after a heart attack and 60.34% had controlled high blood pressure. Both of these results are positive factors in preventing recurring heart attacks. The Plan increased the rate of members who have received an LDL-C screening from 65.22% in 2004 to 79.25% in 2006. Additionally, members with an LDL-C screening less than 100 mg/dl (controlled) increased from 30.43% in 2004 to 40.40% in 2006.

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Passport Health Plan

Diabetes Program

DESCRIPTION: Passport Health Plan recognizes that Kentucky is ranked 7th in the Continental United States in incidence of diabetes. In 2005, the Kentucky Diabetes Fact Sheet reported 8.9% percent of Kentuckians had a diagnosis of diabetes and an estimated 111,900 individuals had undiagnosed diabetes resulting in a total of 385,900 (approximately 1 in every 8 adults) diagnosed and undiagnosed cases of diabetes. Furthermore, diabetes is the 5th leading cause of death by disease in Kentucky, and Kentucky Medicaid spent $611 million on diabetes in 2003.

ACTION TAKEN: The Plan uses claims and pharmacy data to identify adult members with diabetes. All newly identified members receive a welcome letter that introduces them to the program and provides information on how to contact a diabetes program coordinator. On a quarterly basis, all program participants receive educational materials, including dietary recommendations. The Plan sends reminders for eye exams and other diabetes-related testing twice a year. Diabetes disease managers contact members who have had an emergency room visit or hospital admission for diabetes and may not be managing their diabetes appropriately. Care Managers assess members' needs and provide information about the disease. The Plan stratifies members based on the severity of their disease and the types of services they have used. Members receive educational materials and services tailored to their specific needs.

OUTCOMES: In 2006, The Plan achieved continued improvement the following areas:

- An increase in members who received an HbA1c to 84.63% from 64.93 in 1999.
- A decline in members who noted poor control of diabetes with an HbA1c of greater than 9.0% to 34.52% from 49.05% in 1999.
- An increase in members who received a diabetes eye exam to 52.96% from 37.91% in 1999.

In 2003, the National Committee for Quality Assurance (NCQA) chose the Plan's diabetes disease management program for a Best Practices award. The award recognized the Plan's support of effective physician practice patterns and members' use of effective care.

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Great Lakes Health Plan

Driving Members to the Primary Care Doctor, Non-essential Drug Program

DESCRIPTION: The key to members' health is strengthening relationships with their primary care providers (PCP). Two populations greatly benefit from a stronger relationship with their PCP: members who use the emergency room for primary care, and the member who is a subject of polypharmacy. Polypharmacy is the unwanted duplication of drugs, and often results when patients go to multiple physicians or pharmacies. Typically, polypharmacy occurs when prescribed medications duplicate or interact with each other. PCPs may not be aware of all of the drugs prescribed and Medicaid members may not fully comprehend potential dangers associated with taking multiple drugs.

ACTION TAKEN: An With support from the Great Lakes Health Plan (GLHP) network physicians, pharmacists, and nurses on our Pharmacy and Therapeutics Committee, GLHP developed The Non-Essential Drug Coordination Program (NEDCP).

Members who average eight or more medications per month in the prior quarter have coverage for nonessential medication, but only if their prescription is written by their PCP. PCPs with qualifying members receive a quarterly report that includes the medications and prescribers of members subject to polypharmacy.

GLHP provided education to PCPs on polypharmacy in physician newsletters and correspondence to focus on polypharmacy and potentially reduce medication errors and resulting adverse events.

OUTCOMES: While total prescription drug utilization (Rx Vol/1000) is down for drugs identified as non-essential, the overall drugs (essential and non-essential), prescription costs (Rx cost per member per month (PMPM)) and ER visits continue to rise (1.7% and 2.2% respectively). Admissions and overall medical costs (exclusive of pharmacy) are down (1.2% and 4.2% respectively) compared to the prior period. Physician visits PMPM also increased.

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Passport Health Plan

Early Periodic Screening Diagnosis and Treatment (EPSDT) Program

DESCRIPTION: EPSDT preventative health services are available to all members under the age of 21. Approximately 70% of the population is under the age of 21. National Child Advocates successfully lobbied to ensure Medicaid children received preventative health services to prevent childhood illnesses. As a result, each state is required to provide outreach and education to this population. In 1997, the Centers for Medicare & Medicaid Services (CMS) established an 80% EPSDT compliance/participation goal to be meet by 2006.

ACTION TAKEN: EPSDT staff members make phone calls to families who haven't received the recommended EPSDT screening. Members who cannot be reached by phone are given a home visit through the Plan's contract with the Department of Health. EPSDT screens are also a part of the Plan's Provider Recognition Program. Providers are incented for increasing their screening and participation rates. Providers receive monthly "screens due" reports for their panel that identifies members due for EPSDT screenings.

OUTCOMES: In 1997, the statewide EPSDT screening rate was 17% prior to the Plan's inception. Since 1997, the Plan has improved the EPSDT screening rate to a remarkable 93%. In 2006, the Plan also exceeded the goal set by CMS and achieved a well child compliance rate of 93% and a participation rate of 73% for the federal fiscal year ending September 30, 2007.

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UnitedHealthcare of Florida, Inc. /AmeriChoice (UnitedHealth Group Company)

Emergency Department Diversion Program Program

PROGRAM DESCRIPTION:

- Establishment of an effective Emergency Room Diversion Program to identify medical and psychosocial risk factors that lead to multiple emergency room encounters
- Effective implementation of tailored interventions to mitigate the risks of inappropriate care and improve a recipient's ability to leverage alternative health care, community resources and facilitate the establishment of primary care physician-enrollee relationship

PROBLEM DESCRIPTION:

- Reduce inappropriate emergency room utilization
- Reduce hospital admissions due to misuse of emergency room services
- Reduce inappropriate prescriptions linked to emergency room services
- Provide recipient education
- Provide recipient resources

ACTION TAKEN:

- Identification of enrollees utilizing the ED for non-urgent services via daily hospital "Real-Time – 24 hour post ER visit" Referrals
- Outreach and follow-up calls with recipient
  - Telephonic
  - Letter
  - Other sources
- Enrollee assessment and identification of possible gaps in care/medical needs and coordination of care to meet the needs, i.e. referral to specialist as needed through the PCP.
- Case/Disease Management referral as determined by diagnosis, enrollee needs or enrollees behavioral patterns, i.e. frequent ER usage
- Partnership and collaboration with PCP in managing the care of our recipients and ensuring continuity of care
- Collaboration with mental health for recipients with behavioral/chemical dependency issues

OUTCOMES:

- Recipient – PCP engagement for improved management of health care needs
- Engage community resources to address additional recipient needs
- Reduction in utilization metrics

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Select Health of South Carolina

Emergency Room Outreach Program

DESCRIPTION: Historically, the Medicaid population has had high emergency room (ER) utilization rates. Unfortunately, the ER does not provide the appropriate level of care for most patients. Patients receive higher quality care with more continuity and coordination when they are redirected to their primary care provider. In addition, appropriate use of the emergency room and primary care providers can result in considerable cost-savings.

ACTION TAKEN: In 2004, Select Health of South Carolina established the ER Outreach Program. The initial outreach targeted members with three ER visits in one month. As part of the program, nurse case managers contacted members to educate them about appropriate ER use, help them establish care with their primary care providers (PCPs) and identify barriers to care. The program later expanded to include members with three ER visits in three months. Select Health's Contract Management Department supported the program by contracting with more urgent care centers and incentivizing PCP offices to keep later weekday and weekend office hours for improved member access. The Member Services Department additionally participated by providing education to members identified

OUTCOMES: From 2005 to 2007, ER visits decreased from 760 per 1,000 members to 565 per 1,000 members. This was a 25 percent reduction in ER utilization.

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MDwise

Encouraging New Members to Schedule Primary Medical Provider (PMP) Visits

DESCRIPTION: In MDwise's current contract with the state of Indiana, we are required to encourage members to see their physician within 90-days of enrolling in the MDwise plan. We are also charged with doing a member incentive that promotes health and personal responsibility. Our goal for this program is to improve well-child rates for HEDIS and to instill in members the medical home concept. We want our members to understand care that is managed and coordinated their PMP with the right tools will lead to better outcomes.

ACTION TAKEN: All new members to MDwise are sent a letter which addresses the importance of seeing their PMP. The letter lists the member's doctor and the doctor's phone number. The rules for the incentive program are listed along with a list of gift options the member can choose from. The member is instructed to schedule an appointment with their doctor within 90-days. The letter has a built-in coupon which the doctor or office staff sign and date. It is then faxed in to MDwise. The appointments are confirmed, logged into a database and a $10 gift card is mailed.

OUTCOMES: Currently MDwise is experiencing an approximate 8% response rate on this incentive. Providers are taking advantage of the opportunity to see new patients and determine where annual exams are needed.

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Select Health of South Carolina

EPSDT Provider Outreach Program

DESCRIPTION: More than 85 percent of Select Health's membership is children under the age of 21 years old. These children are eligible for periodic preventive health screenings at no cost to them, yet attempts to increase the rates of EPSDT visits have been a consistent challenge for the plan throughout the years. Member's apathy, provider's unfamiliarity with the EPSDT schedules and past screening history along with billing questions have been identified as barriers to achieving the plan goal.

ACTION TAKEN: A provider EPSDT outreach program was developed with a goal to provide PCPs the education and tools necessary to improve practice rates. Included in outreach efforts:

- A provider survey which indicated that providers would be receptive to participating in new initiatives and included their feedback on barriers to success.
- Pilot project to allow select providers to distribute gift card incentives immediately following EPSDT visits.
- Personalized automated EPSDT reminder calls to members of providers participating in pilot.
- Monthly list distributed to PCPs of members who are "now due" and "past due."
- Routine on-site provider EPSDT orientation and education visits.

OUTCOMES: Feedback received from providers found the now due and past due reports very helpful in their outreach efforts.

Preliminary pilot provider EPSDT rates have demonstrated a 3-5 percent increase in the first 60 days of project. Pilot providers report that utilization of incentives have increased successful outreach to patients and decreased EPSDT no-show rates.

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Passport Health Plan

ER Utilization Program

DESCRIPTION: According to the CDC's report on the Annual Number of Visits to Hospital Emergency Departments, nationwide ER visits in 2004 totaled 110 million as compared to 89 million nationwide in 1992. This report also notes that Medicaid recipients including the SCHIP program accounted for 80.3 per 100 persons seen in the ER with Medicare recipients being 47.1 per 100 persons. Approximately 12.5% of all ER visits are classified as non-emergent by the triage process. Passport Health Plan has also noted an increase in ER Utilization since 2000. Non-emergent use of the ER for primary care services plays a major role in the Plan's total ER Utilization. The ER Utilization Program is targeted at reducing the non-emergent use of the ER.

ACTION TAKEN: The Plan identifies members by the ER facility reports and through claims review. Those identified by the facilities are reviewed and categorized by chief complaint and discharge diagnosis. Those members seen in the ER for non-emergent care are contacted by the Plan's ER Coordinator. The ER Coordinator provides education regarding the appropriate use of the ER, plan benefits such as the 24-hr nurse line for medical advice, use of immediate care centers, and use of after-hours calling to their PCP. The ER Coordinator also evaluates for any barriers the member may have to receive care from the PCP, provides the member with the phone number of their PCP, and encourages follow-up. In addition, we mail targeted educational material for specific non-emergent chief complaints. The materials offer home care solutions such as who can treat colds and when to call the provider. A registered nurse is available to answer any questions or concerns the member may have. Members are also identified quarterly by claims data. Any member with a quarterly increase of 5 or more ER visits from the previous quarter and or 12 ER visits in a rolling quarter are referred to Case Management for outreach and care coordination. Members with asthma, diabetes, or a high-risk pregnancy are referred to specific disease management programs.

OUTCOMES: The Plan achieved a reduction in ER visits per 1000 member months from 70.65 per 1000 member months in 2005 to 65.56 per 1000 member months for 2006. This is a significant reduction in ER usage for non-emergent purposes.

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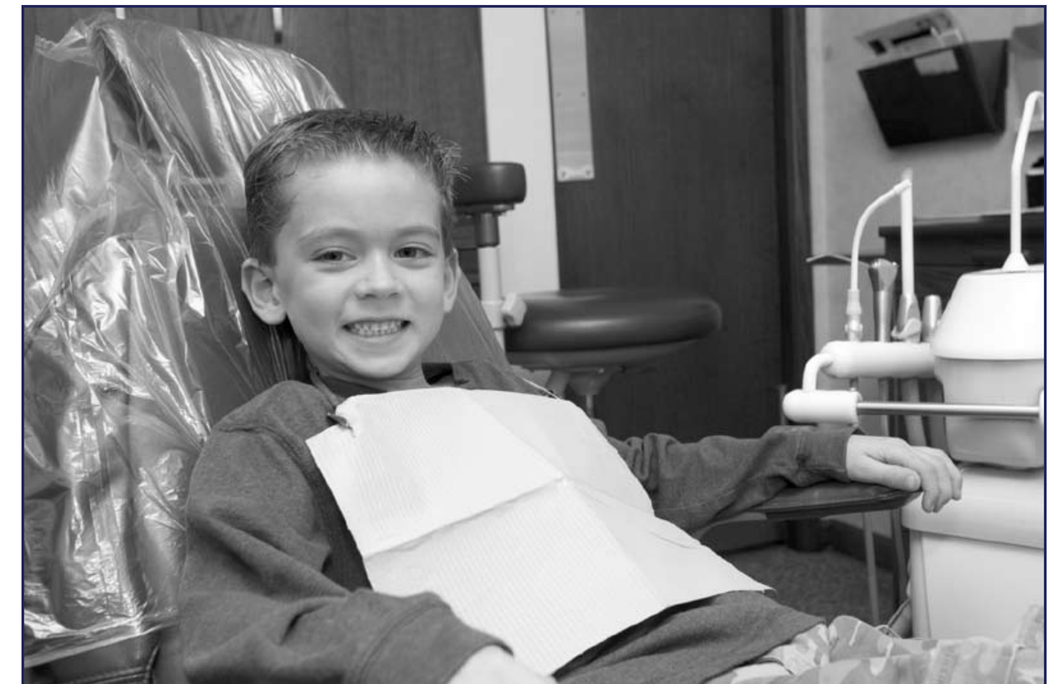
Horizon NJ Health

Head Start/Early Head Start Dental Initiative Program

DESCRIPTION: Early tooth decay is the most prevalent and preventable disease among US pre-school aged children. With limited access to care and caregivers not aware of the importance of early preventive oral health, children on Medicaid are most at risk. General dentists lack training for treating and managing children's oral health in offices and fewer pediatric dentists are available.
In addition, primary care physicians are not required to make dental referrals, until patients are three years old while caregivers seldom realize the importance of early, regular dental visits. The American Academy of Pediatric Dentistry recommends children visit a dentist when the first tooth erupts or before their first birthday.



ACTION TAKEN: A program covering oral health education, daily brushing, biannual oral evaluations, fluoride varnish applications and follow-up care was developed by a local dental champion. The Oral Health Pilot program was initiated among public preschools and Head Start facilities in the diverse community of Asbury Park, NJ. Working with the dental provider network, handling outreach to community health advisory committees of various Head Start programs all helped to encourage and advance more communities in adopting the program. Currently, the program is the focus of a collaborative effort with New Jersey's MCOs that provide Medicaid benefits and NJ's Medicaid Fee for Service (FFS) Dental program.

OUTCOMES:

- Oral health needs identified/treated earlier for children, previously without care treatment
- Head Start programs (at no cost) can meet and satisfy Federal dental screening requirements in a "stand-alone" program
- "Dental homes" to help children live healthier lives.
- Decreased dental and medical costs for children

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Select Health of South Carolina

Health Ministry Empowerment Tour

DESCRIPTION: Statistics show that minority women disproportionately suffer from chronic disease and other related illnesses. In addition, a significant number of minority women, especially those in rural communities, lack access to preventive health and other support services. In response to these issues, Select Health of South Carolina partnered with IMARA Woman magazine — a South Carolina-based lifestyle and personal growth publication for minority women — to create the Health Ministry Empowerment Tour.

ACTION TAKEN: The Empowerment Tour is a spin-off of the Keystone Mercy Health Ministry Program for Women. Held each year in three rural communities across South Carolina, the Empowerment Tour is designed to help minority women implement positive lifestyle changes. At each tour stop, experts offer workshops on a variety of topics ranging from health and nutrition to homeownership and money management. The tour also includes medical screenings and an inspirational keynote address. Past speakers include Rev. Bernice King -- daughter of the late Dr. Martin Luther King Jr., gospel recording Artist Ann Nesby and award-winning actress and motivational speaker Dr. Tonea Stewart.

OUTCOMES: Since its inception in 2003, the Health Ministry Empowerment Tour has provided health education and quality of life resources to nearly 3,000 South Carolina women.

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Great Lakes Health Plan

Healthy First Steps (HFS) Program

DESCRIPTION: For every 1,000 Michigan live births, approximately seven infants die before reaching their first birthday. In 2006, 940 infants under the age of one year died, resulting in an infant mortality rate of 7.4 per 1,000 live births.. The disparity between the black infant mortality rate and the rate for white infants continues. In 2006 the white infant mortality rate was 5.4 per 1,000 live births while the black rate was 14.8 per 1,000 live births. The Michigan infant mortality rate continues to be higher than the national rate. The 2005 provisional infant death rate for the United States is 6.8.

ACTION TAKEN: Great Lakes Health Plan (GLHP) designed a pregnancy care program called Healthy First Steps (HFS). HFS serves to optimize the health and well-being of members who are pregnant and their infants. The program is member-centric and facilitates collaboration between members and their healthcare team. HFS promotes self-care management, active decision making and participation in healthcare interventions and outcomes. Comprehensive care management and access is provided for antepartum, intrapartum, and postpartum newborns. The program is designed to follow and provide care management services from the physician's office and /or clinic and hospital to the member's home.

OUTCOMES:

- Improved partnerships leading to improved care management
- Positive relationships with practitioners and hospitals
- Positive relationships with community resources
- Improved member engagement in OB care

In 2007, HFS enrollee's infant mortality rate per thousand members was 0.8%.

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Health Parnters of Philadelphia, Inc.

“Healthy HEDIS Outcomes” Campaign

DESCRIPTION: Health Partners is a health plan that provides equal access to quality care to underserved residents in the Greater Philadelphia region. Our 140,000 members are less likely to seek proper medical care because of socio-economic disadvantages.

Our 2007 goal was to maximize our preventive care outreach, targeting conditions that most affect our members. Thirteen areas of concentration were identified using the Healthcare Effectiveness Data and Information Set (HEDIS). We kicked off our campaign with a focus on diabetes HBAlc and cholesterol because our members were most challenged in these areas, based on our 2006 HEDIS scores.

ACTION TAKEN: Internally, the campaign included the introduction of 13 HEDIS “Super Measures” (live size action figures representing target measures), which were used to educate and generate awareness of our HEDIS goals.

Externally, we held 18 screening events at community venues and two signature screening events: one for African-American members featuring singer Patti LaBelle; and the other for Latino members featuring singer Frankie Negron. In addition to the testing, members received diabetes education and management tips.

We used movie tickets as incentives to increase attendance. It was the first time that a Medicaid health plan was allowed to use incentives to improve outcomes.

OUTCOMES: Health Partners achieved a year-end increase of 11 percent over our HEDIS 2007 goal for HBAlc (blood sugar control). The HBAlc increase was almost 7 percent over our year-end 2006 total. The Diabetes LDL (good cholesterol control) measure increased almost 2.5 percent and 6.8 percent over our year-end 2006 total.

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Keystone Mercy Health Plan / Select Health of South Carolina, Inc. / AmeriHealth Mercy Health Plan / Pediatric Associates Health Plan (a program of the AmeriHealth Mercy Family of Companies)

Healthy Hoops® Program: Using Basketball to Help Children Better Manage Their Asthma

DESCRIPTION: Asthma is the most common chronic disease among children in America, according to the National Center for Health Statistics. In 2003, Keystone Mercy Health Plan, an AmeriHealth Mercy Family of Companies affiliate, noted a sharp increase in the number of pediatric members diagnosed with asthma, primarily in West Philadelphia. Corresponding to the increase in asthma diagnoses were increases in emergency room visits and hospitalizations.

ACTION TAKEN: To address this growing problem, Keystone Mercy created Healthy Hoops. Healthy Hoops is an innovative health education and management program that used basketball to teach children with asthma and their families how to manage their illness. This NCQA-recognized program uses a coalition of local health care providers and community organizations coupled with full physical screenings, individualized health action plans and targeted health education. The result is improved health outcomes for members and decreased utilization and costs for health plans.

OUTCOME: The following outcomes represent clinical measures as well as claims data for Philadelphia participants the year before and the year following Healthy Hoops:

- 1,110 Healthy Hoops participants
- 528 were Keystone Mercy members
- Decreased overall emergency room utilization - ↓6.4%
- Decreased overall inpatient utilization - ↓22.2%
- Less reliance on rescue albuterol (puffs/week) - ↓25%
- Fewer nocturnal awakenings due to asthma (awakenings per month) - ↓20%
- Increased fill/refill rates for controller medicines) ↑11.7%
- Improved beta-$_2$ agonist to inhaled corticosteroid ratio - Δ 1.5 in 2006 to 1.37 in 2007
- Improved lung function
  - FEV_1 ↑6.9% - 68% improved or maintained stable FEV_1 measurements
  - FVC ↑7.6% - 62% improved or maintained stable FEV_1 measurements

Qualitative results:

- 96.8% would recommend Healthy Hoops to others
- 96.8% found that Healthy Hoops helped them to manage their child’s asthma
- 90.3% reported the parents education class “beneficial”
- 88.2% are actively using the information they learned in Healthy Hoops to manage their child’s asthma now
- 86% noted that Healthy Hoops participation improved asthma management for another family member who was not a participant
- 83.9% of primary care providers found enhanced treatment adherence

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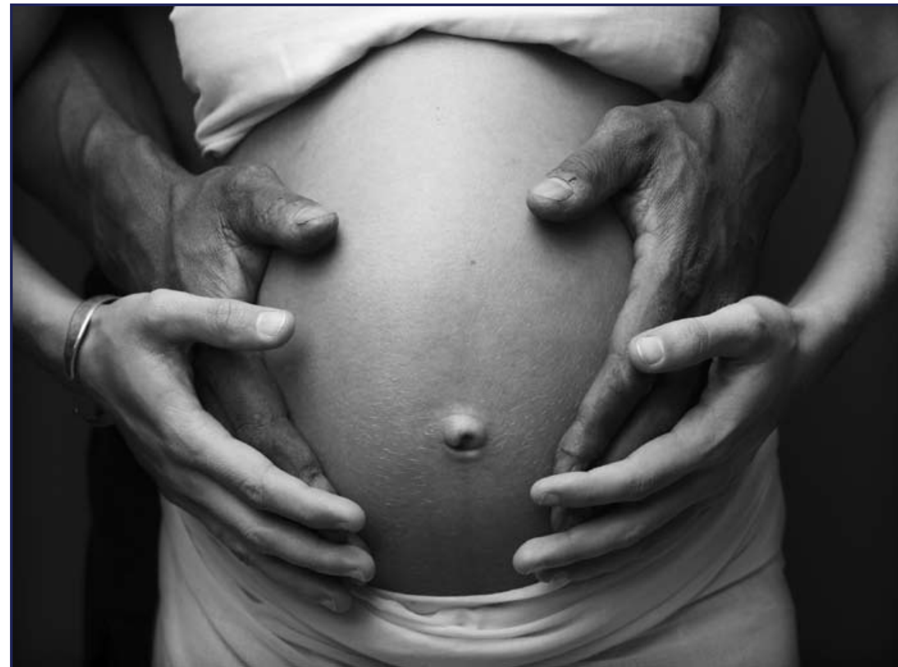
Select Health of South Carolina

Healthy Moms and Babies Prenatal Outreach Program

DESCRIPTION: As part of its prenatal care management program, Select Health's prenatal department works with physicians to monitor the health of pregnant women and classify them as either high- or low-risk based on the outcome of a health risk assessment, which is completed at the physician's office. Once identified, high-risk members are assigned a registered nurse while low-risk members are assigned an outreach specialist.



After reviewing some of the cases and observing that some low-risk members were in fact high risk, Select Health's prenatal department identified a need to develop an improved process of classifying high- and low- risk members.

ACTION TAKEN: The department decided that the prenatal nurses would personally assess all identified pregnant members. The nurses would be able to identify potential risk factors and provide case management for these newly-identified high-risk members. The earlier and more intensive intervention would result in more favorable pregnancy outcomes.

The prenatal team also arranged on-site provider visits to explain this enhanced program and to encourage consistent use of the Risk Assessment form.

OUTCOMES: Approximately 25 percent of all of Select Health's maternal deliveries are identified high-risk members. Over the last six months, the prenatal team has been able to increase identified high-risk members by 13 percent overall.

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AmeriHealth Mercy Health Plan

"Healthy You, Healthy Me" Childhood Obesity Program

DESCRIPTION: Today's children and youth are the most overweight generation in the history of the United States. According to the National Center for Health Statistics, the prevalence of overweight in children and youth has more than tripled over the last 35 years. In addition to the increase in type II diabetes in children, which was formerly only seen in adults, overweight children also have increased the rates of diagnosed hypertension, asthma, and sleep apnea. (NIHCM, 2003) Factors contributing to this epidemic include improper nutrition, physical inactivity, genetics, and lifestyle.

ACTION TAKEN: In an effort to combat this epidemic, AmeriHealth Mercy Health Plan partnered with the Neighborhood Center in Harrisburg, Pa. to create our "Healthy You, Healthy Me" Childhood Obesity Program. The program uses the CATCH (Coordinated Approach To Child Health) Kids Curriculum, which was developed with funding from the National Institutes of Health (NIH) to help youth, their parents and caregivers in both home and community settings to meet the overall goal of preventing obesity. This curriculum provides activities and programs that encourage improved nutritional choices and increased physical activity in youth ages 7 to 13.

OUTCOMES: Self-inventories were given to participants to assess how they felt about the importance of nutrition and activity. In addition, pre- and post-BMI screenings were completed by AmeriHealth Mercy Health Plan's medical staff. As a result of the program:

- 50 percent of the participants decreased their BMI in 2006.
- 74 percent of the participants decreased their BMI in 2007.

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AmeriChoice of New York by United HealthCare

Innovative Chronic Care Management Model for High Risk Medicaid

DESCRIPTION: In 2007, AmeriChoice of NY Medicaid Health Plan moved to a unique chronic care management model to identify and provide the highest risk, Medicaid population with targeted comprehensive care management services. Using a claims-based risk stratification process, provided by AmeriChoice, Care management was provided by an integrated model incorporating telephonic Care Managers and Field Based Local Care Managers. Outcomes and lessons learned will be discussed.

ACTION TAKEN: In 2007, AmeriChoice of NY Medicaid Health Plan moved to a unique chronic care management model to identify and provide the highest risk, Medicaid population with targeted comprehensive care management services. Using a claims-based risk stratification process, provided by AmeriChoice, Care management was provided by an integrated model incorporating Telephonic Care Managers and Field Based Local Care Managers.

OUTCOMES:

- Expertise with claims-based risk stratification software to design targeted chronic care management interventions;
- Understanding of the added value of doing comprehensive assessments to develop realistic CCM plans to engage and promote self-management;
- Understanding and appreciation for the challenges of measuring outcomes for clients in a brief intervention.

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Horizon NJ Health

Lead Screening and Case Management Program

DESCRIPTION: New Jersey's rate of lead poisoning is above the national average and one of the highest in the Northeast. Often, lead poisoning is not obvious, might go unnoticed, but can cause learning and behavioral problems and, at high levels: seizures, coma and death.

According to the Centers for Disease Control and Prevention about 434,000 children ages 1 to 5 have blood levels greater than the recommended blood levels. Children under six are at risk, because they develop rapidly. Social and economic factors can affect lead poisoning, since children at or below the poverty levels live in older housing and are at the greatest risk.

Lead poisoning is preventable, yet preventive care is not a priority of the population served.

ACTION TAKEN: To ensure that children from 9 months to age six years have at least one blood level taken and to improve the compliance rate to, at least, 80%.

From 2001 through 2007, significant lead screening rates improved, attributed to Horizon NJ Health's rigorous educational and awareness campaign for members and physicians, including the improved data sharing between the company and the State of New Jersey through the Medicaid State Lead Database.

- Highly successful outreach calls
- Quarterly reminder letters with informational materials to physicians and members
- Extended education/encouraged use for filter paper (Medtox) lead testing method to improve screening rates –convenient in doctor's office.

OUTCOMES:

Blood Lead Screening Analysis Table

Key Indicator	2001	2002	2003	2004	2005	2006	2007
	30.00%	52.00%	64.00%	74.00%	84.00%	86.00%	83.00%

Blood Lead Screening Rates Age 1-6 years old

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Horizon NJ Health

Medicaid HMO Improving Pharmaceutical Diabetes Management through Drug Utilization Review (DUR) and Pharmacy Case Management (PCM)

DESCRIPTION:

- Horizon NJ Health has a comprehensive retrospective DUR program that systematically collects and analyzes data on drug utilization.
- Retrospective review identifies members, including those with diabetes and micro or macroalbuminaria, who do not fill appropriate medications, such as Angiotensin Converting Enzyme Inhibitors (ACEIs) or Angiotensin Receptor Blockers (ARBs) in accordance with national guidelines
- Microalbuminuria is a marker for increased risk for nephropathy and for cardiovascular disease.
- For members not initiated as a direct result of the DUR; additional outreach is conducted through the PCM program to improve the quality of care for Horizon NJ Health members

ACTION TAKEN:

- August 2006:
  - Targeted letters sent to PCPs and eligible members with micro-or macroalbuminuria who did not have an ACEI or ARB filled from September 2005 to June 2006
  - 19.8% of the members had an ACEI or ARB filled subsequent to mailing
- September 2007
  - Targeted members that still had not filled an ACEI or ARB as a result of the intervention
- These members were subsequently enrolled in the Pharmacy Case Management program for potential initiation of therapy
  - Prescribing PCPs were targeted for telephone/facsimile contact regarding therapy initiation
- February 2008
  - Total initiation of appropriate ACEI or ARB therapy increased to 33.07%.

OUTCOMES: In September 2007, one year after the original PCP mailing, the follow-up (post intervention) phase was evaluated

- Increase in eligible members' initiation of ACEI or ARB drug therapy from 19.8% to 33.07% Post Intervention
- Outcome measure: total initiation of ACEI or ARB therapy through documented prescription fills

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MDwise

Member Advocate Program / HELPlink

DESCRIPTION: The Medicaid members that we serve, struggle with a variety of psycho-social issues, on a day-to-day basis. This leaves health care low on the list of priorities for many families who may struggle, for example, to put food on their table. To address this problem, , MDwise developed a Member Advocate unit of social work trained and licensed staff to educate and intervene with members to identify and alleviate barriers to getting health care. Interventions are primarily done telephonically.

ACTION TAKEN: In 2003, MDwise initiated its HELPlink program in which Member Advocates assist members with issues such as missed medical appointments, accessing services, and appropriate use of the hospital emergency room. Member advocates also provide information to members on how to work with their caseworker and secure community resources such as utility assistance, support groups, or child care. MDwise members are encouraged to call MDwise customer service and request to speak to a member advocate if they need help. Providers can request these services for their MDwise patients by completing a Member Intervention or Education Request form.

OUTCOMES: Since 2003, the demand for HELPlink services has grown and MDwise Member Advocate staff has increased from 2 to 4. MDwise developed a database that captures common issues and actions that HELPlink interventions entail. Intervention requests have grown from 665 in 2005 to 4,615 in 2007 (in 2007 MDwise doubled its membership). MDwise Member Advocates are able to contact 53% of members referred.

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Great Lakes Health Plan

Member Empowerment in Self Care

DESCRIPTION: Great Lakes Health Plan (GLHP) identified a high readmission rate in the high risk, high cost population. In Qtr 4 2006, a key tactic employed was to engage these members to play an active role in their healthcare self management. We believe if members understand the importance of compliance with their medical treatment plan developed by their primary care physician (PCP), it will yield a reduction in both impatient admissions and emergency room visits and improve the quality of their lives.

ACTION TAKEN: GLHP developed a member compliance contract to educate and empower members to be responsible and accountable for self-care. The contract is editable/individualized based on the specific needs/issues of the member.

Each high risk member is assigned to a personal care manager (PCM). The PCM uses the contract as a teaching tool to empower members in self care management.the PCM reviews the contract and educates the members on expectations and accountabilities. The member is asked to sign the contract if he/she understands it and is in agreement. A signed copy is given to the member and the PCP.

OUTCOMES: While the member compliance contract is a new intervention, in 2007 GLHP experienced a slight reduction in the 30 day readmission rate and 5% reduction in the ER rate for the high risk member cohort. We expect to see further reduction in these measures in 2008

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Passport Health Plan

Mommy & Me Program

DESCRIPTION: The March of Dimes PeriStats 2004 report ranks Kentucky in the top ten states for preterm deliveries. Between 1994 and 2004, the rate of preterm deliveries increased nearly 14% in the United States. In 2004, there were approximately 508,000 preterm deliveries in the United States or 12.5%. Low Birthweight (LBW) births accounted for 9.3% of PHP live births in 2007. Very Low Birthweight (VLBW) births accounted for 1.7% of PHP live births in 2007.

ACTION TAKEN: The Plan identifies pregnant members through provider referrals, member self-referrals, and referrals from local health departments. The Plan mails educational material to emphasize the importance of early prenatal care, introduce the Mommy & Me program, and tells members how to reach a program representative. Members also receive a comprehensive, easy-to-read guidebook, entitled *Mommy & Me Basics: A Guide to a Healthy Pregnancy, Delivery and Baby Care*. Upon referral, staff contacts members by phone to identify high-risk factors that could lead to pregnancy complications or poor birth outcomes. The staff refers the members to community agencies that can assist them during their pregnancy such as WIC, transportation, infant resources, financial assistance and housing. The *Mommy & Me* staff continue to follow-up with the member through the postpartum period. In addition, the staff is notified if a member has missed an appointment for prenatal care and works with the member to address reasons for missed appointments and assists with future appointments to ensure they receive the recommended care.

OUTCOMES: In 2006, 89.24% of our pregnant women received their first prenatal visit in the first trimester or within 42 days of enrollment as compared to 85.27% in 2000. In 1999, 68.51% of the Plan's female members received 81% of the recommended number of prenatal visits as compared to 82.74% in 2006. In 1999, 57.94% of female members received postpartum visits between 21 and 56 days after delivery as compared to 74.44% in 2006.

In addition, all plan rates remain above targeted Healthy Kentuckians 2010 goals of 7.6% preterm deliveries, 5% LBW, and 1.4% VLBW.

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MDwise

"Move It!" In-School Program Fighting Childhood Obesity Disease

DESCRIPTION: Currently, overall obesity rates in Indiana are around 25% with childhood overweight in Indiana estimated to be around 20-40%. In both cases the numbers seem to be increasing. The medical problems associated with this overweight state are likewise increasing. These include diabetes, high blood pressure and heart disease. (Indiana State Department of Health)

ACTIONS TAKEN: MDwise teamed up with Radio Disney Indianapolis WRDZ 98.3 FM to present Move-It!, a youth fitness program that encourages an active lifestyle for kids. Move It! is a national initiative and Radio Disney's response to an epidemic effecting kids of all ages . . . Childhood Obesity.

Radio Disney showcased the importance of staying active through the theme "Get Off Your Seat and On Your Feet"! Each tour stop was a high energy, interactive show featuring music and prizes all while highlighting the benefits of exercise. Children enjoyed Ms. Bluebelle, the MDwise mascot, performing the Cha Cha Slide.

OUTCOME: We were able to reach over 8,240 students with our "Get Off Your Seat and On Your Feet" message during the first year.

Over 50% of the students that participated in Move-It! during the 2007-2008 school year were on a free/reduced lunch program at their school – 4240 Total!

Each child received a goodie bag which included a letter from MDwise to parents about the importance of healthy eating and exercise, a Ms. Bluebelle card with the MDwise toll free number for a health message, and stress balls.

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United Healthcare, Inc. / AmeriChoice

Multi-Disciplinary Rounds

DESCRIPTION: Inpatient cases were being handled individually and reviews with medical directors were handled one on one. Case managers and utilization review professionals were performing functions independently of each other. Team collaboration was absent and missed opportunities existed. A holistic approach to member care and coordination was absent.

ACTION TAKEN: Daily case reviews were indicated with the entire healthcare team at the plan. In addition to case managers and utilization review staff, we engaged our vendor for behavioral health services as part of the daily case review team. The purpose of these rounds is to serve as a mechanism to keep the team focused on our most vulnerable subset of members. All disciplines participate to provide input and issue resolution to members needs. The entire spectrum of healthcare delivery is addressed and applied to each unique individual. Every hospitalized member is reviewed every day they are inpatient.

OUTCOMES: This process has brought the previous segmented disciplines together as a unified approach to achieving maximum outcomes for our members. This standardized, multi-disciplinary approach ensures that all inpatient members are thoroughly reviewed and afforded care throughout the continuum including behavioral, medical and social.

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Select Health of South Carolina

New Member Orientations

DESCRIPTION: As part of its commitment to providing quality services to its members, Select Health's Member Services Department conducts outreach to all new members in an effort to educate them about the health plan, confirm member contact information and receipt of member material and to assign a primary care provider.

Prior to 2006, successful outreach rates were only 49 percent. Many members were unwilling to participate in the orientation or were unreachable due to outdated address or telephone information.
In addition, Select Health experienced an increase in auto-assigned members who had limited knowledge of how the health plan worked.

ACTION TAKEN: In an effort to educate auto-assigned members about the health plan and to increase the number of successful new member orientations, Select Health's Member Services Department initiated a multi-faceted program designed to improve the new member orientation rate.
Components of the program included:

- Providing a monthly $10 personal care allowance to members who completed new member orientation
- Stagger staffing on weekdays and weekends in an effort to contact members during non-work hours
- Distribute "We tried to contact you" postcards after unsuccessful phone attempt

We help people get care, stay healthy and build healthy communities.

- Research past claims history for updated contact information

OUTCOMES: In 2005, the success rate often ranged from 39 percent to 44 percent. Following implementation in 2006, the success rate increased to 60 percent. In 2007, the rate was further improved upon to 63 percent.

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Horizon NJ Health

NJ Division of Youth and Family Services (NJ DYFS) Foster-Care Care Management Program

DESCRIPTION:
Children in the NJ DYFS Foster-Care/Adoptive/Kinship Legal Guardianship programs:

- Receive Medicaid from New Jersey State through the age of 18.
- Are required to enroll into a managed health care plan.

Horizon NJ Health currently has 6,118 such members.
By definition, these members have special needs that require:

- Intensive care management, attention and ongoing services
- Coordination of medical and psychological services for many
- Direct linkages to community resources

Social Workers in this Horizon NJ Health program are required to provide aggressive outreach to the resource families (formerly foster parents) and assist in coordinating necessary services.

ACTION TAKEN:

- Initiated dynamic outreach and research using various Horizon NJ Health and NJ databases and registries.
- Developed sophisticated computer systems and workflows to ensure that no DYFS member "falls through the cracks" with the goal: preventative health.
- Complex Needs Assessments and individualized care plans created for these members which included input from involved parties.
- Changes in the level of care are reviewed and determined by an interdisciplinary team.

OUTCOMES:

- There are currently 73% of Horizon NJ Health DYFS members in active care management versus 67% at the inception of the program.
- Since the program began, the State of New Jersey has audited Horizon NJ Health and scores have consistently improved from a corrective action plan status to the most recent score of 88 out of 100 in March 2008.
- Proactive and coordinated care management of medical, psychological and other support services are active and continue.

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Great Lakes Health Care

One Call Resolution

DESCRIPTION: One Call Resolution is the single most important key challenge to improving member satisfaction with GLHP's Customer Service. In 2005, unsettled by member dissatisfaction, GLHP embraced the need to take drastic steps to improve service to our members.

GLHP identified that the incoming call volume of the Customer Service Department was high compared to industry averages. GLHP attributed the high volume to return phone calls from members whose inquiries, questions or concerns were not fully addressed in initial phone calls necessitating follow-up calls to seek resolution. Member feedback highlighted the degree of member frustration associated with incomplete responses.

ACTION TAKEN: GLHP:

- Staggered staff work hours to ensure more work schedule flexibility for staff and to ensure optimal call center staffing during peak call hours thus decreasing the Representatives' sense of urgency to end calls to respond to the next caller.
- Retrained existing staff.
- Hired and trained experienced Call Center Staff
- Revised procedures to create more structured, methodical approaches to problem solving

One Call Resolution measures the successful resolution of the customer's inquiry on the first contact made by the caller, eliminating the need for the customer to call back on the same issue.

OUTCOMES: Since implementing One Call Resolution in 2006, GLHP's member satisfaction with customer service improved 20 percentage points resulting in statistically significant improvement, also GLHP was rated #1 among Michigan Medicaid plans for customer service in 2007.

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MDwise

Partnership Councils

DESCRIPTION: The Partnership Council concept emerged out of a shared belief that certain health outcome improvements can best be achieved through collaboration among health plans, providers and other key stakeholders. MDwise has a rich history of collaboration with the provider community, by virtue of its provider sponsorship and direction. Key providers from mental health community, local MDwise delivery systems, and Federally Qualified Health Centers (FQHC) are just a few of the Partnership Council participants that come together in targeted areas of the State of Indiana.

ACTION TAKEN: In 2007, MDwise held its first Regional Partnership Councils meetings in Terre Haute and Fort Wayne Indiana. MDwise was able to obtain a greater perspective of regional needs and priorities, creating the opportunity for flexibility and creativity in pursuing solutions to local health problems and sustaining long-term improvement. Council Meetings were expanded to other regions in 2008. (podcasts, website, and "NICU packet")

OUTCOMES: MDwise Regional Partnership Councils are one of several vehicles allowing local providers, members and community based organizations in all regions of the state to have a voice in MDwise programs and initiatives.

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Health Partners of Philadelphia, Inc.

A PEP Race to Victory

DESCRIPTION: Health Partners members with chronic diseases like hypertension and diabetes are supposed to visit their primary care physician (PCP) at least twice a year. Through Health Partners PEP (Patient Evaluation Program) outreach, members with chronic diseases are identified and biannual appointments are scheduled for them.

In 2007, Health Partners encountered challenges and this compromised Health Partners' ability to track PEP outreach efforts. This made it difficult to identify members who had been seen by their PCP and those who were still in need of PEP outreach.

ACTION TAKEN: Bill George, president & CEO, declared November as PEP Month to motivate employees to get on board with our PEP outreach efforts and established a work group to devise a specific plan of action.

Health Partners took a critical look at our high medical needs members to determine who had received their biannual visit and who had not. Then, we went into damage control mode:

- Our Health Outcomes department provided PEP awareness and education to our primary care physicians and large group specialists.
- Our Operations and Health Care Economics departments created lists and printed claims forms for members whose PCPs had not been properly credited or paid for PEP services.
- Our Document Control department organized the huge volume of printed claims by provider locations and handled the imaging of all of the returned forms on a priority basis.
- Our Physician Field Operations department personally visited 374 physician offices to deliver and retrieve the claim forms used to verify the PEP visits.
- Our Claims and Finance departments worked nights and weekends to process the claims in a timely fashion and create special checks so that providers could recognize and track payments.

OUTCOMES: Our increased efforts to achieve our 2007 PEP outreach goals led to several mutually beneficial and positive outcomes for Health Partners members, providers and employees. First, by examining our list of high medical needs members more closely we were able to verify the number of members who were still in need of PEP outreach and ensure that these members received the care that they needed to maintain their health. We also identified approximately 20,000 members whose PEP encounters

had not been previously counted. Second, by explaining the PEP outreach program to our providers and group specialists, we were able to increase support for the program, thereby increasing cooperation from physicians and improving health outcomes for our members. Third, we were able to ensure that our providers received proper payment for services rendered to our high medical needs members. Fourth, Health Partners staff exceeded its corporate goals for PEP encounters in 2007, thus fulfilling its mission to continually improve the health outcomes of our members.

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Select Health of South Carolina

Provider Relations Process Improvement

DESCRIPTION: The plan's quality initiative to promote provider satisfaction with services provided by claims.

- Electronic claim/encounter submissions (EDI), increasing the number of claims submitted electronically; best practice goal of 65 percent.
- Rework rate, decreasing the overall amount of claims requiring reprocessing after the initial claim adjudication; best practice goal of 3.35 percent.
- Auto-Adjudication rate, increase the number of claims that were accurately adjudicated without human intervention; best practice goal of 70.9 percent.

Increased efficiency in these areas would improve payment accuracy and timeliness, having a positive affect on provider satisfaction. Improvements in the timeliness of encounter information would allow for earlier identification of at-risk members for enrollment into Case and Disease Management.

ACTION TAKEN: Successful programs that were implemented included:

- Hired Claims Analyst to review claims, promote EDI and conduct large-scale training within the provider community
- Targeted high volume providers for transition from paper to electronic claims submission
- Implemented online Remittance Advice
- Created and distributed Prior-Authorization Grid for providers outlining services requiring prior authorization
- Created and distributed specific EDI claim submission section within the new provider billing instruction manual
- Configured and implemented Clinical Editing logic to claims system
- Implementation of Preferred/Acceptable/Discouraged/Unacceptable/Team-Based Installation (PADU/TBI) to improve provider setups and agreement alignment within the claims system

OUTCOMES: For two consecutive years (2005 & 2006), all three key indicators trended positively resulting in significant improvements over the original baseline statistics calculated from 2004 operations. Electronic data interchange (EDI) rates improved by almost 28 percent; rework rate decreased by over 3%; auto-adjudication increased by 13 percent.

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Great Lakes Health Care

Raising Awareness: COPD is a Killer Disease

DESCRIPTION: COPD (chronic obstructive pulmonary disease) is the fourth leading cause of death in the U.S. The disease affects one in four Americans over the age of 45. Nationally, more than 12 million people have COPD and another 12 million may have it, but are undiagnosed.

Breathing problems associated with COPD are the top causes for respiratory admissions and readmissions of GLHP members. Historically, what is now called COPD was most often seen as a disease of older men. Today, men and women suffer from the disease equally at a younger age.

ACTION TAKEN: In 2007, GLHP launched a campaign as part of its COPD Disease Management Program designed to improve awareness among its primary care doctors (PCPs) to improve early diagnosis of the disease and degree of severity for purposes of timely and appropriate treatment to prolong life. PCP education focused on:

- COPD clinical practice guidelines
- Spirometry as the standard for diagnosing COPD
- Outpatient management of COPD
- Differential diagnosis of COPD versus asthma
- Inpatient management of COPD

Concurrently, GLHP launched a member awareness campaign on:

- Importance of spirometry testing
- Recognizing symptoms of COPD
- Smoking cessation

OUTCOMES: Prior to implementation of the campaign in 2007, only about 1/3 of members with COPD had appropriate testing for disease diagnosis and severity. Year to date in 2008, this rate is almost at 50%. In comparison, the 2007 National Medicaid 90th percentile for spirometry testing was 39%.

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Keystone Mercy Health Plan

Safe Playground Program

DESCRIPTION: According to Safe Kids Worldwide, preventable injuries are the leading cause of death for children under the age of 14 in the U.S., with more than 14 million children sustaining preventable injuries that require medical attention each year. Among Keystone Mercy members, such injuries are one of the leading causes of ER visits for children. In addition, play is especially important to the physical development and health of children, especially in preventing obesity. It is also vital to mental and social development. Physical activity has also been shown to increase academic performance, reduce youth violence, and contribute to breaking the cycle of poverty.

ACTION TAKEN: GAs part of the organization's "Power to Change a Child's World" program, Keystone Mercy Health Plan started the Safe Playground Program in 2007 to help decrease the number of children sustaining preventable injuries because of a lack of safe play spaces and after school activities. Keystone Mercy sought out schools that did not have safe play sites, and were located in areas where a high percentage of the student body came from underserved families at or below the poverty line.

OUTCOMES: Since 2007, Keystone Mercy has built three new playgrounds at elementary schools in Philadelphia, Delaware and Montgomery counties, contributing to the safety and healthy development of more than 1,400 children. Keystone Mercy's leadership team and associates, along with community members, built the playground structures from the ground up, painted murals, and cleaned the surrounding areas – all in one day at each location.

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Passport Health Plan

Somali Women's Empowerment Group

DESCRIPTION: Every community in the United States is adjusting to an influx of refugees and immigrants who have or will access both public and private health care services. Participating providers alerted the Plan to difficulties they were experiencing with pregnant Somali members and their cultural beliefs that relate to pregnancy and delivery. Somali beliefs differ dramatically from the Western approach, and in many cases put the member and baby at risk of poor birth and health outcomes.

ACTION TAKEN: The Plan worked with community advocates to convene the Somali Women's Empowerment Group to educate the women about Western perinatal practices and to become health navigators within their community. When the women were asked what they hoped to gain from this experience, they replied with "I want to learn English." In response to their answer, we introduce them to the Plan's education booklet, entitled *Mommy & Me Basics: A Guide to a Healthy Pregnancy, Delivery and Baby Care*. The booklet gave us an opportunity to initiate dialogue about perinatal care. We began by reading *Mommy & Me Basics* to them. At that time we discovered that most of the women could not read. We took this opportunity to explore different avenues of education to assist the women in learning English. We had *Mommy & Me Basics* created in audio format in English and Somali. The women now have two sets of information, the audio version and hard copy of the book in both languages. As we reviewed the book each week, the women followed along in the format they felt most comfortable using. This was an excellent opportunity to have a one-on-one conversation focusing on perinatal care and other health issues that affect the women directly.

OUTCOMES: Since the program's inception, the Plan has seen an improvement in member satisfaction, utilization of benefits, and literacy skills. Specifically, we've seen a significant improvement in deliveries. For example, Somali women did not previously understand why they could not eat prior to delivery. Their cultural belief was one that if you eat a good meal you will have strength for delivery. As a result of this belief, Somali women would postpone their trip to the hospital until the very last moment which is a very unsafe practice. Through the empowerment group, the women were educated on why Western medicine does not advise women to eat prior to delivery. The women now understand the practice and reasoning. Most importantly, the women have taken this message back to their communities for improved overall birth outcomes.

As a result of this project, the Plan is creating a basic health navigator program for the newly resettled refugees. Additionally, the program has alerted the Plan to the literacy and health struggles these refugees face and our need to act and accommodate.

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Passport Health Plan

Tiny Tot Transition Program

DESCRIPTION: To promote a smooth transition to home for newborns with serious health conditions and to reduce the risk of re-hospitalization, the Plan established the Tiny Tot Transition Program for Medicaid members in 2001. A key part of the program is educating new mothers about infant care and the importance of creating a healthy home environment.

All newborns that remain in the hospital beyond their mothers' stay are followed by Tiny Tot program nurses. Tiny Tot program nurses work to promote communication among the neonatologist, pediatrician, neonatal intensive care unit nurse, and other members of the infant's health care team. Program nurses are responsible for assisting with discharge planning and working with the family for at least 30 days following discharge.

OUTCOME: Approximately 6,500 members have been served through this program. In 2007, the program served 1,184 neonates with an average length of stay of 17.4 days which was a 1% decrease last year. 98% of detained neonates had a primary care provider visit within 30 days of discharge. The rate of re-admission within 30 days of discharge was 9% which was down from 10% in 2001..

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Keystone Mercy Health Plan / AmeriHealth Mercy Health Plan

WeeCare Maternity Program

DESCRIPTION: The WeeCare program targets women with high-risk pregnancies and helps ensure that both the mother and baby receive the care they need for a healthy pregnancy and delivery. A high-risk pregnancy is one in which the mother:

- Is less than 18 years old.
- Has prior pregnancy issues including pre-term labor, spontaneous bleeding, uterine irritability, or pre-eclampsia/eclampsia.
- Has current pregnancy issues including multiple gestation, bacterial vaginosis, or sexually transmitted disease.
- Has a medical history of diabetes, hypertension, cardiac disease, asthma, or HIV/AIDS.
- Is involved in alcohol use, recreational drug use, or tobacco use.
- Is referred from an obstetrical practitioner for other reason.

ACTION TAKEN: GPregnant members who are at high risk for preterm labor and/or other pregnancy complications receive written educational materials and are assigned a nurse care manager. All high-risk members receive a comprehensive health assessment. Following the health assessment, the nurse care manager develops an individualized plan of care for the member, with input from the member and her obstetrician.

Nurse care managers perform a number of important duties including:

- Contacting high-risk members by telephone to remind them of upcoming prenatal and other medical appointments and making follow-up calls to confirm that appointments were kept.
- Addressing a member's social needs such as coordinating transportation services as needed, making referrals to community and behavioral health resources, and coordinating interpretation and translation services as necessary.
- Working with pregnant members to select a pediatrician and schedule the first newborn appointment, and talking to members about the EPSDT program and the importance of regular well-baby visits and immunizations. Our care managers help moms-to-be to find resources to care for their newborn, such as infant clothing, diapers, or even a safe place to live.
- Following members through the postpartum period to help coordinate any special medical needs for the mom or baby and to encourage postpartum and pediatric visits. The care manager also administer a postpartum depression survey for all high-risk members and refer them as needed to the appropriate resources.

OUTCOMES: In a review of neonatal intensive care unit (NICU) admissions versus overall admissions numbers between November 2007 and February 2008 (as compared to the same time period last year), there has been a steady decrease in NICU usage.

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Passport Health Plan

YES, You Can! Stop Smoking Program

DESCRIPTION: The CDC notes, "Cigarette smoking remains the leading preventable cause of death in the United States accounting for approximately 1 of every 5 deaths (438,000 people) each year." Currently, the CDC estimates that 20.9% of adults smoke cigarettes in the United States. It has been estimated that along with the significant health toll, the economic burden is more than $75 billion a year in medical expenses with another $92 billion per year in lost productivity. Currently, the state of Kentucky has one of the highest rate of smokers at 28.7%. Each year more than 8,000 Kentuckians will die of illnesses caused by tobacco use.

ACTION TAKEN: Passport Health Plan implemented a smoking cessation pilot program for 200 members. The Plan took a pharmacological and behavioral modification support approach. In the program, each member is assigned a care manager who contacts them weekly during the initial 12 weeks and then at 6, 9, and 12 months. We collaborate with community support resources and web-based support services to offer as much support to the member as possible. We developed a series of educational materials to assist members with any issues they experience. Some examples include nicotine withdraw triggers, deep breathing, exercise, and diversion techniques. We also provide the practitioner with a progress report every 4 weeks during the initial 12 weeks.

OUTCOMES: In 2007, we enrolled 229 members and had 100 verbalize being smoke-free at 12 weeks and stayed smoke free at the 6 month timeframe. This is a 43.6% quit rate. Most members utilized an oral stop smoking medication and a small number utilized a nicotine replacement patch. Due to the success rate, the Plan has decided to make the program a permanent program offered to members.

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Keystone Mercy Health Plan

Young Publishers Program – The Power to Change a Child's World

DESCRIPTION: A major health care issue for our nation is obesity and poor eating habits. Over the past 30 years, the childhood obesity rate has more than doubled for pre-school-aged children and adolescents ages 12 to19. The rate has more than tripled for children ages 6 to 11 year. More than nine million children over the age six are considered obese. Of course, obesity is only part of the health crisis we face as a nation due to unhealthy eating practices. In addition, health literacy, which is a patient's ability to read, understand and act on health information, is a health issue impacting nearly 90 million people in the United States.

ACTION TAKEN: The Keystone Mercy Young Publishers Program helps students gain important knowledge about health matters while enhancing their literacy skills. Each class of students and teachers forms a virtual publishing company in which they write a story book about their health care workshop, and experience the rewards of publishing first hand. The initiative consists of 10 one-hour workshop sessions over the course of about eight weeks during which students are presented with health information by a nutritionist and writing instructions by a writing coach. This information is used as the foundation for the healthy lifestyle lessons they will share through their fictional stories. After the book is printed, the children present it at a book signing called the Authors' Tea.

OUTCOMES:

- Thirty fourth-grade students at Saint Francis DeSalles School participated in the Young Authors Program and published *Granola vs. Candy Land*, a book describing the importance of health and nutrition.
- Eighteen Village Charter School students from the sixth, seventh and eighth grades participated in the Young Publishers Program and published *Tucadeluca's Big Asthma Attack*, a book which describes the importance of asthma management.

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Part II: Managed Care Industry Statistical Data

The following pages offer the most current statistical data released from the Centers of Medicare & Medicaid Services (CMS) on June 30, 2007.

CMS Statistics

Managed Care Trends

As of June 30, 2007

YEAR	TOTAL MEDICAID POPULATION	MANAGED CARE POPULATION	OTHER POPULATION	% MANAGED CARE ENROLLMENT
2007	45,962,271	29,463,098	16,499,173	64.10%
2006	45,652,642	29,830,406	15,822,236	65.34%
2005	45,392,325	28,575,585	16,816,740	62.95%
2004	44,355,955	26,913,570	17,442,385	60.68%
2003	42,740,719	25,262,873	17,477,846	59.11%
2002	40,147,539	23,117,668	17,029,871	57.58%
2001	36,562,567	20,773,813	15,788,754	56.82%
2000	33,690,364	18,786,137	14,904,227	55.76%
1999	31,940,188	17,756,603	14,183,585	55.59%
1998	30,896,635	16,573,996	14,322,639	53.64%

These figures represent point-in-time enrollment as of June 30th for each reporting year.

The **unduplicated** managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits. This table also provides **unduplicated** national figures for the Total Medicaid population and Other population. The statistics also include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

Medicaid Managed Care Enrollment - *As of June 30, 2007*

ROW NO.	NAME OF STATE	MEDICAID ENROLLMENT	MANAGED CARE ENROLLMENT	PERCENT IN MANAGED CARE
1	Alabama	724,424	471,824	65.13%
2	Alaska	96,146	0	0.00%
3	Arizona	989,519	890,046	89.95%
4	Arkansas	625,866	511,272	81.69%
5	California	6,465,346	3,286,293	50.83%
6	Colorado	381,113	358,636	94.10%
7	Connecticut	405,360	298,914	73.74%
8	Delaware	143,883	96,296	66.93%
9	Dist. of Columbia	142,482	92,229	64.73%
10	Florida	2,194,986	1,355,169	61.74%
11	Georgia	1,502,464	965,043	64.23%
12	Hawaii	202,126	161,447	79.87%
13	Idaho	179,734	152,424	84.81%
14	Illinois	2,003,200	568,000	28.35%
15	Indiana	825,820	599,636	72.61%
16	Iowa	366,049	283,204	77.37%
17	Kansas	272,090	139,025	51.10%
18	Kentucky	713,961	448,113	62.76%
19	Louisiana	934,899	636,429	68.07%
20	Maine	254,479	171,554	67.41%
21	Maryland	692,773	501,822	72.44%
22	Massachusetts	1,081,823	641,665	59.31%
23	Michigan	1,520,378	1,343,333	88.36%
24	Minnesota	594,270	367,473	61.84%
25	Mississippi	548,385	0	0.00%
26	Missouri	822,685	344,991	41.93%
27	Montana	80,002	44,598	55.75%
28	Nebraska	209,722	170,377	81.24%
29	Nevada	170,152	144,354	84.84%
30	New Hampshire	108,953	84,165	77.25%
31	New Jersey	878,125	619,566	70.56%
32	New Mexico	414,101	256,425	61.92%
33	New York	4,120,044	2,558,666	62.10%
34	North Carolina	1,317,033	847,718	64.37%
35	North Dakota	52,418	29,339	55.97%
36	Ohio	1,719,016	1,194,349	69.48%
37	Oklahoma	592,446	411,554	69.47%
38	Oregon	395,632	359,073	90.76%
39	Pennsylvania	1,773,296	1,439,391	81.17%
40	Puerto Rico	1,066,900	922,379	86.45%
41	Rhode Island	180,864	114,106	63.09%
42	South Carolina	654,677	149,738	22.87%
43	South Dakota	100,853	99,446	98.60%
44	Tennessee	1,182,221	1,182,221	100.00%
45	Texas	3,002,317	2,020,944	67.31%
46	Utah	201,073	165,459	82.29%
47	Vermont	146,239	123,222	84.26%
48	Virgin Islands	7,236	0	0.00%
49	Virginia	694,950	446,033	64.18%
50	Washington	993,118	849,184	85.51%
51	West Virginia	303,835	135,387	44.56%
52	Wisconsin	851,761	410,566	48.20%
53	Wyoming	61,026	0	0.00%
	TOTALS	**45,962,271**	**29,463,098**	**64.10%**

The unduplicated Medicaid enrollment figures include individuals in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards. The unduplicated managed care enrollment figures includes enrollees receiving comprehensive and limited benefits.

Dual Eligible Enrollment - *As of June 30, 2007*

STATE	MEDICAID DUAL ELIGIBLES
Alabama	184,846
Alaska	12,002
Arizona	125,737
Arkansas	101,416
California	1,091,121
Colorado	67,155
Connecticut	78,340
Delaware	20,762
District of Columbia	19,304
Florida	488,160
Georgia	228,762
Hawaii	26,083
Idaho	25,914
Illinois	374,859
Indiana	129,651
Iowa	68,532
Kansas	58,437
Kentucky	164,107
Louisiana	153,500
Maine	87,480
Maryland	88,772
Massachusetts	220,100
Michigan	211,689
Minnesota	109,909
Mississippi	132,830
Missouri	228,732
Montana	18,706
Nebraska	33,124
Nevada	32,748
New Hampshire	20,009
New Jersey	152,821
New Mexico	46,733
New York	622,682
North Carolina	296,206
North Dakota	13,287
Ohio	235,448
Oklahoma	95,381
Oregon	64,803
Pennsylvania	338,098
Puerto Rico	217,539
Rhode Island	34,132
South Carolina	126,272
South Dakota	17,635
Tennessee	249,332
Texas	507,711
Utah	22,412
Vermont	31,449
Virginia	144,040
Washington	124,960
West Virginia	65,466
Wisconsin	187,975
Wyoming	8,356
National Total	**8,205,525**

This table provides an unduplicated number of Medicaid dual eligibles receiving full or partial Medicaid benefits.

Number of Managed Care Entity Enrollees by State - *As of June 30, 2007*

STATE	HIO	COMMERCIAL MCO	MEDICAID-ONLY MCO	PCCM	PIHP	PAHP	PACE	OTHER
Alabama	0	0	0	376,760	471,824	0	0	0
Alaska	0	0	0	0	0	0	0	0
Arizona	0	0	890,046	0	85,295	0	0	0
Arkansas	0	0	0	467,713	0	433,774	0	0
California	515,351	2,693,356	49,650	0	132	382,466	1,975	5,911
Colorado	0	0	36,707	29,189	370,560	0	1,074	0
Connecticut	0	209,940	88,974	0	0	0	0	0
Delaware	0	0	96,296	0	0	0	0	11,210
Dist of Columbia	0	0	88,893	0	3,336	0	0	0
Florida	0	583,954	138,417	564,510	567,607	324,318	134	9,029
Georgia	0	0	938,512	23,943	2,588	0	0	0
Hawaii	0	107,064	48,738	0	1,771	0	0	1,833
Idaho	0	0	0	151,711	0	713	0	0
Illinois	0	105,500	38,100	424,400	0	0	0	0
Indiana	0	0	532,705	66,931	0	0	0	0
Iowa	0	4,654	0	137,985	283,204	0	0	0
Kansas	0	0	116,854	21,969	0	0	202	0
Kentucky	0	0	148,534	299,579	0	0	0	0
Louisiana	0	0	0	636,429	0	0	0	0
Maine	0	0	0	171,554	0	0	0	0
Maryland	0	0	479,065	0	0	22,632	125	0
Massachusetts	0	121,530	242,732	277,403	299,016	0	1,700	0
Michigan	0	205,128	766,922	0	1,343,332	0	270	0
Minnesota	0	330,689	36,784	0	0	0	0	0
Mississippi	0	0	0	0	0	0	0	0
Missouri	0	26,495	318,334	0	0	0	162	0
Montana	0	0	0	44,534	0	0	0	0
Nebraska	0	32,038	0	38,703	0	0	0	170,377
Nevada	0	77,458	0	0	0	144,354	0	0
New Hampshire	0	0	0	0	0	84,165	0	0
New Jersey	0	224,494	395,072	0	0	0	0	0
New Mexico	0	192,676	59,402	0	256,196	0	315	0
New York	0	770,734	1,735,087	17,939	16,977	6,444	2,846	8,639
North Carolina	0	0	0	830,773	64,336	0	0	0
North Dakota	0	0	0	29,339	0	0	0	0
Ohio	0	10,055	1,183,575	0	0	0	719	0
Oklahoma	0	0	0	10,406	0	401,148	0	0
Oregon	0	27,014	246,716	8,689	343,330	350,192	633	346,944
Pennsylvania	0	962,297	0	256,391	1,255,473	37,030	1,027	0
Puerto Rico	0	908,211	0	0	469,738	0	0	0
Rhode Island	0	44,101	70,005	0	0	32,933	81	0
South Carolina	0	0	89,564	54,347	0	5,473	354	0
South Dakota	0	0	0	74,071	0	99,446	0	0
Tennessee	0	706,280	475,941	0	826,833	0	298	1,840,760
Texas	0	118,370	1,118,257	713,324	324,386	0	908	0
Utah	0	0	0	47,413	227,064	144,061	0	0
Vermont	0	0	123,222	0	0	0	0	0
Virgin Islands	0	0	0	0	0	0	0	0
Virginia	0	260,492	121,306	64,235	0	0	0	0
Washington	0	499,016	0	3,946	849,184	0	228	0
West Virginia	0	135,387	0	20,962	0	0	0	0
Wisconsin	0	320,611	88,572	0	617	0	766	0
Wyoming	0	0	0	0	0	0	0	0
TOTALS	515,351	9,677,544	10,762,982	5,865,148	8,062,799	2,469,149	13,817	2,394,703

This table provides duplicated figures that include enrollees receiving comprehensive and limited benefits. Total number of enrollees includes those who were enrolled in more than one managed care plan. Figures also include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

CMS Statistics

National Breakout of Managed Care Entities and Enrollment

As of June 30, 2007

MANAGED CARE ENTITY TYPE	# OF PLANS	# OF ENROLLEES
Health Insuring Organization	4	515,351
Commercial Managed Care Organization	202	9,677,544
Medicaid-only Managed Care Organization	143	10,762,982
Primary Care Case Management	33	5,865,148
Prepaid Inpatient Health Plan	120	8,062,799
Prepaid Ambulatory Health Plan	39	2,469,149
Program of ALL-inclusive Care for the Elderly	37	13,817
Other	11	2,394,703
TOTAL	589	39,761,493

This table provides **duplicated** figures by plan type. The total number of enrollees include 10,298,395 individuals who were individuals who were enrolled in more than one managed care plan. It also includes individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards

CMS Statistics

New Medicaid Managed Care Plans

As of June 30, 2007

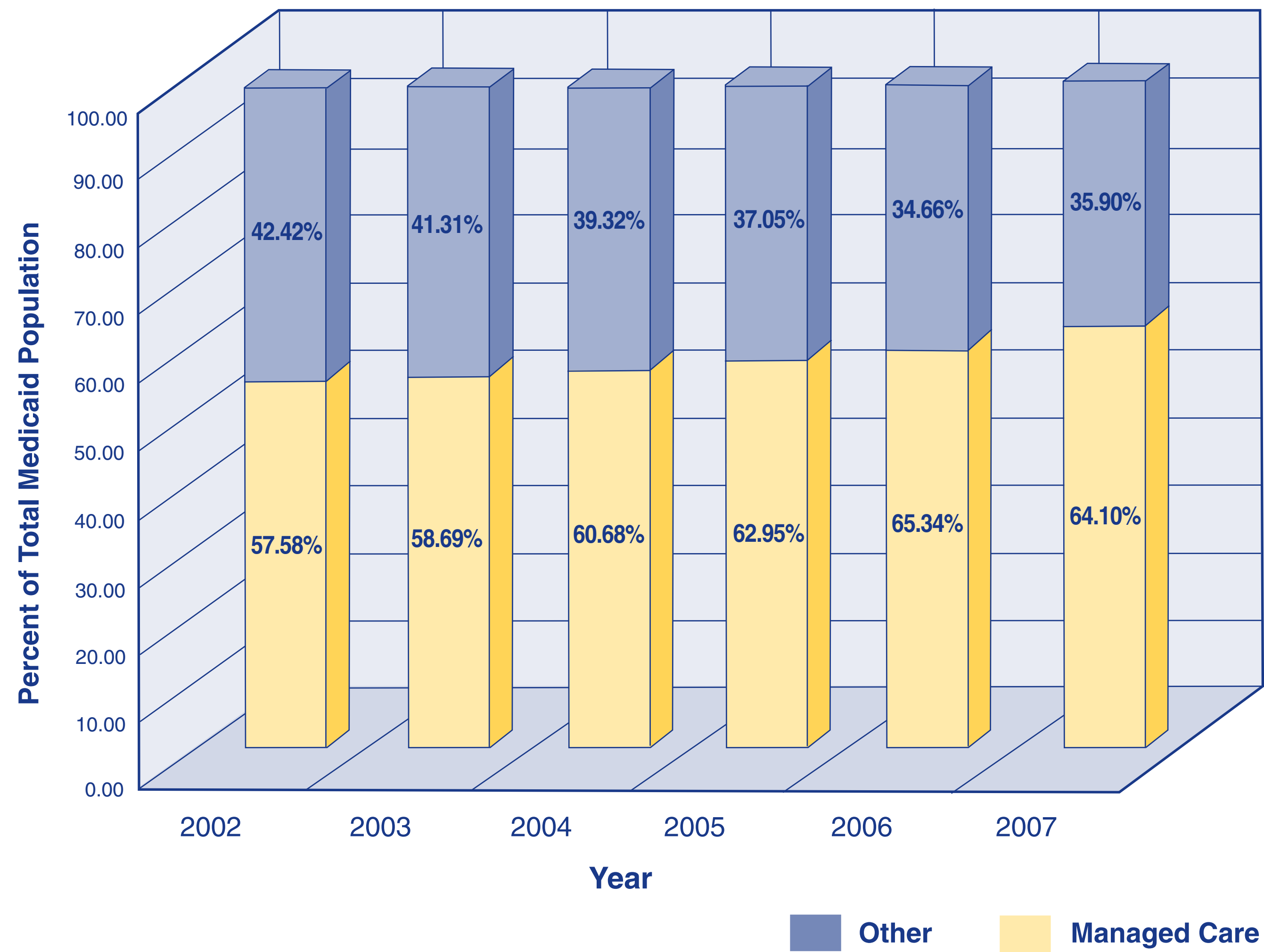
- **Arizona** – Bridgeway Health Solutions[2] and SCAN[2] are new MCO plans under the Health Care Cost Containment System program.
- **Florida** – Access Health Solutions(Reform)[4], Children's Medical Services(Reform)[4], First Coast Advantage(Reform)[4], NetPass(Reform)[4], and Universal Health Care(Reform)[4] are new Medical-only PIHP plans under the new Florida Medicaid Reform program. Amerigroup(Reform)[1], Buena Vista(Reform)[1], Healthease(Reform)[1], Human Family(Reform)[1], Preferred Medical Plan(Reform)[1], Staywell(Reform)[1], Total Health Choice(Reform)[1], United Health Care(Reform)[1], Universal Health Care(Reform)[1], and Vista Health plan of South Florida(Reform)[1] are new MCO plans under the new Florida Medicaid Reform program. American Eldercare[1], America's Health Choice[1], Amerigroup (NHD)[1], Citrus (NHD)[1], Florida's Comfort Choice[1], Hope of Southwest Florida Inc.[1], Little Havana[1], Neighborly Care Network[1], Project Independence[1], United Health Care (NHD)[1], United Home Care[1], Universal Health Care (NHD)[1], Urban Jacksonville[1], and Vista Health Plan[1] plans are new MCO plans under the new Nursing Home Diversion Program. JMH Health Plan[1] is a new MCO plan under the Managed Health Care program.
- **Idaho** – Medicare-Medicaid Coordinated Plan[1] is a new MCO plan under the Medicare-Medicaid Coordinated Plan program.
- **Illinois** – Illinois Health Connect[3] is a new PCCM under the Illinois Health Connect Primary Care Case Management program.
- **Indiana** – Anthem[1] is a new MCO plan under the Hoosier HealthWise program.
- **Kansas** – Midland Care Services[8] is a new PACE plan under the PACE program. UNICARE Health Plan of Kansas, Inc.[2] is a new MCO plan under the HealthWave 19 program.
- **Maryland** – JAI Medical Systems-PAC[5], Maryland Physicians Care-PAC[5], and United HealthCare-PAC[5] are new medical PAHP plans under the Health Choices program.
- **Michigan** – Care Resources[8] is a new PACE plan under the PACE program.
- **Missouri** – Harmony Health Plan of Missouri[2] is a new MCO plan under the MC+ Managed Care/1115 and MC+ Managed Care/1915(b) programs.
- **Nevada** – Anthem Blue Cross Blue Shield Partnership Plan1 is a new MCO plan under the Mandatory Health Maintenance program.
- **Ohio** – Anthem Blue Cross Blue Shield Partnership Plan[2] and Wellcare of Ohio[2] are new MCO plans under the State Plan Amendment for Ohio's full-risk Managed Care program.
- **Oregon** – Kaiser Permanente Oregon Plus[2] and ODS Community Health Inc.[2] are new MCO plans under the Oregon Health Plan program.
- **Pennsylvania** – Community Care Behavioral Health-North Central[6] and Community Care Behavioral Health-Northeast[6] are new mental health plans under the HealthChoices program. New Courtland LIFE[4] is a new medical PIHP plan under the Long Term Capitated Assistance program.
- **Puerto Rico** – Red Medica[1] and Salud Dorado Con Medicare[1] are new MCO plans under the Medicare Platino 1915(a) program.
- **Rhode Island** – RISmiles[7] is a new dental plan under the 1115 RISmiles program.
- **Tennessee** – AmeriChoice[1] and AmeriGroup Community Care1 are new MCO plans under TennCare program.
- **Washington** – Columbia United Providers[1] is a new MCO plan under the Healthy Options program.

[1] Commercial MCO
[2] Medicaid-only MCO
[3] PCCM
[4] Medical-only PIHP
[5] Medical-only PAHP
[6] Mental Health PIHP
[7] Dental PAHP
[8] PACE
[9] Disease Management PAHP
[10] Transportation PAHP
[11] Other

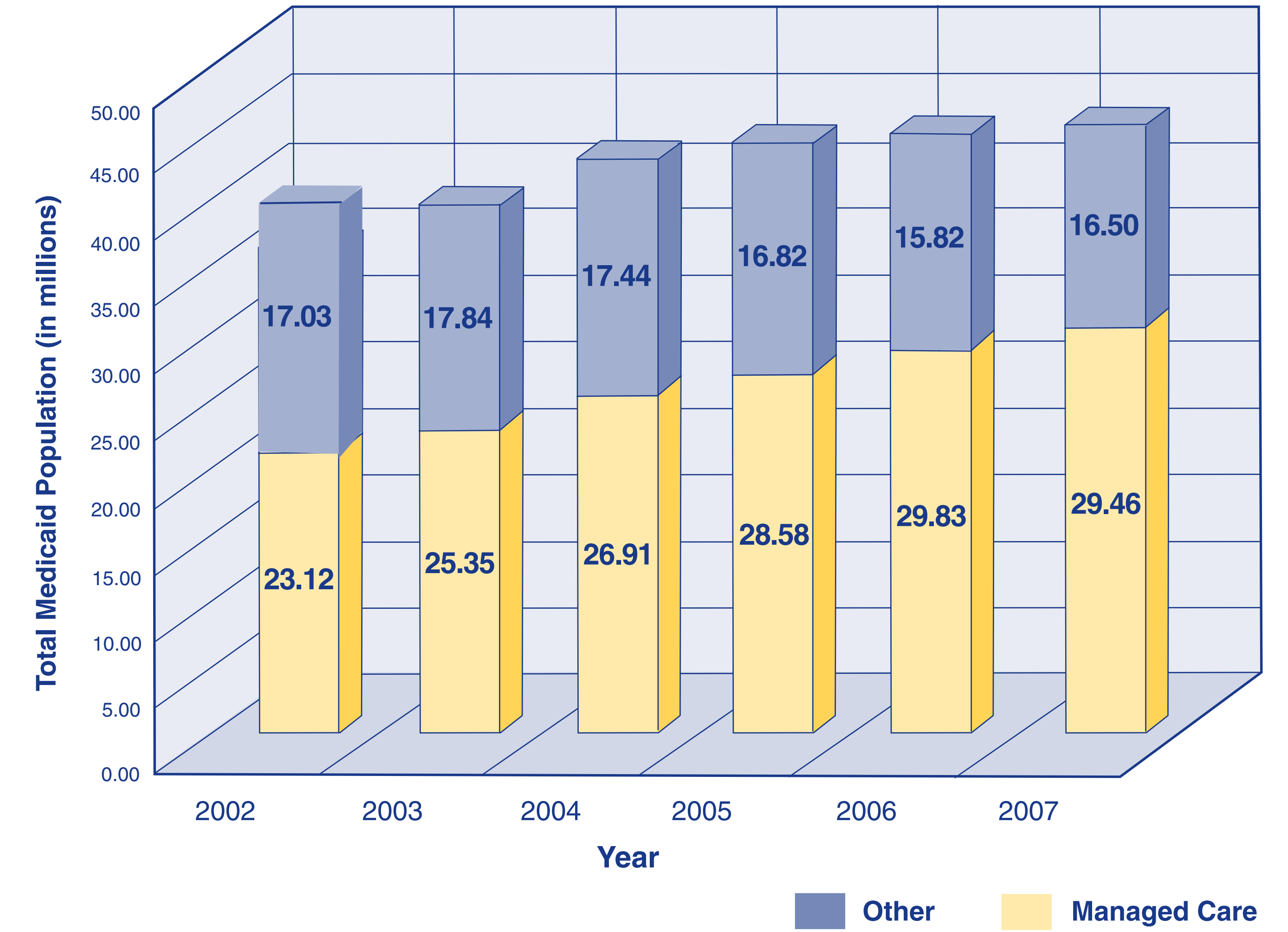
Number of Managed Care Entities by State - *As of June 30, 2007*

STATE	HIO	COMMERCIAL MCO	MEDICAID-ONLY MCO	PCCM	PIHP	PAHP	PACE	OTHER
Alabama	0	0	0	1	2	0	0	0
Alaska	0	0	0	0	0	0	0	0
Arizona	0	0	27	0	1	0	0	0
Arkansas	0	0	0	1	0	1	0	0
California	4	24	2	0	1	12	4	1
Colorado	0	0	1	1	6	0	1	0
Connecticut	0	2	2	0	0	0	0	0
Delaware	0	0	1	0	0	0	0	1
Dist of Columbia	0	0	3	0	1	0	0	0
Florida	0	36	2	1	12	4	1	3
Georgia	0	0	1	1	1	0	0	0
Hawaii	0	2	1	0	2	0	0	1
Idaho	0	0	0	1	0	1	0	0
Illinois	0	1	1	1	0	0	0	0
Indiana	0	0	3	1	0	0	0	0
Iowa	0	1	0	1	1	0	0	0
Kansas	0	0	2	1	0	0	2	0
Kentucky	0	0	1	1	0	0	0	0
Louisiana	0	0	0	1	0	0	0	0
Maine	0	0	0	1	0	0	0	0
Maryland	0	0	7	0	0	3	1	0
Massachusetts	0	2	2	1	1	0	6	0
Michigan	0	4	9	0	18	0	2	0
Minnesota	0	6	3	0	0	0	0	0
Mississippi	0	0	0	0	0	0	0	0
Missouri	0	1	5	0	0	0	1	0
Montana	0	0	0	1	0	0	0	0
Nebraska	0	1	0	1	0	0	0	1
Nevada	0	2	0	0	0	1	0	0
New Hampshire	0	0	0	0	0	1	0	0
New Jersey	0	2	3	0	0	0	0	0
New Mexico	0	2	1	0	1	0	1	0
New York	0	23	18	4	12	1	4	1
North Carolina	0	0	0	2	1	0	0	0
North Dakota	0	0	0	1	0	0	0	0
Ohio	0	1	8	0	0	0	2	0
Oklahoma	0	0	0	1	0	1	0	0
Oregon	0	2	13	1	9	8	1	1
Pennsylvania	0	11	0	1	31	1	4	0
Puerto Rico	0	16	0	0	2	0	0	0
Rhode Island	0	2	1	0	0	1	1	0
South Carolina	0	0	2	1	0	2	1	0
South Dakota	0	0	0	1	0	1	0	0
Tennessee	0	5	4	0	2	0	1	2
Texas	0	5	12	1	1	0	2	0
Utah	0	0	0	1	12	1	0	0
Vermont	0	0	1	0	0	0	0	0
Virgin Islands	0	0	0	0	0	0	0	0
Virginia	0	5	2	1	0	0	0	0
Washington	0	9	0	1	1	0	1	0
West Virginia	0	3	0	1	0	0	0	0
Wisconsin	0	34	5	0	2	0	1	0
Wyoming	0	0	0	0	0	0	0	0
TOTALS	**4**	**202**	**143**	**33**	**120**	**39**	**37**	**11**

Total Annual Medicaid Population Distribution by Year
Managed Care vs. Other
As of June 30, 2007



Total Annual Medicaid Population Distribution by Year
Managed Care vs. Other
As of June 30, 2007



Regional Break-Out of Medicaid Managed Care Enrollment

- As of June 30, 2007

US REGION	MEDICAID ENROLLMENT	MANAGED CARE ENROLLMENT	% REGION BENEFICIARIES ENROLLED IN MANAGED CARE	% NATIONAL MANAGED CARE ENROLLMENT
I - Boston	2,177,718	1,433,626	65.83%	4.87%
II - New York	6,072,305	4,100,611	67.53%	13.92%
III - Philadelphia	3,751,219	2,711,158	72.27%	9.20%
IV - Atlanta	8,838,151	5,419,826	61.32%	18.40%
V - Chicago	7,514,445	4,483,357	59.66%	15.22%
VI - Dallas	5,569,629	3,836,624	68.88%	13.02%
VII - Kansas City	1,670,546	937,597	56.13%	3.18%
VIII - Denver	876,485	697,478	79.58%	2.37%
IX - San Francisco	7,827,143	4,482,518	57.26%	15.21%
X - Seattle	1,664,630	1,360,681	81.74%	4.62%
TOTALS	**45,962,271**	**29,463,098**	**64.10%**	**100.00%**

The **unduplicated** managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits. This table also provides **unduplicated** Medicaid enrollment figures by region. The enrollment figures include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

States with Comprehensive Health Care Reform Demonstrations

- As of June 30, 2007

US STATE	MEDICAID ENROLLMENT	EXPANSION ENROLLMENT	MANAGED CARE ENROLLMENT	% ENROLLED IN MANAGED CARE
Arkansas	625,866	232	511,272	81.69%
Arizona	989,519	140,577	890,046	89.95%
California	6,465,346	29,862	3,286,293	50.83%
Delaware	143,883	23,236	96,296	66.93%
Florida	2,194,986	174,187	1,355,169	61.74%
Hawaii	202,126	19,724	161,447	79.87%
Kentucky	713,961	0	448,113	62.76%
Maryland	692,773	22,632	501,822	72.44%
Massachusetts	1,081,823	112,850	641,665	59.31%
Minnesota	594,270	59,044	367,473	61.84%
Missouri	822,685	78,996	344,991	41.93%
New York	4,120,044	505,806	2,558,666	62.10%
Oklahoma	592,446	0	411,554	69.47%
Oregon	395,632	18,481	359,073	90.76%
Rhode Island	180,864	22,302	114,106	63.09%
Tennessee	1,182,221	34,951	1,182,221	100.00%
Utah	201,073	18,812	165,459	82.29%
Vermont	146,239	34,562	123,222	84.26%
Wisconsin	851,761	98,743	410,566	48.20%
TOTALS	**22,197,518**	**1,394,997**	**13,929,454**	**62.75%**

The **unduplicated** managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits. This table also provides **unduplicated** Medicaid enrollment figures by region. The enrollment figures include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

Medicaid Managed Care Enrollment

- As of June 30, 2007

RANK	STATES	WAIVER TYPE	MANAGED CARE ENROLLMENT
STATES 1-10			
1	California	1915(b), 1115(a), 1932(a), 1915(a), PACE	3,286,293
2	New York	1115(a), 1915(a), PACE	2,558,666
3	Texas	1915(b), 1915(b)/(c), PACE	2,020,944
4	Pennsylvania	1915(b), 1915(a), PACE	1,439,391
5	Florida	1915(b), 1115(a), 1915(b)/(c), 1915(a)/(c), PACE	1,355,169
6	Michigan	1915(b), PACE	1,343,333
7	Ohio	1932(a), PACE	1,194,349
8	Tennessee	1115(a), PACE	1,182,221
9	Georgia	1915(b), 1932(a)	965,043
10	Puerto Rico	1915(a)	922,379
	Subtotal		16,267,788
	National Managed Care Grand Total		29,463,098
	Percentage		55.21%
STATES 11-20			
11	Arizona	1115(a)	890,046
12	Washington	1915(b), 1932(a), PACE	849,184
13	North Carolina	1915(b)/(c), 1932(a)	847,718
14	Massachusetts	1115(a), PACE	641,665
15	Louisiana	1932(a)	636,429
16	New Jersey	1915(b), 1932(a)	619,566
17	Indiana	1915(b)	599,636
18	Illinois	1932(a), 1915(a)	568,000
19	Arkansas	1915(b), 1115(a)	511,272
20	Maryland	1115(a), PACE	501,822
	Subtotal		6,665,338
	National Managed Care Grand Total		29,463,098
	Percentage		22.62%

The **unduplicated** managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits.

CMS Statistics

2007 Enrollment Facts Sheet

Major changes from June 30, 2006 to June 30, 2007

- **California** – Kaiser Foundation[1] is now KP Cal, LLC[1].
- **Florida** – A Healthy State[9] is now Healthier Florida[9]. United Healthcare dba Evercare[1] is now United Evercare[1]. Vista South Florida1 is Now Vista Health plan of South Florida[1]. Access Behavior Health[6] is now Lakeview Center, Inc[6]. Provider Service Network[11] has changed their managed care entity from "Hospital Based Network PIHP" to "Shared Savings Model".
- **Georgia** – The State Medicaid Managed Care Enrollment decrease was due to the conversion of the Non-Emergency Transportation Broker program from a 1915(b) to a 1902(a)(70) under the Deficit Reduction Act (DRA). Non-Emergency Transportation plan 10 was removed due to the conversion of the Non-Emergency Transportation Broker program from a 1915(b) to a 1902(a)(70) under the Deficit Reduction Act(DRA).
- **Kansas** – Children's Mercy Family Health Partners[2] is a new plan under the HealthWave 19 Program.
- **Kentucky** – Human Service Transportation plan[10] was removed due to the conversion of the Human Service Transportation program from a 1915(b) to a 1902(a)(70) under the Deficit Reduction Act(DRA).
- **Maryland** – Helix Family Choice[2] is now Medstar Family Choice[2]. Coventry Diamond Plan[2] is now The Diamond Plan[2].
- **Michigan** – CEI[6] is now Authority of Clinton-Eaton-Ingham Counties[6].
- **Missouri** – Mercy Health Plan[2] merged with Community Care Plus[2] to form Mercy CarePlus[2] plan under the MC+ Managed Care/1115 and MC+ Managed Care/1915(b) programs. Family Health Partners[2] is now Children's Mercy Family Health Partners[2]. The State Medicaid Dual Eligible Enrollment increase was due to an increase of enrollment in all categories of dual eligible. The State Medicaid Managed Care Enrollment decrease was due to the conversion of the 1915(b) Non-Emergency Medical Transportation (NEMT) program to a Medicaid State plan.
- **New Jersey** – The State Medicaid Enrollment Managed Care Enrollment increase was due to an increase in eligibility and enrollment Statewide.
- **North Carolina** – The State was unable to determine the actual managed care enrollment because they were not able to separate their PCCM enrollees that are also enrolled in their mental health program. Therefore, the State's managed care enrollment is based upon their PCCM and MCO enrollment.
- **Ohio** – The State Medicaid Managed Care Enrollment increase was due to a statewide expansion of managed care. The statewide expansion is now complete with the exception of one county in which managed care will be implemented in early 2008.
- **Oklahoma** – LogistiCare plan[10] was removed due to the conversion of the Non-Emergency Transportation program from a 1932(a) to a 1902(a)(70) under the Deficit Reduction Act(DRA).
- **Pennsylvania** – The State Medicaid Managed Care Enrollment decrease was due to a more accurate approach of extracting data for 2007 by eliminating duplication of recipients that were in more than one plan.
- **Puerto Rico** – The State Medicaid Enrollment increase was due to the inclusion of the SCHIP expansion population that was not included in 2006. Alianza de Medicos de Sur Este, Inc.[1] and San Judas Medical Services[1] should not have been included in 2006 because the plans were not funded by Medicaid.
- **Utah** – Non-Emergency Transportation is now Non-Emergency Medical Transportation.
- **Virginia** – Peninsula Health Care, Inc.[1] is now Anthem Peninsula Health Care, Inc.[1]. Healthkeepers, Inc.[1] is now Anthem Healthkeepers, Inc.[1]. Priority Health Care, Inc.[1] is now Anthem Priority Health Care, Inc.[1]. AmeriGroup Virginia, Inc.[2] is now Amerigroup Community Care[2]. LogistiCare Solutions plan[10] was removed due to the conversion of the Virginia Non-Emergency Transportation Service program from a 1915(b) to a 1902(a)(70) under the Deficit Reduction Act(DRA).
- **Wisconsin** – Elder Care of Dane-Partnership[2] is now Care Wisconsin[2].

[1] Commercial MCO	[5] Medical-only PAHP	[9] Disease Management PAHP
[2] Medicaid-only MCO	[6] Mental Health PIHP	[10] Transportation PAHP
[3] PCCM	[7] Dental PAHP	[11] Other
[4] Medical-only PIHP	[8] PACE	

CMS Statistics

National Summary of Medicaid Care Programs and Enrollment

As of June 30, 2007

MANAGED CARE TRENDS

YEAR	TOTAL MEDICAID POPULATION	OTHER POPULATION	MANAGED CARE POPULATION	% MANAGED ENROLLMENT	% OTHER ENROLLMENT
2002	40.15	17.03	23.12	57.58%	42.42%
2003	43.19	17.84	25.35	58.69%	41.31%
2004	44.36	17.44	26.91	60.68%	39.32%
2005	45.39	16.82	28.58	62.95%	37.05%
2006	45.65	15.82	29.83	65.34%	34.66%
2007	45.96	16.50	29.46	64.10%	35.90%

CMS Statistics

Operating Authorities by State *- As of June 30, 2007*

State	1915(b)	1115(a)	1932(a)	1915(a), Voluntary	Concurrent 1915(b)/(c)	Concurrent 1915(a)/(c)	1905(t)	1937	PACE
Alabama	x			x					
*Alaska									
Arizona		x							
Arkansas	x								
California	x	x	x	x					x
Colorado	x			x			x		x
Connecticut	x								
Delaware		x							
DC			x	x					
Florida	x	x			x	x			x
Georgia	x		x						
Hawaii		x							
Idaho	x							x	
Illinois			x	x					
Indiana	x								
Iowa	x		x						
Kansas			x						x
Kentucky		x	x						
Louisiana			x						
Maine			x						
Maryland		x							x
Massachusetts		x							x
Michigan	x				x				x
Minnesota	x	x	x	x	x				
*Mississippi									
Missouri	x	x							x
Montana	x								
Nebraska	x		x						
Nevada			x						
New Hamp.	x								
New Jersey	x		x						
New Mexico	x								x
New York		x		x					x
No. Carolina			x		x				
No. Dakota			x						
Ohio			x						x
Oklahoma		x							x
Oregon	x	x							x
Pennsylvania	x			x					x
Puerto Rico				x					
Rhode Island	x	x							x
So. Carolina				x			x		x
So. Dakota			x	x					
Tennessee		x							x
Texas	x				x				x
Utah	x	x							
Vermont		x							
*Virg. Islands									
Virginia	x								
Washington	x		x						x
West Virginia	x							x	
Wisconsin		x	x		x				x
*Wyoming									
Total	26	18	19	11	6	1	2	2	20

**These States do not have managed care.*

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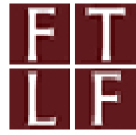

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