

**Medicaid Managed Care Payment Methods and Capitation Rates in 2001:
Results of a New National Survey**
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Introduction

Managed care continues to grow as a part of state Medicaid programs. Enrollment in full-risk HMOs increased by 40.6% between 1997 and 2001¹. Despite the overall increase in enrollment, in many states there were fewer plans available and willing to serve an increasing number of enrollees (Holahan et al. 2002). A small number of states have been unable to attract a sufficient number of plans and no longer have full-risk managed care in their Medicaid programs. Managed care payment rates are a major issue for all states in their efforts to sustain Medicaid managed care. While other factors are important, rates clearly affect plans' willingness to participate in the program and the kinds of services they are able to offer and the providers they are able to attract (Coughlin et al. 2001).

We conducted a survey of Medicaid managed care payment methods and capitation rates in 1998 (Holahan et al. 1999). Information was collected on how states set rates and how they made adjustments for differences in age and gender, treatment of maternity expenses, and benefits. We made adjustments for these and other factors to allow for comparisons of rates across states. Finally, we computed adjusted rates for each state which allowed state policymakers and other interested parties to understand how Medicaid programs were paying managed care plans across the states. The results

¹ "Medicaid Managed Care Enrollment Report, Summary Statistics as of June 30, 1997." and "Medicaid Managed Care Enrollment Report, Summary Statistics as of June 30, 2001." Centers for Medicare & Medicaid Services. <http://www.cms.gov/medicaid/mcaidsad.asp>. (Accessed 9 September 2002).

showed a twofold variation in rates with the highest rates in Connecticut and Massachusetts and the lowest in California.

This paper updates the earlier one by providing data on methods and rates employed by states in January 2001. As in the previous report we begin by discussing changes in Medicaid managed care enrollment by state. We then describe how states set rates, what adjustments are made for age, gender and maternity, risk factors such as HIV/AIDS, whether they make regional adjustments and which services are carved out from the benefit package. We next describe procedures we use in making adjustments for all of these factors—as the same set of adjustments used in 1998. We conclude by providing data on the levels of rates being used in the responding states.

Background

States have adopted Medicaid managed care both to contain costs as well as to improve access to care. There are two broad kinds of managed care: primary care case management (PCCM) programs and capitated health maintenance organizations (HMOs). In general, PCCMs pay primary care physicians a fixed fee, generally \$3 to \$6 per member per month in addition to regular fee-for-service payments for care. Primary care physicians are expected to influence but are not held financially responsible for use of specialists and inpatient stays. Unlike PCCMs, capitated HMOs assume financial risk for inpatient and outpatient services and often for prescription drugs, dental care and other services. Plans receive a fixed dollar amount per month per beneficiary for a specified benefit package.

Research evidence suggests that PCCMs have had some effect on providing access to a usual source of care, but little effect on utilization. HMOs have had similar

effects on access to a usual source of care but greater impacts on utilization (Zuckerman et al. 2002 and Garrett et al. 2001). States in general have moved toward capitated HMO alternatives as their preferred strategy. In general they believe that HMOs are more effective at controlling costs and also help achieve budget predictability.

Many states began with voluntary Medicaid managed care (MMC) plans but have moved towards mandatory arrangements. However, states frequently maintain voluntary MMC for some vulnerable populations and, increasingly, PCCM models in some rural areas. Table 1 provides data on Medicaid managed care penetration on June 30, 2001. The table shows that nationally 5.2 million (14.8%) Medicaid beneficiaries were enrolled in PCCM programs and 13.0 million (36.6%) in full-risk arrangements (data excludes behavioral health and other limited service plans). The table also shows the number of full-risk plans. While states like California, New York and Michigan have large numbers of plans, most have fewer than ten plans and many states fewer than five. Other studies suggest the number of plans participating has declined in recent years (Holahan et al. 2002 and Felt-Lisk 1999). Many states have found it increasingly difficult to retain commercial plan participation in Medicaid and as a result a higher share of plans are Medicaid-only plans compared with previous years.

Table 1 shows that there are seventeen states with more than 50.0% of their Medicaid enrollees in a full-risk managed care plan; these are the major Medicaid managed care states. There are nine states that have between 25.0% and 50.0% of their enrollees in Medicaid managed care. New York and Florida could arguably be considered major Medicaid managed care states. Florida has over 500,000 enrollees and New York over 650,000, but these represent only 27.0% of Medicaid enrollees in Florida

and 25.0% in New York. Eight additional states have between 10.0% and 25.0% of their enrollees in Medicaid managed care plans, and five have fewer than 10.0%. Some of this variation occurs because HMO's tend to be in urban areas and some states are more urban than others.

In total, thirty-nine states (including the District of Columbia) have full-risk plans and twelve do not. Of the twelve, ten have PCCM programs only. Two states (Alaska and Wyoming) have no Medicaid managed care of any kind. States with PCCM programs only are Alabama, Arkansas, Georgia, Idaho, Louisiana, Maine, Mississippi, Montana, South Dakota and Vermont.

Table 2 provides information on changes between June 1997 and June 2001 on Medicaid managed care enrollment. The data show that there was significant growth (over 35%) in enrollment in full-risk plans in a large number of states. Several of these states' full-risk enrollment growth represents an expansion of Medicaid managed care per se. In others such as California, Maryland, Michigan, New Mexico and Pennsylvania, there were major shifts in the structure of their Medicaid managed care programs with a large increase in enrollment of full-risk plans and declines in use of PCCM arrangements.

On the other hand, in a number of states there were declines in enrollment in Medicaid (full-risk) managed care. Georgia, Maine, Mississippi and Vermont ended their full-risk programs and other states including Hawaii, Illinois, New Hampshire, Ohio, Oklahoma, Oregon and West Virginia experienced a significant decline in Medicaid managed care (full-risk) enrollment. In still another set of states there were substantial increases in PCCM programs.

The increased enrollment in Medicaid managed care in a substantial number of states, together with declines in others, and the evidence on the reduced number of plans in many states, means that Medicaid managed care is surviving but struggling. The goal of Medicaid managed care was providing Medicaid enrollees with access to mainstream managed care plans. But a large number of these plans have now left the market, citing increased frustration with Medicaid managed care, particularly inadequate capitation rates and the onerous administrative demands of state Medicaid programs (Coughlin et al. 1994). States often counter that mainstream plans were attracted to Medicaid when enrollment was voluntary since rates were attractive because managed care plans attracted healthier beneficiaries. Since rates were based on the average level of expenditures they were more than adequate to serve the healthier than average beneficiary. As states moved to mandatory enrollment Medicaid beneficiaries who were less healthy enrolled in plans and, it is alleged, rates typically were not increased to compensate for the change in case mix.

The result was that mainstream plans found capitation rates increasingly inadequate. Together with other issues they faced in Medicaid and in the commercial market, continued participation in MMC became increasingly unattractive leading to an exit of a large number of the mainstream plans in many states. States also faced the need to protect safety net providers because Medicaid has been a major source of revenue for providers that serve the uninsured. These providers were often closely linked with Medicaid-only plans. The preferences given to these plans in some states also made it more difficult for mainstream plans to be competitive. Many states now have fewer commercial plans and increasingly rely on Medicaid-only plans. In this environment

states still need to adequately pay these plans because Medicaid is such an important source of the revenues for their providers. Thus, rate adequacy is important both because many states are still attempting to retain commercial plans in MMC and because of the dependence of safety net providers on Medicaid revenues.

Survey Design

We mailed surveys to Medicaid directors in all 50 states and the District of Columbia and asked states with capitated HMO programs to respond. The survey was designed to elicit information that was comparable to the 1998 survey and not available from secondary sources. The questions applied to only capitated HMO programs for Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF) and poverty-related eligibility groups; i.e., low-income unemployed parents, poverty-related children (PRC), and poverty-related pregnant women (PRW). We did not include State Children's Health Insurance Program (SCHIP) enrollees, the elderly and disabled, and the medically needy. The population covered represents the majority of MMC caseloads, as relatively few states require participation in fully capitated MMC for elderly and disabled population.

The survey asked questions about rate-setting methods, adjustments for disproportionate share hospital (DSH) payments and graduate medical education (GME), add-on payments and adjustments for maternity care and deliveries, and services carved out from capitation. We also asked questions about how states made adjustments for safety net providers, high-risk cases, and state administrative savings as well as rate updating processes and methodologies. In addition, states were asked to provide

capitation rates or average accepted bids that were effective in January 2001 and per member per month (pmpm) equivalent values for carved-out services.

Table 3 shows the types of Medicaid managed care programs that were in place as of January 2001. A total of 39 states, including the District of Columbia, operated capitated Medicaid managed care; of these, twelve had statewide mandatory HMO enrollment, and sixteen allowed beneficiaries a choice between HMOs and PCCM programs. The remaining eleven states had mandatory and/or voluntary enrollment in capitated managed care programs in some areas of the state. Of the possible 39 states with capitated MMC, 36 responded to the survey and provided information on payment methods and rates. Nebraska, Oregon, and Tennessee declined to respond. (In 1998, 41 states responded but only 36 provided data on rates.) The participating states accounted for approximately 87 percent of the nation's Medicaid managed care beneficiaries enrolled in capitated managed care programs in 2001.

Payment Methods - Administrative Pricing, Negotiation and Competitive Bidding

Table 4 provides data on the payment systems used by the 36 states that have responded to our survey. States use three approaches to establish rates. About half (19) of the 36 states that responded to the survey used some form of administrative pricing. Essentially, the states set rates that plans can accept or not accept in deciding upon participation. This is similar to the approach Medicaid uses in paying physicians and other providers. Managed care plans of course must also meet a variety of other standards in order to participate. These states typically use data from their fee-for-service experience to establish rates, making adjustments to reflect the expected health status of HMO enrollees, cost containment goals and other objectives.

Seven states negotiate with plans individually, while ten states use some form of competitive bidding. In most cases these systems are never purely rate setting, negotiation or bidding. Even the administered rate setting states often involve some negotiation with plans. States that negotiate or use competitive bidding also use fee-for-service data as a basis of establishing an acceptable rate range. States that use competitive bidding often find that negotiations are necessary to arrive at acceptable rates.

Several states have moved away from competitive bidding, seemingly for two reasons. One is that the administrative burden associated with the competitive bidding process is thought to be too great. Second, the rates that are developed through competitive bidding have been too frequently disputed, subjected to political pressures and are often subsequently adjusted, sometimes substantially. Of the states that responded that they had competitive bidding in 1998, Arizona, the District of Columbia, Hawaii, Indiana, Michigan, Missouri, New Mexico, Oklahoma and Washington all continue to use bidding as the basis of rate setting. However, Illinois, New York, Pennsylvania, Rhode Island and Texas moved to either an administrative rate setting system or to negotiations. Of the states that responded to our previous survey, New Hampshire is the only state reporting that they have moved to competitive bidding.

Capitation Rate Adjustments

The capitation rate data that states originally submitted to us are presented in Table 5. There were extraordinary variations in the capitation rate data that states originally submitted to us, reflecting the differences in the ways states established rates. A direct comparison of these data across states would not be meaningful. In this section

we describe the kinds of adjustments that states make to address a variety of differences in expected health care costs.

Age, Sex and Region. Virtually all states adjust for age and sex, while over 70 percent make regional adjustments (Table 6). The states with the simplest demographic adjustments are Hawaii, Kentucky, New Hampshire and Pennsylvania. Hawaii has one rate per region (island), Kentucky has two statewide rates (one for AFDC/TANF recipients and the second for poverty related groups) and New Hampshire has two statewide rates (one for children under age 19 and the second for those 19 and over). Pennsylvania has two rates (one for each of the two regions in which it has managed care), with an additional rate adjustment for newborns. At the other extreme, Iowa has 108 rate cells—sixteen age/sex groupings and six regions. Kansas similarly has fifteen age/sex cells across six regions.

Health Status. Six of the thirty-six states reported risk adjusted payment systems based on health status for Medicaid, up from two in our 1998 Survey. Colorado relies on a disability payment system (DPS), which identifies and groups diagnoses that are chronic in nature and are associated with higher future costs. Maryland has implemented a risk adjustment system based on the Adjusted Clinical Groups diagnostic classification systems developed by Johns Hopkins University to risk adjust demographic rate cells. Delaware and Utah report using the Chronic Illness and Disability Payment System to adjust rates. Washington and Minnesota also indicated they were initiating risk adjustment for some of their beneficiaries. A seventh state, Michigan, reported beginning risk adjustment for the disabled.

HIV/AIDS. Some states also make adjustments in rates for HIV/AIDS patients, but the majority of states do not. Some people with HIV/AIDS are eligible for Medicaid as disabled persons and the survey was not intended to cover them. But many continue to work and thus do not qualify for SSI and remain on Medicaid as AFDC/TANF eligibles. A few states, for example, New York, report moving these patients out of managed care and paying for their services on a fee-for-service basis. Many states that did not report establishing separate rates did indicate that they had carved out HIV/AIDS drugs or all pharmacy costs.

Some states did report specific arrangements for HIV/AIDS patients. For example, Arizona makes \$525 supplemental payment for members receiving HIV/AIDS drugs each month. Maryland establishes separate rates for HIV/AIDS enrollees. Michigan provides additional funds for plans serving HIV/AIDS patients. New Jersey makes separate capitation rates for HIV/AIDS patients and pays separately for the cost of protease inhibitors. Wisconsin pays the actual cost of care for HIV/AIDS patients including pharmacy costs.

Maternity Care. Twenty-eight of the thirty-six states make separate adjustments for maternity rates (Table 7). The other states presumably account for the expected cost of maternity care in the rates for females in childbearing years. Twenty-one make direct lump-sum payments to health plans for maternity expenses in addition to paying regular capitation rates. These lump-sum payments are typically used to reimburse plans for prenatal, delivery and postpartum costs. One state (New Mexico) pays separate rates for pregnant women meeting the poverty-related eligibility standards as well as AFDC/TANF pregnant women. Eleven states pay separate rates for poverty-related

pregnant women only and eight states pay higher rates for infants and children under age one that are expected to compensate plans for the cost of the birth related expenses.

Carve-Outs. States also address the problems of high cost cases through carving out certain services in their capitated arrangements. This allows states to pay for these services separately, either on a capitated or fee-for-service basis. Carve-outs also limit the exposure of the plans from the cost associated with an unusually large number of high cost enrollees and allow states to avoid interagency or intergovernmental disputes. States carve out many kinds of services including mental health and substance abuse services, dental care, pharmacy, organ transplants, vision, private duty nursing or personal care and non-emergency transportation as well as other services (Table 8). The use of carve-outs has increased between 1998-2001. For example, of the states responding to the 2001 survey, 72.0% reported carving-out mental health services, 61.0% for substance abuse, 67.0% for dental care and 44.0% for pharmacy. Corresponding percentages in 1998 are 58.0% for mental health services, 50.0% for substance abuse, 59.0% for dental care and 29.0% for pharmacy care.

Twenty-six of the thirty-six states (72.0%) reported carving out mental health services. Most carve out mental health completely while others carve out all services beyond a certain number of visits or inpatient days. For example, Michigan carves out mental health services in excess of 20 outpatient visits in a contract year. New York covers mental health and substance abuse services up to thirty days combined for inpatient services, twenty visits and sixty visits for outpatient mental and substance abuse respectively. Any service use in excess of these limits are paid by the plan which is in turn reimbursed by the state under the state's stop loss program. Twenty-two of the

thirty-six states (61.0%) carve out substance abuse services. Again, most states carve out all substance abuse services, while some carve out all services beyond certain limits.

Twenty-four of the thirty-six reporting states (67.0%) carve out dental services. Most carve out all services; while some include selected services within their rates. For example, Colorado and West Virginia require plans to cover emergency dental services only, the rest are carved out. Massachusetts requires plans to cover emergency dental care and oral surgery performed by a physician. Texas carves out EPSDT dental services.

Sixteen states (44.0%) carve out pharmacy services. Nine carve out all pharmacy services while others such as California and Missouri carve out most HIV and AIDS drugs. Michigan carves out drugs related to behavioral health.

Disproportionate Share Hospital (DSH) Payments. Most states exclude disproportionate share hospital (DSH) payments from Medicaid capitation rates, in part because hospitals have claimed that HMOs do not pass through DSH payments in the form of higher payment rates. The 1997 Balanced Budget Amendment included provisions that require states to make Medicaid DSH payments directly to hospitals rather than its managed care entities except for payment arrangements in effect on July 1, 1997. Six states (Hawaii, Illinois, Minnesota, New York, Washington and Wisconsin) reported including DSH payments in the capitation rates (Table 9).

Graduate Medical Education. Most states exclude graduate medical education payments from their capitation rates. Eight states report including GME payments in their capitation rates (Table 9). These are Indiana, Kentucky, Massachusetts, Minnesota, New Jersey, Ohio, Washington and Wisconsin.

Reinsurance. A final adjustment to rates in some states is for reinsurance. Managed care plans in all states can in theory purchase reinsurance in the private market using funds available through their capitation payments. But some states directly offer to provide reinsurance. Typically, the actuarial value of the reinsurance is carved out of the capitation payments. Examples of a reinsurance provisions include Arizona where once a plan meets an annual deductible the state reimburses the plan at 75% of the costs above the deductible. The state will pay 85% of the cost in the case of transplants and hemophilia after the deductible. New York offers reinsurance in which the plan pays all costs for care up to \$50,000 for an individual's inpatient care per year. The plans then pay 20% (and the state 80%) between \$50,000 and \$350,000 and nothing beyond that.

Rate Standardization Methodology

Standardizing Rate Cells across All States

In order to compare capitation rates across states, adjustments were made to account for the variations in each of the areas mentioned above. These adjustments do not include changes to rates due to an initiation of new contracts, presence of or variation in stop-loss or reinsurance arrangements, unreported differences in carved-out services across states, and selection bias under capitated programs with voluntary enrollment. Once the adjustments were made to the state-submitted capitation rates, the following set of standardized rates were calculated for each state:

- Infants up to 1 year old.
- Males and females ages 1 through 13.
- Females ages 14 through 34.
- Males ages 14 through 44.
- Females ages 35 through 44.
- Males and females ages 45 through 64.

The basic idea behind the rate standardization is as follows. We first disaggregate state-submitted rate information by each year of age, sex, and region for each state. These data are used to aggregate state submitted rate information into our six groups. We then create blended rates for states with separate capitation rates for AFDC/TANF and PRW or PRC, standardize treatment of maternity care costs across states—particularly, the use of lump-sum payments for delivery expenses, and reduce rates by estimated DSH and/or GME dollar amounts for states that included DSH and/or GME payments in their capitation rates. We then use 1990 U.S. Census data on the population below 200 percent of the federal poverty level (FPL) as weights to aggregate across age, sex, and region to calculate statewide rates for each of our six groups². Finally, we make adjustments for carved out services by adding on the estimated pmpm dollar amounts of carved-out services to the appropriate rate cells.

Standardizing Eligibility Categories across States

Eight states paid separate rates for poverty-related women and/or children. For age-sex categories with separate poverty-related rates, we used a three-year average of Current Population Survey (CPS 1997, 1998, 1999) data to estimate the number of women and/or children on Medicaid who were enrolled through AFDC/TANF or poverty-related criteria and created a blended rate for each year of age, sex, and region. In order to obtain reliable estimates of the number of AFDC/TANF and poverty-related

² We used a three-year average of Current Population Survey (1997-1999) data for all adjustments that were made prior to aggregating across age, gender, and region, e.g. to calculate separate weights for AFDC/TANF and poverty related women. Since aggregation required county-level data, we used 1990 U.S. Census data to create age/sex specific population weights by county. The Actuarial Research Corporation (ARC) provided estimates of carve-out dollar amounts by the six age/sex category, and calculated population weights for these groups using 1999 and 2000 (March 2000 and 2001) Current Population Survey data. These weights take into account the de-linking of Medicaid and AFDC/TANF. We used the population weights calculated by the ARC to aggregate across the six age/sex categories to obtain statewide capitation rates.

eligibles, we used national CPS data for all but one state (Texas). State level CPS data were used to calculate blended rates for Texas since the sample size was large enough for this state (no other states with large CPS samples had separate rates for AFDC/TANF and poverty related groups).

Standardizing Treatment of Maternity Expenses across States

Adjustments were made to rates for newborns and females in childbearing years (ages 14 to 34 and 35 to 44) to incorporate these special maternity payments into standardized rate cells. The adjustments for maternity payments are intended to create comparable rates across states for the age-sex categories that were affected by these special payment arrangements and are described in detail below.

For states that paid separate lump-sum payments, we incorporated the lump-sum payment amounts into Medicaid capitation rates for females ages 14 to 34 and females ages 35 to 45. We first converted the lump-sum payment to a monthly basis and then apply these payments to the percentage of pregnant women on Medicaid within each of the two age groups. We estimated the percentage of pregnant women among females ages 14 to 34 and 35 to 44 enrolled in Medicaid using a three-year average of CPS data described above. According to the national 1997-1999 CPS data, approximately 12.4 percent of females ages 14 to 34 and 5.2 percent of females ages 35 to 44 enrolled in Medicaid were pregnant during the year. Sample sizes were too small to use state level CPS data. Monthly capitation rates for females in the two age groups were adjusted upward assuming that plans received lump-sum payments for 12.4 percent of females ages 14 to 34 and 5.2 percent of the females ages 35 to 44 enrolled.

When states paid separate rates for PRW, we created blended rates for females ages 14 to 34 and 35 to 44 by calculating a weighted average of the two rates using counts of women on Medicaid who were enrolled through AFDC/TANF and pregnant women on Medicaid enrolled through poverty-related criteria. Again, we used a three-year average of CPS data to obtain these estimates. In the case where a state paid a separate rate for all pregnant women (AFDC/TANF and PRW), we simply used the national CPS estimates of pregnant females on Medicaid for the two age groups described above to create blended rates.

For states that transferred some pregnancy expenses into newborn rates, we first estimated the amount of excess capitation, the portion of the newborn capitation attributable to pregnancy related costs, and transferred that amount to females ages 14 to 34 and 35 to 44. We used data from states that did not include maternity expenses in newborn rates to calculate “typical” differentials between rates for children less than one and children of other ages (e.g. how much more states paid for age two vs. less than age one, ages 1 to 5 vs. less than age one). We used these differentials to estimate the excess capitation for the remaining states. For example, assume that, for states without maternity adjustment, we estimated that newborns were 1.5 times as costly as children ages 1 to 2, 2.5 times as costly as children ages 1 to 5. We assumed these would be the appropriate differences in capitation rates, absent any pregnancy related expenses. We then took the difference between the newborn rate originally submitted by a state and our estimate of the newborn rate based on the capitation rate for children in the same region, and applied the excess amount to rate cells for females ages 14 to 34 and 35 to 44 using the national CPS estimates of the percentages of pregnant women on Medicaid in each of

these age groups. The effects of these maternity adjustments on capitation rates for females 14 to 44 are summarized in table 10.

Standardizing DSH and GME Exclusions

We made adjustments for DSH and GME by deducting the estimated pmpm equivalent amounts for DSH and/or GME payments for the relevant states. For states that included DSH payments, we estimated the DSH amounts incorporated in rates by first calculating the “share” of DSH spending attributable to adults and children from the ratio of 1998 Medicaid spending for adults and children to 1998 Medicaid spending—the most relevant year available—for the adults, children, and disabled combined (1998 HCFA-64 data). This amount, less a 5 percent adjustment for managed care savings, was converted to a pmpm equivalent using 1998 Medicaid enrollment counts for adults and children (1998 HCFA-2082 data).

Few states provided pmpm equivalent percents or dollar values for the costs of GME incorporated in the rates. If a state did not provide a pmpm equivalent for GME costs, we used the GME payment information collected for the 1998 survey and reduced the share of GME amounts from the standardized capitation rates³. Estimated DSH and GME deductions used in the adjustments are reported in Table 11.

Standardizing Benefit Packages across States

To adjust for differences in carve-outs (and benefit packages, if applicable), we added the pmpm equivalent amounts of the carved out services onto the standardized rates so that the carve-out adjusted rates represented capitation rates for comparable

³ For the 1998 study, a survey data on GME payments as a percentage of inpatient-care spending was used to estimate a state’s GME spending, and for each state, the portion of the GME spending attributable to AFDC/TANF adults and children were converted into pmpm equivalent amount. We took the estimated share of GME pmpm equivalent amount and reduced the standardized capitation rates by that percentage

benefit packages. The estimates for the carved out services were made by the Actuarial Research Corporation (ARC). Due to constraints in available data, estimates were limited to six service categories: (1) mental health, (2) substance abuse, (3) dental, (4) vision, (5) prescription drugs, and (6) organ transplants. The remaining services that states sometimes carve out are generally minor in terms of expenditures and should not have significant effects on our final capitation rates.

For mental health and substance abuse services, ARC used expenditure data from proprietary databases of a private employer-covered population. These data were used to calculate the amount spent on mental health and substance abuse services as a percentage of total spending. Although the populations are very different, the estimated proportions of charges attributable to mental health and substance abuse were comparable to those estimated using data from states that submitted carve-out pmpm dollar amounts. Data on dental and prescription drug expenditures were obtained from the HCFA-2082 data for AFDC/TANF child and adult populations. States with no data or unreliable data were omitted from the estimation; data from the remaining states were used to calculate spending on dental care and prescription drugs as a percentage of total spending. Prescription drug expenditures were adjusted upward to reflect increasing drug costs based on the Centers for Medicare & Medicaid Services (CMS) National Health Accounts. Finally, data on vision and organ transplant services were obtained from ARC's proprietary database of private HMO expenditures. These expenditure data were used to calculate the proportions of charges attributable to vision and organ transplant services.

when a state did not provide a pmpm equivalent amount for GME. See Holahan et al. 1999 for detail on the methodology.

We provided ARC with a matrix of carved out services similar to table 8 and data on capitation rates for each of the six rate cells described above after adjustments were made for eligibility category, maternity expenses, and DSH and GME payments. In order to estimate carve-out dollar amounts, ARC classified states into three categories based on the amount of carve-out information provided by a state for a particular service: 1) states with complete data on carve-out services and costs; 2) states with partial data on carve-out services and costs; and 3) states with no cost information on carve-out services. The estimation methods for states in the first and third categories were relatively straightforward compared with states in the second category, where the estimation involved determining the relationship between the information provided by the state and what was actually carved out.

States in the first category provided a list of services that were carved out and associated dollar amounts broken down by age or a weighted average capitation amount for a particular service. For these states, ARC used the amounts as provided and estimated the relative use of the service by the populations in each of the six age-sex cells from the appropriate donor database (HCFA-2082 or private market data). The estimated pmpm dollar amounts were distributed according to the estimated relative weights.

The second category includes states that have restrictions on what portion of a service is carved out, and/or states that only know the costs for a subgroup of the covered population. For these states, ARC estimated carve-out dollar amounts on a case-by-case basis. For example, Michigan carves out mental health services in excess of 20 outpatient visits per year, but a pmpm estimate was not available. In this case, ARC estimated the proportion of mental health costs attributable to outpatient visits in excess

of 20 visits per year using an appropriate donor database and determined the pmpm dollar amount of this carve out. This amount was distributed to the six age-sex cells using the same method as in the first case.

Finally, when a state did not provide cost information on carved-out services, ARC used the donor databases to estimate spending on the specific service relative to total spending for adults (14 years and above) and children (0 to 13 years). ARC then applied the resulting percentage to the capitation rates to obtain pmpm estimates for the carved out service for adults and children. Relative spending ratios within adult and child rate cells were used to distribute the estimated pmpm dollar amounts to the four adult and two child rate cells, except when a state used a single rate. For states with a single rate, the estimated carve-out amounts were smoothed across all age groups.

Table 12 presents ARC's estimates of the costs of carve-out services. The upper panel provides a weighted average of carve-out rates for those states that submitted carve-out pmpm data, while the lower panel is for states that indicated they carved out the service but did not provide cost information. We used a two-year average of CPS (2000, 2001) data on non-SSI Medicaid recipients to weight the carve-out rates across states to produce the estimates in Table 12. The carve-out amounts were generally comparable in these two groups, with the exception of pharmacy costs. The estimates of pharmacy carve-out rates for states that did not provide data are consistently higher than states that did submit cost information. However, since only California, New Jersey, and North Carolina provided pmpm estimates for their pharmacy carve-outs, the weighted average of carve-out rates for these three states may not be representative of other states.

Moreover, the differences are small in magnitude compared with the capitation rates and are not likely to affect our results.

Payment Rates

The basic results of these various adjustments are presented in Tables 13 and 14. Table 13 provides data for each of the six categories for all states that provided data. The table shows that the highest rates were for newborns and the lowest for children ages one to thirteen. Recall that we attempted to exclude the cost of childbirth from the newborn rates. While the adjustment was inevitably imperfect, the end result was an average capitation rate for newborns of \$251. The average rate for children ages one to thirteen was \$93. For females in the prime childbearing years (14-34 years of age) the average rate after adjustment for the various ways states treat maternity expenses was \$219. The greatest variation among states was for newborns with a coefficient variation of .46. The least variation was among females ages 14-34 where the coefficient variation was .29. Stated differently, there was about a tenfold variation in rates for newborns and about a threefold variation for females 14-34.

Table 14 provides statewide average capitation rates. We compute the statewide averages in two ways. The first uses population weights based on the actual distribution by age and sex of each state's Medicaid population (AFDC/TANF and poverty-related groups), as shown on the 2000-2001 CPS. The second uses national weights. The latter eliminates any differences in the statewide average that would be caused by the different composition of the Medicaid populations within the state. The table shows that there is slightly more than a twofold variation in the aggregate statewide Medicaid capitation rates. (This is somewhat less than the variation in Medicaid acute care spending for

adults and children, which varies by a factor of almost three.⁴) Using national weights, the states with the highest rates are the District of Columbia, Kentucky, Minnesota, New Mexico, North Carolina and North Dakota. States with the lowest rates are Florida, Kansas, Michigan, Oklahoma and Texas.

In general, states with a high proportion of children will have lower rates when state weights rather than national weights are used and vice versa. For example, states like Arizona and New Mexico have lower rates when state weights rather than national weights are used. In both states, over 50% of their Medicaid caseload were children between the ages of 1-13. Less than 10% are adults over the age of 45. In contrast, in states like Virginia and Kansas, over 25% of their caseloads are adults over the age of 45 while only about 40% are children between the ages of 1 and 13. In these states, capitation rates are higher when state weights rather than national weights are used.

Table 15 provides data on the within-state variation in rates for those states that establish rates for sub-state areas. We found that 22 of the 36 states had sub-state rates, varying from six states that had two regions (Colorado, Delaware, Illinois, Maryland, Nevada and Pennsylvania) to California and Washington that have twelve and Ohio and Wisconsin with fourteen. In some cases the variation was relatively large, e.g. 36% in Connecticut, 30% in Maryland and 28% in Texas. At the other extreme, there was only a 1% variation between the two regions in Colorado, less than a 1% in Illinois and Nevada.

It is important to be able to compare Medicaid rates not only among states but also with some other benchmarks. For example, it would be useful to know whether these rates are low relative to alternative rates available to commercial managed care plans. If one of the objectives of Medicaid managed care is to increase the number of

⁴ Urban Institute estimates from HCFA-2082 data for 1998.

plans willing to participate in Medicaid managed care, then the level of Medicaid rates relative to the private market is important. Unfortunately data on private market capitation rates for commercial plans for non-elderly populations are not available in any useful way. There is no way of knowing whether benefit packages and covered populations are comparable. Neither is Medicaid fee-for-service data available to compare with capitation rates. The most recent data on Medicaid fee-for-service acute care expenditures that is available is 1998 and the data does not allow us to examine fee-for-service expenditures for the same populations (AFDC/TANF and poverty related groups) for which we have capitation rate data.

We can make useful comparisons by using Medicare data, under the assumption that although Medicare expenditures are clearly higher than for a Medicaid or private non-elderly population, they should be generally reflective of the relative variations among states in fee-for-service expenditures. If the variation in Medicare rates is highly correlated with the variation in private sector rates, it will be indicative of the relative adequacy of Medicaid rates compared to commercial rates. Prior to the Balanced Budget Act (BBA), Medicare rates were based on county level fee-for-service expenditures. Since the BBA, there has been a 2% limit (in most years) on growth in rates in high cost counties and a floor in low cost counties. Thus, this is not as clear a comparison as one would like but is probably the best available. To make these comparisons we used the county level Medicare adjusted average per capita cost, or AAPCC. We used weights only for those counties for which states provided us Medicaid rates; i.e., only those counties with fully capitated MMC.

The results are shown in Table 16. Column 1 provides the state weighted Medicaid managed care rates shown in Table 14. Column 2 provides the same data in the form of index numbers calculated by taking the ratio of the state-wide Medicaid managed care rate to the 50th percentile. Thus, Arizona has a ratio of 0.87, indicating that its Medicaid rates are 13% below the national median rate. On the other hand, Minnesota has a ratio of 1.34, indicating that its rates are 34% above the national median rate. The Medicare rates shown in Column 3 will reflect differences in the demographic composition of the counties' Medicare populations as well as in expenditures for the fee-for-service population. The Medicare rates in all cases are, not surprisingly, above the Medicaid capitation rates. Column 4 provides a set of index numbers again comparing each state's average Medicare rates with the 50th percentile of Medicare rates. Column 4 shows California and the District of Columbia are 23% and 25% above the national average while Iowa, New Mexico and Utah are 15% below.

We then computed ratios of the two index numbers. These ratios, shown in column 5, are the same algebraically as computing the Medicaid/Medicare rates for a state comparing the result to the average (median) Medicare/Medicaid ratio for the nation. These ratios indicate whether a state's Medicaid capitation rates are high relative to Medicare rates. For example, if the state has a relatively low index for Medicaid but a high index for Medicare, the Medicaid to Medicare ratio would be relatively low and Medicaid rates would arguably be low relative to the market. On the other hand, if the Medicaid/Medicare ratio was relatively high, Medicaid rates would seem to be quite adequate.

The results show a very low correlation between Medicaid and Medicare rates. The underlying assumption is that the Medicare rates generally vary with costs in the market. States whose Medicaid rates are in line with the market would be expected to have relative indices close to 1.00 (column 5), say between .90 and 1.10. States that have values above 1.10 could be thought of as having high Medicaid rates and those below .90 as having low Medicaid rates. For example, Connecticut, D.C., Maryland, Massachusetts, Ohio and Rhode Island all have Medicaid and Medicare rates which are above the national median, thus high Medicaid rates but high cost markets. On the other hand, Colorado, Kansas, South Carolina, Utah and Wisconsin all have low Medicaid rates but also have low cost markets. Iowa, Minnesota, New Hampshire, North Carolina and Virginia each have Medicaid rates which are above the median but Medicare rates which are below the median; clearly Medicaid rates would appear relatively high in these states. States which have Medicaid below the median but Medicare rates which are above may face issues of rate adequacy; these are Arizona, California, Florida, Illinois, Michigan, New Jersey, New York, Nevada, Pennsylvania and Texas.

Table 17 provides data for both 1998 and 2001, using the same CPS data to weight rates across the six population groups and across regions.⁵ We use the same weights so that changes in covered populations would not distort the comparisons. We provide similar data on changes in the Medicare rates for each state using only the counties that have Medicaid managed care. Again, we use the Census weights to aggregate the Medicare rates across counties.

⁵ 1998 and 2001 rates are calculated using the same weights: we used 1990 U.S. Census data to aggregate across counties and then used 1999 and 2000 (March 2000 and 2001) Current Population Survey data to aggregate across the six age/sex categories.

There are a number of interesting findings in this table. First, the average increase in Medicaid rates was about 18%, slightly under 6% per year. Five states reported reductions in rates over this period (Colorado, Hawaii, New Jersey, North Dakota and Texas). On the other hand, thirteen states have rates of growth in Medicaid capitation rates in excess of 20%. It seems that a large number of states took advantage of strong economic conditions to increase provider payment rates. It could well be that these states were faced with a number of plans in financial distress. The fear of lower plan participation could have resulted in some of the large rate increases.

Medicare rate increases averaged about 10% over the period, roughly half the rate of increase of Medicaid rates or more. This low rate of growth in Medicare rates is related to the controls in the 1997 BBA on fee-for-service spending and somewhat to the change in the payment structure for Medicare+Choice Plans. Twenty-one of the 32 states in which we have data in both years had Medicaid rate increases that exceeded the increases in Medicare rates. Another point of comparison is the increase in Medicare spending per enrollee for Medicare+Choice enrollees, which provides an estimate of the growth in Medicare managed care spending (without being limited to counties with MMC). Data computed by the Center for Studying Health System Change shows that Medicare+Choice spending increased by 15.1 percent between 1998 and 2001 (Grossman et al. 2002).

While Medicaid rates grew faster than Medicare rates during this period, they did not grow as fast as commercial premiums. Data from Kaiser/HRET annual surveys, while not adjusted for changes in population characteristics or benefits, shows a 26.0

percent increase in rates over the same period⁶. Analysis of the same data by the Center for Studying Health System Change, limiting to the estimates to firms with more than 200 workers, revealed an increase of 23.7 percent⁷.

Conclusion

In this paper we have shown that 13.0 million or 36.6% of Medicaid beneficiaries are in full-risk managed care arrangements. Seventeen states now have more than 50% of their Medicaid enrollees on a full-risk managed care plan. The number of people in full-risk managed care plans grew by 41% between June 1997 and June 2001. Twenty states had increases of over 35% in their capitated managed care enrollment. At the same time, there were declines in enrollment in a number of states as well. Four states ended their full-risk managed care programs and five others experienced significant reductions in Medicaid managed care (full-risk) enrollment.

There remains considerable variation in how states set rates. Nineteen of the thirty six states continue to simply establish rates that are available to any plan meeting state standards and willing to participate. Seven other states negotiated rates, where ten states used competitive bidding. The number of states using competitive bidding fell from fourteen states in 1998.

There was significant movement towards sophisticated risk adjustment payment systems using health status measures in our states between 1998 and 2001. Colorado and Maryland continued with the systems they had in 1998, while Delaware, Minnesota,

⁶ Data from “Exhibit 3.3: Increases in Employer Health Insurance Premiums Compared to Increases in Overall Inflation and Workers’ Earnings, 1989-2001.” in Williams, C., Treloar, J., Lundy, J., Levitt, L., and Wang, J. 2002. “Trends and Indicators in the Changing Health Care marketplace, 2002.” Washington, D.C.: Kaiser Family Foundation. Chartbook May 2002.

⁷ Data from “Figure 1: Trends in M+C Spending, Commercial Premiums and Commercial Health Care Costs, 1994-2001.” in Grossman, J.M., Strunk, B.C., and Hurley, R.E. 2002. “Reversal of Fortune:

Utah, and Washington initiated new systems. There are many other ways that plans can adjust for risk. At the most basic level, plans adjust for age and sex. Some states adjust in some manner for maternity expenses and a few make adjustments for HIV/AIDS patients. A large number of states carve out specific services, particularly mental health, substance abuse, dental care and prescription drugs. Carve outs are often employed because managed care plans have difficulty in providing the services, but they also serve the purpose of protecting the plans against unusual risks.

The results on capitation rates show a twofold variation among states, for several reasons. First, capitation rates generally reflected existing fee-for-service expenditures. Since there are considerable variations in fee-for-service expenditures, this has translated into variation in Medicaid capitation rates. Some states have attempted to control fee-for-service expenditures to minimize costs, while others have been more generous. Some states are also limited by the upper payment limit which constrains capitation rates to be no greater than a state's fee-for-service payments for comparable populations. If states have low fee-for-service payments, then it is difficult for them to increase capitation rates regardless of their objectives.

Other factors are also important. For example, if a state has relatively strict eligibility criteria or if enrollment is difficult, it could lead to adverse selection; that is the state has a less healthy group of beneficiaries. As a result, utilization and therefore expenditures will be higher and this will affect the fee-for-service base on which the capitation rates are established. States with a mix of PCCMs and HMOs may also find that there is favorable selection into the HMOs and adjust rates downward to compensate.

Medicare+Choice Collides with Market Forces.” Washington, D.C.: Center for Studying Health System Change. Issue Brief No. 52.

In some states, Medicaid managed care is predominantly in urban areas. Such states tend to have higher rates than states where enrollment is distributed throughout the state.

The adequacy of Medicaid managed care rates is a major issue to states, Medicaid managed care plans and Medicaid beneficiaries. These data will hopefully provide information that will allow observers to be better informed on the issue. But the results by themselves do not answer the question of rate adequacy as it relates to plan participation. The reasons for the entry and exit of plans are complex. There seems little doubt that the level of rates, as well as the way states adjust for risk will affect the willingness of managed care plans to serve the Medicaid clientele. It seems clear that a number of other factors matter as well. We discussed these in our previous report and they merit being repeated.

The first factor that determines the adequacy of a set of rates is the history of managed care in the state. In a state that has many plans and a highly competitive commercial market it is likely that more plans will be willing to participate in Medicaid at a given level of rates, all else being equal. On the other hand, if managed care is relatively new and there is relatively little competition, rates would have to be higher to attract the entry of a sufficient number of plans.

Second, the adequacy of rates depends on the plans' ability and willingness to adapt to the product being purchased by the state. The cost of health care is not simply exogenous. Managed care plans have some flexibility in adapting the product to serve the Medicaid population, e.g. the number of providers in a network, utilization controls and provider payment rates. The willingness to adapt the product may be limited by concerns about how the plan will be viewed in the broader commercial and Medicare

markets or that it will be identified as a “Medicaid plan.” A plan obtaining the reputation for providing limited access in the Medicaid market may be tarnished in its ability to compete elsewhere.

Third, rate adequacy will be affected by the amount of excess provider capacity in the states. Plans that can take advantage of an excess supply of doctors and hospitals and negotiate lower provider payment rates will be more likely to accept lower capitation rates from the state. In states where these conditions do not exist, plans will not be able to negotiate low provider payment rates and capitation rates will have to be higher to allow plans to cover those costs.

Fourth, the degree of Medicaid managed care regulation will affect the adequacy of rates. The more regulation the higher the cost of doing business as a managed care plan. Rates will have to be higher in “high regulation” states to attract a sufficient number of plans.

Fifth, other state policies can affect how plans will view the rates. For example, states that make a high level of disproportionate share payments to hospitals will probably be able to pay lower capitation rates. Hospitals will be able to accept lower rates from managed care plans because they are receiving Medicaid revenues from other sources. All of these reasons suggest that the reported level of rates should not be used to suggest that one state’s rates are adequate and another’s are not.

In constructing these rates we had to make a number of estimates and adjustments. For example, we adjusted for maternity costs, GME, DSH and several carve-outs. We did not adjust for the use of stop-loss arrangements. To the extent there were errors in these adjustments and key differences in the factors that are not accounted

for, the rates we report will be affected. However, we do not expect these problems to be large. An additional caveat is that these rates apply to only AFDC/TANF and poverty-related groups and do not reflect the relative payment that states make to other population groups.

Despite these caveats, the results show more than a twofold variation among states in rates, as they did in 1998, for fairly comparable populations. Even if our various adjustments were perfect that reality would not be much changed. The key issue is whether the rates that states are paying yield satisfactory levels of plan participation, beneficiary access and quality of care. If states with low rates have plenty of plans participating and no issues of access or quality, its rates can be presumed to be adequate. But most likely states are getting what they paid for, in terms of the number and the kinds of plans participating, in beneficiary access and quality of care. States with low rates are probably not buying the same product as states with higher rates. The implications of these product differences for beneficiary access, quality of care and health are beyond the scope of the study.

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Table 1 *Medicaid Managed Care Penetration by State, June 30, 2001*

State	Total Medicaid Enrollment (thousands)	Medicaid Managed Care Enrollment (thousands)			Managed Care Penetration (%)	
		Total	PCCM	Full-Risk (# Plans)	PCCM	Full-Risk
Alabama	652.4	318.5	318.5	0.0 (0)	49	0
Alaska	115.6	0.0	0.0	0.0 (0)	0	0
Arizona	549.3	491.2	0.0	491.2 (15)	0	89
Arkansas	443.6	257.7	257.7	0.0 (0)	58	0
California	5,487.1	2,859.6	21.2	2,838.5 (30)	0	52
Colorado	268.7	175.4	52.9	122.5 (5)	20	46
Connecticut	331.3	239.8	0.0	239.8 (4)	0	72
Delaware	102.0	83.4	0.0	83.4 (2)	0	82
District of Columbia	123.7	77.5	0.0	77.5 (5)	0	63
Florida	1,923.1	1,160.9	635.2	525.7 (14)	33	27
Georgia	1,040.6	629.2	629.2	0.0 (0)	60	0
Hawaii	163.2	118.0	0.0	118.0 (6)	0	72
Idaho	133.7	37.9	37.9	0.0 (0)	28	0
Illinois	1,455.6	136.5	0.0	136.5 (5)	0	9
Indiana	616.8	433.0	323.5	109.5 (3)	52	18
Iowa	233.2	108.6	49.6	59.1 (4)	21	25
Kansas	205.3	118.2	72.4	45.9 (1)	35	22
Kentucky	607.7	422.2	301.9	120.2 (1)	50	20
Louisiana	826.0	56.5	56.5	0.0 (0)	7	0
Maine	222.3	96.1	96.1	0.0 (0)	43	0
Maryland	616.7	421.4	0.0	421.4 (6)	0	68
Massachusetts	954.8	616.2	424.0	192.2 (4)	44	20
Michigan	1,137.6	704.0	0.0	704.0 (21)	0	62
Minnesota	501.8	326.2	0.0	326.2 (8)	0	65
Mississippi	586.0	297.9	297.9	0.0 (0)	51	0
Missouri	839.6	378.8	0.0	378.8 (9)	0	45
Montana ¹	73.2	47.0	47.0	0.0 (0)	64	0
Nebraska	201.5	63.4	28.0	35.3 (2)	14	18
Nevada	124.3	47.5	0.0	47.5 (3)	0	38
New Hampshire	78.6	6.2	0.0	6.2 (1)	0	8
New Jersey	759.2	459.1	0.0	459.1 (6)	0	60
New Mexico	331.8	212.5	0.0	212.5 (3)	0	64
New York	2,803.5	712.2	16.1	696.2 (29)	1	25
North Carolina	959.1	674.1	625.7	48.4 (4)	65	5
North Dakota	43.8	25.5	25.1	0.4 (1)	57	1
Ohio	1,293.4	277.6	0.0	277.6 (9)	0	21
Oklahoma	442.4	299.3	136.9	162.4 (4)	31	37
Oregon	413.0	254.3	14.7	239.7 (15)	4	58
Pennsylvania	1,369.2	1,031.4	171.4	860.0 (8)	13	63
Rhode Island	163.0	111.6	0.0	111.6 (3)	0	68
South Carolina	644.3	41.7	14.0	27.7 (1)	2	4
South Dakota	81.8	62.9	62.9	0.0 (0)	77	0
Tennessee	1,426.6	1,426.6	0.0	1,426.6 (8)	0	100
Texas	1,821.6	649.7	222.2	427.6 (14)	12	23
Utah	138.6	91.7	8.7	83.0 (4)	6	60
Vermont	128.6	78.2	78.2	0.0 (0)	61	0
Virginia	475.7	291.8	134.9	156.8 (6)	28	33
Washington	766.4	477.6	4.2	473.4 (9)	1	62
West Virginia	264.1	122.2	79.3	42.9 (2)	30	16
Wisconsin	514.7	206.1	0.0	206.1 (15)	0	40
Wyoming	39.7	0.0	0.0	0.0 (0)	0	0
United States	35495.9	18235.1	5243.7	12991.5 (290)	14.8%	36.6%

Source : Urban Institute analysis of data from the Health Care Financing Administration (Centers for Medicare & Medicaid Services).

Notes : Total unduplicated Medicaid enrollment figures include individuals enrolled in State health reform programs that expand eligibility beyond traditional Medicaid eligibility standards. PCCM = primary care case management. # Plans = Number of participating health plans.

1/ Montana ended its full-risk program on June 30, 2000.

State	PCCM Enrollment (thousands)			Full-Risk Enrollment (thousands)		
	1997	2001	Change 1997-2001 (%)	1997	2001	Change 1997-2001 (%)
Alabama	130.8	318.5	143.5%	0.0	0.0	0.0%
Alaska	0.0	0.0	0.0%	0.0	0.0	0.0%
Arizona	0.0	0.0	0.0%	349.1	491.2	40.7%
Arkansas	159.5	257.7	61.6%	0.0	0.0	0.0%
California	130.5	21.2	-83.8%	1,700.5	2,838.5	66.9%
Colorado	56.1	52.9	-5.7%	70.0	122.5	74.9%
Connecticut	4.8	0.0	-100.0%	227.2	239.8	5.6%
Delaware	0.0	0.0	0.0%	65.1	83.4	28.2%
District of Columbia	33.6	0.0	-100.0%	47.2	77.5	64.4%
Florida	536.3	635.2	18.4%	360.2	525.7	45.9%
Georgia	532.1	629.2	18.3%	25.7	0.0	-100.0%
Hawaii	0.0	0.0	0.0%	134.7	118.0	-12.4%
Idaho	32.4	37.9	16.9%	0.0	0.0	0.0%
Illinois	0.0	0.0	0.0%	187.0	136.5	-27.0%
Indiana	125.0	323.5	158.8%	95.0	109.5	15.3%
Iowa	59.0	49.6	-15.9%	29.3	59.1	101.6%
Kansas	79.2	72.4	-8.6%	15.3	45.9	200.6%
Kentucky	268.2	301.9	12.6%	0.0	120.2	-
Louisiana	40.5	56.5	39.7%	0.0	0.0	0.0%
Maine	11.4	96.1	741.8%	1.1	0.0	-100.0%
Maryland	234.4	0.0	-100.0%	113.2	421.4	272.1%
Massachusetts	312.8	424.0	35.5%	104.8	192.2	83.4%
Michigan	461.2	0.0	-100.0%	404.3	704.0	74.1%
Minnesota	0.0	0.0	0.0%	168.1	326.2	94.0%
Mississippi	75.2	297.9	296.3%	6.1	0.0	-100.0%
Missouri	0.0	0.0	0.0%	264.5	378.8	43.2%
Montana ¹	43.4	47.0	8.3%	1.8	0.0	-100.0%
Nebraska	19.0	28.0	47.6%	19.1	35.3	85.3%
Nevada	23.7	0.0	-100.0%	2.7	47.5	1665.8%
New Hampshire	0.0	0.0	0.0%	9.1	6.2	-31.9%
New Jersey	0.0	0.0	0.0%	384.6	459.1	19.4%
New Mexico	77.9	0.0	-100.0%	61.4	212.5	246.0%
New York	24.1	16.1	-33.5%	627.8	696.2	10.9%
North Carolina	351.0	625.7	78.3%	0.0	48.4	-
North Dakota	24.3	25.1	3.4%	0.0	0.4	-
Ohio	0.0	0.0	0.0%	352.8	277.6	-21.3%
Oklahoma	0.0	136.9	-	175.3	162.4	-7.4%
Oregon	0.0	14.7	-	287.4	239.7	-16.6%
Pennsylvania	258.6	171.4	-33.7%	611.8	860.0	40.6%
Rhode Island	0.0	0.0	0.0%	70.9	111.6	57.3%
South Carolina	8.9	14.0	57.5%	5.4	27.7	412.0%
South Dakota	41.5	62.9	51.4%	0.0	0.0	0.0%
Tennessee	0.0	0.0	0.0%	1,188.6	1,426.6	20.0%
Texas	123.3	222.2	80.2%	152.7	427.6	180.1%
Utah	20.3	8.7	-57.1%	73.5	83.0	12.8%
Vermont	0.0	78.2	-	22.9	0.0	-100.0%
Virginia	191.9	134.9	-29.7%	114.9	156.8	36.5%
Washington	6.7	4.2	-37.2%	455.9	473.4	3.8%
West Virginia	79.3	79.3	0.0%	46.2	42.9	-7.1%
Wisconsin	0.3	0.0	-100.0%	204.9	206.1	0.6%
Wyoming	0.0	0.0	0.0%	0.0	0.0	0.0%
United States	4,577.1	5,243.7	14.6%	9,238.3	12,991.5	40.6%

Source : Urban Institute analysis of data from the Health Care Financing Administration (Centers for Medicare & Medicaid Services).

Notes : Total unduplicated Medicaid enrollment figures include individuals enrolled in State health reform programs that expand eligibility beyond traditional Medicaid eligibility standards. PCCM = primary care case management.

1/ Montana ended its full-risk program on June 30, 2000.

Table 3 *Managed Care Program Enrollment Type, January 2001*

States	Mandatory HMO Program Only		Mandatory PCCM Program Only		Mixed Mandatory Managed Care (PCCM or HMO) Programs Only ¹		Voluntary Managed Care (PCCM and/or HMO) Programs Only	
	Statewide	Selected Counties	Statewide	Selected Counties	Statewide	Selected Counties	Statewide	Selected Counties
Alabama			X					
Arizona	X							
Arkansas			X					
California		X				X		X
Colorado				X		X		
Connecticut	X							
Delaware	X							
District of Columbia	X							
Florida				X		X		
Georgia			X					
Hawaii	X							
Idaho				X				X
Illinois								X
Indiana					X			
Iowa		X		X		X		
Kansas				X		X		
Kentucky		X		X		X		
Louisiana				X				
Maine			X					
Maryland	X							
Massachusetts					X			
Michigan	X							
Minnesota		X						
Mississippi			X					
Missouri		X						
Montana				X				
Nebraska						X		
Nevada		X						X
New Hampshire							X	
New Jersey	X							
New Mexico	X							
New York ²		X				X		X
North Carolina		X		X		X		
North Dakota				X		X		
Ohio		X						X
Oklahoma		X		X				
Oregon	X							
Pennsylvania		X		X		X		
Rhode Island	X							
South Carolina								X
South Dakota			X					
Tennessee	X							
Texas		X		X		X		
Utah		X						X
Vermont			X					
Virginia		X		X		X		
Washington		X						X
West Virginia		X		X		X		
Wisconsin ²		X						X
Totals	12	17	7	15	2	14	1	10

Source: Urban Institute 2001.

Notes: States were asked to provide county-level data for these various types of Medicaid managed care programs. The columns indicate the type of program(s) currently operational in each state. For example, states in column 1 have only mandatory HMO programs operating in the state as of January 2001. HMO = health maintenance organization, PCCM = primary care case management. Alaska and Wyoming are not included in the table because they do not have managed care.

¹ A state is categorized as having a mixed mandatory managed care if it has a county with one of the following program combinations: a) mandatory HMO and mandatory PCCM; b) mandatory HMO and voluntary PCCM; or c) mandatory PCCM and voluntary HMO.

² Some counties have both mandatory and voluntary HMO due to zip code implementation.

Table 4 <i>Approaches to Establishing Rates</i>				
State	Administered	Negotiated	Competitive Bidding	Future Updating Process
Arizona			X	Rebids rates every five years with a review of cost utilization, program changes, and inflation trends for rate increases in renewal years.
California	X			Sets rates on an annual basis.
Colorado	X			Sets rates on an annual basis using health-based risk-adjustment system.
Connecticut		X		Negotiates rates with each plan.
Delaware	X			Sets rates on an annual basis.
District of Columbia			X	Rebids and negotiates rates every two years.
Florida	X			Sets rates on an annual basis.
Hawaii			X	State sets rate ranges for competitive bidding. Contracts are for three years with a possibility of interim adjustments and/or extensions.
Illinois		X		Negotiates rates every two to three years.
Indiana			X	Competitively bids every two years and conduct annual rate adjustments based on medical component of the consumer price index or negotiation.
Iowa	X			Sets rates on an annual basis.
Kansas	X			Sets rates (generally) on an annual basis.
Kentucky		X		Negotiates rates on an annual basis.
Maryland	X			Sets rates on an annual basis. Enrollee with more than 6 months of medical history are placed in risk adjusted rate categories based on Adjusted Clinical Groups.
Massachusetts		X		Negotiates rates on an annual basis.
Michigan			X	Rebids rates on a periodic basis.
Minnesota	X			State sets and negotiates rates on annually or biannually.
Missouri			X	Rebids rates every two years with annual interim adjustments for inflation.
Nevada	X			Sets rates on an annual basis.
New Hampshire			X	Rebids and negotiates rates every year unless extensions are approved.
New Jersey	X			Sets rates on an annual basis.
New Mexico			X	Rebids rates every two years with possibility of interim adjustments.
New York		X		Negotiates or adjusts for inflation on an annual basis.
North Carolina	X			Sets rates on an annual basis then negotiates with each plan.
North Dakota		X		Renegotiates rates every two years.
Ohio	X			State sets rates every 6 months to a year, or when known changes occur in benefits or FFS provider rate.
Oklahoma			X	Rebids rates on an annual basis.
Pennsylvania	X			Sets rates on an annual basis. HMOs are given opportunity to comment on the rates.
Rhode Island		X		Negotiates rates on an annual basis.
South Carolina	X			Sets rates on an annual basis.
Texas	X			Sets rates on an annual basis.
Utah	X			Sets rates on an annual basis with input from plans.
Virginia	X			Sets rates on an annual basis.
Washington			X	Rebids rates on an annual basis.
West Virginia	X			Sets rates on an annual basis.
Wisconsin	X			Sets rates on an annual basis.
Totals (36)	19	7	10	
Percent	53%	19%	28%	

Note: Three states with capitated MMC (Nebraska, Oregon, and Tennessee) did not respond to the survey.

State (Region)	First Submitted Age/Sex Group and Rate	Second Submitted Age/Sex Group and Rate	Third Submitted Age/Sex Group and Rate	Fourth Submitted Age/Sex Group and Rate	Fifth Submitted Age/Sex Group and Rate
Arizona (#1) ¹	<1 M/F \$331	1-13 M/F \$75	14-44 F \$131	14-44 M \$96	45+ M/F \$228
Arizona (#5) ¹	<1 M/F \$311	1-13 M/F \$70	14-44 F \$117	14-44 M \$90	45+ M/F \$225
California (Los Angeles)	AFDC/TANF All (Local Initiative) \$97	PRW (Local Initiative) \$895	AFDC/TANF All (Commercial Plan) \$92	PRW (Commercial Plan) \$886	
Colorado (Denver)	AFDC/TANF Child \$45	AFDC/TANF Adult \$164	PRC \$58	PRW \$191	
Connecticut ² (New Haven)	<1 M/F \$544	1-14 M/F \$99	15-39 F \$208	15-39 M \$124	40+ F \$219
Delaware (New Castle)	<1 M/F \$399	1-10 M/F \$59	11-17 F \$88	11-17 M \$51	18-44 F \$187
District of Columbia ³	<1 M/F \$460	1-2 M/F \$78	13-18 F \$157	19-36 F \$230	All Others \$162
Florida (#1,#2)	<1 M/F \$243	1-5 M/F \$56	6-13 M/F \$37	14-20 F \$111	14-20 M \$42
Florida (#11)	<1 M/F \$366	1-5 M/F \$83	6-13 M/F \$55	14-20 F \$167	14-20 M \$64
Hawaii (Kauai)	All \$137				
Illinois (Cook) ⁴	0-2 F \$259	0-2 M \$306	3-13 F \$41	3-13 M \$51	14-20 F \$173
Indiana (Central) ¹	0-11 mo. M/F \$346	1-5 M/F \$75	6-12 M/F \$62	13-20 M/F \$92	21-64 F \$198
Iowa (#1) ⁵	0-59 days F \$1,096	0-59 days M \$1,432	60-364 days F \$142	60-364 days M \$142	1-4 F \$56
Kansas (Wyandotte) ⁶	<1 M/F \$430	1-5 F \$37	1-5 M \$41	6-14 F \$33	6-14 M \$32
Kentucky (#3)	AFDC/TANF All \$151	PR All \$210			
Maryland (Baltimore City) ⁷	<1 M/F \$206	1-5 F \$78	1-5 M \$99	6-14 F \$71	6-14 M \$91
Massachusetts (state)	All \$173				
Michigan (#1) ¹	AFDC/TANF All \$97				
Michigan (#10) ¹	AFDC/TANF All \$96				
Minnesota (Hennepin)	<1 F \$793	<1 M \$900	1-2 F \$174	1-2 M \$198	2-15 F \$90
Missouri (state) ⁸	AFDC/TANF <1 M/F \$486	AFDC/TANF 1-6 M/F \$79	PRC 0-6 M/F \$155	AFDC/TANF 7-13 M \$86	AFDC/TANF 14-20 \$102
Nevada (state)	<1 M/F \$322	1-6 M/F \$60	7-13 M/F \$57	14-44 F \$124	14-44 M \$99
New Hampshire (state)	<19 M/F \$166	19-64 M/F \$143			
New Jersey (state)	<1 M/F \$405	1-2 M/F \$113	F 2-14 & M 2-20 \$60	15-44 F \$140	21-44 M \$121
New Mexico ¹	AFDC/TANF <2 mo. M/F \$2,910	PRC <2 mo. M/F \$944	All 2-11 mo. M/F \$272	All 1-5 M/F \$98	All 6-14 M/F \$116
New York (state)	<6 mo. M/F \$201	6 mo.-14 yr. F \$77	6 mo.-20 yr. M \$84	15-20 F \$173	AFDC/TANF 21-64 M/F \$193
North Carolina (state)	<1 M/F \$288	1-5 M/F \$48	6-13 M/F \$29	14-20 F \$87	14-20 M \$65
North Dakota (state)	AFDC/TANF 0-1 F \$165	AFDC/TANF 0-1 M \$240	PRC 0-1 F \$343	PRC 0-1 M \$242	AFDC/TANF 2-5 F \$65
Ohio (Butler)	<1 M/F \$445	1 M/F \$101	2-13 M/F \$67	AFDC/TANF 14-44 \$189	PR 14-18 F \$108
Oklahoma (Central)	<1 M/F \$301	1-5 M/F \$65	6-14 M/F \$93	15-20 F \$114	15-20 M \$121
Pennsylvania (Southeast)	All \$136				
Rhode Island (state)	<1 M/F \$262	1-5 M/F \$75	6-14 M/F \$63	15-44 F \$177	15-44 M \$113
South Carolina (state) ⁶	<1 M/F \$313	1-6 M/F \$44	7-13 M/F \$29	14-18 F \$52	14-18 M \$38
Texas (Travis) ¹	0-1 M/F \$391	AFDC/TANF Child \$57	PRC \$73	PRW \$165	AFDC/TANF Adult \$108
Utah (state) ⁹	<1 M/F \$260	AFDC/TANF 1-21 F \$59	AFDC/TANF 1-21 M \$63	AFDC/TANF 21-64 \$151	AFDC/TANF 21-64 \$160
Virginia (Northern)	<1 M/F \$342	1-5 M/F \$84	6-14 M/F \$53	15-20 F \$170	21-44 F \$259
Washington (#1)	<1 M/F \$295	1-5 M/F \$73	6-18 F \$78	6-18 M \$52	19-34 F \$246
Washington (#12)	<1 M/F \$314	1-5 M/F \$78	6-18 F \$83	6-18 M \$56	19-34 F \$261
West Virginia	<1 M/F \$352	1-4 M/F \$66	5-14 M/F \$49	15-24 F \$100	25-49 F \$127
Wisconsin (#1)	AFDC/TANF All \$114	PRW \$527			
Wisconsin (#10)	AFDC/TANF All \$133	PRW \$636			

Notes: M = male, F = female, AFDC/TANF = Aid to Families with Dependent Children/Temporary Assistance for Needy Families, PRW = poverty-related pregnant women, PRC = poverty-related children.

1) Unweighted averages of health plan specific rates.

2) Connecticut paid a lump-sum payment to cover maternity expenses in 1998, but not in 2000.

3) The capitation rates are unweighted averages of health plan specific rates. Redefining of rate cells in 2001 resulted in a significant increase in the capitation rates paid for children ages 3-12.

4) Illinois has separate rates for TANF-MANG (medical assistance no grant) population.

5) The capitation rates are unweighted averages of health plan specific rates. Newborn rate is significantly higher in 2001 compared to 1998 because Indiana did not enroll 0-60 day old infants in managed care in 1998.

6) Capitation rates for pregnant women in 2001 are lower compared to the 1998 rates but plans are paid lump-sum payment to cover maternity expenses in 2001.

7) Non-risk adjusted rate cells.

8) Missouri paid a separate capitation rate for poverty-related pregnant women in 1998, but has separate poverty-related capitation rates for male and female ages 0-20 in 2001.

9) Utah paid a separate capitation rate for non-TANF pregnant females in 2001 but not in 1998.

Table 6		<i>Description of Rate Adjustment Factors</i>		
State	Age	Sex	Region	Description of Submitted Rate Cell Ranges
Arizona	X	X	X	45 rate cells: M/F <1, M/F 1-13, F 14-44, M 14-44, M/F 45+ across 9 regions. The state provided rates for each plan participating within a region. We used an unweighted average of these plans' rates as regional rates.
California	X	X	X	24 rate cells: AFDC/TANF Adult and Child and PRW across 12 urban two-plan counties.
Colorado	X	X	X	8 rate cells: AFDC/TANF Adult, AFDC/TANF Child, PRW, and PRC across Denver and non-metro area plus risk adjustments based on Disability Payment System.
Connecticut	X	X	X	48 rate cells: M/F <1, M/F 1-14, M 15-39, F 15-39, M 40+, and F 40+ across 8 counties.
Delaware	X	X	X	7 rate cells: M/F <1, M/F 1-10, F 11-17, M 11-17, F 18-44, M 18-44, and M/F 45+ across 2 regions.
District of Columbia	X	X		5 rate cells: M/F <1, M/F 1-2 (12?), F 13-18, F 19-36, and F 37-64 & M 14-64.
Florida ¹	X	X	X	80 rate cells: M/F <1, M/F 1-5, M/F 6-13, F 14-20, M 14-20, F 21-54, M 21-54, and M/F 55+ across 10 regions.
Hawaii ²	X	X	X	4 rate cells: State provided one rate per region (island) weighted by member months.
Illinois	X	X	X	20 rate cells: F 0-2, M 0-2, F 3-13, M 3-13, F 14-20, M 14-20, F 21-44, M 21-44, F 45+, and M 45+ across 2 counties.
Indiana	X	X	X	18 rate cells: M/F 0-11 mo, M/F 1-5, M/F 6-12, M/F 13-20, F 21+, and M 21+ across 3 regions. The state provided plan-specific rates within each region. We used an unweighted average of these plan rates as regional rates.
Iowa	X	X	X	108 rate cells: F 0-59 days, F 60-364 days, F 1-4, F 5-14, F 15-20, F 21-24, F 25-34, F 35-49, F 50+, M 0-59 days, M 60-364 days, M 1-4, M 5-14, M 15-20, M 21-24, M 25-34, M 35-49, and M 50+ across 6 regions.
Kansas	X	X	X	90 rate cells: M/F <1, F 1-5, M 1-5, F 6-14, M 6-14, M 15-21, AFDC/TANF F 15-21, AFDC/TANF F 22-29, AFDC/TANF F 30-34, AFDC/TANF F 35+, PRW 15-21 & AFDC/TANF Pregnant Women <22, PRW and AFDC/TANF Pregnant Women 22-29, and PRW and AFDC/TANF Pregnant Women 30+ across 6 regions.
Kentucky			X	2 rate cells: M/F AFDC/TANF and PR.
Louisiana				
Maryland ³	X	X	X	24 demographic rate cells and 9 ACG risk adjusted cells: M/F <1, F 1-5, M 1-5, F 6-14, M 6-14, F 15-20, M 15-20, F 21-44, M 21-44, F 45+, M 45+, PRW, and 9 risk adjusted cells across 2 regions.
Massachusetts	X	X	X	1 rate cell: age, sex, and regional variations are adjusted for prior to rate negotiations with each MCO.
Michigan	X	X	X	10 rate cells: AFDC/TANF adults and children across 10 regions.
Minnesota	X	X	X	33 rate cells: F <1, F 1, F 2-15, F 16-49, F 50+, M <1, M 1, M 2-15, M 16-49, M 50+, and PRW and AFDC/TANF Pregnant Women across 3 regions.
Missouri	X	X	X	10 rate cells: AFDC/TANF M/F <1, AFDC/TANF M/F 1-6, AFDC/TANF M/F 7-13, AFDC/TANF F 14-20, AFDC/TANF M 14-20, AFDC/TANF F 21-44, AFDC/TANF M 21-44, AFDC/TANF M/F 45+, PR M/F 0-6, and PR M/F 7-20 across the state.
Nebraska				
Nevada	X	X		6 rate cells: M/F <1, M/F 1-6, M/F 7-13, F 14-20, M 14-20, F 21-44, M 21-44, and M/F 45+.
New Hampshire	X			2 rate cells: M/F <19 and M/F 19+.
New Jersey	X	X	X	6 rate cells: M/F <1, M/F 1, F 7-14 & M 7-20, F 15-44, M 21-44, and M/F 45+ across the state.
New Mexico	X	X		14 rate cells: AFDC/TANF M/F <2 mo., M/F 2-11 mo., M/F 1-5, M/F 6-14, F 15-21, M 15-21, F 22-39, M 22-29, M 30-39, M/F 40-49, M/F 50+, PR <2 mo., PRW 15-29, and PRW 30-49. The state provided plan-specific payment rates. We used an unweighted average of those rates.
New York	X	X	X	5 rate cells: State provided statewide average rate across five eligibility categories—M/F <6 mo., F 6 mo.-14, M 6 mo.-20, F 15-20, M/F 21-64—and 9 regions.
North Carolina	X	X	X	14 rate cells: AFDC/TANF M/F <1, AFDC/TANF M/F 1-5, AFDC/TANF M/F 6-13, AFDC/TANF F 14-20, AFDC/TANF M 14-20, AFDC/TANF F 21-44, AFDC/TANF M 21-44, AFDC/TANF M/F 45+, PR M/F <1, PR M/F 1-5, PR M/F 6-13, PR F 14-20, PR M 14-20, and PRW.
North Dakota	X	X		24 rate cells: AFDC/TANF F 0-1, AFDC/TANF F 2-5, AFDC/TANF F 6-11, AFDC/TANF F 12-18, AFDC/TANF F 19-21, AFDC/TANF F 22-44, AFDC/TANF F 45-64, AFDC/TANF M 0-1, AFDC/TANF M 2-5, AFDC/TANF M 6-11, AFDC/TANF M 12-18, AFDC/TANF M 19-21, AFDC/TANF M 22-44, AFDC/TANF M 45-64, PR F 0-1, PR F 2-5, PR F 6-11, PR F 12-18, PR F 19-21, PR F 22-44, PR M 0-1, PR M 2-5, PR M 6-11, and PR M 12-18.
Ohio	X	X	X	126 rate cells: AFDC/TANF M/F <1, AFDC/TANF M/F 1, AFDC/TANF M/F 2-13, AFDC/TANF F 14-44, AFDC/TANF M 14-44, AFDC/TANF M/F 45+, PRC F 14-18, PRC M 14-18, and PRW 19+ across 14 regions.
Oklahoma	X	X	X	24 rate cells: M/F <1, M/F 1-5, M/F 6-14, F 15-20, M 15-20, F 21-44, M 21-44, M/F 45+ across 3 regions.
Pennsylvania			X	2 rate cells across 2 regions.
Rhode Island	X	X		6 rate cells: M/F <1, M/F 1-5, M/F 6-14, F 15-44, M 15-44, and M/F 45+ across the state.
South Carolina	X	X		9 rate cells: M/F <1, M/F 1-6, M/F 7-13, F 14-18, M 14-18, F 19-44, M 19-44, M/F 45+, and PRW across the state.
Texas	X	X	X	42 rate cells: M/F <=1, AFDC/TANF Children, AFDC/TANF Adults, PRW, PRC 1-5, and FMC 6-18 across 7 regions.
Utah	X	X		6 rate cells: M/F <1, F 1-21, M 1-21, F 21+, M 21+, and PRW across the state.
Virginia	X	X	X	40 rate cells: M/F <1, M/F 1-5, M/F 6-14, F 15-20, M 15-20, F 21-44, M 21-44, and M/F 45+ across 5 regions. We used only regions with HMOs in operation.
Washington	X	X	X	96 rate cells: M/F <1, M/F 1-5, F 6-18, M 6-18, F 19-34, M 19-34, F 35-64, and M 35-64 across 12 regions.
West Virginia	X	X		8 rate cells: M/F <1, M/F 1-4, M/F 5-14, F 15-24, F 25-49, M 15-34, M 35-49, and M/F 50+ across a limited area of the state.
Wisconsin	X	X	X	28 rate cells: State provided PRW and single rate for all other members across 14 regions.
Totals (36)	34	33	27	
Percent	94%	92%	75%	

Notes: M = male, F = female, AFDC/TANF = Aid to Families with Dependent Children/Temporary Assistance for Needy Families, PRW = poverty-related pregnant women, PRC = poverty-related children, PR = poverty-related, ACG = adjusted clinical group, MCO = managed care organization, FMC = federal mandate children.

1) Florida has 11 rate districts, but district 1 and 2 are combined to have one set of capitation rates.

2) Molokai's rate was dropped from the analysis because Census data did not include population counts for this island.

3) Risk-adjusted rate cells (ACG) were not used for analysis.

Table 7 <i>Summary of Special Payment Arrangements for Maternity Expenses</i>				
State	Lump-sum Payment	Separate Rates for PRW and AFDC/TANF Pregnant Women	Separate Rate for PRW Only	Transfer Pregnancy Expenses to Newborn Rates
Arizona	X			
California			X	
Colorado	X			
Connecticut				
Delaware	X			
District of Columbia				
Florida				
Hawaii				
Illinois				
Indiana	X			X
Iowa				X
Kansas	X		X	
Kentucky				
Louisiana				
Maryland	X		X	
Massachusetts				
Michigan	X			
Minnesota			X	X
Missouri	X			
Nebraska				
Nevada	X			
New Hampshire				
New Jersey	X			X
New Mexico		X		X
New York	X			
North Carolina	X		X	
North Dakota				X
Ohio	X		X	
Oklahoma	X			
Oregon				
Pennsylvania	X			X
Rhode Island	X			
South Carolina	X		X	
Tennessee				
Texas	X		X	X
Utah	X		X	
Virginia				
Washington	X			
West Virginia	X			
Wisconsin			X	
Totals (36)	21	1	10	8
Percent	58%	3%	28%	22%

Notes: PRW = poverty-related pregnant women, AFDC/TANF = Aid to Families with Dependent Children/Temporary Assistance for Needy Families.

Table 8 *Services Carved Out from Capitation Payments*

State	Mental Health	Substance Abuse	Dental	Pharmacy	Organ Transplants	Vision	Speech/Hearing	Private Duty Nursing or Personal Care	EPSDT	Chiro-practic	HIV/AIDS Related Services	Non-Emergency Transport	Interpreter/ Translation Services	Other
Arizona	x	x									p ¹			
California	x	p ²	x	p ³	x	p ⁴			p ⁵	x				x ⁶
Colorado	x	NA	p ⁷							NA		x		
Connecticut														
Delaware	p ⁸	p ⁸	x	x				p ⁹				x		
District of Columbia	x	x			x									
Florida	x ¹⁰		o		x ¹¹			x ¹²			x ¹³		x	
Hawaii	p ¹⁴	p ¹⁴	x	p ¹⁵	p ¹⁶	p ¹⁷	p ¹⁸	x	p	p ¹⁹		p		
Illinois			x											
Indiana	x	x	x											
Iowa	x	x	x	x				x		o	x	x		
Kansas	x	x	x		p ²⁰									x ²¹
Kentucky	x	x										x	NA	
Maryland	x										p ²²			x ²³
Massachusetts			p ²⁴					x				x		
Michigan	p ²⁵	x	x	p ²⁶				NA						
Minnesota			p ²⁷											
Missouri	p ²⁸	x		p ²⁹	x ³⁰		x	x		x	x ¹³			
Nevada	p ³¹		x	p ³²				p ³³				x		x ³⁴
New Hampshire	p ³⁵	p ³⁵	p ³⁶	x	p ³⁷	p ³⁸	p ³⁹	NA		NA		NA		
New Jersey	x	x		p ⁴⁰			p ⁴¹	x			x		NA	x ⁴²
New Mexico										NA				
New York	p ⁴³	p ⁴³	o	x				x				o ⁴⁴		
North Carolina	x	x	x	x				x						
North Dakota			x ⁴⁵	x				x						
Ohio	p ⁴⁷	p ⁴⁷												
Pennsylvania								x ⁴⁸				x		
Rhode Island			x		x				p ⁴⁹	x	p ⁴⁹	x		
South Carolina	x ⁵⁰	x ⁵⁰	x					x		x		x	x	x ⁵²
Texas			p ⁵³	x								x		
Utah	x	x	x	x						x		x		
Virginia	p ⁵⁴	x ⁵⁵												x ⁵⁶
Washington	x	x	x	p ⁵⁷		p ³⁸		p ⁵⁸		p ¹⁹		x	x	
West Virginia	x	x	p ⁷	x								x		
Wisconsin			o		p ⁵⁹					x	x			
Totals (36)	25	21	24	16	9	6	4	14	3	9	8	15	3	7
Percentage	69%	58%	67%	44%	25%	17%	11%	39%	8%	25%	22%	42%	8%	19%

Notes: **x** = carved-out service, **p** = partially carved-out service, **o** = service is capitated at health maintenance organization's option, **NA** = not covered under the state Medicaid program.

- 1/ The state has a catastrophic reinsurance supplemental payment for members receiving HIV/AIDS drugs.
- 2/ Outpatient heroin detoxification treatment is excluded.
- 3/ HIV and AIDS drugs classified as nucleoside analogs, protease inhibitors, and non-nucleoside reverse transcriptase inhibitors approved by the FDA after 7/1/1997 are excluded.
- 4/ The fabrication of optical lenses are directly reimbursed to the optical labs by DHS. The managed care contractors provide all other covered services, including contact lenses and eyeglass frames.
- 5/ EPSDT supplemental services provided as California Children's Services or as mental health services or dental services are excluded.
- 6/ Services covered under waiver programs such as the In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, the AIDS and AIDS Related Conditions Waiver Program, and the Multipurpose Senior Services Waiver Program. Care in long-term care facilities for longer than the month of admission plus one month is carved out. Such facilities include Skilled Nursing Facilities, Subacute Facilities, Pediatric Subacute Facilities and Intermediate Care Facilities.
- 7/ Cover emergency dental services only.
- 8/ All outpatient services over 30 units for children, and all outpatient services over 20 units and inpatient services over 30 units for adults are carved out.
- 9/ Private duty nursing/personal care services over 28 hours per week are carved out.
- 10/ An exception in one region, where community services are required services.
- 11/ Bone marrow, cornea, and kidney are covered by the HMOs and are included in the capitation rate.
- 12/ Most private duty nursing and personal care services are provided through Children's Medical Services network, thus, in effect are carved out.
- 13/ HIV/AIDS treatment for those in AIDS or other long term care waivers is carved out.
- 14/ The health plans are responsible for mental health and substance abuse services, except when an adult is determined to be severely mentally ill or a child is determined to have a serious emotional disturbance.
- 15/ RespiGam and Synagis are excluded.
- 16/ Cornea, kidney, and bone transplants and related pharmacy costs are the responsibility of the HMOs. All other organ transplants and post operative care for up to one year are carved out.
- 17/ Adult vision services are limited to eye exam and eye glasses every two years.
- 18/ Partially carved out to behavioral health carve-out plan and Department of Education.
- 19/ Chiropractic care is a benefit for children under the age of 21 only.
- 20/ Heart, liver, bone marrow transplants are carved out.
- 21/ Family planning and factor drugs (?) and related pharmacy expenses are carved out.
- 22/ Viral load test is carved out.
- 23/ Carve-out of school health is mandatory.
- 24/ Emergency dental care and oral surgery performed by a physician are included in the capitation rate.
- 25/ Mental health services in excess of 20 outpatient visits each contract year are carved out.
- 26/ Psychotropic drugs and pharmacy related services prescribed by providers under the state's contract for specialty behavioral services are carved out.
- 27/ Carved out in five counties.
- 28/ Mental health services for children in state custody are carved out.
- 29/ Protease inhibitors are carved out.
- 30/ Organ transplants are not covered under the managed care program. However, pre- and post-transplant services are covered under the managed care program.
- 31/ Coverage of children with serious emotional disturbance and adults with serious mental illness is optional.
- 32/ Antiretroviral agents are carved out.
- 33/ Personal care aid (home care) is carved out.
- 34/ Hospice care is carved out.
- 35/ Acute mental health and substance abuse over 20 visits per calendar year are carved out.
- 36/ Children under 19 years receive preventive, and restorative treatment services, but not orthodontics.
- 37/ Experimental organ transplants are excluded.
- 38/ Eye glasses are not covered.
- 39/ Outpatient visits in excess of 35 visits per calendar year and inpatient care in excess of 60 days per calendar year are carved out.
- 40/ Protease inhibitors, clotting factors 8 and 9, and atypical anti-psychotic medications are carved out.
- 41/ All rehabilitative services are carved out.
- 42/ Abortion and related services, and medical day care are carved out.
- 43/ Stop-loss applies to mental health /substance abuse services after 30 days combined for inpatient services, 20 visits and 60 visits, for outpatient mental health and substance abuse, respectively. Any service use in excess of these limits are paid by the plan, but reimbursed to the plan by the state under the state's stop-loss program.
- 44/ May be carved out at the option of the local social service district.
- 45/ Routine services are carved out.
- 46/ Eye glasses and optometrist services are carved out.
- 47/ Most mental health outpatient services are billed directly to Medicaid fee-for-service by community mental health/substance abuse boards. HMOs are responsible for prescription drug services provided through community mental health boards.
- 48/ If a service is covered under the waiver, it is paid by HMOs. Otherwise personal care services are carved out.
- 49/ Not carved out, but may be subject to stop-loss provisions.
- 50/ The HMOs provide only assessment services for mental health and alcohol and other drug abuse services.
- 51/ The HMOs have elected to provide one pair of eye glasses per year to members 21 and older without Medicaid reimbursement.
- 52/ Institutional long term care is carved out after 30 days.
- 53/ EPSDT dental services are carved out.
- 54/ Limited to state plan option mental health services, which includes: intensive in-home children/adolescents; day treatment children/adolescents; day treatment/partial hospitalization; psycho social rehabilitation; crisis intervention; case management; intensive community treatment (pending); crisis stabilization; and mental health support.
- 55/ Substance abuse services are limited to pregnant women on an inpatient basis.
- 56/ Abortions are carved out.
- 57/ Pharmacy services prescribed by a community mental health center, dentist, planned parenthood or other services administered by Health Department are carved out and are paid fee-for-service. Protease inhibitors are also excluded.
- 58/ Personal care services are carved out.
- 59/ All organ transplants, excluding kidney and cornea transplants, are paid on a fee-for-service basis.

Table 9 <i>DSH and GME Inclusions by State</i>		
State	Includes DSH in Capitation	Includes GME in Capitation
Hawaii	X	
Illinois	X	
Indiana		X
Kentucky		X
Massachusetts		X
Minnesota	X	X
New Jersey		X
New York	X	
Ohio		X
Washington	X	X
Wisconsin	X	X
Totals	6	8
Percentage of Surveyed States (36)	17%	22%

Notes : DSH = Disproportionate share hospital, GME = graduate medical education.

State	Treatment of Maternity Expenses	Statewide Rates Before Maternity Adjustments		Statewide Rates After Maternity Adjustments	
		Females 14-34	Females 35-44	Females 14-34	Females 35-44
Arizona	Lump-sum payment.	116.38	116.23	170.02	138.70
California	Separate rate for PRW.	95.69	95.87	208.08	331.59
Colorado	Lump-sum payment.	177.12	180.36	219.59	198.02
Delaware	Lump-sum payment.	165.46	178.78	215.95	199.75
Illinois	Separate rates for PRW.	192.75	201.70	204.55	208.26
Indiana	Lump-sum payment and higher rate for newborns.	164.90	199.91	218.54	222.21
Iowa	Higher rate for newborns.	221.05	180.46	240.48	188.52
Kansas	Separate rates for PRW by age category and lump-sum payment.	94.33	151.54	142.40	165.89
Maryland	Lump-sum payment and separate rate for PRW.	136.67	179.02	253.50	228.22
Michigan	Separate maternity case rate that includes a "kicker" to cover OB/GYN costs.	91.87	91.90	134.07	109.41
Minnesota	Separate rate for PRW and higher rate for newborns.	225.57	239.02	390.99	352.13
Missouri	Lump-sum payment.	120.00	128.57	164.34	147.00
Nevada	Lump-sum payment.	123.84	123.84	183.02	148.43
New Jersey	Lump-sum payment and higher rate for newborns.	132.76	135.53	220.66	172.06
New Mexico	Separate rates for all pregnant women and higher rate for newborns.	246.51	272.97	334.05	311.77
New York	Lump-sum payment.	172.04	181.06	201.09	193.13
North Carolina	Separate rate for PRW and lump-sum payment.	110.67	125.67	151.39	147.71
North Dakota	Higher rate for newborns.	341.35	435.55	360.49	443.50
Ohio	Separate rate for PRW and lump-sum payment.	175.49	188.31	212.68	208.11
Oklahoma	Lump-sum payment.	108.34	106.59	136.96	118.49
Pennsylvania ¹	Lump-sum payment and higher rate for newborns.	123.82	124.53	123.82	124.53
Rhode Island	Lump-sum payment.	173.58	177.12	232.13	201.45
South Carolina	Separate rate for PRW and lump-sum payment.	99.44	111.97	141.59	129.30
Texas	Separate rate for PRW, lump-sum payment, and higher rate for newborns.	127.90	147.98	195.96	177.52
Utah	Separate rate for PRW and lump-sum payment.	117.67	151.40	169.11	167.21
Washington	Lump-sum payment.	206.81	213.96	248.11	231.13
West Virginia	Lump-sum payment.	110.77	126.72	150.85	143.38
Wisconsin	Separate rate for PRW.	112.29	112.12	185.98	156.65

Notes: PRW = poverty-related pregnant women, PRN = poverty-related newborns, PRC = poverty-related children. Rates do not include subsequent adjustments for disproportionate share hospital, graduate medical education provisions, and carved-out services.

¹ Capitation rates before and after the maternity adjustments are the same because the state submitted pregnancy cost adjusted capitation rates.

Table 11 <i>DSH and GME PMPM Estimates</i>		
State	DSH PMPM Estimates	GME PMPM Estimates
Hawaii	\$0.62	
Illinois	\$3.23	
Indiana		0.4%
Kentucky		1.1%
Massachusetts		3.0%
Minnesota	\$3.41	1.6%
New Jersey		3.2%
New York	\$12.23	
Ohio		2.0%
Washington	\$10.99	0.4%
Wisconsin	\$0.49	6.2%

Notes : DSH = disproportionate share hospital, GME = graduate medical education, PMPM = per member per month.
GME PMPM estimates are in percentages since the majority of the states that included GME payments in their capitation rates provided GME estimates as a share of their capitation payments.

Table 12 *Unadjusted and Adjusted Service Carve-Out Rates*

Carve-Out Rates for Those States That Submitted Carve-Out PMPM Information							
	Number of States	Newborns <1	M/F 1-13	F 14-34	F 35-44	M 14-44	M/F 45-64
Mental Health	6	0.59	5.13	9.67	9.42	7.51	7.60
Substance Abuse	4	0.00	0.02	0.69	0.40	2.14	0.90
Dental	7	0.00	4.26	6.97	6.63	5.95	6.74
Pharmacy	3	3.10	0.41	2.03	1.66	2.54	5.50
Organ Transplant	2	0.38	0.42	0.61	0.58	0.51	0.53
Vision	1	0.49	0.49	0.49	0.49	0.49	0.49
Carve-Out Estimates for Those States That Did Not Submit Carve-Out PMPM Information							
	Number of States	Newborns <1	M/F 1-13	F 14-34	F 35-44	M 14-44	M/F 45-64
Mental Health	17	0.89	4.39	7.07	7.27	5.45	5.28
Substance Abuse	18	0.06	0.10	0.65	0.46	1.76	0.65
Dental	16	0.02	3.26	3.82	3.94	3.93	3.70
Pharmacy	12	10.46	3.51	15.71	15.25	10.86	14.65
Organ Transplant	7	0.75	0.76	1.29	1.30	1.29	1.31
Vision	5	0.76	0.82	1.51	1.63	1.54	1.55

Source : State submitted data or estimates provided by Actuarial Research Corporation (ARC). ARC relied on proprietary private market data to estimate mental health, substance abuse, organ transplant, and vision carve-outs.

Notes : PMPM = per member per month, M = male, F = female.

Table 13 *Across-State Variation in Adjusted Medicaid Managed Care Capitation Rates*

State	Rate Period	Newborns <1	M/F 1-13	F 14-34	F 35-44	M 14-44	M/F 45-64
Arizona	10/1/00 - 9/30/01	330.83	81.56	182.05	150.96	105.03	242.63
California	10/1/00 - 9/30/01	96.70	103.19	219.03	342.87	105.85	105.31
Colorado	7/1/00 - 6/30/01	52.94	70.10	241.81	220.94	174.45	182.62
Connecticut	10/1/00 - 9/30/01	535.21	97.65	201.26	209.83	137.37	219.19
Delaware ¹	1/1/01 - 12/31/01	410.57	65.75	248.44	230.51	158.60	397.03
District of Columbia	4/1/99 - 3/31/01	463.06	160.20	234.80	192.27	176.60	172.38
Florida	7/1/00 - 6/30/01	275.96	58.94	177.89	192.74	116.20	214.30
Hawaii	7/1/00 - 6/30/01	147.71	147.36	148.04	147.50	147.98	147.78
Illinois	7/1/00 - 6/30/01	274.89	84.26	198.10	207.05	132.50	241.35
Indiana	1/1/01 - 12/31/01	179.77	82.17	257.45	261.64	261.67	263.44
Iowa	7/1/00 - 6/30/01	185.98	81.55	292.27	234.74	161.36	267.11
Kansas	7/1/00 - 6/30/01	352.05	55.81	160.31	184.63	113.19	179.88
Kentucky	7/1/00 - 6/30/01	192.70	206.70	199.73	200.17	168.69	158.44
Maryland	1/1/01 - 12/31/01	177.31	74.88	262.06	237.34	194.43	377.51
Massachusetts	7/1/00 - 6/30/01	167.66	171.52	170.75	170.75	170.75	170.75
Michigan	10/1/00 - 9/30/01	92.75	96.30	140.15	115.05	98.37	97.00
Minnesota	1/1/01 - 12/31/01	233.77	83.10	390.99	352.13	130.53	278.50
Missouri ²	12/1/00 - 11/30/01	226.88	112.37	166.19	148.49	136.12	232.05
Nevada	1/1/01 - 12/31/01	321.73	61.15	188.81	154.22	104.91	345.51
New Hampshire	8/1/00 - 6/30/01	180.90	181.45	170.85	166.10	169.27	165.71
New Jersey	10/1/00 - 6/30/01	165.56	65.23	230.35	181.42	115.98	271.88
New Mexico	10/1/00 - 6/30/01	244.36	109.03	334.05	311.77	227.72	304.10
New York	4/1/00 - 3/31/01	138.19	75.94	227.80	219.06	180.71	204.97
North Carolina	10/1/00 - 9/30/01	334.27	61.52	231.78	229.43	293.67	390.66
North Dakota	7/1/00 - 6/30/01	126.42	82.53	410.99	503.23	149.28	329.68
Ohio	7/1/00 - 6/30/01	455.09	66.96	221.62	217.53	110.35	354.31
Oklahoma	7/1/00 - 6/30/01	318.68	82.27	136.96	118.49	96.88	155.96
Pennsylvania	1/1/01 - 12/31/01	131.63	132.38	132.23	132.94	132.52	133.34
Rhode Island	1/1/01 - 12/31/01	262.86	74.17	244.36	213.68	124.56	238.43
South Carolina	1/1/01 - 12/31/01	314.85	45.05	163.64	151.86	187.44	278.49
Texas	9/1/00 - 8/31/01	212.75	64.90	217.05	196.63	148.01	164.12
Utah	7/1/00 - 6/30/01	282.08	79.71	206.08	204.64	166.30	186.85
Virginia	7/1/00 - 6/30/01	367.68	79.69	244.69	265.03	199.76	315.60
Washington	1/1/01 - 12/31/01	295.46	68.75	266.05	249.00	122.11	205.96
West Virginia	7/1/00 - 6/30/01	380.80	70.95	185.23	177.27	108.67	205.86
Wisconsin	7/1/00 - 6/30/01	113.47	118.28	192.64	163.31	118.73	118.57
High		535.21	206.70	410.99	503.23	293.67	397.03
75th Percentile		326.28	106.11	244.53	232.63	172.60	278.50
50th Percentile		239.07	81.56	211.57	202.41	142.68	216.75
25th Percentile		166.61	67.86	174.37	164.71	116.09	168.23
Low		52.94	45.05	132.23	115.05	96.88	97.00
Average		251.21	93.15	219.35	212.65	151.29	231.04
Standard Deviation		115.22	38.13	63.35	74.39	45.04	81.54
Coefficient of Variation		45.86	40.93	28.88	34.98	29.77	35.30

Source : Urban Institute, 2001 Medicaid Managed Care Payment and Implementation Survey, Washington, DC, 2001.

1) Delaware's rates are updated on "as needed" basis in response to demands from managed care organizations.

2) Rate periods varies by region so that a January 2001 rates would include December 2000 – November 2001 rates for Eastern region, March 2000 – February 2001 rates for Central region, and February 2000 – January 2001 rates for Western region.

Table 14*Statewide Adjusted Rates and Selected Medicaid Managed Care (MMC) Program Characteristics*

State	Statewide Adjusted MMC Rate (State CPS)	Statewide Adjusted MMC Rate (Nat'l CPS)	Medicaid Population in Full-Risk Plans (%)	Medicaid Population in PCCM Plans (%)	Current Enrollment Type of Full- Risk Operation
Arizona	131.54	141.42	81	0	Mandatory
California	137.79	134.46	50	0	Mandatory/Voluntary
Colorado	134.36	135.41	37	19	Mandatory
Connecticut	169.37	164.93	72	0	Mandatory
Delaware	159.61	182.79	79	0	Mandatory
District of Columbia	186.40	193.06	65	0	Mandatory
Florida	135.82	126.45	26	34	Mandatory
Hawaii	147.64	147.64	74	0	Mandatory
Illinois	146.36	148.32	10	0	Voluntary
Indiana	164.84	174.14	19	48	Mandatory
Iowa	181.43	167.84	23	22	Mandatory
Kansas	134.84	119.64	16	41	Mandatory
Kentucky	191.95	192.74	31	33	Mandatory
Maryland	180.05	179.76	81	0	Mandatory
Massachusetts	170.96	170.96	16	48	Mandatory
Michigan	105.35	105.01	67	0	Mandatory
Minnesota	202.36	191.49	63	0	Mandatory
Missouri	151.79	149.85	40	0	Mandatory
Nevada	128.06	148.43	39	0	Voluntary
New Hampshire	175.95	175.07	6	0	Voluntary
New Jersey	143.04	141.46	59	0	Mandatory
New Mexico	186.94	207.52	64	0	Mandatory
New York	149.41	143.79	24	0	Mandatory/Voluntary
North Carolina	188.68	189.11	5	64	Mandatory/Voluntary
North Dakota	209.34	206.21	1	54	Voluntary
Ohio	162.30	168.07	21	0	Mandatory
Oklahoma	118.32	117.72	35	34	Mandatory
Pennsylvania	132.52	132.50	64	11	Mandatory
Rhode Island	159.29	150.11	69	0	Mandatory
South Carolina	141.38	135.67	3	2	Voluntary
Texas	127.63	129.36	19	11	Mandatory
Utah	140.21	143.57	56	0	Mandatory
Virginia	190.35	180.56	30	29	Mandatory/Voluntary
Washington	154.67	149.33	55	1	Mandatory
West Virginia	143.81	135.49	13	21	Mandatory
Wisconsin	132.44	133.20	44	0	Mandatory/Voluntary
High	209.34	207.52			
75th Percentile	178.00	177.41			
50th Percentile	150.60	148.88			
25th Percentile	135.33	135.45			
Low	105.35	105.01			
Average	156.02	155.92			
Standard Deviation	25.37	26.30			
Coefficient of Variation	16.26	16.87			

Source: Urban Institute 2001.

State	Statewide Adjusted MMC Rate (State CPS)	Number of Region/ Geographic Rate Cells	High Regional Rate	Low Regional Rate	Regional High/Low Index
Arizona	131.54	9	135.68	127.30	1.07
California	137.79	12	160.40	129.15	1.24
Colorado	134.36	2	135.23	133.65	1.01
Connecticut	169.37	8	206.85	151.90	1.36
Delaware	159.61	2	166.09	151.73	1.09
Florida	135.82	9	148.26	119.65	1.24
Hawaii	147.64	4	151.77	129.88	1.17
Illinois	146.36	2	149.55	148.91	1.00
Indiana	164.84	3	167.90	160.83	1.04
Iowa	181.43	5	184.62	176.55	1.05
Kansas	134.84	6	155.86	122.90	1.27
Maryland	180.05	2	213.75	164.74	1.30
Michigan	105.35	10	113.85	95.49	1.19
Minnesota	202.36	3	235.16	184.68	1.27
Nevada	128.06	2	128.06	127.99	1.00
Ohio	162.30	14	178.08	143.39	1.24
Oklahoma	118.32	3	119.99	117.16	1.02
Pennsylvania	132.52	2	144.44	122.27	1.18
Texas	127.63	7	136.64	106.82	1.28
Virginia	190.35	4	211.01	170.58	1.24
Washington	154.67	12	165.38	142.64	1.16
Wisconsin	132.44	14	145.86	122.85	1.19
High	202.36	14	235.16	184.68	1.36
75th Percentile	164.20	9	175.54	151.86	1.24
50th Percentile	142.07	5	153.82	131.76	1.18
25th Percentile	132.46	2	138.59	122.87	1.05
Low	105.35	2	113.85	95.49	1.00
Average	148.98	6	161.57	138.68	1.16
Standard Deviation	24.76	4	32.09	23.03	0.11
Coefficient of Variation	16.62	68	19.86	16.61	9.47

Source : Urban Institute 2001.

Notes: CPS = Current Population Survey. Several states do not adjust capitation rates based on geography or did not submit rate data on a regional basis.

State	Statewide Adjusted MMC Rate (State CPS)	State MMC Rate to 50th Percentile	Weighted AAPCC Rates for MMC Regions	State AAPCC Rate to 50th Percentile	Index of State MMC to 50th Percentile/ State AAPCC to 50th Percentile
Arizona	131.54	0.87	509.69	1.01	0.86
California	137.79	0.91	617.71	1.23	0.75
Colorado	134.36	0.89	488.01	0.97	0.92
Connecticut	169.37	1.12	536.37	1.06	1.06
Delaware	159.61	1.06	522.31	1.04	1.02
District of Columbia	186.40	1.24	632.29	1.25	0.99
Florida	135.82	0.90	551.06	1.09	0.82
Hawaii	147.64	0.98	451.80	0.90	1.09
Illinois	146.36	0.97	599.85	1.19	0.82
Indiana	164.84	1.09	473.59	0.94	1.16
Iowa	181.43	1.20	427.61	0.85	1.42
Kansas	134.84	0.90	468.93	0.93	0.96
Kentucky	191.95	1.27	503.43	1.00	1.28
Maryland	180.05	1.20	602.57	1.20	1.00
Massachusetts	170.96	1.14	583.72	1.16	0.98
Michigan	105.35	0.70	568.26	1.13	0.62
Minnesota	202.36	1.34	436.64	0.87	1.55
Missouri	151.79	1.01	504.36	1.00	1.01
Nevada	128.06	0.85	565.54	1.12	0.76
New Hampshire	175.95	1.17	461.70	0.92	1.28
New Jersey	143.04	0.95	572.82	1.14	0.84
New Mexico	186.94	1.24	427.06	0.85	1.46
New York	149.41	0.99	646.12	1.28	0.77
North Carolina	188.68	1.25	443.05	0.88	1.42
North Dakota	209.34	1.39	415.01	0.82	1.69
Ohio	162.30	1.08	535.79	1.06	1.01
Oklahoma	118.32	0.79	471.90	0.94	0.84
Pennsylvania	132.52	0.88	664.26	1.32	0.67
Rhode Island	159.29	1.06	510.44	1.01	1.04
South Carolina	141.38	0.94	441.20	0.88	1.07
Texas	127.63	0.85	559.73	1.11	0.76
Utah	140.21	0.93	427.82	0.85	1.10
Virginia	190.35	1.26	465.70	0.92	1.37
Washington	154.67	1.03	464.39	0.92	1.11
West Virginia	143.81	0.95	479.51	0.95	1.00
Wisconsin	132.44	0.88	436.72	0.87	1.01
High	209.34	1.39	664.26	1.32	1.69
75th Percentile	178.00	1.18	566.90	1.12	1.13
50th Percentile	150.60	1.00	503.89	1.00	1.01
25th Percentile	135.33	0.90	456.75	0.91	0.84
Low	105.35	0.70	415.01	0.82	0.62
Average	156.02	1.04	512.97	1.02	1.04
Standard Deviation	25.37	0.17	70.07	0.14	0.25
Coefficient of Variation	16.26	16.26	13.66	13.66	24.43

Source: Urban Institute 2001.

Notes: County adjusted average per capita cost (AAPCC) rates are from the Centers for Medicare & Medicaid Services Web site. Rates are as of calendar year 2001 and include only Medicare Part A and B for aged beneficiaries. Data do not include payments for elderly disabled or elderly with end-stage renal disease.

Table 17*Changes in Adjusted Medicaid Managed Care (MMC) and Medicare AAPCC Rates*

State	Statewide Adjusted MMC Rate (State CPS)		Statewide AAPCC Rates for MMC Regions		1998 - 2001 MMC Rate Change (%)	1998 - 2001 AAPCC Rate Change (%)
	1998	2001	1998	2001		
Arizona	126.29	131.54	469.95	509.69	4.16	8.45
California	94.68	137.79	578.17	617.71	45.54	6.84
Colorado	137.57	134.36	443.28	488.01	-2.33	10.09
Connecticut	161.57	169.37	488.28	536.37	4.83	9.85
District of Columbia	143.39	186.40	595.82	632.29	29.99	6.12
Florida	117.29	135.82	511.87	551.06	15.80	7.66
Georgia	94.29	n.a.	526.98	n.a.	n.a.	n.a.
Hawaii	150.25	147.64	385.23	451.80	-1.73	17.28
Illinois	112.22	146.36	570.46	599.85	30.42	5.15
Indiana	94.98	164.84	429.78	473.59	73.54	10.20
Iowa	142.60	181.43	380.78	427.61	27.23	12.30
Kansas	115.07	134.84	423.43	468.93	17.18	10.75
Kentucky	156.42	191.95	434.30	503.43	22.71	15.92
Maine	102.74	n.a.	376.09	n.a.	n.a.	n.a.
Maryland	145.75	180.05	562.64	602.57	23.53	7.10
Massachusetts	169.32	170.96	541.99	583.72	0.97	7.70
Minnesota	151.78	202.36	388.97	436.64	33.33	12.26
Mississippi	126.92	n.a.	488.30	n.a.	n.a.	n.a.
Missouri	140.32	151.79	460.62	504.36	8.18	9.50
Nevada	96.74	128.06	496.35	565.54	32.37	13.94
New Hampshire	148.90	175.95	399.65	461.70	18.17	15.53
New Jersey	152.16	143.04	531.27	572.82	-5.99	7.82
New Mexico	138.04	186.94	378.04	427.06	35.43	12.96
New York	108.24	149.41	581.36	646.12	38.04	11.14
North Dakota	221.83	209.34	367.00	415.01	-5.63	13.08
Ohio	147.91	162.30	501.59	535.79	9.73	6.82
Oklahoma	92.18	118.32	436.19	471.90	28.36	8.19
Rhode Island	133.49	159.29	469.28	510.44	19.33	8.77
South Carolina	132.45	141.38	397.29	441.20	6.74	11.05
Tennessee	101.20	n.a.	470.61	n.a.	n.a.	n.a.
Texas	133.20	127.63	533.77	559.73	-4.18	4.86
Utah	137.22	140.21	372.75	427.82	2.18	14.78
Virginia	146.33	190.35	426.02	465.70	30.09	9.31
Washington	130.47	154.67	403.94	464.39	18.55	14.96
West Virginia	132.87	143.81	456.54	479.51	8.23	5.03
Wisconsin	116.13	132.44	391.23	436.72	14.05	11.63
High	221.83	209.34	595.82	646.12	73.54	17.28
75th Percentile	146.72	176.98	515.65	561.18	30.02	12.47
50th Percentile	133.34	150.60	458.58	495.72	17.67	9.97
25th Percentile	114.36	137.30	399.06	459.22	4.66	7.69
Low	92.18	118.32	367.00	415.01	-5.99	4.86
Average	132.02	157.21	463.05	508.41	18.09	10.22
Standard Deviation	26.18	24.28	68.91	67.27	17.43	3.39
Coefficient of Variation	19.83	15.44	14.88	13.23	96.39	33.15

Source : Urban Institute 2001. AAPCC rates are from the Centers for Medicare & Medicaid Services Web site.