

# How States Are Using Comprehensive Medicaid Managed Care to Strengthen and Improve Primary Health Care

Sara Rosenbaum, Maria Velasquez, Alex Somodevilla, Elizabeth Gray, Rebecca Morris, Morgan Handley, and J. Zoe Beckerman

## ABSTRACT

**ISSUE:** Federal regulations set broad standards for what state Medicaid managed care contracts must address. But these contracts can vary enormously both in their details and in the degree to which the purchaser sets specific expectations versus broader aims.

**GOAL:** To identify and compare the primary care–related elements of state Medicaid managed care contracts.

**METHODS:** Review of written purchasing specifications contained in contract documents covering the low-income population that are used by 39 states and the District of Columbia, as well as open-ended interviews with state officials from states selected for their geographic and demographic diversity.

**FINDINGS:** Our review revealed both similarity and variation across all domains of primary care purchasing. Discussions with state leaders suggest multiple explanations for variation on commonly shared topics: on-the-ground health care conditions, population health needs and priorities, procurement rules, state priorities, cost, and recognition of industry capabilities and limitations. States vary widely as to when they use a more prescriptive approach to their purchasing specifications versus one involving broader deference to contractor judgment about how to operationalize a broadly stated aim. Understanding this key variability is essential to efforts to research and better identify what works in Medicaid managed care.

## TOPLINES

- ▶ Medicaid managed care can be a useful tool for states seeking to improve primary health care for people with low incomes
- ▶ There are some similarities, but also significant differences, in how state Medicaid programs approach primary care purchasing



## INTRODUCTION

Managed care has evolved into a basic feature of Medicaid because it gives states the ability to better control coverage, care, and costs, as well as to introduce and pursue important changes in care delivery to improve health and health care. By 2017, 70 percent of all Medicaid beneficiaries were enrolled in comprehensive plans offered by managed care organizations (MCOs), and one study estimates that Medicaid managed care accounts for half of all Medicaid spending.<sup>1</sup>

MCOs are responsible for implementing the details of Medicaid coverage and care specified in purchasing agreements with states. Increasingly, states use managed care contracts to introduce payment and care innovations.<sup>2</sup>

As a centerpiece of health care, primary care plays an especially important role in managed care, and the vast majority of Medicaid beneficiaries today receive most forms of primary care as a managed care benefit. Primary care's importance is also reflected in the fact that many of the federal measures used to examine the quality of care in Medicaid focus on primary care.

Medicaid managed care operates within a complex legal framework that includes contracts spelling out a state's performance expectations regarding coverage, care, access, payment, quality improvement, and other matters. State contracts also identify population health improvement priorities, areas for specific investment, and desired innovations in care and payment reform. The contracting process is guided not only by federal rules but also by each state's Medicaid policy and the complex procurement rules applicable to major state purchases. Designing and administering contracts is a complex process. One of the most challenging aspects of Medicaid managed care purchasing is deciding what goals are most important to emphasize in highly detailed and specific purchasing specifications and what goals are best communicated through broadly worded aims that leave the contractor with more discretion in implementation. In addition, the absence of any mention of a particular activity related to coverage, care, or performance does not mean that the plan does not engage in that activity;

it simply signifies that the state leaves the matter to the contractor's full discretion. Different states emphasize different priorities; all use a mix of high specificity, broadly worded aims, and avoidance of particular topics. Furthermore, federal regulations are general enough to permit all three approaches on a variety of matters.

This issue brief provides an in-depth examination of the primary care-related elements of state Medicaid managed care contracts. Contracts were examined in depth for all states that used comprehensive managed care for low-income beneficiaries as of the end of 2018 (39 states and the District of Columbia). Our review covers eight major domains of primary health care, along with a number of subtopics within each domain. Domains and subtopics were selected in consultation with state Medicaid leaders and experts in Medicaid managed care. The Commonwealth Fund's searchable [Medicaid Managed Care Contract Analysis Database](#) contains the actual terms of state contracts across the domains; it allows users to explore contracts by topic or state for detailed purchasing specifications.

For detailed study methods, see "[How This Study Was Conducted.](#)"

## FINDINGS FROM CONTRACT ANALYSES

### Overall Results: General Similarity and Variation

States' managed care agreements have much in common but also can vary significantly ([Appendix](#)). For example, all states address areas of focus required under federal rules: cultural competence, appointment wait times, provider-patient ratios, and travel time and distance. By contrast, 19 states specify adult immunizations as a specific covered benefit, while seven specifically address the issue of prior authorization for primary care.

Where performance is concerned, nearly all states (39) measure performance in the area of women's health, while 24 use performance to help determine how they will carry out auto-enrollment, which is the process of assigning beneficiaries to plans when they do not actively select a specific plan. (In general, auto-enrolled beneficiaries have fewer health problems, resulting in fewer expenses.)

Integration of primary care and behavioral health care is a key priority for many states, and all states require care coordination and case management to support this integration; in addition, 30 states specify some degree of team care and 22 specify use of value-based payments related to behavioral health integration.

### A Closer Look at Key Domains of Managed Care and Primary Care

**Primary care benefits and coverage rules.** Federal Medicaid managed care rules do not explicitly define primary care, nor do the rules identify specific services considered basic primary care services that must be included in MCO contracts. States vary in how they define primary care and what benefits they include that might be thought of as primary care benefits (Exhibit 1). Only nine

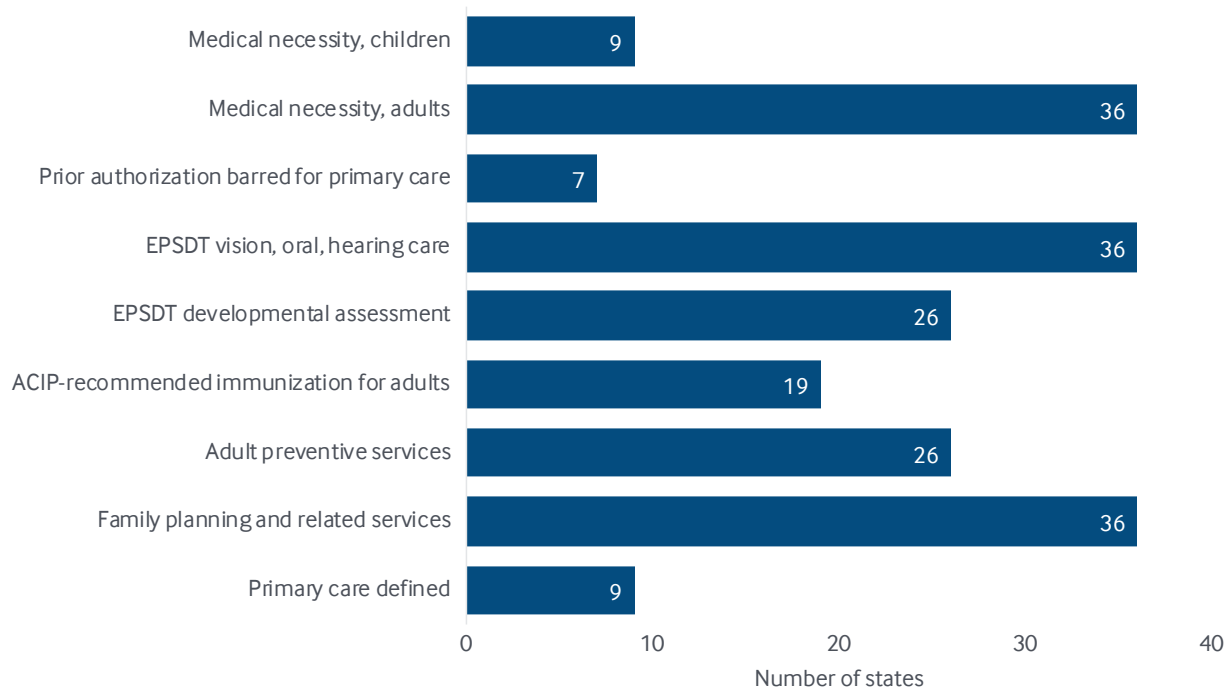
states provide a definition of what constitutes “primary care,” and definitions vary.

In their contracts, nearly all states specify an adult medical necessity standard that MCOs are expected to apply. Fewer states (nine) describe Medicaid’s special pediatric medical necessity standard, possibly because the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program — the federal Medicaid program for children and adolescents under age 21 — already contains robust requirements for children’s health care.

Other specific contract benefits also vary across states. For example, not all states expressly include family planning as a contract benefit, instead appearing to leave family planning as a Medicaid fee-for-service benefit. This choice may reflect the fact that, in the case of family planning, federal Medicaid law gives beneficiaries the right to seek covered care from the provider of their choice.

### Exhibit 1. Primary Care Coverage Provisions

*Number of states that reference a given subtopic in their contractual agreements*



Data: George Washington University analysis of 40 state Medicaid managed care purchasing documents including requests for proposal, model contracts, and/or executed contracts publicly available as of October 1, 2019.

In another example, 26 of the 40 state contracts specify one or more preventive care services for adults. The federal government mandates certain preventive services for adults who obtained coverage as a result of the Affordable Care Act's expansion of Medicaid (routine immunizations recommended by the Centers for Disease Control and Prevention and preventive care with an A or B rating from the U.S. Preventive Services Task Force). However, these requirements do not apply to the traditional adult Medicaid population, which consists principally of pregnant women, very low-income parents, and adults with disabilities.

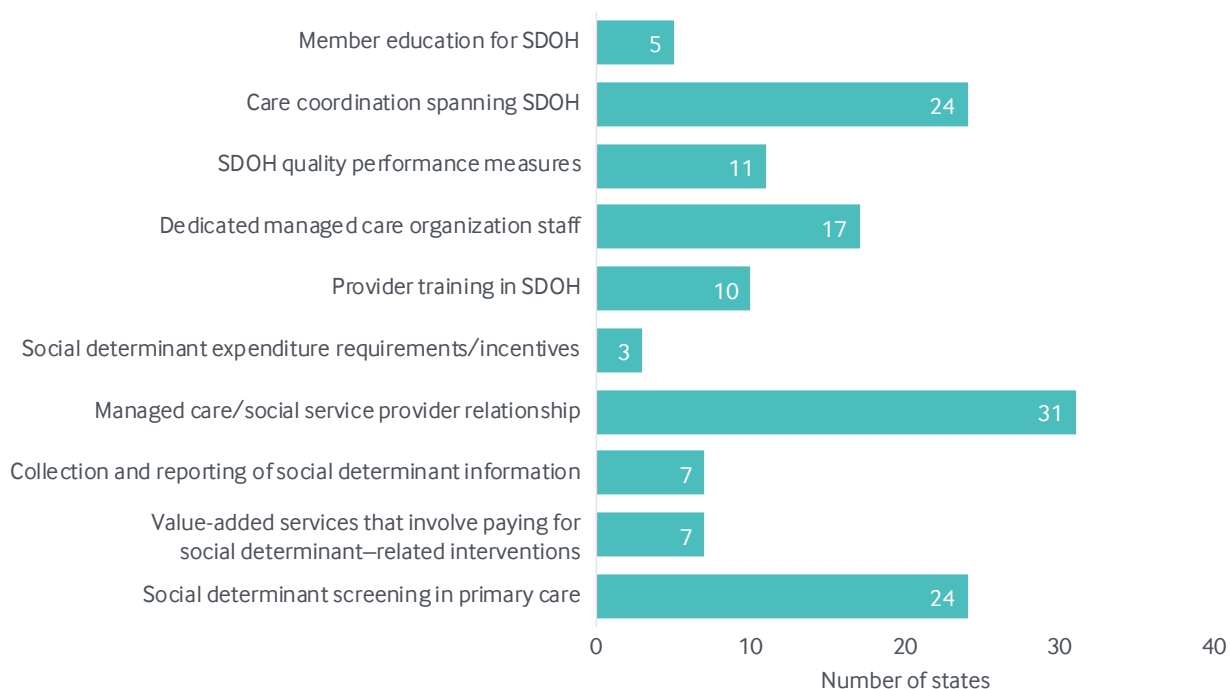
**Social determinants of health.** We also found variation in how states address the relationship between managed care and social determinants of health in contracts (Exhibit 2). Thirty-one states require MCOs to maintain relationships with providers of health-related social and educational services, while seven states require MCOs to collect and report information related to social

determinants of health. Additionally, as permitted under federal rules, seven states treat social determinant of health activities as value-added services, meaning that the states encourage MCOs to offer such services but do not include the cost of these activities when calculating Medicaid payment rates.

Social determinants of health also offer a clear example of state variation with respect to the specificity of contract expectations. Two contrasting state examples, California and Indiana, are highlighted below. California's expectations are highly specific with respect to the timing of the assessment process, the content of the assessment, and follow-up care expectations. Indiana, by contrast, specifies a general expectation that social barriers will be identified, leaving broad discretion to its contractors regarding the nature of the assessment process (including whether to conduct an individual assessment at all) and the reporting of results.

## Exhibit 2. Contract Provision Related to Social Determinants of Health

*Number of states that reference a given subtopic in their contractual agreements*



Data: George Washington University analysis of 40 state Medicaid managed care purchasing documents including requests for proposal, model contracts, and/or executed contracts publicly available as of October 1, 2019.

## CONTRACT TERMS RELATED TO ASSESSING SOCIAL DETERMINANTS: CALIFORNIA AND INDIANA

**California:** “Services for Adults 21 . . . and older. Contractor shall cover and ensure that an [individual health assessment] is performed within 120 days of enrollment. Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes but is not limited to: (1) a comprehensive history including but not limited to mental and physical systems, and social and past history . . . Contractor shall ensure that medical providers use [a specified clinical tool] and other relevant clinical evidence as part of the basis for identifying Members’ health education needs and conducting educational intervention... . Contractor shall provide resource information, educational materials and other program resources to assist providers to provide effective . . . Services . . . Contractor shall ensure that all new Members complete the [health education needs assessment] within 120 calendar days as part of the initial assessment and that all existing members complete [the screen] . . . No later than their next scheduled screening exam. . . . Interventions are conducted and arrangements are made for follow-up services to address the needs identified. Contractor is responsible to assist primary care providers in the development and delivery of culturally and linguistically appropriate health education interventions and assure provisions for low-literate, illiterate, and visually impaired Members . . . Contractor shall use data . . . To help identify newly enrolled . . . Members who may need expedited services.”

**Indiana:** “Contractors shall also be responsible for identifying and addressing social barriers which may inhibit a member’s ability to obtain preventive care.”

**Primary care patient supports.** We also looked at the supportive services that states require contracted MCOs to provide to primary care patients. These include the use of community health workers, resources to ensure care continuity and ease transition across care sites, and patient supports that improve access to needed care. “In lieu of” flexibility is another type of support that states might require. Under federal rules, MCOs are allowed to adopt alternative approaches to normal coverage and care requirements, such as offering covered benefits at home and in other nontraditional settings.

At least to some degree, all states address continuity of care and beneficiary access supports. However, only 12 states specifically address the use of community health workers as a form of patient support for some or all populations.

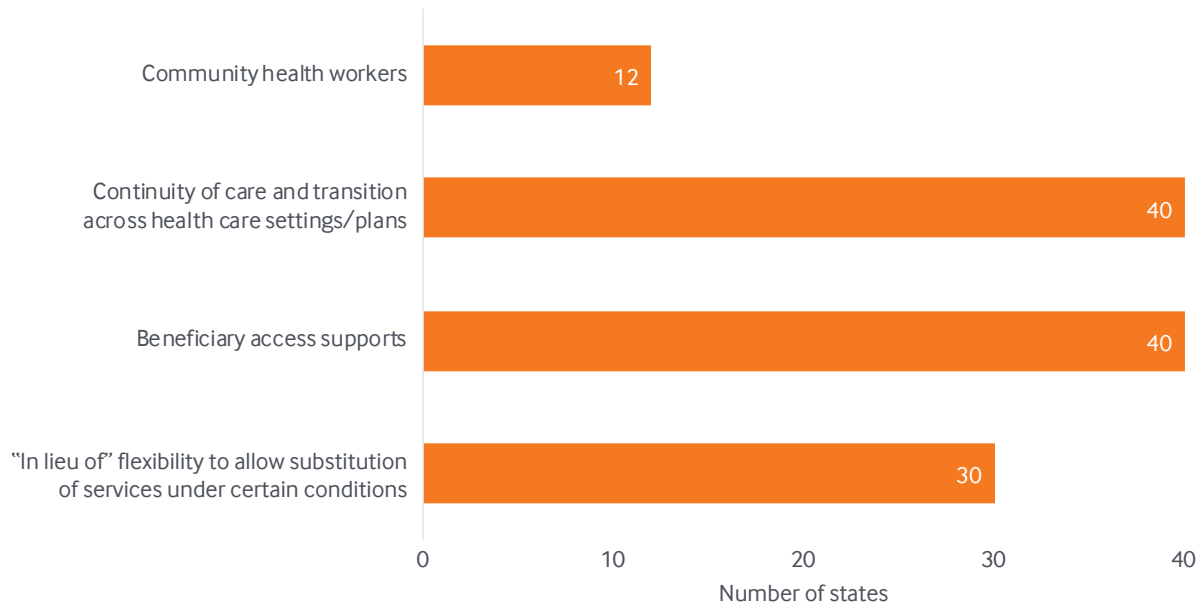
**Performance measurement and quality improvement.** We found greater consistency across states in terms of the performance areas that states choose to measure, and the areas of practice they target for quality improvement. All states measure consumer experience in primary care and pediatric and adult preventive care, and nearly all are prioritizing women’s preventive health. Fewer states (26) are looking at primary care practice support for network providers. To some degree, 29 states require contractors to tie value-based payment to primary care effectiveness.

**Primary care payment methods and incentives.** Federal regulations permit states to provide overall direction to contractors on payment approaches, particularly with respect to payment innovations aimed at improving quality. Twenty-seven contracts contain specifications related to payment and clinical quality (Exhibit 5), while six specify an approach that links payment to health outcomes. Nineteen states specify payment approaches that specifically address practice transformation as an aspect of payment.

**Information exchange and health IT.** In recent years, the ability to report on and exchange quality-of-care information electronically has been a matter of increasing focus. The contracts generally reflect this focus: 35 states specify use of adaptive technology for people with disabilities, 32 address mobile technology, 36 have provisions related to information exchange with other agencies and programs, and 39 address information exchange across care settings. A smaller number (13 contracts) specify expectations regarding e-prescribing.

### Exhibit 3. Primary Care Patient Supports

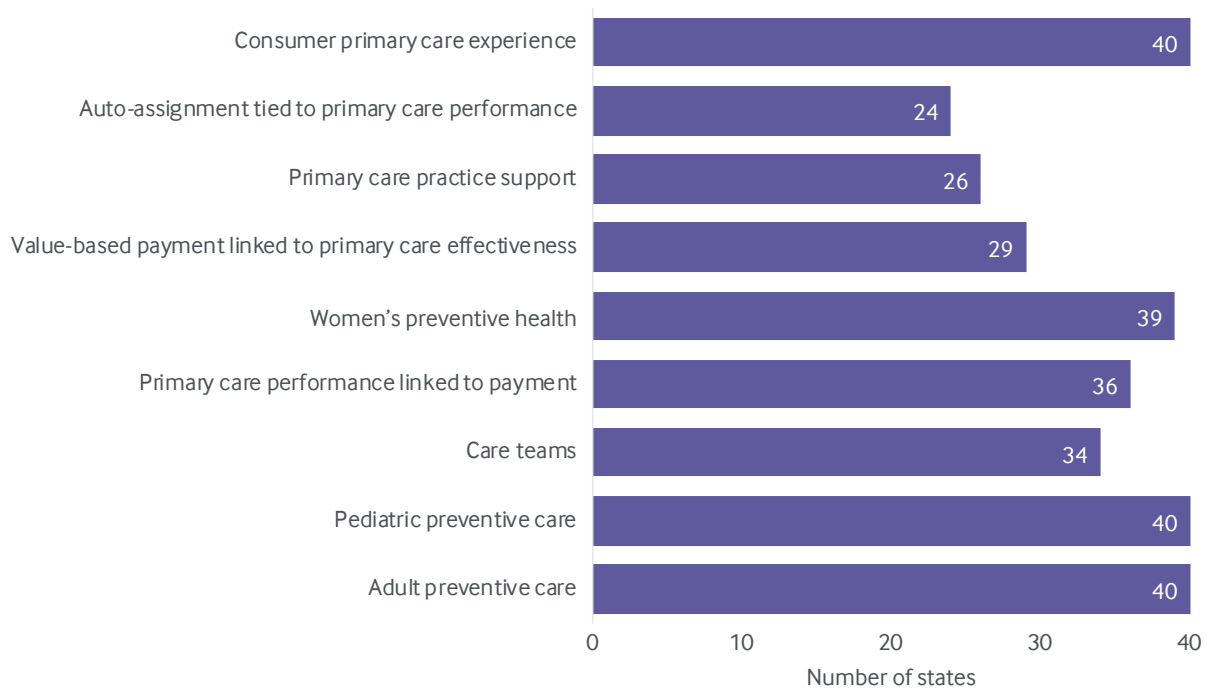
Number of states that reference a given subtopic in their contractual agreements



Data: George Washington University analysis of 40 state Medicaid managed care purchasing documents including requests for proposal, model contracts, and/or executed contracts publicly available as of October 1, 2019.

### Exhibit 4. Performance Measurement and Quality Improvement

Number of states that reference a given subtopic in their contractual agreements

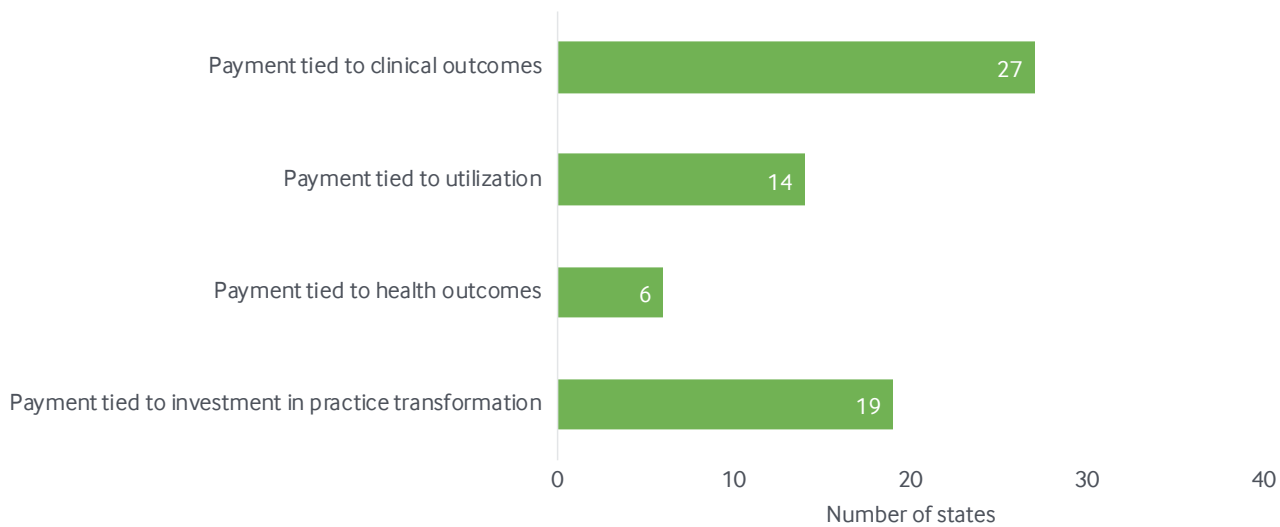


Data: George Washington University analysis of 40 state Medicaid managed care purchasing documents including requests for proposal, model contracts, and/or executed contracts publicly available as of October 1, 2019.



## Exhibit 5. Primary Care Payment Methods and Incentives

Number of states that reference a given subtopic in their contractual agreements



Data: George Washington University analysis of 40 state Medicaid managed care purchasing documents including requests for proposal, model contracts, and/or executed contracts publicly available as of October 1, 2019.

**Behavioral health integration and primary care.** Few issues have received greater attention in recent years than how to best integrate behavioral health and primary care. As with other topics, general similarities across states can mask differences in the degree of specificity states include in their contracts. For example, as detailed in the [Appendix](#), 40 states expect care coordination across medical and behavioral health services, while 30 specify multidisciplinary team approaches addressing collaboration between mental health and primary care providers. The examples below, taken from the contract data base, shows how expectations may vary.

### STATE PURCHASER INTERVIEWS

Our interviews with seven state managed care purchasers added to our understanding of the challenges and considerations that arise for states in designing their contracts. Many common themes emerged. For example, all states identify key purchasing priorities that help guide their efforts. Some states targeted health improvements for specific vulnerable populations, such as reducing maternal mortality or improving health outcomes for beneficiaries

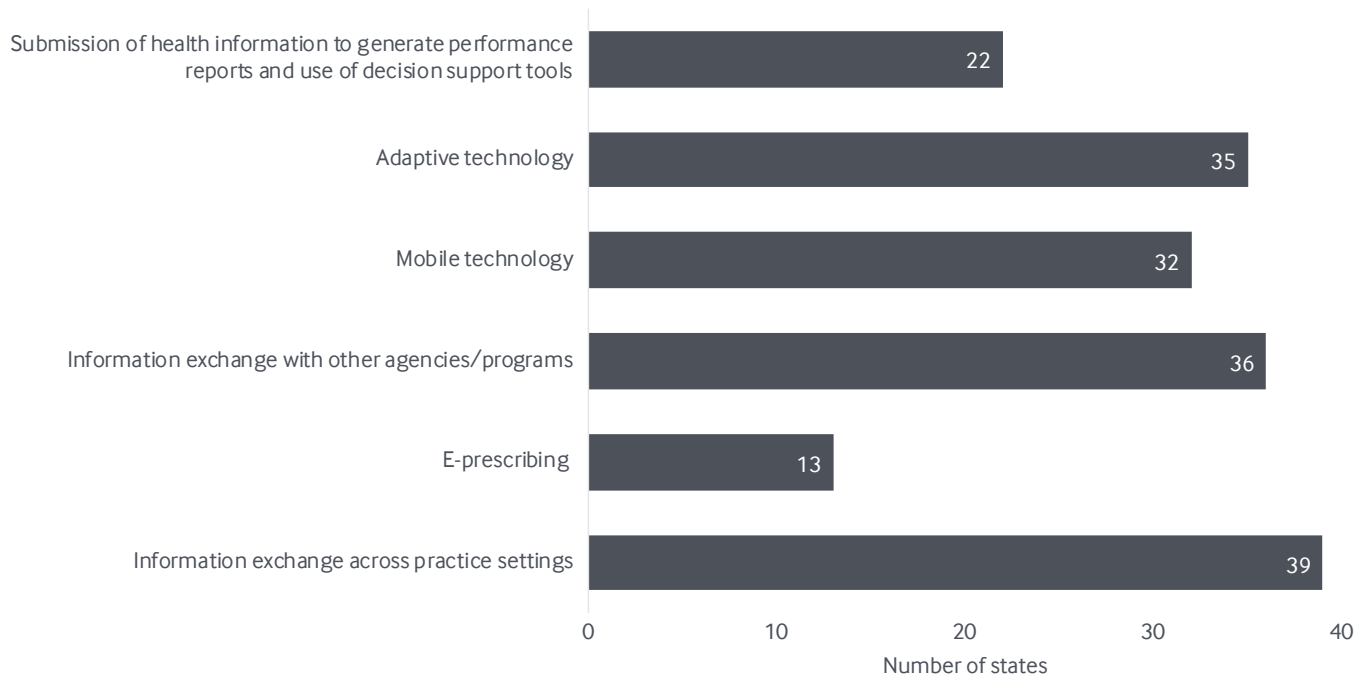
with physical and behavioral health conditions. Other states focused on strengthening some aspects of health system performance, such as behavioral health integration into primary care.

Not surprisingly, all states reported that, in setting priorities, they were guided by gubernatorial or legislative initiatives, and many reported extensive interactions with other state agencies involved in serving the same populations for different health or social needs. States identified consumer and advocate engagement in the planning process as a major source of influence in developing priorities. Also considered important were the views expressed by the managed care industry itself, or by key provider groups, regarding the feasibility and practicality of specific initiatives or strategic directions.

Certain themes consistently arose. States were eager to learn about how other states tackled common problems, and all states were eager to know when to use more specific purchasing standards, when to use more general aims, and when to rely on industry practice regarding specific matters without having to articulate their own expectations.

## Exhibit 6. Information Exchange and Health Information Technology

Number of states that reference a given subtopic in their contractual agreements



Data: George Washington University analysis of 40 state Medicaid managed care purchasing documents including requests for proposal, model contracts, and/or executed contracts publicly available as of October 1, 2019.

### USE OF MULTIDISCIPLINARY CARE TEAMS: MASSACHUSETTS AND DELAWARE

**Massachusetts:** “Care Management. The Contractor shall provide Care Management activities to appropriate Enrollees . . . . The Contractor shall provide each such identified Enrollee with Care Management as follows: a. Care Management shall include activities such as but not limited to: . . . Designating a care team of providers and other individuals involved in the Enrollee’s care. The care team shall include, at a minimum: a) The Enrollee’s Care Coordinator or Clinical Care Manager; b) The Enrollee’s PCP; c) The Enrollee’s behavioral health provider (if applicable) or Contractor’s BH CP [Behavioral Health Community Partner], as appropriate; d) The Enrollee’s LTSS provider (if applicable) or Contractor’s LTSS CP [Long-Term Services and Supports Community Partner], as appropriate; and e) Any additional individual requested by the Enrollee; 6) Providing team-based Care Management, including meetings of the care

team at least annually and after any major events in the Enrollee’s care or changes in health status, or more frequently if indicated. (Attachment A: Model MCO Contract, pp. 93-94, September 2017, Massachusetts Medicaid Managed Care RFR Amendment).”

**Delaware:** “Primary Care Provider (PCP). 3.9.8.1. PCP Responsibilities.... 3.9.8.1.3. The State encourages the Contractor to promote and support the establishment and use of patient-centered, multi-disciplinary, team-based approaches to care, including but not limited to: patient-centered medical homes (PCMHs); nurse-managed primary care clinics; integrated primary and behavioral health services; use of non-traditional health workers; and accountable care organizations (ACOs). (pp. 190-191, December 2017, Delaware Medicaid Managed Care Contract).”



## BEHAVIORAL HEALTH INTEGRATION: HAWAII AND RHODE ISLAND

**Hawaii:** “Regional Enhanced Referral Networks. The Health Plan shall develop regional enhanced referral networks of primary care and behavioral health providers. The Health Plan shall: 1) Identify the primary care, mental health and substance use providers in a shared geographic area to build an enhanced referral network. . . . 2) Develop a process for relationship development between providers with a shared understanding of treatment service and capacity across organizations within the region. 3) Collaborate with other Health Plans to develop standardized resources to streamline administrative time for providers, including the following shared tools to support enhanced referral: a) Referral form b) Care compacts c). . . . 4) Provide support for provider-driven decisions about the need for referral (or a change in level of care) through care coordination and care management. . . . 5) Be accountable for bidirectional referral processes ensuring timely and effective referral and access to whole person services for members with behavioral health conditions (including access to primary care and specialty mental health and substance use services). 6) Provide access to a provider network that accommodates the members

while reflecting the regional variation of services. a) The Health Plan shall take into account the following in developing of the networks: i) Utilization (including hot spotting of high need areas) and travel patterns; ii) Availability of specialty behavioral health services and alternative solutions such as telehealth, Project ECHO [Extension for Community Healthcare Outcomes], and other virtual innovations to support whole member care; . . . 7) Collaborate with providers and other Health Plans to collect data on referral process and reporting to DHS. . . . (pp. 118-120, August 2019, Hawaii Medicaid Managed Care RFP).”

**Rhode Island:** “Care Management Program. . . EOHHS [Executive Office of Health and Human Services] considers interactive communications between Primary Care Providers, behavioral health providers and other Specialists to be an important program objective to ensure that members receive the right care in the right setting. The Contractor is encouraged to promote interactive communication methods or systems that enable timely exchange of member information between collaborating providers. (pp. 87-88, July 2018, Rhode Island Medicaid Managed Care Contract).”

Respondents had a uniform desire for empirical evidence regarding the impact of greater or lesser specificity. They wanted to know when certain approaches to a particular priority area showed positive results so that they could be clearer in their expectations rather than leaving an issue to contractor discretion. They also wanted to know when such evidence was lacking or inconclusive, so that they could build greater contractor discretion on key matters into their contracts.

Respondents viewed research as necessary and valuable, given the multiple challenges state purchasers face in the areas of acute medical underservice, customs and practices of care delivery, cost considerations, procurement complexities, capabilities of MCOs to carry out complex changes in care delivery, and uncertainty

regarding what works. Above all, states wanted to know how other states approach the same set of issues.

## DISCUSSION

Across all insurance markets, Medicaid managed care represents perhaps the most complex undertaking for purchasers. The Medicaid population is deeply impoverished and faces elevated health risks. Managed care systems serve poor communities that face serious shortage of health care providers and, in some cases, are health care deserts. These problems require solutions extending well beyond what insurance alone can fix. States and their managed care partners endure uncertainty about when purchasing expectations should be precise as opposed to flexible. With relevant health services research lacking, there is uncertainty about what works under relevant conditions.

When developing managed care agreements, states are aware that their decisions have major implications even for basic access to care. The purchasing agreements we examined reflect this understanding of a deeper mission; all states focus on health care delivery, the need for patient supports, and investments and incentives that may serve to strengthen critical aspects of primary care. States may vary considerably in the on-the-ground realities they face, but they share a desire for tools that can help them understand not only what works but how to translate what works into purchasing specifications that reflect a balance of flexibility and accountability.

Despite their differences, respondents consistently pointed to a single overriding focus: how to make primary care more accessible and effective for high-need populations. Despite their differences, the contracts have much in common, suggesting areas of high focus for researchers working in collaboration with state purchasers. Moreover, the mix of high specificity and broad aims coupled with deference suggests that there is much to be learned about why states make the choices they do. These choices may reflect state knowledge about the efficacy of a particular approach (or the lack of evidence); alternatively, key differences may be a greater reflection of the policy and political priorities present in any state.

## CONCLUSION

All states consider improving the scope, quality, accessibility, and performance of primary care to be a major objective of Medicaid managed care. Some address it in terms of performance improvement; others do so in terms of initiatives aimed at special populations. But there is widespread recognition that improving health care for the poor rests on improving primary care, and this fact not only is expressed by states in interviews but is reflected in the terms of formal purchasing agreements that are foundational to managed care.

To support state efforts to use managed care to improve primary care, several investments emerge as essential. The first is empirical evidence of what works under actual on-the-ground conditions. The second is technical support

in developing the purchasing documents themselves and for the challenge of balancing hard power and soft power considerations. The third is the opportunity for shared learning and shared experiences, not only across states themselves, but in more eclectic groups consisting of states, experts in health care and managed care, and consumers.

## HOW THIS STUDY WAS CONDUCTED

### Contract Collection

This project focuses on comprehensive Medicaid managed care purchasing agreements covering the low-income beneficiary population. Specialized agreements focusing on selected health conditions and treatments (such as behavioral health carve-out agreements) and limited-scope managed care agreements (such as contracts covering only primary care or certain inpatient or ambulatory services) were excluded.

Documents relevant to the state purchasing process were collected between January 1 and October 1, 2019. All documents relevant to our research were readily available through each state's website of publicly available documents. In the atypical case where a document could not be located, we contacted the state agency to secure what we needed.

This is a point-in-time study. Contracts evolve through modification and amendments and periodically undergo major revision or replacement. Commonly, a contract is in effect for a multi-year term, so these documents are constantly evolving. At the same time, because purchasing documents cover multiple years and involve the development and implementation of complex service delivery arrangements, they shed important, contemporaneous light on state approaches to large-scale health care purchasing.

### Analyzing the Contract Contents

As the contracts were being collected, we assembled an advisory group consisting of experts in primary health care, officials from managed care organizations, state purchasers, and researchers. With the help of this group, we identified

the eight major domains of primary health care that would form the organizational strategy for our analysis. Within each of the eight major domains, we further identified, with the help of our advisers, multiple topics of particular interest to states, managed care organizations, and other users. These domains and topics were converted into Word table shells. A trained group of analysts, working under the direction of two senior lawyers with extensive managed care experience, then analyzed the content of each of the collected documents. For each domain and topic, the analysis indicated whether the document did or did not address the particular issue to any degree or in any manner.

To ensure the accuracy of our review and interpretation, at least two analysts read each contract for each of the domains and topics. In addition, weekly meetings were held during which the team reviewed inconsistencies or questions regarding how particular provisions should be flagged and categorized.

### State Agency Interviews

In addition to reviewing the contracts, we conducted seven in-depth, open-ended interviews with states selected on the basis of their geographic diversity, the variable nature of their on-the-ground conditions (large and small states, urban and rural states), and key population characteristics. The purpose of these interviews was to learn more about challenges states face in the development of purchasing agreements, the factors that they associate with the key priorities they choose, and their experiences in making the choice about hard power (high specificity of expectations) versus soft power (allowing greater health plan discretion, identifying certain aims as more generalized and aspirational). The results of these interviews helped sharpen our understanding of why contracting strategies may vary on similar matters, as well as our thinking about how to present the information we collected.

### NOTES

1. Kristin Allen, *Medicaid Managed Care Spending in 2018* (Health Management Associates, April 2019).
2. Centers for Medicare and Medicaid Services, *Medicaid Managed Care Enrollment and Program Characteristics 2017* (CMS, Winter 2019).

## APPENDIX. STATE-BY-STATE VARIATION WITHIN THE PRIMARY CARE–RELATED DOMAINS OF MEDICAID MANAGED CARE CONTRACTS

### Primary Care Payment Methods and Incentives

Payment Tied to Clinical Outcomes	27 states
Payment Tied to Utilization	14 states
Payment Tied to Health Outcomes	6 states
Payment Tied to Practice Transformation Investment	19 states

### Access Measures and Provider Network Design

Cultural Competence	40 states
Appointment Wait Times	40 states
Provider–Patient Ratios	40 states
Time and Distance	40 states

### Performance Measurement and Quality Improvement

Consumer Primary Care Experience	40 states
Auto-Assignment Tied to Primary Care Performance	24 states
Primary Care Practice Support	26 states
Value-Based Payment Linked to Primary Care Effectiveness	29 states
Women’s Preventive Health	39 states
Primary Care Performance Linked to Payment	36 states
Care Teams	34 states
Preventive Care, Children	40 states
Preventive Care, Adults	40 states

### Relationship to Social Determinants of Health (SDOH)

Member Education for SDOH	5 states
Care Coordination Spanning SDOH	24 states
SDOH Quality Performance Measures	11 states
Dedicated MCO Staff	17 states
Provider Training in SDOH	10 states
Social Determinant Expenditure Requirements/Incentives	3 states
Managed Care/Social Service Provider Relationship	31 states
Collection and Reporting of SDOH Information	7 states
Treatment of SDOH Activities as Value-Added Services	7 states
Social Determinant Screening in Primary Care	24 states

### Behavioral Health Integration

Team Care	30 states
Coordination/Care Management	40 states
Behavioral Health Screening for Adults	37 states
Value-Based Payments	22 states
Telemedicine	25 states
Mental Health Parity	33 states

**Primary Care Patient Support**

Community Health Workers	12 states
Continuity of Care and Transition Across Health Care Settings/Plans	40 states
Beneficiary Access Supports	40 states
“In Lieu Of” Flexibility to Allow Substitution of Services Under Certain Conditions	30 states

**Primary Care Coverage**

Medical Necessity, Children	9 states
Medical Necessity, Adults	36 states
Prior Authorization Barred for Primary Care	7 states
EPSDT Vision, Oral, Hearing Care	36 states
EPSDT Development Assessment	26 states
ACIP-Recommended Immunization for Adults	19 states
Adult Preventive Services	26 states
Family Planning and Related Services	36 states
Primary Care Defined	9 states

**Information Exchange and Health IT**

Submission of Health Information to Generate Performance Reports and Use of Decision-Support Tools	22 states
Adaptive Technology	35 states
Mobile Technology	32 states
Information Exchange with Other Agencies/Programs	36 states
E-prescribing	13 states
Information Exchange Across Practice Settings	39 states

Notes: EPSDT is the Early and Periodic Screening, Diagnostic, and Treatment program, which is the federal Medicaid program for children and adolescents under age 21. ACIP is the Advisory Committee on Immunization Practices.

Source: George Washington University analysis of 40 state Medicaid managed care purchasing documents, including RFPs, model contracts, and/or executed contracts publicly available as of October 1, 2019.

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