Medicaid Accountable Care: Accountable Care Organizations, Medicaid, and Medicaid Health Plans

Prepared for the Medicaid Health Plans of America

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Redefining the possibilities

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Executive Summary

The Affordable Care Act (ACA) provides States with opportunities to improve care and lower costs through innovative payment and care delivery models. In particular, the Accountable Care Organization (ACO) model has generated considerable attention in the medical community, spurred by recent federal regulations for the Medicare ACO program issued by the Centers for Medicare and Medicaid Services (CMS).

Both public and private insurers are experimenting with the concept. As States consider design of Medicaid ACO programs or ACO components, MHPA wishes to comment on the application of the ACO model to Medicaid.

ACOs show potential as a means to improve care. However, Medicaid health plans already fulfill much of the promise of ACOs via managed care. If States are interested in improving care, they should consider expanding on an already successful model, managed care.

For States wishing to use ACOs to serve Medicaid beneficiaries, Medicaid health plans are a necessary partner for success. Simply put, States and providers need help implementing ACOs. Medicaid health plans can establish, partner with, and serve Medicaid ACOs while addressing the specific needs of Medicaid enrollees, providers, and State programs.

Introduction and Background

What is an ACO?

The ACO Learning Network lays out several key principals for ACOs. The ACO Learning Network is an initiative created by the Brooking Institute and the Dartmouth Institute for Health Policy and Clinical Evaluation, two of the leading proponents of the ACO concept.

Key Principles:

- Clear aims: better overall health through higher-quality care and lower costs with a focus on patients.
- Establish provider organizations accountable for achieving better results for all of their patients at a lower cost.
- Align financial, regulatory, and professional incentives with the aims of better health through higher-quality care, lower costs.

[1]

History

ACOs address the inadequacies of the fee-for-service system and empower providers to become accountable for quality and cost across an entire patient encounter. Accountable care incorporates the concepts of managed care, pay-for-performance, gain sharing, and integrated, patient-centered care.

One of the first examples of the ACO model is the Physician Group Practice (PGP) demonstration. The Centers for Medicare and Medicaid Services (CMS) created PGP in April of 2005. The demonstration incentivizes physician groups to increase quality and lower costs. Providers receive payments based on the estimated savings they generate for Medicare, as long as they also meet quality performance standards.

Building on the success of the PGP demonstration, ACA created the Shared Savings program, which expands on the PGP model. ACA also includes provisions for a Medicaid Pediatric ACO demonstration. The Medicare Shared Savings program allows all eligible Medicare providers to form ACOs. These ACOs must report certain quality metrics, like preventative screenings and rates of hospital acquired infections. If ACOs reduce Medicare patient costs while maintaining performance standards, then the providers receive part of the savings for the reduction in costs. However, if patient costs are higher than estimates, providers must eventually cover the higher costs themselves.

- **Provider Accountability and Support: Holds providers up to quality standards and gives them the resources to meet those standards.**
- **Predictive Modeling: Ensures that providers are capable and prepared to implement ACO model.**
- **Primary Care Capacity and Coordination: Gives patients medical homes to better coordinate care.**
- **Financial Performance and Analytics: Inform providers of the financial impact of their care decisions.**
- **Health IT: Helps to prevent care mistakes and allows for adequate quality reporting.**
- **Comprehensive and Chronic Care Management: Reduces costs and improves care for chronic patients.**
- **Provider Profiling and Network Management: Provides adequate health access for patients.**
- **Evidence-Based Guidelines and Care Protocols: Promotes ideal care scenarios for all patients.**
- **Best Practices: Provide examples of high-performance providers to serve as models for other providers.**

Current ACO Developments

Medicare ACOs have garnered considerable attention, but other insurers and providers are also experimenting with the concept.

State ACOs

Some States have already begun to consider implementation of the ACO concept for Medicaid. Legislators in 24 States and the District of Columbia filed bills that address ACOs. Utah submitted an Accountable Care Organization Section 1115 Waiver demonstration. If accepted by CMS, this waiver would convert Utah's Medicaid program from a managed care model to an ACO model. Utah will contract directly with Medicaid ACOs rather than with Medicaid health plans. In addition to quality and access standards, ACOs must also provide medical homes for all Medicaid enrollees.

Dual-Eligible Shared Savings Demonstration

CMS created a demonstration project for the dual-eligible population. Participating States can partner with Medicaid health plans and providers to reduce Medicare and Medicaid health costs. If States reduce health costs, then they get a percentage of the savings. The dual-eligible demonstration shows the flexibility of the ACO concept. CMS limited eligible enrollees to a specific provider population and combined certain ACO concepts, like shared savings, with existing care models, like manage care.

Private ACOs

Private insurers have also begun to experiment with ACOs. The Brooking Institute and the Dartmouth Institute for Health Policy and Clinical Evaluation created a pilot program for provider shared savings contracts with private insurers. The pilot program includes 5 provider networks in Arizona, California, Kentucky, and Virginia. These providers entered in to shared savings contracts with Anthem, United Health, and Humana. If ACOs reduce costs, then they will be eligible for shared savings, like the Medicare ACO program.

Potential ACO Threats and Opportunities for Medicaid Health Plans

ACOs pose certain threats and opportunities for States, providers, and Medicaid health plans. As States consider the adoption of the ACO model, Medicaid health plans will continue to consider the risks and rewards of the ACO model.

Potential ACO Threats and Opportunities for Medicaid Health Plans	
Threats	**Opportunities**
• ACOs could evolve into a competitive alternative to the capitated health plan model in some States. • Providers in some States may be eager to supplant health plans in marketplace. • ACO model is expected to encourage further provider consolidation, with adverse effects on prices and choice. • Competitive threat intensifies as providers consolidate and redesign care delivery.	• Shared savings is a means to address cost pressures and reward efficient providers, all while protecting quality. • ACOs provide a new market for administrative services from Medicaid health plans: o Data collection and quality reporting o Data warehouses, analytics, and predictive models o Administrative services o Access to an extensive Medicaid provider network • ACOs are a means to compete for Medicaid expansion and health exchange market.

Medicaid Health Plans Already Accomplish the Goals of ACOs

Three key components of an ACO are performance measurement, accountability, and financial incentives.[2] MHPA agrees that these are important strategies for reforming health care delivery. However, Medicaid health plans are already using those same components without ACOs. More importantly, this established framework of managed care offers lower cost and higher quality care than fee-for-service care.

Performance Measurement

- HEDIS measures provide adequate quality measurements for Medicaid beneficiaries
- Cultural competency regulations require proper care environments for all races and ethnicities
- Performance standards tie quality measurements to care requirements to maintain health quality

Cultural Competency in Action: California's Managed Care Cultural and Linguistic Requirements

Medicaid health plans must meet several accountability standards held by States. For example, California's Cultural Competency Plan requires adequate health access regardless of cultural or language background.

Specific Medicaid health plan requirements include:

- 24 hour access to interpreter services for all members with limited English proficiency (LEP).
- Contractors must inform members that free interpretive services are available.
- Members may also rely upon friends, family members, or other interpreters at their own cost.
  - Such services are available during discussions of all health information.
- All materials must be translated if 3,000 people or 5% (whichever is less) of members have LEP in a certain language.
- Health plans must submit a Cultural and Group Needs Assessment after 2 years to promote the provision and utilization of LEP services, and provide an annual report on the use and effectiveness of current LEP services.

Medicaid health plans' performance standards ensure accountable care for Medicaid enrollees. Private and public insurers should look to existing Medicaid managed care quality metrics as they look to implement quality standards in ACO programs.

<u>HEDIS</u>

One of the most important components of the ACO model is performance measurement. Providers cannot receive shared savings unless they meet certain quality criteria. Medicaid health plans already have an established set of criteria, the Healthcare Effectiveness Data and Information Set (HEDIS). Developed by the Nation Committee for Quality Assurance (NCQA), HEDIS performs the difficult task of measuring quality for the Medicaid population.

Cultural Competency

Medicaid enrollees are more racially and ethnically diverse than the overall American patient population.[3] Publicly insured African-American and Hispanic patients have worse quality indicators than their white counterparts on a range of quality metrics such as pediatric dental visits and rates of obesity and diabetes.[4] Community health advocates argue for unique care approaches, like foreign language support services, to improve care delivery.[5] Proper quality metrics must account for the unique cultural needs of the Medicaid patient population. States already require Medicaid health plans to fulfill cultural competency requirements. These requirements ensure that Medicaid health plans meet the unique needs of Medicaid beneficiaries.

Performance Standards

Quality measurement is only effective if it is used to develop standards of appropriate care. States have already established performance and quality requirements for Medicaid health plan participation. States can establish sanctions for Medicaid health plans that fail to meet standards, and create performance incentives for Medicaid health plans that exceed requirements. These standards ensure that States benefit from quality measurement.

Accountability

- Managed care contracts hold Medicaid health plans accountable for the cost and quality of care.
- States pay Medicaid health plans through payment methods, like capitation, that encourage cost-effective care.
- Existing State managed care financial viability and accountability standards ensure that Medicaid health plans are able capable of providing care.

Managed Care Contracts

Medicaid managed care contracts are an essential tool to establish accountability. States enter in to individual contracts with Medicaid health plans to provide care to Medicaid beneficiaries. States use these contracts to ensure that Medicaid health plans remain accountable to beneficiaries. Contracts may include sanctions for low-performance plans and benefits for high-performance plans. States may also threaten not to renew contracts with especially low-performance plans. These types of incentives keep Medicaid health plans accountable to beneficiaries.

State Managed Care Payment

State managed care payment mechanisms also hold Medicaid health plans accountable for the quality and cost of patient care. For example, many Medicaid health plans operate under capitated rate agreements with States. If enrollee care costs are below the rate of capitation, then the plan can keep the extra revenue. If enrollee care costs are above the rate of capitation, then the plan is liable to cover those costs. Capitation incentivizes cost-effective care.

Financial Viability and Accountability Standards

Medicaid health plans and States are committed to maintaining quality standards for Medicaid patients and providers. Financial accountability in any model of care is important. Medicaid health plans must pass strict financial certification in order to participate in Medicaid.

Financial Incentives

While ACOs are a new concept, care improvement incentives are not. Medicaid health plans have long had such incentives at both the provider and patient level. With years of experience, Medicaid health plans have gained valuable insight in to using incentives for better performance outcomes.

Experience with Incentive Programs: Inland Health Empire

Inland Health Empire is a Medicaid health plan in California. It has used performance incentives since 1997 to improve quality of care. Their first pay-for-performance plan was an immunization program that offered higher reimbursement rates for more timely immunizations. Inland Health Empire continues to incentivize both providers and beneficiaries to improve care.

Two examples of their incentive programs include:

- Enhanced Primary Care Access
  The Enhanced Primary Care Access program encourages primary care practices to provide a wider range of services than other primary care providers in order to decrease patient costs for other services like emergency room care. Expanded provider services include longer office hours and care management staff. In return for developing these additional resources, providers receive increased reimbursement rates.

- Diabetes Management
  Inland Health Empire's Diabetes Management program offers increased services to beneficiaries that enroll in the program as incentives. For instance, members have access to additional staff resources like nutritionists and diabetic educators. Members can also receive free transportation to clinics for care.

Proven Track Record and Potential for Future Improvement

ACA has generated a renewed excitement in the potential for health care innovation. However, Medicaid Health Plans were lowering costs and improving quality for State Medicaid programs long before ACA was enacted. Also, as States continue to grapple with increased cost constraints, significant savings potential remains in Medicaid managed care.

Lower Costs
Medicaid health plans reduce costs for States. In 2004, the Lewin Group synthesized the results of 14 studies on the effect of Medicaid managed care on costs. They found that Medicaid managed care reduced costs for their patient population in nearly all instances.[6] Cost reduction varied from 2% to 19%.[7]

Higher Quality
While Medicaid health plan performance may vary from plan to plan, many Medicaid plans have demonstrated a continued commitment to increase the quality of care for Medicaid beneficiaries. Through increased care coordination, beneficiary outreach, and the use of information technology, Medicaid health plans have improved care for millions.

Potential for Cost and Quality Improvement

Medicaid health plans have the potential to further reduce costs and improve quality for States. Although a large number of Medicaid beneficiaries participate in Medicaid managed care, Medicaid health plans are responsible for a small percentage of overall health expenditures. For instance, only six States have Medicaid programs where Medicaid health plans are responsible for over 30% of Medicaid costs.[8]

If Medicaid health plans were responsible for a larger percentage of Medicaid expenditures, then they could continue to reduce costs. A 2006 Lewin study stated that fully capitating Medicaid costs could result in a savings of up to $87 billion over ten years to the Medicaid program.9 Lewin published the study before ACA expanded the Medicaid population, so potential cost savings are likely higher than first projected.

Also, Medicaid health plans provide an excellent format for continued quality improvements like the implementation of Patient-Centered Medical Homes (PCMH). Established quality indicators and substantial regulatory oversight by States and the federal government provide an ideal environment for PCMH implementation.

As States consider different Medicaid reforms, Medicaid health plans provide proof that managed care can work for both States and their beneficiaries.

Medicaid Health Plans Essential for Successful Medicaid ACOs

While managed care is a proven option for improving Medicaid, several States may consider focusing on the ACO model. Those State Medicaid programs will have challenges adapting to the ACO model of care. However, ACOs may reduce costs and improve quality if States can properly design models to suit their Medicaid programs. Medicaid health plans involvement is necessary to accomplish that goal.

- Medicaid health plans have the capabilities, systems, and financial resources to help States and providers implement Medicaid ACOs.
- Medicaid health plans understand the unique needs of Medicaid enrollees and have established working relationships with Medicaid providers, particularly safety-net providers.
- Most States have an actualized strategy regarding Medicaid health plans that can be applied to ACOs.

Benefits of Medicaid Health Plan Participation in Medicaid ACOs		
For States	**For Beneficiaries**	**For Providers**
• Quality measures are already in place. • Accountability safeguards • Can administer Medicaid ACOs without significant State administrative or financial resources. • Flexible enough to cater ACO capabilities to State needs.	• Existing provider networks ensure adequate health access. • Knowledge of patient population. • Experienced outreach and enrollment practices. • Already required to account for linguistic and cultural capacity.	• Capable of paying upfront ACO implementation costs. • Experienced risk modeling. • Established relationships with primary care providers. • Can provide assistance in partnership with or as a service to providers.

Financial Viability

- Medicaid health plans are more financially able to cover upfront ACO implementation costs.
- Medicaid health plans are experienced insurance risk managers and already engaged in complimentary initiatives to improve quality of care for low-income consumers.

ACO Implementation Costs

Safety-net providers will likely require financial assistance to make the necessary changes required to become ACO providers. Medicaid health plans are in a strong financial position, and are poised for significant enrollment growth in 2014-2016. Unlike States or providers themselves, Medicaid health plans may have the additional resources to provide upfront ACO implementation costs.

Medicaid health plans provide cost effective care allowing States to demonstrate significant cost containment. In fact, expanded Medicaid eligibility and continued success of cost and quality control has made managed care an increasingly popular option for many States. Medicaid health plans are responsible for about $100 billion in Medicaid services today. Over the next several years, States will

issue a projected $ 80 billion in new managed care contracts.[10] A healthy financial outlook enables Medicaid health plans to invest in new care models, like ACOs. If Medicaid health plans support providers with infrastructure and administrative investments, there will be an incentive for providers to work in conjunction with health plans to form ACOs.

Risk Management

Providers must make medical decisions that do not hurt their financial viability. Risk management issues were one of the main reasons many providers gave up on provider-operated managed care in the past. With proper risk management provided by Medicaid health plans, providers can make educated treatment decisions that improve quality without fear of financial collapse. Medicaid health plans are experienced risk managers that can handle both ACO financial and performance risk.

The ACO model necessitates financial risks for providers. ACOs will lose money if shared savings do not make up for reduced care costs. In a two-sided shared savings model, providers are at risk of not receiving reimbursement for care costs above projected estimates. Medicaid health plans can provide the financial modeling necessary to ensure that care delivery changes will yield financial returns. ACOs administered by Medicaid health plans would have the benefit of quality financial modeling when making financial decisions.

In the ACO model, cost reduction only leads to shared savings if providers meet quality standards. Managed care plans have the necessary expertise to design quality improvement strategies that ensure providers meet quality standards. If States allow Medicaid health plans to form ACOs, they can design performance improvement plans that meet quality standards.

Experienced Medicaid Provider and Enrollee Interaction

- Medicaid health plans already have access to enrollees and provider networks.
- Medicaid health plans can tailor ACO services to State and provider needs.

Market Penetration

70% of Medicaid recipients are in some form of managed care.[11] With such a large percentage of patients already under their care, Medicaid health plans have an established relationship with many of the patients that might receive care from ACOs through a Medicaid health plan framework. This relationship will only grow with Medicaid expansion, as States will rely on Medicaid health plans to control costs for newly-eligible enrollees.

Part of the work of developing ACOs will be forming collections of providers that can properly handle all facets of patient care. Medicaid health plans have established networks themselves, so ACOs developed by Medicaid health plans would start with adequate provider access.

Flexibility

States may want to experiment with different variations of the ACO concept rather than implement the entire model of delivery. ACO models may also differ depending on the level of State experience with managed care. Medicaid health plans are prepared to cater to the unique needs of each State.

- States and provider communities can focus on specific ACO concepts like shared savings, or quality reporting. Medicaid health plans can provide those specific services.

- States may wish to limit ACO beneficiary populations to specific enrollee groups. Medicaid health plans have a history managing the care of specific Medicaid enrollee groups.
- Depending on State and provider preference, Medicaid health plans can provide assistance either in partnership with ACOs or as a service to ACOs in a client-vendor relationship.
  - Medicaid health plans could work with States to operate Medicaid ACOs through their managed care contracts. Medicaid health plans would coordinate with providers and administer the ACOs.
  - Other States, like Utah, may wish to contract directly with ACOs. In this scenario, Medicaid health plans could provide services like data collection, network development, and shared saving support.

Possible ACO Model Variation Depending on State Managed Care Environment			
Environment	**Weak Managed Care**	**Moderate Managed Care**	**Strong Managed Care**
Payment	• ACO Bonus Only	• ACO Bonus and Penalty	• Global Fee, Partial Cap
Responsibility	• Bonus for low spending • Bonus contingent on quality scores • No insurance or performance risk	• Bonus for low spending • Penalty for higher spending • Partial performance risk but no insurance risk	• Retain savings from low spending • Absorb cost of higher spending • Bonuses for quality • Partial insurance and performance risk
Operation	• FFS claiming as usual • Distribute bonus payments to ACO providers • Coordinate care	• FFS claiming as usual • Distribute bonuses and pay penalties • Coordinate care	• Receive global payment or partial capitation • Share net savings and losses with ACO providers • Coordinate care
Incentives	• Incentive to reduce volume, redesign care • Enough to compensate for lower FFS volume?	• Strong incentive to constrain utilization and redesign care • But will provider volunteer for down-side risk? Especially poor performers?	• Finances aligned with lower utilization growth and care redesign

Medicaid ACO Policy Prescriptions

States wishing to implement Medicaid ACOs should consider the following policies when creating their ACO laws:

- **No Non-provider Participation Restrictions**
  Medicaid health plans financial participation is crucial if providers are to be able to afford the significant implementation costs required of ACOs. States should not limit the participation of Medicaid health plans in ACOs.

- **Prevent Antitrust Issues**
  Current State and federal antitrust laws hamper the formation of ACOs. Medicaid health plans and providers will need State antitrust protection so they can align incentives to control cost and improve quality. States should offer anti-trust safe harbor protection for Medicaid ACOs.

- **One-sided Shared Savings Model**
  Medicaid ACO regulations should be limited to one-sided shared savings models where providers still receive reimbursement even if costs are larger than projected. Two-sided shared savings may discourage providers from participating. If States implement ACOs in conjunction with managed care, then Medicaid health plans will be capable of limiting costs even without the threat of increased cost liability for ACO providers.

- **Value Improvement as Well as Quality**
  Safety net providers care for a sicker population with more limited resources than other hospitals. States should reward ACOs for improving the quality of care for sick patients just as they should reward ACOs for maintaining high overall quality.

- **Allow Targeted ACO Patient Populations.**
  ACOs may be more effective when focused on specific patient populations with related issues and problems. States should allow specialty ACOs that focus on specialty populations.

- **Require HEDIS Quality Metrics and Managed Care Performance Standards to ACOs**
  States should use the same quality metrics and performance standards for ACOs as they use for Medicaid health plans. Uniform metrics and standards will ease implementation, provide continuity across the care spectrum and ensure accountability.

- **Allow for Automatic Beneficiary Assignment and Limited Out-of-Network Access**
  States should implement automatic beneficiary assignment and allow Medicaid health plans to limit access to out-of-network providers. These measures will allow ACOs to deal with Medicaid churn. Also, automatic enrollment and access limits will provide safeguards for investing in increased care for patients without fear that the patient will switch providers before ACOs receive a return on their care investments.

Conclusion

States are struggling to meet the demands of their Medicaid enrollees while also preparing for Medicaid expansion. ACOs are an attractive approach to quality and cost control. They have the potential to realign care delivery, foster medical homes, and decrease care costs.

However, Medicaid health plans provide an established means to accomplish those same goals. Medicaid health plans have the expertise and skills to meet the needs of the Medicaid population.

MHPA realizes that some States may choose to experiment with other care models despite the proven record of managed care. Medicaid health plans are a vital partner for States wishing to use the ACO model. Their financial expertise, enrollee and provider experience, and strong relationships with States provide a solid foundation for ACO development. Regardless of the means of implementation, the involvement of Medicaid health plans is critical to the success of health delivery improvement in Medicaid.

Glossary

"Affordable Care Act"- enacted in March of 2010, the Patient Protection and Affordable Care Act or Affordable Care Act (ACA) was created to expand health insurance access and reduce health care costs. Two of the important measures in ACA were the expansion of Medicaid eligibility and the creation of the Medicare Shared Savings Program.

"Capitation"- is a method of health care payment whereby a health care plan or provider is paid a set amount of money per enrollee. Capitation is an alternative to fee-for-service where a provider is paid a set amount per service provided.

"Churn"- means cycling in and out of insurance or a public benefit program. Churn is problematic for Medicaid ACOs. In the ACO concept, providers receive shared savings for reducing health costs for patients that participate in the ACO. Unstable patient populations will complicate ACO beneficiary assignment and make it difficult to determine which providers deserve shared savings payments.

"Dual eligibles"- are beneficiaries eligible for both Medicare and Medicaid.

" Healthcare Effectiveness Data and Information Set (HEDIS)" – is a tool used by many health plans to measure health care performance. HEDIS uses 75 measures across 8 aspects of care.

"One-sided shared savings"- is a method of ACO payment. A government or health plan projects overall health costs for all beneficiaries in an ACO. If costs are lower than projected, the ACO receives a percentage of the difference between projected costs and actual costs. However, if actual costs are high than projected costs, the ACO is still entitled to receive payments for those larger than expected costs.

"Nation Committee for Quality Assurance (NCQA)"- is a private, not-for-profit organization whose mission is to improve health care by developing metrics that adequately track care quality.

"Patient-Centered Medical Homes (PCMH)"- are a model of care delivery. They provide a central location for health information and health care decision making for the patient. Usually established in a primary care setting, PCMHs encourage a more collaborative health care delivery system for patients.

"Two-sided shared savings"- is a method of ACO payment A government or health plan projects overall health costs for all beneficiaries in an ACO. If costs are lower than projected, the ACO receives a percentage of the difference between projected costs and actual costs. If costs are higher than projected, then the ACO is liable for the increased costs.

ACO Resources

"The ACO Learning Network"- is a joint project created by the Engelberg Center for Health Care Reform at Brookings and the Dartmouth Institute for Health Policy & Clinical Practice. The purpose of the organization is to provide resources to those who wish to learn more about the ACO concept. The ACO Leaning Network has also developed "The ACO Toolkit," an instruction manual for organizations interested in developing ACOs. On the web at www.acolearningnetwork.org.

"Center for Medicare and Medicaid Innovation (CMI)"- Established by ACA under the Centers for Medicare and Medicaid Services, CMI was created to help test new health care payment and delivery programs. CMI has the authority to develop pilot and demonstration programs with States and providers that experiment with innovative programs. On the web at innovations.cms.gov.

"The Commonwealth Fund"- is a private foundation that looks to improve health quality, access and affordability. The Commonwealth Fund supports independent research focused on improving health care. Many of these projects are available for review on their website. On the web at www.commonwealthfund.org.

"Health Affairs"- is a peer-reviewed health policy journal. Formed in 1981, *"Health Affairs"* explores both domestic and international issues of health policy. Recent articles in the journal have focused on the ACO model. Although most of their articles requirement payment, some of the articles and blog posts on their website is free. On the web at www.healthaffairs.org.

"The Kaiser Family Foundation"- is a private foundation focused on major issues facing the United States health system as well as global health policy. Kaiser produces independent health care research, serves as an information clearinghouse for health care analysis, and organizes public health campaigns. Aside from the reports and analysis on their website, Kaiser also electronically publishes a daily health policy report that covers the relevant health policy news of the day. On the web at www.kff.org.

Endnotes

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[2] Id.

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Medicaid Health Plans of America

Medicaid Health Plans of America is the leading national organization solely dedicated to representing health plans participating in Medicaid managed care. The Association's primary focus is to provide research, analysis, and organized forums that support the development of effective policy solutions to promote and enhance the delivery of quality healthcare. On the web at www.mhpa.org.

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