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MEDICAID

States Turn to Managed Care to Improve Access and Control Costs

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The Honorable John D. Dingell
Chairman, Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

Rising costs and enrollment are severely straining Medicaid, the largest government program financing health care for the poor. During most of the 1980s, Medicaid costs grew up to 10 percent a year, and, in 1989, began to rise even more rapidly. In fiscal year 1992, federal and state spending on Medicaid totaled $119 billion—a 29-percent increase over the previous year's total. In addition, the number of beneficiaries from 1991 to 1992 increased an estimated 10 percent to about 31 million.

Medicaid was intended to make health care more accessible to the nation's poor. Yet in many communities Medicaid beneficiaries cannot find physicians who are willing to treat them. Two primary reasons for the reluctance of physicians to take Medicaid patients are the program's historically low reimbursement rates and cumbersome administrative requirements. In response to the access problem as well as that of growing costs, many states have been experimenting with Medicaid managed care programs. Managed care is widely viewed as one approach that may yield dividends in terms of access, quality, and cost savings.

We and others have reported on certain problems with states' managed care programs under Medicaid. These problems include limitations on access to care; poor quality of services; and weak oversight of providers' financial reporting, disclosure of ownership, and solvency. Mindful of these problems, you requested that we take a broader look at managed care program initiatives states have developed, focusing on the following: (1) states' use of managed care programs; (2) the difficulty states face in implementing certain program components; (3) the effect of the managed care approach on health care access, quality, and cost; and (4) the presence of features that assure the quality of health services and providers' financial stability.

In doing this work, we surveyed the Medicaid offices in the 50 states and the District of Columbia.[1] We performed more detailed work in six states—Arizona, Kentucky, Michigan, Minnesota, New York, and Oregon.

[1]For the purpose of this report, we refer to the District of Columbia as a state.

In each of these states we interviewed Medicaid officials, advocacy group representatives, and health care providers. We also interviewed Health Care Financing Administration (HCFA) headquarters' officials with responsibility for developing program guidance and overseeing the states' managed care programs. We reviewed the general literature on Medicaid managed care as well as state-prepared and commissioned evaluations of managed care programs' effects on health care access, quality, and cost. Direct comparisons across studies are difficult because of the different methodologies used in the studies and the varying program designs.

The results of our work are summarized below and discussed in detail in appendixes I through IX. Appendix X contains a discussion of our methodology. Our work was performed in accordance with generally accepted government auditing standards.

Background

States confront two serious problems in meeting their responsibility to provide health services to Medicaid beneficiaries—the uncontrolled growth of health care costs and the lack of physicians and other providers willing to treat Medicaid patients. Under traditional fee-for-service (FFS) arrangements neither the state nor any other entity monitors the physician's provision of services. Medicaid's fee-for-service arrangements have been widely recognized as inadequate in terms of controlling costs and assuring quality care.

In addition, access issues compound cost problems. Some Medicaid patients unable to obtain primary care from a physician turn to emergency rooms—a costly and inappropriate alternative. Under these circumstances, care can be episodic and fragmented, resulting in duplicated tests, inappropriate combinations of prescriptions, or hospitalizations that could have been prevented. Still others delay obtaining treatment altogether until their condition worsens and requires costly hospitalization.

In response to cost and access problems, states have increasingly turned to managed care delivery systems. Managed care in Medicaid is not a single health care delivery plan, but rather a continuum of models that share a common approach. At one end of the continuum are prepaid or capitated models that pay organizations a per capita amount each month to provide or arrange for all covered services. At the other are primary care case management (PCCM) models, which are similar to traditional fee-for-service arrangements except that providers receive a per capita

management fee to coordinate a patient's care in addition to reimbursement for the services they provide. Common to all managed care models in the Medicaid program is the use of a primary care physician to control (i.e., to act as a "gatekeeper") and coordinate the delivery of health services in a cost-conscious manner.

Although there have been prepaid health plans in Medicaid since the 1960s, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35, section 2175(b)) gave states greater flexibility to design managed care health plans under section 1915(b) of the Social Security Act.[2] In addition, HCFA allows states to experiment with innovative approaches to managing Medicaid through research and demonstration projects authorized under section 1115 of the Social Security Act.[3] In most cases, states must obtain a waiver from HCFA of federal statutory requirements when developing managed care programs.

Results in Brief

As one response to the skyrocketing costs of providing health care to Medicaid beneficiaries, most states are rapidly developing or expanding their managed care programs. From 1987 to 1992, states' total enrollment of Medicaid beneficiaries into managed care programs has more than doubled. Currently, two-thirds of the states have programs, and by 1994 nearly all states expect to have at least one managed care program in place.

Many states using or planning to use managed care in their Medicaid programs are choosing the PCCM approach for paying providers. Providers appear more willing to participate in the Medicaid program when it is structured on a PCCM approach because reimbursement for individual services continues to be made on a fee-for-service basis. At the same time most states are targeting their Medicaid-eligible populations of low-income women and children for enrollment in managed care programs.

States choosing managed care for their Medicaid programs report facing difficult implementation issues. First, in planning the implementation of a managed care program states have found that problems can arise if they move forward too quickly, do not have staff expertise, and have not developed a community base of support. Second, if states decide to move

[2]42 U.S.C. Section 1396n(b). These section 1915(b) waivers allowed HCFA to grant states exclusions from Medicaid program requirements concerning statewide implementation of the program, comparability of services, and recipient freedom-of-choice in plan selection.

[3]42 U.S.C. Section 1315.

a greater number of Medicaid beneficiaries into managed care settings by making enrollment mandatory, they must obtain federal approval. Third, states have had difficulty encouraging the participation of commercial managed care plans, such as health maintenance organizations (HMO). Finally, to make managed care work, states have to develop education programs so that beneficiaries will understand how to access services in this unfamiliar environment.

Medicaid managed care plans have had mixed results in improving access to care, assuring the quality of services, and saving money. The literature and views of beneficiary advocacy groups indicate that beneficiaries' access to care in managed care plans is slightly better than in traditional fee-for-service settings. Studies report that the quality of managed care services is about equal to those provided under Medicaid fee-for-service. Finally, conflicting reports on program savings render findings on costs inconclusive.

States moving to managed care are under increasing pressure to monitor access and quality of services provided to Medicaid beneficiaries to ensure that providers' medical decisions are not compromised by financial incentives. While fee-for-service payments give providers incentives to provide too many services, capitation payments give providers incentives to provide too few services. There have been problems in services being provided and high disenrollments suggesting beneficiary dissatisfaction. Further, in the past, states did not have monitoring programs in place that could detect when providers had accepted too much financial risk and were in danger of becoming insolvent. States are working to improve their quality assurance and financial monitoring systems and looking to HCFA for help in developing better ways to measure quality and provider solvency.

States Increase Use of Managed Care in Their Medicaid Programs

Medicaid managed care enrollment more than doubled between 1987 and 1992, and included about 3.6 million beneficiaries nationwide (about 12 percent of the total Medicaid population), as of June 30, 1992. Thirty-six states were operating one or more managed care programs for Medicaid beneficiaries in February 1993. Our survey found that states participating in managed care are employing a wide variety of managed care models. We found that 17 states have established PCCM programs, 7 states have established partially capitated programs, and 25 states have established fully capitated programs. Ten of the 13 states that were planning to implement managed care programs for their Medicaid beneficiaries expected to use fee-for-service PCCM models.

Increasingly, states are choosing PCCM programs because providers are more willing to participate in a fee-for-service, rather than a capitated-based reimbursement system. Because of low reimbursement rates, assumption of financial risk, and administrative burden, states have struggled to attract providers to capitated models of managed care. Case management programs are attractive to states and providers alike because they retain the concept of managed care but continue with fee-for-service reimbursements that are free from the financial risk providers assume under capitation.

All of the 36 states with managed care programs target their programs to the Aid to Families with Dependent Children (AFDC) population.[4] Other Medicaid populations are included by states to varying degrees. While Supplemental Security Income (SSI) and SSI-related individuals account for about 27 percent of the Medicaid population, their health care costs account for about 70 percent of Medicaid expenditures.[5] AFDC and AFDC-related beneficiaries, on the other hand, constitute about 70 percent of all persons eligible for Medicaid, but only account for about 29 percent of Medicaid costs because they generally require fewer and less expensive services than the SSI population. In part, these populations are attractive managed care candidates because it is presumed they would benefit more than other populations from the types of preventive services that are the hallmark of a managed care service delivery strategy. The theory is that through managed care these populations will obtain cost effective preventive services, thus avoiding more costly services later. In addition, these populations are similar, particularly in age, to those being predominantly served by commercial HMOs.

[4]AFDC is a federal/state entitlement program that provides cash welfare payments to certain low-income families—particularly those with an absent parent. AFDC-related populations includes certain groups the states are required to cover whose circumstances are similar to AFDC, but who are not receiving cash assistance; all pregnant women and children that are eligible based on their family income relative to the federal poverty level, and children who would be eligible for AFDC except that they do not meet the program definition of dependent child.

[5]SSI is a means-tested, federally-administered income assistance program for needy aged, blind, or disabled persons. SSI-related individuals include aged, blind, and disabled persons receiving state supplemental payments, in addition to SSI. SSI-related individuals also include people who have too much income to qualify for SSI or supplemental payments but too little to cover their health care costs. These individuals reside in a nursing home or other medical institution or, at state option, in the community. States can set an upper level for eligibility for the groups at up to 300 percent of the SSI payment.

Implementation of Managed Care Raises Difficult Issues

Regardless of the managed care model used, states report facing a set of difficult implementation issues. Four important issues involve planning, making enrollment mandatory, setting capitation rates, and educating beneficiaries about the program.

Planning for Implementation Is Important

State Medicaid officials and other experts have emphasized the importance of the planning phase for a managed care program. Specifically, states need to take enough time to plan, acquire staff expertise, and develop a base of support with the community being served. Taking such an approach allows a state to develop the operational structure necessary for a program that is quite different from traditional fee-for-service. Because of these differences, a commitment of staff resources with the right expertise needs to be made. Finally, we observed that states with successful managed care programs had developed a strong base of community support with persons, such as physicians, who were critical to the success of the program.

Many States Consider Mandatory Enrollment Critical

Twenty-six states have mandatory managed care programs. State officials report a preference for making enrollment in managed care mandatory because they believe it improves beneficiaries' access to care by developing stable doctor-patient relationships. Such a requirement also assures a large pool of eligible beneficiaries to attract providers and to maintain the providers' financial viability.

States must obtain federal approval to mandate enrollment in managed care programs, restrict beneficiaries' movement in and out of plans, and, on occasion, lock in individuals to a specific plan. States obtain this approval by applying to HCFA for a program waiver. States generally mandate enrollment only in areas with sufficient providers to allow beneficiaries a choice of health plans.

Except for demonstration project waivers, which are generally not renewed, states must renew their managed care waivers every 2 years, regardless of how long or how successfully they have run their managed care programs.[6] State officials view the waiver process as an undue administrative burden requiring the use of scarce resources to prepare waiver applications and renewals.

[6]Appendix IX contains a description of the federal waiver process used for Medicaid managed care programs.

Low Payment Rates Make Attracting Commercial HMOs Difficult

Attracting sufficient numbers of providers for Medicaid managed care presents states with a major challenge, because Medicaid rules require that managed care rates not exceed the aggregate cost of the historically low fee-for-service reimbursement rates. In the past, Minnesota, which has a strong tradition of managed care, has had some trouble attracting and even in retaining commercial HMO participation in the Medicaid managed care program because of dissatisfaction over reimbursement, according to a state official.

Education Efforts Key to Assuring Beneficiary Participation in Managed Care

The assignment of a beneficiary to a primary care physician does not guarantee access to health care, and, as a result, states and the plans themselves report using different strategies to educate beneficiaries. States assert that managed care is most successful when beneficiaries understand and are willing to comply with rules for obtaining care. Marketing can be used to educate beneficiaries about health plans, but it also has been used to mislead or coerce beneficiaries to gain their enrollment. For example, contracting health plans may tell beneficiaries that they are required to enroll in that plan when in fact the beneficiaries have a choice of plans.

Impact of Managed Care on Access, Quality, and Cost Is Mixed

The major reasons states report moving to managed care delivery systems are their frustration with rising and uncontrolled Medicaid costs under fee-for-service arrangements, poor access to health care for beneficiaries, and uncertain quality. Studies of these issues, as well as of our reviews of the programs in the six states we visited, indicate that managed care has achieved a slight improvement in access and general beneficiary satisfaction. However, quality has stayed about the same as traditional Medicaid fee-for-service arrangements. Although states report cost savings to HCFA, other studies dispute such findings.

Slight Improvements in Access Reported

Studies evaluating access to care have drawn different conclusions, but generally indicate a slight improvement under Medicaid managed care. These studies use a variety of measures to evaluate access to health care that tend to focus on the frequency of patient visits, appointments, and office waiting times. They generally do not assess the number and availability of providers in a particular service area. For example, several studies assessing access in Medicaid managed care in the early 1980s compared beneficiaries' experiences in capitated state demonstration programs with traditional fee-for-service. In a summary of findings

comparing managed care demonstration sites to fee-for-service sites in two states,[7] access to care was perceived by beneficiaries to be greater than that of traditional fee-for-service. However, results assessing objective measures of access—including waiting times for appointments, travel time, and office wait time—were mixed in one state and equivalent to fee-for-service in the other.

More recent studies and our review of the programs in the six states we visited, generally indicate better access to routine and preventive care and a reduction in inappropriate emergency room visits. Beneficiary advocacy groups in four of the six states we visited also reported improvements in access. Advocacy groups in the other two states believed that managed care had not contributed to better access.

Quality Similar to That Found in Traditional Fee-For-Service Programs

National studies and those performed in the six states we visited show evidence that the quality of care provided in Medicaid managed care programs about equal to that provided in traditional Medicaid fee-for-service programs. However, these findings are based on assessments of the structure of a provider's plan or on selected medical outcomes. For example, several studies in 1991 and 1992 compared outcomes among groups of pregnant women enrolled in managed care and traditional fee-for-service programs. They consistently found no significant difference among the groups. Also, external evaluations of quality in the six states' programs generally concluded that care was about the same as that provided in traditional Medicaid programs.

Cost Savings Are Uncertain

Although recent studies provide evidence that Medicaid managed care programs save money, others conclude that savings have only been achieved in staff or group model HMOs. Still others point to the difficulty in measuring actual cost savings and the possibility of disparate results based on the methodology used.

All six states we visited reported cost savings over their estimates for traditional fee-for-service. There is some dispute over these results, however, based on the methodologies and assumptions states used to

[7]Deborah Freund, Lewis Rossiter, Peter Fox, Jack Meyer, Robert Hurley, Timothy Carey, and John Paul, "Evaluation of the Medicaid Competition Demonstrations," Health Care Financing Review, Vol. 11, No. 2, 1989, pp. 81-97.

measure savings.[8] State Medicaid officials with capitated programs report another benefit of managed care—that of better predictability of their Medicaid costs because of the fixed nature of capitation payments. They also report that managed care programs can reduce the inappropriate use of emergency rooms.

Oversight of Managed Care Plans Needs Strengthening

Under the capitated approach to reimbursement, the financial incentives to underserve beneficiaries create added pressure on states to carefully monitor the access and quality of care delivered. In 1990, we found that in the Chicago area, small groups of physicians under subcontracts with managed care plans had assumed much of the financial risk of treating beneficiaries and were at risk of insolvency.[9] At that time, there were few requirements for states to monitor providers' financial viability, thereby leaving beneficiaries unprotected from the providers' need to cut back on office visits or needed but costly treatments. In addition, in 1985, we reported on the interconnected business relationships during the first two years of Arizona's managed care program that could have enabled health plans to divert Medicaid funds to inappropriate private use.[10]

Currently, states that operate managed care programs must comply with federal requirements intended primarily to assure quality in capitated programs. The six states we visited had established a quality assurance system—with components that entail reviewing data on the utilization of services provided,[11] reviewing patients' medical records, providing grievance procedures for patients to appeal decisions, and conducting patient satisfaction surveys. Federal requirements place greater emphasis on plan structure and administrative functions than on actual health outcomes. Recently, HCFA established a quality assurance initiative that aims at subjecting Medicaid managed care plans to current quality assurance standards and making the standards consistent with those in Medicare and the private sector.

[8]An attempt was made in these studies to control for all other factors in order to assess the effect of managed care alone, but data and methodological limitations in evaluating these programs precluded controlling all factors that might influence cost.

[9]Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 27, 1990).

[10]Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985).

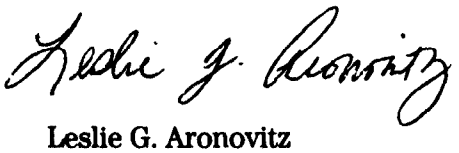
[11]Utilization reviews assess the amount and necessity of services provided to a particular patient or a whole population.

In addition, HCFA currently requires states to review plans' financial reports for solvency, ownership, and control. Generally, state Medicaid agencies report having limited experience in financial monitoring and sometimes rely on the regulatory oversight of other state agencies, such as the insurance or public health departments, to perform these reviews. As we found in 1990, there are still no requirements for states to monitor the financial condition and solvency of subcontractors who provide managed care for Medicaid beneficiaries. As a result, the states may not know when subcontractors have assumed too much financial risk and thus, may be motivated to provide fewer services to beneficiaries than are necessary. HCFA recently issued regulations to minimize the financial incentives placed on an individual physician in a plan.[12]

We discussed a draft of this report with HCFA officials in the Medicaid Bureau and the Office of Research and Demonstrations. They generally agreed with the information presented. We have incorporated their comments where appropriate. We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Health Care Financing Administration, the Director of the Office of Management and Budget, and other interested parties. We also will make copies available to others on request.

Please call me on (202) 512-7104 if you or your staffs have any questions about this report. Other major contributors are listed in appendix XI.

Sincerely yours,



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[12]57 Fed. Reg. 59024.

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Abbreviations

AFDC	Aid to Families with Dependent Children
AHCCCS	Arizona Health Care Cost Containment System
FFS	fee-for-service
HCFA	Health Care Financing Administration
HMO	health maintenance organization
KenPAC	Kentucky Patient Access and Care System
PCCM	primary care case management
SSI	Supplemental Security Income

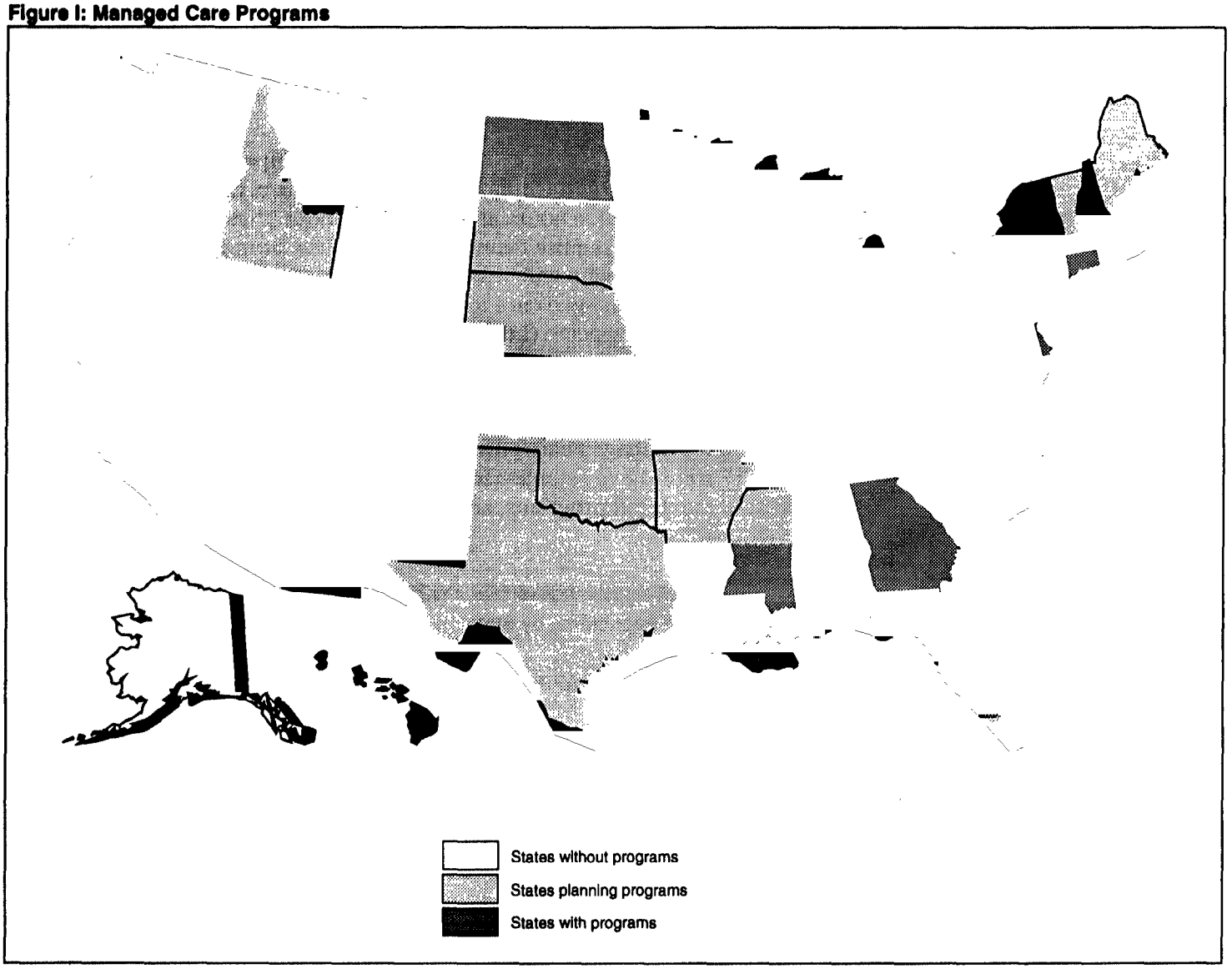
Medicaid: States Turn to Managed Care to Improve Access and Control Costs

The Medicaid program has been growing at a substantial rate. Combined state and federal program expenditures have nearly doubled since 1989, and the $119 billion cost of the program in fiscal year 1992 has now equalled the total cost of the Medicare program. At present, state Medicaid expenditures are second only to combined state costs of elementary and secondary education. Confronting such growth in program costs, the potential for managed care to control costs while improving access has appealed to many states.

States Increase Use of Managed Care in Their Medicaid Programs

According to HCFA, Medicaid managed care enrollment more than doubled between 1987 and 1992, and included about 3.6 million beneficiaries nationwide as of June 30, 1992. This represents about 12 percent of the total Medicaid population. Federal legislation in 1981, that permitted greater experimentation in the Medicaid program was a catalyst for states to consider managed care. However, the real stimulus in developing managed care programs has occurred in the last several years, as states contend with increasing growth in the Medicaid population, spiraling program costs, and limited state budgets. As shown in figure I.1, 36 states were operating one or more managed care programs for Medicaid beneficiaries in February 1993. Another 13 states planned to implement managed care programs by January 1994.

Figure I: Managed Care Programs



States' Use of Managed Care

Survey data show that states participating in managed care are employing a wide variety of managed care models. These range from models that provide all health care in exchange for a prepaid set monthly fee—generally called fully capitated plans—to fee-for-service PCCM programs. In PCCM programs, participating primary care physicians receive payments for each service delivered plus a case management fee to coordinate an individual's health care needs. Many arrangements fall

somewhere in between. Partially capitated plans, for example, receive a fixed monthly payment per enrolled individual for a limited range of services—such as physician services and referral care such as specialty and diagnostic services.

Managed care models seek to establish relationships between providers and beneficiaries, thereby improving access to care. States require providers to set office hours and provide 24-hour physician coverage. They also encourage or require beneficiaries to select from participating providers the one who will be responsible for coordinating their care. Common to all managed care models in the Medicaid program is the use of a primary care physician (i.e., to act as a "gatekeeper") and coordinate the delivery of health care services in a cost conscious manner.

Table I.1 shows the types of managed care programs and the populations targeted for managed care enrollment for each state. We found that since 1982, 17 states have established PCCM programs, 7 states have established partially capitated programs, and 25 states have established fully capitated programs.

Table I.1: Type of Managed Care Program Used and Target Population, by State

		Type of program(s)			Target population(s)[a]					
State	Managed care program	Fully capitated	Partially capitated	FFS PCCM	AFDC recipients[b]	AFDC related[c]	SSI recipients[d]	SSI related[e]	Medically needy[f]	Number enrolled[g]
Alabama	•	•			•	•				15,399
Alaska										0
Arizona	•	•			•	•	•	•		365,623
Arkansas										0
California	•	•		•	•	•	•	•	•	610,000
Colorado	•	•	•	•	•	•	•	•		127,000
Connecticut										0
Delaware										0
Florida	•	•		•	•	•	•			382,000
Georgia										0
Hawaii	•	•			•	•				3,572
Idaho										0
Illinois	•	•			•					100,000
Indiana	•	•			•					733
Iowa	•	•		•	•	•				50,000
Kansas	•			•	•	•	•	•	•	56,000

(continued)

State	Managed care program	Type of program(s)			Target population(s)[a]					Number enrolled[g]
		Fully capitated	Partially capitated	FFS PCCM	AFDC recipients[b]	AFDC related[c]	SSI recipients[d]	SSI related[e]	Medically needy[f]	
Kentucky	•			•	•	•				303,831
Louisiana	•			•	•	•	•	•	•	22,560
Maine										0
Maryland	•	•		•	•	•	•		•	300,000
Massachusetts	•	•		•	•	•	•	•		245,000
Michigan	•	•	•	•	•	•	•	•		327,265
Minnesota	•	•			•	•	•	•	•	79,516
Mississippi										0
Missouri	•	•		•	•					36,000
Montana	•			•	•					49,000
Nebraska										0
Nevada	•		•		•	•	•			14,000
New Hampshire	•	•			•	•				7,700
New Jersey	•		•		•	•	•	•		18,000
New Mexico	•			•	•	•	•			90,000
New York	•	•	•	•	•	•	•	•	•	158,215
North Carolina	•			•	•	•	•	•	•	57,596
North Dakota										0
Ohio	•	•			•	•				147,000
Oklahoma										0
Oregon	•	•	•		•	•				82,877
Pennsylvania	•	•			•	•	•	•	•	220,000
Rhode Island	•	•			•	•	•	•	•	1,100
South Carolina	•	•			[h]	[h]	[h]	[h]	[h]	240
South Dakota										0
Tennessee	•	•			•					29,645
Texas										0
Utah	•		•		•	•	•	•	•	126,096
Vermont										0
Virginia	•			•	•	•				32,000
Washington	•	•			•	•				34,596
West Virginia	•			•	•	•				59,345
Wisconsin	•	•			•	•				117,000
Wyoming										0
Washington, D.C.	•	•			•	•				14,989

(Table notes on next page)

[a]If a state has at least one managed care provider serving some Medicaid clients within a target population, the state is identified as serving this population through its managed care programs.

[b]AFDC includes families actually receiving cash assistance.

[c]AFDC-related is a variety of groups including pregnant women and children who are not receiving cash assistance but are eligible based on family income relative to the poverty level.

[d]SSI includes the aged, blind, or disabled that are receiving cash assistance.

[e]SSI-related includes people who meet SSI requirements except that they have too much income to qualify for SSI or supplemental payments, but too little to cover their health care costs. States can set an upper level of eligibility for the groups at up to 300 percent of the SSI financial eligibility level.

[f]Medically needy includes individuals that become eligible because they have impoverished themselves due to medical expenses.

[g]State officials provided estimates of enrollment as of December 1992, January 1993, and February 1993. Officials form Alabama, Hawaii, Indiana, Missouri, New Jersey, Tennessee, Utah, Washington, and Washington D.C. said that enrollment data reported to HCFA in June 1992 were still relatively accurate as of February 1993.

[h]Serves only mental health recipients.

As shown in table I.2, in February 1993, 10 of the 13 states that were planning to implement managed care programs for their Medicaid beneficiaries expected to use fee-for-service PCCM models.

Table I.2: Types of Managed Care Programs Planned, by State

	Type of program(s) planned		
State	Fully capitated	Partially capitated	FFS PCCM
Arkansas			•
Connecticut	•		
Delaware	•	•	
Georgia	•		•
Idaho			•
Maine	•	•	•
Mississippi		•	•
Nebraska[a]	•	•	•
North Dakota			•
Oklahoma	•	•	•
South Dakota			•
Texas	•		•
Vermont			•

[a]The state is considering all types of managed care program models but no decision on which type(s) of plans will be implemented has been made.

States are more readily choosing PCCM programs because providers are more willing to participate in a fee-for-service rather than a capitated-based reimbursement system. Providers also enjoy more independence in a PCCM program because their medical decisions with the different incentives are not subject to the same types of utilization reviews found in most capitated programs. In addition, access is guaranteed for beneficiaries because everyone must have a primary care physician.

Although some states have included other population groups in their managed care programs, most target Medicaid managed care programs to AFDC and AFDC-related beneficiaries. States target this population because AFDC and AFDC-related beneficiaries most closely resemble patients in existing primary care practices and generally do not require the same specialized health care services as the SSI population. While SSI and SSI-related individuals account for about 27 percent of the Medicaid population, their health care costs account for about 70 percent of Medicaid expenditures. AFDC and AFDC-related beneficiaries, on the other hand, comprise approximately 70 percent of all Medicaid beneficiaries, but only account for 29 percent of Medicaid costs because they generally require fewer and less expensive services than the SSI population. They are also the group with the greatest access problems.

Implementation of Managed Care Raises Difficult Issues

States have faced a number of difficult implementation issues in designing their managed care programs and have used the flexibility provided under the waiver process to tailor programs to their own needs. Their approaches reflect a measure of provider and community support, the states' prior experiences with managed care, and the states' demographics.

Our review in six states found that Oregon, Michigan, and New York rely on a variety of approaches to serve different regions of the state. Oregon primarily contracts with providers on a partially capitated basis to serve AFDC beneficiaries in the state's more populated areas, but also contracts with fully capitated HMOs. As of January 1993, the program operated in 16 of the states' 36 counties and serves more than one-third of the state Medicaid population.

Michigan and New York both contract with fully and partially capitated as well as PCCM providers. Michigan currently contracts with seven HMOs, four clinics, and nearly 1,700 individual physicians and serves one-third of the states' Medicaid population. In 1991, New York passed legislation mandating enrollment of 50 percent of its eligible Medicaid population in managed care within 8 years. As of January 1993, the state had enrolled approximately 7 percent of the Medicaid population in managed care.

Kentucky, Arizona, and Minnesota, on the other hand, primarily rely on one managed care model for participating Medicaid beneficiaries in their states. Kentucky experienced prior problems with a capitated program and, as a result, developed a PCCM program that is essentially statewide and serves about 61 percent of the state's Medicaid population. Arizona was the last state in the country to establish a Medicaid program and developed a fully capitated managed care program beginning in 1982. Arizona's program is now statewide and serves about 88 percent of the state's Medicaid population. Minnesota's fully capitated program serves about 20 percent of its Medicaid population and operates primarily in a major metropolitan area as well as a few rural counties.

Regardless of the approach taken, the states found that to establish managed care programs they had to deal with some common issues, including:

- planning for implementation,
- mandating all beneficiaries to enroll,
- attracting commercial HMOs to participate, and
- developing beneficiary education strategies.

Planning for Implementation Is Important

State Medicaid officials and other experts stressed that taking time to plan and implement a program, acquire staff expertise, and develop a base of support with the community served are important. Implementing a program slowly allows time to create an organizational structure; develop administrative expertise; properly educate staff, providers, and beneficiaries; establish adequate rate-setting and reimbursement mechanisms; and put in place quality assurance and oversight and monitoring mechanisms. Arizona experienced major problems when it first implemented its program, primarily because it was implemented too fast, according to state officials. Minnesota, on the other hand, required 3 years from the time its managed care program was approved until the first beneficiaries were enrolled.

State officials strongly believe that when a state begins a managed care program, because it is so different than the traditional fee-for-service program, a commitment of staff resources with the right expertise needs to be made. The activities of staff running a managed care program include recruiting providers, often including commercial HMOs; setting payment rates; and the collection and monitoring of information from providers. One expert pointed out that commercial HMOs have been deterred from participating in Medicaid in the past because they would begin to discuss participation with state Medicaid staff, only to find that the state staff had no expertise in managed care and, therefore, were not reliable partners.

We observed that states with successful managed care programs had developed a strong community base of support. This included the endorsement or, at least, involvement of physicians, private plans, beneficiary advocacy groups, and state legislators. In effect, states assured that the people who were critical to the success of the program had bought in to its structure and operation.

Many States Consider Mandatory Enrollment Critical

One of the biggest problems facing Medicaid beneficiaries in traditional fee-for-service is their inability to find an appropriate provider willing to care for them. Many state Medicaid officials believe that a major benefit of managed care is that it improves individuals' access to a primary care physician, which can reduce inappropriate and expensive trips to hospital emergency rooms. Many states have tried to maximize this benefit by requiring Medicaid beneficiaries to enroll. States believe that mandated enrollment also assures a large pool of eligible beneficiaries to attract and maintain providers, limits the health plans' financial risk, and increases

program cost savings.[1] In our survey of Medicaid officials, we found that 26 states have mandatory managed care programs.

States must obtain federal approval to mandate enrollment in managed care programs, restrict beneficiaries' movement in and out of plans, and, on occasion, lock in individuals to a specific plan. States obtain this approval by applying to HCFA for a program waiver. States generally mandate enrollment only in areas with sufficient providers to allow beneficiaries a choice of health plans. Also, federal regulations require states that mandate enrollment in managed care to contract only with providers that have beneficiary grievance procedures.

The six states we visited operate at least one managed care program in which participation is mandatory for a specific target population. Participation is mandatory for most Medicaid managed care beneficiaries in Arizona and Kentucky. In areas where managed care is operating, Minnesota and Oregon have generally mandated enrollment. In contrast, Michigan only mandates participation in 4 of the 24 counties where managed care is available; however, it is in the process of developing a statewide mandatory program. New York operates a largely voluntary program, with mandated enrollment only in its program serving southwest Brooklyn.

States generally mandate enrollment only in areas with sufficient providers to allow beneficiaries a choice of health plans and providers. For example, Oregon mandates enrollment when there is at least one physician for every 1,200 Medicaid beneficiaries. Although enrollment is mandatory except for Native Americans in all counties in Arizona, beneficiaries in most counties may choose between two or more health plans. In Michigan, Medicaid managed care beneficiaries have a choice of three different plans in three counties and a choice of two plans in an additional five counties. Most beneficiaries in states with Medicaid managed care programs may also select from a number of primary care physicians participating in the plans.

Disenrollment Is a Problem

Inherent in capitated managed care is the expectation that beneficiaries will remain in a particular plan for a sustained period of time, thereby allowing the primary care physician to establish a relationship with and monitor the care of the patient. However, this has been a problem in Medicaid managed care, where beneficiaries frequently become ineligible

[1]When a Medicaid beneficiary has a choice between a managed care and the traditional fee-for-service program, managed care is considered voluntary. When only managed care is offered—even when there is a choice among managed care plans—the program is mandatory.

for Medicaid or disenroll from the plan. Even in programs with mandatory enrollment, beneficiaries, with few exceptions, can move from one plan to another.

Beneficiaries have difficulty adjusting to the structure and rules of managed care plans especially the requirements to seek prior authorization from their primary care physician for services. Others leave managed care programs because they become dissatisfied with the quality of services they receive or their lack of access to their providers.

In addition, turnover results from beneficiaries becoming ineligible for Medicaid. To stabilize enrollments, a few states guarantee beneficiaries Medicaid eligibility for a specific length of time, notwithstanding changes in their financial status. Federal Medicaid rules currently provide funding for guaranteed eligibility, although this can be a costly decision. However, a few states believe this policy is necessary to attract providers.

Another way to stabilize beneficiary enrollment in managed care plans is to lock in beneficiaries for a specified period of time. Federal law requires that beneficiaries be allowed to change their plans monthly. However, states can be exempt from this requirement if they have a section 1115 demonstration waiver. In Arizona, Medicaid beneficiaries are only allowed to switch plans once a year, during an open enrollment period. In Minnesota, beneficiaries may change plans for any reason during the first year of initial enrollment and subsequently during a 30-day open enrollment period each November.[2] Beneficiaries have an initial period of time to change plans if they are dissatisfied, and states have established grievance procedures that allow for disenrollment and reassignment to another plan at any time when it is justified and approved by the state.

Low Payment Rates Make Attracting Commercial HMOs Difficult

Historically, states have had difficulty in attracting and retaining participation by commercial managed care health plans, such as HMOs. A key issue in establishing managed care programs is setting payment rates. A major problem for the states is that Medicaid managed care has been developed in the context of historically low fee-for-service reimbursement rates. For capitated plans that receive a monthly fee for each covered beneficiary, federal regulations require that the rate not exceed the cost of the traditional fee-for-service program. However, states must calculate

[2]The open enrollment period is only available in two counties with mandatory programs in Minnesota (Hennepin and Dakota). The plan change option does not apply in the state's third mandatory county (Itasca), which only offers one health plan. However, beneficiaries enrolled in this plan may change primary care physicians once each year.

rates that are high enough to attract sufficient numbers of providers. To assure that rates exceed this threshold, states initially calculate capitation rates based on a percentage of their past fee-for-service expenditures and adjust them to reflect geographic or caseload differences experienced by providers. In subsequent years, actuaries assist states in developing rates. Due to the complexity of rate setting and states' lack of experience, Medicaid officials in four states we visited expressed the need for increased federal technical assistance to be provided by HCFA.

In Minnesota, capitation rates for the AFDC population are approximately 90 percent of the fee-for-service costs and 95 percent for the SSI and non-SSI aged population. Two counties use rates based on the fee-for-service costs in a five-county area, while another county bases rates on its own historical costs. According to state officials, in the past, despite Minnesota's strong tradition of managed care, the state Medicaid managed care program has had trouble attracting and especially retaining commercial HMOs because of HMOs' dissatisfaction with reimbursement rates.

Until recently, one of Oregon's commercial HMOs in the Portland area periodically stopped accepting Medicaid beneficiaries because it thought the payment rates were inadequate. Under proposed revisions to its Medicaid program, the state notified current and potential providers that it plans to increase its payment rates. State Medicaid officials credit this announcement as a factor in attracting three additional commercial HMOs to participate in Oregon's program.

Because Arizona did not previously operate a Medicaid program, state officials could not base past rates on historical fee-for-service Medicaid costs. Using financial and utilization data collected for the previous contracting period, the state estimates rates, then compares plan bids to the estimates. When bids fall outside of the range of the state-estimated rates, plans are asked to revise their bids or a contract will not be awarded.

To limit some of the financial risk associated with capitated programs, some states have developed strategies, such as requiring plans to purchase reinsurance. States also contract with providers on a partially capitated or PCCM basis in order to protect the plans and participating providers from the financial risk of costly care, such as inpatient hospital services.

Education Efforts Key to Assuring Beneficiary Participation in Managed Care

In managed care, beneficiaries must know to seek care first from their primary care provider who will provide or authorize needed treatment. Many must also learn how to distinguish between emergency and more routine medical needs. Because they have relied on emergency rooms for nonurgent care, beneficiaries may need to change this behavior. One Medicaid expert noted that lack of beneficiary education is one of the major problems cited by commercial HMOs in dealing with the Medicaid population. To mitigate these problems, states or the plans themselves conduct outreach and beneficiary education programs.

All six states we visited conduct some form of beneficiary education program. These programs are run by state Medicaid staff, local Medicaid enrollment offices, and the plans themselves. Activities in some states include presentations to beneficiaries, community groups and advocacy organizations, and brochures and other information mailed to individuals. Beneficiaries may also attend orientation sessions or receive more information about a plan once they have enrolled.

In New York, for example, plans conduct their own outreach and education. Some have representatives stationed in local social service district offices at various times or at community gatherings to recruit clients. These representatives provide information to beneficiaries about their health plans and the managed care program in general. Once individuals enroll, some plans conduct orientation sessions for new members and provide information on health services through newsletters. A few plans have toll-free telephone numbers that members can call to gain further information on how to access services.

Low Assignment Rates Are One Indicator of Successful Programs

One way states measure the success of education efforts is through assignment rates for mandatory programs—the percent of beneficiaries who fail or refuse to select a primary care provider and who have a provider assigned to them. Experience has shown that beneficiaries who make their own selections are generally more satisfied with their care and are more responsive.[3] Assignment rates in the four states we visited that collect such data range from about 4 percent in Minnesota and about 5 percent in Michigan to about 17 percent in Arizona and Kentucky. An Oregon official reported that they do not collect these data routinely. New York only recently implemented a mandatory program in one area and does not have any data on assignment rates.

[3]Trish Riley, Andrew Coburn, and Elizabeth Kilbreth, Medicaid Managed Care: The State of the Art, A Guide for States (Portland, Me.: National Academy of State Health Policy, 1990), p. 42.

Arizona takes steps to mitigate the effects of assigning beneficiaries to a primary provider. If a beneficiary does not choose a provider, the state will try to assign them to the one in which other family members are enrolled. If this is not possible, the beneficiary will be assigned to a provider by a computer model that tries to balance enrollments across providers participating in the program. However, persons who are automatically assigned to a plan may change providers during Arizona's annual open enrollment season. Initially, Minnesota had used a private independent broker to enroll Medicaid beneficiaries. This resulted in an unsatisfactorily high assignment rate exceeding 50 percent of AFDC beneficiaries. To mitigate the problem, the state agreed to fund enrollment costs if the county would takeover the enrollment process. Now that county offices of the State Department of Social Services handle beneficiary enrollment, education, and advocacy, the assignment rate has dropped to between 3 and 4 percent. County staff encourage Medicaid beneficiaries to select a plan during the orientation process but allow them 30 days to make a choice. County staff also follow up by telephone and mail to encourage them to select a plan. The only people assigned to health plans are those who do not attend a presentation or do not respond to follow-up contacts.

Direct Marketing Can Lead to Abuses

While marketing can be used to educate beneficiaries about health plans, it can also be used to mislead or coerce beneficiaries in order to gain their enrollment. In 1974, we found that individual plans in California commonly conducted door-to-door marketing—sometimes using unscrupulous approaches.[4] Some contractors told beneficiaries that the state required them to join, when in fact, the program was voluntary. Contractors also failed to disclose that enrolled beneficiaries had to use the HMO's providers, or offered beneficiaries additional benefits that never materialized. Door-to-door marketing is still permitted in California although the practice continues to be problematic, and abuses have been reported. State officials plan to phase out door-to-door marketing in their proposed expansion of managed care.

Federal Medicaid regulations require prepaid health care contracts to specify the methods by which the HMO will assure its marketing materials are accurate and not misleading.[5] Direct marketing has been prohibited by most states because of the potential for abuse. Of the six states we visited, only Michigan and New York allow plans to conduct direct marketing. In

[4]U.S. GAO, Better Controls Needed for Health Maintenance Organizations Under Medicaid in California (B-164031, Sept. 10, 1974).

[5]HCFA has recently developed marketing guidelines for state Medicaid programs to use in assessing the materials and practices used by contracting health plans.

New York, each plan is responsible for its own marketing. Health plans recruit beneficiaries in local social service district offices or at community gatherings. Some of Michigan's HMOs rely heavily on door-to-door marketing and visit locations often frequented by welfare recipients, such as food stamp outlets.

Indications of Improved Access, Equal Quality, Uncertain Cost-Savings

The key reasons that states report moving to managed care in their Medicaid programs are (1) their frustration with rising and uncontrolled Medicaid costs, (2) poor access to health care for their beneficiaries, and (3) uncertain quality of care. One key expectation is that beneficiaries will establish long-term relationships with physicians, obtain appropriate and timely health care services, and ultimately achieve improved health status. In the traditional Medicaid program, eligibility is no guarantee of services because physicians often refuse to treat Medicaid beneficiaries. In our review of studies on Medicaid managed care and interviews with officials and beneficiary advocacy groups, we found that, to date, program results are showing:

- slight improvements overall in access to care;
- improved beneficiary satisfaction, as measured by beneficiary advocacy groups, in four of the six states;
- quality of care that is the same as traditional Medicaid fee-for-service; and
- cost-savings being reported by the states, but that are inconclusive.

Many of the evaluations of Medicaid managed care have limitations. For example, many of the data used in the evaluations are dated, coming from the HCFA demonstrations of the early and mid-1980s. Medicaid managed care evaluations, in general, focused on either capitated arrangements or PCCM. Further, evaluations of the quality of care provided to Medicaid managed care beneficiaries have focused on one medical outcome or procedure rather than a more general review of services. The current body of research on Medicaid managed care does not provide a complete picture.

Access to Care Equal or Slightly Improved

Encouragement of managed care has been based on the premise that through managed care programs beneficiaries have better access to care and that they are more apt to obtain medical services in a timely and appropriate manner than under a traditional Medicaid fee-for-service program. There is, however, some disagreement about how best to assess improvements in access to care. Some experts argue that access is one

component of quality care, and that measuring access alone does not address whether beneficiaries improve their health. Others argue that, compared to Medicaid beneficiaries' historically difficult time in finding physicians, their ability to even make an appointment is significant.

Debate also exists about the proper measures of access. To find out if beneficiaries have access to care, studies do not generally assess the number and availability of providers in a particular service area. Instead, they employ various proxy measures that assess provider responsiveness and beneficiaries' compliance with managed care rules. Studies on access also typically incorporate beneficiary and advocacy satisfaction data. Although the study findings we looked at were mixed, they generally concluded that there were or can be improvements in access when using managed care models over Medicaid's traditional fee-for-service programs.

Several studies assessing access in Medicaid managed care compared beneficiaries' experiences in managed care demonstration programs with traditional fee-for-service. In 1983, HCFA funded an evaluation of Medicaid demonstrations in six states—California, Florida, Minnesota, Missouri, New Jersey, and New York. The alternative delivery systems represented by the demonstrations contained a number of features—most notably capitation, case management, limitations on provider choice, and provider competition.

One study concluded that data for beneficiaries in managed care did not show any reduction in either diagnostic testing or follow-up visits for three common ambulatory problems.[6] Another reported substantial reductions in the proportion of persons with at least one emergency room visit for both adults and children in the demonstrations.[7] These findings suggest that the use of a gatekeeper can alter a Medicaid beneficiaries' pattern of emergency use. However, much weaker evidence of the gatekeeper effect was shown for persons with at least one visit. Finally, in a summary of findings comparing managed care demonstration sites to fee-for-service in two states,[8] access to care was perceived by beneficiaries to be greater than that of traditional fee-for-service. However, results assessing

[6]Timothy Carey and Kathi Weis, "Diagnostic Testing and Return Visits for Acute Problems in Prepaid Case-Managed Medicaid Plans Compared With Fee-for-Service," Archives of Internal Medicine, Vol. 150, No. 11, 1990, pp. 2369-72.

[7]Robert Hurley, Deborah Freund, and Donald Taylor, "Emergency Room Use and Primary Care Case Management: Evidence From Four Medicaid Demonstration Programs," American Journal of Public Health, Vol. 79, No. 7, 1989, pp. 843-46.

[8]Freund, Rossiter, Fox, Meyer, Hurley, Carey, and Paul, "Evaluation of the Medicaid Competition Demonstrations."

objective measures of access including waiting times for appointments, travel time, and office wait time were mixed in one state and equivalent to fee-for-service in the other.

In its 1992 annual report, the Physician Payment Review Commission reviewed the effectiveness of managed care in serving Medicaid beneficiaries and other policy options for improving their access to care.[9] Based on a review of the literature and discussions with health care experts, Commission members concluded that managed care appeared to lessen emergency room use and reduce expenditures for states and the federal government. It also noted that, on balance, the evidence showed that with an enhanced quality assurance system greater use of managed care in Medicaid could improve access to health care for beneficiaries.

Independent reviews specifically addressing access to care were performed in four of the six states we reviewed and reported mixed results. The methodology used in most of this research typically compared access to care for Medicaid managed care beneficiaries with access in traditional Medicaid fee-for-service or other insurance programs.

In a 1989 report, for example, SRI International, a private research group, compared access to routine care in Arizona's Health Care Cost Containment System (AHCCCS) with the New Mexico Medicaid fee-for-service program.[10] Based on a survey of beneficiary households in 1985, the report concluded that access to routine care was better in AHCCCS. The SRI report noted, however, that AHCCCS beneficiaries reported increased difficulty in receiving emergency care.

A more recent study in Arizona evaluated access to cancer screening services for women in Medicaid managed care.[11] The study concluded that poor women receiving health care through a managed care Medicaid program received Pap smears and mammograms at the same rate as

[9]Annual Report to the Congress, Physician Payment Review Commission, 1992.

[10]Evaluation of the Arizona Health Care Cost Containment System: Final Report, SRI International, January 1989. To assess access to care, SRI International conducted surveys of 897 AHCCCS, AFDC, and SSI clients in Arizona and 553 Medicaid fee-for-service clients in New Mexico who had been enrolled at least 12 months as of March 1985. The sample in Arizona was selected based on zip code, AHCCCS enrollment, age, urbanicity, and race. A comparable sample was selected for New Mexico. Results were weighted based on response rates of the sample groups and the characteristics of those sampled.

[11]Bradford Kirkman-Liff and Jennie Kronenfeld, "Access to Cancer Screening Services for Women," American Journal of Public Health, Vol. 82, No. 5, 1992, pp. 733-735.

women with other types of health insurance, while the uninsured were less likely to have had either type of service.

Based on a questionnaire sent to 6,000 managed care beneficiaries, a University of Kentucky researcher measured access in the state's PCCM program—the Kentucky Patient Access and Care System (KenPAC) —in terms of timeliness of care, geographic access, and refusal of care by physicians.[12] In 1991, the client questionnaire showed that access to care had been maintained or improved over beneficiaries' previous experiences with Medicaid. A 1990 report on Michigan's capitated Clinic Plan also concluded that overall the plan's beneficiaries were receiving a level of access to care that was equal to that provided to Medicaid fee-for-service beneficiaries.[13]

In 1992, we studied Oregon's managed care program and reported that Medicaid beneficiaries were generally satisfied with their access to medical services.[14] We reported that the Oregon Healthcare Cost Containment Advisory Committee found that some beneficiaries had difficulty adjusting to the restrictions inherent in managed care—such as more limited use of emergency rooms—but the program had received few formal complaints. We pointed out that HCFA and the Oregon Advisory Committee indicated general satisfaction with the program and the access to services it provided. This was true despite our finding that the program's capacity at times had been strained.

[12]Joyce Beaulieu, Evaluation of KenPAC III: Final Report, November 29, 1991. To measure quality, a questionnaire was mailed to over 6,000 KenPAC clients, and follow-up questionnaires were sent to assure an acceptable response rate. Of the 6,000 questionnaires mailed out, 44.5 percent were returned and entered into the data base, 3.5 percent were returned not completed, and 52 percent were not returned. Primary care physicians were also surveyed about the quality of care provided through KenPAC, with questionnaires mailed to all 1,530 participating physicians. The response rate was 28 percent, with 428 completed questionnaires received.

[13]An Evaluation of the Cost Effectiveness, Access to Care, and Quality of Care of the Capitated Clinic Plan of the Michigan Medicaid Program, Health Management Associates, Michigan Peer Review Organization, and Gini Associates, September 1990. This report was prepared for the Medical Services Administration of the Michigan Department of Social Services. Access to care was evaluated in five ways: (1) the plan's utilization rates were compared to available utilization measures for HMOs and for the state's other Medicaid managed care plan—Physician Sponsor Plan; (2) data on the number of physicians and their specialties serving the plan's clients was collected and analyzed; (3) the average waiting times for various types of physician appointments was determined and compared to Medicaid fee-for-service clients; (4) the number of clients leaving the plan but still retaining their Medicaid eligibility was compared to the disenrollment rates for three other groups of Medicaid clients (fee-for-service, HMO, and the Physician Sponsor Plan); and (5) the complaint process and complaint history at each of the plan's clinics was examined.

[14]Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992).

Finally, evidence of improved access to care came from Medicaid beneficiary advocacy groups in four of the six states we visited. Although beneficiary advocates in Arizona, Kentucky, Minnesota, and Oregon voiced some concerns about how managed care programs operated, they none the less had noticed a definite improvement in access to care after the programs began. On the other hand, representatives of beneficiary advocacy groups in Michigan and New York did not believe that managed care had contributed to better access.

Quality of Care Matches Traditional Fee-For-Service

Measuring the quality of managed care is an inexact and evolving process. However, national studies and those performed in the six states show some evidence that although managed care is vulnerable to underserving beneficiaries,[15] the quality of care in Medicaid managed care programs has at least equalled that provided in traditional Medicaid fee-for-service programs. Again, studies typically focus on one or two services or treatments delivered by the health care system. Researchers and Medicaid managed care experts agree that a more comprehensive set of indicators needs to be developed before conclusions on overall quality can be made.

Several studies in 1991 and 1992 compared the level of prenatal care and actual birth outcomes among pregnant women enrolled in managed care and traditional fee-for-services programs. This is a convenient proxy measurement for quality of care because managed care tends to target the AFDC population, and there is a high demand for these services among this group. In most cases, these studies found no significant difference between managed care and fee-for-service beneficiaries and concluded that there was no decreased quality of care provided to enrollees in managed care. However, most of the studies did find that compared to non-Medicaid groups Medicaid beneficiaries in both types of programs fared much worse.

A 1991 study of pregnancy outcomes and prenatal care among women and infants in two managed care demonstration sites—Santa Barbara, California, and Jackson County, Missouri—concluded that there was no decrease in quality of care provided to beneficiaries in capitated Medicaid programs compared with fee-for-service programs. To reach this conclusion the study reviewed: (1) frequency of prenatal visits, (2) mean

[15]An incentive to underserve can occur when providers in capitated programs agree to deliver or arrange for all services needed by enrolled individuals in exchange for the per-capita payments. Providers are liable for the difference when the cost of services to all enrolled recipients is greater than the total payments received. Conversely, providers retain the difference when the cost of services is lower than the amount received as capitation payments.

birth weight and incidence of low birth weight, (3) complication of pregnancy and cesarean section rates, and (4) length of pregnancy-related hospital stays.[16]

A 1992 study that looked at pregnancy outcomes and prenatal care in Washington state found that Medicaid beneficiaries enrolled in managed care used prenatal care similarly to those in Medicaid fee-for-service and showed equal or modestly improved birth weight distributions. However, Medicaid managed care beneficiaries showed poorer use of prenatal care and birth outcomes compared with non-Medicaid enrollees in the same plan.[17] The latter finding was also reported in a 1991 study of the Philadelphia HealthPASS managed care program.[18] However, the usefulness of the HealthPASS study was limited by several factors. For example, obstetrical care was exempted from the gatekeeper requirements out of concern that this would create a barrier to care. In addition, the authors questioned whether the results of the study could be generalized because the study focused on only one site where 40-50 percent of West Philadelphia residents delivered their babies.

Independent studies in the six states we reviewed compared the quality of health care services being provided to Medicaid managed care beneficiaries to those enrolled in traditional fee-for-service programs. Some compared Medicaid managed care not only to other Medicaid populations, but to generally accepted medical standards for all patients in the state. These studies reported no diminution in quality for managed care beneficiaries in relation to fee-for-service enrollees. Although the studies of care in Minnesota and Oregon cited a need to improve some types of care, including well child care.

[16]Timothy Carey, Kathi Weis, and Charles Homer, "Prepaid Versus Traditional Medicaid Plans: Lack of Affect on Pregnancy Outcomes and Prenatal Care," Health Services Research, Vol. 26, No. 2, 1991, pp. 165-181.

[17]James Krieger, Frederick Connell, and James LoGerfo, "Medicaid Prenatal Care: A Comparison of Use and Outcomes in Fee-for-Service and Managed Care," American Journal of Public Health, Vol. 82, No. 2, 1992, pp. 185-90.

[18]Neil Goldfarb, Alan Hillman, John Eisenberg, Mark Kelley, Arnold Cohen, and Miriam Dellheim, "Impact of a Mandatory Medicaid Case Management Program on Prenatal Care on Birth Outcomes," Medical Care, Vol. 29, No. 1, 1991, pp. 64-71.

An evaluation of Michigan's Physician Sponsor Plan was conducted for fiscal years 1988 to 1990.[19] The evaluation found that ambulatory care provided through the Physician Sponsor Plan was modestly superior to such care in the state's fee-for-service Medicaid program. The Physician Sponsor Plan beneficiaries had fewer cases where established criteria for quality were not met and a higher percentage of cases which met all of the quality criteria. In 1990, a similar evaluation was released of ambulatory care in Michigan's capitated Clinic Plan.[20] The evaluation, based on 1988 data, concluded that, in essence, there appeared to be no difference in the quality of ambulatory care provided to Clinic Plan and fee-for-service beneficiaries.

The New York State Department of Social Services, Office of Audit and Quality Control, conducted evaluations of two managed care plans in Erie County, New York.[21] [22] The 1991 reports concluded that the overall quality of medical care provided to Medicaid beneficiaries in the plans exceeded

[19]Evaluation of the Michigan Medicaid Program's Physician Sponsor Plan, FY 1988-1990, Health Management Associates, Michigan Peer Review Organization, and Gini Associates, February 1992. This report was prepared for the Medical Services Administration of the Michigan Department of Social Services. The basic method used to assess quality of care was to choose a set of criteria with which to measure quality and then apply these criteria to care provided to groups of beneficiaries in the Physician Sponsor Plan and fee-for-service program. Thirty physicians were selected per plan. For each selected physician, a random sample of five beneficiaries was drawn. The sampling procedure was performed twice—once for the Physician Sponsor Plan physicians and once for fee-for-service physicians. If a physician had both Physician Sponsor Plan and fee-for-service beneficiaries, the physician could appear in both samples. An on-site ambulatory care record review was then conducted for each of the 300 beneficiaries (150 Physician Sponsor Plan and 150 fee-for-service beneficiaries).

[20]Evaluation of Michigan Medicaid's Clinic Plan. A sample of patients who had three or more physician visits during 1988 was selected from both the capitated Clinic Plan and the fee-for-service program. Once the sample was drawn, ambulatory records were reviewed by trained nurse reviewers who applied a generic protocol that can be used to assess ambulatory encounters. The records were reviewed to determine whether the physicians followed appropriate processes in providing care. In addition, for two types of medical encounters—well-baby care and prenatal care—more detailed review criteria was used to assess quality. When an obstetric hospitalization occurred in 1988, the hospital record was also examined. Diagnostic-specific criteria were applied to the entire hospital episode.

[21]Erie County Department of Social Services, Physician Case Management Program I, Compliance Review of the Freedom of Choice Waiver Requirements Issued by the Health Care Financing Administration of the United States Department of Health and Human Services, New York State Department of Social Services, March 1991. This study analyzed the quality of care for 32 beneficiaries who were in the program at least 6 months and had at least one medical encounter with their primary care physician. Additionally, medical records for 13 of the 32 beneficiaries were reviewed for care they had received before enrollment to establish a quality of care comparison.

[22]Erie County Department of Social Services, Physician Case Management Program I, Compliance Review of the Freedom of Choice Waiver Requirements Issued by the Health Care Financing Administration of the United States Department of Health and Human Services, New York State Department of Social Services, March 1991. This study analyzed the quality of care for 37 beneficiaries who were in the program at least 6 months and had at least one medical encounter with their primary care physician. Additionally, medical records for 13 of the 37 beneficiaries were reviewed for care they had received before enrollment.

the care they received before enrollment. The evaluators of both plans determined that physicians participating in the plans had a higher degree of compliance with recommended examinations and procedures for well-child care and treatment protocols for sick-child visits. The evaluation of one plan showed a higher rate of preventive adult care visits and treatment protocols for common adult illnesses. The other plan did not enroll adults. Surveys of households participating in the two plans showed that 85 percent and 93 percent of the households, respectively, indicated that quality of care was equal to or better than that which they encountered before enrollment.

As reported in 1991, Kentucky Medicaid beneficiary and provider surveys conducted by researchers at the University of Kentucky found that the quality of care had been maintained or improved in the state's PCCM program.[23] Over 50 percent of the beneficiaries responding to the survey reported that their health care was better and nearly 40 percent felt it was about the same. Only 5 to 6 percent felt that the quality of their health care was worse.

After evaluating Arizona's AHCCCS program, SRI International concluded in 1989 that the quality of care, while not ideal, was generally at least as good, and in some cases better, than that provided by New Mexico's traditional fee-for-service Medicaid program.[24] Care for children under AHCCCS was in greater conformance with generally accepted pediatric guidelines than was care under New Mexico's program. Compliance with recommended immunization schedules was found to be comparable to the New Mexico program, but the rates were generally below the American Association of Pediatrics national standards in both states. Pregnancy care and pregnancy outcomes were similar in the two states, except that AHCCCS had a higher cesarean section rate, a smaller number of prenatal visits, and a later initiation of prenatal care.

[23]Beaulieu, Evaluation of KenPac III: Final Report.

[24]Evaluation of the Arizona Health Care Cost Containment System: Final Report, SRI International, January 1989. To assess the quality of care received through AHCCCS, researchers from SRI evaluated four conditions: (1) prenatal care, (2) pregnancy outcomes, (3) well-child care, and (4) treatment of otitis media. These conditions frequently occur among the study population. Researchers compared outcomes for the AHCCCS population with outcomes for a comparable population in New Mexico that received care through a Medicaid fee-for-service program. Data were collected from outpatient and inpatient medical records for 738 AHCCCS recipients and 730 New Mexico Medicaid clients; 445 children in each state with primary care utilization between July 1986 and April 1987; and 293 women in the AHCCCS program and 285 women in New Mexico's Medicaid program with pregnancy outcomes between November 1985 and April 1987 and with at least 9 months of continuous AHCCCS enrollment or New Mexico Medicaid eligibility.

We reported in 1992 that Oregon's Medicaid managed care program met federal requirements for safeguarding the quality of care.[25] Oregon's Health Care Cost Containment Advisory Committee concluded that quality of care for Medicaid beneficiaries differed little from that of the general population, and advocacy group representatives we interviewed were generally satisfied with the quality of services provided under Oregon's program. Lastly, medical record reviews by the Oregon Medical Professional Review Organization identified relatively few quality problems in Oregon's managed care program, except that health screening and preventive services for children needed to be improved.

Finally, Minnesota contracted with the Joint Commission on Accreditation of Healthcare Organizations to conduct a quality assurance review in 1990.[26] The review identified a set of indicators to determine whether health plans were providing a quality of care that met community standards. The Joint Commission found that immunization levels remained low at all three childhood levels reviewed and prenatal care and women's health care were good but incomplete. The health plans scored well in areas such as home care planning, post-surgical readmissions, and emergency room care.

However, a review of Minnesota's managed care program completed in 1992 by another independent organization, HealthPro, reached a different conclusion.[27] This study reported an overall lower level of compliance by the managed care plans with standards for all major components of care established by a panel of health practitioners. HealthPro's review included

[25]Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992). As part of the evaluation, we contracted with a group of physicians from the George Washington University to validate Oregon's independent medical record review process performed by the Oregon Medical Professional Review Organization. The consulting physicians used the peer review organization's criteria and process to review a sample of the records the peer review organization reviewed in 1990. A proportional random sample of about 10 percent of the records the peer review organization reviewed was selected.

[26]The Minnesota Department of Human Services contracted with the Joint Commission on Accreditation of Healthcare Organizations to conduct a 1989 quality assurance review of its managed care program. The review is discussed in a report issued by the Department of Human Services in March 1991, Minnesota Medicaid Interim Report. As part of the review, the Joint Commission conducted a review of medical records to determine if care was being provided by health plans in a manner that community standards. The conditions of interest reviewed were: prenatal care, well-baby care (birth through 11 months), well-baby care (12 months through 4 years), late childhood care, otitis media, chemical dependency, home care, preventive health care, women's health care, surgical readmission within 30 days of discharge, and use of emergency services. The Joint Commission's 1989 quality assurance review was completed in June 1990.

[27]State of Minnesota Prepaid Health Plans Review of Quality Health Care, HealthPro, February 15, 1992.

an assessment of well-baby, early and late childhood, women's preventive, prenatal, and chemical dependency care.

Cost-Savings Reported but Still Being Debated

The results of studies on the effect of managed care on Medicaid program costs are unclear. While states report cost-savings, there are questions about how significant these savings are once all factors affecting cost are considered. Whether managed care can save money in the Medicaid program is uncertain. Nevertheless, there is evidence that managed care can result in more predictable program expenditures when capitated programs are used. This is due to the fact that once Medicaid directors know how many people are enrolled in their program, they can compute capitation rates and determine their total costs.

The body of research that has tried to evaluate managed care's effect on cost-savings in the Medicaid program has taken a variety of methodological approaches. Our review of the literature found some studies with designs that contained a control group. Other studies depended more on pre- and post-measurement. Finally, some of the studies are analyses across many independent evaluations. An attempt was made in all of these studies to control for all other factors, in order to assess the effect of managed care alone, but data and methodological limitations in evaluating these programs precluded controlling all factors that might influence cost. Finally, presented here are two types of studies—those measuring cost savings, and those measuring cost-effectiveness, by holding other factors constant.

In its 1992 annual report, the Physician Payment Review Commission concluded that although research studies of Medicaid managed care temper the claims of advocates, on balance they demonstrate that managed care can often lower costs.[28] The Commission also noted that an important benefit of capitated managed care is that it makes expenditures more predictable. That is, if a plan contracts to provide all care for $150 per month, the state will never have to pay more than $150.

Testimony by the Congressional Budget Office in 1992 suggested that, of both public and private managed care programs, only staff and group model HMOs have been able to achieve significant reductions in costs per

[28] Annual Report to the Congress, Physician Payment Review Commission, 1992.

enrollee.[29] On the other hand, a 1991 analysis of previous evaluations of 25 managed care programs in 17 states concluded that managed care programs—including PCCMs—were able to achieve modest cost savings.[30] Health researchers at Virginia Commonwealth University and Indiana University based their assertions on a subset of 13 programs that were judged to have the most reliable evaluations. According to their report, approximately 80 percent of the programs reported cost savings ranging from 5 to 15 percent.

The question of cost savings is made even more complex by other factors, such as favorable selection,[31] that could affect program expenditures. In 1992, the Rand Corporation conducted an evaluation of the cost and use of capitated medical services in state programs.[32] Researchers compared Medicaid HMO programs in New York and Florida and found very different results. In analyzing the effect on costs, Rand concluded that HMO-type plans can save money but these savings may be the result of patient mix rather than efficient program management. Florida's program attracted many of the sicker poor and thus saved money with a capitated payment system. New York, on the other hand, had difficulty convincing beneficiaries to enroll in managed care and those who did were healthier than those who remained in the fee-for-service system. New York spent more on these beneficiaries than it would have under fee-for-service because their medical needs were relatively low. The potential for cost savings in the long term may depend on whether the states can anticipate such selection activity and adjust capitation levels accordingly.

Studies we obtained of Medicaid managed care programs and specific plans in the six states generally show them to be cost-effective.[33] However,

[29]Statement of Robert D. Reischauer, Director, Congressional Budget Office, before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992. According to this statement, less structured managed care organizations had little or no effect on health care spending. The Congressional Budget Office concluded that staff model HMOs and fully integrated group model HMOs can reduce hospital use by 15 to 20 percent, which in turn can lower total health spending for their clients by perhaps 10 to 15 percent. Other forms of managed care had been found to have an effect ranging from no impact to 8 percent reduction in hospital use.

[30]Robert E. Hurley and Deborah A. Freund, Primary Care Case Management Evidence From Medicaid: Synthesizing Program Effects by Program Designs, 1991.

[31]Favorable selection means that healthier people who are less expensive to care for enroll in the HMO, while sicker people do not.

[32]Joan Buchanan, Arleen Leibowitz, Joan Keesey, Joyce Mann, and Cheryl Damberg, Cost and Use of Capitated Medical Services: Evaluation of the Program for Prepaid Managed Health Care, The Rand Corporation, Santa Monica, Calif., 1992.

[33]In the context of this discussion cost-effective means that managed care programs spent less money than would have been spent on the same population for the same services under the traditional fee-for-service program.

some health care experts acknowledged that there are data limitations impair their ability to measure and compare costs. Despite these problems, some Medicaid officials believe their managed care programs have achieved cost-savings compared to fee-for-service programs. The officials generally attributed the savings to effective management of care by providers and, in particular, to reductions in the inappropriate use of emergency rooms and prescription drugs.

In 1991, HCFA reported $227 million in projected 2-year cost-savings from states operating Medicaid managed care programs with 1915(b)(1) waivers. In November 1992, a HCFA official provided us with a revised 2-year savings projection totaling about $326 million.[34] The six states we visited commissioned independent evaluations of some of their programs and all reported substantial cost savings.

In Arizona, SRI International reported that the cost of the AHCCCS program (excluding administrative costs) during its first 5 years averaged 6 percent less than what a fee-for-service Medicaid program would have cost.[35] Evaluations of two Medicaid managed care programs in Erie County, New York, reported that the programs were less costly than an actuarial equivalent fee-for-service program would have been.[36] A cost analysis of both programs concluded that there were substantial savings in the areas

[34]HCFA computed these savings by totaling individual state 2-year projected savings reported for operating 1915(b)(1) waiver managed care programs as compared against the estimated costs for traditional fee-for-service. However, while each state waiver program covers a 2-year period, the periods vary.

[35]Evaluation of AHCCCS. Cost-savings were calculated as the difference between the actual incurred costs and the estimated cost of a fee-for-service Medicaid program in Arizona. The cost of a fee-for-service program was estimated by calculating the per-capita costs of Medicaid programs in several states and adjusting the costs for differences in eligibility and geography. The comparison states were chosen based on the quality of cost and eligibility data kept in these states and the similarity of the Medicaid programs in these states to the AHCCCS program in Arizona. Administrative costs were not included in this analysis because the comparison was considered unreliable. The study noted that it may be difficult to compare Arizona to states that have more than 20 years of experience operating Medicaid programs because Arizona had only 5 years of experience with the AHCCCS program and management of the program was changed from a private administrator to a state agency.

[36]Erie County Physician Case Management Compliance Review Program I; Erie County Department of Social Services, Physician Case Management Program II, Compliance Review of the Freedom of Choice Waiver Requirements Issued by the Health Care Financing Administration of the United States Department of Health and Human Services, New York State Department of Social Services, March 1991. To measure cost-effectiveness, researchers in both studies compared 1 year of medical costs for Physician Case Management Program beneficiaries to one year of medical costs for nonparticipating Physician Case Management Program beneficiaries. For these comparisons 100 participating Program I, 100 participating Program II, 100 nonparticipating Program I, and 50 nonparticipating Program II beneficiaries were randomly selected. Eighteen beneficiaries from the nonparticipating group were eliminated from the Program I evaluation because they were found to have participated in case management.

of inpatient hospitalization, outpatient clinic care, physician services, pharmaceutical services, and emergency room services.

Two studies in Kentucky also concluded that Medicaid managed care saved money. Estimates of the cost savings differed significantly because the two studies assumed different population estimates and utilization rates when calculating the savings. One study estimated that the program saved $125 to $150 million annually,[37] while the other estimated that the program saved $13 million in 1987 and would save $93 million in 1994.[38]

Evaluations by an independent actuarial firm found Oregon's Medicaid managed care program to be cost-effective.[39] An October 1991 evaluation concluded that from October 1988 through September 1990, the program had saved about $8.7 million, or $8.78 per enrollee per month, when compared with the estimated costs of health care under traditional Medicaid fee-for-service.

An evaluation of one of Michigan's managed care plans—the Physician Sponsor Plan—determined that the combined cost savings for AFDC and SSI recipients in fiscal year 1989-90 was $24.2 million or 17.5 percent of the

[37]Beaulieu, Evaluation of KenPac III: Final Report. Savings were based on projected changes in utilization patterns due to the KenPAC program. Units of service were multiplied by cost per unit of service, adjusted for inflation, and the estimated number of people eligible for KenPAC. Gross savings were adjusted to take into account the administrative costs of running the KenPAC program.

[38]Request for Waiver Extension Under Section 1915(b)(1) of the Social Security Act, Commonwealth of Kentucky, Kentucky Patient Access and Care System, October 29, 1991. To determine cost-effectiveness, the research considered (1) the growth in client population, (2) the cost per eligible and utilizing client, and (3) the units of service utilized per client. The estimated cost-savings were based on the difference between the projected number of units of service utilized under KenPAC and the projected number that would have been utilized without KenPAC. Administrative costs and management fees were also considered in determining net savings.

[39]Evaluations of cost-effectiveness, necessitated by HCFA requirements for waiver renewal, were performed by Coopers and Lybrand. The most recent evaluation Cost-Effectiveness Analysis for the PCO [Physician Care Organizations] Program for the Period October 1988 through September 1990, is dated October 17, 1991. The cost-effectiveness of Oregon's physician care organizations was measured as the difference between providing services on a fee-for-service basis and the costs of the prepaid program's administration plus capitation and incentive payments for the physician care organizations. The costs of inpatient and outpatient maternity services were excluded from the calculation because pregnant women who are in their third trimester of pregnancy when they become eligible for Medicaid have the option of continuing to receive services on a fee-for-service basis.

combined expected Medicaid fee-for-service expenses.[40] After deducting nonmedical expenses (management fees and administrative costs), the net savings was $20.2 million or 14.6 percent of the expected fee-for-service medical expenses. An evaluation of Michigan's Capitated Clinic Plan calculated medical expense savings of $1.1 million for 1988.[41] After deducting incentive and administrative costs of the plan, the net savings was $767,001, or 15.2 percent of expected costs for the plan's beneficiaries.

Finally, Minnesota examined the cost experience of its Medicaid managed care programs and estimated cost savings.[42] The resulting study estimated that the state's Prepaid Medicaid Demonstration Project saved $13.7 million in the 3-year period from 1987 through 1989. Estimated savings for the AFDC Voluntary Program was slightly more than $400,000 in 1989.

[40]Evaluation of the Michigan Medicaid Program's Physician Sponsor Plan. The basic methodology for the analysis of AFDC cost-effectiveness was to compare the cost experience of a sample of Medicaid clients enrolled in the Physician Sponsor Plan to the cost experience of a sample of Medicaid clients who were enrolled in the traditional fee-for-service program. The study period covered services provided between October 1, 1989, and September 30, 1990. The total actual cost for Physician Sponsor Plan's AFDC beneficiaries was calculated by summing the costs of medical services, administrative costs, and monthly management fees. In the cost-effectiveness analysis of the Physician Sponsor Plan SSI population, a different design was used because the health status differences between the Physician Sponsor Plan and fee-for-service populations were so great. A methodology was employed using a longitudinal sample to measure the effect on medical costs of the Physician Sponsor Plan program. This methodology compared the change in costs over a 2-year period for a sample of Physician Sponsor Plan SSI beneficiaries and a sample of fee-for-service SSI beneficiaries. In choosing the AFDC and SSI samples, only persons who were Medicaid eligible and enrolled in either the Physician Sponsor Plan or fee-for-service programs for at least 6 months were selected. In addition, only those persons receiving some medical services during the study period were selected.

[41]Evaluation of the Michigan Medicaid Clinic Plan. The evaluation of basic cost-effectiveness was performed by comparing the actual costs incurred by the plan's clients in calendar year 1988 with the 1988 expected costs for a similar group of clients in the fee-for-service market. The actual costs for the plan's clients were calculated by summing actual capitation payments, actual inpatient costs, actual inpatient bonus payments, administrative costs, system modification costs, and marketing incentive costs for 1988.

[42]Minnesota Prepaid Medicaid Programs: Analysis of Cost Savings, Calendar Years 1987-1989, prepared by the Minnesota Department of Human Services, April 1991. A fee-for-service comparison group was used to estimate cost savings. The Minnesota fee-for-service program has some managed care components, but the Minnesota Department of Human Services considers the comparison group to be the most accurate measure of the success of Minnesota's prepaid health plans. It is the Department's goal to compare prepaid programs with the state's current fee-for-service delivery system, and the fee-for-service experience is the standard federal measure of prepaid program savings.

Monitoring, Oversight, and Financial Reporting of Managed Care Plans—a Continuing Challenge to States

States' move to managed care has not been without risks. While fee-for-service payments give providers incentives to provide unneeded services to Medicaid beneficiaries, capitation payments give financial incentives to provide too few services. This creates added pressure on states to carefully monitor the access and quality of care delivered. In the past, providers sometimes accepted too much financial risk in capitated programs and later became insolvent. States did not have monitoring programs in place to identify such situations. There have also been problems with the quality of services being provided and high disenrollments, suggesting beneficiary dissatisfaction. At present, states are working to improve their quality assurance and financial monitoring systems and are looking to HCFA for help in developing better ways to measure quality and provider solvency.

States Require Plans to Meet Standards for Quality, Although Additional Quality Measures Are Needed

When states enroll Medicaid beneficiaries into managed care programs and encourage them to participate, they vouch for the quality of the health care services provided. State Medicaid officials believe that managed care programs will improve the quality of health care available to beneficiaries compared to traditional fee-for-service. States, health care providers, and HCFA all have roles in assuring the quality of care beneficiaries receive.

States operating managed care programs must comply with federal requirements that are primarily intended to assure quality in capitated programs. For example, the state Medicaid agency is required to conduct a medical audit of each contractor at least once a year.[43] This audit includes a review of patient utilization data to determine if the plan is providing an overall acceptable level of services.

States are also required to monitor plans' enrollment and termination practices and assure proper implementation of contractors' grievance procedures.[44] They are also required to contract for an annual external review of the quality of services furnished by the contracting plans.[45] These reviews normally include an examination of a sample of patients' medical records to evaluate the appropriateness of physicians' medical decisions. Our case study states periodically conduct beneficiary satisfaction

[43] 42 C.F.R. 434.53

[44] 42 C.F.R. 434.63.

[45] Section 1902(a)(30)(C) of the Social Security Act. Most states meet this mandate by contracting with a Professional Review Organization. These reviews tend to examine the structural capacity of plans, compliance with professional licensing standards, medical records reviews, and review of clinic sites. This requirement can also be waived.

surveys, disenrollment surveys, or both to identify aspects of their programs that need improvement.

In addition to the state, capitated plans also have a responsibility to evaluate their own service quality. Plans are required to establish an internal quality assurance system that: (1) generates utilization data like that collected under Medicaid fee-for-service programs; (2) provides for review by appropriate health professionals of the provision of health services; (3) provides for systematic collection of performance and patients results data; (4) provides for the interpretation of performance and patient results data to practitioners; and (5) provides for making needed changes.[46]

Although states and participating plans are required to maintain these quality assurance systems and procedures, they have not always complied. In our prior work, we have documented some of the potential problems that arise when safeguards and oversight systems do not function properly.

In 1990, we reported that Chicago area HMOs did not have adequate systems in place for identifying quality of care problems.[47] In addition, we found that during fiscal years 1986-88, over 58,000 Medicaid beneficiaries voluntarily disenrolled from the Chicago-area HMOs. HCFA, and independent evaluations of Chicago's managed care contractors, found that the plans' internal quality assurance programs were seriously deficient. We reported that the plans had not adequately documented the services they provided on patients' medical records, did not systematically collect utilization data, and did not follow up from prior reviews to see if corrective actions were taken. As a result, we reported that Medicaid beneficiaries enrolled in Chicago's HMOs were prone to underservice and inadequate care.

Two years later, we reported on our work in Oregon. We found that the state's program meets federal quality assurance requirements by ensuring that participating health plans maintain internal quality assurance systems.[48] We reported that these systems provided enough data to the state and outside reviewers to conclude that Oregon's program was generally providing care equal to that provided to the non-Medicaid

[46]42 C.F.R. 434.34.

[47]Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 27, 1990.)

[48]Medicaid: Oregon's Managed Care Program and Implications for Expansion (GAO/HRD-92-89, June 19, 1992).

population. In one area—health screening for children—we reported the need for improvement where providers had been slow to take corrective action.[49]

State Medicaid directors uniformly report that much more work is needed in the area of quality assurance for managed care programs. They argue that most of the federal requirements address the structure and processes of quality assurance systems but are not designed to actually measure patients' health outcomes. Further, they believe that current requirements are also designed to identify quality problems in traditional commercial HMO arrangements and do not reflect the diversity of models of managed care that states are now using in their Medicaid programs.[50]

Historically HCFA has left it to the states to oversee the quality of care delivered by managed care providers. Recently, however, HCFA has initiated a quality assurance reform initiative that will provide standards for internal quality assurance programs when states contract with capitated plans. HCFA has been consulting with representatives from the managed care industry, the states, and beneficiary advocacy organizations to identify appropriate quality assurance systems and policies. HCFA officials report that their goal is to subject Medicaid managed care plans to current quality assurance procedures and make them consistent with those in Medicare and the private sector.

Strong Financial Oversight by States Helps Assure Viability of Providers

Financial oversight of participating health plans is also critical to the success of any managed care program because the financial condition and viability of a plan directly affects its ability to provide continued services. Also, a plan in financial trouble has increased incentives to underserve beneficiaries. Moreover, if a plan becomes insolvent, beneficiaries must enroll in other plans and their health care is disrupted. States also may be liable for the plan's debt. Accordingly, states are responsible for assuring that contracting plans are fiscally sound—especially in the case of new providers who will be assuming the financial risk of prepaid care for the first time. Each state we visited that had capitation programs required the plans to purchase reinsurance to protect against insolvency.

[49]The Oregon Medical Professional Review Organization conducted annual patient records reviews and, at the time of our work, had found relatively few problems, with the exception of screening for children. Our group of consulting physicians from The George Washington University had the same findings. After their review, the statewide advisory committee had concluded that the quality of care showed little difference compared to the general public.

[50]Riley, Medicaid Managed Care p. 108.

Due to concerns that prepaid plans have a financial incentive to withhold needed services, HCFA requires states to obtain proof that contracting plans are financially responsible and have adequate protection against insolvency. States periodically must examine plans' financial records, and plans must comply with disclosure rules by reporting information related to ownership and financial control. Federal disclosure requirements were enacted, in part, to protect states from subcontracting arrangements among related businesses that could divert funds from the provision of health care. In our earlier work on Arizona's program, we identified many interconnected business relationships that potentially could enable health plans to divert Medicaid funds from their intended purpose—the provision of health care.[51]

HCFA provides little guidance to states on what constitutes assurances of financial solvency.[52] Consequently, states develop their own criteria and monitoring systems. Comparisons of a plan's performance over time to detect patterns of financial performance are important for a thorough evaluation of solvency. States also rely on a prospective analysis of a plan's financial statements, using generally accepted financial ratios, or on the regulatory oversight of other state agencies, such as the Insurance or Public Health Departments.

Michigan, for example, relies on two other state agencies to monitor fully capitated providers that participate in its Medicaid program. The Department of Public Health oversees the health care delivery system while the Insurance Bureau monitors financial stability. Together, these agencies conduct on-site visits and review medical records, quality assurance programs, utilization data, marketing materials, reinsurance programs, and subcontract provisions.

In our report on Chicago's Medicaid managed care program, we found that small groups or individual physicians were placed at significant financial risk, which gave them a financial incentive to reduce the frequency of services provided.[53] Physicians or subcontractors who assume the financial risk of treating a group of beneficiaries need to distribute this risk over a large number of patients. Otherwise, costly care for one or a few patients

[51]Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985).

[52]Recently, HCFA produced a draft of solvency guidelines for Medicaid HMOs. This is the product of work done by HCFA staff, state Medicaid staff, and representatives of the HMO industry and is intended to be consistent with Medicare requirements and industry practices.

[53]GAO/HRD-90-81, Aug. 27, 1990.

can create financial stress that could ultimately affect clinical decisions. HCFA recently issued regulations to minimize the financial incentives placed on an individual physician participating in a managed care health plan.[54]

Federal Waiver Programs Do Not Allow for Permanent Medicaid Managed Care Programs

One final issue concerning Medicaid and managed care involves the waiver process. Most states have applied for and received waivers of Medicaid rules to develop their managed care programs. States need to obtain waivers from certain statutory requirements that allow them greater latitude in program design.[55] Most state officials we surveyed in states operating Medicaid managed care programs reported that the waiver process was administratively burdensome. Congressional proposals have called for changes to the requirement for federal waivers, including elimination for managed care programs as long as certain assurances—such as adopting a quality assurance program—are made.

Federal waivers afford states some latitude to develop managed care programs, but there is currently no provision for states to permanently adopt these programs. States must renew 1915(b) waivers every 2 years, and 1115 demonstration project waivers are usually not renewed. This is the case no matter how many years the program has been operating or how successful it has proven to be. State officials consider the waiver process an administrative burden and an impediment to developing managed care in some cases because of the time and resources that have to be used for obtaining a waiver and renewals.

Officials also stated that the time involved in securing a waiver approval or renewal has slowed implementation of new managed care programs or expansions of existing ones. Some state officials believe that, at a minimum, it would be more beneficial to HCFA and themselves if the duration of the waiver was increased. These officials stated, and HCFA has agreed, that 2 years is unreasonably restrictive for long running programs, given their level of experience and knowledge. HCFA is examining ways to eliminate unnecessary and cumbersome paperwork requirements.

[54]57 Fed. Reg. 59024.

[55]Appendix X contains an explanation of the federal waiver process used for Medicaid managed care programs.

Conclusions

In an environment of rising Medicaid costs, serious budget constraints, and increasing enrollments, states are rapidly turning to managed care as a way to improve health care delivery to Medicaid beneficiaries, while also achieving greater control over costs. States are using various managed care models and approaches. The move towards PCCM programs is indicative of states' efforts to attract providers and improve access.

Although the framework for managed care, with its emphasis on primary care physicians, has the potential for improved access and quality, there is still some question about whether beneficiaries in Medicaid managed care achieves better outcomes under this system. Certain measures of access—such as office wait times and emergency room use—show improvements under managed care. The quality of care provided to beneficiaries generally matches that of traditional Medicaid fee-for-service care. Better measures of medical outcomes still need to be developed and refined before the question of quality can be answered with any certainty. Finally, states report significant cost-savings compared to fee-for-service programs, although these claims are disputed by certain experts. Fully capitated managed care programs appear to offer the best control and predictability over Medicaid spending; however, PCCM programs can improve control over cost compared to traditional fee-for-service.

Given the direction states have chosen, their current challenge is to establish comprehensive data collection and monitoring systems to oversee their programs. HCFA and the states need to assure that quality assurance systems and financial safeguards are in place, and that they generate accurate and timely financial and utilization data to identify providers who may be vulnerable to excessive financial risk and underservice.

Finally, states argue that they spend considerable resources to comply with the federal waiver application process to get approval for their managed care programs—resources they would prefer spending on expanding their programs. This is the case even for programs that have been in existence for over a decade and that are accepted as successful, such as Minnesota and Arizona. HCFA agrees the process is burdensome and is looking for ways to institute changes.

A Comparison of Medicaid Managed Care Programs in Arizona, Kentucky, Michigan, Minnesota, New York, and Oregon[a]

State	Arizona	Kentucky	Michigan	Minnesota	New York	Oregon
Program title	Arizona Health Care Cost Containment System	Kentucky Patient Access and Care System	Michigan managed care programs	Minesota mandatory and voluntary prepaid medical assistance programs	New York managed care programs	Oregon Health Care Cost Containment System
Start date	1982	1986	1972	1975	1967	1985
Waiver type(s)	1115	1915(b)	1915(b)	1115	1915(b)	1915(b)
Organization and reimbursement	Fully capitated HMOs	Fee-for-service PCCM with $3.00 case management fee	Fully capitated HMOs; partially capitated Clinic Plans; and fee-for-service PCCMs with $3.00 case management fee	Fully capitated HMOs	Fully capitated HMOs and Physician Health Service Plans; partially capitated Physician Case Management Programs; and fee-for-service PCCMs with $2.14 case management fee	Fully capitated HMOs, partially capitated Physician Care Organizations (PCOs)
State reinsurance[b]	For fully capitated plans	Not applicable	Not offered	For fully capitated plans	For fully capitated plans	For fully capitated and partially capitated plans
Statewide	Yes	Yes[c]	No	No	No	No
Eligible populations	AFDC, AFDC-related, SSI, and SSI-related	AFDC and AFDC-related	AFDC, AFDC-related, SSI, and SSI-related	AFDC, AFDC-related, SSI, SSI-related[d], and medically needy	AFDC, AFDC-related, SSI, SSI-related, and medically needy	AFDC and AFDC-related
Enrollment type	Mandatory in 15 counties	Mandatory in 112 counties	Mandatory in 4 counties, voluntary in 20 counties[e]	Mandatory in 3 counties, voluntary in 6 counties	Mandatory in southwest Brooklyn, voluntary in all counties	Mandatory in 14 counties, voluntary in 2 counties
Percent state Medicaid population participating	88	61	34	20	7	35
Beneficiaries' ability to change plans[f]	Once per year	At anytime	HMOs: After first 6 months or during biannual open enrollment periods Other plans: At anytime	Mandatory counties: Once during first year and during annual open enrollment period Other plans: Monthly	Depends on Plan: At anytime, or during first 30 days and after 6 months	HMOs: Monthly PCOs: At anytime after 6 months

(Table notes on next page)

[a]All data as of January 1993.

[b]Plans may obtain reinsurance through private insurers.

[c]The Kentucky program operates in 112 of the state's 120 counties.

[d]Only SSI aged population is included; blind and disabled populations are not included.

[e]The state is planning to mandate enrollment in all counties with adequate provider participation.

[f]In all state programs most beneficiaries may change plans at anytime due to special circumstances and with the state's approval. In New York, local social service districts must approve the change.

Arizona: a Statewide Fully Capitated Managed Care Program

Arizona operates the only statewide Medicaid managed care program in which nearly all services provided to Medicaid beneficiaries are paid on a capitated basis. Participation in the program is mandatory for all Medicaid beneficiaries in the state except American Indians who may choose the Indian Health Service as their Medicaid provider. Nearly 88 percent (365,623) of Arizona's 416,079 Medicaid beneficiaries, and over 85 percent of the state's physicians participated in the managed care program as of January 1993.

Background

Before 1982, Arizona was the only state not participating in the federal Medicaid program. Instead, county governments were financially responsible for providing health care to the indigent. However, a statewide county government fiscal crisis—due in part to escalating health care costs—resulted in the state legislature seeking federal assistance to provide health care to Arizona's low-income population.

Arizona's Medicaid program—AHCCCS—began operating in 1982 as a demonstration project. Initially, the state contracted with an outside firm to administer the program. The firm's responsibilities included: (1) tracking beneficiary enrollment, (2) resolving beneficiary grievances and appeals, (3) auditing the financial solvency of health plans, and (4) monitoring the quality of care being provided by health plans. However, state officials said that the firm did not adequately perform in accordance with the contract.

Under the firm's administration, health plans complained that accurate enrollment data were not provided to them and monthly capitation payments were late. In addition, beneficiaries complained of long waiting periods in doctors offices and receiving poor health care. Several health plan administrators from two plans were subsequently indicted by the state on charges of conspiracy, illegally conducting an enterprise, fraud, and theft. Administrators of one of the plans were found guilty and the other case is still pending.

State officials attributed these problems to poor management and oversight by the contracting administrative firm, resulting from the state trying to implement the program too quickly.[1] Spending most of their time on implementation activities—such as establishing Medicaid eligibility—state officials and the contracting administrator did not have

[1]Implementation problems for AHCCS were described in Medicaid: Lessons Learned From Arizona's Prepaid Program (GAO/HRD-87-14, March 6, 1987).

enough time to develop monitoring and oversight systems that could detect fraud and other abuses.

Because of these initial managerial and oversight problems and subsequent contractural disagreements, the state assumed the administration of AHCCCS in 1984. AHCCCS management instituted financial monitoring systems that required: (1) annual audits of health plans, (2) posting of bonds by plans to guarantee performance, (3) reports of business transactions between health plans and subcontractors, and (4) advanced approval of some agreements between health plans and subcontractors.

To develop AHCCCS, the state obtained an 1115 waiver. The original 1115 waiver was authorized for 3 years, renewed by HCFA for an additional 2 years, and subsequently extended by federal legislation for another two years.[1] One year into the extension Arizona obtained a new 1115 waiver which covers the addition of long term care services to the state program. This new 5-year 1115 waiver was scheduled to terminate in October 1993. However, in January of this year, HCFA extended the waiver until October 1994.

Health Care Delivery System

The AHCCCS program is divided into two main components—the AHCCCS acute care program and the Arizona long-term care system. In general, private and county government health plans contract with AHCCCS to provide acute and primary care services. All health plans subcontract with providers, such as physicians and hospitals to actually deliver services.

The AHCCCS Program

Medicaid beneficiaries enrolled in the AHCCCS acute care program may receive all acute and primary care services available through a traditional Medicaid program except mental health services for adults who are not "seriously mentally ill".[2] Fourteen health plans contract with AHCCCS to provide these services. All of these plans are required to provide the same services to beneficiaries; however, subcontracting arrangements with

[1]P.L. 100-203, Section 4115(a).

[2]AHCCCS does provide mental health services to individuals diagnosed as "seriously mentally ill", a mental disorder in which persons exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent, resulting in long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relations, homemaking, self-care, employment and recreation. Although persons with primary diagnoses of mental retardation, head injuries, senile dementia or Alzheimer's Disease frequently have similar problems or limitations, they are not included in this definition.

individual physicians, group practices, hospitals, laboratories, and clinics may differ.

The 14 health plans have enrollments ranging between 1,900 to 128,000 members. One of the health plans operating in Arizona is the largest HMO in the country which only enrolls Medicaid beneficiaries.[3] All of the health plans are HMOs which are, in large part, owned by or affiliated with a hospital. Some of the plans provide services in more than one county, and the service areas of some may overlap. For example, the largest contracting health plan provides services to AHCCCS beneficiaries in 12 of Arizona's 15 counties.

The Arizona Long-Term Care System

Arizona is one of a few states to have incorporated long-term care services into their Medicaid managed care program. In December 1988, long-term care services for the developmentally disabled became available through AHCCCS. Then, in January 1989, the elderly and the physically disabled were added. In all but two counties, Apache and Santa Cruz, AHCCCS has been able to establish contracts for the delivery of long-term care services on a capitated payment basis. Services in Apache and Santa Cruz are reimbursed on a fee-for-service basis.

Reimbursement

All health plans are paid a monthly per capita capitation fee. Because Arizona did not previously operate a Medicaid program, state officials could not base their capitation rate on historical fee-for-service Medicaid claims. Therefore, the payment rate for contracting plans is based on financial and utilization data collected for the previous contracting period.

Encounter data, when available, allow AHCCCS to group beneficiaries into risk pools based on eligibility criteria and medical care utilization patterns. For each service category in a risk pool, health plans compile encounter data to determine utilization rates per service category in units per 1,000 members, the cost per unit, and co-payments received. Using this data, the plans calculate a gross capitation rate. This rate is subsequently adjusted for items such as reinsurance and deferred liability payments. Once the plans have calculated and adjusted capitation rates for all rate codes, they submit their bids to AHCCCS. AHCCCS compares these bids to its own estimated capitation ranges for each rate code. If a bid falls outside of the range, the plan is not awarded a contract or is asked to revise its bid.

[3]HCFA Medicaid Coordinated Care Enrollment Report as of June 30, 1992.

Arizona offers both reinsurance and deferred liability payments to contracting health plans. Reinsurance helps protect plans from bearing the full cost of extremely expensive medical cases. AHCCCS reinsures the plans at levels that vary according to member category, plan size, and diagnosis. For Medicaid beneficiaries, the reinsurance deductible ranges from $10,000 for a plan with less than 1,000 members per county to $30,000 for a plan with more than 10,000 members per county. AHCCCS pays 80 percent of the cost of a member's treatment in excess of the deductible. Deferred liability payments limit a plan's financial responsibility for beneficiaries hospitalized or receiving medical care on the day of enrollment into a plan. The plan will only have to incur a portion of the cost of the care provided.[4]

Although AHCCCS pays all health plans on a capitated basis, subcontractors may be paid on a capitated or fee-for-service basis. In the plans we visited, subcontracting general practitioners are typically paid a capitated fee per beneficiary while specialists are paid on a fee-for-service basis.

Eligibility

Arizona requires all persons eligible to participate in Medicaid, except Native Americans, to enroll in the state's managed care program, including AFDC and SSI recipients. Arizona also provides services to: pregnant women and infants up to age 1 with incomes not over 140 percent of the federal poverty level; to children under age 6 with incomes not over 133 percent of the federal poverty level; and to children up to age 14 with incomes not over 100 percent of the federal poverty level.

The Department of Economic Security determines eligibility for all Medicaid applicants except those who are aged, blind or disabled SSI recipients. Eligibility for SSI recipients is determined by the Social Security Administration. Once a beneficiary's eligibility is established, it is initially guaranteed for 6 months. After that period continuous enrollment is contingent upon the beneficiary's eligiblity. Therefore, AHCCCS beneficiaries who lose their Medicaid eligibility within the first 6 months of their enrollment in managed care are not disenrolled from the Medicaid program until their seventh month of enrollment.

Enrollment

Enrollment in a health plan is mandatory for all Medicaid beneficiaries except Native Americans. Native Americans who are eligible for Medicaid may choose to receive medical services through the Indian Health Service

[4]If a beneficiary is hospitalized on the day of enrollment, the state will pay 50 percent of allowable inpatient hospital charges for the first 15 days of the client's enrollment. If the client is a newborn, the state will pay for all charges from the day of enrollment to the day the newborn is discharged.

or a health plan participating in the Medicaid program. The Indian Health Serivce bills AHCCCS for services and AHCCCS pays on a fee-for-service basis. No state matching funds are required for the payment of health care services provided through the Indian Health Service.

All Medicaid beneficiaries required to enroll in managed care must choose a health plan in their county within 10 days or be automatically assigned to a plan. Although beneficiaries have the freedom to choose a health plan, historically, about 17 percent do not. Once enrolled in a plan, Medicaid beneficiaries are given 4 days to choose a primary care physician, Otherwise they are automatically assigned to one.

In Arizona, Medicaid beneficiaries enrolled in managed care programs may change plan membership once a year during the open enrollment season. In 1992, about 5 to 6 percent of beneficiaries changed plans. Beneficiaries may also request and obtain a plan change at any time, if during the enrollment process, administrative procedures were not followed. For example, if a beneficiary was automatically enrolled in a plan without being given a full 10 days in which to make a choice, they could request a change. Beneficiaries may also be allowed to change plans if they file a grievance with AHCCCS and their request for a change is approved. If persons lose their Medicaid eligibility but regain it within 90 days, they are automatically assigned to their former plan.

Marketing and Outreach

Marketing and outreach are on-going activities for providers. AHCCCS administrators prepare special presentations to recruit providers into the program. If a provider is interested in participating, the AHCCCS administration will offer assistance in designing and developing the managed care plan. Throughout the year, AHCCCS also gives presentations to community organizations and produces educational materials for potential beneficiaries. Brochures about AHCCCS, eligibility, and coverage are provided in Medicaid eligibility and enrollment offices.

Health plans also produce educational materials for potential Medicaid beneficiaries. At Medicaid enrollment offices, beneficiaries can receive informational pamphlets on plans. AHCCCS does not allow plans to directly market to beneficiaries or provide incentives to influence a beneficiary's enrollment choice. Once enrolled in a plan, the AHCCCS beneficiary receives a membership handbook which outlines the plan's administrative processes and medical services. Plans may also develop special educational programs or informational pamphlets for their beneficiaries.

Monitoring and Oversight

The AHCCCS administration has developed several standards and tools which it uses to measure the medical and financial performance of contracting plans. To help ensure that Medicaid beneficiaries receive quality medical care, AHCCCS staff monitor the plans through on-site visits to health plans and the offices of subcontracting physicians, yearly financial and operational audits, medical record audits, beneficiary satisfaction surveys, and grievance reports from beneficiaries and providers.

AHCCCS also requires plans to develop quality assurance systems, which must include a grievance process for reviewing and adjudicating complaints. If a plan does not resolve a grievance within 10 working days, AHCCCS reviews the grievance and conducts a hearing. Plans are also responsible for ensuring the quality of care provided by, and the financial viability of, their subcontractors. AHCCCS audits each individual physician subcontractor at least once every 4 years.

In cases of non-compliance with AHCCCS medical or financial standards, plans may be sanctioned by having their capitation payment withheld or not being permitted to acquire new members. As of January 1993, AHCCCS had issued 35 sanctions to 11 health plans. The vast majority of these sanctions were for the failure of plans to provide information—such as encounter data—to AHCCCS.

In recent audits of health plans, AHCCCS noted that some plans need to: (1) develop formal strategic plans with short and long-term priorities, (2) improve the process of collecting utilization data and create stronger utilization control systems, and (3) improve financial and accounting policies and procedures.

In addition to AHCCCS' own internal quality assurance studies, HCFA requires independent evaluations. A study released by SRI in January 1989, reported that the quality of care provided through AHCCCS was at least equal if not better than the care provided through traditional Medicaid programs in New Mexico—a state with a comparable Medicaid population.[5] Furthermore, patient satisfaction surveys conducted for the state in 1989, showed that nearly 60 percent of current and past adult

[5]Care for children under AHCCCS was in greater compliance with generally accepted pediatric guidelines than under New Mexico's program. However, for pregnant women the results were less clear. Pregnancy care and pregnancy outcomes were similar in the two states, with the exception that Arizona had a higher cesarean section rate, a smaller number of prenatal visits, and a later initiation of prenatal care.

beneficiaries were completely satisfied with the care they received through AHCCCS.

Researchers from SRI, on the other hand, advised the AHCCCS administration to monitor member satisfaction more closely and to use encounter data to identify problems with, and improve the quality of, care. SRI said that quality assurance activities were particularly important because of the incentive under AHCCCS for health care providers to inappropriately limit the utilization of services. As of January 1993, no other independent evaluations of the AHCCCS acute care program had been conducted.

Kentucky: a Managed Fee-For-Service Program

Kentucky's Medicaid managed care program, called KenPAC, was specifically designed to avoid repeating prior state problems with a capitated managed care program. KenPAC is a fee-for-service program in which the beneficiary chooses, or is assigned, a single primary care physician who acts as a coordinator of that beneficiary's total health care. At any time, beneficiaries can request to change providers, or providers may request reassignment of a beneficiary. Beneficiaries may select providers in Kentucky or other states contiguous to their county of residence. The program is essentially statewide, operating in 112 of Kentucky's 120 counties as of January 1993. It serves the AFDC and AFDC-related populations. Over 61 percent (303,831) of the state's Medicaid beneficiaries are served by the program.

Background

KenPAC is a primary care case management program administered by the state Department of Medicaid Services. The program began operating in February 1986 under a 1915(b) waiver. Administrators chose to design a primary care case management program to increase access and to enhance the quality of medical services by improving the coordination of care. Administrators did not consider a capitated approach because a short-lived capitated program in 1983 and 1984 ended with allegations of inadequate access to care. Officials wanted to develop a program that emphasized preventive and primary care.

Health Care Delivery System

KenPAC primary care physicians contract with the Kentucky Department of Medicaid Services to deliver services to Medicaid beneficiaries. These physicians are responsible for identifying and coordinating the primary and specialty care needed by beneficiaries. All services provided through a traditional Medicaid program are available to KenPAC participants. However, mental health and long-term care services are not managed under the KenPAC program.

Organization

Primary care physicians contract with KenPAC to coordinate services for Medicaid beneficiaries. In an effort to ensure quality, KenPAC restricts the number of beneficiaries physicians may have in their caseload. Furthermore, only certain types of physicians may become contracting primary care providers.

As of January 1, 1993, KenPAC had 1,086 physicians providing services to 303,831 beneficiaries. Each contracting primary care physician may serve

no more than 1,500 Medicaid patients. On average, primary care physicians serve approximately 279 Medicaid patients, as well as their private patients. Generally, physician participation is limited to those Medicaid participating physicians or clinics whose practices are centered around general or family medicine, pediatrics, internal medicine, and obstetrics or gynecology.

Covered Services

All services provided through a traditional Medicaid program are available to beneficiaries. Primary care physicians are responsible for providing most of the services beneficiaries need. If a patient needs a service the primary care physician cannot provide, the physician must authorize a referral. If the beneficiary attempts a self-referral, the beneficiary's Medicaid card will warn the provider that the claims for services not authorized by primary physicians may not be paid. Primary care physicians are not responsible for managing the delivery of ophthalmologic, psychiatric, and obstetrical care. Therefore, beneficiaries may obtain these services from any available Medicaid provider without authorization from their physician.

Reimbursement

Both KenPAC and other Medicaid providers are paid for delivered services according to the same fee-for-service schedule. However, contracting KenPAC physicians also receive a $3.00 management fee per patient per month, but no more than $3,000.[1] The $3,000 per month limit is thought to be adequate compensation for patient management services. State administrators would like to develop a system to enhance reimbursement to providers who deliver services within appropriate utilization rate ranges to serve as an incentive for "good" patient managers.

Eligibility

KenPAC serves individuals who fall within the general category of "families with dependent children". Such individuals may be receiving Aid to Families with Dependent Children (AFDC) cash grants and medical assistance or medical assistance only. This includes pregnant women and infants with incomes up to 185 percent of the federal poverty level, children up to the age of 6 with incomes up to 133 percent of the poverty level, and children up to the age of 9 with incomes up to 100 percent of the poverty level. Specifically excluded are aged, blind, and disabled Supplemental Security Income (SSI) beneficiaries, individuals in nursing

[1]The state may grant exceptions to this limit.

facilities, mental hospitals, foster care or subsidized adoption status, and medically needy beneficiaries that have spent down their income.

The state decided to focus the program around the AFDC population because this population has had more difficulty finding providers than other Medicaid beneficiaries. State officials have always envisioned adding other Medicaid beneficiaries but many logistical barriers must be overcome to do so. First, some Medicaid beneficiaries, such as aged, blind, or disabled SSI beneficiaries, need more specialty care. Second, state officials are reluctant to include populations that are also eligible for Medicare because they do not want to restrict provider choice for Medicare beneficiaries. Third, the state believes that it would have difficulty providing outreach and educational services to SSI recipients because the Social Security Administration is responsible for determining Medicaid eligibility for these populations and the state agency does not deal directly with these populations.

Enrollment

Currently, enrollment in KenPAC is mandatory in most counties for all persons eligible to participate. However, Medicaid managed care beneficiaries may choose their primary care provider and may change providers at any time.

According to a KenPAC official, in 1991, researchers from the University of Kentucky found that 83 percent of beneficiaries chose their own provider. Beneficiaries in counties with mandatory enrollment who do not choose a provider will be assigned to one.

KenPAC enrollment is conducted by staff in the field offices of Kentucky's Department for Social Insurance. After a face-to-face interview, the beneficiaries are given a list of participating KenPAC providers and an informational pamphlet. Beneficiaries may choose from among participating providers in the county in which the beneficiary resides or in any county, including those out of state, contiguous to the county of residence.

Reassignment may be initiated by either beneficiaries or providers. Beneficiaries who wish to change selected or assigned providers must contact Department of Social Insurance field office staff. As long as the beneficiary has selected another appropriate provider from within the service area, the change becomes effective within 1 to 2 months.

Providers who wish a beneficiary to be reassigned must notify the beneficiary in writing with a copy of the letter sent to the Department of Medicaid Services. The Department then notifies the Department for Social Insurance which subsequently notifies the beneficiary in writing of the need to select a new KenPAC provider. It may take 2 or more months to complete the reassignment process. Whether the enrollment change is initiated by the beneficiary or provider, the assigned provider must continue to deliver care until the change becomes effective.

Marketing and Outreach

KenPAC provides informational and instructional pamphlets to both beneficiaries and providers. Unlike in voluntary programs, marketing to KenPAC beneficiaries is not necessary because enrollment is mandatory in most counties. On the other hand, KenPAC officials do market the program to primary care providers. There is no direct marketing to beneficiaries by individual physicians.

Beneficiaries

Individuals obtain information from two sources: (1) local Medicaid enrollment offices and (2) primary care providers. First, when a beneficiary begins the Medicaid enrollment process at the Department for Social Insurance, they receive information on KenPAC—including a list of participating providers and enrollment procedures. Once enrolled with a primary care provider, the provider may provide more detailed information on services and on the patient's rights and responsibilities. KenPAC does not require providers to prepare member handbooks or other literature for patients.

Providers

When providers apply to participate in Kentucky's Medicaid Program, they receive a letter explaining the KenPAC program and asking them if they would like to participate in this program as well. Along with the letter, potential providers also receive detailed information on their responsibilities as KenPAC providers.

Monitoring and Oversight

The KenPAC administration monitors the delivery of services by contracting providers. According to researchers from the University of Kentucky, the majority of KenPAC beneficiaries believe that the quality of care provided through KenPAC has not changed, or has improved, relative to fee-for-service Medicaid programs. The researchers also reported that the program costs less than fee-for service programs. Moreover, researchers

from the University of Kentucky reported in 1989 and 1991 that their survey results showed KenPAC beneficiaries feel that they can better resolve problems that might arise with their doctor or the quality of medical care they receive. The vast majority of beneficiaries believed that they were treated with respect by their KenPAC physician and said that if they were unhappy with the medical care they were receiving, they would talk with their doctor.

Kentucky officials monitor access and quality in the KenPAC program in several ways. First, as part of the annual independent assessment required by HCFA, beneficiary and provider surveys are conducted. Second, state staff periodically review medical records. In 1991, six such reviews were performed. Third, the KenPAC administration collects and monitors grievance reports from providers and beneficiaries. To assist providers and beneficiaries with problems, the state also maintains a toll free number for immediate problem resolution.

KenPAC's Utilization Review System monitors services received by KenPAC beneficiaries and provides feedback to KenPAC patient managers pertaining to the overall utilization patterns of their KenPAC caseloads. All participating KenPAC providers are given monthly reports that present their individual rates for seven utilization measures in comparison to the corresponding rates for the six provider specialty groupings and the statewide rates. Detailed utilization reports are used by the program staff in conjunction with other available systems data to determine unacceptable practice patterns and to take appropriate corrective action.

Maintaining quality of care and access to care that is at least equivalent to that in a fee-for-service program is required for freedom-of-choice waiver programs. Beneficiary and provider surveys conducted by the University of Kentucky in 1989 indicate that quality of care has been maintained or improved under KenPAC. Beneficiary surveys also indicate that access has either been maintained or improved. In addition, studies of KenPAC have shown that the program is more cost-effective than a fee-for-service program. In Kentucky's 1991 waiver renewal request, officials report that KenPAC saved $13 million in 1987 and may save $93 million in 1994. On the other hand, the University of Kentucky reported in a study conducted in 1991 that KenPAC should save between $125 million and $150 million per year. The difference occurred because the University assumed a greater number of beneficiaries, which resulted in a greater potential for relative savings.

Michigan: a Mixed-Model Managed Care Program

Michigan began developing fully-capitated managed care programs for Medicaid beneficiaries as early as 1972. In 1982, it became one of the first states to establish a fee-for-service primary care case management program, and a year later, started a partially capitated program, referred to as the Clinic Plan. In response to consumer and advocacy concerns, Michigan instituted quality assurance procedures such as a consumer complaint hotline, grievance systems, disenrollment tracking, spot checks on the 24-hour availability of physicians, and consumer satisfaction surveys. Michigan's multiple model managed care approach serves an estimated 34 percent (327,265 as of January 1993) of the state's Medicaid population.

Background

In 1972, the Michigan Department of Social Services started contracting with HMOs to provide health care services to Medicaid beneficiaries. In 1982, when many states were implementing capitated programs in an attempt to contain escalating Medicaid costs, Michigan physicians wanted to retain the fee-for-service payment system. The state medical society and the Michigan Association of Osteopathic Physicians and Surgeons devised the Physician Sponsor Plan in response to a legislative request for a proposal outlining an alternative reimbursement approach. After gaining federal approval, Michigan began implementing the Physician Sponsor Plan in July 1982 under a 1915(b) waiver. In April 1983, the Clinic Plan was implemented on a pilot basis under a separate 1915(b) waiver as another health care delivery alternative.

Health Care Delivery System

The delivery systems used for each of Michigan's Medicaid managed care programs cover a wide range of managed care program models. The HMO program is a fully capitated, managed care delivery system. The Physician Sponsor Plan is a managed fee-for-service primary care case management delivery system, while the Clinic Plan is a partially capitated program.

HMO Program

Seven state qualified HMOs, six of which are also federally-qualified, participate in Michigan's Medicaid managed care program. Individual HMO plan enrollments ranged from 1,661 to 87,322 as of January 1993. These HMOs are located in nine of Michigan's 83 counties, with most HMO beneficiaries being located in the Detroit metropolitan area. The HMOs either directly render services or contract with other providers to deliver services. The HMOs are staff or independent physician association model organizations, and cover all services except dental, long-term care, and

non-emergency medical transportation. If a Medicaid beneficiary requires long-term care services, the individual disenrolls from the HMO and receives these services through the fee-for-service Medicaid program. The beneficiary, however, can receive dental services from a fee-for-service provider, maternal support services and family planning from a family planning clinic, ambulatory mental health services from a community mental health agency, and still remain enrolled in an HMO.

Physician Sponsor Plan

Under the Physician Sponsor Plan, Medicaid beneficiaries select a primary care physician to act as their physician sponsor. As of January 1993, approximately 1,668 physicians contracted with the state to participate in this plan. Each physician sponsor either directly renders or authorizes most medical services. However, the following services do not require an authorization: emergency services, chiropractic, podiatric, hearing, vision, family planning services obtained at a family planning clinic, nurse midwife, and dental. Radiology, pathology, and pharmacy services do not require direct authorization but must be ordered by a physician.

Clinic Plan

Each year, the Department of Social Services contracts with clinics and physician group practices to deliver ambulatory and physician care to Medicaid beneficiaries. As of January 1993, four clinics with service areas in three counties contracted with the state. The individual clinics had enrollments ranging from 1,238 to 7,079. Services not covered by the clinic plans include hospice, long-term care, dental, inpatient, and mental health services. Inpatient services, which are not included in the Clinic Plan capitation rate, must specifically be authorized by the clinic. If the Medicaid beneficiary is placed in a long-term care setting, the individual must disenroll from the Clinic Plan and receive services through the fee-for-service Medicaid program. Beneficiaries, however, may receive dental, mental health, and inpatient hospital services and remain in the Clinic Plan. Family planning services are available in either the clinic setting or a family planning clinic. All nonemergency inpatient hospital admissions must be authorized by the Medicaid beneficiary's clinic.

Reimbursement

Michigan's managed care programs have a variety of payment arrangements. The state does not offer reinsurance to health plans for risk protection, but such protection is available to plans from private insurers. In the past the state offered reinsurance as an incentive, and is again discussing the option with health plans.

HMO Program

HMOs are fully capitated for the services they provide. The Department of Social Services sets the capitation rates which are based on the fee-for-service costs of a like population for covered services in the contractor's service area. The Department of Social Services rate setting process considers cost and eligibility data specific to county, cash assistance program, age, and sex. After a number of adjustments, the final projected total is dispersed into age/sex/program rate categories, and the estimated per capita cost is calculated. Reimbursement rates range from 90 to 99 percent of fee-for-service costs.

Physician Sponsor Plan

Physician sponsors receive fee-for-service payments for services provided plus a case management fee of $3 per month per enrolled beneficiary up to a maximum of $3,000 per month. This case management fee is intended to offset the cost of maintaining a 24 hour on call system, reviewing periodic utilization reports, and establishing referral mechanisms as required by the Department of Social Services.

Clinic Plan

The Clinic Plan program is partially capitated for most ambulatory services, while inpatient hospital charges are the state's responsibility. Clinic Plans receive a monthly capitation fee per enrollee for all plan covered services. The capitation rate is calculated at 100 percent of average fee-for-service costs. Inpatient services authorized by the Clinic Plans are paid on a fee-for-service basis by the Medical Service Administration of the Department of Social Services. While Medicaid pays the facility charge, the Clinic Plan is still responsible for physician costs related to the admission.

Clinic Plans share in any savings accrued as a result of the program. An incentive payment is paid to the Clinic Plan contractor if costs are less than 80 percent of what was expected if the beneficiary had been in fee-for-service. The incentive equals 50 percent of the difference between actual cost and 80 percent of expected costs. There is no penalty if Clinic Plan inpatient costs are higher. The Clinic Plan is at full risk for capitated ambulatory services, but has no risk for inpatient care.

Eligibility

All of Michigan's programs are targeted to AFDC, AFDC-related, SSI, and SSI-related beneficiaries. The Department of Social Services determines eligibility and notifies providers of any changes. Michigan does not offer a minimum period of state guaranteed eligibility for Medicaid beneficiaries.

Enrollment

In September 1992, HCFA approved the state's waiver modification request to expand mandatory enrollment beyond Wayne County (Detroit), and to include non-Medicare SSI and SSI-related program categories in addition to AFDC. The state is in the process of making the mandatory program statewide and has completed notification mailings in three additional counties. As of January 1993, four counties had mandatory enrollment and Medicaid beneficiaries were enrolled in managed care in 24 of the state's 83 counties. Beneficiaries have a choice of any of Michigan's three managed care program models in three counties, and a choice of two program models in eight counties. A state official estimated that about 34 percent of the state's Medicaid population was enrolled in managed care programs as of January 1993. The state is planning to have managed care enrollment in all counties by the end of 1994, and will determine which counties will have mandatory enrollment based on provider participation levels.

In all counties where managed care programs exist, persons who have recently been determined eligible for Medicaid receive a pamphlet called Choose Now from the District Social Service Office. The pamphlet describes the three state managed care programs and asks beneficiaries to fill out the registration/enrollment mailer. Where enrollment is mandatory for an eligible individual, that individual is required to select a managed care provider within 4 to 6 weeks. In Wayne County (Detroit), if the beneficiary does not make a choice, he or she is automatically enrolled with a Managed Care Entry Plan provider in their district.[1] As of January 1993, over 15,000 individuals (about 5 percent of Michigan's total Medicaid managed care population) who were required to select a health plan had not and were automatically assigned to a managed care provider.

Once enrolled in a managed care program, a Medicaid beneficiary's ability to disenroll varies on the type of program. The HMO and Clinic Plan both require a disenrollment form to be completed at the disenrolling beneficiary's health plan. However, this is not necessary with the Physician Sponsor Plan. Beneficiaries enrolled in a federally qualified HMO

[1]Each state social service district has one Managed Care Entry Plan provider. This provider is a Physician Sponsor Group, HMO, or Clinic Plan that has contracted with the state to deliver services at 5 percent less than the normal capitation rate or forgo the monthly case management fee in exchange for guaranteed enrollment. Beneficiaries remain in the entry plan until they make a choice. Eventually the state plans to "roll over" entry plan enrollees into regular managed care enrollment after 6 months if the beneficiary still has not made a choice, but this will require an enrollment systems computer change to automate the system. Currently the entry plan assignment process is only utilized in Wayne County, but will be expanded to other counties as the managed care program expands.

are locked into that HMO for 6 months or until an open enrollment period.[2] There are two open periods (May and November) during a year. Beneficiaries enrolled in Clinic Plans may change plans or providers, or disenroll at any time. Beneficiaries enrolled in the Physician Sponsor Plan may change providers upon request to the Department of Social Services. Except in unusual circumstances, the change will take from 2 to 6 weeks to become effective.

Marketing and Outreach

The state takes the lead in marketing and outreach activities in mandatory enrollment counties. The state places information and mail-in enrollment forms in district social service offices, and mails beneficiary notification letters requesting completion of the enrollment form.

Individuals as well as providers receive educational information describing the program, how to enroll, and their responsibilities for obtaining or providing services under the system. Beneficiaries and providers may also listen to tapes over the telephone which describe the program.

In addition, providers conduct marketing and outreach. Physician Sponsor Plan providers may enroll beneficiaries during office visits. Clinic Plan providers may distribute marketing materials, which have been approved by the Department of Social Services, to Medicaid eligible individuals. Marketing materials must provide adequate information to make an informed choice in the selection of a participating plan and physician. The Clinic Plan must assure that each beneficiary understands how to use the plan and the restrictions that apply.

HMOs provide the Department of Social Services with marketing materials to mail to all eligible Medicaid individuals in a given service area. Interested beneficiaries may then contact the HMO for further information and enrollment forms.

Several HMOs rely heavily on door-to-door marketing, although they can not target Medicaid beneficiaries individually. These HMOs visit locations where Medicaid beneficiaries might likely be, such as food stamp outlets or other social service offices, and canvas low income neighborhoods. To address concerns about potential abuses and misrepresentations that can

[2]There is no lock-in for beneficiaries automatically assigned under the Managed Care Entry Program even if the provider is a federally qualified HMO.

occur in direct marketing, the state has strengthened contract provisions regarding marketing practices.

Monitoring and Oversight

Monitoring programs and oversight responsibilities differ slightly for each of the programs. For the most part, monitoring and oversight consists of: (1) quality of care reviews conducted by an independent organization; (2) beneficiary satisfaction surveys; (3) toll-free telephone lines for beneficiaries and providers to call for information or with complaints; (4) on-site contract compliance reviews; and (5) random checks of providers to ensure 24-hour on call coverage for beneficiaries. In addition, evaluations of the state's programs have reported that managed care decreases the cost of delivering health care to beneficiaries while maintaining access and quality.

In Michigan, two agencies are assigned responsibility for monitoring HMOs. The Michigan Department of Public Health monitors the health care delivery systems of HMOs and the Insurance Bureau of the Department of Licensing and Regulation monitors the financial condition of HMOs. The state's public health department conducts periodic on-site inspections of medical records and reviews health plan quality assurance programs, utilization reporting, and subcontracts for all referral services. The insurance bureau monitors marketing practices, grievance, and reinsurance programs.

Every other year, the Medical Services Administration conducts on-site inspections for contract compliance. The HMOs are required to submit various items for review such as current approved Medicaid marketing material and current, updated listings of contractors. While on site, Medical Service Administration staff reviews, among other things, the claims processing system, insurance policies, and samples of filed grievances. Upon completion of the on-site inspections, the HMO receives a report of the findings.

An independent evaluation of Michigan's Physician Sponsor Plan, released in February 1992, was conducted jointly by Health Management Associates, the Michigan Peer Review Organization, and Gini Associates, for fiscal years 1988 to 1990. The evaluation reported that ambulatory care was modestly superior to such care in the state's fee-for-service Medicaid program. The plan's beneficiaries had fewer cases where established criteria for quality were not met and a higher percentage of cases which met all of the quality criteria. In 1990, the same three organizations

conducted a similar evaluation of ambulatory care provided during 1988 in Michigan's partially capitated Clinic Plan. The report generally concluded that the quality of ambulatory care provided to Clinic Plan and fee-for-service beneficiaries was equal.

An independent agency evaluates the Physician Sponsor Plan under a contract with the Department of Social Services, to monitor access to care. The most recent contractor regularly surveyed beneficiaries 6 weeks and 6 months after enrollment to ascertain the beneficiary's experience under the plan. Based on results for the period March 1, 1989 to February 28, 1990, a report by KPMG Peat Marwick, released in June 1990, concluded that Physician Sponsor Plan beneficiaries are generally pleased with their choice of sponsor, satisfied with the medical care they have received, and have an ongoing relationship with their physician. The report also concluded that primary physician access had improved through use of 24-hour physician access telephone numbers and beneficiary information toll-free lines.

Evaluations of Michigan's mixed model managed care program report that managed care has resulted in cost savings. Through 1990, the state reported an estimated cost savings of $96 million for the HMO program compared to expenditures for fee-for-service beneficiaries. Estimated savings reported for 1989 were $12.7 million, and $15.9 million for 1990. A February 1992 independent evaluation of Michigan's Physician Sponsor Plan determined that the overall cost combined cost savings for AFDC and SSI beneficiaries in fiscal year 1989/90 was $24.2 million, or 17.5 percent of the combined expected Medicaid fee-for-service expenses. After deducting non-medical expenses (management fees and administrative costs), the net savings was $20.2 million or 14.6 percent of the expected fee-for-service Medicaid expense.

The September 1990 evaluation of the Clinic Plan estimated medical expense savings of $1.1 million for 1988. After deducting incentive and administrative costs, the net savings were estimated to be $767,001, or 15.2 percent less than the amount that would have been spent had the individuals been enrolled in the fee-for-service system.

Minnesota: a Fully Capitated Managed Care Program

Minnesota has nearly a 20-year history of operating Medicaid managed care programs, beginning with an HMO contract in 1975. The Minnesota Prepaid Demonstration Project was one of the first five 1115 waiver projects authorized by HCFA in the early 1980s to demonstrate competition in the Medicaid program by testing cost effective alternatives for payment and delivery of services. The demonstration waiver permits Minnesota to: (1) require a 12-month "lock in" for HMO Medicaid beneficiaries, (2) contract with non-federally-qualified HMOs and prepaid health plans, and (3) allow more than 75 percent of a plan's enrollment to be Medicaid and Medicare beneficiaries. The state also operates a voluntary managed care program for which the state did not need to seek a waiver. Together, Minnesota's managed care plans serve 20 percent of the state's Medicaid population (79,516 beneficiaries as of January 1993).

Background

Minnesota's managed care program is administered by the Department of Human Services which contracts with health plans and monitors plan performance. The Minnesota Department of Health regulates HMOs through financial assessments and quality assurance reviews. To reduce redundant efforts by state agencies, the Department of Human Services has contracted with the state's health department since 1975 to review specific administrative and internal quality assurance components of health plans. Minnesota has contracted with HMOs to provide Medicaid covered health services since 1975, according to a state official. In 1982, HCFA approved the state's proposal to develop a mandatory waiver program. After an extensive and lengthy planning process, the first program beneficiaries were enrolled in 1985.

Because HCFA does not routinely extend approval for demonstration waivers, state officials have encountered difficulty in continuing the program. In 1987, the state requested a 2-year project extension of the 1115 waiver program. HCFA denied the request but encouraged the state to convert the program to a 1915(b) waiver program. However, Minnesota officials considered the enrollment lock-in features of the demonstration waiver, which were not an option in 1915(b) waivers, crucial to the continued participation by providers.[1] Therefore, while the state submitted a 1915(b) waiver proposal, it also sought congressional action to extend the demonstration program for 2 years.

[1]Several health plans had stopped participating in the state's voluntary managed care program citing the lack of enrollment stability and the potential for clients that incur high medical costs such as with a high risk pregnancy to leave the plan. The 1115 waiver program allowed health plans to prevent Medicaid clients from disenrolling during their first 12 months of enrollment.

In 1988, Minnesota was granted an 18-month statutory extension of the demonstration program.[2] After the statutory extension of the demonstration program, state officials withdrew the 1915(b) waiver proposal. In 1990, the program was extended by federal statute for an additional 5 years, through June 1996.[3] At the same time, Congress authorized the expansion of prepaid managed care to other counties.

Health Care Delivery System

Minnesota contracts with seven HMO type health plans (including staff, clinic, and IPA model HMOs) in nine of the state's 87 counties. Three of these plans were specifically created for the Medicaid program—two continue to serve only Medicaid beneficiaries. Most of the plans are located in the metropolitan Minneapolis-St. Paul area, although two operate in northern rural counties. Limited state resources and difficulty in developing provider networks—especially in rural areas—are two primary reasons that the Medicaid managed care program is not statewide, according to state officials.

The state operates four managed care programs,[4] two of which serve primarily the Medicaid population. The mandatory demonstration program operated in three counties with an enrollment of 78,509 and the non-waiver voluntary program operated in six other counties with an enrollment of 941 as of January 1993. Individual plan enrollment in the mandatory program ranges from 3,238 to 44,069 while voluntary plan enrollment ranged from 9 to 855 as of January 1993. Two plans participate in both programs in separate counties and several plans serve multiple counties within a single program. Both programs operate substantially the same at the county level, except for the 12-month lock-in requirement of the mandatory program, which permits beneficiaries to change plans only once in 12 months. In all but one county, where the mandatory program is operating, beneficiaries are offered a choice of health plans.

Minnesota's managed care programs offer Medicaid beneficiaries a comprehensive list of services including preventive, diagnostic, therapeutic, and rehabilitative health care services. Certain services—long-term care, institutional care for the mentally retarded, and

[2]P.L. 100-485 Section 507.

[3]P.L. 101-508 Section 4733.

[4]The state's other two programs are a small federally-assisted Social HMO with a 1115 waiver providing long-term care and primary care to primarily Medicare beneficiaries (enrollment 275) and the General Assistance Managed Care program which serves the non-Medicaid poor (enrollment 16,268). Enrollment figures as of January 1993.

institutional care and case management services for the mentally ill—are not managed within the health plans but are available to Medicaid beneficiaries from fee-for-service providers.

Reimbursement

Reimbursement rates are based on historical fee-for-service costs, adjusted for inflation. Capitation rates for services to AFDC beneficiaries are approximately 90 percent of the fee-for-service base and approximately 95 percent for the aged population (SSI and non-SSI). One county—Hennepin (Minneapolis)—pays county specific rates. Dakota (suburban Minneapolis-St. Paul) and Ramsey (St. Paul) counties pay a metropolitan rate based on equivalent fee-for-service costs in a five county area. Plans do not negotiate rates for Medicaid beneficiaries because the state calculates rates for each population and geographic area.

All plans are fully capitated. The county and providers share the risk for the Itasca Medical Plan. Private or state sponsored inpatient reinsurance, to limit the financial risk of costly inpatient care, is available to the health plans. Under the state-sponsored insurance program, the state pays 80 percent and the plan 20 percent for any inpatient costs over $15,000 per Medicaid beneficiary per contract year. Many plans purchased state sponsored reinsurance the first year it was offered, but now purchase it privately at lower rates than the state offers. Others assume the risk themselves.

Eligibility

The counties determine Medicaid eligibility and help enroll eligible persons in the state's Medicaid managed care program. Individuals apply for Medicaid eligibility at the local county social service offices where county staff assist Medicaid eligible individuals with selection of their managed care health plan.

The mandatory program serves the AFDC, AFDC-related, SSI and SSI-related aged and medically-needy populations. The voluntary program primarily serves the AFDC population, with one plan serving all Medicaid populations.

Unlike some states, Minnesota does not provide a minimum state guaranteed eligibility for Medicaid beneficiaries, because of the additional expense, according to a state official. State managed care officials have recommended changes in federal law to include what they term "rolling eligibility," which would maintain Medicaid eligibility an additional month,

and save plans the costs of disenrolling and reenrolling beneficiaries, and minimize additional costs to the state.

Enrollment

The county offices of the Department of Social Services are responsible for beneficiary enrollment, education, advocacy, and referral of appeals to the state. County beneficiary education staff give presentations on available health plan options and assist persons eligible for Medicaid with health plan selection.

The counties encourage Medicaid beneficiaries to select a plan during the orientation process, but allow 30 days to make a choice. The counties conduct follow-up by phone and mail to encourage the beneficiary to select a plan. The only persons assigned to health plans are those who do not attend a presentation or respond to follow-up contacts. The current assignment rate for newly eligible beneficiaries is about 3 to 4 percent. Satisfaction surveys sent by the state Department of Human Services during open enrollment periods and when health plans withdraw from the program show a reluctance on the part of individuals to change providers or enroll in managed care plans. However, the surveys show satisfaction once beneficiaries had established relationships with health plan providers. The percent that changed plans during the open enrollment periods from 1986 to 1990 dropped from about 5 to 3 percent in Hennepin County and from 6 to 1 percent in Dakota County, according to state enrollment surveys.

In the past, the state experienced problems with beneficiary enrollment. Initially, the state contracted with a private broker to enroll beneficiaries. During this period, the assignment rate exceeded 50 percent of AFDC beneficiaries and many did not use their assigned providers or understand managed care procedures. As a result, one health plan dropped out of the program citing the adverse financial effect of unauthorized, out-of-plan bills. The plan did not want the burden of providing services for unwilling beneficiaries who were uneducated in the managed care process, according to a state official. The state finally agreed to fund enrollment costs if the county would enroll beneficiaries.

One feature of the mandatory enrollment program is the 12-month beneficiary lock-in to a given health care plan as long as the beneficiary continues to be eligible for Medicaid. In November 1991 the "lock in" rule was amended to allow beneficiaries the opportunity to change health plans for any reason once during the first year of enrollment. Two

counties, Hennepin and Dakota, also offer a 30-day open enrollment period each November.[5] Beneficiaries who lose Medicaid eligibility are automatically disenrolled from the program. Individuals who regain eligibility within 60 days return to the plan from which they disenrolled. Those who lose eligibility for longer than 60 days re-enter the program and repeat the provider selection process.

Marketing and Outreach

Minnesota does not allow direct marketing by Medicaid managed care health plans to potential beneficiaries. All plan selection information is either mailed to individuals by the county, or provided at the local county Economic Assistance Office. Health plans prepare brochures and informational materials that must be approved by the state before being distributed by the counties. The state does some education of health plans through ongoing discussions and information about upcoming bid requests. The state does not directly recruit physicians, but will, at the request of interested providers, hold meetings and distribute information about Minnesota's managed care program.

Monitoring and Oversight

Minnesota's quality assurance monitoring and oversight program consists of five main elements: (1) yearly external reviews of program administration and quality by an outside audit agency; (2) yearly state beneficiary satisfaction surveys conducted during open enrollment periods and when health plans withdraw from the program,[6] (3) state ombudsman and county advocates who respond to beneficiary complaints; (4) a grievance and appeals process for conducting hearings and resolving complaints; and (5) financial reporting and solvency reviews. In addition, Minnesota performs limited utilization reviews by analyzing hospital admissions, length of stay, and medical and surgical data.

External quality assurance reviews conducted for 1988, 1989, and 1990/1991 generally found that health plans improved internal quality assurance programs over the period of these studies. Reviews of medical records also show improvement, although records lack uniformity with regard to the listing of medications and ongoing medical issues.

Beneficiary satisfaction surveys, conducted by the Department of Human Services, reflect reluctance on the part of individuals to change providers

[5]The option to change plans does not apply to Itasca County which has only one plan, but beneficiaries may change individual physicians within the plan.

[6]Some health plans also conduct their own client satisfaction surveys on an annual basis.

or to enroll in managed care health plans. However, the surveys also found considerable beneficiary satisfaction among individuals who had established relationships with health plan providers. The November 1990 Open Enrollment Survey concluded that the low numbers of individuals wishing to change health plans are indicative of the general satisfaction with the level of health care being provided.

A 1991 state managed care interim report on the grievance process found that in the 5 years—from 1986 through 1990—beneficiaries filed a total of 173 formal administrative and service grievances with the state. This total represents less than 0.2 percent of the January 1993 program enrollment. The report concluded that the small number of formal grievances suggests a relatively high level of satisfaction.

The state attributed the low number of appeals to the work of the state ombudsman and county health care advocates who resolve problems between beneficiaries and health plans before they become grievances. A May 1992 state managed care status report cited a continued trend in low numbers of formal grievance hearings and appeals through March 1992.

Both the Department of Human Services and state's department of health obtain and review the financial reports from participating providers. Individual health plans monitor their own subcontractors. The state holds health plans responsible for the actions of subcontractors, including complaints that subcontractors did not provide adequate services.

The Department of Human Services has also undertaken studies to determine if cost savings are associated with the Medicaid managed care program in 1987, 1988, and 1989. The results show estimated savings of $5.7 million in 1987, $6.5 million in 1988 and $1.5 million in 1989. As predicted by the state, the 1989 analysis yielded more moderate savings than in the previous years due to the recalculation of capitation rates using more current years' experiences as a base.

Although these reports estimate cost savings, the state acknowledges serious limitations in the 1987 and 1988 precision of these results. The limitations include the fact that fee-for-service comparison data included retroactive months of eligibility and that capitation rates for 1987 and 1988 were based on fixed inflation factors that tended to increase the appearance of cost savings. Despite these limitations, the state concluded that the studies suggest an ability to control health care cost trends through a managed, capitated health care delivery model.

New York: a Mixed-Model Managed Care Program

New York is in the process of implementing a statewide managed care program. State officials expect that, within 8 years, 50 percent of all Medicaid beneficiaries eligible to participate in a state Medicaid managed care program will be enrolled. As of January 1993, about two million of New York's approximately three million Medicaid beneficiaries were eligible to enroll in managed care, but only 158,215 (7 percent) had done so. State officials say that low capitation payments for Medicaid physicians and the lack of provider networks in many areas—especially rural areas have slowed the development of Medicaid managed care programs in the state.

Background

New York has had a Medicaid contract with a federally-qualified HMO since 1967. Yet, in 1982, only two HMOs had contracts with the state. In 1984, state officials decided to develop more Medicaid managed care programs throughout the state, but wanted local social service districts[1] to design and administer them. In the opinion of state officials, district administrators understood the health care needs of local Medicaid beneficiaries and could discuss managed care arrangements with local health care providers. State legislation was passed between 1984 and 1991 to encourage districts to design Medicaid managed care programs; however, most did not. Consequently, 1991 legislation requires all districts to develop managed care programs by 1994. By 1994 all districts must have enrolled 50 percent of all beneficiaries eligible to enroll in managed care. The New York Department of Social Services must approve each district's program.

New York has a total of 64 managed care programs under five 1915(b) waiver programs. The remaining programs, developed by social service districts, do not include features which require waiver approval.[2]

Enrollment in managed care programs varies greatly depending, in part, on how long the program has been operating and its location. The oldest program, a contract with the Health Insurance Plan of New York City, enrolls the most Medicaid beneficiaries—40,969. A relatively new program in rural Columbia County enrolls only 66 Medicaid beneficiaries.

[1]The state of New York is divided into 62 counties, but 58 local social service districts. Each county is one social service district, except for the social service district of New York City which contains five counties in one social service district. Social service districts have full responsibility for administering the Medicaid program and social service programs.

[2]New York also operates a small social HMO with an 1115 waiver that was not the focus of our study.

Health Care Delivery System

Because each social service district develops its own program, a wide variety of managed care programs exists. Some districts have chosen to contract with existing HMOs; others have developed their own Medicaid-only HMOs, called physician health service plans. In addition, some districts have developed a physician case management plan or a PCCM plan.

As of January 1993, 26 of New York's 58 social service districts operated 64 managed care programs. Twenty-five HMOs with a total of 50 independent contracts, six physician health service plans, seven physician case management plans, and one PCCM provided services to Medicaid beneficiaries in one or more districts. Fifteen districts operate more than one type of managed care program.

All Medicaid managed care beneficiaries in New York receive a comprehensive list of services. If a contracting health plan offers fewer services, the beneficiary, although enrolled in managed care, may receive those services through the fee-for-service Medicaid program.

Reimbursement

HMOs and physician health service plans contract to provide services on a fully capitated basis. In most physician case management plans, which are partially capitated, providers—generally primary care physicians—receive monthly capitation payments for services they deliver. Medicaid services not directly rendered by the provider are paid on a fee-for-service basis. In addition, two physician case management plan programs have "bonus sharing arrangements" in which providers share 40 percent of any savings from delivering services through managed care rather than fee-for-service. In the PCCM program, providers receive a monthly per capita case management fee of $2.14 plus fee-for-service payment for delivered services.

Capitation payments for HMOs and physician health services plans are based on the cost of providing services to the population enrolled in each plan and the cost of administering and marketing each plan. The state, however, does not allow plans to receive monthly capitation payments that exceed 95 percent of the historical average monthly cost of delivering services in a traditional fee-for-service Medicaid program.

State officials are exploring ways to revise capitation rates for physician case management plans to more accurately reflect appropriate utilization of services. Current rates are based on historical Medicaid fee-for-service

expenditures for the primary care services delivered in each county. Because beneficiaries in areas with few providers tend not to obtain primary care or seek care in hospital emergency rooms, the current rates underestimate the utilization of primary care services. Consequently, the state believes capitation rates for physician case management plans are too low to cover the cost of all necessary primary care services.

New York offers fully capitated plans the opportunity to purchase state sponsored reinsurance, which protects plans when medical costs for a beneficiary exceed a specific dollar amount. If an enrolled beneficiary's medical costs in a given contract period exceed a certain amount, the state pays for additional needed care. The state pays for such care on a fee-for-service basis until the beneficiary disenrolls or until the contract period ends, whichever comes first. Currently, the reinsurance protection ranges from $35,000 to $100,000 per beneficiary per contract period. The threshold established for a particular plan depends on the type of plan, the health care services covered by the plan, and the plan's enrollment size.

Eligibility

Most New York Medicaid managed care programs serve only the AFDC population, although a few serve SSI recipients or medically needy beneficiaries as well. Two plans serve only children.

The state developed managed care programs for the AFDC population because it most closely resembles the population in commercial health plans. In addition, providers are more willing to serve AFDC recipients under capitated contracts because they tend to be more healthy than other groups eligible for Medicaid, and therefore, present less financial risk. Finally, state officials reported that determining capitation rates for some groups, such as SSI, is more difficult because some of these beneficiaries are also eligible for Medicare.

New York guarantees Medicaid eligibility for a 6-month period for persons enrolled in physician health service plans and in federally qualified HMOs or the largest state-qualified HMO—the Health Insurance Plan. The state does not guarantee eligibility for beneficiaries enrolled in other state-qualified HMOs. As a result, beneficiaries are disenrolled from their health plan when they lose Medicaid eligibility. Approximately half of health plan disenrollments result from beneficiaries losing Medicaid eligibility, while the other half are voluntary.

Enrollment

Participation in most managed care programs in the state is voluntary. In one region of the state—southwest Brooklyn—officials mandated participation for all beneficiaries to increase the number of enrollees. State officials will consider mandating participation in other areas where enrollment goals are not being reached.

Plans enroll beneficiaries, although enrollment procedures vary among plans. HMOs and physician health service plans may enroll beneficiaries at local social service district offices or at plan facilities, while those in physician case management plans or the PCCM may only do so at local district offices.

In most cases, Medicaid beneficiaries may disenroll from a plan at any time. The state allows some health plans to prevent beneficiaries from disenrolling during their first 6 months in the program. In other cases, beneficiaries may do so for any reason during the first 30 days, but may not disenroll during the subsequent 5 months without approval from the local social service district. Beneficiary requests to disenroll may be allowed if, for example, dissatisfied with their provider, they are unable to travel to a provider's office, or their health plan's provider network does not meet their needs.

Marketing and Outreach

Health plans and local social service districts focus marketing and outreach activities on Medicaid beneficiaries. District do not have any formal outreach programs directed at helping providers understand managed care and their responsibilities as managed care providers. State officials have, on occasion, met with providers to explain the program and encourage participation.

Because beneficiary participation in managed care is mostly voluntary, the health plans generate enrollment by marketing their programs. Each plan is responsible for its own marketing. Some plans have representatives stationed in local enrollment offices or at eligibility offices. These representatives assist the beneficiary with understanding the benefits and characteristics of their plans and the managed care program. Some plans also conduct orientation sessions for new members, and provide information on health services through newsletters. A few have toll-free numbers which members can call to gain further information on how to access services.

Through their outreach and education activities, social service districts try to ensure that Medicaid beneficiaries understand their rights under the managed care program, how the program operates, and how to appropriately access services. Districts require health plans to provide beneficiaries who join managed care programs with member handbooks. These handbooks include a description of a plan's provider network, grievance procedures, benefits covered, and instructions on how to access services, how to receive care in an emergency, how to obtain services not covered by the plan, and how to obtain transportation services.

Social service districts may also meet with providers to discuss the development of managed care programs and encourage participation. In Erie County (Buffalo), discussions between social service district administrators and providers led to the development of bonus sharing arrangements for two programs operating in the district.

Monitoring and Oversight

The state monitors the medical and financial performance of all managed care programs in several ways. First, the state requires health plans to provide various state departments with data on their programs. Plans must file quarterly and annual financial and utilization reports with the New York Department of Health, the Department of Insurance, or the state Department of Social Services. These departments use the financial and medical data to periodically review the performance of health plans.

Second, the state contracts with independent organizations to periodically review district managed care programs. One company, the Island Peer Review Organization, conducts annual reviews of the quality and accessibility of care provided by HMOs and physician health service plans. In the past, two independent assessments of physician case management plans have been conducted by the New York Department of Social Services, Office of Audit and Quality Control. This year, that office plans an assessment of the PCCM program.

Third, the state requires plans to develop internal quality assurance systems and to monitor the financial solvency of their subcontractors. As part of the quality assurance system, each plan must have procedures to monitor and adjudicate beneficiary grievances. In addition, plans must provide the state with a quarterly disenrollment report which includes beneficiary's reasons for disenrolling. Some plans and social service districts also conduct beneficiary satisfaction and disenrollment surveys.

The state does not directly monitor the financial solvency of subcontractors or the quality of care provided by them. Each plan with subcontracting arrangements must monitor subcontractors and be accountable to the state for the their actions.

Oregon: a Partially Capitated Managed Care Program

Oregon's current managed care program delivers health services through two types of health plans—fully capitated and partially capitated. A fully capitated plan, such as an HMO, provides comprehensive outpatient and inpatient services under a monthly capitation fee. Oregon's partially capitated plans—called physician care organizations—provide physician services, outpatient laboratory and X-ray, and child health screening services under a capitation payment. These plans also manage the use of inpatient, emergency room, and outpatient hospital services, as well as prescription drug services for their beneficiaries, though these latter services are reimbursed on a fee-for-service basis.

As of January 1993, the program covered 16 of the state's 36 counties, and served a population of 82,877 (approximately 35 percent of all persons eligible for Medicaid in Oregon). While the program is not statewide and serves only the AFDC population, participation is mandatory in 14 of 16 counties in which it operates. Oregon has received national attention for its controversial proposal for statewide expansion of Medicaid managed care while proposing to limit some services. The Bush Administration rejected the state's initial proposal saying that it violated the Americans With Disabilities Act.[1] However, it encouraged the state to redesign the plan. The state has resubmitted the proposal.

Background

Oregon initiated Medicaid managed care in the context of serious state budget shortfalls in the mid-1980s. The primary goal of the program has been to improve the quality of care available to Medicaid beneficiaries while controlling Medicaid program costs. Currently, the program operates under a 1915(b) waiver.

Health Care Delivery System

As of January 1993, the Oregon program consisted of 22 physician care organizations and four HMOs. These providers subcontract with other health care providers so that services not delivered by the primary provider may be delivered by the subcontracting provider. Whether beneficiaries are enrolled in an HMO or a physician care organization, they receive all services authorized under Oregon's Medicaid state plan. Long-term care and mental health services are not managed by physician care organizations or HMOs.

The central component of the program is its partially capitated physician care organizations, which are groups of primary care physicians that

[1]P.L. 101-336.

provide services for an enrolled group of beneficiaries at a fixed periodic rate. As of January 1993, 22 physician care organizations with a combined enrollment of 62,704 operated in the state. Contracting physician care organizations have a variety of business structures including individual practice associations, multi-specialty clinics, public health and hospital-based clinics, and primary care clinics. Regardless of their structure, all physician care organizations subcontract with hospitals, physicians, and/or laboratories to deliver services.

Oregon does not require physician care organizations with fewer than 500 beneficiaries to provide services under capitated arrangements. As of January 1993, three contractors operated managed fee-for-service physician care organizations with a combined enrollment of 933. These contractors deliver services on a fee-for-service basis but manage the delivery of these services.

Oregon also contracts with four HMOs to deliver health care services. As of January 1993 enrollment in the four HMOs totaled 20,173.

Reimbursement

Physician care organizations provide all physician services (primary and specialty) and some outpatient services on a capitated basis. HMOs provide all services on a capitated basis. In Oregon, the capitation rates for the physician care organizations and the HMOs are calculated by a private actuarial firm. Capitation rates for the plans are based on Medicaid fee-for-service claims data collected through the state's Medicaid Management Information System. Data on paid fee-for-service claims are added to estimates of incurred but not yet paid claims to derive an average annual capitation rate. Once these rates are determined, they are adjusted for individual plans to reflect known geographic differences in utilization rates and the relative number of maternity cases per 1000 beneficiaries. According to the state's actuaries, an adjustment for maternity cases helps the capitation rate more accurately reflect the financial risk individual plans face for providing maternity services.

All noncapitated services, such as inpatient services, are reimbursed according to the state's fee-for-service schedule. However, Oregon uses financial incentives to encourage the physician care organizations to manage the non-capitated patient services they authorize. Specifically, if a plan's Medicaid beneficiaries use fewer non-capitated services than the geographically adjusted statewide average for an equivalent fee-for-service Medicaid population, the Office of Medical Assistance Programs shares the

savings with the plan on a 50-50 basis, after deducting program administrative costs. Like capitation payments, however, these savings payments carry the potential for inappropriate reductions in medical services. To minimize this potential, the state places a ceiling of $4.25 per member per month on the amount of incentive payments to plans. The HMOs in the program are not entitled to receive these incentive payments.

To help protect the providers against loss from extraordinarily expensive cases, Oregon offers health plans protection in the form of reinsurance that sets a dollar limit on the financial liability for services provided to individual Medicaid beneficiaries. Plans may purchase this protection through a reduction in the capitation rates they receive. If a plan that purchases reinsurance incurs expenditures for a beneficiary that exceed the reinsurance ceiling selected by the plan, the state will pay for additional services for that beneficiary on a fee-for-service, rather than capitated basis. This reinsurance is available to both partially and fully capitated plans. As of January 1993, 18 physician care organizations and two HMOs had purchased state reinsurance. The other two HMOs are self-insured. Of the four remaining physician care organizations, only one is partially capitated and self-insures. The other three physician care organizations operate as managed fee-for-service providers which are not at risk for the cost of services and therefore do not require reinsurance.

Eligibility

Oregon developed its program around low-income women and children. The state would like to include more Medicaid eligible populations in its program; however, staffing resources have limited its ability to redesign the program, develop outreach programs for other populations, and develop provider networks.

Staff in the branch offices of the Adult and Family Services Division of the state's Department of Human Resources determine eligibility for Oregon's managed care program. The current program serves only the AFDC and AFDC-related populations. The state has targeted the program at AFDC families because they are the most healthy Medicaid group, the most easily assimilated into mainstream medical practice, and the most likely to use expensive emergency room services. The state would like to add the aged, blind and disabled SSI populations to the program. According to officials, these groups have been excluded from the program because of insufficient staffing resources to work on a program for them, and the need for programmatic changes to be able to include them. Needed programmatic changes include the following: requirements for additional case

management support within the health plans, especially for the elderly and disabled enrollees; increased use of advocates or ombudsmen within the state system; revised enrollment procedures to accommodate the needs of beneficiaries unable to make decisions for themselves, such as assignment of state-appointed guardians for elderly patients suffering from dementia or for developmentally disabled patients; changes in the rate setting methodology, similar to the maternity adjustment, that would recognize the different enrollment levels among plans and the special health care needs of elderly and disabled patients; and additional quality assurance standards and guidelines.

Enrollment

Until a preestablished participating physician to beneficiary ratio (1:1200) is reached, enrollment in managed care is voluntary. Since this provider to beneficiary ratio has been reached in 14 of 16 counties where the program operates, enrollment is currently mandatory in these counties. Medicaid beneficiaries such as pregnant women in their third trimester who are receiving care from a provider not in the managed care program are excluded from the mandatory enrollment requirement because the state does not want to disrupt these beneficiaries continuity of care.

Branch office staff in the Adult and Family Services Division of the state's Department of Human Resources explain the HMO and physician care organization options to eligible beneficiaries, and enroll them in an HMO or a physician care organization. During the enrollment process, beneficiaries must choose a plan. As of January 1993, in all 14 of the counties where enrollment is mandatory, beneficiaries have a choice of at least 2 health plans. All family members must enroll in the same health plan, in most cases. If beneficiaries do not choose a plan, the Adult and Family Services Division will assign them to one. Within each physician care organization or HMO, the beneficiaries can choose a primary care physician.

Once enrolled in a physician care organization, beneficiaries are locked into the plan for 6 months. At the end of this 6-month period, beneficiaries may voluntarily disenroll or change plans. Before this 6-month period, beneficiaries may disenroll or change plans for cause (such as moving to a different service area or a service area without a physician care organization). Beneficiaries who desire to change plans must contact their family services division caseworker and allow about a month for the change to be made. A beneficiary may also change physicians up to twice in one year, and can change physicians if they first contact their plan.

Beneficiaries enrolled in an HMO are enrolled from month to month and may disenroll at will.

Contractors may also request to disenroll a beneficiary. A contractor's request must be made in writing and approved by the Office of Medical Assistance Programs. However, no provider may terminate any beneficiary's enrollment because of an adverse change in the beneficiary's health.

Marketing and Outreach

The Adult and Family Services branch offices provide beneficiaries with information that describes the prepaid programs. The branch offices also provide a health care orientation to all new members, which includes information on covered services, how to select a plan or physician, and the grievance process. There is no direct marketing to beneficiaries by providers.

Monitoring and Oversight

The state has established a variety of oversight mechanisms to monitor quality of care and the financial stability of plans. Oregon's Health Care Cost Containment Advisory Committee concluded that the quality of care for Medicaid managed care beneficiaries differed little from that for the general population. Furthermore, medical record reviews conducted by the Oregon Medical Professional Review Organization identified relatively few quality problems in the managed care program. In addition, a study conducted in 1991 by actuaries from Coopers and Lybrand concluded that the program has saved the state money.

There are several components to Oregon's monitoring program including: (1) medical chart reviews, (2) on-site contract standards monitoring, (3) beneficiary and provider grievance reviews, (4) beneficiary orientation reviews, (5) beneficiary hearings, (6) oversight by the legislatively appointed Health Care Cost Containment Advisory Committee, (7) beneficiary comprehension surveys, and (8) beneficiary satisfaction and disenrollment surveys. Each of these components provides staff at Oregon's Medicaid agency with feedback on the quality of care and access to care being delivered through the physician care organizations. Medicaid staff determine if beneficiaries are able to get accurate information about the program, contracting plans, and the plan's policies and procedures. Staff also monitor the implementation of the program and plans' compliance with contracting standards, such as quality assurance procedures.

Studies of Oregon's managed care program conducted by Coopers and Lybrand for the Office of Medical Assistance Programs reported that the program has saved money and has been well received by beneficiaries and providers. Furthermore, a review by the statewide Health Care Cost Containment Committee said that the quality of care provided by the program differs little from that for the general population. During the period from October 1988 through September 1990, actuaries from Coopers and Lybrand estimated that the program saved about $8.7 million, or $8.78 per beneficiary per month. In addition, beneficiary satisfaction surveys conducted by the medical assistance office from 1986 through 1990 have shown that nearly three-quarters of the beneficiaries who responded have been satisfied with the quality of care they received. However, the usefulness of these surveys is limited by low response rates and other factors involving the design of the survey.

Medicaid Managed Care and the Waiver Process

When states establish managed care programs they must usually obtain one of two types of waivers from HCFA. Section 1115 of the Social Security Act allows HCFA to waive certain Medicaid statutory requirements to assist states with specific demonstration projects to test new policy alternatives. These are referred to as research and demonstration waivers. Section 1915(b) of the Social Security Act allows states to carry out competitive programs by waiving specific program requirements, such as a beneficiary's choice of provider. These freedom-of-choice waivers are granted by HCFA without the states having to meet the formal evaluation requirements of a section 1115 demonstration program. HCFA is responsible for approving initial waivers and waiver renewals, under authority delegated by the Secretary of Health and Human Services.

Section 1115 Waivers

Section 1115 of the Social Security Act allows HCFA to, among other things, waive certain Medicaid statutory requirements to assist states with specific demonstration projects. These waivers are usually granted for research purposes, to test a program improvement, or investigate an area of interest to HCFA. Such demonstration projects are experimental in nature, limited in time, and require a tightly structured research design.

While not easy to obtain, section 1115 waivers have stimulated some important experimentation. For example, the first PCCM program was created in Massachusetts in 1979 under this waiver authority. Also, Arizona—previously the only state without a Medicaid program—created an experimental statewide capitated Medicaid program in 1982 under a section 1115 waiver.

Section 1115 projects are usually approved for periods of 3 or 4 years and are usually not renewed. However, extensions have been granted to some programs, and the Congress has periodically intervened in the waiver process by exempting some states from specific requirements. For example, Arizona's Health Care Cost Containment System received a 2-year extension from HCFA and a 1-year legislated extension. The Minnesota Prepaid Demonstration Project received a 5-year legislated extension for its managed care program.

Section 1115 research and demonstration waivers are necessary when a state wants to pursue policy options that cannot be addressed under a state plan amendment or program waivers (for example, 1915(b)). In general, HCFA's section 1115 waiver authority is used to waive provisions of section 1902 and 1903 of the Social Security Act. In the case of Medicaid

managed care projects, for example, waivers of section 1903(m) are frequently requested. The types of waivers that have been granted include:

- Beneficiaries are required to enroll in a single prepaid plan and may not disenroll;
- Beneficiaries are "locked-in" to any particular prepaid plan for more than 1 month (or 6 months for federally qualified HMOs and prepaid community health centers);
- Continued enrollment and state payment of premium for beneficiaries who enroll in a prepaid plan is guaranteed, regardless of any subsequent loss of Medicaid eligibility, for more than 1 month from the initial effective date of enrollment (or more than 6 months in the case of enrollees in federally qualified HMOs or prepaid community health centers);
- An individual provider or a prepaid plan (other than the type defined in the state's Medicaid plan) is to be at risk for inpatient as well as ambulatory services, or for more than two federally mandated noninpatient services; and
- After 3 years of operation, an HMO wishes to continue serving Medicaid patients on a prepaid risk basis but does not have 25 percent of its enrollment from non-Medicare, non-Medicaid sources.[1]

Although HCFA's section 1115 waiver authority is quite broad, obtaining such a waiver is more cumbersome than obtaining program waivers. In addition to research value, such projects must include a viable research design and rigorous evaluation methodology. As such, the approval process for such waivers is generally subject to more scrutiny than that of program waivers such as 1915(b).

Section 1915(b) Waivers

In 1981 states' ability to experiment with managed care and case management approaches to organizing the delivery of services to Medicaid beneficiaries was significantly enhanced by the addition of section 1915(b) to the Social Security Act. Section 1915(b) allows states to obtain waivers to certain federal Medicaid requirements without the need to meet the formal requirements of a section 1115 demonstration program. Specifically, this provision allows states to apply to HCFA for exclusion from the so-called freedom-of-choice requirements, as well as from requirements of uniform statewide operation (statewideness), and identical benefits for different types of beneficiaries (comparability).

[1]In addition to the above 1903 provisions, HMOs may need waivers to sections 1902(a)(10) and 1902(c)(13)(E), which require payments to Federally Qualified Health Centers and Rural Health Centers on a cost basis.

Freedom-of-choice was an early tenet of Medicaid that allowed its beneficiaries the same liberty to select among providers as the privately insured. This principle was considered an important quality safeguard, because it meant that beneficiaries could "vote with their feet" and seek out high-quality providers.

States need a freedom of choice waiver granted under section 1915(b) to operate a managed care program which includes any of the following policy options:

- Beneficiaries are required to select a primary care provider;
- Beneficiaries are "locked-in" to their primary care provider, even if voluntarily selected, for more than 1 month at a time (unless the provider is a federally qualified HMO or prepaid community health center);
- The range of providers available to beneficiaries is restricted by state action, for example, the state contracts only with prepaid plans;
- Beneficiaries participating in a fee-for-service PCCM program receive additional services or lower copayments than other Medicaid beneficiaries. (No waiver is needed to provide additional benefits to enrollees in a prepaid plan through the plan);
- "Bonus" payments are made to case managers (whose basic reimbursement is either fee-for-service or partial capitation), based on reduced fee-for-service expenditures for the case manager's enrolled panel of patients; or
- The managed health care program (other than a voluntary enrollment prepaid plan) operates in only part of the state or affects only certain categories of beneficiaries.

The Waiver Approval Process

HCFA is responsible for approving initial waivers and waiver renewals, under authority delegated by the Secretary of Health and Human Services. HCFA's Medicaid Coordinated Care Office, located in the Medicaid Bureau, administers the 1915(b) waiver process with the help of HCFA's 10 regional offices. HCFA's Office of Research and Demonstrations has responsibility for section 1115 projects. HCFA does not have data on the length or cost of the waiver approval or renewal process.

Staff at HCFA headquarters are assigned to various aspects of the 1915(b) waiver process, including individual state waiver projects and specific waiver issues such as streamlined applications, quality assurance, and rate setting and actuarial assistance. HCFA regional office responsibilities include: (1) providing guidance to states in preparing waiver requests to

ensure that they comply with the statutory and regulatory requirements; (2) reviewing proposals before they are sent to HCFA headquarters; and (3) conducting compliance reviews of the section 1915(b) waiver programs.

Objectives, Scope, and Methodology

Our report objectives were to explore (1) states' use of managed care programs, (2) the difficulty states face in implementing certain program components, (3) the effect of the managed care approach on health care access, quality, and cost, and (4) the presence of features that assure the quality of health services and providers' financial stability.

During our review, we (1) surveyed Medicaid officials of all 50 states and the District of Columbia to collect information on managed care programs and to elicit opinions on factors that lead to successful programs;[1] (2) conducted reviews of six state managed care programs (Arizona, Kentucky, Michigan, Minnesota, New York, and Oregon) to obtain a more in-depth understanding of their operations; (3) reviewed state and national evaluations of managed care programs as another measurement of program performance; (4) interviewed officials from HCFA's Medicaid Bureau and Office of Research Demonstrations, state Medicaid officials, other local health care individuals and advocacy groups to obtain information on the effectiveness of these programs; and (5) reviewed the literature on managed care.

Our 50 state survey was conducted by telephone in a structured interview format. We obtained information on the status of Medicaid managed care in each state, including whether a program was in operation, planned for the future, or was not being considered. We also obtained information on program organization, structure, reimbursement mechanism, eligibility groups served, current enrollment, and whether the program was mandatory or voluntary. An initial survey was undertaken from February to April 1992. A follow up to the initial survey was conducted during January and February 1993 to update state program information.

The six case study states were selected as a nonrandom judgmental sample representing a diversity of geographic areas and a variety of managed care approaches. In the six states, we interviewed state and local program officials as well as other interested parties, including health care advocacy groups. We also visited selected managed care plans in each state. We interviewed officials and obtained documentation to determine how the various state programs were organized and operated and how

[1]In our review we focused on Medicaid managed care programs that served the broad general cash assistance population. While there are many other special population managed care programs or programs with elements of managed care, such as those for substance abusing pregnant women, Social HMOs, special programs for long term care, and targeted case management programs for recipients who are considered to be abusing the system, we did not consider such programs in our review.

they address issues of access, quality, and cost-effectiveness of health care delivery.

We also reviewed the general literature on Medicaid managed care including nationwide studies, as well as state-prepared and commissioned evaluations of managed care programs in the six selected case study states. We examined the literature and evaluations to determine the effect of managed care on the access, quality, and cost of health care, and to identify results of health outcome comparisons with traditional fee-for-service. Some of the findings referred to in our report are derived from studies of the HCFA demonstrations of the early and mid 1980s. Further, studies in general have focused either on capitation arrangements or PCCM. Finally, many of the studies on quality focused on one medical outcome or procedure, rather than a more general review of services. The current body of research on Medicaid managed care does not provide a complete picture.

In addition, complete and comparable data did not exist to precisely measure access to care, quality of care, or cost-effectiveness of the managed care programs in the six states we reviewed. Consequently, we relied on existing federal, state, and independent reviews and evaluations and on the opinions of federal, state, and local officials to describe managed care in these states.

While we did not independently verify the validity or reliability of the information we obtained, we provided the case study states with a draft profile summarizing program information for review and comment. We also reviewed our report findings with HCFA and three independent health care experts, and incorporated their comments as appropriate. We performed our work in accordance with generally accepted government auditing standards.

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