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MEDICAID

States Turn to Managed Care to Improve Access and Control Costs

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SUMMARY

Medicaid, the largest government program financing health care for the poor, is severely strained by rising enrollment and spiraling costs. Although the program was intended to make health care more accessible to the nation's poor, Medicaid beneficiaries often cannot find physicians willing to treat them. Nearly all states are responding by establishing managed care programs--health care delivery approaches that use primary care physicians to provide, or arrange for, health care in a cost-conscious manner. Through a nationwide survey of state Medicaid programs and detailed work in Arizona, Kentucky, Michigan, Minnesota, New York and Oregon, GAO reviewed states' efforts to implement managed care.

Medicaid managed care is not a single health care delivery approach, but a continuum of models. At one end are prepaid or capitated programs that pay a per capita amount each month for all covered services. At the other end are primary care case management (PCCM) programs, which retain fee-for-service reimbursement with an added per capita management fee. Although prepaid models are still the most common, states are finding it easier to recruit providers to PCCM programs. 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.

States choosing managed care for their Medicaid programs report facing difficult implementation issues that include: (1) planning the implementation; (2) moving to mandatory enrollment; and (3) establishing beneficiary education programs. To the extent that states use prepaid managed care models, attracting commercial HMOs with appropriate capitation rates is an often-stated problem.

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 the quality of managed care services as 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. There have been problems with underservice 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 are looking to HCFA for help in developing better ways to measure quality and provider solvency.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here to testify on the role of managed care in state Medicaid programs. Our report on this subject is being issued today.[1]

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 at an average 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 increased between 1991 and 1992 by an estimated 10 percent, to about 31 million.

Medicaid was established 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. 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.

Managed care in Medicaid is not a single health care delivery plan but rather a continuum of models that share a similar approach. Common to all managed care models in the Medicaid program is the use of a primary care physician to control and coordinate the delivery of health services in a cost-conscious manner.

We and others have reported on certain problems with states' managed care programs under Medicaid. These problems included 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 the managed care program initiatives that 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.

We surveyed Medicaid officials in the 50 states and the District of Columbia and performed more detailed work in six states--Arizona, Kentucky, Michigan, Minnesota, New York, and Oregon. In each of these states we interviewed Medicaid officials, advocacy group

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[1]Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, March 17, 1993).

representatives, and health care providers. We also interviewed experts on the topic from around the country.

STATES INCREASE USE OF MANAGED CARE IN THEIR MEDICAID PROGRAMS

Medicaid managed care enrollment has more than doubled between 1987 and 1992, and currently includes about 3.6 million beneficiaries nationwide. This represents about 12 percent of the Medicaid population. As shown in appendix I, thirty-six states were operating one or more managed care programs for Medicaid beneficiaries in February 1993. These states are also employing a wide variety of managed care models. 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 end are primary care case management (PCCM) models, which are similar to traditional fee-for-service arrangements except that providers receive a small case management fee per enrollee per month to coordinate a patient's care in addition to reimbursement for the services they provide.

Since 1982, 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 target their programs to the Aid to Families with Dependent Children (AFDC) population.[2] Other Medicaid populations are included by states to varying degrees. While Supplemental Security Income (SSI) and SSI-related

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[2]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 includes certain groups the states are required to cover whose circumstances are similar to AFDC, but who are not receiving cash assistance; that is, 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.

individuals account for about 27 percent of the Medicaid population, their health care costs account for about 70 percent of Medicaid expenditures.[3] 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 in commercial health maintenance organizations (HMOs).

IMPLEMENTATION OF MANAGED CARE RAISES DIFFICULT ISSUES

Regardless of the managed care model used, all 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.

In our review, state Medicaid officials and other experts 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. Arizona, for example, experienced major problems because it tried to implement its program too fast, according to state officials. Minnesota, on the other hand, developed a relatively stable program that required three years to implement. State officials also report a preference for making enrollment in managed care mandatory. Such a requirement assures a large pool of eligible beneficiaries to attract providers and to maintain the providers' financial viability. This improves beneficiaries' access to care and helps them develop stable doctor-patient relationships. Twenty-six states have mandatory managed care programs.

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[3]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 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 300 percent of the SSI payment.

In fact, 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. Minnesota, for example, which has a strong tradition of managed care in the state, has experienced some difficulty in attracting and even more in retaining commercial HMO participation in the Medicaid managed care program because of dissatisfaction over reimbursement, according to a state official. In addition, 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.

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 on these issues as well as 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,[4] access to care was perceived by beneficiaries to be generally 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--

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[4]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.

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, 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 also reported improvements in access. Advocacy groups in the other two did not believe that managed care had 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 found 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 between the two groups of beneficiaries. 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 some recent studies provided evidence that Medicaid managed care programs saved money, others conclude that savings have been only achieved in staff or group model HMOs. Still others point to the difficulty in measuring actual cost-savings and the disparate results possible based on the methodology used. For example, one study reported that due to favorable selection the managed care plan had enrolled healthier beneficiaries.[5] As a result, the state spent more for Medicaid beneficiaries enrolled in managed care than it would have if they had remained in fee-for-service.

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

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[5]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.

assumptions states used to measure savings.[6] 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 PCCMs can improve control over costs compared to traditional fee-for-service because they 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 in the Chicago area, small groups of physicians had assumed, under subcontracts with managed care plans, much of the financial risk of treating beneficiaries and were at risk of insolvency.[7] At that time, there were few requirements for states to monitor providers' financial viability, thereby leaving enrollees 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 in Arizona's first managed care program that could have enabled health plans to divert Medicaid funds to inappropriate private use.[8]

States require plans to meet standards for quality, although additional quality measures are needed. 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 quality assurance systems--with components that entail reviewing data on the utilization of services provided,[9] 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

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[6]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.

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

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

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

Medicaid managed care plans to current quality assurance standards and making the standards consistent with those in Medicare and the private sector.

HCFA also requires states to review plans' financial reports for solvency, ownership, and control. 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 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 physicians participating in a managed care health plan,[10] one of the problems that can arise in a subcontracting risk arrangement.

CONCLUSIONS

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 achieve 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.

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 such systems generate accurate and timely financial and utilization data to identify providers who may be vulnerable to excessive financial risk and do not provide needed services to beneficiaries.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions you might have.

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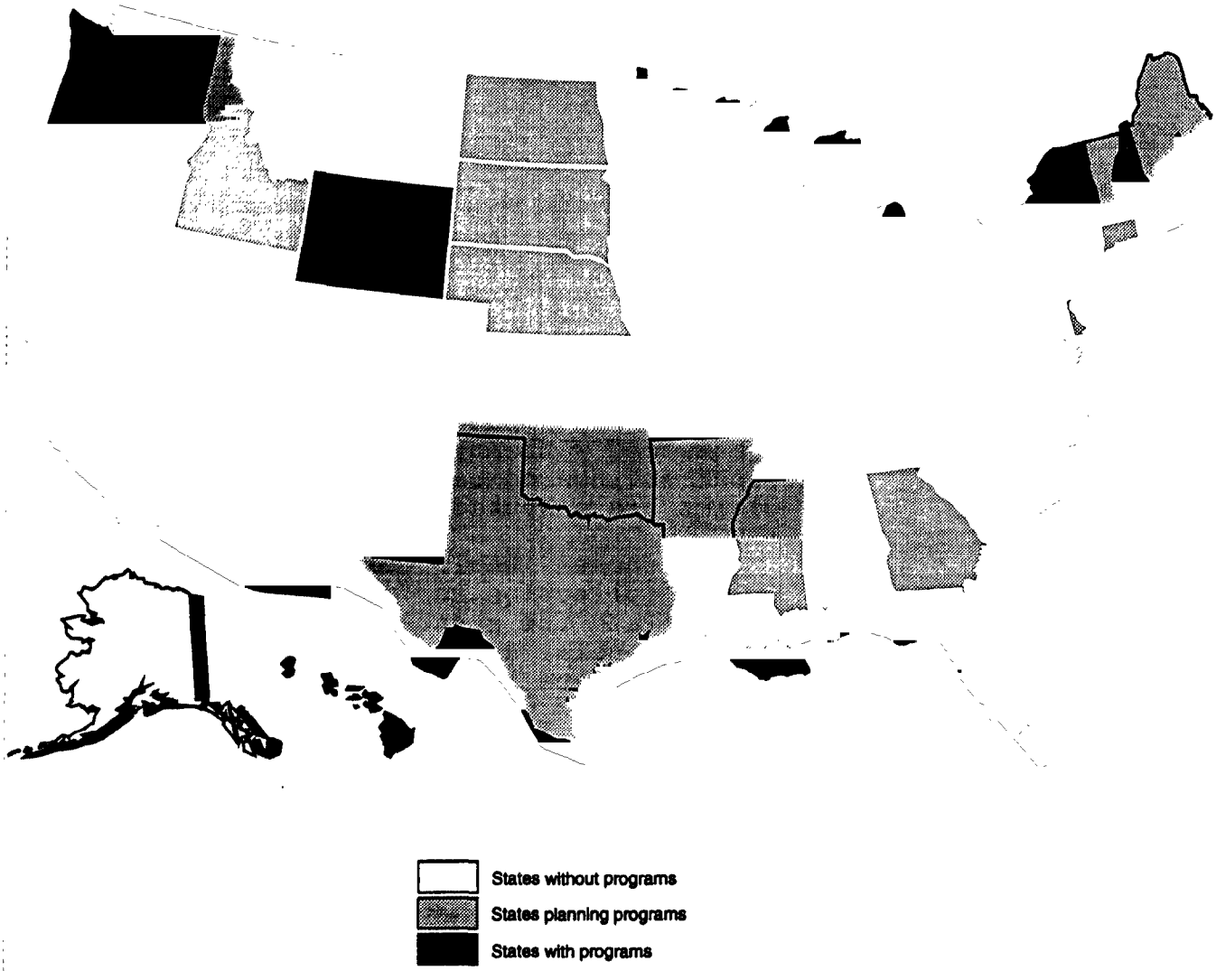
[10]57 Federal Register 59024.

MEDICAID MANAGED CARE



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