

MEDICAID

MANAGED HEALTH CARE

PROGRAMS



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This Report

Entitled "Medicaid Managed Health Care Programs," this study was conducted to describe State-implemented managed care programs and their perceived effectiveness in terms of meeting the medical needs of the patients enrolled in these programs.

The report was prepared by the Regional Inspector General, Office of Analysis and Inspections, Region VII. Participating in this project were the following people:

Region VII, Kansas City

Richard J. Meyer, Project Director
Timothy Dold
Philip O'Hare

Region IX, San Francisco

Apryl Williams
Robert Grauman

Region I, Boston

Barry McCoy

Headquarters

Annette Cameron
Mark Krushat
Penni St. Hilaire

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RICHARD P. KUSSEROW
INSPECTOR GENERAL

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Executive Summary

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) provides States with the flexibility to develop managed care programs in which Medicaid recipients can enroll voluntarily or are assigned to a provider who authorizes the recipients' care. In order to be approved by the Health Care Financing Administration (HCFA), these programs cannot exceed the cost of fee-for-service, or restrict emergency care, or substantially impair access to and quality of medical care.

The findings of this report are based on a review of other studies, and personal discussions with a total of 250 recipients, providers, and State agency personnel involved with 20 of the 31 programs approved as of September 1985. Although limited in number, we believe those discussions raised relevant issues about managed care programs.

Findings

Cost containment was the major reason for implementing managed care programs. However, State data that we reviewed was inconclusive as to the cost-effectiveness of these programs, especially during the first several years of operation.

Other concurrent State cost containment activities (such as diagnosis related group (DRG) systems, selective hospital contracting, and limiting payment for emergency room services) may reduce the savings potential for managed care programs.

Some States did not adequately consider factors such as age, sex, aid category, geographic location, and third party payments in establishing prepaid rates. This resulted in some of the prepaid rates being set too high, which reduced the cost-effectiveness of the program.

Most of the managed care recipients we talked to (48/60) feel the quality of their care and access to care is the same or better than fee-for-service care.

Some of the recipients we talked to (20/60) reported having difficulty obtaining necessary care after normal office hours because they could not reach their case manager. Case managers agree to provide 24-hour availability to care.

Some States do not implement managed care programs (or terminate them after implementation) because they are unable to obtain physician, community, or legislative support and/or because they cannot substantiate that the programs are cost-effective.

Introduction

Background

The Medicaid program is a Federal-State program that was created in 1965 to provide medical assistance for eligible poor people. Approximately 22 million low-income people are presently covered by Medicaid.

Since its creation in 1965, Medicaid has grown to be the single largest item in most State budgets. Its rising costs have caused Congress and States to take action to contain Medicaid expenditures. Fiscal year 1984 expenditures for Medicaid totaled over \$37 billion, the Federal share of which was \$20 billion.

Policy changes as a result of The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) provide States more flexibility to implement innovative approaches to providing health care for Medicaid recipients. States are able to receive waivers from the Federal government of certain program requirements in order to implement changes that restrict the freedom of choice Medicaid recipients have in obtaining medical care. Currently, more than one-half of the States have received approval to alter their Medicaid programs to implement one or more types of managed health care programs in an attempt to reduce Medicaid costs.

Managed care programs waive the statutory requirement of freedom of choice that individual Medicaid recipients have in obtaining services from qualified providers. Under a waiver approved by the Health Care Financing Administration (HCFA), States can develop managed care programs in which recipients enroll voluntarily or are assigned to a specific provider for their medical care. This provider then serves as a gatekeeper, who must authorize any care the recipient receives. This provider may be a private physician, part of a group practice, or a Health Maintenance Organization (HMO). The objective of these programs is to contain costs by eliminating unnecessary hospital emergency room and outpatient department visits, and to coordinate patient care in order to eliminate the practice of recipients visiting several physicians ("doctor shopping"). To be approved, State waiver requests must assure the Secretary that the costs of their managed care program will not exceed the costs of fee-for-service, the program is consistent with the objective of the Medicaid program, there is no restriction on emergency care, and there is no substantial impairment of access to and quality of care.

Managed care reimbursement systems that a State may choose to develop for waiver consideration are:

- ° full capitation--a health care provider is paid a set monthly amount for each recipient in return for providing the needed medical services; therefore, the provider incurs a degree of risk for services/charges that are in excess of the capitated payment;
- ° partial capitation--certain services may be paid based on a capitated rate and the provider incurs a lesser degree of risk; and
- ° modified fee-for-service--with or without case management fees or incentive arrangements.

A State's managed care program may include one or a combination of the above reimbursement systems. For example, States may elect to reimburse HMO-type providers with a fully capitated payment, or designate physician case managers who receive a modified fee-for-service plus a case management fee.

Case managers are physicians who are responsible for personally providing general medical care for their clients, and coordinating and monitoring specialized medical care and emergency room treatment. The case manager must provide service 24 hours per day and is required to authorize all types of medical services provided by other physicians and entities on behalf of their assigned recipients. They can be paid up to \$3 per month per patient for managing their client's care.

Purpose

The purpose of this inspection was to describe State-implemented managed care programs and their perceived effectiveness in terms of meeting the medical needs of the patients enrolled in these programs. The objectives were to review reports on how States determine whether managed care programs are cost-effective, and to determine how prepaid managed care rates are established. We also surveyed respondent attitudes about: (1) access to and quality of care; (2) changes in utilization patterns; (3) why some States have not implemented managed care programs; and (4) why some programs have been terminated.

Methodology

At the time of our study, in September 1985, 31 managed care programs were in operation. The programs were available to about 3 million of the 22 million Medicaid recipients in the United States.

Onsite visits were made to 20 programs located in Missouri, Michigan, Wisconsin, Kentucky, Colorado, Kansas, California, Utah, and New York. These States were selected because they have most of the approved programs; some of these programs have been in operation long enough that they have applied for a renewal; some had terminated their program; and some chose not to ask for a renewal of the waiver.

We also contacted two States, Georgia and Mississippi, that at the time of our inspection did not have an operational managed care program.

Six of the 20 programs which we looked at were physician case management programs. Four of these programs paid a case management fee. Two did not. The remaining 14 programs were capitated programs. Capitated programs pay the provider a set fee for the services he/she agrees to provide to his/her Medicaid clients. A brief summary of the 20 programs and whether they were approved under Sections 1915(b) or 1115 of the Social Security Act, is included in the appendix.

The study was conducted by reviewing waiver applications and renewal requests, and analyzing studies conducted by States and others. Personal discussions were held with 60 recipients; 63 physicians; 31 other health care providers, such as HMO's and clinics; 34 advocacy groups; 38 State Medicaid staff; 10 Health Care Financing Administration staff; and representatives from GAO, OMB, and the National Governors Association. The respondents we talked with were randomly selected from the 20 programs included in our study, and do not represent a statistically valid sample.

Managed care recipients were asked about their overall attitudes and opinions concerning the effects that managed care programs have had on their access to care. We asked them to compare the quality of care they are receiving under the managed care program to the quality of care they received under fee-for-service.

We also asked managed care providers, advocacy groups, State and Federal Medicaid staff, and other government representatives for their opinions on the effects of managed care on access, quality and utilization of medical services.

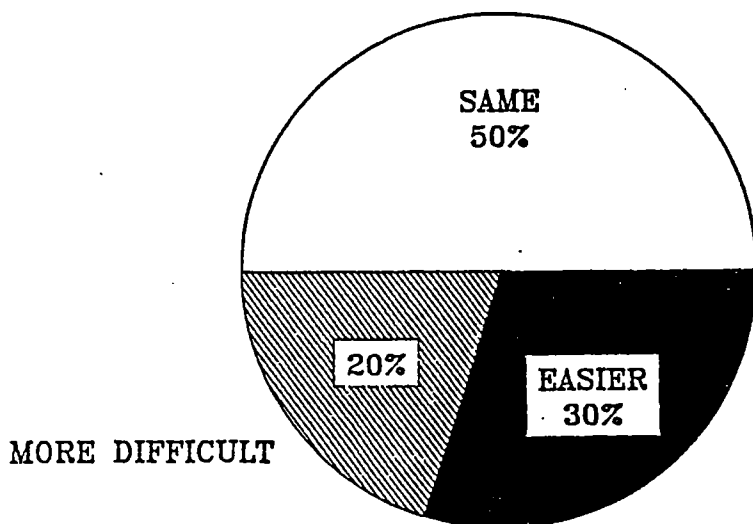
Access/Quality of Managed Care

The study found that the elements that most affect the attitudes about access to medical care and the quality of that care are physician availability after hours, restrictions on emergency room care, how recipients are assigned a case manager, and how referrals for specialized care are handled.

Section 1915(b) of the Social Security Act provides that a Medicaid State Agency, in applying for a managed care waiver, must document that reasonable access to quality services is assured for recipients enrolled in an approved case management system.

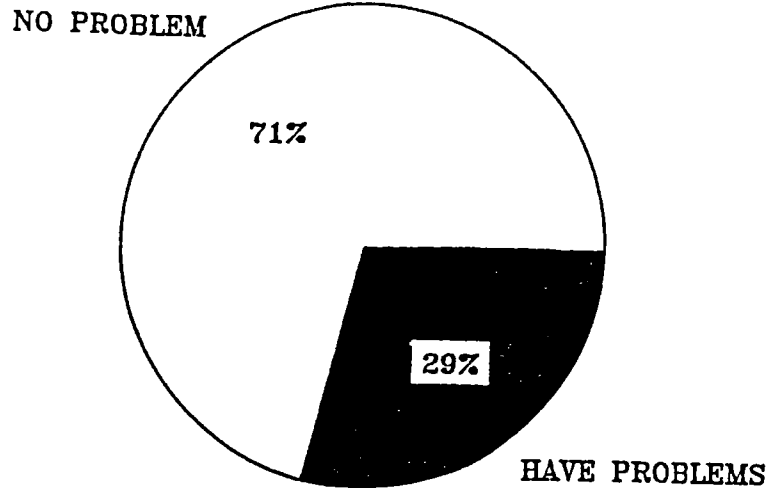
We asked 60 Medicaid recipients enrolled in various types of managed care programs whether it was easier for them to receive medical care now than before they enrolled. Of these, 48 (80 percent) said that access to medical care is the same or better than before they enrolled in a managed care program. Twelve (20 percent) said it is more difficult for them to receive medical care now.

ACCESS



Our findings corroborated an internal study conducted by the State of Kansas. It found 67 percent of the managed care recipients said access to care was about the same, 13 percent thought it was easier, and 20 percent said it was more difficult for them to get medical care now than before they were enrolled in a managed care program.

PROVIDER AVAILABILITY



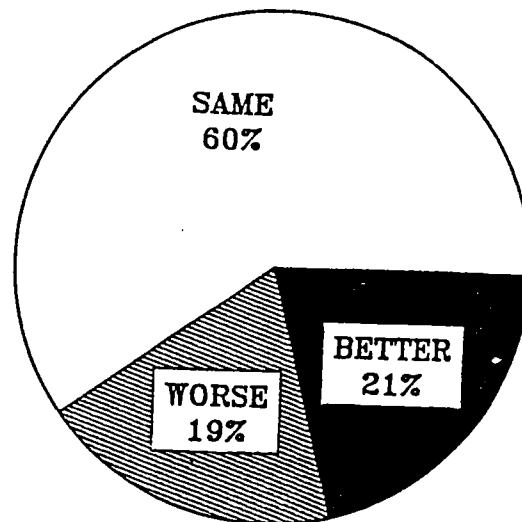
Most (71 percent) of the 60 recipients we talked to had no problems contacting their case managers after hours. Some of the statements made by recipients who had problems contacting their case managers after hours were:

"Can't get in touch with a doctor. Just get their answering service."

"One Sunday evening I needed care and it was difficult to get in touch with my doctor to get approval to go to the hospital emergency room."

An internal study by the Michigan League for Human Services showed that 30 percent of their managed care recipients needed to contact their doctor after hours. Forty-seven percent of these were assisted by their case manager. Thirteen percent waited for the office to open or handled the problem themselves. Twenty-five percent tried to call their case manager and did not get an answer so they went to the emergency room. Fifteen percent did not know where to call and also went to the emergency room. Based on the findings of the study, 40 percent of the recipients ended up at the emergency room because they could not reach their case manager even though case managers agreed to be available 24 hours a day.

QUALITY OF CARE



A small portion (19 percent) of the 60 recipients we talked to felt the care they are receiving under managed care is worse than the care they had been receiving. They complain about not being able to contact their case manager after hours, transportation problems resulting from being assigned to a doctor other than their regular doctor, and referral problems.

Ninety percent of the 63 physicians we talked to felt that the quality of the care received by managed care recipients was as good or better than the care they received before. Ten percent felt it was worse, and related this decline in the quality of the care to the recipient being assigned to a doctor other than the physician who had been treating them regularly. Of the 60 recipients we talked with, 80 percent had selected the plan of care they are using and twenty percent were assigned.

An internal study by Kansas reflected similar findings. They interviewed physicians who participated in a managed care program. Seventy percent of the physicians interviewed thought the quality of care was the same, and 20 percent said managed care improved the quality of care because continuity of care was improved. The remaining 10 percent thought the quality of the care received was worse.

The regulations preclude States from restricting freedom of choice if it results in a reduction in the quality of services provided. One of the States we visited issued restricted Medicaid cards to recipients who did not enroll in the managed care program, which denied payment for these recipients' medical care except in emergencies. HCFA did not approve the renewal request for this managed care program because of this restriction.

Referrals

Recipients and case managers were asked to comment on the referral process. About three-fourths of the recipients who wanted a referral to another doctor or a specialist were referred. The reason most often given by the case manager for not making the referral was that they felt they could handle the problem. The doctor would talk to the patient and try to convince them that the referral was not necessary:

"I tell them the services I feel are necessary. If they insist on doing something different, I suggest they get another doctor."

"We tell them what we feel is necessary. If they choose to do something else they have to pay for it themselves."

"For those in the gray zone I make the referral to avoid a lawsuit."

Private physicians and other health care providers don't like the procedures for making referrals to other doctors because (1) they feel it involves too much paperwork, and (2) once a referral is made, the referring physician feels it should not be necessary for him/her to continue to follow-up on the referral. Some physicians involved with an HMO or other type of capitated plan feel they are restricted from making some referrals they feel are necessary because of the added cost of these referrals.

Emergency room restrictions

Patients and providers expressed concerns about monitoring emergency room usage. Physicians are concerned about their liability when the emergency room calls and asks them to authorize or refuse treatment without seeing the patient. Patients are also unhappy with attempts to monitor their emergency room usage. Some of the comments made by recipients were:

"I don't like the plan, because by the time I call my sponsor to see if he thinks it's an emergency my children and I could be dying or dead."

"When I went to the emergency room, I had to call my baby's sponsor to get his approval first. I don't think this program should apply in emergency cases."

The effect of these efforts on reducing emergency room usage are covered in the utilization section of this report.

Complaint Systems

Several States have implemented a system for monitoring client complaints and problems about access and quality of care and recipient attitudes about the program they are using for their health care. The system typically consists of a phone number that the recipients can call if they have a complaint or a problem. Two of the States we visited said these monitoring systems are not providing the amount of feedback on recipient attitudes they thought they would. In one State, 80 percent of the clients did not know about the number. A busy signal study conducted by the phone company in another State found that during a typical one-week period, over 3,500 calls to the number to call about complaints, problems or provider questions could not be completed because the lines were tied up. Those clients that do reach the complaint office complain most about the restrictions on emergency room usage and being assigned to a doctor other than their regular doctor.

Summary

More positive recipient attitudes, and more appropriate recipient utilization, can be effected if the States take action to address the problems of recipients being unable to contact their case manager after hours, being assigned to a doctor other than their regular physician, and not being able to get in touch with someone if they have a problem.

While physicians had positive comments about the program, and see managed care as a way to provide continuity of care, reduce overutilization, and maintain or increase their patient load, they continue to have concerns about their liability when they are asked to pre-authorize emergency room visits.

Utilization

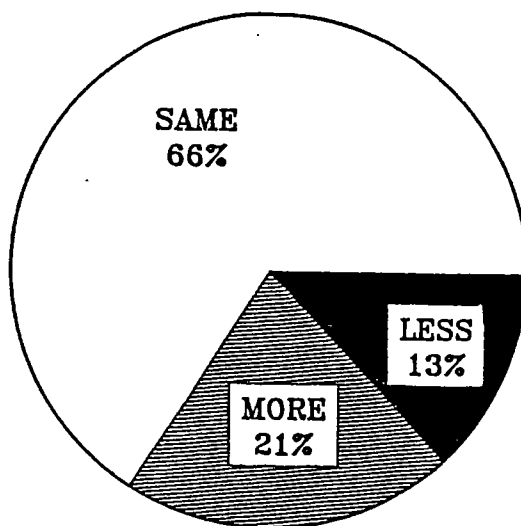
We found that many of the physician case managers and State agencies we talked to did not know the effect of their managed care program on utilization of health services.

Of the 63 physicians we talked to, 45 perceived no change in the number of office visits by recipients enrolled in managed care programs. These physician case managers felt confident about responding to this question as most had provided care to the same patients on a fee-for-service basis. Eight physicians thought the number of office visits decreased and five physicians thought office visits had increased. The remaining five physicians did not know.

About one-half of the physician case managers thought the number of visits to emergency rooms and out patient departments had decreased as a result of Medicaid recipients being enrolled in their managed care program. Forty-four percent of the case managers didn't know whether emergency room usage had changed even though they are responsible for authorizing all care, including emergency room and out patient services.

The 60 recipients we contacted were also asked how often they see a doctor now compared to before they were enrolled in a managed care program. The following chart reflects their responses:

DOCTOR VISITS



Two of the States we visited compared emergency room usage before and after their programs were implemented. One of them found that for a 12-month period, emergency room expenditures decreased 36 percent for managed care clients. They were unable to tell from their data whether this was because of managed care, or the result of other efforts at reducing emergency room usage. A hospital administrator said the decline in his hospital was due to physicians becoming more sensitive to the need to do all they can in their office instead of sending their patients to the emergency room.

The other State had anticipated that their managed care program would produce significant savings in emergency room usage. These savings did not materialize because the State changed its Medicaid reimbursement policies for emergency room care for all Medicaid recipients. The State no longer pays the emergency room rate for routine medical care provided in the emergency room. Hospitals are paid the standard office visit fee-for-service for routine care. This has reduced emergency room usage by all Medicaid recipients because the hospitals only provide emergency care for these recipients. Recipients needing routine care are referred for an office visit. This State compared emergency room usage for managed care recipients to those not enrolled in the program and found the impact on emergency room use to be negligible, because of the overall reduction in emergency room utilization which resulted from the reimbursement changes.

The emphasis in the Medicaid program fee-for-service reimbursement program is on monitoring overutilization to detect instances where physicians provide unneeded services, since reimbursement for the physician is based on the number and type of service billed to the program. Physician billings are monitored to identify those physicians that provide more than the normal amount of services per patient and/or at a higher than normal cost. Monitoring systems for prepaid health plans must look at underutilization, denial of services, poor quality of care, and excessive barriers to care. These physicians are paid the same amount for each patient whether or not the patient is provided medical care. Physicians in these prepaid plans should be monitored to identify those physicians that are providing less than the normal amount of services per patient. Systems to provide this type of monitoring were not in place in the programs we visited.

Why States Implement or Terminate Managed Care Programs

State Program Directors said that Medicaid cost containment was the major reason for applying for a waiver to implement managed care programs, but not the only reason. There was an expectation that continuity of care for the recipient as a result of managed care would result in better health care delivery to Medicaid recipients and reduce Medicaid costs. Another important factor was greater control of fraud, abuse, and waste in the Medicaid Program. Recipients would not be able to use unnecessary services, and the provider would have an incentive not to exceed the norms of his/her peer group. In States with a county operated system, managed care was seen as a mechanism to return program control to the county.

State agency efforts to successfully implement a waiver involved long-range planning of one to three years for all but one of the waiver programs. Seven of the nine States we visited had to make legislative changes to authorize these programs. Seventeen (50 percent) of the advocacy groups we talked with were extensively involved in the States' waiver request(s). Case workers were used to explain the choices available to the recipients. Fiscal agents were extensively involved in implementing about a third of the managed care systems. HMO's were also involved because of their expertise in rate setting.

Physician support of the case management plan was essential in order to get the plan approved. Ninety percent of the 63 physicians we talked to stated that their Medicaid patient load had either remained the same or increased as a result of participating in the managed care program. In one State where the managed care program would have limited their patient load to 1,500 clients, the physicians were able to get an injunction against the program until this restriction was raised to 2,000 patients.

To ensure physician participation, one State selected a waiver proposal submitted by local physicians. The State's decision in favor of the physician plan gave the State the opportunity to enroll private physicians who would otherwise have been opposed to a managed care program. This was very important since resistance to initial waiver applications in three States was from physician groups. In one case, physician opposition to the

waiver was covered in the local press to the extent that it became a political issue and was part of the reason the waiver was not renewed.

Only three waiver program directors said that they had no recipient enrollment problems. The most common type of waiver enrollment problem was the recipient who did not select a primary care physician or HMO provider. When recipients did not select a case manager, the program assigned clients.

Another problem faced by waiver program directors is getting a waiver approved or renewed. Out of 54 waiver approval or renewal requests, 43 percent have either been withdrawn or disapproved by HCFA. The primary reason for not approving a waiver program is because of insufficient cost savings documentation. State respondents said that initially a receptive Federal environment and the cost cutting efforts by State Medicaid programs made it fairly easy to get approval of a waiver proposal. Now HCFA is requiring more cost-effectiveness documentation for initial waivers and waiver renewals. This change in requirements to receive approval for a waiver is very frustrating for the States. They feel they need more specifics on the documentation required to prove cost-effectiveness. Two States included in our study do not have an approved managed health care waiver. There has been a lack of legislative initiative in each State, although there have been some preliminary discussions on cost savings coming from the legislature in one of the States. In one of the States, the State legislature has been approached several times by the Medicaid State Agency for support of a waiver program.

Summary

Our study found that States are interested in implementing managed care waivers because they think they can save money, improve care, and better control recipient and provider fraud and abuse. The problems they have in trying to implement or renew a waiver are:

- Physician opposition if they feel it may reduce their Medicaid patient load.
- Advocacy groups opposition to restrictions on recipient freedom of choice.
- Lack of legislative support to make the changes required to implement the program.
- Inability to provide data that proves the program is cost-effective. HCFA is requiring better cost-effective documentation now than when the waiver legislation was originally implemented.

Rate Setting

Our study found that States use a variety of methods to establish their prepaid rates. Several States used the prepayment information from another State to set their capitation rate. One State, since their experience with prepaid plans was limited, relied primarily on Statewide fee-for-service data and prepaid plan data from another State to establish the rates for their 1115 demonstration project. A spokesman for that State said that they had overestimated hospital costs for the AFDC category and that Statewide Medicaid cost containment efforts were not correctly estimated when the prepaid rates were set. This resulted in the capitation rates being set too high.

In some State plans, factors such as age, sex, aid category and geographical location were used to set capitation rates. This is similar to the process used by HMO's. In other States, a fee-for-service payment amount was used. Those States that did not have experience with prepaid capitation programs often relied on professional consultants to develop the capitation rates. Consultant fees for these services were as much as \$70,000 which was an additional start-up cost.

In one State Program, HCFA approved a capitation rate based on 100 percent of fee-for-service and an incentive pool. HCFA would not renew the waiver because the capitation rate and incentive pool payment was more than 100 percent of fee-for-service. The State believed that the amount paid from an incentive pool based on projected savings should not be considered as part of the capitation amount, even if the projected savings did not materialize and resulted in the program costing more than under fee-for-service.

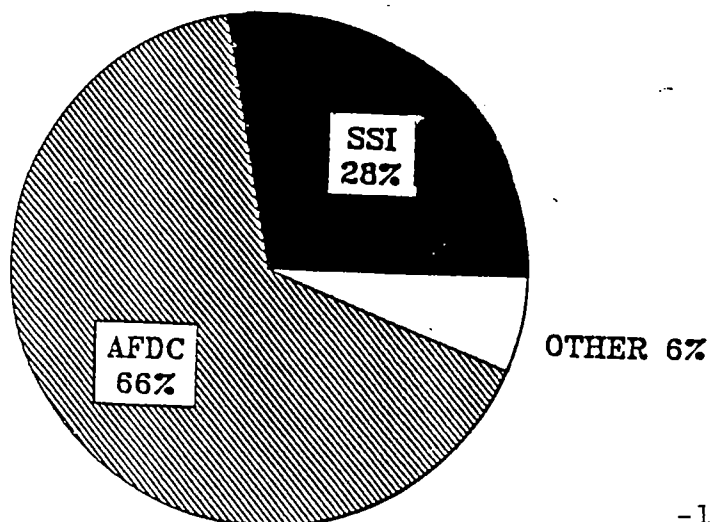
Another reimbursement methodology involving local county control of a program was designed to save 5 percent over fee-for-service. The State calculated the fee-for-service costs by aid category covered in the program and determined that the payment to the county would be 5 percent less. This should have resulted in a savings of 5 percent. However, 1.2 percent of the 5 percent held back by the State was paid to the county for administrative costs. This reduced the maximum savings to 3.8 percent less than would have been paid under fee-for-service. The 3.8 percent projected savings were further reduced by other expenses such as start-up costs, and duplicated administrative costs, such as the amount paid to the fiscal agent to process enrollments and disenrollments, pay providers, and produce report information. The State and the county both provided these services. Also, the county hired a medical director and other staff to administer the program. The county budgeted their administrative costs at between 3 and 4 percent but received only 1.2 percent from the State. The State does not feel they can provide the county more than 1.2 percent since they still have substantial fixed costs for the program. The result is that the 5 percent savings projected in the waiver request when the rates were established are not materializing.

Determining the capitation rate also involves deciding how collections from private insurance and other third party payers will be handled. One State plan provides the option for the provider to collect the amounts from the third party or let the State do it. If the provider collects the third party payments, the State projects the amount that would have been collected from the third parties for the recipients covered by the provider and reduces the capitation rate accordingly. The State does not track third party collections to determine whether the amount projected equals the amount actually collected.

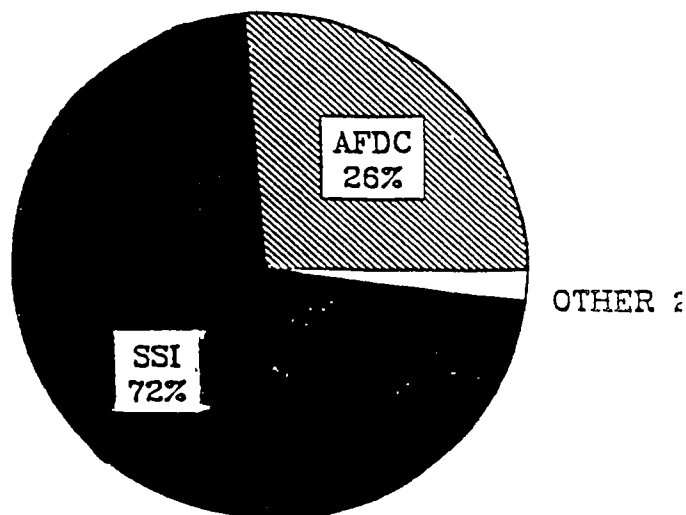
The current trend in rate setting is to reduce Medicaid spending by setting limits on the amounts paid to a provider (prepaid plans), reducing the use of expensive emergency room care, and eliminating doctor shopping, so that more services can be provided for more clients. Most of these efforts are designed to reduce the program costs of the services provided. Our study found that the same effort is not being directed at reducing administrative costs. In fact, in some cases, these costs are increasing. Additional systems are being developed, consultants are being hired to help with the rate setting, extra staff are being hired to enroll recipients, answer questions, etc. While setting lower rates for the amount paid for the service provided Medicaid recipients can reduce Medicaid program expenditures, these reductions may be more than offset by increases in the administrative costs of these programs. These increases should be a consideration in the rate setting and in projections of the cost-effectiveness of these programs. The States should make the same concerted efforts to reduce both administrative and program costs.

Some managed care programs that we looked at provided coverage for AFDC eligibles and SSI Medicaid-eligibles. Others restricted coverage to only AFDC mothers and children. Medicaid expenditures for the AFDC population for fee-for-service are 26 percent of the total expenditures, as compared to 72 percent for SSI Medicaid-eligibles for fee-for-service and nursing home costs. Therefore, in order to realize the maximum amount of savings for these programs, States should be encouraged to include SSI Medicaid-eligibles (not in nursing homes) in their managed care programs.

ELIGIBILITY



EXPENDITURES



Cost-Effectiveness

Section 1915(b) of the Social Security Act provides that in its waiver request to implement a 1915(b) case management program the State must present sufficient documentation that reasonably supports a conclusion that the project will be cost-effective and efficient and consistent with the objectives of the Medicaid program. Total costs must be shown under the waiver for program benefits, administrative costs, systems modification, marketing incentives and similar items. These costs and savings must then be compared with costs and savings which would have been incurred in the State for like services for recipients without a waiver.

Unlike the 1915(b) waivers there are no regulations requiring the 1115 demonstration projects to be cost-effective. HCFA Central Office approves the applications and monitors all demonstration projects.

States Projected Savings

We reviewed data that three of the States with 1915(b) physician case management programs presented to HCFA during the first several years of operation to support their conclusion of cost-effectiveness. As shown by the following statistics, the reported savings based on States' projections did not materialize or included savings from other sources.

Kansas Primary Care Network			
Case Management Fee	\$839,196.00		
Reported Savings	<u>471,581.53</u>		
Added Cost			\$367,614.47
Colorado Physician Sponsor			
Estimated Savings	\$2,663,000.00		
Actual added Cost			\$988,800.00
Michigan Physician Primary Sponsor Plan			
	1982		1983
Admin. Costs	\$264,492		\$ 593,844
Case Mgmt. Fees	<u>3,141</u>		<u>441,603</u>
Program Costs	\$267,633		\$1,035,447
*Program savings	- 5,842		- 821,382
Added cost	<u>\$(261,791)</u>		<u>\$(214,065)</u>
**Less projected HMO savings	<u>-121,065</u>		<u>- 272,889</u>
Savings/Loss with HMO savings	\$ (140,726)		\$ 58,824

*The same projected program savings of \$5.58 per recipient per month was used for both years.

**HMO Savings were based on the theory that HMO enrollment increased because of competition caused by managed care.

Kansas did a comparison study between clients enrolled in a managed care program and clients not covered by managed care programs. The study covered 12 months prior to, and 12 months after, implementation of the managed care program. Since other major program changes were implemented at the same time, the comparisons were based on the percentage of increase or decrease in services between counties with or without managed care programs.

The study showed a \$20.23 savings per year per recipient in the counties with managed care programs. However, these savings did not take into account the \$3 monthly per client case management fee paid to managed care physicians, or additional ongoing administrative costs caused by managed care, such as the State central office administrative costs and a monthly fee paid to the fiscal agent. Also, the projected savings did not include the initial cost of over \$150,000 paid to the fiscal agent, or the salary of a new staff person added to monitor the managed care program.

If just the \$36 per year cost (12 months x \$3) of the case management fee is added to the average yearly cost per recipient, the result is a yearly increase in cost of \$15.77 per client for managed care recipients ($\$36.00 - 20.23 = \15.77) rather than a savings of \$20.23 per client. Projecting this increase to the total managed care population for this State (23,311 recipients) results in an additional Medicaid expenditure of \$367,614 over fee-for-service in a 12-month period. This increase does not take into account any of the other additional administrative costs incurred with the project.

The Colorado waiver renewal request projected that the program would save \$2,663,000 for the AFDC-Adults and Children and SSI Medicaid-eligibles covered by the program. The State collected data on actual monthly Medicaid expenditures for the 12 months prior to implementing the program and used this to project future savings. Estimated savings were based on projected enrollment in the program and reduced cost of services provided by the program.

We reviewed actual monthly expenditures for these Medicaid recipients for 12 months prior to implementation of the program, and 12 months after implementation. The data showed that the monthly cost per recipient had increased \$1.03. If the \$1.03 per recipient per month is projected to the State's estimated 80,000 Medicaid-eligibles, the additional yearly costs of the managed care program would be \$988,800, rather than a savings of \$2,663,000.

Michigan compared the cost of services for clients that were on fee-for-service to the ones enrolled in managed care. During 1982 and 1983, the program lost \$475,856 after costs of operation and start up costs were considered. To offset this, the State calculated a dollar savings for the managed care program based on increased enrollment in HMO programs. The HMO's are not part of the managed care system in this State. This produced a net program savings in 1983. The theory was that competition created for the HMO's by the managed care program caused HMO's to increase their efforts to enroll recipients.

These three States had collected more cost data than other States in order to evaluate the cost-effectiveness of their programs. They are continuing to work with HCFA to explore methods of making their programs cost-effective. One example of this is in Kansas, where they are looking at reducing or eliminating the case management fee.

Summary

Cost containment is the primary reason States implement managed care programs. Our study found that the following problems make it difficult to substantiate a clear finding of cost-effectiveness.

- ° In order to be renewed beyond the original 2 years the program must show that total costs, systems modifications, marketing and administrative costs do not exceed the costs that would have been incurred without the waiver. Absorbing these costs in these first 2 years of operation makes it difficult to show the program is cost-effective. Spreading these costs over more than 2 years would make it easier to prove cost-effectiveness.
- ° Paying a case management fee increases program costs. Eliminating the case management fee could make programs more cost-effective. One program would have saved about \$470,000 if they had not paid a case management fee. Paying the case management fee resulted in the program losing over \$360,000.
- ° Establishing prepaid rates that reflect the population being served under a capitated plan is difficult to do and also affects the cost-effectiveness of the program.

Summaries of Reviewed Managed Care Programs

1915(b) Case Management Programs

Kansas Primary Care Network

This program covers 23,000 AFDC recipients in two rural counties and one urban county. Physician case managers are paid the regular fee-for-service plus a \$3 case management fee per enrolled recipient per month. The program is being expanded to five other counties.

California Primary Care Case Management

Two organizations provide care to about 2,000 AFDC and SSI Medicaid enrollees in Los Angeles and San Diego counties. Reimbursement is capitated at 95 percent of fee-for-service. Ambulatory patient care contains a \$10,000 stop loss provision with the exception of dialysis services. The State plans to expand the program.

California Selective Hospital Contracting

All hospitals Statewide, with the exception of psychiatric hospitals, rural hospitals and areas in other pilot projects, are included in the program. The program provides all inpatient hospital services for 2.8 million eligible recipients. Each hospital is reimbursed a negotiated per diem rate, which is determined by using fee-for-service data. The program does not cover doctor's office visits.

Michigan Primary Physician Sponsor Plan

Approximately 70,000 AFDC recipients in a large urban population county are enrolled in the program. Reimbursement is 100 percent fee-for-service plus a \$3 per recipient per month case management fee. The State is working with HCFA to renew the program.

Michigan Capitated Ambulatory Program

This program serves approximately 4,500 recipients. All Medicaid recipients are covered by the program. The providers are paid a capitated rate based on 100 percent of fee-for-service. They are at risk for provided services, but not for inpatient costs. Additional reimbursement is provided if inpatient hospital costs are reduced by 20 percent.

Michigan 6-month HMO Program

This waiver covers two HMOs that did not meet the 75/25 ratio of private/public patient mix. All categories of aid are covered with the exception of general assistance and medically needy. There are almost 42,000 recipients covered by this program. The reimbursed rate is 90 percent of fee-for-service.

Michigan Primary Mental Health Clinic Sponsor Program

All mental health outpatient services and day treatment programs are included in the program. The purpose is to reduce costly institutional care. Coverage is Statewide, except for one rural county, and applies to all Medicaid recipients in need of mental health services. Reimbursement is limited to a \$42 per day maximum capitated rate.

Kentucky Citicare

A Health Insuring Organization established a prepaid capitated program in one large urban county. About 40,000 AFDC and medically needy recipients were covered under the waiver. Providers were paid a capitated rate of 95 percent of fee-for-service plus a provider incentive pool. The State chose not to renew this waiver.

Colorado Primary Care Physician Program

This is a Statewide physician case management program. The physicians are paid on a fee-for-service basis and also receive an incentive pool payment twice a year. No case management fees are paid. All AFDC adults and children not enrolled in an HMO are required to enroll in the program. A total of 53,000 recipients are enrolled.

Wisconsin Mental Health Gate Keeper Plan

Statewide, except for two large urban counties. It covers 420,000 recipients who can receive outpatient and professional day treatment services, plus institutional care for persons 22-64 years of age. This is a fee-for-service program with no case management fee. The objective is to contain costs, curb abuse, and provide integrity to the provider.

Wisconsin HMO Preferred Enrollment Initiative

Thirteen HMOs with 120,000 AFDC recipients in two large urban counties are included in the program. They operate under risk contracts and are paid a monthly capitated rate. The State plans to apply for an extension of the waiver and is contemplating incentives for providers to lower contract bids.

Utah Selective Hospital Contracting

This program was never implemented, based on a study that recommended a DRG-related system over the selective contracting model. It was determined that selective contracting serves only as a temporary means of controlling costs rather than a long-term solution. This program does not cover doctor's office visits.

Utah DRG Method for Hospital Reimbursement

The DRG program is Statewide and covers all hospital inpatient services. It does not cover emergency room or outpatient services. The State adopted HCFA's DRG codes with some modifications. The program does not include any stop-loss provisions or incentive pools. Preliminary data shows inpatient costs have dropped for each of the last 2 years.

Utah Social Services Prepaid Health Plan

This is a Statewide program that covers all Mental Health Clinics. About 60,000 recipients diagnosed as handicapped/developmentally disabled, mentally ill, functionally impaired, or substance abusers are covered under this program. The State plans to continue this program.

Utah Choice of HMO or Primary Care Network

This program offers the recipient the choice between one of two HMOs or a physician case manager program. The program is offered Statewide, with the exception of rural counties which do not have HMOs. All 43,000 Medicaid recipients are covered under the program. The physicians are paid 100 percent of fee-for-service. No case management fees or incentive pools are included in the program. Each of the HMOs has its own rates based on the recipient's eligibility category.

New York 5-Month HMO Lock-In Program

This program involved two HMOs in two suburbs. Only 71 AFDC recipients were enrolled in these two HMOs. Due to the small enrollment, the waiver was terminated after 2 years of operation.

1115 Demonstration Projects

Missouri Prepaid Health Project

This program provides a choice of pre-paid health plans or a physician sponsor plan. The case managers are paid a \$1.50 case management fee. The program covers one large urban county with 27,500 AFDC and unemployed parent recipients. Expansion to other urban counties is anticipated.

New York Monroe County Medicap Plan

Since Monroe County had experience with HMOs, the State received a demonstration grant to test enrolling the Medicaid population in a prepaid capitated program. The rates are based on 95 percent of fee-for-service. Projected enrollment is 58,000 recipients. Expansion will be considered based on the results of the program.

California Santa Barbara Health Initiative

Eligible recipients in this county total 21,000. All categories of aid are included under the waiver. Any health care provider who wishes to receive payment for services rendered to recipients in this county can do so only by contracting with the Health Initiative (HI). The capitated payments to the HI are 95 percent of fee-for-service. This has been converted into monthly rates per recipient and aid category. The majority of recipients have case managers that are paid this monthly rate based on the number of recipients assigned to them.

California Monterey County Health Initiative

This program was developed as a demonstration project to test the feasibility of a competitive case management medical care model. The Medi-Cal recipients in this county totalled 26,000. All were included in this project. A \$3 per recipient case management fee was paid to the case managers. The project is now bankrupt.

Health Care Financing Administration
Comments on
OIG Draft Medicaid Managed Health Care Programs

The Health Care Financing Administration (HCFA) was briefed on the initial findings of the study prior to preparing the draft report, and later given an opportunity to comment on the draft report. Their comments have been very helpful in preparing the final report. Some of the major areas addressed by their comments were:

- The point was made that this report was not clear as to whether the data we looked at showed that these programs cost more than they save, or that the data is inconclusive. The report has been clarified to state that the data we looked at was inconclusive in showing whether these programs are cost-effective.
- Concern was expressed with our finding that elimination of the \$3 per month case management fee would make the programs more cost-effective. HCFA made the point that if this does not result in exceeding the cost of providing similar services under the ongoing State Medicaid program, the statutory and regulatory requirements are met. While we agree, we still feel States should be encouraged to follow the example of two States offering other incentives to encourage physician participation, saving \$2 million per year by not paying a case management fee, and thereby increasing the cost-effectiveness of the program.
- Concern was expressed with added administrative costs that would result from modifying the State Medicaid Management Information System (MMIS) to assess cost-effectiveness and quality of care for managed care programs. One of the primary findings of our study was that no systems exist to measure the cost-effectiveness of these programs or if they provide quality care to the recipients participating in them. While implementing systems to do this will no doubt add to the administrative cost of these programs, we believe the costs would be justified, just as they are by other ongoing State Medicaid Programs.
- In response to our finding that States feel they need more technical assistance in areas such as the criteria used by HCFA to evaluate cost-effectiveness, the point was made by HCFA that they do provide this assistance but that there is a limit on how much they can do and still meet the statutory requirements of providing States with maximum flexibility to establish these programs. We have clarified this section as to the type of technical assistance we are suggesting.

- ° The point was made that our suggestion to include the SSI Medicaid population would not result in as large a savings as indicated, since much of the SSI Medicaid cost involves nursing home expenses that would not be included in a managed care program. We have clarified this section of the report.
- ° Several comments were made about areas of the report that did not specify whether the type of program being discussed was a waiver approved under Section 1915b or 1115 of the Act. We have corrected this.
- ° Other comments involved suggested clarification and word changes which we have made.