Evaluation of Medicaid Health Reform Demonstrations

This is the second of two CMS-sponsored evaluations of five Medicaid State Reform Demonstrations awarded under Section 1115 of the Social Security Act. In 1995, CMS selected the Urban Institute (with subcontractors Research Triangle Institute and Mathematica Policy Research, Inc.) to evaluate the following five programs:

- Demonstration Project for Los Angeles County, California
- Kentucky Health Care Partnership Program
- Minnesota PMAP+ Program
- New York Partnership Plan
- Vermont Health Access Plan (VHAP)

The evaluation consisted of a series of studies focusing on various salient aspects of the demonstration programs, and of the Medicaid reform efforts initiated through 1115 waivers throughout the 1990s. Additional funds were provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) for a more detailed look at the waivers' impact on substance abuse and mental health services. The following is a summary of major findings. Links to the *Final Report* and selected topical reports can be found at the bottom of this page.

Beneficiary Experiences Under Medicaid Before Managed Care

- **TANF and poverty-related populations.** A survey of TANF and poverty-related Medicaid beneficiaries in rural Minnesota showed that TANF beneficiaries fared reasonably well under fee-for-service Medicaid. Almost all reported having a usual source of care other than the emergency room and a doctor visit over the past year. On the other hand, more than half of adult beneficiaries and one-quarter of children reported some type of unmet need, and about one-quarter of respondents reported visiting an emergency room (ER), in the last 12 months.

- **SSI populations.** Pre-managed care surveys of disabled SSI beneficiaries in Kentucky and New York revealed that the vast majority had a usual source of care and had seen a physician in the past 12 months. Nearly one-half of respondents reported at least one ER visit in the last year. They also reported longer travel and wait times than TANF and poverty-related beneficiaries and significant levels of unmet need.

- **Lessons Learned.** For both groups of beneficiaries, Medicaid managed care system might achieve cost-effective improvements by reducing ER use for non-immediate needs, reducing travel times to care and wait times in office before being seen and reducing unmet need for doctor and dental care. For disabled beneficiaries in particular, Medicaid managed care programs must also account for the diversity of their health care needs.

Program Implementation and Operational Experiences under Medicaid Managed Care

- **Minnesota's PMAP+**. Expansion of Medicaid managed care in Minnesota was slowed by resistance from a range of powerful stakeholders. Counties were concerned about potential cost shifting under managed care and resentful of the imposition of a single program from outside. Providers echoed these concerns, and some consumer groups also feared the effects of "rationing" care. In response to these concerns, the county role in plan selection and in the capitation implementation timetable was expanded, and counties were given the option of creating county-based purchasing (CBP) models as an alternative to PMAP+. By 2003, 70 of Minnesota's 87 counties had implemented PMAP+.

- **New York's Partnership Plan.** By April 1999, all major urban areas in upstate New York had started mandatory managed care for TANF and expansion populations. Implementation for TANF populations in New York City was slow, however, and no mandatory enrollment of SSI populations had occurred anywhere in the state. Resistance by local governments, a strong state economy and declining Medicaid enrollment (reducing the fiscal imperative for managed care), lukewarm support from New York City hospitals and a strained relationship between the state and the Health Care Financing Administration (now CMS) were cited as impediments to more rapid expansion of managed care. Despite these challenges, as of January 2003, the Partnership Plan had been implemented in 21 of the state's 57 counties and all parts of New York City, but only for TANF and poverty-related populations.

- **The Kentucky Health Care Partnership Program.** The State's waiver plan divided the State into 8 regions, and sought to establish managed care Partnerships to serve as the sole-source providers of Medicaid coverage within each region. In late 1997, Partnerships were formed in the two most urban regions of the state: Region 3 (Louisville) and Region 5 (Lexington). By October 2000, however, none of the other regions had formed partnerships and Region 5 had decided to dissolve its partnership. Many of the regions were so sparsely populated that they had difficulty generating the necessary capital to initiate a Partnership. A comparative analysis of Region 3 and Region 5 suggests that Region 3's success was due to the design of their payment plan for providers, their extensive public relations and administrative services efforts and the long history of provider collaboration on indigent care issues in their Region.

- **The Vermont Health Access Plan.** The State initially planned to implement mandatory capitated Medicaid managed care statewide. In 1996, they were able to execute contracts with two plans, and mandatory enrollment was completed in nearly all areas of the state by May 1997. Within two years, both plans dropped out and the State implemented a Primary Care Case Management managed care program in their place. Several factors contributed to the demise of Vermont's effort to establish a capitated managed care program, including difficulty

maintaining health plan participation and having a health system with few inefficiencies even before capitation.

- **Lessons Learned.** Minnesota, Kentucky, New York and Vermont all have substantial rural areas. The common problems faced by all four in their efforts to introduce Medicaid capitation applied in large part to their efforts in the rural parts of their states. State should ensure that each area where capitated managed care is planned has a sufficient number of covered lives, be prepared to allow flexibility for provider networks, be realistic in assessing potential cost-savings, set feasible capitation rates and allow for local differences and local input.

Effects of Medicaid Managed Care on Beneficiaries

- **TANF and TANF- Related Beneficiaries in Rural Minnesota.** Results from surveys conducted before and after implementation of managed care show that PMAP+ had virtually no significant impact on beneficiaries' access to and quality of care. Although parents were significantly less likely to find it easy to obtain prescription drugs for their children in managed care than in fee-for-service, there was no increase in unmet need for drugs among children. Given the State's contention that program costs were lower under managed care, the major achievement of Medicaid managed care in rural Minnesota may have been to maintain the same level of care as under fee for service but at lower cost.

- **Rural Health Care Experiences under Medicaid.** An analysis of the 1997, 1999, and 2002 waves of the National Survey of America's Families showed that rural-urban differences in access to care are much smaller for Medicaid beneficiaries than for either low-income privately insured individuals or the uninsured. Furthermore, rural beneficiaries in counties with Medicaid managed care were more likely to have a usual source of care and to have had a doctor visit in the past year and less likely to have an emergency room visit than rural beneficiaries under fee-for-service Medicaid.

- **Urban and Rural Disabled Beneficiaries.** An study of National Health Interview Survey data from 1997-2001 showed that urban SSI beneficiaries in managed care counties were significantly less likely than those in fee for service counties to report any contact with health care providers in the past year. Beneficiaries in urban counties with mandatory Medicaid HMO coverage in particular were significantly less likely to have had a specialist visit in the past 12 months than urban beneficiaries in counties with other forms of managed care or in fee for service. SSI beneficiaries in rural managed care counties, in contrast, were more likely to have a usual source of care other than an ER, and were more likely to have had contact with physician extenders dental visits within the past year than their counterparts in fee-for-service counties.

- **Lessons Learned.** The Minnesota findings suggest that managed care may not have much effect on improving access to care or care delivery patterns for TANF

and TANF-related populations in rural areas. A nationwide look at rural Medicaid managed care, however, revealed improved access to ambulatory care providers and reduced emergency room use. A national examination of disabled Medicaid populations showed that managed care has some potential for improving health care delivery, particularly for primary care services, for rural beneficiaries. This finding does not carry over to urban areas, however, suggesting that states should be cautious about extending managed care coverage to disabled Medicaid beneficiaries in those areas.

Commercial Plan Choices in a Changing Medicaid Market

- **Medicaid Managed Care Plan Exit.** Managed care plan data for 2000 and 2001 were studied to determine factors associated with the exit of commercial managed care plans from Medicaid. Plans with a large share of the local Medicaid managed care market and that serve large proportions of total Medicaid enrollees are less likely to quit the Medicaid market, as are plans affiliated with Blue Cross/Blue Shield, provider-sponsored plans and for-profit plans. Higher capitation rates reduce the likelihood of plan exit, while mandatory enrollment in managed care has the opposite effect. A strong managed care presence in the private market seems to help plans continue participating in Medicaid.

- **Lessons Learned.** States should establish sound capitation rates that reflect the true costs of serving the Medicaid population, and ensure that service carve-outs and similar policies are not interfering with plans' ability to manage care. States should work to ensure that plans can enroll an adequate number of Medicaid enrollees to operate effectively.

Reconfiguring the Safety Net: The Experience of Los Angeles County

- **The Los Angeles County Demonstration Project.** By 1995, years of shrinking revenue streams, health service demand increases and the cost of maintaining the county's deteriorating health system infrastructure had culminated in a funding crisis for the county. In response, CMS granted a five-year financial relief package in federal Medicaid funding, in return for which the County agreed to fundamentally restructure its delivery of health care to the indigent.

- **Accomplishments.** The Public-Private Partnership (PPP) program, which extended county-funded indigent care provision to the private sector, was universally considered one of the big successes of the waiver program. In addition, referral centers were created to provide access to specialty care in for the indigent in locations other than the ER. While the County's major medical center was effectively downsized, the effort to privatize two hospitals failed due to a lack of potential buyers and community opposition.

- **Lessons Learned.** Substantial financial relief and a serious restructuring effort may not be enough to restore financial viability to a public safety-net health care

system on the brink of collapse. Waiver efforts did succeed in expanding access to non-hospital indigent care, cutting the number of inpatient beds, inpatient days, and average length of stay and producing cost savings for hospitals. The County's health system still had not achieved financial stability by the end of the initial waiver, and a new waiver was approved to provide additional financial assistance for 2001-2005. Whether actions under the new waiver will stimulate enough additional financing and operational reforms in the County's system to make it financially stable remains an open question.

Pharmacy Assistance Programs and Determinants of Enrollment and Impacts of Enrollment on Use and Costs of Drugs and Medical Services

- **Vermont's Pharmacy Assistance Programs.** Vermont offers three pharmacy benefit programs to low-income elderly and disabled residents: VHAP Pharmacy, VScript and VScript Expanded. Expenditures under VHAP Pharmacy and VScript are eligible for the federal match under the State's Section 1115 waiver program. Most pharmacy program participants are low-income Medicare beneficiaries.

- **Enrollment.** The pharmacy assistance programs enrolled a substantial minority (16 percent) of Vermont's Medicare beneficiaries. Compared to those eligible but not enrolled, enrollees are likely to be older, have less education, have lower income, live alone and be sicker. People with other drug coverage have 85 percent lower odds of enrolling compared to people without coverage. Lack of awareness is also a barrier to enrollment. Analyses suggest that the pharmacy assistance programs have lowered the rate at which beneficiaries spend down to full Medicaid benefits.

- **Impact on Medicare Spending.** Enrollment in a pharmacy assistance program was associated with a 17 percent reduction in annual expenditures for inpatient services and a 19 percent increase in annual expenditures for professional services. Enrollment in VScript and VScript Expanded was associated with a 35 percent increase in annual expenditures for professional services. Enrollees in VScript Expanded also exhibited a 25 percent increase in outpatient facility costs.

- **Lessons Learned.** State pharmacy assistance programs play an important role in providing outpatient prescription drug coverage to vulnerable Medicare beneficiaries. Subsidies provided under the new Part D drug benefit to the non-dually eligible low-income population will be crucial for building on the achievements made by states and ensuring continued access among the near-poor. While the new Medicare drug benefit may help reduce the number of unnecessary hospitalizations, Part D coverage may lead to offsetting increases in hospital outpatient and Part B expenditures.