THE CAPITOL FORUMS
On Health and Medical Care

Medicaid Managed Care

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background information for the discussion at the

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MEDICAID MANAGED CARE

An issue brief prepared by Joanne T. Fucello, MSW
for discussion at the March 2, 1994, Capitol Forum

THE ISSUE:

How to best provide New Jersey's Medicaid eligible population with quality health programs and services in a cost-effective manner.

INTRODUCTION

In response to escalating costs in the Medicaid program, as well as to other programmatic problems with access and quality of medical care, states have been aggressively exploring managed care for Medicaid beneficiaries as a means to effect cost savings and improve access to quality health care. The New Jersey Division of Medical Assistance and Health Services (Medicaid) is actively involved in its plan to move specific beneficiaries in New Jersey's Medicaid population — Aid to Families with Dependent Children (AFDC) recipients — into managed care.

The Medicaid program uses traditional fee-for-service arrangements with physicians and other providers to treat Medicaid patients, an arrangement that offers little incentive to control costs. Access to physicians is also a significant problem in the Medicaid program, whose goal was to make health care accessible to the needy. A chronic programmatic problem has been the lack of physicians and other providers to treat Medicaid patients. Providers cite low reimbursement fees and administrative burdens under the program as a disincentive to provide care. In the absence of primary care physicians, Medicaid recipients turn to costly emergency room use for non-emergency or non-traumatic care. Research has also shown that Medicaid recipients delay getting care for a health problem and then seek treatment only after an illness has progressed to a point where costly hospitalization is required.

This shift to managed care away from traditional, indemnity fee-for-service insurance plans in both the public and the private sectors represents an effort to control costs and coordinate medical care in a cost-efficient manner by integrating the previously separate financing and delivery systems of health care. This issue brief will focus on the Medicaid program, which in New Jersey is funded by a 50/50 federal/state dollar-match (the match ratio varies from state to state), and its status regarding managed care. Included in this brief are an examination of what other states are doing with Medicaid managed care, where New Jersey is in the process and an overview of some of the critical issues states confront in operating Medicaid managed care programs. The brief will conclude with questions for discussion.

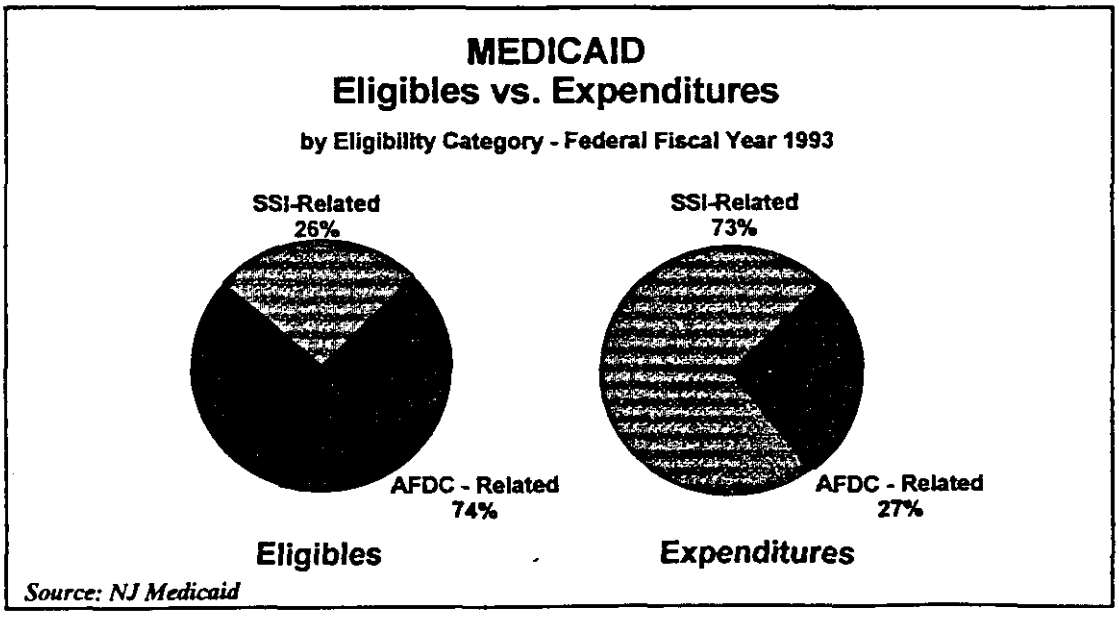
The National Medicaid Picture

1965 Federal legislation amending the 1935 Social Security Act created Title XVIII (Medicare, Parts A&B) and Title XIX (Medicaid), which is a program that pays providers for medical services rendered to those defined as "needy." In the simplest of terms, the universe of Medicaid eligibles is comprised of two programmatic categories: Aid to Families with Dependent Children (AFDC) families (primarily women and children) and Supplemental Security Income (SSI) recipients, who are the elderly, blind and disabled. In addition to categorical eligibility, Medicaid eligibility is also determined by specified income and asset standards.

An inverse relationship emerges when these two groups are analyzed comparing Medicaid eligibles with Medicaid expenditures. While AFDC-related beneficiaries comprise 74 percent of the Medicaid eligible population, they account for only 26 percent of Medicaid expenditures. In comparison, SSI-related beneficiaries, who comprise only 26 percent of the Medicaid eligible population, account for 73 percent of Medicaid expenditures, primarily used for payment of services rendered in institutional facilities such as nursing home and other long-term care facilities (See Chart 2, "Medicaid — Eligibles vs. Expenditures").

The designers of the Medicaid program in 1965 did not imagine the program would develop and grow as it has over the past decades, with continued expansion of eligibility categories and program services. In Fiscal Year 1992, federal and state spending for the Medicaid program nationally was $119 billion, an increase of 29 percent from 1991. 1993 outlays are approximated at $130 billion, covering an estimated 31 million Medicaid recipients. This amount is four times what the program budget was in 1983.

Chart 2



patient mix of clients. The 1993 GAO Report, "States Turn to Managed Care to Improve Access and Control Costs," found that states mandate enrollment only in areas where there are sufficient providers so that beneficiaries have a choice of health plans. A Federal waiver is required in order to mandate enrollment in managed care plans.

Why Target the AFDC Population for Medicaid Managed Care?

The young population of Medicaid recipients represented in AFDC families, in particular children and young parents, are appropriate candidates for managed care, with its strong emphasis on preventive care. For example, the issues around pregnant women have always represented a significant problem to the Medicaid program. Each year, Medicaid covers approximately 1.5 million births, a disproportionate share of which are low birth weight and drug-addicted babies (Wall Street Journal, June 11, 1993). Many of these babies require expensive and extensive hospital stays. With managed care programs, the Primary Care Physician (PCP) would monitor and manage the pregnant woman's care, prenatal care would be coordinated and neonatal health problems could be reduced. Under Medicaid managed care, states require physicians to set up 24-hour, seven-day-a week availability.

In an effort to be sensitive to the unique needs of the AFDC population, certain Medicaid HMO programs are currently experimenting with ways of reeducating women and getting mothers to commit to stay with prenatal care, through activities such as group educational programs and prenatal counseling. Outreach programs have also been found to be essential in informing and educating AFDC recipients about the Medicaid managed care program services. The AFDC populations have a need for preventive services and they are also similar in age to the majority of the population being served by commercial HMOs — the younger, healthier clients.

Medicaid Managed Care in New Jersey

The New Jersey Picture: Expenditures and Populations Served

In New Jersey for State Fiscal Year 1994, the total Medicaid appropriation (Federal and state 50/50 share combined) is $4,000,846,000. Of the total appropriation, $1,132,070,000 or 28 percent is for nursing homes; $1,084,077,000 or 27 percent, is for other program services (which include Medicaid eligibility expansion groups ($393,054,000), home health services, dental, transportation and other program services); $990,393,000 or 25 percent, is for inpatient care; $417,821,000 or 10 percent, is for outpatient care; $266,501,000 or 7 percent, is for prescription drugs and $109,984,000 or 3 percent, is for physician services (See Chart 3, "State Fiscal Year 1994 Medicaid Benefits").

evolved into the Garden State Health Plan, which is a Federally approved, state-run plan, one of the first of its kind. The Garden State Health Plan currently operates in 10 counties and has an enrollment of approximately 18,000 Medicaid clients. The Garden State Health Plan will be linked with the developing Medicaid managed care program. While the drive is to enroll AFDC Medicaid clients, other Medicaid recipients, such as Supplemental Security Income (SSI) program participants, may enroll in the Garden State Health Plan.

Current Status and Future Plans

The New Jersey Health Care Cost Reduction Act (P.L. 1991, c. 187) required that HMOs operating in New Jersey submit a plan as to how they would enroll Medicaid clients into their networks. The Department of Human Services also put forward a plan to develop a state-wide network of managed care providers for Medicaid recipients. New Jersey's Division of Medical Assistance and Health Services and the Office of Managed Health Care are actively engaged in implementing the plan to enroll Medicaid's Aid to Families with Dependent Children (AFDC) population in HMOs by December 1996. The targeted AFDC population for HMO enrollment totals approximately 400,000, which is approximately 95 percent of the total AFDC and AFDC-related population.

Medicaid's strategy for implementing the mandatory enrollment of its AFDC population into managed care involves a three-tier approach, beginning in January 1994, with a completion date of December 1996. Enrollment begins first in Camden and Gloucester counties (January - July 1994), and continues with enrollment for Hudson and Essex counties (to be accomplished within the next 6-month period). The second tier of the plan involves bringing into managed care the mid-sized counties (Passaic, Union, Middlesex, Mercer, Atlantic, Monmouth, Cumberland, and Bergen). The third and final tier is enrolling AFDC Medicaid beneficiaries in the remaining smaller counties.

The Medicaid managed care program currently has two contracts with HMOs as part of its plan outlined above to transition AFDC beneficiaries into managed care. The contracts are with HIP Rutgers Health Plans and HMO Blue (Medigroup South), in alliance with Mercy Health Plan of New Jersey. Enrollment is at approximately 20,000.

Regarding the standardization of financing and delivery of services, the Department is developing a standardized service package for use across all HMOs in the state, including the Garden State Health Plan. The standard service package for managed health care offers a wide range of services, including preventive, diagnostic, therapeutic and rehabilitative health care services. (Medicaid "Standard Service Package for Managed Health Care," 1994). Certain institutional services such as nursing facility care, residential treatment center care, psychiatric hospital, interme-

National Evaluation: Access, Quality & Cost

Evaluative research on Medicaid managed care is on-going. Current and past research has focused on the three dimensions of access to services, quality of care and cost savings comparison, as well as on program design and service utilization and delivery. While there are limitations to many of the studies on Medicaid managed care (some are outdated and others are narrow in their analyses), we can identify some benefits and problem areas in managed care in the areas of access, quality and cost. The March 1993 GAO Report, "States Turn to Managed Care to Improve Access and Control Costs," reviews various Medicaid managed care programs across the nation and analyzes programs in six states — Arizona, Kentucky, Minnesota, Michigan, New York and Oregon. The states operated a variety of managed care plans from fully capitated to PCCM model types and model type mixes. In its report, the GAO reviewed studies on Medicaid managed care, interviewed officials and beneficiary advocacy groups and made several general findings. The GAO found that Medicaid managed care program results are showing: "slight improvements overall in access to care; improved beneficiary satisfaction (as measure by beneficiary advocacy groups); quality of care that is the same as traditional Medicaid fee-for-service; and cost-savings being reported by states, but that are inconclusive."

Access

One of the goals of Medicaid managed care is to improve access to physicians and providers, the result of which would be a reduction in care being delivered through inappropriate delivery systems, such as emergency rooms and hospitals. The assigned primary care physician would coordinate and managed the care for his/her assigned clients. While several research studies have shown that access to care under managed care was greater than under traditional fee-for-service, others have concluded than there was no significant findings one way or the other. A 1989 study of the HCFA demonstration project in six states —California, Florida, Minnesota, Missouri, New Jersey and New York — found that "there were substantial reductions in the proportion of persons with at least one emergency room visit for both adults and children in the demonstrations." (Hurley, Freund and Taylor, 1989).

Quality

The issue of quality of care is inextricably bound up with the access issue. Past and ongoing research on quality of care in service delivery under Medicaid managed care is plagued by some of the same methodological problems as evaluating quality of care in traditional health care — the type of indicators used to assess quality, such as selected medical outcomes or selected treatment plans. The GAO reported that of the six states in its study, there was no "diminution" in quality for managed care

GAO Report found managed care programs to be generally cost-effective. In 1991, HCFA reported $227 million in projected 2-year cost savings from states operating Medicaid managed care programs with 1915(b)(1) waivers (which is what New Jersey will be doing in its Medicaid managed care plans). In November 1992, the GAO reports that HCFA's revised 2-year savings projection totaled approximately $326 million. Programs with section 1915(b)(1) waivers are required by HCFA to demonstrate the their managed care programs exhibited cost savings. Cost savings under managed care were believed to be a result of better management of medical care for patients and reduced use of emergency room care (1993 GAO Report).

Conclusion

It is clear that based on their experience, the Federal government and individual states see that managed care in the Medicaid program has potential to improve access to care, ensure quality of care and effect some cost savings. While research indicates that implementation problems are many and cautions that plan design and implementation be slow, the pressure to reduce spending is driving states to move forward in Medicaid managed care. At this point in time, Medicaid managed care analysts (as do managed care analysts in general) identify quality assurance issues and comprehensive monitoring of providers to be critical in the success or failure of managed care programs. States are encouraged to develop efficient systems to monitor and oversee the programs and to create tools for standardized data collection to monitor effectiveness in the areas of access, quality and spending.

Fiscal and Risk Capacity - Cost Containment and Rate-Setting

The 1993 GAO Report identifies that in the past, providers accepted too much financial risk in capitated programs and then became insolvent. Of the states surveyed, the GAO found that each state which had capitation programs required the plans to purchase reinsurance to protect against insolvency. Michigan, for example, uses its Department of Health to monitor its Medicaid managed care health care delivery system and its Insurance Bureau to oversee financial issues with its contracted providers. How much and which kind of financial reporting is required to guard against financial insolvency and a disruption of health care services to beneficiaries?

How will New Jersey work towards attracting commercial HMOs to accept Medicaid enrollees? In the past, states have had difficulty negotiating with commercial HMOs because of the low payment rate. Federal regulations require that for capitated programs, the rate not exceed the cost of the traditional fee-for-service program. Capitation requires extensive work on rate-setting. How will this be accomplished?

Is privatization a reasonable choice for New Jersey for its Medicaid managed care program? What type of public-private partnership exists for this to be a viable alternative?

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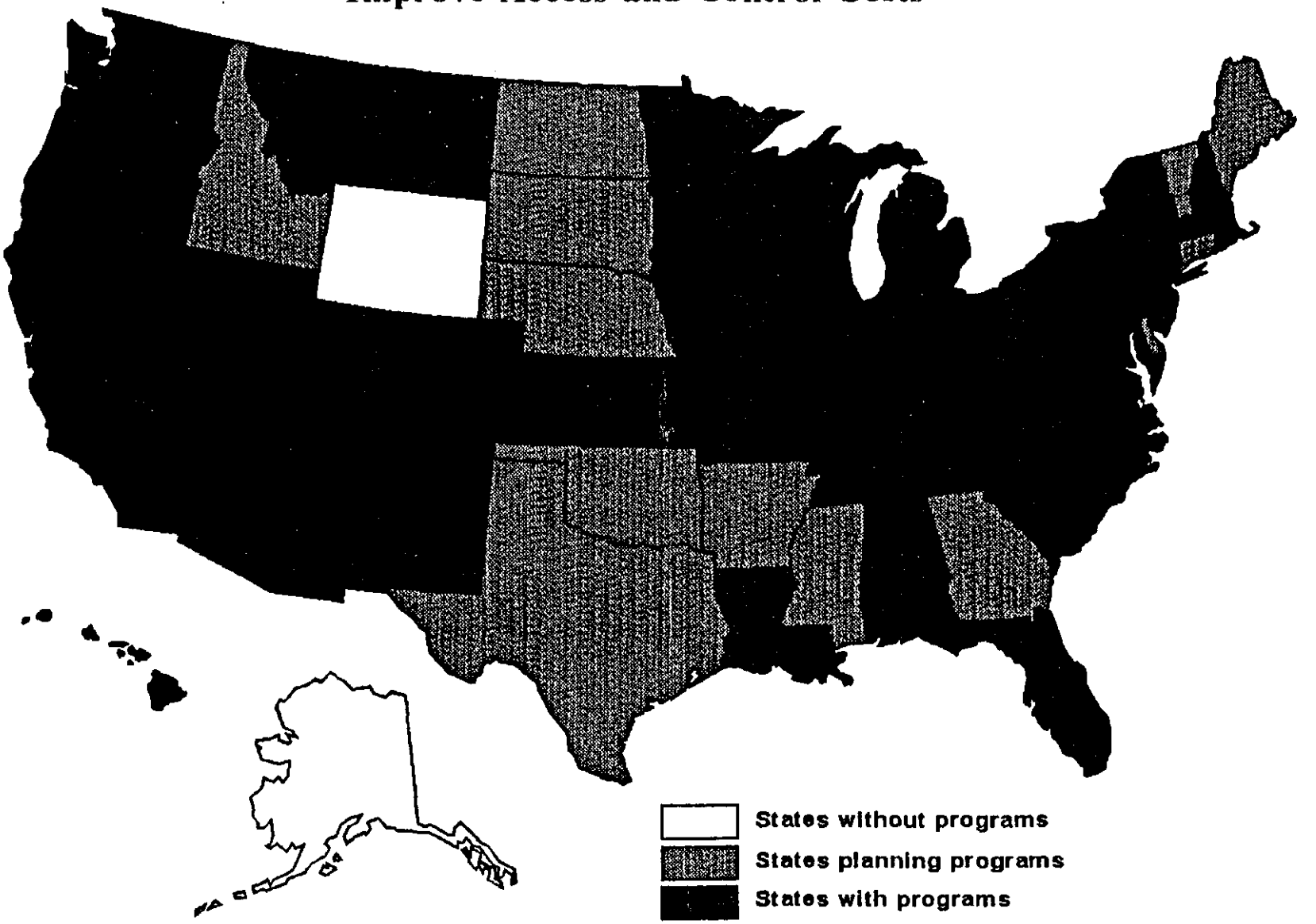
Medicaid: States Turn to Managed Care to Improve Access and Control Costs



Source: See References #10

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

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]	
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
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.	•	•			•	•				14,969

[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 from Alabama, Hawaii, Indiana, Missouri, New Jersey, Tennessee, Utah, Washington D.C. said that enrollment data reported in June 1992 were still relatively accurate as of February 1993.
[h]Serves only mental health recipients.

Source: See References #10