

Public Policy Monograph

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**MEDICAID
MANAGED CARE:
SAVINGS,
ACCESS
AND QUALITY**



AMERICAN ACADEMY *of* ACTUARIES

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works closely with state officials on issues related to insurance.

This report was prepared through the Academy's State Health Committee by a group of actuaries who are experts in Medicaid and managed care. The State Health Committee provides states and elected officials assistance on health insurance and other health actuarial issues. The purpose of this monograph is to assist the public policy process through the presentation of clear, objective analysis.

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Executive Summary

Managed care has been a part of private health coverage for over 20 years. The forms of managed care vary widely, but their goal of reducing health care costs to those purchasing the coverage is consistent. Recently states have begun to introduce managed care into their Medicaid programs. The goal of these activities is to reduce costs and increase quality of care with an additional goal of increasing access to care.

States have taken a variety of approaches to managed care. But they all start with a waiver from federal Medicaid program mandates, which lets a state vary from federal coverage and eligibility rules, and, in particular, introduce managed care programs.

Most managed care programs involve a transfer of risk. This means that states contract with health plans or health care providers for the provision of care within some fixed-cost arrangement. In this way, the providers assume the risk of any fluctuations in health care costs, by accepting an up-front, fixed payment for the provision of care, which may in fact vary in both volume of services and cost.

The managed care programs currently in place use a variety of risk transfer mechanisms. In some, everyone must enroll in one of several health plans that are paid a fixed, or capitated, amount by the state. The health plans must then provide all the health care required by the individual. Others pay on a capitation basis for some services, such as physician services, while paying by fee-for-service for others. Finally, still others have introduced managed fee-for-service arrangements that encourage utilization control through approval and review procedures.

The amount and source of cost savings achievable from managed care varies by the type of managed care program, services incurred, the population to which it is being applied, and the current level of cost and utilization of the population.

There are two broad categories of Medicaid eligibles: (1) children and mothers in the Aid to Families with Dependent Children (AFDC) program and (2) the aged, blind, and disabled in the Supplementary Security Income (SSI) program. The health care needs of these two groups are clearly different: the AFDC population incurs more maternity and acute care costs, while the SSI population incurs more costs associated with chronic illnesses. Also, the SSI population is more likely to have Medicare coverage, which reduces a state's liability for their health care costs.

Potential savings vary according to type of health care service. Inpatient utilization tends to be high for the Medicaid population and, thus, provides a major opportunity for savings. Emergency room utilization as well tends to be high. The magnitude of the savings obtained by eliminating their use is diminished by the cost of the services that are substituted for them. However, generally care in outpatient settings can be delivered at lower cost than the hospital based alternatives. Any inpatient cost reductions are offset to some extent by the expense of increased outpatient costs as utilization is

shifted from a facility like a hospital to a physician's office.

Another major contributing factor to Medicaid costs is generally poor health habits. Treatment is often postponed until costly acute care is required. Some managed care programs have been successful at improving health care access and encouraging the population to seek primary care resulting in decreased acute care needs.

SUCCESS FACTORS

WITH MEDICAID MANAGED CARE

Several factors are critical to increasing the likelihood of realizing cost savings from managed care programs. These include **effectively communicating managed care goals and processes** to both the health care providers and health plans, as well as to the Medicaid beneficiaries. There must be **sufficient access to health care providers**, especially primary-care providers. This supports the goal of shifting care from a hospital facility to the physician's office, and is also essential to maintain quality of care.

Incentives that reward quality as well as cost-effectiveness must be in place and should be sustained. This allows health plans and providers, who make the effort to maintain and reduce costs, to benefit from their actions. **Utilization management programs** should focus on those areas that account for the greatest portion of costs, while at the same time preserving a sufficiently broad focus to manage the overall cost. In other words, cost reductions should not reduce costs for one expense category while increasing them by a corresponding amount for others.

The **financial stability and administrative systems** of the health plans should be assessed and monitored closely to ensure the long-term viability of the managed care system as a whole. Lack of financial reliability, or poor service resulting from deficiencies in the administrative systems, will undermine the success of any managed care approach.

Since most Medicaid managed care approaches include some degree of competition among health care providers or health plans, **some regulation of marketing and sales practices** should be considered to ensure that plans are not being marketed in a way that might mislead beneficiaries or undermine the overall success of the managed care arrangement.

Finally, **sufficient time should be allowed** for the managed care programs to exert their effect. Since success with managed care requires that both providers and beneficiaries learn new behaviors, inevitably some time will elapse after the implementation of a managed care program and clear evidence of its cost effectiveness.

IMPLEMENTATION CONSIDERATIONS

States can save money in contracting a managed care program, but it may sharply impact the state's cash flow. Capitation payments are usually made during the first few business days

for each month. At the beginning of implementation, the state is still paying off the residual claims from the fee-for-service program. Since most state budgets are on a cash basis, Medicaid funding increases when a managed care program is initiated.

In implementing a managed care program, several design features can affect the timing and magnitude of savings. First, the **program can be voluntary or mandatory** for Medicaid beneficiaries. A mandatory program lets the state realize cost savings more quickly. But a voluntary approach, when used as a transition to a mandatory program, gives all the parties more time to adapt to changes. Bear in mind that a voluntary approach is likely to be subject to adverse selection, in that people can choose to participate in such a way as to add to costs.

The managed care program could be **implemented on a pilot basis or statewide**. The pilot approach lets the managed care activities be targeted to areas with higher costs and thus maximizes relative cost reductions.

The **program can be competitively bid, or a state can set a rate** and a health plans or providers can choose to participate. The latter approach may give states greater control over rates and expenditures, however states that accept bids almost always place limits on how high or low the bids can be. However, the established rates may end up being too high or too low for particular areas, which can affect the willingness of plans and providers to take part and the program's success in lowering costs.

FEDERAL REFORM OF MEDICAID

Congress has proposed that the current method of federal funding for Medicaid be replaced with block grants or a similar allocation method to states. This approach would transfer all the risk of the program from the federal government to the states.

In addition to the policy issues surrounding the block grant approach presented lawmakers, political and ideological differences arose during the debate to reform Medicaid in the 104th Congress. The primary issue to resolve was whether to keep Medicaid as a federal entitlement or turn it over to the states.

An alternative to block grants would have repealed a number of federal standards and provided states with more flexibility to determine how to provide health care, but would have preserved the federal entitlement including federal eligibility standards and benefits. Another approach discussed by a group of bipartisan governors, would turn the program into a state entitlement and remove the original block grant allocation formula.

These Medicaid reform proposals could have implications both to the federal government in helping to stabilize the federal deficit, as well as to states. These implications will be driven by the population included in the program, the implementation approaches chosen, and the degree of the transfer of risk between the federal government, state government, and other involved parties.

States' Requirements in Medicaid Programs

Medicaid is an aggregation of programs providing both acute and long-term care services to various populations. In general, eligibility for the programs relies on various criteria but emphasizes means testing — that is, income and/or assets must be below stated thresholds. Funding for these programs comes from both federal and state sources. The design is at the state level, but the programs must meet certain federal standards to receive the federal matching funds. The costs of Medicaid have been increasing at a rate significantly greater than most other economic indices. This is partly due to an increase in the populations served by these programs and partly due to an increase in health care costs and utilization. Because of these cost increases, Medicaid is part of the current public policy debate. Most of the proposals to date have focused on acute care services. In addition to system wide proposals to overhaul Medicaid, there is a great amount of state specific experimentation underway.

Several state governments, with approval of the federal government, are in the process of transferring the financial risk entailed in providing health care coverage for their Medicaid populations to private health plans. Until recently, the federal government has been reluctant to change rules that originated with the basic precepts of the original Medicaid program. The Clinton Administration has continued the process of considering state applications to waive Medicaid program rules, thus allowing states to experiment with novel service delivery and risk-sharing options.

There are limits to the new flexibility, though. States must cover a list of mandatory services as prescribed by the federal government. These include inpatient and outpatient hospital services, nursing facility services for individuals age 21 or older, physician services, laboratory services, early and periodic screening, diagnostic and treatment (EPSDT) for individuals under 21 (comprehensive physicals), family planning services, home health services for any individual entitled to nursing facility care, rural health clinics and federally qualified health center services, and services of nurse-midwives, certified pediatric nurse practitioners, and certified family nurse practitioners. States can opt to go beyond this basic list and include coverage of additional services as well.

In addition to specifying rules for covered services, each state's fee-for-service program must meet four guidelines regarding beneficiaries' access to care and comprehensiveness of coverage. A brief description of each guideline follows:

1. Amount, duration, and scope: Each service must be of sufficient amount, duration, and scope for a reasonable expectation of achieving its purpose.
2. Comparability: The services available to any "categorically needy beneficiary" (defined below) in a state must, generally, be equal in amount, duration, and

scope to those available to any other categorically needy beneficiary in the state.

3. Uniformity throughout the state: The amount, duration, and scope of coverage must be the same statewide.
4. Freedom of choice: Beneficiaries must be free to obtain services from any provider willing and qualified to provide the services.

WAIVERS

States can bypass federal mandated rules and implement managed care programs by obtaining a waiver from the federal government. The Health Care Financing Agency (HCFA) grants two kinds of Medicaid waivers: Section 1115 demonstrations and Section 1915(b) "freedom of choice" waivers. These can be comprehensive or limited; both, however, are granted for limited time periods. States seeking to implement statewide comprehensive reforms require Section 1115 waivers. Section 1115 waivers allow states to test new approaches to benefits, services, eligibility, program payments, and service delivery, often on a statewide basis. These approaches are aimed at testing innovative cost containment strategies. States can also expand program eligibility beyond traditional Medicaid populations.

More limited in scope is a Section 1915(b) waiver, also referred to as a Freedom of Choice waiver. These waivers permit states to require beneficiaries to enroll in managed care plans. To receive such a waiver, states must prove that these plans have the capacity to serve Medicaid beneficiaries who will be enrolled in the plan. States often use Freedom of Choice waivers to establish primary care case management programs and other forms of managed care.

The penetration of managed care within the Medicaid population has been slow, in part due to the complexity of the waiver process. Another problem with integrating managed care into the Medicaid population is the rapid turnover in Medicaid eligibles. The actual participants who are eligible for Medicaid is not constant over time. Individuals who may be eligible for Medicaid coverage at one point in time, may not be eligible for coverage at a later date. Since managed care has not been widely used within the Medicaid populations, many managed care plans do not have the requisite information for evaluating the risk characteristics or utilization patterns of the Medicaid population. In order to protect themselves against unexpectedly high costs, therefore, many health plans transfer the risk to participating providers, through downstream risk-sharing arrangements. Such arrangements would typically pay providers on a per capita basis or as a percentage of the fund paid by the state, thus having the providers (physician groups, hospitals or other entities) bear the risk for both the cost and value of services. Alternatively, the reimbursement level may be reduced if the volume of services is excessive.

ELIGIBILITY

States must provide coverage to individuals based on eligibility criteria, in regard to two main categories: the categorically needy or the medically needy. Most states define the categorically needy as individuals who receive Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) cash assistance. States may also cover persons who are medically needy, i.e., people whose income, after deducting incurred medical expense, falls below the threshold level set by the state for this category.

Essentially, the program offers coverage to three broad categories: families, children and pregnant women, the aged and the disabled. Coverage for families, children, and pregnant women was linked historically to their receiving cash assistance (potentially or in fact) under the AFDC program. (All states have set AFDC eligibility below the federal poverty line.) In addition, state Medicaid programs usually cover anyone eligible for SSI, which provides cash assistance to low-income aged, disabled, and blind individuals. However, states are required to provide coverage for SSI and AFDC individuals.

TRANSFER OF RISK

States utilize various risk-transfer arrangements in their Medicaid managed care programs, and it is not unusual for a state to have several types of programs operating simultaneously. In full-risk capitation programs, states contract with private or county-run health plans to provide a full range of services to Medicaid beneficiaries. These health plans can include HMOs, insurers, and other diverse organizations that may participate in this program. States can also contract with the federally funded community health centers that serve Medicaid and other low-income individuals. Full-risk capitation programs are now the fastest-growing type of Medicaid managed care program.

Partial capitation programs resemble the carve-out programs of the private sector: States contract directly with providers, on a capitation basis, for a defined set of services. The state continues to pay fee-for-service reimbursement for any services not part of the contractual arrangement.

Primary care case management (PCCM) is considered a managed care program, but it does not rely on risk transfer as a mechanism for controlling utilization. Instead, primary care providers are responsible for approving and monitoring most services, and they are paid a per-eligible fee for their case management work. However, all their professional services are reimbursed on a fee-for-service basis.

STATE ACTION

Faced with budget projections that indicate that Medicaid expenditures are, or soon will be, the biggest single item in their budgets, many states are taking advantage of the new hospitable waiver process to reform their Medicaid programs and reap the benefits of managed care. Six states have imple-

mented Section 1115 waivers programs.

However, state officials are becoming concerned that federal budget cuts that affect the Medicaid program may force them to recalculate their payments to managed care plans, irrespective of the specific type of risk-sharing arrangements they have in place. Cuts in federal payments to states could worsen the risk profile of the Medicaid beneficiary pool, if states respond by tightening their eligibility criteria. (Health status may be worse for the poorest segment of the population.) Utilization of acute care services may also increase if states no longer cover the services that facilitated early detection of illnesses.

KEY FEATURES OF COVERAGE IN REPRESENTATIVE STATES WITH SECTION 1115 WAIVERS

Arizona: The Arizona Health Care Cost Containment System (AHCCCS), a fully capitated statewide Medicaid system, was approved under a Section 1115 waiver in 1982. At that time, it was the only state not participating in the federal Medicaid program. All eligible individuals are required to enroll in one of the participating private health plans, which are paid a capitated amount by the state. Health plans are selected by a competitive bidding process. The capitation arrangement covers all the covered services, although the state pays for some services on a fee-for-service basis if a beneficiary receives care before joining a health plan. Beneficiaries are required to stay in their chosen health plan for a minimum of one year.

Key element: Risk transfer through capitation.

Oregon: Oregon uses a prioritized list of services as a basis for its Medicaid program. Prioritization is generally based on a consensus-building process that in concept compares the cost of treatment with the ability of such treatment to improve health status. The program covers 565 of the 696 health services included in a list developed by a state commission; any future changes to the list must be approved by HCFA. By omitting some services that would normally be covered, Oregon has been able to expand eligibility to all individuals under 100 percent of the poverty level. Oregon contracts with (1) 20 fully capitated health plans, (2) physician care organizations that are capitated for physician services but not at risk for other services such as inpatient services and prescription drugs, and (3) managed fee-for-service plans (in rural areas). For each enrollee, plans are paid one of 20 different capitation rates, based on the enrollee's eligibility category and geography.

Key elements: Risk transfer through full and partial capitation. Prioritized list of services, as a trade-off between limiting costs and expanding eligibility.

Hawaii: Hawaii has combined three programs—Medicaid, the General Assistance medical care program (GA), and the State

Health Insurance Program (SHIP)—into one, Health QUEST. The program expands eligibility up to 300 percent of the poverty level for non-disabled persons and uses a sliding premium scale for those between 133 and 300 percent of poverty. Only five of the 26 prepaid health plans in Hawaii submitted bids to become a part of the QUEST system; all were awarded contracts. The state pays managed care plans capitated rates that vary by age, gender, eligibility category (AFDC, GA, SHIP, etc.), and region.

Key element: Risk transfer through capitation.

Rhode Island: Rhode Island's waiver program began on August 1, 1994. This program, in time, will shift all AFDC eligible individuals into capitated managed care programs and expand coverage to pregnant women and children under 6 years of age to between 185 and 250 percent of poverty. Five plans have been awarded contracts; one is composed of several community health centers. Roughly 40 percent of Medicaid beneficiaries in Rhode Island receive services through community health centers. Although the program expands eligibility, it will be budget-neutral over a 5-year period.

Key element: Risk transfer through capitation.

Tennessee: Tennessee's waiver lets the state provide coverage to all uninsured residents, regardless of income. The state contracts with 12 managed care organizations and pays them a capitated amount per enrollee. Providers are currently paid \$1,280 per enrollee, roughly 20 to 50 percent less than traditional Medicaid payments. Enrollment in TennCARE has been suspended at a level of 1.1 million individuals, over 300,000 of whom were previously uninsured. TennCARE charges premiums, deductibles, and copayments based on income for individuals above 100 percent of the federal poverty level. The program emphasizes preventive care by covering all such services without copayments or deductibles. However, because of its low capitation rates, some providers have declined to participate in the program; consequently, there are primary-care-provider shortages in some areas of the state.

Key element: Risk transfer through capitation.

Minnesota: Minnesota's recently approved waiver application would expand the state's current Medicaid managed care programs statewide. All Minnesota Care enrollees would be covered by managed care. Minnesota Care provides coverage for acute-care services to families with incomes below 275 percent of the federal poverty line. Without a Medicaid waiver, Minnesota would have been responsible for the entire cost of the Minnesota Care program; with it, the state will pay only 46 percent of the program's projected cost. Minnesota currently pays managed care plans based on a methodology similar to Medicare's average adjusted per capita cost (AAPCC) method, which uses age, sex, Medicare status, institutional and eligibility status, and county of residence to calculate capitation rates. Under the waiver, families with children will pay premiums based on family income. Sliding-scale premiums and cost-sharing by the federal government should generate program savings and allow the state to expand coverage

Key element: Risk transfer through capitation.

RAMIFICATIONS OF FEDERAL REFORMS

If the federal government approves some form of block grants, states may no longer need waivers to implement managed care options for their Medicaid population. However, greater flexibility will come at a cost to the states as the total amount of money coming from the federal government will be reduced. The states will be compelled to choose among several options: tighter eligibility; cut payments to providers; reduce the amount, duration, or scope of services covered; or move beneficiaries into managed care plans. If the cuts are sufficiently severe, states may be forced to implement multiple strategies to stay within budget and still maintain services for low-income population.

If cuts in federal payments compel material reductions in capitation payments from states to health plans, it is unclear whether Medicaid managed care will remain a viable market for private health carriers. The remaining sections in this monograph will provide some insight for states interested in setting up a Medicaid managed care program.

Critical Factors for Success with Medicaid Managed Care Programs

Certain factors are critical to the success of all Medicaid risk transfer programs, regardless of the specifics of program design. Some are critical to the success of commercial managed care programs as well; some, however, are relevant to Medicaid populations only. A description of eleven such factors follows.

GOVERNANCE/POLICY DIRECTION

Both the state-level risk-transfer program and each of the organizations to which the risks are transferred will need effective policy guidance from state boards or similar policy-setting bodies. To be fully effective, the boards need to include, or have ready access to, people with knowledge/expertise in:

- The delivery of health care to the Medicaid population covered by the program.
- Managed care techniques.
- The delivery of related social services to the Medicaid population covered by the program.
- Grass-roots knowledge of the beneficiary community(s) covered by the program.
- Business/finance and actuarial science, especially pertaining to health insurance.

The boards should provide guidance and direction in the planning and implementation of risk transfer programs. They should also provide ongoing oversight of program operations, insisting upon and reviewing regular reports on critical issues, some of which are unique to particular programs, but including, at minimum, details regarding access to care, quality of care, and finances.

Finally, it is essential that the lines of authority and areas of responsibility—administrative, clinical, and financial—be clearly defined and communicated. This requirement relates closely to the next critical success factor.

EFFECTIVE COMMUNICATION

There are significant barriers to effective communications in a Medicaid risk transfer program: the difficulty of coordinating public and private sector organizations; a transient, mobile beneficiary population; language and literacy barriers; diverse cultural patterns, especially with respect to health care issues; problems of poverty; and compounding health care problems.

It is important that open communication is fostered

among and between the state, the Medicaid beneficiaries, the health plan, and health care providers.

A broad range of subjects must be communicated clearly to maximize the program's success. They include detailed information about the Medicaid program (policies, eligibility, finances, restrictions, limitations, etc.); information regarding the delivery of health care, such as how to choose a primary care physician, what to do when that physician is not available, medical emergencies, etc.; and information on specific health care problems—required frequency of appointments, possible treatments, restrictions in activities, medications, etc.

COMMUNITY UNDERSTANDING, ACCEPTANCE, AND SUPPORT

Regardless of the soundness of the program design or the good intentions of those who propound them, most Medicaid risk transfer programs create questions and hesitation — among beneficiaries, their advocates, health care providers, and health plans. Moreover, no program, no matter how sound its design, can withstand concerted efforts to undermine it. Therefore, it is essential that all the key players — beneficiaries, health care providers, and health plans — understand, accept, and support the program. In addition, the program should receive sufficient ongoing support from the public.

This success factor is directly linked to the composition of the board that oversees the program. Community acceptance is more likely if the board includes people who are familiar with the beneficiary communities and those communities are encouraged and stimulated to participate actively in board deliberations and decisions.

SUFFICIENT ACCESS TO HEALTH CARE PROVIDERS

Both the gains in quality and reductions in cost achievable through Medicaid risk transfer programs depend on shifting health care delivery from the emergency room and hospital inpatient setting to other, less costly settings — especially the primary care physician's office, for care provided either directly by the physician or physician extenders. Therefore, it is essential that sufficient primary care be available, bearing in mind that the definition of "sufficient" can vary greatly, depending on local circumstances. But at a minimum, primary care must be accessible — in terms of location, availability of transportation, office hours, ease of access, and language.

INCENTIVES FOR COST-EFFECTIVENESS AND HIGH-QUALITY CARE

For a workable system, four key constituencies must see tangible rewards in response to their cost-effective behaviors: state government, the health plans/organizations to which risk is transferred, health care providers, and beneficiaries.

Incentives among all these must be aligned, which is a difficult, but not impossible task. Some possible incentives are block grants to states, capitation payments to health plans and/or providers, incentive payments, increased patient volume (if desired), and cash or other rewards to beneficiaries. It is important that good performance not be penalized by rapid reductions in reimbursements that reflect managed care efficiencies, although political and budgetary pressure can lead to precisely this result. The guiding principles must be alignment among financial incentives and sharing of any savings achieved.

The other approach, penalties for cost-ineffective behaviors, is more ambiguous. Possible penalties might include removal from the program, benefit restrictions, and financial penalties. Public policy parameters may limit or preclude many potential penalties, at least with respect to individuals, as opposed to organizations. As a result, a focus on incentives rather than penalties is likely to be more acceptable.

The risk characteristics and average health care costs of Medicaid beneficiaries vary widely. If Medicaid beneficiaries can select among competing health plans, it is also important that the amounts paid to each health plan properly reflect the risk characteristics of the beneficiaries for whom the plan is responsible. Therefore, a risk adjustment mechanism will be necessary if the proposed program has any element of choice—for example, if the state allows beneficiaries to select between the current program and a managed care health plan. This choice creates risk segmentation and a risk adjustment mechanism would be needed to spread the risk over all carriers or health plans involved in the program.

Failure to do so may result in unintended windfalls to plans selected by populations with favorable characteristics, along with unintended penalties to plans selected by populations with unfavorable characteristics. Neither the windfalls nor the penalties may be related to the plan's effectiveness or efficiency, thereby diluting or subverting the incentives for cost-effectiveness.

EFFECTIVE UTILIZATION MANAGEMENT

Given sufficient access to care, and incentives that work to promote cost-effective behavior, enhancing quality and reducing costs depends on effective utilization management. Successful programs achieve savings primarily in three areas—reduction in emergency room visits, reduction in the volume of hospital inpatient care, and control of prescription drug costs. Achieving these results depends, in turn, on effective utilization management in general, and, in particular, on inclusion of the following programs:

- Aggressive emergency room triage, with cost-effective alternatives available for treatment of less urgent problems.
- Concurrent review of inpatient hospitalizations, coupled with early discharge planning, social service support programs, and home health care.
- Case/disease management, tailored to particular conditions common among the chronically ill and/or special Medicaid eligibility categories.
- Improved access to primary care, via primary-care physician group practices, primary-care clinics, physician assistants, etc.—coupled with incentives to use primary care rather than hospital-based care.
- Regular prenatal care, commencing early in pregnancy (and thus requiring an aggressive and effective outreach program to pregnant women eligible for Medicaid).
- Use of a cost-effective drug formulary, coupled with tight-control programs to prevent excessive prescription/dispensing of drugs.
- Availability of mail-order drugs, properly controlled, for the chronically ill in particular.

Effective utilization management programs are particularly dependent on effective communication programs and must, in some instances, overcome cultural and behavioral barriers to cost-effective health care. They are also dependent on good information systems, an element of the next critical success factor.

EFFECTIVE ADMINISTRATION SYSTEMS

Effective administration systems are also critical to the success of these programs. These include the systems internal to the state Medicaid program and the connections between the states' systems and those of the health plans or providers assuming risk. The key systems are those that handle enrollment, communication with beneficiaries, payment for health care services, utilization management and measurement, quality measurement and management, and management information in general.

The qualifying criteria for a health plan wishing to participate in a Medicaid risk transfer program should include careful specification as to the plan's systems capacity and testing to be sure that the health plan's systems meet capacity standards. The systems of the state Medicaid program must also be able to support risk transfer arrangements and health plan interfaces. This may require significant investment in system development and/or improvements.

FINANCIAL STABILITY/RISK-BASED CAPITAL OF ORGANIZATIONS ASSUMING RISK

The transfer of risk to health plans can result in financial incentives that reward cost-effective performance. However, defaults by organizations unable to perform adequately can

negate the positive performance of other organizations. Therefore, it is important that the risk-assuming organizations have sufficient financial capacity to accept the risks transferred to them, including the ability to withstand the statistical deviations from expected results that inevitably occur.

The risk-based capital standards recommended by the American Academy of Actuaries for organizations assuming health insurance risks can be used as a guide to minimum capital requirements, which depend on the specifics of the risks assumed.

One factor that determines the amount of capital required is the level of stop-loss/reinsurance protection in place for a given health plan. States may want to impose minimum stop-loss insurance requirements, or provide that protection themselves by limiting the proportion of the Medicaid risk that is transferred to the health plans. For example, the state could reimburse the health plan for a portion of health care costs above some stipulated threshold level, thus retaining much of the risk of high-cost patients within the state Medicaid program it could carve out, from the risks transferred via capitation, the cost of specified high-cost, low-frequency conditions or procedures—for example, AIDS or organ transplants.

Another risk to the solvency of health plans relates to capitation payments. Extremely severe cuts in the capitation rates states pay to managed care plans may lead to health plan insolvencies. Capitation payments may prompt plans to withhold services from Medicaid beneficiaries.

CONTROL OF MARKETING ABUSES

Unfortunately, some plans have made fraudulent or misleading statements to Medicaid beneficiaries, inducing them to enroll in health plans that failed to deliver the benefits promised or were otherwise inappropriate for the beneficiaries.

To prevent such abuses, the state must either control all the health plans' marketing materials and practices tightly or, as an alternative, control the assignment of members to health plans. Another alternative seen in some states is to provide professional enrollment counselors. Although controlling the assignment of members to health plans may appear anti-com-

petitive, the characteristics of the Medicaid population (short-term eligibility status, communications barriers, special health problems) may well fit quite well with a state-controlled assignment process—effectively shifting the “customer” role in the competitive process from the individual beneficiary to the state program itself.

FAVORABLE REGULATORY ENVIRONMENT FOR MANAGED CARE

Achieving improvements in quality and cost savings for Medicaid beneficiaries requires effective managed care techniques. Regulatory restrictions on managed care organizations will tend to impair the risk transfer program and lessen the gains that emerge. State-mandated coverage of specific medical conditions, limitations on managed care techniques, or restrictions on formation or administration of provider networks may reduce or negate the positive effects sought. Of course, the costs of such restrictions—to the Medicaid program and others—must be weighed against public policy considerations that may dictate that such costs are worthwhile. In general, however, a regulatory climate conducive to managed care is an important success factor for any Medicaid risk transfer program. It is also important that the state regulates the entire health care delivery and insurance market consistently, in order not to provide incentives or advantages for specific insurance markets.

SUFFICIENT PHASE-IN TIME

Medicaid risk transfer programs are inevitably complex. They involve myriad issues that pertain to communications, systems, public policy, and public perception. While it is important not to delay implementation unnecessarily, it is advisable to implement risk transfer on a phased-in basis. Two alternatives are gradual implementation, by county or other geographic subset of the state, or implementation by eligibility category.

Size and Source of Savings from Managed Care

FEE-FOR-SERVICE DATA

Estimating the amount of savings a given Medicaid program can expect from implementing managed care depends on measures of the level of utilization in the predecessor fee-for-service programs, that is, those without managed care. While there are varying amounts of data available, depending on the state, some general observations can be made on the amount and form of data available, and specific Medicaid issues related to interpreting data.

ELIGIBILITY CATEGORY AND UTILIZATION

The level of utilization varies significantly by eligibility category. As stated before, the categories are AFDC and SSI. SSI is further separated into aged, blind, and disabled. (For statistical purposes, the blind are usually grouped with the disabled since there are very few blind eligibles.) The different eligibility categories show different utilization rates and patterns. For example, hospital utilization rates in the SSI program tend to be two to six times that of the AFDC program because of the greater health care needs of the SSI population.

A significant difference between the aged and the blind/disabled is that a much higher percentage of the aged are eligible for Medicare. While Medicare eligibility does not affect underlying utilization, it does affect Medicaid's liability for the cost of the services. Medicare eligibility strongly influences the types of medical services for which Medicaid is responsible. For example, Medicare covers 90% or more of inpatient hospital care, about 80% of physicians' services and provides no coverage of prescription drugs. Thus Medicaid must be analyzed as a collection of programs, not as a single entity.

CATEGORIES OF SERVICE

The specific amount of potential savings achieved by introducing managed care will vary by medical service category. The following are comments about Medicaid in general; each state may differ from what is noted here.

Hospital Inpatient and Emergency Room Services

Inpatient utilization is very high in most states. Frequently, Medicaid eligibles are treated by physicians unfamiliar with their medical history — in part because about one-quarter of physicians do not accept Medicaid patients at all, while another one-third limit the number of Medicaid patients they will accept. Also, relatively fewer physicians are based in low-income areas. Hospital-based clinics and emergency rooms may be the easiest places for Medicaid eligibles to get care. Consequently, emergency room utilization rates are frequently high, ranging from three to six times that in a normal commercial population. Also, physicians' lack of knowledge about

particular Medicaid patients may result in higher admission rates, since physicians may more readily admit a patient they are not familiar with than one whose medical history they know in detail.

In addition, many states reimburse hospitals at a higher rate, relative to cost or charges, than physicians. This is especially true when all the various forms of reimbursement are included, such as medical education and disproportionate-share payments.

Physician Services

In general, all populations have a high use of physician services. However, the relative lack of access to physicians by Medicaid eligibles may partially offset this tendency. The difficulty in securing accurate, detailed data on utilization rates for physician services limits the accuracy of this measurement, unless the state has proper database capacity.

Long-term Care

Long-term care services, used primarily by the SSI population, consume a significant proportion of Medicaid costs. For example, in 1991, long-term care services were responsible for about 37 percent of total Medicaid costs. Since very few managed care programs include long-term care services, it is unclear what the potential savings might be. Arrangements that have capitated all components of Medicaid's long-term care program for over 7 years have estimated savings as high as 20 percent. The cost and coverage implications of long-term care services in relation to Medicaid, as well as Medicare, deserve greater attention outside this monograph.

SOURCES OF DATA

Many states provide experience data on their fee-for-service Medicaid populations, especially in preparation for managed care contracting. The amount of detail and quality of the data vary by state. Cost-per-eligible data is almost always available, but the data are not always in sufficient detail to allow full actuarial analysis of the Medicaid risk. Utilization data may not be available or difficult to interpret because of discrepancies in coding methods. Moreover, there is a need for more detailed census data of the covered population than what is currently available. For example, some states may report SSI enrollees in the aggregate and nearly all report AFDC data in very broad age and sex categories. Detailed actuarial analysis requires that the census reports and claims data be more refined.

LOCAL ISSUES

Utilization patterns of Medicaid eligibles are strongly influenced by the reimbursement methods the states use. Several states have set physician fee schedules as low as 50 percent of what is paid under Medicare, or even less. Physician partici-

pation in Medicaid in these states is extremely low, since the reimbursement paid for services may be less than the physician's overhead, with nothing included as compensation for the physician's time.

Some states have very low physician fee schedules but reimburse hospital-based clinics more favorably. These clinics may not be considered part of a hospital outpatient department, but instead, have separate cost-based reimbursement rules. This practice allows them to accept Medicaid patients if reimbursement is consistent with private-practice physician reimbursement. Thus, utilization of physician services may be relatively low when these clinics are available, since the clinics accept Medicaid patients much more readily than physicians do.

In some states, emergency-room reimbursement is very low, as low as 10 percent to 20 percent of the charges billed. Thus, the usual result—significant savings when unnecessary emergency room visits are moved to a physician's office may not apply, except for the savings that may accrue from improved continuity of care.

MANAGED CARE DATA

The following tables provide examples and analysis of comparisons between fee-for-service and managed care programs, statewide utilization differences, and potential savings under Medicaid programs.

Table 1 compares utilization rates in a Medicaid AFDC fee-for-service population with the utilization rates experienced by PCA STAR Health Plan in its first year of operation in Travis County, Texas. It is important to note that the PCA STAR population is the same AFDC population as before managed care began. The unmanaged utilization rates are for a baseline period, before the HMO began operation.

The managed care program significantly decreased both emergency room visits and inpatient day utilization, while increasing the rate of preventive services. But there is room for greater efficiency: compare the utilization rates posted in the tenth year of Arizona's managed Medicaid program. In addition, unmanaged Medicaid AFDC inpatient utilization in California was about 350 days per 1,000 during 1992–94.

Table 1
Medicaid AFDC Eligibles Annual Utilization per Thousand Eligibles

	Travis County, Texas		
	Unmanaged Program	First Year of Managed Care	Arizona Year 10
Emergency Room	930	660	163
Inpatient Days+	1,090	530	421
Neonatal Cases	4.94	4.34	—
Neonatal Days	115	60	—
EPSDT*	350	530	1,360
Immunization	490	910	—

*Early and periodic screening diagnostic & treatment

+Includes newborn days

Table 2
Arizona Health Care Cost Containment Services (AHCCCS)
Annual Utilization per 1,000 Eligibles

	Year 9	Year 10	Year 11
Emergency Room Visits	165	163	194
AFDC			
SSI Medicare	79	85	106
SSI Non-Medicare	160	145	163
Hospital Inpatient Days (Includes Newborn)			
AFDC	448	421	409
SSI Medicare	1,234	1,127	1,011
SSI Non-Medicare	1,449	1,377	1,420

Table 2 summarizes the statewide utilization rates in Arizona's managed Medicaid program in the ninth, tenth, and eleventh years of operation.

With managed care, Medicaid emergency room utilization rates are much lower than in unmanaged populations (a finding generally consistent with a commercial population). Unmanaged Medicaid emergency room utilization rates range from 500 to 1,200 visits per 1,000. Fee-for-service hospital inpatient utilization in an AFDC population averages 700 to 1,000 days per 1,000.

Table 3 presents a simple model of the annual cost per capita for AFDC and Disabled eligibles. Blind eligibles are excluded due to their low number. Aged eligibles are excluded due to their high proportion of Medicare coverage, which means that most of the managed care savings accrue to Medicare, not Medicaid. The data are based on national average Medicaid experience for federal fiscal year 1991.

Table 4 presents ranges for the potential savings from managed care, as compared with an unmanaged program. The ranges were selected after a review of the data on managed care savings achieved to date in both Medicaid and commercial populations.

The low end of the range represents potential savings from a program with a moderate degree of management—in the early years of a managed care program. The high end of the range represents potential savings from a highly effective,

Table 3
Medicaid Annual Cost per Capita Federal Fiscal Year 1991

Category of Service	AFDC	Disabled
Facility: Hospital inpatient	\$ 611	\$2,080
Hospital outpatient*	156	400
Physician	351	1,360
Pharmacy	78	640
Other	104	480
Subtotal	\$1,300	\$4,960
Long-term care	—	\$3,140
Total	\$1,300	\$8,000

*Includes emergency room care

Table 4
Potential Managed Care Savings From Unmanaged Medicaid Program

Category of Service		Percentage
Facility:	Hospital inpatient	40% to 60%
	Hospital outpatient	30% to 40%
Physician		-20* to 0
Pharmacy		0 to 10
Other		0 to 10

*Indicates increase in utilization due to shifting from hospital services

well-managed program—a mature managed care program. These savings are not guaranteed; the programs require substantial efforts by both managed care health plans and participating providers. Actual managed care programs may achieve utilization savings either above or below the ranges shown.

Long-term care is not included: there are not enough data on the potential savings in this category. Note that long-term care accounts for roughly 40% of the costs for the disabled.

Table 5 shows the medical cost savings that result when the utilization savings cited in Table 4 are applied to the per capita costs noted in Table 3 (assuming no change in provider reimbursement levels). These savings are in medical costs only; the amounts shown will be partially offset by the managed care plans' administrative costs, (which range from 8 percent to 14 percent of total medical costs). Administrative costs for traditional state Medicaid programs' costs are considerably less—from 2 percent to 4 percent of total medical costs.

Table 5
Overall Potential Managed Care Savings

AFDC	17% to 34%
Disabled	14% to 30%

IMPLEMENTATION CONSIDERATIONS

Many important issues confront states introducing Medicaid risk contracting for the first time, including administration and policy issues. The proper consideration of these issues can reduce the risks that may otherwise result from the way the program is put in place.

A new Medicaid risk program affects four major groups: health plans (the managed care organizations), providers, Medicaid beneficiaries, and the state Medicaid agency. The support of all these groups is critical to the success of this program.

ADMINISTRATIVE ISSUES

The introductory period is a crucial time; good communications among all the groups mentioned above are vital. This task includes releasing information on time, holding meetings

to allow the health plans and state Medicaid agency to exchange information, and releasing communiqués to beneficiaries announcing and promoting the new managed care program. Effective communications produce several benefits: wide acceptance of the program, sufficient time for the health plans to assess the risk involved and determine whether they want to participate in the program, a greater capacity among health plans to develop quality networks to service the Medicaid population, and a greater probability that beneficiaries will view the change as positive. In a voluntary system, they may be more inclined to choose the managed care option.

On the other hand, poor communications have negative consequences, both short- and long-term, for a new program: the adversarial relationship, which may become firmly entrenched, between the state Medicaid agency and the health plans, confusion among all parties concerned, a decision by some health plans not to participate (possibly resulting in no coverage at all in some areas), and difficulty in developing provider networks. Also, in subsequent years, some health plans may decide to pull out, precipitating instability in the program.

During the program's initial phases, it is imperative that the state Medicaid agency enforce all its regulations strictly (e.g., restrictions on sales and advertising). There may be some pressure to relax some of the rules, to help the program gain momentum, and then tighten up later on. But, this tactic can cause problems: health plans may come in just to amass short-term profits and then quietly exit the market.

Even though managed care contracting can save states money, it may sharply impact cash flow. Capitation payments are usually made during the first few business days for each month. At the beginning of implementation, the state is still paying off the residual claims from the fee-for-service program. Since most state budgets are on a cash basis, Medicaid funding increases when a managed care program is initiated.

Depending on a given state's goals, there are various ways to implement a Medicaid risk program. The goals can be influenced by the several groups mentioned above, and by political and economic factors as well.

POLICY ISSUES

Three items in particular affect the way a Medicaid risk program is implemented. They include whether a program is mandatory or voluntary, statewide versus a pilot program in specified areas, and if the state Medicaid agency promulgates rates or invites a competitive bids.

Medicaid risk programs can be mandatory or voluntary. If the program is mandatory, all Medicaid beneficiaries must receive services from a health plan that participates in the program. Otherwise, the state maintains its current program, and beneficiaries can select between the current program and a managed care plan that creates risk segmentation.

A voluntary program may or may not be permanent. If not, it is used as a transition to a mandatory program. Using a voluntary program in this fashion has several advantages. First, it helps beneficiaries, providers, and health plans become familiar with managed care as it functions within the Medicaid

program. Second, beneficiaries have time to experiment with managed care. Finally, health plans and providers can limit their risk while adjusting to the needs of a new population. On the other hand, a mandatory program lets the state realize its desired cost savings immediately.

Also, a Medicaid risk program can be put in place statewide, or introduced as pilot programs set up in specific areas. State officials may decide to cover the whole state, thereby providing more beneficiaries with access to managed care. In addition, the state would realize greater savings. But starting out with pilot programs offers benefits, too: the program can focus on areas with a high concentration of beneficiaries and health plans (e.g., metropolitan areas), and this approach allows time for identifying and correcting any problems before expanding the program to the entire state. In addition, it would provide more time for figuring out how to deal with areas that have little penetration by health plans and/or sparse provider coverage (e.g., rural areas). It is important to give the state Medicaid agency an opportunity for some transition period, instead of having to switch abruptly from a fee-for-service program into a managed care program all at once, which can be a difficult conversion.

Finally, the state Medicaid agency must decide whether to promulgate reimbursement rates or engage in a bid process. Promulgating reimbursement rates gives the state greater control over both rates and corresponding expenditures. Also, it is less time consuming than evaluating competitive bids. However, if the service areas that the health plans choose do not align exactly with the areas the state used in developing the reimbursement rates, the rates may be too high or too low for a given health plan within a given service area. This situation could result in a state not realizing its anticipated savings, health plans choosing not to participate, or health plans modifying their coverage areas to maximize their income, a move that could limit the size of the population with access to managed care.

A competitive bid process enables states to evaluate the overall savings, and would also allow health plans to obtain reimbursement rates that more accurately reflect actual costs in their particular service areas. Note that, in a bid process, the state may specify maximum rates and accept the bid for all or a portion of a health plan's service area. On the other hand, some health plans may submit bids which are lower than can be supported by their managed care systems. If allowed to participate in the program, these health plans run a risk of financial difficulty.

Problems can occur if the state regulates part of the process or regulates inconsistently. For example, the state approves hospital rates and sets HMO capitation levels based on Medicaid experience, assuming that managed care will increase savings. Medicaid experience reflects deeper hospital discounts than HMOs have and requires HMOs to accept capitation but does not allow negotiation of hospital rates. Therefore the HMOs will probably lose money unless they can cut utilization significantly. In other states, HMOs can negotiate hospital rates yet are still unlikely to experience as deep a discount as Medicaid.

COVERED POPULATIONS

Most states begin their programs by covering their AFDC population. Later, the program may be expanded to other populations, such as the aged, blind, and disabled. These are higher risks, because of their morbidity characteristics and/or the credibility of the claims data used to estimate the reimbursement rates. Finally, certain populations, such as the aged residing in nursing homes, are normally excluded from the Medicaid risk program.

COVERED SERVICES

As a starting point, health plans are normally required to cover all the services currently administered by the state's current Medicaid program. These services are defined by both state and federal laws. Also, unless there is some regulatory dispensation, health plans must comply with the state HMO statutes; in consequence, coverage may expand if HMO regulations specify richer benefits than what is covered by Medicaid. If so, the state should adjust capitation rates to take into account the increase in coverage. In the same vein, a state may require that health plans cover additional services above and beyond those administered by the current Medicaid program. On the other hand, the state may carve out certain benefits (such as transplants and mental health coverage) and have them covered under a separate program, by other state agencies, or by retaining and managing the risk within the current Medicaid program. In this case, reimbursement rates are adjusted for the exclusion of these services. Finally, there may be some type of stop-loss coverage, where the state covers 100 percent of the expenses beyond a specified limit.

Health plans may be allowed to charge nominal copayments for certain services, but, in many instances, this is not practical. Most Medicaid services cannot be denied for failure to make the copayment.

PARTICIPATION IN THE MEDICAID RISK PROGRAM

States may impose a variety of requirements on the health plans that wish to participate in the Medicaid risk program. One of the more common is that the health plan be a state-and/or federally qualified HMO. Also, a health plan may be allowed to participate only if it accepts the state's contract, when the state is dictating rates, or, with a competitive bid process, if the state accepts its bid. Other participation requirements could be that all health plans operating within the state must participate in the Medicaid program or that any health plan that covers state employees must provide Medicaid coverage as well.

COMMUNITY SUPPORT

As discussed in the section on critical factors for success, for a program to prosper, both providers and beneficiary communities must support it. The state Medicaid agency and the

health plans need to help both groups understand the benefits of applying managed care to the Medicaid program.

Providers may already feel the added burden of managed care in their non-Medicaid business (e.g., more paperwork, more scrutiny by health plans, and being asked to assume risk). Applying managed care techniques to the Medicaid program may exacerbate this situation. The following points illustrate this issue:

- Paying providers according to the Medicaid fee schedule (or an equivalent capitation rate) may not be viewed positively by the providers, since the Medicaid fee schedules are usually so low and since there will be closer scrutiny of their practices.
- Capitating providers will be difficult, because a health plan may not be able to pay its commercial capitation rates.
- Primary-care physicians, in particular, may be asked to provide more services in a managed care environment for the same—or less—money.

Therefore, health plans will have to work hard to develop acceptable payment mechanisms. This is important because health plans need to maintain good relations with providers, not only for the Medicaid risk program but also for their commercial business and any future work on other types of risk contracts (e.g., Medicare and CHAMPUS).

The Medicaid agency and the health plans will have to expend considerable effort in educating the beneficiary community about managed care, because it requires significant behavioral changes on their part. Some examples of the new rules for beneficiaries: use emergency rooms for emergencies only, keep appointments, seek care before an illness has reached a critical stage, and use more preventive care. The last point is especially important for the AFDC population, since pre- and post-natal care is a critical component of managed care for this group.

The Medicaid agency and the health plans face two major problems in gaining the support of this population. First, there is a high amount of turnover, every month, among Medicaid beneficiaries. Second, the monetary incentives (such as copayments and coinsurance) employed in the commercial market will not work in the Medicaid populations.

DATA AND REIMBURSEMENT RATE DEVELOPMENT

One of the bigger problems, for both the state Medicaid agency and the health plans, is the data that Medicaid agency must rely on in developing reimbursement rates, because the Medicaid program has in the past been run on a fee-for-service basis. Therefore, the data will not likely be in a form easily adaptable to the managed care environment. Some data issues result from the fact that data have been collected on groups made up of broad age bands. Health plans do not have the ability to audit the Medicaid agency's data, and there are credibility issues that arise from data quality and/or small sample sizes.

When a Medicaid risk program is implemented, health plans must rely on the state Medicaid agency for data for the first year and, possibly, the second year as well. Even when a health plan participates from the beginning of the program, it may not have sufficient credible data of its own compiled by the time the renewal date comes around. (This is true as well for any rapidly growing block of new commercial business.) The lack of credible data results from fluctuations in eligibility, and therefore the analysis for renewal must be done before the first year is complete. This is especially true under a voluntary system, where even a year's worth of data may not be credible.

Another option is to use experience data from other states. In doing this, plans must bear in mind that Medicaid programs vary from state to state. Some differences relate to eligibility requirements, covered services, and the existence of a Medicaid risk program.

One final point: the state may have problems sending the requisite data and actuarial reports to the health plans in a timely fashion.

SELECTION AND FINANCIAL RISKS

Selection and financial risks abound in a Medicaid risk program, affecting the state Medicaid agency, providers, and health plans directly and the beneficiaries indirectly. Many of the usual risks of a commercial business apply in Medicaid, too (e.g., ending up with a different demographic mix than what was used in developing the rates if the rates are not demographically specific). However, some are unique to this program:

- If the state implements a voluntary program, there will be risk selection, but it will be difficult to project who will be affected more, the health plan or the state Medicaid program. The level of selection depends on many factors, which can vary from one locale to another.
- In a voluntary system, if the health plan has to offer richer benefits, poorer risks might select the health plan versus the state non-managed program. On the other hand, poorer risks may be less compliant and less likely to voluntarily enroll in a health plan.
- Since beneficiaries do not pay premiums, their basis for selection will differ from the factors considered in a commercial setting.
- Health plans may select against the program, by choosing only the service areas with the highest reimbursement rates, or a health plan may cover only a portion of the area used in deriving the reimbursement rates. As a result, the rates may be excessive or insufficient.
- If a state carves out benefits, or has stop-loss coverage, the adjustments to the data used to develop the rates may, or may not be, appropriate to cover these changes.
- States may choose to arbitrarily limit or cut future reimbursement rates due to budget constraints.

Federal Reforms to Medicaid

The 104th Congress deliberated on a proposal to replace current federal funding for the Medicaid program with a form of block grants to the states. This concept has far-reaching implications for both the federal government, in helping to stabilize the federal deficit, as well as the states, in terms of the adequacy and flexibility of funding for meeting the needs of the populations served by this major social program.

BLOCK GRANTS

To borrow two terms from the area of pensions, the proposal to implement Medicaid block grants represents an attempt by the federal government to move away from a “defined benefit” approach to this social program with undefined (and historically uncontrolled) costs to a “defined contribution” approach to funding. This implies that:

- The federal government’s costs would be fixed prospectively, most likely at a lower rate of spending.
- States are free to pursue the local approaches that they believe can best serve the needs of their Medicaid population.

The implementation of Medicaid block grants would dramatically shift the risk of the cost drivers of the Medicaid program away from the federal government to the states (and indirectly other stakeholders). Cost drivers include the:

- Number and types of Medicaid eligibles
- Types of benefits and services provided
- Reimbursement of benefits and services provided.

The nature of these drivers, and the particular risks associated with them, are not uniform among the states. This factor will need to be considered in the design and implementation of Medicaid block grants. The variations and risks associated with each of these cost drivers are addressed further below.

NUMBER AND TYPES OF MEDICAID ELIGIBLES

The magnitude of the eligible group varies considerably by state, because of differences in demographics, local economic conditions, and general income levels. Currently, the federal contribution varies according to the average state income per capita. Furthermore, the numbers of eligibles can change over time, due to changes in the population, shifting economic conditions, aging of the population, and immigration patterns.

The risks associated with defining the eligible classes and changes in the magnitude of those eligible classes over time will shift to the states under a block grant program. For some states, the ability to maintain the current class of Medicaid

eligibles will depend on the extent of initial federal funding under the program. In addition, even if the initial funds allocated to the states are adequate, the financial risk of changes in this population, over both the short and long term, will be shifted entirely to the states.

TYPES OF BENEFITS OFFERED

The benefits currently mandated under Medicaid programs are quite comprehensive and include long-term care as well as most areas traditionally covered under a private health insurance program. There are a number of optional services that most states also offer such as prescription drugs, prosthetic devices, hearing aids, optometric services and dental services. Beneficiary cost sharing can also vary by state but is mandated to be minimal.

Some states have obtained federal waivers that allow implementation of managed care alternatives through restriction of “freedom of choice.” These alternatives can provide improved access and reduced costs through education and outreach programs, which encourage and facilitate necessary preventive care for Medicaid beneficiaries in less costly ambulatory sites.

While there is not a great deal of variation in benefits offered by the states, this is a consideration in federal reforms of Medicaid. It may be necessary for states to limit the benefits offered, such as Oregon’s approach to define the covered services based on a fixed budget.

REIMBURSEMENT OF BENEFITS AND SERVICES PROVIDED

While the covered population and covered services have grown over the years, Medicaid has traditionally controlled increases in its Medicaid expenditures through its constraint on Medicaid reimbursements to providers. This can lead to some cost shifting to the private sector as well as decreases in the number of participating providers.

Hospitals are typically reimbursed on a prospective-payments system similar to Medicare. Typical reimbursement is estimated at 60 percent of private sector payment levels. In addition, disproportionate share allowances are given to certain hospitals that serve a large proportion of Medicaid eligibles and are inadequately able to pass on costs to the private sector.

It is also important to note that costs per capita associated with Medicaid can vary with the nature of the eligible groups. For example, costs for the aged, disabled, and blind are substantially higher than AFDC costs. Furthermore, the prepaid cost structure will be further influenced by how the eligible class is defined. As indicated above, there is significant variation by state.

While some reform proposals will shift the risks associated

with Medicaid reimbursements to the states, many of them have already taken steps to shift that risk to providers and health plans through prepaid health care. Any move toward a defined contribution approach from the federal government is likely to continue this trend.

IMPACT AND IMPLICATIONS OF MEDICAID FUNDING

A key issue in implementing Medicaid reform will be how to allocate funds to the states. Any allocation formula will need to balance the overall magnitude and needs of the “targeted populations” in each state with current federal funding allocations to the various state Medicaid programs. As noted above, the variations in the current state Medicaid programs can show up in definitions of the eligible groups, and the level of benefits provided, as well as in how providers are reimbursed for their services.

To the degree that funds are reallocated based on the overall needs of the targeted population in each state, some states would be “overfunded” for the current programs offered, while others would be “underfunded.” This latter effect may shift funding burdens to the states or cause some states to curtail existing benefits or eligibility.

An allocation formula that preserves the current allocation of federal funds for Medicaid will have the effect of locking in disparities among states in current Medicaid programs. States that look to expand their programs must do so through state funding only. Conversely, the equity of the existing allocation formula may not make sense if some states curtail their existing programs with no change in federal funding.

The allocation of Medicaid funds should consider the efficiency of the existing Medicaid programs in each of the states. In moving to a defined contribution approach, the expectation is that the states will have greater freedom to pursue more cost-effective approaches to implementing their Medicaid programs. However, the state Medicaid programs that are most efficient at present (e.g., because of managed care programs, low fee schedules, etc.) will have the greatest difficulty in achieving further savings and would thus be penalized to the degree that this was not considered in the allocation process.

Any evaluation of efficiency of existing programs should be done with an appropriate actuarial analysis of benefit levels and adjustment for the risk attributes of the various eligible populations.

Another key issue: how to handle changes in targeted populations over time. A fixed block-grant-allocation formula will shift to the states the risk of changes in the eligible classes due to changes in the economy, immigration, or poverty levels. Again, this may force increased state funding or a cutback

in programs for the states most heavily affected, particularly if the state’s Medicaid program is already being managed cost effectively. One option would be to adjust the block grant or allocation over time, based on changes in the eligible population, to avoid disproportionate impacts on some states.

ALTERNATIVES TO THE BLOCK GRANT APPROACH

In addition to the policy problems the block grant approach presented lawmakers, political and ideological differences arose during the debate to reform Medicaid in the 104th Congress. The primary issue to resolve between policy makers was whether to keep Medicaid as a federal entitlement or turn it over to the states.

The administration alternative to block grants would have repealed a number of federal standards and provided states with more flexibility to determine how to provide health care, but would have preserved the federal entitlement including federal eligibility standards and benefits.

Another approach, discussed by a group of bipartisan governors who were attempting to resolve the impasse, would have turned the program into a state entitlement and remove the original block grant allocation formula.

The basic idea of the state entitlement approach is to guarantee Medicaid coverage to targeted populations at the state level, rather than the federal level, and to have the guarantee, or entitlement, enforced by state, rather than federal courts. Under this approach, states would determine who is eligible for benefits, and the benefits they would receive (although the federal government would be able to define some benefits). The proposal contained a limit on federal spending for each Medicaid recipient or per-capita spending caps.

Some of the implications of the block grant approach also apply to the per-capita cap plan. Specifically, the per-capita cap approach does not address the nature of the eligible groups (whether they are disabled, aged, or blind). Although a policy of per-capita spending caps could take into consideration changes in population and immigration patterns, it may also lead to expansion of the eligible population since states would receive allocations for federal money per beneficiary, and they would have an incentive to expand the pool of eligible Medicaid recipients.

These Medicaid reform proposals could have implications both to the federal government in helping to stabilize the federal deficit, as well as to states. These implications will be driven by the population included in the program, the implementation approaches chosen, and the degree of the transfer of risk between the federal government, state government, and other involved parties.

Conclusion

Managed care has been a part of private medical insurance for many years and is increasingly becoming a part of public health care coverage. Most managed care approaches include an element of risk transfer from the state to either health care plans or to providers. Currently 49 states offer some form of managed care in their Medicaid program.

Cost and utilization savings can result where managed care programs are employed. The amount and timing of these savings is dependent upon the populations that are subject to the programs, how the programs transfer risks, and the programs' implementation methods.

All of these dimensions should be considered when developing a Medicaid managed care program, predicting its savings impact, and implementing the program.

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