South Dakota Legislative Research Council

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Medicaid Managed Care

Introduction

With rapidly increasing costs in medical care throughout the 1980s, and with a surge in the growth of private industry managed care throughout that same period, changes in the way the Health Care Financing Administration paid for Medicaid were all but inevitable. Though waiver programs to implement managed care aspects to Medicaid have been available to the states since the early 1980s, only in recent years has the trend towards this goal quickened nationwide. South Dakota has been involved in implementing Medicaid managed care since 1993, and has thus far met with success in implementing its program.

Though "managed care" can be a confusing concept and a topic often stigmatized by a very unfavorable connotation, it is certainly a growing and undeniable trend in health care today. Its effects on South Dakota's Medicaid program have been, and continue to be, profound. Therefore, it is important that lawmakers have a solid understanding of this concept and how it relates to South Dakota's Medicaid recipients. This memo will first present an overview of the concept of managed care, followed by an overview of managed care as it relates to Medicaid. It will conclude with a summary of South Dakota's Medicaid managed care program.

What is Managed Care?

Managed care is a health care financing methodology which centralizes the means of paying for health care, and organizes the provision of care to oversee both utilization and quality. Essentially, it is easiest to understand when compared to its opposite, fee-for-service care, which we all know, and which is still predominant in South Dakota. Under fee-for-service, when you have a health care need, you see a doctor and are subsequently billed for that doctor's services. The more patients a doctor sees and the more procedures he performs, the more he is paid (by the individual or by an insurance company). Under fee-for-service, quality is normally good, but "utilization" is often very high. Therefore, costs are very high.

In California in the early 1970s some health professionals began to formulate a way of combating the rising costs of health care due to

high utilization. This new method became known as "managed care," and spread slowly throughout the 1970s and early 1980s. Under managed care in its most basic form, a physician is assigned to a "population," which pays a premium not to the physician but to a managed care organization. The organization then pays each participating physician a monthly fee, dependent upon the number of individuals within the physician's "population." This fee is commonly known as a "per member per month" fee (PMPM). Purely as an example, let us say a cardiologist is a member of a managed care organization. If he is assigned to a population of 10,000 and receives a $1.50 PMPM, then he is paid $15,000 monthly, whether his workload is heavy or light. PMPM figures are a highly volatile part of a physician's managed care contract and may vary widely depending upon the characteristics of the population, the geographic location, or the managed care organization's level of desire to have a particular physician on the panel. This entire concept is known as "capitation."

Normally, a physician is then required to get by on the PMPM. That means that the physician must pay all expenses through that money, and there is no way of making more. Profit comes by controlling utilization. The less costs which a physician incurs, the more he will make. The greater his costs, the less he will make. If he has contracted poorly, or overutilizes, he may even lose money.

Into this enters one of the chief concerns about managed care: quality. The saying in managed care is that a physician loses money on a patient as soon as the patient walks in the door. With that outlook, where is the incentive to provide thorough care? What mechanism exists to keep a physician from "dumping" a patient onto another specialist via a referral?

These are real concerns, but there are certainly two arguments on this topic. Though there are unscrupulous managed care doctors who prescribe Tylenol and bedrest to patients who really require a series of expensive tests and medications, there are also unscrupulous doctors who gouge patients under the fee-for-service setting. As a serious example, one cardiologist in California was caught performing three angioplasties on three successive days for one patient, instead of doing the job at once, since he could then charge three times as much. Proponents of managed care argue that under their system, the disreputable doctor is easier to spot and discipline, since payments are closely watched, as are utilization levels and quality of outcomes. In the free-for-all fee-for-service setting, there are few such oversights.

Though capitation is the basis for managed care funding, the basis for the management of care itself lies in the "gatekeeper" theory. Under fee-for-service care, a patient is free to make an appointment with any specialist for care above and beyond that which his general practitioner can provide. Managed care advocates believe that

individuals do not always make the best choice in this matter, due to a lack of knowledge or information, and over-utilization often occurs; the process is not very efficient. Under a managed care program, a patient *must* be referred to a specialist *by* his primary care physician if the specialized care is to be covered. This makes the primary care physician (PCP)[1] a gatekeeper to specialized care.

In most managed care situations, a new member patient must choose a PCP (or have one selected for him). With exceptions, this PCP is then essentially the only doctor the individual is to deal with primarily. This arrangement gives the PCP a chance to become acquainted with his patients' needs and specific health problems, which is, of course, desirable for the sake of quality care. If a patient needs specialized care from an otolaryngologist (ear, nose, and throat doctor), for instance, the patient must be referred by the PCP to an otolaryngologist working with the managed care organization, if such an option is available. Even if the patient feels certain that his sinus infection or earache requires specialist help, the PCP must first determine that fact, and then decide which otolaryngologist is most able to help in the situation. The managed care theory behind this practice is that such referrals will lead to decreased utilization of highly expensive specialized medicine.

Of course, a danger exists that the PCP may try to "dump" patients onto specialists without need, in an attempt to lower his own office costs. Managed care proponents would argue that the very structure of managed care works to prevent this in most cases. Physicians on a managed care panel are subject to "utilization review," sometimes known as "physician profiling" or "report cards." These reports track a physician's expenses, referrals, and outcomes, and can often detect irregularities that may be symptomatic of unscrupulous behavior. Also, since specialists in a managed care environment must watch their own costs, they will not sit idly by when patients walk into their offices on referral with problems best cared for by a primary care physician. Under fee-for-service scenarios, little prevention exists to steer patients away from the highest-cost care. As one source summarizes it:

> The paradoxical assertion that *by restricting free access to care its availability can be ensured* was once one of the most controversial features of Medicaid managed care, but now is recognized as one of its major contributions.[2]

Managed Care in Medicaid

The last section was a short and simple description of a very complex and controversial subject. Likewise, the place which managed care holds in Medicaid nationwide is also very complex and differs

[1] A PCP can be a general practitioner, pediatrician, OB/GYN, rural clinic, or at times an internal medicine specialist, depending upon the plan's provisions.

[2] Freund, Deborah and Robert Hurley. "Medicaid Managed Care: Contributions to Issues of Health Reform." *Annual Review of Public Health*. 1995, p. 476.

from state to state. However, the basics of Medicaid managed care are relatively constant.

Essentially every state now utilizes some form of managed care in organizing Medicaid services and payments. As of June 30, 1996, 13.3 million beneficiaries, or 40% of the nation's Medicaid population, were enrolled in managed care plans.[3]

Title XIX of the Social Security Act provides states with two major mechanisms for implementing managed care (and other innovations) into their Medicaid programs. These two mechanisms come in the form of "1915(b)" and "1115" waivers, which states apply for through the Health Care Financing Administration (HCFA):

1915(b) Waivers. Most states' 1915(b) waivers allow exemptions from federal law requiring (1) freedom of choice, whereby beneficiaries may obtain services from any provider; (2) comparability, requiring that the scope of covered services be the same for all categorically needy beneficiaries; and (3) "statewideness," the requirement that the Medicaid program operate uniformly throughout the state.

1115 Waivers. These "research and demonstration" waivers allow states to pursue Medicaid projects that test new and innovative ideas relating to benefits and services. The projects are approved for a limited time period, usually 3 to 5 years, and must not increase a state's overall costs within that time frame. 1115 waiver programs may expand eligibility, require enrollment in managed care organizations, modify coverage of community health centers or eliminate disproportionate share payments for hospitals.[4]

These two waivers can be used by states in a wide variety of ways. However, in implementing managed care programs, three major forms have been identified, ranging from most intrusive to least intrusive:

à *Full-risk capitation programs.* These programs look most like private sector plans. States, like private employers, contract with HMOs to provide care to Medicaid recipients. States, however, also contract on a full-risk basis with federally funded community health centers that have traditionally served Medicaid and other low-income recipients.

à *Partial capitation programs.* In these programs, states contract directly with providers on a capitation basis for a sub-set of services but continue to pay non-capitated services on a fee-for-service basis.

à *Primary Care Case Management (PCCM).* Under this type of program all services are paid fee-for-service and primary care providers are recruited and paid on a per-person

[3] "Managed Care in Medicare and Medicaid." Department of Health and Human Services. July 15, 1997. http://www.hhs.gov/news/press/1997pres.

[4] *Medicaid Survival Kit*. National Conference of State Legislatures. Nov. 1996. Chapter 8, page 8.

basis for case management.[5]

The purpose of implementing managed care for Medicaid is to reduce costs to the state and federal government, and to increase oversight of health care access. Medicaid has historically provided low reimbursement in the fee-for-service arena, and this has often led to a certain degree of neglect of Medicaid patients. A responsibility rests upon each state to ensure that this trend does not worsen under capitation. HCFA policy states that capitated payments must not exceed what was originally spent under the fee-for-service system[6]; therefore, the low payments cannot change. What can change is increased oversight of outcomes.

The transition to managed care for state Medicaid programs can prove tumultuous and expensive. During that period of change, two administrative structures may be necessary, one to continue overseeing the original system as it is phased out, and another to oversee the new system as it moves in. As one source states, "For the first years of a new system, states may have to check on patients both overusing and underusing health services."[7] Medicaid is a huge portion of any state budget. Any attempt to transform it is bound to involve added costs at the outset.

Medicaid Managed Care in South Dakota

Dramatic growth in Medicaid costs of over nine percent annually helped drive the state Department of Social Services to seek an alternate form of administering the program. Due to the lack of managed care structures within the state, the Department decided to implement a limited managed care approach in the form of Primary Care Case Management. Under this arrangement, primary care physicians would be paid a PMPM case management fee (currently $3.00) to act as "gatekeeper" for their specified Medicaid population. Other services are paid for on a fee-for-service basis.

South Dakota obtained a 1915(b) waiver from the U.S. Department of Health and Human Services in 1993 to implement its program. The main objectives of the program, as stated in the waiver request, were "to reduce costs, prevent unnecessary utilization, reduce inappropriate utilization, and assure adequate access to primary care by Medicaid recipients."

The new program was started in Codington County as a pilot in September 1993. As time went by more counties were added until implementation was completed in December 1995. Implementation in each county involved gaining medical contacts, training physicians and recipients, and deciding upon final enrollment.

Enrollment has been opened to a majority of the state's Medicaid eligibles and is mandatory for those who qualify. The number of qualifying individuals equals over 40,000, or roughly two-thirds of the

[5] Lewin-VHI. *States as Payers: Managed Care for Medicaid Populations.* National Institute for Health Care Management. Feb. 1995, page ES-2. Also, cf. *Medicaid Survival Kit* and Freund/Hurley.
[6] Freund and Hurley, p. 482.
[7] Rickett, Kamala and Stephen Somers. "Haste Makes Waste." *State Government News.* August 1996, p. 10.

state's Medicaid population. Among those who are exempted from the plan are institutionalized individuals, individuals for whom Medi*care* is the primary payer, and others who, on a case-by-case basis, the Department has decided would benefit from an exemption due to special medical needs.

Participating Medicaid eligibles are given a plastic Medicaid Identification Card and may choose a physician to be their primary care provider. If the recipient does not make that choice, then a PCP will be assigned to them by the Department. Each recipient's caseworker explains the program in depth and helps each recipient choose an appropriate PCP. Potential PCPs include:

1. Family and general practitioners;
2. Pediatricians;
3. Internal medicine specialists;
4. Obstetricians/gynecologists;
5. Clinics certified as a Rural Health Clinic;
6. Clinics certified as a Federally Qualified Health Center;
7. Clinics designated as an Indian Health Clinic.[8]

Relatively wide latitude is usually given for PCP visits, considering the rural nature of the state. "In-house" referrals, for example, are normally acceptable for cases when a specific doctor is out of town or otherwise not available.

The designated PCP must make a referral for any specialty work needed. The referral consists of a "purple card," which serves as proof of the referral and also contains information for billing Medicaid. Referrals are *not* necessary in the following cases:

à True emergencies à Family planning
à Dental services à Podiatric services
à Optometric services à Chiropractic services
à Immunizations à Specified mental health services
à Ambulance à Independent lab transportation services.[9]

Providers now receive monthly managed care paid claims reports to help them track utilization. The reports are also meant to aid in the clinical tracking of patient care for the providers. These reports list each patient served by the physician that month, with a complete listing of all services billed to Medicaid. This allows the physician to examine what specialist care was given, what pharmaceuticals were prescribed, etc.

In a related vein, the Department is also producing "profile reports" on participating PCPs. Physician profiling is a basic managed care concept, which involves tracking physician utilization and, ideally, outcomes, on a monthly basis and then comparing the performance of a group of physicians one to another. Profiles are looked upon by the medical community as anything from important tools for saving costs to threats and invasions upon a physician's necessary work. The job of the

[8] From the DSS internet site (see end of paper).

[9] *Ibid.*

managed care official is to present the profile report as an important working tool, yet at the same time examine it with an eye towards detecting overutilization or poor quality of care.

South Dakota's physician profiles include such data as caseload, total claims in dollars, and specialty referrals as a percent of claims. It is important for administrators to look at such figures, however, with any specific conditions in mind. No two Medicaid populations are alike, and seemingly "bad" numbers from one physician may not necessarily point to "bad" practices. Because of the preliminary status of the program as a whole and the need to allow for gradual changes, the Department currently profiles physicians on an informative basis only and takes no real corrective actions against outlier data.

Results and Conclusions

South Dakota's Medicaid managed care program appears to have proven a success. Estimated savings brought about by the plan's existence for FY97 alone total $7.2 million. Total savings since inception appear to have been from $25 to 30 million of general and federal funds.

Program Director Dave Christensen credits much of the project's success to the cooperation of physicians, who helped make managed care work. Mr. Christensen was also pleased with the level of cooperation received by Medicaid eligibles.

The next step for the program is to ensure the highest possible quality. The Department is already working on this through the use of extensive, face-to-face, mandatory quality control interviews with recipients, as well as provider surveys. However, the Department wishes to move on to cutting-edge clinical outcome surveys as well, in order to determine the level of care, both from the patient's standpoint and from a medical standpoint. This has always proved a difficult task for the health care provider industry, but it is a crucial next step to ensuring a healthy population.

Recommended Reading (available through LRC)

Freund, Deborah and Robert Hurley. "Medicaid Managed Care: Contributions to Issues of Health Reform." *Annual Review of Public Health*. 1995, pp. 473-494.

Holahan, John, et al. "Insuring the Poor Through Medicaid 1115 Waivers." *Health Affairs*. Spring 1995, pp. 199-216.

Lewin-VHI. *States as Payers: Managed Care for Medicaid Populations.* National Institute for Health Care Management. February 1995.

Medicaid Survival Kit. National Conference of State Legislatures. November 1996.

Rickett, Kamala and Stephen Somers. "Haste Makes Waste." *State Government News.* August 1996, pp. 9-10.

Stuart, Elaine. "Healthy Diets." *State Government News.* June/July 1995, p. 25.

Recommended Web Sites

Center for Health Care Strategies: http://www.chcs.org/CHCS/resource.htm

Health Care Financing Administration: http://www.hcfa.gov/

Kaiser Family Foundation: http://www.kff.org/

S.D. Medicaid Managed Care Program:
http://www.state.sd.us/state/executive/social/medicaid/index.htm