MOVING TOWARD MEDICAID MANAGED CARE

The purpose of this report is to explain the basics of the Medicaid program and highlight key issues related to shifting significant numbers of Medicaid recipients into managed care. It does not address the larger question of whether managed care is the best option for the future of the Medicaid program.

THE MEDICAID PROGRAM

Medicaid is a health care program created by the federal government in 1965 through the Social Security Act. It is funded by a combination of federal and state money and is widely recognized as a health care program for those poor enough to qualify for cash public assistance. What is less well-known is that it is also a program for the elderly and people with disabilities who have exhausted their resources.

Medicaid is one of the largest expenses of the federal and state governments. From federal fiscal years 1988 to 1994, it was one of the fastest growing, with national spending on Medicaid more than doubling from $52.6 billion to $137.1 billion. Likewise, in Louisiana during that same period total Medicaid spending quadrupled from less than a billion dollars in 1988 to nearly $4.5 billion by 1994. However, since then Louisiana’s Medicaid spending has been reduced significantly. In the 1997 fiscal year, spending is expected to total about $3.1 billion. Nationally, the rate of increase has slowed as well due to changes in federal policy and states’ attempts to limit growth. In federal fiscal year 1996, total federal Medicaid spending increased only 3.3% from the previous year.

The Health Care Financing Administration (HCFA) promulgates the federal rules and regulations of the Medicaid program. It also monitors state programs and sometimes allows states to waive certain federal requirements. (See Box 1 entitled “The Health Care Financing Administration Waivers and Medicaid Managed Care.”) Louisiana’s Department of Health and Hospitals (DHH) writes the state rules, pays the providers, and oversees the health services provided.

On any given day in 1995 the federal Medicaid program covered about 36 million people or about 13% of the population. In Louisiana, 785,399 people or 18% of the state’s total population received services through the program. In fiscal year 1995, 52% of births in the state were covered by Medicaid. In the 1997 fiscal year, spending on Louisiana’s Medicaid program represents approximately 26% of the state’s total budget.
BOX 1
THE HEALTH CARE FINANCING ADMINISTRATION WAIVERS AND MEDICAID MANAGED CARE

To adopt a Medicaid managed care program states generally need the approval of the Health Care Financing Administration (HCFA), the federal agency that oversees Medicaid. Louisiana will soon apply for a waiver for its proposed pilot program.

There are two types of waivers for which states may apply: “program” waivers and “research and demonstration” waivers. Generally, program waivers are easier to secure and are less broad in scope.

There are two types of program waivers:

(1) Home and community-based waivers (1915(c)) allow states to develop alternatives to placing Medicaid recipients who need long-term care in institutions. Louisiana now has five 1915(c) waivers serving the elderly and adults with disabilities, those who are mentally retarded or have developmental disabilities, adults with loss of sensory or motor functions, the elderly, and those with traumatic brain injury and related conditions. The five waivers serve a total of 2,641 Medicaid recipients.

(2) Freedom of choice waivers (1915(b)) allow states to waive federal provisions requiring that (a) beneficiaries have the right to seek their own Medicaid providers, (b) the scope of benefits for the categorically needy be the same statewide, and (c) the program operate uniformly across the state. Louisiana needs a 1915(b) waiver to implement its managed pilot program in a seven-parish region.

Research and demonstration waivers (1115) allow states greater flexibility in trying new Medicaid policy proposals. In exchange, states must commit to a program that can be formally evaluated. In December 1994, Louisiana applied for an 1115 waiver to cover most of the state’s Medicaid population. In 1995, the application was amended to convert the state’s charity hospital system into a public HMO. HCFA rejected the funding proposal in the request.

The state and federal governments share the cost of Medicaid. In some states, however, local governments also contribute to it. A federal medical assistance percentage (FMAP), based on per capita income, is calculated for each state every year. It is the percentage of each dollar spent on a state’s Medicaid program that the federal government contributes. The rate at which the federal government contributes to state programs will range from 50% to 77% for federal fiscal year 1998. Louisiana’s rate will be 70.03%. This means that for the medical services provided under Medicaid, the federal government will pay approximately 70 cents of every dollar spent. Louisiana will pay the other 30 cents. The amount the state contributes is generally called the “state match.”

State fiscal year 1997 is an anomaly because the state has contributed at a lower match rate as part of a special arrangement with the federal government. (See “Louisiana’s Medicaid Spending History.”) Rather than requiring the state to contribute funds at the normal 28% state match rate, the federal government allowed the state to contribute at a rate of 19%. The state contributed $600 million to its program rather than the $767 million that would normally have been required. In exchange, the state agreed to accept a $2.6 billion cap on federal funds. In fiscal year 1998, the state will contribute at its “real” match rate, resulting in about a $902 million general fund contribution.

Medical services provided through the program are paid for through the match rate and program administration is paid for separately, with the federal government paying 50% of states’ administrative costs. However, because of Louisiana’s special arrangement with the federal government, the state received a lump sum in fiscal year 1997 for both medical and administrative costs associated with Medicaid.

What Control Do States Have Over Their Medicaid Programs?

While federal guidelines dictate many aspects of the Medicaid program, states can influence their programs in four basic ways (within federal allowable limits and subject to HCFA approval): through the eligibility guidelines they establish; through the reimbursement rates they pay to health care providers; through the scope of benefits they provide; and how they deliver services. (See Box 2 entitled “Federal Actions Affecting Medicaid.”) Increasingly, states are choosing to restructure the delivery of services, by shifting recipients to managed care plans. This typically requires federal government approval. (See Box 1 entitled “Health Care Financing Administration Waivers and Medicaid Managed Care” and “Managed Care” section.)

Eligibility

Those eligible for Medicaid generally fall into two categories: “categorically needy” and “medically needy.” “Categorically needy” are those who qualify for
Medicaid is an entitlement program. That means that if a person meets the program's eligibility criteria, he or she is entitled to receive its services. In 1996, Congress considered changing Medicaid from an entitlement program to a block grant. Under a block grant, the state would receive a lump sum from the federal government. The state would be free to shape its own program because fewer federal restrictions would apply. However, once the block grant money was spent, there would be no more federal money. If more people needed services, the state would have to pay for them if it chose to provide the services. Congress did not adopt the block grant proposal.

Congress is now considering several major changes to the Medicaid program, including: repealing the Boren amendment (see p. 4) and reducing disproportionate share (DSH) spending. (See "Louisiana's Medicaid Spending History.") Much of the savings, federal policy makers hope to achieve in Medicaid over the next five years, will likely come from changes to the DSH program. Congress is also considering eliminating the requirement that states secure federal waivers before implementing Medicaid managed care. In February, President Clinton had proposed per capita caps on Medicaid spending. However, this is no longer being considered.

Medicaid because (1) their income and assets are less than a certain amount, (2) they are elderly and poor, or (3) they have a disability and are poor or are blind and poor.

The federal government requires that state Medicaid programs cover certain low-income groups:
- In the past, if a person qualified for cash assistance from the Aid to Families with Dependent Children (AFDC) program, he or she automatically qualified for Medicaid. Those who qualify for Temporary Assistance to Needy Families (TANF), the program that replaced AFDC in 1996, do not automatically qualify for Medicaid. However, in general, those who qualify for TANF are also eligible for Medicaid.
- Those receiving Supplemental Security Income (SSI). SSI is a federal program that provides cash assistance to the people with disabilities and elderly who meet certain income criteria.
- Low-income pregnant women and children (federal law allows states to cover pregnant women and children whose incomes are at or less than 185% of the federal poverty level; Louisiana covers them up to 133% of the federal poverty level)
- Infants born to Medicaid-eligible pregnant women
- Children under 6 in low-income families
- Certain older children in families with incomes up to the poverty level
Children who receive adoption assistance or foster care
• Some Medicare recipients and certain other groups

Beyond these groups, states may choose to cover the medically needy as well as other groups. (See Table 1.) One of the reasons it is difficult for states to control Medicaid spending is that they cannot limit the type or number of services provided to those whom their program covers.

“Medically needy” refers to an optional eligibility category for individuals whose income exceeds the level that would allow them to qualify for Medicaid. However, these individuals have significant medical bills that, once paid, leave them with income and assets so low that they qualify for Medicaid.

Pressure to reduce spending in the Medicaid program led state policy makers in fiscal year 1997 to eliminate the “medically needy” optional eligibility category that was jointly funded by state and federal money. Instead, they funded it only with state money. This allowed the state to further limit eligibility and services. It is likely that “medically needy” will be restored in fiscal year 1998 as a category that will be funded by both state and federal money.

Reimbursement Rates

Each state sets its own reimbursement rates, the rates at which it pays health care providers for treating Medicaid recipients. Federal law includes rate-setting guidelines but does not require states to use a particular method. One of the guidelines requires that the rates be high enough to attract an adequate number of providers to meet the needs of the Medicaid-eligible population.

### Table 2
**Medicaid Mandatory Services**

States must provide the following services as part of their Medicaid programs in order to receive federal funds:

- Physicians’ services
- Inpatient hospital services
- Outpatient hospital services
- Federally qualified health center (FQHC) services and other ambulatory services
- Medical and surgical dental services
- Nursing facility services for those age 21 or older
- Home health services
- Family planning services and supplies
- Laboratory and x-ray services
- Pediatric or family nurse practitioner services
- Early and periodic screening, diagnosis and treatment (EPSDT) services for those younger than 21 (and treatment of any conditions discovered whether state otherwise provides service or not)

**SOURCE:** Louisiana Department of Health and Hospitals.

Reimbursement rates for hospitals and nursing homes must meet the criteria of the federal Boren amendment. Prior to the amendment in the early 1980s, states were required to reimburse hospitals and nursing homes for Medicaid at the same rate as for Medicare. The Boren amendment freed states from that requirement. The intent was to help states control Medicaid costs. The amendment required that the reimbursement rates be high enough to cover the costs of an efficiently and economically operated business that is complying with federal quality and safety standards. Many states responded by reducing reimbursement rates. This resulted in lawsuits by hospitals and nursing homes that claimed reimbursement rates were too low.

DHH attempted to freeze hospital rates in 1988 but settled out of court when the hospitals challenged the action. Since then, DHH has provided annual inflationary increases to these providers to avoid challenges. A proposal to repeal the Boren amendment is under consideration in Congress. (See Box 2 “Federal Action Affecting Medicaid.”)

### Scope of Benefits

The federal government stipulates a basic set of services that each state’s Medicaid program must cover. These include basic physician and hospital services, lab services and X-rays, among other things. (See Table 2.) In addition to the required services, states may offer other “optional” services. In
Table 3
Optional Medicaid Services States May Offer

<table>
<thead>
<tr>
<th>Services Louisiana Offers</th>
<th>Screening services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatrists' services</td>
<td>Preventive services</td>
</tr>
<tr>
<td>Optometrists' services</td>
<td>Rehabilitative services</td>
</tr>
<tr>
<td>Chiropractors' services</td>
<td>Inpatient hospital services for age 65 or older in institutions for mental diseases (IMDs)</td>
</tr>
<tr>
<td>Psychologists' services</td>
<td>Nursing facilities services for age 65 or older in IMDs</td>
</tr>
<tr>
<td>Medical social workers' services</td>
<td>Intermediate care facilities for the mentally retarded</td>
</tr>
<tr>
<td>Nurse anesthetists' services</td>
<td>Inpatient psychiatric services for those younger than 21</td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>Christian Science nurses</td>
</tr>
<tr>
<td>Clinic services</td>
<td>Christian Science sanatoriums</td>
</tr>
<tr>
<td>Dental services</td>
<td>Nursing facilities services for younger than 21</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>Emergency hospital services</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>Personal care services</td>
</tr>
<tr>
<td>Speech, hearing and language disorders</td>
<td>Transportation services</td>
</tr>
<tr>
<td>Prescribed drugs</td>
<td>Case management services</td>
</tr>
<tr>
<td>Dentures</td>
<td>Hospice care services</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>Respiratory care services</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td></td>
</tr>
<tr>
<td>Diagnostic services</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis-related services</td>
<td></td>
</tr>
</tbody>
</table>

Of 34 possible services, Louisiana offers 16.

SOURCE: Health Care Financing Administration, Publication No. 02155-96.

federal fiscal year 1995, Louisiana offered 16 optional services. (See Table 3.) Among the 50 states, the minimum number of optional services offered was 15 and the maximum was 33. Forty states offered at least 20 optional services.

How Services Are Delivered

States exercise discretion over how services are delivered. In recent years the most notable trend has been a shift from a fee-for-service delivery system to managed care. Under a fee-for-service system, a health care provider is reimbursed each time a medical service is provided to a patient. Under managed care, a provider is paid a fixed sum (capitation rate), usually per month, to provide a patient’s care. The provider receives the same payment regardless of whether a patient receives no services or many costly services in a given month. Just as managed care has expanded in the private sector, it is expected to be a larger part of Louisiana’s Medicaid program in coming years. (See “Managed Care” section.)

THE DEMOGRAPHICS OF LOUISIANA’S MEDICAID PROGRAM

Medicaid provides health care for low-income families, the poor elderly and people with disabilities who are poor. Although AFDC recipients, other children under 21, and pregnant women made up about 67% of Louisiana’s total Medicaid recipients in federal fiscal year 1995, spending on these groups was only 31% of the total. Conversely, the elderly, blind and people with disabilities were only 34% of the total number of recipients. But spending on these groups accounted for about 69% of the total. (See Figure 1.) The elderly were 13% of the total number of recipients and 25% of total spending. People with disabilities were 20% of the total number of recipients and 43% of total spending.

LOUISIANA’S MEDICAID SPENDING HISTORY

From 1988 to 1994, Louisiana’s Medicaid program grew tremendously. The total spending quadrupled and the number of people receiving services
was 80% higher in 1994 than it was in 1988, increasing from 432,807 to 778,223. Spending peaked in 1994 and has declined each year since. It decreased by about 7% from fiscal year 1994 to 1995, 21% from state fiscal year 1995 to 1996, and about 7% from state fiscal year 1996 to 1997. Spending is expected to increase slightly in fiscal year 1998.

There were several reasons for the substantial increase from 1988 to 1994. The federal disproportionate share (DSH) policies of the late 1980s resulted in significant federal reimbursement for Louisiana. DSH began as a well-intentioned federal effort to ensure that hospitals treating a “disproportionate share” of low-income patients be reimbursed for that care. Such hospitals were reimbursed at 300% of their unreimbursed costs of treating these patients. In Louisiana, this resulted in a windfall for the state because the state-operated hospitals treat a large number of poor people.

The charity hospitals received the DSH payments and returned the excess, or “overcollections,” to the state. That money was then used as state match to receive more federal Medicaid money. In this way, Louisiana greatly expanded its Medicaid program with no real cost to the state. Federal money was simply recycled, labeled as state money and then used to attract more federal money. Louisiana’s overcollections that were used to fund the state match increased from $22 million in fiscal year 1989 to $781 million in fiscal year 1995.

During this period, Louisiana’s Medicaid program quadrupled, from less than a billion dollars to more than $4 billion. Significant attention has been paid to the fraud among some private providers that came with the increased spending. DHH has taken a number of steps to address those problems. The positive side of the disproportionate share growth was that the state was able to provide a substantial number of health care services to an expanded number of people at almost no additional cost to the state. Although the program almost certainly would not have grown so much without DSH funds, its growth still would have been significant since Medicaid costs rose rapidly during that period and Congress expanded Medicaid eligibility.

When Congress realized that states were maximizing federal funds in ways that had not been intended, it reduced the DSH reimbursement rates, first to 200% of unreimbursed costs and then to the current 100%. This loss of federal money required Louisiana to make significant Medicaid budget cuts in recent years.

At the federal level, Congress is considering proposals to reform DSH to save money in the Medicaid program over the next five years. It will be up to Congress to decide upon the extent of the savings.

Other factors also contributed to the significant growth in the Medicaid program in the late 1980s and early 1990s. Congressional expansion of eligibility allowed states to extend eligibility to pregnant women and children with incomes up to 185% of the federal poverty level. Louisiana chose to expand its eligibility only to 133% of the federal poverty level. Congress also required states to cover certain other low-income children. Medical cost inflation also contributed to growth in Medicaid spending.
SPENDING IN FISCAL YEAR 1998

Louisiana's Medicaid program is expected to total about $3.28 billion in fiscal year 1998, up from the estimated $3.13 billion in spending for fiscal year 1997. For fiscal year 1998, the state will contribute about $902 million in general fund money to the program. The remainder will be funded by the federal government. Policy makers continue to try to control Medicaid costs. The Legislature recently passed a bill to impose moratoriums on long-term care hospitals and mental health clinics and centers. In addition, the bill would extend the existing moratoriums on additional nursing home beds and home health agencies. Louisiana ranks third in the nation in the number of Medicare and Medicaid home health agencies. The state has the sixth highest rate of nursing home beds.

Another bill that attempted to control costs would have required Medicaid patients to make copayments for services. However, the bill never received a committee hearing.

MANAGED CARE

States that have shifted Medicaid recipients into managed care have done so primarily for two reasons: (1) budget predictability and cost control and (2) better continuity of care. Louisiana policy makers are also considering managed care for these reasons.

Even though Louisiana residents with Medicaid coverage have access to health care, the current system for delivering that care is not conducive to preventive or continuous care. Compared to other states, Louisiana has a large number and a high rate of acute and long-term care institutions and agencies. (See Table 4.) However, many of the state's residents, including many Medicaid recipients, lack access to the most basic preventive and primary care medical services. In 1995, 20.5% of Louisiana's population lacked health insurance. In the same year 23.7% of the population lacked access to primary care, the second highest percentage in the nation. These residents often end up seeing a doctor only when their condition has become severe. Health care is likely to be less expensive and more effective if it is provided when someone is first ill rather than after an illness becomes more serious.

Managed care is a method of delivering health care services that focuses on preventing illness and coordinating the services patients receive. Managed care proponents also point to an increased ability to predict and control costs. Managed care differs from a fee-for-service system under which a health care provider is paid each time he or she provides a service to a patient. Although there are different types of managed care, they share certain characteristics:
- encourage the use of networks of providers
- attempt to control the frequency of services enrollees receive and the setting in which they receive them
- shift at least some risk of the cost of providing care to the providers because they are paid a fixed sum for a patient's care regardless of how much care the patient actually receives

The incentives for providing care under managed care are entirely different than under a fee-for-service system. Under managed care, a fixed payment, called the capitation rate, is paid to the primary care provider. Whether a patient receives no services in a given month or numerous services, the provider receives the same payment. The idea is that under this system providers will focus more on keeping patients healthy.

Table 4
Acute Care Facilities in Louisiana

<table>
<thead>
<tr>
<th>Compared to other states, Louisiana ranked:</th>
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<tbody>
<tr>
<td>5th in the number of for-profit hospitals (1995)</td>
</tr>
<tr>
<td>6th in the rate of nursing home beds (1991)</td>
</tr>
<tr>
<td>6th in the number of state and local government-owned hospitals (1995)</td>
</tr>
<tr>
<td>10th in the number of psychiatric hospitals (1995)</td>
</tr>
<tr>
<td>10th in the number of hospitals (1995)</td>
</tr>
<tr>
<td>8th in the number of hospital beds per 100,000 population (1995)</td>
</tr>
<tr>
<td>9th in the number of Medicare and Medicaid-certified hospitals (1997)</td>
</tr>
<tr>
<td>16th in the number of hospital beds (1995)</td>
</tr>
</tbody>
</table>

However, critics of managed care contend that it creates an incentive to provide fewer services to patients. The primary care provider serves as a "gatekeeper" of a patient's care. This means a patient must have a referral from the primary care provider before receiving treatment from another provider.

Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are two common types of managed care plans. HMOs provide comprehensive medical services in exchange for a capitated payment. In 1994, 8.6% of Louisiana's total insured population was enrolled in HMOs. Under a PPO, health care purchased from a "preferred provider" is less expensive than from other providers.

State Medicaid programs may contract with managed care plans on a fully or partially capitated basis. Full capitation means that most medical services are paid for through the capitation rate rather than on a fee-for-service basis. The managed care plan, rather than the state, bears most of the risk for the cost of providing care. Partial capitation provides the state with the best opportunity for savings. Partial capitation means that some services are "carved out," that is, paid for on a fee-for-service basis while the others are paid for through the capitation rate. Partial capitation may result in cost shifting of patients into the fee-for-service system.

A primitive form of managed care is primary care case management (PCCM). Some states, including Louisiana, contract for Medicaid services under this model in which the state pays primary care providers a nominal monthly fee to serve as "gatekeepers." The state continues to bear the risk of the cost of providing care, which is paid for on a fee-for-service basis. As a result, PCCM does not help control or predict costs.

Today Louisiana has a limited PCCM managed care program, CommunityCARE, in 20 rural parishes that covered 45,181 enrollees in 1995. This represented fewer than 6% of the state's total Medicaid recipients that year. Providers are paid $3 per patient per month to manage their patients' care. This form of managed care is essentially a fee-for-service system with a gatekeeper. It does not allow for budget predictability or savings. The Legislature recently approved expanding the program to more parishes.

Saving Money Through Medicaid Managed Care

Many states have adopted managed care as a tool to control burgeoning Medicaid costs. All but two states use it or plan to use it as part of their Medicaid programs. In 1996, about 12 million Medicaid recipients nationwide were enrolled in managed care plans, up from the approximately 800,000 in 1983. A number of states have been successful in controlling costs of providing care to children and pregnant women, who represent the bulk of Medicaid recipients.

Some states that have adopted managed care and invested in making it work have saved money because of it. Though estimates of potential savings vary, and much depends on a state's willingness to carefully plan the change, savings of about five to 15% annually have been estimated. A key question in assessing potential savings, though, is to consider to whom the savings will accrue—the taxpayers or the managed care organizations. Arizona enacted a profit cap on participating Medicaid managed care plans after an HMO realized a $25 million profit.

It is too soon to tell whether managed care can be successful in controlling the costs of providing care to people with disabilities and the elderly Medicaid populations. Few states have had experience in Medicaid managed care for these groups.

Louisiana and Medicaid Managed Care

DHH's "Goals 2000" plan states that 100,000 of the state's Medicaid recipients will be enrolled in managed care or voucher plans by June 30, 1998. By the year 2000, the department's goal is to ensure 240,000 Medicaid recipients have a relationship with a primary care physician through managed care or voucher plans. The department has proposed a managed care pilot program that would shift about 28,000 Medicaid recipients from the fee-for-service system to an HMO. (See "Louisiana's Medicaid Managed Care Pilot Program" section.) The plan was recently approved by the Legislature. DH will soon submit it to HCFA, which must approve it before it may be implemented.

Potential Benefits of Medicaid Managed Care

Medicaid managed care, if planned and carried out carefully, has the potential to improve the quality of care Medicaid patients receive. It will also provide for increased budget predictability and may result in cost savings. The reasons for this are its emphasis on preventive and primary care, better coordination of and access to
care, and ongoing assessments of the care provided.

Because managed care uses primary care doctors or “gatekeepers” to oversee care, the chance of patients receiving unnecessary or conflicting services is reduced. Providers have an incentive to keep patients well. The focus is shifted from treating illnesses to keeping patients from becoming sick in the first place. More attention is paid to health education as well as to preventive and primary care.

Patients are also likely to have better access to care. Unlike the fee-for-service system, in which Medicaid recipients must find and travel to participating providers on their own, a managed care plan cannot refuse to see an enrollee. Under some contracts, the plans also provide transportation if needed.

Many states require that Medicaid health maintenance organizations (HMOs) have internal quality assurance systems as well as complaint processes. Under a managed care Medicaid program, a state has more control over quality than under fee-for-service. For example, if a state finds that a given HMO’s services are inadequate in some way, it can choose to terminate the contract.

**Potential Drawbacks of Medicaid Managed Care**

Medicaid managed care can potentially create incentives to limit care. Additionally, it is harder to track the quality and frequency of care under a managed care system than under a fee-for-service system. A politically unpopular aspect of Medicaid managed care is that its administrative costs are higher than a fee-for-service system.

The incentives to limit care stem from the fact that a plan or a provider receives the same payment whether no care is provided or very expensive care is provided. Medicaid recipients may have conditions that are more severe because they lacked access to basic health care before they enrolled in Medicaid. Medicaid recipients sometimes are not continuously enrolled, that is they lose and then regain eligibility. Therefore, there may be less incentive to provide the preventive care that results in future savings. If a Medicaid recipient’s eligibility status changes often, he or she also may not receive consistent enough preventive care to make a difference.

Under managed care, it is more difficult to track the care provided. After health care professionals provide services under the fee-for-service system, they submit a claim to Medicaid in order to be paid. The claim shows the services provided. Medicaid officials can detect fraudulent claims by checking with the patient to verify that the service was provided. Under a managed care system, there are no claims since providers are paid a capitation rate. This makes monitoring the care and detecting fraud more difficult.

Administrative costs are higher under Medicaid managed care than under fee-for-service. New management information systems must be purchased initially. The oversight agency must have a staff capable of evaluating the information. Ongoing monitoring and quality assessments are essential to a successful Medicaid managed care program. Despite the increased administrative costs, the medical care provided under managed care is often less expensive than under fee-for-service, so states often realize a net savings.

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**LOUISIANA’S MEDICAID MANAGED CARE PILOT PROGRAM**

DHHR will soon apply to the HCFA for approval of a two-year 1915(b) waiver of federal Medicaid law. (See Box 1 entitled “The Health Care Financing Authority Waivers and Medicaid Managed Care.”) The waiver would allow DHHR to test Medicaid managed care before trying it on a larger scale. Expanding the program to more than just the waiver participants would require additional legislative and HCFA approval.

The DHHR pilot program proposes trying Medicaid managed care in a seven-parish south central region of the state that includes Houma, Thibodaux and Morgan City. The proposal would require about 28,000 Medicaid recipients in that region to enroll in a managed care plan. The participants include about 17,000 who are Medicaid-eligible because of their ties to AFDC. Another 11,000 are eligible because they are enrolled in the Child and Maternal Health Program (CHAMP), also known as the federal SOBRA program. This group includes: pregnant women with incomes at or below 133% of the federal poverty level; children younger than six whose family income is less than 133% of the federal poverty level; and children ages six to 13 whose family income is less than 100% of the federal poverty level. The recipients would receive the same benefits they receive under the current fee-for-service system. In addition they would receive adult preventive care and healthy lifestyle education. High-risk pregnant patients
would also be eligible for case management.

DHH would contract with at least two HMOs to serve as the fully capitated managed care plans. Participating HMOs would be required to comply with the federal 75/25 rule that requires at least 25% of a plan’s total enrollees be commercial (non-Medicaid/non-Medicare) enrollees. This is to ensure that companies do not create substandard “Medicaid HMOs.”

Actuaries working for DHH would determine an acceptable capitation range. However, the range would not be revealed to the bidders. The bids would then be evaluated based on: the capitation rates (where they fall within the range); member enrollment and disenrollment procedures and policies; organizational structure; fiscal solvency; provision of benefits package; and, whether a plan meets DHH’s standards for: primary care provider capacity ratio (1,500 Medicaid managed care patients per provider or 2,000 managed care patients total per provider); travel distance to primary care provider (within 30 minutes or 30 miles of patient’s home); travel distance to specialists (75 miles from patient’s home; 60 miles or 60 minutes for laboratory or radiology services); quality of care management plan; member services; data reporting capabilities.

Medicaid managed care enrollees would be granted a window of time during which to choose an HMO and a primary care doctor. If they do not choose, DHH will assign one. As in commercial managed care plans, the primary care doctor would serve as the gatekeeper of the patient’s care. All specialized care would have to first be approved by the primary care provider.

The participating HMOs would be required to include “essential community providers” in their networks. These are providers who have historically treated indigent patients. They include rural health clinics, one children’s hospital, community health centers, small rural hospitals or any hospitals owned or operated by a hospital service district, state charity hospitals, doctors who have participated in the Medicaid program for five years and federally qualified health centers.

For Leonard J. Chabert Medical Center’s (the charity hospital in the pilot program region) Medicaid funding to continue, it would have to negotiate with the HMOs to provide services. Additionally, the doctors affiliated with the charity hospital would have to join the HMOs.

The HMOs would be prohibited from marketing their plans directly to potential enrollees. Instead, DHH would contract with a health benefits manager (HBM), a neutral party that would provide enrollees with marketing materials from each HMO and help them select one. DHH must approve HMOs’ marketing materials before they may be used. The HBM would also be required to have a staff that can respond to complaints and answer questions about enrolling in and dropping out of the plans. The HBM would be responsible for conducting outreach and education programs, surveying members about the care they received, and developing marketing materials for new enrollees. Many states use their fiscal intermediary, the company that processes and pays claims under fee-for-service, as the HBM.

The proposed pilot program includes four ways in which the quality of the services would be evaluated: each participating HMO would be required to have a comprehensive “continuous quality improvement” plan that examines both clinical and non-clinical quality of care; DHH would annually monitor the HMO through on-site reviews; participating plans must agree to this and make records and staff available to DHH; DHH would contract with an external organization to provide an independent assessment of the HMOs; the Department of Insurance and HCFA would monitor the plans.

To measure the effectiveness of the pilot program, DHH would gather data from before and after the pilot program begins to compare low birth weight births, preventive care visits during the first year of life, preventive care visits for four-, five-, and six-year-olds, adolescent comprehensive well care visits, mammograms, cervical cancer screening and access to care.

LESSONS FROM OTHER STATES’ MEDICAID MANAGED CARE EXPERIENCES

Almost all states require at least some of their Medicaid recipients to enroll in managed care plans. Louisiana is beginning its move to Medicaid managed care by trying first to treat the healthiest and least expensive Medicaid population. This is a logical way to build a base of experience as well as acclimate Medicaid recipients and providers to managed care. It’s also the way other states have done it. However, the real challenge of Medicaid managed care lies in determining whether the state can use it to successfully provide care for the Medicaid recipients with the most complex and expensive health care needs—people with dis-
abilities and the elderly. Few states have significant experience in doing so. Presented here is information about other states’ Medicaid managed care programs and experiences.

Arizona

Arizona, a noted leader in Medicaid managed care, operates the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Long Term Care System (ALTCS), mandatory Medicaid managed care programs that contract on a fully capitated basis with HMOs. The two plans covered 337,213 people in June 1995. AHCCCS covers the AFDC and other low-income populations while ALTCS covers the disabled and elderly. AHCCCS, established in 1982 through an 1115 waiver of the Social Security Act, was the first statewide Medicaid managed care program. In 1988 ALTCS was created to cover the disabled and elderly. As of July 1996, ALTCS covered about 88% of the state’s people with disabilities Medicaid-eligibles.

Arizona had the unique advantage of creating its program from scratch. The state never had a fee-for-service Medicaid program from which it had to transition. Even so, the state experienced the difficulties of being the first to create a statewide managed care program. In its early days, the program had a number of problems including a private firm, responsible for most of the program’s administration and oversight, that lacked the appropriate experience. Other problems included finding solvent health plans, willing providers and experienced staff. The problems were addressed and today the program serves as a model for the country with a number of innovations. The state has a sophisticated, competitive bid evaluation system as well as incentives for providers to report information about services provided (encounter data), often a problem under Medicaid managed care.

Tennessee

Tennessee’s Medicaid managed care program, TennCare, is a statewide program that contracts with HMOs and PPOs. Begun in January 1994, it is an ambitious plan that attempts to control costs and extend health coverage to the uninsured. It has some of the broadest enrollment provisions of Medicaid managed care programs in the country.

Initially, TennCare extended coverage to eligible uninsured, uninsurable and Medicaid-eligible individuals. However, in January 1995 the program closed enrollment in the uninsured category. The other two categories remain open today. Current TennCare enrollment consists of 1.2 million, 841,893 of whom are Medicaid-eligible and 321,814 who are uninsured or uninsurable. Included in the total enrollment are 138,931 people with disabilities Medicaid recipients who are required to enroll in managed care plans.

Under pressure to save money, the state shifted its entire Medicaid population to managed care so quickly that many recipients and providers were confused about the changes and their choices. The capitation rates paid to managed care companies were less than actual costs under the fee-for-service system. A number of providers and managed care companies suffered substantial losses as a result. Tennessee’s experience emphasized the value of transitioning to managed care slowly.

Oregon

Oregon’s Medicaid program is part of a broader effort, the Oregon Health Plan (OHP), to expand health insurance coverage to the uninsured. OHP consists of several health care reform efforts: (1) extending Medicaid eligibility to state residents with incomes less than the federal poverty level, (2) establishing an insurance pool for those who are unable to obtain coverage because of their health, and (3) expanding the range of insurance options available to small businesses and improving their employees’ ability to keep their health insurance if they change jobs.

The Medicaid portion is designed to cover all residents with incomes less than the poverty level. The program received national media attention because of its method for ranking health conditions and treatments and then providing coverage only for certain ones. In July 1995, the program covered 527,557 recipients. It enrolled nearly 120,000 new participants in its first year. The state had previous experience with Medicaid managed care through a section 1115(b) waiver prior to the passage of the OHP. (See Box 1 entitled “The Health Care Financing Administration Waivers and Medicaid Managed Care.”) The Medicaid managed care expansion under OHP has been based on an 1115 waiver. The state had a generally smooth transition in enrolling its low-income Medicaid recipients in managed care. This has been attributed to several factors: the state is small (2.8 million residents with the majority concentrated in two metropolitan areas); the state’s population is fairly homogenous; the state had sufficient managed care penetration.
prior to OHP and experience with Medicaid managed care; and the state had a substantial period of time to plan the program. In 1995, the state began enrolling people with disabilities Medicaid recipients in managed care plans. The state generally mandates such enrollment but does allow recipients with disabilities, under certain circumstances, to receive services on a fee-for-service basis. About 71% of the state's people with disabilities Medicaid-eligibles are enrolled in managed care plans.

**Key Considerations in Shifting Medicaid Recipients To Managed Care**

**Characteristics of the Medicaid Population:** Several characteristics of the Medicaid population may challenge commercial managed care plans. Medicaid recipients are likely to differ from the general population in a number of ways. Their lives are more likely to be unstable, economically and socially. They are likely to be less educated and have lower incomes. They are more likely to belong to racial or ethnic minorities and to live in medically under served areas. They are less likely to have access to transportation, a particular problem in Louisiana with its large rural areas. Because of changing economic circumstances, Medicaid recipients often qualify for Medicaid for only several months at a time. This is a problem for managed care, which relies heavily on long-term preventive care to achieve savings. They are also more likely than the general population to have disabilities. Managed care plans are just beginning to develop experience in dealing with their special needs.

**Time:** Several states have suffered for shifting their Medicaid populations to managed care too quickly. Arizona, while today running a model Medicaid managed care program, initially had serious problems. It allowed only three months for implementation from HCFA approval of its waiver to operation of the program. Likewise, Tennessee's managed care program (TennCare) was operating within two months of HCFA approval. In the year prior to the creation of TennCare, fewer than three percent of its Medicaid population were enrolled in managed care. TennCare enrolled all Medicaid recipients as well as some of the uninsured. Quite literally overnight the system shifted from predominantly fee-for-service to predominantly managed care. Many of the providers did not yet know which networks they would join. Many Medicaid recipients were forced to choose a plan without knowing whether their doctor would belong to it. During TennCare's early months, some providers did not get paid or had to wait a long time for payment. The key participants (recipients, providers, and administrative staff) in any new Medicaid managed care plan need time to adjust to a new system.

**Enrollment and Education:** In the transition to Medicaid managed care, recipients must choose the managed care plan in which they want to enroll. They must also select a primary care doctor. Faced with the option of two or more plans, they may not understand the choices and the differences among them. In many states, if an enrollee does not select a plan, the state automatically assigns one. After recipients are enrolled in a plan, they must be educated about how it works. Louisiana's high adult illiteracy rate may compound the difficulties for recipients in choosing a plan.

Many states have addressed this by providing recipients with counselors or ombudsmen.

Several states have learned that allowing managed care plans to directly market their products to Medicaid recipients provides too many opportunities for illegal activities in an effort by plans to maximize earnings. California, New York, Florida, Tennessee and Maryland experienced these kinds of problems. These activities have included bribes offered to public officials for information about recipients, incentives such as gifts to encourage recipients to enroll, misinformation about access to care under the plan, and enrolling people who were ineligible. These states have since changed their policies. One study suggested that a low rate of automatic assignment to plans may be an indicator of a successful enrollment policy.

Louisiana's proposed pilot program prohibits plans from directly marketing their products to Medicaid recipients. In the other states that have enacted such a prohibition, state employees or external contractors market the products rather than the managed care plans. Many states require that their oversight agencies approve marketing materials before they may be used. A state's decision about whether to use state employees or to hire an external contractor depends on its situation. Each approach also has advantages and disadvantages.

The benefit of using an outside firm is that it can generally respond better to the demands of a short-term busy enrollment period. The reason for this is that it does not have to adhere to state personnel rules so it often has more flexibility in expanding or reducing its workforce. It may also be able to provide the needed information systems that would be
Box 3
THE DIFFERENCE BETWEEN MEDICAID AND MEDICARE

People often confuse the Medicaid and Medicare programs. Medicaid is a public health care program for the poor, people with disabilities who are poor, and the elderly poor. Medicare is a public care program for the elderly, people with disabilities, and people with permanent kidney failure. Some elderly and people with disabilities are covered by both programs.

Medicare consists of two parts: Hospital Insurance (generally known as Part A) and Supplementary Medical Insurance (generally known as Part B). Part A covers hospital inpatient services, skilled nursing facilities, home health services and hospice care. Part B covers physician services, outpatient hospital services, medical equipment and supplies and other health services and supplies. Care not covered by Medicare is typically paid by the patient, by Medicaid, or by private insurance. Medicare is funded in part by employer and employee taxes and premiums paid by beneficiaries. Medicaid is not tied directly to a tax, nor do beneficiaries pay premiums.

Part A of Medicare provides limited nursing home coverage. This is the only nursing home coverage Medicare provides. Medicare pays for only about 5% of nursing home costs nationally while Medicaid pays for about half.

Box 4
CAPITATION RATES AND RISK

Setting capitation rates for participating managed care plans is a difficult task. If the rates are too high, the program will be expensive for the taxpayers and will result in excess profits for the managed care plans. With rates too low, plans must assume excessive risk. As a result, plans may not be interested in contracting with the state or if they do contract, they may become insolvent or services may be withheld. In determining capitation rates, consideration should be given to the demographics of the patient population. Care for a large number of people with disabilities will cost more than care for pregnant women and children. If the states pay the same capitation rate for all Medicaid recipients, plans have an incentive to enroll only the healthiest patients.

States approach the rate setting problem in different ways. Some set their rates at a percentage of the fee-for-service costs for a given population (for example, AFDC-related or people with disabilities). Other states use actuarial firms to set rates or a range of rates. Arizona has developed a sophisticated system. First an actuarial range is established. Then bidders are provided with special software that takes them step by step through their assumptions about the provision of care. If a bid is too high or too low, the state allows a bidder to negotiate and bid again. Bids are evaluated based on more than just the capitation rate. Consideration is also given to a plan’s network, program, and organizational structure.

Managed care plans often protect themselves from excessive losses by purchasing reinsurance. Arizona requires that plans purchase state-sponsored reinsurance. Louisiana’s pilot program proposes requiring plans to purchase com-
mmercial reinsurance and then to submit "shadow claims" (encounter data) as a record of the care provided. If a plan fails to submit the information timely, then sanctions and penalties will apply. Several states are experimenting with "risk corridors," limits on the losses and also the profits that a plan may experience.

Data Collection and Analysis: To gauge the effects of its Medicaid managed care program, a state needs sufficient data about the care provided. This is difficult to collect in a capitated system because providers do not file a claim each time they provide a service. Therefore, states need to create incentives for providers to gather and report this information about "encounters." Arizona found that paying providers prospectively (before services are provided) eliminated the incentive to report encounter data. The state encourages encounter reporting by paying the state-sponsored reinsurance based on encounter data. However, because Louisiana is expected to require plans to purchase commercial reinsurance, this incentive could not apply. DHH proposes sanctions and penalties for providers who fail to report encounter data timely.

Contracting With Community Providers: Many states require managed care plans to include "essential community providers" (sometimes called safety net providers) in their network of providers. Louisiana's proposed pilot program includes such a requirement. These providers are often excluded from managed care plans. These are providers from whom Medicaid enrollees often receive care. Including them in a

managed care network may provide enrollees with continuity of care.

Number and Distribution of Providers and Managed Care Plans: When more Medicaid participants are enrolled in managed care plans, it will be essential that there be a sufficient number and even distribution of primary care providers throughout the state. This has been a problem in Louisiana, particularly in the rural areas. There are also fewer managed care plans in the northern and more rural parts of the state.

Limiting "Carve-Outs": "Carve-outs" are services that are paid for on a fee-for-service basis when all other services are provided on a capitated basis. The problem with carve outs is that they limit the coordination of care, essential to the effectiveness of managed care. In addition, they create an incentive for cost shifting. However, most states carve out behavioral health services and contract with specialized mental health managed care plans.

People With Disabilities — A Special Case: People with disabilities have special and varied medical needs. Although nationally and in Louisiana they do not represent the majority of Medicaid recipients, spending on their needs represents a significant share of total Medicaid spending. Few states have experience providing managed care to people with disabilities. As of July 1996, only six states required some or all of their Medicaid recipients with disabilities to enroll in managed care plans. Ten states allowed recipients with disabilities to enroll voluntarily in managed care plans but few have chosen to do so. Louisiana, like most states as they move to managed care, has chosen to begin with a pilot program that covers the healthiest group of Medicaid recipients—low-income families and children.

Enrolling people with disabilities in managed care presents challenges for the states as well as for the managed care plans. One of the challenges states face is setting appropriate capitation rates. Because people with disabilities’ needs vary—some people have huge annual medical expenses while others with only mild disabilities may not need costly care—capitation rates need to be set in a way that accounts for the potential costs that certain patients may incur. This eliminates incentives for companies to deny or limit care to those patients whose care is expensive. Monitoring care for people with disabilities may also require greater administrative effort than is needed for the general Medicaid population.

Managed care plans focus on primary care and tend to limit access to specialty care. However, specialty care is often what people with disabilities need most. This raises the question of whether the person with a disability should have as his primary care doctor the specialist he sees. Another problem is that many managed care plans use "medical necessity" as a standard for approving treatment. To deem a treatment medically necessary typically means it will result in a significant improvement in a patient’s condition. But people with disabilities often do not have conditions that will improve significantly with medical care. Medical care for many of them is simply necessary to maintain their health status. It is unclear whether managed care for people with disabilities could potentially save money as it may for the general population.
CONCLUSION

Louisiana expects to soon start shifting Medicaid recipients to managed care on a limited basis. It is likely that managed care will be used more in future years for Medicaid. Such a change is significant because rather than being an insurer and claims processor, the state becomes a purchaser of managed care products.

The states that have had the most success with Medicaid managed care have devoted significant time, money and effort to planning. The cautious approach that Louisiana's Department of Health and Hospitals has adopted should help make its pilot program successful. However, most states have significant Medicaid managed care experience only with the healthiest Medicaid recipients.

The greater challenge will lie in determining whether managed care would be appropriate for the Medicaid recipients who have complex and expensive health care needs.

While managed care may potentially improve care and save money, it is not a panacea for Medicaid.
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