Syracuse University
SURFACE

Center for Policy Research | Maxwell School of Citizenship and Public Affairs

1-1-2000

Medicaid, Managed Care, and Kids. 12th Annual Herbert Lourie Memorial Lecture on Health Policy

Deborah A. Freund
Syracuse University, Maxwell School, Center for Policy Research, dfreund@syr.edu

Follow this and additional works at: http://surface.syr.edu/cpr

Part of the Health Policy Commons

Recommended Citation
Freund, Deborah A., "Medicaid, Managed Care, and Kids. 12th Annual Herbert Lourie Memorial Lecture on Health Policy" (2000). *Center for Policy Research.* Paper 23.
http://surface.syr.edu/cpr/23

This Working Paper is brought to you for free and open access by the Maxwell School of Citizenship and Public Affairs at SURFACE. It has been accepted for inclusion in Center for Policy Research by an authorized administrator of SURFACE. For more information, please contact surface@syr.edu.

THE 12TH ANNUAL
HERBERT LOURIE MEMORIAL LECTURE ON HEALTH POLICY

Medicaid, Managed Care, and Kids

Deborah A. Freund

No. 20/2000

Deborah A. Freund, Ph.D., MPH, is an internationally known health economist, recognized particularly in the areas of Medicaid, health care outcomes, and PharmacoEconomics, a field she is credited with beginning. She assumed the position of Vice Chancellor for Academic Affairs and Provost of Syracuse University on August 1, 1999. She is also Professor of Public Administration and Economics, and Senior Research Associate in the Center for Policy Research, Maxwell School of Citizenship and Public Affairs. Freund earned an MPH in Medical Care Administration from the University of Michigan School of Public Health in 1975 and a Ph.D. in Economics from the University of Michigan in 1980. She has written more than 100 articles and chapters, two books, and has been the principal investigator of grants and contracts totaling more than $40 million. She has also been on the editorial board of nine journals.

The Policy Brief series is a collection of essays on current public policy issues in aging, health, income security, metropolitan studies, and related research done by or on behalf of the Center for Policy Research (CPR) at the Maxwell School of Citizenship and Public Affairs.

Single copies of this publication may be obtained at no cost from the CPR Web site at <http://www-cpr.maxwell.syr.edu> or from the Center for Policy Research, 426 Eggers Hall, Syracuse, NY 13244-1020.

© 2000, Syracuse University. This publication may be distributed freely for educational and researcher uses as long as this copyright notice is attached. No commercial use of this material may be made without express written permission.

Medicaid, Managed Care, and Kids

Today, I will talk about what **managed care** for **Medicaid** is, how it influences kids, and how it relates to the **State Child Health Insurance Program (CHIP).** I will focus on what we have learned over the last 20 years through research about cost, use, and quality. I will also discuss some of the expectations we had for children covered by Medicaid managed care. Finally, I will talk about the future of Medicaid managed care and the implications for CHIP.

Managed care is risk-based care. That is, the providers of service generally are at risk from a financial perspective. Managed care plans provide a wide range of comprehensive health care services to an enrolled population of patients in exchange for a fixed periodic payment per head, called the **capitation** rate. **Health maintenance organizations (HMOs),** which are the best known form of managed care and a common form of Medicaid managed care, typically employ some form of capitation to pay the providers who are affiliated with them or engage in other payment relationships that share the risk of the typical insurance company with those providers. Services can be provided through either a decentralized or highly centralized set of medical facilities.

Primary care case management (PCCM) is another plan type utilized for Medicaid managed care contracting. In a PCCM, Medicaid beneficiaries enroll with a specific primary care provider or agency, often called the **gatekeeper,** who is responsible for coordinating their medical care and for arranging all necessary referrals to consultants, hospitals, or special

Note: Terms that appear in **bold** are defined in the glossary at the end of the text.

services. Typically, the gatekeeper's prior approval is required for the managed care company to pay for specialty and hospital except in true emergency situations.

The central question we examine is: How do these two forms of managed care, HMOs and PCCMs, compare in terms of expenditures, utilization rates, and quality of care, in contrast to the old fee-for-service Medicaid system, which is rarely seen anymore? And specifically: How well do they meet the needs of kids?

Background

In 1993, with Eugene Lewit at the Packard Foundation, I wrote,

> Though the evidence suggests that managed care is here to stay, there is disagreement about what, if any, impact managed care has had on health care and costs. Moreover, little of the deluge of propaganda and research on the effects of managed care has focused in a rigorous empirical and scientific manner on whether managed care is good for children and pregnant women. Our research suggests that available research does not support most claims of large cost savings or improved quality of care for children and pregnant women as a result of managed care.

What, if anything, has happened since 1993 to change this assessment?

Managed care has actually been around in some form since at least the 1960s, when Kaiser Permanente in the northwest region, under the leadership of a man named Ernie Saward (well known in the Rochester, New York, community before then), started, with funding support from the State of California, enrolling low-income persons. There was nothing in those days named managed care, although there were **prepaid group practices**, Kaiser being one of the first established in 1948.

It was actually in the Nixon administration that the term "health maintenance organization" was coined. Paul M. Ellwood, M.D., a Minneapolis physician who directed the American Rehabilitation Foundation, had been arguing for several years that the fundamental structural incentives associated with fee-for-service medicine should be shifted. The financing system, according to Ellwood, should reward health maintenance rather than reward providers for each service rendered. As an alternative to both fee-for-service and centralized governmental financing, Ellwood recommended prepayment for comprehensive care. He suggested calling these groups of providers "health maintenance organizations." His efforts led, in part, to the passage of the National Health Maintenance Act of 1973 which provided funding for grants and loans to new HMOs.

However, it wasn't until Ronald Reagan became President in 1980 that any decision was made to try to move people covered by Medicare and Medicaid into managed care. I happened to be on the first panel that was drawn up during the Reagan Administration to award the first national contracts for Medicaid to enroll persons in HMOs, or what came later to be known as managed care organizations. The Omnibus Budget Reconciliation Act (OBRA) of 1981 allowed states for the first time to enroll parts of their Medicaid populations into managed care through a process called waivers. Waivers allowed states to essentially break the laws governing "statewideness." Under the law, statewideness meant care had to be delivered to all Medicaid beneficiaries in the same way. A lot of places in those days wanted to break the law and selectively provide managed care opportunities to Medicaid beneficiaries residing in some but not all localities in the state. We'll talk about why in a minute.

If you look at what's happened to Medicaid enrollment in managed care over the years, you can see the tremendous growth that happened in the 1990s. If you will recall, in the early 1990s there was an economic recession that coincided with the start in this growth. Discretionary or entitlement spending in the states started to outstrip the ability of the states to pay for it, and legislatures all over the country were looking for anything that

would help reduce costs. In health care, a lot of people decided that managed care enrollment would accomplish this objective in the Medicaid program. That is why we saw the large growth.

Forty states started to experiment with moving groups of Medicaid-eligible persons into managed care, first in a voluntary way and then, by the late 1990s, on a mandatory basis. Now, 48 of 50 states use this vehicle for their Medicaid population. In many of those states it's the only game in town.

Whereas in the early 1990s only about 10 percent of the approximately 3 million people eligible for Medicaid were in managed care, by 1998 it was 53.6 percent or 16.6 million Medicaid beneficiaries, and now it's almost 60 percent. As the non-standard populations, such as those with chronic illness who are covered through SSI, or what was SSI, become enrolled, we will continue to see growth.

The percentage of the total Medicaid population in managed care varies widely, although most states have at least 25 percent, and 31 states have at least half (including New York) of their Medicaid beneficiaries in managed care. Medicaid managed care in New York goes back to the beginning of Medicaid, but it was quite limited until the early 1990s. Legislation in 1991 and 1992 initially spurred the growth of voluntary programs, but that growth quickly leveled off. In 1995 New York applied for a **section 1915(b) waiver** to move to a mandatory program, and it was approved in 1997. Other states, like Minnesota, Washington, and Massachusetts, where the penetration is over 75 percent, have been in this business almost since the beginning.

In 1998, 41.4 million people were enrolled in the Medicaid program, including 18.9 million children, 7.9 million adults, 3.9 million elderly, and 6.6 million people who were blind or disabled. About 55 percent of the enrollment in Medicaid managed care is children.

Medicaid managed care originally started with mostly voluntary enrollment, but by 1998, 82 percent of all the states had moved

into mandatory enrollment, where there is no choice: it's an HMO or nothing if you're in Medicaid. For those states that use the primary care case management, or PCCM vehicle, the same is true, only since it's viewed as less restrictive, those that mandate it do so 93 percent of the time.

Welfare Reform and the Beginning of CHIP

In 1988, Medicaid provided health insurance for 15.6 percent of all children. By 1993, Medicaid coverage of children grew to 23.9 percent. During this same time period, however, employer-sponsored insurance coverage for children under age 18 declined from approximately 64 percent to 57 percent. As a result, many children residing in families with incomes too high to qualify for Medicaid were left uninsured (HCFA 2000).

In 1996, Congress decided to get rid of welfare as we knew it and passed the Personal Responsibility and Work Opportunity Reconciliation Act, which among other things broke the link between welfare eligibility and Medicaid eligibility. Previously, you had to be eligible for welfare to get Medicaid. Aid to Families with Dependent Children (AFDC) was replaced by Temporary Assistance to Needy Families (TANF) and Medicaid is a stand-alone program. On the heels of that reform, Congress passed the Balanced Budget Act of 1997, which established the Child Health Insurance Program (CHIP). Its basic aim was to enroll all uninsured children in a health insurance program. States were given three options: expanding their Medicaid program to cover uninsured kids, rolling our their own CHIP program, or some combination of the two, as long as they met certain criteria. As of June 2000, 23 states and territories have expanded their Medicaid programs, 15 started CHIP programs, and 18 turned to a combination of the two.

States that actually expanded their Medicaid programs, extending them to include kids who didn't qualify for Medicaid before the new law but now did, used a managed care model. Similarly, those that chose to develop their own programs, which by and large were supposed to mimic more what a private sector

program would look like, also chose to use the managed care model and sometimes the local Medicaid managed care delivery system or part of that delivery system to deliver care to those kids. You can't look these days at the CHIP program without realizing that it's strongly connected to Medicaid managed care. Therefore, what we can learn from Medicaid managed care for kids may also apply to those kids who never had health insurance before but now are covered by CHIP. Often, the kids covered under CHIP are going to the same providers as those who are covered under Medicaid managed care.

The percentage of uninsured children who actually receive coverage through the CHIP program also varies greatly by state. New York is in the highest group, with more than half of uninsured children covered, while many other states have barely figured out how to do it (currently, 15 states cover 15 percent or less of their uninsured children). Despite how well we're doing, only 2 million of the 7.2 million uninsured kids under age 19 in the entire country were covered by CHIP as of last year, and a large fraction of those, of course, were in New York. So we have a long way to go.

Research Findings

Now, I want to talk now about the particular research that I've done focusing on Medicaid managed care for over almost two decades, highlighting the findings and what we might conclude about best practices in Medicaid managed care. By and large, all of my studies focus solely on what was then known as AFDC, which is why I decided today to talk about kids. In my own CHIP study, we are focusing particularly on kids with special health care needs, those who are chronically and seriously ill, and who access other state resources, because little is known about them.

Across all my studies I have looked at three program prototypes:

- **Type 1: Fee-for-Service Primary Care Gatekeeping**
  Enrolled with primary care physician/clinic

No financial incentives, but may pay case management fee

These are the PCCM programs

- **Type 2: At-Risk Primary Care Gatekeeping**

  Enrolled with primary care physician/clinic

  Financial incentives for primary care physicians and maybe others

- **Type 3: HMO/Prepaid Health Plan Enrollment**

  Enrolled with integrated delivery system

  Plan is paid capitation

In a Type 3 program model, for example, you might have three HMOs in a community, and a Medicaid beneficiary must get enrolled and get all his or her health care from one of the three.

Hypotheses: What did we expect to find when there is a high degree of penetration of Medicaid managed care?

Essentially, the premise is that access would improve, resulting in better quality of care, to the extent that it could be measured. And money would be saved along the way. Specifically, we believe that as more Medicaid-eligible individuals are enrolled into managed care:

1. Hospital use will decline.

In the early days of prepaid group practice and HMOs, the idea was if you prepaid for health care, you would think very hard about how every health care dollar was spent, and you would cut out everything that was unnecessary. The prevailing wisdom at the time was that a lot of things that happened in the hospital were unnecessary, and that expensive hospital use could be reduced.

2. Emergency room (ER) use will decline.

It's simply a truism that people who are uninsured or poor have lacked access to health care and to physicians, and because of it used emergency rooms for their care. There were also people

who believed that Medicaid beneficiaries didn't take care of themselves, or might even have been drug abusers and doctor-shopped, simply went from doctor to doctor to doctor, or ER to ER to ER, to get prescriptions.

Now, as for physician use, there was a controversy.

3a. One group said if you provide greater access to mainstream medicine and a relationship with a primary care physician that they never had, then physician use, at least on the outpatient side, should go up.

3b. But specialty use might go down if it had been overutilized or misutilized.

4. Expenditures or costs would be reduced through lessened hospital and emergency room use.

We tried to find out through all of these studies whether or not those hypotheses were borne out by the data.

Data and Methodology

With a few exceptions, all of these studies were quasi-experiments. We observed people who were in Medicaid managed care in one community and then tried to find a similar community in that state where Medicaid managed care hadn't been introduced, and compared the experience of the people who were in Medicaid managed care to that of people who were not. We wanted to look at what happened to Medicaid beneficiaries before they went into managed care and after in comparison to Medicaid beneficiaries who were not in managed care.

We used a variety of sources of data. The predominant data that I'm talking about today is claims data. When a health care provider bills for a service they submit an insurance claim. The claim essentially says: "I provided this service to this person and this is what my charge is." The provider sends it in and expects some reimbursement, these days a lot lower than what they would have hoped for in the past. In managed care, because

providers aren't paid on a fee-for-service basis, there is no reason to submit a claim. Instead, we used pseudo-claims; states mandated physicians who were seeing Medicaid beneficiaries under managed care to submit an informational claim without a charge, simply to say what they did to whom, and for what reason. Or we actually used their encounters, where we went into their offices or into the managed care plans and collected the data ourselves. For some of the quality of care analyses, we actually did large extractions from medical records and patient surveys.

The variables we used throughout our research include: age, race, sex or gender, months of eligibility, enrollment in Medicaid managed care and for how long, previous expenses, self-reported health status, and detailed clinical information about the patients' experiences.

I now summarize findings from many of my studies that have appeared in the literature. [For a list of articles from which these observations were taken, see References at the end of the text.]

Medicaid Competition Demonstrations, 1983-1989

We observed demonstration programs in California, Missouri, Minnesota, and New Jersey. In reporting these findings to you, I have taken away all the numbers because they cloud the story that I want to tell.

- **Hospital use:** there wasn't an effect a lot of the time, but when there was it was in the right direction: managed care leads to less hospital utilization.

- **Emergency room use:** this is the strongest finding across my studies. ER use takes a plummet under Medicaid managed care and that's precisely what you want.

- **Physician care, in particular primary care physician care:** it does not go in the direction that you would want to see. That is, you see fewer visits to both primary care physicians and specialists than under fee-for-service. Later on I'll show

you that this result is related to the way those physicians are paid, that is, it's due to capitation payment.

- **Cost savings:** where they occurred, the cost savings were not great. Legislators who were looking for big declines in what they would pay from public coffers for Medicaid would not be happy. Even where there was a significant decrease in expenditure, it was in the range of 10 percent or less, and most of the time we didn't find that.

Meta Analysis, 1992

When we broadened our field of inquiry to look at all the studies that existed as of 1992, what did we find? Basically we found the same thing. There were 250 studies at that time, but we eliminated those that didn't have some kind of comparison group or some kind of statistical analysis that would allow us to compare the underlying populations. That left 25 studies, including waiver packages, that met our criteria. We then analyzed results from a subset of 12 programs with the strongest methodologies.

In inpatient use, we saw very mixed results; it wasn't convincing across all of the studies that Medicaid managed care produced much of a decline. This really makes sense if you think about what's going on with kids. Aside from those who were seriously ill, they were in the hospital largely for birth or for minor things. We saw a similar pattern of use for moms. So if this was the place you were going to save, at least hypothetically, this is not the place you would expect to find large savings.

Emergency room use declined in 75 percent of the studies. In 75 percent of the studies, physician visits either declined or there was no change. Only in 25 percent of the studies did physician visits for kids increase. Finally, 58 percent of the studies showed some cost savings, in the range of 5 to 20 percent.

Mandatory versus Voluntary Enrollment

Of the 25 programs we studied, 19 involved mandatory enrollment and 6 had voluntary enrollment. The major question

was: Do you have to conscript Medicaid beneficiaries to get the advantages, if any, of Medicaid managed care? Basically the bottom line is that you do. You realize greater savings if you mandate enrollment in managed care, particularly through declines in hospital use, but you can achieve similar reductions in ER use through either voluntary or mandatory programs.

Capitation versus Fee-for-Service Reimbursement

How much of that is really due to Medicaid managed care versus the particular way in which you pay a hospital or a physician? Of the 25 programs in the study, 17 paid by capitation and 8 by fee-for-service. We found an increase in physician use 63 percent of the time under fee-for-service, compared to 35 percent of the time when physicians were paid under capitation. Therefore, if you want to increase primary care physician use you don't want to pay physicians with capitation but if you are interested in reducing specialty use, capitation may be the approach.

We also observed a decrease in emergency room use approximately 50 percent of the time, regardless of the method of reimbursement. We attributed this result to the effect of the gatekeeper mechanism.

With regard to inpatient use, you can reduce inpatient use whether or not you pay hospitals on a capitation rate. It all has to do with the type of utilization review that you use. It isn't in the payment mechanism. What seems to matter is the overall payment to the managed care organization, and not the specific way in which you pay providers.

Summary of Program Effects by Prototype

Of the 25 programs we studied, 8 were Type 1, 11 were Type 2, and 6 were Type 3, as described earlier. Type 1 programs exhibit the largest increase in physician visits, while the largest declines appear in the fully capitated models. For ER use, because it all comes through a gatekeeper, it doesn't matter what model you use. You can achieve declines in inpatient use from all three

models. And similar cost savings are achieved by all three models.

1915(b) Waiver Program Evaluations, 1993-1997

Research evaluating the 1915(b) waiver program show some things that are similar. When we looked at access to care, we were basically looking at whether Early Periodic Screening and Diagnostic Testing (EPSDT) referrals continued under managed care in comparison to fee-for-service. Where we could measure it, it did. Similarly, what happened to the rate of ambulatory sensitive conditions? These are conditions where hospitalizations are thought to be avoidable by good primary care. Where we could measure it across all studies, we found that there were fewer of these hospitalizations that could have been avoided under managed care in comparison to fee-for-service, which people in the field like to attribute to better access to care, one of the goals of Medicaid managed care.

When we looked at the direction of significant impacts on utilization and expenditures for Medicaid children, we found exactly the same things in the 1990s as I found in the 1980s.

Preventive Care: Immunizations, Birth Weight

Finally, we looked at claims data to measure the impacts on quality of care. Once again, my 1980s study did it, but with very different data. A key question is, of course: Was there any clinical or outcomes benefit to the patients? And the answer is sometimes there was, but more often there wasn't.

We looked at compliance with well child care periodicity schedules on two occasions. In one case we found an improvement, and in one we didn't. Where we could look at compliance with immunization schedules, we found almost no difference, and I'll tell you why. First of all, managed care and Medicaid fee-for-service have very, very low immunization compliance rates. A lot of these plans actually carve out immunizations; states don't pay managed care companies to provide immunizations. People have to continue to go to health

departments or clinics to get them. And when it's not coordinated, they don't get it. There were many instances where people got them in private physicians' offices, because those physicians believed in immunizations so much that they provided them themselves, without compensation.

We also looked at birth weight. If mothers get into prenatal care earlier by virtue of managed care, does the birth weight of those babies rise? Generally there's a very high correlation between poverty and birth weight. If a child is born into poverty it is much more likely to weigh five pounds or less at birth, because its mom has had poor nutrition, probably didn't get good access to health care for herself, and didn't have prenatal care, among other things. Basically we found no difference at all between programs. Where we could measure it, where birth weights actually improved in two cases, they improved very little.

Conclusion

So where does this leave us? What's the bottom line? The bottom line, I think, is that managed care is here to stay, even though it hasn't met its promises. We're going to continue to see it used for Medicaid. The use changes that we expected to see happened on the hospital and ER side, but there's no evidence that access to physician care nationally improved. Quality improvement is sometimes demonstrated, but not all that often. Savings are modest.

The Challenges for CHIP

Earlier I mentioned that of the 7.2 million kids nationally who might be eligible for CHIP program, only 2 million or so were enrolled. We're having problems just getting those kids into CHIP, getting them health insurance. When we lay Medicaid managed care models on top of that, we may find that, unless we're careful, there will be no improvement in quality and we will have spent a lot of money. This means that we have to focus our efforts on outreach to the families, to entice them into CHIP,

and then on how to get physician care. We probably can't meet those two goals through models of Medicaid managed care.

Best Practices

When Medicaid managed care came into full force in the 1990s (versus the gradual way it was phased in during the 1980s), it was during a time of economic recession, when we were looking for large savings, or at least to blunt the rate of growth of expenses. As a result, no new money was put in, and overall the rate of reimbursements was cut. If new monies were put in, it was simply because more people became eligible through either mandatory or voluntary eligibility expansions to Medicaid.

Medicaid has underpaid every provider since its beginning, but Medicaid managed care is in the position of trying to do something that the fee-for-service system was never able to do. As you know if you read the front page, there's been a major exodus out of managed care in the Medicare program, and we're beginning to see that exodus in Medicaid, too, due to underfinancing.

If we don't tackle all of our problems in a cooperative way, and if we're unable to spend more money, we will be unable to protect our children and their future. How we do it remains to be seen. I can envision a public sector solution and I can envision a private sector solution.

Nevertheless, I conclude in the year 2000 with exactly what I wrote in 1993. Our review, and mine today, suggests that available research does not support most claims of cost savings and improved quality of care for children and pregnant women in Medicaid as a result of managed care.

Thank you.

References

Medicaid Competition Demos

Carey, Timothy S., Kathy Weis, Charles Homer. 1991. "Prepaid versus Traditional Medicaid Plans: Lack of Effect on Pregnancy Outcomes and Prenatal Care." *Health Services Research* 26(2).

Freund, Deborah A., Louis F. Rossiter, Peter D. Fox, Jack A. Meyer, Robert E. Hurley, Timothy S. Carey and John R. Paul. 1990. "Evaluation of the Medicaid Competition Demonstrations." *Health Care Financing Review* 11(2):81-97.

Freund, Deborah A., Robert E. Hurley, Killard W. Adamache, and Josephine Mauskopf. 1990. "The Performance of Urban and Public Hospitals and Neighborhood Health Centers Under Medicaid Capitation Programs." *Hospital and Health Services Administration* 35(4), Winter:525-546.

Freund, Deborah A. and Eugene M. Lewit. 1993. "Managed Care for Children and Pregnant Women: Promises and Pitfalls." *Health Care Reform* 3(2), Summer/Fall: 92-123. <http://www.futureofchildren.org/hcr/HCR.pdf>.

Hurley, Robert E. and Deborah A. Freund. 1988. "Provider Selection or Assignment in a Mandatory Case Management Program: Determinants and Their Implications for Utilization." *Inquiry* 25(3), Fall:402-410.

Hurley, Robert E., Deborah A. Freund, and Barbara J. Gage. 1991. "Gatekeeper Effects on Patterns of Physician Use." *Journal of Family Practice* 32(2), February:167-174.

Hurley, Robert E., Deborah A. Freund, and Capt. Donald E. Taylor. 1989. "Emergency Use and Primary Care Case Management: Evidence from Four Medicaid Demonstration Programs." *American Journal of Public Health* 79(7), July:843-847.

Hurley, Robert E., Deborah A. Freund, and Capt. Donald E. Taylor. "Gatekeeping the Emergency Department: Impact of a Medicaid Primary Care Case Management Program." *Health Care Management Review* 14(2), Spring:63-72.

Hurley, Robert E., John R. Paul, and Deborah A. Freund. 1990. "Going into Gatekeeping: An Empirical Assessment." *Quality Review Bulletin* 15(10):306-314.

Hurley, Robert. 1991. "Rollover Effects in Gatekeeper Programs: Cushioning the Impact of Restricted Choice" *Inquiry* 28(4), Winter:375-84.

1915(b)

LoSasso, A., N. Gavin, and D. Freund. 1998. "Children's Preventive Care Use Under Two Mature Medicaid Managed Care Plans in California." *Health Care Financing Review* 19(4):69-83.

Ming Tai Seale, A. LoSasso, and D. Freund. Forthcoming. "The Long Term Effects of Medicaid Managed Care on Obstetrical Care in Three California Counties." *Health Services Research*.

Research Triangle Institute. 1997. "Evaluation of Medicaid Managed Care Programs with 1915(b) Waivers: Final Interim Report." Prepared for the Office of Research and Demonstrations, Health Care Financing Administration under HCFA Contract No. 500-92-0033. February.

Meta Analysis

Hurley, Robert, Deborah Freund, and John Paul. 1993. *Managed Care in Medicaid: Lessons for Policy and Program Design.* Chicago: Health Administration Press.

Other References

Health Care Financing Administration (HCFA) is the federal agency that administers Medicare, Medicaid, and the State Child Health Insurance Program (SCHIP). See, for

example, *A Profile of Medicaid: Chartbook 2000*, at <http://www.hcfa.gov/stats/2Tchartbk.pdf>.

Lee, Jason S. 1997, *Managed Health Care: A Primer.* Congressional Research Service, Library of Congress, Publication 97-913 EPW. <http://www.senate.gov/~dpc/crs/reports/ascii/97-913>.

Center for Studying Health System Change (HSC)

HSC is a non-partisan policy research organization. Under the leadership of Paul Ginsburg, HSC provides incisive, timely analyses about the effects of health system change to inform the thinking and decisions of policy makers in government and industry. HSC does not advocate policy positions, but is a resource for decision makers on all sides of the issues because of its reliable data and objective analyses. HSC, funded exclusively by The Robert Wood Johnson Foundation, is affiliated with Mathematica Policy Research, Inc. Its most recent publication is:

"Some Communities Make Progress in Reducing Children's Uninsurance." Data Bulletin #19. October 2000. Michael H. Park, Peter J. Cunningham. <http://www.hschange.com/ CONTENT/276/>. Although the rates of uninsurance for children nationally did not change between surveys conducted in 1996-1997 and 1998-19991, some communities experienced a significant decline in children's uninsurance rates during this period, according to recent findings from the Center for Studying Health System Change (HSC). The children's uninsurance rates dropped from 7 percent to 3 percent in Boston, from 17 percent to 12 percent in Little Rock and from 7 percent to 4 percent in Syracuse. They also declined in Miami, Greenville and Cleveland, although these decreases were not statistically significant.

Kaiser Family Foundation

The Kaiser Commission on Medicaid and the Uninsured is the Foundation's largest operating program and serves as the organizing vehicle for the Foundation's work on health care for low-income people. The Commission functions as a policy

institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is based at the Foundation's Washington, DC office. Publications about Medicaid and CHIP include:

Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures. Prepared by Donna Cohen Ross and Laura Cox. October 2000. <http://www.kff.org/content/2000/2166/hjksmall.pdf>.

The Characteristics and Roles of Medicaid-Dominated Managed Care Plans. Prepared by Suzanne Felt-Lisk. February 2000. <http://www.kff.org/content/2000/2180/CharacteristicsandRoles.pdf>

Medicaid Enrollment in 50 States: June 1997 to December 1999. Prepared by Eileen R. Ellis and David M. Rousseau. October 2000. <http://www.kff.org/content/2000/2210/>.

Health Coverage for Low-Income Children. <http://www.kff.org/content/1999/2144/>.Last updated in March 2000.

The Kaiser Project on Incremental Health Reform. In November 1996, the Kaiser Family Foundation initiated a project to examine different strategies for expanding health insurance coverage to America's growing uninsured population. The Foundation asked two leading health policy experts with experience in Democratic and Republican leadership roles, Judith Feder and Sheila Burke, to direct the project's work in considering and evaluating the potential for, and likely impact of, alternative incremental reform options. This continuing effort has made important contributions to the public and policy dialogue about covering the uninsured. With new proposals emerging across political parties as we head

into the 2000 election, the project's analysis of tax-based reform options along with direct subsidy or government expansion options is directly relevant and useful to the debate.

Analysis of a Specific Tax/Health Credit That Provides Insurance to All Children. Wendell Primus. <http://www.kff.org/content/1999/19991112d/>.

Children's Health Insurance Coverage: Tax Credit and Publicly Sponsored Children's Insurance Pool. Linda Blumberg. <http://www.kff.org/content/1999/19991112e/>.

A Premium Subsidy Program for Modest Income Children. Mark Merlis and Richard E. Curtis. <http://www.kff.org/content/1999/19991112f/>.

Children's Health Insurance: The Difference Policy Choices Make. John Holahan, Cori Uccello, and Judith Feder. <http://www.kff.org/content/1999/19991112g/>.

The New Child Health Insurance Program: A Carefully Crafted Compromise. Alan Weil. October 1999. <http://www.kff.org/content/1999/19991112l/>.

Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says. Lisa Dubay. October 1999. <http://www.kff.org/content/1999/19991112m/>.

A Guide to Managed Care Terms and Acronyms

Medicaid

Title XIX of the Social Security Act is a program which provides medical assistance for certain individuals and families with low incomes and resources. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the federal and state governments to assist states in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-

related services to America's poorest people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally-assisted income maintenance payments.

Within broad national guidelines which the federal government provides, each of the states:

1. establishes its own eligibility standards;
2. determines the type, amount, duration, and scope of services;
3. sets the rate of payment for services; and
4. administers its own program.

Thus, the Medicaid program varies considerably from state to state, as well as within each state over time. (From the HCFA Web site, at <http://www.hcfa.gov>.)

Section 1915(b) Waiver

The Social Security Act authorizes the Secretary of the Department of Health and Human Services to waive requirements of Section 1902 of the Act to administer specific *freedom of choice waiver programs* to mandatorily enroll beneficiaries in managed care programs, provide additional services via savings produced by managed care, create a "carve-out" delivery system for specialty care, and/or create programs that are not available statewide. In 1998, 35 states and the District of Columbia operated 84 Section 1915(b) waivers.

Children's Health Insurance Program (CHIP)

Also known as Title XXI of the Social Security Act, CHIP was established by Congress in the Balanced Budget Act of 1997 (P.L. 105-33). CHIP provides states with funds to provide health insurance for children whose families earn too much to qualify for Medicaid, yet not enough to afford private health insurance. At the federal level, CHIP is administered by the Health Care Financing Administration, which also administers Medicare and Medicaid.

States have three options for covering uninsured children. They can use CHIP funds to provide coverage through separate children's health insurance programs, expand coverage available under Medicaid, or combine both strategies. An additional goal of SCHIP is to identify and enroll children already eligible for Medicaid but not enrolled. To date, all 50 states, territories, and the District of Columbia have established CHIP programs.

Title XXI requires performance measurement, evaluation, and the collection and analysis of data that are critical to understanding the impact of CHIP on children's coverage, access to care, and use of health care services. Many states have also streamlined the application process, and improved procedures to assure that children retain coverage for as long as they are eligible.

CHIP eligibility is generally limited to "targeted low-income children," defined in section 2110 of Title XXI as a child whose family income exceeds the Medicaid applicable income level, but not by more than 50 percent, or whose family income is at or below 200 percent of the federal poverty lines, whichever is higher. However, states have broad flexibility under the federal SCHIP law to provide coverage to children at higher income levels through the use of income disregards. (Summarized from The Children's Health Insurance Program web site at <http://www.hcfa.gov/init/children.htm>.)

Managed Care

A managed care plan integrates the financing and delivery of specified health care services by means of four key elements:

1. arrangements with selected providers to furnish a comprehensive set of health care services to plan members;
2. explicit standards for the selection of participating health care providers;
3. formal programs of quality assurance and utilization review;
4. significant incentives for members to use providers associated with the plan.

Prepaid Group Practice

Health benefit plans that provide a defined set of health services to an enrolled population for a predetermined premium.

Provider Network

An organizations of providers (physicians and hospitals) that services managed care plans. Network providers are selected with the expectation that they will deliver care inexpensively, and enrollees are channeled to network providers to control costs. Individual providers may belong to several different networks. Individual managed care plans may develop their own networks by contracting directly with providers, "rent" access to existing networks, or pool their local networks to build networks over large geographic areas.

Indemnity Health Insurance Plan with Utilization Controls ("Managed" Indemnity Insurance)

These plans allow freedom of choice of provider and pay providers on the basis of undiscounted fee-for-service. Plans typically employ some form of utilization management such as preadmission certification and concurrent review for hospitalizations and high-cost care management (see Utilization Management below). Under current rubric, these plans are not considered to be "managed care."

Forms of Managed Care

Health Maintenance Organization (HMO)

The term "health maintenance organization" was coined by Dr. Paul Ellwood, who had concluded that fee-for-service compensation arrangements created "perverse incentives" which rewarded physicians and institutions for treating illness and then withdrew those rewards when health was restored. Ellwood proposed a nationwide system of prepaid group practices, which he believed would help control costs and provide effective care. This became the focus of President Nixon's 1971 Health

Message to Congress and led to support for development of HMOs in the 1973 HMO Act (Lee 1997).

A health maintenance organization is a managed care plan that provides a wide range of comprehensive health care services to an enrolled population of patients for a fixed periodic payment (called a capitation rate). In addition to the four key elements of managed care plans enumerated above, HMOs typically employ some form of capitation payment to providers and provider risk sharing, and many deliver care through integrated medical facilities.

Four models of HMOs have been identified:

1. Staff model HMOs provide services directly through physicians who are salaried employees of the plan.
2. Group model HMOs contract with an independent group of practitioners to provide services.
3. Network HMOs contract with two or more group practices. Under both the group and network models, physicians may be paid on a fee-for-service, salaried, or capitated basis.
4. Independent practice association (IPA) HMOs contract directly with individual physicians in private practice. Physicians are paid on either a discounted fee-for-service or capitation basis.

Preferred Provider Organization (PPO)

An arrangement by an insurer to provide medical services through a panel of preferred providers who contract to deliver services at lower-than-usual fees in exchange for prompt payment and a certain volume of patients. The PPO usually also provides some utilization review services. Enrollees are not restricted to the panel of providers but incur lower out-of-pocket costs if they use participating providers.

Point-of-Service (POS) Plan

Combines characteristics of both HMOs and PPOs to balance cost control with freedom of choice. Enrollees select a primary care physician gatekeeper from a network of physicians

contracted to the plan. The cost to the enrollee for care provided by a network provider is very low or nothing. Enrollees may obtain care from out-of-plan providers but with significantly higher cost sharing.

Primary Care Case Management (PCCM)

A form of managed care for Medicaid enrollees under which a specific person or agency (typically a clinic), called a *gatekeeper* (see definition below), is responsible for coordinating the medical care of an enrollee and for arranging for necessary referrals to consultants, hospitals, or special services. Prior approval of the gatekeeper for specialty or hospital care is typically required except in true life-or-death emergencies.

Single Service or Target Managed Care

Managed care applied to specific services, such as mental health and substance abuse services, prescription drugs, and dental care. Plans may include utilization review, networks with gatekeepers, case management services, and discounted prices from network providers.

Important Cost and Utilization Management Features of Managed Care Health Plans

Financial Incentives

Capitation. An all-inclusive payment to a physician or hospital to provide all specified health care services to an enrollee during a designated period of time. Places most of the financial risk for utilization on the provider.

Discounted charges and fee schedules. Managed care plans use their purchasing power to negotiate fee schedules or percent discounts from contracted providers' usual charges for services provided to enrollees.

Performance incentives. Financial incentives paid to physicians to encourage cost savings, which may include allowing physicians to keep the difference between the capitation rate and actual patient costs, a return of an amount withheld from fee-for-

service reimbursement to cover potential cost overruns, and/or a bonus or share in the profit of the organization.

Utilization Management

Precertification, concurrent review, and discharge planning. Programs designed to reduce the use of inpatient services by requiring a review of the reasons for an elective admission prior to the admission (precertification), monitoring the progress of the patient after admission (concurrent review), and providing for the expeditious discharge of the patient (discharge planning).

Gatekeeper (case management). Typically a primary care physician whose role is to refer and authorize payment for specialty, emergency and hospital care, and other special services.

Preauthorization. A procedure which requires permission from the insurer or gatekeeper physician before a patient can use a service (specialist referral, emergency room visit, hospital admission) for which the plan will pay.

Physician practice profiles. Profiles of individual physicians' practice patterns created from claims data, which may be used by plan medical directors to "educate" providers with divergent patterns and by plans to purge from their network physicians who appear to deliver poor quality or excessively expensive care.

High-cost case management. Coordination of health care and sometimes other support services from a variety of providers for individuals with complex and length or chronic illnesses. Used to facilitate cost-effective care, may facilitate home care and reduce overall costs of expensive illnesses.

Probable Effects of Different Health Insurance Plans on the Delivery of Medical Care						
Characteristics of Medical Care	**Indemnity Plan with Utilization Controls**	**Preferred Provider Organization (PPO)**	**IPA/Network Model HMO**	**Staff/Group-Model HMO**	**Point-of-Service**	**Medicaid PCCM**
Ability to choose providers	○	-	-	-	-	-
√Preventative care	○	+	+	+	+	?
√Illness-related visits to primary care physicians	○	+	+?	+?	+?	?
√Visits to specialists	○	+	?	-	+?	-
Use of diagnostic tests	-	-	-	-	-?	-
Rate of surgery	-	-	-	-	-	-
√Admission to hospital	-	-	-	-	-	-
√Use of emergency room	?	?	-	-	-	-

Key: Expected impact of plan on consumer use/physician practice (all else equal) as compared to traditional fee-for-service indemnity insurance plans or, in the case of Medicaid PCCMs, traditional fee-for-service Medicaid plans.

○ No change
- Tends to decrease
+ Tends to increase
? Direction unclear
√ Studied by Freund in her articles

Source: Freund and Lewit (1993).