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NEW APPROACHES TO PROVIDING HEALTH CARE TO THE POOR: MEDICAID FREEDOM OF CHOICE WAIVER ACTIVITIES

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I. Key Issues

The medicaid program was established in 1965 to give the nation's poor better access to needed health care services. As a result utilization of health services by this segment of the population has increased. Since medicaid's enactment, health care services have become more readily available although there continues to be some concern over assimilation of the low income population into so-called "mainstream" medicine. Many believe that the actual number of providers who participate in medicaid is quite limited as compared to programs like medicare. The reasons for this unwillingness to participate in medicaid has been the subject of a great deal of attention over the years. As recently as 1981, changes in the statute were made to alter the way States negotiated for providers' services.

In 1981, Section 2175 of Public Law 97-35 was adopted in an attempt to increase the efficiency of medicaid service delivery by allowing States to implement innovative approaches to providing care. States were able to receive waivers of certain programmatic requirements in order to implement these approaches. Among the requirements which could be waived is the requirement that medicaid recipients be free to select the provider of their choice—the so-called "freedom of choice" provision. Proponents of the change believed States would use this new flexibility to negotiate with provider groups—assuring those provides a large number of clients in return for more comprehensive and better managed services. Critics of Section 2175 felt that any waiver of the freedom of choice requirement would further restrict medicaid recipients' access to health services.

As of February 29, 1984, twenty-four States had submitted seventy-four waiver requests under the Section 2175 authority. Thirty-three of these requests have been approved. To date, no evaluation of these State efforts has been completed which examines the effect these waiver projects have had on:

—Recipient access to services;
—Quality of care;
—Health care providers participation; and
—Medicaid utilization and expenditure levels.

In 1982 Congress restricted the scope of the Section 2175 authority by eliminating the Secretary's ability to waive any of the requirements States must meet upon entering into risk-sharing contracts for the provision of services.

II. Background

One important objective of the original Federal medicaid legislation was to eliminate the existence of two separate medical care delivery systems. One system, available to that portion of the popula-

tion which had insurance coverage or the financial resources to pay for the care they needed, provided readily accessible, high quality services through a broad array of providers—i.e., mainstream medicine. The second system provided services, often with fewer amenities, to needy recipients through a limited number of providers, such as public hospitals, willing to accept this "welfare" clientele. The concept underlying the medicaid program was to provide the nation's poor population with access to "mainstream" medicine.

The legislative language which is most often associated with this goal of providing "mainstream" medicine to the low-income population is the freedom of choice provision found in section 1902(a)(23) of the medicaid statute. This provision, stipulates that eligible individuals be allowed to obtain medicaid services from any provider—whether it be an institution, individual practitioner, or prepaid plan—which meets reasonable standards set by each State. (The provision does not apply to Puerto Rico, the Virgin Islands, or Guam.) In effect, States were precluded from adopting policies which constrained recipients from seeking care from the provider of their choice.[1]

Increases in the utilization rates of our nation's poor since the adoption of medicaid indicate that the program has been successful in achieving its goal of increasing that population's access to medical care. Its success in integrating the poor into the mainstream of American medicine is less clear. Certain factors appear to continue to limit the medicaid population's access to the full spectrum of health care providers. These factors include:

—Limited availability of health care providers, primarily physicians, in areas with high concentrations of low-income families,
—Lack of transportation to more distant health care delivery sites,
—Discriminatory behavior by health care institutions and practitioners, and
—Low medicaid reimbursement rates which make medicaid recipients less desirable in relation to other patients.

In particular, the last factor is believed to have limited participation of certain providers, principally physicians, and therefore made access more difficult for medicaid recipients. One study of the problem found that in 1975, 32 percent of physicians did not take medicaid patients. Individual States' estimates have placed this figure even higher. Another study revealed that access is further limited by the fact that most physicians who do participate in the program limit the number of medicaid patients to a small percent of their practice. Research indicates that increasing medicaid's established fees for physician services might significantly increase program participation rates. One study estimated that a 10 percent increase in medicaid's established fees would result in a 7 percent increase in physician participation rates.

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[1] The only real exception to this policy was a provision allowing States to require recipients who elect to enroll in health maintenance organizations to receive care only from the HMO for a period of no less than six months The purpose of this provision was to provide the HMO's with some incentive to enroll medicaid recipients. In 1981, Public Law 97-35 replaced this provision with one allowing only a 30-day period of restricted HMO enrollment (lock-in).

Low participation rates result in a small percentage of physicians caring for the majority of medicaid patients. A recent study found that 5.5 percent of physicians see over 25 percent of all medicaid patients. This study also raised some question about the quality of care received by these medicaid patients, noting that physicians with large medicaid practices (over 30 percent of their total caseload) had fewer credentials and were twice as likely to be foreign medical graduates.

Because of this limited access to physicians, medicaid recipients, particularly in urban areas, seek other, usually more expensive sources of primary health care in hospital outpatient departments, including emergency rooms. For example, statistics from the State of Maryland indicate that the number of medicaid outpatient department visits and physician office visits were equal. However, in Baltimore, which has the largest concentration of medicaid recipients in the State, the ratio of medicaid hospital outpatient department visits to physician office visits was 2 to 1. Not only were medicaid recipients in Baltimore using twice as many outpatient department visits as physician office visits, but each outpatient department visit cost three times as much as a physician office visit.

Thus, while Federal medicaid policy prohibited States from directly limiting medicaid recipients' freedom of choice, other factors, including State medicaid reimbursement levels, were effectively restricting access to physician care. In addition, as the program developed, attention was drawn to the fact that not only was the medicaid freedom of choice provision failing to achieve its ultimate objective, but it also carried with it a series of related costs. As fiscal pressures forced State medicaid officials to more tightly administer their programs, they began to argue that the medicaid "freedom of choice" policy had the following negative effects:

It precluded States from making more efficient use of limited program dollars by channelling recipients to lower cost facilities in instances where the quality of the care provided would not be adversely affected. The State of Illinois, for example, pointed out that in 1980, inpatient costs per day at the hospitals within Cook County ranged from $129.66 to $409.53, a more than three-fold difference, yet the State was prohibited from channelling medicaid recipients to the low-cost facilities.

It prohibited States from developing innovative delivery/reimbursement approaches which would offer physicians a more stable number of medicaid patients in return for a more active role by the physician in managing the overall care of those patients. Additionally, the continuity of care such arrangements might offer was lost.

Given the fiscal condition of both the Federal and State governments, the legislative changes agreed to by Congress in 1981 did not seek to resolve the medicaid access problem by mandating increases in program reimbursement to attract more physicians. Rather, the opportunity for achieving a long-range solution to both the medicaid provider participation and cost problems was offered to States in legislation which limited rather than expanded recipients freedom of choice.

III. Section 2175 of Public Law 97-35

Section 2175 of Public Law 97-35 the Omnibus Reconciliation Act of 1981, provided greater flexibility to the States in administering their medicaid programs. In creating sections 1915 (a) and (b) of the Social Security Act, it authorizes certain exceptions to certain medicaid program provisions including the freedom-of-choice requirement. These exceptions are of two general types.

(1) 1915(a) EXCEPTIONS

First, under section 1915(a) of the Act, State medicaid programs will no longer be found out of compliance with Federal requirements concerning freedom of choice, statewideness,[2] and comparability of services[3] if a State: (a) enters into certain arrangements to purchase laboratory services or medical devices through competitive bids; or (b) establishes either a "lock-in" program which restricts for a reasonable period of time the choice of provider by a beneficiary who has overutilized services, or a "lock-out" program which prohibits providers with questionable practice patterns from participating in medicaid.

(2) 1915(b) WAIVERS

The second way in which States may be exempted from the freedom of choice requirement is by obtaining a Federal waiver. Under section 1915(b) of the Social Security Act, as created by section 2175, the Secretary of Health and Human Services could, in certain situations, waive the State plan requirements contained in sections 1902 (for a statewide program, freedom of choice, and comparable services for all recipients); and/or the provisions in 1903(m) which generally limit State risk-sharing arrangements to federally qualified HMO's.[4] These requirements could be waived in order to allow a State to:

1. Implement a primary care case management system or specialty physician services arrangement;
2. Allow a locality to act as a central broker in assisting medicaid recipients in selecting among competing health plans;
3. Share with recipients, through the provision of additional services, not available to other recipients, savings resulting from recipients' use of more cost-effective health care; and
4. Restrict recipients to receiving services (other than in emergency situations) from only efficient and cost-effective providers.

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[2] A State Medicaid plan must, in general, be in operation through a system of local offices on a statewide basis in accordance with equitable standards for assistance and administration that are mandatory throughout the State. If administered by political subdivisions of the State, the plan must be mandatory on such political subdivisions.

[3] There are two "comparability of services" requirements for a State plan: (1) services made available to any categorically needy individual may not be less in amount, duration, or scope than the services made available to any medically needy individual; and (2) services made available to any individual in the following groups must be equal in amount, duration, and scope for all individuals within the group: (a) the categorically needy, and (b) a covered medically needy group.

[4] The Secretary's ability to waive the provisions of 1903(m), which govern the requirements for Medicaid risk contracts, was subsequently rescinded in Public Law 97-248. This will be discussed further in a later section of this report.

One of the often-cited flaws of the health care marketplace is the absence of incentives for individuals to make cost-conscious decisions when utilizing health care services. Many believe this situation exists within the medicaid program, which limits recipients' financial liability for services to no more than nominal copayment requirements.

Although a number of States, under statutory authority which existed prior to passage of Public Law 97-35, had already implemented recipient lock-in programs or bulk purchasing arrangements similar to those afforded by the newly added section 1915(a), the waiver provisions of 1915(b) offered a significant expansion in the range of major policy options open to the States.

The four types of approaches authorized by 1915(b) all attempt to increase the importance of price considerations in the decision about when, where, and how to utilize health care services. Each of these approaches, however, can be seen as focusing its efforts at increasing the price consciousness of a different player in the health care decision-making process.

Section 1915(b)(1), for example, which allows States to establish primary care case management systems (or primary care networks, as they are sometimes called), focuses its efforts upon the primary care physician.

In practice the definition of a "primary care physician" quite often differs across the States, with some identifying certain specialties—family practice, internal medicine, obstetrics/gynecology, pediatrics—while others consider a primary care physician to be any physician willing to provide such services. These physicians, in carrying out their traditional gatekeeper responsibilities in the health care marketplace, play a very important role in health care utilization decisions. By heightening the primary care physicians' involvement in the delivery of all services—both financially and as the overall case manager of care, primary care case management systems attempt to increase physician awareness of the cost implications of their delivery and referral decisions. Savings are expected to result from these systems through the reduction in inappropriate use of hospital emergency rooms and inpatient facilities.

Subsection (2) of 1915(b) attempts to make recipients more aware of the implications of their utilization decisions by allowing local units of government to provide them information about the range of health care options open to them. To the degree that this information will explain fully the advantages which alternative health plans offer (including any additional services which cost-effective plans may offer), recipients may become more cost-conscious in selecting providers. Further, to the extent that the local units of government which will provide this information-brokering service also contribute to the State share of medicaid program costs, there will be a direct financial incentive to highlight the benefits to the recipient of selecting a cost-effective provider.

Subsection (3) of 1915(b) also focuses on increasing the cost consciousness of medicaid recipients by offering them expanded coverage in the form of additional services, if they select cost-effective providers or treatment modalities.

The last subsection, 1915(b)(4), places upon the State the responsibility for selectively entering into cost-effective arrangements

with providers. States have always had strong fiscal incentives to promote cost-conscious utilization of services because of their joint responsibility for program costs, however, Federal requirements in the past have limited the strategies States have been able to employ to achieve this objective.

TIMING ON APPROVAL OR DENIAL OF WAIVERS

The Secretary is authorized to grant waivers of State plan requirements under 1915(b) only in cases where the proposed approaches are found to be cost effective, efficient, and not inconsistent with the intent of the medicaid program. The conference report accompanying Public Law 97-35 calls for the Secretary to act on the waiver requests within 90 days of submission. These waivers can be granted for a period of up to two years although a State may request a continuation. Such continuations are deemed granted if a written denial notice is not forwarded to the State by the Secretary within 90 days of submission of the continuation request. The Secretary is further required to monitor the implementation of waivers which are granted and is empowered to terminate any waiver when, after notice and opportunity for a hearing, there is a finding of nonconcurrence. A report on the 2175 waivers must be submitted by the Secretary to Congress no later than September 30, 1984.

IV. State Responses to Section 2175 Waiver Authority

A. GENERAL

The States have responded to the provisions of Section 2175 as shown in Appendix A, Table 1. By the end of February 1984, a total of 74 waiver requests had been submitted by 24 States. Fifteen States have received approval to implement 34 different programs, the majority of these being primary care case management systems. The number of approved applications (33) shown in Table 1 exceeds the number of individual programs authorized because several of the programs were determined to fall within more than one waiver category.

A general discussion of the programs approved within each waiver category is presented below. Summaries of all waiver applications received by the Health Care Financing Administration as of February 29, 1984, are presented in Appendix A to this report.

(1) Case Management Arrangements

Under Section 1915(b)(1) of the medicaid statute, States may receive waivers to implement primary care case management systems or specialty physician services arrangements. The primary care case management systems are a relatively new concept in medicaid, aimed at increasing the primary care physicians' role in the overall management of their patients' care. Under these systems, a case manager is responsible for locating, coordinating, and monitoring primary care and/or other medical care and rehabilitative services on behalf of the medicaid recipient. The recipient is not constrained to consulting the primary care provider in emergency situations.

The definition of "specialty physician services arrangements" was not clear during the first two years of the 2175 waiver authority. The final Federal regulations governing the program (published in the May 24, 1983 Federal Register) attempted to remedy this situation by explaining that specialty physician services arrangements differ from a case-management system in that they allow States to restrict recipients to providers of specialty physician services for those specific specialty services, regardless of whether the restriction is part of a case-management system.

No State has yet applied for a waiver to establish a specialty physician services arrangement. However, of the 33 waiver applications approved by the end of February 1984, 21 had been authorized under the general category of case management systems. The way in which the case management concept is being applied varies somewhat across the States.

Fourteen States have received approval to establish new primary care case management systems.[5] These systems share some common characteristics in that medicaid recipients are allowed or required to select a provider from whom they would receive their primary care. This provider is also responsible for coordinating all other care the individual requires. The types of providers who may serve as the recipient's primary care provider varies.

Two States (Michigan and Wisconsin) received waivers under the dual authorities of case management and selective contracting to establish mental health case management systems. Michigan's Primary Mental Health Clinic Program provides a case management arrangement which authorizes both inpatient and outpatient mental health services. Wisconsin uses its local mental health boards to provide the same functions.

(2) Localities Serving as Brokers

Section 2175 included language authorizing waivers to allow towns, counties, or other local units of government to serve as central brokers in aiding recipients to select from among competing health plans. The model upon which this provision was based was the Project Health demonstrations in Multnomah County, Oregon. Project Health provided information to individuals seeking medical assistance about the different prepaid health plans available in the Portland, Oregon area.

To date, no State has cited this category as the principal legislative authority under which a waiver application was submitted.

(3) Sharing of Savings With Recipients

This category allows States to provide incentives to medicaid recipients for utilizing cost-effective providers. These savings may only be shared in the form of providing additional services not covered under the State's regular medicaid program. No cash payments may be made to recipients.

Soon after Public Law 97-35 was enacted, a number of States requested waivers under this authority to do such things as increase

[5] These States are: California, Colorado, Kansas, Kentucky, Massachusetts, Michigan, Nevada, New Hampshire, New York, North Carolina, Pennsylvania, Tennessee, Utah, and Wisconsin. The Massachusetts program was terminated by the State before it was ever implemented.

copayments for emergency rooms and transportation services. These requests were not consistent with the intent of this provision and were rejected. Two States with approved waivers (Kentucky and Tennessee) did reference this provision in requesting authorization to provide additional services under their primary care case management system.

(4) Selective Contracting

The final category under which States can receive 2175 waivers is selective contracting. Under this authority, States may obtain waivers that require medicaid recipients to obtain nonemergency services from or through specified providers or practitioners who comply with the State reimbursement, quality, and utilization standards.

Waivers under this category can only be granted if:

The applicable State standards are consistent with access, quality, and efficient and economic provision of covered care and services;

The restrictions it imposes do not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services; and

The restrictions it imposes do not apply in emergency situations.

As of February 29, 1984, eight waiver applications from six States had been approved under the selective contracting waiver authority. Half of these applications were designed to implement case management-like systems, with the proposed programs being approved under both the case management and selective contracting authorities. These case management systems do not differ significantly from the ones described earlier; the fact that they were approved under dual authorities is due in large measure to the States having written the waiver requests in that manner.

One waiver was granted to allow the State of Washington to begin contracting with select pharmacies to provide medications for medicaid recipients in certain nursing homes. All three of the remaining waivers approved under the provision are to selectively contract for inpatient hospital care. Of these, Utah has decided to develop a diagnosis related group-based hospital reimbursement system rather than selectively contract, and Kentucky has not yet implemented its program. The State of California's selective contracting program for inpatient hospital care has been operational since October 1982, and will be discussed further.

B. SELECTED STATE WAIVER ACTIVITIES

Descriptions of the waiver activity in the States of Michigan and California will give the reader greater detail on the types of programs being implemented under the section 2175 authority. These two States were selected because each had the earliest approved waivers in two major areas of waiver activity. Michigan in the area of primary care case management systems, and California in the area of selective contracting for hospital services. Because of their early activity, their approaches have served to some extent as models for applications from other States. They are also both rela-

tively far along in their implementation in comparison to other States whose waiver requests were approved at a later time.

1. Michigan

The State of Michigan has used the 2175 waiver authority in four different ways.

Michigan received approval in early 1982 to establish its Primary Care Physician Sponsor Program (PCPS), a primary care case management system in the Detroit area (Wayne County). Under this program all medicaid recipients in the area select a physician sponsor from among available physicians participating in the program. These physician sponsors serve as the case managers for the recipients enrolled with them. The physician sponsor provides primary health services and accepts responsibility for the recipient's total health care. The sponsor guarantees 24-hour access to a physician, and agrees to authorize, locate, coordinate, and monitor all visits to other physicians, laboratory and pharmacy services, and hospital services (except emergency services). With proper notice, recipients are allowed to change physician sponsors.

To facilitate effective monitoring of care, sponsoring physicians receive periodic reports from the State describing the services provided to their enrolled recipients. The sponsoring physician is reimbursed at the usual fee-for-service rates plus a monthly case management fee of $3 for each recipient. Michigan estimates that the physician sponsor program might reduce the cost to the State of providing care for enrolled recipients by 7 to 10 percent if the program's performance parallels the State's experience with Health Maintenance Organizations (HMO's).

Medicaid providers offering primary care (e.g., general practitioners, family practitioners, internists, and pediatricians) are eligible to participate in this program. Participating providers are required to meet medicaid standards for quality, utilization, and cost of care; otherwise they may be sanctioned or terminated from the physician sponsor program.

As of early September 1983, 26,000 individuals were enrolled in the waiver program. Although a formal evaluation of the program has yet to be conducted, initial indications are that the utilization levels of this group have been lowered. An interesting side effect of the waiver program appears to be an increased marketing effort by HMO's in the Wayne County area. From July 1982 to July 1983, medicaid HMO enrollment in the area had increased from 65,000 individuals to 80,000.

A second Michigan waiver application to establish a statewide case management program, called the Capitated Ambulatory Program, was also approved in early 1982. Under this waiver recipients are given the option of obtaining most of their primary health care from a specific provider who receives a capitation payment for providing on an "at-risk" basis, a negotiated package of medical benefits. By "at-risk" is meant that the provider of the service is financially at risk for the cost of services in excess of an agreed upon amount. All medicaid-approved clinics or groups of physicians offering primary care are eligible to participate as providers under this program. Recipients entering the program are allowed to

select their provider and, once enrolled, may change providers, but only with proper notice.

Participating providers are required to contract with the medicaid program to provide a comprehensive health care package which includes offering 24-hour access to health services and taking responsibility for locating, coordinating, and monitoring service on behalf of the recipient. These providers are paid an agreed upon capitation rate, which is not to exceed 100 percent of projected fee-for-service charges.

Michigan estimated that if the Capitated Ambulatory Program produces savings similiar to those experienced with its HMO contracts, inpatient hospital utilization may be reduced approximately 20 percent. This would result in an overall savings to the program of 10 percent on inpatient care, since the State will share its savings with participating providers.

Since the approval of its waiver to establish the Capitated Ambulatory Program on a statewide basis, Michigan has requested an amendment to allow a phased-in implementation.

As mentioned earlier, Michigan has also received section 2175 waivers to lock-in medicaid HMO enrollees for an initial 6-month period and to establish a case management program for mental health services.

2. California

Under the authority to restrict medicaid recipients to cost-effective providers (selective contracting), California has received approval to establish the Selective Provider Contracting Program (SPCP) through which it has contracted with selected hospitals in geographic areas of the State for the provision of inpatient services to medicaid (in California, Medi-Cal) recipients. The development of this program was mandated by State legislation which made sweeping changes in the State's Medi-Cal program.

Under the Selective Provider Contracting Program, hospitals were given the opportunity to compete for contracts with the State to serve the Medi-Cal population. The State was required to contract with enough hospitals to provide sufficient capacity for Medi-Cal patients, selecting those hospitals which offer the State the most cost-effective service arrangements. In order to implement the program, a special hospital negotiator was appointed within the Governor's office to negotiate the rates, terms, and conditions of contracts with hospitals for the State fiscal year beginning July 1982. For subsequent fiscal years, the special negotiator's functions were assumed by a California Medical Assistance Commission established January 1, 1983.

Since the process of contracting with hospitals could not be carried out simultaneously throughout the State, the negotiator began the contracting process in selected geographic areas, the focus in the first year being urban areas. A standard approach to contracting was followed. The negotiator initially contacted all hospitals in a given area to determine their interest in contracting with the Medi-Cal program. Factors considered in determining which hospitals to contract with included, among other issues: recipient access, utilization controls, and an ability to render quality services efficiently and economically.

Under the State statute, the negotiator was given complete freedom to determine the reimbursement approach to use when contracting with hospitals including the possibility of capitation or prepayment arrangements. In practice, however, contracts were awarded on the basis of the amount a hospital would charge on a per diem basis. The negotiator was required to consider the total amount of funds appropriated for inpatient hospital services when negotiating contracts.

The hospital contracting requirements did not apply to hospital inpatient services rendered by HMO's, other organized health systems, or State hospitals. Similarly, until June 1983 regional specialty hospitals such as children's hospitals were not required to have a contract with the Medi-Cal program. Services provided by these hospitals were reimbursed until then on the same basis as under the State's previous reimbursement methodology.

To assure access to services of adequate quality, the State requires recipients to use the general acute care hospitals under contract with the State that are within reasonable geographic distance. The guideline for this "reasonable" distance was identified in the State's waiver application as 30 minutes driving time for most areas of the State (urban and suburban). Those recipients whose travel time from their home exceeds this guideline would not be restricted to contract facilities. In addition, contracting hospitals were required to provide admitting privileges to physicians serving Medi-Cal recipients within its 30-minute driving radius. They cannot deny medical staff membership or clinical privileges for reasons other than a physician's individual lack of qualifications as determined by professional and ethical criteria. All Medi-Cal recipients are able to receive services from any hospital in an emergency situation, including transportation services in cases where there is the threat of permanent impairment.

During the program's first year of operation the State contracted with 245 hospitals in areas which historically accounted for 88 percent of the State's total Medi-Cal expenditures. The effects of the program on Medi-Cal expenditures, recipients, and providers are not fully known at this time. The language contained in the originating State statute required that neither the State nor the individual hospital make public any information regarding their specific contract. This made the obtaining of specific information on hospitals rates very difficult. The State, however, does estimate a significant drop in Medi-Cal hospital expenditures. How much of that drop is due to the selective contracting program and how much is due to other significant changes made in the scope of the Medi-Cal hospital benefit is unclear. A major evaluation effort financed by HCFA and to be conducted over the next several years is expected to shed some light on these and other issues associated with the 2175 waivers.

C. PRIVATE SECTOR INITIATIVES

In assessing whether the Section 2175 waiver activities represent (a) a step forward in providing quality health care for the medicaid population at a reasonable cost or (b) excessive encroachment on the individual's right to see the provider of his or her choice, it is

important to consider the alternative means that are available to contain medicaid costs.

When faced with limited financial resources and rapidly rising health costs, States have always had the ability to curtail medicaid spending by tightening eligibility standards or reducing service coverage. These waiver projects are viewed by many States as an alternative to benefit reductions, a means of using program dollars more efficiently. The trade-off implicit in this approach is less freedom of choice for sustained or improved benefits.

Although fiscal pressures may have forced State medicaid programs to take the lead in making such trade-offs, the public sector is certainly not alone in making these difficult decisions. Employers and other private sector payers of health care costs are also beginning to realize that some restriction in personal choice may be the price that must be paid to keep health care utilization and costs under control.

Evidence of this fact can be found in the high degree of interest evidenced by private sector employers and other groups in contracting with preferred provider organizations or PPO's. In general, under such an arrangement, in return for an employer providing incentives to its employees for utilizing the services of the PPO (such as reduced cost-sharing requirements), the PPO will agree to provide services at a discounted rate. Over the next several years, this and other forms of direct contracting relationships are likely to develop in the private sector as payers struggle to bring health care costs under control. In this light, the limitations on provider selection associated with the Section 2175 waiver projects may be viewed as the public-sector counterpart to the innovations being explored in the private sector.

V. Federal Requirements for Medicaid Risk-Sharing Contracts

A significant change to the section 2175 waiver authority was made by Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1983 (TEFRA). A provision in that Act rescinded the authority of the Secretary to waive the requirements of section 1903(m) of the Social Security Act. Section 1903(m) stipulates that States cannot contract on an at-risk basis with an entity which provides a certain number and type of services unless certain conditions are met. If an entity provides: a) inpatient hospital services and any other mandatory medicaid service [6] (except rural health clinic services) or b) any three mandatory services, that entity must meet the following standards before a State can enter into a risk contract with it for the provision of medicaid services:

It must meet the requirements for a federally-qualified or State-certified HMO, or it must have been provisionally determined to be one by a State;

It must have a prepaid membership of which no more than 75 percent consists of medicare beneficiaries and/or medicaid recipients;

[6] The "mandatory" medicaid services are: inpatient hospital services; out-patient hospital care; lab and X-ray services; physician services; rural health clinic services; skilled nursing facility and home health care for individuals over 21, EPSDT, and family planning services; and nurse midwife services. These services must be offered to categorically eligible recipients.

It must provide services in accordance with a contract it has with a State and receive payments determined on an actuarially sound basis;

It must allow DHHS or the State the right to audit its books;

It must not have enrollment, reenrollment, or disenrollment policies which discriminate against individuals on the basis of their health status or requirements for health care;

It must allow individuals to terminate their coverage after their first month in the plan; and

It must provide for coverage of out-of-plan emergency services.

Proponents of the deletion of the 1903(m) waiver authority argued that allowing the Secretary to waive these requirements might lead to contracting abuses similar to those which occurred during the medicaid pre-paid health plan scandals experienced by California in the 1970's. During that period, lax contracting controls resulted in discriminatory marketing practices, denied access to needed services, and other problems.

Several States have claimed that eliminating the Secretary's ability to waive the requirements of 1903(m) has severely restricted their ability to develop cost-effective capitation-based alternatives to the fee-for-service structure, either because, with unrestricted disenrollment policies, medicaid recipients may drop out of an HMO or other prepaid arrangements before becoming accustomed to the service delivery system of such plans, or because the State must offer some assurances of the stability of their population to providers in order to induce them to assume case management responsibilities.

The provision removing the Secretary's authority to waive the stipulations of 1903(m) does not apply to waivers which were previously granted and for which arrangements covered by the waivers were in place prior to August 10, 1982. Eleven 1903(m) waiver applications from seven States had been submitted at the time Public Law 97-248 was enacted. Of these, four (from Michigan, New Hampshire, Pennsylvania, and Wisconsin) had been approved prior to August 10.

In an attempt to not close the door completely on State efforts to capitate individual physicians for primary care services, the conference report accompanying Public Law 97-248 included the following clarification:

> It is the understanding of the conferees that the types of entities subject to the requirements of section 1903(m) would not include contractual arrangements between the State and an individual physician, or a group of physicians, under which (1) case management is the primary purpose; (2) hospital services are not provided directly by, or under contract for payment to, such physician or physician group; (3) the physician or physician group receives at least 25 percent of its gross revenues from non-medicaid and non-medicare patients (through fee-for-service or other reimbursement methods); (4) the medicaid revenues that the physician or physician group would otherwise receive from the arrangement will not increase more than 20 per-

cent as a result of a decrease in the use by beneficiaries under management of hospital and other covered services; and (5) primary care services are available on a 24-hour basis.

DHHS has determined, however, that the report language does not relax the constraints imposed on at-risk contracts by Section 1903(m).

Subsequent to the removal of the Secretary's ability to waive section 1903(m) requirements, two States (Kentucky and Tennessee) have contracted out on a risk-basis for an array of services by using intermediary "health insuring organizations" (HIO's), a term identified in federal regulations. The States' risk contracts with these entities do not have to meet 1903(m) requirements because technically the HIO's do not provide services. Rather, they in turn contract out for smaller service packages with several groups of providers. As agents of the State, however, the HIO's contracts with each of these different groups of providers must either meet 1903(m) requirements, or be for fewer services than the number that would require compliance with 1903(m).

APPENDIX A: SUMMARY OF 2175 WAIVER APPLICATIONS

TABLE 1.—STATUS OF SECTION 2175 "FREEDOM OF CHOICE" WAIVER APPLICATIONS AS OF FEB. 29, 1984

Type of program	Received	Approved	Pending	Withdrawn	Disapproval
Case management	36	21	3	7	5
Locality as central broker	0	0	0	0	0
Share cost savings	12	4	1	1	6
Restrict providers	19	8	9	2	0
No specific provision	7	0	0	5	2
Total waiver requests	74	33	13	15	13
Total States submitting requests		24			
Total States with approved waivers		15			

Source: Health Care Financing Administration.

SUMMARY OF WAIVER REQUESTS RECEIVED UNDER AUTHORITY OF SECTION 2175 OF PUBLIC LAW 97-35, AS OF FEB. 29, 1984

[Description of proposals, types of waivers requested, and dates of initial request and final disposition]

State	Waiver type	Status
California (10 requests)		
To waive 1902(a) (1), (10), and (23) and 1903(m) to allow On-Lok (capitated long-term care) to become a fully operational health plan. (7/6/82).	Case management	Withdrawn (8/18/82).
To waive 1902(a) (1), (5), (13) and (23) to permit implementation of a program which will allow California to selectively contract with hospitals. (7/13/82).	Restrict providers	Approved (9/21/82); effective (10/1/82).

SUMMARY OF WAIVER REQUESTS RECEIVED UNDER AUTHORITY OF SECTION 2175 OF PUBLIC LAW 97-35, AS OF FEB. 29, 1984—Continued

(Description of proposals types of waivers requested, and dates of initial request and final disposition)

State	Waiver type	Status
To waive 1902(a)(23) to require that all mental health services in selected counties be provided through local mental health programs operated by DMH and offered through "Short/Doyle Providers" rather than through fee-for-service providers (9/22/82). Modification to waiver approved on 12/20/82. Request to change effective date from 12/20/82 to 1/1/84. (10/12/83) Approved (12/14/83); effective (1/1/84).[1]	No specific provision	Withdrawn 7/28/83.
To waive 1902(a) (1) and (23) to implement a primary care physician case management system where case manager acts as "gatekeeper" to enrolled recipients. (9/30/82).	Case management	Approved (12/20/82); effective (12/20/82).
To waive 1902(a) (1), (13)(A), (23) and (30) to allow the State, through its Special Negotiator, to contract with the counties to provide Medicaid services. Two requests. (12/16/82).	Restrict providers; case management.	Withdrawn (5/18/83).
To waive 1902(a) (1) and (10) to allow the State to implement, evaluate and adjust systems in a controlled environment before completing plans for Statewide implementation of guaranteed enrollment provisions for AFDC beneficiaries enrolled in HMO's. (12/16/82).	Case management	Withdrawn (10/27/83).
To waive 1902(a) (1) and (23) to provide inpatient and outpatient hospital services, psychiatric hospital services for persons under 21 and over 65, and clinic services in selected counties, which will allow California to consolidate fee-for-service Medi-Cal mental health services with county-operated Short-Doyle mental health programs. (9/9/83).	Restrict providers	Additional information requested.
To waive 1902(a) (1), (5), (23) and (30) in order to implement the San Mateo organized health system. Two requests. (12/7/83).	Case management; restrict providers.	Under review (2).
Colorado (3 requests):		
To waive 1902(a) (1) and (23) to implement a case management system. (1/29/82).	Case management	Approved (3/3/82); effective (3/3/82).
To waive 1902(a) (1) and (23) to implement a primary care physician case management program. (6/25/82). Modification to waiver approved on 8/2/82. Request to change effective date from 8/2/82 to 5/1/83. (11/7/83). Approved (1/12/84).[1 2]	Case management	Approved (8/2/82; effective (8/2/82)
Addendum to primary care physician case management program waiver approved on 8/2/82. To waive 1902(a)(10) to allow State to make selection of a primary care physician a requirement for eligibility.	Case management	Disapproved (2/16/83).

SUMMARY OF WAIVER REQUESTS RECEIVED UNDER AUTHORITY OF SECTION 2175 OF PUBLIC LAW 97-35, AS OF FEB. 29, 1984—Continued

[Description of proposals types of waivers requested and dates of initial request and final disposition]

State	Waiver type	Status
Connecticut (2 requests).		
To waive 1902(a)(14) and 42 CFR 447 54 to allow the State to impose a taxi and livery service and larger copayments than permitted by the regulations. (12/3/81).	Share cost savings	Disapproved (3/2/82).
To waive 1902(a) (14) and (10) to waive comparability and maximum copayment requirements to allow a copayment on medical transportation when the cost of the trip is under $10 00. (5/3/82).	Share cost savings	Disapproved (7/29/82).
Georgia		
To implement a case management system for recipients (children under 21 referred under EPSDT) requiring dental services. (1/10/83).	Case management	Additional information requested
Hawaii (2 requests):		
To waive 1902(a) (7) to allow the State to release the names of eligible AFDC recipients to Kaiser Foundation Health Plan so recipients may be contacted and informed of their eligibility to enroll in the Plan's program. (6/30/82).	No specific provision	Withdrawn (10/12/82).
To waive 42 CFR 431.51(a) to lock-in recipients to a prepaid, comprehensive dental care program called Denta-Guard. (4/25/83).	Restrict providers	Withdrawn (5/9/83).
Kansas:		
To waive 1902(a) (1) and (23) for two years, beginning 7/1/83 to implement a physician case management system (Kansas Primary Care Network). (4/4/83).	Case management	Approved (6/27/83); effective (7/1/83)
Kentucky (5 requests):		
To waive 1902(a) (1), (10) and (23) to implement a prepaid health plan called Citicare. Three requests. (7/19/82). Modification waivers approved on 11/10/82. Request to change effective date to 6/1/83 or the date the program is actually implemented (3/22/83). Approved (5/6/83).[1]	Case management; share cost savings, restrict providers.	Approved (3) (11/10/82); effective (11/10/82).
To waive 1902(a) (1), 13(A) and (23) to provide inpatient acute care hospital services through a preferred provider arrangement to individuals in Fayette County eligible for medical assistance. (6/16/83).	Restrict providers	Approved (12/30/83); effective (1/1/84).
Maine:		
To waive 1902(2)(10). (B)(i) to implement a $.50 copayment on drugs. (11/25/81).	No specific provision	Disapproved (1/5/82).
Massachusetts (2 requests).		
To waive 1902(a)(1) to permit the State to continue and expand its case management system, which was developed under a Federal grant. (7/21/82).	Case management	Approved (10/15/82); terminated by State (12/28/82)
To waive 1902(a) (1) and (23), 1902(e)(2) and 1903(m)- (2)(A)(ii) to implement case management through Commonwealth Health Care Corp (7/22/82).	Case management	Withdrawn 12/30/82.

SUMMARY OF WAIVER REQUESTS RECEIVED UNDER AUTHORITY OF SECTION 2175 OF PUBLIC LAW 97-35, AS OF FEB. 29, 1984—Continued

[Description of proposals, types of waivers requested, and dates of initial request and final disposition]

State	Waiver type	Status
Michigan (10 requests):		
To waive 1902(a)(1), (7) and (23) to implement a case management system under which recipients select physician sponsors. (11/10/81).	Case management	Approved (2/9/82); effective (2/9/82).
Modification to waiver approved on 2/9/82. Request to revise effective date to 7/1/82. (11/8/83). Approved (1/12/84).[1]		
Modification to waiver approved on 2/9/82. Request to waive 1902(a)(10) to eliminate the prescription copayment for PPSP-enrolled recipients. (11/28/83) Additional Information Requested.[1]		
To waive 1902(a)(23) and 1903(m)(2)(A)(ii) to implement State's Capitated Ambulatory Program (11/30/81).	Case management	Approved (4/22/82); effective (4/22/82).
Modification to State's Capitated Ambulatory Program waiver approved on 4/22/82. Request to waive 1902(a)(1) to phase-in program rather than initially implement on a Statewide basis. (6/16/82). Approved (8/25/82).[1]		
Modification to waiver approved on 4/22/82. Request to extend waiver of 1902(a)(1) for State's Capitated Ambulatory Program. (11/29/83). Approved (2/24/84).[1 2]		
Modification to waiver approved on 4/22/82. To extend by one year the State's Capitated Ambulatory Program, except 1903(m) provision. (9/16/82). Approved (12/15/82).[1]		
To waive 1903(m)(2)(A)(vi) in order to lock-in HMO and PHP enrollees for a six-month period following their enrollment. (12/16/81).	Restrict providers	Approved (4/14/82); effective (1/1/82).
To waive 1902(a)(10)(B) to impose copayments on individuals age 21 and over of $2.00 per podiatric visit; $3.00 per hearing aid; $.50 per prescription; and $1.00 per chiropractic visit. Three requests. (6/28/82).	Share cost savings	Disapproved (9/23/82).
To waive 1902(a) (1) and (23) to implement State's Primary Mental Health Clinic Sponsor Program (PMHCSP), a case management arrangement which will restrict (1) outpatient mental health services and (2) medical day treatment services. Two requests. (10/7/82).	Case management; restrict providers.	Approved (2) (2/17/83); effective (2/17/83).
Mississippi:		
To waive 1902(a)(10) to allow additional inpatient days to be available to low-weight newborns. (2/5/82).	No specific provision	Withdrawn 3/16/82.
Nebraska:		
To waive 42 CFR 440.230(c)(1) to impose reimbursement and time limitations on delivery of psychiatric services (11/17/81).	No specific provision	Withdrawn (12/2/81).

SUMMARY OF WAIVER REQUESTS RECEIVED UNDER AUTHORITY OF SECTION 2175 OF PUBLIC LAW 97-35, AS OF FEB. 29, 1984—Continued

[Description of proposals, types of waivers requested, and dates of initial request and final disposition]

State	Waiver type	Status
Nevada (2 requests):		
To waive 1902(a) (1), (10) and (23) for a Primary Care Case Management Program to operate in Las Vegas and Reno geographic areas. (6/27/83).	Case management	Approved (9/27/83); effective (9/27/83).
To waive 1902(a) (1) and (23) to implement a single source pharmacy project. (12/7/83).	Restrict providers	Additional information requested.
New Hampshire (2 requests):		
To waive 42 CFR 440.240 447.53, and 447.55 to allow State to impose a minimum $10 copayment on outpatient hospital visits and a $3.50 copayment on prescription drugs. (10/28/81).	Share cost savings	Disapproved (1/25/82).
To waive 1902(a) (10) and (23) and 1903(m) to implement a case management system through use of an HMO to provide and manage health care services on a prepaid capitation basis. (3/31/82). Modification to waiver approved on 6/1/82. Request to eliminate six-month restriction on recipient disenrollment privileges. Approved (7/30/82).[1]	Case management	Approved (6/1/82); effective (1/1/83).
New York (3 requests):		
To waive 1903(m)(2)(A)(vi) to require new enrollees in an HMO to remain enrolled for a minimum enrollment period. (2/22/82).	Case management	Approved (5/11/82); effective (5/11/82)
To waive 42 CFR 431.50 and 431.51 to limit psychological service to organized mental health clinics. (3/24/82).	No specific provision	Additional information requested.
To waive 1902(a) (1) and (23) to restrict Medicaid recipients to the most cost-effective ambulence and livery providers by means of a competitive bidding contract. (1/13/84).	Restrict providers	Under review.
North Carolina (2 requests):		
To waive 1902(a) (1), (7) and (10), in order to implement Gatekeeper/Capitation with Incentive plan. Two requests. (8/24/82).	Case management; share cost savings.	Approved (2) (3/8/83); effective (1/15/83).
Ohio (2 requests):		
To waive 1902(a)(10) to permit the State to exempt individuals enrolled in an HMO with a risk contract from copayments that will otherwise be imposed on all optional services. (8/23/82).	Share cost savings	Withdrawn (9/30-82).
To waive 1902(a)(23) to permit structured provision of certain home and community-based services to eligible individuals. (1/11/84).	Restrict providers	Under review.
Oregon (3 requests):		
To waive 1902(a) (1), (7), (10) and (23) to implement a pilot capitated physician care case management program for Medicaid recipients in selected geographical areas. Three requests. (7/22/83).	Case management; share cost savings; restrict providers.	Additional information received (3).

SUMMARY OF WAIVER REQUESTS RECEIVED UNDER AUTHORITY OF SECTION 2175 OF PUBLIC LAW 97-35, AS OF FEB. 29, 1984—Continued

[Description of proposals, types of waivers requested, and dates of initial request and final disposition]

State	Waiver type	Status
Pennsylvania (3 requests):		
To waive 1902(a) (1) and (23) and 1903(m) to implement a case management system which restricts the provider from whom a recipient can obtain primary care services. (3/8/82).	Case management	Withdrawn (6/25/82).
To waive 1902(a)(23) and 1903(m)(2)(a)(i) and (ii) to implement a case management system (Primary Care Capitated Program). (5/4/82).	Case management	Approved (6/30/82); effective (6/30/82).
To waive 1902(a) (1), (10), and (23) to provide case management services through an HIO for all service except long term care (SNF, ICF, ICF/MR, I/P psychiatric) to enrollees initially in Allegheny, Dauphin, and Philadelphia Counties. (8/18/83).	Case management	Withdrawn (10/28/83).
Tennessee (5 requests):		
To waive 1902(a) (1) and (23) to implement a physician case management system in Maury County and Memphis-Shelby Counties, through which medical assistance eligibles can be assigned to a single primary care provider who will control the quality, utilization and cost of care provided. Three requests (12/7/82).	Case management (3)	Approved (3) (3/1/83); effective (3/1/83).
To permit the Tennessee Medicaid Program to implement a prepayment program through a sole-source contractual agreement with the Tennessee Primary Care Network. Two requests (1/21/83).	Case management; share costs savings.	Approved (4/19/83); effective (7/1/83).
Modification to waiver approved on 4/19/83. Request to change effective date from 7/1/83 to 12/1/83. (8/8/83). Approved (11/4/83).[1]		
Utah (3 requests):		
To waive freedom of choice requirements in 42 CFR 431.51 to allow the State to require recipients to choose a primary care provider (from among two HMO's and fee-for-service physicians) that will be responsible for patient care and all referrals to specialists, labs, hospitals and pharmacies. (11/24/81).	Case management	Approved (3/23/82); effective (3/23/82).
Modification to waiver approved on 3/23/82. Request to extend waiver for an additional two-year period. (1/24/84). Under Review.[1]		
To waive 1902(a) (1), (5), (23), and (30) and 1902 (a)(13)(A) to implement a selective provider contracting program. (12/27/82).	Restrict providers	Approved (3/11/83); effective (9/9/83).
To waive 1902(a) (1), (10) and (23) to create a prepaid health plan to provide comprehensive clinic services and day treatment services to DD/MR, adult mentally ill, child mentally ill, frail elderly, adult handicapped, and chronic substance abusers. (9/2/83).	Restrict providers	Additional information received.

SUMMARY OF WAIVER REQUESTS RECEIVED UNDER AUTHORITY OF SECTION 2175 OF PUBLIC LAW 97-35, AS OF FEB. 29, 1984—Continued

[Description of proposals, types of waivers requested, and dates of initial request and final disposition]

State	Waiver type	Status
Washington (5 requests):		
To waive various regulations under authority of 1915(b)(1) (case management) to modify utilization control/review requirements. Three requests. (10/16/81).	Case management	Disapproved (3) (1/13/82).
To waive various regulations to institute a $5.00 copay for emergency hospital and outpatient visits, except on the institutionalized. (10/26/81).	Case management	Disapproved (1/20/82).
To waive 1902(a)(23) to implement a prepaid capitation plan to pay for prescription drugs provided to recipients in selected long-term care facilities. (4/19/82). Modification to waiver approved on 9/16/82. Request to change effective date from 9/16/82 to 7/1/83. (7/8/83). Approved (8/31/83).[1]	Restrict providers	Approved (9/16/82); effective (9/16/82).
West Virginia:		
To waive 1902(a) (1), (10) and (23) to permit implementation of a primary care case management prepaid health care plan, called "West Virginia Capitated Case Management (WVCCM)" (4/12/83).	Case management	Withdrawn (4/21/83).
Wisconsin (6 requests):		
To waive 1902(a) (1) and (23) and 1903(m) to: (1) implemented HMO primary care case management system; (2) exempt HMO enrollees from copayment; and (3) implement gatekeeper prudent buyer plan for mental health care. Three requests. (2/11/82). Modification to case management waiver approved on 5/12/82. Request to extend primary care case management system waiver for an additional two-year period. (2/13/84). Under Review.[1] [3]	Case management, share cost savings; restrict providers.	Approved (2) (5/12/82); effective (5/12/82); gatekeeper plan (1) approved (11/8/82); effective (11/8/82).
To waive 1902(a) (1) and (23) to require recipients not enrolled in an HMO to select (or have the State select for them after a reasonable opportunity) a primary care physician (or network). (8/27/82).	Case management	Approved (1/5/83); effective (1/5/83).
To waive CFR 435.831, which requires a prospective period of not more than 6 months to be used to compute income for the medically needy in determining Medicaid eligibility. (11/1/82).	No specific provision	Disapproved (2/10/83).
To waive 1902(a) (1), (10), (14) and (23) to provide case management, supportive home care, alternative care and respite care to individuals who require an ICF/MR level of care. (2/22/83). [Companion to 1915(c) waiver request received on same date.].	No specific provision	Withdrawn.

[1] Indicates request for minor modification of an approved waiver—not counted as separate waiver request

[2] Indicates new approval.

[3] Indicates new request