S. HRG. 102-745

MEDICAID MANAGED CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

ON

S. 2077

APRIL 10, 1992

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

57-779—CC WASHINGTON : 1992

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-039144-X

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MEDICAID MANAGED CARE

FRIDAY, APRIL 10, 1992

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:40 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan presiding.

Also present: Senators Durenberger and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H-12, March 28, 1992]

RIEGLE CALLS HEARING ON MEDICAID MANAGED CARE; HEALTH SUBCOMMITTEE TO DISCUSS MOYNIHAN-DURENBERGER BILL

WASHINGTON, DC—Senator Donald W. Riegle Jr., Chairman of the Finance Subcommittee on Health for Families and the Uninsured, Thursday announced a hear on managed care legislation.

The hearing will be at *9:30 a.m., Friday, April 10, 1992,* in Room SD-215 of the Dirksen Senate Office Building.

Riegle (D., Mich.) said the hearing will focus on legislation introduced by Senators Daniel Patrick Moynihan (D., N.Y.) and Dave Durenberger (R., Minn.), both members of the Finance Committee.

"Efforts to promote managed care and to improve the Medicaid program are needed to reform our health care system. Many of the current health care reform proposals would encourage the use of manage care in the Medicaid program, including HealthAmerica, the bill I introduced with Senators Mitchell, Rockefeller, and Kennedy," Riegle said.

"I look forward to learning more about the bill introduced by Senators Moynihan and Durenberger, S. 2077, which gives states more flexibility to operate managed care programs," Riegle said.

Moynihan said, "With Medicaid costs rising at 20 percent a year, and large numbers of welfare recipients unable to find a physician who will take care of them, we should be encouraging states to contract with managed care plans, not discouraging it. That's the purpose of S. 2077."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. A very good morning to our guests and our witnesses, some of whom will have seen me here before. I arrived at 20 minutes after 9:00 and was told this was not my subcommittee and would I please go away. So, I did. [Laughter.]

This is Senator Riegle's Subcommittee on Health for Families and the Uninsured. And we are going to have a hearing on Medicaid Managed Care.

And our first witness, if you can hold just a moment, is my distinguished fellow New Yorker, and our distinguished colleague, Representative Ed Towns.

I want to hear from Senator Durenberger, and we want to hear from all of you, as inauspiciously as the morning may have begun.

If you would indulge me, Senator, just to make a brief remark. I have a statement which I will place in the record at this point. And to say that, at most, I have a neighbor's acquaintance with this. My colleague, Senator Durenberger, is a genuine expert.

But, as Chairman of the Subcommittee on Social Security and Family Policy, I sort of look over the garden fence into your place from time to time and I see similarities. I see a situation which is not unfamiliar.

The world is full of this sort of thing—at least it has been in my 40 some years in government—where there are theoretical explanations for something that is going on, but which nobody understands because they cannot follow the theoretical explanations. And a lot of just plain confusion takes place.

The simple fact is that in the 1960's, we put in place a further extension of the Social Security system which had been on the national agenda for about 30 years, which is health insurance—for Medicare and Medicaid.

And it was some very dear friends of mine that said that Medicaid might cost $500 million a year, maybe, at the outside. And, in no time at all, it was costing $500 million a week, and no one understands it. And everyone feels they are being ripped off somewhere here or there, or something is going wrong and bad people are making bad decisions.

As far as I can tell in this area, as in aspects of welfare policy, what we have is a very simple case of Baumol's Disease. If you know—and I see everybody nodding in agreement—Baumol's Disease—anybody want to give us a brief run down on Baumol's Disease? Well, it is health care. Baumol's Disease. All right.

Bill Baumol, who is a professor of economics at NYU and at Princeton began worrying in the 1960's about why there was a great increase in the cost of the performing arts.

Why was the Metropolitan Opera always broke, and why was the union, the orchestra always on strike when everything else seemed to be going nicely?

And he and William Bowen, who was then president of Princeton, came up with this simple, conceptual model which has now had a generation of testing in empirical settings. And it works. It just works. It explains things.

The economics profession uses the term "Baumol's Disease;" he says cost disease. Which is, that in different sectors of the economy you get different rates of growth of productivity. And, therefore, relative prices change.

The point is, that if you want a Dixieland Band to play at your re-election rally today, you need the same number of people that you needed in Storyville in 1905.

But you have to pay them more than they would have gotten in 1900, because they like to get paid about the same price that people who work in factories do, or farms.

If you want to play a Mozart Quartet, it takes four people, and it takes just as long as when Mozart played it with Hayden. If you play the Minute Waltz in 50 seconds, it increases productivity, but not quality. [Laughter.]

And this explains everything. Yesterday we had a meeting on health care costs and we had a dean of a very influential school. We are talking about Baumol's Disease, Senator. And I said, well, we have got Baumol's Disease in health care, do we not? And he said, no, we do not. And I said, well, now, look, Mr. Dean, when a doctor sees a patient today it takes about half an hour. Mind you, he can do some good for the patient today which he probably could not have done 50 years ago. But it also took half an hour.

And the dean said, no, not true. Most doctors do not see patients that way, or, if they do, they have them get 96 tests beforehand. And I said, well, Mr. Dean, that means productivity has gone from one-half a person hour per patient visit to 48 hours. Productivity is regressing.

That does not sound like a lot, but it is why lawyers are so much more expensive. It takes the same amount of time for a brilliant prosecuting attorney to make his summation to the jury as it did when Clarence Darow was around. It is why universities are broke everywhere. The same professor teaches the same 20 people.

Manufacturing productivity in the United States goes up, up, up. This sector does not. Baumol suggests that by the year 2040 health care will require 35 percent of GNP, and that we will be able to afford it.

But we will probably spend the intervening half-century saying, who is responsible for this, and seeing it is a failure in the health sector, when, in fact, it reflects success in agriculture.

When the Social Security Act was enacted, one-quarter of the American population lived on farms. And 55 years later, 2 percent live on farms. That is a success, but it means doctors cost more. End of subject.

Senator Durenberger.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, I had to smile when you raised the subject of Baumol's Disease and everyone looked knowledgeable on the subject. They really did not—none of us—knew what you were talking about. [Laughter.]

But the reality is, we knew we were going to learn. Those of us who have always enjoyed the acquisition of knowledge in the way in which only you can do it simply look forward to that with great anticipation, and now, I must say, with pleasure.

Perhaps I would like to make an observation to put what you just said in the context of this subcommittee, if you will, and sort of the other half of the hat that you wear.

The whole Nation now, either at this level or in New York, or in Minnesota, or someplace like that, is struggling with how to achieve these national and personal goals of how do we get universal access to superior quality care, which we presume in this country, to some kind of a universal coverage system where we are all covered for the financial risk that is inherent in medical care.

Senator MOYNIHAN. Yes.

Senator DURENBERGER. But how do we get all of that at either a reduced or a predictably increasing cost, and how do we get it out of the system in which the financing is much more equitable than the current financing?

Senator MOYNIHAN. Yes.

Senator DURENBERGER. I just asked the gentleman from Minnesota about how many ways——

Senator MOYNIHAN. Mr. Baird?

Senator DURENBERGER. Mr. Baird.

Senator MOYNIHAN. Yes.

Senator DURENBERGER. How many ways there are to become eligible for the Medicaid program. The response blew my mind. I think you are well aware of that. But, in the practical sense, the equity in access to the system bothers people as much as anything else does.

So, I have come to the conclusion that if we are going to meet the goals of universal coverage, universal access, high quality care, that all means we are going to have to have more as a society. If we are going to meet the goal of containing costs, we are going to have to spend less.

There are only two ways to do that. You go to some kind of a governmental system in which you reduce something in order to have the more but pay the less, or you deal with the issue which you addressed so well—productivity—in some way.

That leads me, I think, to the second conclusion that I have come to, and that is that the most important subcommittee in this committee that relates to health care is yours, not this one. The major Federal challenge is to improve the income security of every American.

The way in which we combine tax policy, social insurance policy, and all of the rest of these sort of Federal policies is really the key to providing the universal coverage to the financial risk.

Then when we get into the difficult issue, when we get to the inter-governmental side of this and we talk about the production system, the doctors, the hospital, the home health agencies, and all the rest of the sort of thing out there, and how are we going to get some productivity in the system?

There, I have concluded, we are going to have to rely on community in some sense. And whether it is State, local, or the private sector combined with the local community, we cannot do productivity at this level. We cannot get the high quality and all of the rest of that sort of thing dictated out of this committee.

Furthermore, I have come to the conclusion that it is for one very simple reason; because we cannot be trusted. We cannot be trusted.

If you or I make a proposal like RBRVS or managed care in the Medicaid system, or anything else that we believe improves quality, expands coverage, and expands the access and contains the cost, the presumption is, Dick Darman is behind it.

Or, a cap on entitlements, which we are dealing with on the floor right now, is behind it. And what is behind that, of course, is a $4 trillion debt brought on by a lot of profligates who cannot say no to their constituents.

So, I am deeply concerned that, both in your subcommittee and this, and in the Medicare Subcommittee, we sort of hasten the process of dealing with the appropriate Federal role in income security and start moving down, if you will, or over, if you will, to community the decisions that are going to have to be taken in regards to improving quality and access to care.

Senator MOYNIHAN. I think that states it very well. The not-so-invisible hand of the sinister Dr. Darman. Would Senator Hatch wish to comment in that vein?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman. I appreciate your leadership in this area as well. I have enjoyed your——

Senator MOYNIHAN. No. I have no leadership in this area.

Senator HATCH. No, no. You have leadership in every area.

Senator MOYNIHAN. I am a voyeur.

Senator HATCH. I have been watching you. You are all-embrasive. You are like that nebulous——

Senator MOYNIHAN. That sinister Dr. Darman.

Senator HATCH. Well, I am pleased to be with you this morning to discuss improvements in the Medicaid program. S. 2077 represents, I think, significant legislation in this area.

I look forward to learning from our panelists about the advantages and the disadvantages of coordinated care programs, HMO's, pre-paid health programs, and primary care case management programs, as they apply to all individuals receiving Medicaid.

It seems only reasonable that we examine the application of coordinated care to the Medicaid population. During the past two decades, we have witnessed considerable innovation in the organizational management of health care in the United States, the most important development of which is the growth of coordinated care, to use the President's term.

Health maintenance organizations and preferred provider organizations now serve 40 million Americans. In 1989, over 27 percent of all employees in medium and large firms received care through health maintenance organizations, HMO's, or preferred provider organizations, PPO's.

While Medicare recipients lagged significantly behind the private sector enrollment, this approach is nevertheless being encouraged within that population. Currently, only about 11 percent of Medicaid recipients receive service through coordinated care programs.

We know that the State's share of Medicaid represents the fastest-growing component of many State budgets. And this trend has consequences that limits State resources to meet other equally important needs of its citizens.

Much of the increased expenditure is attributable to Federal Medicaid mandates. In my home State of Utah, for instance, the increased Medicaid costs associated with Federal mandates and health care inflation have reduced the State's ability to deal with educational challenges and other critical State needs.

And, similarly, our Utah AFDC program has been affected by the growth of Medicaid costs and requirements. Congress needs to act to bring relief to States.

It is believed that Medicaid cost growth would be slowed by encouraging greater reliance on coordinated care and by providing States with greater flexibility. I believe that.

For this reason alone, we ought to examine this bill. And I commend those who are pushing it. We should not ignore a potentially effective remedy to Medicaid cost growth.

I also agree that coordinated care programs have many benefits. First, they take responsibility for the entire episode of any illness, and for the future welfare of the patient. Thus, plans have incentives to keep patients healthy and to ensure the most rapid and complete recovery from illness.

They also provide preventive services, and, most importantly, coordinated care plans employ a variety of mechanisms to ensure high-quality care and coordination of services.

These include utilization reviews to determine whether services are medically necessary and appropriate, pre-admission certification, second surgical opinions, patient case management, and the use of primary care physicians as coordinators and managers of care.

Yet, we need to be more mindful of how our deliberation this morning fits into the whole health reform picture.

Now, I believe there are four major objectives that must be operative in reforming any of our health care programs, including Medicaid. And I will be consciously applying these principles to legislation in health as it comes forward.

One, would be access to health care and financial security for all American families. Two, would be reduction in growth of the health care cost growth rate. Three, improvement of the long-term health and well-being of Americans. And, fourth, the maintenance of the quality of care.

Coordinated care approaches can be designed to meet these very objectives. And we should change existing laws that discourage coordinated care. And I appreciate the fact that S. 2077 creates a provision guaranteeing Medicaid participants a choice of coordinated care plans and physicians and recognizes the importance of quality care.

I am uncertain, however, as to whether coordinated care programs are a panacea for the needs of all Medicaid patients or recipients.

In particular, I wonder how well-suited these programs are for the specialized health needs of disabled Americans who depend on Medicaid. There are over 10,000 persons with disabilities in Utah alone who depend on Medicaid.

Moreover, much of Utah's health care is delivered in rural areas. So, I am eager to learn if, and how, coordinated care approaches meet the needs of patients in rural settings, as well.

Clearly, coordinated care does have some advantages. They offer useful lessons and potentially productive applications. And, for this reason, coordinated care programs should be thoughtfully considered.

I want to commend my colleague from New York and my colleague from Minnesota for holding this hearing today and for the work that they have done in this area. I am certainly interested in working with them and will do so as we try to come up with the answers to our health care needs in this country.

Mr. Chairman, if you will forgive me, I have to go to the Judiciary Committee for another hearing.

Senator MOYNIHAN. Sure.

Senator HATCH. But I wanted to come and express my regard for both of you and for what you are trying to do, and my future support.

Senator MOYNIHAN. Thank you very much, sir. We understand. We are all supposed to be not only in various committees, we are also supposed to be on the floor, as well. You are very kind to have come. We appreciate those remarks very much.

Senator HATCH. Thank you, Mr. Chairman.

Senator MOYNIHAN. And, now, sir. Representative Towns, who is a good friend, has been very patient with us. We are limiting our witnesses to a fixed time, but not you. We will treat you like a Senator this morning. Once you have the floor, you can speak indefinitely. You may wish to put your statement in the record as if read and proceed, but you proceed exactly as you wish. Good morning, and welcome.

STATEMENT OF HON. ED TOWNS, A U.S. REPRESENTATIVE FROM NEW YORK

Congressman TOWNS. Thank you very much, Mr. Chairman, and to Senator Durenberger. I am honored to be here today to testify before this subcommittee.

Making quality health care services available to Medicaid recipients is one of the biggest challenges facing this country. And it is a battle we simply cannot afford to lose.

At present, one-third of African-American deaths each year could be prevented if adequate health care were available. We have to correct the situation now before even more lives are needlessly lost.

For this reason, I strongly support S. 2077, the Medicaid Managed Care Improvement Act. I will introduce its House counterpart very soon.

By coordinating services and making sure that physicians are responsive to patients' needs, managed care can both use our health care dollars more effectively and improve the quality of care Medicaid recipients receive. And that is extremely important.

We need to encourage, not discourage, managed care and State Medicaid programs. This legislation will eliminate the needless obstacles that stand in the way of many States and prevent them from providing the highest quality of care.

Despite managed care's many proven successes, some are still skeptical, particularly when it comes to managed care for the Medicaid population. For them, managed care means rationed care.

In my view, nothing could be further from the truth. An examination of the myths surrounding managed care is long overdue. And there are a few points that I would like to address.

First, is the view that managed care should not be encouraged because it unfairly restricts Medicaid recipients' freedom of choice. Freedom of choice becomes a meaningless concern when there are few or no providers willing to serve you. Therefore, there is no choice.

The New York State Association of Counties found that Medicaid recipients were much more likely than non-Medicaid patients to be hospitalized for sub-acute conditions. That is, common conditions, such as ear infections, asthma, hypertension, and diabetes.

What is alarming about this finding is the fact that these conditions would ordinarily not require hospitalization if the patient had been treated at an earlier stage on an out-patient basis.

This lack of access to primary care is readily apparent in the district that I represent. Of the 331 primary care physicians practicing in North Central Brooklyn, only 18 accept Medicaid and meet the basic criteria for an acceptable medical practice.

That is, 24-hour coverage, 20 or more regular office hours a week, and admitting privileges at a hospital. Thus, for many of my constituents, freedom of choice all too often means choosing among a costly, low-quality Medicaid mill, a hospital emergency room, or, more likely, doing without care altogether.

Enrollment in a managed care plan, by contrast, can assure that Medicaid recipients in Brooklyn and elsewhere have access to physicians whose credentials are carefully evaluated and who are required to be available to their patients on an around-the-clock basis.

Let me cite just two examples of the kind of success managed care systems can achieve. HealthPartners of Philadelphia improved health care for infants simply by persuading 142 out of 145 mothers to deliver at the same hospital where they received prenatal care.

Alabama decreased its infant mortality rate from 12.1 to 10.9 percent within 1 year through the use of a primary care case management system.

Because of low Medicaid reimbursement rates, without a managed care plan, it is unlikely that mothers in either State would have seen a doctor on a regular basis. And they would most likely ended up delivering their babies in an emergency room.

The success these programs have achieved is largely due to the emphasis on continuity of care, which is extremely important, Mr. Chairman; an element that is missing from the fee-for-service Medicaid program.

Second, I would like to address the concern that Medicaid-only managed care plans provide second-class medicine. The so-called 75–25 composition of enrollment rule prohibits a State from contracting with a managed care plan unless the plan has at least 25 percent commercial enrollment.

The 75–25 rule was intended to promote quality of care by assuring that a plan's Medicaid members would receive the same services as its private pay members.

The 75–25 rule, however, ignores the realities of the inner city neighborhoods where most Medicaid recipients live. Over one-third of the population in the district I represent, for instance, is eligible for Medicaid. I repeat: 30 percent are eligible for Medicaid.

A better approach, and the one adopted by S. 2077, is to eliminate the 75–25 rule and replace it with a more direct means of assuring quality of care. We should not permit arbitrary measures of quality to continue to retard the development of managed care for the Medicaid population.

Finally, Mr. Chairman, I would like to emphasize that managed care need not displace the elements of the health care system that are working.

The most successful managed care networks are the ones that draw upon the experience and expertise of those in the neighborhoods, notably the community health centers, who have traditionally provided primary care.

Indeed, the local community health centers are an integral part of the managed care network being developed in my district, and I expect them to enter into similar arrangements with managed care plans across the Nation.

The rules currently governing managed care in the Medicaid program may be well-intentioned, but they do not work. They have produced a health care system that favors Medicaid mills and hospital emergency rooms, over-coordinated delivery mechanisms.

This is a system, Mr. Chairman, in which 25 percent of the citizens of New York City do not have access to a primary care physician, and a system in which one-third of African-American deaths could have been prevented if adequate care had been available. We can no longer tolerate these rigid and counterproductive rules.

It is time we permitted States the flexibility that they need to truly coordinate, and, thereby, improve the health care available to Medicaid recipients.

Let me thank you for the opportunity to appear before this committee. And, at this time, I am prepared to answer any questions. Thank you very much.

Senator MOYNIHAN. We thank you, sir.

[The prepared statement of Congressman Towns appears in the appendix.]

Senator MOYNIHAN. I will say Mr. Chairman, because I believe you are Chairman of the Congressional Black Caucus this year.

Congressman TOWNS. Yes, I am.

Senator MOYNIHAN. You began and ended with a pretty powerful statement to the effect that the present system is one in which we find inadequacy in the care of African-Americans.

If one-third of African-American deaths could have been prevented by adequate care, we have a disparity. I have to assume that that is not true with the population as a whole. Can you get us some data on that?

Congressman TOWNS. I would be delighted to, Mr. Chairman.

Senator MOYNIHAN. Yes. Obviously you are working from some experience.

Congressman TOWNS. I would be delighted to.

Senator MOYNIHAN. Yes. That would be a powerful thing. I would also—and I will speak for Senator Durenberger in this as well—that situation in Alabama, that is an impressive thing.

If anybody can change any demographic number like an infant mortality rate that quickly, something happened. I mean, something shocked the system. If you can drop infant mortality from 12.1 to 10.9 in 1 year, well, you know, there ought to be a prize for that.

Congressman TOWNS. Right.

Senator MOYNIHAN. Something happened. That interests me, because these things do not change very fast. And these ratios do not. When they do, look up and pay attention.

You think that it was the use of a primary care case management system in Alabama?

Congressman TOWNS. No question about it, that coordination, Mr. Chairman, is extremely important. What has happened in many instances, especially in New York City and in many neighborhoods, the emergency room has become the family physician where there is no coordination.

Senator MOYNIHAN. Yes.

Congressman TOWNS. But when you have coordination where a patient can receive counseling, it makes a major difference in terms of what happens in terms of the quality of health care. And, also, I think that we would be amazed to find how much it costs to actually provide these services in the emergency room. So, I think that it makes sense to move in this direction.

Senator MOYNIHAN. I think that is what we know about medicine, that it is preventive medicine that gets all the economic returns.

You have a situation where, I guess it is only in the last 50 years, that medical care really helped patients beyond the most elemental things; lying down and resting. A century ago, most medical care injured patients, and it took a lot of discipline to stop.

I think medical school students—I do not know this for sure—are sort of taught about the death of George Washington. Anybody who knows this, correct me. But I think he had a bronchial infection of some kind. And he was attended upon by two doctors who were London-trained. And they bled him and then they gave him some poison.

And he did not really respond very well to that, so they bled him some more and poisoned him some more. The patient was not responding, so they called a specialist down from Washington who trebled the dose of poison. And that was the end of the father of our country.

Well, it took a long time to stop poisoning. I bet you would be surprised. I would like to know in our own New York when was the last hospital where patients were bled. Probably into this century.

But now that we have some capabilities, they have got to be available to everybody. It is a civil right, I think. The laws do not entitle you to immortality; everybody in this room is going to die. But prematurely and for lack of the social provision that others routinely can get, that is not fair.

Mind you, in New York State, one of the problems, I think, is it not, that Medicaid pays general practitioners $11 a visit.

Congressman TOWNS. That is correct.

Senator MOYNIHAN. Well, we cannot blame the Federal Government for that.

Congressman TOWNS. That is right.

Senator MOYNIHAN. And I am sure in your district and all around, $11 will not do. That is a problem we can take up with our State legislature.

Congressman TOWNS. Right.

Senator MOYNIHAN. Senator.

Senator DURENBERGER. Mr. Chairman, I am very grateful to hear the Chairman say what he said about his commitment to the legislation, carrying it on the House side. We could not have a better colleague. And I sure hope that we find a vehicle to get this done this year.

Congressman TOWNS. Thank you.

Senator MOYNIHAN. Yes. And we thank you for offering to introduce it on the other side. That goes to Energy and Commerce?

Congressman TOWNS. That is correct.

Senator MOYNIHAN. Will you explain to me why? No, do not. Do not.

Congressman TOWNS. Do you have 2 days?

Senator MOYNIHAN. Yes. It is Friday and we would be over into the weekend. I could not possibly do that. Thank you very much, sir.

Congressman TOWNS. Thank you so much for allowing me to come.

Senator MOYNIHAN. The administration is going to speak to us. I wonder if we could just ask Mr. Moley, who is Deputy Secretary for Health and Human Services, and Ms. Shikles, who is the Director of the Health Financing and Policy Issues in the General Accounting Office, to come forward.

Mr. Moley. Ms. Shikles. Good morning to you both. Mr. Secretary, you are first on the list. Again, we can put your testimony in the record as read. You proceed exactly as you wish.

STATEMENT OF KEVIN E. MOLEY, DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES

Secretary MOLEY. Thank you. I would ask, Senator, that you put my full testimony in the record.

Senator MOYNIHAN. That will be done.

[The prepared statement of Secretary Moley appears in the appendix.]

Secretary MOLEY. I will paraphrase briefly, if I may. First of all, I would like to say we are very pleased to be here today to voice our strong support from the administration for——

Senator MOYNIHAN. What did you say? I think that is the first time we have heard that in this room this year. [Laughter.]

Secretary MOLEY. Let me say it again, Senator.

Senator MOYNIHAN. Now, careful. Darman's watching. [Laughter.]

Secretary MOLEY. We are very pleased to offer our strong support for S. 2077. I want to take this opportunity also to commend you and Senator Durenberger as authors of this bill.

We strongly believe that coordinated care systems have demonstrated their value to communities all over the country through expanded access for their citizens.

To the many who take advantage of their services, they offer continuity of care instead of a hodge-podge of fragmented, fee-for-service care.

They also offer improved quality through preventive services, and, in particular, early attention to problems that if left untreated could pose serious health problems.

Coordinated care systems offer an extra advantage of less paperwork burden and administrative hassle.

At the outset, let me underscore our general support and our willingness to work with the committee toward enactment of this bill this year. We have some concerns, primarily technical, which we have been working with committee staff to resolve.

Senator MOYNIHAN. Mr. Secretary, take your time. We want to hear you. And do not feel you are imposing on us. Take all the time you want to.

Secretary MOLEY. This is a rare moment, Senator, when we are in such agreement. [Laughter.]

I will try to prolong the good will.

Senator MOYNIHAN. Enjoy it awhile. Yes.

Secretary MOLEY. As I said, we are confident that the concerns, which are primarily technical, can be resolved to the full satisfaction of both the department and the committee.

That being said, let me make a few brief remarks on the bill. Current law requires that without a freedom-of-choice waiver, Medicaid clients are to be given a choice between managed care and what I will call "unmanaged care" and the fee-for-service system.

The linchpin of this legislation is the change which eliminates the requirements for these waivers and which releases States from the time-consuming waiver process, as well as the time-consuming waiver renewal process. This would give States greater flexibility to manage health care for their Medicaid recipients.

Bluntly stated, fee-for-service medicine is increasingly unable to meet the needs of the Medicaid population. Today's Medicaid client faces greater difficulty accessing care through providers of the fee-for-service system. Many refuse to treat Medicaid clients.

Those who accept Medicaid frequently have long waiting periods for appointments, and have practices a long distance from a client's community.

Fortunately, coordinated care holds special promise for State Medicaid programs and their recipients. Use of coordinated care systems can give more people a better value for their health care dollars.

Coordinated care systems provide clients a point of entry into the health care system where their total health care can be managed. Providers will know the patient and the patient's medical history.

Use of coordinated care will increase the opportunity for appropriate preventive care to be started before health problems get out of control, and for continuity of care throughout the medical system.

Clients often report that they use the emergency room because they do not have a regular source of care.

Senator MOYNIHAN. If I could just interrupt. Now, what you are just saying is what Representative Towns just told us. You are speaking from the point of view of the national perspective, and he is describing North Central Brooklyn. And you are saying the same thing.

Secretary MOLEY. In fact, in closing, I will have more to say specifically about Congressman Towns' testimony, of which we, in general, are very supportive.

Having access to a primary care provider is, without doubt, a much better alternative for clients than waiting in an over-burdened emergency room for care from an unfamiliar provider.

A recent IG study indicates that one-half to two-thirds of Medicaid emergency room visits are non-emergency in nature.

Moreover, treatment in an emergency room results in costs of care three to five times higher than the cost of care received in a more appropriate setting for the same condition.

Greater flexibility to the States will also help States improve control over soaring Medicaid costs, a problem of keen concern to both the Congress and the administration.

On average, States now spend over 20 percent of their budgets on health care. And, unfortunately, despite our best efforts, health care expenditures continue to grow.

By 1993, combined Federal and State expenditures for Medicaid are expected to have grown by 250 percent over 1989 levels.

In a recent IG study, States with managed care programs reported savings. For example, Kentucky's primary care case management program reduced infant mortality rates, and, in the process, saved $25 million.

As another example, Arizona's exclusive use of coordinated care for Medicaid recipients shaved nearly 6 percent off of projected fee-for-service costs.

And, in Wisconsin, HMO's save over 7 percent, compared to Medicaid fee-for-service and can still afford to pay higher rates to their primary care doctors.

Despite the potential of coordinated care, 9 out of 10 Medicaid clients continue to receive care through fee-for-service systems.

In closing, Senator, let me reiterate our support for S. 2077, for your efforts to improve the Medicaid program by fostering greater use of coordinated care.

This legislation provides States with a greater ability to control their Medicaid expenditures, and, at the same time, offers a quality alternative to the more traditional fee-for-service system that has poorly served Medicaid clients.

Expanded use of coordinated care, as specified in your bill, is consistent with the direction the President has chartered for health care reform. Thank you for the opportunity to comment.

In closing, I would like to simply say that I was also struck by the similarity of Congressman Towns' testimony. And I would like to expand briefly on his comments with respect to Alabama.

In Alabama there is a Medicaid Commissioner, Carol Hermann, who previously served with us in the Health Care Financing Administration. She is a very strong supporter of coordinated care.

And what is striking is not just the overall reduction in Alabama. Specifically, through using a primary care case management system in Jefferson County, where Birmingham is located, we have seen significant reductions: from 14.1 per 1,000 births in 1988, to 11.9 in 1989, and preliminarily 11.7 in 1990.

So, that is what has influenced the overall State programs, our experience in Jefferson County where we had this problem, and having a Medicaid Commissioner with experience and considerable faith in the use of managed care.

Senator MOYNIHAN. Well, that is what we were looking for.

Secretary MOLEY. Indeed. A direct reflection. A little bit of reiteration of what Congressman Towns was relating to you.

Senator MOYNIHAN. Fine. Mr. Secretary, would you mind repeating your testimony? It was such a refreshing thing. [Laughter.]

Secretary MOLEY. At least the first part and the last part about our support.

Senator MOYNIHAN. I have some questions. We will get back to them. And Senator Durenberger will be back here in one moment. But let us turn to Ms. Shikles, and Mr. Jensen, your colleague. Good morning.

Ms. SHIKLES. Good morning.

Senator MOYNIHAN. We will proceed just exactly as you wish.

STATEMENT OF JANET L. SHIKLES, DIRECTOR OF HEALTH FINANCING AND POLICY ISSUES, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY RICHARD N. JENSEN, SENIOR ECONOMIST, U.S. GENERAL ACCOUNTING OFFICE

Ms. SHIKLES. Mr. Chairman and members of the subcommittee, we are pleased to be here today to testify on the role of managed care and State Medicaid programs.

GAO has been looking at these programs for years and currently has several reviews under way. Based on this work, we have gained insights that may be helpful to the Congress as it considers removing barriers to States' use of managed care in the Medicaid program.

Federal and State policymakers are increasingly turning to managed care as a way of getting better access and quality for the money they spend. To make managed care work, however, adequate safeguards and oversight are crucial.

Our previous reviews of Medicaid managed care programs have identified problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency.

For example, our 1990 report on Chicago area HMO's participating in Medicaid managed care illustrates the abuses that can occur if safeguards and oversight are not adequate.

Senator MOYNIHAN. Yes.

Ms. SHIKLES. One of the major problems that we reported was the incentive to under-serve. While the incentives inherent in fee-for-service health care may encourage providers to deliver too many services, pre-paid managed care may encourage providers to deliver fewer services than enrollees need.

These incentives were created in Chicago when some of the HMO's passed through to their subcontractors the total financial risk of providing care.

We also found inadequacies in the Chicago HMO's' quality assurance programs, utilization data, and followup to correct quality of care problems.

Now, on the other hand, while we did find serious problems in the Chicago program, our current review of Oregon's program indicates that concerns about many of these problems can be significantly lessened through oversight and appropriate safeguards.

Senator MOYNIHAN. May I just interject to say that that is a nice point. If the fee-for-service system will tend to over-serve, the economics of group care contains an incentive to under-serve. Yes. Sure. So you have to watch that.

Ms. SHIKLES. Right.

Senator MOYNIHAN. If you move from this system at present to another system, keep in mind that you are reversing incentives here.

Ms. SHIKLES. That is right.

Senator MOYNIHAN. Do not keep looking for people who are being over-served when, in fact, your problem would be the opposite.

Ms. SHIKLES. And we think Oregon, as we looked at their program, looked at some of the problems from earlier programs and then made sure that that did not happen, just to protect against that.

Senator MOYNIHAN. Yes.

Ms. SHIKLES. Oregon's program, which began in 1985 with HCFA approval, is generally very well-accepted by client advocacy and provider groups. The Oregon program has grown gradually to an enrollment of about 65,000, primarily women and children.

The State has contracts with 16 health service providers, with enrollments ranging from 800 to more than 16,000 Medicaid managed care clients. All but one of these providers are capitated for physician and out-patient services.

Senator MOYNIHAN. Wait. Wait. What is "capitated?" Where is this, right here? You meant decapitated? [Laughter.]

Ms. SHIKLES. They are paid a set amount of money for services.

Senator MOYNIHAN. There you are. Why do you not just keep it to per capita. All right. No capitated.

Ms. SHIKLES. What they do in Oregon is that they make the physician organizations, with one exception, at risk for services that they personally provide.

And the hospital care is still paid predominantly on an in-patient basis. And where Chicago got in trouble is they put all the financial risk of providing an individual's care on a small group of doctors.

And then if the doctor misjudged what the cost of the care would be, either the doctor did not pay the hospital bill, or, in many cases, did not provide the services because they did not have the money. So, that is the differences.

Senator MOYNIHAN. Yes. Yes.

Ms. SHIKLES. As I said, in developing its program, Oregon put a number of safeguards in place to prevent inappropriate reductions in service delivery and quality.

For example, the State limits the financial risk most providers assume to the cost of the physicians own services, lab, X-ray, and well-child care, and the State also provides optional stop-loss or insurance to limit the financial risk physician care organizations might face.

To ensure adequate quality, Oregon requires providers to maintain internal quality assurance programs and annually conducts an independent review of medical records through a contract with a physician review organization.

Further, Oregon assesses quality through client satisfaction and disenrollment surveys, and a grievance procedure.

Senator MOYNIHAN. Now, hold it right there. Disenrollment surveys——

Ms. SHIKLES. Yes.

Senator MOYNIHAN [continuing]. For the decapitated? [Laughter.]

Ms. SHIKLES. That is one thing that we would like to recommend that you consider adding to your bill: a survey of disenrollment. And what that means——

Senator MOYNIHAN. You mean discharged patients?

Ms. SHIKLES. Patients willingly——

Senator MOYNIHAN. It is hard enough to understand each other in the world, anyway. Why use language—stick to simple, Webster's College Abridged. All right. In conclusion.

Ms. SHIKLES. In conclusion, managed care programs can offer an opportunity to improve access to quality health care.

Because of the financial incentives of such programs and the vulnerability of the Medicaid population, we believe a set of safeguards must be instituted to assure adequate protection for recipients. These include a quality assurance system that requires client satisfaction and surveys of recipients who voluntarily leave the HMO, a grievance procedure and an outside, independent review of medical records.

Further, to reduce financial risk, States need to monitor the financial arrangements between the contracting plan and its individual providers for excessive incentives not to provide necessary services. That is the problem we identified in the Chicago program.

Senator MOYNIHAN. Yes.

Ms. SHIKLES. It needs to monitor utilization data to determine if appropriate amounts of services are being provided. And it needs to monitor subcontracts in the same manner as it monitors the contracts, because we have found in the past that problems occur at the subcontracting level.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions.

Senator MOYNIHAN. You have answered a great many of them already. Mr. Jensen, were you associated with these studies?

Ms. SHIKLES. Mr. Jensen is responsible for much of the work that is going on looking in Medicaid and managed care programs for GAO.

[The prepared statement of Ms. Shikles appears in the appendix.]

Senator MOYNIHAN. I would like to thank you and welcome you to the subcommittee. That seems to me to be very much in the manner of GAO: very incisive and insightful.

I wonder if I could ask, Mr. Secretary. Would you be good enough to look over this testimony and talk to Ms. Shikles and Mr. Jensen.

And, if there is some way we can incorporate some of these cautionary observations in this testimony, will you tell us? And fairly soon, because we would like to move this fairly soon. The nice point is, the incentives reverse when you go from fee-for-service to group care.

Secretary MOLEY. Yes, indeed. We are well aware of that, Senator. In fact, your bill also requires quality assurance programs.

And, to further those ends, as well as recommendations from the Secretary, we have a Medicaid Managed Care Quality Assurance

Reform Initiative under way in our Medicaid Bureau, which Christina Nye, former Medicaid Director in Wisconsin, is heading up. So, we will be more than glad to work with GAO and others to assure that as we move from one set of incentives to another, we take into account the "disincentive for under-service."

Senator MOYNIHAN. All right. Two things to ask of you. And if we could get those comments pretty soon now, because we would like to move, as you would, too.

Just two items. You said that the Inspector General had some cost estimates on the increased costs of emergency care as against routine care.

Secretary MOLEY. Yes, you are correct. We have figures showing that between one-third and one-half of Medicaid emergency room visits are unnecessary, and, more importantly, that those emergency room visits are as much as three to five times as costly.

Senator MOYNIHAN. Yes. Could you give that to the subcommittee?

Secretary MOLEY. Certainly, Senator.

Senator MOYNIHAN. That, we would like to have. That is what we are talking about. But then you said that Medicaid costs grew by 250 percent.

Secretary MOLEY. Since 1989.

Senator MOYNIHAN. Say it again so I can get it.

Secretary MOLEY. Medicaid costs have grown by 250 percent since 1989.

Senator MOYNIHAN. 1989 to 1992. Is that it?

Secretary MOLEY. That is correct.

Senator MOYNIHAN. Good God, man. Really?

Secretary MOLEY. And we have, obviously, as you can imagine, grave concerns about this. And, depending on what year you use as a baseline, we are still seeing Medicaid increases trending forward as much as 15–20 percent.

Senator MOYNIHAN. Sort of per annum.

Secretary MOLEY. Yes, sir.

Senator MOYNIHAN. All right. Now, there you have got—and I am not asking you to get involved—Baumol's Disease.

Secretary MOLEY. It has got it bad, Senator.

Senator MOYNIHAN. It has got it bad. And it needs emergency or long-term care. The price index, CPI, would be growing, what, 3.5 percent, 4 percent this year? And the price changes in this sector will be three to four times the price changes in the other sector.

And the theory predicts this. Economists know things. They can explain why some things happen. And this is not going to go away. And we are going to try to live with this phenomenon.

But I think if we understand that we have got something on our hands that will not change and can only be intelligently adapted to, we will be better off. We thank you very much. Senator Durenberger will thank you.

But I asked Mr. Moley if he did not want to repeat his testimony because it was such an agreeable experience. It is like the cherry blossoms out there. Senator.

Senator DURENBERGER. Thank you, Mr. Chairman. Let me begin with a couple of questions on the cost issue, and let me also clarify any ambiguity in my characterization of the Director of OMB.

I always pride myself as one of the few Republicans that does not attack him. I used the name in sort of a generic sense. That is that he is perceived—he and his predecessor—as the ogres behind cutting the costs of everything that the Federal Government does——

Senator MOYNIHAN. Am I to think, my dear friend, that you were summoned into the back room by a phone call from the Secretary? [Laughter.]

Senator MOYNIHAN. Mr. Darman is a friend of a quarter century of mine, and I enjoy banging him on the head at every possible chance. He likes it. [Laughter.]

If you do not do that, he does not feel he is not doing his job.

Senator DURENBERGER. All right, Mr. Chairman. But that may just be my entry to talk about costs. I would rather talk about this in the context of quality. I have a question or two to ask in that regard, too.

First, would it not be fair, Kevin, to characterize some substantial part of the 200 percent increase in the Medicaid costs as an increase in the Federal contribution because of the games the States have been playing with voluntary contributions and that sort of thing? It is not the actual costs of the actual services that have increased by 200 percent.

Secretary MOLEY. That is correct, Senator. In large measure, the 250 percent figure I used is related to the taxes and donations issue, with which we have all struggled over the last 6 months or a year.

Senator MOYNIHAN. Would you help me? I did not hear that. The what issue?

Secretary MOLEY. The taxes and donations issue related to disproportionate share hospitals accounts for a great amount of that 250 percent.

But, on the other hand, as I also indicated, depending on what baseline we used in terms of going forward, we are still looking at increased costs in the neighborhood of anywhere from 15 to 20 percent per year.

Senator DURENBERGER. Now, could either of you help us understand where those 15–20 percent increases are coming? As the Senator from New York indicated, doctors in New York are being reimbursed, under New York law, at $11 for an office visit.

I think it is approximately the same in Minnesota, I am assuming. Since we do not know what charges are, or how they arrive at them. But I am told that in my own State of Minnesota that they are being reimbursed at 44 or 45 percent of charges. So, the providers are theoretically being underpaid already.

So, why the 15–20 percent increase each year? From where does that increase come? Is it in increased eligibility, it is in increased utilization, is it in a few high-tech cases, is it the big drain on long-term care? In other words, if we are going to try to manage access to this system in some way, what is it that we are managing?

Secretary MOLEY. As Senator Moynihan indicated, the CPI is somewhere around 3 to 3.5 percent currently. The medical CPI is probably somewhat double that. You also have an increase in the number of recipients, given the state of the economy.

Having said that, I had this discussion yesterday at the Greater New York Hospital Association's annual meeting with Professor Dunlop, a former colleague.

Senator MOYNIHAN. John.

Secretary MOLEY. Yes.

Senator MOYNIHAN. Secretary Dunlop.

Secretary MOLEY. Secretary Dunlop.

Senator MOYNIHAN. Yes. Oh. Good.

Secretary MOLEY. And we also visited later at Mt. Sinai Hospital, which, as you know, borders on East Harlem. And a lot of what was discussed yesterday with respect to this growth rate had to do with the things we have talked about on numerous occasions: technology; the aging of the population, which is a Medicare, not a Medicaid-related phenomenon; disability; and, of course, the number of beneficiaries is increasing. But I think you also have to relate it to some of the excesses associated with the current incentives under fee-for-service.

In all truthfulness, we have circumstances in the city of New York and elsewhere across the country where we have walk-up, store-front Medicaid mills which are quite frankly, in some instances, unfortunately nothing more than billing services. They have an incentive to bring people through the system without relating it to the quality of care delivered to the Medicaid recipient.

And that is why Secretary Sullivan was so taken and so interested by his visit to Health Partners in Philadelphia.

Taking money out of the "back door" of the system—that is the three to five times the cost of an emergency room visit compared with coming in the "front door" of the system, i.e., the clinic, the physician's office or the community health center, et cetera—we can see dramatic cost reductions. This is true in the case of Health Partners in Philadelphia, which is paying market fees for physicians. And, as a result, we are extremely supportive of this bill, as you know.

Ms. SHIKLES. I might add that, clearly, it is all of the things that Kevin said. And it is clearly that Medicaid is now enrolling more people. The people they are seeing are often much sicker.

Many more women who are pregnant that are not getting access to care in the community. So, by the time they deliver that baby in the hospital, these are very low birth weight babies that you see in hospitals around the country. And the Medicaid cost is very high.

Some of them are also drug-exposed babies. I know, Senator, you had a hearing on that issue that we participated in about a year ago. And these are very high costs to the Medicaid program. People are much sicker, they are not getting care, they have to wait to get care.

Senator MOYNIHAN. Well, we had Secretary Sullivan up here, what was it, 2 years ago?

Ms. SHIKLES. Right.

Senator MOYNIHAN. And he had a print-out of the costs of a drug-affected child somewhere.

Ms. SHIKLES. Right.

Senator MOYNIHAN. And it was a foot high, and we learned that $800,000 or something like it had been required to get that child through its first year in life. And God help it thereafter.

Ms. SHIKLES. No. We participated in that hearing. And that is one of the very beneficial features of your legislation, that it does focus more on trying to make sure that Medicaid recipients get guaranteed primary care when they need it in the community.

Senator DURENBERGER. The reason that I need to explore the question with both of you is I am informed that CBO has scored this as having no savings in it and actually increasing the costs, principally, I guess, because of the 6-month extension of coverage after eligibility. I need, Kevin, you, in particular to react to that. And, Janet, if you can, as well.

I understand you to say that eligibility is increasing. The severity of cases is increasing because of the lack of health and preventive services. Technology expenses are doubling or tripling the CPI. I am assuming, in a fee-for-service system that is only paid $11 for an office visit, that there is hardly a doctor in New York, and maybe in other places, that does not upgrade the code, or something like that, in order to get something more than $11.

Or, perhaps, does not see somebody twice as often for half as much time in order to at least get the price of two office visits in for the time of one. So, a lot of this kind of thing has gone on in the Medicare system, I imagine, goes on to a fare-thee-well in this system as well.

The presumption in the bill before us is if we can change the motivations, both for the users of the system and the providers in the system and give them both the same objective—which is to stay healthy and use appropriate medical services, and so forth, and that there is some financial risk in not doing it appropriately—that we are bound to have both a healthier population and a lower cost.

Yet, the good old Congressional Budget Office on whom we have to rely so heavily says, you ain't right. You do not get any savings out of this system. Why is that?

Secretary MOLEY. Well, Senator, we just received this information. I gather you did also just within the last 24 to 48 hours. Our HCFA actuaries will be taking a closer look at this, but quite frankly, we have some doubts as to the estimate, at least preliminarily.

Despite all of our experience—experience with the statewide AHCCCS program in Arizona; the indications I gave you earlier with respect to Wisconsin; what we know about lowering infant mortality rates in Alabama; the Health Partners situation in Philadelphia, intuitive that this information is, except in the case of Arizona and Wisconsin where we know we have had lower rates of increased cost—we know health care costs are going up.

It is a question of the rate of increase. The rates of increase, with coordinated care programs have been lower. And, as I said, we are supportive of the bill.

We are very concerned about the CBO estimate. And our HCFA actuaries will be taking a very close look at it and I hope we will be coming up with a different result.

Senator DURENBERGER. Well, maybe some of the people who are involved in these plans can help us answer that one, as well. But that is always critical to the passage of the good that we try to do around here.

Senator MOYNIHAN. Yes.

Senator DURENBERGER. Mr. Chairman, that is all the questions I have.

Senator MOYNIHAN. Well, thank you very much, Mr. Secretary, Ms. Shikles, and Mr. Jensen. This was very solid testimony. I guess we are going to have to get your actuaries on the job, too. But you will take counsel, as you did say, from the GAO.

And if there are things we need to do and adjustments we need to make, if you are not satisfied with the bill as it is, let us know and we will make the changes.

Secretary MOLEY. We look forward to working with you, Senator.

Senator MOYNIHAN. And I would like to thank you, Mr. Secretary, for mentioning, on our committee, Senator Packwood, who is our Ranking Member, of course, and Senator Roth, are also sponsors of this legislation.

Secretary MOLEY. Indeed.

Senator MOYNIHAN. We thank you all. Our next panel will consist of some people who are in the practice that we are discussing.

Mr. Robert Baird, who is the Deputy Assistant Commissioner for Health Administration of the State of Minnesota. Mr. Baird, we were introduced earlier by Senator Durenberger. You have a colleague with you?

Commissioner BAIRD. Mr. Chairman, that is correct. Ms. Horvath, from the American Public Welfare Association.

Senator MOYNIHAN. Oh. Well, we welcome you. We are very happy to have you here. And Alicia Pelrine, who is here for the National Governors' Association. We welcome you back.

Ms. PELRINE. Thank you, Senator.

Senator MOYNIHAN. Commissioner, you are first on our list. We are very happy to have you, sir. Proceed as you will.

STATEMENT OF ROBERT BAIRD, DEPUTY ASSISTANT COMMISSIONER FOR HEALTH ADMINISTRATION, STATE OF MINNESOTA, ST. PAUL, MN, ON BEHALF OF THE AMERICAN PUBLIC WELFARE ASSOCIATION, ACCOMPANIED BY JANE HORVATH, DIRECTOR, HEALTH POLICY UNIT, THE AMERICAN PUBLIC WELFARE ASSOCIATION

Commissioner BAIRD. Mr. Chairman, thank you very much. Senator Durenberger. I appreciate the opportunity to speak today about the Medicaid Managed Care Improvement Act of 1991.

In the interest of time, I will highlight why managed care is so important to State Medicaid agencies and what this bill would do to facilitate development of all forms of managed care.

However, prior to saying that, I think it is incumbent upon me to say that I am proud to represent the State of Minnesota, that has a long history of the provision of managed care, both in the public and private sector.

We have been in this business since the mid-1960's. And, in the Medicaid program alone, we have had managed care since 1970. So, we do have somewhat of a track record that we are very proud of.

Today we have approximately 20 percent of our Medicaid population enrolled in one form of managed care or another, both traditional and non-traditional.

Across the United States, however, there are 31 States who have a whole variety of managed care entities. They cover about 2.7 million Medicaid clients.

States believe—and they believe this very, very strongly—that managed care programs hold much promise in promoting preventive and primary care for Medicaid clients, particularly.

Managed care programs are based on assuring access by clients to preventive care. Managed care providers, regardless of what might have happened in Illinois, do have certain incentives to provide and to follow through with clients to ensure that proper care is received.

In general, I believe that most States look to managed care for five specific reasons. The first is the potential for greater access to care and improved continuity of care—and I cannot emphasize too much the continuity—which leads to healthier recipients.

Second, managed care programs can facilitate more appropriate utilization of services. Third, managed care programs are able to improve the quality of care delivered. Managed care programs also improve client and provider satisfaction.

And, finally, managed care can help contain costs in both the short and long-term by producing better client health outcomes resulting from improved access to, and continuity of, care.

In general, S. 2077 would allow States to develop risk-based and non-risk-based managed care systems without any of the multitude of waivers now required by the Federal law. The legislation would also allow two positive modifications in eligibility which States strongly support.

The first is guaranteed eligibility for up to 6 months, and the 1-month rolling eligibility. Both provide continuity of care, which is really very important to the overall client health outcomes.

The legislation would allow limited mandatory enrollment. However, we are concerned that the conditions under which S. 2077 permit mandatory enrollment when there is only one entity in the geographic area is too restrictive perhaps. We have suggestions for slightly broader language which will retain the spirit of the basic provision.

Senator MOYNIHAN. Sir, I just wanted to ask you. You have suggestions. You will see that we get them?

Commissioner BAIRD. Yes, sir. We surely will. Absolutely.

Senator MOYNIHAN. Because you are speaking not just for Minnesota, but for the American Public Welfare Association. And we listen.

Commissioner BAIRD. Thank you. There have been some indications that quality assurance in the bill does not go far enough. It is our opinion that the quality assurance in the bill goes much, much further than that which exists in current statutory requirements.

We would like to emphasize, however, that while the bill is based upon those practices, we would like to retain as much flexibility as possible to enable the Medicaid program to move forward with the state-of-the-art quality assurance indicators.

And, so, as a consequence, we believe that the best way to get the quality assurance requirements out is to enable the Health Care Financing Administration to do that, either through the regulatory process, or through the issuance of the Medicaid manual.

There has been concern expressed about the fact that the bill does not address marketing issues. The State Medicaid programs would support language that require State review and approval of HMO marketing techniques.

State agencies believe the time has come to recognize that managed care is no longer unique and unusual. It is becoming a mainstream delivery system and should no longer be subject to all the multitude of waiver requirements. States are committed to making managed care work for Medicaid clients.

Together with the Medicaid Bureau, we have established a Managed Care Technical Advisory Group to improve and refine manual instructions and address quality of care issues.

While States are committed to making managed care work to improve the access and to improve the quality of care for Medicaid clients, most States recognize—and I would really emphasize this—that it is not a panacea.

In the health care system we do not believe that this addresses the larger issues of health care financing, nor should we be addressing that at this moment.

However, what we would say is that State Medicaid agencies and the American Public Welfare Association remain ready to work with members of the subcommittee to assist in moving this legislation forward.

On behalf of the State Medicaid Directors' Association and American Public Welfare Association, we strongly support this initiative. Thank you.

Senator MOYNIHAN. Thank you.

[The prepared statement of Commissioner Baird appears in the appendix.]

Senator MOYNIHAN. We will get back to it, but you all have established a managed care technical advisory group. So, you have some experience already in this.

Commissioner BAIRD. Mr. Chairman, that is correct. Through the cooperation of the Health Care Financing Administration, particularly the Medicaid Bureau. This is a group that is in place and working. It incorporates both staff from the Medicaid Bureau and about 10 States.

Senator MOYNIHAN. We will get to questions after we have heard from the National Governors' Association and Alicia Pelrine. We welcome you back to this committee.

STATEMENT OF ALICIA PELRINE, DIRECTOR, COMMITTEE ON HUMAN RESOURCES, NATIONAL GOVERNORS' ASSOCIATION, WASHINGTON, DC

Ms. PELRINE. Thank you, Senator. It is good to be back. I am Alicia Pelrine, the director for human resources policy, with the National Governors' Association. And I am here this morning to tell you that the Governors strongly support your legislation and appreciate very much its introduction.

As you Senators both know well, Governors have made reform of the national health care system a major priority of theirs for at least 2 years now.

And, last year, when they adopted their policy for reform of the health care system, that included a vision of a system that would provide health care to all Americans that was quality care at prices that everyone could afford.

That vision of an American health care system includes a continuum of services, ranging from good preventive and primary care through the provision of acute care, and long-term and rehabilitative care; for delivery systems that are cost-effective and efficient; and for care management practices that assure that people get care at the most appropriate levels and in the most appropriate settings.

It strikes us as no accident that many attributes of the Governors' vision are embodied in a good managed care system.

But, Senators, from our perspective, this legislation is not about adding a new service delivery system to the Medicaid program, this legislation is about creating a statutory change that removes managed care from the administrative burdens imposed in the Medicaid program to enable States to test experimental approaches.

In fact, managed care has been part of Medicaid for 15 years now. Prior to 1981, States had to go through the process of establishing managed care systems as part of formal demonstration projects, with rigorous evaluations and outcome evaluations.

Since 1981, the system of managed care was elevated from the status of empirical research to the slightly more accessible but still somewhat Byzantine waiver process. And, if you will permit me a metaphor from my Catholic school upbringing Senators, that is kind of like being elevated to purgatory. You can see heaven and you know it is a whole lot better, but you ain't there yet.

The passage of this legislation would enable managed care systems to achieve full legitimacy in the Medicaid program, and we believe its time has come.

For, even in spite of the waiver process—and I was going to bring a completed State managed care waiver package in here today, but I could not find a hand truck to roll it in for you.

Senator MOYNIHAN. That is so important. Yes.

Ms. PELRINE. More than 30 States have established managed care programs, operating through 225 plans and serving about 2.7 million Medicaid recipients.

Our question is, why should managed care continue to be considered a novel experiment in Medicaid, when over 40 million non-Medicaid recipients are currently enrolled in managed care throughout the country.

And, I might add, that 100 of those 40 million are the employees of the Nation's Governors, through the National Governors' Association.

We have learned a whole lot in the last 11 years. We have become more sophisticated in the management of these programs. We think we have a whole lot more tools at our command.

And, certainly, your legislation continues to facilitate our continued growth and sophistication and our ability to run good managed care programs—not the least of which is taking it out from under the status of waivers.

I would invite anyone who thinks that is a small thing to volunteer to spend some time in a Medicaid program; start a process of applying for a waiver for a managed care program, and stick with it through the process.

You have to get that list of 20, single-spaced pages of questions on the 89th day from the Medicaid Bureau to truly understand the frustration of the waiver process.

Senator MOYNIHAN. Or if not to actually do it, just to lift it.

Ms. PELRINE. Right. Just to lift it. Two things in particular that I would mention. One, is that in this legislation, Congress has continued to give recognition to the special status of the community and migrant health centers which have a special status in Medicaid under the federally-qualified health care finally referred to as the FQHC program in Medicaid.

FQHC's serve a very important function, particularly in inner city areas and in rural areas, and the provision of good primary care and services and medical homes to Medicaid clients.

We would encourage you to consider emphasizing their special status and giving Medicaid programs a greater incentive to use FQHC's as a part of a managed care system by perhaps enhancing the Federal match provided for services through the FQHC's.

Very quickly, I would also like to say——

Senator MOYNIHAN. No, no. Not quickly. We want to hear from you.

Ms. PELRINE. I see the yellow light, sir. We would also encourage, as others have, the notion in the legislation that would eliminate the 75–25 percent rule.

While we understand that that was established as a proxy for quality, no group that has looked at this, including the National Academy for State Health Policy, has found any evidence that it does, in fact, serve as that kind of a proxy.

Senator MOYNIHAN. Yes. Yes.

Ms. PELRINE. States have to have the ability to develop plans that meet the economic and demographic needs.

And, if I could give you a quick example of a rural example: in Key West, FL, where the State of Florida operates a managed care program, they have to have a waiver from the 75–25 rule because there are not 25 percent of the population who are private pay in that community.

And, without their managed care program, those people would be seeking care in hospital settings, which is exactly what none of us want.

Senator MOYNIHAN. What we have been hearing.

Ms. PELRINE. In closing, Senator, let me just say that we have all heard, and certainly States and Governors know well the criticisms of the Medicaid program—not enough access to physicians; the inability to establish a medical home for our clients; the inappropriate use of emergency rooms for the provision of primary care—but managed care systems are designed to alleviate those kinds of problems.

We think it is time that they took a full seat at the table in the health care system. We thank you again for this legislation and we stand ready and willing to work with you as it moves through Congress with our full support. Thank you.

Senator MOYNIHAN. Thank you, again.

[The prepared statement of Ms. Pelrine appears in the appendix.]

Senator MOYNIHAN. I heard one thing there which I could not find in your testimony, which is that there are 40 million Americans in HMO's now who are perfectly self-sufficient and non-indigent people.

Ms. PELRINE. That is correct. Including all of my colleagues and myself from the NGA.

Senator MOYNIHAN Yes. All right. Now, I wonder if Senator Durenberger would not agree. I think we have heard from Ms. Pelrine that the problem here is there are them what think that these are somehow stigmatized arrangements and that you are going to put the poor people in them.

I have heard that for 30 years now. And what we want to do is say, right now only privileged people can get into HMO's, but we are going to let the poor have access, too. I mean, if we said it that way we might have a better reception. But there are 40 million HMO members, as you say, nationally.

Ms. PELRINE. Yes, sir.

Senator MOYNIHAN. Very impressive. Your testimony, Commissioner, and yours, Ms. Pelrine, just encourages me to think that this is kind of now a matured idea. I was impressed that you all, in 1990, set up an advisory task force. You know what we are talking about. It is not something, well, let us take another look at this next year, maybe. You are ready to have us legislate this year.

Commissioner BAIRD. Yes, sir.

Ms. PELRINE. Yes, sir.

Senator MOYNIHAN. Senator Durenberger.

Senator DURENBERGER. Yes, Mr. Chairman. Thank you. I wonder if I can come back with the two of you to the question I was asking the earlier panel about where the cost increases are. You need not be precise, but give us an idea.

I know that one of the problems in the system has been that this committee, in its sensitivity to the needs of low-income persons, has been increasing the mandates, decreasing the amount of money, and increasing eligibility. We have heard that articulated well by the Governors who just said, stop, let us digest what we have, or please send us adequate financing for that.

So, we know that there is part of that pressure in recent years, in particular, on the States. But among the other issues that we raised with the earlier panel—the excess of utilization, the severity of illness, the high cost of technology, the pressure on the system from long-term care, and those issues—could you give us some idea of where the principal causes of cost increase are coming from?

Ms. PELRINE. Senator, I am really glad you asked that question, because I would like to take issue, if I could very quickly, with one little exchange that went on with the previous panel. In fact, last year the Federal contribution to Medicaid was somewhere in the neighborhood of $65 billion.

By the administration's own calculations, going into our discussions last year about the States' use of voluntary donations and provider taxes, that accounted for roughly $3 billion, which, by my calculations, is a little less than 5 percent; hardly a major contributor to a 250 percent increase in costs. I would also question the 250 percent increase. I think the reasons that have been laid before you is a pretty accurate and inclusive list.

The only other thing I would suggest is that one of the things that is happening increasingly is that States are losing law suits to the provider community, particularly hospitals and nursing homes, over our payment methodologies and payment rates.

In most cases, the voluntary contributions and tax programs were put in place to pay the cost of the judgments rendered by the courts in those law suits.

So, certainly the provider community's concern and their use of the Boren Amendment to demand increased payment from the States has been another major factor in cost increases.

Senator DURENBERGER. Commissioner Baird.

Commissioner BAIRD. I would just like to second what has been said. But I would also like to really point out that I believe that technology, the access to technology, and the concern about law suits against providers if they do not do all of the tests that possibly could be done have had a real negative impact upon health care costs across this country.

In our own State, I can tell you that long-term care costs, not only the skilled nursing or nursing facility costs, but also costs in the facilities for the developmentally disabled, have been a major variable in driving up the cost.

But, I think of all of the variables, technology probably has been the most expensive thing in the acute care side.

Senator DURENBERGER. Now, one of the reasons that 40 million people are in some kind of managed care plan is that they find that more attractive than other plans, the people do.

But some of the other reasons are that a plan that is put at some financial risk to provide adequate quality care becomes, in some cases, more financially attractive to go into it. In other cases, it actually does more good for you. It is hard to tell one from the other.

But it seems to me there is a growing consensus now in the private pay area, and hopefully it will eventually get to the public pay area. That, in America, with an $821 billion medical bill, we are getting exactly what we pay for: just a whole lot of services. We are getting 9,000 doctor services under Medicare, because we have 9,000 codes by which we pay doctors.

We are getting 468 varieties of services from hospitals, because that is exactly what we are paying for. We are not paying to keep people well, we are not paying to restore health, or function, or productivity at home or at work, or quality of life, or any of those things. We are paying for a bunch of services.

And, of course, that is what we mandate here, too. We continue to mandate more services from particular providers, so we are not doing anything to improve that.

One of the reasons I think Minnesota has been in managed care for so long, and one of the reasons why probably our doctors and hospitals charge less than anybody else in the country is that we have tried, in some of these cases, to move off of the fee-for-service approach and try to use a larger approach to meeting people's needs.

Oftentimes that raises quality questions. I mean, the presumption is, unless you do this service, that service, and the other service, somebody missed something in this process.

I wonder, Bob, if you would not take a minute on the issue of quality. This is one of the problems we always face in this, particularly when we are talking about low-income persons. Perhaps you can tell us a little bit about what Minnesota does to assure quality in the managed care programs.

I have gone, I think, to most, if not all, of Minnesota's managed care projects. I have seen on the front door there are at least three languages for the visiting hours. Inside, I will find as many as 17 interpreters. I am seeing a whole lot of things that I know relate to quality.

Senator MOYNIHAN. Yes.

Senator DURENBERGER. I do not know that we have ever mandated interpreters for those who are culturally sensitive to how the needs ought to be expressed.

But, in Minnesota, we do that sort of thing. Whether it is mandated or not, it is needed. And that, too, is an element of quality. Maybe you can give us some idea of what we do in Minnesota.

Commissioner BAIRD. Senator Durenberger, I think there are about a half a dozen specific things that we try to accomplish to ensure quality.

The first one is in our contracts. We try to ensure compliance, particularly in areas such as immunizations, 24-hour access to care, access to a nurse line for people to be sure that what they want to do is the most appropriate thing to do.

The point that you just made, certainly, sensitivity to cultural differences, the provision of interpretive services, is an example of that.

But, also, what we have tried to do is to train the folks that manage the plans, the people in the doctors' offices and clinics, to help them to become culturally sensitive to the differences in the individuals that they serve.

We require internal quality assurance programs. That must exist in each one of the plans. In addition to that, there is the external review that is done on all of our plans.

We want an adequate service network. That is, that an individual does not have to travel an excessive distance or use an excessive amount of travel time to get to the service.

There is sensitivity to special population needs. For example, we emphasize high-risk pregnancy, including women who become Medicaid-eligible in the third trimester; transition provisions for clients with special needs that have an existing relationship with a provider outside of the system so we do not destroy a pre-existing relationship; and we try to counsel and educate inappropriate users of the system—for example, drug abusers—and we try our best to ensure the solvency of each of the plans that we do business with. And I think those are the highlights of any kind of a quality assurance program.

And we would just like to say that S. 2077 really reinforces those things that we have been trying to do, and we strongly support the inclusion of that language in the bill.

Senator DURENBERGER. All right. Thank you both very much.

Senator MOYNIHAN. We thank you. Ms. Horvath, you have got a microphone. Do you want to use it?

Ms. HORVATH. No. I was just back up.

Senator MOYNIHAN. Nice to have you here. Commissioner Baird, thank you very much for coming all the way from Minnesota. Thank you again, Ms. Pelrine, as always.

In order that all of our remaining witnesses will be heard, I am going to ask that all four witnesses come forward and join each other. You are all the same sort of folk and probably mostly know each other.

Mr. Liu, of the Children's Defense Fund. We know you well, sir. Michele Melden, who is a staff attorney with the National Health Law Program. Ms. Melden has come all the way from Los Angeles, CA.

Julio Bellber, who is director of the William F. Ryan Community Health Center in New York. Bill Ryan is a friend of mine from 40 years ago. Mr. Bellber is here on behalf of the National Association of Community Health Centers.

And, finally, Anthony Watson, who is president of the Health Insurance Plan of Greater New York, to which I belonged 40 years ago—HIP, as it is called. He is here on behalf of the Group Health Association of America.

All right. We will proceed just as the list goes. First, to you, sir, on behalf of the Children's Defense Fund.

STATEMENT OF JOSEPH LIU, SENIOR ASSOCIATE, CHILDREN'S DEFENSE FUND, WASHINGTON, DC, ACCOMPANIED BY SARA ROSENBAUM, SENIOR ATTORNEY, CHILDREN'S DEFENSE FUND

Mr. LIU. Mr. Chairman, the Children's Defense Fund appreciates this opportunity to testify before you today on this exceedingly important topic.

CDF is a national public charity which provides long-range advocacy on behalf of America's children. We pay particular attention to the needs of low-income, minority, and disabled children.

Today, nearly 43 million Americans are medically under-served. Millions of Medicaid beneficiaries face an unending struggle to find decent sources of health care. Public providers, under-funded and overwhelmed, are unable to furnish even basic services.

All to often, hospital emergency rooms have become the family doctor of poor families and children.

Senator MOYNIHAN. We have been hearing this all morning, have we not?

Mr. LIU. Managed care is simply a means of organizing and paying for health care. Where managed care builds on a good, quality health system, the results can be good. But managed care works only as well as the underlying system providing the care.

We support greater State flexibility to develop primary care case management arrangements that link beneficiaries with a medical home, like Kentucky's KenPack model.

Coordinated care arrangements for high-risk pregnant women, coupled with federally-mandated eligibility expansions, have made a tremendous difference in infant mortality in States like Mississippi, Alabama, and South Carolina.

Where there is no risk placed on individual providers, these plans can reduce emergency care use and improve access for poor women.

Managed care can also be a disaster, however. Under-capitalized plans, inadequately paid, and poorly regulated threaten beneficiaries when incentives for under-service are created.

Good providers can be ruined and State initiatives can end up channeling millions of dollars into plans with little or no interest in building good health systems. Managed care, in these instances, can become "cash cows," as the Inspector General recently termed a plan in Philadelphia.

In the case of Medicaid managed care plans, we have to be especially careful. Because we often find 60–70 percent of the enrollees are children, and almost all of the others are young women in their prime childbearing years.

In refashioning the managed care provisions in Medicaid, Congress must build on the right providers, must ensure adequate capitation, protect community health programs, and guarantee beneficiaries stable enrollment.

The danger that we are most afraid of is that Medicaid mills will simply learn that they can incorporate themselves as Medicaid managed care plans and rip off the program by under-serving rather than over-prescribing.

Senator MOYNIHAN. Yes. And we have heard that this morning, too. I have a feeling that this is some coherent experience out there.

Mr. LIU. Absolutely. Current law requires that Medicaid managed care plans attract one commercial enrollee for every three Medicaid or Medicare beneficiaries. Under Medicare, the rules are more stringent: one to one.

This has been a proxy for quality because it forces the plans to attract people who have a choice.

Senator MOYNIHAN. Yes. Sure.

Mr. LIU. And if we are going to relax the safeguard, as S. 2077 proposes, we have to have other protections. At a minimum, we feel that risk-based managed care plans should meet the financial and quality standards established by the federally-qualified HMO program and by Medicare's competitive medical plans.

The FQHMO and Medicare CMP certification programs are well-recognized standards for HMO and managed care plans. And we think we should build on their experience and their structure for Medicaid as well.

As in Medicare, HCFA should review all Medicaid managed care contracts, and, in addition, as Ms. Shikles from GAO mentioned, we should look carefully at subcontracts that plans have with individual providers.

And, as in Medicare, unscrupulous and fraudulent marketing practices, like door-to-door solicitation, should be banned. There is no reason why Medicaid beneficiaries should be exposed to plans and to practices that are not good enough for Medicare.

States also must have greater flexibility to set adequate payment levels. Current law fixes capitation rates at the cost of providing services on a fee-for-service basis.

The current upper payment level should be eliminated in favor of a requirement that all risk plans be paid at an actuarially sound rate, set by the Secretary, that reflects geographic variation, age, sex, disability, and eligibility status.

We are also very concerned about the fate of community public health providers, like federally-qualified health centers' under-managed care arrangements.

They have absolutely no capacity to absorb losses caused by insufficient payments, other than curtailing or terminating services for poor people.

The federally-qualified health centers and public health providers must be guaranteed the right to participate in any plan operating in their service area, or else Medicaid should continue to pay these providers on an out-of-plan basis. Without these protections, we end up draining resources from the uninsured to subsidize Medicaid programs.

In addition, we also believe that Medicaid beneficiaries and managed care plans should have stable enrollment. It is good for plans and it is good for the enrollees.

And we would propose extending the continuous coverage in your bill from 6 months to 12 months to make sure that plans can have a good idea of who is going to be in, and kids will not get "churned," under-served in anticipation of their disenrollment.

We look forward to working with you to develop quality managed care plans in Medicaid by building on Medicare financial safeguards, assuring adequate payment, using community health centers and federally-qualified health centers, and guaranteeing stable enrollment. Thank you very much.

[The prepared statement of Mr. Liu appears in the appendix.]

Senator MOYNIHAN. We thank you very much, sir. If I could just make a general observation. To exaggerate just a little bit, the question before the Congress, for our National polity, you might even say, is not whether we are going to improve Medicaid, but whether we are going to abolish it. I hope that would sink in out there in the world. That is what we are debating on the floor right now.

This morning we read in the Washington Post that the President is rushing to approve today a waiver for welfare programs in Wisconsin in which a welfare mother who has a second child gets paid half. That child is only going to eat just half as much.

Now, if anybody told you 30 years ago that this would be approved, they would not believe it. In an election year, the President decides that that kid gets half. And in New Jersey that kid gets nothing.

I attended a conference at Yale awhile back in trying to watch this time warp. The advocacy groups are in a time warp. I remember a President, 23 years ago who proposed a guaranteed annual income. And those who presumed to speak for the poor said, not enough. We will not take that. Well, would they love to get it today. But hubris.

Ms. Melden, welcome to our cherry blossoms. And this whole hearing may turn out to have been a giant waste of time if the amendment now being debated on the floor is passed. However, that is what time it is. I hope advocates get it clear. If not, it does not matter; it will happen anyway. Good morning, and welcome.

STATEMENT OF MICHELE MELDEN, STAFF ATTORNEY, NATIONAL HEALTH LAW PROGRAM, LOS ANGELES, CA

Ms. MELDEN. Good morning. I want to start out by expressing our appreciation for listening to the client voice this morning on this bill. As you know, I work with the National Health Law Program.

Senator MOYNIHAN. Yes.

Ms. MELDEN. We provide legal assistance to legal services offices serving the poor around the country. And I hope that we are not in a time warp. I think that we all share the goal of improving access for our clients, and doing it in a cost-effective way.

I want to emphasize this morning that managed care, particularly capitated managed care that involves financial incentives——

Senator MOYNIHAN. I am sorry. Particularly?

Ms. MELDEN. Capitated managed care.

Senator MOYNIHAN. Oh. We are back to capitated.

Ms. MELDEN. That is right.

Senator MOYNIHAN. Come on. There is a better way to say that.

Ms. MELDEN. At-risk. At-risk managed care.

Senator MOYNIHAN. Now, you have got to help me on this. I am not quite clear. I thought that was just a way of paying on the basis of the number of people involved.

Ms. MELDEN. Well, what it means is that the plans take a set amount of money per enrollee, which means that they are at risk if the cost of care exceeds the amount of payment taken.

Senator MOYNIHAN. Oh, I see. I see. I have it.

Ms. MELDEN. All right. Good. Well, those financial risks create serious incentives against providing necessary services and the poor are particularly vulnerable to those risks.

In my work at the National Health Law Program, I work with clients around the country who are facing serious problems in getting the kind of care they need in managed care plans, and particularly the ones that are at risk.

A number of studies have also corroborated that these risks do involve sometimes people getting under-served. I think because of that we cannot be too careful in instituting the kinds of safeguards that protect against those risks.

We believe that this bill is moving in the wrong direction by eliminating two safeguards that have been critical for clients. The first is the waiver requirement which States need to get when they want to mandate enrollment in managed care.

The waiver process is a terribly important point for addressing, identifying, and correcting problems up front before implementation begins. It is also an important opportunity for the poor and their advocates to raise client concerns.

I have talked with advocates around the country who felt that they were able to secure some very important safeguards through the waiver process. One good example is the Southwest Brooklyn Managed Care Demonstration Project.

There, a number of issues about having sufficient numbers of providers involved and using existing community resources were raised. And I think that everybody came out feeling that they were able to create a plan that is almost a model for other plans. So, I do not think that we want——

Senator MOYNIHAN. Southwest Brooklyn. Where?

Ms. MELDEN. Southwest Brooklyn Managed Care Demonstration Project.

Senator MOYNIHAN. Where? Give me a neighborhood.

Mr. WATSON. Coney Island, Bay Ridge area.

Senator MOYNIHAN. Coney Island and Bay Ridge.

Mr. WATSON. Right.

Senator MOYNIHAN. Those are two different neighborhoods.

Mr. WATSON. They are two different neighborhoods, but they comprise the demonstration area.

Senator MOYNIHAN. Yes.

Mr. WATSON. The State approved eight plans; only two are participating: HIP and Lutheran Medical Center. The other six have yet to participate.

Senator MOYNIHAN. And Lutheran Medical. Well, we asked a question and got an answer. Thank you. Ms. Melden.

Ms. MELDEN. All right. The other requirement that we think is very important for recipients is the requirement that at least 25 percent non-Medicaid and non-Medicare recipients be enrolled. This is often thought of as a crude proxy for assuring quality, but one of the problems that our clients face is that they move on and off public assistance. And plans that are only enrolling those recipients have a limited incentive to invest in preventive care.

When they are enrolled along mainstream commercial enrollees, the plans are forced to compete to keep those clients satisfied. And, also, those clients have the freedom to vote with their feet and walk out if not satisfied.

And I would go along with the recommendation that the Children's Defense Fund put forward, which was to extend continuous enrollment for our clients so that we establish a stable base and the incentives to invest in preventive care are there.

I also want to point out that the other kind of managed care plan which is not at-risk and not capitated is the primary care case management model which pays fee-for-service. What it does is it uses a gatekeeper to control utilization.

There are a number of very good examples of those plans delivering access to the kind of care that our clients need. People talked about Alabama; South Carolina is another good example; so is Kentucky. Those plans have actually brought down infant mortality rates without the risks that are involved with capitation.

In fact, a recent Research Triangle Institute report on managed care found that the PCCM's were able to save money and offer better access in a number of at-risk managed care plans.

Senator MOYNIHAN. Yes.

Ms. MELDEN. Finally, this legislation puts forth some improvements in quality assurance. But I would like to say that these do not go far enough.

At this time, HCFA, along with the National Academy of State Health Policy, have funding to develop improved quality standards. I would suggest waiting for their studies to come out and evaluating their recommendations before eliminating critical protections that exist now.

Also, a recommendation that we would like to make is to require States to take a more aggressive role in monitoring quality of care. A number of GAO studies have pointed out that States sometimes have been lax in their duties to do this.

We suggest that one improvement would be to give enforcement authority to State regulatory agencies that are already regulating commercial HMO's. They have far more experience than State Medicaid agencies. And this would have the added benefit of giving the same quality controls available to the middle class population to the Medicaid population, even if they are not enrolled in commercial HMO's.

I want to thank you for inviting us this morning. I will be happy to work with you in the future on developing quality assurances. Thank you.

Senator MOYNIHAN. Of course. Thank you for coming. We will have questions for this morning.

[The prepared statement of Ms. Melden appears in the appendix.]

Senator MOYNIHAN. Now, sir. If I am not mistaken—I do not know this, but my sense is that HIP is probably the original HMO, is it not?

Mr. WATSON. We are the second oldest.

Senator MOYNIHAN. Second oldest. And, sir, you have a colleague with you, if you could just introduce him to the committee.

Mr. WATSON. Jim Doherty, who is President of the Group Health Association of America.

Senator MOYNIHAN. Good morning, sir. We welcome you to the committee. Since we are going along like this, if you could now proceed, sir.

STATEMENT OF ANTHONY L. WATSON, PRESIDENT, HEALTH INSURANCE PLAN OF GREATER NEW YORK, NEW YORK, NY, ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA

Mr. WATSON. Thank you. I have been sitting here this morning listening to two different sets of witnesses: those from regulatory agencies from the States telling you that HMO's are part of the mainstream of health care in America, and the others which I would characterize as representing doom and gloom. You have got to watch out for those HMO's. They ration health care; capitated programs are bad.

For 40 years, we have had managed care programs that deliver as fine a health care product as any the world delivers. It is not rationed, the capitation payment makes no difference.

What matters is the integrity of the program. The regulatory agencies know which ones are good and which ones are bad. To keep the stereotype going, however, does a disservice to the health care system in America.

Senator MOYNIHAN. I am going to take the liberty of interrupting you to just make a personal statement in support of that. I remember when I was signed up with the HIP. It would be 40 years ago.

And I had finished my wander jahre, as the Germans used to say. I had been in Europe on the GI bill and all that. I come back, and life is going to get serious now. I have got a job. And it was with the International Rescue Committee.

It was obviously a progressive sort of group. And we were part of HIP. And I can remember that there was just a plain prejudice against HIP. It cannot be very good because maybe it is socialist or something.

Mr. WATSON. Communism was a better word they used.

Senator MOYNIHAN. They used that. Yes. Yes. The best doctors in the world were in Manhattan. So, I just want to say I have been where you are describing.

Mr. WATSON. Mr. Chairman, we serve 1.1 million people of all socio-economic backgrounds. And I speak for our association, and for most of its members. HIP in New York State serves approximately 45 percent of all the Medicaid enrolled in managed care. They are enrolled in my program. We have concerns. We think that a plan should have to have a mix of Medicaid patients in with its regular patients.

A Medicaid patient in HIP is indistinguishable from any other patient. We try to face reality. We take a Medicaid patient and change their cultural health patterns.

We would be happy to provide this committee with medical data that shows that a non-managed care Medicaid patient is admitted to hospital nearly twice as often as our Medicaid members. We will provide you with that and additional data.

Senator MOYNIHAN. We would like that.

Mr. WATSON. We will provide you with data that shows you that our pregnant Medicaid patients and babies are the same weight and have the same health status as our regular members, be they employees of Citibank, or Chemical Bank, or New York City employees.

To state that we ration care or that because we put our medical groups at-risk financially for some kind of financial incentive is a broad-brush stereotype that has to stop in this country. Again, I reiterate. You should look at programs individually. There are dishonest people not only in health care, but also in banking, and every other area.

Group Health Association of America strongly supports your bill because it brings managed care into the mainstream and will provide for the Medicaid population superior health care. That can be proven unquestionably. Thank you.

Senator MOYNIHAN. Thank you, sir.

[The prepared statement of Mr. Watson appears in the appendix.]

Senator MOYNIHAN. Mr. Doherty, would you like to make any statement?

STATEMENT OF JAMES DOHERTY, PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Mr. DOHERTY. Only on behalf of the association that I have been around for 20 of those 40 years that Tony talks about.

We are the only organization in the country that has recognized that when you have pre-payment and capitation, there is an inherent logic in the proposition that they will under-treat.

The studies show otherwise. The AMA commissioned a study that started out as hostile 7 or 8 years ago, and it resulted in a statement that our care was as good as, if not better, because of its organized aspects.

But, nonetheless, recognizing that that inherent logic is not going to go away, we are the only organization in the country that instituted, with a grant from the Robert Wood Johnson Foundation and a match from our own plans an independent, non-dominated by any organization, quality assurance agency, NCQA, that now contracts with three or four States in order to oversee managed care. NCQA contracts with the automobile industry; the Xerox Corp.; General Electric, and other major purchasers of care including the Medicaid agency in Pennsylvania, to oversee quality care. We have no control over that agency. The only thing we have asked is that peers do the reviewing.

But we felt a little bit that we were protesting our innocence too much simply because we think that people like Ms. Melden and others are not looking at the inherent unregulation of the fee-for-service out-patient sector.

And the idea is that the option to even bad managed care, if they are getting the care, if there is some monetary rip-off—is better than no care under fee-for-service. And that is a better option than the emergency room of a hospital. That is what I wanted to say; my two cents.

Senator MOYNIHAN. Thank you, Mr. Doherty. But I have a question I have to ask you. If managed care is so effective, why have you not cured Tony Watson's cold? [Laughter.]

Mr. DOHERTY. I do not know. And I would also like to know why he gives me his cold. [Laughter.]

Senator MOYNIHAN. There will be another hearing on this matter, I will assure you. All right. We will go on now to our final witness. You are very welcome, indeed. All these New Yorkers are suddenly showing up.

Julio Bellber, who is executive director of the William F. Ryan Community Health Center, and he is here on behalf of the National Association of Community Health Centers. We welcome you, sir.

For those who are not my age, Bill Ryan was a Democratic Congressman on the West Side of New York. I would like to think I could called him friend. Sir.

STATEMENT OF JULIO BELLBER, EXECUTIVE DIRECTOR, WILLIAM F. RYAN COMMUNITY HEALTH CENTER, NEW YORK, NY, ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Mr. BELLBER. Thank you, Mr. Chairman. My name is Julio Bellber. I am the executive director of the William F. Ryan Community Health Center, a federally-funded community health center located in New York City.

I would like to thank Senator Riegle for calling this hearing and I appreciate the opportunity to speak with you today on behalf of the National Association of Community Health Centers regarding the issue of Medicaid managed care.

This association represents the Nation's more than 600 federally-supported community and migrant homeless health care centers and their 6.4 million low-income medically under-served patients; two-fifths of whom are Medicaid recipients.

As health care providers, which, for more than 25 years have furnished comprehensive primary health care almost exclusively to Medicaid patients and low-income persons, NACHC believes that community and migrant health center directors like myself can offer insight into the complexities and challenges involved in attempting to revamp the provision of Federal law regarding Medicaid managed care.

As the director of one of the Nation's largest community health centers which has actively participated in Medicaid managed care programs for more than 4 years, I am particularly pleased to be able to testify before you today.

Health centers remain a constant source of comprehensive primary health care for low-income patients, regardless of whether they are covered by Medicaid.

For this reason, Congress amended the Medicaid statute to assure health centers of adequate Medicaid support for their services furnished to beneficiaries, known as Federally Qualified Health Care program.

In this way, the public health service grant funds which constitute less than one-half of the funds health centers need to operate, can be conserved for the uninsured patients.

Health centers have a dual health care mission to treat all Medicaid and Medicare patients and to treat persons regardless of their health insurance status and in accordance with their ability to pay for care.

This feature is crucial, because it means that when Medicaid patients lose their Medicaid coverage, as they do so frequently, they can remain enrolled at the health center.

It is their ability to offer continuous care that makes community and migrant health centers a unique and so valuable, especially in the context of managed care.

In recent years, a number of Medicaid patients served by health centers have increased significantly because of both recent Medicaid expansions and the decline in the proportion of private physicians who participate in the program, particularly in the case of maternal, infant, and child health.

No Medicaid legislation that Congress considers this year will have a greater impact on beneficiaries' access to health care than a revision in the program's managed care provision.

If well-constructed, managed care legislation may improve program performance. If not, the amendment could further reduce sources of quality health care for the poor.

A major task of this committee in developing managed care legislation is to reconcile the mission and structure of health centers with managed care reform.

The goal of Medicaid managed care reforms is to promote development of health care delivery arrangements that collectively have come to be known as managed care: organizations that enroll patients on a formal membership basis, that act as gatekeepers and as deterrents against unnecessary and inappropriate use of care, and that frequently—but not by all means always—are paid on a partial or full-risk, per capita basis.

We are confident that these two goals promoting and stabilizing health centers and encouraging managed care are highly compatible.

The health centers' experience with the Medicaid managed care program also points to real dangers that must be avoided if centers are to survive and flourish as sources of care for their entire community and if the twin objectives in managed care of patient access and cost containment are to be achieved in a sound fashion.

We are pleased that Senator Moynihan and his staff have expressed a commitment to assuring that managed care reforms do not inadvertently limit the capacity of health centers or harm patients by creating incentives to under-serve them.

In revising the managed care provision of the statute, we believe that it is essential that the legislation do the following: One, to assure that all Medicaid managed care programs are of good quality; by eliminating the current upper payment limits for providers of Medicaid managed care to assure that payment rates are actuarially sound; by establishing Federal solvency and stop-loss standards, as well as Federal standards for managed care contracts that must be met prior to implementation of State managed care initiatives.

These are particularly important safeguards if the committee is to eliminate the current 75/25 rule and the current waiver system for implementing restricted Medicaid freedom of choice programs.

Two, to assure that patients have continuous access to their providers by guaranteeing annual periods of Medicaid eligibility for beneficiaries enrolled in managed care plans; to not place health care providers, such as health centers and other providers furnishing key community health services for the poor and the underserved, in a position in which the only means of offsetting losses caused by low Medicaid reimbursement and high patient care needs are grants to serve the poor, including the very grant funds which Congress has given health centers to serve the uninsured; by continuing current statutory protections for federally-qualified health centers that assure their rights to participate in Medicaid and to engage in managed care arrangements that do not place their Federal grants for the uninsured at financial risk; by incorporating special protections for health center services and community and public health services, such as homeless and migrant programs, school-based clinics, immunization programs, to assure their continued Medicaid coverage for patients enrolled in managed care; by increasing the Federal match services furnished by health centers to the Medicaid beneficiary.

Senator MOYNIHAN. Mr. Bellber, I am going to have to ask you to wrap up. Otherwise, we run up against the Senate rules.

Mr. BELLBER. Mr. Chairman, the last one is, by including legislation; a special three to five State demonstration to permit community-based health programs, such as health centers, local aid agencies, public hospitals that manage care for the under-served and their communities.

And I will answer any questions.

[The prepared statement of Mr. Bellber appears in the appendix.]

Senator MOYNIHAN. Thank you very much. Everyone's testimony will be placed in the record as if read. You may be sure of that.

I do not know that I have any particular questions here. I do think it is important to note that while we are having this hearing about how to improve our arrangements and provisions, the United States Senate is debating the abolition of the whole thing.

I mean, the first such debate I think we had. We are not talking about increasing these programs, we are talking about eliminating them. And we have got people still living in a time warp. What time is it?

I would like to ask Mr. Watson and Mr. Doherty, in particular, but I will hear from anybody. You, sir, mentioned the homeless. There is no more visible symbol of social inadequacy, I think, in our big cities than the homeless population.

And, yet, I cannot help thinking, we still have not got it clear what is going on. At the last public bill signing ceremony that President Kennedy had on October 28, 1963, he signed the Community Mental Health Center Construction Act of 1963. And he gave me a pen. The pen is still here.

And we were going to have a community mental health center for every 100,000 people in the country, and we were going to empty out our mental institutions and they were all going to be treated locally.

And we were going to have 2,000 of these by the year 1980. And we emptied out our mental institutions, but we did not build the community mental health centers. We got to about 450 and stopped.

And the next thing you know, you find the schizophrenics of the population sleeping in door ways. And we are wondering, why are they sleeping in door ways? Because they are not where they were and we have not provided where they are supposed to be.

Does this come into the HMO's, do you run into this? Does HIP run into this?

Mr. WATSON. Well, certainly as a major provider of health care and as a citizen of New York, both HIP and I are concerned with that. We do not have a responsibility directly for the homeless because they come under many categories. Another myth in current acceptance is that most of them are mental health patients discharged from State hospitals. I think in the early 1970's that was true, but not today.

If you look at the homeless, the people in the shelters today, they are probably people who are unemployed with one kind of criminal conviction or another and who cannot get jobs; the result of an economy that is certainly not improving, not in the kind of areas where they are located. It is just not simply a matter of the mentally ill.

While I think that the release of the mentally ill was not well-thought. The theory was that these patients were going to go to out-patient centers to get their medication. Unfortunately, they just do not show up to get their medication. But that certainly is not the majority of the problem. It is a societal problem.

And, certainly, we try to do our part. We go into those kinds of shelters and we give immunizations and do health screen checks. But it is not a solution to the problem. And I do not want to sit here and pretend that we are providing them with total health care; we are not.

Senator MOYNIHAN. Mr. Liu, you had your hand raised.

Mr. LIU. Thank you. The parallel that you raised in the health care setting that you raised with the homeless is cost-shifting. What we have now is that when we do not have a primary health care system, we shift people into hospitals, into high-cost places. And the costs end up getting picked up by insured people; by you and I.

And if the entitlement cap that is before the Senate passes, we are going to undermine Medicaid and Medicare and we are going to dump these costs onto insured Americans. And we are going to undermine our entire health care system. It is not just going to poor people.

Senator MOYNIHAN. Well, I do not disagree, but I am not sure we have the votes. And, with that, since time is running, I have to turn to my colleague, Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you. I thank all of the witnesses for their comments, all of which show that people have looked very carefully, not only at this bill, but have spent a lot of time analyzing the issue of low-income access and coordinated care.

I need to ask the practitioners a couple of questions that at least relate in part to some of the quality of criticisms that have been made.

As I understand the way we have drafted this, the State plan option part of this bill retains the existing Federal requirements for risk-based managed care plans.

It allows the States to operate managed care programs without having to seek waivers, like the Medicaid Statewide waivers or the comparability standards, in effect, allowing States to make managed care to norm under the State plan.

Could you give all of us some reassurance? One of the witnesses before you testified and raised some concerns about the need to maintain the waiver process.

Can you give us some assurance that that will encourage more appropriate care and better quality care than sticking completely with the current waiver system?

Mr. DOHERTY. The problem with waivers is more mechanical than anything else. It just does not fit in an HMO-defined population. If these people are going to be ducking in and out of eligibility all of the time, then HMO's cannot do their budgets. You cannot do your medical budgets, or your financial budgets.

So, to get rid of the waiver process, as well as the 75/25 for other reasons, are essential to HMO's being able to operate as HMO's within Medicaid.

We have always felt that there should be strong external review mechanisms. The Federal office of HMO's, or the Medicaid portion over in HCFA, has become very much aware of the notion that you have to have good external quality review systems. And I think they are to be congratulated, Christina Nye and her office, for the work that they are doing in breathing down our necks and our plan's necks.

Senator MOYNIHAN. And you find that works?

Mr. DOHERTY. Yes. There is no way you are going to guarantee absolute high-quality care no matter how much review you have. I mean, you are dealing with a human factor here in terms of physicians treating patients.

And, also, as Dr. Elwood, from your State, and others, have indicated, we do not have a scientific exact way of measuring quality.

Senator MOYNIHAN. That is what I meant.

Mr. DOHERTY. Yes.

Senator MOYNIHAN. But you find that people of reasonable good will can agree with the findings.

Mr. DOHERTY. Right. And this bill provides that the States have to take a look at the number of grievances that have been filed against the HMO's, whether by the enrollees or whether by organized outsiders, or whomever. So, the State has to look at those and see how they are disposed of, or if they are being taken care of.

Mr. WATSON. Let me give you a classic example. We have full-time people stationed in income maintenance centers so that when a person comes in to apply for welfare and they are given Medicaid, we are there on the spot to sign them up. We offer them inducements to come to have their physical exam, their entry examination to determine what is wrong with them.

The majority of the people that we enroll are mothers, single mothers with children. And we offer them a whole range of baby products including cribs, electric blankets so we can determine what is wrong with that family and institute prenatal and preventive care.

If there is any kind of financial inducement in this practice it is to identify what is wrong so we can treat it and to stop the problem from becoming an expensive one. We will submit an evaluation of this program for the record.

Senator DURENBERGER. Julio.

Mr. BELLBER. I just wanted to say that community health centers, for the last 25 years, under different payment mechanisms, have been providing primary care and have basically been contributing to reducing on the back end, I guess, the same as HMO's, the expensive cost of in-patient care.

So, I think capitational pre-payment is a mechanism. But I think what we are talking about here is a system of health delivery that I think assures some primary care and some preventative services that has an impact on the ultimate in-patient cost, which is the very expensive cost.

You are going to have to pay for it one way or another, in a capitative form or in a fee-for-service form. You start to provide the services if you want to have the savings.

Senator DURENBERGER. Well, I appreciate that. We worked very hard to try to deal with this particular issue. One of the statements of one of the witnesses, or one of the criticisms is that we rely on internal review mechanisms. And, as one of the authors—I will only speak for myself—I am proud of that fact.

I think if we do not internalize quality care, you are not going to get quality care, no matter how many people are on the outside telling you you have to do it.

So, one of the things that both of you have indicated—and Bob Baird, in a rather extensive elaboration of what Minnesota does and what plans are required to do in Minnesota—is that the whole point of this really is to internalize a commitment to the patient.

Senator MOYNIHAN. And that does not bother you one bit.

Senator DURENBERGER. But, in fact, we have, as one of you have pointed out, we have specifically provided for external, independent review of each of the health plans' quality assurance activities.

And we provide, as I understand it, that that be conducted by a peer review organization or some other organization that is external to the plan and to the Medicaid process which has been approved for the work that they do by the Secretary of HHS.

Mr. DOHERTY. External review to make sure the internal review is working.

Senator DURENBERGER. Yes. Exactly. That is the point of it. Is there anything to criticize on that that you can think of?

Mr. WATSON. Why don't I provide to the committee HIP's quality assurance program and how we go out and make sure that it is being met?

Senator MOYNIHAN. Good.

Senator MOYNIHAN. On that note, the hour of noon having been reached, I would like to say that Senator Riegle has asked me to extend his regrets that he is not here. He is on the floor in the debate to try to abolish all of these things.

He has asked that he submit a statement for the record, and the record will be maintained open, if we can, for that purpose.

We want to thank you all. But I really want to end up with a stern imprecation, which is that, Mr. Doherty, you are to see that the Health Insurance Plan in New York sees that Watson gets some cough drops, else he will never make it to the bill signing ceremony. [Laughter.]

Mr. DOHERTY. I do not think we cover those.

Senator MOYNIHAN. Thank you all very much.

[Whereupon, the hearing was adjourned at 12:00 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF ROBERT BAIRD

INTRODUCTION

Mr. Chairman, members of the Subcommittee, I am Robert Baird, Deputy Assistant Commissioner for Health Administration for the Minnesota Department of Human Services. I am also the chairman of the Operations Committee of the State Medicaid Directors' Association of the American Public Welfare Association. The Operations Committee is responsible for Medicaid issues related to information systems, third party liability and, most relevant today, Medicaid managed care. I have chaired this SMDA committee for six years and have worked in the Medicaid program since 1967 in various capacities.

I appreciate the opportunity to speak today about the "Medicaid Managed Care Improvement Act of 1991" (S. 2077) sponsored by Senators Moynihan and Durenberger. I will highlight why managed care is so important to state Medicaid agencies and what this bill would do to facilitate development of all forms of managed care.

Minnesota has a long history of managed care in both the public and private sectors. The Minnesota Medicaid Program has been involved in managed care for over 20 years. Today we have approximately 20 percent of our Medicaid clients involved in a variety of managed care programs.

WHY S. 2077 IS IMPORTANT TO STATES

Currently 31 states operate Medicaid managed care programs and 2.7 million Medicaid clients are enrolled in these programs. Medicaid managed care encompasses a variety of program types. For purposes of this discussion, I think it is useful to refer broadly to Medicaid coordinated, or managed, care as encompassing a wide spectrum of care management, from traditional capitated systems such as health maintenance organizations and primary care case management programs that are typically medically-oriented fee for service programs in which a primary care physician is the care manager, to case management which is also fee for service but with a non-medical professional coordinating a broad array of social and health services for individual clients. S. 2077 would address and improve all of these types of Medicaid coordinated care.

As you are probably aware, states have looked to a variety of methods by which to contain Medicaid program costs in the last decade. What has become clear is that one truly effective method of stemming program expenditure growth is the delivery of effective primary and preventive care, especially with respect to the younger populations covered by the Medicaid program. While this sounds very simple, the reality is that achieving early, effective primary and preventive care for Medicaid-eligible women and children is not a simple process. Eligibility rules are such that clients are not continuously eligible and interruptions in care occur. Providers often do not want to participate in Medicaid. A traditional fee for service system is not conducive to educating clients on the benefit of preventive care and appropriate use of services.

States believe that coordinated care programs hold much promise in promoting preventive and primary care for Medicaid clients. Coordinated care programs are based on assuring client access to preventive care. Coordinated care providers have incentives to follow through with clients to ensure that proper care is received. Coordinated care programs can also facilitate the involvement of providers who may otherwise not consider participating in the program.

In general, I believe most states look to coordinated care for five specific reasons. The first is the potential for greater access to care and improved continuity of client care, leading to healthier clients. Second, coordinated care programs can facilitate more appropriate utilization of services. Third, coordinated primary care programs are able to improve the quality of care delivered. Fourth, coordinated care programs improve client and provider satisfaction. Finally, coordinated care can help contain costs in the short and long term by producing better client health outcomes resulting from improved access to, and continuity of, care. Capitated managed care programs also allow states to better anticipate cost increases. This is a crucial issue for states now; they need to be able to plan for expenditures so they do not face unanticipated year-end cost overruns that require immediate program cuts in order to balance the state budget. The ability to plan is vital to protecting the overall state Medicaid program. Because this legislation would facilitate state development of Medicaid coordinated care, states are anxious to see it enacted.

EFFECT OF THE LEGISLATION

In general, S. 2077 would allow states to develop risk-based and non-risk managed care systems without any of the multitude of waivers now required under federal law.

The bill would eliminate the current managed care requirement that at least 25% of an HMO's enrollment must be private pay patients. This has been a very troublesome requirement for many state programs because the geographic area of a plan's operation often does not have a sufficient private pay base to meet this rule. This problem occurs in both rural and urban areas, where the poor may be geographically isolated from others who would have private pay group health options. In addition, some states including Minnesota have established government-run health maintenance organizations specifically designed to care only for Medicaid clients. These programs were not developed for the private market. While the rule was originally intended as a proxy measure of quality, state Medicaid agencies believe this current enrollment requirement does not assure either financial solvency or quality care. Many other factors assure financial viability and quality. Since the 75/25 rule is in fact an impediment in many cases, state agencies believe that this requirement should be eliminated in favor of specific federal quality assurance activities, as offered by S. 2077.

In terms of quality assurance, the Moynihan/Durenberger legislation would establish in federal law specific quality assurance obligations for managed care plans, the states, and non-state quality assurance reviewers. This is much more specific than what currently exists in federal statute. The requirements are based on current best practice among state Medicaid programs and would require specific internal and external quality assurance mechanisms and reviews.

The legislation would also allow changes or enhancements in eligibility rules that states believe will act as incentives for both clients and providers to participate in Medicaid managed care. It would allow guaranteed eligibility for up to six months for clients enrolled in an HMO. This means the HMO can be assured that a client will not be made ineligible and dropped from the rolls in that period of time. This overcomes a significant HMO provider complaint that Medicaid eligibility creates an administrative burden for managed care plans and does not parallel private pay enrollment. Secondly, the bill would permit "rolling eligibility" for clients enrolled with an HMO or fee for service primary care case management provider. This option allows the state to continue a client on Medicaid if the client would otherwise lose coverage due to excess income or resources, if the state expects the client would again become eligible in the following month. Both these provisions address the on-again, off-again nature of Medicaid eligibility that is associated with AFDC and SSI eligible clients by providing more continuous coverage throughout a year. Both these provisions could provide incentives for clients to choose to enroll in coordinated care programs because of the clear benefits of more continuous coverage.

The legislation would allow mandatory enrollment without a waiver only under certain conditions that allow clients a degree of choice among plans or providers. State agencies are concerned, however, that the conditions under which S. 2077 permits mandatory enrollment when there is only one HMO or a primary care case management system in a geographic area are too restrictive. State agencies have suggestions for slightly broader language that will retain the spirit of the basic provision. In general, though, mandatory enrollment is important to promote client enrollment in a system of care from which they can benefit. Such enrollment can reduce the need for HMOs to market their services to the population, thus reducing HMO costs and the potential for inappropriate marketing behavior by managed care plans. It is also important to note that the legislation, while permitting mandatory enrollment, does not permit clients to be locked in to a particular plan without a waiver. Clients would be permitted to leave a particular plan or a particular provider whenever they choose. Many people confuse mandatory enrollment and "lock-in," and mistakenly believe these are the same thing. Many states believe that lock-in is important so that a client does not frequently shift between managed care plans or drop out the program before a plan has an opportunity to provide effective preventive care. Lock-in is common in the private sector where an individual is required to stay with a plan for up to one year before they can change plans or coverage. States now obtain waiver authority to restrict disenrollment for periods of six months but permit disenrollment during that period for cause. Many states would prefer to see lock-in provisions incorporated into S. 2077 while allowing client disenrollment for cause.

RESPONSES TO CONCERNS RAISED ABOUT S. 2077

I would like to highlight some of the concerns about this legislation that have been raised and to address them from the state Medicaid agency perspective.

Some have said that the quality assurance in the bill does not go far enough. I would point out that S. 2077 goes much further than current statute in this area. The bill incorporates current best practice but leaves some measure of flexibility for the evolution of best practice. Statutory flexibility in quality assurance will be absolutely essential to improvement. If statute specifies and then freezes such things as specific outcome measures and specific quality measures for example, there will be no easy way for Medicaid to keep pace with improving standards without dew federal legislation. We believe much of the specifics of quality assurance should be left to federal regulation and HCFA manual instructions that can change more rapidly to keep pace with improving best practice.

For those who believe that this legislation adds nothing new to Medicaid managed care quality assurance, I would point out a recent draft report by the HHS Inspector General on Medicaid HMO quality assurance (Report #OEI–05–92–00110, presented on 3/26/92 before the House Subcommittee on Oversight and Investigations). The report examines 13 quality assurance standards, many of which would be required under S. 2077, and finds that not all states explicitly require all these key standards. Under S. 2077, almost all those standards would have to explicitly addressed. Clearly, then, this legislation represents forward movement and improvement.

I am also aware of concerns raised by advocacy groups that Medicaid managed care may pose a threat to funding of public health activities. This is a complicated issue that I do not propose to thoroughly address here. I would only say that states do take a comprehensive view of health care delivery and financing systems. States will balance the needs of public health entities and the needs of Medicaid clients for coordinated service delivery and the potential to provide a mainstream source of care and services. States will also evaluate the need to create efficiency in the health care delivery system overall and find the best method, or methods, by which to do that. The outcome of this evaluation and the solutions to the questions posed will be different in each state; indeed the answers and solutions may be different in different regions within a state. States have an ongoing concern about access to services for the uninsured. They will seek to enhance public health related services when appropriate as they implement managed care for Medicaid clients. Further, it should be remembered that not every Medicaid client will be enrolled in managed care for a host of reasons. States will need to address sources of care for those Medicaid clients remaining in the fee for service sector. Again, states will need to find the best way to address this issue within state-specific parameters, all of which cannot be accounted for in federal legislation. I would urge that Congress resist any effort to impose one federal solution on an issue that is diverse and multifaceted.

There has been concern raised about the fact that the bill does not address HMO marketing in any way and marketing has been a problem in a few states. State agencies would support language in the bill that requires state review and approval of HMO marketing practices and strategies. We also understand that the Medicaid Bureau is considering strengthening state guidance in this area. Several states addressed the problem of marketing practices by changing incentives for plans or eliminating direct marketing by plans.

With regard to payment rates, we believe this legislation takes a balanced approach that allows states the latitude necessary to establish equitable rates. The bill intends that states could adjust their fee for service expenditure base to account for minimal access under a fee for service system by adjusting the base to anticipate improved access and increased utilization that would be expected of a managed care operation. In this way, the approach contained in S. 2077 is fiscally responsible but flexible enough to allow adequate rate setting. This approach builds on the current work of the Health Care Financing Administration.

SUMMARY

State agencies believe the time has come to recognize that managed care is no longer unique or unusual—it is becoming a mainstream service delivery system across this country and should no longer be subject to waiver applications and renewals.

States have the experience to make managed care work and work well for the benefit of Medicaid clients. I would urge critics not to cling to some of the more significant past failures and shortcomings of managed care as the reason not to move forward today. The industry has matured since the 1970s, and the states and HCFA have become more effective in administering and overseeing managed care operations.

States are committed to making managed care work for Medicaid clients. The State Medicaid Directors' Association together with the Medicaid Bureau, established a managed care technical advisory group in 1990 to improve and refine manual instructions and address quality of care issues. Further, we believe that a bill such as S. 2077 can establish federal standards that can be a basis for further health reform at both the state and federal levels. While we believe S. 2077 is very distinct from efforts aimed at broad health care reform, many of the proposals at the state and federal levels stress development of managed care and the improvements in S. 2077 could complement the managed care components of these efforts.

While states are committed to making managed care work to improve the access to, and quality of, care for Medicaid clients, most states recognize it is not a panacea for all the problems in Medicaid nor all the problems of the health care system. These larger problems will be left to the larger debate on health care financing reform. However, managed care can be an important tool to build a better program and can help address some of the critical issues of health care delivery that affect Medicaid clients. I would hope that critics of coordinated care will weigh the more traditional concerns against the possibility of improved access to care. States need the flexibility found in the "Medicaid Managed Care Improvement Act of 1991" to better address the needs of those the program was intended to serve, the clients.

State Medicaid agencies and APWA remain ready to work with members of this Subcommittee to assist in moving this legislation forward this year.

Thank you.

PREPARED STATEMENT OF JULIO BELLBER

Mr. Chairman and Members of this Subcommittee: My name is Julio Bellber. I am Executive Director of the William F. Ryan Community Health Center, a federally-funded community health center located in New York City. I would like to thank Senator Riegle for calling this hearing and I appreciate the opportunity to speak with you today, on behalf of the National Association of Community Health Centers (NACHC), regarding the issue of Medicaid managed care. NACHC represents the nation's more than 600 federally-supported community, migrant and homeless health care centers and their 6.4 million low-income, medically underserved patients, two-fifths of whom are Medicaid recipients. As health care providers which, for more than 25 years, have furnished comprehensive primary health care almost exclusively to Medicaid patients and other low income persons, NACHC believes that community and migrant health center directors like myself can offer insights into the complexities and challenges involved in attempting to revamp the provisions of federal law relating to Medicaid managed care. As the director of one of the nation's largest community health centers, which has actively participated in Medicaid managed care programs for more than 4 years, I am particularly pleased to be able to testify before you today.

In recent years, the number of Medicaid patients served by health. centers has increased significantly, because of both recent Medicaid expansions and the declining proportion of private physicians who participate in the program (particularly in the case of maternal and child health). No Medicaid legislation Congress considers this year will have a greater impact on beneficiaries' access to health care than revisions in the program's managed care provisions. If well constructed, managed care legislation may improve program performance. If not, the amendments could further reduce sources of quality health care for the poor.

A major task of this Committee in developing managed care legislation is to reconcile the mission and structure of health centers with managed care reform. The goal of Medicaid managed care reforms is to promote the development of health care delivery arrangements that collectively have come to be known as managed care: organizations that enroll patients on a formal membership basis, that act as gatekeepers and as deterrents against unnecessary and inappropriate use of care, and that frequently (but by no means always) are paid on a partial or full-risk capitation basis. We are confident that these two goals—promoting and stabilizing health centers and encouraging managed care—are highly compatible.

But health centers' experiences with Medicaid managed care programs also point to real dangers that must be avoided if centers are to survive and flourish as sources of care for their entire community, and if the twin objectives in managed care of patient access and cost containment are to be achieved in a sound fashion. We are pleased that Senator Moynihan and his staff have expressed their commitment to assuring that managed care reforms do not inadvertently limit the capacity of health centers or harm patients by creating incentives to underserve them.

In the most real sense, health centers have spent more than a quarter century providing managed care to Medicaid beneficiaries. A complicated web of medical and health problems envelops many poor persons. But the level of funds to support the health center programs is extremely low. Federal community and migrant health center grants cover less than half of all health center costs and are sufficient to fund centers at an annual operating level of only about $200 per patient. This is far below the annual per capita expenditure level on personal health care in the U.S. As a result, centers have had to learn to be particularly adept at doing the very things that those who advocate for managed care point to as essential to a successful program.

By law, health centers are located exclusively in medically underserved areas. Thus, centers have first and foremost made their services particularly accessible to poor community residents. Modest budgets and extraordinary patient demand (the 600 federally funded health centers, represent only 15 percent of the number needed to reach all 43 million medically underserved urban and rural Americans) have compelled health centers to emphasize the provision of primary and preventive health services in the lowest possible cost health care settings.

Health centers predominantly operate as staff-model primary care health clinics. The terrible shortage of physicians that plagues medically underserved urban and rural communities, the low salaries health centers are able to pay, and the proven effectiveness of the non-physician health personnel employed by health centers in reaching underserved populations, means that center staffing costs are relatively low. The great difficulties encountered by center patients in gaining access to specialized ambulatory and inpatient health care has made careful, continuous primary medical management an imperative. Translators and bilingual staff, integrated health and social service programs, and other patient and community supports have further strengthened centers' ability to deal with patients' complex needs in a low cost, highly integrated manner. And because health centers actively involve patients in both program and policy development as well as day-to-day operations, they have been able to adapt to changing patient needs.

Finally, and perhaps most importantly in this context, health centers have a dual health care mission: to treat all Medicaid and Medicare patients, and to treat all persons regardless of their health insurance status and in accordance with their ability to pay for care. This feature is crucial, because it means that when Medicaid patients lose their Medicaid coverage (as they do so frequently), they can remain enrolled at health centers. It is their ability to offer continuous care that makes community and migrant health centers so unique and so valuable, especially in the context of managed care.

In expanding access to primary health care, health centers have had an enormous impact on the health of the communities they serve. Reductions of as much as 40 percent in infant mortality rates have been achieved. Immunization rates have improved significantly. And the incidence of dangerous complications of routine health problems (such as rheumatic fever following untreated streptococcal infections in children) has decreased dramatically. At the same time health centers have demonstrated their ability to achieve major reductions in the use of inpatient services by Medicaid beneficiaries and have lowered Medicaid per-patient spending significantly. Health centers' effectiveness has led to recommendations for their expansion by both the President and by Republican and Democratic Members of Congress.

For several years this Committee has paid growing attention to the achievements of health centers and the barriers that confront them as they attempt to carry out their dual mission of serving both Medicaid and uninsured patients. Recognizing the need to assure adequate levels of Medicare and Medicaid payment so that the modest grants health centers receive for uninsured patients can be conserved, Congress has amended both statutes to guarantee full Medicare and Medicaid coverage of health center services and to assure reasonable levels of payment under both programs. This program is now known as the Federally Qualified Health Centers program. These Medicaid protections apply both in states that operate managed care systems as well as in those whose Medicaid plans build on more traditional service and payment arrangements. On behalf of our patients, we are deeply grateful for these protections and for this Committee's leadership, particularly that of Senator John Chafee.

In revising the managed care provisions of the statute, we believe it is essential that the legislation do the following:

- Assure that all Medicaid managed care programs are of good quality;
- Assure that patients have continuous access to their providers; and
- Not place health care providers such as health centers and other providers furnishing key community health services for the poor and uninsured in a position in which the only means for offsetting losses caused by low Medicaid reimbursement and high patient care need are grants to serve the poor, *including the very grant funds which Congress has given health centers to serve the uninsured.*

A. QUALITY CARE

Assuring the quality of care in managed care involves far more than requiring plans to develop and adhere to quality assurance procedures (although these certainly are essential). Good quality care is simply impossible to achieve, in our view, if plans are underpaid. Moreover, in the case of plans operating at financial risk, good quality care is impossible if participating providers are either allowed, or required, to assume financial risks for specialty and/or inpatient care far beyond their capacity to do so, or if plans are poorly capitalized and functioning without sufficient protections for states, the federal government, participating health care providers, and most importantly, patients. States should be required to demonstrate that their programs meet these basic structural requirements.

In general, managed care, especially mandated managed care, should be utilized only if plans are carefully developed with federal oversight and if payment rates are actuarially sound, *without regard to whether such rates exceed the upper payment limits utilized in state Medicaid fee-for-service programs.* The current prohibition on managed care rates that exceed state upper payment limits means that in many states, already inadequate payment rates will be reduced even further. This means, in turn, that good providers will have to expose themselves to major funding shortfalls (particularly if they are caring for patients with multiple health needs). It also means that state managed care programs will risk attracting providers that seek to inappropriately hold down utilization of health care because additional services would push costs beyond allowable levels.

It is true that in some communities, shifting care from high-cost emergency room settings (and thereby reducing the attendant high inpatient admission rates) will yield sufficient savings to offset incentives toward underuse. But this is by no means universally the case. This is particularly true in states that already have taken aggressive steps to reduce emergency room payment rates for non-emergencies and that have built in mechanisms for averting inappropriate inpatient admissions, such as prior authorization. Thus, the upper limit on Medicaid payment rates should be eliminated.

In the case of managed care plans operating on a risk basis, we believe that federal floors for stop-loss protections for participating physicians, clinics and other providers, as well as solvency safeguards must be established. The standards used by the Secretary of HHS in administering the Medicare prepaid health program offer an instructive starting point.

We also believe that there are certain providers, such as those enrolling fewer than several thousand patients, that should not be permitted to be placed at financial risk at all in managed care. The Medicare managed care program requires managed care arrangements without risk where minimum enrollment and solvency safeguards are not present. That practice should be carried over into the Medicaid statute, as well.

Good quality managed care also means being able to demonstrate that plans have all appropriate linkages to the care and services that patients need. Of special importance are pediatric linkages, since the vast majority of patients enrolled in most state plans are children. These linkages range from all levels of outpatient and inpatient perinatal care to pediatric specialty services for children with physical, mental and developmental disabilities and delays, to linkages to state special education and early intervention programs and WIC services. Moreover, all plans should be capable of furnishing or arranging for the full range of services now covered for children through the Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) program. Also crucial are linkages to specialized care programs for persons with HIV and with alcohol and substance abuse exposure. We therefore recommend the establishment of minimum service contract requirements for Medicaid managed care plans.

The safeguards we have enumerated are especially critical if this Committee eliminates the current "75/25" rule that pertains to full-risk managed care plans that contract with state Medicaid programs and if the Committee decides to repeal the current waiver process for implementing restricted freedom of choice systems. If states are to be permitted to establish full-risk Medicaid only patient care programs, then there must be far more protection than simply a written quality assurance plan. The sad truth is that it is easier to get away with poor quality and inadequate care when the only enrollees are Medicaid women and children. We see this every day in New York City, in which grossly inappropriate care is furnished by certain physicians and clinics that treat only Medicaid beneficiaries. The only difference between these providers' activities now and under managed care is that the profit incentives will change. Currently the adverse incentive is to overserve patients. In risk-based managed care, the opposite incentive is present. Only those plans that have demonstrated basic financial and quality of care soundness, as defined by the Secretary, should be permitted to operate outside of the "75/25" rule.

B. CONTINUOUS ACCESS TO SERVICES

One of the best safeguards that can be built into managed care (and one that promotes quality, as well) is to assure that patients remain continuously enrolled in plans. Plans that are not available to the uninsured and that are paid in advance of furnishing care (as is the case with risk-based capitated arrangements) may be tempted to delay the provision of care on the assumption that by the time the need can no longer be put off, the patient will have lost Medicaid eligibility and will no longer be a patient of the plan.

Optimally, all Medicaid patients enrolled in managed care plans would be entitled to Medicaid so long as they remain enrolled in managed care. If this is not possible, then we urge this Committee to require, or at least allow, states, to extend annual eligibility periods to all Medicaid beneficiaries enrolled in managed care plans. Currently, for example, children can expect to be enrolled in Medicaid for only between 6 and 9 months, depending on their basis of eligibility. Annual enrollment would be a major improvement and a real, positive incentive for enrolling in managed care.

C. PROTECTIONS FOR HEALTH CENTERS AND COMMUNITY PUBLIC HEALTH PROGRAMS

It is important to assure that the current Medicaid protections in place for federally qualified health centers (which include all health centers receiving federal grants as well as clinics that meet all federal grant requirements) be maintained. This means retaining the federally qualified health center service mandate and assuring the continuation of reasonable cost reimbursement for health centers, whether or not participating in managed care. These two protections mean that all health centers will be able to participate as managed care providers and that those that do participate (either as their own plans or as sub-contractors to larger plans) need not do so at risk of financial loss. In state after state, including my own, health centers that have had to bear direct financial responsibility for loss have found themselves with major revenue shortfalls as a result of low payment rates, high patient need, and an inability to control the services of specialty care providers not working at centers. In the context of Medicaid managed care, Public Health Service (PHS) policy prohibits health centers from using their grant funds to offset Medicaid revenue losses in risk-based plans or, as subcontractors, from establishing capital reserves with their grants. Many of these centers and their patients thus face profound survival threats.

The reasonable cost protections for health centers participating in managed care has a direct precedent in the Medicare cost-based HMO program. Protection against risk does not diminish in the slightest centers' capacity to provide managed care. Moreover, centers should be able to participate in financial incentive plans and share in savings from reduced patient utilization of inpatient hospital care. Since health centers are skilled at hospital utilization reduction and since their revenues must by law be used to expand patient services, including primary and preventive care, permitting centers to participate in cost savings programs makes good sense.

Of particular importance is treatment under managed care of certain types of services, furnished by both health centers and other community public health programs. These services include school health, special education and early intervention health services for children with disabilities, prenatal care, childhood immunization services, migrant health services, head start nursing, family planning services, health care for the homeless, STD services, and Medicaid covered services furnished under WIC. Managed care plans that do not enter into subcontractual arrangements for the provision of these services to their patients derive the benefits of these programs for their patients without having to support them.

Already in New York City, health care providers for the homeless are reporting being unable to obtain Medicaid reimbursement for their patients when serving them in shelters, because they have restricted Medicaid cards which are good only with their managed care plans. Yet they may be miles away from the plans and without any means to obtain services at them.

We strongly urge that this Committee identify certain services in addition to those furnished by federally qualified health centers as community health services whose inclusion in Medicaid managed care program is required. For these services federal law should require that managed care plans subcontract with providers of such services. Alternatively states should be required to reimburse providers of these services on an out-of-plan basis.

Finally, we believe that increasing federal financial support for health center services at the same level that family planning services are paid would create a strong incentive for states' use of health centers as managed care providers. We also strongly support recommendations made by the Children's Defense Fund, in its testimony before you today, to provide grants to consortia of community public health providers, including health centers, local health agencies and disproportionate share (DSH) hospitals serving medically underserved areas, to develop managed care capabilities in their community. Without service development funds, these providers, who are so essential to all low income community residents, will be unable to make the transition to managed care.

PREPARED STATEMENT OF REPRESENTATIVE JOHN CONYERS, JR.

Mr. Chairman and Members of the Subcommittee, I thank you for the opportunity to submit this statement for the record of your hearings on managed care in Medicaid.

As Chairman of the House Committee on Government Operations, which is charged with overseeing the economy and efficiency of all levels of government, as a member of the Congressional Black Caucus, and as a representative from the city of Detroit, where 27 percent of the population lacks health insurance, the delivery of health care services to the medically underserved has become one of my greatest concerns.

I have taken particular interest in the problems and progress of the Medicaid program, which provides health care to millions of the neediest Americans and is rapidly becoming a crushing financial burden on Federal and state governments alike. It is from this perspective that I wish to discuss my views of the potential impact of managed care in Medicaid and S. 2077, the Medicaid Managed Care Improvement Act, on program beneficiaries and the facilities that provide health care services to them.

Mr. Chairman, as you know all too well, Medicaid has become a fiscal nightmare for both Federal and state governments. The Federal government spent $52.5 billion for its share of providing health services to over 28 million Medicaid recipients in Fiscal Year (FY) 1991, and is projected to pay $72.5 billion in FY 1992 and $84.5 billion in FY 1993. Total Federal-State Medicaid spending is estimated at $92.1 billion in FY 1991 and projected to reach $127 billion in FY 1992—well over 4.5% of all projected Federal outlays.

In Michigan, Medicaid is now a $3 billion program. The Michigan Medicaid program serves as its own fiscal intermediary and processed 50 million claims from about 1 million Michigan residents last year. Among other critical services, the Medical Services Administration (MSA), Michigan's Medicaid agency:

- provides payment for 180,000 inpatient hospital stays per year;
- paid for delivering over 40% of all the babies in Michigan last year—over 62,000 of 153,000 births;
- paid for 12 million patient days in nursing homes, and is now paying for all or part of the care for ⅔ of all nursing home patients.

The Medicaid program has become the largest single expenditure category in more than half the states, according to the National Governors' Association. In Michigan, expenditures have increased from $1.5 billion in 1985—9% of the state budget—to $3 billion in 1991—14% of the budget.

As a result, Michigan has attempted almost every cost-containment measure that held promise of controlling costs—with mixed results. The MSA's FY 1993 budget is predicated upon enrollment of all 1 million Michigan Medicaid recipients in managed care over the next two years through Social Security Act Section 1915(b) "freedom of choice" waivers.

Medicaid managed care enrollment in the U.S. has increased from 187,340 in 1981 to 2,837,500 in 1991, and this growth is expected to continue. Approximately 11 percent of all Medicaid beneficiaries are currently enrolled in managed care programs. Available data indicates that Medicaid managed care may change use patterns and generate cost savings of 2 percent to 15 percent. Less is known about the utilization and health effects of managed care for Medicaid recipients and medically underserved populations.

While I acknowledge that there may be some attraction to managed care in Medicaid for Federal and state governments, I am alarmed by the pace at which Congress is considering such dramatic reforms to this critical multibillion-dollar program. These proposed reforms are presumably based on the experience of individual plans and programs, with little apparent regard to some of the glaring failures of managed care in Medicaid, where this approach has on occasion amounted to little more than a thinly-veiled attempt to control skyrocketing health care expenditures on the backs of those in greatest need of these services.

Let me address three major issues that this legislation raises for the purpose of examining the potential shortcomings of this approach and possible remedies. They are:

- Some of the failures of managed care in Medicaid and the behavior of high-risk, pregnant Medicaid recipients in these programs as documented by the General Accounting Office, researchers and local public health entities;
- Potential threats to the financial viability of community public health services and Federally Qualified Health Centers that Medicaid managed care presents; and
- Possible impact of this legislation on hospitals that serve a disproportionate share of Medicaid recipients and the medically underserved.

FAILURES OF MANAGED CARE IN MEDICAID AT THE STATE AND LOCAL LEVEL

Mr. Chairman, as you can imagine, conversation in Detroit often comes around to the topic of automobiles. In Detroit, managed care in Medicaid is likened by both providers and policymakers to required auto maintenance by car dealerships. In those instances where service departments vigorously pursue owners to regularly maintain their vehicles, this "case management" works well. But in some cases where service departments neglect to send those little yellow cards to car owners, or make it exceedingly difficult for owners to secure needed maintenance, essential oil changes and tune-ups go unattended and cars break down with owners scratching their heads in confusion or frustration.

This analogy can be applied to the "consumer behavior" of Medicaid recipients enrolled in managed care programs. Medicaid recipients are often the neediest, least educated members of the medically underserved population. Many do not have the faintest concept of the essential benefits of prenatal care, regular checkups or responsible lifestyle choices unless their providers make them aware of them. Further, any number of factors—from access to public transportation, to cultural or linguistic barriers, to lack of child care—prevent Medicaid managed care programs from properly getting through to their enrollees when outreach efforts are made. The result is possible short-term cost savings for governments but diminished health and utilization for enrollees that may result in greater long-run costs.

Detroit

Michigan's Medicaid program utilizes several Health Maintenance Organizations (HMOs) and Physician Sponsored Programs (PSPs) to provide health services for thousands of Medicaid recipients in Detroit. A recent study by Dr. Marilyn Poland of Wayne State University's Institute of Maternal and Child Health at Detroit's Hutzel Hospital examined the health of a sample of Medicaid-eligible pregnant women enrolled in Medicaid HMOs and a sample of women receiving health care on a fee-for-service (FFS) basis. These two groups were similar in age, parity, and medical risk. Dr. Poland found that those women enrolled in managed care were just as likely as FFS women to receive no care or inadequate amounts of prenatal care, to have unplanned pregnancies (lack of family planning), and to use drugs, alcohol and tobacco before and during pregnancy.

Further, HMO patients complained that physicians were significantly less likely to answer their questions and they complained more often about long waits, discontinuity of care, and refusals to refer them for special services such as drug treatment and tertiary care. The fact that these HMOs refused to refer women to drug treatment was confirmed this year in testimony before Governor John Engler's Task

Force on Drug-Exposed Infants. Dr. Poland's study concluded that if Medicaid-eligible women living in Detroit are required to use managed care, many will not benefit from this system of care because it does not currently address their needs, values, or lifestyles.

Washington State

Krieger, et al. (American Journal of Public Health, February 1992) studied 5,936 Medicaid deliveries in Washington state and found mixed effects of managed care on birth outcomes. The mothers in the study group had voluntarily chosen to enroll in one of three managed care plans or maintain their conventional FFS Medicaid. Under one of the managed care plans, the proportion of low birthweight infants was significantly lower than the proportion under FFS Medicaid. Under another it was insignificantly lower, while under the third, the proportion of low birthweight infants was insignificantly higher than under FFS Medicaid. Krieger also compared the characteristics of prenatal care in the three managed care plans to care in FFS Medicaid. Only one of the plans had significantly fewer women with late or no prenatal care, again relative to FFS Medicaid. The other two showed insignificant differences. Once a woman initiated care, there were apparently no differences in the number of visits she made. However, in terms of the overall adequacy of care (measured by a complex system known as the Kessner Index), the managed care plans again showed mixed findings. One had significantly fewer women with inadequate care while another had significantly more with inadequate care.

Milwaukee

Mr. Chairman, the 1989–1990 measles outbreak in Milwaukee provided a tragic opportunity to examine the performance of managed care in Medicaid against a disease easily prevented by immunization—one of the hallmark services of managed care. The outcome was a frightening, stark portrait of a classic failure of managed care in Medicaid.

At the time of the outbreak a report from the Centers for Disease Control declared measles to be "on the verge of elimination from the United States." The Milwaukee outbreak, however, involved over 1,000 cases, where almost 70 percent of the cases were children under four years old and 26 percent of those infected had to be hospitalized. Three children died.

The outbreak was studied by the City of Milwaukee Health Department and their findings were published in the July 1990 Wisconsin Medical Journal. The Department found that of those cases ages 1 to 4 years old, about 70 percent were enrolled in Medicaid managed care programs. Among the infected HMO enrollees, 67 percent were unvaccinated for measles, 30 percent regularly used emergency rooms for primary care, and 25 percent reported having no personal physician. The Department researchers concluded that these figures suggest:

> "a gap between the disease prevention or health maintenance philosophy and local practice. . . .
>
> "[C]onsidering the extremely high morbidity and mortality rates associated with the measles outbreak and the attendant costs (more than $1.5 million in hospitalization costs for 1989 alone) it was clearly in the economic interest of the HMOs to aggressively pursue immunizing their high-risk clients. Yet only one of six Milwaukee HMOs expended significant new resources. By February 1990, the Milwaukee Health Department had stepped in and vaccinated approximately 11,000 HMO clients free of charge. This saved the HMOs a minimum of $300,000 and probably at least double that amount if charges for routine physicians visits are factored in. Had the HMOs expended as much up front in September 1989 when they were first warned of the epidemic, much of their hospitalization expenses may have been avoided. . . .
>
> "Not only measles but overall mortality rate comparisons between black and white infants and children in Milwaukee suggest the existence of a medically vulnerable 'urban underclass' that is not being protected by traditional means."

GAO examinations of managed care in Medicaid

The General Accounting Office has documented other breakdowns of managed care programs across the country. GAO found in some of its studies:

- Incentives to underserve Medicaid HMO enrollees and inadequacies in HMOs' quality assurance programs, utilization data and follow-up in Chicago (HRD 90-81);

- Poor implementation of case management and quality assurance measures, low capitation rates and contractor losses in a Philadelphia Medicaid managed care program (HRD 88–37);
- Abuse of Federal requirements for disclosure of ownership and control arrangements and related-party transactions by an Arizona Medicaid HMO, which prevented Federal and state investigators from ascertaining whether capitation funds were being appropriately used to provide health care services for the Medicaid population (HRD 86–10).

Mr. Chairman, these are only a handful of findings that suggest that the effects of managed care may indeed vary widely from one plan to the next, and that national reforms that give states wider latitude to engage in managed care in Medicaid should be developed very carefully.

FINANCIAL VIABILITY OF COMMUNITY PUBLIC HEALTH SERVICES AND FEDERALLY QUALIFIED HEALTH CENTERS UNDER MEDICAID MANAGED CARE

I am an advocate of community (Public Health Service Act grantee) and Federally Qualified Health Centers (FQHCs). Over 600 federally-funded community, migrant and homeless health care centers across the country provide health care services to almost 6.5 million medically underserved patients, about 40 percent of whom are Medicaid recipients. With limited support from the Federal Government, these facilities have over the past 25 years filled a critical gap in our rapidly eroding health care system.

Detroit is home to several of these essential facilities, whose mission can be described as nothing less than God's work and that represent the "safety net" for the city's medically underserved population.

Further, I am currently assisting an effort to examine the feasibility of converting of one of Detroit's bankrupt hospitals into an FQHC to increase the availability of primary care services in the city, services which inarguably are in desperate need. There are two benefits of such an approach to the fiscal crisis of urban hospitals. One, it maintains a health facility in communities where hospitals are often forced to shut down due to heavy uncompensated care burdens and low Medicaid reimbursement rates. Two, it delivers low-cost, high quality primary care services at the front end of patient care when costs can be kept to a minimum. If conversion of the facility in Detroit is financially viable it could potentially serve as a national model in other medically underserved urban areas where hospitals are being forced to close.

I have placed this much confidence in FQHCs in Detroit, one of the nation's capitals of managed care in Medicaid, for a number of reasons. Health centers were providing a cost-effective, managed continuum of care long before the concept of capitation or prepayment for Medicaid services was ever conceived. For the last 25 years health centers have been reaching the quality of care goals and cost savings that managed care advocates are looking for. It is for this reason that Congress, led by Senator John Chafee and the Senate Finance Committee, explicitly and solely protected FQHCs from growing utilization of managed care programs by state Medicaid agencies through the Social Security Act Section 1915(b) waiver process in the Omnibus Reconciliation Act (OBRA) of 1989. Approval of a Section 1915(b) waiver by the Health Care Financing Administration allows states to "lock-in" or require Medicaid recipients to enroll in specific managed care plans. Such a waiver states clearly, however, that when establishing a managed care program, states must utilize FQHCs as providers, and cannot deny FQHCs the reasonable cost reimbursement that Congress mandated they will receive from Medicaid agencies. No other health care provider has received such congressional recognition.

My interpretation of S. 2077 is that it runs counter to this special status granted to FQHCs and potentially does serious damage to the financial viability of these essential facilities. The result, I fear, of this bill's enactment, might be diminished access to primary care for the medically underserved if the reimbursement needs of community health centers are disregarded and these facilities are effectively financially eliminated. This legislation may mean further destabilization of community health centers when the numbers of the uninsured are at an historic level and continue to increase—facilities this Committee sought to give financial stability to through the FQHC provisions of OBPA 1989. Let me explain my reservations to this legislation in its current form in this regard.

Unlike private physicians or clinics, FQHCs—due to their unique mission—require cost-based reimbursement and must be completely protected against risk-based payment plans if their survival is to be insured. Community health centers serve virtually only low-income patients, and are required by law to accept all comers. Much like disproportionate share hospitals (discussed below), due to their geographic location, historical patterns of patient behavior, and the mission of these facilities, community health centers will continue to serve this population regardless of reimbursement rates or capitation arrangements. They thus have no bargaining power with managed care plans and are therefore forced to accept whatever payment rates and risk exposure these plans demand. Further, community health centers are prohibited by law from establishing capital reserves and have few privately insured patients over which to spread costs of indigent care. They therefore have absolutely no capacity to absorb losses caused by Medicaid payments that are insufficient to cover their costs (explaining their need for cost-based reimbursement). Their only option is to use their scarce Federal funds—used to pay for health care for the uninsured—to cover the shortfall, or by curtailing or terminating services to those in greatest need of them. The same can unfortunately be said of critical community-based public health services, such as for persons with communicable diseases, school health services, sexually transmitted disease services, immunization clinics and prenatal care programs.

Under the new Primary Care Case Management (PCCM) system established by S. 2077, states require Medicaid recipients to enroll in a PCCM system without going through the Section 1915(b) waiver system—effectively eliminating all of the FQHCs' current legislatively-mandated protections I mentioned earlier. The bill then eliminates the requirement that PCCMs paid on a risk basis either (1) pay FQHCs their cost (if FQHCs are subcontractors) or (2) be paid at cost (if the FQHC is a prime contractor).

For example, Ohio uses the new PCCM option in Cleveland. The state Medicaid agency has told all community health centers that it is paying a risk-based rate for primary care and that the centers can take it or leave it. The centers are no longer guaranteed their cost reimbursement—as Congress intended—and are no longer guaranteed to be "in-plan."

S. 2077 does not eliminate FQHC services as mandated services. But the PCCM provisions of S. 2077 virtually eliminate FQHCs' right to cost-based reimbursement in a PCCM system and their right to refuse a Medicaid contract that does not provide for it. To those policymakers who contend that cost-based reimbursement to FQHCs is "regressive" or "antiquated," I respectfully point out that that incentive was built into the statute because we need these centers so desperately. Community health centers are nonprofits in their purest form, and require unique support from governments for their unique mission.

At a time of contracting budgets and decreasing access to health care for the medically underserved, community health centers should be receiving additional support from government at all levels rather than threats to their already tenuous financial condition. I would therefore recommend that S. 2077 prohibit states from excluding FQHCs from a managed care system on either a contract or subcontract basis that refuse to contract for less than cost-based reimbursement, and require that all state Medicaid managed care plans using FQHCs on a contract or subcontract basis pay cost-based reimbursement. Anything less would endanger these essential facilities.

DISPROPORTIONATE SHARE HOSPITALS

Similar to community health centers, in its current form S. 2077 offers few apparent protections for hospitals with large volumes of indigent patients—like several of those in metropolitan Detroit and other depressed urban centers. Under current legislation, Medicaid is required to provide an adjustment to payments for hospitals which serve a disproportionate share of indigent patients.

However, as states move to greater reliance on managed care contracts for Medicaid patients—as Michigan is currently doing and as S. 2077 would give states freer rein to do—there is no existing or foreseeable requirement that managed care programs recognize facilities serving disproportionate share of indigent patients in establishing payment rates.

Mr. Chairman, as you know, this is a major concern because these disproportionate share hospitals will continue to provide care to the Medicaid and indigent population due to their geographic location, historical patterns of patient behavior, and the mission of these hospitals, regardless of contractual arrangements or payment rates. These hospitals are at a distinct disadvantage in negotiating managed care contracts due to their already financially distressed condition, and the fact that these patients will continue to come to their doors. Further, inner-city hospitals have few private-paying patients over which to spread these losses. In 1990, hospitals in Wayne County1 which includes metropolitan Detroit, provided more than $147 million in uncompensated care. Four Detroit hospitals filed for Chapter 11 bankruptcy protection or entered foreclosure proceedings in 1991 alone.

Under S. 2077 in its current form, if these critical facilities want to be paid at all, then they are forced to contract with the managed care plans. Because of this unequal negotiating position, there must be protections provided by this legislation to assure that those hospitals serving a disproportionate share of Medicaid and indigent patients are reimbursed at a fair and reasonable rate to maintain their operations.

As health care cost containment pressures continue to grow, and government revenue pressures increase, growing numbers of the medically underserved will be left without access to basic health care services. These patients often become the responsibility of the provider of last resort—the urban hospital.

RECOMMENDATIONS AND CONCLUSION

Mr. Chairman, I hope this effectively explains some of my concerns about the expansion of managed care in Medicaid. This is not to say that I am completely opposed to this approach; indeed, in my own health care reform legislation that I am preparing to introduce I support the use of managed care as a continuum of health care services. Further, Detroit is home to Comprehensive Health Services, a nationally prominent Medicaid-waiver HMO that has done a remarkable job of providing health care to the medically underserved. What gives me pause are some of the flagrant failures of managed care where it was ultimately the neediest that paid the price, and the current lack of recognition to the requirements and accomplishments of community health centers and urban hospitals.

Medicaid represents the lower tier of America's two-tiered health care system, Mr. Chairman, and these two tiers are collapsing while their costs explode. In the short term, we can hold hearings like this one, scrape together a little more money or introduce legislation in a frantic attempt to plug the holes. But the real answer to these problems the subcommittee will hear about today, I believe, is a health care system that insures all Americans under the same policy: providing universal, national health insurance.

The benefits of national health insurance, Mr. Chairman, would be enormous. Detroit needs it most because we are hit twice as hard as the rest of the nation. Over 300,000 Detroit residents lack health insurance—that's 27% of the city's population and twice the national rate. Detroit's infant mortality rate is twice that of the rest of the nation, and approaches that of the poorest Third World nations. The average Detroit resident can expect to live nine years less than other Americans. Few places in America have a more desperate need for a new health system than Detroit.

Mr. Chairman, I am an advocate of a national health insurance program based on the single-payer Canadian model, with modifications to take account of the strengths of the U.S. system. Basically, the Federal Government would guarantee health insurance to all Americans, just as it guarantees retirement insurance through Social Security. The program would be administered by the 50 states, whose governments are closest to the people. Fair fees and budgets would be negotiated with doctors and hospitals to further contain costs.

The General Accounting Office, the non-partisan research arm of the Congress, conducted an 18-month study for me on the lessons a Canadian-style single-payer system has to offer the U.S. GAO estimated savings of $67 billion in one year under such a plan by reducing the paperwork morass caused by so many insurance companies. They further estimated that such savings would be enough to insure all Americans currently without coverage and eliminate copayments and deductibles for everyone else. No other health care reform proposal can make such a claim.

Under national health insurance, Americans would still have the freedom to choose the doctors of their choice. Doctors would not be employed by the government any more than they are today. Hospitals would still be publicly or privately run. Hospitals like Southwest Detroit, North Detroit General and others would be relieved of the crushing burden of uncompensated care, as all Americans would have their doctor's bills paid for them. Without the mountains of paperwork and the incessant competition with other facilities, doctors and hospitals could get back to caring for people rather than competing for market share.

I held numerous hearings last year on the need for national health insurance and remain convinced that it is the only way for us to pull ourselves out of the health care crisis. The costs of doing nothing, Mr. Chairman, are far too great. Enactment of national health insurance, therefore, would be my primary recommendation to the subcommittee to addressing the problems of Medicaid. Barring that, I would like to discuss some considerations for S. 2077.

Due to the financial sensitivity of the Medicaid program and the vulnerability of Medicaid recipients, a set of strict safeguards must be instituted in any managed care legislation to protect states, providers and recipients alike. This includes:

- a requirement that all PCCMs using FQHCs on a contract or subcontract basis pay cost-based reimbursement, and prohibit states from excluding FQHCs from a PCCM system on either a contract or subcontract basis that refuse to contract for less than cost-based reimbursement;
- a requirement that all PCCMs using disproportionate share hospitals on a contract or subcontract basis pay reasonable rates with an indigent care offset, and prohibiting states from excluding disproportionate share hospitals from a PCCM system on either a contract or subcontract basis that refuse to provide an indigent care offset;
- a quality assurance system that requires patient satisfaction with available services, and allows and monitors voluntary disenrollment;
- grievance procedures for enrollees;
- strict Federal and state oversight with a defined corrections process when shortcomings are identified;
- funds to insure effective outreach services, such as for transportation, case management, bilingual case workers, and development of culturally-specific education programs;
- risk protection for pediatricians, obstetricians, and primary care physicians (family practitioners, general internists);
- sound payment rates with mandated minimums that account for geographic and demographic factors;
- effective maintenance of patient data by contractors.

Mr. Chairman and members of the subcommittee, once again I thank you for the chance to share my thoughts and concerns.

PREPARED STATEMENT OF JOSEPH LIU

Mr. Chairman and Members of this Subcommittee: The Children's Defense Fund (CDF) appreciates this opportunity to testify before you today on this exceedingly important topic. CDF is a national public charity which provides long range and systematic advocacy on behalf of American children. CDF pays particular attention to the needs of low income, minority, and disabled children.

Today nearly 43 million Americans—55 percent of whom are women of childbearing ages and children and 36.5 percent of whom are Medicaid beneficiaries—are medically underserved and without access to basic primary health care.[1] Millions of beneficiaries face an unending struggle to find decent sources of primary health care. At local public health clinics, waits for maternity care of as long as 16 weeks have been documented. Public providers, overwhelmed by the sheer numbers of patients who are desperately ill, are unable to furnish even basic immunization services in a timely fashion. Hospital emergency rooms serve as the family physician to countless poor families and children.

Despite all that is known about the importance of comprehensive primary health services, particularly for children and women of childbearing age, this nation still has thousands of communities without sufficient primary health services. Our stagnating infant mortality rates, disastrously low childhood immunization rates, and epidemics of totally preventable killers such as tuberculosis and other preventable diseases are all testaments to our failed system of primary health care for poor and minority Americans.

Managed care—the provision of health care through a single point of entry and the enrollment of beneficiaries in a prepaid health care organization such as an HMO—is simply a means of organizing and paying for health care. Where managed care builds on a good quality health care system it can be a real benefit to families. People have a place to go for health care, and the care they receive is of good quality.

But managed care works only as well as the underlying system providing the care. The results can be promising where managed care builds on good health providers committed to achieving savings by expanding access to cost effective primary health services in cost-efficient settings and careful management of chronic conditions and disabilities. Years of experience with high quality group health plans organized on a prepaid staff model and community based health programs specializing in serving the poor such as children and youth projects, maternity and infant care projects, and community health centers have taught us this lesson.

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[1] Hawkins, Daniel and Rosenbaum, Sara, *Lives in the Balance* (National Association of Community Health Centers, Washington, D.C.) 1992.

Managed care can also be a disaster. undercapitalized plans operating without a solid base of cash reserves against financial risk and without substantial reinsurance protection, that are inadequately paid, poorly regulated, and without substantial stop-loss protections for participating individual providers (in the case of health insuring organizations, individual provider associations, and other non-staff model plans using contractual arrangements with area health providers) constitute a potential threat to both beneficiaries and the providers that become involved with them. If safeguards are not in place, then good health providers can be ruined and state initiatives can end up attracting entrepreneurs with little or no interest in building first rate health care systems. Managed care becomes little more in these cases than a conduit of millions of dollars into entities that provide inadequate services—"cash cows" as the Office of the Inspector General recently termed a managed care plan Philadelphia.

In the case of managed care programs serving Medicaid beneficiaries, Congress and the states have every reason to be particularly careful. In most states, the chief managed care enrollees are women of childbearing age and children. In many plans it is not unusual to find that 60 to 70 percent of the enrollees are children and that virtually all other enrollees are young women in their prime childbearing years. The quality of maternity, pediatric and women's health care these plans offer should be of paramount concern.

Moreover, uppermost in Congress' and states' minds should be the fact that extremely poor young women and children tend not to be experienced health care users with the ability to make themselves heard if they do not like the treatment they are receiving. Indeed, recent data from the National Medical Expenditure Survey show that the poor are the *least* likely of all income groups to "shop" for medical care or to use multiple sources of health care. In refashioning the managed care principles embodied in the current Medicaid statute, it is incumbent on federal and state policymakers to assure that managed care programs build on the *right* providers, protect community health providers from undue financial risk exposure, include safeguards for the basic public health system for the uninsured and underserved, and are sufficiently funded to deliver quality care on a continuing basis.

The federal government maintains detailed standards on every aspect of risk-based managed care plans in Medicare. In the case of Medicaid, however, where managed care plan enrollees are predominately women and children who receive AFDC, the federal statute and regulations are relatively spare. The question is whether the standards should be released further and, if so, whether for both non-risk managed care plans and mandated enrollment initiatives in risk-based managed care.

Women and children deserve protection and monitoring standards no less rigorous than those in place for elderly and disabled Medicare beneficiaries. All risk-based managed care plans in Medicaid should meet the federally qualified health maintenance organization requirements of the Public Health service Act or qualify as Medicare competitive medical plans. While states play a major role in assuring the safety, solvency, and appropriateness of Medicaid managed care arrangements, there must be rigorous federal standards and monitoring of plans. At stake is the well being of millions of children and women of childbearing age, not to mention billions of dollars in federal funds.

We have identified the areas of concern in revising current provisions of law relating to the use of risk and non-risk managed care programs on both a mandated and voluntary basis. To summarize, we believe that there exist considerable grounds for broadening states' authority to require beneficiaries to enroll in non-risk, non-prepaid plans. Where mandated or voluntary enrollment in prepaid risk plans is concerned, we believe that congress should proceed with extreme caution. Our belief is shared by both the congressionally appointed Physician Payment Review commission and by a special task force in which CDF participates which was convened in 1991 by HCFA to review current Medicaid managed care law and make recommendations. The concerns we have identified are based on our ongoing review of the major problems for both beneficiaries and participating doctors and clinics that have arisen under managed care plans in the past.

1. In the event that the "75/25" rule is raised, there must be federal standards to ensure that payment rates are actuarially sound, with federally set minimum levels that take into account both geographic and demographic considerations. Moreover, risk-based plans must be adequately capitalized.

One of the key issues to be addressed is whether to leave in place the current statutory requirement that full-risk plans (§1903(m) providers) draw at least 25 percent of their enrollees from non-Medicare and Medicaid patients (under Medicare the rule is a more stringent 50/50). The purpose of this requirement is to assure both quality and solvency. If this provision is to be relaxed further, as S. 2077 proposes, then minimum safeguards are vital. Low reimbursement levels and inadequate plan capitalization are the two most basic threats to Medicaid beneficiaries and participating providers. Perhaps the surest way to cause major problems is to under-finance a plan operating on a risk basis and to then pay it inadequate capitated rates. At that point, incentives for significant under-service are a virtual certainty.

Payment levels: Under current law, Medicaid payments to plans cannot exceed the cost of furnishing services on a fee for service basis. Yet low payment levels already are a chief cause of low provider participation in Medicaid. Moreover, they do not take into account the additional administrative and service responsibilities of the plans.

The current upper payment limit should be eliminated in favor of a requirement that all full and partial risk plans be paid at a rate which is actuarially sound. Actuarial standards that take into account geographic and demographic variation should be set by the Secretary. At a minimum, the subpopulations of women and children for whom minimum payment ranges are needed include FDC-enrolled children and women of childbearing age and pregnant women and children enrolled on the basis of poverty.

Children whose Medicaid status is based on their poverty status tend to enroll at the point at which they need a health service; thus, their per capita annual cost levels are about one and a half times those for AFDC children (whose enrollment in Medicaid is based on receipt of cash assistance, not necessarily on immediate medical need). In the case of low income pregnant women, their Medicaid eligibility is based on a medical condition—pregnancy—and a need for health services. As a result, they are inappropriate candidates for risk-based payment systems. In addition, in light of historic and severe underfinancing of obstetrical services, the Secretary should establish regional maternity care fee schedules that would be incorporated into all managed care plans.

Adequate capitalization: If plans fail, they take millions of dollars in state and federal Medicaid revenues and provider payments with them, exposing agencies, physicians, hospitals and clinics to economic disaster. Medicare standards regarding capitalization of risk plans should apply equally to Medicaid full-risk plans with appropriate adjustment for partial-risk plans.

Stop loss: **A key issue is how much risk individual providers participating in capitated risk plans will be permitted to absorb.** Pediatricians, family physicians and obstetricians must be protected against undue risk. There is no evidence that women and children overuse the services of these types of providers. Indeed, to the extent that managed care can reduce dependence on emergency rooms, one can expect use of these office-based physicians to increase. Risk levels for primary care office-based practitioners who participate in risk-based plans should be on an aggregate, not an individual basis, and their exposure should be no greater than the level permitted in the case of physicians who participate in Medicare HMOs.

Furthermore, Title V funded clinics, federally qualified health centers (FQHCs) and public hospitals must be protected against risk completely. Both serve virtually only low income patients. Both Title V assisted clinics and FQHCs must accept all Medicare and Medicaid patients. They thus have no bargaining power with plans and end up having to accept whatever payment rates and risk exposure plans demand. They have absolutely no capacity to absorb losses caused by payments that are insufficient to cover their costs other than by curtailing or terminating services to poor people.

Moreover, federally funded community health centers (the overwhelming majority of all FQHCs) are prohibited by law from establishing capital reserves. Without an assurance of complete protection against risk, their federal grants (meant to serve the poor uninsured) will be used to offset financial losses from Medicaid.

Nor can public hospitals afford major losses under risk based plans. They are a pivotal element of the safety net for the poor, and heavy risk exposure can cause a loss of services not only to Medicaid beneficiaries but to all persons in the institution's service area.

All three types of providers must be guaranteed the right to participate in any plan operating in their service are (or to function as their own plan). And all three must be protected against risk for the sake of both Medicaid patients and all low income and uninsured patients in the community.

2. Continuous annual Medicaid enrollment should be given to children in managed care plans. Furthermore, no child losing categorical Medicaid eligibility should be disenrolled before a redetermination on the basis of poverty status.

Under current law states can guarantee at least 6 months of Medicaid coverage for plan enrollees, but only for enrollment in full-risk plans. This option should be expanded to cover all types of managed care plans and should be lengthened to a full 12-month period. continuous eligibility for Medicaid is essential for children and an important means of protecting children enrolled in managed care plans. currently Medicaid coverage of children lasts between 8 and 11 months on average. Annual eligibility periods would mean that children enrolling in plans would be guaranteed relatively long periods of service under the plan, and would have a greater opportunity to develop strong link to a more appropriate health care setting. Continuous eligibility for Medicaid also would reduce the likelihood that plans would "churn" (i.e., underserve) children in anticipation of their rapid disenrollment.

To further protect children against churning by plans, no child whose Medicaid is based on AFDC eligibility should be disenrolled from the program upon loss of cash assistance until continuing eligibility as a poverty-level child has been determined. This protection is included in S. 4, the child Welfare and Preventive Services Act.

3. Beneficiaries and providers should have a choice among at least three unaffiliated plans before enrollment can be mandated.

Managed care should be permitted on a mandated basis only if providers and patients have a choice among at least three unaffiliated plans. Regional franchises (the practice of mandating enrollment even where there is only one plan in a service area if the plan has signed up the majority of Medicaid participating physicians) should not be permitted, because such single plan franchises can harm both individual practitioners and patients. Plans that control an entire region and that have the power to lock out any physician or clinic that will not agree to their terms can set unfair conditions of participation by physicians and clinics and force acceptance of low payment rates and high individual practitioner risk exposure.

Certain providers, such as federally funded community health centers and Title V assisted health agencies, must participate in a franchise arrangement regardless of how unfair the terms and conditions are, because by law they must treat Medicaid and Medicare patients. Moreover, patients are placed at great risk by plan conditions that in essence threaten to force either medical underservice or plan insolvency.

Mandated enrollment into single plan franchises should not be permitted. In any region with only one plan, enrollment should remain voluntary, so that beneficiaries can continue to receive care from non-plan physicians and clinics, with beneficiaries able to choose between the plan and remaining with a non-enrolled provider.

4. Protections for federally qualified health centers and rural health clinics must be maintained.

Under current law federally qualified health center (FQHC) and rural health clinic (RHC) services are both mandatory. Both types of services must be reimbursed on a reasonable cost basis. These protections should be preserved because of the high quality care for poor these programs furnish and because of their dual mission to care for both uninsured and publicly insured poor persons. All managed care plans must be required to offer provider contracts to the FQHCs and RHCs located in their service areas. FQHCs and RHCs that elect to operate their own managed care programs rather than enter into a subcontract with another program should have the right to do so, as is permitted under current law. In either case, as is true under current law, reimbursement must be continued on a reasonable-cost basis in order to ensure that FQHCs and RHCs do not bear risk through the grants they receive to care for the poor and uninsured.

5. It should be clear that nothing in managed care plan contracting changes the obligation of states to furnish beneficiaries with all services and service settings covered under their state Medicaid plans.

A state Medicaid agency's contract with a *managed care plan* does not alter the state's obligation to provide plan enrollees with all benefits covered under the *Medicaid plan*. For example, regardless of whether a plan offers dental care, all states are obligated to provide dental care to all enrollees under 21, because the services are mandated under the Medicaid EPSDT program. The same is true for other required services which all states must offer beneficiaries. If not available through a managed care plan, the state must pay for the services if used outside the plan.

In the case of EPSDT services, this clarification is particularly important. children under 21 are entitled to all medically necessary care and services allowed under federal law, even if not furnished to adults. Many plans may not offer or be paid for all care and services (and indeed, may not even be aware of what their pediatric patients are entitled to receive).

All managed care plans should be required to furnish health assessments that meet the EPSDT periodic screening standard, and all plans should be required to provide or arrange for all services covered under the state Medicaid plan that a child may need, even if such services are not part of the plan's scope of service or capitated reimbursement rate (plans electing to furnish additional services beyond their basic contract should of course be paid additional amounts). This requirement is of particularly critical importance for children with special health care needs, who frequently will need care and services available only through specialty providers and in specialized settings. All of these services are now mandated in all states under EPSDT and must not be lost to children in managed care.

6. There must be special protection for providers of key community health services that otherwise would be considered "out of plan."

There are a wide range of community public health programs that rely on Medicaid revenues to sustain their services. School health, Head Start, special education and early intervention, public prenatal care and immunization clinics, migrant health services, family planning clinics, homeless health care, and clinics for persons with communicable diseases such as tuberculosis and sexually-transmitted diseases all use Medicaid revenues to maintain a fragile safety net of public health services. Some, such as FQHCs or hospitals, may be managed care providers in their own right. However, these services are in grave danger of being "locked out" of Medicaid in areas covered by managed care plans if the plans refuse to extend service contracts to these programs.

An example of such a "lock-out" is a FQHC that furnishes school health services under contract to a school district. Some of the clinic's patients may also be enrolled with the FQHC as managed care patients. Others, however, may be patients of other plans, which refuse to reimburse the school clinic for services furnished and instead insist on children being served at their own sites—often an impossibility for children and families.

In order to guarantee the continued viability of these services, all plans in a service area should be required to use these programs as sub-contractors or else contribute to the cost of their maintenance through a pro-rated portion of their payment rates. Another option would be for states to continue to pay for critical categories of community public health services on an out-of-plan basis. Without this adjustment, key service programs for poor women and children stand to lose a critical and irreplaceable revenue support.

7. All plan contracts, quality assurance plans, payment levels, and service and utilization monitoring should be subject to strong federal oversight.

Just as there is strong monitoring of all Medicare HMOs, clear state requirements and federal compliance review protocols are needed for any Medicaid managed care plan, risk or non-risk. This is particularly true, however, in the case of plans that are risk based, paid millions of dollars prospectively for services not yet furnished, and part of a mandatory enrollment system.

Federal review should include pre-clearance of all risk contracts to assure:

- adequate capitalization,
- adequate reimbursement levels,
- enrollment of quality of providers and service settings,
- well articulated responsibilities by the plan and the state in the case of services covered under the state plan but not offered by or through the managed care plan and appropriate safeguards for both providers and beneficiaries,
- look-behind medical audits to assess the quality of care furnished by the plans, and marketing arrangements are safe (and that do not use such potentially fraudulent dangerous techniques as door-to-door solicitation).

8. Safeguards Against Marketing Abuses

All managed care plans should be required to submit a marketing plan for state approval. Some managed care plans have engaged in fraudulent and deceptive marketing practices using high-pressure tactics and door-to-door solicitation, which is banned by Medicare. Eliminating marketing abuses would discourage the entrance of unscrupulous managed care plans into Medicaid.

9. Maintenance of encounter data should be required.

Because of the difficulty of measuring the quality of care, a key indicator of quality (and of plan compliance with contract requirements relating to the provision of services) is encounter data. All plans should maintain encounter data, particularly data pertaining to prenatal care utilization, EPSDT assessments, and childhood immunizations. In addition, plans should be required to maintain data on referrals for services covered under the state Medicaid plan but not furnished by the managed care plan, authorized and unauthorized emergency services, and patient data on coordination with closely related programs such as WIC, special education and early intervention services and services for children with special health care needs.

10. Funds to permit consortia of community-based programs to develop managed care programs and capacity.

As we noted at the outset, managed care is an organizational structure and potentially a reimbursement methodology. It cannot in and of itself create services where there are not. Currently private and commercial plans have access to the capital needed to move into new communities acquire land and space and develop operation capacity. Community based institutions such as local and state health agencies, FQHCs, public hospitals and disproportionate share hospitals located in medically underserved areas may not have access to development funding and therefore cannot compete. To assure that these vital community health providers have the resources they need to develop the capacity to furnish managed care, we propose the addition of a special demonstration program for three to five states now in the process of major Medicaid managed initiatives. These demonstration grants would be available to consortia of public and private non-profit and institutional primary care providers located in medically underserved areas or furnishing health care to medically underserved populations. The purpose of the grants would be to permit these consortia to plan, develop and operate comprehensive managed care programs that meet federal and state requirements and that provide services to medically underserved persons. Without this type of initiative there is great danger that these essential providers simply will never be in a position to make the managed care evolution. If this happens, then the safety net system of primary and inpatient care for the underserved will have been lost.

Prepared Statement of Michele Melden

My name is Michele Melden. I am a staff attorney with the National Health Law Program. We provide legal assistance to local legal services programs throughout the country serving the poor. Over the past decade, we have been active in monitoring Medicaid managed care programs nationwide.

We are writing on behalf of clients who are Medicaid recipients to oppose legislation introduced by Senator Moynihan, S. 2077. This bill would authorize rapid expansion of Medicaid managed care programs, each involving large numbers of enrollees, while eliminating key federal protections presently available to recipients: first, the bill dispenses with the requirement that states obtain freedom of choice waivers before mandating recipient enrollment; second, the bill eliminates the present requirement that Medicaid recipients be enrolled in managed care plans that enroll at least 25% non-Medicaid and non-Medicare recipients (mixed enrollment requirement).

We oppose the above changes because they eliminate critical federal protections available to Medicaid beneficiaries. This bill institutionalizes a two-tier health care system, where the poor are relegated to the bottom tier without the same quality protections available to the rest of the population. Instead, we recommend enhancing the federal government's role in developing clear, uniform quality assurance guidelines that are badly needed for Medicaid managed care enrollees.

A. AUTHORIZING RAPID ENROLLMENT OF MEDICAID RECIPIENTS INTO MANAGED CARE PLANS WOULD BE VERY DANGEROUS

The preamble to the proposed legislation states that "managed care represents one of the few ways that States can control costs without harming recipients."[1] In addition, the preamble states that managed care is "needed to improve access."[2]

While cost containment is an admirable goal, the reality is that managed care threatens significant harm to Medicaid recipients. Managed care that pays providers on a per capita basis ("capitation"), as opposed to a fee-for-service basis, introduces

[1] Cong. Rec. at S18388 (Nov. 26, 1991).
[2] Id.

financial disincentives against providing care. This creates a conflict of interest for providers between providing care and maximizing profits. The danger is that recipients will be deprived of much needed access.

The costs of inadequate access are high: delayed preventive and prenatal care that can result in permanent disabilities, much higher medical costs later, and even death. In addition, when states pay managed care plans on a capitated basis, the plans take fees regardless of whether services are provided. Paying plans that fail to provide care is a waste of limited Medicaid dollars.

There is ample evidence showing that managed care does not "improve access." On the contrary, Medicaid managed care enrollees suffer from alarmingly poor health outcomes resulting from inadequate access to prenatal and preventive care:

1. Federally financed studies on the Medicaid managed care demonstration projects found access in managed care programs was no better than access under traditional Medicaid, and in fact, managed care enrollees suffered similar rates of poor birth outcomes.[3]

2. A recent study published on HealthPASS, a mandatory managed care plan in Philadelphia, revealed that access for enrolled recipients in West Philadelphia was just as inadequate as access available to nonenrolled recipients.[4] In both groups 39% of the enrollees had inadequate access to prenatal care (on average, women were unable to schedule their first prenatal visit until their 5th month of pregnancy, well beyond medically recommended standards), and 20% of the infants were born with low birth weight and required expensive intensive care at birth.[5]

Despite clear evidence of underservice, HealthPASS was recently called a "cash cow" in an Inspector General's interim advisory report: owners and directors made "more than a generous return" of over $16.6 million during the first two and one-half years, and investors were advanced about $5.5 million interest free.[6]

3. Recent data supplied by the Dayton Area Health Plan (DAHP) in Ohio, a mandatory managed care plan for Medicaid recipients, revealed alarmingly poor outcomes. Nearly 30,000 of the 40,000 Medicaid enrollees are children who are particularly vulnerable to inadequate service: 71% fewer children received lead blood tests in 1991 than when DAHP began in 1989, only 25% of the children were fully immunized, and only 7% of the children who received "EPSDT"[7] screens were referred for follow-up treatment, compared with the national average of 27%.[8] The largest Head Start Program in the county served by DAHP reported that at the start of the 1991 school year, as many as 50% of the children did not get full EPSDT screens, including critical hearing and vision screens, and that many children who were screened still had not received doctor-ordered and federally mandated follow up care six months later.[9]

In addition, in 1989, only 29% of enrolled pregnant women received prenatal care in their first trimester, representing a 10% increase in delays during DAHP's first year of operation, while access for Medicaid recipients in other parts of the state, using fee-for-service care, was better and remained stable during that same period of time, at 35%.[10]

4. According to the most recent federally financed study on managed care, provider care case management (PCCM) systems that use gatekeepers to control utilization, but reimburse on a fee-for-service rather than capitated basis, have been more successful in "striking the desired balance" between cost control and expanding access.[11] According to this study, the financial risks associated with capitation have resulted in fewer participating providers and more disruption of existing pro-

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[3] Freund, Rossiter, Fox, Meyer, Hurley, Carey & Paul, "Evaluation of the Medicaid Competition Demonstrations," 11 *Health Care Fin. Rev.* 81 (Winter 1989); Anderson & Fox, "Lessons Learned from Medicaid Managed Care Approaches," *Health Affairs* 71, 80 (Spring 1987).

[4] Goldfarb, Hillman, Eisenberg, Kelley, Cohen & Dellheim, "Impact of a Mandatory Medicaid Case Management Program on Prenatal Care and Birth Outcomes," 29 *Med. Care* 64 (Jan. 1991).

[5] Id.

[6] *See* 46 *Medicine & Health* 1 (Feb 17, 1992).

[7] Medicaid's "Early and Periodic Screening, Diagnosis, and Treatment" (EPSDT) program is the key preventive health program available to poor children eligible for Medicaid. 42 U.S.C. §1396d(r). The program mandates preventive health screens and necessary follow-up treatment.

[8] *See* "Warning Signs: A Fact Sheet on the Dayton Area Health Plan" at 3, prepared by Legal Aid Society of Dayton, Inc., Ohio State Legal Services Association, and National Health Law Program (March 1992) (available from NHeLP-Los Angeles).

[9] Id. at 4.

[10] Id. at 10.

[11] Hurley, Freund & Paul, *Managed Care in Medicaid—1981–1990: Lessons From a Decade of Diffusion and Confusion* 176–79, study sponsored by HCFA Cooperative Agreement No. 18-C-99490/3-01 and the Research Triangle Institute (Oct. 1991).

vider to patient relationships than occurred in PCCMs.[12] Moreover, the study noted that some PCCMs that pay fee for service have realized much greater savings than capitated managed care plans due to higher administrative feasibility and more widespread provider participation.[13]

As long as access in managed care, and particularly in capitated managed care, is problematic, this is not the right time to relax critical federal protections, such as the freedom of choice and mixed enrollment requirements.

II. FREEDOM OF CHOICE

Under S. 2077, states could mandate enrollment of Medicaid recipients in managed care plans as long as there are at least two plans available from which to choose, or there is one plan that enrolls at least two-thirds of the area's physicians. This would eliminate the requirement that states obtain "freedom of choice" waivers from the federal government before mandating enrollment.

The waiver process, however, provides some very important protections for beneficiaries. The waiver process enables the federal government, through the Health Care Financing Administration (HCFA), to identify potential problems before implementation begins, and to require states to make assurances that they will address those problems upfront. In addition, recipients and providers have an opportunity to comment on the proposals in advance of implementation. The danger of trapping recipients in a managed care plan that may not serve them, and indeed, will have financial disincentives against serving them, is too great to dispense with this process for ensuring pre-implementation problems are addressed.

For example, critical factors that need to be addressed are whether: (a) the plan has enrolled sufficient numbers of providers who agree to serve recipients without delay; (b) the providers are geographically accessible to recipients; (c) state quality care protections are adequate; (d) sufficient planning time has been set to ensure that the managed care plan is coordinated with the state's Medicaid system; and (e) the state's methods for setting capitation rates and regulating risk pools are actuarially sound.

III. MIXED ENROLLMENT

The preamble to the proposed legislation states that the 75–25% requirement (of Medicaid to private enrollees) should be eliminated in order to expand access in "urban ghettoes," stating that recipients who live in those areas are most likely to "abus[e] the system," by reselling drugs obtained at "Medicaid mills" or overusing emergency care.[14]

Recipients have a keen interest in avoiding "Medicaid mills," often found in urban areas where *physicians* providing substandard care have learned how to abuse the Medicaid system by profiting at the expense of recipients. However, promoting segregated Medicaid-only managed care will not remedy this problem, and may instead, institutionalize the risks of such mills.

Studies on the Medicaid demonstration projects indicated that providers participating in Medicaid-only managed care plans were, for the most part, providers who already participated in Medicaid.[15] Therefore, if Medicaid-only managed care plans have failed to attract new physicians, there is no evidence that promoting Medicaid-only managed care will expand access.

The mixed enrollment requirement provides some very practical protections for Medicaid recipients. First, current capitation rates are too low. They are set with the expectation of saving money in relation to dismally low Medicaid fee-for-service rates, thereby threatening to replicate the access problems endemic in the fee-for-service system. Even former HCFA Administrator, Gail Wilensky, has acknowledged that new methodologies may be necessary to set capitation rates with full recognition that current fee-for-service rates have resulted in lower levels of access and fragmented care, and that the new methodologies are likely to result in spending more than is being spent in fee-for-service.[16] Inadequate reimbursement rates are a principal reason why mainstream HMOs are reluctant to participate, such as Kaiser or Foundation Health Plan in California. We should be suspicious of plans that enter the market just to enroll Medicaid beneficiaries.

[12] *Id.* at 178.
[13] *Id.* at 167.
[14] *Cong. Rec.* at S18388 (Nov. 26, 1991).
[15] Anderson & Fox, "Lessons Learned from Medicaid Managed Care Approaches," *Health Affairs* 71 (Spring 1987).
[16] Wilensky & Rossiter, "Coordinated Care and Public Programs," 10 *Health Affairs* 62, 74–75 (Winter 1991).

The fact that the Medicaid rate is inadequate creates serious risks of underservice for recipients. The mixed enrollment requirement can buffer this risk by relying on plans that have an experience with capitation against which the Medicaid rate can be compared. The most recent HCFA-sponsored study on managed care noted that rate-setting is often a "complex enterprise with little experience or expertise to draw on within the Medicaid agencies." [17] In fact, some plans, such as Contra Costa County Health Plan in California, have indicated that they could not have taken Medicaid recipients without mainstream-enrollees because the Medicaid rates have been inadequate and it has been necessary to cross-subsidize their health costs with rates paid by non-Medicaid enrollees.

Finally, it is a meaningful protection for Medicaid beneficiaries to require managed care plans to compete for and maintain enrollment of a mainstream population, particularly where the Medicaid recipients are deprived of the opportunity to "vote with their feet." In fact, the GAO recently testified that Oregon's success in providing adequate care to Medicaid managed care enrollees was due to the predominant use of mainstream HMOs.[18]

Medicaid recipients, and particularly the AFDC-linked recipients (primarily women and children) who are most often enrolled in managed care, move on and off Medicaid. The plans, therefore, have limited incentives to invest in preventive care. Plans that have proved that they will provide adequate preventive and follow-up care to mainstream populations are more likely to provide adequate care to Medicaid recipients.

In any case, states presently have the ability to temporarily defer the mixed enrollment requirement by applying to HCFA for a waiver for a maximum of three consecutive years.[19] The plans need only show that they have taken and are taking reasonable steps to enroll non-Medicaid and non-Medicare beneficiaries.[20]

IV. STRENGTHENED FEDERAL GUIDANCE AND OVERSIGHT IS NECESSARY

This legislation proposes to relax federal oversight at the very time that HCFA, along with the National Academy of State Health Policy, has undertaken studies and plans to propose *increased* quality assurance guidelines. In addition, Congressman Dingell has recommended a number of studies on the quality of care provided in Medicaid managed care plans across the country. Before reducing quality assurance, and before eliminating freedom of choice and mixed enrollment protections, recommendations made by the above studies should be evaluated first.

Senator Moynihan's bill goes in the wrong direction to relax federal quality assurance. Besides proposing elimination of the freedom of choice and mixed enrollment requirements, the proposed legislation provides very minimal quality safeguards that fail to offer any improvements over current requirements.

The proposed legislation relies on the use of internal "Quality Assurance Programs" (QAPs) to protect quality. This plan allows the fox to guard the henhouse. According to the legislation, each managed care plan will adopt its own QAP, pursuant to which each plan will identify what areas it will monitor, and each plan will adopt its own standards and methods for assessing quality of care.[21] In essence, each plan will be reinventing its own wheel, and the only standard to which the plan will be held will be its own.

The GAO has reported recently on the dangers of inadequate oversight when states permit managed care plans to operate with too much flexibility.[22]

Our clients would prefer federal guidance and oversight on the standards to be used to measure quality. We recommend that the federal government adopt clearly articulated and uniform standards:

(a) to measure adequate access to physicians, through physician to patient ratios (relating both to primary care and specialty providers), geographic and transportation factors, and timeliness of waits for appointments;

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[17] Hurley, Freund & Paul, *supra* note 10 at 178.

[18] GAO, "Managed Care: Oregon Program Appears Successful but Expansions Should be Implemented Cautiously," (T–HRD–91–48) (Sept. 16, 1991).

[19] 42 U.S.C. §1396b(m)(2)(D).

[20] *Id.*

[21] *Cong. Rec.* at S18389 §3(a)(1)(A)(xiv)(VI).

[22] *See eg.*, GAO, "Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area," (HRD–90–81) (Aug. 1990) (state's failure to monitor contracting and subcontracting arrangements created dangerous risks of underservice); GAO, "Managed Care: Oregon Program Appears Successful but Expansions Should be Implemented Cautiously," (T–HRD–91–48) (Sept. 16, 1991) (GAO recommends that Oregon strengthen its oversight of providers for fear that expanded managed care raises risks of financial abuse and plan insolvencies).

(b) to measure access and quality of care through outcomes, such as fulfillment of requirements to provide eligible children with full EPSDT screens, fulfillment of requirements to provide pregnant women with timely prenatal care, and birth outcome measurements;

(c) to ensure capitation rates are adequate to ensure access to all required services, including essential preventive and prenatal care;

(d) to ensure risk pools are actuarially sound; and

(e) to ensure that financial incentives imposed on individual physicians do not impinge on recipients' access to needed care.

These standards should be used as benchmarks to which all plans are held. Failure to meet these benchmarks should result in the ability of enrollees to disenroll immediately, and in a prohibition against the plan's enrolling any new recipients until corrective actions are taken. Medicare provides a similar protection which is missing for Medicaid enrollees.[23] We recommend that in addition to providing for federal authority to enforce the above remedies, beneficiaries should be provided a private right of action to enforce these remedies themselves.[24]

V. STRENGTHENED STATE OVERSIGHT IS NECESSARY

We recommend requiring states to take a more aggressive role in monitoring Medicaid managed care plans. Most states have developed regulatory systems to monitor commercial Health Maintenance Organizations (HMOs). We suggest applying the same regulations to Medicaid managed care and giving enforcement authority to the same regulatory agencies. Even if Medicaid recipients do not have the benefit of actually being enrolled in commercial HMOs, they would be subject to the same quality controls as the insured middle-class population.

We also recommend making federal funding available to assist states in their regulatory activity over managed care, just as is done for nursing homes.

VI. CONSUMER INPUT IS NECESSARY

The proposed legislation requires that a group composed of state Medicaid staff, physicians, and representatives from public or private HMOs meet to make recommendations on criteria to be used to determine underutilization.[25] While this is a good idea, consumers are conspicuously absent from this group. We believe it is critical that beneficiaries be represented in this process for determining criteria to be used to measure underutilization.

VII. RECOMMENDATIONS

1. Do not eliminate the freedom of choice requirement. The federal waiver process provides an essential means for identifying and correcting problems before mandated enrollment is implemented.
2. Do not eliminate the mixed enrollment requirement. Access to mainstream HMOs that are forced to compete for enrollees who have the freedom to "vote with their feet" is an important protection against the risks of underservice.
3. Require the federal government to adopt clearly articulated and uniform standards by which access and quality of care can be measured.
4. Strengthen the federal government's and states' role in monitoring plans' compliance, and provide an independent means by which recipients can enforce these requirements as well.
5. Include consumers in any group evaluating criteria for measuring underutilization and any other issues related to quality of care.

Thank you for your consideration.

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[23] *See* 42 U.S.C. §1395mm(i)(6)(B)(ii) (once the Secretary notifies an HMO of its violations, the HMO may not enroll new recipients until the Secretary is satisfied that corrective action has been taken). In fact, Medicare provides extensive and comprehensive regulations governing managed care that is voluminous in comparison to the scant regulations governing Medicaid managed dare. *Compare* 42 C.F.R. §417 *et seq.* with 42 C.F.R. §§434.20–434.78.

[24] While HCFA has enforcement authority to prevent noncomplying plans from enrolling new enrollees, HCFA has been remiss in exercising this authority. *See* "HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards," GAO/HRD-92-11 (Nov. 12, 1991).

[25] *Cong. Rec.* at S18390 §4(a) (Nov. 26, 1991).

Prepared Statement of Kevin Moley

INTRODUCTION

I am pleased to be here today to voice our strong support for S. 2077, a bill aimed at tearing down the barriers which preclude States from taking full advantage of the benefits coordinated care can bring to the Medicaid program.

Let me take this opportunity to commend Senators Moynihan and Durenberger, the authors of the bill, and to recognize Senators Packwood and Roth, who are also cosponsors. We are grateful for the opportunity to foster our continuing dialogue on this and other key health policy issues.

Coordinated care systems have demonstrated their value to communities all over the country through expanded access for their citizens. To the many who take advantage of their services, they offer continuity of care instead of the hodge—podge of fragmented care. They can also offer improved quality through preventive services, and in particular foster early attention to problems that, if left untreated, could have serious health effects. Coordinated care systems can also offer an extra advantage of less paperwork burden and administrative hassle.

This Administration believes that coordinated care offers a proven, high—value choice for quality health care in the United States. Coordinated care opt ions are an essential building block in the President's comprehensive plan for health care reform. They are an integral component of a market—based, competitive system and are key to cost control nationwide.

The Administration supports coordinated care as an essential ingredient in any progressive movement toward health care reform in general.

At the outset, let me express the Administration's general support for S. 2077 and underscore our willingness to work with the Committee toward its enactment this year. We have some concerns with the bill as drafted which we are currently working to resolve in staff—level discussions. We are confident that these concerns can and will be resolved to the full satisfaction of both the Department and this Committee, and we will continue to make passage of a Medicaid coordinated care bill a priority.

COMMENTS ON THE BILL

That being said, let me make a few brief remarks on the bill.

Advantages of Coordinated Care for Medicaid

Coordinated care holds special promise for State Medicaid programs and their recipients. bluntly stated, fee-for-service medicine is increasingly failing to meat the needs of the Medicaid population. Today's Medicaid client faces greater difficulty accessing care through providers in the fee-for-service system.

Coordinated care systems provide clients with a point of entry into the health care system where their total health care can be managed. Providers in a coordinated care system will know the patient and the patient's medical history. This increases the opportunity for appropriate preventive care to be started before health problems get out of control.

Many Medicaid clients report using the emergency room because they do not have a regular source of care. Having access to a primary care provider through a coordinated care organization is, without a doubt, a much better alternative for a client than waiting in an over-burdened emergency room for care from an unfamiliar provider. A recent study by the HHS Office of Inspector General indicates over one-half to two-thirds of Medicaid emergency room visits are non-emergency. Moreover, our IG found that treatment in an emergency room increases the cost of the care from 3 to 5 times over the care received in a more appropriate setting for the same condition.

State Flexibility and Freedom of Choice Waivers

The Department supports providing States greater flexibility to manage health care for their Medicaid clients and to take control of Medicaid costs. On average, States now spend over 20 percent of their budgets on health care. Health care expenditures for Medicaid continue to grow. As States devote more and more of their budgets to health care, they feel the need for greater flexibility in controlling health care costs and an obvious way to do this is to take advantage of high quality, cost-effective coordinated care options.

The bill permits States to offer Medicaid clients a choice among coordinated care options and eliminates Federal approval of the "freedom of choice" waivers. Choices for Medicaid clients would be between, at a minimum, two coordinated care plans, or a coordinated care plan and a primary care case management program. The one exception to this would be in an area where at least two-thirds of Medicaid providers belong to the coordinated care organization. In this case, the client would have a choice among primary care providers participating with that particular coordinated care entity.

Current law requires that, without the "freedom of choice" waiver, Medicaid clients are to be given a choice between managed care and the "unmanaged care" in the fee-for-service system. This, as I already mentioned, often turns into costly trips to the local emergency room for non-emergency care. States, where the "freedom of choice" waiver has been granted, have been able to increase access to care and many have also been able to reduce inappropriate use of the emergency room.

Waivers to existing law are an appropriate' process for the Federal government to provide control and oversight for new concepts where there is some uncertainty about what the economic and behavioral implications might be for the programs and beneficiaries for which we are accountable. Therefore, as HMOs and other forms of coordinated care began to become part of the delivery process for Medicaid clients, it was appropriate that certain conditions be placed regarding the exclusive use of these organizations.

Coordinated care is, however, no longer new. HMOs and other forms of coordinated care have proven themselves on both the quality front and the cost-effectiveness front, both in the private sector and the public sector.

States that have extensively used coordinated care and primary care case management report substantial successes. For example, Kentucky's primary care case management program reduced infant mortality rates and, in the process, saved $25 million. Arizona's exclusive use of coordinated care for Medicaid shaved nearly six percent off of projected fee-for-service costs. HMOs serving the Medicaid population in Wisconsin are able to pay their primary care doctors more than Medicaid fee-for-service rates due to savings from reductions in unnecessary emergency services and hospitalizations. These HMOs cut expensive emergency room use by a third and inpatient hospital days by more than half.

Despite the promise of coordinated care, 89 percent of Medicaid clients continue to receive care through fee-for-service systems.

New QA Requirements Replace 75 Public/25 Private Enrollment Rule

The bill also permits coordinated care entities specified in this bill to serve a total Medicaid client base, eliminating the requirement that 25 percent of the enrollees be private pay. The actual effect of the 75/25 provision, as it is referred to, is that coordinated care plans have significant difficulty in meeting the private pay requirement, largely due to demographic and geographic reasons. The disappointing, end result is that fewer cost-effective, coordinated care options are available for these clients.

The primary purpose for the 75/25 provision has been to assure quality. Quality assurance is an area in health care which evolves regularly with sophisticated advancements toward measuring and improving quality. As this bill recognizes, the 75/25 requirement has not been that effective as a "proxy" for quality. As a replacement for the 75/25 requirement, S. 2077 provides that coordinated care plans establish an extensive quality assurance plan with State oversight responsibility and meet specific standards that measure quality of care. While the Department supports the replacement of the 75/25 requirement with quality assurance standards, we would caution against imposing burdensome standards that create barriers to managed care, or place a managed care institution at a competitive disadvantage to fee-for-service care.

Case Management

We are concerned with the language of Section 5 which relates to case management. This section does not affect the coordinated care portion of the bill. We are concerned that the provisions of section 5 may be too broadly written and interpreted. We will continue to work with the Committee on drafting language in this and other parts of the bill so that Federal spending would not increase thereby subjecting the bill to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990.

CONCLUSION

In closing, let me reiterate our general support for S. 2077 and for your efforts to improve the Medicaid program by fostering greater use of managed care. The legislation both provides States with the ability to control Medicaid expenditures and offers a quality alternative to the more traditional fee-for-service system that has poorly served Medicaid clients.

Expanded use of coordinated care, as specified in S. 2077, is at the core of the President's Comprehensive Health Care Reform Program. It promises high quality cost-effective care to all Americans. Thank you for the opportunity to comment and I will be glad to answer any questions.

PREPARED STATEMENT OF ALICIA PELRINE

Good morning, Mr. Chairman, members of the subcommittee. I am Alicia Pelrine, group director for human resources for the National Governors' Association. I appreciate the opportunity to talk with you today, on behalf of the nation's Governors, about the pending legislation to help states establish and operate managed care programs under Medicaid.

The Governors strongly support this legislation. Last year at their annual meeting, Governors put reform of the nation's health care system at the top of their agenda. The broad-ranging policy adopted at that meeting calls for a national health care system that is affordable, available, and of high quality for all Americans. Their vision of an American health care system includes a continuum of services including the availability of preventive and primary health care, delivery systems that are cost-effective as well as cost-efficient, and care management practices that assure appropriate levels of care in the most appropriate settings without reducing the quality of care. It is not by accident that many of the attributes of that vision are embodied in good managed care systems.

This legislation is not about adding a new service delivery system to the Medicaid program. This legislation creates a statutory change that will remove managed care systems from the administrative burdens imposed in the Medicaid program to enable states to test experimental approaches. In fact, managed care has been a part of Medicaid for more than 15 years. Prior to 1981, states had the option to establish managed care systems as part of formal demonstration projects with rigorous research designs and outcome evaluations. In 1981, managed care systems were elevated from the status of empirical research to the slightly more accessible but still somewhat Byzantine and administratively complex status of waivers.

With the passage of this legislation, managed care system can achieve full legitimacy in the program. Its time has come. For despite the cumbersome and difficult waiver process, managed care has proliferated into the Medicaid program. As of June 1991, more than 30 states have established Medicaid managed care programs operated through 225 plans and serving about 2.7 million beneficiaries—about 10 percent of the population. Why should managed care in Medicaid be considered a novel experiment when 40 million non-Medicaid citizens are currently enrolled in managed care programs?

These 11 years have been important. Much has been learned and a body of best practices has emerged. States now know of the sophistication and expertise required to implement a good managed care plan. Medicaid agencies have developed the specialized knowledge to administer such programs. A wealth of information and expertise is available regarding the assessment of fiscal solvency of programs. States have increasingly benefited from each other's experiences and are now designing and implementing systems that assure access to quality care for their clients.

The legislation offers some important provisions to facilitate the use of managed care in Medicaid. States would be able to establish risk-based, capitated managed care programs, and primary care case management programs without any waivers. Eliminating the waiver process frees precious staff time for other important functions in Medicaid agencies. This is not trivial and for those skeptics who think that the process is neither intensive nor trying, I challenge them to volunteer time at a Medicaid agency to write a waiver request and then be part of the process by which it is evaluated and, with luck, ultimately approved. The frustration of receiving five pages of questions on the "eighty-ninth day" must be experienced to be appreciated.

The legislation retains many of the existing federal requirements for risk-based managed care plans. Moreover, the legislation retains current law standards on protection from insolvency as well as a variety of other provisions that protect the client. The bill also has provisions that would make it easier to attract managed care providers. Under certain conditions, states could impose mandatory enrollment into a managed care plan, and states would have the option to receive federal matching funds for Medicaid Health Maintenance Organization (HMO) enrollees for up to six months, regardless of whether the individual remains eligible for Medicaid during that six-month period.

Since 1989, Congress has given community and migrant health centers special status in Medicaid under the Federally Qualified Health Care (FQHC) Program. Chief among benefits is 100 percent reasonable cost reimbursement for services. This legislation retains current law regarding FQHCs. However, there are some concerns about the relationship between FQHCs and Medicaid under managed care. For example, FQHCs, through their grantee status, must serve all comers regardless of their ability to pay. Moreover, their grantee status prohibits them from establishing a risk reserve unless they are a direct contractor of the Medicaid agency. FQHCs provide important care to populations in need in underserved areas. Congress can further affirm that special status and encourage the use of FQHCs in the delivery of care to Medicaid recipients by establishing enhanced federal matching funds for services provided by FQHCs.

The legislation also eliminates the 72/25 rule. This rule caps the number of Medicaid recipients in any HMO at 75 percent. While this rule was established as a proxy measure for quality, the National Academy for State Health Policy has found no evidence to support this claim. While the rule was assumed to ensure that the remaining 25 percent of a plan's clients to be private pay, in practice, they frequently represent clients from state-funded indigent care programs. The 72/25 rule is impractical. States must have the ability to establish plans that meet the demographic and geographic needs of the Medicaid population. For example, the Florida Medicaid program has a prepaid plan to provide care to recipients in Key West, Florida. The plan must have a waiver of the 75/25 rule in order to function because there are not enough non-Medicaid clients to meet the private pay percentages. Yet without the plan, Medicaid recipients might would have to seek primary care in an inappropriate hospital setting.

Quality of care at Medicaid HMOs has been a major point of debate. Clearly, quality does not and should not be sacrificed in the name of cost-efficiency. However, the quality provisions of the legislation reflect the best practices ad experiences of the last decade. HCFA continues to work with states and others to improve quality standards for managed care systems.

We have all heard the plethora of criticisms of the Medicaid program—limited or no access to physicians, the inability to establish a "medical home" for clients, the inappropriate use of emergency rooms for primary care. Managed care systems are designed precisely to address these problems. The states and the federal government have spent enough time testing managed care in Medicaid. It is time to give managed care a "full seat at the table." We hope that this legislation will get the full support that it needs for passage.

Thank you again for allowing me to appear before this subcommittee. The Governors and their staff look forward to working with you as we work to provide affordable health care for all Americans.

PREPARED STATEMENT OF DONALD W. RIEGLE, JR.

Today, the Finance Subcommittee on Health for Families and the Uninsured of which I am Chairman will hear testimony about S. 2077, the Medicaid Managed Car~ Improvement Act, introduced by Senators Moynihan and Durenberger and examine managed care plans under the Medicaid program. I commend Senators Moynihan and Durenberger for their leadership in moving forward to enable states to use managed care plans in their Medicaid programs without needing a special waiver from the Department of Health and Human Services.

Increasing the availability of managed care is a goal shared by many of the health care reform proposals that have been introduced. HealthAmerica, the bill I introduced with Senators Mitchell, Rockefeller, and Kennedy, includes provisions to promote the use of managed care. It increases access to managed care for small business through insurance reform, and it makes managed care options available to people enrolled in the new public health insurance plan. It also removes current barriers that limit the use of managed care in the public and private sectors. The Finance Subcommittee I chair has heard testimony about the need and support for these changes.

Managed care plans, when properly designed, can provide comprehensive coverage for recipients while making efficient use of health care resources. The Medicaid Managed Care Improvement Act gives states greater flexibility to provide managed care through their Medicaid program, giving them a way to control health care costs while maintaining or even expanding the level of benefits a low-income family will receive. This bill also recognizes the variety of arrangements that make up managed care, allowing states to use some of the newer forms of managed care plans.

This hearing will give us an opportunity to bring together representatives of beneficiary groups, providers, state Medicaid administrators, and other interested groups to talk about managed care programs under Medicaid. I want to work with Senators Moynihan and Durenberger to make it easier for states to enact managed care plans under their Medicaid programs, while maintaining the highest possible quality of care for beneficiaries.

PREPARED STATEMENT OF SENATOR WILLIAM V. ROTH, JR.

Mr. Chairman, today's hearing will focus on legislation to give states more flexibility in running their Medicaid plans. I am an original cosponsor of Senator Moynihan's bill the "Medicaid Managed Care Improvement Act of 1991" (S. 2077) because I believe that it will provide States with a greater ability to make their Medicaid programs more effective in providing health care to low income individuals by implementing managed health care principles.

In addition to supporting managed care as a means to deliver quality cost effective health care in this bill, I am developing another proposal which will also incorporate managed care as a key component. I am currently devising a system to increase access to health care for small groups who currently are faced with prohibitive health care premiums by introducing a model managed care system in the Federal Employee Health Benefits Plan (FEHBP) and then opening up the plan for buy-in by the small business and working uninsured.

Managed care, in the form of health maintenance organizations, preferred provider organizations, and primary care case management programs, has demonstrated that it is a cost-efficient and high quality means of providing health care. We should grant states latitude as they attempt to slow the rate of increasing health care costs and improve the care delivered to low-income individuals.

The Delaware Department of Health and Social Services Secretary Thomas Eichler has indicated his strong support for this proposal. In a letter to me, Secretary Eichler stated that " . . . this bill would do a great deal to improve access to appropriate health care while also reducing the enormous costs associated with delayed, inappropriate or unnecessarily costly utilization." In my view, combining quality care and reduced costs is certainly a worthy goal for any states.

The nature of a typical managed health care plan is to stress access to primary care. It is well-known that one of the positive aspects of the focus on primary care in managed care plans is that it is prevention oriented with increased access to routine exams and diagnostic tests. Greater access to routine preventative care such as physician examinations also provides individuals with more consistent care and treatment with better follow-up for patients. The continuity of care in a managed care setting is particularly significant for individuals with chronic illnesses or extended conditions. All too often, Medicaid patients seek care only once they are very ill in hospital emergency rooms or other areas of last resort because they do not have physicians' in their area who accept Medicaid. Managed care would redress this current deficiency.

This bill will also benefit States since it will eliminate the onerous Federal rules now impeding many states from putting in place managed care plans under Medicaid. At this time when States are under a great deal of fiscal pressure and are also faced with high numbers of uninsured individuals, I believe the Federal Government should work to allow States greater flexibility in approaching the problem of coverage. States will have a better opportunity to extend health care coverage in a manner tailored to each state's Medicaid population's need. As the system becomes more cost-efficient, health care could be extended to a larger population without reducing benefits to those already being served.

In Delaware, the Indigent Health Care Task Force has been studying how to resolve the problem of the 72,000 uninsured in the state or 12% of the State's non-elderly population. In this challenging fiscal environment, managed care is an appropriate tool for States to turn to in trying to control costs without cutting benefits or restricting eligibility. The bill now being discussed in today's hearing could help extend access to those currently uninsured. As I work to develop my proposal which will build on the FEHB plan, I look forward to learning how managed care can work in a positive way to increase access to quality affordable health care.

PREPARED STATEMENT OF JANET L. SHIKLES

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today to testify on the role of managed care in state Medicaid programs. GAO has been looking at these programs for years and currently has several reviews underway.[1] Based on this work we have gained insights that may be helpful to the Congress as it considers removing barriers to states' use of managed care in the Medicaid program.

BACKGROUND

Medicaid, the largest government program financing health care for the nation's poor, is being severely strained by the continuing rise in its size and cost. From 1989 to 1991, total recipients increased almost 18 percent, to 27.7 million. This number is expected to reach 30.1 million in 1992. Just as telling as the rise in people receiving services is the escalation in program costs. For 1992, expenditures are estimated at $127.2 billion, a 38 percent increase over the 1991 total of $92.2 billion. Some predictions see Medicaid matching—if not exceeding—the size of the Medicare program by the middle of this decade.

At the same time as this tremendous growth is occurring, however, there is a general unhappiness with the traditional fee-for-service Medicaid program. Problems in accessing the health care system can be acute for Medicaid recipients because few providers actively participate. As a result, emergency rooms are used inappropriately—and at a very high cost—as primary care clinics.

Faced with continued growth in the number of Medicaid recipients and program costs, federal and state policy makers are turning to managed care as a way of getting better access and quality for the money they spend. "Managed care", or "coordinated care" as it is sometimes referred to, is widely used in private sector health care. Generally it refers to a health care delivery system with a single point of entry. A primary care physician participating in the health plan provides basic care and decides when a referral to a specialist or admission to a hospital is necessary. Usually the health plan receives a set monthly fee (called a capitation payment) to provide care and is then put at financial risk. That means that if the cost of services provided to an enrollee client is greater than the fee received by the health plan, the health plan loses money.

Managed care plans in Medicaid cover a wide variety of health delivery arrangements. These range from health maintenance organizations (HMOs) that are capitated for providing all health services an enrollee needs, to groups of physicians in independent practice who are paid a small case management fee in addition to fee-for-service payment for managing other services delivered (primary care case management).

GREATER USE OF MANAGED CARE PERCEIVED AS WAY TO IMPROVE ACCESS AND QUALITY

In the 1980s, the federal government increased states' options for use of managed care delivery programs as a way to contain costs in the Medicaid program. Although there have been managed care programs in Medicare and Medicaid since the 1970s, the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981—P.L. 97–35) gave states greater flexibility in contracting with HMOs or other managed care health plans. In 1982, the Health Care Financing Administration (HCFA) approved Medicaid managed care demonstrations in 6 states. OBRA 1981 also allowed the Secretary of Health and Human Services, through HCFA, to grant states waivers of federal Medicaid rules—specifically, the requirement that recipients have a free choice of providers to permit the states to develop, among other things, managed care systems.[2]

By 1991, 32 states and the District of Columbia had one or more managed care plans for Medicaid recipients. Medicaid managed care enrollment increased from 187,340 in 1981 to 2,837,500 in 1991, and growth is expected to continue. Approximately 11 percent of all Medicaid recipients currently are enrolled in managed care programs. Of this total 36 percent are in HMOs and 45 percent are in primary care case management fee-for-service programs.

The Administration, facing the same pressures from program growth as the states, is advocating managed care as a potential solution to problems of cost, qual-

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[1] For example, GAO is currently completing its review of the managed care program in Oregon, as it relates to the broader demonstration the state has proposed. We are also conducting a review of Medicaid managed care programs throughout the country. These studies were requested by Reps. Henry Waxman and John Dingell, respectively. Information in this testimony on the Oregon Medicaid managed care program draws on testimony presented in a hearing before Mr. Waxman's subcommittee last fall. ("Managed Care: Oregon Program Appears Successful But Expansions Should Be Implemented Cautiously" (GAO/T–HRD–91–48, September 16, 1991)).

[2] For this reason, many of the current Medicaid managed care programs are called "freedom of choice" waiver programs. They also may be called "section 1915(b)" waiver programs, referring to the section of the Social Security Act in which they are described.

ity, and access for Medicaid recipients. The President's Comprehensive Health Reform Program presented in February 1992 proposed a radical transformation of the Medicaid program from a fee-for-service system to a managed care system.

SAFEGUARDS AND OVERSIGHT MISSING IN CHICAGO MANAGED CARE PROGRAM

To make managed care work, adequate safeguards and oversight are crucial. Our previous reviews of Medicaid managed care programs have identified problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency.[3] For example, our 1990 report on Chicago area HMOs participating in managed care under contract to the Illinois Medicaid agency, illustrates the abuses that can occur if safeguards and oversight are not adequate.

One of the major problems we reported was the incentive to underserve. While the incentives inherent in fee-for-service health care may encourage providers to deliver too many services, prepaid managed care may encourage providers to deliver fewer services, and poorer quality services, than enrollees need. These incentives were created in Chicago when some of the HMOs passed through to their subcontractors the financial risk of providing care.

The HMOs were paid a capitated rate by the state for providing care, thus assuming the financial risk of providing the care. In some instances, however, the HMOs subcontracted with medical groups or individual practice associations, who would then contract for services with primary care physicians. At each stage the financial risk of providing care was passed along in the form of a capitation payment. This resulted in a large amount of risk being placed on an individual or small group of physicians, increasing the likelihood that clinical decisions would be inappropriately influenced by the cost of implementing those decisions.

One possible indication that Medicaid recipients enrolled in the Chicago HMOs were having trouble getting needed services was their high turnover rate. Over 58,000 Medicaid recipients voluntarily left their HMOs during fiscal years 1986 through 1988 to return to fee-for-service.

We also found inadequacies in the Chicago HMOs quality assurance programs, utilization data, and follow-up to correct quality of care problems. Although the disenrollment mentioned above could indicate widespread dissatisfaction with the services being provided, the state did not conduct, or have the individual HMOs conduct, patient satisfaction surveys. Despite warnings from both the contracted peer review organization and state quality assurance staff about a lack of services provided to enrollees, the state did not move quickly to determine whether there was a documentation problem or needed services had actually not been provided.

OREGON MANAGED CARE PROGRAM AVOIDS INHERENT PROBLEMS

While we found serious problems in the Medicaid managed care program in Chicago, our current review of Oregon indicates that concerns about many of these problems can be lessened through oversight and appropriate safeguards. Oregon's Medicaid managed care program, which began in 1985 with HCFA approval, is generally well accepted by client advocacy and provider groups.

The Oregon program has grown gradually to an enrollment of about 65,000, primarily women and children. The state has contracts with 16 health service providers, with enrollments ranging from 800 to more than 16,000 Medicaid managed care clients. All but one of these providers are capitated for physicians and outpatient services only. Inpatient services for these Medicaid clients are provided on a fee-for-service basis.

In developing its program, Oregon put a number of safeguards in place to prevent inappropriate reductions in service delivery and quality.[4] For example,

—the state limits the financial risk most providers assume to the cost of physician, laboratory, X-ray, and well-child services;

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[3] *Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans* (GAO/HRD-86-10, Nov. 22, 1985); *Medicaid: Lessons Learned From Arizona's Prepaid Program* (GAO/HRD-87-14, Mar. 6, 1987); *Medicaid: Early Problems in Implementing the Philadelphia HealthPASS Program* (GAO/HRD-88-37, Dec. 22, 1987); and *Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area* (GAO/HRD-90-81, Aug. 27, 1990).

[4] The state currently has pending with the Secretary of Health and Human Services a proposal to substantially expand its Medicaid program. The demonstration project is designed to expand Medicaid eligibility to all persons with incomes up to 100 percent of the federal poverty level while redefining the scope of health care services the state will reimburse. Services will be provided through a managed care system that is moving toward full service prepaid health plans capitated to provide inpatient as well as ambulatory care. Full implementation is scheduled to begin six months after approval of the proposal.

—the state provides optional state-sponsored insurance (stop-loss) to limit the financial risk physician care organizations face;
—the state pays a capped bonus to participating providers for savings from inpatient utilization below target levels, reflecting treatment decisions made by all physicians, as a group, for all Medicaid patients enrolled in that provider; and
—the providers have incentive arrangements with their individual physicians based on treatment decisions made by all physicians about all patients.

To ensure adequate quality, Oregon requires providers to maintain internal quality assurance programs and annually conducts an independent review of medical records through a contract with a physician review organization. Further, Oregon assesses quality through client satisfaction and disenrollment surveys, and a grievance procedure.

CONCLUSIONS

In conclusion, managed care programs can offer an opportunity to improve access to quality health care. Because of the financial incentives of such programs and the vulnerability of the Medicaid population, we believe a set of safeguards must be instituted to assure adequate protection for recipients. These include a quality assurance system that requires client satisfaction and disenrollment surveys; a grievance procedure; and an outside independent review of medical records. Further, to reduce financial risks, states need to monitor:

—the financial arrangements between the contracting plan and its individual providers for excessive incentives not to provide necessary services;
—utilization data to determine if the appropriate amount of services are being provided;
—subcontracts in the same manner as contracts because the same problems can arise.

Finally, effective state and federal oversight is needed along with prompt corrective actions when problems are identified.

PREPARED STATEMENT OF CONGRESSMAN ED TOWNS

Mr. Chairman, members of the Subcommittee, I am honored to be here today. Making quality health care services available to Medicaid recipients is one of the biggest challenges facing this country. And it is a battle we simply cannot afford to lose. At present, one-third of African-American deaths each year could be prevented if adequate health care were available. We have to correct this situation now, before even more lives are needlessly lost.

For this reason, I strongly support S. 2077, The Medicaid Managed Care Improvement Act, and will introduce its House counterpart. By coordinating services and making sure that physicians are responsive to patients' needs, managed care can both use our health care dollars more effectively and improve the quality of care Medicaid recipients receive. We need to encourage, not discourage, managed care in state Medicaid programs. This legislation will eliminate the needless obstacles that stand in the way of many states and prevent them from providing the highest quality of care.

Despite managed care's many proven successes, some are still skeptical particularly when it comes to managed care the Medicaid population. For these people, managed care means "rationed" care. In my view, nothing could be further from the truth. An examination of the myths surrounding managed care is long overdue. And there are three points in particular that I'd like to address.

First is the view that managed care should not be encouraged because it unfairly restricts Medicaid recipients' freedom of choice.

I disagree. In most cases managed care can actually increase Medicaid patients' access to health care. Under the current fee-for-service system, freedom-of-choice all too often means no choice. "Freedom-of-choice" becomes a meaningless concern when there are few or no providers willing to serve you.

A recent comparison of Medicaid and non-Medicaid hospital admissions in New York State reveals the failure of the current system to assure that Medicaid recipients have access to the services they need. That study, commissioned by the New York State Association of Counties, found that Medicaid recipients were much more likely than non-Medicaid patients to be hospitalized for "subacute" conditions—that is, common conditions such as ear infections, asthma, hypertension, and diabetes. *What is alarming about this finding is the fact that these conditions would ordinarily not require hospitalization if the patient had been treated at an earlier stage* *on an outpatient basis.* This study concluded that, even in higher income communities where there are plenty of doctors, there is little assurance that Medicaid recipients have access to them.

This lack of access to primary care is readily apparent in the District I represent. Of the 331 primary care physicians practicing in North Central Brooklyn, only 18 accept Medicaid and meet the basic criteria for an acceptable medical practice—that is, 24-hour coverage, 20 or more regular office hours a week, and admitting privileges at a hospital. Thus, for many of my constituents, freedom of choice all too often means choosing among a costly, low-quality Medicaid mill, a hospital emergency room, or, more likely, doing without care altogether.

Enrollment in a managed care plan, by contrast, can assure that Medicaid recipients in Brooklyn and elsewhere have access to physicians whose credentials are carefully evaluated and who are required to be available to their patients on a round-the-clock basis. Moreover, the services provided by these doctors would be closely monitored, so there is little chance of the substandard care recipients too often receive in the traditional fee-for-service Medicaid program. Managed care can achieve these results by guaranteeing participating doctors higher rates and a large pool of patients; in return, the physicians must adhere to the plans' stringent quality standards. Under these circumstances, managed care can only be considered to increase, rather than diminish, the choices and the quality of health care services available to Medicaid recipients.

Let me cite just two examples of the kind of success managed care systems can achieve:

- Healthpartners of Philadelphia improved health care for infants simply by persuading 142 out of 145 mothers to deliver at the same hospital where they received prenatal services.
- Alabama decreased its infant mortality rate from 12.1 to 10.9 within one year through the use of a primary care case management system.

Because of low Medicaid reimbursement rates, without a managed care plan, it is unlikely that mothers in either state would have seen a doctor on a regular basis, and they would most likely have ended up delivering their babies in an emergency room. The success these programs have achieved is largely due to their emphasis on *continuity* of care—an element that is missing from the fee-for-service Medicaid program.

Second, I'd like to address the concern that Medicaid-only managed care plans provide second class medicine.

Again, I disagree. Non-Medicaid enrollment by itself simply can not guarantee quality. And it is the prohibition against Medicaid-only plans in current law that has proven to be one of the most significant obstacles faced by managed care plans that wish to serve a Medicaid population.

The so-called "75-25" composition of enrollment rule prohibits a State from contracting with a managed care plan unless the plan has at least 25 commercial enrollment. The 75–25 rule was intended to promote quality of care, by ensuring that a plan's Medicaid members would receive the same services as its private-pay members.

The 75–25 rule, however, ignores the realities of the inner-city neighborhoods where most Medicaid recipients live. Over one-third of the population of the district I represent, for instance, is eligible for Medicaid. There are just not enough privately-insured individuals for a plan to satisfy the 25 commercial enrollment requirement. As a result, few plans are interested in serving the area. Even if a commercial plan were to venture into my district, it is highly unlikely that it would be willing or able to address the particular needs of my constituents—which are very different from those of the typical private-pay enrollee.

A better approach, and the one adopted by S. 2077, is to eliminate the 75–25 rule and replace it with more direct means of assuring quality of care. We should not permit arbitrary measures of quality to continue to retard the development of managed care for the Medicaid population.

Finally, I'd like to emphasize that managed care need not displace the elements of the health care system that are working. The most successful managed care networks are the ones that draw upon the experience and expertise of those in the neighborhoods, notably the community health centers, who have traditionally provided primary care. Indeed, the local community health centers are an integral part of the managed care network being developed in my district, and I expect them to enter into similar arrangements with managed care plans across the country.

The rules currently governing managed care in the Medicaid program may be well-intentioned, but they do not work. They have produced a health care system that favors Medicaid mills and hospital emergency rooms over coordinated delivery mechanisms. This is a system, Mr. Chairman, in which 25% of the citizens of New York City do not have access to a primary care physician. And a system in which one-third of African-American deaths could have been prevented if adequate care had been available.

We can no longer tolerate these rigid and counter-productive rules. It is time we permitted States the flexibility they need to truly coordinate, and thereby improve, the health care available to Medicaid recipients.

Prepared Statement of Anthony Watson

Good morning Mr. Chairman and members of the Subcommittee, my name is Anthony Watson. I am President of the Health Insurance Plan of Greater New York (HIP). HIP is a non—profit group model health maintenance organization (HMO) HIP serves approximately 1.1 million members in the five boroughs of New York City; Nassau, Suffolk and Westchester counties and through its affiliate- plans in New Jersey and southeast Florida. I am also a member of the Group Health Association of America's (GHAA's) Board of Directors.

I appear here today on behalf of GHAA, the oldest and largest trade association for HMOs whose member organizations serve more than two—thirds of the 36.5 million individuals enrolled nationwide in 550 HMOs.

HMO Participation in Medicaid

Over time, HMOs have emerged as a proven mechanism for providing quality, comprehensive health care at an affordable price. Through their integrated systems, HMOs can improve upon the episodic and uncoordinated way in which many Medicaid beneficiaries frequently receive medical care in the fee-for-service system. We emphasize early access and preventive services such as prenatal and well baby care; avoiding more serious and costly illnesses, and ultimately enhancing an individual's economic productivity. Further, the HMO panel of providers guarantees beneficiary access to physicians and necessary health care services.

In an era of continuing health care inflation, HMOs offer both public and private sector purchasers a proven mechanism for providing beneficiaries access to comprehensive quality care at a reasonable price. In New York State, for example, HIP has served the Medicaid population since the inception of the state Medicaid program in 1966. We are the largest provider of managed care in the state of New York, providing comprehensive health care to more than 40,000 New York Medicaid enrollees. We also serve an additional 1,575 Medicaid enrollees in the state of New Jersey thru a newly initiated contract with the State.

HMOs must meet a long list of requirements dealing with benefit offerings, access and availability of services, quality of care, rate setting, limits on copayments, financial solvency, physician incentive arrangements and marketing. States and Congress have done this through strong state licensure laws for HMOs and the Federal HMO Act. In many cases, the standards to which we are held are higher than for any other segment of the health care marketplace.

Unfortunately, a variety of obstacles limit the effective involvement of HMOs in the Medicaid program. According to the Health Care Financing Administration (HCFA), as of June 1991, 134 HMOs participated in the Medicaid program, enrolling almost 1.3 million Medicaid beneficiaries. While HMOs are located in almost every state, currently only 25 state Medicaid agencies contract with HMOs.

Barriers to Participation

An April 1990 GHAA survey identified two fundamental problems that limit and may eventually decrease the effective involvement of HMOs in the Medicaid program; marketing and adequate payment levels. (See Attachments.)

Marketing. Due to the nature of the Medicaid system, marketing an HMO product can be a time—consuming and expensive process. First, states generally cannot provide HMOs with direct access to Medicaid beneficiary names and addresses, so any marketing by an HMO is done largely on an individual basis. This is a different practice for HMOs since most HMOs primarily have group contracts with employers.

Second, marketing is also complicated because unlike HMO commercial enrollment which is annual, Medicaid enrollment is on a day-to-day basis, thus making it difficult for HMOs to plan and forecast services based on a stable enrollment.

Third, the welfare system complicates matters by disenrolling Medicaid beneficiaries as soon as they lose their categorical eligibility. Continuity of health care services is impeded if beneficiaries are not re-enrolled into the HMO they had prior to this brief break in eligibility.

More discussion of these issues is included in the attachments, but as you can tell, the impact of these factors result in a disjointed and costly process and one that is unlike any other HMO beneficiary population experiences.

Payment. Payment to HMOs serving Medicaid beneficiaries is a serious problem and is left to the discretion of the fifty states. States pay HMOs a prepaid, capitated rate to provide services to Medicaid beneficiaries. The only effective restriction on Medicaid HMO capitation levels is that the states cannot pay HMOs more than the cost of serving comparable Medicaid individuals on a fee-for-service basis.

In practice, HMOs are typically paid considerably less—sometimes as much as ten percent less, than the already low reimbursement paid in the fee-for-service Medicaid sector. Yet, in addition to providing medical care for the capitation, HMOs must also pay for a number of services not provided under the fee-for-service system, including: marketing, oversight of quality assurance, administrative costs and coordinating care. These costs are not reflected in the fee-for-service medical cost-base formula.

States should provide HMOs with an additional capitation allowance for administrative costs. When Medicaid beneficiaries enroll in HMOs, states are relieved of substantial utilization review and claims processing expenses, which are shifted to HMOs.

We believe that payment to all Medicaid providers must be actuarially sound. The federal government should require that Medicaid rates paid to HMOs be verified as reasonable by an outside, independent actuary. Adequate payment levels are essential if Medicaid wants to assure adequate provider access for Medicaid beneficiaries including participation by HMOs.

GHAA believes that alternatives to fee- for-service based rates should be explored, particularly in areas with high HMO penetration or where the fee-for-service base is inadequate or already subject to extensive cost containment. Until such alternatives are developed, it would be more appropriate to pay the equivalent of the full fee-for-service payment level until such time as better alternatives are developed.

COMMENTS ON S. 2077

GHAA strongly supports the encouragement of HMO participation in Medicaid. S. 2077, the "Medicaid Managed Care Improvement Act of 1991," introduced by Senator Moynihan, goes a long way in addressing some of the barriers to HMO participation that exist in the present Medicaid program. These include:

Expanding Medicaid Managed Care Participation. S. 2077 would make it easier for state and county Medicaid agencies to contract with various managed care entities. Managed care entities under the bill include, but are not limited to, HMOs. Under S. 2077, managed care plans would also include entities such as preferred provider organizations (PPOs) and primary care case management programs (PCCMs).

The bill allows Medicaid agencies to contract with these entities without first going through the federal waiver process. HHS would still review all contracts, but it would no longer be on a prior approval basis.

We support this provision. Federal prior approval requirements are administratively burdensome, costly and time consuming. We support the provision in the bill that would convert the current waiver requirements to state plan amendments, with more appropriate beneficiary protection provisions and federal oversight. We believe that giving the Secretary "look behind" authority is an appropriate and efficient way to administer the program.

However, given the vague nature of the definition of managed care, we are concerned about allowing non-HMO entities without any knowledge or experience in managed care to begin programs. Unfortunately, the fact that the HMO industry as a whole performs well, and importantly, that member satisfaction is very high, is sometimes lost when press attention, or a report, focuses on a few isolated problems. We are concerned that problems arising from non-HMO entities entering the managed care program without adequate oversight will only add to this problem.

While not all HMOs are federally qualified, all HMOs must meet certain state licensure laws and regulations which govern quality assurance, solvency, benefits and access. Although there is, of course, variation among the states, in recent years state HMO regulators and insurance commissioners have toughened requirements and attempted to gain uniformity by adopting model laws in this area.

We believe that *any* managed care entity contracting with Medicaid should have to be state licensed or certified and meet uniform standards on solvency, quality assurance and access to adequate provider networks. Without licensing requirements and regulatory oversight, the quality, stability and solvency of managed care plans cannot be guaranteed.

Similarly, as the Children's Defense Fund notes, not all providers are able to assume the financial risk inherent in an HMO managed care system. HMOs provide care for patients for a preset, fixed payment and incentive arrangements with providers are designed to promote efficient and effective delivery of quality health services. The goal is to preserve quality care and eliminate unnecessary services. HMOs use a complex variety of arrangements to accomplish this including physician incentives which are used to affect an appropriate pattern of practice, while not directly or indirectly making any specific payments that induce a physician or physician group to limit or reduce medically necessary services to a specific member.

Watts Health Foundation, Inc. in Los Angeles, California, serves as an excellent example of a non-profit corporation that operates federally qualified health centers (FQHCs) as well as a federally qualified HMO, United Health Plan. Although organizations who operate both FQHCs and an HMO with a Medicaid contract should be reviewed for possible duplication, these organizations are rare.

In fact, many HMOs with Medicaid contracts have had very limited involvement with community health centers (CHCs) and FQHCs. HMOs have found that some FQHCs see no reason to contract with an HMO for Medicaid enrollees since they can obtain a higher initial payment directly from the state. Additionally, HMOs have health care delivery requirements that provide standards for participating physicians and other health care professionals who contract with them. These requirements also include "shared risk arrangements" and many FQHCs are not prepared to be at risk for outpatient care.

For these reasons, we strongly oppose any recommendations to amend the current bill language to require mandatory subcontracting with certain health providers. We feel that required arrangements with such entities undermine the ability of the HMO to coordinate care and could seriously jeopardize the HMOs financial solvency, not to mention the quality of care provided to the beneficiary.

75/25 Enrollment Requirement/Quality Assurance. S. 2077 eliminates the current 75/25 enrollment requirement, whereby a plan cannot enroll more than 75 percent of its enrollment from public plans, i.e. Medicaid and Medicare; and substitutes specific internal and external quality assurance requirements in its place.

Because of the geographic distribution of Medicaid populations, a commercial population base of 25 percent may not be feasible for some providers committed to serving these low-income areas. While the 75/25 rule was intended to insure quality of care to Medicaid beneficiaries, there are better and more direct ways of assuring quality care without reducing access to care. Recognizing this, Congress made special allowances to permit waivers for certain HMOs under special circumstances. However, obtaining these waivers has been a long, tedious and sometimes political process.

All HMOs, whether federally qualified, state licensed, or contracting with Medicare or Medicaid, must have an internal quality assurance system. In addition to the HMO internal quality assurance programs, many HMOs are also assessed through systems of external review. In recent years, this external review process has become increasingly well-defined. In fact, HMOs which contract under the Medicare risk program are the only type of health care provider which have ambulatory care reviewed. GHAA supports external review of quality of care.

The National Association of Health Maintenance Organization Regulators (NAHMOR), which represents state regulators, has developed model legislation, regulations, and guidelines for quality assurance programs. At present, there is variation in state licensure requirements pertaining to HMOs, but it is anticipated that many states will follow the NAHMOR recommendations. NAHMOR's work represents an important initiative to improve state-level external review.

GHAA fully supports the concept of having HCFA work with states to determine and assure that HMOs and other managed care entities meet appropriate quality standards. One concern however, is the continued development of multiple and varying layers of quality review, as well as inconsistencies in quality assurance standards and requirements across states and across programs within states. Since all HMOs are already subject to state licensure requirements, we hope consideration will be given to reinforcing the processes already underway to create more uniformity and appropriate levels of oversight at the state level when fashioning modifications to the state—administered Medicaid programs.

We believe that *all* managed care plans contracting with state Medicaid programs should meet certain basic requirements on financial solvency, quality assurance and adequate networks. We believe these measures should, to the extent possible be uniform and should not be different for different populations, i.e.; private payers and public payers. These standards should be understood and accepted by industry, as well as by public and private purchasers. Responding to a variety of diverse reporting requirements only adds to the HMO's administrative overhead and detracts from their efficiency. Further, it reduces the amount of Medicaid dollars being spent directly on providing health care services.

Mandatory Enrollment. S. 2077 would permit mandatory enrollment in qualified managed care plans at the state option under certain situations.

While we have never supported mandatory enrollment, we know that several states, including New York, have developed programs of this type. Given this, we are concerned about the provision in the bill that requires a plan to include at least two—thirds of all physicians in a geographic area to participate under mandated enrollment. This is unrealistic given the current payment rates and geographic limitations in the Medicaid program. We would suggest that the current language be amended to read "a network adequate to provide for the services of the population as determined by the states under the oversight of the Secretary."

Guaranteed Eligibility/Continued Eligibility. S. 2077 permits, at the state's option, guaranteed eligibility, with state payment, for up to 6 months in a managed care plan regardless of whether the individual remains eligible for Medicaid during that six month period. The bill also permits a one month continued eligibility period in either managed care plans or PCCMs for Medicaid enrollees who briefly lose their eligibility but who can be reasonably expected to become eligible for enrollment in the month following ineligibility.

GHAA strongly supports both of these provisions noting that the federal matching payment available through the bill's conforming amendment to section 1902(e)(2) is a very important incentive to maintain continuity of care. Without federal matching, it is questionable whether states will include such a guarantee of eligibility in their state Medicaid plans or prepaid contracts.

CONCLUSION

Over time, the Medicaid program should aim to restructure itself so that it more closely resembles—from an enrollment perspective—employment based coverage. That is, beneficiaries should be encouraged to make an affirmative choice among a range of health plan options on an annual basis and remain with the plan for a year, as is the case with employed populations. For enrollees in HMOs this would enhance the ability of HMOs to coordinate preventive care and establish relationships between enrollees and providers outside of the emergency room, thus reducing costs, increasing the overall health care of the beneficiary, and reducing HMO administrative expenses. Finally, this would stabilize enrollment for HMOs and enable them to develop appropriate provider contracts and staffing levels for this population.

We believe that S. 2077 and the recommendations we have offered are positive steps in addressing some of the problems in the current Medicaid system and would serve to improve the quality and continuity of care by encouraging additional HMO involvement in the Medicaid program.

GHAA looks forward to the opportunity of working with you Mr. Chairman and members of the Committee in making HMOs a viable option in the Medicaid program. We thank you for the opportunity to testify today.

Attachments.

GROUP HEALTH ASSOCIATION OF AMERICA, INC.,
Number 11, August 1990.

GHAA SURVEY OF MEMBER PLANS WITH MEDICAID CONTRACTS: FINDINGS

[By Irma E. Arispe, Ph.D., Senior Research Associate]

Data from the Health Care Financing Administration (HCFA) show that as of June 1989, an estimated 1.1 million Medicaid beneficiaries were enrolled in HMOs and prepaid health plans (PHPs). Over 75 percent of these individuals were enrolled in 127 federally and state qualified HMOs.[1] These statistics, together with an overall increasing interest in the role of managed care in containing health care costs, have turned attention to the importance of better understanding the nature of Medicaid contracting with HMOs and PHPs. In the spring of 1990, at the request of GHAA's Subcommittee on Medicaid and the Uninsured, GHAA's Research and Analysis Department worked with the Johns Hopkins Health Plan to develop a survey

[1] "Report of Medicaid Enrollment in Capitated Plans as of June 30, 1989." Health Care Financing Administration, Medicaid Bureau, Medicaid Managed Care Office. June 1990.

for member plans with Medicaid contracts to gain insight into the nature of HMO participation in the Medicaid program, to assess satisfaction with program participation, and to identify obstacles to the effective participation of health maintenance organizations in the Medicaid program. The purpose of this study was to enable GHAA to provide HCFA, the states, and others interested in the Medicaid program with input to address the difficulties created for HMOs by the current structure of the program. This Research Brief highlights findings of this endeavor. A separate piece developed for the Subcommittee on Medicaid and the Uninsured discusses recommendations to address obstacles with the current program.

I. HMOS AND THE MEDICAID PROGRAM

According to the *GHAA National Directory of HMOs 1990*, as of year end 1989, 114 (or 19%) of the 591 plans had contracts with Medicaid.[2] These plans have a somewhat different profile from HMOs in general. Table 1 shows that compared to the distribution of all plans, a relatively larger percentage of plans with Medicaid contracts are staff model plans while a relatively smaller percentage are IPAs. Plans with Medicaid contracts are likely to be larger (40% have 50,000 or more members compared to 30% of all plans) and older (50% are 8 years or older compared to 32% of all plans). Finally, while the overall profile of plans shows that two-thirds have for-profit tax status, the vast majority of plans with Medicaid contracts are not-for-profit (70%).

II. PROFILE OF RESPONDENTS

The 52 GHAA member plans with Medicaid contracts are distributed equally across model types. Like other plans with Medicaid contracts, they tend to be larger, older, and not-for-profit plans. Thirty-seven of these plans (71%) responded to our survey. They represent 18 states (see Attachment 1) and enroll 507,217 Medicaid beneficiaries, or almost half of all Medicaid covered individuals enrolled in HMOs and PHPs.

The vast majority of these enrollees are covered by Aid to Families with Dependent Children or AFDC (86%). Two-thirds of the responding plans reported that 90–100% of their Medicaid enrollment is composed of AFDC beneficiaries. Other Medicaid enrollees include the aged, blind, and disabled (beneficiaries of the Supplemental Security Income program, or SSI), refugees, and "General Assistance" or "Medical Assistance" (state assistance programs for medically needy who are not Medicaid eligible). One plan reported that its Medicaid enrollment is composed entirely of non-AFDC Medicaid enrollees; this plan, a social HMO (SHMO), enrolled Medicaid beneficiaries age 65 and over.

The average number of enrollees per plan was 13,708; however, for most plans, Medicaid enrollees constitute a small portion of total enrollment. As shown in Table 2, for one-quarter of the plans, Medicaid enrollment comprised 1% or less of total enrollment. For half of the plans, Medicaid enrollees comprised less than 9% of total enrollment. Only 11% of plans were composed mainly of Medicaid enrollees (90–100%). Half of the plans have been involved in the Medicaid program for more than 10 years.

III. HMO PARTICIPATION IN THE MEDICAID PROGRAM

Rate Setting and Administrative Allowances

We asked plans how the state set their Medicaid rates and found that a variety of mechanisms are used including a percentage of the fee-for-service (FFS) equivalent, negotiated, cost based, or a combination of mechanisms. The predominant means by which rates are set is a percentage of the fee-for-service equivalent; 32% of plans reported that their rates were based exclusively on a flat percentage of the FFS equivalent. An additional 11% reported that a percentage of the FFS equivalent was used together with other mechanisms such as negotiation. Of the 26 plans whose rates included a percentage of the FFS equivalent, 31% received 96–100% of the FFS equivalent (See Table 3).

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[2] GHAA figures on number of HMOs and number of plans with Medicaid contracts are somewhat lower than those cited above by HCFA. This difference is due in part to the fact that HCFA data count multiple contracts with the same HMO as different plans.

Table 1.—PROFILE OF PLANS WITH MEDICAID

Plan Characteristics	All Plans (N=591)		Plans with Medicaid (N=114)	
	N	Percent	N	Percent
Model Type:				
Staff	61	10	25	22
Group	80	14	16	14
Network	89	15	20	18
IPA	361	61	53	46
Plan Size:				
0–19,999	242	41	45	39
20,000–49,999	178	30	24	21
50,000–99,999	82	14	18	16
100,000+	89	15	27	24
Plan Age:				
< 1 year	19	3	2	2
2–3 years	95	16	14	12
4–7 years	284	48	40	35
8–15 years	126	21	34	30
16+ years	67	11	24	21
Tax Status:				
Not for Profit	207	35	79	69
For Profit	384	65	35	31

Source: Analysis of Data from GHAA's National Directory of HMOs, 1990.

Table 2.—MEDICAID AS A PERCENTAGE OF TOTAL ENROLLMENT

[N = 37]

Percent of Total Enrollment	Number of Plans	
	N	Percent
1% or less	9	24
2–5	11	30
6–10	1	3
11–20	5	13
21–50	3	8
51–75	3	8
76–89	1	3
90–100	4	11
	37	100

Source: GHAA's Survey of Member Plans with Medicaid Contracts, 1990.

Table 3.—RATE SETTING—PERCENT OF THE FEE-FOR-SERVICE EQUIVALENT PAID TO RESPONDING PLANS

[Valid N = 26]

Percent of FFS	N	Percent
50% or less	1	4
51–75	2	8
76–90	4	15
91–95	11	42
96 or more	8	31

Source: GHAA's Survey of Member Plans with Medicaid Contracts, 1990.

Respondents were also asked if their plan received an administrative allowance in their rates and 46% reported that they did receive such an allowance.

Analysis of these data by state is not feasible, because the nature of rate setting and payments for services is complex and highly variable both between states and within a given state. For example, some states pay plans a "savings sharing bonus," in which an actuary determines what the plan has saved the state during that year and gives the plan a percentage of that savings. In this instance, two plans in the same state may report having received a different reimbursement. In addition, with respect to administrative payments, under a nonrisk contract, the net savings of administrative costs the Medicaid agency achieves by contracting with the plan (instead of purchasing the service on a FFS basis), may be returned to the plan as a reimbursement.

Nevertheless, rate-setting and administrative allowances are seen as highly important issues by the plans, both in terms of their own participation in the Medicaid program as well as for encouraging the future participation of other plans. These issues are discussed further in Section V, PROPOSALS TO CHANGE THE MEDICAID PROGRAM.

Stop-Loss Protection

Sixty-eight percent of the plans (N=25) reported that their state offered some type of stop-loss protection. Fifty-two percent of these plans (N=13) reported stop-loss levels ranging from $15,000 to $75,000 per patient per year, and the most frequently reported level was $25,000. Other plans reported that the stop-loss level was set at a specific number of days (e.g., 45 days) or that the level was negotiated on a plan to plan basis.

Thirty-eight percent of plans reported disease-category specific stop-loss provisions. One plan reported a limit on psychiatric days and ambulatory mental health visits. In most instances, however, the stop-loss provision was for AIDS. States have had difficulty establishing appropriate capitation rates for AIDS due to the relative lack of experience with the disease and the evolving treatment guidelines (e.g., indications for the use of AZT have changed). These factors lessen the utility of historical data as a basis for setting capitation rates. Consequently, reported stop-loss provisions vary as states struggle with how to appropriately cope with this problem. For example, the stop-loss limit for AIDS cases in the state of Maryland is $100,000. For full-blown AIDS cases, all health care expenses are counted against this stop-loss limit, regardless of whether the condition is related to AIDS. For Medicaid beneficiaries who are HIV positive (asymptomatic) or with Aids Related Complex (ARC), only expenses related to the condition itself (e.g., testing, AZT, etc.) are counted against the stop-loss. In contrast, the state of Michigan, rather than providing a monetary stop-loss to the plans, returns that person to the fee-for-service Medicaid program.

Quality Assurance

Medicaid regulations state that all HMO and PHP contracts must provide for an internal quality assurance system to achieve utilization control. We asked plans whether their state had established standards or requirements applicable to the plan's internal quality assurance program and two-thirds reported the existence of such standards. By and large, these standards are the same as those used in the state's HMO licensure program.

A variety of methods are used to verify compliance with these standards. The predominant means of verifying compliance are through periodic on-site review of the quality assurance program (70% of plans reported using this method) and review of the written quality assurance plan (57% used this method). Other means of verifying compliance include review of quality assurance committee meetings, monitoring complaints, and chart review. One plan reported that an explanation must accompany each voluntary disenrollment form the HMO submits to the state.

IV. SATISFACTION WITH MEDICAID

In general, most plans report being somewhat satisfied with their participation in the Medicaid program, despite expressed dissatisfaction with specific aspects such as data collection and reporting, rate setting, and responsiveness of the state. However, when asked to assess their satisfaction with Medicaid relative to their experience with other payers, we found a significantly higher level of dissatisfaction with the Medicaid program.

Table 4 arrays several aspects of the Medicaid program and shows the plans' reported satisfaction with the various aspects. Plans were most dissatisfied with state management of disenrollment (67% reported being dissatisfied), followed by state data collection (46%), state rate setting, state responsiveness to HMO needs, and state openness to changes in the program (44% each). The majority of plans were neutral with respect to opinions about their state's willingness to consider options requiring federal waivers, and opinions concerning federal marketing regulations. Opinions were mixed regarding satisfaction with state marketing regulations and state data reporting. No program aspect received a high satisfaction rating, but the most favorably rated aspect of the program was the state's system of data reporting (40% of respondents were satisfied, but 43% were dissatisfied).

Despite the lack of satisfaction with specific aspects of the Medicaid program when asked to evaluate overall satisfaction, 60% of plans reported that they were somewhat satisfied with their plan's participation. No plan reported being extremely satisfied, 27% said they were somewhat dissatisfied, and only 3% (1 plan) reported being extremely dissatisfied. However, when asked to compare their experience with Medicaid to their experience with other payers, it is clear that relative to other payers, experience in the Medicaid program is much less satisfying. Forty-seven percent of plans were either somewhat or much more dissatisfied with participation in the Medicaid programs 38% were neutral, and 15% were either somewhat or much more satisfied with Medicaid (See Table 5).

Table 4.—SATISFACTION WITH MEDICAID

[Specific Aspects of the Program]

Program Aspects	(Percent)		
	Satisfied	Neutral	Dissatisfied
1. Rate Setting	32	24	44
2 Federal marketing regs	24	54	22
3. State marketing regs	38	24	38
4. State data collection	22	32	46
5. State data reporting	41	16	43
6. State management of disenrollment	14	19	67
7. State willingness to consider options requiring Federal waivers	27	57	16
8. Responsiveness to HMO needs	32	27	41
9 Openness to changes	24	32	44

Source: GHAA's Survey of Member Plans with Medicaid Contracts, 1990.

Table 5.—SATISFACTION WITH MEDICAID

Satisfaction	N	Percent
Overall Satisfaction:		
Extremely satisfied	0	0
Somewhat satisfied	22	60
Neither satisfied nor dissatisfied	4	11
Somewhat dissatisfied	10	27
Extremely dissatisfied	1	3
Compared to Experience with Other Payers:		
Much more satisfied with Medicaid	2	5
Somewhat more satisfied with Medicaid	3	8
Equally satisfied with Medicaid	13	35
Somewhat more dissatisfied with Medicaid	13	35
Much more dissatisfied with Medicaid	3	8
Missing	3	8

Source: GHAA's Survey of Member Plans with Medicaid Contracts, 1990.

An open-ended question requested the respondents' opinions about the most satisfying and/or dissatisfying aspects of their participation in the program. Plans reporting satisfaction with the program cited the support of state and local staff as well as staff in the regulatory agency, a good rapport with state, county, and local officials, and efforts made by these officials to address and resolve problems in the Medicaid program. The most frequently expressed reasons for dissatisfaction appeared to be the state's handling of involuntary disenrollment, overworked staff in the Medicaid department, and low reimbursement levels. These results suggest considerable variability across the states in their approach to developing managed care programs.

V. PROPOSALS TO CHANGE THE MEDICAID PROGRAM

Respondents were presented a list of 17 proposals to modify the Medicaid program as it relates to HMOs and to rate each proposal on a scale from extremely desirable to extremely undesirable. Table 6 arrays the proposals by the percentage of respondents who rated the proposal as desirable. The proposals most frequently rated as desirable are: state funded support for incentives to enroll in HMOs (89% reported this proposal as somewhat or extremely desirable), the rolling eligibility guarantee (87%), six month guarantee of eligibility (86%), inclusion of administrative expenses in the determination of reimbursement rates (86%), and increased capitation rates (84%).

Many plans are neutral in their opinions concerning the proposal to modify the 75/25 rule (41% rated the option as neither desirable nor undesirable). Opinions were mixed on the issue of mandatory assignment to HMOs if no choice is made (38% rated the options as somewhat or extremely desirable, 11% were neutral, and 46% rated the option as somewhat or extremely undesirable).

The majority of proposals presented were rated as highly desirable. To obtain a more detailed assessment of the relative desirability of the proposals, plans were asked to rank them on two dimensions: (1) importance for their continued viability as a participant in the Medicaid program; and (2) the importance of the proposal in terms of encouraging other HMOs to participate in the program. Each proposal received a score depending on its ranking by the respondent.[3] Table 7 displays the proposals in rank order.

Increased capitation rates is the most highly ranked proposal both for the plans' continued Medicaid participation as well as to encourage the future participation of other plans. Thirty-five percent of the plans reported that this proposal is most important for their continued participation, and its score was significantly higher than scores for any other proposal. This proposal received an even higher score from the respondents in terms of its effectiveness in encouraging participation of other plans in the Medicaid program (43% of respondents ranked this proposal as first in importance).

Table 6.—PROPOSALS TO CHANGE MEDICAID

[In rank order]

Proposal	Assement (Percent)			
	Desirable	Neutral	Undesirable	Missing
State funded support for incentives to enroll in HMOs	89	8	0	3
Guarantee payment for brief periods of loss of eligibility (i.e., Rolling eligibility)	87	8	0	5
Include administrative expenses in reimbursement	86	0	0	14
Provide 6 month guarantee of eligibility	86	3	0	11
Increase capitation rates	84	16	0	0
Mandate that states educate Medicaid recipients about the option of HMOs	81	5	5	9
Establish allotment for HMO marketing expenses in Medicaid HMO rates	73	16	0	11
Require positive choice of health care option (e.g., Medicaid fee-for-service vs. HMO vs. other)	73	11	3	13
Establish standards for rate-setting methodology	70	11	5	14
Allow HMOs access to names or addresses of Medicaid recipients	70	16	10	4
Allow marketing staff direct access to Medicaid recipients in welfare offices at the time of initial eligibility determination	70	14	11	5
Establish automatic reenrollment in the HMO after reestablishment of Medicaid eligibility	70	8	8	14
Require that Medicaid recipients choose a single primary health provider	65	19	3	13
Restrict freedom of Medicaid recipients to disenroll	54	14	24	8
Mandatory assignment to HMOs if no choice is made	38	11	46	5
Modify the 75/25 rule	29	41	19	11

Source: GHAA's Survey of Member Plans with Medicaid Contracts, 1990.

[3] Plans were asked to rank the three most important proposals for their continued participation in the Medicaid program, and the three most important for encouraging other plans to participate. Proposals ranked first received a score of 1, those ranked second received a score of 2, and those ranked third received a 3.

Table 7.—RANKING OF PROPOSALS BY IMPORTANCE TO THE PLAN AND IMPORTANCE FOR ENCOURAGING NEW HMO PARTICIPATION

[Top Rated Proposals [1]]

Ranked in order of importance to the responding plan		Ranked in order of importance for encouraging new Medicaid participation	
Score	Proposal	Score	Proposal
47	Increase Capitation Rates	57	Increase Capitation Rates
32	Rolling eligibility guarantee	26	Six month guaranteed eligibility
18	Six month guaranteed eligibility	22	Include administrative expenses in determination of HMO reimbursement rates
14	Allow HMOs marketing staff access to welfare offices	21	Rolling eligibility guarantee
12	Include administrative expenses in determination of HMO reimbursement rates	13	State support for incentives to enroll
11	State support for incentives to enroll	9	Establish allotment for HMO marketing expenses
11	Automatic Reenrollment	6	Automatic Reenrollment
9	Restrict freedom to disenroll	5	Restrict freedom to disenroll
8	Mandate that states educate Medicaid recipients about the HMO option	5	Require positive choice (HMO vs. FFS vs. other)
7	Establish allotment for HMO marketing expenses	5	Allow marketing staff access to welfare offices

[1] Includes proposals with a score of 5 or more.

Source: GHAA's Survey of Member Plans with Medicaid Contracts, 1990

The next most important proposals for the plans' continued participation in the Medicaid program are rolling eligibility, a 6 month guarantee of eligibility, and access to Medicaid- beneficiaries in welfare offices at the time of initial eligibility determination. That these options are ranked next in importance speaks to the operational difficulties plans have with marketing and enrollment in the current Medicaid program. These findings are consistent with reported reasons for satisfaction discussed in the previous section. Plans reported being most dissatisfied with their state's management of disenrollment. Furthermore, when plans were satisfied with their participation, it was because of the state's efforts to address the issue of changing eligibility in the Medicaid program. The following comments made by respondents describe the difficulties of changing eligibility:

—"One month we received over 200 disenrollments because they had not been done on a timely basis at the welfare office. This caused an administrative burden on the plan and devastated our forecasted enrollment. A six month guarantee of eligibility would be very helpful—it would prevent Medicaid beneficiaries from enrolling one month and disenrolling the next month. This kind of turnover is a waste . . ."

—"Management of disenrollment due to loss of eligibility (is a problem). Although disenrollment from (our) HMO is automatic—when eligibility is regained, reenrollment into the HMO is *not* automatic. The HMO is required to re-enroll the individual."

In instances where the HMO must reenroll individuals, access to the Medicaid beneficiary may be key.

Plans reported that the 6 month guarantee of eligibility and rolling eligibility would also be important to encourage other plans to participate in the Medicaid program. Other highly ranked proposals to encourage the participation of other plans relate to creating financial incentives (inclusion of administrative incentives in rate setting and state support for incentives to enroll in HMOs).

VI. CONCLUSIONS

We asked the plans how likely they are to remain in the Medicaid program if there are no significant changes to its structure. Sixty-five percent report they are very likely to remain in the program; however, this figure may be misleading since some plans have limited discretion as to whether to participate in the program. For example, some respondents must participate as a condition of receiving other contracts with the state; others are social HMOs with a mission is to serve this population. In addition, plans which are located in inner city areas must participate in some form with Medicaid by virtue of the number of Medicaid beneficiaries in their service area.

More noteworthy is the 35% of plans whose future participation in the Medicaid program is less certain. One respondent writes:

> "It is very difficult to maintain a positive attitude towards a program which imposes unattainable standards that bear no resemblance to fee-for-service or even to commercial prepaid managed care program standards, and which are unrealistic and possibly even undesirable within the context of the population being served."

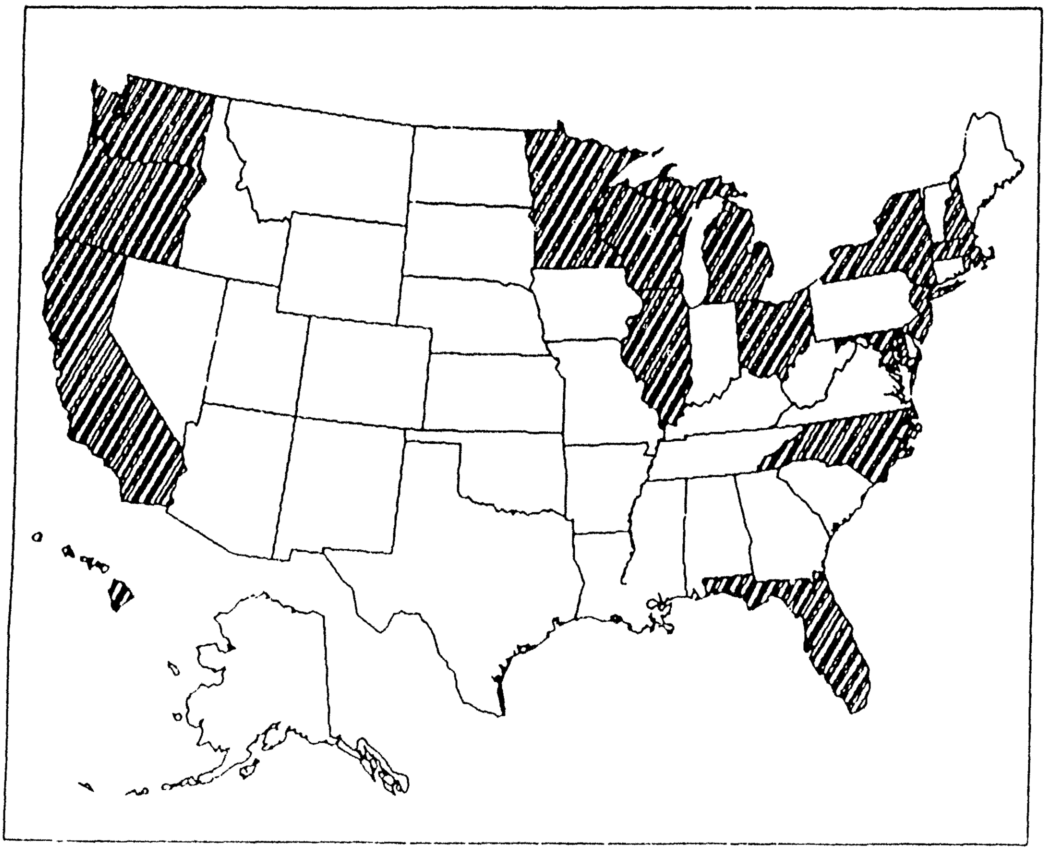
For plans such as these, a more cooperative working relationship with Medicaid officials may make the difference in their continued participation. Another respondent writes,

> "Perhaps the biggest challenge to our program is changing clients' expectations and care-seeking behavior so that the managed care system can work well for them. HMOs cannot accomplish this task alone. It will take the constructive participation/involvement of providers, welfare case-workers, community organizations, state and local agencies, and, of course, the clients."

Despite the difficulties of HMO-participation in the Medicaid program, the majority of plans intend to remain. The chief reason they cite for doing so is their ideological commitment to serve this population. Our final question to respondents was an open-ended question: "What are the most important factors underlying your plan's decision to participate in the Medicaid program?" There was consistency in their responses; sixty percent wrote of their ideological commitment to providing managed care to Medicaid beneficiaries as a quality alternative to general Medicaid.

Attachment 1

Distribution of Respondents Across States[1]



[1] Shaded areas mare the 18 states in which responding GHAA member plans with Medicaid contracts are located: California, Florida, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Washington and Wisconsin.

GROUP HEALTH ASSOCIATION OF AMERICA, INC.,
Washington, DC., August 1990.

HMO PARTICIPATION IN THE MEDICAID PROGRAM

AN ASSESSMENT OF THE OBSTACLES AND RECOMMENDATIONS FOR CHANGE

Background—Medicaid and HMOs

Over time, health maintenance organizations (HMOs) have emerged as a proven mechanism for providing quality comprehensive health care at an affordable price. HMOs serve to enhance access and coordinate comprehensive care while increasing the efficiency of an often disjointed health care system.

Because of their integrated systems, HMOs can improve upon the episodic and uncoordinated method in which many Medicaid beneficiaries frequently receive medical care. The HMO emphasis on preventive services such as prenatal and well baby care, can avoid more serious and costly illness, and ultimately enhance an individual's economic productivity. This has the potential of improving quality and increasing the effectiveness of the dollars spent within the Medicaid program.

In an era of continuing health care inflation, HMOs also offer government a proven mechanism for encouraging access to quality care at a reasonable price. In many states, the greater efficiency of the HMO system can result in savings to the Medicaid program. Even in states where current fee-for-service Medicaid provider payments are so low that reasonable capitation rates may not result in direct dollar savings to the Medicaid program, HMOs still offer the potential of longer range savings and better control over the escalating costs of health care.

Unfortunately, a variety of obstacles limit the effective involvement of HMOs in the Medicaid program. According to the Health Care Finance Administration, HMOs enrolled about 850,000 Medicaid beneficiaries in 1988—which represents less than five percent of the total Medicaid enrollment. Although 127 HMOs were involved in the Medicaid program, they represent only about a quarter of all HMOs. HMOs are located in almost every state, but only 28 states involved HMOs in their Medicaid programs.

The Special Challenge of Medicaid Participation

There are two fundamental problems with the Medicaid HMO program:

- *Marketing* is a largely individualized, hit-or-miss process, since states generally cannot provide HMOs with direct access to Medicaid beneficiary names and addresses. Incentives for enrollment are relatively weak, since HMOs cannot offer Medicaid beneficiaries the enhanced benefits or savings which have appealed to other population groups. The welfare system complicates matters further by involuntarily disenrolling Medicaid beneficiaries as soon as they lose their Medicaid eligibility, sometimes for erroneous reasons. Marketing is further complicated because unlike commercial enrollment which is annual, Medicaid enrollments are on a month to month basis. While intended as a beneficiary protection, this detracts from the ability of an HMO to plan and forecast based on a stable enrollment. It also may fail to encourage continuity of care.
- Reimbursement to HMOs for serving Medicaid beneficiaries is almost entirely at the discretion of the fifty states; the only effective restriction on Medicaid HMO capitation levels is that the states cannot pay HMOs more than the cost of serving comparable Medicaid individuals on a fee-for-Service basis. In practice, HMOs are typically paid considerably less—sometimes as much as ten percent less than the equivalent cost of serving Medicaid beneficiaries. Yet HMOs must also pay for a number of other services—including the understandably high cost of marketing, claims processing and utilization review, and general program administration—within this limited allotment, which is based on comparable *medical* expenses for the non-HMO Medicaid population.

Taken together, these factors mean that not only is it difficult to increase Medicaid enrollment; it is also hard to *maintain* current enrollment levels.

Obstacles for HMOs in the Medicaid Program

The problems confronting HMOs participating in the Medicaid program are numerous and multi-faceted:

The Complexity of HMOs and the Target population.

- HMOs are novel to many beneficiaries, since they represent a radically different approach to providing insurance and medical care simultaneously. While the concept of choice of plans is increasingly common for employed populations, it may be new to many Medicaid beneficiaries. Most people find that adjusting to an HMO requires a period of time after enrollment.
- Medicaid beneficiaries typically have not had any experience with HMOs in the past. Like anyone else, the Medicaid beneficiary tends to favor the known and understandable over the unknown and complicated.
- In many areas, Medicaid beneficiaries are accustomed to a style of medical treatment very different from HMOs, meaning that HMO enrollment requires still further adjustment. For example, they are often more used to the available yet episodic care offered by hospital emergency rooms than a system of managed care with its focus on primary care.

2. *The Circumstances of Marketing.*

- Federal regulations require that state Medicaid agencies generally keep the names and addresses of Medicaid beneficiaries confidential; this requirement prevents states from disclosing Medicaid beneficiaries' names and addresses to HMOs.
- Thus, because they do not know exactly where Medicaid beneficiaries reside, HMOs in many states frequently have no alternative in their Medicaid market-

ing efforts but to blanket certain areas which are likely to have large concentrations of indigent people—and therefore Medicaid beneficiaries. They must literally market door-to-door, seeking out Medicaid beneficiaries.

- These areas are typically public housing projects or low income neighborhoods where crime and drug abuse rates are high. Recruiting and retaining marketing staff to work in these areas is difficult.
- While some states have used enrollment in welfare offices and the available Section 2175 waiver process to address these difficulties, these options have their own limitations and marketing continues to be a major barrier within the program.

3. *Disincentives and Incentives.*

HMOs wishing to attract Medicaid enrollees generally can offer few, if any, powerful incentives to persuade Medicaid beneficiaries to enroll:

- In many states, Medicaid beneficiaries have an apparent freedom of choice among medical providers which is unknown to most privately insured Americans in this era of managed care growth. Because enrolling in an HMO basically means surrendering this apparent freedom of choice and restricting oneself and one's family to a more limited group of providers, many Medicaid beneficiaries are understandably resistant to the idea of joining an HMO.
- In many states, Medicaid coverage is quite comprehensive; typically, the Medicaid program in these states does not require cost-sharing (copayments or deductibles) and includes virtually the full range of health services. Under these circumstances, HMOs can offer few if any additional health services to entice individuals covered by Medicaid to enroll.
- The factors which have made HMOs most appealing to other income groups include reduced out-of-pocket expenditures for either health insurance premiums or health care expenses. These savings are often simply not available to Medicaid beneficiaries; few if any of them share in the costs of their health care, so HMOs can offer no real financial incentives for them to enroll.
- Important features of HMO coverage such as access, personalized care, continuity of care, and prevention are largely intangible. Hence they are not persuasive as "sales features."

4. *Disenrollment-Voluntary and Involuntary.*

HMOs with Medicaid programs experience two kinds of disenrollment which are unknown to HMOs which primarily serve commercial enrollment groups:

- First of all, Medicaid beneficiaries enjoy far greater freedom to disenroll at any time than do those enrolled in HMOs through their employer; while those privately employed may usually disenroll only once a year unless they change employers, Medicaid enrollees in most states have virtually unrestricted freedom to drop HMO coverage at any time.
- Second, the welfare system, which governs Medicaid eligibility, frequently produces high rates of disenrollment as a result of loss of Medicaid eligibility; frequently, this loss of eligibility is caused by errors in eligibility determination, resulting in incorrect disenrollments.
- It is not uncommon for HMOs serving Medicaid populations to expend considerable effort merely to sustain their Medicaid enrollment levels, making it difficult to generate any increase in enrollment.

5. *State Medicaid HMO Rate-Setting.*

Federal regulations allow states extremely broad discretion in setting the rates which they offer to HMOs in the Medicaid program:

- Unlike Medicare, which employs a uniform national rate-setting methodology for participating HMOs, the Medicaid program is a crazy-quilt of varying state approaches to HMO rate-setting. Effectively, states may set HMO capitation rates at any level they like, as long as they do not exceed the cost of providing "the same services on a fee-for-service basis, to an actuarially-equivalent non-enrolled population group."
- Such a system only intensifies the budgetary pressures on states to underpay HMOs in the Medicaid program. The general inclination to hold down provider payments is reinforced by a system which imposes a ceiling on HMO payment levels, while allowing broad state discretion in rate-setting.
- Given the variation in state payment practices and data collection systems, state date-setting in this largely unstructured system is extremely variable and sometimes inequitable.

6. *Cost Pressures.*

In practice, most state Medicaid HMO capitation rates are much lower than the equivalent cost of serving Medicaid fee-for-Service patients. Many states pay HMOs as little as 90 percent of the comparable cost of serving fee-for-service patients, sometimes even less. These low payment levels produce several complications:

- Serving a population with demonstrably higher morbidity and mortality rates than the general population, HMOs must produce cost savings sufficient to beat by several percentage points states' Medicaid fee-for-service payments which have been constrained by state budgetary restrictions and consequent efforts to limit costs.
- Most states offer HMOs little or no financial support for administering the program. Thus, their limited capitation rates, based exclusively on a percentage of *medical* costs of the Medicaid fee for-service program, must also be used to pay for claims processing, utilization review, member services, provider relations, and general administrative costs, further increasing the pressure on already compressed rates.
- Within this restricted payment structure, HMOs must also finance their Medicaid marketing efforts which, for the reasons noted above, can be quite costly.
- While HMOs might ideally want to fund the available—albeit often limited—incentives to increase the attractiveness of HMO enrollment for Medicaid beneficiaries (e.g. transportation), most have virtually no financial margin from which to do so.
- In some states, there is reason to question the appropriateness of paying HMOs at less than 100 percent of the fee-for-service equivalent. Two developments may have made the 100-percent limit inappropriate. In a few states, the Medicaid HMO program is so large that the Medicaid fee-for-service sector no longer provides a reasonable basis for rate-setting because it is too small and/or unrepresentative. In other states, the state may have been so successful in its Medicaid fee-for-service budget reducing cost-containment initiatives that it is unreasonable to expect that HMOs achieve additional short run cost-savings of any significant magnitude. In such circumstances, there may even be reason for paying HMOs 100 percent of fee-for-service, and then adding allowances for administrative and marketing expenses which are not built into the rates.

7. *The Challenge of Federal/State Administration.*

HMOs face 50 different Medicaid programs since considerable discretion is allowed States implementing the program. State capabilities and commitments to an effective HMO program vary.

- This variability makes HMO involvement in the Medicaid program less attractive in some states than others. Some states—for example—have unreasonable and burdensome reporting requirements.
- Variability results in particular difficulties for nationally or regionally based plans, which have to adhere to multiple state interpretations and requirements.
- On the other hand, federal oversight of Medicaid HMO involvement has resulted in its own problems. The 2175 waiver process, for example, is complex and burdensome, lessening the interest of states in using these options. Although some recent improvements have been made, historically federal guidance and assistance to states about HMO involvement in the Medicaid program has been limited.

Recommendation

There are a number of steps which the federal government and states can take to address these difficulties and promote the involvement of HMOs in the Medicaid program.

1. *Steps Which Can Reduce Barriers to Enrollment*

- *Guaranteed Eligibility.* Extend current provisions allowing six month guaranteed eligibility beyond federally qualified HMOs and certain other select organizations to include state licensed HMOs. Guaranteed eligibility is a relatively low cost enhancement which provides a vehicle for improving continuity of care, enhancing HMO appeal, and stabilizing HMO enrollment. States should be encouraged to include this option in their programs. Any additional costs for eligibility guarantees should be separately funded by the program and not taken from the existing capitation rates for HMOs.
- *Rolling Eligibility Guarantee.* Individuals who lose and regain Medicaid eligibility within a relatively brief period of time should be automatically re-enrolled in the program option they previously selected. In addition, eligibility protection

should be provided for brief periods (e.g., 3 months) of loss of eligibility. These provisions will reduce considerably the marketing burden on plans while promoting continuity and timeliness of care.

- *Lock-in.* Extend current provisions allowing six month lock in beyond federally qualified HMOs and certain other select organizations to include state licensed HMOs. This provision encourages enrollees to consider health plan choices on a basis more similar to that of employed populations, and encourages continuity of care.
- *Freedom of Choice Waivers (2175 waivers).* The federal government should develop alternatives to the present freedom of choice waivers that are less burdensome administratively. One option is to convert these to state plan amendments, with appropriate beneficiary protection provisions. Improvements on the current process will remove some of the disincentives currently facing states considering these initiatives, while reducing the continuing administrative burden on states with ongoing programs.
- *Encouragement for More Broad Reaching Reforms.* Over time, Medicaid should aim to structure the program such that it resembles—from an enrollment perspective—employment based coverage. That is, beneficiaries should be encouraged to make an affirmative choice among a range of plan options on an annual basis and remain with the plan for a year, as with employed populations. Some consideration also might be given to developing stronger tangible incentives for beneficiaries to enroll in HMOs. This will increase the likelihood that beneficiaries are in a managed care setting and receive coordinated care. It also will reduce HMO administrative expenses and enhance the ability of HMOs to stabilize enrollment and develop appropriate provider contracts and staffing levels.
- *75/25 Rule.* Current exemptions to the 75/25 rule should be broadened to include public HMOs. Consideration also should be given for exemptions of HMOs in medically undeserved areas, with appropriate mechanisms for assuring quality and fiscal solvency. Because of the geographical distribution of Medicaid enrollment, a commercially insured population base may not be feasible for some providers heavily committed to serving the Medicaid population. While the 75/25 rule was intended to protect beneficiaries, it may have the unintended effect of reducing access to care. Modifications to the 75/25 rule respond to this dilemma while assuring that the beneficiary protections intended by the 75/25 rule are met.
- *Marketing Improvements.* States should take action to enhance the caliber of information provided beneficiaries about the HMO options and to make more efficient the enrollment process. Although confidentiality restrictions probably prohibit release of beneficiary names and addresses, states can undertake a limited number of mailings of HMO marketing and enrollment information per year. States can develop mechanisms to allow HMOs access to Medicaid eligibles in welfare offices. Better access and improved communication and coordination also can be developed between HMOs and eligibility or welfare office staff to improve their understanding of the HMO options and their ability to present these options equitably and effectively. All of these changes will reduce the need for individual marketing, particularly on a door-to-door basis in low income areas.

2. *Steps Which Can Make Rates Equitable and Attractive*

- *Actuarial Certification.* The federal government should require that Medicaid rates paid to HMOs be certified as reasonable, by an outside, independent, actuary. HMOs look to government to assure that it is a reliable business partner; rates should be based on an actuarially sound, reproducible basis.
- *Administrative Cost Allowance.* States should provide HMOs with an additional capitation allowance for administrative costs. When Medicaid beneficiaries enroll in HMOs, states are relieved of substantial utilization review and claims processing expenses, which are shifted to HMOs. The HMOs also incur marketing expenses when enrolling Medicaid beneficiaries. These costs are not reflected in the fee-for-service medical cost base.
- Alternative Rate Setting Approaches. Alternatives to fee-for-Service based rates should be explored, particularly in areas with high HMO penetration or where the fee-for-service base is inadequate or already subject to extensive cost containment. Rather than paying HMOs a percentage of fee for-service, it may be more appropriate to pay the equivalent of the full fee-for-service payment level until such time as better alternatives are developed. If alternatives to fee-for-service are developed, they should be actuarially appropriate, with reasonable increases for medical inflation.

- *Reporting Requirements.* Both federal and state government should take care to establish clear, reasonable reporting requirements for HMOs which are coordinated and consistent with those used by other payors, and are not unrealistically burdensome. HMOs are subject to a variety of regulatory requirements, as well as payor demands. The need to respond to a variety of diverse reporting requirements adds to the HMO's burden and detracts from efficiency. In addition, extensive data requirements unique to any particular payor can serve as a disincentive to participate in the program.

3. *Steps Which Can Support State Managed Care Efforts*

- *Information.* The federal government should establish a clearinghouse for information on state Medicaid experience with HMOs and managed care, including effective practices and available data. Because of the nature of the federal/state relationship, state experiences are not easily accessible beyond that state. This is inefficient since it requires each state to learn lessons already learned in other states. While each state is unique, there is now sufficient experience that a mechanism for better sharing experiences becomes invaluable. To be maximally effective, this should extend beyond lists of bibliographies or separate reports, to targeted syntheses on an issue or subject specific basis.
- *Technical Assistance.* The federal government should provide states with technical assistance in rate setting methods and other technical areas which may be beyond the capabilities of many state staffs. States vary in their sophistication and level of understanding of HMOs. Technical assistance can strengthen state efforts and enhance the quality of managed care programs undertaken.
- *State Guidance.* The federal government should give better and more effective guidance to states on waiver and other federal requirements. This can improve both the consistency and clarity of federal requirements and objectives, and the efficiency with which states can develop programs to better involve HMOs in the Medicaid program.

CONCLUSION

In light of the obstacles confronting HMOs in the Medicaid program, it is not surprising that the level of HMO participation in the program has not been higher. To enroll Medicaid beneficiaries calls for a level of commitment and a willingness to struggle against rating problems and bureaucratic impediments unknown to many HMOs.

Even HMOs which do accept Medicaid enrollees are finding that it is less and less in their interest to continue doing so. Marketing problems are endemic to the program as it is presently structured. Disenrollment rates for many HMOs are so high that marketing staff must work most of any given month simply to maintain current enrollment levels. Incentives to enroll in HMOs are relatively meaningless for most Medicaid beneficiaries. Capitation rates are often so low that they fail to make up for these problems.

Given the continued inability of government to limit cost inflation and assure access to high quality care in the Medicaid program, the reasons for greater support for Medicaid HMO enrollment are compelling. Equally compelling, however, are the reasons for HMOs to hesitate about participating in the Medicaid program until some important fundamental changes are instituted.

Without action on the part of the federal government to facilitate HMO participation, the level of participation will not rise and is bound to decline. An important opportunity for meaningful cost control without benefit curtailment will be lost. This is particularly unfortunate since HMOs provide an important vehicle for providing quality comprehensive care at an affordable price. Greater enrollment in these kinds of options ultimately will improve the continuity of care provided Medicaid beneficiaries and the effectiveness and impact of the available health dollars.

1990 MEDICAID TECHNICALS

Under the Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508), Congress agreed to several "technical amendments" that had been suggested by GHAA in our earlier testimony on Medicaid participation. These include:

- extending waivers of 75/25 composition rules to public HMOs;
- extending the 6-month minimum enrollment period option to Competitive Medical Plan (CMP) eligible organizations;
- extending the enrollment lock-in to CMP eligible organizations; and

- automatically reenrolling of individuals who lose eligibility and regain eligibility within a two month period to the HMO the individual was initially enrolled in.

COMMUNICATIONS

STATEMENT OF THE CHILDREN'S HEALTH FUND

MEDICAID MANAGED CARE

The Children's Health Fund supports the provision of primary pediatric care via mobile medical units to medically underserved children in New York City, New Jersey, Texas, Mississippi, and West Virginia, and advocates on behalf of increased access to health care for all children. Therefore, we are well aware of the need to enhance access to primary care providers, the quality of available services, continuity of care, comprehensiveness of services, and utilization of primary care providers on a regular basis. Managed care has the potential to accomplish exactly those goals for Medicaid recipients. However, unless managed care programs are carefully designed and closely monitored, they will actually impede the access to health care which they are meant to enhance.

We are particularly concerned that the Medicaid Managed Care Improvement Act of 1991 (S. 2077) would eliminate certain federal safeguards which protect the rights of Medicaid recipients and enhance the quality of services they receive.

FEDERAL WAIVER REQUIREMENT FOR MANDATORY ENROLLMENT

The elimination of "freedom of choice" waivers, under circumstances in which there are at least two plans from which to choose or one plan which incorporates at least two thirds of an area's physicians, as proposed under S. 2077, would allow states to mandate enrollment in managed care plans without prior federal approval. Such federal oversight provides important protection to Medicaid beneficiaries, the erosion of which could lead to serious health consequences for this population. The waiver process offers the federal government the opportunity to identify potential implementation problems in advance, to elicit state assurances to avoid them, and to investigate the quality and accessibility of managed care plans before Medicaid recipients can be enrolled in them on a mandatory basis. It also provides an opportunity for the inclusion of Medicaid recipients and providers in the planning process. Moreover, the waiver renewal process averts the deterioration of quality over time. Elimination of the waiver process would weaken the ability of the federal government to monitor the quality of care provided to Medicaid recipients. Such federal safeguards are critical to ensure that recipients are not mandatorily enrolled in plans which will not serve them well.

75% MEDICAID/25% PRIVATE MIX

The elimination of the federally required mix of 75% Medicaid recipients and 25% private patients enrolled in managed care plans would eliminate another quality safeguard and is unlikely to improve access to services, as there is little evidence that permitting Medicaid-only plans increases physician participation. Low Medicaid capitation rates provide a financial incentive to underserve patients which can be countered by experience in providing managed care to private patients and higher private capitation rates. In addition, the need to attract private patients, who enroll in managed care plans only by choice, is likely to improve the quality of services provided, respect shown to patients, and timeliness of appointments. The ability that states currently have to defer the mixed enrollment requirement by means of a waiver allows sufficient leeway to attract private patients slowly. Eliminating patient mix requirements altogether would jeopardize the quality of services provided to Medicaid beneficiaries.

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QUALITY ASSURANCE

The success of managed care is largely dependent upon the provision of high quality primary care services. In addition to the existing safeguards discussed above, the federal government should increase its monitoring and guidance with regard to quality assurance. Specifically, strict guidelines should be developed and enforced to monitor access to physicians (as evidenced by patient to provider ratios, geographic accessibility, availability of transportation, waiting times for appointments, and evening and weekend hours); quality of care (as evidenced by outcome measures, records of patient encounters, and compliance with programs such as EPSDT); comprehensiveness of services provided (which must be comparable to state requirements for fee-for-service Medicaid); treatment protocols; and adequacy of reimbursement rates. The federal government should also develop requirements regarding both internal and external monitoring mechanisms and reporting requirements to be included in any state plan.

PATIENT PROTECTIONS

In addition to careful monitoring of quality of services provided, the rights and freedoms of Medicaid managed care enrollees must be carefully protected. Once enrolled in a managed care plan, especially in instances of mandatory enrollment, Medicaid recipients are particularly vulnerable to neglect or mistreatment by providers. Capitation always creates a financial disincentive to providing services, since payment is made regardless of care provided. Typically, such disincentives are countered by the benefits of reducing more acute and costly care by providing adequate primary care. However, in the case of Medicaid recipients, who often lose benefits for periods of time and may not be reinstated to the same managed care plan, the incentive to provide primary care is reduced. Government oversight will need to be strengthened in order to compensate.

Moreover, managed care is not an appropriate method of delivering services to everyone. There are some families for whom managed care could actually impede access to services. Those include families with chronic health conditions or special health care needs, those who have developed an established relationship with a primary care provider, and those who are transient or homeless.

Measures must be implemented so that families for whom managed care is inappropriate will not be encouraged to enroll. Recruitment of Medicaid beneficiaries and marketing materials must be monitored. Disenrollment by families who are dissatisfied or for whom managed care becomes inappropriate must be expedited.

The federal government should develop explicit patient protections to be included in any state plan. These provisions should include exemptions for those for whom managed care is inappropriate; mechanisms for transferring from one plan to another or one provider to another; grievance procedures; disenrollment allowances; and a plan for providing emergency services. Furthermore, the federal government should develop guidelines to ensure that patients are adequately informed, prior to enrollment, regarding utilization, choice of provider, extent of benefits, access to services not included in the plan but covered by Medicaid, grievance procedures, disenrollment, physician transfer, and plan transfer options.

PROVIDER NETWORK

For low-income populations, underutilization of health care services is as great a problem as overutilization. Any federal legislation regarding Medicaid managed care must ensure that Medicaid recipients will not be turned away from providers, either because they seek care in a new neighborhood or because they seek care from a more accessible provider. To that end, a mechanism must be developed so that out-of-plan providers can be incorporated into the managed care reimbursement system. For example, designated alternative programs serving patients enrolled in other managed care plans could be permitted to directly bill Medicaid or the managed care provider for the provision of such services. States could withhold a portion of managed care payments to cover the cost of out-of-plan services. Such a mechanism would ensure that patients will not be turned away and will provide an added incentive to managed care plans to reach out to their enrollees and provide adequate primary care.

In general, providers who cannot offer the traditional managed care plan model are in danger of being shut out of areas in which Medicaid managed care is adopted. If such providers are unable to obtain a subcontract with an existing managed care plan, they would have to provide care without reimbursement. Meanwhile the state and federal government would be continuing to make per capita payments to managed care plans for services they may not be providing. Special programs designed to mitigate the barriers to access to care would be the first to be undermined. These include such valuable community resources as school-based clinics, mobile medical units, programs serving special populations (children in day care or Head Start, women and children considered at-risk, or people who are homeless), and programs offering special outreach or case management services. Nonetheless, these will remain the most accessible providers to certain populations. It is critical that all patients, especially those who are transient or at-risk of poor health outcomes, can obtain care and that the actual providers of that care can be equitably reimbursed.

CONCLUSION

Medicaid managed care could significantly enhance the quality of care available to Medicaid recipients. In order to so, federal quality assurance guidelines and monitoring will have to be strengthened. The reductions of federal and mandates and oversight proposed in S. 2077, would do just the opposite, and could undermine efforts made by states and localities to develop sound managed care programs. More significantly1 a failure by the federal government to play a major role in quality assurance and patient protection, could lead to serious deterioration of the already fragile health of our poorest citizens. We urge you to take the opportunity afforded by consideration of S. 2077 to strengthen the role of the federal government in enhancing the quality of health services accessible to Medicaid recipients.

Specifically we recommend:

1. Do not eliminate the federal waiver requirement for mandatory enrollment.
2. Do not eliminate the federal requirement that at least 25% of patients in managed care plans are private.
3. Augment federal quality assurance guidelines and requirements for state monitoring.
4. Develop specific patient safeguards to be included in any state plan.
5. Ensure that a full range of accessible health care providers is incorporated into managed care implementation programs.

STATEMENT OF THE CHILDREN'S HOSPITAL OF WISCONSIN

Mr. Chairman and Members of the Subcommittee, my name is Jon Vice and I am the President of Children's Hospital of Wisconsin (CHW) located in Milwaukee, Wisconsin. I am also a Trustee of NACHRI, the National Association of Children's Hospitals and Related Institutions.

The purpose of my testimony is to express Children's Hospital of Wisconsin's support of S. 2077—the Medicaid Managed Care Improvement Act of 1991—and to urge the Committee to include an amendment that addresses Medicaid disproportionate share hospital (DSH) payments for AFDC HMO Medicaid admissions.

CHILDREN'S HOSPITAL OF WISCONSIN

Children's Hospital of Wisconsin is the only hospital in Wisconsin dedicated solely to the care and treatment of children. Founded in 1894, Children's Hospital serves children with all types of illnesses, injuries, birth defects and other disorders throughout Wisconsin, the Upper Peninsula of Michigan and beyond.

Children's Hospital is a private, independent, not-for-profit hospital. It is a major teaching affiliate of the Medical College of Wisconsin and is associated with eight schools of nursing. In December 1988, Children's Hospital moved from its downtown Milwaukee location into its present building located on the grounds of the Milwaukee County Medical Complex. Our state-of-the-art 222 bed facility saw a record 16,243 infants, children and adolescents in 1991, and more than 68,000 children were seen in the hospital's specialty outpatient clinics. The Emergency Department/Trauma Center treated 36,708 children and performed nearly 7,000 surgical procedures.

MANAGED CARE IN WISCONSIN

Wisconsin is one of 31 states that currently participates in a Medical Assistance Health Maintenance Organization (MA/HMO) Program, providing services for approximately 122,000 AFDC recipients in Milwaukee, Dane, and Eau Claire Counties since 1984. According to the Wisconsin Department of Health and Social Services Office of Policy and Budget, the MA/HMO Program has impacted significantly on the access to services and quality of care to its participants, and on Medical Assistance costs. The net savings due to MA/HMO enrollment are approximately $9.6 million per year. While three counties participate in the MA/HMO Program, almost 95 percent of the savings are attributable to HMO enrollment in Milwaukee County due to the large number of enrollees.

MEDICAID DSH PAYMENTS FOR MEDICAID HMO ENROLLEES

There is an anomaly concerning the availability of Medicaid DSH adjustment payments for Medicaid beneficiaries enrolled in MA/HMOs that drastically reduces the effective Medicaid DSH adjustment for hospitals in certain counties. In certain areas of the state—including Milwaukee County, which accounts for a substantial portion of Wisconsin's total Medicaid payments—many Medicaid beneficiaries must be enrolled in a Medicaid HMO. Under the Wisconsin State Medicaid Plan, however, payments to hospitals by HMOs do not reflect a Medicaid DSH payment adjustment. The result of Wisconsin's policy on Medicaid DSH payments for HMO patients is that the hospitals with the largest Medicaid patient percentages in the state receive Medicaid DSH adjustment payments for only a fraction of their Medicaid patients.

For example, Wisconsin Medicaid inpatient reimbursement for Children's Hospital in 1991 totaled $15,586,745 (including 3.5% DSH) and the AFDC HMO inpatient reimbursement totaled $12,242,200, for a grand total of $27,828,945. The DSH adjustment ($527,618) only applied to the non-AFDC HMO impatient admissions. However, if Disproportionate Share was paid for AFDC HMO inpatient reimbursement, then Children's Hospital would be entitled to an additional $428,477.

Mr. Chairman, with this example noted we should not be led to believe that hospitals will automatically enter an age of eternal solvency. Hospitals will still continue to receive far less in payments as compared to their charges. For instance, HMO Medicaid charges for 1991 were $19,281,700 and payments were $12,242,200 or 63.5%. If the DSH adjustment were extended to HMO inpatient days, the rate of charges to payments would be 65.7%, or a disparity between charges and payments of 34.3%.

S. 2077 proposes to expand managed care services to Medicaid recipients, which in turn would significantly increase the number of MA/HMO patients at Children's Hospital of Wisconsin. This increase in MA/HMO patients would result in a decrease of reimbursement of disproportionate share. Therefore, Children's Hospital of Wisconsin urges the Committee to include an amendment to S. 2077 that AFDC HMO inpatient days be counted toward the Disproportionate Share Hospital (DSH) supplemental payments.

CONCLUSION

Children's Hospital of Wisconsin fully supports Senator Moynihan's initiative to expand coordinated care under the Medicaid program with one amendment: to count AFDC HMO inpatient days toward the DSH supplemental payments. With this provision, Children's Hospital will be able to work collaboratively with HMOs and the state to ensure the delivery of quality health care services to Wisconsin's children.

CLINICAL ASSOCIATES IN INTERNAL MEDICINE, LTD.,
Phoenix, Arizona, April 1, 1992.

WAYNE HOSIER,
U.S. Senate,
Committee on Finance,
Washington, DC.

Dear Sir: I am responding to the Press Release No. H-12 dated March 26, 1992 regarding Senator Riegle's hearing on Medicaid Managed Care Health Subcommittee to discuss the Moynihan-Durenberger bill, to be heard on Friday, April 10, 1992 in Room SD-215 of the Dirksen Senate Office Building.

As a physician who has been serving the indigent population in the city of Phoenix for several years, with private health insurance as well as our Medicaid program called AHCCCS, I wish to put an input as to managed care programs.

Some of the managed care programs tend to restrict the number of physicians that can participate as to specialty which, therefore, leads to a captive audience of patients having to go to certain physicians who have been delegated based on specialty as the only individuals that will serve that managed care program.

This leads frequently to an overloading of numerous patients from family practitioners to a few specialists in each specialty and results in decreased service in terms of wait for appointments as well as amount of time and energy given to the appointment that the patient has made.

Further, I vehemently object to the concept of physician capitation, in which a physician is paid a flat fee per month to see as many patients as will be referred to his specialty, or if he is in primary care, to his Intermal Medicine or Family Practice, independent of the time that he can allot to these or the amount of effort that may be required as a specialists, i.e., cardiac catheterizations, heart surgery, bronchoscopies, etc.

Over the years, it has come to my attention that numerous patients state that they have poor access to physicians who have been capitated as in many cases, that physician has little interest in seeing more patients when he is not being remunerated more than what the capitation is and will receive that capitated check independent of when he can get that patient into his schedule, which in some cases, may be a matter of weeks.

Capitated physicians frequently will not give the same degree of attention as private insurance patients who are fee-for-service and whose fees tend to sometimes stimulate them to do a more thorough study of a patient vis-a-vis invasive procedures such as cardiac catheterization, bronchoscopy, heart surgery, etc.

It is a poor system that capitates the physician in that patients frequently do not get needed attention or diagnostic procedures they deserve and more or less are placed on medications that will relieve their symptomatology and some of the physiology of their condition, but not necessarily correct it.

Accordingly, if any types of cost containment programs are initiated via managed care, it should be on the basis of fee-for-service to be negotiated and several physicians in each specialty, as well as in Family Practice and Internal Medicine.

No physician should feel that he has a lock on a specialty and, therefore, can either keep patients waiting, collect capitated fees which sometimes are several thousand dollars per month with little availability and less intensive study to a large number of patients.

Patients should have a right to choose from numerous physicians within a specialty and from primary care physicians, such that good care is accessible and fees are negotiated by the managed care program that is offered.

I have had personal problems with certain managed care programs selecting one Pulmonologist in the Phoenix area to service a hospital or a few hospitals. My referring physicians have also had difficulty, both with the personality as well as the accommodation and availability of a single specialist who offers services to a large number of patients who are kept waiting sometimes for weeks in order to have a brief appointment, many times without much of a diagnostic workup.

This has neither suited the primary care physician or the patients, and I cogently urge the Members of the Senate to carefully consider my remarks prior to determining what type of managed care should be offered to the public.

It is realized that a capitated program is probably one of the least expensive as it tends to fix expenses at a reasonable rate to a number of physicians, both primary care and specialty, and doesn't reward to these specialists any fees for having done a more indepth study of the patient, which frequently is required, sometimes at a diagnostic center and sometimes in a hospital setting.

It is my understanding we wish to decrease the cost of medical care in the United States, but not at the expense of quality, and I feel that by a negotiated fee-for-service and the managed care determining the frequency of services, and reviewing the services offered retrospectively, to assure that there has been no abuse of procedures as well as diagnostic studies, that we can effect good medical care to our population without deterring them from having appointments or having needed diagnostic procedures and surgeries.

Thank you for allowing me to present this. If I am not selected to appear before the Senate, I would at least wish these remarks to be made available to Senator Donald Riegle as well as to the remainder of the Health Subcommittee, to discuss the Moynihan-Durenberger Bill.

Respectfully yours,

DAVID C. RABINOWITZ, *D.O.*

STATEMENT OF THE COMMONWEALTH OF PENNSYLVANIA

Mr. Chairman: Thank you for the opportunity to provide comments on the "Medicaid Managed Care Improvement Act of 1991" sponsored by Senators Moynihan and Durenberger. The Commonwealth of Pennsylvania strongly supports this very important and timely legislation.

Pennsylvania, not unlike many states is caught in a "Catch-22" situation with increasing federal mandates, a "disastrous national economy," rising and uncontrollable health care costs, and significant litigation. All have contributed to an explosion of human service needs in our state.

Within the past two years, we have added more than 200,000 citizens, 13,000 per month to our medical assistance rolls. The cost to provide care for medical assistance recipients has nearly doubled. The increase in state spending alone for medical assistance has increased from $1.1 billion in fiscal year 88–89 to $2.1 billion in fiscal year 92–93. Medical assistance represents 19% of the total Commonwealth budget and approximately 43% of the Department of Public Welfare's budget. State government has become the second biggest underwriter of medical care in Pennsylvania.

Cost, however, is but one concern. Even more major than cost is the tragedy of babies dying, women going without pre-natal care, children going without immunizations and physicians refusing to accept medical assistance clients. Access to high quality health care is unobtainable for many people who in fact have medical assistance. Certain people may argue that managed care for medical assistance recipients creates or encourages a second class health care delivery system or a two-tiered system of medical care. The two tiered system of medical care already exists when people who have medical insurance, albeit Medicaid, cannot get or receive quality medical care.

Most of us are also aware of the problems of the traditional fee for service delivery system. There are little or no safeguards to protect the integrity of the health care delivery system in fee for service. There are also no incentives inherent in the fee for service system, which encourage the appropriate use of health care services. Nor are there incentives which encourage continuity of care. Health education and special health promotions are almost non-existent in the fee for service system. Yet within a coordinated care system all of these things are possible. As we struggle with issues of quality of care, how can anyone argue that a system as fragmented as the unmanaged fee for service system is a better choice than a system that at least offers the opportunity to remove the barriers that may improve health care delivery for medical assistance clients.

In Pennsylvania, we have had real success with coordinated care. We have offered Health Maintenance Organization (HMO) enrollment as an option to Medical Assistance recipients since 1976; however not until the implementation of the Health Insuring Organization (HIO) in Philadelphia, known as HealthPASS, did we begin to see any significant growth in HMO participation. An HIO is similar to an HMO in function. The primary difference is that the HIO by law cannot provide services directly. Therefore, the HIO must enter into agreements with a sufficient number of providers to ensure that recipients have-access to care. In Pennsylvania, the state Medicaid agency has regulatory oversight for the HIO.

Prior to the implementation of HealthPass in 1986, there were about 30,000 people enrolled in HMO's. Since the implementation of HealthPass, we have seen HMO enrollment increase to more than 100,000 people in Philadelphia alone, a 300% increase. We strongly believe that the implementation of HealthPass, which replaced the fee for service option in designated parts of Philadelphia, is responsible, in part, for the proliferation in HMO enrollment in Philadelphia.

Pennsylvania would like to be able to expand our highly successful HealthPass program to other areas of the state; however federal officials contend that we may not do so.

In Pennsylvania, we are taking President Bush at his word, and asking him to give us flexibility to improve our Medicaid program. We are prepared today to expand our current managed care programs, including the HealthPass program across the State; however current law prohibits us from doing so. We need help and we need it now. We strongly support the "Medicaid Managed Care Improvement Act of 1991."

First the "Medicaid Managed Care Improvement Act" allows states to establish coordinated care as a regular part of the Medicaid program. The use of coordinated care as an alternative to the fee-for-service program is viewed by Pennsylvania as an opportunity to ensure that clients have access to continuous medical care, improve the quality of medical care delivered, increase client and provider satisfaction, emphasize preventive and routine medical care while decreasing the dependency on emergency rooms, and finally to contain spiraling health care costs.

Based on a recent assessment of the HealthPass program in Philadelphia, we know that the use of emergency rooms for routine care can be reduced significantly through coordinated care plans. In Pennsylvania we project that we will spend approximately $60 million in emergency room care alone in fiscal year 1991–1992. Some portion of this $60 million will undoubtedly be spent on non-emergency care.

We also know through studies done for both the HealthPass program and the HMOs that serve our clients, that provider and client satisfaction is greater in coordinated care programs. Finally, we know that there are significant cost savings to the State and Federal governments. The savings from the HealthPass program will equal approximately $20 million during fiscal year 1991–1992.

S. 2077 would eliminate the current requirement that at least 25% of an HMOs enrollment be non-medicaid/medicare patients. This provision removes an arbitrary measure of quality and provides for specific internal and external quality assurance requirements instead. In addition, it removes for many states a barrier inherent in urban inner city neighborhoods. That is, the unavailability of both providers and commercial clients in the area to be served.

We strongly support standards of quality assurance, including standards for fiscal solvency. We should however be extremely careful here; 75/25 does not ensure fiscal solvency as some people claim. If that were the case, a number of large HMOs with 100% commercial members, who have become insolvent in recent years, should still be operating. Many of the federally and state qualified HMOs have experienced solvency problems within recent years. Therefore, rather than inadequate or arbitrary measures that do not give the protection needed, states should be allowed the flexibility of developing fiscal solvency requirements that protect funds designated to pay providers for medical care rendered to recipients. To that extent we have requirements with two of our coordinated care providers that all funds designated for provider payment be placed in escrow. In these cases, the Commonwealth has the sole authority to approve payment out of the escrow. We require our plans to have either stop-loss protection through the Department of Public Welfare or a private reinsurer. In addition, the HealthPass contractor is required to maintain unencumbered funds in the escrow to protect against administrative overruns. These arrangements, we believe, enhance protection of provider payments and as such will ensure provider participation and continued access to care. We are contemplating making these requirements mandatory for all coordinated care contractors, including state and federally qualified HMOs.

We have a number of additional requirements for our coordinated care contractors. First each of our contractors is required to have an independent assessment, conducted by an external peer review organization, annually. Each plan is required to have an internal quality assurance program that is at the very least consistent with the State Health Department's quality assurance standards. All of the HMOs conduct client satisfaction surveys and also conduct disenrollment surveys. They all have a grievance committee, and in the case of HealthPass, there is an independent complaint and grievance committee that monitors the appropriateness of the contractor's identification and resolution of complaints and grievances. In addition, clients always retain their right to appeal to the State if they have a grievance which they feel has not been adequately addressed. All of the plans have some type of hot line for enrollees. HealthPass, has separate designated toll-free lines for providers and members. In addition, HealthPass, and at least one of the HMOs, has a very sophisticated system that allows them to determine length of time it takes to answer calls, amount of time calls are on hold and number of calls waiting in queue. Translation services are available for enrollees through each of the individual plans. Finally, each plan has a quality assurance committee and several subcommittees, some which include consumers, which address standards and protocols as well as quality of care delivered.

Guaranteed eligibility is an important element of S. 2077. HMOs in our State who do not currently contract with us have identified the lack of guaranteed eligibility, coupled with a rolling eligibility provision, as a major barrier to contracting with us. S. 2077, would permit mandatory enrollment with a coordinated care plan or primary care case manager. This provision is extremely important to us. Based on our positive experience with HealthPass, we would like to implement Health Insuring Organizations across the state, where appropriate. Our experience indicates, that when you eliminate the fee-for-service option, HMO enrollment increases. In the case of South and West Philadelphia, we have made coordinated care mandatory. Client freedom of choice is maintained in their ability to select between the contracting coordinated care providers in the area. The HIO is necessary in order to include more of the difficult to manage and higher cost clients who either opt out of the HMO, do not select an HMO, or who are more difficult to manage. For example, the population enrolled in the HMOs is primarily AFDC; while the HIO has a much smaller percentage of AFDC recipients but a larger enrollment of general assistance and disabled recipients.

It should also be noted that recipients still have the freedom to choose between participating providers within the coordinated care plan network. They are free to switch providers after a designated period of time without cause to any other provider available within the plan's network. Therefore, the notion that these recipients are unmercifully left without a choice to remain with providers who mistreat them is simply wrong. Realistically speaking, freedom of choice is better guaranteed within the coordinated care environment, where there are always providers who are willing to accept them. The dual system of care exists primarily in the unmanaged, uncoordinated, fee-for-service system where many individuals with medical assistance cannot locate a provider willing to accept medical assistance for payment.

I have addressed major portions of the bill which are of substantial importance to the Commonwealth of Pennsylvania. Because of the importance of this legislation and what it would enable us to do in the area of coordinated care for our recipients, Pennsylvania wholeheartedly supports your efforts, and offers any support we can give to achieve successful passage of the bill.

Thank you again for the opportunity to comment on this proposed change which could have a monumental effect on developing a system of health care delivery for the medical assistance population which is accessible, of high quality, more satisfactory for recipients and providers, and is cost efficient as well.

Statement of the Hemophilia Association of New York and the National Transplant Support Network

This written testimony is submitted on behalf of the clients of the Hemophilia Association of New York and the National Transplant Support Network. Our organizations represents thousands of people with disabilities and chronic illnesses who require comprehensive and affordable health care to maximize functioning or stay alive. Many of the clients we represent access health care through the Medicaid system.

We strongly opposes legislation introduced by Senator Moynihan (S. 2077) which would enable states to mandate enrollment of Medicaid recipients in managed care plans without allowing freedom of choice waivers, and would eliminate the current requirement that managed care programs enroll at least 25% non-Medicaid and non-Medicare recipients.

The proposed legislation purports that "managed care represents one of the few ways that States can control costs without harming recipients" and that managed care is "needed to improve access." While cost containment is a commendable goal, managed care in fact, has been proven to increase the cost of care for the medically fragile population.

Managed care that pays providers on a per capita basis as opposed to a fee-for-service basis, creates disincentives against providing care. Additionally, in a per capita system, fees are paid regardless of whether services were provided. Paying for services not rendered would cause a further drain on the precious few Medicaid dollars currently available. We have already seen that capped payment to providers has caused a number of physicians to "walk away" from the Medicaid population. The financial risks associated with this type of system have resulted in fewer participating providers and increased disruption of existing provider/patient relationships.

The proposed legislation eliminating the 25–75% requirement (Medicaid/Medicare to private enrollees) to expand access, will not stop people "who abuse the system or overuse emergency care." Instead, those abuses will continue and we will see an increase in "Medicaid mills." Medicaid managed care demonstration plans have failed to attract new physicians, therefore expanded access seems improbable.

Existing managed care programs have often proven detrimental to the health of the chronically ill and disabled. Primary care for people with chronic disease is most effectively provided by specialists in their disease. Established, comprehensive specialty care centers for many chronic illnesses already act to coordinate over-all health care for their patients and have historically proven to be the most cost effective delivery system of health care to this population.

Primary care providers as defined by this legislation, are not trained to recognize or treat the often subtle and complex symptoms associated with these illnesses. They will be unfamiliar with conditions that can effectively be treated on an outpatient basis at relatively little cost, as opposed to more expensive in-patient treatment. Managed care by primary care practitioners may add to Medicaid costs, not help to control them. In fact, there have been cases of mis-diagnosis by managed care physicians which have led to lengthy hospitalizations and/or the death of the patient. (NYFAHC is currently opposing similar legislation in New York State and submits written statements from several organizations, detailing the negative aspects of managed care along with this testimony.)

S. 2077 allows for the relaxation of federal oversight at the very time that HCFA has undertaken studies and plans to propose *increased* quality assurance guidelines. These studies need to be reviewed and evaluated prior to eliminating freedom of choice and mixed enrollment protections.

Allowing individual states to create their own Quality Assurance Programs will cause each plan to adopt and monitor their own different standards and methods with concern to assessing quality of care. This system will only create additional, costly bureaucratic layers for which there is neither the personnel or funding and is a giant step backwards in medical care. Federal oversight and guidance will guarantee uniform standards. The federal standards must provide for adequate access to competent care and ensure that reimbursement to physicians does not create an adverse affect on recipients' access to care.

The proposed legislation requires that a group composed of state Medicaid staff, physicians and representatives from public and private HMOs make recommendations on criteria to be used. The people who will utilize the system, namely the consumer have not been included. We recommend that input from the consumer sector is vital and necessary in evaluating criteria for measuring underutilization and all other issues related to quality of care.

We appreciate the opportunity to comment on Bill S. 2077.

Attachment.

STOP THE BLEEDING

HEMOPHILIA ASSOCIATION OF NEW YORK, INC • 104 East 40th Street, Suite 506, New York, NY 10016
Tel 212 682 5510
Fax. 212 983 1114

March 30, 1992

To The Legislators of New York State

Re: "Managed Health Care"

For chronically ill people, it has been proven that "managed care" is actually inappropriate health care and has literally cost lives due to physician's lack of knowledge about a specific chronic illness and the lack of coordination of health care services.

Example 1.

A hemophilic patient with an inter-cranial bleed was treated at a managed care facility and was mis-diagnosed as having the flu. After 3 days, the patient was finally referred to and admitted by a local hospital. The lack of immediate and appropriate health care resulted in the patient's death.

Example 2.

A hemophilic patient seen at another managed care facility was diagnosed as "probably having an ulcer" and was sent home. A hemophiliac with an untreated, bleeding ulcer will bleed to death. Only by the initiation of law suit by the patient's parents, was the child able to be referred for appropriate care.

Primary care for people with chronic disease is most effectively provided by specialists in their disease. Existing comprehensive specialty care centers for many chronic illnesses already act to coordinate over-all health care for their patients.

For hemophilia, the federally designated comprehensive treatment centers were shown, in the first decade of their existence, to have saved the taxpayers almost $2 billion in cost of care and other economic benefits. The proposed managed care would effectively dismantle this carefully constructed, model system, losing its proven economic and human benefits. Primary physicians would be reimbursed for unnecessary visits which serve only as a conduit to specialty care.

continued...

The effect of managed care proposals which limit number of visits and access to specialty care would be to ration patient care not on the basis of good medical practice or good economics, but on an arbitrary formula.

Our clients have consistently found enrollment in HMO's and PPO's to be a barrier to proper care. Ironically, failure to treat patients promptly and appropriately can change an easily treated medical event into a costly one, requiring hospitalization and prolonged treatment.

The current managed care proposals do not address the fact that many of these consumers have long established relationships with care providers. Will they be forced to switch primary physicians?

Will consumers be allowed to dis-enroll or switch providers?

There is no provision for geographic location, i.e. consumers in very rural areas may have to commute to larger towns and cities for health care.

There is no provision for educating the consumers as to what is or isn't appropriate care for their particular health situation.

Are referrals to specialists referrals to the consumer's current physician, or are the specialists also part of the managed care system?

Managed care is not a way of containing health costs, rather it shifts dollars from patient care to a bureaucratic structure that deprives the consumer most in need of access to care providers with special expertise. It would be most effective to spend for patient care the dollars that would be devoted to such a bureaucratic structure.

Who are the case managers, primary physicians and the specialists? What are their qualifications? Who determines if the qualifications are appropriate?

We strongly feel that managed care has not been analyzed properly and that this concept should be used as a "Quality Outcome Study" and not a legislative proposal.

Submitted by the Trustees of the Hemophilia Association of NY, Inc.

March 30, 1992

TO: LEGISLATORS, STATE OF NEW YORK
FROM: SUSAN M. DOOHA, NATIONAL TRANSPLANT SUPPORT NETWORK, NEW YORKERS FOR ACCESSIBLE HEALTH COVERAGE
RE: MANAGED CARE DEMONSTRATION PROJECT

I believe that this proposal should be opposed. It is based on the assumption that people with chronic conditions and disabilities are indiscriminate users of health care, rather than that they are attempting to responsibly manage their condition to avoid exacerbation and death. There is a further assumption that there are no managed care models for people who have chronic conditions and disabilities. This is not true. However, to my knowledge, there has been no outcome-based study of the cost-effectiveness of managed care programs for "high risk" people, i.e. those with chronic conditions or disabilities, including the medically fragile. Studies to date have mentioned our communities only as a footnote, never as the focus. To institute a managed care demonstration program at this time without appropriate parameters to define the model based on study would be extremely ill-considered. At least there should be some basis for determining the parameters of the demonstration in a way that is not intolerably vague and devoid of concern for patient rights and quality of care. A foundation study would have to be crafted with participation from the health care consumer community before a demonstration project could be responsibly undertaken.

Many proponents of managed care reflect a real concern that there is an acute care bias in the system and that patients with health conditions or disabilities receive too little attention to their primary care needs and have little coordination of care. However, here there is an emphasis on managed care as a cost-savings measure which may tend to produce incentives to deny appropriate care. This is especially troubling for our communities which represent people whose conditions may be exacerbated or who may die if not treated appropriately.

In general, the demonstration project proposal is overly vague and would have to be substantially reworked to be adequate. It has no provision for education of consumers; it has no provision for external review of quality assurance; it has no provisions for withdrawal from the program; it does not recognize that managed care may be inappropriate for some people with special care needs; it does not delineate reimbursement provisions sufficiently to ensure that there are no financial incentives to inappropriately deny care; it does not provide for who will be responsible for assuring quality of care when outside referrals are made. It does not stipulate whether enrollment is mandatory or voluntary. It does not identify which "high risk" users are targeted or why. It does not provide for exemptions based on the need to prevent a lessening of patient access to appropriate services or language barriers or lack of geographic proximity to managed care centers which are appropriate or disruption of existing relationships with primary care providers or for individuals with medically fragile conditions or who have complex medical and social problems for whom managed care programs are not equipped.

The provision requires that the corporation establish a "managed care demonstration project for <u>high risk insured individuals</u> but does not define "high risk". It does not provide for how many people would have to be enrolled. It does not provide for health care consumer representation in setting up the demonstration project. It does not provide information about targets for how many people would be enrolled. It does not provide for review of the PLANS for the managed care program prior to activating the demonstration project.

There is no definition of who can be a " provider." This may be understood in the light of the desire to see managed care as a cost-saving program as intended to ensure that internal medicine practitioners rather than specialists provide for coordination of care. This does not take into account the fact that for some patients, it MUST be a specialist who does the primary care coordination. For example, a transplant recipient's care is managed according to a carefully designed protocol that includes rigorous testing and a regimen of medications. An internal medecine practitioner will not be familiar with complex transplant related symptoms or medications. They will not be able to identify conditions that can be treated on an outpatient basis at relatively little cost as opposed to the more expensive inpatient treatment required if the problem is not correctly identified. Therefore managed care provided by primary care practitioners may lessen a patients access to appropriate services.

For example, a practitioner not familiar with transplant will not recognize lethargy and fatigue as possible symptoms of rejection of the transplanted organ. Therefore cost-effective routine treatment of rejection will be supplanted by expensive in-patient care when the rejection becomes more extreme. The outpatient treatment costs would be for laboratory services, a clinic visit each day for 4-6 consecutive days would total very little. This is substantially less expensive than the cost of inpatient treatment of a rejection episode which may require an insurer to pay substantially more. Since an episode of rejection that is untreated or not treated in a timely way, can lead to death or at least retransplantation, failure to provide access to appropriate care by assigning a care coordinator with appropriate skills can hardly be said to be cost-effective.

So, it will impose a further level of intervention based on cost, i.e. "care coordination" between individuals with health conditions and the care they need. It gives primary practitioners (not defined) the ability to deny care without ensuring that they are familiar with the conditions they are treating. There is no requirement that the primary care practitioners be knowledgeable about the conditions of the patients they treat and be able to identify a mild problem from a severe one. There is no requirement of sensitization although it has been documented that there is discrimination by practitioners against people with disabilities and certain health conditions.

There is no definition of what is the "timely" provision of care.

Choice in the context of this demonstration project is meaningless because there is no consumer education provision. It states that patients will select a primary care practitioner but does not indicate any responsibility on the part of the plan to educate the patient about the skills, experience, expertise of the various providers. And there is no provision for enabling them to change providers if the care they receive is not adequate to meet their needs or is not appropriate for them. Without information, how are the patients to know whether they will have appropriate access to services? What if the provider does not understand their condition or needs? To say that the patient may choose a provider is meaningless if they have no education about that provider or ability to change providers. The promise of choice is therefore meaningless. What if there are no designated providers available with appropriate expertise to handle the patient's needs, would the patient be exempted?

What does this provision mean by "specialty care" services?

What does "utilization review" mean? Are there penalties attached to being a high user of health care? This would tend to discriminate against people with chronic conditions. What will be the basis of the utilization review? insurance protocols? medical protocols? Will sanctions be applied if someone is found to be a high user? suppose they are high users because that is a true reflection of their medical needs.

What are the standards for judging when a referral is appropriate? Whose protocols will determine? How do we know that necessary services will not be denied?

Where a patient receives care from outside a provider's network, suppose the provider network does not include people with the experience to manage the patient's care and the care outside amounts to more than 20% of the patient's care per calendar year? Is the patient going to be denied care? Does this mean that a cancer patient can only see an oncologist 20% of the time? This is absurd, it provides an incentive to increase the number of other visits so that the relative number of visits to an oncologist would not exceed 20%.

There is a provision here which indicates that participants shall not be responsible for more than 25% of the cost of outside referred providers. This suggests that on top of co-pays for services provided by the care coordinator and primary care practitioner that there will be additional costs for outside referrals. There is no cap on what this amount could be.

Where services are contracted for outside the provider network, who is responsible for the quality of that care? Unless the coordinator/provider is responsible, then quality assurance provisions can be evaded by simply referring to a physician outside the network. What are the provisions for reimbursement for outside providers? Financial mechanisms are important as they can be sources of discrimination and denial of care.

There is no provision for client education about a grievance procedure. What is the value of a grievance procedure if no one knows how to use it? What is the value of a grievance procedure if it is not timely? What is the procedure for emergencies pending the outcome of a grievance procedure?

What information is there about the rights of patients? What standards are there for client education about these rights?

There is not adequate provision for monitoring of quality of care. Who must review and approve plans under the demonstration project for measuring quality or care and determining what protocols will be followed, what data will be collected, how the outcome of the demonstration will be measured? There are problems with the existing managed care systems reviewed by IPRO now based on failure to collect and retain appropriate data.

Most important, there is no provision for consumer input. There is no requirement that consumer representatives be involved in planning or evaluation of the demonstration project. There is no standard for determining what would make the project successful, or if it is unsuccessful, what would be done to eliminate it or to correct it. There is no end date on the project.

STATEMENT OF THE LEGAL AID SOCIETY

The Civil Division of The Legal Aid Society represents indigent persons throughout New York City in their efforts to obtain medical assistance. We are submitting this statement to express our serious concerns about Senate Bill 2077, the Medicaid Managed Care Improvement Act of 1991.

If done with care and deliberation, managed care programs for Medicaid recipients ultimately may increase access to care and enhance the quality of services received by our poorest residents. However, the drive to implement managed care in New York State appears to have a different initial motive and that is to contain Medicaid expenditures. With the pressure to balance the budget through rap id implementation of managed care programs, and with the inherent dangers of risk-based capitation arrangements with managed care providers, access to health care for the poor is in jeopardy.

Because we are gravely concerned about the consequences of hasty implementation of managed care in New York City, we urge you to consider amendments to S. 2077. First, S. 2077 should include federal safeguards to ensure that managed care plans will promote access to health care. Second, managed care programs should not be taken out of the Health Care Finance Administration ("HCFA") waiver process and mandatory managed care projects should be permitted on a demonstration basis only until there is sufficient experience data to guarantee that limitations on consumer choice will not have drastic consequences.[1] Third, the quality assurance provisions of S. 2077 should be expanded and enhanced to provide meaningful guidance to the states and to ensure comprehensive oversight of managed care providers. Fourth, federal law should continue to require that managed care programs serve a mixture of Medicaid and non-Medicaid clients.

1. MANAGED CARE PLANS MUST BE DESIGNED TO INCREASE ACCESS TO HEALTH CARE

In June of 1991, the Governor of New York State signed into law Chapter 165 of the Laws of 1991. This new law requires that the New York State Department of Social Services (NYSDSS) and local social services districts develop plans and implement managed care programs with enrollment goals of 50% of the Medicaid population by five years after a local plan is approved. Based on the number of people eligible for Medicaid in June 30, 1991, by the fifth year of this plan, almost 700,000 Medicaid recipients in New York City will be enrolled in either mandatory or voluntary managed care.

Health consumers in New York City who rely on Medicaid are deeply concerned about the rapid expansion of managed care for several reasons. First, there is a paucity of primary care doctors in low income communities and communities of color in which Medicaid recipients reside.[2] Instead of imposing conditions on provider participation that will ensure access to health care, providers courted to sign on to offer managed care to Medicaid recipients are not required to have a proven track record either as managed care providers or providers familiar with the Medicaid population. Without an adequate provider base, and subject to limitations on their ability to identify independent sources of medical care, Medicaid consumers will be shut out from receiving necessary and timely services.

Second, the New York State plan does not adequately insulate medical care providers from financial concerns when they make medical decisions for their patients. Where managed care programs are not shielded from the profit motive, there are financial disincentives against providing care.[3] In New York State these concerns

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[1] We oppose implementation of mandatory managed care programs under all circumstances. Our experience with the management and oversight of fee-for-service Medicaid confirms that the states and localities are ill-prepared to guarantee access to health care in a closed system. We fear that without some opportunity to exit from the managed care system, provider complacency will result in the wide-spread denial of necessary medical services. For all of the reasons that we believe that the waiver process is critical prior to implementation of managed care health programs, it is even more important where mandatory participation is required.

[2] *See* 1990 Primary Care report by the Community Service Society.

[3] A critical factor in the viability and effectiveness of Medicaid managed care programs studied by the Government Accounting Office ("GAO") has been the degree to which "perverse incentives" in prepaid managed care were identified. The GAO found that unless providers are insulated from economic concerns in making health care delivery decisions, prepaid managed care encourages providers to deliver fewer services, or poorer quality services, than are medically necessary. *See e.g. Managed Care: Oregon Program Appears Successful But Expansions Should be Implemented Cautiously* (GAO/T-HRD-91-48, Sept. 16, 1991); *Medicaid: Oversight of Health Maintenance Organizations in the Chicago Ares (GAO/HRD-90-81, Aug. 27, 1990; Medicaid: Early Problems in Implementing the Philadelphia HealthPass Program* (GAO/HRD-88-37, Dec. 22, 1987); *Medicaid: Lessons Learned from Arizona's Prepaid Program* (GAO/HRD-87-14, Mar. 6, 1987). Without adequate safeguards and strict oversight, scarce Medicaid dollars will be spent

are real. Due to the small and untested managed care provider base, new managed care providers will be recruited from the ranks of existing Medicaid providers, many of whom victimize Medicaid recipients in their practices by over-prescribing, mis-diagnosing and over-billing Medicaid. In New York City a real cause for concern is that "Medicaid mills" will reappear as "managed care mills." In this incarnation, instead of providing too many services, managed care programs will offer Medicaid recipients little or none of the primary and preventative care to which they are entitled.

Third, the New York State plan does not provide sufficient start-up money for the localities to guarantee that managed care programs, whether large or small, will be able to perform all the functions necessary to provide comprehensive care to Medicaid recipients.

Fourth, sufficient protections are not in place to guarantee that persons with special health care needs who have access to care from specialized care providers, such as multiple sclerosis, sickle cell, organ transplant or AIDS patients, are automatically exempted from mandatory managed care programs.

Fifth, under the New York plan, continuity of care within managed care plans is not guaranteed. Because managed care programs are being allowed to pick and choose the patient population they want to serve and the services they want to cover Medicaid recipients will not even be ensured continuity of managed care providers. For example, if a managed care program has contracted with the State to serve only general assistance recipients, a single woman will lose continuity of coverage if she becomes pregnant, has a child, or if she becomes eligible for SSI. Such a scenario is contrary to the purposes of managed care and documents the real risk of disruption and lack of access to needed care.

Many other patient protections are not in place. Providers are not being required to conform to state-wide monitoring or treatment protocols (because none have been developed) or to record comparable encounter data. Similarly with the State's emphasis on recruitment of primary care providers, little has been done to develop the large network of specialists needed for a State and City-wide managed care program.[4] Also, providers are being allowed to subcontract services for Medicaid recipients, even though this has proved problematic in other localities. Providers are not being required to enter into affiliation agreements with the local hospitals to ensure that emergency and urgent care will be provided in the most expeditious form.[5] Providers are not required to have 24 hour walk-in services, even though in New York City a vast number of Medicaid recipients have no ability to access 24 hour telephone consultations because they do not have phones.

If managed care is going to work in New York, there must be careful and deliberate planning to protect Medicaid recipients from abuse. In other parts of the country, where there has been hasty implementation of managed care, serious problems have developed. *See* n.3. Rather than permitting wholesale experimentation on Medicaid recipients, S. 2077 should include requirements that meet these concerns. Without guarantees built into the managed care system to ensure increased access to medical care, the decision to restructure fee-for-service Medicaid into a managed care system will destroy whatever safety net Medicaid now provides.

While intended to improve access to adequate medical care, S. 2077 lacks sufficient standards to accomplish this goal. It delegates to the individual managed care plans the choice of which Medicaid-funded services to cover and it does not provide for access to medically necessary non-emergency services which a participating plan chooses not to cover. It does not include adequate protection from individual physician incentives to limit care inappropriately. And it fails to recognize that additional funds are needed to cover the costs of a successful transition to managed care. Incorporating these protections is essential to insure adequate access to necessary medical care.

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to support the administrative costs of managed care instead of the health care costs for Medicaid recipients. To avoid this outcome, necessary safeguards include: limiting the financial risk of providers by excluding inpatient services, providing incentive arrangements based on the aggregate of treatment decisions made by all physicians about all patients and limiting the use of subcontractors. The protections currently provided by Section 1876(i)(8) (42 U.S.C. §1395mm(i)(8)) should be strengthened to meet these concerns.

[4] The relationship between the primary care provider and specialists is of concern to the Medicaid recipient. In choosing among managed care plans, for example, recipients in New York City have been thwarted in their ability to see medical specialists not only because of the difficulty in obtaining referrals and delays in obtaining appointments, but because specialists are often located at some distance from the neighborhood base served by the managed care provider.

[5] Nor is the State requiring that managed care plans include payments to hospitals for triage services. This is essential to guarantee that managed care patients will not be turned away from hospital emergency rooms when they have emergency or urgent medical needs.

2. RETAIN OR EXPAND THE HCFA WAIVER PROCESS

The Medicaid Act requires states to provide Medicaid recipients with the freedom to choose where and when to obtain necessary medical care. With managed care, and especially mandatory managed care, those choices are removed from the consumer. For this reason, states have been required to obtain a waiver from HCFA before introducing managed care programs. An important prerequisite for the waiver is that states include "adequate safeguards for provider participation." 42 U.S.C. s1396n(c)(2)(A). Because the freedom of choice is so fundamental to the Act, it should not be done away with lightly. Because thoughtful planning is required before implementation of managed care programs, the waiver review process serves a critical function. It is a mistake to eliminate this requirement as is proposed in S. 2077.

In New York State the HCFA waiver process may make the difference between an irrational and chaotic managed care program which will be doomed to fail and a program that will successfully achieve the goal of improving access to health care.

Under current federal law, before New York State can implement its managed care plan, the State must obtain a waiver from HCFA. The waiver process is essential if the significant problems with the New York plan are to be averted or minimized before they are implemented. With the proposed elimination of the requirement of a federal waiver, and with the very real pressures put on the State to expand managed care to contain Medicaid expenditures, New York State's managed care initiative may become a managed care fiasco.

In New York City, the waiver process has already served an important function by requiring careful advance planning before implementing managed care programs. The best example is the experience with the Southwest Brooklyn Managed Care Demonstration Project. The Brooklyn demonstration project is the first mandatory managed care project in New York City. The local social services district in New York City, the Human Resources Administration ("HRA"), worked very closely with the community in the conception, development and execution of the project. In choosing the location for the demonstration project the City undertook, with the aid of a community advisory committee, an in-depth analysis of the sufficiency of the provider base to support mandatory managed care participation.

Having identified one section of New York City that had a sufficient provider base, the City began a careful and deliberate recruitment process to expand even further the availability of providers and the managed care options for the community. This was recognized to be a necessity in light of the mandatory aspect of the plan.[6]

New York City encouraged hospitals to consult with the managed care providers to begin the process of working out the delicate but critical relationship among providers to deliver emergency care. Two of the principal health maintenance organizations relied upon in the mandatory project were firmly established in the community prior to implementation of the project. The other providers were given significant lead time to develop programs tailored to the known needs of the community.[7]

On a parallel track, the New York City Human Resources Administration has worked to develop a more comprehensive client health education and managed care enrollment system to replace the haphazard and sometimes coercive system used in other localities.[8] In the Southwest Demonstration Project, for the first time, Medicaid recipients are supposed to be provided with literature about their health care options and the methods of accessing managed care. Enrollment is supposed to occur only after the recipient has had the opportunity to meet with a designated case-

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[6] The availability of a good provider base in southwest Brooklyn is anomalous in New York City. As discussed elsewhere, perhaps the most significant problem faced by New York City in its plan to implement mandatory managed care is the lack of a sufficient provider base in most poor neighborhoods. We serve clients who reside in these underserved communities and are acutely aware of our clients' real problems in locating health care providers.

[7] Even with these laudable goals, during the course of planning, the providers and the hospitals were unable to enter into affiliation agreements which would establish lines of responsibility for treatment of emergency and urgent care cases. This was due, in part, to the failure of the State and City to develop model affiliation agreements. HCFA should require managed care providers to enter into affiliation agreements with local hospitals to ensure sufficient emergency and urgent medical care coverage for managed care recipients.

[8] Client educational materials are woefully lacking in the rest of New York City where managed care enrollment is voluntary. The most common complaint we receive from Medicaid recipients in New York City is that they were not even aware that they had signed up for a particular managed care program (often months earlier) and, consequently, were completely unfamiliar with the steps required to access care through the designated managed care program. In most instances, Medicaid recipients learn about managed care options directly from the managed care provider on a catch-as-catch-can basis. This should not be permitted to continue.

worker who is not employed by any of the managed care plans to evaluate the health care needs of family members.[9]

New York State submitted its application to HCFA for a waiver to implement the Southwest Brooklyn Managed Care Demonstration Project as a mandatory managed care program on August 15, 1991. Approval was granted in November 1991. Because of the HCFA waiver requirement, New York carefully planned its project and took steps to ensure that the planned program was adequate to serve the needs of the community. Without the waiver process and its requirement for adequate provider participation, New York and other states lack the incentive to develop and design mandatory managed care plans that will be calculated reasonably to serve the health care needs of the community.[10] In view of the widespread emphasis on managed care implementation as a health care cost savings measure, the pressures to cut corners and hastily implement ill-planned services will be enormous.

2. EXPAND QUALITY ASSURANCE PROVISIONS AND RECIPIENT PROTECTIONS IN THE DESIGN AND IMPLEMENTATION OF MANAGED CARE PROGRAMS

Because of the limited availability of medical providers in low income communities and communities of color, and because the start-up money available to new providers is inadequate, providers with little or no experience in running managed care programs will be encouraged to enter the managed care system. At the same time, because providers are scarce, the State is hesitant to impose too many obligations on the providers. Consequently, the State will be unable to ensure the maintenance of quality standards and reasonable, timely access to medical services. Nor will the State be able to guarantee that providers will be insulated from economic concerns when making health care delivery decisions. Senate Bill 2077 should be amended to detail the range and scope of quality assurance required of managed care programs, and the minimum standards of adequate medical care delivery.

Currently, HCFA mandates that States ensure that localities require individual managed care providers to develop internal quality assurance mechanisms. This chain of delegation is frighteningly long, and places full responsibility for maintaining adequate health care on the parties least experienced in monitoring health care quality, and most biased in the analysis. Instead, HCFA should be charged with the responsibility to do three things: first, HCFA should develop *internal* auditing and monitoring standards as required components of a state's plan;[11] second, HCFA should require all state plans to include a comprehensive *external* monitoring component for all managed care programs;[12] and third, HCFA should spell out the patient protections and provider mandates required of each state's managed care plan. The resources necessary to develop, implement and monitor on an on-going basis all managed care programs within a locality are an essential feature of a managed care plan. If sufficient monies are not allocated for these purposes the plan should be rejected at the time of the request for a waiver.

This proposal is not made in the abstract. In New York State, the managed care plan includes insufficient additional resources (of either staff or money) to develop a state-wide managed care monitoring plan or to survey the quality of the large number of managed care programs to be started within the next five years. The State plan does not set forth minimum standards for timeliness of appointments, treatment and referrals. It does not include standard treatment protocols even where there is national consensus on a course of treatment for certain conditions. New York State's Department of Health is already overburdened and cannot meet its monitoring obligations for state hospital facilities. It will not be able to survey even a small number of the managed care providers state-wide. The cost of oversight is not insignificant, but it must be included in development of a state's plan

[9] The plan to educate Medicaid consumers in the demonstration project is only partially in place. Client materials have not yet been developed. Health care educators who speak only English in a heavily Latino, Asian and Russian community undermine the effectiveness of the health education process. And coercion in the enrollment process has not entirely been eliminated, even during the voluntary phase of enrollment, because that the State has imposed utilization thresholds and other restrictions on Medicaid coverage for Medicaid recipients who are not enrolled in managed care programs.

[10] Significantly, because federal waivers must be renewed every few years, states will also be precluded from downgrading the quality and protections of the approved managed care plan. Without continuing federal oversight, there is real concern in New York State that capitation fees used to entice managed care participation will be reduced some years into the plan, thereby reducing the quality and accessibility of services.

[11] At the very least, HCFA should require the States to develop internal auditing mechanisms which will be required of all plans within the state.

[12] Currently, only health maintenance organizations must, under federal law, be subjected to external auditing.

or the Medicaid recipient will experience that cost by being denied access to necessary care.[13]

Similarly, the New York State plan does not clearly spell out recipient protections which should be guaranteed under managed care. These include: liberal exemption and transfer procedures from one managed care plan to another and from one provider to another within a given plan; grievance procedures; and access to emergency care services.

4. ENSURE PAYOR MIX IN MEDICAID QUALIFIED HMO'S

Under Medicare, reimbursement for HMO coverage is made only where patients' enrolled in the HMO include at least 50 percent commercially insured participants. Under federal regulations, Medicaid qualified HMO's need only ensure that 25 percent of the participants are commercially insured. S. 2077 seeks to eliminate even this requirement.

The requirement of a payor mix in HMO's is an important protection for Medicaid patients, especially in the context of a mandatory managed care program. Locked into a particular provider network, the Medicaid consumer is extremely vulnerable to abuses by the managed care provider. These abuses can include significant delay in the delivery of services, the outright refusal to provide services or impediments to access to emergency care. The presence of paying consumers ensures that the provider will make greater efforts to maintain higher standards of practice, including timely appointments and respect for patients.

In conclusion, we urge modification of S. 2077 to strengthen the guarantees of consumer access to adequate health care through Medicaid managed care programs. Thank you for considering our comments.

LEGAL SERVICES FOR THE ELDERLY,
New York, NY, April 23, 1992.

Senator DONALD W. RIEGLE, JR., *Chairman,*
Subcommittee on Health for Families and the Uninsured,
U.S. Senate,
Committee on Finance,
Washington, DC.

RE: Hearing Friday April 10, 1992, S. 2077 Medicaid Managed Care Improvement Act of 1991

Honorable Senator Riegle: Legal Services for the Elderly advocates on behalf of indigent elderly New Yorkers for decent health care through Medicaid, Medicare and other government-funded programs. Many of our clients are frail and homebound. Many live with serious disabilities or chronic or deteriorating conditions. We are extremely concerned that a hastily designed and implemented managed care program will have a devastating impact on our elderly clients' access to health care. For this reason, we respectfully oppose Senate Bill 2077, which would exempt managed care from the HCFA waiver process, and from the amount, duration and scope and enrollment mix requirements of the Medicaid Act.

We fully support the thorough comments of The Legal Aid Society of New York City, sent to you by letter dated April 23, 1992, and urge you to consider them carefully. In addition, the proposed exemption of managed care from the federal waiver process and other proposed changes are of special concern for the elderly poor. While the New York legislature drafted and debated the bill establishing the managed care program, now codified in Social Services Law section 364–j, in 1991, we strongly opposed making the program mandatory rather than voluntary, at least for the elderly, blind and disabled. We also urged that numerous protections be included. A copy of our analysis of the then-proposed law, as well as our comments on the subsequently promulgated state regulations, are attached.

In the end, most of our concerns were rejected by the state legislature. The law was made mandatory for all Medicaid recipients, providing very limited exemptions. It fails to include such basic components as the right to a fair hearing. It allows speedy implementation of the program without prior testing of the numerous new computer systems and procedures necessary for enrollment and quality assurance,

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[13] Nor does it appear that New York City has allocated adequate start-up funds to implement managed care programs. The New York City Council Finance Division has questioned whether the funds available in New York City for fiscal year 1993 "are sufficient to support the costs associated with developing a quality (managed care) program." New York City Council Comment on the Mayor's Preliminary Fiscal 1993 Budget and Financial Plan, March 25, 1992, p.26.

and without adequate guarantees that the network of physicians will be large enough to treat patients without delay and difficult travel.

With every branch of state and local government under pressure to meet the statutory deadlines for enrolling thousands of recipients, we are very concerned that dangerous shortcuts will be taken and critical safeguards omitted. Already we were told that the state Department of Health is not adding any new staff, let alone the dozens of persons necessary to carry out effective quality assurance and surveillance. **The federal waiver application and review process provides an absolutely critical objective review by an outside entity, which is not subject to the internal political pressures inherent in state and local government.**

It is bad enough that New York City and other localities must accomplish the daunting task of complex and sophisticated program design and implementation with little guidance from either the legislature or the state agencies, which are also hampered by inadequate resources and time pressure. We urge Congress not to deprive elderly and other poor New Yorkers of the critical oversight provided by HCFA through the waiver process, and of the protection of the federal Medicaid standards for enrollment mix and amount, duration and scope of services. We also endorse the recommendation of The Legal Aid Society that Congress enact more quality assurance and other federal safeguards to ensure that access to care is enhanced, rather than hindered by managed care.

Thank you for your consideration.

Very truly yours,

VALERIE J. BOGART.

STATEMENT OF THE MERCY HEALTH PLAN, PHILADELPHIA, PA

We are grateful for the opportunity to submit written testimony in support of S. 2077, the "Medicaid Managed Care Improvement Act of 1991."

MERCY HEALTH PLAN

Mercy Health Plan is a nine-year-old managed care organization that currently serves 57,000 Medicaid recipients in Southeastern Pennsylvania, including Philadelphia. Because we do not meet the 75–25 requirement, we serve as a sub-contractor to a licensed HMO. While we may not actually be a licensed HMO, we function in a manner identical to one.

OUR MISSION

Mercy Health Plan's mission is to care for the poor. We define "poor" as those who are Medicaid recipients, and we provide care specially tailored to their needs. Our plan does not enroll non-Medicaid clients. The plan we have developed to care for Medicaid recipients acknowledges that while all people need the same kind of health care, one type of health care plan is not necessarily appropriate for everyone.

THE "75–25" RULE: BAD MEDICINE FOR MEDICAID RECIPIENTS

Mercy Health Plan supports the provision of S. 2077 that would eliminate the so-called "75–25" rule. The idea behind the 75–25 requirement was that the presence of commercial clients would ensure quality care for Medicaid recipients. In theory, a plan would be required to provide the same services to Medicaid members that they provided to commercial members and could not provide separate, "inferior" services to Medicaid patients.

While the quality of health care services must be the same for both the Medicaid and the commercial population, the approach to providing that care to the Medicaid population is different than that necessary for the commercial population.

Nine years of experience have taught us that caring for Medicaid recipients does indeed require special effort and additional services. In the commercial population, the biggest medical problems are heart disease and cancer. Because of this, commercial plans develop "healthy lifestyles" programs, teach people how to eat properly and exercise, and devote considerable resources to cancer screenings and other such programs.

Within the Medicaid population served by Mercy Health Plan, however, the biggest problems are high infant mortality and drug and alcohol abuse. Fighting these problems takes very special, highly targeted steps—steps we take because the Medicaid population is the only population we serve.

Consider our efforts on behalf of women and infants. In the general population, the infant mortality rate is roughly seven percent. Among the urban poor that our plan serves, the infant mortality rate is twenty-two percent—three times as high. To address this significant problem, Mercy Health Plan introduced a perinatal risk reduction program called "WeeCare."

WeeCare is truly comprehensive. It begins with "case-finding"—going out into the community to find our pregnant members. We then make sure they get prenatal care by helping them find an obstetrician and making an appointment. We make sure they keep that appointment, providing bus fare or helping them find a baby-sitter if necessary.

We also create a social support system for these women. A perinatal care nurse meets with a woman's obstetrician to learn about any special problems or needs. That nurse then goes to the home of the pregnant woman to discuss all instructions and to make sure they are truly understood. That nurse returns periodically to ensure that everything is all right We also employ social workers to help with other problems that may arise during pregnancy. Many of the pregnant women we serve know little about pregnancy and childbirth. They need a great deal of education, and we provide it.

WeeCare offers additional support services when complications arise during pregnancy. Consider, for example, the problems that arise when a single mother is identified as high risk during her sixth month and is told that bed rest will be required for the rest of her pregnancy. We provide a housekeeper to take care of the apartment and look after the children. This investment of $40 a day, we have found, can save thousands of dollars a day in neonatal intensive care unit expenses. This approach works. In the first year of WeeCare, our perinatal risk reduction program cut the infant mortality rate in half within the population we serve.

Another area in which we have developed services to meet the needs of our special clientele is immunizations. In the general population, about ninety percent of the population receives its childhood immunizations at the appropriate time. Within the Medicaid population, the compliance rate is less than half of that—about forty percent.

Correcting this problem requires education, outreach, and a commitment of resources. Mercy Health Plan is making that commitment in a new pilot project to promote immunizations. Our social workers visit new mothers, explain the importance of immunizations, and make appointments for immunizations. Then, we follow up and make sure that they keep those appointments. While we only recently started this program, our initial results are extremely encouraging. Within the small group with which we are working, we have raised the immunization rate to over ninety percent—the same rate as in the population as a whole.

We can develop such effective approaches because we understand the people we serve. We spend our time, our talent, and our creativity serving the Medicaid population, and we support dropping the 75–25 rule and freeing others to employ the same single-minded approach to serving their Medicaid clients that we do.

QUALITY ASSURANCE

Mercy Health Plan is also pleased to see the enhancement of Quality Assurance as part of S. 2077. There is no Quality Assurance in the fee-for-service Medicaid program, and that program suffers considerably as a result. In contrast, we work hard to review the work of our participating providers, and we work equally hard with those providers to improve their outcomes. In fact, Mercy Health Plan's Quality Assurance standards are more stringent than those currently required by the federal government.

An important part of Quality Assurance is the discretion we exercise in allowing providers to join our plan. Not every physician who wishes to participate in Mercy Health Plan is allowed to do so. Our credentialing committee reviews the qualifications of every physician who seeks to join our plan. We evaluate every applicant's qualifications; check their references; review malpractice histories; and examine their work performance through the National Practitioners Data Bank.

We perform intensive utilization review on inpatient care. We refer members to individual physicians rather than hospitals, ensuring that one physician, not a large, unaccountable team, provides the care. At the same time, we employ safeguards to ensure that there is no cutting of corners on care and no under-utilization of services.

Mercy Health Plan employs a rigorous Quality Assurance Program. This program is overseen by our Health Services Department and administered by a special Quality Assurance Committee. We establish standards for all inpatient and outpatient medical care and continually review all services provided, with a particular focus on those services that are performed most often and entail the greatest medical risk. Aggregate data on quality care is prepared monthly by our Health Services Department and then reviewed by our Senior Management Committee. Issues requiring medical judgment are referred to our medical director or the Quality Assurance Committee. We audit individual cases, providing a further vehicle for uncovering potential problems. When problems are identified, the associate director of our Health Services Department works directly with the provider to ensure that any necessary improvements are implemented immediately.

Our members, too, have an important role in Quality Assurance. Our formal grievance procedure—provided, in writing, to all members when they enroll—gives all members an opportunity to seek redress for problems they believe they have encountered in dealing with our plan. People with grievances may present their problems directly to our grievance committee and may bring a spokesperson if they wish. Minutes of the proceedings are available to all affected parties, decisions are made within thirty days, and those decisions may be appealed through a process that ultimately leads to the Pennsylvania Department of Public Welfare.

Together, these procedures ensure that Mercy Health Plan provides the best, most appropriate care it can to its members at all time. We develop rigorous standards of performance, monitor and audit that performance closely, and invite our members, the beneficiaries of our activities, to help us in that process.

ADDITIONAL SERVICES

Because we focus on just the Medicaid population, we feel we are attuned to that population's needs and can develop benefit packages that better meet those needs. Our benefits, for example, include eyeglasses and dental services in some provider categories where they are not already mandated.

We also have a twenty-four-hours-a-day hotline for members to call if they have a medical problem. If a parent is awakened in the middle of the night by a sick baby, she might not be able to tell if the problem is severe enough to require a trip to the emergency room. With our hotline, a nurse can ask questions about the baby's condition and determine the proper course of action. If the nurse determines that the mother should take the baby to the emergency room, we might help the mother determine what bus to take. If the problem is severe enough, we call for an ambulance ourselves. This type of service is unique to a Medicaid HMO, as are some of the services described previously, such as transportation assistance, day care, and homemakers.

PROVIDER REIMBURSEMENT

These and other programs can be very resource-intensive and expensive, but providing care the way we do costs less than providing care through a fee-for-service system because our system better manages use of services.

Mercy Health Plan's financial arrangements are typical of those for Medicaid managed care providers and indicative of managed care's extraordinary potential as a means of serving the Medicaid population in a more cost-effective manner. We receive between ninety-two and ninety-five percent of the reimbursement that Medicaid fee-for-service providers receive. This means there is an inherent cost savings in our program for the taxpayers.

We can provide our care for less money because of several efficiencies built into our program—and built into all managed care programs.

- First, we eliminate the financial incentives providers have to over-prescribe medical services. Under the fee-for-service system, the more care a doctor provides, the more money that doctor receives. In managed care plans, we pay our primary care physicians on a capitated basis—that is, they receive a specific amount of money every month for every patient in their care, regardless of how little or how much care they provide.
- Second, we make cost a consideration in the purchase of services.
- Third, by building our system around primary care providers, we reduce reliance on expensive hospital emergency rooms as the traditional health care provider of choice within the Medicaid population.

The cost savings generated by these steps are so substantial that our plan, despite receiving less money from the state Medicaid program than the fee-for-service system, can actually pay our providers are money for the care they provide.

One of the keys to our ability to control our costs is our focus on preventive care. We work hard to ensure that our expectant mothers take their pregnancies to full term and deliver healthy babies of a normal birth weight. That saves an enormous amount of money and more than compensates for the extra resources we devote to making that result possible.

The hallmark of managed care is coordination of care. When people are assigned to a single physician, they get continuity of care. They see the same doctor every time they have a problem, and that doctor gets to know them and their needs. Fee-for-service patients, on the other hand, typically head straight to the hospital emergency room every time they have a problem. There, they receive extremely expensive treatment for their immediate problem and are discharged. If there is an underlying problem, however, the emergency room is about the last place you want to go.

Consider, for example, an emergency room-related problem we encounter fairly often. A person suddenly develops a problem breathing and goes to a hospital emergency room. There, the physician accurately identifies the problem as an asthma attack, provides treatment, and the patient home. This happens periodically to the same person and occasionally results in a two- or three-day stay in a hospital. In contrast, when patients have a primary care physician, they can be put on a prescribed maintenance routine. In our plan, we even send outreach workers to the homes of people with asthma to discuss their do so in a the importance of adhering to the prescribed routine. Thus, even though the patient may have more frequent contact with the health care system, we keep the cost of care down through more appropriate contact and by avoiding the expensive emergency room and hospitalization.

We also work hard to eliminate abuse in the prescription of drugs. In the fee-for-service system, patients go from doctor to doctor, obtain duplicate prescriptions, and sometimes sell their drugs on the street. In our plan, only authorized physicians prescribe medication. Our on-line pharmaceutical review program calls our attention to any patients that manage to get duplicate prescriptions. This stops people from defrauding our plan and the entire Medicaid system. It also keeps our costs low without sacrificing either quality or access.

CONCLUSION

Managed care has a great deal to offer our Medicaid population and our country. Such plans can provide better, more appropriate services that truly meet the needs of the Medicaid population; they can do so in an efficient, cost-effective manner, thereby helping to control rising health care costs; and they can fulfill both of these goals without compromising quality or reducing access to care.

For too long, federal legislation has effectively tied the hands of those of us who wish to provide managed care plans for Medicaid recipients. This legislation attempts to loosen those restraints while proposing important steps that ensure that as we employ innovative managed care among larger portions of the Medicaid population, we do so in a caring, effective manner; that we never sacrifice quality for our bottom line; and that we never lose sight of the special needs of the people we have been chosen to serve.

For these reasons, Mercy Health Plan urges the Senate Finance Committee to support S. 2077, the Medicaid Managed Care Improvement Act of 1991.

STATEMENT OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, INC.

NACHRI—the National Association of Children's Hospitals and Related Institutions—is pleased to submit this statement for the printed record of the April 10, 1992, hearing by the Senate Finance Subcommittee on Health for Families and the Uninsured regarding "Medicaid Managed Care."

Any change in federal Medicaid policy has the potential to have a disproportionate impact on children to their advantage or detriment, since children represent nearly 50% of all recipients of Medicaid assistance. If implemented with sensitivity to the special health care needs of children and financial requirements of providers of care to children, "coordinated" or "managed care" offers the promise of increasing meaningful access to appropriate health care for the more than 10 million children—nearly one out of every six children in the United States—who now rely on Medicaid for access to health care.

With this statement, NACHRI encourages the Subcommittee on Health for Families and the Uninsured, and the Finance Committee, to consider three sets of "special protections" to ensure that managed care fulfills its promise for children who are assisted by Medicaid.

BACKGROUND

NACHRI is the only national, voluntary association of children's hospitals. It represents more than 100 institutions in the United States, including freestanding, acute care children's hospitals; pediatric departments of major medical centers; and specialty hospitals, such as pediatric rehabilitation and chronic care facilities. Virtually all of the children's hospitals are teaching hospitals and research centers, and many function as regional referral centers for specialized care. Virtually all children's hospitals are major providers of care to children under Medicaid. On average, a children's hospital devotes 40% of its care to children assisted by Medicaid.

While they are best known as tertiary level hospitals providing highly specialized care for very sick, disabled, or injured children, children's hospitals also are major providers of outpatient care, including primary, emergency, and specialty care in ambulatory settings. Indeed, the children's hospital often functions as the primary care pediatrician for low income children living in the surrounding neighborhood, as well as the specialized hospital caring for children with acute and chronic care conditions throughout the region.

As a result of their missions of service to children, children's hospitals embody many of the principles underpinning managed care. Because it is in the best interests of a child's developmental as well as physical well-being, physicians associated with children's hospitals seek to avoid hospitalization, whenever medically possible. Because they specialize in the care of children who often have very challenging conditions, children's hospitals emphasize the importance of coordination of care among medical and social service specialists to ensure the child receives only the most appropriate and effective delivery of care. Because they see in their emergency rooms the consequences of the inability of families to obtain primary and preventive care for their children, children's hospitals have become major proponents of primary care, both in organizing primary care clinics and in advocating preventive care in their communities.

In addition, a growing number of children's hospitals across the nation have direct experience with capitated managed care by virtue of their caring for children enrolled in both public and private managed care programs. Their experience suggests that before Congress were to expand Medicaid managed care, consideration should be given to three sets of "protections" for children and their providers of care:

- protections for children, including children with special health care needs;
- protections for the financial health and programmatic integrity of both managed care programs and providers;
- protections for children's hospitals as unite providers of highly specialized care.

PROTECTIONS FOR CHILDREN

Benefits for Children.—In expanding managed care for recipients of Medicaid assistance, Congress should preserve the right of children under Medicaid to all services essential to children. These should include not only pediatricians, pediatric subspecialists, and pediatric inpatient care, but also Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits; in particular, the 1989 federal requirement that Medicaid must cover all medically necessary care prescribed for a child as a result of an EPSDT screen. In addition, Congress should ensure—as it already has done for young children receiving inpatient care in disproportionate share hospitals—that medically necessary care for children is not subject to arbitrary limits, such as limits on length of hospital stay which do not take into account the needs of the child.

Children with Social Health Care Needs.—Congress should take specific steps to protect access to appropriate health care for the most vulnerable children under Medicaid—children with "special health care needs" served by targeted state programs such as the State of Texas' Chronically Ill and Disabled Children's Program or the California Children's Services program. They include children with conditions such as cystic fibrosis, spina bifida, cerebral palsy, and cancer. These children require highly specialized services, often provided by regional care facilities with the ability to coordinate multi-specialty services in one place tailored to each child's unique and complex needs. Even their primary care requires management by a specialist, because their underlying condition can profoundly affect all of their other health care needs.

Congress should distinguish this population of children with special health care needs from the overall Medicaid population enrolled in capitated managed care for two purposes. Federal policy should ensure that they receive the coordination of care by specialists they require, including referrals only to qualified providers as defined by state programs for children with special health care needs and case management by physicians and nurses with expertise in the treatment of rare or complex pediatric conditions. Federal policy also should ensure rates of reimbursement—either by separately determined capitated rates or fee-for-service schedules—sufficient to meet the financial requirements of the specialized care these children require.

Monitoring Children's Health Care.—Congress should require that Medicaid managed care entities maintain records and report on services and evaluations performed for each child, including well-child care and immunizations, according to standards developed by the American Academy of Pediatrics. Such reporting requirements should be accompanied by active monitoring, with implementation of incentives and disincentives to discourage delay or under-utilization of necessary and essential services. Record keeping and state monitoring of service utilization are essential to fulfilling both the benefits of preventive care and children's need for continuity of care.

PROTECTIONS FOR FINANCIAL HEALTH AND PROGRAMMATIC INTEGRITY

Financial Health of the Managed Care Entity.—Congress must establish standards that will ensure the fiscal health and solvency of the managed care entity. Children's hospitals have found that unless they are held financially accountable to rules ensuring their solvency, managed care entities—even those fulfilling the promise of managed care—can put in jeopardy children and their providers of care if these entities fail financially. In addition to requiring that managed care entities be capable of assuming the financial risk of capitated arrangements and assuring uninterrupted service, Congress also should ensure that the state Medicaid program will bear the financial responsibility in the case of a managed care entity's default. The risk of insolvency of managed care entities cannot be borne by health care providers already caring for enrolled patients at often significant financial discount. Similarly, Medicaid managed care entities should have to comply with standards such as those now in effect under Medicare for physician incentive plans which discourage the shifting of substantial financial risk to individual or small groups of physicians, with whom the entity subcontracts.

Programmatic Integrity of the Managed Care Entity.—The promise of managed care is critically dependent on the proven experience of the managed care entity with the delivery of health care and its ongoing accountability for quality of care and patient satisfaction. Congress should require, in conjunction with expanded managed care under Medicaid, a quality assurance system, with review of service utilization, standards of care, and patient as well as provider satisfaction.

Financial Health of Providers of Care Under Managed Care.—Medicaid is widely recognized to reimburse providers of care substantially below the cost of care. Unless state payments to Medicaid managed care programs and their payments in turn to health care providers are held accountable to the requirements of the Boren Amendment for reimbursement of the costs of efficiently and economically delivered care, providers serving large numbers of Medicaid recipients could be placed in serious financial jeopardy. In addition, Congress should ensure that managed care inpatient days qualify for purposes of states determining hospitals' qualification for disproportionate share (DSH) status. Congress also should ensure that states continue to provide DSH payment adjustments—either through direct state payment of the adjustments to hospitals or through modified state capitated rates to the managed care entities coupled with DSH payment requirements.

Choice.—One of the most important determinants of both the financial health and programmatic integrity of private managed care is the stimulus of free market competition created by subscribers who can choose among a variety of both fee for service providers and managed care programs. If federal policy cannot replicate such choice, at a minimum Congress should ensure the benefits of the market place for mandated managed care under Medicaid by requiring that Medicaid recipients have a choice of two or more managed care entities, which may be either experienced capitated plans or provider networks. If Medicaid recipients are given the choice of only a single plan, it must encompass all area providers desiring to participate and all minimum essential services for children and pregnant women, with no fewer than two-thirds of the area physicians serving this population participating.

PROTECTIONS FOR CHILDREN'S HOSPITALS

Protections Against Exclusion. Children's hospitals provide highly specialized and coordinated care, often involving teams of several different specialists to meet the health care needs of an individual patient. This coordination of health and social services within a single entity is the essence of what managed care is intended to achieve. In many communities, managed care recognizes the importance of inclusion of appropriate pediatric providers and subspecialists, but in some, children's hospitals find themselves or their affiliated physicians excluded from a managed care program because of unacceptably low contract payment rates—regardless of the condition of the patient or the ability of the hospital to meet best a child's special health care needs. Such exclusions have troubling implications for children's access to care, given the fact that children's hospitals currently are major providers of care to children under Medicaid. In ensuring that Medicaid managed care entities provide all essential services, Congress should require the inclusion of children's hospitals willing to accept payment rates that meet minimum standards, such as rates comparable to what the state's Medicaid program otherwise would pay for patients not enrolled in managed care or what the state's program of services for children with special health care needs would pay. In either case, the payment rates should include disproportionate share payment adjustments.

Opportunity to Be the Managed Care Entity.—Children's hospitals are highly sophisticated providers of not only acute and tertiary level care but also primary and ambulatory care, including, in some instances, the development and implementation of capitated managed care programs. Congress should ensure that the opportunity exists, under Medicaid managed care, for participation of a pediatric provider network serving only or predominantly children, administered by providers or their administrative entity. Such pediatric managed care would have to meet all of the requirements for Medicaid managed care entities in terms of subscriber choice as well as scope, continuity, and accessibility of services for children but not services for other populations.

CONCLUSION

Please call upon NACHRI if we might be of assistance to the subcommittee in developing further any of these proposed protections for children. including patients of children's hospitals, in advancing Medicaid managed care.

NATIONAL MULTIPLE SCLEROSIS SOCIETY,
New York, NY, April 23, 1992.

Senator DANIEL PATRICK MOYNIHAN,
Russell Senate Office Building Room 464,
Washington, DC.

Re: S. 2077 Medicaid Managed Care Improvement Act of 1991

Dear Senator Moynihan: We are writing on behalf of the New York City Chapter of the National Multiple Sclerosis Society to express our serious concerns about the potential impact of Senate Bill 2077 on Medicaid recipients with multiple sclerosis (MS) and other individuals with special needs.

We have reviewed in draft the comments of The Civil Division of the Legal Aid Society of New York City and the comments of the National Health Law Program, Inc (NHELP). We agree with the points raised by these organizations but are additionally concerned that mandatory managed care will not serve the needs of individuals with medical conditions requiring special expertise. Our statement will focus solely on this issue.

Multiple sclerosis is a chronic disease of the central nervous system for which there is no known cause or cure. In MS the myelin sheath that surrounds nerve fibers in the brain and spinal cord becomes damaged, causing the formation of sclerosed or hardened patches of scar tissue.

Symptoms of MS vary greatly depending upon where the sclerosed patches occur. They may include tingling sensations, numbness, slurred speech, blurred or double vision, muscle weakness, poor coordination, unusual fatigue, muscle cramps, spasms, problems with bladder, bowel and sexual function, and paralysis. There may be mental and emotional changes as well. These symptoms may occur in any combination and can vary from very mild to very severe. The typical pattern is marked by periods of active disease called exacerbations and quiescent periods called remissions. Other people may experience a chronic, progressive form of the disease.

MS is difficult to detect or diagnose because early symptoms are spotty, other neurological conditions have similar symptoms, and there is still no definitive test to confirm or rule out MS, although MRIs (magnetic resonance imaging) help clarify diagnosis.

It is also not easy to treat. Although MS cannot be cured, skilled medical providers can administer treatment that may control or alleviate some symptoms of the disease. For example, there are medications which can provide symptomatic relief for acute attacks. Muscle relaxers specific to MS aid in reducing spasms. There are therapeutic strategies for easing bowel and urinary distress. Physical and/or occupational therapy can help people remain independent.

A comprehensive system of care, under the direction of a physician knowledgeable about the unique suggestions of this neurological disorder, is crucial to keeping people with MS as healthy as possible and in the community. Not only is it better for the patient, care coordinated by a neurologist who specializes in MS saves Medicaid money in the long run by minimizing symptomatology.

It is our experience that skilled care for a complex disease like MS is not readily available, even if you have your choice of doctor and the ability to pay privately. Not all neurologists are MS-literate or up-to-date on treatment strategies or even knowledgeable in the ways to handle manifestations of the disease, such as bladder and bowel problems or extreme spasticity. Recognizing the crying need of our members to find adequate care for their disease and committed to the concept of a comprehensive care system, the New York City Chapter helps support six MS clinics in the five boroughs of Manhattan. Each accepts Medicaid patients. There patients receive a comprehensive range of managed coordinated care aimed at minimizing symptoms and maximizing potential. The freedom to choose care at such a comprehensive center is a basic health care right regardless of the an individual's source of payment. Senate bill 2077's Medicaid managed care proposal will restrict such access to specialized, comprehensive care.

Don't turn back the clock by foreclosing Medicaid recipients from adequate care for multiple sclerosis. Amend your bill so that Medicaid patients are guaranteed referral and access to the medical specialists who are the most capable of handling the complexities of diagnosis such as MS.

Very truly yours,

MARGARET DOMANSKI, *A.C.S.W., Director of Chapter Services.*

ANNE DAVIS, ESQ., *Director of Legal Services.*

MICHELE MADONNA, *R.N., M.A., Director of Clinical & Educational Services.*

STATEMENT OF THE PRIMECARE HEALTH PLAN, INC.

Mr. Chairman and Members of the Subcommittee, my name is Larry Rambo and I am the President and Chief Executive Officer of PrimeCare Health Plan, a Health Maintenance Organization (HMO) based in Milwaukee, Wisconsin.

PrimeCare strongly supports S. 2077—the Medicaid Managed Care Act of 1991—which seeks to expand coordinated care services under the Medicaid program. However, S. 2077 must include an amendment that states that federally matched Medicaid funds must not be used for non-Medicaid purposes.

PRIMECARE, INC.

PrimeCare Health Plan is a network model HMO which was established in 1983. PrimeCare was acquired by Heritage Health Systems, Inc. in June 1986, and in the process converted to a for-profit corporation. In 1990, PrimeCare was acquired by United HealthCare Corporation, and since January 1991, PrimeCare is the largest HMO in the state of Wisconsin, with approximately 157,500 enrollees. PrimeCare is also a major provider for Medicaid recipients, with more than 57,000 (35%) beneficiaries.

PrimeCare became the first HMO in Wisconsin to receive regulatory approval to market a Point-of-Service HMO/Indemnity product in 1990. As of July, 1991, approximately 30% of the total commercial enrollment is in a point-of-service product. PrimeCare's parent company, United HealthCare Corporation, is a national leader in health care cost management, serving both providers and purchasers of health care since 1974. The company's services, available to PrimeCare beneficiaries, include HMOs, PPOs, multiple option and point-of-service plans, pharmaceutical cost management, managed mental health and substance abuse services, utilization management, workers compensation/casualty services, specialized provider networks, employee assistance services, Medicare and managed care programs for the aged, health care evaluation services, information systems and administrative services. As of February, 1992, United's total health plan enrollments were 1,602,900 and enrollments in total specialty companies were 15,568,000.

MANAGED CARE IN WISCONSIN

Wisconsin is one of 31 states that currently participates in a Medical Assistance Health Maintenance Organization (MA/HMO) Program, providing services for approximately 122,000 AFDC recipients in Milwaukee, Dane, and Eau Claire Counties since 1984. According to a recently published report by the Wisconsin Department of Health and Social Services Office of Policy and Budget entitled "An Evaluation of the Medicaid Health Maintenance Organization Program," the MA/HMO Program has impacted significantly on Medical Assistance costs and the access to services and quality of care to its participants.

The net savings due to MA/HMO enrollment are approximately $9.6 million per year. While three counties participate in the MA/HMO Program, almost 95 percent of the savings are attributable to HMO enrollment in Milwaukee County due to the large number of enrollees.

The state's evaluation found that the utilization of hospital services whether measured by admission, inpatient days of care or length of stay all showed a decline in use. "Patient days per 1,000 enrollees dropped by 53 percent from levels that existed prior to HMO enrollment (i.e., fee-for-service) in 1983 in Milwaukee and Dane counties." There was a 30 percent decline in admissions and the average length of hospital stay declined by 33 percent (about two days).

HEALTH INSURANCE RISK SHARING PLAN (HIRSP)

The State of Wisconsin Office of Insurance Commissioner has established the Health Insurance Risk Sharing Plan (HIRSP) to assist individuals who do not have access to private health insurance. Deficits in the program are to be funded by health insurance companies in Wisconsin based on their premium.

PrimeCare believes the assessment should be on commercial premiums and not revenues received to provide services to Medicaid recipients. In essence, the State is forcing us to take federally matched funds designated for the Medicaid program and divert them to a program not eligible for matching funds. The cost to PrimeCare was $350,000 in 1991 and is estimated to be $500,000 in 1992 from our Medical Assistance revenues.

S. 2077 proposes to expand coordinated care services under Medicaid which will increase the number of AFDC HMO enrollees in PrimeCare and other HMOs throughout the state. In essence, the HIRSP assessment on PrimeCare's premium will increase substantially each year, clearly reducing our ability to provide services to the people these funds were intended to benefit. Moreover, the HIRSP assessment is a disincentive for HMOs to be established and to accept contracts involving Medicaid beneficiaries.

CONCLUSION

PrimeCare believes that providing managed care to Medicaid beneficiaries serves as a quality alternative to Medicaid. PrimeCare wholeheartedly supports Senator Moynihan's initiative to expand coordinated care through the Medicaid program with an amendment that federally matched Medicaid funds cannot be used for non-Medicaid purposes.

STATEMENT OF THE SINAI SAMARITAN MEDICAL CENTER

Mr. Chairman and Members of this Committee, I am William Jenkins, President of Sinai Samaritan Medical Center located in Milwaukee, Wisconsin. I would like to take this opportunity to express Sinai Samaritan's support for S. 2077, the Medicaid Managed Care Improvement Act of 1991, and request that an amendment be included that would provide for a disproportionate share hospital payment for AFDC HMO inpatient days.

SINAI SAMARITAN MEDICAL CENTER—AURORA HEALTH CARE

Sinai Samaritan Medical Center is an affiliate of Aurora Health Care, a regional not-for-profit health care system comprised of two major medical centers, a comprehensive home care organization, and 15 ambulatory care facilities. Aurora Health Care provides more health care services to the people of Southeastern Wisconsin than any other provider.

Aurora Health Care's integration as a system began in June of 1984 with the affiliation between St. Luke's Medical Center (founded in 1903) and Good Samaritan Medical Center (formerly Lutheran Hospital and Deaconess Hospital, founded in 1863 and 1910, respectively). In 1987, Mount Sinai Medical Center (founded in 1903) became part of Aurora Health Care. While Aurora Health Care is less than a decade old as a system, its history in Southeast Wisconsin actually dates back more than 125 years.

Sinai Samaritan Medical Center is now the last remaining hospital in downtown Milwaukee. Over the last seven years, five acute care facilities have closed in downtown Milwaukee, eliminating more than 1000 beds. From data we have gathered, we believe that Milwaukee is now the largest city in the United States with just one hospital left in its downtown. Therefore, the financial viability of this institution is an absolute necessity to the residents of this city.

Sinai Samaritan has done a great deal to contain costs while still maintaining the highest quality of care for its patients. In 1990, Sinai Samaritan ranked second in total patient admissions among acute care hospitals in southeastern Wisconsin with more than 21,000 patient admissions. Today, Sinai Samaritan clearly illustrates the serious challenges facing urban health care providers:

- 75% of Sinai Samaritan's inpatient admissions are Medicare, Medicaid or Medicaid-HMO cases, the costs of which are significantly under-reimbursed by the government.
- Births at Sinai Samaritan continue to rise year after year. In 1990, Sinai Samaritan ranked first among southeastern Wisconsin hospitals for number of deliveries with more than 5,200 births. Teen pregnancy and pre-natal drug abuse are resulting in hundreds of low birth weight infants and ever increasing admissions to the neonatal intensive care unit.
- The Medical Center's emergency department and outpatient clinics are the points of access for growing numbers of poor and elderly patients with complex needs. Sinai Samaritan also operates the only emergency department in the central city, last year providing nearly 60,000 visits.

The financial burden on Sinai Samaritan Medical Center is overwhelming. Among the Milwaukee area acute care hospitals, Sinai Samaritan Medical Center's share of total Medicaid patient discharges is 53.6%. The Milwaukee County Medical Complex and Children's Hospital of Wisconsin follow with 9.6% and 7.6%, respectively.

MANAGED CARE IN WISCONSIN

Wisconsin is one of 31 states that currently participates in a Medical Assistance Health Maintenance Organization (MA/HMO) Program, providing services for approximately 122,000 AFDC recipients in Milwaukee, Dane, and Eau Claire Counties since 1984. According to the Wisconsin Department of Health and Social Services Office of Policy and Budget, the MA/HMO Program has impacted significantly on the access to services and quality of care to its participants, and on Medical Assistance costs. The net savings due to MA/HMO enrollment are approximately $9.6 million per year. While three counties participate in the MA/HMO Program, almost 95 percent of the savings are attributable to HMO enrollment in Milwaukee County due to the large number of enrollees.

MEDICAID DSH PAYMENTS FOR MEDICAID HMO ENROLLEES

There is an anomaly concerning the availability of Medicaid DSH adjustment payments for Medicaid beneficiaries enrolled in MA/HMOs that drastically reduces the effective Medicaid DSH adjustment for hospitals in certain counties. In certain areas of the state—including Milwaukee County, which accounts for a substantial portion of Wisconsin's total Medicaid payments—many Medicaid beneficiaries must be enrolled in a Medicaid HMO. Under the Wisconsin State Medicaid Plan, however, payments to hospitals by HMOs do not reflect a Medicaid DSH payment adjustment. The result of Wisconsin's policy on Medicaid DSH payments for HMO patients is that the hospitals with the largest Medicaid patient percentages in the state receive Medicaid DSH adjustment payments for only a fraction of their Medicaid patients.

Mr. Chairman, although I believe this proposal would be a helpful one if amended properly, it should be noted that hospitals will not receive a financial windfall from its passage. For example, in 1991, Sinai Samaritan had non-HMO Medicaid total charges of $20,834,347 and payments of $10,328,732 representing 49.6% of total charges. The DSH adjustment increases the percentage of actual payment to 56.7%. In that same year, Sinai Samaritan experienced HMO inpatient total charges of $32,443,183 and payments of $20,089,372 totaling 61.9% of charges. Extending the DSH adjustment to hospitals for their HMO inpatient services would allow us to capture an additional $883,536, thereby reducing our shortfall between charges and payments to 35.4% versus 38.1%. Thus, hospitals will continue to experience an alarming disparity between actual charges and payments, but they will be far less burdensome.

Sinai Samaritan Medical Center urges the Committee to include an amendment to S. 2077 that AFDC 10 inpatient days be counted toward the Disproportionate Share Hospital (DSH) supplemental payments.

CONCLUSION

Sinai Samaritan Medical Center fully supports Senator Moynihan's initiative to expand coordinated care under the Medicaid program with one amendment: to count AFDC HMO inpatient days toward the DSH supplemental payments. With this provision, Sinai Samaritan will be able to work collaboratively with HMOs and the state to ensure the delivery of quality health care services to Wisconsin's Medicaid beneficiaries.

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